

Board of Directors Meeting (to be held in PUBLIC)

Tuesday, 2 July 2019 at 1pm in the Boardroom

Murray Building, James Cook University Hospital

		Enclosure	Led By	
1. Opening Items				
1.1	Welcome and Apologies for Absence (<i>information</i>)	<i>Verbal</i>	Chairman	
1.2	Board Declarations of Interest Register (<i>information/approval</i>) (Any new conflict of interest and any actual or potential conflict of interest in relation to any matter to be discussed)	<i>Verbal</i>	Chairman	
1.3	Minutes of Previous Meeting (approval)		Chairman	
1.4	Matters Arising (<i>discussion/information/approval</i>)	<i>Verbal</i>	Chairman	
1.5	Action Log (<i>information</i>)		Chairman	
1.6	Patient/Staff Story	<i>Presentation</i>	Director of Nursing and Quality	
1.7	Chairman's Report (<i>discussion/information</i>)	<i>Verbal</i>	Chairman	
1.8	Chief Executive's Report (<i>discussion/information</i>)	<i>Verbal</i>	Chief Executive	
2. Strategy and Planning				
2.1	Strategic Issues Affecting the Trust and Wider Health Economy update (<i>discussion</i>)	<i>Verbal</i>	Chief Executive/Chairman	1.45
2.2	Friarage Hospital Northallerton update (<i>discussion</i>)	<i>Verbal</i>	Deputy Chief Executive	
2.3	Staff Engagement and Corporate Culture (<i>discussion/information</i>)	<i>Verbal</i>	Chief Executive/Chairman	
3. Quality, Safety, Performance and Finance				
3.1	Quality, Safety, Performance and Finance Exception Report (<i>discussion/information/approval</i>)		Deputy Chief Executive/ Director of Nursing and Quality/ Medical Directors/ Director of Finance	2.25
3.2	Healthcare-associated Infection Monthly Report (<i>information/approval</i>)		Director of Nursing and Quality	2.55
3.2.1	Annual Healthcare-associated Infection Report (<i>information</i>)			
3.3	Safe Staffing Monthly Report (<i>discussion/information</i>) - including safe staffing in Critical Care		Director of Nursing and Quality	3.10
3.4	Learning from Deaths Q1 Report 2019-20		Medical Director	3.15

(discussion/information/**approval**)

4. Governance/Assurance				
4.1	Visits, Accreditations and Inspections (<i>discussion/information</i>) - CQC Inspection	<i>Verbal</i>	Chairman/ Chief Executive	3.25
4.2	Compliance with CNST Standards Update (<i>discussion</i>)		Medical Director	3.35
4.3	Chair's Logs from Board Committee Meetings (<i>discussion/information/action</i>)		Committee Chairs	3.40
4.3.1	Finance and Investment Committee – 13 June 2019	<i>Verbal</i>		
4.3.2	Risk Committee – 13 June 2019			
4.3.3	Quality Assurance Committee – 25 June 2019			
5. Closing Items				
5.1	Any Other Business	<i>Verbal</i>	Chairman	4.00
5.2	<i>Risks</i> <i>Any Risks discussed during meeting for consideration of adding to Risk Registers or Board Assurance Framework</i> (<i>discussion/approval</i>)	<i>Verbal</i>	Chairman	
5.3	Evaluation of Meeting (<i>discussion</i>)	<i>Verbal</i>	Chairman	
5.4	Date and Time of Next Meeting (<i>information</i>) The next meeting is scheduled to take place on Tuesday, 3 September 2019 (<i>information</i>)			

Board of Directors Meeting (held in PUBLIC)
held on 7 May 2019
Boardroom, Murray Building, James Cook University Hospital

Present:

Alan Downey	Chairman
Amanda Hullick	Deputy Chair
Maureen Rutter	Non-executive Director/Senior Independent Director
Mike Ducker	Non-executive Director
Richard Carter-Ferris	Non- executive Director
David Heslop	Non-executive Director
Debbie Reape	Non-executive Director
Siobhan McArdle	Chief Executive
Adrian Clements	Deputy Chief Executive and Medical Director (Urgent and Emergency Care & Friarage)
David Chadwick	Medical Director (Planned and Specialist Care)
Gill Hunt	Director of Nursing and Quality
Steven Mason	Director of Finance
Sath Nag	Medical Director (Community Care)
Andrew Owens	Medical Director (Corporate Clinical Support Services)

In attendance:

Helen Edwards	Director of Communications
Lynn Hughes	Company Secretary
Plym Auty	Elected Governor (Hambleton and Richmondshire)
Chloe Fairbarns	Consultant Anaesthetist
Tony Roberts	Deputy Director for Clinical Effectiveness (<i>item BoD/02/19/16 only</i>)
Helen Rogers-Shaw	Johnson and Johnson Medical
Christopher Selt	Registrar
Angela Seward	Lead Governor (Elected Governor for Rest of England)
Roagah Shafer	Staff Side Chair

BoD/05/19/01 Apologies for Absence

1.1 Apologies for absence were received from Siobhan McArdle, Chief Executive.

BoD/05/19/02 Declaration of Interests

2.1 The updated Register of Board member's interests was received and noted.

2.2 The Chairman asked Directors to declare any interest relevant to their role as members of the Board of Directors and, in particular, relevant to any matter to be discussed at the meeting. None were declared.

BoD/05/19/03 Minutes of Previous Meeting

3.1 **Resolved:** the minutes of the previous meeting held on 5 February 2019 were accepted as a true record.

BoD/05/19/04 Matters Arising

4.1 There were no matters arising in addition to those included on the agenda.

BoD/05/19/05 Action Log

5.1 The two actions were discussed in turn:

BoD/02/19/11.4 Communication and Engagement Strategy - it was noted that the strategy was planned to be presented to the Council of Governors at its next meeting and following that metrics would be developed and shared with the Board. It was agreed that the metrics would be presented to the Board by the September 2019 Board meeting.

BoDC/02/19/21.1 Evaluation of Meeting (Clinical Intelligence Unit) - it was noted that the Meridian system had gone live which will be used to support the work of the Clinical Intelligence Unit going forward. It was agreed to close this action.

BoD/05/19/06 Patient/Staff Story

6.1

Gill Hunt provided an update on the tepee which had arrived at the James Cook hospital site on 20 March 2019. She reported that the tepee had been a huge success to date with 6765 visits by patients and their families, carers and staff. Gill explained that users of the tepee are encouraged to complete a postcard to share their experience with the Trust. Gill then shared a number patient and staff experiences with the Board which demonstrated how well the tepee had been received. She explained that there had been a range of positive media coverage on the tepee by BBC Tees, the Gazette and ITV Tyne Tees.

6.2 **Resolved:** the patient/staff story was well received by the Board.

BoD/05/19/07 Chairman's Report

7.1

The Chairman gave a verbal update report which highlighted the following matters:

2019 Nightingale Awards

He was pleased to report on the Trust's second nursing and midwifery Nightingale Awards which were held on 3 May 2019 which had been a huge success with over 200 nominations received with 19 winners announced.

Maureen Rutter highlighted the success of the event and encouraged the Board to consider extending to all staff groups.

North Yorkshire County Council Richmond area constituency meeting

Adrian Clements and James Dunbar, Clinical Director for the Friarage hospital attended the North Yorkshire County Council Richmond area constituency meeting to update members on the urgent temporary change to the Friarage. They also provided an update on performance and data since the temporary changes had been put in place.

Care Quality Commission Inspection

The Trust was in receipt of a draft report from the Care Quality Commission (CQC) following their recent inspection. It was noted the Trust has the opportunity to consider the report and respond on any factual inaccuracies.

Smokefree Campaign

The Trust's campaign to become 'smokefree' was launched in the first week of April 2019 and work continued to implement the Trust's smokefree policy.

Media Coverage

Media coverage during April 2019 was reported with reference drawn to media coverage on the urgent temporary changes to the services at the Friarage, and twins who made history at James Cook, both undergoing scoliosis surgery in the same week.

Governor Elections

The election campaign to fill the six governor vacancies had commenced with elections due to close on 28 May 2019.

7.2 **Resolved:** the Chairman's report was noted.

BoD/05/19/08 Chief Executive's Report

8.1 Adrian Clements confirmed that the Chief Executive's update report had been covered by the Chairman in BoD/05/19/07 above.

BoD/05/19/09 Strategic Issues Affecting the Trust and Wider Health Economy

9.1 The Chief Executive provided an update on the ongoing work chaired by Sir Ian Carruthers. The plans to reconfigure acute services across the Tees Valley were well advanced and plans would be presented to the Boards of the three Trusts (South Tees, North Tees and County Durham & Darlington) by the end of February 2019.

9.2 **Resolved:** the update on Strategic Issues Affecting the Trust and Wider Health Economy was noted.

BoD/05/19/10 Friarage Hospital Northallerton Update

10.1 Adrian Clements provided an update on performance since the urgent temporary change had been put in place to the period ending 21 April 2019. He confirmed that there had been no patient safety issues to report during that timeframe. Work continued at the Trust to monitor the activity and provide regular updates to the Senior Leadership Team and the Medical Director at NHS England. In addition to that the Trust held weekly operational meetings with the Yorkshire Ambulance service.

10.2 In response to the Chairman's query it was noted that representatives from the Trust attend the monthly local authority Scrutiny of Health meetings to provide update reports.

10.3 **Resolved:** the Friarage Hospital Northallerton Update report was noted.

BoD/05/19/11 Quality, Safety, Performance and Finance Assurance Report

11.1 The Quality, Safety, Performance and Finance report was discussed drawing attention to the following:

11.1.1 Adrian Clements was pleased to report achievement of the Accident and Emergency 4-hour performance (95.96% against the 95% target) for March 2019 but he explained that April had proved to be much more challenging.

11.1.2 David Chadwick reported on the Referral to Treatment (RTT) March 2019 performance against the 18-week standard as 89.04% which was below the 92% target. He explained work continued to improve RTT performance with a number of workstreams in place, including waiting list management which initiated discussion around the processes in place. Maureen Rogers highlighted that performance issues against the RTT target had been the topic at the Trust for a number of years and the Board agreed that it supported Operational Management Board in its current workplans with the aim of making the continued improvements to the quality of patient care whilst working to meet early diagnosis as outlined in the NHS 10 Year Long Term Plan.

11.1.3 Performance against the cancer 62-day standard was reported at 75.10%

below the 85% target. David Chadwick reported that work continued to improve performance which initiated a detailed discussion with Non-executive Directors seeking assurance on performance going forward. David Chadwick explained that an increase in demand had been noted together with a number of workforce issues which had a negative impact on progress made against the performance improvement plan. The Board noted that the Trust continued to perform well against all other cancer targets.

11.2 With regards to Healthcare Associated Infection, Gill Hunt reported that the Trust had 41 Trust apportioned cases which was below the 54 year end threshold which she would discuss further on the agenda. She also reported that in relation to safer care the Trust had seen a 11.7% decrease in falls in comparison to the same period in 2017/18. An increase in the number of pressure ulcers has resulted in a deep dive exercise taking place which had been discussed at the Quality Assurance Committee in April 2019. The Quality Assurance Committee had requested that the pressure ulcer risk is added to the Board Assurance Framework.

11.3 Adrian Clements reported that there had been a marginal improvement made during the month against the sickness absence target. He explained work continued to improve the SDR and mandatory training performance against the set targets. Maureen Rutter referred to the Trust's staff survey results and the need to improve the quality of SDRs carried out at the Trust to support and develop the Trust's workforce.

11.4 Financial performance as at 31 March 2019 was noted as £2m better than plan which the Board were pleased to note. As a result of that the Trust was awaiting confirmation from NHSE/I on the amount of PSF funding it would receive for meeting the control total. Discussion then took place around the letter received from NHSE/I on the limited amount of capital available across the NHS and the implications that could have on capital investment and replacement of medical equipment plans at the Trust.

11.5 **Resolved:** the Quality, Safety, Performance and Finance Assurance Report as at 31 March 2019 was noted.

BoD/05/19/12 Healthcare Associated Infection Report

12.1 Gill Hunt spoke to the report for the month ending 31 March 2019. She explained that the Trust's *Clostridium difficile*-associated diarrhoea objective for 2018/19 was to have no more than 54 trust-apportioned cases among patients aged over 2 years. One trust-apportioned case was reported in March 2019 which resulted in a total of 41 trust-apportioned cases up to the year end as at 31 March 2019 which the Board were pleased to note.

12.2 It was noted that there had been no Trust-assigned cases of MRSA bacteraemia in March 2019, with only one Trust-apportioned case for the full year. She reminded the Board that there was no official MSSA bacteraemia target and four trust-apportioned cases were reported in March 2019 which resulted in a total of 42 trust-apportioned cases for the full year.

12.3 Gill Hunt reported that since the new national reporting changes had come into effect regional Trusts had seen an increase in the number of cases reported.

12.4 **Resolved:** the Board noted the year-end position and the actions taken to support the actions being taken to manage Healthcare Associated Infection at the Trust.

BoD/05/19/13 Safe Staffing Report

- 13.1 Gill Hunt presented the monthly Safe Staffing report which included Registered Nurses (RN), Midwives (RM) and Health Care Support Workers (HCSW), levels of acuity against the dependency needs of patients across the Trust which is to ensure there is an appropriate level and skill mix of staff to provide safe and effective high quality care.
- 13.2 She explained that from April 2019 all staffing reports presented to the Board must comply with NHSI Workforce Safeguards which are required to include a signed declaration by the Director of Nursing or appropriate Director for the staff group(s).
- 13.3 The Board noted the fill rate against the planned rosters for March 2019 which included an overall level of:
- RN/RM day shift 92.8%, night shift 94.2%
 - HCSW day shift 91.2%, night shift 106.6%
- 13.3 Gill Hunt reported that since the last Board meeting she had met with Maureen Rutter and Debbie Reape to discuss safe staffing to look at any improvements that could be made going forward. She explained that an annual review was planned to be carried out which would compare the Trust against the national benchmark. The outcome of the annual review was planned to be presented to a future Board meeting.
- 13.5 In response to Debbie Reape's query Gill Hunt explained that there were a number of vacancies on ward 34 which are being monitored closely at all times with staff reallocated from other areas of the Trust to provide support if required.
- 13.6 **Resolved:** the Staff Staffing report was noted.

BoD/05/19/14 Learning from Deaths Quarterly Report

- 14.1 Andrew Owens spoke to the Quarter four report.
- 14.2 It was noted that numbers are reported separately for patients with learning disabilities and known mental health issues. For the year to the end of March 2019, 1,847 deaths were recorded, of which 1,347 had received a review or investigation and seven deaths were considered to be potentially avoidable. For patients with a mental health issue, 132 were identified of which 30 have been reviewed, with 0 deaths considered potentially avoidable. Potential learning from both good care and from problems in care were discussed and noted.
- 14.3 Andrew Owens referred to the mortality indicator dashboard and explained that the dashboard included the number deaths from April 2008 to March 2019. There were 160 deaths recorded in March 2019 (*this was in comparison to 161 deaths recorded in the same period in 2018; and 179 deaths recorded in the same period in March 2017*).
- 14.4 The Board were reminded that the Summary Hospital-level Mortality Indicator (SHMI) includes all in-hospital deaths plus deaths within 30 days of discharge. It is published on a quarterly basis (*including 12 months of data in each release*) by NHS Digital and is an official government statistic. The current report covers January 2018 - December 2018 and the comorbidity score for the Trust and England is shown in quarters from January 2015 to September 2018 which showed a static coding level for the Trust with a higher and rising rate for England. The chart for Palliative Care Coding for January 2016 to March 2019

showed that the number of cases with the relevant codes is static or falling slightly at the Trust.

- 14.5 **Resolved:** the Board noted the Trust will continue to monitor and learn from deaths data and respond accordingly.

BoD/05/19/15 Visits, Accreditations and Inspections

- 15.1 It was noted that this item had been covered in the Chairman's report.

BoD/05/19/16 Human Trafficking and Modern Slavery Act Commitments

- 16.1 It was noted that Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

- 16.2 The aim of this statement was to demonstrate the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

- 16.3 The Board of Directors considered and approved the statement of compliance for the financial year ended 31 March 2019 and the Trust's plans in place to continue to support the requirements of the legislation.

- 16.4 Steven Mason agreed to check that the required assurance had been received from the Head on Procurement and the Director of Human Resource prior to the statement being uploaded on the Trust's website. **ACTION (S Mason)**

- 16.5 **Resolved:** the Board approved the statement of compliance for the financial year ended 31 March 2019 and the Trust's plans in place to continue to support the requirements of the legislation.

BoD/05/19/17 Chairs' logs from Board Committee meetings

17.1 Audit Committee

The Chair's log from the Audit Committee meeting held on 23 April 2019 was noted. Richard Carter-Ferris, Audit Committee explained it had agreed the following items would be escalated to the Board:

- two high risks had been reported by PwC the Trust's internal auditors following their audits on ICT which Kevin Oxley was leading;
- there had been non-completion of two audits reported in relation to medical staffing;
- Steven Mason had been asked to arrange for all SLT Audit Leads to be invited to future Audit Committee meetings for any audits that included high risk recommendations

- 17.2 **Resolved:** the Audit Committee Chair's log from the 23 April 2019 meeting and escalated items were noted.

BoD/05/19/18 Finance and Investment Committee

18.1

The Chair's log from the Finance and Investment Committee meeting held on 25 April 2019 was noted. Mike Ducker, Chair of the Finance and Investment Committee explained it had agreed the following items would be escalated to the Board:

- Serious concern was raised regarding the Trust's capital spend allocation for 2019/20 (*the Trust is awaiting a response from its application for emergency capital submitted to NHSE/I*), and the Trust's

- EPR project funding also which also requires urgent consideration;
- Concern was raised over the large efficiency programme (2019/20) to hit the Control Total, and the high reliance on regional systems improvements to deliver that.

18.2 **Resolved:** the Finance and Investment Committee Chair's log from the 25 April 2019 meeting and escalated items were noted.

BoD/05/19/19 Workforce Committee

19.1 The Chair's log from the Workforce Committee meeting held on 25 April 2019 was noted. Amanda Hullick, Chair of the Workforce Committee explained it had agreed the following items would be escalated to the Board:

- NHSI will assess Trust's compliance with Workforce Safeguarding Standards which will cover all clinical staff and the Director of Nursing planned to confirm on a monthly basis to the Board in a statement that she is satisfied with the outcome of any assessment that staffing is safe, effective and sustainable;
- the Radiologist workforce risk raised was agreed would be added to the BAF.

19.2 **Resolved:** the Workforce Committee Chair's log from the 25 April 2019 meeting and escalated items were noted.

BoD/05/19/20 Operational Management Board

20.1 The Chair's log from the Operational Management Board Committee meeting held on 25 April 2019 was noted. Adrian Clements explained it had agreed the following item would be escalated to the Board: Critical Care risk to be added to the Board Assurance Framework following sign off by the Trust's risk process.

20.2 **Resolved:** the Operational Management Board Chair's log from the 25 April 2019 meeting and the escalate item was noted.

BoD/05/19/21 Quality Assurance Committee

21.1 The Chair's log from the Quality Assurance Committee meeting held on 30 April 2019 was noted. Maureen Rutter, Chair of the Quality Assurance Committee explained it had agreed the following would be escalated to the Board:

- Two new risks would be added to the Board Assurance Framework:
1. lack of capital to replace and provide medical equipment could have a negative impact on quality and patient safety; and
 2. pressure ulcer concern to be added to risk 2.1

21.2 **Resolved:** the Quality Assurance Committee Chair's log from the 30 April 2019 meeting and escalated items were noted.

BoD/05/19/22 Any Other Business

22.1 There was no other business.

BoD/05/19/23 Risks

23.1 There was a discussion on the risks which had been raised throughout the meeting which had also been discussed at reporting Committees to the Board. The Board noted that these risks would be added to the Board Assurance Framework.

BoD/05/19/24 Evaluation of Meeting

24.1

It was noted that the meeting had covered a wide range of issues, including strategy, governance, risk management, service quality, patient safety, and operational and financial performance.

BoD/05/19/25 Date and Time of Next Meeting

25.1

The Board meeting to be held in Public was arranged to take place on Tuesday, 2 July 2019 at 1pm.

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Board of Direction Action Log (meeting held in Public)

Date of Meeting	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
7.05.19	BoD/05/19/16.4	Human Trafficking and Modern S	Steven Mason agreed to check that the required assurance had been received from the Head on Procurement and the Director of Human Resource prior to the statement being uploaded on the Trust's website	S Mason	2.07.19	Completed. Assurance from the Head of Procurement and Director of Human Resources provided to the Company Secretary prior to the annual statement being uploaded on the website	Completed
5.2.19	BoD/02/19/11.4	Communication and Engagement Strategy	It was agreed metrics would be developed following discussion with the Council of Governors at its next meeting. Metrics would be presented to the Board at its September meeting	H Edwards	3.09.19	Work on track to prepare metrics for presentation to September Board meeting.	Open

Board of Directors	
Agenda item	3.2
Title of Report	Healthcare-associated infection (HCAI) report for May 2019
Date of Meeting	2 July 2019
Presented by	Gill Hunt, Director of Nursing and Quality/DIPC
Authors	Richard Bellamy, Infection Control Doctor, JCUH Astrida Ndhlovu, Lead Nurse, Infection Prevention and Control Helen Day, Deputy Director of Nursing/Deputy DIPC Gill Hunt, Director of Nursing and Quality/ DIPC
Approved by	Gill Hunt
Previous Committee/Group Review	Not applicable
Purpose	<p style="text-align: center;">Approval <input checked="" type="checkbox"/> Decision <input type="checkbox"/></p> <p style="text-align: center;">Discussion <input type="checkbox"/> Information <input checked="" type="checkbox"/></p>
Alignment to Trust's Strategic Objectives	<p><input checked="" type="checkbox"/> 1. We will deliver excellence in patient outcomes and experience</p> <p><input checked="" type="checkbox"/> 2. We will drive operational performance to deliver responsive, cost effective care</p> <p><input type="checkbox"/> 3. We will deliver long term financial sustainability to invest in our future</p> <p><input type="checkbox"/> 4. We will deliver excellence in employee experience to be seen as an employer of choice</p> <p><input type="checkbox"/> 5. We will develop clinical and commercial strategies to ensure our long term sustainability</p>
Alignment to Board Assurance Framework	BAF 2.1
Legal/Regulatory Compliance Requirements (if applicable)	<ul style="list-style-type: none"> • Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • NHS Improvement • NHS England
Recommendation(s)	The Board of Directors is asked to note the current position in respect of HCAI and for their support for the actions being taken.

1. Executive Summary

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, *Methicillin Resistant Staphylococcus aureus* (MRSA) and *Methicillin Sensitive Staphylococcus aureus* (MSSA) bacteraemia, bacteraemia due to *glycopeptide-resistant enterococci*, *Escherichia coli* (E.coli), Extended Spectrum Beta Lactamase (ESBL)-producing coliform infections and other important healthcare-associated infections for the month of May 2019. The report also highlights antimicrobial stewardship and environmental cleaning in relation to HCAI management.

- The *Clostridium difficile*-associated diarrhoea objective for 2019/20 is to have no more than 81 community-onset healthcare-associated (COHA) plus healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There were 6 COHA + HOHA cases in May 2019. There have been 16 COHA + HOHA cases in the first 2 months of 2019/20. We are currently over trajectory.
- The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There were 0 trust-assigned cases in May 2019. There have been 0 trust-assigned cases in the first 2 months of 2019/20.
- There is no official MSSA bacteraemia target for 2019/20. There was 1 trust-apportioned case in May 2019. There have been 4 trust-assigned cases in the first 2 months of 2019/20.

2. Recommendation

The Board of Directors is asked to note the current position in respect of HCAI and for their support for the actions being taken.

1. SURVEILLANCE DATA

1.1 *Clostridium difficile*

C diff	Total 2018/19	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Total 2018/19 to date	Target for 2018/19
Total cases	120	12	14	8	11	17	9	8	11	5	6	18	7	25	NA
Not trust apportioned	79	8	7	5	7	10	9	5	7	3	5	8	1	9	NA
Trust-apportioned	41	4	7	3	4	7	0	3	4	2	1	10(4)	6(3)	16(7)	81
- JCUH	33	2	4	2	4	6	0	3	4	1	1	10	4	14	
-FHN	3	1	2	0	0	0	0	0	0	0	0	0	1	1	
-Carters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Redcar	2	0	1	0	0	1	0	0	0	0	0	0	1	1	
-East CI	1	1	0	0	0	0	0	0	0	0	0	0	0	0	
-Guis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Rutson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Friary	2	0	0	1	0	0	0	0	0	1	0	0	0	0	
-Lambert	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Table 1

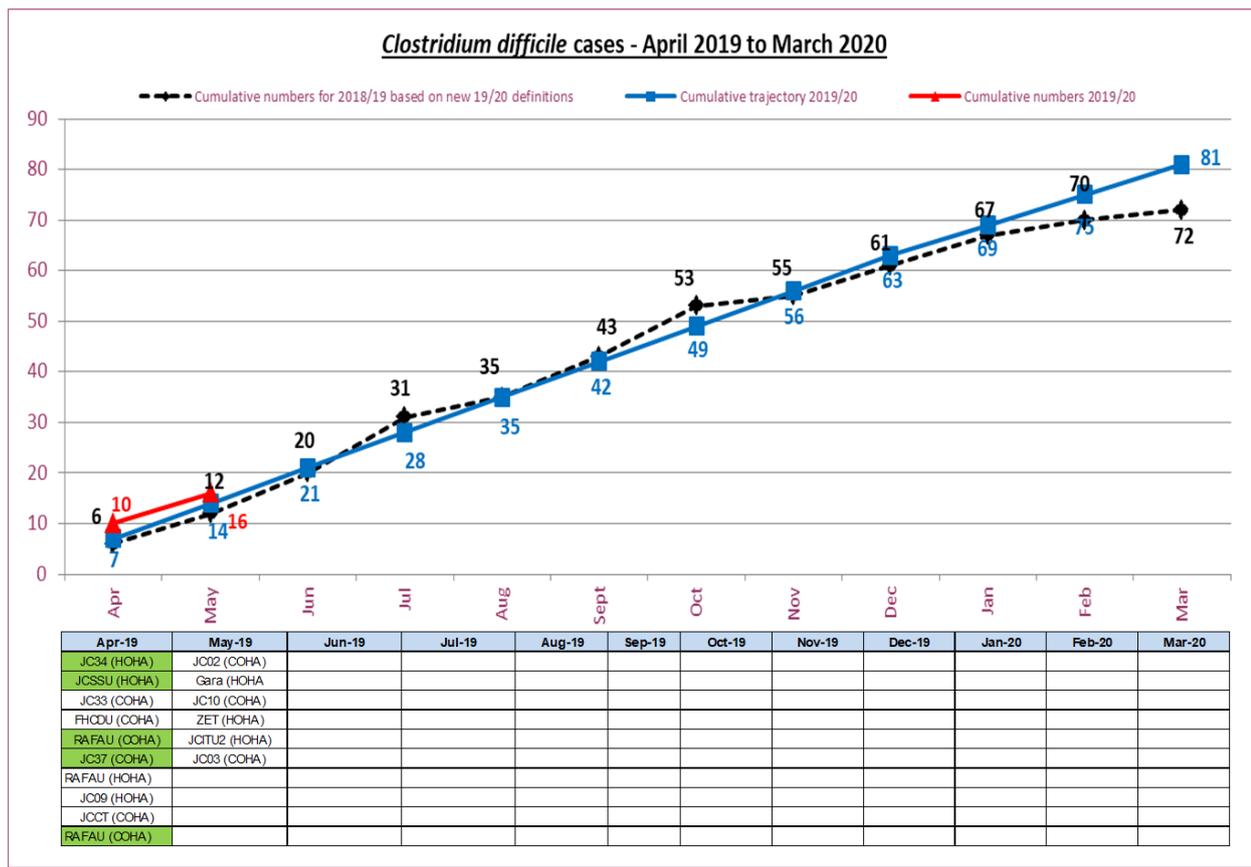
There were 7 cases of *C. difficile* infection in May 2019, 3 of which were classed as COHA and 3 were classed as HOHA, totalling 6 classed as trust-apportioned according to the new definition (table1). The 2019/20 annual objective is to have no more than 81 COHA + HOHA cases. In the first 2 months of 2019/20 there have been 16 trust-apportioned cases (COHA = 9; HOHA = 7). All actions to ensure that robust controls are in place are monitored through IPAG and the monthly Centre Clinical Standards meetings-held with Matrons.

The 2019/20 *C. difficile* definitions are as follows:

- Hospital onset healthcare associated (HOHA): cases detected in the hospital ≥ 2 days after admission.
- Community onset healthcare associated (COHA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
- Community onset indeterminate association (COIA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks,
- Community onset community associated (COCA): cases that occur in the community (or within <2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

Deaths within 30 days after *C. difficile* diagnosis: for April 2019, 4 patients died during this period. Since April 2009, 297/1663 patients (18%) have died during the 30 day follow-up period.

Graph 1: Cumulative Trust-apportioned *C. difficile* cases 2019/20 compared to trajectory:



Graph 1

Appeal successful

Root Cause Analysis (RCA) and panel reviews are undertaken for all trust-apportioned *C. difficile* cases. Panel reviews are chaired by the DIPC or her Deputy and are attended by CCG colleagues. If the panel agrees that there were no deficiencies in care then the case may be discounted from the total for performance measurement purposes. There have been no episodes of linked cases by ribotype identified since June/July 2017.

The average hand hygiene self-assessment score in May 2019 was 91.17% and the peer review average was 89.86%.

1.2 MRSA bacteraemia

MRSA	Total 2018/19	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Total 2019/20 to date	Target for 2019/20
Total cases	9	0	2	1	0	0	2	0	1	1	0	0	0	0	Zero tolerance
Not trust assigned	8	0	2	0	0	0	2	0	1	1	0	0	0	0	Zero tolerance
Trust assigned	1	0	0	1	0	0	0	0	0	0	0	0	0	0	Zero tolerance

Table 2

There were no cases of MRSA bacteraemia in May 2019 (table 2). In the first 2 months of 2019/20 there have been 0 cases.

1.3 MSSA bacteraemia

There were 12 cases of MSSA bacteraemia in May 2019; 1 of which was classed as trust-apportioned (table 3). In the first 2 months of 2019/20 there have been 4 trust-apportioned MSSA bacteraemia cases.

MSSA	Total 2018/19	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Total 2019/20 to date	Target for 2019/20
Total cases	134	8	13	13	10	9	8	12	10	8	11	12	12	24	NA
Not trust apportioned	92	6	11	9	6	5	6	8	7	5	7	9	11	20	NA
Trust apportioned	42	2	2	4	4	4	2	4	3	3	4	3	1	4	NA

Table 3

Whilst there is no external target for MSSA, the trust has set an internal target to maintain the 15% reduction of Staphylococcus aureus infections based on the 2016/17 baseline. This means no more than 35 combined MRSA and MSSA trust-apportioned cases in total. The trust is currently on trajectory for this. Enhanced training for Aseptic Non-Touch Technique (ANTT) is being implemented across the trust for all relevant staff groups to address avoidable causes of MRSA and MSSA bacteraemia related to invasive procedures.

1.4 Surveillance for other healthcare-associated infections (table 4)

	Total for 18/19	May 2019	Total for 19/20
Bacteraemia due to glycopeptide-resistant enterococci	10	0	0
Bacteraemia due to <i>E. coli</i>	550	45	91
• Trust-apportioned	128	14	27
• Not trust-apportioned	422	31	64
ESBL producing coliform infections	953	79	155
• sample taken in community	599	43	95
• sample taken in our trust	354	36	60
• bacteraemias	28	5	6
Bacteraemia due to <i>Klebsiella</i> species	134	15	22
• Trust-apportioned	37	5	6
• Not trust-apportioned	97	10	16
Bacteraemia due to <i>Pseudomonas aeruginosa</i>	37	5	7
• Trust-apportioned	12	1	1
• Not trust-apportioned	25	4	6
Other alert organisms			
• invasive group A streptococcus	1	0	0

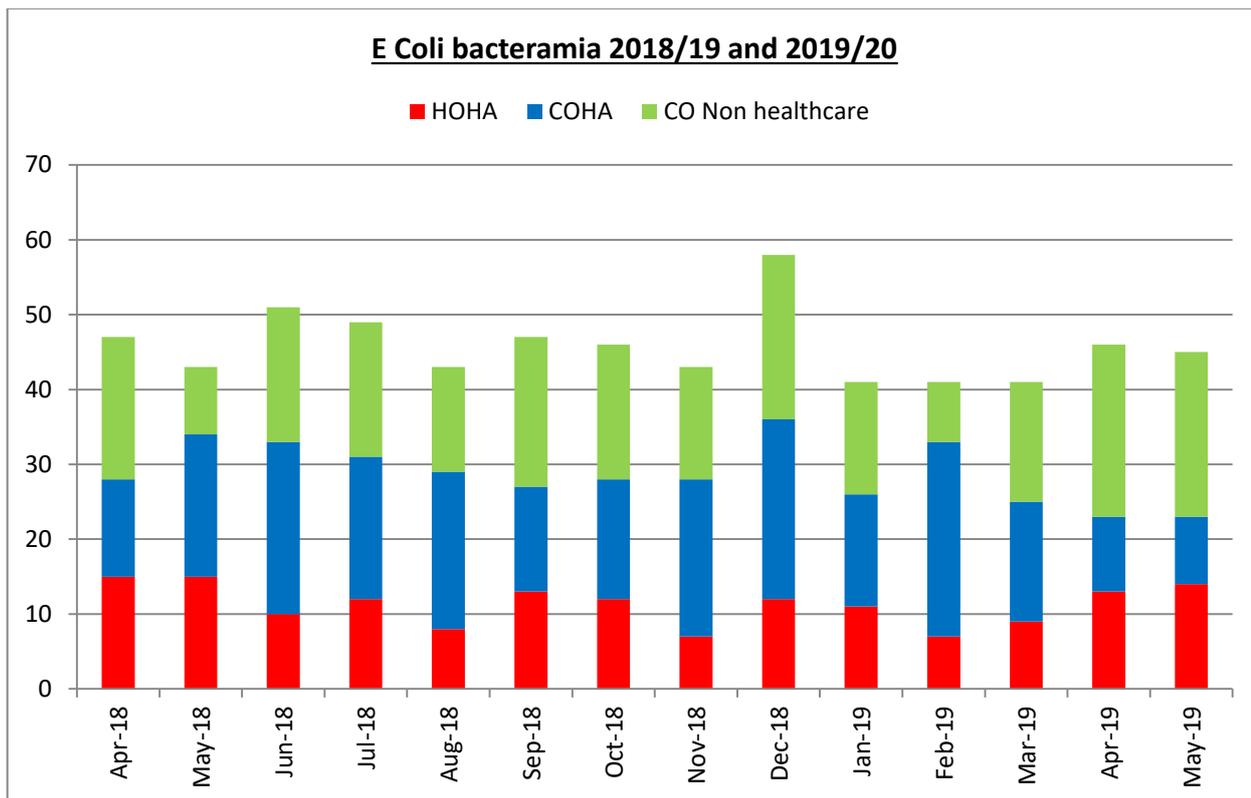
Table 4

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in healthcare associated GNBSI by 2021.

In May 2019 the trust reported a total of 65 cases of the three GNBSI organisms which are part of national surveillance (*E.coli*, 45; *Klebsiella sp.* 15; *Pseudomonas aeruginosa* 5). Of these, 20 cases were classed as trust-apportioned (30%) as defined by the Department of Health definition. This demonstrates the need to continue working in collaboration with the wider community as part of the Tees-wide collaborative which supports a number of initiatives within the community setting. In addition a detailed audit of 5 sets of notes per week are being audited retrospectively to ascertain patient-related contributory themes in the challenge to identify causes of *E. Coli* infections.

The trust continues to take part in the national GNBSI urinary tract infection collaborative hosted by NHS Improvement/NHS England. The focus of this improvement programme is hydration in both the community setting in the older population and care home setting with a number of resources being made available as well as specific hydration campaigns. This work is being led by a post holder working with the IPC team, currently hosted by the trust and funded through health and social care funding the 'Better Care Fund'. Initiatives in the community will be emulated and implemented within the acute trust in order to reduce these infections.

Graph 2 – E Coli bacteraemia cases 2018/19 and 2019/20



Graph 2

Antimicrobial Stewardship

The trust is continuing with a number of antimicrobial stewardship initiatives including the ARK project.

The antibiotic guidelines are being developed into a user-friendly app in conjunction with North Tees Hospitals. The “Antibiotic Sepsis/ Infection (not sepsis)” poster was released in January 2019.

The antimicrobial CQUIN for 2019/20 focuses on 3 areas:

1. Diagnosis and antibiotic prescribing for lower urinary tract infections.
2. Antibiotic prophylaxis for colorectal surgery.
3. Diagnosis and antifungal prescribing for systemic fungal infections.

The antimicrobial pharmacy team are currently piloting audits for these CQUINs.

Environmental Cleaning

The average cleaning scores by month are as follows (table 5):

The James Cook Site:

Risk Category	NSC Target	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
High Risk	95%	99%	98%	98%	98%	98%	98%	98%	98%	98%	99%	99%	99%
Significant Risk	85%	97%	97%	97%	97%	97%	97%	97%	96%	97%	98%	97%	97%
Low Risk	75%	96%	95%	94%	94%	95%	95%	95%	94%	95%	96%	96%	95%

Table 5

Cleaning scores have been maintained on the JCUH site (table 5). Three areas failed C4C inspection in May 2019 on the James Cook site, Wards 2 and 7 and the ground floor Murray Building. Maintaining cleaning standards remains an area of continued focus in conjunction with our service provider SERCO. The monthly cleaning standards review meetings continue to be led by the Director of Estates and cleaning scores continue to be monitored via IPAG. The trust will be adopting the new cleaning standards in 2019 which utilise red, amber and green risk categories.

The Friarage, Friary, East Cleveland and Redcar Primary Care Hospital (table 6):

Risk Category	NSC Target	FHN Site	Friary	East Cleveland	Redcar PCH
Very High Risk	98%	98.17%	100%		100%
High Risk	95%			96%	100%
Significant Risk	85%	98.82%		95%	100%
Low Risk	75%	100%		95%	100%

Table 6

2. OUTBREAKS

Diarrhoea & vomiting outbreaks	Annual total 18/19	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Total 1920 to date
Total number	1	0	0	0	0	0	0	0	0	1	0	0	0	0
Total number of patients affected	1	0	0	0	0	0	0	0	0	1	0	0	0	0
Total number of staff affected	12	0	0	0	0	0	0	0	0	12	0	0	0	0

Table 7

There were no outbreaks of diarrhoea and vomiting in May 2019 (table 7).

3. OUTBREAK OF GES – CARBAPENEMASE-PRODUCING MULTI-DRUG-RESISTANT PSEUDOMONAS AERUGINOSA INFECTION IN ICU2/3, GHDU, WARDS 4 AND 24HDU AND OTHER AREAS

During May 2019, we have not identified any further patients who have the *GES-carbapenemase-producing Pseudomonas aeruginosa* infection. We believe the three cases detected in early 2019 were infected during the outbreak in 2014/2015.

In total there have been 24 confirmed patients identified who are colonised or infected with a GES carbapenemase-producing strain of *Pseudomonas aeruginosa* in our trust since November 2014.

4. OXA-48-CARBAPENEMASE-PRODUCING KLEBSIELLA PNEUMONIAE

Acute trusts in North and South locality across Teesside have seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing *Klebsiella pneumoniae* over the last year. In April 2019 we did not identify any further cases that carried the strain which has been linked to this cluster. We do not believe transmission has occurred unknowingly in our trust. An extensive contact screening programme has only identified one case.

5. INFLUENZA

The influenza season is now over and we are back at baseline levels. The total overall cases of Influenza during the winter of 2018/19 was 324. *Influenza A* predominated this year.

6. CRITICAL CARE

Isolation capacity for patients with infection continues to pose a challenge particularly on ICU2 and ICU3. Processes to mitigate risk of transmission continue to be put in place including increased presence of the IPC team to support staff.

In May 2019, we have not identified any cases of MRSA transmission or colonisation or infection or COHA + HOHA *C. difficile* infection on Critical Care. There was previously a potential cluster of 3 patients with *Enterobacter cloacae* Amp C in sputum but strain-typing has not identified a link between them.

GNBSIs particularly *Pseudomonas aeruginosa* and *Klebsiella* bacteraemia accounted for a significant number of cases in Critical Care in 2018/2019. These infections are associated with multiple invasive devices more likely to be found in critical care patients. Projects directly linked to reducing Central Venous Catheter (CVC) contamination have been implemented in all critical care areas. In May 2019 we have identified 4 cases of GNBSI in Critical Care.



South Tees Hospitals
NHS Foundation Trust

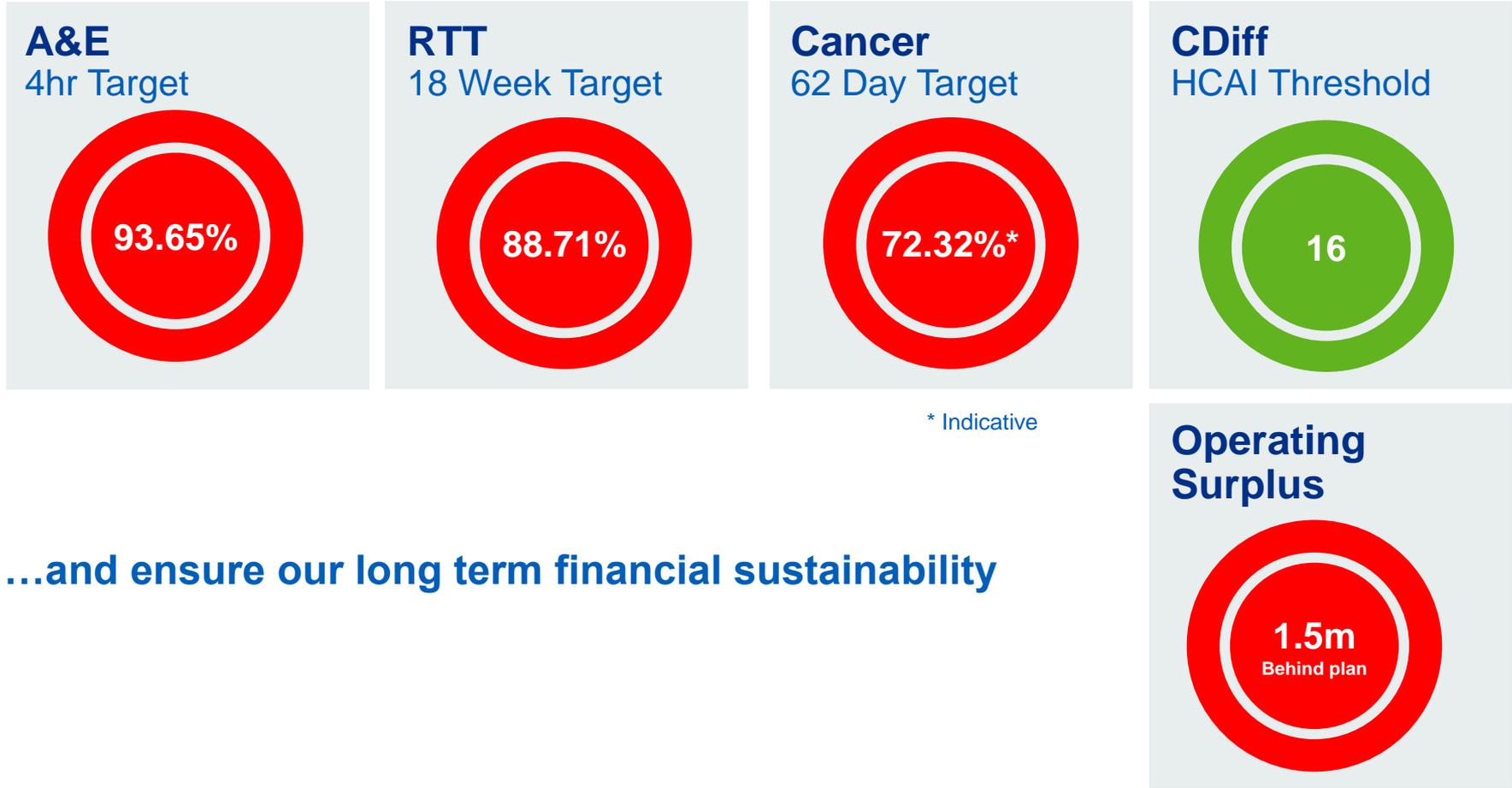
Quality, Operational & Finance Performance Report

2nd July 2019

Must Do's

Must Do's 2018/19 – May 2019

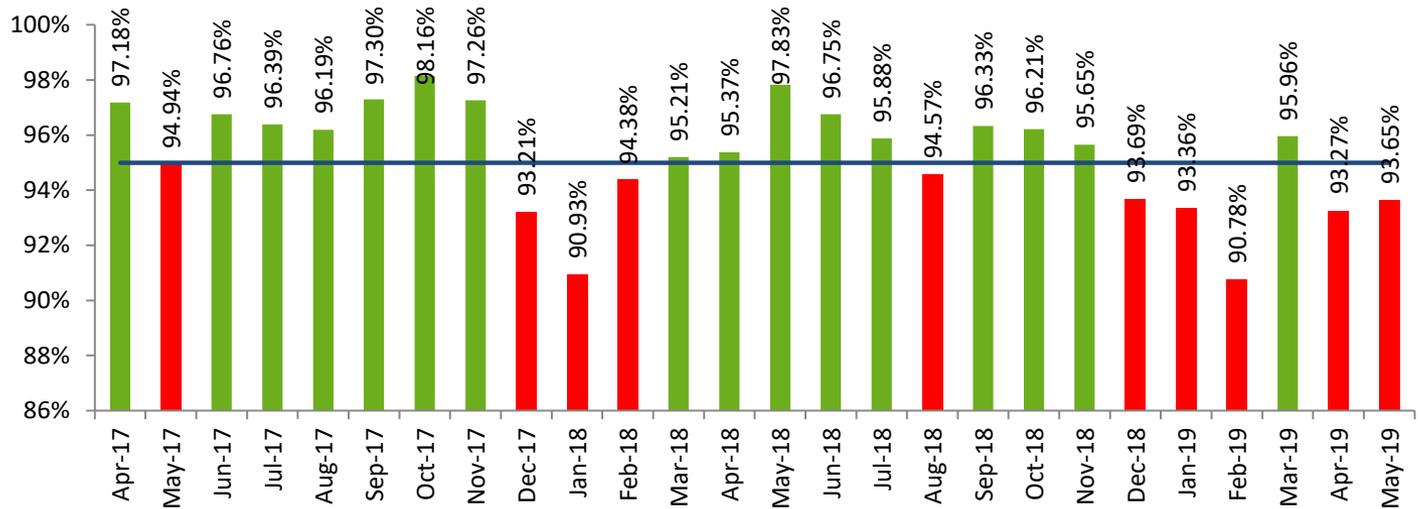
Deliver Excellence in Patient Outcome and Experience....



* Indicative

...and ensure our long term financial sustainability

Performance - A&E



95%
TARGET

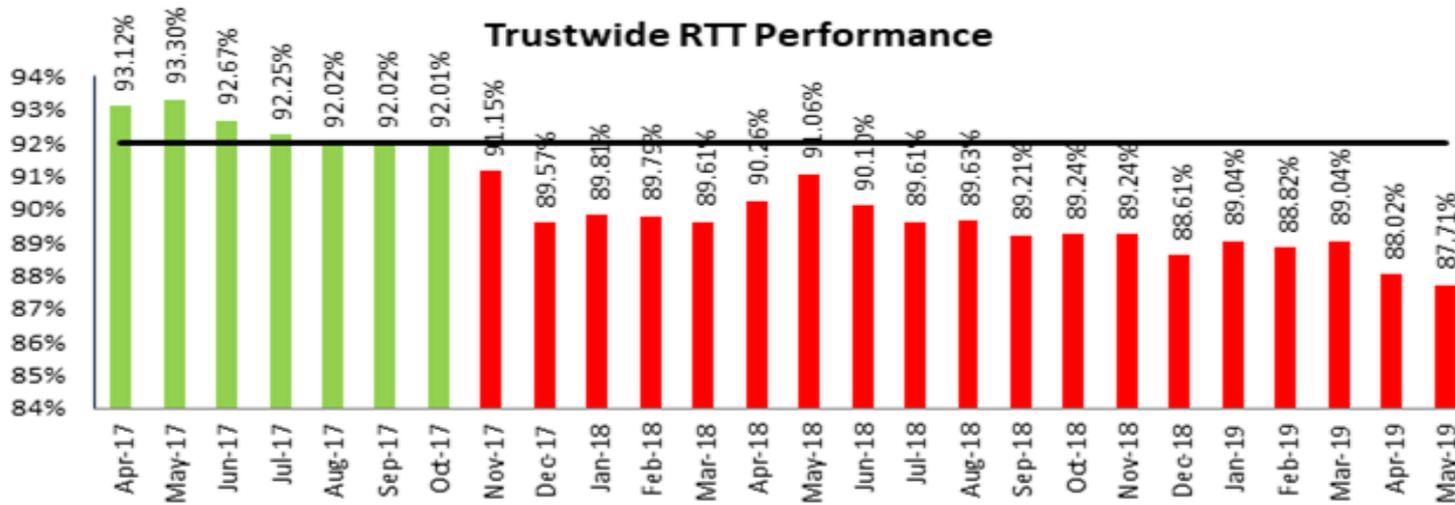
May 19
93.65%

June to date (at 17/619)
94.75%

Regional Rank	Trust	May-19
1	Harrogate and District NHS Foundation Trust	94.50%
2	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	94.17%
3	South Tees Hospitals NHS Foundation Trust	93.65%
4	Northumbria Healthcare NHS Foundation Trust	92.82%
5	Gateshead Health NHS Foundation Trust	92.71%
6	South Tyneside And Sunderland NHS Foundation Trust	87.94%
7	North Cumbria University Hospitals NHS Trust	85.38%
8	County Durham and Darlington NHS Foundation Trust	84.47%
9	York Teaching Hospitals NHS Foundation Trust	81.88%
-	North Tees and Hartlepool NHS Foundation Trust	-
	ENGLAND	86.64%

May 19
Ranked 3rd in the region

Referral to Treat



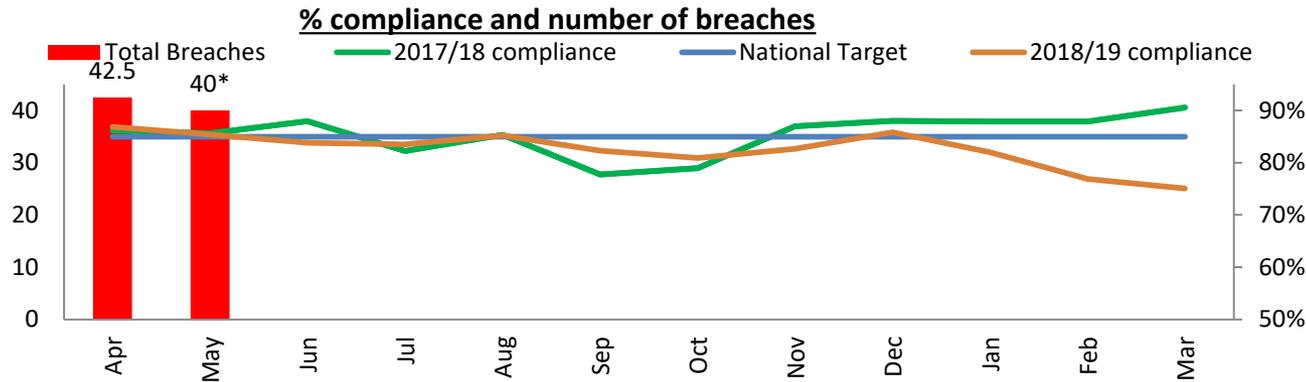
92%
TARGET

April 19
87.71%

Regional Rank	Trust	Apr-19
1	North Tees and Hartlepool NHS Foundation Trust	94.00%
2	South Tyneside And Sunderland NHS Foundation Trust	92.43%
3	Northumbria Healthcare NHS Foundation Trust	92.38%
4	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	92.17%
5	Gateshead Health NHS Foundation Trust	91.66%
6	County Durham and Darlington NHS Foundation Trust	90.75%
7	Harrogate and District NHS Foundation Trust	88.50%
8	South Tees Hospitals NHS Foundation Trust	88.02%
9	York Teaching Hospital	79.97%
10	North Cumbria University Hospitals NHS Trust	74.42%
	ENGLAND	86.52%

April 19
Ranked 8th in the region

Performance – 62 Day Cancer Standard



% compliance and number of breaches

*** Indicative**

Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
82.67%	85.84%	82.02%	76.90%	75.57%	75.50%	72.32%*

Regional Rank	Trust	Apr-19
1	Harrogate and District NHS Foundation Trust	89.19%
2	County Durham and Darlington NHS Foundation Trust	89.04%
3	Gateshead Health NHS Foundation Trust	88.80%
4	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	81.33%
5	North Cumbria University Hospitals NHS Trust	80.87%
6	York Teaching Hospitals NHS Foundation Trust	80.59%
7	North Tees and Hartlepool NHS Foundation Trust	80.14%
8	Northumbria Healthcare NHS Foundation Trust	77.30%
9	South Tees Hospitals NHS Foundation Trust	75.50%
11	South Tyneside and Sunderland NHS Foundation Trust	72.91%
	ENGLAND	79.40%

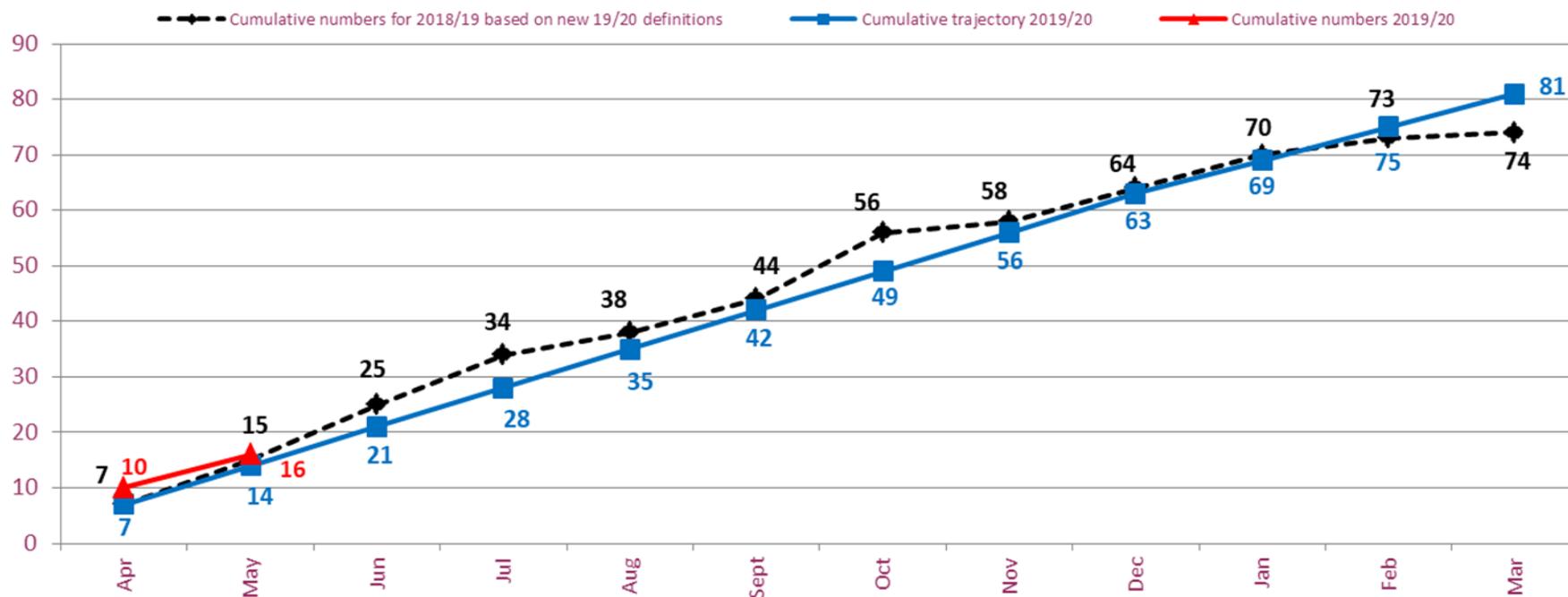
**April 19
Ranked 9th in the
region**

Operational Management

2

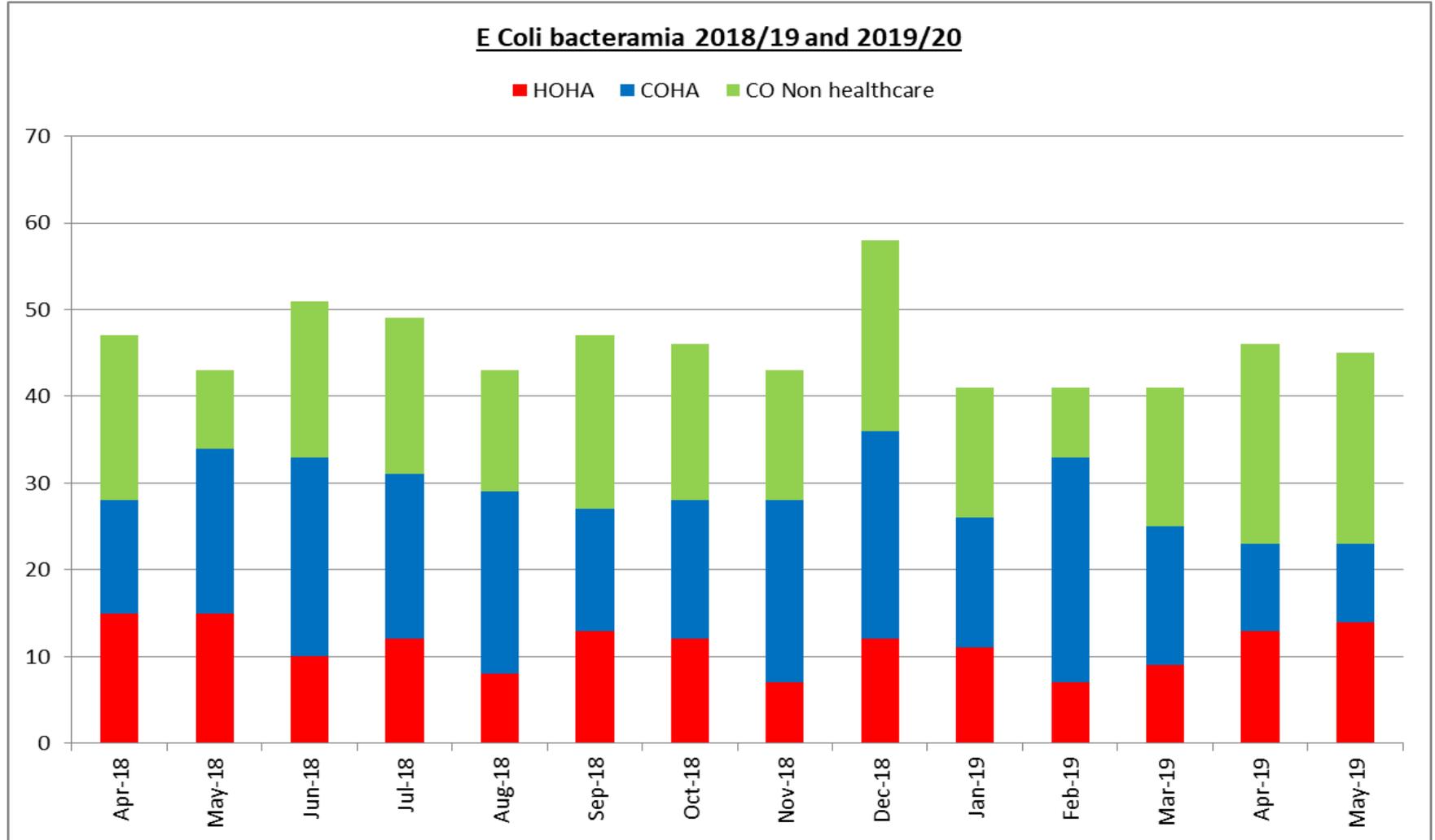
Trust Apportioned Clostridium Difficile

Clostridium difficile cases - April 2019 to March 2020



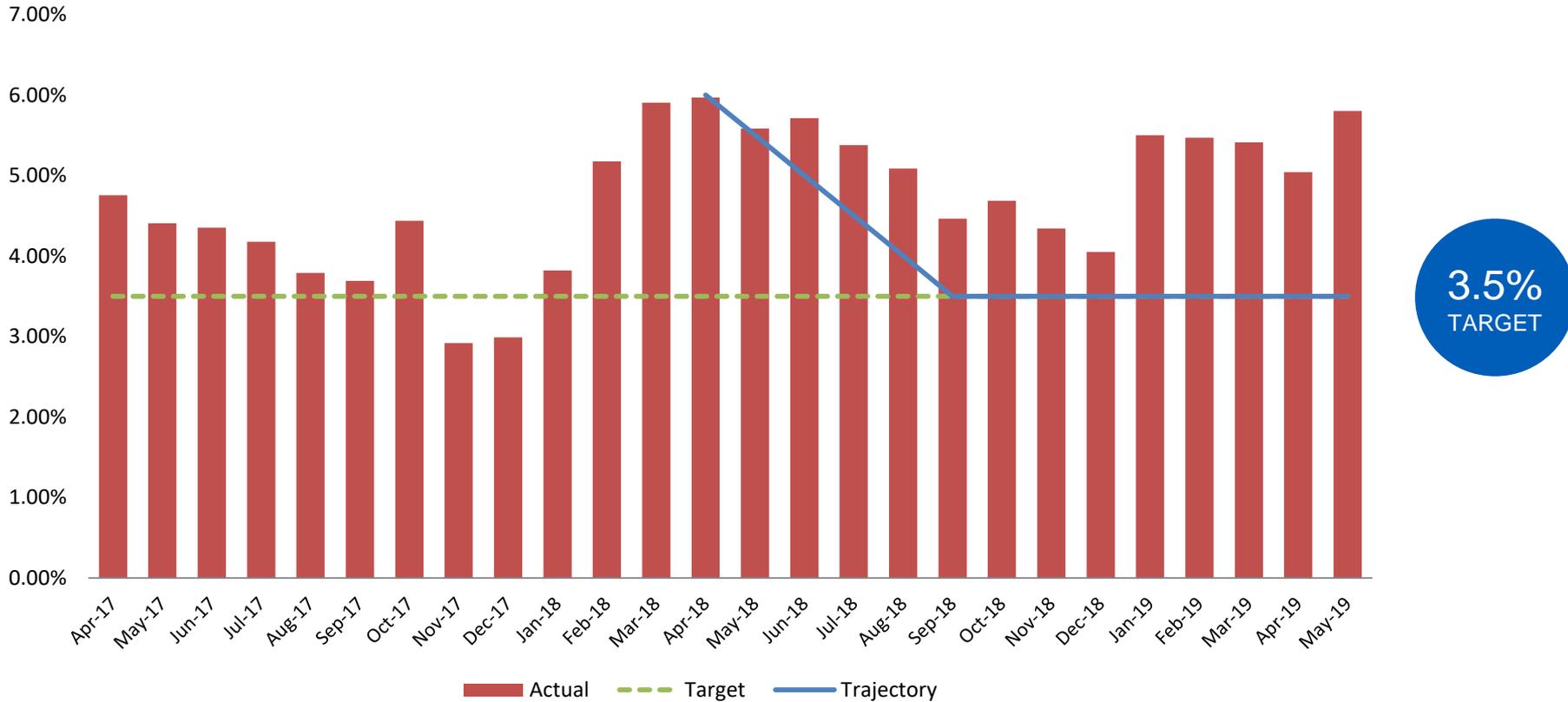
Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
JC34 (HOHA)	JC02 (COHA)										
JCSSU (HOHA)	Gara (HOHA)										
JC33 (COHA)	JC10 (COHA)										
FHCDU (COHA)	ZET (HOHA)										
RAFAU (COHA)	JCITU2 (HOHA)										
JC37 (COHA)	JC03 (COHA)										
RAFAU (HOHA)											
JC09 (HOHA)											
JCCT (COHA)											
RAFAU (COHA)											

E Coli Bacteremia



Delayed Transfer of Care (DToC)

Percentage DToC against Midnight Bed Occ

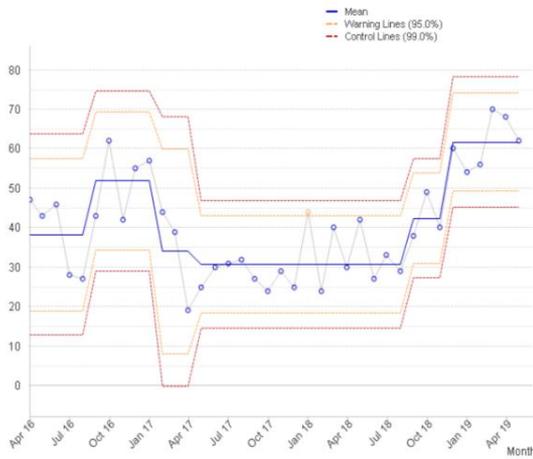


Patient Outcome and Experience

3

Delivering Safe Care

New or deteriorating category 2 pressure ulcers May 2019

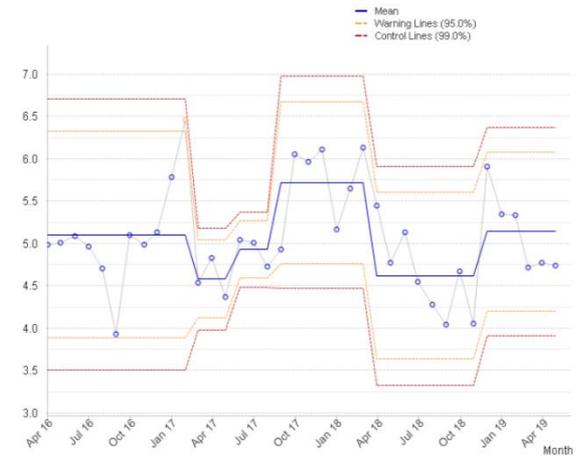


Inpatient rate is 2.2 per 1000 bed days.



45 community category 2 pressure ulcers

Falls May 2019



Rate 4.7 per 1000 bed days.

Continued Focus on Refreshed Pressure Ulcer Prevention Strategies

Patient Experience

Trust

How do patients rate us out of 10...?



South Tees Hospitals
NHS Foundation Trust

Consistency & coordination of care



8.23

Treatment with respect and dignity



9.43

Involvement



8.88

Good Doctors



9.21

Good Nurses



9.61

Noise at night



7.83

Kindness and compassion



9.55

Cleanliness



8.94

Hand Hygiene



9.54

Medicines



8.89

Pain control



9.30

In May 2019 patients gave us an overall rating of...

8.80 out of 10

% of patients surveyed would highly likely or likely recommend this ward to their families and friends

97%

No of patients on new medication

310

No of respondents

563



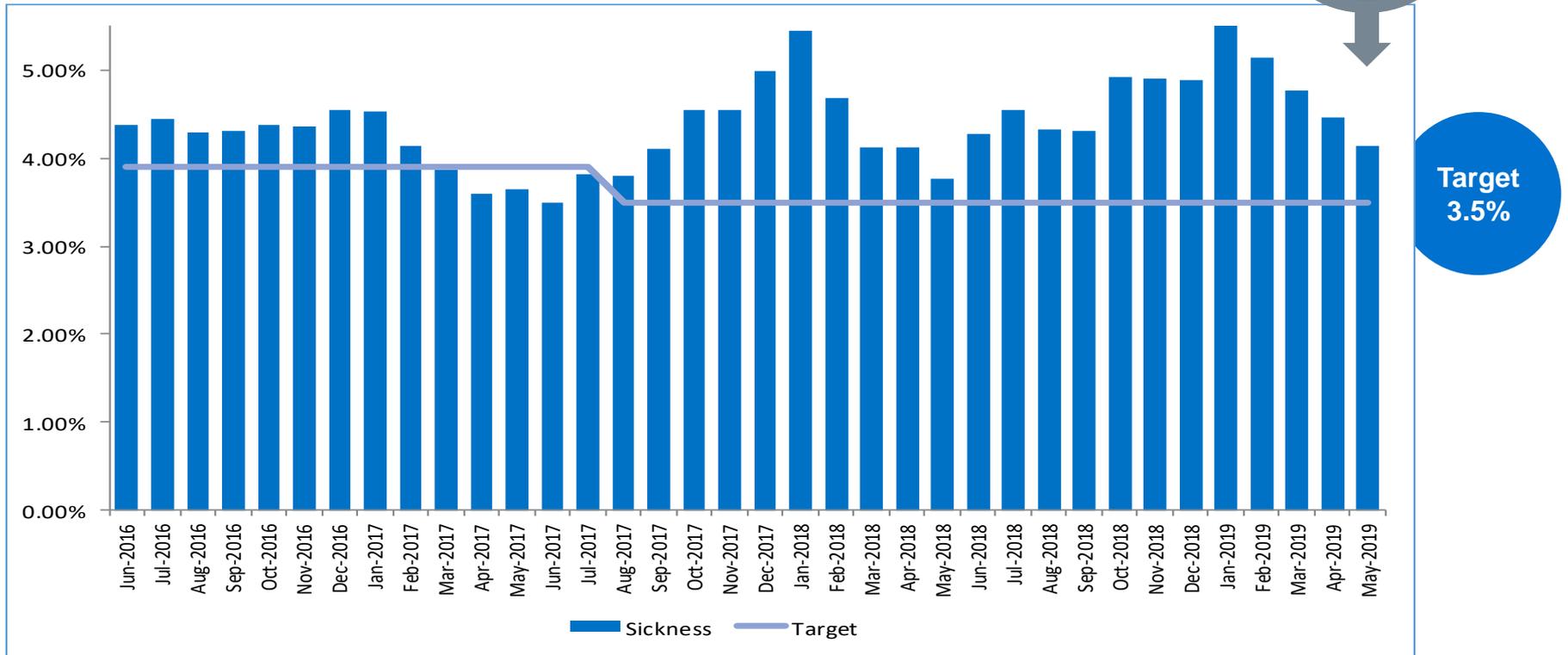
Excellence in Patient Outcome and Experience

www.southtees.nhs.uk

People

4

People % Sickness Rate



SDR % Rate - 77.25% (Target 80%)

2016/17	2017/18	2018/19	2019/20
71.27%	84.70%	77.83%	77.20%

Training % Rate 88.23% (Target 90%)

2016/17	2017/18	2018/19	2019/20
89.35%	92.38%	90.31%	88.65%

Finance

5

Summary Financials by center – May 2019

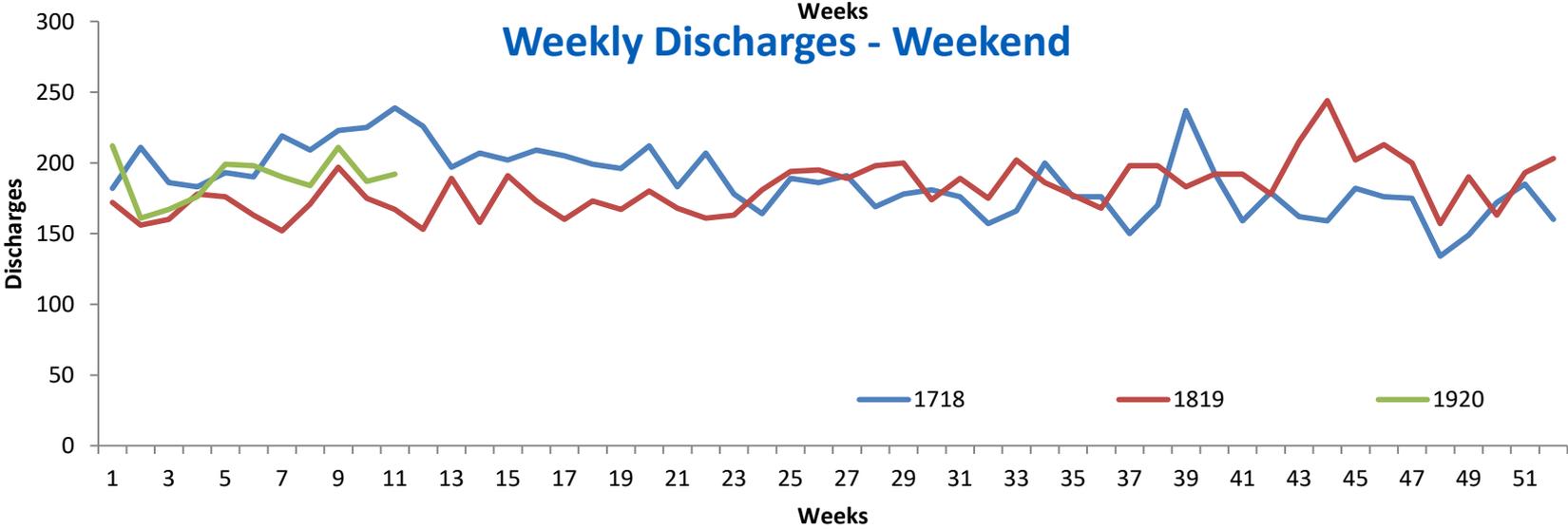
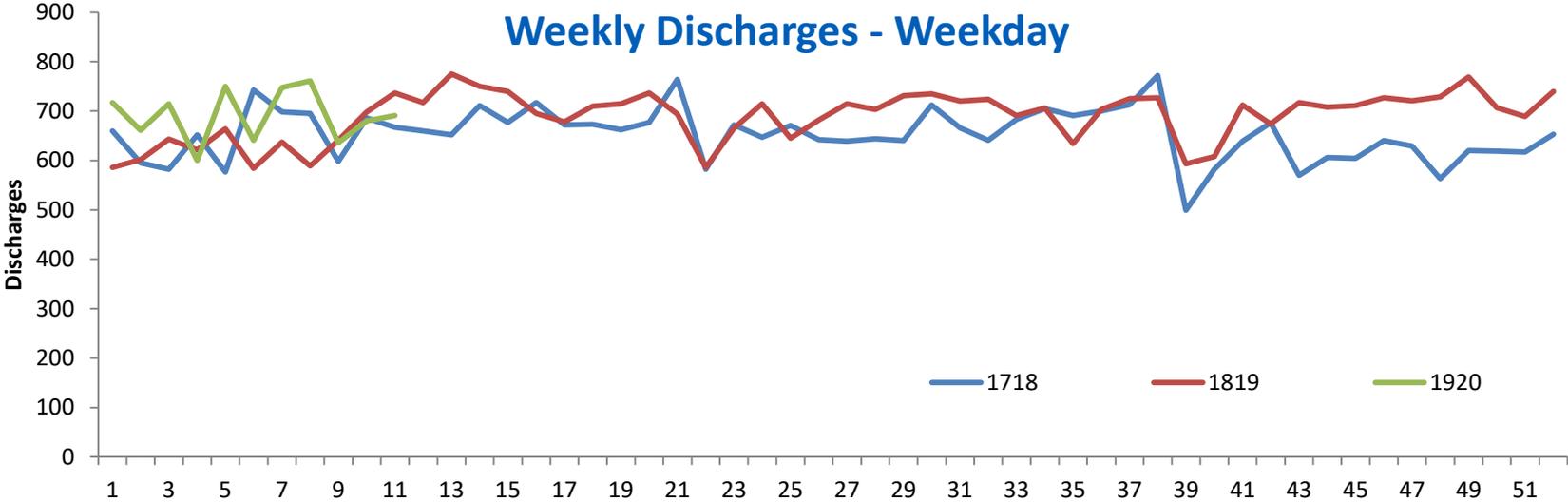
Corporate Clinical Services	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Other Income	3,622	4,285	662
Pay	(6,002)	(5,870)	132
Non Pay	(2,609)	(3,138)	(528)
Total	(4,989)	(4,723)	266
Community Care	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Other Income	828	815	(13)
Non Pay	(6,592)	(6,717)	(124)
Pay	(16,124)	(16,374)	(250)
Total	(21,888)	(22,275)	(388)
Specialist & Planned Care	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Other Income	570	579	9
Non Pay	(13,665)	(13,402)	263
Pay	(20,413)	(20,554)	(141)
Total	(33,508)	(33,377)	131
Urgent & Emergency Care	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Other Income	178	170	(8)
Non Pay	(2,114)	(2,091)	23
Pay	(14,406)	(14,714)	(308)
Total	(16,343)	(16,635)	(292)
Corporate	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Nhs Clinical Income	95,157	94,738	(419)
Other Income	831	(131)	(962)
Pay	(6,584)	(5,979)	605
Non Pay	(15,653)	(16,061)	(408)
Restructuring Costs	-	(92)	(92)
Depreciation And Interest	(3,979)	(3,966)	13
Other Non Operating	(1,038)	(1,021)	17
Total	68,734	67,487	(1,246)
Trust Control Total	(7,993)	(9,523)	(1,529)

- Trust headlines YTD M2
- Control total
- Behind plan by £1.5m
- Loss of STF funding £1.0m, underlying overspend of £0.5m
- Full year plan is a control total surplus of £3.2m
- Productivity and Efficiency savings
- YTD savings of £1.0m
- Full year plan of £31.9m with £22.0m delivered by the wider system.

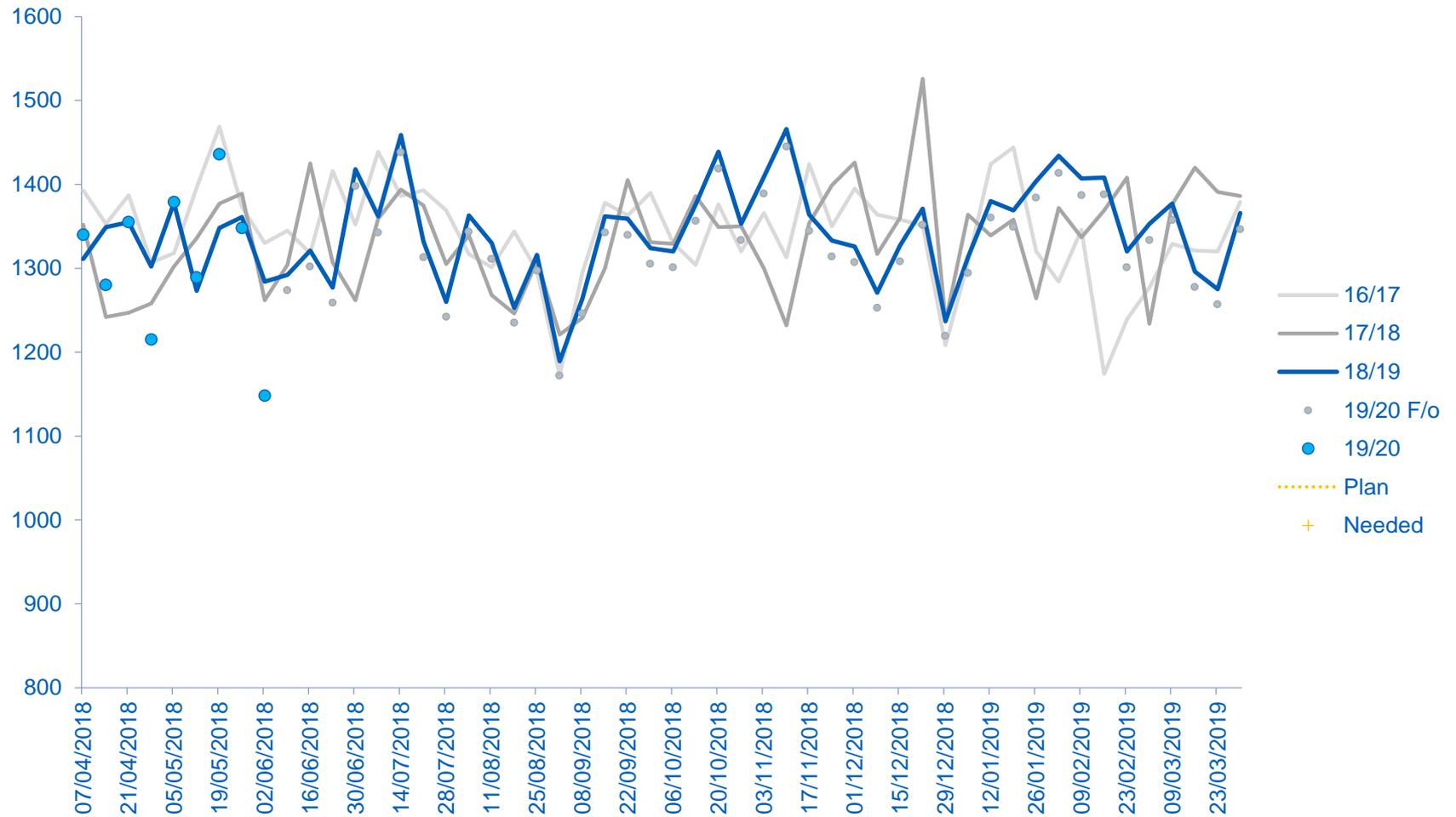
Appendices

6

JCUH Adult Ward Discharge Rates

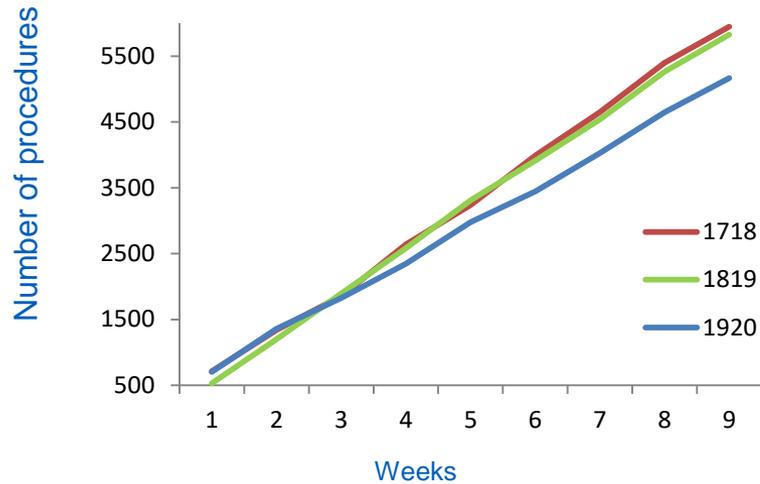


Non-Elective Delivery - All



Elective – Theatre Throughput

Elective overnight and day case - 9 week delivery period from beginning of FY19/20 compared with FY17/18 & FY18/19

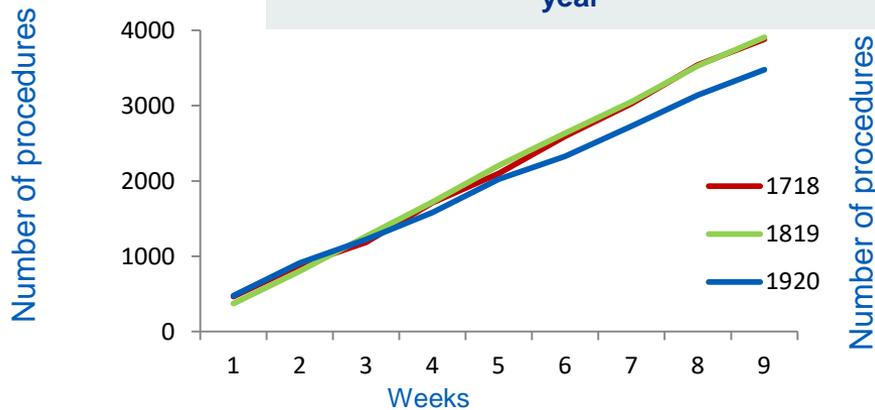


11.3% less cases undertaken in last 9 week period this year when compared to last.

YTD 11.3% less than last year

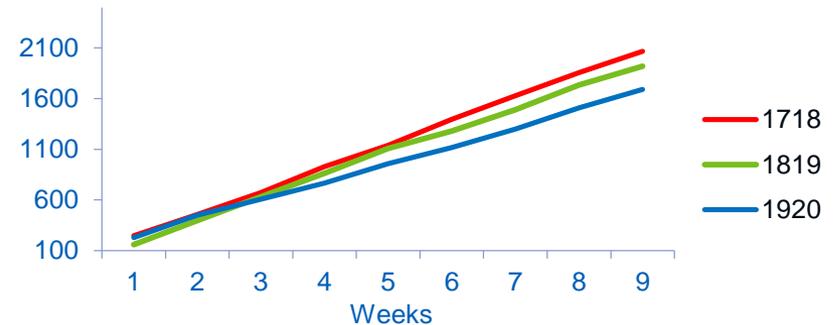
Elective day case

YTD 11% less when compared with last year



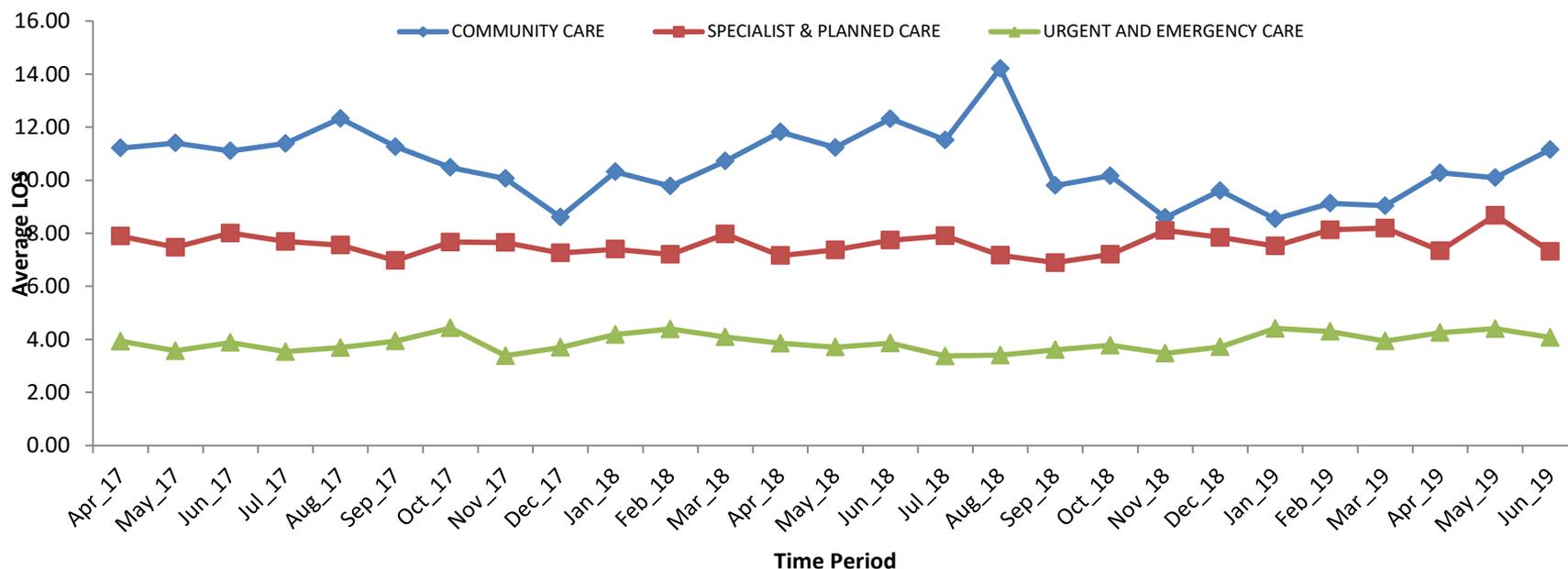
Elective overnight

YTD 11.9% less when compared with last year



Emergency Length of Stay by Centre

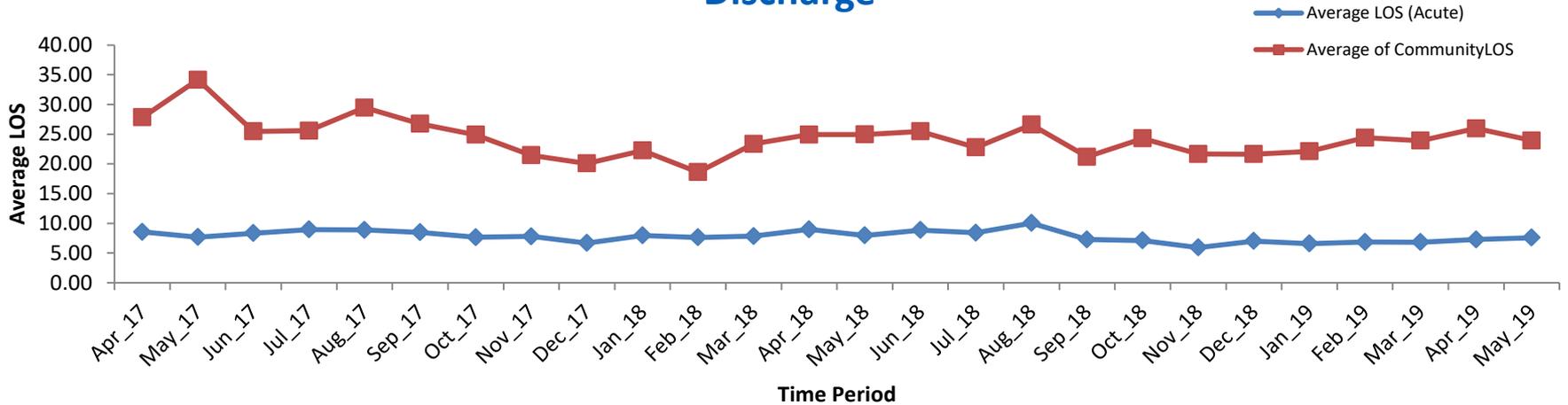
Emergency LOS by Centre at Discharge - 1st April 16 - 16th June 19



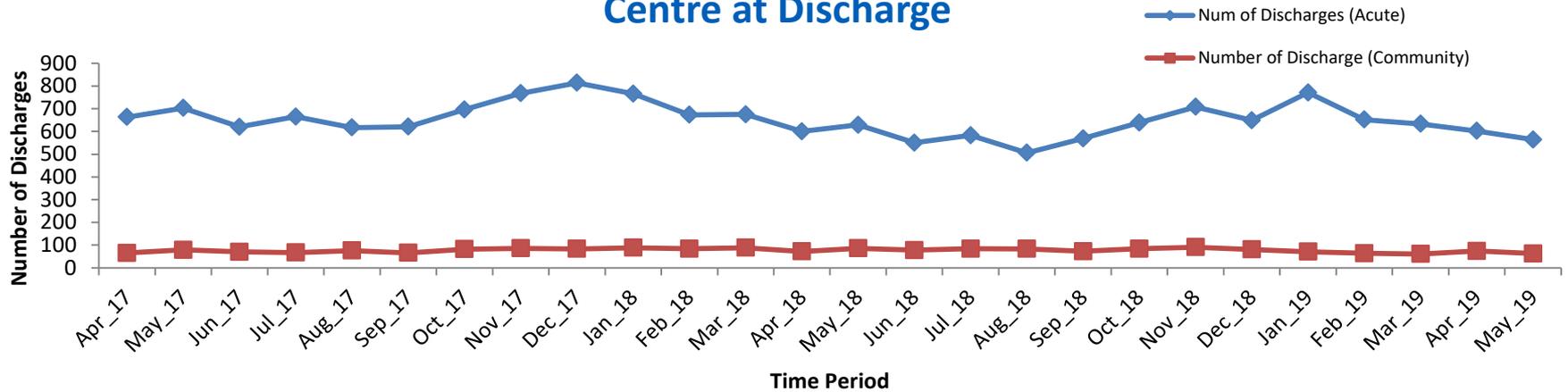
AVG LOS	Community Care	Specialist & Planned Care	Urgent & Emergency Care	Grand Total
1718	10.7	7.6	3.9	7.2
1819	10.4	7.6	3.8	6.9
1920	10.4	7.9	4.3	7.2

Emergency LOS for Community Centre by Site Type

Average LOS by Site Type for Patients Under Community Care Centre at Discharge



Number of Discharges by Site Type for Patients Under Community Care Centre at Discharge



Board of Directors	
Agenda item	3.2.1
Title of Report	HCAI Annual Report
Date of Meeting	2 July 2019
Presented by	Mrs Gill Hunt, Director of Nursing & Quality/DIPC
Author	Dr Richard Bellamy, Infection Control Doctor, JCUH Ms Astrida Ndhlovu, Lead Nurse, Infection Prevention and Control Mrs Helen Day, Assistant Director of Nursing/Deputy DIPC Mrs Gill Hunt, Director of Nursing & Quality/ DIPC
Approved by	Mrs Gill Hunt, Director of Nursing & Quality/DIPC
Previous Committee/Group Review	Infection Prevention Action Group Quality Assurance Committee
Purpose	Approval <input checked="" type="checkbox"/> Decision <input type="checkbox"/> Discussion <input type="checkbox"/> Information <input checked="" type="checkbox"/>
Alignment to Trust's Strategic Objectives	<input checked="" type="checkbox"/> 1. We will deliver excellence in patient outcomes and experience <input type="checkbox"/> 2. We will drive operational performance to deliver responsive, cost effective care <input type="checkbox"/> 3. We will deliver long term financial sustainability to invest in our future <input type="checkbox"/> 4. We will deliver excellence in employee experience to be seen as an employer of choice <input type="checkbox"/> 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	BAF 2.1(1)
Legal/Regulatory Compliance Requirements (if applicable)	<ul style="list-style-type: none"> • Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • Trust's licence • NHS Improvement
Recommendation(s)	Board of Directors is asked to note the year end position in respect of HCAI and for their support for the actions being taken to maintain high standards of care.

Executive Summary

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, Methicillin-resistant *Staphylococcus aureus* (MRSA) and Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia, bacteraemia due to glycopeptide-resistant enterococci, Extended Spectrum Beta Lactamase (ESBL)-producing coliform infections and other important healthcare-associated infections for 1st April 2018 to 31st March 2019.

- The *C. difficile*-associated diarrhoea target for 2018/19 was to have no more than 54 Trust-apportioned cases of *C. difficile* among patients aged over 2 years. There have been 41 Trust-apportioned cases during this financial year.
 - MRSA bacteraemia target is that of zero tolerance. There has been 1 Trust-assigned case for 2018/19 financial year.
 - There was no official MSSA bacteraemia target for 2018/19. There have been 42 Trust-apportioned cases during this financial year.
 - The organisation set an internal target for a 15% reduction in trust-apportioned *Staphylococcus aureus* bacteraemia from the 2016/2017 baseline. This means we should have had no more than 35 cases and we have had 43 during this financial year.
1. All infection prevention and control activities are monitored by The Infection Prevention Action Group (IPAG) which reports to the Quality Assurance Committee (QAC). A summary report demonstrating that the committee has discharged its duties as per the terms of reference was presented at the QAC meeting in May 2019.
 2. The Trust has achieved its *Clostridium difficile* target for 2018/19. There were a total of 120 cases, 41 of which were Trust-apportioned. This is within the upper threshold of 54 Trust-apportioned cases. There has been a 14.6% decrease in the number of Trust-apportioned episodes of *C. difficile*-associated diarrhoea compared to 2017/2018 and a 2.6% increase in non-Trust-apportioned cases. Root cause analysis is performed on all Trust-apportioned *C. difficile* episodes and a case review chaired by the Director of Nursing/Director of Infection Prevention and Control (DIPC) or deputy DIPC is held. Audits of death certificates where *C. difficile* was the definite or probable main cause has been included as an appendix to this report.
 3. MRSA bacteraemia target is that of zero tolerance. There were 9 cases, 1 of which was classed as Trust-assigned in 2018/19. In 2017/18 There were 4 cases of MRSA bacteraemia, 1 of which was trust-assigned. Root cause analysis is performed on all MRSA bacteraemia episodes and a case review chaired by the Director of Nursing/DIPC or Deputy DIPC is held. A full audit report of these cases has been included as an appendix to this report.
 4. There was no official MSSA bacteraemia target for 2018/19. There were 134 cases, 42 of which were Trust-apportioned. There has been a 22.9% increase in combined Trust-apportioned MSSA and trust-assigned MRSA bacteraemia cases compared to 2017/18 and a 1.0% decrease in non-Trust-apportioned cases. Root cause analyses are performed for Trust-apportioned MSSA bacteraemias followed by a departmental case review.
 5. Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in avoidable bacteraemia by 2021. There were 721 cases of the three GNBSI organisms which are part of national surveillance, 178 of which were classed as trust-apportioned. This is a 7.3% increase in total cases compared to 2017/18 and a 7.2% increase in hospital-apportioned cases.
 6. The Trust had 10 cases of bacteraemia due to Glycopeptide-resistant *Enterococci* in 2018/19. There were 7 cases in 2017/18.
 7. ESBL-producing coliforms cause a large number of infections and they are the commonest multi-drug resistant Gram negative organisms affecting patients in the Trust and in the local

community. In 2018/19 the Trust had 28 cases of bacteraemia due to ESBL-producing coliforms, compared to 25 in 2017/18.

8. The cluster of multi-drug-resistant GES-carbapenemase-producing *Pseudomonas aeruginosa* which was identified in 2014/15 has continued in 2018/19 although there is no evidence of ongoing spread in the renal unit or in critical care. In total 24 patients have been affected by the GES carbapenemase-producing strain. This continues to be monitored.
9. Further cases of oxa-48 carbapenemase-producing *Klebsiella pneumoniae* carriage were detected in 2018/19. We have not detected any cases of transmission within our trust during 2018/19, despite extensive contact-tracing and screening. The gradual increase in cases we have seen in the last year is a combination of cases which have been acquired in other hospitals or care homes or where there has been no clear risk factor. This will continue to be monitored.
10. During the winter months, outbreaks of Norovirus infection have previously caused severe disruption both nationally and to our Trust. During 2018/19 there was 1 cluster which met our definition of an outbreak and this affected 1 patient and 12 staff members.
11. Influenza outbreaks caused severe disruption to the NHS, both nationally and to our Trust in 2017/18. During 2018/19 there were a total of 325 cases on Influenza. There were no outbreaks involving closure of whole wards.
12. A number of antimicrobial stewardship initiatives are in place in the trust. Based on our current antibiotic usage we believe we will probably not have achieved the AWaRe and total consumption target components of the CQUIN.
13. There have been significant improvements in endoscope decontamination practices and traceability, over the last 3-4 years.
14. An international issue was identified in 2016 with regard to patients who have had cardiac surgery who have subsequently developed endocarditis due to *Mycobacterium chimerae*. To date no patients who have had cardiac surgery in our Trust have been found to be affected.
15. The submission rate of the monthly 'Clean Your Hands' audits was 95%. The overall average of compliance with the 5 moments of hand hygiene as reported is 94% with peer audit scores being 91%.
16. Cleaning standards have been maintained on all of the trust hospital sites over 2018/19 with the majority of cleaning scores above the required threshold. Joint monitoring with the trusts Environmental Monitoring Team continues and cleaning scores are monitored through IPAG.
17. The IPC team have continued to develop and use 'tool box teaching' packages. This approach has enabled a more flexible approach to training and education. The IPC team have undergone significant changes in personnel in 2018/2019, have maintained a seven day service and are now up to full establishment which will enable increased education and training initiatives in 2019/20.

Recommendation

Board of Directors is asked to note the year end position in respect of HCAI and for their support for the actions being taken to maintain high standards of care.

1. INTRODUCTION

This annual report summarises information on healthcare-associated infections for the period 1st April 2018 to 31st March 2019 including a summary of alert organisms and conditions. It includes information on Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia, Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and *Clostridium difficile*-associated diarrhoea. The report also includes a brief summary of the key measures which are used to reduce the risk of healthcare associated infections.

2. SURVEILLANCE DATA

2.1 *C. difficile*-associated diarrhoea

The total figure for *C. difficile* cases from April 2018 to March 2019 was 120. In 2017/2018 there were 125 cases so there has been a small decrease compared to last year. Between 2007 and 2013 there was a steady reduction in total numbers each year but numbers then increased between 2013 and 2015 before again starting to fall. In 2018/2019 the total number of cases was still 5.2% higher than in our lowest ever year.

The Trust target for 2018/19 was to have no more than 54 cases of Trust-apportioned *C. difficile* infection. Trust-apportioned means all cases occurring among inpatients in our trust excluding patients where the first positive sample was submitted on the day of admission or during the next two days (note the definition for Trust apportioned *C.difficile* is different to that for MRSA and MSSA bacteraemia and that this definition is also changing again for 2019/20). Between April 2018 and March 2019 the Trust had 41 patients in this category. In 2017/2018 there were 48 trust-apportioned cases so there has been a 14.6% decrease compared to last year. 2018/2019 was the lowest annual total of trust-apportioned cases we have ever had.

Between April 2018 and March 2019 there were 79 non-Trust-apportioned *C. difficile* cases compared to 77 the previous year. This is a 2.6% increase.

Table 1 shows cases of *C.difficile* by month and cumulative totals for 2018/2019

C diff	Total 2017/18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total 2018/19 to date	Target for 2018/19
Total cases	125	8	11	12	14	8	11	17	9	8	11	5	6	120	NA
Not trust apportioned	77	5	8	8	7	5	7	10	9	5	7	3	5	79	NA
Trust apportioned	48	3	3	4	7	3	4	7	0	3	4	2	1	41	54
- JCUH	45	3	3	2	4	2	4	6	0	3	4	1	1	33	
-FHN	3	0	0	1	2	0	0	0	0	0	0	0	0	3	
-Carters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Redcar	0	0	0	0	1	0	0	1	0	0	0	0	0	2	
-East Cl	0	0	0	1	0	0	0	0	0	0	0	0	0	1	
-Guis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Rutson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Friary	0	0	0	0	0	1	0	0	0	0	0	1	0	2	
-Lambert	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Table 1. Total number of *C.difficile* figures for 2018/2019

The 2019/2020 annual objective is to have no more than 81 *C. difficile* cases which are classed as either 'hospital-onset healthcare-associated' or 'community-onset healthcare-associated'. This target is slightly more difficult than our target of 54 trust-apportioned cases as we can expect an approximately 65-70% increase with the new definition. Cases are defined as follows:

- a) Healthcare-onset healthcare-associated: cases detected in the hospital ≥ 2 days after admission,

- b) Community-onset healthcare-associated: cases that occur in the community (or ≤ 2 days of admission) where the patient has been an inpatient in the trust reporting the case in the previous 4 weeks,
- c) Community-onset indeterminate-association: cases that occur in the community (or ≤ 2 days of admission) where the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks,
- d) Community onset community associated: cases that occur in the community (or ≤ 2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

As required by national *C. difficile* guidance, the Trust monitors how many of the patients who develop *C. difficile*, subsequently die within the following 30 days, regardless of cause. Since April 2009, 292/1639 patients (18%) have died during the 30 day follow-up period.

A cluster of *C. difficile* is described as two or more cases which may be linked. During 2017/2018 the Trust had 2 confirmed clusters. There have been no further episodes of linked cases by ribotype since June/July 2017.

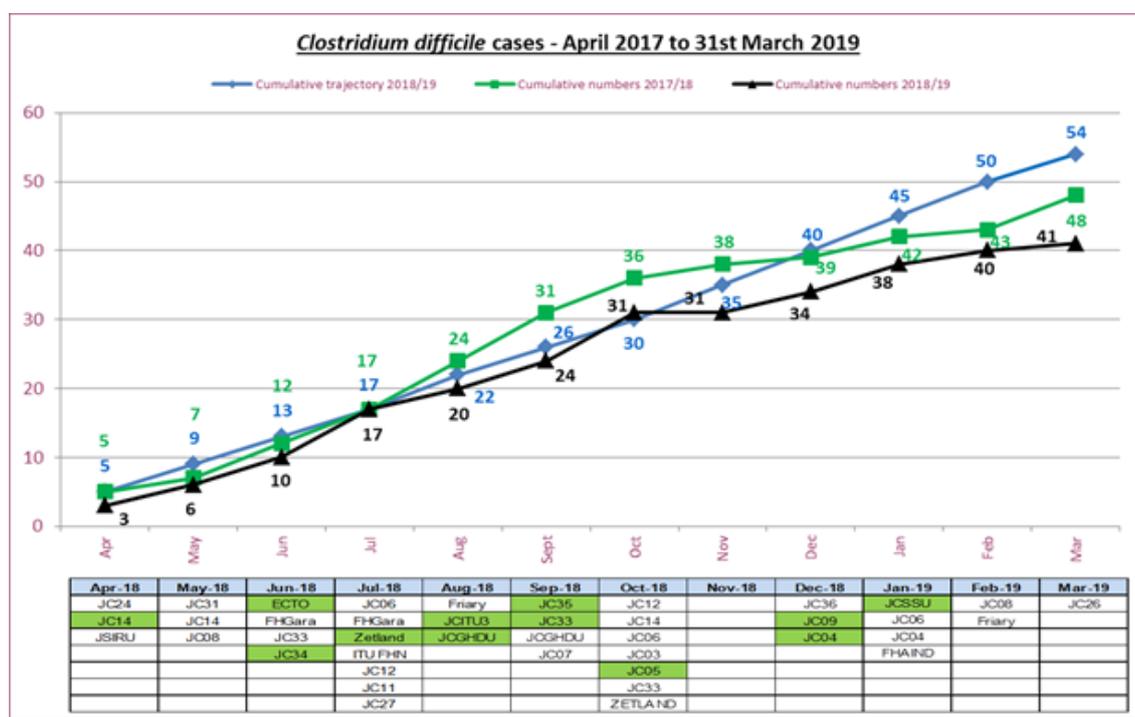


Figure 1. Cumulative totals of *C. difficile* from April 2017-March 2019

Appeal successful

Root Cause Analysis (RCA) and panel reviews are undertaken for all trust-apportioned *C. difficile* cases. Panel reviews are chaired by the DIPC or her Deputy and are attended by CCG colleagues (Hambleton and Richmondshire CCG confirmed an agreed process in line with South Tees CCG in Q4 2018/19 and have attended panel since then).

The Trust successfully appealed 12 cases via this process with South Tees CCG in 2018/19. 4 cases were successfully appealed in 2017/18.

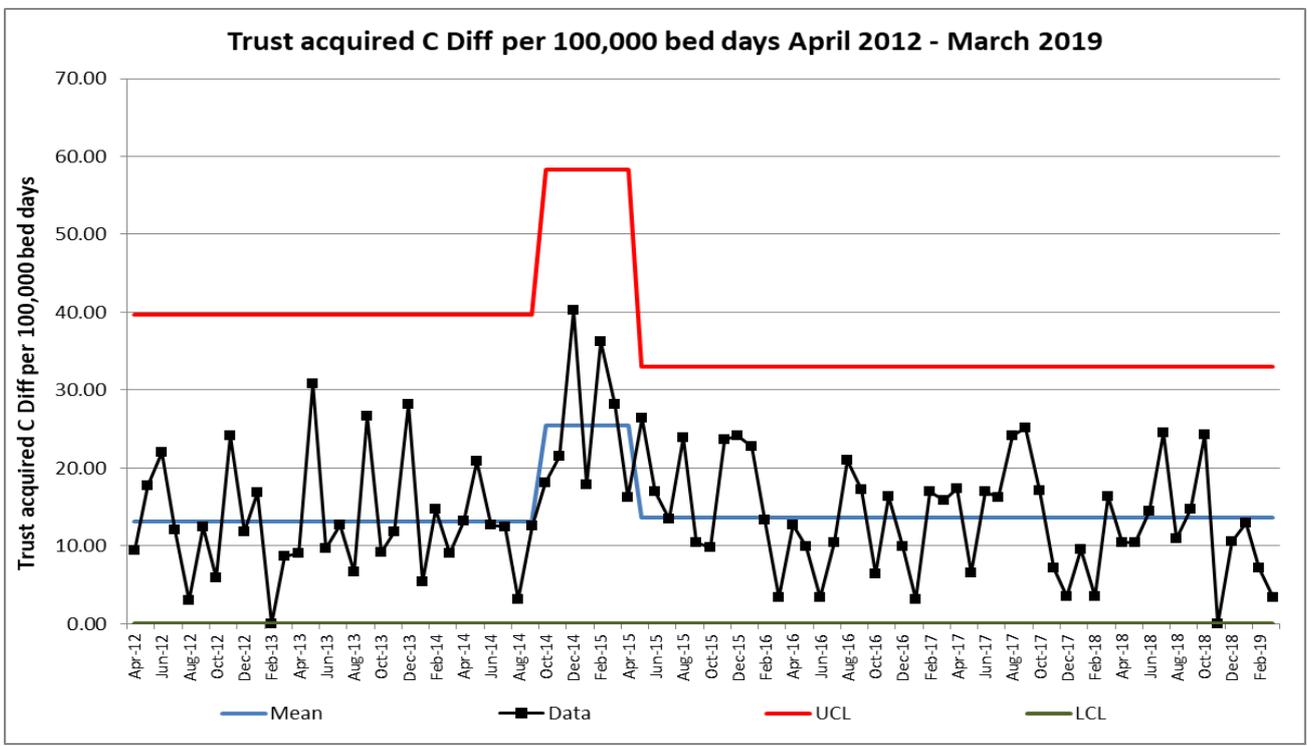


Figure 2. Trust acquired *C.difficile* per 100,000 bed days April 2012-March 2019

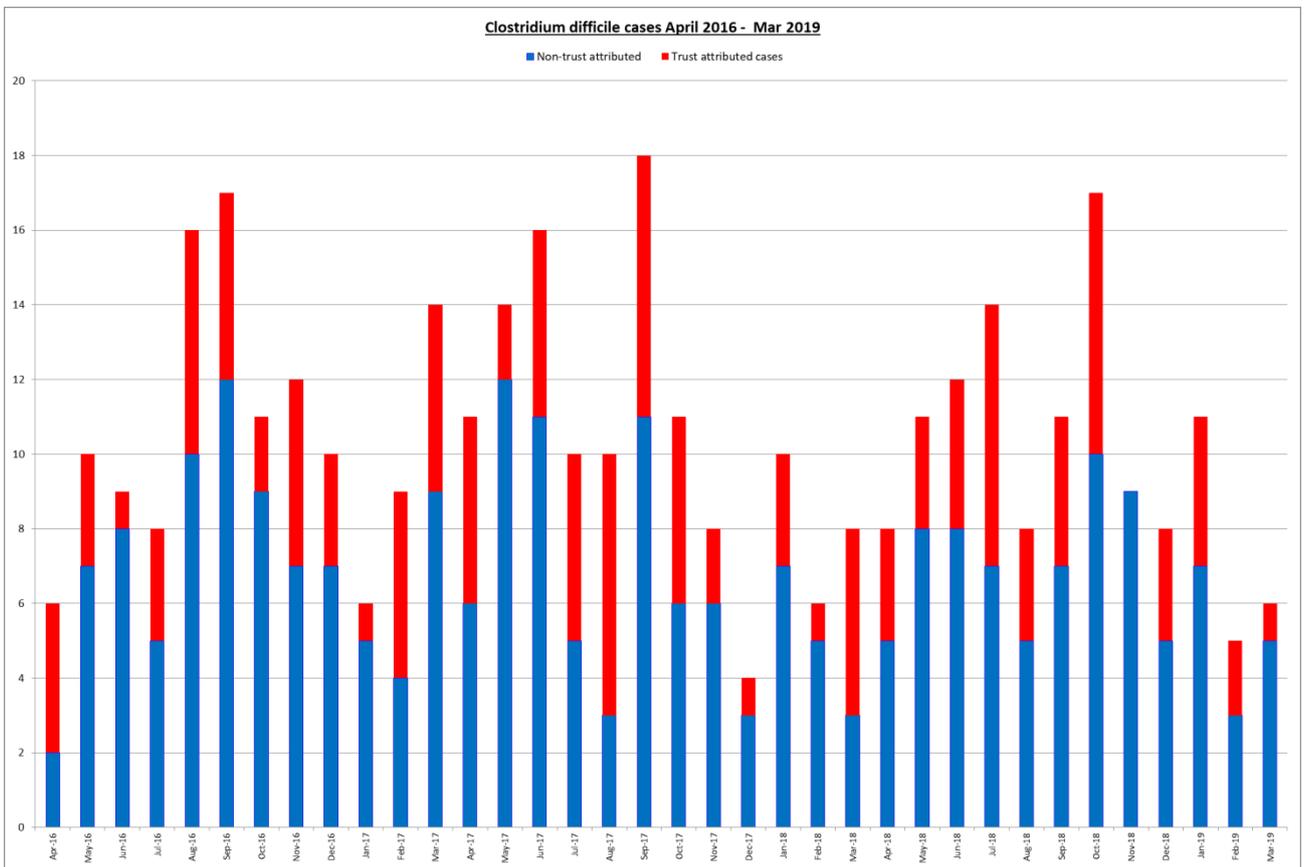


Figure 3. Trust and non-Trust attributes cases of *C.difficile* April 2016-March 2019

The main themes identified from the RCA process are as follows;

1. Delays in testing patients with diarrhoea for *C difficile*.
2. Delays in isolating patients with suspected or confirmed *C. difficile*.
3. Delays in commencing the use of the diarrhoea assessment tool.

As a consequence of the above recurrent themes and feedback from staff, we are pilot-testing a new diarrhoea algorithm to replace the diarrhoea assessment tool and to encourage earlier testing of stool samples and facilitate earlier isolation.

C. difficile death certificate audit

During 2007 the Healthcare Commission published a report on an investigation into deaths which had occurred at Maidstone and Tunbridge Wells NHS Trust and caused by *C. difficile*. In response to this, in 2007/8 we audited all deaths, from April 2005 to March 2008, at South Tees Hospitals where *C. difficile* was recorded on the death certificate. This was a similar method to that used by the Healthcare Commission. This audit has been repeated annually. Separate audits are now produced for JCUH and FHN.

In 2018/19, there were 5 cases included in the audit of JCUH cases and 0 cases at FHN. The death certificate counterfoils indicated that for 0 of these patients *C. difficile* or toxic megacolon was recorded as the primary cause of death (under Ia). For 5 patients *C. difficile* was recorded as a contributing/ predisposing factor in the patient's death (see table below). In the infection control doctor's assessment, *C. difficile* was the main cause of death for 0 patients and was a contributing/ predisposing factor for 4 patients. No deficiencies in care were identified, which were deemed to have contributed to the patients' deaths.

Section of death certificate	Number of death certificates	How this audit would have classified the death certificate
Ia (ie main cause)	0	0
Ib (predisposing factor)	1	0
Ic (predisposing factor)	0	0
II (contributory cause)	4	4
Was not or would not have been included on death certificate	0	1
Unable to complete death certificate (ie post-mortem was needed but not performed)	NA	0

Table 2. Classification of cases where *C. difficile* was entered on the death certificate, 2018-2019

This audit is attached as appendix 1 to this infection control report.

2.2 MRSA bacteraemia

The Department of Health set acute hospital trusts the target of reducing MRSA bacteraemia by 60% by the end of the 2007/2008 financial year compared to the baseline figure recorded in 2003/2004. Therefore, South Tees Hospitals target for 2007/8 was 27 Trust-assigned cases based on a baseline of 69 cases; whether or not a case is Trust-assigned is now determined by a case review. Since that time the number of episodes of MRSA bacteraemia fell progressively and has been maintained at a low baseline since around 2011/12.

MRSA	Total 2017/18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total 2018/19 to date	Target for 2018/19
Total cases	4	0	2	0	2	1	0	0	2	0	1	1	0	9	NA
Not trust assigned	3	0	2	0	2	0	0	0	2	0	1	1	0	8	NA

Trust assigned	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1	NA
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Table 3. MRSA bacteraemia cumulative totals for 2018/19 and compared to 2017/18

MRSA bacteraemia target is that of zero tolerance. There were 9 cases of MRSA bacteraemia in 2018/19, 1 of which was classed as trust-assigned. In comparison, there were 4 cases in 2017/2018, 1 of which was classed as Trust-assigned.

Since June 2006 every episode of MRSA bacteraemia has been investigated as a clinical incident to help identify lessons to be learnt and to guide improvements in practice. Since February 2008 the Director of Nursing/DIPC or deputy DIPC has chaired a case review meeting with the appropriate clinical staff. This has enabled a number of lessons to be learnt and has helped the Trust to focus attention on avoidable causes of MRSA bacteraemia.

In 2018/19, 4 episodes of bacteraemia were investigated. One of these patients died during the current admission, No avoidable causal factors, related to our trust, were identified. This compares to 1 case with an avoidable factor identified in 2017/18 and 7 cases with avoidable causal factors in 2016/17. The causes of MRSA bacteraemia are summarised in table 4 below.

Cause	Number of episodes (Trust-assigned cases)	Number where an avoidable factor was identified in our Trust	Number of patients who died due to MRSA or who died during the current episode of illness
Infected prosthetic knee replacement	2(0)	0	0
Community-acquired pneumonia	2(0)	0	0
Sacral pressure sore	1(1)	0	0
Post-op wound infection	1(0)	0	0
Infected discitis	1(0)	0	0
Skin infection related to psoriasis	1(0)	0	1
Contamination (possibly in lab)	1(0)	0	0
Total	9(1)	0	1

Table 4 Summary of causes of MRSA bacteraemia for 2018/2019

A report has been produced on these MRSA bacteraemias, for those who require more detail than is available in the current summary (see appendix 2).

2.3 MSSA bacteraemia

Between April 2018 and March 2019 there were 134 episodes of MSSA bacteraemia. 42 of these cases were classified as Trust-apportioned (defined as all cases occurring in inpatients other than those where the blood culture was taken on admission or on the day after admission).

There is no external target for MSSA bacteraemia. However, the trust set an internal target for a 15% reduction from the 2016/17 baseline of 41 trust-assigned MRSA and trust-apportioned MSSA cases combined. This gives an upper threshold of 35. We have exceeded this upper threshold as we had a combined total of 43 trust-apportioned cases during 2018/19. There has been a 22.9% increase in combined Trust-apportioned MSSA and trust-assigned MRSA bacteraemia cases compared to 2017/18 and a 1.0% decrease in non-Trust-apportioned cases.

Since February 2008 a root cause analysis to be performed and a case review meeting held within the relevant clinical centre/directorate for every Trust-apportioned MSSA bacteraemia.

MSSA	Total 2017/18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total 2018/19 to date	Target for 2018/19
Total cases	130	9	23	8	13	13	10	9	8	12	10	8	11	134	NA
Not trust apportioned	96	6	16	6	11	9	6	5	6	8	7	5	7	92	NA
Trust apportioned	34	3	7	2	2	4	4	4	2	4	3	3	4	42	NA

Table 5. MSSA bacteraemia cumulative totals for 2018/19 and compared to 2017/18

The commonest causes of MSSA bacteraemia in 2018/19 were:

- Pneumonia (30 cases)
- Skin and soft tissue infection (30 cases)
- Septic arthritis (9 cases)
- Central venous lines (8 cases)
- Surgical site infection (6 cases)
- Peripheral venous cannulae (6 cases)

Enhanced training for Aseptic Non-Touch Technique (ANTT) is being implemented across the trust for all relevant staff groups to address avoidable causes related to invasive procedures.

2.4 Surveillance for other alert organisms

Other alert organisms detected in 2018/19 compared to 2017/18	Total for 18/19	Total 17/18
Bacteraemia due to glycopeptide-resistant enterococci	10	7
Bacteraemia due to <i>E. coli</i>	550	500
• Trust-apportioned	129	106
• Not trust-apportioned	421	394
ESBL producing coliform infections	953	798
• sample taken in community	599	490
• sample taken in our trust	354	304
• bacteraemias	28	25
Bacteraemia due to <i>Klebsiella</i> species	134	131
• Trust-apportioned	37	41
• Not trust-apportioned	97	90
Bacteraemia due to <i>Pseudomonas aeruginosa</i>	37	41
• Trust-apportioned	12	19
• Not trust-apportioned	25	22
Other alert organisms		
• invasive group A streptococcus	1	1

Table 6. Surveillance of GNBSI and other alert organisms

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in avoidable bacteraemia by 2021. During 2018/2019, the trust reported a total of 721 cases of the three GNBSI organisms which are part of national surveillance (*E.coli* 550; *Klebsiella* species 134; *Pseudomonas aeruginosa* 37). Of these, 178 cases were classed as trust-apportioned (24.7%) as defined by the Department of Health definition. This is a 7.3% increase in total cases compared to 2017/18 and a 7.2% increase in hospital-apportioned cases. This demonstrates the need to continue working in collaboration with the wider community as part of the Tees-wide collaborative which supports a number of initiatives within the community setting.

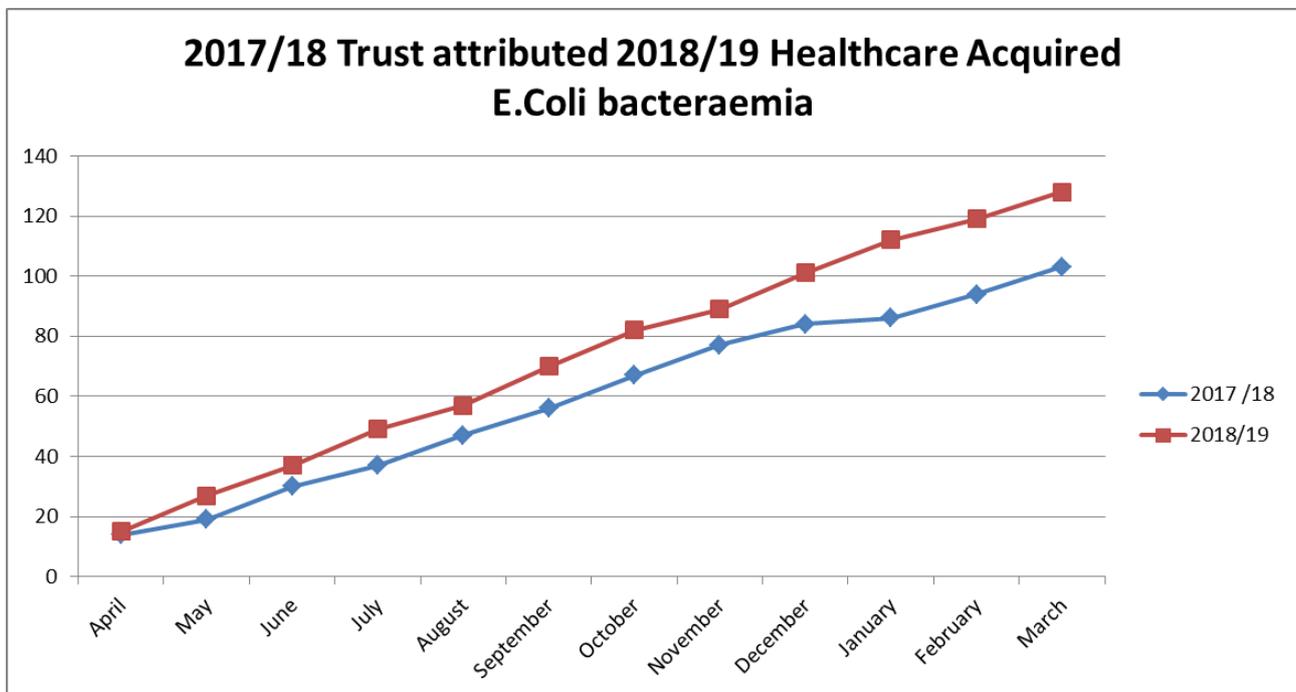


Figure 4. Trust attributed E.coli bacteraemia for 2017/18 and 2018/19

Initiatives in the community will be emulated and implemented within the acute trust in order to reduce these infections. The trust continues to take part in the national GNBSI urinary tract infection collaborative hosted by NHS Improvement/ NHS England. The focus of this improvement programme is hydration and urinary catheter care in both the community setting in the older population and care home setting. A number of resources have been made available to support targeted hydration campaigns. This collaborative work is being led by the IPC post currently hosted by the trust and funded through the 'Better Care Fund'.

ESBL-producing coliforms are highly antibiotic-resistant Gram-negative bacteria. The majority of isolates of these organisms are from the urinary tract, but they also cause wound infections, biliary and gastrointestinal tract infections, pneumonia and bacteraemia. The majority of infections are community-acquired. ESBL producing coliforms are not included in mandatory national surveillance, however, prevalence data regarding bacteraemias enables the most effective comparison year on year. In 2018/19 there were 28 bacteraemias due to ESBL-producing coliforms, compared to 25 in 2017/18.

Glycopeptide-resistant Enterococci are highly antibiotic-resistant Gram-positive bacteria. The majority of infections are healthcare-associated. They are included in mandatory national surveillance. In 2018/19 there were 10 bacteraemias caused by glycopeptide-resistant Enterococci, compared to 7 in 2017/18.

In 2012/13 we introduced monitoring for *Pseudomonas aeruginosa* in the water supply in critical care areas supported by active monthly surveillance. *Pseudomonas aeruginosa* has been detected periodically in several areas and action plans developed.

We have had an outbreak of GES-carbapenemase-producing, multi-drug-resistant *Pseudomonas aeruginosa* over the last 5 years, originally linked to critical care and the renal dialysis unit and urology ward. In total 24 patients have been affected by the GES carbapenemase-producing strain. The 3 cases that were identified during 2018/19, probably acquired the organism several years previously. A large number of actions have been taken. We believe that cases have occurred due to patient-to-patient transmission rather than due to water-borne infection or another environmental source.

Acute trusts in the North and South locality across Teesside have seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing *Klebsiella pneumoniae* over the last year. The major risk factors have been inpatient admission to other trusts or residence in particular care homes. We do not believe transmission has occurred unknowingly in our trust. An extensive contact screening programme has only identified one case of transmission.

2.5 Surveillance for other alert conditions

There was a single case of healthcare-associated invasive group A streptococcus infection in a non-maternity patient in February 2019. Previously there was a single non-maternity case in 2010/11 and 2 maternity cases in 2013 and 2017.

No cases of any of the other alert conditions included in the surveillance policy (HIC 29) have been identified since April 2006.

Legionella has been detected in the water supply in several areas during the last 8 years. There have been no cases of Legionnaires' disease acquired in our Trust. Currently we believe that our control measures are proving effective.

2.6 Orthopaedic surgical site infection surveillance

The trauma and orthopaedic directorate conduct mandatory surgical site infection surveillance following elective hip and knee replacement surgery at both the JCUH and FHN sites. This data was presented at IPAG in March 2019 and highlighted no concerns. However other surgical site surveillance across the Trust is highly variable and plans for 2019/20 are to ensure a more robust monitoring and assurance framework

2.7 Outbreaks of diarrhoea and vomiting

During the winter months each year there have been outbreaks of Norovirus infection, which have caused significant disruption to the Trust. The Trust was particularly affected by Norovirus during the winter of 2006/2007 and again in. in 2011/12 and 2012/13. Since 2013 to date the Trust has not been significantly affected by large numbers

Year	Patients affected	Staff affected
2006/7	606	151
2007/8	221	82
2008/9	187	54
2009/10	215	102
2010/11	40	30
2011/12	250	114
2012/13	383	166
2013/14	43	8
2014/15	22	18
2015/16	73	16
2016/17	17	14
2017/18	42	15
2018/19	1	9

Table 6. Comparison of patients and staff affected by winter vomiting disease during outbreaks at South Tees Hospitals between 2006/7 and 2016/17

2.8 Influenza

In 2018/19 we produced an infection control policy on influenza and other acute respiratory tract infections to provide more detailed and specific guidance than was provided in our isolation policy and other generic policies. This has proved useful in ensuring greater consistency with infection control measures for acute respiratory infections.

Influenza had a much smaller impact on our trust in 2018/19 compared to the previous winter. This was probably due to the much greater vaccine efficacy and lower community burden this year.

The trust achieved an 80.2% vaccination rate for clinical staff this year. This is a major factor in protecting patients, staff members and their families.

3. ANTIMICROBIAL STEWARDSHIP

The Trust has an antimicrobial policy, antimicrobial guidelines and an antimicrobial stewardship committee. This committee reports jointly to IPAG and to the Drug and Therapeutics Committee. In 2018/19 there was a national CQUIN with respect to antimicrobial stewardship:

- 2% reduction in total antibacterial consumption compared to the 2017/2018 financial year.
- 2% reduction in carbapenem usage compared to 2017/2018.
- Increase the proportion of “Access” antibiotics the Trust uses by 3% compared to 2016 calendar year. This is taken from the WHO AWaRe categories.

Based on our current antibiotic usage we believe we will probably not have achieved the AWaRe and total consumption targets. The latter target was particularly difficult because we made changes to the antimicrobial guidance in response to audit data which showed a rise in co-amoxiclav resistance among Gram-negative bacteria. The guidance has been released as a “Sepsis and Infection (not sepsis)” poster in January 2019. The antibiotic guidelines are being developed into a user-friendly ‘app’ in conjunction with North Tees Hospitals NHS Foundation Trust. This should improve the functionality of the guidance making it much easier to follow and use.

The antimicrobial CQUIN for 2019/20 focuses on 3 areas:

1. Diagnosis and antibiotic prescribing for lower urinary tract infections.
2. Antibiotic prophylaxis for colorectal surgery.
3. Diagnosis and antifungal prescribing for systemic fungal infections.

The trust is continuing with a number of antimicrobial stewardship initiatives including the ARK project.

4. DECONTAMINATION

The key issues in relation to decontamination during 2018/19 are:

Decontamination work continues to look at safe and effective ways of reprocessing and use of scopes. Trisoft Tracking and Traceability was rolled out across the organisation in 2018/2019.

It was noted in 2018/2019 that biopsy sheaths for the scopes to enable endoscopy procedures to be carried out in accordance with the CJD policy were not available in the organisation. Plans are in place to purchase the sheaths to reduce the likelihood of contamination during procedures.

Single use nebuliser masks have been introduced in 2018/2019 to mitigate the risk of Pseudomonas acquisition when the nebulisers are reused.

Hydrogen peroxide vapour (HPV) continues to be used to eliminate the presence of microorganisms in rooms where there are cases of infection. HPV is not always possible to deploy in small rooms such as toilets and bathrooms. In 2018/2019 a misting sporicidal canister was introduced for use in areas where HPV could not be achieved.

A complete site survey of the organisation was undertaken in 2018/2019 to ensure that installation of hand hygiene dispensers was completed in all areas.

There has now been full implementation of electronic scanning traceability for flexible endoscopes being used and decontaminated across the trusts.

No cases of endocarditis due to Mycobacterium chimaera have been identified in our trust. The procedures to minimise the risk of heater-cooler contamination remain in place.

The building work for the decontamination room proposed for theatres has not yet been commenced. This remains an important infection control priority.

5. HAND HYGIENE

The average hand hygiene self-assessment score between April 2018 and March 2019 was 94% and peer review average was 91%. Peer reviews are conducted by IPCNs and Clinical Matrons during monthly Clinical Assurance rounds and independent reviews carried out by Therapeutic Care Volunteers.

A return summary of the audit returns is attached as an appendix to this report.

6. CLEANING

The trust continues to monitor monthly cleaning scores through IPAG.

The James Cook Site:

Risk Category	NSC Target	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
High Risk	95%	99%	99%	99%	98%	98%	98%	98%	98%	98%	98%	98%	99%
Significant Risk	85%	97%	98%	97%	97%	97%	97%	97%	97%	97%	96%	97%	98%
Low Risk	75%	95%	95%	96%	95%	94%	94%	95%	95%	95%	94%	95%	96%

Table 7. Cleaning scores for James Cook site for 2018/2019

Cleaning scores have been maintained on the JCUH site. One area failed C4C inspection in March 2019 on the James Cook site: Occupational Health. Maintaining cleaning standards remains an area of continued focus in conjunction with our service provider SERCO. The monthly cleaning standards review meetings continue to be led by the Director of Estates and cleaning scores continue to be monitored via IPAG. The trust will be adopting the new cleaning standards in 2019 which utilise red, amber and green risk categories.

The Friarage, Friary, East Cleveland and Redcar Primary Care Hospital:

Risk Category	NSC Target	FHN Site	Friary	East Cleveland	Redcar PCH
Very High Risk	98%	99.31%	99.77%		100%
High Risk	95%			95%	100%
Significant Risk	85%			96%	100%
Low Risk	75%	95.83%		94%	100%

Table 8. Cleaning scores for community sites for 2018/2019

The scores on The James Cook site are an aggregated monthly score. Some clinical areas have been through a period of weekly monitoring until the cleaning score reached the required target as agreed with the service provider.

The IPC team commenced screening all requests for terminal cleans in October 2017. This has continued throughout 2018/2019.

7. TRAINING AND EDUCATION

A suite of toolbox teaching packages have been developed and delivered over 2018 /19. These bite size packages facilitate opportunistic education in the clinical areas as well as more formal planned sessions.

The toolbox teaching includes:

- Antibiotic Guardian toolbox teaching
- Clostridium difficile toolbox teaching
- ANTT toolbox teaching
- MRSA toolbox teaching
- Multi Drug resistant toolbox teaching
- Peripheral intravenous cannula toolbox teaching
- Urinary Catheter toolbox teaching

In total 590 members of staff have received training from the IPC team in 2018/19.

8. CONCLUSION

Securing reductions in the incidence of healthcare associated infection continues to be a quality priority for the organisation in 2018/19 as we drive to eliminating avoidable harm.

Richard Bellamy
Astrida Ndhlovu
Helen Day
Gill Hunt

Appendix 1	C. difficile death certificate audit (JCUH & FHN)	 Clostridium difficile death cert audit Apr :
Appendix 2	MRSA clinical incident report	 Clinical incident reports summary Apri
Appendix 3	Cleanyourhands completion of audits programme	



South Tees Hospitals **NHS**
NHS Trust

Audit of deaths where Clostridium difficile was included on the death certificate at JCUH

CLINICAL AUDIT DATABASE NO. 1685

April 2018 - March 2019

Audit Report By:

Richard Bellamy

Lead Clinician:

Richard Bellamy

1. Background & Aims

During 2007 the Healthcare Commission published a report on an investigation into deaths which had occurred at Maidstone and Tunbridge Wells NHS Trust which were caused by Clostridium difficile. Following the publication of this report it was decided to attempt to identify how many deaths at South Tees Hospitals NHS Trust may have been caused by Clostridium difficile. It was decided that we would audit deaths where Clostridium difficile was recorded on the death certificate. This is a similar method to that used by the Healthcare Commission. In the first report death certificates were examined from all wards at JCUH and FHN from April 2005 to March 2008 inclusive (ie 36 months). I examined the cases in detail to determine if Clostridium difficile had contributed to each patient's death and if it had been the primary cause of death. A second cycle of this audit prospectively covered the period April 2008 to March 2009. An annual report has been conducted prospectively since then. This is the twelfth annual report and prospectively covers 1st April 2018 to 31st March 2019. FHN is now covered separately.

I have attempted to determine whether there were deficiencies in the care of patients with Clostridium difficile by examining the same factors considered by the healthcare commission:

- Use of inappropriate broad-spectrum antibiotics
- Whether the patient had appropriate investigations
- Whether appropriate specialists were involved in the patient's care
- Whether the patient received appropriate treatment for Clostridium difficile
- Whether there was adequate management of the patient's nutritional needs
- Whether there was adequate management of the patient's hydration needs
- Whether skin care had been adequate
- Whether there had been other deficiencies in care which may have contributed to the patient's death

2. Objective of Audit

To determine how many patients at James Cook University Hospital died as a direct result of Clostridium difficile infection between April 2018 and March 2019.

To determine how many patients at James Cook University Hospital died between April 2018 and March 2019 where Clostridium difficile contributed to the cause of death.

To determine whether patients, who died directly from Clostridium difficile or where this was a contributing factor, were correctly managed.

3. Standards of care to be measured

For patients who died from Clostridium difficile:

- 100% should not have received inappropriate broad-spectrum antibiotics
- 100% should have had appropriate investigations

- 100% should have had appropriate specialists involved in their care
- 100% should have received appropriate treatment for Clostridium difficile
- 100% should have had adequate management of their nutritional needs
- 100% should have had adequate management of their hydration needs
- 100% should have had adequate skin care (ie should not have developed a pressure sore).
- 100% should not have had any other deficiencies in care which may have contributed to their death

4. Method

This was a prospective audit. All consultants and ward managers were informed that Dr Bellamy must be informed of any deaths where Clostridium difficile was recorded on the death certificate. Since January 2011 all cases were seen by the weekly Clostridium difficile ward round and this ensured all Clostridium difficile-associated deaths were identified. After identifying the deaths, the patients' notes were reviewed along with all radiological investigations and all results on the pathology database. A standard pro-forma was completed from the former Healthcare Commission (see Appendix 1). As this did not identify deficiencies in care and lacked details, a further root cause analysis form was completed, which was based on the information collected by the Healthcare Commission at Maidstone and Tunbridge Wells (see Appendix 2).

5. Findings

5 death certificates were identified where Clostridium difficile (or a recognisable abbreviation) or pseudomembranous colitis had been recorded on the death certificate.

It is possible that there have been other deaths due to Clostridium difficile between April 2018 and March 2019 which this audit has failed to detect. The reason for this is that the general practitioner may have completed the death certificate if the patient had been discharged from hospital.

Therefore it is possible that there are additional deaths which have been recorded as Clostridium difficile which are held by the Office for National Statistics which were not identified by this audit. It is extremely unlikely that this will be more than 1-2 cases.

5 patients were included in this audit. The death certificate counterfoils indicated that for 0 of these patients, Clostridium difficile or toxic megacolon was recorded as the primary cause of death (under Ia). For 5 patients, Clostridium difficile was recorded as a contributing/predisposing factor in the patient's death (for 1 patient it was recorded under Ib, for 0 patients under 1c and for 4 patients under II) (see table 1 for summary).

Table 1: Inclusion of Clostridium difficile in the classification of the cause of death

Section of death certificate	Number of death certificates	How this audit would have classified the death
------------------------------	------------------------------	--

		certificate
Ia (ie main cause)	0	0
Ib (predisposing factor)	1	0
Ic (predisposing factor)	0	0
II (contributory cause)	4	4
Was not or would not have been included on death certificate	0	1
Unable to complete death certificate (ie post-mortem was needed but not performed)	NA	0

No death certificates incorrectly omitted C. difficile when it was relevant. One death certificate included C difficile where the infection control doctor felt it was not relevant to the patient's death.

In my assessment Clostridium difficile was the definite or probable main cause of death for 0 patients and the possible main cause of death for a further 2 patients. It was judged to be unlikely to be the main cause of death or not the main cause for 3 patients. Among the 3 patients for whom Clostridium difficile was judged unlikely to be the main cause of death, it was judged that for 0 patients it was definitely or probably a contributing/predisposing factor and for 2 patients it was possibly a contributing/predisposing factor and for 1 patient it was unlikely or not a contributing/predisposing factor (see table 2 for classification).

If I had completed the death certificates myself I would have coded Clostridium difficile as the main cause of death (Ia) for 0 patients, as a predisposing factor for 0 patients (Ib/Ic) and as a contributing factor (II) for 4 patients. There were 0 cases for which I could not have completed the death certificate and a coroner's post-mortem would have been needed. For 1 case I judged that C difficile did not need to have been on the death certificate as it was unlikely to be a contributing factor. See table 1 for summary.

Table 2: Cases where Clostridium difficile was judged to be the main cause or a contributing/predisposing cause of death

	Main cause of death	Contributing/predisposing factor (excluding cases where classed as definite, possible or probable main cause of death)
Definite	0	0
Probable	0	2 (0)
Possible	2	2 (2)
Unlikely	3	1
Not involved	0	0
Unable to answer	0	0

For the 4 patients where Clostridium difficile was judged to have been appropriate to write on the death certificate as a contributing/predisposing factor or as the main cause of death (or where it was judged unclear) the following deficiencies in care were identified:

- 0/4 had received inappropriate broad-spectrum antibiotics.
- 0/4 had not had appropriate investigations (eg an abdominal X ray).
- 0/4 did not have appropriate specialists (gastroenterologists, infectious disease physicians or microbiologists) involved in their care.
- 0/4 did not receive appropriate initial treatment for Clostridium difficile.
- 0/4 did not receive vancomycin at a time when it was indicated.
- 0/4 had a significant delay in starting treatment.
- 0/4 did not have an adequate assessment of their nutritional needs
- 0/4 probably became malnourished due to lack of nutritional assessment.
- 0/4 did not have adequate monitoring of fluid balance
- 0/4 suffered clinically important dehydration as a result of poor monitoring.
- 0/4 did not have an adequate assessment of skin condition
- 0/4 developed a pressure sore in the trust.
- 0/4 had other deficiencies in care which may have contributed to death.

However for 3 patients the death was not discussed with the coroner. In future the medical examiner system should provide greater consistency in discussing cases with the coroner.

6. Conclusions

This audit identified 0 patients where Clostridium difficile had definitely or probably been the main cause of death. A further 2 cases were identified where it was probably a contributory factor.

Care was generally appropriate for patients with C difficile.

For 3 patients the case was not discussed with the coroner even though Clostridium difficile had been recorded on the death certificate.

7. Recommendations

1. As the audit provides reassurance that appropriate care is being given to patients with C difficile there are no specific recommendations other than continuation of the multi-disciplinary ward round and continuation of the C difficile death certificate audit.

8. Action Plan

1. This report will be presented to the Infection Prevention Action Group and included as an appendix to the infection control annual report.
2. The Clostridium difficile multi-disciplinary ward round will continue at JCUH.
3. This audit should continue so that all future deaths where Clostridium difficile is recorded on the death certificate will be analysed using the root cause analysis tool and former Healthcare Commission tool.

Reviewers had to make a judgment on the likelihood of *C. difficile* infection (CDI) contributing to or being the main cause of an individual's death **based on their review of that person's records / case notes**. Each case was assessed by at least two reviewers who then discussed their assessment of contribution / cause of death and agreed a joint assessment.

The questions below were used to help reviewers make these judgments – they **were not** in themselves used to determine the final assessments directly.

Appendix 1: Healthcare Commission audit tool



Cause of Death

Please specify if and how CDI was mentioned on the patient's death certificate

- Yes If Yes, Category
 No
 Unable to determine

How would you categorise the patient's condition on admission?

- The patient had an acute or chronic condition expected to be rapidly fatal within 1 month
- The patient had an acute or chronic condition expected to be fatal within 1-12 months
- The patient had an acute or chronic condition expected to be fatal in over 12 months
- The patient had an acute or chronic condition not expected to be fatal
- Insufficient data to categorise as above

If insufficient data, please specify

Was there evidence that the patient was recovering from the illness for which they were admitted?

- Yes No N/A Unable to determine

Was there evidence that the patient died as a direct result of the admitting illness?

- Yes No N/A Unable to determine

Aside from CDI, what other serious illnesses were diagnosed in hospital?

Illness	Comment on severity

Was there evidence that diarrhoea and / or other symptoms and signs of CDI had improved before death?

- Yes No N/A Unable to determine

Was any of the following present after diagnosis of CDI?

Marker	Yes	No	Not measured or recorded
White cell count > 15,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creatinine level > 150	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Albumin level < 25	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CRP level > 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever $\geq 38^{\circ}\text{C}$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain, tenderness or distension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea > 5 times a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deterioration in mental status not explicable by other illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was there evidence that the clinical course was:

	Yes	No	Unable to determine
Compatible with death from an admission illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compatible with death from a pre-existing illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compatible with death from a complicating illness (not CDI)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compatible with severe CDI?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compatible with death from CDI?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does the evidence suggest that in this patient CDI:

	Definitely	Probabl y	Possibl y	Unlikely	No
Contributed to this patient's death?	<input type="checkbox"/>				
Was the primary cause of death?	<input type="checkbox"/>				

Please comment on the above:

Appendix 2: Clostridium difficile death certification audit form (following items covered in the Maidstone and Tunbridge Wells investigation)

Patient's name

Date of birth

Hospital number

Dates of positive C difficile positive samples

Date of death

Coding of death certificate

Ia

Ib

Ic

II

Description of patient episode

Was the patient appropriately assessed for C difficile disease (radiology etc)?

Were appropriate specialists involved (gastroenterology, ID or microbiology)?

Did the patient receive broad-spectrum antibiotics which were inappropriate?

Was the patient given appropriate treatment for C difficile infection?

Was this treatment commenced prior to the stool result being available, at diagnosis of C difficile or only after unacceptable delay?

Was the patient treated with oral vancomycin?

Was fluid balance monitored appropriately?

Was dehydration appropriately managed?

Was nutritional status adequately assessed?

Was feeding provided appropriately?

Was the patient isolated?

Did isolation occur when diarrhoea began or only when C difficile diagnosed?

Did the patient have an assessment of pressure areas?

Did the patient develop a pressure sore during the episode?

Were there any other apparent deficiencies in care?

Post-mortem information

Conclusion

Lessons learnt

Did C difficile contribute to the patient's death?

1. **Definite** (post-mortem findings and/or Ia or lower and bowel symptoms, hydration or nutrition definitely contributed to death)
2. **Probable** (Ib or lower and bowel symptoms, hydration or nutrition probably contributed to death)
3. **Possible** (Ib or lower and unclear whether bowel symptoms, hydration or nutrition probably contributed to death)
4. **Unlikely** (diarrhoea not significant prior to death)
5. **No** (response to treatment, asymptomatic prior to death)

Was C difficile the main cause of the patient's death?

1. **Definite** (post-mortem findings and/or Ia and compatible with information in notes)
2. **Probable** (Ib or lower and no other reasonable cause of death)
3. **Possible** (Ib or lower and other reasonable cause of death found in addition)
4. **Unlikely** (diarrhoea not significant prior to death)
5. **No** (response to treatment, asymptomatic prior to death)

Given all of the information how would I have coded death certificate?

Ia
Ib
Ic
II

Signature _____ GMC number _____



South Tees Hospitals **NHS**
NHS Trust

Audit of clinical incident investigations on patients with MRSA bacteraemia

CLINICAL AUDIT DATABASE NO. 2376

April 2018 - March 2019

Audit Report By:

Richard Bellamy

Lead Clinician:

Richard Bellamy

Report on clinical incident investigations on patients with MRSA bacteraemia: April 1st 2018 to 31st March 2019

1. Summary

This report summarises the findings of clinical incident investigations on 9 episodes of MRSA bacteraemia between April 1st 2018 and 31st March 2019. One of these patients died during the current admission. An avoidable causal factor, due to care delivered by South Tees Hospitals, was identified in none of the bacteraemia cases. A primary care factor was felt to be an avoidable causal factor in the MRSA bacteraemia in none of the cases. In 1 case there was an avoidable causal factor in the care delivered in another acute NHS trust. This year there was 1 Trust-assigned case. The two most common causes were infected total knee replacement (2 cases) and community-acquired pneumonia (2 cases).

2. Introduction

Since June 1st 2006, a clinical investigation has been performed on all cases of MRSA bacteraemia. In April 2007 a report was produced summarising the findings of all of the cases investigated between June 1st 2006 and 31st March 2007. These investigations were commenced following guidance from the Department of Health.¹ This audit has continued ever since. This thirteenth annual report summarises the cases between April 1st 2018 and March 31st 2019.

3. Methods

Each case was investigated by the same consultant infectious diseases physician. The reports were produced as soon as possible after identification of the MRSA bacteraemia. The investigation was based on review of the medical and nursing notes, results of investigations and supporting documentation. Where possible the patient was interviewed and/or examined by the investigator. Staff members caring for the patient were interviewed when appropriate. Draft reports were circulated to the relevant consultants and senior nursing staff and to colleagues in primary care for comments. Draft reports were revised if additional information became available at a later date, for example from the matron's root cause analysis. Case reviews were subsequently held to discuss the findings of the investigations and to determine what actions could be taken to prevent further cases.

Standard of care:

0% of patients with MRSA bacteraemia should have an avoidable cause attributed to the Trust.

4. Causes of bacteraemia

9 episodes of bacteraemia were investigated: 8 from JCUH and 1 from FHN. One of these patients died during the current admission.

An attempt was made to determine if there were identifiable deficiencies in care, which were felt to have been a direct contributor to the bacteraemia. A case was classified as avoidable only if it was felt that the bacteraemia would not have occurred if the deficiencies in care had not occurred. A case was not classified as avoidable if

deficiencies in care were identified but it was believed that they did not lead to the bacteraemia. It was also not classified as avoidable if standard protocols were being followed, even if these protocols have subsequently been changed after recognition that they may be leading to excess cases of bacteraemia. An avoidable cause was identified in 0 bacteraemia cases. In 0 cases a primary care factor was felt to have been a causal factor for the MRSA bacteraemia. In 1 case there was an avoidable causal factor in the care delivered in another acute NHS trust. This case was an infected knee replacement.

The causes of bacteraemia are summarised in table 1.

Table 1: Summary of MRSA bacteraemia episodes

Cause	Number of episodes (Trust-assigned cases)	Number where an avoidable factor was identified in our Trust	Number of patients who died due to MRSA or who died during the current episode of illness
Infected prosthetic knee replacement	2(0)	0	0
Community-acquired pneumonia	2(0)	0	0
Sacral pressure sore	1(1)	0	0
Post-op wound infection	1(0)	0	0
Infected discitis	1(0)	0	0
Skin infection related to psoriasis	1(0)	0	1
Contamination (possibly in lab)	1(0)	0	0
Total	9(1)	0	1

5. Conclusions

Clinical investigation of 9 episodes of MRSA bacteraemia identified 0 cases with an avoidable causal factor at our Trust. Additional cases where an avoidable factor could not be identified may also have been caused by unrecorded breakdowns in infection control.

The total number of cases of MRSA bacteraemia remains low compared to several years ago.

7. Action plan

1. This report will be presented to the Infection Prevention Action Group and included as an appendix to the infection control annual report.
2. This audit should continue as a part of the MRSA case review process to attempt to learn further lessons to prevent MRSA bacteraemia.



Richard Bellamy
Infectious diseases physician

8. References

1. Letter from Duncan Selbie to SHA chief executives dated 9th June 2006.

Board of Directors	
Agenda item	3.3
Title of Report	Safe Staffing Report – Nursing and Midwifery
Date of Meeting	2 July 2019
Presented by	Gill Hunt, Director of Nursing and Quality
Author	Eileen Aylott, Assistant Director of Nursing, Workforce
Approved by	Gill Hunt, Director of Nursing and Quality
Previous Committee/Group Review	
Purpose	<p style="text-align: center;">Approval <input type="checkbox"/> Decision <input type="checkbox"/></p> <p style="text-align: center;">Discussion <input checked="" type="checkbox"/> Information <input checked="" type="checkbox"/></p>
Alignment to Trust's Strategic Objectives	<p><input checked="" type="checkbox"/> 1. We will deliver excellence in patient outcomes and experience</p> <p><input checked="" type="checkbox"/> 2. We will drive operational performance to deliver responsive, cost effective care</p> <p><input type="checkbox"/> 3. We will deliver long term financial sustainability to invest in our future</p> <p><input checked="" type="checkbox"/> 4. We will deliver excellence in employee experience to be seen as an employer of choice</p> <p><input type="checkbox"/> 5. We will develop clinical and commercial strategies to ensure our long term sustainability</p>
Alignment to Board Assurance Framework	
Legal/Regulatory Compliance Requirements (if applicable)	<ul style="list-style-type: none"> • Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • NHS Improvement • NHS England
Recommendation(s)	The Board of Directors is asked to receive and note the content of this report.

1. Executive Summary

South Tees Hospitals NHS Foundation Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses (RN), Midwives (RM) and Health Care Support Workers (HCSW), matches the acuity and dependency needs of patients within the organisation. To ensure there is an appropriate level and skill mix of staff to provide safe and effective high quality care.

The requirement to publish nursing and midwifery staffing levels on a monthly basis is explicit and is one of the ten expectations specified by the National Quality Board (2013 and 2016).

From April 2019 all staffing reports presented to the Board must comply with NHSI Workforce Safeguards and require a signed declaration by the Director of Nursing or appropriate Director for the staff group (s).

The fill rate against planned rosters for the month of May 2019 at an overall level was:

- RN / RM day shift 92.7%, night shift 95.4%
- HCSW day shift 92.3%, night shift 110.3%

2. Recommendation

The Board of Directors is asked to note the content of the report and to be assured that staffing levels are sufficient to deliver safe, high quality care with systems and processes in place should staffing levels fall short of those planned.

Workforce Safeguard Compliance and Governance

Signature



Date 25 June 2019

Gill Hunt, Director of Nursing and Quality

1. UNIFY Safe Staffing Return

The Trust's safer staffing submission to UNIFY for May 2019 was submitted on 17th June 2019 with the summary of overall fill rate in the table below with the full report in Appendix 1.

Table 1 – Overall UNIFY Return fill Rate 2018/2019

2017/2018	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
January 2018	90.7%	91.2%	93.0%	109.1%
February 2018	89.4%	89.2%	93.1%	107.4%
March 2018	91.1%	92.6%	94.2%	109.2%
April 2018	91.0%	94.7%	96.4%	110.9%
May 2018	92.1%	91.4%	96.2%	112.1%
June 2018	92.7%	93.1%	94.6%	109.5%
July 2018	91.4%	92.3%	94.3%	107.3%
August 2018	91.3%	91.3%	94.5%	108.1%
September 2018	93.7%	92.4%	95.6%	109.4%
October 2018	94.0%	94.9%	95.4%	107.0%
November 2018	95.7%	94.2%	96.8%	105.5%
December 2018	94.6%	92.0%	94.8%	104.2%
January 2019	96.8%	94.0%	96.0%	106.4%
February 2019	93.7%	94.7%	94.3%	108.4%
March 2019	92.8%	91.2%	94.2%	106.6%
April 2019	94.2%	94.7%	95.8%	105.8%
May 2019	92.7%	92.3%	95.4%	110.3%

Centre Associate Directors of Nursing lead the twice daily SafeCare meetings Monday to Friday with Clinical Matrons providing weekend leadership in this area. Temporary staffing requirements are reviewed daily together with acuity, dependency and clinical judgement to ensure safe and efficient staffing.

Specialist Nurses, Critical Care Outreach and Corporate Nurses have all supported wards with complex patients and those with higher acuity and dependency but do not appear in the fill rate. Matrons provide oversight and assurance across their areas addressing red flags and supporting decision making.

Paediatric and Midwifery teams meet daily to review staffing across the floor and move staff accordingly. Unavailability is adjusted to meet the needs of the service with managers working clinically as required to maintain safe staffing. HCA fill rates were low in some areas of the centre but as the workforce is predominantly RN led these numbers are low. Following the last biannual safe staffing review the number of HCA's on ward 21 and 22 are being reviewed as part of a centre business case.

Wards with an RN fill rate of less than 80% (RAG rated red)

Ward 34 planned staffing overnight was 3 RN's and 4 HCA but they have worked with 2/3 RN's (ratio 1:13.5) and 4 HCA's. The Registered Nursing Associate and Assistant Practitioner have also worked some nights in support of RN's. The ward is supported on a daily basis by the matron, with staff deployed from within Centre as needed. A number of new RN's will fill vacancies in September 19.

Older People's Medicine (Previously Ward 12) planned to have 5 RN during the day and 4 RN at night but worked with 4 (ratio of 1:7) and 3 (ratio of 1:9) respectively. There was an average of 27 patients on the ward during May so safe nurse to patient ratios were maintained. The ward has recruited to a number of their vacancies and will be receiving a nurse undertaking OSCE prep shortly.

Romanby Ward FHN was planning 4 RN during the day but worked with 3 (ratio 1:6). With an average of 19 patients safe staffing was maintained.

Military non committed hours are provided at month end and have been added to the UNIFY report for the following areas: Critical Care, AAU, AMU, and Wards 2, 5, 35, 36 and 6.

The military ghost roster pilot is planned to go live in August/September on Critical Care and will be rapidly rolled out across other areas if successful.

Staff have been redeployed to maintain safe staffing and professional judgment used to triangulate staffing ratios, CHPPD and conversations with the nurse in charge of each shift.

2. Temporary Staffing

The total number of hours for RN and HCA has decreased slightly during May providing a 67% fill rate overall. Agency Nurses and dedicated NHSP staff have contributed to Critical care to give the trust flexibility and resilience with 1,060 hours of nursing agency worked across Critical Care (ITU/GHDU) and theatres.

Daily review of all shifts continues to take place during the morning SafeCare meeting with ADoN's to ensure both safe and efficient allocation of staff.

3. Red Flag Reporting

A total of 96 red flags have been reported during May. These are investigated by Clinical Matrons prior to the morning SafeCare meeting on a daily basis and action to address taken in real time. The predominant themes are Shortfall in RN time (37) and opening of 'amber' beds (27). Action taken to mitigate risk is captured on the system providing an audit trail or response to the alert.

Red Flags Raised	Day	Night	Grand Total
AMBER Beds Open	21	6	27
Less than 2 RNs on shift	10	4	14
Missed 'intentional rounding'	4	1	5
RED Beds Open	7	4	11
Shortfall in RN time	31	6	37
Vital signs not assessed or recorded	2		2
Grand Total	75	21	96

Amber beds are used as part of routine escalation during surge and are managed within planned staffing levels. The system alerts the matron to the opening of amber beds which ensures the matron can support patient flow as required.

The system records 3 counts per day so an escalation bed may only be open for part of a day and then reclosed.

4. Redeployed staff

SafeCare gives the Trust the ability to redeploy staff from an area with excess hours to one which is short using the acuity and dependency calculation to support patient care and ensure effective use of resource. During the month of April a total of 732 hours were redeployed across adult inpatient areas via SafeCare.

5. Care Hours Per Patient Day (CHPPD)

CHPPD is a national measurement recorded monthly through the UNIFY safe staffing report and is a Model Hospital metric. Triangulation between hours planned vs hours worked in this report should be considered with CHPPD and professional judgement to ensure areas have safe and efficient levels of staffing. The Model Hospital metric also provides the Trust with a peer review option to enable us to compare with hospitals of a similar size and complexity as well as the National trend.

The latest Trust results published on the Model Hospital website are from February 2019 and were 8 against a peer group median of 7.9 and a national median of 7.9.

6. Band 5 Vacancy Rate and Recruitment Activity

The number of unfilled Band 5 posts at the beginning of June was 90. The Pre-registration nursing interviews took place on 5th June with 97 adult students attending. Pre-employment checks are underway with 91 appointments made.

A refreshed 2 year nursing workforce demand and supply projection paper will be completed following the final allocations from 5th June interviews and will include the critical care workforce plan. This will inform future recruitment options, including further potential overseas recruitment.

7. Staff Retention

The trust turnover remains at approximately 9% which is lower than the regional average and much better than the National average.

NHSI will be providing all Trusts with a retention pack on a quarterly basis from September 2019 which will inform the Trusts own retention work.

8. Workforce Safeguards

The six monthly safe staffing reviews for adult inpatients, paediatrics wards commenced on 1st June with Theatres and A+E completing their reviews in line with workforce plans. NHSI have produced a number of new evidence based safer nursing care tools for specific specialities which are to be made available to the trust Nursing workforce Lead through the CNO Safe Staffing Fellowship. The Head of

Professions will be working with the N+M Workforce Lead to include AHP staffing where possible this year working towards compliance.

Eileen Aylott
Assistant Director of Nursing Workforce
June 2019

References

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Safe, sustainable and productive staffing in urgent and emergency care
https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_urgent_and_emergency_care.pdf

Appendix 1 JCUH

James Cook	Hours								< 80	80-95	> 95															
	Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS Average fill rate - RNRMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RNRMs (%)	NIGHTS Average fill rate - HCA (%)	Parenting	Sickness	Parenting	Sickness	Number of inpatient falls	Number of Formal Complaints	No of Trust Grade 2 PU	No of Trust Grade 3-4 PU	CHPPD	Registered Midwives/ Nurses	Care Staff	Overall		
Critical Care	11,155.23	10,272.23	2,604.00	2,131.00	11,160.00	9,816.00	1,116.00	768.00	92.1%	81.8%	88.0%	68.8%	5.20%	3.80%		9.00%				7		876	229	3.3	26.2	
RAFAU	2,503.25	2,112.75	1,877.33	1,575.33	1,164.67	1,152.00	1,261.00	1,473.83	84.4%	83.9%	98.9%	116.9%	7.30%	5.80%	5.30%	3.30%	13		2			828	3.9	3.7	7.6	
JC06 Gastro	1,421.25	1,488.25	1,768.00	1,476.92	1,069.58	1,017.83	712.58	782.08	104.7%	83.5%	95.2%	109.8%		5.50%		13.50%	4		1			839	3.0	2.7	5.7	
JC09 (Ward 9)	1,856.25	1,543.08	1,465.50	1,734.42	1,128.00	1,092.00	1,116.00	1,374.17	83.1%	118.3%	96.8%	123.1%		1.90%		8.80%	6		2			808	3.3	3.8	7.1	
OPM (Older Persons Medicine)	1,858.33	1,467.57	2,228.65	1,821.27	1,188.00	1,032.00	1,116.00	1,430.67	79.0%	81.7%	86.9%	128.2%	13.60%	7.80%	2.70%	11.70%	4		1			826	3.0	3.9	7.0	
JC28 (Ward 28)	1,863.83	1,615.00	1,114.50	1,068.83	1,488.00	1,344.00	744.00	861.50	86.6%	95.9%	90.3%	115.8%	9.50%	3.80%	6.00%	3.50%	8		2			580	5.1	3.3	8.4	
Ward 3	1,426.00	1,472.33	1,786.08	1,797.75	1,069.83	1,069.83	715.33	737.33	103.2%	100.7%	100.0%	103.1%				6.60%	6					842	3.0	3.0	6.0	
Short Stay (JC02)	1,860.00	1,858.50	1,488.00	1,518.67	1,488.00	1,327.00	1,116.00	1,160.50	99.9%	102.1%	89.2%	104.0%			3.40%	6.00%	1.30%	5	1	1		760	4.2	3.5	7.7	
Ward 5 Surgery	1,488.33	1,183.92	1,116.00	990.33	744.00	744.00	744.00	708.00	79.5%	88.7%	100.0%	95.2%	7.50%			1.70%				1		434	4.4	3.9	8.4	
PCAU	744.00	802.00	744.00	756.00	744.00	744.00	372.00	360.00	107.8%	101.6%	98.4%	96.8%		4.30%		16.70%	2					254	6.0	4.4	10.4	
JC35 (Ward 35)	1,114.75	1,352.75	1,471.00	1,278.50	744.00	840.00	744.00	751.00	121.4%	86.9%	112.9%	100.9%	11.50%	3.20%		12.10%	1					600	3.7	3.4	7.0	
JC31 Vas	1,114.25	1,340.75	1,488.00	1,373.67	744.00	744.00	744.00	750.00	120.3%	92.3%	100.0%	100.8%	13.40%	3.90%		1.50%	1					523	4.0	4.1	8.0	
Ward 7 Colo	1,861.42	1,730.92	1,840.00	1,812.08	1,116.00	1,080.00	744.00	870.50	93.0%	98.5%	96.8%	117.0%	8.40%	3.70%		6.50%	5		2			987	2.8	2.7	5.6	
JC04 (Ward 4)	1,639.33	1,420.67	1,102.75	1,132.58	1,116.00	991.33	743.17	918.83	86.7%	102.7%	88.8%	123.6%	4.60%	13.00%	13.40%	12.70%	2	1	1			708	3.4	2.9	6.3	
JC14 Oncology (Ward 14)	1,853.92	1,653.58	1,121.83	1,184.23	1,116.00	1,104.00	744.00	864.00	89.2%	105.6%	98.9%	116.1%		8.20%	14.50%	12.70%	7					661	4.2	3.1	7.3	
JC33 Speciality (merger of ward 18 and ward 27)	1,482.00	1,197.00	1,485.33	1,291.33	1,116.00	1,029.50	736.17	843.33	80.8%	86.9%	92.2%	114.6%		15.10%	6.10%	0.20%	2		1			561	4.0	3.8	7.8	
JC34 (Ward 34)	1,478.17	1,359.33	2,010.00	1,724.70	1,332.00	852.33	1,488.00	1,587.17	92.0%	85.8%	64.0%	106.7%	4.60%	7.70%		3.60%	4		1			808	2.7	4.1	6.8	
JC25 Elective Ortho	1,074.97	978.45	1,081.98	905.48	725.83	703.00	371.33	371.00	91.0%	83.7%	96.9%	99.9%	14.10%	12.60%	17.00%	19.30%	1					567	3.0	2.3	5.2	
JC36 Trauma	1,859.98	1,684.98	1,855.82	1,716.48	1,119.67	1,083.33	1,121.00	1,249.67	90.6%	92.5%	96.8%	111.5%	5.20%	2.70%	5.40%	16.00%		2	5			934	3.0	3.2	6.1	
Spinal Injuries	2,492.10	2,174.10	1,924.88	1,601.37	1,488.00	1,404.00	1,404.00	1,099.33	87.2%	83.2%	94.4%	98.9%	6.30%	10.80%		5.60%			1			571	6.3	4.7	11.0	
Cardio MB	743.80	762.00	371.35	511.17	743.67	743.67	0.00	379.67	102.4%	137.7%	100.0%	-	8.60%	1.30%		21.40%						248	6.1	3.6	9.7	
CCU JCUH	2,652.00	2,196.00	372.00	406.17	1,860.00	1,845.92	0.00	19.33	82.8%	109.2%	99.2%	-		1.40%		7.70%	1		1			276	14.6	1.5	16.2	
CICU JCUH	4,062.25	3,452.92	1,255.50	709.50	3,660.00	3,276.00	744.00	636.00	85.0%	56.5%	89.5%	85.5%	5.90%	7.00%		10.40%		1		1 (3)		255	26.4	5.3	31.7	
JC24 (Ward 24)	1,500.67	1,416.67	1,175.33	1,223.67	1,116.00	1,092.00	744.00	1,019.00	94.4%	104.1%	97.8%	137.0%	3.20%	1.80%		1.10%	3					640	3.9	3.5	7.4	
JC27 Neuro	1,469.92	1,381.50	1,151.83	1,391.90	744.33	746.50	960.00	1,221.67	94.0%	120.8%	100.3%	127.3%		0.50%		4.00%	2					471	4.5	5.5	10.1	
JC26 (Ward 26)	1,131.33	1,023.33	743.67	1,178.02	744.00	708.67	372.00	1,132.13	90.5%	158.4%	95.3%	304.3%	7.50%	7.70%	12.50%		4					574	3.0	4.0	7.0	
JC29 (Ward 29)	1,487.50	1,311.50	1,115.48	1,037.48	1,116.00	1,092.00	744.33	732.33	88.2%	93.0%	97.8%	98.4%		3.00%	9.60%	4.90%	1		3			641	3.7	2.8	6.5	
JCCT (Ward 32)	1,594.00	1,565.33	1,221.33	1,159.85	1,113.75	981.75	744.00	811.00	98.2%	95.0%	88.1%	109.0%	4.30%	5.00%			1		3			607	4.2	3.2	7.4	
Cardio HDU	2,112.25	1,917.25	372.08	372.00	1,716.00	1,440.00	372.00	336.00	90.8%	100.0%	83.9%	90.3%	6.80%	3.30%								199	16.9	3.6	20.4	
Ward 8	1,869.25	1,798.00	1,859.08	1,541.58	1,117.42	1,117.42	732.00	751.33	96.2%	82.9%	100.0%	102.6%		10.30%	6.00%	6.60%	3		2			880	3.3	2.6	5.9	
JC24 HDU	1,501.28	1,478.37	384.00	348.00	1,488.00	1,424.00	372.00	336.00	98.5%	90.6%	95.7%	90.3%	1.70%	10.30%		14.60%						211	13.8	3.2	17.0	
JC21 (Ward 21)	2,232.00	1,940.00	744.00	464.50	2,232.00	1,872.00	372.00	324.00	86.9%	62.4%	83.9%	87.1%		10.40%	12.20%	13.20%						609	6.3	1.3	7.6	
JC22 (Ward 22)	1,114.00	1,197.00	594.00	476.50	1,044.00	1,008.00	96.00	174.00	107.5%	80.2%	96.6%	181.3%		4.40%		17.50%						295	7.5	2.2	9.7	
JCDS (Central Delivery Suite)	3,713.83	3,633.83	1,452.00	731.00	4,083.33	3,757.33	1,110.00	718.50	97.8%	50.3%	92.0%	64.7%	1.00%	2.90%		6.00%						315	23.5	4.6	28.1	
Neonatal Unit	5,752.50	5,172.00	372.00	208.00	5,220.00	4,722.00	0.00	192.00	89.9%	55.9%	90.5%	-	6.40%	4.50%	31.10%							687	14.4	0.6	15.0	
Paediatric Intensive Care Unit (PICU)	1,860.00	1,590.00	232.50	182.50	1,860.00	1,584.00	0.00	0.00	85.5%	78.5%	85.2%	-	3.20%	4.50%								73	43.5	2.5	46.0	
Ward 17 JCUH	2,232.00	1,891.50	1,115.83	1,028.83	1,487.83	1,500.83	1,116.00	1,008.00	84.7%	92.2%	100.9%	90.3%	12.10%	2.30%	11.60%							889	3.8	2.3	6.1	
Ward 19 Ante Natal	1,257.00	1,036.50	310.00	292.00	743.83	743.83	0.00	0.00	82.5%	-	100.0%	-	2.70%	0.50%		3.00%						275	6.5	1.1	7.5	
Site average									92.6%	92.5%	94.3%	112.7%														

FHN	Hours								< 80	80-95	> 95	RN				HCA				CHPPD	Registered Midwives/Nurses	Care Staff	Overall	
	Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS	DAYS	NIGHTS	NIGHTS	Parenting	Sickness	Parenting	Sickness	Number of inpatient falls	Number of Formal Complaints	No of Trust Grade 2 PU					No of Trust Grade 3-4 PU
									Average fill rate - RN/RMs (%)	Average fill rate - HCA (%)	Average fill rate - RN/RMs (%)	Average fill rate - HCA (%)												
Ainderby FHN	1,424.17	1,340.67	1,069.50	1,012.00	713.00	714.00	713.00	764.17	94.1%	94.6%	100.1%	107.2%				6.00%	6		3	574	3.6	3.1	6.7	
Romanby FHN	1,533.83	1,165.83	1,171.45	1,124.78	713.00	707.50	713.33	932.50	76.0%	96.0%	99.2%	130.7%		13.80%	7.00%	11.20%	1		2	593	3.2	3.5	6.6	
Rutson FHN	871.48	852.00	1,198.28	1,083.92	713.00	713.00	713.00	713.00	97.8%	90.5%	100.0%	100.0%	6.40%	0.30%		15.60%				446	3.5	4.0	7.5	
Gara Orthopaedic FHN	808.25	783.75	711.00	711.00	713.00	701.50	356.50	333.50	97.0%	100.0%	98.4%	93.5%		13.50%		4.50%	1			367	4.0	2.8	6.9	
Maternity FHN	1,321.33	870.33	484.50	178.50	743.67	719.67	0.00	12.00	65.9%	36.8%	96.8%	-	7.10%	0.90%		3.30%				15	106.0	12.7	118.7	
									86.1%	83.6%	98.9%	107.9%												

East Cleveland	Hours								< 80	80-95	> 95	RN				HCA				CHPPD	Registered Midwives/Nurses	Care Staff	Overall	
	Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS	DAYS	NIGHTS	NIGHTS	Parenting	Sickness	Parenting	Sickness	Number of inpatient falls	Number of Formal Complaints	No of Trust Grade 2 PU					No of Trust Grade 3-4 PU
									Average fill rate - RN/RMs (%)	Average fill rate - HCA (%)	Average fill rate - RN/RMs (%)	Average fill rate - HCA (%)												
Tocketts Ward East Cleveland Hospital	1,430.75	1,169.17	2,061.00	1,796.50	960.33	884.33	1,545.33	1,782.83	81.7%	87.2%	92.1%	115.4%		14.90%		8.40%	4		2	733	2.8	4.9	7.7	
									Site Average	81.7%	87.2%	92.1%	115.4%											

Redcar	Hours								< 80	80-95	> 95	RN				HCA				CHPPD	Registered Midwives/Nurses	Care Staff	Overall	
	Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS	DAYS	NIGHTS	NIGHTS	Parenting	Sickness	Parenting	Sickness	Number of inpatient falls	Number of Formal Complaints	No of Trust Grade 2 PU					No of Trust Grade 3-4 PU
									Average fill rate - RN/RMs (%)	Average fill rate - HCA (%)	Average fill rate - RN/RMs (%)	Average fill rate - HCA (%)												
Zetland	1,947.33	1,695.83	3,450.33	2,776.15	1,116.00	1,104.00	1,116.00	1,248.00	87.1%	80.5%	98.9%	111.8%		2.60%	3.20%	3.80%	9		2	864	3.24055	4.65758	7.8913	
									Site Average	87.1%	80.5%	98.9%	111.8%											

Friary Community Hospital	Hours								< 80	80-95	> 95	RN				HCA				CHPPD	Registered Midwives/Nurses	Care Staff	Overall	
	Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS	DAYS	NIGHTS	NIGHTS	Parenting	Sickness	Parenting	Sickness	Number of inpatient falls	Number of Formal Complaints	No of Trust Grade 2 PU					No of Trust Grade 3-4 PU
									Average fill rate - RN/RMs (%)	Average fill rate - HCA (%)	Average fill rate - RN/RMs (%)	Average fill rate - HCA (%)												
Friary Community Hospital	968.00	865.00	1,308.00	1,259.25	620.00	620.00	620.00	570.00	89.4%	96.3%	100.0%	91.9%	4.10%	1.70%		3.10%	2			367	4.0	5.0	9.0	
									Site Average	89.4%	96.3%	100.0%	91.9%											

James Cook	Hours								< 80	80-95	> 95	RN				HCA				CHPPD	Registered Midwives/Nurses	Care Staff	Overall	
	Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS	DAYS	NIGHTS	NIGHTS	Parenting	Sickness	Parenting	Sickness	Number of inpatient falls	Number of Formal Complaints	No of Trust Grade 2 PU					No of Trust Grade 3-4 PU
									Average fill rate - RN/RMs (%)	Average fill rate - HCA (%)	Average fill rate - RN/RMs (%)	Average fill rate - HCA (%)												
AMU JCUH	2,232.00	2,124.00	1,488.00	1,441.67	1,860.00	1,848.00	1,679.83	1,599.00	95.2%	96.9%	99.4%	95.2%	7.00%	4.20%	4.30%	7.80%	6	1	1	656	6.1	4.6	10.7	
AAU JCUH	2,976.67	3,254.83	1,764.00	1,689.33	1,860.00	1,812.00	1,116.00	1,188.00	109.3%	95.8%	97.4%	106.5%	6.80%	1.80%	8.20%	2.40%	6		1	590	8.6	4.9	13.5	
Mat Assessment Unit	1,391.83	1,332.13	279.00	279.00	744.00	732.00	0.00	0.00	95.7%	100.0%	98.4%	-	4.80%	4.40%						28	73.7	10.0	83.7	
FHN																								
Clinical Decisions Unit FHN	1,779.83	1,665.83	1,071.50	1,053.83	1,069.83	1,029.33	713.67	702.17	93.6%	98.4%	96.2%	98.4%	7.70%	4.00%		8.00%	3	1	3	449	6.0	3.9	9.9	

	< 80	80-95	> 95	
	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
Trust Average				
Community Care	88.6%	83.2%	94.6%	108.0%
Planned Care	99.4%	89.5%	96.1%	103.8%
Specialist	90.0%	104.1%	94.0%	127.7%
Urgent and Emergency Care	92.9%	92.3%	96.9%	101.7%
Trust Average	92.7%	92.3%	95.4%	110.3%

Board of Directors	
Agenda item	3.4
Title of Report	Learning From Deaths Monthly Dashboard Quarterly Report
Date of Meeting	2 July 2019
Presented by	Andrew Owens, Medical Director (Corporate Clinical Support Services)
Author	Jo Raine, Data Analyst Mortality Surveillance Tony Roberts, Deputy Director (Clinical Effectiveness)
Approved by	Andrew Owens, Medical Director (Corporate Clinical Support Services)
Previous Committee/Group Review	Quality Assurance Committee
Purpose	Approval <input type="checkbox"/> Decision <input type="checkbox"/> Discussion <input type="checkbox"/> Information <input checked="" type="checkbox"/>
Alignment to Trust's Strategic Objectives	<input checked="" type="checkbox"/> 1. We will deliver excellence in patient outcomes and experience <input type="checkbox"/> 2. We will drive operational performance to deliver responsive, cost effective care <input type="checkbox"/> 3. We will deliver long term financial sustainability to invest in our future <input type="checkbox"/> 4. will deliver excellence in employee experience to be seen as an employer of choice <input type="checkbox"/> 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	Care Quality Commission NHS Improvement
Recommendation(s)	The Board is asked to note that the Trust will continue to monitor and Learning From Deaths data, and act accordingly.

Learning From Deaths Monthly Dashboard May 2019

1 Responding to Deaths

- 1.1 In March 2017 the National Quality Board published *Guidance on Learning from Deaths* (LFD)¹ and a national work programme has been established for LFD. NHS Improvement hosted a conference on 14 December 2017 LFD: One Year On and have published case studies².
- 1.2 The Trust published its *Responding to Deaths* Policy (in line with the national LFD requirements) in September 2018. It sets out the Trust's approach to learning from deaths in care: <https://www.southtees.nhs.uk/about/trust/responding-deaths-policy/> There are broadly three opportunities to learn:
 - at the time of certification of death. The Trust has established a Medical Examiner Service which commenced work in May 2018. All deaths receive some scrutiny and for those deaths not referred to the Coroners this includes a 'stage one' case record review, discussion with the attending team and a discussion with the bereaved family
 - at a 'stage two' case record review, usually conducted within weeks of a death, any death identified by a 'stage one' case record review plus all deaths of patients with learning disabilities, serious mental illness, where an incident or complaint has been reported, within 30 days of a surgical procedure or where a 'mortality alert' from a range of sources has occurred.
 - at the time of investigation when a death has occurred where an incident has been reported through the Trust's incident reporting system (Datix).
- 1.3 The Learning From Deaths dashboard has been redesigned to make it more easily interpreted and reports the number of deaths, the number deaths with 1st stage reviews (by Medical Examiners), number of deaths with 2nd stage reviews or investigations and the number of those deaths judged to show evidence of preventability. Numbers are reported separately for patients with learning disabilities and known mental health issues. For the year to end of May 2019, there were 1,844 deaths, of which 1,522 received a review or investigation (1,265 1st stage only) and 6 deaths were considered to be potentially avoidable. In the same period there were 12 deaths in patients with learning disabilities, of which 2 received a review or investigation and 0 deaths were considered to be potentially avoidable. For patients with a mental health issue, 147 were identified of which 22 have been reviewed, with 0 deaths considered potentially avoidable. Potential learning from both good care and from problems in care are outlined. Changes that are being implemented relate to better coordination and documentation of care and these will be easier to address as enhancement to the use of electronic patient records occur and the impact of these changes will also become easier to assess from digital records.

¹ <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>

² https://improvement.nhs.uk/uploads/documents/Learning_from_deaths_case_studies_Web_version.pdf

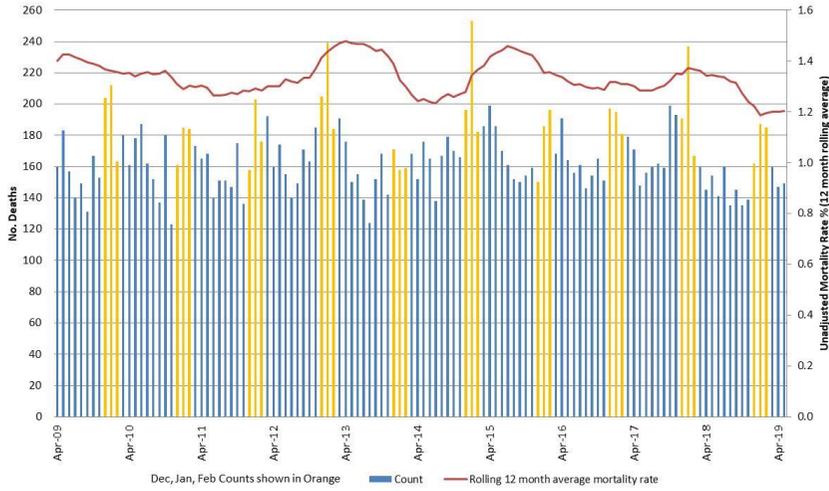
2 Mortality indicators

- 2.1 The dashboard includes the number deaths from April 2009 to May 2019. There were 149 deaths recorded in May 2019. In the same period in 2018 154 deaths were recorded (148 deaths in May 2017)
- 2.2 The Summary Hospital-level Mortality Indicator (SHMI) includes all in-hospital deaths plus deaths within 30 days of discharge. It is published on a quarterly basis (including 12 months of data in each release) by NHS Digital and is an official government statistic. Current reporting is January 2018 - December 2018. The SHMI is the ratio of observed mortality rate/expected mortality rate (based on a statistical estimate of expected mortality). The SHMI is 107 and is 'as expected' (ie within the variation expected statistically).
- 2.3 The chart for Palliative Care Coding for April 2017 to May 2019 shows that the number of cases with the relevant codes is relatively static.
- 2.4 A breakdown of deaths per site for the Trust shows that the vast majority occur at James Cook University Hospital (79% of all deaths) At the Friarage Hospital, numbers of deaths have fallen in the last few months. This may be due to recent operational changes at the Friarage. Numbers of deaths in community hospitals remain fairly static at an average of 11 deaths per month.

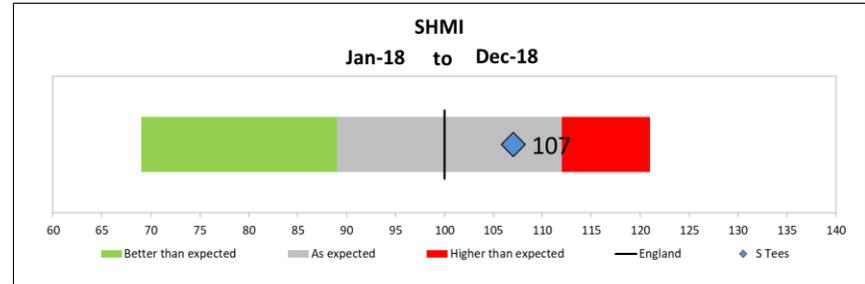
3 Next steps

- 3.1 The Learning From Deaths work was reported in the annual Quality Account published in June 2019.
- 3.2 The Medical Examiner Service has been operational since May 2018, and 56% of deaths have received a stage one review with 253 deaths being recommended for 2nd stage review of which 55 have since been completed. The new service will also impact on the number and complexity of second stage reviews completed and this will be monitored through the Learning From Deaths dashboard.
- 3.3 Mortality indicators will continue to be monitored. Issues around the recording of comorbidities and specialist palliative care coding are being addressed through relevant departments of the Trust.
- 3.4 This Learning From Deaths Quarterly Dashboard is a development of previous Board reporting and will continue to evolve. A longer report is considered by the Patient Safety Group who report to the Quality Assurance Committee (QAC) who report to the Board of Directors.

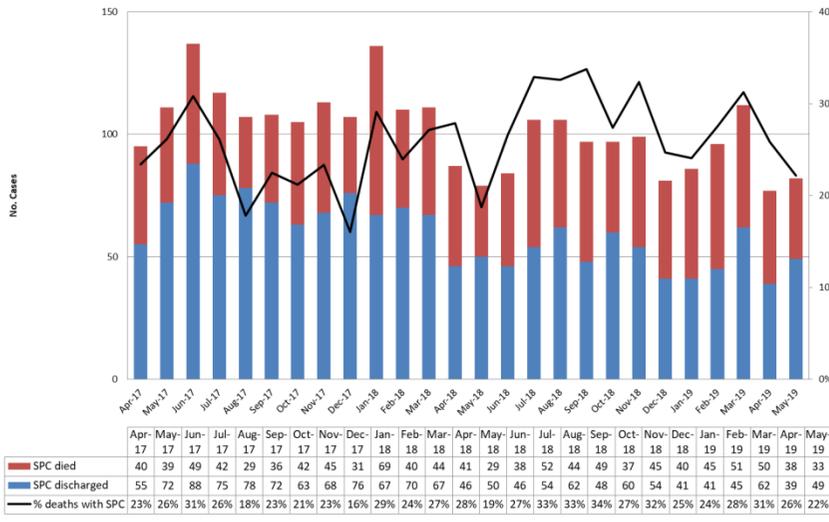
Count of deaths and 12 month average unadjusted mortality rate (%)
April 2009 - May 2019



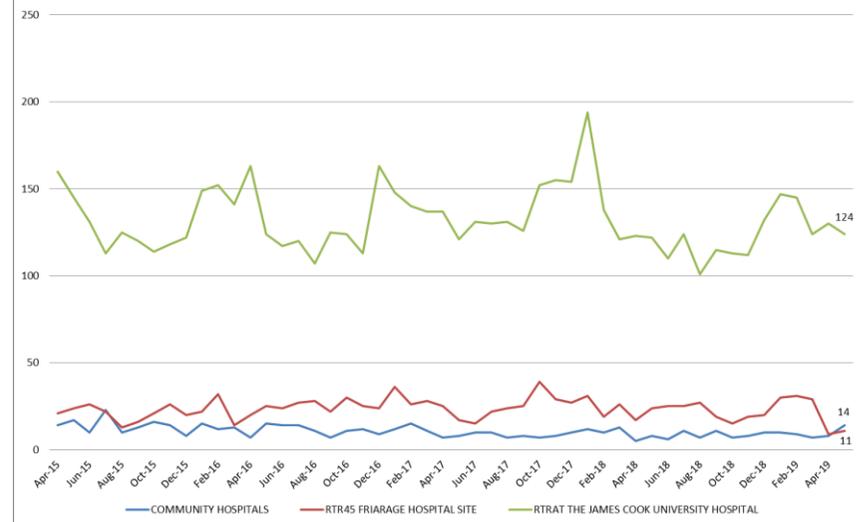
SHMI
Jan-18 to Dec-18



Specialist Palliative Care Coding (Z515) April 2017 - May 2019



In-hospital deaths by site Apr 2015 - May 2019



Learning from Deaths Monthly Dashboard - May 2019



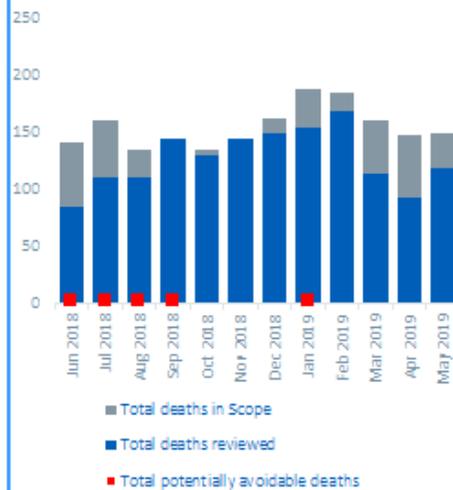
South Tees Hospitals
NHS Foundation Trust

Total number of deaths reviewed and deaths judged preventable from the case notes
(includes patients with identified learning disabilities or serious mental illness)



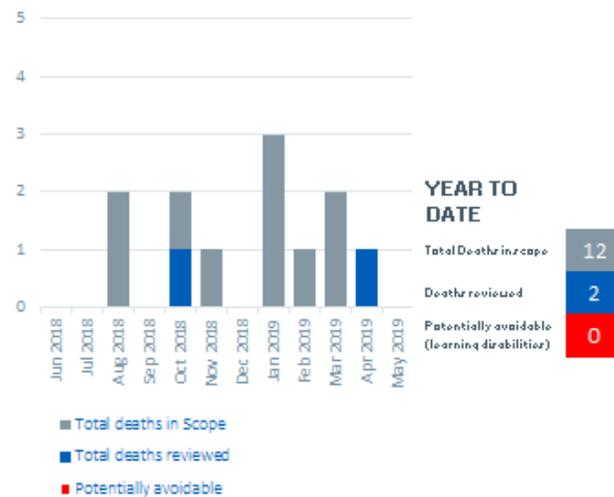
All patients:

Mortality over time, total deaths and deaths considered potentially preventable



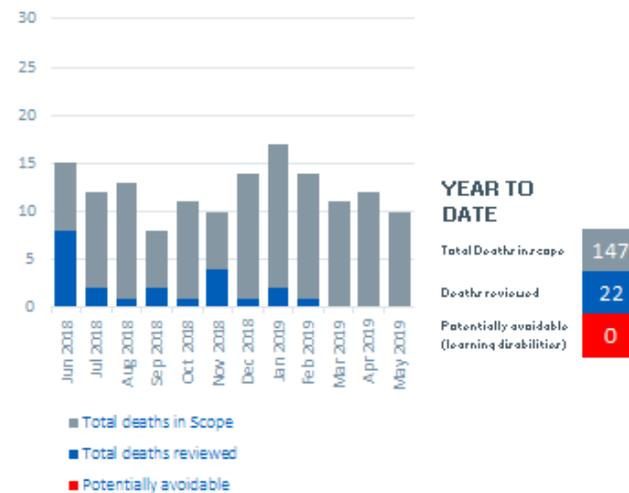
Patients with learning disabilities:

Mortality over time, total deaths and deaths considered potentially avoidable

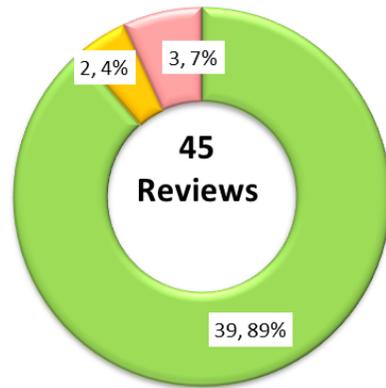


Patients with a serious mental illness:

Mortality over time, total deaths and deaths considered potentially avoidable



Mortality Surveillance Reviews May 2019



- Good Practice / No preventability
- Room for improvement / No preventability
- Good Practice / Some evidence of preventability
- Room for Improvement / Some evidence of preventability
- Unable to Grade

Of the 45 deaths reviewed in the month, 89% of patients were judged to have received good care with no preventability, 2 cases (4%) were ruled to show no preventability with room for improvement in care. 3 cases (7%) showed some preventability with room for improvement in care. 96% of deaths were Expected.

2 cases were highlighted as identifying learning from good care (cases can appear in more than one category) and 14 cases were highlighted as identifying learning from problems in care.

Positive lessons were around multi-specialty involvement and good advanced decision making, with good communication with family and patient wishes regarding place of death being honoured. Negatives reflected poor quality of documentation re completion of vital information, filing etc., DNACPR not being completed properly or not being available/appropriately filed in HCR, inappropriate repatriation to acute setting against patients stated wishes re: place of death.

REVIEWS IDENTIFYING LEARNING FROM GOOD CARE		2
Good coordination of clinical care / senior input / advanced decision making		2
Good communication with family		1
Patient's stated wishes were followed		1

REVIEWS IDENTIFYING LEARNING FROM PROBLEMS IN CARE		14
Poor quality of documentation		5
DNACPR not in place or invalid or not followed and CPR undertaken		4
Inappropriate transfer/repatriation from Community Hospital - delay or other problems		2
Verification of death not in notes		2
Attitude of staff		1
Availability of appropriate bed (nonICU) compromising care		1
Delayed or poor clerking		1
Inappropriate Referral to Coroner / query need for PM		1
Incomplete physiological observations / deterioration not escalated		1
Lack of ICU Bed		1
Mis- or Missed Diagnosis		1
Patient's stated wishes not followed		1
VTE assessment not completed/not acted on		1

Risk Committee

Chair's Log

Date: 13 June 2019

Meeting: Risk Committee	Date of Meeting: 13 June 2019
Connecting to: Board of Directors	Date of Meeting: 2 July 2019
Key topics discussed in the meeting	
<p>Risk Management Structure - noted the continued focus on risk management at all levels in the organisation and welcomed the increased resources at Quality Business Partner (QBP) level. Focus has been from Chief Executive throughout the organisation. Greater traction from the Risk Validation Group was noted and welcomed.</p> <p>The Board Assurance Framework (BAF) was reviewed and several observations made – please see below:</p> <ul style="list-style-type: none"> • We continue to make good progress and the document continues to evolve. There is still some tidying up to do with completion of some dates and filling the gaps in the control framework for some risks where we are not yet at the required level. • It is important that the wording for all risks complies with best practice: • Due to...there is a risk that....leading to..... • It was agreed that clear statement of the reason and the consequence is essential to assess the control framework. • the Committee discussed the increase in the volume of risks on the BAF and challenged whether they are indeed all “board level” or whether they should be on risk logs elsewhere in the organisation. Suggestions were made to relegate, remove or consolidate some of the risks to give the BAF more focus. • the two recent external assessments were discussed. It was agreed we would wait for the formal report from the Care Quality Committee (CQC) before looking to review the content required in BAF. The cyber security report from PwC the Trust’s Internal Auditors required an increase in the risk score and immediate action to mitigate the position. It was agreed this would be escalated to the Board. • the Financial risks were considered. It was noted a re-write of them is underway overseen by FIC. The meeting discussed the risks included on the risk register and concluded that the lack of access to capital was to have the score raised to the maximum and that this was a serious concern which required escalation to the Board for immediate action. • the workforce risk was discussed and the Committee asked that a risk concerning staff engagement was considered and added to the BAF. <p>Not for inclusion in the BAF, the Committee also considered that a review of the Brexit related risks be undertaken given the changing political landscape.</p> <p>15+ risk register - content discussed (limited due to time constraints). It was noted that there is still inconsistency in the way risks are articulated (not in best practice format) and gaps in the completion dates and owners. Risk Validation Group overseen by the Executive Risk Group to address this.</p> <p>Chairs log Executive Risk Group – noted.</p> <p>The meeting concluded that it was happy with the process for high level identification and management of risk and that more time would be devoted to the next meeting to examine the process.</p>	

Actions agreed in the meeting	Responsibility / timescale
<p>Continue to work on format of risks in all risk registers in particular ensuring risks articulated in best practice format and gaps in controls/actions are consistent.</p> <p>BAF- articulate suggestions to relevant Exec/ Committee Chair for review of BAF content.</p> <p>Review risk around Brexit and consider if anything needs to be raised to Board level.</p> <p>Agenda item for next meeting agreed to be added to focus on assurance of risk management process through the organisation.</p>	<ul style="list-style-type: none"> • Gill Hunt/Kevin Oxley – immediate • Lynn Hughes/Gill Hunt/Kevin Oxley – immediate • Kevin Oxley - immediate • Lynn Hughes – agenda next meeting
Escalation of issues for action by connecting group	Responsibility / timescale
<p>Lack of access to Capital - seen as a significant risk to both patient safety and the medium term viability of the organisation. Immediate action is required to debate the position and agree a substantial communication plan to stakeholders and regulators articulating our concerns.</p> <p>IT environment and security of data - seen as a significant risk to both patient safety and our desire to drive greater efficiency through technology. This is connected to the lack of access to the capital point but also requires a strategy to be developed including investment and particularly for cyber security compliance with the Internal Audit PwC report.</p> <p>Both above points to be discussed at the July 2019 Board</p>	<ul style="list-style-type: none"> • Chairman/Steven Mason - July Board
Risks (Include ID if currently on risk register)	Responsibility / timescale
None	



Quality Assurance Committee

Chair's Log

25 June 2019

Connecting to: Board of Directors	Date of Meeting: 2 July 2019
Key topics discussed in the meeting	
<ul style="list-style-type: none"> • Monthly Quality Report • CQC Update – Final report awaited • HCAI Annual Report • Monthly SI Report • Clinical Audit Annual Report 18/19 & Forward Plan 2019/20 • Q4 Patient Experience Report • Annual Complaints Report • FHN Urgent Temporary Change Update – No patient safety / quality issues • Board Assurance Framework – Quality Risks – No BAF available • Chairs logs from reporting groups 	
Actions agreed in the meeting	Responsibility / timescale
<ul style="list-style-type: none"> • Maternity risks – update to QAC in July 	<ul style="list-style-type: none"> • S. Nag / G. Hunt - July 2019
Escalation of issues for action by connecting group	Responsibility / timescale
Nothing to escalate	
Risks (Include ID if currently on risk register)	Responsibility / timescale
None	