South Tees Hospitals
NHS Foundation Trust

Board of Directors meeting (to be held in Public)

Date: 5 June 2018

South Tees Hospitals NHS Foundation Trust

Board of Directors (to be held in Public)
5 June 2018

Please note that in accordance with the Board of Director's Standing Orders, no filming or recording of the meeting is permitted.

AGENDA

	Subject	Paper/ Page No	LED By	Time
1	**Welcome and Apologies for Absence**	Verbal	Chairman	14.00
2	**Declarations of Interests** *Any new conflict of interest and* *Any actual or potential conflict of interest in relation to any matter to be discussed*	Verbal	Chairman	
3	**Minutes of the Previous Meetings** (**approval**) Meeting held in Public on 6 March 2018		Chairman	14.05
4	**Matters Arising** (*discussion*/**approval**)	Verbal	Chairman	
5	**Action Log** (*information*/**approval**)		Chairman	14.10
6	**Patient Story** (*discussion/information*)	Verbal	Research and Innovation Director	14.15
6.1	Research and Innovation Report 2017/18		Medical Director (Education, Research and Innovation)	
7	**Chairman's Report** *(discussion/information)*	Verbal	Chairman	14.35

8	**Chief Executive's Report** *(discussion/information)* ***Quality, Performance and Finance Assurance Report by Exception*** **Strategic Update** - Committee in Common - Friarage Update - Carillion Facilities Management Transition Update	**Presentation** Verbal	Chief Executive	14.40
9	**Quality and Patient Safety**			
9.1	Healthcare Associated Infection Report		Director of Nursing	15.10
9.2	Safe Staffing Monthly Report		Director of Nursing	15.20
9.3	Annual Infection Prevention Control Report		Director of Nursing	15.30
9.4	Learning from Deaths Quarter 4 Update		Medical Director for Clinical Support Services	15.40
10	**Governance/Compliance** (*information*/**approval**)			15.55
10.1	Trust's Constitution		Chairman	
11	**Items for Assurance and/or Information** *(discussion/information)*			16.00
11.1	Finance and Investment Committee Chair Logs		Finance and Investment Committee Chair	
11.2	Quality Assurance Committee Chair Logs		Quality Assurance Committee Chair	
11.3	Workforce Committee Chair Logs		Workforce Committee Chair	
11.4	Audit Committee Chair Log		Audit Committee Chair	
12	**Any Other Business** (*discussion/information*/**approval**)	Verbal	Chairman	16.10
13	**Date and Time of Next Meeting**	Verbal	Chairman	

The next meeting of the Board of Directors will be held on Tuesday, 4 September 2018 in the Board Room, Murray Building, James Cook University Hospital, Marton Road, Middlesbrough

South Tees Hospitals NHS
NHS Foundation Trust

APPROVED Board of Directors Meeting (held in Public)
6 March 2018 at 2pm
Boardroom, Murray Building, James Cook University Hospital

Present:

Mr A Downey	Chair Designate (Chair of the meeting)
Ms A Hullick	Acting Chair
Mr R Carter-Ferris	Non-executive Director
Mrs M Rutter	Non-executive Director
Mr M Ducker	Non-executive Director
Mrs S McArdle	Chief Executive
Mr A Clements	Medical Director (Urgent & Emergency & Friarage)
Mr S Mason	Interim Director of Finance
Mrs G Hunt	Director of Nursing & Quality
Dr S Nag	Medical Director (Community Care)
Mr D Chadwick	Medical Director (Planned and Specialist Care)

In attendance:

Mrs T Evans	PA to Chief Executive
Ms L Hughes	Company Secretary
Mrs S Poskitt	Associate Director of Nursing (Urgent and Emergency and Friarage) (*item BoD/03/05 only*)

Observing:

Mr H Rodgers-Shaw	Regional Commercial Manager, Johnson & Johnson Medical Limited
Ms J Stirland	Business Developer, Healthperm Resourcing Ltd
Mr I Johnson	Business Development Manager, IMS Maxms IT Company

The Chair Designate welcomed everyone to the meeting. He explained that it was Mike Ducker, Non-executive Director and Lynn Hughes, Company Secretary first Board meeting at the Trust.

BoD/03/01 Apologies for Absence and Quorum

1.1 Apologies were received from Mr J Tompkins and Mr D Heslop, Non-executive Directors and Mr C Coates, Chair for the Senior Medical Staff Forum.

BoD/03/02 Minutes from meeting held on the 5 December 2017

2.1 **Resolved:** the minutes of the previous meeting held in Public on the 5 December 2017 were accepted as an accurate record.

BoD/03/03 Matters Arising from the minutes and any outstanding Actions

3.1 **Resolved:** i) there were no matters arising in addition to those included on the agenda; and
ii) there were no outstanding actions from previous meetings.

BoD/03/04 Declaration of Interests

4.1 The Chair Designate requested that Directors declared any actual or potential conflict of interest relevant to their role as a member of the Board of Directors and in particular to any matter to be discussed at the meeting. It was noted that the Board of Directors Declaration of Interests had been updated to include Mr A Downey, Chair Designate's interests. It was agreed that the

updated register would be displayed on the Trust's website subject to the removal of the two Board members who had recently left the Trust.

4.2 There were no interests declared in relation to open items on the agenda.

4.3 **Resolved:** i) the updated Board of Directors Register of Interests was agreed to be uploaded on the Trust's website subject to the removal of the two Board members who had left the Trust; and
ii) there were no interests declared in relation to open items on the agenda.

BoD/03/05 Patient Story – Urgent and Emergency Care and Friarage Hospital

5.1 The Board of Director listened to the Patient Story presented by the Associate Director of Nursing which described how the Urgent and Emergency Care Centre had responded to patient's complaints. They were pleased to note the Centre received a very low number of complaints but despite that they had implemented a new complaint handling process and as a consequence of that there had been a reduction in the number of complaints received.

5.2 It was also noted that the Quality Assurance Committee routinely reviewed the Trust's complaint process seeking assurances on lessons learnt for sharing across the Trust's Centres.

5.3 **Resolved:** the Patient Story was noted.

BoD/03/06 Chief Executive Integrated Performance Report

6.1 The Chief Executive drew reference to exceptions within the report:

6.1.1 Performance against the Accident and Emergency (A&E) four hour target for January 2018 was 90.93%, slightly below target which analysis had found predominantly attributable to inpatient bed availability. The Medical Director (Urgent & Emergency & Friarage) was pleased to report that an improvement had been noted for February and March 2018 with performance against plan promising to meet the 95.7% year-end target by 31 March 2018. In relation to bed availability Mrs M Rutter, Non-executive Director queried plans in place to reassess the 2017 bed re-configuration. In response to that the Chief Executive confirmed that the Senior Leadership Team had discussed plans to undertake a further review.

6.1.2 In January 2018 an increase in Delayed Transfers of Care (DToC) was noted as a result of the health and social care arrangements in place. It was noted that plans were in place to focus on patient flow to improve discharge arrangements of patients before 12noon and the Chief Executive was pleased to report that Ms Penny Bateman had been appointed as Operations Director for Urgent and Emergency Care & Friarage who would focus on improving patient flow.

6.1.3 18 week Referral to Treatment (RTT) performance for January 2018 was under trajectory at 89.81% against the 92% target. The Chief Executive confirmed that plans were in place to improve RTT performance to meet the target by 31 March 2018.

6.1.4 The Board were pleased to note that for the third consecutive month the Trust had achieved the 62 day cancer target. The Chief Executive confirmed that with the introduction of the new fast track process faster diagnosis and treatment could lead to the prioritisation of 150 patients per month.

6.2 With regards to Clostridium-difficile (Cdiff) the Board were pleased to note that the Trust was currently within trajectory levels.

6.2.1 The Chief Executive drew reference to operational performance: 1.8% reduction in non-elective admissions and a 0.6% reduction in A&E attendances. In response to Mrs M Rutter, Non-executive Director's query regarding elective activity the Chief Executive confirmed that the focus during March 2018 was to maximise elective overnight and day cases in core standard hours with plans continually discussed with consultants to enable delivery of the programme of work.

6.2.2 With regards to Patient Outcomes and Experience, the Director of Nursing and Quality reported focus continued to reduce the Trust's attributed category two pressure ulcers with the number of falls reduced to 5.1 per 1000 bed days in January 2018 and a reduced rate of falls noted in Community Care, Urgent and Emergency Care. It was noted that each Centre evaluated actions each month and refreshed action plans for the next month with oversight in place by the Quality Assurance Committee.

6.2.3 The Chief Executive highlighted that the 1000 voices provided evidence on how patients rated the Trust with a score of 9.6 out of a possible 10 for January 2018. The score for cleanliness had shown a decline with evidence suggesting that was attributable to vacancy factors and a change in supervisory positions which were currently being addressed.

6.2.4 With regards to the Trust's sickness rate there had been an increase of sickness absence in January 2018 with 5.44% against the 3.5% target. As a result of that a deep dive exercise was underway with the outcome planned to be reported to the Workforce Committee later that month. It was agreed that the Director of Human Resources would be invited to present the findings of the deep dive exercise to the Board at its April 2018 meeting.

ACTION (P Iddon)

6.3 The Acting Chair queried the arrangements that were in place for staff unable to present for work due to the recent extreme weather conditions. In response to that the Chief Executive confirmed that a briefing had been circulated to all staff informing them that accommodation was available onsite to clinical staff if required; and for all the staff that missed work due to the weather conditions they would be expected to work an additional shift or take annual leave accordingly. The Board were pleased to note that overall staff had managed to work as planned with absences mainly reported in Theatres and within the Admin and Clerical staff group.

6.4 With regards to finance, the Interim Director of Finance reported that as at 31 December 2018 the Trust's control total was £6m behind plan. He confirmed that the Trust was in discussion with NHS Improvement and the Department of Health around borrowing support for 2018/19.

6.5 The Chief Executive highlighted the National Planning Guidance for 2018/19 and drew reference to the change of name of Accountable Care Systems to Integrated Care Systems.

6.6.1 **Healthcare Associated Infection (HCA) Report**

The Director of Nursing confirmed the Trust's Clostridium difficile objective for 2017/18 was no more than 55 Trust apportioned cases against patients of two years and above. In February2018 there was one Trust apportioned case reported in additional to the 42 reported from April to 31 January 2018. The

Trust was on trajectory but the Board had noted earlier in the meeting there was a potential risk of breaching the upper threshold.

6.6.2 It was noted that there is no official target for MRSA bacteraemia or MSSA bacteraemia. With regards to MRSA bacteraemia the Trust had zero assigned cases in January 2018 with one Trust assigned case in the first 10 months of the year. There had been 27 MSSA Trust apportioned cases from April to 31 January 2018 with five MSSA Trust appointed cases in January 2018. It was noted that two high risk areas had failed the cleaning standard and as a result of that remedial action had been taken to revert to weekly monitoring.

6.6.3 The Director of Nursing confirmed that throughout January 2018 the Trust had noted a high number of patients presenting with seasonal flu. In response to Mr R Carter-Ferris, Non-executive Director's query regarding the staff flu vaccination target, the Director of Nursing and Quality confirmed that the Trust had achieved 72% compliance against the 70% target.

6.6.4 In conclusion, the Director of Nursing reported that the antibiotic stewardship had performed well and the Trust's ability to achieve the CQUIN target this financial year looked promising.

6.7 **Resolved:** i) the Chief Executive Integrated Performance Report was noted; and
ii) the Director of Human Resources would be invited to present the findings of the sickness absence deep dive exercise to the Board at its April 2018 meeting.

BoD/03/07 Modern Slavery Annual Statement

7.1 The purpose of the report was to provide an update on the commitments which the Trust made in 2017 and the actions carried out by the Trust in year to comply with the requirements of the Modern Slavery and Human Trafficking Act (2015). The Board agreed that the statement displayed on the Trust's website would be updated to include the new Chairman's details and to reflect actions carried over the last year. **ACTION (L Hughes)**

7.2 **Resolved:** the update on compliance to the Modern Slavery and Human Trafficking Act (2015) and arrangements to update the statement on the Trust's website was noted.

BoD/03/08 Fit and Proper Person Annual Statement

8.1 The Acting Chair explained that in accordance with the Care Quality Commission (CQC) fit and proper person requirements and duty of candour which came into force for all NHS providers under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Regulation 5 and Schedule 4. All newly appointed Board members had met the requirements and the remaining of Board members had completed an annual self-declaration to confirm continued compliance.

8.2 **Resolved:** the Board noted the assurance received on Board member's compliance against the fit and proper person requirements.

BoD/03/09 Any Other Business

9.1 The Acting Chair explained that this was her last meeting as Acting Chair, she would return to the role as Non-executive/Deputy Chair from April 2018. The Board sincerely thanked the Acting Chair for covering the position over the last 15 months.

9.2 The Chair Designate thanked Mrs T Evans, PA to the Chief Executive for taking the minutes of Board meetings over the past year.

BoD/03/10 Items for Information

10.1 **Integrated Quality, Finance and Performance Report**

Resolved: the Integrated Quality, Finance and Performance Report (including nurse acuity) was received and noted.

10.2 **Quality Assurance Committee's Chairs Log**

Mrs Rutter, Non-executive Director (Chair of Quality Assurance Committee) drew reference to the two items for escalation to the Board with assurance sought around non-compliance against Children's level three and three plus Safeguarding Training. In response to that the Medical Director (Urgent & Emergency and the Friarage) provided reassurance that an action plan to address non-compliance was under development for completion by 31 March 2018.

10.2.1 It was also noted that three information governance incidents were reported to the Quality Assurance Committee.

Resolved: the Quality Assurance Committee Chair's Log was received and noted from the meeting held on 20 February 2018.

10.3 **Audit Committee Chair's Log**

Mr Carter-Ferris, Non-executive Director (Chair of Audit Committee) asked the Board to note that the Audit Committee had agreed the option to extend Audit One and KPMG contracts for a further two years (subject to Council of Governors ratification on 13 March 2018). **ACTION (S Mason)**

10.3.1 **Resolved:** the Audit Committee Chair's Log was received and noted from the meeting held on 13 February 2018.

10.4 **Finance and Investment Committee Chair's Log**

The Board noted the four escalation items, three of which were included on the Board agendas: i) the budget process for 2018/19; ii) the year end forecast was unchanged since its re-forecast at 31 December 2018; and iii) the Trust's cash position continued to be of significant concern. The Board also noted that iv) discussions with Carillion had taken place.

Resolved: the Finance and Investment Committee Chair's Log was received
10.4.1 and noted from the meeting held on 18 January 2018.

BoD/03/11 Date and Time of Next Meeting

11.1 The next Board meeting (held in Public) is scheduled to take place on 5 June 2018 in the Boardroom, 2nd Floor, Murray Building, James Cook University Hospital.

Board of Direction Action Log

Date of Mtg	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
6.03.18	BoD/03/06.2.4	**Chief Executive Integrated Performance Report**	a deep dive exercise was underway with the outcome planned to be reported to the Workforce Committee later that month. It was agreed that the Director of Human Resources would be invited to present the findings of the deep dive exercise to the Board at its April 2018 meeting	P Iddon	3.04.18	Completed - received by the Board at its meeting held in Private on 3 April 2018	Completed
6.03.18	BoD/03/07.2	**Modern Slavery Annual Statement**	agreed that the statement displayed on the Trust's website would be updated to include the new Chairman's details and to reflect actions carried over the last year	L Hughes	2.04.18	Completed - statement updated on Trust's Internet	Completed
6.03.18	BoD/03/10.3	**Audit Committee Chair's Log**	agreed the option to extend Audit One and KPMG contracts for a further two years (subject to Council of Governors ratification on 13 March 2018)	S Mason	13.03.18	Completed - Council of Governors ratified Audit Committee's approval	Completed

South Tees Hospitals
NHS Foundation Trust

Chief Executive Report

5th June 2018

Excellence in Patient Outcome and Experience

NHS
South Tees Hospitals
NHS Foundation Trust

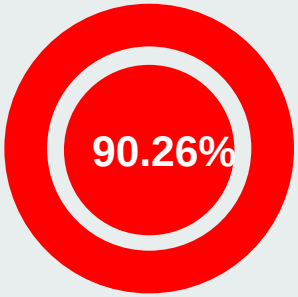
Must Do's

Must Do's 2018/19

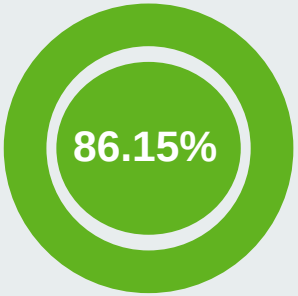
Deliver Excellence in Patient Outcome and Experience….

A&E
4hr Target

RTT
18 Week Target



Cancer
62 Day Target

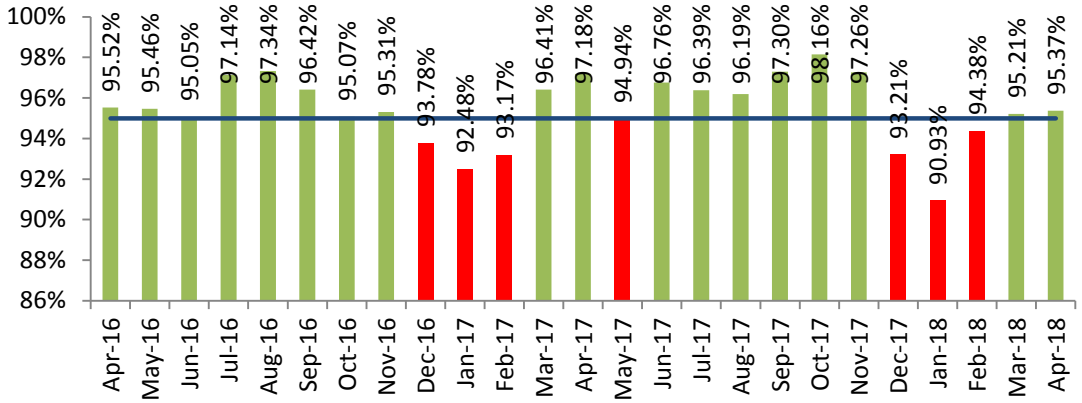


CDiff
HCAI Threshold

Financial Position

…and ensure our long term financial sustainability

Performance - A&E



95% TARGET

April

95.37%

Q1 to Date:
96.45%

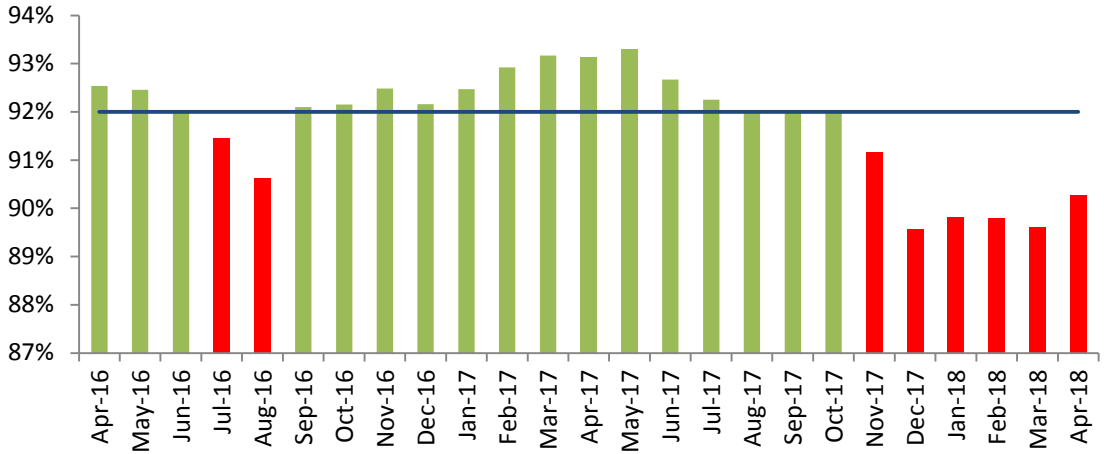
1718 : 95.68%

Regional Rank	Trust	Apr
1	Northumbria Healthcare NHS Foundation Trust	98.84%
2	North Tees and Hartlepool NHS Foundation Trust	97.75%
3	Gateshead Health NHS Foundation Trust	95.80%
4	**South Tees Hospitals NHS Foundation Trust**	95.37%
5	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	94.23%
6	Harrogate and District NHS Foundation Trust	94.14%
7	South Tyneside NHS Foundation Trust	93.25%
8	County Durham and Darlington NHS Foundation Trust	89.79%
9	City Hospitals Sunderland NHS Foundation Trust	88.44%
10	York Teaching Hospitals NHS Foundation Trust	85.10%
11	North Cumbria University Hospitals NHS Trust	84.65%
	ENGLAND	**88.52%**

April 18 Ranked 4th in the region

May to Date = 97.72% (As at 25.5.18)

Referral to Treat



92% TARGET

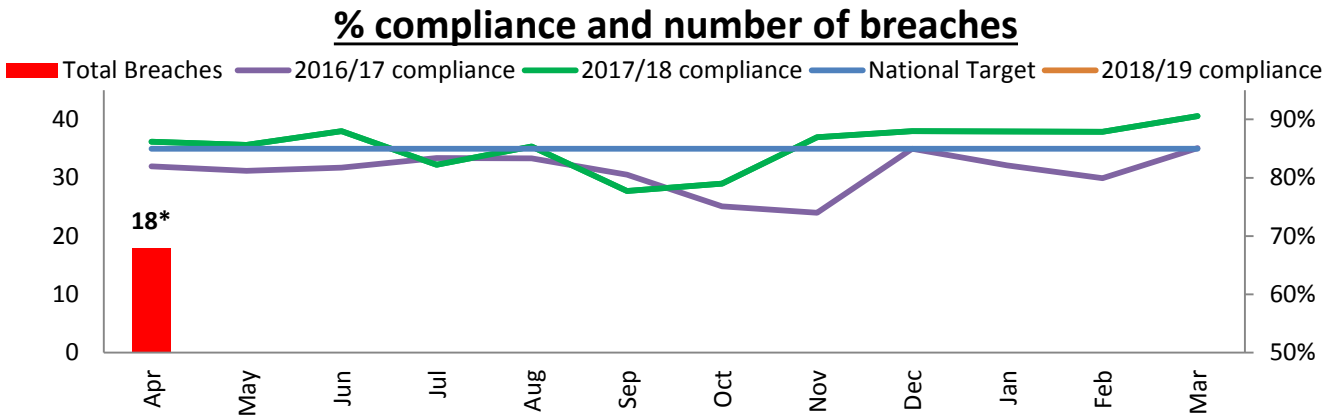
Apr 18
90.26%

Regional Rank	Trust	Apr
1	South Tyneside NHS Foundation Trust	95.6%
2	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	93.6%
3	Gateshead Health NHS Foundation Trust	93.1%
4	City Hospitals Sunderland NHS Foundation Trust	93.0%
5	North Tees and Hartlepool NHS Foundation Trust	92.8%
6	Northumbria Healthcare NHS Foundation Trust	92.1%
7	County Durham and Darlington NHS Foundation Trust	92.0%
8	Harrogate and District NHS Foundation Trust	90.2%
9	**South Tees Hospitals NHS Foundation Trust**	**89.6%**
10	York Teaching Hospital	89.4%
11	North Cumbria University Hospitals NHS Trust	84.2%
	ENGLAND	**87.2%**

Apr 18 Ranked 9th in the region

Recovery program across all area

Performance – 62 Day Cancer Standard



% compliance and number of breaches

* Indicative

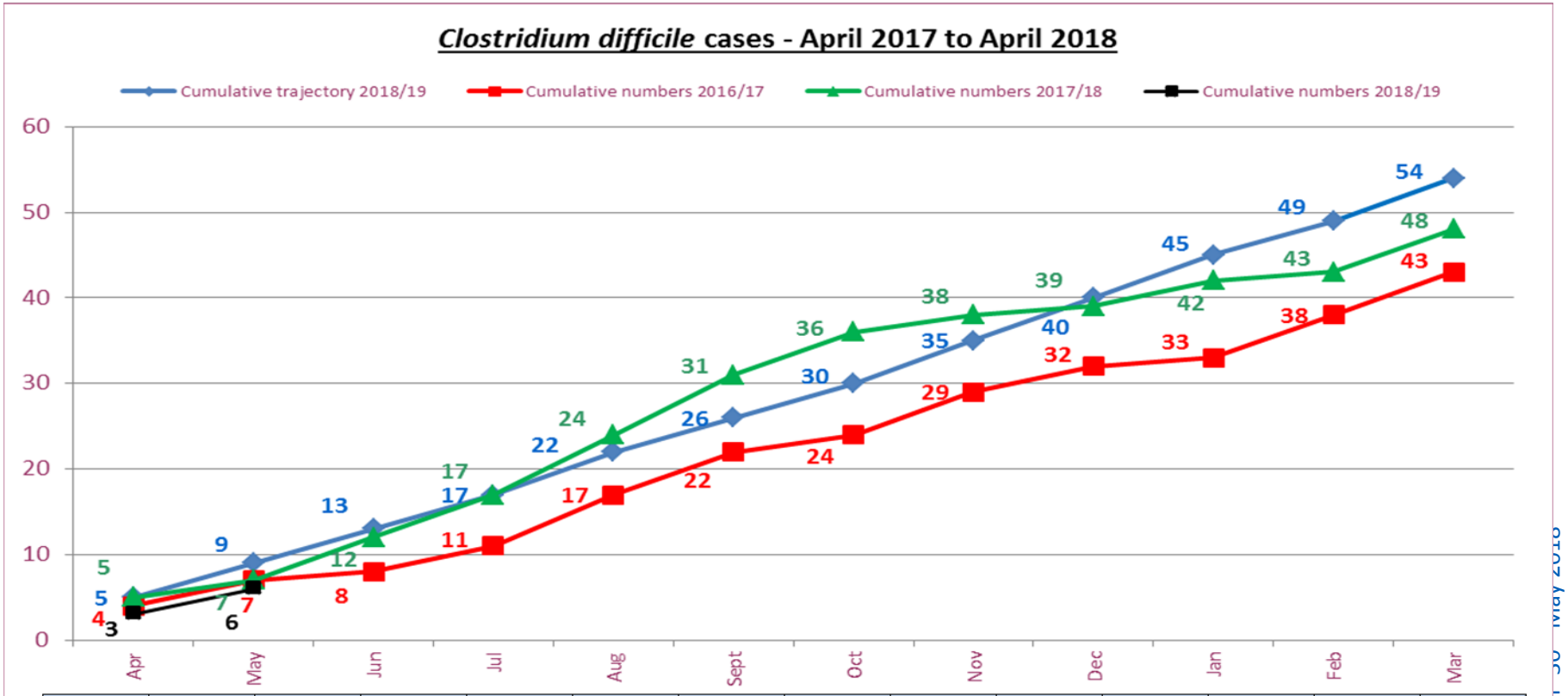
Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
79.1%	86.14%	88.01%	87.92%	87.90%	89.56%	86.15%*

Regional Rank	Trust	Mar
1	North Tees and Hartlepool NHS Foundation Trust	92.90%
2	South Tyneside NHS Foundation Trust	92.31%
3	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	90.72%
4	**South Tees Hospitals NHS Foundation Trust**	**90.55%**
5	County Durham and Darlington NHS Foundation Trust	90.32%
6	Harrogate and District NHS Foundation Trust	89.72%
7	Northumbria Healthcare NHS Foundation Trust	89.13%
8	Gateshead Health NHS Foundation Trust	88.57%
9	York Teaching Hospitals NHS Foundation Trust	86.01%
10	North Cumbria University Hospitals NHS Trust	85.71%
11	City Hospitals Sunderland NHS Foundation Trust	85.71%
	ENGLAND	84.65%

Feb 18 Ranked 4th in the region

May – forecasting to fail for the first time in six months

Trust apportioned Clostridium difficile



Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
JC14	JC11	JC12	JC33	JCITU2	JC07	FHAIND	JC33	JC34	JC08	JC24	JC34	JC24	JC31
JC34	JC35	JCGHDU	JC34	JC11	JC03	JC05	JC36		FHAIND		JC10	JC14	JC14
JC25		JC28	JCGHDU	JC12	JC07	FHAIND			JC07		JC03	JSIRU	JC08
JSIRU		JC14	JC33	JC02	JCITU	JCITU2					JC03		
JC07		FHROM	AAU1	JC07	JC07	JCITU2					JC06		
				JC09	JC11								
				JCGHDU	JCGHDU								

We must ensure that our standards do not slip through the summer

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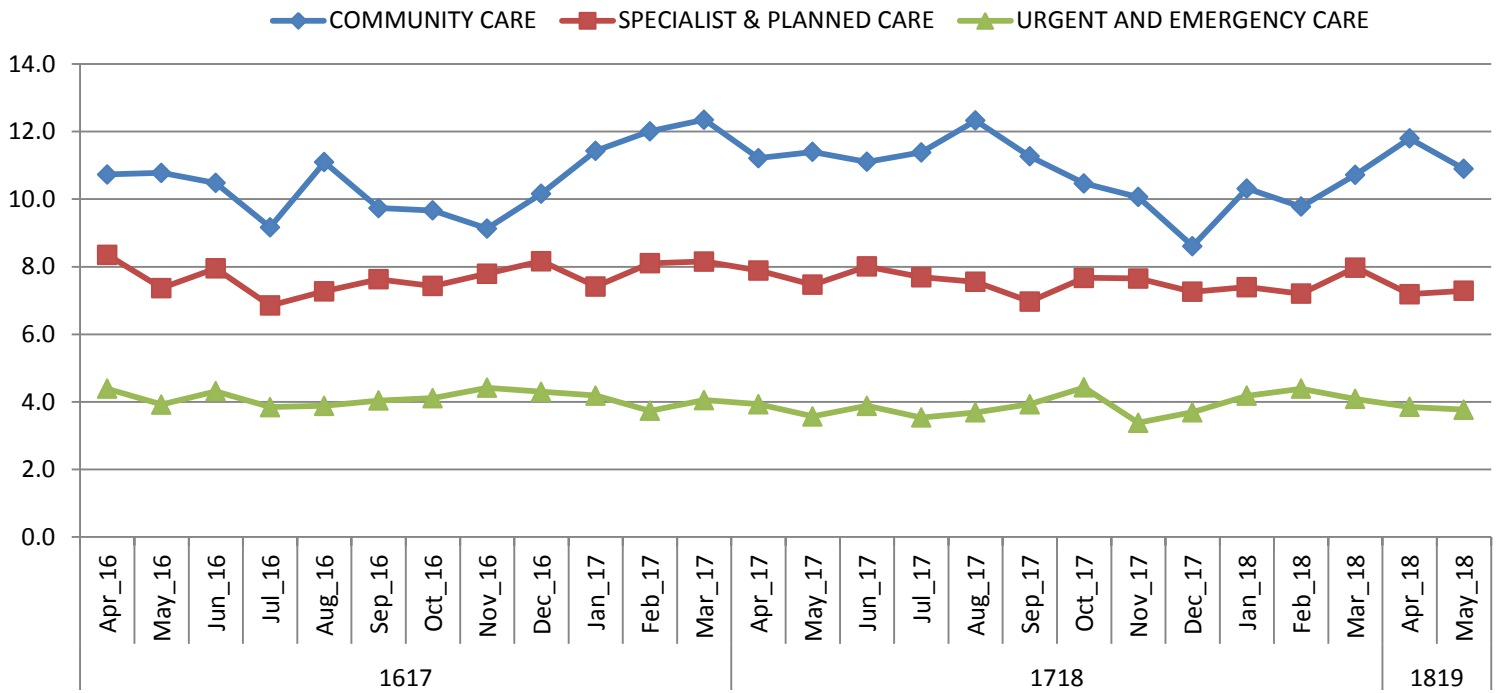
Operational Management

NEL Length of Stay by Centre – April 2016 – 21st May 2018



NEL AVG LOS	Month			
Centre	Community Care	Specialist & Planned Care	Urgent & Emergency Care	Grand Total
1617	10.5	7.7	4.1	7.3
1718	10.7	7.6	3.9	7.2
1819	11.4	7.2	3.8	6.9

Overall small NEL length of stay improvement across the Trust

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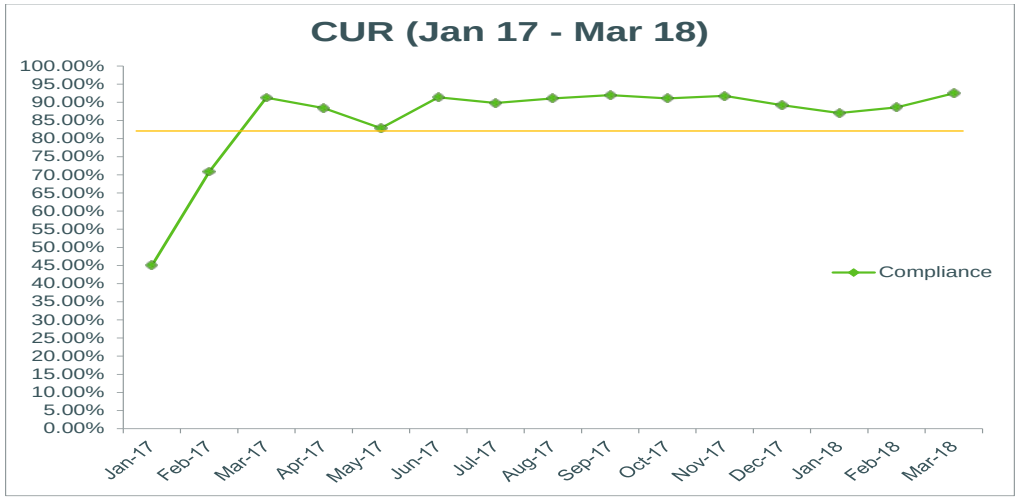
Patient Outcome and Experience

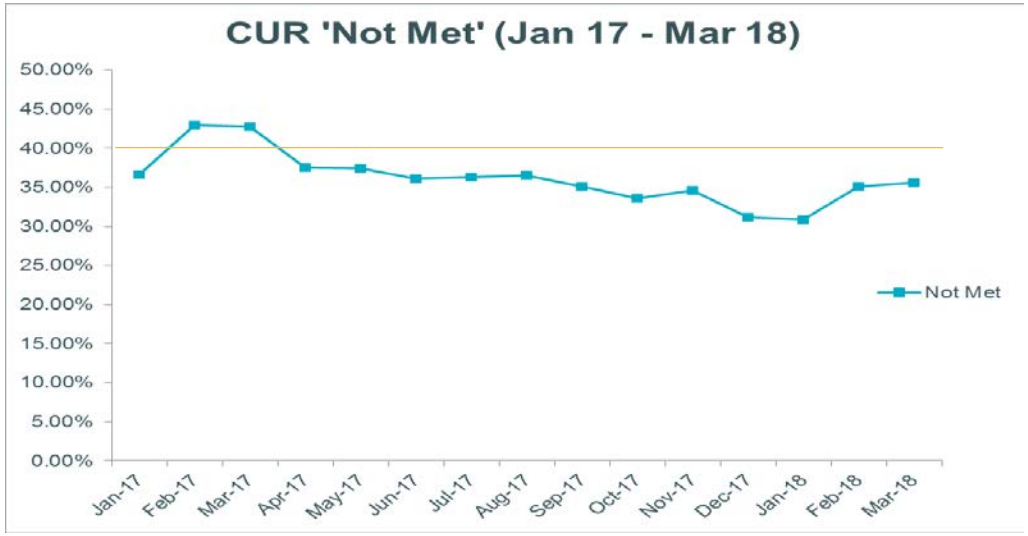
Clinical Utilisation Review (CUR)



90% TARGET

Quarter 4
89.1%

Full Year
90.1%



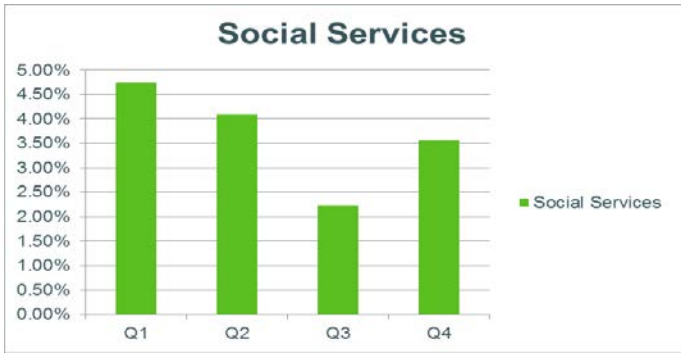
40% TARGET

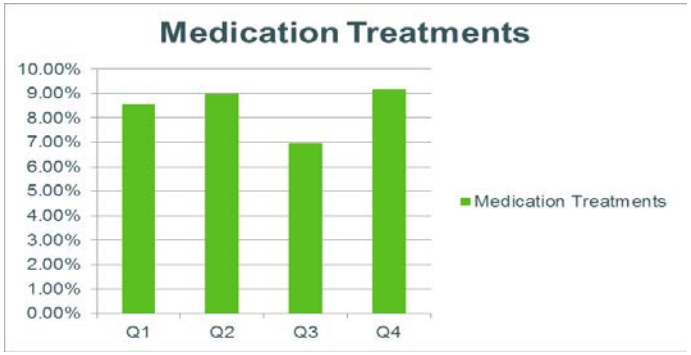
Quarter 4
32.16%

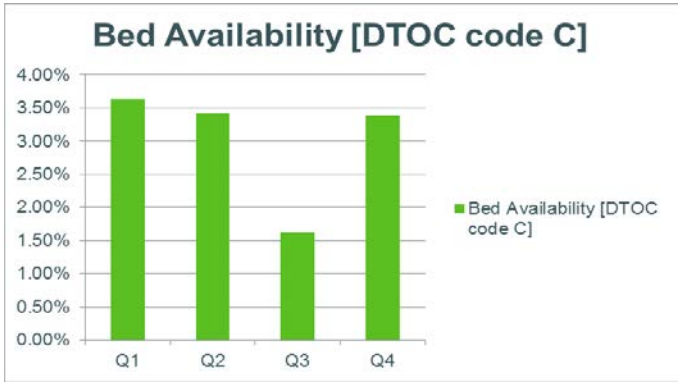
Full Year
34.47%

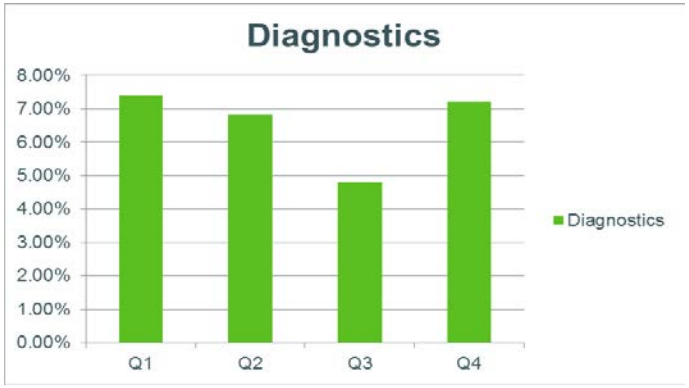
CUR CQUIN compliant across both domains

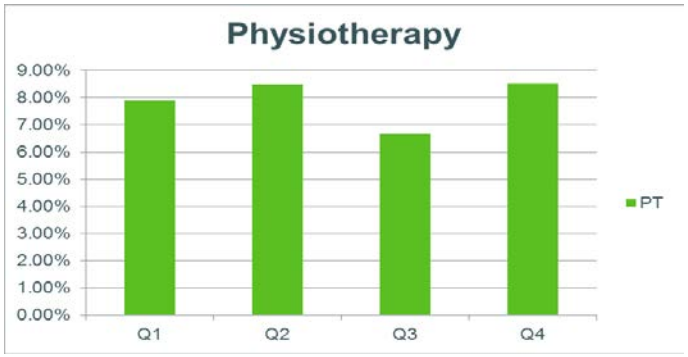
Not Met compliance – Top 5 themes











Increase in numbers across 4 of 5 domains in Q4 from Q3 - require operational focus to prepare for winter planning

2018/19 approach

Winter Planning

Frailty strategy

Major incident planning

Discharge care planning

Establishment of operational working group

2018/19 CQUIN compliance

NHS
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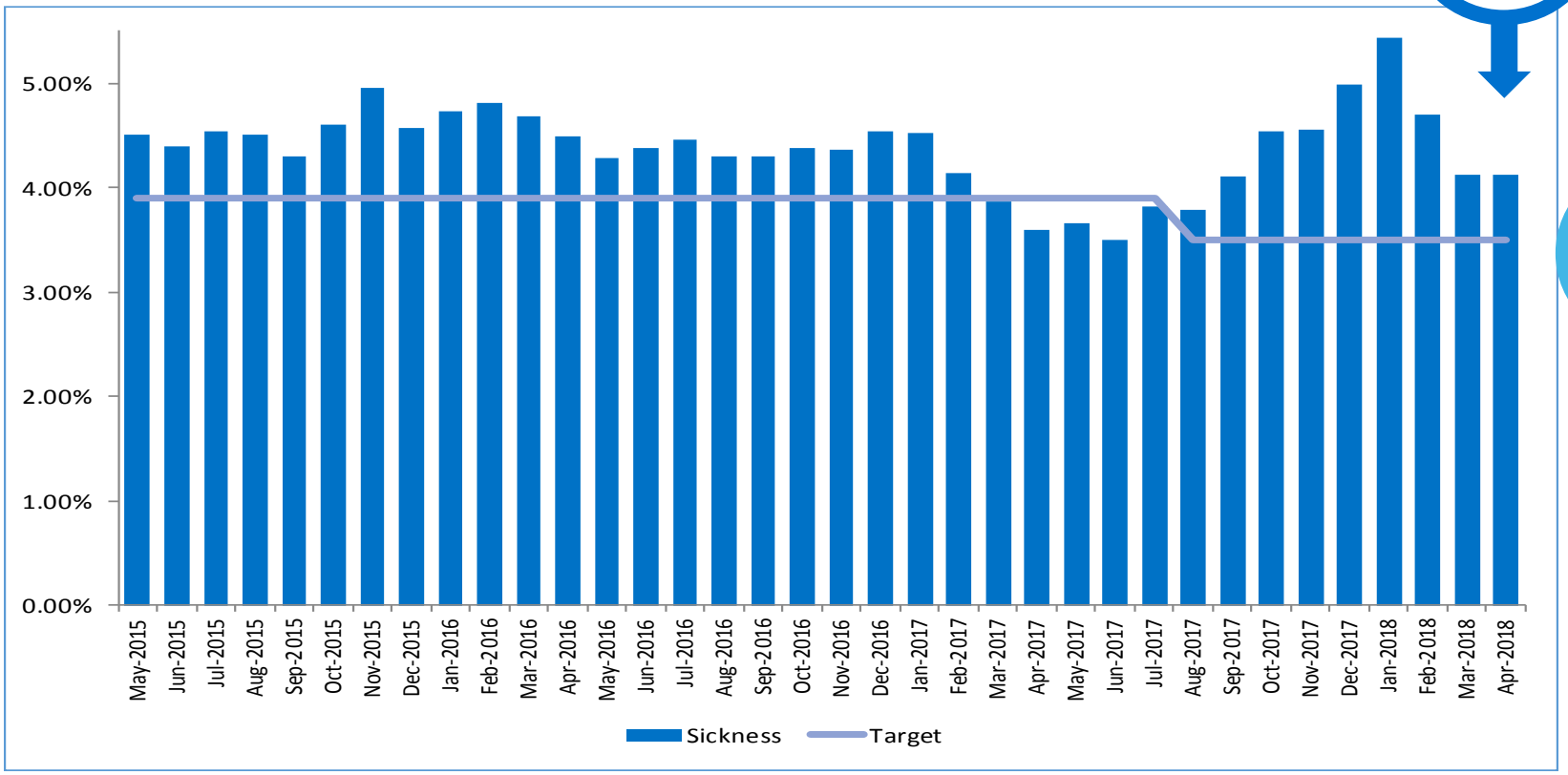
NHS Foundation Trust

People

People

Sickness % Rate



SDR % Rate - 84.67% (Target 80%)

2015/16	2016/17	2017/18	2018/19
68.58%	71.27%	84.70%	84.67%

Training % Rate 92.35% (Target 90%)

2015/16	2016/17	2017/18	2018/19
79.75%	89.35%	92.38%	92.35%

People

Sickness % Rate by Staff Group

Staff Group	April	March	% Change
Add Prof Scientific and Technic	4.35%	4.30%	0.05%
Additional Clinical Services	5.02%	5.28%	-0.26%
Administrative and Clerical	3.61%	3.07%	0.54%
Allied Health Professionals	2.83%	2.79%	0.04%
Estates and Ancillary	5.96%	6.52%	-0.56%
Healthcare Scientists	1.92%	1.82%	0.10%
Medical and Dental	2.18%	1.36%	0.82%
Nursing and Midwifery Registered	4.65%	5.02%	-0.35%
Students	0.00%	0.16%	-0.16%

Major focus on absence management

South Tees Hospitals
NHS Foundation Trust

Finance

Income and Expenditure position – M1

Summary Financials	Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Annual Plan £'000	Current Forecast £'000	Forecast Difference £'000
Total Income	**47,277.3**	**47,410.0**	**132.6**	**580,945.5**	**580,945.5**	**(0.0)**
Managers, Infrastructure & Administration	(3,882.2)	(3,735.5)	146.7	(41,103.3)	(41,103.3)	0.0
Medical & Dental (Excl Junior Doctors)	(6,492.8)	(6,345.1)	147.8	(73,763.7)	(73,763.7)	0.0
Medical & Dental (Junior Doctors)	(2,487.8)	(2,498.4)	(10.6)	(29,853.6)	(29,853.6)	(0.0)
Nursing & Midwife Staff	(9,466.2)	(9,191.4)	274.8	(111,715.7)	(111,715.7)	(0.0)
Healthcare Assistants and Support staff	(3,685.2)	(3,668.7)	16.5	(44,406.6)	(44,406.6)	0.0
AHP, Scientific, Therapeutic and Technical	(4,445.7)	(4,200.4)	245.3	(51,231.5)	(51,231.5)	-
Agency Staff External	-	(407.1)	(407.1)	-	0.0	0.0
Vacancy Factor	457.5	-	(457.5)	5,490.1	5,490.1	0.0
Total Pay Expenditure	**(30,002.4)**	**(30,046.5)**	**(44.1)**	**(346,584.2)**	**(346,584.2)**	**0.0**
Clinical Supplies and Services	(4,575.1)	(4,659.7)	(84.7)	(54,630.7)	(54,630.7)	0.0
Drugs	(1,305.0)	(1,228.4)	76.6	(15,660.3)	(15,660.3)	0.0
General Supplies and Service	(404.8)	(403.8)	1.0	(4,857.9)	(4,857.9)	0.0
Ext Staffing And Consultancy	(1,224.5)	(1,149.7)	74.8	(1,894.2)	(1,894.2)	0.0
Healthcare service purchase	(475.5)	(404.1)	71.4	(5,705.8)	(5,705.8)	0.0
Miscellaneous Services	(2,816.1)	(2,825.4)	(9.3)	(32,993.4)	(32,993.4)	0.0
Pbr Excluded Drugs And Devices	(4,874.1)	(4,856.4)	17.7	(58,489.6)	(58,489.6)	0.0
Premises & Fixed Plant	(1,872.8)	(1,469.0)	403.8	(21,673.4)	(21,673.4)	0.0
Research, Education and Training	(80.8)	(76.1)	4.8	(970.0)	(970.0)	(0.0)
PFI Unitary Payment	(2,243.5)	(2,065.8)	177.7	(25,221.9)	(25,221.9)	0.0
Total Non Pay Expenditure	**(19,872.3)**	**(19,138.5)**	**733.8**	**(222,097.4)**	**(222,097.4)**	**0.0**
EBITDA	**(2,597.3)**	**(1,775.0)**	**822.3**	**12,264.0**	**12,264.0**	**0.0**
Depreciation and Interest	(2,156.6)	(2,137.4)	19.2	(25,879.0)	(25,879.0)	(0.0)
Other non-operating expenses	(498.4)	(493.7)	4.7	5,519.0	5,519.0	(0.0)
Restructuring Costs	(570.2)	(570.2)	-	(2,000.0)	(2,000.0)	(0.0)
Underlying Surplus/(Deficit)	**(5,822.6)**	**(4,976.4)**	**846.2**	**(10,096.0)**	**(10,096.0)**	**0.0**

South Tees Hospitals
NHS Foundation Trust

Strategic Overview

SUMMARY REPORT	South Tees Hospitals NHS NHS Foundation Trust
Board of Directors	Date of meeting: 5 June 2018

Subject	Research and Innovation
Prepared by	Dr Caroline Wroe, Research and Innovation Director Joe Millar, Research and Innovation Manager Sharon Brown, Innovation Hub Administrator
Approved by	
Presented by	Professor Andrew Owens, Medical Director for Education Research and Innovation Caroline Wroe, Research and Innovation Director
Name of meeting considered/approved by	Quality Assurance Committee (22 May 2018)

Purpose:		
1. To report to the Board on Research and Development (R&I) Department performance for 2017/2018. **2.** To outline future Research and Innovation plans and identify risks	Decision	
	Approval	
	Information	●
	Assurance	●

Executive Summary

South Tees Hospitals NHS Foundation Trust achieved the following successes in Research & Innovation (R&I) performance during 2017/18:

- Recruited 3758 patients into clinical research trials, a 9% increase on performance in 2016/17 and the Trust's highest ever recruitment, ranking 3rd in North East and North Cumbria and in the top 10% of NHS Trusts.
- Recruited to 202 different clinical trials, ranking 2nd in Region and in the top 5% of NHS Trusts.
- Awarded 4 new innovation grants with an overall value of £4.3M from European, Innovate UK, i4i and AHSN funding streams on rehabilitation, Sepsis diagnostics, Point of Care and early diagnosis of cancers with an overall allocation to South Tees of >£120,000
- Restructured both Research and Innovation teams to enhance middle tier leadership and sustainability
- Delivered the performance targets set by the Local Clinical Research Network
- Opened 2 new NIHR South Tees sponsored trials

Next Steps

Planned R&I Activity in 2018/19

RESEARCH

- Development of the Durham Tees Valley Research Alliance - Proposal for Tees wide R&D operational alliance
- Commission middle tier leaders with individual research delivery work streams to maximise recruitment and performance within teams
- Enhance financial support to improve invoicing and maximise income
- Develop Principle Investigator (PI) and Chief Investigator (CI) support networks, increase the number of PI's and facilitate 2-3 new CI's to open South Tees sponsored NIHR clinical trials
- Develop joint academic/clinical posts for NMAHP's in partnership with Teesside University and the Local Clinical Research Network

INNOVATION

- Create a sustainable pathway for the mapping and delivery of Innovation grants
- Continue engagement with THIP and submit a further 3-5 grant applications
- Work with the AHSN and NHS England to spread successful innovations in relation to Innovation Technology Payment (ITP) and Innovation Technology Tariff (ITT).

Supports Trust Strategy Map in the following areas

quality & patient safety		business sustainability		operational excellence		organisational capability	
deliver integrated care		improved cost control		improved patient flow		improved information	●
forefront of clinical innovation	●	increased productivity	●	improved innovation processes	●	continuous service improvement culture	●
specialised services development	●	increased revenue & market share	●	strong governance & risk management	●	workforce development	●

service quality and safety		enhanced services	●			strong partnerships & engagement	●

If a key risk(s) has been identified, please describe below

1. Reduction in income secondary to a fall in Local Clinical Research Network funding and reduction in commercial income
2. Although performance has increased, % of market share has fallen (i.e. South Tees performance has not matched that of NENC competitors) and volume of commercial research has fallen
3. Current financial support is resulting in delayed invoicing and challenges for the management of South Tees sponsored studies
4. NIHR are likely to move funding to support primary care and public research in the next few years, this is likely to result in a further significant reduction in allocated funding

Research Activity Summary

Recruitment Performance

As shown in Figure 1, 3758 patients were recruited to research trials in 2017-18 which is the Trust's highest ever recorded number, a 9% increase from 2016-17. This is similar to the average National increase (also 9%), whereas in the North East and North Cumbria there was a 19% increase (note in the previous FY there was a 3% decrease in recruitment regionally vs 24% increase in South Tees performance). The performance of South Tees Hospitals NHS Foundation Trust in 2017/8 represents 8.6% of the total patient recruitment from all NHS Trusts in the North East and North Cumbria region.

Figure 2 shows the number of trials open. The Trust recruited to 202 NIHR Portfolio studies in 2017-18. Figures 3 & 4 show the change in commercial activity, the expansion of commercial research activity remains a key target, due to the associated benefits this brings in terms of increasing available treatment options for patients and generating research income. In 2017/18 the number of commercial studies and recruits were lower than in 2016-17, resulting in reduced research income. Commercial engagement will continue to be an area to focus in 2018/19 through strategic R&I managerial lead and the development of the Durham Tees Valley Research Alliance.

Performance by Centre

Research is taking place in all clinical centres (see Figures 5 and 6) across a broad range of clinical specialities. The three highest recruiting specialties (as defined by the NIHR) in 2017-18 were Cancer, Reproductive Health and Injuries & Emergencies, while the three with the highest number of recruiting studies were Cancer, Reproductive Health and Cardiovascular Disease.

National Accolades

In 2017/18 South Tees Hospitals NHS Foundation Trust received national accolades for 1 Global first recruit for the Orthopaedic team (GLOBAL ICON Shoulder study) and 1 UK first recruit (INSPIRE spinal cord injury study)

South Tees sponsored NIHR Trials

Dr David Austin – PROACT trial: This is a major clinical trial funded by the National Institute of Health Research. The research is looking at whether a commonly used heart drug called enalapril can help to prevent damage to the heart which can sometimes be caused by certain types of chemotherapy.

Mr Prasad – INSPIRE trial: This trial is a collaboration with InVivo Therapeutics Corporation. The research is to assess a new type of Neuro-Spinal Scaffold and whether this aids the recovery of patients with certain types of Spinal Cord Injury.

Achievement of Performance targets

Performance in Initiating and Delivering Clinical Research

Each quarter the Trust is required to report on performance in:

- Recruiting the first patient to a clinical trial within 70 days of a valid research application ('performance in *initiating* clinical research')
- Recruiting the target number of participants within the agreed time for closed commercial trials ('performance in *delivering* clinical research').

The proportion of trials that achieved the 70 day target in the latest available report (2017/18 Q3) was 82%, exceeding the overall national figure of 60%.

The Trust is also measured on the number of research studies that are set up within 40 days. 89% of all new studies in 2017/18 achieved the 40 day target.

Figure 1: Number of recruits

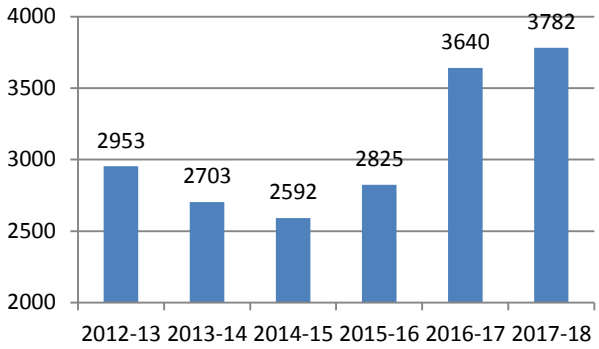


Figure 2: Number of recruiting studies

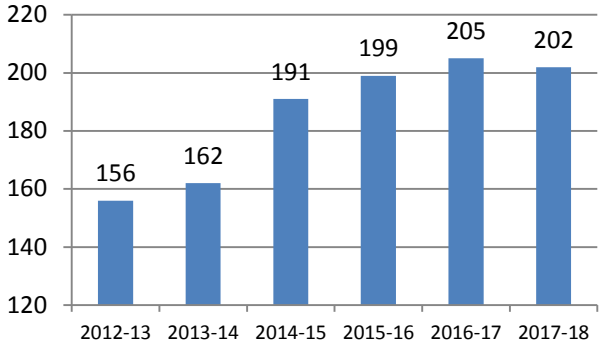


Figure 3: Number of recruits (commercial only)

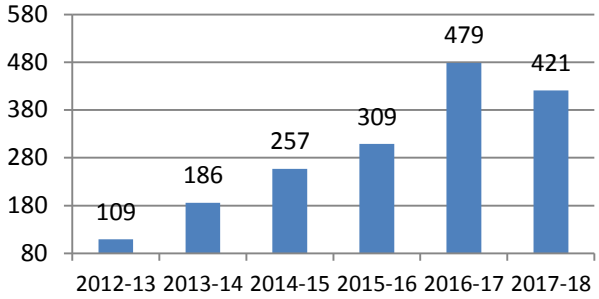


Figure 4: Number of recruiting studies (commercial only)

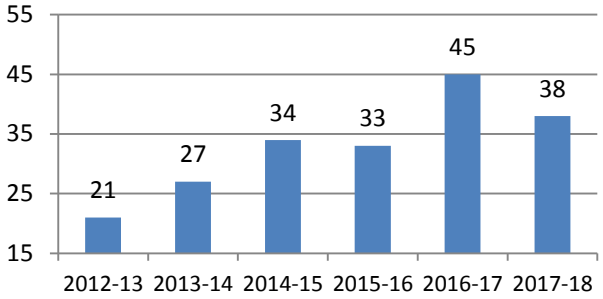


Figure 5: Recruitment by Centre

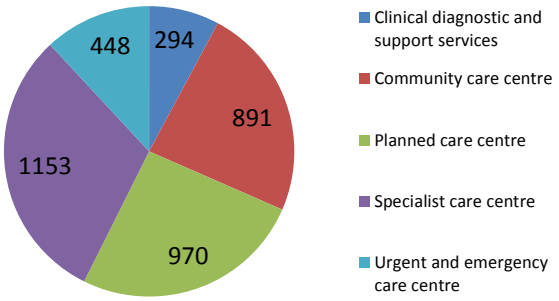
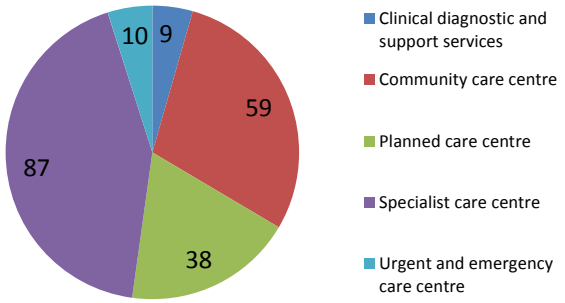


Figure 6: Recruiting studies by Centre



Research income

The primary source of R&D income remains the Local Clinical Research Network; funding allocation for 2018/19 is £2,170,307 (a reduction of 12.5% from 2016/17). This allocation contributes to the salary costs of 37 Nursing, Midwifery & AHP staff, 11 clinical and data support staff, 73 consultant medical staff and supports staff in pathology, pharmacy and radiology to deliver clinical trials.

The secondary sources of income are Research generated income and Research capability funding. Research generated income comes mainly from commercial trials. This was £1.6m in 2015-16, but has decreased to £836,148 in 2017-18; and reflects the drop in commercial trial numbers. NIHR Research Capability Funding (RCF) is allocated in proportion to the total amount of other NIHR income and on the number of NIHR senior investigators in the Trust. In 2015/16 this was £100,158, in 2016/17 was £183,247, and in 2017/18 was £281,171. The allocation for 2018/19 has not yet been confirmed but is projected, based on existing criteria, to be £378,481. In partnership with the Trust Chief Investigators (CI's) a new process has been introduced in 2018/19 to allocate 70% of the funding to the CI lead teams and 30% to support the development of research careers and new CI's within the Trust.

Innovation activity Summary

Tees-Health Improvement Partnership (T-HIP)

In 2017/18 South Tees was part of partnerships awarded 4 new innovation grants with an overall value of £4.3M from European, Innovate UK, i4i and AHSN funding streams on rehabilitation, Sepsis diagnostics, Point of Care and early diagnosis of cancers. The overall allocation to South Tees is >£120,000.

Bright Idea Awards 2017:

- Dr Jon Murray lead the Renal team at South Tees to First Prize in the Patient Safety and Quality Improvement for Reducing patient harm associated with Acute Kidney Injury.
- Miss Jo Cresswell (Consultant Urologist) and the Urology research team contributed to the regional work that won first prize in the Outstanding Industry Collaboration with the NHS Improved tests for bladder Cancer (ARQUER research team)

South Tees Innovation med tech/product development:

1. The Cervix Visual Assessment Guide won best at the multi-regional AHSN showcase event and sales of the guide for 2017/2018 are at £6,500 with marketing of the guide continuing to training providers and GP practices through CCG's.
2. The innovations team successfully applied for grants worth £50,000 from the AHSN for the development and support of med tech devices and tech transfer.
3. South Tees and working with Focus Games to develop a healthcare board game promoting good nursing care, the game is currently in production.

Table 1: Innovation Grants awarded in 2017/18

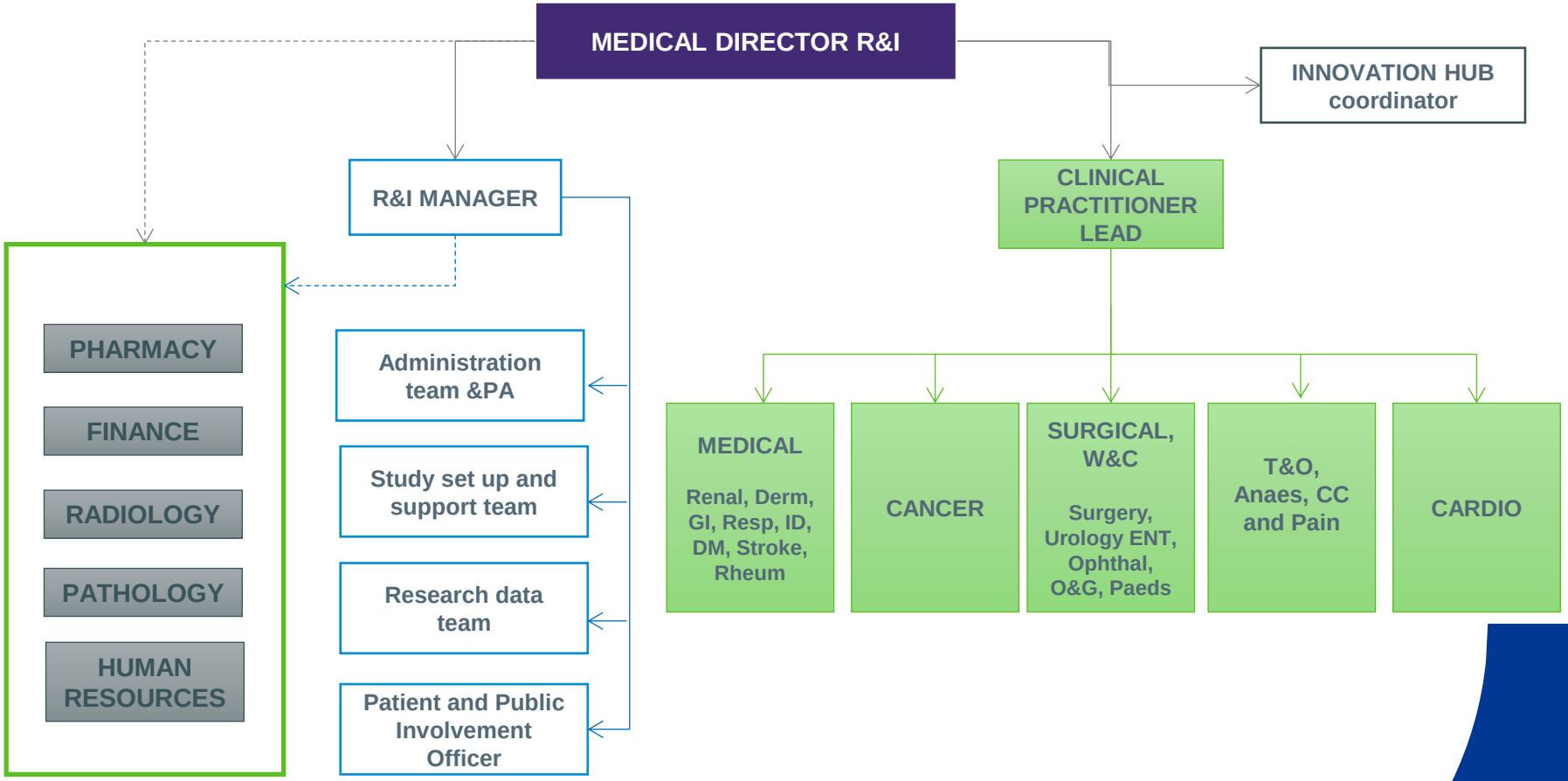
Grant name	Source of funding	Partners	Total grant value/£	Allocation to South Tees/£
Intelliscan (smart MRI for cancer diagnostics)	Innovate UK	Teesside University, TWI (THIP)	830,294	30,000
Sepsis PoC Diagnostic System (wearable diagnostics for sepsis)	NIHR i4i	Teesside University (THIP)	150,000	8064
V4Rrehab (virtual reality rehabilitation program)	European	Teesside University	2,410,000	tbc
Quickfit (smart design for rapid prosthetics development)	Innovate UK	TWI Teesside University Lusstech (THIP)	1,170,378	83,545

Summary of R&I outcomes from 2016/17 targets

Target	Outcome
Deliver the performance targets set by the National Institute of Health and research and the Local Clinical Research network for research set up and delivery	Achieved Q2-4. Resulting in additional income of £15,000
Restructure both Research and Innovation, bringing together the departments under joint senior management and clinical leadership to facilitate the flow of innovations through into clinical research, prioritising the development of new chief investigator led studies Embed new structure to enhance cross cover for study support, maximise opportunities to recruit patients to clinical trials and engage underperforming specialities. Improve communication to wider Trust	Restructure began in July and completed in December 2017. The new structure is attached at Appendix A. Clinical team leads in post and reviewing performance and engagement led by Clinical Research Lead Alison Chilvers 2078/18 Specialty R&I reports to be send to CD's at the end of May and Medical Directors to receive a centre report. April-July working with Teesside University Graphic design to create a film to promote engagement in and understanding of research
Re-establishment of research patient ambassadors Develop and strengthen research Patient representation in research ideas and trial delivery	Patient Ambassador Liaison for the Trust and South of the NIHR NENC now in post. Interviews for Patient Ambassador due in May 2018 Well-developed specialties are establishing topic specific patient engagement (e.g. Orthopaedic, Rheumatology, Cancer, Renal, Cardiology)
Introduce new SOP's for management of research income and Research capability funding	Completed and for introduction in Q1&2 of 2018/19
Provide specialist new chief investigator training and mentoring programme	Initially poor uptake. To be re-introduced in Q3&4 of 2018/19 working with Durham Tees Valley Research Alliance
Introduction of Health Care Assistant role in R&D	Apprentice research HCA role developed by team lead Kerry Collings and 2 started in January 2018
Increase financial income through commercial activity, South Tees sponsored clinical trials, grant applications and innovation ideas taken to market	Although commercial income has fallen, both RCF and innovation grants have increased
Build relationships with 1. Teesside University and TWI as part of the Tees Healthcare Innovation Partnership (THIP) 2. External academic partners and stakeholders 3. Industry	Increase in the number of grants submitted and awarded South Tees representation on NENC research strategy group Development of the Durham Tees Valley Research Alliance

R&I Structure

RESEARCH SERVICES	RESEARCH SUPPORT TEAM	CLINICAL RESEARCH TEAM	INNOVATION



SUMMARY REPORT	South Tees Hospitals NHS NHS Foundation Trust
Board of Directors	Date of meeting: 5 June 2018

Subject	Healthcare-associated infection report for April 2018
Prepared by	Richard Bellamy, Infection Control Doctor, JCUH Judith Connor, Assistant Director of Nursing / Deputy DIPC Gill Hunt, Director of Nursing/ DIPC
Approved by	Gill Hunt, Director of Nursing / DIPC
Presented by:	Gill Hunt, Director of Nursing / DIPC

Purpose: To provide performance information in relation to healthcare-associated infections.		
	Decision	
	Approval	
	Information	
	Assurance	●

Executive Summary

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, MRSA and MSSA bacteraemia, bacteraemia due to glycopeptide-resistant enterococci, E.coli, ESBL-producing coliform infections and other important healthcare-associated infections for the month of April 2018.

- The *Clostridium difficile*-associated diarrhoea objective for 2018/19 is to have no more than 54 trust-apportioned cases among patients aged over 2 years. There were 3 trust-apportioned cases in April 2018.
- There is no official MRSA bacteraemia target for 2018/19. There were 0 Trust-assigned cases in April 2018.
- There is no official MSSA bacteraemia target for 2018/19. There were 3 Trust-apportioned cases in April 2018.

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.

Supports Trust Strategy Map in the following areas

quality & patient safety		business sustainability		operational excellence		organisational capability	
deliver integrated care		improved cost control		improved patient flow		improved information	
forefront of clinical innovation		increased productivity		improved innovation processes		continuous service improvement culture	
specialised services development		increased revenue & market share		strong governance & risk management	●	workforce development	
service quality and safety	●	enhanced services				strong partnerships & engagement	

HEALTHCARE ASSOCIATED INFECTION REPORT (DATA TO 30th APRIL 2018)

1. SURVEILLANCE DATA

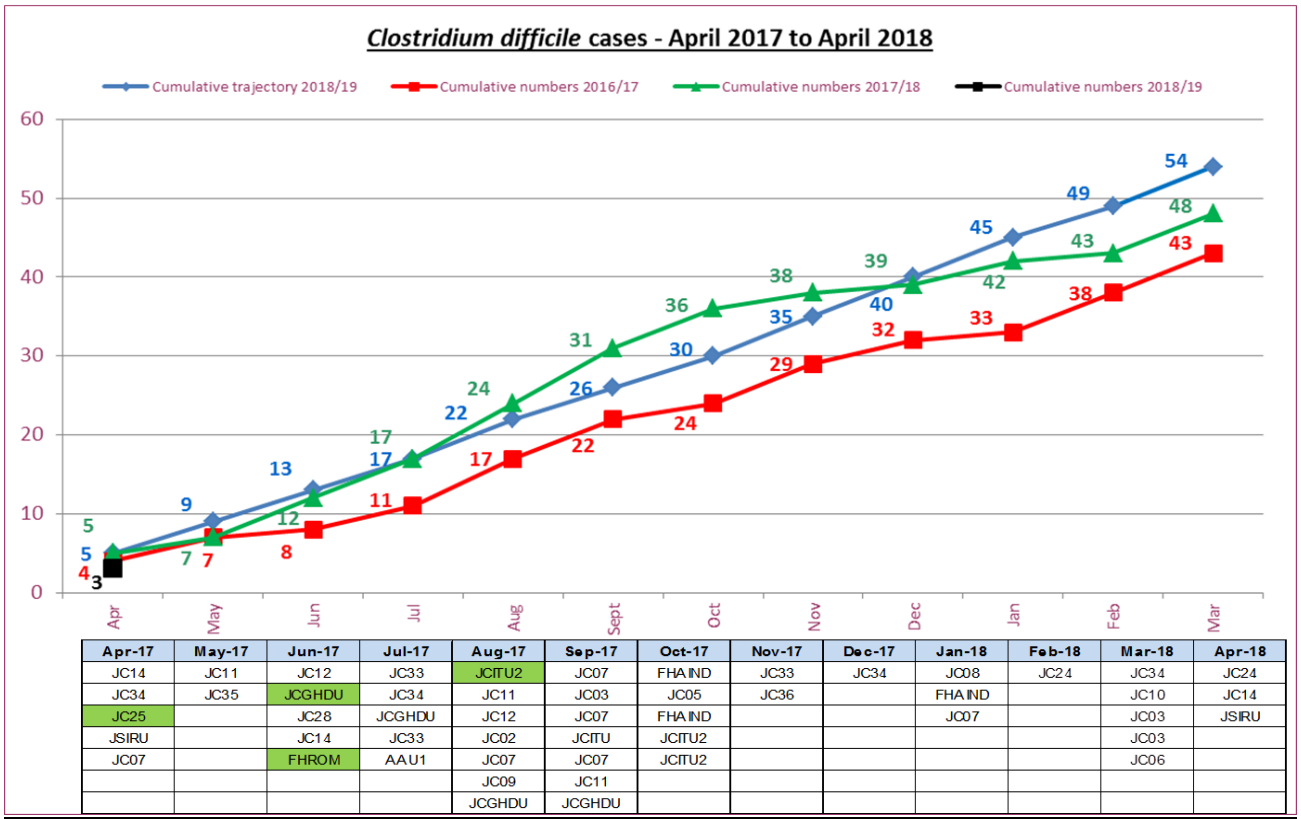
1.1 Clostridium difficile

C diff	Total 2017/18	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	Total 2018/19 to date	Target for 2018/19
Total cases	125	13	16	10	10	18	11	8	4	10	6	8	8	8	NA
Not trust apportioned	77	11	11	5	3	11	6	6	3	7	5	3	5	5	NA
Trust apportioned	48	2	5	5	7	7	5	2	1	3	1	5	3	3	**54**
- JCUH	45	2	5	5	7	7	3	2	1	2	1	5	3	3	
-FHN	3	0	0	0	0	0	2	0	0	1	0	0	0	0	
-Carters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Redcar	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-East Cl	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Lambert	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

There were 8 cases of *C. difficile* infection in April 2018, 3 of which were classed as trust apportioned. The annual objective is to have no more than 54 trust-apportioned cases.

Deaths within 30 days after *C. difficile* diagnosis: for March 2/8 patients died during this period. Since April 2009, 279/1540 (18%) have died during the 30 day follow-up period.

Graph 1: Cumulative Trust-apportioned *C. difficile* cases 2018/19 compared to 2017/18 & 2016/17 trajectory

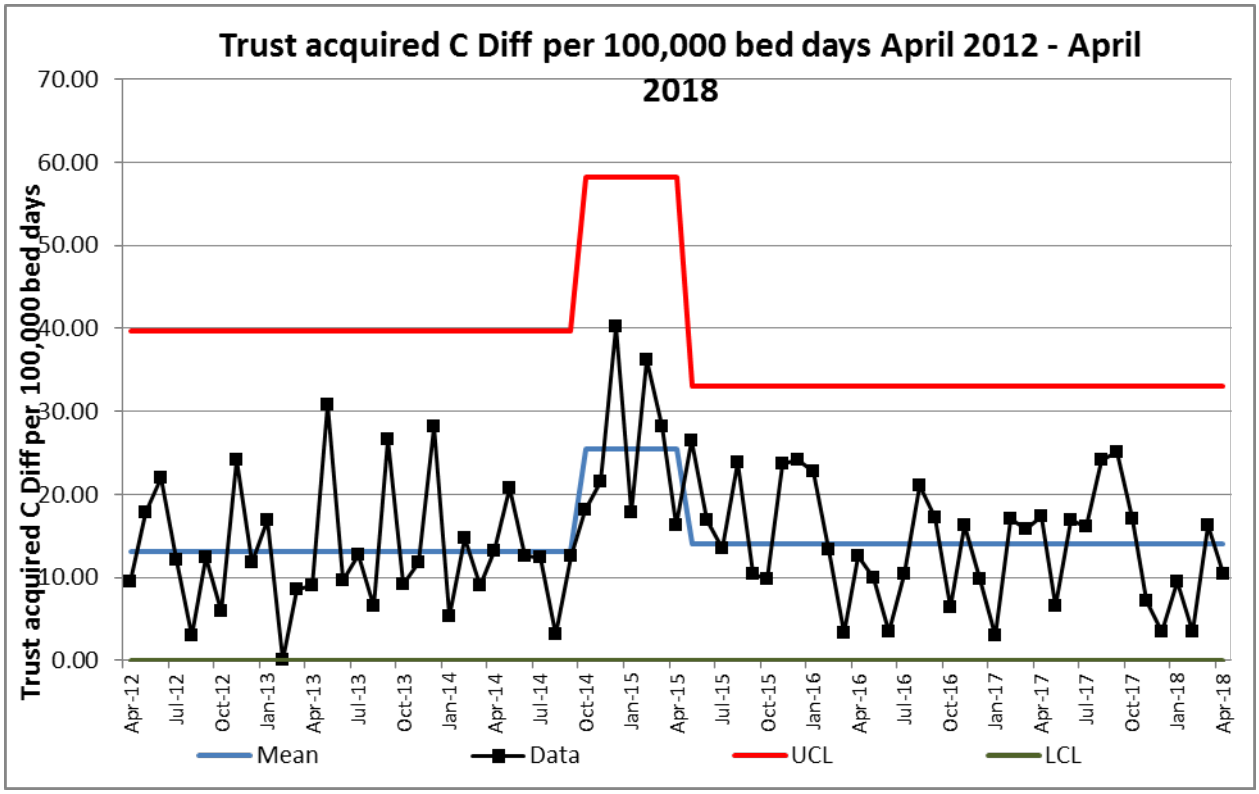


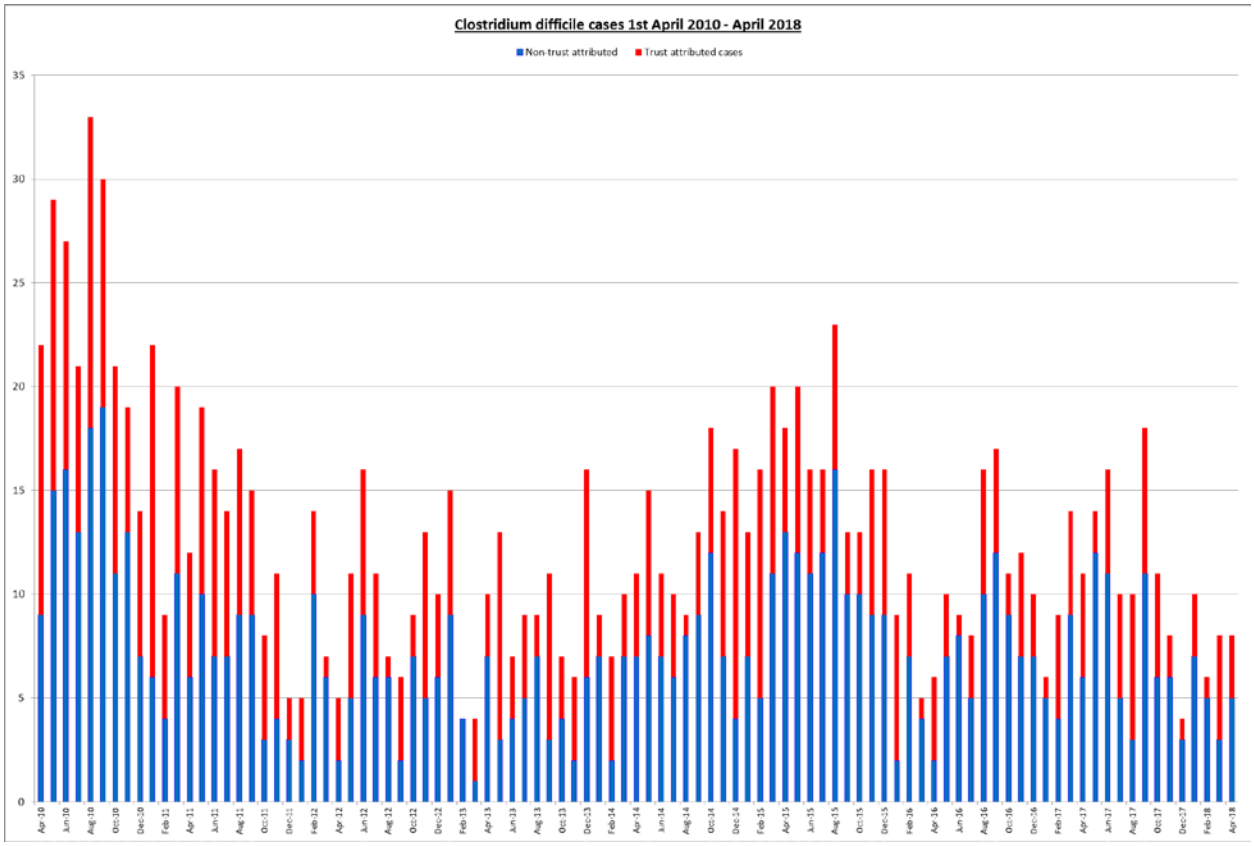
Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
JC14	JC11	JC12	JC33	JCITU2	JC07	FHAIND	JC33	JC34	JC08	JC24	JC34	JC24
JC34	JC35	JCGHDU	JC34	JC11	JC03	JC05	JC36		FHAIND		JC10	JC14
JC25		JC28	JCGHDU	JC12	JC07	FHAIND			JC07		JC03	JSIRU
JSIRU		JC14	JC33	JC02	JCITU	JCITU2					JC03	
JC07		FHROM	AAU1	JC07	JC07	JCITU2					JC06	
				JC09	JC11							
				JCGHDU	JCGHDU							

Graph 1 – Key

Successfully appealed	

Graph 2: Rate of Clostridium *difficile* infection per 100,000 bed days.





Root Cause Analysis (RCA) and panel reviews are undertaken for all trust-apportioned *C. difficile* cases.

In terms of patient risk factors for the reported cases in April:

- 1 of the 3 patients was over the age of 65 years
- All 3 patients had antibiotic therapy within 3 months of the current admission
- All 3 patients were prescribed a protein pump inhibitor.

The opinion of the review panel was that one case was appealable as no lapses in care were identified, this case has therefore been referred to the Commissioners for their consideration.

There have been no further episodes of linked cases by ribotype since June / July 2017.

The average hand hygiene self-assessment score in April 2018 was 93.54% and peer review average was 92.5%. The trust has reached an agreement with our hand hygiene product supplier for the installation of new dispensers and corresponding campaign materials with a start date 4th June 2018.

The IPC team began screening all requests for terminal cleans in October 2017. This process has resulted in a 56.5% reduction in terminal cleans in April 2018 from Octobers baseline.

Antibiotic Stewardship

For 2018/2019 the antimicrobial resistance (AMR) CQUIN will be a 1-2% reduction for total antibiotic use compared to 2017/2018 and a 2-3% reduction for carbapenems. Due to the large reduction in carbapenem use our trust achieved in 2017/2018, this will be a very challenging target. The piperacillin/tazobactam target is being replaced by a target to increase the proportion of antibiotics used which are classed as "Access" (or narrow spectrum) by the World Health Organisation. This is a complex target which we will be considering in detail as part of our antibiotic stewardship initiatives for 2018/19. The ARK (Antibiotic Review Kit) research project has been completed, however the trust will continue to use the audits to support our continued efforts to audits to increase the proportion of antibiotics which are stopped at the 48-72 hour review and thus reduce total antibiotic usage. The Trust's short stay drug chart has been amended to incorporate the ARK decision aid within the antimicrobial boxes and is now in circulation.

Environmental Cleaning

The average cleaning scores by month are as follows:

The James Cook Site:

Risk Category	NSC Target	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
High Risk	**95%**	96%	97%	98%	98%	98%	98%	98%	98%	98%	99%	98%	99%
Significant Risk	**85%**	96%	95%	96%	97%	96%	98%	98%	97%	98%	98%	98%	97%
Low Risk	**75%**	95%	92%	93%	93%	91%	95%	95%	95%	95%	96%	96%	95%

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%**	97.89%			99.4%
High Risk	**95%**			96%	99.7%
Significant Risk	**85%**	98.15%		95%	100%
Low Risk	**75%**	96.88%		93%	100%

Cleaning scores have been maintained on the whole despite the liquidation of the Carillion Group in January. No areas failed the C4C inspection in April 2018 on the James Cook site. Maintaining cleaning standards remains an area of continued focus and actions to deliver improvements, working with the service provider, are being led by the Director of Estates. Cleaning scores continue to be monitored at the monthly cleaning standards review meetings and via IPAG.

1.2 MSSA bacteraemia

MSSA	Total 2017/18	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	Total 2018/19 to date	Target for 2018/19
Total cases	130	7	12	8	10	5	17	13	10	10	9	21	9	9	NA
Not trust apportioned	96	6	10	6	7	4	11	11	7	5	6	17	6	6	NA
Trust apportioned	34	1	2	2	3	1	6	2	3	5	3	4	3	3	NA

There were 9 cases of MSSA bacteraemia cases in April 2018; 3 of which were classed as trust-apportioned. RCA investigations are being completed for these cases to identify any themes or organisational learning.

There is no external target for MSSA or MRSA bacteraemia.

1.3 MRSA bacteraemia

There were no cases of MRSA bacteraemia cases in April 2018.

MRSA	Total 2011/18	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	Total 2018/19 to date	Target for 2018/19
Total cases	4	0	0	0	0	0	0	0	0	2	0	0	0	0	NA
Not trust assigned	3	0	0	0	0	0	0	0	0	2	0	0	0	0	NA
Trust assigned	1	0	0	0	0	0	0	0	0	0	0	0	0	0	NA

1.4 Surveillance for other healthcare-associated infections

	Total for 17/18	**April 2018**	**Total 18/19**
Bacteraemia due to glycopeptide-resistant enterococci	7	1	1
Bacteraemia due to E. coli	500	47	47
• Trust-apportioned	106	15	15
• Not trust-apportioned	394	32	32
ESBL producing coliform infections	798	67	67
• sample taken in community	490	41	41
• sample taken in our trust	304	26	26
• bacteraemias	25	1	1
Bacteraemia due to Klebsiella species	131	11	11
• Trust-apportioned	41	2	2
• Not trust-apportioned	90	9	9
Bacteraemia due to Pseudomonas aeruginosa	41	2	2
• Trust-apportioned	19	2	2
• Not trust-apportioned	22	0	0
Other alert organisms • invasive group A streptococcus	1	0	0

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

In April 2018 the trust reported a total of 60 cases of the 3 GNBSI organisms which are part of national surveillance (Ecoli, 47, Klebsiella sp. 11 and Pseudomonas aeruginosa 2). Of these, 19 cases were classed as trust-apportioned (31.6%) as defined by the Department of Health definition. This re-enforces the need to provide further support to the wider community in order to reduce these infections.

The trust continues to support this ambition, participating in the Teeswide Infection Prevention and Control Collaborative (TIPCC) and implementing health economy system wide projects.

2. OUTBREAKS

Diarrhoea & vomiting outbreaks	Annual total 17/18	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	Total 18/19 to date
Total number	*3*	0	0	0	0	0	1	0	0	0	0	2	0	0
Total number of patients affected	*42*	0	0	0	0	0	11	0	0	0	0	31	0	0
Total number of staff affected	*15*	0	0	0	0	0	2	0	0	0	0	13	0	0

There were no significant outbreaks of diarrhoea and vomiting in April 2018.

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

There were two new patients identified with GES carbapenemase-producing Pseudomonas aeruginosa in September and October 2017. It is not clear when the two patients acquired the infection but they do not appear to be linked. There were no further cases detected in April 2018.

In total there have been 21 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

The region has seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing Klebsiella pneumoniae. Several patients have been found to be colonised by this organism when they have been admitted to JCUH. Historically when this has occurred we have screened patients who have had any contact with the index case. Prior to February 2018, no contacts had acquired the oxa-48 carbapenemase-producing Klebsiella pneumoniae strain in our hospital.

In February and March 2018 two patients were admitted to JCUH and found to have this organism.

Over 100 patients have been identified who have been classed as contacts. All of these patients have been screened prior to discharge or on re-admission for patients who have already been discharged. To date two of these contacts have been found to carry the oxa-48 carbapenemase-producing Klebsiella pneumoniae strain. Two outbreak meetings have been held to consider the actions required. We believe that we have controlled the outbreak effectively and prevented further spread.

5. DECONTAMINATION

A monthly report is prepared by the Lead for Decontamination and presented to IPAG. Key points from the most recent report are as follows:

- A report is to be prepared to identify the cost pressure to the organisation to standardise single patient / single use nebulisers.
- Following evaluation the trust will move to a standardised 3 in 1 disinfectant disposable wipe which will replace 2 products we are currently using. This will provide a significant cost reduction to the trust and eliminate the risk of user error.

6. RECOMMENDATIONS

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

SUMMARY REPORT	South Tees Hospitals NHS NHS Foundation Trust
Board of Directors	Date of meeting:5 June 2018

Subject	Safe Staffing Report – Nursing and Midwifery
Prepared by	Eileen Aylott – Assistant Director of Nursing, Workforce
Approved by	Gill Hunt – Director of Nursing and Quality
Presented by	Gill Hunt – Director of Nursing and Quality

Purpose: The purpose of this report is: 1. To provide assurance to the Board in relation to nursing and midwifery safe staffing levels for the month of April 2018. 2. To provide context in relation to the UNIFY safe staffing submission for the month of April 2018.	Decision	
	Approval	
	Information	•
	Assurance	•

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).

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

- RN / RM day shift – 91%, night shift 96%
- HCSW day shift 94%, night shift 110%

Recommendation

The Board 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.

Safe Staffing Levels April 2018

1.0 Executive Summary

The purpose of this report is:

1. To provide assurance to the Board in relation to nursing and midwifery safe staffing levels for the month of April 2018.
2. To provide context in relation to the UNIFY safe staffing submission for the month of April 2018.

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), match the acuity and dependency needs of patients within the clinical areas of the Trust. This includes ensuring that there is an appropriate level and skill mix of staff to provide safe and effective and efficient care.

The SafeCare module is operational with daily review of safe staffing by Centre Associate Directors of Nursing (ADoN) and Clinical Matron's (CM) in hours and Patient Flow out of hours. Red flags and Clinical Judgement status are discussed and mitigated in real time.

2.0 UNIFY Safe Staffing Return

The Trust's safer staffing submission to UNIFY for April 2018 was submitted on 16th May 2018 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 2017/2018

2017/2018	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
April 2017	92.7%	99.0%	95.3%	111.9%
May 2017	91.0%	97.4%	95.0%	109.5%
June 2017	91.5%	98.3%	93.5%	109.1%
July 2017	88.7%	97.4%	93.9%	111.0%
August 2017	87.2%	96.9%	92.1%	113.1%
September 2017	88.3%	100.3%	91.7%	113.9%
October 2017	88.7%	96.6%	93.1%	116.0%
November 2017	88.5%	95.1%	93.6%	109.6%
December 2017	87.1%	92.8%	92.6%	107.9%
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%

Average fill rate for both RN and HCA has increased overall during April.

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 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 with both full and part shifts. 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. These areas are not currently on SafeCare and changes may not always be captured on the roster.

No areas had an RN fill rate for days or nights of less than 80% during April.

2.0 Temporary Staffing

The number of temporary staffing hours requested during April decreased but the fill rate increased to 79.4% (remaining 16% above the National Average). Daily review of all shifts booked has taken place during the morning SafeCare meeting with ADoN's.

4.0 Red Flag Reporting

A total of 149 red flags have been reported during April. 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 a shortfall in RN hours (34), opening of 'amber' beds (49) and 'Red beds' (13). Action taken to mitigate risk is captured on the system providing an audit trail or response to the alert.

Row Labels	Count of Red Flag Type
AMBER Beds Open	49
Delay in providing pain relief	3
Less than 2 RNs on shift	3
Missed 'intentional rounding'	7
RED Beds Open	13
Shortfall in RN time	34
Vital signs not assessed or recorded	5
Grand Total	**114**

5.0 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 March 829 hours were redeployed across adult inpatient areas via SafeCare.

6.0 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. At a macro level our CHPPD is relatively consistent with peers, the latest published data was in January 2018 during

which time we were slightly below our peer group of 8.3 CHPPD with an overall CHPPD at South Tees Hospitals NHS Foundation Trust of 8.2.

7.0 Staff Retention

The retention of nurses and midwives is as important as the recruitment activity undertaken to fill vacant posts. The Model Hospital Dashboard provides comparator data and shows retention at South Tees is higher than both our peer group and the national median and has improved during the last year. Current turnover in RN's is 9% compared to 11% at April 17. Continued focus is imperative.

8.0 Band 5 Vacancy Rate and Recruitment Activity

Band 5 vacancies remain static at approximately 50 unfilled posts. Student nurse interviews for September jobs will take place in June with 92 candidates shortlisted. Panels have been arranged to run in the Community for District Nursing, FHN and JCUH.

The OSCE preparation programme continues to support staff preparing for the NMC examinations with a second cohort of 5 nurses expected to arrive from the Philippines at the end of June.

9.0 Annual Safe Staffing reviews

A full Accident and Emergency safe staffing review is planned to run for 7 days using the BEST tool during June 2018 in line with the recently published (NHSI, 2018) safe staffing publication.

The Trust received the Children and Young Peoples Staffing Nursing Care Tool (CYP SNCT) in May and are planning to run the first 20 day (Monday to Friday) data collection starting in the first week of June.

Neonatal staffing has been reviewed by the Head of Midwifery together with safe Midwifery Staffing as suggested by (NHSI, 2018) recent guidance as both services are interlinked and has been reported to Centre Board.

The District Nursing safe staffing pilot is currently being planning with Allocate Software to run with 3 identified teams – dates to be confirmed.

All reports will be agenda items at the Workforce Committee

10. Recommendation

The Board 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.

References

Department of Health (2016) **Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. An independent report for the Department of Health by Lord Carter of Coles** https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

National Quality Board (2016) **How to ensure the right people, with the right skills are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability.** London

Safe, sustainable and productive staffing in maternity services https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_Maternity_final_2.pdf

Safe, sustainable and productive staffing for neonatal care and children and young people's services https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_Neonatal_mYLJCHm.pdf

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									< 80	80-95	> 95																			
		Hours								DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Registered								Unregistered							
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights					Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total
UEC	Critical Care	9,707.17	9,137.17	2,519.83	1,722.00	9,720.00	9,064.10	1,080.00	756.00	94.1%	68.3%	93.3%	70.0%	13.30%	0.40%	5.20%	5.80%	0.00%	0.00%	4.20%	29.1%	10.40%		4.90%	1.10%	1.00%		3.40%	21.0%
UEC	AMU JCUH	2,160.00	2,150.50	1,440.00	1,412.67	1,800.00	1,788.00	1,278.67	1,242.00	99.6%	98.1%	99.3%	97.1%	11.70%				0.50%		2.30%	14.5%	13.10%		5.10%	5.90%	0.60%			24.8%
UEC	RAFAU	2,407.50	2,090.50	1,429.28	1,461.28	1,080.00	1,068.00	1,440.00	1,164.00	86.8%	102.2%	98.9%	80.8%	12.70%	0.40%	4.20%	1.80%	0.30%		1.70%	21.0%	15.70%	0.40%		3.70%			1.20%	21.0%
PL	JC06 Gastro	1,380.08	1,109.58	1,725.00	1,360.00	690.17	690.67	690.00	770.75	80.4%	78.8%	100.1%	111.7%	13.50%	0.90%	11.40%	4.40%	0.50%		3.20%	33.8%	11.90%	0.40%	9.80%		0.20%			22.3%
COM	JC09 (Ward 9)	1,789.00	1,453.00	1,440.00	1,405.33	1,080.00	1,080.00	1,080.00	1,056.40	81.2%	97.6%	100.0%	97.8%	13.70%			4.00%	1.30%		1.60%	20.5%	12.10%		5.10%	5.10%	3.30%		3.30%	28.9%
COM	Ward 12 General Medicine	1,592.37	1,351.37	1,438.65	1,469.98	1,080.00	936.00	720.00	1,118.50	84.9%	102.2%	86.7%	155.3%	9.50%	5.40%		8.90%	1.60%		4.70%	30.1%	9.20%		5.40%	5.20%	0.10%			19.9%
COM	JC28 (Ward 28)	2,160.00	1,735.50	1,077.83	1,071.50	1,440.00	1,416.00	720.00	780.00	80.3%	99.4%	98.3%	108.3%	13.20%	0.30%	4.30%	6.50%	0.90%		2.50%	27.7%	12.00%		7.40%	8.80%	0.10%		1.10%	29.5%
UEC	AAU JCUH	2,880.00	2,774.33	1,692.00	1,480.33	1,800.00	1,764.00	1,080.00	1,068.00	96.3%	87.5%	98.0%	98.9%	14.10%	0.20%	11.00%	0.20%	0.90%	0.40%	2.40%	29.3%	14.50%	0.70%		1.30%			2.60%	19.0%
COM	Ward 3	1,382.00	1,349.17	1,722.17	1,644.33	1,040.33	910.50	692.67	944.00	97.6%	95.5%	87.5%	136.3%	17.40%		4.00%	6.10%	0.40%		5.20%	33.1%	12.10%	3.70%	4.30%	9.50%			2.50%	32.1%
COM	Ward 11 Elderly Care	2,128.47	1,830.13	1,255.65	1,651.15	1,080.00	948.00	720.00	1,452.00	86.0%	131.5%	87.8%	201.7%	8.60%	9.20%	2.90%	7.10%	2.00%		3.10%	32.8%	7.80%		2.70%	13.50%	0.30%		0.80%	25.0%
PL	PCAU	816.00	789.00	816.17	750.42	720.00	660.00	360.00	360.00	96.7%	91.9%	91.7%	100.0%	10.40%			2.20%	0.90%		17.20%	30.7%	18.70%			18.00%	1.40%			38.0%
PL	JC35 (Ward 35)	1,800.00	1,619.75	1,446.00	1,182.00	816.00	815.42	720.00	780.00	90.0%	81.7%	99.9%	108.3%	17.80%		5.30%	2.00%	0.20%		4.50%	29.8%	13.30%	0.50%	4.40%	5.90%			2.20%	26.3%
PL	JC05 Vas	1,082.17	1,022.17	1,200.00	1,018.00	720.00	684.00	720.00	732.00	94.5%	84.8%	95.0%	101.7%	11.60%		6.60%	8.50%	1.00%		5.10%	32.8%	10.90%	1.30%	14.50%	4.60%	3.20%		2.40%	37.0%
PL	Ward 7 Colo	1,803.75	1,693.83	1,797.50	1,527.50	1,080.67	1,056.67	900.25	864.67	93.9%	85.0%	97.8%	96.0%	9.10%		4.40%	1.50%	0.40%		6.20%	21.5%	6.30%	0.50%		16.80%				23.6%
SP	JC04 (Ward 4)	1,584.00	1,348.42	1,073.75	1,162.75	1,075.00	1,050.33	720.00	811.33	85.1%	108.3%	97.7%	112.7%	14.50%		5.20%	8.70%	0.30%		4.50%	33.3%	11.20%		8.90%	6.70%	0.50%		0.50%	27.7%
SP	JC14 Oncology (Ward 14)	1,807.58	1,461.08	1,080.00	1,259.67	1,080.75	1,080.75	720.00	768.00	80.8%	116.6%	100.0%	106.7%	13.50%		4.60%	12.00%	0.20%		2.80%	33.1%	12.70%	0.60%		1.50%	1.50%		1.20%	17.4%
SP	JC33 Specialty (merger of ward 18 and ward 27)	1,548.00	1,416.00	1,325.67	1,362.83	1,080.00	1,068.00	720.00	775.33	91.5%	102.8%	98.9%	107.7%	13.40%	0.70%	0.10%	0.40%	0.60%		6.50%	21.8%	12.40%	3.40%			3.80%	3.00%		22.6%
PL	JC34 (Ward 34)	1,579.17	1,385.33	1,980.00	1,633.67	732.00	720.00	1,428.00	1,420.42	87.7%	82.5%	98.4%	99.5%	14.10%			7.60%	0.60%		3.00%	25.2%	13.30%	0.40%		7.70%	0.20%			21.6%
PL	Ward 25 Ortho Plan	1,039.82	868.33	1,037.00	1,014.17	691.00	693.00	345.00	403.63	83.5%	97.8%	100.3%	117.0%	13.40%			10.30%	0.20%		2.20%	26.1%	9.00%			3.30%	1.20%			13.5%
PL	JC36 Trauma	1,799.50	1,785.50	1,443.00	1,421.50	1,080.00	1,083.00	1,080.25	1,119.00	99.2%	98.5%	100.3%	103.6%	9.90%	0.50%	4.50%	2.00%	2.70%		3.90%	23.4%	13.40%	2.30%		7.80%	1.30%		1.20%	26.0%
SP	Spinal Injuries	2,420.32	2,305.47	1,870.82	1,636.48	1,440.00	1,440.00	1,080.00	1,080.00	95.3%	87.5%	100.0%	100.0%	14.60%		5.00%	7.60%	0.70%		5.20%	33.2%	16.30%			7.50%	0.50%		1.00%	25.3%
SP	Cardio MB	720.00	720.00	360.00	423.17	720.00	720.00	0.00	36.00	100.0%	117.5%	100.0%	-	12.90%			6.80%			1.50%	21.3%	20.30%				1.20%			21.5%
SP	CCU JCUH	2,208.00	1,908.00	360.00	374.83	1,800.00	1,752.00	0.00	0.00	86.4%	104.1%	97.3%	-	13.10%		7.80%	3.10%	0.80%		2.10%	26.9%	19.30%						2.70%	22.0%
SP	CICU JCUH	3,098.00	2,994.83	1,216.50	664.42	2,968.00	2,845.33	720.00	528.00	96.7%	54.6%	95.9%	-	18.10%	1.10%	1.30%	8.20%	1.80%		4.30%	34.7%	17.80%	0.70%		6.00%	0.70%		0.90%	26.1%
SP	JC24 (Ward 24)	3,077.42	2,763.67	1,332.00	1,915.00	2,520.42	2,476.42	1,080.00	1,445.83	89.8%	143.8%	98.3%	133.9%	8.60%		4.80%	9.40%	0.40%		5.00%	28.3%	13.90%	1.00%	3.90%	9.20%	0.30%			28.3%
SP	JC27 Neuro	1,396.00	1,432.82	1,058.67	1,252.17	720.00	721.92	924.00	1,136.00	102.6%	118.3%	100.3%	122.9%	12.00%	2.60%		3.30%	0.40%		4.70%	23.0%	11.80%			7.10%	1.10%		0.80%	20.8%
SP	JC26 (Ward 26)	1,087.00	1,014.42	726.67	1,487.33	720.00	720.00	360.00	911.19	93.3%	204.7%	100.0%	253.1%	9.40%	1.60%		0.40%	1.10%		7.40%	19.8%	8.50%			3.10%	0.80%		16.90%	29.2%
SP	JC29 (Ward 29)	1,437.50	1,293.50	1,077.67	1,089.67	804.00	804.00	360.00	623.58	90.0%	101.1%	100.0%	173.2%	16.10%		7.40%	3.70%	1.10%		6.20%	34.5%	9.70%				4.20%		2.50%	16.4%
SP	CADU	726.00	630.00	504.00	370.67	0.00	0.00	0.00	0.00	86.8%	73.5%	-	-	14.50%			7.90%				22.3%	9.20%				0.20%			9.5%
SP	JC31 (Ward 31)	1,877.47	1,781.63	1,182.00	1,190.67	1,079.83	1,079.83	720.00	789.50	94.9%	100.7%	100.0%	109.7%	13.00%			2.80%	1.00%		5.80%	22.6%	14.50%			0.50%	4.80%		3.90%	23.7%
SP	Cardio HDU	2,016.00	1,898.33	360.00	288.00	1,632.00	1,524.00	360.00	312.00	94.2%	80.0%	93.4%	86.7%	14.40%	0.20%		1.70%	1.10%		8.20%	25.7%	14.00%			2.50%	9.60%		3.80%	29.9%
PL	Ward 8	1,804.67	1,570.67	1,799.83	1,583.50	1,080.00	1,032.00	1,080.00	984.00	87.0%	88.0%	95.6%	91.1%	10.60%		4.40%	10.10%	0.50%		4.30%	29.9%	7.40%		5.40%	12.80%			4.60%	30.2%
COM	JC21 (Ward 21)	2,160.00	1,984.00	714.00	457.50	2,160.00	1,856.00	360.00	336.00	91.9%	64.1%	85.9%	93.3%	14.80%	0.20%	8.30%	1.80%	2.10%	0.20%	3.90%	31.4%	12.30%	1.10%		11.60%				24.9%
COM	JC22 (Ward 22)	1,074.50	1,068.50	557.00	489.00	972.00	882.00	108.00	144.00	99.4%	87.8%	90.7%	133.3%	12.00%	0.40%		4.00%	2.00%		4.60%	23.0%	11.40%	1.50%			0.70%			13.6%
COM	JCDS (Central Delivery Suite)	3,743.33	3,656.08	972.00	633.25	3,957.50	3,540.50	744.00	705.00	97.7%	65.1%	89.5%	94.8%	11.90%	0.20%		4.30%	1.80%		6.10%	24.4%	12.90%			6.10%	1.80%		4.50%	25.4%
COM	Neonatal Unit	5,282.50	4,284.50	360.00	480.00	4,320.00	3,624.00	0.00	276.00	81.1%	133.3%	83.9%	-	11.70%		6.00%	7.50%	0.80%		0.90%	26.9%	9.80%	1.40%			1.00%			12.2%
COM	Maternity Assessment Unit	1,327.33	1,267.33	297.00	297.00	720.00	720.00	0.00	0.00	95.5%	100.0%	100.0%	-	13.40%	1.60%	5.40%	6.80%	4.10%		2.80%	34.1%	15.30%				6.20%			21.5%
COM	Paediatric Intensive Care Unit (PICU)	1,800.00	1,601.50	225.00	181.50	1,800.00	1,560.00	0.00	0.00	89.0%	80.7%	86.7%	-	9.20%	3.40%	6.80%	4.90%	1.80%		4.30%	30.5%	15.70%							15.7%
COM	Ward 17 JCUH	2,160.00	2,108.50	1,330.50	1,206.00	1,439.85	1,403.85	21.50	9.50	97.6%	90.6%	97.5%	-	11.80%			7.40%	1.80%		5.40%	26.3%	8.90%		11.60%		1.90%		0.30%	22.7%
COM	Ward 19 Ante Natal	1,232.50	1,045.50	225.00	194.00	716.83	716.83	0.00	0.00	84.8%	-	100.0%	-	9.70%			7.00%	15.10%		4.70%	36.5%								
UEC	Short Stay	1,344.00	1,160.00	900.00	918.67	720.00	720.00	624.67	660.67	86.3%	102.1%	100.0%	86.8%	8.40%			0.90%	0.90%		5.70%	16.0%	7.30%				1.00%			8.3%
									Site average	91.1%	97.6%	96.0%	116.2%																

FHN

		Hours								< 80	80-95	> 95		Registered								Unregistered							
		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 - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total
COM	Ainderby FHN	1,367.50	1,153.50	1,039.50	1,017.33	690.00	690.00	690.00	839.50	84.4%	97.9%	100.0%	121.7%	10.50%	1.30%	6.20%	3.50%	0.60%		4.10%	26.2%	14.00%			4.80%	0.80%		11.40%	31.0%
UEC	Clinical Decisions Unit FHN	1,708.50	1,401.50	1,027.00	1,177.00	1,035.00	1,000.50	690.00	701.50	82.0%	114.6%	96.7%	101.7%	16.00%		7.80%	5.80%	2.00%	2.40%	4.10%	38.1%	10.20%			2.30%	1.00%		3.40%	16.9%
UEC	FHICU (ICU FHN)	1,080.00	966.00	312.00	207.00	1,080.00	900.00	0.00	12.00	89.4%	66.3%	83.3%	-	14.90%	0.50%		14.10%	0.30%		3.80%	33.5%	23.30%							23.3%
COM	Romanby FHN	1,195.50	1,001.50	1,279.00	1,105.25	690.00	690.00	686.75	686.75	83.8%	86.4%	100.0%	100.0%	14.00%			4.20%			1.30%	19.5%	9.90%	1.40%	5.30%	19.70%	1.00%			37.2%
COM	Rutson FHN	859.98	830.98	1,307.97	1,188.97	690.00	690.00	690.00	667.00	96.6%	90.9%	100.0%	96.7%	15.00%	2.40%		2.20%	3.20%		7.10%	29.8%	13.90%			10.30%	2.10%		2.20%	28.6%
PL	Allerton Ward FHN	1,440.00	1,207.00	1,080.67	1,026.92	720.00	720.00	720.00	696.00	83.8%	95.0%	100.0%	96.7%	14.50%	4.40%	3.20%	6.40%	0.20%		6.90%	35.6%	12.10%	1.30%		1.30%	0.30%		1.30%	16.1%
PL	Gara Orthopaedic FHN	801.00	785.50	699.50	673.00	690.00	679.50	345.00	334.50	98.1%	96.2%	98.5%	97.0%	12.60%	2.00%		1.40%	1.00%		2.30%	19.3%	18.40%			3.40%	0.10%			22.0%
COM	Maternity FHN	988.33	925.83	394.50	216.50	720.00	708.50	12.00	12.00	93.7%	54.9%	98.4%	-	10.60%		15.60%	2.70%	0.80%		1.40%	31.1%	23.30%				7.40%			30.8%
									Site Average	89.0%	87.8%	97.1%	102.3%																

East Cleveland

		Hours								< 80	80-95	> 95		Registered								Unregistered							
		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 - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total
COM	Tocketts Ward East Cleveland Hospital	1,305.25	1,287.00	1,758.00	1,626.83	1,040.67	918.17	1,038.42	1,247.17	98.6%	92.5%	88.2%	120.1%	16.00%		5.50%	11.80%	0.90%		3.50%	37.8%	12.40%	3.50%	3.30%	10.20%	0.80%		4.40%	34.6%
									Site Average	98.6%	92.5%	88.2%	120.1%																

Redcar

		Hours								< 80	80-95	> 95		Registered								Unregistered							
		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 - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total
COM	Zetland	1,626.33	1,430.08	2,166.32	1,878.13	1,036.33	967.33	1,036.00	1,372.50	87.9%	86.7%	93.3%	132.5%	11.60%	1.20%	4.80%	9.50%	0.80%		6.60%	34.4%	12.40%	3.80%		16.20%	2.20%		1.90%	36.5%
									Site Average	87.9%	86.7%	93.3%	132.5%																

Friary Community Hospital

		Hours								< 80	80-95	> 95		Registered								Unregistered							
		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 - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total	Leave	Other A/L	Parenting	Sickness	Study Day	Unknown	Working Day	Total
COM	Friary Community Hospital	1,055.00	969.50	946.80	947.30	601.50	601.50	300.00	300.00	91.9%	100.1%	100.0%	100.0%	12.20%	0.90%		6.00%	0.50%	0.40%	4.70%	24.6%	9.20%	1.10%		3.90%	3.50%		0.10%	17.7%
									Site Average	91.9%	100.1%	100.0%	100.0%																

	< 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	90.2%	92.5%	93.7%	120.8%
Planned Care	90.4%	88.8%	98.6%	102.3%
Specialist	92.0%	108.1%	98.5%	130.6%
Urgent and Emergency Care	91.4%	89.5%	94.9%	89.7%
Trust Average	91.0%	94.7%	96.4%	110.9%

SUMMARY REPORT	South Tees Hospitals NHS NHS Foundation Trust
Board of Directors	Date of meeting: 5 June 2018

Subject	Infection prevention and control Annual Report in relation to MRSA, *Clostridium difficile* and other healthcare-associated infections, April 2017 to March 2018.
Prepared by	Richard Bellamy, Infection Control Doctor, JCUH Judith Connor, Assistant Director of Nursing / Deputy DIPC Gill Hunt, Director of Nursing/ DIPC
Approved by	Gill Hunt, Director of Nursing / DIPC
Presented by	Gill Hunt, Director of Nursing / DIPC

Purpose: To provide performance information in relation to healthcare-associated infections.		
	Decision	
	Approval	
	Information	
	Assurance	●

Executive Summary

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, MRSA and MSSA bacteraemia, bacteraemia due to glycopeptide-resistant enterococci, ESBL-producing coliform infections and other important healthcare-associated infections for 1st April 2017 to 31st March 2018.

- The *C. difficile*-associated diarrhoea target for 2017/18 was to have no more than 55 Trust-apportioned cases of *C. difficile* among patients aged over 2 years. There have been 48 Trust-apportioned cases during this financial year.
- There was no official MRSA bacteraemia target for 2017/18. There has been 1 Trust-assigned case during this financial year.
- There was no official MSSA bacteraemia target for 2017/18. There have been 34 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 34.9 cases and we have had 35 during this financial year.

Recommendation

The 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.

Supports Trust Strategy Map in the following areas

quality & patient safety		business sustainability		operational excellence		organisational capability	
deliver integrated care		improved cost control		improved patient flow		improved information	
forefront of clinical innovation		increased productivity		improved innovation processes		continuous service improvement culture	
specialised services development		increased revenue & market share		strong governance & risk management	●	workforce development	
service quality and safety	●	enhanced services				strong partnerships & engagement	

INFECTION PREVENTION AND CONTROL ANNUAL REPORT - APRIL 2017 TO MARCH 2018

Executive Summary

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 will be presented at the QAC meeting in May2018.

2. The Trust has achieved its *Clostridium difficile* target for 2017/18. There were 125 cases, 48 of which were Trust-apportioned. This is within the upper threshold of 55 Trust-apportioned cases. There has been an 11.6% increase in the number of Trust-apportioned episodes of *C. difficile*-associated diarrhoea compared to 2016/2017 and an 18.1% decrease in non-Trust-apportioned cases. The Trust has a detailed *C. difficile* action plan. Root cause analysis is performed on all Trust-apportioned *C. difficile* episodes and a case review chaired by the director of nursing/DIPC is held. Audits of death certificates where *C. difficile* was the definite or probable main cause are continuing.

3. There was no official MRSA bacteraemia target for 2017/18. There were 4 cases, 1 of which was classed as Trust-assigned. There were 9 cases of MRSA bacteraemia, 7 of which were trust-assigned in 2016/2017. Root cause analysis is performed on all MRSA bacteraemia episodes and a case review chaired by the director of nursing/DIPC is held.

4. There was no official MSSA bacteraemia target for 2017/18. There were 130 cases, 34 of which were Trust-apportioned. There has been a 15% decrease in combined Trust-apportioned MSSA and trust-assigned MRSA bacteraemia cases compared to 2016/17 and a 6.6% decrease in non-Trust-apportioned cases. Root cause analyses are performed for Trust-apportioned MSSA bacteraemias followed by a departmental case review.

5. The Trust had 7 cases of bacteraemia due to glycopeptide-resistant enterococci in 2017/18. There were 8 cases in 2016/17.

6. ESBL-producing coliforms cause a large number of infections and they are the commonest multi-drug resistant Gram negative organisms affecting the Trust and the local community. In 2017/18 the Trust had 25 cases of bacteraemia due to ESBL-producing coliforms, compared to 9 in 2016/17.

7. The cluster of multi-drug-resistant GES-carbapenemase-producing Pseudomonas aeruginosa which began in 2014/15 has continued in 2017/18 although there is no evidence of ongoing spread in the renal unit or critical care. In total 21 patients have been affected by the GES carbapenemase-producing strain. This continues to be monitored.

8. In February and March 2018 we had two episodes of transmission of oxa-48 carbapenemase-producing Klebsiella pneumoniae. These were detected by extensive screening and we believe we have prevented further transmission but this will continue to be monitored.

9. During the winter months, outbreaks of Norovirus infection have previously caused severe disruption both nationally and to our Trust. During 2017/18 there were 3 outbreaks affecting 42 patients and 15 staff.

10. It must be acknowledged that the IPC team have undergone significant changes in personnel in 2017/2018 which has resulted in a dilution of the knowledge and experience of the team members. Personal development plans are in place and an overall team plan is in development. Despite this the team have taken on additional operational responsibilities

such as monitoring influenza cases and approving terminal clean requests made during routine working hours.

11. There have been significant improvements in endoscope decontamination practices and traceability, over the last 2 years.

12. An international issue was identified in 2016 with regard to patients who have had cardiac valve surgery who have subsequently developed endocarditis due to Mycobacterium chimerae. The infection has been linked to exposure to heater-cooler units and the trust has implemented decontamination practices and water testing. In accord with national guidance the Trust has previously notified all patients who have had such surgery that there is a very small risk they could develop this infection, estimated at 1 in 5000 patients. To date no patients who have had cardiac surgery in our Trust have been found to be affected.

13. The submission rate of the monthly 'Clean Your Hands' audits was 98%. The overall average of compliance with the 5 moments of hand hygiene as reported is 94% with peer audit scores being 93%.

14. Cleaning standards have been maintained on all of the trust hospital sites over 2017/18 with cleaning scores above the required threshold. Joint monitoring with the trusts Environmental Monitoring Team continues and cleaning scores are monitored through IPAG.

15. The IPC team have continued to develop and use bite size tool box teaching packages. This approach has enabled a more flexible approach to training and education.

1. INTRODUCTION

This annual report summarises information on healthcare-associated infections for the period 1st April 2017 to 31st March 2018 including a summary of alert organisms and conditions. It includes information on meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia, meticillin-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 for April 2017 to March 2018 was 125. In 2016/2017 there were 137 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. In 2017/2018 the total number of cases was still 12% higher than in our lowest ever year.

The Trust target for 2017/18 was to have no more than 55 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 is different to that for MRSA and MSSA bacteraemia). Between April 2017 and March 2018 the Trust had 48 patients in this category. In 2016/2017 and 2015/16 there were 43 and 61 trust-apportioned cases respectively so there has been an 11.6% increase compared to last year and a 21% decrease compared to 2 years ago. 2016/2017 was the lowest annual total of trust-apportioned cases we have ever had.

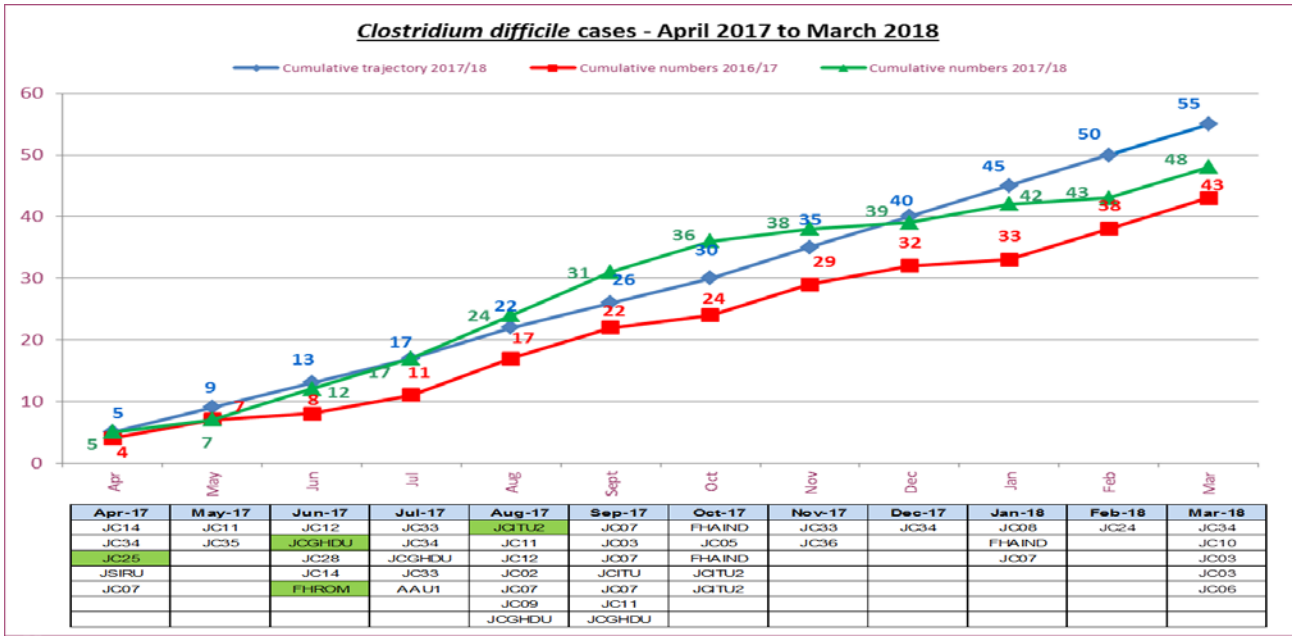
Between April 2017 and March 2018 there were 77 non-Trust-apportioned C. difficile cases compared to 94 the previous year. This is an 18.1% decrease.

C diff	Total 2016/17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total 2017/18 to date	Target for 2016/17
Total cases	137	11	13	16	10	10	18	11	8	4	10	6	8	125	NA
Not trust apportioned	94	6	11	11	5	3	11	6	6	3	7	5	3	77	NA
Trust apportioned	43	5	2	5	5	7	7	5	2	1	3	1	5	48	**55**
- JCUH	36	5	2	5	5	7	7	3	2	1	2	1	5	45	
-FHN	3	0	0	0	0	0	0	2	0	0	1	0	0	3	
-Carters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Redcar	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-East Cl	1	0	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	3	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Friary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Lambert	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

As required by national *C. difficile* guidance, the Trust monitors how many of the patients who develop *C. difficile* who die within the following 30 days, regardless of cause: Since April 2009, 277/1532 (18%) have died during the 30 day follow-up period.

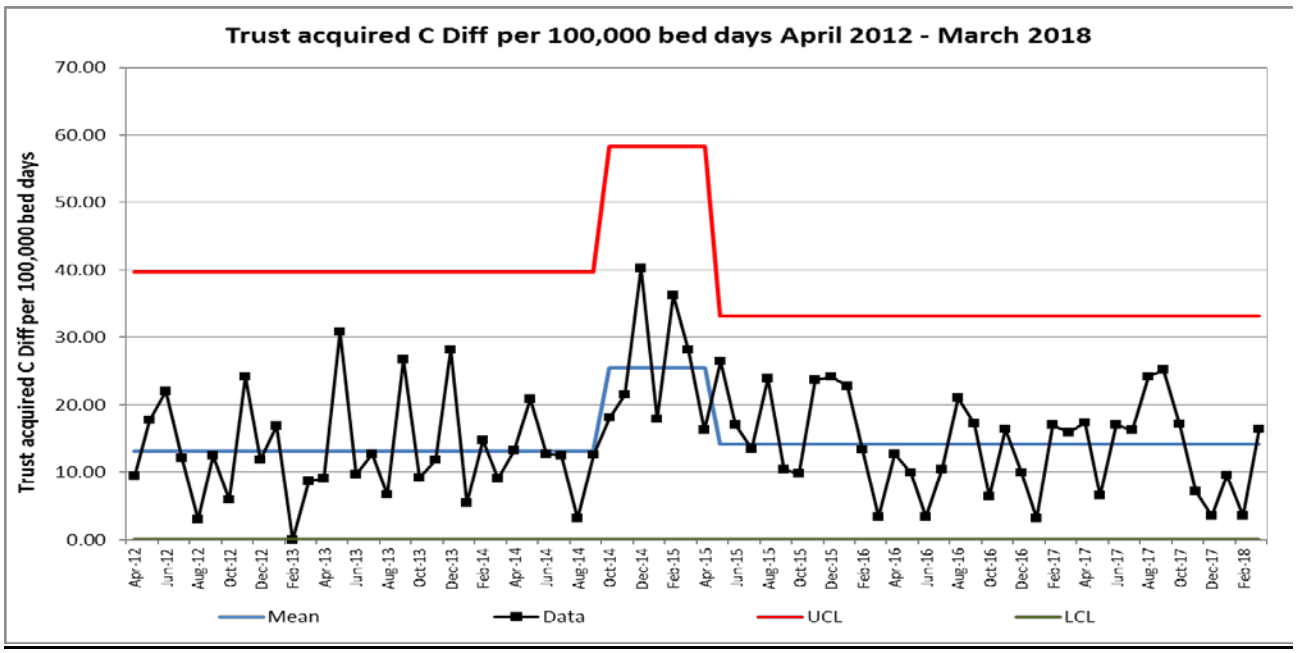
A cluster of C. difficile is described as two or more cases which may be linked. During 2015/2016 the Trust had 7 clusters affecting wards 3, 34, 28, 24 (two clusters), the Lambert Hospital and the Rapid Access Frailty Assessment Unit (RAFU). Linked cases (i.e. the same ribotype) were confirmed on wards 3, 28, RAFU and the Lambert Hospital. There were no linked cases detected between January 2016 and June 2017. However between June 2017 and October 2017 we had 4 potential clusters affecting wards 11, 34, 33 and 7. Linked cases (i.e. the same ribotype) were confirmed on wards 11 and 33. There have been no further episodes of linked cases by ribotype since June / July 2017.

Graph 1: Cumulative Trust-apportioned *C. difficile* cases 2017/18 compared to 2016/17 trajectory



Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
JC14	JC11	JC12	JC33	JCITU2	JC07	FHAIND	JC33	JC34	JC08	JC24	JC34
JC34	JC35	JCGHDU	JC34	JC11	JC03	JC05	JC36		FHAIND		JC10
JC25		JC28	JCGHDU	JC12	JC07	FHAIND			JC07		JC03
JSIRU		JC14	JC33	JC02	JCITU	JCITU2					JC03
JC07		FHROM	AAU1	JC07	JC07	JCITU2					JC06
				JC09	JC11						
				JCGHDU	JCGHDU						

Graph 2: Trust acquired *C. difficile* cases per 100,000 bed days from April 2012 to 31st March 2018



Root Cause Analysis (RCA) and panel reviews are undertaken for all trust-apportioned *C. difficile* cases. If no lapses in care are identified, a referral is made for appeal. Hambleton, Richmondshire and Whitby Clinical Commissioning Group undertake this process on behalf of South Tees Clinical Commissioning Group. The Trust has successfully appealed 4 cases via this process in 2017/18.

The table below shows the trust-apportioned cases from April 2017 to March 2018, identifying where elements of appropriate management have been undertaken or omitted.

	Apr-17					May-17	Jun-17					Jul-17					Aug-17						Sep-17					Oct-17					Nov-17	Dec-17	Jan-18		Feb-18	Mar-18				
Were the following assessment and management elements completed?	Case1	Case2	Case3	Case4	Case5	Case6	Case7	Case8	Case9	Case10	Case11	Case12	Case13	Case14	Case15	Case16	Case17	Case18	Case19	Case20	Case21	Case22	Case23	Case24	Case25	Case26	Case27	Case28	Case29	Case30	Case31	Case32	Case33	Case34	Case35	Case36	Case37	Case38	Case39	Case40	Case41	Case42	Case43	Case44	Case45	Case46	Case47	Case48
The patient has received Antibiotics in previous 12 weeks to this episode of care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	U	✓	✓	✓	✓	✓	✓	✓	X	✓	X	✓	✓	✓	✓	N/A	✓	✓	X	X
Normal Bowel habit assessment on admission	✓	X	✓	X	✓	✓	✓	X	✓	✓	X	✓	X	✓	✓	X	✓	✓	X	X	✓	X	X	X	X	✓	X	✓	X	✓	✓	X	✓	✓	✓	X	✓	X	✓	X	✓	✓	X	X	✓	✓	X	✓
If symptomatic of diarrhoea was the trusts diarrhoea assessment tool completed?	X	✓	✓	X	X	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X	✓	X	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X	✓	X	✓	✓	✓	X	✓
Bristol Stool score recorded	X	✓	✓	X	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
If suspected infectious diarrhoea: was a clinician informed and agreed for sample to be sent for MC&S and Virology?	X	✓	✓	X	X	✓	✓	✓	✓	✓	X	✓	✓	X	✓	✓	U	✓	✓	✓	X	✓	X	✓	X	X	✓	✓	✓	✓	X	✓	✓	✓	✓	N/A	✓	✓	✓	✓	U	✓	✓	✓	✓	✓	✓
Was the patient Isolated within 2 hours of suspicion of infected diarrhoea?	✓	✓	✓	✓	X	✓	✓	X	✓	✓	✓	X	✓	✓	X	✓	X	X	X	✓	X	X	X	✓	X	✓	X	X	✓	✓	X	✓	✓	X	X	X	✓	✓	✓	X	✓	✓	X	✓	X	X	X	X
Did the side room have en-suite facility?	✓	✓	✓	✓	✓	X	✓	X	X	X	✓	✓	✓	✓	X	✓	✓	X	X	X	X	X	X	X	✓	X	N/A	N/A	X	X	X	X	✓	✓	N/A	X	✓	✓	✓	X	X	✓	X	✓	X	X	X	✓
Patient commenced appropriate pathway and bundle for isolation eg PPE (full length fluid repellent gowns), chlorine based products for cleaning, signage, single use equipment etc.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Was the patient given the appropriate information leaflet and given advice about hand hygiene?	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X	✓	✓	✓	✓	X	✓	✓	✓	✓	N/A	✓	✓	✓	✓	✓	✓	N/A	X	X	✓	✓	✓	✓	✓	N/A	X	✓	✓	✓
Reviewed by medic and severity assessment completed within 6 hours?	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	X	✓	✓	X	✓	✓	✓	✓	X	X	✓	✓	X	✓	✓	N/A	✓	✓	X	✓	✓	✓	N/A	✓	✓	X	✓	✓	X	X	X	✓	X	✓	✓	✓
Did the patient have an abdominal x-ray is assessed as moderate or severe based on severity assessment?	X	✓	✓	X	✓	✓	X	X	X	X	✓	N/A	✓	X	✓	✓	U	X	X	X	X	X	✓	X	X	✓	N/A	✓	✓	X	✓	X	✓	X	✓	X	✓	X	✓	X	X	X	X	N/A	X	✓	✓	✓
Appropriate antibiotics based on severity assessment prescribed and administered in line with trust guidelines?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	U	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A	✓	✓	✓	N/A	✓	✓	N/A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maintenance of documentation i.e. stool chart, nutrition/hydration.	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Evidence of MDT review	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	U	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	U	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Apr-17					May-17	Jun-17					Jul-17					Aug-17						Sep-17					Oct-17					Nov-17	Dec-17	Jan-18		Feb-18	Mar-18				
Does the patient have the following risk factors?	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8	Case 9	Case 10	Case 11	Case 12	Case 13	Case 14	Case 15	Case 16	Case 17	Case 18	Case 19	Case 20	Case 21	Case 22	Case 23	Case 24	Case 25	Case 26	Case 27	Case 28	Case 29	Case 30	Case 31	Case 32	Case 33	Case 34	Case 35	Case 36	Case 37	Case 38	Case 39	Case 40	Case 41	Case 42	Case 43	Case 44	Case 45	Case 46	Case 47	Case 48
>65 years old	X	✓	✓	✓	X	✓	✓	✓	X	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X	✓	✓	✓	X	✓	✓	✓	X	✓	✓	✓	✓
Recent Antibiotics	✓	✓	X	X	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	U	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	U	X	X
Taking protein pump inhibitors (PPI)	✓	✓	✓	✓	X	✓	✓	✓	X	✓	X	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	X	X	✓	✓	✓	X	X	✓	X	X	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	X	✓	✓	✓	✓
Known history of *Clostridium Difficile* infection (CDI)	X	X	X	✓	X	X	X	X	X	X	X	X	X	✓	X	✓	X	✓	X	X	X	X	X	X	X	X	X	U	X	X	X	X	X	X	X	X	X	✓	X	X	X	X	X	X	X	X	X	X
Link to CDI case	✓	X	X	N/A	X	X	X	X	X	X	U	X	✓	X	X	U	U	X	X	X	U	X	X	U	X	X	✓	X	✓	✓	U	X	X	X	✓	U	X	X	X	X	X	X	X	X	X	X	X	X
Immune supressed	✓	X	X	X	X	X	X	X	✓	X	✓	✓	✓	X	X	✓	✓	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	U	X	✓	X	X	✓	X	X	X	X	X	X	X	X
Multiple intra hospital transfers	✓	✓	X	✓	X	✓	✓	✓	✓	X	X	X	X	X	✓	X	X	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	X	X	X	✓	X	✓	X	✓	X	X	X	X	✓	✓	✓	✓	X	X	X	X
Underlying oncology	✓	X	X	X	X	X	✓	X	✓	X	✓	X	✓	✓	X	✓	✓	X	X	X	X	X	X	X	X	X	X	X	✓	✓	X	X	X	✓	X	X	✓	X	X	X	X	X	X	X	X	✓	X	X
Care Home resident	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	✓	X	X	X	✓	X	X	X	X	✓	X	X	X	X	X	✓	X	X	X	X	X	X	✓	X	X	X
History of abdominal surgery	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	U	X	X	X	✓	✓	✓	X	✓	X	✓	✓	✓	X	✓	X	X	X	✓	X	X	X	X	X	✓	X	✓	X	X	✓	X	X
Admission to critical care	X	X	X	X	X	X	✓	X	✓	X	X	X	X	X	✓	X	X	✓	✓	X	✓	✓	X	✓	X	✓	X	✓	✓	✓	X	✓	X	X	✓	✓	X	✓	X	X	✓	X	✓	✓	X	X	X	X
PEG tube and feed	✓	X	X	✓	X	X	✓	X	✓	X	X	X	X	X	✓	X	X	✓	✓	X	X	U	X	✓	X	X	X	✓	X	✓	X	✓	X	X	X	✓	✓	X	X	X	✓	X	X	✓	X	X	X	X	X
> 2 admissions to hospital	X	✓	X	X	X	✓	✓	✓	X	X	X	X	X	X	X	X	X	X	X	X	✓	X	✓	X	✓	X	✓	X	X	X	✓	X	X	X	X	X	✓	✓	X	✓	✓	X	X	X	X	X	X	X	U

In summary the main patient risk factors for the 48 cases were:

- 38 of the 48 patients were over the age of 65 years
- 42 of the 48 patients have had antibiotic therapy within 3 months of the current admission
- 35 of the 48 patients have been prescribed a protein pump inhibitor
- 24 of the 48 patients have had multiple intra–hospital transfers
- 12 of the 48 patients had had multiple hospital admissions

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

1. Delays in testing patients with diarrhoea for C *difficile*. Where patients present with symptoms of diarrhoea and are on antibiotics or other medication therapy that may cause diarrhoea there not been timely consideration or documentary evidence of consideration of C *difficile* for this group of patients. This is particularly challenging where patients are on complex therapies.

2. Delays in isolating patients with suspected infectious diarrhoea before the diagnosis of C. *difficile* is made within the 2 hour target as per trust policy. In 16/17 we did not meet this target for 21 patients from the 43 cases identified, in 17/18 we did not meet this target for 24 patients from the 48 cases identifed. However, in all cases appropriate universal IPC precautions were implemented and all patients were accomodated appropriately on a positive stool sample result.

3. Delays in commencing the use of the diarrhoea assessment tool was a particular challenge in 2016/17 this has improved significantly in 2017/18 with the introduction of an IPC Nurse being based with the front of house teams in August 2017. This new model has also had an impact in the early isolation and sampling of patients coming through the acute admission areas however we have not seen this translate to a reduction in the number of patients who have had multiple intra hospital transfers as this increased from 15 in 2016/17 to 24 in 2017/18. It is acknowledged that a number of these transfers would be appropriate e.g critical care to a ward, in 19 of these cases the patient had more than 2 intra-hospital transfers which included ward moves, 4 patients also had inter-hospital transfers which includes community hospitals. Only 5 patients remained on 1 ward throughout their episode of care.

Full details of all actions taken in combating C. difficile are contained within the overall HCAI annual plan and the CDI Action tracker which was initiated in response to an increase in numbers in August 2017.

***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 which were 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 2017/18, there were 2 cases included in the audit of JCUH cases and 3 cases at the FHN that required investigation The death certificate counterfoils indicated that for 1 of these patients *C. difficile* or toxic megacolon was recorded as the primary cause of death (under Ia). For 4 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 5 patients. No deficiencies in care were identified, which may have contributed to the patients' deaths.

Classification of cases where *C. difficile* was entered on the death certificate, 2017-2018

Section of death certificate	Number of death certificates	How this audit would have classified the death certificate
Ia (ie main cause)	**1**	**0**
Ib (predisposing factor)	**0**	**0**
Ic (predisposing factor)	**0**	**0**
II (contributory cause)	**4**	**5**
Was not or would not have been included on death certificate	**0**	**0**
Unable to complete death certificate (i.e. post-mortem was needed but not performed)	**NA**	**0**

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 (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 post-infection 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 2016/17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total 2017/18 to date	Target for 2017/18
Total cases	9	2	0	0	0	0	0	0	0	0	2	0	0	4	NA
Not trust assigned	2	1	0	0	0	0	0	0	0	0	2	0	0	3	NA
Trust assigned	7	1	0	0	0	0	0	0	0	0	0	0	0	1	**NA**

There was no official MRSA bacteraemia target for 2017/18. There were 4 cases of MRSA bacteraemia in 2017/18, 1 of which was classed as trust-assigned. In comparison, there were 9 cases in 2016/2017, 7 of which were 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 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 2017/18, 4 episodes of bacteraemia were investigated. One of these patients died during the current admission. A report has been produced on these MRSA bacteraemias for those who require more detail than is available in the current summary.

An avoidable causal factor, related to our trust, was identified in 1 bacteraemia and this is a considerable decrease compared to 2016/17, where 7 cases had avoidable causal factors. The causes of MRSA bacteraemia are summarised in the table 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**

Catheter-associated urinary tract infection	1(1)	1	0
Community-acquired pneumonia	1(0)	0	0
Infected foot ulcer	1(0)	0	1
Nephrostomy-associated	1(0)	0	0
Total	4(1)	1	1

The key lesson learnt was that a screen for MRSA was omitted.

2.3 MSSA bacteraemia

Between April 2017 and March 2018 there were 130 episodes of MSSA bacteraemia. 34 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). The Trust-apportioned MSSA bacteraemia figure is unchanged compared to 2016/17.

There is no external target for MSSA or MRSA bacteraemia. However, the trust set an internal target for a 15% reduction from the 2016/2017 baseline of 41 trust-assigned MRSA and trust-apportioned MSSA cases combined. This gives an upper threshold of 34.9 for 2017/18. We have had a combined total of 35 trust-apportioned cases in the 12 months of the financial year.

Since February 2008 the medical director and director of nursing have instructed 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 2016/17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total 2017/18 to date	Target for 2017/18
Total cases	138	8	7	12	8	10	5	17	13	10	10	9	21	130	NA
Not trust apportioned	104	6	6	10	6	7	4	11	11	7	5	6	17	96	NA
Trust apportioned	34	2	1	2	2	3	1	6	2	3	5	3	4	34	NA

A thematic analysis of all trust attributed staphlococcus bacteraemia from 1st April 2017 -31st October 2017. This was been conducted by interrogating the DCS system for all cases and reviewing the RCA reports and a review of the patient medical records for cases. In total 38 cases were reviewed.

In summary the analysis revealed:

- The trust was on track to achieve the 15% reduction in staph aureus infections.
- That 50% of patients who develop a staph aureus blood stream infection were over the age of 50.
- All patients who developed a staph aureus infection were admitted as emergency admissions.

- The majority of patients had multiple identified risk factors.
- 6 cases of trust apportioned MSSA blood stream infections had an invasive device identified as the source of the infection and the 1 trust apportioned MRSA blood stream infection identified a urinary catheter as the source.

The following actions were identified:

- The trust will continue with its policy for screening and adhere to the isolation policies for these infections.
- Continue with monthly prevalence data capture to promote ownership within clinical areas.
- Continue with Saving Lives programme.
- Improve analysis of saving Lives data to establish where practice needs to improve and how IPC nurses can support this.
- The Infection Prevention and Control team to continue to support clinical practice in identifying previously positive patients and promote good IPC practice in clinical areas in line with trust /national policy.

2.4 Surveillance for other alert organisms

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction by 2021. Acknowledging that the majority of these infections have a community onset we have contributed to and submitted a health–economy wide action plan in conjunction with our 2 Commissioning groups.

The trust is continuing to actively participate in the newly formed Tees-wide Health and Social Care Infection Prevention and Control Collaborative (TIPCC), having attended 3 meetings to date. The overall purpose of this group is to develop and deliver local strategies to ensure that no person is harmed by a preventable infection. This aim will be enacted through the delivery of the agreed health economy action plan for the reduction of GNBSI in the first instance but also to look for further opportunities to work across the health economy in other aspects of infection prevention in the wider public.

The trust participated in 2 regional workshop facilitated by the Academic Health Science Network and NHS Improvement to advance the current local action plans into a more cohesive plan for the region in terms of commonality where there are opportunities to develop solutions together.

Resource was deployed from the current resource within the IPC team in January 2018 to facilitate a more in-depth analysis of cases which will then inform future practice and policy and drive reductions for these infections. The analysis of the Q4 2017/18 identified that the upper and lower urinary traction infection was the primary source of E coli bacteraemia (64%), for Klebseilla species urinary tract infection (11%) and Hepatobiliary (11%) and for pseudomonas aeruginosa the primary source was identified as lower respiratory tract infection (27%); followed by lower urinary tract infection (18%); intravascular device (18%) and skin and soft tissue (18%). The analysis also showed that the provenance of the patients were admitted from home and not nursing/residential as depicted in the table below.

Organism	Total cases Q4 2017/18	Provenance: Home	Provenance: Nursing / Residential Care	% of Q4 cases
E Coli bacteraemia	116	93	23	80%
Klebsiella species	35	31	3	88.6%
Pseudomonas	11	10	1	91%

aeruginosa				

The IPC team is currently working with the Deputy Director (Clinical Effectiveness) reviewing our E-Coli data alongside the trusts sepsis and mortality data which will inform actions for setting improvement performance indicators.

The trust was successful in bidding against the 'Better Care Fund' a joint fund held by Local Authorities and our commissioning colleagues to host a IPC nurse. This role in 2017/18 primarily focussed on the provision of training, education and environmental advice to with care home providers. The trust has been again successful in gaining further funding to extend this role for 2018/19. Following on from the initial analysis of our data this role will continue to support the care home sector but will also working collaboratively with our partner organisations to develop products that will support the wider public health agenda locally.

ESBL-producing coliforms are highly antibiotic-resistant Gram-negative bacteria. The majority of isolates of these organisms are from urinary tract infections, but they also cause wound infections, biliary tract infections, pneumonia and bacteraemia. The majority of infections are community-acquired. For making comparisons between years the data on bacteraemia is most valid. They are not included in mandatory national surveillance. In 2017/18 there were 25 bacteraemias due to ESBL-producing coliforms, compared to 9 in 2016/17.

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 2017/18 there were 7 bacteraemias caused by glycopeptide-resistant Enterococci, compared to 8 in 2016/17.

Other alert organisms detected in 2017/18 compared to 2016/17

	Total for 16/17	**Total 17/18**
Bacteraemia due to glycopeptide-resistant enterococci	8	7
Bacteraemia due to E. coli	440	500
• Trust-apportioned	91	106
• Not trust-apportioned	349	394
ESBL producing coliform infections	832	798
• sample taken in community	541	490
• sample taken in our trust	291	304
• bacteraemias	13	25
Bacteraemia due to Klebsiella species		131
• Trust-apportioned	N/A	41
• Not trust-apportioned		90
Bacteraemia due to Pseudomonas aeruginosa		41
• Trust-apportioned	N/A	19
• Not trust-apportioned		22
Other alert organisms	0	1
• invasive group A streptococcus		

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 4 years, originally linked to critical care and the renal dialysis unit. In total 21 patients have been affected by the GES carbapenemase-producing strain, 2 of which were

identified during 2017/2018. 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.

North Tees Hospitals Foundation Trust have had a cluster of patients affected by a single strain of oxa-48 carbapenemase-producing Klebsiella pneumoniae. Several patients have been found to be colonised by this organism when they have subsequently been admitted to JCUH. Historically when this has occurred we have screened patients who have had any contact with the index case. Prior to February 2018, no contacts had acquired the oxa-48 carbapenemase-producing Klebsiella pneumoniae strain in our hospital.

In February 2018 we had a patient admitted through the Emergency department, ward 37 and the rapid access frailty assessment unit, who was found to have this organism in a urine sample. The patient had previously been an inpatient in North Tees critical care unit but was not previously known to carry this organism. Around 40-50 patients have been identified who have been in the same bay as this patient who have had to be classed as contacts. We are currently screening all of these patients prior to discharge or on re-admission for patients who have already been discharged. To date one of these contacts has been found to carry the oxa-48 carbapenemase-producing Klebsiella pneumoniae strain. An outbreak meeting was held on 12th March 2018 to consider the actions required.

In March 2018 we had a further patient admitted through ward 33 and the High Dependency Unit (HDU), who was found to have oxa-48 carbapenemase-producing Klebsiella pneumoniae bacteraemia associated with a Hickman line infection. The patient had previously been an inpatient in North Tees critical care unit and ward 38 but was not previously known to carry this organism. One contact of this patient had a positive rectal screen for oxa-48 carbapenemase-producing Klebsiella pneumoniae. This patient moved from HDU to ward 3 before this was known. Around 20 patients have been identified who have been in the same bay as these two patients who have had to be classed as contacts. A follow-up meeting was held on 3rd April 2018 to consider the new cases and review the actions to date.

2.5 Surveillance for other alert conditions

There was a single case of hospital-acquired invasive group a streptococcus infection in 2010/11 and a further case in June 2013. We had a third case of this infection in 2017 in a maternity patient. 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 7 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 division of trauma conduct mandatory orthopaedic surgical site infection surveillance at both the JCUH and FHN sites. This data was presented at IPAG in May 2018.

Other than this surgical site surveillance across the Trust is highly variable. There is a need to improve data to ensure that patients are being protected from harm.

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 seriously affected by Norovirus during the winter of 2006/2007. During the winter of 2010/11 the situation improved dramatically at JCUH, where there were no outbreaks of Norovirus. During the following two

winters in 2011/12 and 2012/13 we were significantly affected by Norovirus outbreaks. This improved greatly over the last 5 years.

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

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
2017/2018	42	15

Comparison of the number of patients and staff affected by winter vomiting disease during outbreaks at South Tees Hospitals throughout 2017/18

Diarrhoea & vomiting outbreaks	Annual total 16/17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total 17/18 to date
Total number	*1*	0	0	0	0	0	0	1	0	0	0	0	2	3
Total number of patients affected	*17*	0	0	0	0	0	0	11	0	0	0	0	31	42
Total number of staff affected	*14*	0	0	0	0	0	0	2	0	0	0	0	13	15

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 2017/18 there was a national CQUIN with respect to antimicrobial stewardship:

- Reduce total antimicrobial use by 1% compared to 2016 calendar year.
- Reduce carbapenem use by 1% compared to 2016.
- Reduce piperacillin/tazobactam use by 1% compared to 2016.
- Ensure at least 90% screening, antibiotic initiation within 1 hour and review of antibiotic prescriptions for those with sepsis up to 72 hours later:

Based on our current antibiotic usage we believe we will have achieved the required reductions for piperacillin / tazobactam and carbapenem use and for screening and antibiotic initiation for sepsis. We are not yet sure if the reduction for total antibiotics prescribed will have been achieved as it partly depends on admission data.

The CQUIN for 2018/2019 will be a 1-2% reduction for total antibiotic use compared to 2017/2018 and a 2-3% reduction for carbapenems. Due to the large reduction in carbapenem use this year, this will be a very challenging target. The piperacillin/tazobactam target will be replaced by a target to replace the proportion of antibiotics used which are classed as “Access” (or narrow spectrum) by the World Health Organisation. This is a complex target which we will be considering in detail as

part of our antibiotic stewardship initiatives for 2018/19. Potentially we may be producing a combined guideline with North Tees Hospitals, though this could create challenges in achieving the carbapenem CQUIN.

The ARK (Antibiotic Review Kit) research project was undertaken during 2017/2018. Nationally we were the second hospital site to introduce ARK. We achieved a very high rate of engagement with the eLearning tool and we saw good use of the tool. We intend to continue the initiative and supporting audits. The Trust's short stay drug chart has been amended to incorporate the ARK decision aid within the antimicrobial boxes and is now in circulation. The project aims to increase the proportion of antibiotics which are stopped at the 48-72 hour review and thus reduce total antibiotic usage.

For 2017/2018 Quality Premiums for CCGs include the need to:

- reduce E coli bacteraemia by 10% and
- reduce the ratio of trimethoprim : nitrofurantoin prescriptions by 10%
- reduce the absolute number of trimethoprim prescriptions for patients aged over 70 years by 10%.

4. DECONTAMINATION

The key issues in relation to decontamination during 2017/18 are:

SSD

Tracking and Traceability: The Endoscopy Decontamination Department are currently introducing a more robust and comprehensive traceability system for flexible endoscopes. This is currently in its trial stages and will be rolled out operationally by the end of April 2018. The system also allows for computerised tracking of local procedures in the clinical areas and facilitates full patient traceability.

Drying cabinets have been installed and commissioned in the Endoscopy unit on the James Cook site and the surgical admissions unit on the Friarage site. This ensures that scopes are stored securely and meet decontamination regulations.

The Trust has recently invested in a new state of the art washer disinfector and low temperature steriliser to start to reprocess all of its robotic instrumentation on the James Cook site which will negate instruments having to be sent off site to be re-processed.

General

A refreshed process for the replacement of pipeline filters was implemented in March 2018

The IPC team continue to work with procurement colleagues to ensure that products are effective and represent value for money. Current reviews include changes to medical device wipes.

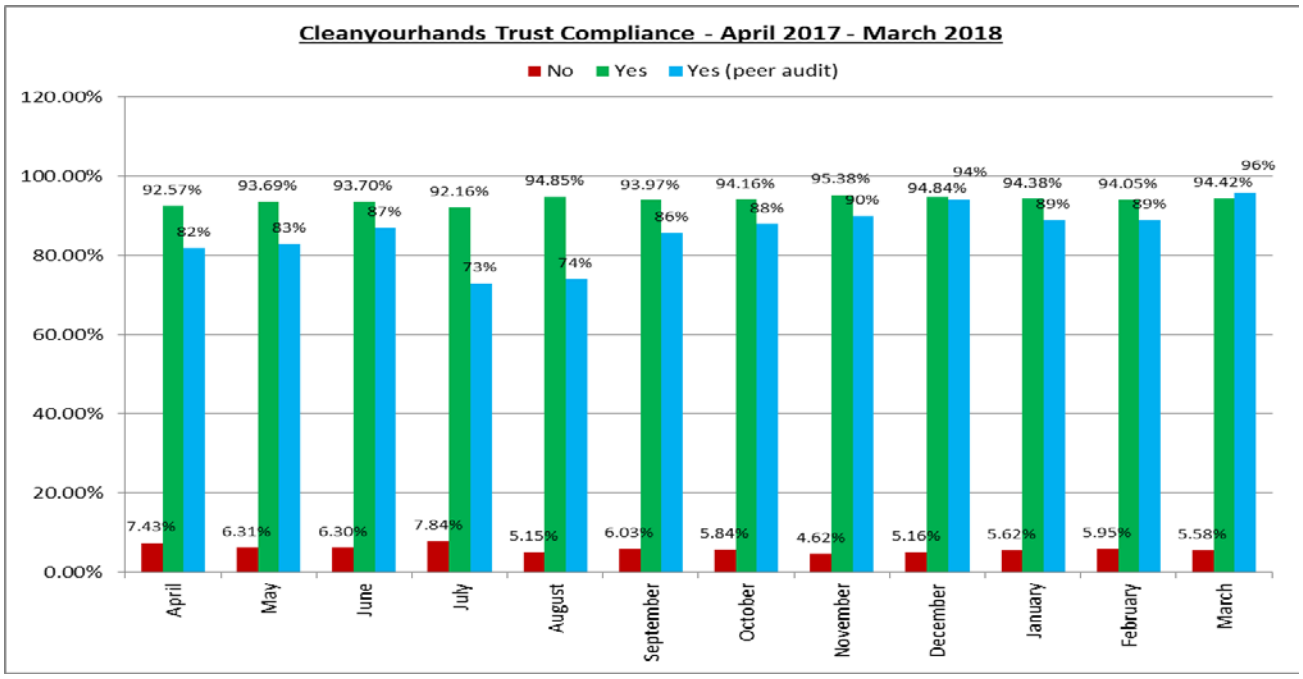
Theatres

Heater cooler and decontamination room water sampling continues within cardiothoracic theatres where we have had sporadic increased bacterial counts. Pipeline and tap disinfections have been carried out throughout the year to mitigate risks. The requirement for a dedicated decontamination area needs to be considered in 18/19 in the context of completing priorities.

5. HAND HYGIENE

The average hand hygiene self-assessment score between April 2017 and March 2018 was 94% and peer review average was 93%. Peer reviews are conducted by IPCNs, Clinical Matrons during monthly Clinical Assurance rounds and independent reviews carried out by our Therapeutic Care Volunteers.

The table below depicts the overall reported compliance scores for both self-assessment and peer audits.



The table below depicts the overall reported centre compliance scores for hand hygiene competency assessments conducted in 2017/18.

Centre	Compliance
Clinical support services	Theatres – 96.12% AHP's - 64.34%
Community Care Centre	85%
Planned Care Centre	92.19%
Specialist Care Centre	80%
Urgent & Emergency Care Centre	91%

6. CLEANING

The trust continues to monitor monthly cleaning scores through the IPAG as well as meeting with the service provider for The James Cook site monthly. This meeting is now replicated at the Friarage Hospital site and is chaired by the Lead Nurse for the Friarage. Cleaning standards have been maintained over 2016/17 using the Credits for Cleaning (C4C) audit tool. Joint monitoring continues with the trusts Environmental Monitoring Team.

	The James Cook University Hospital			The Friarage Hospital			Redcar Primary Care Hospital				East Cleveland Primary Care Hospital			The Friary Primary Care Hospital
Risk Category	High Risk	Significant Risk	Low Risk	Very High risk	Significant risk	Low Risk	Very high risk	High Risk	Significant risk	Low risk	High Risk	Significant risk	Low risk	Very High Risk
NSC Target	95%	85%	75%	98%	85%	75%	98%	95%	85%	75%	95%	85%	75%	98%
Apr-17	98%	97%	97%	98.70%	97.90%	98.95%	99.20%	99.50%	99.10%	95.20%	95%	93%	87%	99.90%
May-17	96%	96%	95%	98.43%	98.53%	97.46%	99.80%	98.90%	97.60%	98.10%	96%	87%		99.80%
Jun-17	97%	95%	92%	97.68%	96.10%		98.10%	98.60%	95.70%	100%	95%	88%	85%	99.90%
Jul-17	98%	96%	93%	98.83%	96.90%	92.93%	99.60%	99.30%	100%	100%	95%	97%	87%	99.90%
Aug-17	98%	97%	93%	97.71%	96.81%		100%	100%	100%	100%	96%	95%	94%	
Sep-17	98%	96%	91%	99.06%	93.10%	55.56%	99.10%	98.30%	99.30%	99.30%				99.80%
Oct-17	98%	98%	95%	98.27%	97.12%	60.95%	99.60%	99.60%	99.70%	100%				99.80%
Nov-17	98%	98%	95%	97.72%	97.32%	64.63%	99.40%	99.30%	99.50%	99.50%	96%	95%	95%	99.80%
Dec-17	98%	97%	95%	95.13%	97.48%	45.45%	99.60%	99.40%	99.80%	99.20%	97%	96%	94%	99.80%
Jan-18	98%	98%	95%	95.34%	88.84%	56.60%	99.40%	99.70%	100%	100%	95%	95%	92%	100%
Feb-18	99%	98%	96%	97.95%	94.95%	100%	99.60%	99.60%	99.60%	100%				99.80%
Mar-18	98%	98%	96%	97.95%	90.63%	98.10%	99.40%	99.40%	99.50%	99.40%	95%	95%	95%	100%

It must be noted that these scores on The James Cook site are an aggregated monthly score as 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. This has resulted in a 43.9% reduction in terminal cleans in February from Octobers baseline. The decision aid which has been developed for the Emergency Department was tested throughout March 2018 and following evaluation will be adapted for all other clinical areas. Early indications suggest this is being utilised well resulting in fewer calls coming through to the IPC team from the Emergency Department.

7. TRAINING AND EDUCATION

A suite of toolbox teaching packages have been developed and delivered over 2017 /18. 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
- CVD/Hickman Line toolbox teaching
- MRSA toolbox teaching
- Multi Drug resistant toolbox teaching
- Peripheral intravenous cannula toolbox teaching
- Urinary Catheter toolbox teaching

In total 2937 members of staff have received training from the IPC team in 2017/18, however, the IPC link nurses and ward managers were trained to deliver the tool box teaching packages for C *difficile* and MRSA for their own staff and recorded at ward level.

57 trust staff have fully completed the in-house IPC course from 125 available places. 14 staff booked on to the course did not attend due to staffing pressures in the clinical areas and 21 staff attended but did not complete the course.

Due to operational pressures and competing priorities only 3 formal clinical audits were carried out over 2017/ 18. However, the trust introduced a revised monthly audit programme for a number of clinical IPC practice, this included monthly data collection for urinary catheters and peripheral venous catheters. A review of audit expectations had been undertaken over 2017/18 which has resulted in the combining of a number of audits leading to 4 audits which will be required to be carried out annually as well as the established monthly Saving Lives programme.

The IP&C annual plan was presented to IPAG in May 2017 for approval. Due to unplanned staff shortages in the IPC team during 17/18 all areas have not had the planned environmental audit. However, this has been mitigated by a number of measures including: monitoring via cleaning standards meetings; weekly patient safety action group and increased IPCN presence in the clinical areas. Wards with a case of CDI or other infection have been prioritised to ensure that this information is collected and available for discussion at the root cause analysis panel.

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.

9. RECOMMENDATIONS

The Board of Directors are asked to note the current position in respect of HCAI and for their support for the actions that have taken place over 2017/18.

SUMMARY REPORT	South Tees Hospitals NHS NHS Foundation Trust
Board of Directors	Date of meeting : 5 June 2018

Subject	Learning From Deaths (Q4 Report)
Prepared by	Jo Raine, Data Analyst Clinical Effectiveness / Mortality Surveillance Coordinator and Tony Roberts, Deputy Director (Clinical Effectiveness)
Approved by	Mr Simon Kendall, Medical Director CDSS
Presented by	Mr Simon Kendall, Medical Director CDSS
Name of meeting considered/approved by	Operational Management Board, Quality Assurance Committee and Mortality Surveillance Group

Purpose: The national *Learning From Deaths* policy requires all Trusts to publish, through public facing Board papers, details of how they learn from deaths in care, as detailed in their trust's *Responding to Deaths* policy (South Tees published on our website in September 2017).		
	Decision	
	Approval	
	Information	●
	Assurance	

Executive Summary

This report updates the format of the existing monthly and quarterly Board reporting of mortality. Data included is: count of deaths over a 10 year period to March 2018; SHMI Oct 2016 to Sep 2017 (107 'as expected'); HSMR Jan to Dec 2017 (112 'higher than expected'); and rates of palliative care and comorbidity coding.

The Learning From Deaths Dashboard includes the number of deaths, the number of deaths reviewed or investigated and the number of those judged to be potentially preventable. Data is provided separately for patients with Learning Disabilities.

Data from the Mortality Surveillance Reviews for Jan to Mar 2018 shows that of the 113 deaths reviewed in the period 93% were judged to have received good care with no preventability. In contrast, 9 cases (8%) showed room for improvement with some evidence of preventability.

Recommendations

The Board of Directors is asked to note that the Learning From Death work will be reported in the annual Quality Account which will be published in June 2018.

Supports Trust Strategy Map in the following areas

quality & patient safety		business sustainability		operational excellence		organisational capability	
deliver integrated care	●	improved cost control		improved patient flow		improved information	●
forefront of clinical innovation		increased productivity		improved innovation processes		continuous service improvement culture	
specialised services development		increased revenue & market share		strong governance & risk management	●	workforce development	
service quality and safety	●	enhanced services				strong partnerships & engagement	

If a key risk(s) has been identified, please describe below

The Trust has 'higher than expected' Hospital Standardised Mortality Ratio for the period Jan-Dec 2017. Quarterly releases of updated 12 month periods will probably continue to show the trust as an outlier for some time, particularly as the winter peak in Jan-Apr 2018 will be included in the next four data releases. The Mortality Surveillance Group will monitor this throughout the year.

The first Quality Account description of the Trust's estimate of the number of deaths judged to be potentially preventable will be published in June 2018.

Learning From Deaths Quarterly Dashboard

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 studies[2].

1.2 The Trust published it's *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 is establishing a Medical Examiner Service which will ensure, when the service is fully established, that all deaths receive scrutiny, including a 'stage one' case record review, discussion with the attending team and crucially 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 follows the national suggested format and reports the number of deaths, the number of deaths reviewed or investigated and the number of those deaths judged to show evidence of preventability. Numbers are reported separately for patients with learning disabilities. For the year to end of December 2017, there were 2,102 deaths, of which 508 received a review or investigation and 2 deaths were considered to be potentially avoidable. In the same period there were 19 deaths in patients with learning disabilities, of which 10 received a review or investigation and 0 deaths were considered to be 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.

2 Mortality indicators

2.1 The dashboard includes the number deaths from April 2008 to March 2018. Winter months (December, January and February) are shown in orange so that the pattern for winter peaks is clear. The winter of 2017-18 includes the third highest peak in the last ten years. This gives the trust some

[1] https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
[2] https://improvement.nhs.uk/uploads/documents/Learning_from_deaths_case_studies_Web_version.pdf

advanced notice of the likely impact on risk adjusted indicators that take some time to report. A briefing has been made available to all staff ni the Trust[3].

2.2 Two risk-adjusted mortality indicators are included in the dashboard. 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 October 2016 to September 2017. 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). The Hospital Standardised Mortality Ratio (HSMR) includes approximately 80% of in-hospital deaths and uses different risk adjustment methods. Current reporting is January to December 2017. The HSMR is 112 and is 'higher than expected'.

2.3 SHMI and HSMR risk-adjust deaths in diagnostic groups based on the primary diagnosis coded in the first Finished Consultant Episode (FCE), risk-adjusted for age, sex, method of admission and comorbidities (ie other clinical conditions coded in secondary positions). The Comorbidity score per FCE for South Tees and England is shown in quarters from October 2014 to December 2017. This shows the broadly static coding level for South Tees and the higher and rising rate for England. The relative difference is adversely affecting the HSMR and accounts for part of the difference in value between the SHMI and HSMR (as HSMR is more sensitive to this issue than SHMI). HSMR (but not SHMI) also adjusts for specialist palliative care coding and the chart for Palliative Care Coding for January 2016 to March 2018 shows that the number of cases with the relevant codes is static or falling slightly. This is adversely affecting the HSMR by about 3 points.

3 Recommendations

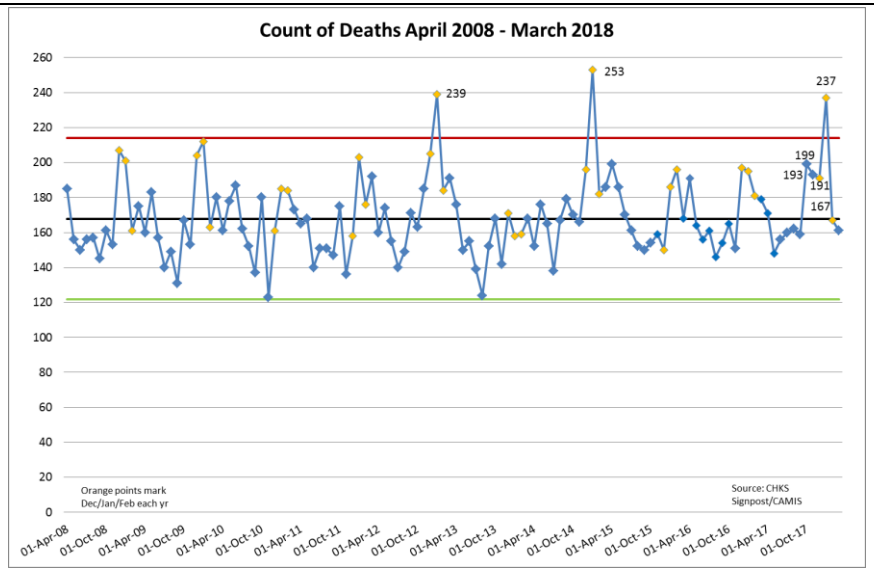
3.1 The Learning From Death work will be reported in the annual Quality Account which will be published in June 2018.

3.2 The Medical Examiner Service is being established and when fully operational will allow all deaths to receive stage one review. The new service will also impact on the number 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 Mortality Surveillance Group (MSGG) who report to the Quality Assurance Committee (QAC) who report to the Board of Directors.

[3] http://information/cbis/documents/news/BIU%20Mortality%20Briefing%2014-2-18.pdf


Count of Deaths April 2008 - March 2018
260
240
220
200
180
160
140
120
100
80
60
40
20
0
253
239
237
199
193
191
167
Orange points mark
Dec/Jan/Feb each yr
Source: CHKS
Signpost/CAMIS
01-Apr-08
01-Oct-08
01-Apr-09
01-Oct-09
01-Apr-10
01-Oct-10
01-Apr-11
01-Oct-11
01-Apr-12
01-Oct-12
01-Apr-13
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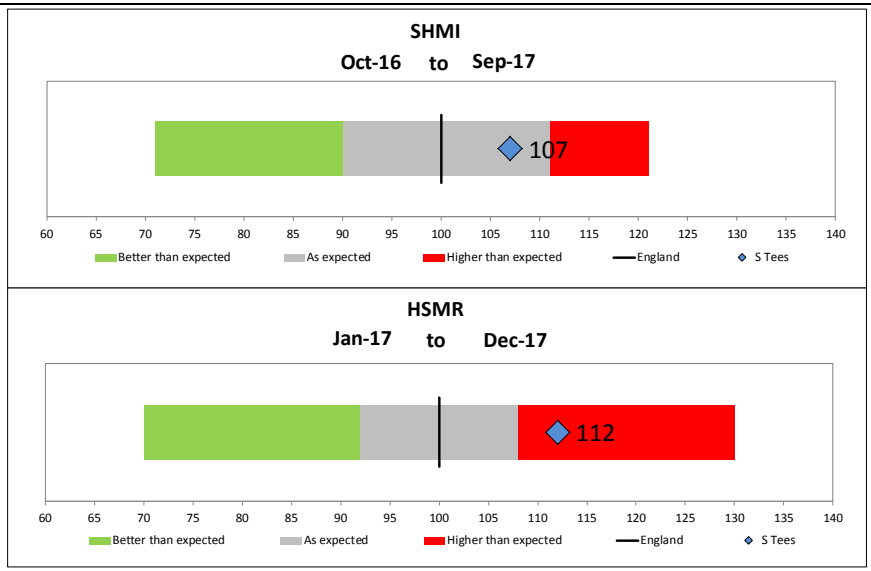
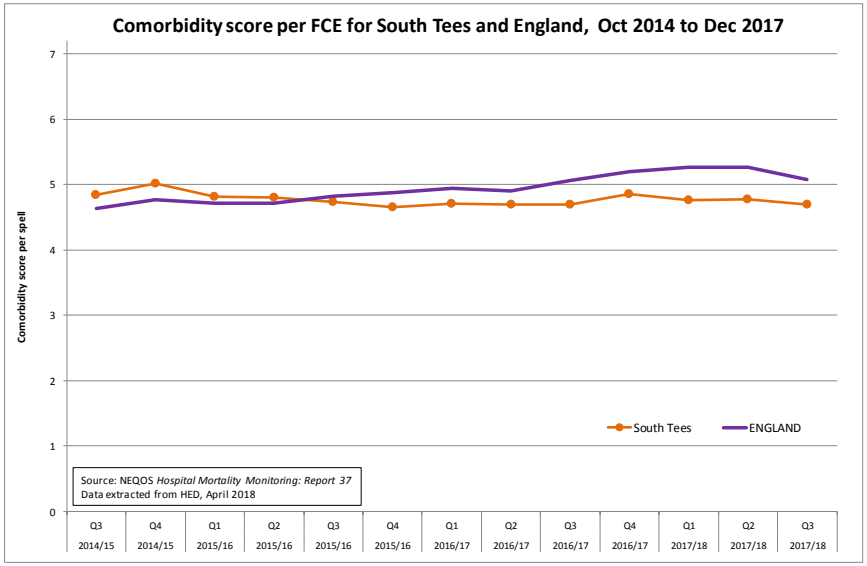
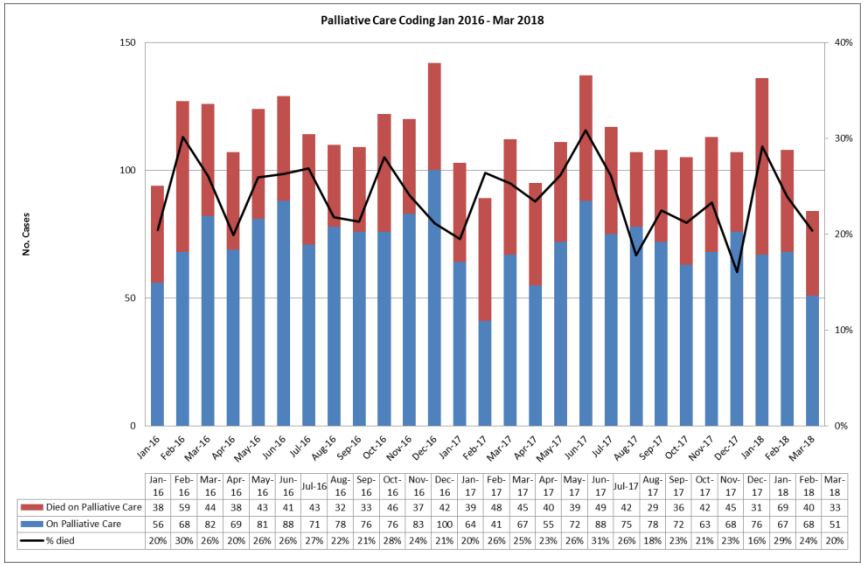
01-Oct-16
01-Apr-17
01-Oct-17


SHMI
Oct-16 to Sep-17
107
60 65 70 75 80 85 90 95 100 105 110 115 120 125 130 135 140
Better than expected
As expected
Higher than expected
England
S Tees
HSMR
Jan-17 to Dec-17
112
60 65 70 75 80 85 90 95 100 105 110 115 120 125 130 135 140
Better than expected
As expected
Higher than expected
England
S Tees


Comorbidity score per FCE for South Tees and England, Oct 2014 to Dec 2017
Comorbidity score per spell
7
6
5
4
3
2
1
0
South Tees
ENGLAND
Source: NEQOS Hospital Mortality Monitoring: Report 37
Data extracted from HED, April 2018
Q3 2014/15
Q4 2014/15
Q1 2015/16
Q2 2015/16
Q3 2015/16
Q4 2015/16
Q1 2016/17
Q2 2016/17
Q3 2016/17
Q4 2016/17
Q1 2017/18
Q2 2017/18
Q3 2017/18


Palliative Care Coding Jan 2016 - Mar 2018
No. Cases
150
100
50
0
40%
30%
20%
10%
0%
Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18
Died on Palliative Care 38 59 44 38 43 41 43 32 33 46 37 42 39 48 45 40 39 49 42 29 36 42 45 31 69 40 33
On Palliative Care 56 68 82 69 81 88 71 78 76 76 83 100 64 41 67 55 72 88 75 78 72 63 68 76 67 68 51
% died 20% 30% 26% 20% 26% 26% 27% 22% 21% 28% 24% 21% 20% 26% 25% 23% 26% 31% 26% 18% 23% 21% 23% 16% 29% 24% 20%

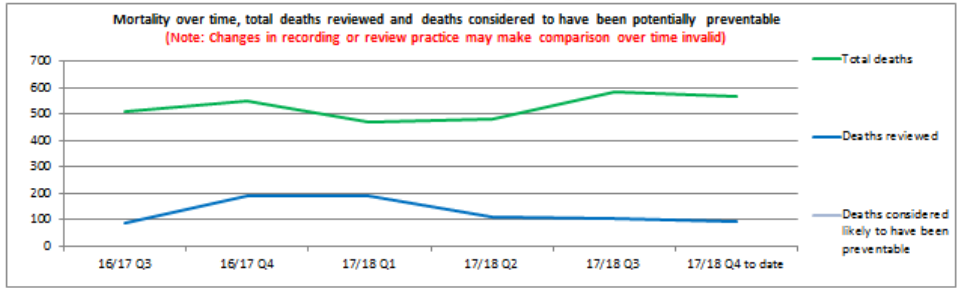
South Tees Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - March 2018

Summary of total number of deaths and total number of cases reviewed (by month of death)

Total number of deaths, deaths reviewed and deaths deemed preventable (includes patients with identified learning disabilities)

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (preventability score of 4+)	
This month	Last month	This month	Last month	This month	Last month
161	167	2	32	0	0
This quarter (QTD	Last quarter	This quarter (QTD	Last quarter	This quarter (QTD)	Last quarter
565	583	95	106	0	0
This year (YTD)	Last year	This year (YTD)	Last year	This year (YTD)	Last year
2102	2034	508	578	2	3

Time Series: Start date 16/17 Q3 End date 17/18 Q4



Total deaths reviewed by preventability score

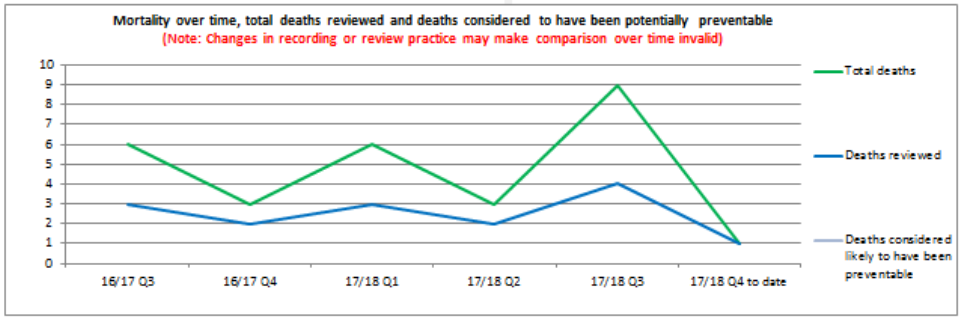
Score 1 Definitely not preventable			Score 2 Slight evidence for preventability			Score 3 Possibly preventable (less than 50:50 but close call)			Score 4 Probably preventable (more than 50:50 but close call)			Score 5 Strong evidence for preventability			Score 6 Definitely preventable		
This Month	2	100.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%
This Quarter (QT	61	93.8%	This Quarter (QT	3	4.6%	This Quarter (QTI	1	1.5%	This Quarter (QTD)	0	0.0%	This Quarter (QTD	0	0.0%	This Quarter (	0	0.0%
This Year (YTD)	407	93.6%	This Year (YTD)	19	4.4%	This Year (YTD)	7	1.6%	This Year (YTD)	2	0.5%	This Year (YTD)	0	0.0%	This Year (YT	0	0.0%

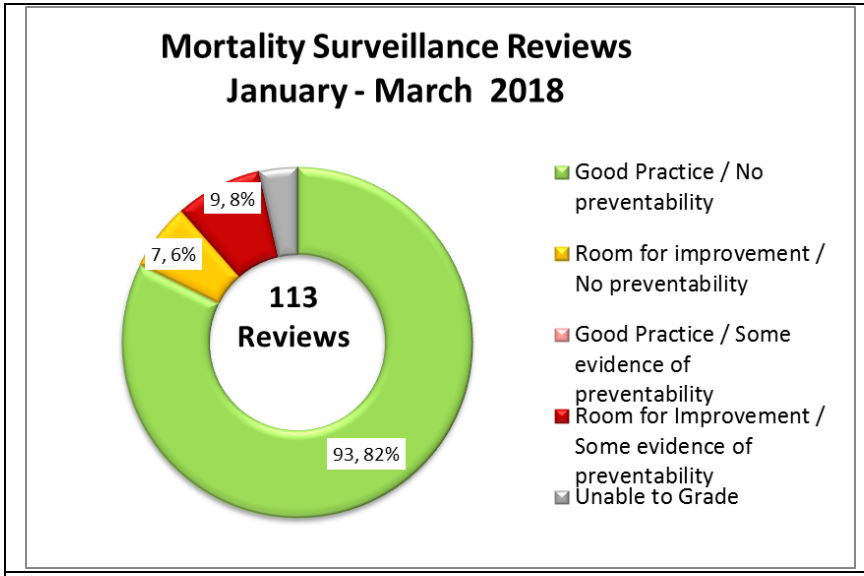
Summary of total number of learning disability deaths and total number reviewed (by month of death)

Total number of deaths, deaths reviewed and deaths deemed preventable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed		Total number of deaths considered to have been potentially avoidable (preventability score of 4+)	
This month	Last month	This month	Last month	This month	Last month
0	1	0	1	0	0
This quarter (QTD	Last quarter	This quarter (QTD	Last quarter	This quarter (QTD)	Last quarter
1	9	1	4	0	0
This year (YTD)	Last year	This year (YTD)	Last year	This year (YTD)	Last year
19	23	10	13	0	0

Time Series: Start date 16/17 Q3 End date 17/18 Q4





Of the 113 deaths reviewed between Jan and Mar 2018 93% of patients were judged to have received good care with no preventability. 7 cases (6%) were judged to have had care which showed room for improvement without evidence of preventability and 9 cases (8%) showed room for improvement with some evidence of preventability.

30 cases were highlighted as identifying learning from good care (cases can appear in more than one category) and 24 cases were highlighted as identifying learning from problems in care.

There are important issues in both, relating to coordination of care (including in cases of deterioration or problems in escalation), workflow and documentation.

The Trust is enhancing its electronic records and this will help with these issues.

In four cases availability of (non-ICU) beds was identified as a problem.

REVIEWS IDENTIFYING LEARNING FROM GOOD CARE	30
Good coordination of clinical care / senior input / advanced decision making	16
Good communication with family	15
Good documentation	8
Patient's stated wishes were followed	5
Palliative care instituted appropriately	3

REVIEWS IDENTIFYING LEARNING FROM PROBLEMS IN CARE	24
Poor coordination of clinical care / lack of senior input / advanced decision making	10
Incomplete physiological observations / deterioration not escalated	8
Availability of appropriate bed (nonICU) compromising care	4
Medication Error	4
Patient fall not escalated properly	4
Poor quality of documentation	4
Delay in test results / tests being undertaken	3
Delay in treatment/surgery due to staff shortages/equipment failure	3
Inappropriately aggressive treatment	3
Poor communication with family	3

SUMMARY REPORT	South Tees Hospitals NHS NHS Foundation Trust
Board of Directors	Date of meeting: 5 June 2018

Subject	Amendments to the Trust's Constitution
Prepared by	Lynn Hughes, Company Secretary
Presented by	Alan Downey, Chairman
Name of meeting considered/approved by	Council of Governors meeting (8 May 2018)

Purpose: To update the Trust's Constitution to meet legal and regulatory requirements.		
	Decision	
	Approval	●
	Information	
	Assurance	●

Executive Summary

The Constitution forms part of the terms of a Foundation Trust's provider licence as granted by the Independent Regulator of Foundation Trusts. Monitor's responsibilities (*who now operates with the National Health Service Development Authority as NHS Improvement*) under the previous legislation for approving and keeping a watch over Foundation Trust Constitutions have passed to the Board of Directors, Council of Governors and the Foundation Trust members.

On behalf of the members, Governors are expected to ensure that the Constitution complies with the law, is appropriately drafted for their Foundation Trust, and up to date. The Council of Governors, in consultation with the Board of Directors, can change the Constitution. However, the Trust is required to present any changes to its membership at its next Annual Members Meeting.

A Council of Governor Working Group was formed to review the Trust's Constitution. Changes were presented to and approved by the Council of Governors at its 8 May 2018 Meeting.

Recommendation

The Board is asked to:

1. Endorse the decision to approve the changes to the Trust's Constitution made by the Council of Governors at its 8 May 2018 meeting to ensure that the Trust's Constitution meets the requirements of the NHS Health and Social Care Act 2012; and
2. Make the necessary arrangements to present the summary of changes to the Trust's next Annual Members Meeting in September 2018.

Supports Trust Strategy Map in the following areas

quality & patient safety		business sustainability		operational excellence		organisational capability	
deliver integrated care		improved cost control		improved patient flow		improved information	●
forefront of clinical innovation		increased productivity		improved innovation processes		continuous service improvement culture	
specialised services development		increased revenue & market share		strong governance & risk management	●	workforce development	
service quality and safety		enhanced services				strong partnerships & engagement	●

If a key risk(s) has been identified, please describe below

-

Board of Directors

5 June 2018

Amendments to the Trust's Constitution

1.0 Background

1.1 Every NHS Foundation Trust is required to have a Constitution drafted in accordance with the legislation that creates NHS Foundation Trusts as Public Benefit Corporations.

1.2 The Constitution forms part of the terms of a Foundation Trust's provider licence as granted by the Independent Regulator of Foundation Trusts. Monitor's responsibilities (*who now operates with the National Health Service Development Authority as NHS Improvement*) under the previous legislation for approving and keeping a watch over Foundation Trust Constitutions have passed to the Board of Directors, Council of Governors and the Foundation Trust members.

1.3 On behalf of the members, Governors are expected to ensure that the Constitution complies with the law, is appropriately drafted for their Foundation Trust, and up to date. The Council of Governors, in consultation with the Board of Directors, can change the Constitution, however, in compliance with the Health and Social Care Act 2012 the Trust is required to present any changes to its membership at its next Annual Members Meeting.

1.4 A Council of Governor Working Group was formed to review the Constitution and recommend changes to ensure it is legally and regulatory compliant. Changes were presented to and approved by the Council of Governors at its 8 May 2018 Meeting (*a summary of the changes can be found at Appendix A together with the Governor Constitution Working Group Membership*).

2.0 Next Steps

2.1 The Board is now being asked to endorse the Council of Governor decision to approve changes to the Trust's Constitution.

2.3 Subject to the updated Constitution being approved arrangements will be made to present the changes to the Trust's membership at its next Annual Members Meeting to give members an opportunity to vote.

2.4 As a result of the large amount of changes made to the Constitution a marked up version is available to review at the Board meeting or by contacting the Company Secretary.

3.0 Recommendation

The Board is asked to:

1. Endorse the decision to approve the changes to the Trust's Constitution made by the Council of Governors at its 8 May 2018 meeting to ensure that the Trust's Constitution meets the requirements of the NHS Health and Social Care Act 2012; and
2. Make the necessary arrangements to present the summary of changes to the Trust's next Annual Members Meeting in September 2018.

Appendix A

Governor Constitution Working Group

The Governor Constitution Working Group included the following Governors:

- Angela Seward, Lead Governor (Elected Public Governor, Rest of England and Wales)
- Rebecca Hodgeson (Elected Public Governor, Middlesbrough)
- Plym Auty (Elected Public Governor, Hambleton and Richmondshire)

The Group met with the Company Secretary in April and May 2018 to review the Constitution. The agreed recommended changes to meet the requirements of the Health and Social Care Act 2012 would be put to the Council of Governors for approval.

Summary of Constitution Changes

The Constitution changes were presented to and approved by the Council of Governors at its 8 May 2018 meeting.

A summary of the changes are listed below:

- *Quoracy arrangements*
- *Board of Directors Agenda and Minutes* (Governors to be provided with the Agenda prior to Board meetings and copies of Board minutes)
- *Mergers and Significant Transactions* (Governors responsibilities in such circumstances if and when the Trust was considering any merger/significant transaction(s))
- *Declaration of Interest updated requirements*
- *Senior Independent Director role description and responsibilities*
- *Annual Members Meeting requirements*
- *Process to amend the Trust's Constitution*
  (changed from the previous requirement of gaining Monitor (Trust's Independent Regulator) approval to the Council of Governors/Board of Directors granting approval whilst giving members the opportunity to vote on any changes at the Annual Members Meeting

Finance & Investment Committee
Chair's Log

Meeting: Finance & Investment Committee	**Date of Meeting**: 22 March 2018
Connecting to: Board meeting	**Date of Meeting**: 3 April 2018
Key topics discussed in the meeting	
• Month 11 and YTD financial performance • 2017/18 end-of-year forecast • 2018/19 budget update	
Actions agreed in the meeting	Responsibility / timescale
• We must continue to keep a tight grip on finances. Adverse variance of £2.5m v forecast in February implies a risk to hit year-end forecast of £17.5m deficit (excluding STF). • Revised terms of reference for FIC were discussed and agreed, subject to amendments which will be incorporated. • The Committee noted the requirement for the Board to submit a self-certification report on compliance with the conditions of the NHS provider licence.	• DoF and whole Executive team – ongoing • FIC Chair – 27 March 2018
Issues for Board escalation/action	Responsibility / timescale
• DoF to report to Board on 2017-18 year-end position and 2018-19 budget. • Board to note the risk to achieving year-end forecast (£17.5m deficit, excluding STF)	• DoF – 3 April 2018

Finance & Investment Committee
Chair's Log

Meeting: Finance & Investment Committee	**Date of Meeting**: 19 April 2018
Connecting to: Board of Directors meeting	**Date of Meeting**: 2 May 2018
Key topics discussed in the meeting	
• Month 12 and YTD financial performance • 2017/18 end-of-year forecast outturn • 2018/19 budget proposal	
Actions agreed in the meeting	Responsibility / timescale
• outturn performance noted improvement against the revised forecast with a predicted outturn of an over spend of £16.9 million compared to the original £17.5 million. • annual accounts due to be completed by 24 April 2018 with the external auditors due on site by 26 April 2018. Any issues to be discussed with Mr Carter-Ferris, Chair of Audit Committee. • 2018/19 Budget - key change agreed was an increase in the control total which now permitted the Trust to overspend by £10.1 million. Revised budget to be reported to the Board.	• DoF and whole Executive team – ongoing • DoF – 2 May 2018 • DoF – 2 May 2018
Issues for Board escalation/action	Responsibility / timescale
• DoF to report to Board on 2017-18 year-end position and 2018-19 budget submission to NHS Improvement.	• DoF – 2 May 2018

Finance & Investment Committee
Chair's Log

Meeting: Finance & Investment Committee	**Date of Meeting**: 24 May 2018
Connecting to: Board meeting	**Date of Meeting**: 5 June 2018
Key topics discussed in the meeting	
• Month 1 financial position • Progress on proposals to reduce costs and generate income	
Actions agreed in the meeting	Responsibility / timescale
• The Finance Director was asked to reconsider the decision to report income one month in arrears. The committee's preference is to see the best estimate of prior month income rather than the budgeted figure. • Future reports on capital expenditure should include a graph showing the planned timing of capex across the year. • In future the table headed "Productivity and Efficiency Plans" should indicate when savings have been signed off by EDs.	Director of Finance
Issues for Board escalation/action	Responsibility / timescale
• Board to note the scale of the accrual for lifecycle maintenance under the PFI contract. • Board to note: while applauding the ongoing efforts to identify and deliver productivity and efficiency savings, the committee is not yet sufficiently assured that the plan is likely to deliver in full. Further measures may be needed, including additional programme management resource and identification of additional savings.	For discussion at the Board meeting on 5 June 2018

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 20 March 2018
Connecting to: Board of Directors	**Date of Meeting**: 03 April 2018

Key topics discussed in the meeting	

• Review of ToR & Workplan - Approved
• IG toolkit proposed annual submission
• Maternity Services Analysis
  - Safer Maternity Care
  - National Maternity and Neonatal Health & Safety Collaborative
  - National Maternity Survey
• CQC Action Plan / Compliance update
• Proposed Quality Priorities
• Monthly SI Report
• Monthly Quality Report
• BAF – Review of Quality Risks
• Five years of Cerebral Palsy Claims- A thematic review of NHS resolution data (2017)
• Each baby counts – full report 2015 (2017)	

Actions agreed in the meeting	**Responsibility / timescale**
• Clinical Assurance Task & Finish group to be set up to collate and look at CQC evidence – to report to QAC on a quarterly basis	• Gill Hunt / Emma Carter / Quarterly
• Timeline & Action Plan for CNST self-assessment in maternity services to be an agenda item in April and May 18. –	• Gill Hunt / Emma Carter / April 2018
• IPAG escalation regarding single use screws and plates being resterilised if not used – Kim Clements and Craig White to write a risk report to go to Clinical Standards Sub group for discussion	• Sath Nag to feedback to QAC in April 2018
• Cerebral Palsy data to be brought back to the April meeting for further review	• Fran Toller / Yvonne Regan / Lynne Young / April agenda
Escalation of issues for action by connecting group	**Responsibility / timescale**
• IG toolkit – Mandatory training aspect - Daily update and comms to be sent out from Deputy CEO • Board Champion for Maternity identified as Dr Sath Nag	• Gill Hunt to arrange with Adrian Clements
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
None	

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 24 April 2017
Connecting to: Board of Directors	**Date of Meeting**: 1 May 2018

Key topics discussed in the meeting	
• Safer Maternity Timeline and Action Plan • Five years Cerebral Palsy Claims - Gap Analysis • Draft Quality Account and annual quality priorities • Q4 learning from Deaths report • Medication error update • Monthly SI report • Monthly Quality report • BAF – Quality risks • Life cycle planning • Chairs logs from reporting sub groups	
Actions agreed in the meeting	**Responsibility / timescale**
• Further examination of coding and the impact upon Mortality data	• Tony Roberts / May QAC agenda
• Palliative care coding/activity – understand if there has been a change of practice	• Fran Toller
• Implement strategies to increase incident reporting	• Judith Connor to feedback progress in June 2018
• Ongoing monitoring of medication practice on ward 29	• Sath Nag to liaise with the CD and Matron for Cardiology
Escalation of issues for action by connecting group	**Responsibility / timescale**
• Devices (inc Cameras) to be audited	• Kevin Oxley to bring back in June 2018
• Continued focus on falls prevention strategies	• Gill Hunt - ongoing
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Life cycle works access to Theatres	• Kevin Oxley – Bring plan to May 2018 QAC

Workforce Committee
Chair's Log

Connecting to: Board	**Date of Meeting**: 15 March 2018

Key topics discussed in the meeting

Formal Noting

- RCF confirmed that Chair of Workforce Committee would revert back to AH from April 2018
- RCF would remain on the committee and DH would stand down from the committee

Absence Management Strategy & Deep Dive

- Comprehensive review of sickness position over the past three months and deep dive presented by HR
- The HR team presented their refined measurement and support processes for absence management across the trust going forward
- Currently the Trust measures long and short term absence. HR proposes to also report individuals that have hit a trigger, where in the absence process staff are who have hit triggers, and the time taken to progress through the stages of the absence procedure
- This performance data will be reported at Trust / Centre / Line Management level with all line management held accountable for managing these cases with the support of HR

Operating Model & Resource Planning

Nursing Workforce

- Recruitment and Retention of RN's (B5 current position) - 41 unfilled posts / 24 nurses in pre-employment checks / Vacancy rate 4.3% / Average annual parenting leave amongst RN's 5.5% / RN turnover (leaving the Trust) 9.37%
- Job plan review underway for 250 Specialist Nurses. BIU have built a productivity tool which will be used to optimise the workforce
- ACTION – review and recommendations to be implemented by DoNs and ADNs

AHP Workforce

- A review of this workforce group is underway using the following method:

  1. Create Target operating models for services across CDSS
  2. Use capacity and demand to help model workforce plans
  3. Standardise job planning across AHP's
  4. Identify apprentership needs and training support required to deliver a 5 year plan

- ACTION - Service Managers and CDs to take ownership of the review, development of workforce plans and implementation activities

Medical Workforce

- The Medical Workforce Bill for the Trust is currently under review to:-

  1. Reduce discretionary spend

  2. Reverse the trend of a decline in productivity i.e income versus spend on pay

  3. Drive productivity smoothing across the year

- ACTION - MDs and CDs to take ownership of this review and implementation activity

Admin & Clerical Workforce

- Patient Connect - Centralise patient appointment booking and management processes, and patient letter production into a shared services model

- Agreed there should be an internal and external communications strategy for Patient Connect

- ACTION – Briefing for Governors to be delivered on Patient Connect

Information for Formal Noting

Guardian of Safe Working Report

- Report for period December 2017 to February 2018 shows 60% of training grade doctors are now on the new contract

- Exception reports remain at lower levels than are being reported by other Trusts, however, the numbers have increased over this period - the majority of exception reports relate to additional hours of work

- Vacancies are being actively recruited to plus ongoing discussions in relation to increased use of Advanced Nurse Practitioners on rotas

- Internal locum fill rates are around 95%

- Tier 2 visa rejections by Home Office. Contingency plans in place and information has been provided to Department of Health and local MPs to inform discussion with parliament

Policies Approved at OMB

- Capacity Policy, Relocation Policy and Maternity Policy

Policies Pending Approval at OMB

- Working Time Policy and Correction and Recovery of Payments Guidance

Travel & Expenses

- The case for change proposed changes to Travel & Expenses

Actions agreed in the meeting	Responsibility / timescale
Further AHP update at next committee meeting	Karl Hubbert – 14 Jun 18
Future operating model updates to include challenges and actions to address this	All – 18/19 plans
Presentation on Patient Connect for Governors	Andrea Brown
Internal and external communication strategy for Patient Connect	Communications Lead – TBC once appointed
Escalation of issues for action by connecting group	**Responsibility / timescale**
IT Strategy e.g. WIFI availability is concerning medical and education collegues	RCF to escalate
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
None	

Audit Committee
Chair's Log to Extraordinary Board

Meeting: Audit Committee	**Date of Meetings**: 21st May 2018
Highlights for: Board Meeting	**Date of Meeting**: 24th May 2018

Overview of key areas of work

- Reports received from :

1. **Audit One (Counter Fraud)** – annual update given. Overall a better understanding of the Fraud landscape which has also identified some opportunities for improved processes. The 18/19 work plan was presented with areas such as Purchase Card usage, Lease Car processes and Supplier Fraud identified as opportunities for review. Overall we are in a better place than previous years but there are always opportunities to mitigate fraud happening.

2. **PWC (Internal Audit)** - delivered the Internal Audit report for the year. Management guided PWC to review high risk areas so we would improve our overall control environment. These reviews have identified high risk findings that lead PWC to rate the internal control framework as "containing significant weaknesses and non-compliance in the framework of governance, risk management and control". PWC will review areas for improvement with DoF and ensure mitigating controls are implemented.

3. **KPMG (External Audit)** delivered their External Audit report covering the following areas:
    - Financial Statements – unqualified opinion
    - Quality Accounts content – unqualified opinion
    - Quality Report – indicators- qualification query
    - Value For Money – Qualified (as we are in enforcement)
    - KPMG will issue an unqualified Group Audit assurance certificate to the NAO
    - The main issue identified by KPMG is in relation to income recognition (disputes between STNHS and CCGs).
    - KPMG confirmed their agreement with the trust's view that the accounts should be prepared on a going concern basis

Financial Statements, Quality report and governance statements

- Committee reviewed the above documents along with auditors and agreed that subject to areas below being satisfactorily completed the documents were ready to be put to the board for approval.

- One major issue was identified at the meeting which was discussed with KPMG relating to pension benefits in remuneration report. Having checked, the Trust had been informed by NHS Pensions that the current calculations for two voting Board members was incorrect but they were unable to provide the correct figures in time to be included within the Remuneration Table. As a result of that the Trust has asked for all calculations to be checked. Management believe that the numbers provided by NHS Pensions are erroneous and have discussed with KPMG the best approach. The action is for Finance (DoF and B Simpson) to work with KPMG and NHS Pensions to review and if necessary update numbers included in report.

- KMPG highlighted that they audit several trusts and the process at STNHS this year end was again ahead of other Trusts and the standards and controls were very good.

Actions to be taken	Responsibility / timescale
• Vote of thanks to all teams involved in year end in light of KPMGs comments	Done at AC but please re-iterate and minute at Board
Board action	**Responsibility / timescale**