South Tees Hospitals
NHS Foundation Trust

Quality Account 2020-2021

20 July 2021

PART ONE - Statement on Quality from the Chief Executive

I am delighted to introduce the 2020/21 Quality Report as Chief Executive of South Tees Hospitals NHS Foundation Trust.

Receiving good NHS services is the most important thing to more than 1.5 million patients, carers and families in the Tees Valley, North Yorkshire and beyond who depend and rely on them. It is the most important thing to everyone who works at South Tees NHS Hospitals Foundation Trust too.

Since the autumn of 2019, we have been empowering our clinicians to take decisions about how we manage our resources and deliver care across our hospitals and services – supported by our amazing scientific teams, administrative, support staff and volunteers.

We have done this through our Clinical Policy Group (CPG) which draws its membership from our clinical directors, nursing and allied health professional leaders, chief medical officer, chief nurse, executive team, operational managers, chairs of staff-side, our senior medical staff forum, and our BMA representative.

The CPG has created ten clinically-led improvement collaboratives (service groups) - natural care communities of surgeons, physicians, nurses, midwives, scientists, allied health professionals and administrative and support colleagues, which have come together to make their services even better for our patients. At the heart of our clinical collaboratives is our Leadership and Safety Academy which encompasses our patient safety faculty and provides a range of support, including leadership and management training, quality improvement skills, team and service support, coaching and human factors training.

A clinical led service is absolutely vital – not just for our local communities in Teesside and North Yorkshire, but for patients across the North East and beyond who rely on us as a major cancer and regional trauma centre.

We are an anchor tertiary healthcare provider – delivering world-class cardiothoracic, spinal, cochlear implant, neurosciences, gynaecology and urology care for patients across the region – and one of only three hospital trusts in the UK operating three robotic surgical systems. Our major trauma centre sees half of all trauma cases in the North East and Cumbria.

By enabling clinicians to come together to shape and deliver the best possible care of our patients, we were rated by our colleagues in the 2020 NHS Staff Survey as the most improved Trust in the country.

This clinically-led approach has been at the heart of our response to COVID-19. During the last year, our clinicians have treated more than 3,000 patients with COVID-19 and it is testament to the hard work and dedication of our fantastic colleagues that, at the same time, they delivered more than 25,000 operations, including over 14,500 planned surgeries.

Our laboratory colleagues were amongst the first in the country to develop round the clock on-site testing for COVID-19 and James Cook Hospital was one of the world's first COVID vaccination centres.

Our significant contribution to the COVID-19 research effort is a mark of our determination to remain at the forefront of clinical research as a driver of safe, quality care.

Despite the unprecedented challenges which the NHS has faced this year, we have seen a number of significant improvements of which we are immensely proud in our clinically-led mission to always put safety and quality first.

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

Signed: 

Sue Page CBE
Chief Executive

Date: 27.07.21

PART TWO - Priorities for Improvement and Statements of Assurance from the Board

Priorities for improvement

Review of progress with the 2020/21 quality priorities.

In last year's Quality Account we identified the following as our quality priorities for 2020/21.

Quality Priorities 2020/21		
Safety	**Clinical Effectiveness**	**Patient Experience**
Increase incident reporting by 10% per year. This will also mean an increase in incidents reported to the NRLS.	To identify, develop and implement a Quality Strategy for the trust and embed an agreed approach to quality improvement methodology	Continuing work to further develop the patient experience programme using Meridian, specifically focusing on implementation of the new FFT guidance and 'hard to reach' groups.
Reduce the occurrence of Never Events and ensure there is a focus on safe surgical practice including improving the safety culture within theatres and continue the LocSSIPs work.	To implement and embed the STAQC accreditation process for the trust and the Quality Assurance framework	Embed the revised complaints management process within the trust in line with the revised Patient and Carers Feedback Policy
Improve the quality of incident investigations at all levels including those for Serious Incidents and those reported on Datix.	Ensure patients have a safe, effective and timely discharge	Improve the Outpatients Department (OPD) experience through 'task and finish' groups to review and continue the work that has taken place during 2019/20.

SAFETY

DOMAIN – Safety
Quality Priority
Increase incident reporting by 10 per cent during the year. This will also mean an increase in incidents reported to the NRLS (National Reporting and Learning System).
Agreed Actions
How will we do this? A robust incident reporting action plan will be developed describing specific actions which will include: • Completion of a comprehensive review of incident management process including discussing with staff at all levels and all staff groups to understand barriers to reporting – engage medical and nursing colleagues. • Complete a review of coding structures and usage • Review of incident types that are uploaded to NRLS to try and increase the threshold of what we upload. • Implement Datix Cloud IQ including Datix Anywhere Mobile reporting App. • Develop reporting mechanism to show number of incidents reported by 1,000 bed days. • Develop and implement a standardised incident report form on Datix for use across the Trust as well as short forms that can feed into the main system. • All new starters receive a session on incident reporting at Trust Induction. • Focused work on wards/departments to ensure staff have the skills and knowledge to recognise report and investigate incidents in a timely manner. • Outstanding incidents are reviewed on a weekly basis as part of the Patient Safety wall. • A weekly rapid review of open harm events with QBPs (Quality Business Partners) and patient safety will continue with the aim of closing down incidents within the week that they are reported.
Measures of Success
• Graphs showing increased incident reporting over the 12 month period • Revised policy signed off and implemented • Monthly incident reports outlying progress and shared at various groups/committees

End of Year Progress

Completion of a comprehensive review of incident management process including discussing with staff at all levels and all staff groups to understand barriers to reporting – engage medical and nursing colleagues.

There is a Patient Safety section on Trust induction every month for all new Trust staff which covers elements of incident reporting and culture and how to log an incident on Datix.

Reporting numbers continue to improve.

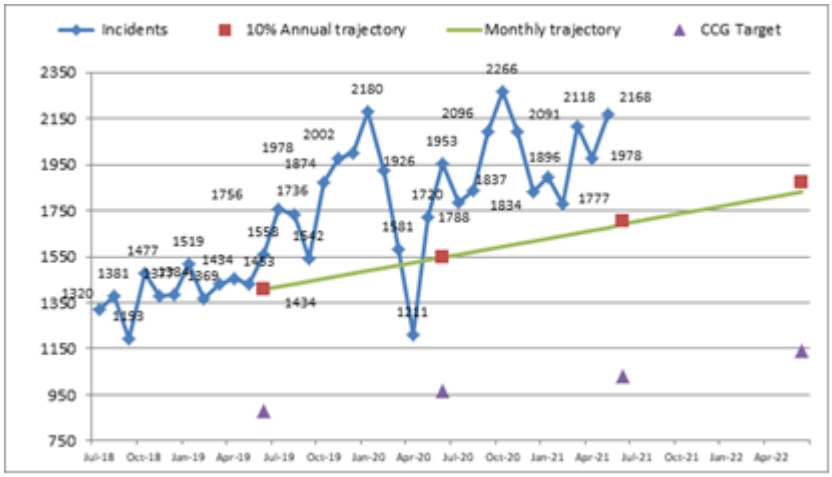

Figure 1: Incident Reporting Figures since 2018

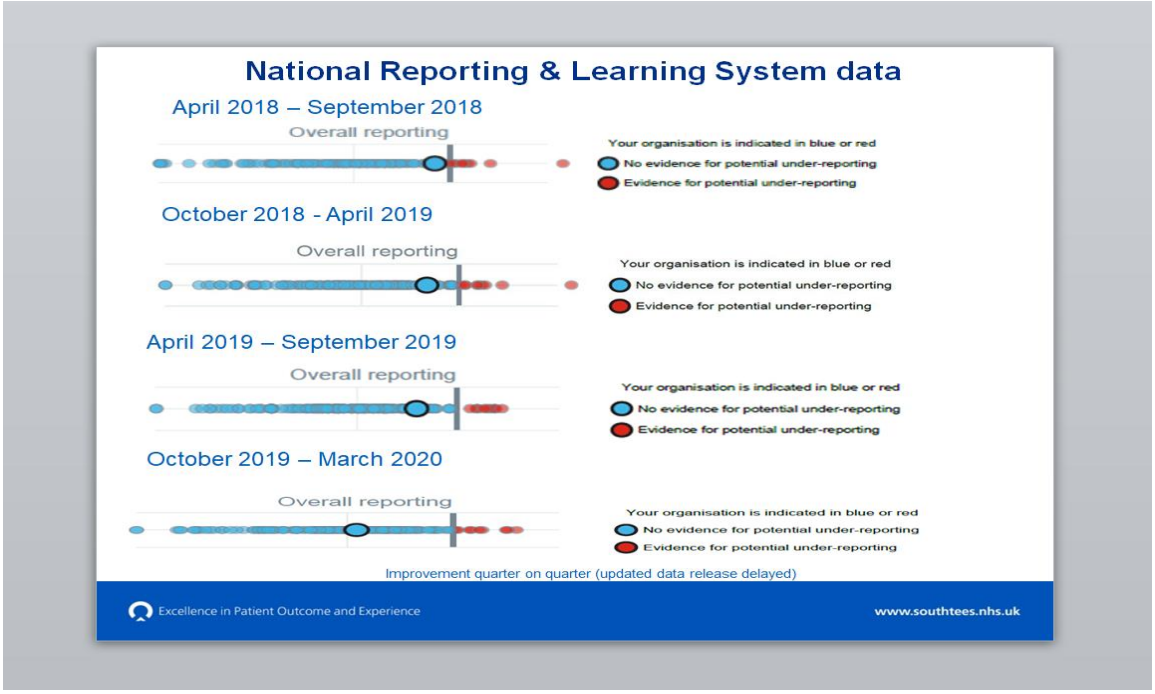

Figure 2: NRLS data since 2018

DOMAIN – Safety

Quality Priority – Reduce the occurrence of Never Events and ensure there is a focus on safe surgical practice including improving the safety culture within theatres and continue the LocSSIPs work.

Agreed Actions

How will we do this?

- To establish a safer surgery group
- To agree terms of reference
- To agree a project plan
- To review the LocSSIPs and implement and consistent approach to their applications, including an audit plan
- To deliver Human Factors training, Trauma Risk Management (TRiM) and empathic listeners to support staff learning and wellbeing.

Measures of Success

Despite the challenges faced by South Tees NHS Foundation Hospitals Trust during the last 12 months due to COVID-19, improvements have continued to focus on the delivery of Safer Surgery.

- Clear Terms of Reference have been established which set out the purpose and connectivity of the group into the wider organisation.
- A Safer Surgery Improvement Plan which is developed.
- Progress on the development of Local Safety Standards for Invasive Procedures (LocSSIPs) is outlined in the Safer Surgery Improvement Plan tracked under Organisational Factors and progress is reviewed through the Task and Finish group.
- LocSSIPs have been developed and implemented with clinical and project oversight and an audit cycle agreed.
- Monitor changes in staff culture through national and local survey results and feedback from staff training and wellbeing support offered.

End of year progress

The focus on safety remains paramount. We are delighted to report that this past year, despite the significant challenges faced by every colleague due to the COVID-19 pandemic, we have not experienced any surgical Never Events in 2020/21.

In response to the Trust's 2019 NHS Staff Survey results, and work which has taken place subsequently, a follow-up local survey identified a 61 per cent improvement in safety culture. A

local behaviour charter has also been developed with theatre and anaesthetic staff and implemented.

Forty six Trust wide LocSSIPs have been reviewed and implemented in a consistent format across the organisations, with an annual audit cycle agreed, which focuses on priority auditing of the LocSSIPs where we have previously had a never event.

Sharing and Learning and Training

There are 10 trained assessors in Trauma Risk Management (TRiM) in the theatre department. Trauma Risk Management (TRiM) is a peer delivered risk assessment and ongoing support system, designed specifically to help in the management of traumatic events. It is not a clinical intervention and individuals are identified following incidents who are invited to take part in an assessment, with trained assessors). On completing the initial assessment, scores are recorded against individual risk factors; the assessor can also provide support and signposting if needed. Most people do not need to be referred to a counsellor; they can be observed and reassessed one month later. Those who do need counselling intervention will be advised at the assessments.

A number of colleagues within the operating department have come forward to become Empathic Listeners (with support from our Medical Psychology team colleagues), to listen and support colleagues. The Empathic listeners are identified through a rainbow badge so that staff can approach them confidentially if they wish to.

A list of the Empathic Listeners is displayed within the theatre department. The aim of the group is to establish daily which Empathic Listeners are available for colleagues to access daily from 7am – 9pm.

A Training Strategy has been developed which sets out the principles for developing training for all staff within the perioperative environment. The first department induction for staff was held on the 26th May 2021.

Human Factors

As a response to supporting colleagues' welfare, Schwartz rounds are held and facilitated by our psychology team. These allow colleagues to share their thoughts, feelings and requirements following the COVID-19 Pandemic and the effects of safety throughout this time.

DOMAIN – Safety
Quality Priority
Continue to improve the quality of incident investigations.
Agreed Actions
How will we do this? A robust incident reporting action plan has been developed describing specific actions which will include: • Focused work on wards/departments to ensure that Staff have the skills and knowledge to recognise report and investigate incidents in a timely manner. • Full programme of Incident investigation training including SMART objectives and report writing. • A cohort of incident "investigators" to be established. • Review SI templates • Review RCA toolkit and implement Institute for Healthcare Improvement "Patient Safety Essentials" toolkit. • Datix Cloud implementation - Investigation module • Prepare for the introduction of Patient Safety Incident Response Framework (PSIRF)
Measures of Success
• Continued improvements to incident investigations • Datix Cloud implemented – investigation module utilised • All relevant staff trained • Prepared for the launch of PSIRF

Progress
Datix Cloud to be implemented – investigation module to be utilised There has been some delay in launching Datix cloud due to COVID-19 and some technical issues which still require a resolution. Whilst it has not been rolled out across the Trust, much work has continued behind the scenes, with data cleansing and alignment, and staff training. This included an investigation module which has been set up and allows chronologies and tools to be added to an investigation. **All relevant staff trained** With colleagues in STRIVE and at NHSE/I, a training programme has been developed for staff at various different levels across the Trust. Twenty-four colleagues attended a 2 day course on 'Skills, Knowledge and Report Writing' training, with a further 19 staff attending for the half day report writing element. In preparation for the Trust moving over to the new Patient Safety Incident Response Framework (PSIRF), in 2022, training sessions on the 'Introduction to Investigating Well' and more detailed tools and techniques, knowns as 'The ABCs' were attended by a total of 35 colleagues from across the Trust during the last year. **Prepared for the launch of Patient Safety Incident Response Framework (PSIRF)** A Local Patient Safety Action plan has been developed, under the 5 headings below and is monitored monthly at the monthly Patient Safety Sub Group (PSSG). Key to the success of this will be getting the processes right and continuing with our wider cultural journey, which supports learning and training for our staff. A Trust-wide Patient Safety Action plan has been developed in the 5 key domains: - • To review Floor to Board Governance • Organisational learning needs to be strengthened • Training and Education needs to be available to all staff • Process and Policy needs to be strengthened • To ensure there is a cultural change within the Organisation

CLINICAL EFFECTIVENESS

DOMAIN Clinical Effectiveness
Quality Priority. **To identify, develop and implement a Quality Strategy for the Trust and embed an agreed approach to Quality Improvement methodology**
Agreed Actions
How will we do this? • To develop a Quality Strategy • To agree a Quality Improvement (QI) approach for the Trust • Gain staff's views and input into developing the Strategy • Establish a Leadership and Safety Academy
Measures of Success
• Transformation of the approach to QI and 'Improvement Culture' within the Trust • A common language for improvement • Resonance and ownership of the process across teams and hierarchies • Development of leadership confidence and capability in improvement practice, leading to improved patient outcomes, improved service provision and so improved patient care, embedded via organisational and leadership development programmes alongside QI training.
End of year progress
Following feedback from the CQC inspection in 2019 and the subsequent scoping in 2019/2020 the Trust established a new Leadership and Safety Academy, along with an associated overarching strategy to structure its support to the Trust. This will be pivotal to developing our Trust Quality and Safety Strategy, which has been delayed until next year as a result of limited capacity to progress this during COVID-19. Establishment of this team commenced in March 2020 and since it's conception it has been building, delivering and evaluating a suite of QI training offers and 'improvement project support interventions', alongside other functions within the Trust, relating to Leadership Development, whilst also engaging with external providers to supplement this delivery offer. The QI agenda is still a core part of the team's focus and delivery of training and intervention support continues, with the use of QI methodologies in a more blended approach to service improvements across the board.

It is recognised that in order to support an organisational shift, which sees a culture of continuous quality improvement as part of its core business and one which is relevant to staff in all roles and grades, that a blended and responsive business model is key to success.

The Leadership and Safety Academy is made up of a series of subject matter experts in the fields of Organisational Development, Leadership/Management Development and QI, all of whom can cross-deliver training and intervention support across all three core themes. This approach provides a resilient and responsive delivery model to better support teams and individuals across the organisation in being able to access understand and implement the improvement tools which are best suited to their needs.

Training, improvement, project support and QI coaching is available to all staff in the Trust, as well as being available (where capacity permits) to regional partner organisations in order to share best practice and resources, whilst developing stronger systemic partnerships.

Our strategic intent is to create a culture of transformation, collaboration and continuous quality improvement in the Trust.

To enable this we will need to continue to build a system for continuous learning through continuous, quality improvement, effective leadership and ongoing organisational development, with a culture of compassion and safety mindedness, with Human Factors closely intertwined.

DOMAIN Clinical Effectiveness

Quality Priority

To implement and embed the South Tees Accreditation for Quality of Care (STAQC) accreditation programme

Agreed Actions

How will we do this?

- Designing the STAQC tool - establish an electronic method for assessing the quality of clinical care, culture and safety, across all 128 wards, units, teams and departments.
    - This was achieved by utilising the electronic Meridian platform to embed the entire STAQC programme, enabling the STAQC facilitators to collate both the relevant previous six month process and outcome data and the 'on the day' assessment data. This is an efficient and consistent way of collating data to generate scores and feedback reports.
- Facilitate a shared governance approach to continuous improvement by frontline staff by fostering ownership, competitiveness and pride via the STAQC programme.
    - The STAQC team work in collaboration with the clinical areas to complete the self-assessment which provides a baseline on which to develop action plans and initiate quality improvement (QI) required to gain accreditation. The STAQC team act as enablers and empower the clinical teams to reflect, act and take ownership of the required changes and agree together when they are ready for their assessment.
    - The clinical teams have access to QI and other relevant training if required. The STAQC team work programme is varied and ranges from ensuring managers and Matrons know how to access data and utilise Meridian right along to the 'softer' skills ensuring inclusivity and teamwork.

Measures of Success

- The above objectives have been achieved.
- For the STAQC team to commence the programme delivery before the 31st March 2021
- By the end of Q4 all clinical teams to have commenced their 'journey' to STAQC accreditation by virtue of plan completing their self-assessment or in the process of completion.
- Rapid assessment of clinical areas by the STAQC team has enabled a draft plan of how all areas will be accredited through 2021/22.

Redcar Urgent Treatment Centre receiving their diamond accreditation.

End of year progress

In March 2021 as the impact of COVID-19 on the Trust operational capacity started to ease plans to further implement STAQC commenced. In Q4, one assessment was carried out in February 2021 with Redcar Urgent Treatment Centre achieving diamond accreditation on the first attempt.

Table 1 outlines our progress up to the end of March 2021 and our plans for STAQC accreditation during 2021/22.

Self-assessment complete – total as at 31/3/21	116/128	□ STAQC journey poster in place □ STAQC plan & QI projects in place	**Key actions:** □ Ensure genuine readiness vs eagerness to prevent lack of sustained progress and change □ STAQC team maintain comprehensive work plan transparent to all teams □ Constant focus on shared ownership				
STAQC awarded as at 31/3/21	1/ 128	□ Diamond review					
Estimated assessment target date in place for 21/22	Based on 1. STAQC team capacity 2. Team preparedness and engagement		Q1 2021 10	Q2 2021 34	Q3 2021 40	Q4 2021/22 37	No date identified 7

Table 1: STAQC progress summary

The STAQC programme complements and enhances professional knowledge and empowers colleagues and teams to make the changes they want to make. STAQC celebrates the positive impact of strong multi-disciplinary partnership working and allows a culture of continuous improvements to deliver safe, effective, compassionate care to patients.

DOMAIN Clinical Effectiveness

Quality Priority - Ensure patients have a safe, effective and timely discharge

Agreed Actions

How will we do this?

Evaluate the "STOP" initiative and consider scaling this up to other wards. The initiative ensures the nurse in charge has the final oversight of the discharge of their patients and the patient has the information to empower them to challenge any aspects of their discharge arrangements. There will continue to be improvements made such as including clear discharge pathways in the documentation to enable effective discharge planning.

Measures of Success

- Decreasing rate of delayed transfers of care to be below the 3.5% upper threshold
- Decreasing average length of stay in the acute setting – individual directorates to set own targets by end Q2 relative to baseline to achieve either top quartile or top decile against national benchmarks
- Decreasing number of patients with a length of stay over 21 days
- Improving trend of discharges before 12 midday, towards the target of 33% by the end of Q4
- Decrease in the 'Clinical Utilisation Review (CUR) not met' rate using Medworxx analysis. Reduction on the 2019/20 position of 35.54 per cent
- Reduction in the delays for the main categories associated with 'CUR not met' reason codes
- Decreased number of discharge related PALS and patient complaints
- Set baseline and improvement trajectories for decreasing length of stay in patients with clinical frailty by end Q1
- Decreasing levels of harm in patients with frailty. Baseline and improvement targets to be set by end Q2 and monitored via Datix and the frailty dashboard

End of year progress

- The national targets for discharge changed during 2020/21 with the focus moving from measuring Delayed Transfers of Care to reviewing patients against the criteria to reside. The monitoring of this target ceased nationally. Patients who don't meet the criteria to reside are to be discharged by 5pm, with the main focus being put on reducing the number of patients who have a long length of stay.
- STOP initiative developed and launched

Figure 3: STOP Discharge Checklist

- Regular review of delayed discharge and length of stay metrics and associated actions put in place. This takes place operationally at a weekly ‘‘Where Best Next?’’ meeting and strategically at a monthly “Home First” system-wide meetings attended by key staff members of the acute Trust, Local Authorities and the CCG.
- Embed the role of the Frailty Liaison Team to increase the focus on the frail patients to ensure they are admitted to the most appropriate clinical environment to maximise chances of early discharge and prevention of deconditioning.
- Embed the SAFER principles – having a focus on criteria led discharge and ensuring an estimated date of discharge is set based on clinical evidence.
- Implement a robust model of working for the integrated discharge team and the integrated Single Point of Access.
- Ensure improvement plans for ‘CUR not met’ categories are in place and implement an escalation process using daily automated reports sent to managers from Medworxx.

The Frailty team

- Documenting the Comprehensive Geriatric Assessment has improved although not completed for all frail patients. There has been a reduction in the patient’s length of stay when the team are involved.
- Patient experiences are being captured to inform future service improvements.

- The emphasis is on embedding the role of the frailty liaison team to increase the focus on frail patients, to ensure they are admitted to the most appropriate clinical environment, to maximise chances of early discharge and the prevention of deconditioning.

PATIENT EXPERIENCE

DOMAIN Patient Experience
Quality Priority: Continuing work to further develop the patient experience programme using Meridian, specifically focusing on implementation of the new FFT guidance and 'hard to reach' groups.
Agreed Actions
It has been recognised through patient feedback received via PALS that the Outpatient Department (OPD) experience could be further improved upon. The main areas for improvement identified were communication, waiting times for appointments and delays in the OPD. **How will we do this?** • Continue with the on-going work with the 'Task and Finish 'group work in relation to communication, waiting times for appointments, the patient experience of the OPD and information provided to patients. • A Standard Operating Procedure (SOP) is being developed for reception staff greeting patients to the department, this includes, the 3 point check and Accessible Information Standards (AIS) communication question. A SOP has also been developed for answering the telephone to ensure that there is a Trust standard for responding to telephone communication. • Monitor and be reactive to patient feedback from surveys, Governor Drop Ins, Mystery Shopper, PALS and complaints about the OPD experience. • A comprehensive training package is underway for new staff and a rota for role specific duties, including answering the telephone, working on reception and pulling notes for clinics is in place.
Measures of Success
• Reduction in PALS and formal complaints in relation to the OPD. • Increase in positive feedback from patients through surveys regarding the OPD experience • Development of a SOP for reception staff • Patient feedback

- Comprehensive training package.

End of year progress

- The patient surveys have been implemented across the majority of wards and departments; however, there are small pockets such as Ambulatory Care areas which require a more specific survey developing to meet their needs.
- The Friends and Family Test (FFT) question has been updated as per the guidance as of 1 April 2020 and now asks for the 'Overall Experience' of the ward/department.
- The FFT has been added to all patient surveys rather than being a standalone survey, this is in line with the national guidance.
- Prior to the COVID-19 pandemic the trust's response rate had improved significantly.
- Get well cards were produced and sent to patients following their discharge to ask that they contact the Patient Experience Team to give their feedback.
- The Patient Experience Facilitators continue to support the wards and departments with Meridian and provide one to one training.
- The new FFT guidance is now embedded in the organisation in all patient surveys.
- The patient surveys using the Meridian system are implemented across the Trust and is used in the STAQC process.
- Work continues to ensure hard to reach groups are provided with an equal opportunity to provide feedback regarding their care and treatment with the support of the Learning Disability Specialist Nurse.
- Patient surveys are translated into the five main languages.
- Sentiments have been added to the patient surveys.

DOMAIN Patient Experience
Quality Priority Embed the revised complaints management process within the Trust in line with the revised Patient and Carers Feedback Policy
Agreed Actions
It was recognised that historically there was an inconsistency across the Trust in the way that complaints were investigated and also written responses to complainants. An end to end review of the complaints process was carried out from the autumn of 2019. The Patient Experience and Carers Feedback Policy was ratified in February 2020 and the new complaints process, detailed in the policy, has been implemented across the Trust. **How will we do this?** • Produce a standardised investigation process for complaints that mirrors the investigation process used for an incident, to ensure a consistent approach across the organisation. • A lead investigator is allocated for all complaints to co-ordinate the investigation process. • Ensure all elements of the complaint are understood, investigated and responded to the complainant's satisfaction and within the appropriate timeframe. • Embed the revised complaints management process within the Trust in line with the revised Patient and Carers Feedback Policy.
Measures of Success
• Increase in complaints being closed within the response timeframes. • Decrease in reopened complaints relating to the complaint not being investigated appropriately. • Patient Experience and Carers Feedback Policy approved and implemented. • Lead investigator allocated for all complaints. • Ensure all elements of a complaint are understood, investigated and responded to within agreed timeframes. • Decrease in re-opened complaints.

End of year progress
• The Patient and Carer Feedback Policy has been ratified and implemented, which documents the roles and responsibilities of staff in the complaints process. Roll out of the policy across the organisation has been delayed due to the impact of COVID-19. • A complaint response template has been devised and in use trust-wide since 1 April 2020. • Quarterly review of the complaints process using the Patient Association Guidance, for assurance by the PPG has been delayed due to the pandemic. • Review of the Healthwatch report 'Shifting the mindset' on complaints, published January 2020 has been completed. • Awaiting the final framework for complaints by the PHSO to review against the Patient and Carer Experience Feedback Policy. The Trust has registered interest with the Parliamentary and Health Service Ombudsman (PHSO) to be a 'pilot site' for the implementation of the new complaint framework. • Increase in the complaint response timeframes to above the Trusts' internal target. • There has been a 14 per cent reduction in further contact (re-open) following response (written or meeting) in Q1 & Q2 however there was a significant decrease in formal complaints received due to the pandemic. • The Trust response invites complainants to return should they have further issues arising from the original complaint and this is seen as good practice by the PHSO. • The Patient and Carer Feedback Policy was approved in February 2020 and is embedded in the organisation.

DOMAIN Patient Experience
Quality Priority: Improve the Outpatients Department (OPD) experience through 'task and finish' groups to review and continue the work that has taken place during 2019/20.
Agreed Actions
The Trust is committed to ensuring that when patients attend for an outpatient appointment they have a positive experience. Investigation of PALS data demonstrated that a significant amount of contacts were with regard to outpatient appointments (21 per cent), with patients unsure of when their appointment were and unable to contact the relevant department, or in some cases unsure of what their appointment were for. **How will we do this?** A robust patient experience action plan will be developed by the end of June 2019 highlighting specific actions which will include: • Review of communication letters to patients to ensure adequate and effective communication, this will include information relating to accessible information and asking patients if they would like the information in another format. This review will consider the information sent pre-appointment, information provided during appointments and post-appointment follow up. • Strengthen the governor 'drop-in' programme to ensure that robust action plans are put in place to address issues identified during their visits and ensure that there is evidence that actions have been completed within agreed timescales. Feedback will be provided quarterly to the Quality Assurance Committee (QAC) and the Council of Governors to provide assurance that actions identified have been implemented. • Ensure there are robust systems in place to respond to patient feedback relating to outpatient appointments. • Implementation of a 'secret shopper' initiative within OPD's to inform future improvement work. • Re-launch the FFT programme within Outpatients.
Measures of Success
• Completion of baseline assessment of information communicated to patients relating to outpatients appointments. • Programme of Governor's drop in sessions and evidence of actions taken following these visits.

- Implementation of the 'secret shopper' initiative across the trust.
- Reduction in the number of PALS queries relating to OPD appointments.
- Introduction of FFT within outpatients.

End of year progress

- Review of the appointment letter templates is being undertaken by the leads for administration services and an Accessible Information Standard question regarding communication requirements has been added to all appointment letters.
- A rolling Governor drop-in programme was developed for 2019/20, however due to the COVID-19 Pandemic these were cancelled and will resume when visiting restrictions have been removed.
- The action plans will continue to be monitored by the Patient Experience Sub Group.
- The launch of the Mystery Shopper was delayed due to the COVID-19 pandemic, this was due to patients not attending outpatient appointments and the use of paper was discouraged during the Pandemic.
- An 'Attend Anywhere Appointment' survey was developed and patients who have had either a telephone or video appointment are being sent the survey to complete.
- Outpatient Appointment Letter Project – Reduce templates from over 2,000 down to 5-10 core templates. Standardised format making letters from STHFT instantly recognisable and simplifying the content for ease of understanding. Project due to be completed end of September 2021. New templates will receive internal approval before being shared with external stakeholders prior to implementation and an Accessible Information statement will be included on all letters. Strict governance will be placed around requests for amendments or new letters being created to ensure only "live" versions are used and to prevent the trust ending up with the same issue in the future.
- The 'Attend Anywhere Appointment' survey is being utilised and response rates improved.
- The Chart below represents the responses to the 'Thinking about your virtual clinic appointment, overall how was your experience of our service' question: -

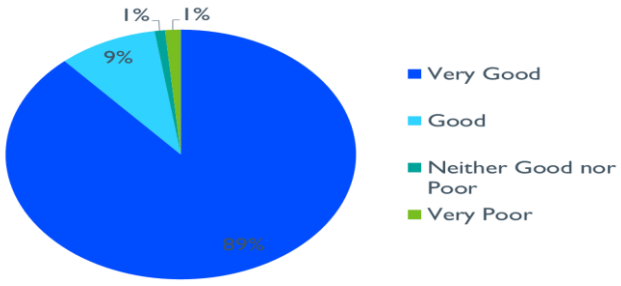

Figure 4: Responses to 'Thinking about your virtual clinic appointment, overall how was your experience of our service'

2021/22 Quality Priorities

The Trust has agreed the following priorities for 2021/22 following a consultation process. Due to the Trust's response to the COVID-19 pandemic, some of this year's quality priorities have been carried over from last year.

Quality Priorities 2021/22		
Safety	**Clinical Effectiveness**	**Patient Experience**
Increase incident reporting by 10% per year. This will also mean an increase in incidents reported to the NRLS	To develop and implement a Quality & Safety Strategy for the Trust	Reduce the incidence of avoidable category 3 and 4 pressure ulcers in order positively impact on patients who are most at risk
Reduce the occurrence of Incidents with Harm, including Never Events, by training 90% of relevant staff in Human Factors	Identify and reduce unwanted variation by participating in the Getting it Right First Time (GIRFT) programme and implementing recommendations	Establish a Trust-wide inclusive patient experience user group which represents the diverse range of patients who come into contact with our services
Develop and Implement a robust plan for the organisation to move over to the new Patient Safety Incident Response Framework when it is published and launched in 2022	To continue delivering the Trust's end of life strategy and use local and national data sources to identify areas for improvement for mortality	Using always events methodology, Improve the patients' experience in the area of letters and written communication to above 90% through a 'task and finish' groups.
	Complete all relevant NICE quality standards assessments in order to: • Understand the priority areas to focus on quality improvement • Identify potential areas for local audit • Identifying services that are of poor quality	
	Ensure patients have a safe, effective and timely discharge	

PATIENT SAFETY

DOMAIN – Patient Safety
Quality Priority
Increase Incident Reporting by 10 per cent per year. This will also mean an increase in incidents reported to NRLS.
Rationale
Following on from the improvement work in 20/21 the Trust trajectory is on track for increasing reporting of incidents but there is more to do. CQC Essentials states: 'An increase in reporting of patient safety incidents is a sign that an open and fair culture exists where staff learn from things that go wrong. Organisations with a culture of high reporting are more likely to have developed proactive reporting and learning to ensure the services they provide are safe'. The experience from other sectors, such as the aviation industry, shows clearly that as reporting levels rise the number of serious incidents begins to decline ('Seven Steps to Patient Safety'). In fact, in the acute healthcare sector, low levels of reporting from an individual trust is recognised as a cause for concern and warrants further investigation of safety.
Agreed Actions
How we will do this? • Implement Datix Cloud IQ including the Mobile Phone App "Datix Anywhere" that enables anyone to report an incident on a mobile device at the touch of a button. • Increase the number of incidents reported, support engagement with staff and ensure incidents are investigated as soon as possible. • Staff working remotely can log incidents as soon as they occur, rather than having to wait until they are on site again. • This revolutionary new application has an intelligent design that allows for the quickest entry of data in customisable forms, which means the reporting of incidents can be done instantly, encouraging active surveillance within a learning culture. • In July 2020, a regular weekly upload to NRLS will commence. Incidents cannot be uploaded until they are finally approved in the collaboratives. • A weekly report showing outstanding incidents will be sent to senior colleagues to encourage the processing of incidents and the timeliness of the investigation process is tracked at the 'Quality Wall' every week • A Patient Safety Action Plan will be developed to outline the work that the Trust is undertaking to address and maintain its focus and commitment to patient safety. • One of the objectives is to introduce patient safety influencers/ambassadors within wards and departments – the role will incorporate a Datix champion element which will also support the increased reporting of incidents.

Measures of Success
• Increase in the numbers of incidents reported • Increase the numbers of incidents reported by groups of staff who do not traditionally report as many incidents – for example medical staff • Increase numbers of near misses reported • Increase the number of incidents uploaded to the NRLS by 10 per cent year on year for the next three years (this will be year 3 of 3). • Introduction to the patient safety influencer/ambassador role

DOMAIN: Patient Safety
Quality Priority
Reduce the occurrence of incidents with harm, including Never Events, by training 90 per cent of relevant staff in Human Factors
Rationale
As we move to a Just Culture approach our human factors training programme is core to our development of skills within patient safety. Patient safety incorporates learning from incidents, learning from our mistakes, improving team dynamics, human factors training and understanding the affect and effect of our behaviour on one another (civility/decency). We will be offering formal training, training within teams (in situ) and simulation training to move towards a Just Culture as our norm. We are also offering training via external agencies in patient safety investigation, human performance and empathy and will offer at least one full trust patient safety day to ensure that the messaging is widespread and can be accessed by all within the Trust.
Agreed Actions
We will provide training across the suite of programmes as set out below:

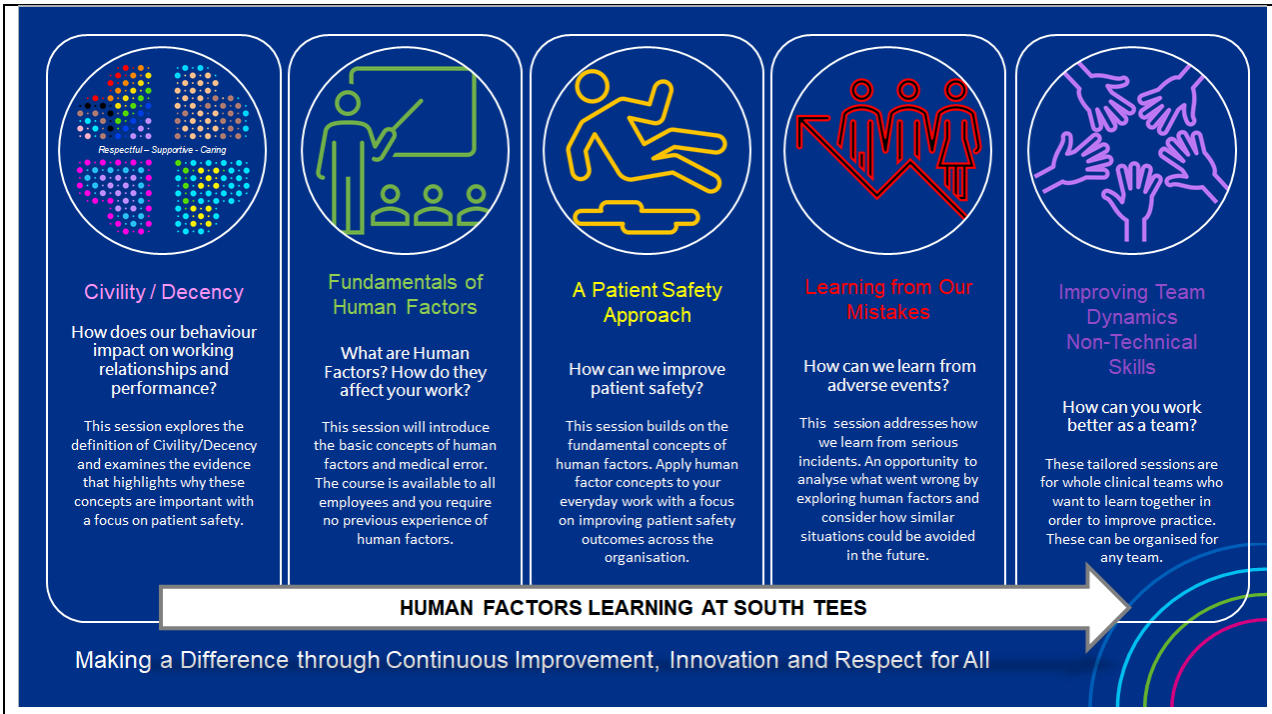

Figure 5: Human Factors Learning

Subject to COVID-19 restrictions, and in addition to the staff we have already trained across the Trust, we will be offering 1,200 places across our internal and external courses

Measures of Success

- Courses are able to run
- Attendance at courses
- Feedback via evaluation
- Changes in patient safety and culture questions/responses in staff survey results

DOMAIN – Patient Safety
Quality Priority
Develop and Implement a robust plan for the organisation to move over to the new Patient Safety Incident Response Framework when it is published and launched in 2022
Rationale
In March 2020, NHS England and NHS Improvement published the introductory Patient Safety Incident Response Framework (PSIRF). The new framework is being implemented through a phased approach with a number of nationally appointed 'early adopter' Trusts and commissioners working to implement it during the course of this year. Although wider implementation across the NHS was planned in 2021, this has now been delayed and non-early adopter organisations (including the Trust) must continue to use the existing Serious Incident Framework until Spring 2022. The Trust is using the time leading up to the full introduction of the PSIRF to plan for this change. A thematic analysis will be undertaken in order to determine the category of incidents the Trust chooses to investigate and the level of investigation required. Under the new framework, each organisation must develop a Patient Safety Incident Response Plan (PSIRP), setting out how incidents have been identified and investigated (reviewed every two years). Under the Patient Safety Incident Response Framework (PSIRF), there is no distinction between incidents and Serious Incidents – the framework advises how to respond to a Patient Safety Incident (PSI). The same definition remains in place for a PSI: "unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving healthcare". The framework seeks to establish 'proportionate responses' to incidents – which is in contrast to the Comprehensive Root Cause Analysis investigations which are required for all Serious Incidents (SIs) under the current Serious Incident Framework (SIF). The PSIRF recognises and encourages other methods of investigation to encompass the learning opportunities. These include: • Case note review • Time mapping • Being open conversations • After Action Review • Audit

The PSIRF also recognises that some incidents will not require any further investigation or that no further response is required.

Agreed Actions

- The Patient Safety Team will attend a nine module learning programme "Patient Safety Incident Investigations" commissioned by NHS England and Improvement (North East and Yorkshire) and share the learning and new knowledge during 2021/22.
- The Patient Safety Team has commenced a review of the patient safety incident reporting data over the last three years, from 1st April 2018 to 31st March 2021. During 2021/22 and via a Task and Finish group, themes need identifying and triangulating to review this data alongside patient safety concerns highlighted through complaints, mortality review processes, coroners' inquests, litigation claims, infection prevention and control-related audits, and other relevant clinical audits which have been completed.
- The group will make recommendations in order that they can determine the categories for investigation.
- A Task and Finish Group will be established with the output of this being the Patient Safety Incident Response Plan (PSIRP).
- The Trust will agree our PSIRP with our lead commissioners, NHS Tees Valley CCG who will assure effective application of local PSIRPs and PSII standards.
- Develop a strategic plan to prepare the Trust for the implementation of the PSIRF
- Achievement of a cultural change will be key to the success of this with the need for organisations to establish behaviours of an 'effective and compassionate patient safety reporting, learning and improvement system underpinned by openness and transparency.

Measures of Success

- Completion of the learning programme for key people who attended.
- Review completed of the patient safety incident reporting data over the last 3 years.
- Task and finish group established to complete this review.
- Patient Safety Incident Response Plan (PSIRP) developed and agreed with lead commissioners and within the Trust.
- Development and agree a strategic plan to prepare for implementation.
- Evidence of a patient safety reporting and learning culture though triangulation of data through various sources including, staff feedback, Freedom To Speak Up (FTSU) Guardians, staff survey results and incident reporting numbers/trends.

CLINICAL EFFECTIVENESS

DOMAIN – Clinical Effectiveness
Quality Priority
To develop and implement a Quality and Safety Strategy for the Trust
Rationale
Patient safety and quality is an integral part of the Trust and the Trust therefore strives to ensure that patient safety is at the forefront of patient care as well as ensuring that the care provided is of a high quality. One of the priorities from 2020/21 was to develop a quality strategy however it was agreed that both quality and safety are pivotal and therefore a combined Quality & Safety (Q&S) strategy will be developed. There has also been a delay in developing this strategy as a result of the pandemic. In March 2020, NHS England and NHS Improvement published the introductory Patient Safety Incident Response Framework (PSIRF). The new framework is being implemented through a phased approach with a number of nationally appointed 'early adopter' Trusts and commissioners working to implement it during the course of this year. The PSIRF sets out changes to the approach which will be taken by the NHS as a response to patient safety incidents. The current system (Serious Incident Framework (SIF) is a reactive process which can also be rigid and bureaucratic and may fail to reduce the recurrence of harm. The aim of the PSIRF is to refocus systems and processes and also improve the quality of investigations and whilst bringing a sustained reduction in risk and changing behaviours to this more proactive approach. The PSIRF should support the NHS to further improve patient safety by outlining how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted. This will be incorporated into the Q&S Strategy. Achieving cultural change will be key to the success of this with the need for organisations to establish behaviours of an 'effective and compassionate patient safety reporting, learning and improvement system' underpinned by openness and transparency, just culture and continuous learning and improvement.
Agreed Actions
How will we achieve this? • Staff pledges will be made during April/May • Pledges made will be collated, with the output from these being incorporated into the Quality & Safety Strategy to ensure that the staff voice is heard and captured. • The Q & S Strategy will be aligned with the PSIRF • Review Floor to Board Governance • Strengthen Organisational Learning

- Training and education available to all staff
- Strengthen process and policy
- Positive culture change within the Organisation
- Develop the Q & S strategy and publish it by the end of October 2021

Measures of Success

- Staff pledges are collated and shared
- The Quality and Safety Strategy is published
- Staff can talk about the strategy, its implementation and the evidence to support it

DOMAIN – Clinical Effectiveness

Quality Priority

Identify and reduce unwanted variation by participating in the Getting it Right First Time (GIRFT) programme and implementing recommendations

Rationale

Getting It Right First Time (GIRFT) is an NHS improvement programme delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis. The GIRFT team visit every Trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

Communication is a vital part of ensuring GIRFT's successes within the organisation. By having a clear vision of the benefits that GIRFT can bring into the Trust, engaging staff through communicating that vision, and ensuring that the processes are designed in a way that is not burdensome for the clinicians. The Trust is able to fully embrace GIRFT as a key enabler towards delivering a cycle of continuous improvement for its patients.

The Trust already has a well-established internal annual Quality Surveillance Programme (QSP) comprising of 74 specialised services (including sub-services). As future GIRFT programmes are beginning to align to NHS England and NHS Improvement to capture both provider and clinical insights, it has become evident that both programmes should be affiliated to a central in-house repository. There are therefore plans in place to ensure the inputs and outputs of the GIRFT programme will, as far as possible be integrated within these existing programmes of work.

Agreed Actions

How will we get there?

- Ensure the Trust participates in all relevant GIRFT deep dives.
- Ensure that action plans are clinically led and are implemented following recommendations from deep dives to demonstrate service improvement.
- Ensure good practice is shared across the trust and GIRFT data is triangulated.
- Maintain regular communication with the regional GIRFT implementation managers.
- Ensure relevant groups/committees are briefed regularly on the outcome of GIRFT visits and any subsequent action plans.

Measures of Success

- Reports and triangulation from GIRFT visits
- Evidence of implementation of agreed action plans and service improvement
- Communication regarding good practice
- Liaison with the regional GIRFT manager
- Production of regular progress reports to committees

DOMAIN – Clinical Effectiveness

Quality Priority –

To continue delivering the Trust's End of Life Strategy and use local and national data sources to identify areas for improvement for mortality

Rationale

The Trust is committed to delivery of the End of Life (EoL) 2020-2023 Strategy.

The strategy sets out a 3 year plan when preventing death is no longer an option as to how we will continue to treat and support our patients throughout their last months and weeks of life. Our strategy is underpinned and guided by three national key documents:

- Ambitions for Palliative and End of life care – a framework for local action 2015-2020 (National Palliative and End of Life Care Partnership: 2015)
- One Chance to get it right (Leadership Alliance for the Care of Dying People: 2014)
- NHS Long Term Plan (2019)

The Trust is committed to systems working and delivering on the priorities of our Integrated Care System, whilst ensuring that as an organisation that we make the ambitions a reality, through strong leadership commitment and empowerment.

Our 6 ambitions are as follows:

Figure 6: End of Life Ambitions

In order to achieve our ambitions and to embed the principles outlined by Leadership Alliance there are five foundations to be successful in our vision;

- Personalised Care Planning
- Involving and Supporting
- Education and Training
- 24/7 Access
- Leadership

In order to achieve our ambitions the Trust will work collaboratively with colleagues in primary care, voluntary sector including Teesside Hospice and Clinical Commissioning Groups.

Delivery of the Strategy is overseen by the Chief Nurse and the Trust Chief Medical Officer. The EoL Strategy Group is responsible for the implementation of the strategic objectives and for measuring progress. The Strategy Group reports to the Quality Assurance Committee.

Agreed Actions

How will we get there?

To continue delivering the Trusts EoL strategy we will:

- Use local and national data sources to identify areas for improvement for mortality
- Draft a work plan for 2021/22 and ensure this is signed off by the Trust and shared both internally and externally with our partners.
- Develop and deliver the plan under the 6 main work stream headings which aligned to the 6 ambitions set out above
- Progress and monitor the action plan through the EOL Strategy Group.

Measures of Success

Measures of success have been identified for each objective.

The Personalised Care Programme aims to have specific care for all patients within the palliative care remit for each individual. My care wishes folder is a focus of personalised and supported care for all, with roll out training for staff colleagues to embed this new initiative.

Involving and Supporting

Ongoing work with the Trust wide SPC (Specialist Palliative Care) teams promoting dying matters and having focused conversations to support with a strong aim to become a part of daily focus with early interventions with patients, families and carers. Direct feedback from our completed bereavement survey to support our ongoing service development and improvements as required.

Education and Training

Training and education is vital and key to delivering our aims, objectives and ambitions while ensuring our patients and staff are correctly supported, and given the tools to fulfil our patient's needs. Having a designated palliative care training facilitator, interlinking with our medical educator colleague to provide a Trust wide covering service.

24/7 Access

This has been included from 2019 however due to the pandemic this remains a focus through 2021/22. There will be further collaborative working across the Trust, supporting our EoL patients with ongoing care needs.

Leadership

External/national lead support with SPC service review and upcoming collaborative workshop for service alignment and service development. Development and input with Trust NMAHP (Nursing, Midwifery and Allied Health Professional) Strategy.

DOMAIN – Clinical Effectiveness

Quality Priority

NICE Guidance Compliance:
Complete all relevant NICE quality standards assessments in order to:

- Understand the priority areas to focus on quality improvement
- Identify potential areas for local audit

Rationale

The National Institute for Health and Care Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

NICE guidance aims to ensure that promotion of good health and patient care in the NHS are in line with the best available evidence of clinical and cost effectiveness.

NICE publish new and updated guidance on their website as and when it is finalised or updated.

The guidance is checked to ensure it is relevant to services provided by our Trust and then where considered relevant it is sent to the Trust lead/Clinical Director (CD) for that specialty, informing them of the new or updated guidance, and asking for their compliance status against the key recommendations, which is one of the following:

1. Fully compliant
2. Partially compliant with an intention to be fully compliant
3. Partially compliant – don't agree with all of the guidance
4. Partially compliant – due to other factors including environment/funding/commissioning
5. Do not intend to implement – mitigation in place and alternative guidance is being followed
6. Not applicable

NICE Quality Standards (QS) are a set of specific, concise statements that act as markers of high quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.
Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with the NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

Agreed Actions

How will we get there?

- Complete a baseline assessment relating to Quality Standards that have not yet been assessed.
- Develop a project plan to improve compliance with quality standards and also collate evidence to demonstrate compliance
- Ensure the 50 quality standards that have not been assessed are reviewed by the clinical teams and actioned appropriately
- Ensure the backlog of NICE Guidance is disseminated within the Trust to determine whether the Trust is compliant
- Where areas of non-compliance are identified actions are implemented to obtain compliance or where non-compliance is agreed the risks of this will be documented appropriately and action taken where necessary to address risks
- Ensure Technology Appraisals are disseminated and reviewed
- Development of a further project plan to identify evidence of compliance through clinical audit
- Ensure the NICE Guidance tracker is accurate and reflects the current position
- Establish a robust system for managing NICE Guidance compliance going forward
- Ensure areas of non-compliance are escalated appropriately through the NICE Clinical Audit and Service Evaluation Group and upwards through the Clinical Effectiveness Steering Group

Measures of Success
• Backlog of NICE Guidance has been managed appropriately and compliance status obtained for all outstanding ones • Review of the Quality Standards that have not been assessed • Review of the 35 Technology Appraisals that have been disseminated • Up to date NICE Guidance tracker with an established process for disseminating NICE Guidance within an appropriate timescale • Evidence of implementation of Phase 1 of the NICE Project plan • Development and implementation of Phase 2 of the NICE Project plan • Regular reports showing progress made over the 12 month period

PATIENT SAFETY

DOMAIN – Safety
Quality Priority
Ensure patients have a safe, effective and timely discharge
Rationale
Health and social care systems are expected to build upon the hospital discharge services developed since 19th March 2020. Systems should use the Government's additional investment to maintain discharge services through to 30th September 2021. There is a requirement that the reductions in the length of stay for acute admissions are improved upon in year. As a result of the COVID 19 pandemic and the Governments additional investment, this quality priority has been carried forward from last year. Central to the delivery of effective and timely discharge planning is clinical leadership and good communication. This underpins the regular reviews of the treatment and care for people, and ensures a consistent focus on the principles of personalised care. Daily morning board rounds to review every person and make decisions, informed by the criteria to reside, are the foundation for avoiding delays and improving outcomes for individuals. Transfer from the ward to a dedicated discharge area should happen promptly; for persons on Pathway 0 this should be within one hour of that decision being made, and the same day for people on all other pathways. The 'Criteria to Reside' tool was developed in March 2020 with the Academy of Medical Royal Colleges and has since been reviewed with the collaboration of the British Geriatric Society. The tool equips clinical teams to have discussions and make decisions whether a person needs to stay in an acute bed to receive care. This should then lead to a plan concerning the resources and services required to support a safe and timely discharge of that person if they no longer need the support and services of an acute hospital. NHS commissioned (acute and community) hospitals must integrate the daily reviews into their electronic patient information systems during 2021/22. This will ensure live data is available for

all agencies to work from and include those suitable for discharge, the number and percentage of people who have left the hospital, and delay reasons for those unable to be discharged in a timely way. This data forms part of national data performance reporting arrangements.

There is a shared vision across the South Tees Health and Social Care system to embed a Home First culture. We will ensure hospital stays are as short as possible, and that wherever possible, people are supported to return home to recover, regain their confidence and maintain their independence.

The overall objectives for the local health and social care system are:

1. To collectively improve patient flow throughout the hospital and community bed base

2. To embed proactive discharge planning processes that drive daily discharges and improve patient flow

3. To improve overall bed management and bed utilisation

Having a Home First mind set is the guiding principle so that everyone in the system will support people to return home if that is where they were admitted from and if they are safe to do so. The focus is on admission avoidance and providing wrap around services in the community.

The Trust is committed to the safe and prompt discharge of patients from acute care. It recognises that appropriate and timely discharge planning is fundamental to the provision of effective health care, and to the wellbeing of the patient.

The Trust recognises that all patients who no longer meet the 'Criteria to Reside' in hospital should be discharged, or appropriately transferred as soon it is clinically safe to do so.

Agreed Actions

How will we get there?

- Develop a case management approach to transfers of care - developing the discharge team and engaging with other teams to facilitate timely discharges by August 2021
- Implement the SAFER approach - embed ward processes that improve discharge processes by September 2021
- Implement a Home First Service for patients returning home who need some support by September 2021
- Strengthen the Single Point of Access so that there is one contact number for the wards when seeking support for a patients discharge by September 2021
- Implement a weekly review of all patients with a long length of stay by July 2021
- Develop Patient Safety At A Glance (PSAG) boards to include criteria to reside assessments, ensuring Estimated Dates of Discharge (EDD) and Planned Date of Discharge (PDD) are visible and maintained by September 2021
- Develop and initiate staff engagement and training regarding new discharge processes by September 2021
- Initiate the Modern Ward Rounds Collaborative (National project) and embed by March 2022
- Develop Community Hospital pathways by October 2021

Measures of Success
• At least 95 per cent of patient's aged-65+ leaving hospital should be going straight home/usual place of residence either on discharge pathway 0 or pathway 1. • % of patients not meeting the criteria to reside discharged by 5pm – target 70% • % of patients that have been in hospital over 7 days – target 40% • % of patients that have been in hospital over 21 days – target 12% • A reduction in the % of patients re-admitted as an emergency admission within 30 days of a discharge • A reduction in the average length of stay

PATIENT EXPERIENCE

DOMAIN – Patient Experience
Quality Priority
Reduce the incidence of avoidable category 3 and 4 pressure ulcers in order to positively impact on patients who are most at risk
Rationale
The development of pressure ulcers is a key indicator of quality of care and patient experience. Pressure ulcers are detrimental to patients in terms of their physical, psychological and social well-being, resulting in reduced quality of life (EPUAP 2014). In addition, treating pressure ulcers costs the NHS more than £1.4 million every day (Guest et al. 2017). A common misconception is that pressure ulcers are wholly preventable. An early paper by Hibbs (1988) hypothesised that 95% of pressure ulcers were preventable and this became a widely cited statistic however, later papers highlighted that Hibbs (1988) provided no empirical evidence for this figure. More recent work suggested that preventability may range between 50-60% (Downie et al. 2013). This variability in the literature is important to note as pressure ulcer prevention is commonly held as a marker of good nursing care and on occasion, factors out with the control of the clinical team may be a contributing factor, particularly in the community setting. In addition there is variation in reporting across the ICS and wider, particularly in the community setting. At South Tees our aim is to provide care which is evidenced based and to reduce the patient's risk of pressure damage wherever possible. The approach we are taking is a collaborative one, using mixed methods to optimise process, outcome and education.
Agreed Actions
How will we get there? • Identify focus areas that are demonstrating an increasing rate of pressure ulcers across 6 wards, 3 ITU / HDUs and all of our community services. • Commence a patient-centred improvement initiative that incorporates SMART actions under key headings of a. Education b. Pressure ulcer prevention c. Assessment and risk reduction d. Governance e. Patient experience

- Observe demonstrable progress of the action plan and provide progress reports against this plan as required.
- Identify what measures are required to sustain improvements

Measures of Success

Work in the acute setting will be focused on themes identified in our structured reviews and in the community we will be piloting a different assessment tool to further optimise risk reduction.

- A sustained decrease as intensive improvement support is withdrawn.
- Formation of a Tissue Viability Council
- A review of metrics, measures and the format in which pressure ulcers are reported at the Trust.
- Positive feedback from staff about their experience as part of a collaborative QI initiative
- Ward Managers and 'nurses in charge' to have attended refresh training by end Q3 Link nurses to have attended refresh training by end Q2 if required and to have ongoing protected time to drive quality improvement work.

DOMAIN – Patient Experience

Quality Priority

Establish a Trust-wide inclusive Patient Experience user group which represents the diverse range of patients who come into contact with our Services

Rationale

Utilising existing patient and carer participation groups, with different conditions, across the Trust to: -

- Understand the needs of patients and carers using the services
- Provide insights into how services impact on those using them
- Work with patients, as partners, to improve services and shape new developments
- Ensure patients are involved in improvement projects from the earliest stage
- Involvement in shaping the service they use
- Able to reach diverse groups of patients for ideas, feedback and suggestions – do not need to have a formal role.
- Involvement of carers through external partners
- Share good practice and raise areas of concern
- Build better working relationships with local communities, statutory and voluntary groups
- Help the Trust to communicate about services in ways that are accessible for all

Agreed Actions

How will we get there?

- Contact Clinical Chairs for each Collaborative to identify Patient and Carer Participation Groups (PCPG) which are already in existence.
- Collate a list of active PCPG groups.
- Develop a guide to planning and setting up a patient participation group.
- Patient Experience to host a PCPG conference twice a year, bringing together the groups to share the work carried out.
- Introduce Key Performance Indicators for PCPG

Measures of Success

- Formation of Patient and Carer Participation Groups across the organisation
- Create key performance indicators (KPI)

DOMAIN – Patient Experience

Quality Priority

Using always events methodology, Improve the patients' experience in the area of letters and written communication to above 90% through a 'task and finish' groups.

Rationale

It was identified through the Patient Experience Strategy Group that feedback from complaints and concerns raised by patients consistently identified communication as being one of the top themes. Concerns included;

- Telephones not being answered
- Staff attitude – administration
- Appointment letters were not standardised, did not have the correct information on them, trust logo was not routinely used
- Patient information/leaflets are irrelevant and/or past review dates
- Delays in receiving test results to the patient and GP
- Changes to mediation were not shared with the GP timely

Agreed Actions

How will we get there?

A task and finish group was formed in April 2020 to review communications with patients including;

- Written communication – appointment letters
- Telephone calls – not being answered and voice messages not returned
- Staff attitudes – administration staff
- Patient information/leaflets – information that accompanied appointment letters
- Delays in receiving test results – to the patient and GP
- Changes to Medication – changes to medication made in OPD appointments not sent timely to the GP

Measures of Success

The Task and finish group will use the finding from a recently completed review of communication relating to non-clinical issues. The identified themes and measures below will continue to be monitored through patient feedback.

Appointment letters

- Outpatient Appointment Letter Project – Reduce templates from over 2,000 down to 5-10 core templates.
- Standardised format making letters from STHNHSFT instantly recognisable and simplifying the content for ease of understanding.
- Project due to be complete end of September 2021. New templates will receive internal approval before being shared with external stakeholders prior to implementation.
- Accessible Information Standards statement to feature on all letters. Strict governance will be placed around requests for amendments or new letters being created to ensure only "live" versions are used and to prevent the Trust ending up with the same issue in the future.

Telephones

A number of initiatives were put in place to ensure that telephone calls were answered and answerphone messages were responded to, which included: -

- Providing an email address as an alternative
- Remove telephone calls from reception desks to the office,
- Ensure answerphone is on or telephone is diverted to an appropriate member of staff if on annual leave
- Role specific to answer telephone calls

The Patient Experience Team will ensure that enquirers contacting the Trust to raise concerns about telephone calls not being answered will identify the number the enquirer has been provided to ensure that the number is correct and still in use.

Staff attitude

A customer care training course was put in place in April 2020 and there is a rolling programme for all administrative staff (reception/administrative/secretarial) to attend the training.

Patient information/leaflets

The Patient Experience Team is now managing patient information, the policy is currently under review to ensure the process for the creation and reviewing of existing patient information is embedded.

Changes to medication

Where required, patients are provided with medication request forms following their OPD appointment. Currently the patient takes this request form away and is required to take this to their GP. Following the success of patient letters being emailed across to GPs instead of via

post, discussions with the CCG are taking place to trial scanning medication request forms direct to the GP. The three areas identified to trial are Dermatology, ENT and OMFS. Agreement currently being sought from GPs to commence trial.

Statements of Assurance from the Board

Review of services

During 2020/21, South Tees Hospitals NHS Foundation Trust provided and/or sub-contracted 91 relevant health services. South Tees Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care of in 91 of these relevant health services.

The income generated by the relevant health services reviewed in 2020/21 represents 87.6**%** of the total income generated from the provision of relevant health services by the South Tees Hospitals NHS Foundation Trust for 2020/21.

Participation in Clinical Audit

South Tees Hospitals NHS Foundation Trust is committed to undertaking effective clinical audit across our clinical services and recognises that this is a key element for providing high quality care. Clinical audit enhances patient care and safety, provides assurance of continuous quality improvement and developing and maintaining high quality patient-centred services. The Trust has a well-structured clinical audit programme which is regularly reviewed to ensure it reflects the needs of our acute and community services.

During 2020/21, 61 national clinical audits and 2 national confidential enquiries covered relevant health services that South Tees Hospitals NHS Foundation Trust provides.

During 2020/21, South Tees Hospitals NHS Foundation Trust participated in 89% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. (Eligibility, for the purpose of this report, is defined as those national audits that the Trust could participate in that were not suspended due to the COVID-19 pandemic).

The national clinical audits and national confidential enquiries that the South Tees Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2020/21 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry: -

Title	Eligible	Participated	% cases
Antenatal and newborn national audit protocol 2019 to 2022	✓	✓	100%
British Association of Urological Surgeons (BAUS) Urology Audit: Renal Colic Audit	✓	✓	100%
BAUS Urology Audit: Cytoreductive Radical Nephrectomy Audit	✓	✓	No eligible cases to submit
British Spine Registry	✓	✓	76%
Case Mix Programme (CMP) Also includes Cardiac Intensive Care (Intensive Care National Audit & Research Centre (ICNARC) data)	✓	✓	100%
Child Health Clinical Outcome Review Programme National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD)	✓	Data collection suspended by national team due to COVID -19	n/a
Elective Surgery - National PROMs Programme (Patient Reported Outcomes Measure)	✓	✓	Pre-op: 131.0% Post-op: 55.2%
The Falls and Fragility Fracture Audit Programme (FFFAP) The Fracture Liaison Service Audit (FLS-DB)	✓	✓	49.7%.
Falls and Fragility Fractures Audit programme (FFFAP): National Audit Inpatient Falls	✓	✓	Did not fully participate due to challenges of COVID-19 in 2020/21
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	✓	✓	100%
Infection Control Royal College of Emergency Medicine (RCEM)	✓	✓	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	✓	x	0%
Pain in children Royal College of Emergency Medicine (RCEM)	✓	✓	Ongoing
Homeless Inclusion Health - Royal College of Emergency Medicine (RCEM)	✓	Data collection suspended by national team due to COVID -19	n/a

Title	Eligible	Participated	% cases
Learning Disabilities Mortality Review Programme (LeDeR)	✓	✓	100%
Mandatory Surveillance of Healthcare Acquired Infections (HCAI)	✓	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme – National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Data collection suspended by national team due to COVID -19	n/a
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Secondary Care	✓	✓	Did not fully participate due to challenges of COVID -19 in 2020/21
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	✓	✓	Did not fully participate due to challenges of COVID-19 in 2020/21
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Secondary Care	✓	✓	62%
National Audit of Breast Cancer in Older People (NABCOP)	✓	✓	100%
National Audit of Cardiac Rehabilitation (NACR)	✓	X	0
National Audit of Care at the End of Life (NACEL) 1	✓	Data collection suspended by national team due to COVID -19	n/a
National Audit of Dementia (NAD)	✓	Data collection suspended by national team due to COVID -19	n/a

Title	Eligible	Participated	% cases
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	✓	✓	4%
National Bariatric Surgery Registry (NBSR)	✓	✓	100%
National Cardiac Arrest Audit (NCAA)	✓	✓	>95%
National Cardiac Audit Programme (NCAP) - National Adult Cardiac Surgery Audit	✓	✓	100%
National Cardiac Audit Programme (NCAP)- Myocardial Ischaemia National Audit Project MINAP	✓	✓	100%
National Cardiac Audit Programme (NCAP)- National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	✓	✓	100%
National Cardiac Audit Programme (NCAP)- National Heart Failure Audit	✓	✓	100%
National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia	✓	Data collection suspended by national team due to COVID -19	n/a
National Diabetes Audit – Adults: National Core Diabetes Audit	✓	X	0%
National Diabetes Audit – Adults: National Diabetes Foot Care Audit	✓	✓	100%
National Diabetes Audit – Adults: National Diabetes Transition	✓	Data collection suspended by national team due to COVID -19	n/a
National Diabetes Audit – Adults: National Diabetes Inpatient Audit (NaDIA) -reporting data on services in England and Wales	✓	X	Did not participate due to exceptional challenges of COVID -19 in 2020/21
National Diabetes Audit – Adults: NaDIA-Harms - reporting on diabetic inpatient harms in England	✓	X	Did not participate due to challenges of COVID-19 in 2020/21

Title	Eligible	Participated	% cases
National Diabetes Audit – Adults: National Pregnancy in Diabetes Audit	✓	✓	100%
National Early Inflammatory Arthritis Audit (NEIAA)	✓	X	Did not participate due to challenges of COVID -19 in 2020/21
National Emergency Laparotomy Audit (NELA) Year 6	✓	✓	100%
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer (NOGCA)	✓	✓	100%
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBOCA)	✓	✓	100%
National Joint Registry (NJR)	✓	✓	>95%
National Lung Cancer Audit (NLCA) 1	✓	✓	100%
National Maternity and Perinatal Audit (NMPA)	✓	✓	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	✓	✓	100%
National Ophthalmology Database Audit (NOD)	✓	✓	83.6%
National Paediatric Diabetes Audit (NPDA)	✓	✓	100%
National Prostate Cancer Audit	✓	✓	100%
National Vascular Registry	✓	✓	100%
Neurosurgical National Audit Programme	✓	✓	100%
NHS provider interventions with suspected/confirmed carbpenease producing Gram negative colonisations / infections	✓	Data collection suspended by national team due to COVID -19	n/a
Paediatric Intensive Care Audit Network (PICANet)	✓	✓	100%
Perioperative Quality Improvement Programme (PQIP)	✓	✓	Continuous
Sentinel Stroke National Audit programme (SSNAP)	✓	✓	100%
Serious Hazards of Transfusion Scheme (SHOT)	✓	✓	100%
Society for Acute Medicine Benchmarking Audit	✓	✓	100%
Surgical Site Infection Surveillance	✓	Data collection suspended by national team due to COVID -19	n/a

Title	Eligible	Participated	% cases
The Trauma Audit & Research Network (TARN)	✓	✓	100%
UK Cystic Fibrosis Registry	✓	✓	100%
UK Registry of Endocrine and Thyroid Surgery	✓	✓	100%
UK Renal Registry National Acute Kidney Injury programme	✓	✓	100%

Table 3: National Clinical Audits

The reports of 6 national clinical audits were reviewed by the provider in 2020/21 and South Tees Hospitals Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Title of Audit	Actions
National Bariatric Surgery Registry (NBSR)	Nurse specialist and dietician appointed to support data entry.
Falls and Fragility Fractures Audit programme (FFFAP): - National Hip Fracture Database	Orthopaedics has re-organised the trauma cover to an Orthopaedic Consultant of the week model.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): - Pulmonary rehabilitation	The team has adopted the new NACAP verbal consent model as our initial assessments are conducted over the telephone or video.
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Transfusion team is engaged with Trust's Electronic Patient Record (EPR) development to facilitate a bespoke electronic solution. A National Patient Information Leaflet has been issued for haemoglobinopathy patients receiving transfusion and is now in use within the Trust..
BAUS Urology Audit – Bladder Outflow Obstruction (BOO) Audit	Two new laser machines have been acquired at South Tees, and one at North Tees, where the service is also delivered. This will significantly improve capacity for Holmium Laser Enucleation of the Prostate (HoLEP, the most common procedure offered to BOO patients). Two minimally-invasive surgical treatments have been introduced with others to follow. Some patients who may have had HoLEP or TURP can now be offered these new procedures, some in an ambulatory setting. This should help reduce overall waiting time for BOO surgery.
National Prostate Cancer Audit	Practice has been changed so that MRI is now done before biopsies and we are now offering transperitoneal biopsies.

Table 4: National Clinical Audit Reports

Local Clinical Audits

The reports of local clinical audits reviewed by South Tees NHS Hospitals Foundation Trust in 2020/21 are shown below, and the Trust intends to take the following actions to improve the quality of healthcare provided.

Title of Audit	Actions
Evaluation of our practice regarding Sodium-glucose Cotransporter-2 (SGLT2) Inhibitors in patients with Type 2 Diabetes Mellitus and coronary artery disease	• Integration of SGLT 2 inhibitors into take home medication by speciality interventional cardiology nurses • Enforcement of SGLT2 inhibitors pathway in junior doctors and CCU nurses • Raise awareness of importance of SGLT2 inhibitors within consultant group
Prescribing compliance with NICE guidance for secondary prevention following bypass surgery	• Review list of medications recognised by Cardiothoracic Surgery database to ensure automatic prompts only appear when appropriate. • Agree whether reasons for not prescribing medications should have been duplicated in the 'drugs' section of the database as well as the 'instructions to GP' box. • Clarify the definition of the database question 'previous MI' to ensure accuracy and consistency.
Adapted NHS Protect Audit	• Pharmacy team feed results back to individual wards and teams to facilitate change / improvement in practice • The implementation of Omnicell drug cabinets continues as per the roll out plan. • This audit has been reviewed and will be added to the Trust's Meridian audit system, to allow easier monitoring and live feedback to individual ward areas and facilitate local improvements.
Controlled Drugs	• The implementation of Omnicell drug cabinets continues as per the roll out plan. • A Medication safety event was held in February based on "Controlled drugs" to raise awareness around areas such as prescribing / storage / registers which have been identified as issues by the audit. • This audit has been reviewed and will be added to the Trust's Meridian audit system, to allow easier monitoring and live feedback to individual ward areas and facilitate local improvements.
Medication Omitted	• Medicines Reconciliation training day put in place for Band 4

Doses – high risk medicines	technicians to increase the number of staff able to identify omitted doses. • A medicine safety week targeting doctors and prescribing took place from 26/04/21 and should improve paperwork and allow easier identification of omitted doses. • This audit has been reviewed and will be added to the Trust's Meridian audit system, to allow easier monitoring and live feedback to individual ward areas and facilitate local improvements.
Medicines Reconciliation	• A Medicines Reconciliation training day put in place for Band 4 technicians to increase the number of staff available to conduct Medicines Reconciliation. • This audit has been reviewed and will be added to the Trust's Meridian audit system, to allow easier monitoring and live feedback to individual ward areas and facilitate local improvements.
Compliance to Sepsis 6	• 1 Whole Time Equivalent (WTE) Band 6 approved Recruitment to post in progress • Frequent live observation and monthly audit reports facilitated by Senior Clinical Educator • Educational package and resources to upload to intranet
How effective is the Rheumatology Ambulatory Care Unit (RACU)	• To improve and streamline the administration of RACU o Centralise the RACU booking system to one consultant / secretary o Log the RACU slots so that a record is available that referral has been received and actioned. o Develop RACU planner available on rheumatology shared drive • To improve the consultant support to the SpR o SpR slot to be supported by on-call consultant for the week; to ensure SpR and consultant are aware of this.
Quality of information and surgical consent in patients with a diagnosis of malignant melanoma	• Organise results patients into earlier appointments at the One Life Centre so that samples can be sent same day. Seek HCA support as required to reduce workload of Clinical Nurse Specialists and alleviate delays in clinic. • Already implemented that HCA support available at JCUH and FHN. • Extra clinic slots opened at One Life Centre. • Tracking spreadsheet used to monitor results/action.
Audit on patient awareness of importance of effective contraception while on Methotrexate, Mycophenolate and Leflunomide	• Introducing robust consent forms would enable improved and systematic counselling by monitoring clinic nurses • The Consent forms have a checkbox for counselling regarding specific topics like infection risk, pregnancy etc. were patients initial as part of documentation to improve evidence of counselling against pregnancy while on teratogenic disease-modifying antirheumatic drugs (DMARDs).

	• AR UK leaflet is available for health care professionals to issue to patients. • Laminated MHRA guidance sheet on effective forms of contraception has been made available to monitoring clinic nurse to inform patients during counselling.
History taking, classification and documentation of penicillin allergy	• Improvement in documentation of penicillin allergy • Increased use of penicillin test doses in selected patients
Vertebral Fractures	• Pathway agreed for all lumbar and thoracic x-rays for patients within service criteria to be identified to the service for vertebral fractures to be identified. • Added an identifiable code / phrase to limit the amount of x-rays that are required to be reviewed.
Intravenous Antibiotic (IVAB) Audit	• Referrals from the Respiratory team are of a higher standard than those from the general wards – patients are always discharged with the correct equipment, medication, diluents and drug administration form – however 1 patient did not have a referral form in their notes but there was a detailed conversation documented. • Referrals from the General wards have been discharged without the correct equipment, medication, diluents and there are problems with the referral form more frequently. • If there is a problem with a line – blockage / leakage etc., systems are now in place for access to the Outpatient Parental Antibiotic Therapy Department (OPAT)
Audit of post falls management on the Older People's Medicine ward	• Design and implement new post-falls assessment proforma that includes a multi-professional review involving both doctors and nurses
Preventing infections in immunosuppressed patients	• Each specialty to appoint lead to review infection risk screening.
Managing blood glucose in COVID patients started on Dexamethasone in the non-critical setting	• Education launched about the importance of monitoring and managing hyperglycaemia in the context of COVID patients started on dexamethasone • Simple flowchart derived from the guidance for ease of management
Consenting for COVID- 19 related risks in neurosurgery	• Introduce the team to British Association of Spine Surgeons (BASS) information leaflet • Up-to-date stickers in use for spinal procedures • Design a poster to remind to consent for COVID-19 risks and leave on the wall in the ward where we keep consent forms and one in Out Patient clinic
An audit assessing	• Education and training in use of quantitative neuromuscular

intra-operative neuromuscular blockage monitoring and reversal, and postoperative residual neuromuscular blockade in post-anaesthesia recovery	blockade monitors (currently available in every theatre at JCUH) • Introduction of guidelines for monitoring of neuromuscular blockade intraoperatively with neuromuscular blockade monitor and use of reversal agents for reversal of neuromuscular blockade if required. • Encourage improved documentation of neuromuscular blockade monitor use and reversal agent use on anaesthetic chart
Audit of Vascular Admissions documentation	• Trial the use of a proforma as a cost-effective tool in standardising surgical admission documentation, and to re-audit the quality of surgical admission documentation 4 weeks following implementation of the proforma.

Table 5: Local Clinical Audit Reports

Getting it Right First Time Programme (GIRFT)

Getting It Right First Time (GIRFT) is an NHS improvement programme delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis. The GIRFT team visit every Trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

During 2020/21 six virtual GIRFT deep dives have been undertaken and include cranial neurosurgery, lung cancer, plastic, burns and hand surgery, oral MFS, paediatric orthopaedics (trauma and elective) and neurology. Further deep dives are planned for 2021/22.

Observation notes have been received identifying recommendations for improvement as well as notable good practice for each of the teams. Workforce issues for respiratory consultants and the shortfall in lung cancer specialist nurses in particular correspond with the compliance issues noted within the SDIP. The general quality of coding was also highlighted as an area for improvement across all teams.

Several services have met with the regional GIRFT implementation managers with the support of the quality assurance manager to report on progress following deep dive visits enabling them to

update their implementation plans and seek further support as required. Robust collaboration between GIRFT and the trust means that the organisation is no longer seen as a "challenge trust" by the GIRFT regional hub.

The Quality Surveillance & GIRFT Lead role has been structured into the Patient Safety & Quality Directorate and a Quality Assurance & Reporting Facilitator recruited into post to enhance the surveillance portfolio in meeting the national surveillance agendas.

The table below provides an outline of the Trust's participation in the GIRFT programme: -

Specialty	Initial Visit	Re-Visit	Future Proposed Visit/Re-visit 2020/21
Acute & General Medicine	23/09/2019		
Anaesthetic & Perioperative Medicine	19/12/2018		
Breast Surgery			**To be arranged**
Cardiology	25/09/2019		
Cardiothoracic Surgery	31/08/2017		
Cranial Neurosurgery	29/09/2016	**31/07/2020**	
Dermatology	27/03/2019		
Diabetes			
Emergency Medicine	**11/05/2021**		
Endocrinology	18/10/2019		
ENT	08/01/2018		
Gastroenterology	30/08/2019		
General Surgery	03/12/2018		
Geriatric Medicine	Did not participate		**Awaiting dates from GIRFT**
Hospital Dentistry	03/07/2019		
Intensive & Critical Care	18/07/2018		
Lung Cancer	**28/09/2020**		

Specialty	Initial Visit	Re-Visit	Future Proposed Visit/Re-visit 2020/21
Mental Health CAMHS			
Neonatology			**To be arranged**
Neurology	15/05/2019	**22/01/2021**	
Obstetrics & Gynaecology	17/07/2017		
Oral MFS			**05/08/2021**
Ophthalmology	10/05/2017		
Orthopaedic Surgery Orthopaedic Trauma Surgery	31/01/2014 **20/10/2020**	01/10/2018	
Outpatients			
Paediatric Critical Care	**10/06/2021 Joint - North of England Network ODN**		
Paediatric Gen Surgery	01/02/2018		
Paediatric Orthopaedics (Trauma & Elective)			To be arranged
Pathology			**To be arranged September 2021**
Plastics/Burns/Hand Surgery	**05/10/2020**		
Radiology	11/03/2019		
Renal	06/03/2019		
Respiratory			**To be arranged**
Rheumatology			
Spinal Surgery	05/07/2017		
Stroke	15/03/2019		
*Surgical Site Infection Audit	2017/2018	May-Oct 2019	
Urology Surgery	15/03/2017		**Revisit date to be arranged**
Vascular Surgery	05/10/2016	12/10/2018	

Table 6: GIRFT Programme

*Surgical site infection (SSI) is an important area of focus for GIRFT. Post-surgery infections can cause significant harm to patients and result in increased hospital stay, readmissions and re-operations. They are also a significant cost to the NHS. Participating in the survey is an opportunity

to better understand our trust's SSI rates, to review and improve local practice, and to report on this to the Trust Management and Board.

Communication is a vital part of ensuring GIRFT's successes within the organisation. By having a clear vision of the benefits that GIRFT can bring into the Trust, engaging staff through communicating that vision, and ensuring that the processes are designed in a way that is not burdensome for the clinicians, the Trust is able to fully embrace GIRFT as a key enabler towards delivering a cycle of continuous improvement for its patients.

The Trust already has a well-established internal annual Quality Surveillance Programme (QSP) comprising of 74 specialised services (including sub-services). As future GIRFT programmes are beginning to align to NHS England and NHS Improvement to capture both provider and clinical insights, it has become evident that both programmes should be affiliated to a central in-house repository. There are therefore plans in place to ensure the inputs and outputs of the GIRFT programme will, as far as possible be integrated within these existing programmes of work.

Annual Quality Surveillance Programme

As part of the Quality Assurance and Improvement Framework (QAIF) all specialised services including cancer are subject to the quality surveillance process.

Due to the COVID-19 pandemic annual self-declarations for 2020/21 were paused and remain paused for 2021/22. The current position is as follows:

- The annual self-declaration process for 2021/22 will not take place during 2021/22. Therefore, the Quality Surveillance Information System (QSIS) portal will not open for submissions on 1 April 2021.
- Specialised and cancer peer-review routine programme visits for 2021/22 will remain paused. This position may be reviewed in June 2021.
- Highly specialised services will be required to submit their annual outcome data for 2020/21 through the Specialised Services Quality Dashboards (SSQD). Therefore, the portal will open on 29 April 2021 to allow data to be submitted alongside Q4 2020/21 data.
- The SSQD submission process will continue on a voluntary basis. Governance around approvals for submission will remain relaxed and there will be no requirement for a second approval to submit data. This position will be reviewed in June 2021.

The Trust is required to complete annual self-declarations against a set of clinical quality indicators where information is not available through existing data sources. The declarations are a statement of compliance endorsed by the Chief Executive (or delegated authority) and are submitted through the Quality Surveillance Information System (QSIS) web portal. The submission deadline is set to 30 June every year.

There are a total of 74 specialised services on the South Tees Hospitals NHS Foundation Trust's directory of services. As well as submitting self-declarations each year, some of these services are also required to submit data as part of the (SSQD). Previously QSIS was separated from the SSQD platform – now all information can be accessed in one place on QSIS.

Annual Assessment Outcomes

In total 73 specialised services were required to undertake the self-declaration process throughout 2020/21, and the annual assessments were notified to the Trust in January 2020. Options were derived following the completion of the annual assessment process which included commissioner review of the Trust's self-declarations and other quality information including SSQD alerts, CQC reports, Healthcare Quality Improvement Partnership (HQIP) audits and other relevant national clinical audit flags.

The annual assessment outcomes will be used by regional commissioning teams to monitor the quality of service delivery and compliance with NHS England/Improvement's service specifications.

The table below details all specialised services annual assessment outcomes. The options for surveillance are summarised as follows:-

Option 1 – ROUTINE Surveillance:

Annual assessment has confirmed that the service is either 100% compliant with no risks identified or services that have not reached 100% compliance, but the regional teams have determined that this is not a material issue.

Option 2 – ENHANCED surveillance:

Provider Action – where it is agreed the non-compliance is amenable to a short-term action plan (6 months), the Trust will be required to submit a Service Development Plan (SDIP). This will be specified within the contract and monitored via contractual processes.

a) **Commissioner Action –** where it is identified that the non-compliance is not amenable to a short-term action plan, the commissioner will notify the Trust, within 6 months of the discussion, of the action that they intend to take to ensure a sustainable compliant service in the future.

b) **Provider and Commissioner Action –** where it is determined that the non-compliance in one service is amenable to both a short-term and longer-term action plan.

There are **37** services under **routine** surveillance and a further **36** services under **enhanced** surveillance, 23 for provider action, 10 for commissioner action and 3 for both provider and commissioner action; these are demonstrated in Table 9.

Services Routine Surveillance	Services Enhanced Surveillance
Acute Kidney Injury (Adult)	Adult Critical Care: Cardiac Intensive Care Unit (JCUH) ***Commissioner action***
Assessment and Preparation for Renal Replacement Therapy including establishing dialysis access)	Adult Critical Care: General Critical Care Unit (JCUH) – ***Commissioner action***
Cancer Anal (Adult)	Cancer Brain and Central Nervous System: Brain and other rare brain tumours –***Provider action***
Generic Brain (CNS)	Cancer Brain and Central Nervous System: Non-surgical – ***Provider action***
Cancer Gynaecological: Local Gynae Team (Diagnostic Service)	Cancer Brain and Central Nervous System: Pituitary – ***Provider action***
Cancer Skin (Adult)	Cancer Brain and Central Nervous System: Spinal – ***Provider action***
Cancer Chemotherapy Adult: Chemotherapy ITC	Cancer Gynaecological: Specialist Gynaecology Team – ***Provider action***
Cancer Services for Teenagers & Young Adults: TYA Designated Hospital at JCUH	Cancer Head & Neck (Adult): Local Head & Neck Support Teams – ***Commissioner and Provider action***
Cancer Unknown Primary	Cancer Head & Neck (Adult): Specialist Head & Neck Team – ***Provider action***
Cardiology: Cardiac Magnetic Resonance Imaging (Adult)	Cancer Head & Neck (Adult): Specialist Thyroid Team – ***Provider action***
Cardiology: Electrophysiology and Ablation Services (Adult)	Cancer Oesophageal & Gastric (Adult): Specialist Upper GI Team – ***Provider action***
Cardiology: Implantable Cardioverter Defibrillator and Cardiac Resynchronisation Therapy (Adult)	Cancer Specialised Kidney, Bladder & Prostate (Adult) – ***Provider action***

Services Routine Surveillance	Services Enhanced Surveillance
Cardiology: Primary Percutaneous Coronary Intervention (Adult)	Cancer: Kidney Service – ***Provider action***
Colorectal: Complex Inflammatory Bowel Disease	Cancer Chemotherapy Adult: Chemotherapy Higher Intensity – ***Provider action***
Colorectal: Faecal Incontinence (Adult)	Cancer Chemotherapy Adult: Clinical Chemotherapy – ***Provider action***
Complex Gynaecology: Recurrent Prolapse and Urinary Incontinence	Cancer Services for Teenagers & Young Adults: TYA Designated Hospital at the Friarage – ***Commissioner action***
Complex Gynaecology: Severe Endometriosis	Cancer Acute Oncology Service – ***Commissioner and Provider action***
Complex Gynaecology: Urogenital Anorectal Conditions	Cardiac Surgery (Adult) – ***Provider action***
Cystic Fibrosis	Cardiology: Inherited Cardiac Conditions (All Ages) – ***Provider action***
Haemato-oncology	Complex Disability Equipment – Prosthetics (All Ages) – ***Provider action***
Implantable Hearing Aids for Microtia, Bone Anchored hearing Aids and Middle Ear Implants (All Ages)	Complex Spinal Surgery (All Ages) – ***Provider action***
In Centre Haemodialysis	Ear Surgery: Cochlear Implants (All Ages) – ***Commissioner action***
Local Breast Cancer Team	External Beam Radiotherapy Services delivered as part of a Radiotherapy Network (Adult) – Provider action
Local Colorectal Services (Colorectal Cancer MDT)	Haemodialysis to treat established renal failure in the home – ***Provider action***
Neonatal Critical Care	Local Lung Cancer Team – ***Commissioner and Provider action***
Neurosciences: Specialised Neurology (Adult)	Major Trauma (Adult) – ***Commissioner action***
Neurosurgery (Adult)	Major Trauma (Children) – ***Commissioner action***
Paediatric High Dependency Care	Neuro-interventional Services for Acute Ischaemic & Haemorrhagic Stroke – ***Commissioner action***
Specialised Endocrinology Service (Adult)	Paediatric Intensive Care – ***Commissioner action***
Specialised HIV Services (Adult)	Paediatric Medicine Endocrinology and Diabetes – ***Provider action***
Specialised Immunology (All Ages)	Paediatric Surgery (& Surgical Pathology, Anaesthesia & Pain) – ***Provider action***
Specialised Ophthalmology (Adult)	Peritoneal Dialysis to treat Established Renal Failure – ***Provider action***

Specialised Ophthalmology (Paediatrics)	Skull Base Service – ***Provider action***

Services Routine Surveillance	Services Enhanced Surveillance
Specialised Orthopaedics (Adult)	Specialised Burn Care (All Ages) – ***Commissioner action***
Specialised Services for Infection Diseases (Adult)	Specialised Services for Haemoglobinopathy Care (All Ages) – ***Commissioner action***
Spinal Cord Injuries (All Ages)	Specialised Vascular Service (Adult): Arterial – ***Provider action***
Thoracic Surgery (Adult)	

Table 7: Services under Surveillance

Specialised Services Quality Dashboards (SSQD)

The SSQDs are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. SSQDs are a key tool in monitoring the quality of services, enabling comparison between service providers and supporting improvements over time in the outcomes of services commissioned by NHS England. For each SSQD, there is a list of agreed measures for which data is to be collected. These measures are included in a "metric definition set". The information provided by the SSQDs is used by NHS England specialised services commissioners to understand the quality and outcomes of services and reasons for excellent performance.

The table below lists the Trust specialised services that required submission of data against a set of metrics for 2020/21:-

Specialised Service	*Internal/External Source Requirements	Comments
Adult Critical Care: • General Critical Care • Cardiac Intensive Care	External Source Data (Intensive Care and National Audit & Research Centre (ICNARC) Required quarterly	Populated via ICNARC and validated by Trust
Cancer Chemotherapy (Adult)	External and Provider data Required quarterly	New requirement from Q2 2020/21 only

Specialised Service	*Internal/External Source Requirements	Comments
Cancer Malignant Mesothelioma	Provider data Required quarterly	New requirement for 2020/21 Provider data populated and validated by Trust
Cardiac Surgery	External Source Data (Hospital Episode Statistics (HES) Required quarterly	Data populated from external source and validated by Trust
Cardiology: • Cardiac Magnetic Resonance Imaging (Adult) • Electrophysiology & Ablation Services • Implantable Cardioverter Defibrillator and Cardiac Resynchronisation Therapy (Adult) • Primary Percutaneous Coronary Intervention (Adult)	Provider data Required quarterly **External source data** Required quarterly Provider data Required quarterly Provider data Required quarterly	New requirement for 2019/2020 Provider data populated and validated by Trust Data populated from external source and validated by Trust Provider data populated and validated by Trust Provider data populated and validated by Trust
Colorectal: • Faecal Incontinence (Adult)	Provider data Required quarterly	Provider data populated and validated by Trust
Complex Disability Equipment – Prosthetics (All Ages)	Provider data Required quarterly	Provider data populated and validated by Trust
Cystic Fibrosis (Children)	Provider and external source data requirement quarterly	Provider data populated and validated by Trust
External Beam Radiotherapy Services Delivered as part of Radiotherapy Network	External Source Data (Public Health England (PHE) Required quarterly	Data populated from external source and validated by Trust (with provider data required for Q4)
Hepatobiliary and Pancreas – Cirrhosis of the Liver (Adults)	External Source Data (HES) Required quarterly	Data populated from external source and validated by Trust
Implantable Hearing Aids for Microtia, Bone Anchored Hearing Aids and Middle Ear Implants (All Ages)	Provider data Required quarterly	Provider data populated and validated by Trust

Specialised Service	*Internal/External Source Requirements	Comments
In Centre Haemodialysis (ICHD)	External Source Data (Renal Registry) Required quarterly	Data populated from external source and validated by Trust
Neonatal Critical Care	External Source Data (Clevermed) Required quarterly	Data populated from external source and validated by Trust
Neuro-interventional Services for Acute Ischaemic & Haemorrhagic Stroke	External Source Data (Sentinel Stroke National Clinical Audit Programme (SSNAP) Annual requirement	Data populated from external source and validated by Trust. To be submitted in Q3 only
Specialised Complex Surgery for Urinary Incontinence and Vaginal and Uterine Prolapse (16 years and above)	Provider data Required quarterly	New requirement for 2020/21 Provider data populated and validated by Trust
Specialised Burn Care: • Adults • Paediatrics	External Source Data (IBID) Required quarterly	Data populated from external source and validated by Trust
Specialised Endocrinology Services (Adult)	Provider data Required quarterly	Provider data populated and validated by Trust
Specialised Human Immunodeficiency Virus (HIV) Services (Adult)	External Source Data (PHE HARS) Required annually	Data populated from external source and validated by Trust. Annual submission in Q3
Specialised Immunology (All Ages)	External Source Data (MDAS) Required quarterly	Data populated from external source and validated by Trust
Specialised Kidney, bladder and prostate Cancer Services (Adult)	Provider data Required quarterly	Provider data populated and validated by Trust
Specialised Vascular Services (Adult): Arterial	Provider data Required quarterly	Data not yet submitted by the Trust for 2019/2020
Spinal Cord Injuries (All ages)	External Source Data (NSCID) Rolling annual requirement/quarterly	Provider data required only for Q1 to meet rolling year requirement
Thoracic Surgery (Adult)	Provider data	New requirement for 2019/2020 Provider data populated and validated by Trust

Table 8: Specialised Services

*Data is either pulled directly from a national data source or is submitted by the Trust

Annual Quality Surveillance Programme

The Trust has continued to streamline its approach in delivering NHS England's national annual quality surveillance programme, and over the last 18 months to incorporate GIRFT improvement programme in order to align its national and local quality surveillance information.

In more recent months the process for the local management of compliance and regulatory visits, inspections and accreditations has been reviewed and re-launched to finalise the last in a series of measures to bring quality surveillance activity into one robust arena for monitoring and reporting through the trust's governance structures in line with the national agendas.

As part of the Quality Assurance and Improvement Framework (QAIF) all specialised services including cancer are subject to the quality surveillance process.

The Trust is required to complete annual self-declarations against a set of clinical quality indicators where information is not available through existing data sources. The declarations are a statement of compliance endorsed by the Chief Executive (or delegated authority) and are submitted through the QSIS web portal. The submission deadline is set to 30 June every year.

Developments such as the introduction of new reporting processes for specialised services under enhanced surveillance in the form of a quarterly SDIP and SSQD outlier alerts reports are now well embedded into the trust's quality reporting structure with good clinical engagement and adherence to reporting schedules.

There are a total of 74 specialised services on the South Tees Hospitals NHS Foundation Trust's directory of services. As well as submitting self-declarations each year, some of these services are also required to submit data as part of the SSQD. Previously QSIS was separated from the SSQD platform – now all information can be accessed in one place on QSIS.

Annual Assessment Outcomes

At the end of February NHS England announced to acute service providers that:

- The annual self-declaration process for 2021/22 will not take place during 2021/22. Therefore, the Quality Surveillance Information System (QSIS) portal will not open for submissions on 1 April 2021.

- Specialised and cancer peer-review routine programme visits for 2021/22 will remain paused. This position may be reviewed in June 2021.

- Highly specialised services will be required to submit their annual outcome data for 2020/21 through the SSQDs. Therefore, the portal will open on 29 April 2021 to allow data to be submitted alongside Q4 2020/21 data.

- The SSQD submission process will continue on a voluntary basis. Governance around approvals for submission will remain relaxed and there will be no requirement for a second approval to submit data. This position will be reviewed in June 2021.

Clinical Research

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

The Trust's active engagement in research is reflected by the high number of research studies being undertaken. The number of patients receiving relevant health services provided or sub-contracted by South Tees Hospitals NHS Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee is 4613. This number does not include participants recruited into the NOVAVAX COVID vaccine trial at University Hospital of Hartlepool, which was delivered by R&D staff from across the whole Durham Tees Valley Research Alliance (DTVRA) including South Tees Hospitals NHS FT.

In 2019/20 the Trust recruited 3196 patients enrolled in 162 different research studies. While the number of recruits decreased by 14% from the previous year, the year-on-year fall was less than the overall 40% fall experienced by the NHS Trusts across the North East and North Cumbria region.

The Trust routinely met the NIHR (National Institute for Health Research) target deadlines (40 days from receiving a complete research application) for setting up new trials to help ensure that there

are minimal avoidable delays to research activity and income. The Trust also provided prioritised and expedited the set-up and delivery of 'Urgent Public Health' badged Covid-19 research studies.

The Trust continued its formal research alliance with two other NHS Trusts (North Tees and Hartlepool Hospitals NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust) in order to increase patient opportunities to participate in research known as the Durham Tees Valley Research Alliance (DTVRA). This restructure created a streamlined management tier and a single combined research study set-up team designed to help ensure that research study opportunities are shared across all 3 Trusts and fully utilised.

The Trust continues to successfully deliver major NIHR grant-funded trials and this year was awarded 2 NIHR grants, an Innovate UK grant and other commercial and charity research grants.

Patient Engagement

We routinely appoint patient representatives to the steering committees of our NIHR grant funded studies and carry out other patient and public involvement activity for individual trials, for instance focus group sessions. Feedback from patients who have participated in NIHR studies within the trust is sought via the NIHR "Patient Research Experience Survey" with feedback reviewed at our monthly R&D Directorate meetings.

Goals Agreed with Commissioners – use of the CQUIN Payment Framework

During 2020/21 block payments were made to NHS Providers and were deemed to include CQUIN, there were no separate CQUIN schemes nor was there a separate allocation of funding.

Care Quality Commission (CQC) Compliance

1. Background

In July 2019 South Tees NHS Hospitals Foundation Trust received a report from the CQC following an inspection in January and February 2019. The Trust received an overall rating of 'requires improvement' and the report contained 26 'must do' recommendations and 22 'should do recommendations. A detailed action plan was developed for all recommendations and submitted to CQC.

Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Delivery of the action plan is overseen by a small group of senior leaders who meet frequently as a Huddle Group to review and challenge sources of evidence.

Regular updates are provided to the Senior Leadership Team, via the Interim Director of Clinical Development. The huddle focusses on ensuring there are effective ongoing assurance mechanisms in order to translate the action plan into business as usual. The priorities are to ensure effective Trust-wide monitoring is in place for all actions and to be assured that where a concern has been identified in one core service, it would not be the case elsewhere in the trust.

A 'next steps' plan has been shared with the Trust Board. This along with a new meetings structure to QAC will provide the necessary governance and assurance to the CPG/SLT and the QAC going forward.

Progress

There are a total of 164 detailed actions which were devised from the original 49 must and should do requirements.

A number of these detailed actions were repeated for different areas/ specialities and these were subsequently merged onto 1 overarching trust-wide action 2.4 – "Ensure all Serious Incidents are reported within 48 hours from May 2019". This gives an overall total of 153 individual detailed actions (actions 2.4 (Trust-wide), 49.4 (Critical care), 66.3 (Diagnostic imaging) & 79.3 (Medicine (including older people) were merged).

The tables below show the number of actions that have been completed and the number of actions rated red due to either, action not being completed by the required time, or lack of evidence to demonstrate that the action has been completed: -

All 153 detailed actions

Overview	
4	Off track
42	Expected to deliver actions
106	Completed actions
1	Embedded in practice

The actions have also been separated into the 'must do' actions and the 'should do' actions and the actions that have a financial implication.

Must Do Actions

Overview – Must Do's	
1	Off track
23	Expected to deliver actions
24	Completed actions
1	Embedding in practice

Of the 49 overall actions, 1 Must do action is currently rated red.

- The off track action relates to staff training compliance in respect of mandatory training with the trust's current rate as of April 2021 being 84.32%. The target of 90% is challenging and higher than many trusts. ESR project has been completed and all core 11 mandatory training packages are now available on ESR.
- The Workforce Team have an ongoing training programme, which includes drop in clinics, attending collaborative meetings and operating a call support system
- Any member of staff who is identified as not accessing ESR for a period time will be contacted by the Workforce Team and offered support.

Work is continuing to ensure the action plan is fully implemented.

In addition CQC preparation is underway to ensure that the trust is prepared for the next CQC inspection though as yet no date for this has been arranged and the actions agreed have been signed off by the Trust Board.

Quality Assurance Framework

NHS England and NHS Improvement (NHSE/I) have highlighted organisations that are excelling at ward accreditation. When used effectively ward accreditation can drive continuous improvement in standards and increase patient and staff experience. The South Tees Accreditation for Quality of Care (STAQC) is a methodology that has been developed and the CQC key Lines of Enquiry are embedded in the methodology.

Well Led Review

In December 2019 the Board of Directors undertook a self-assessment exercise against the well led KLOE and an overall rating of "requires improvement" was identified. The output of this exercise and assessment was that that a Board level and owned action plan was developed to address the gaps identified and to move the overall assessment of requires improvement to good.

The action plan was further updated for Board in January, July and September 2020 and the overall action plan incorporated into the Trust wide CQC action plan for improvement.

The Board has received previous reports on preparing for a CQC inspection. This included a timetable for carrying out a number of activities including a well led assessment at a number of levels in the Trust. This would seem an appropriate time to do the Board level well led assessment due to a number of factors:

- Changes to the membership of the Trust Board, including a newly appointed Non-Executive Directors and Executive Directors,
- Emphasis on partnership working within the wider ICP/ICS and joint working with NTHT.
- Appointment of an interim joint Chair and soon to be appointed substantive joint Chair.
- The importance of robust corporate governance within new organisational structures and collaboratives.
- The importance of leadership development and its impact on improving care.
- The effective delivery of the annual work programme, strategic objectives and vision.

It is proposed that the Board of Directors self-assessment is undertaken on 3 August 2021 at the Board development day. The session will be facilitated and will focus on reviewing the key lines of enquiry for well led and agreeing the level of assurance and overall rating for well led.

Recognising this is only one level of assessment, CPG / SLT will also undertake a self-assessment which will be carried out in July and as identified above, the Collaboratives are currently carrying out self-assessments against all key lines of enquiry and the information from these self-assessments will be fed in to the overall assessment when all parties have completed the exercise. This will result in three different levels of action plans for the well led line of enquiry.

Moving to Good

The Trust has signed up to the 'Moving to Good' Programme which is offered and facilitated by NHSE/I. Senior representatives of the trust attended the first workshop on the 30th October 2019 in Leeds. Through participation of this programme, the trust, along with 10 other trusts, will receive bespoke support from NHSI/E, whilst also being partnered with a similar organisation which has been rated as either good or outstanding.

The programme is an expert-led, practically focussed series of workshops on specific topics including:

- Culture
- Governance
- Quality improvement
- Staff engagement

The programme offers:

- On-site support for boards and senior leaders, including access to supporting documentation
- An opportunity to pair with other trusts in the region
- Focussed project on safety, with training on QI and action learning sets
- Interactive learning and talks
- Dedicated regional programme team and access to on-going support

Whilst the 'moving to good' programme has been suspended during COVID 19, work continues throughout the Trust to progress the areas identified as part of the programme, including the safety

project. The patient safety faculty was set up in November 2020 and its purpose is to develop safe practice to lead and co-lead the organisation around 5 main themes:

- Floor to Board Governance
- Organisational Learning
- Education
- Process and policy
- Cultural change

The patient safety faculty will link closely with the clinical policy group who will be the driving force of the learning behind the outcomes of the above themes linking NHS Quest, Patient safety Faculty, CSU (Clinical Support Unit), STRIVE, CQC and STAQC (ward accreditation scheme) together.

System Engagement

Engagement meetings continue to take place between the Trust and the CQC as well as focused meetings on specific areas including how the trust manages discharges and pressure ulcers.

Ward Accreditation

NHS England and NHS Improvement (NHSE/I) have highlighted organisations that are excelling at ward accreditation. When used effectively ward accreditation can drive continuous improvement in standards and increase patient and staff experience.

The STAQC programme has been aligned with the CQC fundamental standards (key lines of enquiry), the integrated performance report and the Trust's objectives. STAQC provides a mechanism and process to drive and support the Trust's ambition of 'Getting Back to our Best'. Wards and departments are assessed against multiple standards grouped under the following four headings:

- Culture of compassionate care
- Well led
- Avoidable harm
- Effective care

On 25th January 2021 the accreditation team awarded Redcar Urgent Treatment Centre full 'diamond level' STAQC accreditation. This outcome was decided by reviewing multiple data sets, feedback following a visual inspection and observations of the department alongside data and feedback gathered in the previous 6 months.

Ward 32 received Diamond Accreditation in March 2021.

A number of further wards and departments are making good progress with their self-assessment, QI work and evidence portfolios.

STAQC is instrumental to the Trust's approach to quality and patient safety and our preparation for CQC's next inspection of the Trust.

NHS number and general medical practice code validity

South Tees Hospitals NHS Foundation Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES which are included in the latest published data.

The percentage of records in the latest published data for February 21 data which:

Included the patient's valid NHS number was:

- 95.1% for admitted patient care;
- 100% for outpatient care; and
- 99.6% for accident and emergency care.

Included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

Data Security & Protection Toolkit compliance

Information Governance is assessed as part of the annual national process of submitting compliance with the NHS Data Security and Protection Toolkit (DSPT), which is based upon the National Data Guardians 10 Data Security Standards. The content of the DSP Toolkit is aimed at providing assurance around technical aspects of cyber security, information security and data protection compliance.

Unlike the older IG Toolkits 3 tiered system, the 2020/21 DSPT submission is assessed against compliance with 42 assertion areas which are comprised of over 130 pieces of evidence, 110 of these are mandatory.

Due to the impact of COVID-19 the submission dates have been moved to the 30th June 2021. The Trust maintains an action plan regarding compliance which is monitored at the bi-monthly Information Governance Steering Group and reported to the Trusts Senior Information Risk Owner (SIRO) as well as being reviewed by the annual DSPT Internal audit review – the findings of which are monitored and discussed at the Trusts Audit and Risk Committee.

Last year's submission (2019/20) was confirmed as "Standards Not Met – Plan Agreed" with 4 outstanding items of the 110 requirements – although compliance was not ultimately achieved during the year (and these areas remain non-compliant in the 2020/21 submission) the plan was regularly updated and submitted to NHS Digital.

Currently 102 of the 110 requirements have been met and the action plan will be submitted to NHS digital to update the trusts compliance which will be "Standards Not Fully Met - Plan Agreed". Information on the final submission due in June 2021 will be included in next year's Quality Accounts.

Clinical coding

South Tees Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2020/21 by the Audit Commission.

Learning from Deaths

During 2020/21, 2,032 patients of South Tees Hospitals NHS Foundation Trust died. This comprised the number of deaths which occurred in each quarter of that reporting period:

518 in the first quarter;

388 in the second quarter;

526 in the third quarter;

600 in the fourth quarter.

By 31st March 2021, 1,968 case record reviews and 27 investigations have been carried out in relation to 2,032 deaths above.

In 27 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

5 in the first quarter;

8 in the second quarter;

6 in the third quarter;

8 in the fourth quarter*

*This figure is accurate at the time of this report and the low number for Q4 relates to timely provision of notes to the Medical Examiner (ME) Service. Since there has usually been an incident reported and an investigation, the patient case notes are usually in high demand across several parts of the organisation and therefore the review cannot be carried out until these have been received.

There were no deaths, representing 0% of the patient deaths during the reporting period, that were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: -

0 representing 0% for the first quarter;

0, representing 0% for the second quarter;

0, representing 0% for the third quarter;

0, representing 0% for the fourth quarter.

These numbers have been estimated using an adapted version of the Preventable Incident, Survival and Mortality Study (PRISM) methodology. The Trust established a Medical Examiner Service in May 2018. Approximately 96% of deaths (those not referred for Coronial investigation) are scrutinised by Medical Examiners. Anywhere there may be a problem in care (or meet specific criteria) is reviewed by a central team led by Respiratory medicine and Renal consultants. Each review results in 2 grades, one for quality of care and one for preventability of the death.

240 case record reviews and 24 investigations were completed after 31/03/2020 which related to deaths which took place before the start of the reporting period.

Deaths are reviewed by a central team led by Respiratory and Renal Consultants. Each review results in two grades, one for quality of care and one for preventability of the death.

Staff who 'Speak Up' (Including Whistleblowers)

As part of the adoption of the new model, significant investment was made in FTSU. The ultimate goal of this investment was to help to continue to change and improve the culture across the organisation. Senior leaders, the Board, Chair and Chief Executive have been proactive in both ensuring the service was strengthened and that the Guardians had access to senior leaders whenever needed.

Following an open recruitment and selection process, a team of four Guardians were appointed with ring-fenced time dedicated to raising awareness of FTSU and dealing with issues raised. In the last nine months this new model has seen a significant shift in both the way the model was implemented and the views of the 9,300 colleagues the Guardians work with.

The increased visibility, awareness and accessibility to the Guardians and their increased profile has assisted the Trust to answer concerns raised in a timely manner. This has been met with positive outcomes recorded for the majority of concerns raised.

A wide range of data is collected by the FTSU Guardians. The information collected and collated in the last 12 months reflects the significant positive impact the new model for speaking up has had for staff and patients between April 2020 and March 2021.

A total of 62 issues were raised with the FTSU Guardians during this time period, compared to 25 reported during 2019 to 2020.

Forty-three per cent of colleagues chose to raise issues openly, 25.8% were raised confidentially and 30.6% were raised anonymously. However, it should be noted that in the previous year only 24% of staff chose to speak up openly which suggests there is increasing trust in the FTSU process.

The Freedom to Speak up model will form part of all staff mandatory training from 2021 onwards with various levels of engagement available. Speaking up is becoming business as usual at South Tees.

The 2020 Staff Survey results showed marked improvements in staff perceptions of speaking up across the Trust and the team is focused on further improvement in 2021.

A reporting tool developed by the previous Guardians was enhanced and it added to the methods staff can report any concerns they may have. There are three ways of reporting concerns and they can be reported by individuals or groups of staff.

- Anonymously – no one, including guardians, know your name. It is important when making an anonymous notification to provide sufficient details to allow for an investigation – for example, which area, ward or department you are referring to. The lack of identification means individual feedback cannot be given to an anonymous referrer, but generic feedback can be given to a department.
- Confidentially – the Guardians team will know your name but will not disclose it to anyone else. This allows the guardians to gather any missing or unclear information and to provide feedback following an investigation.
- Openly – you have agreed to your name being shared with the investigators. You will also be able to be provided with feedback.

In addition to the reporting tool, staff are able to report their concerns in person to the Guardians. There is also a dedicated email account and trust mobile numbers for each Guardian for staff to use. These contact methods are regularly promoted on the staff intranet system, in weekly staff briefings and by the Organisational Development team at the end of training sessions organised by them.

Feedback to Staff

Colleagues can receive feedback either by email or face to face depending on their preference, provided they have passed on their details and not reported their concerns anonymously. Staff are also encouraged to report detriment to the Guardians and this is monitored and reported back to the National Guardians Office.

With the introduction of the new model and the vastly increased awareness across the organisation due in part to the dedicated time available.

Total Number of Concerns Raised April 2020-March 2021	**62**
Raised Anonymously	19
Raised Confidentially	16
Raised Openly	27

Table 9: Number of Concerns Reported during 2020/21

Reporting against core indicators

In addition to the progress with our locally identified quality priorities and our performance against national performance targets, we also monitor measures from the NHS Outcomes Framework. The data reported below is data that is publicly available from NHS Digital; we have included benchmarking data where this is available. The most recently available data from NHS Digital has been used however, it should be noted that due to the nature of some of the measures and the data collection systems, the time period reported for some of the measures may be some time in the past.

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

Domain 1 - Preventing people from dying prematurely

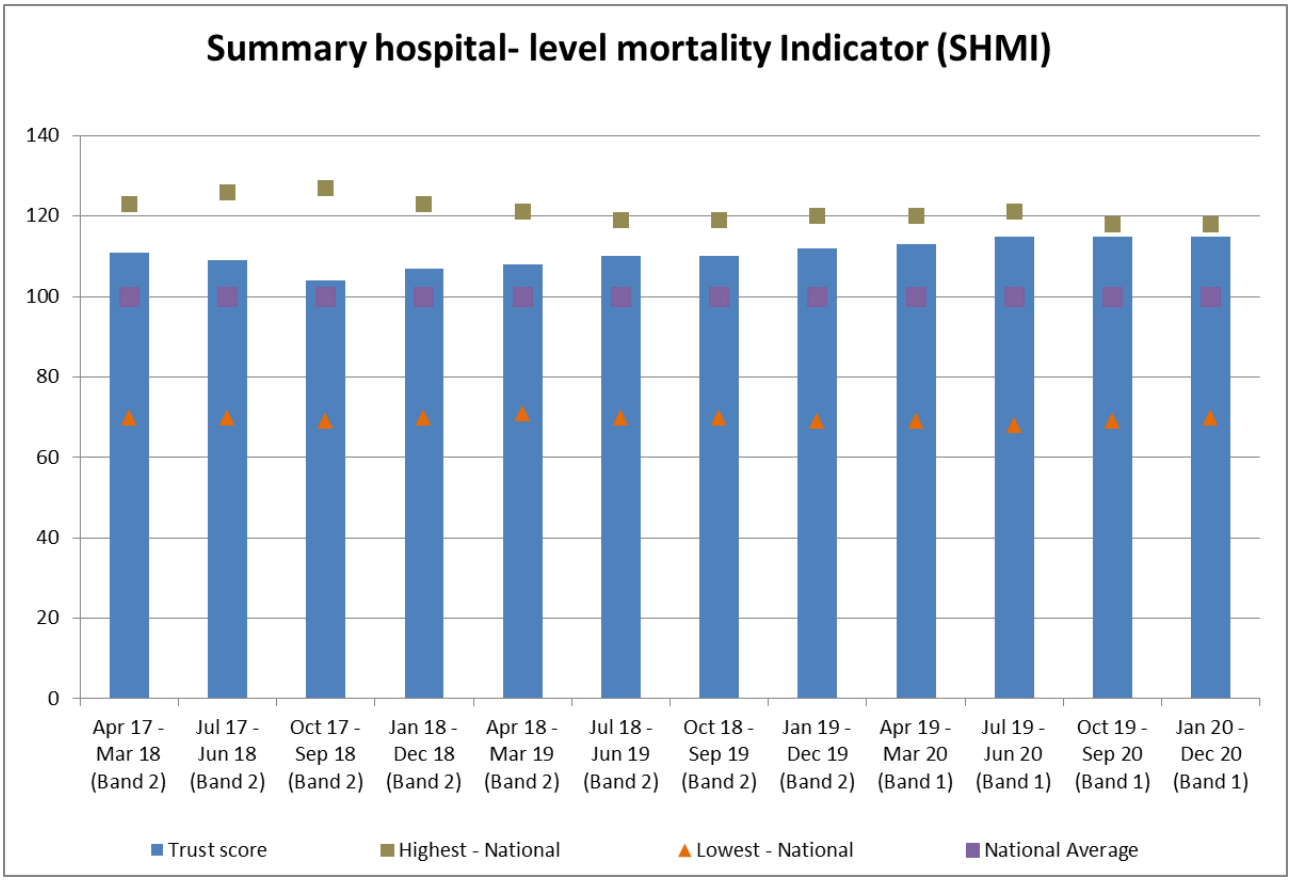

Figure 7: Summary Hospital Level Mortality Indicator (SHMI) (Data source: NHS Digital)

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

1. The SHMI is not designed to account for the COVID-19 pandemic and although spells coded for COVID-19 have been removed by NHS Digital from the indicator calculation, the large reduction in the number of admissions to hospital, particularly during wave 1, has had a substantial impact on the expected number of deaths. Therefore, although the number of observed deaths has fallen compared to previous years, the expected number of hospital deaths has fallen by a greater number due to reduction in the number of admissions. The fall in the number of admissions has not been experienced evenly across the country, with areas with high levels of COVID-19, such as the North East, experiencing a greater impact.

2. Despite the high level of need in the population the Trust serves, the organisation has historically fallen behind other trusts in recording the number of other medical conditions patients have, alongside the main illnesses being treated. The Trust is in the process of implementing electronic records systems which are expected to address this comorbidity recording anomaly.

3. Patients who are treated within a single day for unplanned care without the need for admission are currently moved from the dataset which is used to calculate SHMI, to another emergency care dataset and this therefore removes low-risk patients from the dataset's calculation. This change in the way patients who are treated within a single day for unplanned care without the need for admission are recorded, has taken place earlier than in other trusts.

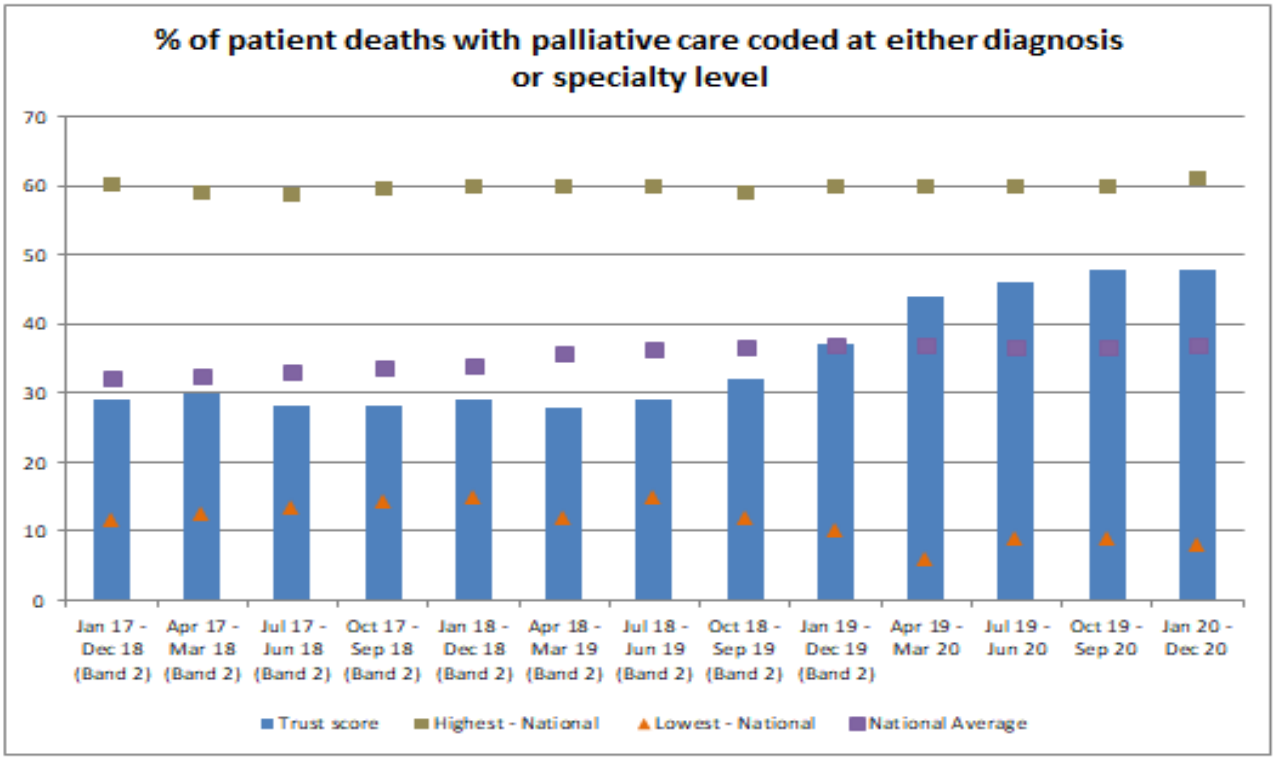

Figure 8: Percentage of Patient Deaths with Palliative Care Coded (Data source: NHS Digital)

The percentage of patient deaths with specialist palliative care coding is has been higher than the national average in the last four reporting periods and is now stable at around 48%. This reflects the work that was done to ensure that all the specialist palliative care provided to patients was captured in the coding used to calculate SHMI. This involved a comparison between two digital systems used to record the care provided.

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

The number of deaths in the trusts is variable from year to year, depending on the severity of respiratory and other seasonal infections each year and the pattern during the COVID-19 pandemic has been unlike any previous year in the trusts history. However, the trend outside the seasonal variations and this pandemic years has remained stable over a long period of time, despite an aging population and increasing complexity of the conditions patients have when admitted to hospital. Work likely to affect mortality rates, particularly in elderly patients admitted to medical wards, includes sustained work on identification and management of deteriorating patients (the National Early Warning Score is electronically recorded in the Emergency Departments and Acute Assessment Units as well as all wards of the hospital), identifying and managing patients with sepsis, prevention of falls, and work identifying patients level of frailty and providing appropriate support.

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

No applicable indicators.

Domain 3 - Helping people to recover from episodes of ill health or following injury

Patient Reported Outcome Measures (PROMs)

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

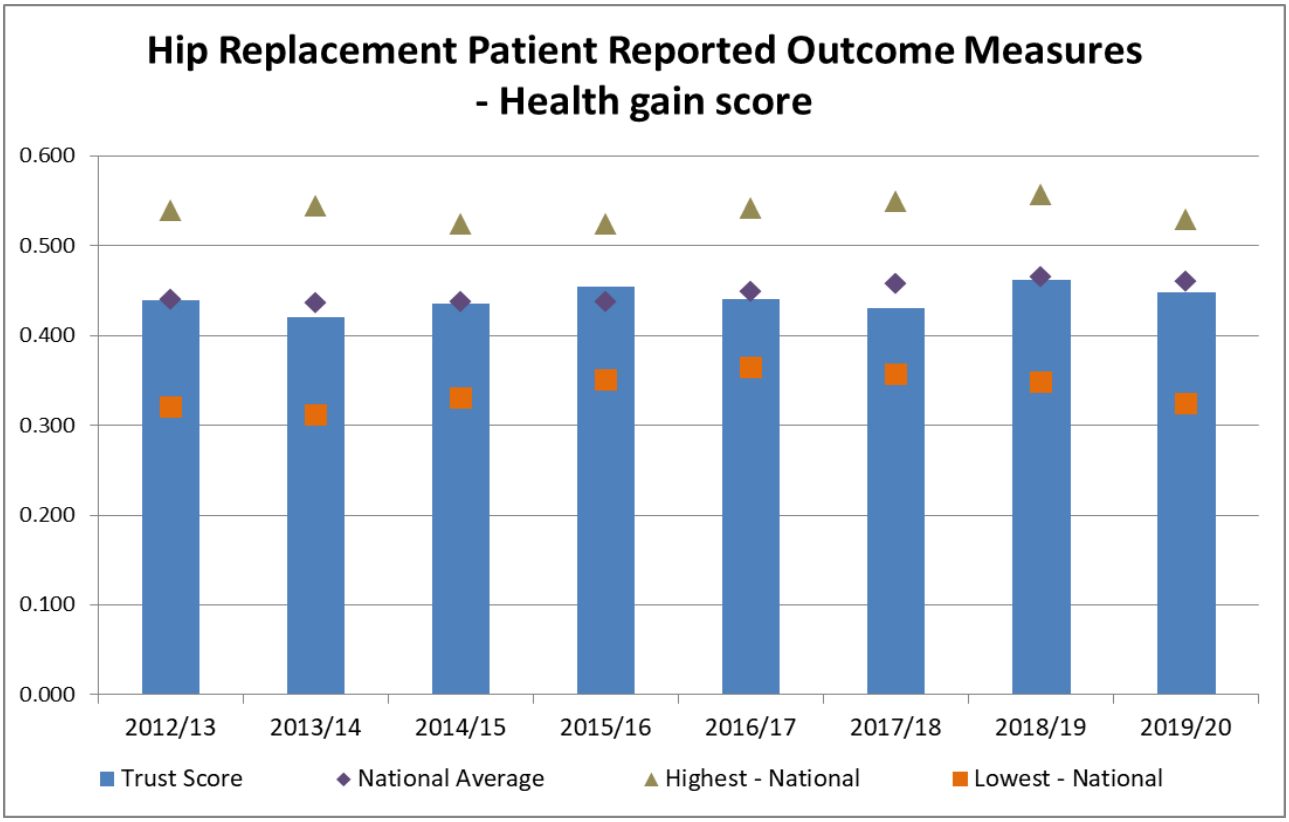

Figure 9: Hip Replacement PROMS

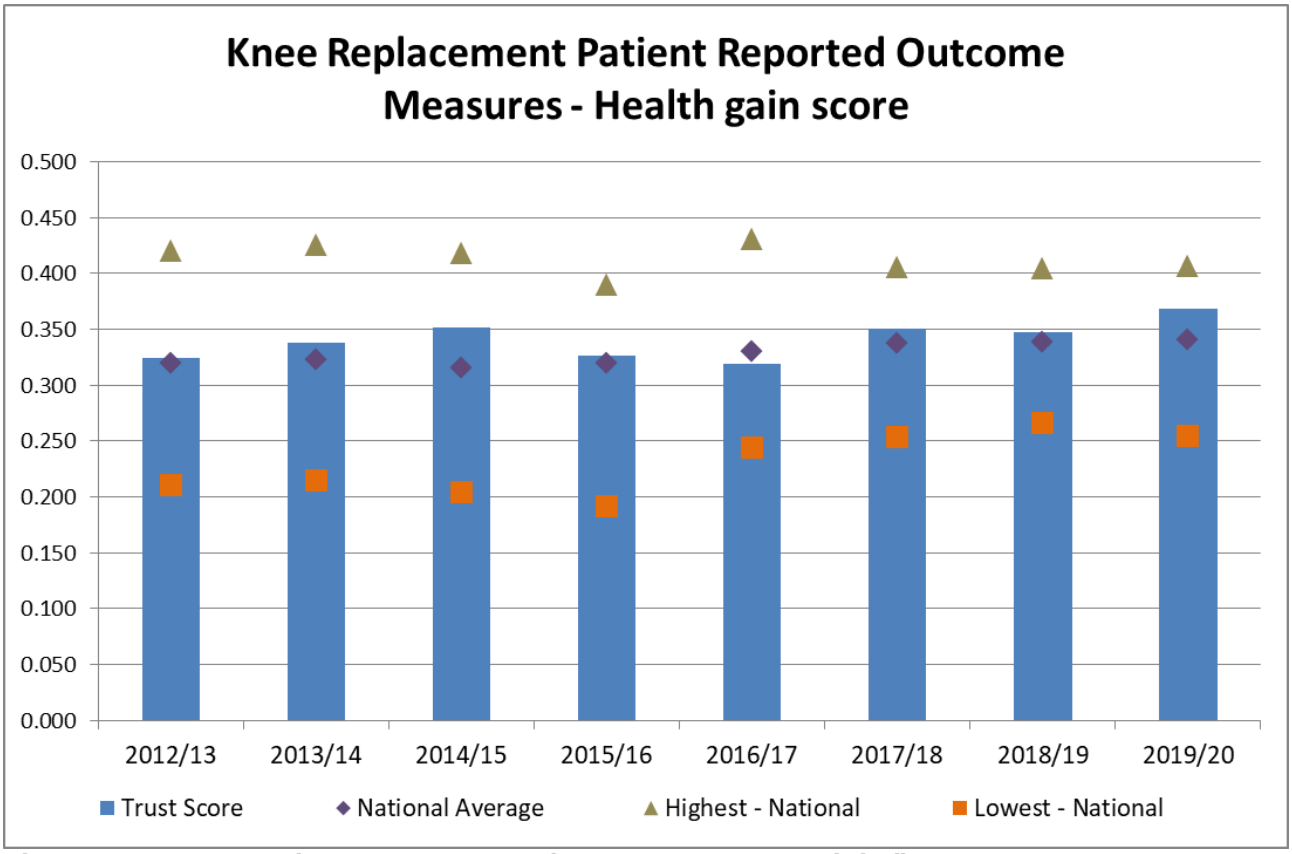

Figure 10: Knee Replacement PROMS (Data source: NHS Digital)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the specialist review and pre-assessment process ensures that patients are offered the procedure likely to deliver the most benefit and best outcome. The health gain scores for hip replacements and knee replacements are in line with the national average.

The Trust has taken the following actions to improve these scores, and therefore the quality of its services: providing regular feedback of the scores to clinical teams and benchmarking performance across the NHS and other hospitals in the North East, through a regular report produced by the North East Quality Observatory Service (NEQOS), to ensure the quality of services is maintained.

Production of data has been disrupted by the COVID-19 pandemic.

Re-admission within 28 days

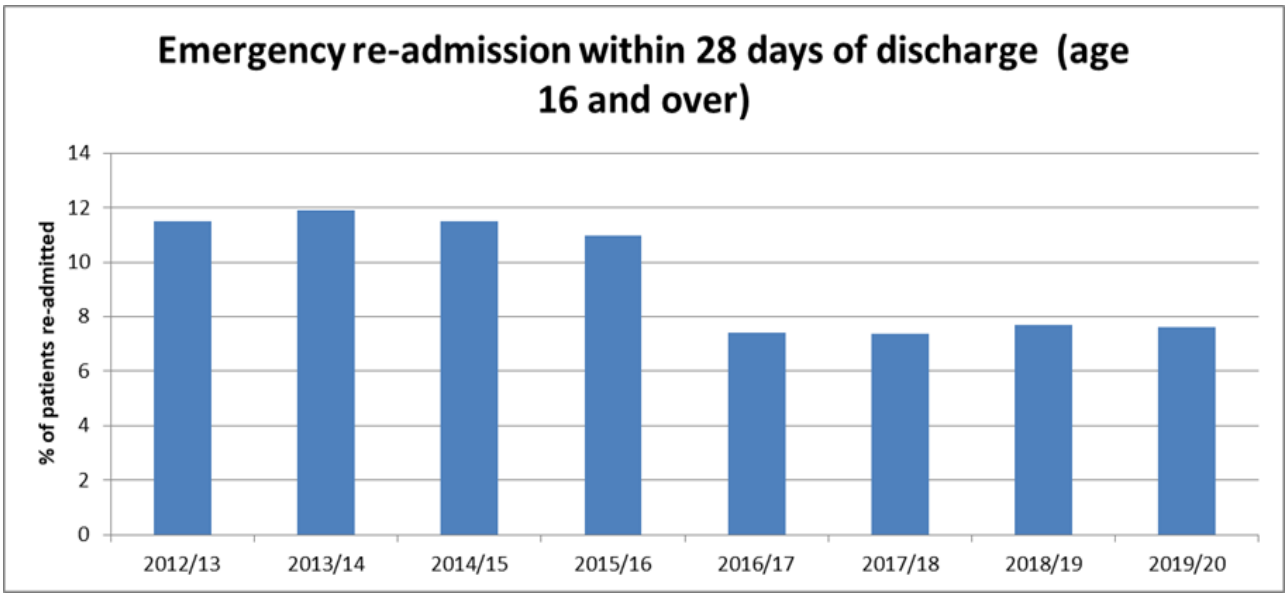

Figure 11: Emergency Readmissions Aged 16 and over (Data source: Local patient administration system)

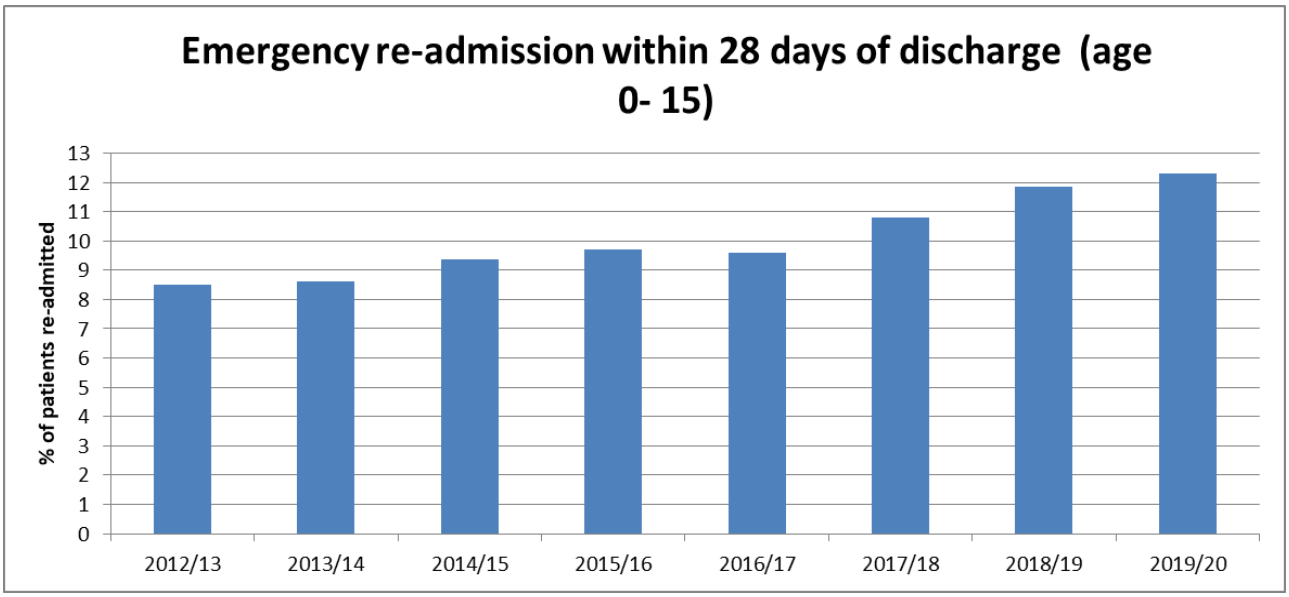

Figure 12: Emergency Readmissions Aged under 16 (Data source: Local patient administration system)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the percentage of re-admissions for patients aged over 16 decreased from 12.3% in 2019/20 to 10.0% in 2020/21.

Domain 4 - Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients

	Trust Scores		Performance	
Domain	**2018/19**	**2017/18**	**80th percentile for 2018/19**	**Performance in top 20% for 2018/19**
Access and waiting	87.0	89.4	85.4	Yes
Safe, high quality, coordinated care	68.6	69.9	68.4	Yes
Better information, more choice	68.6	70.8	69.1	No
Building closer relationships	88.7	88.9	87.1	Yes
Clean, comfortable, friendly place to be	82.9	83.1	82.4	Yes
Overall	79.2	80.4	78.1	Yes

Table 10: Responsiveness to Personal Needs (Data source: https://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/sup-info)

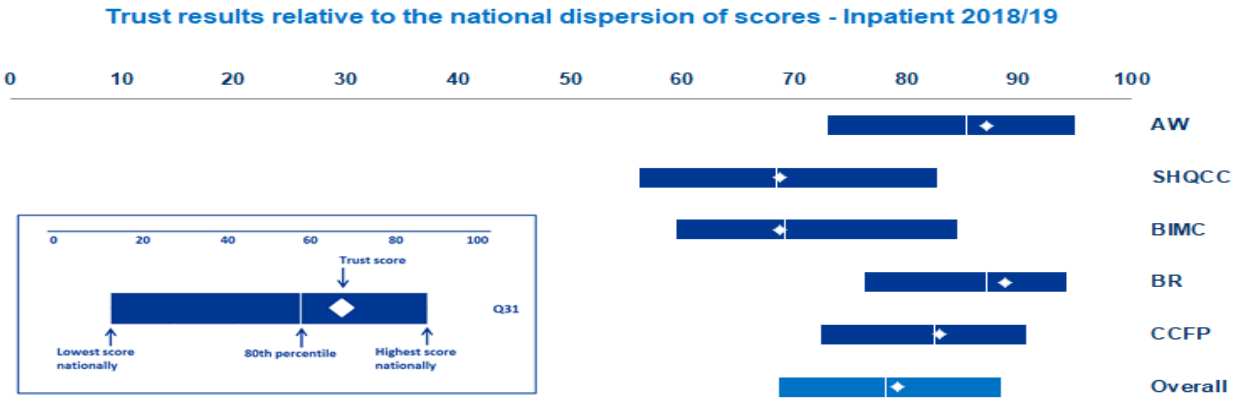

Figure 13: Responsiveness to Personal Needs (https://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/sup-info)

Due to the COVID-19 pandemic, production of data has been disrupted due to work pressures; therefore the data shown still represents the 2018/19 submission data – the latest data available.

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust clinical standards focus on delivering care in a sensitive and person-centred way.

The Trust's overall performance is in the top 20% nationally. The only domain where the Trust narrowly missed a top 20% performance score was the 'Better information, more choice' domain.

The Trust intends to take the following actions to improve this data and the quality of its services. The Trust continues to collect patient experience data and triangulate all patient feedback. The collection of inpatient feedback provides an immediate feedback to the wards thereby enabling staff to recognise and respond to patient queries and concerns immediately.

Staff who would recommend the Trust as a provider of care to their family and friends

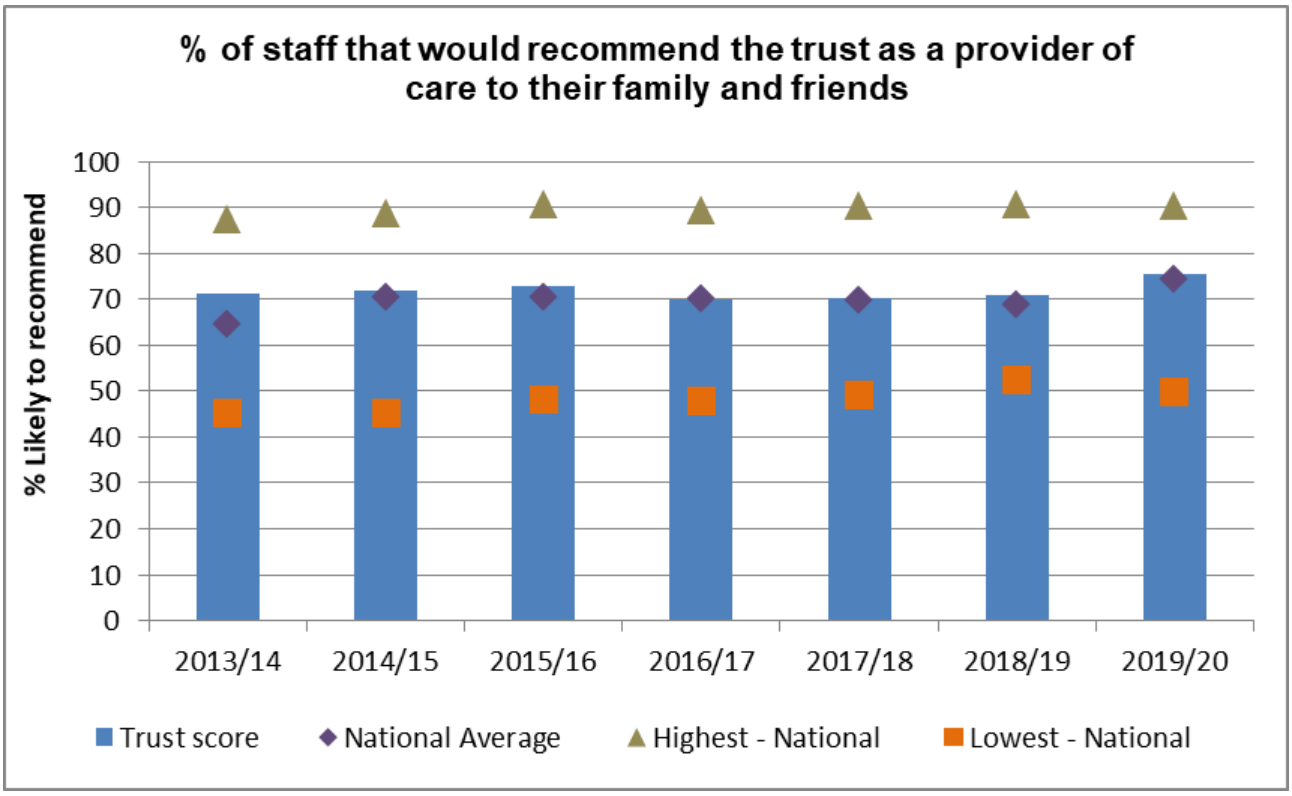

Figure 14: Percentage of Staff who would recommend the Trust (Data source: NHS Digital)

Figure 14 shows the percentage of staff who would recommend the Trust to their family and friends.

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust scores have been consistent over the last 5 years, with 2019/20 scoring the highest.

The South Tees Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and thereby the quality of its services. It continues to work with staff to improve the quality of care provided to patients. In addition the Trust promotes the achievements of staff in delivering high quality care through regular staff bulletins, staff briefings and providing other opportunities for staff feedback. The Trust has undergone a number of significant changes and is now empowering clinical leaders to make decisions around how the organisation allocates its resources and delivers care.

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

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

The VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic.

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust monitors compliance on a monthly basis and has achieved the required standard.

The South Tees Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services; the completion of a VTE risk assessment is monitored monthly through audit to ensure that the actions required following assessment are completed as well as recording that the assessment has taken place. Issues identified from the audit are further investigated and actions put in place to address any areas of concern.

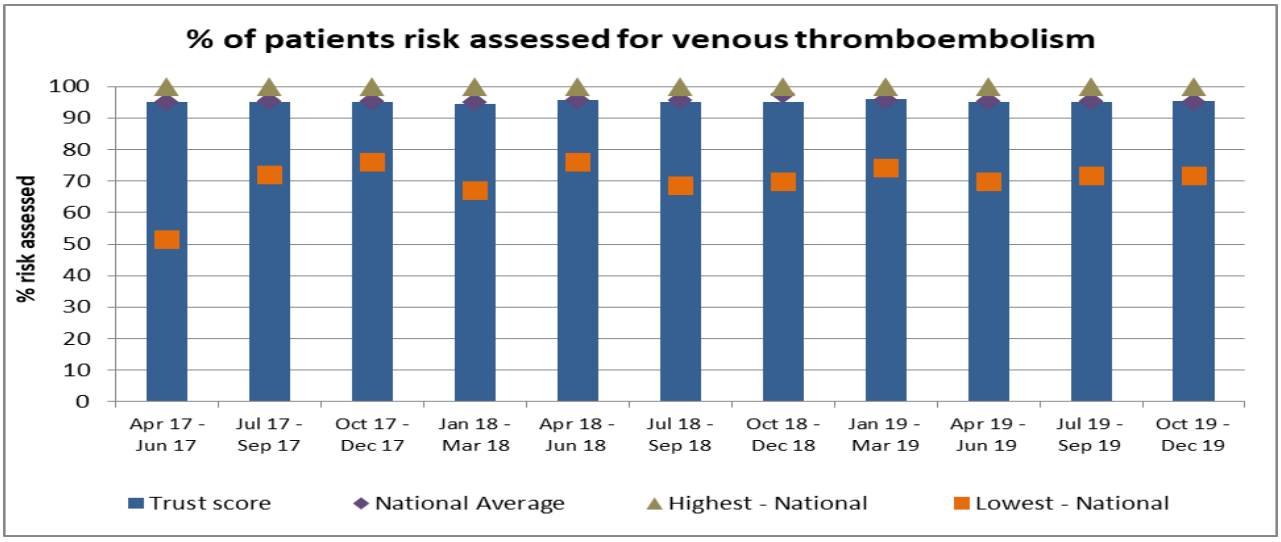

Figure 15: Percentage of Patients assessed for VTE (Data source: NHS Digital)

Clostridium difficile (C.difficile) Infections

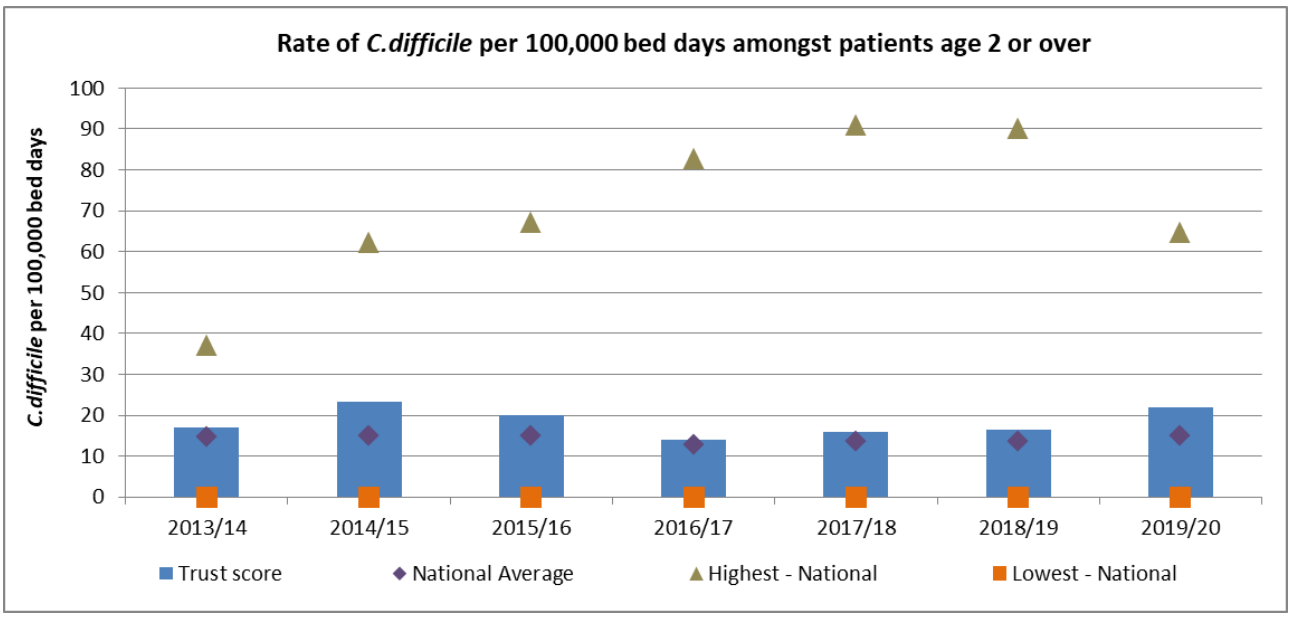

Figure 16: Rate per 100,000 bed days of cases of *C.difficile* infection reported within the Trust amongst patients aged 2 or over. (Data source: NHS Digital)

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust is committed to driving down healthcare acquired infections, and achieved its lowest ever incidence Clostridium difficile infections in 2018/19, with a slight increase again in 2019/20 as indicated in the graph above.

The South Tees Hospitals NHS Foundation Trust has taken actions to improve this rate, and so the quality of its services; the Trust has a comprehensive action plan for the prevention of trust-

attributed Clostridium difficile infections which is monitored through the Infection Prevention & Control Strategic Group. In addition to this all trust-attributed cases have a Root Cause Analysis (RCA) and panel reviews are undertaken. Panel reviews are chaired by the DIPC or her Deputy and are attended by CCG colleagues. If the panel agrees that there were no deficiencies in care then the case may be discounted from the total for performance measurement purposes. These panels were postponed during the COVID-19 emergency period but RCAs have picked up the trust-attributable cases that occurred from July 2020 onwards.

Identifying a single root cause in cases of C. difficile is challenging and is often associated with one or more influencing factors; patient factors e.g. existing long term conditions, and/or medical factors such as the requirement for antibiotics or laxatives and/or process concerns, e.g. delays in isolation.

Rate of patient safety incidents reported within the Trust and the number and percentage of such patient safety incidents that resulted in severe harm or death

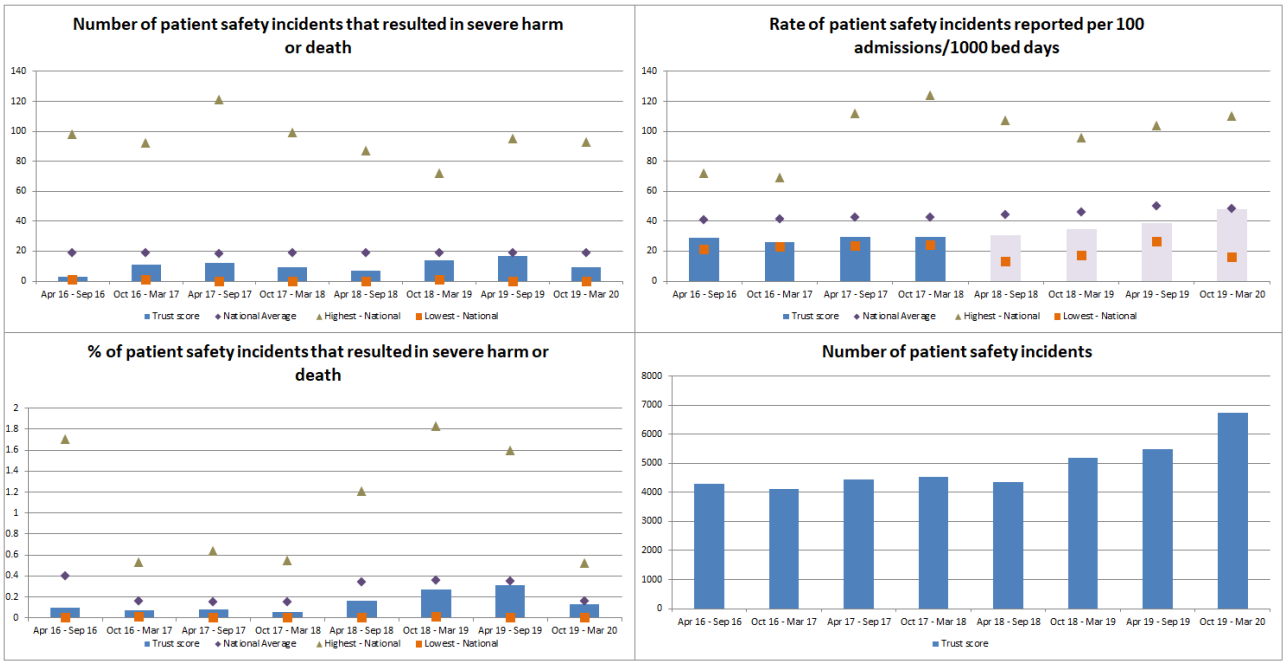

Figure 17: Rate of Patient Safety Incidents Reported (Data source: NHS Digital)

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

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust had recognised that the rate of incidents and the number of incidents reported had fallen.

Incident reporting was, therefore, previously identified as a quality priority and further information on the action taken to improve incident reporting is described in Part 2 of this report.

As shown in the graph, incident reporting has increased significantly over the last year. The Trust is currently exploring ways of making incident reporting easier, via the use of voice recognition software and other technology that should facilitate this process. Each indicator is governed by standard national definitions.

PART THREE – Other information

An overview of the quality of care based on performance in 2020/21 against indicators

This section of the Quality Account contains a review of our quality performance during 2020/21. It also includes comments on the development and content of the quality account provided by a range of external stakeholders.

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

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

The following section reviews the work of a range of quality work streams during 2020/21 these have been selected as the key indicators by the Board that demonstrate the quality of care provided by this organisation.

Patient Safety

Pressure Ulcers

The development of pressure ulcers is recognised as a key indicator of the quality of care delivered and a fundamental aspect of patient care. Pressure ulcers are detrimental to patients in terms of their physical, psychological and social well-being, resulting in reduced quality of life (EPUAP 2014).

During 2020/21 the Trust continued to focus on reducing the number of pressure ulcers in both the acute and community settings. Overall, the Trust did not achieve a reduction in the rate of pressure damage. COVID-19 has been noted as a factor in the increase in the rate of pressure ulcers (particularly in critical care) and has been cited as a factor nationally.

Preventing pressure damage remains a priority. The Trust has developed a pressure ulcer collaborative to help tackle this increase, and the action plan can be seen below: -

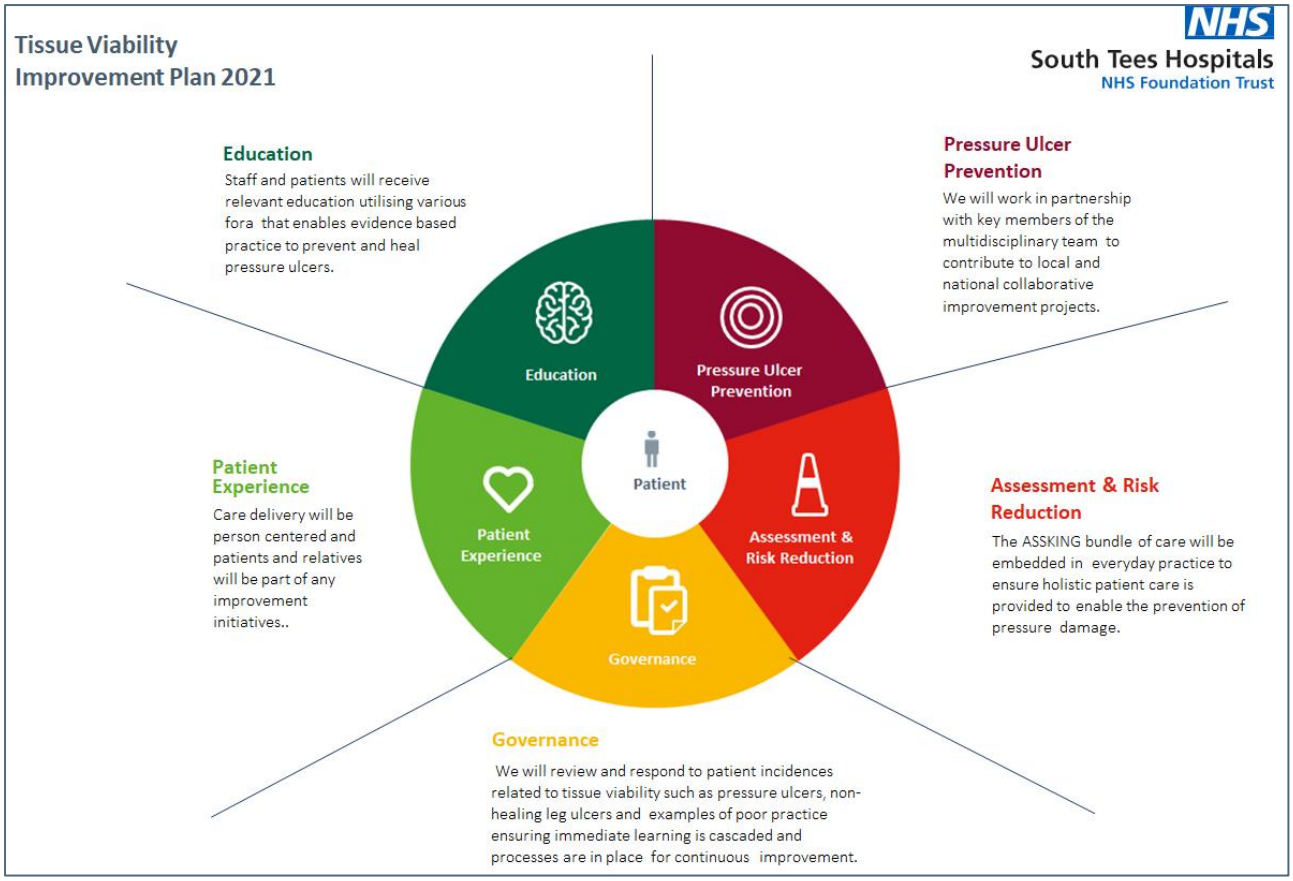

Figure 18: Summary of PU Collaborative approach

Pressure ulcers have been identified as a Quality Priority and further information on the action taken is described in Part 2 of this report.

Falls

In line with the Trust's priority to improve patient safety and reduce harm, the prevention and learning from fall incidents is a priority for staff across the Trust. During 2020/21 there has been a sustained focus on reducing falls and the impact of the pandemic on falls is yet to be determined with the rate of falls in the organisation still in line with the trajectory.

Focused interventions have included improvements to signage, continence and delirium care planning, medication reviews and interventions to prevent muscle loss, specifically for older and frail patients and bay nursing. Early results have indicated nearly a 50% reduction of falls through the introduction of bay nursing in some of the high risk ward areas.

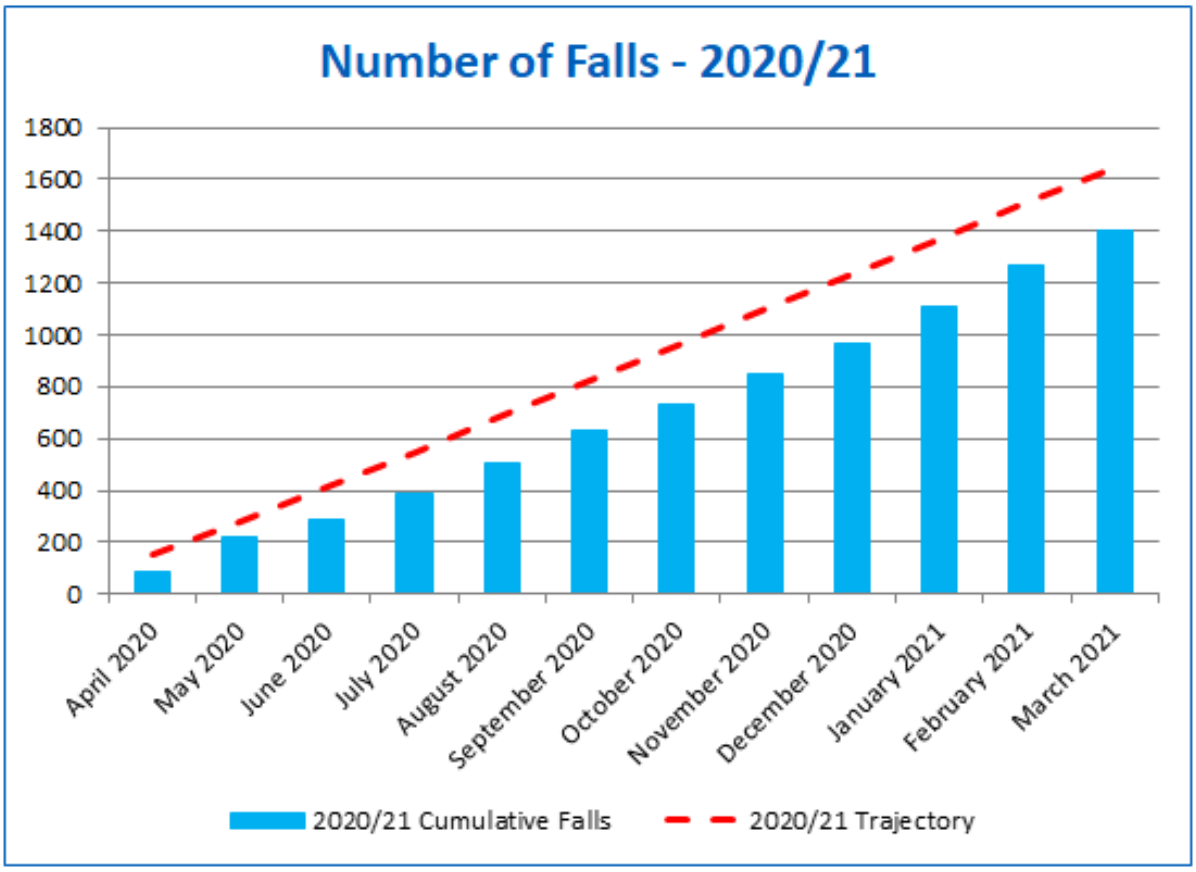

Figure 19: Patient Falls 2020/21

Actions to reduce falls include:

- Falls are reported via the incident reporting system and the reporting form for falls has been strengthened to enable more detailed reporting and identification of trends and themes to inform further improvement initiatives. Through analysis of incident data environmental issues such as light levels, weight of doors and toilet seat height identified as issues have all been addressed to reduce the incidence of falls.
- In 2019/20 nursing documentation was reviewed and strengthened with additional falls prevention prompts aligned to the falls CQUIN. Further reviews of nursing documentation to simplify the aggregation of falls risk is currently being undertaken to ensure those at risk receive the interventions that they need.
- The new directorate reporting template includes falls as a standing agenda item and provides a regular opportunity to monitor performance and share good practice. More detailed analysis is conducted by each ward and actions are monitored through our input into the Patient Safety Sub-Group (PSSG).
- The introduction of STAQC accreditation into the organisation will also assist in the measurement of quality metrics for falls within all the clinical areas.

- On-going interventions include monitoring the completion of the Trust's falls assessment to ensure individual patient's risks are being addressed. We are in the process of strengthening a multidisciplinary approach to falls reviews and the process had recently been modified to highlight areas of good practice, facilitate a process of learning and encourage ownership of actions. It is envisioned that learning will also be cascaded to junior members of the team as they also become part of the panels. Effective handovers between the multidisciplinary teams will strengthen a system for flagging patients identified at risk of falling and these patients are discussed at ward rounds and this is highlighted on the patient boards.

Duty of candour

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

The Trust's process to discharge its Duty of Candour is described in the 'Being Open' policy which is available to all staff. An overview of Duty of Candour is included in the Trust's Induction programme. In addition the incident reporting system and investigation documentation includes prompts to ensure the Duty of Candour requirements are considered. An audit of incidents with a severity graded as moderate or greater has taken place and the results are being analysed in order that the policy can be improved. The audit results show 100% compliance during the last year. Following the updated guidance from the CQC in respect of Duty of Candour, a presentation has been developed to share across the Trust.

Adult Safeguarding

Safeguarding is a positive duty placed on all of us under Section 42 of the Care Act (2014) to promote the wellbeing of vulnerable people and protect them from harm whether or not the harm is intentional and irrespective of whoever causes the harm. Safeguarding duties are rooted in law; based around the protection of human rights. As a public authority the Trust must follow the Human Rights Act (1998) in everything we do and treat people in accordance with their rights.

In 20/21 there were 630 safeguarding concerns (10%↑): 163 Trust (42%↑) and 467 safeguarding concerns were reported to the local authority relating to external care and support providers.

Medication errors have not risen, and further work will take place in 2021/22 to ensure that discharge processes continue to be strengthened around discharge medication arrangements and communication.

There were 26 detentions under the Mental Health Act which is a 53% increase from 17 the previous year. There have been 577 urgent authorisations / standard applications for patients deprived of their liberty which is an 18% increase from 19-20 when 489 applications were made.

Making safeguarding personal

The focus of the Making Safeguarding Personal (MSP) agenda is on safeguarding processes supporting the individual to develop or maintain a private life in safety and free from abuse. At its heart it is about people being enabled to live the life they choose. Adults should be asked what outcome they would like from safeguarding procedures. This is audited on a quarterly basis and the results overall have improved from 61% in 2019-20 to 85% in 2020-21.

Key areas of learning during 2020-21

- Discharge
- Pressure ulcers
- Medication
- Communication

Children's Safeguarding

The Trust has a statutory, regulatory and contractual requirement to safeguard children and young people, including unborn babies, in accordance with:

- The Children Act 1989 & 2004,
- Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHSE 2015),
- Multi-agency risk assessment conferences (MARAC) and Domestic Homicide Reviews (Domestic Violence, Crime and Victims Act 2004).
- Counter-Terrorism and Security Act 2015 (PREVENT agenda).
- Modern Slavery and Human Trafficking Act (2015).
- Mandatory reporting of Female Genital Mutilation (FGM Act 2003 section 5b).

- NHS Standard Contract Requirements

In 20/21 there have been 4604 enquiries to the Children's Safeguarding Team and the highest number of enquiries related to unborn babies. 227 child protection medicals have been completed with only 6 completed out of the 24 hour performance target. Safeguarding supervision has continued with 98% - 100% compliance during the Covid pandemic. The Safeguarding Children Team also actively contribute to the multi-agency work across the South Tees Safeguarding Children's Partnership and undertake regular audits to gain assurances around safeguarding practice and participate in multi-agency Child Safeguarding Practice Reviews and Domestic Homicide Reviews.

Model for Looked After Children (LAC) practice

A child is looked after by a local authority if a court has granted a care order to place the child in care, or a council's children's services department has cared for the child for more than 24 hours. Within 5 working days the Trust should be notified the child has become looked after and be provided with parental consent for an initial health assessment to be carried out by a paediatrician. The initial health assessment must be carried out within 20 working days. These are statutory time scales.

Following their initial health assessment, each child will have a review health assessment at a statutory interval for their period of time in care. Children under 5 years are reviewed every six months and children over that age annually. These reviews are requested, collated, distributed and quality assured by the LAC team but carried out by other provider Trust's.

The LAC system is complex and highly interdependent on the timely actions of multiple agencies and multiple professionals within those agencies. Additionally a number of local children are placed in areas outside of the Trust footprint, and a number of children from outside our area are placed here. The LAC team has a role in statute and contract in relation to all of these children. Where a child is looked after by North Yorkshire County Council their health needs are coordinated by Harrogate District Foundation Trust. Data provided in the report therefore is in relation to South Tees Children. Middlesbrough has some of this highest numbers of children looked after in the country and numbers are growing.

The total number of looked after children as of 31/03/2021 is 917 this includes 321 in Redcar & Cleveland and 596 in Middlesbrough.

Clinical Effectiveness

Mortality

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

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

Mortality statistics are reported to the Trust Board on a quarterly basis and have been since 2008. These include the number of deaths, the unadjusted mortality rate and the Summary Hospital-level Mortality Indicator (SHMI), the NHS's official risk-adjusted mortality metric.

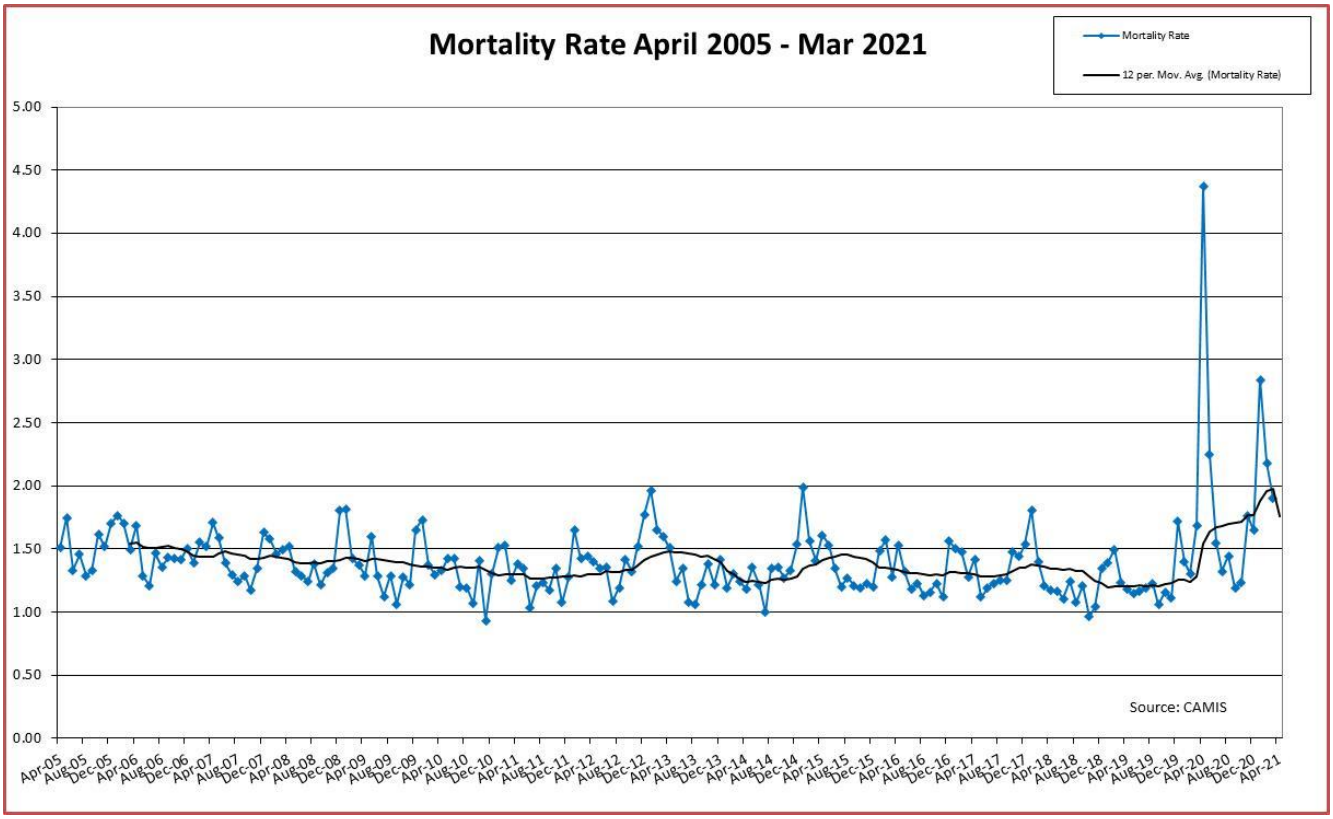

Figure 20: Unadjusted Mortality Rate April 2005 – March 2021 (including rolling 12 month averages) (Source: CAMIS)

It should be noted that in line with previous Quality Accounts information more recent data will be reported in next year's report to allow comparisons with previous years to be made.

Unadjusted mortality measures the number of deaths as a percentage of patient inpatient and day case spells, excluding well babies (less than 28 days old). It is most useful for seeing the pattern of deaths through time. Looking at the trend from April 2005 – March 2021 it can be seen that a winter peak is experienced in most years, especially in 2013, 2015 and 2017. The two peaks caused by the COVID-19 coronavirus pandemic in March - April 2020 and January – February 2021 are the highest the trust has ever experienced.

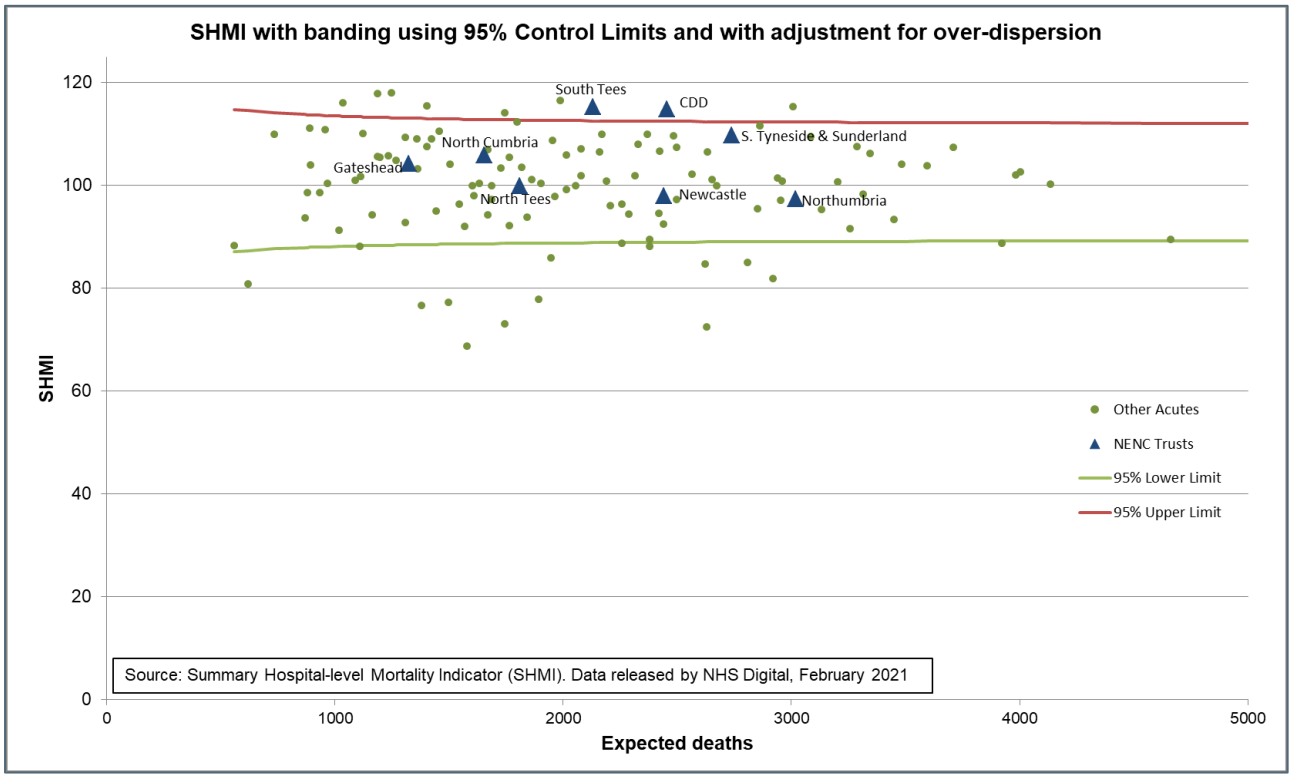

Figure 21: SHMI with 95% Control Limits and with adjustment for over-dispersion for Oct 2019 – Sep 2020 (Source: SHMI Data Release NHS Digital Mar 2021)

The Summary Hospital-level Mortality Indicator (SHMI) is designed to allow comparison between Trusts across the NHS. It includes deaths in hospital as well as deaths within 30 days of discharge from hospital. The SHMI for the Trust has been 'as expected' (i.e. within the amount of variation that can be anticipated by chance) in all data releases to date and the SHMI is currently 115 (Oct 2019 – Sep 2020). This means that the number of deaths in hospital or within 30 days of discharge from hospital is higher than the number expected using a statistical model. The SHMI was not designed to monitor mortality during the pandemic and so NHS Digital remove any hospital spells containing

a COVID-19 spell. The number of patients attending hospitals, particularly during the first wave of the pandemic was much lower than would normally be the case and so the number of hospital spells from which an expected number of deaths could be estimated was much lower than usual.

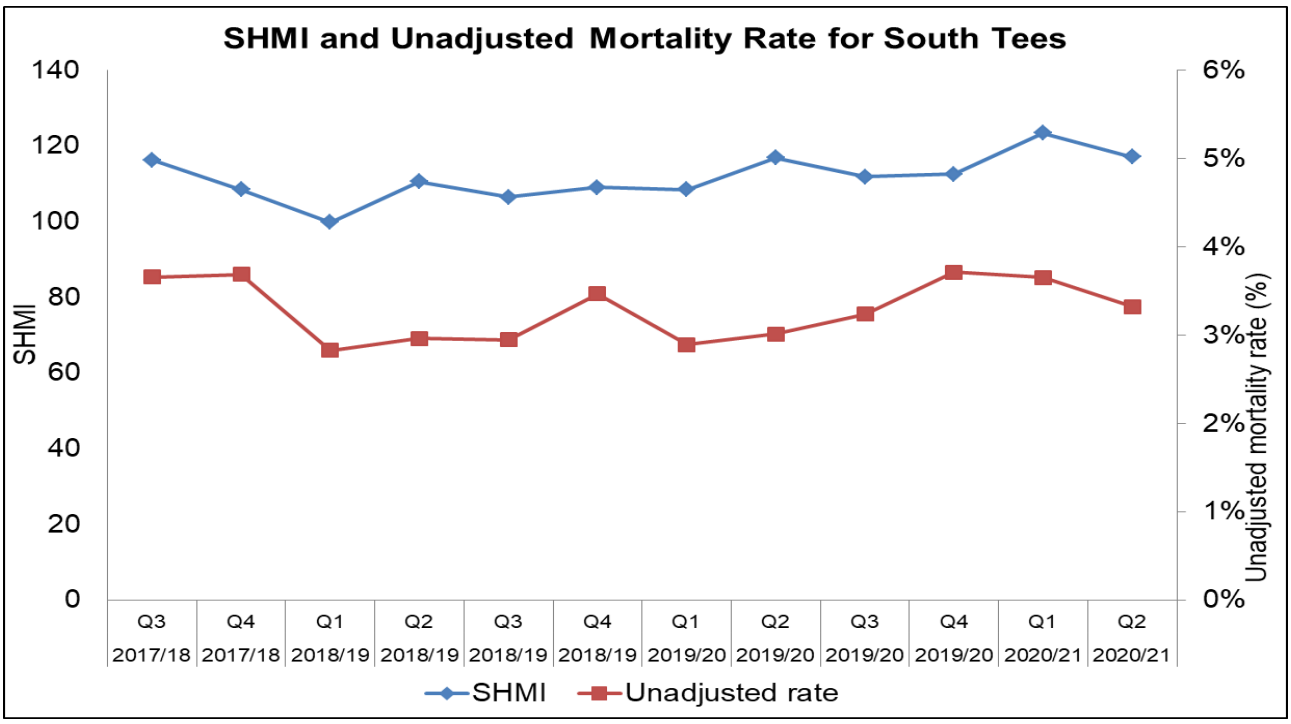

Figure 22: SHMI and Unadjusted Mortality Rate for South Tees (Source: Data extracted from HED Mar 2021)

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

Re-admissions

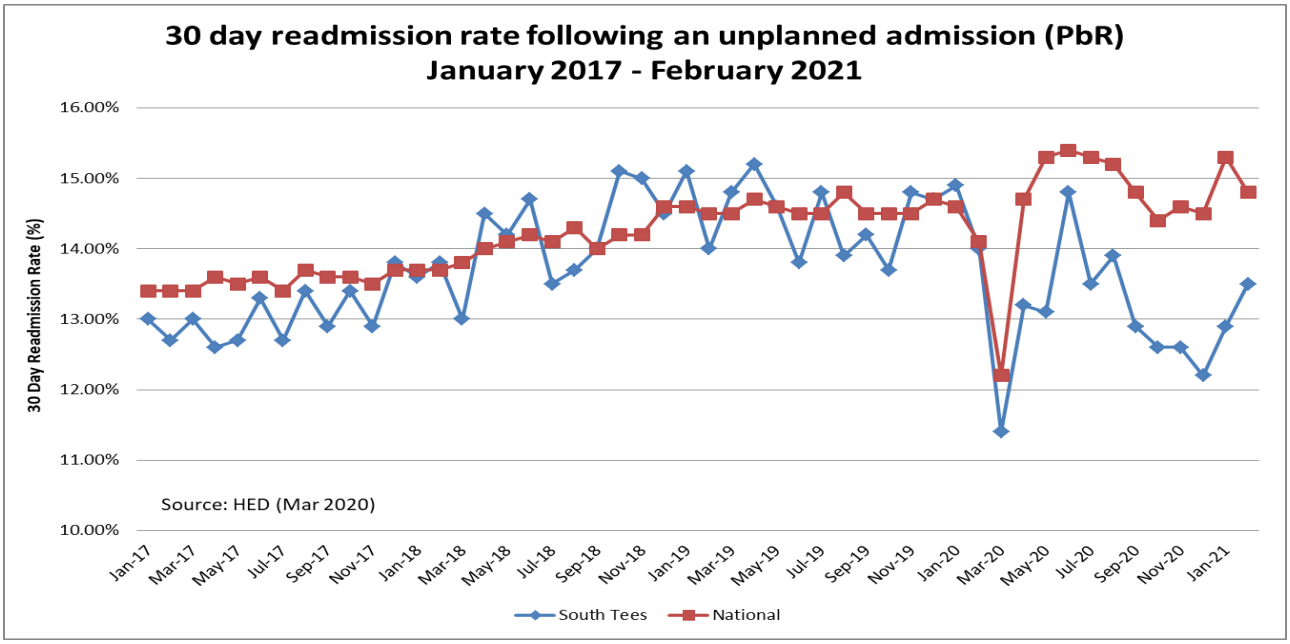

Figure 23: 30 day readmission rate following an unplanned readmission (Payment by Results)

Over the period illustrated, 30 day readmissions for the Trust has averaged 13.7% compared to the national average of 14.2%. For some patients this further admission is not linked to their recent hospital stay but for others, they have returned to hospital because of complications after their discharge. These complications may be related to their needs not being adequately established at pre-assessment, through to acquiring an infection during their hospital stay or due to their rehabilitation not progressing as planned. The graph demonstrates that the re-admission rate was impacted substantially by the pandemic.

Nutrition and hydration – getting the balance right

The Trust aims to:

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

Nutrition and Hydration during COVID-19

A number of our planned developments within our nutrition and hydration workstreams have been delayed by the impact of the COVID-19 pandemic over the last year. Across the Trust all services were required to quickly mobilise for the rapidly changing patient needs both as a consequence of the illness itself or as an impact of the COVID-19 lockdown procedures that we were required to impose. Staffing resources have also been affected by this and our priority has had to be on

supporting frontline care delivery. Where possible new protocols, care plans and patient information were developed for the provision of nutritional care pathways across clinical areas. New ways of working had to be implemented to ensure that nutritional care continued for those patients out in the community who were unable to be seen for 'face to face' care, with the introduction of 'virtual' clinics and telephone support for care homes.

Nutritional Screening

Patients are assessed on admission using the Malnutrition Universal Screening Tool (MUST), which is a validated screening tool to detect malnutrition in adult patients. The following graph demonstrates compliance with completion of the screening tool within 24 hours of admission, and whether subsequent appropriate actions have taken place.

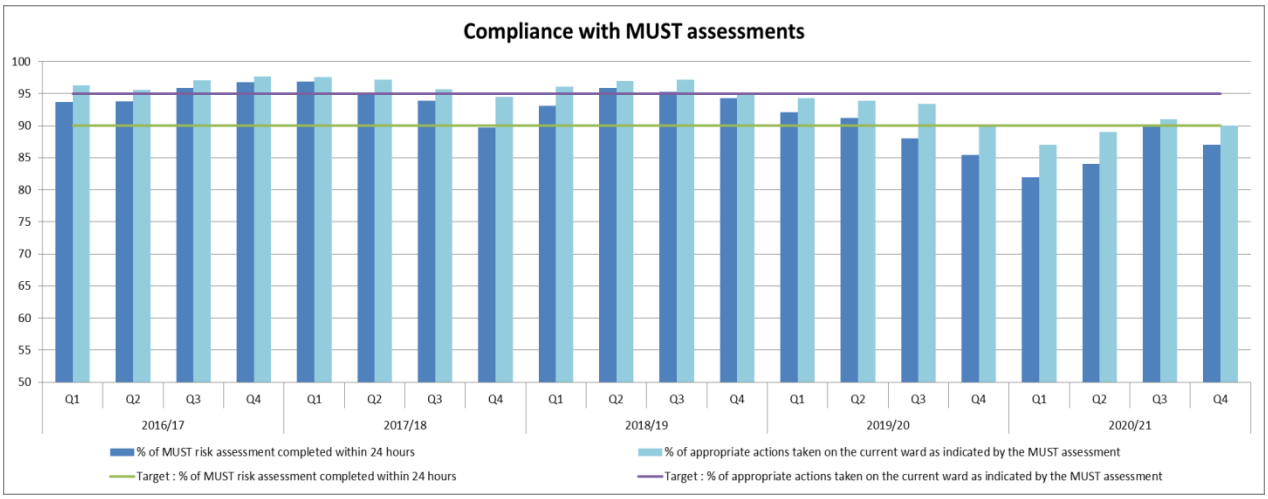

Figure 24: Compliance with Must Assessments (Data source: Local audit)

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

Over the last year we have seen a significant deterioration in MUST compliance audit results (with an improvement noted in Quarter 3), however the largest contributing factor to this has been the COVID-19 pandemic, and the trends in compliance reduction directly correlate with surge activity. This has impacted significantly on clinical staffing from day to day staffing levels, increasing patient numbers and complexity, staff being redeployed to new clinical areas across the organisation, higher levels of new staff being recruited, reduction in training time and ability to deliver it.

As we come out of the pandemic there are now a number of initiatives that will contribute to improving compliance.

- Wards are currently working on their self-assessments and action plans as part of STAQC. Nutrition and hydration is a standard that is assessed within this and has / will facilitate

identification of improvement actions / requirements for staff education and support at local level.

- The Trust Pressure Ulcer Collaborative workstreams are further contributing to this focus of work and additional spot check audits and targeted education sessions have been set up.
- New online video resources have recently been developed for the intranet to assist with staff education on nutritional assessment processes and tools.
- Work has commenced within the Trust to introduce the electronic patientrack system which will incorporate nursing documentation and assessments. The MUST screening tool will be included within the implementation of this which will significantly improve completion and compliance with MUST assessments, highlight actions required and will potentially automatically generate referrals.

Focus on Hydration

As a follow on from the successful pilot of a hydration project in 2019 using a traffic light water jug system, it was agreed to implement the project across the trust. An audit on RAFAU - prior to the initial pilot had indicated that the average daily oral intake of water per patient was approximately 500mls with no patients achieving over a litre of oral intake. The aim of the pilot and the role out of the project is to promote hydration with the resulting reduction in dehydration and incidence of 'acute kidney injury' (AKI). This was planned for 2020 but, for obvious reasons, this was delayed. The project group reformed early in 2021 and the project is being launched across the majority of adult wards in JCUH, FHN and the PCH's during Nutrition and Hydration week – starting 14th June 2021.

The project involves the use of a traffic light jug system to improve hydration with patients. Patients on the wards are given a water jug with a red lid at the start of the day. Once empty the jug is refilled and the lid changed to an amber colour and then again eventually to a green lid. The aim being that, by the end of the day, the patient would have consumed enough water (approximately 1500 to 2000mls) to ensure that they are adequately hydrated. Other neighbouring Trusts are also looking at introducing this project including County Durham and Darlington Foundation Trust.

Seven Day Services

The government launched the seven day services programme to ensure that patients that are admitted as an emergency receive high quality consistent care, whatever day they enter hospital. Ten clinical standards were identified initially with four priority standards for implementation by 2020. This has continued throughout 2020/21.

These four standards mean that emergency patients;

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

The Trust changed medical and surgical rotas during the acute phase of COVID-19 to ensure 7 day working.

The Trust is awaiting further guidance on how the Seven day services agenda will be taken forward and what shape assurance will take. It is anticipated that this will be put on hold for the time being given the COVID pressures.

Given that the Trust is currently in Covid recovery, the only way that we can be assured that we are compliant with standards a, b and c is to undertake another audit. Given the nature of ward rounds in South Tees, the Trust is compliant with standard.

The Trust has been advised by the Regional Improvement Team – North (NHSEI) that there is no need currently to undertake another audit for regional submission in view of the on-going Covid-19 situation. Our seven day service has proved pivotal in the delivery of safe and effective patient care throughout the COVID-19 pandemic.

NHS Doctors and Dentists in Training

Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires: “a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps” and NHSI has requested that there should be a statement in the Trust's Quality Account regarding this.

The vacancy rate was greatly improved in 2020/2021 compared to the previous year with the annual vacancy rate dropping from 6.4% to 4.1%. Vacancies have been covered in the main via re-adjusting rotas to accommodate the reduced number of Doctors. Vacancies have been actively recruited to throughout the year whilst an increased use of recruitment of Doctors via the Medical Training Initiative has helped to fill ST3+ level vacancies in a number of specialties. Longer delays

to start dates where experienced when recruiting overseas doctors, due to COVID-19 travel restrictions/guidelines.

Gaps on rotas tend to be short term due to sickness or emergency leave, however there has been an increase in the number of long term rota gaps due to COVID 19 sickness, isolation and risk assessment adjustments, where required. The Trusts Medical Rota Team track Junior Doctor Absence and any Doctors hitting trigger points are picked up by the relevant team (e.g. postgraduate team for Foundation Doctors, Lead Employer Trust for LET employed Doctors). Advanced Nurse Practitioners are successfully being utilised to cover gaps in some areas, working alongside Doctors in training.

The Medical Rota Team continue to fill approximately 95% of all locum shifts each month with the majority (approximately 91%) being filled by internal locum cover as opposed to agency. The regional locum bank (FlexiShift) hosted by the North East Lead Employer Trust (LET) is now well established for all LET employees and the Trust are exhausting the option to enrol locally employed trust doctors also. The regional bank provides the Trust with access to an additional pool of LET employed doctors who work in other Trusts and GP surgeries. The team continue to utilise the master vendor agency HCL where required.

In line with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, we have an established Guardian of Safe Working (GOSW), reporting quarterly to the Board and Workforce Committee, and a Junior Doctors' Forum meeting quarterly. Attendance at the Junior Doctor Forum has increased considerably following the August 2020 intake of Junior Doctors, with a number of members becoming accredited BMA representatives, taking up vacant seats on the Joint Local Negotiating Committee (JLNC).

Patient Experience

The Trust uses a number of sources to understand the patient experience in the organisation, and as discussed earlier in the report, the trust has implemented the 'real time' patient experience programme across all inpatient wards.

Complaints and PALS

In addition to this, we analyse our complaints, Patient Advice and Liaison (PALs) enquiries/concerns and compliments to understand the experience of our patients, with a view to continually improving this.

	2019/20	2020/21				
	Total	Q1	Q2	Q3	Q4	Total
Number of Formal Complaints	**470**	35	77	101	78	**291**
Number of PALS received	**2512**	325	498	486	400	**1709**
Number of Compliments	**404**	75	128	147	66	**416**

Table 10: Number of Complaints and PALS Concerns/Enquiries Received during 2019/20 (Source: Datix)

Overall the Trust has seen a decrease in formal complaints and PALS. The decrease in formal complaints & PALS is entirely due to the COVID-19 pandemic. In April 2020, NHS England & Improvement put a 'pause' on the NHS complaint process, to allow staff to be utilised to support frontline services during the pandemic. The Trust did not implement the 'pause' to the complaint process and continued, where possible, to respond in writing to formal complaints, supported by the corporate team and staff who were identified as 'extremely clinically vulnerable' and therefore unable to work clinically.

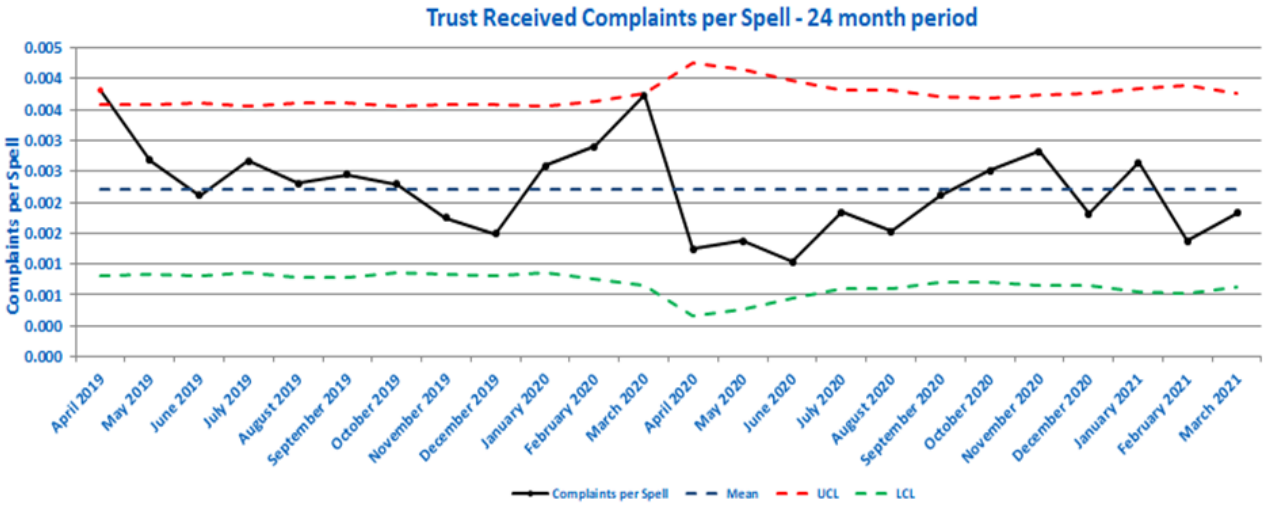

Figure 25: Complaints Received Over a 24 Month Period

There was an upward trend seen December 2019 to March 2020, however at the beginning of the COVID-19 pandemic and National Lockdown there was a significant decrease in formal complaints being received. Spells naturally decreased during the COVID-19 pandemic, but as the majority of complaints are logged after a spell in hospital, the reduction in complaints per spell started from April 2020 onwards. The complaints per spell remained low in comparison to previous years.

Friends and Family Test (FFT)

The Trust continues to deliver the Friends and Family Test in line with national guidance. The Trust performs well against national data with the percentage of patients that are very likely or likely to recommend, with performance generally in line or higher than the national average for inpatient areas and above the national average for maternity services.

Response rates are however lower than the national average and the Trust continues to try different methodologies to improve this. However, the introduction of 'key performance indicators' for all inpatient areas from 1 February 2020 has seen the response rate improve month on month.

Due to the COVID-19 pandemic, data collection was suspended and has only recently re-commenced.

	Jan-21				Feb-21				Mar-21			
	Response Rate		% likely to recommend		Response Rate		% likely to recommend		Response Rate		% likely to recommend	
	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England	Trust	England
Inpatient	6%	15%	97%	95%	7%	16%	97%	94%	11%	18%	96%	95%
A&E	6%	11%	94%	88%	-	11%	-	88%	1%	11%	87%	87%
Antenatal			87%	90%			90%	91%			-	90%
Birth	-	10%	*	96%	-	10%	*	95%	4%	12%	100%	95%
Postnatal ward			97%	92%			93%	93%			99%	94%
Post natal			*	90%			*	92%			*	92%
Outpatient			98%	94%			93%	93%			94%	93%
Community			-	95%			-	96%			100%	95%

Table 11: Family and Friends Test Data by Month Data source: NHS England

National Patient Surveys

National Adult Inpatient Survey 2020

Fieldwork is nearing close for this survey and will be completed by 9th July 2021. The final raw data will be submitted on behalf of the Trust on the timetabled 16th July 2021.

The indicative date that CQC will publish their official report on is 1st November 2021.

National Maternity Survey 2019

There were 139 completed surveys from women who gave birth during February 2019 within the organisation with a response rate of 39%. The average score for each question showed an improvement from 82% in 2018 to 83% in 2019.

The Trust scored in the top 20% on 17 questions and scored in the bottom 20% on 2 questions, during pregnancy, the provision of a telephone number for a midwife or member of the midwifery team to contact and following the birth, having the opportunity to ask questions about the labour and the birth.

Overall the survey results reflect a positive patient experience in relation to the questions asked in the 3 domains, labour and birth, staff during labour and birth and care in hospital and after birth. Areas identified for improvement were, contact information in the antenatal period, discharge and communication after the birth. An action plan has been developed to secure and sustain improvements.

The next National Maternity Survey is due to take in 2021 with the indicative date that CQC will publish their official report on is 1st January 2022.

Urgent and Emergency Care Survey 2019

The national survey of Urgent and Emergency Care surveys patients attending type 1 services, which include A&E departments (casualty or emergency departments). Type 3 services include urgent care centres, urgent treatment centres and minor injury units. For adult patients seen at a type 1 service between October 2018 and March 2019 showed that a total of 315 surveys were completed therefore the trust had a response rate of 25%. For adult patients seen at a type 3 services between October 2018 and March 2019 showed that a total of 139 surveys were completed therefore the trust had a response rate of 33%

The survey findings for type 1 and 2 showed the average score was up 1.4% on 2016. The Trust was in the top 20% of trusts on 17 questions and the bottom 20% in 0 questions. Areas of strength were in the domains for, waiting times, doctors and nurses, care and treatment, leaving A&E and respect and dignity

The 2021 Urgent and Emergency Survey has taken place with the indicative date that CQC will publish their official report on is 1st August 2021.

CQC National Children and Young Peoples Inpatient/Daycase Survey 2020

Fieldwork is nearing close for this survey and will be completed by 9th July 2021. The final raw data will be submitted on behalf of the Trust on the timetabled 16th July 2021.

The indicative date that CQC will publish their official report on is 1st November 2021.

National NHS Staff Survey 2020

The NHS annual staff survey was carried out from October to December 2020. The survey mode was mixed and the sample type was census with a response rate of 28% (2452 members of staff). There were 128 organisations in the benchmarking group with a median response rate of 45%% (combined acute and community trusts)

Key findings in relation to Quality and Safety were as follows:

Staff Engagement

Question	Improvement/ deterioration	2019	2020	National Average 2020
Motivation				
I look forward to going to work	Improvement	49.1%	53%	58.5%
I am enthusiastic about my job	Improvement	67.4%	70.2%	73.1%
Time passes quickly when I am working	Improvement	74.2%	75%	76%
Improvements/ suggestions				
There are frequent opportunities for me to show initiative in my role	Improvement	69.9%	72.9%	71.9%
I am able to make suggestions to improve the work of my team / department	Improvement	71.1%	73.1%	73%
I am able to make improvements happen	Improvement	49%	53.9%	55.4%

in my area of work				
Recommendation of the organisation as a place to work/ receive treatment				
Care of patients / service users is my organisation's top priority	Improvement	58.7%	74.4%	79.4%
I would recommend my organisation as a place to work	Improvement	44.4%	59.1%	66.9%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	Improvement	64.3%	75.5%	74.3%

Quality of care

Question	Improvement/ deterioration	2019	2020	National Average 2020
I am satisfied with the quality of care I give to patients / service users	Improvement	74.7%	80.3%	82%
I feel that my role makes a difference to patients / service users	Improvement	87.3%	89%	89.7%
I am able to deliver the care I aspire to	Improvement	60.1%	65.1%	70%

Safety Culture

Question	**Improvement/ deterioration**	**2019**	**2020**	**National Average 2020**

My organisation treats staff who are involved in an error, near miss or incident fairly	Improvement	47%	57.4%	61.4%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	Deterioration	62.5%	72.3%	72.7%
We are given feedback about changes made in response to reported errors, near misses and incidents	Deterioration	50.6%	57.9%	61.9%
I would feel secure raising concerns about unsafe clinical practice	Improvement	67.6%	72.1%	71.8%
I am confident that my organisation would address my concern	Improvement	50.4%	58.6%	59.1%

Health and Wellbeing

We have taken an integrated approach to promote a holistic health and wellbeing strategy, working with a range of partners to assist staff make healthier choices and to address the bio psychosocial factors that affect health.

There are a number of factors that affect staff wellbeing and this can be partly attributed to the fact that work can often be physically, emotionally and psychologically demanding. In addition, for many of our staff, our services operate for 24 hours a day, 365 days of the year. Financial and social wellbeing also play a key part in maintaining good mental health.

Taking into account all of these factors, we developed a Health and Wellbeing Strategy which is underpinned by five strategic objectives, these include:

Developing positive environments

Ensuring our policies and practices support health and wellbeing

Supporting a healthy body for all

Encouraging a healthy mind and reducing stigma associated with mental health

Promoting and supporting financial wellbeing

2020/21 has been a year like no other, with the outbreak of COVID and the declaration of a worldwide pandemic in March 2020. This has had one of the greatest impacts on the NHS in its history and in particular upon its amazing and dedicated workforce. Never before has the need to support our staffs health and wellbeing been such an essential element of our People Plan.

As a Trust we recognised at an early stage that peoples overall health and wellbeing would be placed under significant pressure. In light of this, we had to quickly adapt our original plan and created in interim COVID Health and Wellbeing Strategy. This developed into a reactive phase followed by a recovery phase.

As a result during the reactive phase we put in place the following: -

- Introduced access to COVID testing on site from the beginning of March 2020 for staff and their household members.
- Invested in recruiting additional psychological support services via the appointment of additional psychologists and counsellors.
- Line managers undertook health and wellbeing conversations with staff with the option of referral to Occupational Health for more specialist support.
- Managers and teams provided daily support through daily team huddles pre-briefs and debriefs.
- Covid risk assessments were undertaken for all BAME staff and staff that were classed as Shielding, Clinically Vulnerable or Extremely Clinically Vulnerable, as well as all pregnant staff. This included a wellbeing phone call to check-in proactively on concerns relating to both mental and physical wellbeing including reviewing the staff member's current deployment in work or a home setting.
- Weekly calls from Occupational Health team to all staff that have been affected by a Covid positive result and those who have been identified with Long Covid.
- Introduced 'wobble rooms' to provide a safe space for staff to take some time out and deal with the difficult situations that have arisen as a result of Covid.
- Helplines set up offering advice on Covid testing, counselling and psychological support.

- Access to a range of free wellbeing apps covering a wide variety of wellbeing issues including sleep issues, mindfulness, suicide prevention.
- Set up both a Hardship Fund and an Advance of Pay process to support financial wellbeing.
- Project Wingman – which is a charity founded in March 2020 in direct response to the Covid-19 pandemic. The purpose of Wingman was to explore how grounded aircrew could support NHS staff during the current health crisis. Wingman provided the Trust with airline crew into our hospital sites to look after our staff during their breaks in dedicated lounges
- Provision of free hot food and drinks including meals for nightshift staff.
- Working with our Staff Side colleagues we put in place a range of temporary and permanent people policy changes. These included:
- Changes to the attendance policy to ensure anytime that was recorded as Covid absence would not be considered in any absence management processes.
- Change in the annual leave policy enabling the carry forward of annual leave.
- Roll out of agile working arrangements.
- Full implementation of flexible working arrangements.
- Protecting pay and allowances for all temporarily redeployed and shielding staff.
- Free car parking.

As we move towards a recovery phase from Covid we have further developed a Health and Wellbeing Strategy. The focuses in this stage are: -

- Enable rest
- Support staff back to roles
- Health and wellbeing initiatives
- Psychological support
- Staff engagement

To support this we have a number of activities which have commenced or are in the planning stages for roll out during the next year.

On top of this amazing work our Occupational Health team have continue to provide normal business and usual activities including physiotherapy services, annual health campaigns and roll out of the flu vaccination which achieve a 92.50 % take up this year, which is our best ever take up utilising a creative and fun campaign. Due to Covid restrictions the team have utilised new and creative approaches to deliver their services including the roll out of wellbeing videos and access to online services.

Equality, Diversity and Inclusion

The Trust's strategic organisational goals are supported by the Equality Diversity and Inclusion (EDI) Steering Group, chaired by the Director of Human Resources and reporting to the People Committee and the Trust Board. The Trust continues to follow the duties of the Equality Act 2010, which legally protects people from discrimination in the workplace and in wider society.

The Public Sector Equality Duty which supports the following:

- Better health outcomes
- Improved patient access and experience
- A represented and supported workforce
- Inclusive leadership

The Trust has an Equality, Diversity and Inclusion Steering Group with membership representatives from across departments, staff side colleagues to embed equality, diversity and inclusion across the Trust.

The Trust EDI objectives are:

- Becoming a leading organisation for promotion of opportunity and diversity, for challenging discrimination, and for promoting equalities of opportunities in employment and the services we provide.
- Creating an organisation which recognises the contribution of all staff and which is supportive, fair and free from discrimination.
- Ensuring our staff have a positive experience at work, are offered opportunities to meet their full potential, and demonstrate the Trust's values.
- Ensuring that our Trust is regarded as a model employer.

Staff Equality and Diversity Information

Headcount - Gender	2020/21	2019/20
Female	8001	7295
Male	1820	1608
Grand Total	9821	8903

FTE - Gender	2020/21	2019/20
Female	6656.65	6194.55
Male	1566.70	1478.47
Grand Total	8223.35	7673.02

Headcount - Religious Belief	2020/21	2019/20
Atheism	1345	979
Buddhism	30	23
Christianity	4552	3848
Do not wish to disclose	2558	3084
Hinduism	101	85
Islam	239	198
Judaism	4	3
Other	817	633
Sikhism	16	11
Undefined	159	39
Grand Total	9821	8903

FTE - Religious Belief	2020/21	2019/20
Atheism	1145.56	883.1
Buddhism	25.9	20.54
Christianity	3846.44	3335.88
Do not wish to Disclose	2077.17	2572
Hinduism	86.69	78.24
Islam	210.05	182.93
Judaism	2.96	2.96
Other	697.29	559.32
Sikhism	13.8	10
Undefined	117.50	28.07
Grand Total	8223.35	7673.02

Table 12: Staff E&D Information

The Trust EDI Steering Group meets monthly and includes the Patient Experience Lead and integrates work from other Trust strategies (i.e. health and wellbeing, education, learning and development) to ensure our patients and carers have a positive experience .

The work of the group has included the development of EDI network groups, providing a forum for individuals to come together, to share ideas, raise awareness of challenges and provide support to each other. The network groups identified so far are:

- Lesbian, Gay, Bisexual and Transgender Networks (LGBT+)
- Black Asian Minority Ethnic Network (BAME)
- Disability and Long Term Health Network (including Mental Health Network)
- Faith Network

Additionally the Trust is in the process of creating a Women's network group following a very successful launch of the celebrating International Women's Day.

From the start of 2021 a new calendar of EDI awareness events has commences including to date LGBTQ+ history month, Chinese New Year through a cultural food experience, Common Wealth Day, Autism Awareness week, Ramadan and Mental Health Week.

The Trust's is committed to EDI education and a range of training is made available to staff, in addition to mandatory EDI training. The training focuses around the Trust's commitment to ensure all staff are free from discrimination and feel equally supported in career progression and opportunities.

The Trust has reviewed its Workforce Race Equality Scheme and data, to support further EDI action planning. The Trusts Workforce Disability Equality Scheme and supporting information is being used to underpin and provide an evidence base in the development of the Health and Wellbeing Strategic Plan.

The Trust was successful in securing funding from the NHS Leadership Academy Programme to introduce a programme of Reciprocal Mentoring. Following initial meetings with national and regional representatives from the Leadership Academy a project implementation plan has been developed to establish 20 pairs of mentors. Each pair will consistent of a BAME colleague and a member of the Trusts Senior Leadership team.

We are the first Trust in our region to take part in the Reciprocal Mentoring Programme and we are looking for 20 BAME colleagues who are interested in making a difference for our current and future workforce and services working in partnership with our BAME staff network.

Reciprocal mentoring is a mutually beneficial relationship where each participant learns from each other and improves their professional performance. They hold each other accountable and give each other encouragement and feedback on their goals.

Reciprocal Mentoring is a systemic intervention designed to enable change that leads to greater equity of outcomes across the whole organisation.

In reciprocal mentoring the mentors are partners developing each other's ability to make significant improvements in equity.

Our programme will be design to last for up to 18 months and requires a long term commitment to working in partnership to influence change for our workforce.

The Trust is part of a North East and North Cumbria, EDI and regional pilot on overhauling recruitment and selection practices, specifically around areas identified nationally as requiring change. This will benefit the Trust in enhancing further our approach to recruitment and selection practices.

Sickness Absence

The Trust is committed to promoting and maintaining the health, safety and welfare of all staff and believe in encouraging its workforce to have good wellbeing, to live healthily and to achieve a good work life balance. Our Absence Management Policy and processes are designed to provide a framework to assist in the health and wellbeing of our employees and to promote a healthy workforce and provide efficient patient, safe and effective patient care.

We continue to focus on sickness absence and have made significant improvement to improve the support we provide to managers, ensuring that ensuring that both long and short term sickness is managed in accordance with the sickness absence policy.

We continue to work in close partnership with the Occupational Health Department and have developed case management forums to ensure that both staff and management are supported throughout the absence period, with a view to retaining, returning and rehabilitating staff into the workplace.

In additional to general occupational health advice and provision, we are working in partnership with a number of professional bodies offering support and counselling services and actively encourage staff to seek the help and support they need to aid their recovery.

In 2019/20 the average sickness absence rate for the Trust was just over 4% which slightly exceeded the Trust target of 3.9%. We are confident that the focus on absence management will enable us to meet the 3.9% target within 2021/22.

Quality and Equality Impact Assessment

The need for a formal Quality and Equality Impact Assessment (QEIA) process as part of robust governance arrangements is well recognised. This process has been developed to ensure the trust has the appropriate steps in place to safeguard quality whilst delivering significant changes to service delivery and also understand the impact of the change either negatively or positively on any groups of the community which may be affected. The process is based on the guidance issued by the National Quality Board and the Equality Act 2010.

The Trust has a Quality and Equality Impact Assessment (QEIA) Policy that advises when changes to services are being planned, the impact on quality and equality must also be considered.

The QEIA process should be used to assess the impact that any new policy, service change or cost improvement programme may have on the quality of care provided to patients at South Tees Hospitals NHS Foundation Trust and provides a robust and consistent framework to both inform decision making and agree assurance metrics.

The impact on equality and diversity also needs to be assessed - whether people could be treated differently in terms of race, religion, disability, gender, sexual orientation, pregnancy, gender reassignment, civil partnerships or age. This supports the Trust in meeting its obligations under the Equality Act 2010 to undertake equality impact assessments.

QEIA's are monitored and reviewed on a monthly basis via centres, as part of reviewing the actual impact throughout the implementation stage and during the final review after the business plan has been implemented. Thereafter, review will be business as usual or at any change of circumstance

The Trust uses a standard Quality & Equality Impact Assessment tool and risks are assessed using a standard risk assessment matrix.

All QEIA's are presented at centre Governance Boards, prior to them being submitted and presented to the QEIA panel by the lead manager and/or clinician.

The completed QEIA is then presented by the service lead to the Trust QEIA Panel – Chief Nurse, Deputy Director of Patient Safety & Quality and the Quality Assurance & Compliance Lead for final approval to progress. No change should be commenced without approval of the panel.

Regular reports are presented to the Quality Assurance Committee outlining QEIA's that have been discussed as well as the outcome.

During COVID-19 panels were held twice weekly to review service changes and then latterly with services restarting were arranged as required.

Junior Doctors

Doctors and Dentists in Training

Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires: "a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps" and NHSI has requested that there should be a statement in the Trust's Quality Account regarding this.

The vacancy rate was greatly improved in 2020/2021 compared to the previous year with the annual vacancy rate dropping from 6.4% to 4.1%. Vacancies have been covered in the main via re-adjusting rotas to accommodate the reduced number of Doctors. Vacancies have been actively recruited to throughout the year whilst an increased use of recruitment of Doctors via the Medical Training Initiative has helped to fill ST3+ level vacancies in a number of specialties. Longer delays to start dates where experienced when recruiting overseas doctors, due to COVID-19 travel restrictions/guidelines.

Gaps on rotas tend to be short term due to sickness or emergency leave, however there has been an increase in the number of long term rota gaps due to COVID 19 Sickness/isolation/risk assessment adjustments, where required. The Medical Rota Team track Junior Doctor Absence and any Doctors hitting trigger points are picked up by the relevant team (e.g. postgraduate team for Foundation Doctors, Lead Employer Trust for LET employed Doctors). Advanced Nurse Practitioners are successfully being utilised to cover gaps in some areas, working alongside Doctors in training.

The medical rota team continue to fill approximately 95% of all locum shifts each month with the majority (approximately 91%) being filled by internal locum cover as opposed to agency. The regional locum bank (FlexiShift) hosted by the LET is now well established for all LET employees and the Trust are exhausting the option to enrol locally employed trust doctors also. The regional bank provides the Trust with access to an additional pool of LET employed doctors who work in other Trusts and GP surgeries. The team continue to utilise the master vendor agency HCL where required.

In line with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, we have an established Guardian of Safe Working (GOSW), reporting quarterly to the Board and Workforce Committee, and a Junior Doctors' Forum meeting quarterly. Attendance at the Junior Doctor Forum has increased considerably following the August 2020 intake of Junior Doctors, with a number of members becoming accredited BMA representatives, taking up vacant seats on the Joint Local Negotiating Committee (JLNC).

Developing a Sustainable Workforce

Addressing Workforce Shortages

We have some difficulties recruiting people, particularly where there are national shortages such as medical staff, specialist nursing midwives and some allied health professionals. In addition our workforce retirement projections over the next five years are a concern in some areas. Working for South Tees isn't just about a job; it is about being part of something that is special and valued. We

will support our people to be able to recognise and celebrate the difference that they make to our patients and our communities and to each other.

In order to attract and retain the right people in the most effective ways we will develop joined up approaches to employment to meet the needs of our diverse workforce throughout their career. We will develop and implement a workforce planning model for clinical and non-clinical roles to support the delivery of national, regional and local healthcare objectives.

Building our relationships with higher education and further education sectors will provide an opportunity for us to develop a talent pipeline and also enable our colleagues to develop into new roles.

Objectives

- Develop a long term sustainable workforce planning process to identify workforce needs now and in the future with recruitment plans in place to support them, alongside efficient resourcing plans to ensure that we utilise our people to support the, alongside efficient resourcing plans to ensure that we utilise our people when and where they are needed
- Establish real time reportable establishment and vacancy rates for our clinical collaborative to support recruitment
- Develop creative and flexible values based approaches to recruitment, attracting and retaining colleagues who are looking for flexibility throughout their employment
- Overall reduction in agency spend and overtime
- Work with our colleagues and local communities to develop South Tees as the employer of choice

Measures of Success

- Each collaborative has a robust workforce plan
- We attract, recruit and retain an efficient, effective and diverse workforce
- Values based recruitment is embedded and evidenced
- Continued improvement in colleagues recommending South Tees as a place to work evidenced in the national staff survey
- Welcome day is relaunched leading to a positive on boarding experience

Tackling Bullying

Embedding Equality, Diversity and Inclusion

Through our equality, diversity and inclusion initiatives we will look to promote our values and behaviours at every opportunity and specifically to engender a sense of belonging for all by creating an environment where we value unique differences.

We will embrace diversity and promote inclusion, free from any type of negative behaviours. We will strive to ensure our workforce is representative of the communities that we serve, and recognise the contribution of workforce is representative of the communities that we serve, and recognise the contribution of all colleagues and is supportive, fair and free from discrimination and ensure there is psychological safety for all

Objectives

- Ensure open and transparent opportunities for all
- Review people policies and procedures
- Create diverse and inclusive culture
- To keep our colleagues safe and well at work

Measures of Success

- We have a diverse workforce representative of the communities we serve
- Staff networks are embedded, meet regularly and have membership from across the Trust
- We can demonstrate equitable and fair processes so that all colleagues feel valued and able to challenge discrimination
- An embedded reciprocal mentorship programme

Employee Engagement

Staff Engagement – Creating a Sense of Belonging

We want to make the Trust a great place to work and encourage our staff to develop their careers here. It is important for our staff to know that we listen and take action on suggestions for improvement.

Working together we will develop an engagement plan which will enable the Trust to communicate and listen to our colleagues, introducing innovative ways of communicating ensuring colleagues know how to share ideas and are engaged and involved in the improvement process. There will be open, transparent and positive ways for staff to raise concerns and identify learning opportunities in

adopting just culture approaches. We seek to reward, praise and celebrate colleagues for their contribution to their colleagues and the people we serve.

Objectives

- Actively engage and listen to colleagues so they feel values and respond positively to annual staff survey and regular check in surveys to improve job satisfaction
- Ensure that we have open and honest and transparent and positive channels in which colleagues can rise concerns
- Reward, praise and celebrate colleagues for the contribution they make to the Trust, patients and other colleagues

Success looks like

- Staff survey engagement scores increase year on year and colleagues fell valued, engaged and happy at work
- Robust staff survey action plans owned in each clinical collaborative
- Colleagues are willing to and regularly offer feedback which is acted upon

Recruitment

Included in addressing workforce shortages above

Day Nursery

Playdays Nursery is an excellent onsite facility, offering quality and flexible childcare for our staff's children whilst they are at work. It was awarded a 'good' rating following our recent Ofsted inspection. Nursery fees are competitive in comparison to other local nurseries, offering the staff assurance that their COVID 19 Pandemic.

Relationships with Trade Unions

We continue to develop our partnership with Trades Unions colleagues, with a Partnership Agreement which supports the following aims:

1. Promotes close co-operation between staff and managers within the Trust by providing a forum in which all matters affecting staff can be discussed and relevant information passed on. This includes NHS policies and strategies, Trust operational and financial performance, key Trust service strategies, objectives and projects e.g. corporate level/ large scale change management projects.

2. Provides opportunities for joint problem-solving in relation to issues affecting the well-being of employees and the efficient operation of the organisation. It is recognised good practice that management and staff side will consult on any significant decision that is likely to affect staff members.
3. Supports consultation in relation to key changes in our HR policies.

The Joint Partnership Committee (JPC) attended by both management and Staff Side colleagues meets on a monthly basis; agenda items including the areas summarised above. The NHS and Trust continues to be a changing and challenging environment with both management and Staff Side recognising that their interest are mutually compatible with the aim of preserve jobs and the quality of services.

Employment Policies

The Joint Partnership Committee ensures that HR policies and procedures are fit for purpose, reflective of any changes to employment law and support equality and diversity within the workplace. The JPC also provides Staff Side with an opportunity to be updated regarding other policies that are led by other corporate areas e.g. Freedom to Speak Up; Raising Concerns at Work policy. Policies are revised and presented to JPC on a scheduled basis.

Social Economic Responsibility

- We continue to support the local community and widen the accessibility of learning and development through the apprenticeship levy offering new starters and staff a vocational route to enter and progress within the organisation.
- We are actively recruiting to apprenticeship roles. Included are the Advanced Clinical Practitioners, Nursing Associates as well as Health Care Support and Business Administration.
- We offer graduates, through the Graduate Management Scheme, the opportunities to develop knowledge and skills operationally and strategically within their chosen field.

Performance against key national priorities

	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	20/21 Target
Safety									
Clostridium (c.) difficile - meeting the C difficile objective	57	76	61	43	48	41	89	79	81
all cancers: 62 day wait for first treatment from:									
Urgent GP referral for suspected cancer	84.70%	85.30%	79.10%	81.10%	85.44%	82.65%	77.23%	75.52%	85%
NHS Cancer Screening Service Referral	94.80%	92.60%	89.80%	89.00%	94.55%	87.14%	94.41%	62.77%	90%
18 weeks referral to treatment time (RTT									
Incomplete Pathways	95.20%	95.70%	93.20%	92.20%	91.45%	89.49%	83.33%	63.20%	92%
Accident & Emergency									
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	96.70%	94.90%	95.80%	95.33%	95.68%	95.24%	88.35%	83.45%	95%
Diagnostic Waits									
Patients waiting 6 weeks or less for a diagnostic test	99.60%	98.70%	98.82%	99.15%	97.46%	98.26%	94.04%	72.57%	99%

Table 13: Performance against National Priorities

Table 13 shows the Trusts performance against key national priorities.

- C difficile – the Trust recorded 79 cases of C difficile during 2020/21 which was under the target of 81 and this remains a focus for 2021/22.
- Urgent GP Referral for Suspected Cancer (62 day cancer wait target for first definitive treatment) – our year end performance was 75.52% against a target of 85%. Recovery plans are in place to support improvement in the patient pathway and performance.
- 4 hour Accident and Emergency waiting time target - year-end performance was 83.45% against a target of 95%. Factors affecting the performance include an increase in acuity of patients and very high intensity users attending A&E. Capacity within the hospital during the winter period has affected patient flow. Recovery plans are in place to address such issues.
- Referral to Treatment (RTT) 18-week target – our year-end performance was 63.20% which is below the national target of 92%. Recovery plans and trajectories are in place to address areas of concern.
- Diagnostic Waits – (waiting 6 weeks or less) – our year-end performance was 72.57% with a target of 99%. Recovery plans and trajectories are in place to address areas of concern.

Annex 1: Statements from Clinical Commissioning Groups and Healthwatch and Scrutiny of Health

Healthwatch Middlesbrough and
Healthwatch Redcar and Cleveland
Pioneering Care Partnership
Pioneering Care Centre
Carer's Way
Newton Aycliffe
DL5 4SF
Tel: 0800 118 1691
Email: healthwatchsouthtees@pcp.uk.net

www.healthwatchmiddlesbrough.co.uk
www.healthwatchredcarandcleveland.co.uk

Dear David,

Healthwatch South Tees response to South Tees Hospitals NHS Foundation Trust Quality Account 2020-2021

Healthwatch South Tees (HWST) is pleased to have the opportunity to again comment on the STHNHSFT Quality Account however, this is a large document and to enable adequate perusal of its content by external interested parties, sufficient time must be allowed for this to take place in future, otherwise their ability to produce meaningful comment becomes very much limited.

Overall, this report reflects the high standards of care the area has grown to expect from this healthcare institution. None-the-less, we would make the following comments, given below:

Healthwatch South Tees comments:

There is an abundant use of acronyms, although these are initially defined, it is time consuming to repeatedly go back and find the definition in the text. It would be helpful if there could be a separate page of definitions.

The section on patient safety is broken into sections, each with its measures of success and end of year progress, few of which are quantified against previous years and so it becomes difficult to establish how much progress has actually been made. This is particularly illustrated in the section ensuring patients that have a safe, effective, and timely discharge (page 38).

Perhaps the "end of year progress" is really an aspiration, this is not at all clear. However, it is pleasing to see the action proposed/taken with regard to patient communication which we are aware has been a particular issue of concern during the pandemic period, when it is likely to have been exacerbated by associated staff shortages.

It is good to see so many departments within the Trust engaging in so much local and national clinical audit, which is likely to result in benefit for patient care. Similarly, participation in the 'Getting it Right First Time Programme' by a variety of departments with more planned in the future can only be of benefit for patient care. Hopefully, such participation will lead to a reduction in the number of services currently requiring enhanced surveillance (page 57).

Healthwatch South Tees commented on the Trust's quality report last year, noting that following the CQC inspection in 2019, the Trust received an overall rating of 'requires improvement' and the inspection report contained 26 'must do' recommendations and 22 'should do recommendations. This year's report states that only one of the 'must do' recommendations are now reported to be 'off track' (page 66; compliance with mandatory training) and we note that work is continuing to ensure the action plan to remedy this is fully implemented.

With regard to reporting against core indicators, it is concerning to observe that the Summary Hospital Level Mortality Indicator continues to show a mortality rate above the national average, despite events peculiar to 2020/21, although it is recognised that this will in part be a reflection of the Trust's catchment population. However, it is pleasing to note that the reduction in re-admissions of adult patients within 28 days of discharge seen in 2016/17 continues to be maintained. Unfortunately, this is not shown to be the case in children where the trend shown in figure 14 (page 80) appears to be upward. Healthwatch South Tees also notes that patient's experience of their stay in the Trust's hospitals appears to be positive (page 81).

The Trust continues to perform well in prevention of cases of Clostridium difficile infection but perhaps it should be mentioned that this organism, although of importance, may be regarded as a proxy for hospital acquired infection as a whole, which might be shown in more detail.

Healthwatch South Tees is pleased to see that pressure ulcers have been identified as a quality priority because of their impact on the quality of life as lived by many frail and older people suffering from long term conditions. Also, that the increasing trajectory of falls shown over the past few years (page 89) is being addressed as a priority because of the impact this must have on length of stay and the subsequent impact this has on the health of the patients concerned.

In the section on performance against key national priorities (page 120), Healthwatch South Tees hopes to see a reduction in the numbers waiting more than 62 days for definitive treatment following urgent GP referral for suspected cancer and, a reduction in the numbers of those waiting more than six weeks for a diagnostic test by the time of next year's quality report.

The proportion of patients waiting more than four hours in A & E prior to admission, transfer or discharge over the past year may be a reflection of the numbers accessing A & E and the difficulties some patients have had in accessing primary care services. This is an issue currently under investigation by Healthwatch South Tees.

We hope that you find our comments useful and help to inform areas to consider over the next 12 months.

Kind Regards

Lisa Bosomworth
Healthwatch South Tees Development & Delivery Manager

healthwatch Middlesbrough healthwatch Redcar and Cleveland

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NHS
North Yorkshire
Clinical Commissioning Group

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Reference: 1358-2021-SP-JLS

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19 July 2021

Dr Hilary Lloyd
Chief Nurse
South Tees NHS Foundation Trust
The Murray Building
The James Cook University Hospital
Marton Road
Middlesbrough
TS4 3BW

Dear Hilary

Re: 2020-21 Quality Account for South Tees Hospitals NHS Foundation Trust

Many thanks for the submission of the South Tees Hospitals NHS Foundation Trust Quality Account. This details what the Trust has done to improve the quality of our commissioned services in 2020/21 and how you intend to make further improvements during 2021/22. North Yorkshire Clinical Quality Group (NYCCG) welcome the opportunity to review and are pleased to provide a response statement for the Trust's Quality Report for 2020/21. It is noted that the Quality Account is in draft and some information is awaiting therefore NYCCG comments are on the draft account. This draft Quality Account has been reviewed in accordance with the Department of Health and Social Care (Quality Accounts) Amendment Regulations 2017.

This report has been shared with key individuals across NYCCG and their views have been collated into my response. As Commissioners of healthcare, we are committed to ensuring the provision of high-quality services for our population and take seriously our responsibility to commission services that not only meet quality and safety standards, but also listen and respond to patient feedback to help inform service developments.

Firstly, we would like to take this opportunity to thank all staff at the Trust for their hard work and dedication during the on-going COVID19 pandemic, which we acknowledge has had an impact on the achievement of some of the priorities and targets set for 2020/21. The system response to this issue has been incredible and seen a requirement for a flexible approach to patient care and we would like to express our appreciation to South Tees Hospitals NHS Foundation Trust for your part in the local NHS and wider system response.

Overall NYCCG considers the draft Quality Account of 2020/2021 to be a fair reflection of the Trust performance and acknowledges the progress made to improve patient safety, outcomes and experience.

NHS
North Yorkshire
Clinical Commissioning Group

The key successes and challenges of the priorities are clearly reflected in the draft Quality Account. NYCCG note the achievements that have been made against the priorities set by the Trust for 2020/21 and accept that due to the pandemic and system pressures some have been transferred to 2021/22. We welcome the plans to monitor the performance.

NYCCG particularly notes:

- The Trust's commitment to the new National Patient Safety developments and this includes notably the future development of the Patient Safety Incident Response Framework. The CCG would welcome involvement in the workstream of identifying the category of incidents that the Trust chooses to investigate, and the level of investigation required. The improvement and investment in achieving the performance in incident reporting and the continuing work to improve the quality of the investigation report is noted

- The Trust acknowledging that they have not had any further surgical never events and the work that they have instigated to support safe surgical practice. The CCG would welcome continued involvement with the remaining categories of reported never events that have caused concern. It is recognised that there is ongoing work to try and reduce this figure and it has been set as a quality priority for the forthcoming year with a target to train 90% of staff in Human Factors. The CCG acknowledges the "Just Culture", Freedom to Speak Up Guardian and Empathic Listeners approach that the Trust continues to adopt which encourages staff to speak up facilitating a culture of openness, learning, support and fairness.

- Whilst the Trust acknowledge that due to Covid the publication Quality & Strategy will be delayed, there is adequate evidence within the quality report to provide assurance that feedback from the CQC inspection has led to the formation of a new Leadership and Safety Academy/strategy.

- It is positive to see the achievements of the STAQC process despite the pressures that the clinical teams have been exposed to during the pandemic.

- Patient experience especially within the outpatient departments and the complaints process. The CCG is assured that the focus has remained on this important aspect of care provision and that despite national guidance of a step-down approach to the complaint timescales the Trust chose not to implement this and maintained compliance.

- NYCCG notes the significant improvement work taken by the Trust following the CQC inspection report in 2019 in which the Trust received a 'requires improvement' rating. We acknowledge the commitment towards the longer term need for a wider program of change and improvement and is pleased to be working with the Trust to deliver improvements to quality and safety of patient care in a partnership approach.

NHS North Yorkshire Clinical Commissioning Group
Head Office, 1 Grimbald Crag Court, St James Business Park, Knaresborough, HG5 8QB

Clinical Chair: Dr Charles Parker
Accountable Officer: Amanda Bloor

NHS
North Yorkshire
Clinical Commissioning Group

NYCCG welcome the opportunity to review the draft Quality Account and confirm that the account is a fair reflection of the Trust performance and acknowledges the progress made to improve patient safety and experience despite the challenges brought about by the ongoing pandemic. The key successes and challenges of the 2019/20 quality priorities are reflected in the draft Quality Account. We look forward to continued partnership working to ensure that there remains a coordinated, collaborative approach towards safeguarding the quality and safety of services provided to our patient population, whilst developing new ways of working to deliver improvements across pathways of care that have local impact especially relating to both the Friarage Hospital and the Friary.

Yours sincerely

Sue Peckitt
Chief Nurse
NHS North Yorkshire CCG
suepeckitt@nhs.net

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Clinical Chair: Dr Charles Parker
Accountable Officer: Amanda Bloor

Councillor David Coupe
Chair, Middlesbrough Council's Health Scrutiny panel
C/o Town Hall
Middlesbrough
TS1 9FT

Ian Bennett – Deputy of Quality and Safety

17 July 2021

Dear Ian,

SOUTH TEES HOSPITALS NHS FOUNDATION TRUST QUALITY ACCOUNT 2020/21

Comments from a meeting of Middlesbrough Council's Health Scrutiny Panel held on 13 July 2021 in respect of the South Tees Hospitals NHS Foundation Trust Quality Account 2020-21.

The Health Scrutiny Panel welcomed the opportunity to consider and comment on the quality of services at the Trust.

The Health Scrutiny Panel has met previously with Trust representatives to consider the Trust's quality priorities and overall performance, and is grateful to representatives of the Trust for attending and discussing the key features of the 2020-21 Quality Account.

The Panel was aware of the challenges faced by the Trust, notably the actions following the CQC's inspection in July 2019, as well as the ongoing pressures brought about by the Covid Pandemic. Nevertheless, it was greatly impressed by the Trust's achievements and the hard work, commitment and dedication of its staff during such unprecedented times.

The Panel was particularly impressed the Trust has been able to deliver ground breaking services, such as procedures involving MitraClip in Cardiothoracic operations despite the confines of Covid restrictions. The Panel was also extremely pleased to see that the Care Quality Commission's recent inspection of the Trust's Radiology services found it was offering one of the best in the Country.

The move to making the Trust clinically led was evident and the Panel were very reassured that patient safety remains a high priority. The Panel was pleased to hear that, through initiatives such as *Getting it Right First Time* and *Freedom to Speak Up,* extensive organisational development continued with all staff to ensure incident reporting, organisational learning and overall transparency was improved.

The Panel were extremely pleased to hear that zero surgical *never events* had been recorded in 2020-21, compared to the previously recorded eight instances in 2019/20. It

was also assured that the Trust was not complacent in this regard and that ongoing actions were being taken to maintain this record, including placing the importance of reporting *near-miss* events.

In terms of performance against the national priorities; Members were concerned about the number of indicators not achieving their targets, some by significant margins. While there were mitigating circumstances for this, and this pattern was reflected in other Trusts, Members were keen to see improvements against all performance indicators in the next Quality Account document.

The Panel was pleased that the number of complaints and PALS enquiries had fallen since 2019/20, although appreciated this could be attributed to a reduction in patients visiting the Trust during the Pandemic. However, the Panel was reassured that despite changes to the complaints process, including the use of Microsoft Teams to engage with complainants, patients continued to receive robust complaint responses.

It is evident the Trust has continued to provide exceptional services with regards to Covid testing and issuing PPE, with 134,000 Covid Swabs tests and the delivery of one million aprons, four million facemasks and seven million pairs of gloves. The Panel was also pleased to hear that, before the programme moved to Primary Care, James Cook hospital had administered 71,000 vaccines. Due to this work, the Panel acknowledges that the Trust has also provided significant support to the wider health and care system.

As with previous reports, the Panel felt that the Trust is well prepared for coping with further waves of COVID-19, and had confidence in the Trust's medium to long term plans.

The Quality Account Priorities for 2021/22 were identified as below.

- Safety
  - Increase incident reporting by 10% per year. This will also mean an increase in incidents reported to the NRLS.
  - Reduce the occurrence of Incidents with Harm by training 90% of relevant staff in Human Factors
  - Develop and Implement a robust plan for the organisation to move over to the new Patient Safety Incident Response Framework when it is published and launched in 2022

- Clinical effectiveness (Measuring, Accrediting, Discharging)
  - To develop and implement a Quality & Safety Strategy for the trust
  - Identify and reduce unwanted variation by participating in the Getting it Right First Time (GIRFT) programme and implementing recommendations
  - To continue delivering the trust's end of life strategy and use local and national data sources to identify areas for improvement for mortality
  - Complete all relevant NICE quality standards assessments in order to:
    - Understand the priority areas to focus on quality improvement
    - Identify potential areas for local audit
    - Identifying
  - Ensure patients have a safe, effective and timely discharge

Patient experience (Collecting, Responding, Improving)

- Reduce the incidence of avoidable category 3 and 4 pressure ulcers in order positively impact on patients who are most at risk
- Establish a trust-wide inclusive patient experience user group which represents the diverse range of patients who come into contact with our services
- Using always events methodology, Improve the patients' experience in the area of letters and written communication to above 90% through a 'task and finish' groups.

The Panel is supportive of the 2021/22 priorities and looks forward to continuing to receive updates on progress during the year ahead.

Finally, the panel wishes to place on record its gratitude for the tremendous amount of work that has taken place over the last year by staff across the Trust.

Yours sincerely,

Councillor David Coupe
Chair of Middlesbrough Council's Health Scrutiny Panel

Hello David

Thank you for sharing your Draft Quality Account with me. As we haven't undertaken any specific work with the public / patients attending South Tees Hospitals over the past year (I only came into post in September) we don't have any specific comments to make on your accounts.

Hopefully next year.

Ashley Green

Chief Executive Officer
Healthwatch North Yorkshire

NHS
Tees Valley
Clinical Commissioning Group
First floor, 14 Trinity Mews
North Ormesby Health Village
Middlesbrough
TS3 6AL

15th July 2021

Dr. Hilary Lloyd
Director of Nursing & Midwifery
South Tees Hospitals NHS Foundation Trust
The James Cook University Hospital
Marton Road
Middlesbrough
TS4 3BW

Dear Dr Lloyd

Re: Statement from NHS Tees Valley Clinical Commissioning Groups on South Tees Hospitals NHS Foundation Trust Quality Account 2020/21.

NHS Tees Valley Clinical Commissioning Group (TVCCG) is pleased to provide a response to the Trust's Quality Account for 2020/21 and would like to thank the Trust for inviting the Commissioners to contribute to its development this year. The CCG looks forward to actively engaging with the Trust in the coming year and the formal response is provided as follows:

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

In so far as we have been able to check the factual details, the CCG's view is that the information provided within the annual quality account is an accurate and fair reflection of the Trust's performance for 2020/21.

Like many organisations across the country, STHFT faced a challenging year in 2020/21 as a result of the COVID-19 pandemic. The CCG would like to commend the Trust on the commitment and dedication demonstrated during this difficult time, in particular the Trust's achievement in developing round the clock on-site testing and becoming one of the first COVID vaccination centres.

The Commissioners recognise that the Trust has worked hard to improve both the recognition and reporting of patient safety incidents. The CCG acknowledges the work with staff to explore 'barriers to reporting', which includes focused work on wards/departments and introducing incident reporting at staff induction. This has yielded positive results in achieving the aim of a 10% increase in incident reporting within the Trust, which is also reflected in the NRLS data. That said, the CCG acknowledges that further work is still to be done to improve staff accessibility to incident reporting. The planned implementation of the 'Datix Cloud IQ' including the mobile phone app will support this, enabling staff to report incidents remotely, which is particularly useful when working within a community setting. The CCG supports the Trust in its continued focus on patient safety incidents for 2021/22 including the aim of increasing incident reporting overall by a further 10%.

Understandably, both the CCG and the Trust remain concerned about the impact on patient care of 'Never Events' and the CCG supports the Trust's plan to continue to include Never Events as a quality priority for 2021/22 aiming to achieve 90% of relevant staff trained in 'Human Factors'. It is disappointing to note that Never Events incidents have continued to occur throughout 2020/21, however, the CCG support the continued focus on the delivery of 'Safer Surgery' and the ongoing work around the development and implementation of Local Safety Standards for Invasive Procedures, prioritising areas where Never Events have previously occurred.

The progress the Trust is making in preparation for the full implementation of the new Patient Safety Incident Response Framework (PSIRF) planned for March 2022 is acknowledged. The development of a PSIRF plan which will set out how the Trust plan to identify and investigate incidents including the categories of incidents to be investigated; this is key to the changes in the Serious Incident process. The CCG looks forward to working collaboratively with the Trust to ensure the standards are met.

The introduction of a Trust Quality Strategy, aiming to give all staff personal responsibility for providing quality care within their areas, alongside the introduction of a nationally accredited process is welcomed by the Commissioners to achieve overall quality improvements within the Trust. The CCG look forward to reviewing the strategy when it is published at the end of October 2021.

The full implementation of the South Tees Accreditation for Quality of Care (STAQC) framework with embedded CQC key lines of enquiry will help provide assurance of the quality of care being delivered across the Trust. The CCG is pleased to note the progress of this work despite the impact of COVID-19. The Trust has estimated assessment dates in place for 2021/22 for 121/128 areas and the CCG awaits the results of these assessments. The Redcar Urgent Treatment centre and

ward 32 have demonstrated a positive start with both achieving Diamond accreditation this year. However, further work is required around Malnutrition Universal Screening Tool (MUST) assessments which have shown a significant deterioration during 2020/21. Nutrition and hydration are a standard that is assessed within the STAQC framework and the Commissioners look forward to seeing patient MUST assessment compliance improve during 2021/22.

Safe, effective and timely discharge was identified by the Trust as a key area for improvement; this has the benefit of reducing both patient harm and costs as well as improving patient care. A target of maintaining delayed discharges to below 3.5% was set. However, national targets in this area ceased and moved to reviewing patients against the criteria to reside in hospital. The CCG recognises the positive approach of the 'STOP' initiative that was implemented within the Trust, giving the 'Nurse in Charge' in each area final oversight of a patients discharge. This ensures that patients are provided with full information on discharge arrangements, empowering them to challenge any aspect. The CCG fully supports the decision to continue the focus on safe, effective, and timely discharge into 2021/22 due to the impact of the Covid-19 pandemic and in utilising the additional Government funding provided until September 2021. The planned implementation of a number of initiatives to improve patient discharge including the NHSE/I SAFER approach, strengthening the single point of access service and staffing engagement and training in new discharge processes are welcomed by the CCG. The outcomes will be reflected in the end of year performance measures, which the CCG are keen to monitor.

The CCG support the Trust's decision to include End of Life care as a quality priority for 2021/22 by delivery of the End of Life Strategy (2020/23) to support patients and families during this difficult time. A collaborative approach involving the Trust, Primary Care, Voluntary sector, and the CCG is welcomed. Planned direct feedback from patients and families will be an accurate reflection of improvements achieved and the CCG look forward to reviewing this in the forthcoming year.

Patient feedback is key to informing service improvements and the CCG is pleased to note the Trust success in last year's quality priority of continuing work to develop the patient experience programme including the implementation of the Meridian system and the Friends and Family test (FFT) guidance including the 'hard to reach groups'. To ensure continuing improvement in patient experience, the CCG is supportive of the plan to include the establishment of a Trust wide inclusive patient experience user group as a quality priority for 2021/22. The Commissioners are keen to see the impact of this initiative in future patient feedback and the forthcoming key performance indicators to be established by the Trust.

The CCG recognises the Trust's work to improve the management of complaints including the implementation of a new patient and carer policy as well as standardising the process for complaints. These changes have had a positive impact both with a reduction in the response timeframes achieved above the Trust target and a 14% reduction in the re-opening of complaints. The Trust does acknowledge a significant reduction in formal complaints received due to the pandemic.

The Commissioners accept that the Trust still has some improvements to make in patient experience and support the identified areas of improvements in communication. The CCG looks forward to seeing the results of the work of the task and finish groups set up to tackle the communication issues raised by patient and family feedback. Some of the changes planned include using standardised templates for outpatient appointment letters, testing the scanning and emailing of patient medication requirements to GPs and a rolling programme of customer care courses for administrative staff. The success of these changes will be measured in the forthcoming years patient feedback, which the CCG looks forward to reviewing.

Pressure ulcers have been by identified by the Trust as a quality priority for 2021/22, with a focus on wards that report an increasing incidence. The intention to support ward managers to attend training and have protected time to drive quality initiatives to achieve a reduction in patients suffering pressure damage is welcome. The Commissioners acknowledge the work completed so far in preventing pressure ulcers includes the implementation of the Tissue Viability Improvement plan (2021).

Of particular concern is the 10% reported increase in Safeguarding concerns during 2020/21,there is the reported 163 incidents relating to Trust practices which is a notable 42% increase. The CCG is keen to understand the detail behind these concerns and the Trust has highlighted that in-depth work will be carried out during 2021/22.

The Commissioners will continue to work collaboratively with the Trust following the Care Quality Commission (CQC) inspection report where a ‘Requires Improvement’ outcome was received in July 2019. The CCG is pleased to note that 48 out of the 49 ‘must do’ recommendations are completed or expected to deliver actions. For the one action deemed ‘off track’ relating to mandatory training compliance, the CCG is pleased to note that the Trust has ongoing actions to increase the training compliance from the current 84% to the target of 90%. There is acknowledgement that the Trust is also preparing for the next CQC visit, for which no date is yet set.

The recruitment of the Freedom to Speak Up Guardians and 'ring fenced' time within the Trust has seen an increase in the number of staff raising issues from 25 (2019/20) to 62 (2020/21), demonstrating staff trust in the process. This is also reflected in the 2020 staff survey which is positively received by the Commissioners.

The Commissioners note that the Trust continues to report above national average Summary Hospital-level Mortality Indicator (SHMI) mortality values; these are approaching the highest in the national range. The Trust offers mitigating factors to the high values registered including the impact of COVID–19 particularly wave 1 and the effect on hospital admissions. In addition, two recording anomalies have been identified; one of which is the Trust's lack of recording of patient's other medical conditions which is currently being addressed. Secondly, low risk patients who are treated within a single day and are not admitted are not included in the dataset and this has occurred earlier than in other Trusts nationally. The CCG will continue to provide robust scrutiny and challenge in relation to mortality outcomes during 2021/22 and will continue working with the Trust to identify opportunities for shared learning across the health economy.

Clinical research is both a national and Trust priority and the Commissioners congratulate the Trust on the acquisition of two NIHR grants and supports the Trust with the continuation of research studies to ensure new treatments and therapies are available to the people of Teesside.

Commissioners fully support the identified quality priorities for 2021/22 and acknowledge that these will underpin continued progress by the Trust in meeting their overall quality improvement goals. The CCG looks forward to continuing to work in partnership with the Trust to assure the quality of services commissioned on behalf of their population in 2021/22.

Yours sincerely

Jean Golightly
Executive Director of Nursing and Quality
NHS Tees Valley Clinical Commissioning Group

Annex 2: Statement of directors' responsibilities in respect of the quality report

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2020 to May 2021
- Papers relating to Quality reported to the Board over the period April 2020 to May 2021
- Feedback from North Yorkshire CCG requested 08/07/2021
- Feedback from Healthwatch South Tees requested 08/07/2021
- Feedback from Healthwatch North Yorkshire requested 08/07/2021
- Feedback from the Health Scrutiny Panel, Middlesbrough Council requested 08/07/2021
- Feedback from the Governors dated 17/07/2021
- The 2020 national staff survey 14/09/2020
- The Head of Internal Audit's annual opinion over the Trust's control environment – not required for 2020/21.
- CQC inspection report dated July 2019
- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual (which incorporates the Quality Accounts regulations) (published at www.monitor-hsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Date: 27/07/2021 Neil Mundy, Interim Joint chair

Date: 27/07/2021 Sue Page, Chief Executive

Annex 3: How to provide feedback on the accounts

We welcome feedback on this report and suggestions for the content of future reports.

If you wish to comment please go to the Quality Accounts page on the Trust website (www.southtees.nhs.uk).

Annex 4: Glossary of terms

18 Week RTT (Referral to Treatment)

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

A&E

Accident and emergency (usually refers to a hospital casualty department).where patients attend for assessment

Acute

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

Allied Health Professional (AHP)

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

Aseptic Non Touch Technique (ANTT)

The Aseptic Non Touch Technique (ANTT®) is the standard intravenous technique used for the accessing of all venous access devices regardless of whether they are peripherally or centrally inserted.

Assurance

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

Black, Asian and minority ethnic (BAME)

All ethnic groups except White ethnic groups; it does not relate to country origin or affiliation.

Better Care Fund (BCF)

The national fund was set up to support moving resources into social care and community services and to support the avoidance of admissions to hospital.

Board of Directors (of Trust)

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

Care Quality Commission (CQC)

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

Clinical audit

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

Clinical Commissioning Group (CCG)

These are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. They are clinically led groups that include all of the Practitioner groups in their geographical area with the aim of giving GPs and other clinicians the power to influence commissioning decisions for their patients. These organisations are overseen by NHS England and manage primary care commissioning, including holding the NHS Contracts for GP practices.

CUR (Clinical Utilisation Review)

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

Clinician

Professionally qualified staff providing clinical care to patients.

Commissioners

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

Commissioning for Quality and Innovation (CQUIN)

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

Consultant

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

Council of Governors

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

Criteria Led Discharge (CLD)

The lead clinician for a patient's care identifies the clinical criteria for their discharge. These criteria are discussed with the patient and the multi-disciplinary team and are recorded. A competent member of the multi-disciplinary team then discharges the patient when the clinical criteria for discharge have been met.

Datix

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

Daycase

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

Department of Health

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

Duty of Candour

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

Echocardiogram (ECG)

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

Elective

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

Electronic Patient Record

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

Electronic Prescribing System

Allows prescriptions to be transmitted and populated electronically, replacing paper and faxed prescriptions.

Emergency

An urgent unplanned episode of care.

Escherichia coli (E. coli)

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

Falls:

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

Finished Consultant Episode

An NHS term for a consultant episode which has ended due to discharge, transfer or death. A consultant episode is the time a patient spends in the continuous care of one consultant using hospital site or care home bed(s) of one health care provider or, in the case of shared care, in the care of two or more consultants.

Foundation Trust

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

Gastroenterology

The branch of medicine that deals with disorders of the stomach and intestines.

Governance

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

GNBSI (Gram negative blood stream Infections)

A group of blood stream infections that include Escherichia coli *(E.coli*), Klebsiella spp. and Pseudomonas aeruginosa.

HCAI

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

Healthcare Quality Improvement Partnership

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

Healthwatch

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

Hospital Episode Statistics (HES)

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

Hospital Standardised Mortality Ratio (HSMR) - this is a standardised tool for measuring mortality and is calculated using the ratio of observed (O) to expected (E) deaths. The observed number of deaths for a hospital is the sum of the actual number of deaths in that hospital.

HSMR (Hospital Standardised Mortality Ratio)

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

IAPT (Improving Access to Psychological Therapies)

Services that provide evidence based treatments for people with mental health issues, for example anxiety and depression.

Inpatient

Patient requiring an overnight stay in hospital.

Interventional Endoscopy

Is a minimally invasive procedure that involves the use of a thin, flexible tube (or scope) that is equipped with a camera and light at its tip.

Interventional Radiology (IR)

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

LocSSIP (Local Safety Standards for Invasive Procedures)

These are local processes/procedures in place to reduce the number of patient safety incidents related to invasive procedures, in which surgical 'Never Events' can occur.

Malnutrition Universal Screening Tool (MUST)

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

MAR (Medicine Administration Record)

A report that serves as a legal record of the medicines administered to a patient by a health care professional.

Medical Examiners

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

Medworxx

Patient flow management system used in South Tees

Meridian

IT programme that facilitates Trust-wide data collection via surveys and audits.

Multidisciplinary Team (MDT)

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

National Institute for Health Research (NIHR)

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

National Institute for Health and Clinical Excellence (NICE)

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

NCEPOD

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

National Patient Survey Programme

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

NHS Improvement (NHSI)

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

NEQOS (North East Quality Observatory Service)

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

NEWS2

This is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.

NRLS (The National Reporting & Learning System)

The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Since the NRLS was set up in 2003, the culture of reporting incidents to improve safety in healthcare has developed substantially.

Overview and Scrutiny Committees

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

PALS (Patient Advice and Liaison Service)

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

Patient Reported Outcome Measures (PROMs)

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

Payment by Results

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

Plan Do Study Act (PDSA)

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

Pressure Ulcer

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

Providers

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

Regulations

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

Research

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

Risk

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

Risk Assessment

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

RCA (Root Cause Analysis)

Is a systematic process for identifying "root causes" of problems or events including serious incidents to prevent a recurrence.

Schwartz Rounds

Schwartz Rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare.

Secondary Uses Service (SUS)

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

Service user

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

SMART (Specific, Measurable, Agreed, Realistic, Time-bound)

Used in objective setting, ensuring objectives are clear and easy to understand, whilst making sure they provide clear goals.

STAQC (South Tees Accreditation for Quality of Care)

STAQC is a ward / department accreditation programme which brings together key measures of nursing and clinical care into one overarching framework.

STRIVE (South Tees Research, innovation and education)

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

Summary Hospital-level Mortality Index (SHMI)

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

South Tees Hospitals NHS Foundation Trust

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

Ultrasound

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

Urinary Catheter

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