### Title:
Quality Account 2011/12

### Purpose:
The final draft of the 2011/12 Quality Account is presented to the Board for approval.

### Summary:
The Quality Account for 2011/12 has been produced in compliance with the National Health Service (Quality Accounts) Regulations 2010. The process to produce the Quality Account has been considered by the Audit Committee and the external auditors have provided an unqualified limited assurance report in respect of the content of the Quality Report.

The statement from NHS Tees is awaited and the outstanding dates in annex 2: Statement of directors’ responsibilities in respect of the quality report will be added when these are available.

### Prepared By:
Ruth James
Deputy Director of Healthcare Governance and Quality

### Presented By:
Ruth James
Deputy Director of Healthcare Governance and Quality

### Recommendation:
The Board of Directors is asked to approve the Quality Account for 2011/12

### Implications

<table>
<thead>
<tr>
<th>Legal</th>
<th>Financial</th>
<th>Clinical</th>
<th>Strategic</th>
<th>Risk &amp; Assurance</th>
</tr>
</thead>
<tbody>
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</table>

### Action/Decision

<table>
<thead>
<tr>
<th>Action/Decision</th>
<th>Assurance</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
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</tbody>
</table>
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PART ONE

Statement on quality from the chief executive

Ensuring we keep our patients safe and free from harm is crucial to providing consistent high quality care and remains very much at the heart of everything we do at South Tees Hospitals NHS Foundation Trust.

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

I am pleased to say there were many examples of initiatives in this report which have enhanced the safety, experience and outcomes for all patients in 2011/2012.

Our work for piloting a campaign which has helped hospital trusts reduce harm from pressure ulcers, falls, urinary catheters and blood clots, earned the patient safety team a national Safety Express award from the Department of Health.

The team have also shared their experiences with others and initiated the roll-out of the safety thermometer – which helps clinical areas examine their own practices and implement changes in their working environment.

The progress we have made since the first Quality Account was produced two years ago has been impressive but as the organisation sets out its key priorities for 2012/2013, we acknowledge there is always more we can do.

Our partnership with community services colleagues from Hambleton, Richmondshire, Middlesbrough, Redcar and Cleveland has presented a real opportunity to make continuous clinical improvements, bring healthcare closer to home and lower waiting times.

We will also continue to learn from others by benchmarking with other hospitals, sharing good practice and, of course, listening to what people say about us.

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

I am pleased therefore, to have the opportunity to present our Quality Account for 2011/2012 which I believe to be a fair and accurate report of our quality and standards of care.
*Insert signature*

Simon Pleydell
Chief Executive
PART TWO
Priorities for improvement.

Quality of care and patient safety is one of the core themes which underpin the trust’s values and objectives and we are continually exploring opportunities to make further improvements.

Review of progress with the 2011/2012 quality priorities.

In the 2010/11 Quality Account we identified the following areas for quality improvement focus:
- Further reducing healthcare associated infections
- Focus on discharge management to improve patient care
- To improve standards and delivery of nutritional care across the trust
- Continue to focus on reducing avoidable deaths in hospital (reduce risk adjusted hospital mortality/reduce hospital standardised mortality rate),
- Improving end of life care

Part 3 of the Quality Account provides details of the work done to support these quality improvements during 2011/2012, the following section summarises the progress made against the goals identified for each priority area:

Priority 1 – Further reducing healthcare associated infections. For 2011/2012 our goal was to continue to reduce MRSA bacteraemia and *C. difficile* cases and to have no more than 4 MRSA bacteraemia and 112 hospital attributed cases of *C. difficile*.

The table below shows that the trust was successful in achieving this goal:

<table>
<thead>
<tr>
<th>MRSA bacteraemia (trust-attributed)</th>
<th>2009/2010 (Acute Hospitals)</th>
<th>2010/2011 (Acute Hospitals)</th>
<th>2011/2012** (Acute and Community Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual target</td>
<td>24</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Number reported</td>
<td>9*</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>% reduction compared to previous year</td>
<td>25% decrease</td>
<td>33% decrease</td>
<td>67% decrease</td>
</tr>
</tbody>
</table>

Priority 2 - Focus on discharge management to improve patient care, improve clinical outcomes and reduce re-admissions. The position against the goals for 2011/2012 is described below:

- For appropriate pathways we aimed to send out at least 98% of discharge summaries within 24 hours of discharge, at the end of March 2012 across the trust as a whole 84% of discharge summaries were issued within 24 hours. Whilst the target was not met there was improvement from the baseline of 80% in March 2011 and at individual specialty level some did exceed the 98% target, work continues to drive further improvement.

- Giving patients a planned date of discharge improves their experience by allowing them to plan around their expected discharge and gives them more confidence when returning home. In March 2011 25% of patients were given a planned date of discharge and we set an improvement target to exceed 60% in the acute trust by the end of 2011/2012. At the end of March 2012 56% of patients had a planned date of discharge which is a significant improvement on the previous year but misses the target we set. Some divisions performed particularly well; neurosciences (92%), cardiothoracic services (92%) and women and children services (75%), and we are looking at these areas to see what lessons we can learn to improve compliance across the whole Trust. Further detail of the on-going work we are doing to improve the discharge process is described in Part 3 of this report.

Priority 3 - To improve standards and delivery of nutritional care across the trust. For 2011/2012 the trusts goals were to ensure all patients are screened to assess their risk of malnutrition and this is appropriately acted upon. Progress towards the targets we set is described below:

<table>
<thead>
<tr>
<th>Infection in patients aged 2 years and over (trust-attributed)</th>
<th>(Acute Hospitals)</th>
<th>(Acute Hospitals)</th>
<th>(Acute and Community Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual target</td>
<td>280</td>
<td>116</td>
<td>112</td>
</tr>
<tr>
<td>Number reported</td>
<td>141</td>
<td>125</td>
<td>67</td>
</tr>
<tr>
<td>% reduction compared to previous year</td>
<td>47% decrease</td>
<td>11% decrease</td>
<td>46% decrease</td>
</tr>
</tbody>
</table>

Data Source: Trust apportioned MRSA counts from HPA website (www.hpa.org.uk)
Data Source: Counts of Trust apportioned Clostridium Difficile cases taken from HPA (www.hpa.org.uk)

*The 2009/2010 quality account reported total MRSA bacteraemias – from 2010/2011 this was changed to report only those attributed to the trust.
**In 2011/2012 the trust’s target and the numbers of cases reported includes community hospitals.
- Improve the percentage of patients who have a malnutrition risk assessment within 24 hours of admission; at the end of March 2012 our audits showed
  - In the acute hospitals compliance was 88% compared to 81% in the previous year.
  - In the community nursing services across Middlesbrough, Redcar and Cleveland and Hambleton and Richmondshire, there was compliance of 99% with the requirement to screen for malnutrition, all localities met their targets for nutritional screening and ensuring that appropriate care plans are in place.
  - In Middlesbrough, Redcar and Cleveland community hospitals 93% of patients were screened for malnutrition in 24 hours. This data is not available in a comparative format for Hambleton and Richmondshire community hospitals and this is an area of work for 2012/2013
  - Ensure that at least 95% of patients who trigger intervention following a malnutrition risk assessment receive it; our audits showed that we did not achieve this standard in the acute hospitals and at the end of March 2012 80% of patients in this category had documented actions recorded in their notes when intervention was triggered. Further details on this and the steps we are taking to address this are described in Part 3 of this report

Priority 4 - Continue to focus on reducing avoidable deaths in hospital (reduce risk adjusted hospital mortality/reduce hospital standardised mortality rate). In 2011/2012 the trust’s goal was to achieve a year-on-year improvement in the Risk Adjusted Mortality Index (RAMI). The long term trend showing a consistent year on year reduction is described in detail in Part 3. In the 12 months January - December 2011 the RAMI was 80.3 compared to 91.8 for the previous 12 months.

Priority 5 – Improving end of life care. For 2011/2012 the trust’s goal was to provide high quality care with dignity and compassion to all patients who are nearing the end of their lives, this was measured in the following ways:
  - To increase the number of dying patients on an end of life care pathway. For the acute hospital our target was to improve from the 2010/11 baseline of 84% to more than 92%, and the local audit at the end of 2011/2012 showed 92% compliance. In community nursing the target was to improve from the baseline of 70% to more than 90% which was achieved with a end of year position of 98%.
  - To record the preferred place of care in all patients whose care is managed on the end of life care pathway and to monitor the number of patients who achieve this. During 2011/2012 an audit was undertaken
which showed that in the acute hospital 80% of patients who died achieved their preferred place of care and in the community the compliance was 97%.

- To reduce admissions/readmissions of patients from care homes at the end of life – this work is on-going.

Further detail of the work to improve end of life care is reported in Part 3.

**Quality Priorities for 2012/2013**

The process to select the quality priorities for improvement in 2012/2013 across South Tees Hospitals NHS Foundation Trust acute and community services is described in Part 3, the areas chosen were those that were identified most frequently in the consultation process; these were supported and approved by the Board and the Council of Governors. For 2012/2013 the quality account priorities are grouped under the three domains of quality; patient safety, clinical effectiveness and patient experience and the work we plan to do to make improvements in these areas is described below.

**Patient Safety**

<table>
<thead>
<tr>
<th>Priority 1 – Continue to focus on discharge management in order to improve patient care, improve clinical outcomes and reduce re-admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale:</strong></td>
</tr>
<tr>
<td>Ensuring that the process of discharging a patient from hospital or community health service is planned, timely, supported by good documentation and effectively communicated is key to ensuring that patients don’t stay in hospital longer than they need to and that when they leave hospital they, and others, involved in their care know what to expect and how to manage any on-going healthcare needs.</td>
</tr>
<tr>
<td>The trust’s goals are:</td>
</tr>
<tr>
<td>• To provide timely and quality discharge documentation and communication to patients &amp; carers, GPs and community hospitals/care homes.</td>
</tr>
<tr>
<td>• All patients will be given a planned date of discharge to improve the patient experience whilst receiving health care during their hospital stay and to give them more confidence when returning home.</td>
</tr>
<tr>
<td><strong>Initiatives for 2012/2013</strong></td>
</tr>
<tr>
<td>• Roll out of new discharge documentation.</td>
</tr>
<tr>
<td>• All complex discharge patients to have a completed discharge plan</td>
</tr>
<tr>
<td>• All patients transferred from an acute to a community bed to have a transfer plan</td>
</tr>
<tr>
<td>• Care co-ordination/case management model to be agreed and implemented</td>
</tr>
</tbody>
</table>
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South Tees Hospitals NHS Foundation Trust Draft Quality Account – May 2012

- Nurse/therapy-led discharge to be the default
- Ensure effective handover/e-discharge within 24 hours to inform primary care and community services
- Ensure discharge on planned date of discharge or before is the norm

**Monitoring**
- Percentage of complex discharge patients with a completed discharge checklist.
- Percentage of patients transferred with a complete discharge checklist
- Number of e-discharge summaries issued within 24 hours of discharge
- Number of patients who achieve planned date of discharge
- Audit of the quality of information in discharge summaries

Progress with be reported through quarterly performance and CQUIN reports to the Board and a midyear Quality Account progress report to the Integrated Governance Committee and the Board of Governors.

**Implementation Leads**
Deputy director of service transformation

**Board Sponsor**
Director of operational services

**Priority 2 – Further reducing healthcare associated infections**

**Rationale:**

Ensuring we know what to do to avoid infection and actually doing this for every patient are two crucial components of delivering safe, clean care. Adopting a ‘zero tolerance’ approach to infection requires leadership and constant vigilance at all levels within the trust.

We are working very hard to continue to bring down rates of healthcare associated infections (HCAI) but we can never be complacent in this area – one patient with any healthcare associated infection is one too many.

The trust’s goals are:

- To continue to reduce MRSA bacteraemia and *C. difficile* cases assessed by delivery of the 2012-13 improvement targets of no more than 3 MRSA bacteraemia and 80 trust-attributed cases of *C. difficile*.
- To continue to improve the infection prevention and control (IPC) skills and knowledge of all trust staff in relation to their role in reducing all healthcare associated infections (HCAI).
- To continue to maintain adherence to *The Health and Social care Act 2008 - Code of Practice for health and adult social care on the prevention and control of infections and related guidance.*
Initiatives for 2012/2013

- Fully embed the HCAI action plan repository
- Review of HCAI communication and reporting.
- Re-design the IPC training portfolio
- Complete an IPC team review to provide a seamless trust-wide service.

Monitoring

- Monthly reporting of MRSA and C.difficile to the Board.
- Monitoring of the HCAI action plan repository compliance will be through Board of Directors monthly reports and the infection prevention action group. The exception reports will identify any non-compliance.
- Assess revised communication and reporting process through user feedback.
- Monitor IPC training figures.
- IPC team review will be monitored through the IPC executive group.

Implementation Leads

- Infection control doctors
- Assistant director of nursing (Deputy DIPC)
- Clinical matrons

Board Sponsor

Deputy chief executive and director of nursing and patient safety

Clinical Effectiveness

Priority 3 – To continue to improve standards and delivery of nutritional care across the trust

Rationale:

Today, an unacceptable number of people are becoming malnourished when they are in hospital. They become malnourished because they don’t get food they can eat or the help they need to eat it.

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

It is not acceptable to this organisation that our patients may become malnourished, and that malnutrition is not being detected and treated in hospital and in community settings.

This trust has a proactive and organised approach to combating malnutrition overseen by the nutrition steering committee and its importance is recognised as a key priority for the organisation.
Although the organisation has made significant improvements during 2011/2012, it is felt that this is an area where further improvements can be made to fully achieve the trust goals.

For 2012/2013 the trust’s goals are:

- To achieve greater than 90% of patients being screened to assess their risk of malnutrition within 24 hours of admission and ensure this is appropriately acted upon
- To ensure we meet the needs of patients who require help with eating or drinking
- To provide choices of food and drink for people to meet their diverse needs making sure the food and drink we provide is nutritionally balanced and supports their health.

### Initiatives for 2012/2013

**Implementation of the trust food & nutrition strategy:**

- To address all aspects of the delivery of nutrition and hydration to our patients
- To promote a culture of ‘Food First’ within the organisation
- To implement packages of competency based training for food and nutrition across the organisation

**Nutritional screening:**

- Exploring opportunities to extend nutritional screening to short-stay and outpatient areas
- On-going monthly monitoring of compliance with completion of the malnutrition screening tool

**Assisted Feeding:**

- Implementation of Standard Operating Procedures for delivery of food and drinks at ward level
- Employ a creative approach to optimise the mealtime experience.

**Catering:**

- Introduction of new steam concept meals across areas in the trust where demand and mealtimes are unpredictable e.g. maternity, high dependency areas.
- Explore options for provision of a menu that is locally sourced and minimises the carbon footprint, while meeting nutritional standards and reflecting patient choice
- Ensuring effective processes are in place to capture patient feedback in relation to delivery of food and hydration and employ a ‘you said, we did’ approach.
- To review the trust’s protected mealtime policy to ensure patients are not
interrupted during mealtimes unnecessarily

Monitoring

- Measuring of compliance with malnutrition risk assessment.
- In community hospitals measuring the number of patients requiring fluid balance monitoring who receive it.
- Undertake a review of the quality of the completed fluid balance charts in the community hospitals.
- Undertake a programme of in-year audits and patient involvement exercises
- Nutrition Action Plan will include targets for improvement.

Progress with be reported through quarterly CQUIN reports to the Board and a midyear Quality Account progress report to the Integrated Governance Committee and the Board of Governors.

Implementation Leads

Director of nutrition & dietetics (Chair Nutritional Standards Committee (NSC), clinical standards rep)
Clinical manager, dietetics (chair, food and nutrition group)
Lead clinical matrons for nutrition (NSC, food and nutrition, essence of care, hydration)
Lead consultant for nutrition (nutrition team)
Assistant director of nursing (patient experience)
Assistant director hotel services

Board Sponsor

Deputy chief executive and director of nursing and patient safety

Patient Experience

Priority 4 - Improve communication

Rationale:

Issues with communication are often cited as a contributory factor in complaints. Improving communication with patients around their discharge arrangements and their medication is highlighted in patients’ surveys.

The trust’s goal is:
To ensure that patients feel staff communicate with them in a clear and understandable way.

Initiatives for 2012/2013

- If patients have to wait longer than expected in outpatient clinics provide an
explanation for the long waiting time and the expected duration of the wait.

- Improve the provision of information leaflets to patients
- Improve communication with patients relating to medications at time of discharge
- Support and train staff in breaking bad news and having difficult conversations
- Ensure that hospital passports are actively used by healthcare staff caring for patients with learning difficulties

### Monitoring

- Incorporate questions relating to communication in the quarterly patient experience surveys.
- Reducing incidents coded as ‘communication’ compared to the 2011/2012 baseline
- Reducing the number of complaints where poor communication is a key factor compared to the 2011/2012 baseline
- Undertake an audit of the use of hospital passports for patients with learning difficulties.

Progress with be reported through bi-annual patient experience strategy reports and a midyear Quality Account progress report to the Integrated Governance Committee and the Board of Governors.

### Implementation Leads

Deputy director of nursing

### Board Sponsor

Deputy chief executive and director of nursing and patient safety

### Priority 5 - Right care, right place, right time (reduce delays, improve patient flow and cancellations)

#### Rationale:

Ensuring patients receive the required level of care in the most appropriate setting for their needs - which reflects their choice - is key to providing safe, effective care which is also a positive experience for patients and their families.

The trust's goals are:

- To develop an integrated system of services, which enables the care of patients to be delivered in a safe, effective and more timely way.
- To ensure that each patient’s on-going care needs are assessed at the earliest possible point in the care pathway and a plan of care (agreed with the patient’s families and other agencies) is implemented in a timely manner.
- To reduce delays and have minimum cancellations.
- Reduce the number of patients admitted to wards other than their own speciality due to capacity pressures.
Agenda Item 10.1

Initiatives for 2012/2013
- Develop the intermediate tier of services in the community, including the virtual ward and rapid response team
- Care co-ordination/case management model to be agreed and implemented
- Development and implementation of divisional transformation plans to achieve outcomes identified within the strategic blueprint.

Monitoring
- Strategic blue-print outcome measures (to be finalised)
- All projects will be monitored through the project assurance office

Progress will be reported through project reports to the Board and a midyear Quality Account progress report to the Integrated Governance Committee and the Board of Governors.

Implementation Leads
Deputy director of service transformation

Board Sponsor
Director of operational services

Statements of assurance from the Board

Review of services

During 2011/2012, South Tees Hospitals NHS Foundation Trust provided and/or sub-contracted 110* NHS services (*contractual activity by treatment function).

South Tees Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care of these NHS services.

The income generated by the NHS services reviewed in 2011/2012 represents 100% per cent of the total income generated from the provision of NHS services by the trust for 2011/2012.

Participation in Clinical Audit

South Tees Hospitals NHS Foundation Trust has a well-structured clinical audit programme which adapts to the needs of the Trust and now includes the
community services division. We know that high quality clinical audit enhances patient care and safety, and provides assurance of continuous quality improvement.

During 2011/2012, 23 national clinical audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and 5 national confidential enquiries covered NHS services that South Tees Hospitals NHS Foundation Trust provides.

During that period South Tees Hospitals NHS Trust participated in 96% (22) national clinical audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and 100% national confidential enquiries of those which it was eligible to participate in.

The national clinical audits and national confidential enquiries the South Tees Hospitals NHS Foundation Trust was eligible to participate in during 2011/2012 are listed below together with the number of cases submitted to each audit or enquiry, if applicable:

<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>Participation/Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer:</strong></td>
<td></td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Head and neck cancer (DAHNO)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>National lung cancer (NLCA)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Oesophago-gastric cancer</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td><strong>Women and Children:</strong></td>
<td></td>
</tr>
<tr>
<td>National neonatal audit (NNAP)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Paediatric intensive care (PICA Net)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Diabetes, (RCPH national paediatric diabetes audit)</td>
<td>100% of requested data submitted</td>
</tr>
<tr>
<td>Heavy menstrual bleeding (HMB)</td>
<td>Baseline questionnaire distributed in clinics (1 February 2011 to 31 January 2012). One-year follow-up questionnaire sent to patients' homes (February 2012 to February 2013).</td>
</tr>
<tr>
<td>Childhood epilepsy (epilepsy 12)</td>
<td>Data collection period closed November 2011. Our unit selected for inter-related reliability study in April 2012. Final report will be launched in September 2012</td>
</tr>
</tbody>
</table>

**Heart:**
<table>
<thead>
<tr>
<th>Adult cardiac surgery</th>
<th>Continuous data collection</th>
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<tbody>
<tr>
<td>Coronary interventions</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Myocardial inschaemia (MINAP)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Heart rhythm management</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Heart failure</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Acute stroke (SINAP)</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td><strong>Long Term Conditions:</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>The 2011 national report is due to be</td>
</tr>
<tr>
<td></td>
<td>published in May 2012 which will</td>
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<tr>
<td></td>
<td>include comparative data between the</td>
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<tr>
<td></td>
<td>2010 and 2011 audits and will be</td>
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<td></td>
<td>reported to Clinical Standards sub</td>
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<tr>
<td></td>
<td>committee</td>
</tr>
<tr>
<td>Inflammatory bowel disease (IBD)</td>
<td>National report published February</td>
</tr>
<tr>
<td>audit</td>
<td>2012 - local report to be presented to</td>
</tr>
<tr>
<td></td>
<td>clinical standards, date TBA</td>
</tr>
<tr>
<td>Pain Database</td>
<td>Year two (September 2010-2011) case mix</td>
</tr>
<tr>
<td></td>
<td>data. Patient outcomes and experience</td>
</tr>
<tr>
<td></td>
<td>data collection Year three (September</td>
</tr>
<tr>
<td></td>
<td>2011- September 2012)</td>
</tr>
<tr>
<td><strong>Older People:</strong></td>
<td></td>
</tr>
<tr>
<td>The carotid interventions audit</td>
<td>Round 4 – which included operation</td>
</tr>
<tr>
<td></td>
<td>performed between 1 October 2010 and</td>
</tr>
<tr>
<td></td>
<td>30 September 2011 is now in the</td>
</tr>
<tr>
<td></td>
<td>data analysis stage.</td>
</tr>
<tr>
<td>Hip fracture database</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td><strong>National Confidential Enquires (NCE):</strong></td>
<td></td>
</tr>
<tr>
<td>National confidential enquiry into</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>maternal and child health (CEMACH)</td>
<td></td>
</tr>
<tr>
<td>/perinatal mortality MBRRACE-UK)</td>
<td></td>
</tr>
<tr>
<td>NCEPOD alcoholic liver disease</td>
<td>100% of requested data submitted –</td>
</tr>
<tr>
<td></td>
<td>enquiry continues into 2012/2013</td>
</tr>
<tr>
<td>NCEPOD bariatric surgery</td>
<td>Organisational questionnaire</td>
</tr>
<tr>
<td></td>
<td>submitted, at the time of the study,</td>
</tr>
<tr>
<td></td>
<td>South Tees did not offer this surgical</td>
</tr>
<tr>
<td></td>
<td>procedure.</td>
</tr>
<tr>
<td>NCEPOD subarachnoid haemorrhage</td>
<td>100% of requested data submitted –</td>
</tr>
<tr>
<td></td>
<td>enquiry continues into 2012/2013</td>
</tr>
<tr>
<td>NCEPOD cardiac arrest procedures</td>
<td>100% data submitted, National report</td>
</tr>
<tr>
<td></td>
<td>pending</td>
</tr>
<tr>
<td>Risk factors (National Health</td>
<td>South Tees was unable to participate</td>
</tr>
<tr>
<td>Promotion in Hospitals Audit)</td>
<td>in this audit for this round due to lack</td>
</tr>
</tbody>
</table>
Listed below are other national clinical audits the trust has and continues to participate in:

<table>
<thead>
<tr>
<th>Audit Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular Society of Great Britain &amp; Ireland: vascular society database</td>
<td>(VSSGBI VSD)</td>
</tr>
<tr>
<td>Intensive Care National audit &amp; Research Centre (ICNARC): case management programme dataset (CMPD)</td>
<td></td>
</tr>
<tr>
<td>National elective surgery patient reported outcome measures: 4 operations</td>
<td></td>
</tr>
<tr>
<td>National Infarct Angioplasty Project (NIAP) adult cardiac interventions:</td>
<td>coronary angioplasty:</td>
</tr>
<tr>
<td>Renal Joint Registry: hip and knee replacements</td>
<td></td>
</tr>
<tr>
<td>Renal Replacement Therapy (Renal Registry)</td>
<td></td>
</tr>
<tr>
<td>Trauma Audit Research Network (TARN) severe trauma</td>
<td></td>
</tr>
<tr>
<td>NHS Blood &amp; Transplant: potential donor audit</td>
<td></td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion</td>
<td></td>
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<tr>
<td>British Thoracic Society: respiratory diseases (COPD)</td>
<td></td>
</tr>
<tr>
<td>Diabetes (RCPH National Paediatric diabetes Audit)</td>
<td></td>
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<tr>
<td>National cardiac arrest audit</td>
<td></td>
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<tr>
<td>Coronary Angioplasty (NICOR)</td>
<td></td>
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<tr>
<td>Potential donor audit</td>
<td></td>
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<tr>
<td>National Audit of Seizure Management (NASH)</td>
<td></td>
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<tr>
<td>BTS Paediatric Asthma</td>
<td></td>
</tr>
<tr>
<td>BTS – Emergency use of Oxygen, Adult Community Acquired Pneumonia, Non-Invasive Ventilation (adults), Pleural Procedures, Adult Asthma, Bronchiectasis</td>
<td></td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
<td></td>
</tr>
<tr>
<td>Care of the Dying in Hospital (NCDAH) - South Tees did not submit data</td>
<td>for the NCDAH - we carry out our own, more indepth audit, looking at a larger sample than the national audit and included quality of the care pathway. A new document &quot;Care pathway for last days of life&quot; is a common document that has been introduced to all areas in South Tees locality.</td>
</tr>
<tr>
<td>National Diabetes inpatient audit – Presentation to Clinical Standards in April 2012</td>
<td></td>
</tr>
</tbody>
</table>
The table below shows the national clinical audit reports which were reviewed by the provider in 2011/2012 and the actions that South Tees Hospitals NHS Foundation Trust intends to take to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>Title of Audit</th>
<th>Review and Action Plans/ Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD Perioperative case study</td>
<td>Audit findings were presented to Clinical Standards Sub Group in March 2012 – a gap analysis is to be undertaken in conjunction with the Consent to Treatment audit (carried out in March 2012). Some issues raised were extended length of time for fasting prior to surgery and communication needed improving. Further work is planned and will be reported back to Clinical Standards in May 2012.</td>
</tr>
<tr>
<td>National Audit of the Management of Familial Hypercholesterolaemia (FH)</td>
<td>Results of audit presented to Clinical Standards Sub-group. Local audit being carried out to follow up the national audit and establish the implications of identifying the predicted FH relatives of affected cases in the UK</td>
</tr>
<tr>
<td>Trauma Audit Research Network (TARN)</td>
<td>Themed report 2011 Issue 1 – Thoracic Injuries – report showed that South Tees performance is in the top 15 hospitals with the highest statistics for excess survivors per 100 patients over a four year period.</td>
</tr>
<tr>
<td>Diabetes National Impatient Audit</td>
<td>There has been marginal improvement in medication incidents; e-prescribing is planned for the future. 50% of patients are referred to Diabetes Specialist Nurses within 72 hours of admission, more specialist nurse time is required in this area.</td>
</tr>
<tr>
<td>National Falls Audit</td>
<td>South Tees action plan used by the Royal College of Physicians as an example of best practice. Strengths include pain control, thromboprophylaxis, use of integrated fracture care pathway, attempt at mobilisation within 24 hours, multifactorial risk assessments, continence assessments, gait and balance assessments, clinical assessment of osteoporosis, involvement of patient or carer in discharge arrangements. Areas to improve are early assessment by Orthogeriatrician,</td>
</tr>
</tbody>
</table>
operation waiting times, assessment by Occupational Therapist, home hazards assessments, reduction of psychotropic and sedative drugs, intervention plans to be shared with patients. There is now a fragility fracture nurse in post.

Potential Donor Audit
The number of donors had fallen with the single largest contributor to this being a low consent rate. Consent rates were also low in another large trust in the area, suggesting this was a regional issue. The trust has done well with all of the other Key Performance Indicators, outperforming national averages for the identification of potential donors, referral to the donation team and approach to families.

Stroke Improvement National Audit Programme (SINAP)
The trust has put a lot of investment into stroke. The introduction of weekend clinics, weekend stroke specialist reviews, weekend therapy working and an increase in nursing levels has made a great difference and most patients are seen by a consultant. Majority of patients are admitted into the stroke unit within 4 hours of arrival.

Local Clinical Audits
Examples of local clinical audits reviewed by the provider in 2011/2012 with actions planned to improve the quality of healthcare provided are presented in the table below:

<table>
<thead>
<tr>
<th>Title of Audit</th>
<th>Review and Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-wide Record Keeping Audit:</td>
<td>The results remain consistent with the previous years’ audits – Implementation of standardised documentation is imminent, which will address the issues identified in the audit</td>
</tr>
<tr>
<td>Sepsis audit</td>
<td>The audit has shown a reduction in mortality. From 53% to 36%. This is due to heightened awareness and increased timely recognition and treatment. There has been a significant improvement in the times to delivery of all elements of care. Further actions are Trust</td>
</tr>
<tr>
<td>Agenda Item 10.1</td>
<td></td>
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<tr>
<td>---</td>
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<tr>
<td><strong>South Tees Hospitals NHS Foundation Trust Draft Quality Account – May 2012</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Agenda Item 10.1</strong></td>
<td><strong>wide education. Access to specialist nurse advice for the staff. Visible aids, sepsis screening tool, stickers and tags to be placed on all thermometers. Screen savers to be introduced across trust PC’s. Posters. Sepsis 6 boxes to be launched across every ward and department.</strong></td>
</tr>
<tr>
<td><strong>Deterioration patient audit</strong></td>
<td><strong>A regional comparison audit with Safer Care North East deteriorating patients’ regional strategy group. The trust has performed extremely well against the standards. There were 7 standards with partial compliance and 15 fully compliant standards.</strong></td>
</tr>
<tr>
<td><strong>Trust wide Medications policy</strong></td>
<td><strong>The overall results were positive, demonstrating a good knowledge and general compliance with the policy. Areas for improvement are around legibility and signing of drug charts, allergy documentation, route of administration, “as required” medication prescribing. Actions taken are: Circulation of a pharmacy newsletter providing audit results and advice for prescribers highlighting the main areas for concern. General review of postgraduate training. Review of the need for all grades of staff undergoing continuing training and updates on prescribing. Pilot “Safe prescribing Standards – check and correct” as a method of staff training and development.</strong></td>
</tr>
<tr>
<td><strong>VTE Thromboprophylaxis audit</strong></td>
<td><strong>Improvements have been made since the appointment of the Anticoagulation Team. Compliance with appropriate Thromboprophylaxis in March 2011 was 68%, this has increased to 90% in March 2012.</strong></td>
</tr>
<tr>
<td><strong>The management and investigation of hyperglycaemia in patients with ACS in JCUH CCU Clinical Audit Prize winner 2011</strong></td>
<td><strong>From published data and anecdotal evidence, control and investigation of hyperglycaemia on JCUH CCU is of high quality. This audit cycle has improved compliance, but not yet achieved the aim of 100% compliance. Whilst it is disappointing that 100% compliance has</strong></td>
</tr>
</tbody>
</table>
not yet been achieved, it is worthwhile putting our achievement into a wider context, comparing our local results with the closest national comparator – MINAP data – JCUH has significantly higher compliance when benchmarked against national data. Some of the interventions to improve practice further are:

2. Improved visibility of pathways. ‘Green for glucose’ campaign – pathways on green paper to improve visibility in notes.
3. Requirement to check lab glucose against initial glucometer reading and follow protocol according to the higher value.

An Internal Audit Report of the Clinical Audit process in South Tees has been published. The following are being implemented in response to the report.

- A rolling programme of presenting national and trust-wide priority clinical audits to committees is being introduced in 2012/2013 to ensure there is appropriate scrutiny of results and facilitate action planning.
- Annual clinical audit plans from all directorates are to be submitted by the end June every year.
- A matrix to assess potential risk areas is to be implemented, ensuring that ‘high’ risk audits (any procedures/protocols etc that may pose a risk to patient safety/staff/financial risk) are highlighted and built into the annual plan.

Improvements have been made in the Clinical Audit services during 2011/2012 including:

- Standardised reporting across the trust – the report template includes sections to show re-audit results which clearly show any improvements in practice.
- Standardised registration proforma introduced, with all registrations being authorised by the directorate Clinical Audit lead – this has helped to ascertain the level of audit activity and also ensured that any projects undertaken are Clinical Audit, and if not are referred to the Research and Development Department.
- Clinical Audit training is well attended, feedback from candidates is that the course is informative and helpful. The course is also available for Community Division staff.
- The majority of ‘local’ audits have been supported by the Central Clinical Audit Team.
- Closer working relationships with Directorate and Divisional Clinical Audit personnel, which has improved with the implementation of the Clinical Audit Policy in 2010.

Commitment to research as a driver for improving the quality of care and patient experience

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

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

Goals agreed with commissioners - use of the CQUIN payment framework

A proportion of the organisation’s income in 2011/2012 was conditional on achieving quality improvement and innovation goals agreed between us and NHS Tees and North Yorkshire and York (primary care trusts), through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2011/2012 and for the following 12 month period are available on request from the performance management department, South Tees Hospitals NHS Foundation Trust, The James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW or email performance.management@stees.nhs.uk

The income conditional upon achievement of the CQUIN measures in 2011/2012 was £6,790,625 of this the trust received a payment of £5,740,636.
What others say about us

Statements from the Care Quality Commission

The trust is required to register with the Care Quality Commission and our current registration status is:

“The CQC has registered South Tees Hospitals NHS Foundation Trust to provide services”

We do not have any conditions on registration.

The Care Quality Commission has not taken enforcement action against the organisation during 2011/2012.

South Tees Hospitals NHS Foundation Trust had a planned review by the Care Quality Commission (CQC) on 6th January 2012 and the full report is available on the trust and the CQC website. The findings for the unannounced inspection visit were:-

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.

The CQC found that The James Cook University Hospital of South Tees Hospitals NHS Foundation Trust was meeting this standard.

The CQC found that people were treated with dignity and respect. They were given clear information about treatment options and were involved in making decisions and choices about their care and treatment, including discharge arrangements.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The CQC found that The James Cook University Hospital of South Tees Hospitals NHS Foundation Trust was meeting this standard.

People received effective, safe and appropriate care, treatment and support that meets their needs.
Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs.

The CQC found that The James Cook University Hospital of South Tees Hospitals NHS Foundation Trust was meeting this standard.

The CQC found that people were safe and their health and welfare needs were met by sufficient numbers of appropriate staff.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.

The CQC found that the James Cook University Hospital of South Tees Hospitals NHS Foundation Trust was meeting this standard.

The CQC found that the trust had good systems in place to audit and monitor the quality of services it provides.

The day the CQC visited the trust (Friday 6 January 2012) was exceptionally busy across the hospitals and community services so the assessors witnessed the true challenges we face as a large and complex organisation.

The findings of the report is a fantastic outcome for our organisation and reflects the commitment and high quality of care all our staff continue to give to our patients’ day in and day out.

The Secretary of State asked CQC to inspect termination of pregnancy services across the NHS and independent sector in March 2012, the James Cook and Friarage sites were inspected on the 22nd of March. We are awaiting the formal report.

Data Quality

NHS Number and General Medical Practice Code Validity

South Tees Hospitals NHS Foundation Trust submitted records during 2011/2012 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which:

Included the patient's valid NHS Number was:
• 99% for admitted patient care;
• 99.7% for outpatient care; and
• 98.9% for accident and emergency care.

Included the patient’s valid General Practice Code was:
• 99.2% for admitted patient care;
• 98.9% for outpatient care; and
• 99.8% for accident and emergency care.

**Information Governance toolkit attainment levels**

The Information Governance (IG) toolkit uses a framework of standards, which are designed to ensure organisational compliance with statutory and mandatory requirements concerning the management of patient, staff and corporate information. The IG toolkit has been developed as the principal mechanism by which IG policy can be broken down into measurable components in order to assess an organisation’s performance annually through a system of self-assessment and audit. The IG toolkit enables the organisation to develop a strategy and annual work programme to raise the level of compliance year-on-year, and also improve its information risk management process. A toolkit score level of 0-1 equates to a grade red and a score level of 2-3 equates to a grade green.

For South Tees Hospitals NHS Foundation Trust the Information Governance Assessment Report overall score for 2011/2012 was 73% and was graded red (unsatisfactory).

The two standards in which the trust did not achieve level 2 were:

**Requirement 9-112** - To ensure organisational compliance with the law and central guidelines relating to Information Governance (IG), staff must receive appropriate training. Therefore, IG training is mandatory for all staff, (comparable to health and safety training) and staff IG training needs should be routinely assessed, monitored and adequately provided for.

At the end of March 2012 70% of staff had received IG toolkit training against a target of 95%. An action plan is being developed to ensure we are able to improve on this and attain the required standard during 2012/2013.

**Requirement 9-324** - A fundamental principle of the Data Protection Act 1998 is to use the minimum personal data to satisfy a purpose and to strip out information relating to a data subject that is not necessary for the particular
processing being undertaken. This principle is aligned with the Caldicott Principles familiar to NHS and Social Care organisations and is supported by both common law confidentiality obligations and the Human Rights Act 1998 which provides a privacy right for individuals.

The trust is not currently fully compliant with this requirement, actions to address this are:

- The Head of Information is working closely with the IG department to identify alternative process change along with suitable tools required, to establish an internal safe haven for information exchange and pseudonymisation functionality for secondary use purposes.
- An action plan is in place and a draft Standard Operating Procedure for the Secondary Use of Data has been developed and is under consultation.

South Tees Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Review of Trust Data Quality Strategy and supporting policies
- On-going weekly validations of key data items/fields
- Training & Awareness of data quality issues
- Use of external toolkits, ie CHKS, SUS and Audit Commission to identify data quality issues and implement solutions

Clinical coding error rate

South Tees Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary diagnoses 3.5% incorrect,
- Secondary diagnoses 2.5% incorrect.
- Primary procedures were 2.1% incorrect
- Secondary procedures 0% incorrect.

These results should not be extrapolated further than the actual sample audited. The audit sample was 100 Ophthalmology and 100 random selections from Secondary Users Service (SUS).
PART THREE

Review of Quality

This section of the quality account contains a review of our quality performance during 2011/2012. It also includes an explanation of who was involved in the development of the quality account and comments on the development and content of the quality account from a range of external stakeholders.

Continuous quality improvement is part of the trust’s culture. It is at the heart of our values and drives our objective setting, and we are continuously exploring new ways to improve quality and safety. In September 2010 quality and safety information on all Foundation Trust’s in England was collated from publicly available data (CQC rating, Dr Foster Safety Score, mortality data, infection rates, Monitor rating, patient and staff satisfaction scores). Organisations that performed in the top 20% on all indicators were invited to consider participation in a collaboration of high performing NHS foundation trusts called the QUEST Network, the objective of which is to share best practice and pursue excellence in clinical outcomes. South Tees Hospitals NHS Foundation Trust joined the Network in the first wave of 11 trusts in February 2011.

In its first year collaborative members agreed to work on three improvement programmes designed to test ways of delivering a better and safer service with the aim to achieve greater outcomes at an accelerated pace.

- Mortality reduction
- Reducing the number of hospital re-admissions.
- Harm-Free Care (four harms - Venous thromboembolism (VTE), pressure ulcers, catheter associated urinary tract Infection (CA-UTI) and falls) This work stream is to be delivered under the banner of ‘Safety Express’.

Safety Express aims to deliver harm-free care (defined by the absence of pressure ulcers, harm from falls, CA-UTI and VTE) in 95% of patients by developing safety-focussed ward leadership and safety culture, improving the quality of clinical care and ensuring the ward infrastructure supports harm-free care.
Safety Thermometer is a prevalence survey to measure the level of harm-free care at a particular point in time. Initially the trust piloted the use of the Safety Thermometer in four acute wards at The James Cook University Hospital. In line with the trust’s revised patient safety strategy and corporate objectives this has increased to 42 clinical inpatient areas, which includes all community hospital wards. Monthly meetings are held with the project leads in the four areas of harm to discuss the data in order to focus improvement support to clinical areas.

The trust routinely uses a range of quality and safety measures to assess performance and identify additional areas for improvement. Quality measures covering patient safety, clinical effectiveness and patient experience have been built into templates known as ‘dashboards’, which show performance at departmental, divisional and trust level.

At monthly performance meetings executive directors meet with staff from each division so that actions can be agreed to improve performance where necessary. A simple traffic-light grading system helps to quickly show areas that may be weaker in performance so that actions can be taken to improve that area.

This information is shared with the board of directors, board of governors, senior clinicians, managers and governors to provide assurance the trust is on target to deliver its key targets.

The following sections review a range of quality work streams undertaken during 2011/2012 including further detail on the work undertaken in relation to the priorities which were identified in the 2010/2011 Quality Account.

**Patient Safety**

**Reducing healthcare associated infections (HCAI)**

Reducing healthcare acquired infections has been a quality improvement priority in each of the trust’s quality accounts and is supported by continued implementation and monitoring of the trust’s three-year healthcare associated infection (HCAI) strategy During 2011/2012 there continued to be a year-on-year improvement in the number of health care associated infections.
A range of initiatives were identified at the start of the year to support improvements in this area and the following section provides an update on our progress:

2011/2012 was the second year of the infection prevention and control link practitioners’ programme which includes promoting ward level ownership and accountability for infection prevention and control audits, observations and teaching. This programme has helped to reinforce infection prevention messages at ward level. The third year of the programme has now commenced and will be monitored as part of the 2012/2013 priorities.

The trust has developed a trust-wide decontamination strategy, which includes clear roles and responsibilities and monitoring arrangements around patient equipment cleaning and decontamination (commodes, mattresses, etc.). The strategy will be implemented and monitored through the decontamination steering group.

During 2011/2012 the organisation reinforced the importance of prioritising ‘time to isolation’ for patients with suspected C. difficile and staff have been educated in the importance of isolating patients in single rooms on the basis of symptoms rather than waiting for test results. ‘Time to isolation’ is monitored through the C.difficile outbreak meetings, root cause analysis on MRSA bacteraemia and C.difficile cases and routine IPC patient surveillance.

During 2011/2012 a programme of HCAI related ‘patient experience’ surveys was implemented. A robust monitoring and reporting process is under development to allow the analysis of themes and sharing of any lessons back to the clinical teams and to influence the training programme.

The infection prevention and control (IPC) team have developed a risk assessment tool for ward/department use to be led by IPC link practitioners. A standardised escalation protocol is to be developed to ensure that infection risks are identified on divisional risk registers so that they are subject to robust scrutiny and actively managed to reduce risks.

The graphs below show the considerable progress in reducing hospital associated infections with MRSA and C.difficile which has been made in
Reduction falls

Patient falls are among the most common patient safety incidents reported in hospitals and are a leading cause of death in people ages 65 or older. The trust has joint falls management policies with both the Tees and North
Yorkshire primary care trusts which aim, as far as possible, to reduce the incidence of falls and fall-related injuries for the populations served.

The number of falls incidents reported in the acute hospital continues to reduce:

<table>
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<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls incidents</td>
<td>2,426</td>
<td>2,181</td>
<td>2,162</td>
<td>2,075</td>
</tr>
<tr>
<td>reported in</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospital.</td>
<td>Falls per</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1000 bed</td>
<td>6.88</td>
<td>6.24</td>
<td>6.14</td>
</tr>
<tr>
<td></td>
<td>days</td>
<td></td>
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</tr>
</tbody>
</table>

Data Source: Falls incidents - DATIX incident reporting system
Bed days - local patient administration system

In addition to monitoring the number of falls incidents reported, the trust also reviews the number of falls in the context of the number of beds occupied by patients. This rate of falls has shown a year-on-year reduction until 2011/2012 when the rate has increased. This is partly due to the work we are doing to reduce the occupancy of acute hospital beds and in 2011/2012 there were 6,000 fewer occupied bed days compared to the previous year which impacts on the calculation of the rate of falls. The other contributory factor is the change in the case mix of patients cared for in the acute hospital beds with a higher proportion of elderly patients who are at greater risk of falling while in hospital.

Data Source: Falls incidents - DATIX incident reporting system
There were 34 falls resulting in a fracture in patients in the acute hospital setting, this compares with 26 during 2010/11. The table below shows the number of falls which have resulted in a fracture over the last four years.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls resulting in a</td>
<td>44</td>
<td>33</td>
<td>26</td>
<td>34</td>
</tr>
<tr>
<td>fracture in the acute</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospitals.</td>
<td></td>
<td></td>
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</tbody>
</table>

Data Source: Falls incidents - DATIX incident reporting system

Falls data for community hospitals shows that in 2011/2012 there were 412 falls incidents reported which equates to a rate of 7.8 falls per 1000 bed days. The case mix of the patients in the community hospitals is different to that in the acute hospital and there are slight differences in the categorisation of falls incidents between the acute and community hospitals which will be standardised in 2012/2013.

There were 7 falls resulting in a fracture in the community hospitals during 2011/2012, there is no comparative trend data as the community services were previously delivered in a different configuration using different incident reporting systems.

It is disappointing that we have not been able to sustain the reduction in fractures resulting from a fall seen last year and this remains an area of focus for patient safety work in the trust. Analysis of the occasions when patients fall has shown that in the majority of cases the fall occurred from the bed or when patients got out of bed without support. The trust has invested in new
adjustable height beds and additional bed rails, we are reviewing the use of sedation at night and we have introduced the process of ‘intentional rounding’ across all acute and community wards. ‘Intentional rounding’ is a process where health professionals carry out regular checks with individual patients at set intervals to ensure that they have everything they need close to hand or to provide support if the patient needs to leave their bed.

**Improving wound care**

Pressure ulcers represent a major burden of sickness and reduced quality of life for patients creating significant difficulties for patients, their carers and families. During 2011/2012, the trust has continued to be proactive in its approach to achieve year-on-year improvements within the identification of both pressure ulcers and moisture lesions, highlighting those patient groups at risk and implementing early intervention to prevent development and deterioration of skin damage.

The trust policy on pressure ulcer management has been revised to cover acute and community settings and now includes both pressure ulcers and moisture lesions. Staff receive monthly training alongside one-to-one departmental updates in the identification, assessment, reporting and documentation processes. Incident reports are monitored monthly in conjunction with the lead nurse for wound care to ensure repetitions and correct gradings are monitored and filtered to ensure accuracy. A root cause analysis is carried out for all grade three and four pressure ulcers to ensure lessons are learned through the development of action plans and monitoring.

An annual point prevalence audit took place in March 2011. This audit reviews all the inpatients across the acute and community hospital settings at a point in time and is not influenced by the continuous drive to improve the incident reporting culture in the trust which we expect to lead to better recognition and increased incident reporting.

<table>
<thead>
<tr>
<th>Acute Hospital acquired pressure ulcer prevalence</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients audited</td>
<td>901</td>
<td>879</td>
<td>949</td>
<td>917</td>
<td>850</td>
</tr>
<tr>
<td>% with hospital acquired pressure ulcer</td>
<td>8.88%</td>
<td>5.4%</td>
<td>5.8%</td>
<td>3.3%</td>
<td>2.82%</td>
</tr>
<tr>
<td>% with a grade 1 or 2 hospital acquired</td>
<td>7.88%</td>
<td>4.3%</td>
<td>5.2%</td>
<td>3.3%</td>
<td>2.82%</td>
</tr>
</tbody>
</table>
Prevalence audits were carried out in the community hospitals for the first time in 2011/2012, the most recent audit showed the prevalence of hospital acquired pressure ulcers to be 3.2% in the community hospitals with no grade 3 or 4 hospital acquired pressure ulcers.

**Improving discharge management**

Improving discharge management was identified as a priority in last year’s Quality Account and continues to be a high priority area of work.

During 2011/2012 we have made progress with a number of initiatives relating to discharge. In addition to the measures reported in Part 2 of the Quality Account this work included the following:

- The trust audited accuracy of discharge summaries in quarter 1, this showed that although a number of standards showed good compliance there was scope for improvement, the audit has been repeated in March 2012 and the results will be used to focus further work in 2012/2013.

- Enhanced recovery pathways in colorectal, MSK, gynaecology and urology commenced during 2011/2012. This initiative will be rolled out to vascular surgery and breast surgery during the coming year.

- The sending out of discharge summaries to GP Practices electronically using combined approach with North Tees & Hartlepool NHS Foundation Trust is currently being tested.

- The discharge percentage by time of day has improved. In October only 52% of our patients had been discharged by 4pm whereas in March the position was 74%.

- The implementation of risk stratified follow-up calls is progressing with the readmissions project and is in place in the cardiothoracic division and acute medicine. Surgery is piloting their scheme.
Improving discharge remains an area of focus which is integral to our work to improving the patient pathway and will continue to be a quality account priority for 2012/2013.

**Clinical effectiveness**

**Reducing unnecessary deaths in hospital - mortality**

The importance of reporting mortality statistics at Board level, a process which is now embedded in South Tees, was highlighted in the Francis Report into the failures at the Mid-Staffordshire Trust (February 2010). Historically there has been a range of ways of calculating mortality statistics which has caused problems when comparing hospitals across the country and identifying organisations with excessive mortality. Following the Francis Report the Department of Health established a national group to make recommendations about use of mortality measures by hospitals. The group recommended the development of a new hospital mortality measure – the Summary Hospital-level Mortality Indicator (SHMI). The SHMI reports all hospital mortality plus deaths within 30 days of discharge from hospital, using data linked from death certificates to hospital activity data. South Tees NHS Hospitals NHS Foundation Trust routinely monitors three mortality measures; unadjusted mortality, the Risk Adjusted Mortality Index (RAMI) and the Summary Hospital-level Mortality Indicator.

Unadjusted mortality is a simple measure of the number of deaths as a percentage of patient inpatient episodes. Looking at the trend from April 2005 to December 2011 we see a small but steady decline with the death rate falling from 1.5% to 1.27%. In November 2010, the trust had an unadjusted mortality rate below 1% for the first time since current reporting arrangements were established. The comparison to a peer group of hospitals (ie those trusts that are similar to South Tees) is shown below:
The risk adjusted mortality index (RAMI 2010) is an index statistically calculating individual patient risk based on data in the national 2008/2009 database. Risk Adjusted Mortality is falling across the NHS. Values below 100 reflect better performance while values over 100 indicate that there were more deaths than expected using the 2008/2009 adjustment. The RAMI compares the actual deaths to the number of expected deaths using a methodology developed by CHKS, a benchmarking company. This takes account age, sex and all recorded diagnoses and procedures and predicts the risk using a logistical regression model. The graph below, drawn from the regional hospital mortality monitoring reports, shows RAMI for South Tees compared the North East Region and England averages for July 2008 to June 2011.
Using more recent data available internally to the trust, the 12 months January - December 2011 was 80.3 compared to 91.8 for the previous 12 months.

Comparison between RAMI and unadjusted mortality rate over time shows a slight downward trend in unadjusted mortality rate and a much more dramatic decrease in RAMI.

The Summary Hospital Level Mortality Indicator (SHMI) is the new hospital-level indicator which reports all deaths in hospital and all deaths that occur within 30 days of discharge from hospital across the NHS in England. It compares the observed number of deaths for each hospital with the number expected from a statistical model that takes account of patients’ age, sex, method of admission to hospital and comorbidities. SHMI was introduced to standardise mortality reporting so that national comparisons can be made.

The SHMI for the trust within North East Hospitals for the period July 2010 to June 2011 was 96. This means there were fewer deaths than might be expected statistically and we had one of the best results in the North East of England.

Following integration of community services monitoring of mortality was extended to include community hospitals. Data for Carter Bequest, East Cleveland, Guisborough and Redcar Primary Care Hospitals is available from
2008. Data for the Friary, Rutson and Lambert Hospitals is included from April 2011.

Over the period January to December 2011, there were 202 deaths recorded in community hospitals, averaging 16.8 per month over the period. The overall unadjusted mortality rate was 10%, significantly higher than that for the two acute hospitals in the trust – the James Cook and the Friarage (unadjusted mortality rate of 1.27% over the same period). This is because of the very different nature of the services provided in the community hospitals and the high proportion of patients who receive palliative and terminal care in them.

Work to identify further opportunities to reduce mortality continues and from quarter 4 2011/2012 all directorates will review all deaths in hospital to ensure that avoidable factors which may contribute mortality are identified and addressed.

**Readmissions**

A number of patients return to hospital within 30 days of discharge. For some patients this further admission is not linked to their recent hospital stay but for others, they have returned to hospital because of complications after their discharge.
These complications may be related to their needs not being adequately established at pre-assessment, through acquiring an infection during their hospital stay or down to their rehabilitation not progressing as planned.

In South Tees, unplanned readmission rates within 30 days of discharge from hospital are around the same in 2011 as they were in 2010, averaging 6.98% in 2011 compared to 7.02% in 2010. We will continue to focus on readmissions because it is an important measure of quality.

Improve standards and delivery of nutritional care across the Trust.

Recent national studies have shown that an unacceptable number of people are becoming malnourished when they are in hospital. They become malnourished because they don’t get food they can eat or the help they need to eat it. Being malnourished increases the risk of infection and increases the length of time it will take them to recover.

This trust has a proactive and organised approach to combating malnutrition overseen by the Nutrition Steering Committee and its importance is recognised as a key priority for the organisation. To provide choices of food and drink for people to meet their diverse needs making sure the food and drink we provide is nutritionally balanced and supports their care plan.
During 2011/2012 we have made progress with a number of initiatives relating to nutrition. In addition to the measures reported in Part 2 of the Quality Account this work included the following:

- To improve compliance with malnutrition screening the risk assessment tool has been further revised to reflect feedback from the clinical matrons. The updated tool has been piloted in 3 areas across the trust, and will be introduced trust-wide from March 2012, the pilot will be supported by a training programme delivered by the nutrition nurse specialist.

- An ‘ask for a snack’ campaign has been run in January 2012 at James Cook and March 2012 at the Friarage, plus Middlesbrough, Redcar and Cleveland community hospitals to raise awareness of the extra snacks available between meals in the hospital, and the importance of encouraging patients to take these as part of a high protein, calorie diet. In March 2012 new ‘medium risk / MUST 1’ high protein, high calorie patient information pack was launched to raise patient awareness. The campaign will be taken to each ward / relevant clinical area across the trust.

- Daily diet sheets have been produced and implemented to be used by ward staff (nursing and catering) to communicate patients’ dietary requirements - including whether high protein menus, between meal snacks and / or assistance with feeding are required.

- During 2011/2012 the trust implemented the use of a malnutrition screening tool for children and achieved 100% compliance with the use of the tool at the end of March 2012.

- The trust achieved its objective to maintain or improve the 95% compliance with the nutritional standards for catering.

- Nutrition roadshows were carried out in January 2012 (James Cook) and March 2012 (Friarage).

- A volunteer / buddy system is underway to provide assistance with feeding and the mealtime volunteers group meets regularly to discuss progress. Training programme being addressed.
- The use of red jug lids to identify patients requiring assistance with drinks is in place across both acute hospital sites,

- Kitchen communication boards and red tray system to identify patients who require help with feeding introduced in community hospitals

- Patient experience event has been held to involve patients in evaluating food choices.

**Patient experience and the environment**

**Improving End of Life Care**

The publication of the first national End of Life Care Strategy (July 2008) has seen an unprecedented focus on the care of people nearing the end of their lives. The role of the acute hospital trust in the delivery of end of life care is essential if this vision is to be realised. Although evidence suggests that the majority of people would prefer to die in their own homes, in reality around 60% of deaths occur in hospitals. In light of this, South Tees Hospitals NHS Foundation Trust has a responsibility to ensure that it has the organisational processes and procedures in place to aid patient choice, along with an educated workforce who are able to deliver that choice in a timely and effective manner.

The trust has around 2,000 in-patient deaths per year. With present focus on reducing re-admissions and reducing inpatient stay; end of life care provision has the potential to deliver on these important agendas.

During 2011/2012 we have made progress with a number of initiatives relating to end of life care. In addition to the measures reported in Part 2 of the Quality Account this work included the following (data sources are local audits):

- A&E are continuing to inform the consultant in palliative medicine of ‘inappropriate’ admissions for further investigation to help reduce the number of dying patients unnecessarily admitted to hospital.

- The Macmillan discharge project continues which has increased the number of terminally ill patients in hospital who are discharged home to die which improves compliance with the patient’s wishes and reduces the use of acute hospital beds.
- The palliative care consultant has implemented a programme of presentations to directorates across the trust to raise awareness of steps to consider which will improve the notification to primary care colleagues of patients who are terminally ill. Written guidance has also been produced and is in process of being printed. This will support improving access to appropriate support at the end of life.
Patient surveys and experience

Patients rate trust highly in outpatient survey

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

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

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

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

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

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

Areas where improvements could be made were also identified in the survey and include patients receiving copies of letters sent between hospital doctors and the family GP.

Work has already started to determine the best approach to improve the trust’s performance in these areas.

The report is the fourth national survey of adult outpatients (aged 16 or over) in NHS hospitals in England and almost 73,000 patients who visited one of 163 acute or specialist NHS trusts took part - a national response rate of 53 per cent. At South Tees, 490 patients (58%) responded.
Improving the ward environment for dying patients receives national praise

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

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

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

The project was overseen by a South Tees team including the deputy director of planning, divisional manager for acute medicine, a consultant in palliative medicine, a senior nurse in planning and the managing director of Endeavour – the trust’s private sector partner.

A passport to improved communication and experience

Traffic-light coded hospital ‘passports’ devised by Tees Esk and Wear Valleys NHS Foundation Trust were adopted by the trust to improve the experience of patients who have learning disabilities when they are admitted to hospital.

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

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

- A ‘red’ page for vital information including personal and medical details
- An ‘amber’ page which contains information on things that are really important to the patient in helping staff care for them
- And a ‘green’ page which contains personal preferences as to what the patient likes and dislikes
The overall aim of the passport is to improve communication between patients with learning disabilities, their carers’ and hospital staff and reduce the frustration patients and carers sometimes find having to keep repeating the same details to different health care professionals.

This way the patient can hopefully have an improved experience of the hospital while being an inpatient.

**Young people on interview panel**

Young people are leading the way in patient participation by being involved in staff recruitment interviews.

Following on from the work done for ‘You’re Welcome’ – quality criteria for young people in hospital - members of the young persons group at James Cook held a focus group as part of the interview process for the post of paediatric intensive care unit manager.

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

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

The involvement of children and young people in planning our services is crucial and feedback from the young people involved highlighted that they felt valued and that it greatly increased their confidence.

**Overview of the quality of care based on performance in 2011/2012 against indicators.**
The trust performed well against the national performance measures:

### Performance against key national priorities

<table>
<thead>
<tr>
<th>MONITOR compliance framework</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>Target</th>
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<tr>
<td><strong>HCAI</strong></td>
<td></td>
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<tr>
<td>Clostridium difficile year on year reduction of infection rates</td>
<td>141</td>
<td>125</td>
<td>67</td>
<td>112</td>
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<tr>
<td>Reducing post-48 hour MRSA bacteraemia rates</td>
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<td>6</td>
<td>2</td>
<td>6</td>
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<td><strong>Cancer – 11/12 figures are indicative - awaiting final validation</strong></td>
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<tr>
<td>Cancer waits 2 week wait target</td>
<td>95.4%</td>
<td>93.6%</td>
<td>93.7%</td>
<td>93%</td>
</tr>
<tr>
<td>2 week wait breast symptom referrals - % seen within 2 weeks</td>
<td>96.3%</td>
<td>96.2%</td>
<td>95.9%</td>
<td>93%</td>
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<tr>
<td>Cancer wait 31 day wait for first definitive treatment for all cancers</td>
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<td>98.1%</td>
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<td>96%</td>
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<tr>
<td>Cancer wait 31 day wait for subsequent drug treatments for all cancers</td>
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<td>99.9%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Cancer wait 31 day wait for subsequent surgery treatments all cancers</td>
<td>98.8%</td>
<td>98.8%</td>
<td>99.1%</td>
<td>94%</td>
</tr>
<tr>
<td>Cancer wait 31 day wait for subsequent radiotherapy treatments all cancers</td>
<td>NA</td>
<td>99.5%</td>
<td>98.7%</td>
<td>94%</td>
</tr>
<tr>
<td>Cancer wait 62 day wait for the first definitive treatment for all cancers</td>
<td>88.3%</td>
<td>85.2%</td>
<td>86.9%</td>
<td>85%</td>
</tr>
<tr>
<td>Cancer wait 62 day wait for treatment of all cancers referred from a National screening service.</td>
<td>92.5%</td>
<td>94.7%</td>
<td>94.5%</td>
<td>90%</td>
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<td><strong>18 weeks referral to treatment time (RTT)</strong></td>
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<tr>
<td>18 Week RTT for admitted patients</td>
<td>93.3%</td>
<td>95.4%</td>
<td>92.1%</td>
<td>90%</td>
</tr>
<tr>
<td>18 Week RTT for non-admitted patients</td>
<td>98.6%</td>
<td>98.8%</td>
<td>98.8%</td>
<td>95%</td>
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<td><strong>A&amp;E</strong></td>
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<tr>
<td>4 hour maximum wait in A&amp;E from arrival to admission, transfer or discharge</td>
<td>98.9%</td>
<td>98.4%</td>
<td>97.5%</td>
<td>95%</td>
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<td>Agenda Item 10.1</td>
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<tr>
<td>Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability.</td>
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</tbody>
</table>
Identification of local improvement priorities

In order to establish the priorities for the quality account, engagement has taken place with staff, patients and key external stakeholders. Information has been collated from a number of sources including surveys, questionnaires, complaints and direct feedback.

Staff

- Matrons/senior nurses (questionnaire)
- Clinical directors and chiefs of service
- Patient safety conference (questionnaire)
- Community services reference group

Patients

- Issues identified in local and national surveys
- Local Essence of Care audit
- Complaints and PALS data
- Choices website

Council of Governors

- Direct feedback at Council of Governors meeting

External Stakeholders

- Local Improvement networks (LINks)
- Overview and scrutiny committees (OSC)
- Care Quality Commission quality and risk profile
- Incidents reported by external organisations

The feedback from the consultation was presented to the Board of Directors in March 2011 who agreed the five quality priorities described in Part 2.
Annex 1: Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees.

Statement from NHS North Yorkshire and York:

As an Associate Commissioner, NHS North Yorkshire and York are pleased to be able to review and comment on South Tees Hospitals NHS Foundation Trust Quality Account for 2011/12.

Over the past 12 months we have worked hard together as Commissioners and Providers to improve the quality of patient services for the residents of North Yorkshire, particularly those within the Hambleton, Richmondshire and Whitby localities. Through the contract management process the Trust has provided assurance to us as Commissioners, by sharing a range of data and quality metrics which have assured us of the quality of patient services.

The Quality Account for South Tees Hospitals NHS Foundation Trust provides a clear, accurate, and open story of the quality of patient care provided. We are especially pleased to note the following achievements:-

- South Tees Hospitals are one of the highest scoring 20% of Trusts in England in the Care Quality Commission’s Outpatient Survey 2011.
- The use of “passports” to improve the care of patients with Learning Disabilities
- James Cook University Hospital were highly commended in the Building Better Healthcare Awards
- Workshops to help cancer patients combat the visible side-effects of treatment (and feel better about themselves) now run at the holistic cancer care centre.
- Young people sit on the interview panels as part of the recruitment process

South Tees Hospitals NHS Foundation Trust has also demonstrated significant improvements across the CQUIN indicators for 2011/12. Indicators for 2012/2013 are currently being agreed for both Acute and Community CQUINS with the Trust and Hambleton, Richmond and Whitby CCG.

The priorities identified in the Quality Account for 2012/2013 clearly identify the three elements of quality i.e. patient safety, clinical effectiveness and
patient experience and have a real synergy with the outcomes we are seeking to achieve across the whole health economy and focus on:–

Patient Safety
- Discharge Management
- Further reducing healthcare associated infections

Clinical Effectiveness
- To improve standards and delivery of nutritional care

Patient Experience
- Improve communication
- Right care, right place, right time (reduce delays, improve patient flow and cancellations)

As a commissioner we commend this Quality Account for its accuracy, honesty, and openness. We recognise that South Tees Hospitals NHS Foundation Trust strives to deliver good quality patient care, and we look forward to working with the Trust to bring about further improvements in quality during 2012/2013.

Julie Bolus
Director of Nursing
NHS North Yorkshire and York

Statement from NHS Tees

Statement from Middlesbrough, Redcar and Cleveland and North Yorkshire LINks

All the LINks were pleased to see that South Tees Trust has made significant improvements over the last 12 months and that plans and initiatives are in
place to continue working towards further improvements over the next 12 months.

Regular meetings between the LINk’s and the Trust have continued throughout the year, Host teams meeting quarterly and LINk members twice a year. These meetings have enabled any concerns and issues to be raised and discussed are felt to be a positive way of engaging and working together. The LINk values the good working relationship with the Trust and the opportunity to take part in activities including the PEAT inspections and commenting on the Quality Account. In addition the opportunity to feed in patient experiences and carry out Enter and View visits.

LINk would recommend that the final version is in a suitable format and font size for ease of reading and that different versions are available for all sections of the public.

The comments below are a joint response from Middlesbrough, Redcar and Cleveland and North Yorkshire LINks.

Quality Account 2011 – 12

Part Two – Priorities for Improvement 2012/2013

Patient Safety

Priority 1 – Continue to focus on discharge management in order to improve patient care, improve clinical outcomes and reduce re-admissions

- Members were pleased to see that the Trust continues to focus on discharge management in order to improve patient care and that the initiative for nurse/therapy-led discharge is to be the default over the coming year. However, it would be useful to see the statistics for this type of discharge within the monitoring of this priority in order to measure its success.

Priority 2 – Further reducing Healthcare associated infections

- It is very good news that the level of healthcare associated infections has fallen again this year and remains under the allocated target. Members would like to see this downward trend continue regardless of whether it remains a priority.

Clinical Effectiveness

Priority 3 – To continue to improve standards and delivery of nutritional care across the trust

- Members were pleased that the Trust recognises the importance of the link between nutrition and health and wellbeing and have, amongst
other initiatives, included ‘Employ a creative approach to optimise the mealtime experience’.

- As well as achieving overall goals, the LINk would welcome this information broken down to show how each ward/area of the Trust was contributing to the figures. Anecdotal evidence reported to the LINk’s would suggest that there are wide variances across the Trust in achieving good nutritional standards.

**Patient Experience**

**Priority 4 – Improve communication**

- It is appreciated that improving communication can be difficult to measure and it is pleasing to hear that the Trust is implementing new initiatives in this area. The LINk’s feel that whilst supporting these new initiatives there is wider work to be done in improving communication between health staff and patients and carers and hope that this will be encouraged across the Trust.

- LINks would hope that the current coding of ‘Communication’ remains as it is in 2011/12 in order to accurately compare with the baseline in future years.

**Priority 5 – Right care, right place, right time (reduce delays, improve patient flow and cancellations)**

- Although it is good to see that this is a priority area within the Quality Account, the LINk is unsure how the new initiatives will improve the rate of cancellations.

- Members would like to know more about the plans and how the Trust intends to implement them and what the impact will be on patients and their families.

- The LINk’s would like regular progress reports throughout the year on progress towards achieving this.

The LINks did not identify any significant omissions of concern

**Statements from Overview and Scrutiny Committees**
Annex 2: Statement of directors’ responsibilities in respect of the quality report

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

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011-12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to June 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
  - Feedback from the commissioners dated 17/05/2012
  - Feedback from governors dated 10/05/2012
  - Feedback from LINks dated 18/05/2012
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/05/2012;
  - The [latest] national patient survey XX/XX/20XX
  - The [latest] national staff survey XX/XX/20XX
  - The Head of Internal Audit’s annual opinion over the trust’s control environment dated XX/XX/20XX
  - CQC quality and risk profiles dated 12/04/2012
- the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the
Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitormhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

NB: sign and date in any colour ink except black

..................................................Date..........................................................Chairman
..................................................Date..........................................................Chief Executive
Annex 3: How to provide feedback on the account

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

If you wish to comment please go to the Quality Accounts page on the Trust website (www.southtees.nhs.uk).
Annex 4: GLOSSARY OF TERMS

A&E
Accident and emergency (usually refers to a hospital casualty department).

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

Audit Commission
The Audit Commission regulates the proper control of public finances by local authorities and the NHS in England and Wales. The Commission audits NHS trust’s, primary care trust’s and strategic health authorities to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the health service, and, working with the Care Quality Commission, undertakes national value-for-money studies. Visit: www_audit-commission.gov.uk/Pages/default.aspx.

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

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

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

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

Clinician
Professionally qualified staff providing clinical care to patients.

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

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

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

Coronary Artery Bypass Graft (CABG)
Grafting a section of vein to allow blood to by-pass blocked coronary arteries and therefore supplies the heart muscle. Around 10,000 people annually undergo this procedure that lasts several hours.

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

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

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

Emergency
An urgent unplanned episode of care.

Foundation Trust
A type of NHS Trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS foundation trust’s provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS foundation trust’s 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.

Global Trigger Tool
This is a trigger tool which reviews case notes in order to help identify and measure adverse events. Randomly selected clinical records are reviewed to identify any events which may have caused harm to patients, so any necessary changes can be put in place to reduce harm.

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

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

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

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

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

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

Inpatient
Patient requiring at least one overnight stay in hospital.

Local Involvement Networks
Local Involvement Networks (LINks) are made up of individuals and community groups which work together to improve local services. Their job is to find out what the public like and dislike about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways in which an existing service could be made better. LINks also have powers to help with the tasks and to make sure changes happen.

Matching Michigan
The National Patient Safety Agency launched the “Matching Michigan” project aimed at reducing catheter-associated bloodstream infections in intensive care units (ICUs). It is based on a model which, over an 18 month period, saved around 1,500 patient lives in Michigan by introducing measures that reduced central venous catheter (CVC) associated bloodstream infections.

Monitor
The independent regulator responsible for authorising, monitoring and regulating NHS foundation Trust’s.

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

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

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

National patient surveys
The National Patient Survey Programme, coordinated by the Care Quality Commission, gathers feedback from patients on different aspects of their experience of recently received care, across a variety of services/Settings. Visit: www.cqc.org.uk/usingcareservices/ healthcare/patientsurveys.cfm

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

Patient
Those in receipt of health care.

Periodic reviews
Periodic reviews are reviews of health services carried out by the Care Quality Commission (CQC). The term ‘review’ refers to an assessment of the quality of a service or the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services. Visit: www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/periodicreview2009/10.cfm

Primary care trust
A primary care trust is an NHS organisation responsible for improving the health of local people, developing services provided by local GPs and their teams (called primary care) and making sure that other appropriate health services are in place to meet the needs of local people.

Providers
Providers are the organisations that provide NHS services, for example NHS trust’s and their private or voluntary sector equivalents.

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

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

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

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

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

Secondary Uses Service (SUS)
The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. Visit:
www.ic.nhs.uk/services/the-secondary-uses-service-sus/using-this-service/data-quality-dashboards

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

**South Tees Hospitals NHS Foundation Trust**
Includes the Friarage Hospital (FHN) and James Cook University Hospital (JCUH) and from April 2011, community services in Hambleton, Richmondshire, Middlesbrough, Redcar and Cleveland

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

**Special review**
A special review is a review carried out by the Care Quality Commission (CQC). Special reviews and studies are projects that look at themes in health and social care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national-level findings based on the CQC’s research. Visit: www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/specialreviews/specialreviewsandstudies2009/10.cfm