16th July 2021

Andrea Hetherington

**Director of Corporate Affairs & Legal / Trust Secretary / Freedom to Speak Up Guardian**
South Tyneside & Sunderland NHS Foundation Trust

Sunderland Royal Hospital

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Sunderland

SR4 7TP

**ST&SFT Quality Report 2020/21**

Dear Andrea,

Please see below the statement on behalf of the Durham, South Tyneside and Sunderland Healthwatch which cover the Central Integrated Partnership.

We are grateful, as three independent Healthwatch, to be given the opportunity to comment upon the new Trust's first Quality Report. Equally we were pleased to see the Care Quality Commission rated the Trust good, following its first inspection as South Tyneside and Sunderland NHS Foundation Trust. This is reiterated by your Chief Executive Quality Statement which shows a quiet pride against a job well done in bringing two very different communities together as one Trust.

We have noted and made allowance for the impact of COVID-19 on performance. We have also noted the reference to the Patient, Carer, Public Experience Committee. Healthwatch are members of the committee and know, at first hand, what an active committee it is in monitoring and helping to improve many of the standards recorded in this report, therefore, services for users, their families and friends. The Healthwatch chairs wondered if there could be a place, in future reports, given over to a statement from the chair of this committee?

In general we found, even in this uniquely difficult time, performance was met and exceeded, however, consistent reference to regional and national comparators would have added much needed context as would more detailed destructions of programmes, initiatives and mitigating actions. Making the use of abbreviations and acronyms should be kept to the absolute minimum but where they are used, they should be consistent with respect to the use of upper and lower case lettering. Clarity and ease of reading should be universal feature of the text. We know there was a task and finish group in the Trust, looking at the application of the Accessible Information Standard so public documents should follow the guidance in the standard. A glossary of terms would also be a useful addition. The perception that we are left with is that work within the Trust is clearly a team effort from board to the front line which leaves the reader reassured that all is well.

In the section under the heading:Priorities for improvement and statements of assurance from the board, we found much to praise. There were two areas where we would like to see performance improve: Do not attempt cardiopulmonary resuscitation and missed dose rate. The former was subject to a formal letter to the Trust, following the issuing of guidance by the Chief Nursing Officer and National Medical Director on 7thApril, 2020. The reply from the Trust fully reassured us that all matters referred to in the letter were being followed by the Trust. It is, however, concerning to see the results in the table on page 14, where only one measure is above 80% and the remainder range from 54th to the 76th percentile. It is noted that these are paper based results from 2017/18 and a new electronic system has been introduced with, it states, improved performance. There are no figures given to support the claim, therefore, we look forward to improved results in next years report.

The Trust acknowledges the missed dose rate, as shown in the table on page 19, is a significant increase in doses not administered. We have noted the reference to the pandemic. Given the robust plan described to improve performance we look forward to more reassuring results next year.

Consideringthe section on clinical effectiveness we noted the 10 Safety in Action statements and reassuring associated description. The setting of many aspirational targets was further noted. In sepsis screening assessment and treatment within 1 hour by antibiotics, exceeding the target was particularly welcome to acknowledge. The way deprivation and disability was included, we thought, an appropriate focus given the national priority being given to the impact both have on health and well-being. Healthwatch applauded that the Trust had enthusiastically taken up the national initiative: Getting it Right First Time and their regret felt of the slowing of the programme due to COVID. Never-the-less we are pleased to see the two deep dives that took place into neonatology and spinal services and we further look forward to the five legacy deep dives which will be signed off and followed through when the pandemic abates. We noted the Medical Director' personal commitment to learning from case record reviews and investigations conducted in relation to deaths. The concerted action the Director took to inspire clinical teams to adhere strictly to Trust policy stood out. These actions linked to the advanced adoption of Medical Examiner role should ensure all procedures are closely followed with the related benefit to patients.

The 10 national clinical standards and associated 4 chosen targets have given good results in 3 out of the 4 chosen. Target 2 it is recognised by the Trust, even allowing for the impact of COVID, with a performance of 66% against a target of 90% needs reviewing. We have noted the review is complete and feedback set up so we look forward to the positive impact of these actions in the next report.

Learning from Patient feedback was naturally an area which took our attention as it relates directly to our statutory activities. We noted the strong performance across seven target areas; in particular the theme of being well informed and involved in their care was quickly noticed. In the areas for improvement we noted the reference to the patients perception that staffing appeared low and that the hospital food was rated low. We know, however, from the PLACE based inspections that we have been involved in that the Trust tries hard to provide a nutritious and appetising menu. We look forward to the improvements that should be brought about in 21/22 by the new reporting methods and initiatives referred with respect to volunteers.

Under the heading of: reduced incidents of healthcare acquired infection, we noted a very good but not quite 100% target performance in hand hygiene and use of personal protective equipment. It would have been appropriate in this section if a reference had been linked to coping with the pandemic with respect to the extra measures that had to been taken to manage the virus.

The chairs thought the Delirium Toolbox was a very helpful addition in this area of increasing need among older patients.

We noted some good results in the: Leaving Hospital Questions. There were, however, almost a quarter where the score was low. The common theme was information exchange. We look forward to the plans for improvement having a positive impact upon the theme.

The Trust achieved well against the national targets set by NHS England, however, patient choice is a recurring issue the health service needs to improve.

Under: Priorities for Quality improvement, the Healthwatch chairs took note of the “Our Quality Strategy 2018 -2023 – Improving Quality Together”. We were impressed by the full range of quality initiatives which appear in the audit . In particular we noted the, almost universal, reporting to the Patient, Care rand Public Experience Committee which we agree, as previously mentioned, is a most useful and interactive forum, made up of Trust executives, non-executives and Trust partners, to keep quality, for all who use or come in contact with the service, on the right track.

It is noted that it is a requirement to include a reference to all audits but it is to the credit of the Trust that it has kept pages attributed to the reproduction of these details to a manageable number. In some quality reports this entry can run to 20 pages! We understand that the Quality Report is to be reviewed nationally and it is hoped that this section, although necessary, can be displayed more efficiently.

The section on research studies was particularly welcome, especially the 11 dedicated studies linked to COVID-19. We have seen in reaction to the pandemic, how research, its development and dissemination can be safely speeded up by a quantum and it is hoped this experience can be reproduced and embedded throughout the NHS. The several pages given over to innovations is further evidence of the Trusts pro-activity at the horizon of care and treatment.

As stated at the start of our commentary we were reassured to note the Trust's “Good “ rating given by the CQC. All Trusts are required to have a mandatory inspection during their first year of establishment and it is a remarkable achievement to bring two previous Trusts together, with distinctive cultures and from very different communities, and deliver such a positive performance. It is further noted under the CQC's powers the Trust has satisfied all statutory requirements.

Under the heading Other information – review of quality, Healthwatch have made the following observations:

First, it does seem an unusual title for such a wide range of, what are quite crucial areas of patient care and treatment. Unless this is prescribedperhaps, a more relevant title could be used in future or, if it is specified, perhaps this could be mentioned as part of the national review.

For patient safety we noticed that the figures covered quite a range, therefore, drawing a conclusion is difficult, however, we would have liked to have seen reference to a plan for moving towards the lowest national rate. For “Degree of Harm” we noted the very good practice in bullet point 6 but making a statement about moving to the lowest, 0%, achievement would show the Trust’s ambition in this area. The Trust states under Patients Safety that the aim is to be one of the safest in the world; shouldn't the ambition be to be the safest in the world? It is welcome to see the new system has reduced risk but there is no explanation of how. We applaud embedding Duty of Candour into the ethos of the Trust. This ,however, is another area again where numbers a small and consequently conclusions are difficult to draw. Elsewhere, in such circumstances, de minimis is used or a note could be added to all tables where the data sample is too small for drawing conclusions etc. The wording, “too small to be meaningful” could be added as a legend.

The dramatic improvement from 43.75% to 76% for 10 day target for those aspects to be completed as the initial phase of the Duty would benefit from qualification.

Serious incidents appear not to be a large number, however, falls incidents are 3 times more frequent than any other category. Is there any learning to be had from other Trusts Quality Reports with respect to this common risk? Also, is there data available from the recent audit which could clarify why the Trust missed the target? Finally, we noted the good news of only 1 infection control incident. Is this related to the extra measures to protect patients and staff from COVID and if so could the learning be shared?

We think the amount of text and detail, especially with respect bullet points showing actions of mitigation, for “Never Events” should be fuller.

You start with the response to COVID-19 under “Clinical Effectiveness”. We noted the response, however, other than winning the contract for infection protection and control, we found little to comment upon. Winning the contract deserves our congratulations and shows the confidence of providers in the Teams expertise at the Trust; we were particularly pleased to note the assurance the contract gave to care homes.

The section which covers hospital acquired infections covers: several bacterial infections and safer surgery. The unavoidable case of methicillin resistant staphylococcus aureus would benefit from further description of why it was deemed unavoidable.

With respect to Clostridioidesdifficlle infection we wondered if there had been any learning from the precautions taken to minimise COVID transmission? The last bullet on this topic needs further explanation and how the medical staff were directly involved in the mitigating actions needs to be described, because there is no reference in the report.

For Methicillin Sensitive Staphylococcus Aureus the RCA, described earlier as root cause analysis but here only by acronym, process needs to be described. We noted the three incidences of infection described, the second of which, seems something that should not have happened.

We noted the good results with respect to Escherichia coil.

The second paragraph describing the safer surgery check list, we thought, was good example of what is easily read by a general readership and easy to understand. The sign out and sessional compliance results were a concern to us. We would hope the “initiatives in the pipeline” to bring about the necessary improvement should be brought forward.

The next sub-heading in the report is: Focusing on Patient Experience.

Under national surveys we noted with regret that the national Maternity survey, for understandable reasons, was cancelled. It would have been very valuable given that maternity services transferred, in large part, to Sunderland, under the Path to Excellence Programme – Phase 1. We hope that the survey will be conducted at the earliest opportunity.

Under the, “Patient Cancer Experience – 2019”, we noted the extract from the cancer dashboard but wondered why this particular set of questions had been displayed and the relevance of question 55 and it's low score to the Trust's Quality Report? With respect to the tabulated dark and light blue highlighted areas and the push-to-web initiative our comments were:

* is there a plan to increase further the success under the area highlighted dark blue;
* is there a plan to improve the performance in the light blue area, and;
* has digital exclusion been considered and mitigated under the push-to-web initiative?

The next sub-section is : Local Patient Experience Surveys and The Friends and Family Test.

We acknowledge the commitment to the surveys and test but did we pick up from the way that the section is written that not all areas of the Trust participate? We look forward to the results from the new electronic feedback method. We wondered how popular the QR codes were and if they tended to be the province of or acted as an exclusion to any users? We liked the work that the Lead Nurses were doing to involve patients so as to mitigate the impact of COVID on the survey work.

Significant partnerships and alliances seem to be thriving; we were particular pleased about the reference to the Council.

As Healthwatch we know the positive impact young volunteers can have so keep up the good work and the areas chosen to use their unique skill set are very relevant. It is also heartening to see that, as a Trust, you are thinking more broadly than acute treatment by including mental health and learning disability.

With respect to translation an interpretation services we are pleased to see South Tyneside has been added to the contract. With an increased demand since July, with the figure of 4837, shows there is a considerable need.

For complaints and advice we note the principles and time scales followed and appreciate that if the time scales can't be met, then new time scales are agreed with the complainant. Did the Trust look into the dip in complaints in comparative quarters – was this associated with the impact COVID had on reducing demand, especially in the Emergency Departments?

Healthwatch South Tyneside having chosen palliative and End-of-Life Care as a priority following the sudden loss of St Clares in 2018 saw the 14.5% of complaints linked to the death of a patient as a specific interest. South Tyneside would be pleased to receive some more information on the issue. This is especially relevant with the beds in Haven Court about to become fully operational, which should be influenced by the recently approved pan-borough strategy for this service.

Under categories of complaints, we would like to point out, if you group all the clinical complainants together, they become the single largest category at over 150 complaints. This is a matter of concern because it is something the Trust can control. How does the figure of 12 cases referred to the Ombudsman stand when compared with other similar Trusts?

We are pleased to see that team is emphasised when learning and improvement is considered. Not just the operational team but from the Trust Board to involving everyone in the organisation. It is good to see the Trust is willing to support their words with funded action. All the initiatives are highly relevant but the employment of a falls prevention lead, given the earlier data, is particularly welcome. The packaging font size initiative , caught our eye, if you don't mind the pun. This could be seen as leading the way as a society wide initiative, for it is not only medicines labelling that suffers from printing that's too small to read.

In the time of COVID, volunteers have had to adjust their lives too, so it is excellent to read even with COVID's associated ramification of isolation that hospital radio continued to bring some light entertainment into people’s lives.

For Healthwatch listening to peoples stories, is our touchstone, so honouring volunteers week in this way is wholeheartedly endorsed. It is also a great initiative, to use what could be fallow time in the world of volunteering due to the pandemic, to rethink volunteer roles and create new ones; the dining champion should be an interesting role!

In the final section on performance against targets, the Trust, first focuses on Quality Improvement. Explaining, “what is quality “ we recognise this is difficult to do but the explanation could be a little more reader friendly. It is good to see a further mention about work to reduce falls which shows it is being addressed consistently throughout the report. The case study on the “Older Peoples Treatment Collaborative” has 5 excellent objectives. It is good to see charitable funds being used wisely and for impact on: falls , pressure ulcers, reducing deterioration, hydration and nutrition and medicines management. The focus on staff retention is also applauded.

The way outcomes are measured is noted but the Masters initiative with Sunderland University sounds very innovative and has such a large cohort too; we would like to hear more about the course and its syllabus. We don't know if it's linked but it is pleasing to note the positive changes in ward based culture.

Food is a pleasure at any time of life but as one gets older it becomes even more so, therefore, the mouthcare project should increase the pleasure, not to mention the nutrition, that patients get from enjoying their food. As lay people we don't always immediately associate the holistic benefit of good nutrition to other fundamental issues such as healthy tissue.

Finally, from the comments received, afternoon tea, seems to be a favourite time of the day and must help in improving not just health issues but well-being as well; sadly so reduced by the pandemic. You complement this with a happy day where each meal is designed to bring a smile to peoples faces.

We note the performance against key targets and the legends associated with the tables. Comparators from similar trust would be a useful addition and any target where the variance is in double figures should be subject to more explanation. Some targets are subject to review. Does this include the ambulance delay targets, for they seem impracticable.

 Emergency departments, due to the pandemic, have been through a particularly odd time, with reduced demand and consequently increased performance. More detail on regional and national comparators would have added helpful context. We know, however, throughout attendance at the Emergency Department Development Board (EDB) how seriously this matter is sought to be managed and we applaud the innovative work between leaders on the board and the specialist at the commissioning support unit, to derive models for action which will allow ED demand to

pro-actively managed.

Referral to Treatment Time. We note the catastrophic but unstoppable impact of COVID on elective care and treatment. The whole mix here including the link to primary care referral variability makes the whole picture difficult to visualise. The reduction from the build up to 9800 people waiting, more than 18 weeks, to a reduction to 5000, over a short time is very reassuring for the future. We also notice the build to over 500, of 52 week waiters, which must be disheartening for the Trust, coming as it did, from a zero base.

 We note the innovation, as elsewhere nationally, of the use of telephone and digital solutions but as we return to more normal working the costs and benefits of this need careful consideration. Some trusts measure the benefits to patients and the wider community, in terms of reduced emissions from car journeys. Early adopters are linking it to their contribution to the reduction of their carbon footprint.

Good to see we are staying with the leading cadre and that your colleagues in primary care are helping with the potential change in GP referral patterns as the country comes out of most/all legal restrictions. More detail of the workstreams, referred to here, would be welcome.

For cancer it is great to see the majority of targets continue to be met, and that you are doing well by regional and national comparison. To feel that you are not on your own but the sadly missed target is a shared experience nationally, which must mean there is scope for learning leading to faster recovery. It would be a great step forward, if the Trust could somehow garner the 14% reduction in referrals via primary care colleagues and others. It is good to see the Trust rising to the tougher 28day waiting target and improving its performance against it by 15%.

We struggled to note the main message in this section as we found paragraph one could have benefited from a simpler explanation of relative performance. We note the speciality backlogs and the capacity difficulties but are rest assured that the 15 workstreamswill deliver the answers required to overcome these issues.

You state that NHS Improvement, the regulator of trusts performance, has not made formal segmentation in 20/21, the judgement to put trusts into one of 4 descending performance and concomitant support groups. Judging, however, by the Trust's performance, the universal and holistic monitoring, involvement of the CCG and CQC rating, we feel confident that the Trust will be fine. We have copied part of the text from the report, although we think it relates to the national situation, it sums up the Trust's leadership and staff's attitude to this area and the whole report: “ the review will ensure access standards continue to ensure the sickest and most urgent patients are given priority, are easy to understand for patients and the public and are practically achievable”. It is also hoped that the new standard for emergency departments will be a better monitoring tool. As Healthwatch we believe that all standards should based on information for impact.

## Yours sincerely,

Peter Bower

Healthwatch South Tyneside Chair



Christopher Cunnington- Shore

Healthwatch County DurhamChair



John Dean

Healthwatch Sunderland Chair