Public Document Pack

Tees Valley Joint Health Scrutiny Committee

Date: Thursday, 8 May 2025
Time: 10.00 am
Venue: Council Chamber, Civic Centre, Ridley Street, Redcar, Yorkshire, TS10 1TD.

Membership: -

Darlington BC: Councillors Holyroyd, Layton and Scott
Hartlepool BC: Councillors Boddy, Moore and Roy
Middlesbrough BC: Councillors Cooper, Morrish and Vacancy
Redcar and Cleveland BC: Councillors Cawley, Crane and Kay
Stockton-on-Tees BC: Councillors Besford, Coulson and Hall

Agenda		**Pages**
1.	Appointment of Chair for 2025/2026	
2.	Appointment of Vice Chair for 2025/2026	
3.	Apologies for Absence	
4.	Declarations of Interest	
5.	Minutes of the meeting held on 13 March 2025	3 - 10
6.	Tees Valley Joint Health Scrutiny Committee - Protocol and Terms of Reference	11 - 16
7.	South Tees Hospitals NHS Foundation Trust Quality Account for 2024/2025 - Deputy Director of Quality University Hospitals Tees	17 - 100
8.	North Tees and Hartlepool NHS Foundation Trust Quality Account for 2024/25 – Deputy Director of Quality University Hospitals Tees	101 - 212
9.	Work Programme for 2025/26	213 - 221

10. Any other items which the Chair considers urgent

Tees Valley Joint Health Scrutiny Committee

MINUTES AND DECISION RECORD

13 March 2025

The meeting commenced at 10am in the Civic Centre, Hartlepool.

Present:

Responsible Authority Members:
Darlington Borough Council -
Hartlepool Borough Council - Cllr Boddy (CH), Cllr Roy
Middlesbrough Council - Cllr Cooper
Redcar and Cleveland Borough Council – Cllr Cawley (VC), Cllr Kay,
Stockton Borough Council - Cllr Besford, Cllr Coulson (substitute for Cllr Miller), Cllr Hall

Also Present:

Mark Cotton, Assistant Director of Communications and Engagement, North East Ambulance Service (NEAS)
Rachael Lucas, Assistant Director of Quality & Safety, NEAS
Beverley Murphy, Chief Nurse, Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)
Shaun McKenna, General Manager, Adult Mental Health – Urgent Care, TEWV

Officers:

Caroline Breheny (R&CBC)
Gemma Jones, (HBC)
Susan Lightwing (MBC)
Caroline Leng (R&CBC)
Joan Stevens (HBC)
Gary Woods (SBC)

32. Apologies for Absence

Cllr Crane, Cllr Holroyd, Cllr Layton, Cllr Moore, Cllr Morrish, Cllr Miller, Cllr Scott and Hannah Miller.

33. Declarations of Interest

None

34. Minutes of the meeting held on 9th January 2024

Confirmed.

35. North East Ambulance Service (NEAS) NHS Foundation Trust Quality Account for 2024/25 – *Assistant Director of Quality and Safety, NEAS*

Representatives from NEAS were in attendance to present to the Committee their current position and performance and to provide an update on the 2024/25 quality priorities.

Data was provided to Members in relation to Patient Safety Incidents. It was noted that 3,327 patient safety incidents had occurred in the period April 2024 to January 2025. This equated to 2.7% per 1000 calls answered. There were 18 patient safety incident investigations with 2 meetings taking place per month focussing on incident reporting.

In relation to patient experience/feedback, 418 complaints had been received with 1294 appreciations also recorded. Work is undertaken to investigate how to improve practice after complaints are received. Appreciation stories are also fed back to the board.

The Committee was informed that, of the 11 Ambulance Service Trusts in England, NEAS were first in relation to ambulance response times, although it was recognised there was still room for improvement. In terms of Friends and Family satisfaction the 111 service gained a satisfaction score of 78.4%.

An update on the 2024/25 quality priorities was provided and focussed on patient safety, clinical effectiveness and patient experience. With regards to patient safety, learning from deaths and the prevention of future deaths reports were discussed. It was noted that policies and procedures had been reviewed to improve learning, alongside bringing teams together to share learning outcomes from Coroners. Improved engagement with bereaved families and carers, Corners and medical examiners was also highlighted. Future work included making the Learning from Deaths process more efficient so that resources could be focused on areas that lead to change.

The second element of patient safety discussed was infection and prevention control. Achievements had included the reviewing of governance arrangements, audit tools, reporting and training. An application software based audit process had been introduced as well as the development of a local action plan. NEAS will continue to review polices and procedures to ensure they comply with national standards.

In terms of Clinical Effectiveness the Committee was informed that work undertaken had focussed on –

- reviewing the process for identifying a deteriorating patient
- introduction of a critical care desk
- further training provided to Specialist Paramedics in Critical Care (SPCC)
- deploying 2 specialist care rapid response vehicles
- improving the learning from the clinical audit of incidents
- improving the use of pre-hospital alerts

The final priority discussed related to patient experience with NEAS working to improve how the Trust triangulates and shares learning from incidents, complaints and lived experience. This included working with voluntary ogranisations to gather public feedback to help inform the new clinical strategy. Other achievements were improving colleagues' awareness of processes relating to complaints, claims and 'learning from events' meetings. Future work will focus on introducing the learning from claims into forums such as multi-disciplinary meetings.

In the questions that followed Members gained the following information –

- Mechanisms regarding how Coroner information is fed back to staff were explained.
- Emphasis is placed on systemic learning and how the organisation can learn to prevent future deaths. This is achieved via an executive bulletin that is circulated monthly and is also available on the internal website. Elements of this are also fed back into training sessions.
- All staff have mandatory training and different teams feed into this.
- In respect of vehicle cleaning methods, an audit tool is used to understand the 'hot spots' and how these methods can be improved.
- The percentage of Paramedics with advanced training was not available to the Committee but would be shared at a later date.
- 2 rapid response vehicles are based in 2 separate units across the North East, one of which is based in Hartlepool. Concerns were expressed that this was quite far north for the people of Redar. It was noted that use of these vehicles is monitored and that specialist paramedics are also situated in emergency departments.
- Some complaints focused on response times to incidents, this was being considered as an area for improvement.
- In relation to response times, NEAS are the only Ambulance Service that achieves the cat 1 response target.

- NEAS were also the fastest for category 2 response times, with 90% responding within 40mins. Whilst the NHS England target is 30min, NEAS are aiming for 18 mins, it was acknowledged that this may take some years to achieve this.
- It was highlighted that there was still room for improvement in terms of response times.
- In response to Friends and Family satisfaction, there was high appreciation for crew attitude however, this was also the subject of some complaints and this was monitored.
- The way calls are prioritised was explained.
- Call categories can change depending on the situation.
- A vast amount of work has gone into hospital turn around times.
- Work has also taken place to support patients that do not require hospital care and can be treated at home.

Representatives from NEAS were thanked for their presentation.

Decision

(i) The Committee considered and commented on the update on performance in 2024-2025 and the priorities for quality improvement in 2025-2026
(ii) That a statement of assurance will be prepared and submitted to the Trust, with final approval delegated to the Committee Chair and Vice-Chair
(iii) That data will be shared in relation to the number of Paramedics with advanced training.

36. Tees Esk and Wear Valleys (TEWV) NHS Foundation Trust Quality Account priorities update 2024/25 – *Chief Nurse, TEWV*

The Chief Nurse was in attendance to provide the Committee with the Quality Account priorities update for 2024/25. Priorities were co-created with people using the service and led by people with lived experience. Priorities included –

- Patient experience: Promoting education using lived experience
- Patient Safety: Relapse prevention
- Clinical effectiveness: Improving personalisation in urgent care.

Work undertaken has focussed on the promotion of education using lived experience. This has meant an increase in peer support workers and work undertaken to reduce the number of children graduating into adult mental health services by making sure their needs are being met.

Relapse prevention involves looking at a patients relapse indicators and in advance care planning, taking a more personalised approach.

Clinical effectiveness includes working to improve personalisation in urgent care with a view of reducing the need for patients to tell their story more that once. 85% staff will have undertaken the online training module in personalised care planning. The impact of this training will be assessed by evaluating the quality of patient experience feedback. Work will continue with services users to identity the priorities ahead building on the elements discussed, ensuring that the focus is having an impact on the people in their care.

Members were given an overview of the Niche assurance review which was commissioned by NHS England. This assessed to what extent the care TEWV provide is compliant with current standards and expectations, with a focus on the experiences of young people in their care. The report found that the quality of child and adolescent services had improved significantly. This had provided the Trust with assurance that young people would receive care in line with good practice and mandatory practice. In terms of the Child Adolescent Mental Health Service (CAMHS) the Trust now provides support via intensive home treatment teams and intensive positive behaviour support multidisciplinary teams.

Referring to the latest CQC well led inspection, data was provided in terms of the findings of each service as detailed on the presentation. An update was provided regarding the improvement plan with only 1 action now overdue.

Referencing the recent CQC crisis report publication published in February 2025, Members were informed a rating of ‘good’ had been achieved. Representatives explained the report had demonstrated the Trusts continuous improvement and positive impact on peoples experience of the Trust. This was against a national backdrop of increased demand for services. It was acknowledged there was more work to be done including improving the reporting of mandatory and statutory training and line supervision.

In the discussion that followed a Member asked if more people are being treated at home as this was the cheaper option. The Representative explained that for some admission into hospital is appropriate to allow them to be kept safe. However, being admitted to hospital was problematic for a person as this could impact on their caring responsibilities and the loss of control over their life. Ensuring hospital admission was the correct option for a person was key.

A Member asked for more information about how young people decide on their own care. It was explained that evidence suggests that involving young people in the decisions relating to their care can help them develop and manage their own life with a sense of choice. Clear assessments are in place but choice is given where possible, alongside working with the young person’s family and support network. The mechanism of how people share their stories was also explained including how information is shared and reported on the electronic systems.

Attention was also drawn to the fact that supporting patients is not done in isolation and TEWV work with partners to help address a patients issues. Work takes place with Local Authorities and the Voluntary Sector regarding areas such as employment options and taking part in meaningful activities. TEWV have also established a voluntary and peer support programme.

Members were pleased that the crisis service had received a rating of good but commented there was no breakdown of how this had been achieved. Concerns were also expressed about the waiting list for CAMHS. Representatives explained that improvements will focus on making sure staff are well trained and properly supervised. The quality of risk assessment and care plans had greatly improved in this area.

In terms of recruitment there are currently no vacancies in secure inpatient services. However, the Trust were mindful that a drop in student nurses was anticipated and were looking at what they could do to fill the gap. The Trust were also looking at new ways of capturing clinical supervision recording.

A discussion was held in relation to waiting lists across CAMHS in particular those waiting for assessments for neuro diverse disorders. Representatives commented that this was a national problem and ways to manage this were being explored.

In terms of the CQC well led inspection, the 1 recommendation overdue related to 2 policies being reviewed in line with best practice. In part this was due to the Trust being able to demonstrate that the training is being embedded which will take some months.

A Member referred to tables detailed in the presentation which related to the CQC well led inspection and asked if clinical supervision was happening on wards. Reassurances was provided that supervision is happening but previously there was not a systematic way of reporting this but this was now being reviewed.

Representatives from TEWV were thanked for their presentation.

Decision

(i) The Committee considered and commented on the update on performance in 2024-2025 and the priorities for quality improvement in 2025-2026.

(ii) That a statement of assurance will be prepared and submitted to the Trust, with final approval delegated to the Committee Chair and Vice-Chair.

37. Crisis Screening, Triage and Assessment Overview - Durham and Tees Valley – *General Manager, Adult Mental Health – Urgent Care, TEWV*

Information was provided to the Committee regarding crisis screening, triage and assessment in Durham and Tees Valley. Specifically, the implementation of the new digital telephony system launched in March 2024. Originally a 12-hour day shift service this was now 24/7 and could be accessed via NHS 111 (option 2). This was now a single source of access and with all calls being screened by the Durham and Tees Valley screening service. The use of screening tools has meant that patients are directed to the most appropriate source of support. This has allowed crisis team clinicians to focus their time on those that need it the most.

Since the implementation of the screening team the service has seen a reduction in call volume and repeat callers. Any patients waiting over 7 minutes are offered a call back. It was noted that only 3% of calls were abandoned by patients, with call answer rates remaining positive. However, despite being better than that national average it was acknowledged that there was still room for improvement. Further information on call times was detailed in the presentation.

The service, based at West Park Hospital, answers calls from Durham and the Tees Valley and calls are then passed to local teams. There has been a significant improvement to triage call answer rates. The child and adolescent mental health service has sustained a call answer rate of 95%. There had also been a significant volume of calls to the professional line. Data was provided in relation to the service for the month of December 2024.

The next steps for the service were outlined and the Committee were advised that in terms of workforce pressures, the service currently had no vacancies. There had been some technical issues which were expected to be resolved in April 2025. In terms of future improvements, 2 safe havens were to be opened across the Tees Valley and the service had begun to work closely with the voluntary sector and neighbourhood based services. This was with a view of supporting patients and preventing them from needing crisis care.

In the discussion that followed a query was raised in terms of multiple ambulances attending for one patient. It was explained that some situations, when assessed for safety, may generate that level of response however, learning from those types of situations was ongoing.

Members asked if the Samaritans number was still being shared with patients. Representatives explained that the majority of patients were being referred to the TEWV listening service and work was taking place around the publicity for accessing the 111 service for mental health.

Further information was provided in relation to the abandoned calls and the 7 minute call back function, this was being closely monitored.

Members were pleased to see that patients were being signposted to different sources of support and thanked Representatives for their detailed presentation.

Decision

(i) Members noted the content of the adult mental health service urgent care presentation.

38. Work Programme for 2024/2025

The Work programme was noted. The Chair explained that future items for the work programme would be discussed at the first meeting of the municipal year

The Chair expressed thanks to Members for their attendance and contributions during 2024/25 as this was the final meeting scheduled for the current municipal year. As per the established rotational arrangements, support of the Committee would pass onto Redcar and Cleveland Borough Council for the 2025-2026 municipal year, with the first meeting being held on the 8th May 2025.

The meeting concluded at 12pm.

CHAIR

Protocol for the Tees Valley Health Scrutiny Joint Committee

1. This protocol provides a framework for carrying out scrutiny of regional and specialist health services that impact upon residents of the Tees Valley under powers for local authorities to scrutinise the NHS outlined in the NHS Act 2006, as amended by the Health and Social Care Act 2012, and related regulations.

2. The protocol will be reviewed as soon as is reasonably practicable, at the start of each new Municipal year. Minor amendments to the protocol that do not impact on the constitutions of the constituent Tees Valley Authorities will be determined by the Joint Committee at the first meeting in each Municipal year. An amended protocol, following agreement from the Tees Valley Health Scrutiny Joint Committee will be circulated for information to:-

Tees Valley Local Authorities

3. Darlington; Hartlepool; Middlesbrough; Redcar and Cleveland; Stockton-on-Tees (each referred to as either an “authority” or “Council”).

NHS England Area Teams

4. Durham, Darlington and Tees Area Team.

NHS Foundation Trusts

5. County Durham and Darlington Trust; North Tees and Hartlepool Trust; South Tees Hospitals Trust; Tees, Esk & Wear Valleys NHS Trust; North East Ambulance Service.

Integrated Care Board

6. North East and North Cumbria ICB.

Tees Valley Health Scrutiny Joint Committee

7. A Tees Valley Health Scrutiny Joint Committee (“the Joint Committee”) comprising the five Tees Valley Authorities has been created to act as a forum for the scrutiny of regional and specialist health scrutiny issues which impact upon the residents of the Tees valley and for sharing information and best practice in relation to health scrutiny and health scrutiny issues.

Membership

8. When holding general meetings, the Joint Committee will comprise 3 Councillors from each of the Tees Valley Local Authorities (supported by appropriate Officers as necessary) nominated on the basis of each authority's political proportionality, unless it is determined by all of the constituent Local Authorities that the political balance requirements should be waived.

9. The terms of office for representatives will be one year from the date of their Authority's annual council meeting. If a representative ceases to be a Councillor, or wishes to resign from the Joint Committee, the relevant council shall inform the Joint Committee secretariat and a replacement representative will be nominated and shall serve for the remainder of the original representative's term of office.

10. To ensure that the operation of the Joint Committee is consistent with the Constitutions of all Tees Valley Authorities, those Authorities operating a substitution system shall be entitled to nominate substitutes. Substitutes (when not attending in place of the relevant Joint Committee member, and exercising the voting rights of that member) shall be entitled to attend general or review meetings of the Joint Committee as non-voting observers in order to familiarise themselves with the issues being considered.

11. The Joint Committee may ask individuals to assist it on a review by review basis (in a non-voting capacity) and may ask independent professionals to advise it during a review.

12. The quorum for general meetings of the Joint Committee shall be 6, provided that 3 out of 5 authorities are represented at general meetings. The quorum for Tees-wide review meetings, in cases where some Authorities have chosen not to be involved, shall be one third of those entitled to be present, provided that a majority of remaining participating authorities are represented. Where only 2 authorities are participating both authorities must be represented.

13. The Joint Committee will conduct health reviews which impact upon residents of the whole of the Tees Valley. If however one or more of the Councils decide that they do not wish to take part in such Tees-wide reviews, the Joint Committee will consist of representatives from the remaining Councils, subject to the quorum requirements in paragraph 12.

14. Where a review of a 'substantial development or variation' will only affect the residents of part of the Tees Valley, Councils where residents will not be affected will not take part in any such review. In such cases, the Joint Committee will liaise with the Councils where residents will be affected, in order to assist in establishing a separate joint body (committee) to undertake the review concerned. The composition of the committee concerned may include representatives from other Local Authorities outside the Tees Valley, where the residents of those Authorities will also be affected by the proposed review. The chairmanship, terms of reference, member composition, procedures and any other arrangements which will facilitate the conducting of the review in question will be matters for the joint body itself to determine.

15. It is accepted, however, that in relation to such reviews, the relevant constituent authorities of the committee concerned may also undertake their own health scrutiny reviews and that the outcome of any such reviews will inform the final report and formal consultation response of the committee.

Chair and Vice-Chair

16. The Chair of the Joint Committee will be rotated annually between the Tees Valley Authorities in the following order:-

    - Stockton-on-Tees
    - Hartlepool
    - Redcar & Cleveland
    - Middlesbrough
    - Darlington

17. The Joint Committee shall have a Vice-Chair from the Authority next in rotation for the Chair. At the first meeting of each municipal year, the Joint Committee shall appoint as Chair and Vice-Chair the Councillors nominated by the relevant Councils. If the Chair and Vice-Chair are absent from a meeting, the Joint Committee shall appoint a member to act as Chair for that meeting. The Chair will not have a second or casting vote.

18. Where the Authority holding the Chair or Vice-Chair has chosen not to be involved in a Tees-wide review, the Chair and Vice-Chair of the Joint Committee for the duration of that review will be appointed at a general meeting of the Joint Committee.

Co-option of other Local Authorities

19. Where the Joint Committee is to conduct a Tees-wide scrutiny review into services which will also directly impact on the residents of another local authority or authorities outside the Tees Valley, that authority or authorities will be invited to participate in the review as full and equal voting Members.

Terms of Reference

20. The Joint Committee shall have general meetings involving all the Tees Valley authorities:-

    - To facilitate the exchange of information about planned health scrutiny work and to share information and outcomes from local health scrutiny reviews;

    - To consider proposals for scrutiny of regional or specialist health services in order to ensure that the value of proposed health scrutiny exercises is not compromised by lack of input from appropriate sources and that the NHS is not over-burdened by similar reviews taking place in a short space of time.

21. The Joint Committee will consider any proposals to review regional or specialist services that impact on the residents of the whole Tees Valley area. The aim will be for the Joint Committee to reach a consensus on the issues to be subject to joint scrutiny, but this may not always be possible. In these circumstances it is recognised that each council can conduct its own health scrutiny reviews when they consider this to be in the best interests of their residents.

22. In respect of Tees Valley-wide reviews (including consideration of substantial developments or variations), the arrangements for carrying out the review (eg whether by the Joint Committee or a Sub-Committee), terms of reference, timescale, outline of how the review will progress and reporting procedures will be agreed at a general meeting of the Joint Committee at which all Tees Valley Authorities are represented.

23. The Joint Committee may also wish to scrutinise services provided for Tees Valley residents outside the Tees Valley. The Joint Committee will liaise with relevant providers to determine the best way of achieving this.

24. The basis of joint health scrutiny will be co-operation and partnership within mutual understanding of the following aims:-

- to improve the health of local people and to tackle health inequalities;
- ensuring that people's views and wishes about health and health services are identified and integrated into plans and services that achieve local health improvements;
- scrutinising whether all parts of the community are able to access health services and whether the outcomes of health services are equally good for all sections of the community.

25. Each Local Authority will plan its own programme of health scrutiny reviews to be carried out locally or in conjunction with neighbouring authorities when issues under consideration are relevant only to their residents. This programme will be presented to the Joint Committee for information.

26. Health scrutiny will focus on improving health services and the health of Tees Valley residents. Individual complaints about health services will not be considered. However, the Joint Committee may scrutinise trends in complaints where these are felt to be a cause for concern.

Administration

27. The Joint Committee will hold quarterly meetings. Additional meetings may be held in agreement with the Chair and Vice-Chair, or where at least 6 Members request a meeting. Agendas for meetings shall be determined by the secretariat in consultation with the Chair.

28. Notice of meetings of the Joint Committee will be sent to each member of the Joint Committee five clear working days before the date of the meeting and also to the Chair of the constituent authorities' relevant overview and scrutiny committees (for information). Notices of meetings will include the agenda and papers for meetings. Papers "to follow" will not be permitted except in exceptional circumstances and as agreed with the Chair.

29. Minutes of meetings will be supplied to each member of the Joint Committee and to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information) and shall be confirmed at the next meeting of the Joint Committee.

30. Meetings shall be held at the times, dates and places determined by the Chair.

Final Reports and Recommendations

31. The Joint Committee is independent of its constituent Councils, Executives and political groups and this independence should not be compromised by any member, officer or NHS body. The Joint Committee will send copies of its final reports to the bodies that are able to implement its recommendations (including the constituent authorities). This will include the NHS and local authority Executives.

32. The primary objective is to reach consensus, but where there are any matters as regards which there is no consensus, the Joint Committee's final report and formal consultation response will include, in full, the views of all constituent councils, with the specific reasons for those views, regarding those matters where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

33. The Joint Committee will act as a forum for sharing the outcomes and recommendations of reviews with the NHS body being reviewed. NHS bodies will prepare Action Plans that will be used to monitor progress of recommendations.

Substantial Developments or Variations to Health Services

34. The Joint Committee will act as a depository for the views of its constituent authorities when consultation by local NHS bodies has under consideration any proposal for a substantial development of, or variation in, the provision of the health service across the Tees Valley, where that proposal will impact upon residents of each of the Tees Valley Local Authorities.

35. In such cases the Joint Committee will seek the views of its constituent authorities as to whether they consider the proposed change to represent a significant variation to health provision, specifically taking into account:-

    - changes in accessibility of services
    - impact of proposal on the wider community
    - patients affected
    - methods of service delivery

36. Provided that the proposal will impact upon residents of the whole of the Tees Valley, the Joint Committee will undertake the statutory review as required under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013. Neighbouring authorities not normally part of the Joint Committee, may be included where it is considered appropriate to do so by the Joint Committee. In accordance with paragraph 22, the Joint Committee will agree the arrangements for carrying out the Review.

37. Where a review does not affect the residents of the whole of the Tees Valley the provisions of paragraphs 14 and 15 will apply and the statutory review will be conducted accordingly.

38. In all cases due regard will be taken of the NHS Act 2006 as amended by the Health and Social Care Act 2012, and the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013.

Principles for Joint Health Scrutiny

39. The health of Tees Valley residents is dependent on a number of factors including the quality of services provided by the NHS, the local authorities and local partnerships. The success of joint health scrutiny is dependent on the members of the Joint Committee as well as the NHS.

40. The local authorities and NHS bodies will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct. Personal and prejudicial and/or disclosable pecuniary interests will be declared in all cases in accordance with the code of conduct and Localism Act 2011.

41. The scrutiny process will be open and transparent in accordance with the Local Government Act 1972 and the Access to information Act 1985 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be considered in private and only if the Joint Committee so decide. Papers of the Joints Committee can be posted on the websites of the constituent authorities as determined by each authority.

42. Different approaches to scrutiny reviews may be taken in each case. The Joint Committee will seek to act as inclusively as possible and will take evidence from a wide range of opinion including patients, carers, the voluntary sector, NHS regulatory bodies and staff associations. Attempts will be made to ascertain the views of hard-to-reach groups, young people and the general public.

43. The Joint Committee will work to continually strengthen links with the other public and patient involvement bodies such as local Healthwatch.

44. The regulations covering health scrutiny require any officer of an NHS body to attend meetings of health scrutiny committees. However, the Joint Committee recognises that Chief Executives and Chairs of NHS bodies may wish to attend with other appropriate officers, depending on the matter under review. Reasonable time will be given for the provision of information by those asked to provide evidence.

45. Evidence and final reports will be written in plain English ensuring that acronyms and technical terms are explained.

46. The Joint Committee will work towards developing an annual work programme in consultation with the NHS and will endeavour to develop an indicative programme for a further 2 years. The NHS will inform the secretariat at an early stage on any likely proposals for substantial variations and developments in services that will impact on the Joint Committee's work programme. Each of the Tees Valley authorities will have regular dialogue with their local NHS bodies. NHS bodies that cover a wide geographic area (e.g. mental health and ambulance services) will be invited to attend meetings of the Joint Committee on a regular basis.

47. Communication with the media in connection with reviews will be handled in conjunction with each of the constituent local authorities' press officers.

NHS
South Tees Hospitals
NHS Foundation Trust

Quality Account

2024-25

Caring
Better
Together

Table of Contents

3. Overview of quality of care and performance indicators

   3.1 Overview of quality of care

   Patient Safety

   a. Medication Safety
   b. Compassionate Engagement & evaluation of FLO
   c. Martha's Rule

   Clinical effectiveness indicators

   a. Research and Innovation
   b. STAQC and Ward 12 journey
   c. MIYA and digital journey

   Patient experience and involvement indicators

   a. Patient surveys – national and local
   b. Patient Experience and EDI
   c. Patient Experience Involvement Bank

   3.2 Performance against key national priorities

   3.3 Additional required information
   Seven-day services
   Freedom to speak up
   Rota gaps for doctors and dentists in training

4. Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

5. Annex 2: Statement of directors responsibilities for the quality report

6. Annex 3: Glossary of terms

1. Statement on quality from the chief executive of the NHS foundation trust

To be inserted

Stacey Hunter

Group Chief Executive Officer
South Tees Hospitals NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust

1.1 Introduction

South Tees Hospitals NHS Foundation Trust provides hospital and community services – see South Tees Hospitals NHS Foundation Trust for detailed information and news. In brief:

Hospital services:

- The James Cook University Hospital (JCUH). Based in Middlesbrough, James Cook Hospital provides a 24-hour emergency department, 24-hour urgent treatment centre, regional trauma centre and a wide range of specialist services.
- Friarage Hospital (FHN). Based in Northallerton, the Friarage Hospital has a 24-hour urgent treatment centre and is the Trust's main site for planned orthopaedic surgery.
- Redcar Primary Care Hospital. Based in Redcar, a variety of services are provided including an urgent treatment centre and Zetland Ward, which provides care for adult patients with a wide range of conditions, particularly those requiring rehabilitation and palliative care.
- East Cleveland Primary Care Hospital. Services provided by East Cleveland Hospital in Brotton include a wide range of outpatient clinics and Tocketts Ward, providing rehabilitation and palliative care closer to home, and cares for adult patients with a wide range of conditions.
- The Friary Community Hospital. Based in Richmond, the Friary Hospital provides a range of outpatient services, and adult inpatient care on the nurse-led Victoria Ward including palliative care, rehabilitation following surgery, monitoring of new drug therapy or convalescence to enable discharge plans to be completed.

Community services:

South Tees Hospitals NHS Foundation Trust Community Health Services are responsible for providing physical healthcare for people in their own homes or as close to home as possible. Community health services aim to support people to live independently and to avoid hospital admission as well as facilitating discharge from hospital to support recovery at home. Community health services allow patients to receive care in their own homes, including care homes but also in community hospitals, intermediate care facilities and clinics. Services include:

- District Nursing provides care such as complex wound management, intravenous antibiotics, vaccinations, diabetes management, palliative and end of life care, urinary catheter care, medications administration, long term conditions management, pressure ulcer management and prevention etc.
- Urgent Community Response provides a 2-hour crisis response to patients at risk of hospital admission.
- Hospital at Home includes Frailty Virtual Ward and Respiratory Virtual Ward and provides complex hospital level care to patients who would otherwise be in hospital, and to those at risk of poor health outcomes.
- Tees Valley Community Diagnostic Centre.
- Specialist Palliative Care.
- Specialist Stoma Therapy
- Chronic Heart Disease Management.
- Community Diabetes Care.
- Community Occupational Therapy.
- Community Physiotherapy, including MSK, Pulmonary Rehabilitation.
- Community Podiatry and Orthotics.
- Community Dietitian Service.
- Community Speech and Language Therapy.
- Community Continence Services.
- Community Falls Prevention Service.
- Community Rehabilitation, including Stroke Rehabilitation and General Rehabilitation.
- Stroke Early Supportive Discharge Services
- Community Paediatric Services.

- Wheelchair Services.
- Intermediate Care Services.
- Home First Service, providing therapy support and personal care for patients awaiting social care packages.
- Home Ventilation Services.
- Lymphoedema Services.
- Tissue Viability Services.
- Maternity Services, such as prenatal and perinatal care services.
- Cardiac Rehabilitation.
- Haematology Services.

Many of these services involve partnership working across health and social care teams, made up of a wide variety of professionals, such as district nurses, allied health professionals, specialist nurses, mental health nurses, pharmacists, and GPs.

2. Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

a. Review of progress with the quality priorities defined for improvement in 2024/25

The Quality Account provides an opportunity for the Trust to reflect on its achievements over the last 12 months. This includes a look back at the progress made against the Group Quality Priorities for 2024/25 that were defined in the 2023/24 Quality Account and are summarised in table 1 below.

The Trust agreed the following Group Quality Priorities for 2024/25 following a consultation process with clinical colleagues at both South Tees Hospitals NHS Foundation Trusts and North Tees and Hartlepool NHS Foundation Trust and the Council of Governors.

Group Quality Priorities 2024/25		
Patient Safety	**Clinical Effectiveness**	**Patient Experience**
We will continue to embed our Patient Safety Incident Response Plans, developing a positive, just and restorative safety culture, which supports openness, fairness and accountability. Ensuring that colleagues with the right skills and competencies are involved in the relevant aspects of the patient safety response.	We will ensure continuous learning and improved patient outcomes following implementation of best clinical practice, using data from clinical audits of compliance against evidence-based standards.	We will develop and implement a Group Mental Health Strategy to improve care and share learning for our patients who are experiencing difficulties with their mental ill health.
We will continue to optimise the Trust's ability to respond to and learn from incidents, safeguarding concerns, claims and inquests to improve outcomes for our patients whilst embedding PSIRF.	We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.	We will proactively seek patient feedback and ensure there is continuous improvement in care and treatment because of the feedback we receive.
We will improve medication safety and continue to optimise the benefits of ePMA and evaluate the impact on learning from medication incidents	We will develop and implement shared decision making and goals of care.	We will respond in a timely way to complaints, supporting patients and families through difficult circumstances and implement quality improvements as a result of the learning.

Table 1 – Group Quality Priorities 2025/26

Our drive for improvement, agreed actions, aims and progress at the end of 2024/25 for each quality priority are detailed below.

Patient safety quality priorities

1. Positive, just and restorative safety culture.

The organisation needs a culture where staff, patients and their families, feel empowered and psychologically safe to raise and discuss safety issues and where everyone involved will be treated fairly and restoratively. A positive safety culture will support effective learning and improvement, in order to prevent, where possible, future patient harm. Colleagues involved in responses to patient safety events need to be equipped with the knowledge and skills to support compliance with the principles of the Patient Safety Incident Response Framework (PSIRF).

Aims

We planned to;

- Scrutinise the results within the patient safety and culture questions in the 2023 NHS Staff survey and triangulate against other relevant data; to identify areas for focused support and improvement.
- Optimise safety event management approaches across the organisation; to obtain the maximum learning from the analysis of these to link in with PSIRF plans.
- Undertake a training needs analysis against PSIRF standards to assess overall compliance and identify any gaps.
- Review current actions being undertaken in relation to culture that will impact and support the safety culture priority.

We aimed to achieve the following measures of success;

- An improvement in NHS Staff survey results.
- Increased reporting of events, timely review and actioning of events; to provide demonstrable learning and improvement.
- Increased numbers of staff who have completed the relevant training as identified in the training needs analysis. e.g.
    - PSIRF
    - National Patient Safety Curriculum levels
    - Family Liaison Officer (FLO)

Progress and achievements

- We have continued to provide further cohorts of FLO training and there are currently 93 trained Family Liaison Officers across the organisation.
- A patient safety workshop was facilitated by a Patient Safety Partner, Patient Safety Specialist from North Tees & Hartlepool NHS Foundation Trust and Patient Safety Lead from South Tees Hospitals NHS Foundation Trust in December 2024. The 4-hour workshop used a case study based on a recent Health Services Safety Investigations Body (HSSIB) investigation to develop participants knowledge and skills when undertaking patient safety reviews. This was based on teaching from the NHSE Patient Safety Syllabus Level 3 and 4 training. The session included the application of human factors models, such as Systems Engineering Initiative for Patient Safety (SEIPS) and Systems-Based Technique for Accident Analysis (Accimap), duty of candour, and the hierarchy of controls in developing meaningful action plans. Over 60 colleagues attended the session, which received positive feedback, and there are plans to deliver further sessions, as part of a regular education programme in 2025.
- The NHSE Patient Safety Syllabus (Levels 1a and 1b) was introduced as part of mandatory training requirements in September 2024. Level 1a is the starting point for all NHS staff, and current completion rate is 66.35%. Level 1b is the essentials of patient safety for boards and senior leadership teams, the current completion rate is 26.14% and an area for focus into the next year.
- A training needs analysis is underway to inform the roll out of Level 2 of the Patient Safety Syllabus.
- Two Patient Safety Specialists have now completed Level 3 and Level 4 NHSE Patient Safety Syllabus training.

- Duty of Candour letter templates have been updated collaboratively with patient experience colleagues, to ensure plain language is used and the documents meet the national reading age of 9-11 years old. Patient Experience checked the readability of the letter against the Flesch-Kincaid grade. The layout was changed to meet the NHS standards.
- The NHS staff survey results for 2024 Q20a "I would feel secure in raising concerns about unsafe clinical practice" in 23/24 was 71% which has reduced to 70%. Although this is disappointing, this remains equivalent to the national average for this metric and high levels of incident reporting have been maintained.
- In 2023/2024, a total of 29,278 incidents were recorded on the Datix system. In 2024/2025 30,459 incidents were recorded.
- March 2025 showed the lowest number of open incidents in the organisation.

Summary and future plans

- High levels of incident reporting have been maintained, and the ongoing focus remains the timely review and closure of incidents, and providing meaningful feedback to those who report incidents.
- We will continue to deploy Family Liaison Officers to support patients and their families and/or carers affected by adverse events.
- Collaborative work has been undertaken regionally to develop a feedback tool for the Family Liaison Officer Service, supported by one of our Patient Safety Partners and Health Innovation North East and North Cumbria. Feedback from this will be available within future reports.
- We will focus on increasing compliance with Patient Safety Syllabus Level 1a and 1b training, and undertake a training needs analysis to inform the roll out of Level 2 of the patient safety syllabus.

2. Learning from incidents, safeguarding concerns, claims and inquests.

This quality priority set out our aim to continue to optimise the organisations' ability to respond to and learn from incidents, safeguarding concerns, claims and inquests to improve outcomes for our patients whilst embedding the PSIRF. The NHS Patient Safety Strategy 2019 sets out that 'an organisation that identifies, contains and recovers from errors as quickly as possible will be alert to the possibilities of learning and continuous improvement'. Through the implementation of the PSIRF we aimed to optimise our ability to triangulate information from a range of sources, maximising opportunities to learn and improve.

Aims

We planned to;

- Analyse the information available within our reporting system to triangulate and identify potential areas of improvement.
- Improve the sharing of learning across the University Hospitals Tees Group using innovative and creative approaches to maximise improvement opportunities.
- Analyse NHS Staff Survey findings in relation to patient safety elements.
- Ensure compassionate engagement is embedded within the organisations processes so that all individuals involved have their needs met.
- Provide consistent feedback to individuals who have taken the time to report events or concerns.

We aimed to achieve the following measures of success;

- Evaluation / outcomes of the Family Liaison Service.
- Demonstrate the impact of quality improvement projects identified through triangulation of data.
- Improvement in NHS Staff survey results in relation to patient safety elements.
- Sound evidence of triangulated learning within corporate patient safety reports.

Progress and achievements

We have established a weekly Patient Safety and Quality Panel. The meeting is chaired by the Medical Director and Director of Nursing. The aim is to increase organisation-wide engagement with the patient and safety agenda, and to enable timely review and clear lines of accountability and escalation for actions to be taken. This meeting allows for a Trust-wide overview of patient safety, patient experience, mortality

review, Infection, Prevention & Control (IPC), Care Quality Commission compliance with fundamental standards, legal services and safeguarding and the respective teams update from the previous week. The second half of the meeting focusses on individual Collaboratives, who present an overview of the key safety and quality themes and improvement work undertaken in the previous two months. Learning points are shared on a weekly basis with the Communication Team for inclusion in the weekly Safety and Quality Bulletin.

There has been focused work on effective incident management, particularly legacy incidents, which has resulted in a demonstrable reduction in the number of open incidents. However, we must now focus on being able to demonstrate improvements in practice and outcomes as a result of incident reporting, including feedback to reporters.

There is continued evidence of improved triangulation with the Medical Examiner service and mortality review team, leading to improvements in relation to IPC, nutrition and hydration of vulnerable patients and documentation within digital solutions.

Our Patient Safety team lead a 'current cases' meeting held on a fortnightly basis, to triangulate information and learning from patient safety, patient experience, learning from deaths, claims, inquests and safeguarding data, to enable escalation of emerging themes and shared learning.

Our Patient Safety Learning Response Panel is held on a weekly basis and attended by a wide range of professionals from across the Trust. New and emerging incidents and risks are discussed at the panel and a proportionate learning response is agreed in line with the Patient Safety Incident Response Plan (PSIRP).

Collaborative work has been undertaken regionally to develop a feedback tool for the Family Liaison Officer service, supported by one of the organisations Patient Safety Partners' and Health Innovation North East and North Cumbria.

Summary and future plans

- Feedback from the Family Liaison Officer evaluation tool will be available.
- Triangulated learning will become more embedded as the corporate patient safety reports develop.
- The 2024 NHS staff survey results for Q20b "I am confident my organisation would address my concerns" has shown a reduction from 54% to 53%, which is disappointing and reinforces the need for the organisation to demonstrate learning after an incident is reported. This will be an area for continued focus into 2025/2026, including meaningful feedback to reporters.

3. Medication safety and optimising the benefits of ePMA.

There are an estimated 237 million medication errors per year in the NHS in England, with 66 million of these potentially being clinically significant. These errors are estimated to cost the NHS at least £98 million and contribute to the loss of more than 1700 lives annually. NHS England maintains that increased uptake of electronic prescribing and medicines administration (ePMA) systems by trusts would correspond with a 30% reduction in medication errors compared to traditional methods, and a similar reduction in patient adverse drug events.

Image; members of the team involved in the digital role out of Cath Labs

In 2024/25 we have continued the optimisation of the ePMA system to improve patient safety. Having successfully rolled out to the majority of inpatient areas, we are now focused and committed to introducing ePMA to more specialist areas. This has included high dependency units. Our commitment to becoming fully digitilised has been demonstrated by the electronic team who were nominated for a Health and Safety Journal Improvement award in 2024 for their digitilisation of Cath Labs, the first in the country to achieve this.

Collaborative work has begun with North Tees and Hartlepool NHS Foundation Trust bringing together our medicines safety experience with ePMA and sharing how we respond to national and local patient safety data to improve our local safety.

Aims

We planned to:
- Agree key performance indicators for patient safety standards across our organisation and North Tees and Hartlepool.
- Share ePMA experience for ideas of improvement.
- Promote the use of ePMA for ideas of quality improvement.
- Monitor medication incidents and review areas of improvement and implement the relevant changes.

We aimed to achieve the following measures of success;
- Agree a standard set of ePMA KPIs and clinical dashboards for patient safety that is monitored through our patient safety groups for trends and areas of improvement.
- Number of quality improvement projects and research undertaken utilising ePMA to improve patient safety.
- A system review and recommendations for improvement and implementation of these.
- Improvement in antimicrobial audit compliance.
- Quality Improvement Programme schemes.
- Number of changes implemented post medication incident review.

Progress and achievements

We have been actively monitoring medication errors through our monthly Safer Medication Practice Group meetings. In comparison to 2023/24 we have seen a reduction in the maximum level of medication related harm incidents with 0 severe harm incidents reported (1 in 2023/24) and an increase of 400 more no harm incidents reported. This demonstrates that the organisation has a strong culture of reporting providing opportunity to learn from near misses.

The Electronic Prescribing Governance Group also meets monthly to review incidents that might require system fixes, allowing for quick actions to prevent future issues. Recent system improvements include switch off of non-formulary medications to prevent mis-selection and missed doses, and adjusting prescribing rules to reduce errors, such as preventing incorrect dose calculations.

Collaboration with North Tees Hospital has been effective, sharing key data on medication-related harm, never events, and improvements to the ePMA every quarter.

Our electronic prescribing dashboards have been upgraded to allow real-time tracking of prescribing. One example where this has been used is in a project to reduce the use of lidocaine patches which have been proven to be inefficient and not cost effective. By utilising reporting data, setting up alerts and instructions in the ePMA system, along with clinical education, prescribing has been reduced by one-third.

New dashboards for insulin and diabetic medications have also been launched, which allows clinical staff to monitor patients in real-time and ensures timely reviews.

In October 2024, the antimicrobial team hosted the Big Switch Antimicrobial Stewardship (AMS) study day, which was a success with full attendance. This event, along with ongoing AMS training across all departments and improvements to ePMA prescribing, has contributed to a steady decline in the use of broad-spectrum antibiotics.

Image; AMS Study Day

In February 2025, the Antimicrobial Prescribing Guideline was launched as a group guideline for colleagues across both our organisation and North Tees and Hartlepool NHS Foundation Trust. This has been supported by the utilisation and uptake of the Eolas medical application (App), which now has 900 users across both organisations. This App is now being populated with as many prescribing guidelines as possible to ensure our clinicians have quick access to resources for safe prescribing.

The parkinsons medication dashboard was utilised in its first improvement project to assess for an improvement in 'on-time' medication administration, which was demonstrated to increase by 6% in January and February 2025 in comparison to the previous year after targeted education and review of stock availability.

We continue to collect pharmacy metric data from the electronic systems; this includes medication reconciliation which is currently being completed on 90% of all patients admitted to our hospital.

Missed doses continue to be monitored to identify areas for improvements. The missed doses dashboard highlighted some standard prescribing practices that did not reflect the patients' needs, such as in maternity and we have been able to make amendments to reduce these. Additionally, we have utilised our ePMA to report on the timeliness of administration of crucial pain medication to our post-operative patients.

Summary and future plans

- We are committed to continuing our collaboration across the Group to share knowledge and experience of safe medication practices utilising digital tools.
- We are working to align our key performance indicators for safe medication practices across the Group.
- We will continue to progress with the digitalisation of critical care areas.
- We will continue to develop reporting functionality within the systems to identify, monitor and analyse prescribing trends and patterns.

Clinical effectiveness quality priorities

1. Learning and improving patient outcomes from clinical practice and clinical audits.

In order to provide patients with the best possible clinical outcomes, this quality priority aimed to ensure processes that support continuous learning were developed and embedded across the organisation. These processes would be supported by data sources and InPhase for triangulation and to promote best practice.

Aims

We planned to;

- Co-ordinate evidence collation against the CQC Single Assessment Framework to support continuous learning and improved patient outcomes.
- Monitor progress with implementation of, and compliance with, relevant NICE Guidance.
- Undertake a partnership approach to support locally agreed joint audits between the Group (focusing on those where the patient pathway intersects both Trusts).

- Monitor development and progress with action plans from National Clinical Audits and high priority local audits.

We aimed to achieve the following measures of success:

- A contemporaneous database of evidence across all major clinical areas, demonstrating a CQC level of good or outstanding, or where these targets are not met there is evidence of improvement planned or underway.
- Implementation of all relevant NICE Guidance (or risk-assessed alternative) with priority guidance included within locally approved Clinical Audit Forward Programmes and Plans.
- Successful Group reporting of joint audits of the wider patient pathway, with a transparent approach to sharing audit findings to improve patient outcomes.
- Establish and deliver reporting processes for monitoring action plans from National Clinical Audits and high priority local audits.

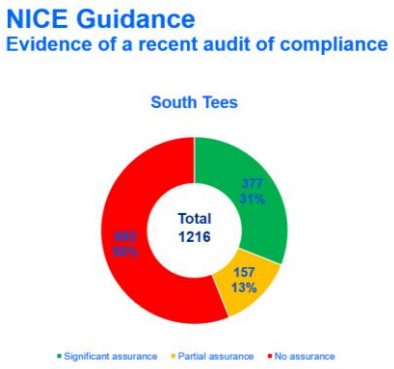
Progress and achievements

The CQC App in InPhase is now entering the user acceptance testing phase with the developers. The CQC App has been showcased at the CQC Compliance Group and was well received, acknowledging the benefits that the App will bring.

Our InPhase Consultant is working with the InPhase Development Team to develop the first iteration of the triangulation dashboards. Once this is complete we will then move to the user acceptance testing phase. Governance and oversight remains in place at site level including prioritisation and monitoring of national audits, which are at risk of not being delivered.

An options paper was presented to the Group Executives at the end of January, which approved the moving to InPhase at a group level to include all of the apps including CQC App, which will give consistency across the group and both sites. Executive leads will be identified at each site for oversight.

NICE guidance remains top priority for local clinical audit support. Clinical areas are identifying their priority audits for the upcoming Clinical Audit Forward Plan 2025/26, for presentation and approval at their respective site Clinical Effectiveness Steering Groups. Any unaudited NICE guidance will form part of each clinical service's local audit priorities.



Work has been undertaken to clarify which national clinical audits the Trust is participating in, including those which are at risk of reduced or non-submission.

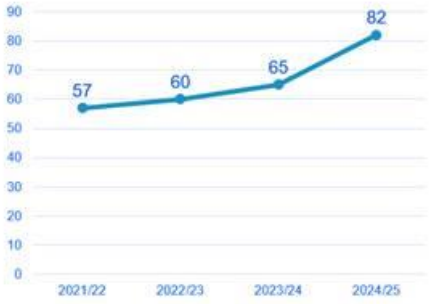
National Clinical Audit
Exception reporting

	South Tees
National clinical audits 2024/25	82
High risk (non-submission)	10
Medium risk (reduced submission)	10

National Clinical Audit
Workload by organisation over the past four years

Year	National audits eligible to participate in
2021/22	57
2022/23	60
2023/24	65
2024/25	82

44% increase in national audit demand over the period



The organisation currently shares a vascular referral pathway for patients who fit certain criteria in respect of lower leg wounds. North Tees and Hartlepool are a “spoke” service, currently referring patients fitting such criteria to our organisation, who provide the “hub” service as a regional tertiary vascular centre. Clinical guidance is being reviewed, in order to update and incorporate relevant NICE guidance, so that a pathway audit can be undertaken in partnership across the Group.

Development of the Triangulation App in InPhase will be reviewed as part of the wider group InPhase apps and rollout. Governance and oversight remain in place at site level including prioritisation and monitoring of national audits which are at risk of not being delivered.

Improvement plans from national clinical audits continue to be monitored via local clinical audit registration systems, while work on implementation of InPhase moves forward.

Summary and future plans

Priorities for 2025/26 will focus on:

- **NICE Guidance**
  - Implementation of all relevant NICE guidance (or risk-assessed alternative).
  - Evidence that NICE guidance is prioritised in local audits as part of the Clinical Audit Forward Plans.
- **GIRFT**
  - Evidence of clinical engagement in all locally relevant GIRFT reviews.
  - Development and implementation of local improvement plans, against GIRFT review recommendations.
- **National Clinical Audit**
  - Participation in mandatory national clinical audits.
  - Evidence of sharing local results of national clinical audits.
  - Development and implementation of local improvement plans, following publication of national clinical audit reports.
- **Systems support**

- Establishment of a common reporting framework for NICE guidance, Clinical Audit and GIRFT across the Group.

2. Mortality review processes and learning from deaths.

From the 9 September 2024, the Medical Examiner (ME) Services have scrutinised all inpatient deaths and a growing proportion of out-of-hospital deaths in their localities. South Tees Hospitals NHS Foundation Trust uses the same approach and mortality review questions (from the national Structured Judgment Review Plus (SJR Plus) tool, however they do not have the same recording system for recording reviews of deaths. Evidence of learning and change is difficult to assemble therefore we will support specialties to use InPhase to record specialty mortality review in the coming year.

Aims

We planned to;

- Move the Medical Examiners Service to statutory basis on 9 September 2024.
- Work towards standardising specialty mortality reviews.
- Evaluate whether specialty mortality reviews can be captured on InPhase, bringing this information alongside the SJR Plus model.
- Grow a robust Learning from Deaths team to ensure we meet the above priorities.
- Secure the most appropriate platform to record Structured Judgement Reviews.
- Change recording of Medical Examiner scrutiny to InPhase pending the introduction of the National Medical Examiner database.
- Appoint a Clinical Mortality Reviewer.
- Begin recording Specialty Mortality Reviews in InPhase
- Work with the wider Quality team to ensure that themes emerging from learning from deaths are triangulated against data from Patient Experience, Patient Safety and Clinical Effectiveness and that improvement work is undertaken where necessary to address the learning.
- Continue to ensure there are proportionate learning responses following the outcomes from mortality reviews in line with the Trust's Patient Safety Incident Response Plan (PSIRP).

We aimed to achieve the following measures of success:

- Medical Examiner referral for mortality review (number and % of deaths)
- Use of the Structured Judgement Review Plus model
- Mortality reviews completed, time to review from Medical Examiner/Patient Safety referral
- Accurate identification of deaths graded as potentially preventable. Ensuring follow up of these cases is timely and comprehensive
- Numbers of deaths considered under PSIRF by category of response.

Progress and achievements

The Mortality Surveillance team has grown and is made up of a central team of four consultants and a nurse with expertise across many specialties.

We work collaboratively with the Learning Disability team, to assist them with completing LeDeR (Learning from Lives and Deaths) reviews and offer a consultant level of grading for preventability of deaths. Historically LeDeR reviews took around two days to complete. We have now integrated them into our Structured Judgement Reviews on InPhase and following a consultant review, the team are able to utilise the review, adding in any additional Learning Disability specific information required for the LeDeR. These reviews can now be completed in around two hours. This new system is working well and is integrated into working practice with the backlog of their reviews significantly reduced.

The recording of Medical Examiner scrutiny in InPhase has continued pending the introduction of the National Medical Examiner database.

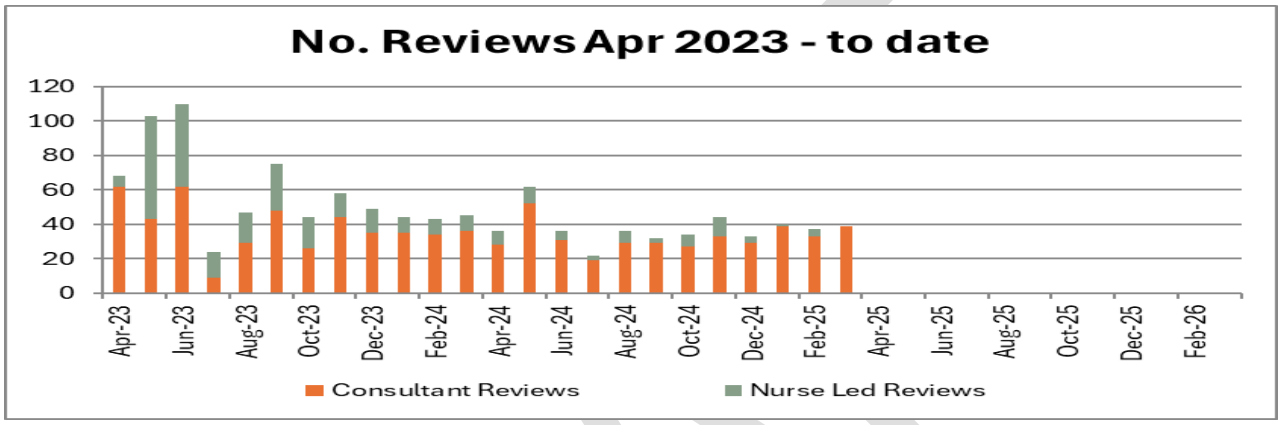
The recording of specialty mortality reviews on InPhase is progressing. This is now live and has been rolled out across 3 specialties; Haematology, Cardiology and Intensive Care. There are plans for

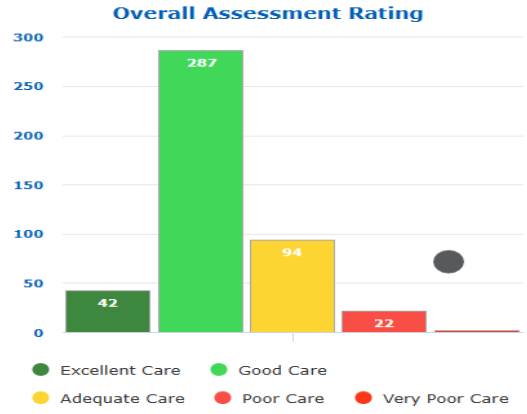
Gastroenterology and Endoscopy to begin recording reviews over the coming months. Work is progressing to continue with the rollout across the Trust with identification of mortality leads for each specialty being our next focus, working with the Trust Safe and Effective Care Leads for each collaborative to be able to achieve this.

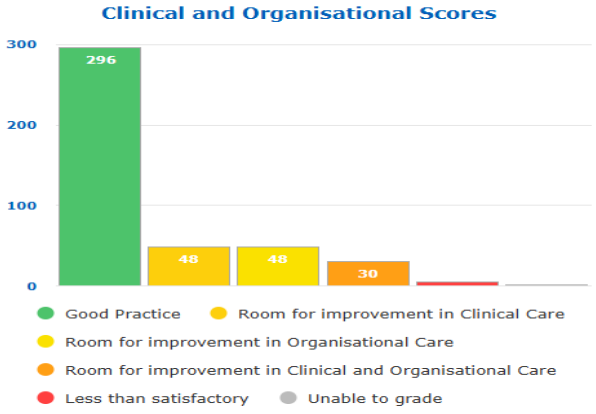
We are well integrated with the wider Quality team to ensure that themes emerging from learning from deaths are triangulated against data from Patient Experience, Patient Safety and Clinical Effectiveness. The Mortality Surveillance Team regularly attend Patient Safety meetings including Learning Response Panel, Current Cases and the newly established weekly Site Safety & Quality Panel.

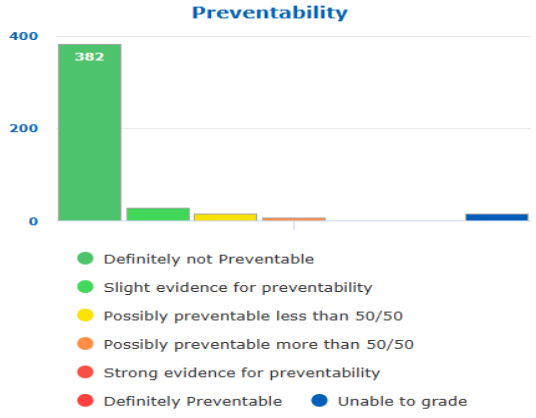
The outcomes from mortality reviews are shared and discussed on a weekly basis and cases are reviewed and discussed at the Learning Response Panel to ensure proportionate learning responses in line with the Trust's Patient Safety Incident Response Plan.

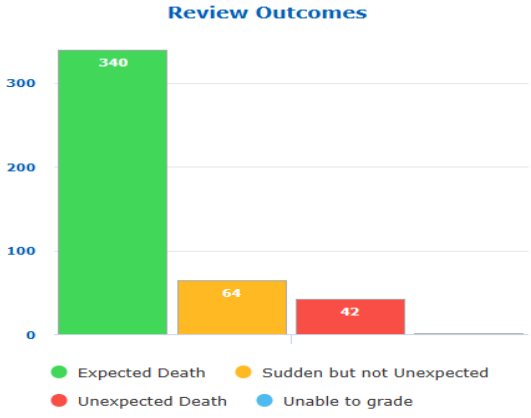
Since April 2024 we have completed 451 reviews, shown in the graphs below. Completion of the reviews on InPhase allows the team to access data, as evidenced in the graphs below.

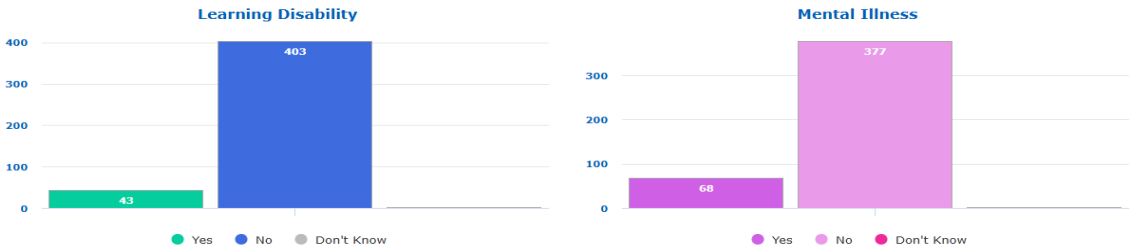


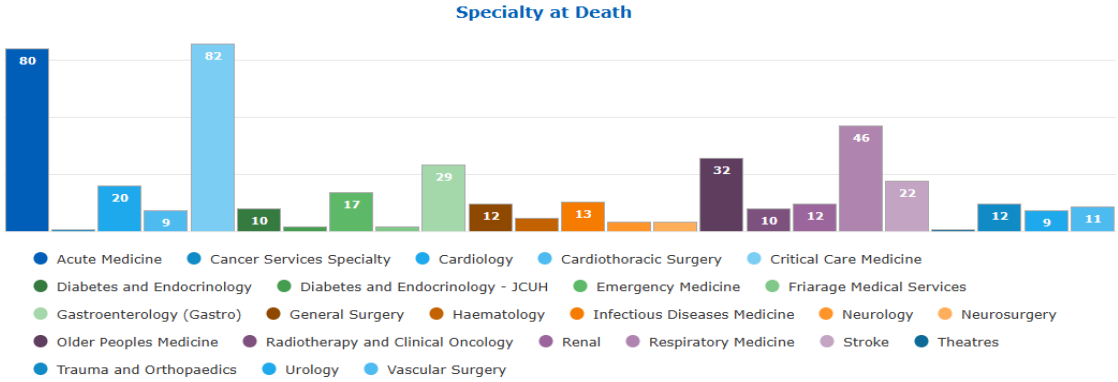






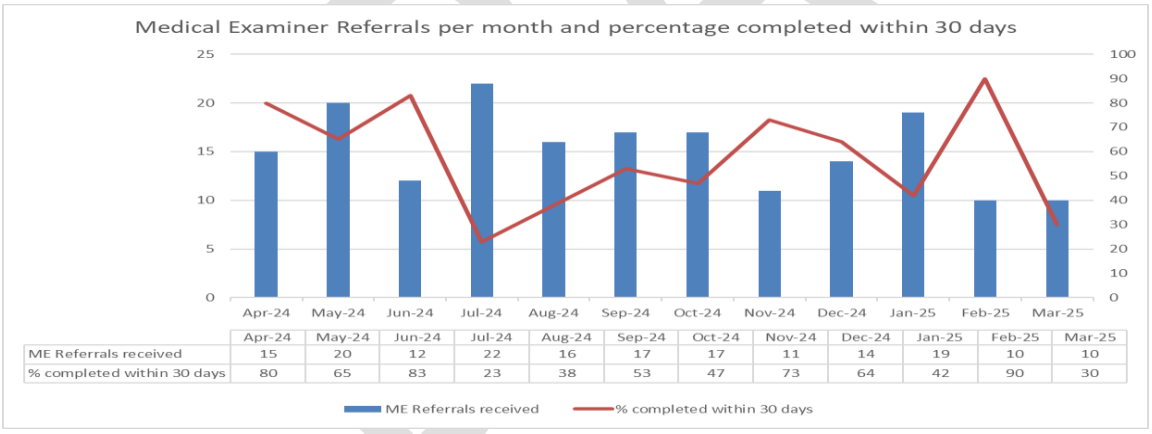






Key Performance Indicators (KPIs).

To ensure timely completion of reviews, it was agreed that cases referred by the Medical Examiner Team would be reviewed within 2 weeks for urgent cases and 4 weeks for less urgent cases. As of the end of March 2025, 23.5% of required cases were being reviewed within 2 weeks of death and 54.6% within 30 days as detailed in Figure 1 below.



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
ME Referrals received	15	20	12	22	16	17	17	11	14	19	10	10
% completed within 30 days	80	65	83	23	38	53	47	73	64	42	90	30

Figure 1 – Medical examiner referrals per month and % completed

The Mortality Surveillance team have completed review of all referrals prior to January 2025.

As well as the Medical Examiner referrals, the team has a target of reviewing 20% of all deaths for assurance purposes. This figure includes all Learning Disability deaths, all deaths in people aged 18-40, deaths in people with a serious mental health condition, all deaths during an elective admission and deaths where it was reported that harm occurred to the patient. A number of randomly selected cases are also reviewed for assurance. Recent guidance from the Royal College of Emergency Medicine indicates that any death where there has been an Emergency Department attendance within the past 14 days should be reviewed and the team are developing a process to ensure this is achieved.

Summary and plans for future work

- 20% assurance reviews to be completed within 6 months – currently working to 10 months.
- 80% of Medical Examiner reviews to be completed within 1 month - currently 55%.

- Draft a framework for the completion of Mortality & Morbidity reviews, clearly identifying Mortality & Morbidity Leads for each service.
- Begin recording Specialty Mortality Reviews in InPhase.
- Continue to work with the wider Quality team to ensure that themes emerging from learning from deaths are triangulated against data from Patient Experience, Patient Safety and Clinical Effectiveness and that improvement work is undertaken to address the themes.
- Continue to ensure there are proportionate learning responses following the outcomes from mortality reviews in line with the Trust's PSIRP.

3. Shared decision making and goals of care

People want to be more involved in decisions about their health and care. Shared decision-making ensures individuals are supported to participate in decision-making process as they wish. Shared decision-making helps people understand their care, treatment, and support options, including the risks, benefits, and consequences. It allows them to make informed choices based on high-quality, evidence-based information and personal preferences. Goals of care describe what a patient wants to achieve during treatment, considering their clinical situation. These goals, both medical and personal are set through the Shared decision-making process.

NICE guideline (NG197) Shared Decision-Making covers how to make shared decision-making part of everyday care in healthcare settings. It promotes ways for healthcare professionals and people using services to work together to make decisions about treatment and care. It includes recommendations on training, communicating risks, benefits, and consequences, and how to embed shared decision making in organisational culture and practices.

We have a 2025/2026 Commissioning for Quality and Innovation (CQUIN) indicator focused on achieving high-quality shared decision-making conversations in specific specialised pathways to support recovery.

Aims

We planned to:

- Conduct a gap analysis against NICE guideline (NG197) recommendations and develop a Trust-wide improvement plan to embed shared decision-making into practice.
- Implement shared decision-making across the organisation ensuring accredited training, staff toolkits, recording system and patient decision aids are available for staff and patients.
- Engage clinical teams in developing procedure-specific consent forms, ensuring risks, benefits, and consequences are personalised and supported by high-quality decision aids. Ensure the digital consent solution supports universal personalised care.
- Develop E-Consent and ensure policies are reviewed and aligned.
- Pilot good-quality surgical risk assessment tools in Trauma and Orthopaedics to guide shared decision-making.
- Develop decision support tools within Oncology to support patients in making high value decision about the treatment pathways they wish to proceed.

Progress and achievements

The Digital Consent Project is progressing toward establishing a robust digital solution for informed consent and shared decision-making. A clinical engagement roadshow was held, where over 60 clinical and operational stakeholders reviewed potential suppliers. Four vendors, Bloomsbury Health, Concentric, Eido, and Magentas presented their solutions. A funding application has been submitted to the Hospitals Charity, and procurement plans are in place.

A service-level gap analysis was conducted in palliative chemotherapy, early-stage lung cancer, and renal disease pathways to assess alignment with NICE NG197. Patients attending these clinics completed a nine-item questionnaire assessing shared decision-making discussions with their doctor. A total of 51 responses were collected from each pathway during each audit period. Results showed

an average shared decision-making score of 89% in Q2 and 87% in Q4, exceeding the target of 65%. Findings highlighted areas for improvement, including:

- The need for standardised shared decision-making training.
- The need for patient decision support aids.
- Increased patient engagement.
- The need for recording shared decision-making conversations.

To address gaps, a Shared Decision-Making Improvement Plan has been developed and presented for Clinical Policy Group review. Additionally, an "Ask 3 Questions" poster has been finalised to encourage patient participation in decision-making.

Efforts to strengthen shared decision-making education and training are ongoing. A proposal from TPC Health is under review, and a shared decision-making e-learning module and staff toolkit are in development, led by accredited trainers.

Summary and future plans:

- Finalising and implementing the Shared Decision-Making Improvement Plan to standardise best practices.
- Launching the digital consent system, subject to securing funding.
- Review patient journeys across different pathways and identify decision points to examine provision of choices, decision aids and understandable information to support patients to make informed decisions.
- Standardise shared decision-making training for staff across the Trust.

Moving forward, the focus is on fully embedding shared decision-making into clinical interactions. This will ensure:

- Patients are empowered to make informed decisions.
- Staff are supported with the right tools and training.
- Decisions reflect both clinical evidence and individual preferences.

Patient experience quality priorities

1. Patient feedback and continuous improvement in care and treatment.

The work was focused on providing equitable opportunities for patients, carers and families to proactively provide feedback on our services. This would enable us to ensure our services meet the needs of the local population.

Aims

We planned to:

- Form a Group Patient and Carer's Involvement Group.
- Ensure patient representation at all key meetings across the organisation.
- Share areas of good practice across the organisation, develop a 'Good Practice' report.
- Ensure information (verbal/written) about health conditions and treatment plans is provided in a format the patient and carer understand.

We aimed to achieve the following measures of success:

- Improve the response rate to the Friends and Family Test (FFT) survey.
- Increased engagement with marginalised communities.
- Distribution of a 'Good Practice' report on a quarterly basis.

Progress and achievements

There is a pilot in progress for the FFT question, which is being sent via text message to all patients who have been discharged or attended an outpatient appointment. It is expected that reduction in the length of the survey will improve the response rate.

Key meetings are being reviewed to identify where representation of people with experience of care is important/essential within the organisation. Work is ongoing to ensure we have people with experience of care in our patient involvement bank. People from the involvement bank have been involved in projects and ongoing work within the organisation.

Work has commenced with the North Tees Lived Experience Lead and South Tees Patient Involvement Facilitator to form a Tees Patient and Carer Involvement Group. The team looking after involvement within both organisations have met to explore how to move forward with the Tees Patient and Carer's Involvement Group. There are plans in place to consider the terms of reference for this group following review of terms of practice of patient groups from other NHS Trusts and good practice around patient and participatory groups.

A Carers Group met in November 2024 to develop a Carers Charter. The group which included, Hartlepool Carer, Carers Together, Stockton Carers Service and Dementia Hub and Healthwatch (Stockton, Hartlepool, North Yorkshire, South Tees and Redcar & Cleveland) agreed to the commitments in the Charter. It is planned that the Carers Group will continue to meet and a Terms of Reference will be developed for the meeting.

The Patent Information/Experience Teams have completed the How to Write Simply training. Work has commenced with the Regional Health Literacy team, to review all new patient information and those coming up for review, to ensure the reading age is appropriate to the population. The patient information relating to physiotherapy will be the first speciality to undergo the review.

Links have been made with a number of marginalised communities including:

- Recover Connections Lady's group (alcohol and addiction).
- George Dura (Communities Champion for diverse communities).
- Teesside Society for the Blind.
- Middlesbrough multi-Agency.
- Doorways – homeless.
- Neurodiverse peer group.
- Hart Gabels (LGBTQ+).
- Aapna services (people with ethnic minority background).

From visiting these groups, some of the members have joined our involvement bank and many more diverse groups in the area have been approached. We aim to reach out to more diverse groups in 2025 to broaden the involvement bank and reach out to more of our public.

Two members of the neurodiverse peer group were invited to be part of the neurodivergent training that is offered by the organisation. They were involved with sharing their lived experience, but they also provided feedback to the course leader/trainer about the content of the course. Listening to and involving those with lived experience will benefit staff who access the training course and hopefully improve the service we provide for patients who are neurodiverse.

We visited Teesside Society for the Blind. This was to make menus on inpatient wards more accessible for partially sighted and blind patients. The members of the group were very engaged in explaining what works and meets their needs. Braille menus would not be feasible as they are expensive, and most people cannot read braille. They shared other useful ideas that have and will be put in place for accessing menus.

It was identified by the Fairer Access Team that many children were missing appointments, therefore missing out on the treatment and care they need. Telephone consultations were made to parents/carers of children who had missed an appointment. This generated a lot of useful feedback which can be used

to improve our hospital services and reduce the number of children not brought to appointments. It will also support children who may be vulnerable to missing appointments.

The Help for Heroes Nurse has been recruited and has begun working with members of the Armed Force and Veterans, in our care and sign posting them to support services where required.

Summary and plans for ongoing work

There has been some good progress made which will continue into 2025/26. We will continue with our plans to form a Group Patient and Carer's Involvement Bank and endeavour to increase the membership. Engagement with our local communities will continue to ensure we continue to gain insight into people's experience.

2. Responding in a timely way to complaints & implementing quality improvements.

The organisation must ensure we provide responses to complaints timely ensuring we meet the timeframes agreed with the patient, carer and families, ensuring compliance with NHS Complaints Standards. We will strive to support the patient, carer and families during complex and distressing complaint investigations, utilising Family Liaison Officers (FLO) and ensure continuous improvement to services from complaints.

Aims

We planned to:

- Monitor the agreed timeframe for responses for all complaints.
- To provide support to the patient, carer and families during complex and distressing complaint investigations, utilising FLOs.
- Signpost to the Independent Complaint Advocacy Services.
- Produce monthly, quarterly and annual reports.

We aimed to achieve the following measures of success:

- Reduction in complaint repeated subjects.
- Monitoring of complaint extensions.
- Increase the allocation of FLOs to support complainants.
- 75 % of founded and/or partially founded complaints will have evidence of key learning identified and how this have been shared within collaboratives / care groups.

Progress and achievements

We are continuing to monitor on a weekly basis, the complaints which are open over 5 months and report them to the Senior Leadership Team for awareness and action. The number of extensions to the complaint timeframe continues to be monitored through the monthly Group Patient Experience Report.

Our Patient Experience Team monitor complaints approaching timeframe for completion to ensure extensions are completed where required and communication with the complainant is maintained.

The involvement of the FLO support is identified in conjunction with the Patient Experience and Corporate Patient Safety Teams, for serious or complex complaints. The FLO enables the patient, carer and families voice to be heard, understood and valued throughout the process.

We have continued to routinely signpost our patients who raise concerns to the Independent Complaint Advocacy Services. This service offers patients/carers and their families support to write letters and attend complaint meetings. Offering valuable support to navigate the complaint process and understand the outcome of a complaint.

Summary and plans for ongoing work

Moving into the coming year, work is planned to continue with the Carer organisations and Healthwatch, agreeing Terms of Reference for the meeting and inviting carers to be involved in the meeting. We will continue to provide support to the patient, carer and families during complex and distressing complaint investigations, utilising FLOs and ensure all complainants are signposted to the Independent Complaint Advocacy Services.

3. Development and implementation of a Group Mental Health Strategy.

Physical and mental health care have traditionally been delivered separately. While investment and improvements in mental health services is welcome, physical, and mental health services will only truly be equal when we stop viewing physical and mental health as distinct from one another. Many patients across the Trust have mental health needs which need addressing, alongside their physical health needs if we are to achieve high quality care and good clinical outcomes. The organisation provides a number of services for people who are particularly vulnerable or present an elevated risk.

Aims

We planned to;

- Review both Trusts Mental Health Strategies and identify similarities and differences.
- Identify 3 priority areas to work on collectively at Group level.
- Develop a Group Mental Health dashboard.
- Establish a Group Mental Health Strategic Group, which brings together expertise from both sites.
- Identify mental health training opportunities, specific to professional groups and services.
- Clarify the mental health risk assessment tools used and compliance levels.

We aimed to achieve the following measures of success;

- Gap analysis from review of both Mental Health Strategies.
- Agree top 3 priorities.
- Implementation and visibility of a Mental Health Dashboard.
- Group level Mental Health meeting to be established, with clear terms of reference and a cycle of business.
- Training plan, with types and numbers of staff trained in each quarter for each site.
- Compliance levels with mental health risk assessment tools within identified departments.

Progress and achievements

A Mental Health Strategic Group has recently been established with agreed terms of reference and membership including nursing, medical and Allied Health Professional (including psychology) colleagues, communication/public relation colleagues as well as representation from North Tees NHS Foundation Trust and our partner mental health trust covering Psychiatry Liaison. This ensures the Group has a clear outline of purpose.

Three priorities were initially agreed as follows;

<u>Suicide Prevention</u>
There is a strong commitment to reducing national suicide rates. Colleagues have worked collaboratively with the Suicide Prevention Lead across the health and care system to mirror the national, regional and local plan around suicide prevention.

<u>Right Care Right Person – Phase 1 (concerns for welfare and patients who walk out of health care facilities)</u>
A new way of working to support people in mental health crisis. This went live across Teesside on 18 September 2024. At the centre of Right Care, Right Person is a threshold to assist the police in deciding when it is appropriate for them to respond. The threshold for a police response to a mental health-related incident is:

- To investigate a crime that has occurred or is occurring.

- Or to protect people, when there is a real and immediate risk to life, or of a person being subject to or at risk of serious harm.

For each incident, the most appropriate service to respond will be identified. The police will always attend incidents where the threshold is met as above. Plans of what to do when a patient absconds from hospital have been shared with clinical colleagues and on call teams to ensure the most appropriate team is called to support. Right Care, Right Person is well established within our practice and is now business as usual.

Maternity Mental Health

South Tees Enhanced Psychological Support (STEPS) has been established within maternity services to offer psychological support in pregnancy. The team consist of a mental health midwife, a clinical psychologist, and an obstetric consultant supporting women/birthing people with their mental health during and after pregnancy. STEPS in maternity is a trial service funded by Middlesbrough Family Hubs to support the birthing people who live within Middlesbrough Council boundary.

Further priority areas

Following discussion at the Group Mental Health Strategic meeting, a total of 5 priority areas of focus have been agreed and will be progressed into the coming year;

- Maternal Mental Health.
- Suicide Prevention.
- NCEPOD Mental Health in Young People and Adults.
- Restraint and aligning the site Restraint Policy.
- Trauma informed care.

The organisation has completed further streams of work, including the development of a mental health communications plan and intranet site. This is available to all Trust staff and provides a wealth of information in one place relating to Mental Health. The Trust has implemented the Mental Health dashboard which provides data relating to Dementia, Delirium, MCA/DoLS, Eating Disorders and Deliberate Self-Harm. The dashboard will also be used as part of the health inequalities workstream.

A gap analysis has been completed by the Trust Education Lead to identify Mental Health training opportunities, specific to professional groups. The team looked at topics which staff and leaders would want for their staff, and the relevance of this to their areas. The Education Lead and Psychology Department agreed to pilot some of these priority training areas and have begun to roll out in 4 core areas across the Trust.

Summary and future plans

There has been good progress with the initial work in establishing a Group Mental Health Strategic Group.

The key next steps are to;

- Review Mental Health Strategies to align strategies and develop a Group Mental Health Strategy.
- Focus on the 5 priority areas and formulate a Mental Health Work Plan to ensure equity of offer across the Group.
- Benchmark Maternal Mental Health services and develop a Group plan.
- Review and develop a Suicide Prevention Plan.
- Benchmark NCEPOD Mental Health in Young People and Adults and develop a Group plan.
- Review and develop a Group restraint policy.
- Develop a Group offer for education to staff on Trauma Informed Care.

b. Quality priorities defined for improvement in 2025/26.

The Trust has agreed the following Group Quality Priorities for 2025/26 following a consultation process with clinical colleagues at both North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trusts and the Council of Governors.

Patient Safety	Clinical Effectiveness	Patient Experience
Carried forward from 24/25 We will continue to optimise the Trust's ability to respond to and learn from incidents, safeguarding concerns, claims and inquests to improve outcomes for our patients and reduce the risk of reoccurrence.	**Carried forward from 24/25** We will ensure continuous learning and improved patient outcomes following implementation of best clinical practice, using data from clinical audits of compliance against evidence-based standards.	**Carried forward from 24/25** We will develop and implement a Group Mental Health Strategy to improve care and share learning for our patients who are experiencing difficulties with their mental ill health.
Carried forward from 24/25 We will improve medication safety and continue to optimise the benefits of ePMA and evaluate the impact on learning from medication incidents	**Carried forward from 24/25** We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.	**Carried forward from 24/25** We will proactively seek patient feedback and ensure there is continuous improvement in care and treatment because of the feedback we receive
New Quality Priority 25/26 We will reduce the risk of acquiring healthcare associated infections in line with NHS England standard contract objectives such as Clostridioides Difficile, Meticillin Resistant Staphylococcus Aureus, Gram-Negative Blood Stream Infections (ECOLI, Klebsiella, and Pseudomonas) alongside other infections to improve outcomes for our patients whilst embedding IPC practices.	**Carried forward from 24/25** We will develop and implement shared decision making and goals of care.	**Carried forward from 24/25** We will respond in a timely way to complaints, supporting patients and families through difficult circumstances and implement quality improvements as a result of the learning.

2.2 Statements of assurance from the Board

1. Relevant health services

During 2024/25, South Tees Hospitals NHS Foundation Trust provided and/or sub-contracted 92 relevant health services. South Tees Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 92 of these relevant health services. The income generated by the relevant health services reviewed in 2024/25 represents 92.8% of the total income generated from the provision of relevant health services by the South Tees Hospitals NHS Foundation Trust for 2024/25.

2. National clinical audits and national confidential enquiries

South Tees Hospitals NHS Foundation Trust is committed to undertaking effective clinical audit across our clinical services and recognises that this is a key element for providing high quality care. Clinical audit enhances patient care and safety, provides assurance of continuous quality improvement and developing and maintaining high quality patient-centred services.

The Trust has a well-structured clinical audit programme which is regularly reviewed to ensure it reflects the needs of our acute and community services.

During 2024/25, 70 national clinical audits and 4 national confidential enquiries covered relevant health services that South Tees Hospitals NHS Foundation Trust provides.

During 2024/25, South Tees Hospitals NHS Foundation Trust participated in 61/70 (87%) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the South Tees Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2024/25 are listed in Table 2, alongside the number of cases submitted to each audit or enquiry as a number or percentage of the number of registered cases required by the terms of that audit or enquiry.

Mandatory National Clinical Audits	Participation	% cases submitted
BAUS Penile Fracture Audit	Yes	100%
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Yes	100%
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes	100%
Breast and Cosmetic Implant Registry	Yes	100%
British Hernia Society Registry	No	
Case Mix Programme (CMP)	Yes	100%
Emergency Medicine QIP: Care of Older People	Yes	50%
Emergency Medicine QIP: Mental Health (Self-Harm)	Yes	100%
Emergency Medicine QIP: Time Critical Medications	Yes	100%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%

Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Yes	100%
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Core Audit	No	
National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	Yes	100%
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)	Yes	100%
National Audit of Cardiac Rehabilitation	No	
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (NAD)	Yes	100%
National Bariatric Surgery Registry	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Yes	100%
National Bowel Cancer Audit (NBOCA)	Yes	100%
National Kidney Cancer Audit (NKCA)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	100%
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
National Ovarian Cancer Audit (NOCA)	Yes	100%
National Pancreatic Cancer Audit (NPaCA)	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Adult Cardiac Surgery Audit (NACSA)	Yes	100%
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	100%

National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes	100%
UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	100%
Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Yes	100%
National Comparative Audit of Blood Transfusion: Audit of Blood Transfusion against NICE Quality Standard 138	Yes	100%
Bedside Transfusion Audit	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Joint Registry	Yes	100%
National Major Trauma Registry	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Obesity Audit	Yes	100%
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit	No	
National Ophthalmology Database (NOD): Cataract Audit	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review Tool	Yes	100%
National Respiratory Audit Programme (NRAP): COPD Secondary Care	Yes	100%
National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation	Yes	100%
National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	Yes	100%
National Respiratory Audit Programme (NRAP): Children and Young People's Asthma Secondary Care	Yes	100%
National Vascular Registry (NVR)	Yes	100%
Perioperative Quality Improvement Programme	Yes	100%
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS):	No	

Oncology & Reconstruction		
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	No	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	No	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-melanoma skin cancers	No	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	No	
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT) UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	Yes	100%

Table 2 - national clinical audits

National Confidential Enquiries (NCEPOD):

The Trust participated in all 4 national confidential enquiries (100%) that it was eligible to participate in, namely:

NCEPOD study	Participation	% cases submitted
ICU Rehabilitation	Yes	100%
Acute Limb Ischaemia	Yes	100%
Blood Sodium	Yes	100%
Emergency Paediatric Surgery	Yes	71.4%

The reports of 5 national clinical audits were reviewed by the provider in 2024/25 and South Tees Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Fracture Liaison Service Database
The 2024 annual report evidenced good correspondence from service and data used in regional meetings. Quarterly meetings took place with consultants and nurses and the local network. The Trust is looking into how to minimise its 'did not attend' (DNA) rate.

Audit shows we capture an excellent 96% of fractures for Middlesbrough and Redcar and Cleveland. Spinal identification is much better than peers and national averages, as the x-rays are flagged as "Fracture Liaison Service" if fracture is found on the scan. This can then be searched and uptake is much better. There is currently no comparative service for Hambleton and Richmondshire, however any fracture which occurs within that area is captured in the audit as James Cook University Hospital.

Key Performance Indicator #2 – non spine case ID is 42% compared to 21% nationally.
Key Performance Indicator #6 – falls risk assessment was 82% compared to 61% nationally.

National Diabetes Foot Care Audit
People with First Expert Assessment (FEA) within 0-13 days after referral is the best in the region at 68%. People Alive and Ulcer Free (AAUF) at 12 weeks after FEA is 63%, third highest in region among peers.

National Lung Cancer Audit (NLCA)
An excellent 98% data completeness was achieved for recording route to diagnosis. 99% of patients were seen by a Lung Cancer Nurse Specialist, and this was highest in the region. This has improved significantly from only 13.2% in 2020 (target is 90%). 91% of patients with Non-Small Cell Lung Cancer had curative treatment, and this was the highest in the region.

Myocardial Ischaemia National Audit Project (MINAP)
Data taken from the 2022/23 national report and online power BI dashboard indicates that James Cook University Hospital delivered the second most STEMI and NSTEMI cases in the region, 632 and 1458 over a 12-month period. 98% of patients are seen by a Cardiologist and 94% are admitted to a cardiac ward. 92% of patients undergo an angiogram during admission. 93% of patients have an echocardiogram during admission. 98% of all patients are discharged on all recommended medication.

National Comparative Audit of Bedside Transfusion Practice 2024
Fully compliant with all audit quality standards, therefore there were no improvements required.

3. Local audit

The reports of 3 local clinical audits were reviewed by the provider in 2024/25 and South Tees Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Pressure Ulcer Prevention Benchmark – Critical Care Medicine
The benchmarking process in North East and Yorkshire (NEY) Adult Critical Care Networks has been established for many years and the process is continually evolving to ensure relevant benchmarks are developed and units collaborate to determine and standardise best practice interventions and drive quality improvement locally, across a network and the wider region.

Audit results showed that all patients were assessed for pressure ulcer risk within 6 hours of admission. Results also demonstrated that all patients had evidence that BESTSHOT areas had been inspected as per risk assessment or at least every 4 hours. The inspection noted skin integrity/condition and any colour changes or discoloration.

Particular attention was focussed around medical devices. It was evident that medical devices such as endotracheal tube, nasogastric tube and indwelling catheters had been repositioned as per risk assessment or at least every 4 hours for every patient.

There was documented evidence that all patients had been repositioned as per risk assessment or at least 4 hourly unless clinically contraindicated. All of the patient's skin was clean and dry. Where this is not possible, appropriate measures had been taken to minimise/prevent moisture build-up e.g. barrier creams /absorbent dressings.

It was evident that all patients included in the 2nd cycle had their nutrition/hydration status recorded at the daily multidisciplinary team meeting; this was an improvement from 80% in the 1st cycle.

Flexible Fibre-Optic Bronchoscopy
The audit demonstrated a high level of adherence to safety and consent protocols for bronchoscopy procedures at James Cook University Hospital, with 90% of the reviewed medical records showing fully completed forms. A minor issue identified with the Local Safety Standards for Invasive Procedures (LocSSIP) form indicates a need for increased vigilance to ensure all sections (including patient identification stickers) are correctly completed.

Assessing Prescribing of Cladribine for Treating Relapsing–remitting Multiple Sclerosis for Compliance with NICE Technology Appraisal Guidance #616

Cladribine was prescribed in accordance with NICE recommendation 1.1 or 1.2 or, if not in accordance, documented acknowledgment of NICE recommendation or MDT discussion prior to prescribing for all patients included in the audit. A re-audit is planned in one year to gain assurance of continued compliance.

4. Clinical Research

The number of patients receiving relevant health services provided or subcontracted by South Tees NHS Foundation Trust in 2024/25 that were recruited during that period to participate in research approved by a research ethics committee was 7715 (across 168 studies and 33 clinical specialties). This is higher than our previous year (7345) despite 2023/24 being our highest recruitment at that time.

Our Tees Valley Research Alliance (TVRA) Strategy to be delivered across both partner trusts (North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust) in the University Hospitals Tees (UHT) Group is a patient focused strategy to deliver improved outcomes through two main streams; Growing Research and Supporting Research. Whilst our recruitment has increased, our focus this year has been on supporting the development of research skills for our staff and our own research workforce as outlined in the sections below.

Performance

Figure 2 Recruitment over time

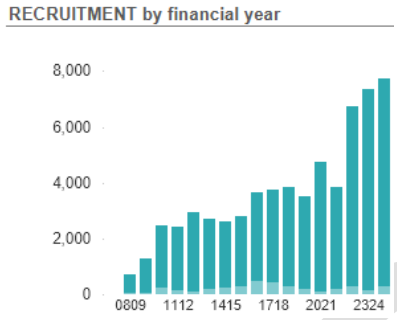
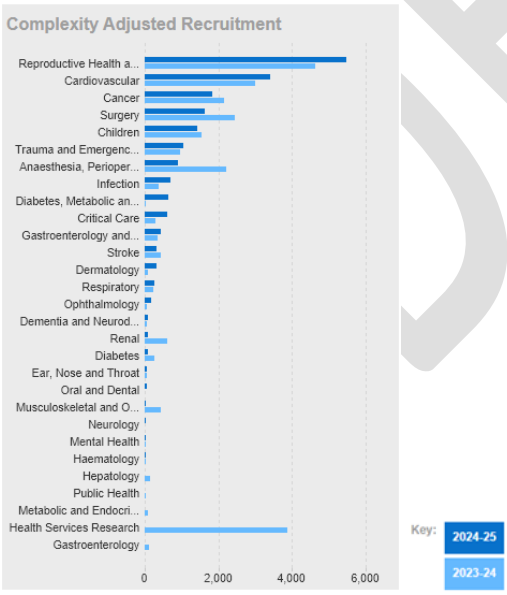


Figure 3 Recruitment by clinical specialty



There is detailed information about our clinical research and innovation work in Part 3 of this report.

5. CQC registration, reviews and investigations

South Tees Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. South Tees Hospitals NHS Foundation Trust has no conditions on registration.

The CQC has not taken enforcement action against South Tees Hospitals NHS Foundation Trust during 2024/25.

South Tees Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2024/25.

There were no announced or unannounced inspections by the CQC during 2024/25.

All reports are available at:
South Tees Hospitals NHS Foundation Trust - Overview - Care Quality Commission (cqc.org.uk)

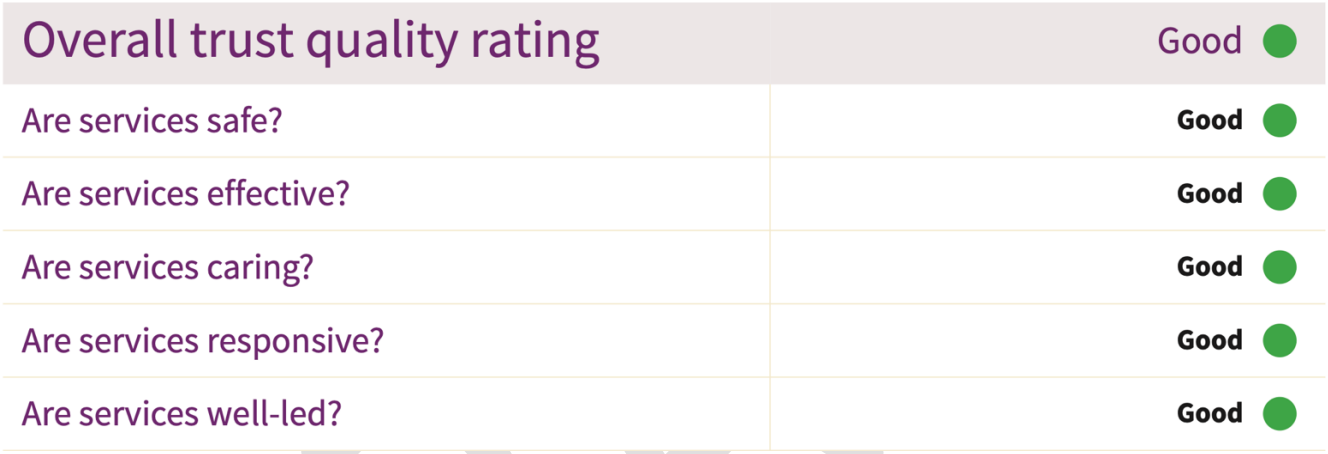


Figure 4: South Tees Hospitals NHS Foundation Trust overall CQC rating

6. Submission of records to the Secondary Uses Service

South Tees Hospitals NHS Foundation Trust submitted records during 2024/25 to the Secondary Uses Service for inclusion in the Data Quality Maturity Index (DQMI).

The percentage of records in the latest published data for November 2024 which included the patient's valid NHS number was:

- 99.9% for admitted patient care
- 100% for outpatient care, and
- 99.4% for emergency department care.

The percentage of records in the latest published data for November 2024 which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care, and
- 100% for emergency department care.

7. Information Governance grading

Information governance is assessed as part of the mandatory annual national process of submitting compliance with the NHS Data Security and Protection Toolkit (DSPT), which is currently based upon the National Data Guardian's 10 Data Security Standards. The content of the DSPT is aimed at providing

assurance around technical aspects of cyber security, information security and data protection compliance.

The 2024/25 DSPT submission was assessed against compliance with 34 assertions areas which are comprised of 108 mandatory evidence items. South Tees Hospitals NHS Foundation Trust DSPT status for 2023/24 was 'standards met'.

The 2023/24 DSPT review has been performed by PwC (PricewaterhouseCoopers LLP) as part of a national standardisation exercise, the findings of which are monitored and discussed at the Trust Audit and Risk Committee.

The 2024/25 DSPT submission is significantly different from previous years as it is now aligned to the Cyber Assessment framework (CAF). The Cyber Assessment Framework provides a systematic and comprehensive approach to assessing the extent to which cyber and information governance risks to essential functions are being managed.

At the time of writing, the status of the 2024/25 DSPT is that the Trust has provided information on all 39 outcomes. The Trust is gathering evidence to support the submission. The final submission date is 30 June 2025.

Data Security
The confidentiality and security of information regarding patients and staff is monitored and maintained through the implementation of our Governance Framework which encompasses the elements of law and policy from which applicable Information Governance (IG) standards are derived.

Personal information is increasingly held electronically within secure digital systems, it is inevitable that in complex NHS organisations, especially where there is a continued reliance upon manual paper records during a transitional phase to paperless or a paper light environment, that a level of data security incidents can occur.

Any incident involving loss or damage to personal date is comprehensively investigated by the Trust in line with its Data and Cyber Breach Management Policy and graded in line with the NHS Digital 'Guide to the Notification of Data Security and Protection Incidents'.

All incidents are graded using the NHS Digital breach assessment criteria and our risk assessment tool according to the significance of the breach and the likelihood of those serious consequences occurring. The incidents are also graded according to the impact on the individual or groups of individuals rather than on the Trust. Those incidents deemed to be of a high risk are reportable to the Information Commissioners Office (ICO) via the Data Security Protection Toolkit within 72 hours of being reported to the Trust.

We actively encourage staff to report any suspected data protection and cyber breaches irrespective of their severity in line with its reporting policy.

We have had no reportable incidents during the reporting period.

8. Clinical coding audit

South Tees Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2024/25 by the Audit Commission.

9. Data quality

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

- Data that is collected, recorded, and reported within the Trust complies with national data standards outlined in the NHS Data Dictionary and is clinically coded in compliance with data classifications set out by World Health Organisation and NHS Digital ICD10 and OPCS 4.9.

- To help and support the clinical collaboratives, the Business Intelligence Unit and the Data Quality Team develop analytical tools and reports to help identify operational and clinical efficiencies and to help improve their data quality.
- To maintain compliance with legal and regulatory requirements, the Trust routinely monitors the completeness and quality of data. Monitoring reports and audits are used to improve processes, training documentation and use of computer systems. Examples of monitoring include:

Type of Monitoring	Frequency	Responsibility
External and internal audit of data quality of differing aspects of the Trust's data.	Annual (external) Weekly and ad-hoc (internal)	Clinical Coding Team
Check of completeness and validity of data submitted to Secondary Uses Service and other mandatory returns.	Weekly	Finance and Business Intelligence Unit Team Leads
Validation of blank or invalid patient demographic details.	Weekly	Data Quality Team
Validation of inpatient and outpatient activity.	Weekly	Data Quality Team
Investigation of queries, issues, errors as they arise.	Ad-hoc	Data Quality Team
Benchmarking of audit inputs and outputs to identify discrepancies that may indicate data quality improvements required.	Annual cycle	Clinical Effectiveness

All members of staff involved in recording patient data have the responsibility to ensure they keep up to date with NHS data standards and recording guidance relevant to their role. Online data quality awareness sessions are available via the data quality intranet. These sessions are easily accessible and cover key data recording standards along with a range of guidance documents which keep members of staff updated on any new or changes to data recording.

The guidelines and procedures contain guidance and advice relating to the collection of data along the patient pathway ensuring as a Trust we are following national guidance. Staff are recommended to carry out these sessions on a yearly basis.

10. Learning from deaths

During 2024/25, 1,966 patients of South Tees Hospitals NHS Foundation Trust died. This comprised of the number of deaths which occurred in each quarter of that reporting period:

- 453 in the first quarter.
- 441 in the second quarter.
- 532 in the third quarter.
- 540 in the fourth quarter.

By 31st March 2025, 258 case record reviews and 50 investigations have been carried out in relation to 1,966 deaths above. In 50 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 85 in the first quarter.
- 79 in the second quarter.
- 65 in the third quarter.
- 29 in the fourth quarter.

8 representing 0.4% of the patient deaths during 2024/25 are judged to be due more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 4 representing 2.2% of the number of deaths which occurred in the quarter for the first quarter.
- 2 representing 2.2% of the number of deaths which occurred in the quarter for the second quarter.
- 2 representing 1.8% of the number of deaths which occurred in the quarter for the third quarter.
- 0 representing 0.0% of the number of deaths which occurred in the quarter for the fourth quarter.

These numbers have been estimated using the adapted version of the SJR Plus tool.

The Trust established a Medical Examiner Service in May 2018. Approximately 98% of deaths are scrutinised by Medical Examiners and referred to the Mortality Surveillance team (a central team of four consultants and a nurse with expertise across many specialties) if any concerns are raised. Each review results in two grades, one for quality of care and one for preventability of the death. Referrals may be made as a result of this review to the Patient Safety team or back to the parent specialty.

There were 50 mortality surveillance reviews conducted as a result of Patient Safety enquiries in 2024/25 (of deaths that occurred in that period).

Four of the 2024/25 cases were judged to be probably preventable (more than 50/50), all with room for improvement in clinical and/or organisational care. Three were considered possibly preventable (less than 50/50) again all with room for improvement in clinical and/or organisational care. Five cases had slight evidence for preventability, four of which also required improvement in care. The remaining 33 cases had no preventability.

The seven cases, which were as a result of Patient Safety enquiries, were considered probably or possibly preventable are summarised below;

- Patient with urology disease. Lost to follow up for 10 months during which time the underlying disease progressed significantly.
- Pausing of Edoxoban post operatively following fractured neck of femur.
- Uncertainty in decision making regarding whether to proceed with chest drain and anticoagulation.
- Failure to recognise or treat ileus appropriately.
- Delay in MDT review to listing for surgery.
- Delay in reversing warfarin.
- Delayed referral to Critical Care.

There was one case not referred by Patient Safety, but identified by mortality surveillance which was a patient with renal cancer, lost to follow up which significantly limited treatment options.

In total, eight cases representing 0.4% of total patient deaths (1966 deaths in period) were judged more likely than not to have been due to problems in the care provided to the patient.

A further 11 reviews pertained to Patient Safety enquiries from 2023/24.

One of the 2023/24 cases was judged to have strong preventability with room for improvement in organisational care.

Two cases were judged to have slight evidence of preventability, the remainder had no preventability.

193 case record reviews and 11 investigations were completed after 31 March 2024 which related to deaths which took place before the start of this reporting period. This number has been estimated using the SJR Plus tool.

1 representing 0.1% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the SJR Plus tool.

3 representing 0.1% of the patient deaths during 2023/24 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting against core indicators

1. Summary Hospital-level Mortality Indicator (SHMI) and Palliative Care Coding

AWAITING DATA UPDATE EARLY MAY

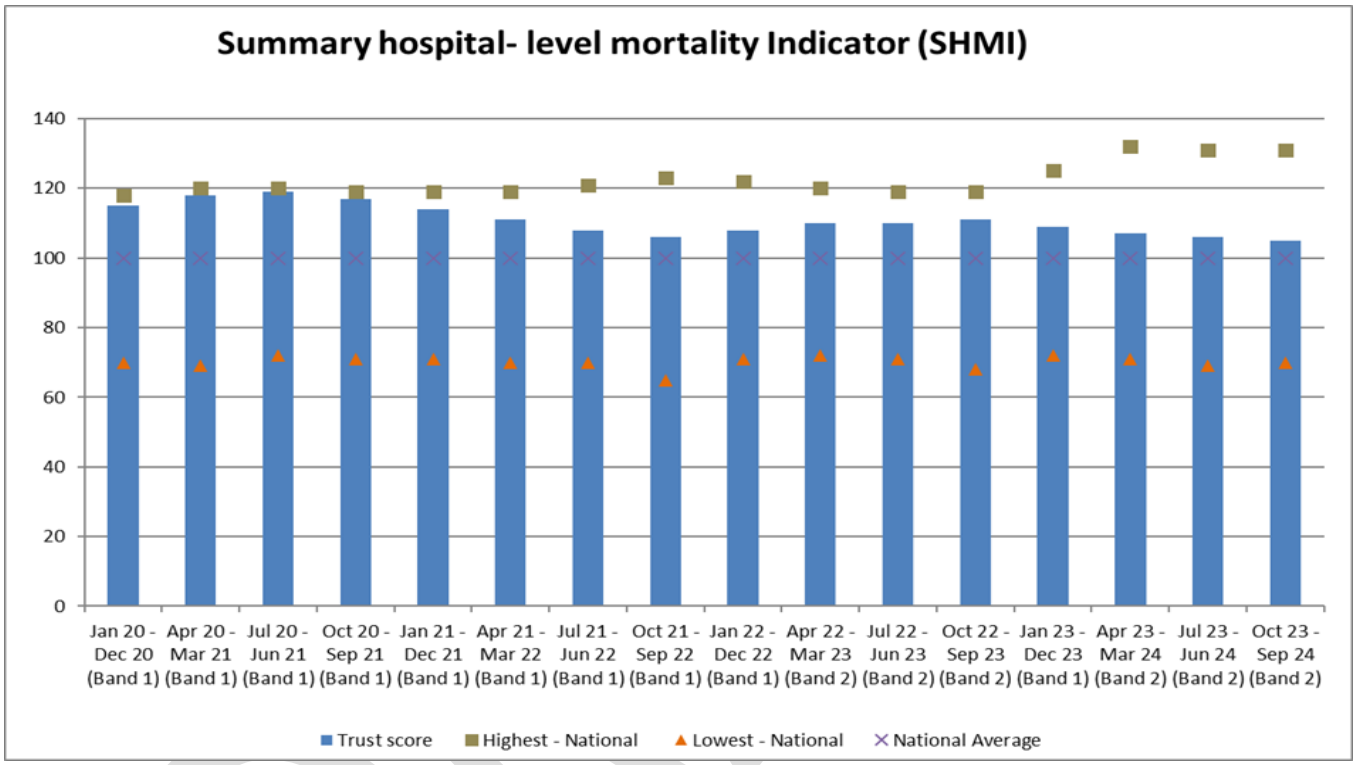


Figure 5: Summary Hospital Level Mortality Indicator (Data source: NHS Digital)

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

1. The SHMI is not designed to account for the COVID-19 pandemic and although spells coded for COVID-19 have been removed by NHS Digital from the indicator calculation, the large reduction in the number of admissions to hospital, particularly during wave 1, has had a substantial impact on the expected number of deaths. Since January to December 2023, spells with COVID-19 are included, with a corresponding small increase in deaths and discharges of around 2%. However, SHMI has fallen compared to the pandemic period and is 'as expected' meaning that the number of observed deaths is within the statistical limits, compared to the estimated number of hospital deaths expected given the population of patients cared for in the Trust. The fall in the number of admissions has not been experienced evenly across the country, with areas that had high levels of COVID-19, such as the North-East, experiencing a greater impact.
2. Despite the high level of need in the population the Trust serves, the organisation has historically fallen behind other Trusts in recording the number of other medical conditions patients have, alongside the main illnesses being treated. The Trust is in the process of implementing electronic records systems which are expected to address this comorbidity recording anomaly over time. There may be a short-term reduction as the system is refined and becomes embedded in clinical practice. The improvement that occurred in the 12 months to December 2023 in coding of elective spells has continued into the current period (October 2023 – September 2024) and the small fall in non-elective spells has reversed.

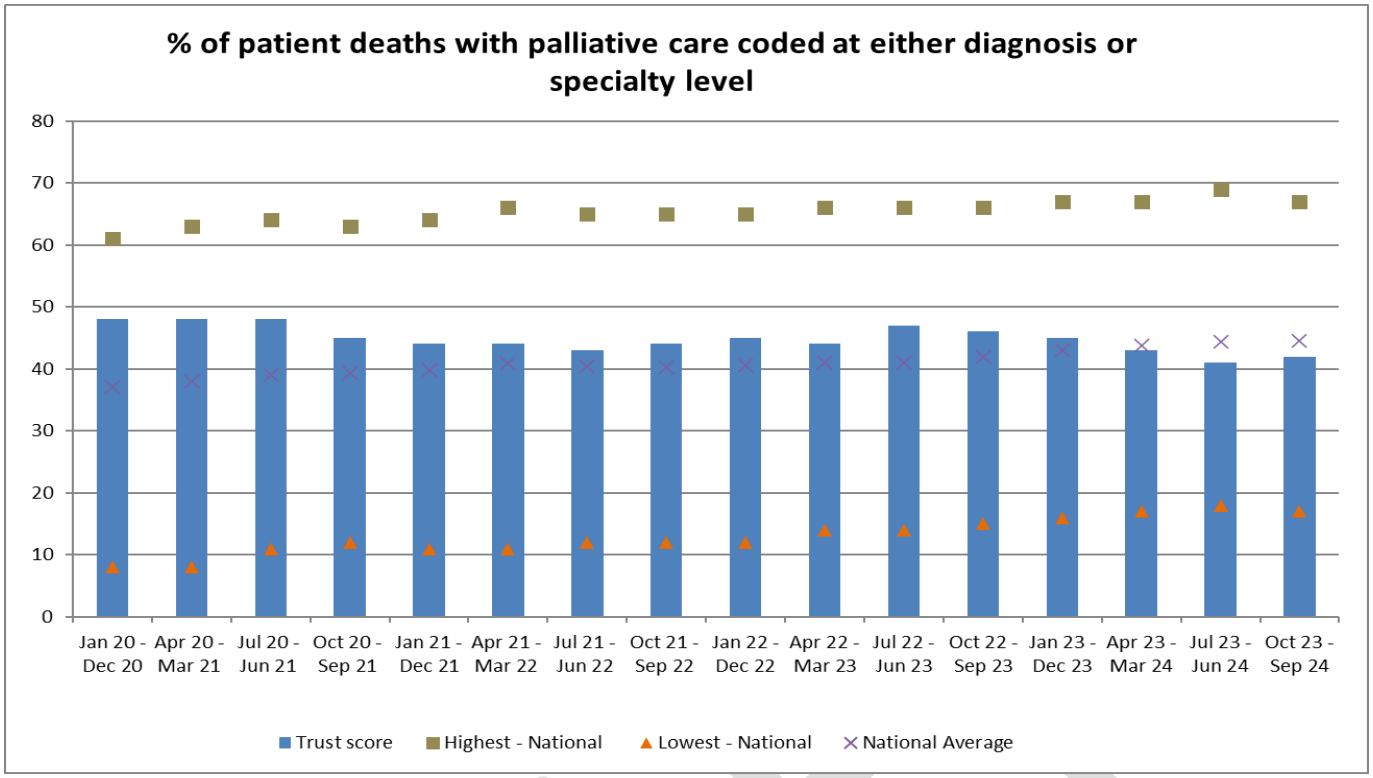


Figure 6: Percentage of Patient Deaths with Palliative Care Coded (Data source: NHS Digital)

The percentage of patient deaths with specialist palliative care coding has been higher than the national average in the last twelve reporting periods at around 45% but has fallen behind in the last three periods, thought the gap is starting to close again. The Trust is actively engaged in ensuring this ground is made up.

The Trust has taken the following actions to improve the indicators and therefore the quality of its services:

NARRATIVE AWAITING REVIEW

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

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

2. Patient reported outcome measures

Patient reported outcome measures (PROMs) measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a healthcare

procedure and provides an indication of the outcomes or quality of care delivered to NHS patients (http://www.hscic.gov.uk/proms). The score reported is an adjusted health gain score based on case mix, a higher number indicates a better health gain.

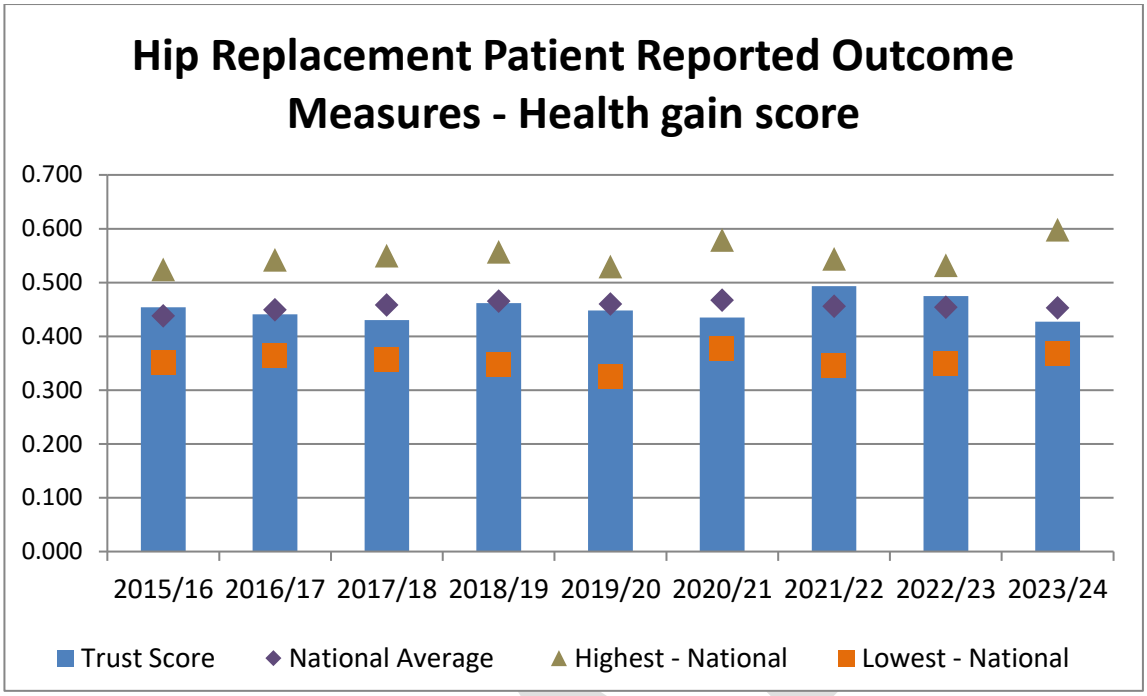


Figure 7 - Hip Replacement Patient Reported Outcome Measures - Health gain score

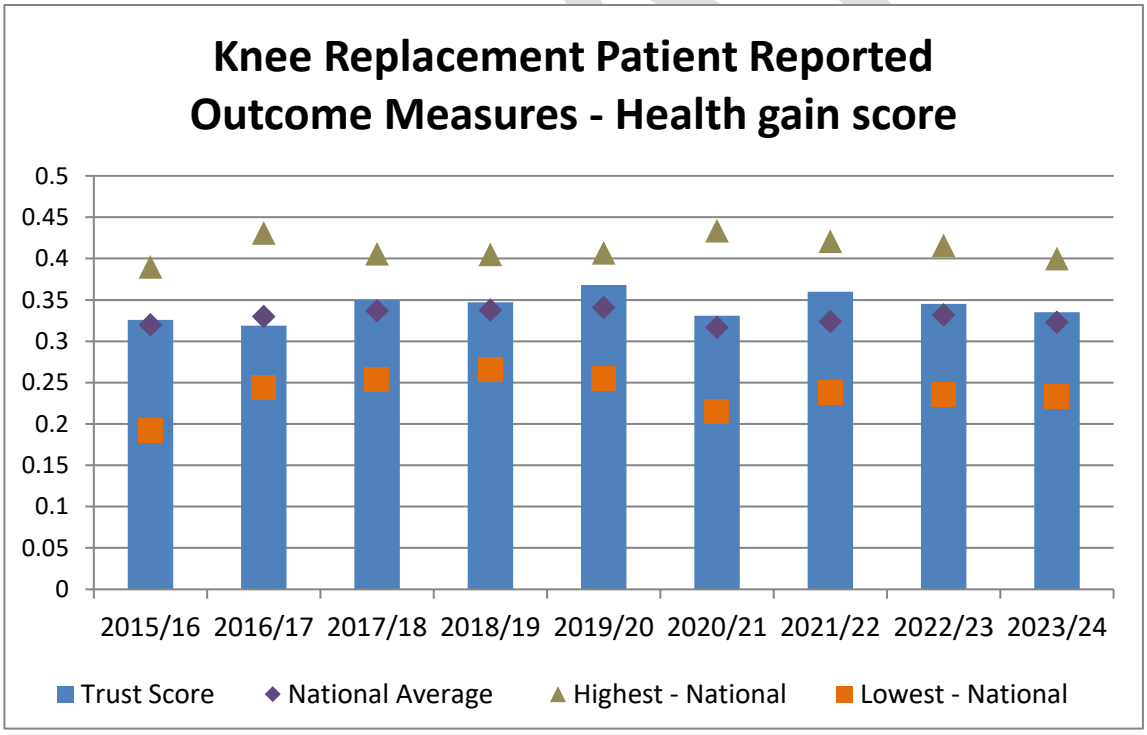


Figure 8 - Knee Replacement Patient Reported Outcome Measures - Health gain score

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

NARRATIVE AWAITING REVIEW

- The specialist review and pre-assessment process ensures that patients are offered the procedure likely to deliver the most benefit and best outcome.

- The health gain scores for hip replacements and knee replacements are in line with the national average.
- Production of data has been disrupted by the COVID-19 pandemic.

The Trust has taken the following actions to further improve these scores, and therefore the quality of its services:

- Providing regular feedback of the scores to clinical teams and benchmarking performance across the NHS and other hospitals in the North-East, through a regular report produced by the North-East Quality Observatory Service (NEQOS), to ensure the quality of services is maintained.

3. 30-day readmissions

Whilst there will always be some unavoidable reasons for emergency readmission after a patient is discharged, and the relationship between discharge and readmission is complex, a low percentage of patients having emergency readmission is a marker of safe and effective care.

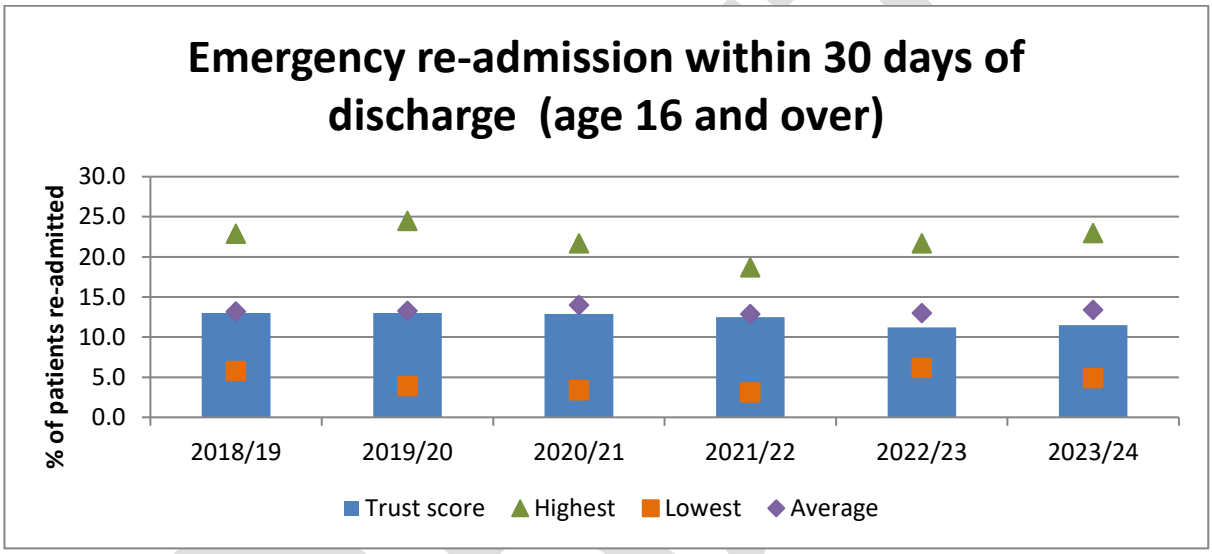


Figure 9 - Emergency re-admission within 30 days of discharge (age 16 and over)

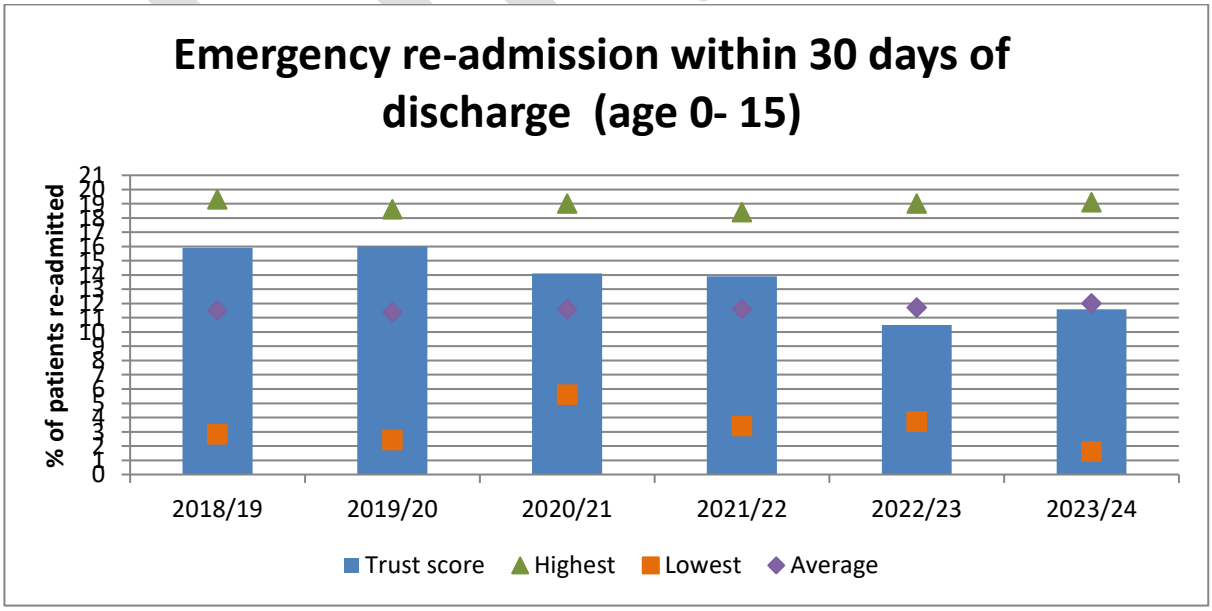


Figure 10 - Emergency re-admission within 30 days of discharge (age 0- 15)

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

- The percentage of re-admissions for patients aged over 16 decreased from 12.9% in 2020/21 to 11.5% in 2023/24.
- The percentage of re-admissions for patients aged 0 – 15 decreased from 14.1% in 2020/21 to 11.6% in 2023/24.

The Trust has taken the following actions to further improve these scores, and therefore the quality of its services:

The Trust continues to be focused on improving patient care and reducing emergency re-admissions. A preliminary data analysis has been completed which shows a slight increase across the organisation. This is spread against all age groups apart from the under 44 years. Patients reattending are those that would be expected and fit into the national picture of patients with ongoing chronic conditions or respiratory conditions and are similar across the group. Further analysis and work is underway to review practice and ideas for reduction.

4. Responsiveness to the personal needs of its patients during the reporting period

NHS Digital has not published any data since the 2021 data included in the last Quality Account.

5. National Inpatient Survey

The results of the NHS Adult Inpatient National Survey were published by the CQC on 21 August 2024. The survey involved 131 acute NHS trusts in England. There were 63,573 responses received, with a national response rate of 42%. The sample for the survey included patients aged 16 years or older who spent at least one night, during November 2023, in an NHS hospital, and were not admitted to maternity or psychiatric units. Each NHS trust selects a sample of 1,250 patients, by including every consecutive discharge that met the eligibility criteria, counting back from 30 November 2023.

We had a response rate of 42%, with 1,250 patients invited to take part and 485 patients participating in the survey. There were slightly more female respondents than male and less than 1% of participants stated they were intersex or preferred not to say. Most respondents were aged over 66 years of age, and the ethnic group was predominantly white (as shown in figures 11-13 below).

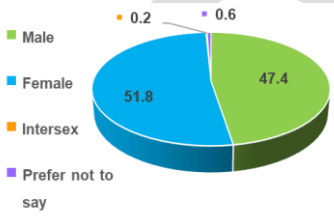


Figure 11 – Sex

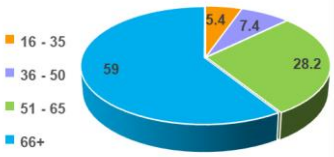


Figure 12 – Age

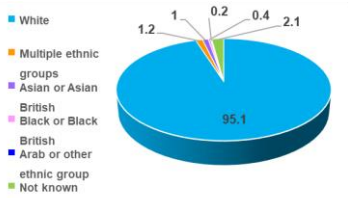


Figure 13 - Ethnicity

All questions are grouped into sections. We scored 'About the same' as most trusts in all sections (The hospital and ward, care and treatment, leaving hospital, admission to hospital, doctors, nurses, operations and procedures, feedback on quality of care, respect and dignity and overall experience).

We scored 'Better than most trusts', in one question relating to access to food outside of mealtimes, and 'Somewhat better than most trusts' in four questions (see below);

- Were you able to get hospital food outside of set mealtimes?
- If you brought medication with you to hospital, were you able to take it when you needed to?
- How much information about your condition or treatment was given to you?
- To what extent did staff involve you in decisions about you leaving hospital?
- After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

Questions showing a decrease in scores, since 2022, were about the length of time on a waiting list before admission to hospital. Explanations from staff for reasons for changing wards during the night in a way our patients could understand.

Three questions we scored the highest in when compared with the national average. Most of these scores had remained the same or increased since 2022. These included –

- Were you able to get hospital food outside of set mealtimes?
- After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?
- How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?

We scored the lowest in three questions compared with the national average.

- Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- Before you left hospital, were you given any information about what you should or should not do after leaving hospital?

Our response to the Inpatient survey results

An action plan was developed with the clinical staff to improve in the areas identified with the lowest scores. With regards to the Virtual Wards, a leaflet is given to patients, and a short video has been developed to introduce patients to the Hospital at Home Service and improve their understanding of the risks and benefits of the Virtual Ward.

We acknowledge that leaving hospital can cause some of our patients, their carers and families to feel vulnerable. Patients being discharged through our discharge suite are provided with information about the right team to contact should they feel their condition is deteriorating once they are at home.

Patients being transferred to wards during the night is kept, where possible, to a minimum. However, on occasions it is necessary to move patients during the night. To ensure this is kept to a minimum our clinical matrons provide the patient flow team with list of patients who are medically optimised for discharge on a daily basis. This allows the team to identify patients during the day and hence reduce the amount of movement overnight. A patient information leaflet is being developed for the Assessment Units, so patients and their relatives know what to expect with regards to transfer.

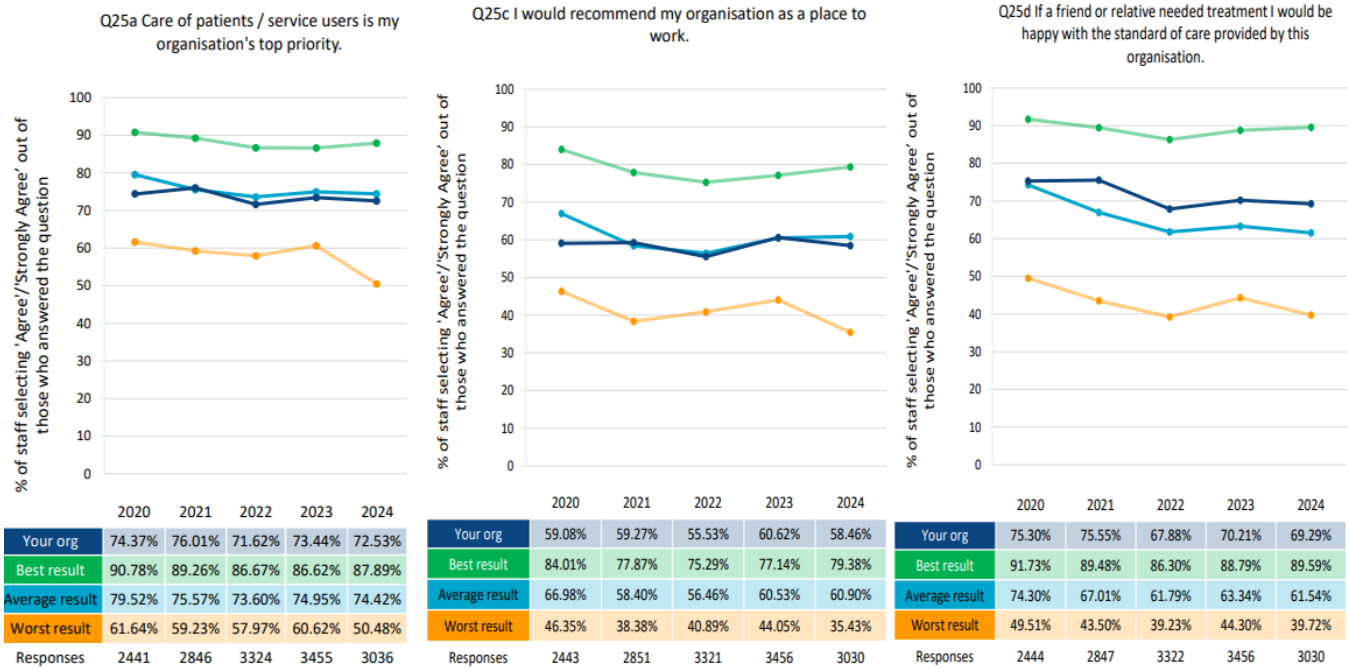
On review of the survey results, 78% of patient's comments about staff and 71% of patient's comments about care and treatment were positive. 67% of patient's comments about the pathway of care and 69% of patient's comments on hospital environment and facilities were negative.

Areas for improvement

Figure 14 - Areas for attention following comment analysis

Areas for improvement (identified in Figure 14) have been discussed with clinical staff and included in the action plan. Actions include, the implementation of clinical matron assurance rounds for the discharge process, environment and nighttime assurance rounds. A clinical matron group has been established leading on the pain management workstream, specifically tasked to improve pain re-assessments. The wards now display information relating to pain, pain assessment and re-assessment.

c. Staff Friends and Family Test



	2020	2021	2022	2023	2024
Your org	74.37%	76.01%	71.62%	73.44%	72.53%
Best result	90.78%	89.26%	86.67%	86.62%	87.89%
Average result	79.52%	75.57%	73.60%	74.95%	74.42%
Worst result	61.64%	59.23%	57.97%	60.62%	50.48%
Responses	2441	2846	3324	3455	3036

	2020	2021	2022	2023	2024
Your org	59.08%	59.27%	55.53%	60.62%	58.46%
Best result	84.01%	77.87%	75.29%	77.14%	79.38%
Average result	66.98%	58.40%	56.46%	60.53%	60.90%
Worst result	46.35%	38.38%	40.89%	44.05%	35.43%
Responses	2443	2851	3321	3456	3030

	2020	2021	2022	2023	2024
Your org	75.30%	75.55%	67.88%	70.21%	69.29%
Best result	91.73%	89.48%	86.30%	88.79%	89.59%
Average result	74.30%	67.01%	61.79%	63.34%	61.54%
Worst result	49.51%	43.50%	39.23%	44.30%	39.72%
Responses	2444	2847	3322	3456	3030

Table 3. NHS Staff Survey results relevant to staff friends and family test

The South Tees Hospitals NHS Foundation Trust has seen some slight declines in the following areas in 2024, following an improvement in 2023:

- Recommending the organisation as a place to work.
- Care of patients/service users is my organisations top priority.
- If a relative or friend needed treatment, I would be happy with the standard of care.

However, we have remained above average for the response to the question 'if a relative or friend needed treatment, I would be happy with the standard of care'.

The South Tees Hospitals NHS Foundation Trust intends to take the following actions to further improve this percentage and thereby the quality of its services.

- Collaboratives will review their staff survey results to understand the areas where further developments are needed and discuss these with their teams.
- South Tees Hospitals NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust have formed a University Hospitals Tees Group, which will enable the best possible patient care to be delivered across the Tees Valley area. As part of the Group, we have developed five clinical boards to develop transformation strategies within six key clinical areas.
- The Trust continues to promote the development of the Group and the exciting opportunities for improving patient care via various briefings, bulletins, and other communications.

6. Venous thromboembolism risk assessments

The National Institute for Clinical Excellence (NICE) recommends that all patients admitted to hospital should be assessed for their risk of developing venous thromboembolism (VTE). Patients at higher risk can then be treated with appropriate prophylactic medication to reduce the risk of developing VTE. This measure shows the percentage of eligible inpatients who were risk assessed. A high percentage score is good, with a national target of at least 95% patients being risk assessed.

National data collection was paused during, and following the COVID pandemic, however we continued to monitor and act on our own data internally. Figures from 2022-2024 were in the region of 86-89%. Whenever we looked closely at areas with higher levels of non-compliance we found problems with data collection rather than problems with clinical practice.

Throughout 2024, electronic prescribing and note keeping, including electronic VTE risk assessment, was introduced throughout the organisation. This has led to more reliable capture of completed VTE risk assessments in comparison to previous paper-based risk assessments.

National data collection resumed in early 2025 with our own submitted figure (based on electronic VTE risk assessment) being 95.45% for quarter 3 of 2024-25. This gives reassurance that the lower values seen in 2022-2024 were truly due to problems with data collection as there has been no significant change in clinical practice over recent years.

VTE continues to be a high clinical priority within the organisation. VTE risk assessment data continues to be reviewed and discussed at quarterly Thrombosis Committee meetings with escalation to the Clinical Effectiveness Steering Group where appropriate. We also continue to review all cases of hospital acquired VTE, giving feedback to clinical teams where appropriate.

7. Clostridioides difficile (*C. difficile*) Infections rates

Clostridioides difficile infection is caused by a type of bacteria and is an important cause of infectious diarrhoea in healthcare settings and in communities.

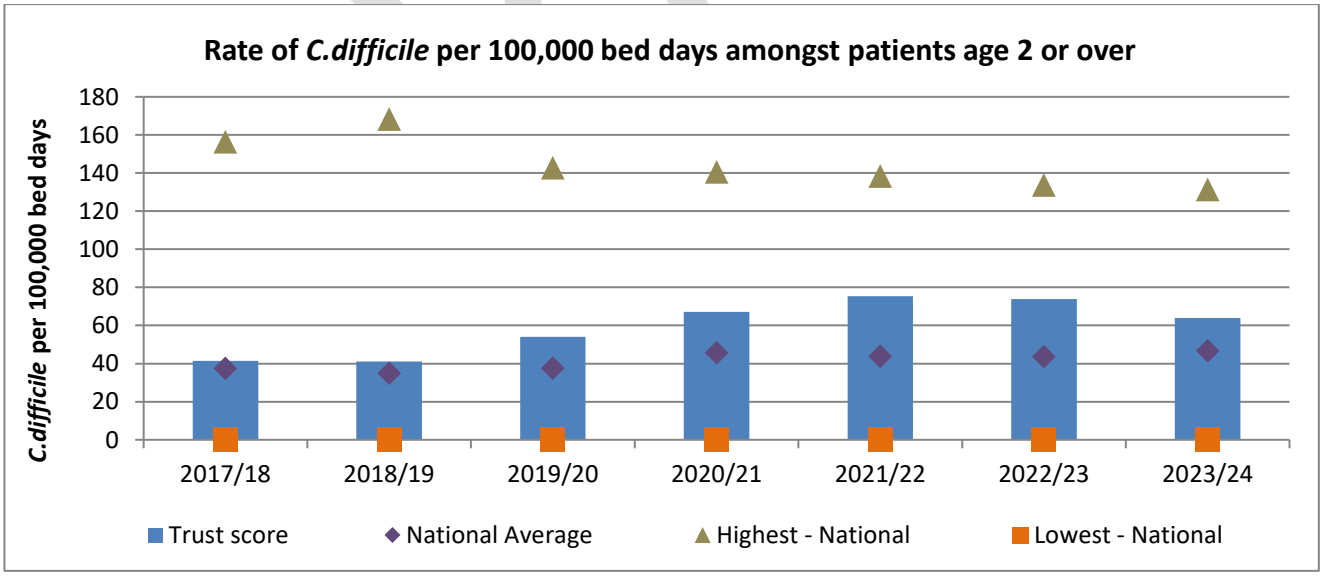


Figure 15: Rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over. (Data source: NHS Digital)

The Trust reports healthcare associated *C. difficile* cases to UK Health Security Agency via the national data capture system against the following categories:

- Hospital onset healthcare associated (HOHA): cases that are detected in the hospital 2 or more days after admission (where day of admission is day 1), and

- Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.

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

- The Trust is required under the NHS Standard Contract to minimise rates of *C. difficile* infection so that it is no higher than the threshold level set by NHS England.
- The data (figure 15 above) reflects the ongoing work within the Trust in relation to *C. difficile* infection. More specific information around performance is reported in section 3.2.

The South Tees Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services:

- The Trust has a comprehensive action plan for the prevention of all Trust-attributed Healthcare Associated Infections including *C.* difficile, which is monitored through the IPC governance route via the Infection Prevention and Control Strategic Group and reported through to the Safe and Effective Care Strategic Group, Quality Oversight Group and Quality Assurance Committee.
- Alongside this recovery plan, each of the clinical collaboratives hold their own C.difficile action plan relevant to their area of clinical expertise and report on this through their own appropriate governance structures. The senior team also meet with the Deputy Director of IPC twice yearly to discuss progress and actions aligned to this.
- All trust-attributed cases have a Rapid Learning Summary undertaken in line with PSIRF. These reviews are then assessed against a criteria for further discussions and review via a case review which are chaired by the Deputy Director of Infection Prevention and Control (DDIPC) or a senior infection prevention and control (IPC) nurse. All learning from these reviews is shared across the organisation to ensure actions implemented for future improvements. Identifying a single root cause in cases of C. difficile is challenging and they are often associated with one or more influencing factors such as patient factors e.g., existing long-term conditions, and/or medical factors such as the requirement for antibiotics or laxatives and/or invasive procedures and investigations.
- Learning from the Rapid Review process and aligned to the recovery plan escalation to the senior nursing team meeting to ensure completion of actions across the organisation is via weekly quality and safety panels and senior meetings.
- Continuous update of the C.difficile training packages for all staff.
- Membership of the North East and North Cumbria ICB ‘Deep Dive’ around C.difficile continues.
- Membership of NHS England national ‘Deep Dive’ around C. difficile continues.
- The organisation has a focus around antimicrobial prescribing and in particular, Co-Amoxiclav, as we are an outlier in respect of this including antimicrobial ward rounds, shared learning and training and education.

8. Patient safety incidents

The National Reporting and Learning System (NRLS) was decommissioned on 30 June 2024.

The Trust successfully went live with the Learning from Patient Safety Events (LFPSE) reporting platform on 20 November 2023, moving away from the historical manual uploading process required by the NRLS system.

The LFPSE service creates a single national NHS system for recording patient safety events. It introduces improved capabilities for the analysis of patient safety events occurring across healthcare, and enables better use of the latest technology, such as machine learning, to create outputs that offer a greater depth of insight and learning that are more relevant to the current NHS environment.

Comparative benchmarking data is not yet available from LFPSE to include in this year’s Quality Account. However, once fully functional, LFPSE will;

- Make it easier for staff across all healthcare settings to record safety events, with automated uploads from local systems to save time and effort, and introducing new tools for non-hospital care where reporting levels have historically been lower.
- Collect information that is better suited to learning for improvement than what is currently gathered by existing systems.
- Make data on safety events easier to access, to support local and specialty-specific improvement work.
- Utilise new technology to support higher quality and more timely data, machine learning, and provide better feedback for staff and organisations.

We have included some more recent related data from our internal data reporting below.

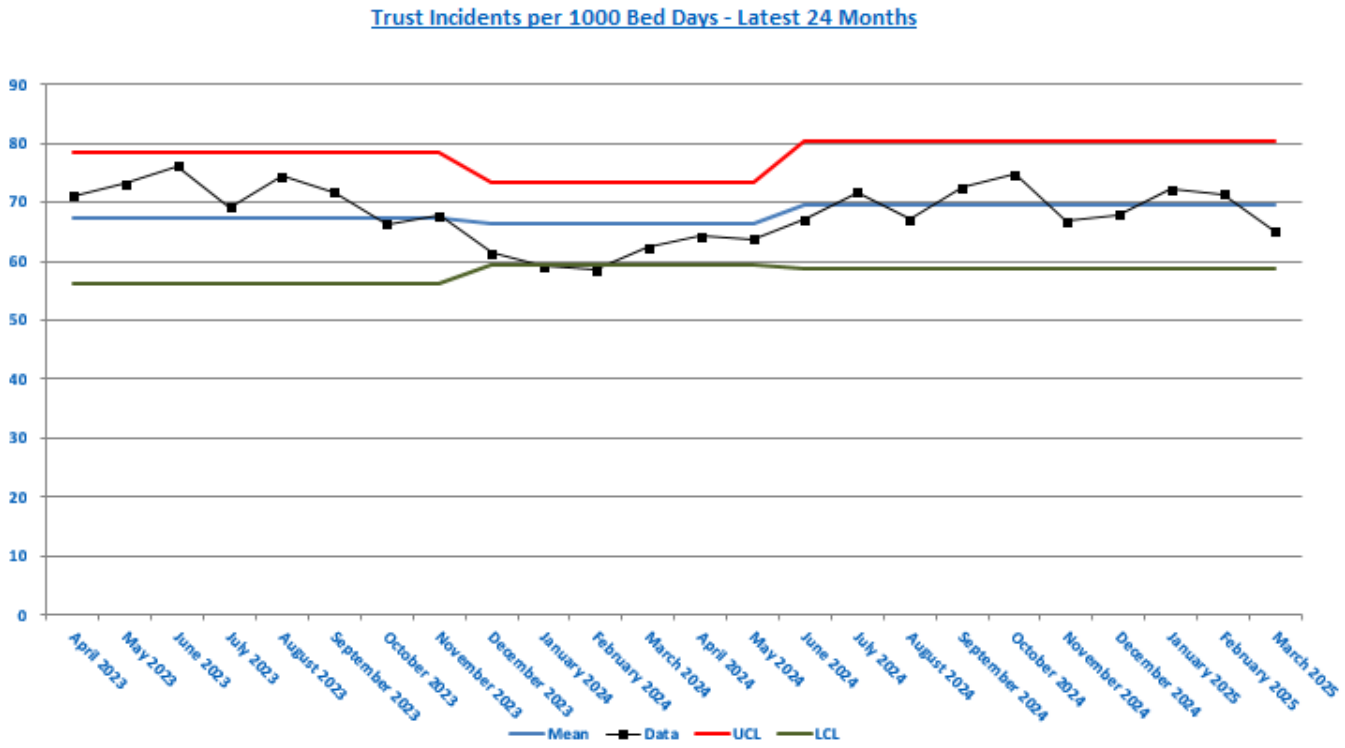


Figure 16 – Trust incidents per 100 bed days

Incident reporting in the Trust has remained stable at around 2500 incidents per month. Bed base data was recalculated in the Trust in September 2023, which showed an increase of 3000 bed days, trends in incidents per 1000 bed days remain within expected controls.

Patient Safety Incident Response Framework (PSIRF)

We transitioned to PSIRF on 29 January 2024, replacing the previous serious incident (SI) framework. Data is therefore no longer available for the number of serious incidents reported per 1000 bed days

Never Events

We reported five Never Events during 2024/25.

These included three wrong site intravitreal injections in ophthalmology; one transfusion of incorrect blood products; and one wrong site surgery in relation to insertion of a chest drain. Never Events are investigated using Patient Safety Incident Investigation (PSII) methodology, as outlined in the Trust's Patient Safety Incident Response Plan (PSIRP).

NHSE is currently undertaking a review of the Never Event list to determine if there are truly strong and systemic barriers in existence to prevent these incidents from occurring. The list is likely to change and therefore future data may not be comparable.

Year	Number of Never Events
2024-2025	5
2023-24	3
2022-23	7 (1 has since been retracted)
2021-22	4
2020-21	8
2019-20	8
2018-19	5

Table 4: Number of Never Events reported annually since 2018/19

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

- The Trust's incident reporting levels have remained consistent between 2023/24 and 2024/25, however the number of bed days within the Trust has increased by 3000 since September 2023, which has impacted on the data as illustrated in figure 16.

The South Tees Hospitals NHS Foundation Trust intends to take the following actions to further improve this percentage and thereby the quality of its services:

- Review LFPSE thematic and benchmarking data once this is available.
- Continue to encourage high rates of reporting, with a focus on the timely review and management of incidents and providing meaningful feedback to reporters.

9. Patient Friends and Family Test

The 2024/25 patient friends and family test (FFT) data is provided in section 3.1 of this report.

3. Overview of quality of care and performance indicators

3.1 Overview of quality of care

Patient Safety

a. Medication safety

In the UK, it is estimated that 60% of all adults take at least one prescribed medication, with an increasing trend in the number of prescriptions processed year on year as the population ages and the prevalence of long-term conditions increased.

Ensuring the safe use of medication involves a co-ordinated effort between all healthcare professionals, patients and carers. Within the organisation, we have been actively monitoring medication errors through the monthly Safer Medication Practice Group meetings. These reviews show that the organisation has a strong culture of reporting, with 99% of events reported causing low or no harm. The electronic prescribing governance group also meets monthly to review incidents that might require system fixes, allowing for quick actions to prevent future issues. Recent system improvements include tracking non-formulary medications and adjusting prescribing rules to reduce errors (such as preventing incorrect dose calculations).

The trust's electronic dashboards have been upgraded to allow real-time tracking of prescribing patterns, which has helped identify trends. One example is working with primary care to reduce the use of lidocaine patches. By setting up alerts and instructions in the ePMA system, along with clinical education, we've successfully cut down prescribing by one-third.

We have also launched a new dashboard for insulin and diabetic medications, which allows clinical staff to view current admitted patients across the organisation in real-time and ensures timely reviews.

Image; AMS Study Day

In November 2024, the antimicrobial team hosted the Big Switch Antimicrobial Stewardship (AMS) study day, which was a success with full attendance. This event, along with ongoing AMS training across all departments and improvements to ePMA prescribing, has contributed to a steady decline in the use of broad-spectrum antibiotics.

Our Pharmacy have been adapting and expanding the role and skills of our team to meet the evolving needs of healthcare, with a commitment to improving patients care and supporting the wider healthcare team. In 2024 we have trained our pharmacy technicians to complete transcribing of medication and utilisation of our therapeutic substitution and prescription optimisation policies, which means our skilled staff can assist with ensuring medication charts are accurate for our inpatients.


Image; Beth Mongomerie

In 2024 we also saw the evolvement of the new ward based assistant technical officers (WATOs), developing new skills to support with ward based medicines safety. The WATOs have evolved to undertake roles such as reviewing of ward medication requests to ensure safe and appropriate medication supplies. More recently, some WATOs have been trained to gather information on medications that patients were taking prior to admission, so that this information can be reviewed by qualified pharmacy colleagues to ensure safe and effective prescribing for inpatients.

Beth Mongomerie (Pharmacist) was awarded 1st place at the Great North Pharmacy Research Conference in August 2024 for her post on WATOs delivering counselling to patients

The introduction of pharmacy technicians using patient group directives (PGDs) in the UK has been embraced within the organisation and this has been demonstrated by the Specialist Pharmacy Technician in the antimicrobial team who manages a de-labelling of spurious penicillin allergies. The aim of this is to identify patients in the hospital who have a documented penicillin allergy but may not have a true allergy. This service has successfully de-labelled 45% of patients seen by the service and referred a further 27% for more investigations. By ensuring documented allergies are accurate, we are expanding the treatment options available to patients and helping to prevent antibiotic resistance. We are further scoping the use of technicians using PGDs in other specialist areas such as accident and emergency and rheumatology.

This year we have introduced a pharmacist into the discharge lounge team, which is an exciting and valuable step in enhancing patient care. The overall aims are to improve the safety and efficiency of the discharge process by ensuring patients receive the medication they need on discharge. We are pleased to share we have received multiple compliments about Hannah describing her as *“an amazing asset to the team...with Hannah helping with medication issues, I am able to provide nursing care needed for the patients in the suite...Hannah goes above and beyond”.*

Hannah is now part of the discharge group to look at overall discharge in the trust and implement solutions. She is also working on ensuring patients have continuation of care in the discharge suite and are receiving doses of medication when they are due whilst waiting to go home.

The clinical pharmacy team continue to play a crucial role in ensuring the safe use of medication across the organisation, currently 90% of patients are seen by the pharmacy team during their admission and 50% of these are within 24 hours of admission. In August we audited the interventions made by the clinical

pharmacy team, and in 1 day 329 interventions were made. 32% of the interventions made would have prevented patient harm, and 93 interventions would have reduced the patient's length of stay.

Medication safety will always remain a crucial priority within the organisation, and significant achievements have been made over the past year. Over the next year we are aiming to utilise digital tools and data more regularly to review our practices, expand the roles and responsibilities, roll out more educational training videos to staff with key learning about medication safety and continue to collaborate with research to improve medication safety for all patients.

b. Compassionate Engagement and evaluation of the Family Liaison Officer

The Trust transitioned to the patient safety incident response framework (PSIRF) in January 2024. The four key pillars of PSIRF include compassionate engagement and involvement of those affected, a systems-based approach to learning, considered and proportionate responses and supportive focussed on strengthening response systems.

Learning from patient safety incidents

Throughout 2024/25 we have continued to review and learn from patient safety incidents using a range of methodologies outlined in our PSIRF policy and plan such as After Action Reviews, hot debriefs, thematic analysis and patient safety incident investigations (PSII). We have implemented a safety and quality panel, which provides a weekly overview of emerging safety and quality data and allows for effective escalation of areas of concern. Each week, three key messages are produced and shared in a bulletin by the Trust communications team, to ensure effective sharing of learning trust-wide.

Family Liaison Support

The Trust is committed to delivering a restorative and just culture. There are now 93 trained family liaison officers (FLO) within the Trust. FLO are deployed in pairs, to support patients and their families or carers, following adverse events such as patient safety incidents and complex complaints. FLOs act as a conduit between investigation teams and a patient and their family and ensure that the patient and family's voice is heard, and their questions are answered as part of investigation reports. Patients and their families are given the opportunity to contribute to investigation reports, which may include the inclusion of a photograph, impact statements and patient and family memory captures.

The NHSE PSIRF standards outline that family engagement in adverse events should be evaluated. Collaborative work has been undertaken regionally to develop a feedback tool for the FLO service, supported by one of our Patient Safety Partners and Health Innovation North East and North Cumbria.

The Trust's Duty of Candour letter templates have been updated collaboratively with patient experience colleagues, to ensure plain language is used to meet the needs of our patients and their families and aid effective communication.

Restorative practice

In addition to FLO training, a further cohort of staff have completed restorative practice training. Restorative practice focuses on relationship building and conflict resolution, addresses the consequences of harm and allows for repair and learning. This practice informs emotional literacy and social skills building, and compliments the FLO role when supporting affected patients and their families. Examples of restorative practice include the facilitation of restorative conversations and supporting patients and their families to access psychological therapies following adverse events.

Patient safety investigation training

A patient safety investigation workshop was facilitated by a patient safety partner, patient safety specialist and patient safety lead. The 4-hour workshop used a case study based on a recent Healthcare Safety Investigation Branch process to develop participants knowledge and skills when undertaking patient safety reviews, based on teaching from the NHSE Patient Safety Syllabus Level 3 and 4 training. The session

included the application of human factors models (such as the System Engineering Initiative for Patient Safety and Accident Mapping), Duty of Candour, and the hierarchy of controls in developing meaningful action plans. Over 60 colleagues attended the session, which received positive feedback, and there are plans to deliver further sessions, as part of a regular education programme in 2025.

NHS Patient safety syllabus training

The NHSE Patient Safety Syllabus (Levels 1a and 1b) was introduced as part of mandatory training requirements in September 2024. Level 1a is the starting point for all NHS staff, and Level 1b is the essentials of patient safety for boards and senior leadership teams. A training needs analysis is underway to inform the roll out of level 2 of the patient safety syllabus. Two of our Patient Safety Specialists have now completed Level 3 and Level 4 NHSE Patient Safety Syllabus training.

Patient Safety Partners

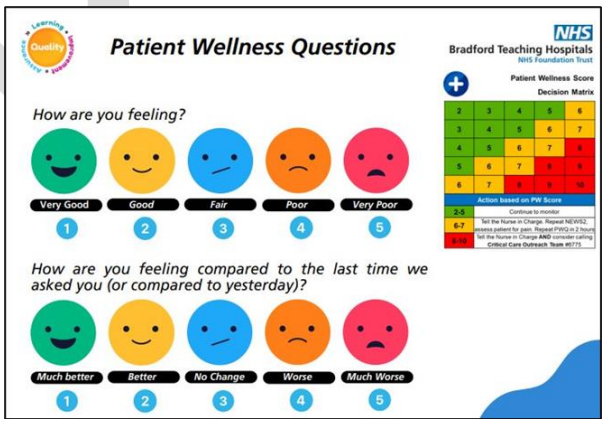
The patient safety partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across health care in the UK. A PSP is a person with lived experience as a patient, caregiver, or family member who works with healthcare services to improve patient safety. The goal of the PSP role is to enhance the quality of care and reduce risks of harm by integrating real-world patient perspectives. We now have three PSPs, who continue to contribute to a range of patient safety activities, including observational data collection, review of patient communication, development of standard operating procedures and attendance at patient safety review panels.

c. Martha's Rule

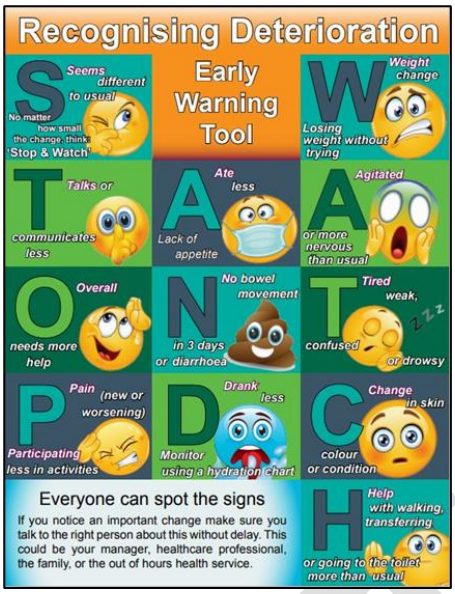
Martha's Rule is an initiative designed to give patients and their families the right to request an urgent clinical review by a different team if a patient's health appears to be deteriorating. The process is designed to empower families, carers, and patients to speak up about any concerns. Martha's Rule consists of 3 components, which are –

1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

A digital assessment is currently in development. The assessment is to include two pathways. The first pathway will introduce a patient wellness questionnaire, which has been adapted from the tool currently used at Bradford Teaching Hospitals NHS Foundation Trust.



The second pathway allows for the safeguarding of our vulnerable patient population who are unable to express their own concerns. We will use the STOP AND WATCH tool from the regional North East and Cumbria learning disabilities network.



Call for Concern was introduced in 2022, allowing patients, relatives and carers to escalate concerns directly to critical care outreach if they feel concerns related to their acute care needs are not being listened to, heard or understood by the primary care team. All escalations via this route are triaged via the critical care outreach team. Every patient that is escalated receives an independent review. The team supports the ongoing management of the patients care, provides interventions, maintains communication between families and the multi professional team and signpost to other services.

Since the service has been introduced, it has received over 100 referrals. There is already an established staff route of escalation to the critical care outreach team.


Step 4

When the critical care outreach team receive your call, they will need to know:

- The patients name
- The ward they are on
- A brief description of the issues and what has already been done about it
- Your contact details and relationship to the patient if not the patient referring.

When NOT to make a C4C call

C4C is a patient safety initiative, recognising the contribution that close family and friends make in recognising when their loved ones are unwell.

For any general concerns please discuss with the ward team.

Patient Experience

South Tees Hospitals NHS Foundation Trust would like your feedback. If you wish to share your experience about your care and treatment or on behalf of a patient, please contact The Patient Experience Department who will advise you on how best to do this.

This service is based at The James Cook University Hospital but also covers the Friarage Hospital in Northallerton, our community hospitals and community health services.

To ensure we meet your communication needs please inform the Patient Experience Department of any special requirements, i.e. Braille/ Large Print.

T: 01642 835964
E: stees.patient.experience@nhs.net

The James Cook University Hospital, Marton Road, Middlesbrough, TS4 3BW. Switchboard: 01642 850850

Author: Critical care outreach team
Issue Date: September 2022 Review Date: September 2024

NHS
South Tees Hospitals
NHS Foundation Trust

Critical Care Outreach Team

Are you concerned about a patient?

Call 4 concern©

A patient safety initiative

C4C

This leaflet contains information that may be helpful during your stay in hospital.

Safety and Quality First

Key Benefits

- Encouraging patients, relatives and carers to escalate concerns.
- Safeguarding of vulnerable patient populations.
- Organisational oversight of self-reported deterioration.
- Standardised escalation processes.
- Prompting clinical staff to recognise subtle signs of deterioration in vulnerable patients.

Clinical effectiveness indicators

a. Research and Innovation

Clinical Research

Research is now one of the 8 domains reporting into the University Hospitals Tees Group Board through individualised Trust Board Assurance Frameworks (BAF) which outline the risks to achieving our strategic aims. Monthly reporting of progress against the BAF is provided to the Group Quality Assurance Committee.

We have 164 Principal Investigators (PIs) supporting the delivery of research studies across the organisation this year. The number of non-medical Principal Investigators has decreased this year from 31 to 30.

Achievements of note:

- Our Research delivery teams in Infectious Diseases and Cardiology were both successful in achieving the first UK patient recruited into one of their studies this year.
- Our Research Nurse Helen Harwood is the fifth highest recruiting Principal Investigator (PI) in the North East & North Cumbria area.
- We have engaged more proactively with our membership of the Northern Health Science Alliance (NHSA) over the last 12 months and progressed from being the least represented member on workstreams and sub-groups to one of the most represented.
- Professor Amar Rangan has been appointed President elect- British Orthopaedic Association.
- Professor Enoch Akowuah has been appointed President elect - Society for Cardiothoracic Surgery in Gt Britain & Ireland.

Nursing Midwifery and Allied Health Practitioner (NMAHP) Development

The Chief Nursing Officer (CNO) Research Lead, in collaboration with Teesside University, have secured 4 Chief Nurse PhD Fellows in 2024/25 with another 2 planned to start in 2025/26 to develop NMAHP clinical academic careers. In 2024/25 we have 4 NMAHPs beginning an INSIGHT funded research masters programme equating to funding of £31,000. Research has now been included into our quality care accreditation programme (STAQC) and we have introduced the Multi professional Practice Based Research Capabilities Framework to develop practitioners research pillar. To support writing skills for publication/ grants/ research we secured funding for a writer in residence (0.2 WTE) from the Royal Literary Fund. Over 150 staff have accessed workshops or 1:1 writing support since October 2024 from across both trusts.

The CNO Research Lead and Tees Valley Research Alliance (TVRA) Clinical Research Manager have developed a bespoke research placement for student nurses that will now run bi-annually which will increase research placements from 2 per year to 20 per year. We will formally review this pilot and if successful will extend across the University Hospitals Group. Our Research Operations Manager is supporting our non-registered research staff with training and accreditation through the Care Certificate and have 3 members of the team formally accredited as “Clinical Research Practitioners”.

Tees Valley Research Alliance (TVRA) Sponsored studies

The TVRA has been successful in being awarded over £6.7M in grant awards in the last year to conduct their own studies. £40K of this was for general trust sponsored studies, £4.4M for Academic Centre for Surgery (ACeS) led studies and £2.3M for Academic Cardiovascular Unit (ACU) led studies.

We have 20 studies open that have been developed by our own trust researchers that we sponsor and a further 35 under consideration. Further detail is provided in table 5 below.

Trust sponsored studies by support team	Pipeline	Set up	Open	In follow-up
ACU	8	1	6	1
ACeS	7	4	7	2
TVRA team	9	6	7	2
Total	**24**	**11**	**20**	**5**

Table 5 – Trust sponsored studies by support team

We work collaboratively with external academic partners from Teesside, Newcastle, Hull, York and Durham Universities and are proactively developing collaborative research delivery models with colleagues from Primary Care and community pharmacies for vaccine trials.

Innovation

The challenge is an innovation culture to help guide the organisation down the path to Excellence in Healthcare, driving change and improving the quality of care being delivered. Innovation is the art of solving real world problems. We look to improve healthcare delivery creating an environment for healthcare innovation in which we can generate new ways of working, thinking, and engaging with healthcare to produce potentially transformative products and services for the benefit of our patients.

Innovation, alongside Research, is one of the eight domains reporting into the University Hospitals Teees group board through individualised Trust Board Assurance Frameworks (BAF) which outline the risks to achieving our strategic aims. Monthly reporting of progress against the BAF is provided to the Group Quality Assurance Committee.

With the appointment of David Ferguson as Director of Innovation, from April 2024 and interim Director of Innovation for University Hospitals Tees from April 2025, an Innovation Strategy is being developed and is expected to be incorporated across the University Hospitals Tees Group considering expected group working. Further work around the strategy will take place in early 2025/2026 and overall, the organisation continues to develop a culture of innovation and continues the work needed to progress the ideas that staff have raised.

In 2024/25 staff made 22 enquiries to Innovation to develop their own ideas or unmet needs, or to bring innovative ideas into the organisation to improve patient care and of these enquiries, of which 8 are currently undergoing further assessment. 3 are medical devices, 1 is an unmet need and the organisation is reviewing opportunities to find a solution, 3 are software solution ideas and 1 is a service.

Work is ongoing from previous cohort enquiries, with a breakdown of these provided in figure 17 below.

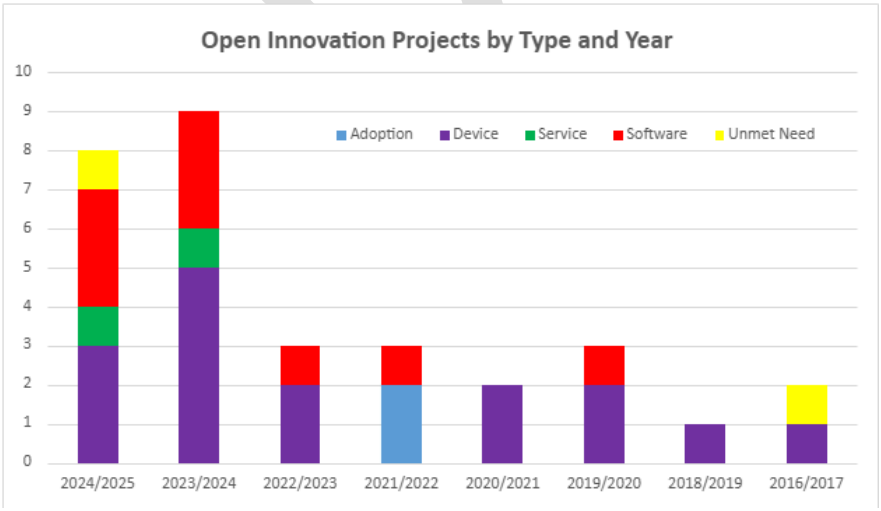


Figure 17 – Open Innovation Projects

Innovation, utilise the Health Innovation North East and North Cumbria (HI NENC) Innovation Pathway (https://innovationpathway.healthinnovationnenc.org.uk/) which consists of 5 gateways: Idea Assessment, Idea Development, Evaluation, Commercialisation, Adoption & Spread. Figure 18 below shows the gateways the open projects are at on the Pathway.

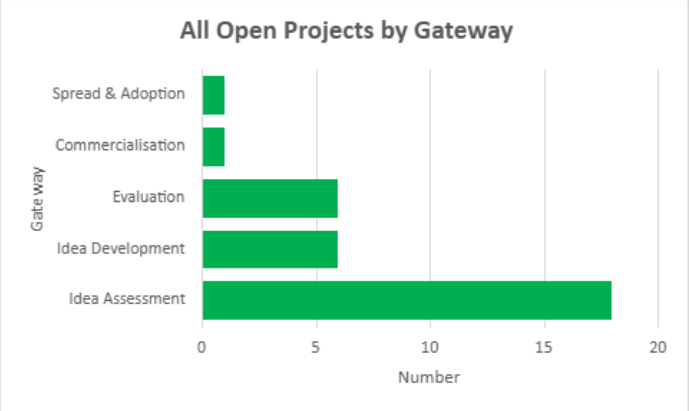


Figure 18 – Open projects by gateway

We have launched Anatostat, a service for advanced surgical planning from an idea raised in 2020. A proof-of-concept service has been in place, and this has received favourable feedback. This opportunity is also now available to the wider NHS and we are looking at opportunities to spread into other public sector areas. In 2024/25, Intellectual Property has been protected in relation to this project via domain names purchased in the name of the service and a Trademark has been secured.

b. STAQC and Ward 12

The South Tees Accreditation for Quality of Care (STAQC) programme was established in July 2020, to provide a comprehensive assessment and assurance of the quality of care within all clinical areas.

Accreditation is linked with organisational success, enhanced patient experience and increased staff morale. The STAQC Accreditation Programme intends to support clinical teams to move to outstanding. This can be achieved through a culture of continuous improvement, empowering strong leadership, reduction of unwarranted variation, and promotion of positive engagement with both staff and patients.

The programme focusses on individual service visits as part of an ongoing agenda of work that will not only provide the opportunity for the organisation to celebrate the good work across our services but to understand the compliance with the fundamental standards of care aligned to the CQC Quality statements. The programme is to ensure that we address any areas of non-compliance through wraparound support but most importantly provides robust follow up to assure the support has worked and the changes have been sustained.

There are 240 ward, teams and departments that are eligible for accreditation. All teams undertaking STAQC are required to complete a preliminary self-assessment against the STAQC standards. From this starting point the STAQC team role is to support and enable ward and department leaders to make the necessary changes to practice, to meet the STAQC standards. The self-assessment document then becomes a work plan and is not fully completed until the point of diamond accreditation. The STAQC team act as enablers and empower the clinical teams to reflect, act and take ownership of the required changes and agree together an improvement plan and readiness for formal accreditation.

There are specialist accreditation tools for inpatients, theatres, paediatrics, maternity, departments, critical care and community areas. In January 2025 an updated version of the inpatient, department and theatre standards were launched which align to the CQC Quality Statements. There is a continued work plan through 2025/26 to continue to update the existing standards.

There has been a continued focus during 2024 to continue with embedding the STAQC accreditation programme into all clinical areas. Baseline accreditations have continued as a starting point to the formal

process, providing clinical areas with a robust action plan and expected timebound actions required to achieve either a gold or diamond accreditation.

Post accreditation assurance checks continue monthly to all diamond areas accredited, with a touch point for managers to offer support and guidance if required. This has proved successful in maintaining standards and keeping STAQC at the forefront.

Total achievements at end of year			**Key actions for STAQC team**
	2023/24	**2024/25**	• To maintain a comprehensive work plan, transparent to all teams. • To continue to roll out new updated standards aligned to quality statements • To maintain a constant focus on shared ownership. • To undertake research/service evaluation into the impact of the programme.
Diamond accreditations	40	56	
Gold accreditations	52	66	
Baseline accreditations	17	34	

Table 6 – STAQC accreditations by level of achievement

Case study on Ward 12 (Older Persons Medicine) STAQC journey

Ward 12 is a 27 bedded ward which specialises in acute older persons medicine (OPM) - care of those 65 and over. The multidisciplinary team provide treatment for a variety of patients with a range of complex health needs both physical and mental and therefore uphold how essential parity of esteem is in administering quality and holistic care. The ward typical admits, cares for and discharges between 60-70 patients per month.

The vision for the ward is to provide the highest quality specialist multidisciplinary care to older people in an environment that is both supportive and friendly but also with an ethos of continuous improvement. The ward has been on a significant journey over the past four years, changing specialities from caring for COVID 19 patients to a short stay unit then to OPM. These multiple changes resulted in challenges with retention, recruitment and the morale of staff. Joining OPM has had a positive impact on the ward, the team now have no vacancies and are continuing to work on creating a skilled workforce, dedicated to the care of the older persons. The team have achieved this through introducing new ways of working, provided with structure and introduced to new processes, all of which significantly improved patient care and staff wellbeing and morale, culminating in a more empowered and resilient workforce.

Throughout the STAQC journey, engagement from the team meant they were able to use the accreditation standards to drive and support the development of the ward, investment in the team, training, and development of the staff.

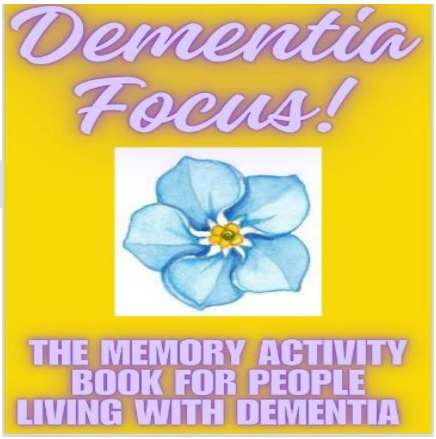
The unit was accredited a Diamond STAQC award in August 2024. Some of the areas of excellence included:

- Excellent environmental work undertaken, to make the ward accessible for patients with dementia, learning disabilities and sensory impairments.
- The investment of the team in terms of learning, development and training to ensure they have the skills needed for providing excellent care for the older person.
- An integrated MDT approach to care was witnessed on the ward with medics, AHPs and nurses working closely together to meet the needs of the patient, the MDT room at the end of the ward is a positive addition as it helps to facilitate these relationships.
- Robust processes were in place around documentation and all appropriate care plans and risk assessments were witnessed and care was detailed and tailored to the patients' needs.
- The creation and implementation of a patient information leaflet for patients and relatives, to share vital information about the area and ward routine, to help enhance communication and the patients experience.
- Excellent service improvement projects to enhance the safety on the ward, such as the introduction of a triangle in the bedspaces as a visual reminder for all staff the patient is at high risk of falls and

the use of clock faces to prompt the regular movement of patients at high risk of pressure ulcers is to be commended upon.

- The inclusivity and diversity of the team, the ward recently won a prize for the cultural diversity board they created, to celebrate this they held a tea party providing the different cuisines from the countries their staff represent and colleagues' dresses in their national dresses.

- Excellent teaching programme created by Advanced Care Practitioners (ACP's), this is held weekly and is tailored around patient safety/training needs identified from the medical team and the ward. This learning is enhanced with SIM and VR headsets.
- One of the ward sisters Katy has devised a welcome pack for patients with dementia. This includes a forget me not, carers passport, car parking concessions and a dementia activity book. The dementia activity book helps to encourage family involvement and cognitive stimulation, this is in the process of being rolled out throughout the rest of the organisation and is to be commended upon.



- During Dementia Action Week, the team planned a full week of activities raising awareness of dementia and delirium. They held a tea party to which family members were encouraged to attend and invited a singer to provide entertainment for the patients. This is just another example of how the ward go above and beyond for their patients.

Well done Ward 12!

Summary

The plan for 2025/26 is to achieve eight accreditations per quarter. This is based on the STAQC team capacity and redeployment, team preparedness and engagement and operational pressures.

c. Digital Transformation

In 2020 the organisation instructed our digital provider to deliver a single platform Electronic Patient Record (EPR) and provide integration with existing systems.

The MIYA Programme team was established in 2021 to drive the digital transformation journey. The multidisciplinary approach towards implementation has contributed to continued success.

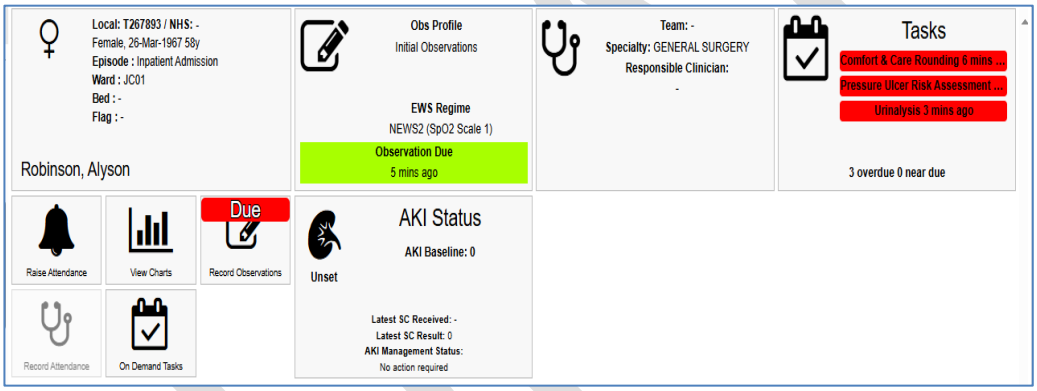
Patientrack

Digital electronic observations have been embedded in adult inpatient services since 2014. However,

Patientrack was introduced in 2021 to supersede the existing platform and introduce further modules and assessments, leading to 22 paper assessments being digitised so far.

Key Benefits

- Organisational oversight of unwell patients
- Tasks are automatically scheduled
- High visibility
- Remotely accessible
- Accessible by multiple users
- Role specific access
- Real time data and reporting



Electronic Prescribing and Medicines Administration (ePMA)

In 2022 ePMA replaced paper medication management and is currently live in all inpatient areas excluding Critical Care and the Neonatal Unit. The remaining areas, including Outpatient areas and Day Units are scheduled to go-live over the next year.

Key Benefits

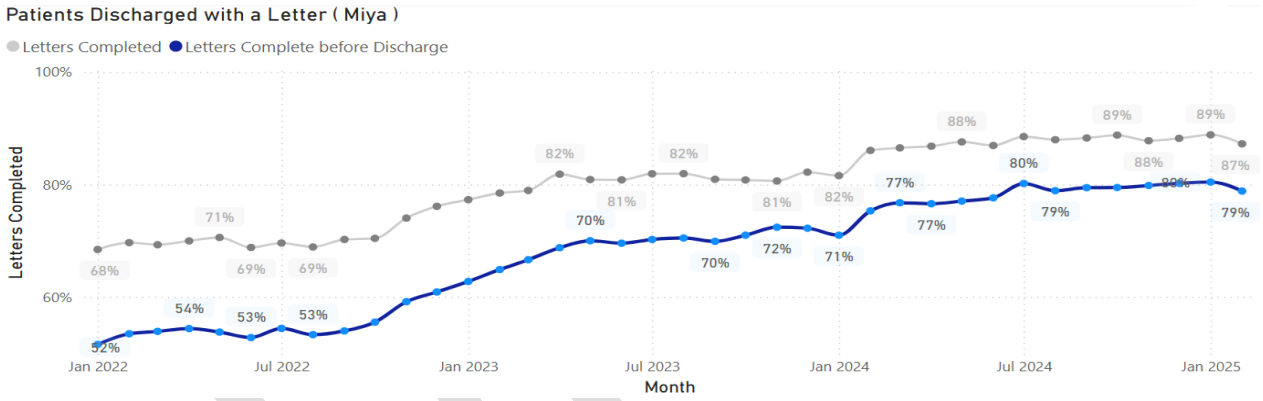
- Clinical decision support which highlights known interactions and contraindications with medications
- Pre-configured order sets which are validated sets of medication to support prescribers with minimising errors and omissions
- Full traceability
- Clear and accurate prescriptions aiming to reduce medication and transcribing errors
- Eradication of mislaid paper charts
- Improved efficiency
- Cost savings in stationery
- Remotely accessible

Electronic Discharge

A new discharge letter solution on MIYA was also introduced at the same time as EPMA to improve integration between medicines management and discharge letters. The discharge letter is populated from the EPR with the patients discharge medication automatically, and sent electronically to the patients General Practitioner (GP).

Key Benefits

- Reducing omissions
- Reducing transcription errors
- Increases time to care
- Improves efficiency



Smartpage

Smartpage was introduced to replace the existing Hospital @ Night system. Requests are triaged by the critical care outreach team, who allocate all requests to the designated team members. Requests are allocated and prioritised related to acuity of illness and clinical requirement. The system enables organisational oversight of both acuity of illness and workload.

Key Benefits

- Organisational oversight of workflow, service demand and patient acuity
- Highly visible
- Remotely accessible
- Real time data
- Promotes communication between clinical areas and medics

Clinical Noting

Miya Noting allows for documentation of patient care to be recorded electronically by the multi-disciplinary team. It was introduced into the organisation in October 2023, with 40 areas now live. This

includes specialist documentation in areas such as Surgery, Orthopaedics and Cardiology. The remaining areas are planned to go-live over the next 6 months.

Key Benefits

- MDT notes in one location – AHP's/Nurses/Doctors
- Accessibility – more than one health professional can document at one time
- Remote access by specialist teams
- Legible documentation
- Ability to set tasks whilst documenting
- Fully auditable

Bed Management

Access and Command is a bed management system which allows ward transfers to be requested and allocated electronically, supporting the Site Team to acquire real-time and accurate visibility of organisational bed capacity, demand and patient status. This promotes efficient and effective communication between the department staff and the Site Team.

Key Benefits

- Accurate real time visibility of organisational bed capacity
- Promotes communication between site team and clinical teams to enable patient flow
- Enable early identification of delayed discharge
- Appropriate decision making to optimise bed utilisation

Patient experience and involvement indicators

a. Patient surveys – national and local

Examining feedback from patients gives the organisation a direct insight into what is working well – and not so well – in the way we deliver care. From the feedback we can share across the organisation examples of good practice in order to learn and make improvements.

Local Trust Surveys and Friends and Family Test (FFT)

There are currently 64 patient surveys utilised in the Trust covering all wards, departments, and community services. All responses are reviewed by the Patient Experience Team.

The FFT question is included in most of our local surveys. It invites feedback on the overall experience of using a service and offers a standardised range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience, and results can be compared with other trusts.

Data from April 2024 to January 2025 shows the Trust is above the national average for the percentage of people with a positive experience of inpatient, A&E / UTC, Outpatient, and Community Services.

		2024/25			
		Response Rate		% positive experience	
		Trust	England	Trust	England
Inpatient		16%	21%	98%	95%
A&E		9%	11%	80%	79%
Outpatient		14%	15%	97%	94%
Community		8%	4%	98%	94%
Maternity	Antenatal			91%	92%
	Birth	16%	12%	91%	92%
	Postnatal ward			91%	92%
	Postnatal community			94%	93%

Table 7: Inpatient, A&E/UTC, Outpatient, Community and Maternity FFT results benchmarked against national results (April 2024 – January 2025). Data source NHS England.

The Maternity FFT surveys patients at four touchpoints (antenatal, birth, postnatal inpatient, and postnatal community), and overall results for the Trust are slightly below the national average for antenatal care, birth care and postnatal ward care. The results for postnatal community care are above the national average.

National Surveys

The Trust participates in several national surveys run by the Care Quality Commission (CQC). The published reports are scrutinised to assess trust performance compared to previous performance, the performance of local trusts, and the national average scores. Action plans are developed to address any areas for improvement, and these are monitored by the Patient Experience Steering Group. The key findings of the most recently published National Adult Inpatient Survey are summarised in Section 2.3.

National Urgent and Emergency Care Survey – Type 1 Accident & Emergency Department

The latest National Urgent and Emergency Care Survey report was published by the Care Quality Commission on 21 November 2024. There were 35,670 responses received, with a national response rate of 26%. The sample for the survey included patients aged 16 years or older who attended Accident and Emergency Care services during February 2024. Each NHS trust selects a sample of 1,250 patients, by including every consecutive attendance that met the eligibility criteria, counting back from 29 February 2024.

In total 120 NHS trusts with a Type 1 accident and emergency department took part in the survey. We had a response rate of 24.14%, with 224 patients responding to the survey. There were slightly more female respondents than male. Most respondents were aged over 66 years of age, and the ethnic group was predominantly white.

We scored ‘Better than most trusts’ in one question, ‘About the same’ as other trusts in 26 questions and somewhat worse than most trusts in two questions. The question we scored ‘Better than most trusts’ in, to what extent did you understand the information you were given on how to care for your condition at home? The 2 questions we scored ‘Somewhat worse than most trusts’ in, were regarding being able to get food or drinks whilst in A&E. Being given information on how to care for a condition at home, including any verbal, written or online information.

Following a review of the survey results and patients comments an action plan was developed. These included privacy for discussing conditions with reception staff and computer screens readable by patients with other patients’ details. Within the new build of the Urgent Treatment Centre (UTC) and the redesign of the reception area a new ‘booking in area’ commenced on 6 January 2025. This provides a dedicated area for patients who wish to disclose confidential information privately. The staff reviewed the positioning of laptops and computer screens to ensure patient information is not accessible by patients waiting in cubicles.

Comments were received in regard to the waiting times, being informed of how long to be examined or treated, and being kept updated on wait time. Our Emergency Department (ED) has procured a visible and audible display which provides updated information on waiting times and other key messages. This is updated by the triage nurse on an hour by hour basis ensuring key messages for UTC, ED and the Children & Young Person Department (CYPED) are presented.

The environment, access to food and drinks was one of the lower scoring questions. The department has installed a water station for the main waiting area and a snack station for patients, which includes biscuits and bottled water. Volunteers and the Serco team provide regular refreshments to all patients in the department. Patients commented that there were not enough seats in the waiting area. It is expected that the streaming of patients at Reception will ensure there is enough seating available for patients. Patients are asked to attend with only one family member where possible to prevent overcrowding in the waiting area.

Patients felt they were not involved in decisions about their care and treatment. Discussions with all the medical and nursing teams have taken place to emphasise the importance of engagement with patients, carers and family members. The clinical team will continue to review feedback to determine if improvements are being achieved.

It was identified that discussions about further health or social care services needed after leaving ED and, information on how to care for their condition at home, was not adequate. The frailty team now have a cubicle in the ED to ensure there is an opportunity for in-depth conversations with patients who have complex needs, prior to discharge. Safety netting advice includes who the patient, carer or family member should contact if they have any concerns, including the district nurse, GP and social care information.

National Urgent and Emergency Care Survey – Type 3 – Urgent Treatment Centre

The latest published National Urgent and Emergency Care Survey report was published by the CQC on 21 November 2024. The NHS National Survey involved 120 acute NHS trusts in England, of these 70 had direct responsibility for running a Type 3 department. There were 10,325 responses received, with a national response rate of 26%. The sample for the survey included patients aged 16 years or older who attended Urgent Care services during February 2024. Each NHS trust selects a sample of 950 patients, by including every consecutive attendance that met the eligibility criteria, counting back from 29 February 2024.

We had a response rate of 27.14%, with 152 patients participating in the survey. There were significantly more female respondents than male respondents. Most respondents were aged over 66 years of age, and the ethnic group was predominantly white.

We scored 'About the same' as other trusts in 26 questions and worse than most trusts in one question.

Following a review of the survey results and patient comments, an action plan was developed which included a focus on the following areas of work;

- The patient's communication needs were not identified by staff during the booking in process. Communication needs posters are displayed on the doors of reception and reception staff ask the patient if they require any additional communication needs. This is identified on the IT system with any communication needs with symbols (ear – hearing, eyes – visual impairment, butterfly – autism). We procured the services of a new translation and interpretation provider in November 2024, which should improve the timeframe for providing translation and interpretation.

- It was identified that our pain management whilst in the Urgent Treatment Centre was not as good as it could be. The staff have introduced pain score evaluation on triage and pain relief is given. The pain score is evaluated to monitor the effectiveness of the pain relief. The staff use the Tannoy to inform patients to ask staff if they require more pain relief.

- The patients identified that that there was no access to food and drinks. A hydration trolley has since been installed in the department, providing water and juice, a vending machine is available. Signs have been placed around the department informing patients that they can ask for bottles of water.

National Cancer Patient Experience Survey

The most recent National Cancer Patient Experience Survey report was published on 18 July 2024 for the survey carried out in April - June 2023. This survey involved 132 NHS Trusts with 121,121 people responding to the survey nationally, yielding a response rate of 52%.

Within our Trust, 1369 patients were invited to take part in the survey. 722 surveys were completed with a response rate of 53%. 50% of respondents identified as female, 44% identified as male and 6% did not state gender. 63% of respondents were aged between 65 and 84. 91% of respondents were from a white British background. This is a similar pattern to survey results within previous years.

Patients were asked to give an overall rating of care within the trust with a range of 0 – 10. 0 being very poor – 10 being very good. We received an overall score of 8.9. This was an slight improvement from 8.8 in 2022.

We scored above the expected range in three questions. We also scored higher in these questions in comparison to 2022 scores and the national average. We scored below the expected range in two questions. The trust also scored lower in these questions in comparison to 2022 scores and the national average.

We scored higher than the national average for overall care in breast, haematology, upper gastroenterology, colorectal, head and neck, urology, gynae-oncology and skin. The trust scored slightly lower than the national average in overall care within the lung tumour group but only by a very small margin.

On review of the results and comments, an action plan was developed. Individual departments were asked to review the results by tumour site and develop their own action plan. It was identified that we needed to improve our staff's ability to communicate and explain treatment options. There is an ongoing investment in communication skill training. We need to improve waiting times for treatments and clinic, in particular, haematology, lung and upper gastrointestinal. There is ongoing liaison with the specific multidisciplinary teams to review and reduce waiting times.

Patients are able to access appropriate support in the community and voluntary sector. There has been a review of support services available within the community, with colorectal and upper gastroenterology teams. And liaison with the Macmillan Information Centre Lead to ensure visibility of their service and specific support into the Upper Gastro and Colorectal teams.

There are also wider actions related to ongoing administrative processes to ensure more timely appointments and patient receipt of letters which has been part of wider trust improvements. There is ongoing work across the region with the lead cancer nurses to ascertain areas of improvement and to provide support and learning from other trusts who have shown improvements in their results.

<u>National Maternity Survey</u>

The most recent National Maternity Survey report was published by the CQC on 28 November 2024.

The survey asked for feedback from individuals aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 29 February 2024 on their experiences of antenatal care, labour and birth, and postnatal care.

We had a response rate of 38%, with 125 patients participating in the survey from the 335 service users invited. More than half of respondents were aged over 30, the ethnic group was predominantly white, and respondents' religious group was mainly no religion and Christian. 53% of responders had given birth to their first baby.

Compared with 120 other NHS Trusts, the organisation scored 'About the same' as other trusts in 26 questions. 'Better than expected' in one question and 'Somewhat better' than expected in five questions. The trust did not score worse than expected in any questions. We performed statistically significantly worse than 2023 results in 2 questions, relating to the postnatal period. There was no significant difference in scores from 2023 for the remaining 44 questions.

Following a review of the results and survey comments, an action plan was developed with the clinical staff. Work commenced around personalised care, using the service user voice to create videos to share with staff. The Birth Reflections service was advertised and there was an increase in the availability of this service. The discharge video was updated to ensure that the information provided was relevant. A review of the visiting was undertaken as some of the comments raised were relating to a partner or someone else close to the patient involved in their care being able to stay as much as you wanted. This is managed on an individual basis considering the privacy and dignity for all patients. Pain management after the birth was also raised in the comments and medication 'lock boxes' were ordered. This will allow patients to access pain medication timelier, improving staff 'time to care'. Comments were received about

the tongue tie service as the patients felt they were not listened to. The Tongue Tie Service is becoming embedded in the organisation and is improving the experience of the patients utilising this service.

b. Patient Experience and EDI

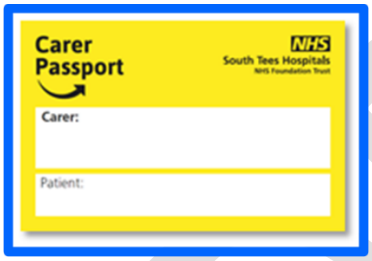
Equality of service delivery to different groups within the NHS is for everyone. Anyone needing the NHS should receive the same high-quality care every time they access services. However, we know that some people in our communities can experience barriers or judgement when using NHS services.

We recognise the challenges that patients and service users could face, including language barriers, support to access services or stigma regarding accessing mental health services. Understanding our patient and service user needs is our priority as it helps us to ensure our services are accessible, safe and inclusive for everyone.

We are committed to identifying, understanding and overcoming any barriers for our patients and service users. This ensures that the way we work and the services we offer respond inclusively to cultural, physical and social differences.

Our Health Inequalities Group provides direction and oversight to ensure the organisation focuses on reducing health inequalities in the most vulnerable groups and national/local clinical priority areas.

Commitment to Carers
We value the fundamental role carers have in securing the health, comfort and welfare of the people they care for. We identify a carer as a person of any age who provides unpaid help and support because of their illness, frailty or disability. This could be for a parent, child, partner, relative or close friend. Including carers in care and treatment offers better outcomes for the patient and creates a fuller picture of a patients' needs.



A Carer's Passport is for a patient's main carer providing;

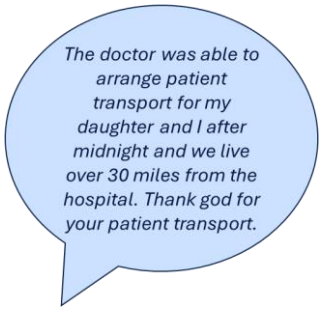
- An opportunity for carers to visit out of hours, which reassures patients and makes them feel at ease.
- The option to stay overnight as required.
- Free or discounted car parking for carers visiting regularly.
- Active involvement in the meetings and discussions about the patient's care needs.
- An understanding that the carer can support with feeding, dressing and other aspects of care.

We work closely with carer support agencies, including, Carers Together who are an organisation that serve Middlesbrough and Redcar and Cleveland and, Carers Plus who serve North Yorkshire. They are dedicated to improving carers' quality of life. We worked in partnership with Carers Together, developing the Hospital Discharge: A Guide for carers, to support the transition of patients and their carer from hospital to home. The hospital discharge guide provides useful information to carers to support this process.

We are committed to hearing and understanding our carers experiences, using our carers survey. The Patient Experience Team contact the carer following discharge from our care, to complete the survey. The results of the carers survey are presented at the Patient Experience Steering Group, to identify areas of work, to improve the patients and carers experience.

We collect quantitative and qualitative data which is used to highlight positive outcomes but also what we need to address.

Patient Transport
Some people who have a medical need can receive transport to and from hospital through non-emergency patient transport services (PTS). The trust has identified and actively applied a criteria to ensure that patients who are receiving the service are eligible to be in receipt of NHS public funded transport. When speaking to patients, here are examples of comments about the PTS.



c. Patient Experience Involvement Bank

The Patient Involvement Bank was established in August 2022. Since that time involvement bank members have been offered a variety of projects, focus groups and improvements to be involved in.

During 2024/25 the involvement bank members have provided feedback or attended events organised at the Trust to share their thoughts and offer feedback. This supports our staff to see and understand the patient's perspective and very often change how we deliver our services.

Listed below are examples of ways that our involvement bank members have provided support;

- The Personalised Care Lead requested feedback from our Patient Involvement Bank on the poster for the Shared Decision-Making guidance.
- The Ask 3 Questions is a new strategy that will be implemented to support patients when making decisions about the treatment and care they receive.
- Patients from our involvement bank shared their thoughts on the poster which supported making crucial changes to the poster.

Ask 3 questions

Emergency Care – Mental Health Study Day

The Emergency Department (ED) held a mental health study day for their staff. Volunteers were from the Recovery Connections, a charity based in Middlesbrough, who support people recovering from a drug or alcohol addiction shared their lived experience of mental health struggles whilst visiting the ED. This made a difference to the staff's understanding of the patient's perspective, which allowed them the opportunity to talk about how practice could change to offer more empathy and support for patients who attend with drug and alcohol problems.

Our fantastic volunteers have also offered to support staff with patients whilst in the ED.

Supporting our Neurodivergent Patients: A workshop on Autism and ADHD
Patients from the Neurodiverse Group attended the staff Autism and ADHD training to share their experience while attending the hospital. The feedback from the staff was very positive, as staff were able to understand from the patient's perspective the need for reasonable adjustments being in place to support them whilst being in the hospital environment. Further work is in development, with the Neurodivergent group, to create a podcast to be used during training sessions.

Epilepsy
One of the Trust Consultant Neuropsychologist reached out to patients with epilepsy to support some teaching at Teesside University to a group of trainee clinical psychologists. The patients attended to share their experiences of living with epilepsy, which brought greater insight for the staff on the training session. The patients have been invited to be involved in the session next year.

Radiology pre-assessment project
A new pre-assessment system for patients attending for radiology procedures has been developed. The new system is being trialled and assessed by patients and our patient involvement bank members.

Water inflated pessary event
A patient focus group, for patients who currently use Gellhorn pessaries for vaginal prolapse has taken place. The discussion during the Focus Group meeting, was led by the patients, who fed back much qualitative information around their experiences of the pessary. This led to some innovative ideas around future goals for a new pessary design.

Psychology and therapy in Cancer Services leaflets
The psychology service were keen to increase accessibility to cancer patients and receive feedback from patients about their webpage and leaflets. The online materials have been shared with patients who have or are recovering from a cancer diagnosis. From their own experiences, they have been able to share their experiences between diagnosis and the first appointment. They have also commented on the relevance of the leaflets. The leaflets have also been shared with the patient involvement bank members. Feedback has been that written materials do not cater for all, and it has been suggested mini videos are added alongside the written content. Also, the leaflet that suggests and explains mindfulness activities needs videos to demonstrate the activity. This project is ongoing with support from the patient involvement bank.

Academic Centre for Surgery
Support was needed with the CAREFUL study (Continuous Arterial monitoring in Elderly and Frail patients for hip fracture surgery to prevent low blood pressure).

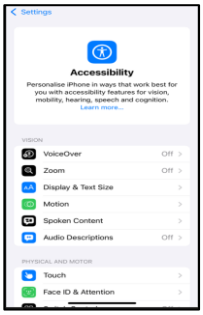
The team needed patients to share their views on a research project to improve the care provided for patients with broken hips. Representatives from the Involvement Bank and the public at community groups, attended the focus group session. Feedback was very positive; with lots of discussion and ideas generated.

AHP research
The AHP Professional Lead gathered feedback from our internal reporting system (Datix) to identify themes for future projects and gathered feedback from service users and carers in the community to find out what is working/not working and how access to services can be improved. Conversations with patients and carers provided valuable qualitative information. Community groups were also visited including Teesside Stroke Group, Dementia Action Teesside and Senses Wellbeing CIC where further information and suggestions for improvements was offered.

Lung Cancer Expert Patient Panel
A lung cancer expert patient panel has been set up for The James Cook University Hospital and Friarage Hospital. The panel will provide support to patients who are on the pathway to recovery.

Patient menus
Feedback from Teesside Society for the Blind suggested that the patient menus needed to be more accessible, taking into consideration;

- The average reading age of the local population is 9 years.
- If patients cannot access the menu, a member of staff reads the options out.
- Font size is not accessible for some patients.
- Meal codes can make menus confusing and overwhelming.
- Images/photos of the meals can support with meal choices.
- Glossy and eye-catching menus.



Following the feedback the menus were uploaded to our internet page for patients to access via the website. We shared this with the Teesside Society for the Blind, for them to access the menu via the website. Using the website, they were able to increase the font size, and those who had the accessibility function on their phone were able to listen to the menu being read out.

The response to this from the sight impaired community was positive. They felt their input made a change to the accessibility of the menu, which met their needs

Translation and Interpretation Service
In November 2024, we commissioned Everyday Language Solutions, to provide foreign language and British Sign Language Translation Services 24 hours a day, 365 days a year, to our patients, carers and their relatives. Early indication is that the service is receiving positive feedback from the staff using the service. It is positive that incidents reported about translation and interpretation has decreased.

Patient Engagement Portal
The Patient Engagement Portal (PEP) was rolled out to all patients at the beginning of 2024.
It is a text message service that provides digital letters and communication to patients. It aims to improve patient experience and safety, reduce use of paper and save time.

There have been some suggestions made from patients to improve the PEP, and we understand that this form of communication does not work for everyone. Patients are still able to receive paper copies of their letters, should they wish.

Feedback has included:

Veteran Aware

As a Veteran Aware organisation, we aim to provide the highest standard of care for the armed forces community, based on the principles of the Armed Forces Covenant. The Armed Forces Covenant is a promise by the nation ensuring that those who serve, or who have served, in the armed forces, and their families, are treated fairly. We were supported by Help for Heroes to recruit a Help for Heroes Nurse to support patients who are members of the Armed Forces, Reservists and Veterans.

The role of the Help for Heroes nurse ensures that;

- Specifically designed information and leaflets for our Armed Forces patients are provided, using a poster with QR codes.
- Patients and their family members are identified as being employed, or a family member of a patient who is serving or has served in the Armed Forces.
- Regular pastoral visits to support patients.
- Support services are in place following discharge from hospital.
- Veterans are signposted to the H4H Recovery College which is designed specifically for the Armed Forces Community.
- Free courses are provided to help manage physical and mental well-being.

Patient Stories

Patient stories are a continuous improvement tool to support improvement of services and patient and carer experience, through listening and learning from the patient voice.

Patient stories can be positive, negative, or combine elements of both. Through patient stories we capture evidence of the quality of services, share the learning about what was good and what needs to be improved with the clinical teams, and then take forward any improvements identified together.

Patient stories are collected face-to-face with the patient, carer or relative, and provide an opportunity to ask for more information or clarity where needed about what the patient experienced, to help to identify where improvements can be made. A patient story captures the patient's experiences from their point of view and this enables us to focus on what matters most to the patient.

3.2 Performance against key national priorities

AWAITING DATA REFRESH

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	24/25 Targets
All cancer – 62 day wait for first treatment from											
Urgent GP referral for suspected cancer	**79.10%**	**81.10%**	85.44%	**82.65%**	**77.23%**	**75.52%**	**73.83%**	**60.40%**	**57.8%**	**57.8%**	85%
NHS Cancer screening service referral	**89.80%**	**89.00%**	94.55%	**87.14%**	94.41%	**62.77%**	**50.00%**	**68.71%**	**55.0%**	**29.4%**	90%
18 weeks referral to treatment time (RTT)											
Incomplete pathways	93.20%	92.20%	**91.45%**	**89.49%**	**83.33%**	**63.20%**	**65.37%**	**65.99%**	**63.78 %**	**60.12%**	92%
Accident & Emergency											
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	95.80%	95.33%	95.68%	95.24%	**88.35%**	**87.25%**	**75.52%**	**68.22%**	**67.33 %**	75.01%	95%
Diagnostic Waits											
Patients waiting 6 weeks or less for a diagnostic test	**98.82%**	99.15%	**97.46%**	**98.26%**	**94.04%**	**72.57%**	**68.71%**	**77.57%**	**76.06 %**	85%	99%

Table 8: Performance against national priorities

Key findings:

Cancer waiting times

- Our 2024/25 year end performance for the all cancer 62-day wait for first definitive treatment for suspected cancer was 61.0% (February 2025). This includes 73.6% compliance for consultant-led upgrades, 56.3% compliance from screening (smaller numbers, average 5 per month), and 52.7% compliance for patients referred from their GP as urgent suspected cancer.
- At the end of March 2025, 154 patients were waiting more than 62 days for first definitive treatment. Clinical harm reviews are undertaken for assurance on all patients exceeding 104 days.
- In February 2025 South Tees Hospitals NHS Foundation Trust was placed into NHS England performance oversight regime Tier 2 for cancer 62-standard. This provides rigorous oversight of the Trust's improvement plans for this standard.
- In addition to accountability to the NHSE tiering performance meeting, cancer action plans are routinely reviewed and monitored through the Cancer Delivery Group, informed by a programme of pathway reviews.
- Improvement and sustainability plans are focusing on prostate diagnostic pathways, radiotherapy demand and capacity, histopathology turnaround, amongst other actions. The positive impact of these changes on patient pathway duration will be evident from June 2025.

Key Performance Indicator	Period	Target	Performance	SPC	Regional Rank (out of 8)	National Rank (out of ~136)	National Centile
Cancer 2 Week Wait	Feb-25	93%	71.9%		-	116/133	13
Cancer 28 Day Faster Diagnosis	Feb-25	77%	75.9%		7/8	114	14
Cancer 31 Day All Stages	Feb-25	96%	86.8%		7/8	124/135	8
Cancer 31 Day First Treatment	Feb-25	96%	90.7%		7/8	109/135	19
Cancer 31 Day Subsequent Treatment	Feb-25	96%	82.1%		7/8	117/133	12
Cancer 62 Day All Routes	Feb-25	85%	61.0%		8/8	106/134	21
Cancer 62 Day Consultant Upgrade	Feb-24	85%	73.6%		6/8	105/134	22
Cancer 62 Day Screening	Feb-24	90%	56.3%		5/8	73/124	41
Cancer 62 Urgent Suspected	Feb-24	90%	52.7%		7/8	107/130	18

Table 8 - Performance against cancer headline standards

- Please note that the '2 week wait' standard is no longer a nationally reported standard, however it is reported for completeness and continues to be monitored internally to support pathway improvement.

Elective care performance

- For elective care (referral to treatment target), the focus is on reducing the number of patients waiting the longest for non-urgent treatment. Few patients waited more than 78 weeks for treatment during the year, and by the end of March 2025 the number of patients waiting more than 65 weeks was reduced to 47. However the number of 52-week waits and overall waiting list remained high and above 23/24, driven by increasing referrals and capacity constraints in some specialities.
- In 2025/26 we will work to eliminate waits greater than 65 weeks and reduce 52-week waits to less than 1% of the waiting list, as well as improving overall compliance with referral-to-treatment within 18 weeks from 60% to 65%.
- This will be achieved through improvements in productivity (such as theatre and clinic utilisation), booking processes (ensuring patients are seen in date order so far as possible and clinically appropriate) and waiting list validation (ensuring patients are not waiting for an appointment or treatment where there is a more suitable alternative).

Diagnostic performance

- Diagnostic performance improved throughout 2024/25, with 87.2% compliance with 6-week standard at end March 2025. The Trust has a trajectory to 94.1% compliance in aggregate across the 9 modalities reported for national planning, by March 2026.
- Improvement in performance in 2025/26 will be enabled by increased capacity, with the opening of the Tees Valley Community Diagnostic Centre in April 2025.

Urgent and emergency care performance

- Performance against the A&E 4-hour standard improved by over 5% in 2024/25 to 75.5% in March 2025, but fell short of our agreed trajectory to reach 77% by end March 2025. Performance in the three Urgent Treatment Centres consistently exceeded 95%.
- The James Cook University Hospital Urgent Treatment Centre opened in April 2024 and provides a more appropriate care setting than an emergency department for more minor illness and injury, reducing delays in care for these patients and producing a step change improvement in 4-hour waits overall. However, performance at Trust level dipped during the winter months due to the impact of seasonal pressures leading to a greater volume and acuity of illness than seen in 2023/24. This resulted in high bed occupancy impacting on patient flow despite the implementation of beneficial initiatives such as continuous flow to the receiving wards, additional non-invasive ventilation capacity and patient transfer teams. Work to optimise patient flow, and alternatives to

ED for appropriate patient cohorts, will continue in 2025/26 to meet the agreed trajectory of 78% by end March 2026.

- To support the regional ambulance service response times, the Trust has focused on reducing ambulance handover delays. Joint working protocols are embedded and staff allocated to care for patients arriving by ambulance to release the ambulance crews. The focus for 2025/26 will be on minimising any handovers taking longer than 45 minutes.
- For 2025/26 there is continued focus on reducing ambulance handover delays in order to release ambulance crews ready to respond to their next call, supporting ambulance service response times, and ensuring patients do not spend more than 12 hours in the ED, reducing clinical risk for patients who require admission.
- In community services, urgent response times consistently exceeded the national target throughout the year, and additional hospital at home capacity was created to care for over 100 patients at home in the peak winter months.

3.3 Additional required information

Seven-day services

Ten NHS Seven Day Hospital Services Clinical Standards were developed in 2013 to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges. The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week. Full details of all the clinical standards are available at: NHS England Seven-day-services clinical standards. Trust Boards should assess, at least once a year, whether their acute services are meeting the four priority seven-day services clinical standards, using an updated board assurance framework (BAF) and guidance published in February 2022.

After the challenges of the COVID-19 response, the BAF for Seven Day Services re-focused attention on the four key standards. A full assessment against these standards was completed for STHFT in September 2022.

Repeat audit March 2025 shows that the Trust remains in a position of not being comprehensively compliant with Standard 2, ‘consultant review for all new admissions within 14 hours’, in every specialty throughout the week. This is due to more limited duration consultant presence on-site at weekends in specialities with smaller numbers of emergency admissions. The Trust is assured of timely senior clinical assessment for patients admitted as an emergency in all the higher volume specialties and when the patient is unwell or deteriorating. The Trust wide roll out of electronic patient records enables monitoring of the timely assessment and review of patients.

The Trust is also assured that arrangements are in place for daily senior review, and that there is safe access to diagnostic and consultant-led interventional services over the seven-day period, demonstrating compliance with these standards. In addition, the Trust is working with regional provider and commissioning colleagues to implement 7-day access to the mechanical thrombectomy hyper-acute stroke intervention, as a national clinical priority.

Freedom to speak up

The Freedom to Speak Up (FTSU) Guardian service, is providing a framework to ensure that we support our workers to do the best job that they can, to keep our patients safe, through the delivery of high-quality services. This is by offering a robust service that empowers workers to speak up about anything that concerns them, this feedback can then be used to inform future strategies to support our continual learning and improvement.

The Guardians Team continue to work to improve the Speaking Up Culture throughout the organisation by raising awareness of FTSU and other routes by which colleagues can raise concerns, tackling barriers to speaking up and by ensuring that issues raised are used as opportunities for feedback, learning and improvement. The FTSU Guardians act as independent and impartial sources of advice to staff, supporting staff to speak up when they feel unable to do so via other routes and ensuring that an appropriate person reviews the issues raised and provides feedback on the action taken. This is an evolving service as we align ourselves with changing national guidance, organisational IT systems and the Group system of working.

Table 9 shows that a total of 153 concerns were raised with the Guardian Team between April 2024 - March 2025 compared to a total 125 in the previous 12 months. This represents an overall increase of 22.48.% year on year. The number of concerns raised anonymously during 2024/25 was 63 which is an increase of 13.16% based on last year's data.

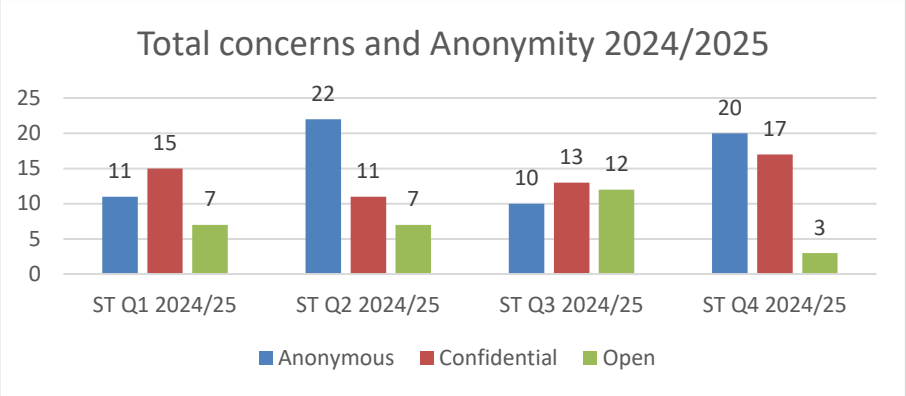


Table 9 – total concerns raised

Table 10 shows the high-level themes recorded against the concerns received in 2024/5.

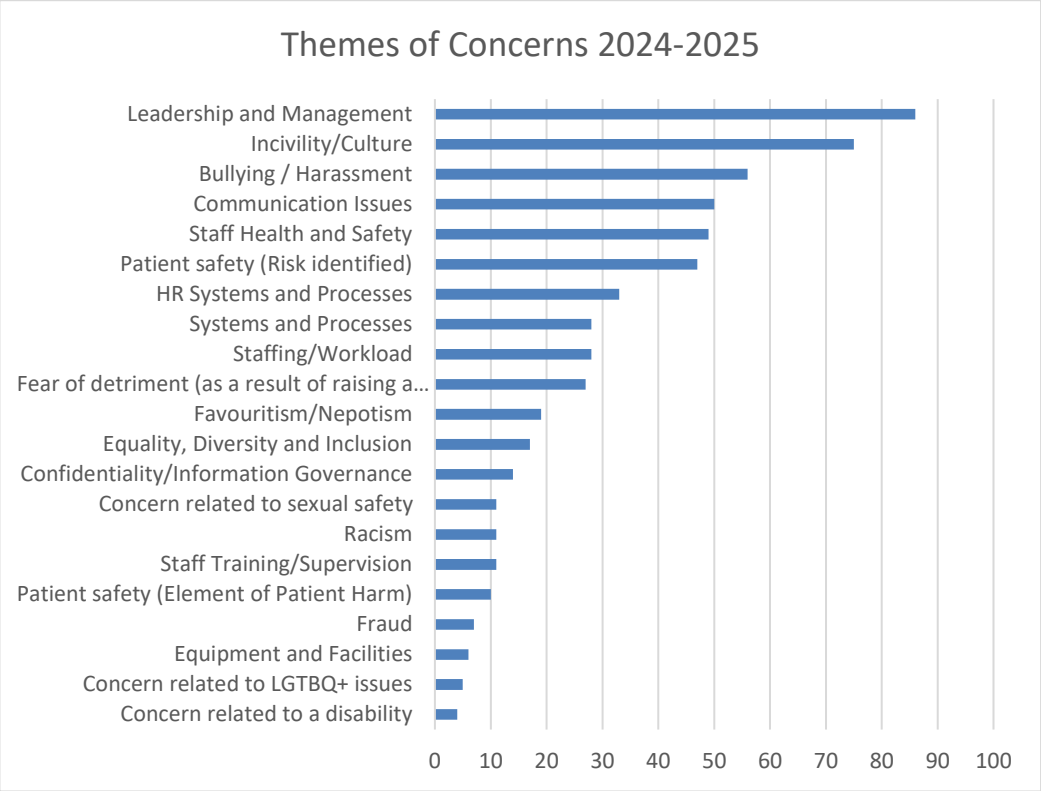


Table 10 – Themes from Freedom to Speak up concerns

Proactive work to date

Some of the work completed to date within the Guardian Team includes working with our colleagues in mandatory training to have all modules of the FTSU e-learning “Speak Up”, “Listen Up” and “Follow Up” available via ESR for all staff. The modules aim to promote a consistent and effective FTSU culture across the system which enables workers to speak up and be confident they will be listened to, and action taken. Having this training now on ESR means that the guardians will be able to monitor compliance and triangulate this data alongside other sources of information to support focused work. The guardians have also developed a series of workshops that can be delivered across sites face to face with staff groups.

To date 61% of staff have completed the three different elements of FTSU training since it went live in October 2024.

Since April 2024, the guardians have delivered training to approximately 1,400 staff members and students across sites and Teesside University. Guardians support with training on a reoccurring basis with the Trust induction, Care Certificate, International Nurses induction, directorate and audit meetings.

Every October the National Guardians Office, together with FTSU guardians, leaders, managers and workers across the healthcare sector, celebrate Speak Up Month - a month to raise awareness of FTSU and make speaking up business as usual for everyone. This year’s speak up month involved a Group Board Development session supported by the National Guardians Office, with pledges being made by staff from across the Trust.

A FTSU Hearing It session was held with the CEO, where workers could learn more about speaking up and ask any curious questions or express any concerns they may have about speaking up, over 280 staff joined this session. As part of the Group model the FTSU guardians also produced a FTSU themed podcast for staff which was shared across the sites.

Following the publication of the annual staff survey the guardians also completed a peer review with another NHS organisation. This was an opportunity to have positive conversations on creating an open and safe speaking up culture and tackling incivility in the workplace and is something that guardians are looking to continue with other organisations.

Future Plans

Over the next twelve months the guardians have identified several opportunities, including:

- A single reporting system that can be utilised across the Group model.
- Development of a detriment standard operating policy to support tackling barriers of detriment for workers speaking up.
- Continued engagement with group networks, to help build relationships with the network leads, the FTSUG attends all the 'meet the network leads' sessions and has been invited to be part of the staff hub, which has recently been established.
- Expansion of the FTSU champion network, through a fair recruiting process, as per National Guidance. FTSU champions are trained, can attend quarterly network meetings, have informal bi –annual 1-2-1 and are asked to support staff and signpost and collect high level themed data for triangulation.

Rota gaps for doctors and dentists in training

South Tees Hospitals NHS Foundation Trust would like to present the following information about rota gaps and other linked work streams.

For the most part, resident doctor medical rotas are managed through a collaboration between the corporate medical rota team and the clinical rota leads in the specific departments of the Trust. We have taken great steps forwards in the electronic rostering of medical staff and have circa 700 medical staff (all grades) rostered on this platform. The full Trust roll out of the system continues and will give the Trust greater insight into the rota gaps that occur and more accurate and contemporaneous data.

In terms of current gaps, we offer the following information from our establishment data. We continue to fill gaps on rotas in line with the Management of Gaps on Junior Rotas Policy to ensure there is a consistent approach throughout the Trust:

	No of gaps in establishment by tier of rota	**How mitigated**
Medical Rotas	0.5 Neurology - T1	Out of hours - backfilled with locum.
	2.5 - Acute - T1	Recruitment
	1 - Chemical Pathology - T1	Recruitment
	1 - Emergency Department - T1	Recruitment/out of hours - backfilled with locum
	1 - Emergency Department - T2	Recruitment to backfill vacancy/locum
	1 - General Psychiatry - T1	Backfill not required

	1 - ICU - T2	Recruitment/out of hours - backfilled with locum
	1 - Infectious Diseases - T1	Out of hours - backfilled with locum.
	2 - Renal - T1	Recruitment/out of hours - backfilled with locum
	2 - Respiratory - T1	Out of hours - backfilled with locum.
	1 - Clinical Oncology	Backfill not required
	1- Dermatology - T2	Recruitment
	1.5 -Trauma & Orthopaedic - T1	Recruitment/out of hours - backfilled with locum
	10 - Neonates - T2	Locum
	14 - Radiology - T1/2	Rota adjustments / locum
	2 - Histopathology - T2	Backfill not required
	2 - ICU - T1	Recruitment/out of hours - backfilled with locum
	2 - Gastroenterology - T1	Out of hours - backfilled with locum.
	2 - Haematology - T2	Backfill not required
	2 - Urgent Treatment Centre - T2	Locum
	2- Spinal Injuries - T2	Locum
	22 - Paediatrics - T1/2	Rota adjustments/Recruitment/Locum.
	3 Clinical Oncology - T2	Backfill not required
	30 - General Internal Medicine - T2	Rota adjustments/Recruitment/Locum
	4 - Trauma & Orthopaedic - T2	Recruitment/out of hours - backfilled with locum
	4 - Obstetrics and Gynaecology - T1/2	Recruitment/out of hours - backfilled with locum
	4.5 - Older People Medicine - T1	Out of hours - backfilled with locum.
	5 - Neurology - T2	Rota adjustments / locum
	5.5 - Diabetes - T1	Out of hours - backfilled with locum.
	6 - General Medicine - T1	Out of hours - backfilled with locum.
	9 - Cardiology - T1	Out of hours - backfilled with locum.
Surgical Rotas	1 - Ear, Nose and Throat - T1	Out of hours - backfilled with locum.
	4 - General Surgery - T2	Out of hours - backfilled with locum.

	1 - Oral Maxillofacial Surgery - T1	Backfill not required
	1 - Urology - T1	Out of hours - backfilled with locum.
	1 - Vascular Surgery - T2	Out of hours - backfilled with locum.
	2 - Plastic Surgery Rota T2	Recruitment
	3.5 - Neurosurgery - T1	Out of hours - backfilled with locum.
	6 - Cardiothoracic Surgery - T2	Rota adjustments/Recruitment/Locum
	8 - Neurosurgery - T2	Recruitment/Locum

Table 11 – rota gaps

During this financial year our clinical rota lead has reviewed several rotas across the Trust. These reviews aim to make these rotas fit for purpose, ensuring the correct number of resident doctors for both safe staffing and excellent training experience. This also ensures we have clarity on the cost of these rotas and should reduce the need for bank/locum staff.

During this period, we have continued to use a newer exception reporting process. An exception report can be submitted by a resident doctor when they have worked beyond their planned shift timings. Having a process which is widely accessible has increased our reporting rates, allowing us to have a greater insight into issues faced by our resident doctors. We then continue to work with the services to overcome these issues where possible.

In 2023/24, 263 exception reports were raised. During 2024/25, 575 have been raised; 11 of these had immediate safety concerns associated with them. 28 fines were incurred to a cost of £2712.68 to the Trust. Over this year we have also strengthened our fines process and there is now a designated resident doctor fines account.

Our Guardian of Safe Working (GOSW) along with our corporate medical rota team continue to provide routine reports to the People's Committee, Trust Board, Joint Local Negotiating Committee and the Resident Doctor Contract Forum. We have now aligned our annual GOSW report to the academic year. All consolidated reports are available for public view:. Statutory documentation - South Tees Hospitals NHS Foundation Trust

The GOSW meets regularly with junior British Medical Association (BMA) reps and the Chief Medical Officer's (CMO) office to ensure we are all working towards addressing issues highlighted to the GOSW through exception reports or other avenues of escalation.

The Trust continues to aspire to be an employer of choice for resident doctors.

4. Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

5. Annex 2: Statement of directors responsibilities for the quality report

TO BE COMPLETED

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

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

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

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19.*
- 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 2024 to March 2025.
    - papers relating to quality reported to the board over the period April 2024 to March 2025.
    - feedback from commissioners dated 17 May 2024.
    - feedback from governors dated 21 May 2024.
    - feedback from local Healthwatch organisations dated 10 May 2024.
    - feedback from Tees Valley Joint Health Scrutiny Committee dated 12 June 2024.
    - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 May 2023.
    - the latest national patient survey published February 2024 (Maternity).
    - the latest national staff survey published 7 March 2024.
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 25 June 2024.
    - CQC inspection reports dated 24 May 2023 and 19 January 2024 (Maternity).
- 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.
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

27 June 2024 Derek Bell, Group Chairman

27 June 2024 Stacey Hunter, Group Chief Executive

6. Annex 3: Glossary of terms

TO BE FINALISED

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

A&E
Accident and Emergency usually refers to a hospital casualty department where patients attend for assessment.

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

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

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

BadgerNet
BadgerNet is an electronic clinical system for maternity and neonatal care.

Black, Asian and minority ethnic (BAME)
All ethnic groups except white ethnic groups; it does not relate to country origin or affiliation.

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

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

CQC Quality Statements
The Care Quality Commission (CQC) are specific, measurable commitments that providers in the healthcare and social care sector must meet to deliver high-quality, person-centered care.

Clostridioides difficile infections (CDI)
Clostridioides difficile infection (CDI) is caused by a type of bacteria and is an important cause of infectious diarrhoea in healthcare settings and in communities.

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. Services are commissioned by integrated care boards and are overseen by NHS England on a regional basis.

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

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

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

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

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

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

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

Electronic Prescribing and Medicines Administration (EPMA)
Allows prescriptions to be transmitted and populated electronically, replacing paper and faxed prescriptions.

Emergency
An urgent unplanned episode of care.

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

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 Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public and staff, and are governed by a Board of Governors comprising people elected from and by the membership base.

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

Health care associated infections (HCAI)

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

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

HQIP (Healthcare Quality Improvement Partnership)
The Healthcare Quality Improvement Partnership was established in 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality improvement.

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

Health Services Safety Investigations Body (HSSIB)
HSSIB is fully independent arm's length body of the Department of Health and Social Care. It is independent of the NHS, it is hosted under the Care Quality Commission (CQC). Their role is to carry out independent patient safety investigations.

Inpatient
Patient requiring an overnight stay in hospital.

InPhase
A suite of Oversight Apps to achieve swift, triangulated, compliance, assurance and monitor continuous improvement in the NHS.

Integrated Care Board (ICB)
This is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

LeDeR
LeDeR stands for **Le**arning from Lives and **De**aths - People with a Learning Disability and Autistic People. LeDeR is a national service improvement programme commissioned by NHS England where the death of every adult with a learning disability and autistic people is reviewed.

Learn from Patient Safety Events (LFPSE)
A national NHS system for the recording and analysis of patient safety events that occur in healthcare.

LocSSIP (Local Safety Standards for Invasive Procedures)
These are local processes/procedures in place to reduce the number of patient safety incidents related to invasive procedures, in which surgical 'Never Events' can occur.

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

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

MIYA Noting Electronic Patient Record
MIYA is a software platform for recording and managing patient information. This aims to be a central record system rather than paper notes or other electronic systems and should improve patient care and safety.

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

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

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

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

NHS England (NHSE)
NHS England leads the National Health Service (NHS) in England

NEQOS (North-East Quality Observatory Service)
Provides quality measurement for NHS organisations in the North-East (and beyond), using high quality expert intelligence to secure continually improving outcomes for patients.

North Tees and Hartlepool NHS Foundation Trust
Includes University Hospital of North Tees, University Hospital of Hartlepool, Peterlee Community Hospital.

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

PALS (Patient Advice and Liaison Service)
A service that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

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

Payment by Results
A system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated.

PLACE (Patient-led Assessments of the Care Environment)
PLACE assessments are an annual appraisal of the non-clinical aspects of the NHS and independent / private healthcare settings, undertaken by teams made up of staff and members of the public (known as

patient assessors). The team must include a minimum of 50% patient assessors. They provide a framework for assessing quality against common guidelines and standards.

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

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

PSIRF (Patient Safety Incident Response Framework)
Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRP (Patient Safety Incident Response Plan)
Sets out how the organisation will respond to patient safety incidents. The PSIRP outlines which patient safety incidents should be reviewed and investigated and which approach should be applied in different scenarios.

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.

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.

Spell
A continuous period of time spent as a patient within a trust, and may include more than one episode.

STAQC (South Tees Accreditation for Quality of Care)
STAQC is a ward / department accreditation programme which brings together key measures of nursing and clinical care into one overarching framework.

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

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

South Tees Hospitals NHS Foundation Trust

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

TEWV

Tees, Esk and Wear Valleys NHS Trust, supporting Mental Health and Learning Disabilities for County Durham and Darlington, Teesside, North Yorkshire, York and Selby.

NHS
North Tees and Hartlepool
NHS Foundation Trust

Quality account

2024-25

Caring Better Together

Table of contents

Part 1. Statement on quality from the Chief Executive

Group Chief Executive's Statement

To be updated

What is a Quality Report/Account?

Quality Accounts are the Trust's annual reports to the public about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to define our priorities for the next year to indicate how we plan to achieve these and quantify their outcomes.

Our Quality Pledge

Our Board of Directors receive and discuss quality, performance and finance at every Board meeting. We use our Quality Committee to provide assurance in relation to patient safety, effectiveness of service, quality of patient experience and to ensure compliance with legal duties and requirements; the Audit Committee is to review our systems of internal control. Non-Executive directors with recent and relevant experience chair both the Quality and Audit Committees, these in turn report directly to the Board of Directors.

The Board of Directors seek assurance on the Trust's performance at all times and recognise that there is no better way to do this than by talking to patients and staff at every opportunity. A departmental visiting programme supports this oversight.

Quality Standards and Goals

The Trust values the contributions made by all members of the organisation to ensure challenging standards and goals are achieved which are set to deliver high quality patient care. The Trust also works closely with commissioners of the services provided to set challenging quality targets. Achievement of these standards, goals and targets form part of the Trust's four strategic quality aims.

2024-25 Quality Improvement Priorities

2:1

The Quality Account provides an opportunity for the Trust to reflect on its achievements over the last 12 months. This includes a look back at the progress made against the quality priorities for 2024/25 that were defined in the 2023/24 Quality Account and are summarised in the table below.

The Trust agreed the following Group Quality Priorities for 2024/25 following a consultation process with clinical colleagues at both North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trusts and the Council of Governors.

Group Quality Priorities 2024/25		
Patient Safety	**Clinical Effectiveness**	**Patient Experience**
We will continue to embed our Patient Safety Incident Response Plans, developing a positive, just and restorative safety culture, which supports openness, fairness and accountability. Ensuring that colleagues with the right skills and competencies are involved in the relevant aspects of the patient safety response.	We will ensure continuous learning and improved patient outcomes following implementation of best clinical practice, using data from clinical audits of compliance against evidence-based standards.	We will develop and implement a Group Mental Health Strategy to improve care and share learning for our patients who are experiencing difficulties with their mental ill health.
We will continue to optimise the Trust's ability to respond to and learn from incidents, safeguarding concerns, claims and inquests to improve outcomes for our patients whilst embedding PSIRF.	We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.	We will proactively seek patient feedback and ensure there is continuous improvement in care and treatment because of the feedback we receive.
We will improve medication safety and continue to optimise the benefits of ePMA and evaluate the impact on learning from medication incidents.	We will develop and implement shared decision making and goals of care.	We will respond in a timely way to complaints, supporting patients and families through difficult circumstances and implement quality improvements as a result of the learning.

Our ambition for improvement, agreed actions, aims and progress at the end of 2024/25 for each quality priority are detailed below.

Patient safety quality priorities

Priority 1

DOMAIN – Patient Safety

a. Safety culture

Quality Priority – We will continue to embed our Patient Safety Incident Response Plans, developing a positive, just and restorative safety culture, which supports openness, fairness and accountability. Ensuring that colleagues with the right skills and competencies are involved in the relevant aspects of the patient safety response

Aims

The rationale of this quality priority are;

- The organisation needs a culture where staff, patients and their families, feel empowered and psychologically safe to raise and discuss safety issues; where everyone involved will be treated fairly and restoratively.
- Having a positive safety culture will support effective learning and improvement, in order to prevent, where possible, future patient harm
- Colleagues involved in responses to patient safety events need to be equipped with the knowledge and skills to support compliance with the principles of PSIRF.

The agreed aims were to;

- Scrutinise the results within the patient safety and culture questions in the 2023 NHS Staff survey and triangulate against other relevant data; to identify areas for focused support and improvement.
- Optimise safety event management approaches across both organisations to obtain the maximum learning from the analysis of these to link in with PSIRF plans.
- Undertake a training needs analysis against PSIRF standards to assess overall compliance and identify any gaps.
- Review current actions being undertaken in both organisations in relation to culture that will impact / support the safety culture priority.

Progress

During 2024/2025 the following progress has been made;

- During quarter 4 a further cohort of FLO training has been undertaken, and therefore there are 34 trained FLOs for North Tees & Hartlepool.
- A patient safety workshop was jointly facilitated by a Patient Safety Partner, Patient Safety Specialist (NT&HP) and Patient Safety Lead (ST) in December 2024. The 4-hour workshop used a case study based on a recent HSSIB investigation to develop participants knowledge and skills when undertaking patient safety reviews, based on teaching from the NHSE Patient Safety Syllabus Level 3 & 4 training. The session included the application of human factors models (such as SEIPS and Accimap), duty of candour, and the hierarchy of controls in developing meaningful action plans. Over 60 colleagues attended the session, which received positive feedback, and there are plans to deliver further sessions, as part of a regular Group education programme in 2025.
- The NHSE Patient Safety Syllabus (Levels 1) was introduced as part of mandatory training requirements in 2023-24. Level 1a is the starting point for all NHS staff, and current completion rate is 97.5%.
- A training needs analysis is underway to inform the roll out of level 2 of the patient safety syllabus.
- The Trusts Duty of Candour policy has been monitored through continuous internal audit and also by AuditOne, the Trusts external auditors. The internal audits have shown continuing improvement and the AuditOne Report shared with the Trust Board advised there was “Good” compliance with the Trusts policy.
- Duty of Candour letter templates have been updated collaboratively with a range of experienced colleagues, to ensure letters are compassionate, use plain language and cover the relevant requirements set out the regulations.

- The NHS staff survey results for 2024 Q20a "I would feel secure in raising concerns about unsafe clinical practice" in 23/24 was 71% which has reduced to 70% which although disappointing, remains equivalent to the national average for this metric – high levels of incident reporting have been maintained
- During 2023-24, there were 18,049 safety events reported in Datix / In Phase. During 2024-25 (to end February) 15,201 have been reported into In Phase. This reduction reflects the predicted impact of the changes in the Trusts reporting system during quarter 4, 2023-24. The initial reduction was around 25%; the Trusts Patient Safety Event Response Plan identified that the aim was to increase reporting by 2% each month during 2024-25; this was achieved from April 2024, with reporting improving by at least 4% each month until December 2024 when it has stabilised.

Summary and plans for ongoing work

- Following the change to the Trusts incident reporting system during quarter 4 2023-24; there was a predicted reduction in reporting; the reporting has gradually increased over 2024-25 although it is not quite to the previous levels. This is being monitored closely and there have been ongoing strategies implemented to support further ongoing improvements.
- We will continue to deploy FLO to support patients and their families/carers affected by adverse events or complaints.
- Collaborative work has been undertaken regionally to develop a feedback tool for the family liaison officer service, supported by one of the Trust's patient safety partners and Health Innovation North East and North Cumbria. Feedback from this will be available within future reports

During 2025-26 there will be a training needs analysis undertaken across the Group to inform the roll out of

DOMAIN: Patient Safety

b. Learning from incidents

Quality priority: We will continue to optimise the Trust's ability to respond to and learn from incidents, safeguarding concerns, claims and inquests to improve outcomes for our patients whilst embedding PSIRF.

Aims

The rationale of this quality priority are;

- An organisation that identifies, contains and recovers from errors as quickly as possible will be alert to the possibilities of learning and continuous improvement (The NHS Patient Safety Strategy, 2019).
- Through the implementation of PSIRF we will optimise our ability to triangulate information from a range of sources, maximising opportunities to learn and improve.

The agreed aims were to;

- Analyse of the information available within the reporting systems across both Trusts to triangulate and identify potential areas of improvement.
- Improve the sharing of learning across the Group using innovative and creative approaches to maximise improvement opportunities.
- Analyse NHS Staff Survey findings in relation to patient safety elements.
- Ensure compassionate engagement is embedded within all Trust processes so that all individuals involved have their needs met.
- Providing consistent feedback to individuals who have taken the time to report events or concerns.

Progress

Progress on these aims, includes;

- The governance of the Trust's Safety processes has been adapted over the year to share good practice across the Group. Site meetings have been aligned and are attended by representatives across the Group to support shared learning and improvement; with learning points being identified and shared across the Trust after each meeting. The impact of these changes will be monitored during 2025-26.
- The Trust's Care Groups have been, since quarter 3, providing monthly updates to the weekly Safety panel covering all their triangulation across all areas of safety, learning and improvement work. This supports sharing of learning and joint approaches towards thematic reviews and sustainable quality improvements.
- There has been focused work on effective safety event management, including legacy events reported in Datix. There has been ongoing support provided to staff not only around the reporting to safety events in the new In Phase system; but also for the staff who are required to manage these. There has been an overall reduction in the number of open incidents; however, this needs to be sustained. The implementation of In Phase "live" dashboards is supporting the monitoring of this from Ward to Board levels. The Trust must also focus on being able to demonstrate improvements in practice and outcomes as a result of safety reporting, including feedback to reporters. The In Phase system has recently been updated to include a mandatory feedback response to the reporter; the impact of this will be evaluated to inform further improvements.
- There is continued evidence of improved triangulation with the Resuscitation team, Medical Examiner service and Trust Mortality Leads, leading to improvements in relation to management of deteriorating patients, recognition of the dying patient, nutrition and hydration of vulnerable patients and documentation within digital solutions.
- Current cases are discussed within the Patient Safety Response Process meetings; new and emerging events/risks are also discussed here and a proportionate learning response is agreed in line with the Patient Safety Incident Response Plan. This also supports triangulation of information and learning from patient safety, patient experience, learning from deaths, claims, inquests and safeguarding data. This can support the identification and escalation of emerging themes and shared learning.
- Collaborative work has been undertaken regionally to develop a feedback tool for the family liaison officer service, supported by one of the Trust's patient safety partners and Health Innovation North East and North Cumbria.
- There is a planned analysis of the Trusts Patient Safety Incident Investigations to ensure the national standards for the investigations are being covered; a significant part of this is the engagement of staff involved to gain their perspective of any actions that would impact on and reduce any potential recurrences. The direct involvement of staff also supports them feeling involved in any changes, improvements and promote further sharing with colleagues.

Summary and plans for ongoing work

- Feedback from the Family Liaison Officer (FLO) evaluation tool will be available within future reports.
- Triangulated learning across the Trust / Group will become more embedded as the changes to the governance structures are implemented over 2025-26.
- The 2024 NHS staff survey results for Q20b "I am confident my organisation would address my concerns" has shown a reduction from 61.51% to 60.52%, which is disappointing and reinforces the need for the organisation to demonstrate learning after an incident is reported. The NHS Staff Survey results for 2024 specific to safety are currently being analysed to assist in planning actions to be initiated during 2025-26.
- Therefore, this will be an area for continued focus into 2025/2026, including meaningful feedback to reporters and also collaboration with the Trusts Communications team to ensure there is formal feedback through established routes in line with the trusts' Communication plans.

DOMAIN – Patient Safety

c. Medication safety and optimising the benefits of ePMA.

Priority Statement

We will improve medication safety and continue to optimise the benefits of ePMA and evaluate the impact on learning from medication incidents.

Rationale

There are an estimated 237 million medication errors per year in the NHS in England, with 66 million of these potentially being clinically significant. These errors are estimated to cost the NHS at least £98 million and contribute to the loss of more than 1700 lives annually. NHS England maintains that increased uptake of electronic prescribing and medicines administration (ePMA) systems by trusts would correspond with a 30% reduction in medication errors, compared to traditional methods, and a similar reduction in patient adverse drug events. Both trusts have implemented ePMA within in-patient areas and will collaborate in improving patient safety by optimizing the benefits of ePMA.

Agreed actions

- To agree key performance indicators (KPIs) for patient safety and standardise across the two organisations on a clinical electronic dashboard for each organisation
- Implementation of EPMA functionality for clinically led quality improvement projects and research for clinical staff
- Share safety improvements implemented on EPMA system across the Group.
- Utilise EPMA to audit antimicrobial prescribing to ensure compliance with guidance and reduce antimicrobial consumption
- Monitor prescribing practices to ensure compliance with formulary
- Monitor medication incidents and review areas for improvement and implement the relevant changes

Measure of success

- Agree standard set of EPMA KPIs and clinical dashboards for patient safety that is monitored through trust patient safety groups for trends/areas of improvement.
- Number of quality improvement projects/research undertaken utilising EPMA to improve patient safety
- Improvement in antimicrobial audit compliance
- Quality Improvement Programme schemes
- Share changes implemented post medication incident review
- Coordinate group safety forums to discuss and share actions to National Patient Safety Alerts

Progress and achievements 2024-25

- Digitisation of the insulin paper chart to reduce the need for dual processes, and missed doses.
- Allowing prioritization of patients for pharmacy review using specific drugs classes or patient alerts.
- Improving data reporting (including missed doses reports etc.) with ongoing work to develop these.
- Supporting integration with the pharmacy system to reduce the amount of transcription required and save time.
- Warfarin and insulin prescribing have now been transferred from paper chart to EPMA.
- Improving in the prescribing of transdermal patches.

- Review of EPMA inphase medication incidents at EPMA steering group. This then feeds into the digital steering group and then to the Trust Board.
- Use of Tallman lettering to reduce the risk of look-alike sound-alike (LASA) errors.
- Never events alert about withdrawing insulin from pen devices added on EPMA diabetes chart.
- Safety alert 'Phenytoin infusion needs to be administered with filter' added on TrakCare and Omnicell to improve staff awareness.
- Dilution advice for sertraline oral solution pre-populated on Ascribe dispensing system following regional safety incidents.
- Teicoplanin loading dose order set created on TrakCare to improve prescribing practice and reduce inappropriate prescribing of loading dose.
- The cumulative dose (across all routes of administration, regular and when required) within 24 hours are created for Paracetamol and cyclizine to reduce the risk of dose being administered above the maximum doses. Symbol appears on the chart to indicate when nearer the total.
- Alert appears when entering high or low blood glucose readings. This is accompanied by escalation advice and links to guidance.
- Adrenal insufficiency/adrenal crisis symbol created on TrakCare to raise staff awareness.
- Developed Trust safety bulletin that highlights the importance of early recognition and management of adrenal crisis.
- Delivered training to pharmacy staff and non-medical prescribers about adrenal insufficiency and issue of Steroid Emergency Card/Steroid Treatment Card. TrakCare training about long term steroid use delivered to foundation doctors by Informatics Lead Pharmacist.
- Completion of NatPSA action checklist and implement safety initiatives.
- Medicines reconciliation data on performance and interventions collected using EPMA.
- Plan to develop antibiotic order sets for prescribing in the most common infections with the role out of Eolas App (single antibiotic guideline across the University Hospitals Tees group).
- Order sets will improve compliance with antimicrobial guidelines by enabling prescribers to prescribe by condition rather than individually picking the antibiotic. They will also enable a built in 'antibiotic review' to be prescribed within a designated time frame from the start of the prescription.
- Current audit around antibiotic use prior to patients developing C.difficile infection by trainee pharmacist. This will help us to report trends in offending antibiotics and improve future prescribing.
- EAU to trial printing FP10HP (green prescription) electronically to improve quality of prescriptions sent to community during out of hours.
- Roll out of EPMA to Intensive Care Unit (ITU).

Ongoing Plans /Next step

- Work continues across the Group to agree a standard set of joint KPI's
- Work has commenced on standardising medicines reconciliation collection data across both Trusts.

Priority 2

Domain- Effectiveness of Care

a. Learning and improving patient outcomes from clinical practice and clinical audits.

Priority statement:

We will ensure continuous learning and improved patient outcomes following implementation of best clinical practice, using data from clinical audits of compliance against evidence-based standards.

We will ensure continuous learning and improved patient outcomes following implementation of best clinical practice, using data from clinical audits of compliance against evidence-based standards.

Rationale
In order to provide patients with the best possible clinical outcomes, the Trust will ensure processes that support continuous learning are developed and embedded. This will be supported by data sources and InPhase for triangulation and to promote best practice.

Overview of agreed actions

- Co-ordinate evidence collation against the CQC Single Assessment Framework to support continuous learning and improved patient outcomes.
- Monitor progress with implementation of, and compliance with, relevant NICE Guidance.
- Undertake a partnership approach to support locally agreed joint audits between the Group (focusing on those where the patient pathway intersects both Trusts).
- Monitor development and progress with action plans from National Clinical Audits and high priority local audits.

Progress and achievements

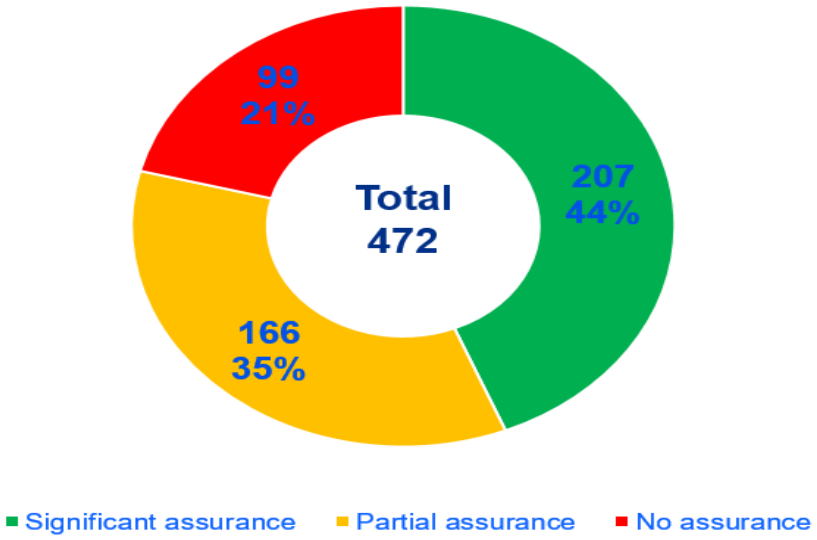
The CQC App in InPhase is now entering the final testing stage, with the current 'go-live' date being set as 14th April 2025. The CQC App has been showcased at the CQC Compliance Group and was well received by the Members of the group, acknowledging the benefits that the App will bring.

Likewise, it is anticipated that the 'go-live' date will be 14th April 2025 for the first iteration of the triangulation dashboards. Governance and oversight remains in place at site level including prioritisation and monitoring of national audits, which are at risk of not being delivered.

An options paper was presented to the Group Executives at the end of January, which approved the moving to InPhase at a group level to include all of the apps including CQC App, which will give consistency across the group. Executive leads will be identified for oversight. The CQC Operational Group continues to meet monthly, chaired by the site Deputy Chief Nurse. It supports and instructs the CQC Check and Challenge subgroup in respect of independent review of evidence submitted by clinical teams following their own internal validation within the Care Group Senior Management Teams.

NICE guidance remains top priority for local clinical audit support. Clinical areas are identifying their priority audits for the upcoming Clinical Audit Forward Plan 2025/26, for presentation and approval at the Audit & Clinical Effectiveness (ACE) Council. Remaining unaudited NICE guidance will form part of each clinical service's local audit priorities.

NICE Guidance
Evidence of a recent audit of compliance



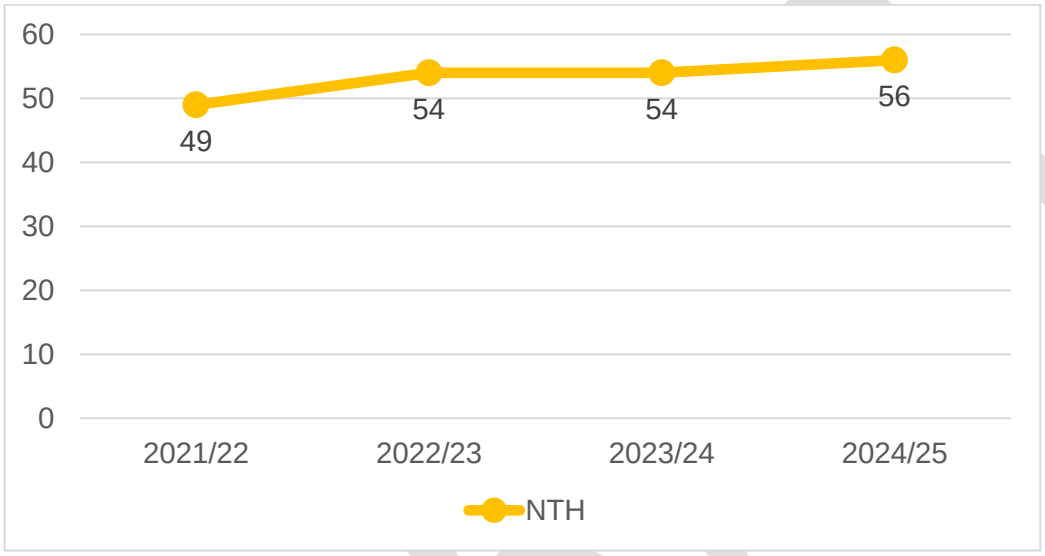
Work has been undertaken to confirm which national clinical audits are at risk of reduced or non-submission.

National Clinical Audit
Exception reporting

	North Tees and Hartlepool
National clinical audits 2024/25	61
High risk (non-submission)	2
Medium risk (reduced submission)	3

National Clinical Audit
Workload over past four years

Year	National audits eligible to participate in	National audits submitted
2021/22	49	46 (94%)
2022/23	54	51 (94%)
2023/24	54	50 (93%)
2024/25	56	52 (93%)



Some local collaborative work was agreed around the shared Vascular services pathway with our Tertiary Centre. The organisations currently share a referral pathway for patients who fit certain criteria in respect of lower leg wounds. North Tees and Hartlepool are a “spoke” service, currently referring patients fitting such criteria to South Tees, who provide the “hub” service as a regional tertiary vascular centre. Clinical guidance is currently being reviewed by the lead vascular team, in order to update and incorporate relevant NICE guidance, so that a pathway audit can be undertaken in partnership across the Group.

Development of the triangulation app in InPhase will be reviewed as part of the wider group InPhase Apps and rollout. Governance and oversight remains in place at site level including prioritisation and monitoring of national audits which are at risk of not being delivered.

Improvement plans from national clinical audits continue to be monitored via local clinical audit registration systems, while work on implementation of InPhase moves forward in Group collaboration.

Plans for ongoing work
Moving forward, the quality priorities for 2025/26 will focus on:

- **NICE Guidance**
  - Implementation of all relevant NICE Guidance (or risk-assessed alternative).
  - Evidence that NICE guidance are prioritised in local audits as part of the Clinical Audit Forward

Plans.

GIRFT

- Evidence of clinical engagement in all locally relevant GIRFT reviews.
- Development and implementation of local improvement plans, against GIRFT review recommendations.

- **National Clinical Audit**
  - Participation in mandatory national clinical audits.
  - Evidence of sharing local results of national clinical audits.
  - Development and implementation of local improvement plans, following publication of national clinical audit reports.
- **Systems support**
  - Establishment of a common reporting framework for NICE guidance, Clinical Audit and GIRFT across the Group.

2. DOMAIN- Effectiveness of care

Mortality review processes and learning from deaths.

b. We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes

1. Rationale
   The medical Examiner (ME) Service scrutinizes all inpatient deaths. A proportion of deaths are reviewed using the Structured Judgment Review (SJR) tool via the Inphase Mortality Module. Findings are presented quarterly to the Trust Safety Panel but triangulation of themes and evidence of learning has been challenging to assemble.

2. Overview of agreed actions
   We are reviewing arrangements within the Group to improve the reporting, align the themes from Learning from Deaths with the themes from other quality related activity and use these to drive improvements in care.

3. Progress and achievements
   a. The ME Service is now statutory from 9 September 2024
   b. The Mortality Module on Inphase is now set up to receive referrals and record reviews.
   c. Quarterly thematic review reporting to Safety Panel to support learning and triangulation across all areas of safety, experience and quality.
   d. Multidisciplinary team of reviewers established with monthly SJR sessions

4. Plans for ongoing work
   a. Ongoing collaboration with South Tees under the Group Structure
   b. Review of Specialty Mortality and Morbidity work, with a view to capturing this on InPhase alongside SJR
   c. Expand team of reviewers
   d. Work towards SJR of 15% of deaths.

Priority 2

Effectiveness of Care

b. Learning from Deaths-we will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes

Rationale

The medical Examiner (ME) Service scrutinizes all inpatient deaths. A proportion of deaths are reviewed using the Structured Judgment Review tool via the Inphase Mortality Module. Findings are presented quarterly to the Trust Safety Panel but triangulation of themes and evidence of learning has been challenging to assemble.

Overview of agreed actions

We are reviewing arrangements within the Group to improve the reporting, align the themes from Learning from Deaths with the themes from other quality related activity and use these to drive improvements in care.

Progress and achievements

a. The ME Service is now statutory from 9 September 2024
b. The Mortality Module on Inphase is now set up to receive referrals and record reviews.
c. Quarterly thematic review reporting to Safety Panel to support learning and triangulation across all areas of safety, experience and quality.
d. Multidisciplinary team of reviewers established with monthly SJR sessions

Plans for ongoing work

e. Ongoing collaboration with South Tees under the Group Structure
f. Review of Specialty Mortality and Morbidity work, with a view to capturing this on InPhase alongside SJR
g. Expand team of reviewers
h. Work towards SJR of 15% of deaths.

Domain- Effectiveness of Care

c. Shared decision making and goals of care.

1. Rationale

We have an obligation based on NHS legal frameworks to involve and consult patients, with their families and carers, where appropriate on all decisions about their care and treatment. The UK Supreme Court Montgomery judgement marks a decisive shift in the legal test of duty of care in the context of consent to treatment, and the Health and Care Act 2022 has established obligations towards patients' involvement in care decisions, enabling patient choices, and providing information in a way patients understand; with the aim to reducing health inequalities related to service delivery and clinical outcomes. Hence, the need to develop and implement shared decision making principles across our pathways as one of the clinical effectiveness domains.

2. Overview of agreed actions

The 2023/2024 quality account provided an initial direction for the 2024/2025 financial year on the shared decision making quality priority, to develop and implement shared decision making and goals of care. At the beginning of 2024/2025, these areas were agreed as areas of focus:

- We will undertake a gap analysis against recommendations within NICE guidance NG197 Shared Decision Making to develop a Trust wide improvement plan to put shared decision making into practice.
- We will engage with clinical teams regarding the development of procedure specific consent forms, ensuring that information on risks, benefits and consequences is personalised and supported by good quality patient decision aids.
- We will develop E-Consent and ensure policies are reviewed and aligned

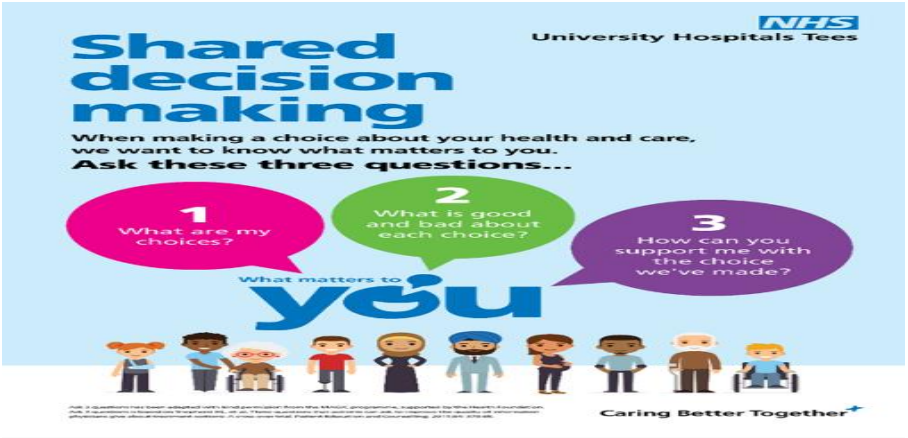
3. Progress and achievements

- **On E-Consent:** A roadshow for interested vendors was organized and successfully completed. The funding application and business case for digital consent procurement have been completed and submitted to the Hospitals Charity. Once funding is secured, this will go out to tender to already verified vendors. NTH evaluation report for the A digital consent pilot within the podiatric surgical pathway was implemented, evaluated and completed. The trial has proven successful with 92% of patients surveyed reporting that it was easy to use compared to traditional consent method.

  Additionally service users commented that it made consent more accessible (including accounting for visual impairment needs and translation needs), and even those who would consider themselves to be not computer literate found it an easy to use and informative process. The staff also reported that they found it easy to use, feel more confident that the consent process is robust and patients have more time to consider their options before signing the consent form. These recommendations are critically considered in developing a sustainable digital consent process across University Hospital Tees

- **On implementing shared decision making:** A clinical audit against Shared Decision Making NG197 was completed using two major service areas within Healthy Lives Care Group. Good clinical practices were identified as well as gaps signaling a need for improvement. A training needs assessment was also completed with significant training needs identified among. These findings informed the training of 7 accredited shared decision making trainers across NTH; in addition, recommendations from the clinical audit has informed the development of the University Hospital Tees Shared Decision Making Improvement Plan.

  A 2024/2025 CQUIN report was also completed within Healthy Lives Care Group with the report showing a high quality SDM patient experience of 98.9% satisfaction above the 75% compliance rate. To support SDM implementation, a patient facing ‘Ask 3 Questions’ poster was developed to support patient prepare to have a shared decision making conversation during their appointments.



4. Plans for ongoing work

For 2025/2026, these will be focuses on these:

1. Ratify the Shared Decision Making Improvement plan after incorporating feedback from all stakeholders
2. Implement recommendations within Shared Decision Making improvement plan including:
    a. -Preparing patients and public
    b. -Training and development for staff members
    c. -Reviewing Commissioned services/ pathways
    d. -Strengthening strategic leadership and supportive systems
3. Engage with clinical teams regarding the development of procedure specific consent forms, ensuring that information on risks, benefits and consequences is personalised and supported by good quality patient decision aids.
4. Develop E-Consent and ensure policies are reviewed and aligned

Priority 3

Domain- Patient experience

a. Patient feedback and continuous learning in care and treatment.

Rationale

- Provide equitable opportunities for patients, carers and families to proactively provide feedback on services.
- To ensure services meet the needs of the local population.

Agreed Actions

- We will form a Group Patient and Carer's Involvement Group.
- Patient representative at all key meetings across the organisation.
- Share areas of good practice across the organisation, develop a 'Good Practice' report.
- Information (verbal/written) about health conditions and treatment plans is provided in a format the patient and carer understand.

Progress in 2024-25

It is essential we provide equitable opportunities for patients, carers and families to proactively provide feedback on services. This helps to challenge our thinking, provide patient centred services and more personalised care.

Group Patient and Carer's Involvement Group

The Involvement teams at University Hospitals Tees are developing a terms of reference for this Group, following a review of terms of practice of patient groups from other NHS Trusts and good practice around patient and participatory groups.

Carer's Charter

Following the feedback from a lived experience involvement and engagement event last September, a Carer's Group was set up in November 2024 and have agreed on a Carer's Charter which is currently undergoing consultation in our both hospital Trusts. This is on target to be implemented in Quarter 1 2025-26. The Charter is University Hospital Tees' commitment to carers of all ages. The commitment to carer includes:

We will make sure you have a named nurse on duty to contact. This will be someone who is caring for the person you care for.

We will listen and value your expert knowledge about the person you care for.

We will work with you to provide individual care for the person you care for.

We will include you in any decisions about the person you care for. If this is not possible, we will explain why.

We will give you information for a carer support group. They can give you advice, guidance and support.

Involvement Bank

The North Tees and Hartlepool Trust involvement Bank was launched in March 2024 for our local people who can give a little time to join the bank to help us by: taking part in visits and inspections attending meetings, workshops and events, providing feedback and stories based on treatment, designing surveys, taking part in research projects, designing patient pathway and quality improvement projects, supporting staff recruitment, developing training for staff, sharing ideas on how we could improve our services. We have over 47 people with lived experience signed up in the bank. Key meetings have been identified where representation of people with experience of care is important/essential and members of the Bank have started to attend some meetings including People, Patient and Public with Lived Experience, Patient and Carer Experience Council, Safeguarding Council and Clinical Governance Group amongst others.

People from the bank have also been aligned to support the delivery of our undergraduate program, delivery of quality improvement training, and review of patient leaflets amongst other projects within the Trust. We are in the process of aligning the involvement bank in North Tees and Hartlepool Foundation Trust and South Tees NHS Foundation Trust to form a Group involvement and coproduction Bank for the University Hospital Tees. This work will continue to increase involvement.

Patient Information Leaflets

The Information Review Group now has three people with lived experience from the Involvement Bank who support review of the content of leaflets, ensuring they are easily understandable and the reading age is appropriate. This also included input from a local school who visited the Trust and gave their feedback on some leaflets aimed at children and young people. Likewise, the review of our new hospital leaflets by a member of the involvement bank with a learning disability.

Widening diversity within our Maternity and Neonatal Voice Partnership

The involvement and engagement with diverse communities has supported the Trust to widen diversity in the representation of members of the Trust Maternity and Neonatal Voice Partnership. The MNVP focuses on widening engagement and gathering maternity services feedback from our diverse range of service users. The involvement bank provided opportunity for four women from ethnic minority communities to support the work and activities of our MNVP.

Patient, People and Public with Lived Experience (PPPLE)

This working Group was set up in 2022 to improve engagement and co-production of our services. All Involvement and Co-production work for NorthTees filters into this Group. The Group has helped to strengthen Involvement by:

- Developing a process and proforma so staff can easily inform patients of improvements and developments.
- Supporting a system of collating and analysing patient feedback from multiple sources.
- Co-designed a tool kit for staff to have a standard approach and understand how to involve PPPLE.
- Developed a central register of already established community groups and people who could contribute in providing insight into our services.
- Supporting our services to become accessible and inclusive for all through collaboration with key stakeholders.
- Developed a training programme so our staff understand how/when to work with people to get the best from the collaboration.
- Co-developed a co-production and lived experience plan on a page which supports patient and community engagement.

A training package has been developed which gives staff the knowledge and skills needed to work with people with lived experience. The training is now available to all staff. The training has been facilitated by the lived experience lead and completed by over 65 members of our eligible workforce.

Increased engagement with marginalised communities

We have ongoing partnership working with people from marginalised communities. We have held engagement session in partnership with Refugee Futures who supports refugees and asylum seekers who fled their homes to settle in the Tees Valley, including Iranians, Arabians, and people from other ethnic minority communities. Such partnership provides information about NHS services and seeks to address any barriers people may face in accessing healthcare. The Lived Experience Lead continues to develop this essential work.

Increased community engagement with the population we support.

We have seen an increased engagement with the population we support and partnership with our local population and communities. We have had engagement with the population we support through visits to warm spaces, libraries, community centres, Faith and community groups such as the Northern Cancer Group, Christians against poverty, Hartgables, children in care, and one life amongst others. Likewise, a lived experience involvement and engagement event that provided a safe space for our patients, carers,

family members of patients, and third sector organisations to explore their experiences of our discharge service and provide ideas for quality improvement.

Such engagement has been a meaningful source of collecting feedback and listening to the population we support. The lived experience event provided ideas that has supported the Trust PSIRF action plan and the development of a Group carers charter. Additionally, there has been collaboration with local authorities, the voluntary sector, Commissioners, local and regional Trust networks across the ICB and national networks, to support the Trust to embed best practice and a strong culture of co-production whilst empowering people who use services through the Trust involvement bank.

Friends and Family Test

Following each attendance or discharge a text message is sent to patients asking how they rate our services. We also offer paper based method to capture this data, if that is the patient's preferred option. The aim is to develop the methods of capturing this feedback during 2025-26.

Ongoing work into 2025-26

Involvement bank

Continuous recruitment of people with lived experience into our Trust involvement bank to reflect various experiences of the services we provide. Likewise, engagement with our changing population and communities to ensure we continue to gain insight into people's experiences of care and what people want, using their ideas to form the final approach when making changes and developing care pathways.

Welfare support for members of our involvement bank to ensure they feel empowered and safe to offer useful insight when working with us. Likewise, identifying opportunities to link members of our involvement bank to become more involved and engaged.

Multiagency approach in addressing the barriers to accessing care for people within the Engagement with Inclusion Health Groups.

We are currently utilising a multi-agency and multi-disciplinary approach to identify targeted interventions to deliver integrated and accessible services for people within the inclusion health groups in the population we support. Likewise, improve our feedback mechanism for people within this group, learning from their experiences of care to enable us recommend equitable access to services for these groups. Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple interacting risk factors for poor health, such as stigma, discrimination, poverty, violence, and complex trauma. People from this communities suffer inequalities in terms of access, uptake, experience, and outcomes of healthcare services. The scope of this group includes people experiencing or at risk of homelessness, vulnerable migrants and asylum seeking population, people in contact with criminal justice system, people with a learning disability, people from a minority community, sex workers, people with a substance misuse, people with a serious mental illness, carers, including young carers and LGBTQIA+ community.

Co-design and facilitation of trauma informed care to support our workforce to understand and embed the principles of trauma informed care into how we deliver care to minimise the stigma and re-traumatisation people within the inclusion health groups face when they present to our hospital.

Further engagement, involvement, and partnership working with people and communities.

Further collaboration with local authorities, the voluntary sector, Commissioners, local and regional Trust networks across the ICB and national networks, to support the Trust to embed best practice and a strong culture of co-production whilst empowering people who use services.

Lived Experience Training and support for eligible workforce

The lived experience lead would continue to facilitate the working with people with lived experience to training to eligible workforce to support staff gain knowledge and understand how to involve patients, public, and people with lived experience in meaningful community engagement and community engagement.

Compliments

North Tees receives many compliments, and this information is available for Care Groups to review via Inphase Feedback module. Compliments are shared during meetings and communications throughout the Trust.

Patient Stories

Patient stories are shared at many forums in the Trust, from Patient and Carer Experience Council to the Trust Board meetings. The stories are told in the patient, carer or relatives words and show their journey through our services. We try to identify stores where we could have done better and we then share the improvements that have been made to ensure the experience is improved in the future for our patients.

Domain- Patient experience

b. Responding in a timely way to complaints & implementing quality improvements.

Rationale

- Provide responses to complaints timely ensuring we meet the timeframes agreed with the patient, carer and families.
- Support to the patient, carer and families during complex and distressing complaint investigations, utilising Family Liaison Officers.
- To ensure continuous improvement to services from complaints.

Agreed Actions

- Monitor the agreed timeframe for responses for all complaints.
- To provide support to the patient, carer and families during complex and distressing complaint investigations, utilising Family Liaison Officers.
- Signpost to Independent Complaint Advocacy Services (ICA).
- Produce monthly, quarterly and annual reports.

Progress

The number of over 5 month open complaints has reduced significantly during 2024-25. A monitoring process is in place via the Senior Leadership Team meetings.
The Inphase Feedback module now allows easy visibility for Care Groups to monitor complaint deadlines.
Complaint timescales are discussed by the Patient Experience Team and Patient Safety Teams during weekly meetings to identify issues and improve the complaints responded to within target.
A process is in place to identify where a complex complaint may require the support of a Family Liaison Officer. This has improved communication throughout the complaint process, particularly during distressing complaint investigations.
All complainants are advised of the ICA services details and how ICA can support complainants throughout the complaint process.
A University of Tees Patient Experience and Involvement quarterly report was developed and provides in-depth patient experience information.
An annual North Tees Patient Experience and Involvement Report is produced and available via the Trust website.

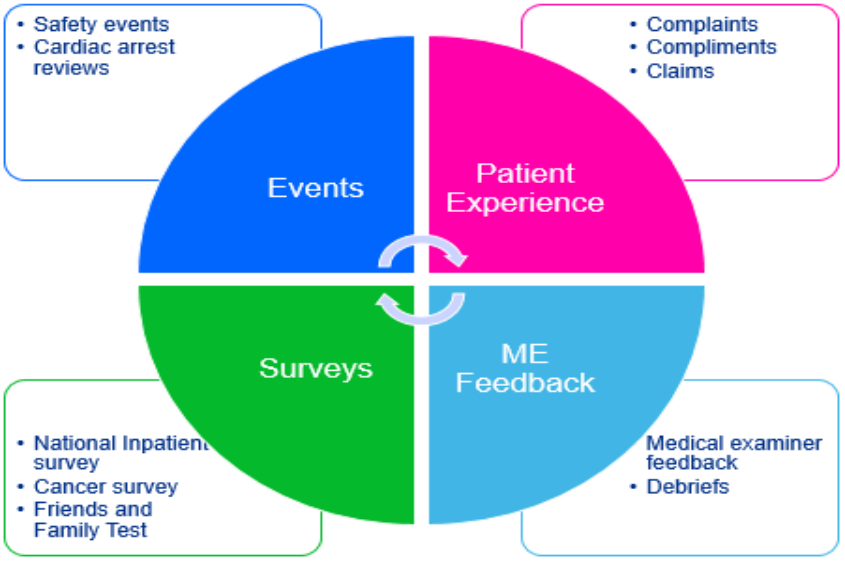
Improvements following during 2024-25

We continue to work alongside our patients and relatives to respond to their complaints in a timely and compassionate way. Where we identify learning opportunities we share these using a tool (PEARLS of wisdom) which focusses on learning and identifying improvements from the patient's experience. Where appropriate we encourage patients and relatives to become involved with our learning journey. We also use the national patient survey as a way for us to review and implement actions to improve the experience of our patients.

We recognise to achieve a high standard of quality and safety in the care delivered across our services we will review a consistent set of Patient safety activities with our service and stakeholders. A triangulation and thematic analysis approach will be used to determine patient safety priorities and patient experience to establish where improvement work should be focussed.

Within this triangulation the newly established 'Patient Safety Clinics' and the Clinical Quality Accreditation Framework reports will be vital in identifying themes of improvement whilst supporting areas in QI projects and creating a learning culture within services.

Patient Safety and experience triangulation



Putting our population first

- Diagnostic recovery reduction to less than 6 weeks wait
- Greater oversight of cancer pathways to allow targeted efficiencies, treatment and reviews
- Diabetes care home pilot to improve the experience of patients ensuring a reduction in hospital attendance
- Development of a haematology specialist nurse for community outreach meaning patients are able to be treated in their own home and reduce the risk of admission for this group of patients
- Reviewed the internal and external transfer checklist and updated to improve communication across services
- Hosted a discharge event bringing together patients, relatives and services to further develop support and communication provided
- Contacted patients for health prevention using the Making Every Contact Count (MECC) approach

- Supported learning reviews related to skin integrity to ensure improved quality of care
- Introduced reduce draw blood tubes for full blood count and coagulation reducing the amount of blood needed from the patient, the number of times patient required to be bled and improving care.
- Introduced education sessions including 'back to basics' and communication to improve care and experience of patients within Emergency Assessment Unit (EAU)
- Focus on improving time sensitive medications with the use of stop clocks to alert staff when medications are due ensuring patients receive their medication when prescribed.
- Developed patient leaflets to improve information provided in areas relating to patient feedback
- Skin care prevention and management training for care homes.
- Patient/care giver feedback sessions in collaboration with Hartlepool Local Authority.
- Use of the i-stumble app to improve the management of patients who have fallen at home.
- Improved access to specialised seating for patients unable to sit in a standard chair to improve safety, positioning, comfort and pain following patient feedback.
- Supported learning reviews related to skin integrity to ensure improved quality of care
- Introduced reduce draw blood tubes for full blood count and coagulation reducing the amount of blood needed from the patient, the number of times patient required to be bled and improving care.
- Introduced a fundamentals of care training day within orthopaedics to support patient care, communication and treatment
- Focus on improving time sensitive medications with the use of stop clocks to alert staff when medications are due ensuring patients receive their medication when prescribed
- Deteriorating specialist nurses developed a training package to support identification and treatment of Acute Kidney Injury (AKI) and Sepsis to prevent further deterioration of patients

Transforming our services

- One of the top performing trusts in the country for four hour standard and ambulance handover ensuring a better patient experience and timely care.
- Development of an ambulatory area in the Emergency Department to relieve clinical room occupancy to ensure that patients are seen as timely as possible.
- Use of Artificial Intelligence in radiology to improve time of reporting being received by patients.
- Introduction of Point of Care testing ensuring a more efficient service for patients.
- Continued to develop managing heart failure at home programme providing heart failure patients with a digital solution to enable greater oversight and improved management of their condition.
- Tees Valley combined paediatric spinal and orthopaedic MDT to improve waiting times and management of children presenting with a complex spinal orthopaedic condition.
- Continued development of Virtual wards in order to increase effective management of patients in their own home, avoiding admissions and reducing hospital length of stay.
- Collaborative working with North East Ambulance Service (NEAS) to avoid admissions for patients who can be managed in their own home.
- Online appointment booking and cancellations for outpatient clinics.
- Use of voice recognition for letters within clinics this has improved the wait time for letters to patients in various services.
- Maintained elective hub accreditation with a focus on increasing activity to further support reductions in waiting times for procedures.
- Increased appointments in pre assessment to reduce clinic times and further improve the patient experience.

Health and Wellbeing

- Introduction of Quality and Safety clinics which provide an opportunity for the teams to discuss patient safety events, patient feedback, claims and risk sharing learning and developing improvements.
- Introduced a targeted lung health check programme to help reduce wait times for patients.
- Developed a process to support frequent attenders to Emergency Department to help improve experience and overall health of these patients.
- Continued to promote the Active Hospital concept in areas to support patients' mobility and length of stay for inpatients and promote active lifestyles for outpatients.
- Updated current bereavement package to provide more support to bereaved families.
- Use of VR headsets to improve symptoms of palliative patients that are bed bound.
- Continued to promote the Active Hospital concept in areas to support patients' mobility and length of stay.
- Gastroenterology team held a Pancreatic Patient Education event to provide information and education about their diagnosis and management.
- Continued development of the Waiting Well service as a way to support patients who are waiting for procedures and who need support to maintain their health and wellbeing throughout their journey. Supporting health inequalities and working with population health.
- Established pain management clinics to support the Waiting Well work ensuring patients pain is better managed whilst waiting for treatment, pre and post operatively.
- Continued to promote the Active Hospital concept in areas to support patients' mobility and length of stay.

Valuing people

- Increased Parkinson specialist nurses to ensure patients can be seen timely and improve overall experience and treatment.
- Further recruitment of an asthma nurse to improve experience and treatment for asthma patients.
- Continued to provide regular training and teaching sessions for staff to ensure that they are kept up to date, enhance practice and improve quality of patient care.
- Provided hyperglycaemia training following complaints regarding management of diabetes care and linked to the trust Patient Safety Event Response Plan (PSERP) priorities.
- Continue to provide 'It all starts with me' training for staff with key concepts around civility, values and communication to support improvements in care.
- Continue to develop Quality Improvement (QI) knowledge through Bronze QI face to face and e-learning sessions ensuring all staff know how to make improvements from feedback.
- Continue to provide 'It all starts with me' training for staff with key concepts around civility, values and communication to support improvements in care
- Continue to develop Quality Improvement (QI) knowledge through Bronze QI face to face and e-learning sessions ensuring all staff know how to make improvements from feedback

Domain Patient Experience

c. Development and implementation of a Group Mental Health Strategy.

We will develop and implement a Group Mental Health Strategy to improve care and share learning for our patients who are experiencing difficulties with their mental ill health.

Rationale

Physical and mental health care have traditionally been delivered separately. While investment and improvements in mental health services is welcome, physical, and mental health services will only truly be equal when we stop viewing physical and mental health as distinct from one another.

Many patients across both Trusts have mental health needs which need addressing, alongside their physical health needs if we are to achieve high quality care and good clinical outcomes. Both Trusts provides a number of services for people who are particularly vulnerable or present an elevated risk.

Overview of agreed actions

Review both Trusts Mental Health Strategies and identify similarities and differences.

Identify top 3 priority area to work on collectively at Group level.

Develop a Group Mental Health dashboard.

Establishment of a Mental Health Strategic Group, which brings together expertise from both sites.

Identify Mental Health Training opportunities, specific to professional groups and services.

Clarify Mental Health risk assessment tools used and compliance levels.

Progress and achievements

A Group Mental Health Strategy Group has been formed with representatives from both Trusts. A key piece of work is the development of a Group Mental Health Strategy document with a shared vision and key priorities.

Identified key priorities across the Group:

- Maternal Mental Health
- Suicide Prevention
- Right Care Right Person
- NCEPOD Mental Health in Young People and Adults
- Restraint and aligning the site Restraint Policy.
- Trauma informed care

North Tees and Hartlepool has a dashboard which is used within 'Keeping People Safe' meetings to identify areas of risk. This includes violence and aggressions events reported and the actions required to minimise the risk for staff and patients, including environmental risk assessments and bespoke actions for high risk areas.

The 'Keeping People Safe Group' has covered a broad range of topics including operational process for about Right Care Right Person.

A key piece of work has been the revising the Trusts policy relating to the management of violence and aggression. The key additions proposed to the policy relate to taking a more trauma informed approach, including expanded roles and responsibilities for staff, managers and security teams, focusing on preventative measures and support for employees affected by violence. Local management of events, standardised templates for risk assessments and patient letters and equality and diversity were all strengthened within the policy. There was alignment with South Tees Policy detailing sanctions available, making the process more robust and transparent. Due to the scale of the changes within the policy, it has been discussed at both the safe and effective care strategic group and health, safety and Security Council meetings.

Compliance against local Health Risk Assessment is monitored though the 'Keeping People Safe' meeting. Main area of focus for local risk assessments are from our highest risk areas for violence and aggression that we have identified through our data. This includes Ward 26/36/40/42 and ED.

There was a scoping exercise in August 2024 looking at the availability of appropriate training for staff, including formal education and cultural work. This included:

- There is no formal mandatory mental health training but some is available via e-learning as part of NCEPOD, 'Treat as One' recognising the link between physical and mental health
- Teesside University hold a Masterclass in mental health and training could be funded through CPD monies
- There is specific MH training for Emergency Care and details sent to the team to facilitate recruitment onto this
- There are Mental Health first aiders across the Trust with refresher courses every 2/3 years

4. **Plans for on going work.**

Finalise the Group Mental Health Strategy with representatives across both organisations and disciplines

Draft Quality priorities defined for improvement in 2025/26.

The Trust has agreed the following Group Quality Priorities for 2025/26 following a consultation process with clinical colleagues at both North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trusts and the Council of Governors.

Quality Priorities 2025/26		
Patient Safety		**Patient Experience**
New QP 25/26 We will reduce the risk of acquiring healthcare associated infections in line with NHS England standard contract objectives such as Clostridioides Difficile, Meticillin Resistant Staphylococcus Aureus, Gram-Negative Blood Stream Infections (ECOLI, Klebsiella, and Pseudomonas) alongside other infections to improve outcomes for our patients whilst embedding IPC practices.	Carried forward from 24/25** We will ensure continuous learning and improved patient outcomes following implementation of best clinical practice, using data from clinical audits of compliance against evidence-based standards.	Carried forward from 24/25** We will develop and implement a Group Mental Health Strategy to improve care and share learning for our patients who are experiencing difficulties with their mental ill health.
Carried forward from 24/25** We will continue to optimise the Trust's ability to learn from incidents, claims and inquests to improve outcomes for our patients whilst embedding PSIRF.	Carried forward from 24/25** We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.	Carried forward from 24/25** We will proactively seek patient feedback and ensure there is continuous improvement in care and treatment because of the feedback we receive.
Carried forward from 24/25** We will improve medication safety and continue to optimise the benefits of ePMA and evaluate the impact on learning from medication incidents	Carried forward from 24/25** We will develop and implement shared decision making and goals of care.	Carried forward from 24/25** We will respond in a timely way to complaints, supporting patients and families through difficult circumstances and implement quality improvements as a result of the learning.

The Trust will continuously monitor and report progress on each of the above indicators throughout the year by reporting to the Board.

2:2

2025-26

Statement of assurance from the Board

Review of Services

During North Tees and Hartlepool NHS Foundation Trust provided and/or subcontracted 103 relevant health services. The majority of our services were provided on a direct basis, with a small number under sub-contracting or joint arrangements with others.

North Tees and Hartlepool NHS Foundation Trust has reviewed all the data available to them on the quality of care in 103 of these relevant health services. The income generated by the relevant health services reviewed in 2023-24 represents 92.1% of the total income generated from the provision of relevant health services by the North Tees and Hartlepool NHS Foundation Trust for 2023-24.

National clinical audits and national confidential enquiries

The Healthcare Quality Improvement Partnership (HQIP) provides a comprehensive list of national audits which collected audit data during 2024-25 and this can be found on the following link:

http://www.hqip.org.uk/national-programmes/quality-accounts/

During 2024-25, **53** national clinical audits and **3** national confidential enquiries covered the relevant health services that North Tees and Hartlepool NHS Foundation Trust provides.

During 2024-25, North Tees and Hartlepool NHS Foundation Trust participated in **92%** of national clinical audits and **100%** of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquires that North Tees and Hartlepool NHS Foundation Trust participated in, and for which data collection was completed during 2024-25, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Mandatory National Clinical Audits	Participation	% cases submitted
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Yes	100%
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes	100%
Breast and Cosmetic Implant Registry	Yes	100%
British Hernia Society Registry	No	
Case Mix Programme (CMP)	Yes	100%
Emergency Medicine QIP: Care of Older People	Yes	100%
Emergency Medicine QIP: Mental Health (Self-Harm)	Yes	100%
Emergency Medicine QIP: Time Critical Medications	Yes	100%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Yes	100%

Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Yes	100%
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Core Audit	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	No	
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (NAD)	Yes	100%
National Bariatric Surgery Registry	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Yes	100%
National Bowel Cancer Audit (NBOCA)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	100%
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
National Pancreatic Cancer Audit (NPaCA)	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	100%
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project	Yes	100%

(MINAP)		
National Comparative Audit of Blood Transfusion: Audit of Blood Transfusion against NICE Quality Standard 138	Yes	100%
Bedside Transfusion Audit	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	No	
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Joint Registry	Yes	100%
National Major Trauma Registry	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Respiratory Audit Programme (NRAP): COPD Secondary Care	Yes	100%
National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation	Yes	100%
National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	Yes	100%
National Respiratory Audit Programme (NRAP): Children and Young People's Asthma Secondary Care	Yes	100%
Perioperative Quality Improvement Programme	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	No	
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	Yes	100%

National Confidential Enquiries (NCEPOD):

The Trust participated in all **3** national confidential enquiries (100%) that it was eligible to participate in, namely:

NCEPOD study	Participation	% cases submitted
ICU Rehabilitation	Yes	100%

Blood Sodium	Yes	100%
Emergency Paediatric Surgery	Yes	100%

National Clinical Audits

The reports of **35** national clinical audits were reviewed by the provider in 2024-25 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions taken/in progress
BTS National Pleural Services Audit	The Trust is a very high volume pleural service, providing a full range of pleural interventions. Around half of the trusts in the survey have less than 300 procedures per year, whereas our Trust has 500. The Trust also has more than the median average of patients reviewed per year. There should be a pleural nurse for every 300 procedures, however there is no pleural nurse in place currently. Action plan includes: • Approving the business case to find funding for a pleural specialist nurse • Funding for a dedicated pleural ultrasound lead • Support for pleural services in shaping the organisational development of out of hours provision
NRAP Adult Asthma Audit 2023	Overall good improvements have been made, mainly due to the dedicated asthma nurse. Recommendations include: • Expanding the pool of staff able to deliver the care bundle • Working with the Emergency Assessment Unit and Emergency Department to assess what elements could be delivered by pre-existing staff • Changing the approach to acute asthma immediate assessment and management
NCEPOD Young Person's Mental Health	Work is ongoing to identify a transition nurse. The Trust launched 'We Can Talk' training across the Trust, resulting in 94% of staff completing one or more of the core curriculum modules. 98% of staff who completed the training said that it would have a moderate or significant impact on the way they do their job. 97% of staff would recommend the training to their colleagues. 91% of trainees thought that all hospital staff would benefit from the training.
National Audit of Cardiac Rehabilitation	Areas of good performance included: good completion rates and completion of assessment 1 & 2, mode of delivery. Areas requiring improvement include waiting times for MI/CABG procedures, marital status checking and employment status, as the service targets getting

	people back to work. CABG procedure waiting time and MI wait times are not currently being met due to patients going onto a waiting list at South Tees and this is currently being looked into.
National Oesophago-Gastric Cancer Audit	Good performance was shown in diagnosis confirmed by a second pathologist, which was higher than the national average. Working on non-interventional treatment for patients with minimal symptoms.
National Falls Audit 2023	Overall excellent results with good performance shown in the completion of the multi-factorial risk assessment (MFRA) and improved compliance in completion of the delirium assessment. Although good improvements were shown in the completion of lying and standing BP measurement, more work is ongoing around this. Action plans are in place for conducting a hot debrief after a fall.
NCEPOD Community Acquired Pneumonia	Audit results showed significant numbers of patients presenting with pneumonia do not have any typical features of pneumonia on arrival. CURB65 score was documented in 26.6% of patients. NEWS2 score was documented in 78.5% of patients. Antibiotics were started after more than 4 hours in 27.5% of patients. Written information about Community Acquired Pneumonia was provided to 33.7% patients. An X-Ray was requested in 51.7% of patients at discharge. 37.6% hospitals have a lead clinician for pneumonia. It was noted that there is no smoking cessation service at Hartlepool, however this is being reviewed.
National Neonatal Audit Programme	Good results were shown in Retinopathy of Prematurity (ROP) screening being undertaken, although there is some difficulty in this screening being provided quickly at South Tees, and relies on the availability of the Ophthalmologists. A referral form has been created to send to the Ophthalmology team. A new lead has recently been identified for Ophthalmology in Paediatrics at South Tees, and the ward matron at North Tees is linking in with them to look at how this can be improved. There has not been a single case of blood culture proven sepsis in the neonatal unit. There have also been no cases of necrotising enterocolitis. The unit is working towards UNICEF Baby Friendly Initiative accreditation, and have already achieved stage 1. All staff have received the training required to be able to support mothers with expressing breast milk.

	A risk was identified around not being fully compliant with staffing ratios for British Association of Perinatal Medicine (BAPM) compliance. This was placed on the risk register. A robust escalation pathway to increase the amount of nursing staff available for times of increased acuity and occupancy is now in place and the Trust has also received neonatal critical care funding for additional staff, which has helped increase compliance. Overall good improvements have been made in the key areas from the previous report. Data is regularly reviewed to escalate immediate concerns. Key areas of focus are Breast Milk and ROP. Will be continuing to work with the perinatal team on the preterm bundle.
National Epilepsy 12 audit	63% of children and young people diagnosed with epilepsy had input from a paediatrician with expertise and an epilepsy nurse. It was noted that there was no mental health service for children and young people who had an identified mental health condition. Colleagues attended a course to recognise mental health concerns in children. Good results were shown in children and young people having investigations within the first year of care - this was slightly better than the national average. Only 37% of children and young people obtained their electroencephalogram (EEG) within 4 weeks of request as patients have to be referred to South Tees.
NJR 20th Annual Report 2023 – Upper Limb	Good results were shown in consent and valid NHS number. Overall, practice is in line the National Joint Registry standards and appropriate implants are being used locally. Looking to improve on the collection of Patient Reported Outcome Measures (PROMs).
NCEPOD Testicular Torsion	A local audit had been undertaken to acquire more significant detail. Patient follow-up has improved, but needs to continue. A patient leaflet is to be developed. The team is to develop a pathway with South Tees, to incorporate out-of-hours care via transfer to the specialist centre.
National Heart Failure Audit	Good performance with discharge planning, referral to a Heart Failure Specialist Nurse and referral to the Cardiac Rehabilitation Service. Work is required to ensure Consultant Cardiologist follow-up is arranged by the point of discharge. Currently this is arranged post-discharge by the Heart Failure Specialist Nurse, which does not achieve the audit standard. Working on a business plan to develop 7-day service for Heart Failure Specialist Nursing, as some patients admitted/ discharged over the weekend are not seen by them.

Myocardial Ischaemia National Audit Project	98% of patients were seen by a cardiologist and 80% were admitted to a cardiac ward or unit where the patient will spend the majority of their first 24 hours in hospital. 100% of patients received an angiography (consistent with previous years). 100% of patients were discharged on all eligible secondary medication. Only 52% of patients transferring to JCUH received an echo prior to their transfer, owing to time constraints. This is currently being addressed.
National Early Inflammatory Arthritis Audit	Limited Rheumatology Consultant workforce prevented participation in this audit. The British Society of Rheumatology guidance recommends one Rheumatology Consultant per 60-80,000 population. The Trust has a population of around 400,000 and currently have only two active consultants instead of the recommended five. This issue has been added to the Trust's risk register.
National Hip Fracture Database	Good performance in admission to specialist ward and prompt orthogeriatric review. Mortality of elderly patients with fractures is low and better than the national average. The Trust is below the national average for prompt surgery and prompt mobilisation. One of the main factors is lack of theatre time/space. A new consultant has been recruited and additional lists created to improve performance. Some work is being undertaken with the Anaesthetic Trauma Lead to better optimise patients prior to theatre. A business case is to be submitted to appoint a Nurse Practitioner, based on current lost income from the Best Practice Tariff (which is anticipated would be achieved if the post was implemented).
National Fracture Liaison Service Audit	Bone protection treatment is very good. Data submission for 2024 was lower than previous years, due to staffing issues. This is currently being addressed. Dexa scanning within 90 days requires improvement. The Trust currently has only one Fracture Liaison Nurse, who has a very large workload. The newly employed consultant will be reviewing this service, with the aim of identifying areas for improving efficiency.
NCEPOD Out of Hospital Cardiac Arrests (update)	A local re-audit was brought back to the ACE Council to see if improvements had been made since the national report. Compliance with temperature control management had increased to 91%

	(compared to 26% previously). Good performance was also evident with coronary intervention, final assessment of neuro-prognostication and potential of organ donation (as actively explored on all appropriate patients). Physical, psychological, cardiac and neurological rehabilitation were all re-assessed and demonstrated 100% compliance with standards.
NHS England Learning Disabilities Audit	100% of patients surveyed felt they were always treated with respect. Staff felt they could deliver safe care. Learning disability and autism are flagged via TrakCare to identify needs. A local audit for Deprivation of Liberty Safeguards (DoLS) is required. Reasonable adjustments require improvement. Monitoring of re-admission of patients with learning disabilities and autism (if flagged on TrakCare) is required.
National Bowel Cancer Audit	Good performance shown in case ascertainment, pre-treatment TNM staging, above the network and national results. Good results also shown in patients being seen by a Clinical Nurse Specialist. 2-year mortality rate was 11.1%, below all other hospitals in the region. Regular meetings take place with hospitals in the region to share good practice.
Sentinel Stroke National Audit Programme	Good results were shown in patients receiving a scan within 12 hours (with the majority being scanned within 1 hour of coming into hospital). Majority of patients were admitted to a stroke unit within 4 hours of coming into hospital. 89% of patients are seen at 6 months by a stroke specialist (compared to 50% nationally). Results were poor for patients seen by the Speech and Language team within 72 hours, due to limited staffing resources (this was noted to be low regionally). Collaborative working being undertaken with colleagues from JCUH and RVI to establish a 24/7 Thrombectomy service.
RCEM Infection Prevention & Control QIP	Staff will be reminded to document and ask questions regarding potential vulnerabilities on initial assessments. Encouraging good hand hygiene and the use of PPE will be done through monthly hand hygiene audits moving forward.
National Joint Registry: Shoulder & Elbow report	Excellent overall compliance with national standards. Consenting patients for inclusion in the registry has improved since the previous report.

	Patient reported outcome measures (PROMs) continue to improve, but still need to be timelier. Nurse practitioners have recently taken up this role, so this will improve further.
Serious Hazards of Transfusion (SHOT) report	Good evidence of adopting conservative blood management culture during times of amber alert. Encouraging clinical areas to report more openly, to support ongoing learning.
NHS Blood & Transplant Bedside Transfusion audit report	Transfusion Co-ordinators are delivering training sessions across wards via daily huddles to remind staff of requirements. Although monitoring of pulse, blood pressure, temperature and respiratory rate at 15 minutes after transfusion start and at the end of each transfused unit was better than the national average, there remained significant room for improvement.
Royal College of Emergency Medicine (RCEM) Mental Health Quality Improvement Project	It was agreed at the ACE Council that the recent RCEM audits were of poor quality and did not provide timely analysis in order to assist the clinical teams with local quality improvement. This will be raised with RCEM.
National Lung Cancer Audit report	Audit data collection and quality are rated as high for the Trust. Chemotherapy rates for small cell lung cancer are to be reviewed, to ensure all patients are receiving appropriate treatment.
NCEPOD End of Life Care	Normalising conversations about end of life care. A “Dying Matters Week” is to be held in May, to promote clear communication. 7-day palliative care provision available, but currently unable to provide face-to-face support at weekends, due to staff shortage. Aiming to collaborate with regional providers. NCEPOD recommends training patient-facing healthcare staff in end of life care. Clinical Lead has requested this to be added to the mandatory training programme on ESR.
National Diabetes Foot Care Audit	There is a nationwide requirement to improve the timescale for onward referral from Community teams to the MDT. Some local staff training will be undertaken to improve the capture of patients with foot ulcers on SystmOne.
RCEM Cognitive Impairment in Older People 2022/23	Improvement in documenting action taken based on screening process findings, when compared to previous year. 73% of patients with delirium had a clearly documented delirium action plan.

	Use of the 4AT screening document is notably reduced compared to the previous year. Clinical Lead is working with the Alcohol Team to look at overseeing the screening for delirium. The clinical team will write to RCEM about the poor quality of this national audit.
National Cardiac Arrest Audit	Return of spontaneous circulation at 20 minutes was within predicted range (even not accounting for comorbidity and deprivation factors). The North East region is identified as having the lowest life expectancy in England. Whilst cardiac arrest rate, management and critical care admission post-arrest are similar in the region, there are a number of actions which are being undertaken: • An "Arrest Team Handover" QIP • Debrief training for medical registrars • Collaborative work between Critical Care Outreach and Resuscitation Training Team Recent results have improved since this report, and are being monitored.
National Prostate Cancer Audit	The Trust has improved across all audit standards relating to investigation and management of prostate cancer. Numbers of confirmed cases have increased over time, and this is potentially attributable to positive nationwide communications strategy to raise awareness amongst men.
BTS Respiratory Support Audit	The national comparative audit identified the Trust had a better proportional uptake of patients on the respiratory support unit, when compared to the national average. Time until treatment is shorter, escalation status and frailty score were better and good collaborative multi-disciplinary team working between the respiratory support unit and ward. Areas identified for improvement included the need for 24/7 consultant cover and increased non-invasive ventilation training to rotational staff.
National Audit of Inpatient Falls: 2024 report	Work is ongoing to increase documentation of lying and standing blood pressure. The falls educator is linking with the enhanced care team to ensure knowledge and skills are maintained. A trial of a post-falls checklist to ensure patients who have had a fall have a consistent documentation of review for injury.

All national audit reports are considered by the Audit and Clinical Effectiveness (ACE) Council

which reports to the Safe and Effective Care Strategic Group (SECSG).

Local Clinical Audits

The reports of **82** local clinical audits were reviewed by the provider in 2024-25 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions taken/in progress
Day Case Arthroplasty Audit	Actions to be taken include a review of short acting spinal anaesthetics and advanced planning to help reduce length of stay for all patients.
Safeguarding Adults Audit	There will now be electronic flagging available on the patient record where there are safeguarding concerns.
Biologic treatment cessation for Rheumatoid Arthritis	Clinical staff will aim to stop or reduce patient's biologics if their disease activity has become stable – as per NICE guidelines. Staff will also consider alternate cause of symptoms if patients are stable without immune modulation.
Management of Constipation in Children	Improvements required in follow up care to ensure that the follow up is consistent and adequate for these patients. As a result of the audit finding, patients will now have access to the nurse-led constipation service.
Venous Thromboembolism (VTE) Documentation	Focus on improvements in the daily assessment of VTE risk although initial admission risk assessment was excellent.
Assessment and Aetiology in Paediatric Audiology	There were some cases where the results were not recorded in line with British Society of Audiology standards and this will be reviewed in detail.
Oxygen Prescribing in the Emergency Department	Training to be provided to improve awareness around oxygen prescribing and where to formally confirm target oxygen saturations.
Sedation of Children and Young People in the Community Dental Service	Some areas of documentation recognised to ensure that all consent forms are signed and the pre-sedation assessment is scanned to the patient electronic records.
Correlation of MRI with Prostate Biopsy for Prostate Cancer	Although MRI reporting has improved there is still some work to be undertaken to improve compliance. Work to be undertaken with local trusts to compare our results and these results will be shared with the North East Urological Society.
Transfusion-associated Circulatory Overload (TACO) audit	Training sessions have been completed with all relevant staff in addition to existing mandatory training. An electronic checklist will be launched on the patient record system.

2024 –25 Clinical Research

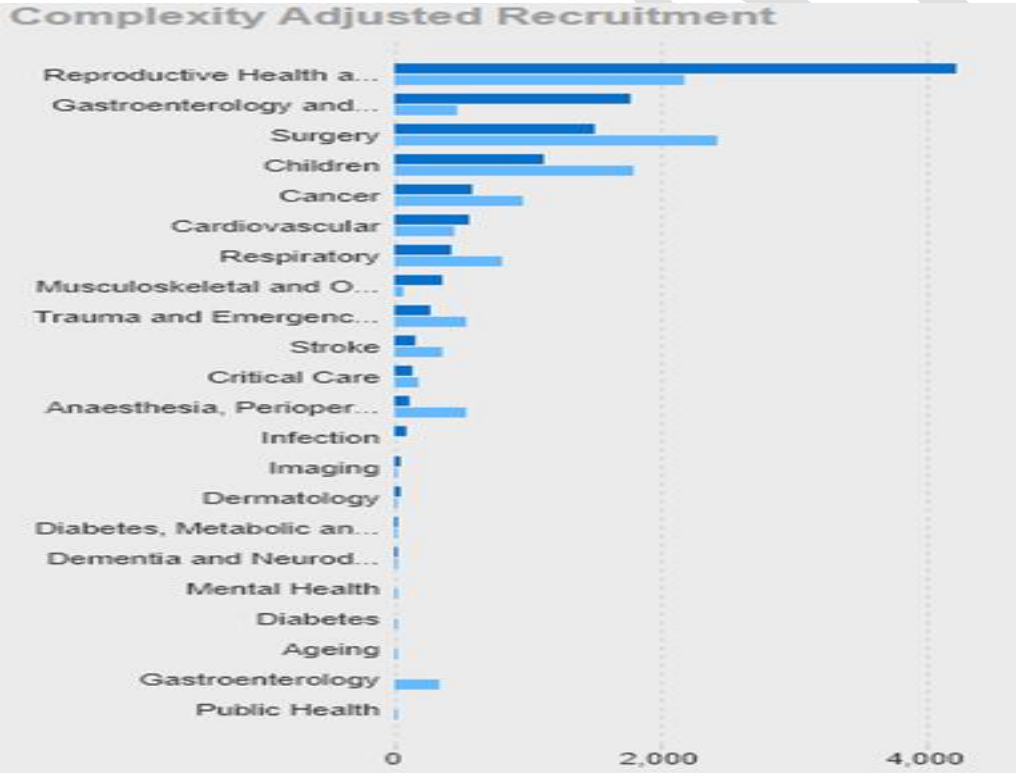
Clinical Research (North Tees)

The number of patients receiving relevant health services provided or subcontracted by North Tees & Hartlepool NHS Foundation Trust (NTH) in 2024/25 that were recruited during that period to participate in research approved by a research ethics committee was 5077 (across **87 studies** and **27 clinical specialties**). This is higher than the same time point in our previous year (4171) despite 2023/24 being our highest recruitment at that time

Our Tees Valley Research Alliance (TVRA) Strategy to be delivered across both partner trusts in the University Hospitals Tees (UHT) Group is a patient focused strategy to deliver improved outcomes through two main streams– Growing Research and Supporting Research. Whilst our recruitment has increased, our focus this year has been on supporting the development of research skills for our staff and our own research workforce as outlined in the sections below.

Performance

Fig 1 Recruitment by clinical specialty



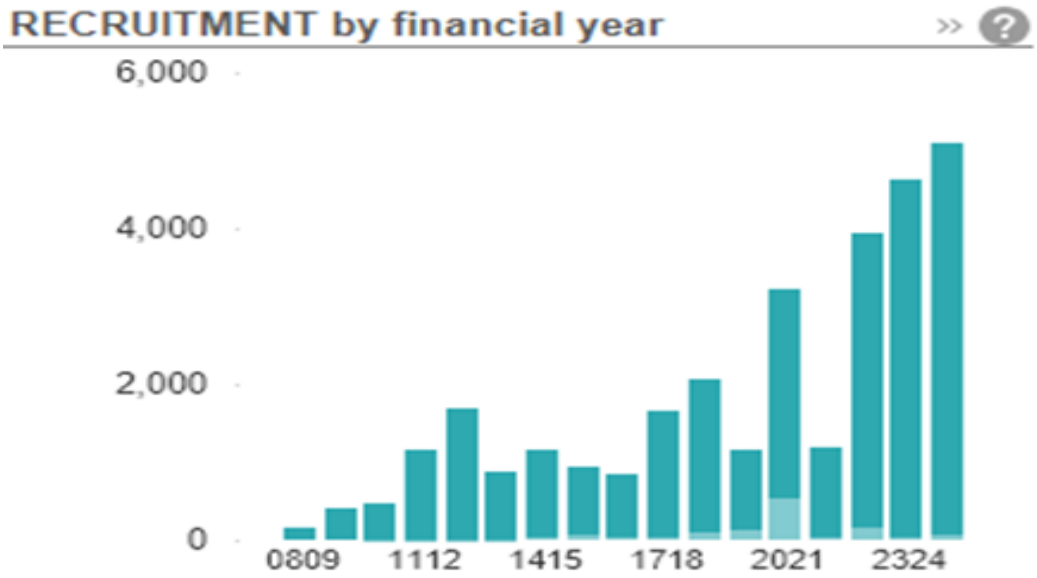


Fig 1 Recruitment over time

Research is now one of the 8 domains reporting into the group board through individualised Trust Board Assurance Frameworks (BAF) which outline the risks to achieving our strategic aims above. Monthly reporting of progress against the BAF is provided to the Group Quality Assurance Committee.

We have 88 Principal Investigators (PIs) supporting the delivery of research studies across NT this year. The number of non-medical Principal Investigators has remained the same this year 12.

Achievements of note:

- NTH Research Midwife is the top recruiting PI in the North East & North Cumbria
- We have engaged more proactively with our membership of the Northern Health Science Alliance (NHSA) over the last 12 months and progressed from being the least represented member on work streams and sub-groups to one of the most represented

Nursing Midwifery and Allied Health Practitioner (NMAHP) Development

The CNO Research Lead, in collaboration with Teesside University, have secured 4 Chief Nurse PhD Fellows in 2024/25 with another 2 planned to start in 2025/26 to develop NMAHP clinical academic careers. In 2024/25 we have 4 NMAHPs beginning an INSIGHT funded research masters programme equating to funding of £31,000. Research has now been included into our quality care accreditation programme and we have introduced the Multi professional Practice Based Research Capabilities Framework to develop practitioners research pillar. To support writing skills for publication/ grants/ research we secured funding for a writer in residence (0.2 WTE) from the Royal Literary Fund. Over 150 staff have accessed workshops or 1:1 writing support since October 2024 from across both trusts.

The CNO Research Lead and TVRA Clinical Research Manager have developed a bespoke research placement for student nurses that will now run bi-annually which will increase research placements from 2 per year to 20 per year. The TVRA Research Manager has established a Research Link nurse pilot to be a single point of contact and research "ambassador" within clinical teams in NTH. We will formally review this pilot and if successful will extend across the UHT group. Our Research Operations Manager is supporting our non-registered research staff with training and accreditation through the Care Certificate and have 3 members of the team formally accredited as "Clinical Research Practitioners".

Trust Sponsored studies

The TVRA has been successful in being awarded over £6.7M in grant awards in the last year to conduct their own studies. £40K of this was for general trust sponsored studies, £4.4M for Academic Centre for Surgery (**ACeS**) led studies and £2.3M for Academic Cardiovascular Unit (**ACU**) led studies.

We have 20 studies open that have been developed by our own trust researchers that we sponsor and a further 35 under consideration. Details below.

Trust sponsored studies by support team	Pipeline	Set up	Open	In follow-up
ACU	8	1	6	1
ACeS	7	4	7	2
TVRA team	9	6	7	2
Total	**24**	**11**	**20**	**5**

We work collaboratively with external academic partners from Teesside, Newcastle, Hull, York and Durham Universities and are proactively developing collaborative research delivery models with colleagues from Primary Care and community pharmacies for vaccine trials.

INNOVATION

The challenge is an innovation culture to help guide the Trust down the path to Excellence in Healthcare, driving change and improving the quality of care being delivered. Innovation is the art of solving real world problems. We look to improve healthcare delivery creating an environment for healthcare innovation in which we can generate new ways of working, thinking, and engaging with healthcare to produce potentially transformative products and services for the benefit of our patients.

Innovation, alongside Research, is one of the eight domains reporting into the group board through individualised Trust Board Assurance Frameworks (BAF) which outline the risks to achieving our strategic aims above. Monthly reporting of progress against the BAF is provided to the Group Quality Assurance Committee.

Innovation at North Tees & Hartlepool NHS Foundation Trust is provided by NTH Solutions. Due to the resignation for the Head of Innovation at NTH Solutions and other business matters, some restructuring within NTH Solutions has taken place with a Business Development & Innovation team put in place from January 2025 which is very much in its infancy.

With the appointment of an interim Director of Innovation for University Hospitals Tees from April 2025, an Innovation Strategy is being developed and is expected to be incorporated across the group considering expected group working. Further work around the strategy will take place in early 2025/2026.

2024-25 Care Quality Commission (CQC) registration, review and investigations

North Tees and Hartlepool NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions for all services provided.

CQC Rating

The most recent CQC visit took place between the 3 to 26 May 2022. The Trust has been rated as **'Requires Improvement'**, additional detail regarding the recent visit is located in the CQC section on page 95.The Care Quality Commission (CQC) published a report in September 2022, following the inspection of two core services, maternity and children and young people. The Trust's overall rating as highlighted below is 'requires improvement'. The report outlined 13 'must do' actions and 18 'should do' actions. The Trust has since addressed all the CQC must and should do actions from the inspection.

Overall rating for this Trust	Requires Improvement

Are services at this Trust safe?	Requires Improvement
Are services at this Trust effective?	Requires Improvement
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Good
Are services at this Trust well-led?	Requires Improvement

The full inspection report can be found at: http://www.cqc.org.uk/provider/RVW

CQC Contact and Communication

The Trust has regular CQC engagement meetings. In addition to these regular telephone contact is maintained as required. There has also been the opportunities for CQC staff to make informal visits to clinical areas at their request when on site.

Some information related to the Trust's CQC actions is available to the public on the Trust's website http://www.nth.nhs.uk/patients-visitors/cqc/. Quarterly news bulletins are being published and are available to the public on the Trust's website. http://www.nth.nhs.uk/patients-visitors/cqc/news-bulletin/

2.2 Duty of Candour

Duty of candour is the requirement to be open and transparent with people who use the Trust's services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. All healthcare professionals have a "professional" duty of candour which is to be applied at all times in relation to care and treatment.

The "legal" requirements around duty of candour are defined and specifically laid out in the CQC Regulation 20. All NHS Trusts are required to fulfil specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The Trust has had a policy in place since the regulations were introduced in 2014; this was updated in 2023 when the CQC published additional guidance and also following analysis of the Trusts latest CQC report in 2022. The policy details for staff how application of the professional requirements and also the legal requirements should be communicated to patients and their families and/or carers and then recorded.

On a weekly basis, the Trust's Safety Panel are advised about all events reported with significant harm where the regulations would need to be considered and applied; most of these relate to events where harm has been reported as moderate harm or above. This can also include events linked to formal complaints that have been received and the duty of candour regulations are considered applicable. This sharing of information highlights cases to panel members, provides details of the application of the regulations within clinical areas, and where necessary, identifies any challenges in relation to applying the regulations.

The Trust e-learning package in relation to duty of candour has been updated; and this training has been mandated for all medical staff and other staff, grade 6 and above; at the end of March 2025 97.5% of the relevant staff have completed the training, this is monitored monthly through the Trusts mandatory training reports and displayed on the Yellowfin dashboard. The e-learning package is, however, available for all Trust staff to complete and in quarter 4 2024-25, the module can be repeated as and when a member to staff wishes to have an update.

Since the publication of its 2022 CQC report, the Trust has undertaken continuous cycles of quality audit of cases where the legal candour regulations have been applied, these audits have shown continued improvements that have been identified following quality improvement measures implemented after previous cycles. The Trust also requested that AuditOne review the application and compliance with the Trust policy, this has been completed during 2024-25 and the report provided to the Board identified "Good" compliance with the policy, with four low and moderate recommendations which have been actioned and closed.

The Trust is continuing the 6 monthly cycles of internal audit, this is being transferred into the In Phase audit module during quarter 1, 2025-26 and will support the provision of a "live" audit dashboard to monitor compliance. The Trust policy is currently being reviewed to align the requirements with the policy at South Tees; this will assist in aligning both the professional and regulatory aspects of candour across the Group.

Commissioners Assurance

There have been no visits during 2024-25.

Submission of records to the secondary uses service

North Tees and Hartlepool NHS Foundation Trust submitted records during 2024-25 to the Secondary Uses Service (SUS) for inclusion in the Data Quality Maturity Index (DQMI which are included in the latest published data**.**

The percentage of records in the published data as at the end of February 2025:

Which included the patient's valid NHS number was:	%	Which included the patient's valid general medical practice code was:	%
Percentage for admitted patient care	**99.94%**	Percentage for admitted patient care	**100%**
Percentage for outpatient care	**99.7%**	Percentage for outpatient care	**100%**
Percentage for accident and emergency care**	**99.63%**	Percentage for accident and emergency care	**100%**

Information governance (IG)

Data Protection Assurance

Assurance continues to be provided to the Board of Directors that systems and processes are being constantly assessed and improved to ensure that information is safe. In accordance with UK GDPR Article 37, we have an appointed Data Protection Officer (DPO) who provides support, advice and assurance to the Board in respect of obligations pursuant to legislation, monitors compliance and acts as a point of contact for data subjects and the supervisory authority (ICO).

The Data Security and Protection Standards for health and care are set out in the National Data Guardian's (NDG) ten standards and are measured though the completion of the Data Security Protection Toolkit (DSPT). All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

The Trust submitted its DSPT submission on the 29 June 2024. The Trust has self-assessed compliance with all standards and all mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the Trust scored as all ***'Standards Met'*** for the 2024 DSPT.

The 2023-24 DSPT was also subject to external audit, a sample of thirteen of the mandatory assertions taken across the ten standards were audited by External Audit (Audit One) during March and April 2024 prior to the DSPT submission.

The Trusts independent risk assessment scored the Trust as **'Substantial'** for all ten National Data Guardian Standards and the overall confidence level of the independent assessor in the veracity of the self-assessment was also rated as '***Substantial'.***

The 2024/25 DSPT submission is significantly different from previous years as it is now aligned to the Cyber Assessment framework (CAF). The Cyber Assessment Framework provides a systematic and comprehensive approach to assessing the extent to which cyber and information governance risks to essential functions are being managed.

At the time of writing, the status of the 2024/25 DSPT is that the Trust has provided baseline information on all 39 outcomes. The Trust is gathering evidence to support the submission. The final submission date is 30 June 2025.

Data Security

The confidentiality and security of information regarding patients and staff is monitored and maintained through the implementation of our Governance Framework which encompasses the elements of law and policy from which applicable information Governance (IG) standards are derived.

Personal information is increasingly held electronically within secure digital systems, it is inevitable that in complex NHS organisations, especially where there is a continued reliance upon manual paper records during a transitional phase to paperless or a paper light environment, that a level of data security incidents can occur.

Any incident involving loss or damage to personal date is comprehensively investigated by the Trust in line with its Data and Cyber Breach Management Policy and graded in line with the NHS Digital 'Guide to the Notification of Data Security and Protection Incidents'.

All incidents are graded using the NHS Digital breach assessment criteria and our risk assessment tool according to the significance of the breach and the likelihood of those serious consequences occurring. The incidents are also graded according to the impact on the individual or groups of individuals rather than on the Trust. Those incidents deemed to be of a high risk are reportable to the Information Commissioners Office (ICO) via the Data Security Protection Toolkit within 72 hours of being reported to the Trust.

We actively encourage staff to report any suspected data protection and cyber breaches irrespective of their severity in line with its reporting policy.

We reported one incident to the ICO during the reporting period, a reduction from four in the previous year. The reported incident is related to 'inappropriate disclosure by a staff member', the incident has since been closed without action by the ICO and the Trust has taken appropriate action to mitigate.

In order to further strengthen existing Trust policy and to prevent repeat incidents in areas where incidents have occurred the following key actions were undertaken:

- Review of IG policies and standard operating procedures to ensure they reflect the specific needs and practicalities of each internal department and they reflect the changing needs of legislation and national guidance.
- Continued programme of comprehensive quality assurance and spot checks to ensure all departments are complying with Trust policies relating to the protection of personal data.
- Continue to provide annual Data Security Training inclusive of Cyber Security and the provision

of targeted training in areas of non-compliance.

- Robust monitoring of departmental action plans following incidents to ensure appropriate actions have been implemented via the Digital Governance Committee.
- Full annual review of information assets and information flows through the Trust within a redesigned framework to comply with GDPR requirements.
- Regular staff awareness campaigns run via communications team targeting areas of non-compliance.
- HR processes followed where repeated non-compliance has been found.

Freedom of Information (FOI)

The Trust continues to respond to Freedom of Information requests from members of the public on a range of topics across all services and departments, complying with the 20 working day limit to do so. The act is regulated and enforced by the Information Commissioners Office (ICO). The ICO hold powers to enforce penalties against the Trust when it does not comply with the Act, including but not limited to monetary fines. For the year 2024-25 the Trust received 747 requests with a compliance level, as at 31 March 2025, of 94%. This was achieved despite Trust services experiencing significant pressures and demands on services.

The Trust will be taking the following actions to improve data quality Clinical coding audit

Clinical coding translates medical terms written by clinicians about patient diagnosis and treatment into codes that are recognised nationally.

North Tees and Hartlepool Foundation Trust was *not subject* to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

The Audit Commission no longer audits every Trust every year where they see no issues. The in-house clinical coding audit manager conducts a 200 episode audit every year as part of the Data Security and Protection (DSP) Toolkit and also as part of continuous assessment of the auditor.

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Primary diagnoses correct	91.00%	90.50%	90.50%	91.00%	91.00%	**90.00%**
Secondary diagnoses correct	93.56%	93.72%	85.98%	89.19%	83.13%	**89.94%**
Primary procedures correct	93.75%	90.82%	97.66%	90.42%	91.21%	**94.90%**
Secondary procedures correct	88.33%	91.49%	82.35%	83.10%	90.28%	**90.51%**

The 2024-25 audit is still being carried out so the results are not yet available, but the services reviewed within the sample are 200 finished consultant episodes (FCEs) taken from all surgical specialties and include day cases.

The errors include both coder and documentation errors of which the coding errors will be fed back to the coders as a group and individually. The documentation errors will be taken to directorate meetings.

Depth of coding and key metrics are monitored by the Trust in conjunction with mortality data. Targeted internal monthly coding audits are undertaken to provide assurance that coding reflects clinical management. Any issues are taken back to the coder or clinician depending on the error. The clinical coders are available to attend mortality review meetings to ensure the correct coding of deceased patients.

Our coders organise their work so that they are aligned to the clinical teams. This results in sustained improvements to clinical documentation. This supports accurate clinical coding and a reduction in the number of Healthcare Resource Group changes made. This is the methodology which establishes how much we should get paid for the care we deliver. We will continue to work hard to improve quality of information because it will ensure that NHS resources are spent effectively.

Specific issues highlighted within the audit will be fed back to individual coders and appropriate training planned where required. North Tees and Hartlepool NHS Foundation Trust will be taking the following actions to improve data quality. In 2015 the coding department underwent a re-structure in order to facilitate coding medical episodes from case notes.

Unfortunately, due to the impact of COVID and losing three WTE coders, the department has failed to code the episodes within the required time scales. This has resulted in a backlog of workload and the difficult decision was taken to pull back from coding all medical episodes from the ACN and case notes and use the discharge summary as the source documentation. There were exceptions, however, to minimise the impact on the mortality indicators and all long stay and deceased patients continue to be coded from the case notes.

A contract coder has also been employed to help to reduce the backlog. There is a recovery plan in place and it is hoped the deadlines will be back to the SUS flex deadline in the summer. The HSMR and SHMI mortality indicators are constantly being reviewed and so far, the change in coding practice has not had a negative impact on them. When the medical coding does return to full ACN and case notes, EAU and ambulatory will still be coded from the discharge summary as the increase in daily workload coupled with the imbalance in the team dynamic means that maintaining coding accuracy while continuing to achieve 100% of coding within the mandatory time deadlines is increasingly challenging.

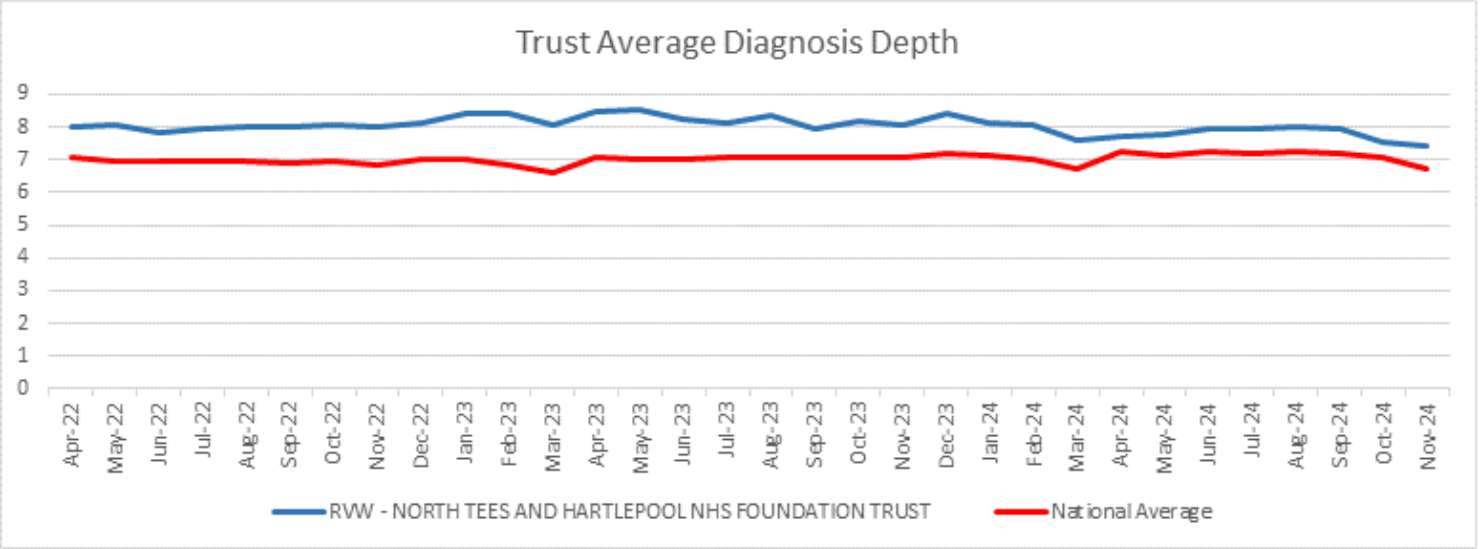
In July 2020 the Trust went live with Active Clinical Notes (ACN). Active Clinical Notes allows traditional paper-processes and pathways to be made available digitally. This means the clinical details of patient's diagnoses and treatments are now added directly to the patient's Electronic Patient Record. As a result of this change it has allowed the coding department to introduce an opportunity for some of the coders to work from home.

In June 2021 the Coding Department started a twelve-week homeworking trial period. After the initial trial period the homeworkers coding was audited and the results showed the quality of coding carried out at home was on a level with the coding carried out within the trust. As a result, the home working was made permanent. Continuous audits will be carried out to ensure the levels of accuracy are maintained.

The department carries out monthly reviews of the coding which highlights any 'rule breakers'. The 'rule breakers' are any codes that have been assigned that break the national clinical coding standards. Any 'rule breakers' found are fed back to the clinical coder concerned and the coding is updated before the freeze date.

Diagnosis Coding Depth National and Trust Trend (April 2020 to December 2023)

The Trust has maintained the improvements in accuracy and depth of coding, the following chart demonstrates the Trust average (blue) against the national average (red). The Trust has improved the quality of discharge documentation and actively engaged clinicians to work closely with Clinical Coding. The latest depth of coding shows the Trust having an Average Diagnosis Depth of **7.44** (November 2024) compared with the national average of **6.75.**



2024-25 learning from deaths

The medical Examiner (ME) Service scrutinizes all inpatient deaths. A proportion of deaths are reviewed using the Structured Judgment Review tool via the Inphase Mortality Module. Findings are presented quarterly to the Trust Safety Panel but triangulation of themes and evidence of learning has been challenging to assemble.

We are reviewing arrangements within the Group to improve the reporting, align the themes from Learning from Deaths with the themes from other quality related activity and use these to drive improvements in care.

Progress and achievements

a. The ME Service is now statutory from 9 September 2024
b. The Mortality Module on Inphase is now set up to receive referrals and record reviews.
c. Quarterly thematic review reporting to Safety Panel to support learning and triangulation across all areas of safety, experience and quality.
d. Multidisciplinary team of reviewers established with monthly SJR sessions

The National Quality Board (NQB, 2017) requires that Trusts have a rigorous approach to Learning from Deaths and has set out standards to ensure this takes place. Responding to and learning from the deaths of inpatients within our Trust ensures valuable opportunity for improvement is not overlooked. The Trust seeks to do this compassionately and with engagement of families and carers as partners in the process.

Plans for ongoing work

- Ongoing collaboration with South Tees under the Group Structure
- Review of Specialty Mortality and Morbidity work, with a view to capturing this on InPhase alongside SJR
- Expand team of reviewers
- Work towards SJR of 15% of deaths.

Part 2:3 Core set of Quality Indicators

Summary Hospital-level Mortality Indicator (SHMI)

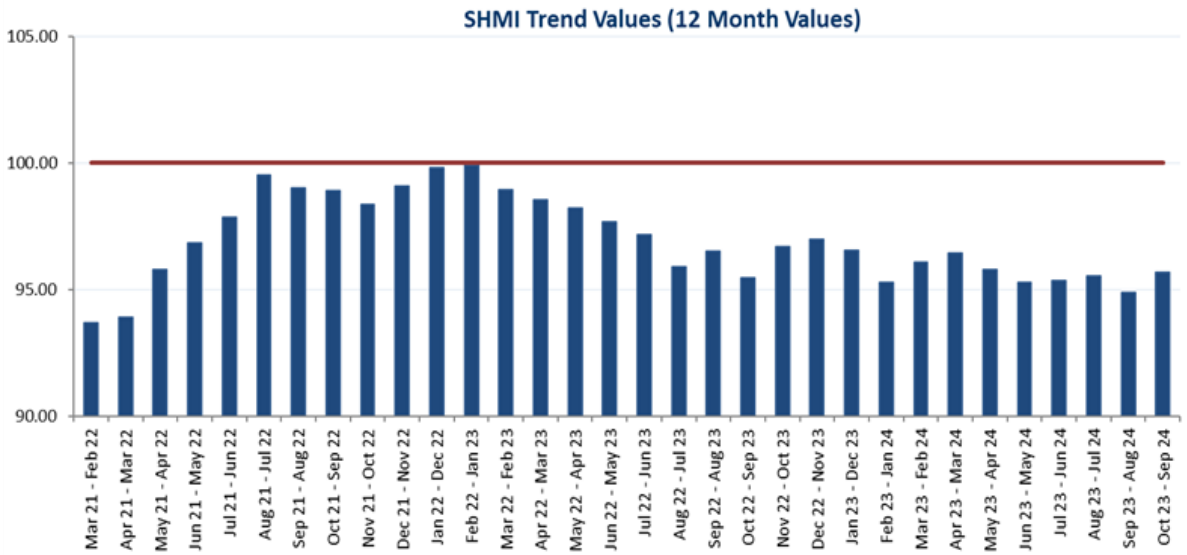
The **SHMI** indicator provides an indication on whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline in England.

SHMI includes *deaths up to 30 days after discharge and does not take into consideration palliative care*.

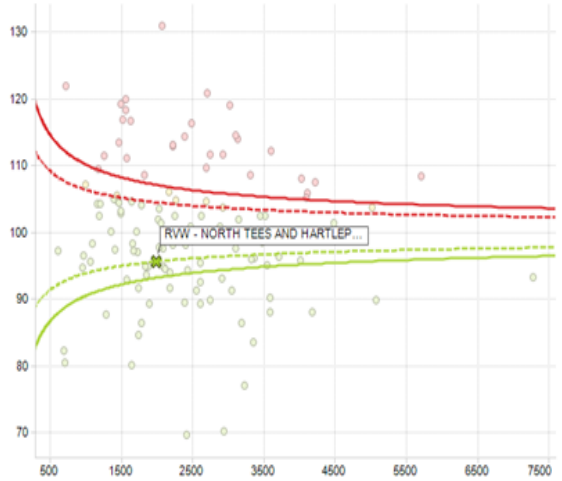
The latest SHMI value of **95.69** (October 2023 to September 2024) continues to reside in the **'as expected'** range.

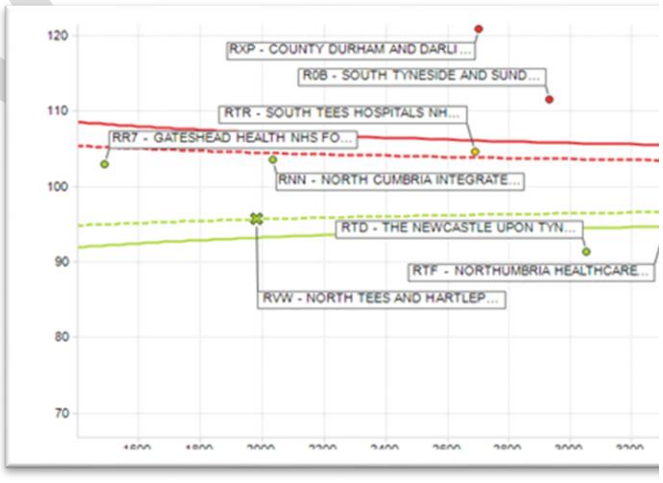
Reporting Period	*CMR	SHMI	National Mean
Oct 23 - Sep 24	3.16%	95.69	100
Sep 23 - Aug 24	3.16%	94.87	100
Aug 23 - Jul 24	3.19%	95.52	100
Jul 23 - Jun 24	3.19%	95.35	100
Jun 23 - May 24	3.19%	95.29	100

*Crude Mortality Rate (CMR)



National View	Regional View





*Data obtained from the Healthcare Evaluation Data (HED)

Trust Raw Mortality- still need updating to latest financial year

The following table and chart demonstrates the raw number of mortalities the Trust has experienced since 2018-19. For the latest financial year of 2023-24, the Trust experienced **1,373** mortalities (April to March), this is **170** fewer mortalities than experienced in 2022-23.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	135	104	102	114	92	108	139	134	132	149	132	113
2019/20	106	142	90	118	117	124	126	125	157	146	116	118
2020/21	152	113	101	93	102	106	120	154	206	207	110	83
2021/22	95	87	84	100	113	112	120	113	152	151	120	110
2022/23	153	117	111	134	95	115	113	135	171	158	116	125
2023/24	**132**	**127**	**90**	**102**	**101**	**96**	**124**	**115**	**148**	**129**	**118**	**91**

	April to March
2018/19	1,454
2019/20	1,485
2020/21	1,547
2021/22	1,357
2022/23	1,543
2023/24	1,373

Learning from Deaths Improvement Work

The following are areas of learning and improvement resulting from mortality reviews:

Recognition of Dying –Instances of both timely and delayed recognition of dying.

Recognition of dying is included in palliative care training for all clinical groups. Work is also ongoing to embed a Treatment Escalation Plan within Trakcare to aid timely recognition of the deteriorating patient and aid ceiling of treatment decisions. It was also recognized that this is particularly challenging in patients with dementia and specific teaching on this is proposed.

The Learning from Deaths team recommended some focused education for medical teams around Heart Failure diagnosis and management, following findings from SJRs

Timely recognition of needs and targeted support in patients with a Learning Disability noted as a particular point of good practice and fed back to relevant teams.

Findings around the timeliness and accuracy of documentation were escalated and disseminated to teams.

Patient reported outcome measures

This section is for the data made available to the trust by NHS Digital with regard to the trust's patient reported outcome measures scores for adjusted average health gain (EQ-5D Index) for:

1. Groin hernia surgery
2. Varicose vein surgery
3. Hip replacement surgery, and
4. Knee replacement surgery during the reporting period

April 23 to March 24	*Groin hernia	*Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement	Knee replacement – Revisions
Trust Score	No data	No data	0.419	No data	0.392	No data
National Average	No data	No data	0.458	No data	0.323	No data
Highest National	No data	No data	0.581	No data	0.405	No data
Lowest National	No data	No data	0.352	No data	0.231	No data

Apr 23 to Mar 24, Data from NHS Digital

The North Tees and Hartlepool NHS Foundation Trust has taken the following actions to improve this score and so the quality of its service.

- The Trust continues to carry out multiple reviews, the reviews occur at 6 weeks and 6 months with the final review being at 12 months. The reviews will be carried out by the joint replacement practitioners unless otherwise identified.
- The Trust continues to use the telephone review clinics, thus ensuring

that communication remains open with the patient listening and acting upon any issues/concerns that they may have.

Readmission data

This section is for the data should be made available to the Trust by NHS Digital with regard to the percentage of patients aged (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Age Group	Value	Emergency readmissions within 30 days of discharge from hospital Apr 2023 to Mar 2024
0 to 15	Trust Score	**13.4**
	National Average	13.2
	Band	W = National average lies within expected variation (95% confidence interval)
	Highest National	69.1
	Lowest National	1.6
16 or over	Trust Score	**13.1**
	National Average	15.1
	Band	B1 = Significantly lower than the national average at the 99.8% level
	Highest National	99.6
	Lowest National	1.7

The North Tees and Hartlepool NHS Foundation Trust considers that this data is as described for the following reasons.

- The Trust monitors and reports readmission rates to the Board of Directors and Directorates on a monthly basis. The January 2023 position (latest available data) indicates the Trust has an overall readmission rate of 8.73% against the internal stretch target of 7.70%, indicating the Trust's readmission rates have slightly decreased by 1.06% from the same period in the previous year (9.79% - January 2022).

The North Tees and Hartlepool NHS Foundation Trust has taken the following actions to improve the rate and so the quality of its service.

- The Trust recognises further work is required to reduce potential avoidable readmissions and so a revised process has been agreed which has seen the development of a standardised template to capture data which will be clinically led. Results will be presented to the Learning and Improvement Committee and Business Team.
- Patient pathways continue to be redesigned to incorporate an integrated approach to collaboration with health and social care services.
- Initiatives continue including: a discharge liaison team of therapy staff to actively support timely discharge, social workers within the hospital teams to facilitate discharge with appropriate packages of care to prevent readmission; utilisation of ambulatory care and rapid

assessment facilities; emergency care therapy team in A&E to facilitate discharge and prevent admissions; community matrons attached to care homes and the community integrated assessment team supporting rehabilitation to people in their own homes including care homes.

- These actions have seen a significant reduction in stranded patients and delayed transfers of care which have assisted in the successful management of winter pressures.

Staff survey

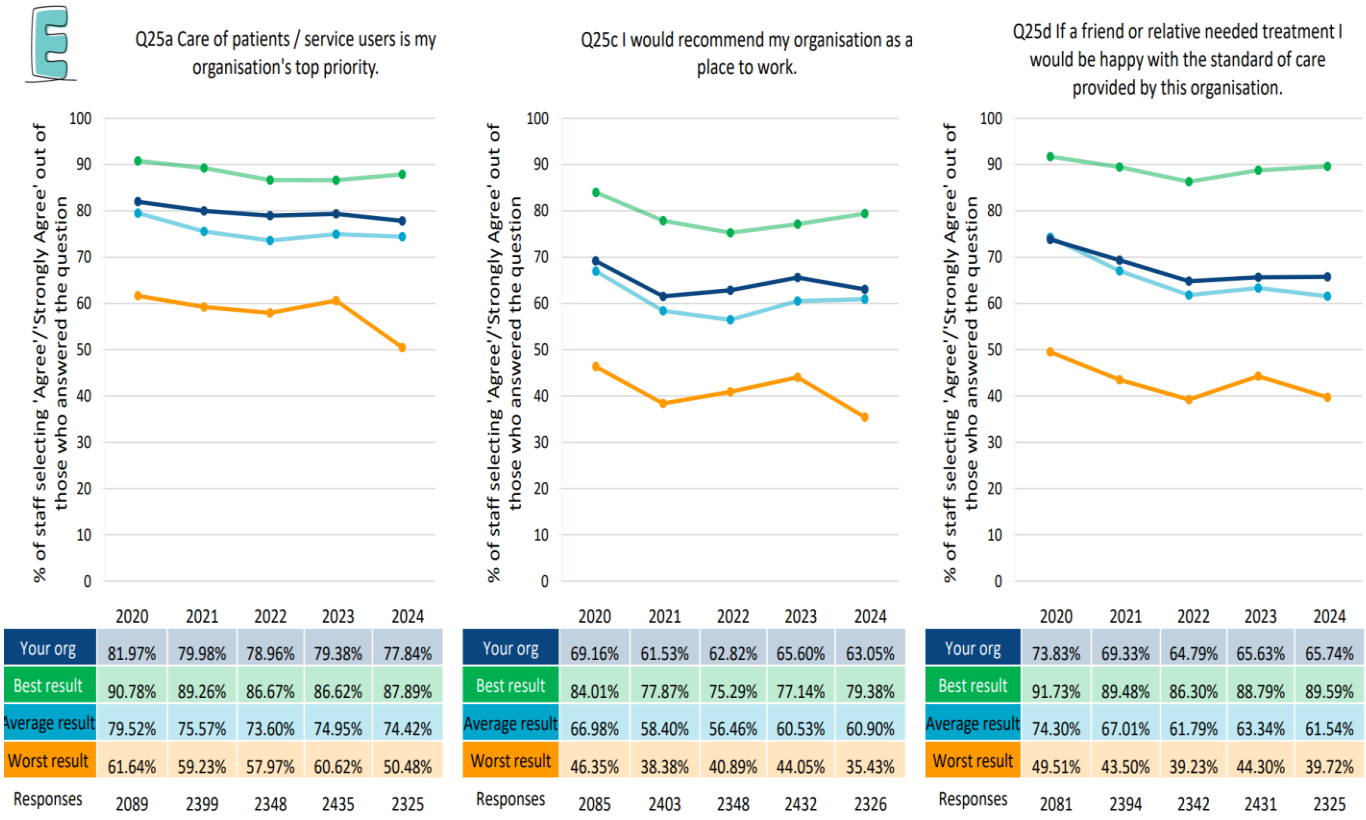
Measure	Measure Description	Data Source
5	The data made available to the trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	NHS DIGITAL

All NHS organisations providing acute, community, ambulance and mental health services are requested to complete the People Pulse survey each quarter.
With aims of:

- "Encouraging improvements in service delivery" – by "driving hospitals to raise their game"

The Trust believes that the attitude of its staff is the most important factor in the experience of patients. We will continue to work with staff to develop the leadership and role modelling required to further enhance the experience of patients, carers and staff.

Staff Friends and Family Test



	2020	2021	2022	2023	2024
Your org	81.97%	79.98%	78.96%	79.38%	77.84%
Best result	90.78%	89.26%	86.67%	86.62%	87.89%
Average result	79.52%	75.57%	73.60%	74.95%	74.42%
Worst result	61.64%	59.23%	57.97%	60.62%	50.48%
Responses	2089	2399	2348	2435	2325

	2020	2021	2022	2023	2024
Your org	69.16%	61.53%	62.82%	65.60%	63.05%
Best result	84.01%	77.87%	75.29%	77.14%	79.38%
Average result	66.98%	58.40%	56.46%	60.53%	60.90%
Worst result	46.35%	38.38%	40.89%	44.05%	35.43%
Responses	2085	2403	2348	2432	2326

	2020	2021	2022	2023	2024
Your org	73.83%	69.33%	64.79%	65.63%	65.74%
Best result	91.73%	89.48%	86.30%	88.79%	89.59%
Average result	74.30%	67.01%	61.79%	63.34%	61.54%
Worst result	49.51%	43.50%	39.23%	44.30%	39.72%
Responses	2081	2394	2342	2431	2325

Table 4. NHS Staff Survey results relevant to staff friends and family test (Data source: NHS Staff Survey benchmark report 2024)

The North Tees and Hartlepool NHS Foundation Trust considers that this data is as described for the following reasons:

The Trust has shown a slight decline in the following friends and family test sections:

- Recommending the organisation as a place to work
- Care of patients/service users is my organisations top priority

However, we have remained above the sector average across all three reported questions

The North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to further improve this percentage and thereby the quality of its services.

- Through a robust structure of assurance committees and groups, the Trust will continue to work with staff and stakeholders to improve the quality of care that we provide to patients.
- North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust have formed a Hospital Group, which will enable the best possible patient care to be delivered across the Tees Valley area. As part of the Hospital Group, we have developed six clinical boards to develop transformation strategies within six key clinical areas.
- The Trust continues to promote the development of the Hospital Group and the exciting opportunities for improving patient care via various briefings, bulletins, and other communications.

National NHS Staff Survey

Question: If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust (%)

Trust Name	2018	2019	2020	2021	2022	2023	2024
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	83	88	87	84	80	81	78
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	59	61	66	60	52	53	54
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**71**	**72**	**74**	**69**	**65**	**66**	**66**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	90	91	91	85	83	77	77
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	71	64	76	76	68	70	69
GATESHEAD HEALTH NHS FOUNDATION TRUST	81	82	80	75	73	74	70
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST		70	71	65	61	63	65
North East	74	75	78	74	69	64	64
England	70	71	74	68	63	64	64
National High	**95**	**-**	**92**	**-**	**-**	**87**	**90**
National Low	**41**	**-**	**48**	**-**	**-**	**52**	**40**

Peoples Pulse – Staff

Care: 'How likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care'.

	April	July	*Sep	Jan	March
Percentage Recommended – Care	N/A	60%	65%	61%	N/A

**From Staff Survey Data*

Work: 'How likely staff would be to recommend the NHS service they work in to friends and family as a place to work'.

	April	July	*Sep	Jan	March
Percentage Recommended – Work	N/A	48%	63%	50%	N/A

**From Staff Survey Data*

Care: 'Care of patients/Service users is my organisation's top priority'.

	April	July	*Sep	Jan	March
Percentage Recommended – Care	N/A	68%	79%	71%	N/A

**From Staff Survey Data*

North Tees and Hartlepool NHS Foundation Trust considers that this data is as described for the following reasons. The Trust continues to actively engage with and encourage staff to complete and return the Staff Survey along with the quarterly People pulse. The results from these surveys are shared with staff to ensure that two way conversations take place in relation to celebrating successes and considering improvements. Information from the Annual Staff Survey is provided at Care Groups level, line manager level and staff level to ensure there is greater understanding of the information.

Annual Staff Survey completion remains the most responded to and representative survey of staff experience with over 2500 completions in the autumn of 2024. The People Pulse survey remains a challenge for the Trust in terms of its staff completions. We have a range of opportunities for staff to be involved in developing changes across the organisation which ensures "we each have a voice that counts" with clear linkage to the NHS People Plan.

National Staff Survey

In the last 12 months I have not personally experienced harassment, bullying or abuse at work from colleagues (National Staff Survey)

2021	2022	2023	2024	2024 National Average
84.83%	84.56%	84.94%	85.33%	81.51%

*

Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? (National Staff Survey)

2021	2022	2023	2024	2024 National Average
62.89%	62.64%	60.98%	56.45%	56.02%

Patient safety

The National Reporting and Learning System (NRLS) was decommissioned on 30 June 2024, with benchmarking data not being published since March 2020.

The Trust successfully went "live" with the Learning from Patient Safety Events (LFPSE) reporting platform on 29th December 2023, moving away from the historical manual uploading process required by the NRLS system. This change was made at the same time as the Trust transitioned to a new safety reporting system, In Phase, which was set up to reflect the new national requirements and to also support the needs of the Trust safety systems.

The LFPSE service creates a single national NHS system for recording patient safety events, events logged into the Trust reporting system, or logged from an external source, are automatically transferred into the national system. This approach introduces improved capabilities for the national analysis of patient safety events occurring across healthcare, and enables better use of the latest technology, such as machine learning, to create outputs that offer a greater depth of insight and learning that are more relevant to the current NHS environment.

During 2023-24, there were 18,049 safety events reported in Datix / In Phase. During 2024-25 (to end February) 15,201 have been reported into In Phase. This reduction reflects the predicted impact of the changes in the Trusts reporting system during quarter 4, 2023-24. The initial reduction was around 25%; the Trusts Patient Safety Event Response Plan identified that the aim was to increase reporting by 2% each month during 2024-25; this was achieved from April 2024, with reporting improving by at least 4% each month until December 2024 when it has stabilised.

On 29th January 2024, the Trust transitioned from the Serious Incident Framework into the Patient Safety Incident Response Framework (PSIRF). In line with the ethos of PSIRF the Trust is building a learning and improvement culture where staff, patients, families, carers, and all who engage with the Trust are encouraged to share their experiences and their concerns. The Trust recognises that learning comes from understanding what goes wrong (incidents), what nearly goes wrong but is "saved" by the actions of those involved (near misses) and also what goes well, despite the daily challenges of healthcare (good care). The Trust promotes the reporting of all episodes of care where there is potential for learning and improvement, collectively called 'events'.

Alongside the transition to PSIRF the Trust has also implemented a new Local Risk Management System (LRMS) which incorporates the new national reporting requirements from the Learning from Patient Safety Events (LFPSE) system, and the Trust policy has been updated to reflect the changes and promote timely reporting, response and management of safety events, focused on the potential for learning rather than the level of harm.

The review and investigation of events is focused on identifying opportunities for learning and improvement to prevent future harm, using a systems based approach to investigation, and incorporating human factors analysis and quality improvement methodology. The quality assurance of event data is promoted at all stages of review and response to reflect the most up to date information known about the event.

All patient safety events reported on the Trust LRMS are shared with the LFPSE. This allows a national view to be obtained in relation to all patient safety events regardless of harm level. Previously, each Trust received regular analysis from the NRLS, benchmarking data has not been received since 2020. The Trust is awaiting the release of analysis of event data that will be shared from LFPSE to aid improvement and learning. The Trust is in regular communication with the national patient safety team to support the resolution of any issues being identified in the new system and its interface with the Trust.

The North Tees and Hartlepool NHS Foundation Trust has taken the following actions to improve the proportion of this rate and so the quality of its services:

- It is acknowledged that a positive safety culture is associated with increased reporting and as such, the Trust continuously monitors the frequency of event reporting and strives to increase reporting in all areas. The Trust is promoting the reporting all events (incidents, near misses and good care) regardless of the level of harm to ensure awareness of both known and emerging risks, identify themes and trends, and provide valuable insight into preventing future harm. It is acknowledged that during this period of transition there has been a dip in reporting as staff familiarise themselves with the new system and question format. The Trust are continuing to support staff with a range of training opportunities and expect to see reporting return to previous levels.

Learning Response:

In line with PSIRF, and the Trust Patient Safety Event Response Plan (PSERP) 2024-25, and the Trust Policy, events have been identified that require a learning response to further understand the causes, and those that are well understood and require an improvement response.

The Trust will ensure compliance with the national requirements for reporting and investigation as set out in the PSIRF guidance. Additionally, the Trust identified four local priority areas for focused work over the period of the Trust PSERP and project teams initiated which include a clinical lead, a quality improvement lead and a patient safety lead. The four priority areas are: Child not Brought for Appointment; Delayed recognition and management of the sick child; Management of Diabetes; and Quality of Discharge information.

The Trust has developed a decision making process to identify those events with significant potential for learning. The process details how events will be reviewed at local level and, where appropriate, identified for escalation. The process ensures that those events that require an in-depth response to understand the causal factors and identify learning receive the appropriate level of investigation and are monitored through to closure. To support this the Trust have developed alternate learning responses for those events that do not meet the national criteria for a Patient Safety Incident Investigation (PSII).

The weekly multidisciplinary Safety Panel reviews all incidents of moderate harm or above, agrees the level of investigation and reviews the application of duty of candour regulations by the clinical directorates. Where there is any discrepancy, the investigating team are asked to provide further details for review and discussion. In complex cases where the identification of the required level of investigation is unclear, the incident and all evidence collated through the investigation to date is reviewed by senior executives for a decision.

Incidents that meet the national requirements for reporting are managed in line with PSIRF guidance (NHSE, 2022). Any event that is identified as requiring a PSII or a Trust alternate learning response will be presented at a monthly panel on conclusion of the response. The panel will include multiprofessional representatives (clinical and non-clinical) from each Care Group to ensure shared learning, broad discussion and appropriate challenge. PSIIs will then be presented through the Quality Oversight Group and Quality Assurance Committee. Where safety recommendations are identified, these will be considered by the appropriate Care Group and for SMART actions to be identified. Where these are linked to a Trust Group (i.e. Fall Group or Deteriorating Patient Group) these can also be incorporated into a wider improvement plan and monitored to completion. As this process has been implemented over the last year there have been adjustments made in the process; as the Trust develops its PSERP for 2025-26 the policy will also be updated to provide updated details in relation to the event management and oversight processes.

The Trust works in close collaboration with the local CQC inspectors and the ICB in relation to incident reporting and regularly communicates in relation to incidents meeting the national reporting requirements and also regarding overall trends in incident reporting.

The national analysis of information undertaken by NHSE / LFPSE identifies where actions need to be taken in relation to national trends. This analysis can initiate a national safety alert. The Trust is fully compliant with all National Patient Safety Alerts that have been published in relation to this analysis. Processes are in place to ensure there is continual review of processes in order to provide on-going assurance.

Improvement response

Where the causal factors of an event are well understood, the burden of undertaking an in-depth investigation can outweigh the learning to be gained. Where possible the Trust has developed event proforma or checklists to be completed within the LRMS. The data can then be collated and analysed by the relevant Trust Group and incorporated into their assurance framework or improvement plan. Where new or emerging issues are identified a group or cluster of events can be reviewed using a thematic approach to identify additional learning.

2024-5- National inpatient surveys

Patient Experience Surveys

Below are a list of the national surveys that the Trust conducted between April 2024 and March 2025.

National Surveys

Survey	Published	Trust Response rate
CQC National Inpatient Survey 2023	September 2024	40%
CQC National Maternity Survey 2024	November 2024	40%
CQC National Urgent and Emergency Care Survey 2024	November 2024	26%
National Cancer Patient Experience Survey 2023	July 2024	51%

Local Surveys

Survey	Results	Number responses
Endoscopy Patient Survey 2024	June 2024	328 patients
Monthly Endoscopy Patient Survey 2024	Monthly	520 patients
Rapid Diagnostic Service 2024	January 2025	122 patients
Family Health Counselling Survey 2024	January 2025	21 patients
Breast Screening Service Survey 2024	December 2024	109 patients
Alcohol Care Team - 2024	January 2025	32 patients
Learning Disability Survey 2024	January 2025	40 patients
Maternity Bereavement Survey 2024	January 2025	13 patients
Cardiology Annual Survey 2025	February 2025	103 patients
Monthly Cardiology Patient Survey	Monthly (commencing Dec 24)	135 Patients
Community Integrated Assessment Team	August 2024	43 patients
Colposcopy Service Survey 2024	May 2024	57 patients
Managing Heart Failure at Home Service	February 2025	21 patients
iMSK Personalised Care Project (CQUIN)	January 2025	143 patients
Maternity Personalised Care Project (CQUIN)	January 2025	15 patients
Digital Consent Survey (Personalised Care Project)	January 2025	42 patients
Tobacco Dependency Treatment Service	May 2024	24 patients
Virtual Ward Service	February 2025	49 patients

National Surveys

We take part in the national survey programme. This is a mandatory Care Quality Commission (CQC) requirement for all acute NHS trusts. Each question is nationally benchmarked so we can understand how we scored when compared with other trusts.

CQC National Inpatient Survey 2023 – Key results

The Trust randomly selected adult inpatients discharged during November 2023. We had a 40% response rate with 464 surveys completed. The results are out of 10, the higher the score, the better the reported experience.

How we scored?
All our questions scored ***"About the same"*** as other trusts nationally. However, the table below shows where our scores were significantly worse when compared to the 2022 survey.

Where we could do better – scores that were significantly worse than in 2022	*2023*
Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	7.8
Before you left hospital, were you given any written information about what you should or should not do after leaving hospital?	7.3

Although we did not have any scores significantly higher this year, the table below shows where our scores remained consistently high.

Some positives – where we see scores remain high	*2023*
When you asked doctors questions, did you get answers you could understand?	8.7
Did you have confidence and trust in the doctors treating you?	9.1
When doctors spoke about your care in front of you, were you included in the conversation?	8.8
How much information about your condition or treatment was given to you?	9.0
Were you given enough privacy when being examined or treated?	9.5
Overall, did you feel you were treated with kindness and compassion while you were in hospital?	9.0

A selection of comments taken from the National Inpatient Survey 2023

"Everyone on the ward were fantastic. I thanked them all. They were all kind, helpful, attentive and very welcoming. They also had a welcoming smile always"

"Patient care on the wards and in theatre was exquisite! Lovely people helping those at their most vulnerable!"

"The admission process was so efficient and every member of staff I came into contact with were friendly helpful and reassuring. The theatre process was faultless and the aftercare prior going to the ward was better than I could have imagined all down to the wonderful staff".

"Night time trying to sleep when too much noise and people working doing their jobs".

"Ambient noise at all times was horrible".

"Myself and other patients had to wait an extremely long time, sometimes over an hour for a nurse to respond to the call button due to under staffing".

"Having left (discharged) the ward, had to wait over 3 hours and just before the closing of the discharge hub (5 pm). I received medication and discharge letter - what a way to treat patients. The place was not very warm".

National Cancer Patient Experience Survey 2023 – Key results

This is part of the NHS Cancer Patient Experience Survey Programme and designed to monitor national progress on cancer care to help drive local quality improvements. Our sample consisted of adults with a primary diagnosis of cancer discharged April, May and June 2023. A total of 360 patients returned a questionnaire, a response rate was 51%. Scores are displayed as percentages.

How we scored?

We had 3 questions scoring ***"lower than expected"***. Although we did not have any questions scoring ***"better than expected"***, we did have 5 questions where scores were significantly higher than the 2022 survey. Please see below tables;

Where we could do better – scores lower than expected	*2023*
Beforehand patient completely had enough understandable information about surgery.	85%
Patient completely had enough understandable information about response to surgery.	81%
Patient was given information that they could access about support in dealing with immediate side effects from treatment.	82%

Where score was significantly worse than in 2022	*2023*
Patient was given enough information about the possibility and signs of cancer coming back or spreading.	60%

Areas of good practice – where scores were significantly better than in 2022	*2023*
Patient received all the **information needed about the diagnostic test** in advance	95%
Patient was told they could have a **family member, carer or friend with them when told diagnosis**	87%
Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	84%
Patient's family, or someone close, was definitely **able to talk** to a member of the team looking after the patient in hospital	76%
Care team gave family, or someone close, all the **information needed to help care** for the patient at home	61%

A selection of comments taken from the National Cancer Patient Experience Survey 2023

"Cannot fault anyone in this hospital from volunteers porters, admin staff all offered to help nurses up to doctors / consultants outstanding".

"Would just like to say, I would always choose North Tees Hospital for my treatment. The staff are amazing along with the treatments and aftercare".

"My consultant could not have been any better in the way he has looked after me over the years. My chemo was very well run and staff were brilliant".

"I would have liked a bit more info or a diet plan after the operation so I could be sure I was eating the right diet".

"Only one thing is I would have liked to have been informed of my results sooner that was the most horrific time the weeks of waiting".

"Perhaps more "joined up" thinking between hospital departments and G.P".

CQC National Maternity Survey 2024 – Key results

Women 16 years or over who had a live birth in February 2024 were invited to take part. A total of 117 women responded, a response rate of 40%.

How we scored?

We scored ***"better than expected"*** in 2 questions and ***"somewhat worse or worse"*** in 3 questions. 4 questions scored significantly worse when compared to the 2023 survey. Please see below tables;

Where we could do better – scored worse/somewhat worse	*2024*
If you raised a concern during labour and birth, did you feel it was taken seriously?	6.6
Thinking about your care during labour and birth, were you treated with respect and dignity?	8.5
Thinking about your care during labour and birth, were you treated with kindness and compassion?	8.3

Where scores were significantly worse than in 2023	*2024*
At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	8.0
Thinking about your care during labour and birth, were you involved in decisions about your care?	7.9
Did you have confidence and trust in the staff caring for you during your labour and birth?	8.1
During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	7.3

Areas of good practice – scored better than expected	*2024*
Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?	8.1
Did a midwife or health visitor ask you about your mental health?	9.7

"My midwife from the Rowan suite was amazing! She was always there when needed and as a first time young mum, she gave me so much support".

"My midwife when I was in final stages of labour was amazing and stayed with me all the

time even through surgery".

"Our midwife was absolutely amazing. She made my experience such a comfortable one and was so caring/understanding. I was able to feel in control at all times and felt the staff really listened to me/ my needs".

"I was refused pain relief from the beginning after being offered it with my first. The bedside manner of the midwives towards me was incredibly rude".

"First time mums should be given adequate information regarding childbirth, breastfeeding and what to expect after childbirth. As a first time mum, I was lost on a lot of things, I needed answers to so many questions and couldn't find answers. I didn't know what to expect, neither was I guided by my assigned midwife on the things I am supposed to do or know as a first time mum".

"The help with breastfeeding in the hospital was rushed, this affected the inability to breastfeed. There was no antenatal advice on breastfeeding or colostrum harvesting. At the 8 week postnatal appointment my C-section scar was not checked and my medical history was not reviewed".

CQC National Urgent and Emergency Care Survey 2024 – Key results

Patients aged 16 and over were eligible for the survey if they attended A&E or Urgent Care Centre in February 2024. A total of 368 people responded, a response rate of 26%.

How we scored?

5 questions scored ***"better/somewhat better"*** for A&E department. All questions in the Urgent Care Survey scored ***"about the same".*** There were 0 questions scoring worse than other trusts in both surveys. Please see below table;

Areas of good practice – scored better/somewhat better	***2024***
While you were waiting, were you able to get help with your condition or symptoms from a member of staff?	6.6
Were you given enough privacy when being examined or treated?	9.4
Did you have enough time to discuss your condition and treatment with the doctor or nurse?	8.4
Did you have confidence and trust in the doctors and nurses examining and treating you?	8.7
If a family member, friend or carer wanted to talk to a doctor or nurse, did they have enough opportunity to do so?	7.8

"I absolutely would recommend to be seen by the junior doctor that dealt with my issues. She was so bubbly and caring and made me feel at ease so much and helped me by making jokes and reassuring everything was going to be ok and nothing was too much for her". **(A&E)**

"The staff were great and checked in on everyone in the A&E asking if anyone needed any assistance or help if anything was worse with their condition while we waited to be seen. Excellent service". **(A&E)**

"Hartlepool Urgent Care is lovely and I went there over the years for myself and my boys. I was always satisfied with treatment I received and never felt that professionals (i.e. nurses, doctors) didn't do enough. Always felt in safe hands! Thank you!" **(UCC)**

"I was glad to have an appointment via 111. I waited around 5 minutes to be seen, was

diagnosed quickly and given prescriptions for antibiotics. It is a sad situation when I cannot even get through to my GP via telephone or get an early appointment". **(UCC)**

"The waiting area is quite small and can be very busy and occasionally stressful i.e. while I was there was a prisoner been lead out by police kicking and screaming obscenities". **(A&E)**

"As I was vomiting and in pain I was embarrassed at not being given privacy until my husband requested the nurse if I could be put in a private room until I was examined by a doctor". **(A&E)**

"I was told after x-ray I had probably sprained my ankle. I had presented with pain from what I believed to be from historic repair to my ankle and ligaments which I described in detail but the practitioner looked disinterested and disbelieving". **(UCC)**

"I am normally fit and well and aged 80 years. Also working self employed/independently and driving. I was treated like a poor old woman and reminded that I was 80 years old. That has had a detrimental impact on me that I can't get out of my mind". **(UCC)**

Action plans

When survey results are published or locally compiled, results are feedback to the clinical teams via; senior clinical practitioner meetings, directorate and ward meetings, Trust councils committees and external meetings where patient representatives are present such as the Cancer Patient group and the Patient and Carer Experience Council. Results are also feedback via clinical governance and education sessions.

Action plans are led by the Care Groups who present the results and their action plans to the Patient and Carer Experience Council.

"I would have liked a little more privacy at reception when explaining my condition". **(UCC)**

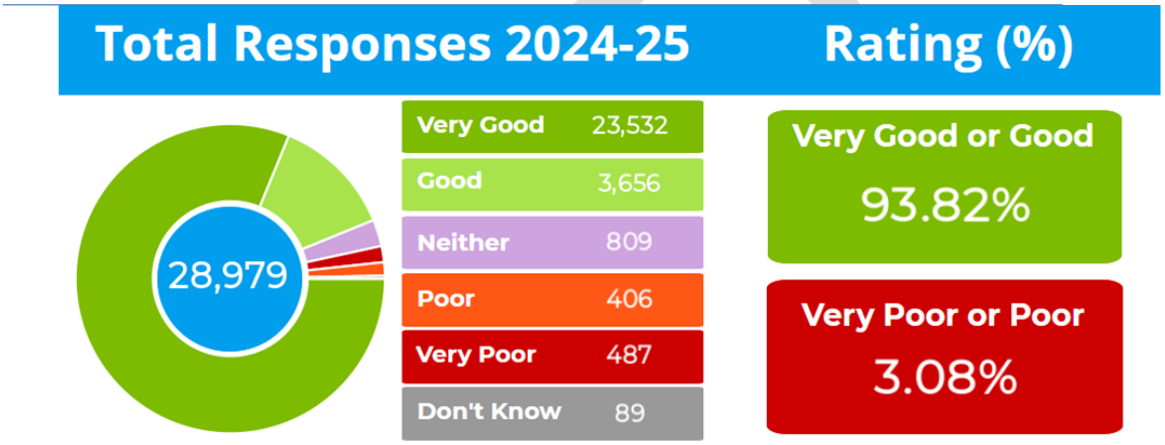
Action plans

When survey results are published or locally compiled, results are feedback to the clinical teams via senior clinical practitioner meetings, directorate and ward meetings, Trust councils committees and external meetings where patient representatives are present such as the Cancer Patient Group and the Patient and Carer Experience Council. Results are also feedback via clinical governance and education sessions. Action plans are led by the Care Groups who present the results and their action plans to the Patient and Carer Experience Committee.

FFT

The Trust has created and developed an in-house data collection and reporting system that covers
70 areas for the Friends and Family Test across both sites and community.

North Tees and Hartlepool NHS Foundation Trust
Returns for 1 April 2024 to 31 March 2025 from all our services
The Trust continuously monitors the positive and negative comments on a weekly basis to ensure that any similar issues or concerns can be acted upon by the ward matrons. This helps in reducing the reoccurrence of similar issues in the future.



Total Responses	Month												
FFT Response	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total
Very Good	2,324	2,067	2,093	2,400	1,822	2,138	1,571	1,121	1,771	2,403	2,154	1,668	23,532
Good	375	368	301	318	282	336	234	233	255	392	326	236	3,656
Neither Good nor Poor	83	85	68	75	56	55	32	36	66	104	79	70	809
Poor	35	44	40	40	27	33	15	12	34	51	33	42	406
Very Poor	49	46	26	53	36	54	29	12	33	57	53	39	487
Don't know	14	14	7	3	5	6	4	3	7	9	11	6	89
Total	2,880	2,624	2,535	2,889	2,228	2,622	1,885	1,417	2,166	3,016	2,656	2,061	28,979

Word Cloud

*Data from Trusts Friends and Family database and Inhealthcare

"Excellent welcoming Staff in Dept. Seen straight away due to flexible times given to come for an XRay"

"All the staff were so friendly and made you feel at ease. Excellent service."

"Punctual appointments. Caring attention. Informative."

"Had to wait 1 1|2 hours."

"Facilities are very poor. No patient and nurse contact only to ask a question."

Part 3:1 Additional Quality Performance measures during 2024- 25

This section is an overview of the quality of care based on performance in In addition to the three local priorities outlined in Section 2, the indicators below further demonstrate that the quality of the services provided by the Trust over 2024-25 has been positive overall. The following data is a representation of the data presented to the Board of Directors in consultation with relevant stakeholders for the year 2024-25. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements.

Our digital journey

We received an InterSystems digital award received in July 2024 following success in going paper free with patient records. We hosted Bendigo Health and Fundraising Foundation who are based in Australia who came over to find out more about its use of an electronic patient records system over the last decade. The Bendigo health team took away information including lessons learned, challenges faced and collaboration efforts amongst all the departments.

We were also presented with two prestigious awards recognising our commitment to developing and using innovative technology to support patients. The awards celebrate the very best in health technology innovation with one award for recognising the state of the art monitoring of patients with

Double award win for trust

heart failure in their own home and the other in revolutionalising the patient record process. We

were also winners at the annual Health Tech Awards in the categories of Best remote monitoring solution and best use of technology(Acute care)

In December 2024 the team won the regional Health Innovation Northeast and North Cumbria Barcode technology innovation award. This was a recognition of our success in using barcode technology to further improve the overall care we give to patients. We have partnered with Global View Health Care working on CareScan on a programme that uses barcodes and scanners to track surgical products and devices during patient care delivery.

This is a programme that uses barcodes and scanners to track surgical products and devices during the delivery of patient care.

Other shortlisted teams for digital awards

- The end of life care team were recognised for their work improving care for patients with a cancer of the lining of the lungs.
- The education team for work providing T-Level placements to young people interested in a career in the
- Most Impactful Use of Technology on Clinical Practice - **InterSystems & North Tees and-HSJ Hartlepool FT -** TrakCare - Improves Efficiency of Nurse Admissions Process
- Patient Safety Collaboration of the year - **InterSystems & North Tees and Hartlepool FT - HSJ**Electronic Observations (eObs) and sepsis reduction with TrakCare EPR

Other celebrations

- The Electronic prescribing and medicines administration (EPMA) has been recognised in the top five blueprints across all NHS Trusts.
- Regional winner of the Digital, Data and Technology Team of the year Skills Development Network award.

2.Deteriorating patient

Critical Care Outreach is an established service providing 24/7 since 2018 offering intensive care skills to patients with, or at risk of, critical illness receiving care in locations outside of the intensive care unit. They support the prevention and/or facilitation of admission to the critical care unit and follow up care after discharge from critical care.

Over the last 5 years the Critical Care Outreach (CCOR) activity, despite covid, has increased new referral activity of at least 3%. It does appear that the amount of assessments (i.e. reviews) has reduced but we feel this is related to the experience level and the improved decision making skills within the team.

In October 2022, introduction of 2 WTE Deteriorating Patient Nurse Specialists (DPNS) were introduced to improve the management of sepsis, AKI and/or deteriorating physiology, supporting the education of ward teams on the recognition and response required to manage the deteriorating patient. CCOR and the DPNS service work collaboratively to support patients' both for escalation and ward based ceiling of care to ensure optimal and appropriate care is delivered to the patient.

Teaching/Education

A key objective for the DPNS team is to empower and educate staff, utilising national frameworks, on the management of the sepsis, AKI and the deteriorating patient and have adopted numerous educational platforms to optimise this learning, these include;

- Preceptorship forums for new nurses – teaching on fluid balance, AKI, Sepsis and SBARD.
- Acutely illness Management course (AIMS) – with the Sepsis and AKI sections delivered by the DPNS and CCOR staff.
- Deteriorating Patient Study Day – This day has solely been created by the DPNS team and runs from March to October. It is targeted at a higher level than AIMS and covers; Sepsis, AKI, ABCDE, NIV/CPAP, Trache, HFNC and includes Simulation and debrief. It involves a collaborative faculty of Nursing, AHP, Medical and the simulation team. The DPNS team have created full training manuals to support and enhance learning for the day. The evaluation of the day is extremely positive with pre & post MCQ scores identifying increased knowledge and understanding in the management of the deteriorating patient.
- Annual teaching and simulation for Foundation and Middle grade medical staff
- Enhanced Sepsis training package on the electronic staff records (ESR) system and development of sepsis competencies.
- Annual teaching for ward champions on Sepsis/AKI and deterioration
- Care Essential days – these are aimed at healthcare assistants and enhanced care workers to support them in having an understanding of sepsis/AKI and the needs of the deteriorating patient including when and how to escalate accordingly.
- Ward teaching and also 1:1's which are delivered by the DPNS team.
- Networking with clinical educators across the organisation to disseminate training.
- Updated Blood culture competency/skills pack and associated education.
- The continual development of Business Intelligence deteriorating patient dashboard to show live data and support analysis, learning and improvement, this will move to Inphase once built.
- Critical Care Outreach team lead and support wards with the management of patients requiring NIV, CPAP, NHF and central lines to ensure patients care is optimised and escalated in a timely manner.

- The CCOR team have also developed a neuro fast response simulation day to ensure the deteriorating patient is optimised and safely transferred to a territory centre.

- The Trust recognises the challenges in relation to how the deteriorating patient is identified, treated and managed; the actions outlined above have been implemented over time and there has been sustained improvements identified in the monitoring of compliance. Sepsis/AKI and the management of deteriorating patients is always going to remain a key area of focus that will only increase within the increased acuity, pressures for health services and the background of health inequalities.

3. Clinical Quality Accreditation Framework- (CQAF)

The Clinical Quality Accreditation Programme was refreshed in July 2024 changing from Appreciative support programme to CQAF. The change enabled aligning with the four key ambitions which are in line with the Trust objectives, Fundamental Care Standards and CQC regulation. These are;

- Patient safety,
- Clinical effectiveness,
- Patient experience,
- Well led.

This initiative is part of an ongoing effort to not only celebrate the excellent work across our services but also to ensure compliance with the fundamental standards of care aligned with CQC quality statements. The programme supports individual clinical area visits with the aim of enabling movement to outstanding. It also helps triangulate data giving a holistic overview to drive ward to board assurance.

To date, the programme has successfully reviewed eight acute ward areas. It has facilitated the identification and resolution of any non-compliance issues through a comprehensive support program. A framework for structured support where needed has been implemented and most importantly, there are robust follow-up measures to ensure that improvements are effective and sustained.

The Trust's aim is to assist clinical teams in their journey from providing good to outstanding care for our patients. By fostering a culture of continuous improvement, empowering effective leadership, minimising unwarranted variation, and promoting positive engagement with both staff and patients, we are committed to enhancing the quality of care we deliver.

The Trust is currently exploring options around effective resource utilisation to support delivery of programme at pace and also designing a programme that can cover community areas as well.

Patient Safety

Falls

A fall is defined as an unexpected event in which the participant comes to rest on the ground, floor or lower level. Whenever a fall occurs this is recorded on the local incident reporting system. A post falls checklist is completed and is used to help categorise the fall into the classification of no harm, low harm, moderate harm, severe harm or death. The Trust has a robust system in place to understand the background to all falls that result in significant injury; these incidents are shared with staff for future learning.
Falls with no harm

During 2023-24 the Trust has experienced 780 falls resulting in no harm; this has decreased from 954 in the 2022-23 reporting period. This is a 22% reduction on falls.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021-22	64	76	65	97	106	72	86	79	110	90	75	75	**995**
2022-23	**87**	**84**	**84**	**85**	**106**	**65**	**65**	**81**	**88**	**66**	**71**	**72**	**954**
2023-24	**87**	**65**	**53**	**81**	**80**	**60**	**68**	**71**	**72**	**68**	**33**	**42**	**780**
2024-25	**52**	**32**	**22**	**35**	**40**	**41**	**38**	**39**	**39**	**42**	**39**	**48**	**467**

Data obtained via the Trust's Reporting database April 2025.

Falls with low harm

During 2023-24 the Trust has experienced 271 falls resulting in low harm; this has increased from 248 in the 2022-23 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021-22	16	28	13	8	7	20	13	14	15	22	12	14	**182**
2022-23	**9**	**13**	**22**	**14**	**29**	**21**	**17**	**27**	**26**	**20**	**23**	**27**	**248**
2023-24	**18**	**25**	**19**	**17**	**23**	**14**	**21**	**18**	**15**	**34**	**39**	**28**	**271**
2024-25	**43**	**48**	**44**	**39**	**44**	**28**	**34**	**55**	**49**	**35**	**48**	**36**	**503**

Data obtained via the Trust's Incident database April 2025.

Falls with moderate harm
During 2023-24 the Trust has experienced 30 falls resulting in moderate harm; this has increased from 19 in the 2022-23 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021-22	5	3	2	0	2	0	3	1	1	1	1	1	**20**
2022-23	**1**	**1**	**0**	**3**	**1**	**0**	**2**	**1**	**4**	**1**	**3**	**2**	**19**
2023-24	**4**	**1**	**0**	**2**	**2**	**0**	**0**	**2**	**2**	**4**	**9**	**4**	**30**
2024-25	**2**	**2**	**2**	**0**	**3**	**4**	**1**	**4**	**2**	**3**	**5**	**4**	**32**

Data obtained via the Trust's Incident database April 2025.

Falls with severe harm
During **2023-24** the Trust has experienced **0** falls resulting in severe harm; this remains *unchanged* from **0** in the 2022-23 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021-22	0	0	0	1	0	0	0	0	0	0	0	0	**1**
2022-23	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2023-24	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2024-25	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Data obtained via the Trust's Incident database April 2025.

Falls with death
During **2023-24** the Trust has experienced **2** falls resulting in death; this has increased from ***0*** in the 2022-23 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021-22	0	0	0	0	0	0	0	0	0	1	0	0	**1**
2022-23	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2023-24	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**2**
2024-25	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Data obtained via the Trust's Incident Reporting database March 2024.

Whilst the majority of falls result in no or low harm there has been an increase in falls reported as low and moderate harm. Whilst there were two falls with death, investigation and review concluded that the death was not a direct result of the fall.

The impact of the change to the national system LFPSE and the event reporting system Inphase is potentially having an impact on the reporting levels of harm. As these new systems are implemented investigation needs to be completed in the coming months.

Improvements to the falls assessments and documentation have been supported by the digital team to ensure appropriate assessment, care plans and risk mitigation. The recording of lying and standing blood pressure is now embedded using E-Obs, with work on-going to improve the functionality to allow this to be prescribed electronically. InPhase events falls questions have been designed to ensure that key National Hip Fracture

Database (NHFD) audit information is included.

Post falls management continues to be supported by the Falls Response Team which is now fully embedded and contributing to the safe manoeuvring and management of the patient post fall.

A review of the Falls Policy and the falls meeting structure and membership is underway.

Never Events

The Trust reported one never event during 2024-25, this event related to a retained foreign object following insertion of a chest drain.

Never Events are investigated using Patient Safety Incident Investigation (PSII) methodology, as outlined in the Trust's Patient Safety Event Response Plan (PSERP).

NHSE is currently undertaking a review of the Never Event list to determine if there are truly strong and systemic barriers in existence to prevent these incidents from occurring. If the Never Events Framework is to continue, the list is likely to change and therefore future data may not be comparable.

Year	Number of Never Events
2024-25	1
2023-24	0
2022-23	4
2021-22	2
2020-21	1

Number of Never Events reported annually over the last 5 years since 2020-21

Medication Events Reporting and Learning

Work is ongoing to increase awareness of medicines events or error reporting and improve the way we manage the investigation process. The aim of this work is to ensure we learn from medicines events, share good practice and ultimately improve our processes and patient safety.

For **2024-25**, there were **782** medication related patient safety events reported to the Trust. Around 74% of the events occurred on the wards or in clinical areas, with around 21% occurred in the community settings or care homes, and the remaining 5% in other Trusts or organisations.

The Trust moved from Datix system to InPhase from January 2024 – an online platform with a suite of apps that help us co-ordinate compliance, assurance and continuous improvement. InPhase is a new way for the staff to record events (formerly incidents), friends and family feedback, mortality data and much more.

As the Trust has also upgraded the local risk management system to an LFPSE (Learn from Patient Safety Events) compliant system, the structure of the questions have

changed. LFPSE has a set of mandatory questions when recording patient safety events and this has added to the number of reporting categories on the event page.

Initiatives to improve medication events learning and minimize medication errors

- Trust medication errors or events are discussed weekly in the Senior Clinical Practitioner (SCP) meeting for awareness and action.
- The quarterly updates of medication events are presented in the Patient Safety Steering Group (PSSG) meeting and Medicines Safety Council (MSC) meeting to highlight medication errors trends and themes as well as sharing learning points and recommendations.
- Development of Medicines Safety Hotspots Bulletin to share national medication safety updates and safety events learning in the Trust, which aims to raise and improve staff awareness.
- Medication events or relevant medicines safety information from national bulletins, and MSO (Medication Safety Officer) network meetings are shared in the MSC meeting and other platforms as appropriate.
- Medicines Optimisation Pharmacist Lead (NENC ICB Tees Valley) share ICB Medicines Safety Updates and medication events occurred at the interface between primary and secondary care in MSC meeting.
- Collaboration with Tees Esk and Wear Valleys (TEWV) NHSFT Safety Lead Pharmacist about medication events that involved mental health medications to identify contributing factors and develop plans to mitigate the risk.
- Quarterly Trust Controlled Drugs (CD) incident reports submitted to regional CD LIN (local intelligence network) for feedback and monitoring. This provides opportunities for shared learning and support across the locality to work together with the implementation of safety initiatives.
- Review and complete Trust Never event assurance framework/never event proforma around mis-selection of strong potassium solution and insulin overdose due to abbreviation and incorrect device - provides information about current control/risk reduction plan in place (monitoring, planned outcomes and progress evaluation).
- Collaborate with relevant stakeholders to plan and coordinate actions required by any National Patient Safety Alert (NatPSA) and Central Alerting System (CAS) would help to reduce the medication error risk by having appropriate measures in place.
- Analyse medication events themes and prepare Quality and Safety reports for individual ward annually to raise awareness about the key areas of improvements.
- Dissemination of drug alert memo to all clinical areas to communicate risk of medication errors from look-alike sound-alike drugs and supply disruption.
- 'Focus on Feedback' newsletter- provides information on the lesson learnt from the cases discussed in the Incident Review Panel.
- Deliver teaching and training about safe medication practice and medication events on various platforms (non-medical prescribers meeting, Foundation Practitioners Lead training).
- Work collaboratively with South Tees MSO to share safety improvements implemented post medication events review.
- Care Group presentation of safety events (including medication), rapid/intermediate and Patient Safety Incident Investigation (PSII) learning review and safety improvements.
- Event Response Review Panel meeting to share intermediate and PSII learning (including medication events) in the Trust.

Medicines Management Lead is in post to provide support and coordination for the implementation of safe medicines practice. The role includes ensuring medicines management practice is safe, effective and align to the Trust priorities and objectives; supporting ward staff or managers in the analysis of medication events and participate in developing action plans to

reduce recurrence of these errors; and coordinate multidisciplinary work within the trust.

Pharmacy service improvements in promoting medicines safety

- Ongoing work with Informatics Lead Pharmacist to support safer prescribing of medicines, e.g. expanding use of order sets/sentences to reducing errors during the prescribing process, additional cautions/warning with regards to high-risk medicines, introduction of questionnaires as a prompt/prescribing aid.
- Procurement of contracted medicines now includes a quality assessment for high-risk products, and a process has been implemented at Trust level aimed at reducing potential harm from look-alike sound- alike products by highlighting known risk lines with the MSC.
- The pharmacy department continues to lead on supporting the rollout of Omnicell cabinets in clinical areas. Omnicell technology provides a real-time solution to support staff in locating critical medicines, with the potential to prevent missed doses and supply medicines in a lean manner.
- Expanded use of PharmOutcomes to support Discharge Medicines Service project and safer transfer of care back to primary care/community pharmacy where patients have had changes made to their medications.
- A new role implemented for a pharmacist to support the Frailty team. The role is continually growing but work to date has included active involvement and contribution to the Virtual Frailty Ward round, supporting de-prescribing, development of a medication review linked to falls and medication review of frail patients.
- A pilot project to review how a Specialist Pharmacist Prescriber can contribute to the management of patients who are diagnosed/ being treated for a TIA has now been completed and evaluated. We are now investigating how this can be taken forward into a permanent role within the Trust.
- Investigation of Pharmacist Prescriber support into Out-patient Lipid Clinics to help support national initiatives for primary and secondary prevention of CVD.
- Ongoing work to investigate opportunities for service expansion in clinical areas and best use of skill mix to support achievement of KPIs.
- Ongoing work to provide an interface between TrakCare and Ascribe, to remove errors during the transcribing process and make the ordering process leaner.

Patient Experience- complaints

Complaints are welcomed by the organisation and used to identify and resolve issues quickly. North Tees aim to ensure investigations are thorough and fair and resolve complaints at the earliest opportunity and identify and share learning to improve our services.

We adopted the Parliamentary and Health Service NHS Complaints Standard Framework fully in 2024, implementing many improvements during the review.

Acknowledging Complaints

The Trust continues to work hard to improve customer satisfaction through patient experience. We do recognise that we don't always get things right, and this is why we have a dedicated **patient experience team** to listen to and ensure complaints are investigated.

Stage 1	Local/early resolution, staff in the ward/department contact the complainant to resolve the complaint. The target is 7-working days, either face-to-face or via the telephone. This is followed by a written 'Complaint Resolution Form' to the complainant as the Trust's complaint response, digitally signed by the person with delegated authority to sign complaint responses.
Stage 2	Following an investigation by the Care Group, a meeting with senior staff is arranged by the Care Group and can be face-to-face or virtual. Meeting notes and a cover letter are sent to the complainant as the Trust's written complaint response, signed by the person with delegated authority to sign.
Stage 3	An investigation is undertaken and an executive letter of response is provided by the Care Group to be reviewed and approved by the Group Chief Executive and the Site Medical Director or Site Director of Nursing.

Number of Complaints

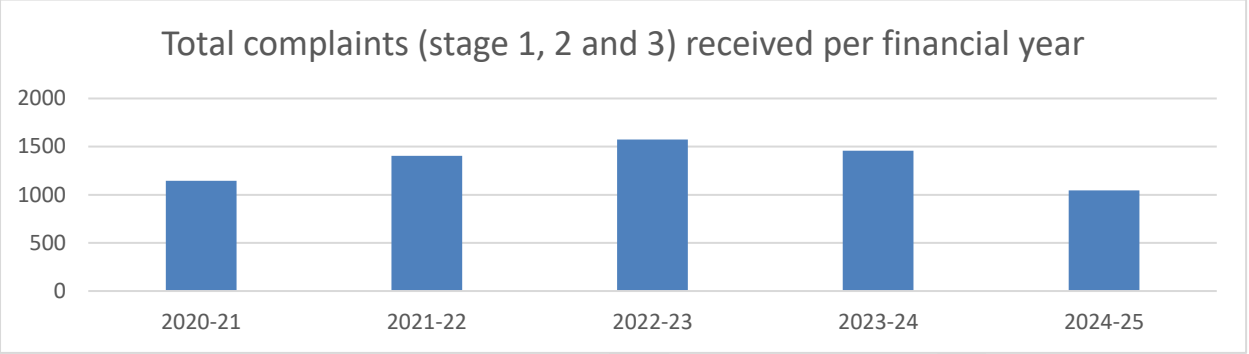
The Trust received 1,096 complaints in 2024-25.

Complaint Stage	Number received
Stage 1	873
Stage 2	94
Stage 3	79
Other (pending consent, triage, other organisations)	50
Total	**1,096**

**Data obtained from the Trust complaint reporting system (Inphase) on 1 April 2025.*

The number of complaints received into the Trust has decreased for 2024-25 to 1,096 from 1,494 the previous year. The number of stage 3 complaints has decreased for the year from 89 for 2023-24 to 79 for 2024-25. Stage 1 complaints accounted for 79.65% of the complaints received during 2024-25, stage 2 accounted for 8.57% and stage 3 complaints accounted for 7.20% of the complaints received during 2024-25. This indicates that the vast majority of complaints are managed locally as a stage 1 early resolution complaint.

The number of complaints received (Stage 1, 2 and 3) over the last 5 year period is shown in the following table for comparison:



**Data obtained from the Trust complaint reporting system (Inphase) on 1 April 2025 for 2024/25 and previous quality account data 2020-21 to 2023-24.*

Complaints by themes

The top 10 complaint themes from the complaints received in 2024-25 are:
(Please note: the data for 2024-25 now includes multiple subjects within each complaint rather just the primary subject, and all are included in the data below). Subject categories were updated on 1 January 2024 in line with National reporting subjects.

Complaints by subject	Total
Communications	650
Patient Care	575
Values and Behaviours	290
Appointments	210
Access to Treatment (prior to care)	172
Medications and Prescribing	147
Admissions and Discharges	142
Privacy, Dignity & Well Being	61
Trust Admin/Policies/Procedures including Patient Record Management	49
Facilities	44

**Data obtained from the Trust complaint reporting system (Inphase) on 1 April 2025.*

The number, stage and themes of complaints are available on the Yellowfin platform and data reviewed weekly during the Senior Clinical Professional Huddles, and within each Care Group. Where there is a concern regarding specific departments or an increase in themes identified, managers are required to review where services require improvement and provide additional support as required. The complaint themes are collated and aggregated analysis is considered in the Group quarterly Patient Experience and Involvement Report.

Classification of complaints closed during 2024-25

Classification	Number of complaints
Upheld	237
Partly Upheld	542
Not Upheld	222

**Data obtained from the Trust complaint reporting system (Inphase) on 1 April 2025.*

Referred to Parliamentary and Health Service Ombudsman (PHSO)

If a complainant feels a complaint is not satisfactorily resolved, the Trust offers a further contact response for issues that have not been previously been responded to, where more information is available or where information has not been understood. Following a complaint response the Trust advice the complainant, if they feel all attempts to resolve have been exhausted that they can go to the PHSO.

During 2024-25 there were 3 cases closed that were upheld or partially upheld following review by the PHSO. The PHSO recommended that letters of apology were sent to complainants in two of the cases. The recommendations from the third case were to produce an action plan to ensure the Trust will not repeat the failing identified ie. that an adequate assessment was not done. The actions from the recommendations are below:

- An Abbreviated Mental Test to be completed if the patient is aged 65 and over in the Emergency Assessment waiting area.
- During patient assessments the Great North Care record would be reviewed and for patient's past medical history by the assessing clinician/practitioner and the information verified with the patient for accuracy.
- A safety message highlighting the above actions to be disseminated to staff by the patient safety team to raise awareness and ensure learning.
- The Trust to explore the possibility of GP letters being uploaded to Trakcare if feasible in the future.
- To review the triage model used in the Emergency Department.

Actions are due for completion by the end of April 2025.

Compliments

The Trust records the number of compliments received within each area. The upward trends in the number of compliments recorded can be seen in the following table:

Financial Year	Number of Compliments
2021-22	4,071
2022-23	4,604
2023-24	5,083
2024-25	7,768

**Data obtained from the Trust complaint reporting system (Inphase) on 2 April 2025.*

"I just wanted to say thank you so much for the fantastic care you gave. The care received was second to none, we were given so much support and compassion and we will always remember this. Keep doing what you're doing as this is a fantastic ward with amazing staff."

Compliment Subject – Top 5

Theme	Total recorded
Care Provided	5,549
Staff to Staff	709
Compassion	676

Communication	563
Attitude	179

**Data obtained from the Trust complaint reporting system (Inphase) on 2 April 2025.*

"Thank you to the staff who dealt with us today. We were in and out within an hour of entering the hospital. Everyone we encountered on our visit was welcoming and helpful. The service we received was fantastic. They put my son at ease and were quick and efficient".

"I am so grateful for the care and support given to me by everyone on the ward. The nurses are incredible. Everyone is so friendly and helpful all of the time, they really look after me."

Patient Experience and involvement

We take feedback seriously and build on it to improve our service offer to ensure positive experience for our patients and their families. Below are examples of some of the feedback received.

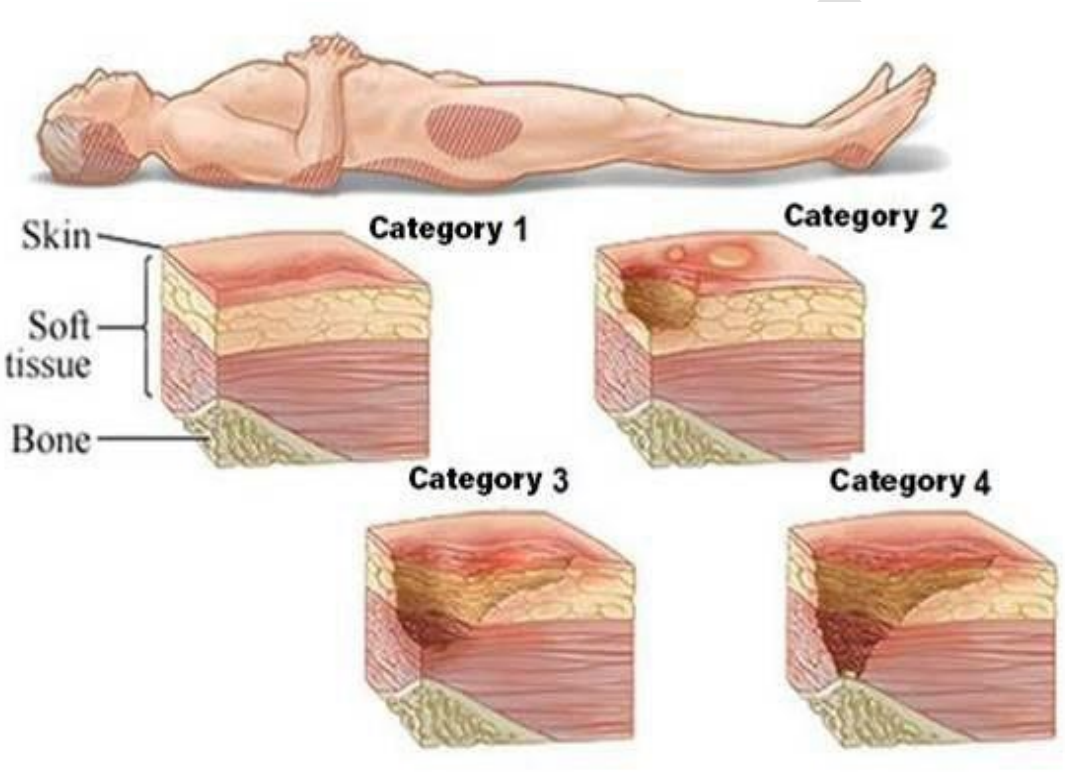
"The treatment I received by both the nurse and the doctor was exemplary: time given to me as a patient, understandable and successful outcome."

"Very friendly and as quick as they could see me. It's a great service and vital for people. It is a credit to the NHS and long may it continue"

"Staff at every level looked after me amazingly and I am very grateful for this".

Pressure Ulcers

Pressure ulcers, also known as **pressure sores**, **bedsores** and **decubitus ulcers**, are localized damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of **pressure**, or **pressure** in combination with shear and/or friction.



Year on Year Comparison – In-Hospital Acquired

Reporting Period	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Category 1	54	92	64	48	74	150	127
Category 2	198	299	233	272	231	308	263
Category 3	35	34	14	16	19	30	51
Category 4	2	3	3	2	0	2	0
Total	289	428	314	338	324	490	441

Data obtained via the Trusts Incident Reporting database. 2024-25 figures (April 2024 - February 2025)

Year on Year Comparison – Out of Hospital Acquired

Reporting Period	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Category 1	55	59	50	41	39	48	27
Category 2	173	152	128	153	103	153	79
Category 3	69	75	46	51	40	65	58
Category 4	9	19	12	14	8	8	9
Total	306	305	236	259	190	274	173

Data obtained via the Trusts Incident Reporting database. 2024-25 figures (April 2024 – February 2025)

Actions taken by the Trust

Pressure damage is one of the top five reported incidents within the Trust, with risk assessment, prevention and management being guided through the application of NICE guidelines and quality standards. Any incidents are reported via the Trust event reporting system, utilising a checklist within the system to capture data in relation to omissions in care that may have contributed to pressure ulcer development. The checklist also supports colleagues reviewing such events by providing a consistent approach towards decision making in relation to the level of investigation required and allows for easy identification of learning.

All pressure related events are validated, by the Skin Integrity Specialist Nurse. Pressure ulcer data is discussed at the monthly Safe and Effective Care Steering Group meeting and the Quality Assurance committee has oversight via the monthly integrated performance report. The TVOG has the remit of reviewing the Trust's programs of improvement, policies, guidelines and patient information leaflets. Quarterly audit data is undertaken by the Care Groups and presented within the TVOG with a review of cases and shared learning, successes and challenges.

An annual pressure ulcer prevalence audit is also undertaken for patients on the community nurse caseload and patients in hospital in-patient beds. This will next take place in June 2025. A decrease in reporting of pressure ulcer events has been noted in the period of 2024-25 for both community and in hospital care, compared with the previous year when a significant increase was noted. This decrease may be contributed to by the introduction of a new reporting system in early 2024 when a decrease in reporting was noted. There remains a positive reporting culture and continued early identification of pressure ulcers, specifically those identified as category 1, which demonstrates that early identification, improved risk assessment and care planning prevents further deterioration and delayed identification. The trust report an increase of category 3 ulcers within the hospital setting but note there were no reports of hospital acquired category 4 ulcers. There were similar numbers of category 3 and 4 ulcers reported in community compared with previous years.

During 2024/25 the Safeguarding Adults Protocol, pressure ulcers and raising a safeguarding concern (DOH July 2024) was introduced in the Trust. This requires consideration of submission of an adult safeguarding alert if a patient meets the criteria for this. The safeguarding questions have been integrated in the Trust event reporting system for the investigator of the event to consider when completing any submissions for trust acquired pressure damage. If the criteria is met a referral will be made following the pathway of the adult safeguarding concern proforma. This work is supported by the SISN and adult safeguarding team, who have been facilitating training by the use of drop in clinics across the Trust. Further drop in clinics are planned to embed this into every day practice. It is expected that there will be an increase in the numbers of safeguarding concerns submitted from the Trust during the implementation of this new process.

The Skin Integrity Collaborative has been continued and expanded during 2024-25 and has been supported by the secondment of a Skin Integrity Specialist Nurse (SISN). The skin integrity collaborative has a focus on quality improvement, education and training, correct validation of pressure ulcers, compliance with risk assessments and care planning and delivery. The SISN is able to support clinical staff at the point of care and those areas who have been part of the collaborative have demonstrated improved accuracy of reporting, improved compliance with risk assessment and care planning with a reduction in the level of harm reported. During 2024-25 an additional collaborative is planned extending the collaborative to more inpatient areas to ensure that harm to patients is reduced across the Trust and patient outcomes are improved. The role of the SISN remains integral in this continued progression.

The agenda for pressure ulcer prevention is underpinned by evidence, research and best practice with measurable outcomes ensuring we do the right thing at the right time. The SISN participated in the internal CQUIN (CCG12) from November 2024 – March 2025, which aimed to continue to evaluate the assessment and documentation of pressure ulcer risk. This is yet to be formally evaluated and will be submitted to the ACE committee in May 2025. The annual prevalence audit was completed in June 2024 with another increase in submission rate from our community teams. The community teams continue to engage with the TVN team for specialist wound care advice and manage complex wounds and patients in their own homes successfully.

Education remains a key focus for the Tissue Viability Team. Working with the clinical staff and managers is critical in the maintenance of a network of Tissue Viability Champions who meet for updates on wound care and all matters related to tissue viability. Following the success of a full day study event in 2024, another is planned for 2025-26 with quarterly meetings to support attendance and allow a full range of topics to be covered.

The annual “Stop the Pressure” event was very successful in November 2024 with a well-circulated campaign. Clinical teams were given important information on a new product introduced with aid with treatment and management of moisture related skin damage. This was following a successful trial of the product within ITU which significantly reduced the incidence of moisture associated skin damage. The “Stop the Pressure” event will be repeated in 2025 with a new focus to help improve patient care.

The tissue viability “Learning Hub” continues to develop with key topics being showcased on the intranet site. The TVN team offer planned and bespoke training events throughout the year on a rolling program to address the needs of the developing workforce.

Embedding of Purpose T, our risk assessment tool which was successfully rolled out Trust wide in 2023/24

has enabled further areas such as paediatrics and maternity to fully implement this tool in their areas. The critical care area continues to use a specific risk assessment tool, CALCULATE, which allows assessment of the risks specifically associated with critical care patients such as medical devices to be considered and reviewed to reduce the chances of device related pressure damage.

The Trust continues to utilise a pressure ulcer assurance framework, which aims to drive and demonstrate progression of excellent practice within pressure ulcer prevention as well as identifying any areas of improvement or action needed. The assurance framework is reviewed quarterly at the TVOG and identifies key actions and learning to help the Trust to continue to reduce the harm from pressure damage.

Infection rates

C. difficile is a bacterium that is found in the gut of around 3% of healthy adults. It seldom causes a problem as it is kept under control by the normal bacteria of the intestine. However certain antibiotics can disturb the bacteria of the gut and *C. difficile* can then multiply and produce toxins which cause symptoms such as diarrhoea.

The trajectory set for 2023-24 for *C. difficile* was reduced from 54 cases to 46. The Trust reported **70** trust-attributable cases for the 2023-24 period. This is a significant increase in cases and is mirrored across the region and nationally. The annual threshold for 2024-25 was 66 cases. The Trust is reporting 79 cases for the period 2024-25.

The Trust has implemented a number of actions to improve the number of C.*difficile* cases:

- The Trust has a comprehensive action plan for the prevention of hospital associated *C. difficile* cases, which is owned by the care groups and is monitored through the IPC governance route via the Infection Prevention and Control Strategic Group and reported through to the Safe and Effective Care Strategic Group, Quality Oversight Group and Quality Assurance Committee.
- All trust attributed cases are reviewed by the care groups via inphase, with input from antibiotic pharmacist and discussed at MDT if the case is an inpatient. The in phases are reviewed and themes identified by the IPC team.
- Membership of the Northeast and North Cumbria ICB 'Deep Dive' around C. *difficile* continues.
- Membership of NHS England national 'Deep Dive' around C. *difficile* continues.
- There has been a change in policy for *C.difficile* cleaning, HPV remains the gold standard and is therefore requested on all C. difficile cases upon discharge or transfer.

Staff continue their efforts to control and reduce opportunities for infections to spread, whether we treat people in our clinical premises or in their own homes. The Trust has increased cleaning provision in line with the national cleaning standards and continues to maintain these standards of increased cleaning. The importance of adherence to high standards of hand hygiene has continued to be a core element of our strategy.

Actions to reduce *C. difficile* are within the healthcare associated infections (HCAI) plan on a page and the Infection Control Assurance Framework covering all infections and practices and is reviewed quarterly. The Trust is also a key partner within the integrated care board (ICB) infection control teams and plans to adopt the co-produced plan on a page, implementing shared learning to help reduce the incidence of *C.difficile* throughout 2024/25.

The following table identifies the number of hospital and community onset cases of *C.difficile* reported by our laboratory.

- Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission

- Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

*Trust C. difficile cases 2022-25

	2022-23	2023-24	2024-25
Hospital onset-Healthcare-associated	48	50	60
Community- onset associated	45	20	19

*Data obtained from Healthcare Associated Infections (HCAI) data capture system

Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia

Staphylococcus aureus is a bacterium commonly found on human skin which can cause infection if there is an opportunity for the bacteria to enter the body. In serious cases it can cause blood stream infection. MRSA is a strain of these bacteria that is resistant to many antibiotics, making it more difficult to treat.

Many patients carry MRSA on their skin and this is called colonisation. It is important that we screen some groups of high risk patients when they come into hospital so that we know if they are carrying MRSA. Screening involves a simple skin swab. If positive, we can provide prescribed skin wash that helps to get rid of MRSA and reduces the risk of an infection developing.

In 2024-25 we report 5 cases of healthcare-associated MRSA bacteraemia to date.

Each case has undergone a post-infection review and with the development of the Trust Patient Safety Incident Review Framework (PSIRF) we have also completed an intermediate learning thematic review. Key work streams are ongoing to improve our processes in relation to MRSA admission screening and decolonisation in 2024/25, which include daily visits to the admission areas to promote timely screening and educate staff.

*Trust MRSA bacteraemia cases 2022-25

	2022-23	2023-24	2024-25
Hospital-onset healthcare-associated	2	2	3
Community-onset healthcare-associated	0	2	2
Community-onset community-associated	2	6	2

*Data obtained from Healthcare Associated Infections (HCAI) data capture system

Methicillin-Sensitive Staphylococcus Aureus (MSSA)

MSSA is a strain of *Staphylococcus aureus* that can be effectively treated with many antibiotics. It can cause infection if there is an opportunity for the bacteria to enter the body and in serious cases it can cause blood stream infection.

In 2024-25 we currently report 49 cases of healthcare-associated MSSA bacteraemia to date.

*Trust MSSA bacteraemia cases 2022-25

	2022-23	2023-24		2024-25
Hospital-onset healthcare-associated	37	33		36
Community-onset healthcare-associated	10	20		13
Community-onset community-associated	65	60		51

*Data obtained from Healthcare Associated Infections (HCAI) data capture system

- Trust Klebsiella species bacteraemia cases 2022-25
-

	2022-23	2023-24	2024-25
Hospital-onset healthcare-associated	17	19	22
Community-onset healthcare-associated	11	12	8
Community-onset community-associated	43	45	44

- *Data obtained from Healthcare Associated Infections (HCAI) data capture system
- Urinary tract infection causes are the highest reported source, and improvements are being made to improve catheter care and reduce catheter use within the trust. This is being done with increased audits and a catheter group being created to work through actions identified from the audits. The catheter group is improving documentation as well as training and education for staff and looking at alternative product use.

Section 3:2 Performance from key national priorities

Appendix B of the compliance framework

National NHS objectives form the basis on which the Trusts' Annual Plan and in year reports are presented. Regulation and proportionate management remain paramount in the Trust to ensure patient safety is considered in all aspects of operational performance and efficiency delivery. The current performance against national priorities, existing targets and cancer standards are demonstrated in the table with comparisons to the previous year.

NHS Oversight Framework Indicators	Standard/Trajectory	2024-25 Performance	2023-24 Performance	Achieved (cumulative)
Cancer 31 day wait for second or subsequent treatment – surgery (Apr 24 to Feb 25 Provisional)	94%	88.16%	89.19%	x
Cancer 31 day wait for second or subsequent treatment – anti cancer drug treatments (Apr 24 to Feb 25 Provisional)	98%	96.65%	98.93%	x
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer) (Apr 24 to Feb 25 Provisional)	85%	55.25%	55.04%	x
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral) (Apr 24 to Feb 25 Provisional)	90%	73.88%	75.64%	x
Cancer 31 day wait from diagnosis to first treatment (Apr 24 to Feb 25 Provisional)	96%	96.34%	96.23%	✓
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) (Apr 24 to Feb 25 Provisional)	93%	84.85%	87.62%	x
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) (Apr 24 to Feb 25 Provisional)	93%	74.07%	83.00%	x

Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (Mar-25)	92%	75.46%	71.15%	x
Referral to Treatment 52 Week Waits (Mar-25)	0	173	218	x
Number of Diagnostic waiters over 6 weeks (Apr 24 to Feb 25)	99%	79.32%	80.19%	x
Community care data completeness – referral to treatment information completeness (Apr 24 to Feb 25)	50%	97.24%	96.69%	✓
Community care data completeness – referral information completeness (Apr 24 to Feb 25)	50%	99.09%	99.75%	✓
Community care data completeness – activity information completeness (Apr 24 to Feb 25)	50%	100%	99.98%	✓
Community care data completeness – patient identifier information completeness (Shadow Monitoring) (Apr 24 to Feb 25)	50%	100%	99.98%	✓
Community care data completeness – End of life patients deaths at home information completeness (Shadow Monitoring) (Apr 24 to Feb 25)	50%	83.94%	84.21%	✓
Other National and Contract Indicators	**Target**	**2024-25 Performance**	**2023-24 Performance**	**Achieved**
Cancelled Procedures for non- medical reasons on the day of op (Apr 24 to Feb 25)	0.80%	0.55%	0.48%	✓
Cancelled Procedures reappointed within 28 days (Apr 24 to Jan 25)	100%	78.06%	75.25%	x
Eliminating Mixed Sex Accommodation (Apr 24 to Mar 25)	Zero cases	0	0	✓
A&E Trolley waits > 12 hours (Apr 24 to Mar 25)	Zero cases	127	54	x
Stroke – 90% of time on dedicated Stroke unit (Apr 24 to Mar 25)	80%	90.41%	82.21%	✓

Stroke – TIA assessment within 24 hours (Apr 24 to Mar 25)	75%	60.14%	71.88%	x
VTE Risk Assessment (Apr 24 to Feb 25)	95%	94.33%	95.97%	x
Sickness Absence Rate (Feb 2025)	4.0%	6.03%	5.44%	x
Mandatory Training Compliance (Mar 2025)	90%	88.93%	90.14%	x
Turnover Rate (Mar 2025)	10.0%	7.24%	7.61%	✓
Operational Efficiency Indicators	**Target**	**2023-24 Performance**	**2022-23 Performance**	**Achieved**
New to Review Ratio (Apr 24 to Mar 25)	1.45	1.90	1.97	x
Outpatient DNA (Combined) (Apr 24 to Feb 25)	9.20%	8.55%	9.58%	✓
Length of Stay Elective (Apr 24 to Mar 25)	3.14	1.96	1.97	✓
Length of Stay Emergency (Apr 24 to Mar 25)	3.35	3.30	3.31	✓
Readmission Elective (Apr 24 to Jan 25)	0.00%	4.38%	4.24%	x
Readmission Emergency (Apr 24 to Jan 25)	9.37%	13.45%	13.57%	x
Occupancy (Trust) (Apr 24 to Mar 25)	92%	92.48%	91.73%	x
Quality Indicators	**Standard/Trajectory**	**2024-25 Performance**	**2023-24 Performance**	**Achieved**
Clostridium Difficile – variance from plan (objective) (Apr 24 – Mar 25)	66	76	70	x
Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia (Apr 24 – Mar 25)	0	6	4	x
Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia (Apr 24 – Mar 25)	36	48	52	x
Escherichia coli (E.coli) (Apr 24 – Mar 25)	69	83	88	x
Klebsiella species (Kleb sp) bacteraemia (Apr 24 – Mar 25)	30	29	31	✓
Pseudomonas aeruginosa bacteraemia (Apr 24 – Mar 25)	15	17	16	x

Trust Complaints - Formal CE Letter (Stage 3) (Apr 24 – Mar 25)	<110	52	89	✓
Trust Falls with Moderate Harm (Apr 24 – Mar 25)	<24	32	30	x
Trust Falls with Severe Harm (Apr 24 – Mar 25)	0	0	0	✓
In Hospital Pressure Ulcers Grade 4 (Apr 24 – Feb 25)	0	0	2	✓
Friends and Family Test - Very Good/Good (Apr 24 – Mar 25)	75%	93.19%	92.13%	✓
Never Events (Apr 24 – Mar 25)	0	1	0	x
Hand Hygiene (Apr 24 – Mar 25)	95%	96.96%	97.36%	✓
Summary Hospital-level Mortality Indicator (SHMI) (Nov 23 – Oct 24)	< 100	96.56	96.40	✓

Cancer 62 day wait for 1st treatment

Cancer waiting times targets exist to improve patient experience and speed up diagnosis and treatment. Time to diagnosis and time to treatment are key indicators for patients about the services they receive, and both can contribute to longer-term patient outcomes. We will continue to focus on diagnosis and treatment and to ensure that as a minimum we meet each of the national cancer waiting times (CWT) standards.

The trust is dedicated to the continued improvement of the cancer faster diagnosis standard to help reduce the number of patients waiting over 62 days and eliminate 104 day waits.
There will be a focus on planning, service improvement and ongoing delivery of the cancer agenda by collaborative working across the group, along with Care Groups and clinical colleagues to support tumour specific pathways that align to National priorities highlighted below.

- Develop shorter and better patient pathways in line with the 28 day Faster Diagnosis standard.
- Continue to view national cancer waiting time targets as a minimum standard, improving and surpassing targets year on year.
- Use data to drive decision-making and prioritisation around pathways.
- Use intuitive Business Intelligence tools to capture data as a by-product of care in ways that reduce the administrative burden.
- Support development of a cancer clinical information system at MDT level, which is fit for purpose.
- Publish outcomes information and make it available to patients, the public and commissioners in a way that can be understood.
- Support the development of decision support and artificial intelligence (AI) to help clinicians in applying best practice.
- Continue the roll out of clinician led PTL.

Achieving the above will secure the provision of a quality service for our cancer patients. Constantly striving to improve patient pathways, patient experience as well as looking at innovative ways to reach both the early diagnosis standard and the faster diagnosis standard, which all feed into improving

patient outcomes.

Freedom to Speak Up (FTSU)

Background to the Freedom to Speak Up Guardian (FtSUG)

The National Guardian Office (NGO) and the Freedom to Speak Up Guardian (FtSUG) role was established in 2016 following the events at Mid-Staffordshire NHS Foundation Trust and the recommendations from the subsequent inquiry led by Sir Robert Francis.

The Francis Report raised 290 recommendations. One of the recommendations was to have a designated person who was impartial and independent working in every Trust. This role would facilitate staff to speak to in confidence about concerns at work including any public interest disclosure. It was acknowledged that staff should be listened to, taken seriously and would not suffer detriment as a result of speaking up. The NGO was established to train and support FtSUG's as well as providing appropriate resources to help establish a healthy "Speak Up, Listen Up and Follow Up" culture. All FtSUG's are locally employed but are trained by the NGO.

Philosophy

The Freedom to Speak Up (FtSU) ethos aims to help promote and normalise the raising of staff concerns ultimately for the benefit of patients and workers. Speaking up not only protects patient safety but can also improve the lives of workers by listening to what they need to be able to do their job, so that they can deliver an excellent service. FtSU is about encouraging a positive culture where people feel they can speak up, their voices will be heard and their concerns or suggestions acted upon. In the seven years since Sir Robert Francis recommendations were implemented, the FtSUG role continues to evolve and move away from a whistleblowing culture to one of permission, encouragement, openness and transparency.

"If we can get the culture right, benefits will follow, including improving patient safety, innovation for improvement, retaining workers and making the National Health Service a great place to work".

Dr Jayne Chidgey-Clark, National Guardian for the NHS

The Trust positively encourages all employees to speak up if they have a concern about risk, malpractice or wrongdoing. Moreover, if there are any behaviours or acts which harm the services the Trust delivers, we have both a duty and right to speak up. Examples may include (but are by no means restricted to):

- Patient safety concerns, quality of care, unsafe staffing.
- A particular way of working or a process that isn't being followed.
- Professional malpractice.
- You feel you are being discriminated against.

- Working relationships e.g. the behaviours of others is affecting your wellbeing or that of your colleagues.
- A bullying culture (across a team rather than individual instances of bullying).
- A breach of confidentiality, trust policy or procedures.
- Suspicion of fraud.
- A criminal offence has been committed or is likely to be committed.
- An idea of an improvement or innovation.

Trust progress 2024 - 2025:

The FtSUG has recruited a further five Freedom to Speak Up Champions (FTSUC's), to expand their FtSUC network, which now stands at nineteen and with a further five people expressing an interest to become a FtSUC. This has been done through a fair recruiting process as per National Guidance and has been promoted through the Trust communications. The FTSUC's who have been recruited, completed an expression of interest form and line management sign off. An informal conversation was held in November, with a panel of the FTSUG and the Head of People services. The FTSUC's have all been trained by the FtSUG, and will attend the quarterly FTSUC network meeting, be buddied up with another FtSUC and will have a bi-annual informal 1-2-1 with the FtSUG and high-level data for triangulation, will be collected.

Every year in October the NGO, together with FtSUGs, leaders, managers and workers across the healthcare sector, celebrate Speak Up Month - a month to raise awareness of FtSU and make speaking up business as usual for everyone. This year's speak up month involved a Group Board Development session supported by the Senior Freedom to Speak Up Support Manager, from the NGO. A FtSU Hearing It session with the CEO, where workers could learn more about speaking up and ask any curious questions or express any concerns, they may have about speaking up, over 280 staff joined this session. As a part of the group model the FTSUGs did a FtSU themed podcast for staff to listen to in their own time. The FtSUG did a green themed hamper, which staff had the opportunity to win if they made a pledge as a result the FTSUG, received hundreds of FtSU pledges with many saying they would look to do the speak up training.

The FtSUG as part of Speak Up Month was asked to be a guest speaker at a Teaching Hospital within the region, to talk about supporting neurodiversity in the workplace. The FTSUG was accompanied by the Head of People Services, giving both a FTSUG and People perspective. This was well received, with positive feedback

To tackle the barrier of detriment for workers speaking up. The FtSUG has developed a detriment presentation and a standing operational procedure on how to manage concerns about detriment. The FtSUG has also devised feedback forms asking if detriment has been suffered as a consequence of speaking up, which will be sent to workers three, six and twelve months after a case has closed. This work aims to educate staff and give them assurance that as an organisation, we do not tolerate detriment, with the hope to mitigate this as a barrier for staff speaking up. This work has been presented at People Group and the FtSUG previously aimed to roll this out in quarter three, however, to align it with the work of the NGO this will now be rolled out in quarter one-four.

As part of the proactive work the FtSUG continues to promote the role via team meetings, floor walking, ward visits and has a high presence within the Trust, which can be demonstrated in the data. Those workers who have spoken up have been from different areas of the organisation and a variety of professional backgrounds including doctors, nursing, Allied Health Care Professionals, administration and student.

As we move to a culture of making speaking up "business as usual", we continue the proactive aspect of the FtSUG role, to encourage workers to report concerns openly, rather than confidentially, by helping them to feel empowered and psychologically safe.

To support this there are currently three training modules on ESR; Speak Up (core workers), Listen Up (middle managers) and Follow Up (senior leaders). The training is not mandatory at North Tees and Hartlepool NHS Foundation Trust and the undertaking of the training is low. The FtSUG as an alternative to completing the training modules, delivers workshops for all three training modules, using each of the

modules as a framework, whilst also using research from webinars, podcast, and courses.

The FtSUG has regular “Keep in Touch” meetings with their Executive Sponsor, Non-Executive Director for FtSU, CEO and Chairman. All other senior leaders have helped create a relational approach to speaking up as well progressing any concerns raised. The FtSUG also presents quarterly updates to People Group, People Committee and Board

To strengthen the organisational approach to the triangulation of data, the FtSUG has become a member of the trusts culture steering group, this group aims to look at the soft intelligence where areas may be suffering difficulty and using the resources to provide an early holistic approach to resolve issues before they become more problematic.

To help build relationships with the network leads, the FtSUG attends all of the meet the network leads sessions and has been invited to be part of the staff hub, which has recently been established

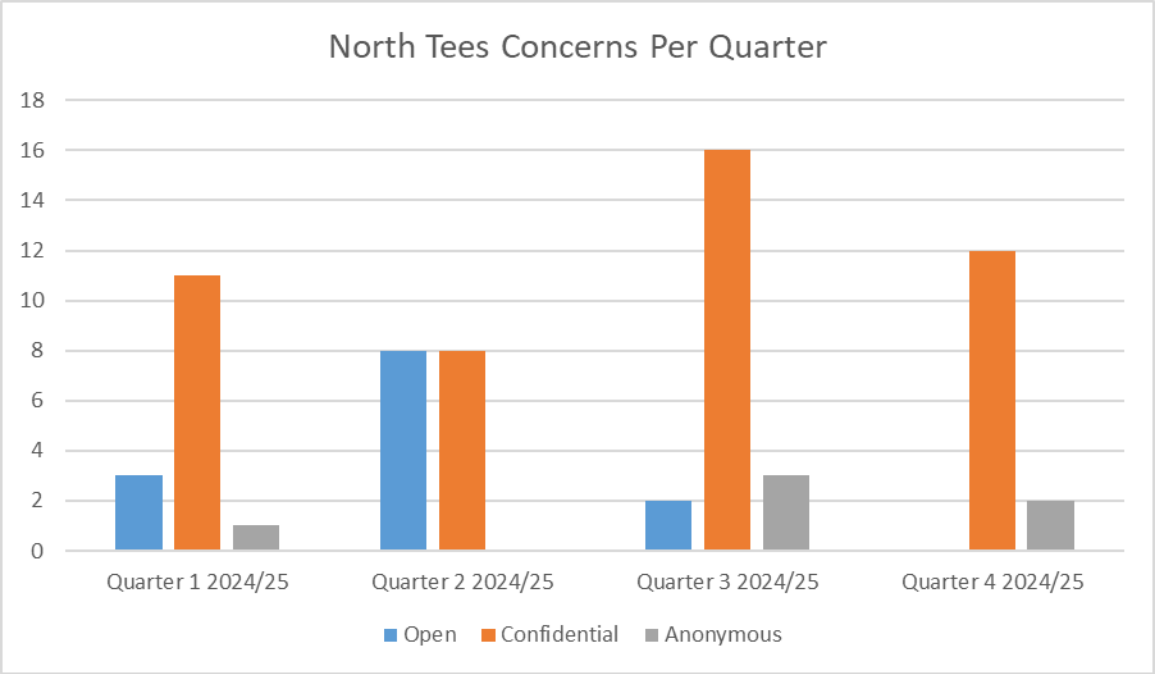
The FtSUG is the Deputy Chair of the Northeast, Yorkshire regional FtSUG network meetings with the aim of learning, sharing best practice, peer support and working collaboratively.

The FtSUG has been looking at how to support Neurodiversity in the workplace, the sexual safety charter, attends the EDI steering group, the , Schwartz round steering group and supports the wellbeing framework.

The FTSUG also attends the following to promote FTSU:

- All Staff Inductions
- Quarterly Patient Safety Council
- Quarterly Care Group Senior Management Team meetings
- Monthly meetings with Care Group Directors.
- Staff network meetings
- Teeside University
- Joint Forum
- Schwartz Round Steering Group
- FtSUG Regional Network meeting.
- Quarterly Senior Practitioner Manager Operational Meeting
- Quarterly Matrons Meeting
- Quarterly Community Forum
- Preceptorship Training
- Undergraduate Medical Students
- Postgraduate Doctors
- T-Level Students
- NTH Solutions Onboarding
- Quarterly Senior Practitioner Manager Operational Meeting
- Quarterly Matrons Meeting
- Quarterly People Group
- Quarterly Group People Committee
- Quarterly Board
- Ward/Directorate Meetings
- Podcasts
- Hearing it with Stacey session
- Trust Walkabouts

National Guardian Office 2024 -2025 Data submitted:



Q1 – 15 Cases (April 2024 – June 2024)
Q2 – 16 Cases (July 2024 – September 2024)
Q3 – 21 Cases (October 2024 – December 2024)
Q4 – 13 Cases (January 2025 – March 2025)
Total number of contacts:65

Method of Reporting Concerns:

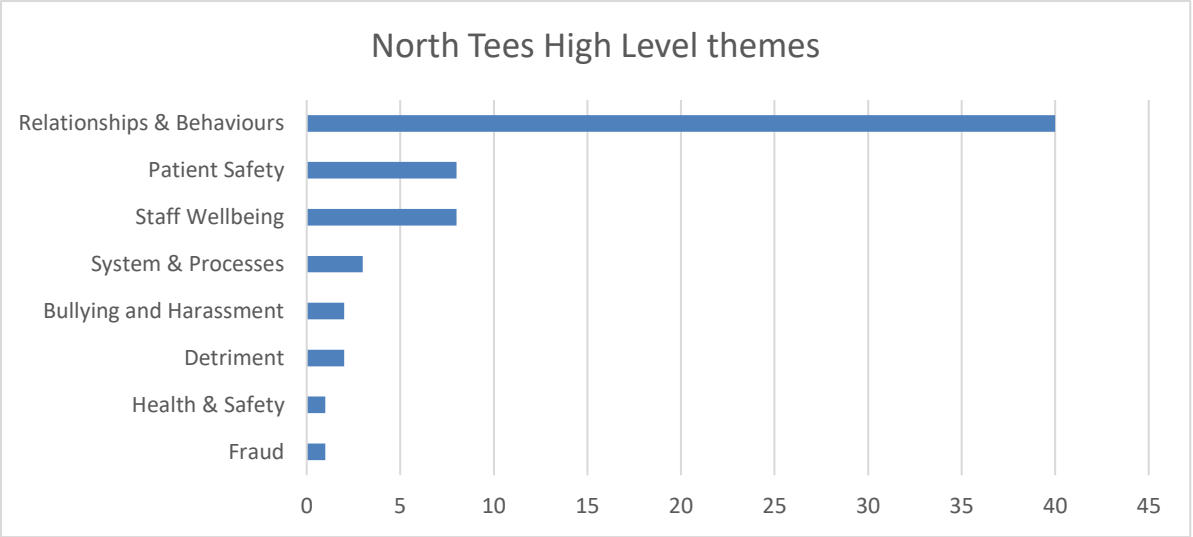
47 contacts were received confidentially (72.3%)
12 contacts were received openly (18.4%)
6 contacts were received anonymously (9.2%)

The workers can raise concerns openly, confidentially and anonymously. The Trusts anonymous reporting was 9.2 %, which is below the national average data, which is submitted quarterly to the NGO. The national data reports anonymous reporting at 9.5%. This gives assurance that workers are happy to speak up confidentially and that they trust their identity will only be shared without their consent. The highest percentage of concerns being raised are done so confidentially at 72.3% and this shows there is a long way to go to making speaking up "business as usual" in an open and transparent way.

Please note, as per the NGO guidelines, all Trusts should be working towards a culture where speaking up is "business as usual". The FtSU ethos is to reduce anonymous reporting where possible and to move into a confidential – open speak up culture. It is important to note that anonymous reporting happens in many organisations and confidentiality remains an important aspect of some cases and processes. Speaking up is accepted in all formats and colleagues are encouraged to report concerns responsibly, with civility and to include any suggested outcomes / improvements if possible.

Reported themes:

1. Relationships & Behaviours
2. Patient Safety
3. Staff Wellbeing
4. System/Process
5. Bullying & Harrassment
6. Detriment
7. Health and Safety
8. Fraud



All open concerns and themes are being progressed or investigated and actioned accordingly. Where applicable, staff have received feedback on follow up recommendations. The FTSUG does regular check ins with both the individual who has raised the concern and the individual looking into the concern.

The FtSUG submits numbers and themes every quarter to the NGO portal and the final submission for the reporting year, Q4 data, will be submitted in April.

Staff Feedback

For quality assurance purposes, staff are invited to provide feedback at the end of the FtSU process. Staff also to continue to offer feedback on an ad hoc and voluntary basis during the FtSU process as well as general comments in team meetings.

Some examples of staff feedback: Feedback from staff since commencing the role includes:

"Thank you for listening, for the first time we are started to be heard and get things moving."

"Thank you for listening, it is good to have someone impartial to talk to for a fair perspective."

"Thank you for listening, I really appreciate all of your help."

"It was great to meet and talk to you when you were on one of your walk abouts and that is what encouraged me to come and speak up to you."

"*Speaking to you was incredibly reassuring, and I feel much more at peace knowing there is*

support available. I truly appreciate your guidance and understanding."

Speaking up can be a challenging, worrying and sometimes lengthy experience. Timescales for investigations, communication, outcomes as well as the ongoing impact of employment tribunals is challenging for our staff. This means that process and / or psychological support continues to be a requirement which requires further consideration. The FtSUG signposts colleagues for wellbeing support to any colleague (or ex colleague) who have raised a work related concern and signposts staff accordingly for psychological support.

The NHS Staff Annual Survey indicates that staff feel that the follow up aspect of raising a concern could be improved and this is an area that will be looked at considerably in the proactive work of the FtSUG in 2025.

There were two cases of detriment reported this year. The FtSUG will prioritise educating staff on detriment through walkabouts, staff meetings, podcasts and the Hearing It sessions with the CEO.

Final Comments

The FtSUG would like to express thanks for the ongoing support from all colleagues who have helped promote and embed the FtSU ethos over the last year as well as continuing thanks to all staff who have spoken up to raise concerns. It takes great courage to speak but this is how as an organisation we learn and grow and become the best version of ourselves.

There is no national requirement for NHS trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account; this is a matter for local discussion between the Trust (or governors for an NHS trust) and its auditor. For quality accounts approval from within the Trust's own governance procedures is sufficient.

Annex B: Quality Report Statement

Statement of Directors' Responsibilities in Respect of the Quality Account

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

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support 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 2023-24* and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2023 to April 2024
  - papers relating to Quality reported to the Board over the period April 2023 to April 2024
  - feedback from commissioners dated June *2024*
  - feedback from governors dated June *2024*
  - feedback from local Healthwatch organisations dated June *2024*
  - feedback from the Adult Services and Health Select Committee and Audit and Governance Committee dated June *2024*
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,
  - the latest national patient survey *2023*
  - the latest national staff survey *2023*
  - CQC Quality Report – Inspection Report 16 September 2022
  - the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
  - the performance information 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 in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
  - the Quality Report has been prepared in accordance with NHS Improvements annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

Chief Executive Chairman

Annex C: We would like to hear your views on our Quality Accounts

North Tees & Hartlepool NHS Foundation Trust value your feedback on the content of this year's Quality Account.

Please fill in the feedback form below, tear it off and return to us at the following address:

Patient Experience Team

North Tees & Hartlepool NHS Foundation Trust

Hardwick Road

Stockton-on-Tees

Cleveland

TS19 8PE

.....

Thank you for your time.

Feedback Form (please circle all answers that are applicable to you)

What best describes you: Patient Carer Member of public Staff Other

Did you find the Quality Account easy to read? Yes No
Did you find the content easy to understand? Yes all of it Most of it None of it
Did the content make sense to you? Yes all of it Most of it None of it
Did you feel the content was relevant to you? Yes all of it Most of it None of it **Would the content encourage you to use our hospital?** Yes all of it Most of it None of it
Did the content increase your confidence in the services we provide? Yes all of it Most of it None of it

Are there any subjects/topics that you would like to see included in next year's Quality Account?

.....
.....
.....
.....
.....

In your Opinion, how could we improve Our Quality Account?

.....
.....
.....
.....
.....
.....

Alternatively you can email us at: **nth-tr.PatientExperience@nhs.net** with the Subject **Quality Accounts**

Glossary

A&E	Accident and Emergency
ACE Committee	Audit and Clinical Effectiveness Committee – the committee that oversees both clinical audit (i.e. monitoring compliance with agreed standards of care) and clinical effectiveness (i.e. ensuring clinical services implement the most up-to-date clinical guidelines)
ACL	Anterior Cruciate Ligament – one of the four major ligaments of the knee
AKI	Acute Kidney Injury
AHP	Allied Health Professional
AMT	Abbreviated Mental Test
AQuA	Advancing Quality Alliance
BI	Business Intelligence
CAB	Citizens Advice Bureau
CABG	Coronary Artery Bypass Graft (or "heart bypass")
CAUTI	Catheter-associated urinary tract infection
CFDP	Care For the Dying Patient
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach Team
CDI	Clostridium difficile Infection
CHKS	Comparative Health Knowledge System
CIAT	Community integrated assessment team (CIAT)
Clostridioides Difficile (infection)	A type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It is easily spread and can be acquired in the community and in hospital
CLRN	Comprehensive Local Research Network
CMR	Crude Mortality Rate
CNS	Clinical Nurse Specialist
COHA	Community onset Healthcare Associated
COPD	Chronic Obstructive Pulmonary Disease
CLIP	Complaints Litigation Incidents Performance
CPIS	Child Protection Information System
CPMS	Central Portfolio Management System
CSE	Child Sexual Exploitation
CSP	Co-ordinated System for gaining NHS Permission
CQC	The Care Quality Commission – the independent safety and quality regulator of all health and social care services in England
CQRG	Clinical Quality Review Group

DAHNO	Data for Head and Neck Oncology (Head and Neck Cancer)
DARs	Data Analysis Reports
DH	Department of Health
DLT	Discharge Liaison Team
DNA	Did Not Arrive
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
DSCP	Durham Safeguarding Children Partnership
DSPT	Data Security Protection Toolkit
DToC	Delayed Transfer of Care
DVLA	Driver and Vehicle Licensing Agency
EAU	Emergency Assessment Unit
E coli (infection)	Escherichia coli infection
ED	Emergency Department
EMSA	Eliminating mixed sex accommodation
EPMA	Electronic Prescribing and Medication Administration
EPR	Electronic Patient Record
EOL	End of Life
ESR	Electronic Staff Record
EWS	Early Warning Score – a tool used to assess a patient's health and warn of any deterioration
FCE	Finished Consultant Episode – the complete period of time a patient has spent under the continuous care of one consultant
FGM	Female Genital Mutilation
FICM	Faculty of Intensive Care Medicine
FOI (act)	The Freedom of Information Act – gives you the right to ask any public body for information they have on a particular subject
FFT	Friends and Family Test
FSCO	First Stop Contact officer
FTSU	Freedom To Speak Up

FTSUG	Freedom To Speak Up Guardian
Global trigger tool (GTT)	Used to assess rate and level of potential harm. Use of the GTT is led by a medical consultant and involves members of the multi-professional team. The tool enables clinical teams to identify events through triggers which may have caused, or have potential to cause varying levels of harm and take action to reduce the risk
GCP	Good Clinical Practice
GM	General Manager
HCAI	Health Care Acquired Infection
HED	Healthcare Evaluation Data (A major provider of healthcare information and benchmarking)
HEE	Health Education England
HENE	Health Education North East
HES	Hospital Episode Statistics
HLSCB	Hartlepool Local Safeguarding Children Board
HMB	Heavy Menstrual Bleeding
HOHA	Hospital Onset Healthcare Associated
HQIP	Healthcare Quality Improvement Partnership
HRG	Healthcare Resource Group – a group of clinically similar treatments and care that require similar levels of healthcare resource
HSCB	Hartlepool Safeguarding Children Boards
HSSCP	Hartlepool and Stockton Safeguarding Children Partnership
HUG	Healthcare User Group
IBD	Inflammatory Bowel Disease
ICC	Infection Control Council
ICE	
ICNARC	Intensive Care National Audit and Research Centre
ICO	Information Commissioners Office
ICS	Intensive Care Society
IG	Information Governance
IHA	Initial Health Assessment
IMR	Intelligent Monitoring Report tool for monitoring compliance with essential standards of quality and safety that helps to identify where risks lie within an organisation
LD	Learning Difficulties
ICE	Integrated Clinical Environment

IG	Information Governance

Intentional rounding	A formal review of patient satisfaction used in wards at regular points throughout the day
IPB	Integrated Professional Board
IPC	Infection Prevention and Control
ISPA	Integrated Single Point of Access
Kardex (prescribing 120ardex)	A standard document used by healthcare professionals for recording details of what has been prescribed for a patient during their stay
KEOGH	Sir Bruce Keogh
Kleb sp	Klebsiella Species (type of infection)
KPI	Key Performance Indicator
LAC	Looked After Children
LADO	Local Authority Designated Officer
LAR	Looked After Review
LD	Learning disabilities
LeDeR	Learning Disabilities Mortality Review
Liverpool End of Life Care Pathway	Used at the bedside to drive up sustained quality of care of the dying patient in the last hours and days of life
LMS	Local Maternity System
LPMS	Local Portfolio Management Systems
LPS	Liberty Protection Systems
LQR	Local Quality Requirements
LSCB	Local Safeguarding Children's Board
MARAC	Multi Agency Risk Assessment Conferences
MATAC	Multi Agency Tasking and Co-ordination
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
ME	Medical Examiner
MEG	Missing Exploited Group
MHA	Mental Health Act
MHRA	Medicines and Healthcare products Regulatory Agency
MIU	Minor Injuries Unit
MINAP	The Myocardial Ischaemia National Audit Project

MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NCRN	National Cancer Research Network
NDG	National Data Guardian
NEAS	North East Ambulance Service
NEEP	North East Escalation Plan
NEPHO	North East Public Health Observatory
NEQOS	North East Quality Observatory System
NEWS	National Early Warning Score
NHS Improvements	The independent regulator of NHS foundation Trusts
NICE	The National Institute of Health and Clinical Excellence
NICOR	The National Institute for Cardiovascular Outcomes
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
NQB	National Quality Board
NRLS	National Learning and Reporting System
NTHFT	North Tees and Hartlepool Foundation Trust
OD Banding	Overdispersion (statistical indicators)
OFSTED	The Office for Standards in Education
PalCall	Palliative care, out-of-hours telephone helpline for patients and carers registered with our services
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PET	Patient Experience Team
PHE	Public Health England
PIC	Patient Identification Centre
PICANet	Paediatric Intensive Care Audit Network
PMRT	Perinatal Mortality Review Tool
PREVENT	the government's counter-terrorism strategy
PROMs	Patient Reported Outcome Measures
Psa	Pseudomonas Aeruginosa (Type of Infection)
Pseudonymisation	A process where patient identifiable information is removed from data held by the Trust

QAF	Quality Assessment Framework
SECSG	Safe and effective care Steering Group

QAC	Quality Assurance Committee –- The committee responsible for ensuring provision of high quality care and identifying areas of risk requiring corrective action
QI	Quality Improvement
R&D	Research and Development
RA	Recruitment Activity
RAG	Red, Amber, Green chart denoting level of severity
RCA	Root Cause Analysis
RCOG	The Royal College of Obstetricians and Gynaecologists
RCPCH	The Royal College of Paediatric and Child Health
REPORT-HF	International Registry to assess Medical Practice with longitudinal observation for Treatment of Heart Failure
RESPECT	"Responsive, Equipped, Safe and secure, Person centered, Evidence based, Care and compassion and Timely" – a nursing and midwifery strategy developed with patients and governors aimed at promoting the importance of involving patients and carers in all aspects of healthcare
RHA	Review Health Assessments
RMSO	Regional Maternity Survey Office
SBAR	Situation, Background, Assessment and Recommendation – a tool for promoting consistent and effective communication in relation to patient care
SCM	Senior Clinical Matron
SCMOoH	Senior Clinical Matron Out-of-Hours
SCR	Serious Case Review
SEPSIS	Life-threatening reaction to an infection
SHA	Strategic Health Authority
SHMI	Summary Hospital Mortality-level Indicator – a hospital-level indicator which reports inpatient deaths and deaths within 30-days of discharge at Trust level across the NHS
sic	The Latin adverb ***sic*** ("thus"; in full: *sic erat scriptum*, "thus was it written"), inserted immediately after a quoted word or passage, indicates that the quoted matter has been transcribed exactlyas found in the source text, complete with any erroneous or archaic spelling, surprising assertion, faulty reasoning, or other matter that might otherwise be taken as an error of transcription.
SINAP	Stroke Improvement National Audit Programme
SLSCB	Stockton Local Safeguarding Children Board
SMPG	Safety Medical Practices Group
SOF	Single Oversight Framework
SOP	Standard Operating Procedures
SPA	Single Point of Access
SPC	Specialist Palliative Care

SPCT	Specialist Palliative Care Team
SPEQS	Staff, Patient Experience and Quality Standards
SPICT	Supportive & Palliative Care Indicator Tools
SPOC	Single point of contact
SSKIN	Surface inspection, skin inspection, keep moving, incontinence and nutrition
SSU	Short Stay Unit
STAMP	Screening Tool for the Assessment of Malnutrition in Paediatrics
STERLING	Environmental Audit Assessment Tool
SUS	Secondary User Service
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
TIA	Transient Ischemic Attack
TNA	Training Needs Analysis
Tough-books	Mobile computers aim to ensure that community staff has access to up-to-date clinical information, enabling them to make speedy and appropriate clinical decisions
TRAKCARE	Electronic Patient Record System
TSAB	Tees-Wide Safeguarding Board
UCC	Urgent Care Centre
UHH	University Hospital of Hartlepool
UHNT	University Hospital of North Tees
UKST	UK Sepsis Trust
UNIFY	Unify2 is an online collection system used for collating, sharing and reporting NHS and social care data.
UTI	Urinary Tract Infection
UV	Ultra Violet
VEMT	Vulnerable, exploited, missing, trafficked
VSGBI	The Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism
WRAP	Workshop to Raise Awareness of PREVENT
WTE	Whole Time Equivalent - is a unit that indicates the workload of an employed person in a way that makes workloads or class loads comparable
4at delirium assessment tool	Bedside medical scale used to help determine if a person has positive signs for delirium

North Tees and Hartlepool NHS Foundation Trust
University Hospital of North Tees
Hardwick, Stockton-on-Tees, TS19 8PE

www.nth.nhs.uk

Caring
Better
Together

Tees Valley Joint Health Scrutiny Committee
8 May 2025

TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME 2025-2026

1. PURPOSE OF THE REPORT

1.1 The Committee is required to consider and agree its work programme for 2025-2026. Members may also like to consider adding any additional items to the work programme.

2. SUMMARY

2.1 Members are requested to consider the attached work programme (Appendix A) for the 2025-26 Municipal year. The work programme includes standing items as well as those that have been prepared based on Officer recommendations and recommendations previously agreed by this Joint Committee.

2.2 As part of the process for establishing the work programme, support officers gather information/intelligence from several sources (Appendix B). The information details a list of topics which are anticipated to be of particular interest to the scrutiny Joint Committee in 2025/26. Members are advised that the list of possible topics is not exhaustive and that additional topics can be added and considered at the meeting.

3. RECOMMENDATION

3.1 It is recommended that Members consider and agree the contents of the work programme and consider any additional areas of work they may wish to include.

BACKGROUND PAPERS

No background papers were used in the preparation of this report.

Contact Officers: -

Caroline Breheny – Senior Democratic Services Officer
Governance, Corporate Resources
Redcar & Cleveland Borough Council
Tel: 01642 444065
Email: caroline.breheny@redcar-cleveland.gov.uk

Caroline Leng – Democratic Services and Scrutiny Officer
Governance, Corporate Resources

Redcar & Cleveland Borough Council
Tel: 01642 444415
Email: caroline.leng@redcar-cleveland.gov.uk

Appendix A

Meeting Date	Topic	Attendance
8th May 2025	TVJHSC: Appointment of Chair & ViceChair	
	TVJHSC: Protocol / Terms of Reference	
	TVJHSC: Work Programme Timetable	
	North Tees and Hartlepool NHS Foundation Trust Quality Account for 2024/25	Deepak Dwarakanath, Medical Director Beth Swanson, Director of Nursing Diane Palmer, Interim Deputy Director of Quality University Hospitals Tees Rachel Scrimgour, Compliance and Regulation Manager
	South Tees Hospitals NHS Foundation Trust Quality Account for 2024/2025	Lindsay Garcia, Director of Nursing Diane Monkhouse, Medical Director
17th July 2025	Tees, Esk & Wear Valley NHS Foundation Trust - CAMHS Update	Jamie Todd, Care Group Director of Operations and Transformation, TEWV
	Tees Respite care/Adult Learning Disability update	Naomi Lonergan, Interim Managing Director, TEWV John Savage, General Manager, Adult Learning Disabilities, TEWV Jamie Todd, Care Group Director of Operations and Transformation, TEWV
	NHS Dentistry Update	David Gallagher, Chief Procurement and Contracting Manager (NENC ICB) Pauline Fletcher, North East and North Cumbria Integrated Care Board (NENC ICB)
	Community Mental Health Transformation	Kim Lawson, Strategic Head of Commissioning (Tees Valley), North East and North Cumbria Integrated Care Board (NENC ICB) Ann Bridges - Executive Director of Corporate Affairs and Involvement, TEWV John Stamp - Associate Director of Partnerships and Strategy, TEWV

		Julian Penton – VCSE partner, Hartlepower Community Trust
TBC July 2025	Community Diagnostic Centre Visit (Tees Valley Community Diagnostic Centre, Stockton)	Michael Houghton, Director of Transformation, North Tees and Hartlepool NHS Foundation Trust (NT&HFT) Jayne Pailor, Head of Radiology and Breast Services (NT&HFT)
2nd October 2025	North East and North Cumbria Integrated Care Board: Winter Plan Update	Karen Hawkins, Director of Delivery [Tees Valley], North East and North Cumbria Integrated Care Board (NENC ICB) Rowena Dean, Chief Operating Officer, North Tees & Hartlepool Foundation NHS Trust (NTHFT)
	Opioid prescribing and dependency across the Tees Valley	Alistair Monk – Medicines Optimisation Pharmacist, NHS North of England Commissioning Support Unit Angela Dixon – Head of Medicines (Tees Valley), (NENC ICB)
	Vaping / Nitro Oxide – Public Health	Mark Adams, Joint Director of Public Health South Tees
	Suicide Prevention Strategy	Andrea McLoughlin – Preventing Suicide (Tees) Public Health Practitioner, Middlesbrough Council Jo Cook – Programme Manager Preventing Suicide, Durham Tees Valley and Forensics, Tees Esk and Wear Valleys NHS Trust (TEWV).
	Health Inequalities	Sarah Paxton - Head of communications, TEWV Catherine Parker – Public Health Lead, TEWV
11th December 2025	Tees Respite Care / Short Breaks Service - Update	Kim Lawson, Strategic Head of Commissioning (Tees Valley), (NENC ICB) Joe Walker, Service Manager, Respite Day and Residential Services, Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) Hannah Warburton, Communications Manager, TEWV
	Clinical Services Strategy Update – Group Model	Mike Stewart, Chief Strategy Officer, University Hospital Tees (UHT)

		Matt Neligan, Chief Strategy Officer, University Hospital Tees (UHT)
	Palliative and End-of-Life Care Strategy – Development / Implementation	Katie McLeod, Deputy Director of Delivery, (NENC ICB) Dr Nicky Miller, Clinical Lead, (NENC ICB)
	NEAS: Staff Safety and performance update	Mark Cotton, Assistant Director of Communications and Engagement (NEAS). Victoria Court, Deputy Chief Operating Officer, NEAS
12th March 2026	North East Ambulance Service: Quality Account 2025-2026 (to include performance updates)	Rachael Lucas, Assistant Director of Quality & Safety (NEAS) Mark Cotton, Assistant Director of Communications and Engagement (NEAS).
	Tees, Esk and Wear Valleys NHS Foundation Trust: Quality Account 2025-2026 (to include performance updates)	Beverley Murphy, Chief Nurse, Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)
	Urgent care / NHS111 / mental health crisis line update	Shaun McKenna, General Manager, Adult Mental Health – Urgent Care, TEWV

Items to be scheduled

- Recruitment and Retention Planning (ICB) Julie Bailey
- Chronic Pain Services – Paula Swindale
- TEWV trends for quality matrix
- NHS England: CQC: Update

Tees Valley Joint Health Scrutiny Committee

Topical Issues 2025/2026

Topic	Details
Reliance on mental health inpatient care for adults with a learning disability and autistic adults.	In the NENC too many autistic people and people with a learning disability are admitted to mental health hospitals. Once in hospital, some people stay much longer than they need to because we do not have the right homes, care, and support in the community. With partners in local Councils, Trusts, and the Northern Housing Consortium NENC ICB has developed a Housing, Health and Care strategy which, informed by a community of practice of people with a lived experience, will support the region to develop more suitable accommodation for people with complex needs and disabilities. The NENC ICB has invested extra resources in the complex case teams and the Trusts clinical intensive support teams, to ensure regular assessments of needs and support within community settings. This will help avoid unnecessary admissions to hospital. In 2024/25 the ICB will intensely focus with partners on opportunities for those people who are ready for discharge from hospital with the longest lengths of stay.[1] Positive progress continues to be made in relation to patients being discharged however the number of patients with a Learning Disability and/or who are autistic in inpatient care remains at 170 as at Jan 25 compared to an end of year target of 154.[2] Members maybe keen to establish how the Housing, Health and Care Strategy developed by local Councils, NHS Trusts and the Northern Housing Consortium is having an impact on the figures within the Tees Valley.
Accessing Specialist Community Perinatal Mental Health Services	This metric is designed to demonstrate progress in increasing access to NHS funded specialist community Perinatal Mental Health (PMH) services and Maternal Mental Health Services (MMHS). It is a twelve-month rolling aggregate. The most recent available baseline for this measure is the twelve-month period March 2023 – February 2024 inclusive. The total number of people accessing relevant services in NENC ICB during that period was 2,335. The plan submission shows a 7% increase on this baseline. However, the plan for 2024/25 only achieves 79% of the national ambition, which for NENC

[1] NENC Integrated Care Board paper 4 June 2024 - 2024/25 Financial and Operational Plans

[2] NENC Integrated Care Board paper February 2025

	is set at 3,156**.** The latest information from the earlier interim planning submissions showed that systems across England were on average planning to achieve 93% of the national ambition, meaning that NENC ICB is still a negative outlier. Improvements would require: • An expansion of the maternal mental health provision to all Consultant led Maternity units (currently the service is only delivered in a small number of pilot sites). • Expansion of the perinatal service capacity. Both actions would require close working between the Local Maternity and Neonatal System (LMNS) and the ICB Transformation and Locality Delivery Teams. Members maybe keen to understand the service provision available in the Tees Valley and progress made in respect of this issue.
Talking Therapies	This indicator tracks the NENC ICB's ambition to expand NHS Talking Therapies services, formerly known as IAPT. The primary purpose of this indicator is to measure improvements in the number of people who have received a course of psychological therapy (2+ contacts, via NHS Talking Therapies) for people with depression and/or anxiety disorders and achieved reliable improvement and reliable recovery. The most recent available baseline for this measure is the twelve-month period March 2023 – February 2024 inclusive. The total number of people accessing relevant services in NENC ICB was 34,295. The plan for 2024/25 shows a modest 2% increase on the baseline. The latest information from the earlier interim planning submissions showed that systems across England were on average planning to achieve 105% of the national ambition. The 2024/25 plan would achieve 86% of the national ambition allocation for NENC, meaning the NENC ICB is a significant negative outlier. The NENC ICB and partners are actively reviewing the options for recovering this ambition. The service provider, service model, referral pathways, investment level and activity level vary significantly across the Locality Delivery team footprints. Members maybe keen to receive an update on the number of people accessing relevant services.
Access to Children and Young People's Mental Health Services	The NHS Long Term Plan (LTP) builds on commitments outlined in the Five Year Forward View for Mental Health to increase the number of children and young people (CYP) accessing help from NHS funded mental health services. The most recent available baseline for this measure is the twelve-month period March 2023 – February 2024 inclusive. The total number of children and young people across the NENC ICB accessing relevant services was 57,205. The plan for 2024/25 is a 4% increase on the baseline (60,897 by March 2025). Members maybe keen to ascertain whether the number of

	children and young people accessing mental health services in the Tees Valley is increasing in line with the NHS Long Term Plan.
Community Mental Health Waiting times relating to neurological pathways for adults and Children and Young People.	Pressures remain within adult and CYPs waiting times, specifically relating to neurodevelopmental pathways. An all-age ADHD and Autism pathway transformation group has been established. The group are working across the system to address key issues in terms of capacity and demand, looking at pathway transformation to ensure a more timelier and appropriate patient experience. In addition, the transformation group is also considering the implications that "right to choose" poses as the numbers of patients opting for this pathway increases.[3] Members maybe keen to gain a greater understanding of the current demands across the Tees Valley in relation to this issue.

Healthwatch themes and engagement work across NENC in 2024/25

The NENC Healthwatch Network includes the fourteen Healthwatch organisations from each local authority area. Each Healthwatch is independent and local Boards set priorities based on feedback from residents.

The Network also has a range of robust and comprehensive methods of information gathering, with particular reference to those who are seldom heard and disadvantaged, which helps the NENC ICB to priority areas of work.

The NENC Healthwatch network covers rural, urban and coastal communities including the most deprived communities in the country. Common themes and trends in the work of the network over the last year have included the following: -

Health Sector priorities:

• **GP access – the majority of Healthwatch still have concerns relating to GP access.** There are 10 of the Healthwatch raising this as an item within their work programmes with a further Healthwatch considering this for inclusion.

• **Dentistry Access – this remains one of the highest reasons residents are contacting Healthwatch for help & guidance.** The Healthwatch Network has concluded a NENC engagement exercise on Dentistry but remains a feature on now 6 of the 14 work programmes.

• **Pharmacy** is beginning to feature more in the concerns by Healthwatch given many pharmacies are removing their supplementary hours. 8 Healthwatch have this within their work programmes.

[3] NENC Integrated Care Board paper - Integrated Delivery Report – December 2024

• **Hospital discharge** - identified by a further 2 Healthwatch compared to the previous reporting in September.

• **Community mental health services** – There are now 10 Healthwatch looking at this area which is a further increase.

• **Learning Disability & Autism** - there is a great deal of concern across the Network looking at the provision of services. In some areas this will examine performance in Primary Care of ensuring Annual Health checks are carried out in a timely manner.

• **Access for those with a sensory disability** - continues to be an area of concern as does the wider concern in ensuring all Health & Care services adhere to the Accessibility Information Standard.

• **NEAS Clinical Strategy** - 12 of the 14 Healthwatch (exc. North Cumbria) have worked with the NEAS and VONNE to review the Trust's Clinical Strategy. Place based engagement events have been held across the NENC region with the final report & recommendations presented to the Trust in November.