NHS
North Tees and Hartlepool
NHS Foundation Trust

Quality account

2024 - 2025

Caring
Better
Together

Part 1
Statement on quality from the Chief Executive

Group Chief Executive's Statement

I am pleased to bring you this year's Quality Account report for North Tees and Hartlepool NHS Foundation Trust, my first as Group Chief Executive.

The Quality Account provides the opportunity to highlight some of the progressive work delivered in the past year. The past 12 months have also allowed us to ensure that our collaboration with South Tees Hospitals NHS Foundation Trust moves to drive for better patient outcomes and experience.

Our patients remain our priority, and we continue to work through a quality improvement lens in all that we deliver. Our key areas for 2024-25 identified in partnership with our stakeholders were patient safety, clinical effectiveness and patient experience.

This document will provide an overview of each of these priorities, our work to date and our ongoing plans for the continued delivery of progress for the populations we support.

We know that looking forward, in line with the national key priorities for the NHS, we face a period of challenge and change. North Tees and Hartlepool NHS Foundation Trust as part of University Hospitals Tees is dedicated to delivering a clinical model that supports and reflects the ambitions of the 10 year plan, including the three key focus areas of hospital to community, analogue to digital, and sickness to prevention.

I would like to thank all of my colleagues whose hard work and commitment enable progress in our clinical services. We would not be able to do this without them. I would also like to thank our local communities for your ongoing support.

To the best of my knowledge, the information contained in this document is an accurate reflection of our outcomes and achievements, which I am pleased to present to you.

Kind regards,

Stacey Hunter

Group Chief Executive

What is a Quality Report/Accounts?

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.

Part 2
2024-25 Priorities for improvement and statements of assurance from the Board

2:1 Priorities for improvement

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: 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;

- There are now 36 trained Family liaison Officers (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 71.7% which has reduced to 70.2% which although disappointing, remains above the national average for this metric – high levels of incident reporting have been maintained. 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. Therefore, this will be an area for continued focus into 2025/2026, including meaningful feedback to reporters in relation to learning and improvement; alongside collaboration with the Trusts Communications team to ensure there is formal feedback through established routes in line with agreed Communication plans.
- We have embedded a culture of safety and continuous improvement supported by our learning from the NHS England Maternity Safety Support Programme and complying with Perinatal Quality Surveillance. The Trust also achieved all ten safety actions from the Maternity Incentive Scheme programme, which aims to improve the quality of care for women, families and newborns.

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.

- The NHS Staff Survey results for 2024 specific to safety are currently being analysed to assist in planning actions that will promote awareness across all staff to be initiated to support the quality priority to be progressed during 2025-26.
- 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 additional training to support PSIRF implementation.

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 Clinical 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.
- During 2023-24, there were 18,049 safety events reported in Datix / In Phase. During 2024-25 16,626 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, with continued improvements each month since.
- 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

- Following the significant change to the Trusts incident reporting system during quarter 4 2023-24; there has been close monitoring of the reporting figures with ongoing strategies implemented to support further sustained improvement.
- 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.
- There will be a continued focus into 2025/2026 in relation to ensuring there is 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.
- This safety quality priority will not be specifically carried forward into 2025-26; however, the actions and work already ongoing will be linked into the overarching safety quality priority that is being carried forward.

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: 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.

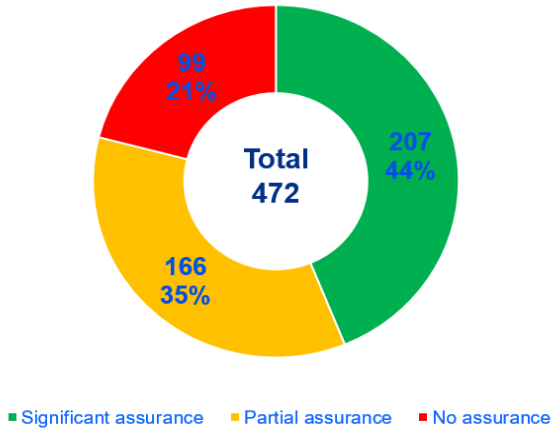
Likewise, it is anticipated that the ‘go-live’ date will be 14th April 2025 for the first iteration of the triangulation dashboards. Governance and oversight remains in place at site level including prioritisation and monitoring of national audits, which are at risk of not being delivered.

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

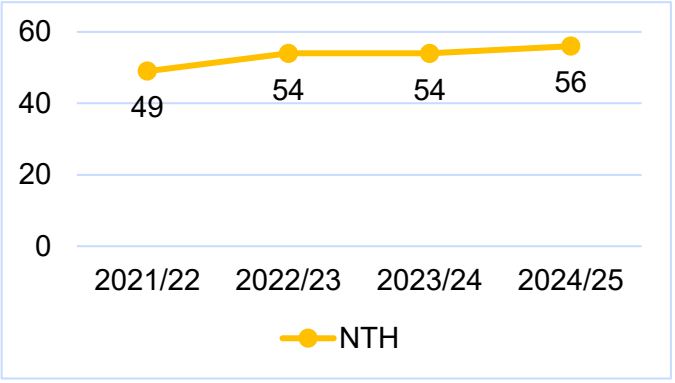
Exception reporting

	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.

b. Mortality review processes and 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 (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.

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

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

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.

c. Learning from Deaths

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d. Shared decision making and goals of care.

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.

Overview of agreed actions

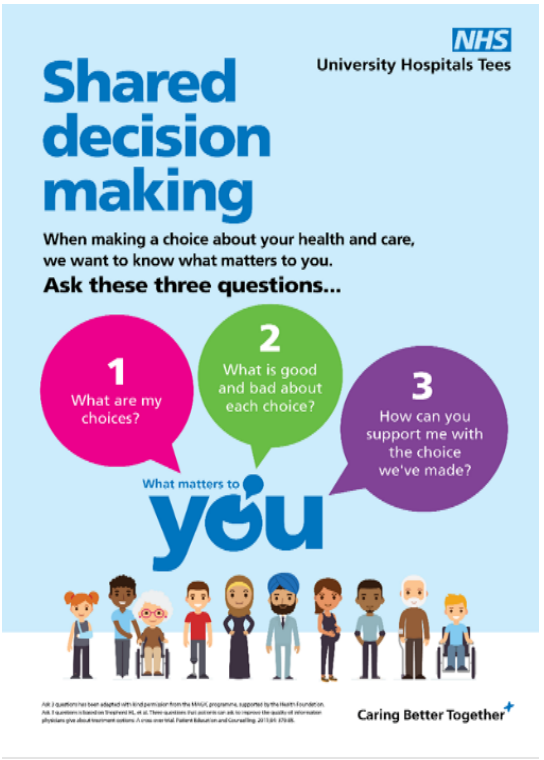
The 2023/2024 quality account provided an initial direction for the 2024/2025 financial year on the shared decision making quality priority, to develop and implement shared decision making and goals of care. At the beginning of 2024/2025, these areas were agreed as areas of focus:

- 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

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.



Plans for ongoing work

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

- Ratify the Shared Decision Making Improvement plan after incorporating feedback from all stakeholders
- Implement recommendations within Shared Decision Making improvement plan including:
    - Preparing patients and public
    - Training and development for staff members
    - Reviewing Commissioned services/ pathways
    - Strengthening strategic leadership and supportive systems
- 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.
- Develop E-Consent and ensure policies are reviewed and aligned

Priority 3: 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.

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

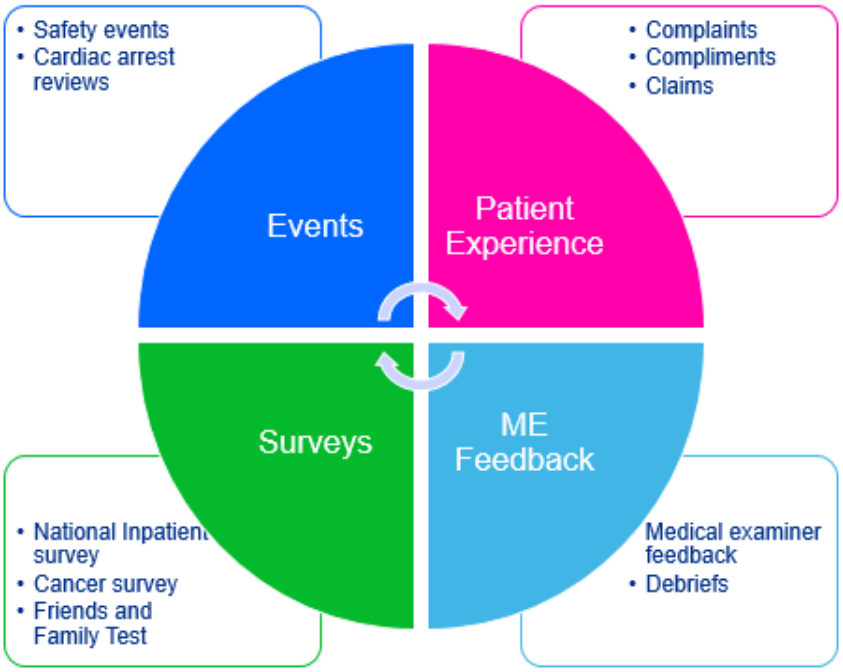
We continue to work alongside our patients and relatives to respond to their complaints in a timely and compassionate way. Where we identify learning opportunities we share these using a tool (PEARLS of wisdom) which focusses on learning and identifying improvements from the patient's experience. Where 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.

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

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	**Clinical Effectiveness**	**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 (MINAP)	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)	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	Yes	100%

(NRAP): Children and Young People's Asthma Secondary Care		
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

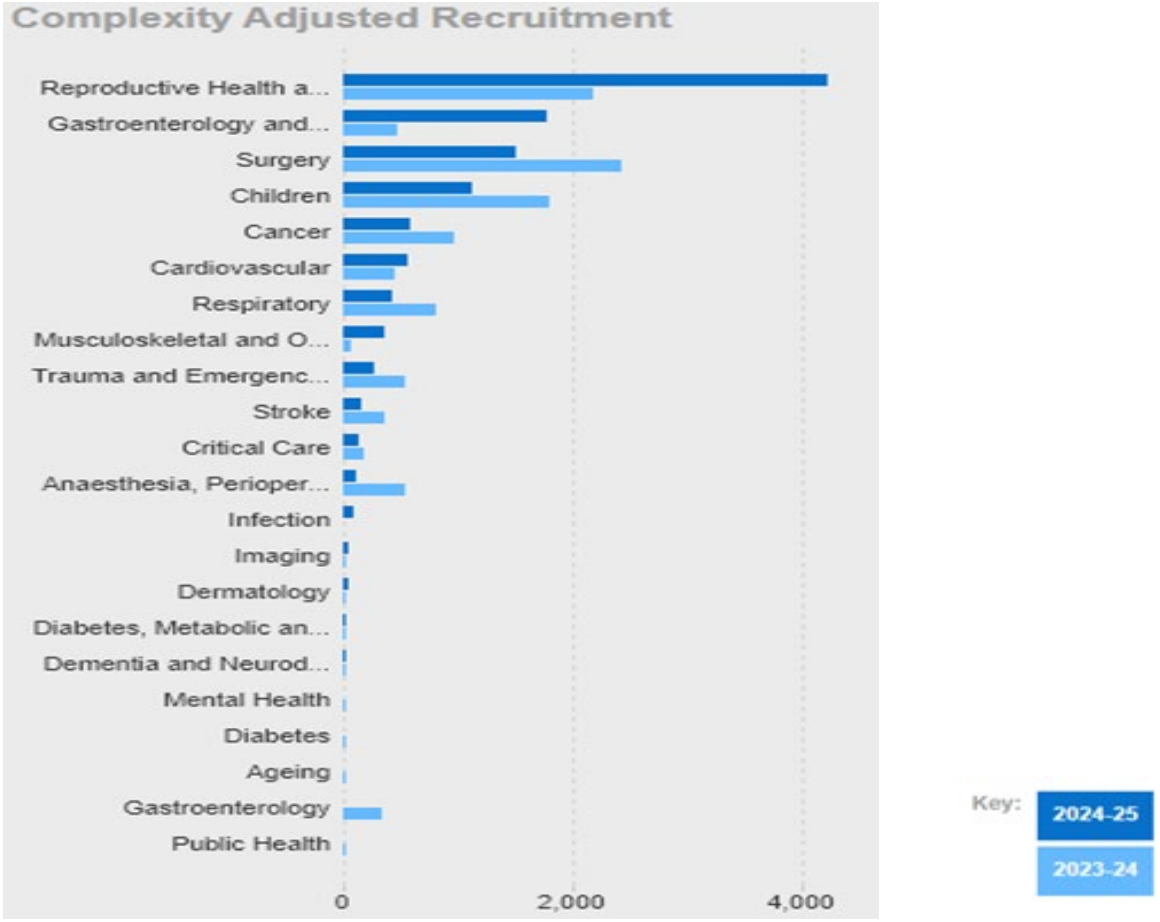
Clinical Research (North Tees)

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

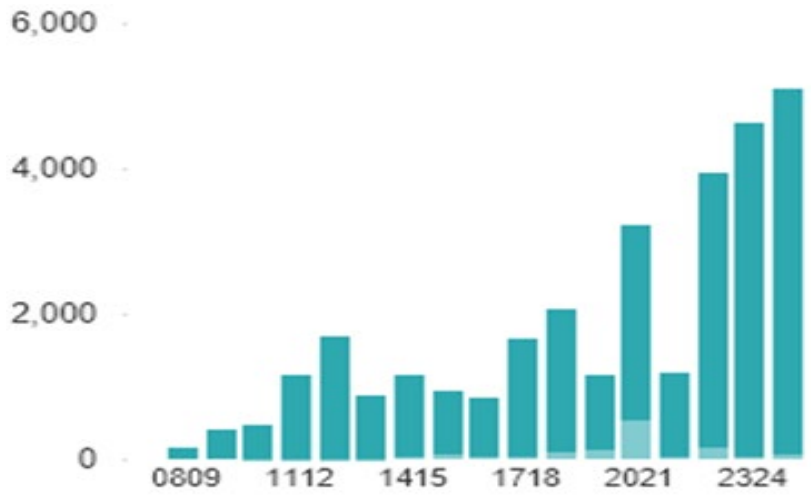
Our Tees Valley Research Alliance (TVRA) Strategy to be delivered across both partner trusts in the University Hospitals Tees (UHT) Group is a patient focused strategy to deliver improved outcomes through two main streams– Growing Research and Supporting Research. Whilst our recruitment has increased, 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



Recruitment by financial year



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 (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 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 Acedemic 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/

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.

Clinical coding

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.

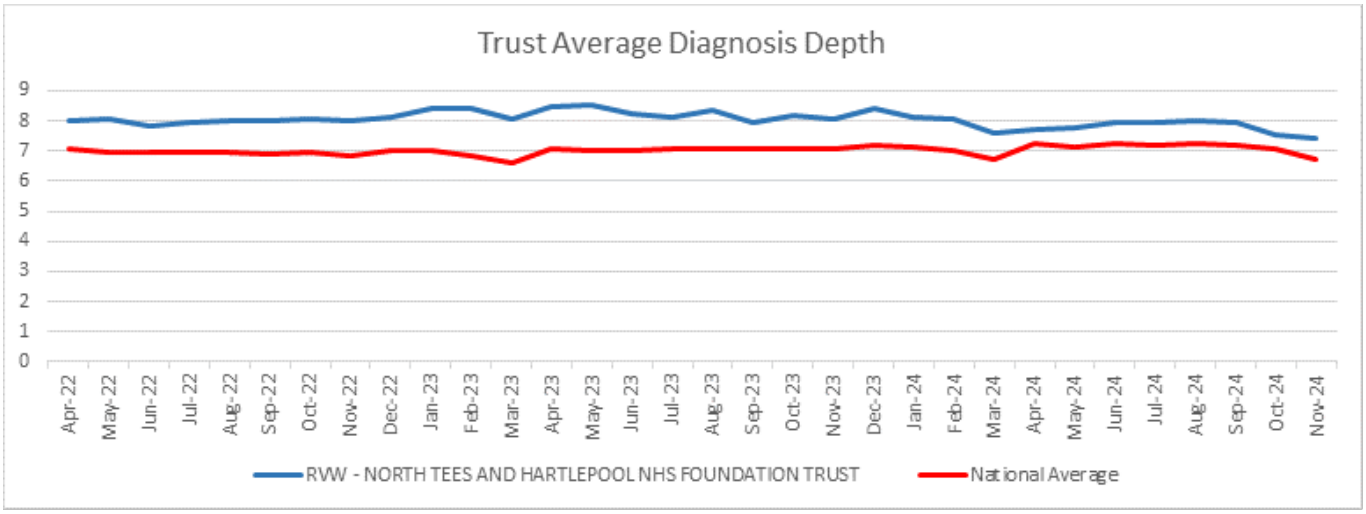
In July 2020 the Trust went live with Active Clinical Notes (ACN). Active Clinical Notes allows traditional paper-processes and pathways to be made available digitally. This means the clinical details of patient's diagnoses and treatments are now added directly to the patient's Electronic Patient Record. 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.**



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.

2024-25 Learning from deaths

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.

During April 2024 to March 2025, 1191 of North Tees and Hartlepool NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

285 in the first quarter;

266 in the second quarter;

329 in the third quarter;

311 in the fourth quarter.

What we have achieved in the last year.

The Trust has complied with the above guidance by:

- Reviewing all relevant mortality data produced by NHS England, in particular the Standard Hospital Level Mortality Indicator (SHMI).
- Identifying deaths which need further investigation.
- Ascertaining learning points to ensure these are used to support changes in practice.
- Ensuring bereaved families have the opportunity to highlight any concerns they may have and to request a mortality review be completed.
- Supporting staff in collecting and using information to initiate quality service improvements and demonstrate learning.
- Reporting findings to the Trust Board.

The Trust has a Medical Examiner (ME) Service scrutinising all inpatient deaths and a growing proportion of out-of-hospital deaths in the locality. The service became statutory in September 2024. Cases identified from the ME service (or elsewhere) for further review undergo retrospective case note review using the Structured Judgement Review (SJR Plus) tool. There is a multidisciplinary panel of trained reviewers with review sessions occurring monthly.

59 SJRs have been completed in 2023-2024.

The Trust Mortality Leads have also:

- Embedded the SJR process on Inphase
- Prepared quarterly thematic reviews for Safety Panel.

Priorities for the next year:

- Further collaboration with South Tees under the University Tees Hospital Group Structure.
- Review of speciality mortality reviews with a view to standardisation and robust recording (on InPhase).
- Continue to grow the Learning from Deaths Team within North Tees
- Create a bespoke dashboard within Inphase to aid reporting.
- 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.

2.3
Core set of Quality Indicators

Summary Hospital-level Mortality Indicator (SHMI)

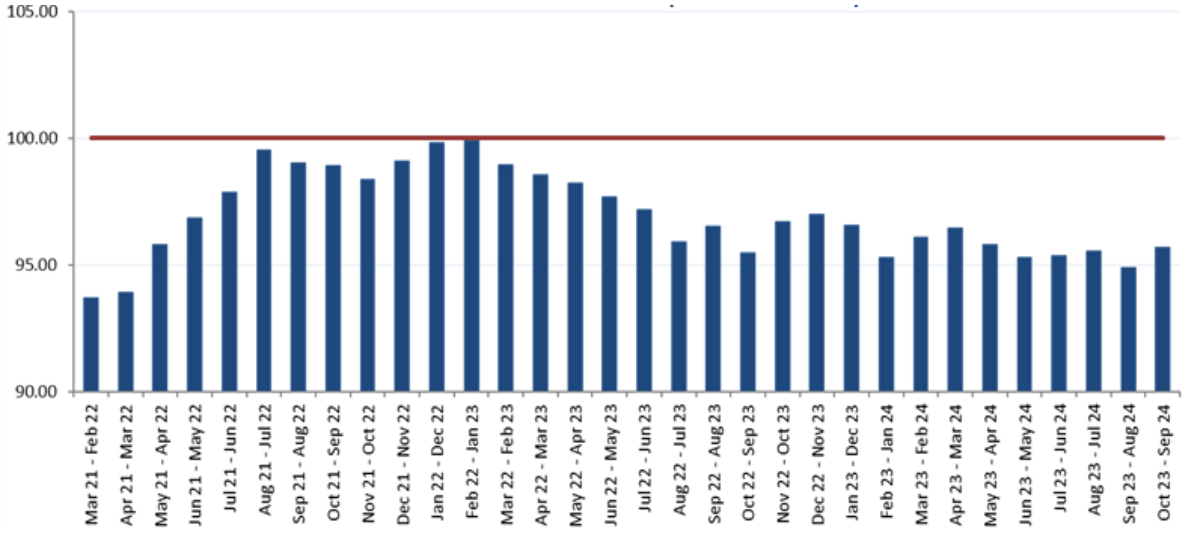
The **SHMI** indicator provides an indication on whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline in England.

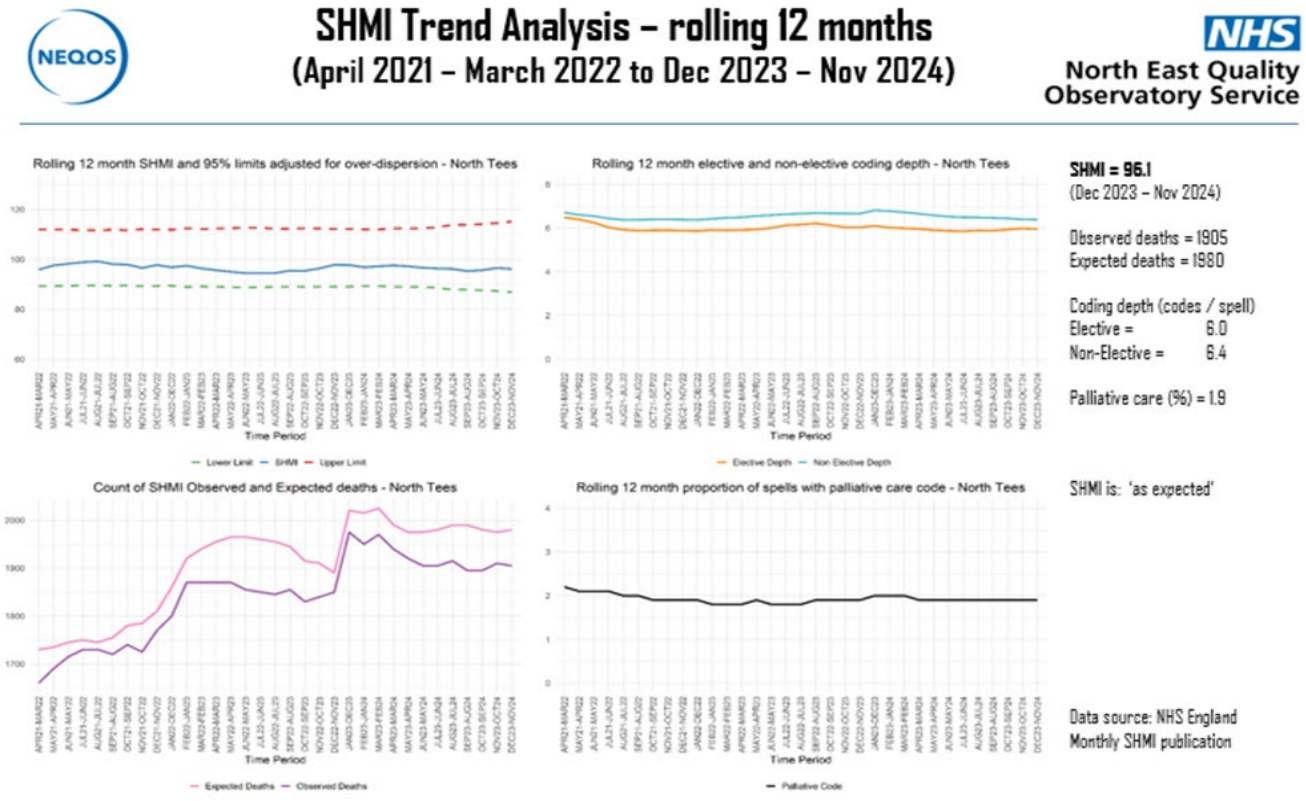
SHMI includes deaths up to 30 days after discharge and does not take into consideration palliative care.

The latest SHMI value of **95.69** (October 2023 to September 2024) continues to reside in the '**as expected'** range.

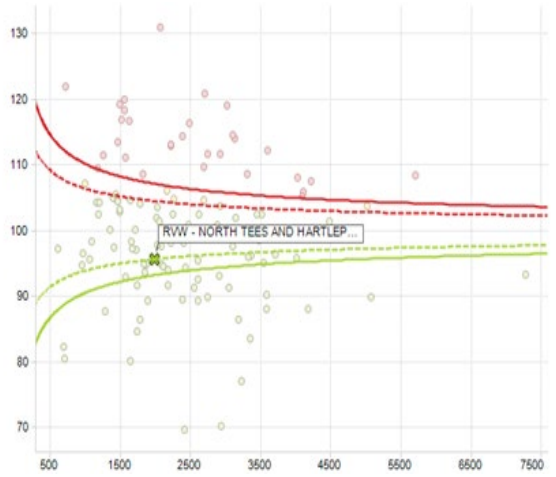
Reporting Period	*CMR	SHMI	National Mean
Oct 23 - Sep 24	3.16%	95.69	100
Sep 23 - Aug 24	3.16%	94.87	100
Aug 23 - Jul 24	3.19%	95.52	100
Jul 23 - Jun 24	3.19%	95.35	100
Jun 23 - May 24	3.19%	95.29	100

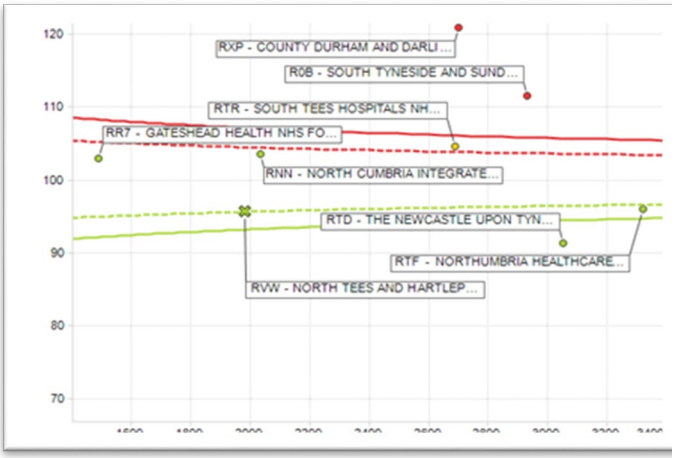
SHMI Trend Values (12 Month Values)





National View	Regional View





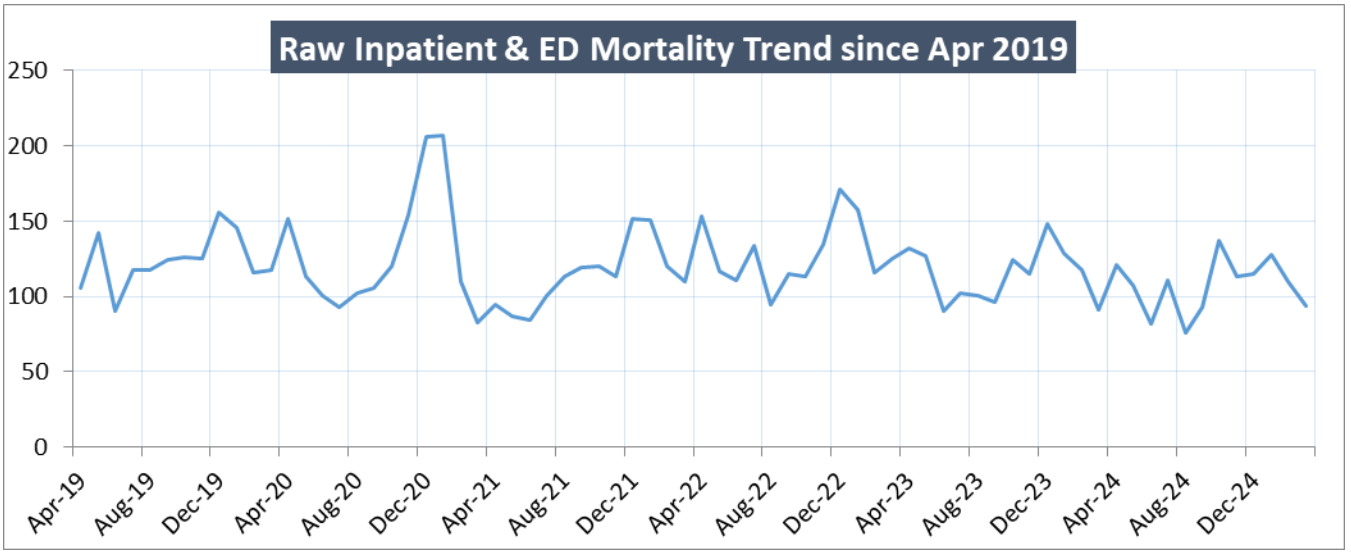
The top graph shows the variation in the SHMI data since 2024 and highlights that it has stayed within the expected range. The funnel chart below shows where we are placed in comparison to national performance. The Trust is well positioned and within the expected range.

Trust Raw Mortality

The following table and chart demonstrates the raw number of mortalites the Trust has experienced since 2019-20. For the latest financial year of 2024-25, the Trust experienced 1,287 mortalities (April to March), this is 86 fewer mortalities than experienced in 2023-24.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2024/25	121	107	82	111	76	93	137	113	115	128	110	94

	April to March
2019/20	1,485
2020/21	1,547
2021/22	1,357
2022/23	1,543
2023/24	1,373
2024/25	1,287



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:

- Groin hernia surgery
- Varicose vein surgery
- Hip replacement surgery, and
- Knee replacement surgery during the reporting perio

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 25 position (latest available data) indicates the Trust has an overall readmission rate of 9.19% against the internal stretch target of 8.4% (Regional average

for 2023-24), indicating the Trust's readmission rates have slightly decreased by 0.76% from the same period in the previous year (9.95% - January 2024).

- Both North and South Tees Trusts are focusing on understanding trends in readmission to identify the most clinically relevant improvement opportunities across medical and surgical care pathways, whilst enabling patients to be cared for out of hospital.
- A clinical audit has been registered across both sites, to identify compliance against guidance and potential protocol, pathway changes with oversight and monitoring via Audit and Clinical Effectiveness Council.
- 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**

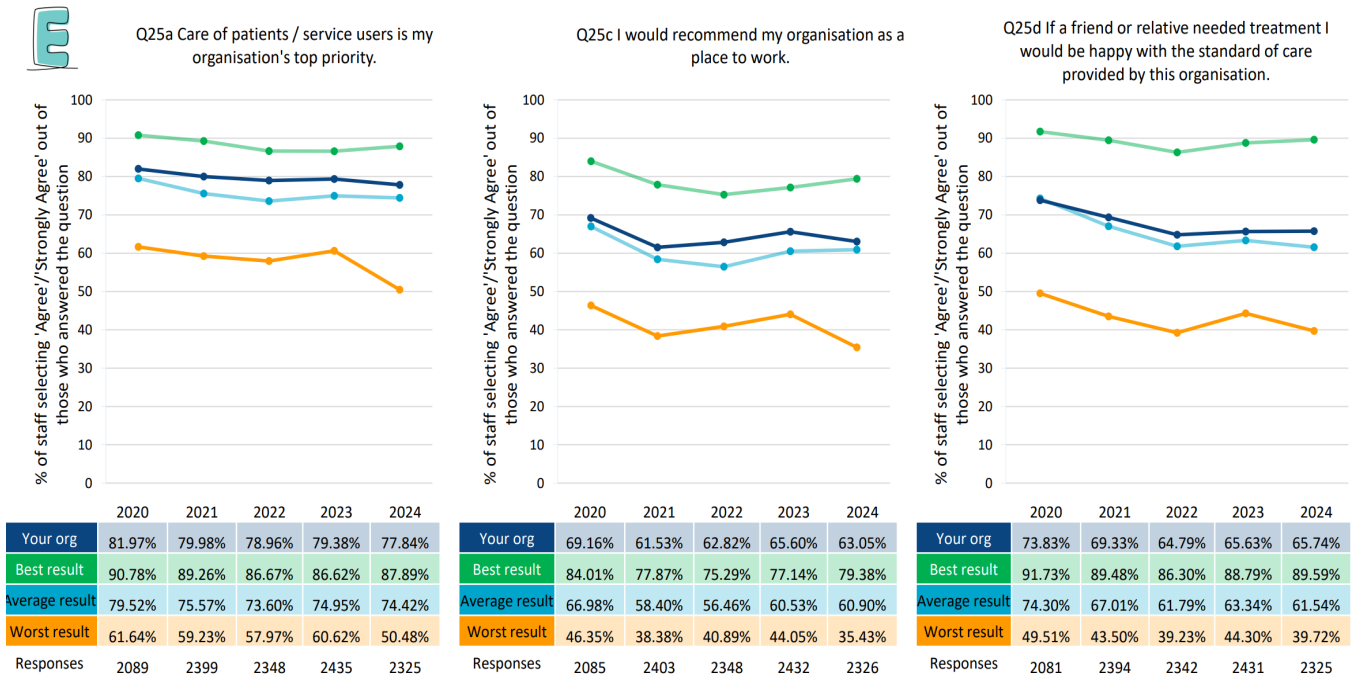
All NHS organisations providing acute, community, ambulance and mental health services are requested to complete the People Pulse survey each quarter.

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

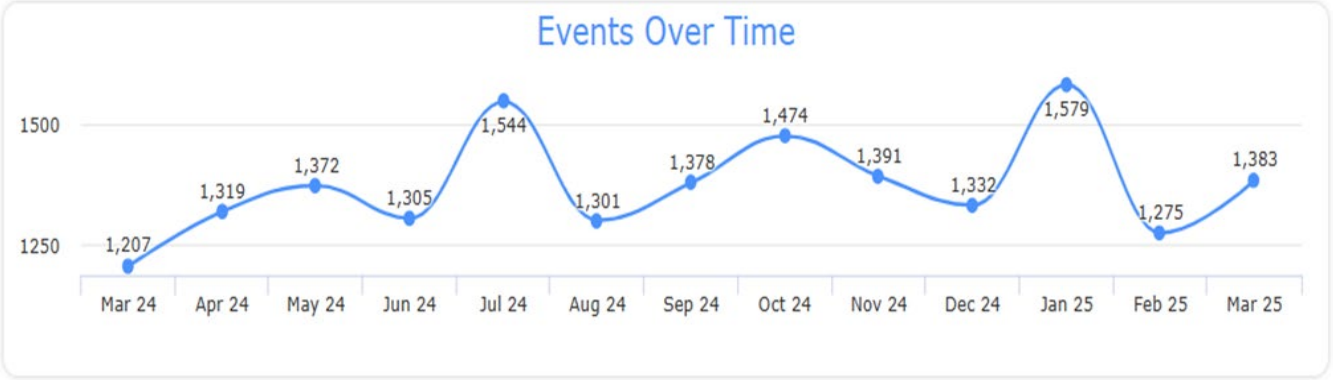
The National Reporting and Learning System (NRLS) was decommissioned on 30 June 2024, with benchmarking data not being published since March 2020.

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 16,626 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, with continued improvements each month since.

The chart below displays the reporting by month over 2024-5.



The drop in reporting of safety events during quarter 4 2023-24 is also reflected in the figure below showing the rate of reporting by per thousand bed days. Using this rate allows a consistent measure to be used each month, reducing variations where possible. The rate shows that during 2024-25, the reporting of safety events by per thousand bed days has been relatively stable but continuing to show a gradual increase.

Trust incidents per 1000 bed days March 2023 – March 2025.

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".

"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)

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	8.5

and dignity?	
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”.

“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_**

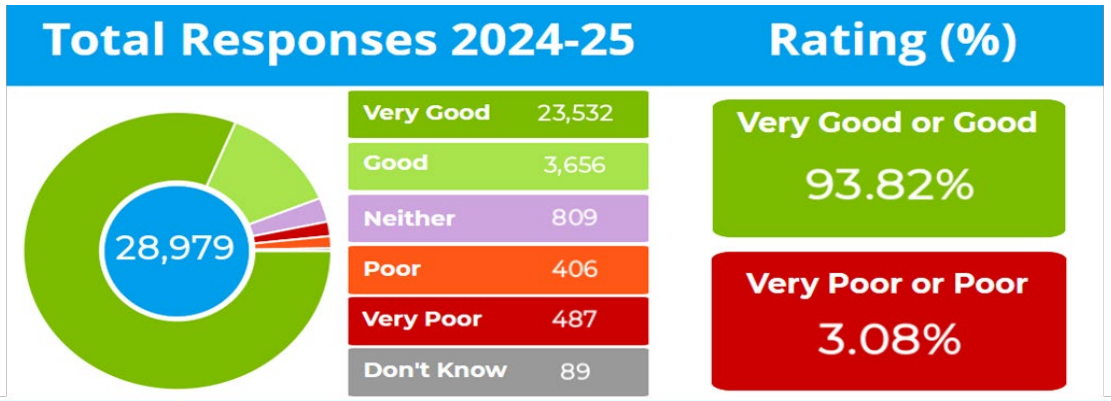
Friend and Family Test (FFT)

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"

Part 3
Overview of quality of care and performance indicators

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 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)

Double award win for trust

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.

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.

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 Reporting 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 Reporting 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 Reporting 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.

Medicine safety

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.

#

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

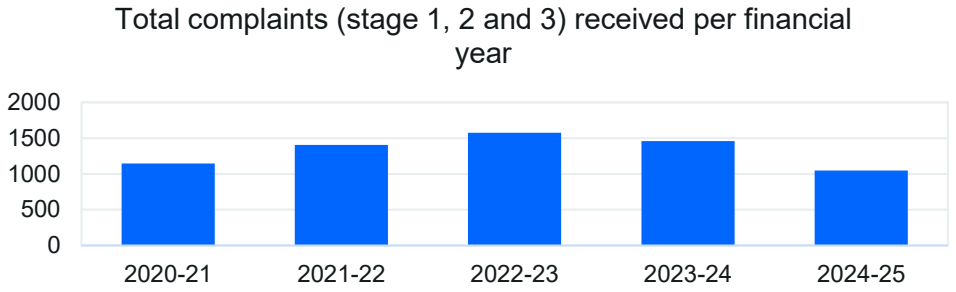
The Trust received 1,096 complaints in 2024-25.

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 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.

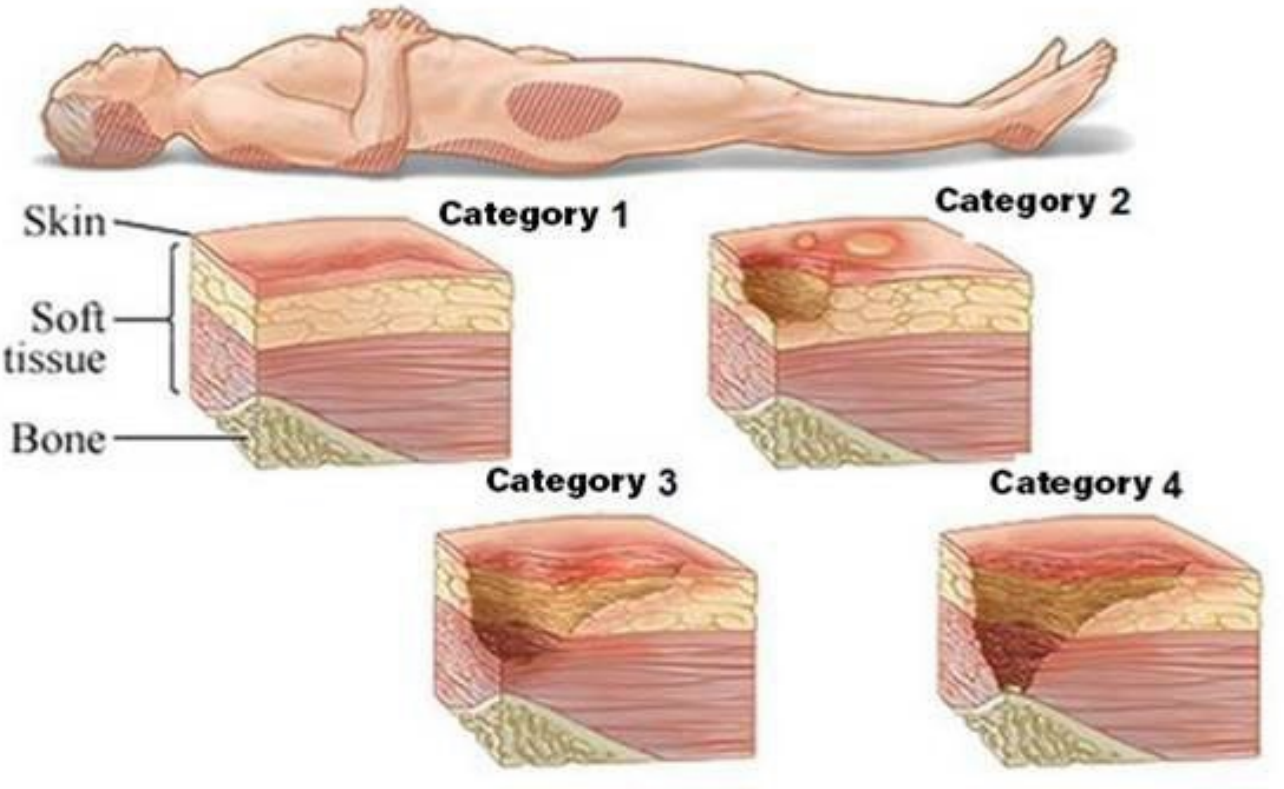
"The treatment I received by both the nurse and the doctor was exemplary: time given to me as a patient, understandable and successful outcome."

"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

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.

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.

3.3
Additional information

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.

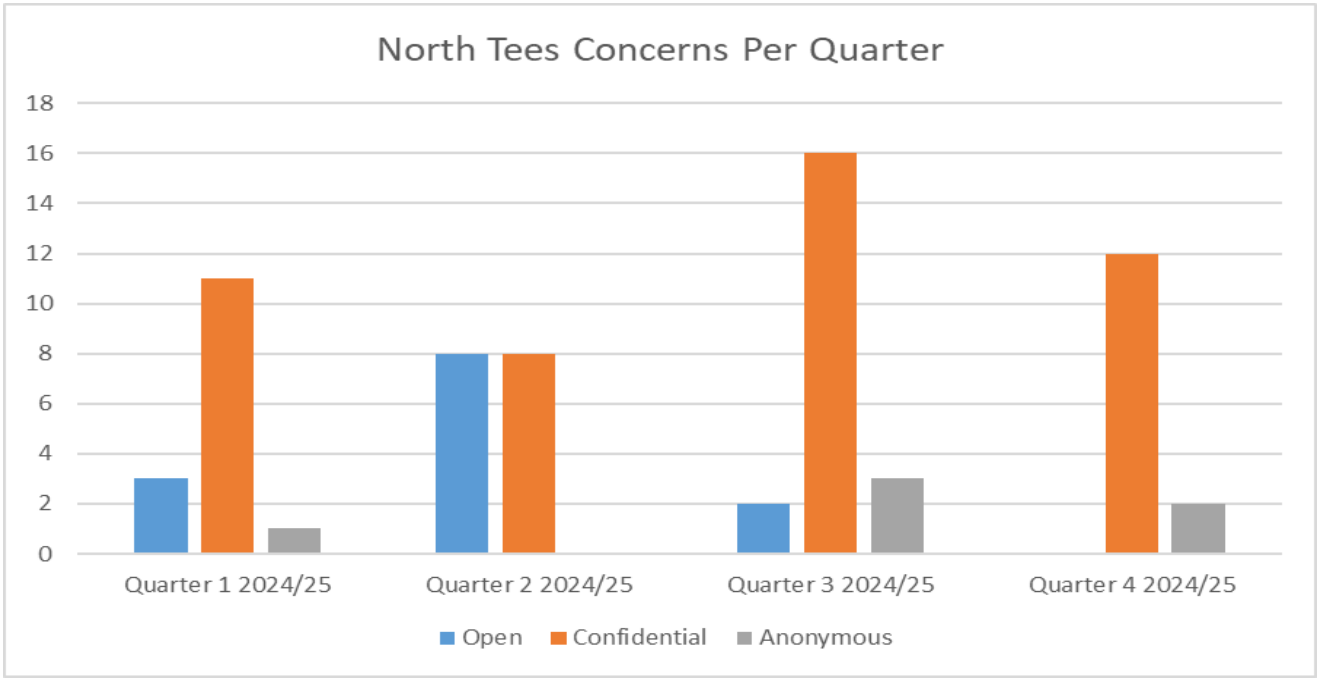
The FtSUG has been looking at how to support Neurodiversity in the workplace, the sexual safety charter, attends the EDI steering group, the , Schwartz round steering group and supports the wellbeing framework.

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%)

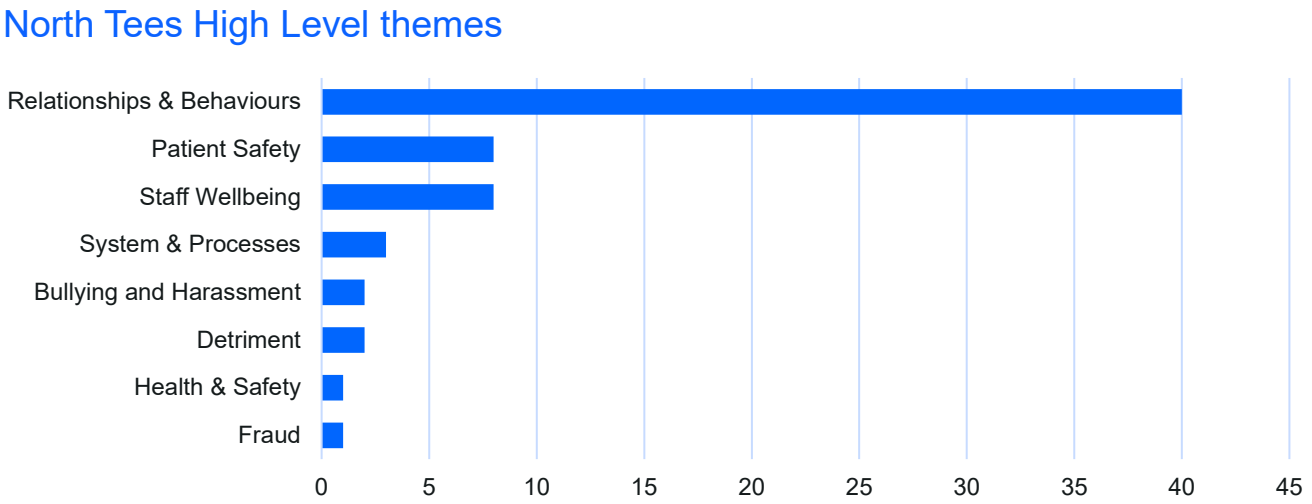
6 contacts were received anonymously (9.2%)

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*

3rd party Statements

Diane Palmer

Deputy Director of Quality (Interim) University Hospitals Tees

Murray Building

James Cook University Hospital Marton Road

Middlesbrough TS4 3BW

Dear Diane,

Friday 30th May 2025

Healthwatch Hartlepool – Response to Annual Quality Account of North Tees and Hartlepool NHS Foundation Trust

Firstly, may I put on record our sincere thanks for visiting Healthwatch Hartlepool with such a detailed presentation in respect of the Trust's Quality Accounts last week prior to the Trust's intention to publish the Draft Quality Account. It was good for our Board members and Volunteer Steering Group to hear from you and Rugare Musekiwa and I believe this was well received and I look forward to hearing from you in respect of the points we raised, particularly around the monitoring of 'transfers of care' but also enhancements & improvements to the 'Friends & Family' monitoring.

As agreed, please find below our Third-Party narrative that the Trust may publish but also may wish to consider when considering the Trust's future Quality Account.

Overall members felt that the information provided was incredibly informative. Our members suggested that 'Transfers of Care' would be a welcome addition to future performance monitoring particularly around the Cardio Vascular Pathways given the waiting times some patients experience when requiring a transfer from North Tees to South Tees. This has been recommended for the last 2 years so we are keen to see some movement on this.

One of the long-standing issues we wish to alert the Trust to again is concerns around communication that was accepted when we published our 2 reports into hospital discharge. Healthwatch Hartlepool are keen to work with University Hospitals Tees around the promotion of thorough 'hand washing' as this seems to be poor presently. Our members were also incredibly

concerned regarding the Infection, Prevention & Control data as well as the prevalence of Covid19.

Other areas of concern raised was the temporary closure of Hartlepool Hospital's Rowen unit and support given within the Maternity pathway around Mental Health support. Consideration for future planning could include a Mother & Baby unit

Communication could also be improved around signage at the hospital sites to reflect actual the wards and purpose. There is a need for appropriate & improved signage for patients especially those living with a disability. Access routes should be clearly identified and appropriate signage displayed / use of plain English and easy read where possible; accessible toilets/changing places conveniently located to promote dignity and independence. We also would request that a greater emphasis need to be made on ensuring the availability of patient leaflets and equality of access to patients who may be Deaf/ Blind /Visually impaired or with dual sensory loss.

Finally, I once again must urge the Trust to better promote the National scheme for help with NHS travel costs, which should be within every hospital letter. This is of great importance given our levels of population health & deprivation across the region.

I sincerely hope the above is helpful in the Trust formulating their future Quality Account and please contact me should you require any further information.

Yours sincerely,

Christopher Akers-Belcher

Chief Executive - Healthwatch Hartlepool

Commissioner statement from NHS North East and North Cumbria Integrated Care Board (NENC ICB) for North Tees and Hartlepool NHS Foundation Trust Quality Account 2024/25.

NHS North East and North Cumbria Integrated Care Board (NENC ICB) is committed to commissioning high quality services from North Tees and Hartlepool NHS Foundation Trust. NENC ICB is responsible for ensuring that the healthcare needs of patients that they represent are safe, effective and that the experiences of patients are reflected and acted upon. The ICB welcomes the opportunity to review and provide comment on this 2024/25 Quality Account.

Overview

The ICB would like to thank the Trust for the openness and transparency reflected in this year's Quality Account. The ICB would like to commend all staff for their commitment and dedication demonstrated throughout these challenging times and for striving to ensure that patient care continues to be delivered to a high standard.

Achievements

The ICB would like to congratulate the Trust and its staff on the achievements made during this period. The ICB recognises the attainments detailed within the quality account, which include:

- The Care Groups being actively engaged and providing reports on all areas of safety, learning and improvement work into Safety Panel meetings.
- Increased use of technology to support the recording of key compliance data
- Continued development of the ePMA system to reduce medication errors, reduce waste, provide education and standardise prescribing.
- Being one of the top performing Trusts in the country for four-hour standard and ambulance handover ensuring a better patient experience and timely care.
- The introduction of a dedicated carers group and development of a carers charter to be adopted across the hospital group.

Areas for Further Development

The ICB recognises the additional work required which has been identified within the quality account. In particular, the work required to improve audit compliance and clinical effectiveness, which is being considered across the hospital group. The ICB acknowledges the work that has been undertaken to improve complaint response times and recognises the further work that is required to achieve and sustain agreed timescales for closure.

Future Priorities

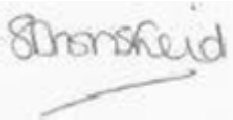
The ICB is fully supportive of the identified Quality Priorities for 2025/2026. The ICB acknowledges the need to embed processes and improvements across quality priorities rolled over from the previous year. We welcome the introduction of a new quality priority to reduce the risk of acquiring healthcare associated infections, recognising that this continues to be a

challenging area across the hospital group. The sharing of learning across the group can only be of benefit to patients and staff alike.

The ICB can confirm that to the best of their ability the information provided within the annual Quality Account is an accurate and fair reflection of North Tees and Hartlepool NHS Foundation Trust performance for 2024/25. It is clearly presented in the required format, contains information that accurately represents North Tees and Hartlepool NHS Foundation Trust quality profile and aspirations for the forthcoming year.

NENC ICB remain committed to working in partnership with North Tees and Hartlepool NHS Foundation Trust to assure the quality of commissioned services in 2025/26.

Yours sincerely,



Sarah Dronsfield

Director Of Quality

NHS North East and North Cumbria Integrated Care Board

ASCH Select Committee

NTHFT Quality Account 2024-2025

Statement of Assurance

Stockton-on-Tees Borough Council

Adult Social Care and Health Select Committee

NTHFT Quality Account 2024-2025 – Third-Party Declaration

Submitted: 3rd June 2025

Consideration of the latest North Tees and Hartlepool NHS Foundation Trust (NTHFT) Quality Account continues to be a key feature of the Committee's annual work programme. This statement reflects upon the presentation given to the Committee in May 2025 which outlined NTHFTs performance against its agreed 2024-2025 quality priorities (and its priorities for 2025-2026), as well as the content of the accompanying draft Quality Account document which provided more detail on Trust activity during this period.

Exhibiting NTHFTs direction of travel towards closer partnership-working with its neighbour, South Tees Hospitals NHS Foundation Trust, the presentation began with a strong emphasis on the establishment and ongoing development of the 'Group' (University Hospitals Tees) approach, including Group (rather than individual Trust) priorities. As time passes, it appears there is less of a distinction between the two Trusts, with collaboration increasing, future plans often interlinked, and Group roles evolving to supplement (possibly supersede?) the Trusts' existing staffing structures.

As for NTHFT, its Summary Hospital-level Mortality Indicator (SHMI) remained comfortably within the 'as expected' range during 2024-2025 and continued to compare very favourably against other Trusts across the region / UK. Trust Raw Mortality data for this period was not stated so could not be assessed alongside previous years.

Infection rate performance has remained frustratingly mixed, particularly given the assurances received when considering the previous year's (2023-2024) Quality Account presentation in March 2024 (the Trust identified *C Difficile* as a key issue yet there has been a further escalation in cases). Whilst accepted that controlling infections has become an increasing challenge for all NHS Trusts, a rising (albeit gradual) trend of NTHFT hospital onset healthcare-associated cases should prompt a review of, and possible change to, existing practices. The Committee endorses the addition of a specific focus around infection control to the 2025-2026 priorities.

In past discussions, the Trust has highlighted rising challenges regarding patients admitted with a diagnosis of delirium / dementia, yet there are only two references to 'dementia' in the draft Quality Account document. Similarly, previous Quality Accounts have included a section on 'Safeguarding Adults' (incorporating data / narrative referenced in the Committee's last third-party statement of assurance) – this no longer appears to be present.

Effective patient flow is a critical element in the success of hospitals, and NTHFT recognised that all its various departments played an important role in performing above regional / national averages across the urgent and emergency care pathway. The Committee commends the work with ambulance services to minimise hospital handover times (reportedly below both regional and national averages), and the continued demonstration of timely discharge processes.

It was noted that NTHFT was a net 'importer' of patients which could sometimes impact upon performance, and that improvements to the emergency assessment area led to the temporary closure of 8-12 beds over the winter period (elements which contributed to the four-hour A&E wait target dipping slightly during the year). Assurance was given that NTHFT would be in a stronger place come winter 2025-2026, though the 'A&E Trolley Waits > 12 hours' measure (cases of which appeared to more than double compared to 2023-2024) within the draft Quality Account's 'performance from key national priorities' section will be monitored by the Committee.

As discussed at the Tees Valley Joint Health Scrutiny Committee in May 2025, violence towards Trust staff remains an unwelcome and distasteful reality (though there appears to be little in the draft Quality Account document on this). The Committee fully supports NTHFTs stated zero-tolerance approach – such incidents can have significant repercussions for staff morale and, in turn, the delivery of vital services.

Family and Friends Test (FFT) data again demonstrated high levels of patient satisfaction with NTHFT services (though there was some disparity in the figures provided in the presentation and the draft Quality Account). Regarding staff FFT feedback, whilst above the national average for indicators provided in the presentation, the draft Quality Account highlights areas for attention (NHS staff survey: 30% of Trust staff not feeling secure in raising concerns about unsafe medical practice; 40% not confident the Trust would address their concerns). NTHFTs desire to develop engagement with its staff is essential – employees at all levels must feel they have a valued stake in the organisation and can be heard.

In other staffing matters, the draft Quality Account includes references to current workforce limitations and the need to review / eradicate shortfalls (e.g. Pleural Specialist Nurse; Rheumatology Consultants, Fracture Liaison Nurse). It would be helpful for NTHFT to provide timescales for when these identified areas will be addressed.

The Committee commends the completed quality improvement initiatives (e.g. new operating theatres / equipment; delivery room enhancements) and the innovative technology development which has been recognised with awards. However, the overarching Trust estate continues to present a challenge that has been prevalent for many years now.

Engagement between the Committee and NTHFT has taken place throughout 2024-2025, with the Trust contributing to the review of local reablement services and providing another update on its maternity services (the Committee welcomes the completion of all actions required by the CQC as part of its improvement plan, but recent media about the negative experience of one mother (leading to multiple signatories to a petition calling for the Trust's maternity provision to be placed into special measures) shows further assurance is required). Concerns have been raised to the Trust about communication issues which have surfaced since the creation of the 'Group' model.

The Committee supports the 2025-2026 priorities – however, given nearly all NTHFT cancer-related targets were not achieved (and were down on 2023-2024 performance), consideration should be given as to whether these require more explicit attention moving forward. The clear focus on all things 'Group' continues to be of interest to the Committee, in particular the potential for this to result in significant changes to the way services are delivered across Stockton-on-Tees and beyond. For now, the Committee awaits the next CQC inspection to give a more up-to-date view on whether NTHFT has made the required improvements which were identified back in 2022.

Tees Valley Joint Health Scrutiny Committee

North Tees & Hartlepool NHS Foundation Trust
Quality Account 2024-2025 – Third-Party Declaration

The Tees Valley Joint Health Scrutiny Committee (TVJHSC) was asked to consider the North Tees & Hartlepool NHS Foundation Trust Quality Account 2024/25.

This letter contains comments made by the TVJHSC, at its meeting on 8 May 2025. The Committee was grateful to representatives of the Trust for attending and discussing the key features of the report and the quality of care provided by the Trust.

In terms of the quality priority setting process for 2025/26 the Committee was informed that a strategic decision had been taken that the cross-cutting priorities set out in 2024/25 would continue to be embedded in 2025/26 to further improve service delivery. The Committee was pleased to note that infection prevention and control had been added as a priority for the upcoming year, reinforcing the Trust's commitment to enhancing patient safety. The Committee is supportive of the 2025/26 priorities and looks forward to continuing to receive updates on progress during the year ahead.

The Committee was pleased to hear that the Trust had performed well against key emergency care indicators and had achieved 85.6% compliance with the 4-hour A&E wait target, placing the Trust among the top three nationally in terms of performance. In addition, it was noted that handover delays were exceptionally low, with 12-hour wait times standing at just 0.5%, compared to the national average of 6.4%. The Committee acknowledged that this was a significant achievement, particularly given the steady rise in demand for urgent and emergency care services.

Workforce Safety Concerns

The Committee expressed concerns regarding workplace violence and the support available to frontline A&E staff and queried whether violence toward healthcare staff had worsened since COVID. The Trust acknowledged that A&E staff were subjected to increased verbal and physical aggression, which necessitated additional security presence at peak hours. The Committee heard that regular discussions were held with Cleveland Police and briefings provided to facilitate proactive intervention strategies where required.

Patient Safety

The Committee was pleased to hear that one of the major advancements in patient safety had been the real-time responsiveness to patient feedback. The Trust highlighted how data collected from patients across multiple sources including formal complaint systems, family and friends' tests, and national satisfaction surveys was triangulated with clinical audit outcomes to provide a comprehensive view of patient experiences. The Trust acknowledged that not all feedback received was positive but that systems were in place to ensure frontline teams were aware of the feedback in real time.

Maternity Safety Assurance and Ongoing Engagement

The Committee expressed concerns about the scale of public dissatisfaction with maternity services at the Trust, citing the petition recently submitted to the Care Quality Commission (CQC), which contained 1,100 signatures from concerned individuals.

The Committee heard that the Trust had actively engaged with the national maternity safety advisor and discussions regarding maternity concerns were ongoing. The Committee was provided with further information on the actions the Trust had taken to improve maternity services, with the Trust confirming that all objectives outlined in the 2022 NHS England maternity safety improvement plan had been met. The Committee heard that the Trust had undergone visits from NHS England and peer review teams, reinforcing external oversight of progress.

The Committee queried whether direct service-user engagement was undertaken in maternity care and the Trust confirmed that maternity patients were encouraged to provide feedback at multiple stages of their journey, ensuring real-time evaluation of service quality. The Committee was assured that Maternity Voices Partnership representatives were also actively involved in reviewing service quality at the Trust, offering a critical service-user perspective on maternity care policies and decisions.

Support for Younger Mothers

The Committee raised a specific concern regarding younger mothers aged 19-21, stating that this demographic often struggled to feel heard during their maternity care experiences. The Trust acknowledged that while a direct policy for peer mentoring had not been formalised, efforts were being made to reflect the needs of younger service users. The Committee heard that the Trust had been exploring community-led maternity support initiatives, particularly in relation to breastfeeding education and postnatal care. The Committee welcomed the updates provided and encouraged the Trust to continue evaluating maternity services, engaging with service users and ensuring transparency in ongoing improvements.

Finally, the Committee strongly condemns the completely unacceptable increase in incidents of verbal and physical aggression against frontline A&E staff at the Trust and wishes to place on record its gratitude for the significant work that has taken place over the last year to deliver quality health services for patients.

Yours sincerely,

Cllr C Cooper (Vice Chair) Tees Valley Joint Health Scrutiny Committee

10th June 2025

Response from Healthwatch Stockton-on-Tees to the Quality Accounts for North Tees and Hartlepool NHS Foundation Trust – June 2025

Healthwatch Stockton-on-Tees are pleased to provide feedback on the 2024/25 Quality Accounts and note the achievements and the clear useful data explaining how North Tees and Hartlepool NHS Foundation Trust is performing against other Trusts in the region and nationally. As a local Healthwatch we also appreciated the time taken by the Trust to attend our May 2025 Board Meeting and present the draft report explaining the details known at the time.

This final report is comprehensive and provides an excellent overview of how the Trust demonstrates quality of healthcare and its general performance, and performance against key indicators and priorities.

We congratulate the Trust on receiving an InterSystems digital award and two awards recognising the commitment to the use of innovative technology to support patients.

We continue to express disappointment that the outcome of the most recent CQC inspection in May 2022, of services relating to maternity and children and young people was 'requires improvement'. We note that the reassurance that the Trust has since addressed all the 13 'must do' and 18 'should do' actions from the inspection. (Please note the report on p46 refers incorrectly to additional information on p95).

However we also note that responses to the CQC National Maternity Survey showed that the Trust scored "better than expected" in two questions and "somewhat worse or worse" in three questions, with four questions scoring significantly worse when compared to the 2023 survey, suggesting that maternity services may continue to need to be prioritised to meet public expectations.

There are also several positive responses to questions in the national inpatient survey.

We also note the work done, and the progress made, towards the three quality improvement priorities agreed for 2024/25, and we support the continuation of those priorities into 2025/26. We assume that the Trust is content that sufficient progress has been made towards the previous sub- 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' , because that priority has been withdrawn for 2025/26.

We support the new Quality Priority focussing on Infection, Prevention and Control, due to the concerns around increased healthcare associated infections. Our response to last year's Quality Accounts highlighted infections as a concern and we are pleased to see that the Trust has

established this priority.

We note work being undertaken to address the issues identified during the Trust's participation in the 35 national clinical audits in 2024/5, and look forward to hearing about progress in due course. We are pleased to see that good results were recognised in many of these, whilst there are also areas where progress is needed.

These include the proportion of children and young people who obtain an EEG within four weeks and the need to recruit more rheumatology consultants. There are also a number of comments relating to the need for staff training and for improving communication with patients, including through leaflets, and by increasing staff numbers such as additional Fracture Liaison Nurses.

Similarly, we look forward to being updated on progress towards the actions arising from the local clinical audits in 2024/25.

We note the challenges in the field of Innovation, partly following the resignation of the Director of NTH Solutions and a subsequent restructure, and we hope that progress can be made to enable a robust innovation culture to be established and embedded.

The results of the most recent staff survey continue to be above the national average, which is pleasing, although there has been a decline in scores for almost all of the indicators provided. We would like to see a reversal in this decline over the coming year.

The section on Medication Events on p80 of the report indicates that were 782 such events in 2024/25, but there is no indication how this compares to previous years, or benchmarking against other Trusts, making it hard to comment on this performance indicator.

We are pleased to see that the number of patient complaints fell by an impressive 27% compared to the previous year. Even more impressive is the 53% increase in the number of compliments recorded. We congratulate the Trust on these figures.

The record of achievements against the compliance framework on pages 93-96 of the report indicates that 21 of the 46 performance standards have been achieved. This indicates that more progress is required against over half of those indicators, many of which relate to the treatment of patients with cancer.

The Trust performs to a good standard in fields of data protection and data security.

We take an active interest in the growing collaboration between the two components of the Trust and would hope that this interaction will be an additional factor in the improved performance over time.

Thank you for the opportunity to review the 2024/25 Quality Account and through this work Healthwatch Stockton-on-Tees continues to welcome the strong working relationship we've developed with the Trust over recent years, and we will continue to work with and support the Trust over the coming 12 months with the aim of further improving the quality of services provided and maximising a positive patient experience.

Yours sincerely

Jonathan Carling

Healthwatch Stockton-on-Tees Executive Board.

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
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
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
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
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
FTSU	Freedom To Speak Up

FTSUG	Freedom To Speak Up Guardian
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
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
IBD	Inflammatory Bowel Disease
ICB	Integrated Care Board
ICC	Infection Control Council
ICNARC	Intensive Care National Audit and Research Centre
ICO	Information Commissioners Office
ICS	Intensive Care Society
IG	Information Governance
ICE	Integrated Clinical Environment
IG	Information Governance
Intentional rounding	A formal review of patient satisfaction used in wards at regular points throughout the day
IPC	Infection Prevention and Control
Kardex (prescribing kardex)	A standard document used by healthcare professionals for recording details of what has been prescribed for a patient during their stay
Kleb sp	Klebsiella Species (type of infection)
KPI	Key Performance Indicator
LeDeR	Learning Disabilities Mortality Review
LFPSE	Learning from Patient Safety Events

LMNS	Local Maternity & Neonatal System
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
ME	Medical Examiner
MHA	Mental Health Act
MHRA	Medicines and Healthcare products Regulatory Agency
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
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
QI	Quality Improvement
R&D	Research and Development
RA	Recruitment Activity
RAG	Red, Amber, Green chart denoting level of severity
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
SEPSIS	Life-threatening reaction to an infection
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
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
STAMP	Screening Paediatric
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
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
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

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