Middlesbrough
moving forward

Legal and Governance

PEOPLE SCRUTINY PANEL

Date: **Monday, 12 May 2025**
Time: **4.30 p.m.**
Venue: **Mandela Room, Town Hall**

AGENDA

1. Welcome and Evacuation Procedure

2. Declarations of Interest

3. South Tees Hospitals NHS Foundation Trust - Draft Quality Account for 2024/2025 — 3 - 86

4. Tees, Esk and Wear Valleys NHS Foundation Trust - Draft Quality Account for 2024/2025 — 87 - 162

5. Any other urgent items which in the opinion of the Chair, may be considered.

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall
Middlesbrough
Thursday, 1 May 2025

MEMBERSHIP

Councillors E Clynch (Chair), J Banks (Vice-Chair), L Hurst, D Jackson, M McClintock, T Mohan, M Nugent, S Platt, S Tranter, Z Uddin, G Wilson and L Young

Assistance in accessing information

Should you have any queries on accessing the Agenda and associated information please contact Claire Jones / Chris Lunn, 01642 729112 / 01642 729742, claire_jones@middlesbrough.gov.uk / chris_lunn@middlesbrough.gov.uk

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NHS
South Tees Hospitals
NHS Foundation Trust

Quality Account

2024-25

Caring
Better
Together

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3. Overview of quality of care and performance indicators

    3.1 Overview of quality of care

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    c. Martha's Rule

    Clinical effectiveness indicators

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

    Patient experience and involvement indicators

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

    3.2 Performance against key national priorities

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

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

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

6. Annex 3: Glossary of terms

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

To be inserted

Stacey Hunter

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

1.1 Introduction

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

Hospital services:

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

Community services:

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

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

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

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

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

2.1 Priorities for improvement

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

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

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

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

Table 1 – Group Quality Priorities 2025/26

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

Patient safety quality priorities

1. Positive, just and restorative safety culture.

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

Aims

We planned to;

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

We aimed to achieve the following measures of success;

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

Progress and achievements

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

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

Summary and future plans

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

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

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

Aims

We planned to;

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

We aimed to achieve the following measures of success;

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

Progress and achievements

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

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

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

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

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

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

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

Summary and future plans

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

3. Medication safety and optimising the benefits of ePMA.

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

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

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

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

Aims

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

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

Progress and achievements

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

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

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

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

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

Image; AMS Study Day

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

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

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

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

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

Summary and future plans

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

Clinical effectiveness quality priorities

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

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

Aims

We planned to;

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

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

We aimed to achieve the following measures of success:

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

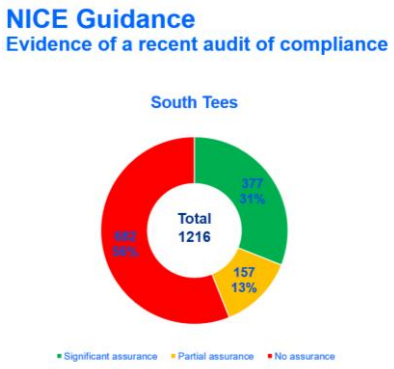
Progress and achievements

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

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

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

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



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

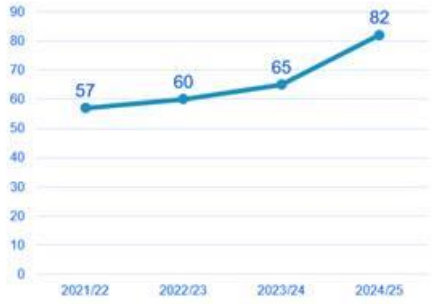
National Clinical Audit
Exception reporting

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

National Clinical Audit
Workload by organisation over the past four years

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

44% increase in national audit demand over the period



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

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

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

Summary and future plans

Priorities for 2025/26 will focus on:

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

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

2. Mortality review processes and learning from deaths.

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

Aims

We planned to;

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

We aimed to achieve the following measures of success:

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

Progress and achievements

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

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

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

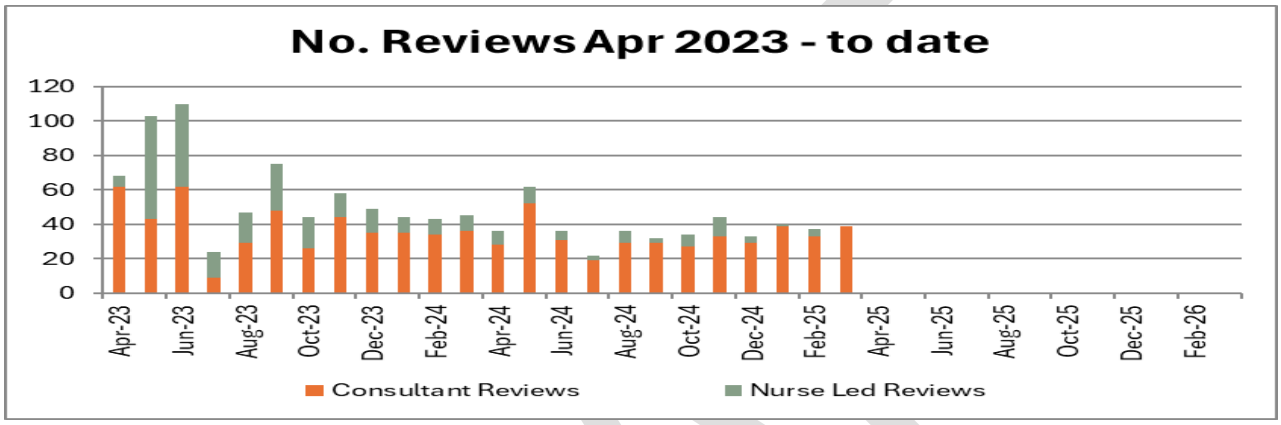
The recording of specialty mortality reviews on InPhase is progressing. This is now live and has been rolled out across 3 specialties; Haematology, Cardiology and Intensive Care. There are plans for

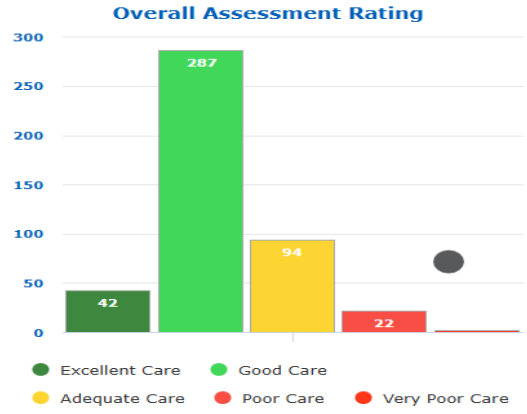
Gastroenterology and Endoscopy to begin recording reviews over the coming months. Work is progressing to continue with the rollout across the Trust with identification of mortality leads for each specialty being our next focus, working with the Trust Safe and Effective Care Leads for each collaborative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

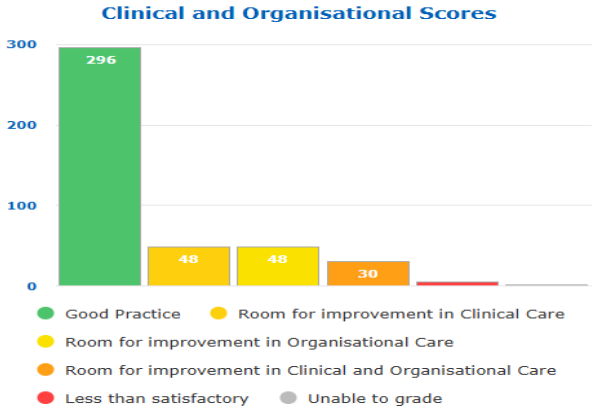
We are well integrated with the wider Quality team to ensure that themes emerging from learning from deaths are triangulated against data from Patient Experience, Patient Safety and Clinical Effectiveness. The Mortality Surveillance Team regularly attend Patient Safety meetings including Learning Response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

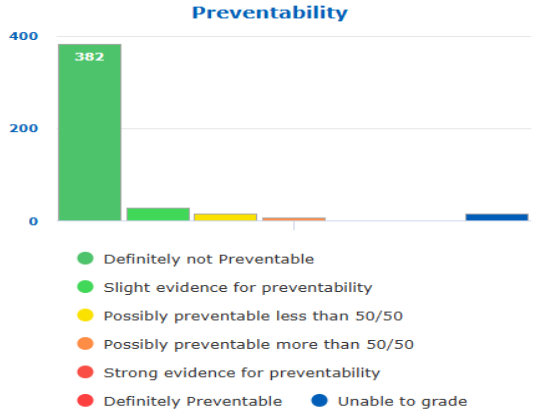
The outcomes from mortality reviews are shared and discussed on a weekly basis and cases are reviewed and discussed at the Learning Response Panel to ensure proportionate learning responses in line with the Trust's Patient Safety Incident Response Plan.

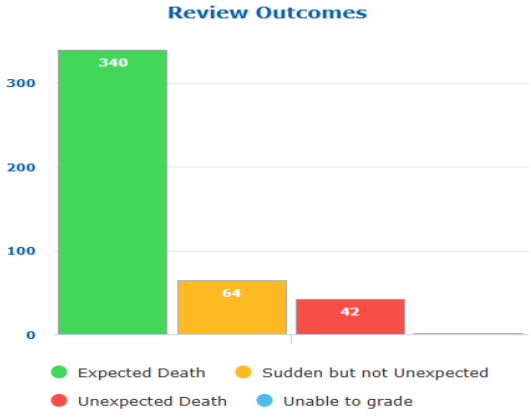
Since April 2024 we have completed 451 reviews, shown in the graphs below. Completion of the reviews on InPhase allows the team to access data, as evidenced in the graphs below.

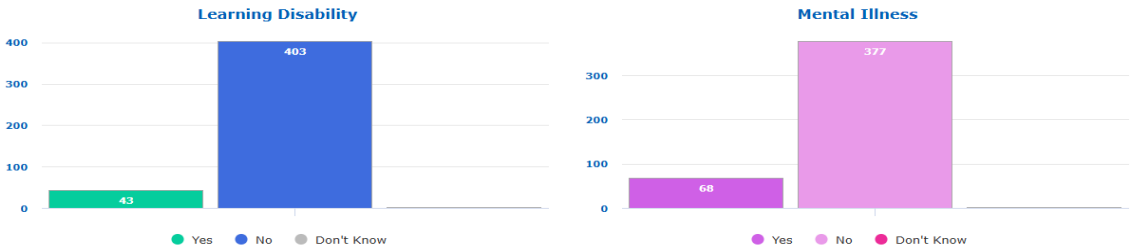


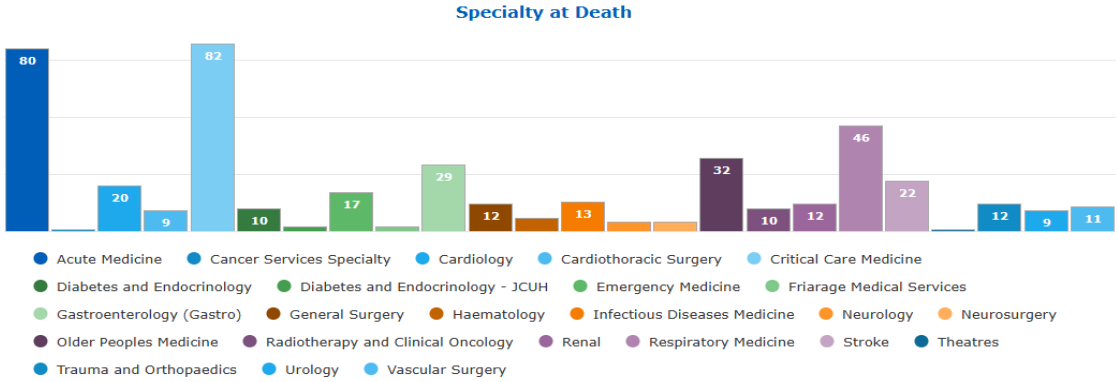






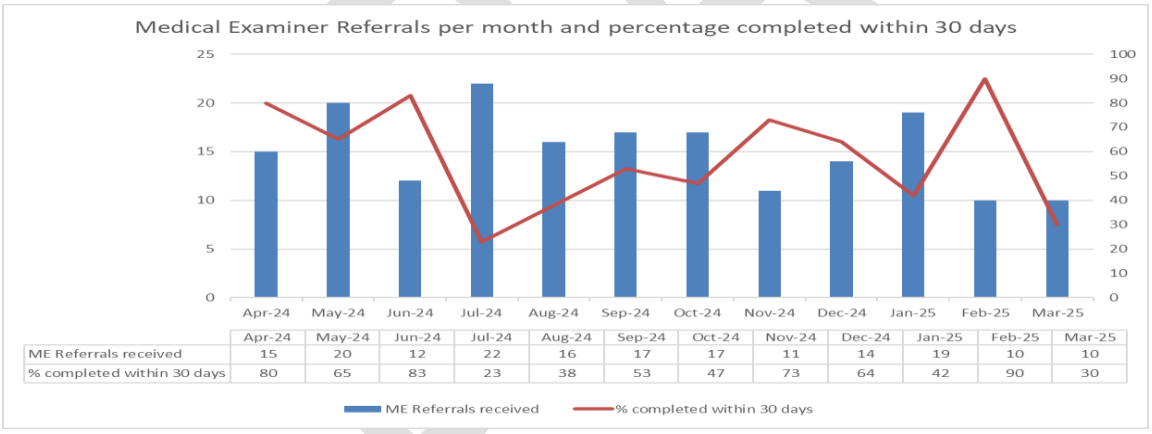






Key Performance Indicators (KPIs).

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



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

Figure 1 – Medical examiner referrals per month and % completed

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

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

Summary and plans for future work

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

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

3. Shared decision making and goals of care

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

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

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

Aims

We planned to:

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

Progress and achievements

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

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

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

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

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

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

Summary and future plans:

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

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

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

Patient experience quality priorities

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

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

Aims

We planned to:

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

We aimed to achieve the following measures of success:

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

Progress and achievements

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

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

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

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

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

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

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

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

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

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

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

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

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

Summary and plans for ongoing work

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

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

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

Aims

We planned to:

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

We aimed to achieve the following measures of success:

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

Progress and achievements

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

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

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

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

Summary and plans for ongoing work

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

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

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

Aims

We planned to;

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

We aimed to achieve the following measures of success;

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

Progress and achievements

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

Three priorities were initially agreed as follows;

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

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

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

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

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

Maternity Mental Health

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

Further priority areas

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

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

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

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

Summary and future plans

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

The key next steps are to;

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

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

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

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

2.2 Statements of assurance from the Board

1. Relevant health services

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

2. National clinical audits and national confidential enquiries

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

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

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

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

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

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

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

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

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

Table 2 - national clinical audits

National Confidential Enquiries (NCEPOD):

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

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

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

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

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

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

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

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

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

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

3. Local audit

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

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

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

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

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

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

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

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

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

4. Clinical Research

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

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

Performance

Figure 2 Recruitment over time

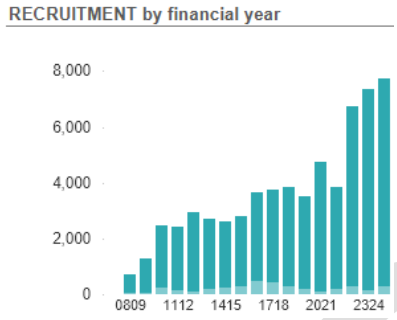
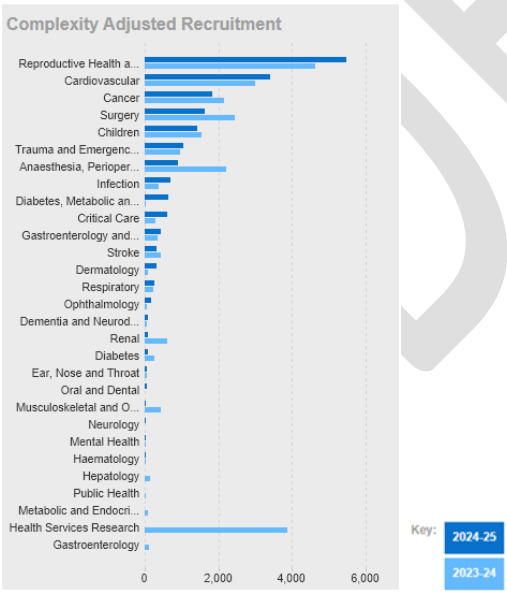


Figure 3 Recruitment by clinical specialty



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

5. CQC registration, reviews and investigations

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

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

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

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

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

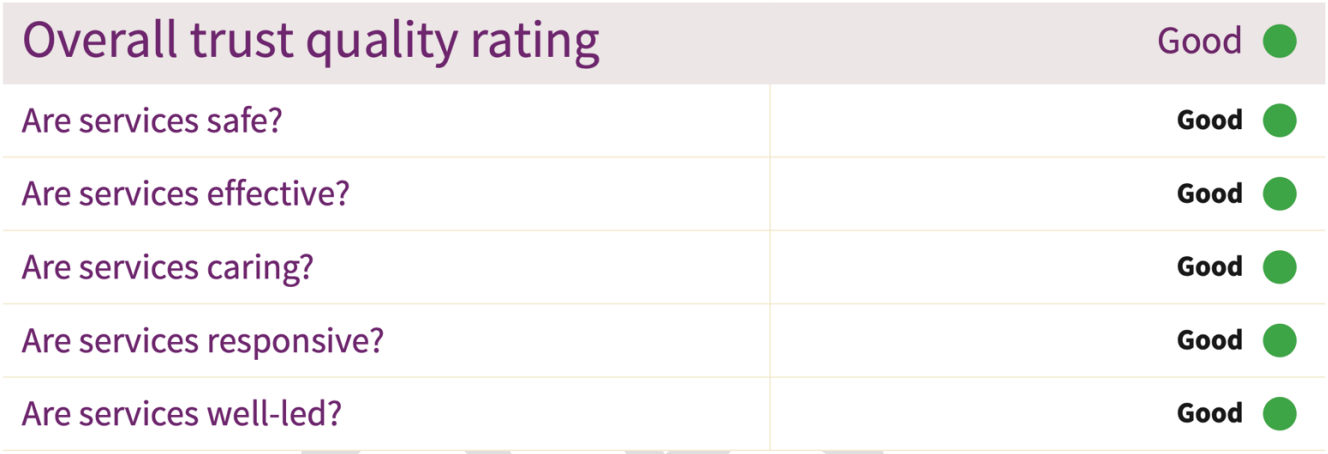


Figure 4: South Tees Hospitals NHS Foundation Trust overall CQC rating

6. Submission of records to the Secondary Uses Service

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

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

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

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

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

7. Information Governance grading

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

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

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

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

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

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

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

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

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

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

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

We have had no reportable incidents during the reporting period.

8. Clinical coding audit

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

9. Data quality

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

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

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

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

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

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

10. Learning from deaths

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.3 Reporting against core indicators

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

AWAITING DATA UPDATE EARLY MAY

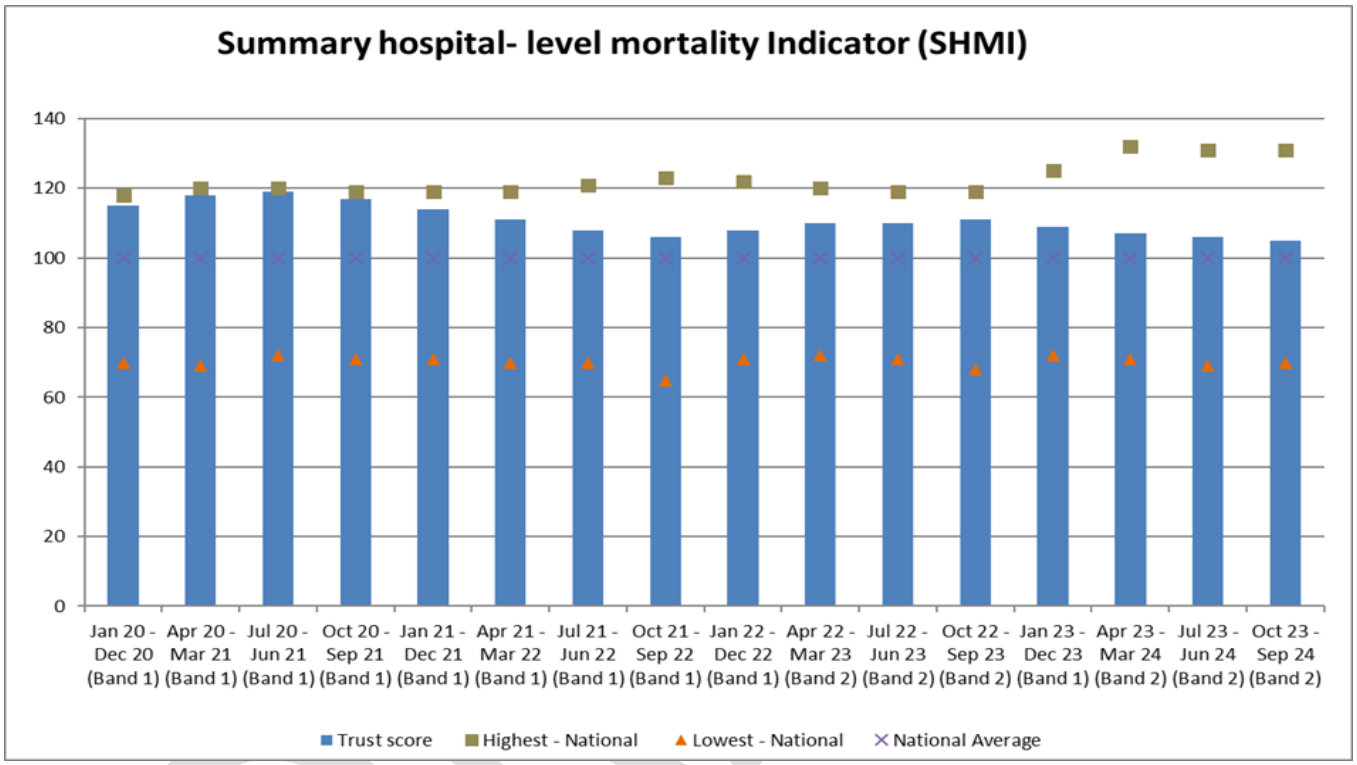


Figure 5: Summary Hospital Level Mortality Indicator (Data source: NHS Digital)

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

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

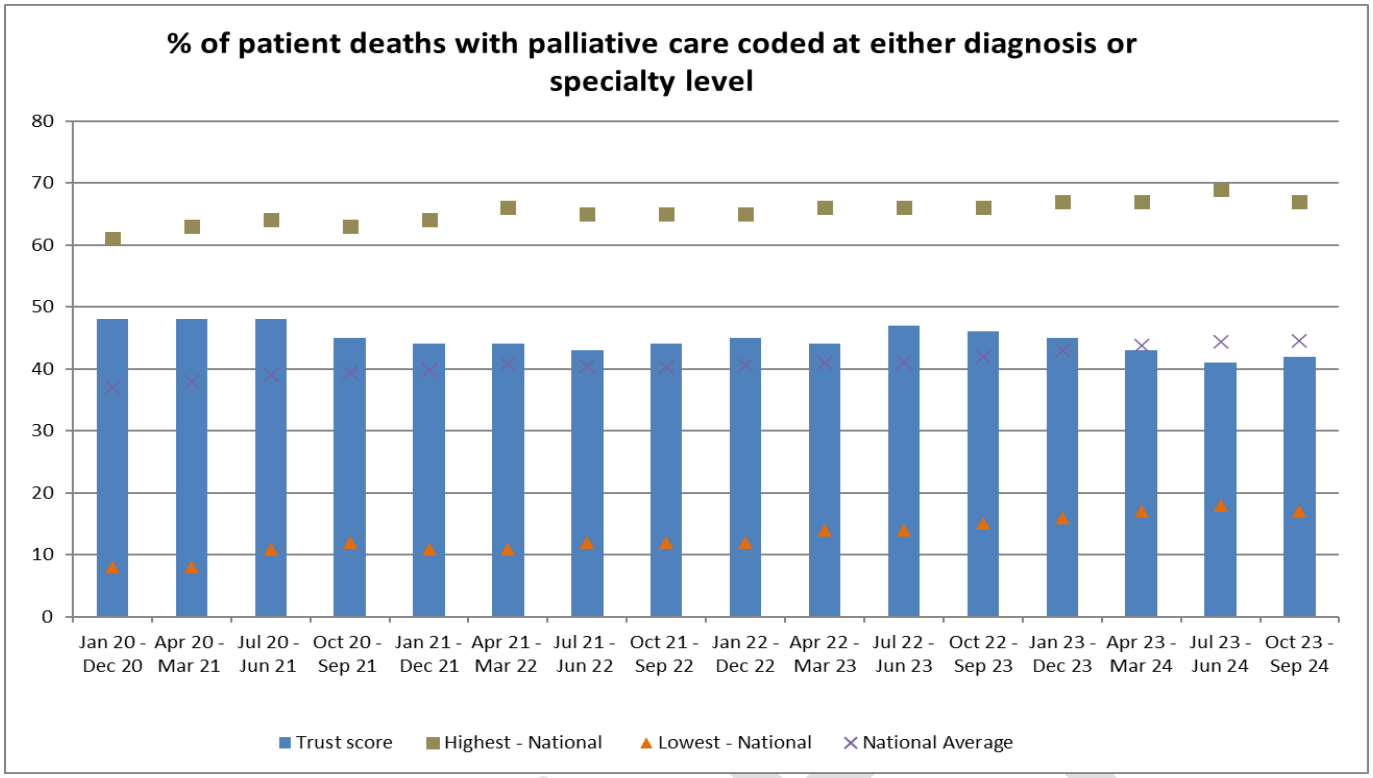


Figure 6: Percentage of Patient Deaths with Palliative Care Coded (Data source: NHS Digital)

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

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

NARRATIVE AWAITING REVIEW

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

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

2. Patient reported outcome measures

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

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

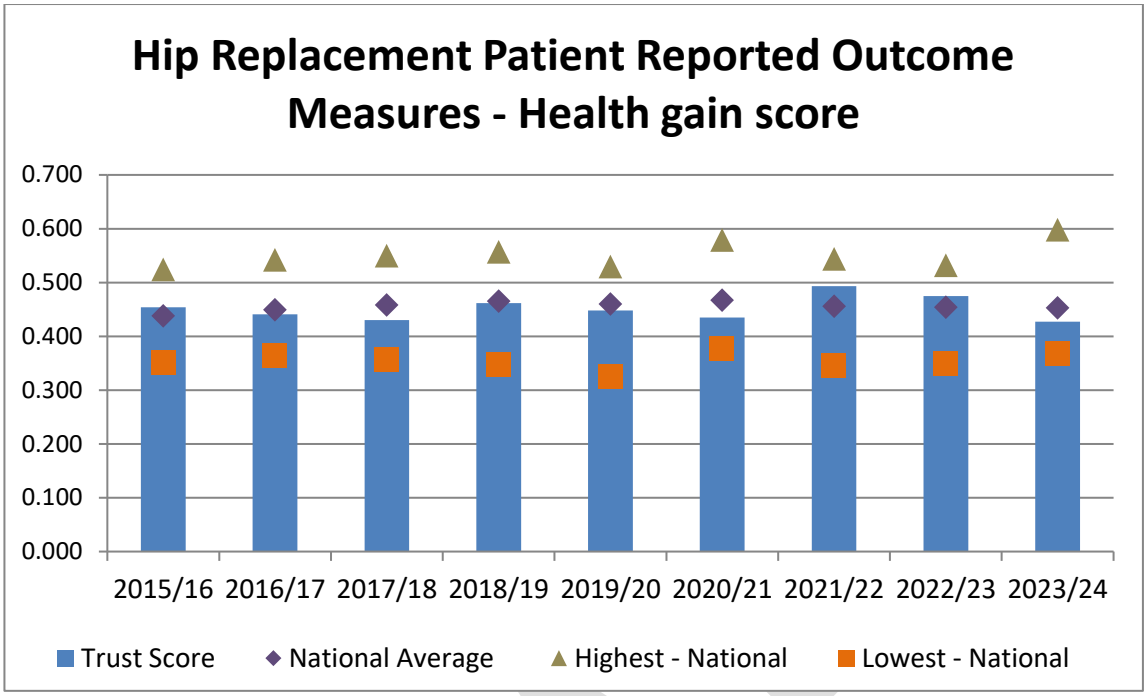


Figure 7 - Hip Replacement Patient Reported Outcome Measures - Health gain score

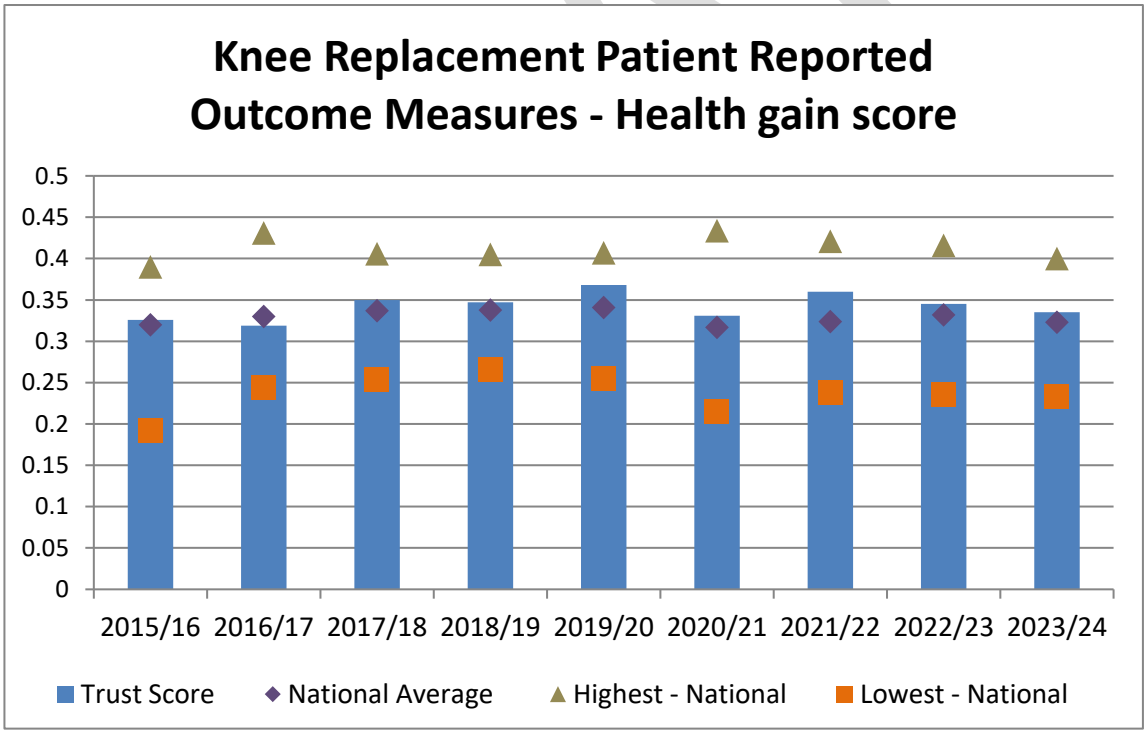


Figure 8 - Knee Replacement Patient Reported Outcome Measures - Health gain score

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

NARRATIVE AWAITING REVIEW

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

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

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

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

3. 30-day readmissions

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

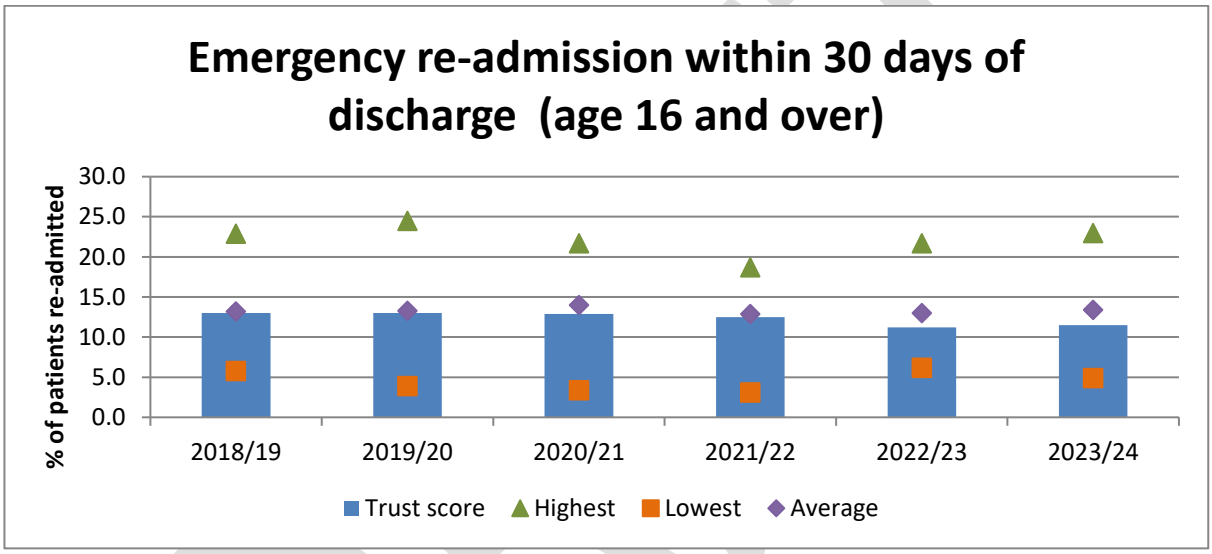


Figure 9 - Emergency re-admission within 30 days of discharge (age 16 and over)

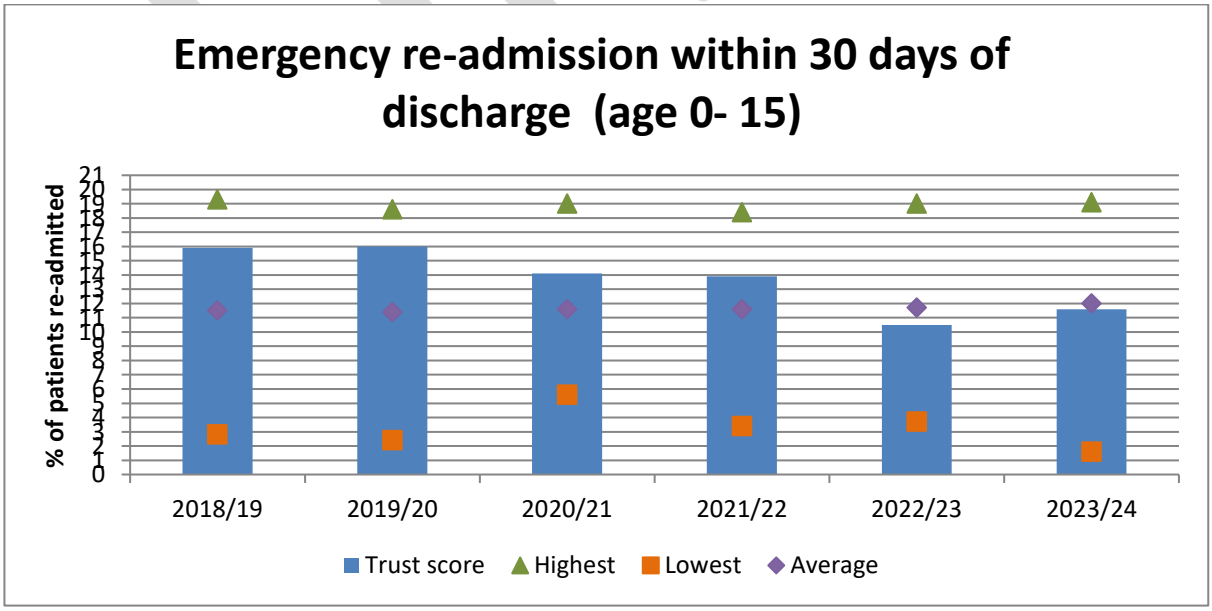


Figure 10 - Emergency re-admission within 30 days of discharge (age 0- 15)

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

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

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

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

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

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

5. National Inpatient Survey

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

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

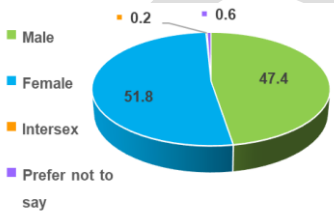


Figure 11 – Sex

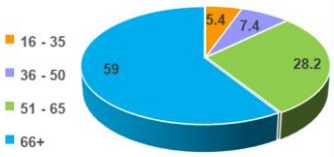


Figure 12 – Age

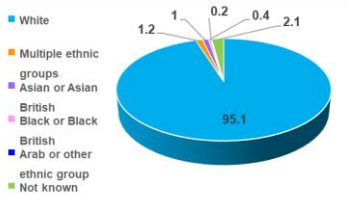


Figure 13 - Ethnicity

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

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

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

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

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

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

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

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

Our response to the Inpatient survey results

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

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

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

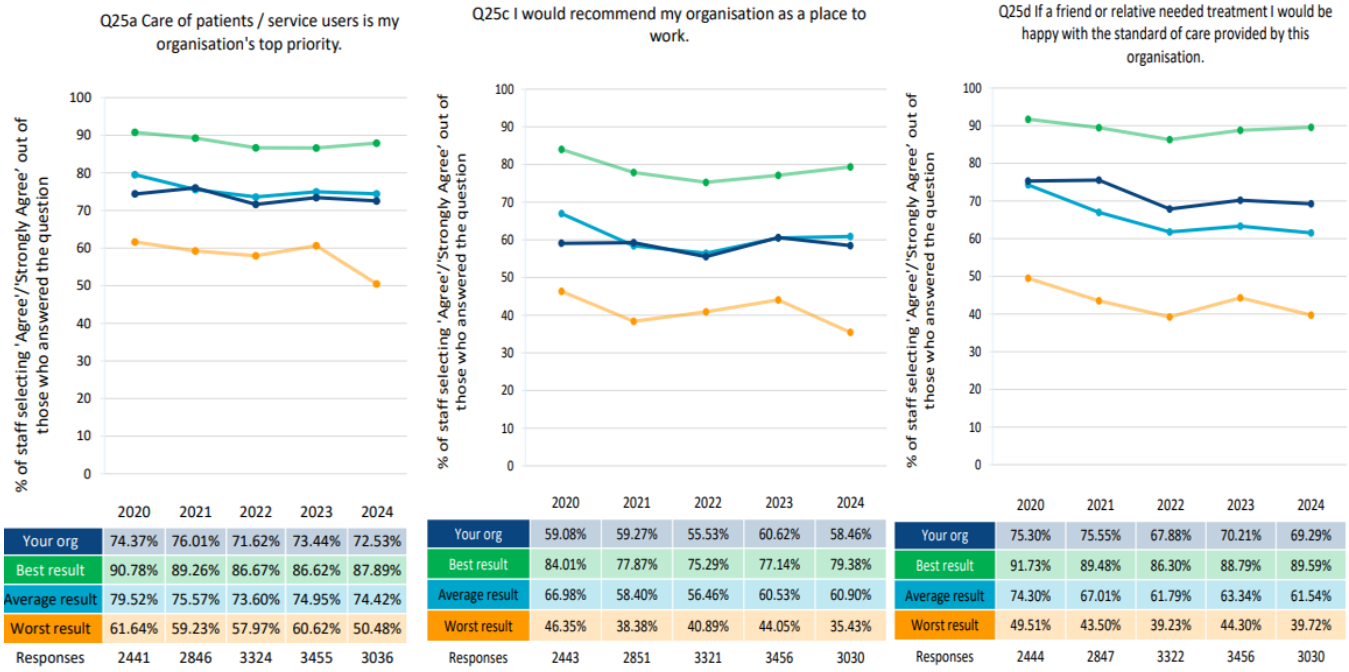
On review of the survey results, 78% of patient's comments about staff and 71% of patient's comments about care and treatment were positive. 67% of patient's comments about the pathway of care and 69% of patient's comments on hospital environment and facilities were negative.

Areas for improvement

Figure 14 - Areas for attention following comment analysis

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

c. Staff Friends and Family Test



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

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

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

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

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

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

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

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

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

6. Venous thromboembolism risk assessments

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

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

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

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

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

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

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

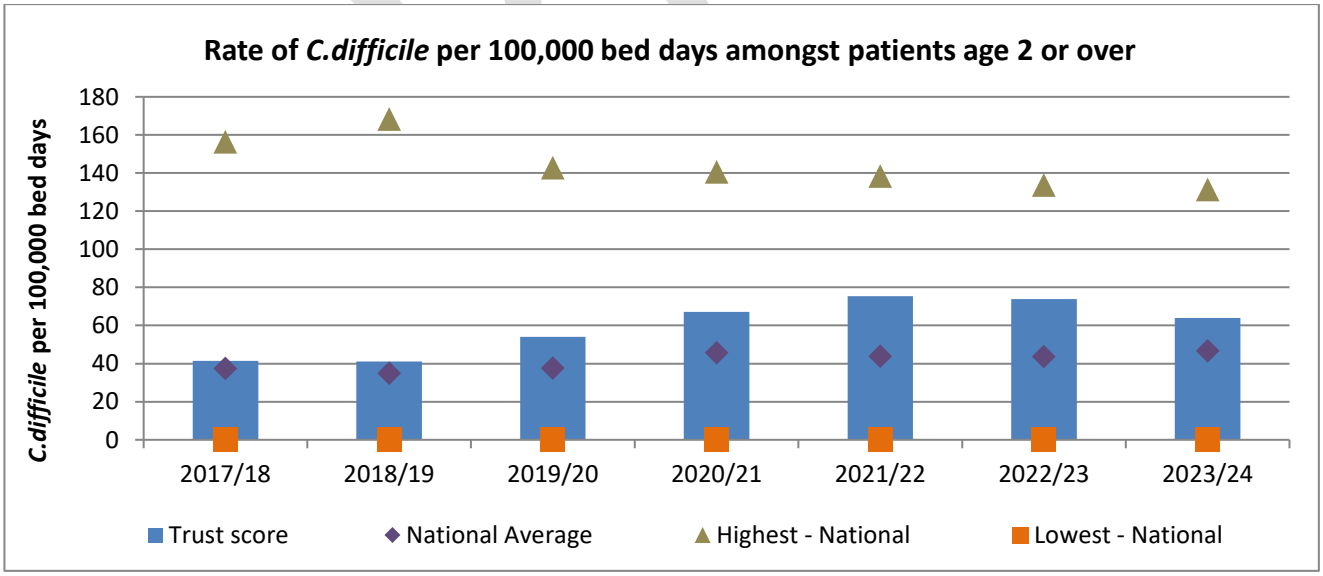


Figure 15: Rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over. (Data source: NHS Digital)

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

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

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

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

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

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

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

8. Patient safety incidents

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

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

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

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

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

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

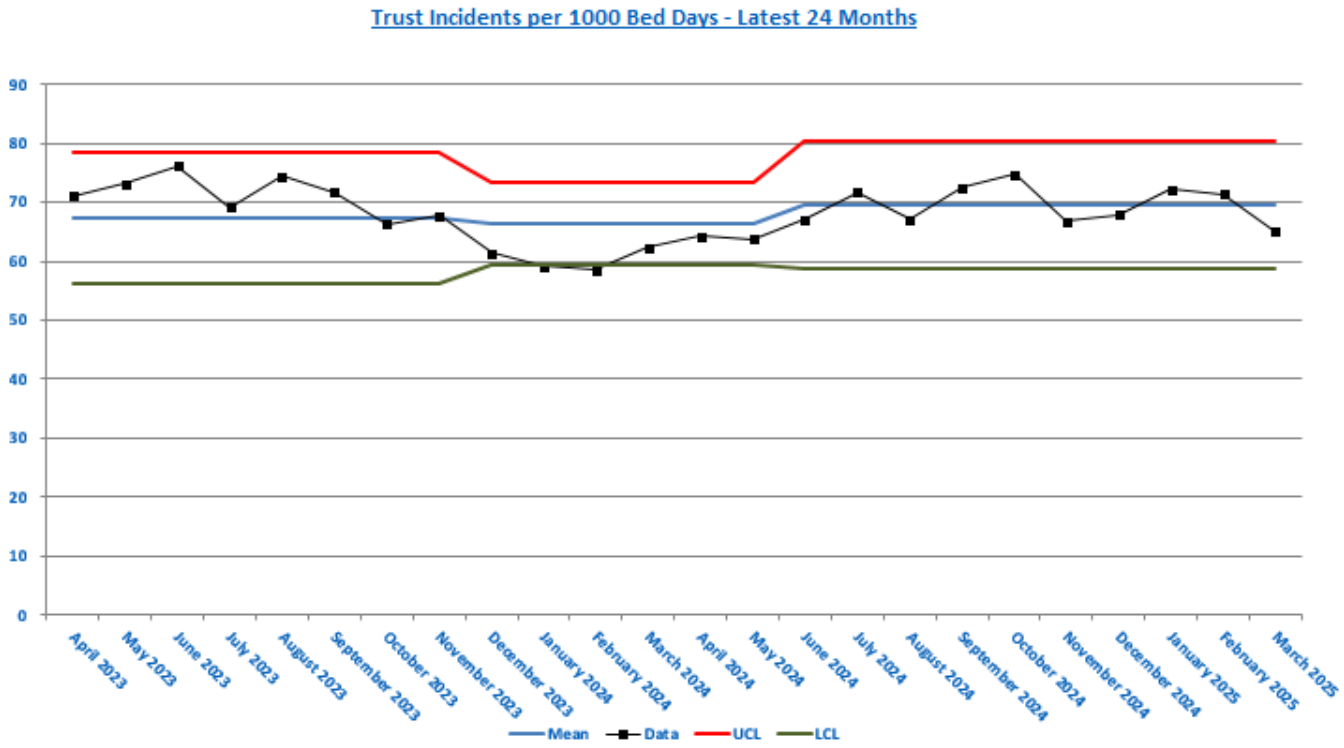


Figure 16 – Trust incidents per 100 bed days

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

Patient Safety Incident Response Framework (PSIRF)

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

Never Events

We reported five Never Events during 2024/25.

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

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

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

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

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

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

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

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

9. Patient Friends and Family Test

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

3. Overview of quality of care and performance indicators

3.1 Overview of quality of care

Patient Safety

a. Medication safety

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

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

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

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

Image; AMS Study Day

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

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


Image; Beth Mongomerie

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

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

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

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

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

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

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

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

b. Compassionate Engagement and evaluation of the Family Liaison Officer

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

Learning from patient safety incidents

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

Family Liaison Support

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

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

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

Restorative practice

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

Patient safety investigation training

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

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

NHS Patient safety syllabus training

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

Patient Safety Partners

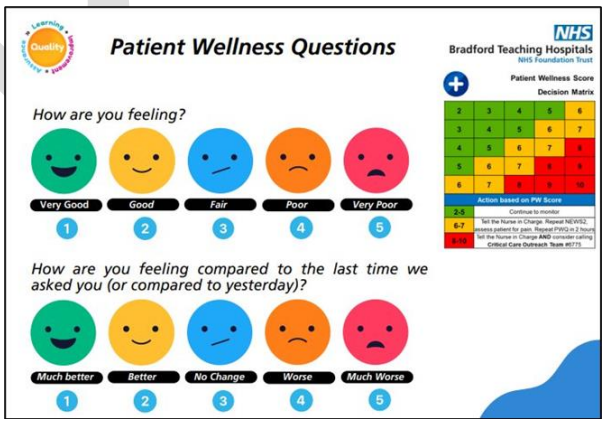
The patient safety partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across health care in the UK. A PSP is a person with lived experience as a patient, caregiver, or family member who works with healthcare services to improve patient safety. The goal of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

c. Martha's Rule

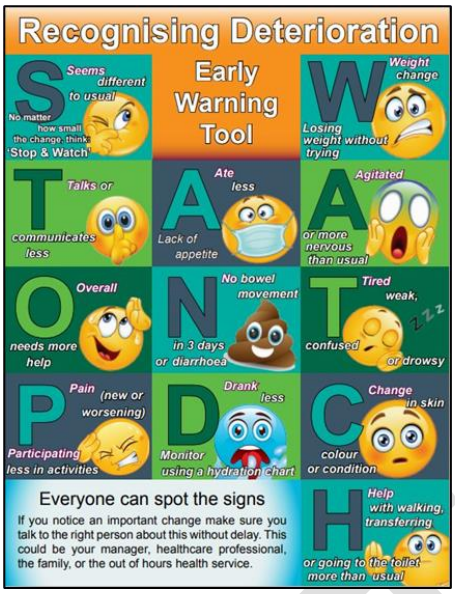
Martha's Rule is an initiative designed to give patients and their families the right to request an urgent clinical review by a different team if a patient's health appears to be deteriorating. The process is designed to empower families, carers, and patients to speak up about any concerns. Martha's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

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

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



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



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

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


Step 4

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

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

When NOT to make a C4C call

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

For any general concerns please discuss with the ward team.

Patient Experience

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

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

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

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

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

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

NHS
South Tees Hospitals
NHS Foundation Trust

Critical Care Outreach Team

Are you concerned about a patient?

Call 4 concern©

A patient safety initiative

C4C

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

Safety and Quality First

Key Benefits

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

Clinical effectiveness indicators

a. Research and Innovation

Clinical Research

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

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

Achievements of note:

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

Nursing Midwifery and Allied Health Practitioner (NMAHP) Development

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

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

Tees Valley Research Alliance (TVRA) Sponsored studies

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

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

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

Table 5 – Trust sponsored studies by support team

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

Innovation

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

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

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

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

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

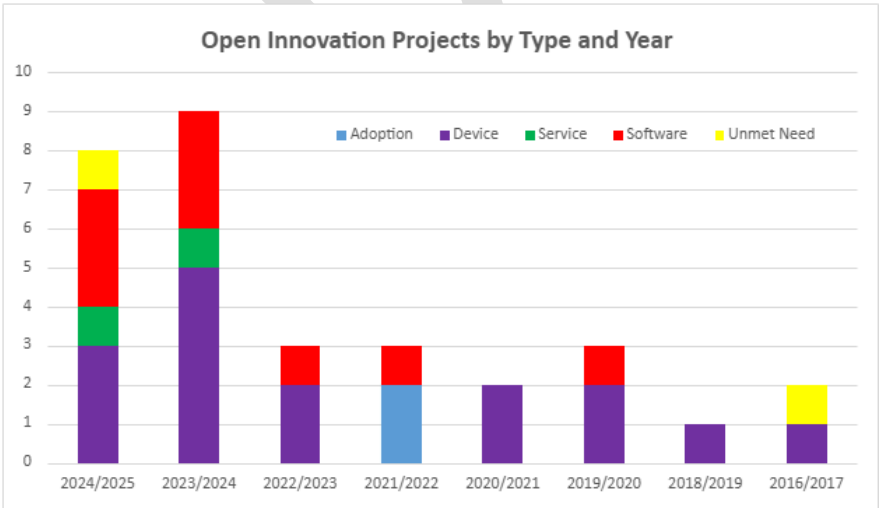


Figure 17 – Open Innovation Projects

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

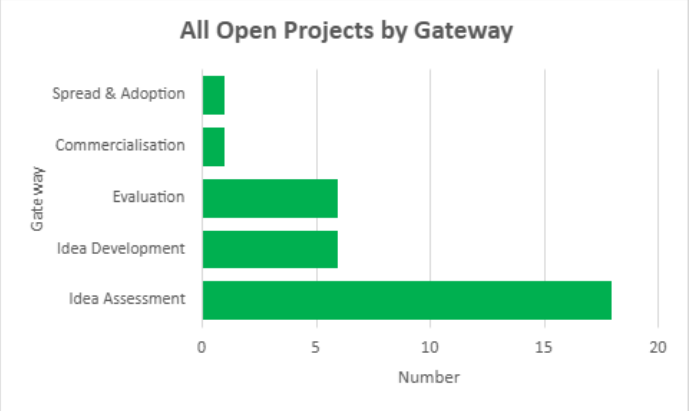


Figure 18 – Open projects by gateway

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

b. STAQC and Ward 12

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

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

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

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

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

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

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

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

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

Table 6 – STAQC accreditations by level of achievement

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

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

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

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

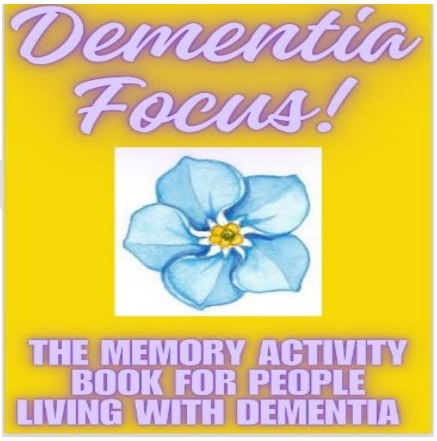
The unit was accredited a Diamond STAQC award in August 2024. Some of the areas of excellence included:

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

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

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

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



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

Well done Ward 12!

Summary

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

c. Digital Transformation

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

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

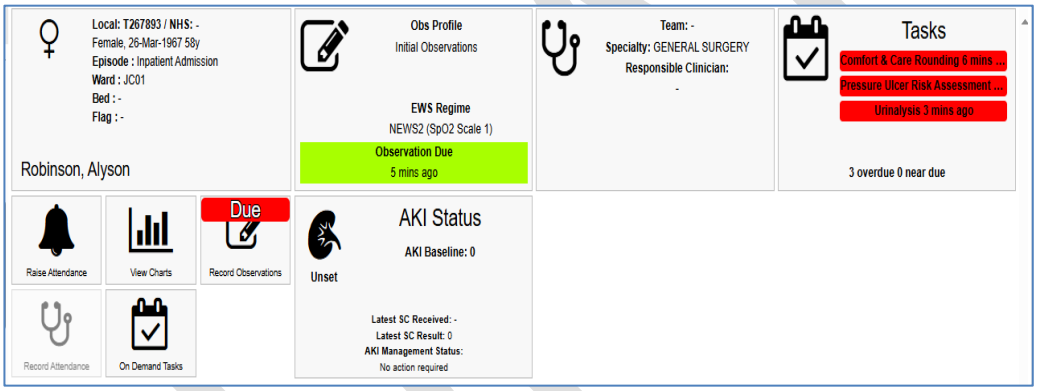
Patientrack

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

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

Key Benefits

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



Electronic Prescribing and Medicines Administration (ePMA)

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

Key Benefits

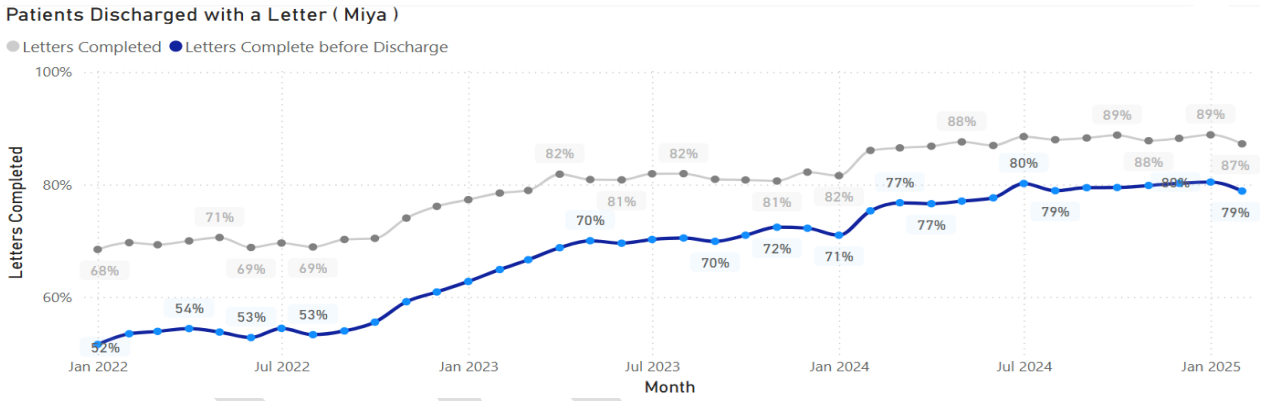
- Clinical decision support which highlights known interactions and contraindications with medications
- Pre-configured order sets which are validated sets of medication to support prescribers with minimising errors and omissions
- Full traceability
- Clear and accurate prescriptions aiming to reduce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

Electronic Discharge

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

Key Benefits

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



Smartpage

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

Key Benefits

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

Clinical Noting

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

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

Key Benefits

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

Bed Management

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

Key Benefits

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

Patient experience and involvement indicators

a. Patient surveys – national and local

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

Local Trust Surveys and Friends and Family Test (FFT)

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

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

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

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

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

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

National Surveys

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

National Cancer Patient Experience Survey

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

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

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

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

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

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

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

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

National Maternity Survey

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

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

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

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

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

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

b. Patient Experience and EDI

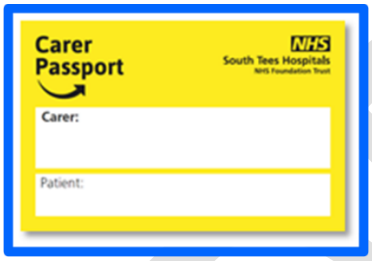
Equality of service delivery to different groups within the NHS is for everyone. Anyone needing the NHS should receive the same high-quality care every time they access services. However, we know that some people in our communities can experience barriers or judgement when using NHS services.

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

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

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

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



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

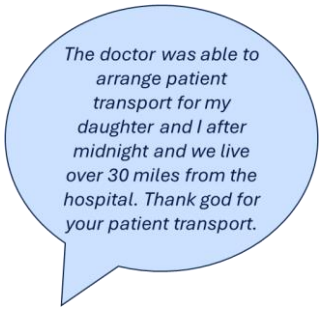
- An opportunity for carers to visit out of hours, which reassures patients and makes them feel at ease.
- The option to stay overnight as required.
- Free or discounted car parking for carers visiting regularly.
- Active involvement in the meetings and discussions about the patient's care needs.
- An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

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

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

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

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



c. Patient Experience Involvement Bank

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

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

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

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

Ask 3 questions

Emergency Care – Mental Health Study Day

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

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

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

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

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

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

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

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

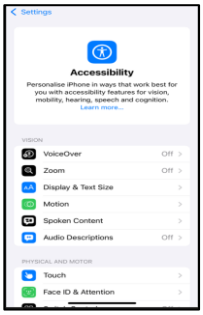
The team needed patients to share their views on a research project to improve the care provided for patients with broken hips. Representatives from the Involvement Bank and the public at community groups, attended the focus group session. Feedback was very positive; with lots of discussion and ideas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

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

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

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

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



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

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

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

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

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

Feedback has included:

Veteran Aware

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

The role of the Help for Heroes nurse ensures that;

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

Patient Stories

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

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

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

3.2 Performance against key national priorities

AWAITING DATA REFRESH

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

Table 8: Performance against national priorities

Key findings:

Cancer waiting times

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

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

Table 8 - Performance against cancer headline standards

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

Elective care performance

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

Diagnostic performance

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

Urgent and emergency care performance

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

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

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

3.3 Additional required information

Seven-day services

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

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

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

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

Freedom to speak up

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

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

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

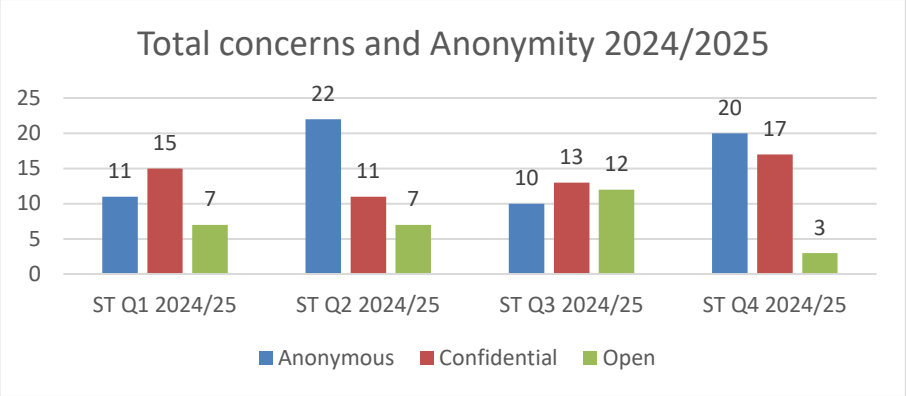


Table 9 – total concerns raised

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

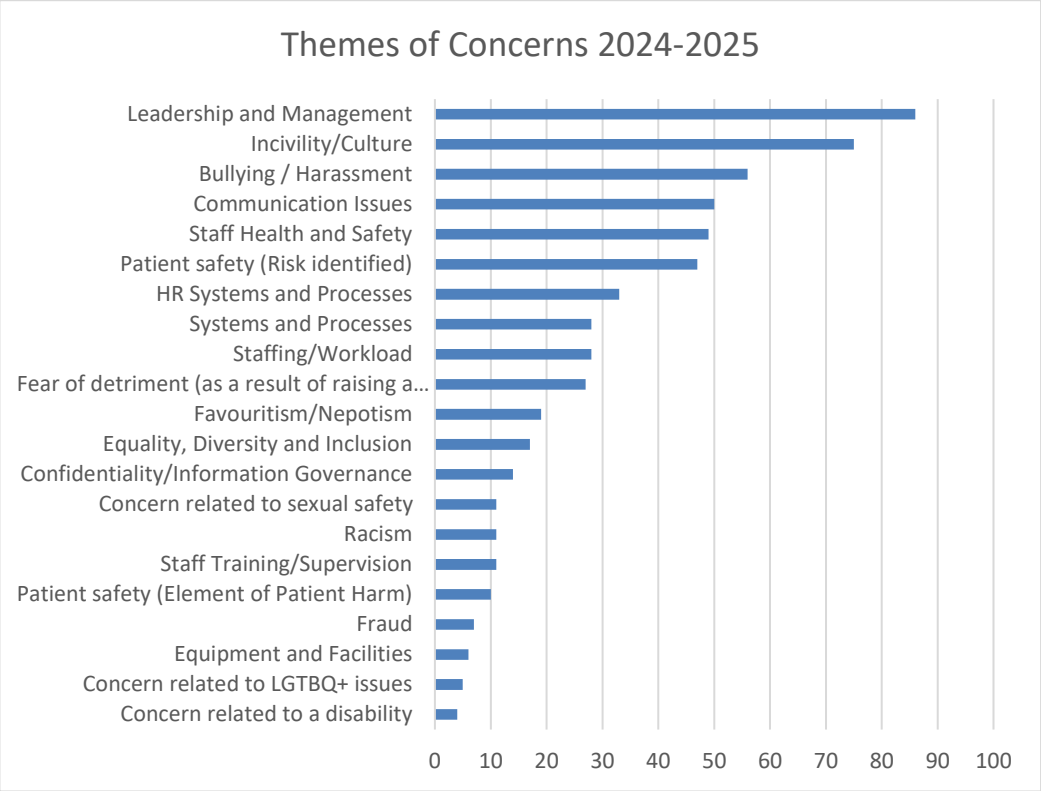


Table 10 – Themes from Freedom to Speak up concerns

Proactive work to date

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

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

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

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

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

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

Future Plans

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

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

Rota gaps for doctors and dentists in training

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

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

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

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

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

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

Table 11 – rota gaps

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

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

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

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

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

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

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

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

TO BE COMPLETED

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

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

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

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19.*
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2024 to March 2025.
    - papers relating to quality reported to the board over the period April 2024 to March 2025.
    - feedback from commissioners dated 17 May 2024.
    - feedback from governors dated 21 May 2024.
    - feedback from local Healthwatch organisations dated 10 May 2024.
    - feedback from Tees Valley Joint Health Scrutiny Committee dated 12 June 2024.
    - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 May 2023.
    - the latest national patient survey published February 2024 (Maternity).
    - the latest national staff survey published 7 March 2024.
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 25 June 2024.
    - CQC inspection reports dated 24 May 2023 and 19 January 2024 (Maternity).
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- the performance information reported in the quality report is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

27 June 2024 Derek Bell, Group Chairman

27 June 2024 Stacey Hunter, Group Chief Executive

6. Annex 3: Glossary of terms

TO BE FINALISED

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

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

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

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

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

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

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

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

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

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

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

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

Clinician

Professionally qualified staff providing clinical care to patients.

Commissioners
Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Services are commissioned by integrated care boards and are overseen by NHS England on a regional basis.

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

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

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

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

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

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

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

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

Emergency
An urgent unplanned episode of care.

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

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

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

Health care associated infections (HCAI)

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

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

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

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

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

Inpatient
Patient requiring an overnight stay in hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

South Tees Hospitals NHS Foundation Trust

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

TEWV

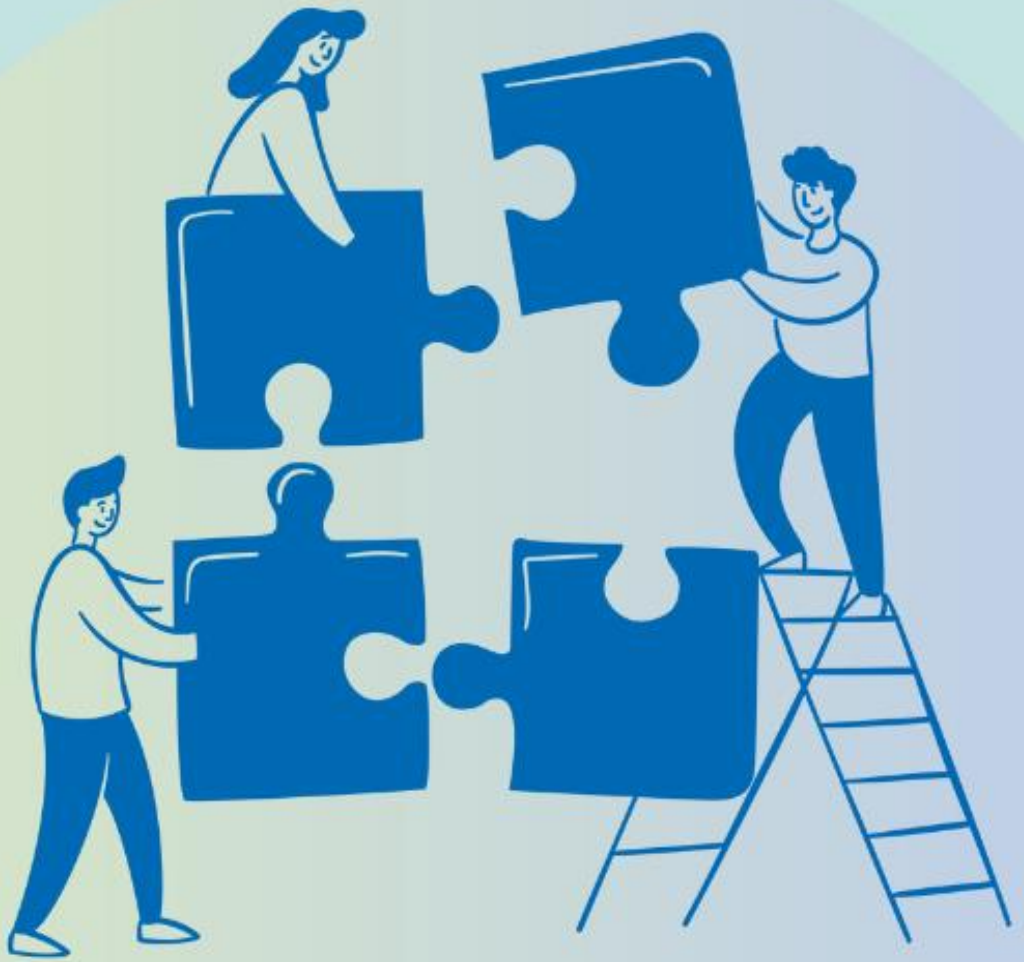
Tees, Esk and Wear Valleys NHS Trust, supporting Mental Health and Learning Disabilities for County Durham and Darlington, Teesside, North Yorkshire, York and Selby.

NHS

Tees, Esk and Wear Valleys

NHS Foundation Trust

Quality Account 2024/25



DRAFT – CONSULTATION

Contents

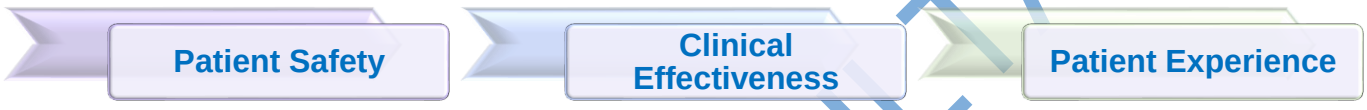
Part One: Introduction and context

1.1 Welcome to the Quality Account and its Purpose

A Quality Account is an annual report describing the quality of services provided by an NHS healthcare organisation. Quality accounts aim to increase public accountability and drive quality improvements in the NHS. All NHS healthcare providers are required to produce an annual Quality Account to provide information on the quality of services they deliver.

This report aims to give a true and fair representation of the quality of our services, including information that is meaningful, relevant and understandable. We hope that the information is useful and demonstrates our commitment and intention to provide high quality and safe services, which is the Trust's highest priority and at the heart of everything we do.

Like all NHS healthcare providers, we focus on three different aspects or domains of quality:



The structure of this Quality Account is in line with guidance published by the Department of Health and NHS England, and contains the following information:

- **Part 1:** Introduction and context
- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2024/25, our priorities for improvement in 2025/26 and the required statements of assurance from the Board
- **Part 3:** Further information on how we have performed in 2024/25 against our key quality metrics and national targets and the national quality agenda

We would value your feedback on this document so that we can improve next year's Quality Account. If you have any comments or would like more information, please contact us using the details below:

By email: tewv.communications@nhs.net

By telephone: 0300 200 0010

1.2 Chief executive's statement on quality

Everything we do is about people, and we are committed to providing safe and kind care for the communities we serve.

Reflecting on the last year, we've seen so many examples of positive change, driven by our colleagues, working alongside our partners and involving our patients and carers. These changes have had a real and meaningful impact on the quality and the safety of the care we provide. You can read more about this throughout this report. However, some of the highlights include the work we've done in our inpatient services, such as culture of care, and work to further reduce restrictive interventions. In the last 12 months we've switched our crisis service over to NHS 111 (select the mental health option) and worked with partners to introduce Right Care, Right Person, which aims to give people in our communities the most appropriate support to meet their needs when in a crisis.

There also continues to be a huge amount of work to support people in our communities. Earlier this year, Hartlepool was mentioned as an example of best practice at a Parliamentary Health Select Committee on community mental health transformation. We're incredibly proud of this partnership work and the positive impact it has had - and there are many other examples of this across our trust.

In February, the Care Quality Commission (CQC) published its report into our mental health crisis services and health-based places of safety. We were rated 'good' which means we retained our previous rating and that the service is performing well and meeting the CQC's expectations. This was another important step in Our Journey to Change. It demonstrated our continuous improvement and the positive impact that this has had on people's experience of our trust. This service supports some of our most vulnerable patients, so maintaining our 'good' rating is incredibly important.

Looking ahead, there continues to be change across the health and social care sector. And we expect more change. Last year saw the publication of the Darzi Report, and we await the publication of the 10-year plan for the NHS. What we do know is that there will be three key areas of focus - hospital to community care, analogue to digital and from treating sickness to preventing it.

The work we've done during 2024-25 fundamentally supports these shifts. Importantly they are also a key focus of our own future plans, and the next stage of Our Journey to Change. This will ensure that we continue to improve the services we provide – with an unwavering commitment to safe and kind care.

Underpinning all of this, is the hard work and dedication of our colleagues, our partners, and the patients and families that we work with to co-create these continued improvements. Thank you to everyone involved.

Patrick Scott
Interim Chief Executive Officer

1.3 About our Trust and the services we provide

We are the Mental Health & Learning Disability NHS Trust for County Durham and Darlington, Teesside, North Yorkshire, York and Selby.

From education and prevention, to crisis and specialist care - our talented and compassionate teams work in partnership with our patients, communities and partners to help the people of our region feel safe, understood, believed in and cared for.

TEWV was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust. In 2008 our Trust became the first mental health Foundation Trust in the North and since then, it has expanded both geographically and in the number and type of services provided. Our Trust now has around 8,100 staff, who work out of more than 90 sites, and an annual income of over £500 million.

We operate across two care group boards – one covering Durham, Tees Valley and Forensic services and one for North Yorkshire, York and Selby.

Across our care group boards, we deliver care under six clinical directorates:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

As a Foundation Trust we are accountable to local people through our Council of Governors and are regulated by NHS England and the Care Quality Commission

Figure 1: Map of the Trust footprint

1.4 Our Journey to Change

In August 2020 we launched **Our Big Conversation** - the biggest listening exercise in the history of our Trust. Over 2,100 people shared 35,800 ideas, comments, and votes, exploring what could be possible if we got everything right and what we must do to achieve this. From the rich conversations and feedback we received from Our Big Conversation, we developed big ideas for change and a new strategic direction called Our Journey to Change.

It sets out why we do what we do, the kind of organisation we want to be and how we will get there by delivering our three goals and living our new values of respect, compassion, and responsibility all the time.

The big goals we have committed to deliver over the next five years are:

- to co-create a great experience for patients, carers, and their families
- to co-create a great experience for our colleagues
- to be a great partner

Our Journey to Change is at the forefront of everything we do.

There has been a huge amount of work since the launch of Our Journey to Change - we're a very different organisation. We continue to make significant progress, with a focus on providing safe and kind care and improving people's experience of our Trust. This was acknowledged in our latest Care Quality Commission (CQC) well led report.

Since the launch of Our Journey to Change 2021, we've seen the positive impact that it's had on people's experience of our Trust. Whilst we know there is more work to do, we are continuing to build on our progress and make further improvements to make sure the communities we serve get the mental health and learning disability services they need and deserve.

Our Journey to Change: The Next Chapter

In July 2024, we once again held Our Big Conversation where we asked four key questions based on:

- Our journey so far
  - **What are the things we've done well over the last few years to improve the experience we provide to people in our care, families and carers, our colleagues and our partners?**
- Improving the experience of people in our care and their families and carers
  - **What big things should we start, stop or change to deliver an exceptional experience to people in our care, their families and carers?**
- Improving the experience of our colleagues
  - **What big things should we start, stop or change to deliver an exceptional experience to our colleagues?**
- Improving the experience of our partners
  - **What big things should we start, stop or change to be a great partner?**

Our Big Conversation 2024 closed on Friday 9th August 2024 and aimed to strengthen existing intelligence about the impact work has had since the Trust's strategic framework was approved back in January 2021.

990 people took part in this, including 752 Trust staff, 143 people with lived experience (service users / ex-service users and family members), and 95 people in partner organisations. The Board also held a strategy

focussed board workshop on 14 September 2024 which considered the feedback from the Big Conversation and changes in our strategic and operational environment such as the Darzi Report (see part 3.3 of this Quality Account document for further information).

Since that September 2024 workshop, an iterative process to develop a revised set of words for Our Journey to Change has taken place. This has included a further Board workshop discussion, reports to the Council of Governors, continued engaged with the lived experience reference group, discussions with the Trust's leadership and management network members and a 'check and challenge' internal and external stakeholder survey.

This process produced ***Our Journey to Change: The Next Chapter***.

The main differences between the Board's ***next chapter*** and the 2021 Our Journey to Change are:

- Much shorter, more memorable vision statement which does not duplicate other parts of OJTC.
- Goal 1 now has a broader quality focus, partly due to lived experience reference group feedback that the outcomes of treatment need to be good as well as the experience of being treated by our Trust and that they expect our staff to be knowledgeable and competent as well as having in line with our values and offering good "customer service".
- In Goal 2, the main change is the inclusion of the objective, "Feel safe to challenge, innovate and celebrate". This reflects both the national agenda (e.g. freedom to speak up) but also a view that after several years of progress it is important to celebrate excellent practice to both support staff morale, aid recruitment and support share and spread
- Goal 3's revised objectives recognise the increased national emphasis on neighbourhood-level integration and on reducing health inequalities compared to 2021. We also recognise our role as a major employer or "anchor institution".
- The behaviours attached to the responsibility value place more emphasis on staff doing their duties well and recognise the need for staff to be productive and support innovation and change. The emphasis on openness, accountability and reliability was particularly important to the lived experience reference group (as is the importance of not just listening but acting on what is heard in the compassion value), while productivity is now a national NHS priority.

Delivery and implementation of the Trust's strategy will continue to be via the implementation of Care Group and corporate plans, including transformation programmes.

1.5 Co-creation

We are embracing patient and carer experience and using their insights to continually improve, working in close partnership with patients, families and carers to provide the best possible experience and outcomes.
We also work together with our partners and regulators to ensure we understand what good looks like, so we bring meaningful change to the care we provide. We refer to this partnership-style of working as co-creation. It is at the heart of Our Journey to Change and is fundamental to how we improve the care we provide to the communities we serve.
We want co-creation to run through everything we do, so that it becomes the normal way of doing things.
Including:

- Care plans written in partnership, where patients and families have choice about their care and make shared decisions with their clinician.
- A thriving and diverse involvement community that supports co-creation across all areas of our Trust, such as policy, research, recruitment, and quality improvement.
- A growing and diverse peer workforce across all services, underpinned by peer values and driven by peer leadership.
- Innovative and diverse methods to really hear the experience of all patients and families and understand the relationship between patient experience, complaints and serious incidents.
- Lived experience leadership roles supporting transformation and culture change. By lived experience we mean people who have experience of mental illness as a patient or carer and who are using their experiences and insights to help others.

We have made sustained progress in this area and we have two Lived Experience Directors who joined the organisation in 2022. Throughout 2024/25 they have established themselves across both of our Care Boards, offering a lived experience lens, insight and challenge across strategic decision making in our trust. We are now the first Trust in the country to have a strategic lived experience leadership team with four strategic lived experience roles working across peer support, co-creation and our two Lived Experience Directors.

The strategic lived experience leadership team have broadened the lived experience input across the organisation, by establishing two Co-creation Boards that work closely with our Care Boards and are shaping how we deliver services - putting patient and carer voice at its heart. As well as leading on big transformational pieces of work across the Trust, including the transition from the Care Programme Approach to Personalised Care Planning, Culture of Care Programme and Patient Safety Partner development, in line with our updated Patient Safety Incident Response Framework (PSIRF).

This year, we have also launched our Co-creation Framework, which has been co-developed over several months with the aim of giving clear definitions, co-creation values and types of co-creation that we can use across the Trust and with our partners.

We also employ Peer Support Workers, who have lived experience of mental illness either themselves or as a carer and these roles are continuing to grow. The quality of our peer work implementation has been recognised as a national example of positive practice. The service has demonstrated that it has the experience and expertise to implement into new service areas across the Trust.

Examples of co-creation and lived experience in action:

- The launch of our Co-creation Framework and next steps.

- The co-creation and co-delivery of training to staff and students by patients at Ridgeway.
- Co-designing and developing our approach to patient safety partners under the Patient Safety Incident Response Framework.
- Launching our staff Lived Experience Network.
- A number of co-creation groups have been established and are working with staff on major transformation projects across the Trust, including Community Transformation in Adult Mental Health Services and the Personalised Care Planning approach.
- Service users and carers have joined our Patient-led Assessments of the Care Environment (PLACE) inspections of our wards to offer a lived experience perspective of the wards.
- Service users and carers are involved in the recruitment of staff across the Trust from Board level to community-based teams.

1.6 Patient stories

Anem

A 19-year-old with a passion for advocating children's mental health is committed to using her own lived experience to make "a real difference" to the lives of others. Anem Sharif, an involvement member with the Trust, is determined to play her part in shaping the future of mental health care across the North East.

"I'm confident in my ability to stand up for what's important, ensuring that children's voices are heard, and their mental health is treated as a priority."
"My goal is to build a career in a child mental health setting, where I can actively contribute to improving services and creating a more supportive environment for young people."
"I aim to inspire young people to overcome challenges, embrace their strengths, and navigate life with resilience and hope."

Anem, from Middlesbrough, first became involved with Child and Adolescent Mental Health Services (CAMHS) at the age of 15. At the time she was used to bottling up her feelings but, after working with "an amazing psychologist", she learned that talking and writing about your feelings really helped.

"My biggest challenge I faced was accepting how I felt – mainly because I was always made to seem like I was dramatic or overthinking," said Anem.
"But the dialectic behaviour therapy (DBT) programme I took part in really helped me to process how I felt – and understand how I felt was valid and totally acceptable."
"As a young person, I know this skill made me more confident within myself, as well as being able to provide reassurance to others when facing difficult times."
"I would definitely encourage other young people to participate in DBT, as it can help shape life in a positive and rewarding way, as well as impacting life in a hopeful way."

Anem's experience with CAMHS has given her great insight into the importance of building resilience – and the need to get back up when you have fallen down.

She said: *"A relapse does not have to mean the end of the journey – when there's someone in recovery there is bound to be urges which may end up leading to a relapse.*
"However, just because there was a relapse doesn't mean it is a reason to give up on yourself and how far you have come. Try and try till you reach your full potential and recover.
"Acknowledge your progress, acknowledge what is going right and acknowledge your strengths."

Anem has collected many hints and tips on her own mental health journey as to how young people can help support each other, which she is keen to share – including:

- Validate each other's feelings
- Be by each other's sides during the difficult times as well as the easier times

- Accept how someone is feeling, even if you cannot understand why that is. By doing so you are encouraging others to process feelings as well as experience emotions and learn how to face them without the fear of judgment.
- Understand that your feelings are valid – but that so are the feelings of others, even if the overall opinion on the topic is different.

Anem said: "My goal is to heal young people. I acknowledge it is never easy, but being in that patient setting and having that lived experience I feel makes me stronger for the role.

"I want to empower and guide young people to realise their full potential and view life through a positive lens."
"By offering support, encouragement, and practical tools for personal growth, I want to help create a generation that not only believes in their worth but also uses that belief to create meaningful, impactful lives."
"Ultimately, my goal is to be a source of light, helping young people transform their mindset and approach to the world, paving the way for them to succeed and thrive."

Anem won the Involvement Member of the Year award at our Star Awards last year, for her work with CAMHS to develop a Dialectical Behavioural Therapy Group for young people.

Niki

An inspirational Redcar mum who felt "on the scrap heap" after struggling with her mental health is now looking forward to a brighter future – thanks to the support of Trust staff.

Niki Wass was in "a dark place filled with pain" when she was admitted to Roseberry Park Hospital in Middlesbrough in 2022, after attempting to take her own life.

"I was convinced my family would be better off without me," she recalls. *"But somehow, I survived, and being in hospital gave me the pause in life I needed to reflect on things."*

Niki, 45, suffered from bouts of depression as an adult, but managed to balance running her own care business with her role as a mum-of-three – until a difficult breakup in 2019. Just a year later she was diagnosed with fibromyalgia and IBS and, as she grappled with family issues, so her anxiety and depression grew progressively worse.

Eventually, she had to step back from her business and was signed off work. Then, COVID-19 hit. As the lockdowns began, so Niki's mental and physical health spiralled downwards.

"I felt worthless, lost all my self-respect, felt lost without a job to be proud of and was in a lot of physical pain too," she said. *"It was a very dark time in my life."*
"My admission to hospital brought the support I needed. But, as time went on, I realised that getting up and doing something would be the key to my recovery – I wanted to help others."

Just three months after her discharge, Niki was back on the wards of Roseberry Park – this time as a volunteer. Her dream of helping others was starting to come true.
Then, when the Trust's Involvement and Engagement (I&E) Team reached out to volunteer services for some administrative support, Niki offered to help – a move which "changed her life".

"Volunteering with the involvement staff gave me a lot of confidence and helped me regain my self-worth," she said. *"I realised I still had something to offer within the workplace."*

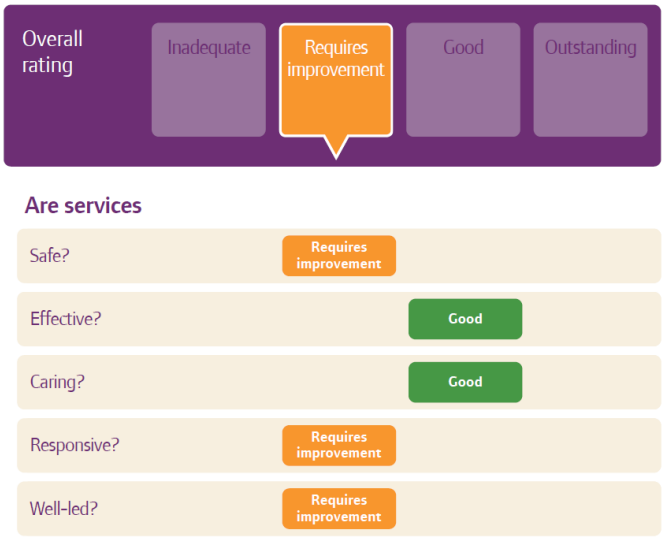
After several months of volunteering, involvement staff – including Dawn Teeley and Jess Wilkinson Niki was encouraged to study for specialist administrative courses and apply for paid jobs.
Within weeks she was offered two posts, and now works as an Outreach Support Co-ordinator with a mental health team – helping others as she has always hoped to do.

"I firmly believe the support I received from the involvement team and volunteer service has been essential to my recovery, and that it's the reason I now have my dream job," she said.

Ann Bridges, Executive Director of Corporate Affairs and Involvement at the Trust, said: "*Niki's inspiring story shows the power of co-creation in supporting the wellbeing of people. By working together with staff, partners and patients, we can really help make a difference to people's lives as part of their recovery, giving them the confidence to take that next step*."

1.7 Our CQC ratings

The CQC's current ratings for our Trust overall and for each key domain is as follows:



Overall, our current CQC rating is **Requires Improvement**

For each key domain our Trust is rated as follows:

Safe	**Requires Improvement**
Effective	**Good**
Caring	**Good**
Responsive	**Requires Improvement**
Well-led	**Requires Improvement**

Further information is provided within section 2.13: What the Care Quality Commission (CQC) says about us.

1.8 What we have achieved in 2024/25

We're making progress on our goals and working together to co-create a great experience for patients, carers and families, for colleagues and to be a great partner.

How we're co-creating a great experience for patients, carers and families

- CQC rated our Mental Health Crisis Services, Health Based Places of Safety and Liaison Services as good following an inspection in June 2024.
- NICHE undertook a Phase 2 Assurance Review of Practice and Governance which focused on patient safety incidents, complaints and safeguarding events. NICHE found that our CAMHS services had implemented and sustained the recommended improvements in practice.
- Hospitality Assured rated the Trust as 'world class' hospitality – the highest standard of customer service quality standard accreditation that can be achieved.
- Teesside Crisis Assessment Suite (CAS) is shortlisted in the Seni Lewis Award category of the Health Service Journal (HSJ) Patient Safety Awards.
- Services have implemented the national OPEL (Operational Pressures Escalation Levels) Framework, which has improved bed occupancy, sustainability of reduced out of area placements and internal governance of patient flow.
- Implemented NHS 111 (select mental health option 2) service, which has improved response times for people needing to access services.
- Introduced York and North Yorkshire Mental Health Treatment Requirement (MHTR) Team to support people sentenced to a community order and who have a mental health need.
- Implemented the Durham Community Reorganisation Plan for MHSOP (mental health services for older people) with significant benefits such as reduced waiting times and enhanced the quality of care.
- Actively engaged with the Culture of Care Programme, backed by NHS England, to help improve the experience of those in our care.
- Delivered trust-wide workshops with clinical and operational colleagues to explore moving from a risk-based culture to one that focuses on therapeutic benefits and outcomes - implementing the GIRFT (Getting it Right First Time) principles across our services.
- Worked with the family of a patient who sadly died in our care to create the Chris's Voice Campaign, which aims to help improve involvement of patients and families in our care delivery.
- The Personalised Care Planning Policy has been developed, ratified and is moving into implementation.
- 600 patients have been supported with their paid employment aspirations and achieved 300 paid employment outcomes.
- 849 concerns have been managed locally at ward or team level (local issue resolution). Complaints were managed as an early resolution complaint (385 in total) and 116 were managed as a formal complaint, ensuring concerns are addressed timely.
- Increased the number of complaints responded to within our originally agreed timeframes by 15%
- Secure Inpatient Services held an equality inclusion event at Ridgeway with awareness sessions and the launch of AQA training for patients to gain a qualification in EDI (equality, diversity and inclusion) and race.
- Launched a dedicated CAMHS (child and adolescent mental health services) web section on our trust website – this was co-created by children and young people, their parents and carers, and staff and is a fantastic resource for everyone.
- 411 patients participated in research approved by a Research Ethics Committee across 28 NIHR (National Institute for Health Research) portfolio research studies (patients receiving relevant health service provided or sub-contracted by our Trust in 2024/2025 that were recruited during that period).
- Successfully contributed to several successful NIHR applications, including a £1.8m NIHR Work and Health Programme Award.
- Promoted PRES (Patient Research Experience Survey) and helped secure hundreds of new sign-ups to Join Dementia Research.
- The Trust were joint fourth place nationally for the number of recruiting 'interventional' mental health research studies.

- The peer workforce increased by 24% meaning more people with lived experience of mental health difficulties are using their experiences and specialist training to support patients, carers and families.
- Launched a 360-degree virtual tour of the Dalesway Unit, Roseberry Park Hospital, to relieve anxiety for first time visitors to the service.
- Significantly reduced our use of IS (independent sector) beds.
- Wellbeing in Mind (North Yorkshire school support service) now supports 64 schools within Hambleton and Richmond, Selby, Scarborough and Ryedale, and Harrogate and York.
- A new six-week course co-designed by veterans for veterans was launched by the ARCH Recovery College.
- Delivered c£2m life cycle expenditure to improve and maintain the Trust's property portfolio to a high standard, aligned with CQC Quality Standards.
- There have been improvements and new facilities at Lanchester Road Hospital, Roseberry Park Hospital and Worsley Court.
- Refurbishment works have started at the One Life Centre in Hartlepool (to be completed by June 2025), providing a much-improved environment for those accessing our services currently at Stewart House.
- Works have started on Jesmond House to provide a multi-speciality hub for the teams in Harrogate and an increased capacity for clinical appointments.
- The agreement for lease has been signed for the new Combined Care Centre at Catterick, providing purpose designed accommodation for community teams, currently based in Colburn, with an increased capacity for clinic appointments.
- Successful bids against national sustainability funds have been achieved for LED lighting, solar panels, and BMS (building management systems).
- Awarded new solar panel funding, saving of £157,000 a year which is supporting investment into patient care.

How we're co-creating a great experience for colleagues

- Achieved the Better Health at Work Award Gold status and are now working towards 'continuing excellence' in 2025.
- A Leadership and Management Academy has been rolled out across the trust to strengthen the skills of current and future leaders and empower colleagues to be the best they can be.
- Over 550 colleagues have been helped by the Reasonable Adjustments Team and have reclaimed £65,452.32 from Access to Work.
- There were 492 nominations received for our annual staff awards (Star Awards), celebrating colleagues who do amazing work and go the extra mile.
- Launched our new staff lived experience network and established co-creation groups to work with staff on major transformation projects across the trust.
- Employed a peer lead for Culture of Care in inpatient services to provide leadership to inpatient peer support workers and support the trust's drive to implement Culture of Care standards.
- Co-created a Co-creation Policy, which includes a clear and robust processes. We have also established 27 Co-creation Champions trained and inducted so far with expansion planned.
- Confirmed funding to establish Peer Worker roles across DTVF (Durham Tees Valley Forensic) Crisis Teams.
- Increased volunteers by 17% (moving from 237 in 2023 to 277 in 2024).
- 59 people attended the Step Towards Employment Programme in 2024, with an average rating for usefulness of the course of 4.6 (out of 5).
- There have been measurable improvements in January 2025 from the NQPS (National Quarterly Pulse Survey), which helps us understand employee experience and support decision making and actions for improvement.
- A full review of mandatory and statutory training has been undertaken aligned to national priorities.
- Personalised care planning training has been implemented and is a mandatory in-person training model with top-ups every three years. We have also recruited to three involvement members to support communication, training, and policy implementation.

- Five positive and safe care trainers have successfully completed a moving and handling train the trainer course to increase the team capacity – work is ongoing to increase the number of trainers who can also train colleagues in Resuscitation.
- Improved clinical supervision recording continues following embedding of the TEWVision system.
- In-person events have resumed for our trust's welcome inductions, delivering two per month.
- Demonstrated a reduction in vacancies, which has had a positive impact on care delivery.
- Reduced use of agency staff within inpatient and community services from 32% (April 2024) to 10% (March 2025).
- Introduced a three-week Ridgeway Welcome Programme at Roseberry Park Hospital for all new Ridgeway staff and increased the staff retention rate to 88%.
- Outsourcing timeframes have reduced to ensure that shifts remain with the bank giving bank workers increased opportunities to fill shifts. Successfully recruited to the bank, via recruitment campaigns, which increased the bank fill rate from 48% to 72%.
- Pre-employment checks moved back in-house (from NHS Business Services Authority) and improved completion time from an average of 59 days to 24 days.
- There has been an extensive review of our Managing Concerns Procedure in collaboration with Staffside (union representatives), further embedding our Just and Learning Culture.
- The first TEWV 10K run took place at York Racecourse in April 2024 with another planned for 2025.
- The first TEWV 5K run took place in and around HMP Kirklevington Grange in March 2025.
- The staff-led Health and Wellbeing Council received 91 bids for charitable funding and approved 42 of them, with services and teams awarded £99,000 for local initiatives.
- Increased health and wellbeing champions from 304 to 349 (+14.8%).
- Launched sexual safety in the workplace toolkit and domestic abuse toolkit to guide managers and colleagues.
- A new Medical Strategy has been developed, following stakeholder involvement, as part of Our Journey to Change, which focused on training the future generation, optimising recruitment of medical staff, being an attractive place to work and having a strong engaged workforce.
- There has also been a new TEWV Charter for the Medical Workforce to ensure high standards of support and professional development for colleagues.
- A Medical Directorate Equality Group has been established to consider issues affecting the experiences of medical students and doctors within our trust including gender, race, LGBTQ+, disability and religious practice and expression.
- The Faculty of Medical Education hosted its annual, internal educational audit visit to enhance quality monitoring and assurance for all postgraduate and undergraduate activity within the trust.
- Team and service-level Workforce Plans have been developed to support services to plan for the future workforce that they need, with support put in place for leadership teams including online training modules, guidance and templates and a Community of Practice.
- Introduced recruitment for 16 and 17-year-olds through apprenticeships, T-levels, volunteering and work experience placements across a variety of roles and specialties.
- Received 50 requests for work experience placements and sourced placements for 36 (73% success rate).
- 184 staff started an apprenticeship and 130 staff completed an apprenticeship.
- Gained a new contract for Liaison and Diversion Services for Durham and Cleveland Police Force areas
- Gained CQC Registration and established the mental health services for the new HMP Millsike.
- The Lived Experience Manager for Learning Disability and Neurodiversity has been honoured with the Outstanding Contribution to Positive Behaviour Support Award by the British Institute of Learning Disabilities (BILD).
- The Trust has won a total of five awards and several highly commended accolades at the National Positive Practice in Mental Health Awards (PPiMH) 2024.
- Nurses, Sue Sargeant and Claire Donnelly, were awarded Learning Disability Nurses of the Year at British Journal of Nursing (BJN) Awards in London following national recognition for their work to stop the over medication of people (STOMP) with a learning disability, autism or both.

- Dr Jennifer Gilligan won Specialty Doctor / Associate Specialist of the Year at the Royal College of Psychiatry (RCPsych) Awards.
- The Volunteer Service Co-ordinator, Kelly Conway, and her therapy dog Ruby, won the animal award at the BBC Make a Difference Awards.
- The NEPACS (North East Prison and Criminal Justice Network) award was won by a member of our SOTT (secure outreach transitions team) and a certificate of excellence was awarded to another STOTT colleague.
- The Health and Justice Mental Health Treatment and Review Team were recognised with a certificate of excellence at NEPACS. The Ruth Cranfield Awards also celebrated exceptional work for rehabilitating prisoners into society and helping cut the risk of re-offending.

How we're working with our partners

- Systemwide, Peer Support Worker Networks have been established in County Durham and York in collaboration with local VCSE (voluntary, community and social enterprise).
- The Co-creation Framework, which has been co-developed over several years has been launched and aims to give clear definitions, co-creation values and types of co-creation that we can use across the trust and with our partners.
- The Trust joined the Yorkshire and Humber Perinatal Mental Health Provider Collaborative, working with seven other providers in Yorkshire and Humber to improve perinatal mental health care.
- The Distress Brief Intervention (DBI) service has been expanded across County Durham, along with partners at Everyturn, following the success of the initial programme in Derwentside.
- Enhanced Health in Care Homes Service, working in partnership with primary care colleagues and carers was awarded Highly Commended at the Yorkshire and Humberside Great British Care Awards 2024.
- We are transforming our services. Personalised care planning, working with partners across the public and voluntary community and social enterprise sector, is transforming the way people with mental illnesses are supported within their local community.
- We have worked with partners to open a new Wellbeing Hub, in Wellington Square, Stockton to support the wellbeing of local people and the Tees Valley Community Mental Health Transformation Programme.
- Forums for learning disabilities have been established, working with North Yorkshire York and Selby Improving Together and Durham Tees Valley and Forensics Group, People with Power to make changes for people with learning disabilities.
- A transitions pilot is being developed with three VCSEs organisations, in partnership with urgent care and peer leaders in our trust – this is a one year pilot to support 18 to 25-year-olds admitted to our wards with intentional lived experience roles.
- We have commenced conversations with CNTW (Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust) to share good practice in the learning and development contract.
- Over 200 people attended our trust's AGM (annual general meeting) in Darlington, which this year showcased our collaborative approach with valued partners to improve the lives of people in our local communities.

Living our values

Our Journey to Change sets out why we do what we do and the kind of organisation we want to become. It also sets out how we'll get there by living our values, respect, compassion and responsibility – all of the time.

It's important that we recognise and celebrate when we're truly living our values, and we encourage people to share examples of this. Each month we hold a living our values award, recognising colleagues who are living our values and the positive impact it has on the experience for people in our care, families and carers, colleagues and our partners. In 2024/25, there was an increase in nominations from patients, carers, partners and colleagues.

1.9 National awards – won and shortlisted

In addition to our Trust achievements listed above, external bodies have recognised the work of individuals or teams through the award shortlisting, or award wins listed in the table below.

Award	Awarding status	Name / category of award	Team / individual
Skills for Health Awards	Winner	Best Healthcare Workforce Collaboration	Reconnect team
Teesside Healthwatch Star Awards	Winner	Excelling in support to others Award	Sue Sargeant
Positive Practice in Mental Health Awards	Winner	Forensic Mental Health Services (including criminal justice, inpatient, liaison & diversion and prison mental healthcare)	Integrated Support Unit, HMP Durham
Positive Practice in Mental Health Awards	Winner	Outstanding Leadership for Band 7 and 8 staff – Individual Award	Richard Hand
Positive Practice in Mental Health Awards	Winner	All Age Eating disorders Services for Adults or Children and Young People	Teesside Children and Young People Community Eating Disorder Service
Positive Practice in Mental Health Awards	Winner	Older adult functional mental health services and/or dementia care	County Durham and Darlington Care Home Liaison Hub
Positive Practice in Mental Health Awards	Winner	Addressing mental health inequalities	The REACH team, Scarborough
Positive Practice in Mental Health Awards	Highly Commended	Innovation in Community Mental Health (including Primary Mental Health Care)	The REACH team – Scarborough
Positive Practice in Mental Health Awards	Highly Commended	Perinatal and maternal mental health	North Yorkshire and York perinatal team
Positive Practice in Mental Health Awards	Highly Commended	Suicide prevention services with a focus on initiatives which encourage multiagency working (LA / PH / NHS / Police / Third sector)	Familiar Faces
Positive Practice in Mental Health Awards	Highly Commended	Outstanding Leadership for Band 7 and 8 staff – INDIVIDUAL AWARD	Karla Shariff
Positive Practice in Mental Health Awards	Highly Commended	Mental Wellbeing of the Workforce	Kestrel Kite ward
Positive Practice in Mental Health Awards	Highly Commended	Mental Wellbeing of the Workforce	Employee Support Service
Positive Practice in Mental Health Awards	Highly Commended	Innovation in Digital Mental Health Care	Recovery College Online

Award	Awarding status	Name / category of award	Team / individual
Positive Practice in Mental Health Awards	Highly Commended	Non-Clinical Team of the Year (inc. admin, facilities, finance, housekeeping etc.)	Employee support services
Positive Practice in Mental Health Awards	Highly Commended	Complex mental health needs, including services working with people with a diagnosis of personality disorder	Wellbeing Unit: Regional Enhanced Mental Health Unit – HMP Hull
Positive Practice in Mental Health Awards	Highly Commended	Specialist Services (including, Veterans, Substance Misuse, Addictions, Housing, Education and Employment)	Individual Placement and Support (IPS) team
British Institute of Learning Disabilities International Positive Behavioural Support conference	Awarded	Outstanding Contribution to Positive Behaviour Support	Debbie Austin
Teesside University: Student Nursing Associate Awards	Winner	Champion for patient/service user care	Danielle Calvert
Teesside University: Student Nursing Associate Awards	Winner	Outstanding care and compassion in patient/service user care	Martin Young
The Learning Disabilities and Autism Awards	Highly Commended	Learning Disability Nurse of the year	Sue Sargeant and Claire Donnelly
Healthcare Financial Management Association (HFMA)	Winner	Unsung Hero of the Year	Emma Cruttenden
Healthcare Financial Management Association (HFMA)	Winner	Finance team of the year	Finance team
Healthcare Financial Management Association (HFMA)	Winner	Lifetime Achievement Award	Drew Kendall
Cavell Star Awards	Winner	Awarded	Hayley Hawksby
NEPACS Ruth Cranfield Award	Winner	Awarded	Stephen Harding
HSJ Patient Safety Awards	Winner	Staff Wellbeing Initiative of the Year	Humber and North Yorkshire Resilience Hub
BBC Radio Tees Make a Difference Awards	Winner	The Animal Award	Kelly Conway and Ruby
RC Psyche Awards 2024	Winner	Specialty Doctor/Associate Specialist of the Year	Jennifer Gilligan

Award	Awarding status	Name / category of award	Team / individual
Great British Care Awards	Highly Commended	Social care nurse of the year	Enhanced Health in care Homes service
Bright Ideas in Health Awards 2024	Winner	Research for Local Health Needs	Increasing Access to Healthy, Affordable Food for Adults Living with Severe Mental Illness in Teesside – Teesside University
Cavell Star Awards	Winner	Awarded	Shelley Glover
Woman Achieving Greatness in Social Care awards	Winner	Outstanding Partner Award	Claire Donnelly & Sue Sargeant, Primary Care Liaison Nurse & Advanced Nurse Practitioner, Tees, Esk & Wear Valleys NHS Foundation Trust
Better Health at Work Award	Awarded	Gold Award	Trustwide wellbeing service
British Journal of Nursing (BJN) Awards	Winner	Learning Disability Nurses of the Year	Sue Sargeant and Claire Donnelly

Part Two: Quality priorities for 2024/25 and required statements of assurance from the Board

2.1 Introduction – purpose of this section

In part two of our Quality Account, we outline our planned quality improvement priorities for 2024/25 and provide a series of statements of assurance from the Board on mandated items as required by NHS England.

In this section, we also review the progress we have made in relation to the quality priorities we set ourselves.

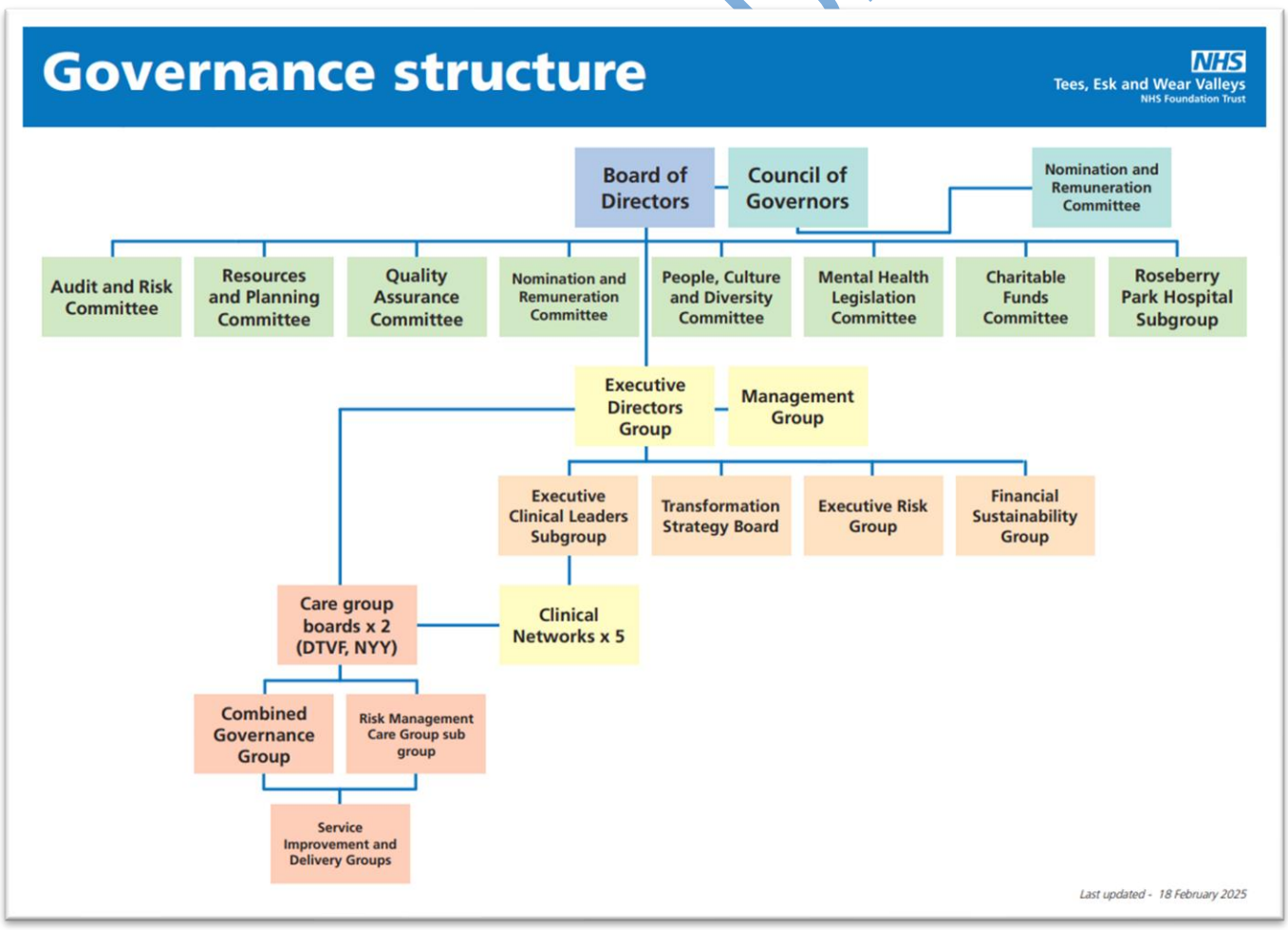
2.2 Our approach to quality governance and improvement

Our Trust has a robust governance infrastructure. Our governance structure is focused on clear oversight and accountability and is supported by the Trust's Accountability Framework.

The governance structure supports the delivery of Our Journey to Change by making sure that we are:

- Clinically led and operationally enabled.
- Better able to align around the regional changes in the form of the two Integrated Care Systems in which we provide services.
- Able to deliver on individual and collective system wide accountability effectively and consistently, by making all roles clearer and manageable for post holders.
- Organised in a more simple, less complex way formally incorporating patient leadership into our structures.

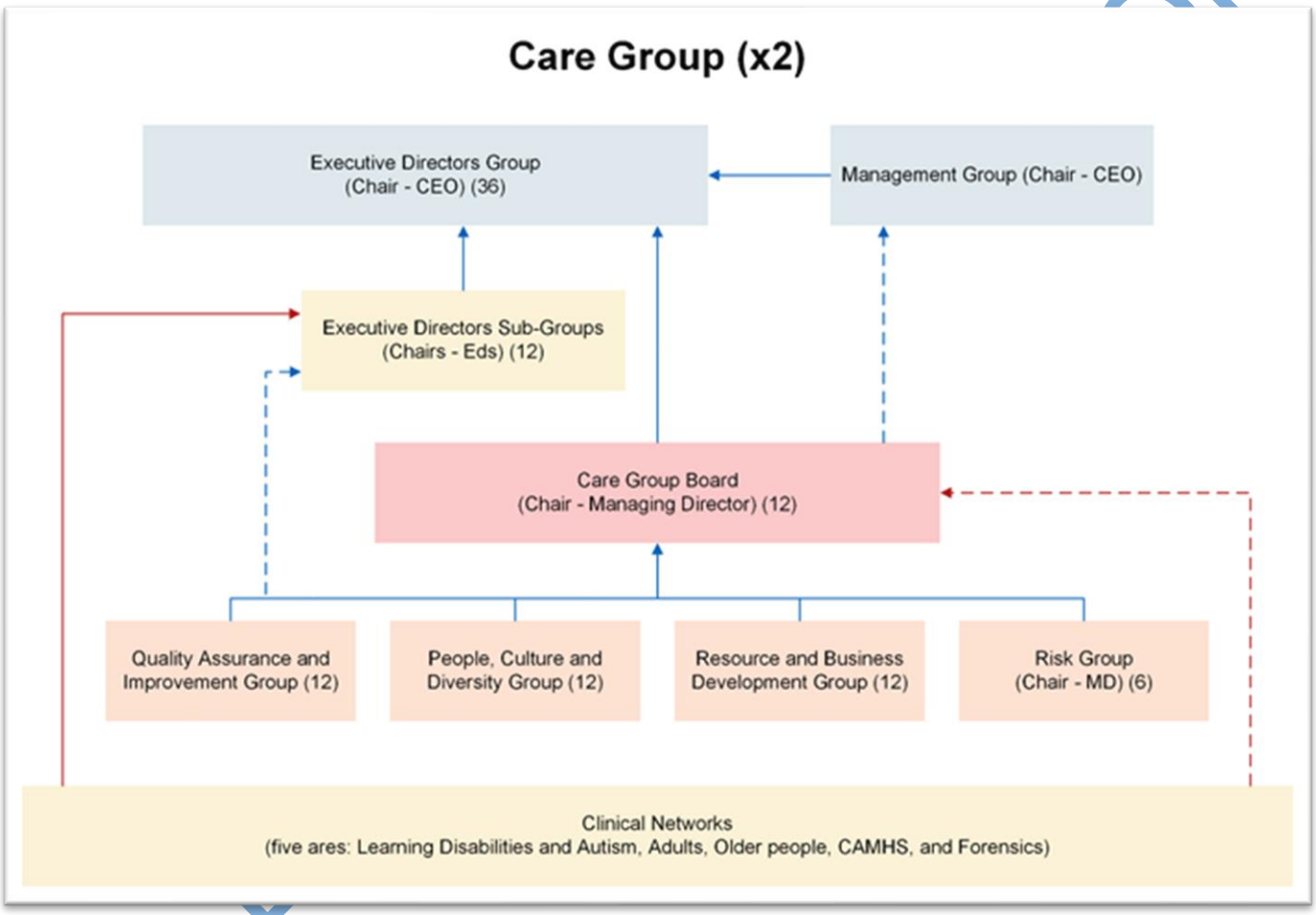
The governance structure in place during 2024/25 is shown in the figure below:



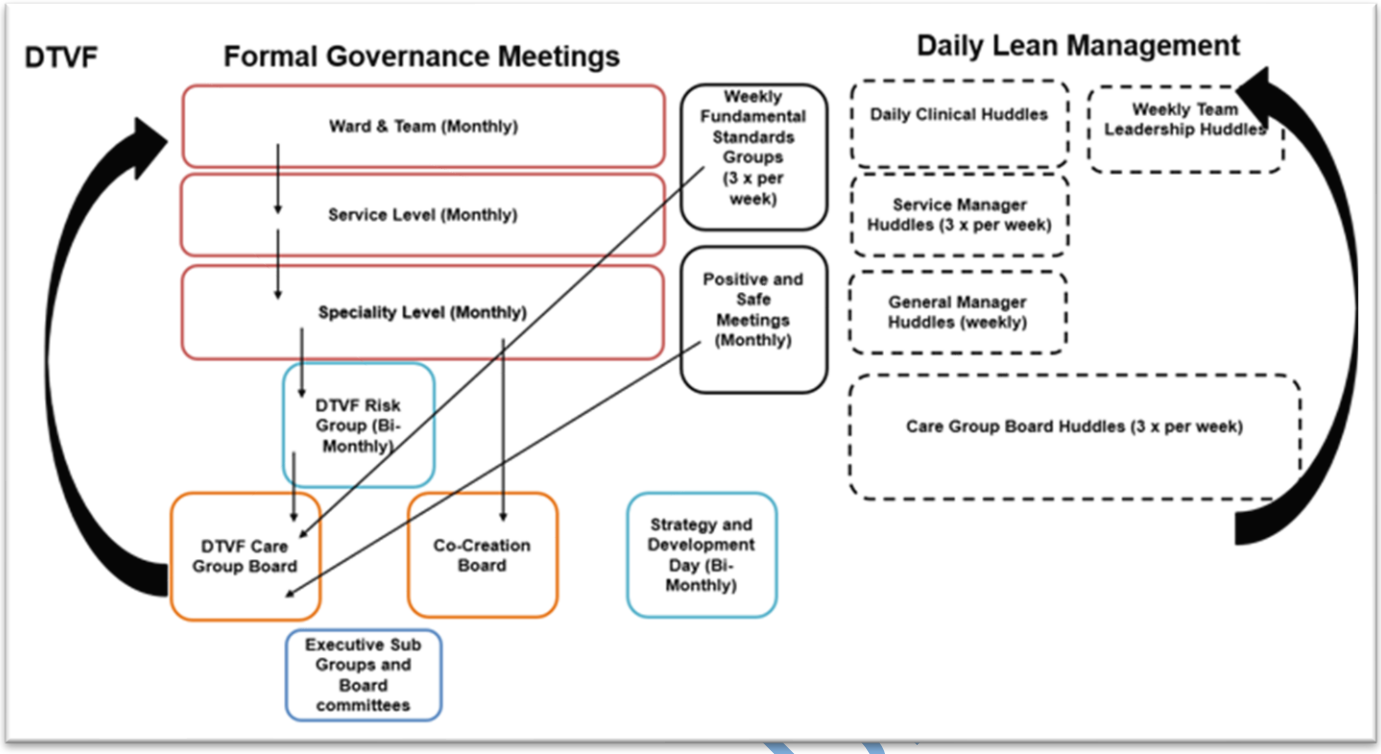
Our Trust Board ensures robust quality governance through the Quality Assurance Committee, a Committee of the Board.

The Quality Assurance Committee is chaired by a Non-Executive Director. Its strategic purpose is to provide assurance to the Board on the quality, safety and effectiveness of clinical and operational services through effective systems, structures and processes.

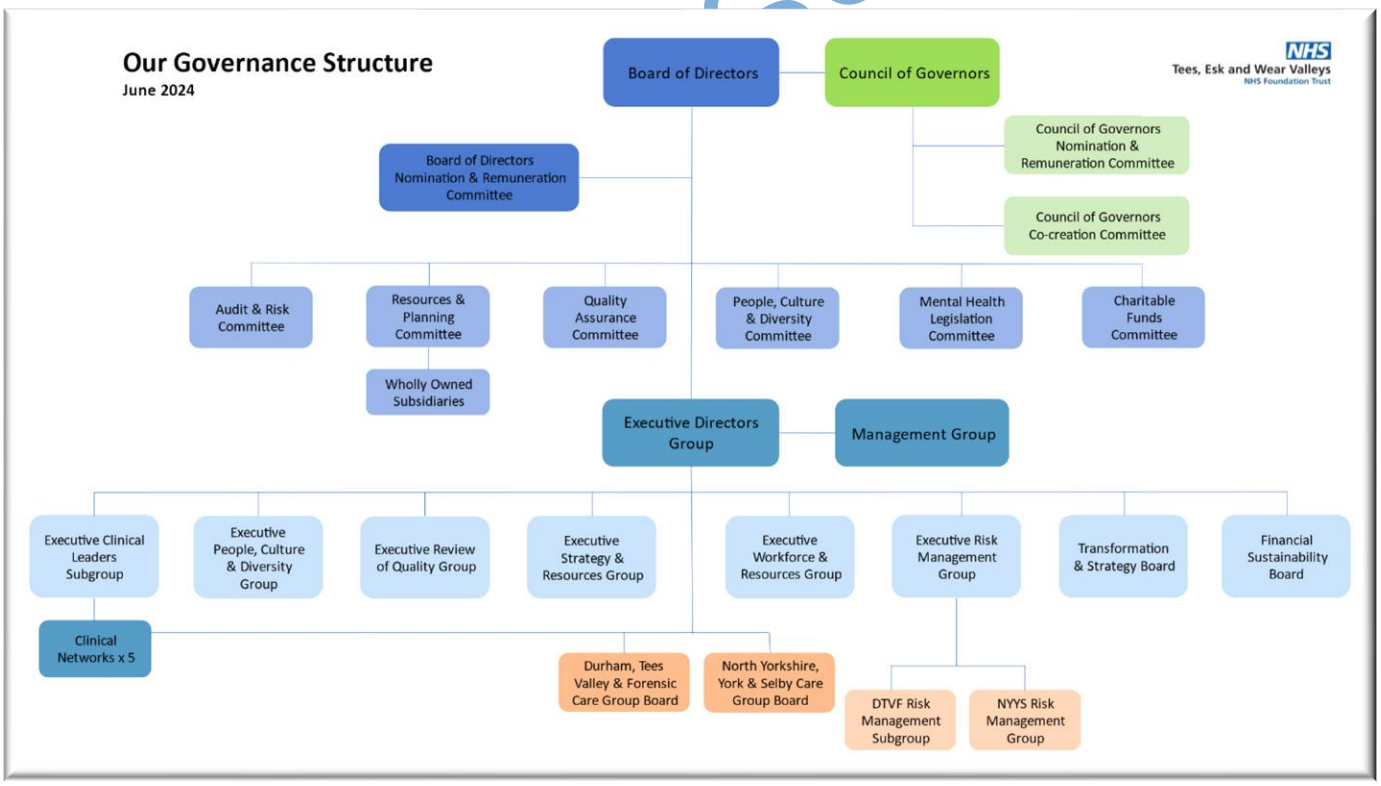
Care Groups:
Each Care Group has quality governance arrangements to address the key elements of quality and safety. These are outlined in the figure below. Each Care Group reports directly to the Executive Directors Group monthly, on quality performance issues that require executive oversight and/or escalation. Each Care Group is also required to provide assurance to the quality assurance committee regarding how it is improving the quality of services.



Durham Tees Valley and Forensic Care Group:



North Yorkshire, York and Selby Care Group:



Quality Assurance and Improvement

Our well established and embedded Quality Assurance and Improvement Programme continues to be used as a system to help us focus on key quality and safety issues. It has supported us to make improvements including to patient care documentation, recognising that high quality documentation is an enabler of high-quality patient care.

The programme comprises of a range of quality assurance tools that are used to gain a holistic assessment of the quality of patient care. These tools have been reviewed during 2024/25 and continue to be updated to ensure that they are informed by current areas of risk, where further assurance is required. The Programme includes Quality Reviews, Peer Reviews and Leadership Walkabouts.

The Quality Assurance and Improvement Programme is an effective method of monitoring compliance against key standards of care related to patient safety, clinical effectiveness and patient experience. It has facilitated significant sustained practice improvements and provides the organisation with both quantitative and qualitative assurance evidence. To further strengthen and streamline clinical audit processes including data collection and oversight of key quality and risk areas reviewed, the Trust has started to integrate some of the Quality Assurance tools into the new InPhase Applications. This will be further developed and expanded into 2025/26, using bespoke dashboards within the InPhase App.

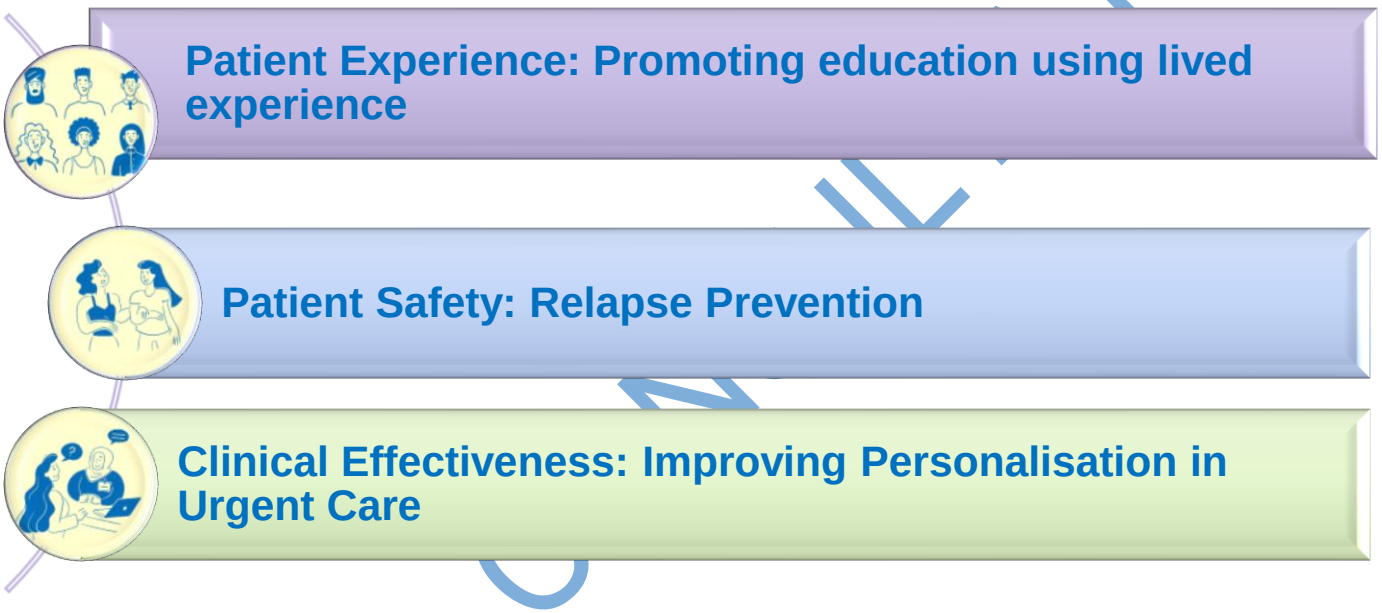
The Quality Assurance and Improvement Programme continues to be reported into the Trust governance structure via the Executive Director's Group and the Quality Assurance Committee.

2.3 Our progress on implementing our 2024/25 quality improvement priorities

As part of the Trust's ongoing commitment to co-creation, it was agreed that from 2024/25, development of the Quality Account Quality Priorities would be led by people with lived experience (and those currently working with Involvement Networks and other community organisations). This approach enables the voice of service users, relatives and carers to be at the heart of quality improvement across the organisation.

The Strategic Fundamental Standards Group have supported the new approach adopted for the development of the 2024/25, co-created priorities and have reviewed proposed measures that align to the priorities.

The Co-Creation Boards have developed the quality priorities for 2024/25 and these were endorsed by the Quality Assurance Committee 04 April 2024:



The following progress can be observed for each of these Quality Priorities:

Why it is important:

This priority is focused on improving accessibility of services and early intervention. Through the identification and review of themes of patient feedback regarding access to services; the use of the Recovery College and patient stories will establish a cycle of learning, which will be shared with key Partners.

What we said we would do and what we did for this Quality Priority:

Our Lived Experience Directors and Involvement Team have experience of developing training sessions for clinical and non-clinical colleagues. The sessions include people with lived experience sharing their experience to support others learning from a lived experience perspective.
The Lived Experience Focus Group and Co-creation Boards told us that it was particularly important for clinical staff in Urgent Care services (including Accident and Emergency, and Primary Care) to understand what is important to patients who present at these services and how they can help to improve patient experience.

The following measures were developed to help us deliver this Quality Priority:

1) We will develop a programme of training that could be offered. This will include facilitating training sessions as well as some formal workshops, in addition to referring to online resources accessible via the Trust Intranet page and other associated communications. We will ensure that this part of the personalised care training that is being delivered internally and externally.

   A Training Lead has been recruited to the Involvement and Engagement Team and commenced in post October 2024. Their role is focused on consolidating existing training packages that the Trust currently use about lived experience and coproduction. This review will incorporate training on personalised care planning. Another function of the Training Lead role is supporting the training roll out across the Trust.

   The Trust Safeguarding and Public Protection Team have been working with groups of young people via Participation Groups and schools to look at what young people think about feeling safe. The voice of the young people will be collated and used in Safeguarding Training and other key work in relation to the impact of parental mental health on children to increase awareness and support early identification of needs for families.

2) We will deliver the identified training programme throughout Quarter 3 and Quarter 4 to internal and external colleagues and Partners (considering voluntary services)

   Training and development sessions have now been co-created on the new 'Co-creation Framework' and are available to all teams.

   The induction and training programme for Involvement and Engagement members has been re-designed and rolled out. Work continues into the new year to co-create a development programme for Involvement and Engagement members.

   Partnerships with local acute Trusts have been strengthened and a range of training opportunities have been made available to enhance care for patients. Health and Justice also continue to deliver training to HMPs and Partner organisations.

Priority Two: Patient Safety: Relapse Prevention

Why it is important:

This priority is focused on timely and proactive access to support for patients who experience relapse in order to minimise harm, particularly through the effective use of patient's safety and care plans.

What we said we would do and what we did for this Quality Priority:

1) We will review how patient's safety and care plans are used for people in community services, and establish best practice standards for these plans

A review of safety and care plans has been undertaken and further work continues on best practice examples for people using community services.

Relapse prevention has been further supported through the implementation of the new Personalised Care Planning Policy which was fully revised following an extensive consultation period and was published January 2025. A communication and engagement campaign has been initiated to embed the new Policy. This policy works interdependently with the new Safety and Risk Management (previously Harm Minimisation) Policy which was published in October 2024.

Outline guidance for the content of patient's safety and care plans is also available for all staff via the 'Ask Cito' robot along with gold standard examples.

2) We will co-create an audit tool to review the plans

The Quality Assurance and Improvement Programme tools include regular review of patient's safety plan and its co-production with the patient (or significant person involved in their care where they are unable to). This is where wellbeing and relapse prevention needs are documented on the electronic patient record.

Over 2024/25, the Quality Assurance and Improvement Programme has demonstrated:

- For Inpatient Services – improvement in 6 of the 7 relevant metrics, including the metric on co-production, with one metric remaining consistent.
- For Community Services – improvement in 5 of the 6 relevant metrics, including the metric on co-production, with one reducing by one percentage point (with good standards of practice still noted)
- Robust oversight is maintained through our Trust's governance structures.

Priority Three: Clinical Effectiveness: Improving Personalisation in Urgent Care

Why it is important:

This priority is focused on improving the effective use of the 'my story once' approach. The priority will be linked with the community transformation work and also aims to improve patient experience when accessing urgent care services.

What we said we would do and what we did for this Quality Priority:

The following measures have been developed to help us deliver this Quality Priority:

1) The 'My Story Once' principles will be incorporated into the new Personalising Care Planning Policy. This will be circulated for consultation

The 'My Story Once' principles have been incorporated into the Personalising Care Planning Policy and the approach is modelled in the training that has been developed.

The Policy was circulated for Trust wide and external consultation and was formally launched January 2025 (supported by communication and training campaigns).

2) We will review and update the associated online training pack which is currently named 'CPA Module' (which will include the 'My Story Once' approach)

The Personalised Care Planning training package has been reviewed and updated.

3) Staff will have undertaken the online training module on personalising care planning

Planning of the training programme has commenced including a face-to-face training day. This is instead of the online training module on personalising Care Planning previously delivered. The new face-to-face training will reflect the interdependency of the policies mentioned previously and will include training on the new Safety and Risk Management Policy, Personalising Care Planning Policy and Working with People being in distress.

Roll out of the training programme will continue into 2025/26 for all applicable staff.

2.4 Our quality journey

We have continued to focus on five areas to support Our Journey to Change strategy and have worked with patients, carers, partners and colleagues to create our strategy made up of five journeys:

The five journeys are:

- **Clinical** – how we will provide high quality, safe, kind, effective and personalised clinical care to the people we support.
- **Quality and Safety** – how we will make our services safer and improve patient experience through evidence-based care.
- **Co-creation** – how we will seek out and act upon the voices of the people we work with to improve care.
- **Infrastructure** – how the places we work, such as our hospitals and offices, the equipment we use, the information we gather and the systems and processes we put in place will support excellent patient care.
- **People** – how we will ensure everyone who works and volunteers with us has a great experience, whether they're permanent employees, people working as bank staff or through an agency, students or volunteers.

These journeys have set out specific ambitions and principles that support the mission, values and goals of Our Journey to Change and have been progressed alongside a programme of works as part of the 2024/25 delivery plan.

It is our ambition is that by 2028, we will achieve the specific aims and measurable improvements set out in our quality journey, through continuous learning and improvement using a range of tools and enablers. This journey has been shaped by our other journeys; clinical, co-creation, people and infrastructure.

In relation to our **Quality and Safety Journey**, the following progress has been made (as presented to the April 2025 Management Group):

- **Personalised Care Planning:** There are 7 key deliverables within this piece of work and currently the following 5 have been achieved:
    a) We have developed and implemented a strategy to increase access to evidence based psychological therapies.
    b) The Trust Policy for Personalised Care Planning has been ratified and published.
    c) We have rolled out DIALOG to enhance co-produced care planning following the launch of Cito.
    d) We have established a Workforce Development Group to support the delivery of transformation.
    e) We have ensured that there is a comprehensive communications plan in place so that all stakeholders are aware of developments and the related implications
- There are 2 deliverables in progress which relate to continuing to work with ICBs to establish effective interoperability between systems and this work will progress as business as usual into 2025/26.

- **Physical Health:** There are 4 deliverables within this piece of work and currently 3 are complete:
    a) We have scoped recommendations to inform our Clinical Advisory Groups with overarching plans in place.
    b) We have established the Clinical Advisory Group priorities, workplan and targets with oversight via our Trust Physical Health Group.
    c) The approach to physical health for people using our services was presented and endorsed by our Executive Directors and Quality Assurance Committee
- The one area which remains in progress relates to the communication plan being developed with subsequent engagement. This work has been completed on our Trust Intranet and empathy mapping took place during January 2025, however further planning is being undertaken as part of a wider internal communications campaign throughout 2025/26 therefore this will continue to the next year as business as usual activities.

- **Improved patient safety**: There are 5 deliverables within this piece of work and currently the following 4 are complete:
    a) We have fully implemented PSIRF and introduced meetings including the Organisational Learning Group (OLG).
    b) We have integrated Suicide Prevention Leads to patient safety
    c) The Trust Positive and Safe Leads have commenced within both Care Groups
    d) We have reviewed priorities and agreed further key patient safety milestones
- The one remaining deliverable remains on track which involves implementing further InPhase Modules and this will be completed by the end of June 2025.

2.5 Our priorities for 2025/26

The quality priorities outlined in this document will be sustained and carried forward over a three-year timeline to ensure sustained continuous improvement and a steadfast commitment to delivering of high quality care. These are some of the most important priorities for people who use our services and we are therefore committed to supporting a strategic approach that aims to embed these priorities over the next 3 years, within our operational framework.

Key areas which we will continue to improve upon to support the Quality Priorities include:

- Assessing the embeddedness and quality of patient's Safety and Care Plans. This includes reviewing the findings from the established Peer Quality Reviews which are undertaken throughout the year and includes measures for the plans in place and their quality.

- Extensive roll out of new training requirements related to Safety and Risk Management, Personalising Care Planning, as well as training in Being with Distress.

- Assessment of the training to review the impact of improvements in personalisation in urgent care, including evaluating the quality of patient experience feedback.

2.6 Statement of assurances from the Trust

In this section of the Quality Account, our Trust is required to provide statements of assurance in relation to a number of key performance indicators which are as follows:

- Review of services provided by or contracted our Trust
- Our 2024 Community Mental Health Survey results
- Our 2024 National NHS Staff Survey results
- Clinical Audit: participation in clinical audits and national confidential inquiries
- Participation in Clinical Research
- What the Care Quality Commission (CQC) says about us
- Information governance
- Freedom to Speak Up
- Community Transformation
- Learning from deaths
- Local Resolution and Complaints
- Data quality
- Mandatory quality indicators

2.7 Review of services provided by or contracted by our Trust

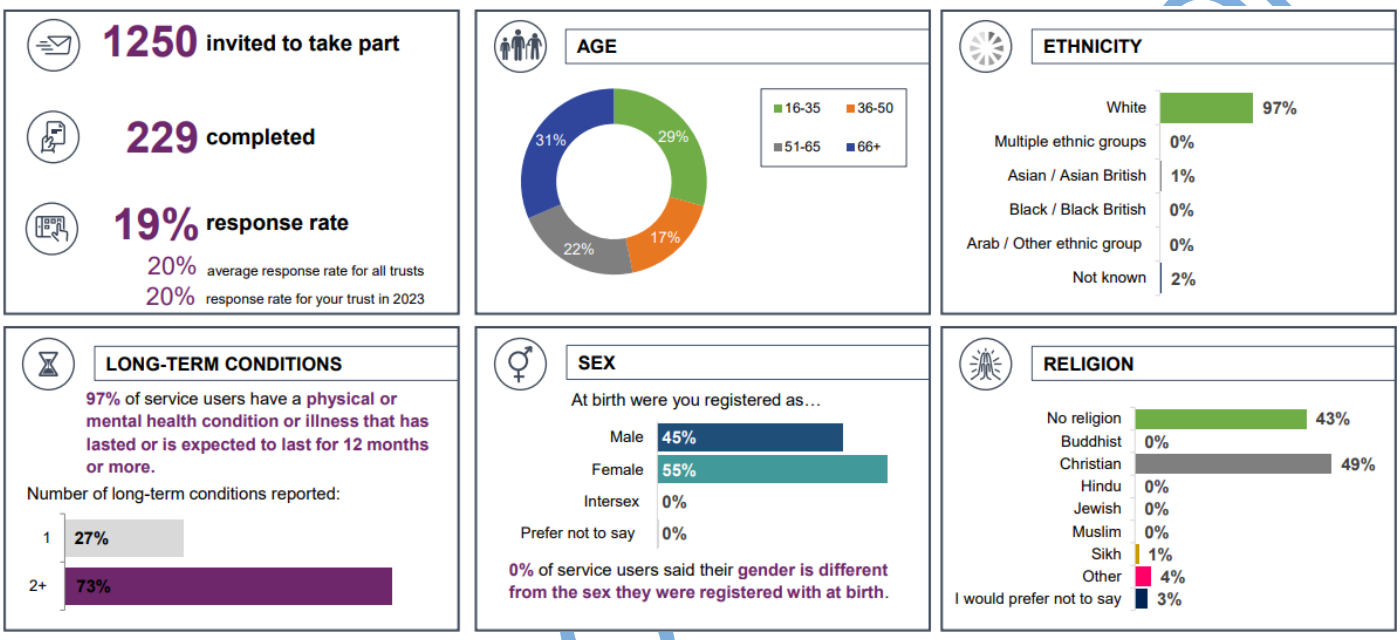
During 2024/25 our Trust provided and/or subcontracted 20 relevant health services. Our Trust reviewed all the data available to us on the quality of care in 20 of these relevant health services.

The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant health services by our Trust for 2024/25.

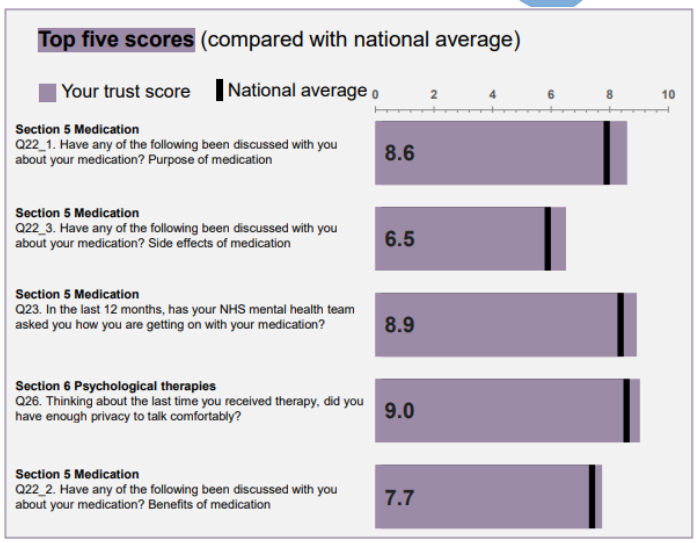
2.8 Our 2024 Community Mental Health Survey results

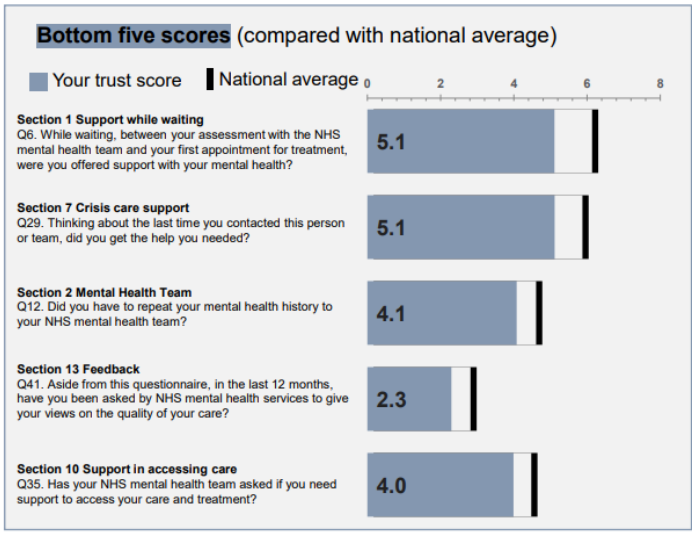
Results of the 2024 Community Mental Health Survey were published 04 April 2025. Feedback was shared from people who received treatment for a mental health condition between 01 April and 31 May 2024. Participants 16 years and older were offered the choice of responding online or via a paper-based questionnaire.

There were 229 completed surveys returned within our Trust for the 2024 Community Mental Health Survey, a response rate of 19%. This is within the same range as to the national average response rate (20%). The following image illustrates the population of our patients who took part in the survey.



The following top five and bottom five scores (compared with the national average) are illustrated as follows:





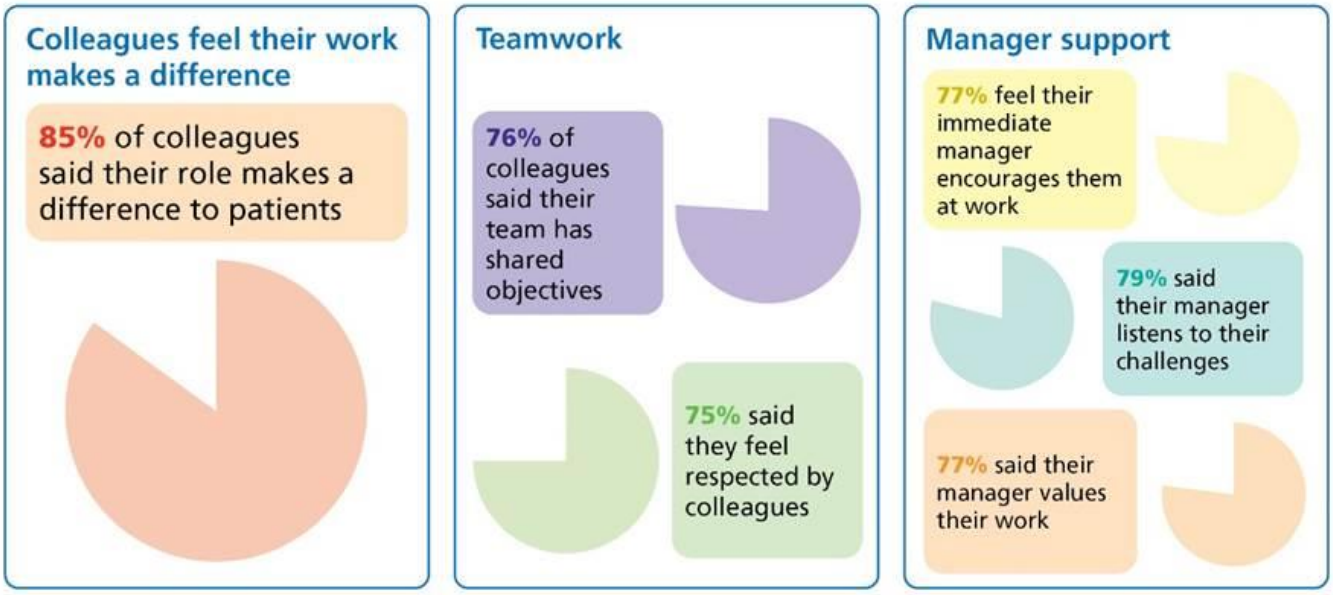
Full results of the survey for our Trust can be found at:
https://www.cqc.org.uk/search/site?fulltext=Mental%20Health%20Survey

2.9 Our 2024 National NHS Staff Survey results

The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. Each autumn NHS staff in England are invited to take part in the survey. It offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling a range of organisations to understand what it is like for staff across different parts of the NHS and work to make improvements.

Our results for the 2024 NHS National Staff Survey were published 13 March 2025 and the following highlights were achieved from receiving 3521 responses:

This year's highlights



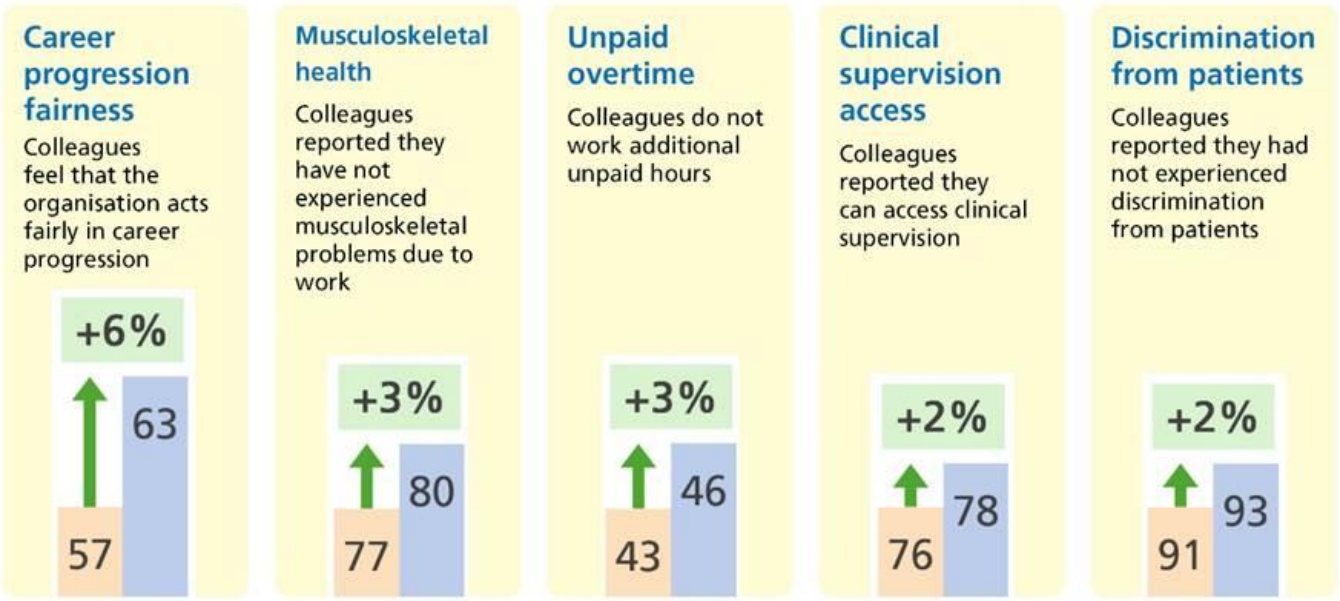
Patient care: colleagues feel their work makes a real difference to patients.
Teamwork: staff say their team has shared objectives and they feel respected by colleagues.
Manager support: staff feel encouraged by their managers, believe their managers listen to their challenges, and feel valued.

Where we're most improved

We've made meaningful progress in several important areas:

- Appraisals
- Reasonable adjustments
- Enough staff to do the job properly
- People feel respected
- Fewer colleagues working unpaid hours

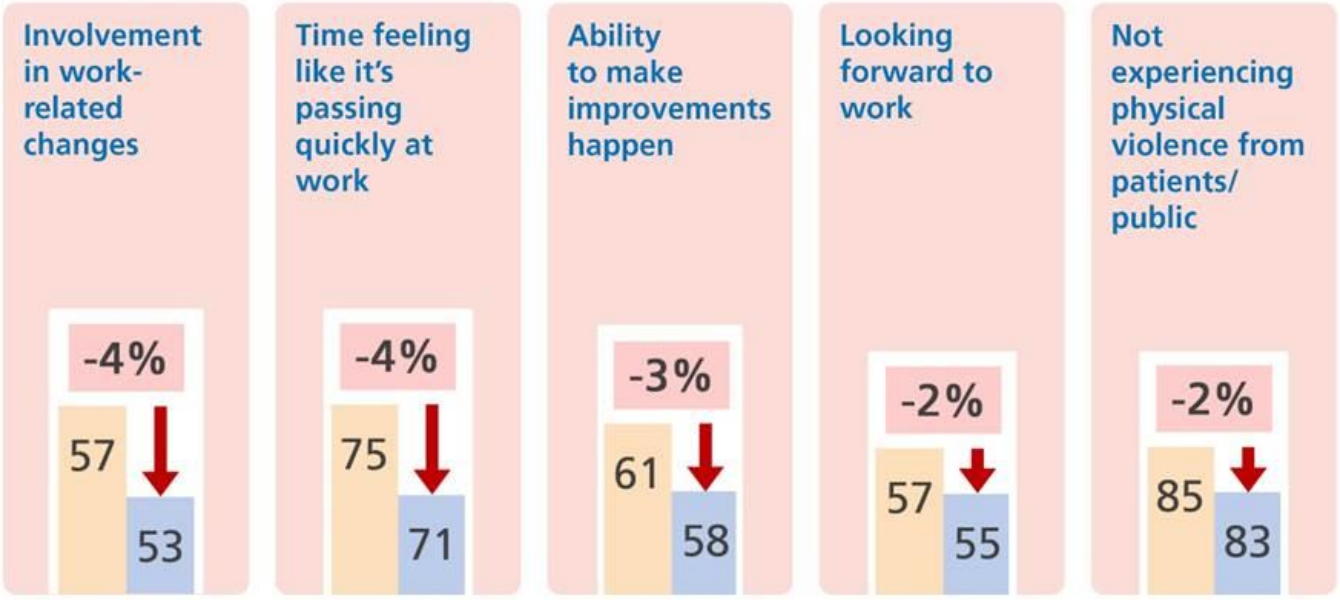
Where we're performing better than the national average



We're proud to be outperforming national averages in key areas:

- Fairness in career progression
- Prioritising health and wellbeing with less staff experiencing musculoskeletal issues due to work
- Reductions in unpaid overtime
- Access to clinical supervision
- Fewer people experiencing discrimination from patients

Where we need more focus



While we're proud of our achievements, we recognise there's still work to do to support you and your team to:

- Feel involved in work-related changes and able to make improvements happen.
- Feel like time passes quickly at work and looking forward to coming into work.
- Feel safe as the number of colleagues not experiencing physical violence from patients or the public has reduced slightly.

What we achieved together following the results of last year's survey

We took significant steps to address staff feedback and several projects have made meaningful changes across our Trust. This included:

- Training reforms: Streamlining mandatory and statutory training to reduce the load and ensure relevance to your roles.
- Health and wellbeing: Achieving Better Health at Work Award Gold status and launching initiatives through a staff-led health and wellbeing council.
- Support for staff: Expanding our reasonable adjustments program, benefiting over 550 colleagues, and launching toolkits for sexual safety and domestic abuse.
- Operational improvements: Reducing recruitment times by 20 days, enhancing digital processes, and establishing a Leadership and Management Academy.

Following the results of this 2024 survey, teams have been asked to review their results and complete Team Worksheets in order to identify areas for improvement and celebrate successes.
Our significant area of focus for 2025/26 is a new suite of management training for all managers (corporate and operational) and clinical leaders in line with the national 'expectations of people managers' framework.

2.10 Clinical Audit: Participation in clinical audits and national confidential inquiries

During 2024/25, **6** national clinical audits and **1** national confidential enquiry covered NHS services that Tees, Esk and Wear Valleys NHS Foundation Trust provides.

During that period, Tees, Esk and Wear Valleys NHS Foundation Trust participated in **100%** national clinical audits and **100%** 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 enquiry that Tees, Esk and Wear Valleys NHS Foundation Trust was eligible to participate in during 2024/25 are as follows:

- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (NAD)
- National Clinical Audit of Psychosis (NCAP)
- POMH Topic 16c: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour
- POMH Topic 21b: The use of Melatonin
- POMH Topic 24a: Opioid Medications in Mental Health Services
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The national clinical audits and national confidential enquiries that Tees, Esk and Wear Valleys NHS Foundation Trust participated in during 2024/25 are as follows:

- National Audit of Dementia (NAD)
- National Audit of care at the end of life (NACEL)
- National Clinical Audit of Psychosis (NCAP)
- POMH Topic 16c: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour
- POMH Topic 21b: The use of Melatonin
- POMH Topic 24a: Opioid Medications in Mental Health Services
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The national clinical audits and national confidential enquires that Tees, Esk and Wear Valleys 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

Audit Title	Cases Submitted	% of number of registered cases required
POMH Topic 16c: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour	Sample provided: 43	**100%**
POMH Topic 21b: The use of Melatonin	Sample provided: 186	**100%**
POMH Topic 24a: Opioid Medications in Mental Health Services	Sample provided: 85	**100%**

Audit Title	Cases Submitted	% of number of registered cases required
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	112 questionnaires sent to the Trust with 71 returned	**63%**

The reports of the **3** national audits were reviewed by the provider in 2024/25 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- The anti-cholinergic medication prescription will be reviewed through the internal webinar.
- The summary of 'Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services' audit findings, along with relevant information and advice to support improved prescribing will be shared via the Medicines Optimisation newsletter.
- A directory has been created on the trust intranet, providing staff with access to relevant palliative care contact details as needed.
- Inpatient nursing staff of Mental Health Services for Older People are being encouraged to complete the online 'End of Life Care' training modules, and this is monitored by the End of Life Care clinical advisory group (CAG) which forms as a working group of the Trust wide Physical Health Group.

The reports of **126** local clinical audits were reviewed by the provider in 2024/25 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- The Trust Procedure for bed rails and bed grab handles was reviewed in light of the findings from clinical audit of bedrails.
- Bespoke MAPPA awareness sessions were delivered to all staff across the Trust. Additionally, a voice over presentation was made available to all staff in the trust intranet page.
- A new mattress audit tool was developed by IPC team for wards to use when self-auditing their patients' mattresses.
- A series of brief online sessions will be delivered to all staff by the Trust Safeguarding team over a six month period, to identify and protect children, vulnerable adults or adults at risk of significant harm.
- The Adult Safeguarding Lead will establish a meeting forum with partner agencies to produce a safeguarding incident reporting flow chart/protocol for prison mental health teams.
- All infection, prevention and control (IPC) audits are continuously monitored by the IPC team and any required actions are rectified collaboratively by the IPC Team and ward staff. Assurance of implementation of actions is monitored by the clinical audit and effectiveness team via the clinical audit action monitoring database. A total of **98** IPC clinical audits were conducted during 2024/25 across inpatient areas, prison teams, and applicable community teams where there are clinic facilities. 66% (65/98) of clinical areas achieved standards between 90-100% compliance. Local clinical audit action plans were implemented in collaboration with the IPC team and the clinical team members to mitigate any areas of noncompliance.

In addition to those local clinical audits reviewed (i.e., those that were reviewed by our quality assurance committee and quality assurance and improvement group), we undertook a further **66** clinical audits in 2024/25 including clinical effectiveness projects by trainee doctors, consultants and other professionals, in addition to those by directorates/specialty groups. These clinical audits were led by the services and individual members of staff to support service improvement and professional development and were reviewed by specialties.

The Clinical Audit and Effectiveness Team is continuing to implement and embed a new electronic application - **InPhase**. This will enhance the efficiency of clinical audits and streamline the process for teams. This platform will allow teams to review their clinical quality information in real time, enabling them

to make informed changes to improve practice. Ultimately, this aims to enhance the quality of care and the experience of patients and their families.

We continued to implement an extensive Quality Assurance and Improvement Schedule during 2024/25. This provides ongoing assurance that key quality and risk issues identified are addressed. Significant improvements in practice and patient safety continue to be facilitated through this programme.

2.11 Participation in clinical research

Our Trust participates in research activity to help provide new knowledge with the potential to be valuable in improving care for patients. It is important such research is open to critical examination and open to all that would benefit from it.

The number of patients receiving relevant health service provided or sub-contracted by our Trust in 2024/2025 that were recruited during that period to participate in research approved by a research ethics committee was **420** across **29** National Institute for Health Research (NIHR) Portfolio research studies. The Trust is fourth place nationally for the number of recruiting 'interventional' mental health research studies.

The Trust recently secured external funding to support a wider range of communities in accessing research participation opportunities. Alongside carrying out research studies, our research team have actively promoted the Patient Research Experience Survey (PRES) and helped secure hundreds of new sign-ups to 'Join Dementia Research'.

As well as acting as a research site and participant identification centre for many studies, our Trust sponsors research including NIHR grant-funded studies. As part of this role, our research and development team actively supports a wide range of researchers and completes governance activities such as conducting monitoring visits, distributing monies, and reviewing and reporting on performance.

During 2024/2025, our Trust successfully contributed to several successful NIHR grant applications including a £1.8m NIHR Work and Health Programme award. We have also created a new regular report to celebrate and help disseminate the outcomes of concluded research studies. We concluded several studies, such as the DREAMS START project for instance which evaluated an intervention for sleep difficulties for those with dementia and their carers; initial results of which showed definitive evidence of clinical effectiveness (click here for the link to the paper).

Alongside this, we have carried out a major overhaul of our research website to include a much wider range of resources and information to assist both researchers and service users.

We continue to work closely with the NIHR Research Delivery Network North East and North Cumbria to support large scale national portfolio research studies, and to measure patient research experience when taking part in studies with feedback and any actions reported to our research governance group. We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers, and staff.

2.12 Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

There were no 2024/25 CQUIN requirements.

2.13 What the Care Quality Commission (CQC) says about us

The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Tees, Esk and Wear Valleys NHS Foundation Trust is required to register with the CQC and its current registration status is registered without conditions for services being delivered by the Trust. The Trust is therefore licensed to provide services.

The CQC has not taken enforcement action against Tees, Esk and Wear Valleys NHS Foundation Trust during 2024/25.

Tees, Esk and Wear Valleys NHS Foundation Trust is subject to periodic reviews by the CQC and the last review was on 29 March 2023 to 02 June 2023. The CQC's assessment of the Tees, Esk and Wear Valleys NHS Foundation Trust following that review was an overall rating of **requires improvement**.

Our Trust's CQC inspection took place 29 March 2023 to 02 June 2023 and the results of the latest trust wide inspection were published on 25 October 2023. Details of the improvements made were listed within the previous Quality Account (2023/24).

In addition, the CQC inspected our AMH Crisis, Acute Liaison Services and Health Based Places of Safety (HBPOS) in June 2024. This was a targeted inspection. The outcome of the inspection was subject to the new Single Assessment Framework (SAF) scoring system and the CQC published the results of this focused inspection on its website 06 February 2025. The service received a rating of Good overall and in 4 of the 5 domains.

The CQC report highlights that staff shared a vision and culture, worked with capable and compassionate leaders and there were sound structures in place for staff to speak up.

- **People were treated as individuals** and offered independence, choice and control.
- There was evidence of a **good learning culture**, and people using the services told the CQC that they **felt safe**.
- **People were safeguarded** by the staff caring for them.
- People had their **needs assessed** and most people said they were involved in the planning of their care and that their **care was regularly reviewed**.
- The CQC saw **staff supporting people** with their mental health needs and the **physical health monitoring**.
- **People received evidenced based care and treatment** and there were regular multidisciplinary meetings where learning could be shared and staff at all levels attended various meetings.
- **People are included** in their care and treatment choices with **carers being involved** where appropriate.
- **People's preferences** were considered when deciding on appropriate treatment options.
- **Carers were included** at assessment stage and throughout.

- There was a **strong quality improvement culture**, and leaders were encouraged to develop themselves and the services.
- Staff told the CQC that the recent move to the 111 service was having a **positive impact**.

Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following action to address the points made in the CQC's assessment:

- Since the inspection in June 2024, a number of improvement actions have been undertaken and collaborative events were held 14 and 24 April 2025. The events helped to develop the formal Improvement Plan with Care Group colleagues and specialty/ directorate leads focusing on any areas of improvement from the inspection report requiring further action.
- The Trust CQC improvement plan was formally submitted to the CQC on 01 May 2025 after approval by our Executive Chief Nurse.
- Actions were developed following the Crisis Improvement Planning events including exploring the use of the Urgent Care tracking Application to capture wider information about patients and practices with our Section 136 Suites, reviewing the training offer to assist with staff understanding of Patient Rights, and strengthening the processes involved in recording the outcomes following Safeguarding Local Authority referrals.
- The quality governance team continue to maintain the evidence repository to provide assurance of completion and implementation of improvement actions. Delivery progress for the CQC improvement plan will continue to be formally reported to the Executive Directors Group and Quality Assurance Committee, noting where actions are implemented and embedded.

Tees, Esk and Wear Valleys NHS Foundation Trust has made the following progress by 31st March 2025 in taking such action:

- The Trust has achieved closure of the 2023 CQC Improvement Plan following the Core Service and Well-led inspection.

Tees, Esk and Wear Valleys NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.14 Information governance

The NHSE Data Security and Protection Toolkit (DSPT) reporting year runs from 1st July to 30th June each year.

For the DSPT reporting year 2023/24, Tees, Esk and Wear Valleys NHS Foundation Trust achieved **Standards Met**.

ODS	Organisation name	Status	Published
RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	23/24 Standards Met	28/06/2024

2.15 Freedom to Speak Up

There are a number of routes through which staff can raise concerns:

- Through their own management or professional structures.
- Through the Freedom to Speak Up team. This is as confidential as the person asks for it to be. Concerns are addressed in agreement with the person who spoke up. We have recently started directing the request for review to the senior leadership team, where appropriate. This has enhanced the process and increased the sense of service ownership and satisfaction from those who spoke up. However, we still offer an independent review for those who feel speaking outside their service is preferrable or want to ensure a level of confidentiality. We also signpost to other services such as employee support services or human resources. Feedback is given to the person on a regular basis, in line with our revised process. As much feedback is given as appropriate although, by the nature of some concerns and investigations, full feedback is not always possible.
  We have a monthly speaking up forum where we share soft intelligence, agree proactive work and agree what information is to be shared with the people and culture committee, the board, and each care group board so that we can triangulate feedback from reviews, service action plans, and share outcomes.
- The online raising concerns form where people could previously complete anonymously has been discontinued.
- Through our safeguarding team or directly to the CQC.
- Through our formal HR processes, the timescales of which vary and are laid out in the relevant policy.
- Through the employee support service who will signpost and provide guidance on how to make best use of the options available.
- Through any trade union of which they are a member.

We have a process for addressing any concerns of detriment or demeaning treatment, in line with national guidance. In addition, concerns are passed to our associate director for operations and resourcing, who share themes with our non-executive director for speaking up on a quarterly basis.

With regard to the medical workforce, the role of Guardian of Safe Working for resident doctors within our Trust sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The work of the Guardian is subject to external scrutiny of doctors' working hours by the CQC and by the continued scrutiny of the quality of training by Health Education England.

The Guardian is required to levy a fine against a department(s) if a resident doctor:

- Works on average over 48 hours/week
- Works over 72 hours in seven days
- Misses more than 25% of required rest breaks
- On non-residential on call (NROC) does not have a minimum of continuous rest of five hours between 10pm and 7am
- Does not have the minimum eight hours total rest per 24-hour non-resident on-call (NROC) shift
- Has more than the maximum 13-hour residential shift length
- Does not have the minimum 11 hours rest between resident shifts

The Guardian of Safe Working for resident doctors within our Trust produces quarterly and annual reports to the Board that focus on gaps in medical rotas, exception reports and safety issues.

The Guardian's annual report for 2024/25 was presented to the Board and the main reasons for locum cover out of hours during were due to sickness (short or long term) and vacancies on the rotas. It should be noted that there were periods of industrial action during this period and there were also a few occasions were locum cover was needed due to maternity or paternity leave.

Exception reports received related mostly to claiming additional hours whilst on NROC, having to stay later than normal working hours or shift end time or missing teaching/training due to staff shortages. Discussions on these issues have taken place at the relevant forums and additional staffing put in place where possible.

2.16 Community transformation

The aims of the Community Mental Health Transformation Framework were to redesign and reorganise core community mental health teams which are place based and to create a core mental health service which is aligned with Primary Care Networks, local authority and voluntary care sector organisations.
Key achievements made as part of the ongoing community mental health transformation work in line with the NHS England five-year programme and next steps and key areas of delivery for the next 12 months are detailed as below:

Durham, Tees Valley Care Group
Key achievements:

- Our lived experience forums are now in place across Durham and Tees Valley boroughs.
- 22% increase in capacity for psychological therapies within community teams.
- Collaborative upskilling all system partners through VCSE led 'learning together' sessions.
- Hubs established in population centres and pop-up hubs in community facilities in more rural areas.
- Trusted assessment process developed collaboratively with VCSE, Social Care, CMHT and Talking therapies and service users – piloting in Middlesbrough ahead of wider role out.
- Significant increase in the number of patients receiving at least 2 contacts in a 12-month period.
- 91% improvement in year-on-year changes in caseloads – caseload increase of 1821 in 2022 has reduced to 165 in 2024.
- 59% reduction in patients waiting for assessment, reduced from 3500 in January 2023 to 1428 in March 2025.
- Over 40,000 appointments in primary care (per annum) by TEWV MH Nurse practitioner or Mental Health and Wellbeing Practitioners in 2024 (Additional Roles Reimbursement Scheme); additional appointments in primary care through GP Aligned team (Durham).
- Only 948 (2.5%) of ARRS patients were stepped up to secondary care services; 14.8% of GPA patients stepped up.
- 15%-20% reduction in secondary care referrals, at a time when we expected secondary care MH referrals to increase (Pandemic impact on Mental Health and Wellbeing and impact of increasing Neuro referrals).

Next steps:

- Resolving ongoing commissioning/Service Development Funding and contracting challenges for system (i.e. within and beyond statutory services contract settlements)
- Improve reporting – from TEWV and from the wider system (activity, outcomes etc).
- Shift from mobilising to embedding and supporting local ownership.
- Address identified areas for more work from Healthwatch stocktakes of progress.
- Continue to extend and embed lived experience forums, roles and infrastructure.
- More robust focus on communications – for staff/ organisations and for people needing support/the public (including websites etc).
- Specific focus on increasing evidence-based interventions, utilising outcomes and effective caseload management.
- Complete recruitment to outstanding schemes (e.g. peer support within TEWV, and Procurement of a Tees valley wide peer support service to work at PCN level).
- Mobilising the remaining "physical" mental health hubs, acknowledging the estate challenges in Durham).
- Improving pathways at place for people with concurrent mental health and substance misuse needs.

North Yorkshire, York and Selby Care Group
Key Achievements:

- Community Mental Health Hub operational at 30 Clarence Street, York. Phased roll out continues to include self-referrals. Pop-up hubs across City of York aligned to 30 Clarence Street.
- 24/7 Crisis Hub Pilot planned to go live in June 2025 (National Pilot Site). Hub will offer round the clock alternatives to a place of safety and aligned closely with Crisis services, VCS and Social Care Services.
- Further MH Hub planned for the East of the City later this year.
- MH Hubs planned across North Yorkshire with an expectation that they will all become operational by the Spring of 2026.
- Procurement process underway for VCS input into hubs (Coordinated by NYC).
- 18 of the 19 PCNs have 1 or more First Contact Mental Health Practitioners (some want more than 3) providing timely access to MH support (average wait 1-2 weeks).
- Improved relationships and communication between Primary Care and Secondary Care services
- Over 30,000 appointments in primary care (per annum) by TEWV First Contact MH Practitioners cross 19 PCNs in North Yorkshire & York Places.
- Just over half were new referrals.
- 15% referred on to Talking Therapies.
- Between 2% and 3% referred on to Secondary Care Services.
- Only 2% required an additional appointment with their GP.
- 3% referred to Social Prescribers.
- MDT meetings within Primary Care including Community MH Team Practitioners and VCS services.
- Complex Emotional Needs Practitioners in post across NY providing expertise, supervision and support for the VCS, Primary Care and the MH Hubs. Further post agreed to cover York.
- New Hybrid Roles created (2 in post, further 2 planned) working in Harrogate and Ripon, between Primary Care, Secondary Care and the new hubs. These roles are designed to more closely align and integrate Primary Care and Secondary Care and to improve patient flow.
- New Eating Disorder Consultants now in post and looking to establish FREED (First Episode Rapid Intervention for Eating Disorders) Champions across NYY.
- Developing leadership capabilities for the MH workforce is a key priority of the national trauma-informed organisational strategy. These are a key priority in our community transformation offer in North Yorkshire & York.
- Listening Exercises in our CMHT's have been started forming the foundation for an understanding of the transformation & Trauma Informed agenda. Supporting a wider system context & relational Trauma Informed repair where required
- We have started to support our CMHT's & partners to creatively maximise the service users experience through examining current capacity & functioning, whilst visioning & planning for improved efficiencies in future delivery.
- We have started to interweave Trauma Informed practice & leadership training & skill & communication awareness training across our CMHT's & system partners. Thus, developing skills & an emotional awareness for our leaders & staff. Already trained NY Police, NYC, Primary Care, CYC.
- Internally, we have established new Transformation Delivery Groups in each Neighbourhood across NYY. These groups will coproduce the local place-based plans for the transformation of the Trust Specialist Services across NYY. These groups develop and implement these plans covering the new models, estates, finance and workforce implications/opportunities and are aligned to the Care Groups Combined Governance Group and the Trusts Transformation Delivery Group. These groups are also aligned to the new MH, LD &A Partnerships in the York and NY Places and the Local Care Partnerships.

Next steps:

- Looking to resolve ongoing commissioning/Service Development Funding and contracting challenges for system (i.e. within and beyond statutory services contract settlements).
- Improve reporting – from TEWV and from the wider system (activity, outcomes etc) through single information system in MH Hubs.
- Working with Ardens to improve information capture for First Contact Mental Health Practitioners into System One and CITO.
- Continue to progress Commitment Plan developed in partnership with NY Healthwatch across partners in NY.
- Continue to extend and embed lived experience forums, roles and infrastructure

- More robust focus on communications – for staff/ organisations and for people needing support/the public (including websites etc).
- Specific focus on increasing evidence-based interventions, utilising outcomes and effective caseload management.
- Complete recruitment to outstanding schemes (e.g. peer support, Social Prescribing and Carer support within the Mental Health Hubs).
- Continue to Mobilise the remaining “physical” mental health hubs with our partners across NYY and explore potential pop-up and virtual solutions for the rural areas across NYY.
- Improving pathways at place for people with concurrent mental health and substance misuse needs.

2.17 Learning from deaths

During 2024-25, 1,744 deaths were reported to the Trust's incident reporting system, with the majority of these considered to be from natural causes. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
499	574	408	263

Of the 1,744 deaths, in line with the national guidance on learning from deaths, 379 deaths fit the criteria for further review of which 186 were case record reviews. This comprised of the following number of case record reviews and investigations which were completed in each quarter of the reporting period:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
130	102	91	56

In mental health and learning disability services we have a number of older people who are cared for in the community and their needs are such they only require minimal contact with us. Many of these people, who die, do so through natural causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further. To support staff in their decision making regarding the investigation of deaths, staff have clear policy guidance, setting out criteria for categories and types of review.

During the reporting period there were 0 deaths that were subjected to both a case record review and an investigation.

Of the 1,744 patient deaths during the reporting period 1.31% are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of 14 representing 2.80% of the number of deaths which occurred in the first quarter; 7 representing 1.21% of the number of deaths which occurred in the second quarter; 2 representing 0.49% of the number of deaths which occurred in the third quarter. There were 0 deaths that occurred during quarter 4 which are judged to me more likely than not have been due to problems in the care provided to the patient.

29 case record reviews and 84 investigations completed after 31/03/2024 related to deaths which took place during the previous reporting period. This meant we undertook a total of 492 case record reviews and investigations. This is a significant decrease on the 601 case record reviews and investigations completed in the 2023/2024 period and reflects the work that was undertaken to close the previous backlog of reviews. Of the 29 case record reviews and 84 investigations completed after 31/03/2024 relating to deaths which took place during the previous reporting period, 13% are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been based on the information contained within Structured Judgement Reviews, After Action Reviews and Patient Safety Incident Investigations carried out under the Learning From Deaths policy and the national Patient Safety Incident Response Framework (PSIRF) which the Trust implemented from 29th January 2024.

During 2024/25 the number of learning points identified from case record reviews and investigations were as follows: 218 in the first quarter, 218 in the second quarter, 190 in the third quarter, and 161 in the fourth quarter.

All learning in the Trust is referred to as actionable learning and supports our approach towards a just and learning culture in line with Our Journey to Change and a systems-based approach to learning as advocated by PSIRF. All learning from patient safety incident investigations is themed and informs key workstreams to address any identified quality and safety issues.

Actionable learning continues to be monitored against the Trust's 12 current learning themes which were identified during 2022/23 and 2023/24, agreed by the Trust Organisational Learning Group. These are:

Our quality assurance and improvement programme is regularly updated to reflect learning from patient safety incidents. It provides assurance that improvements are being made in relation to risk assessment, risk management, care plans and patient and carer involvement and that these improvements are being sustained in both inpatient and community settings. Ongoing quality assurance processes where specific learning themes have been highlighted have been presented through a monthly system wide quality meeting.

Our Trust continues to strengthen arrangements for organisational learning via the Organisational Learning Group which has had a full review of its membership and terms of reference, resulting in multi-disciplinary and executive level membership. The group's role is:

- Develop and maintain processes to learn and improve after patient safety incidents, complaints, safeguarding, leadership visits, investigations etc.

- To alert the Trust of systemic areas for improvement and / or safety issues.
- To ensure the group escalates or delegates concerns or issues to the appropriate forums / workstreams.
- To ensure the organisation has a structure that supports learning and improvement with strong triangulation and governance through:
- Clear collation of information
- Transparent processes to explore and investigate issues based in the PSIRF principles of Just Culture.
- Work with care groups and clinical networks to identify and theme learning opportunities.
- Ensure governance structure that will implement and monitor any identified changes.
- Disseminate learning and developments through a variety of identified solutions.
- Proactively seek out best practice and provide guidance to fundamental standards, clinical networks and care groups to ensure that safe high-quality care remains at the forefront of service delivery.
- To invite identified work streams to feedback areas of development and positive practice to update and share progress.
- Review and raise awareness of wider system learning from across a range of organisations or publications for discussion.

The Organisational Learning Group now has a 12 month work plan based on the 12 themes identified. Learning and good practice identified from case record reviews and investigations can be discussed within the Organisational Learning Group. Learning will be disseminated via clinical networks, fundamental standards, briefings where appropriate, to ensure that learning feeds into existing improvement work.

During 2024/25, themes explored in this forum included Clinical Effectiveness, Record Keeping, Infrastructure, Legislation and Policy Compliance, Safeguarding, Risk Assessment and Patient, Carer and Family involvement and experience.

38 patient safety briefings have been circulated trust wide during 2024/25 as a result of learning.
Examples of these briefings include:

- Raising awareness of risks associated with illicit substances
- Information related to safe practice of manging sharps
- Raising awareness of environmental risks
- Information related to the functionality of CITO (Electronic Care Record system) and recording information
- Raising awareness of risks associated with the use of sanitary bins in unsupervised patient areas
- Recording of third party information within Safety Summary documentation
- Emollients and fire risk

The briefings circulated are specific about any assurance required from services. On receipt of completed actions these are documented in the local safety alert and learning database.

The Environmental Risk Group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm. Any urgent learning from this group is disseminated Trust-wide via patient safety briefings. Environmental surveys with multi-professional input from estates, health and safety and clinical services continue to be undertaken.

Suicide Prevention training and Being with Distress workshops, continues, as well as our mandatory harm minimisation training. The training considers completion of documentation/record keeping, patient/carer involvement and the importance of multi-agency working. Bespoke training sessions in hot spot areas are available on request.

The learning from deaths policy has recently been reviewed to align to PSIRF. It is aligned to Our Journey to Change and will ensure carers and families receive compassionate care following the loss of a loved one. We continue to work in line with national frameworks and programmes to facilitate shared learning/good practice and valid comparisons with other trusts.

2.18 Local Resolution and Complaints

All complaints are managed in line with national guidance, and we are committed to providing opportunities for our patients, their carer, or their families to seek advice or information, raise concerns or make a complaint about the services that the trust provides. Our complaints policy outlines how they can do this and to feel confident that they will be listened to, and their issues taken seriously.

The Trust's approach to Complaints Handling ensures that we get the right process for those who use our services that gives them the best possible outcome in the least amount of time. Our approach fulfils the expectations set out by the Parliamentary and Health Service Ombudsman (PHSO) for NHS Complaint Standards (2022).

We are encouraging people to discuss any issues or concerns they have with staff who are directly involved in the patient's care, as we may be able to sort the issue out to their satisfaction quickly and without the need for them to make a complaint. This process is known as a Local Issue Resolution, and we ask that these are resolved either at the time that they are made or longer than 10 working days. This level of feedback is recorded electronically using InPhase that not only captures the nature of the concerns but also includes the outcome, any actions taken, and any learning identified.

We recognise that we cannot always resolve issues or concerns as they arise and that sometimes people will want to make a complaint. All complaints are managed utilising a pathway approach of either an 'Early Resolution Complaint' or as a 'Formal Complaint' which is locally determined by the Complaints Team. We work on the principle of 'investigate once and investigate well' with the complainant receiving an open and honest written response that outlines any learning to demonstrate how we have listened and taken seriously their complaint.

We recognise that all complaints give a vital and direct insight into the quality of services that we provide. Our Ward and Team Managers have full visibility of all concerns and complaints which they use within their governance discussions for learning purposes. In addition, they are able to triangulate the learning with other sources of intelligence e.g., patient safety incidents etc. Furthermore, all learning is shared with the Trust's Organisational Learning Group.

Our activity in 2024/25 can be summarised as follows:

Financial Year	Local Issue Resolution	PALS	Complaints	Total
2024/25	849	N/A	501	1,350
2023/24	206	1,773	498	2,477
2022/23	N/A	2,446	338	2,784

849 concerns were managed locally at ward or team level whilst the complaints were managed as an Early Resolution Complaint (385 in total) and 116 were managed as a Formal Complaint. This reflects the profile that we had envisaged following our new ways of working and ensures that concerns are addressed timely.

The highest reported themes from those Local Issue Resolutions and Complaints received include aspects of the individuals Care and Treatment, followed by Assessment and Communication Issues. We are unable to compare this data from the previous year following the introduction of the new InPhase system and a change to how we categorise all concerns and complaints.

We have also seen an increase in the number of complaints that have been responded to within our originally agreed timeframes (54% in 2023/24 compared to 69% in 2024/25).

The Complaints Team have received a number of positive feedback following the complaints handling, examples are as follows:

Thank you so much for your support today, I really appreciate having you both there especially going through some not nice things. I am really thankful that I was made to feel at ease and able to get my point across and actually be heard without defensive and trying to shift the blame. Patient/Carer

Just an email to thank you so much for your continued support in this matter. And to thank you so much for being there for us today. It was a good outcome we thought and hopefully things will start and get better for patients on the ward. Although we can't undo what has happened, we are hopeful this will bring some closure and **** can start and move forward with their life. Family Member

Thank you for listening to **** which they had really appreciated your time and felt that you were passionate about your role. **** felt lucky to have someone like you in their corner and felt they were disregarded by staff, and I was made to feel that my concerns were valid and appreciated. Patient

I've read through your letter this morning and have to congratulate you for a very balanced and considerate document. I'd also like to say thank you for dealing with this as you have in such a sensitive way. Staff Member

It was excellent to meet yesterday – I so appreciate all the time you gave me. You were both professional and empathetic, which helps very much in my situation. Family Member

I have to say **** having seen the complaints I think your response is really impressive, I don't know how you do it. Staff Member

I just want to thank you and compliment you on being excellent at your job. I wonder sometimes about why the excellent people with finely honed skills seem to end up in complaints resolution these days when it might be a better idea to have them training people? Patient

**** had recently made a complaint to yourselves. They reported that they were pleased with the response from this and feels that they were listened to. **** tells me that the ward has provided extra support for them and others, and they have been offered psychological support and use of an alarm should they need this. Patient

2.19 Data quality

The latest published Data Quality Maturity Index (DQMI) score is **94%**. This is for November 2024.

Tees, Esk and Wear Valleys NHS Foundation Trust did not submit records during 2024/25 to the secondary uses service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

Tees, Esk and Wear Valleys NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2024/25 by the Audit Commission. We have had our annual external clinical coding audit for the data security and protection toolkit. The results were 93% correct for primary diagnosis and 85.1% correct for secondary diagnosis.

We stopped making commissioning data sets submissions that go to secondary uses service and HES approximately six years ago as the data was duplicated with the Mental Health Services Data Set. The Mental Health Services Data Set data quality for NHS number and GP practice from the Data Quality Maturity Index publication for November 2024 were 99.7% and 100% respectively.

2.20 Mandatory quality indicators

Since 2012/13, all NHS foundation trusts have been required to report performance against a core set of indicators:

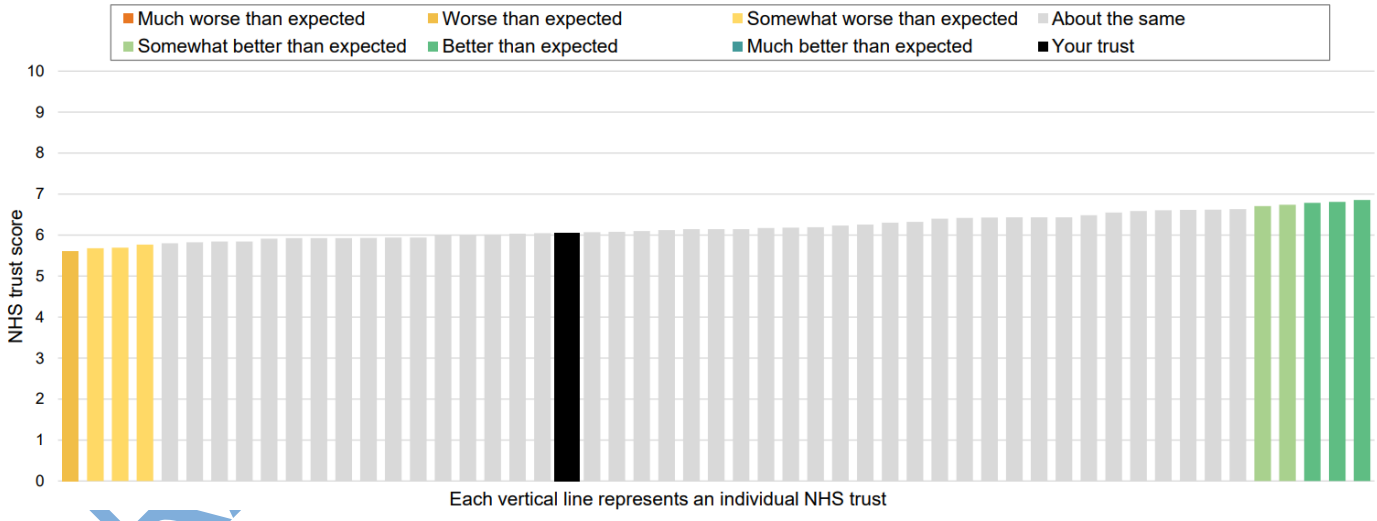
Inpatients that are discharged are followed up within 72 hours
The 72-hour measure is the percentage of people discharged from a CCG-commissioned adult mental health inpatient setting, that were followed up within 72 hours. This includes all people over the age of 18 years.

Of our commissioned services, 2975 patients were discharged between 1 April 2024 and 31 March 2025, of those:

- 2562 (**86.12%**) were followed up
- 413 were not followed up within 72 hours between April 2024 and March 2025.

The introduction of any new Electronic Patient Record has a negative impact on Data Quality. Following the introduction of Cito in February 2024, data quality issues have impacted several patient-based measures across the organisation. To support data quality and to provide oversight that our patients are safe and have been followed up in a timely manner, a thorough, manual validation has been in place through 2024/25. Whilst there are 413 patients **reported** as not receiving a follow up contact within 72 hours; only 154 of these were not actually followed up.

Patients' experience of mental health teams
For 2024, we have reported the mental health section score of the NHS Community Mental Health Survey Benchmark. The Trust has reported a score of 6.1 which is indicated below as 'about the same' compared to all other NHS trusts.



The section score is compiled from the results of the following survey questions below.

Question	TEWV mean score 2024	National average 2024	TEWV mean score 2023	TEWV mean score 2022	TEWV mean score 2021
Were you given enough time to discuss your needs and treatment?	**6.7**	**6.9**	6.9	7.7	7.5
Did you feel your NHS mental health team listened to what you had to say?	**6.9**	**7.0**	*Question updated from 2024*	-	-

Question	TEWV mean score 2024	National average 2024	TEWV mean score 2023	TEWV mean score 2022	TEWV mean score 2021
Did you get the help you needed?	**6.0**	**5.9**	6.0	*Question updated from 2023*	-
Did your NHS mental health team consider how areas of your life impact your mental health?	**6.5**	**6.5**	6.7	*Question updated from 2023*	-
Did you have to repeat your mental health history to your NHS mental health team?	**4.1**	**4.6**	4.7	*Question updated from 2023*	-

National patient safety incident reports

The National Learning from Patient Safety Incidents (LFPSE) system, which the Trust began reporting into at the end of October 2023 is now fully in place and NHS England have developed a reporting dashboard. The 'Reported Data Dashboard' (RDD) draws together all of the nationally reported patient safety incident data and provides a full overview, whether at national, regional or organisational level. Whilst this is now available to organisations within the dataset, this is still being validated prior to being made available on a public website. Local validation has been undertaken to ensure organisational data is accurate to the local system records and this will continue to be undertaken periodically and as any changes are introduced.

Part Three: Further information on how we have performed in 2024/25

3.1 Introduction to part 3

Part 3 of this document contains further information which the legal guidance requires us to include. This includes statutory statements. As with Part 2, this helps to develop an overall picture of quality at our Trust.

3.2 Our performance against our quality metrics

The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

Quality metrics:

Patient Safety indicators	Target	Whole Trust 24/25	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	Further comments
Percentage of patients who report 'yes, always' or 'yes quite a lot' to the question 'do you feel safe on the ward?'	75.00%	**80.66%**	78.63%	55.57%	65.30%	64.66%	Not measured nationally	The end of 2024/25 position was **80.66%** which relates to 1847 out of 2290 surveyed. This is 5.66% above our standard 75.00%.
Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	**0.073**	0.10	0.28	0.17	0.13	The Royal College of Physicians discourage any benchmarking or comparisons due to the high number variables that exist that makes comparison unreliable.	This year's figure equates to 17 Moderate, Severe or Fatal Falls incidents against the 231,992 Occupied Bed Days.
The number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	**27.68**	29.2	33.27	28.84	20.9	N/A	This year's figure equates to 6422 incidents where restrictive intervention was used, against the 231,992 Occupied Bed Days.
The number of medication errors with a severity of moderate harm and above	2.5	**4**	11	13	12	7	N/A	There is no official benchmark for this indicator, as the greater the overall reporting, the more open and psychologically safe the culture can be said to be. A decrease in the more severe incidents can be observed to be a positive finding.
The number of Patient Safety Investigation Incidents (PSII) reported on STEIS	-	**27**	126	144	141	142	N/A	The Trust implemented the National Patient Safety Incident Response Framework (PSIRF) in January 2024 which replaced the National Serious Incident Framework (2015). PSIRF enables organisations to undertake a considered and proportionate response to patient safety incidents. Incidents that would have previously been reported on STEIS and reviewed via the Serious Incident investigation process are reviewed through a multidisciplinary After Action Review (AAR) process. AARs support teams to take a system-based approach to understanding what happened and identifying learning. For those incidents that require further investigation following completion of an AAR, these are

Patient Safety indicators	Target	Whole Trust 24/25	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	Further comments
								reviewed under the Patient Safety Incident Investigation (PSII) process are reported on STEIS. In line with PSIRF, the term Serious Incident is no longer used.

Clinical Effectiveness Indicators	Target	Whole Trust 24/25	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National Benchmark
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	85%	**86.12%**	81.93%	88%	*Previously reported indicator: (Existing percentage of patients on Care Programme Approach who were followed up within 72 hours after discharge from psychiatric inpatient care)*		-
Adults with a long length of stay over 60 for adult admissions	N/A	**10.02%**	12.47%	N/A	12%	N/A	According to the NHS Oversight Framework System Benchmarking as at March 2024, national rank 3 out of 50 mental health providers and are performing within the highest performing quartile (a positive position).
Older adults with a long length of stay over 90 days for older adult admissions	N/A	**35.11%**	58.04%	35%	N/A	N/A	According to the NHS Oversight Framework System Benchmarking as at March 2024, national rank 6 out of 52 mental health providers and are performing within the highest performing quartile (a positive position).

Patient Experience indicators	Target	Whole Trust 24/25	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	National benchmark
Percentage of patients who reported their overall experience as very good or good	92%[1]	**93%**	92.17%	92.16%	94.34%	87%
Percentage of patients that report that staff treated them with dignity and respect	94%	**87.6%**	87.00%	86.69%	84.72%	-
Number of complaints raised	-	**501**	498	338	257	-

Additional supporting comments on areas for improvement

The number of medication errors with a severity of moderate harm and above:
The Electronic Prescribing Medication Administration (EPMA) has been fully implemented on all wards (with the exception of respite wards), including integration work with CITO allowing discharge prescriptions to populate CITO transfer letters. During the first part of the 24/25 financial year, the EPMA Team scoped the use of EPMA within the community teams; looking at FP10 prescription forms, depot and clozapine processes. A number of enhancements to the system were proposed that would allow future implementation of EPMA to community. For the remaining months of the project, the EPMA Team worked on improving and embedding EPMA processes on the inpatient wards, delivering an update that brought group administration, increased the number of regimens and piloted leave generation on EPMA.

[1] Previous target was 94% changed December 2023 to 92%

3.3 Other external reviews/ publications:

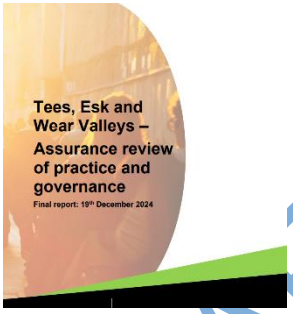
Special review of mental health services at Nottinghamshire Healthcare Foundation Trust
Following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar, and Barnaby Webber, the Secretary of State for Health and Social Care commissioned the CQC to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under Section 48 of the Health and Social Care Act 2008.

In March 2024, the CQC published the first part of the review on the findings of their assessment of patient safety and quality of care provided by NHFT, and progress made at Rampton Hospital since their last inspection in July 2023.
In August 2024, published the second part of their review. The issues identified in NHFT were noted as not unique to this Trust. The CQC found systemic issues with community mental health care and they made recommendations relevant to all providers. NHS England will commission an independent homicide review; the review may result in further recommendations.

All NHS mental health services were asked to complete a stock take to understand the gaps and risks in their services. The assessment framework can be found here:
https://www.england.nhs.uk/publication/guidance-on-intensive-and-assertive-community-mental-health-treatment/

Summaries of both parts of the reviews were considered within the Trust Management Group, Executive Clinical Leaders, Adult Mental Health Clinical Network and the reports were shared with both Care Group Leaders. The Community Mental Health Service Review ICB Maturity index self-assessment was submitted by each Care Group to the relevant ICBs. The Durham Tees Valley and Forensic (DTV&F) Care Group met with NENC ICB and developed an action plan based on the outcomes of the self-assessment. The North Yorkshire and York (NYY) Care Group also developed an action plan and shared this with the HNY ICB. There remains ongoing work to develop the capability to easily identify patients that meet the Assertive and Intensive criteria within the electronic patient recording system.

Assurance Review of Practice and Governance



A report was published in January 2025 which followed a review of our services and focused on where we are currently as an organisation, specifically the experiences of young people in our care. Alongside the report a shorter summary document called Lessons Learned Bulletin was also published. The independent investigation reports page of the NHS England website shows the publications.

This was a rigorous and independent review carried out by Niche Health and Social Care Consulting. It took place last year (2024). The review was commissioned by NHS England to assess whether, and to what extent, the care we provide is compliant with current standards and expectations. It is the final report following the publication in 2023 of a system-wide independent investigation into our CAMHS inpatient provision, and in 2022 reports that reviewed the care of three young women who sadly died in our care.

The findings show that we have made great improvements across our Trust and provides NHS England with good assurance that we are delivering safe and kind care every day to patients. There will be no further independent reviews in relation to the recommendations included in the earlier reports.

In particular the findings show:
- A good level of assurance that clinical practice within CAMHS offered to patients who present with complex cases is now compliant with expected standards.
- A good level of assurance that the governance of quality concerns within these services is now compliant with expected standards.
- A good level of assurance that the overall governance of quality within these services is now compliant with expected standards.

Lord Darzi Independent Investigation of the NHS in England
In July 2024, the Secretary of State for Health and Social Care commissioned Lord Darzi to conduct an immediate and independent investigation of the NHS.
Lord Darzi's report provides an expert understanding of the current performance of the NHS across England and the challenges facing the healthcare system. Lord Darzi has considered the available data and intelligence to assess:

- patient access to healthcare
- the quality of healthcare being provided
- the overall performance of the health system

In line with the terms of reference of the investigation, Lord Darzi has only considered the state of the NHS in England. UK-wide analysis is occasionally used when making international comparisons.

The 160-page report concluded that the NHS is in "serious trouble" financially and operationally and how it has failed to deliver on key obligations to the public since 2015, such as tackling health inequalities, record-long waiting times, workforce pressures and budget deficits.
As a result, millions have been deprived of access to quality care and patient satisfaction is at an all-time low. The report also highlighted how the UK health sector has continuously lagged behind other countries in several key areas, including digital transformation, capital investment, workforce capacity and pandemic response.

We have considered the Darzi report as we developed the Trust's Strategic Framework - **Our Journey to Change: The Next Chapter**. After the Darzi report was published in September 2024, it was discussed within the Executive Directors Group, a Board of Directors Workshop and in our Lived Experience Strategy Reference Group so that this was in mind as they developed the revised version of Our Journey to Change.

Following on from the Darzi report there was an opportunity to take part in the "Change NHS" consultation to inform the drafting of the government's NHS 10 year plan. The Trust successfully submitted a response using the "NHS organisations" template on 29 November 2024.

3.4 External audit

Under guidance from NHS England, the Quality Account 2024/25 is not subject to review by external audit.

3.5 Our stakeholders' views

Our Trust recognises the importance of the views of our partners as part of our assessment of the quality of the services we provide and to help us drive change and improvement.

How we involve and listen to what our partners say about us is critical to this process. We continue to listen and learn from the people we support, their carers and families, our colleagues and our partners.

In line with national guidance, we circulated our draft Quality Account for 2024/25 to the following stakeholders:

- NHS England
- North East and North Cumbria Integrated Care Board
- Humber and North Yorkshire Integrated Care Board
- Local Authority Overview and Scrutiny Committees
- Local Authority Health & Wellbeing Boards
- Local Healthwatch organisations

All the comments we have received from our stakeholders are included verbatim in Appendix 3.

Comments received will support the Trust in achievement of its Strategic Goals and will inform delivery of the Trust's Quality Priorities for 2025/26. Stakeholder comments will also inform key learning for the development of the next year Quality Account.

Appendix 1: 2024/25 Statement of directors' responsibilities in respect of the Quality Account

2024/25 Statement of Director's Responsibilities in respect of the Quality Account - PHIL BELLAS

Appendix 2: Glossary

Adult Mental Health (AMH) Services: Services provided for people aged between 18 and 64 – known in some other parts of the country as 'working-age services'. These services include inpatient and community mental health services. In practice, some patients younger than 64 may be treated in older people's services if they are physically frail or have Early Onset Dementia. Early Intervention in Psychosis (EIP) teams may treat patients less than 18 years of age as well as patients aged 18-64.

Audit: An official inspection of records; this can be conducted either by an independent body or an internal audit department.

Autism: This describes a range of conditions typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays. People with autism are sometimes known as neuro-diverse. Autism cannot be cured, but the mental illnesses which are more common for people with autism can be treated.

Board/Board of Directors: Our Trust is run by a Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is responsible for ensuring accountability to the public for the services in manages. It is overseen by a Council of Governors and monitored by NHS England. It also:

- Ensure effective dialogue between our Trust and the communities we serve
- Monitors and ensures high quality services
- Is responsible for our financial viability
- Appoints and appraises our executive management team

Business plan: A document produced once a year to outline what we intend to do over the next three years in relation to the services that we provide.

Care Planning/ Care Programme Approach: Refer to Personalised Care Planning definition.

Care Quality Commission (CQC): The independent regulator of health and social care in England. They regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, Local Authorities, private companies, and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

Child and Adolescent Mental Health Services (CAMHS): Mental Health Services for children and young people under the age of 18 years old. This includes community mental health services, inpatient services and learning disability services.

Cito: An information technology system which overlays the Trust's patient record system (PARIS) which makes it easier to record and view the patient's records.

Clinical Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.

Clinical Supervision: a supportive mechanism which involves clinicians meeting regularly to reflect on practice, with the intention of learning, developing practice and providing high quality, safe care to patients.

Commissioners: The organisations that have responsibility for purchasing health services on behalf of the population in the area they work for.

Commissioning for Quality and Innovation (CQUIN): A payment framework where a proportion of NHS providers' income is conditional on quality and innovation.

Community Mental Health Survey: a survey conducted every year by the CQC. It represents the experiences of people who have received specialist care or treatment for a mental health condition in 55 NHS Trusts in England over a specific period during the year.

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about factors which contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced.

Co-production/Co-creation: This is an approach where a policy or other initiative/action is designed jointly between our staff and patients, carers, and families.

Council of Governors: Made up of elected public and staff members and includes non-elected members such as the prison service, voluntary sector, acute trusts, universities and local authorities. The Council has an advisory, guardianship and strategic role including developing our Trust's membership, appointments and remuneration of the non-executive directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Crisis Resolution & Home Treatment (CRHT) Team: Provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both the number and length of hospital admissions and to ease the pressure on inpatient units.

Dashboard: A report that uses data on a number of measures to help managers build up a picture of operational (day-to-day) performance or long-term strategic outcomes.

Data Protection and Security Toolkit: A national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Data Quality Strategy: A strategy which sets out clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality data. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

Department of Health: The government department responsible for health policy.

DIALOG+: A clinical tool that allows for assessment, planning, intervention, and evaluation in one procedure and allows more personalised care planning.

Forensic Adult and Mental Health and Learning Disability Services: Work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to a secure hospital from a prison or court, where their needs can be assessed and treated.

Formulation: When clinicians use information obtained from their assessment of a patient to provide an explanation or hypothesis about the cause and nature of the presenting problems. This helps in developing the most suitable treatment approach.

Freedom to Speak Up Guardian: Provides guidance and support to staff to enable them to speak up safely within their own workplace.

Friends and Family Test (FFT): A survey put to service users, carers and staff that asks whether or not they would recommend a hospital/community service to a friend or family member if they need treatment.

Gatekeeper/gatekeeping: Assessing the service user before admission to hospital to consider whether there are alternatives to admission and the involvement in the decision-making processes that result in admission.

General Medical Practice Code: The organisation code of the GP Practice that the patient is registered with. This is used to make sure a patient's GP code is recorded correctly.

Guardian of Safe Working: Provides assurance that rotas and working conditions are safe for doctors and patients.

Harm minimisation: Our way of working to minimise the risks of sometimes multiple and conflicting harm to both service users and other people.

Health and wellbeing boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system (i.e., local authorities and the NHS) would work together to improve the health and wellbeing of their local population and to reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities, and encourage commissioners to work in a more joined-up way.

HealthWatch: Local bodies made up of individuals and community groups, such as faith groups and resident's organisations associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

Home Treatment Accreditation Scheme (HTAS): Works with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers.

Hospital Episode Statistics (HES): The national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

Improving Access to Psychological Therapies (IAPT): An NHS initiative to increase the provision of evidence-based treatments for common mental health conditions such as depression and anxiety by primary care organisations.

Integrated Information Centre (IIC): Our system for taking data from the patient record (PARIS) and enabling it to be analysed to aid operational decision making and business planning.

Intranet: This is our Trust's internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures.

Learning Disability Services: Services for people with a learning disability and/or mental health needs. We have an Adult Learning Disability (ALD) service in each Care Group and also specific wards for Forensic LD patients. We provide child LD services in Durham, Darlington, Teesside, and York but not in North Yorkshire.

LeDeR: The learning from deaths of people with a Learning Disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a Learning Disability and reduce health inequalities.

Local authority Overview and Scrutiny Committee (OSC): Statutory committees of each local authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the local authority area. All local authorities have an OSC that focusses on health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland councils have a joint Tees Valley Health OSC that performs this function.

Local Issue Resolution (LIR): A recent concern raised that can be explored together with the team or ward in a timely manner

Mental Health Act (1983): The main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. In most cases when people are treated in hospital or in another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old with a mental health problem. They can be treated for functional illness, such as depression, psychosis, or anxiety, or for organic mental illness (conditions usually associated with memory loss and cognitive impairment) such as dementia. The MHSOP Service sometimes treats people less than 65 years of age with organic conditions such as early-onset dementia.

Mortality Review Process: A process to review deaths, ensuring a consistent and coordinated approach, and promoting the identification of improvements and the sharing of learning.

Multi-Disciplinary: This means that more than one type of professional is involved, for example, psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT).

National Institute for Clinical Excellence (NICE): NHS body that provides guidance sets quality standards and manages a national database to improve people's health and to prevent and treat ill health. NICE works with experts from the NHS, local authorities, and others in the public, private, voluntary and community sectors – as well as patients and carers – to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Institute for Health Research (NIHR): An NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of the patients and the public.

National Reporting and Learning System (NRLS): A central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks, and opportunities to continuously improve the safety of patient care.

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

NHS Staff Survey: Annual survey of staff experience of working within NHS trusts.

Non-executive directors (NEDs): Members of the Trust Board who act as a critical friend to hold the Board to account by challenging its decisions and outcomes to ensure they act in the best interests of patients and the public.

North Cumbria and North East Integrated Care System: Consists of four Integrated Care Partnerships – North, South, East, and West (see Integrated Care Partnerships).

PARIS: Our electronic care record, designed with mental health professionals to ensure that the right information is available to those who need it at all times. See Cito definition also.

Patient-led Assessments of the Care Environment (PLACE): Assessments of the hospital environment reviewing how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness, the general building maintenance and the extent to which the environment is able to support the care of those with dementia or with a disability.

Patient Safety Incident Investigation (PSII): PSII's are one method to extensively review and investigate an incident. These are acts and/or omissions occurring as part of NHS-funded healthcare (including in the community), resulting in one of the following - unexpected or avoidable death of one or more people which includes homicide by a person in receipt of mental health care within the recent past, unexpected or avoidable injury to one or more people that has resulted in serious harm.

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

Peer worker: Someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a patient or carer) to support other patients, in line with the recovery approach.

Personalised Care Planning: describes the flexible, responsive and personalised approach following a high-quality and comprehensive assessment means that the level of planning and co-ordination of care for patients can be tailored and amended, depending on a number of factors. Factors include the complexity of a person's needs and circumstances at any given time, the assessed and identified intervention required to meet personalised needs, what matters to them and the choices they make, the views, needs and circumstances of carers and/or other important people in their life, professional judgment and evidence-based practice. It is called 'an approach' rather than a system because of the way these elements are carried out, which is as important as the tasks themselves.

Prescribing Observatory in Mental Health (POMH): A national agency led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Programme: A coordinated group of projects and/or change management activities designed to achieve outputs and/or changes that will benefit the organisation.

Project: A one-off, time limited piece of work that produces a product (such as a new building, a change in service or a new strategy/policy) that will bring benefits to relevant stakeholders. Within our Trust, projects will go through a scoping phase, and then a business case phase before they are implemented, evaluated, and closed down. All projects will have a project plan and a project manager.

Psychiatric Intensive Care Unit (PICU): A unit (or ward) that is designed to look after people who cannot be managed on an open (unlocked) psychiatric ward due to the level of risk they pose to themselves or others.

Quality Account: A report about the quality of services provided by an NHS healthcare provider, the report is published annually by each provider.

Quality Assurance Committee (QuAC): Sub-committee of the Trust Board responsible for quality and assurance.

Quality Assurance and Improvement Groups (QAIG): Care Group forums within the Trust responsible for quality and assurance.

Quarter one/quarter two/quarter three/quarter four: Specific time points within the financial year (1 April to 31 March). Quarter one is from April to June, quarter two is from July to September, quarter three is October to December and quarter four is January to March.

Reasonable adjustments: A change or adjustment unique to a person's needs that will support them in their daily lives, e.g., at work, attending medical appointments, etc.

Research Ethics Committee: An independent committee of the Health Research Authority, whose task it is to consider the ethics of proposed research projects which will involve human participants, and which will take place, generally, within the NHS.

Royal College of Psychiatrists: The professional body responsible for education and training and setting and raising standards in psychiatry.

Safeguarding: Protecting vulnerable adults or children from abuse or neglect, including ensuring such people are supported to get good access to healthcare and stay well.

Single Oversight Framework: sets out how NHS trusts and NHS foundation trusts are overseen.

Staff Friends and Family Test: A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It helps us identify what is working well, what can be improved and how.

Statistical Process Control (SPC) charts: a graph used to show how a process changes over time and to see whether a situation is improving or deteriorating, whether the system is likely to be capable to meet the standard and whether the process is reliable or variable.

Steering group: Made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice/troubleshoot where necessary.

Strategic framework: primarily intended as a framework for thinking about the future and a guide to inform the investment and disinvestment decisions by those tasked with future planning.

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust.

TEWVision: The in-house built application for recording staff clinical supervision, managerial supervision, and appraisals.

Thematic review: A piece of work to identify and evaluate Trustwide practice in relation to a particular theme. This may be to identify where there are problems/concerns or to identify areas of best practice that could be shared Trustwide.

The Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by our Trust.

Unexpected Death: A death that is not expected due to a terminal medical condition or physical illness.

Urgent Care Services: Crisis, Acute Liaison and Street Triage services across our Trust.

Whistleblowing: this is a term used when a worker highlights a concern about their organisation and/or services to the Freedom to Speak Up Guardian or NHS Regulators. This will normally be regarding something they have witnessed at work.

Year (e.g., 2024/25): These are financial years, which start on the 1 April in the first year and end on the 31 March in the second year.

Appendix 3: Stakeholders' views

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