Middlesbrough moving forward | **Legal and Corporate Services**

TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE (TVJHS)

Date: **Tuesday 2nd June, 2026**
Time: **10.00 am**
Venue: **Mandela Room, Middlesbrough Town Hall**

AGENDA

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall

Middlesbrough
22 May 2026

MEMBERSHIP

Councillors D Branson, D Jackson, J Kabuye, N Johnson, M Layton, H Scott, N Anderson, D Bruce, M Jorgeson, C Cawley, S Crane, C Hannaway, M Besford, J Coulson and L Hall

Assistance in accessing information

Should you have any queries on accessing the Agenda and associated information please contact Claire Jones, (01642) 729112, claire_jones@middlesbrough.gov.uk

TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

PROTOCOL FOR THE TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

1. PURPOSE OF THE REPORT

1.1. To seek adoption of the Protocol and Terms of Reference for the Tees Valley Joint Health Scrutiny Committee.

2. SUMMARY

2.1 The Protocol and Terms of Reference, attached at **Appendix A**, are presented to the Tees Valley Joint Health Scrutiny Committee at the beginning of each municipal year.

2.2 The Committee is asked to consider if any changes, or amendments, are required to the Protocol or Terms of Reference prior to its adoption for the 2026/27 municipal year.

3. RECOMMENDATION

3.1 That Members agree and adopt the Protocol and Terms of Reference for the Tees Valley Joint Health Scrutiny Committee for the 2026/27 municipal year.

4. BACKGROUND PAPERS

4.1 No background papers were used in the preparation of this report.

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Protocol for the Tees Valley Health Scrutiny Joint Committee

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

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

Tees Valley Local Authorities

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

NHS Foundation Trusts

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

Integrated Care Board

5. North East and North Cumbria ICB.

Tees Valley Health Scrutiny Joint Committee

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

Membership

7. When holding general meetings, the Joint Committee will comprise 3 Councillors from each of the Tees Valley Local Authorities (supported by appropriate Officers as

necessary) nominated on the basis of each authority's political proportionality, unless it is determined by all of the constituent Local Authorities that the political balance requirements should be waived.

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

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

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

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

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

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

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

Chair and Vice-Chair

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

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

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

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

Co-option of other Local Authorities

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

Terms of Reference

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

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

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

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

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

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

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

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

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

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

Administration

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

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

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

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

Final Reports and Recommendations

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

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

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

Substantial Developments or Variations to Health Services

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

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

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

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

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

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

Principles for Joint Health Scrutiny

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

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

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

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

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

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

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

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

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

Thursday, 12 March 2026

TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

A meeting of the Tees Valley Joint Health Scrutiny Committee was held on Thursday, 12 March 2026 at the Council Chamber, Civic Centre, Ridley Street, Redcar, Yorkshire, TS10 1TD.

PRESENT Councillors C Cawley, S Crane, J Coulson, L Hall, J Kabuye, M Besford, A Roy, M Layton and D Jackson.

OFFICIALS C Breheny, C Jones, T Gilchrist, L McCrindle, S McKenna, C Morton, Raine, J Todd, G Woods, J Young and G Jones.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors S Moore, N Johnson and Boddy.

38 **DECLARATIONS OF INTEREST**

The following declarations of interest (non-pecuniary) were raised: -

• Item 6 and Item 7 – Councillor J Kabuye is undertaking a PhD in public health focusing on mental health.

It was **RECOMMENDED** that the Committee note these declarations.

39 **APPOINTMENT OF VICE CHAIR 2025/26**

Members were invited to make nominations for the position of Vice-Chair, and the following were received:

Councillor Kabuye was nominated by Councillor Layton, seconded by Councillor Besford.

Councillor Jackson was nominated by Councillor Jackson, seconded by Councillor Coulsen.

RESOLVED that Councillor Kabuye be elected as Vice-Chair of the Tees Valley Joint Health Scrutiny Committee for the remainder of 2025/26.

40 **MINUTES OF THE MEETING HELD ON 11 DECEMBER 2025**

The minutes of the meeting held on 11 December 2025 were considered.

RESOLVED that the minutes be approved as a correct record, subject to

an amendment to include Councillor Besford's apologies.

41 **NORTH EAST AMBULANCE SERVICE (NEAS) NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2025/26**

The Committee received a detailed presentation from representatives of the North East Ambulance Service (NEAS) NHS Foundation Trust, including the Deputy Director of Quality and Safety, outlining performance against the Trust's Quality Account priorities for 2025/26 and emerging priorities for 2026/27.

In introducing the report, it was highlighted that NEAS had experienced a year of significant operational pressure, managing approximately one million calls across the region, whilst maintaining its position as one of the highest performing ambulance Trusts nationally. The Committee was advised that alongside performance, a strong emphasis continued to be placed on quality, safety and learning, particularly in ensuring that improvements were sustainable and patient-focused.

Members heard that the Trust had embedded a mature patient safety culture, evidenced by sustained high levels of incident reporting. Whilst approximately 2.7 per cent of calls resulted in recorded patient safety incidents, the majority were categorised as low or no harm. It was emphasised that this reflected a positive organisational culture, where staff were encouraged to report concerns and near misses, enabling the Trust to learn proactively and prevent more serious incidents from occurring.

The Committee also noted the Trust's strong performance in relation to patient experience, with complaints remaining consistently low at around 0.2 per cent of total activity. In contrast, levels of positive feedback and appreciations significantly exceeded complaints. It was advised that patient satisfaction across most service areas was in excess of 90 per cent, with the exception of the NHS 111 service, which had lower satisfaction levels but was subject to targeted investment and workforce expansion to improve responsiveness.

Particular attention was drawn to the Trust's quality priority relating to cardiac arrest and resuscitation outcomes, which had been a major focus throughout the year. Members were informed that this work had delivered measurable improvements, including an increase in 30-day survival rates and overall patient outcomes. The Trust was noted to already perform strongly in this area nationally, and further gains demonstrated a continued commitment to clinical excellence. Members were advised that although this would not remain a standalone priority in the forthcoming year, it would continue to be monitored closely through clinical audit processes to ensure progress was sustained.

A further key area of focus had been workforce development and staff wellbeing. Members heard that significant improvements had been made in clinical supervision arrangements, career pathways, and staff engagement. It was advised that the introduction of a clinical career framework and enhanced support structures had resulted in improved staff survey outcomes, with employees reporting that they felt more supported, valued, and invested in. The importance of supporting staff following traumatic incidents was also emphasised, alongside ongoing work to reduce stigma associated with mental health and to promote staff wellbeing initiatives.

Members also received an update on the work undertaken to improve communication and inclusivity, particularly for patients with learning disabilities. It was highlighted that NEAS had developed its own bespoke training package tailored specifically to ambulance services, which had received national recognition. This work had contributed to improved patient experience and more effective communication with vulnerable groups, although further work was planned to expand patient involvement mechanisms, including the establishment of a Patient Experience Panel.

During discussion, Members welcomed the positive performance outlined within the report and commended the Trust for its achievements in both clinical outcomes and organisational culture. Specific praise was given to the development of career pathways and the use of patient stories at Board level to inform service improvement. However, Members also raised a number of areas for further consideration. These included:

- The availability and accessibility of complaints mechanisms, particularly for individuals who may not be able to access digital platforms;
- The need to ensure that digital exclusion did not act as a barrier to feedback or service access;
- The importance of benchmarking performance against comparable organisations to provide broader assurance; and
- The continued need to prioritise staff mental health and wellbeing, ensuring that support mechanisms were consistently applied across all operational levels.

In response, Members were assured that multiple routes were available for patients to provide feedback, including through staff on scene, and that work continued to enhance accessibility. It was also acknowledged that benchmarking remained complex due to variations between ambulance services, though national learning networks were being utilised to improve comparative understanding.

In concluding the item, the Chair thanked representatives for a comprehensive and transparent presentation, recognising both the scale of demand faced by the service and the progress made in improving quality and safety.

RESOLVED that:

1. The update on the NEAS Quality Account 2025/26 be noted;
2. Members' comments be taken into account in finalising the Quality Account; and
3. A draft Statement of Assurance be prepared on behalf of the Committee and circulated for approval, with final sign-off delegated to the Chair and Vice-Chair.

42 **TEES ESK AND WEAR VALLEY (TEWV) NHS FOUNDATION TRUST URGENT CARE MENTAL HEALTH CRISIS UPDATE**

The Committee received a detailed update from the Director of Operations and Transformation and the General Manager for Adult Mental Health Urgent Care at Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust on the delivery and performance of crisis mental health services across the Tees Valley.

In introducing the report, the Director outlined the significant transformation that had taken place since the introduction of the 24/7 single point of access via NHS 111 (option 2) in April 2024. This model, supported by a dedicated mental health screening team, had been designed to improve the timeliness and quality of responses to individuals experiencing mental health crises. Members were advised that this approach had represented a deliberate deviation from some national models, enabling a more clinically informed triage process at the earliest point of contact.

Performance data presented to Members demonstrated substantial improvements across key indicators. Members noted that call answer rates had increased significantly since implementation, with the service now achieving rates in excess of 95 per cent, compared to a national average considerably below this level. Abandonment rates were reported to be significantly lower than national figures, where approximately 27 per cent of calls were not answered, demonstrating the relative effectiveness of the local model.

In addition, the Trust reported strong performance in relation to responsiveness, including a high proportion of calls answered within target times and a national ranking of 7th out of 54 providers for call answering performance. Members were advised that, while performance against some internal aspirational targets remained slightly below the desired level, the Trust's position compared favourably against national benchmarks, and continuous improvement was being driven through workforce and service redesign.

Members also noted sustained improvements in triage and assessment

processes, including increased rates of calls being answered by trained mental health professionals within seven minutes. It was advised that where an immediate response could not be achieved, robust callback systems were in place, with assurances provided that all patients received follow-up contact and appropriate clinical oversight.

With regard to clinical outcomes, Members were informed that the Trust was performing strongly against national standards for urgent and very urgent referrals. Data indicated that over 98 per cent of urgent referrals were seen within 24 hours, placing the Trust among the highest performing organisations nationally.

The Director further outlined developments in crisis pathway provision, including the continued success of crisis assessment suites, particularly in Middlesbrough, which had been operational for over a decade. These facilities were reported to manage a significant volume of self-presenting patients, alongside referrals from partner agencies such as the Police. Members noted that partnership working had been recognised through national awards, reflecting the effectiveness of multi-agency collaboration in preventing escalation and supporting patient safety.

The Committee also heard about ongoing work to expand capacity and develop community-based alternatives to hospital admission, including proposals for additional mental health crisis beds and enhanced neighbourhood-based models of care. These developments were framed within broader system changes, including the planned rollout of 24/7 neighbourhood mental health centres, which aim to integrate statutory and voluntary sector provision.

During the ensuing discussion, Members welcomed the clear evidence of improvement in crisis response performance and acknowledged that the update addressed many previously raised concerns regarding NHS 111 mental health provision. However, a number of important issues were highlighted for further consideration.

Members emphasised the need for greater transparency in reporting, particularly in relation to:

- The proportion of patients not receiving an initial response within seven minutes;
- The role and effectiveness of callback arrangements; and
- The inclusion of these measures within routine performance reporting.

In addition, Members raised concerns regarding data gaps and inequalities, specifically noting the absence of data relating to ethnicity and access for minority groups. The importance of understanding differential access and outcomes across diverse communities was

strongly emphasised.

A significant area of discussion related to the role of community and voluntary sector provision, including wellbeing hubs and drop-in services. Members expressed concern that current reporting did not fully capture activity within these services, particularly in Stockton, and therefore did not provide a complete picture of demand across the system. Members requested further information on the scale, impact and outcomes associated with such services, and specifically asked that data relating to walk-in presentations and community engagement be provided to the Committee.

Members also explored issues relating to system capacity and demand, noting the high volume of referrals and the continuing increase in individuals seeking support. Concerns were raised regarding the sustainability of current arrangements and the need to ensure that all individuals entering the system received appropriate and timely care, without being repeatedly redirected between services.

In response, the Director acknowledged the challenges associated with demand and workforce capacity, confirming that ongoing work was being undertaken to align staffing levels with peak demand periods and to develop new models of care. It was also noted that some community-based services were commissioned externally, which had implications for data availability and reporting.

In concluding the item, the Chair thanked TEWV representatives for a comprehensive and informative presentation, noting the significant progress made whilst also recognising the continued complexity of delivering mental health crisis services within a pressured system.

RESOLVED that:

1. The update on urgent care mental health crisis services be noted; and
2. Further information be provided to the Committee on community mental health provision, including walk-in activity, wellbeing hubs and associated demand and outcomes.

43 **TEES ESK AND WEAR VALLEY (TEWV) NHS FOUNDATION TRUST - QUALITY ACCOUNT FOR 2025/26**

The Committee received a comprehensive presentation from representatives of Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust regarding the development of the Trust's Quality Account for 2025/26 and the emerging priorities for 2026/27.

In introducing the report, the statutory requirement for NHS Trusts to

produce an annual Quality Account, setting out performance against key quality domains of patient experience, patient safety and clinical effectiveness, alongside priorities for improvement in the forthcoming year were outlined. Members were advised that the Trust was in the process of finalising its Quality Account, with stakeholder consultation scheduled prior to publication by the end of June 2026.

A central theme of the presentation was the Trust's continued commitment to co-production, with quality priorities developed in partnership with individuals with lived experience, carers and wider stakeholders. Members noted that this approach aimed to ensure that service improvement was grounded in real experiences and reflective of the needs of those accessing services.

The Committee was advised that the Trust's three overarching quality priorities remained as:

1. Improving patient experience through education and the use of lived experience;
2. Enhancing patient safety through a focus on relapse prevention; and
3. Strengthening clinical effectiveness through personalised approaches to urgent care.

In relation to patient experience, Members heard about work to embed lived experience within training, governance and decision-making processes. This included the development of co-creation frameworks, strengthened partnerships with external organisations, and initiatives to improve carer involvement. It was also acknowledged that, whilst significant activity was underway, work to ensure consistent strategic oversight and meaningful engagement of carers remained at an early stage.

The Committee was informed that, in respect of patient safety, the Trust had focused on relapse prevention and the development of personalised safety and wellbeing plans. Progress had been made in embedding new policies and training, supported by the Quality Assurance and Improvement Programme. However, Members were advised that further work was required to ensure consistency in practice, particularly in relation to post-discharge support and meaningful carer involvement.

With regard to clinical effectiveness, the presentation highlighted the implementation of the "My Story Once" approach, designed to reduce the need for patients to repeatedly recount their experiences when accessing different services. This work was supported by improvements in information sharing, digital systems, and workforce training, alongside the development of Trust-wide guidance promoting a "One Person, One Assessment" model of care.

Across all three priority areas, assurance was currently rated as “reasonable”, with clear evidence of progress but recognition that further work was required to demonstrate consistent impact and sustainability.

During discussion, Members welcomed the co-production approach and acknowledged the importance of embedding lived experience in shaping services. Members commended the increased focus on personalisation and improved information sharing, recognising these as critical to enhancing patient experience.

However, Members also raised a number of significant concerns and challenges. These included:

- The increasing demand for children and young people’s mental health services, including rising rates of distress and suicide;
- Long waiting times for neurodevelopmental assessments and CAMHS services, and the impact of delays on families;
- A perceived lack of communication and ongoing support for individuals awaiting assessment or treatment; and
- The need for stronger engagement with schools and community settings to support early intervention and prevention.

Members emphasised the importance of ensuring that children and young people had accessible routes to support and highlighted the value of early engagement and education in preventing escalation of need.

Further discussion explored issues relating to equality, diversity and inclusion, with Members seeking assurance regarding cultural competence and the Trust’s ability to meet the needs of diverse populations. It was acknowledged that this remained an area for development and the Director outlined ongoing work to improve understanding of inequalities, including initiatives aimed at becoming an anti-racist organisation and enhancing staff training.

Members also considered the challenges associated with data sharing and multi-agency working, noting the complexity of delivering truly integrated care across organisational boundaries. Whilst recognising existing partnership working, Members stressed the importance of continued progress towards a more unified and accessible system for both patients and professionals.

In response, the concerns raised were acknowledged, particularly in relation to waiting times and communication. It was noted that these challenges reflected wider national pressures and increasing demand. It was confirmed that work was ongoing to reshape pathways, improve communication, and strengthen partnership working, although resource constraints remained a significant limiting factor.

In concluding the discussion, the Chair thanked representatives for a comprehensive and candid presentation, recognising both the progress made and the challenges that remained.

RESOLVED that:

1. The update on the TEWV Quality Account 2025/26 be noted;
2. Members' comments be taken into account in finalising the Quality Account; and
3. A draft Statement of Assurance be prepared on behalf of the Committee and circulated for approval, with final sign-off delegated to the Chair and Vice-Chair.

44 **WORK PROGRAMME 2025/26**

Members reviewed the items scheduled within the current programme and those identified for future consideration during the 2026/27 municipal year. In doing so, the Committee recognised the breadth and complexity of issues within the health system, and the importance of prioritising those matters that presented the greatest impact on patient outcomes and service delivery.

In concluding the item, the Chair reiterated the importance of the Work Programme as a key mechanism for the Committee to discharge its scrutiny function effectively, ensuring transparency, accountability and continuous improvement across the health system.

RESOLVED that the Work Programme be noted.

45 **ANY OTHER ITEMS WHICH THE CHAIR CONSIDERS URGENT**

The Chair raised a few additional areas of concern, most notably in relation to neonatal and maternity service provision across the Tees Valley.

The Senior Democratic Services Officer advised that correspondence had recently been received from NHS England in respect of changes to neonatal services. Members were informed that the date as to when new pathway changes would come into effect was yet to be confirmed, but it was anticipated that plans were due to be implemented during summer 2026.

It was noted that since January 2026 NHS England had established an implementation board to oversee the changes. Representatives from all neonatal service providers were currently developing more detailed mobilisation plans, and this work included ongoing patient engagement activity.

In addition, a task and finish group had been established, which included patient representatives from across the region through a Parent Advisory Group as well as continuing work carried out by Care Co-ordinators from the Neonatal Network who have very close relationships with families. It was advised that as this work progressed across the region, there would be further opportunities for the involvement of families from the Tees Valley area, and this would be specific to focus on any impact for the local area.

The Senior Democratic Services Officer advised that NHS England commissioners had advised that additional information could be provided to Members, as the implementation plans progressed.

During discussion Members drew reference to patient pathways and those involving transfers between hospital sites, with concerns expressed regarding continuity of care, specialist expertise and the overall patient experience for families. Members emphasised that these issues were of significant public interest and fell squarely within the Committee's remit for scrutiny.

Members agreed that the Committee had an important role in ensuring that significant service developments or potential risks were subject to appropriate oversight, particularly where changes could affect patient safety, accessibility or service quality. There was a shared view that future work programming should continue to reflect both locally raised concerns and strategic system priorities, ensuring that the Committee remained proactive in its scrutiny role.

The importance of engaging with partner organisations, including Trusts, Integrated Care Boards and local authorities, was also highlighted, with Members noting that collaborative working was essential to gaining a comprehensive understanding of system pressures and performance.

In response to Members' comments, it was confirmed that the issues raised would be included within the forward Work Programme, with further scoping undertaken where necessary to determine the most appropriate approach to scrutiny. It was also noted that opportunities remained for additional briefings or reports to be scheduled, either at Committee level or through informal Member development sessions, should emerging issues require more immediate consideration.

RESOLVED that an invite be extended to NHS England commissioners to attend a meeting of the TVJHSC to discuss the proposed changes regarding Neonatal Critical Care pathways across the North East and North Cumbria.

Member Report
Update on Neonatal Services
Report to: Tees Valley Joint Health Scrutiny Committee
Report from: Democratic Services
Decision Type: Committee

HEADLINE POSITION

1. Summary of report

1.1 The Tees Valley Joint Health Scrutiny Committee is receiving a presentation from NHS England and the Northern Neonatal Network providing an update on neonatal services across the North East and North Cumbria, at the request of Members during the March 2026 meeting of the TVJHS.

1.2 The presentation outlines the implementation of the national Neonatal Critical Care Review, the proposed pathway changes, and the anticipated impact on patients and families, including those within the Tees Valley area.

2.0 Recommendation

2.1 It is recommended that Members note the information presented and consider the implications of the proposed pathway changes for local services and families.

3.0 Background

3.1 The Neonatal Critical Care Review was published in 2019 and aims to standardise neonatal services nationally, ensuring care is delivered in line with agreed service specifications. NHS England has instructed regional neonatal networks to implement changes to bring services into compliance with these standards.

3.2 The Northern Neonatal Network has undertaken a review of neonatal services across the region and is progressing implementation of pathway changes during summer 2026. Ongoing engagement with families and stakeholders is taking place as part of this process. Representatives from NHS England and the Northern Neonatal Network will be in attendance to present the update and respond to Members' questions

4.0 Background Papers

4.1 There are no background papers to this report.

5.0 Contact Officers

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Update on Neonatal Services

Northern Neonatal Network
NHS England - Specialised Commissioning
North East and North Cumbria ICB

June 2026

Introductions

- Dr Sundeep Harigopal, Clinical Lead of Northern Neonatal Network and Consultant Neonatologist at Newcastle Hospitals
- Charlotte Bradford, Network Manager, Northern Neonatal Network
- Catherine Balazs, Head of Specialised Commissioning, North East North Cumbria, NHS England
- Craig Blair, Director of Commissioning, North East and North Cumbria Integrated Care Board
- Yasmin Sultana Khan, Service Specialist, Specialised Commissioning, North East and North Cumbria, NHS England

Today

- Overview of Neonatal Care
- Implementation of national Neonatal Critical Care Review
- Impact for patients and families
- Summary and next steps

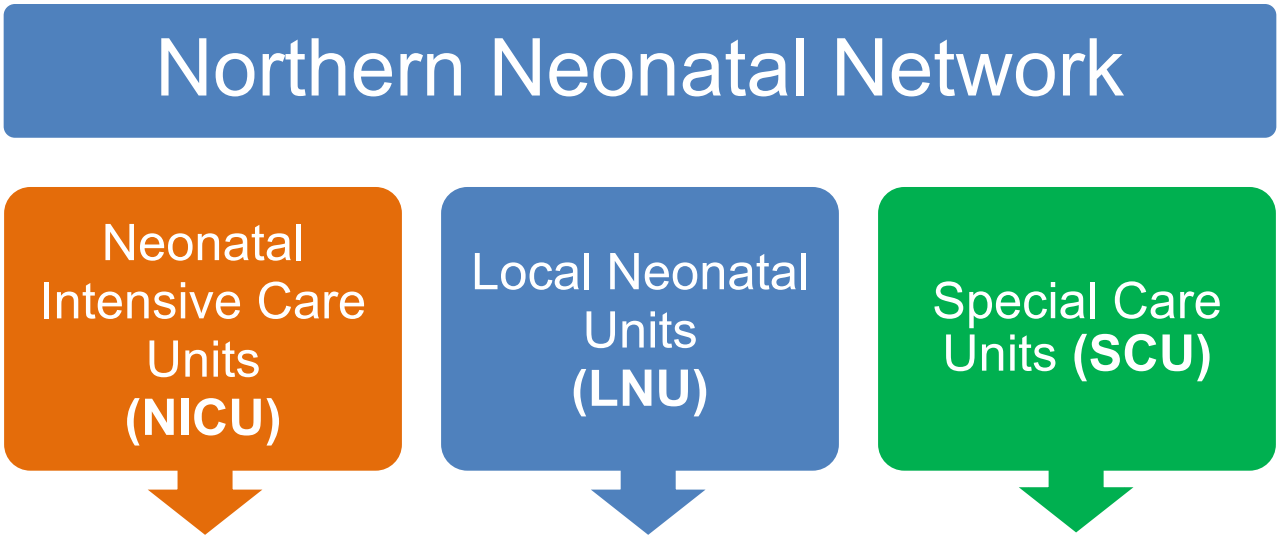
Overview of Neonatal Care

- Neonatal critical care includes intensive care, high dependency care and special care. Neonatal Critical Care Services provide specialist medical and surgical inpatient care for newborn babies requiring ongoing hospital admission after their birth.

- Neonatal services are currently delivered as part of a networked arrangement across the North East and North Cumbria region. This means that when a mother and baby need a neonatal intensive care cot, it is dependent on cot availability – with families having to travel further to access the specialist care they need.

- There is a dedicated neonatal transport service (NNETs) to coordinate the movement and support babies being transferred to and from neonatal units of babies around the region, which is fully functional.

Overview of current Neonatal Care



- Royal Victoria Infirmary (RVI) Newcastle
- Sunderland Royal Hospital
- James Cook Hospital, Middlesbrough

None

- NSECH, Cramlington
- Queen Elizabeth Hospital, Gateshead
- University Hospital of North Durham
- Darlington Memorial Hospital
- University Hospital of North Tees, Stockton
- Cumberland Infirmary, Carlisle
- West Cumberland Hospital, Whitehaven

Background to NCCR…

- **2019** - The Neonatal Critical Care Review (NCCR) was published in 2019 with the aim of standardising neonatal services across the UK by aligning units with defined service specifications.
- **2019- 2023** The Neonatal Network completed the actions and recommendations from a previous review in 2015. This included a pathway change at South Tyneside and Sunderland FT (Sunderland NICU)
- **March 2024** - The Northen Neonatal Network was instructed by NHS England to review the regional service provision and make recommendations to bring services in line with both the NCCR recommendations and the Specialised Commissioning neonatal critical service specification in March 2024.
- **June 2024** - The Neonatal Network constituted a task and finish group in 2024 to take a proposal to the Network Board, Local Maternity and Neonatal Services (LMNS) and NHS England.
- **June 2025 – to December 2025** - A briefing paper describing the proposal for reconfiguration of neonatal services in the network and the associated impact was then taken through NHS England governance meetings and to the ICB Sub-Committee.
- **January 2026** – Communications to advise system partners of implementation of pathway threshold plans for SCUs in line with national service specification. Face to face presentation to North East Joint Overview and Scrutiny committee, information and offers for meetings to Tees Valley and Cumberland OSCs.

Wider national and regional context

- Nationally NHS England does not support deviation from the national service specification, the threshold for any exceptionality must be high, for example remote units on a geographical basis.

- There is a lack of support from regulators for models elsewhere in the North East and Yorkshire region that operate outside of the prescribed national service specification.

- There is a declining birth-rate across the North East region.

Regional position

Review undertaken of all units and their designation by the Neonatal Network to ensure best birth outcomes, consistent with NCCR standards.

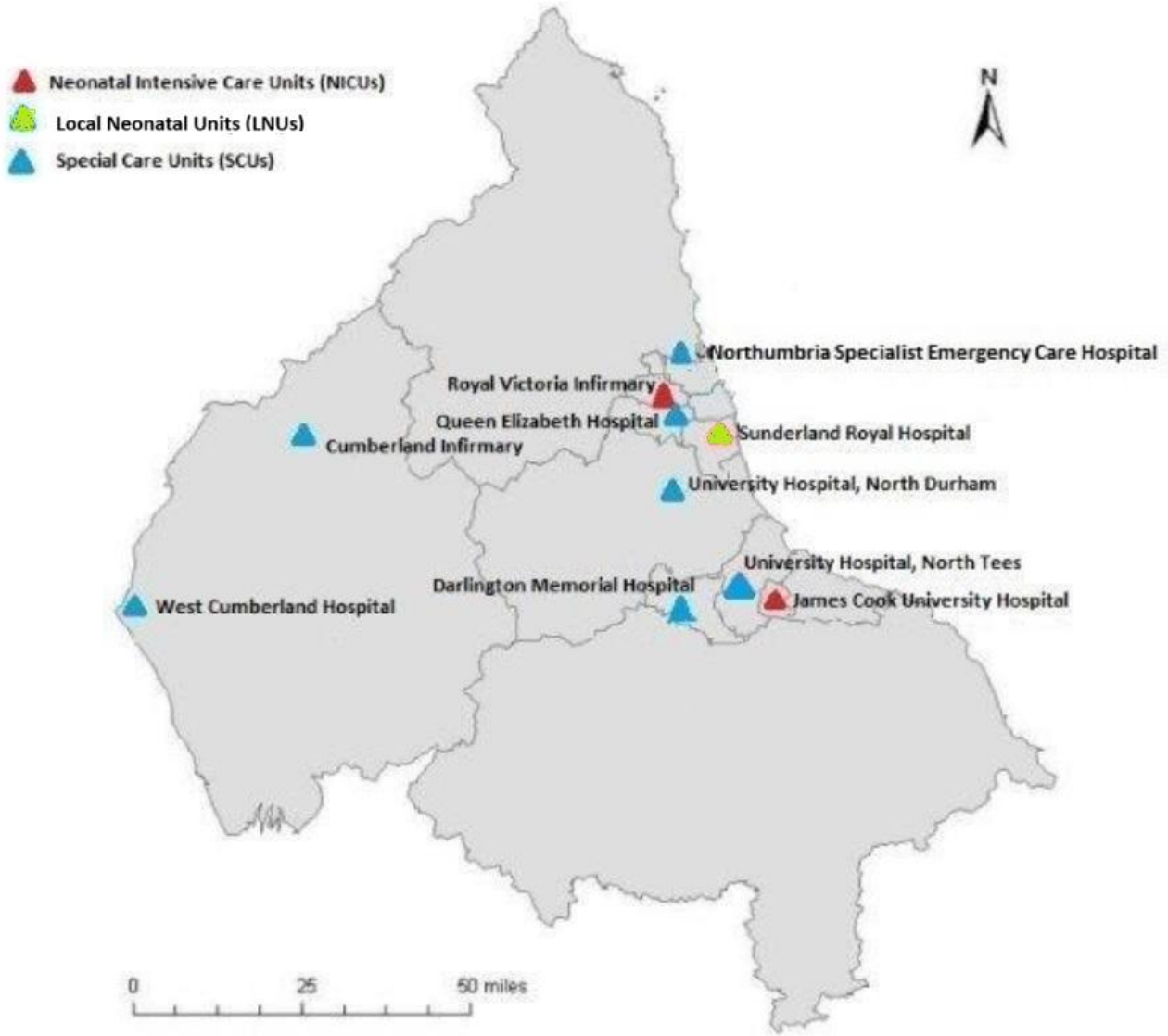
The main changes required in NENC to meet the standards are:

- **5 out of the 7 Special Care Units (SCUs)** need to increase their admission threshold from 30 weeks to 32 weeks gestation in line with NCCR standards and national prescribed service specification (including University Hospital of North Tees and Darlington Memorial Hospital)
- **Sunderland Neonatal Intensive Care Unit (NICU)** to be designated a Local Neonatal Unit (LNU). Sunderland NICU currently takes babies from 26 weeks gestation, and this admission threshold as an LNU will change by one week i.e. to 27 weeks gestation

The above changes will give NENC a dedicated Local Neonatal Unit and 7 Special Care Units that will meet all the national requirements and have potential for them to be gold standard units

Any delay in agreeing the recommendations impacts on wider network changes.

Future neonatal network model…



Impact for families

Context

Between 800 to 850 babies are already moved across the region each year to ensure care is delivered at the right place.

Special Care Units (SCUs)

Approximately **14 babies across the NENC region** will be moved per year with the updated two week pathway (i.e. from SCUs to an LNU or NICU)

For North Tees this would be between 1 to 4 babies per year
For Darlington this would be between 1 to 5 babies per year

These babies would be cared for outside of the North Tees and Darlington SCUs i.e. at South Tees Hospitals (James Cook) until ready to be returned to their local SCU.

Estimated between 2 to 9 babies moved in a year out of 4,320 births (less than 1%)

Feedback from families 2023

'Parents need to understand the reasons why they are being sent where they are being sent'

'There is only a small number impact, but what about the financial impact for these families'

'There is a need for support travelling to a non-local neonatal unit – more information should be made available about this.'

'There is a need to consider the mental health impact for Mums who are accessing neonatal services'

Information on support services

Following families asking for clearer information about practical neonatal support services, the Neonatal Operational Delivery Network has undertaken a comprehensive review of what is available at all sites covering:

- Accommodation available for neonatal families
- Availability of food and refreshments
- Travel
- Parking facilities

The network has provided assurances that there are sufficient support services, facilities and capacity across all sites to support the changes required to meet the service specifications.

Ongoing patient involvement

- Task and finish group in place which includes:
  - Patient representatives from across the region through a Parent Advisory Group
  - Care Co-ordinators from the Neonatal Network who have very close relationships with families

- Key themes from discussions to date have focussed on clearer communication for families accessing neonatal services, specifically in relation to support services that might be available.

- Additional engagement has involved families that have recently used neonatal services as well as women who were currently pregnant but had not had neonatal experience.

- This work was undertaken as informal conversations at neonatal playgroups, on NICUs and SCUs and during several listening events, and **secured feedback from 52 participants**.

Feedback from families 2024/25

Discussions to date have identified the following themes that are being taken forward:

- **Early availability of information:** Neonatal families said they would find travel around the region manageable if they have the correct information beforehand and feel involved in the discussions around any move.

- **Antenatal care conversations:** Families felt neonatal information would be useful at 16-20 weeks, if not at the initial time of booking. There should be an on-going conversation with maternity staff regarding the possibility of families requiring neonatal care for it to become less scary and more normalised.

- **Specialist ambulance transport**: Families provided useful information about the actual movement around the network and the use of the NNeTS transport service and what to expect based on their experiences.

- **Families who have not experienced neonatal care**: Participants understood that if moving their baby led to improved care in terms of meeting their needs, it would be a good thing. Areas of interest to manage any anxieties included family support close to them, having access to their child and information about how the baby would be transferred and if any of this would have any detrimental effects.

Commissioner and wider stakeholder involvement

The changes are supported by system partners:

- Northern Neonatal Network and NHS Foundation Trust representatives
- The North East and North Cumbria Local Maternity and Neonatal System
- NHS England (North East and Yorkshire region)
- North East and North Cumbria Integrated Care Board (via its Joint Committee arrangements with Specialised Commissioning)

Summary and next steps

- Babies already move across the region to ensure than the right care is provided in the right place to ensure highest level of care is given to our babies and families

- The Northern Neonatal Network seeks to progress with implementation of the pathway standards in line with the national review recommendations during summer 2026.

- Further engagement will take place with patients and staff as part of implementation plans and transition to any new pathway arrangements.

Although the impact is small in terms of numbers, the impact of the change and on patient experience will be monitored closely by the Northern Neonatal Network.

Thank you and questions

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Member Report
University Hospitals Tees (UHT) Quality Account 2025/26
Report to: Tees Valley Joint Health Scrutiny Committee
Report from: Democratic Services
Decision Type: Committee

HEADLINE POSITION

1 Summary of report

1.1 The Tees Valley Joint Health Scrutiny Committee is receiving a presentation from University Hospitals Tees (UHT) on its Quality Account for 2025/26.

1.2 The Quality Account outlines performance across the Trust's key quality domains of patient safety, clinical effectiveness and patient experience, and sets out priorities for improvement for 2026/27.

2 Recommendation

2.2 It is recommended that Members:

- Note the information presented; and
- Consider the key issues and priorities set out within the Quality Account.

3 Background

3.1 NHS Trusts are required to publish an annual Quality Account, setting out performance over the previous year and identifying priorities for improvement.

3.2 The 2025/26 Quality Account produced by University Hospitals Tees as a hospital group, covering both North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, and reflecting shared priorities across the organisation.

3.3 The Committee has an opportunity to review the Quality Account and provide feedback on performance and proposed priorities. Representatives from UHT will be in attendance to present the report and respond to Members' questions.

4 Background Papers

4.1 There are no background papers to this report.

5 Contact Officers

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TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

TUESDAY 2 JUNE 2026

QUALITY ACCOUNT 2025/26

UNIVERSITY HOSPITALS TEES
South Tees Hospitals NHS Foundation Trust
North Tees & Hartlepool NHS Foundation Trust

Caring
Better
Together

University Hospitals Tees
Approach to the Quality Account

- This year marks our second full cycle since the formal creation of University Hospitals Tees as a hospital group—uniting the strengths of our two trusts to harness shared opportunities, enhance operational resilience and improve population health outcomes.
- University Hospitals Tees has produced a single Quality Account reflecting our shared quality priorities, and performance and achievements across South Tees Hospitals NHS Foundation Trust and North Tees & Hartlepool NHS Foundation Trust.
- A single Quality Account supports greater consistency, transparency and collaboration across the UHT.
- Residents will continue to access services at their local hospitals however, service delivery will increasingly take place across all UHT hospital sites.

Purpose

- To provide assurance on quality, safety and experience
- To summarise performance in **Middlesbrough, Redcar and North Yorkshire (South Tees)** and **Stockton and Hartlepool (North Tees & Hartlepool)**
- To highlight progress, challenges and next steps

Context

- Single Group Quality Account
- Maintains **local accountability and site-specific transparency**

Our Local Services

South Tees Hospitals NHS Foundation Trust

- James Cook University Hospital
- Redcar & Cleveland community hospitals
- ~1.5 million patient contacts annually
- CQC overall rating: **Good**

North Tees & Hartlepool NHS Foundation Trust

- University Hospital of North Tees
- Lawson Street Health Centre
- Tees Valley Community Diagnostic Hub (Stockton)
- Serving ~500,000 residents
- CQC overall rating: **Requires Improvement**

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Shared Quality Priorities 2025/2026

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

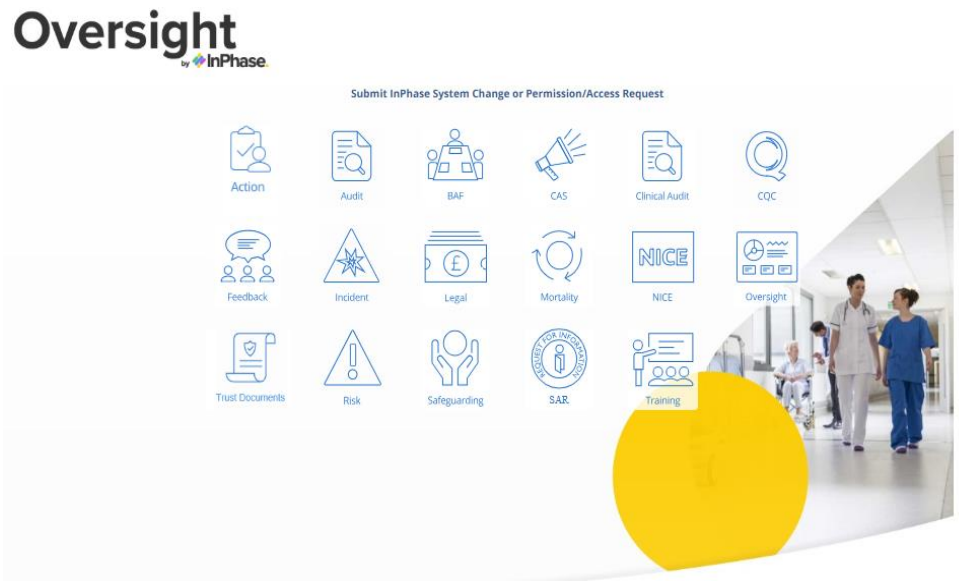
Patient Safety & Learning from Incidents

South Tees

- Full implementation of Patient Safety Incident Response Framework (PSIRF)
- 8 out of 16 PSIRF evaluation recommendations delivered
- Incident reporting dip in March 2026 linked to system change, now recovering

North Tees and Hartlepool

- Medication incident rate ~6.2%
- No medication-related never events
- 50% reduction in time-critical medication omissions



Assurance:

- Unified incident reporting system (Healthcare Guardian) now live across UHT

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Medication Safety & ePMA

South Tees

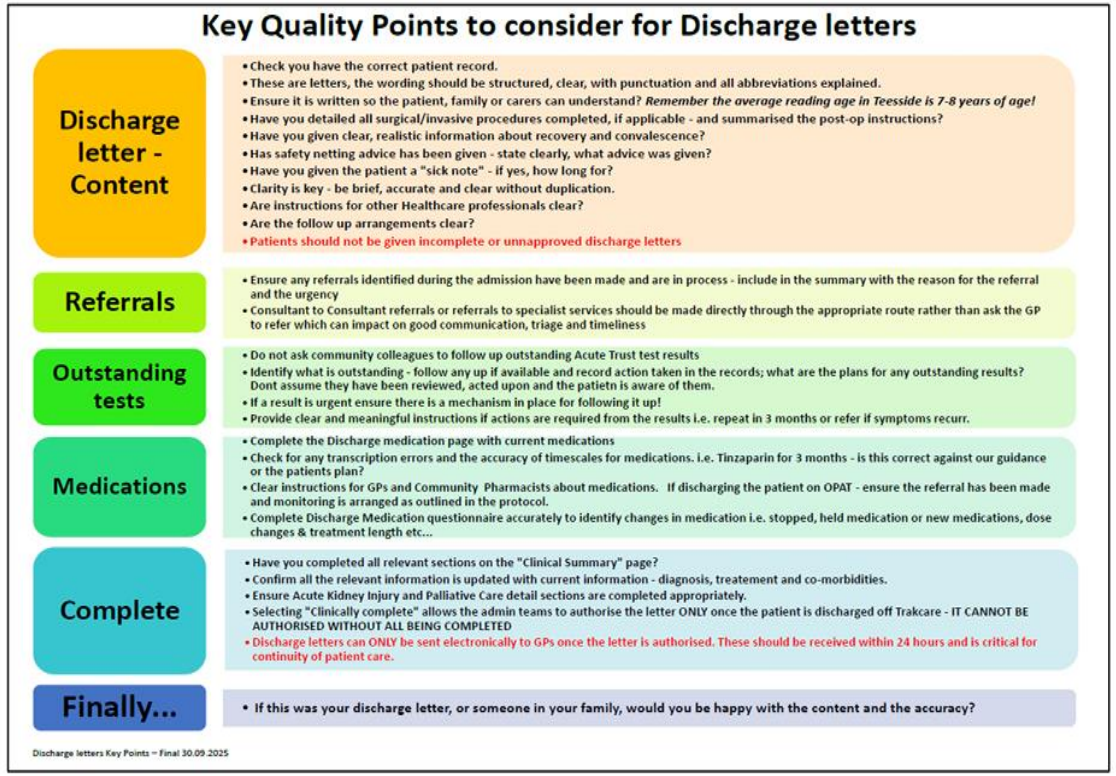
- 17 million medication doses via electronic prescribing (ePMA)
- Lowest regional antibiotic consumption (January 2026)
- Innovative penicillin de-labelling service (national recognition)
- EPMA implemented across all Critical Care areas
- Prescribing Pharmacist within the Discharge Lounge

North Tees and Hartlepool

- EPMA 2.0 fully embedded including IV medications
- Further recruitment into Pharmacy will support medicines reconciliation performance
- Pharmacy recruitment in Lipid Clinics
- Safety Initiatives – PharmOutcomes supporting safer discharge (Box 4)
- Guidance produced to support high quality Discharge Letters

Next steps:

- UHT-wide medicines dashboards and benchmarking
- Developing ePMA dashboards further to support availability of data to support time critical medication (Priority for 26/27)



Infection, Prevention & Control

South Tees

- Expanded FIT testing service
- Regional leadership on antimicrobial stewardship
- Ongoing deep-clean and decant programme
- Did not meet trajectory for CDI however we have seen a decrease on previous year

North Tees and Hartlepool

- Enhanced respiratory IPC support
- Improved audit and compliance structures
- Reduction in CDI – 59 against a threshold of 66

Both Trusts

- IPC Pathways and Care Plans developed within electronic patient record for CDI and MRSA
- Weekly healthcare associated infection (HCAI) reviews
- C. difficile reduction remains a priority for 2026/27

Learning from Deaths and Mortality

South Tees

- 1,835 deaths
- 208 case record reviews completed
- 0.01% judged more likely than not due to care issues

North Tees and Hartlepool

- 1,198 deaths
- 53 case record reviews
- 0% judged more likely than not due to care issues

UHT improvement and focus:

- UHT Learning from Deaths team with increased resource
- Appointed Medical Senior Mortality Lead
- Learning from Deaths UHT Group established
- Single UHT Learning from Deaths framework
- Combined Learning from Deaths report including learning from the ME, child deaths and LEDER

Clinical Effectiveness & Audit

NICE Guidance Compliance

- South Tees: 74.7% compliant
- North Tees and Hartlepool: 99.4% compliant

Local Audit Activity

- South Tees : 369 audits reviewed
- North Tees and Hartlepool: 112 audits reviewed

Assurance:

- New GIRFT & Audit Panel providing stronger oversight

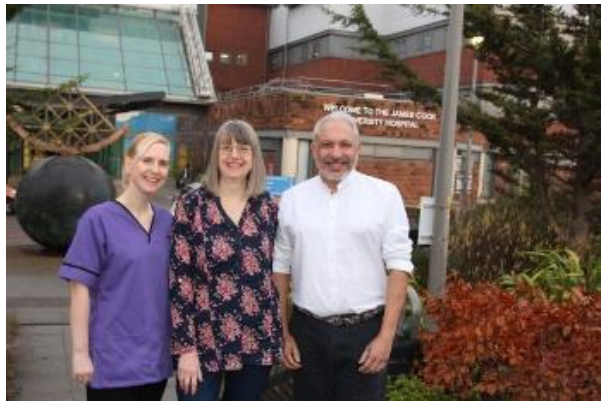
Patient Experience and Complaints

South Tees

- FFT scores above national average
- Response timeliness improving

North Tees and Hartlepool

- FFT scores above national average
- Improved oversight through Clinical Service Unit (CSU) dashboards



Action Taken:

- Unified UHT complaints policy
- Family Liaison Officers embedded
- External audits completed (PwC / Audit One)

Patient Experience and involvement

- Feedback from the National Audit of Dementia highlighted that patients at FHN did not rate the food highly
- The Patient Involvement Facilitator alongside clinical colleagues and patients produced a dementia friendly menu
- Engagement took place with various dementia community groups for feedback
- This improvement work was put forward for a UK Dementia Award which the team went on to win.

The UK Dementia Awards
WINNER
2026

Caring Better Together

Mental Health & Vulnerable Groups

Across Trusts:

- Joint UHT Mental Health Strategy live
- Suicide prevention plan endorsed locally
- 1,267 staff trained in mental health awareness
- Right Care Right Person implemented
- Trauma-informed care programme launched

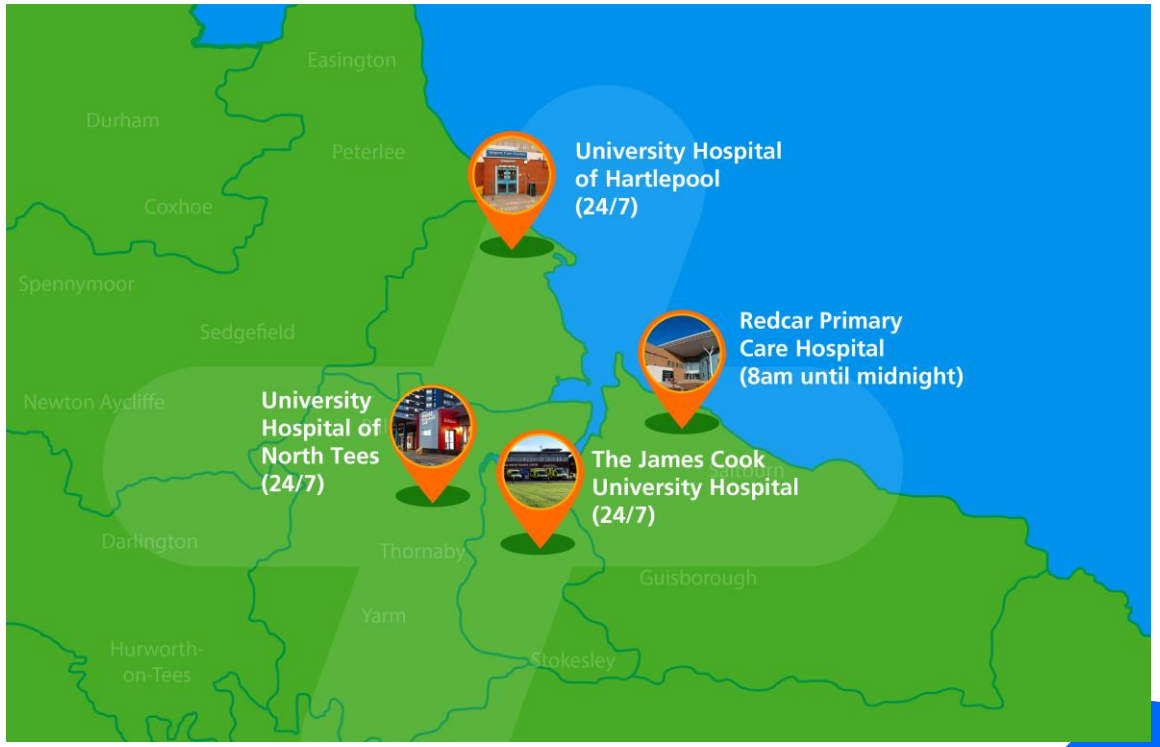
Urgent and Emergency Care

South Tees

- UTC at JCUH: ~60,000 patients/year

North Tees and Hartlepool

- Emergency Assessment Suite: 55 patients/day



Winter 2025/26:

- Ambulance handover delays reduced
- Flow improvements across both sites

Caring Better Together

Urgent and Emergency Care - UTC

Period	Attendances						
	UHNT	UHH	JCUH	RPCH	NTH FT	STH FT	TOTAL
Apr-25	5979	5600	5340	3392	11579	8732	20311
May-25	5934	5548	4545	3530	11482	8075	19557
Jun-25	5785	5470	5136	3468	11255	8604	19859
Jul-25	5785	5579	5074	3622	11364	8696	20060
Aug-25	5445	5043	5055	3407	10488	8462	18950
Sep-25	5552	5460	5112	3276	11012	8388	19400
Oct-25	5766	5456	5254	3454	11222	8708	19930
Nov-25	5835	5644	5431	3382	11479	8813	20292
Dec-25	5933	5528	5450	3510	11461	8960	20421
Jan-26	5718	5249	5173	3432	10967	8605	19572
Feb-26	5324	4929	4545	3237	10253	7782	18035
Mar-26	6197	5870	5484	3898	12067	9382	21449
Total	**69253**	**65376**	**61599**	**41608**	**134629**	**103207**	**237836**

4 Hour Compliance %				
UHNT	UHH	JCUH	RPCH	Overall
99.40%	99.80%	94.62%	95.61%	**97.62%**
99.73%	99.96%	95.89%	98.33%	**98.53%**
99.40%	99.73%	95.44%	97.32%	**98.10%**
99.91%	99.91%	93.18%	98.51%	**97.96%**
99.72%	99.90%	95.79%	99.62%	**98.70%**
99.23%	99.82%	93.82%	98.99%	**97.93%**
99.74%	99.76%	95.09%	98.61%	**98.32%**
99.73%	99.65%	96.11%	97.84%	**98.42%**
99.61%	99.53%	93.98%	96.92%	**97.62%**
99.63%	99.81%	93.18%	98.22%	**97.73%**
99.74%	99.90%	94.81%	98.55%	**98.33%**
99.68%	99.90%	94.46%	98.36%	**98.16%**

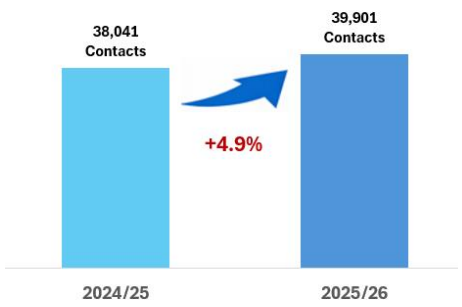
Caring Better Together

Comparison to last winter… South Tees

14-Week Winter Comparison: Mon 03/11/2025 to Sun 08/02/2026 (vs same period last year)

111 Contacts

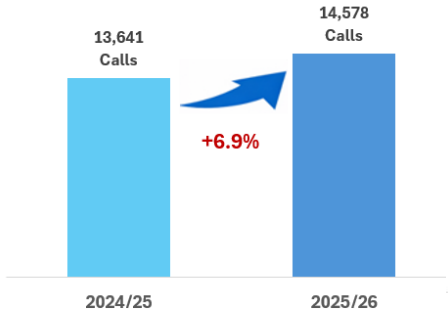
Winter Comparison



There were 1.8k more 111 contacts from residents of Middlesbrough and Redcar & Cleveland compared to the same period last year. This represents an 4.9% increase

999 Calls

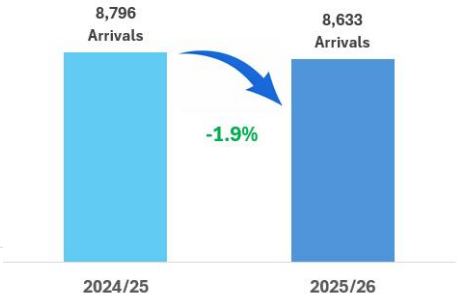
Winter Comparison



There were almost 1k more 999 calls from residents of Middlesbrough and Redcar & Cleveland compared to the same period last year. This represents a 6.9% increase

Ambulance Arrivals to ED

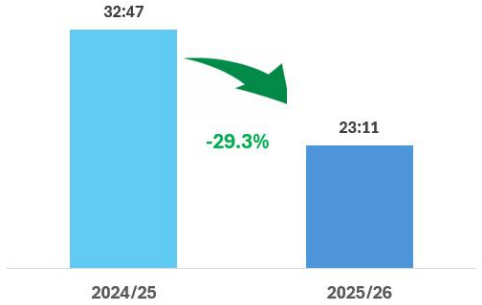
Winter Comparison



Ambulance arrivals to South Tees (STFT) decreased by 1.9% compared to the same period last year. 160 fewer ambulances arrived compared to the same period last year

Average Cat 2 Response Time

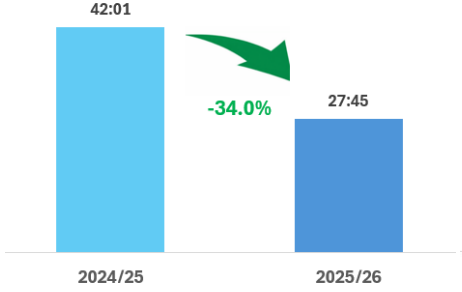
Winter Comparison



Despite the increase in total 999 calls, category 2 response times improved by over 9 minutes compared to the same period last year for residents of Middlesbrough and Redcar & Cleveland . This represents an 29.3% reduction

Average Handover Times

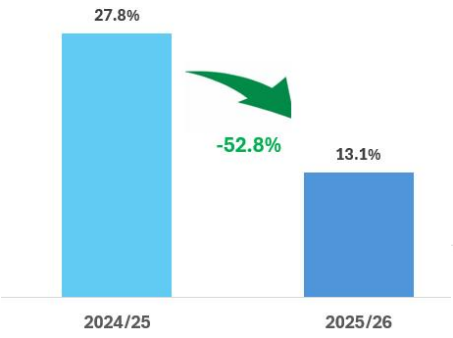
Winter Comparison



Average handover times improved by over 14 minutes compared to the same period last year. This represents a 34% improvement

% Handovers > 45 Minutes

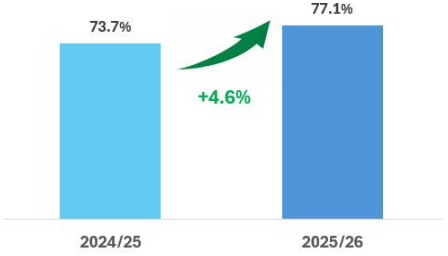
Winter Comparison



There has been a national focus on reducing the percentage of over 45-minute handovers at Emergency Departments this winter. At STFT there was a 52.8% improvement in this metric.

A&E Performance (All)

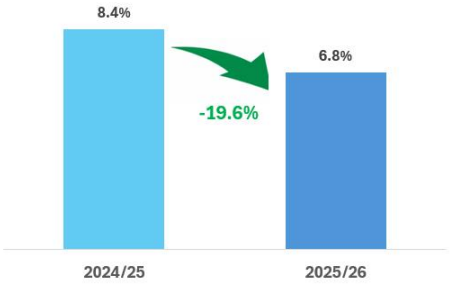
Winter Comparison



There were 3.5k more total attendances to A&E at STFT than there were in the same period last year. Despite this, A&E performance (those seen within 4-hours) improved versus last winter (an improvement of 4.6%)

% Patients Waiting 12-Hours in A&E

Winter Comparison



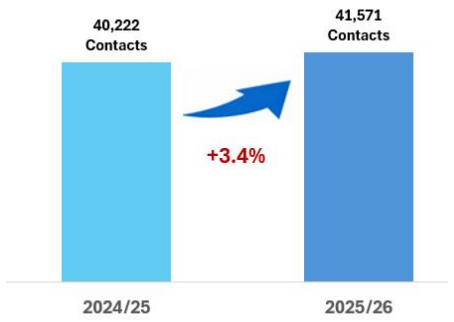
The percentage of type 1&2 attendances to A&E waiting in the emergency department for over 12-hours at STFT improved this winter versus last

Comparison to last winter… North Tees

14-Week Winter Comparison: Mon 03/11/2025 to Sun 08/02/2026 (vs same period last year)

111 Contacts

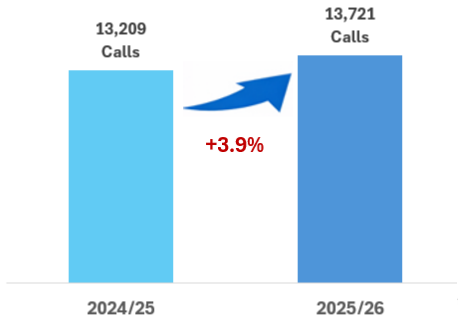
Winter Comparison



There were 1.3k more 111 contacts from residents c Stockton-on-Tees and Hartlepool compared to the sar period last year. This represents an 3.4% increase

999 Calls

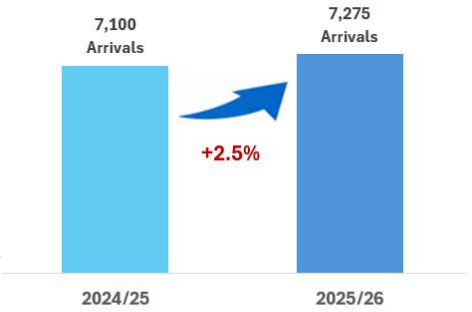
Winter Comparison



There were over 500 more 999 calls from residents of Stockton-on-Tees and Hartlepool compared to the same period last year. This represents a 3.9% increase

Ambulance Arrivals to ED

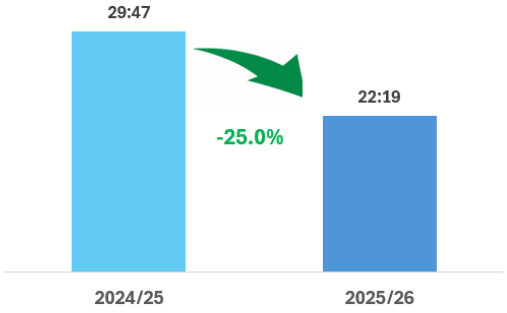
Winter Comparison



Ambulance arrivals to North Tees & Hartlepool (NTHFT) increased by 2.5% compared to the same period last year. Over 150 more ambulance arrivals than last year.

Average Cat 2 Response Time

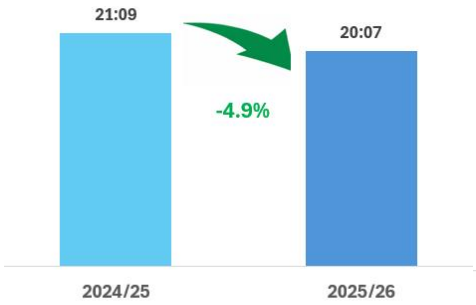
Winter Comparison



Despite the increase in total 999 calls, category 2 response times improved by over 7 minutes compared to the same period last year for residents of Stockton-on-Tees and Hartlepool . This represents an 25.0% reduction

Average Handover Times

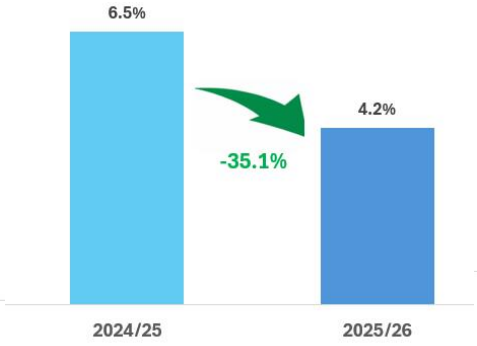
Winter Comparison



Despite this increase in arrivals to NTHFT Emergency Departments, average handover times improved by 1 minute compared to the same period last year. This represents a 4.9% improvement

% Handovers > 45 Minutes

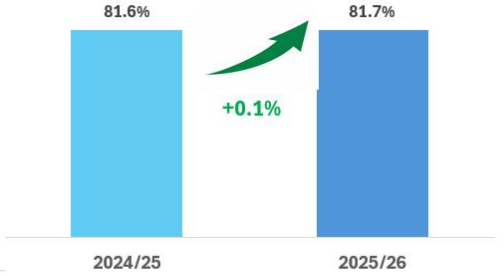
Winter Comparison



There has been a national focus on reducing the percentage of over 45-minute handovers at Emergency Departments this winter. At NTHFT there was a 35.1% improvement in this metric.

A&E Performance (All)

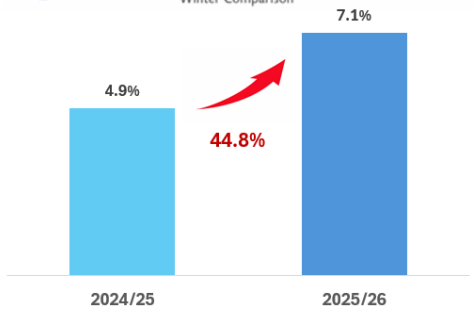
Winter Comparison



There were 400 more total attendances to A&E at NTHFT than there were in the same period last year. Despite this, A&E performance (those seen within 4-hours) improved slightly versus last winter (an improvement of 0.1%)

% Patients Waiting 12-Hours in A&E

Winter Comparison



The trend over NENC is that the percentage of patients waiting over 12-hours in A&E reduced versus last winter. At NTHFT, the percentage of patients waiting over 12-hours in A&E actually increased compared to last winter.

UHT Investment

Supporting the 10 year health plan - improved performance and patient experience (£49m for UHT)

£ Investment

University Hospital of North Tees (£31.24m)

- £3.5m — Additional MRI scanner
- £4m — New discharge lounge
- £22.24m — Critical Care

UHH

- £100,000 — Replacement bone densitometry scanner

FHN

- £1.6m — Replacement CT Scanner

The James Cook University Hospital (£17.8m)

- £2m — Replacement of CT scanner
- £5.5m — Expansion of resuscitation area in urgent and emergency care
- £6.75m — New admissions unit - urgent and emergency care
- £107,000 — Replacement of ultrasound unit
- £160,000 — Replacement of two ECHO machines
- £1.5m — CYPED Corridor

Community services

- £8,000 — Three (Raizor2) lifting chairs for hospital at home
- £20,000 — COPD assessment at home (i-STAT point of care CRP testing)

STHFT Performance against key national priorities.

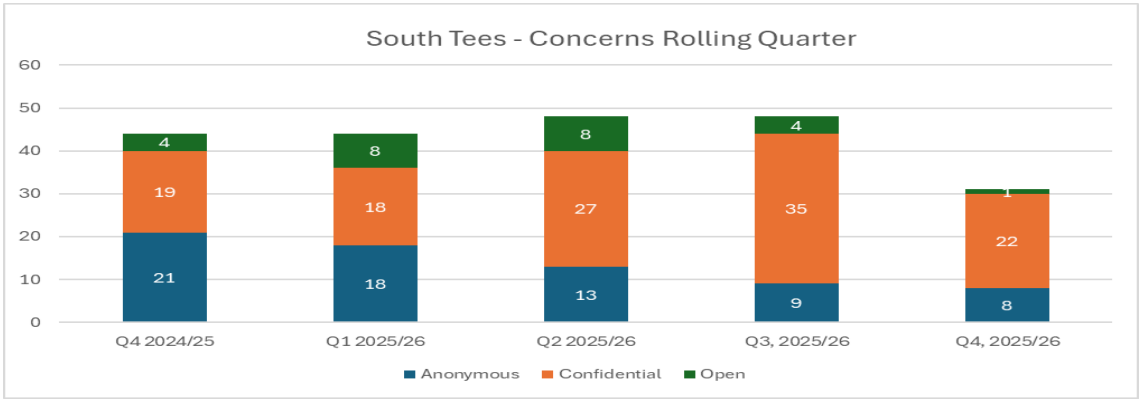
Single Oversight Framework Indicators	Standard / Agreed Trajectory	2025-26 Performance	2024-25 Performance	Achieved
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (Mar 26)	78.1%	80.0%	75.6%	✓
Receipt of two week wait / screening referral to date patient is informed of a diagnosis (FDS) or ruling out cancer (Mar 26)	80.0%	80.1%	72.5%	✓
31-day wait from decision to treat/earliest clinically appropriate date to treatment of cancer (Mar 26)	93.1%	81.6%	82.8%	×
62-day wait from urgent GP referral for urgent suspected cancer or breast symptomatic referral or urgent screening referral or consultant upgrade to first definitive treatment of cancer (Mar 26)	68.3%	70.5%	62.3%	✓
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (Mar 26)	65.0%	65.2%	60.3%	✓
Referral to Treatment 52 Week Waits as a percentage of overall waiting list (Mar 26)	1.0%	1.2%	2.7%	×

NTHFT Performance against key national priorities.

Single Oversight Framework Indicators	Standard/Agreed Trajectory	2025-26 Performance	2024-25 Performance	Achieved
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (March 26)	86.05%	86.19%	85.53%	✓
Receipt of two week wait / screening referral to date patient is informed of a diagnosis (FDS) or ruling out cancer (March 26)	81.00%	75.6%	78.74%	✗
31-day wait from decision to treat/earliest clinically appropriate date to treatment of cancer (March 26)	96.00%	97.8%	96.06%	✓
62-day wait from urgent GP referral for urgent suspected cancer or breast symptomatic referral or urgent screening referral or consultant upgrade to first definitive treatment of cancer (March 26)	75.00%	66.6%	66.98%	✗
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (March)	76.48%	70.52%	75.46%	✗
Referral to Treatment 52 Week Waits as a percentage of overall waiting list (March 26)	1.00%	0.98%	0.83%	✓

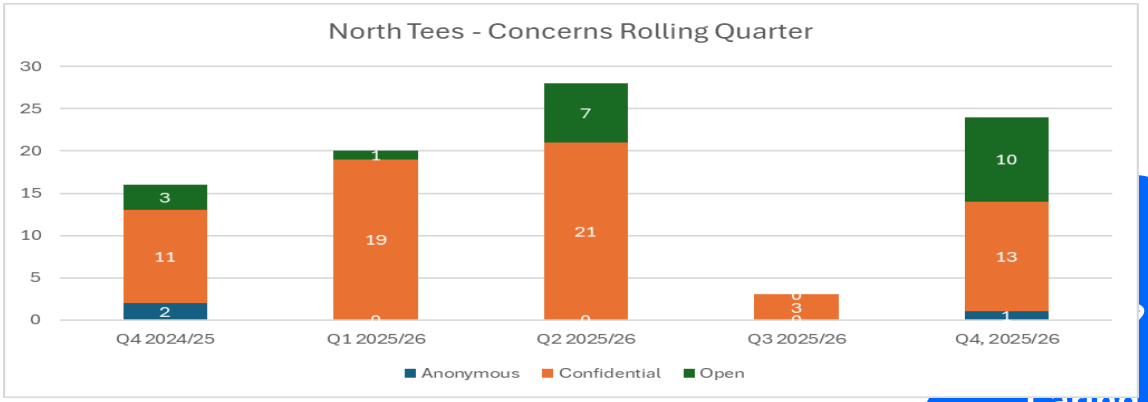
Staff and Culture

- Freedom to Speak Up concerns increased (positive reporting culture)
- Highest theme: inappropriate behaviours

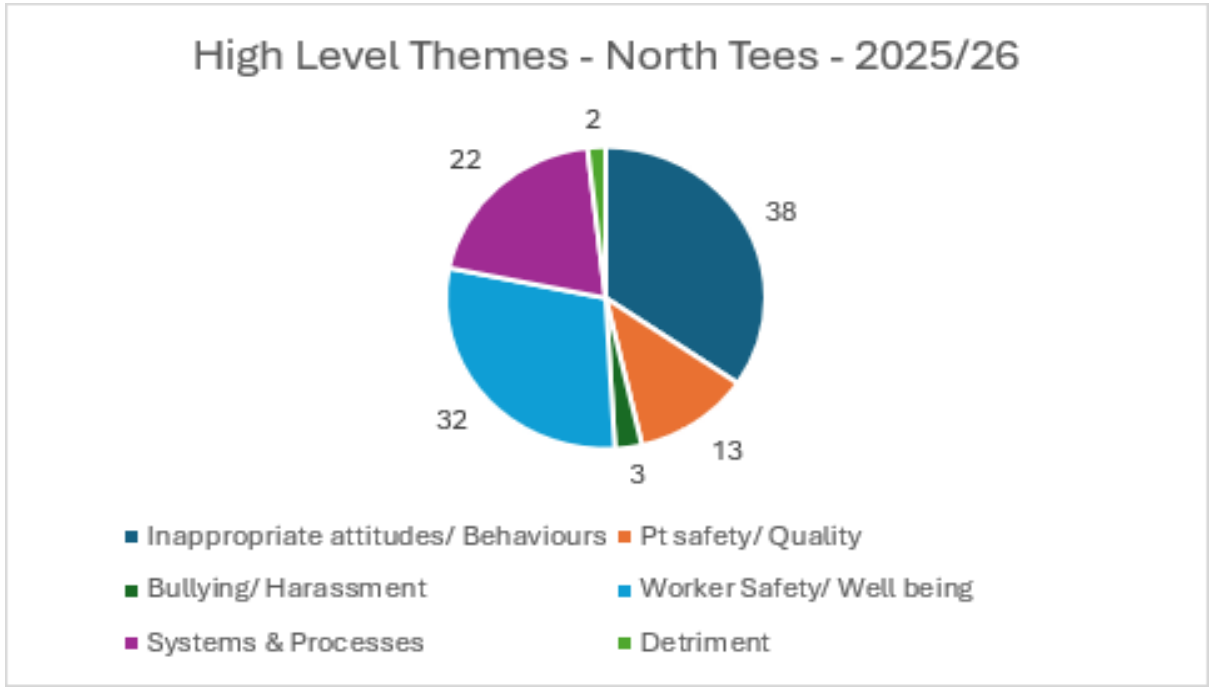


Next steps:

- Clinical Service Unit (CSU) level people plans
- Visible leadership and engagement



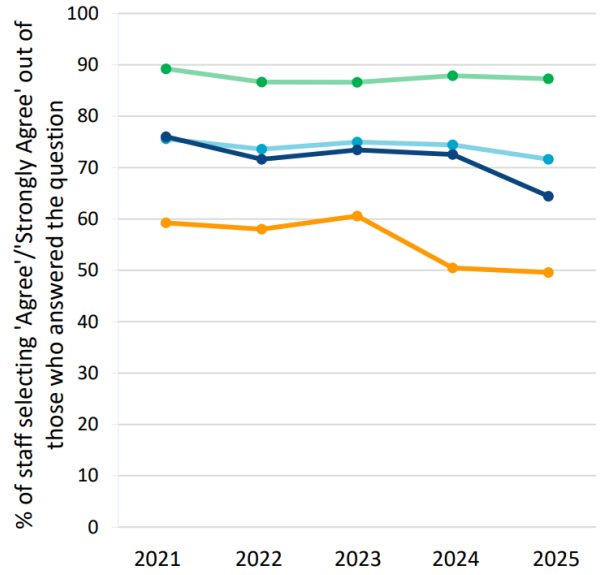
Staff and Culture – themes



Caring Better Together

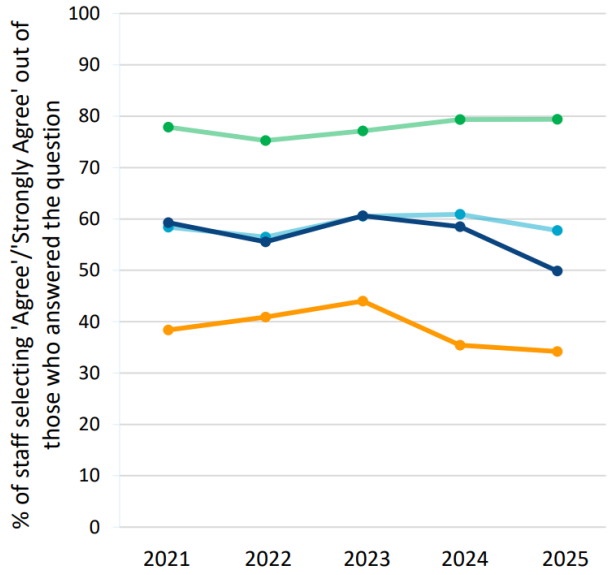
Staff Friends and Family Test – STHFT

Q25a Care of patients / service users is my organisation's top priority.



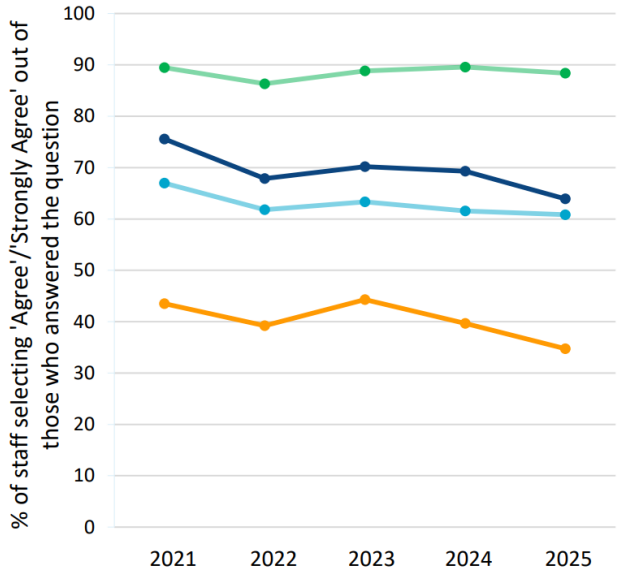
	2021	2022	2023	2024	2025
Your org	76.01%	71.64%	73.44%	72.53%	64.43%
Best result	89.24%	86.64%	86.62%	87.88%	87.31%
Average result	75.58%	73.58%	74.95%	74.42%	71.63%
Worst result	59.25%	57.99%	60.58%	50.48%	49.59%
Responses	2846	3324	3455	3036	2992

Q25c I would recommend my organisation as a place to work.



	2021	2022	2023	2024	2025
Your org	59.31%	55.56%	60.61%	58.49%	49.86%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	2851	3321	3456	3030	2988

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2021	2022	2023	2024	2025
Your org	75.57%	67.89%	70.20%	69.30%	63.90%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	2847	3322	3456	3030	2981

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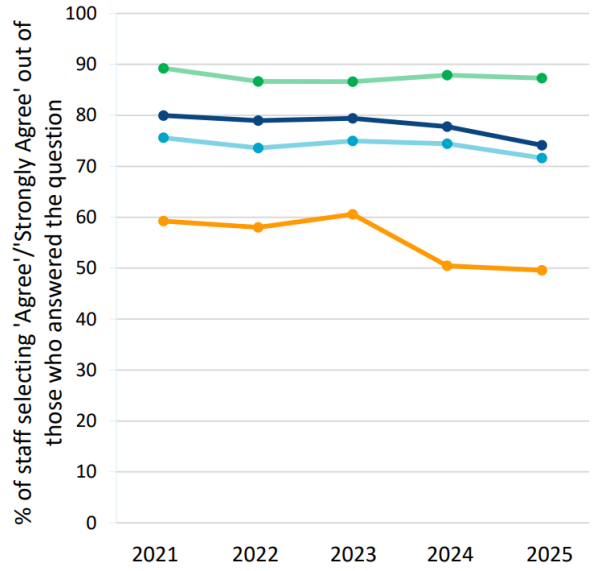
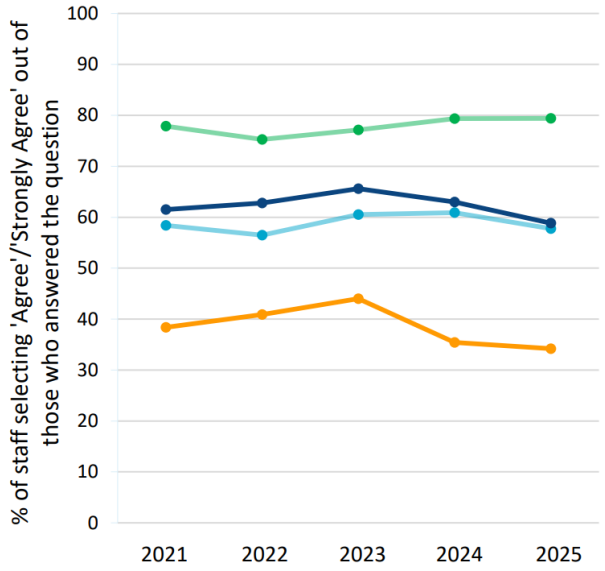
Staff Friends and Family Test – NTHFT

Q25a Care of patients / service users is my organisation's top priority.



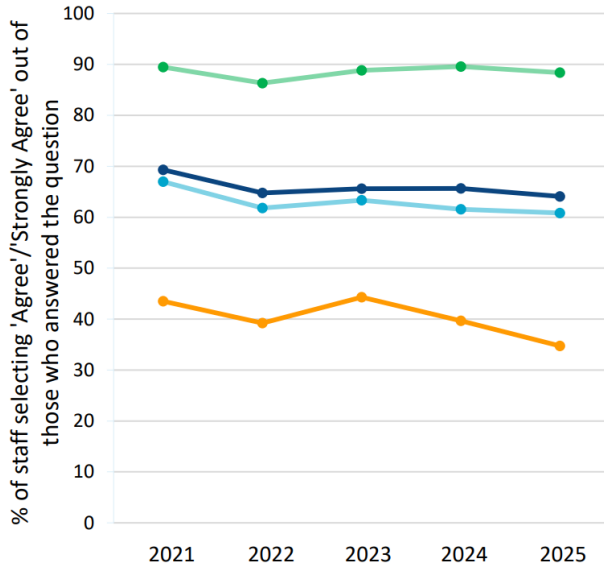
	2021	2022	2023	2024	2025
Your org	79.97%	78.94%	79.39%	77.79%	74.13%
Best result	89.24%	86.64%	86.62%	87.88%	87.31%
Average result	75.58%	73.58%	74.95%	74.42%	71.63%
Worst result	59.25%	57.99%	60.58%	50.48%	49.59%
Responses	2399	2348	2435	2325	2100

Q25c I would recommend my organisation as a place to work.



	2021	2022	2023	2024	2025
Your org	61.50%	62.79%	65.60%	62.99%	58.83%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	2403	2348	2432	2326	2098

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2021	2022	2023	2024	2025
Your org	69.30%	64.74%	65.59%	65.67%	64.08%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	2394	2342	2431	2325	2099

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What does this mean?

Middlesbrough, Redcar and North Yorkshire

- Medication safety
- Mortality review maturity
- UEC performance
- Complaints timeliness

Stockton and Hartlepool

- UEC flow improvement
- Antibiotic Access usage
- Mortality review capacity
- Antimicrobial consumption

Looking forward to 2026/2027
Quality Priorities

- It is proposed that the following 3 Quality Priorities from 2025/26 are discontinued;
  - 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 shared decision making and goals of care
  - 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

- 5 Quality Priorities have been revised and carried forward into 2026/27 to allow for further embeddedness and completion of actions.

Quality Priorities 2026/27

Patient Safety		
Revised Quality Priority 26/27 We will optimise learning from incidents, claims, and inquests to strengthen recognition and response to the deteriorating patient, improving patient safety outcomes and reducing avoidable harm.	**Revised Quality Priority 26/27** We will improve medication safety by optimising the use of the ePMA, and strengthening antimicrobial stewardship. We will achieve this by evaluating and embedding learning from medication incidents to reduce avoidable harm and improve the quality of prescribing against national and local standards.	**Revised Quality Priority 26/27** We will reduce risks of C. difficile, MRSA, GNBSIs (E. coli, Klebsiella, Pseudomonas) and other infections, embedding IPC good practice.
Patient Experience		
Revised Quality Priority 26/27 We will utilise patient and carer feedback as part of our continuous improvement methodology, with a specific focus on improving experience in the Emergency Department and eliminating corridor care.	**Revised Quality Priority 26/27** We will meet national Parliamentary & Health Service Ombudsman complaint standards	
Clinical Effectiveness		
Carried forward from 25/26 We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.		

Quality Priorities 2026/27 ‘in plain language’

Patient Safety

Learning from mistakes and improving care
We will learn from things that go wrong (like incidents and complaints) so we can spot when patients are getting worse sooner and act quickly to keep them safe.

Making medicines safer
We will make sure medicines are used safely and correctly by improving how they are prescribed and learning from any medication errors to prevent harm.

Reducing infections
We will work to prevent infections such as C. diff and MRSA by following good hygiene and infection control practices.

Patient Experience

Listening to patients and improving care
We will use feedback from patients and carers to improve services, especially in A&E, and work to stop treating patients in corridors.

Handling complaints properly
We will make sure complaints are dealt with fairly, quickly, and in line with national standards.

Clinical Effectiveness

Learning from deaths to improve care
We will carefully review deaths and use what we learn to improve care and outcomes for future patients.

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Quality Priorities mapped to strategic objectives

Quality Priority	Strategic Objectives Aligned
Reducing HCAIs	Consistent high-quality care; Using our resources well; Excellence as a learning organisation
Learning from incidents, claims, coroners in relation to recognition and response to the acutely ill patient.	Excellence as a learning organisation; Consistent high-quality care; Outstanding experience for our people
Medication Safety, ePMA, Antimicrobial Stewardship	Consistent high-quality care; Reforming models of care; Using our resources well
Mortality Review & LfD	Consistent high-quality care; Excellence as a learning organisation; Working with partners
Patient/Carer Feedback with a focus on 'Corridor Care'.	Consistent high-quality care; Excellence as a learning organisation; Outstanding experience for our people
Complaints Handling (PHSO)	Consistent high-quality care; Excellence as a learning organisation; Outstanding experience for our people

Proposed Quality Priorities 2026/2027

Each Quality Priority can be measured through:

1. Outcomes

Reduction in harm, variation, inequality, mortality, HCAIs, and medication errors.

2. Processes

Audit compliance, timeliness (reviews, complaints), ePMA uptake, PSIRF methodology application.

3. Experience

Patient-reported outcomes and experience, FFT, complaints quality, equity in feedback.

4. Workforce Capability

Inclusive practice training, QI involvement, safety culture.

5. Population Health

Access equity, diagnostic uptake, prevention outcomes, reduction in health inequalities.

Clinical Service Unit achievements

JAG (Joint Advisory Group (on GastroIntestinal (GI) Endoscopy) Accreditation

- North Tees and Hartlepool Hospital Endoscopy Service was reaccredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) for its highest standard of achievement.

Northern Endoscopy Training Academy (NETA) Academy Awards 2025

- North Tees and Hartlepool Endoscopy Team achieved success at the Northern Endoscopy Training Academy (NETA) Academy Awards 2025, winning the "***The Team of the Year"*** award in recognition of the outstanding teamwork, high-quality patient care, and contribution to endoscopy training across the region.
- Two of our Advanced Clinical Endoscopist were individually honoured with the "***Clinical Trainer of the Year Award",*** reflecting excellence in training, mentorship, and workforce development.

Clinical Service Unit achievements

The introduction of a Community Thoracic Service and a Day-1 Discharge Programme (D1DP) enables patients to recover safely at home with timely specialist review, rather than remaining in an acute hospital setting unnecessarily.

The D1DP demonstrates;
Early discharge following lung resection can be delivered safely and efficiently with high patient satisfaction when supported by a dedicated specialist community thoracic service.

Achievements;

- Significant reduction in length of stay
- Increased post op day 1 discharges
- Safe management of complex patients at home
- Low readmission rates
- High patient-reported satisfaction
- Meaningful financial and capacity benefits

Clinical Service Unit achievements

A new estate for the Emergency Assessment Suite at University Hospital of North Tees

Urgent Emergency Care standards aim to reduce clinical risk though a shared responsibility and enhance patient experience through more timely assessment and appropriate clinical pathways

Based on consistent compliance against these standards we received national UEC incentive funding which allowed us to develop a bespoke emergency assessment environment designed to overcome previous challenges with patient flow and clinical capacity.

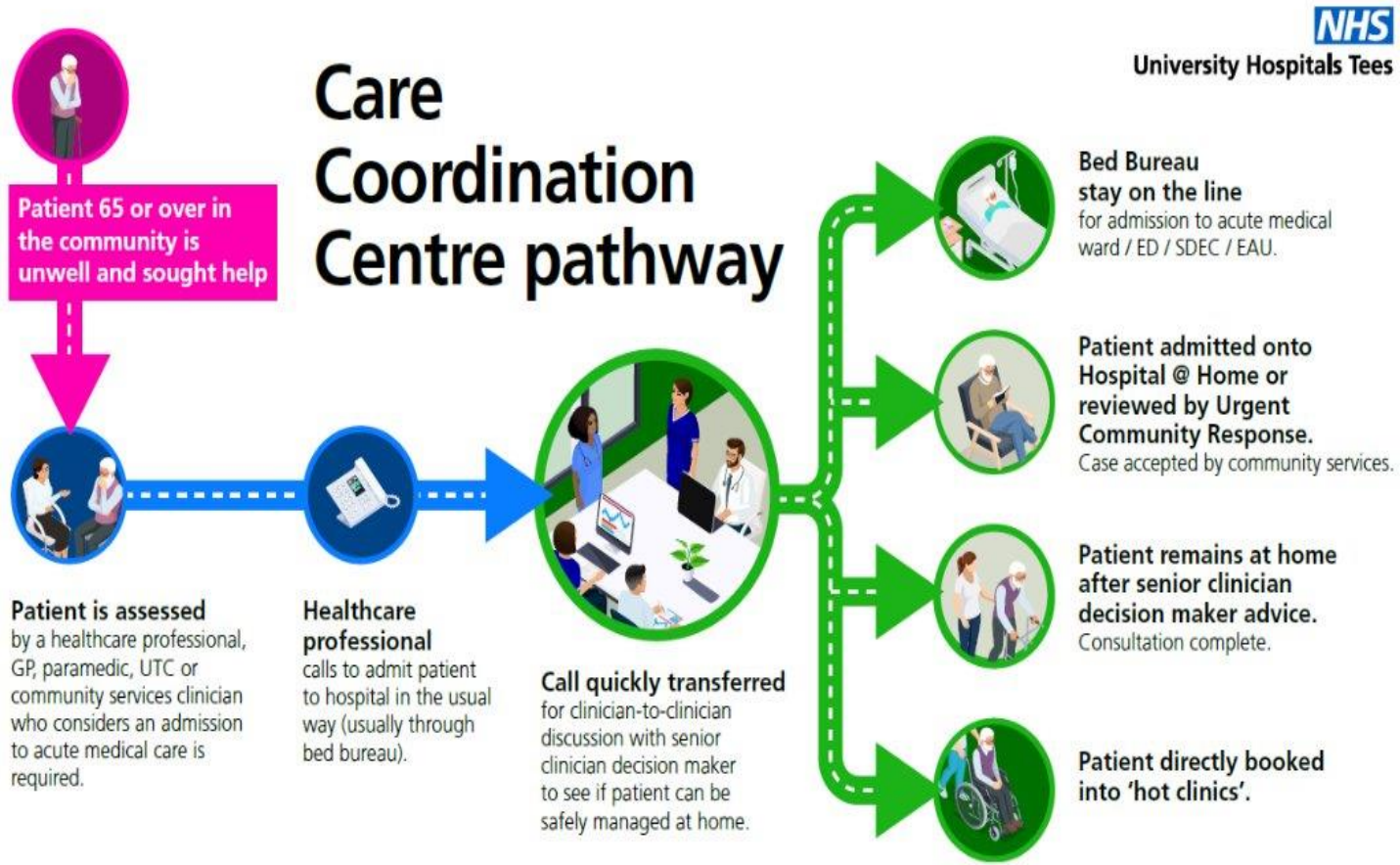
The new Assessment Suite reviews on average 55 patients per day and takes direct ambulance arrivals through paramedic pathways, bypassing ED. This shared responsibility for emergency pathways has led to consistent high achievement of the 4-hour standard and 70% of patients reviewed are discharged home within the same day without a hospital admission.

Clinical Service Unit achievements

- The Care Co-ordination Centre (CCC) commenced a pilot over Winter 2025/26 for patients across STHFT and NTHFT

- More than 1,000 calls were received from ambulance and primary care providers

- More than 300 patients received care at home or in a community venue avoiding admission to the acute site



We welcome your questions

Caring
Better
Together

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NHS
North Tees and Hartlepool
NHS Foundation Trust

NHS
South Tees Hospitals
NHS Foundation Trust

University Hospitals Tees

Draft Quality Account

2025-26

Final publication – 30 June 2026

Caring Better Together

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

I am pleased to present the first combined Quality Account for University Hospitals Tees. Covering the 2025-26 financial year for both North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, this report provides an opportunity to highlight the progress we have made over the past year.

During our second full year of working as a group, we have developed new clinical service units, launched our group values and a long-term strategy, and committed to an ethos of continuous improvement.

We continue to develop and strengthen relationships with our stakeholders, including patients and staff and those outside of our organisation including politicians, local service providers and advocacy groups. Our working relationships with our local authority partners remains key. Initiatives such as the Tees Valley Community Diagnostic Centre can only be achieved by working hand-in-hand with the officers and elected members of local councils.

Several elected members also form a core element of our administration serving as trust governors where their local knowledge and community-focused insight proves invaluable.

Strong local partnership working is central to the development of the Stockton Neighbourhood Health Pilot. As one of just 43 pilot sites across the UK, we will work with our local authority, primary care, community, mental health, social care and voluntary sector partners to develop a new health centre to deliver community-based services for people aged 50–64 with three or more long term conditions in the Stockton central and Portrack areas.

Looking ahead, we recognise that we are operating in a period of ongoing challenge and transformation. We have been open and honest about the difficult issues we face, in terms of financial resources, patient demand and an aging physical infrastructure.

At the heart of everything we do are our patients. They are the reason each and every member of staff comes into work every day. Their safety and health underpin everything we do.

University Hospitals Tees will continue to deliver on local and national priorities including the ‘three-shifts’ outlined in the 10-year plan for the NHS, delivering clinical services which will tackle immediate demand and lay the foundation for healthier communities in the long term.

Overcoming the health, social and financial disadvantages faced by so many in our region is a challenge – a challenge that no single service provider can tackle alone. We will play our part as a leading member of local and wider regional partnership systems to raise not only the physical health but crucially health aspirations of the communities we serve.

The voices of our patients and their loved ones are listened to, their concerns acted upon and we seek to learn and improve from every patient interaction. I would like to thank our patients and wider community for the role they play in improving our services for the future.

In closing, I would like to pay a small tribute to the hard work and commitment we see every day from our colleagues. A hospital group is not the buildings or equipment – it is the people. Our people come into work every day with a sense of purpose and drive that continues to inspire. I would like to thank every colleague who makes University Hospitals Tees the success it is. To the best of my knowledge, the information contained within this Quality Account is an accurate reflection of our performance, achievements and ongoing commitment to quality, which I am proud to present.

Stacey Hunter

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

1.1 Introduction

University Hospitals Tees has produced a single Quality Account on behalf of UHT reflecting our shared strategic direction, governance arrangements and quality priorities across both trusts.

As a Group, we are united by a common vision to improve patient outcomes, safety and experience. Our quality improvement priorities for the year ahead are aligned across both organisations enabling us to maximise opportunities, share learning and deliver improvement at pace and scale.

Producing a single Quality Account supports greater consistency, transparency and collaboration across the UHT. It enables best practice to be shared more effectively, strengthens collective accountability and reflects our ambition to deliver equitable, high-quality care for our populations regardless of where services are delivered.

Trust specific performance and progress continue to be monitored through established governance processes to ensuring strong local accountability is maintained.

During 2025/26 as a Group UHT has undergone significant change, aligning clinical services across multiple hospital sites under new operational model that has seen the development of our Clinical Service Unit model. Despite this challenge we have made significant progress in our quality priorities but also recognising that we have not achieved all that we wished to achieve in 2025/26.

South Tees Hospitals NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust delivers acute and community healthcare services across Middlesbrough, Redcar, East Cleveland, Hambleton and Richmondshire.

The trust operates The James Cook University Hospital in Middlesbrough, Friarage Hospital in Northallerton, and provides community inpatient services at Redcar Primary Care Hospital, East Cleveland Primary Care Hospital and Friary Community Hospital.

Each year, we provide care to around 1.5 million patients across our region and beyond. We are proud to hold an overall ‘Good’ rating from the Care Quality Commission (CQC), reflecting the high standards of care delivered by our services and teams.

Our staff foster a strong culture of safety, quality and continuous improvement. We are committed to innovation and excellence, supported by leading edge clinical research, education, training and development.

The James Cook University Hospital offers an extensive range of specialties on a single site and receives around half of all major trauma cases from across the North East and Cumbria. The Friarage Hospital is one of the region’s fastest-growing healthcare sites, serving communities across the Dales, North Yorkshire and Teesside. This year saw the opening of our £35.5 million surgical centre, doubling the hospital’s capacity for planned operations annually.

Together with our three primary care hospital wards and community NHS teams, we provide care closer to home for people from Hawes to East Cleveland. Our ‘Hospital at Home’ programme enables more patients, particularly those who are frailer, to receive hospital-level care safely and comfortably in their own homes.

North Tees and Hartlepool NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust provides high-quality healthcare for nearly half a million residents across Stockton, Hartlepool and parts of County Durham.

Care is delivered across a range of settings, including Peterlee Community Hospital, our Lawson Street Health Centre hub in Stockton, and the One Life Centre in Hartlepool. These valued community services complement our acute hospitals — the University Hospital of North Tees and the University Hospital of Hartlepool.

The new Tees Valley Community Diagnostic Hub, located on the banks of the River Tees in Stockton, has delivered thousands of diagnostic scans since opening and is now an integral part of the local healthcare system, providing timely access to essential diagnostics for our communities.

The University Hospital of Hartlepool is an accredited surgical hub, supported by advanced robotic surgery. It is also home to the Health and Social Care Academy and the Rowen Suite which will maternity services in the coming year following a temporary closure due to workforce pressures. This much loved hospital remains central to service delivery for local communities.

We continue to face the challenges associated with the ageing estate of University Hospital of North Tees. However, our commitment to investing in our estate remains strong. Recent developments including a new multimillion-pound robotic surgery facility and an emergency maternity theatre suite, demonstrate that our determination to deliver modern, high quality care despite by physical constraints.

Through our Group partnership, University Hospitals Tees brings together our hospitals and services in support of shared ambitions for our patients, service users and staff. By working collaboratively, we are strengthening quality, improving outcomes and building a sustainable future for healthcare across Teesside and beyond.

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 2025/26

The Quality Account provides an opportunity for University Hospitals Tees (UHT) to reflect on its achievements over the last 12 months. This includes a look back at the progress made against the Quality Priorities for 2025/26 that were defined in the 2024/25 Quality Account and are summarised in the table below.

The following Quality Priorities (set out in Table 1) were agreed for both Trusts for 2025/26 following a consultation process with clinical colleagues at both South Tees Hospitals NHS Foundation Trust (STHFT), North Tees and Hartlepool NHS Foundation Trust (NTHFT) and the Council of Governors.

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

Table 1 – Quality Priorities 2025/26

Our drive for improvement, agreed actions, aims and progress at the end of 2025/26 for each quality priority are detailed below.

Patient safety quality priorities

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

This quality priority focused on strengthening the organisations' ability to respond to and learn from incidents, safeguarding concerns, claims and inquests, in order to improve outcomes for our patients while embedding the principles of the Patient Safety Incident Response Framework (PSIRF) across UHT.

Aim;

The aim of this quality priority was to align and strengthen patient safety processes across University Hospitals Tees (UHT). In January 2025, an external evaluation of the implementation of PSIRF was commissioned across both Trusts. The evaluation report was received in July 2025 and set out recommendations to support the development of a consistent UHT wide approach to patient safety grounded in best practice.

In addition to promoting alignment of patient safety processes, the recommendations reinforced the core PSIRF principles of proportionality and focus on learning and improvement. This included strengthening organisational responses to patient safety incidents as well as aligning and improving Duty of Candour processes and arrangements to ensure compassionate engagement with patients, relatives and staff affected by patient safety incidents.

The recommendations from the external evaluation were incorporated into this quality priority and informed the Patient Safety Team's workplan, however, whilst some actions could be delivered within the year, others would require a longer timeframe and therefore have been extended into 2026/27.

Alongside the external review recommendations, the quality priority also included actions to further develop the organisation's ability to triangulate quality and safety data to identify potential areas for improvement, and to improve patient safety-related metrics within the NHS Staff Survey. Progress in these areas is also recognised as longer term, particularly in the context of significant organisational change.

Progress and achievements:

During 2025/26, eight of the 16 recommendations from the external PSIRF evaluation were completed. Notable progress was made in strengthening Duty of Candour arrangements across UHT, including the standardisation of audit processes to monitoring compliance with all statutory elements of the Duty of Candour.

There was also positive progress in aligning patient safety approaches across the organisation. This work required not only changes to process but also cultural change, to support a consistent and learning-focussed approach to patient safety.

Summary and forward plan:

Work is ongoing to finalise a UHT wide Patient Safety Incident Framework Plan (PSIRP), which will set out the organisation's patient safety priorities for the next two years. Analysis is currently underway to review the learning and improvements arising from the previous PSIRPs.

There will continue to be a strong focus on thematic analysis of incidents and on delivering measurable and sustainable improvements with the aim of reducing the need for learning responses to individual incidents where themes and system issues are already understood.

The significant organisational changes across UHT have limited the ability to fully evaluate the effectiveness of some of the previously implemented initiatives. This evaluation work will be undertaken in 2026/27 to ensure that learning is embedded and that improvements deliver meaningful and sustained benefits for patient safety.

2. Medication safety and optimising the benefits of MA.

This quality priority focused on improving medication safety through the continued optimisation of Electronic Prescribing and Medicines Administration (EPMA), and on maximising organisational learning from medication incidents.

Medicines underpin almost every patient pathway, supporting care from admission and inpatient treatment through to discharge and ongoing management in the community. Nationally, over one billion prescription items are dispensed annually across the UK, with acute hospitals administering millions of medication doses each year.

For example, since the implementation of electronic prescribing in 2022, South Tees Hospitals NHS Foundation Trust (STHFT) has recorded over 17 million medication doses via the EPMA platform, *Better Meds*. This represents a significant step forward in the safety, quality and efficiency of medicines management across the organisation. North Tees and Hartlepool NHS Foundation Trust (NTHFT) have achieved similar steps including its implementation of EPMA 2.0 to improve the range of medicines that can be administered to include IV injections and infusions.

Aims:

During 2025/26, this quality priority aimed to:

- Further optimise EPMA to improve patient safety.
- Agree and embed key medicines performance indicators across University Hospitals Tees (UHT).
- Promote the use of EPMA data to support clinically led quality improvement.
- Monitor and improve prescribing practice and medicines administration.

In addition, we aimed to strengthen learning from medication incidents and utilise digital capability to deliver tangible improvements in patient safety. This has included:

- Strengthening clinical protocols to support more consistent, evidence-based practice
- Improving allergy documentation and medicines interaction alerts, reducing the risk of medication related harm.
- Responding rapidly to national safety priorities through timely digital updates and enhancements.
- Demonstrating a reduction in harm from medication related events following digitalisation of prescribing and administration.

Collectively, these improvements support safer prescribing, more reliable medicines administration, and a more resilient medicines governance framework.

Quality Improvement Collaboration
In 2025/26, STHFT was one of 15 NHS trusts selected to join the first Specialist Pharmacy Services (SPS) national Quality Improvement collaborative cohort. This multidisciplinary programme focused on improving the delivery of time critical medicines to inpatients. Participation supported improved understanding and utilisation of medicines data to inform service improvement.

Digitalisation of Critical Care
EPMA was successfully implemented across all STHFT Critical Care areas in 2025, marking a significant milestone in patient safety, clinical efficiency and digital maturity. This included General ITU, Cardiac ITU, High Dependency and Spinal High Dependency Unit. Close collaboration between digital and clinical teams enabled a safe transition from paper-based prescribing within a complex, high acuity environment.

This implementation has improved prescription clarity, removed risks associated with transcription during patient transfers, and enhanced the timeliness of medicines administration. Realtime audit and strengthened clinical decision support for high-risk medicines have further enhanced medicines governance. This achievement provides strong assurance and supports progression to the final phase of the current digital medicines programme, including planned implementation within neonatal services. This will represent all inpatient areas as being on EPMA in line with NTHFT.

Clinical Pharmacy Services
Medicines reconciliation remains a core patient safety function. At STHFT, pharmacy teams reviewed medicines for over 90% of patients admitted during the year, with almost 50% reviewed within 24 hours of admission, both showing year on year improvement.

Clinical pharmacy reviews also continue to increase, with pharmacists reviewing over 5,000 patients in a single month. The most recent biannual intervention audit recorded 353 clinical interventions in one day, equating to an estimated £46,000 in daily cost avoidance through prevention of medication related harm.

The introduction of a prescribing pharmacist role within the JCUH discharge lounge is projected to deliver at least 507 interventions annually, supporting safer discharges and improved patient experience. This role has been positively received by both staff and patients.

At NTHFT, medicines reconciliation performance declined during the second half of the year due to workforce challenges (Figure 1). This has been addressed through additional recruitment, with new staff expected in post by Q2 2026/27.

Service developments at NTHFT included the introduction of pharmacist prescriber roles within lipid clinics, expected to positively impact waiting times and patient outcomes.

Additional safety initiatives at NTHFT included enhanced medicines procurement planning, expanded homecare services, use of *PharmOutcomes* to support safer discharge, and introduction of ‘Good Catch’ and Medicines Safety Star initiatives to promote reporting and learning.

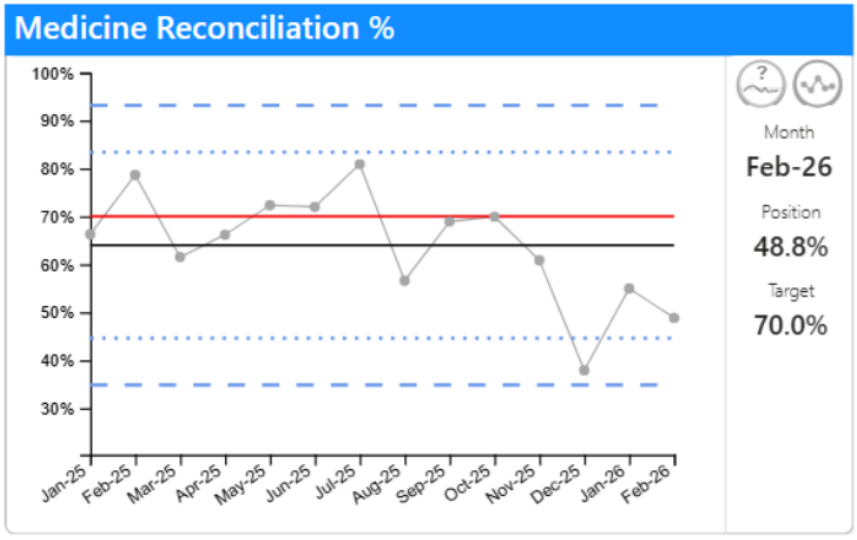


Figure 1 - NTHFT Medicines Reconciliation as % of Admissions

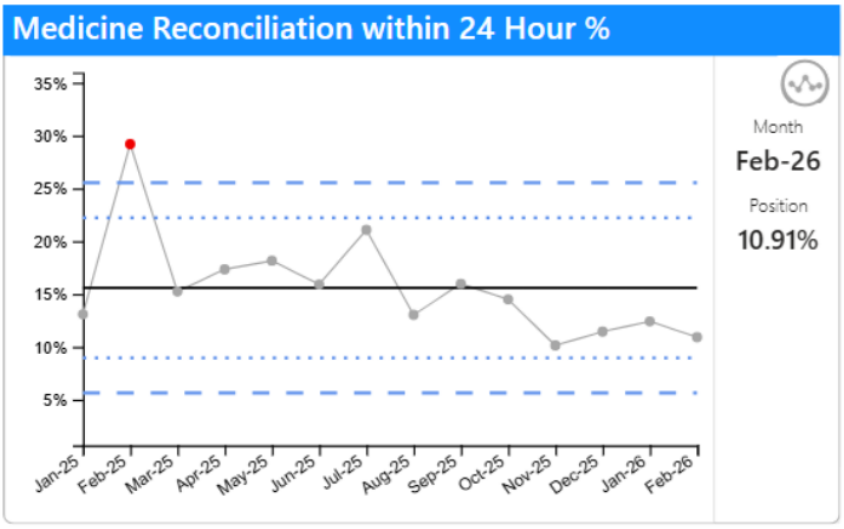


Figure 2 - NTHFT Medicines Completed within 24hrs as % of Admissions

Antimicrobial Stewardship

- **Regional performance:** In January 2026, STHFT achieved the lowest total antibiotic consumption regionally for the first time since 2019.
- **National alignment:** STHFT remains on track against the national ambition to reduce antibiotic consumption by 5% by 2029, with only 0.1% increase against 2019/20. baseline. For NTHFT total antibiotic use increased by 8.2% compared with baseline.
- **AWaRe prescribing:** Use of Access antibiotics increased from 50% to 52% in STHFT, with corresponding reductions in Watch and Reserve agents. NTHFT increased to 60.2%.
- **Digital support:** Eolas, the digital clinical guideline platform, now has over 1,500 users across UHT. The integrated antimicrobial guideline and high use resources (e.g. Hypokalaemia guideline) demonstrate strong staff engagement and clinical value.
- Improvements were demonstrated in Start Smart Then Focus audits and guideline adherence.

Penicillin De-labelling

STHFT has received national recognition for an innovative pharmacist and pharmacy technician led penicillin de-labelling service. Using EPMA to identify suitable patients, eligible individuals are offered testing in controlled settings. Delivery via a Patient Group Direction (PGD) model

represents an innovative and nationally commended approach, and a business case to expand the service, including at NTHFT has been produced.

Medicines Value Programme
Both NTHFT and STHFT have adopted principles from the regional Medicines Value Programme, establishing a UHT Medicines Value Group chaired by the Medical Director. The UHT-wide Medicines Value Policy supports clinical effectiveness, cost efficiency and patient centred outcomes, supported by an exceptionality process where best value medicines are not prescribed.

Medicines Safety KPIs
Medicines Safety Key Performance Indicators (KPIs) are routinely monitored across UHT, including medication related never events and the proportion of incidents resulting in moderate harm and above.

Medicines Safety and Incident Learning
During 2025/26, NTHFT reported a medication incident rate of approximately 6.2%, with no medication related never events. Incidents resulting in moderate harm accounted for approximately 1%, with no severe harm or deaths recorded. STHFT also reported no medication-related never events.

Medication incident themes are reviewed regularly, with learning shared across medicines governance and patient safety forums. Improvement initiatives included:

- Redesign of the Medicines Administration Record to support safer insulin use.
- Standardisation of EPMA order sets aligned with regional palliative care guidance.
- Enhancements to electronic discharge summaries, supported by staff education and the development of visual prompts and posters to support learning and improvement (Figure 3)
- Introduction of hospice liaison support to improve end of life prescribing and transfers of care

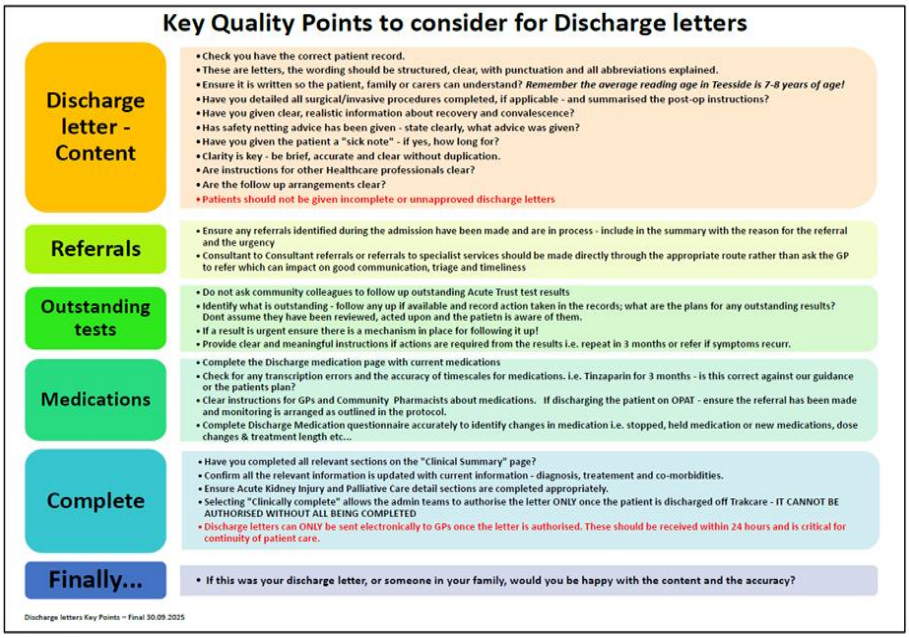


Figure 3 - Guidance on producing high quality discharge letters

Time Critical Medicines
Omission of time critical medicines (TCMs) was identified as a key risk at UHT. A UHT awareness campaign introduced the 'TIMELY' approach, supported by clinical tools, flowcharts and patient facing resources.

Following implementation, incidents at NTHFT that highlighted omitted TCM reduced by approximately 50% and this improvement has been sustained across subsequent quarters (Figure 4). Further work includes targeted education, EPMA alerts and pathway optimisation for high risk conditions such as Parkinson's disease.

At STHFT data was planned to be pulled directly from the EPMA system, however due to challenges with the dataset, this has only become available in March 2026. Further work will be undertaken in 2026/2027 to test the changes made at STHFT.

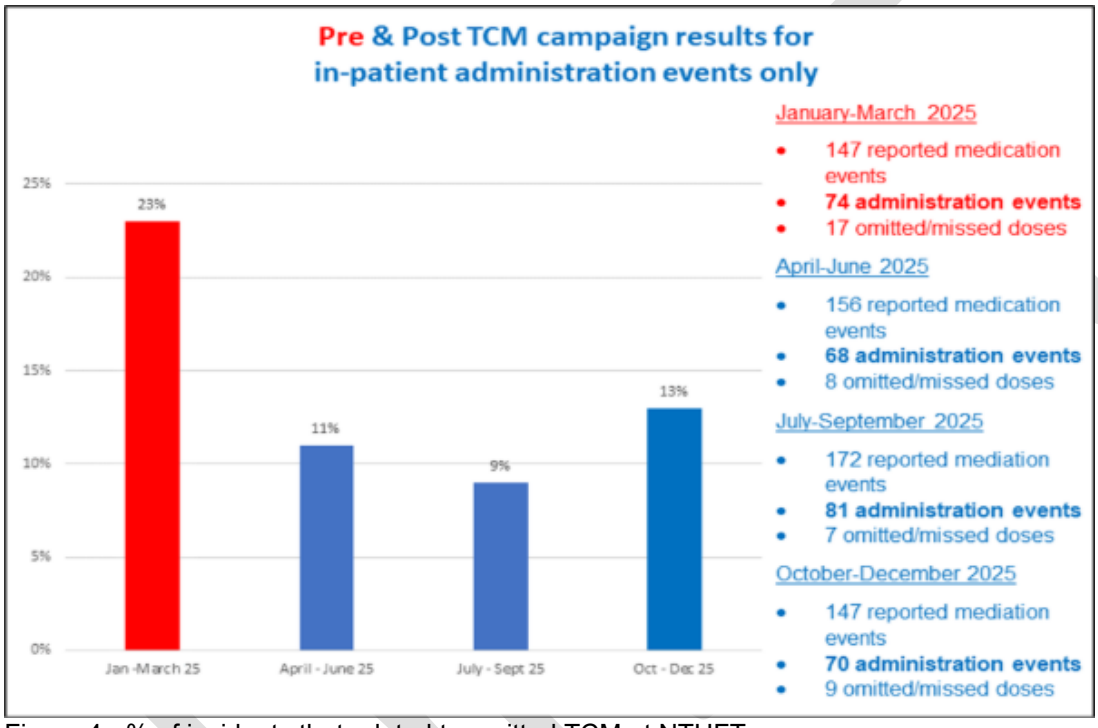


Figure 4 - % of incidents that related to omitted TCM at NTHFT

Summary and forward plan:

Building on progress during 2025/26, priorities for the coming year include:

I. Expanding use of the Eolas digital platform to consolidate UHT wide clinical guidelines
II. Strengthening and aligning medicines governance arrangements across UHT
III. Embedding shared pharmacy performance dashboards to support benchmarking and continuous improvement

These actions will support safer medicines use, improved patient outcomes, and more consistent delivery of high-quality care across UHT.

3. Reducing the risk of acquiring healthcare associated infections

This quality priority reflects our commitment to reducing the risk of patients acquiring healthcare-associated infections (HCAIs), in line with NHS England Standard Contract objectives. These include Clostridioides *difficile* infection (CDI), meticillin-resistant *Staphylococcus aureus* (MRSA), and Gram-negative bloodstream infections (including *Escherichia coli*, *Klebsiella* and *Pseudomonas*). Through this work, we aim to improve patient outcomes while strengthening and

embedding effective infection prevention and control (IPC) practices across University Hospitals Tees (UHT).

Healthcare-associated infections (HCAI) can occur either as a direct result of medical or surgical interventions or as a consequence of contact with a healthcare environment. The term HCAI encompasses a wide range of infections, the most well-known being MRSA and CDI. HCAIs pose a significant risk to patients, staff and visitors and can lead to increased morbidity, mortality and length of hospital stay. They also place a substantial financial burden on the NHS. As such, infection prevention and control remain a core priority for both the NHS and our organisation.

HCAIs are estimated to cost the NHS approximately £1 billion each year, with around £56 million of this incurred after patients are discharged from hospital. In addition to the financial impact, each infection results in increased use of NHS resources and can have a lasting impact on patients' health and wellbeing.

Aims:

During 2025/26, we aimed to:

- Agree clear HCAI and IPC operational priorities across UHT.
- Standardise reporting mechanisms for HCAIs across the organisation.
- Promote access to enhanced learning and education at the point of care.
- Undertake peer reviews across UHT and within the wider region to identify opportunities for improvement.
- Develop and implement a clear audit programme with robust reporting structures to enable timely organisational feedback.
- Monitor all HCAIs across UHT to identify trends and areas of concern, with targeted improvement programmes implemented where increased incidence is identified.
- Work collaboratively with antimicrobial teams across both organisations to strengthen and support the Antimicrobial Stewardship (AMS) strategy (Antimicrobial stewardship is a systematic approach to educate and support health care professionals to follow evidence-based guidelines for prescribing and administering antimicrobials).
- Provide clear governance and assurance through established operational and strategic reporting structures.
- Ensure all HCAIs are reviewed through the Patient Safety Incident Response Framework (PSIRF), supported by a weekly multidisciplinary review panel in collaboration with the patient safety team.
- Develop focused elements of the IPC operational plan aligned to Standard Contract objectives, led by designated members of the IPC team.
- Regularly review, update and deliver the IPC toolbox training programme, with a focus on HCAIs and core IPC practices.
- Continue to report HCAI and IPC performance and key messages through quality and safety governance forums and senior leadership meetings.

Progress and achievements:

During 2025/26, the following progress was made:

- All HCAI cases were reviewed on a weekly basis, with key learning shared through established forums, bulletins and newsletters.
- IPC patient pathways and care plans were developed within the electronic patient record (EPR), with successful implementation for CDI and MRSA.

- The organisational screening programme for organisms such as MRSA was fully reviewed and updated.
- Care pathways for invasive devices were reviewed across UHT, supported by a dedicated focus group with IPC input.
- The 2025/26 audit programme was successfully delivered, including environmental audits of clinical areas, commode and sluice audits, and hand hygiene audits.
- Dedicated respiratory IPC support was provided over the winter period, with updated clinical pathways developed and implemented.
- The FIT testing service at South Tees Hospitals NHS Foundation Trust was further developed, including workforce expansion, investment in filtration equipment to enhance staff safety, and implementation of systems to enable information upload directly into the Electronic Staff Record (ESR).
- A range of AMS-related activities were delivered, including education sessions, ward rounds and shared learning events, alongside the re-establishment of the Antimicrobial Working Group during 2025/26.
- Several wards across UHT underwent decant and deep cleaning as part of our ongoing programme to reduce HCAI risk.
- Audit processes were further aligned across services, including bespoke audits within theatres and the Emergency Department, supported by the development of audits within the Healthcare Guardian electronic system.
- A comprehensive IPC education plan was delivered throughout 2025/26, including the three-day IPC course, enhancement of the link practitioner programme, and targeted intensive support to clinical areas where required.
- Ongoing IPC support was provided to care homes during 2025/26, supported by additional Local Authority investment and a series of well-attended education events across Teesside.
- Compliance with mandatory submission of HCAI surveillance data to UKHSA national systems was maintained throughout the year.
- A comprehensive review of IPC policies across UHT was undertaken and concluded at the IPC Strategic Group in February 2026.
- Governance arrangements for IPC were reviewed and strengthened, resulting in improved alignment between IPC team meetings, the IPC Operational Group and the IPC Strategic Group.

Summary and forward plan:

While some improvements were achieved in reducing HCAI rates during 2024/25 and 2025/26, challenges remain. These will continue to be addressed through a detailed improvement plan and focused external support as we move into the coming year.

Key priorities for 2026/27 include:

- Continued implementation of IPC pathways and care plans within the electronic patient record as capacity allows.
- Further development and embedding of the electronic audit programme to strengthen assurance and feedback.
- Ongoing collaborative work across UHT to align FIT testing processes and enhance recording within the Electronic Staff Record system.
- Continued strengthening of Antimicrobial Stewardship through the Antimicrobial Working Group and the appointment of a new Clinical Lead for AMS.
- Identification of sustainable options for a dedicated decant facility to support enhanced deep cleaning of clinical environments.

- Continued work to align and streamline IPC processes, supporting the development of a consistent UHT-wide approach to infection prevention and control.

Clinical effectiveness quality priorities

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

This quality priority focussed on strengthening the organisation's approach to continuous learning and improvement in clinical practice, with the aim of improving patient outcomes through systematic review of compliance with evidence-based standards. Delivery was supported through the use of clinical audit, participation in national programmes such as Getting It Right First Time (GIRFT), implementation of NICE Guidance and improved systems for triangulating clinical effectiveness data.

To support delivery of best possible clinical outcomes, the organisation sought to ensure that robust and consistent processes were developed and embedded to support continuous learning. This work was underpinned by improved access to data, shared reporting mechanisms and strengthened governance arrangements designed to promote consistent s best practice across University Hospital Tees (UHT).

Aims:

During 2025/26 the organisation aimed to:

- Monitor progress with the implementation of, and compliance with, relevant NICE Guidance.
- Engage in regional GIRFT reviews and demonstrate improvement against agreed recommendations.
- Participate in mandatory national clinical audits, sharing local results and developing and implementing improvement plans where required.
- Develop common datasets and systems to support shared reporting and organisational learning.

Progress and achievements:

NICE guidance: baseline compliance
A baseline assessment of local compliance with all relevant NICE guidance was undertaken during 2025/26, led by an identified clinical lead within each speciality (target: 100%).

North Tees & Hartlepool NHS Foundation Trust

- 99.4% (474 of 477) of relevant NICE guidance was confirmed as compliant.

South Tees Hospitals NHS Foundation Trust

- 74.7% (931 of 1,246) of relevant NICE guidance was confirmed as compliant

This provided a strong baseline position at both Trusts, particularly given the high volume of relevant NICE guidance applicable across clinical services.

NICE guidance: audit evidence of compliance
An audit was undertaken during 2025/26 to identify where contemporaneous local audit evidence of compliance against NICE guidance was available (target: 100%).

North Tees & Hartlepool NHS Foundation Trust

- 47.4% (226 of 477) of relevant NICE guidance had evidence of local audit compliance.

South Tees Hospitals NHS Foundation Trust

- 31.3% (390 of 1,246) of relevant NICE guidance had recent evidence of local audit compliance.

The volume of relevant NICE guidelines, particularly at South Tees Hospitals NHS Foundation Trust, presents a challenge for clinical teams in maintaining up-to-date audit evidence. Where services operate against a large number of guidance, a pragmatic and risk-based approach has been adopted, prioritising audit activity where NICE guidance is associated with higher clinical risk or known variation in practice.

NICE guidance within Clinical Audit Forward Plans
Evidence was sought during the year to confirm that NICE guidance was appropriately prioritised within local Clinical Audit Forward Plans.

North Tees & Hartlepool NHS Foundation Trust

- 100% of forward plans were submitted
- All submitted plans demonstrated planned audit activity mapped to NICE guidance

South Tees Hospitals NHS Foundation Trust

- 91% of forward plans were submitted
- Five services did not submit plans
- No patient safety risk was identified as a result of non-submission
- All submitted plans demonstrate planned activity mapped to NICE Guidance

A standardised Clinical Audit Forward Plan template for 2026/27 has been developed and approved through the Clinical Effectiveness Group and is currently with the service senior management teams for completion.

Engagement with GIRFT
Three GIRFT reviews took place covering both Trusts during 2025.26:

- *Vascular Specialist Services Review* – South Tees Specialist Hub (28 August 2025)
- *Pancreatic Oncology Implementation Review* – Newcastle-upon-Tyne Network (11 February 2026)
- *Chronic Pain Virtual System Review* – North East and North Cumbria Integrated Care System (5 March 2026)

All reviews were well represented by clinical colleagues from across University Hospitals Tees, and local improvement plans were subsequently submitted.

North Tees & Hartlepool NHS Foundation Trust

- Eight GIRFT reviews in 2025/26 required improvement plans. Five of eight plans have been received to date.

South Tees Hospitals NHS Foundation Trust

- Nine GIRFT reviews in 2024/25 required improvement plans.
- Improvement plans have been requested.

During 2025/26, University Hospitals Tees underwent significant changes to governance meeting structures. Legacy single Trust meetings were stood down and replaced with UHT-wide arrangements. This transition resulted in a temporary pause in the review of GIRFT reports and actions.

From April 2026, GIRFT reports and associated action plans will be overseen by the newly established GIRFT and Audit Panel (GAP), which will systematically work through the current backlog of reports requiring review.

Participation in mandatory national clinical audits

North Tees & Hartlepool NHS Foundation Trust

- Participation in 64 relevant national audits during 2025/26.
- Eight confirmed non-submissions and one reduced submission.

South Tees Hospitals NHS Foundation Trust

- Participation in 80 relevant national audits during 2025/26.
- Seven confirmed non-submissions and two reduced submissions.

Participation is monitored through the quarterly Clinical Effectiveness Report to the Quality Oversight Group and Quality Assurance Committee. The Clinical Effectiveness team continues to work with identified audit leads where challenges exist, most commonly relating to workforce capacity and the availability of appropriate data systems.

Sharing and acting on national clinical audit results (presentation within four months of publication)

North Tees & Hartlepool NHS Foundation Trust

- Seven of 29 national audit reports published in 2025/26 were presented centrally within four months.

South Tees Hospitals NHS Foundation Trust

- Nine of 29 national audit reports published in 2025/26 were presented centrally within four months

As part of the revised governance framework, all national clinical audit reports will be reviewed through the GIRFT and Audit Panel (GAP) from April 2026, addressing the current backlog and improving timeliness of review.

Development of improvement plans

All national clinical audit reports presented centrally were supported by a local improvement plan.

- Seven of seven reports for North Tees & Hartlepool NHS Foundation Trust
- Nine of nine reports for South Tees Hospitals NHS Foundation Trust

Development of common systems

- **NICE guidance:** A UHT Clinical Effectiveness subgroup is reviewing existing systems at both Trusts to develop a specification for a shared digital application within the Healthcare Guardian risk management platform.
- **Clinical audit:** A prototype audit application within Healthcare Guardian is being developed for audits requiring longitudinal data collection. Alternative software solutions are also being assessed for short-duration 'snapshot' audits.
- **GIRFT:** The UHT-wide GIRFT and Audit Panel (GAP), chaired by a Deputy Medical Director, has been established to provide a consistent oversight of the GIRFT programme from April 2026.

Unified Clinical Effectiveness Policy

As part of the broader review of governance arrangements, the UHT Clinical Effectiveness Group was established in December 2025, followed by the GIRFT and Audit Panel in April 2026. Once these arrangements are fully embedded, a revised, unified Clinical Effectiveness Policy for University Hospitals Tees will be developed, with the Chairs of these groups acting as joint authors.

Summary and forward plan:

Since the Quality Priorities were set in April 2025, North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust have undergone significant horizontal integration of clinical teams within UHT. While this integration will deliver improved consistency and quality of care over time, it has required substantial effort to redesign and embed new systems of practice and governance.

The impact of this transition is evident in aspects of delivery against this quality priority, particularly during periods when legacy governance arrangements were stood down and replaced with new UHT wide structures. However, as the new governance framework becomes fully embedded, the organisation anticipates improved pace, consistency, and assurance during 2026/27.

2. Mortality review processes and learning from deaths.

It is accepted that for some people cared for in our services, death is an inevitable outcome. For most patients in our care and their families the experience will be excellent, but it is important to recognise that at times of significant pressure the quality of care may be impacted and lead to a poor experience. Therefore, we follow the National Guidance on Learning from Deaths (2017), and both Trusts have a policy on responding to deaths which defines how we review, where necessary commission detailed investigations and learn from the deaths of people who die in our care.

Our learning processes include working alongside the local medical examiners (MEs) who scrutinise the causes of all inpatient deaths in the Trust which are not going to be investigated by the coroner. This independent scrutiny provides additional safeguards for the public and an opportunity for the bereaved to raise concerns and ask questions to someone with significant medical knowledge, but who was not involved in the care of the person who died.

Despite these agreed policies and processes we recognised that there was still more we could do to refine and enhance our approach and processes to learning from deaths.

Aims:

To review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes in both Trusts by:

- Undertaking a benchmarking exercise to compare processes and performance metrics.
- Developing a standardised approach to completing mortality reviews.
- Considering whether specialty mortality reviews can be captured on the same electronic system, bringing this information alongside the Structured Judgement Reviews (SJR) recorded by the corporate mortality reviewers.
- Develop a consistent way of recording and reporting Learning from Deaths across both sites to ensure learning is identified and where necessary, improvement made.
- Draft a framework for the completion of Mortality & Morbidity (M&M) reviews, clearly identifying M&M Leads for each service.
- 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.
- Develop a robust and integrated Learning from Deaths Team across UHT.
- Maintain a diverse team of reviewers to continue a multidisciplinary approach.
- Increase the number of deaths subject to SJR, particularly at North Tees and Hartlepool Trust, aiming to complete a review of 20% of all deaths.
- Specialty death reviews will be undertaken (LEDER, paediatrics, perinatal) and learning identified and acted upon.
- SJRs will be completed without undue delay.
- Continue to ensure there are proportionate learning responses following the outcomes from mortality reviews in line with the Trust's Patient Safety Incident Response Framework (PSIRF).
- Review Learning from Deaths Policies (NTHFT & STHFT) and develop a UHT Learning from Deaths Policy.
- Monitor the number of in-hospital deaths weekly to highlight unexpected changes in mortality.
- Formalise decision making on learning responses when a concern has been indicated.
- Increase opportunities for triangulation of learning and agreement of processes.
- Ensure that learning from the Medical Examiner (ME) is shared within UHT.

Progress and achievements:

- We have undertaken a benchmarking review and compared processes across STHFT and NTHFT and identified that additional resource and refinement of processes are needed to ensure a consistent approach to learning from deaths and that the provision is adequate to meet the framework standards as indicated in the National Learning Guidance on Learning from Deaths (2017). A Lead Learning from Deaths Reviewer has been appointed and additional structure and resource to increase and strengthen the team has been agreed.

- One standardised template for recording SJRs is in development.

- A standardised approach to mortality reviews within Clinical Service Units is yet to be agreed.

- A combined Learning from Deaths quarterly report using one template has been achieved which includes learning from the ME, child deaths and LEDER.

- A weekly report on the number of deaths in both Trusts is available and shared, as are any concerns from SJRs.

- A combined Learning from Deaths Policy is in draft and awaiting consultation and agreement.

- A combined Learning from Deaths Group for UHT is in development; a chair and reporting infrastructure into the Patient Safety Group has been agreed.

Summary and forward plan:

During 2025/26 the aims identified to strengthen mortality review processes have been monitored, modified where necessary, and implemented where possible. Good progress has been achieved, although some progress has been delayed due to identification of resource and funding sources.

As there is now agreement on resource, most of the improvement actions which are outstanding, will be achieved at pace, specifically:

- increased staffing in the Learning from Deaths Team and merge to be one combined team to support both Trusts
- increase in the number of reviewers able to undertake SJRs
- increase at North Tees and Hartlepool Trust the percentage of SJRs completed and the sharing of learning
- development of the Learning from Deaths Group which will oversee the UHT Learning from Deaths Policy and associated processes
- approval of the UHT Learning from Deaths Policy and associated processes.

3. Shared decision making and goals of care

This quality priority outlines our commitment to embedding Shared Decision Making (SDM) as part of our patients' care pathway.

Patient autonomy and active involvement are central to modern healthcare. SDM ensures that individuals are fully informed, supported, and empowered to participate in decisions about their care, including choosing whether to proceed with proposed treatments. This represents a shift

from a paternalistic model to a collaborative partnership, reflecting both statutory requirements and our organisational quality priorities.

The legal context for SDM has been strengthened by the Montgomery v Lanarkshire Health Board judgment, which redefined the professional duty of informed consent. The Health and Care Act 2022 further reinforces the requirement for providers to support informed choice and ensure that information is communicated in an accessible and meaningful way. These principles are integral to reducing health inequalities and maximising clinical outcomes.

To standardise our approach, we have aligned our pathways with NICE Guideline NG197: Shared Decision Making. Embedding these evidence-based principles ensures SDM is not an add-on to care, but a core component of clinical effectiveness and person-centered practice.

Aims:

For 2025/26, our aim was to systematically embed SDM as a sustainable, “business as usual” model. By strengthening governance, strategic leadership, and clinical capability, the Trust has worked to formalise SDM as an expected standard of care across all services.

An SDM Improvement Plan was developed and ratified following engagement with patients, staff, and wider stakeholders. Key objectives included:

- Preparing patients and the public to understand and engage in SDM.
- Training and equipping staff with the skills and knowledge to deliver effective SDM.
- Reviewing commissioned services and pathways to identify priority areas.
- Strengthening leadership and supportive systems to enable reliable delivery of SDM.
- We also worked closely with clinical teams to develop procedure-specific consent forms, ensuring information on risks, benefits, and alternatives is personalised and supported by high-quality decision aids.

Progress and achievements:

Over the past year significant progress has been achieved in the following areas:

1. Supportive Systems & Processes
The Trusts approved a new shared decision-making strategy, aligning organisational culture with NICE NG197.

Oversight has been strengthened through:

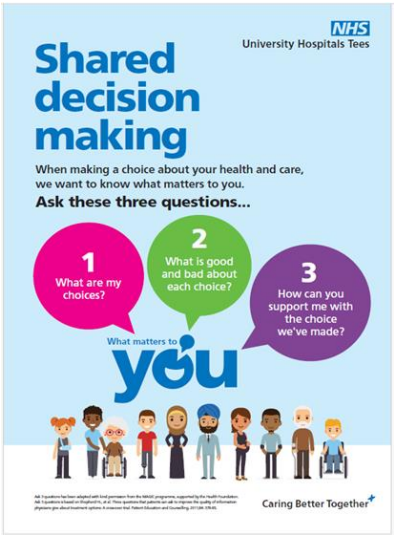
- Appointment of a director-level sponsor for SDM.
- A Patient Director with VCSE expertise acting as non-executive champion.
- Integration of collaboRATE (an audit tool used to assess patient experience in Shared Decision making) and baseline assessment tools into audit processes to support ongoing quality assurance.

2. Prepared Patients
We have expanded our patient-facing resources to support informed choice and proactive engagement. This includes:

- Trust-wide use of “Ask 3 Questions” and BRAN (Benefits, Risks, Alternatives, doing Nothing) materials.
- Incorporation of SDM principles into appointment letters and Patient Information Leaflets.
- Launch of a dedicated SDM webpage on the Trust website and “Choices” platform, offering accessible, evidence-based information and decision support.

3. Trained Teams

To build a sustainable, skilled workforce, we have developed a comprehensive training infrastructure aligned with NICE NG197. Achievements include:



- Establishing a cohort of accredited SDM trainers.
- Training more than 200 staff across diverse clinical services.
- Developing a bespoke UHT SDM e-learning module.
- Co-producing an educational video with senior leaders, clinicians, and service users, including guidance on the legal principles arising from the Montgomery judgment.

To embed SDM within consent processes, we have:

- Initiated a full review of the Consent to Treatment Policy, ensuring SDM is integral to clinical consent.
- Developed a centralised repository of national and internal Patient Decision Aids (PDAs).
- Completed PDA integration at North Tees, with implementation at South Tees underway.
- Submitted a business case for Digital Consent, supporting an 18-month transition from paper-based to digital consent workflows.

Routine clinical audits continue to provide oversight and support continuous improvement

Summary and forward plan:

During 2025/26, we have embedded SDM as a systemic clinical standard, integrating supportive systems, patient preparation, workforce capability, and digital infrastructure in line with NICE NG197. These developments ensure compliance with the statutory duties of the Health and Care Act 2022, positioning SDM as part of everyday clinical practice.

Our forward priorities include:

- Expanding training to include advanced communication skills for risk, probability, and uncertainty.
- Ensuring all staff have access to high-quality learning materials and decision aids in multiple formats.
- Using collaboRATE data to provide feedback to individual clinicians and support continuous improvement in SDM delivery.

UHT is moving from implementation toward national best practice, ensuring that shared decision making is a consistent, measurable right for every service user.

[Patient experience quality priorities]

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

This quality priority sets out our commitment to proactively seeking patient, carer and family feedback and ensuring that this feedback leads to continuous improvement in the care and treatment we provide.

Aims:

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

Progress and achievements:

The Patient Involvement Facilitator has continued to develop the involvement bank and strengthen links with key community groups. Members of the involvement bank have provided feedback on a range of patient information materials, including posters and leaflets. This involvement has been positively received by both staff and participants and has supported improvements to the quality and accessibility of patient-facing information.

The Good Practice Report has now been embedded within the monthly, quarterly and annual Patient Experience Reports, strengthening oversight and enabling learning to be shared more effectively.

During 2025/26 the management of patient information was harmonised to cover both Trusts. The Information Review Group ensures a consistent approach to the oversight and approval of patient information.

The Discharge Task and Finish group has continued to meet and progress key improvement workstreams. A twelve-month review has been completed to identify themes from patient feedback alongside CQC enquiries and safeguarding referrals. A University Hospitals Tees Group has been developed to ensure continuity and good practice is shared to improve the discharge process across both sites.

Formfinity platform is now in place at NTHFT to capture the Friends and Family Test (FFT) responses. At STHFT the transition from the Meridian platform to the Healthcare Guardian platform is complete and embedded.

Summary and forward plan:

A presentation is in development which will enable the Clinical Service Units (CSUs) to provide updates on patient experience and involvement activities at the Experience of Care Council monthly meeting. This will highlight the good practice ongoing with the CSUs and provide the opportunity to share good practice.

To ensure continuity, both NTHFT and STHFT will move to the Healthcare Guardian platform for recording patient surveys and family and friends test (FFT) responses. This will ensure that patients are provided with the opportunity to give feedback at any point during their care and treatment.

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

This quality priority sets out our commitment to responding to complaints, in a timely manner, supporting patients, carers and families through difficult circumstances, and implementing service improvements based on learning from complaints.

Aims:

- To provide timely responses to complaints, meeting agreed the timescales with patient, carer and families and complying with NHS Compliance Standards.
- To provide support to patients, carers and families during complex or distressing complaint investigations, including the use of Family Liaison Officers (FLO'S).
- To ensure continuous improvement to services through learning from complaints.

Progress and achievements:

Timeframes for complaint responses, including compliance with agreed extensions, continue to be monitored, with weekly escalation to the Quality and Safety Panel where required. Oversight is provided through the Experience of Care Council, which reports to the Quality Assurance Committee, ensuring appropriate governance and assurance.

As part of the University Hospitals Tees (UHT) organisational restructure and associated accountability framework, there is a clear ambition to strengthen shared ownership of quality oversight within Clinical Service Units (CSUs). This includes local responsibility for the monitoring and management of complaints and extensions, supporting timely responses, learning and continuous improvement.

The target for reducing the number of complaints open longer than six months has not yet been achieved. As a result, specific targets for 2026/27 will be agreed with the senior leadership teams within each CSU.

For complex complaints, the allocation of Family Liaison Officer's (FLOs) is considered and offered where additional support and communication would benefit patients, carer and families. The introduction of a dedicated system to identify FLO involvement has improved oversight and monitoring of their use. dropdown box identifies where FLOs have been allocated to a complaint, aimed to improve the monitoring of the allocation of FLOs for complaints.

The UHT Experience of Care Council was established in November 2025 replacing the two Trust specific patient experience meetings. This has facilitated and strengthened opportunities for learning and improvement.

During 2025, external audits of the complaints process were undertaken across University Hospitals Tees. Audit One completed an audit at North Tees and Hartlepool NHS Foundation Trust (NTHFT), and Price Waterhouse Cooper (PwC) completed an audit at South Tees Hospitals NHS Foundation Trust (STHFT). Both audit reports have been received and reviewed.

An action plan is being developed in response to the findings, with a focus on strengthening processes and ensuring a consistent, high-quality approach to complaint handling across the Group. This includes the development of a University Hospitals Tees–wide complaints policy and associated process revisions, aimed at improving the timeliness, quality and assurance of complaint responses.

Summary and forward plan:

The introduction of the Healthcare Guardian risk management system across University Hospitals Tees (UHT) has supported further improvement in the management of complaints. The development of complaints dashboards at Clinical Service Unit (CSU) level has improved visibility of performance, enabling teams to take ownership of complaint handling and respond more promptly to learning and emerging themes.

Complaints open for longer than six months continue to be monitored weekly at the Quality and Safety Panel to identify barriers to timely resolution and inform targeted improvement actions. Targets for 2026/27 will be agreed with CSU Associate Directors of Nursing and Heads of Nursing to drive sustained improvement in complaint timeliness and patient experience.0

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

During 2025/26, University Hospital Tees (UHT) progressed its priority to develop and implement a joint Mental Health Strategy across South Tees Hospitals NHS Foundation Trust (STHFT) and North Tees and Hartlepool NHS Foundation Trust (NTHFT). The strategy aims to improve outcomes for patients experiencing mental ill health by strengthening the integration of physical and mental healthcare, enhancing staff capability, and improving organisational governance, safety and partnership working.

The UHT Mental Health Strategy was completed in April 2025 and is now in place across both Trusts. It is supported by a Mental Health Improvement Plan that sets out milestones, timescales and deliverables monitored through established governance structures.

The strategy sets out a clear vision for delivering compassionate, person-centred mental health care.

The anticipated outcomes include:

- A holistic understanding of patient needs to inform care, interventions and discharge planning
- Increased opportunities to address mental health needs alongside physical care
- Stronger organisational governance, safety and risk management
- Defined objectives and KPIs to demonstrate statutory compliance
- Improved collaboration with health, social care, voluntary and community partners
- Increased access to mental health self-help and supportive resources
- Better aligned mental and physical health pathways across both Trusts and our partners

Aims:

The following aims guided the development of the strategy:

- Review and compare STHFT and NTHFT Mental Health Strategies.
- Develop a single, UHT Mental Health Strategy.
- Identify seven priority areas for collective improvement.
- Develop a UHT Mental Health Dashboard.
- Establish a Group Mental Health Strategic Group.
- Identify mental health training requirements by professional group.
- Clarify risk-assessment tools and compliance levels.

Progress and achievements:

1. Suicide Prevention

The Teesside Suicide Prevention Plan 2024–29, developed with Middlesbrough Council and Tees Esk and Wear Valley NHS Trust, has been endorsed locally and outlines eight key actions to reduce suicide. These include improved use of data, targeted support to high-risk groups, safer crisis pathways, reducing access to means, strengthening bereavement support and embedding suicide prevention across all services.

Regionally, suicide deaths decreased across most areas between 2023 and 2024, with updates shared regularly through established reporting processes. The plan is being promoted through the UHT Mental Health Communications page.

2. Right Care Right Person (RCRP)
RCRP has been fully implemented across UHT services to ensure patients receive emergency and urgent care from the correct service. While national pressures have been reported relating to police capacity, this has not yet affected UHT. Continued engagement with police colleagues remains a priority.

3. Restraint Policies and Rapid Tranquilisation
Work is underway to align restraint related guidance across UHT to support consistent practice and minimise restrictive interventions. Key activities include:

- Developing a single SOP for restraint.
- Aligning rapid tranquilisation guidance following an audit.
- Ensuring Mental Capacity Act considerations are embedded.
- Reviewing violence and aggression policies.
- Establishing a working group to progress the documents.
- A dedicated rapid tranquilisation policy will be created for both Trusts, following CQC feedback.

4. Training and Development in Mental Health
Psychology-led training continues to be central to upskilling staff. During 2025/26:

- 1,267 training places were delivered.
- 42 bespoke sessions were provided to wards and departments.
- A new Psychology Training Lead was appointed.
- Ten priority training topics were identified based on staff feedback.
- A Trust-wide Mental Health Awareness Conference took place in October 2025.
- Promotion of training remains challenging due to limitations with the STRIVE platform; alternative solutions are being explored.

5. We Can Talk Training Platform
A small pilot of the We Can Talk training platform showed increased staff confidence in discussing suicide and mental health. However, evaluation identified a need for additional staffing to monitor quality and impact. A £30,000 charitable bid (covering platform access and an Assistant Psychologist) was unsuccessful. CPD funding options will be reviewed. Alternative training packages, including those from Bespoke Mental Health, are being evaluated.

6. Maternal Mental Health
Work with commissioners is ongoing to develop workforce models and improve mental health support for maternity patients, particularly for mild to moderate concerns where gaps exist. Recruitment to key posts is underway, and updates will be provided in Q1 2026/27. Some financial risks remain and will be reflected on the risk register.

7. Children and Young People's Mental Health
Key developments include:

- National engagement to strengthen mental health support in urgent and emergency care.
- Exploration of CPI de-escalation training.
- Consideration of a mental health champion in NTHFT Emergency Department (ED).
- Review of eating disorder pathways.
- Charitable funding for enhanced outdoor spaces in ‘Children & Young People’ (CYP) areas.
- Improved joint working with CAMHS and school partnerships.
- Implementation of simulation training and review of triage tools.
- Over 600 staff previously completed We Can Talk CYP training when funded by NHSE.

8. Trauma-Informed Care

A phased approach is being developed to embed trauma-informed care across UHT. Progress includes:

- Establishment of a working group.
- Appointment of a 6-month Assistant Psychologist (charitable funding).
- Identification of six development domains (governance, policies, workforce, environment, service design, evaluation).
- Commitment to embedding trauma-informed principles within the People Plan.
- Establishment of a Lived Experience Advisory Panel (LEAP).

Work will follow national frameworks, progressing through Trauma Aware → Trauma Sensitive → Trauma Informed → Trauma Responsive stages. A communications plan and readiness assessment using the NHS Scotland tool are underway.

UHT has made strong progress in implementing its joint Mental Health Strategy during 2025/26. Key achievements include establishment of Group wide governance, significant training delivery, alignment of clinical policies, and strengthened regional partnerships. Further work during 2026/27 will focus on embedding trauma-informed care, implementing revised restraint and rapid tranquilisation guidance, progressing maternal and CYP mental health developments, and enhancing training accessibility and quality.

b. Quality priorities defined for improvement in 2026/27.

Following consultation with our Council of Governors and other stakeholders the following Quality Priorities for 2026/27 have been agreed (Table 2)

Patient Safety		
Revised Quality Priority 26/27 We will optimise learning from incidents, claims, and inquests to strengthen recognition and response to the deteriorating patient, improving patient safety outcomes and reducing avoidable harm.	**Revised Quality Priority 26/27** We will improve medication safety by optimising the use of the ePMA, and strengthening antimicrobial stewardship. We will achieve this by evaluating and embedding learning from medication incidents to reduce avoidable harm and improve the quality of prescribing against national and local standards.	**Revised Quality Priority 26/27** We will reduce risks of C. difficile, MRSA, GNBSIs (E. coli, Klebsiella, Pseudomonas) and other infections, embedding IPC good practice.
Patient Experience		
Revised Quality Priority 26/27 We will utilise patient and carer feedback as part of our continuous improvement methodology, with a specific focus on improving experience in the Emergency Department and eliminating corridor care.	**Revised Quality Priority 26/27** We will meet national Parliamentary & Health Service Ombudsman complaint standards	
Clinical Effectiveness		
Carried forward from 25/26 We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.		

Table 2 – Proposed Quality Priorities 2026/27

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 92.9% of the total income generated from the provision of relevant health services by the South Tees Hospitals NHS Foundation Trust for 2024/25.

During 2024/25, North Tees and Hartlepool NHS Foundation Trust provided and/or subcontracted 103 relevant health services. The majority of our services were provided on a direct basis, with a small number under sub-contracting or joint arrangements with others. North Tees and Hartlepool NHS Foundation Trust has reviewed all the data available to them on the quality of care in 103 of these relevant health services. The income generated by the relevant health services reviewed in 2024/25 represents 92.5% of the total income generated from the provision of relevant health services by the North Tees and Hartlepool NHS Foundation Trust for 2024/25.

2. National clinical audits and national confidential enquiries

South Tees Hospitals NHS Foundation Trust (STHFT) and North Tees and Hartlepool NHS Foundation Trust (NTHFT) remain committed to the effective delivery of clinical audit across all services. Clinical audit and participation in national audits and confidential enquiries form a key component of the Trusts' quality assurance arrangements, supporting patient safety, continuous improvement and the delivery of high-quality patient-centred care.

Both Trusts maintain structured and co-ordinated clinical audit programmes which, are regularly reviewed to ensure alignment with national requirements and the priorities of local acute and community services.

Participation in national Clinical Audits

During 2025/26, 77 national clinical audits and three national confidential enquiries covered relevant health services that STHFT provides. During the same period, 61 national clinical audits and three national confidential enquiries covered relevant health services that NTHFT provides.

STHFT participated in 69 of the 77 national clinical audits (90%) and 100% of national confidential enquiries for which it was eligible to participate in; NTHFT participated in 53 of the 61 of national clinical audits (87%) and 100% of national confidential enquiries for which it was eligible to participate in.

The national clinical audits and national confidential enquiries that STHFT and NTHFT were eligible to participate in, and for which data collection was completed during 2025/26 are listed in Table 3, 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 STH	% cases submitted	Participation NTH	% cases submitted
BAUS Boomerang Audit (British audit of the investigation and referral of women with recurrent urinary tract infection using recent guidance)	Yes	100%	Yes	100%
BAUS EMPAST Audit (Evaluating the management pathway for suspected testicular cancer referrals	Yes	100%	Yes	100%
Breast and Cosmetic Implant Registry	Yes	100%	Yes	100%
British Spine Registry	Yes	100%	Yes	100%
Case Mix Programme (CMP)	Yes	100%	Yes	100%
Emergency Medicine QIP: Adolescent Mental Health	No	0%	No	0%
Emergency Medicine QIP: Care of Older People	No	0%	No	0%
Emergency Medicine QIP: Mental Health (Self-Harm)	No	0%	No	0%
Emergency Medicine QIP: Time Critical Medications	No	0%	No	0%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	Yes	100%	Yes	100%
Falls and Fragility Fracture Audit	Yes	100%	Yes	100%

Programme (FFFAP): National Audit of Inpatient Falls (NAIF)				
Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Yes	100%	Yes	100%
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Yes	100%	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Core Audit	No	0%	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	Yes	100%	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	Yes	Zero harms confirmed	No	0%
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)	Yes	100%	Yes	100%
National Adult369 Diabetes Audit (NDA) Transition (Adolescents & Young Adults) Young Type 2 Audit	No	0%	No	0%
National Adult Diabetes Audit (NDA) Gestational Diabetes Audit	Yes	100%	Yes	100%

National Audit of Cardiac Rehabilitation	Yes	100%	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%	Yes	100%
National Audit of Dementia (NAD)	Yes	100%	Yes	100%
National Bariatric Surgery Registry	Yes	100%	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Yes	100%	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Yes	100%	Yes	100%
National Bowel Cancer Audit (NBOCA)	Yes	100%	Yes	100%
National Kidney Cancer Audit (NKCA)	Yes	100%	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%	Yes	100%
National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	100%	Yes	100%
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%	Yes	100%
National Ovarian Cancer Audit (NOCA)	Yes	100%	Yes	100%
National Pancreatic Cancer Audit (NPaCA)	Yes	100%	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	100%	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%	Yes	100%
National Adult Cardiac Surgery Audit (NACSA)	Yes	100%	N/A	N/A

National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	100%	Yes	100%
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	Yes	100%	Yes	100%
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%	Yes	100%
National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes	100%	N/A	N/A
UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	100%	N/A	N/A
Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Yes	100%	N/A	N/A
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit	Yes	100%	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	40%	No	0%
National Emergency Laparotomy Audit (NELA) Laparotomy	Yes	100%	Yes	100%
National Emergency Laparotomy Audit (NELA) No Laparotomy	Yes	100%	Yes	100%
National Joint Registry	Yes	100%	Yes	100%
National Major Trauma Registry	Yes	100%	Yes	32%

National Maternity and Perinatal Audit (NMPA)	Yes	100%	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%	Yes	100%
National Obesity Audit	Yes	100%	Yes	100%
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit	No	0%	N/A	N/A
National Ophthalmology Database (NOD): Cataract Audit	Yes	100%	N/A	N/A
National Paediatric Diabetes Audit (NPDA)	Yes	100%	Yes	100%
National Perinatal Mortality Review Tool	Yes	100%	Yes	100%
National Respiratory Audit Programme (NRAP): COPD Secondary Care	Yes	100%	Yes	100%
National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation	Yes	100%	Yes	100%
National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	Yes	100%	Yes	100%
National Respiratory Audit Programme (NRAP): Children and Young People's Asthma Secondary Care	Yes	100%	Yes	100%
National Vascular Registry (NVR)	Yes	100%	N/A	N/A
Paediatric Intensive Care Audit Network (PICANET) Level 2 Unit	Yes	100%	N/A	N/A

Perioperative Quality Improvement Programme	Yes	100%	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%	Yes	100%
Serious Hazards of Transfusion (SHOT) UK National Hemovigilance Scheme	Yes	100%	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%	N/A	N/A
UK Interstitial Lung Disease (ILD) Registry	No	0%	No	0%
UK Parkinson's Audit	Yes	100%	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	Yes	100%	Yes	100%

Table 3 - national clinical audits

National Confidential Enquiries (NCEPOD):

Both STHFT and NTHFT participated in all three national confidential enquiries (100%) that they were eligible to participate in, as shown in Table 4;

NCEPOD study	Participation STH	% cases submitted STH	Participation NTH	% cases submitted NTH
Acute illness in people with learning disabilities	Yes	100%	Yes	100%
Pleural procedures	Yes	TBC	Yes	100%
Stabilisation of the critically ill child	Yes	100%	Yes	TBC

Table 4 – National Confidential enquiries

Use of Audit Data Findings to improve Quality of Care

National audit confidential enquiries reports are reviewed through established governance arrangements to identify learning, areas of good practice and opportunities for improvement and

support the development of targeted action plans where required. Actions are monitored to ensure that audit outcomes lead to tangible service improvements.

South Tees Hospitals NHS Foundation Trust (STHFT)

During 2025/26, nine national clinical audit reports were reviewed. These audits provided assurance of strong performance in several areas, including dementia care, bowel cancer services and paediatric diabetes outcomes.

Where opportunities for improvement were identified, actions were agreed and implemented. These included: strengthening documentation, addressing service capacity and workforce challenges, enhancing access to seven-day services where required, and improving data quality to support accurate reporting and performance monitoring.

Collaborative working with NTHFT and external partners has supported shared learning and service improvement. Table 5 below provides more details of these actions.

Audit title	Actions taken/in progress
Royal College of Emergency Medicine (RCEM) Quality Improvement Projects 2025/26	Issues with the management of these projects by the Royal College were identified nationally. As this is a paid service, we have raised concerns with the provider about the viability and use of the national results.
Falls and Fragility Audit Programme: National Fracture Liaison Service Database report	The lack of service provision in the Hambleton and Richmond area had an impact on the results. The aim to assess patients within 90 days showed poor results due to limited staffing.
National Respiratory Audit Programme (NRAP) Catching our breath: Time for change in respiratory care	The performance of the trust compared well with other trusts in the region and the teams are reviewing ways to reduce readmissions. Contact has been made to collaborate with North Tees to learn from each other's approaches and improve all services for patients.
National Paediatric Diabetes Audit: Care & Outcomes and Type 2 Diabetes spotlight audit 2023/24	The performance was good in this audit showing that we had excellent clinical outcomes and that there has been a continued improvement over time. There is now an 'Open Access Asthma Clinic' available for patients with the aim of reducing readmission rates.
NATCAN: National Bowel Cancer Audit (NBOCA)	The audit showed excellent results – especially in the number of patients seen by a Clinical Nurse Specialist which was well above the national average. However, the audit identified a need for improvement in some areas and in response to this, the Cancer information team will undertake a data quality audit to ensure that documentation of cases is improved.
National Audit of Dementia (NAD):	The audit showed an excellent care rating for the trust at both James Cook and Northallerton above the national average.

Dementia Care in General Hospitals	Some work will be done to improve the use of delirium screening tools and resources and an action plan has been developed with Dietetics and Education teams following patient feedback at Northallerton.
Sentinel Stroke National Audit Programme (SSNAP)	There were some good results, but performance had dropped recently and there was not a 7-day service available for patients which impacted on the mechanical thrombectomy targets identified in the audit. Discussions with the mechanical thrombectomy lead are to be arranged to better understand the barriers and improve on this performance.
NHS Blood & Transplant National Audit of NICE Quality Standard 138	The audit identified a concern with a reduction in the use of tranexamic acid (used for reducing the risk of bleeding). In response, a reminder is now included on the checklist. Other areas of concern have been addressed such as recording of patient results and the recording of patient consent.
National Audit of Care at the End of Life (NACEL)	Following this audit an action plan has been agreed to develop a mandatory 3 yearly e-learning session on end-of-life care for all staff and look at opportunities to seek funding for a palliative care educator post. The team will also train additional staff to develop and deliver an advanced communication skills training programme. They will also work collaboratively with the Patient Experience Team and colleagues at North Tees to re-establish a trust wide bereavement survey. The team will also focus on chaplaincy support for all patients receiving end of life care and review the provision of support to identify spiritual and religious needs at end of life.

Table 5 - Actions following National Audit

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

During 2025/26, reports from 24 national clinical audit reports were reviewed. Audit findings demonstrated overall good performance across a range of specialties, alongside identified opportunities for further improvement.

Actions taken or underway include improving patient information and communication, enhancing compliance with national standards, strengthening personalised and reasonable adjustment approaches, and addressing service capacity and pathway efficiency. Audit findings have been used to support continuous improvement and strengthen clinical governance arrangements.

Table 6 below provides more details of actions taken.

Audit title	Actions taken/in progress
National Confidential Enquiry into Patient Outcome and Death	Following this audit there is now a patient information leaflet available which explains the services provided. Patients also receive a copy of their clinic letters.

(NCEPOD) Crohn's Disease Study	The audit showed that multi-disciplinary meetings take place on a regular basis and are documented effectively and shared with the GP as appropriate. Good practice was shown in referring patients for surgery when medication alone does not work and a checklist has been developed for patient discharge to improve efficiency and support. The team are developing a project to focus on improving capacity in theatres so that abdominal surgery waiting times can be improved,
National Audit of Dementia (NAD)	The audit showed good performance in patients being screened for delirium. Improvement was also recorded in completing the screening within 24 hours of admission. Good results were also shown in the development of management and care plans.
Learning from lives and deaths – people with a learning disability and autistic people (LeDeR)	This audit identified a need to address delayed discharges which is a regional concern. The team are working with the regional group to improve on this issue. The team are also working on improving Mental Capacity Assessments as identified by the audit.
NHS England Learning Disability Improvement Standards	Following this audit 'Reasonable Adjustments' training is now available online and all staff can access this. A poster campaign and leaflets have been shared with all wards following the audit and 'John's Campaign' (a national disability campaign) has been relaunched in the trust providing support for carers, discounted meals in the canteen, free parking and patient centred visiting.
Royal College of Emergency Medicine (RCEM) Quality Improvement Project: Time Critical Medications	National issues with data collection meant that this audit did not provide the expected reporting consistently over the year. This has been previously reported and discussed directly with colleagues from the Royal College. In the meantime, the Trust is to build a dashboard for staff to highlight omitted doses of time-critical medications. In addition, an awareness campaign in relation to time-critical medications via our staff communications and the Trust's social media platforms has been positively received.
National Oesophago-Gastric Cancer Audit (NOGCA)	The audit highlighted that there is an increased input from Clinical Nurse Specialists at the time of consultation. However, the issue of deprivation in the area coupled with patients presenting late with their symptoms, has led to a lower success rate with patient outcomes compared to the national average.
National Cardiac Arrest Audit	The data from this audit shows an improvement in outcomes but also led to work aimed at improving clinical training.

NRAP Adult Asthma Audit	This audit highlighted good prescribing of inhaled steroids at patient discharge and there is a self-discharge policy under review to address take-home asthma medications for patients.
NRAP Pulmonary Rehabilitation Audit	Following this audit, the Trust has been recognised as a major contributor to a national systematic review to promote pulmonary rehabilitation referral, uptake and adherence in people with Chronic Obstructive Pulmonary Disease.
NHS England Learning Disability Improvement Standards	Following the audit there are lower numbers of learning disability patients awaiting a first appointment date. Staff are now more confident in providing reasonable adjustments as a digital national reasonable adjustments flag is now in place.
Myocardial Ischaemia National Audit Project (MINAP)	This audit identified that a high proportion of patients are now seen by a cardiologist as an inpatient and that swift referral is now done electronically. The audit did, however, identify that echocardiograms are not always done prior to transfer or discharge and this will be addressed.
National Fracture Liaison Service (NFLS) audit	Good overall results were recorded for this audit especially in case ascertainment. There was an increase in falls risk assessments and bone treatment - all above national average
National Heart Failure Audit	This audit showed good results for echocardiograms being undertaken to confirm the clinical diagnosis, medication prescribing being given when the patient is still an inpatient and specialist input for patients with diagnosis of heart failure with reduced ejection fraction. Results were also good with regard to timely referral to cardiac rehabilitation and cardiologist follow-up on discharge.
National Paediatric Diabetes Audit (Core audit)	The audit noted that 100% of children and young people received thyroid and coeliac screening and that 87.4% of them were recorded as using real time continuous glucose monitoring. There was, however, a need to improve on the foot check completion rate as the results were below national averages.
National Paediatric Diabetes Audit (spotlight audit 2023/24)	This audit showed that dietetic and psychological input to the service is better than national average. However, it was also noted that the team does not routinely request liver ultrasound screening for patients with Type 2 Diabetes or perform sleep assessments.
National Paediatric Diabetes Audit (Patient Reported Experience Measures report)	The feedback from families was that they were impressed with the team's level of individualised care and expertise, that there is access to the latest technology and the team are accessible. The families highlighted the need for more regular appointments and follow-up calls for cancelled appointments.

NATCAN: National Bowel Cancer Audit (NBOCA)	This audit recorded a performance status of 94%, which was significantly higher than national figures. The results for 30-day unplanned readmission and/or unplanned return to theatre were better that most trusts locally. Significantly, the 90 day mortality rates were the best in the region and the trust also had excellent results for 2 year survival when compared to other trusts.
Intensive Care National Audit & Research Centre (ICNARC) Case mix programme	The results for this audit were good with all quality indicators being met and it was noted that the process for collecting accurate data in the audit was excellent.
Catching our breath: NRAP COPD report	The audit showed that the team are linking well with community teams to give excellent results. However, it was noted that respiratory specialist review within 24 hours was not routinely achieved due to the lack of a 7-day service. This issue is being reviewed currently.
National Lung Cancer Audit 2023 patient cohort	The audit showed good performance for data completeness, with results better than the national average. Systemic treatment for small cell lung cancer was lower than national average, so another audit was completed which gave assurance that all treatment plans were correct and appropriate for patients.
National Cardiac Arrest Audit	Results showed improvements were made in all areas since the previous report. Survival to discharge for patients showed a significant improvement. A new tool has been implemented to try to improve critical event management – the TAKE STOCK tool - this looks at learning to improve patient care and look after the wellbeing of the team.
NHS Blood & Transplant National Audit of NICE Quality Standard 138	The audit results appeared to show a significant drop in the results regarding transfusion patients receiving verbal and written information about blood transfusion. On review, it was recognised that there should have been a 'not applicable' option available to make the results more reflective of practice. Otherwise, the results were good.
British Association of Urological Surgeons (BAUS): Environmental Lessons Learned and Applied to the bladder cancer care pathway (ELLA)	The audit highlighted good practice in using advice and guidance to improve secondary care referrals. Areas for improvement included delivering a one-stop haematuria assessment, decarbonising the flexible cystoscopy procedure and maximising the day-case bladder tumour resection rate.
National Audit of Care at the End of Life (NACEL)	Following this audit, a review of the 'Caring for the Dying Patient' document is underway, for relaunch. The audit also raised awareness of the need to attend to the spiritual and religious needs of people important to the patient.

	The trust is also developing a face-to-face 7-day Cancer Nurse Specialist resource and working on a new End of Life discharge checklist.

Table 6 - Actions following National Audit

3. Local Clinical audit

Local clinical audit continues to play an important role in identifying and addressing service-specific risks and opportunities for improvement.

South Tees Hospitals NHS Foundation Trust (STHFT)

The reports of 369 local clinical audits were reviewed by the provider in 2025/26. These audits demonstrated the effective use of audit to drive improvements in patient safety, documentation standards and clinical outcomes. Where initial audits identified areas for improvement, re-audit cycles confirmed sustained improvements across multiple services, including radiology, surgery, podiatry and outpatient referral pathways.

South Tees Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (Table 7):

Audit title	Actions taken/in progress
Cancellation of Scheduled Contrast CT scans due to cannulation difficulty and implementation of Ultrasound-Guided Peripheral IV Cannulation	An initial round of audit identified 45 cancellations due to cannulation failure, out of a total of 3174 scheduled contrast CT scans (1.42%) An evidence-based protocol was implemented as part of a local quality improvement initiative, including expansion of ultrasound-guided cannulation training for radiographers, establishment of a formal competency framework for independent radiographer-led cannulation, assurance of more continuous onsite support for complex cases, and maintenance of detailed records of ultrasound -guided attempts and outcomes. Following the improvement phase, a local re-audit was carried out; findings including a significantly reduced cancellation rate of only one patient out of a total of 2917 scheduled contrast CT scans (0.03%)
Compliance with Obtaining Consent in Clinic Prior to Elective Breast and Thyroid surgery	An initial audit looking at documentation of the patient consent process within the elective breast and thyroid surgery clinic identified the need for improvement across all areas, including the need for work around producing a new standardised consent document to highlight previous areas where clinical recording could be improved. Teaching sessions were established to ensure staff were aware of the current national GMC and RCS clinical consent standards. A reaudit following the teaching sessions evidenced that documentation of risks and benefits, copy of consent form being given to the patient, and appropriately trained staff conducting the consent process were now all achieving 100% compliance.

Podiatry Nail Surgery LocSSIP	An audit of the podiatry nail surgery LocSSIP identified several areas of documentation which fell short of the required 100% standard: Documentation of sign-in recorded in 79% of cases, changes in condition since pre-assessment only 25%, checking of allergies in only 50% of cases, and antiplatelet/anticoagulant checked only 25%. As part of the improvement plan, a meeting was held for all staff involved in nail surgery to present the audit results and review all poor areas of documentation. Education and training was provided across the team to improve awareness of weaker areas and the need for increased consistency. Results of a follow-up audit demonstrated 100% compliance for all above items which initially did not meet the required standard.
Audit of appropriateness of referral to Soft Tissue Shoulder and Elbow Clinic	An audit of 1790 referrals to the Soft Tissue Shoulder and Elbow Clinic demonstrated 68.5% of referrals were appropriate for the clinic. The most common inappropriate referrals were fracture cases, ranging from small non-displaced fractures to fracture dislocations. A presentation to both junior and senior doctors was given in order to highlight the issues identified from the audit and reiterate the correct referral criteria for the clinic. A reaudit of 2246 further referrals after education was given, demonstrated an improved compliance of 82.4% appropriateness of referral. A new “Webice” referral in place of the previous direct booking process was also considered instrumental in improving the triage process into the clinic.

Table 7 - Actions following Local Audit

North Tees and Hartlepool NHS Foundation Trust

The reports of 112 local clinical audits were reviewed by the provider in 2025/26. These audits highlighted areas of good practice, alongside targeted actions to address documentation quality, compliance with national guidance and consistency of care delivery. Improvements have been supported through education, digital system enhancements and service redesign.

North Tees and Hartlepool NHS Foundation Trust intend to take the following actions to improve the quality of healthcare provided (Table 8):

Audit title	Actions taken/in progress
Prophylaxis against Infective Endocarditis NICE CG64 (Dentistry)	Action has been taken to highlight patients at risk of infective endocarditis (IE). A ‘toggle’ alert is now entered on to a patient’s medical history if they have an increased IE risk.
Neuromuscular Monitoring during the Peri-Operative period (Anaesthetics)	This audit highlighted some gaps in documentation and inconsistency in ‘train-of-four’ (TOF) monitoring used to assess the depth of neuromuscular blockade. The outcome is that TOF is now a mandatory field in the digital anaesthetic record, more monitoring devices are

	being purchased, and an educational programme has been put in place to ensure consistency.
Chest Wall Injury Management in the Emergency Department (Emergency Care)	This project identified a measurable improvement in the timeliness of analgesia for older patients presenting with chest wall injuries. Patients all now consistently receive analgesia within five minutes of arrival in the department.
Audit of Elective Consent (General Surgery)	Some key documentation issues have been addressed as a response to the audit findings: • The person taking consent and the patient's signature are always included on the form • Confirmation is documented regarding all risks associated with the procedure • Patient consent is confirmed on the day of the surgery • Information leaflets and a copy of the consent form are given to the patient.
Management of Headaches in the Emergency Assessment Unit (Medicine and Elderly Care)	The audit identified an issue with Fundoscopy (a diagnostic tool for headaches) leading to the purchase of a digital fundoscope and a newly developed assessment area for these patients.
Assessment with Compliance and use of the Pleural Procedures Safety Checklist (Medicine and Elderly Care)	This audit highlighted good completion of the checklist, but action is being taken to improve some areas to include the documentation of the technical aspects of the procedure and documenting that patient information has been given out.
Children's Safeguarding Audit (Obstetrics and Gynaecology)	Excellent compliance with the standards of the audit but it highlighted that documentation of parental assessments on the postnatal ward needed to improve. These audit results are to be shared with the team to ensure that this issue is highlighted and acted upon.
Management of Ankle Fractures (Orthopaedics)	Compliance with the audit requirement to document a skin assessment has improved dramatically from 40% to 80% but there are still improvements required and the follow up actions have focused on this area along with a need to improve the documentation of neurovascular status before and after patient mobilisation.
Bacterial Meningitis NICE NG 240 and QS 19	Excellent outcomes regarding blood tests being undertaken prior to giving antibiotics – 100% of patients had all necessary investigations performed. However,

(Paediatrics)	the audit identified the need for a bacterial swab to be performed in all cases of suspected meningitis prior to starting antibiotics.
Ultrasound Detection of Biliary Dilatation in Abnormal MRCP (Radiology)	The audit highlighted an inconsistency in recording/commenting of intra or extra hepatic dilation and has also identified the need for completing ultrasound scanning in a reasonable time frame prior to completing MRCP.

Table 8 - Actions following National Audit

Participation in national and local clinical audit during 2025/26 has provided assurance that both Trusts continue to monitor, evaluate and improve the quality and safety of care delivered to patients. Audit findings consistently inform service improvement, support learning and enable early identification of risk.

Both Trusts remain committed to maximising the impact of clinical audit and national confidential enquiries as an integral component for quality improvement and enhanced patient safety.

4. Clinical Research

Research structure and governance

Research governance is overseen through the Chief Medical Officer (CMO) portfolio and, reports directly into the Academic Committee for Research, Education and Innovation with the Chief Medical Officer as Executive Lead.

Our new Academic Strategy is an enabling strategy for the UHT "Partnerships & Places" strategic pillar and describes our commitment;

To create an innovative and inclusive academy that supports everyone to realise their full potential through research, education, training, lifelong learning and innovation.

The strategy aims to enable staff to realise their potential while contributing to improved outcomes for patients and our wider population.

The Tees Valley Research Alliance (TVRA) Research Strategy is a patient focused strategy and aligns with the Academic strategy. It is delivered through two inter-related programmes of work:

- Research Delivery – supporting the delivery of externally sponsored research studies
- Research Development – supporting the development and growth of research led by UHT researchers

Our research vision is;

"To support and embed the development, delivery and growth of high-quality, patient-focused research in the Tees Valley and beyond"

A new Clinical Leadership model for research is being implemented with the appointment of Director and Deputy roles for Research Delivery and Research Development. In parallel, research performance dashboards are being developed for Clinical Service Units (CSUs) to increase visibility, support oversight and embed a culture of research awareness and engagement.

Risks relating to research and academic strategy delivery are reported quarterly to the Academic Committee via the Board Assurance Framework (BAF). Progress against key milestones is reported bi-monthly to the Strategy Programme Board and quarterly to the Academic Committee for oversight and governance.

Research Delivery

The number of patients receiving relevant health services provided or subcontracted by South Tees NHS Foundation Trust (STHFT) in 2025/26 that were recruited during that period to participate in research approved by a research ethics committee was 6,150 (across 152 studies and 23 clinical specialties).

The number of patients receiving relevant health services provided or subcontracted by North Tees and Hartlepool NHS Foundation Trust (NTHFT) in 2025/26 that were recruited during that period to participate in research approved by a research ethics committee was 7,233 (across 72 studies and 18 clinical specialties).

This represents a total of 13,383 patients recruited across UHT.

Across both Trusts, research delivery was supported by 136 Principle Investigators, including an increase in non-medical Principal Investigators from 30 to 32, reflecting broader multidisciplinary engagement in research activity.

National Performance Metrics

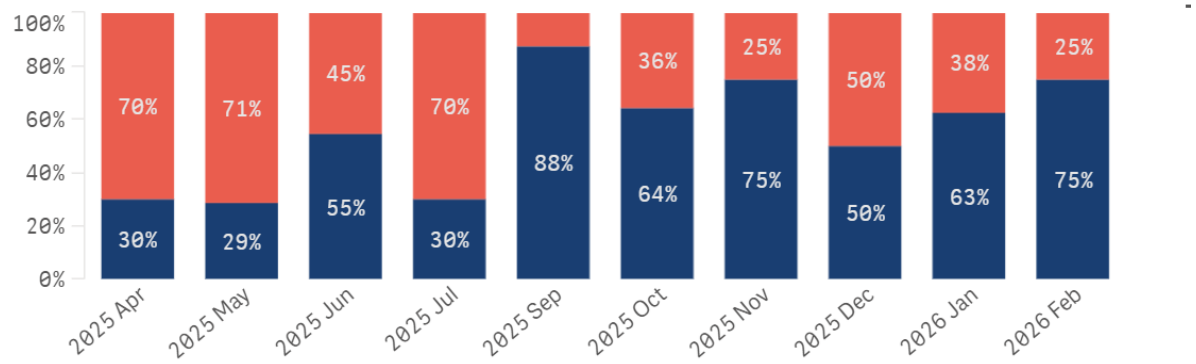
During the year 2025/26, the National Institute for Health Research (NIHR) introduced new national performance metrics to support timely study set-up and delivery:

- 60-day study set up metric (target 80%)
- 30-day recruitment of first participant t following study set-up (target 80%).

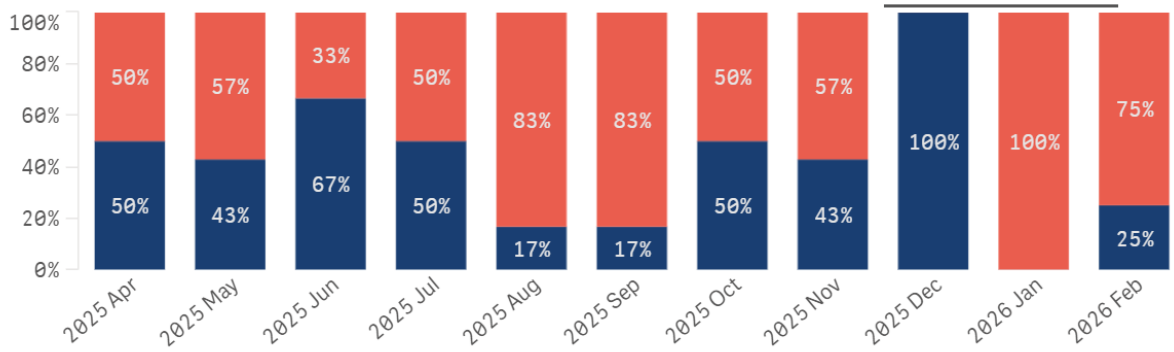
Performance against these metrics will influence up to 20% of the NIHR funding allocation for 2026/27, subject to cap and collar arrangements to prevent destabilisation of budgets.

A range of actions were implemented to improve our performance, including the appointment of dedicated research facilitator, strengthened investigator oversight, improved communication and enhanced reporting at TVRA level. Improvement has been observed in study set-up times during the year; istudy delivery remains an area of continued focus.

Our performance against these metrics is shown in Graph 1 and 2 below.



Graph 1 - % of studies set up within 60 days



Graph 2 - studies recruiting first patient within 30 days

Research Development

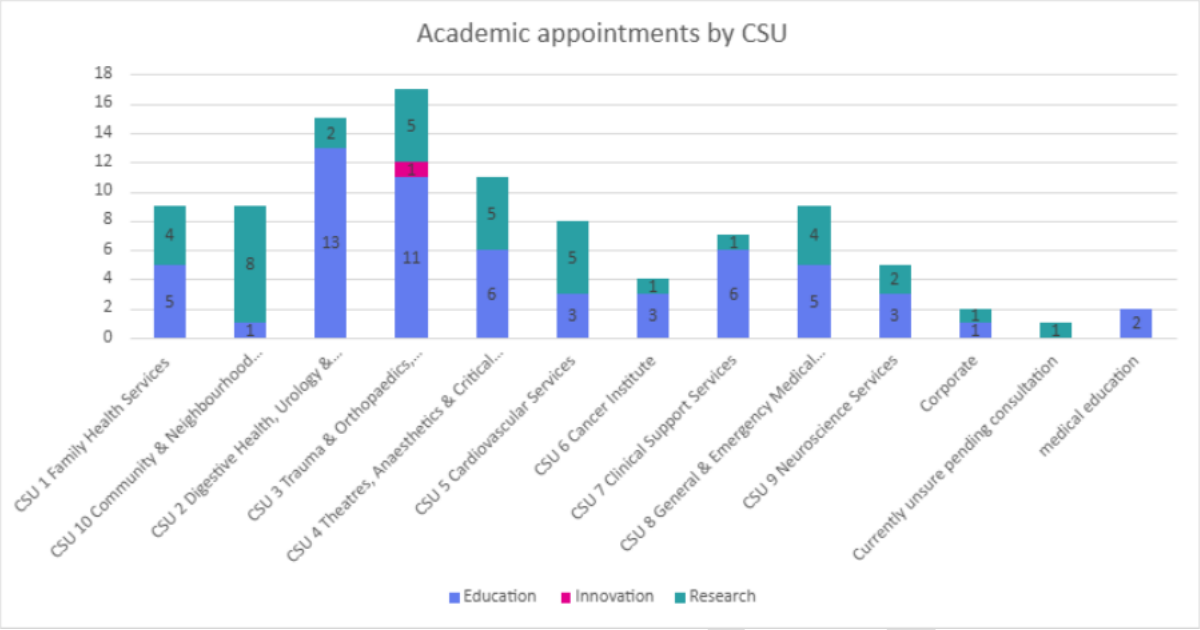
Performance

At year end, there were 41 UHT trust-sponsored studies in pipeline/set-up, 26 open, 5 in active follow-up and 16 closed (Table 9). Details below of distribution according to whether these studies are led by an Academic Research Unit (ARU) or the TVRA CI team.

UHT Sponsored studies	Pipeline	Set up	Open	In follow-up	Closed
Academic Cardiovascular Unit (ACU) Supported	7	4	6	1	4
Academic Centre for Surgery (ACeS) Supported	6	9	9	2	1
TVRA Projects/ CI team Supported	2	13	11	2	11
Total	**15**	**26**	**26**	**5**	**16**

Table 9 – UHT sponsored studies

In a response to our recent “Academic Affiliations Survey” we identified 39 members of staff-reporting honorary or clinical academic appointments relating to research with 11 different Universities. This information has been shared with CSU Leads to support appraisals and career discussions.



Graph 3 – Academic appointments by Clinical Service Unit

Research collaboration continues with regional academic partners including Teesside, Newcastle, Hull, York and Durham Universities. Work is also underway to develop collaborative research delivery models with Primary Care and community pharmacies, including support for vaccine trials.

Nursing Midwifery and Allied Health Practitioner (NMAHP) Development

Three staff members successfully secured NIHR North East and North Cumbria Internship awards, this provided funding of £10,000 each for 9 months. The NMAHP Best Practice Council has continued to grow with over 70 members benefitting from support, guidance and resources for their research journey and clinical academic development.

Research and Academic Highlights

Key academic achievements during 2025/26 include:

- A UKRI Cabinet Office Fellowship awarded to Dr Chris Wilkinson (Academic Cardiovascular Unit), supporting research into data-driven and community-centred approaches to addressing health inequalities.
- Dr Donna Wakefield, Consultant in Palliative Medicine, awarded the 2025 *Wakley Prize Essay* by *The Lancet*, alongside publication in *eClinicalMedicine* exploring inequalities in access to palliative care for people with lung disease.
- For the first time, an NMAHP clinician secured a nationally competitive Tessa Jowell AHP Research Fellowship. Alice Franklin, a physiotherapist supported by the Academic Centre for Surgery, was awarded funding of £178,520 to support early-career academic development.

Innovation

Innovation, alongside Research, is one of the eight domains reporting into the Board via the Board Assurance Frameworks (BAF) which outline the risks to achieving our strategic aims above. Monthly reporting of progress against the BAF is provided to the Quality Committee.

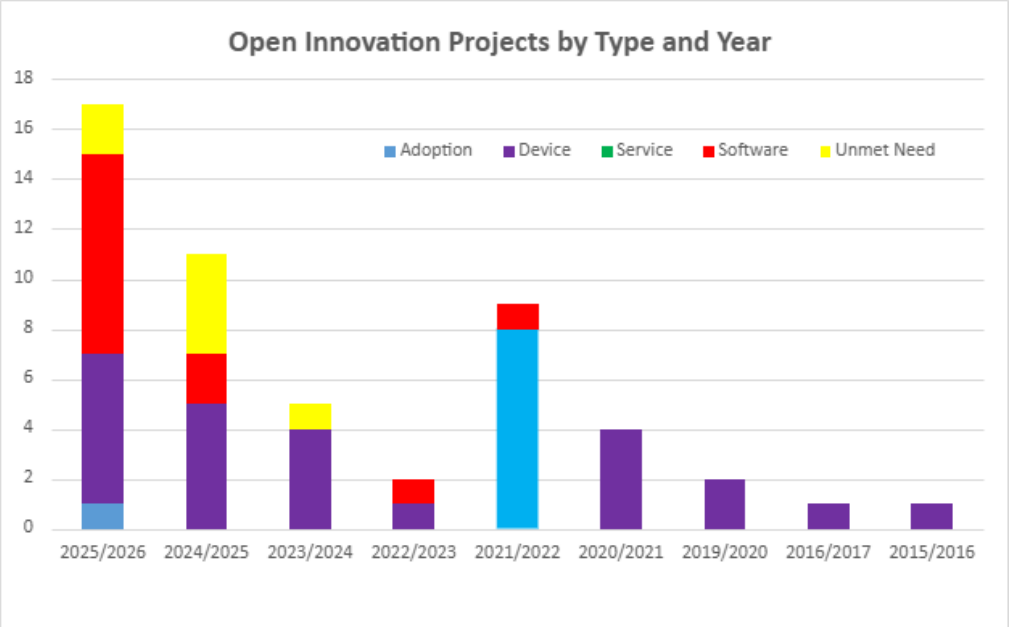
A Group-wide Innovation Strategy has been developed and approved, supporting delivery of a consistent culture of innovation across UHT. Recruitment to a newly established Innovation

Manager post is underway to support delivery of this strategy. The Trusts are also implementing the Department of Health and Social Care Intellectual Property guidance published in November 2025, including updates to IP policies and staff awareness training.

Innovation at NTHFT is supported through NTH Solutions, with a Business Development and Innovation team structure implemented from January 2025. Innovation support at STHFT is delivered directly via Trust staff.

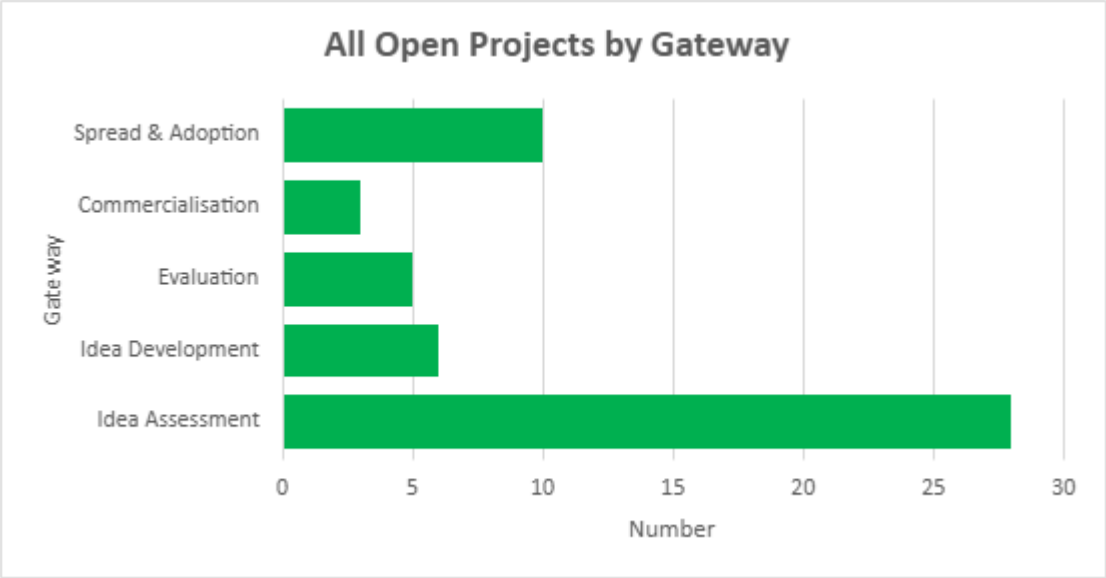
During 2025/26, 31 innovation enquiries were received across UHT. Of these, 17 projects remain under assessment, including medical devices, unmet clinical needs and software solutions. Open projects continue to be supported through the Health Innovation North East and North Cumbria Innovation Pathway.

Work is ongoing on from previous cohort enquiries, with a breakdown of these provided below (Graph 4).



Graph 4 – 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. Below in Graph 5 shows the gateways the open North Tees & Hartlepool and South Tees projects are at on the Pathway.



Graph 5 – All open projects

North Tees and Hartlepool NHS Foundation Trust has entered the development phase of a Well-being Journal that is funded by the Trusts charity, which will be available across UHT to support staff with any physical/ mental ailments they are going through. A patent application for the Birtha Stool has been granted to protect the IP rights.

South Tees Hospitals NHS Foundation Trust has commercialised the Neonatal Chest Drain Training Kit in October 2025, a device kit manufactured and distributed by the Trust, which is a practical high-quality solution designed to support healthcare professionals in mastering this critical procedure with confidence. The kit was first used within the Trust training scheme which received excellent feedback. We have offered an introductory price to other Trusts to gain further feedback. This kit is now available to the wider NHS, and we are looking at opportunities to spread further. In 2025, IP has been protected in relation to this project with design registrations in the UK being secured.

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

There were no CQUIN arrangements over 2025/26.

6. Care Quality Commission registration, reviews and investigations

South Tees Hospitals NHS Foundation Trust (STHFT)

South Tees Hospitals NHS Foundation Trust is registered with the Care Quality Commission (CQC) with no conditions applied to its registration.

The CQC did not take any enforcement action against the Trust during 2025/26, and the Trust did not participate in any special reviews or investigations during this period.

In October 2025, the CQC completed an IR(ME)R inspection of the Radiotherapy Department. No breaches meeting the threshold for enforceable action were identified. Areas for improvement were highlighted, and the Trust developed and submitted an action plan. The CQC subsequently confirmed it was assured by the actions taken and closed the inspection file.

Figure 5 - South Tees Hospitals NHS Foundation Trust overall CQC rating

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

North Tees and Hartlepool NHS Foundation Trust is also registered with the CQC with no conditions applied to its registration.

The CQC took no enforcement action against the Trust during 2025/26, and the Trust did not participate in any special reviews or investigations during the period.

Figure 6: North Tees and Hartlepool Hospitals NHS Foundation Trust overall CQC rating

All reports are available at:

- South Tees Hospitals NHS Foundation Trust - Overview - Care Quality Commission (cqc.org.uk)

- http://www.cqc.org.uk/provider/RVW

CQC Contact and Communication

Both STHFT and NTHFT maintain regular joint engagement meetings with the CQC through scheduled meetings and routine communication. Informal visits to clinical areas are facilitated upon request when CQC staff are on site.

7. Submission of records to the Secondary Uses Service

South Tees Hospitals NHS Foundation Trust submitted records during 2025/26 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 2025 which included the patient's valid NHS number was:

- 100% for admitted patient care
- 100% for outpatient care, and
- 99.6% for emergency department care.

The percentage of records in the latest published data for November 2025 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.

North Tees and Hartlepool NHS Foundation Trust submitted records during 2025-26 to the Secondary Uses Service (SUS) for inclusion in the Data Quality Maturity Index (DQMI which are included in the latest published data.

The percentage of records in the latest published data for November 2025 which included the patient's valid NHS number was:

- 100% for admitted patient care
- 100% for outpatient care, and
- 99.7% for emergency department care.

The percentage of records in the latest published data for November 2025 which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 99.5% % for outpatient care, and
- 100% for emergency department care.

8. Information Governance grading

Both Trusts continue to provide assurance to the UHT Board of Directors that systems and processes for managing information are regularly reviewed and strengthened to ensure the security and confidentiality of data. In accordance with UK GDPR Article 37, we have an appointed Data Protection Officer (DPO) who provides advice and assurance and oversight of compliance with legal requirements, and acts as the point of contact for data subjects and the Information Commissioner's Office (ICO).

The Data Security and Protection Standards for health and care organisations are set out in the National Data Guardian's (NDG) ten standards and are assessed though the completion of the Data Security Protection Toolkit (DSPT). All organisations with access to NHS patient data and systems must complete the DSPT annually to demonstrate the appropriate handling of personal information and adherence to data security requirements.

The DSPT is now aligned to the Cyber Assessment framework (CAF) which provides a structured approach to assessing how well cyber and information governance risks are being managed across essential services.

South Tees Hospitals NHS Foundation Trust

The Trust submitted its 2025 DSPT submission on the 30 June 2025. The Trust has self-assessed compliance with all standards and all mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the Trust scored as all 'Standards Met' for the DSPT.

An external audit was conducted by Price Waterhouse Cooper (PWC) in May 2025, reviewing 12 outcomes across the five CAF objectives. The independent audit rated:

- Overall risk level: Very High
- Confidence level in self-assessment: Low

Assessment Outputs

	Overall risk rating across all five CAF objectives	Confidence level of the Independent Assessor in the veracity of the self-assessment
Independent Assessment Outputs	Very High	Low

An action plan addressing the identified risks has since been fully implemented.

At the time of writing, for the 2026 DSPT, the Trust has submitted baseline information for all outcomes and is gathering evidence ahead of the final submission deadline of 30 June 2026.

North Tees and Hartlepool NHS Foundation Trust
The Trust submitted its 2025 DSPT submission on the 30 June 2025. The Trust has self-assessed compliance with all standards and all mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the Trust scored as all 'Standards Met' for the DSPT.

Audit One conducted an external audit of 12 outcomes across the five CAF objectives. The Independent risk audit rated:

- Overall risk level: Low
- Confidence level in self assessment: High

Assessment Outputs

	Overall risk assurance across all five CAF objectives	Confidence level of the Independent Assessor in the veracity of the self-assessment
Independent Assessment Outputs	Low	High

For the 2026 DSPT, baseline information has been submitted for all outcomes, and evidence is currently being collated for the final submission due 30 June 2026.

Data Security

The confidentiality and security of patient and staff information is maintained through the application of our Governance Framework, which incorporates relevant legislation and policy requirements.

While information is increasingly held electronically within secure digital systems, the continued use of paper records within some services means that data security incidents can still occur.
All incidents involving the loss, disclosure, or compromise personal data are investigated in line with UHT's Data and Cyber Breach Management Policies and graded using the NHS Digital 'Guide to the Notification of Data Security and Protection Incidents'.

Incidents are assessed based on:

- The significance and potential impact on individuals
- The likelihood of harm
- Criteria set out in national breach assessment guidance

Incidents assessed as high risk are reported to the ICO within 72 hours through the DSPT.

Staff are encouraged to report any suspected data protection or cyber incident, regardless of severity, in accordance with Trust policy.

South Tees Hospitals NHS Foundation Trust
During the reporting period we reported 4 incidents to the ICO (an increase from zero in the previous year). These related to:

- 2 incidents of inappropriate access to clinical systems
- 2 incidents of information being sent to an incorrect recipient

Two cases have been closed by the ICO with no further actions. At the time of writing, two remain open pending outcome. All appropriate mitigating actions have been implemented.

North Tees and Hartlepool NHS Foundation Trust
During the reporting period two incidents were reported to the ICO (an increase from one in the previous year). These related to:

- Inappropriate access to clinical systems
- Inappropriate disclosure of information.

.

Both incidents have been closed by the ICO with no action, and the Trust has implemented appropriate mitigations.

Actions taken to strengthen data security

Across both Trusts, the following actions have been undertaken to further strengthen data protection and minimise the likelihood of future incidents:

- Review and update of Information Governance policies and standard operating procedures.
- Continued quality assurance and spot checks across all departments
- Ongoing annual Data Security and Cyber Security Training with targeted sessions in areas of non-compliance.
- Robust monitoring of departmental action plans following incidents through the Digital Governance Committee.
- Annual review of information assets and data flows to ensure compliance with GDPR requirements.
- Regular staff awareness campaigns led by the Communications Team, HR processes enacted in cases of repeated non-compliance.

9. Clinical coding audit

South Tees Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2025/26 by the Audit Commission.

North Tees and Hartlepool NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2025/26 by the Audit Commission.

10. Data quality

Both South Tees Hospitals NHS Foundation Trust (STHFT) and North Tees and Hartlepool NHS Foundation Trust (NTHFT) continue to take actions to strengthen the quality, accuracy and completeness of data recorded across their organisations.

High-quality data is essential to support safe patient care, effective service delivery, operational planning and statutory reporting.

All data collected, recorded and reported by both Trusts complies with national data standards set out in the NHS Data Dictionary, and clinical coding is undertaken in line with classifications published by the World Health Organization and NHS Digital (ICD-10 and OPCS-4.10).

To support clinical and operational teams, Business Intelligence, Management Information and Data Quality functions across both Trusts provide analytical tools, dashboards and reports to identify efficiencies and highlight areas for data quality improvement.

Both Trusts routinely monitor the completeness, accuracy and validity of data to ensure compliance with legal and regulatory requirements. Monitoring reports, audits and validation checks are used to improve processes, strengthen staff training and support consistent use of Trust systems. Examples of routine monitoring undertaken across the Trust are detailed in Table 10 and include:

Type of Monitoring	Frequency	Responsibility
External and internal audit of data quality of differing aspects of the Trust's data.	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

Table 10 – Data monitoring

All staff involved in recording patient information are responsible for following NHS data standards and Trust guidance relevant to their roles. Online data quality awareness sessions are available to all staff via the Trusts intranet platforms. These resources outline key data recording standards, pathway-based data collection requirements and updates on changes to national guidance. Staff are encouraged to complete this training annually.

UHT remains committed to improving data accuracy; improving, strengthening internal controls, and ensuring their data supports delivery of high-quality care and robust decision-making.

11. Learning from deaths

South Tees NHS Foundation Trust

During 2025/26, 1,835 patients of South Tees Hospitals NHS Foundation Trust died. This comprised the number of deaths which occurred in each quarter of that reporting period:

- 449 in the first quarter
- 382 in the second quarter
- 494 in the third quarter
- 510 in the fourth quarter.

By 31st March 2026, 230 case record reviews and 23 investigations have been carried out in relation to 1,835 deaths above. In 23 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:

- 29 in the first quarter
- 49 in the second quarter
- 79 in the third quarter
- 73 in the fourth quarter.

1 representing 0.01% of the patient deaths during 2025/26 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:

- 1 representing 0.1% of the number of deaths which occurred in the quarter for the first quarter.
- 0 representing 0.0% of the number of deaths which occurred in the quarter for the second quarter.
- 0 representing 0.0% 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 Structured Judgement Review Plus tool.

Of the 230 case reviews completed 90% (208) were Definitely not Preventable, 4% (8) showed slight evidence of preventability, 1% (3) were possibly preventable less than 50/50 and 0.5% (1) Definitely Preventable. In 5% (10) of cases, preventability was unable to be graded.

76% (175) showed Good Practice, 12% (24) required room for improvement in clinical care, 9% (20) required room for improvement in organisational care and 4% (8 cases) required room for improvement in clinical and organisational care. In 1% (3) of cases, quality of care was unable to be graded.

The Trust established a Medical Examiner Service in May 2018. Approximately 98% of deaths are scrutinised by Medical Examiners and where concerns are identified a referral made to the Mortality Surveillance team (a central team of up to four consultants and a nurse with expertise across many specialties). Requests for review are also received from the Trust Patient Safety Team. 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, Learning Response Panel or back to the parent specialty.

Learning and actions resulting from death reviews include:

- Greater emphasis on checking blood glucose prior to re-commencing enteral nutritional support, particularly when the patient is receiving supplemental insulin.

- Consideration of earlier insertion of nephrostomy tube.

- Development of a new SOP for oxygen prescription at the time of discharge from hospital.

- Review of pathways for transferring complex patients from emergency settings.

- Recommendations for earlier DNACPR discussions and MDT input.

- Recognition of the need for earlier decision making when the patient is deteriorating.

- Wound Photography was not being done as per G119 and processes not understood or actioned at ward level. Wound photography audit and Task and Finish Group established. Training programme for app rolled out and added to current essential wound care training and pressure ulcer policy updated.

- Update of Policy G27: Insertion and Management of Nasogastric Tubes for Feeding, Hydration, and Medication, which now incorporates a mandatory risk assessment for overnight feeding to enhance patient safety.

- Apixaban and other anti-coagulants issues with prescription and administration.

- In paper medical records, coordination of care was not easily identified as it relied on notes being made of conversations and telephone calls between colleagues. This has improved to some extent with the implementation of MIYA although further developments are needed.

- Information about patients prior to and at the time of referral currently relies on the doctor accepting referral to make a summary in the medical record. Newcastle upon Tyne Hospitals NHS FT have led procurement of a single electronic system for all Trusts in the North East & North Cumbria and Patient Pass (https://www.patientpass.co.uk/) has been chosen with completion of contracts in process currently. An implementation plan for cardiac, renal, vascular, orthopaedic and other specialty services will follow. This means that information about transferred patients will be much easier to audit and that may lead to improvements in care for this important group of patients with complex needs.

- LeDeR identified DNACPR orders which inappropriate rationale including reference to learning disabilities and epilepsy.

- Mental Capacity Assessments were not consistently completed in cases where patients were documented as confused, nor were they always undertaken prior to applications for Deprivation of Liberty Safeguards (DoLS), these concerns have been escalated to the Ward Manager and Matron for further action and oversight.

172 case record reviews and 10 investigations were completed after 31 March 2025 which related to deaths which took place before the start of this reporting period.

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 Structured Judgement Review Plus tool.

1 representing 0.1% of the patient deaths during 2024/25 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Of the 172 case reviews completed 95% (164) were Definitely not Preventable, 3% (5) showed slight evidence of preventability, 0.6% (1) had strong evidence for preventability and in 1% (2) preventability was unable to graded.

83% (143) showed Good Practice, 6% (10) required room for improvement in clinical care, 8% (13) required room for improvement in organisational care and 2% (4 cases) required room for improvement in clinical and organisational care. 1 case) care was less than satisfactory. In 0.6% (1 case), quality of care was unable to be graded.

North Tees and Hartlepool NHS Foundation Trust

During 2025/26, 1,198 patients of North Tees and Hartlepool NHS Foundation Trust died. This comprised the number of deaths which occurred in each quarter of that reporting period:

- 294 in the first quarter.
- 275 in the second quarter.
- 326 in the third quarter.
- 303 in the fourth quarter.

By 31st March 2026, 59 case record reviews have been carried out in relation to 1,198 deaths above. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 1 in the first quarter.
- 15 in the second quarter.
- 20 in the third quarter.
- 23 in the fourth quarter.

2 representing 0.00% of the patient deaths during 2025/26 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:

- 0 representing 0.0% of the number of deaths which occurred in the quarter for the first quarter.
- 0 representing 0.0% of the number of deaths which occurred in the quarter for the second quarter.
- 3 representing 0.1% 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 Structured Judgement Review Plus tool.

Of the 59 case reviews completed 78% (46) were Definitely not Preventable, 12% (7) showed slight evidence of preventability, 5% (3) were possibly preventable less than 50/50. In 2% (1) of cases, preventability was unable to graded.

51% (30) showed Good Practice, 17% (10) required room for improvement in clinical care, 20% (12) required room for improvement in organisational care and 8% (5 cases) required room for improvement in clinical and organisational care. In 3% (2 cases) care was less than satisfactory. In 2% (1 case), quality of care was unable to be graded.

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

Learning and actions resulting from death reviews include:

- Reviewing arrangements within UHT to improve the reporting, align the themes from Learning from Deaths with the themes from other quality related activity and use these to drive improvements in care.
- Ongoing collaboration with South Tees
- Review of Specialty Mortality and Morbidity work, with a view to capturing this on the InPhase system alongside SJRs
- Expand team of reviewers
- Work towards SJR of 15% of deaths

Areas of good practice noted included a request to prioritise comfort and relief of symptoms; clear discussion with patient of forward plan; good communication with family; early referral to alcohol care team.

Areas of concern noted delays in transfer between sites; delay in management of small bowel obstruction; lack of continuity of care; poor wound management; weights not recorded; Trakcare notes not in order; delay in receiving antibiotics in ED; delay in DNACPR.

26 case record reviews and 0 investigations were completed after 31 March 2025 which related to deaths which took place before the start of this reporting period.

0 representing 0% 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 Structured Judgement Review Plus tool.

0 representing 0% of the patient deaths during 2024/25 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Of the 26 case reviews completed 77% (20) were Definitely not Preventable, 15% (4) showed slight evidence of preventability, 5% (2) were possibly preventable less than 50/50, 8% (2) unable to grade.

48% (19) showed Good Practice, 33% (13) required room for improvement in clinical care, 8% (3) required room for improvement in organisational care and 8% (3 cases) required room for improvement in clinical and organisational care. In 5% (2 cases) care was less than satisfactory.

2.3 Reporting against core indicators

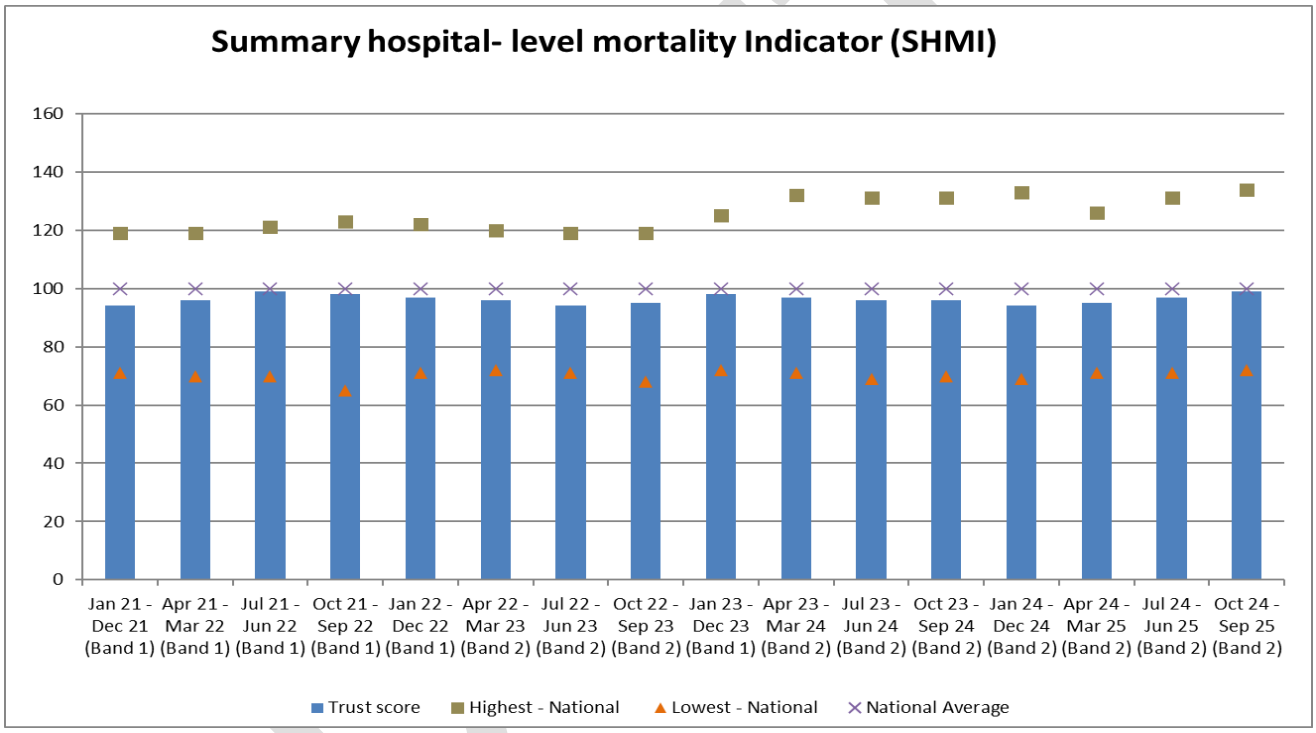
1. Summary Hospital-level Mortality Indicator (SHMI) and Palliative Care Coding

North Tees and Hartlepool NHS Foundation Trust

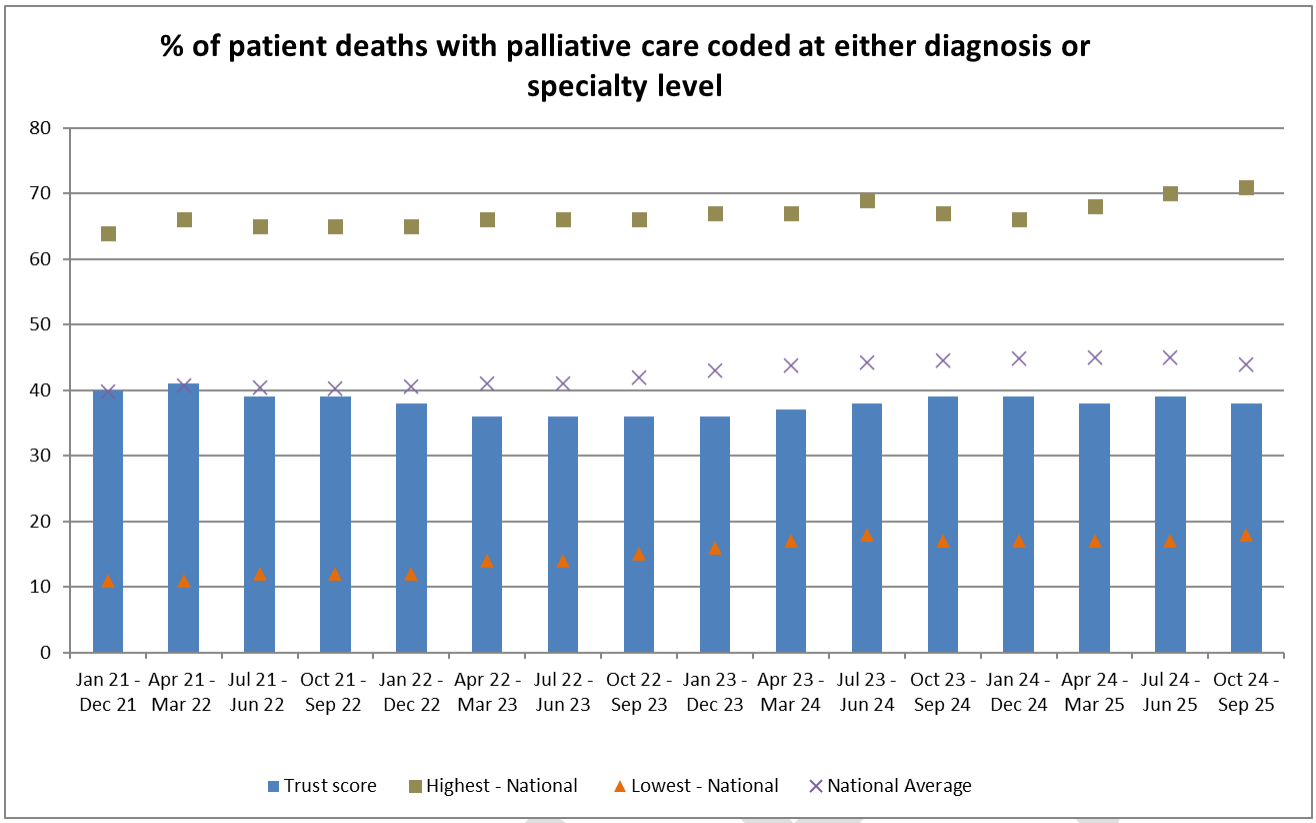
The SHMI indicator provides an indication on whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline in England.

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

The latest SHMI value of 99 (October 2024 to September 2025) continues to reside in the 'as expected' range.



Graph 6 – Summary Hospital-level mortality indicator (SHMI)

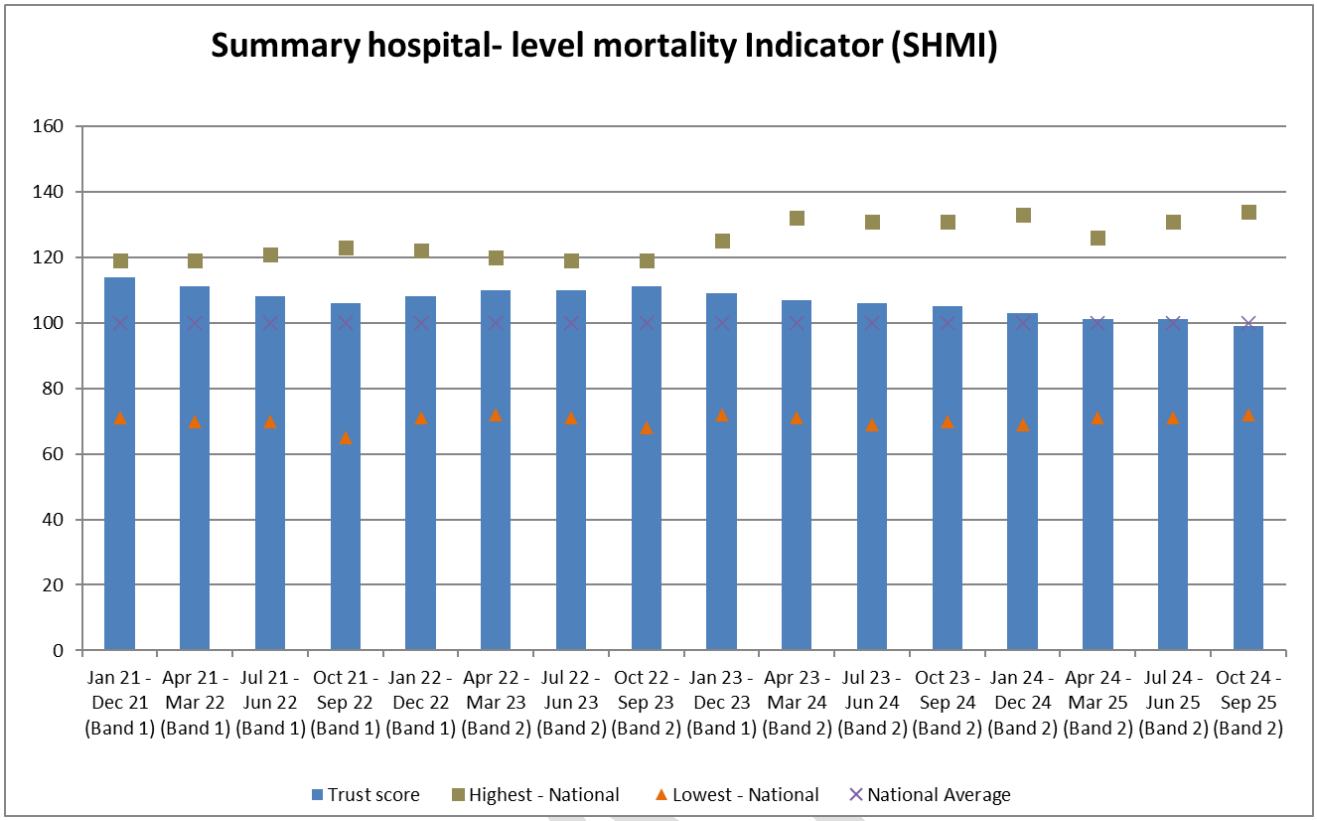


Graph 7 - % of patient deaths with palliative care coded at either diagnosis of speciality level

Learning from Deaths Improvement Work

The following are areas of learning and improvement resulting from mortality reviews:

- Recognition of Dying – Instances of both timely and delayed recognition of dying.
- Recognition of dying is included in palliative care training for all clinical groups. Work is also ongoing to embed a Treatment Escalation Plan within Trakcare to aid timely recognition of the deteriorating patient and aid ceiling of treatment decisions. It was also recognized that this is particularly challenging in patients with dementia and specific teaching on this is proposed.
- The Learning from Deaths team recommended some focused education for medical teams around Heart Failure diagnosis and management, following findings from Structured Judgement Reviews (SJRs).
- Timely recognition of needs and targeted support in patients with a Learning Disability noted as a particular point of good practice and fed back to relevant teams.
- Findings around the timeliness and accuracy of documentation were escalated and disseminated to teams.

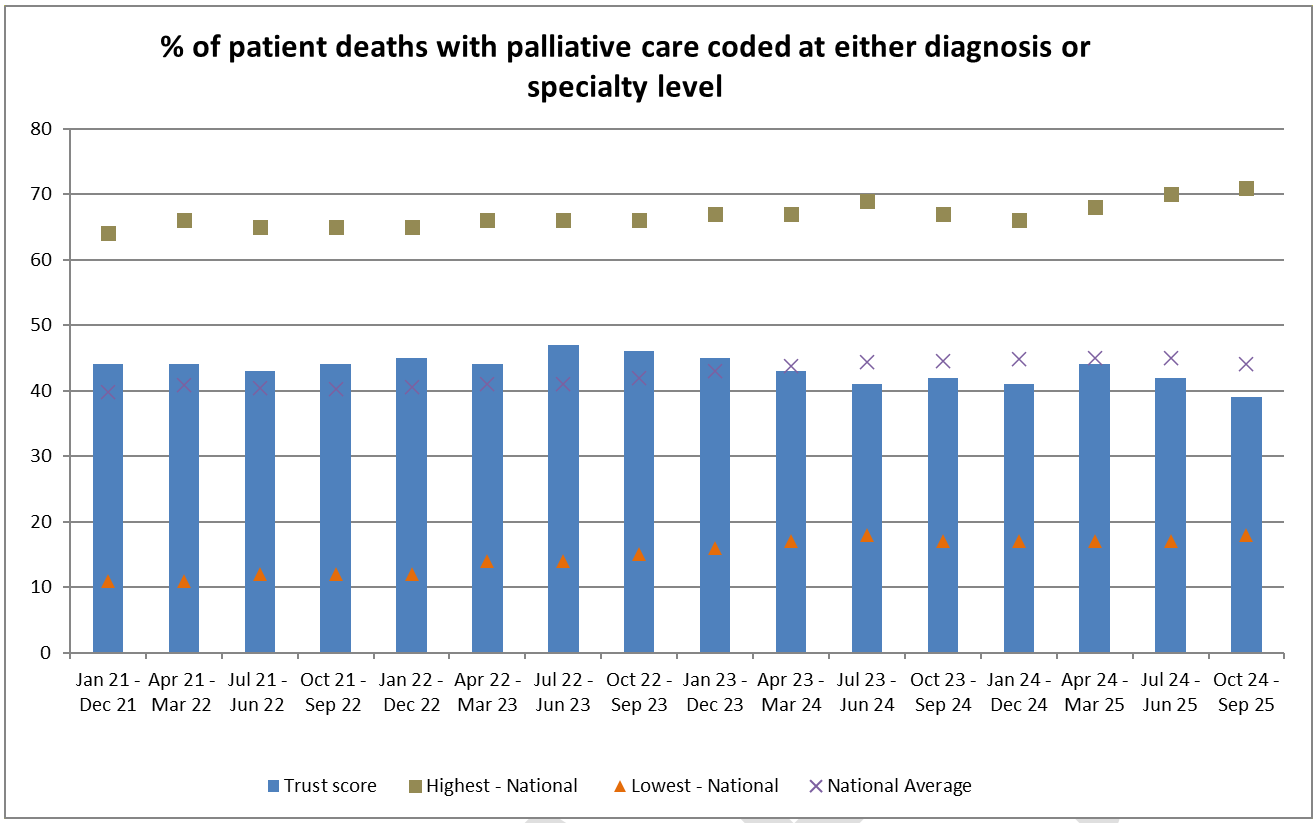


Graph 8 - Summary Hospital Level Mortality Indicator (Data source: NHS Digital)

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

- 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.

- 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 implementation of electronic records systems has aided in a slow but steady improvement in comorbidity recording over the last six quarters though the Trust remains below the national average.



Graph 9 - % of patient deaths with palliative care coded at either diagnosis of speciality level

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 43%. This has fallen behind and the Trust is actively engaged in ensuring this ground is made up.

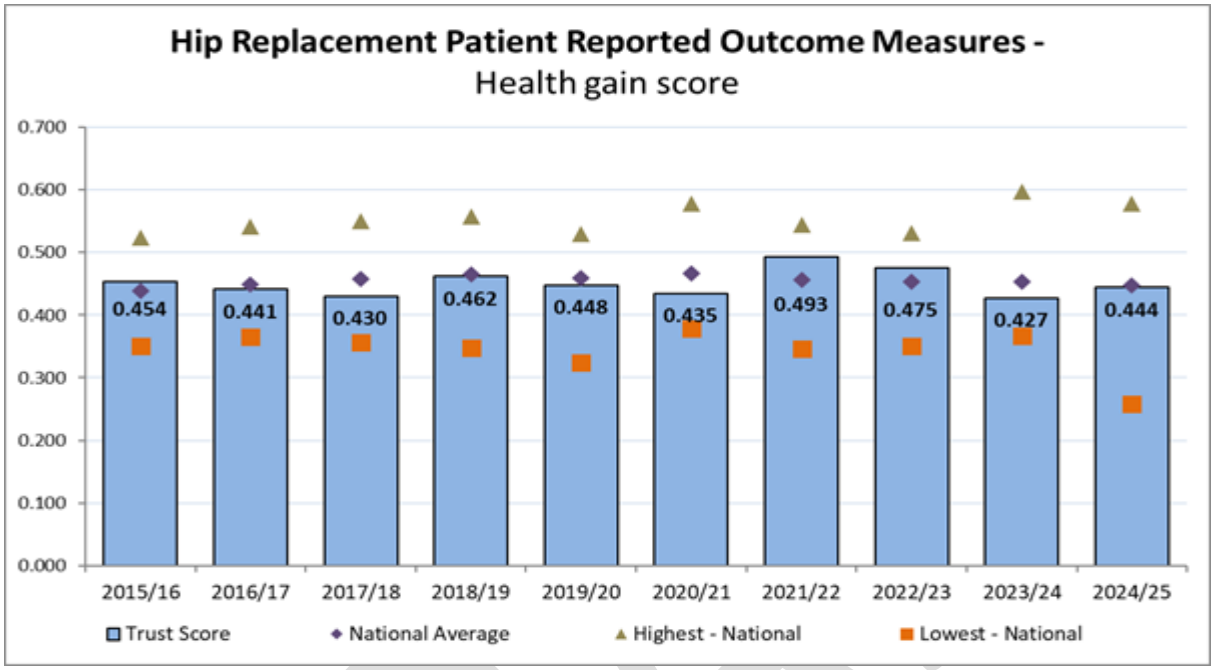
The Trust has taken the following actions to improve the indicators and therefore the quality of its services:

- The Trust has governance committees which monitor and respond to mortality information and the Quality 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.

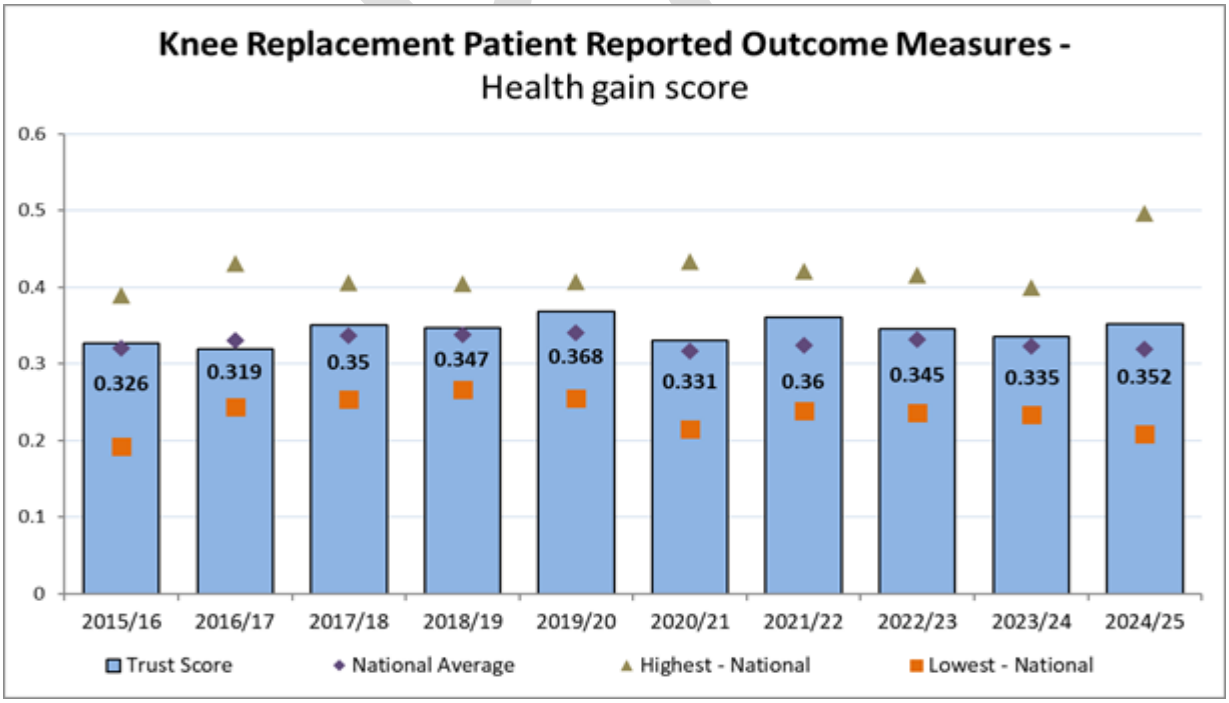
The number of deaths in the Trust is variable from year to year, depending on the severity of respiratory and other seasonal infections each year, and the pattern during the COVID-19 pandemic was unlike any previous year in the Trusts' history. The trend outside the seasonal variations and the pandemic 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 through short questionnaires completed before and after a healthcare procedure. They provide an indication of the effectiveness and quality of care provided to our patients. The PROMs score reflects the case-mix adjusted healthcare gain achieved, with higher scores indicating greater improvement. See below data for both STHFT (Graph 10 and Graph 11) and NTHFT (Graph 12 and Graph 13).

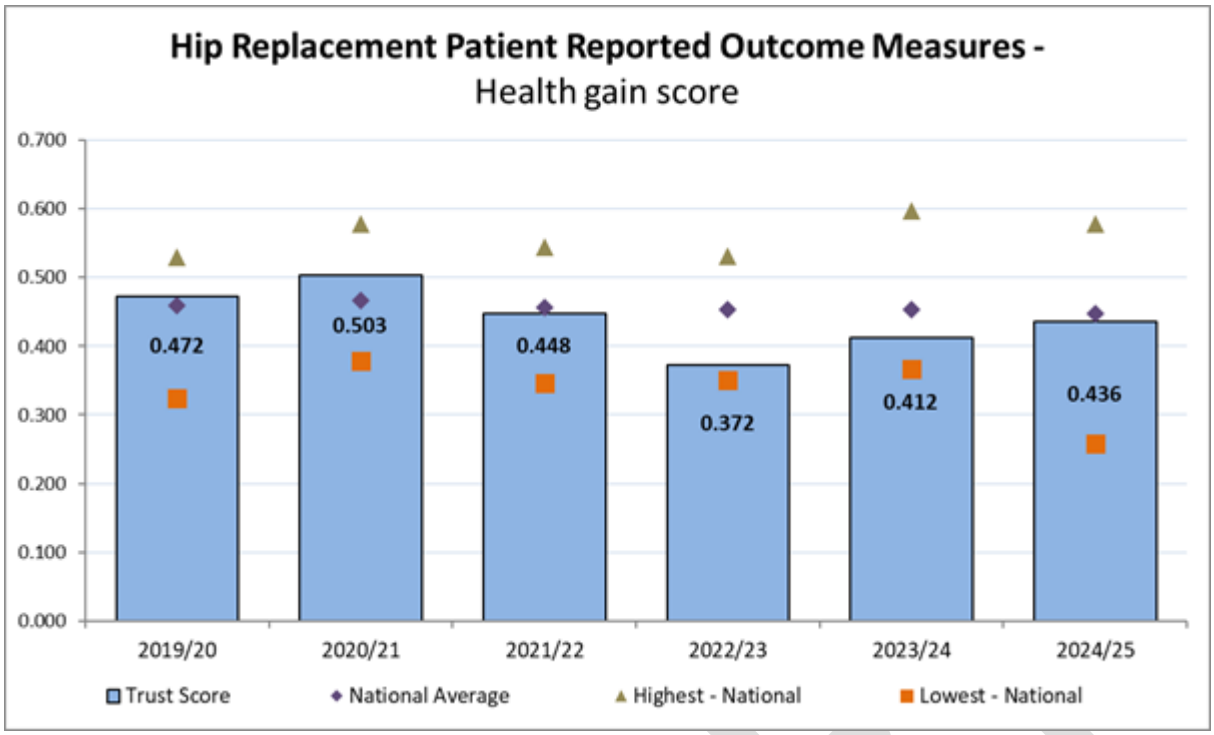


Graph 10 - Hip Replacement Patient Reported Outcome Measures - Health gain score **South Tees**. (Data Source NHS Digital)

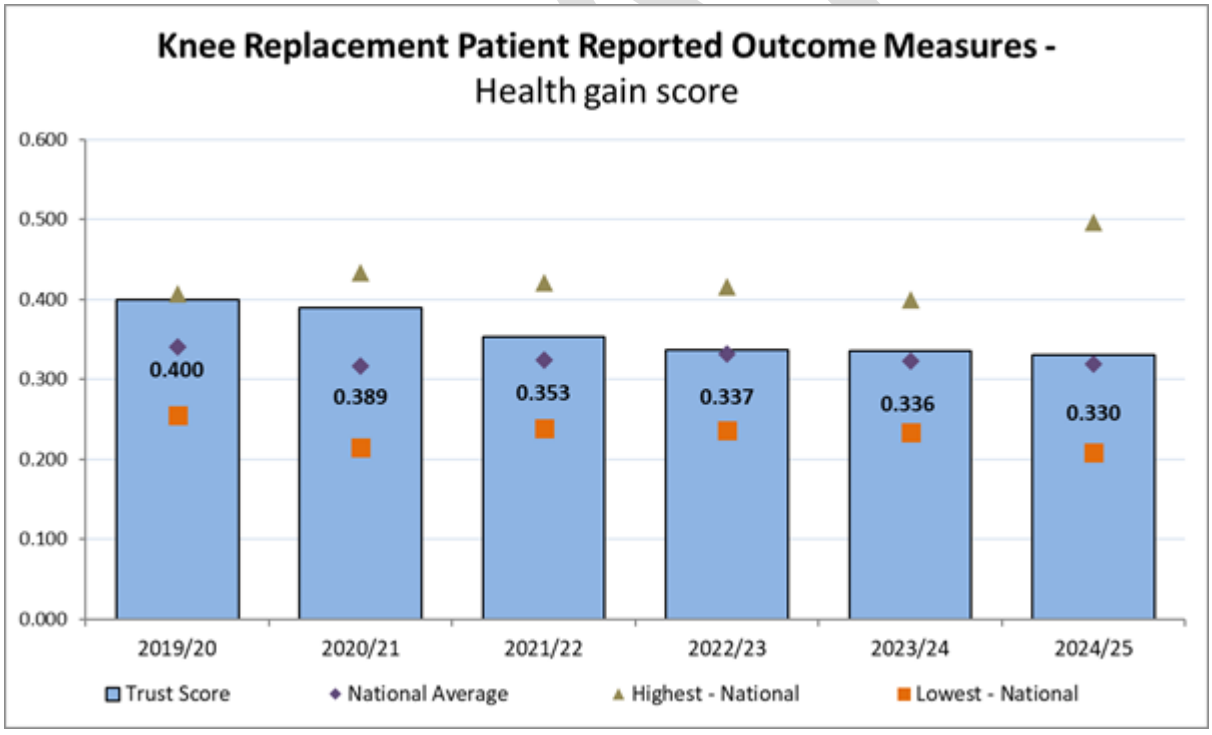


Graph 11 - Knee Replacement Patient Reported Outcome Measures - Health gain score **South Tees**. (Data Source NHS Digital)

North Tees and Hartlepool NHS Foundation Trust



Graph 12 - Hip Replacement Patient Reported Outcome Measures - Health gain score **North Tees**



Graph 13 - Hip Replacement Patient Reported Outcome Measures - Health gain score **North Tees**

We consider that this data is as described for the following reasons:

- The health gain scores for hip replacements and knee replacements are in line with the national average for both Trusts.

To continue improving patient outcomes, UHT:

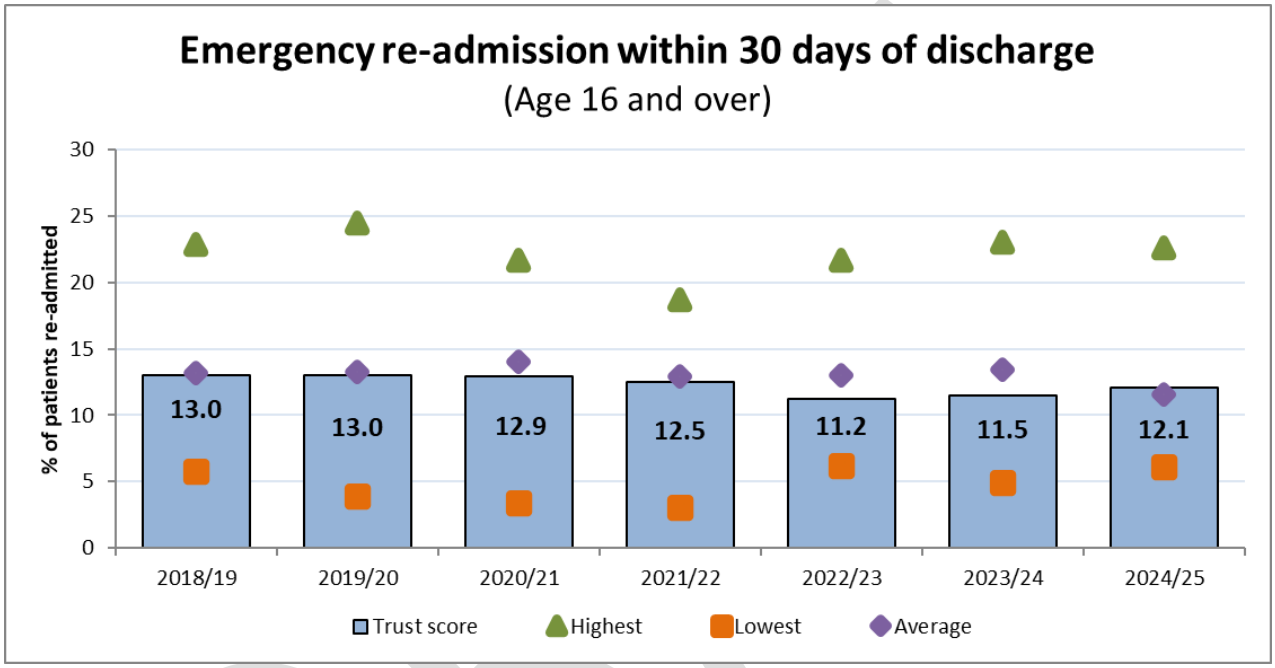
- Provides regular feedback of PROMs to clinical teams

- Benchmarks performance across the NHS and other hospitals in the North-East, using reports from the North-East Quality Observatory Service (NEQOS).

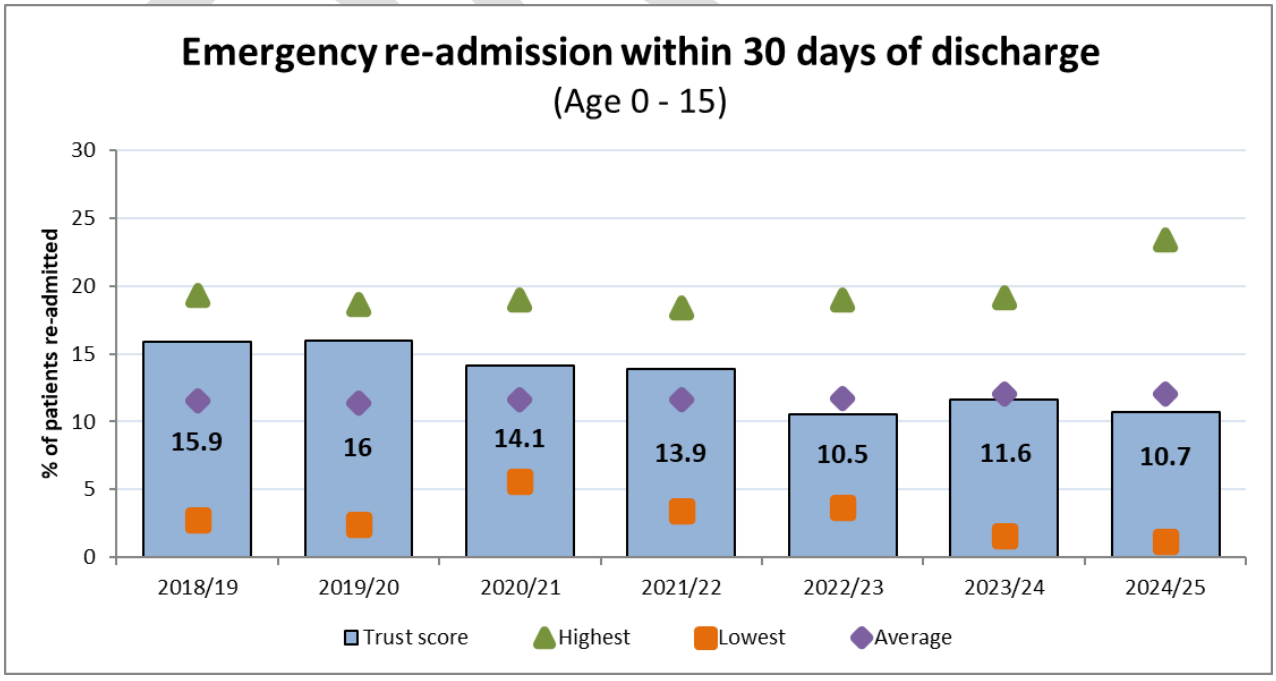
These actions support on-going monitoring and assurance of service delivery.

3. 30-day readmissions

South Tees Hospitals NHS Foundation Trust
Emergency readmissions within 30 days occur for a range of complex clinical reasons: however, a lower rate of readmission is generally considered an indicator of safe, effective and well-coordinated care.



Graph 14 - Emergency re-admission within 30 days of discharge (age 16 and over)



Graph 15 - 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:

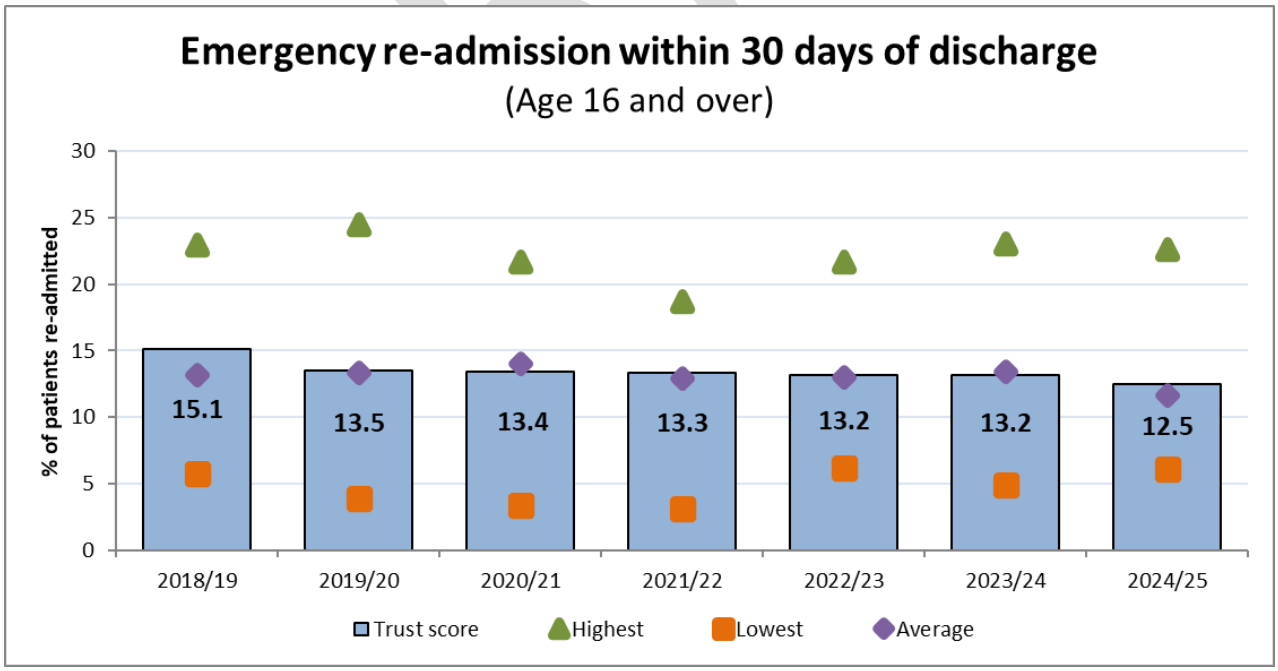
- Readmissions for patients aged **16 and over** increased from **11.5% in 2023/24** to **12.1% in 2024/25**.
- Readmissions for patients aged **0–15** decreased from **11.6% in 2023/24** to **10.7% in 2024/25**.

The Trust continues to focus on reducing avoidable emergency readmissions. A dedicated project group has been established to review readmission data in detail. Comprehensive analysis has been undertaken by speciality, Human Resource Group (HRG), Operational Procedure code and diagnosis code, alongside benchmarking against regional and national peers. Findings have been presented through executive governance processes to determine areas requiring further investigation or audit.

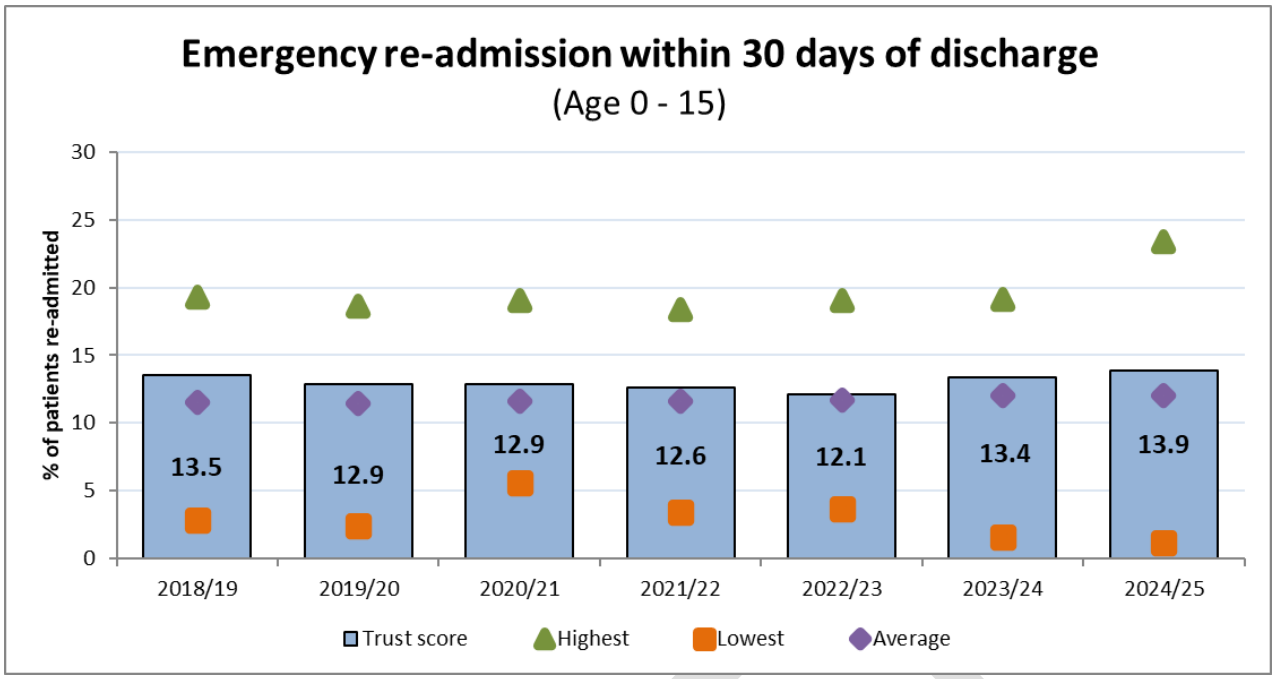
Key areas identified include:

- Specialties for further review: Urology, Bariatric Surgery, Intensive Care Medicine, Endocrinology and Medical Oncology.
- Medical HRG outlier: Vascular procedures and disorders (spell chapter Y) at 13.9%, 3% above regional and 4.8% above national averages.
- Clinical themes: COPD, Pleural Effusions, Sepsis and Diabetes, particularly among patients with high comorbidity scores (9+ conditions).
- Surgical HRG outlier: Endocrine and metabolic system surgery (spell chapter L) at 18.9%, 7.8% above regional and 8.5% above national averages.

North Tees and Hartlepool NHS Foundation Trust
As in other organisations, a proportion of emergency admissions cannot be avoided; however, lower readmission rates are associated with safer discharge, continuity of care and effective post-hospital support.



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



Graph 17 - Emergency re-admission within 30 days of discharge (age 0- 15)

The North Tees and Hartlepool NHS Foundation Trust considers that this data is as described for the following reasons:

- Readmissions for patients aged **16 and over** decreased from **13.2% in 2023/24** to **12.5% in 2024/25**.
- Readmissions for patients aged **0–15** increased from **13.4% in 2023/24** to **13.9% in 2024/25**.

The established readmissions project group is supporting ongoing improvement. Detailed analysis has been undertaken by speciality, Human Resource Group (HRG), Operational Procedure code and diagnosis code, supported by benchmarking against regional and national comparators. Initial audit work has focused on COPD and respiratory patients, with outcomes shared through executive governance forums.

Areas highlighted for further review include:

- Specialties for further investigation: General Surgery, Colorectal Surgery, Paediatrics and Neonatal Critical Care.
- Medical HRG outlier: Skin, Breast and Burns (spell chapter J) at 19.9%, 11.7% above regional and 7.3% above national averages.
- Clinical themes: Diabetes, COPD, Sepsis and Pancreatic disorders, particularly among patients with high comorbidity scores (9+).
- Surgical HRG outlier: Respiratory system surgery (spell chapter D) at 20.6%, 7.3% above regional and 9.1% above national averages.

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. Inpatient surveys

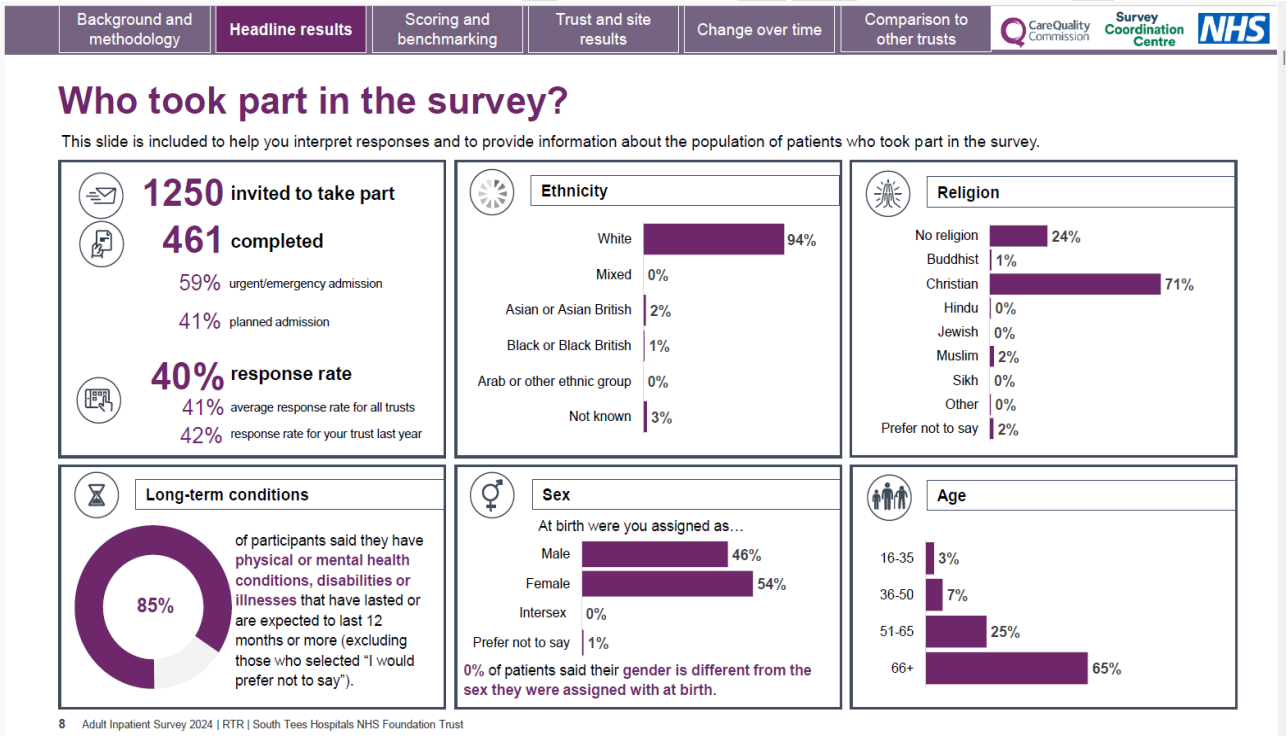
University Hospitals Tees (UHT) participates in a range of national patient experience surveys coordinated by the Care Quality Commission (CQC). South Tees Hospitals NHS Foundation Trust (STHFT) and North Tees and Hartlepool NHS Foundation Trust (NTHFT) report separately for national survey results.

Published survey reports are reviewed to assess performance against previous years, local comparators and national averages. Where opportunities for improvement are identified, action plans are developed and monitored through the Experience of Care Council and the Quality Assurance Committee.

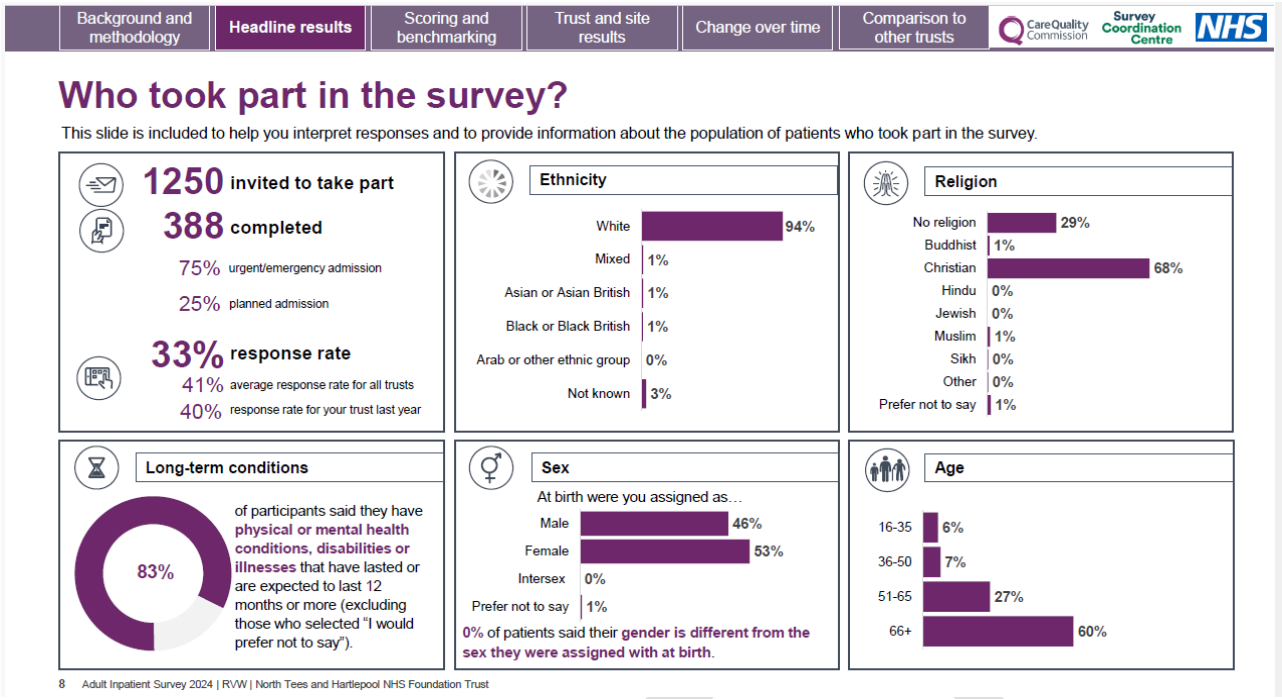
National Adult Inpatient Survey

The most recent National Adult Inpatient Survey was published by the CQC on 9 September 2025. The survey included responses from 62,444 patients across 131 acute NHS trusts in England, with a national response rate of 41%. Eligible participants were adults aged 16 years or over who spent at least one night in hospital during November 2024, excluding maternity and psychiatric admissions.

STHFT achieved a response rate of 40% (461 responses from 1,250 invitations).



NTHFT achieved a response rate of 33.3% (388 responses from 1,250 invitations).



Demographic profiles at both Trusts were consistent with previous years, with the majority of respondents aged over 66 and from a White ethnic background.

Survey performance

STHFT performed **better than expected** in the domains of basic needs, care and treatment, and leaving hospital, and **somewhat better than expected** for overall experience. Performance in all other domains was **about the same** as comparable trusts. No areas were rated worse than expected.

NTHFT performance was **about the same** as other trusts across all survey domains, with one question scoring worse than expected, relating to nurse staffing levels.

Free-text comments were analysed at both Trusts. Overall, 65% of comments at STHFT and 56% at NTHFT were positive. Positive themes focused on staff care and treatment, while areas for improvement included elements of the care pathway and hospital environment.

Improvement actions

A joint action plan was developed focusing on:

- **Workforce and staffing oversight**, including safer staffing processes, workforce assurance meetings and targeted recruitment activity
- **Discharge processes**, including discharge working groups, improved checklist compliance, new patient information, volunteer follow-up calls, system-wide collaboration and improved monitoring through dashboards
- **Medication processes**, particularly safe and timely medicines reconciliation at discharge

Progress against these actions continues to be monitored through established governance arrangements.

National Cancer Patient Experience Survey

The National Cancer Patient Experience Survey was published on 18 July 2024, based on patient experiences between April and June 2024. The national response rate was 50%. Response rates were 49% at NTHFT (350 responses) and 50% at STHFT (723 responses).

Overall ratings of care remained high, with NTHFT scoring 8.8 and STHFT scoring 9.0 out of 10. Both Trusts performed above the expected range in several areas relating to staff communication, support, information provision and involvement of patients and families.

Key findings and actions

Both Trusts identified opportunities to improve communication with patients regarding waiting times for diagnostic results. As a result:

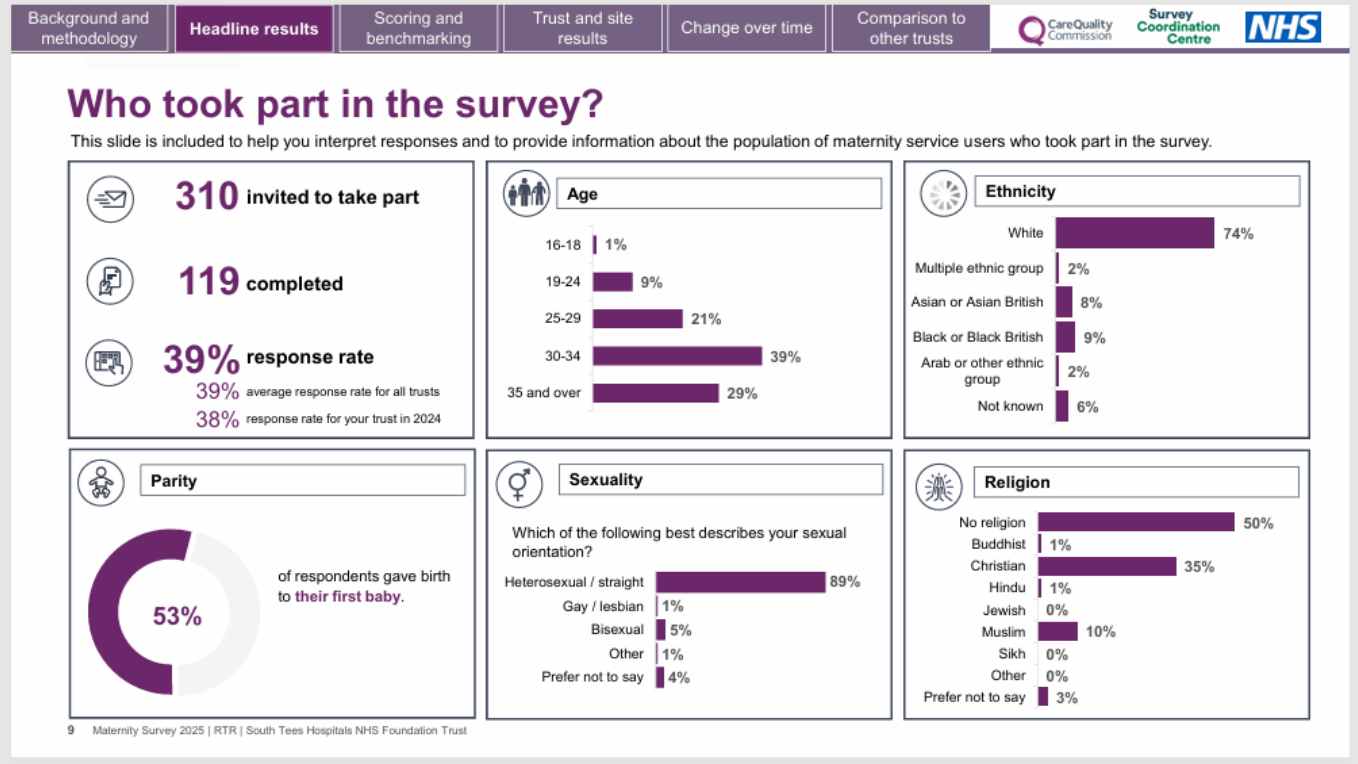
- Task and finish groups have been established across cancer pathways
- Reviews of nurse-led clinic provision are underway to improve capacity and access
- Tumour-specific action plans have been developed, with targeted focus areas including prostate, skin and upper gastrointestinal pathways
-

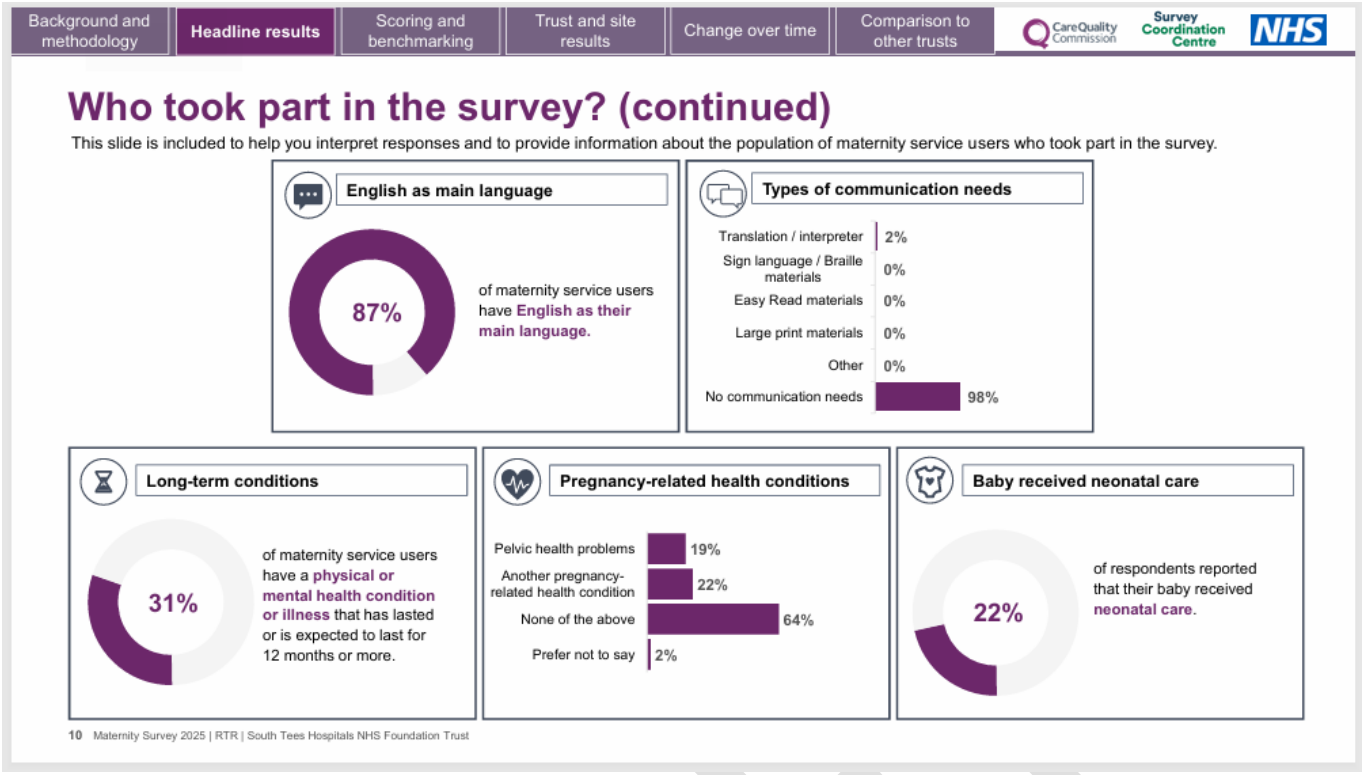
Oversight of these actions is maintained through cancer governance structures and the Experience of Care Council.

National Maternity Survey

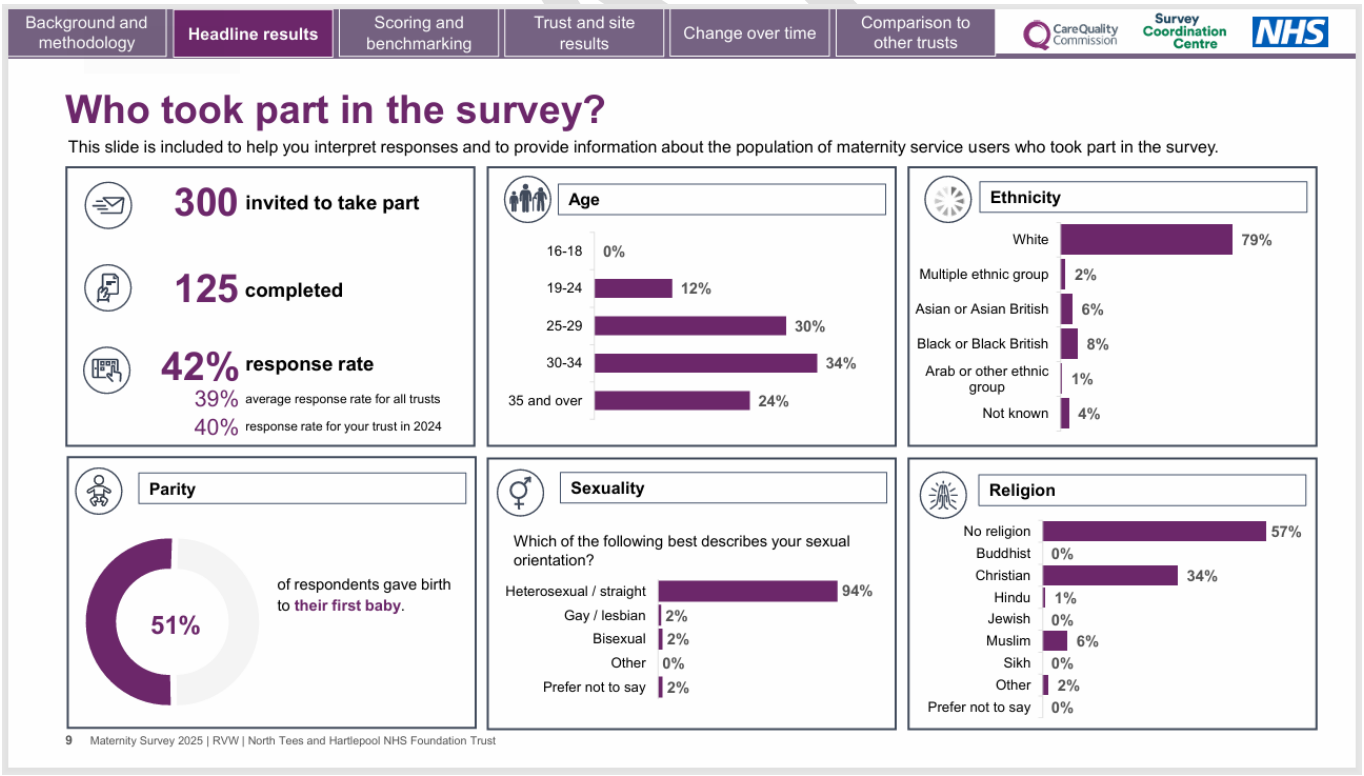
The National Maternity Survey was published in December 2025 and captured experiences of people giving birth in February 2025.

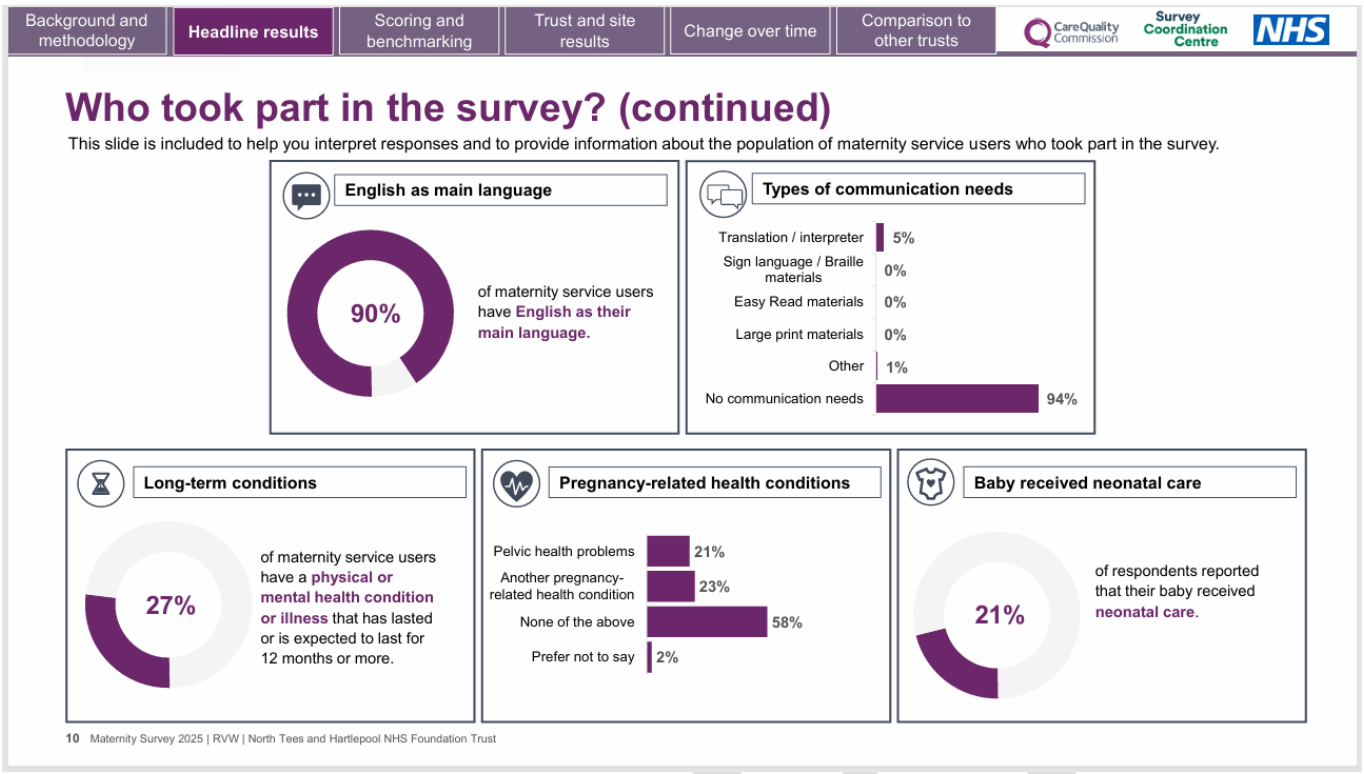
STHFT achieved a response rate of 39%





NTHFT received a response rate of 42%.





Both Trusts performed **about the same as other trusts** across the majority of survey questions, with areas of strong performance and no statistically significant worse-than-expected scores for STHFT.

NTHFT identified areas for improvement relating to communication, involvement in decision-making and pain management.

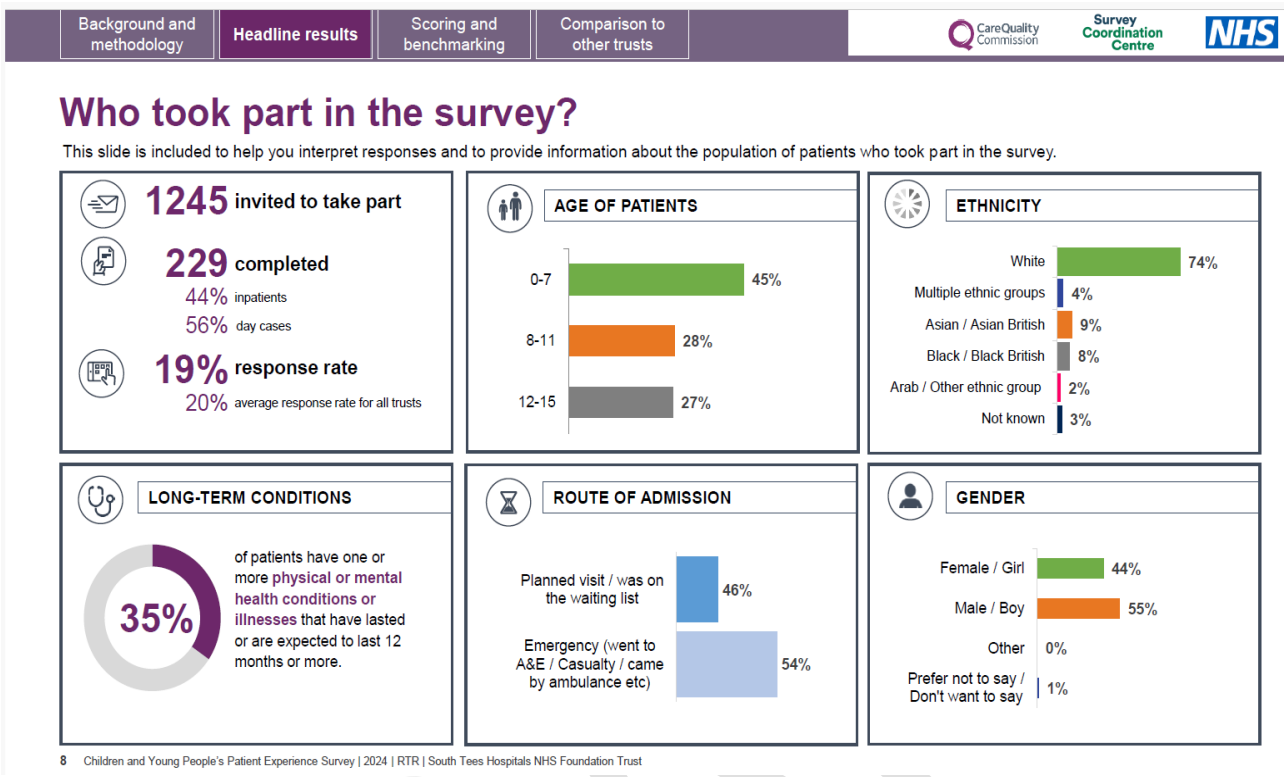
Improvement actions

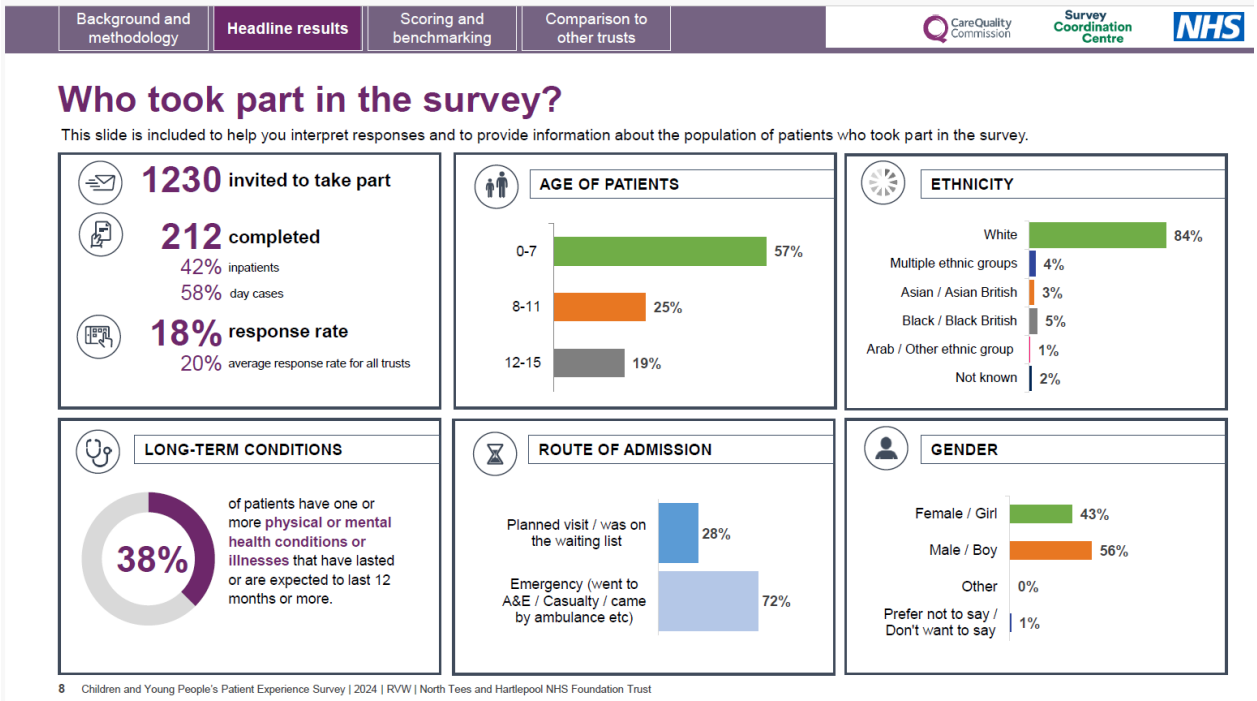
Action plans were developed in collaboration with clinical teams and include:

- Improved access to contact information via BadgerNet
- Enhanced multidisciplinary team training
- Improved communication support for patients whose first language is not English
- Reviews of electronic prescribing and mental health referral processes
- Strengthened infant feeding support

National Children and Young People's Survey

The 2024 Children and Young People's Survey recorded responses from 120 NHS trusts nationally.





Both STHFT and NTHFT performed well compared with national averages, particularly in areas relating to compassionate care, communication and overall experience.

Survey comments highlighted positive experiences of staff kindness, play facilities and ward environments. Areas for improvement included waiting times, post-operative care, discharge information and support for children with additional needs.

Improvement actions

A UHT wide action plan has been established, focusing on:

- Ward environment and co-horting
- Play and activity provision
- Communication about waiting times
- Food availability outside mealtimes
- Discharge information using digital and CYP-friendly formats
- Improved support for children with additional needs

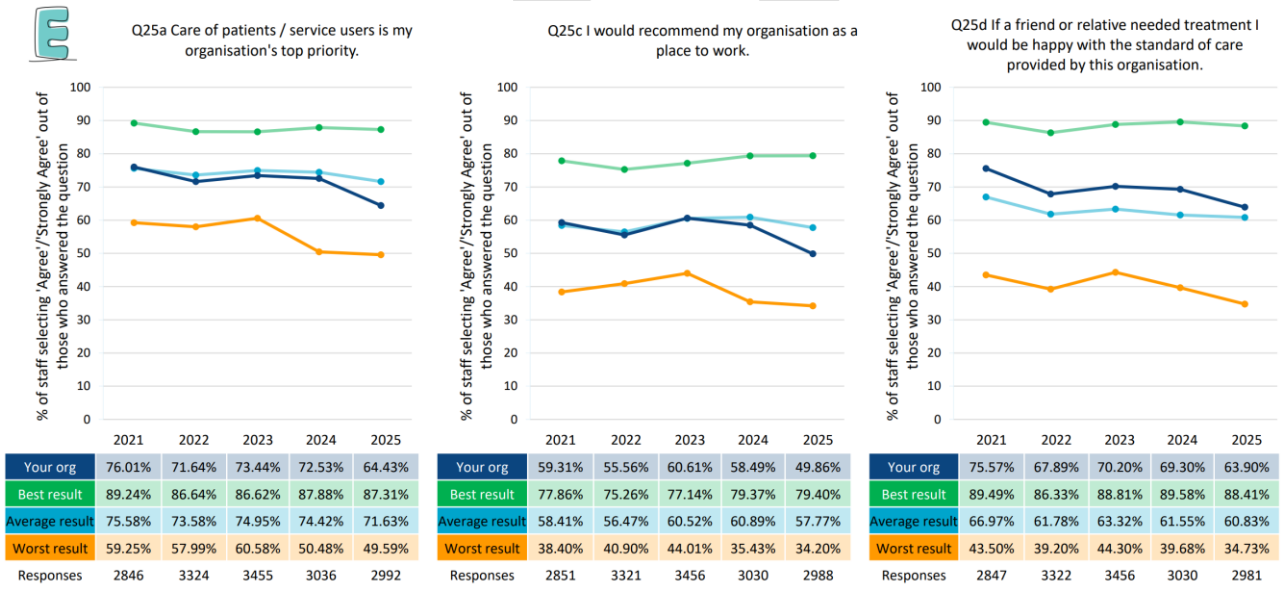
Progress is monitored through the Experience of Care Council.

Governance

The Experience of Care Council is responsible for overseeing and monitoring action plans arising from national patient experience surveys with oversight from the Quality Assurance Committee.

6. Staff Friends and Family Test

South Tees Hospitals NHS Foundation Trust



	2021	2022	2023	2024	2025
Your org	76.01%	71.64%	73.44%	72.53%	64.43%
Best result	89.24%	86.64%	86.62%	87.88%	87.31%
Average result	75.58%	73.58%	74.95%	74.42%	71.63%
Worst result	59.25%	57.99%	60.58%	50.48%	49.59%
Responses	2846	3324	3455	3036	2992

	2021	2022	2023	2024	2025
Your org	59.31%	55.56%	60.61%	58.49%	49.86%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	2851	3321	3456	3030	2988

	2021	2022	2023	2024	2025
Your org	75.57%	67.89%	70.20%	69.30%	63.90%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	2847	3322	3456	3030	2981

Figure 7 - NHS Staff Survey results relevant to staff friends and family test (Data source: NHS Staff Survey benchmark report 2025)

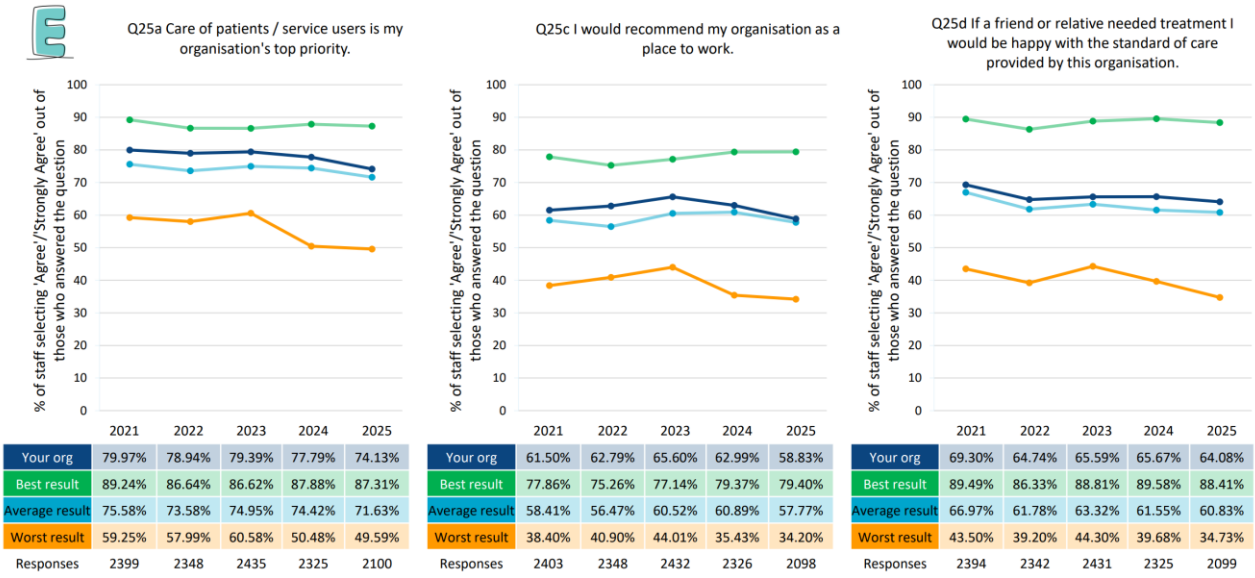
The South Tees Hospitals NHS Foundation Trust has seen a decline in the following areas in 2025:

- 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.

We have reported the lowest scores for these questions over the past 5 years, this is in line with the national average results.

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’.

North Tees and Hartlepool NHS Foundation Trust



	2021	2022	2023	2024	2025
Your org	79.97%	78.94%	79.39%	77.79%	74.13%
Best result	89.24%	86.64%	86.62%	87.88%	87.31%
Average result	75.58%	73.58%	74.95%	74.42%	71.63%
Worst result	59.25%	57.99%	60.58%	50.48%	49.59%
Responses	2399	2348	2435	2325	2100

	2021	2022	2023	2024	2025
Your org	61.50%	62.79%	65.60%	62.99%	58.83%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	2403	2348	2432	2326	2098

	2021	2022	2023	2024	2025
Your org	69.30%	64.74%	65.59%	65.67%	64.08%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	2394	2342	2431	2325	2099

Figure 8 - NHS Staff Survey results relevant to staff friends and family test (Data source: NHS Staff Survey benchmark report 2025)

The North Tees and Hartlepool NHS Foundation Trust considers that this data is as described for the following reasons:

The Trust has shown a slight decline in the following friends and family test sections:

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

However, we have remained above the sector average across all three reported questions.

STHFT and NTHFT, working together as University Hospitals Tees, intend to take the following actions to further improve this percentage and thereby the quality of its services.

- **Strengthening local accountability and staff engagement:** Clinical Service Units (CSUs) will develop clear, measurable people plans incorporating their 2025 survey results. These plans will be discussed with teams, include specific actions to address areas of concern, and be reviewed quarterly to ensure progress is visible and sustained.

- **Making Group transformation meaningful at frontline level:** Through the University Hospitals Tees collaboration with North Tees and Hartlepool NHS Foundation Trust, the Trust will ensure that transformation programmes demonstrate tangible improvements in patient care, staffing resilience, and service quality. Regular updates and case studies will be shared with staff to clearly show how Group working benefits patients and colleagues.

- **Reinforcing patient care and staff wellbeing as core priorities**: The Trust will increase visible leadership engagement, share regular quality and safety updates with teams, and strengthen wellbeing and workforce support initiatives via various briefings, bulletins, and other communications. This will ensure staff feel supported, listened to and

confident that delivering high-quality patient care remains the organisation's primary focus.

7. 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.

Historic data collection at South Tees Hospitals NHS Foundation Trust (STHFT) was hampered by paper-based risk assessments which needed to be individually logged for each patient. Throughout 2024, electronic prescribing and note keeping, including electronic VTE risk assessment, was introduced throughout STHFT. This has led to more reliable capture of completed VTE risk assessments in comparison to previous paper-based risk assessments.

National data collection, previously on hold since the COVID-19 pandemic, resumed in 2025. Figures for the current 2025-2026 year are:

Q1 : 94.9% (South Tees)	95.7% (North Tees & Hartlepool)
Q2 : 95.6% (South Tees)	95.5% (North Tees & Hartlepool)
Q3 : 95.3% (South Tees)	95.5% (North Tees & Hartlepool)
Q4 : 95.72% (South Tees)	94.83% (North Tees & Hartlepool)

Ongoing challenges at STHFT are data capture on wards which do not currently use electronic VTE risk assessment, and data capture of patients treated at satellite sites.

With the development of University Hospitals Tees, future data collection will need to consider both Trusts, initially requiring a review of the data collection processes at both sites to ensure that similar methods are being followed.

VTE continues to be a high clinical priority in University Hospitals Tees. VTE risk assessment data continues to be reviewed and discussed at biannual Thrombosis Committee meetings with escalation to the Clinical Effectiveness Group where appropriate. We also review all cases of hospital acquired VTE, giving feedback to clinical teams where appropriate. The Thrombosis Committee, currently based at STHFT, plans to move to a group meeting with NTHFT colleagues, going forward.

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

C. difficile is a bacterium that is found in the gut of around 3% of healthy adults. It seldom causes a problem as it is kept under control by the normal bacteria of the intestine. However certain antibiotics can disturb the bacteria of the gut and C. difficile can then multiply and produce toxins which cause symptoms such as diarrhoea.

The 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 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 below reflects the ongoing work within the Trust in relation to C. difficile infection.

The Trust reported **225** trust-attributable cases for the 2024-25 period. This is a significant increase in cases and is mirrored across the region and nationally. The annual threshold for 2025-26 was 188 cases. The Trust is reporting 190 cases for the period 2025-26, South Tees Hospitals NHS Foundation Trust is reporting higher and North Tees and Hartlepool Foundation Trust are under trajectory

The Trust continues to implement several actions to improve the number of C. difficile cases:

- The Trust has a comprehensive improvement plan for the prevention of hospital associated infections including C. difficile cases, which is supported by the Clinical Service Units with the ownership of their own internal action plan and is monitored through the IPC governance routes via the Infection Prevention and Control Operational and Strategic Groups and reported through to the Quality Oversight Group and Quality Assurance Committee.

- All trust attributed cases are reviewed by an MDT approach and are individually discussed at weekly MDT meetings and ward rounds if the case is an inpatient. The cases are reviewed and themes identified by the IPC team.

- Membership of the Northeast and North Cumbria ICB 'Deep Dive' around C. difficile continues with further diagnostic sessions planned.

- The Trust has increased cleaning provision in line with the national cleaning standards and continues to maintain these standards of increased cleaning, HPV remains the gold standard and is therefore requested on all C. difficile cases upon discharge or transfer.

- Membership of NHS England national 'Deep Dive' around C. *difficile*. This has involved a diagnostic visit from Global IPC Specialists on 27th March to support with this.

Staff continue their efforts to control and reduce opportunities for infections to spread, whether we treat people in our clinical premises or in their own homes. The importance of adherence to high standards of hand hygiene has continued to be a core element of our strategy.

The following table identifies the number of hospital and community onset cases of C.difficile reported by our laboratory.

	2023-24	2024-25	2025-26
Hospital onset-Healthcare-associated	128 & 74 = 202	146 & 79 = 225	131 & 59 = 190
Community- onset associated	69 & 20 = 89	83 & 19 = 102	49 & 43 = 92

Table 11 - Trust C. difficile cases 2023-26

9. Patient safety incidents

The National Reporting and Learning System (NRLS) was decommissioned on 30 June 2024. Both Trusts have successfully implemented the Learning from Patient Safety Events (LFPSE) reporting platform and moved away from the historical manual uploading process required by the National Reporting and Learning System.

The LFPSE system created 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.

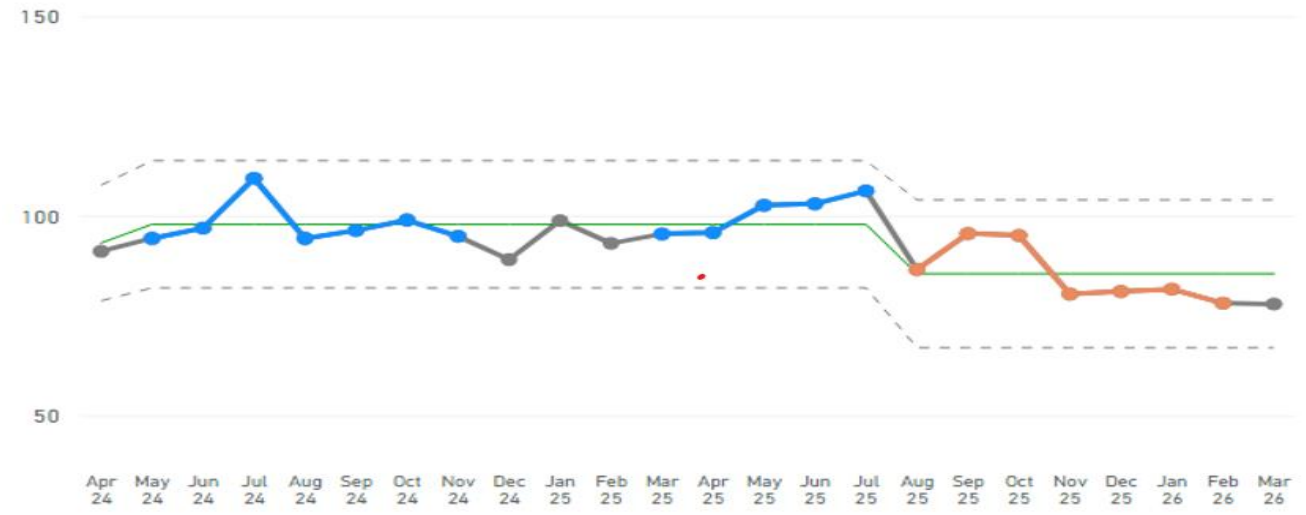
National LFPSE data for quarter 3, 2025/26 reports recording rates for acute Trusts ranging between 13 and 202 incidents per 1000 bed days and in community Trusts the rate was between 1 and 16 incidents per 1000 care contacts.

From the national data set, the North Tees and Hartlepool Trust rate for this period is 81.8 and South Tees is 83.8. UHT data is displayed in Graph 18 and Graph 19 below, this varies from the national data, as not all locally reported events are uploaded to the national system. The Trusts are in regular communication with the national patient safety team to support the resolution of any issues being identified in the new system and its interface with the UHT system.

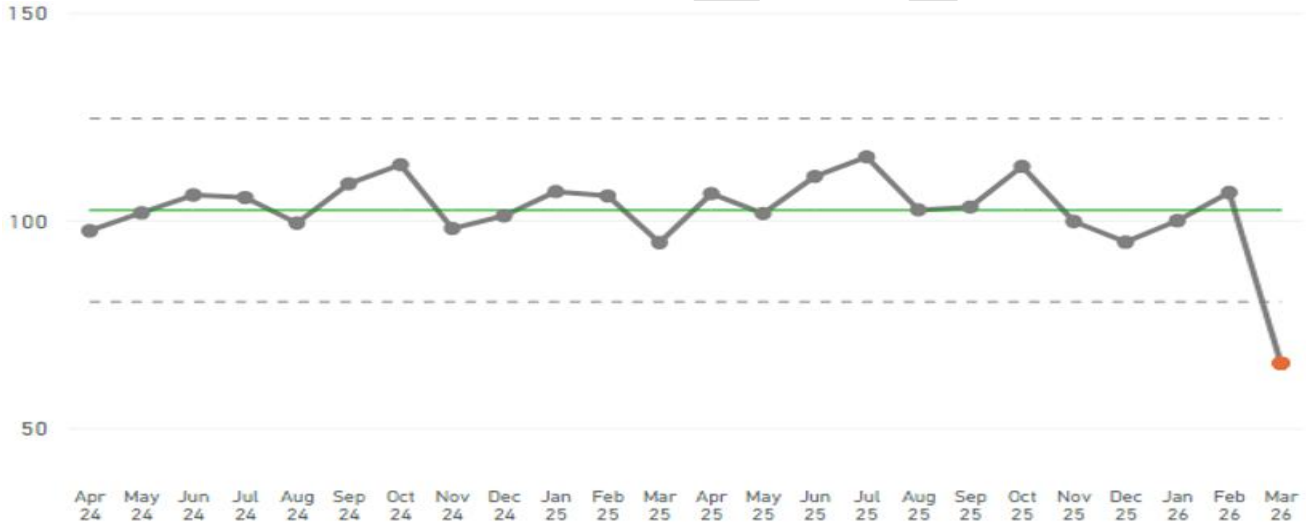
Once fully functional, LFPSE will;

- 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.

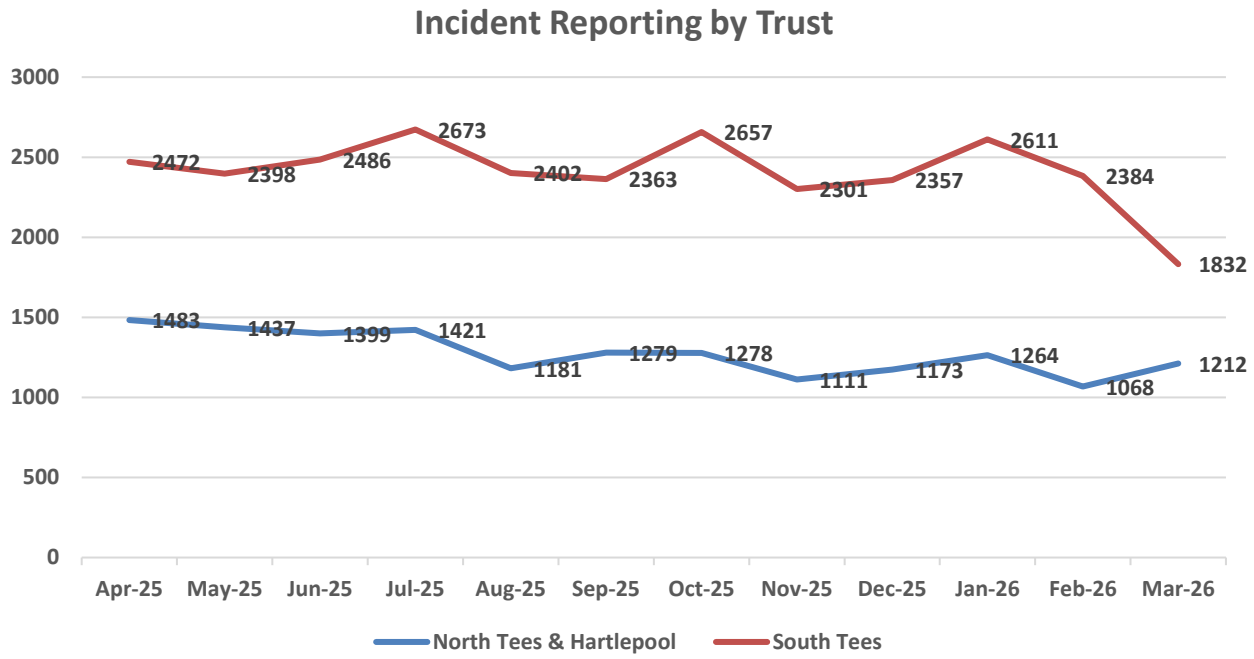
We have included some more recent related data from our internal data reporting below.



Graph 17 – North Tees & Hartlepool Foundation Trust incident reporting rates by per 1000 bed days.



Graph 18 – South Tees Hospitals NHS Foundation Trust incident reporting rates by per 1000 bed days



Graph 19 – Actual incident reporting numbers for each Trust.

UHT implemented a joint incident reporting system during March 2026. This change will integrate the incident reporting for both organisations into a single system, Healthcare Guardian, which had previously been introduced at NTHFT. This change will support wider analysis of patient safety incidents across the Group and will enhance the joint approach towards learning and quality improvement activities. The joint system has been developed to reflect the UHT Clinical Service Unit (CSU) structure which will support incident reporting and allow more in-depth analysis into trends and risks within their individual departments; as well as supporting the overall analysis across the Group. The drop in the incidents per 1000 bed days at NTHFT from November 2025 could be a result of the CSU structure being implemented without the incident reporting system being updated. The impact of the new system is being monitored closely.

During 2023-24, NTHFT had seen a reduction in incident reporting following the introduction of the new system; this trend was reversed gradually during the following year and over this financial year incident reporting had been consistent at around 1200 per month. The introduction of the new reporting system at South Tees was predicted to have a similar impact on incident reporting; this is reflected in the March 2026 data in the charts provided above; however, it is noted that data already being analysed for April 2026 has already shown this has started to be reversed.

There is ongoing activity to support the staff using the system and to ensure safety incidents are reported appropriately. It is acknowledged that a positive safety culture is associated with increased reporting and as such, the Trusts are continuously monitoring the frequency of event reporting and striving to increase reporting in all areas.

Promoting the reporting all events (incidents, near misses and good care) regardless of the level of harm will enhance awareness of both known and emerging risks, identify themes and trends, and provide valuable insight into preventing future harm. One of the key parts of promoting incident reporting is to ensure staff are provided with feedback when they have taken the time to report an incident. The new incident reporting system will support the monitoring of

direct feedback, currently it has only been monitored at NTHFT, during 2025-26 24% of staff who reported incidents had feedback given; this is in comparison with 4% for the previous year.

Patient Safety Incident Response Framework (PSIRF)

Both Trusts transitioned to the Patient Safety Incident Response Framework on 29 January 2024, replacing the previous Serious Incident (SI) framework.

In line with the ethos of PSIRF the Trusts are building a learning and improvement culture where staff, patients, families, carers, and all who engage with the Trust are encouraged to share their experiences and their concerns. The Trust recognises that learning comes from understanding what goes wrong (incidents), what nearly goes wrong but is "saved" by the actions of those involved (near misses) and also what goes well, despite the daily challenges of healthcare (good care). The Trust promotes the reporting of all episodes of care where there is potential for learning and improvement.

A critical part of PSIRF is the engagement of patients and their families/ carers in any investigation; understanding what has occurred from their perspective can give the organisation a different view and often a different approach towards making improvements. Over recent years, the UHT Group has provided training to over 120 staff to fulfil the Family Liaison Officer (FLO) role, the latest cohort was in February 2026. The FLOs provide support to patients and families by providing a compassionate approach towards communications that can be very difficult and distressing; this helps link into the investigation team who are looking at the care provided.

During 2025-26, an external evaluation of the Group's implementation of PSIRF has been completed; the report identified positive progress and made recommendations to strengthen the Group's approach to patient safety, with improvement actions developed. These form the measures within one of the Quality Priorities (please see Section 2.1) and will be supported by the development of the UHT PSIRF plan and policy.

Never Events

Across UHT, we reported eight Never Events during 2025-26, one at North Tees and Hartlepool NHS Foundation Trust and seven at South Tees Hospitals NHS Foundation Trust. These included six "retained foreign body" incidents and two wrong site procedures.

Never Events have previously been investigated using Patient Safety Incident Investigation (PSII) methodology, as outlined in the Patient Safety Incident Response Plans (PSIRP).

Following consultation with the national team in relation to the level of investigation undertaken for each Never Event and how undertaking a lengthy PSII investigation for each fit with the proportionate response methodology established in PSIRF. As part of the overall consultation and change NHS England have advised that whilst they still need to be reported as Never Events, the investigations can be undertaken using a variety of options dependant on the overall impact and learning identified. As a result, three Never Events during 2025-26 are being investigated as After Action Reviews, an option which supports learning but also releases the capacity for clinical teams to implement agreed changes in practice and gain assurance that these have been established.

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	STHFT	NTHFT
2025-26	7	1
2024-25	5	1
2023-24	3	0
2022-23	7	4
2021-22	4	2

Table 11 - Number of Never Events reported annually since 2021-22 (NHSE data)

Learning Response:

During 2025-26, both Trusts have been collaborating to bring safety processes into a single methodology; as such a joint PSIRF plan and policy are in the final stages of development and will be published during quarter 1, 2026-27.

The UHT plan and policy will reflect the changes and promote timely reporting, response and management of safety events. The review and investigation of events is focused on identifying opportunities for learning and improvement to prevent future harm, using a systems-based approach to investigation, and incorporating human factors analysis and quality improvement methodology. The quality assurance of event data is promoted at all stages of review and response to reflect the most up to date information known about the event.

The UHT safety processes have been integrated during 2025-26 to consider information relating to any incidents where there may be significant learning and any incidents moderate harm or above. Safety incidents where there needs to be an in-depth investigation are reviewed through the Learning Response Panel, chaired by the Medical Director or Director of Nursing. This panel agrees the level of investigation and confirms the application of duty of candour regulations. Where there is any discrepancy, the clinical team are asked to provide further details for review and discussion.

Incidents that meet the national requirements for reporting are managed in line with PSIRF guidance (NHSE, 2022). Any event that is identified as requiring a PSII or an alternate learning response will be presented at a monthly Patient Safety Review Panel on conclusion of the response. The panel will include multiprofessional representatives (clinical and non-clinical) from each CSU to ensure shared learning, broad discussion and appropriate challenge. The Chief Medical Director or Chief Nurse chair this panel when PSIIs are presented to gain assurance around learning and improvements; following this the reports are then presented through the Quality Oversight Group and Quality Assurance Committee. Where safety recommendations are identified, these will be considered by the appropriate CSU and for SMART actions to be identified. Where these are linked to the relevant safer care group, such as the Falls, Tissue Viability or Acutely Ill Patient groups. These can then be incorporated into the relevant improvement plan and monitored to completion. As this process has been implemented there have been adjustments made in the process; as the Group Trust develops the joint PSIRF plan and policy they will be updated to provide rationalised details in relation to the incident management and oversight processes.

The Group works in close collaboration with the local CQC inspectors and the ICB in relation to incident reporting and regularly communicates in relation to incidents meeting the national reporting requirements and also regarding overall trends in incident reporting.

The national analysis of information undertaken by NHSE / LFPSE identifies where actions need to be taken in relation to national trends. This analysis can initiate a national safety alert. The Trust is fully compliant with all National Patient Safety Alerts that have been published in relation to this analysis. Processes are in place to ensure there is continual review of processes in order to provide on-going assurance and during 2025-26 these processes are to be aligned across the Group with the implementation of a Central Alerting System (CAS) module in Healthcare Guardian.

Improvement response

Where the causal factors of an event are well understood, the burden of undertaking an in-depth investigation can outweigh the learning to be gained. Where possible there have been additional fields developed in Healthcare Guardian to support gathering of specific information within proformas or checklists. The data can then be collated and analysed by the relevant UHT safer care groups and incorporated into the appropriate framework or improvement plan. Where new or emerging issues are identified a group or cluster of events can be reviewed using a thematic approach to identify additional learning.

10. Patient Friends and Family Test

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 local patient surveys in South Tees Hospitals NHS Foundation Trust (STHFT) and 20 local patient surveys in North Tees and Hartlepool NHS Foundation Trust (NTHFT) being utilised, covering all wards, departments, and community services. The Patient Experience Team reviews all responses.

The family and friends test question is included in the majority 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 family and friends test provide a mechanism to highlight both good and poor patient experience, and results can be compared with other trusts.

Data from April 2025 to January 2026 shows we are above the national average for the percentage of people with a positive experience of inpatient, A&E / UTC, Outpatient, and Community Services. Tables 1 & 2: Inpatient, A&E/UTC, Outpatient, Community and Maternity FFT results benchmarked against national results (April 2025 – January 2026). Data source NHS England.

At STHFT the inpatient, A&E, outpatient and community family and friends test surveys show we are above the national average (Table 13). The Maternity family and friends test surveys patients at four touchpoints (antenatal, birth, postnatal inpatient, and postnatal community). The results show we above the national average in 3 touchpoints, except for the postnatal ward care.

At NTHFT, the Maternity family and friends test surveys overall results are above the national average for 3 of the touch points (Table 14), except for antenatal care, which is slightly below the national average.

		2025/26 – STHFT			
		Response Rate		% positive experience	
		Trust	England	Trust	England
Inpatient		19%	21%	96%	95%
A&E		8%	9%	82%	79%
Outpatient		16%	15%	95%	94%
Community		8%	4%	98%	94%
Maternity	Antenatal			93%	92%
	Birth	14%	13%	95%	92%
	Postnatal ward			90%	92%
	Postnatal community			92%	93%

Table 13 – South Tees Hospitals Foundation Trust FFT percentage positive 2025/26

		2025/26 - NTHFT			
		Response Rate		% positive experience	
		Trust	England	Trust	England
Inpatient		10%	21%	94%	95%
A&E		4%	9%	84%	79%
Outpatient		35%	15%	95%	94%
Community		5%	4%	96%	94%
Maternity	Antenatal			91%	92%
	Birth	5%	13%	98%	92%
	Postnatal ward			96%	92%
	Postnatal community			100%	93%

Table 14 – North Tees & Hartlepool Foundation Trust FFT percentage positive 2025/26

Our aim is to increase our response rates to our patients' surveys across all healthcare setting, providing patients the opportunity to give their feedback at any point in time. We will also move towards utilising a single system to record local patients' surveys and the FFT, ensuring patients are consistently provided the opportunity to give feedback on their experiences of care.

3. Overview of quality of care and performance indicators

3,1. Overview of quality of care

I. Accreditation

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 is a framework designed to drive clinical excellence by aligning service standards with the CQC Quality Statements. This is 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 reviews as part of an ongoing programme 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 Care Quality Commission 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 246 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, which are also aligned to the CQC quality statements. 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 2025 updated versions of the inpatient, department, theatre, community and critical care standards were launched which align to the Care Quality Commission Quality Statements. There is a continued work plan through 2026/27 to continue to update the existing standards remaining, for maternity, paediatrics and accident and emergency.

There has been a continued focus during 2025 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 patient safety and quality of care delivery a focus for all frontline staff in a coordinated manner. In 2025 the reaccreditation processes have been further developed and across the year has been embedded into practice to ensure standards are maintained. All accredited areas will be formally reaccredited every 3 years.

Total achievements at end of year			Key actions for STAQC team
	24/25	25/26	• 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 • To ensure the reaccreditation process remains embedded
Diamond accreditations	56	62	
Gold accreditations	66	60	
Baseline accreditations	34	37	
Reaccreditation baselines	0	18	
Reaccreditations	0	20	
Percent of organisation		49%	

Table 15 – STAQC accreditations by level of achievement

North Tees and Hartlepool NHS Foundation Trust

The Clinical Quality Accreditation Framework (CQAF) was refreshed in July 2024, evolving from the previous Appreciative Support Programme. This update enabled stronger alignment with the Trust's four key ambitions—each reflecting our organisational objectives, the Fundamental Care Standards, and CQC regulatory requirements.

These ambitions are:
- Patient safety
- Clinical effectiveness
- Patient experience
- Well-led services

This initiative forms part of our ongoing commitment not only to celebrate the excellent work taking place across our services but also to ensure sustained compliance with the fundamental standards of care, aligned to CQC quality statements. The programme provides structured support through individual clinical area visits, helping teams progress on their journey towards achieving an outstanding rating. It also strengthens triangulation of data, enabling a holistic view that enhances assurance from ward to board.

To date, eight acute ward areas have been reviewed through the programme. These reviews have supported the identification and resolution of non-compliance issues through a comprehensive support framework. Where required, structured improvement plans have been introduced, accompanied by robust follow-up measures to ensure changes are effective and sustained over time.

The Trust remains committed to supporting clinical teams as they move from delivering good care to consistently providing outstanding care for our patients. By fostering a culture of continuous improvement, empowering strong and effective leadership, reducing unwarranted variation, and promoting meaningful engagement with both staff and patients, we aim to continually enhance the quality of care provided.

We are now exploring options to optimise resource utilisation to accelerate programme delivery, as well as developing an approach that will enable the framework to be extended across community services.

Forward plans for Accreditation

The long term aspiration for University Hospitals Tees is to bring a single accredited programme across the group. Our aim is to create greater equity and consistency, ensuring all sites moving through the accreditation process receive the same level of support, guidance and are celebrated.

Introducing our Clinical Service Units

The achievements of 2025–26 demonstrate what is possible when clinical expertise, strategic vision and community collaboration come together under one shared purpose.

Showcasing Family Health Services (Clinical Service Unit 1)

Throughout the year Family Health Services have evidenced many things to celebrate as areas of good practice that have improved patient care and experience. Recognition of staff contribution in these developments has also been highlighted through awards and patient experience feedback.

Accreditation and service improvement

In maternity services, North Tees and Hartlepool NHS Foundation Trust (NTHFT) achieved Stage 2 accreditation in the Baby Friendly Initiative standards from UNICEF UK. This focuses on ensuring an educated workforce, confirming that staff are trained and competent in supporting infant feeding, managing challenges, and facilitating close, loving relationships. The next steps will be to work towards level 3 accreditation.

The number of pregnant women who used to smoke has reduced from 17% in 2022 to 6% across University Hospitals Tees in 2025. This is thanks to a national smoke-free pregnancy incentive scheme.

Smoking is an addiction that many people struggle with. By providing individualised care to our patients, including face-to-face appointments before and after birth, providing nicotine replacement therapy and vapes and an incentive scheme, parents- to - be have been supported in stopping smoking giving their babies the best start in life.

At NTHFT ongoing work to improve the environment for families experiencing bereavement was further enhanced by the wonderful donation of a bespoke painting by local artist Mackenzie Thorpe.

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In Children and Young People Services at NTHFT, the paediatric diabetes team achieved positive outlier status in the National Paediatric Diabetes audit (NPDA). The team were awarded a membership award by Investing in Children following an external evaluation of the service and with the involvement of children and young people.

Parents of babies staying in The James Cook University Hospital's neonatal unit are now receiving free meal vouchers thanks to the Volunteers' Coffee Lounge. Parents often spend many hours on the neonatal intensive care unit with their child when they are sick or born premature, long after mum has been discharged from maternity care. During this time, they often forget to eat and drink, and when they do it can be very costly.

Research from the charity BLISS, in 2022, estimated that families with a baby in neonate care face an average additional financial burden of £405 per week. The new initiative provides parents with meal vouchers to ensure they stay nourished during long hours at their child's bedside.

Education and research

In Gynaecology, the Urogynaecology Unit at South Tees Hospitals NHS Foundation Trust (STHFT), with support from NTHFT has been recognised as a National Training Centre for subspeciality training in urogynaecology, one of around only 10 in the country .

At NTHFT, Paediatric and Neonatal Research have recruited time to target to all open studies in 2025/26. The Paediatric Department is the second highest recruiter in the North East.

In Children and Young Peoples Services, the Cystic Fibrosis Service, who continue to be an independent Cystic Fibrosis Centre, and the Children's Respiratory team are presenting both nationally and internationally. This year they are presented in;

- The National King's Paediatric Respiratory Service Conference in London.
- European cystic fibrosis conference Lisbon.
- National royal college of paediatrics conference in Birmingham.
- European respiratory conference in Barcelona.

Katie Metcalf, Paediatric Educator at STHFT has presented work on tracheostomy care on a national children and young people webinar.

Our Paediatric Educators have developed a training resource on the management of Diabetic Keto Acidosis in Children, which has been adopted regionally as the baseline teaching for all staff via the Operational Delivery Network for Paediatric Critical Care.

Award-Winning Care

We are very proud of all the staff who have been nominated for, or won awards, from across Family Health Services.

Grace Murray, Digital Midwife, recently accepted a baby lifeline UK MUM award (maternity unit marvels) at a special reception at the House of Commons in recognition of the service improvement brought about by her pioneering work with the Good Things Foundation to provide

maternity patients with data loaded SIM cards. This model is now being adapted throughout the England.

The new digital data service is up and running, with community midwives managing referrals for data support to digital midwives Grace Murray and Laura Stephenson.

Grace Murray commented: “The NHS Long Term Plan recommends that all women should have access to their maternity records, by providing free data we are ensuring that this recommendation is achievable.

In the first University Hospitals Tees Love Admin awards in October 2025,

Rebecca Anderson who works with children and young people was the winner in the ‘Contribution to patient care’ due to her compassionate approach and going the extra mile for young patients and their families.

Georgina Hicks , who works in children and young people services won the ‘AdministrativeAssistant of the year award’ for her work in introducing multiple sytems to support care delivery

In the annual Nightingale awards, several staff across Family Health Services were nominated and won awards :

- Clare Welford, manager of the Childrens Hub at Friarage Hospital Northallerton was successful in winning the Leadership award.
- Jennifer Hooley, Midwife, was the overall winner in the Patient Experience award.
- The CYPED team at STHFT were awarded the annual Children and Young People award for their outstanding resilience and commitment.

Maternity bereavement services at STHFT were finalists in the National Royal College of Midwifery awards, which was a wonderful recognition of the hard work from the team in providing a compassionate and supportive services to families at the most difficult time in their lives.

Showcasing Digestive Health, Urology and General Surgery (Clinical Service Unit 2)

Robotic Surgery

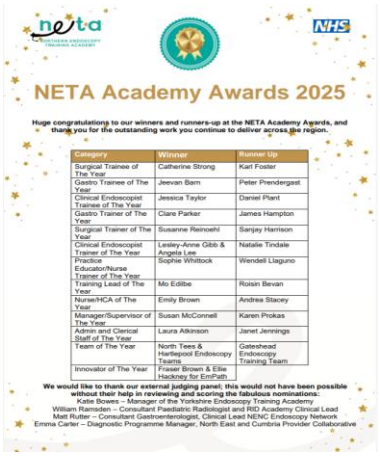
At South Tees Hospitals NHS Foundation Trust an additional robot was leased in October 2025 which has enabled the surgical teams within Digestive Health, Urology and General Surgery to extend its robotic programme which in turn has improved the caner pathway and outcomes for patients. The Trust has been able to secure this additional asset on a permanent basis and therefore the improvements made are forecast to continue.

JAG (Joint Advisory Group (on GastroIntestinal (GI) Endoscopy) Accreditation

The North Tees and Hartlepool Hospital Endoscopy Service was reaccredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) for its highest standard of achievement. The reaccreditation follows a recent annual review and highlights the dedication of the endoscopy team.

Northern Endoscopy Training Academy (NETA) Academy Awards 2025

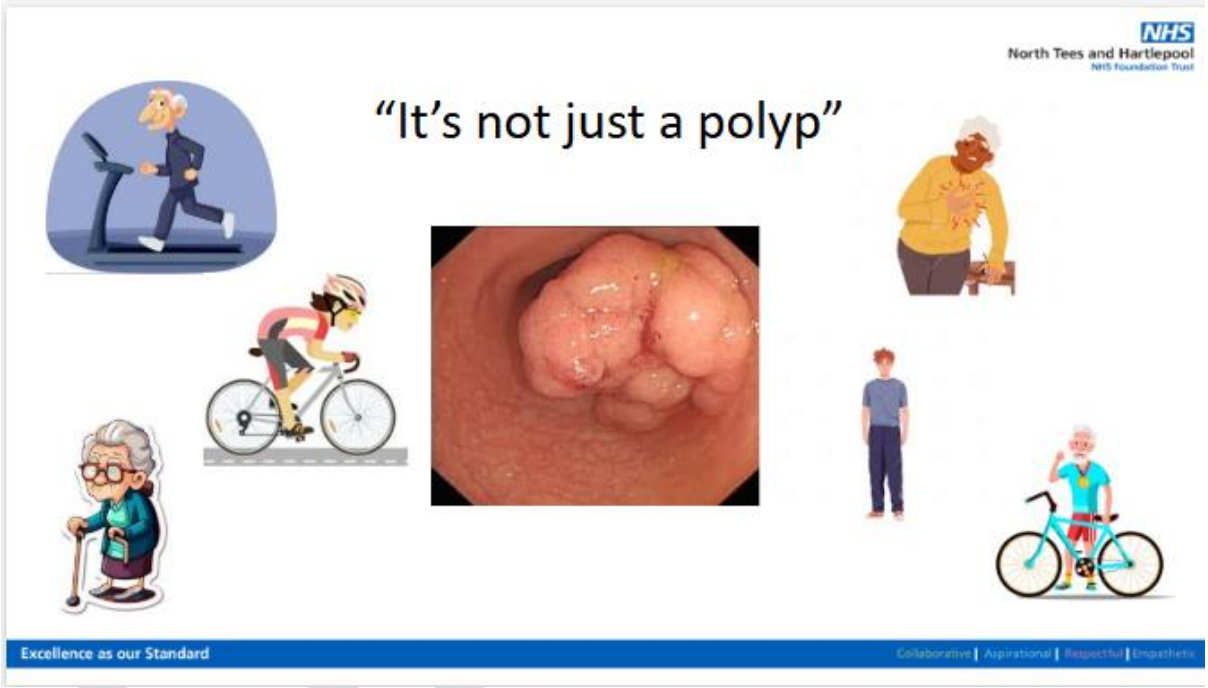
The North Tees and Hartlepool Endoscopy Team achieved notable success at the Northern Endoscopy Training Academy (NETA) Academy Awards 2025, winning the "***The Team of the Year"*** award in recognition of the outstanding teamwork, high-quality patient care, and contribution to endoscopy training across the region. In addition, two of our Advanced Clinical Endoscopist were individually honoured with the "***Clinical Trainer of the Year Award",*** reflecting excellence in training, mentorship, and workforce development.



Transforming Gastrointestinal Cancer Outcomes through Prevention, Early Diagnosis and Digital Innovation

Following the completion of the roll out of the National Bowel Cancer Screening Centre younger age and lower FIT threshold extension programmes in 2024 and 2025 respectively, the service has continued to transform the service by ensuring early diagnosis translates into optimal outcomes by establishing a dedicated complex polyp MDT where decisions are made with patients and their families, following through thorough risk and benefit discussions. This greatly enhances patient experience.

In addition, there is a joint Tees-wide Complex Polyp MDT, ensuring patients across Teesside have access to advanced decision-making and the entire array of endoscopic and surgical treatments for pre-malignant or early malignant polyps.



The service has benefited from having a wide-ranging clinical group who can perform all options of endoscopic therapies available. This includes Endoscopic Mucosal Resection (EMR), Endoscopic Submucosal Dissection (ESD), endoscopic Full Thickness Resection (eFTR) and endoscopic mucosal debridement.

Complementing this, South Tees Hospital Endoscopy service has developed nurse-led colon capsule and capsule sponge pathways to expand minimally invasive diagnostics to improve early diagnosis, reduce reliance on invasive traditional endoscopy and make better use of capacity within the endoscopy service.

All these developments improve accessibility, patient convenience and service efficiency, across the Tees Valley while supporting earlier diagnosis and better use of endoscopy capacity.

Gastroenterology Service

The Hepato–pancreatico-biliary (HPB) team at North Tees and Hartlepool Foundation Trust have received national recognition for the best practice and innovative services they provide. The team has access to the most up to date endoscopy equipment to deliver complex HPB procedures.

They provide approved training courses for colleagues across the country, patient education days on pancreatitis, a lead role in research and host a dedicated HPB medicine trainee every year. This drive for improvement and innovation continuously benefits optimal care for our patients.

Urology Services

The urology service has made significant improvement in its prostrate and haematuria cancer pathways throughout 2025/26 through a multi-disciplinary approach to triage and nurse led pathways to speed up the diagnostic process across both sites. It is recognised that there are still more improvements to be made to get the service where we know it should be.

A new nurse led service for Transperineal biopsies was introduced at Hartlepool Hospital which brings this in line with services at The Friarage Hospital and Redcar Primary Care Hospital and reducing the need to have a general anaesthetic procedure. This has been further improved with a TULA service (Trans Urethral Laser Ablation) procedure, which can safely and more comfortably deal with larger bladder tumours for the first treatment and without a general anaesthetic, or stopping blood thinners. This service is going from strength to strength; we currently have capacity for 15 biopsies per week and we are in the process of adding in monthly lists for those patients who need a general anaesthetic for the biopsy. We currently have 3 trained nurses carrying out the biopsies with another nurse due to start her training in May.

Within North Tees and Hartlepool Hospitals, multidisciplinary team specific clinics have been introduced every week which speeds up appointments for results following a multidisciplinary team meeting. Across South Tees Hospitals, having secured regional Cancer alliance funding, we have trialled the introduction of cancer navigators to virtually manage patients through the pathway. This allows results to be fed back to patients in a more real time way. This has also been overseen by the introduction of a new role to Urology Nurse Consultant to lead and oversee pathway improvements.

Due to these improvements and the work to increase robotic capacity, we have recently treated our first patient with prostate cancer with Robotic surgery with 62 days of the referral from GP, which is a real milestone in our improvement journey.

Alcohol Detox Service

The inpatient detox bed at UHNT was established on the 1st June 2024, the service has continued to demonstrate positive outcomes for patients from this time. Overall, the detox programme has a success rate of 91.1%. There have been no further relapses in this quarter. Over all 8 relapses from June 2024.

The plan is to provide an inpatient detox bed at Jame Cook University Hospital in 2026/27 which will further support the Tees Valley population.

Ward/ Department Accreditation

The Accreditation programme (detailed in Section 3.1) is a quality improvement framework that evaluates clinical areas against standards including safety, patient experience and leadership. All departments across the Clinical Service Unit are on their journey for Accreditation and have either had their baseline assessment or achieved Gold award.

Showcasing Trauma & Orthopaedics, Reconstructive & Plastic Surgery, ENT, OMFS, Dermatology & Ophthalmology Services (Clinical Service Unit 3)

The Ophthalmology team based at James Cook Hospital have been trying to address some of the challenges faced by their patient group by making their pathway through the department easier to follow and understand.

The Ophthalmology team have devised a video to guide patients through their department and understand what they can expect from their appointment. This includes an introduction to the department manager, and a map and directions to the department.

As the Ophthalmology estate is spread over several areas patients with reduced sight sometimes find it challenging to navigate. The video explains how to check in for appointments, and who to go to for guidance if unsure, the video goes on to explain assessments such as visual acuity, measurement of eye pressure and the administration of eye drops and what to expect.

The team discuss the use of virtual clinics and explain that some tests may be completed and then reviewed by the Ophthalmologist in the virtual clinic. The different disciplines within the department are explained in the video and include Orthoptists and Optometrists so patients are aware they may see several team members during their appointment.

For patients requiring surgery the department also conducts a pre-assessment clinic in readiness for surgery. Patients are made aware their time in the department can vary between 30 minutes to 4 hours depending on the teams they need to see. The team plan to play the video on loop in the waiting area's and to share with their patients prior to attending the department, the patients also have access to a QR code that takes them to the Trust Ophthalmology page where there are more useful links and information.

Fiona Klimczak was moved to tears when clinicians switched on her new hearing implant. Fiona, 60, was the first patient at James Cook University Hospital to receive a transcutaneous bone conduction implant (BCI) and she says it has changed her life. Fiona had suffered with severe hearing loss for 13 years after reoccurring infections caused damage to both of her ears.

"Losing my hearing had a big impact on me. I lost confidence, felt I couldn't contribute when in group situations, as I couldn't hear people properly, and was constantly saying 'I'm sorry can you please repeat that', time after time, or mishearing words which was awful."

Fiona, who now works as an assessor and internal verifier for a local training provider, says she often felt like an outsider and did not want to socialise. She also had to give up working in classroom situations as she could not hear the groups of students properly.

Fiona tried traditional hearing aids but the sound quality was not great. Then in 2016 she met ENT (ear, nose and throat) surgeon Anirvan Banerjee who explained that her left ear was so damaged it needed surgery to replace the ear drum.

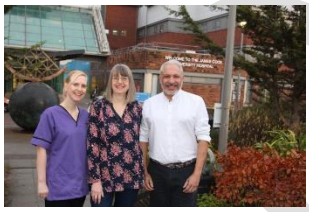
She underwent ear surgery in 2017, 2018 and 2023 but continued to have issues with infections from her hearing aids. Further surgery saw her have a bone anchored hearing aid fitted in 2024 which produced promising results, but her body rejected it shortly afterwards leaving her devastated. After much discussion the James Cook team decided Fiona was a good candidate to try a new transcutaneous device – the Sentio Ti Implant. Fiona knew she had to give it a go and Mr Banerjee carried out the surgery at the Middlesbrough hospital in August 2025.

“Family and friends told me that they thought I was mad to want to put myself through a further surgery, but I felt like this was my last hope at getting some hearing back,” said Fiona.

“I was only in hospital for half a day; the surgery went smoothly and my recovery was quick with no side effects or complications.”

A small titanium implant was secured under the skin behind and above Fiona’s ear which connects to an external processor that is discreetly worn on the head. The device uses a magnetic connection to transmit sound, bypassing the damaged middle ear by vibrating the skull and sending sound vibrations directly to the inner ear.

Absolutely priceless
Fiona said it was such an emotional moment when the sound processor was switched on for the first time: “They asked ‘can you hear me’ and I got tearful and said ‘I can hear you’. I was overwhelmed with joy and felt quite emotional as I could hear clearly.



“I was amazed when I was driving back to my home when a song came on the radio that I recognised from years ago, I heard different riffs and bars in the music which I had never heard before. When walking outside it was wonderful when I heard all different bird songs. I feel connected to the world again, and don’t have to worry about missing conversations or having to laugh falsely when I had missed a joke being told. I don’t have to have subtitles on the television, or the TV volume turned up high. And to be able to hear my granddaughters talking to me, without me second guessing as to what they have said, is absolutely priceless. I feel very fortunate, honoured and privileged to have been the first patient to have had this successful surgery at The James Cook University Hospital. It’s changed my life.”

Reconnecting people
Mr Banerjee said: “Fiona has lived with hearing loss for many years, and seeing her hear clearly again, and the emotion that came with that moment was incredibly moving. Helping her reconnect with her family, her confidence and the world around her is a powerful reminder of why this work matters so much.”

Fiona added: “My heartfelt thanks go to Mr Banerjee and audiologist Lisa Kennedy. I am forever grateful for their care, dedication and support in helping me to hear again.”

Showcasing Theatres, Anaesthetics & Critical Care Services (Clinical Service Unit 4)

Since coming together as University Hospitals Tees, Theatres, Anaesthetics and Critical Care Services have made significant progress in strengthening patient safety, improving workforce capability, and enhancing the quality of care delivered across University Hospitals Tees. This section outlines the key developments, achievements, and priorities that demonstrate our commitment to high-quality, safe and patient-centred care.

1. Workforce Development and GPICS Compliance

A major focus this year has been improving workforce capability in line with national standards. Extensive work has been undertaken to align services across both acute sites with the *Guidelines for the Provision of Intensive Care Services (GPICS)*, leading to improved compliance across North Tees and Hartlepool NHS Foundation Trust. This has included:

- Strengthening skills and competency frameworks
- Increasing access to mandatory and specialist clinical training
- Enhancing clinical leadership capacity
- Supporting multi-professional learning and service-wide development

These improvements ensure that workforce structures are better aligned to national best practice, supporting safer and more efficient patient care and improving long-term sustainability.

2. Martha Rule Implementation – A Nationally Recognised Pilot Site

University Hospital of North Tees has played a pivotal role in advancing the implementation of Martha's Rule, participating as a Phase 2 pilot site. The Trust has been recognised at NHS England level as an exemplar for the progress achieved to date.
Key achievements include:

- Establishing clear escalation pathways for patients and families
- Enhancing staff awareness through targeted training
- Improving response times to clinical deterioration
- Ensuring that patients and their families feel empowered to raise concerns

This work reinforces the organisation's commitment to partnership working with patients and their carers, and ensures safety concerns are responded to promptly and effectively.

3. STACQ Accreditation Across Multiple Departments

Departments across James Cook University Hospital and the Friarage Hospital have now achieved accreditation, demonstrating robust governance, safe practice, and adherence to nationally recognised quality standards. This work will continue with a bespoke Theatre Accreditation where work has now commenced.

This accreditation reflects:

- Strong clinical governance processes
- Consistent use of evidence-based practice
- High-quality patient assessment and monitoring
- A culture of continual improvement

The achievement of accreditation across multiple service areas highlights the progress made in embedding high-quality, standardised care across the organisation.

4. **Safety Culture: Embedding High-Quality Communication**

Strengthening safety culture remains a major priority. Although there are established mechanisms in place such as huddles, debriefs, case reviews and structured meetings, these have not always been used consistently or embedded in a way that fully supports our staff and patients pathways.

The pressures on services over the past year have created challenges in maintaining strong communication and reliable safety processes. Teams have highlighted that operational demands, staffing pressures and rapid changes across services have made it difficult to sustain regular safety conversations and to ensure that learning is shared effectively.

In response, the Clinical Service Unit (CSU) is now placing renewed emphasis on developing a more positive, transparent and reliable safety culture. This includes:

- Reassessing the consistency and quality of safety huddles and debriefs and refreshing the WHO checklists and local variability
- Enhancing the safety culture with weekly group wide CSU safety meetings
- Improving the visibility and accessibility of learning from incidents and near-misses
- Strengthening psychological safety so all staff feel confident to speak up – the change from “Stop I am not happy” to “please can we have a safety pause”
- Ensuring leadership presence is supportive, visible and focused on learning
- Embedding clearer structures for feedback loops so staff understand outcomes of reported concerns

This intensified focus reflects University Hospitals Tees commitment to acknowledging where improvement is needed and taking proactive steps to create safer, more supportive and better-connected teams. Building a stronger safety culture is now a forward priority, and will be a key area of monitoring and development over the year ahead.

5. **Patient Experience: High Levels of Positive Feedback**

The CSU continues to receive a large volume of compliments from patients and carers. Themes emerging from positive feedback include:

- Staff professionalism and kindness
- Efficiency and timeliness of care
- Clear communication
- Holistic support for patients and families

This reinforces the organisation’s commitment to delivering compassionate, patient-centred care, and highlights the dedication of the workforce under demanding conditions.

6. **Opening of the Friarage Surgical Centre and Future Surgical Network Development**

A major milestone was the successful opening of the Friarage Surgical Centre, which has now been operational for nine months. Early outcomes have been highly positive, including:

- Improved patient flow
- Enhanced surgical capacity
- Reduced cancellations
- Increased ability to ring-fence elective procedures

Building on this success, the next strategic step is the development of a Tees Valley Surgical Network, bringing together the Hartlepool Surgical Centre in order to:

- Optimise elective surgical pathways
- Improve resilience and service sustainability
- Reduce waiting times across the system

This reflects a forward-looking approach that aligns local service transformation with national elective recovery priorities.

7. New Maternity Theatre, Robotic Theatre and Recovery Developments

As part of last year's theatre refurbishment programme, the STHFT opened three major new facilities: a new maternity theatre, a dedicated robotic theatre and a state-of-the-art recovery area. These developments represent significant investment in modernising surgical and obstetric care and ensuring services are delivered in high-quality, safe and efficient environments.

The new maternity theatre provides a purpose-built space with improved layout, updated equipment and enhanced infection-prevention measures, supporting safer and more efficient management of urgent and elective obstetric procedures. Staff report that the new environment has strengthened workflow and reliability during time-critical care.

The new robotic theatre has expanded STHFT surgical capability by enabling advanced minimally invasive procedures. This improves precision, supports quicker patient recovery and reduces the need for patients to travel elsewhere for specialist surgery.

The purpose-built recovery area offers a modern, calm and efficient environment with improved staff visibility, enhanced monitoring capacity and increased space, providing a safer and more responsive setting for postoperative care.

These facilities mark an important milestone in STHFT's commitment to modernising its surgical estate and ensuring patients across the region benefit from contemporary, future-ready clinical environments.

8. Sharing Good Practice Across the Region

We have continued to take a proactive role in sharing best practice with partner organisations. Several Hubs and regional Trusts have visited to observe models of care, governance processes, and improvements implemented locally.
This collaborative approach:

- Supports cross-system learning
- Strengthens professional networks
- Encourages alignment to high-quality standards
- Reinforces the Trust's role as a leader in service improvement

Summary
Across all areas, our Clinical Service Unit has demonstrated strong progress against its quality ambitions. The focus on workforce development, safety culture, accreditation, patient experience, and strategic service redesign has created a strong foundation for future improvement. These achievements show a continuing commitment to delivering safe, effective and compassionate care for patients across the region.

Showcasing Cardiovascular Services
(Clinical Service Unit 5)

Introducing a Day 1 discharge programme (D1DP) following thoracic surgery supported by a dedicated community thoracic surgery service.

Background
The expansion of lung cancer screening has led to increased detection of early-stage lung cancer suitable for surgical resection, placing additional pressure on thoracic surgical services. Prolonged hospital length of stay (LOS) limits bed capacity, increases costs, and exposes patients to avoidable hospital-associated risks.

Our established Community Thoracic Service, launched five years ago, has already demonstrated measurable reductions in LOS and readmission rates through structured home-based postoperative review. However, provision was previously limited to a single community visit, restricting discharge before post-operative day (POD) 2.

To safely implement a Day-1 Discharge Programme (D1DP), funding was secured from the Northern Cancer Alliance to expand the service. Two key roles were introduced in April 2025: a Day 1 Discharge Coordinator and a Prescribing Specialist Community Thoracic Physiotherapist (AHP).

This enhanced workforce supports additional home visits on post operative day 3 to 5 and weekly follow-up for up to four weeks post-surgery. The expanded model enables earlier identification of postoperative concerns, timely intervention, and sustained patient reassurance at home.

Results: Demonstrated Success After 6 Months of introducing D1DP

1. Significant Reduction in Length of Stay
- Mean LOS reduced from 4.9 to 3.4 days ($p = 0.0028$)

This represents a clinically and statistically significant improvement in efficiency without compromising safety.

2. Cultural Shift Towards Early Discharge
- Post-operative Day 1 discharge: 51/193 patients (26.4%)
- Post-operative Day 1 or 2 discharge: 106/193 patients (54.9%)

This reflects a substantial and sustained shift in discharge practice utilising Discharge Coordinator who increases opportunities for mobilising patients post thoracic surgery, supported by robust community follow-up.

3. Safe Complex Discharges
- 40/193 patients (20.7%) were discharged with a chest drain in situ
- Supported by Advanced Nurse Practitioner led clinics and specialist community review
- 67% of patients received a home visit the day after discharge

This demonstrates confidence in managing higher acuity patients safely in the community setting.

4. Maintained Safety Profile

- Readmissions reduced to 6.7% (13/193), Compared to 8.4% in 2024 (p = 0.61)

Although not statistically significant, this represents maintained or improved safety despite earlier discharge and increased case complexity.

5. Exceptional Patient Experience

- Patient feedback has been overwhelmingly positive, highlighting: Compassionate communication, confidence in early discharge, value of specialist physiotherapy and reassurance from structured follow-up

"Kindness, compassion and communication – all three demonstrated at all times."
"I was a lot happier being in my own home… knowing the support was in place was very reassuring."

"Physio changed everything and is a must!"

"The team have gone above and beyond and are the best at what they do."

The service provides seamless care from pre-assessment, inpatient treatment (ward/HDU), to structured home follow-up; ensuring continuity across the entire surgical pathway.

6. System Impact and Financial Success
The D1DP has resulted in an estimated 606 bed days saved annually with projected financial benefit.

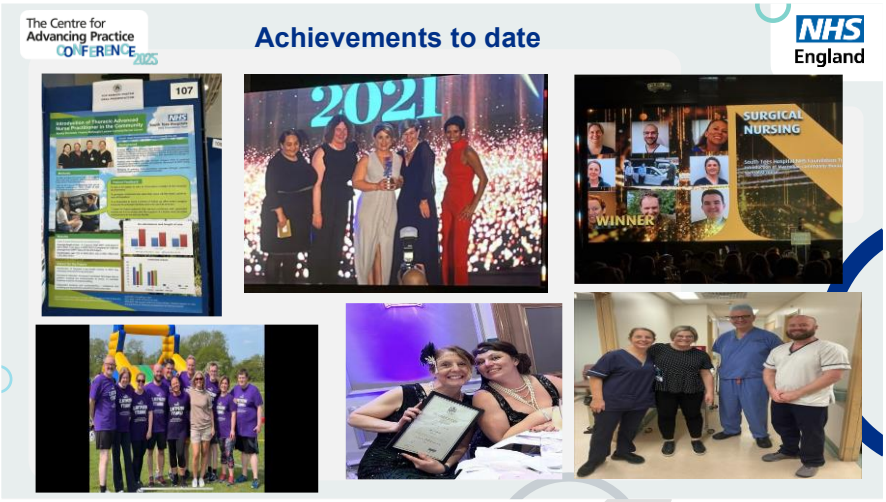
These savings encompass both reduced index admission duration and prevention of avoidable readmissions.

The programme directly supports the ambitions of *the NHS 10 Year Plan for England (2025)* and The *National Cancer Plan for England (2026)* by transferring safe postoperative care into the community while maintaining clinical quality and patient satisfaction.

Summary

This model represents a sustainable, patient-centred transformation of thoracic surgical recovery pathways with multidisciplinary collaboration (ANPs, physiotherapy, discharge coordination), a dedicated community workforce expansion, structured early review and rapid escalation pathways, a clear cultural shift supporting post operative day 1 discharge along with robust prospective data monitoring.

The Day-1 Discharge Programme demonstrates that early discharge following lung resection can be delivered safely and efficiently with high patient satisfaction when supported by a dedicated specialist community thoracic service. The programme has achieved significant reduction in LOS, increased POD1 discharges, safe management of complex patients at home, maintained low readmission rates, high patient-reported satisfaction and meaningful financial and capacity benefits.


The Centre for Advancing Practice
CONFERENCE 2025
Achievements to date
NHS England
2021
SURGICAL NURSING
WINNER


The Centre for Advancing Practice
CONFERENCE 2025
The James Cook University Hospital

Showcasing Cancer Institute
(Clinical Service Unit 6)

Hitting Our Mark: Impact of achieving the Macmillan Quality Environment Mark (MQEM)

The Macmillan Quality Environment Mark (MQEM) is a nationally recognised award that recognises the world-class care provided to patients by hospitals and celebrates environments that provide the highest standards of care. Developed by Macmillan Cancer Support, it assesses how well healthcare environments meet the holistic needs of people living with cancer, focusing on the design and use of space, the user journey, service experience and the extent to which the voices of people affected by cancer shape services. Achieving MQEM demonstrates that our services provide clear organisational commitment to delivering cancer care environments that support dignity, privacy, comfort, and emotional wellbeing alongside high-quality clinical treatment.

Within our Cancer Institute Clinical Services Unit (CSU), all clinical areas have achieved the highest possible MQEM rating of five stars. This represents a significant achievement and reflects consistent excellence across inpatient, outpatient, diagnostic and treatment environments. Five-star status indicates that our environments not only meet but exceed the MQEM quality statements, providing spaces that are welcoming, calm, accessible and responsive to the needs of people living with cancer as well as their families and carers.

The impact of achieving MQEM status across all clinical areas is wide-ranging. For patients and those close to them, it provides assurance that care is delivered in environments designed around their lived experience. Attention to lighting, wayfinding, privacy, noise, accessibility and comfort helps reduce anxiety at what is often a highly stressful time. Feedback gathered as part of the MQEM assessment confirms that high-quality environments positively influence how safe and supported people feel throughout their cancer journey.

Some of the improvements found include a revamped garden, cancer coordinators appointed, installation of light boxes in waiting area and quiet room, upgraded signposting for patients etc.

MQEM status strengthens confidence among stakeholders, regulators and partners. The framework is recognised by the Care Quality Commission (CQC) as evidence of good practice in the delivery of patient-centred environments. Achieving and sustaining five-star ratings across the Clinical Service Unit demonstrates effective leadership and a culture that values continuous improvement. It highlights the Cancer Institute as a leader in providing high-quality cancer care environments at both a regional and national level.

The assessment process itself has had a positive impact on staff engagement and service development. MQEM places strong emphasis on co-production, ensuring that people with lived experience of cancer are involved in shaping and reviewing services. This approach has empowered teams to listen actively to feedback, reflect on practice and implement meaningful improvements. As a result, staff report increased pride in their working environments and a stronger sense of shared ownership for quality and patient experience.

Sustaining five-star MQEM status across all clinical areas reinforces our University Hospitals Tees Cancer Institute commitment to delivering holistic, person-centred cancer care. It demonstrates that we recognise the physical environment as a critical component of quality, safety, and compassion. By embedding MQEM principles into ongoing planning and development, we ensure that our environments continue to evolve in line with patient needs, supporting excellent experiences and outcomes for everyone who accesses our services.

Showcasing Clinical Support Services
(Clinical Service Unit 7)

Cardiac CT one stop imaging

Collaborative working with our Cardiology colleagues has enabled us to facilitate two one-stop CT cardiac sessions at the Friarage Hospital each week. The patients attend Radiology and undergo their pre-appointment assessment with the cardiology team nurses and then have their CT cardiac imaging. The imaging is then "hot" reported and the patient receives their CT cardiac results at the same visit with a copy to take to their GP. This drives down multiple patient visits across both specialties and improves diagnostic waiting times.

Prostate pathway

Our Prostate pathway has significantly improved since implementation of collaborative working throughout Radiology and Urology. The impact of this has seen the patient pathway reduced consistently by an average of 21 days.

Aims/Objectives

- To support faster diagnosis of prostate cancer through eliminating unnecessary steps along the pathway
- Compliance with 28-day faster diagnosis standard, improving performance and better supporting patients not requiring cancer treatment through expedited notification of no cancer diagnosis
- Compliance with 62-day treatment standard, improving trust cancer performance and patient outcomes

Outcomes/Impact

- Community Diagnostic Centre (CDC) equipment and additional capacity has allowed patients to be scanned closer to home which has led to improved patient satisfaction
- Higher specification of MRI equipment and software has supported improved image quality and aligned standards of imaging to that regionally
- Supporting NTHFT urology patients through MRI team scanning their prostate patients within CDC hub
- This is a good example of teamwork and shared ownership.

AI Chest x-ray Software

Background

The AI Diagnostic Fund (AIDF) is a time-limited NHS England programme designed to increase diagnostic capacity, reduce reporting backlogs and support earlier lung cancer diagnosis through the deployment of AI. Under AIDF, STHFT implemented Harrison CXR AI (formerly Annalise Enterprise CXR) as a fully embedded clinical decision-support and worklist triage solution. The solution is fully integrated within existing electronic workflows and deployed trust-wide.

Current position

STHFT is using chest x-ray AI (artificial intelligence) at scale to support AI-enabled triage of chest x-rays.

The Artificial Intelligence software currently assists with:

- Prioritising worklist-automated detection triage and reporting assistance- comparison tool
- Flags urgent or abnormal studies for priority review

- Integration to PACs in use currently
- Potential to assist in reducing the number of critical findings

How we could utilise this further:

- Generation of reporting templates to help with efficiency in reporting turn-around times
- Utilise Secondary Capture, giving access to Radiographers to support out of hours with flagging critical findings for urgent reports
- Utilise Secondary Capture, giving access to all clinicians to provide enhanced confidence in bedside chest x-ray interpretation
- Utilise Secondary capture to help reduce the recalls to the Emergency Department; discharged at point of care where critical finding has not been picked up prior to a radiological report thus reducing costs and the burden on the Emergency Department and reduced length of stay

Showcasing General & Emergency Medical Services (Clinical Service Unit 8)

Our Urgent Emergency Care (UEC) Services

Why is this important:

Front of house urgent and emergency care, often referred to as the 'front door' of the hospital is critical for managing patient flow, improving clinical outcomes, and reducing crowding in emergency departments (ED). By providing rapid assessment, specialised care for frailty, and same-day assessment and treatment, these services ensure that patients receive the right care, in the right place with the most appropriate clinician, avoiding unnecessary admissions.

UEC standards aim to reduce clinical risk though a shared responsibility and enhance patient experience through more timely assessment and appropriate clinical pathways. The key standards are 4 hour compliance - longer waits are known to increase patient mortality, 12 hour waits – over 65 year olds and those presenting with mental health concerns are more likely to experience long waits, and category 2 ambulance handover – improving flow will release ambulance crews to attend sick patients in the community more timely.

What we achieved in 25/26:

A new estate for the Emergency Assessment Suite at University Hospital of North Tees

Based on consistent compliance against these standards we received national UEC incentive funding which allowed us to develop a bespoke emergency assessment environment designed to overcome previous challenges with patient flow and clinical capacity. The new Assessment Suite reviews on average 55 patients per day and takes direct ambulance arrivals through paramedic pathways, bypassing ED. This shared responsibility for emergency pathways has led to consistent high achievement of the 4 hour standard and 70% of patients reviewed are discharged home within the same day without a hospital admission.

Co-located Urgent Treatment Centre at James Cook University Hospital (JCUH), 1 year on

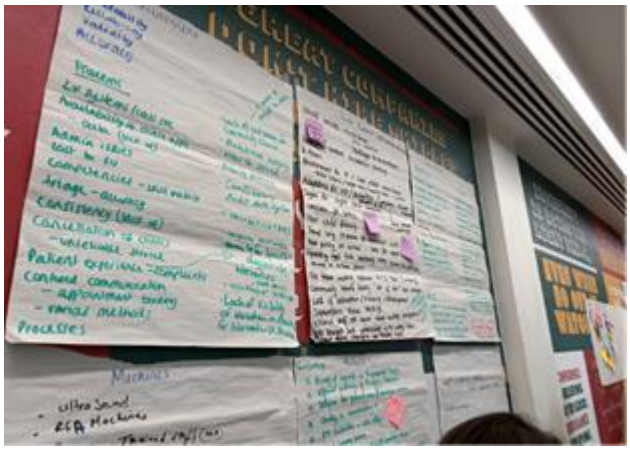
Our co-located urgent treatment centre at JCUH was 1 year old in April 2025. The service is provided through collaboration with partners in North East Ambulance Service and Hartlepool and Stockton GP Federation and both NTHFT and STHFT. It helps people access the right service in the right place according to their needs allowing the Emergency Department (ED) to focus on the most unwell patients. The design provided a new environment which increased the physical capacity across the combined ED, as well as the creating a new reception / streaming desk and modifications to ED waiting area for improved patient experience. Within its first year the service saw over 60,000 patients providing urgent treatment for a range of minor injuries and illnesses, 24 hours per day, 7 days per week with 94% of patients seen, assessed and treated within 4 hours.

Summary and next steps:

Over 2025/2026 we have seen enhancement of the estate and processes that have led to continuous improvement and outcomes for patients using our UEC pathway. During the challenging winter months, we have seen a reduction in over 45 minute ambulance handover delays by 52% at STHFT and 35% at NTHFT and improvements in our overall 4 hour performance. Continued focus on ensuring timely, effective and safe treatment for patients experiencing acute health issues, aiming to improve outcomes for patients and supporting the overall efficiency of emergency care services across University Hospitals Tees. Access to emergency services, regardless of location or time, the enhancement of same day assessment areas across specialities and the quality of care provided based on standardised clinical guidelines and protocols remain key priorities. The emphasis on patient safety and experience ensuring patients are treated with dignity and respect is fundamental.

Showcasing Neurosciences Services
(Clinical Service Unit 9)

What we have achieved – celebrations



CSU 9 are currently aligning our pain (chronic) services across the UHT to benefit both the patients we serve and team collaboration across hospital sites, working together to develop a pain strategy. Teams from across UHT came together to align pain services.

CSU 9 inpatient areas celebrated nutrition and hydration week to the fullest. Each day our teams strive to provide the most appropriate and needed hydration and nutrition to our patients. Ward 26 had a nutrition and hydration focus which involved engaging and celebrating our patients hydration and nutrition needs, linking with Serco, nutrition champions and ward-based team.

Our staff supporting patients with spinal cord injuries fundraised throughout 2026 to facilitate bespoke events with our spinal cord injury patients. The team strive daily to promote a positive approach with this group of patients.

Patient story:
A stroke survivor has credited NHS teams for helping him regain his life.

During the five weeks that Matthew spent at the Friarage Hospital, he was offered support by a multi-disciplinary team to regain his independence. This comprised physiotherapists, occupational therapists, speech and language therapists, rehabilitation nursing and medical team and dietitians, who ensured Matthew was on the pathway to regain his independence.

Thanks to the specialist support, Matthew was discharged from the Friarage Hospital after five weeks, during which he was also referred to the early supported discharge (ESD) team – where he received extensive support from the comfort of his home.

My dad only had an hour left for his life - Mechanical Thrombectomy

An NHS worker is urging people to be aware of a condition that can cause severe brain damage if not treated within four and a half hours – after her dad was on the cusp of losing his life.

Dr Whitehouse, consultant in stroke and geriatric medicine, and her team promptly administered thrombolysis, a medical treatment using “clot-busting” drugs to dissolve blood clots and restore blood flow. The clot-busting drug did not work for Thomas and he was urgently sent to The James Cook University Hospital to undergo mechanical thrombectomy to remove the clot. Thomas successfully underwent the procedure at 4.35 pm.

Comment from patient “‘I am so grateful to the doctors, nurses, consultants and stroke teams at University Hospital Tees, as i know they ruched to see me when I arrived and made me and my family understand how little time I had for my life to be saved’

Summary and next steps:

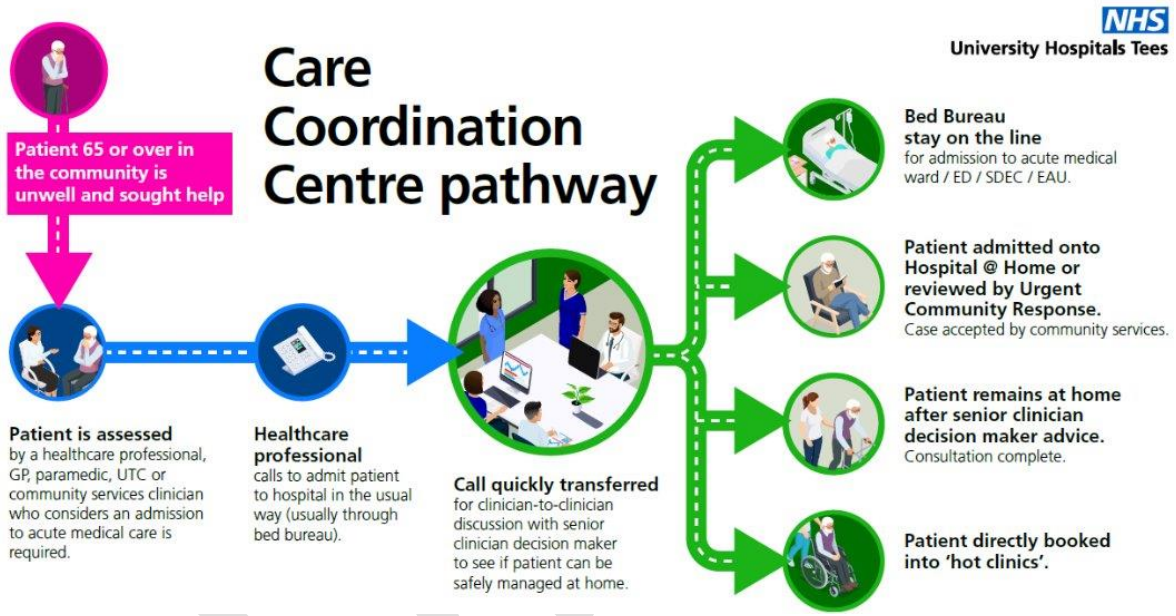
CSU 9 have devised a one to five year priority plan, with Clinical Service Unit colleagues and engagement through patient forums and focus groups. Initial one year priorities include horizontal integration of stroke services and pain services across UHT while providing consistent care and experience for our patients and staff alike. The emphasis being our fundamental ethos f delivering safe care with compassion.

Showcasing Community & Neighbourhood Health Services (Clinical Service Unit 10)

Too many frail older people are conveyed to hospital when their needs could be better met in their own homes. This leads to poor patient experience and overcrowded emergency departments. The Care Co-ordination Centre (CCC) pilot aimed to address this problem by bringing together urgent and emergency care, community health and social care services.

The pilot lasted for three months over winter 2025/26; serving the four districts of Middlesbrough, Redcar and Cleveland, Stockton and Hartlepool. All requests for admission to hospital from GPs, paramedics or other healthcare professionals for patients aged 65 and over were directed to a senior decision maker at the CCC to have a clinical conversation about whether the patient can safely be cared for by community services instead of coming into hospital.

The calls were via the bed bureau (STHFT) and Integrated Single Point of Access (NTHFT) which were the existing contact points for requesting an admission to hospital.



The senior decision makers were mostly secondary care consultant from emergency or acute medicine. These hospital doctors worked hand in hand with senior community nurses to signpost patients to the appropriate place. Where needed, urgent social care could also be arranged. This was an invaluable opportunity to learn about the each other's worlds. The main alternative route was to Hospital at Home. More than 1,000 calls were screened and a quarter of patients entirely avoided hospital.

Close working with partners in ambulance services, primary care, secondary care and community services was key to ensuring the most appropriate care was given in a timely manner for every patient.

The aim of the pilot was to reduce pressure on our emergency departments and demand on hospital beds while also improving patient experience and helping increase independence. Patient feedback from those successfully managed in their own environment was excellent.

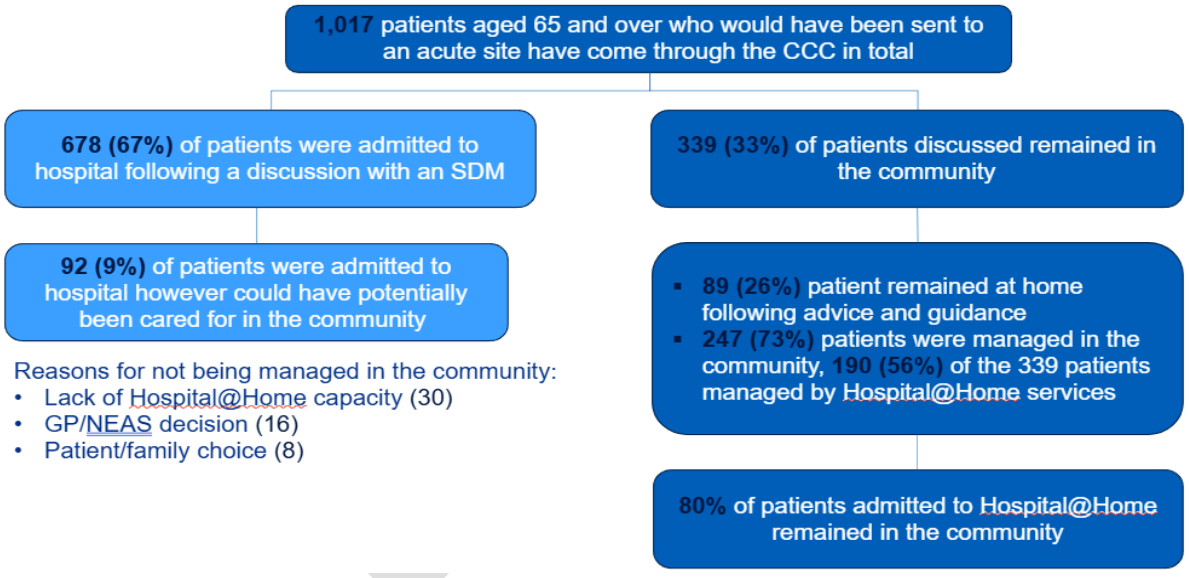
What was the impact?

Data analysts were part of the pilot team and every care journey has been tracked in detail. 33% of calls wanting to admit to hospital were offered an alternative such as Hospital at Home or community response, 89 were given advice and guidance.

Of the 1,071 patients who would have been sent to an acute site:

- 736 patients (69%) were admitted to hospital which was appropriate for what they were presenting with
- 335 patients (33%) remained in the community. Of these patients:
    - 89 patients remained at home following advice and guidance or referred to another community service.
    - 246 patients received a community response of which:
        - 187 received care from the Hospital at Home service
        - 52 patients have received a community response from other services
        - 7 patients were referred into outpatient services

Our analysis of the statistics also showed 80% of patients managed by community services remained at home. The pilot was undoubtedly successful but a parallel audit with North East Ambulance Service found that even more patients could have avoided conveyance to the emergency departments. A continuous quality improvement approach was used. Issues were captured daily and solutions found so that improvements could be made to improve the service.



What happens next?

The personal, organisational and system benefits from this pilot are now informing our plan for future services. There were clear benefits of closer working between community and acute teams, as well as with the ambulance service, that will continue to improve our urgent care response for patients.

All calls made to CCC were recorded, which allowed for learning and feedback to clinicians. There are a number of care pathways that were identified that can be changed to prevent patients from having to attend hospital.

The CCC pilot demonstrated that with senior clinical decision making at a consultant level, community services being horizontally integrated and Hospital at Home teams being appropriately resourced 40% of patients aged 65 and over that are typically for medical admission could be managed at home. This could have a significant impact on the long-term outcomes, support the requirement to move services out into community and provide the right pathway at the right time for patients who need this most.

Further recommended models of CCC need to include working in collaboration with ambulance services, acute and emergency medicine teams and system level integrated working. We are analysing where the most impactful intervention will be, with hope that CCC will become a permanent part our offer for patients.

3.2 Performance against key national priorities

FINAL VALIDATED DATA WILL BE AVAILABLE IN READINESS FOR PUBLICATION – JUNE 2026 ONCE APPROVED BY NHSE

South Tees Hospitals NHS Foundation Trust Single Oversight Framework Indicators	Standard / Agreed Trajectory	2024-25 Performance	2025-26 Performance	Achieved
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (YTD)	77.87%	75.6%		
Receipt of two week wait / screening referral to date patient is informed of a diagnosis (FDS) or ruling out cancer (YTD)	78.38%	71.1%		
31-day wait from decision to treat/earliest clinically appropriate date to treatment of cancer (YTD)	91.95%	82.6%		
62-day wait from urgent GP referral for urgent suspected cancer or breast symptomatic referral or urgent screening referral or consultant upgrade to first definitive treatment of cancer (YTD)	64.27%	61.2%		
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (March end)	65.02%	60.24%		
Referral to Treatment 52 Week Waits (March end)	515	1,542		

Table 16 – STHFT Single Oversight Framework Indicators

North Tees and Hartlepool NHS Foundaton Trust Single Oversight Framework Indicators	2022-23	2023-24 Performance	2024-25 Performance	2025-26 Performance
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (YTD)	N/A	84.78%	85.53%	
Receipt of two week wait / screening referral to date patient is informed of a diagnosis (FDS) or ruling out cancer (YTD)	80.71%	78.18%	78.74%	
31-day wait from decision to treat/earliest clinically appropriate date to treatment of cancer (YTD)	96.49%	96.60%	96.06%	
62-day wait from urgent GP referral for urgent suspected cancer or breast symptomatic referral or urgent screening referral or consultant upgrade to first definitive treatment of cancer (YTD)	70.20%	64.87%	66.98%	
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (March)	75.54%	71.15%	75.46%	

Referral to Treatment 52 Week Waits (March)	38	218	171	

Table 17 – NTHFT Single Oversight Framework Indicators

Key findings:

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 the four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges. These 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. Details of all the clinical standards are available at: NHS England » Seven Day Services Clinical Standards. It is good practice that Trust Boards assess, at least once a year, whether their acute services are meeting the four priority standards, using guidance published in February 2022.

A full assessment against these standards was completed for South Tees Hospitals NHS Foundation Trust (STHFT) in September 2022.

Repeat audit March 2026 shows that STHFT 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 onto acute admissions wards and when the patient is unwell or deteriorating. The Trust wide roll out of electronic patient records (EPR) enables monitoring of the timely assessment and review of patients. Further work on data quality and systematic use of the EPR is required.

The Trust is also assured that arrangements are in place for daily senior review in acute wards, 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

Background to the Freedom to Speak Up Guardian

The National Guardian Office (NGO) and the Freedom to Speak Up Guardian (FtSUG) role was established in 2016 following the events at Mid-Staffordshire NHS Foundation Trust and the recommendations from the subsequent inquiry led by Sir Robert Francis. The Francis Report raised 290 recommendations. One of the recommendations was to have a designated person who was impartial and independent working in every Trust. This role would facilitate staff to speak to in confidence about concerns at work including any public interest disclosure. It was acknowledged that staff should be listened to, taken seriously and not suffer detriment as a result of speaking up.

Philosophy

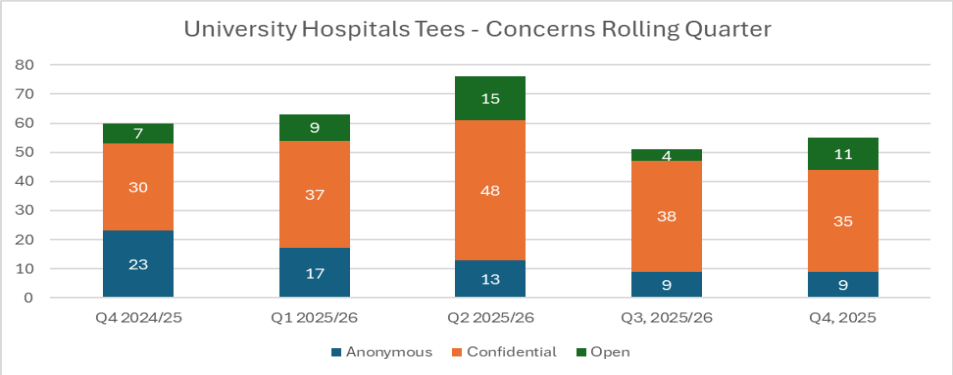
The Freedom to Speak Up (FtSU) ethos aims to help promote and normalise the raising of staff concerns ultimately for the benefit of patients and workers. Speaking up not only protects patient safety but can also improve the lives of workers by listening to what they need to be able to do their job, so that they can deliver an excellent service.

The FtSUG Team at University Hospital Tees (UHT) continue to develop and establish frameworks ensuring that we support staff to do the best job that they can and to keep patients safe, through the delivery of high-quality services. Offering a robust service that empowers workers to speak up about anything that concerns them and then using this feedback to inform future strategies and support our continual learning and improvement. If there are any behaviours or acts which harm the services the Trust delivers, we have both a duty and right to speak up.

UHT progress 2025-2026:

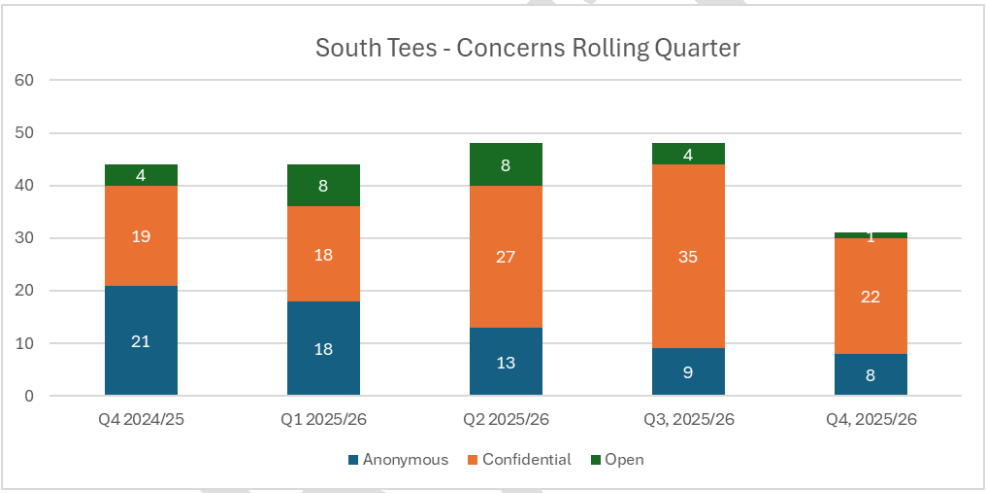
The FtSUG Team works to improve the Speaking Up Culture throughout the organisation by raising awareness of FtSU and other routes by which colleagues can raise concerns, tackling barriers to speaking up and by ensuring that issues raised are used as opportunities for feedback, learning and improvement continues to develop.

Graph 21 shows that 245 concerns were raised with the FtSUG Team from 1 April 2025 – 31 March 2026 compared to 217 in 2024/25. This is an overall increase of 12.90%. The number of concerns raised anonymously decreased in 2025/26 to 48 (19.59%) compared to 62 (28.57%) in 2024/25



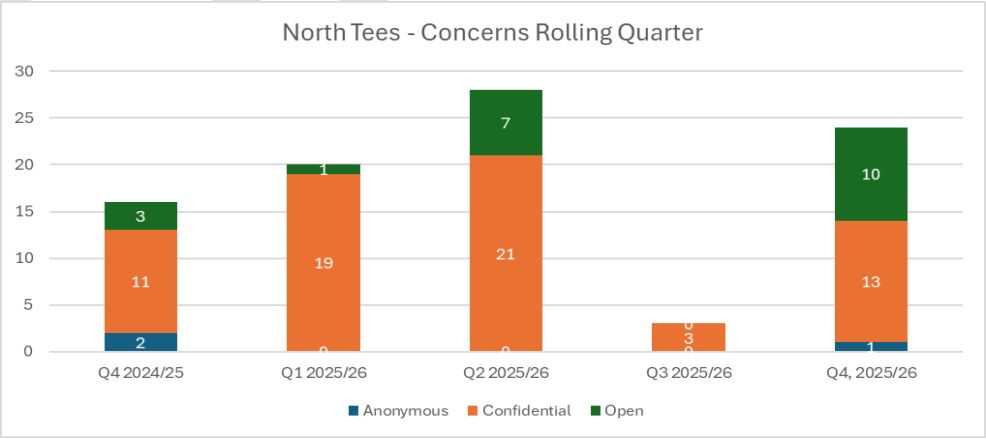
Graph 21 – FtSU concerns raised

Graphs 22 and 23 show the data broken down by South Tees NHS Foundation Trust (STHFT) and North Tees and Hartlepool NHS Foundation Trust (NTHFT).



Graph 22 – STHFT FtSU concerns

There was a decrease in reporting at STHFT in Q4, 2025/26 of 35.42%.

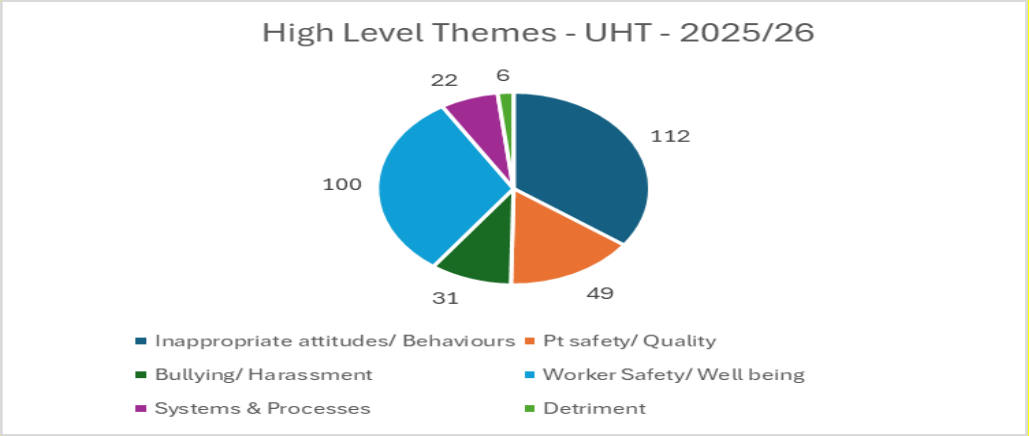


Graph 23 – NTHFT FtSU concerns

There was a significant reduction in reporting at NTHFT in Q3 2025/26 by 89%, but levels of reporting returned to normal levels in Q4.

Graph 24 below shows the high-level themes for UHT recorded against the concerns received in 2025/26 (*one concern can have a number of high-level themes*). Inappropriate

attitudes/behaviours was the highest reported detailed theme. This mirrors the national picture where it is the most reported concern for the 2nd consecutive year from NGO data 2024/25.



Graph 24 – High level themes UHT

Figure 9 provides a breakdown of the more detailed themes across UHT. It is worth noting that North Tees only started to report detailed themes in Q2 2025/26.

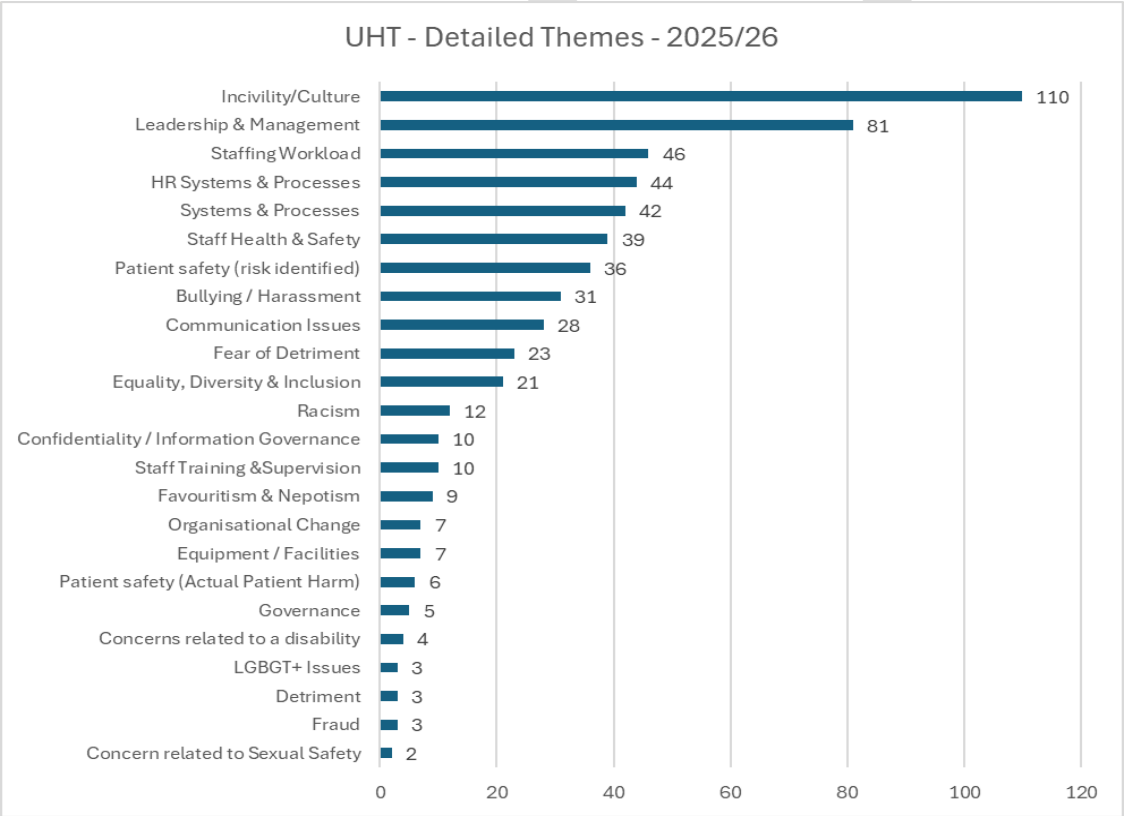


Figure 9 – Themes breakdown UHT

Proactive work

As part of the proactive work the FtSUG team continue to promote the role via promotional platforms, team meetings, floor walking, and ward visits maintaining a high presence across UHT sites. The team have also developed and provided workshops, student awareness sessions at university sites, trust welcome event, care certificate, international staff events, directorate, audit meetings and Speak Up week. The team complete regular peer reviews to ensure effective and consistent provision of the speak up service, triangulation of the annual staff survey is also completed to review the data complete focused walkabouts and events.

All modules of the FtSU e-learning “Speak Up”, “Listen Up” and “Follow Up” are available via the electronic staff record (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. FtSUG’s will be able to monitor compliance and triangulate this data alongside other sources of information to support focused work. The last available figures in August 2025 showed that 61% of staff had completed the three different elements of FtSU training since it went live in October 2024.

Every October the NGO, together with FtSU’s, leaders, managers and workers across the healthcare sector, celebrate Speaking up. This year the event was held over a week and worked to raise awareness of FtSU and make speaking up business as usual for everyone, with staff making pledges to how they will continue to support speaking up across the organisation.

The guardians have a focus on continued professional development as a team and individually. Over the past twelve months all four FtSUG have completed Restorative Practitioner Facilitator training. One guardian has completed a Coaching Apprenticeship Level 5 and another guardian is due to complete in 2026. One guardian is a mental health first aider and completed refresher training in Q2 2025.

The UHT FtSUG team attend regular regional network meetings to support with benchmarking, guardian support, national updates. A UHT FtSUG is a co-chair of the regional network.

Feedback

Feedback from some concern raisers across UHT is shown below:-

“I wanted to reach out to thank you for your support - it truly means a lot, as I feel it’s the only support I have right now”

“Thank you for your support, it really has helped me get my head (and my conscience) together.

Thank you again for your time, I feel as if a big weight has been lifted off my shoulders by speaking with you”.

“Happy for you to close the case, I've had no further issues. Thanks again for your help”.

“I am utmost grateful for your time and energy you put into this, I cannot thank you enough, I really appreciate you, thank you for the love, thank you for your care, thank you for your time thank you for giving me the chance to speak up”.

“Thank you for your support, really appreciated”

“Thank you for your support and signposting me to the appropriate team”

“Thank you for being so supportive and a great benefit for all of the team, following your discussions”

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. To align our services we have purchased the Healthcare Guardian (previously Inphase) app for FTSU and are on the schedule for this to be implemented for Quarter 2 (September 2026).
- A review of the Freedom to Speak up reflection and planning tool with the board. This is a useful self-assessment tool that will help us navigate our service both strategically and operationally, and to help us focus on key priorities within the new organisational structure.
- Continued development and expansion of the Freedom to Speak Up champion network across University Hospital Tees, through a fair recruiting process, as per National Guidance. Freedom to Speak Up champions are trained, can attend quarterly network meetings, can have informal bi–annual 1-2-1s and are asked to support staff and signpost and collect high level themed data for triangulation.
- Following the DASH review, the NGO is due to disband in June 2026. Conversations are still happening nationally to determine what the local, regional and national responsibilities will be with regards to speaking up. The guardians at University Hospital Tees will ensure that all recommendations are implemented.

Resident grade doctors rota gaps and plans to manage

Organisations are reminded that Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires: "a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account".

University Hospitals Tees remains firmly committed to delivering safe, effective, and sustainable medical staffing across all clinical services. Ensuring our resident doctors are supported through well-designed and resilient rotas is fundamental to this, enabling them to thrive in an environment that promotes high-quality training, personal development, and safe clinical practice.

Our rota governance processes are now well established with strong collaboration between departments, rota teams, Clinical Rota Leads, and the Chief Medical Officer's Office. We draw consistently on multiple sources of intelligence, including exception reporting trends, GMC National Training Survey outcomes, and feedback from both resident doctors and educational supervisors, to ensure early identification of pressures and timely, proportionate action. This collective approach places safety, wellbeing, and quality at the centre of our decision-making.

While rota gaps remain in a number of specialties, these are reflective of the broader national and regional workforce picture. Common factors include training programme vacancies, increased out-of-hours demand, work restrictions, and onboarding delays. Services continue to respond positively, using a combination of internal and bank locums, cross-cover arrangements, duty adjustments, and targeted recruitment to non-training roles. Our Locally Employed Doctors continue to play a vital role in supporting service stability in areas facing long-term training vacancies.

Current rota gaps:

Specialty	WTE gaps by rota tier		Mitigation
	North Tees	South Tees	
Anaesthetics	0.4 x Tier 1 3.5 x Tier 2	6.0 x Tier 1	Mix of Internal/bank locums and local recruitment to non-training posts, enhanced rota oversight and daily workforce huddles.
Acute Medicine	1.0 x Tier 1 1.0 x Tier 2		Internal and bank locums, adjustment of duties, and cross cover arrangements
Cardiothoracic Surgery	N/A	1.0 x Tier 2	Internal and bank locums, adjustment of duties, and cross cover arrangements
Colorectal	N/A	1.0 x Tier 1	Internal and bank locums, adjustment of duties, and cross cover arrangements
Diabetes & Endocrinology	0.2 x Tier 2		Internal and bank locums, adjustment of duties, and cross cover arrangements **Note:** 1 x Tier 1 North Tees training gap not included as back-filled by locally employed resident doctor.

Emergency Medicine	1.2 x Tier 1 4.6 x Tier 2		Internal/bank locums, adjustment of duties, and cross-cover arrangements
Ear Nose & Throat	N/A	1.0 Tier 1	Internal/bank locums, adjustment of duties, and cross-cover arrangements
Gastroenterology	0.3 x Tier 1	1.0 x Tier 2	Internal and bank locums, adjustment of duties, and cross cover arrangements
General Medicine - FHN	N/A	2.0 x Tier 2	Mix of Internal/bank locums and local recruitment to non-training posts.
Geriatric Medicine	1.4 x Tier 1 0.6 x Tier 2	1 x Tier 2	Internal and bank locums, adjustment of duties, and cross cover arrangements
Haematology	0.2 X Tier 2		Internal and bank locums, adjustment of duties, and cross cover arrangements
Neurology	N/A	1.0 x Tier 1	Internal and bank locums, adjustment of duties, and cross cover arrangements
Neurosurgery	N/A	1.0 x Tier 1 1.0 x Tier 2	Internal and bank locums, adjustment of duties, and cross cover arrangements
Obstetrics & Gynaecology	2.7 x Tier 1		Mix of Internal/bank locums and local recruitment to non-training posts. **Note:** 1 x Tier 2 North Tees training gap not included as back-filled by locally employed resident doctor.
Orthopaedics	1.0 x Tier 2		Mix of Internal/bank locums and rota/duties adjustment
Paediatrics	1.3 x Tier 1 3.4 x Tier 2	6.0 x Tier 2	Mix of Internal/bank locums and local recruitment to non-training posts.
Renal	N/A	2.0 x Tier 2	Mix of Internal/bank locums and rota/duties adjustment
Respiratory	0.6 x Tier 1 0.2 x Tier 2		Internal and bank locums, adjustment of duties, and cross cover arrangements
Stroke	1.0 x Tier 1		Internal and bank locums, adjustment of duties, and cross cover arrangements
Surgery	0.2 x Tier 2		Adjustment of duties and enhanced oversight by Clinical Rota Lead. **Note:** 2 x Tier 1 North Tees training gaps not included as

			back-filled by locally employed resident doctors.
Urology	N/A	2.0 x Tier 1	Internal and bank locums, adjustment of duties, and cross cover arrangements

Table 16 – Rota gaps

Across Emergency Medicine, Obstetrics and Gynaecology, and Paediatrics, less-than-full-time (LTFT) trainees consistently account for 50%-80% of the resident workforce. While LTFT arrangements support trainee flexibility, they also create operational pressures, particularly in rota design and sustainable service delivery. Their predominantly short-term nature (typically 6-12 months) further limits the ability to secure reliable backfill and maintain continuity. Growing variability in LTFT patterns continues to increase scheduling complexity.

Exception reporting remains an important tool in monitoring workload, contractual compliance, and the broader impact on education and training. The Trust was among the early adopters of the national improvements to reporting systems, making it simpler and more accessible for doctors to raise concerns. The rise in exception reports from August 2025 aligns with national expectations and reflects improved engagement and confidence in the process rather than a deterioration in working conditions.

Exception Reporting	**Aug 2024 – Jul 2025**		**Aug 2025 – Jan 2026**	
	North Tees	**South Tees**	North Tees	South Tees
Number of exception reports	202	537	299	1049
Exceptions marked as an immediate safety concern	4	14	7	14
Number of fines due to safe working hours breaches	15	27	28	28

Table 17 – exception reporting

The Guardians of Safe Working provide regular assurance to the People's Committee and other professional forums, with discussions between Resident Doctors, BMA representatives, and the Chief Medical Officer's Office remaining constructive and focussed on shared solutions. Guardian funds accrued through fines (£3,060 North Tees, £2,713 South Tees) will be reinvested to further strengthen doctor wellbeing and the training environment.

Rota performance continues to be monitored through a triangulated approach, ensuring timely action, promoting staff wellbeing, and supporting a safe, consistent learning environment in line with national standards.

To continue strengthening our medical workforce and improving the experience of our resident doctors, we will progress a number of strategic priorities:

- Enhancing rota forecasting and performance reporting
- Embedding routine, specialty-level rota reviews
- Advancing the rollout of a unified e-rostering and exception-reporting platform across University Hospital Tees

These improvements will enhance data quality, increase visibility of service pressures, and support more proactive workforce planning. Above all, they reinforce our commitment to providing a safe, supportive, and high-quality learning and working environment, fully aligned with our organisational values.

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

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

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 overview and 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 2026 Derek Bell, Chairman

27 June 2026 Stacey Hunter, Chief Executive

13. Annex 3: Glossary of terms

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

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.

Clinical Service Unit
A clinical management structure adopting a leadership approach of director of clinical services, nursing services and operations underpinned by clinical and nursing leads for each specialty

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.

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.

Eolas
A mobile app and storage platform of hospital specific guidelines, protocols and medial resources.

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.

Getting it Right First Time (GIRFT)
A national NHS programme aimed at improving patient care and efficiency by reducing unwarranted variations in clinical practice across hospitals

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.

Healthcare Guardian
An electronic incident and risk management system.

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.

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.

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 Research (NIHR)
The NIHR (National Institute for Health Research) funds health and care research and translate discoveries into practical products, treatments, devices and procedures, involving patients and the public in all our work. NIHR ensure the NHS can support the research of other funders to encourage broader investment in, and economic growth from, health research. NIHR work with charities and the life sciences industry to help patients gain earlier access to breakthrough treatments, and train and develop researchers to keep the nation at the forefront of international research.

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

NHS England Standard Contract objectives
The NHS Standard Contract includes mandatory quality requirements for NHS trusts to minimize Healthcare-Associated Infections (HCAIs), specifically targeting Clostridioides difficile (C. difficile), MRSA and Gram-negative bloodstream infections (GNBSIs) to thresholds set by NHS 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.

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.

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.

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.

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.

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.

Structured Judgement Review (SJR)
A tool used to evaluate the quality of care provided to patients, particularly in the context of mortality reviews.

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.

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.

University Hospitals Tees

A hospital group formed with South Tees Hospitals NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust with one unitary Board.

Member Report
University Hospitals Tees (UHT) - Planned Workforce Reductions
Report to: Tees Valley Joint Health Scrutiny Committee
Report from: Democratic Services
Decision Type: Committee

HEADLINE POSITION

1. Summary of the report

1.1 The Tees Valley Joint Health Scrutiny Committee is receiving a presentation from University Hospitals Tees (UHT) on its planned workforce reductions as part of its Medium-Term Financial Plan.

1.2 The presentation outlines the national and local context, the scale of proposed workforce reductions, and the principles being applied to ensure patient safety and service sustainability. [

2.0 Recommendation

2.1 It is recommended that Members note the information presented and consider the issues raised within the presentation.

3.0 Background

3.1 UHT has identified a requirement to deliver significant cost improvements over the next three years, with staffing costs forming a substantial proportion of overall expenditure. Planned workforce reductions are intended to support financial sustainability while maintaining safe and effective services.

3.2 The Trust has indicated that reductions will be aligned with service redesign, productivity improvements and voluntary workforce measures, supported by engagement with staff and trade unions. Representatives of UHT will be in attendance to present the information and respond to Members' questions.

4.0 Background Papers

4.1 There are no background papers to this report.

5.0 Contact Officers

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NHS
University Hospitals Tees

University Hospitals Tees planned workforce reductions

Tees Valley Joint Health Scrutiny Committee

2 June 2027

Matt Neligan, Deputy Chief Executive and Chief Strategy Officer

Caring Better Together

National and strategic context

- **National economic pressures.** Persistent challenge across the UK with communities feeling this via increased cost of living and instability in broader job market.
- **The NHS contribution.** NHS is a significant proportion of public sector spend with direct impact on the economy and costs rising at an unsustainable level
- **Declining productivity.** Activity being delivered across the NHS in England is broadly similar to pre COVID 19/20 level but there has been a significant expansion of staff since 2019/20
- **Public satisfaction and confidence in the NHS** is low – imperative this is restored through continued improvements in waiting times, patient experiences
- **Life expectancy** is flat over the last decade (first time not increased in over 100yrs) despite 40% more staff in the NHS. The number of years living in ill health is up over the last decade.
- **Requires a reset.** Consensus need to shift to a more proactive care model aligned to the government's 10 Year Health Plan along with a financial reset across the NHS.
- **Industrial relations** presents further challenge. Multiple professional groups have taken industrial action over the last two years. Resident doctors 15 strikes to date.

UHT financial and workforce challenge

- UHT workforce growth since 2019/20 is 2,833 whole time equivalents (wte), comprising 843 at NTH and 1,990 at STH)
- The growth broadly breaks down evenly between (1) additional commissioned work; (2) planned increases to address specific quality and safety issues; (3) COVID / other workforce increases
- The Medium-Term Financial Plan for UHT is an ambitious plan to return to financial sustainability. Both trusts had to offer a break even plan in each of the three years
- **From 26/27, we must deliver:**
  - Cost improvement of around **5.9%** year on year across clinical and corporate services
  - Totalling **£250m over 3 years**
  - Of which **£90m cost improvement programme (CIP) in 26/27**
  - Circa 65% of costs relate to staffing
  - Clear requirement to reduce headcount. **558 wte in 26/27**
  - **This includes a programme of Voluntary Redundancy**

Productivity and workforce

- As a headline, both trusts benchmark as the most productive in the North East
- However to deliver the performance and outcomes we want for our population, within our financial resources, we need to seek out and demonstrate productivity improvement wherever there is opportunity.
- The greatest opportunity is in reducing the cost of elective care

Improving use of PIFU will free up 2,900 appointments a month

- Model Hospital and GiRFT benchmarking identifies our opportunities at specialty level
  - Reducing DNAs
  - Reducing New: Review ratio with more use of PIFU
  - Improving theatre utilisation
  - Best practice in day surgery rates
  - Reducing length of stay
- Horizontal integration unlocks new ways of working and fresh perspective on service models to meet demand safely and effectively

Reducing DNA rates will free up 1,200 appointments a month

- We are committed to workforce productivity improvements
  - Reduce use of bank by 10% year on year
  - Reduce use of agency by 30% year on year
  - Support for sickness absence management reduction towards national ambition of 4.1% (our target is 5.5% initially)
  - Reduce our WTE worked to sustainable levels to deliver our cost improvement plan
  - Maintaining and improving quality and safety of services is the overriding priority

Planned workforce reductions in 2026/27

- **Baseline workforce position.** UHT employs around 15,100 staff (c.9,600 at STH and c.5,500 at NTH).
- **Workforce reduction.** A total of 558 WTE posts will be reduced during 2026/27.This represents around 3.7% of our workforce.
- **Alignment with Service Plans.** Reductions are aligned with service redesign, vacancy assumptions, and voluntary exits for realistic delivery, with safe and effective reduction decisions.
- **Stakeholder Engagement.** Comprehensive engagement with staff, unions, and leaders to ensure safe and supported implementation.
- **Guiding principles agreed.** These include prioritising patient safety, delivering through voluntary workforce reductions initially, return on investment, and collaborative decision-making.
- **Digital and corporate services.** A proportion of workforce reductions will be delivered through digital transformation and corporate services redesign, including automation, process standardisation and consolidation of support functions, enabling sustainable WTE reductions without adverse impact on frontline services.
- **Clinical services transformation.** Further workforce reductions will be achieved through clinical consolidation and integration of services as the clinical strategy is implemented, reducing duplication, improving flow and enabling more efficient deployment of clinical and support staff while maintaining safe patient care.
- **Voluntary redundancy (VR) scheme.** Launched in May to qualifying staff. Application period for voluntary redundancy ends on 1 June 2026 and continues to run in parallel with the current vacancy freeze and ongoing cost improvement plans.

Turnover and sickness

- **Workforce turnover rate.** The current turnover rate is 7.1%, indicating a relatively stable workforce compared to NHS standards. Natural turnover is deliberately leveraged to manage workforce size and reduce redundancies effectively.
- **Executive vacancy review.** Vacancies undergo executive scrutiny assessing affordability, service impact, and alignment with future models and strategy.
- **Sickness absence impact.** Sickness absence is 6.5%, posing a productivity challenge but also offering improvement opportunities. The plan assumes a 1% decrease in sickness absence, lowering rates from 6.5% to 5.5%, reflecting measurable goals. Reduction assumption is backed by specific actions and management focus, including early intervention and case management to reduce sickness absence and new sickness policy.
- **Workforce planning integration.** Turnover and sickness metrics are actively integrated into workforce planning to manage vacancies and improve capacity.

Thank you

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Member Report
(TEWV) Adult Eating Disorders Services Review Update
Report to: Tees Valley Joint Health Scrutiny Committee
Report from: Democratic Services
Decision Type: Committee

HEADLINE POSITION

1. Summary of report

1.1 The Tees Valley Joint Health Scrutiny Committee is receiving a presentation from Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust on the review of Adult Eating Disorder services across the North East and North Cumbria.

1.2 The presentation outlines current service provision, the rationale for reviewing the model of care, and potential future changes to improve outcomes and ensure an appropriate balance between inpatient and community-based services.

2. Recommendation

2.1 It is recommended that Members note the information provided and consider the issues raised within the presentation.

3. Background

3.1 Adult Eating Disorder services are delivered through a provider collaborative between TEWV and Cumbria, Northumberland, Tyne and Wear (CNTW) NHS Foundation Trusts. A review has commenced to assess the current pathway, including inpatient, day and community provision, and to identify opportunities for improvement.

3.2 The review is informed by trends showing reduced demand for inpatient care, increased use of community-based alternatives, and national guidance promoting early intervention and least-restrictive care. Engagement is ongoing with patients, carers, staff and partners to shape future service models.

3.3 Representatives from TEWV NHS Foundation Trust will be in attendance to present the review and respond to Members' questions.

4. Background Papers

4.1 There are no background papers to this report.

5. Contact Officers

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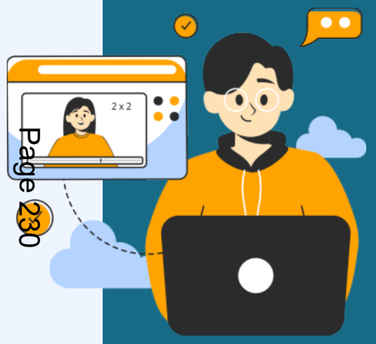
NHS
North East and North Cumbria
Mental Health, Learning Disability and Autism Partnership

Adult Eating Disorders

A review of services

Background



Adult eating disorder services across the North East and North Cumbria are provided by a Provider Collaborative between our trust and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW).

Recent service data shows a sustained reduction in demand for inpatient care alongside increased use of community based and intensive alternatives.

Formal engagement process has commenced to review the pathway and model of care – to understand what is working well, what could improve, and ensure the right balance between inpatient and community-based care.

Engagement involves people with lived experience, families and carers, staff and partners through surveys, workshops, events and data review.

Why we are reviewing our services

Demand for inpatient admissions has reduced significantly in recent years, with bed occupancy reducing from 97% in 2022/23 to 80% in 2023/24, following investment in intensive day services.

The planned closure of Ward 31A at the RVI creates an opportunity to re-evaluate the balance between inpatient, day and community services.

National guidance supports early intervention, least-restrictive care, and strengthening community-based treatment.

There is variation in access and provision across the region, particularly for Cumbria.

The current service

Inpatient Services – covers TEWV and CNTW areas

- Commissioned inpatient capacity: 20 beds
- Ward 31A – Newcastle: 5-bed ward will close on 31 July
- Birch ward – Darlington: 15 commissioned beds, of which 10 are currently operational

Intensive Day Services (IDS)
We provide structured intensive day hospital programmes:
IDS Newcastle – Monday to Friday (8.30-18.00)
IDS Stockton – Monday to Friday (8.30-18.00)

These services offer therapeutic support, structured meal support, dietetics, occupational therapy and psychological treatment as an alternative to admission or as step-down from inpatient care.

IDS at Home (Outreach)
We also deliver IDS at Home, an outreach model providing intensive support within people's homes.

What we know

Location

15 beds at Birch ward, Darlington
5 Beds at 31A, Newcastle

Intensive Daycare Services (IDS)

An investment of approximately £2.6 million in intensive day services, has coincided with reduced bed occupancy

1

Admissions

Admissions to hospital are below current commissioned capacity.

2

3

Weekend Provision

Community, day hospital and outreach services operate Monday–Friday only and service differences exist in Cumbria

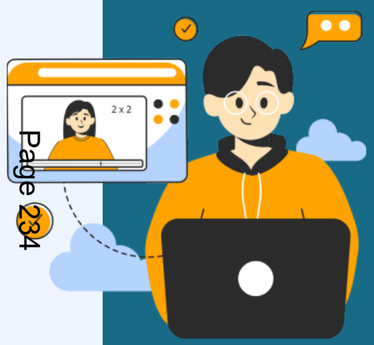
4

5

Forward Planning

Work underway will help us to understand if the number of beds could be safely reduced.

What changes are we considering?



Rebalancing inpatient and community provision. This includes using feedback and bed modelling data from the past five years to safely reduce the number of inpatient beds.

Strengthening community and intensive home-based services, including exploring a seven-day provision.

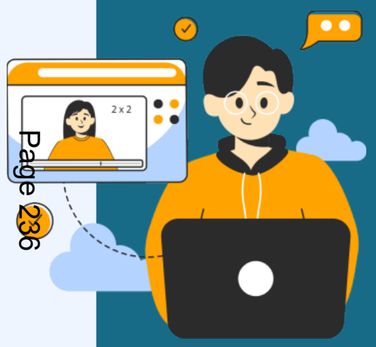
Expanding intensive day services and intensive day services at home as effective alternatives to admission, exploring a seven-day provision.

Addressing the variation in service provision across the region.

What are we asking as part of the engagement?

1. What matters most to you?
2. Is the balance between inpatient and community care, right?
3. To what degree would a stronger seven-day community, or intensive home-based support reduce the need for hospital admission?
4. What support would need to be in place outside hospital, to make recovery in the community feel safe and achievable
5. What would help ensure eating disorder services are fair and accessible for people across the North East and North Cumbria?

Timeline



Listening and evidence gathering: now – Summer 2026

Development of a case for change: Summer 2026

Trust and ICB review: late Summer/Autumn 2026

Options appraisal and further decision making: Autumn 2026 onwards

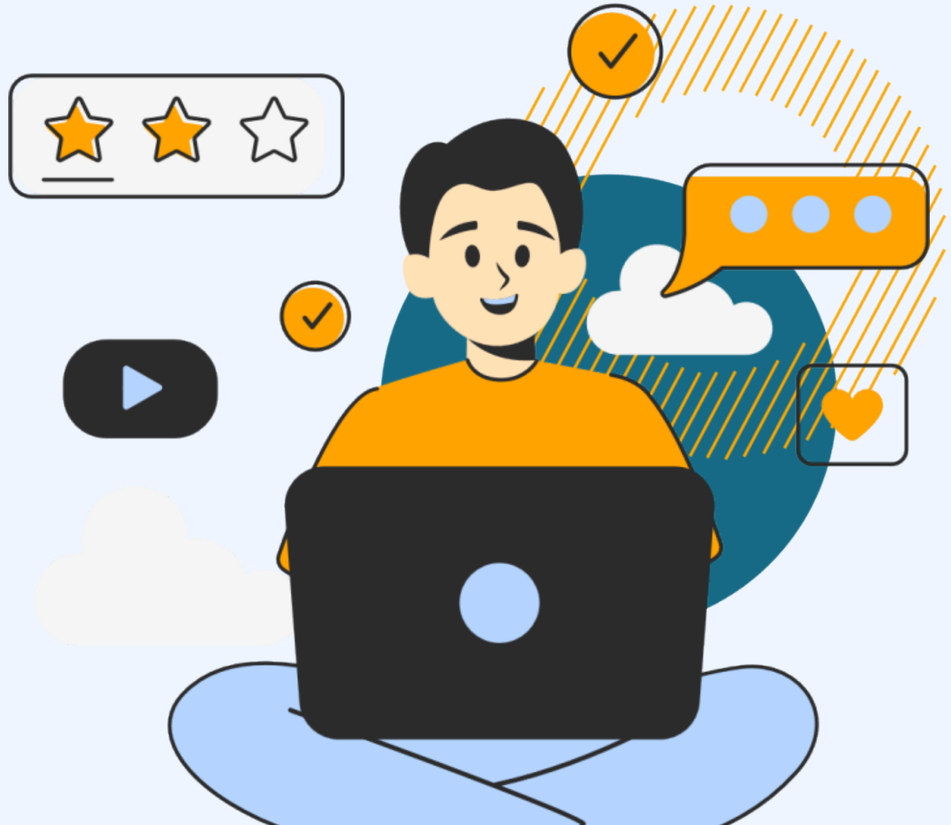
Key assurance for scrutiny committee members

No decisions on service changes have been made at this stage.

Patient safety, access to inpatient care when clinically required, and equitable services across the region remain core principles.

Committee members will be kept informed as engagement outcomes and future consultation proposals progress.

Thank You



Member Report
Tees Valley Joint Health Scrutiny – Draft Work Programme 2026-2027
Report to: Tees Valley Joint Health Scrutiny Committee
Report from: Democratic Services
Decision Type: Committee

HEADLINE POSITION

1. Summary of report

1.1 The Committee is required to consider and agree its work programme for 2026-2027. Members may also like to consider adding any additional items to the work programme.

2. Recommendation

2.1 It is recommended that Members consider and agree the contents of the work programme and consider any additional areas of work they may wish to include.

3. Background

3.1 Members are requested to consider the attached work programme for the 2026-27 Municipal year. The work programme includes standing items as well as those that have been prepared based on Officer recommendations and recommendations previously agreed by this Joint Committee.

4. Background Papers

4.1 There are no background papers to this report.

5. Contact Officers

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TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME 2026-2027

Meeting Date	Topic	Attendance
2 June 2026	TVJHSC: Appointment of Chair & Vice Chair	
	TVJHSC: Protocol / Terms of Reference TVJHSC	
	Delivery of Neonatal Care across North East and North Cumbria Region	Dr Sundeep Harigopal, Clinical Lead of Northern Neonatal Network and Consultant Neonatologist at Newcastle Hospitals Charlotte Bradford, Network Manager, Northern Neonatal Network Catherine Balazs, Head of Specialised Commissioning, North East North Cumbria, NHS England Yasmin Sultana Khan, Service Specialist, Specialised Commissioning, North East and North Cumbria, NHS England
	University Hospitals Tees NHS Draft Quality Account	Matt Neligan, Deputy Chief Executive and Chief Strategy Officer Judith Connor, Deputy Director for Quality Amy Oxley, Deputy Director of Nursing
	University Hospitals Tees - Planned Workforce Reductions	Matt Neligan, Deputy Chief Executive and Chief Strategy Officer Jamie Todd, Director of Operations and Transformation
	Adult Eating Disorder Services Review – TEWV	Shaun Mayo, General Manager of Adult Mental Health Planned Care
	Work Programme Timetable	
23 July 2026	University Hospitals Tees (UHT) Pre-Consultation Business Case	TBC

1 October 2026		
10 December 2026	University Hospitals Tees (UHT) Pre-Consultation Business Case	TBC
4 March 2027	Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) - Quality Account North East Ambulance Service (NEAS) Quality Account	TBC TBC

Items for brought forward for consideration from 2025/26:

- Low Level Needs
- Vaping Legislation follow up (information item only)
- Maternity Mental Health Service
- Recruitment and Retention Planning (ICB)
- Chronic Pain Services – Paula Swindale
- NHS England: CQC: Update
- The impact of waste incinerators on health