Middlesbrough
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Legal and Governance

PEOPLE SCRUTINY PANEL

Date: Monday, 10 June 2024
Time: 4.30 p.m.
Venue: Mandela Room, Town Hall

AGENDA

1. Apologies for Absence

2. Declarations of Interest

3. South Tees NHS Foundation Trust - Quality Account for 2023/2024 — 3 - 86

   Representatives of the South Tees NHS Foundation Trust will be in attendance to present the Trust's draft Quality Account for 2023/2024.

4. Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust - Quality Account for 2023/2024 — 87 - 168

   Representatives of TEWV NHS Foundation Trust will be in attendance to present the Trust's draft Quality Account for 2023/2024.

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

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall
Middlesbrough
Friday, 31 May 2024

MEMBERSHIP

Councillors E Clynch (Chair), J Walker (Vice-Chair), J Banks, L Hurst, D Jackson, M McClintock, J McConnell, J Nicholson, M Nugent, S Platt, J Ryles, S Tranter and G Wilson.

Assistance in accessing information

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

South Tees Hospitals
NHS Foundation Trust

Quality Account 2023/2024

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1. Statement on quality from the chief executive of the NHS foundation trust DRAFTED. NEEDS APPROVAL BY SH

I am pleased to introduce the 2023/24 Quality Account as Chief Executive of South Tees Hospitals NHS Foundation Trust.

As a clinically led organisation the safety and wellbeing of our patients, service users and colleagues - underpinned by our commitment to clinical research, innovation and training - is at the heart of our mission. Our clinicians lead by the way they manage our resources and deliver safe, quality care across our hospitals and services – aided by the experience, professionalism and skills that exist across our clinical and support areas.

It has been another challenging year for the NHS as we continue our recovery from the COVID-19 pandemic while also putting contingency plans in place for ongoing periods of industrial action. With this in mind, I would like to make a special point of thanking all our amazing clinical and non-clinical teams for their continued support, dedication and professionalism.

In May 2023, South Tees Hospitals became one of the first acute hospital trusts in England since the start of the COVID-19 pandemic, to achieve a rating improvement to 'Good' from the Care Quality Commission (CQC) for the care delivered to patients and service users.

When the CQC inspects hospital trusts, the care regulator also reviews whether they are safe, caring, effective and responsive to people's needs, and the trust achieved an overall 'Good' rating in each area. Over the last four years, our experienced clinicians have laid the foundations of a trust where safety and quality are put first, where colleagues feel empowered to make improvements for their patients and service users, where funding is used to invest in the things that experienced clinicians agree will make the biggest difference for the people we serve, and where influence to make positive changes beyond hospital walls is being exercised.

This has only been strengthened further by the formation of our hospital group with North Tees and Hartlepool NHS Foundation Trust in 2024 which will support both organisations' shared goals for our patients, service users and colleagues by formalising the way we already work together in the interests of the people and communities we have the privilege to serve.

The group model means that the two organisations remain separate, so they can represent their communities really effectively, but it has the flexibility to enable the trusts to work at scale to take strategic decisions which benefit the group as a whole and the patients we serve.

To the best of my knowledge, the information contained in this Quality Account is accurate.

Stacey Hunter

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

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 2023/24

The Quality Account provides an opportunity for the Trust to reflect on its achievements over the last 12 months. This includes a look back at the progress made against the quality priorities for 2023/24 that were defined in the 2022/23 Quality Account and are summarised in the table below.

Quality Priorities 2023/24		
Patient Safety	**Clinical Effectiveness**	**Patient Experience**
We will continue to develop a positive safety culture, in which openness, fairness and accountability is the norm.	We will ensure continuous learning and improved patient care from GIRFT and clinical audits.	We will implement the Patient Experience Strategy that has been developed in collaboration with our patients, careers and Healthwatch.
We will continue to optimise the Trust's ability to learn from incidents, claims and inquests to improve outcomes for our patients.	We will strengthen the mortality review processes, ensuring learning from deaths is triangulated and shared.	We will develop and implement a Mental Health Strategy to improve care and share learning for our patients who have mental ill health.
We will increase medication safety and optimise the benefits of ePMA.		We will develop and implement shared decision making and goals of care.

Our ambition for improvement, agreed actions, aims and progress at the end of 2023/24 for each quality priority are detailed below.

Patient safety quality priorities

1. Positive safety culture. COMPLETE

It is widely recognised that staff need to feel psychologically safe to proactively raise and discuss patient safety issues, knowing that they and everyone involved will be treated fairly. They need to feel supported in a restorative way and empowered to learn when things do not go as expected, rather than feeling blamed, to ensure effective organisational learning and prevention of future incidents of avoidable harm. A restorative, just and learning culture is a learning approach to dealing with adverse events, which focuses on harm done rather than blame. The approach recognises that people make mistakes, while ensuring people are held accountable for their decisions. It aims to repair trust and relationships damaged after an incident. It allows all parties to discuss how they have been affected and collaboratively decide what should be done to repair the harm.

The aim of this work was to continue to develop a positive safety culture in which openness, fairness and accountability is expected.

Aims

We planned to:

- Embed a restorative, just and learning culture across the organisation.

- Train 50 key staff in restorative practice.
- Develop a new process and documentation for 'The South Tees Resolution Pathway' to support consistent, constructive, and fair evaluation of the actions of staff involved in incidents.

We aimed to achieve the following measures of success:

- An increase in the percentage of staff agreeing with the question "I would feel secure raising concerns about unsafe clinical practice" in the annual NHS staff survey to above 74%.
- 50 Trust staff completing the restorative practice training during 2023/24.

Progress

Since April 2023, 75 Trust staff have attended Restorative Practice Facilitator 3-day training programme, which has been evaluated very positively. There is a further cohort planned for September 2024. Elements of this training have also been added to the Trust's Manager's Essentials programme to continue to raise awareness of the importance and benefit of an organisational restorative and just culture. In addition, STRIVE colleagues have used their expertise in learning and education to run patient safety learning days, demonstrating an appropriate organisational response to safety events, supporting a positive reporting culture, and building safety learning into leadership development.

Work to embed a restorative, just and learning culture continues within the organisation. The South Tees Way Resolution Pathway has been developed to support staff following any adverse event, including patient safety incidents. The pathway supports the development of a proportionate outcome through open, constructive, and restorative conversations and has now been implemented into practice.

The percentage of staff agreeing with the question "I would feel secure raising concerns about unsafe clinical practice" decreased in the 2023 staff survey results to 71%. Whilst this remained above the national average the result was disappointing, although at the time of the staff survey (October 2023) this work was still in its early stages. Reassuringly, Trust incident reporting figures have remained consistent from 2022/23 (29,318) and 2023/24 (29,278). Analysis of the data showed many areas within the Trust scored well above 74%, with a small number scoring below which has reduced the overall Trust score. This suggests opportunities for targeted work during 2024 and this work will continue into 2024/25.

Summary and plans for ongoing work

There has been considerable good work done during 2023/24 with increasing staff awareness of the importance of an organisational restorative, just and learning culture. We have also implemented resources to support staff and facilitate a proportionate outcome following an adverse event through open, constructive, and restorative conversations.

There is more work to be done to embed this work throughout the organisation and to develop a positive safety culture in which people feel confident that openness, fairness, and accountability is expected.

2. Learning from incidents, claims and inquests. COMPLETE

The NHS Patient Safety Strategy (2019) describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. It notes that an organisation that identifies, contains, and recovers from errors as quickly as possible will be alert to the possibilities of learning and continuous improvement.

It introduced the Patient Safety Incident Response Framework (PSIRF) to replace the previous Serious Incident Framework. This 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.

Through the implementation of the PSIRF, we will improve our ability to triangulate learning from a range of sources, ensuring the Trust has the appropriate skills, experience, and knowledge to undertake system based and proportionate learning responses and sufficient quality improvement (QI) resource to ensure changes are embedded into practice and sustained. This will continue to optimise the Trust's ability to learn from incidents, claims, and inquests to improve outcomes for our patients.

Aims

We planned to:

- Continue our PSIRF implementation journey.
- Ensure proactive management of incidents across the Trust.
- Expand our mediums for sharing learning across the Trust, including examples of learning from good practice.

We aimed to achieve the following measures of success:

- A sustained reduction in the number of incidents logged on the Datix incident management system that remain open, which means that actions and learning have not been completed.
- Improvements in practice following patient safety incidents that can be demonstrated by audit.
- An increase in staff agreeing with the question "I am confident that my organisation would address my concern" in the annual NHS staff survey above 58%.

Progress

The Trust successfully implemented PSIRF on 29 January 2024, with colleagues engaging positively in relevant education and training as set out within national standards. The Trust also went live with the national Learning from Patient Safety Events (LFPSE) reporting platform on 20 November 2023 and incident reporting levels have remained consistent.

Work is ongoing to meet the training requirements of PSIRF and the National Patient Safety Syllabus. Oversight training for senior leaders and the Board has been arranged and plans are in place to introduce Level 1 Patient Safety Training to all staff as part of an e-learning mandatory training course. Accredited external investigation training was arranged for key colleagues to attend in March 2024.

There has been focused work throughout the year to reduce the number of historical open incidents held on Datix and to ensure that new incidents reported are reviewed, actioned and closed in a timely way. Approximately 2500 incidents are reported monthly within the Trust, and at the beginning of 2023 there were 2655 incidents open on the system, indicating that the management of incidents was not always timely. At the end of March 2024, this has reduced to 1537 open incidents (see figure 1). Work continues to ensure effective incident management processes within the organisation.

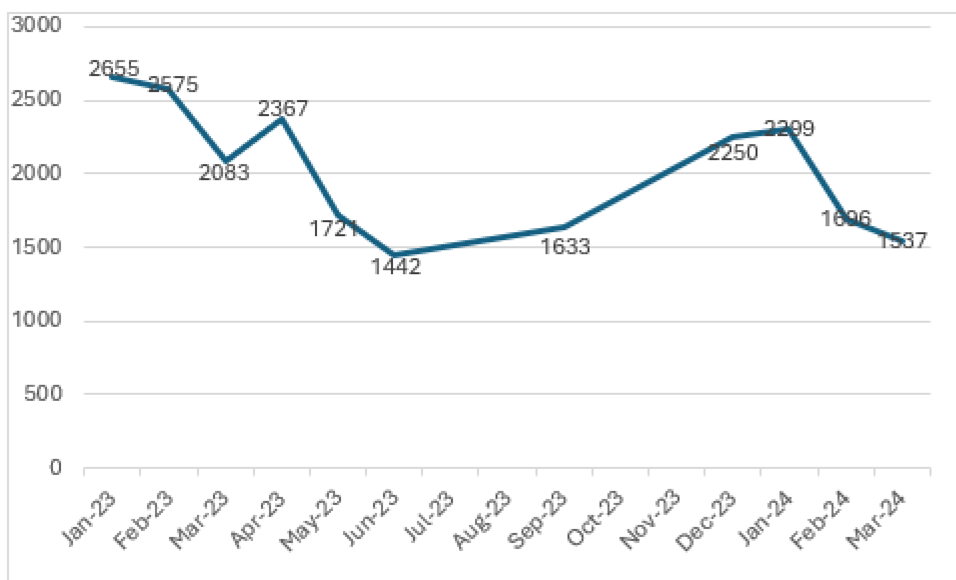


Figure 1: Number of open incidents on Datix January 2023 – March 2024.

Work is planned to produce quarterly reports from patient safety, patient experience, and clinical effectiveness data to triangulate information and identify themes to influence local and Trust wide actions and learning. The Trust Patient Safety Partners are to assist in an audit programme of key safety metrics. Demonstrating improvements in practice following safety incidents using audit is a key part of ensuring learning has been embedded.

There is ongoing work to develop new ways to share the learning from incidents but in the last 12 months:

- A library of completed serious incidents and significant learning events has been developed and is now available on the intranet for all staff. The library enables staff to review incidents and associated learning across the organisation.
- Multidisciplinary team learning events have been introduced that focus on an incident or series of incidents where significant learning has been identified. They provide a facilitated arena for discussion and sharing of learning between different professionals and teams.

The percentage of staff agreeing with the question "I am confident that my organisation would address my concern" decreased in the 2023 staff survey to 54%, which was disappointing. Data analysis confirms many areas within the Trust scored well above 58%, with a small number scoring below which has reduced the overall Trust score. This suggests opportunities for targeted work during 2024.

Summary and plans for ongoing work

There has been good progress with the aims of this work but there is more to do to embed PSIRF in the organisation, to achieve all the measures of success, and to demonstrate quality improvement outcomes. This work will continue as a quality priority into 2024/25.

We are planning to develop learning videos arising from safety events which will be linked to role specific training and monitored on ESR. We will be developing joint work with North Tees to share experience and align the adoption of the PSIRF model and will reflect on the internal reporting of PSIRF outcomes including to the Board.

3. Medication safety and optimising the benefits of ePMA. COMPLETE

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

30% reduction in medication errors compared to traditional methods, and a similar reduction in patient adverse drug events.

We are working to increase medication safety and optimise the benefits of ePMA. The implementation of ePMA in the Trust commenced in June 2022, starting on the Older Persons Medicine Ward and since then it has been gradually rolled out more widely, engaging with each of the clinical teams along the way to ensure patient safety (see figure 2). ePMA is currently live using the Better Meds system on 51 inpatient wards and clinical areas, with work ongoing to implement this within Outpatients and the Neonatal Unit. Theatres have also gone live with the CHA-A system which is also due to be implemented in Critical Care for infusion medication in 2024/25.

Aims

At the beginning of 2023/24 we planned to:

- Reduce the numbers of omitted doses of prescribed medications. These are prescribed doses of medicine that are not given. The aim was to ensure the reason for omission was recorded, and the reason for omission was addressed quickly and appropriately, e.g. when a drug was not available on the ward, this was sourced from the emergency drug store or Pharmacy, particularly in relation to critical medicines.
- Improve antimicrobial stewardship across the organisational to promote and monitor the judicious use of antimicrobials to preserve their future effectiveness. Antibiotic stewardship is the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients.
- Improve the quality of prescribing medications.
- Reduce allergy related incidents.
- Improve the recording of venous thromboembolism (VTE) risk assessments and appropriate prescribing of medication to address the identified risk. See section 2.3 for further information about VTE risk assessments.
- Increase compliance with prescribing based on the Trust formulary.
- Improve the standardisation of prescribing.
- Improve cost-effective prescribing.
- Improve medicines reconciliation by prioritising patients at highest risk. This is the process undertaken by pharmacists to compare a patient's medications prescribed in hospital to the medications that the patient has been taking prior to admission. This is to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

Progress was to be monitored by:

- Regular audits including the monthly omitted doses audit, antimicrobial prescribing audit, prescribing audit (including insulin), allergy status review, and the Clinical Pharmacy intervention audit.
- Compliance with the Commissioning for Quality and Innovation (CQUIN) indicators for 2023/24.
- Evaluating prescribing and administration incidents recorded in the Datix incident management system.
- Reviewing VTE assessment dashboards.
- Reviewing the contract variance report which monitors compliance with national medicines contracts and enables oversight to ensure prescribing practices are within the Trust formulary.
- Reviewing progress with achieving cost improvement schemes by optimising the benefits of ePMA to monitor prescribing practices.

Progress

Achievements have been reported quarterly to the Trust’s Safe and Effective Care Strategic Group and the Quality Assurance Committee, and have included the following headlines:

- 100% compliance with documentation of allergy status.
- Zero transcribing errors on discharge for ePMA wards. This was previously 24% when medications had to be transcribed from a paper chart to the electronic discharge system.

- Improvement in VTE prescribing from >1% non-compliance to <0.2% non-compliance.
- 17% reduction in prescribing errors in the following domains: incorrect time or frequency, incorrect dose, and incorrect route of administration.
- Improvement in prescribing in line with clinical guidelines.
- Reduction in drug interaction interventions.
- Improvement in antimicrobial stewardship indication documented from 82% to 94%.
- Improvement in antimicrobial review date documented from 76% to 100%.
- Improvement in insulin prescribing compliance with policy from 25% to 100%.

Figure 2: Ward 11 ePMA Go-Live Day

Further achievements include an interactive dashboard that shows omitted doses of medications has been developed, implemented, and presented at the senior nursing forums. It empowers staff to review their own areas, take actions to address the reasons recorded for the omitted doses, and therefore to improve compliance with the administration of prescribed medication. There has been some targeted work to ensure the reason for the omission is documented. A reduction in critical omitted doses was seen from 4.7% in July 2023 to 3.6% in August 2023 and this has been maintained.

Utilising an antimicrobial dashboard has helped South Tees achieve the quarter 1 CQUIN target of <40% for switching intravenous antibiotics to oral formulations when this is appropriate for the patient, and a further significant improvement to 9% for quarter 3.

A Parkinson's disease medicines dashboard has been developed and is currently being validated before sharing with wider organisation.

There has been a cost saving of £182,000 from reduction in waste, and duplication of prescribing and ordering, and a further saving of £149,000 for IV to oral antimicrobial switch.

Work has also been focused on developing, configuring, and implementing ePMA in some areas of the Trust that require specific solutions e.g. Critical Care and the Neonatal Unit.

Summary and plans for ongoing work

There has been significant progress with the work on medication safety and optimising the benefits of ePMA during 2023/24 which will continue to provide benefits to patients and the Trust. The senior pharmacy team are continuing to optimise the benefits of ePMA, working with the supplier to develop the system and visiting other organisations to ensure maximum utilisation of the system dashboards.

Other ongoing work includes:

- Development of an audit report of VTE prophylaxis assessments compared with prescribing practices.
- The informatics team working with the supplier to purchase an additional package which will improve the reporting between e-prescribing and electronic noting.
- Testing of the new version of Better Meds which will improve oxygen prescribing and provide further improvements for the clinical pharmacy team including a pharmacist task list which will improve pharmacist efficiency.
- Further improvements in medicines reconciliation documentation which will be implemented after MIYA noting is implemented across the organisation.
- Ongoing discussion with Critical Care to implement Better Meds for non-infusion medication.

Clinical effectiveness quality priorities

1. Learning from GIRFT and clinical audits COMPLETE

This quality priority aimed to improve internal clinical effectiveness processes to ensure effective and continuous learning, particularly from Getting It Right First Time (GIRFT) and clinical audits, to provide patients with the best possible clinical outcomes.

GIRFT is a national programme designed to improve the treatment and care of patients through in-depth reviews of services, benchmarking, and a data-driven evidence base to support change. GIRFT is part of an aligned set of programmes within NHS England and has the backing of the Royal Colleges and professional associations. The reviews of specialties are clinically-led, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians, who examine current practice and suggest recommendations for improvement. The clinicians carrying out the reviews are peers of those delivering the service within the Trust. This mutual understanding helps to ensure achievable recommendations that reflect the unique circumstances of the speciality.

Clinical audit is a quality improvement tool for evaluating and improving patient care and outcomes. This is achieved by systematically reviewing current practices against specific criteria and measuring the impact of changes introduced to generate improvement.

Whilst we have been using GIRFT and clinical audit to identify compliance with best practice, areas for improvement, and actions to deliver positive change, it is challenging to do this efficiently and effectively across a large and complex healthcare organisation like South Tees Trust. To develop and improve these processes the Trust began implementing a software platform called InPhase from late 2022. InPhase is an assurance system that integrates information from different sources and is in use across many Trusts and other agencies including local government and community organisations. We wanted to implement InPhase to enable an integrated view of all relevant clinical effectiveness data and actions for each speciality that would support continuous learning and improved patient care.

Aims

We planned to:

- Develop our software platform InPhase and other digital systems (e.g. electronic patient records) to make the collection of data seamless and visible, to enable benchmarking, interpretation of data at source, identification of learning, and monitoring of the completion of actions to deliver improvement.
- Undertake a gap analysis against the Healthcare Quality Improvement Partnership (HQIP) Best Practice in Clinical Audit to identify areas for improvement in our clinical audit systems and processes. HQIP is the UK's largest clinical audit commissioner, enabling those who commission, deliver and receive healthcare to measure and improve healthcare services.
- Participate in all applicable national clinical audits to ensure we use all these valuable opportunities to benchmark our clinical practice and outcomes and identify any areas for improvement.

We aimed to achieve the following measures of success:

1. Quarterly reports that include relevant clinical effectiveness data for directorate meetings, which will inform and support improvement plans.
2. Revision of clinical audit training and an increase in the number of staff trained in clinical audit to support the on-going evaluation and improvement in clinical care and outcomes for patients.

Progress

Ongoing focus on developing and implementing InPhase.

- InPhase is a platform that can be customised and as experience with it grows, more features and applications can be built, enhanced, and tailored to fit the Trust's range of users.
- In the initial phases the Clinical Effectiveness team worked closely with two specialties to undertake user testing of InPhase and feedback on the clinical audit process including live audit data collection and analysis. During this exercise we identified further development that was needed to enhance the audit collection tool.
- We used InPhase to collect data for several infection prevention and control (IPC) audits which enabled us to develop the data analysis tool.
- More testers were engaged in late 2023. In December 2023 a Trust-wide roll out of InPhase for audit registrations was initiated with processes for user registrations, workflow, audit authorisation and approval testing. This enabled direct registration of audits and service evaluations by specialty audit leads rather than via the Clinical Audit Team.
- We have engaged several clinical teams to test and support the building and further development of the application to record and monitor GIRFT recommendations within InPhase.
- The decision was taken to end the contract with our previous audit system provider in February 2024 which has resulted in a substantial cost-saving to the Trust. As a result, over 100 existing audits have had to be re-created and uploaded to InPhase. During this development phase we have taken the opportunity to review the content of each audit and check if it is still needed or should be revised.
- There has been development of InPhase for actions related to CQC compliance, mortality review process, and for the STAQC team.

Gap analysis against HQIP Best Practice in Clinical Audit

- The gap analysis has been completed. 49 actions have been identified, and implementation of actions is progressing. Currently 53% have been completed.
- The Trust's internal audit provider PricewaterhouseCoopers LLP completed a related audit in August 2023 and identified five areas for action with 13 recommendations. These areas and recommendations mirrored those already identified during the gap analysis and have now all been implemented.

Participation in National Audits

- We participated in 60/65 (92.3%) of national clinical audits we were eligible for with any audits identified as being 'at risk' or with any 'concern' flagged being reported internally. There is increased direct engagement between Clinical Effectiveness (Audit Facilitators) and audit leads or coordinators within the clinical teams. This enables any support needs or potential issues to be identified and actions taken to support the teams.
- During 2023/24 we have analysed our benchmarked performance against 28 published reports of national clinical audits.

Measures of Success

1. New reporting templates for sharing all clinical effectiveness data with directorates and specialties has been developed and includes information on clinical audits, service evaluations, compliance with NICE guidance, GIRFT, metrics for specialised services and registers of external visits. Initial feedback on this has been very positive and indicates improved and increased awareness and engagement with clinical effectiveness and quality data.
2. Initial audit training for Clinical Effectiveness staff was delivered internally, with external training delivered in January 2024 to key Clinical Effectiveness and Patient Safety personnel. Trust-wide audit training material is now being updated and will be published on the intranet as well as delivered in regular training sessions to be organised.

Summary and plans for ongoing work

There will be continued focus and delivery of InPhase including the uploading of all current GIRFT recommendations (over 1800) which will facilitate access for the clinical teams and action owners. There will be continued work on the implementation of the mortality review and CQC app.

We will collate clinical effectiveness data (e.g. audit, NICE guidance, GIRFT, Specialised Services Quality Dashboard) and develop better systems to triangulate information to support clinical teams. Data will be made available for specialties and Directorates at their quality or governance meetings.

Materials and tools for training in clinical audit will be finalised and rolled out via the intranet and training sessions will also be planned. Most of the in-person training on InPhase has been delivered. Clinical Directors have been invited to contact the Clinical Effectiveness team to arrange any local demonstrations or training as needed.

Work continues to implement the actions identified in the gap analysis against HQIP's Best Practice in Clinical Audit.

We will use InPhase to bring together the analysis by the Benchmarking Analyst, information gathered from our audits and GIRFT reviews to assess how we are performing against national standards, what we do well and what we can work on to improve.

2. Mortality review processes and learning from deaths. COMPLETE EXCEPT DATA CHECK

Learning from the deaths of people in their care can help providers improve the quality of the care they provide to patients and their families and identify where they could do more. Clinical mortality review is the process by which medical and other disciplinary experts review the circumstances of an individual death in order to learn and improve care processes. It may identify potential problems in care and in some cases, it may be judged that there is a greater than 50:50 chance that the death could have been prevented. It is important to realise that these judgements based on the records of care, are designed to identify opportunities to learning and cannot replace other legal processes. Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week outside their usual clinical duties to provide independent scrutiny of the causes of death. They are trained in the legal and clinical elements of death certification processes.

Medical examiners (MEs) currently scrutinise all inpatient deaths in the Trust at the time of issue of the medical certification of cause of death or referral to the Coroner. ME scrutiny includes talking to the bereaved family, discussion with the attending team that cared for the patient at the time of death and a proportionate review of the medical records. If during the scrutiny process any concerns are detected, MEs refer for Trust or speciality level mortality review of the care records. Some deaths are recommended by MEs for automatic review for a variety of pre-determined reasons e.g. after elective surgery, patients with learning disabilities etc., and some random cases are also selected for mortality review.

Despite our MEs scrutinising 98% of deaths and the Trust or specialities reviewing in detail 20% of deaths, evidence of learning and change was difficult to assemble. We wanted to improve the reporting of learning from the mortality review process, triangulate themes with other sources of learning and align learning from deaths with the Patient Safety Incident Response Framework (PSIRF) and the Learn from Patient Safety Events (LFPSE) service being introduced in the NHS following the publication of the NHS Patient Safety Strategy (2019). We also wanted to support staff to use InPhase to record specialty mortality review. InPhase is our assurance system that integrates quality, compliance, assurance, and performance information. This work will strengthen the mortality review processes, ensuring learning from deaths is triangulated and shared.

Aims

We planned to:

- Identify and triangulate themes from learning from patient deaths with other sources of learning.
- Support specialties to use InPhase to record specialty mortality review.

We aimed to achieve the following measures of success:

- A reduction in the backlog of Trust mortality reviews. A backlog of approximately 160 cases were awaiting mortality review in April 2023, after the process was paused from March 2020 to September 2021 because of the pandemic.
- The development of key performance indicators (KPIs) in relation to the time to undertake Trust mortality reviews in line with National Quality Board Guidance, and then to meet the KPIs to ensure patient deaths are reviewed in a robust and timely way to optimise learning opportunities.
- The completion of at least one ‘deep dive’ learning summit per quarter to provide an in-depth analysis of learning.

Progress

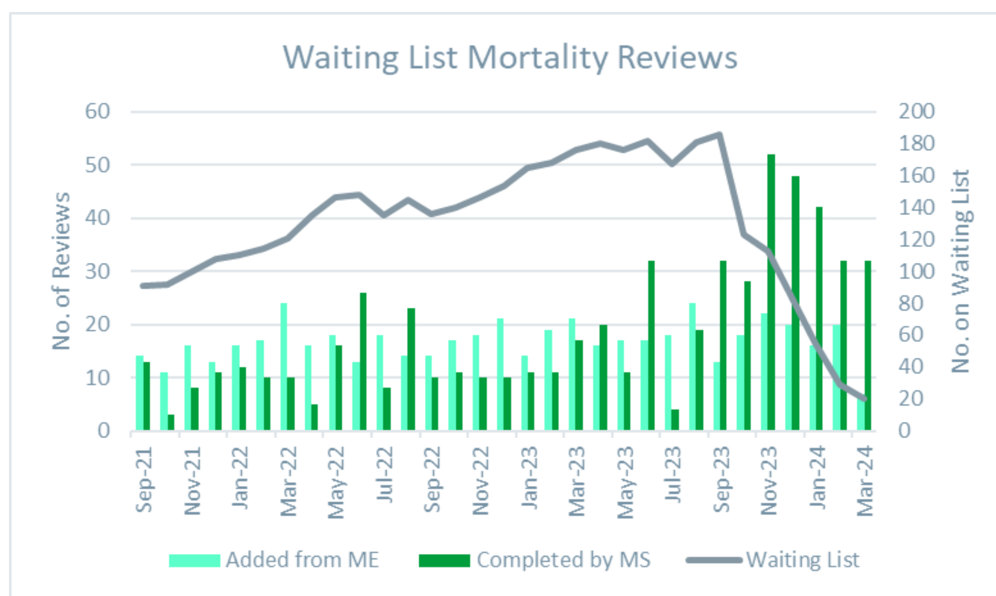


Figure 3: Waiting List – Mortality Surveillance Reviews. (Data so*urce: South Tees Hospitals NHS Foundation Trust Mortality Surveillance Database.) ME = Medical Examiner. MS = Mortality Surveillance Team.*

Figure 3 shows the number of deaths recommended for Trust mortality review. An average of 16 new cases per month are recommended for review. The waiting list at the end of quarter 4 was 20 which is an improvement on the 55 reported in quarter 3 and the 171 reported in quarter 2.

Backlog of Trust Mortality Reviews in April 2023.

In April 2023 there were approximately 160 cases that were awaiting a Trust mortality review. Most of the cases in the backlog were not originally recommended for review by the ME service. They were identified for review prior to this process being introduced for reasons such as the death of a patient admitted for elective surgery, an associated Datix incident rated moderate harm or greater, hospital acquired COVID, tertiary referrals from other trusts, mental health concerns etc.

In May 2023 the Trust commenced a 3-month redeployment of a Band 5 Nurse to support the mortality review process, initially screening the backlog cases into those requiring full review and those that could be closed. Nursing input into mortality reviews has been very positive and has been key to reforming both review processes and increasing the feedback of learning into the Trust. Figure 2 below shows the impact on capacity of adding nurse led reviews. The Trust was able to extend this arrangement until March 2024 and is planning to advertise a permanent role during quarter 1 2024/25.

Access to patient records has also improved with a positive impact on the timeliness of reviews. Mediviewer is a resource for reviewing older (pre-2023) scanned records. The availability of this, and the passing on of records from the Medical Examiner office directly to the Mortality Surveillance Team before they are redirected elsewhere has meant that the waiting list has been greatly reduced. Processes are in place to maintain that level of responsiveness.

Since April 2023 we have completed 710 reviews, 469 consultant led reviews and an additional 241 which were undertaken by the nurse reviewer. 97% of the historic backlog of cases predating April 2023, and 93% of the cases recommended for review (204 out of 217) since April 2023 have been completed. **DATA BEING CHECKED**

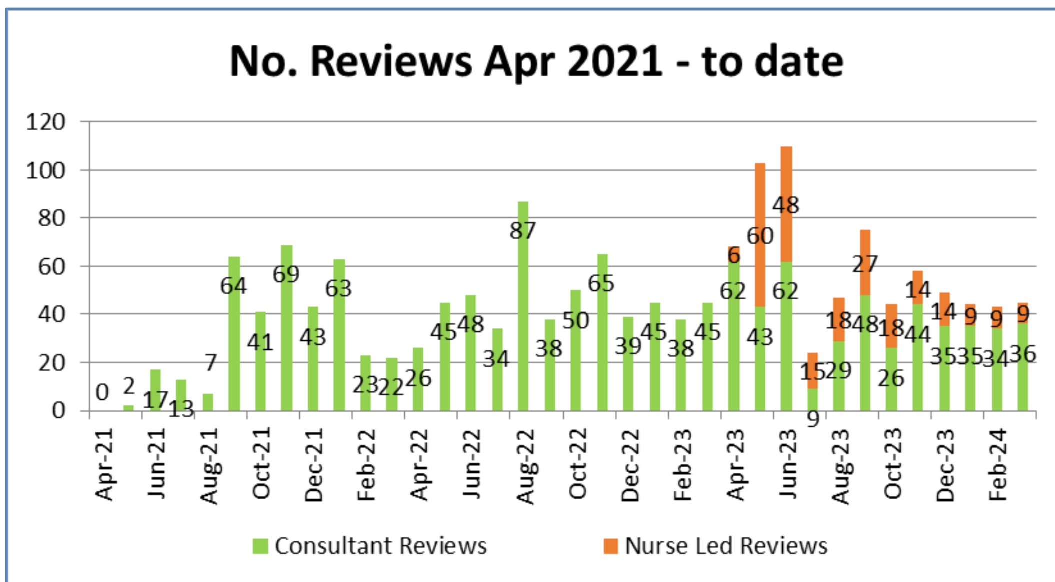


Figure 4: Mortality surveillance reviews from April 2021 to March 2024. (Data source: South Tees Hospitals NHS Foundation Trust Mortality Surveillance Database.)

<u>Integration of Learning from other Safety Events.</u>

Integration with learning from other safety events is progressing. Implementation of Learn from Patient Safety Events (LFPSE) commenced in quarter 3 and implementation of the Patient Safety Incident Response Framework (PSIRF) took place in quarter 4. A series of workshops to review how the Trust can integrate mortality review, PSIRF and LFPSE processes have been held since May 2023 with facilitation by the STRIVE Quality Improvement Team, and this has been very valuable. This work is on-going with further workshops held in quarter 4.

The Trust adopted the Structured Judgement Review Plus (SJR+) methodology and has developed this into InPhase which will replace the current Trust mortality review database. This is facilitating preparations for integration with the changes in learning from other patient safety events and will allow speciality mortality reviews to move into the system during 2024-25.

<u>Deep Dive Learning Events.</u>

The first deep dive learning event held on 27 April 2023 involved presentation of a case involving three surgical specialties and it was attended by a wide audience who discussed the management of a complex patient involving several teams of clinicians. The second event was held on 5 October 2023 and involved the presentation and discussion of four cases. Two involved deaths that were investigated by the Coroner and all involved issues with medications. Learning was discussed and shared with an audience of doctors from across the Trust and involved clinical pharmacist and electronic Prescribing Management and Administration (ePMA) educator support. The third event was held on 21 March 2024 and included 2 cases where nutrition and hydration issues were identified. This was presented to a multi-disciplinary audience with good feedback. A further event was planned for April but has been deferred until June 2024. The cases discussed will highlight concerns related to care at the end of life.

<u>Key Performance Indicators (KPIs).</u>

The Mortality Surveillance Team have developed their reporting to include new KPIs relating to the number of patients requiring and receiving reviews, and the time to review. The time to review usually starts from the time of referral for Trust mortality review by MEs or the Patient Safety Team, but where cases are

selected for other reasons the date of death may be used. Now that the backlog is almost cleared, the Mortality Surveillance Team have agreed to review cases referred by the MEs because of potential concerns within 2 weeks for urgent cases and 4 weeks for less urgent cases. The intention is to monitor the speed of review against these challenging targets during 2024/25.

As of end of March 2024 48% of required cases were being reviewed within 2 weeks of death and 59% within a month.

Summary and plans for ongoing work

The Trust can demonstrate significant progress against the original aims and measures of success. Mortality review processes have been adapted to use scanned medical records and the MIYA Electronic Patient Record and the waiting list has been reduced to 20 cases. The implementation and embedding of PSIRF and LFPSE is on-going, but the development of the SJR+ tool in InPhase will facilitate integration with the learning from other patient safety events, enabling the triangulation of learning to evolve.

Patient experience quality priorities

1. Implementation of the Patient Experience Strategy. COMPLETE

This work was focused on implementing the Patient Experience and Involvement Strategy, developed in collaboration with our patients, carers and Healthwatch. The strategy set out to:

- Recognise the individual needs of patients, carers, and their families, ensuring they are provided with equal opportunities to be heard as partners in their health care.
- Ensure services meet the needs of the community.
- Ensure all patients, carers and their families feel encouraged to be involved in their care and treatment as much they wish to be.
- Improve communication about health conditions and treatment plans to ensure they are understood be those receiving them.

Aims

We planned to:

- Form a patient participation group.
- Ensure a patient representative on all key meetings across the organisation.
- Identify areas of good practice and share across the organisation.
- Ensure verbal and written information about health conditions and treatment plans is provided in a format that the patient and carer understand.

We aimed to achieve the following measures of success:
- Delivery of the actions specified within the strategy for years 1-3.
- Increased deployment of the Family Liaison Officer service to patients and families.

Progress

Working with people

We have formed links with community groups and charities to ensure groups seldom heard from are given the opportunity to feed back. These include groups and charities for people with dementia, Parkinson's disease, epilepsy, stroke, acquired brain injuries, substance misuse. There are also groups for people who have left intensive care, to provide ongoing support after critical illness to them and their families and friends, people who are carers, young carers, deaf and blind, and people who identify as Black, Asian or

minority ethnic (BAME), or neurodivergent. Further links are being developed with Healthwatch North Yorkshire and other community groups. We have also:

- Recruited to the patient involvement bank which will enable patient involvement in key meetings and service development. Recruitment to the children and young persons (CYP) involvement bank and CYP involvement activities will commence in 2024.
- Co-created a leaflet with patients and Healthwatch South Tees to inform patients, carers, families and staff of the Patient Experience and Involvement Strategy.
- Developed a poster to be displayed in Emergency Department (ED) waiting areas to inform other patients and visitors about the reasons for substance misuse, to support an improvement in attitude towards those attending ED. This was suggested by service users and volunteers at North Yorkshire Horizons. An addiction awareness video has also been created to share with staff in the organisation to support with training.
- Shared different designs for the new Urgent Treatment Centre (UTC) at James Cook University Hospital (JCUH) with 25 patients in Redcar UTC and used their feedback to select the designs.
- Engaged with patients regarding research and innovation. Patients have reviewed materials ahead of ovarian cancer research projects, giving feedback and suggesting changes. The Research and Innovations Team have also worked with patients regarding lost property in hospital and the use of patient property boxes to reduce this. A pilot of boxes on three wards is starting on 1 April 2024.
- Started to review complaints to identify if a Family Liaison Officer would be appropriate to support patients, carers, and families through an investigation, and ensure they are kept updated and involved.

Internal Groups and Meetings

Patient stories continue to be presented at Trust Board, Patient Experience Steering Group, and Council of Governor meetings highlighting the impact the stories have had on the Trust and the changes made.

Colleagues leading work on patient experience and involvement and bereavement services now attend Collaborative Board meetings to inform staff of the Patient Experience and Involvement Strategy and how to involve patients in developing services. They also attend internal group meetings such as the Veterans, Nutrition and Hydration, End of Life Care, Health Inequalities Steering Group and Fairer Access Working Group to provide patient feedback. Work continues to support the Maternity and Neonatal Voices Partnership Black and Asian Minority Ethnic Group in conjunction with Teesside University to give feedback on maternity services.

Strategy, Policy and Patient Information

Work has included:

- Four focus groups with patients, carers, and relatives to support the production of a Mental Health Strategy for the Trust.
- Development of a Patient Participation Reimbursement Policy that is awaiting review by the Finance Team.
- Development and publication of an Accessible Information Standards policy to ensure we communicate with patients, carers, and their families based on their identified needs.
- Review of the Patient Information Policy to ensure the process of creating patient information is easy to follow, and that patients and carers can review information being produced.
- Development of internal and external web pages regarding patient involvement to inform staff and the public about our work.
- Creation of a newsletter to share with patients who have signed up to the Involvement Bank to update them about what has happened in the Trust to involve patients and to share new opportunities.

Summary and plans for ongoing work

There has been good work done to prepare start our work on patient engagement and involvement, with new resources developed from patient feedback, and good practice shared through patient stories. We are planning ongoing work to:

- Form a patient participation group and use the patient involvement bank to enable representation from patients on groups within the Trust.
- Progress health literacy for patient leaflets to ensure readability for patients, carers, and families.
- Gain patient, carer, and family feedback ahead of the Translation and Interpretation Service tender process to ensure the services meet their needs.

2. Development and implementation of a Mental Health Strategy. COMPLETE EXCEPT DATA UPDATE

There is increasing evidence that trauma-informed approaches can reduce the negative impact of trauma experiences and support mental and physical health outcomes. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. Trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff.

We recognise the impact of mental health, mental ill health, and trauma on people presenting to the Trust and wanted to identify appropriate strategies to ensure this is understood and that it informs our assessments, interventions, and treatments. This work was therefore focused on the development and implementation of a Mental Health Strategy to improve care and share learning, especially for our patients who have mental ill health. In addition, we wanted to recognise the impact of our work on staff and to develop a culture which is trauma reducing, staff focused, and wellbeing driven.

Aims

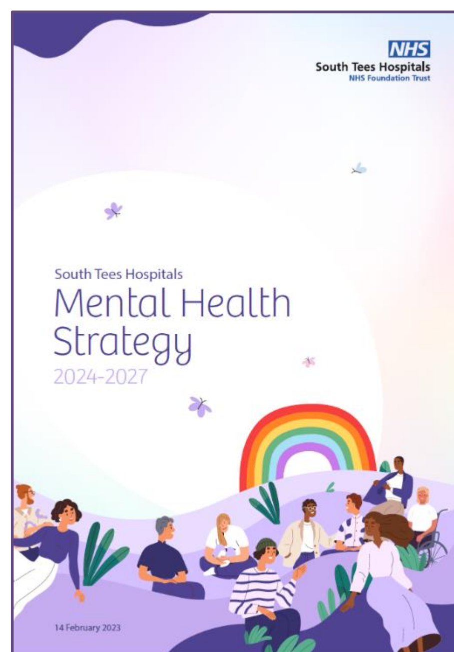
We planned to:

- Introduce a mental health strategic group to provide operational and strategic insight into addressing the mental health needs of our staff and patient community.
- Undertake a needs analysis of our current approach to mental health, identifying what works, what is needed now, and use this to build an implementation plan.
- Implement reporting structures where our mental health strategy journey, plans and outcomes are reported, governed, and agreed.
- Identify key stakeholders, internal and external, including people with lived experience to form our strategic group.
- Develop a staff survey, seeking clarity on the key mental health experiences of staff that need attention.
- Conduct focus groups with people who have lived experience of mental health needs and treatment within our Trust.

We aimed to achieve the following measures of success:

- To increase the percentage of patients attending the Emergency Department (ED) at James Cook University Hospital (JCUH) and the Clinical Decisions Unit (CDU) at Friarage Hospital (FHN) who receive a completed mental health triage following the Royal College of Emergency Medicine 'Mental Health in Emergency Departments' guidance.
- To increase the number of staff working in ED at JCUH and the Acute Medical Unit at FHN who have received mental health training.

Progress



The Mental Health Strategy has been developed, approved and published on the intranet. The focus is to develop, improve, learn from, and enhance the provision of mental health care for our patients, alongside their physical health needs.

The Strategic Mental Health Group is established with agreed terms of reference and membership. Oversight and governance is via the Health Inequalities Steering Group. The Mental Health Strategy Group brings together colleagues from clinical services and subject matter experts regarding safeguarding, the Mental Capacity Act and Deprivation of Liberty safeguards, and patient safety.

Further actions undertaken include identifying a range of organisational mental health assessment tools, to facilitate the identification of individual priorities within clinical services which will be governed by the Mental Health Strategy Group.

Together with the Patient Experience Team we have organised a questionnaire for patients, asking how best to support their mental health when in hospital. We also organised focus groups at James Cook University Hospital, Friarage Hospital and Redcar Community Hospital to further explore patients' needs and perspectives on better integrated mental health and physical health care across the Trust.

We continue to meet with colleagues within the Tees, Esk and Wear Valleys Mental Health Trust to explore care pathways and trauma informed care, and to continue work concerning the connection between mental health and physical health.

Within ED, regular audits of compliance with documenting mental health risk using a paper-based mental health risk assessment tool showed significant improvement over time (see table 1). The aim was to audit at least 15 patients within each audit cycle:

Audit cycle	**All patients presenting to ED with mental ill health, self-harm or overdose have a fully completed mental health risk assessment.**	**The mental health risk assessment will be repeated 4 hourly.**	**All patients at medium or high risk will have a ligature risk assessment completed.**
1	6/18 (33%)	1/18 (6%)	1/18 (6%)
2	10/14 (71%)	4/18 (22%)	7/20 (35%)
3	19/20 (95%)	9/15 (60%)	18/20 (90%)

Table 1: Audit results of compliance with paper-based mental health risk assessment

To improve compliance and patient care, the risk assessment tool was implemented on Symphony, the clinical digital system in use in ED on 15 April 2024. A pre and post implementation audit shows....
RESULTS AWAITED

The team are also participating in the Royal College of Emergency Medicine (RCEM) national mental health audit focused on triage and mental health risk assessment. This is a two-year audit with expected completion October 2024.

CDU at FHN have achieved the target of 90% for mental health training compliance whilst ED at JCUH have not achieved this since July 2023 (see table 2). This will continue to be monitored and progressed next year.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
ED Compliant		91.57%	91.57%									
ED Non-Compliant	81.36%			85.38%	80.67%	81.97%	80.97%	82.99%	84.23%	81.93%	79.03%	74.05%
AMU FHN (CDU) Compliant				90.48%	94.87%	95.00%	97.50%	95.12%	92.86%	95.12%	97.50%	92.68%
AMU FHN (CDU) Non-Compliant	75.56%	85.71%	85.71%									

Table 2: Mental health training compliance CDU and ED April 2023 – March 2024.

Summary and plans for ongoing work

There has been good progress with the initial work and we have published our Mental Health Strategy. We have established a Strategic Mental Health Group to provide strategic and operational leadership as we implement the strategy and mental health improvement plan. There has been demonstrable improvement in mental health risk assessments in ED. To further improve the care of patients in ED, Psychiatry Liaison are planning to review how many patients with a mental health presentation abscond or leave before they have completed a mental health assessment. The purpose is to develop and provide a booklet, as recommended by RCEM, to patients at triage about the Psychiatry Liaison role and what they can do to help. It will provide useful contact numbers in the event they still do not wish to stay in the department and have the mental capacity to decide to leave.

Key next steps are to:

- Continue to monitor our measures of success regarding appropriate mental health triage in ED and CDU, and the training of staff in these areas in mental health.
- Develop a staff survey.
- Enhance patient involvement.
- Continue to review mental health assessment tools and other documents to ensure these contribute to safe and effective care.
- Improve mental health training compliance in ED.

3. Shared decision making and goals of care. COMPLETE

People want to be more involved in decisions about their health and care. Shared decision making ensures that people are supported to be as involved in the decision-making process as they would wish.

Shared decision-making means people are supported to understand the care, treatment, and support options available and the risks, benefits, and consequences of those options, in addition to making decisions about a preferred choice of action, based on evidence based, good quality information and their personal preferences. Goals of care describe what a patient wants to achieve during an episode of care, within the context of their clinical situation. They are the clinical and personal goals that are determined through a shared decision-making process.

We wanted to review best practice and explore how patients are currently involved in shared decision making and agreeing goals of care, before implementing actions to improve by focusing on key services and key clinical situations e.g. when patients face end of life care, increasing frailty, and cardio-pulmonary resuscitation decisions.

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

The Trust has an indicator within the 2023/24 Commissioning for Quality and Innovation (CQUIN) Scheme related to achieving high quality shared decision-making conversations in specific specialised pathways to support recovery.

Aims

We planned to:

- Undertake a gap analysis against recommendations within NICE guideline (NG197) Shared decision making and then to develop a Trust wide improvement plan to put shared decision making into practice.
- Engage with clinical teams regarding the development of procedure specific consent forms, ensuring that information on risks, benefits and consequences is personalised and supported by good quality patient decision aids.
- Facilitate early identification of frailty in patients attending specific clinical areas within the Trust to enable patient centred decisions and joint care planning.

We aimed to achieve the following measures of success:

- An increase in the number of staff trained in end-of-life care. This training includes a focus on shared decision-making and enabling people to be involved in agreeing goals of care at end of life.
- Undertaking a quarterly 'do not attempt cardio-pulmonary resuscitation' (DNACPR) audit and ensuring this drives improvement in end-of-life care planning.
- An increase in the percentage of older people attending CDU and Older Person's Medicine who are clinically assessed to determine their degree of frailty, which will in turn identify their needs and direct a focused care plan based on shared decision making, including those admitted with major trauma.
- Achieving the CQUIN indicator related to shared decision making.

Progress

The Lead Nurse for Cancer and Palliative Care and the Consultant in Palliative Medicine developed a programme of training for staff providing end of life care. This commenced in September 2023 with the first cohort of senior nurses receiving training. By the end of 2023/24 over 500 colleagues had received training. A full time Palliative Care Educator has been recruited and commences in post on 1 May 2024 which will enable the development and delivery of a formal education programme. Role specific training has been mapped to consultants and other relevant groups of staff to ensure this delivers appropriate skills, knowledge, and abilities.

The Lead Nurse for Cancer and Palliative Care has developed a DNACPR audit tool. The first quarterly audit has been undertaken by the Safe & Effective Care Leads and was focused on the health records of deceased patients. The audit report has been presented to the Morbidity and Mortality Review Group and the End-of-Life Steering Group. Following some revision to the audit tool, future audits will be undertaken in clinical areas, using the paper-based and electronic health records of current patients, which will facilitate immediate feedback to improve discussions and documentation in relation to DNACPR shared decision making.

Work has been undertaken with the Clinical Directors of Older Person's Medicine and the Clinical Decisions Unit at FHN to review approaches to increase the number of clinical frailty assessments undertaken with older people attending specific clinical areas within the Trust. A benchmarking exercise of existing frailty data on clinical IT systems was undertaken during quarter 3, with the data suggesting a decrease at both JCUH and FHN sites in the number of assessments undertaken. This is likely to have been impacted by the implementation of the MIYA clinical system for frailty assessments as this data was previously on a different clinical system. The aim is to ensure our digital platforms enable staff to improve the assessment and identification of clinical frailty in patients and to ensure their needs are met via a focused care plan.

In relation to the CQUIN indicator on shared decision making, following discussion and engagement with senior clinicians within the Trust, speciality pathways were identified where patients will receive the shared decision-making questionnaire when they attend clinic appointments. Patients on care pathways for palliative chemotherapy, early-stage lung cancer or renal disease were given a nine-item questionnaire about shared decision-making discussions with their doctor. 51 responses from each pathway were collected in each audit period, and results showed an average score of 89% in quarter 2 and 87% in quarter 4 against a target of 65%. Analysis of the data is underway to identify opportunities to improve the quality of the shared decision-making discussions within each pathway.

Summary and plans for ongoing work

There has been good progress with staff training in end-of-life care to improve shared decision-making and to enable people to be involved in agreeing goals of care at end of life. Quarterly audits of DNACPR discussions and documentation have started and future audits in clinical areas will facilitate immediate feedback to staff to improve DNACPR shared decision making with patients in those areas.

Work has started to evaluate patient experience of shared decision making on some specialist pathways of care. The data will be used to identify opportunities to improve the quality of the shared decision-making discussions within each pathway, before extending the learning into other areas.

A benchmarking exercise in relation to frailty assessments has identified areas for further work to ensure our digital platforms enable staff to improve the assessment and identification of clinical frailty in patients. This will be progressed during 2024/25. When increasing frailty is identified, the focus will be on ensuring patients are involved in decisions about their care, and that their needs are met via a focused care plan.

During 2024/25, one of our clinical teams Trauma and Orthopaedics is going to develop and pilot the use of good quality surgical risk assessment tools to guide shared decision making, and a gap analysis will be completed against NICE NG197.

b. Quality priorities defined for improvement in 2024/25. FORMAL APPROVAL AWAITED

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

Quality Priorities 2024/25		
Patient Safety	**Clinical Effectiveness**	**Patient Experience**
We will continue to embed our Patient Safety Incident Response Plans, developing a positive safety culture in which openness, fairness and accountability are the norm and ensuring that colleagues with the right skills and competencies are involved in all aspects of the patient safety response.	We will ensure continuous learning and improved patient care from GIRFT, NICE and clinical audits.	We will develop and implement a Mental Health Strategy to improve care and share learning for our patients who have mental ill health.
We will continue to optimise the Trust's ability to learn from incidents, claims and inquests to improve outcomes for our patients whilst embedding PSIRF.	We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.	We will proactively seek patient feedback and ensure there is continuous improvement in care and treatment because of the feedback we receive.
We will increase medication safety and continue to optimise the benefits of ePMA and evaluate the impact on learning.	We will develop and implement shared decision making and goals of care.	We will respond in a timely and compassionate way to complaints and implement quality improvements as a result of the learning.

2.2 Statements of assurance from the Board

1. Relevant health services COMPLETE

During 2023/24, South Tees Hospitals NHS Foundation Trust provided and/or sub-contracted 91 relevant health services. South Tees Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 91 of these relevant health services. The income generated by the relevant health services reviewed in 2023/24 represents 93.7% of the total income generated from the provision of relevant health services by the South Tees Hospitals NHS Foundation Trust for 2023/24.

2. National clinical audits and national confidential enquiries COMPLETE

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

The Trust has a well-structured clinical audit programme which is regularly reviewed to ensure it reflects the needs of our acute and community services. During 2023/24, 65 national clinical audits and 4 national confidential enquiries covered relevant health services that South Tees Hospitals NHS Foundation Trust provides.

During 2023/24, South Tees Hospitals NHS Foundation Trust participated in 60/65 (92.3%) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. Eligibility, for the purpose of this report, is defined as those national audits that the Trust could participate in that were not suspended due to the COVID-19 pandemic.

The national clinical audits and national confidential enquiries that the South Tees Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2023/24 are listed below 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.

Title	Eligible	Participated	% cases
Adult Respiratory Support Audit	Yes	Yes	100%
BAUS Nephrostomy Audit	Yes	Yes	Data submission commenced Feb 2024
Breast & Cosmetic Implant Registry	Yes	Yes	Data collection now underway new platform from 21 March 2024
British Hernia Society Registry	Yes	Yes	Not due to start yet
Case Mix Programme (CMP)	Yes	Yes	100%
Child Health Clinical Outcome Review Programme NCEPOD: Juvenile Idiopathic Arthritis	Yes	Yes	Data collection in progress due 15 April 2024
Child Health Clinical Outcome Review Programme NCEPOD: Testicular Torsion	Yes	Yes	100%
Cleft Registry and Audit Network (CRANE) Database	Yes	Yes	100%
Elective Surgery (National PROMS Programme)	Yes	Yes	100%

Emergency Medicine QIPs a) Care of older people	Yes	Yes	100%
Emergency Medicine QIPs b) Mental Health (Self harm)	Yes	Yes	100%
Emergency Medicine QIPs c) Infection Control	Yes	Yes	100%
Epilepsy 12: National Clinical Audit of Seizures and Epilepsies for Children & Young People	Yes	Yes	100%
Falls and Fragility Fracture Audit Programme (FFAP) a) Fracture Liaison Service Database (FLS-DB)	Yes	Yes	100%
Falls and Fragility Fracture Audit Programme (FFAP) b) National Audit of Inpatient Falls (NAIF)	Yes	Yes	100%
Falls and Fragility Fracture Audit Programme (FFAP) c) National Hip Fracture Database (NHFD)	Yes	Yes	100%
Improving Quality in Crohn's and Colitis (IQICC) (known previously IBD Registry)	Yes	No	0%
Learning from lives and deaths of people with a learning disability and autistic people (LeDer)	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme NCEPOD: End of life care	Yes	Yes	Data collection in progress
Medical & Surgical Clinical Outcome Review Programme NCEPOD: Endometriosis	Yes	Yes	86%
National Adult Diabetes Audit (NDA): a) National Diabetes Footcare Audit (NDFA)	Yes	Yes	100%
National Adult Diabetes Audit (NDA): b) National Diabetes inpatient safety audit (NDISA)	Yes	No	0%
National Adult Diabetes Audit (NDA): c) National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	100%
National Adult Diabetes Audit (NDA): d) National Diabetes Core Audit	Yes	No	0%
National Asthma & COPD Audit Programme (NACAP) d) Children & Young People's Asthma Secondary Care	Yes	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	Yes	100% Note: not all data fields due to limited staffing therefore delayed submission of some information.
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Data collection in progress commenced January 2024
National Audit of Dementia (NAD) Round 6	Yes	Yes	100%
National Audit of Pulmonary Hypertension	No	N/A	N/A
National Bariatric Surgery Registry	Yes	Yes	100%

National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Yes	Yes	100%
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Yes	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): a) National Adult Cardiac Surgery Audit (NACSA)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): b) National Congenital Heart Disease Audit (NCHDA)	No	N/A	N/A
National Cardiac Audit Programme (NCAP): c) National Heart Failure Audit (NHFA)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): d) National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): e) Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes	Yes	100%
National Cardiac Audit Programme (NCAP): g) National Audit of Mitral Valve Leaflet Repairs (MVLR)	Yes	Yes (to related registry)	Specified audit not available for submission on NCAP. 100% of cases involving mitral valve repair have been submitted to the related Transcatheter Mitral and Tricuspid Valve Registry.
National Cardiac Audit Programme (NCAP): h) The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	Yes	100%
National Child Mortality Database (NCMD)	Yes	Yes	100%
National Comparative Audit of Blood Transfusion a) 2023 Audit of Blood Transfusion against NICE QS 138	Yes	Yes	100%
National Comparative Audit of Blood Transfusion b) 2023 Bedside Transfusion Audit	Yes	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	33%
National Emergency Laparotomy Audit (NELA)	Yes	Yes	100%
National Gastro-Intestinal Cancer Audit Programme (GICAP) a) National Bowel Cancer Audit (NBOCA)	Yes	Yes	100%
National Gastro-Intestinal Cancer Audit Programme (GICAP) b) National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Yes	100%
National Joint Registry	Yes	Yes	100%

National Lung Cancer Audit (NLCA)	Yes	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	Yes	100%
National Obesity Audit (NOA)	Yes	No	0%
National Ophthalmology Database (NOD) Audit National Cataract Audit	Yes	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	Yes	100%
National Respiratory Audit Programme (NRAP) a) COPD Secondary Care	Yes	Yes	100%
National Respiratory Audit Programme (NRAP) b) Pulmonary Rehabilitation	Yes	Yes	100%
National Respiratory Audit Programme (NRAP) c) Adult Asthma Secondary Care	Yes	Yes	100%
National Vascular Registry (NVR)	Yes	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	Yes	100%
Perinatal Mortality Review Tool (PMRT)	Yes	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	100%
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes	100%
The Trauma Audit & Research Network (TARN)	Yes	No	National incident – the submissions platform closed part way through the year. Remains closed but expected to re-open soon.
UK Cystic Fibrosis Registry	Yes	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	Yes	Change in submission process by provider from January 2024 -expected to submit full dataset by August 2024
UK Renal Registry National Acute Kidney Injury Audit	Yes	Yes	Change in submission process by provider from January 2024 -expected to submit full dataset by August 2024

Table 3: National Clinical Audits 2023/24 eligibility and participation

The reports of three national clinical audits were reviewed by the provider in 2023/24 and South Tees Hospitals Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Bariatric Surgery Registry

Bariatric surgery is a type of operation to help people lose weight for example by making the stomach smaller. The main aim of the registry is to accumulate sufficient data to allow the publication of a comprehensive report on outcomes following bariatric surgery. This will include reporting on weight loss, co-morbidity and improvement of quality of life.

A report of data collected through this registry between April 2018 and March 2022 was analysed and benchmarked against local trusts. The following was noted:

- The emergency re-admission rate within 30 days of surgery is low compared to our neighbouring trusts. This means that fewer patients are having to come back into hospital as an emergency after their surgery. South Tees hospital patients having this type of surgery are staying in longer after their surgery than other trusts which is usually not what we aim for but an increased length of stay can result in better recovery and aftercare of the patient so that their post-surgery diet can be gradually introduced.
- Adverse outcome rates following surgery appeared to be higher than neighbouring trusts. On looking into this further there are small numbers of patients involved (25) therefore the two patients reported to have had an adverse outcome has a big effect on the rate.
- The Bariatric Nurse Specialist has identified an action to reduce waiting times for surgery by introducing a new weight loss injection to help patients lose 10% of their weight more quickly. Staff are being trained in prescribing and administering these injections.

National Lung Cancer Audit

- The standards were within the range with the exception of the proportion of patients seen by a Cancer Nurse Specialist. This has improved a lot from only 13.2% in 2020 (target is 90%) to 87.8% in 2023.
- During this time the team have put in actions to improve the data recording and quality which has also led to this improvement.

National Asthma Audit

- Actions for improvement are to include a request in the discharge letter to GPs that they review the patients two days after their discharge. This will be added to the letter written when a patient is discharged.
- The team are also looking at having later shifts and more staff on shift to capture patients for the asthma audit.

3. Local audit COMPLETE

The reports of three local clinical audits were reviewed by the provider in 2023/24 and South Tees NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Clinical audit of rate of surgical site infection after breast reconstruction

- This was a re-audit to assess the effectiveness of actions identified in previous audit carried out in 2022 which showed a 23% infection rate for patients treated between October 2021 and October 2022.
- Several actions were implemented including ensuring screening for bacteria that are resistant to some antibiotics, full compliance with use of face masks by staff, using an alcohol-based skin preparation and improving the quality of air in the theatres. A checklist to help achieve this was introduced.

- The re-audit was completed in October 2023 and showed a 0% infection rate.

Clinical audit to assess the effectiveness of a procedure called flexor tenotomy to treat diabetic foot ulcers.

- The audit looked at three factors affecting the patients after the procedure and the standards they are aiming for: healing rate (>92%), infection rate (<5%) and healing time (>50% with healing time of 28 days).
- The patients audited were found to have a good healing rate and time but a slightly higher infection rate of 8% compared to <5%.
- The team have looked at when they should consider giving antibiotics after the procedure to help reduce infections.
- An improvement already introduced is to use photography to help document and assess the size of ulcers.

Prompt switching from intravenous to oral antibiotic (CQUIN 03)

The Trust participated in this audit set up by NHS England as part of their work towards reducing the length of hospital stays by ensuring that antibiotics that need to be given in the veins (intravenously) are only used for as long as necessary. Other benefits of switching patients to oral (by mouth) antibiotics from intravenous antibiotics are a reduction in drug costs and the carbon footprint.

The audit is performed every quarter and looks at the proportion of patients who were still having intravenous antibiotics but could have had these orally. The percentages have reduced each quarter of the year; 40% in quarter 1 (April to June), 24% in quarter 2, down to 8.75% in the most recent quarter. The lower this percentage the better as it means less patients are continuing to have the antibiotics in their veins when they could have had them by mouth.

These big improvements have been achieved by using the electronic systems for prescribing medicines, highlighting patients that can change the way they have their medicines, and reviews and advice from specialists during ward rounds. The team also went out to teams with banners and used social media during an antibiotic awareness week in November 2023. The aim was to empower nursing staff to prompt the switching to oral medicines. The team plan to keep up this momentum by further working with matrons and nursing staff from all areas to switch their patients who are improving to oral antibiotics if medically appropriate.

Clinical Research COMPLETE

The number of patients receiving relevant health services provided or subcontracted by South Tees NHS Foundation Trust (STH) in 2023/24 that were recruited during that period to participate in research approved by a research ethics committee was 6504 (across 182 studies and 25 clinical specialties). This is slightly lower than last year (6734) but that was an unusually high recruiting year (see figure 5).

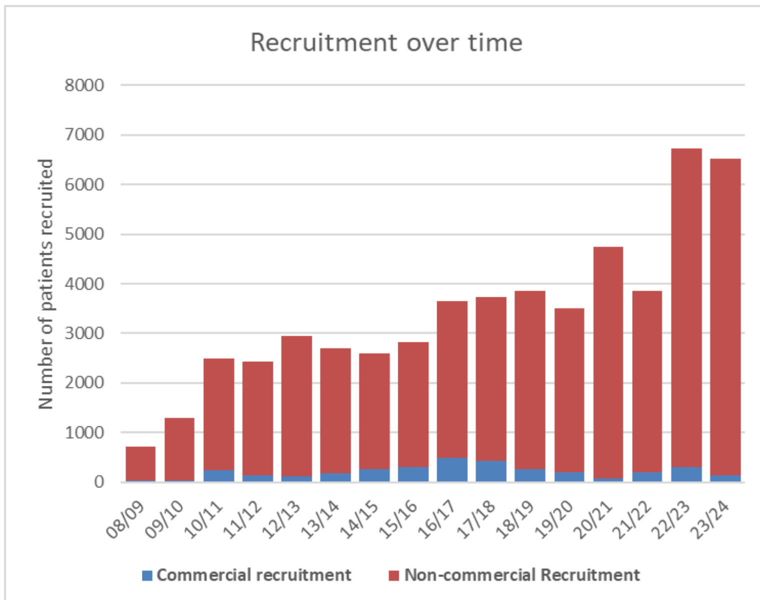


Figure 5: Recruitment to clinical research trials over time.

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

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

A proportion of the South Tees Hospitals NHS Foundation Trust's income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between South Tees Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2023/24 are available on request from the Quality Assurance Team, South Tees Hospitals NHS Foundation Trust, The James Cook University Hospital, Marton Road Middlesbrough TS4 3BW or via email stees.qualityassurance@nhs.net

5. CQC registration, reviews and investigations COMPLETE

South Tees Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. South Tees Hospitals NHS Foundation Trust has no conditions on registration. The CQC has not taken enforcement action against South Tees Hospitals NHS Foundation Trust during 2023/24.

South Tees Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2023/24.

In August 2023 the CQC carried out a short-notice inspection of maternity services at The James Cook University Hospital and the Friarage Hospital as part of its National Maternity Inspection Programme. The CQC reports published in January 2024 acknowledge a number of areas of outstanding practice including the service's transparency and accountability, and the special support it provides for birth parents and foster carers if a baby is placed into the care of the local authority. Inspectors found leaders were visible and approachable and engaged with people and the community to plan and manage services. Staff were also praised for the way they managed safety, infection prevention, safeguarding and care records. Inspectors identified some areas for improvement which are already being addressed through a comprehensive action plan which includes:

- Ongoing recruitment to support maternity services across James Cook and the Friarage in addition to the successful recruitment of all newly qualified midwives who trained at the trust in 2023.
- Improvements to the building and environment at James Cook, including plans to install a new birthing pool. The trust is continuing to seek investment to improve the environment in maternity services.

Despite many positive findings in the report, maternity services at both hospitals have been rated as "Requires Improvement". However, South Tees Hospitals NHS Foundation Trust's overall CQC rating remains as "Good" (figure 6). The James Cook University Hospital and the Friarage Hospital have a CQC rating of good overall, with both hospitals rated as good in all five key questions of safe, effective, caring, responsive and well-led.

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

Overall trust quality rating	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Figure 6: South Tees Hospitals NHS Foundation Trust overall CQC rating

6. Submission of records to the Secondary Uses Service COMPLETE

South Tees Hospitals NHS Foundation Trust submitted records during 2023/24 to the Secondary Uses Service for inclusion in The Data Quality Maturity Index (DQMI). This is a monthly publication intended to highlight the importance of data quality.

The percentage of records in the latest published data for November 2023 which included the patient's valid NHS number was:

- 99.8% 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 2023 which included the patient's valid General Medical Practice Code was:

- 99.9% for admitted patient care
- 99.8% for outpatient care, and
- 99.1% for emergency department care.

7. Information Governance grading COMPLETE

Information governance is assessed as part of the mandatory annual national process of submitting compliance with the NHS Data Security and Protection Toolkit (DSPT), which is currently based upon the

National Data Guardian's 10 Data Security Standards. The content of the DSPT is aimed at providing assurance around technical aspects of cyber security, information security and data protection compliance.

The 2022/23 DSPT submission was assessed against compliance with 34 assertion areas which are comprised of 108 mandatory evidence items. South Tees Hospitals NHS Foundation Trust DSPT status for 2022/23 was 'standards met'.

The 2022/23 DSPT review has been performed by PwC (PricewaterhouseCoopers LLP) as part of a national standardisation exercise, the findings of which are monitored and discussed at the Trust Audit and Risk Committee.

At the time of writing, the status of the 2023/24 DSPT is that the Trust has provided 70 of the 108 mandatory evidence items required, and eight of the 34 assertions in this year's toolkit have been completed. The final submission date is 30 June 2024.

8. Clinical coding audit COMPLETE

South Tees Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2023/24 by the Audit Commission.

9. Data quality COMPLETE

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

- Data that is collected, recorded, and reported within the Trust complies with national data standards outlined in the NHS Data Dictionary and is clinically coded in compliance with data classifications set out by World Health Organisation and NHS Digital ICD10 and OPCS 4.9.
- To help and support the clinical collaboratives, the Business Intelligence Unit and the Data Quality Team develop analytical tools and reports to help identify operational and clinical efficiencies and to help improve their data quality.
- To maintain compliance with legal and regulatory requirements, the Trust routinely monitors the completeness and quality of data. Monitoring reports and audits are used to improve processes, training documentation and use of computer systems. Examples of monitoring include:

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

All members of staff involved in recording patient data have the responsibility to ensure they keep up to date with NHS data standards and recording guidance relevant to their role. Online data quality awareness sessions are available via the data quality intranet. These sessions are easily accessible and cover key

data recording standards along with a range of guidance documents which keep members of staff updated on any new or changes to data recording.

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

10. Learning from deaths COMPLETE

During 2023/24, 1,951 patients of South Tees Hospitals NHS Foundation Trust died. This comprised the number of deaths which occurred in each quarter of that reporting period:

- 440 in the first quarter.
- 443 in the second quarter.
- 512 in the third quarter.
- 556 in the fourth quarter.

By 31st March 2024, 469 case record reviews and 28 investigations have been carried out in relation to 1,951 deaths above. In 28 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:

- 167 in the first quarter.
- 86 in the second quarter.
- 105 in the third quarter.
- 111 in the fourth quarter.

2 representing 0.1% of the patient deaths during 2023/24 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% of the number of deaths which occurred in the quarter for the first quarter.
- 0 representing 0% of the number of deaths which occurred in the quarter for the second quarter.
- 1 representing 0.2% of the number of deaths which occurred in the quarter for the third quarter.
- 1 representing 0.2% 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.

The Trust established a Medical Examiner Service in May 2018. Approximately 99% of deaths are scrutinised by Medical Examiners. Any death where there may be a problem in care (or that meets specific criteria) is reviewed by a central team of four consultants with expertise across many specialties. Each review results in two grades, one for quality of care and one for preventability of the death. Particularly complex cases are further reviewed by a cross-specialty panel of senior medical and nursing staff.

Learning and actions resulting from death reviews include:

- **End of Life Care.** Actions are co-ordinated through the End of Life Care (EoLC) Group. The group is overseeing the update of Care in the Last Days of Life and After Death (Adult) Policy to reflect learning. The group is also supporting the implementation of 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) and other end of life documentation in the MIYA Electronic Patient Record. This will ensure appropriate steps are taken to enable improved completion of relevant documentation and improved visibility of DNACPR and stratified treatment escalation plans, and to facilitate data collection for ongoing monitoring and learning.

- **Documentation** in the medical records. Electronic prescribing and medicines administration (ePMA), also known as e-prescribing has been made available in the majority of inpatient areas during 2023/24, and along with clinical noting and other modules within the MIYA Electronic Patient Record, and implementation of the Opera system (a scheduling and management tool) in theatres, has changed documentation of clinical care. Medical Examiner scrutiny and Trust Mortality Surveillance Reviews are sources of intelligence used to inform the development and implementation of these systems, meaning that the learning from deaths is being incorporated into future documentation of clinical care.

- **Coordination of care** between specialities. In paper records, coordination of care was not easily identified in medical records 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 and remains a key topic discussed by both the MIYA Board and the MIYA Clinical Working Group which lead developments in this field.

- **Transfer of patients from other hospitals**. 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.

362 case record reviews and 10 investigations were completed after 31 March 2023 which related to deaths which took place before the start of this reporting period.

3 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.

4 representing 0.1% of the patient deaths during 2022/23 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting against core indicators

1. Summary Hospital-level Mortality Indicator (SHMI) and Palliative Care Coding COMPLETE BUT DATA REFRESH AWAITED FROM NHS DIGITAL (DUE 9/05/2024).

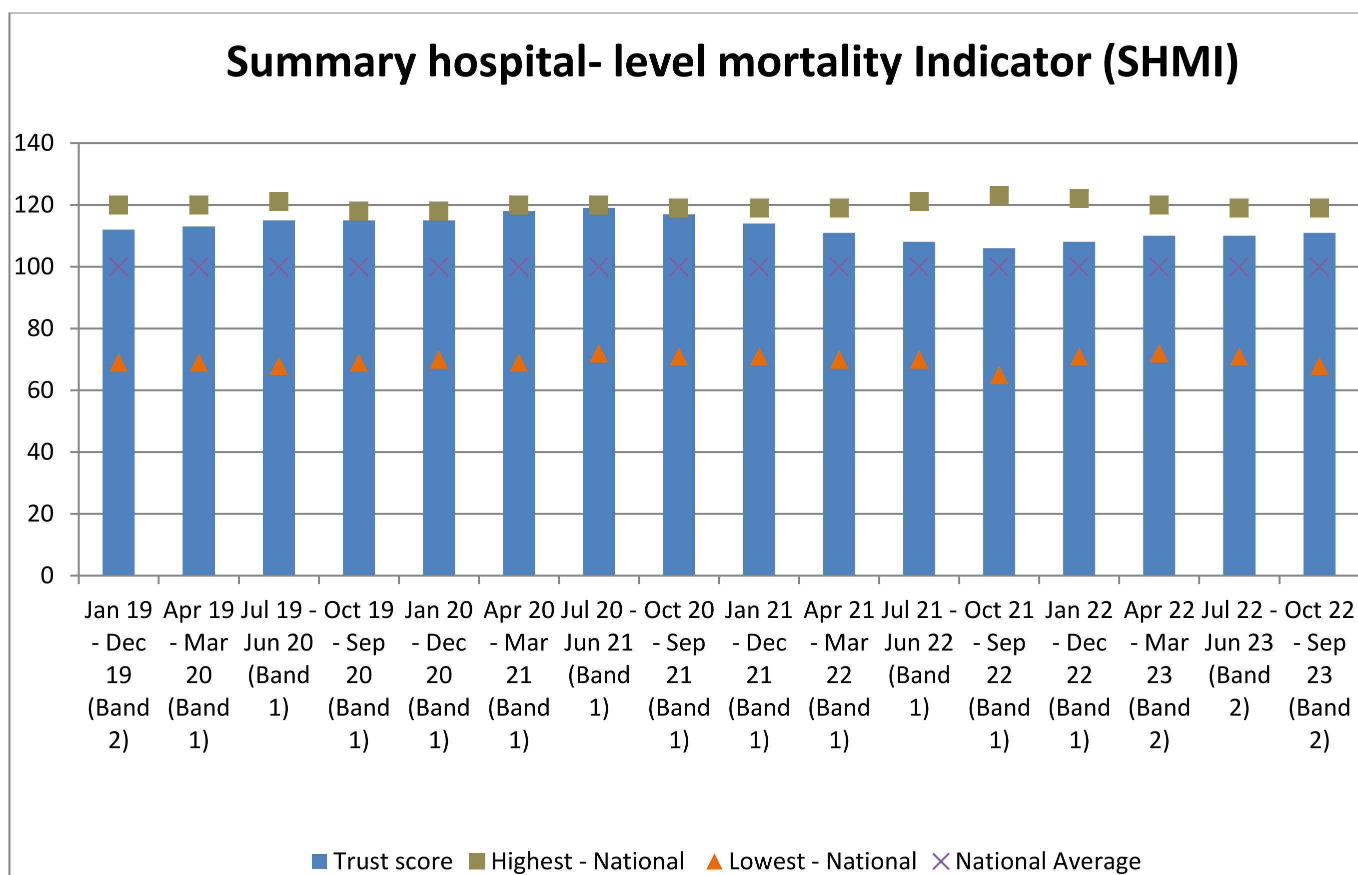


Figure 7: Summary Hospital Level Mortality Indicator (Data source: NHS Digital) To make national average easier to see on graph when data refreshed.

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

1. The SHMI is not designed to account for the COVID-19 pandemic and although spells coded for COVID-19 have been removed by NHS Digital from the indicator calculation, the large reduction in the number of admissions to hospital, particularly during wave 1, has had a substantial impact on the expected number of deaths. For the 12 months January to December 2023 the number of spells included in SHMI is 92% of pre-pandemic levels, partly because 2.5% of spells have been removed by NHS Digital because they contain a spell code for COVID-19. However, SHMI has fallen compared to the pandemic period and is 'as expected' meaning that the number of observed deaths is within the statistical limits, compared to the estimated number of hospital deaths expected given the population of patients cared for in the Trust. The fall in the number of admissions has not been experienced evenly across the country, with areas that had high levels of COVID-19, such as the North-East, experiencing a greater impact.

2. Despite the high level of need in the population the Trust serves, the organisation has historically fallen behind other Trusts in recording the number of other medical conditions patients have, alongside the main illnesses being treated. The Trust is in the process of implementing electronic records systems which are expected to address this comorbidity recording anomaly over time. There may be a short-term reduction as the system is refined and becomes embedded in clinical practice. An improvement has occurred in the 12 months to December 2023 in coding of elective spells and a small fall in non-elective spells, although improvements are expected as electronic records continue to develop.

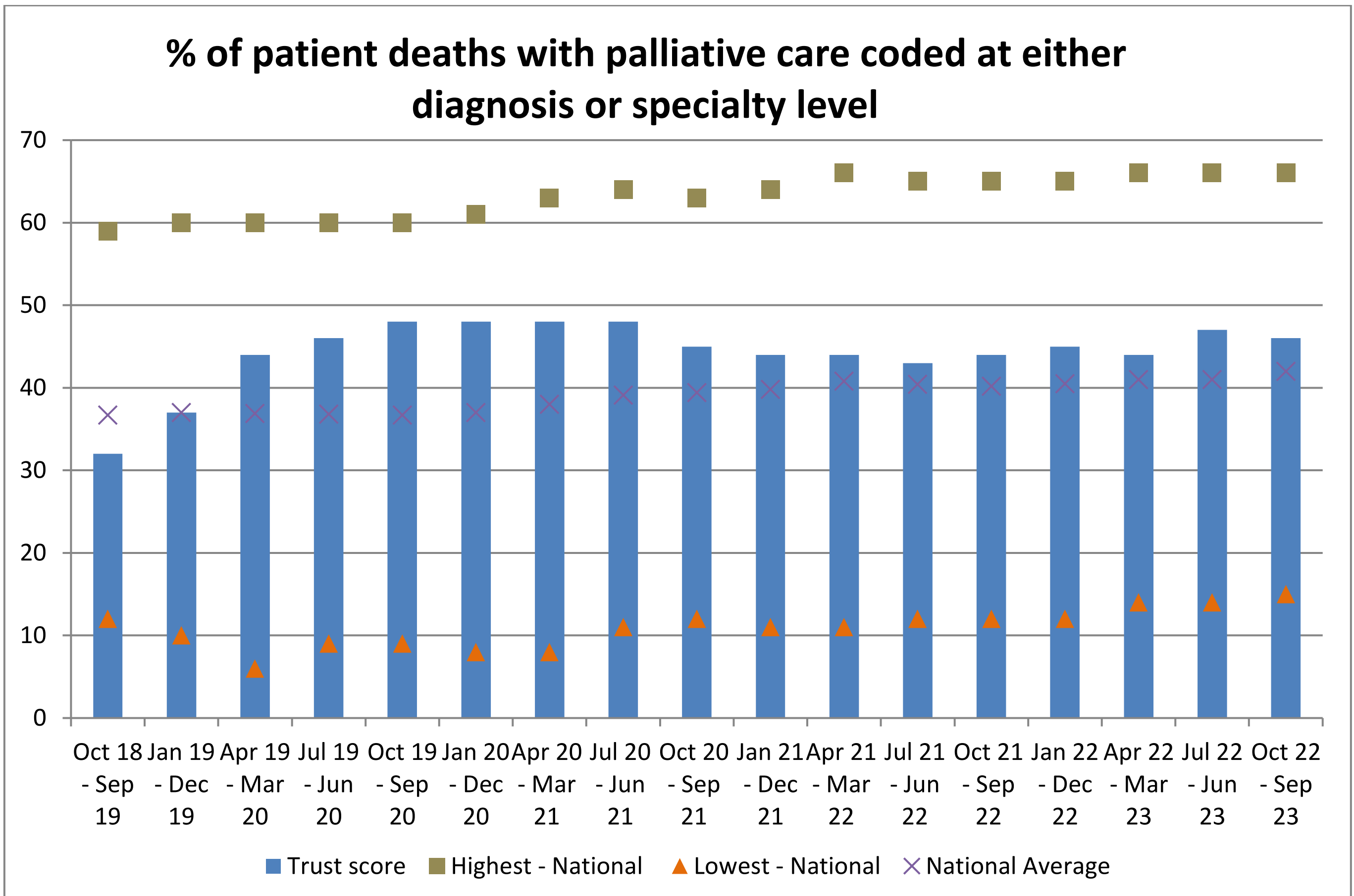


Figure 8: Percentage of Patient Deaths with Palliative Care Coded (Data source: NHS Digital)

The percentage of patient deaths with specialist palliative care coding has been higher than the national average in the last twelve reporting periods and this indicator is stable in the last five at about 45%. This reflects the work that was done to ensure that all the specialist palliative care provided to patients was captured in the coding used to calculate SHMI. This involved a comparison between two digital systems used to record the care provided.

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

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

2. Patient reported outcome measures NO UPDATED DATA AVAILABLE FROM NHSE

Patient reported outcome measures (PROMs) capture a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a healthcare procedure and provides an indication of the outcomes or quality of care delivered to NHS patients (http://www.hscic.gov.uk/proms). The score reported is an adjusted health gain score based on case mix, a higher number indicates a better health gain.

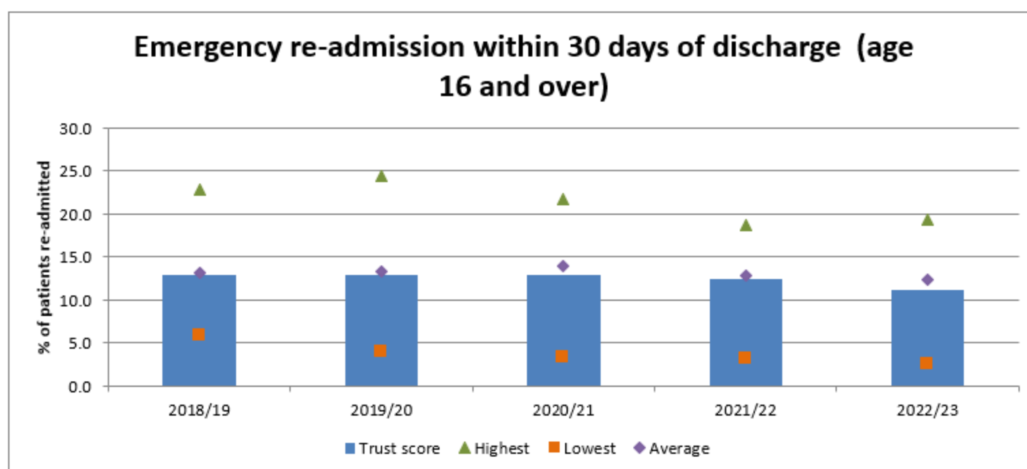
This report would normally include data from NHS Digital in relation to health gain scores for hip and knee replacement patient reported outcome measures.

The North East Quality Observatory Service (NEQOS) have provided a statement:

NHS England have published provisional 2022/23 PROMs data, however due to the earlier publication date there was a significant reduction in the number of PROMs questionnaires received. As a result of this there is insufficient data to make meaningful comparisons and they have not published a score comparison tool. NEQOS analysed and assessed this data, but with all North East and North Cumbria (NENC) Trusts showing fewer than 30 modelled records for both hip and knee replacements NEQOS feel that any reports created using this data would be unrepresentative and not useful. NHS England have not yet confirmed a publication schedule for final 2022/23 data or 2023/24 data.

3. 30-day readmissions COMPLETE

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



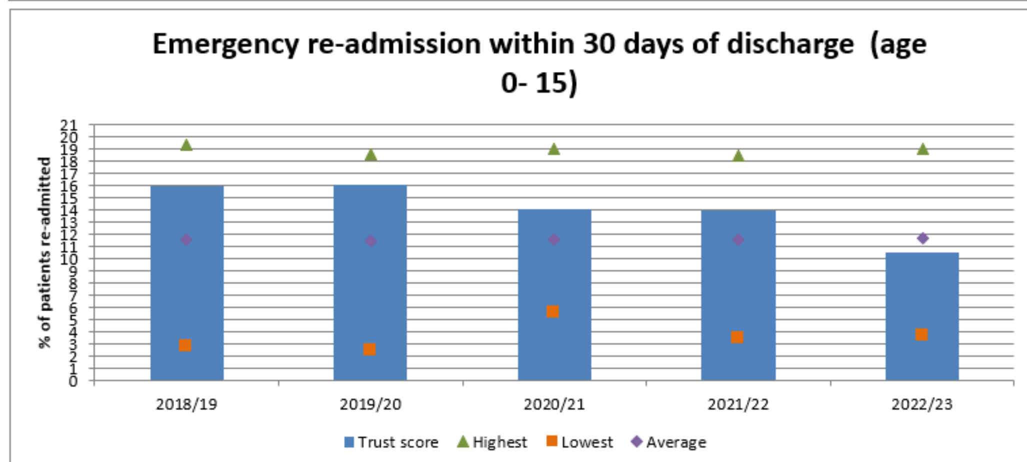


Figure 9: Emergency re-admission data within 30 days of discharge by age category from 2014/15 to 2022/23 (Data source: NHS Digital)

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

- The percentage of re-admissions for patients aged over 16 decreased from 12.9% in 2020/21 to 11.2% in 2022/23.
- The percentage of re-admissions for patients aged 0 – 15 decreased from 14.1% in 2020/21 to 10.5% in 2022/23.

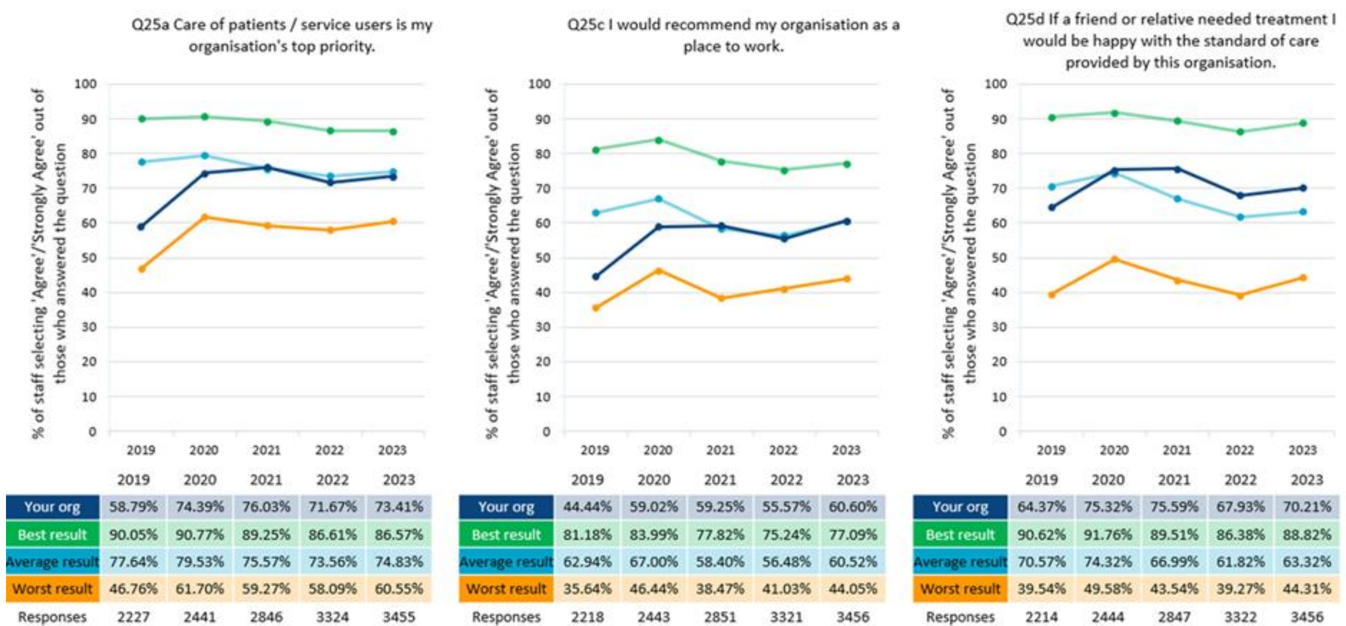
The Trust has taken the following actions to further improve these scores, and therefore the quality of its services:

Whilst the data is a positive reflection of patient care, the Trust continues to be focused on improving patient care and therefore reducing emergency re-admissions. More options for preventing admission and readmission have been developed, for example the establishment of Acute Respiratory Infection Hubs in primary care and increasing use of Same Day Emergency Care, (and this year a new Urgent Treatment Centre at James Cook will open) and this means that children and young people can been seen and treated without inpatient admission.

4. Responsiveness to the personal needs of its patients during the reporting period NO UPDATED DATA ON NHS DIGITAL

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

5. Staff Friends and Family Test COMPLETE



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

	2019	2020	2021	2022	2023
Your org	58.79%	74.39%	76.03%	71.67%	73.41%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	2227	2441	2846	3324	3455

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

	2019	2020	2021	2022	2023
Your org	44.44%	59.02%	59.25%	55.57%	60.60%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	2218	2443	2851	3321	3456

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

	2019	2020	2021	2022	2023
Your org	64.37%	75.32%	75.59%	67.93%	70.21%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	2214	2444	2847	3322	3456

Table 4. NHS Staff Survey results relevant to staff friends and family test (Data source: NHS Staff Survey benchmark report 2023)

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

The Trust has continued to make significant improvements in all areas and is above the sector average for:

- Recommending the organisation as a place to work, and
- if a friend or relative needed treatment, would be happy with the standard of care provided by this organisation.

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

- The Trust will continue to work with staff to improve the quality of care that we provide to patients. The Trust continues to be a clinically led organisation with the Clinical Policy Group making decisions on the best way for the organisation to deliver excellent patient care.
- South Tees Hospitals NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust have formed a Hospital Group which will enable the best possible patient care to be delivered across the Tees Valley area. As part of the Hospital Group, we are developing six clinical boards to develop transformation strategies within six key clinical areas.
- The Trust continues to promote the development of the Hospital Group and the exciting opportunities for improving patient care via various briefings, bulletins, and other communications. These also include developments of our staff networks, development opportunities and recognition for the excellent achievements by staff in the form of 'STAR' awards and the annual #LoveAdmin Awards Celebrations.

6. Venous thromboembolism risk assessments COMPLETE

The National Institute for Clinical Excellence (NICE) recommends that all patients in 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 prevent VTE. This measure shows the percentage of eligible inpatients who were risk assessed. A high percentage score is good.

Our most recent internal data regarding VTE risk assessment (February 2024) shows 86.6% compliance against a target of 95%. This is against a background figure of 87.5% for the year 2023 and 88.8% for the year 2022. Data source is e-CAMIS digital administration system.

While we accept that occasional patients do not receive a VTE risk assessment or prophylaxis, we believe that the majority of non-compliances relate to problems with data collection rather than clinical omission. A review of the three clinical areas with the highest numbers of VTE risk assessment non-compliances, accounting for more than half of the non-compliances across the whole Trust, found no clinical concern. Instead there were problems with poor recording of completed risk assessments on the CAMIS digital administration system and inappropriate counting of day patients who do not need routine VTE risk assessment.

Within the past two years many wards have moved from using paper prescriptions to electronic prescriptions, and VTE risk assessments are now being recorded directly on the electronic prescribing system in these areas. When auditing VTE risk assessment on the electronic prescription system, we see that every ward audited had higher levels of completed VTE risk assessments than recorded on CAMIS. This is because we can now directly count all completed VTE risk assessments rather than relying on the completion of the risk assessment then being recorded on the CAMIS system. The data from our electronic prescribing system shows a completed VTE risk assessment figure of 98.0% vs. 86.6% recorded on CAMIS for February 2024. Electronic prescribing has not yet been rolled out to all clinical areas, but going forward we expect this will resolve many of the data collection problems.

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

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

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

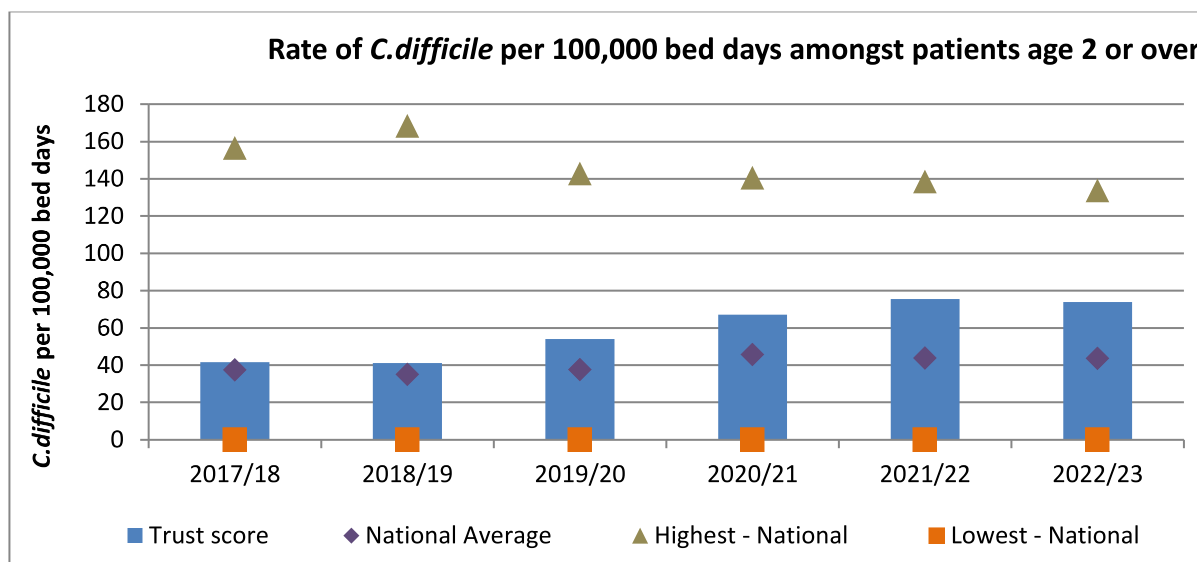


Figure 10: Rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over. (Data source: NHS Digital)

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

- Hospital onset healthcare associated (HOHA): cases that are detected in the hospital 2 or more days after admission (where day of admission is day 1), and
- Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.

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

- The Trust is required under the NHS Standard Contract to minimise rates of *C. difficile* infection so that it is no higher than the threshold level set by NHS England.
- The data (figure 10) reflects the ongoing work within the Trust in relation to *C. difficile* infection. More specific information around performance is reported in section 3.2.

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

- The Trust has a comprehensive recovery action plan for the prevention of Trust-attributed *C. difficile* infections which is monitored through the Infection Prevention and Control Strategic Group and reported through to the Safe and Effective Care Strategic Group.
- Alongside this recovery plan, each of the clinical collaboratives hold their own *C. difficile* action plan relevant to their area of clinical expertise and report on this through the appropriate governance structures.
- All trust-attributed cases have a Rapid Learning Review undertaken in line with PSIRF. These reviews are chaired by the Deputy Director of Infection Prevention and Control (DDIPC) or a senior infection prevention and control (IPC) nurse and have been supported by integrated care board (ICB) colleagues. If the panel agrees that there were no issues in care, then the case may be discounted from the total for internal performance measurement purposes only, as nationally the financial sanctions for C. *difficile* have been removed and the ‘appeals’ process is no longer in use.

Identifying a single root cause in cases of C. *difficile* is challenging and they are often associated with one or more influencing factors such as patient factors e.g., existing long-term conditions, and/or medical factors such as the requirement for antibiotics or laxatives and/or invasive procedures and investigations.

- Learning from the Rapid Review process and aligned to the recovery plan the Trust has implemented a monthly C. *difficile* task and finish group with escalation to the senior nursing team meeting to ensure completion of actions across the organisation.
- Continuous update of the C. *difficile* training packages for all staff.
- Membership of the Northeast and North Cumbria ICB 'Deep Dive' around C. *difficile.*
- Membership of NHS England national 'Deep Dive' around C. *difficile.*

8. Patient safety incidents COMPLETE

The NHS England data looks at three measures related to patient safety incidents reported to the National Reporting and Learning System (NRLS):

1. The number and percentage of patient safety incidents reported that resulted in severe harm or death. A low number and percentage are good.
2. The rate of patient safety incidents reported per 100 admissions / 1000 bed days.
3. The total number of patient safety incidents reported.

Data related to 1 and 2 is benchmarked against national data. Please note that the data below (figure 11) is the most recent patient incident data published by NHS England for Quality Accounts.

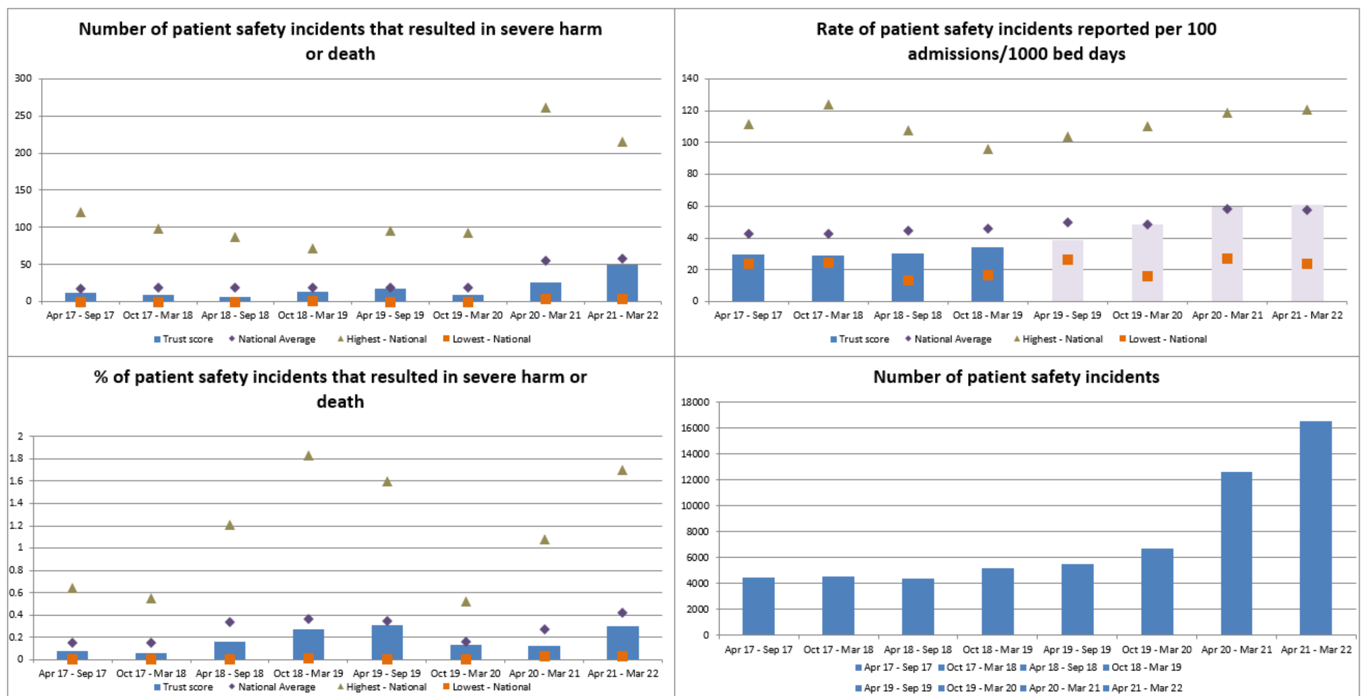


Figure 11: Benchmarked patient safety incident data (Data source NHS England)

We have included some more recent related data from our internal data reporting below (figure 12).

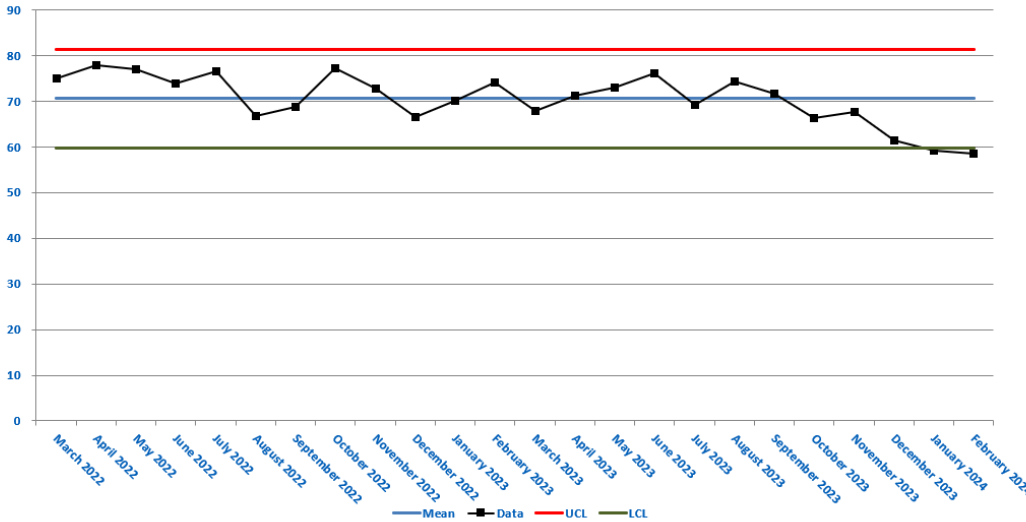


Figure 12: Trust incidents per 1000 bed days March 2022 – February 2024.To refresh with chart from April IPR

As can be seen above (figure 12) there has been a reduction in the number of incidents reported per 1000 bed days despite reporting levels being maintained in line with the expected trajectory. Compared to August 2023, there has been an increase in bed days across the Trust by approximately 3000 which is likely to account for the apparent reduction in associated incidents reported. The number of incidents reported per 1000 bed days increased in March, which may reflect the beginning of the closure of winter beds and therefore a reduction in bed days. The patient safety team will continue to monitor this closely.

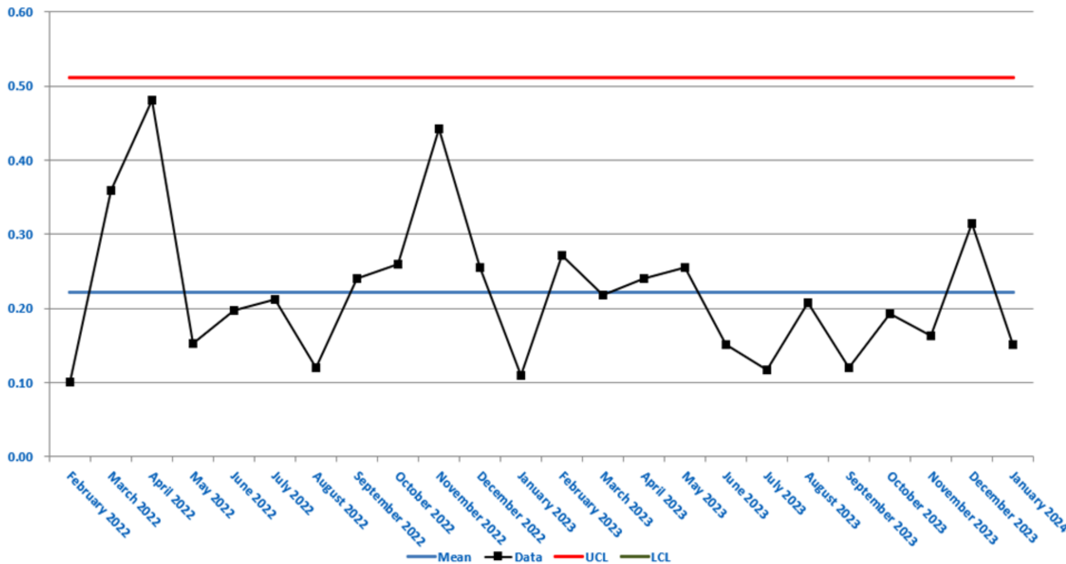


Figure 13: Trust serious incidents per 1000 bed days February 2022 – January 2024

Over the previous 12 months, 92 serious incidents have been reported by the Trust inclusive of never events (figure 13). The average number of serious incidents each month over the last 12 months remained between seven and eight.

The Trust's PSIRF Plan and Policy have been approved by the Trust Board and the ICB and have been implemented since 29 January 2024. Therefore, January will be the last month where incidents will be reported through the serious incident framework.

The Trust reported three Never Events during 2023/24, the lowest number since the national Never Event list was revised in February 2018 (see table 5). This is evidence of the ongoing commitment of all colleagues to provide safe care to our patients. NHSE is currently undertaking a review of the Never Event

list to determine if there are truly strong and systemic barriers in existence to prevent these incidents from occurring. The list is likely to change and therefore future data may not be comparable.

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

Table 5: Number of Never Events reported annually since 2018/19

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

- The Trust's incident reporting levels have remained consistent between 2022/23 and 2023/24, however the number of bed days within the Trust has increased by 3000 since August 2023, which has impacted on the data as illustrated in figure 12.

- The number of Never Events occurring within the Trust during 2023/24 is at the lowest since 2018. This could be explained by the enhanced approach to sharing learning across the Trust, the ongoing work to embed Local Safety Standards for Invasive Procedures (LocSSIPs) to ensure consistency in practice in particular clinical situations, and the move to using a systems approach to patient safety investigations to ensure actions are based on strengthening processes rather than focussing on the actions of individuals.

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

- Over the next year, in order to increase incident reporting, the Trust will focus on sharing the improvements undertaken following incidents being reported to demonstrate the outcomes of this process. The Trust will also continue to embed the restorative and just culture approach to patient safety, to enable psychological safety for all staff groups across the organisation.

9. Patient Friends and Family Test COMPLETE

The 2023/24 patient friends and family test (FFT) data is provided in section 3.1 of this report.

3. Overview of quality of care and performance indicators

3.1 Overview of quality of care

Patient Safety

a. Safeguarding, Mental Capacity, Mental Health Legislation, Learning Disabilities and Autism COMPLETE

Within the last year there has been a joint team effort to focus on promotion of our service. This has included:

- The design of a corporate logo to give us an identity.
- Representation and promotion across two safeguarding weeks for North Yorkshire and nationally in collaboration with our partnerships.
- Opening our doors to facilitate student placements.
- Creation of a team film to highlight and promote what we do.
- A safeguarding conference with a focus on various aspects of exploitation and how this impacts on adults and children.
- Refreshing the role of safeguarding champions.

In addition, our popular newsletters and social media posts have continued to cover a wide range of topics and lessons learnt.

There has also been some work undertaken to develop psychological safety and cohesive work with the safeguarding team including restorative training, leadership training and joint whole team civility and insights sessions.

We have created processes for themes which straddle across all our areas of work, but which needed clearer oversight and governance.

- A gap was identified in how allegations against staff are managed which could lead poor decision making and risk. A joint policy was therefore created and ratified in partnership with HR and a training package created and delivered to both teams. This will now be rolled out across the Trust through the Management Essentials programme.
- The team now collate and report on the number of Freedom of Information requests.
- The multi-agency public protection (MAPPA) agenda is co-worked between safeguarding and security management. A policy has been ratified and there is reporting through safeguarding governance.
- The team nave been upskilled on the local PREVENT picture and the relevant Trust staff have received an annual update.
- The new group Board received safeguarding training in March 2024.

Safeguarding training compliance for all staff has been maintained at a high level and the offer has been widened to an interactive session on Microsoft Teams as well as face to face to assist our staff and ease pressure. Figure 14 below relates to staff who require safeguarding training at different levels and highlights the proportion of those staff who have completed the training (compliant), and those who have not (non-compliant).

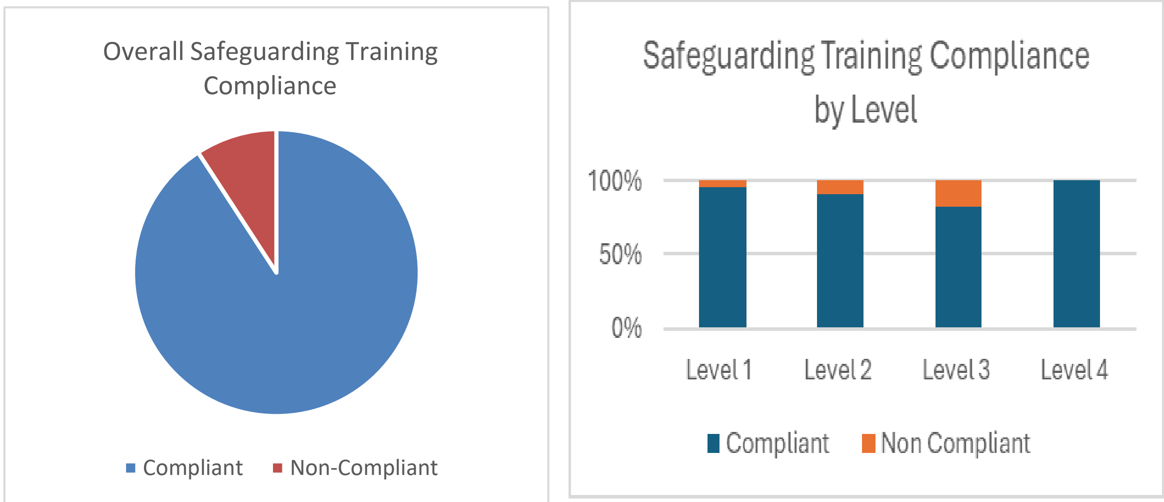


Figure 14: Safeguarding training compliance .

Adult Safeguarding

Safeguarding is a positive duty placed on all staff under Section 42 of the Care Act (2014) to promote the wellbeing of vulnerable people and protect them from harm whether the harm is intentional and irrespective of whoever causes the harm. Safeguarding duties are rooted in law; based around the protection of human rights. As a public authority the Trust must follow the Human Rights Act (1998) in everything it does and treat people in accordance with their rights. The Trust has a clear outline of executive accountability within governance structures, which provides a framework for the sharing of learning across services. This sharing has been strengthened by an ever-growing cohort of safeguarding champions (currently over 100) within clinical teams.

During 2023/24 the team have provided consistent support to our partner agencies within the Teeswide Safeguarding Adult Board (TSAB) and North Yorkshire Safeguarding Adult Board (NYSAB) sub-groups, participating in guidance and policy development, performance reports and multi-agency audits, and engaging with communities during safeguarding weeks. They have developed the quarterly reporting templates to include more core measures and improve data collection.

Key areas of concern have been in relation to discharge, nutrition, and medication. There is now safeguarding representation at both the nutrition and discharge steering groups. Safeguarding support for the new discharge hub at James Cook Hospital including bespoke training and input into discharge documentation saw significant improvement, with discharge dropping from being our number one area of concern, to being outside the top three. The team access the daily patient safety huddles and current cases meetings when needed in order to provide a timely and joined up response to incidents and complaints.

Local partnership learning has identified significant safeguarding risks of self-neglect in people with diabetes. The team now support our diabetic service to reflect and consider how to address challenges such as poor engagement of patients with their diabetic care.

A new Safeguarding Adults Practitioner with experience of mental health practice has begun working with the team. This is very beneficial to managing our complex cases and supporting the development of our Trust mental health strategy.

There has been significant work to promote the role of the Trust Independent Domestic Violence Advisor (IDVA) throughout the Trust with the creation of a promotional poster (figure 15) and an improved referral pathway. Referrals have increased by 55% from last year.

The Mental Health Act (MHA) is the statutory framework used to provide care and treatment for people with mental disorder, which sets out when and how people can be detained for assessment and/or treatment without their consent. The Act provides safeguards designed to protect the rights of the detained person. The Trust may need to detain a small number of patients under the Act on either JCUH or FHN sites where their physical healthcare needs take precedence over their mental healthcare needs. The Trust has a group of staff that carry out the designated staff member (DSM) role and ensure that the rights of the detained person are safeguarded. There is a mandatory annual training programme delivered by the Safeguarding Team for DSMs, and supervision is also available for these staff. Compliance with training is currently 72%, with booked attendance on two further scheduled sessions before 9 April 2024 that will take compliance to 94%.

Figure 15: Poster to highlight the role of the Trust Independent Domestic Violence Advisor (IDVA).

Safeguarding Children and Unborn Babies.

The Safeguarding Children Team are key members of the multi-agency safeguarding systems that are in place to protect unborn babies, children and young people. The role is to ensure staff identify and advocate for vulnerable children, identify safeguarding concerns, and take action in the form of timely referrals to children's social care and specialist support services.

- The Safeguarding Children Team take an average of 1350 calls from Trust staff and partner agencies.
- Trust staff make an average of 495 safeguarding children's referrals per quarter.
- Paediatric consultants carry out an average of 44 child protection medicals per quarter.

The Team continues to represent the Trust at South Tees Safeguarding Partnership meetings and actively contribute to the multi-agency work programme across the Partnership. They contribute to multiagency child safeguarding practice or learning reviews and participate in identifying learning and implementing action plans. The team undertake regular audits to gain assurances around safeguarding practice including:

- Multi-Agency Risk Assessment Conference (MARAC) referral audit
  The audit found that referrals were of good quality and 80% of referrals made were heard at MARAC which is an excellent conversation rate. A recommendation of the audit was to move from handwritten referrals to an electronic referral process and work is ongoing to achieve this.

- <u>Symphony Exploitation Screening tool audit</u>
  An exploitation screening tool is embedded within Symphony (an electronic patient administration system) which encourages staff to consider exploitation risk when a child attends Children and Young People's Emergency Department (CYPED). Following the last audit cycle consideration is being given to different methods of engaging children and young people such as QR code questionnaires.

- <u>Hidden males audit</u>
  This identified that it is still not readily documented who is accompanying a child or birthing person to hospital. This is important to ensure that if a concern arises that it is known who was involved with the child and/or family at that time. The team have designed a poster (figure 16) as part of the actions from this audit which is visible in wards and departments.

Figure 16: Poster to promote recording the name of those accompanying a child or expectant mother to health services.

The Childrens Safeguarding Team and the Children with Complications of Excess Weight (CEW) Team have worked closely since the CEW team was established. The safeguarding support provided has adapted and increased frequency, as the team has grown. The CEW Team report feeling well supported in safeguarding their service users.

The neonatal meetings set up last year have continued to develop. This summer there was a focus on the learning from the Thirlwall inquiry (following the Lucy Letby case) which was shared at the Safeguarding Strategic Group. There has been safeguarding support with the integration and development of user guides for safeguarding documentation on the new maternity and neonatal care record, Badgernet. A pathway assessing bruising in non-mobile babies and children for ED was created and launched.

A Joint Targeted Area Inspection has been anticipated on the subject of serious youth violence. The team have worked with the partnership to prepare for this through looking at cases and scrutinising our practice as individual agencies and collectively.

A new safeguarding specialist practitioner has joined the team with a specific role for young people and transitional safeguarding involving young people moving from children's to adult services.

All Community Midwives are required to have 12 weekly supervision and must attend at least once a quarter. Compliance has consistently remained at over 98% throughout 2023/24. The safeguarding children's team also offer supervision to specialist paediatric staff including:

Safeguarding Supervision – Specialist Paediatric Nurses / AHPs 2023-24	
Neonatal Community Team	Dermatology Nurses
Dieticians	Asthma Nurses
Continence Nurses	Speech and Language Team
Epilepsy Nurses	Cystic Fibrosis Nurses
Enhanced Maternity Practitioners	Therapies Team
Diabetes Nurses	Community Nursing Teams
Enhanced Maternity Support Workers	Complications of Excessive Weight Team

Mental Capacity Act/Deprivation of Liberty Safeguards.

Mental capacity oversight sits within the safeguarding team. The Mental Capacity Act (MCA) Lead post is currently covered by an interim lead due to extended leave.

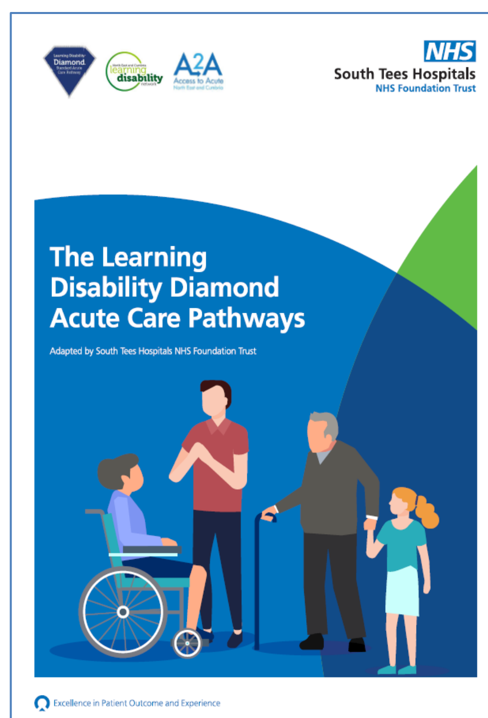
The anticipated Liberty Protection Safeguards legislation to replace Deprivation of Liberty Safeguards (DoLS) has been put on hold by the Government. Waiting for this has given us the opportunity to improve our current MCA and DoLS audit processes to gain better oversight and comparison data. An improved database has been established and the MCA Lead attends regional DoLS forums. Both the permanent and interim MCA Leads have achieved Best Interest Assessor qualifications in the last 12 months.

MCA and DoLS documentation is now integrated into patient records using MIYA Noting which ensures clear records and templates for all staff and a quality standard which can be overseen and reported on remotely.

MCA training currently sits within safeguarding training therefore the compliance levels are the same as those above within figure 14. This training has also been accredited for continuous professional development in the last six months. Bespoke training sessions are provided for staff routinely as well as on request and in response to gaps identified within audits.

Learning Disabilities and Autism.

Over the last year we have significantly increased the number of patients with a learning disability identified on our electronic system. This positive change is a result of a close partnership with our neighbouring mental health and learning disability Trust (Tees Esk and Wear Valley NHS Trust). Due to collaborative working we can identify patients with a learning disability in advance of their involvement with our Trust. In addition, a Learning Disability Liaison Nurse has joined the team to help support people with a learning disability across all areas of patient care, and consequently many more patients than previously have been supported.



There is a national drive to implement training written in conjunction with the family of Oliver McGowan following his death. Mandatory e-learning learning disability training has been implemented for all staff to complete. Meanwhile progress is being made towards an agreed Oliver McGowan regional training model, with the Trust working in partnership with our local ICB on presentation and delivery. The Trust is waiting for the Learning Disability and Autism Training Code of Practice to be published before updating the current training package. However there has been a drive to improve staff knowledge and understanding of reasonable adjustments over the past year, to ensure reasonable adjustments are considered at all points throughout the patient journey.

In conjunction with our Learning Disability Diamond Acute Care Pathways a Maternity Learning Disability Care Pathway has been developed collaboratively with the Northeast and North Cumbria Learning Disability Network, in order that the care received by women with a learning disability accessing maternity care in this Trust is optimal.

The Learning Disability Partnership Group meets every two months. It is well attended by internal and external representatives, with people with lived experience taking an active role.

A gap analysis has taken place in relation to how we support our patients with autism. The Learning Disability Team are progressing this work with a focus on training and care pathway for staff. Most of the team have completed face to face training on neurodiversity in the last six months.

Summary and next steps

Much of the work described will be ongoing, but other work being planned includes:

- Confirmation of the next annual safeguarding audit plan.
- Completion of a harmonisation plan to work cohesively with North Tees Safeguarding Team.
- Further work on the safeguarding content within patient records using MIYA Noting.
- Wide dissemination of the safeguarding film for information.
- Further development of the role of safeguarding champions.
- Agreeing and embedding learning disability and autism training.

b. Nutrition and hydration COMPLETE

Adequate nutrition and hydration is a fundamental standard and basic human right for all patients in receipt of NHS care. All patients should have their nutrition and hydration needs met in line with their assessed requirements and best practice. To achieve this there must be effective systems in place to demonstrate this fundamental standard is being achieved. The Trust now has a well-established Nutrition Steering Group, with supporting workstreams (or councils) for Nutrition and Hydration, Children's Nutrition, Enteral Nutrition and Parenteral and Complex Enteral Nutrition.

Significant nutrition and hydration improvement activity has continued throughout 2023-24, with examples below:

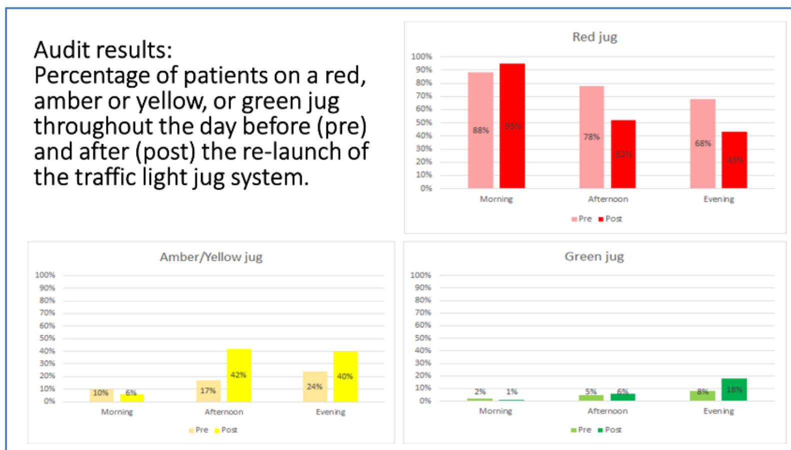
Ward Nutrition Assistants

The role of the ward nutrition assistant has gained an increased profile across the organisation over the last year. We currently have 13 employed as part of ward establishments across the Trust, with additional wards going through the recruitment process. The nutrition assistant is responsible for supporting ward teams by completing food and fluid intake charts, taking patient weights, and monitoring 'traffic light jugs' used to improve patient hydration. They have a key role in assisting ward housekeepers to ensure the correct menu provision for patients with special dietary requirements, to provide extra nourishing drinks and snacks between meals for patients who need them, and to support patients who require assistance with eating and drinking. During the last year work has been undertaken to establish and strengthen their induction programme, and to produce a competency-based training package to support their development. A regular Nutrition Assistant Forum has now been set up to provide ongoing support, engagement, and education.

Improving Hydration

The traffic light water jug system was relaunched across the Trust in September 2023, with support from our ward nutrition assistants and nutrition coordinators, and a greater focus on increasing patient awareness of the importance of good hydration.

Coloured water jug lids are used as a simple visual way of monitoring how much patients are drinking to help minimise their risk of dehydration and acute kidney injury (AKI). Patients are given a water jug with a red lid in the morning. When they have drunk it all (or the equivalent volume of other fluids) the jug is refilled, and the lid is switched to a yellow one. When that is empty it is refilled, and the lid changed to a green one.



Use of the traffic light jug lids was audited before the relaunch in September 2023, and afterwards in November 2023. Results have demonstrated a significant improvement in patients' fluid consumption throughout the day.

Work continues to maintain this positive impact, and the audit will be repeated in 2024 with further local training where it is needed.

Figure 16: Audit results before and after relaunch of the traffic light jug system 2023

Digital Workstream Developments

The nutrition screening tool 'MUST' and nutrition care plans are now on the electronic observations and assessments system Patientrack across the Trust. During 2023-24 the initial phase of the electronic food record chart has also been launched. An evaluation chart has been developed alongside this to prompt staff to review patients' nutrition intake every three days to facilitate timely escalation of patients who may need consideration of additional or artificial nutrition support.

Enteral Tube Feeding Pathways

Some people who cannot get enough nutrients by eating need a feeding tube which is passed through the nose and into the stomach (a nasogastric or NG tube) or into the small bowel (a nasojejunal or NJ tube) for the purpose of enteral feeding. Patients requiring an NJ feeding tube would normally need to have this placed in the Endoscopy or Radiology Department. During the year our nutrition nurse specialists have completed competency training in a new technique of placing NJ feeding tubes called the CORTRAK procedure. This enables safe bedside placement of NJ tubes for patients who meet the criteria, reducing the number of requests for NJ tubes to be placed within Endoscopy or Radiology and facilitating more timely feeding tube placement.

Blended Diet Policy and Toolkit

The Children's Council and Enteral Council have worked together to produce and launch a joint policy on the use of a blended diet via a gastrostomy tube. This provides guidance on how 'home foods' can be safely blended to supplement enteral tube feeding regimens for those requiring long-term feeding and where patients, parents and relatives want to increase involvement in family meals, whilst ensuring this does not compromise nutritional value or nutritional status.

Patient Experience and Catering Surveys

Work continues to evaluate hospital food provision with ongoing collaboration with catering service providers to enhance the mealtime experience.

- The 2023 PLACE audit results for food rated the Trust at 95.34% (national average 90.9%).
- Improved surveys for evaluating hospital catering provision trust-wide were introduced during the latter part of 2022-23 and the overall results for 2023/24 compared to quarter 4 2022/23 show:
    - Overall response rate has increased to 86% from 81%.
    - 76% patients report being provided with a copy of the menu to enable food choice from 55%.
    - 91% of patients report satisfaction with the provision of between meals snacks from 82%.
    - 94% of patients continue to report they were offered meals that met their specific dietary requirements.

Work has also begun to establish more valuable methods of measuring the experience of our vulnerable patients. Close working with the Therapeutic Care Team has captured specific experiences of patients that have enabled a timely response to their individual needs to improve food choice and provision. This has facilitated learning from patient stories that has enhanced training and education of both catering and clinical staff. In addition, the process for identifying and managing adult and child in-patients with known food allergies and intolerances was reviewed and relaunched alongside guidelines for clinical staff.

Nutrition and Hydration Week 2024

The year ends, as always, with the annual national nutrition and hydration campaign. The engagement of clinical teams and wards across the Trust during the 2024 Nutrition and Hydration week (see figure 17) was phenomenal, with activities running daily to promote awareness of the importance of nutrition and hydration amongst our hospital population, and to support our patients with additional requirements. National Swallowing Awareness Day also fell within this week and a range of information resources were shared with staff to enhance their knowledge within this subject area. There was also a focus on nutrition and hydration for our staff.

Figure 17: Photos of activities across the Trust during 2024 Nutrition and Hydration week.

Summary and ongoing work

As part of the Nutrition and Hydration Improvement Plan, ongoing work will include:

- Development of a nutrition and hydration training matrix for all roles.
- Continued collaboration and developments with catering providers to ensure our organisation is compliant with PLACE, National Hospital Food Standards and the British Dietetic Association (BDA) Digest standards for the nutritional quality of food provision.
- Ongoing improvement work on the enteral tube feeding pathways.
- Review and update of the Parenteral Nutrition Pathways for adults and children.
- Completion of the nutrition dashboard to enhance monitoring of data, compliance, quality improvements and patient experience to enable us to be responsive to the needs of patients and the provision of optimal nutritional care.

c. Duty of candour COMPLETE

There is a professional duty of candour for healthcare staff and also a statutory duty of candour. They have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. The statutory duty also includes specific requirements for certain situations known as notifiable safety incidents.

Throughout 2023/24, the Trust has continued to strengthen the approach to duty of candour across the organisation. There have been education sessions provided to clinical staff to increase awareness of the regulatory and good practice elements of duty of candour and to promote the potential of the process to drive up the quality of care within the Trust.

The Trust's CQC inspection report published in May 2023 stated that across the organisation, all staff 'understood and demonstrated an awareness of duty of candour and the importance of being open and honest when delivering care' and that they 'gave patients and families a full explanation when things went wrong'.

Compliance with all elements of the statutory duty of candour is proactively and closely monitored within the Trust, with a bi-monthly report presented at the Patient Safety Steering Group. Any exceptions are routinely followed up by the Patient Safety team until there is evidence that duty of candour requirements have been fully met. Throughout the year, the Trust has monitored all notifiable safety incidents and has confirmed full compliance for each element of the duty of candour at the appropriate stage of the process.

To enhance the Trust's approach to fulfilling the duty of candour, the Family Liaison Officer (FLO) role is now firmly embedded within the organisation. The purpose of the FLO role is to facilitate the delivery of duty of candour, engaging with and supporting patients and/or families following the occurrence of a harmful patient safety incident, and enabling their meaningful involvement in the subsequent patient safety investigation. There are now over 60 trained FLOs within the organisation, with a further training cohort planned in September 2024.

To further strengthen the engagement and support provided to patients and/or families involved in patient safety incidents, the Trust commissioned six cohorts of Restorative Practice Facilitator training throughout 2023/24. The programme studies the ethos of a restorative approach in response to the impact of harmful events and relationship strain within the health setting. This focus explores the needs of impacted individuals and the context for restorative responses to healthcare harm.

During 2023/24, the Trust established a process to provide funding for counselling and therapeutic psychological input for patients and/or families who have been harmed during healthcare. This approach is recommended as best practice within the Harmed Patient Pathway developed by the charitable organisation Action against Medical Accidents (AvMA) and has so far provided timely support to a number of patients and/or their families since being implemented.

In summary, the Trust continues to promote openness and transparency as the default position for working with our patients and their families, with the aim of restoratively meeting the needs of all individuals affected by healthcare harm.

Clinical effectiveness indicators

a. Research and Innovation COMPLETE

Clinical Research

Clinical research helps us to improve patient care. Hospitals that are research active have better patient outcomes. Participation in research can help improve current and future care by finding new ways to diagnose, prevent, treat, or cure disease and disability. All research undertaken in the NHS is rigorously reviewed to ensure it is well designed and there are very clear regulations and guidelines to follow to

ensure that the safety of patients and their data is paramount. We have dedicated clinical and non-clinical staff employed in our trust to ensure that all research receives the relevant reviews and approvals, is conducted exactly as the research protocol directs and that patient safety is monitored throughout. The R&D Department employs over 130 members of staff directly supporting research and offers opportunities to clinical staff to work part-time within research to ensure research is embedded across the organisation. The Trust is a partner organisation within the Clinical Research Network for the North-East and North Cumbria (CRN NENC) and supports the CRN NENC to deliver and lead high quality research as part of the National Institute for Health Research (NIHR) portfolio. In 2019 we joined a strategic alliance with our research and development colleagues in North Tees & Hartlepool NHS Foundation Trust (NTH) to form the Tees Valley Research Alliance (TVRA) to offer an improved, efficient research service that would deliver more research opportunities to the patients of Teesside.

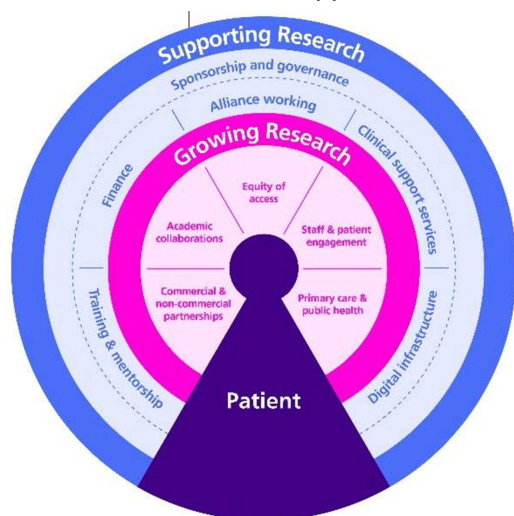


Figure 18: TVRA Strategy 2024

We have refreshed our TVRA Strategy to be delivered across both partner trusts in the Alliance. It is a patient focused strategy to deliver improved outcomes through two main streams 'Growing Research' and 'Supporting Research' (figure 18).

We have established a 'Community of Practice', bringing together researchers with a variety of experience from across the TVRA to support, mentor, learn and develop research collaborations across our two partner Trusts.

Successful contingency funding requests from the CRN NENC have enabled us to fund 12 additional nursing, midwifery and allied health professional (NMAHP) posts (3.15 WTE) in eight clinical areas including peri-operative medicine, renal/urology, critical care, stroke, nuclear medicine and cancer care. These will support existing clinical roles and patient recruitment, creating an embedded research culture within care delivery.

Both TVRA Trusts are now live on the global TriNetX platform (https://trinetx.com). This will allow greater visibility of our trusts to potential commercial research sponsors thus bringing more cutting-edge trials to our populations. It will also allow our own researchers to interrogate our Trust-based patient information systems to support study feasibility reviews.

Trust sponsored studies

The Trust has been successful in being awarded over £13.3 million (M) in grant awards in the last year. £2.5M of this was for general trust sponsored studies, £6.5M for Academic Centre for Surgery (ACeS) led studies and £4.3M for Academic Cardiovascular Unit (ACU) led studies. The recent achievements of the ACU and ACeS highlighted below illustrate the growth in our clinical academic units and how collaboration with external academic partners can attract funding and help secure research appointments into the Trust and lead programmes of impactful research for patient benefit.

Academic Cardiovascular Unit:

The results for a major trial that was recently completed by the cardiovascular research team have been published and presented internationally by Professor Enoch Akowuah. The Mini Mitral trial results can be accessed here (https://jamanetwork.com/journals/jama/article-abstract/2805908). Two MD fellows have been appointed and additional clinical academic fellowships are planned in collaboration with Newcastle

University. Seven applications for research grants led by the unit have been submitted this year and another four submitted as collaborators with other national organisations.

Academic Centre for Surgery:

A joint Senior Lecturer post has been appointed in collaboration with Hull York Medical School in addition to two academic Clinical Fellows. Two associate clinical lead posts will be advertised in 2024/25 to further support their research activity. Seven applications research grants led by ACeS have been submitted this year and another six submitted as collaborators with other national organisations.

Nursing, Midwifery, AHP and Clinical Research Practitioner engagement in research

We have extended the 'Research Support and Best Practice Council' to colleagues from North Tees & Hartlepool Trust. We have increased the number of non-medical Principal Investigators this last year from 24 to 43, with 31 at STH and 12 at NTH.

Patient Engagement

Feedback from patients who have participated in NIHR studies within the Trust is sought via the NIHR Patient Research Experience Survey (PRES) and is reviewed quarterly at our Directorate meetings. Due to high recruitment into trials last year our target for responses to the PRES survey was significantly increased to 644 for this year. Although we have not met the target for responses received, from the 186 responses to date 86% felt their contribution was valued and 89% would take part again if asked.
We have significantly improved the content of staff facing and patient facing internet sites and have developed a patient and staff facing animation to explain the purpose of research and how patients can get involved (https://staffintranet.xstees.nhs.uk/services/academic-centre/research/overview-of-research-at-south-tees-and-how-to-get-involved/).

Innovation

The challenge to improve healthcare delivery creates an environment for healthcare innovation in which we can generate new ways of working, thinking and engaging with healthcare to produce potentially transformative products and services for the benefit of our patients. The Trust is creating a culture of innovation and is committed to supporting our staff to innovate.

During 2023/24 staff made 28 enquiries to the Innovation Team about improving patient care by developing their own ideas or by seeking solutions to address unmet healthcare needs they had identified. Further assessment of 13 of these enquiries is ongoing. Five relate to unmet health needs, five to medical devices and three to non-medical devices. The Trust is reviewing solutions for the unmet healthcare needs which could be in-house software solutions for three, a possible medical device solution is being assessed for one and a non-medical device for another. The medical devices are all under assessment and / or further development. In relation to the non-medical devices, there are two proof of concept prototype devices being evaluated in-house, and another is being assessed as a possible solution may already be available.

Work continues regarding enquiries from 2021/22 and 2022/23. There are three new medical devices being progressed; one has undertaken proof of concept evaluation with the opportunity to evaluate further with medical certification taking place in-house; one has been developed and will undergo proof of concept evaluation; the last is still under development. Two identified unmet healthcare needs are being assessed and the Trust is reviewing opportunities to find solutions. Two software solution ideas have been developed with one undergoing in-house testing with the ambition that this will provide a solution to the wider NHS, and the other is being reviewed to see if it could provide a regional solution.

The Trust is hoping to launch a service for advanced surgical planning in 2024 from an idea raised in 2020. A proof of concept service has received favourable feedback and work continues to look at the opportunities for the Trust to provide this service to the wider NHS. An idea around a novel shoulder stabilisation implant, again raised in 2020, has completed proof of concept evaluation and a wider clinical trial is planned once intellectual property associated with the idea is protected. An agreement with an

industry partner has been completed to provide the Trust with an opportunity for further investment in South Tees Innovation should this lead to commercialisation of the product. An industry partner has also worked with the Trust on an innovative idea with a royalty payment arrangement due to be put in place.

Overall, the Trust continues to develop a culture of innovation and continues the work needed to progress the ideas that staff have raised.

b. STAQC and Endoscopy improvement journey COMPLETE

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

Accreditation is defined as the development of a set of standards so that areas for improvement can be identified and areas for excellence celebrated. Accreditations assess the balance of process and outcome data, environmental impact on care delivery, teamwork, impact on and relationships with relevant services along the patient pathway, staff and patient feedback, evidence of learning and continual improvement. Experience shows accreditation programmes can drive continuous improvement in patient outcomes and increase patient satisfaction and staff experiences at ward/department level. Using a collective sense of purpose teams can support communication, encourage ownership, and achieve a robust programme which measures and influences care delivery.

There are over 200 ward, teams and departments that are eligible for accreditation, which consists of:

1. Pre-assessment review of key outcome data, for example, nurse sensitive indicators, complaints and patient experience, a staff survey, human resources metrics such as sickness and appraisal.
2. An "on the day" assessment. The general assessment tool comprises of 163 items under the key headings of culture of compassionate care, well led, reducing avoidable harm and effective care. These are assessed by undertaking a documentation review, patient interviews, multi-disciplinary team and staff interviews, medical staff interviews and an environmental review.

There are specialist accreditation tools for theatres, paediatrics, maternity, ambulatory departments, critical care, and the emergency department.

There has been a continued focus during 2023/2024 to proceed 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 on a monthly basis to all diamond areas accredited, with a touch point for managers to offer support and guidance if required. This has proved successful in maintaining standards and keeping STAQC at the forefront.

Total achievements at end of year			**Key actions for STAQC team**
	2022/23	**2023/24**	• To maintain a comprehensive work plan, transparent to all teams. • To further refine and develop the programme. • To realign with the CQC quality statements. • To maintain a constant focus on shared ownership. • To undertake research/service evaluation into the impact of the programme.
Diamond accreditations	33	40	
Gold accreditations	31	52	
Silver awards	9	11	
Baseline accreditations	10	17	

Case study on Endoscopy Friarage STAQC journey

The Endoscopy Unit is a department within the Friarage hospital which delivers outpatient diagnostic procedures and surveillance of conditions. The unit performs gastroscopies, colonoscopies, flexible sigmoidoscopies and bronchoscopies serving a patient population from the Yorkshire Dales over to Whitby. The unit sees over 200 patients per week providing procedures seven days a week. The vision of the unit is to become a centre of excellence for training and to provide safe patient-centred care from admission to discharge.

The Endoscopy Department in Friarage hospital started their STAQC journey in December 2021. In July 2022 a new state of the art endoscopy diagnostic hub was opened with the layout of the department conducive to the patients journey and Joint Advisory Group (JAG) requirements. The hub has boosted the number of procedures being able to be performed and provides a one stop shop for patients. It hosts minimally invasive gastrointestinal services which provides an alternative procedure to a conventional endoscopy in selected patients and has access to a cytosponge to aid with the surveillance of patients with Barrett's oesophagus.

Figure 19: Rishi Sunak attending the Endoscopy Diagnostic Hub at Friarage Hospital. Check date / descriptor.

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

The unit was accredited a diamond STAQC award in January 2024. Some of the areas of excellence seen on the day included:

- The waiting room was bright and welcoming, the team had created a personalised staff wall and patients journey board to inform patients of what to expect within the unit. The team had also added activities such as word searches and puzzles to keep patients occupied.
- A staff member had created a distraction box for patients with additional needs and a picture journey book, this was exceptional.
- Staff spoke of an inclusive, cohesive team, with most of the staff saying it is the best team they have worked in.
- A staff achievement board celebrates staff training accomplishments, with all staff having access to the JETS programme, which ensures excellence and robust endoscopy standards are being met.

- The administration team have created a patient query book for patients requiring advice or follow up phone calls, and the team incorporate this into their daily workload demonstrating their responsiveness to patient's needs.
- Excellent student feedback has led to requests from various medical institutions to support their students.
- Excellent, comprehensive, and personalised documentation throughout the full endoscopy pathway was witnessed.

Well done Friarage Endoscopy!

Summary

It's like a ward managers handbook

An effective and manageable way in which to raise

"STAQC was exciting and valuable platform to showcase amazing leadership, team ethos, patient care and our teach, train & retain philosophy, demonstrating effective

The plan for 2024/2025 is to achieve eight accreditations per quarter. This is based on the STAQC team capacity and redeployment, team preparedness and engagement and operational pressures.

c. Fundamental standards of care AWAITING EXAMPLES / CASE STUDY

The Fundamentals of Practice meetings commenced January 2022 and are chaired by the Deputy Chief Nurse (DCN). The intention of this meeting was to triangulate all nursing and quality data to gain an overall understanding of the clinical safety within wards and departments aligned to the Care Quality Commission (CQC) lines of enquiry; culture of compassion, well led, avoidable harm and effective care.

The meetings are held each month with each collaborative and provide a psychologically safe environment for all teams to highlight key issues and celebrate achievements. It is an opportunity to review quality indicator collection (QIC) audits, quality dashboards, patient experience, and infection prevention and control audits. In month safeguarding and CQC enquiries are highlighted, identifying immediate learning and essential sharing. Alongside this learning from structured reviews and never events are also highlighted, and action plans tracked.

Workforce key performance indicators such as vacancies, skill mix, sickness, turnover and exit interviews are also reviewed in order to contextualise any workforce pressures against quality indicators, highlighting any additional support required from the wider organisation.

Having organisational oversight allows transparency of themes that sometimes are in common with each collaborative. When this occurs the DCN requests the clinical matrons to work in collaboration to address key issues in order to gain traction with improvements that are required. Key learning and sharing of good practice is an agenda item at the at Senior Professional Council.

d. In-situ cardiac arrest simulation COMPLETE

In-hospital cardiac arrests are relatively rare, with an incidence of approximately 1.0 per thousand admissions (National Cardiac Arrest Audit 2021-22). Whilst this is positive from a patient safety perspective, it gives clinical staff limited opportunity to utilise and retain their resuscitation skills. Although staff attend annual resuscitation training updates, this training is typically classroom based with an emphasis on technical skills such as basic life support, airway management and defibrillation, and there is limited training regarding non-technical skills such as multidisciplinary team working and communication.

In 2015, the Resuscitation Department implemented in-situ cardiac arrest simulation training in real clinical areas during normal working hours, with participants acting in their normal roles. It has been reported as an effective way to bridge the gap between classroom based learning and clinical resuscitation attempts, and an effective method of uncovering latent safety threats that can then be rectified before they cause harm to patients. These are the previously unidentified problems in a clinical area that may compromise patient safety e.g. equipment problems (broken or missing), system failures, skills or knowledge deficits, and communication errors.

Since 2015, evaluations have shown that participants found the experience very positive, and numerous latent safety threats have been corrected. The aim of this latest evaluation was to assess the in-situ cardiac arrest simulation training facilitated in 2023 against the following key performance indicators:

1. Improved knowledge and technical skills for staff.
2. Familiarisation of staff with equipment and the clinical environment.
3. Improved non-technical skills, especially teamwork and communication.
4. Identification of latent safety threats.

34 simulations were planned between April and December 2023 with 13 cancelled due to clinical pressures on the day. 21 simulations were facilitated and evaluated.

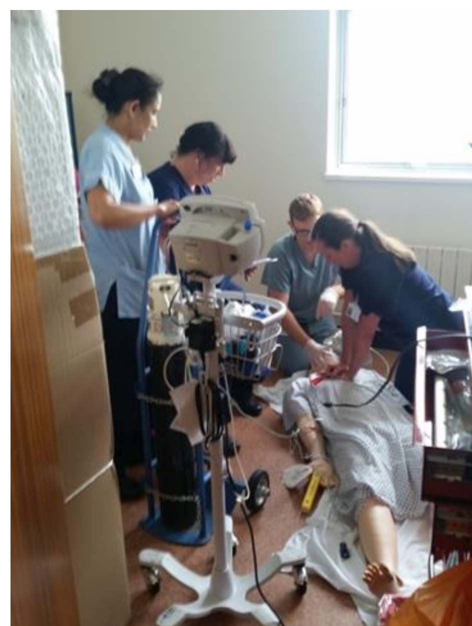


Figure 20: Photo of in-situ cardiac arrest simulation

Areas of good practice.

There were many examples of good practice including:

- Effective A-E assessments from the ward staff (first responders), swift recognition of the deteriorating patient, and prompt response from first responders, confirming cardiac arrest, initiating a 2222 call and prompt starting of high-quality chest compressions.
- Generally good team leadership, and numerous examples of effective, clear communication between ward staff, ward staff and the arrest team and arrest team members**.**
- Consideration to family members.
- Interventions performed effectively by ward staff and the cardiac arrest team.
- Safe defibrillation.

- Prompt arrival of equipment.

Areas identified for improvement.

Things that did not go so well and that might be potential latent safety threats were identified and addressed during the post-simulation debrief. Some examples include:

- The cardiac arrest team were unsure when to administer drugs during a cardiac arrest situation. This is now addressed in cardiac arrest team safety huddles.
- Staff were performing chest compressions for an extended period of time. The importance of staff rotating is reinforced in all resuscitation training sessions.
- Occasionally no clear team leader was identified. The importance of identifying a team leader is discussed at the safety huddle and in both Intermediate Life Support (ILS) and Advanced Life Support (ALS) training.
- Emergency buzzers or pull cords did not work in some areas and on occasions there was difficulty moving the resuscitation trolley due to an uneven floor and ledges. This was escalated to relevant managers to work with the Estates Department.
- Questions were raised and discussed regarding moving heavier patients from the chair to the floor. Advice was given and the team were advised to contact the manual handling team for further advice.
- There were some examples of poor communication. During the debrief the cardiac arrest team were reminded to introduce themselves and use clear closed loop communication (also covered in ILS/ALS training).
- Difficulty was experienced working in a small room. Discussions were held regarding moving the patient where appropriate.

Participant post simulation feedback

The participant evaluation indicated very positive responses regarding improved clinical knowledge in managing emergency events, awareness of the importance of team working and communication in emergency events, and better preparation for a real cardiac arrest event (compared to classroom-based simulation training). Some examples of the feedback:

- “Very well run, good learning opportunity and great debrief and feedback.”
- “It made the situation feel more realistic to be in the real setting using the equipment available on the ward.”
- “I feel the simulation felt very real and I feel it was very beneficial for the whole team to be involved.”

Conclusion

Results of the evaluation confirmed that the key performance indicators continue to be achieved. The recommendations are therefore to:

- Continue classroom-based education to focus upon knowledge and skill acquisition.
- Continue in-situ cardiac arrest simulation training to consolidate classroom-based learning and develop non-technical skills and awareness of the importance of human factors.
- Continue with in-situ cardiac arrest in-situ simulation training to allow for identification and correction of latent safety threats.

Patient experience and involvement indicators

a. Complaints, concerns and compliments COMPLETE EXCEPT DATA UPDATE

South Tees Hospitals NHS Foundation Trust prides itself on delivering seamless high quality, safe healthcare for all. Our vision is to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement, and continuous improvement. However, on occasion some patients,

relatives and carers may not experience the high-quality service we aim to achieve. Where a negative experience has arisen, the Trust seeks to investigate, resolve, and improve using the internal complaints process.

New complaint process

In 2021 the Parliamentary and Health Service Ombudsman (PHSO) released new NHS Complaint Standards, based on best practice in complaints handling and with a focus on early resolution. The PHSO piloted the standards with several NHS organisations and with early adopter sites in 2021-22 to develop supporting materials, training and guidance that would help the NHS embed the standards in its work.

The Trust has experienced ongoing challenges in providing a robust internal complaints process as illustrated in the activity data presented below and is aware of how these impact on patient experience and delays learning. It started the process to adopt the standards during 2023 and is aiming to:

- Effectively resolve all complaints from patients, families, and carers.
- Provide a timely, effective, and proportionate response to complaints.
- Ensure the learning from these improves future practice.

Initial work involved using the PHSO supporting materials to identify key stakeholders and plan the changes needed, including supporting staff within our Clinical Collaboratives who would be involved in the complaint handling process. Following our quality improvement approach, the new process was implemented on 1 January 2024. All patient feedback received by the Patient Experience Team is now initially treated as an enquiry, logged on the Datix Complaint Handling and Management software, and forwarded to appropriate staff in the relevant Clinical Collaborative. Collaborative colleagues contact the enquirer and aim to resolve enquiries at this stage if possible, updating Datix with details of the resolution discussion and any actions and learning arising from the enquiry. If an enquiry can be resolved within 24 hours this will not be counted as a complaint. If it is not possible to resolve within 24 hours, it will be classified as a complaint, escalated to senior staff in the Collaborative, and a timeframe for response agreed with the complainant based on the complexity of the complaint.

Concerns and Complaints Activity

The Patient Advice and Liaison Service (PALS) service has historically offered patients confidential advice, support and information, and has helped to resolve concerns or problems related to NHS care. From 1 January 2024 there are no longer separate PALS and complaints processes, and the data for complaints and enquiries received below (figure 21) reflects this.

The apparent decrease in PALS activity early in 2023 was due in part to a backlog of concerns waiting to be logged by the Patient Experience Team (PET) due to capacity issues. The increase from September to November reflects the recruitment of new staff.

Concerns have been related to all aspects of clinical care and communication. The Patent Experience Team log the concern received and attempt to resolve the concern if they can, for example assisting with appointment issues. Other concerns require appropriate ward or department staff to contact the enquirer and they aim to resolve the concern within the 10-working day timeframe. Overall, aspects of clinical care remain the most complained about subject. The majority relate to the quality of medical care, followed by misdiagnosis or missed diagnosis and clinical opinion being questioned.

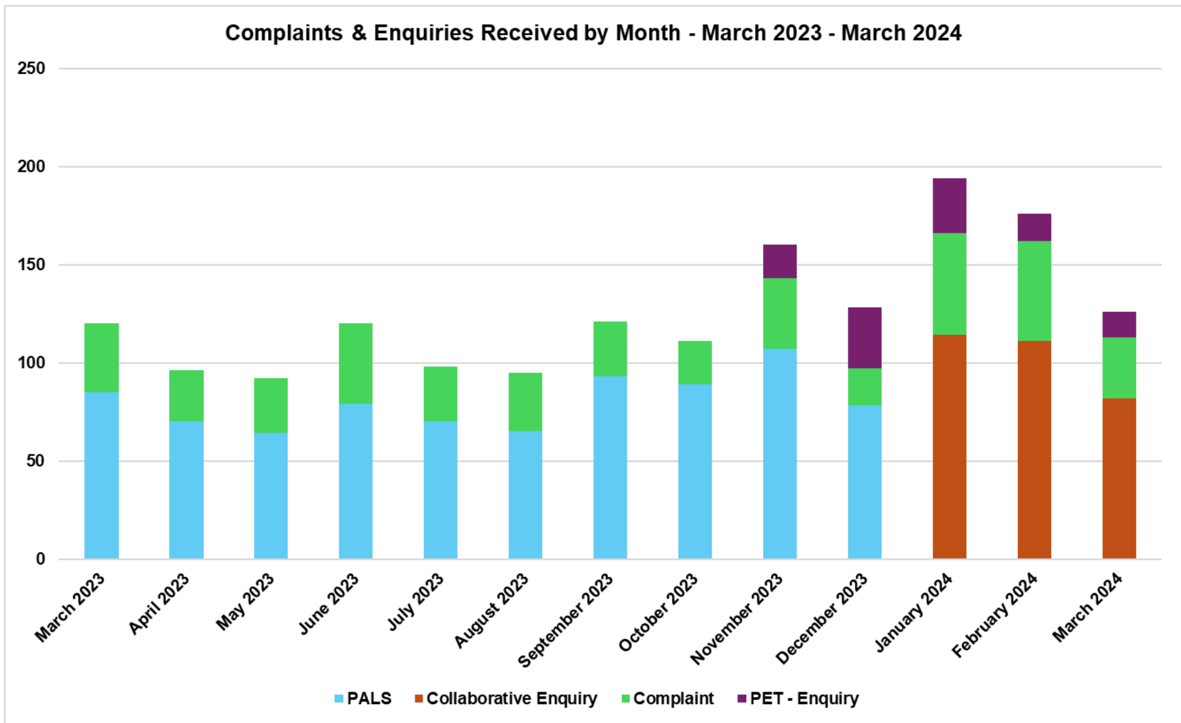


Figure 21: Complaints and enquiries received March 2023 – March 2024.

The closure of informal concerns within 10 working days has consistently fallen below the Trust internal target of 80% (figure 22). The main reasons are late responses from the handler and reflects challenges in locating paper-based healthcare records for review and operational pressures being experienced across the Trust and wider NHS.

96% of complaints received during the last 12 months were acknowledged within three working days. The delays in responding to 14 complaints were due to pressures on the Patient Experience Department. However, the Trust's internal target of closing 80% of complaints within the relevant timeframe has not been achieved during 2023/24 (figure 22). Whilst there was an improvement between July to September, this has not been maintained. Despite monitoring progress with each complaint, and weekly meetings to escalate concerns, completion has been impacted by delays in receiving healthcare records, junior doctors strikes, and the availability of clinical staff to draft responses.

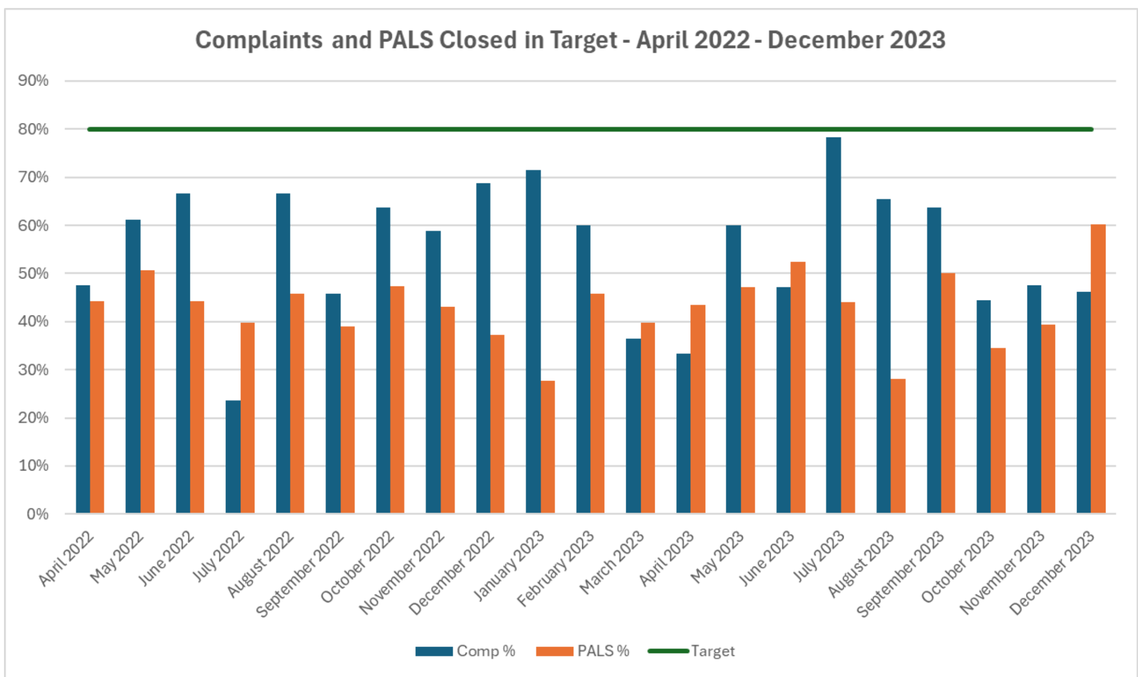


Figure 22: % Complaints and PALS closed within deadline April 2022 – December 2023.

There were 141 complaints closed in quarter 2 and quarter 3 2023/24. Of these, 30 complaints were found to be substantiated, 53 partially substantiated, and 89 unsubstantiated. Awaiting full 2023/24 data

There was a slight decrease in reopened complaints following closure compared to the previous six-month period. See table 6. The main reasons for reopening complaints are new questions relating to the complaint, the recipient disagreeing with the response, new unrelated questions, or a request for a meeting to discuss the complaint response.

January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	Total (Last 12 Months)
3	5	2	1	3	4	0	4	3	2	5	1	33

Table 6: Further contact following receipt of complaint response January – December 2023.

Learning from complaints

Improvements and learning are a key aspect of substantiated complaints. As examples:

- The carer of a patient with Alzheimer's disease raised concerns about staff measuring the patient's medication incorrectly. This was medication brought in with the patient and unfamiliar to the staff. There has been targeted education and training for staff involved in the medication administration process, highlighting the importance of double-checking procedures for all new or unfamiliar medications. The learning has been shared at meetings across the Trust and via a trust-wide safety bulletin.
- Family Liaison Officers supported the family of a patient who deteriorated and died at home from sepsis following surgery. The family felt they could have raised concerns earlier if they had been informed about the signs of sepsis. As a result, a sepsis information card has been developed for post-operative patients.

Compliments Activity

All compliments received by the Trust are uploaded to Datix and shared with the wards and departments (table 7). There is currently a backlog of approximately 125 compliments to be logged for the Collaboratives. Clearing this backlog was part of the patient experience improvement plan and support was provided by the Prospect Placement and the backlog has significantly reduced.

April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	Total
62	20	205	117	18	213	184	247	24	14	11	8	1123

Table 7: Compliments received by Collaborative April 2023 – March 2024 (logged to date).

Summary and ongoing work

The new complaints process will continue to be embedded, and progress with achieving our ambition for timely resolution and responses, and effective learning and improvement will be monitored closely. Following our quality improvement methodology, a follow up workshop to review the ongoing progress with the changes made and to agree any further refinements needed was arranged for early April 2024.

There are also plans to work with the Public Relations Team during 2024 to promote the compliments received by the Trust, ensuring areas of good practice identified by patients, relatives and carers are identified and celebrated.

b. Patient surveys – national and local COMPLETE EXCEPT FFT DATA REFRESH

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. We can share across the organisation examples of good practice in order to learn what works well for people, and areas of concern in order that improvements can be made.

Local Trust Surveys and Friends and Family Test (FFT)

There are currently 89 patient surveys utilised in the Trust covering all wards, departments, and community services. Patients can provide comments on all the local Trust surveys. All comments are reviewed by the Patient Experience Team and appropriate sentiment types are added to each. Some comments may receive multiple sentiments. The data for April 2023 – February 2024 shows that overall, 68.1% of comments have been positive and 11.8% negative (figure 23).

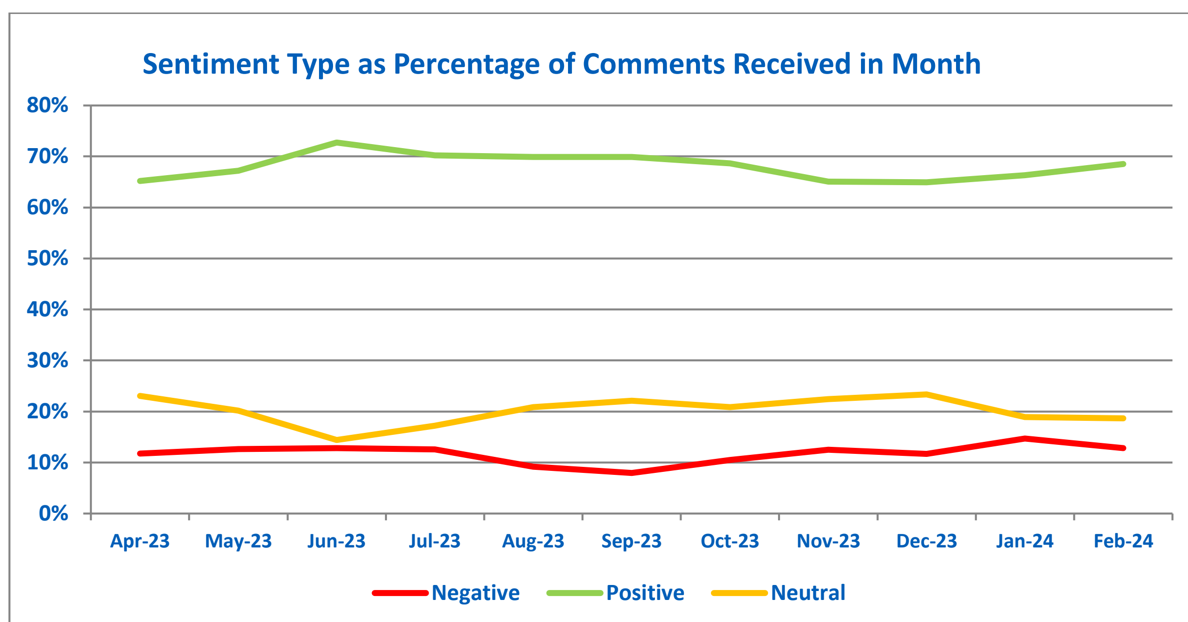


Figure 23 - Patient feedback sentiment analysis by month July – Apr 2023 to Feb 2024

The FFT question is included in most of our local surveys. It invites feedback on the overall experience of using a service and offers a standardised range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience, and results can be compared with other trusts. Data from April 2023 to February 2024 shows the Trust is above national average for percentage likely to recommend services in Inpatient, A&E/UTC, Outpatient and Community (see table 8).

	2023/24			
	Response Rate		% likely to recommend	
	Trust	England	Trust	England
Inpatient	18%	21%	97%	94%
A&E	7%	11%	82%	80%
Antenatal			91%	91%
Birth	16%	13%	88%	94%
Postnatal ward			87%	92%
Post natal			-	92%
Outpatient	4%	4%	97%	94%
Community	6%	4%	98%	95%

Table 8: Inpatient, A&E/UTC, Maternity, Outpatient and Community FFT results benchmarked against national results (April 2023 – February 2024). Awaiting March data and some clarification re missing data.

The Maternity FFT surveys patients at four touchpoints (antenatal, birth, postnatal inpatient, and postnatal community), and overall results for the Trust are above national average for postnatal community care, and below national average for antenatal, birth and postnatal inpatient care (see table 8).

Wards and departments regularly review their patient feedback and display 'You said, we did' notices to highlight improvements made as a result of this.

National Surveys

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

National Adult Inpatient Survey

The last published National Adult Inpatient Survey report in September 2023 was for the survey carried out in November 2022. The survey included patients aged 16 years or over who spent at least one night, during November 2022, in an NHS hospital in England and were not admitted to maternity or psychiatric units. Each NHS trust selected a sample of 1,250 patients by including every consecutive discharge that met the eligibility criteria, counting back from 30 November 2022. Nationally there were 63,224 responses received, with a response rate of 40%. Of the 1,250 patients identified by the STHFT, 507 patients responded to the survey giving a 43% response rate. **Check data.**

In comparison to other Trusts, South Tees scored 'much better than expected' in one question, 'better than expected' in nine questions, 'somewhat better than expected' in four questions, and 'about the same' in thirty-one questions. No questions scored worse than expected. In comparison with results from the 2021 survey, the trust showed a statistically significant increase in two questions, no statistically significant change in forty questions and a statistically significant decrease in one question.

National Urgent and Emergency Care Survey

The latest published National Urgent and Emergency Care Survey report in August 2023 was for the survey carried out in September 2022. This survey looks at the experiences of adults that have used the Emergency Department (ED) or Urgent Treatment Centre (UTC) in an NHS hospital. In total 122 NHS trusts with a Type 1 accident and emergency department took part in the survey. 59 of these trusts also had direct responsibility for running a Type 3 UTC department. Nationally responses were received from 29,357 patients who attended a Type 1 department (response rate 23%), and from 7418 patients who attended a Type 3 department (response rate 22%). South Tees had a response rate of 43% with 1,250 patients invited to take part and 507 patients participating in the survey. **Check data.**

For the ED the Trust scored in the top 20% of trusts for twenty questions, in the middle 60% of trusts for 12 questions and in the bottom 20% of trusts for five questions. In comparison with other NHS trusts in the region the trust's results were better than all trusts in nine questions, somewhat better in six questions, and about the same for 22 questions. No questions scored worse than all trusts. In comparison to the 2020 survey results the trust had a five percent or more increase in five questions and a five percent or more decrease in nine questions.

For the UTC the Trust scored in the top 20% of Trusts for 14 questions, in the middle 60% of trusts for nine questions and in the bottom 20% of trusts for one question. In comparison with other NHS trusts in the region, the Trust's results were better than all trusts in two questions, somewhat better in two questions, and about the same for 26 questions. No questions scored worse than all trusts. In comparison to the 2020 survey results the trust had a five percent or more increase in two questions and a five percent or more decrease in seven questions.

National Cancer Patient Experience Survey

The most recent National Cancer Patient Experience Survey report was published in July 2023 for the survey carried out in April - June 2022. This survey involved 133 NHS Trusts with 61,268 people responding to the survey nationally, yielding a response rate of 53%. For the STHFT 563 patients responded out of a total of 1,076 patients, resulting in a response rate of 52%.

For the four questions relating to overall NHS care, the trust scored equal to or higher than national average across most tumour groups, but lower than national average for skin, head and neck, and urological tumour groups. For overall survey scores in comparison with other NHS trusts in the region, the trust scored above the expected upper range in four questions, and between the expected upper and lower ranges for 57 questions. No questions scored below the expected lower range. In comparison to the 2021 survey the trust scored at least five percent increase in scores for four questions, and at least five percent decrease for seven questions.

National Maternity Survey

The most recent National Maternity Survey report was published in February 2024 for the survey carried out in February – March 2023. The survey asked for feedback from individuals aged 16 years or over at the time of delivery, who had a live birth at the Trust in February 2023 on their experiences of antenatal care, labour and birth, and postnatal care. South Tees and other larger trusts also asked for feedback from all eligible individuals from ethnic minority backgrounds who had a live birth between in January and March 2023. STHFT invited 300 patients to take part in the survey. 127 patients responded giving a 42% response rate, just higher than the national response rate of 41%.
Compared with 121 other NHS Trusts, STHFT scored ‘somewhat better than expected’ in five questions and ‘about the same’ in 49 questions. The trust did not score worse than expected in any questions. In comparison to the 2022 survey, the trust showed a statistically significant increase in two questions. There were no questions with a statistically significant decrease.

Summary and ongoing work

This has been a busy year for patient experience activity across the Trust. The Patient Experience Team support colleagues across the organisation to seek patient feedback and then to effectively use the results to ensure learning and improvement. Moving forward the Trust will be using the Friends and Family Test question, as a guide, to identify where a deeper dive is required, either to share good practice or identify areas of learning for improvement.

c. Patient information improvement COMPLETE

Providing good quality information for patients, carers and parents and communicating that effectively is important to ensure good understanding of health and illness, appointments, procedures, and treatments, and for meaningful shared decision making between patients and clinicians.

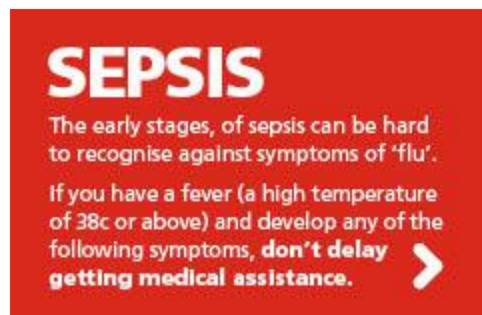
Patient information leaflets

More patient information leaflets have been reviewed and placed on the Trust internet site to be easily accessible by patients and staff. The information is downloadable for printing in the appropriate font size to meet the patient, carer, or parents’ requirements. As of March 2024, there were 524 patient information documents available on the South Tees website, and 60 leaflets in draft awaiting approval. Out of date leaflets are removed from the website to ensure they are not accessible, and the archiving of patient information resources that have been replaced with new versions is now more robust.

The Trust continues to promote the use of posters with QR codes to download patient information, to enable people to easily access the up-to-date version of leaflets, and to reduce the amount and cost of paper.

We provide patients or carers who wish to contact our clinical departments for further information with a telephone number and an email address to provide for people who are unable to communicate using a telephone.

We developed new information resources from patient feedback. As referenced in the complaints report, we developed information for patients, carers and relatives about post-operative sepsis following the death of a patient and a complaint. Post-operative patients are given a Sepsis Card with the signs of post-operative sepsis clearly highlighted and instructions about actions to take if this is suspected. This information is also on the Trust website at https://www.southtees.nhs.uk/resources/sepsis/



Interpretation services

In 2022/2023 the average fulfilment rate for face-to-face interpreting services was 69% and for telephone interpreters was 95.9%. Through regular contract and quality monitoring of our interpretation service we have seen a sustained increase in fulfilling requests for interpretation across the Trust, on average 350 per month each for telephone and face-to-face services.

The fulfilment of requests for a face-to-face interpreting service has been above 80% throughout 2023/24 reaching a maximum of 90% in December (see figure 24). The fulfilment of requests for a telephone interpreting service has been above 95% throughout 2023/24 reaching a maximum of 99% in April 2023 and January 2024 (see figure 25).

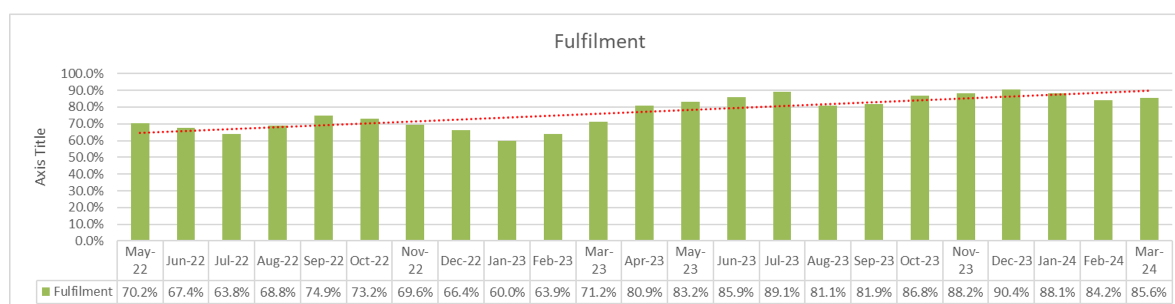


Figure 24: % of requests met by face-to-face interpretation (May 2022 – March 2024).

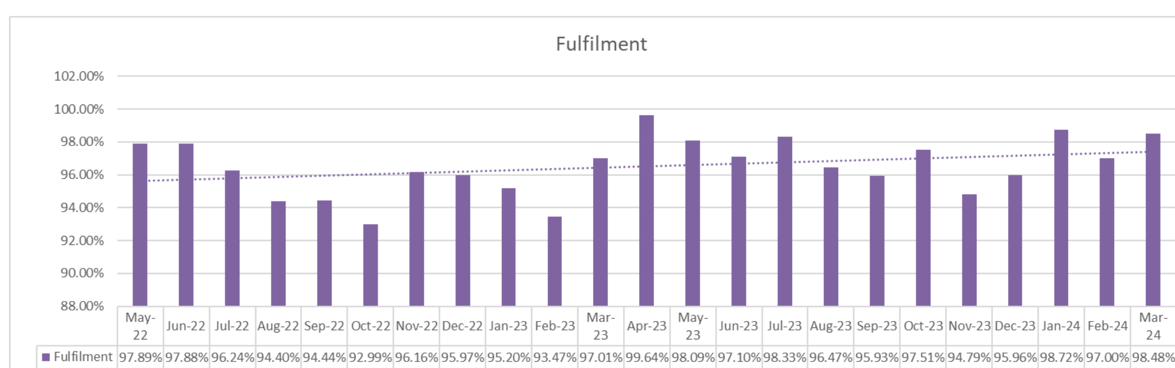


Figure 25: % of requests met by telephone interpretation (May 2022 – March 2024).

The current interpreting and translation service contract is due to expire within the next 12 months. With the support of procurement, and the Service Improvement Team, the Patient Experience Team have commenced a retendering exercise, which will involve key stakeholders and services users in the identification of any future provider.

Specific actions have been taken within Maternity to support interpretation for women whose first language is not English:

- Working with the LMNS the top five languages spoken in Middlesbrough, Redcar & Cleveland were identified, and some patient information leaflets have been made available in all five languages and are available for patients and relatives to download.
- Mobile phones have been made available in clinical areas to assist with telephone interpreting when consent is required for emergency procedures.
- The welcome page on the Badgernet Electronic Patient Record is available in 10 languages and patient leaflets are available in different languages on Badgernet. Badgernet is committed to further translations and there are plans to review this over the current year.

Outpatient Letters Improvement Work

During 2023/24 there has been improvement work to deliver a digital first approach to outpatient communication with patients by delivering outpatient appointment letters and reminders digitally using the DrDoctor Patient Engagement Portal (PEP).

Appropriate outpatient letters and any associated patient information leaflets are sent to the PEP. If we have a mobile number for the patient and they have not opted out, we will send them a text message to notify them that a new letter is available online. Texts will address patients by their first name to avoid confusion about who the appointment is for when several family members use the same mobile number. Patients follow the link and login to view and download their letter. Patients will be sent a reminder after 24 hours if they have not viewed their digital letter, and any patient who does not view their letter online within 48 hours will be sent one by post as usual. When an appointment is within 7 days, patients will be sent their digital letter and paper letter at the same time.

Patients can choose to have all future letters sent by email or to be printed and sent by post. They can also choose to stop receiving text communication about appointments, in which case future letters will be printed and posted. Letters in Braille are currently all sent by post with one side in braille and text on the other side for sighted relatives or carers.

Assuming the patient has not opted out of text communication, outpatient appointment reminders are sent by text 7 days before the appointment. Patients will receive details of their attendance type (face-to-face, video or telephone) and the appropriate appointment booking team telephone number for the clinic they are booked in to. If the appointment is face-to-face, they will receive details of the Outpatient Department, hospital site and nearest entrance where applicable. Patients can also access a map of the location of the hospital and extra information to support a successful outpatient appointment, e.g. to attend 20 minutes early to have blood samples taken, or to bring certain documentation etc.

Summary and ongoing work

There has been important work done during 2023/24 regarding patient information resources, provision of translation services, and the introduction of digital communication for our outpatient services.

Ongoing work will involve reviewing patient information from a health literacy perspective to ensure readability for the communities we service. We will continue to ensure that patient information, about the procedures carried out in the Trust are available in an accessible format to our patients, carers, and relatives to support their care and treatment.

The retendering exercise for translation services will be progressed, and a Trust policy for interpreting will also be developed and implemented.

During 2024/25 the Patient Engagement Portal will start the roll out of:

- Digital letters to the patient and their GP following clinic attendance.
- The opportunity for patients to digitally notify the Trust if they cannot attend their appointment.
- Braille appointment letters sent digitally for the proportion of severely sight impaired people who read braille and have apps to help them read digital communication.

3.2 Performance against key national priorities COMPLETE – AWAITING FULL 23/24 DATA UPDATE. Due 1 MAY 2024.

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24 YTD	23/24 Targets
Safety										
Clostridioides (C) *difficile* – meeting the C. *difficile* objective	61	43	48	41	89	79	138	140	118	N/a
All cancer – 62 day wait for first treatment from										
Urgent GP referral for suspected cancer	79.10%	81.10%	85.44%	82.65%	77.23%	75.52%	73.83%	60.4%	57.4%	85%
NHS Cancer screening service referral	89.80%	89.00%	94.55%	87.14%	94.41%	62.77%	50.00%	68.71%	63.7%	90%
18 weeks referral to treatment time (RTT)										
Incomplete pathways	93.20%	92.20%	91.45%	89.49%	83.33%	63.20%	65.37%	65.99%	64.09%	92%
Accident & Emergency										
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	95.80%	95.33%	95.68%	95.24%	88.35%	87.25%	75.52%	68.22%	67.10%	95%
Diagnostic Waits										
Patients waiting 6 weeks or less for a diagnostic test	98.82%	99.15%	97.46%	98.26%	94.04%	72.57%	68.71%	77.57%	75.22%	99%

Table 9: Performance against National Priorities

Key findings:

- The Trust recorded 118 cases of C. *difficile* during 2023/24 (YTD). The Trust is committed to driving down healthcare acquired infections and achieved its lowest ever incidence of C. *difficile* infections in 2018/19. However, since this time the Trust has seen increasing numbers year on year, with a slight decrease in 2023/24 on 2022/23 figures. Further narrative can be found in part two of this quality account.

- Our year end performance for the all cancer 62-day wait for first definitive treatment from urgent GP referral for suspected cancer was 57.4% YTD (Apr 23 - Jan 24). The 62-day to first treatment standard is supressed as the longest waiters have treatment. Cancer action plans are reviewed and monitored through the Cancer Delivery Group, informed by a programme of pathway reviews.

- Our year end performance for all cancer 62-day wait for first definitive treatment from NHS cancer screening service referral was 63.7% YTD (Apr 23 - Jan 24). Volumes of patients within this target are low which impacts the overall compliance significantly.

- Our year-end performance for the referral to treatment (RTT) 18-week target was 64.09% YTD (Apr 23 – Jan 24). Referral to treatment within 18 weeks trend is consistent and performs above the national average. Focus on reducing the number of patients waiting more than 65 weeks by March 2024 is demonstrated in the reducing trend for 52-week and 65-week waits.

- Our year-end performance for the 4-hour Accident and Emergency waiting time target was 67.10% YTD (Apr 23 - Jan 24). This target remains a challenge and is impacted by a number of factors such as internal and external patient flows and the demand for acute or urgent care services. Although we have seen an improvement in the number of patients awaiting social care, we have

been impacted by increases in non-elective demand. We are however opening a new facility for urgent care streams of patients alongside the current ED department and will monitor the impact of this.

- Our year-end performance for diagnostic waits (waiting 6 weeks or less) was 75.22% YTD (Apr 23 – Jan 24). General radiology waits for CT, MRI and ultrasound scanning (USS) have improved significantly over the year due to additional capacity being sourced through Community Diagnostic Centre (CDC) funding. Recovery plans are in place and further equipment will be installed over the next 8 months which will further support compliance with the patient tracking list.

- As of the end of the 2023/24 financial year, the Trust has 1 patient who has waited more than 78 weeks from referral to treatment.

3.3 Additional required information

Seven-day services COMPLETE.

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

After the challenges of the COVID-19 response, the BAF for Seven Day Services re-focuses attention on the four key standards. An assessment against these standards was completed at South Tees in September 2022. The Trust is not comprehensively compliant with Standard 2 for ‘consultant review for all new admissions within 14 hours’ in every specialty throughout the week. This is due to more limited consultant presence on-site at weekends in specialities with smaller numbers of emergency admissions. The Trust is assured of timely senior clinical assessment for patients admitted as an emergency in all the higher volume specialties and when the patient is unwell or deteriorating. The Trust is also assured that arrangements are in place for daily senior review, and that there is safe access to diagnostic and consultant-led interventional services over the seven-day period, demonstrating compliance with these standards. The Trust is not aware of any issues raised through complaints, serious incidents and staff surveys including the GMC survey of doctors in training that any concerns have been raised in respect of this. The Trust wide roll out of electronic patient records will provide the ability to regularly monitor timely assessment and review of patients.

In addition, the Trust is working with regional provider and commissioning colleagues to develop 7-day access to the mechanical thrombectomy hyper-acute stroke intervention.

Freedom to speak up COMPLETE

'Speaking up is about anything that gets in the way of doing a great job.'[1]

At South Tees Foundation NHS Trust there are now 75 hours dedicated to providing a speak up service to the organisation. It is the responsibility of the Board of Directors to promote and embed an open culture which invites and encourages both positive and negative feedback from all who work within our services. This feedback can then be used to inform future strategies to support our continual learning and improvement.

The Freedom to Speak Up (FTSU) Guardians Team continue to work to improve the speaking up culture throughout the organisation, raising awareness of Freedom to Speak Up and all the routes by which colleagues can raise concerns. This is an evolving service as we align ourselves with changing national guidance, Trust IT systems and the recently adopted Joint Hospital Group Model.
The FTSU model has continued to develop with data collected over the past 12 months and analysed reflecting a positive impact in terms of the numbers of people speaking up, the numbers of people speaking up openly or confidentially and the numbers of people who have accessed the service reporting that they would speak up again.

Figure 26 shows 122 concerns were raised with the guardian team between April 2023 - March 2024 compared to 97 in the previous 12 months. This represents an overall increase of 25.7%.

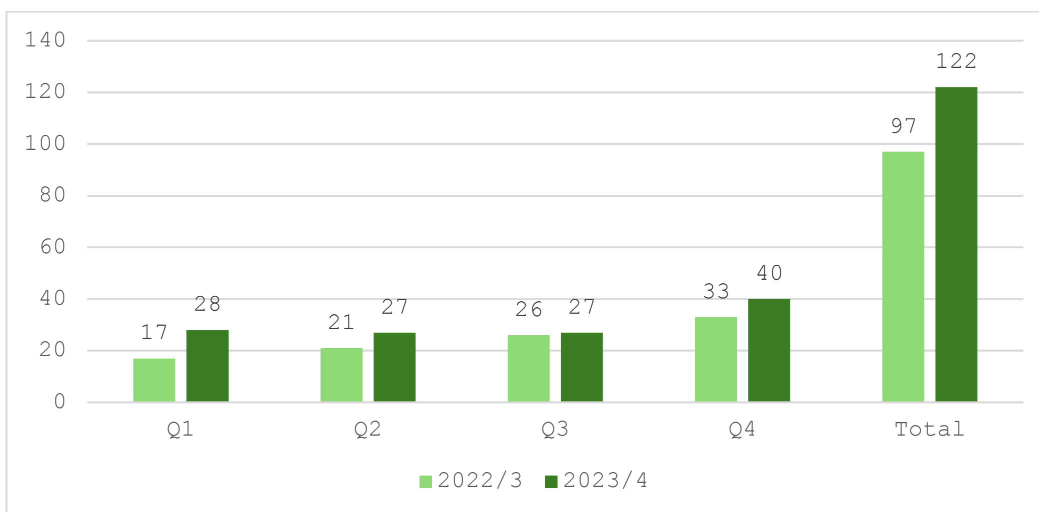


Figure 26: No. of concerns raised with the FTSU Guardians Team 2022/23 and April 2023-March 2024.

Figure 27 below shows the high-level themes recorded against the concerns received in 2023/24. Out of the 122 concerns received, 45.4% were related to inappropriate attitudes or behaviours, 31.1.% were

[1] *https://nationalguardian.org.uk/speaking-up/what-is-speaking-up/*

related to an element of patient safety or quality. 9.3% of concerns featured an element of bullying and harassment, and 14.3% concerns were raised about worker safety or wellbeing.

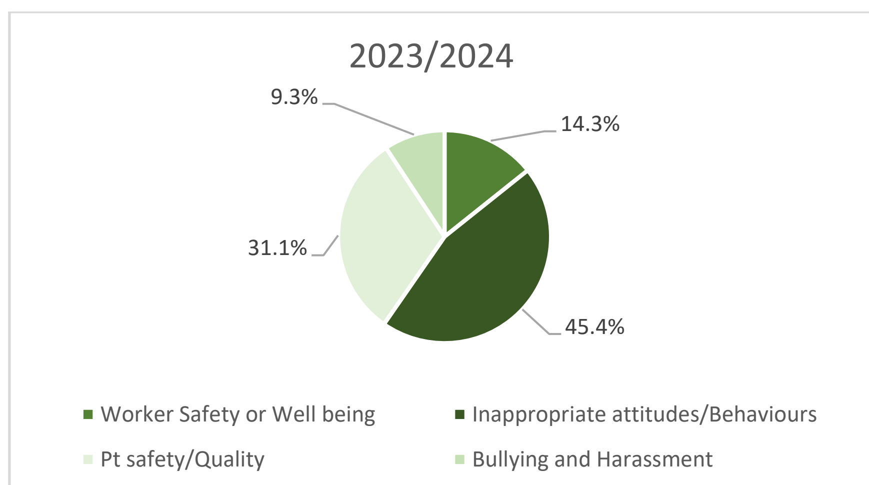


Figure 27: Themes recorded against concerns raised in 2023/24.

2023/24 saw a small positive change in how concerns were raised. 69.9%% of colleagues chose to report their concerns to the FTSU Guardians through an open or confidential route compared to 68.8% last year. And anonymously reported concerns fell slightly from 31.2% in 2022/23 to 30.1% in 2023/24.

Staff Survey and FTSU Questions

The FTSU Guardians use the national NHS Staff Survey data to inform their work. Table 10 shows the recently published results of the FTSU questions asked in the 2023 NHS Staff Survey compared with previous results. Whilst the overall percentages have generally continued to decline this mirrors the national picture, with the Trust remaining above or close to the national benchmarking for three questions, with question Q20b dropping slightly below the national benchmark.

The Guardians will analyse the results further to develop a plan of work for the next 6 months focusing particularly on the areas within the Trust that reported the lowest scores as well as those with the lowest response rate.

Staff Survey Question	2021/22 results	2022/23 results	2023/24 results	2023/24 national benchmarking
Q20a I would feel secure raising concerns about unsafe clinical practice.	76.9%	74.14%	71.05%	70.24%
Q20b I am confident that my organisation would address my concern.	60.7%	58.3%	54.08%	55.90%
Q25e I feel safe to speak up about anything that concerns me in this organisation.	64.62%	63.10%	62.82%	60.89%
Q25f If I spoke up about something that concerned me, I am confident my organisation would address my concern.	49.83%	48.15%	48.69%	48.65%

Table 10: Responses to NHS Staff Survey questions relevant to FTSU 2021/22 to 2023/24.

FTSU Guardian Team work during 2023/24

The FTSU Guardian Team have been working with colleagues in Workforce to make ‘Speak up’ training mandatory for all staff with plans for ‘Listen Up’ and ‘Follow up’ to be developed into workshops delivered across sites. The Guardians continue to share delivery of the FTSU training within induction for new staff and the Care Certificate Programme.

Guardians have built links and work with University of Teesside and the military speak up lead to deliver training to students and military staff.

Local, Regional and National Updates.

As North and South Tees Trusts move into a Group Model, discussions continue between the FTSU Guardians for both trusts around plans for the two services to work more collaboratively and to develop a sustainable plan for proactive and reactive FTSU work.

In November 2023, FTSU services were asked by colleagues at the ICB to provide evidence for their regional audit of the current FTSU procedures in the wake of the Lucy Letby investigation, also known as the Thirlwall inquiry. Each Trust in the region was asked to undertake and submit to the ICB a retrospective audit of two anonymised cases to ensure that correct FTSU processes had been followed. This work was completed by our team in December. The ICB have now spoken with all FTSU Guardians and anticipate sharing their findings and any recommendations over the coming months.

The FTSU Guardians attended the National Guardians conference in Birmingham on 24th of March 2024. Throughout the day attendees explored the barriers to speaking up, with thought-provoking discussion from leaders, experts by experience, professionals from other sectors, and other FTSU Guardians.

Future Plans.

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

- Continuing to embed FTSU model throughout the Trust and implementing of the updated Freedom to Speak Up policy.
- Developing training for staff to clarify what ‘detriment’ is and how detriment from speaking up can be identified and prevented with the delivery of focused workshops for managers and senior managers.
- Continuing to identify the barriers to speaking up and developing opportunities to overcome these including closer work with equality, diversity and inclusion groups.
- Recruitment and expansion of new and existing FTSU Champions from diverse backgrounds, with regular ’lunch & learn’ webinars and meetings, in addition to more formal training twice a year.

Rota gaps for doctors and dentists in training COMPLETE

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".

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

For the most part, junior doctor medical rotas are managed through a collaboration between the corporate medical rota team and the clinical rota leads in the specific departments of the Trust. We have taken great steps forwards in the electronic rostering of medical staff and have circa 500 junior doctors rostered on this platform2. The full Trust roll out of the system continues and will give the Trust greater insight into the rota gaps that occur and more accurate and contemporaneous data.

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

	No of gaps in establishment by tier of rota[3]	How mitigated
Medical Rotas	11 gaps general medical T2	Locum cover
	3 gaps neurology T2	Locum or consultants cover
	8 gaps Paeds T2	Paeds – locum cover
	2 gaps Paeds T1	Paeds – locum cover
	Gaps due to maternity cover - respiratory medicine T1	Business case to cover
	1 gap Lab Medicine T1	Lab medicine gap from 3rd April 2024
Surgical Rotas	1 Neurosurgery	Locum cover
	2 T&O	Locum Cover
	1 Breast	Rota reduced over the placement
	2 Colorectal	Rota reduced over the placement
	1 Upper GI	Rota reduced over the placement
	2 Vascular	Rota reduced over the placement
	2 ENT	Rota reduced over the placement
	3 OMFS	Locum cover

In the latter part of this financial year, we have strengthened the process though which a junior doctor or dentist can report on whether they have worked beyond their planned shift timings. This process is called exception reporting. Having a more streamlined process has already resulted in an increase in reporting, which ultimately will help clinical teams identify trends in staff working patterns and hours that may be unsustainable.

Our Guardian of Safe Working (GOSW) along with our corporate medical rota team continue to provide routine reports to the People's Committee, Trust Board, Joint Local Negotiating Committee and Junior Doctor Contract Forum. A consolidated annual report from the GOSW is available for public view. Statutory documentation - South Tees Hospitals NHS Foundation Trust

Over the last year there have been 263 exception reports raised; eight of these had immediate safety concerns associated with them. Out of the 263 exception reports raised, three of these met the threshold to disburse a fine to the Trust.

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[2] *This number includes both doctors/dentists in training and out locally employed doctors.*
[3] *Generally, most departments work on a three tier rota; T1 – FY1-CT2, T2 – CT2+, T3 – Consultant level.*

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

The CMO has appointed one of our consultants into the role of rota guardian. In the next financial year, all medical rotas will be reviewed to ensure we have a clear understanding of the number of doctors which should be on each rota to provide excellent clinical care while ensuring maximum training opportunities. Having agreed staffing levels on our rotas will allow us to issue more specific and accurate work schedules to our medical staff4. It will also enable better planning in terms of annual leave and bank holiday cover.

The Trust continues to aspire to triangulate data regarding rota gaps in each department with information on quality and safety incidents, and the number of exception reports raised in each area, giving us rich data about our clinical productivity as well as the safety of our staff and patients.

[4] Accurate work schedules are required to ensure accurate pay.

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

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

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

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

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

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2023 to March 2024
  - papers relating to quality reported to the board over the period April 2023 to March 2024
  - feedback from commissioners dated x
  - feedback from governors dated x
  - feedback from local Healthwatch organisations dated x
  - feedback from overview and scrutiny committee dated x
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated x
  - the [latest] national patient survey x
  - the [latest] national staff survey x
  - the Head of Internal Audit's annual opinion of the trust's control environment x
  - CQC inspection report dated x
- 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

..............................Date...Chairman

..............................Date...Chief Executive

6. Annex 3: Glossary of terms FOR FINAL CHECK

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's Maternity Notes is an online portal.

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.

CUR (Clinical Utilisation Review)
The CUR is a clinical decision support tool that enables clinicians to make impartial and objective, evidence-based assessments of whether patients are receiving the right care, at the right place, at the right time and for the right duration. It improves patient flow across the health economy.

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. Clinical Commissioning Groups are the key organisations responsible for commissioning healthcare services for their area. They commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population's health.

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

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

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

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

Day case
Patient who is admitted to hospital for an elective procedure and discharged without an overnight stay.

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 in patient procedure.

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

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

Emergency
An urgent unplanned episode of care.

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

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

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

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

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

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.

Interventional Radiology (IR)
Interventional Radiology" (IR) refers to a range of techniques which rely on the use radiological image guidance (X-ray fluoroscopy, ultrasound, computed tomography [CT] or magnetic resonance imaging [MRI]) to precisely target therapy. Most IR treatments are minimally invasive alternatives to open and laparoscopic (keyhole) surgery. As many IR procedures start with passing a needle through the skin to the target it is sometimes called pinhole surgery.

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

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.

PALS (Patient Advice and Liaison Service)

A service that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient Reported Outcome Measures (PROMs)

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

Payment by Results

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

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.

Purpose T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool)
Is a pressure ulcer risk assessment framework (PURAF) intended to identify adults at risk of pressure ulcer development and makes a distinction between primary prevention (applicable to those at risk of pressure ulcer development) and secondary prevention (applicable to those who already have a pressure ulcer). It has been developed for use in adult populations in hospital and community settings by qualified nursing staff.

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.

RCA (Root Cause Analysis)
A systematic process for identifying "root causes" of problems or events including serious incidents to prevent a recurrence.

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

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

SSKIN (Surface, Skin inspection, Keep moving, Incontinence and Nutrition)
A 5 step model for pressure ulcer prevention.

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

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

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

South Tees Hospitals NHS Foundation Trust
Includes The Friarage Hospital (FHN) and James Cook University Hospital (JCUH) and community services in Hambleton, Richmondshire, Middlesbrough, Redcar and Cleveland.

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

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Tees, Esk and Wear Valleys NHS Foundation Trust

Quality Account

2023/24

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Part one

1.1 Welcome to the Quality Account and its purpose

What is a Quality Account?
A Quality Account is an annual report describing the quality of services provided by a NHS healthcare organisation. Quality accounts aim to increase public accountability and drive quality improvements in the NHS.

Our Quality Account looks back on how well we have done in the past year at achieving our quality goals.

It also looks forward to the year ahead and defines what our priorities for quality improvement will be and how we expect to achieve and monitor them.

The aims of the Quality Account
1. To help patients and carers make informed choices about healthcare providers
2. To empower people to hold providers to account for the quality of services
3. To engage leaders of an organisation in their quality improvement agenda

Who reads the Quality Account?
Lots of different people read the Quality Account. Some are people who we support through our services, their loved ones, colleagues, commissioners, partners and regulating bodies.

We produce our report for anyone who wants to know more about the quality of our services, and how we plan to maintain and improve them.

What information can be found in the Quality Account?
In this document, you will find information about how we measure and review the quality of services that we provide. You will also find our priorities for improvement for the year ahead. Like all NHS healthcare providers, we focus on three different aspects or domains of quality:
- Patient safety
- Clinical effectiveness
- Patient experience

Structure of the Quality Account
The structure of this Quality Account is in line with guidance published by the Department of Health and NHS England, and contains the following information:
- **Part 1:** Introduction and context
- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2023/24, our priorities for improvement in 2024/25 and the required statements of assurance from the Board
- **Part 3:** Further information on how we have performed in 2023/24 against our key quality metrics and national targets and the national quality agenda

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1.2 Chief executive's statement on quality

Welcome to our Quality Account 2023/24. High quality patient care is the core of what we do every day and goes hand in hand with our focus on patient safety and clinical excellence. It's also fundamental in our commitment to achieving our goals - to co-create a great experience for people in our care, carers and families, for our colleagues and to be a great partner.

Whilst we are making progress, nationally and regionally, we continue to see unprecedented demand for our services. Staffing levels also continue to be a challenge across the NHS - and we are no different.

However, we're continuing to work in partnership, as part of the wider health and social care system. This is increasingly important as we focus on place-based care. We're committed to building strong relationships with partners across our communities and working closely with them to collectively support people and meet their needs.

Given the timing of our quality account, it's important to mention the Care Quality Commission (CQC) prosecution as sentencing took place in April 2024. The CQC investigators found that we failed to provide safe care and treatment to two individuals, who sadly died in our care at West Lane Hospital in 2019 and Roseberry Park Hospital in 2020. We pleaded guilty to the two charges as soon as we were able to. The care and treatment for those two individuals wasn't acceptable - they deserved better. We are deeply sorry for the events that led to these tragedies and our thoughts are with their families.

We are now a very different organisation, one that takes responsibility and is moving forwards. The CQC acknowledged this in our latest inspection and that noticeable improvements have been made. This is very much down to the hard work and dedication of colleagues across our trust, and the ongoing support and collaboration with our partners.

As I've reflected over the last year, there have been some significant milestones for our trust. Our latest Care Quality Commission (CQC) report was published in October and inspectors recognised that we're making progress. Overall, seven out of 11 of our services are rated 'good' and four areas are rated as 'requires improvement'. This is an improvement since our last inspection in 2021.

Inspectors could also see a positive culture change and patients said that staff were 'kind and considerate', friendly, kind and supportive' and that they were 'actively involved in their care planning'.

We know there's more to do but the fact that the CQC has told us we're making improvements, and that these positive changes have impacted on the quality of our care, is a really important step in our improvement journey.

There has also been a huge amount of work to ensure we provide safe and kind care, with a clear focus on patient safety, clinical effectiveness and patient experience through our clinical and quality journeys. This has included the successful introduction of the patient safety incident response framework (PSIRF) to ensure learning from incidents and to help prevent an incident happening again and a new incident reporting and quality management system. This means we can learn quickly from incidents, identify common causes and make improvements.

Linked to PSIRF, we also relaunched our organisational learning group. This brings together a range of different teams, such as nursing, patient safety, clinical, therapies and complaints. The group triangulates learning and actions, monitor progress and looks at the impact on the quality of care we provide.

We also implemented assistive technology to enhance patient safety in our wards and launched a new electronic patient record system called Cito at the beginning of 2024.

Whilst these innovations are key for us, people are at the heart of our organisation – and we know that this has a correlation to good patient care. We've been doing some focussed work on recruitment and retention and although there is more to do, we're seeing real progress.

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I also want to mention our continued focus on co-creation, which is the golden thread through everything we do. Our ambition is for patient and carer voice to be sought out, listened to, and acted upon at every level.

There is a lot more detail in this report about the progress we've made, as well as areas where we're continuing to make improvements.

We remain committed to putting quality and safety above all else, working with patients and carers and our partners to support people in our region. And to make sure the communities we serve get the mental health and learning disability services they need and deserve.

Brent Kilmurray
Chief Executive
30 June 2024

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1.3 About our Trust

At Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) we provide a range of inpatient and community mental health, learning disability and eating disorders services.

We serve a population of two million people across County Durham, Darlington and North Yorkshire and are geographically one of the largest NHS Foundation Trusts in England. We also provide mental health care in prisons located in the North East, Cumbria and parts of Lancashire.

We are a catchment area for the largest concentration of armed forces personnel in the UK – Catterick Garrison – and our adult inpatient eating disorder services and adult secure (forensic) wards serve the whole of the North East and North Cumbria.

TEWV was created in April 2006, following the merger of County Durham and Darlington Priority Services NHS Trust and Tees and North East Yorkshire NHS Trust.

In 2008 our Trust became the first mental health Foundation Trust in the North and, since then, it has expanded both geographically, and in the number and type of services provided. Our Trust now has around 8,100 staff, who work out of more than 90 sites, and an annual income of over £480 million.

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

Patients and carers have a say in how they are supported and treated, because we know how important it is to listen and treat people as individuals. Our patients, their families and carers work together with us towards better mental health.

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

Across our care group boards, we provide:

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

1.4 Our Journey to Change

In August 2020 we launched Our Big Conversation - the biggest listening exercise in the history of our Trust. Over 2,100 people shared 35,800 ideas, comments, and votes, exploring what could be possible if we got everything right and what we must do to achieve this.

We heard that some people had a good experience with the Trust, but this wasn't consistent, and we heard that there was a lot we needed to work on.

From the rich conversations and feedback we received from Our Big Conversation, we developed big ideas for change and a new strategic direction called Our Journey to Change.

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

The big goals we have committed to deliver over the next five years are:
- to co-create a great experience for patients, carers, and their families
- to co-create a great experience for our colleagues
- to be a great partner

Our Journey to Change is at the forefront of everything we do, and all our decision making and 'supporting journeys' are aligned to it.

We have five underpinning journeys which are:
- clinical
- quality and safety
- people
- co-creation
- empowering infrastructure

We've now past the halfway point of Our Journey to Change, and we're seeing the positive impact this is having on people's experience of our Trust.

We continue to make significant improvements, with a focus on providing safe and kind care, and this was acknowledged in our latest CQC report. Whilst we know there is more work to do, we are continuing to build on our progress and make further improvements to make sure the communities we serve get the mental health and learning disability services they need and deserve.

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1.5 Co-creation

We're embracing patient and carer experience and using their insights to continually improve; working in close partnership with patients, families, and carers to provide the best possible experience and outcomes. We also work together with our partners and regulators to ensure we understand what good looks like, so we bring meaningful change to the care we provide. We refer to this partnership-style of working as co-creation. It is at the heart of Our Journey to Change and is fundamental to how we improve the care we provide to the communities we serve.

We want co-creation to run through everything we do, so that it becomes the normal way of doing things including:

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

We have made sustained progress in this area and we have two lived experience directors who joined the organisation in 2022. Throughout 2023/24 they have established themselves across both of our care boards, offering a lived experience lens, insight and challenge across strategic decision making in our trust. The lived experience directors have broadened the lived experience input across the organisation, by establishing two co-creation boards that work closely with our care boards and are shaping how we deliver services - putting lived experience voice at its heart. We have also employed a head of co-creation with lived experienced to lead the development of our approach co-creation across the organisation.

Several of our trainers have experience of mental illness and are supporting staff to put themselves in the shoes of both patients and their families so that we show true empathy in the care we deliver.

We also employ peer support workers, who have lived experience of mental illness either themselves or as a carer and these roles are continuing to grow.

Examples of co-creation and lived experience in action:
- The launch of a trust wide staff co-creation network, which has been co-developed with staff, service users and carers and aims to give staff the support and tools to put co-creation into action in their services.
- The co-creation and co-delivery of training to staff and students by patients at Ridgeway.
- Co-designing and co-hosting a patient safety summit across Teesside, which involved a range of local community organisations.
- A number of co-creation groups established and working with staff on major transformation projects across the trust, from the development of our electronic patient record system (Cito), community transformation in adult mental health services and the care programme approach.
- Service user and carers joining our PLACE inspections of our wards to offer their perspective of the wards from lived experience.
- Service users and carers involved in the recruitment of staff across the trust from board level to community-based teams.

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1.6 A patient story

An inspirational North Yorkshire man is using his mental health experiences to support others – after finally seeking help for the anxiety which plagued him for decades.
Marc Blair, 48, battled "a constant background of anxiety" from childhood, which created problems at school, in the workplace and in his personal life.
Now, following treatment from our Trust's North Yorkshire Talking Therapies, he is looking forward to a brighter future – and has set up a support group for men in the same situation.

"*It felt like I was standing at the gates of hell when I was first referred for treatment*," said Marc, from Catterick Garrison. "*It was a very tough time, but the therapy was amazing. "I really appreciate the help I got from Talking Therapies, and now I want to support others. I'm here for them all the way. Helping people helps my own wellbeing, but it also makes me happy.*"

Need to escape
Marc's anxiety struggles first became apparent as a child, when he found sitting in large groups – such as in a classroom or assembly – overwhelming.
His need to "get up and escape" led to dozens of skipped lessons and, ultimately, Marc left school without any qualifications.
"*I didn't realise my feelings were caused by anxiety at the time – no one did. Back then, people didn't really recognise the symptoms, they just thought I was disruptive*," he said. Marc was determined to follow in the footsteps of his father and grandfather by joining the army – and had a long-cherished ambition of becoming a physical training instructor. However, anxiety again became a barrier to success after he secured a place to study sport at college. Within months he had dropped out.
"I loved sport – running and athletics had always been a big thing for me. But it was just too much being around so many strangers. It was very difficult for me," he said.

Troubled times
Marc then enlisted in the army at 17 but, after eight weeks of training, he discharged himself. It was a decision he blames on his anxiety – and which he immediately regretted.

A succession of jobs followed before Marc was eligible to re-enlist. This time it went well – at first. But difficulties started after he was posted overseas, and he ended up going AWOL.

"I won trophies for best physical training and best shot during training. I found things I was good at," he said. "But, after a while, my anxiety returned and I felt the need to escape again."

Marc later transferred to a different regiment and, after three years, left the army and joined the guard service with the Ministry of Defence.

He spent several happy years as a dog handler, among other roles, before becoming a truck driver for a new company. Sadly, his anxiety again caused problems.

"I found the job very, very stressful, and it was the first time since the army that I didn't want to go to work," he said.

Switching roles
The company was sympathetic to his struggles and offered Marc an alternative job as a groundworker, which he enjoyed. Then, in 2021, he moved to a similar role with the MoD.

Despite his initial happiness, his mental health started to deteriorate, so he switched jobs yet again – and went back to truck driving.

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"Anxiety can make you make some very strange decisions," he said. "I knew truck driving wasn't for me, yet I did it again. I lasted about six weeks before the stress became too much.

"My anxiety really started to get the better of me around then. One night, while at an event with my wife and friends, I kept having to go outside. I felt so overwhelmed – like when I was at school."

Seeking support

As the weeks went by, so Marc's anxiety continued to "go through the roof" – putting his marriage under strain. The loss of his mother, followed the collapse of his relationship, left him in a "dark place".

By the time Marc finally sought medical help, he felt as if he was "stood at the gates of hell." Taking part in Talking Therapies, however, helped turn his life around. NHS Talking Therapies provides a range of talking therapies designed for supporting people with symptoms of depression, panic, anxiety, stress, worry and scary thoughts. Joe Greensmith, a psychological wellbeing practitioner, supported Marc through 12 weeks of specialist treatment – helping him to develop skills and techniques to manage his anxiety.

"I had tried to manage my anxiety with exercise, but I needed a structure in my life. Joe helped so much. He was always there for me, always willing to listen to me."

Here to help others

Marc is now keen to use his experience to help others – and recently set up a men's mental health support group in Colburn with a friend.

The drop-in group, named Together Strong, is held in the village hall on the third Monday of every month from 7pm.

"One person's mental health challenges can affect other people within their family and friends," Marc said. "I'm now at the point when I'm finally looking after my mental wellbeing properly. I use the advice Joe gave me to help not only the people in the group, but my friends and family too."

Marc is now planning to train as a mental health counsellor and, in the future, he may even re-take his GCSEs and go on to university.

"I can't help every single person, but if I can make a difference to one person's life, that would be good. Joe helped change my life, and I'd like to do the same for others," he said.

Helen Dodd, the associate practitioner for North Yorkshire Talking Therapies, today praised Marc's work on the new group and said:

"He is an inspiration to us all. Marc's experience demonstrates the empowerment that learning to manage anxiety can bring."

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1.7 The services we provide

We deliver care under six clinical directorates across our care group boards:

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

There is further detail about our Trust and the services we deliver in section 1.3.

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1.8 Our CQC ratings

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

Overall rating: Requires improvement

For each key domain our Trust is rated:

- Safe: **Requires improvement**
- Effective: **Good**
- Caring: **Good**
- Responsive: **Requires improvement**
- Well-led: **Requires improvement**

Further information can be viewed within section 2.13: What the Care Quality Commission (CQC) says about us.

1.9 What we have achieved in 2023/24

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

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

- In our latest inspection report (October 2023), the Care Quality Commission (CQC) recognised we are making progress. Seven out of 11 of our services are rated 'good' and four areas are rated as 'requires improvement'. This is an improvement since our inspection in 2021.
- Introduced a new incident reporting and management system called InPhase. It makes it easier for our colleagues to report incidents, learn quickly from events, involve different areas of the organisation in learning, identify common causes and make improvements.
- Successfully introduced the patient safety incident response framework (PSIRF) to ensure learning from incidents and to help prevent an incident happening again. It includes compassionate engagement and involvement for all involved or affected by a patient safety incident.
- Retained our 2 star rating from the Carers Trust for continuing to work with carers, following the Triangle of Care principles.
- Launched two co-creation boards – one in our Durham, Tees Valley and Forensics care group and one in our North Yorkshire York and Selby care group.
- Supported a further 600 people through our Individual Placement Service, with over 300 people progressing into paid employment in the last year.
- Launched Cito, our new electronic patient record system. This was one of the largest and most ambitious investments in technology to improve patient care that we have undertaken.
- Established our new complaints service, which was co-created with people in our care and carers. Importantly, throughout the review and development, we considered the experiences of people that had used our PALS and complaints service.
- Opened a new sensory room in our children's respite unit in Teesside.
- Launched the 'Think Together Team', a transformation project designed to support children and young people to access mental health services in North Yorkshire.
- Appointed two more positive and safe practitioners to support us to reduce our use of restrictive interventions.
- Our children and adolescent mental health services (CAMHS) teams are now engaging in an 'Investors in Children' accreditation.
- Our eating disorder home treatment (EDHT) team, part of the North Yorkshire and York CAMHS service, marked its milestone first year and has helped to significantly reduce both admissions and re-admissions.
- Our children and adolescent mental health services (CAMHS) launched the iThrive model of care in Durham and Tees Valley. iThrive is designed to support children and young people to access mental health services in Durham and Tees Valley. It aims to talk about mental health and wellbeing help and support in a common language that everyone understands.
- Increased the number of therapy pets by 47%.

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- Organisational development has worked with our experts by experience to develop our culture plan and look at what gaps there are.
- We are co-creating the range of ways in which people can work with us to make it more flexible for people to be paid for the time they give to us.
- Co-creation programme for staff and co creation board for experts by experience is in development.
- We are developing ways to improve the experiences of trans and non-binary patients.
- Working with partners to improve the access to our services for people from Gypsy, Roma, Traveller communities.

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

- Recruited to over 1,780 positions - 781 of these posts were to external candidates.
- Welcomed over 150 newly qualified nurses into our workforce, supporting them in the start of their nursing careers.
- Reduced our use of agency staff by 10%.
- Increased our peer support workforce by 27%.
- 221 staff started an apprenticeship with us and during the same period 120 successfully achieved their apprenticeship.
- A 28% increase in volunteers.
- Our annual staff survey response rate was up 4%. 95% of colleagues said they'd not experienced discrimination from patients, care givers, members of the public or colleagues and 91% said they felt trusted to do their job.
- Continued our international recruitment drive to expand our workforce. We also received the NHS Pastoral Care Quality Award for giving great pastoral support to our internationally recruited nurses.
- Junior doctors ranked our Trust as the top organisation for their training in the North East, in the GMC national training survey.
- Achieved Better Health at Work Award Scheme Silver-level accreditation.
- Recruited more staff health and wellbeing champions – we now have 304 people in these roles supporting colleagues across our trust.
- Received a record number of nominations (484) for our annual staff awards.
- Established a staff-led health and wellbeing council.
- Our staff networks continue to develop - we now have more than 500 colleagues who are members.
- Developed a charter for the medical workforce, outlining our commitments to current and future medical colleagues.
- Reaccredited for reducing restraint network standards for positive and safe care.

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- The intentions to leave process has been updated and improved.
- A new managers programme has been updated and rolled out.
- Promoting and using the National Staff survey and the National Quarterly Pulse Survey – introduced staff experience champions to support with this – increased response rate and maintained or improved in 100/103 areas following being the most improved Mental Health/ Learning Disability and Autism Trust last year. Notably rates of discrimination continue to drop and staff report feeling more fairly treated after an incident or near miss.
- Achievement of Better Health At Work Award Scheme Silver-level accreditation in 2023 (aiming for Gold-level status in 2024).
- Recruited more staff health and wellbeing champions, with 304 staff now in the role.
- Staff-led health and wellbeing council has been established and is meeting regularly – there is a process for spending charitable funds for the benefit of staff wellbeing now in place across the Trust.
- Started a centralised reasonable adjustment pilot to support staff and managers access and implement appropriate workplace adjustments.
- Roll out of core leadership and management training for all staff in formal senior roles continues and Leadership Academy has been scoped and is due to launch in May 2024.
- The Freedom to Speak Up (FTSU) service has continued to see a rise in the number of people accessing the service and reporting that they feel it is a trusted service.

How we're working with our partners

- Our innovative and world-class research team, in partnership with the University of York, delivered the largest clinical trial ever undertaken to combat loneliness and depression.
- Led a pilot of a portable ECG device that helped protect mental health patients during the COVID-19 pandemic, resulting in it being used across the country. Our pilot has now played a key role in changing national guidance around ECGs.
- Expansion of mental health support teams for schools service in Darlington and Durham.
- Community transformation work in Tees Valley has seen the introduction of a peer support network in partnership with Red Balloons. There are plans in place to develop similar networks in Durham and North Yorkshire, York and Selby.
- In partnership with local authorities and commissioned substance misuse service providers in North Yorkshire and Middlesbrough, our teams are taking part in a 12-month pilot to help prevent drug related deaths.
- Signed a Memorandum of Understanding (MoU) with Teesside University, which builds on successful joint working. We'll work collaboratively on a broad range of initiatives to help support students and graduates within the healthcare sector, as well as support the transformation of practice.
- A new two-year project providing mental health and well-being support for women aged 18-25 launched following funding from the North Yorkshire and York community mental health transformation programme.
- Hosted research into food insecurity (also known as food poverty) in collaboration with Fuse, the Centre for Translational Research in Public Health (Teesside University and Newcastle University) and Equally

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Well UK (a collaborative hosted by the Centre for Mental Health). It found that over 50% of people with severe mental illness (SMI) in the north of England live with food insecurity.

- Launched a new hub aimed at helping people leaving prison to re-integrate into the community in Durham. The new hub has been developed by the Reconnected to Health partnership – including our Trust, Humankind, Spectrum Community Health CIC and Rethink.

- Our performance team were governance showcase winners at the NHS Providers Governance Conference 2023 for our new integrated performance approach to quality and performance assurance and improvement.

- Held our first ever hybrid Annual General and Members Meeting (AGM) allowing guests in person and online.

- We are active members of regional work in both integrated care boards (ICBs). We are working on streamlining employment processes and making it easier for colleagues to move around the health care system.

- We are working in partnership with Middlesbrough College on a work-based academy, initially piloting a ‘business admin academy’.

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1.10 National awards – won and shortlisted

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

Award body	Awarding status	Name / category of award	Team / individual
Better Health at Work	Awarded Awarded	Bronze and Silver standard Gold standard	Trustwide wellbeing service NHS Durham and Darlington Talking Therapies
Hospitality Assured	Accreditation Shortlisted	World Class Service Team of the Year	Trustwide hotel services Trustwide hotel services
NIHR School for Public Health Research	Shortlisted	Public Involvement & Engagement	Emma Giles and Jo Smith, Fuse (Food Insecurity in Adults with Severe Mental Illness)
Hull York Medical School Teaching Excellence Awards	Won Won Shortlisted	Physician Associate Tutor of Excellence Award Medicine Phase II & III Tutor of Excellence Exceptional Contribution to Student Experience	Polly Snelling Dora Katalenac Zovko Dora Katalenac Zovko
HSJ Digital	Shortlisted	Driving Change through Data and Analytics	Perinatal mental health clinical outcome reporting
BBC Radio 4 All in the Mind	Shortlisted		Nikki Lonsdale
Health Education England - Durham and Tees valley GP Training programme	Won	Hospital Supervisor of the Year	Grish Rao
NHS Providers Governance Conference 2023	Won	Governance Showcase	Trust performance team
Healthcare Financial Management Association	Won	Unsung Hero of the Year	Adam Hind
NHS England	Accreditation	NHS Pastoral Care Quality	International recruitment team
Nepacs' Ruth Cranfield	Won	Certificate of Excellence	Gemma Fawcett-Smith, registered learning disability nurse, Tracey Forster, speech and language therapist and

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Award body	Awarding status	Name / category of award	Team / individual
			Pam Jenkins, speech and language assistant, HMP Holme House mental health team
Royal College of Psychiatrists	Accreditation Accreditation	Quality network from Eating Disorders (QED) Quality Network for Crisis Resolution and Home Treatment Teams (QNCRHTT)	Adult community eating disorders team Harrogate crisis resolution and home treatment team
National Service User	Shortlisted	Community and Collaboration Award	Ridgeway Recovery Awards Ridgeway Community Day
Nursing Times	Shortlisted Shortlisted	HRH The Prince of Wales Award for Integrated Approaches to Care Nursing in the Community	REACH team (Reducing Exclusion for Adults with Complex Housing needs) REACH team (Reducing Exclusion for Adults with Complex Housing needs)
Nursing Times Workforce	Shortlisted	Preceptor of the Year	Jade Jackson

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Part 2: Quality priorities for 2023/24 and required statements of assurance from the Board

2.1 Introduction – purpose of this section

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

In this section, we will also review the progress we have made in relation to the quality priorities we set ourselves in the 2023/24 Quality Account.

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2.2 Our approach to quality governance and improvement

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

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

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

During 2024 our Trust will be reviewing Our Journey to Change.

During 2023 our Trust's governance structure was reviewed. The process and the report have helped us to reflect on the progress we have made since the Good Governance Institute (GGI) review in 2021 and to enable us to further embed and improve our governance arrangements.
The GGI review shared key themes and specific recommendations. We are currently in the process of preparing a formal response to the key themes and recommendations and developing an action plan to address the key areas. The main themes which we will focus on are:

- Reviewing Our Journey to Change and related priorities and delivery plan
- Reviewing our business planning approach
- Reviewing the governance model within care groups
- Reviewing and streamlining our executive level meeting structure
- Further developing and embedding our accountability framework
- Refining committee terms of reference, agendas and reporting
- Developing our approach to the use of data and its role in reporting
- Implementing our leadership development programme
- Reviewing executive portfolios
- Embedding PSIRF, completing the complaints review and embedding the approach to mortality and morbidity reviews
- Developing our Council of Governors further
- Reviewing and advancing our co-creation work
- Accelerating our developments in learning, innovation and quality improvement.

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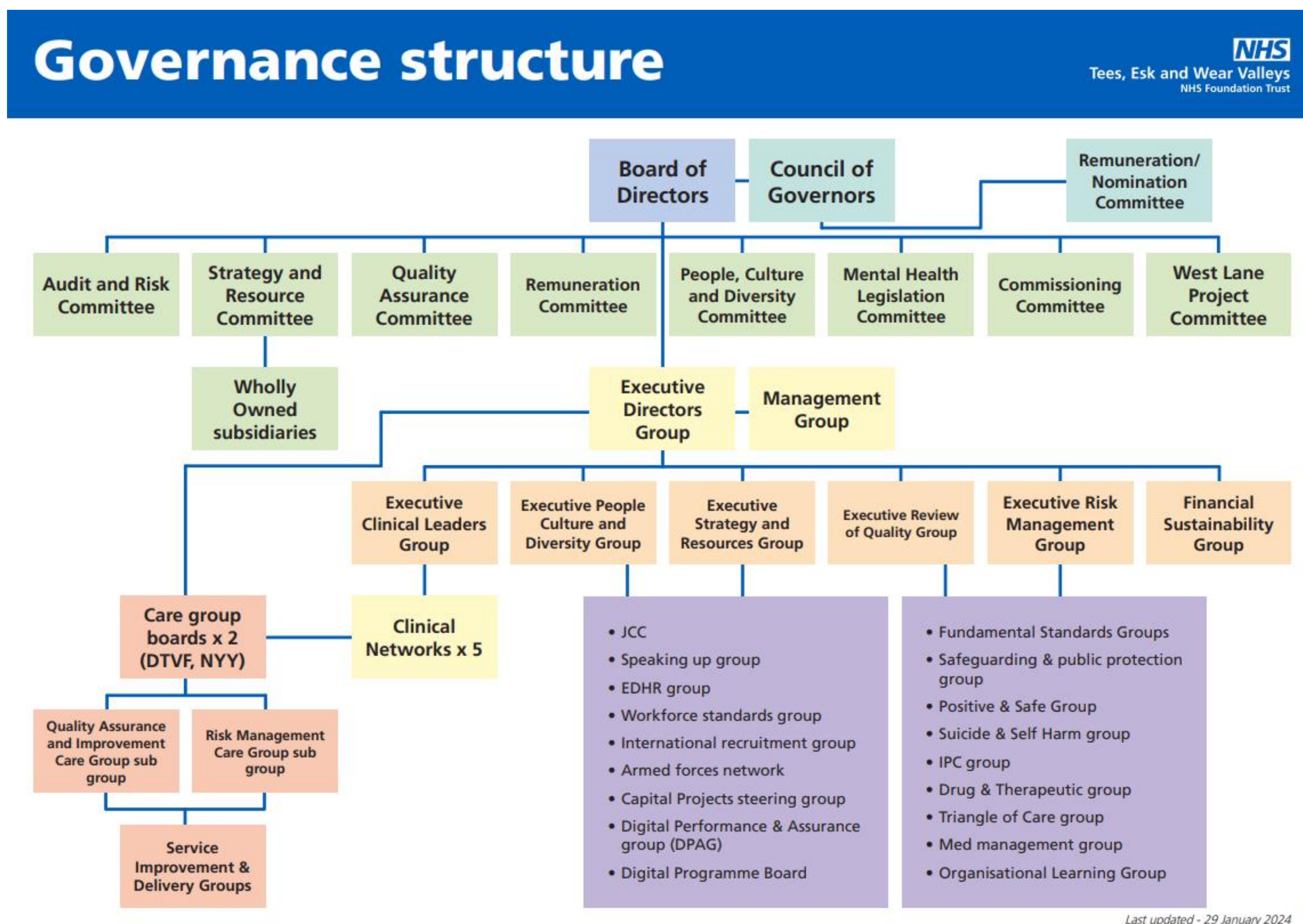
The governance structure in place during 2023/24 is shown in the figure below:



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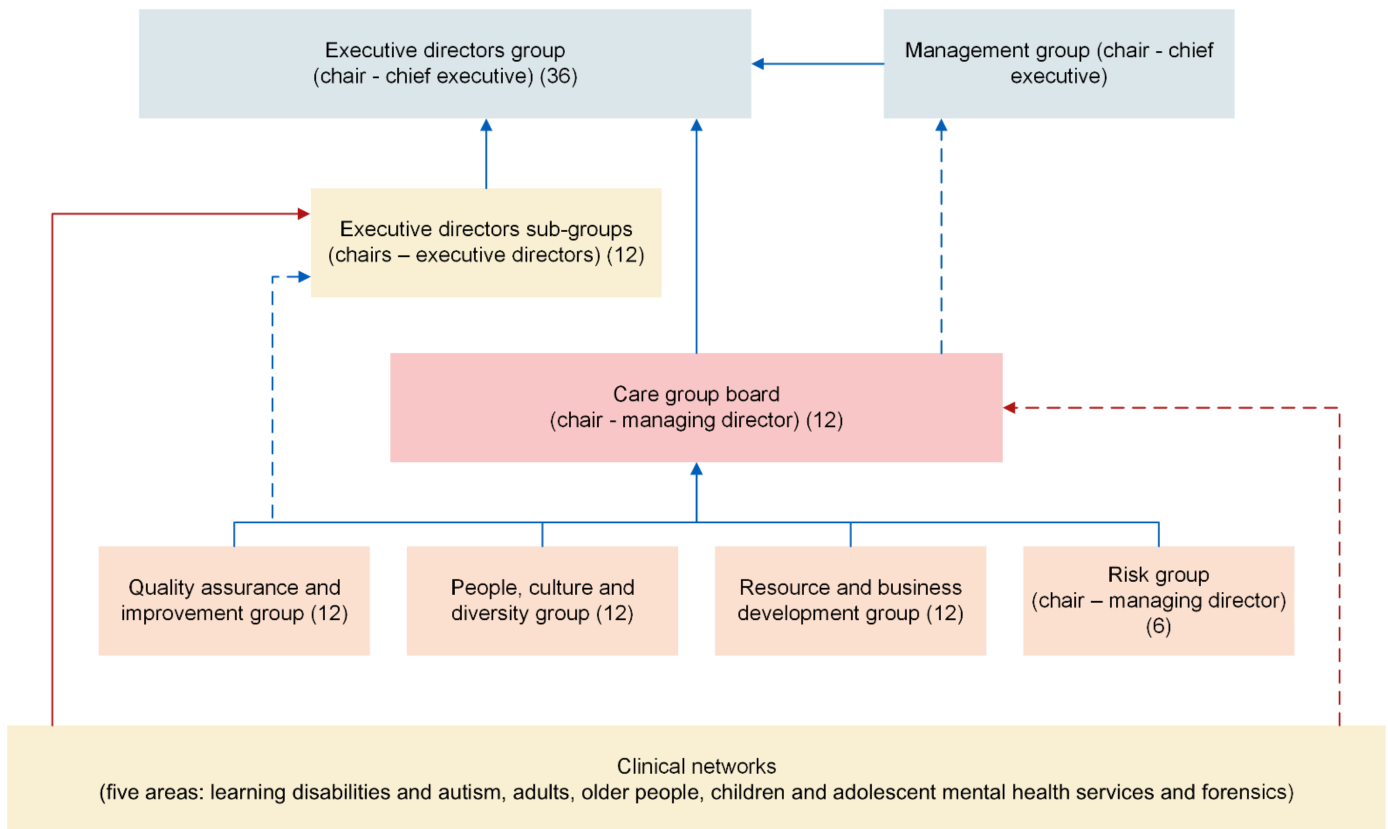
Our Trust Board ensures robust quality governance through the quality assurance committee, a committee of the Board.

The quality assurance committee is chaired by a non-executive director. Its strategic purpose is to provide assurance to the Board on the quality, safety and effectiveness of clinical and operational services through effective systems, structures and processes.

Each care group has quality governance arrangements to address the key elements of quality and safety. These are outlined in the figure below. Each care group reports directly to the executive quality assurance and improvement group monthly, and to the executive directors group weekly on quality performance issues that require executive oversight and/or escalation. Each care group is also required to provide assurance to the quality assurance committee against its quality improvement plans.

Care Group (x2)



Quality assurance and improvement

Our quality assurance and improvement programme was first introduced in April 2021. This is well established and helps us to focus on key quality and safety issues. It has supported us to make improvements including to patient care documents, recognising that high quality documentation is an enabler of high-quality patient care. As part of the programme, there is also observation of practice and discussions with service users, carers and teams within clinical areas. This also helps us to address learning from incidents and support quality assurance and improvement.

The programme comprises of a range of quality assurance tools that are used to gain a holistic assessment of the quality of patient care. These tools have been reviewed during 2023 to ensure that they are informed by current areas of risk, where further assurance is required. Tools currently used are:

- Inpatient quality review
- Community quality review
- HMP 3 part plan
- Peer quality review
- Directors visits

The quality assurance and improvement programme is an effective method of monitoring compliance against key standards of care related to patient safety, clinical effectiveness and patient experience. It has facilitated significant sustained practice improvements and provides the organisation with both quantitative and qualitative assurance evidence. Our practice development practitioners continue to provide coaching, mentoring, training and education to clinical teams to facilitate any required practice improvements.

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Key learning from incidents, patient feedback and other forms of intelligence helps to shape our Trust's quality improvement priorities. They also continue to be monitored using the quality assurance and improvement programme.

Key quality improvement work that our Trust has undertaken during 2023/24 includes:

- Continued implementation of our Trust's positive and safe plan (including reducing restrictive interventions)
- Worked with the HOPE(S) team and employed a HOPE(S) practitioner. HOPE(S) is a human rights-based approach to working with people in long term segregation developed from research and clinical practice.
- Increasing the number of wards using Oxevision (a technology that helps us to improve patient safety in inpatient areas)
- Implementation of the new national patient safety incident response framework (PSIRF)
- Agreed a new approach to intermediate life support (ILS) training
- Strengthened processes for organisational learning through the work of our organisational learning group and fundamental standards groups.

Co-creation is central to our overall approach. We work closely with patients, families and carers to identify and deliver our priorities. As part of our ongoing commitment to co-creation, from 2024/25, our directors of lived experience and co-creation boards will lead on development of our Trust's quality priorities on an annual basis.

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2.3 Our progress on implementing our 2023/2024 quality improvement priorities

In this first section of part 2, we reflect on the progress we made in implementing our quality priorities during 2023/24 and the impact this had for patients and their families/carers. Following this, we set out our quality improvement priorities for 2024/25.

Priority 1 – improving care planning

Why it is important:
In any health and social care organisation, care planning is a vital component of safe and effective patient care and treatment. In July 2021, NHS England published a formal statement advising all mental health trusts to move away from the Care Programme Approach (CPA) in favour of a community mental health framework. DIALOG+ as part of a wider piece of work, is the tool to enable the move away from CPA, while providing a clear, co-created care plan for patients.

The DIALOG+ process approach allows healthcare professionals to have supportive and meaningful conversations with patients about the aspects of their lives that are most important to them. This includes family, relationships, leisure activities and accommodation, in addition to their mental and physical health. It uses a person centred and patient rated scale that measures patient reported outcomes as well as a measure of patient experience. The output of the DIALOG+ assessment will be a care plan that the patient and health professional create together that is specific, co-created and clear. The care plan will be digital, easy to change and updated regularly as agreed with the service user.

The benefits/outcomes we aim to deliver for our patients and their carers are:

- Personal circumstances, and what is most important to the person and those closest to them, are viewed as a priority when planning care and treatment.
- Accessible, understandable and personalised care plan (including a crisis plan) containing contact details of those people and services that are best placed to help when the need arises.
- Discussions that lead to shared decision-making and co-creation of meaningful care plans.
- Agreed plans recorded in a way that can be understood by the patients and everybody else that needs to have this information.
- Information about support from people who have experience of the same mental health needs.

What we said we would do and what we did:

Record all care plans on our new electronic patient record (EPR) system which is called Cito
Cito went live in Feb 2024 and this has enabled us to meet our ambition of recording all patient care plans in this system.

Ensure all clinical staff are trained in our new DIALOG+ care planning system
Now that Cito is live, DIALOG+ is available for all patients. DIALOG+ training has taken place and further training is also planned. A training workstream has been formed to ensure that all relevant staff understand and can use the 3 patient reported outcome measures (which are DIALOG+, goal based outcomes and ReQoL-10) meaningfully in their work and to align with the evolving landscape of mental health care. Cito introduces critical tools like DIALOG and other patient recorded outcome measures (PROMs), enabling a more nuanced approach to understanding and responding to individual patient needs. The shift is guided by a comprehensive policy framework that draws upon the principles set forth in the NHS long term plan and the community mental health framework, emphasising integrated, person-centred care.

Our Trust, in moving from CPA towards a new universal standard of personalised care, has recognised that it relies on an integrated approach across partner organisations (primary care, VCSE, local authority) depending on:

- Joint working across partner organisations

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- Interoperability
- Shared policies and agreements on responsibility and accountability for care and safety management
- Retirement of care coordinator roles and the development of new key worker roles
- Universal access to high quality intervention based (and evidence based) care and support
- Workforce development.
- Co-production at every level.
- A new approach to care planning including the use of DIALOG to guide this.
- A focus on recovery focused outcomes.

Personalised care represents a programme of work focusing on key areas:
- Policy development (TEWV and system-wide)
- Covering roles, responsibilities and accountability for care and safety of patients (TEWV, partner organisations)
- Co-produced care planning - implementing DIALOG to support this (TEWV)
- Increasing access to evidence based psychological therapies and psychosocial interventions (TEWV)
- Workforce development: identifying and addressing skills deficits & training needs. (TEWV)
- Implementation of the key worker role (Integrated care systems (ICS) and all partner organisations including TEWV)
- Interoperability (Integrated Care Boards (ICB).

Next Steps:
- Ratify our Trust's interim policy on personalised care planning
- Roll out of DIALOG to enhance co-produced care planning enabled by Cito.
- Develop and implement strategy to increase access to evidence based psychological therapies
- Establish workforce development group to support delivery of transformation.
- Liaise with and learn from services that are further ahead with delivery of personalized care
- Work with Integrated Care Board (ICBs) and partner organisations to establish the role and responsibilities of the key worker
- Work with ICBs to establish effective interoperability between systems
- Ensure there is a comprehensive communications plan to ensure all stakeholders are aware of developments and the related implications.

The implementation of the interim personalising care policy will mark a significant milestone in the journey toward redefining mental healthcare. This policy, rooted in the principles of personalisation and patient-centred care, sets the stage for a transformative shift in how mental health services are delivered and experienced. The policy underscores the importance of placing patients at the centre of their care journeys, empowering them to actively participate in decision-making, and tailoring interventions to meet their unique needs. The implementation of the policy is not the culmination of a process; rather, it is the continuation of a transformative journey. It is an ongoing commitment to delivering a universal high standard of care, improving patient outcomes, and ensuring that mental health services are inclusive, accessible, and responsive to the needs of all individuals.

Priority 2 – Feeling safe

Why it was important:
Patient safety continues to be our key priority. Our quality journey (the quality strategy) identifies a number of patient safety priorities that we will continue to focus on going forward.

Patients feeling safe on our inpatient wards is a key area for improvement for us. It is acknowledged nationally that some patients report not feeling safe while in the care of mental health services. A survey, undertaken in 2020 by the Parliamentary and Health Ombudsman, examined people's experiences of NHS mental health care in England, reporting that one in five patients reported feeling unsafe.

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On a monthly basis patients on our wards are asked: do you feel safe on the ward? The data from our survey is telling us that on average 78.63% of patients feel safe within our inpatient areas against a target of 75%. There is a lack of consistency in how this data is asked, gathered, and reported on nationally to allow any benchmarking comparisons to be made.

The benefits/outcomes we aimed to deliver for our patients and their carers were:

- Improved patient safety and reduction of patient harm.
- An increase in the percentage of our patients feeling safe when they are in an impatient setting.
- Increased collaboration between patients, staff, and peers.
- A reduction in incidents e.g. violence and aggression, absence without leave, drug misuse.
- Improved understanding of ward environments and why patients feel unsafe.
- Increased opportunity to use digital technology to support the delivery of care.

What we said we would do and what we did:

a) Performance improvement plan (PIP) from services in each care board to provide better oversight and gain momentum on service improvement work.
b) Continue to progress our body worn camera pilot work and evaluate its impact.
c) Continue to implement the Safewards initiative.
d) Expansion of peer support workers and activity coordinators.
e) Co-create information leaflets for people newly admitted to include suggestions for what could help them feel safe.
f) Shared learning from the 'feeling safe' focus groups through the co-creation board.

We reviewed information from patient surveys, incidents, and complaints from all inpatient services to identify any new emerging themes that may help inform our programme of improvement work in this area.

From the review undertaken we were able to identify the following themes:

- The need for environmental improvements – for example, to ensure that patients are familiar with their surroundings while on the ward and that the ward is homely.
- Staffing – for example, ensuring that staff are always visible for patients and that there are enough staff available to meet patient's needs when required.
- The need to increase ward based activities available for patients – this includes ensuring that there are variety of meaningful activities available with good use of outdoor courtyards and access to leave.
- Patient safety – for example, improving personalised care planning, timely interventions and support, and helping patient's to feel safe when there are patients displaying aggression.
- Discharge – for example, ensuring that high quality discharge and crisis plans are in place and that patients are well prepared for discharge.
- Communication – for example, ensuring that telephone calls are answered in a timely way, that appointments are not cancelled at short notice and that patients feel listened to.
- Some concerns being raised by MPs or via CQC rather than being reported directly to the Trust, with repeated contacts from some individual patients.

These themes have informed our quality journey and further development of our quality assurance and improvement programme. In addition, the patient and carer experience team has undertaken a series of focus groups between September 2023 and December 2023 across all inpatient wards. This was to understand what feeling safe means to our patients and staff and ask them what they feel would improve safety.

Some of the things we have done in response to what our patients and staff have said:
Safe and visible staffing

- Continuous recruitment programme for qualified and non-registered nursing staff, including international colleagues.
- Embedding the SafeCare system (a nurse rostering system). This enables efficient allocation of staff and has inbuilt patient safety triggers to support patient safety.
- Recruitment of peer support workers, activity co-ordinators and volunteers.

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- Reinforced zonal observations on the wards.
- Support from partners, for example introduction of a learning disability nurse on a mental health ward to provide bespoke skills when required.

Patient leave
- Introduced a dedicated leave team to support patients to access leave.
- Patient access to leave is consistently discussed in the daily ward huddles.

Patient activities
- Activity coordinators who work on wards across seven days a week.
- Introduced pet therapy animals within some wards.
- Co-created environmental displays and artwork.

Patient environment
- Autism team support with autism environmental checklist to identify any reasonable adjustments.
- Introduction of a new platform to enhance wi-fi capability.

Each care group has developed a patient experience improvement plan that incorporates actions related to a range of patient feedback and includes those actions related to patients feeling safe on our wards. The plans are reported and monitored through the patient and carer experience group and reported for assurance to the care board executive review of quality meetings. This area of patient safety will continue as a priority over the coming year.

What was the outcome / impact?

Indicator	Target	Actual 2021/22	Actual 2022/23	Actual 2023/24
Percentage of inpatients who report feeling safe on our wards	75%	64.37%	56%	**78.63%**
Percentage of inpatients who report that they were supported by staff to feel safe	66%	68.04	85%	**85%**

Priority 3 - Embed the new patient safety incident response framework

Why it was important
The patient safety incident response framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for proportionately responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRF is a contractual requirement under the NHS standard contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services.

What we said we would do and what we did

Be compliant with the national requirements regarding PSIRF.
PSIRF was implemented on 29th January 2024 in line with the key quality priorities within the quality journey and quality strategy. Our Trust's incident policy has been re-written and consulted on. PSIRF actively supports the use of a greater range of evidence-based tools supporting learning from incidents of all severities. Oversight of serious incidents (under the 2015 framework), patient safety incident investigations (under PSIRF) and early learning processes have been reviewed to ensure appropriate rigour.

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It was identified that to ensure compliance with the new national learning from patient safety events (LFPSE) standards, our Trust required a new incident reporting system and has therefore changed to a new system. This gives greater visibility and when optimised and will give the ability to triangulate learning from other parts of the reporting systems e.g., complaints. Importantly this system further supports monitoring and timely review and response to patient safety incidents.

The patient safety huddle is now embedded as routine practice and is operating effectively. The daily huddle reviews all incidents of moderate and above severity and in line with the national PSIR framework, a proportionate response is identified. This supports multi-disciplinary engagement, service user, family engagement and early learning.

The standard action plan is now embedded and is applied to both serious incidents, patient safety incident investigations and early learning processes (now referred to as after-action reviews). Action plans are divided into two-parts, local learning and recognising some learning is organisational, the second part will feed into an organisational learning plan. This will have oversight from the quality assurance and clinical effectiveness team. All previous serious incident action plans from 2021 have been reviewed to ensure the evidence of action completion is robust.

Increase the number of staff completing level 1 and 2 training within the national patient safety syllabus training.

Level 1 and Level 2 training is within the ESR system and monitored. As of March 2024, Level 1 is at 95% and Level 2 is at 79%. Additional training is being delivered to our Trust's patient safety team and members of care groups specific to PSIRF tool and processes. A train the trainer programme is planned for quarter 1 of 2024/25.

Introduce an annual patient safety summit.

A patient safety summit, focused on the impact of inequalities on patient safety, took place in March 2024 and was attended by service users, carers, partners, trust staff and other stakeholders.

Introduce the role of patent safety partners.
Our Trust has an identified non-executive director lead supporting work to develop the new patient safety partner role as part of PSIRF. Work is underway with lived experience directors to identify lived experience workers to participate at various points within the patient safety processes. Lived experience directors are currently invited to and attending directors assurance panels. A monthly patient safety partner oversight group has been commenced. There are now two family liaison officers to support engagement with families and carers offering support and signposting.

Complete the focused work we have initiated on the duty of candour through the delivery of an improvement plan
An internal audit of the duty of candour policy identified some areas for improvement and an improvement plan was developed. As part of the improvement work, a new policy was implemented, and internal training developed and delivered as part of the rollout of the new incident system. Bespoke training has been commissioned from NHS Professionals and is being delivered Trust-wide. Duty of candour has been incorporated into new staff induction and preceptorship induction. Duty of candour compliance is part of the early learning process and is to be re-audited in quarter 1 of 2024/25

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2.4 Our quality journey

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

The five journeys are:

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

The journeys set out specific ambitions and principles that support the mission, values and goals of Our Journey to Change and drives both incremental and large-scale improvement initiatives. The journeys are delivered through a series of programmes and workplans that make up our 2024/25 delivery plan.

The journeys create a strong framework and strategic vision that allow our Trust to prioritise key work. They have introduced rigour and support through a programme management approach and allow the Trust Board to receive assurance that we are making sufficient progress and achieving the outcomes and impact required.

Our quality journey sets out our quality ambitions for the next two years showing where we want our journey to take us. It sets out key principles and explains how our objectives connect to the national NHS patient safety strategy. It also outlines our key strategic quality objectives.

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

We will continue to have an unrelenting focus on patient safety and are committed to:

- Driving improvements in patient safety across our Trust, together with patients, carers and families, colleagues, and partners, and supported by a positive culture.
- Providing a great experience for patients in our care and for patients, carers and families who want to work with us for better mental health in our region.
- Providing safe and kind care that's based on evidence and has outcomes that matter to people.

It is often important to make quick changes to tackle quality issues, and our governance system will promote a culture and processes where data is analysed holistically, and changes implemented swiftly. This means that not everything we need to improve will have a detailed, long-term plan around it.

However, there will be some potential changes which will require lengthy development and implementation periods. These will be governed as projects, grouped into programmes, and be backed by clear business cases which set out the benefits (improvements) that should be seen and when they should be expected to occur.

During 2024/25 the initial set of quality related programmes will be:

- Personalised care planning
- Physical health
- Improve patient safety

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2.5 Our priorities for 2024/25

Implementation of quality priorities supports our Trust in ensuring that safe, high quality care is at the heart of service delivery and is in line with Our Journey to Change and the quality strategy.

Developing our priorities

As part of our Trust's ongoing commitment to co-creation, it was agreed that from 2024/25, development of our quality priorities would be led by people with lived experience. This approach enables the voice of service users, relatives and carers to be at the heart of quality improvement across the organisation.

To support the development of the quality priorities, a service user and carer focus group was held in March 2024. Members of the group were recruited through the involvement team and included those with personal lived experience and also those currently working with involvement networks and other community organisations. The focus group was facilitated by the care group director of lived experience for the Durham, Tees Valley and Forensic care group and the associate director of quality governance and compliance. Key quality issues from national and local sources (including learning from co-creation boards, lived experience directors, involvement networks, serious incidents and other governance intelligence) were shared with the group.

The following quality priorities for 2024/25 were agreed by the group and endorsed by our quality assurance committee:

Priority 1:

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

Priority 2:

- **Patient safety: relapse prevention**
  This priority is focused on timely and proactive access to support for patients who experience relapse in order to minimise harm, particularly through the effective use of well-being plans.

Priority 3:

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

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2.6 Statement of assurances from the Trust

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

- Review of services provided by or contracted our Trust
- Our 2023 Community Mental Health Survey results
- Our 2023 National NHS Staff Survey results
- Clinical Audit: participation in clinical audits and national confidential inquiries
- Clinical research
- Use of the Commissioning for Quality and Innovation (CQUIN) payment framework
- What the Care Quality Commission (CQC) says about us
- Information governance
- Freedom to Speak Up
- Learning from deaths
- PALS and complaints
- Data quality
- Mandatory quality indicators

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2.7 Review of services provided by or contracted by our Trust

During 2023/24 our Trust provided and/or subcontracted 20 relevant health services. Our Trust reviewed all the data available to us on the quality of care in 20 of these relevant health services.

The income generated by the relevant health services reviewed in 2023/24 represents 100% of the total income generated from the provision of relevant health services by our Trust for 2023/24.

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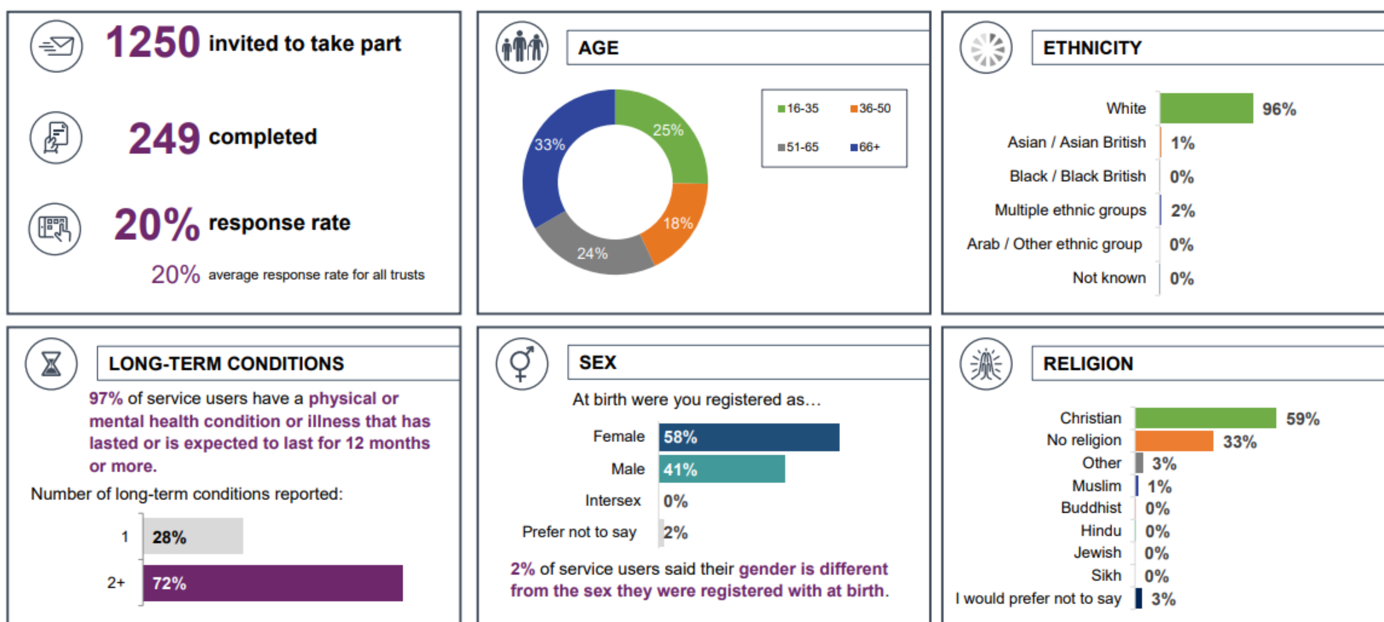
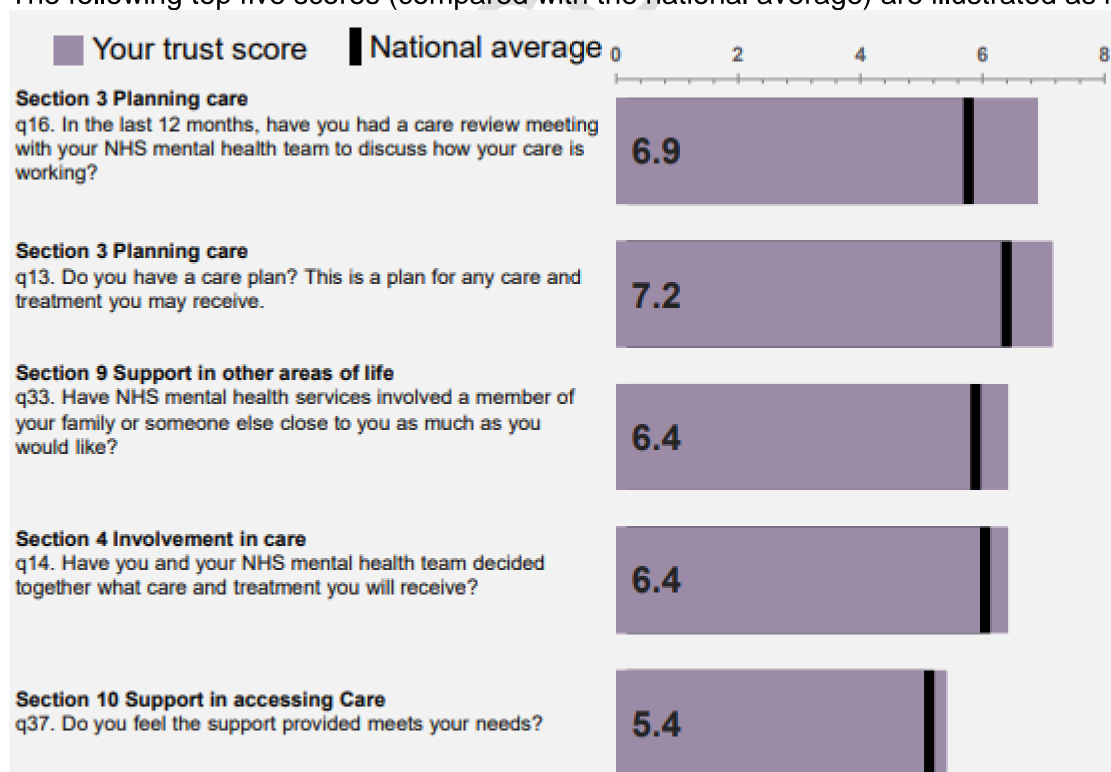
2.8 Our 2023 Community Mental Health Survey results

There were 249 completed surveys returned within our Trust for the 2023 Community Mental Health Survey, a response rate of 20%. This is the same as the national response rate and compares with a rate of 20.9% in 2022. The following image illustrates the population of our patients who took part in the survey.

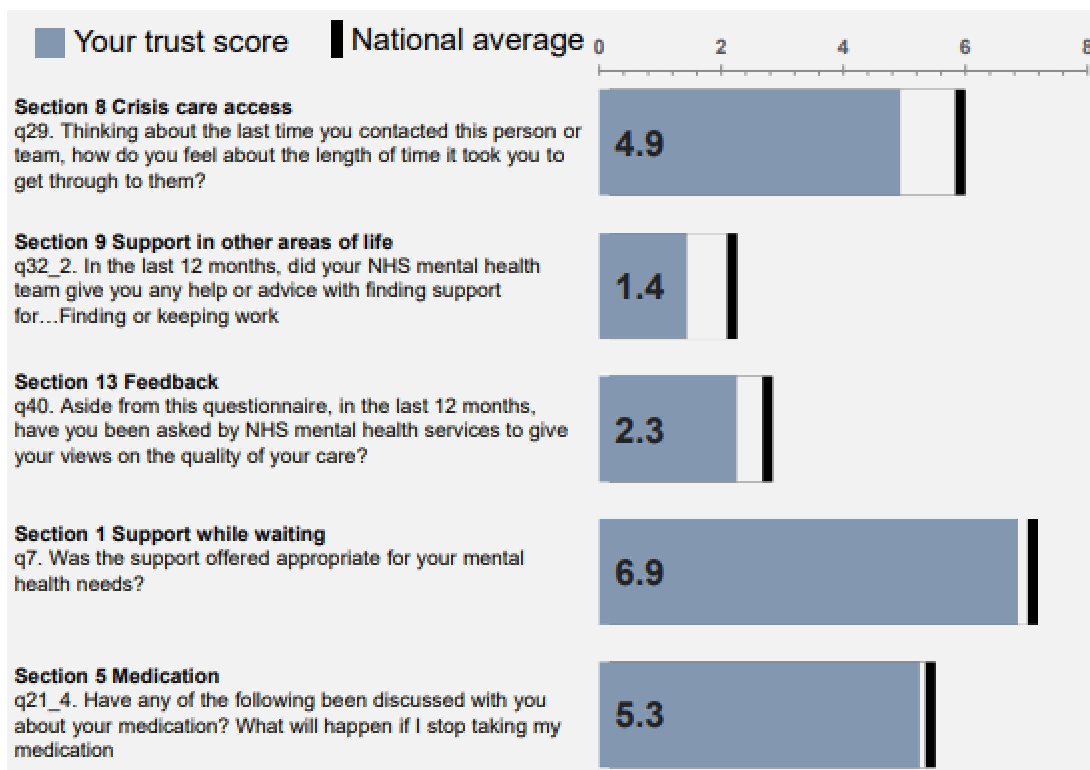


Benchmarking
The 2023 National Community Mental Health Survey was provided by a new supplier. Due to changes made in the sampling period, eligibility of service users included and the mode in which the survey was carried out, there is no comparability with previous years. The initial findings report does not include the lowest and highest national scores. The national results were published on 18th April 2024.

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



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



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

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2.9 Our 2023 National NHS Staff Survey results

Our response rate increased by 4% to 48% which reflected a good return rate nationally. Ongoing progress is noted in the experience of staff in relation to harassment and discrimination, work hours/ time pressures, and experience after a near miss/ incident.

In relation to the people promise elements / themes we improved significantly on: we are recognised and rewarded; we are always learning; staff engagement, and morale. We did not deteriorate on the remaining four (one was unreportable nationally for all organisations).

Due to the way the meetings fell, the staff survey was discussed in detail in the January 2024 people, culture and diversity time out in order to set the priorities for 2024/25 and evaluate impact against the people journey. The group concluded that, to date, the people journey had made good impact and that the plan of work for the next six months was appropriate.

It is proposed that, overall, the staff survey results give good assurance of continued progress. The scores have remained the same or increased in 100 of 113 areas following the significant improvement last year when the trust was the most improved mental health/ learning disability and autism trust in the country.

Work needs to continue on the feedback to teams after an incident and what changes have been made to clinical practice as a result.

The committee also pulled out the theme of staff experience of their team/ team manager. The training and development of immediate line managers will be prioritised this year. We have invested a lot of resource into supporting leaders from service management level and up as a planned stage of implementing the new Trust-wide structure, and continued to run new managers courses and managers' bitesize programmes. We will begin to oversee the uptake of these programmes for all new leaders are team level (operational, clinical and corporate) and integrate the new national resources 'expectations of people managers'.

Communications have begun with local services to support them to explore their own local data and work with their teams to develop local plans.

Key Trust-wide areas of focus are the continuation of the central reasonable adjustments team, flexible working and sharing changes to clinical practice and the outcome/ experience data from people accessing our services.

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The most improved results compared to 2022 are illustrated as follows:

Further detail of the most improved scores:

Most improved scores	Org 2023	Org 2022	Org 2021
Q4c. Satisfied with level of pay	**38%**	31%	38%
Q14d. Last experience of harassment/bullying/abuse reported	**63%**	58%	57%
Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours.	**44%**	40%	42%
Q19c. Staff involved in an error/near miss/incident treated fairly	**55%**	50%	No results *
Q5a. Have realistic time pressures	**29%**	25%	25%

There are, however, a few areas from the NHS National Staff Survey where we're performing below the national average illustrated as follows:

Further detail of the most declined scores:

Most declined scores	Org 2023	Org 2022
Q19d. Feedback given on changes made following errors/near misses/accidents	**63%**	65%
Q20b. Would feel confident that organisation would address concerns about unsafe clinical practice.	**59%**	61%
Q31b. Disability: Organisation made reasonable adjustments(s) to enable me to carry out work.	**74%**	76%
Q19c. Organisation ensure errors/near misses/incidents do not repeat	**68%**	70%
Q7i. Feel a strong personal attachment to my team	**65%**	66%

Areas where our Trust scored higher than the national average:

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Top 5 scores vs Organisation Average	Org	Picker Avg
q15. Organisation acts fairly: career progression	64%	58%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	82%	77%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	95%	91%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	44%	41%
q16b. Not experienced discrimination from manager/team leader or other colleagues	95%	92%

Areas where our Trust scored lower when compared to the national average:

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	55%	62%
q25c. Would recommend organisation as place to work	57%	64%
q6b. Organisation is committed to helping balance work and home life	52%	58%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	74%	80%
q4d. Satisfied with opportunities for flexible working patterns	63%	68%

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

A clinical audit is the process by which the quality of care and services provided are measured against agreed standards. Where services do not meet the agreed standard, the audit provides a framework where suggestions for improvements can be made. A third party conducts national audits. Participating in these audits gives organisations the opportunity to compare their results with other organisations. Local audits are conducted by the organisation itself. For local audits, we evaluate aspects of care that the healthcare professionals themselves have selected as being important to their team. The statements on a clinical audit demonstrate the healthcare provider is concerned with monitoring the quality of their services and improving the healthcare provided.

- During 2023/24, five national clinical audits and two national confidential enquiry covered NHS services that Tees, Esk and Wear Valleys NHS Foundation Trust provides.

- During that period, Tees, Esk and Wear Valleys NHS Foundation Trust participated in 100% of national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

- The national clinical audits and national confidential enquiries that Tees, Esk and Wear Valleys NHS Foundation Trust was eligible to participate in during 2023/24 are as follows:
  - National Audit of Inpatient Falls (NAIF) – continuous audit
  - National Clinical Audit of Psychosis (NCAP) EIP re-audit in EIP Services
  - National Audit of Dementia (NAD): Spotlight Audit for Community-based Memory Services
  - POMH Topic 23a: Sharing Best Practice Initiatives
  - POMH Topic 22a: Use of anticholinergic (antimuscarinic) medicines in old mental health services
  - National Confidential Enquiry into Patient Outcome and Death (NCEPOD): End of Life Care Study
  - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

- The national clinical audits and national confidential enquires that Tees, Esk and Wear Valleys NHS Foundation Trust participated in, and for which data collection was completed during 2023/24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	Cases Submitted	% of number of registered cases required
National Audit of Inpatient Falls (NAIF) – Continuous audit	2	100%
National Clinical Audit of Psychosis (NCAP) EIP re-audit	475 (and a further 7 contextual team level questionnaires)	100%
National Audit of Dementia (NAD): Spotlight Audit for Community-based Memory Services	Sample provided: 50	100%
POMH Topic 23a: Sharing Best Practice Initiatives	Sample provided: 1	100%
POMH Topic 22a: Use of anticholinergic (antimuscarinic) medicines in old mental health services	Sample provided: 303	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): End of Life Care Study	Sample provided: 5 Clinician Questionnaires	100%

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Audit Title	Cases Submitted	% of number of registered cases required
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	62 questionnaires sent to the Trust with 42 returned	68%

- The reports of six national clinical audits were reviewed by the provider in 2023/24 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
  - The criteria for monitoring plasma levels was updated as part of our Trust's psychotropic monitoring guidelines.
  - The Trust has implemented a new patient electronic record system (Cito) and prompts have been built in to ensure that staff ensure that patients prescribed melatonin have a review of side effects within the first three months.
  - The Trust psychotropic monitoring guidelines has been updated to include baseline monitoring requirements for valproate.
  - The Trust pharmacy lithium registers team has implemented a process of searching WebICE for relevant blood tests, and within the patient's electronic care record for a recorded weight/BMI, in the two months prior to the patient starting treatment.
  - Additional carer support workers were recruited to support Carer-focused education and support programme provision for our North Tees, South Tees and North Durham early intervention teams.
  - There has been additional Family Intervention investment provided for our Scarborough, Whitby, Ryedale early intervention teams.

- The reports of 125 local clinical audits were reviewed by the provider in 2023/24 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:
  - A Mental Capacity Act conference was held for non-medical clinical staff to increase awareness and understanding of Section 17 Leave processes.
  - Key amendments have been made to the quality assurance and improvement programme ensuring the quality and risk areas assessed remains relevant to changing systems and processes within the Trust supporting continuous improvements.
  - Communication across all teams has been provided by our safeguarding public protection team to ensure that there is a system in place to easily identify patients who are parents of children and / or patients who have requested a visit from a child.
  - The Trust safeguarding lead social worker has collaborated with the secure inpatient services to increase awareness of the Trust's Forensic child visiting procedure, alongside the child visiting policy thereby ensuring the person with parental responsibility must be contacted in all cases to consult on the visit.
  - All infection, prevention and control (IPC) audits are continuously monitored by the IPC team and any required actions are rectified collaboratively by the IPC Team and ward staff. Assurance of implementation of actions is monitored by the clinical audit and effectiveness team via the clinical audit action monitoring database. A total of 60IPC clinical audits were conducted during 2023/24 across inpatient areas, prison teams, and applicable community teams where there are clinic facilities. **65% (39/60)** of clinical areas achieved standards between 90-100% compliance. Local clinical audit action plans were implemented in collaboration with the IPC team and the clinical team members to mitigate any areas of non-compliance.

In addition to those local clinical audits reviewed (i.e., those that were reviewed by our quality assurance committee and quality assurance and improvement group), we undertook a further 58 clinical audits in 2023/24 including clinical effectiveness projects by trainee doctors, consultants and other professionals, in addition to those by directorates/specialty groups. These clinical audits were led by the services and

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individual members of staff to support service improvement and professional development and were reviewed by specialties.

The Trust has procured an electronic clinical audit application and over the next year will be using this system to make clinical audits more efficient and easier for teams. Teams will be able to review their clinical quality information in a live format and to make any changes needed to improve practice and ultimately the quality of care and the experience of our patients and their families.

We continued to implement an extensive quality assurance and improvement programme during 2023/24. This provides ongoing assurance that key quality and risk issues identified are addressed. Significant improvements in practice and patient safety continue to be facilitated through this programme.

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2.11 Participation in clinical research

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

The number of patients receiving relevant health service provided or sub-contracted by our Trust in 2023/2024 that were recruited during that period to participate in research approved by a research ethics committee was 939. Of the 939 participants, 901 were recruited to 29 National Institute for Health Research (NIHR) portfolio studies. This compares with 827 patients involved as participants in 36 NIHR research studies during 2022/23. As well as acting as a research site and participant identification centre, our Trust sponsors research including six NIHR grant-funded studies. As part of this role our research and development team are actively engaged in governance activities such as site set-up and performance tracking. As sponsor, during 2023/2024, our Trust oversaw the completion of the BASIL+ trial, an urgent public health study. It shows that depression and loneliness can be prevented using structured telephone-based psychological care, delivered over 8 sessions (Behavioural activation to mitigate the psychological impacts of COVID-19 restrictions on older people in England and Wales (BASIL+): a pragmatic randomised controlled trial - ScienceDirect). Another of our sponsored studies explored food insecurity in adults with severe mental illness living in Northern England. The study was co-produced with four peer researchers with lived experience of severe mental illness from its conception to dissemination and found a 50.4% prevalence of food insecurity in the reported sample (Food insecurity in adults with severe mental illness living in Northern England: A co-produced cross-sectional study - Smith - Nutrition & Dietetics - Wiley Online Library).

Other examples of how we have continued our participation in clinical research include: We continue to work closely with the NIHR Clinical Research Network North East and North Cumbria to support large scale national portfolio research studies, and to measure patient research experience when taking part in studies with feedback and any actions reported to our research governance group. 27 different staff members took on the role of principal investigator for NIHR supported studies. We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers, and staff.

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

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

A proportion of Tees, Esk & Wear Valleys Foundation Trust's income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between Tees, Esk and Wear Valleys NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2023/24 are available on request from Ashleigh Lyons, Head of Performance. Email Ashleigh.lyons@nhs.net

There will be no 2024/25 CQUIN requirements.

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

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

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

The CQC has not taken enforcement action against Tees, Esk and Wear Valleys NHS Foundation Trust during 2023/24.

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

Our Trust's CQC inspection took place 29 March 2023 to 02 June 2023. As part of the inspection, the CQC visited 59 of our wards/teams. This comprised of inspections of wards/teams from a range of Core Services including Adult Learning Disability Community and Inpatient services, Secure Inpatient Services and Community and Inpatient MHSOP services. The CQC published the results of the Trust's latest trustwide inspection on its website on 25 October 2023.

The CQC report demonstrates our continuous improvement and the positive impact that this has had on people's experience of the services that we provide. It also acknowledges that we still have more to do.

Importantly, the report recognises the hard work and commitment of Trust colleagues in making improvements. A running theme throughout the report is that our staff are kind and caring and demonstrate our values in the care that they provide. This is something that is seen every day, not just during CQC inspections. We know there is more to do but we're proud that we're moving forward together.

The CQC inspections took place from March to June 2023 and while the Trust's overall rating has stayed at requires improvement, there are no longer any areas that are rated as inadequate and the majority of our services are rated as good. Overall, the CQC recognises that we're making good progress.
This has been a real team TEWV effort. It is of particular note, that Ridgeway (our secure inpatient services), wards for people with a learning disability or autism and wards for older people had all improved since their last inspection.

Inspectors found that our Trust had a clear vision and strategic direction, which is understood by all staff. They could also see a positive culture change. This was demonstrated by colleagues who felt supported and valued and had confidence in our freedom to speak up process. Most importantly by patients who told inspectors that staff were 'kind and considerate', 'friendly', 'kind and supportive' and that they were 'actively involved in their care planning'.

We all agree that further improvements are needed, however, we have come a long way in a relatively short space of time and in difficult circumstances. The areas for improvement are already in our sights and are being worked on every day. As with other trusts throughout the NHS, successful staff recruitment and retention and development of the excellent staff we have, remains a pressing priority and is key to us achieving all our goals.

Key facts and figures:

- Seven out of 11 of our services are rated 'good'. Four areas are rated as 'requires improvement'. This is an improvement since our last inspection in 2021.
- All services were rated as 'good' for caring.
- Nine out of 11 services were rated as 'good' or 'outstanding' for effective.

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- No warning notices were served as a result of the inspection.
- No services were rated as 'inadequate'.

As expected, the areas for improvement include issues seen nationally such as staffing and waiting times. We've also got some more work to do around mandatory training and recording supervision, physical health monitoring and responding to complaints. The backlog of serious incidents is highlighted as a 'must do', and we are committed to completing these in a timely way, with significant progress now made in reducing this. There is a clear plan in place to reduce delays and are making good progress.

We know that there is further work to do however, the fact that the CQC has told us we're making improvements, and that these positive changes have impacted on the quality of our care, is a really important step on Our Journey to Change.

Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following action to address the points made in the CQC's assessment:

- The quality governance team has co-created the CQC improvement plan in collaboration with care group colleagues and specialty/directorate leads, in response to the CQC must and should do recommendations made within the inspection report. Two improvement planning events were held 31 October 2023 and 01 November 2023 to develop the improvement actions. The events were well-attended and the framework used was well received by those involved.
- Improvement actions have been developed taking into account the significant work which has already been completed, avoiding duplication where actions are already being addressed by established workstreams or ongoing improvement plans are being delivered. This includes how we check that there is ongoing assurance of actions being embedded and sustained.
- The Trust CQC improvement plan against the must do recommendations was formally submitted to the CQC on 27 November 2023 after approval by the quality assurance committee 22 November 2023.
- The quality governance team will continue to maintain the evidence repository to provide assurance of completion and implementation of improvement actions. Delivery progress for the CQC improvement plan (must and should do actions) will continue to be formally reported to the Quality Assurance Committee, noting where actions are implemented and embedded.
- Learning themes from the CQC improvement plan informed the Trust-wide learning event held on 3 November 2023, where these were triangulated with broader quality governance intelligence, including learning from serious incidents, quality assurance programme data and complaints feedback.

Tees, Esk and Wear Valleys NHS Foundation Trust has made the following progress by 31st March 2024 in taking such action:

- A revised schedule / work plan for the quality assurance committee includes learning from audits, incidents, CQC visits and complaints. Learning from executive visits is reported into the management group and informs the quarterly learning events (alongside the review of serious incidents, incidents and CQC visit themes).
- A procedure setting standards for responding to requirements and recommendations from external and internal reviews has been implemented.
- All external and internal reviews that result in recommendations will continue to have an associated improvement plan with a clear governance route to ensure delivery through to conclusion (including tracking of recommendations and actions).
- The duty of candour policy has been revised in line with national standards and there is weekly reporting of duty of candour to the executive directors group and the quality assurance committee to confirm compliance with the policy standards.
- Incident reporting on InPhase prompts clinicians to record the rationale where prone restraint is used. The use of prone restraint is reviewed within each care group positive and safe group and the Trust-wide positive and safe group. Performance against the standards is reported up through care groups and the Trust-wide positive and safe group to the quality assurance committee and the mental health legislation committee.
- We have reviewed, updated and implemented the Section 17 Leave Policy. The mental health legislation team has undertaken formal monitoring and checks in relation to completion of Section 17 leave documentation, ensuring that it is fully completed, and that staff are using the correct form. Feedback from these reviews has demonstrated improvements and has been reported to the Trust's

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Mental Health Legislation Committee. We have also included monitoring of leave documentation within our quality assurance schedule to continue to quality assure until we are confident of embedded improvements.

- We have a forward plan for the mental health legislation committee to identify regular reporting requirements from the positive and safe group, including data on the use of restraint and Use of Force Act compliance.
- All governors have been informed of what support is available and from whom within the Trust. Contact details of non-executive directors and their biographies have been shared with all governors, and non-executive directors have been advised to make themselves available to governors wherever possible through normal Trust business, including Council of Governors meetings.
- We have agreed a plan on a page for the use of Speak Up Guardian data and intelligence, how it will be shared and how it will be triangulated with other information / data to lessen the risk of closed cultures.
- We have agreed process for the people, culture and diversity committee regarding how we manage and report Freedom to Speak Up outcomes (without breaking individual confidentiality).
- We have developed a workforce plan for pharmacy professionals and non-registered pharmacy staff.
- We have reviewed all blanket restrictions on Kestrel/ Kite ward to ensure that these are now individually assessed. These have been presented to the reducing restrictive interventions group.
- We have reviewed all wards within the service to ensure that rooms and facilities are accessible for patients with mobility needs, including access to emergency call alarms.
- We have developed a system in collaboration with occupational therapy to ensure that when patients need are assessed and a change of environment is required, that a monitoring and escalation process is in place.
- We have reviewed the contract for the provision of patient food and a new provider is now well established. We have held focus groups with patients to support the development of new ward menus and we have incorporated fridge checks by ward housekeepers into the daily workplan.
- Ward managers have co-produced a system with service users for dissemination and storage of community meeting minutes which will document the outcomes of actions taken.
- We have decommissioned the seclusion facility where an issue was observed in relation to use as a cut through by staff.
- Lockable safes have been checked on admission of new patients and at discharge to ensure that they are in good working order.
- We have developed and undertaken an oxygen assessment against the policy assurance statements for the storage of oxygen. This was reported to the care group quality assurance and improvement group and the executive review of quality group. We have developed and implemented fridge temperature assessments, which covered a 30-day period and assessed practice against the policy assurance statements. Where improvements were required, action plans were agreed and followed up to provide assurance of completion with oversight via the care group governance forums. We are continuing to quality assure until we are confident of embedded improvements.
- We have reviewed site maintenance (including the cleaning schedules) and have regular meetings between the service and the estates and facilities management team to ensure that the unit is well maintained.
- We continue to work in collaboration with the HOPE(S) model for all patients in long term segregation and seclusion. All people will have a plan that has a long-term goal of leaving long term segregation.
- We have reviewed the adult learning disabilities inpatient estates and took actions to ensure that people's living spaces are conducive to recovery and feel welcoming. We continue to work with service users and their loved ones to understand individual preferences.
- Care groups have developed a plan for site visits (peer quality reviews) across 7 days a week and the 24-hour period to ensure that balanced feedback is gathered.

Tees, Esk and Wear Valleys NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

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2.14 Information governance

The reporting deadline for the toolkit is now 30 June 2024, therefore our position remains the same as for our 2022/23 position which is ‘approaching standards’.

We are currently at **90%** completion of our information governance mandatory and statutory training. Our Trust currently has a sickness rate in the region of **5%** so our ability to achieve the **95%** target has been impacted.

However, the current iteration of the toolkit (2023/24) allows organisations to develop their own information governance mandatory and statutory training and set their own key performance indicator (KPI). The Trust is currently in the governance process of bringing this KPI in line with all other mandatory training which is **85%** and which the Trust is already exceeding. This will be mitigated by the introduction of refreshed induction training for new starters which will include information governance training on their first day with the Trust.

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2.15 Freedom to Speak Up

There are a number of routes through which staff can raise concerns:

- Through their own management or professional structures.
- Through the Freedom to Speak Up team. This is as confidential as the person asks for it to be. Concerns are addressed in agreement with the person who spoke up. We have recently started directing the request for review to the senior leadership team. This has enhanced the process and increased the sense of service ownership and satisfaction from those who spoke up. However, we still offer an independent review for those who feel speaking outside their service is preferrable or want to ensure a level of confidentiality. We also signpost to other services such as employee support services or human resources. Feedback is given to the person on a regular basis, in line with our revised process. As much feedback is given as appropriate although, by the nature of some concerns and investigations, full feedback is not always possible.
  We have a monthly speaking up forum where we share soft intelligence, agree proactive work and agree what information is to be shared with the people and culture committee, the board, and each care board so that we can triangulate feedback from reviews, service action plans, and share outcomes.
- The online raising concerns form where people could previously complete anonymously has been discontinued.
- Through our safeguarding team or directly to the CQC.
- Through our formal HR processes, the timescales of which vary and are laid out in the relevant policy.
- Through the employee support service who will signpost and provide guidance on how to make best use of the options available.
- Through any trade union of which they are a member.

We have a process for addressing any concerns of detriment or demeaning treatment, in line with national guidance. We have recently agreed that concerns will be passed to our associate director for operations and resourcing, who will quarterly share themes with our non-executive director for speaking up.

With regard to the medical workforce, the role of Guardian of Safe Working for postgraduate doctors within our Trust sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The work of the Guardian is subject to external scrutiny of doctors' working hours by the CQC and by the continued scrutiny of the quality of training by Health Education England.

The Guardian is required to levy a fine against a department(s) if a postgraduate doctor:

- Works on average over 48 hours/week
- Works over 72 hours in seven days
- Misses more than 25% of required rest breaks
- On non-residential on call (NROC) does not have a minimum of continuous rest for five hours between 10pm and 7am
- Does not have the minimum eight hours total rest per 24-hour non-resident on-call (NROC) shift
- Has more than the maximum 13-hour residential shift length
- Does not have the minimum 11 hours rest between resident shifts

The Guardian of Safe Working for postgraduate doctors within our Trust produces quarterly and annual reports to the Board that focus on gaps in medical rotas and safety issues.

The Board received the Guardian's annual report for 2023/24. During the year, the most common reasons for needing short-term/locum cover was due to vacancies on the rotas and staff sickness (short/long term).

Exception reports received related mostly to claiming additional hours whilst on NROC, having to stay later than normal working hours or shift end time or missing teaching/training due to staff shortages. Discussions on these issues have taken place at the relevant forums and additional staffing put in place where possible.

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2.16 Community transformation

The aims of the Community Mental Health Transformation Framework were to redesign and reorganise core community mental health teams which are place based and to create a core mental health service which is aligned with Primary Care Networks, local authority and voluntary care sector organisations.

Key achievements made as part of the ongoing community mental health transformation work in line with the NHS England five year programme and provides a breakdown of next steps and key areas of delivery for the next 12 months.

Durham Tees Valley care group:
Key achievements of note include; County Durham

- An average increase of 26% in monthly referrals into the Durham mental well-being alliance with contact remaining within 48 hours.
- The number of people signposted to system services rather than referred to secondary care increased 8 fold.
- GP Aligned services received a total of 5,737 referrals in 2022/23 with only 14.8% of those being stepped up into secondary care.
- In the past six months, 22,560 people have seen by first contact practitioners with majority (90+%) having needs met in primary care or through signposting to community offers.
- Community Navigation met 72.5% of people's needs when referred to them, with 94% receiving support within 1 week.
- Access "waiting" caseload (excluding neurodevelopmental) has halved and waiting times for assessment reduced from approximately six weeks to approximately two weeks on average.
- Tees Valley Lived Experience involvement has helped to drive the work forward at all levels with members involved in key decision making.
- Establishment of the primary care workforce has resulted in only 3% of individuals now being stepped up into secondary care services.
- Introduction of the South Tees dual diagnosis team has allowed a completely new way of working which fits individual needs.
- The introduction of a new skill mix, care navigators, have enabled individuals to find support at the right place.
- Restructure of adult mental health community teams has been completed seeing a reduction of three teams into one team that now has two functions.

North Yorkshire, York and Selby care group:

Key achievements of note include:

- Lived experience voices are at the heart of transformation and have driven forward the work of the programme at all levels as key decision makers. The passion and enthusiasm seen from our members has ensured the programmes progress to date and enabled the true meaning of this work to be delivered. Within our Trust, the establishment of lived experience forums will keep the transformation accountable and has created a partnership between service and communities to deliver new and improved services. Work is underway to broaden this approach and support across the whole system. The Roundhouse will provide a central point to seek advice, guidance and support to engage from people with a lived experience.
- The establishment of the new first contact mental health practitioners in the primary care workforce has enabled an individual's needs to be met at the earliest opportunity. Currently less than 5% of individuals being seen in primary care are stepped up into secondary care, this indicates that the right individual care is being met at the right time, in the right place. Relationships and understanding of services have improved and led to closer multi discipline team working (across primary care, secondary care and the voluntary care sector), improving decision making, problem solving and integrating primary and secondary care. Work is under way to develop trusted assessor status for these practitioners which will increase integration further and reduce waiting times. We have held workshops and question and answer sessions across the whole system to look at development and refining pathways to make the system more user friendly. This is already having a positive impact on referral practices.

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- The introduction of a new skill mix, new 'system' roles across complex and emotional needs services, adult eating disorders, peer support, social prescribers, early intervention in psychosis and trauma informed care, have enabled individuals to find support at the right place. Their knowledge of the system and support within offered, as well as their relationships with key delivery partners, has ensured our local communities can navigate the correct support for their needs. These system roles work across the whole system, delivering specialist interventions, advice, guidance, training and co-working in several locations across the communities.
- Place based delivery workstreams with voluntary care sector leads from across the system have been able to act at pace. Capacity has been enhanced across the voluntary care sector and joined up, wrap around and supportive care delivered alongside statutory services, increasing access and interventions available across communities.
- Development of new community mental health hubs in the city of York and across North Yorkshire. We have successfully prototyped a new community mental health hub in the city of York where individuals can access the care they need from the whole system to meet their mental health needs. The model has been co-produced with stakeholders and people with lived experience. The prototype has now moved to implementation and is currently recruiting its full team ready for formal launch in March. Two further hubs are planned for the City of York, whilst other hubs are developing or already partially operational in Selby, Harrogate, Ryedale and Hambleton.
- Community grants have been provided at place to fund small and grass-root voluntary care sector organisations to bolster the resilience, provide the necessary support and wrap-around services to underpin the development of the new community hubs.

Recruitment
In the year 2023/2024, we booked 1,781 start dates with 781 of them being external to the Trust. We have continued with our international recruitment drive to fill nursing posts and expanding our workforce. We remain driven to improve our service, always looking at ways we can streamline and enhance the service we provide.

We have recruited over 150 newly qualified nurses into our workforce, supporting them in the start of their nursing careers.

The apprenticeship and talent team has attended numerous careers events at local schools and colleges – as a direct result of this, we have recruited four young people into permanent posts.

Between April 2023 and March 2024, we had 221 staff start an apprenticeship and during the same period 120 successfully achieved their apprenticeship. We are now working with partner organisations of the Leadership Academy to deliver apprenticeships which incorporate leadership programmes such as Edward Jenner and Mary Seacole.

We are in the process of looking at ways of bringing under 18's into TEWV either as students on placement; as volunteers and as apprentices.

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2.17 Learning from deaths

During 2023-24, 1322 deaths were reported to Tees, Esk and Wear Valleys NHS Foundation Trust's incident reporting system, with the majority of these considered to be from natural causes.

This comprised of the following number of deaths which occurred in each quarter of that reporting period:
- Q1 - 534
- Q2 - 330
- Q3 - 273
- Q4 -185

Of the 1322 deaths, in line with the national guidance on learning from deaths, 259 deaths fit the criteria for further review and 143 mortality reviews were carried out.

In mental health and learning disability services we have a number of older people who are cared for in the community and their needs are such they only require minimal contact with us. Many of these people, who die, do so through natural causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further. To support staff in their decision making regarding the investigation of deaths, staff have clear policy guidance, setting out criteria for categories and types of review.

Of the 1322 of the patient deaths during the reporting period 0.007% are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been based on the information contained within Structured Judgement Reviews carried out under the learning from deaths policy.

It is noted that from 1st April 2023 – 29th January 2024 case record reviews have been defined as those cases falling under the Trust's mortality review process and investigations as cases that have been reported on the Strategic Executive Information System (StEIS) and investigated under the Serious Incident Investigation Framework. From 29th January 2024 we moved from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF). This advocates a proportionate approach to investigation offering further tools for review of incidents. From 29th January 2024 case record reviews continue to be those falling under the trust mortality review process and investigations are those investigated using either an after-action review process or a patient safety incident investigation.

The Trust does not record information in the format previously detailed by the national guidance for this mandated statement. In line with the national guidance, the Trust no longer categorises learning into contributory and incidental findings.

All learning from serious incidents and patient safety incident investigations is themed and informs key workstreams to address any identified quality and safety issues.

- During 2023/2024 PSIRF was implemented. This is in keeping with Our Journey to Change and a focus on just culture and learning. During each quarter the number of learning points identified from case record reviews and investigations were as follows: 120 in the first quarter, 180 in the second quarter, 288 in the third quarter, and 220 in the fourth quarter. This reflects the significant increase in case record reviews and investigations undertaken compared to the previous year.

In 2023/2024 a 12-month thematic multi-disciplinary review was undertaken which built on existing theming work undertaken during 2022/2023. This thematic review extended the original seven learning themes identified from serious incidents investigations.

The original seven themes from serious incidents were identified as:
- Risk assessment and management (safety summary/plan/contingency planning)

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- Care planning
- Safeguarding (including use of PAMIC tool)
- Family involvement
- Record keeping
- Multi-agency working
- Records management

From the 2023/24 review an additional five, themes were identified where it was felt that there needed to be a specific focus. These five additional themes are:

- Physical healthcare
- Personalised care
- Staffing
- Positive and safe care / reducing restrictive interventions
- Environment

Themes from case record reviews were identified as:

- Care planning
- Multi-agency working
- Family involvement
- Physical health monitoring
- Medication monitoring
- Record keeping
- Risk assessment/risk management

- All learning in the Trust is referred to as actionable learning and supports our approach towards a just and learning culture in line with Our Journey to Change and a systems-based approach to learning as advocated by PSIRF.

Actionable learning continues to be monitored against the themes identified. Our quality assurance programme is regularly updated to reflect learning from patient safety incidents. It provides assurance that improvements are being made in relation to risk assessment, risk management, and contingency planning, care plans and carer involvement and that these improvements are being sustained in both inpatient and community settings. Ongoing quality assurance processes have highlighted specific learning themes. These have been presented through a monthly system wide quality meeting. Since January 2024 themes explored in this forum are care planning/CPA/intervention plans, risk assessment, management and safety summaries, physical health, record keeping and staffing.

Our Trust continues to strengthen arrangements for organisational learning via the organisational learning group which has had a full review of its membership and terms of reference, resulting in multi-disciplinary and executive level membership. The group's role is:

- Develop and maintain processes to learn and improve after patient safety incidents, complaints, safeguarding, leadership visits, investigations etc.
- To alert the Trust of systemic areas for improvement and / or safety issues.
- To ensure the group escalates or delegates concerns or issues to the appropriate forums / workstreams.
- To ensure the organisation has a structure that supports learning and improvement with strong triangulation and governance through:
- clear collation of information
- transparent processes to explore and investigate issues based in the PSIRF principles of Just Culture.
- Work with care groups and clinical networks to identify and theme learning opportunities.
- Ensure governance structure that will implement and monitor any identified changes.
- Disseminate learning and developments through a variety of identified solutions.
- Proactively seek out best practice and provide guidance to fundamental standards, clinical networks and care groups to ensure that safe high-quality care remains at the forefront of service delivery.

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- To invite identified work streams to feedback areas of development and positive practice to update and share progress.
- Review and raise awareness of wider system learning from across a range of organisations or publications for discussion.

Learning from case record reviews can be discussed within the organisational learning group, and will be disseminated via clinical networks, fundamental standards, briefings where appropriate, to ensure that learning feeds into existing improvement work. Learning for individuals is also shared with operational teams where appropriate and addressed via supervision and other local governance processes.

Twenty-one patient safety briefings have been circulated trust wide during 2023/24 as a result of learning.

Examples of these briefings include:

- Awareness raising related to spare Emergency Automated External Defibrillator (AED) Pads
- Recording of allergy information in the clinical record
- Information related to the operation of anti-barricade door systems
- Communication with families
- Liaison with the police
- Oxehealth functionality
- Safety planning whilst awaiting admission
- Reviewing of laboratory results
- A number of public health issues in partnership with other agencies linked to increased risks of suicide and potential harmful substances within communities.

The briefings circulated are specific about any assurance required from services. On receipt of completed actions these are documented in the local safety alert and learning database.

The environmental risk group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm. Any urgent learning from this group is disseminated Trust-wide via patient safety briefings. Environmental surveys with multi-professional input from estates, health and safety and clinical services continue to be undertaken.

Connecting for people, suicide awareness training, continues, and our mandatory harm minimisation training was updated to include relevant areas of actionable learning. The training considers completion of documentation/record keeping, patient/carer involvement and the importance of multi-agency working. Bespoke training sessions in hot spot areas are available on request.

The learning from deaths policy is currently under review to align it to PSIRF. It is aligned to Our Journey to Change and will ensure carers and families receive compassionate care following the loss of a loved one.

We continue to work collaboratively as part of the Better Tomorrow Programme to facilitate shared learning/good practice and valid comparisons with other trusts.

A new risk management system has been implemented bringing additional benefits in terms of triangulation of learning and oversight of organisational action plans with oversight from the organisational learning group.

Deaths of people with a dual diagnosis are increasing. Community transformation work has facilitated collaborative pathways across the system it operates within. It aims to create a core mental health service which is aligned with primary care networks and voluntary sector organisations to ensure that services are accessible to the community it serves and inclusive of population need.

- 96 case record reviews and 103 investigations completed after 31/03/2023 which related to deaths which took place before the start of the reporting period. This represents a significant increase and reflects our commitment to resolving any backlog of reviews

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- As stated during 2023/2024, in keeping with Our Journey to Change and in line with our transition to PSIRF, both of which focus on just culture and learning, all learning from case reviews and investigations is considered actionable learning. Within 2023/2024 we completed 199 case record reviews and investigations from deaths occurring in previous years and undertook 402 case record reviews and investigations from deaths in the reporting period. This meant we undertook a total of 601 case record reviews and investigations. This is a significant increase on the 276 case record reviews and investigations completed in the 2022/2023 period. 808 learning points were identified over 2023/2024 and this included the cases in point 6 above.

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2.18 PALS and complaints

All complaints are managed in line with national guidance, and we are committed to providing opportunities for our patients, their carer, or their families to seek advice or information, raise concerns or make a complaint about the services that the trust provides. Our complaints policy outlines how they can do this and to feel confident that they will be listened to, and their issues taken seriously.

In 2023, we carried out a full end to end review of our PALS and complaints function. The review had a very clear aim of ensuring a quicker, simpler, and more streamlined complaint handling service with a strong focus on early resolution and learning.

We implemented our new approach to complaints handling on the 11 December 2023 following a robust cycle of quality improvement whilst ensuring that everything was co-created. The new approach fulfils the expectations set out by the Parliamentary and Health Service Ombudsman (PHSO) for NHS Complaint Standards (2022).

We are encouraging people to discuss any issues they have with our staff, as we may be able to sort the issue out to their satisfaction quickly and without the need for them to make a complaint.

We recognise that we cannot always resolve issues as they arise and that sometimes people will want to make a complaint. We have simplified and streamlined our approach and we no longer differentiate between PALS and complaints, instead we are calling everything a 'complaint'. We are working on the principle of 'investigate once and investigate well' with each complainant receiving an open and honest written response that outlines any learning to demonstrate how we have listened and taken seriously their complaint.

We recognise that all complaints give a vital and direct insight into the quality of services that we provide. As part of the review, we also implemented a new electronic system to give greater visibility and when optimised the ability to triangulate learning from across the trust e.g., patient safety incidents etc. In time this will feed through to the Trust's organisational learning group.

In 2023/24 we received the following concerns:

Financial year	Local issue resolution	PALS	Complaints	Total
2023/24	206	1,773	498	2,477
2022/23	N/A	2,446	338	2,784

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2.19 Data quality

The latest published Data Quality Maturity Index (DQMI) score is **97%.** This is for December 2023.

Our Trust did not submit records during 2023/24 to the secondary uses service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

Our Trust was not subject to the payment by results clinical coding audit during 2023/24 by the Audit Commission.

We have had our annual external clinical coding audit for the data security and protection toolkit. The results were 96% correct for primary diagnosis and 83.1% correct for secondary diagnosis.

We stopped making commissioning data sets submissions that go to secondary uses service and HES approximately five years ago as the data was duplicated with the Mental Health Services Data Set. The Mental Health Services Data Set data quality for NHS number and GP practice from the Data Quality Maturity Index publication for December 2023 were both 100%.

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2.20 Mandatory quality indicators

Since 2012/13, all NHS foundation trusts have been required to report performance against a core set of indicators:

Inpatients that are discharged are followed up within 72 hours.
531 people were not followed up within 72 hours between April 2023 and March 2024.

The 72 hour measure is the percentage of people discharged from a CCG-commissioned adult mental health inpatient setting, that were followed up within 72 hours. This includes all people over the age of 18 years.

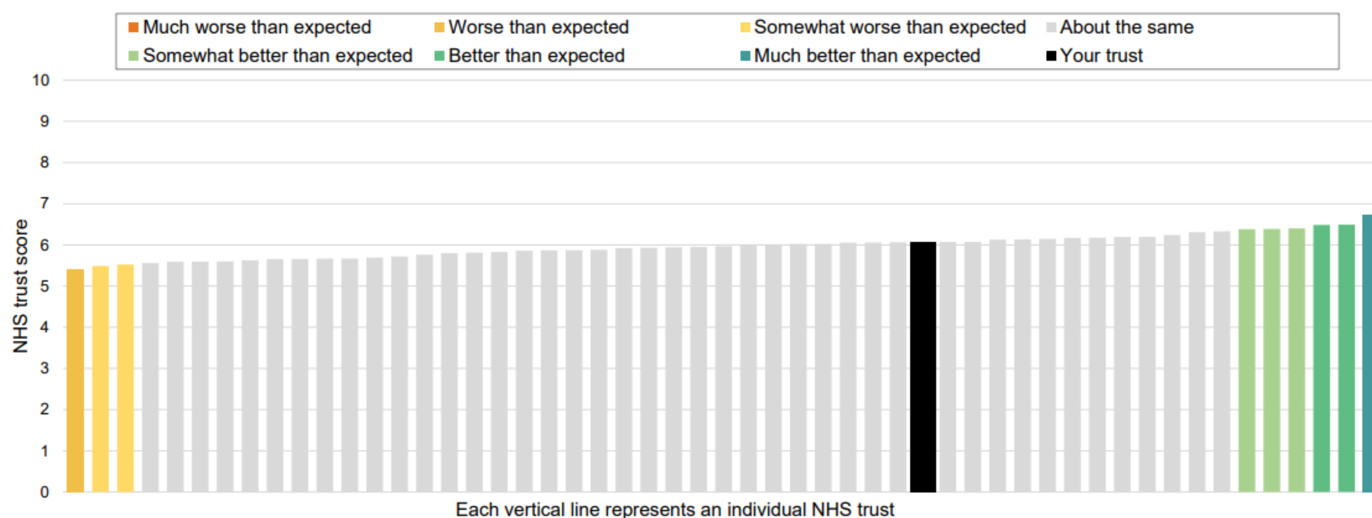
Of our commissioned services, 2938 patients were discharged between 1 April 2023 and 31 March 2024, of those:

- 2407 were followed up
- 531 were not

This measure has been impacted following the implementation of Cito and a comprehensive validation of the data for Quarter 4 is currently being undertaken.

Crisis resolution home treatment acted as a gatekeeping
This is no longer an indicator required to be reported.

Patients' experience of mental health teams
For 2023, we have reported the mental health section score of the NHS Community Mental Health Survey Benchmark (this has been replaced from previously indicated as a health and social care workers section). The Trust has reported a score of 6.1 which is indicated below as 'about the same' compared to all other trusts.



The section score is compiled from the results of the three survey questions below.

Question	TEWV mean score 2023	National average 2023	TEWV mean score 2022	TEWV mean score 2021
Were you given enough time to discuss your needs and treatment?	**6.9**	**6.8**	7.7	7.5
Did you get the help you needed?	**6.0**	**6.0**	*Question updated from 2023*	*Question updated from 2023*
Did your NHS mental health team consider how areas of your life impact your mental health?	**6.7**	**6.4**	*Question updated from 2023*	*Question updated from 2023*

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Did you have to repeat your mental health history to your NHS mental health team?	**4.7**	**4.6**	*Question updated from 2023*	*Question updated from 2023*

National patient safety incident reports

NHS England provided an update in September 2023 on the six monthly reports due in 2023/2024. They confirmed that they have paused the annual publishing of this data while we consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS.
Please refer to the narrative in section 2.17 related to the implementation of the patient safety incident response framework.

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PART 3: Further information on how we have performed in 2023/24

3.1 Introduction to part 3

Part 3 of this document contains further information which the legal guidance requires us to include. This includes statutory statements. As with Part 2, this helps to develop an overall picture of quality at our Trust.

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3.2 Our performance against our quality metrics

The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

Quality metrics:

Patient safety indicators	Target	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	Further comments
Percentage of patients who report 'yes, always' or 'yes quite a lot' to the question 'do you feel safe on the ward?'	75.00%	**78.63%**	55.57%	65.30%	64.66%	Not measured nationally	The end of 2023/24 position was 78.63% which relates to 1453 out of 1847 surveyed. This is 3.63% above our target of 75.00%. It is noted that the metric for scoring has changed this year, previous years have only reported on people who answered 'yes always' to the question, this year 'yes quite a lot' is also included in the rating.
Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	**0.10**	0.28	0.17	0.13	The Royal College of Physicians discourage any benchmarking or comparisons due to the high number variables that exist that makes comparison unreliable.	Analysis of information suggests the slight increase in the rate of falls is associated with the increase in the acuity of patients accessing our services.
The number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	**29.2**	33.27	28.84	20.9		
The number of medication errors with a severity of moderate harm and above	2.5	**11**	13	12	7		
The number of serious incidents reported on STEIS	-	**126**	144	141	142	The Patient Safety Incident Response Framework (PSIRF) was implemented on the 29th January 2024. In addition to changing the way the NHS responds to patient safety incidents, the term 'serious incident' and the rules applying to them are no longer applicable. Trusts now monitor patient safety	

Patient safety indicators	Target	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	Further comments
						incident investigations and to support this we have implemented InPhase as our risk and quality management system. Transfer to the new recording system has highlighted areas where data quality can be improved, and several actions to support improvement in the quality of the incident data have been implemented.	

Clinical Effectiveness Indicators	Target	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National Benchmark
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	85%	**81.93%**	88%	*Previously reported indicator: (Existing percentage of patients on Care Programme Approach who were followed up within 72 hours after discharge from psychiatric inpatient care)*		-
Adults with a long length of stay over 60 for adult admissions	N/A	**12.47%**	N/A	12%	N/A	According to the NHS Oversight Framework System Benchmarking as at January 2024, national rank 7 out of 52 mental health providers and are performing within the highest performing quartile.
Older adults with a long length of stay over 90 days for older adult admissions	N/A	**58.04%**	35%	N/A	N/A	According to the NHS Oversight Framework System Benchmarking as at January 2024, national rank 18 out of 52 mental health providers and are performing within the interquartile range.

Patient experience indicators	Target	Whole Trust 23/24	Whole Trust 22/23	Whole Trust 21/22	National benchmark
Percentage of patients who reported their overall experience as very good or good	92%*	**92.17%**	92.16%	94.34%	87%
Percentage of patients that report that staff treated them with dignity and respect	94%	**88.00%**	86.69%	84.72%	-
Number of complaints raised	-	**498**	338	257	-

** Previous target was 94% changed December 2023 to 92%*

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Further comments on areas for improvement

Number of incidents of physical intervention/ restraint per 1000 occupied bed days (OBDs) – for inpatients

The end of 2023/24 position was 28.5 which relates to 6560 incidents and 230,269 OBDs. This is 9.25 above our target of 19.25

Our North Yorkshire York and Selby care group achieved the target with a rate of **18.4**. Within Durham, Tees Valley and Forensics care group the actual rate was **31.0.**

The high rate of incidents reported in the Durham Tees Valley and Forensic Care Group is linked to a small group of wards supporting specific patients with a range of complex needs often waiting on discharge from hospital.

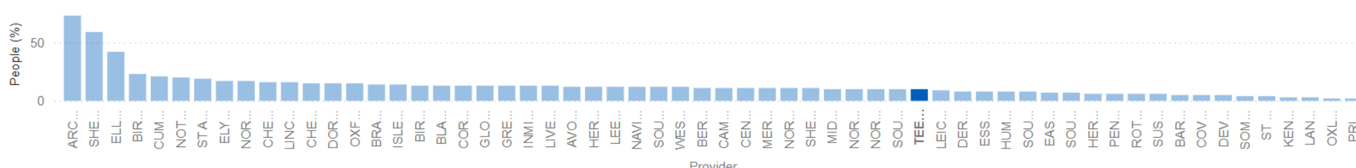
We have made significant improvements in reducing restrictive interventions across our learning disability inpatients areas over the last 12 months, and have presented this work at a range of regional and national events.

To support our ongoing work to reduce the use of restrictive practice across the organisation we have recently appointed 2 new Specialist practitioners to support each of our care groups.

In order to build on our previous work, we are currently cocreating a new 3 year Positive and Safe strategy to support our ongoing journey to reduce the use of restrictive practices.

The graph below taken form the NHS national data illustrates the Trusts positive position against other mental health Trusts nationally.

The graph below taken from the NHS National data illustrates the Trusts positive position against other mental health trusts nationally. We continue to work towards the long-term reduction of all forms of restrictive intervention. A range of actions are in progress via our Restrictive Intervention Reduction Plan.



Percentage of patients that report that staff treated them with dignity and respect

The end of **2023/24** position was **95.47%** which relates to **12,672** out of **13,274** surveyed. This is **1.47%** above our target of **94.00%.**
Broken down by care groups, we are pleased that the majority of our patients are treated with dignity and respect. North Yorkshire, York, and Selby with **96.08%** and Durham, Tees Valley, and Forensics **95.16%.**

We continue to focus on this important area of patient experience. Our patients tell us that treating people with dignity and respect includes staff treating people in a caring and compassionate way which will be strengthened by the work we are doing on our Trust values and empathy training for staff. It is also about involving people in decisions around their care which will be supported by the ongoing quality priority around personalised care planning and our goal of co-creation. Having an environment that respects privacy and dignity is important, and we are proud that we have eliminated all dormitory accommodation and all patient bedrooms are now single, many with ensuite facilities.

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The number of medication errors with a severity of moderate harm and above

The end of **2023/24** position was **12** which is **9.5** above our target of **2.5.**

These 12 were split across the care groups. North Yorkshire, York and Selby had three and Durham, Tees Valley and Forensics had nine medication errors with a severity of moderate harm and above

In 23/24 the key focus was to implement electronic prescribing and medicines administration (EPMA) across all our in-patient units (excluding respite). In total, 52 wards have EPMA, starting with a pilot ward in June 2023 and then all other wards between 05/09/23 and 16/01/24. The focus of 24/25 will be to implement EPMA in community services.

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3.3 Our Performance against the system oversight framework targets and indicators

The NHS Oversight Framework is built around five national themes:

- Quality of care, access and outcomes
- Leadership and capability
- People
- Preventing ill health and reducing inequalities
- Finance and use of resources

A sixth theme focusses on local strategic priorities.

The five themes are underpinned by 31 key performance measures and sub-measures and Trust and Integrated Care Board (ICB) performance is monitored via an allocation to a top, inter or bottom quartile. Typically, those within the top quartile indicate the higher performing Trusts.

To provide an overview of the level and nature of support and the oversight arrangements required across systems, ICBs and Trusts are allocated to one of four segments, determined by the scale and nature of their support needs, ranging from no specific support needs (segment 1) to intensive support needs (segment 4).

Our Trust is currently placed within segment 3; bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required.

There are a number of measures where we are placed in the lowest performing quartile which indicates a position of concern or where we are not achieving the oversight standard.

These are:

- Women accessing specialist community perinatal mental health services (North East & North Cumbria and Humber & North Yorkshire Integrated Care Boards)
- NHS Staff Survey compassionate culture people promise element sub score
- Proportion of staff in a senior leadership role who are from a black and minority ethnic (BME) background
- Staff survey engagement theme score
- Sickness absence rate
- CQC well led rating

Further details on our performance are below:

1) Quality, access and outcomes: mental health
There are five mental health measures monitored as part of the 2023/24 framework; one is monitored at Trust level and four are monitored at ICB level. Our achievement against these has been provided in the tables below.

TEWV	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Number of inappropriate out of areas placement (OAP) bed days for adults by quarter that are either internal or external to the sending provider	0	1608	494	671	516	Interquartile range as at December 2023 (670) 30 out of 56 Trusts

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North East and North Cumbria ICB	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Access rate for IAPT services	100%	87.54%	95.24%	91.24%	106.53 %	Interquartile range as at January 2024 (67%) 31 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100%	113.66%	114.72%	115.34 %	111.53 %	Interquartile range as at January 2024 (95%) 13 out of 42 ICBs
Access rates to community mental health services for adult and older adults with severe mental illness	100%	115.05%	118.13%	123.27 %	122.14 %	Interquartile range as at January 2024 (93%) 24 out of 42 ICBs
Women accessing specialist community perinatal mental health services	100%	194.25%	129.87%	107.83 %	105.76 %	Lowest performing quartile (a position of concern) as at December 2023 (75.4%) 34 out of 42 ICBs

Humber and North Yorkshire ICB	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Access rate for improving access to psychological therapies (IAPT) services	100%	87.30%	83.67%	91.57%	91.75%	Interquartile range as at January 2024 (69%) 28 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100%	122.25%	118.98%	118.19%	111.85%	Interquartile range as at January 2024 (88%) 21 out of 42 ICBs
Access rates to community mental health services for adult and older adults with severe mental illness	100%	103.76%	101.34%	99.29%	96.03%	Interquartile range as at January 2024 (95%) 21 out of 42 ICBs
Women accessing specialist community perinatal mental health services	100%	87.02%	61.83%	60.05%	60.31%	Lowest performing quartile (a position of concern) as at December 2023 (51.5%) 28 out of 42 ICBs

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Quality of care, access and outcomes: safe, high-quality care

Quality of care, access and outcomes: safe, high-quality care	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
National patient safety alerts not completed by deadline	0	**0**	**0**	**0**	**0**	Latest position as published at April 2024
Consistency of reporting patient safety incidents	100.00%	**100.00%**	Not available	Not available	Not available	National reporting paused pending the introduction of the new Learn from Patient Safety Events (LFPSE) service.
Overall CQC rating	N/A	Requires improvement				Interquartile range as at February 2024. 52 out of 69 Trusts. Latest inspection June 2023
NHS Staff Survey compassionate culture people promise element sub-score	As per staff survey benchmarking group results 6.86	6.99				Lowest performing quartile (a position of concern) as at 2022 survey (6.85) 65 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
NHS Staff Survey raising concerns people promise element sub-score	As per staff survey benchmarking group results 6.71	6.68				Interquartile range as at 2022 survey (6.71) 43 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
Adult acute length of stay over 60 days	0%	**13.59%**	**13.30%**	**14.26%**	**12.47%**	Highest performing quartile (a positive position) as of January 2024 (13%) 7 out of 52 Trusts
Older adult acute length of stay over 60 days	0%	**25.81%**	**33.58%**	**42.74%**	**58.04%**	Interquartile Range as of January 2024 (33%) 18 out of 52 Trusts

Quality of care, access and outcomes: Compassionate and inclusive culture

Quality of care, access and outcomes: Compassionate and inclusive culture	Oversight standard	2023/24	Latest national position
Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	1.00	**1.83**	Interquartile range as at 2023 (1.8) 48 out of 69 Trusts. Latest submission July 2023.
Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	1.00	**1.12**	Interquartile range as at 2023 (1.1) 50 out of 69 Trusts Latest submission July 2023.

Leadership and capability: leadership

Leadership and capability: leadership	Oversight standard	2023/24	Latest national position
CQC well-led rating	N/A	**Requires improvement**	Lowest performing quartile (a position of concern) as at February 2024. 54 out of 69 Trusts

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Leadership and capability: leadership	Oversight standard	2023/24	Latest national position
			Latest inspection report published 25 October 2023

People: Looking after our people

People: Looking after our people	Oversight Standard		Q1	Q2	Q3	Q4	Latest national position
Staff survey engagement theme score	As per staff survey benchmarking group results	6.85	**6.94**				Lowest performing quartile (a position of concern) as at 2022 survey (6.85) 65 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	As per staff survey benchmarking group results	7.30%	**7.21%**				Interquartile range as at 2022 survey (7.32%) 24 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	As per staff survey benchmarking group results	13.64%	**13.98%**				Interquartile range as at 2022 survey (13.7%) 34 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	As per staff survey benchmarking group results	22.48%	**22.31%**				Highest performing quartile (a positive position) as at 2022 survey (22.7%) 17 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
Staff Survey – We Are Compassionate and Inclusive People Promise element score	As per staff survey benchmarking group results		**7.40**		**7.49**		Interquartile range as at 2022 survey (7.44) 53 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey
NHS staff leaver rate	None		**10.90%**	**11.12%**	**11.13%**	**11.25%**	Highest performing quartile (a positive position) as at December 2023 (6.52%) 10 out of 71 Trusts
Sickness absence rate (working days lost to sickness)	None		**5.65%**	**6.12%**	**6.38%**	**6.71%**	Lowest performing quartile (a position of concern) as at October 2023 (6.33%) 50 out of 71 Trusts

People: Belonging in the NHS

People: Belonging in the NHS	Oversight Standard	Q1	Q2	Q3	Q4	Latest national position
Proportion of staff in senior leadership roles who a) are from a BME background b) are women c) disabled staff						
BME background	12%	**1.37%**	**1.72%**	**5.88%**	**5.24%**	Lowest performing quartile (a position of concern) as at 2022 calendar year (1.28%) 67 out of 69 Trusts
Women	62%	**65.75%**	**64.22%**	**63.73%**	**65.71%**	Interquartile range as at December 2023 (65%) 25 out of 45 Trusts
Disabled staff	3.20%	**10.96%**	**11.64%**	**8.33%**	**9.05%**	Interquartile range as at 2023 (6.02%) 19 out of 69 Trusts
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	As per staff survey benchmarking 62.38%	**63.83%**				Interquartile range as at 2022 survey (62.4%) 20 out of 71 Trusts Note: Q3 and Q4 Trust data as at 2023 Staff Survey

Finance and use of resources
There are four measures and sub measures monitored as part of finance and use of resources.

Finance and use of resources	Oversight Standard	Q1	Q2	Q3	Q4	Latest national position
Financial efficiency - variance from efficiency plan - Recurrent	N/A	**£1,178,000**	**£3,858,000**	**£6,269,000**	**£12,209,000**	Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.
Financial efficiency - variance from efficiency plan - non-recurrent	N/A	**£363,000**	**£2,645,000**	**£5,349,151**	**£8,638.000**	
Financial stability - variance from break-even	N/A	**£3,881,456**	**£4,424,811**	**£4,700,532**	**£0**	
Agency spending: Agency spend compared to the agency ceiling	100%	**86.26%**	**99.96%**	**91.08%**	**86.39%**	
Agency spending: Price cap compliance	100%	**67.00%**	**63.40%**	**61.61%**	**63.34%**	

Improved performance relative to control totals set in year have supported financial recovery that has allowed the Trust to deliver our 2023/24 breakeven plan, based on a mid-case scenario.

3.4 Other external reviews/ publications:

ICB commissioner and Provider Collaborative safety reviews

Commissioner safety review visits were undertaken in June 2023 which focused on key lines of enquiry derived from a range of performance metrics, soft intelligence and information from partners and stakeholders. Commissioners visited five inpatient wards where there were reported serious incidents involving the unexpected death of patients receiving inpatient care between November 2022 and March 2023:

- Maple Ward, West Park Hospital
- Bilsdale, Roseberry Park Hospital
- Roseberry Ward, Lanchester Road Hospital
- Bedale Ward, Roseberry Park Hospital
- Moorcroft Ward, Foss Park Hospital

During each visit the visiting team assessed the environment, observed staff and patients, and conducted informal interviews with a number of staff members and patients.

The report received by the Trust in September 2023 showed that overall, the outcome of the visits was good with some improved areas of practice identified. The assessment team agreed that based on their findings, patients are being safely cared for and that ward staff and senior management have the care and safety of patients at the forefront of their work.

In addition, the North East and North Cumbria Provider Collaborative (NENC PC) were asked by the Trust quality board if they were assured on the safety of patients within commissioned services. Working with NHS England and the NENC Integrated Care Board (ICB) key lines of enquiry (KLOEs) were agreed, and a reporting template and methodology were developed to ensure consistency. All secure inpatient services were visited during July and August 2023. The NENC PC found no immediate patient safety concerns during their visits. The report received by the Trust in November 2023 reported overall outcomes of the visits were good with some areas that could benefit from improvement. Staff on the units and the Ridgeway leadership team demonstrated that they have the care and safety of patients throughout their work and within their environment.

Letby report

On 18th August 2023, Lucy Letby was convicted of murdering seven babies and attempting to kill six others at the Countess of Chester Hospital. She committed these crimes while working as a neonatal nurse at the Countess of Chester Hospital between June 2015 and June 2016. An inquiry will follow the conviction of Lucy Letby and in parallel, we expect policy changes to be considered by the National Bodies.

The Trust has considered the learning and implications from this event and how we can build the culture of openness that we know is crucial to delivering consistently safe care.

Key implications from this event included:

- A failure of systems around safety incident reporting and risk
- Leadership and governance – process and priorities and skills and competence
- Culture – speaking up, problem sensing, openness – a duty to speak up, and a duty to listen to concerns, far beyond formal Freedom to Speak Up.
- Understanding what a failure to listen to concerns means
- A lack of curiosity from the wider multi-disciplinary team (MDT) and management
- A breakdown of inter professional working – including between managers and clinicians
- Patient safety as the singular priority – within trusts and across the system
- How the partnership of clinicians, managers and patients / families works

We reviewed the learning from this with our Board and key sessions with care group Boards, corporate deputies and executives were facilitated. We adapted the foundations of leadership and management training that all leaders and managers from service management level up (clinical, operational and

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corporate) are required to undertake. Although this event was an extreme case, learning has been taken forward relating to patient safety and governance.

Our response strengthened the oversight of accountability of, and support to, our leaders and managers including:

- Establishing a quarterly meeting led by the chief executive and reporting to the executive directors
- A three year leadership and management core programme is underway
- Reviewing additional portfolio of training offered through each leadership and management structure
- Focus on strengthening of diversity of leadership and management
- Professional reference groups have been established for all professions including new groups for operational colleagues, corporate and administrative roles.
- Bitesize manager training is underway.

Further information regarding the Letby verdict, see: Lucy Letby verdict, a future inquiry and patient safety - Patient Safety Learning

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3.6 External audit

Under guidance from NHS England, the Quality Account 2023/24 is not subject to review by external audit.

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3.7 Our stakeholders' views

Our Trust recognises the importance of the views of our partners as part of our assessment of the quality of the services we provide and to help us drive change and improvement.

How we involve and listen to what our partners say about us is critical to this process. We continue to listen and learn from the people we support, their carers and families, our colleagues and our partners.

In line with national guidance, we circulated our draft Quality Account for 2023/24 to the following stakeholders:

- NHS England
- North East and North Cumbria Integrated Care Board
- Humber and North Yorkshire Integrated Care Board
- Local Authority Overview and Scrutiny Committees
- Local Authority Health & Wellbeing Boards
- Local Healthwatch organisations

All the comments we have received from our stakeholders are included verbatim in Appendix 3.

Insert comments for any feedback received and how these will feed into our future learning for next annual Quality Account

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Appendix 1: 2023/24 Statement of directors' responsibilities in respect of the Quality Account

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Accounts/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 Account/Report.

In preparing the Quality Account/Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2023/24 and supporting guidance
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2023 to March 2024
  - Papers relating to quality reported to the Board over the period April 2023 to March 2024
  - Feedback from the Commissioners dated (*insert date*)
  - Feedback from Healthwatch dated (*insert date*)
  - Feedback from Overview and Scrutiny Committees dated (*insert date*)
  - Feedback from Health and Wellbeing Boards dated (*insert date*)
  - The Trust's complaints information reported to its Quality Assurance Committee of the Board of Directors, which will be published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The latest community mental health survey published 18 April 2024
  - The latest national staff survey published 07 March 2024.
  - CQC inspection report dated 25 October 2023.
- The Quality Account/Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Account/Report is reliable and accurate There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/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 Account 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 Account 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 Account/Report

By order of the Board.

David Jennings
Chair

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30 June 2024

Brent Kilmurray
Chief Executive
30 June 2024

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Appendix 2: Glossary

Adult Mental Health (AMH) Services: Services provided for people aged between 18 and 64 – known in some other parts of the country as 'working-age services. These services include inpatient and community mental health services. In practice, some patients younger than 64 may be treated in older people's services if they are physically frail or have Early Onset Dementia. Early Intervention in Psychosis (EIP) teams may treat patients less than 18 years of age as well as patients aged 18-64.

Audit: An official inspection of records; this can be conducted either by an independent body or an internal audit department.

Autism: This describes a range of conditions typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays. People with autism are sometimes known as neuro-diverse. Autism cannot be cured, but the mental illnesses which are more common for people with autism can be treated.

Board/Board of Directors: Our Trust is run by a Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is responsible for ensuring accountability to the public for the services in manages. It is overseen by a Council of Governors and monitored by NHS England. It also:

- Ensure effective dialogue between our Trust and the communities we serve
- Monitors and ensures high quality services
- Is responsible for our financial viability
- Appoints and appraises our executive management team

Business plan: A document produced once a year to outline what we intend to do over the next three years in relation to the services that we provide.

Child and Adolescent Mental Health Services (CAMHS): See Children and Young People's Services (CYPS).

Care Planning: See Care Programme Approach (CPA).

Care Programme Approach: describes the approach used in specialist mental health care to assess, plan, review and coordinate the range of treatment options and support needs for people in contact with secondary mental health services who have complex characteristics. It is called 'an approach' rather than a system because of the way these elements are carried out, which is as important as the tasks themselves. The approach is routinely audited.

Care Quality Commission (CQC): The independent regulator of health and social care in England. They regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, Local Authorities, private companies, and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

Children and Young People's Services (CYPS): Mental Health Services for children and young people under the age of 18 years old. This includes community mental health services, inpatient services and learning disability services.

Cito: An information technology system which overlays the Trust's patient record system (PARIS) which makes it easier to record and view the patient's records.

Clinical Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.

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Clinical Supervision: a supportive mechanism which involves clinicians meeting regularly to reflect on practice, with the intention of learning, developing practice and providing high quality, safe care to patients.

Commissioners: The organisations that have responsibility for purchasing health services on behalf of the population in the area they work for.

Commissioning for Quality and Innovation (CQUIN): A payment framework where a proportion of NHS providers' income is conditional on quality and innovation.

Community Mental Health Survey: a survey conducted every year by the CQC. It represents the experiences of people who have received specialist care or treatment for a mental health condition in 55 NHS Trusts in England over a specific period during the year.

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about factors which contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced.

Co-production/Co-creation: This is an approach where a policy or other initiative/action is designed jointly between our staff and patients, carers, and families.

Council of Governors: Made up of elected public and staff members and includes non-elected members such as the prison service, voluntary sector, acute trusts, universities and local authorities. The Council has an advisory, guardianship and strategic role including developing our Trust's membership, appointments and remuneration of the non-executive directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Crisis Resolution & Home Treatment (CRHT) Team: Provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both the number and length of hospital admissions and to ease the pressure on inpatient units.

Dashboard: A report that uses data on a number of measures to help managers build up a picture of operational (day-to-day) performance or long-term strategic outcomes.

Data Protection and Security Toolkit: A national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Data Quality Strategy: A strategy which sets out clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality data. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

Department of Health: The government department responsible for health policy.

DIALOG+: A clinical tool that allows for assessment, planning, intervention, and evaluation in one procedure and allows more personalised care planning.

Forensic Adult and Mental Health and Learning Disability Services: Work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to a secure hospital from a prison or court, where their needs can be assessed and treated.

Formulation: When clinicians use information obtained from their assessment of a patient to provide an explanation or hypothesis about the cause and nature of the presenting problems. This helps in developing the most suitable treatment approach.

Freedom to Speak Up Guardian: Provides guidance and support to staff to enable them to speak up safely within their own workplace.

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Friends and Family Test (FFT): A survey put to service users, carers and staff that asks whether or not they would recommend a hospital/community service to a friend or family member if they need treatment.

Gatekeeper/gatekeeping: Assessing the service user before admission to hospital to consider whether there are alternatives to admission and the involvement in the decision-making processes that result in admission.

General Medical Practice Code: The organisation code of the GP Practice that the patient is registered with. This is used to make sure a patient's GP code is recorded correctly.

Guardian of Safe Working: Provides assurance that rotas and working conditions are safe for doctors and patients.

Harm minimisation: Our way of working to minimise the risks of sometimes multiple and conflicting harm to both service users and other people.

Health and wellbeing boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system (i.e., local authorities and the NHS) would work together to improve the health and wellbeing of their local population and to reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities, and encourage commissioners to work in a more joined-up way.

HealthWatch: Local bodies made up of individuals and community groups, such as faith groups and resident's organisations associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

Home Treatment Accreditation Scheme (HTAS): Works with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers.

Hospital Episode Statistics (HES): The national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

Improving Access to Psychological Therapies (IAPT): An NHS initiative to increase the provision of evidence-based treatments for common mental health conditions such as depression and anxiety by primary care organisations.

Integrated Information Centre (IIC): Our system for taking data from the patient record (PARIS) and enabling it to be analysed to aid operational decision making and business planning.

Intranet: This is our Trust's internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures.

Learning Disability Services: Services for people with a learning disability and/or mental health needs. We have an Adult Learning Disability (ALD) service in each Care Group and also specific wards for Forensic LD patients. We provide child LD services in Durham, Darlington, Teesside, and York but not in North Yorkshire.

LeDeR: The learning from deaths of people with a Learning Disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a Learning Disability and reduce health inequalities.

Local authority Overview and Scrutiny Committee (OSC): Statutory committees of each local authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the local authority area. All local authorities have an OSC that focusses on health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland councils have a joint Tees Valley Health OSC that performs this function.

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Mental Health Act (1983): The main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. In most cases when people are treated in hospital or in another mental health facility they have agreed or volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old with a mental health problem. They can be treated for functional illness, such as depression, psychosis, or anxiety, or for organic mental illness (conditions usually associated with memory loss and cognitive impairment) such as dementia. The MHSOP Service sometimes treats people less than 65 years of age with organic conditions such as early-onset dementia.

Mortality Review Process: A process to review deaths, ensuring a consistent and coordinated approach, and promoting the identification of improvements and the sharing of learning.

Multi-Disciplinary: This means that more than one type of professional is involved, for example, psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT).

National Institute for Clinical Excellence (NICE): NHS body that provides guidance sets quality standards and manages a national database to improve people's health and to prevent and treat ill health. NICE works with experts from the NHS, local authorities, and others in the public, private, voluntary and community sectors – as well as patients and carers – to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Institute for Health Research (NIHR): An NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of the patients and the public.

National Reporting and Learning System (NRLS): A central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks, and opportunities to continuously improve the safety of patient care.

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

NHS Long-Term Plan (2019): A new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next five years.

NHS Staff Survey: Annual survey of staff experience of working within NHS trusts.

Non-executive directors (NEDs): Members of the Trust Board who act as a critical friend to hold the Board to account by challenging its decisions and outcomes to ensure they act in the best interests of patients and the public.

North Cumbria and North East Integrated Care System: Consists of four Integrated Care Partnerships – North, South, East, and West (see Integrated Care Partnerships).

PARIS: Our electronic care record, designed with mental health professionals to ensure that the right information is available to those who need it at all times.

Patient Advice and Liaison Service (PALS): A service within our Trust that offers confidential advice, support, and information on health-related matters. The team provides a point of contact for patients, their families, and their carers.

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Peer worker: Someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a patient or carer) to support other patients, in line with the recovery approach.

Prescribing Observatory in Mental Health (POMH): A national agency led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Programme: A coordinated group of projects and/or change management activities designed to achieve outputs and/or changes that will benefit the organisation.

Project: A one-off, time limited piece of work that produces a product (such as a new building, a change in service or a new strategy/policy) that will bring benefits to relevant stakeholders. Within our Trust, projects will go through a scoping phase, and then a business case phase before they are implemented, evaluated, and closed down. All projects will have a project plan and a project manager.

Psychiatric Intensive Care Unit (PICU): A unit (or ward) that is designed to look after people who cannot be managed on an open (unlocked) psychiatric ward due to the level of risk they pose to themselves or others.

Quality Account: A report about the quality of services provided by an NHS healthcare provider, the report is published annually by each provider.

Quality Assurance Committee (QuAC): Sub-committee of the Trust Board responsible for quality and assurance.

Quality Assurance Groups (QuAG): Locality/divisional groups within the Trust responsible for quality and assurance.

Quarter one/quarter two/quarter three/quarter four: Specific time points within the financial year (1 April to 31 March). Quarter one is from April to June, quarter two is from July to September, quarter three is October to December and quarter four is January to March.

Reasonable adjustments: A change or adjustment unique to a person's needs that will support them in their daily lives, e.g., at work, attending medical appointments, etc.

Research Ethics Committee: An independent committee of the Health Research Authority, whose task it is to consider the ethics of proposed research projects which will involve human participants, and which will take place, generally, within the NHS.

Royal College of Psychiatrists: The professional body responsible for education and training and setting and raising standards in psychiatry.

Safeguarding: Protecting vulnerable adults or children from abuse or neglect, including ensuring such people are supported to get good access to healthcare and stay well.

Secondary Uses Service: The single, comprehensive repository for healthcare data in England which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services.

Section 29a Notice: This is a warning notice served by the CQC where concerns are identified across either the whole or part of an NHS trust and where it is decided that there is a need for significant improvements in the quality of healthcare.

Serious incident (SI): An incident that occurred in relation to NHS-funded services and care, to either patient, staff, or member of the public, resulting in one of the following – unexpected/avoidable death, serious/prolonged/permanent harm, abuse, threat to the continuation of delivery of services, absconding from secure care.

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Single Oversight Framework: sets out how NHS trusts and NHS foundation trusts are overseen.

Staff Friends and Family Test: A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It helps us identify what is working well, what can be improved and how.

Statistical Process Control (SPC) charts: a graph used to show how a process changes over time and to see whether a situation is improving or deteriorating, whether the system is likely to be capable to meet the standard and whether the process is reliable or variable.

Steering group: Made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice/troubleshoot where necessary.

Strategic framework: primarily intended as a framework for thinking about the future and a guide to inform the investment and disinvestment decisions by those tasked with future planning.

Substance Misuse Services: Clinical services who work with people who abuse alcohol, illegal drugs or over the counter or prescription medications in a way that they are not meant to be used.

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust.
Thematic review: A piece of work to identify and evaluate Trustwide practice in relation to a particular theme. This may be to identify where there are problems/concerns or to identify areas of best practice that could be shared Trustwide.

The Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by our Trust.

Unexpected Death: A death that is not expected due to a terminal medical condition or physical illness.

Urgent Care Services: Crisis, Acute Liaison and Street Triage services across our Trust.

Whistleblowing: this is a term used when a worker highlights a concern about their organisation and/or services to the Freedom to Speak Up Guardian or NHS Regulators. This will normally be regarding something they have witnessed at work.

Year (e.g., 2023/24): These are financial years, which start on the 1 April in the first year and end on the 31 March in the second year.

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Appendix 3: Stakeholders' views

This Appendix contains letters received from our stakeholders in response to the draft Quality Account circulated to them in May 2024.

To be inserted following consultation

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