



Quality Account

2024 - 2025



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1. Statement on quality from the Chief Executive of the NHS foundation trust

I am pleased to bring you the 2024/25 Quality Account report for South Tees Hospitals NHS Foundation Trust, part of University Hospitals Tees.

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

Our patients remain our priority, and we continue to work through a quality improvement lens in all that we deliver.

Our key areas for 2024-25 identified in partnership with our stakeholders were Patient Safety, Clinical Effectiveness and Patient Experience.

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

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

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

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

Kind regards,



Stacey Hunter
Group Chief Executive

Introduction

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

Hospital services:

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

Community services:

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

- District Nursing provides care such as complex wound management, intravenous antibiotics, vaccinations, diabetes management, palliative and end of life care, urinary catheter care, medications administration, long term conditions management, pressure ulcer management and prevention etc.
- Urgent Community Response provides a 2-hour crisis response to patients at risk of hospital admission.
- Hospital at Home includes Frailty Virtual Ward and Respiratory Virtual Ward and provides complex hospital level care to patients who would otherwise be in hospital, and to those at risk of poor health outcomes.
- Tees Valley Community Diagnostic Centre.
- Specialist Palliative Care.

- Specialist Stoma Therapy
- Chronic Heart Disease Management.
- Community Diabetes Care.
- Community Occupational Therapy.
- Community Physiotherapy, including MSK (Musculoskeletal), Pulmonary Rehabilitation.
- Community Podiatry and Orthotics.
- Community Dietitian Service.
- Community Speech and Language Therapy.
- Community Continence Services.
- Community Falls Prevention Service.
- Community Rehabilitation, including Stroke Rehabilitation and General Rehabilitation.
- Stroke Early Supportive Discharge Services
- Community Paediatric Services.
- Wheelchair Services.
- Intermediate Care Services.
- Home First Service, providing therapy support and personal care for patients awaiting social care packages.
- Home Ventilation Services.
- Lymphoedema Services.
- Tissue Viability Services.
- Maternity Services, such as prenatal and perinatal care services.
- Cardiac Rehabilitation.
- Haematology Services.

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

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

2.1 Priorities for improvement

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

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

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

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

Table 1 – Group Quality Priorities 2025/26

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

Patient safety quality priorities

1. Positive, just and restorative safety culture.

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

Aims

We planned to;

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

We aimed to achieve the following measures of success;

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

Progress and achievements

- We have continued to provide further cohorts of Family Liaison Officer training and there are currently 93 trained Family Liaison Officers across the organisation.
- A patient safety workshop was facilitated by a Patient Safety Partner, Patient Safety Specialist from North Tees and Hartlepool NHS Foundation Trust and Patient Safety Lead from South Tees Hospitals NHS Foundation Trust in December 2024. The 4-hour workshop used a case study based on a recent Health Services Safety Investigations Body (HSSIB) investigation to develop participants knowledge and skills when undertaking patient safety reviews. This was based on teaching from the NHSE Patient Safety Syllabus Level 3 and 4 training. The session

included the application of human factors models, such as Systems Engineering Initiative for Patient Safety (SEIPS) and Systems-Based Technique for Accident Analysis (Accimap), duty of candour, and the hierarchy of controls in developing meaningful action plans. Over 60 colleagues attended the session, which received positive feedback, and there are plans to deliver further sessions, as part of a regular education programme in 2025.

- The NHSE Patient Safety Syllabus (Levels 1a and 1b) was introduced as part of mandatory training requirements in September 2024. Level 1a is the starting point for all NHS staff, and current completion rate is 66.35%. Level 1b is the essentials of patient safety for boards and senior leadership teams, the current completion rate is 26.14% and an area for focus into the next year.
- A training needs analysis is underway to inform the roll out of Level 2 of the Patient Safety Syllabus.
- Two Patient Safety Specialists have now completed Level 3 and Level 4 NHSE Patient Safety Syllabus training.
- Duty of Candour letter templates have been updated collaboratively with patient experience colleagues, to ensure plain language is used and the documents meet the national reading age of 9-11 years old. Colleagues from the Patient Experience Team checked the readability of the letter against a readability test that assesses how easy a piece of text is to understand. The layout was changed to meet the NHS standards.
- The NHS Staff Survey results for 2024 Q20a “I would feel secure in raising concerns about unsafe clinical practice” in 2023/24 was 71% which has reduced to 70%. Although this is disappointing, this remains equivalent to the national average for this metric and high levels of incident reporting have been maintained.
- In 2023/24, a total of 29,278 incidents were recorded on the Datix system. In 2024/25 30,459 incidents were recorded.
- March 2025 showed the lowest number of open incidents in the organisation during 2024/25.
- We have completed the National Perinatal Culture and Leadership Programme and comply with Perinatal Quality Surveillance. The Trust also achieved all ten safety actions from the Maternity Incentive Scheme programme, which aims to improve the quality of care for women, families and newborns.

Summary and future plans

- High levels of incident reporting have been maintained, and the ongoing focus remains the timely review and closure of incidents, and providing meaningful feedback to those who report incidents.
- We will continue to deploy Family Liaison Officers to support patients and their families and/or carers affected by adverse events.
- Collaborative work has been undertaken regionally to develop a feedback tool for the Family Liaison Officer Service, supported by one of our Patient Safety Partners and Health Innovation North East and North Cumbria.

- We will focus on increasing compliance with Patient Safety Syllabus Level 1a and 1b training, and undertake a training needs analysis to inform the roll out of Level 2 of the Patient Safety Syllabus.

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

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

Aims

We planned to;

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

We aimed to achieve the following measures of success;

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

Progress and achievements

We have established a weekly Patient Safety and Quality Panel. The meeting is chaired by the Medical Director and Director of Nursing. The aim is to increase organisation-wide engagement with the patient and safety agenda, and to enable timely review and clear lines of accountability and escalation for actions to be taken. This meeting allows for a trust wide overview of patient safety, patient experience, mortality review, Infection, Prevention and Control (IPC), Care Quality Commission compliance with fundamental standards, legal services and safeguarding and the respective teams update from the previous week. The second half of the meeting focusses on

individual Collaboratives, (a collaborative is a group of hospital services) who present an overview of the key safety and quality themes and improvement work undertaken in the previous two months. Learning points are shared on a weekly basis with the Communication Team for inclusion in the weekly Safety and Quality Bulletin.

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

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

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

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

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

Summary and future plans

- Feedback from the Family Liaison Officer evaluation tool will be available.
- Triangulated learning will become more embedded as the corporate patient safety reports develop.
- The 2024 NHS Staff Survey results for Q20b "I am confident my organisation would address my concerns" has shown a reduction from 54% to 53%, which is disappointing and reinforces the need for the organisation to demonstrate learning after an incident is reported. This will be an area for continued focus into 2025/26, including meaningful feedback to reporters.

3. Medication safety and optimising the benefits of ePMA.

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

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

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



Aims

We planned to:

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

We aimed to achieve the following measures of success;

- Agree a standard set of ePMA key performance indicators (quantifiable measures to assess performance) and clinical dashboards for patient safety that are monitored through our patient safety groups for trends and areas of improvement.
- Number of quality improvement projects and research undertaken utilising ePMA to improve patient safety.
- A system review and recommendation for improvement and implementation of these.
- Improvement in antimicrobial audit compliance.
- Quality Improvement Programme schemes.
- Number of changes implemented post medication incident review.

Progress and achievements

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

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

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

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

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

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

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

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

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



Image; AMS Study Day

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

Summary and future plans

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

Clinical effectiveness quality priorities

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

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

Aims

We planned to;

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

We aimed to achieve the following measures of success:

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

Progress and achievements

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

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

An options paper was presented to the Group Executives at the end of January, which approved the moving to InPhase at a Group level to include all of the apps including CQC App, which will

give consistency across the group and both sites. Executive Leads will be identified at each site for oversight.

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

NICE Guidance

Evidence of a recent audit of compliance

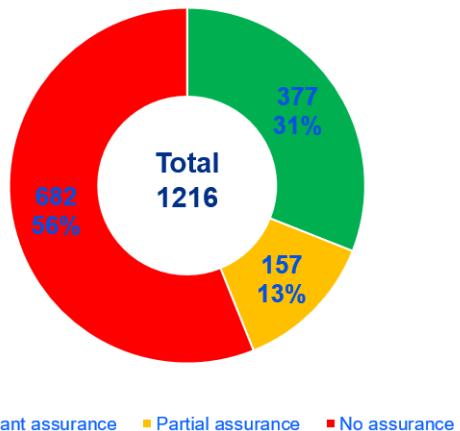


Figure 1 – evidence (in the form of clinical audits) to demonstrate compliance with individual NICE guidance

Work has been undertaken to clarify which national clinical audits the Trust is participating in, including those which are at risk of reduced or non-submission. The reason for non-submission can include lack of local digital solution to support submission to the national audit platform and/or staff resource limitation prohibiting participation.

National Clinical Audit Exception reporting

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

Figure 2 – number of national audits at risk of either non-submission or reduced submission

National Clinical Audit Workload by organisation over past four years

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

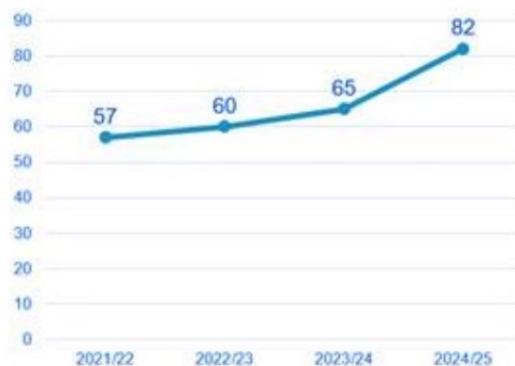


Figure 3 – Number of national audits eligible to participate in since 2021

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

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

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

Summary and future plans

Priorities for 2025/26 will focus on:

NICE Guidance

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

GIRFT

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

National Clinical Audit

- Participation in mandatory national clinical audits.
- Evidence of sharing local results of national clinical audits.

- Development and implementation of local improvement plans, following publication of national clinical audit reports.

Systems support

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

2. Mortality review processes and learning from deaths.

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

Aims

We planned to;

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

We aimed to achieve the following measures of success:

- Medical Examiner referral for mortality review (number and % of deaths).
- Use of the Structured Judgement Review Plus model.
- Mortality reviews completed, time to review from Medical Examiner/Patient Safety referral.

- Accurate identification of deaths graded as potentially preventable. Ensuring follow up of these cases is timely and comprehensive.
- Numbers of deaths considered under PSIRF by category of response.

Progress and achievements

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

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

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

The recording of specialty mortality reviews on InPhase is progressing. This is now live and has been rolled out across 3 specialties; Haematology, Cardiology and Intensive Care. There are plans for Gastroenterology and Endoscopy to begin recording reviews over the coming months. Work is progressing to continue with the rollout across the Trust with identification of mortality leads for each specialty being our next focus, working with the Trust Safe and Effective Care Leads for each collaborative to be able to achieve this.

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

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

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

No. Reviews Apr 2023 - to date

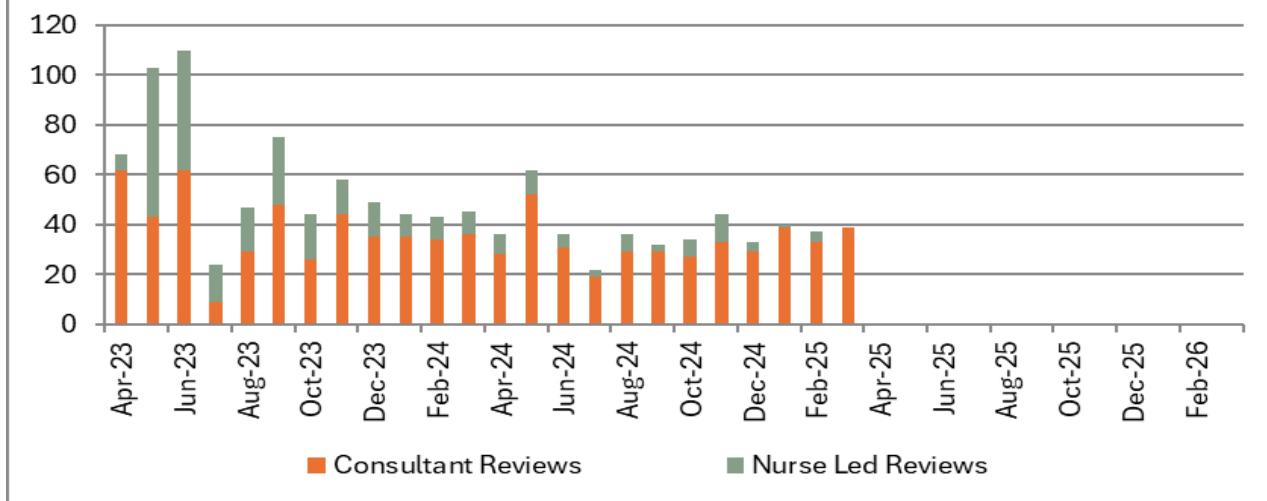
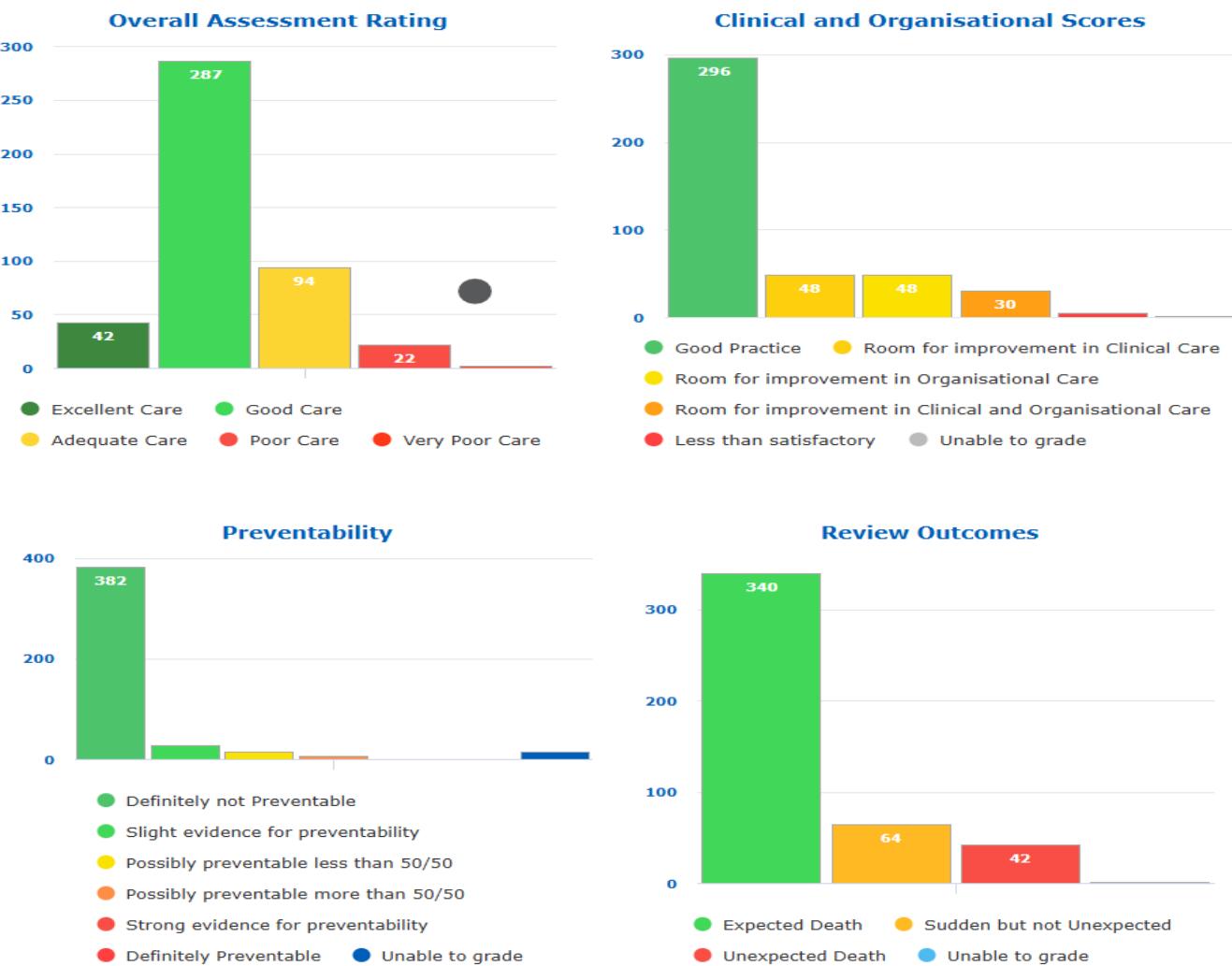
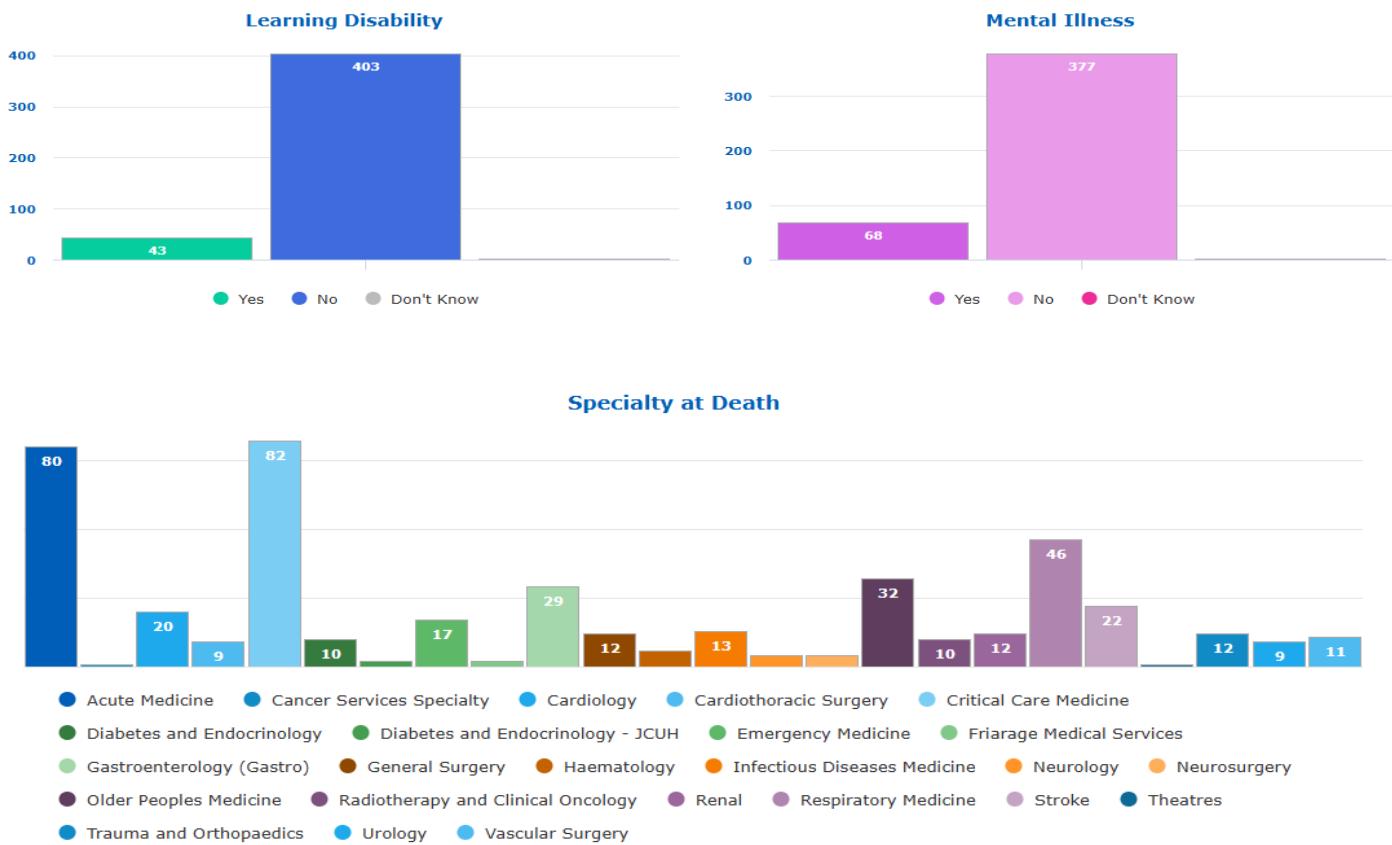


Figure 4 - Number of consultant and nurse led reviews completed





Key Performance Indicators (KPIs).

To ensure timely completion of reviews, it was agreed that cases referred by the Medical Examiner Team would be reviewed within 2 weeks for urgent cases and 4 weeks for less urgent cases. As of the end of March 2025, 23.5% of required cases were being reviewed within 2 weeks of death and 54.6% within 30 days as detailed in Figure 5 below.

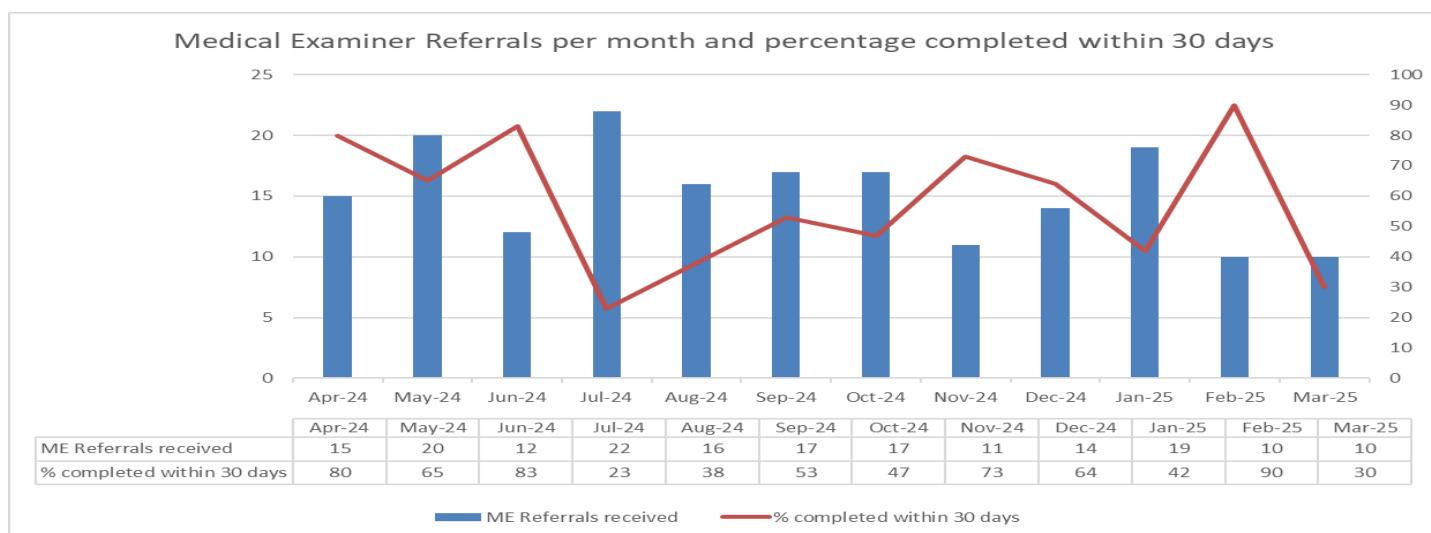


Figure 5 – Medical examiner referrals per month and % completed

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

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

Summary and plans for future work

- 20% assurance reviews to be completed within 6 months – currently working to 10 months.
- 80% of Medical Examiner reviews to be completed within 1 month - currently 55%.
- Draft a framework for the completion of Mortality & Morbidity reviews, clearly identifying Mortality and Morbidity Leads for each service.
- Begin recording Specialty Mortality Reviews in InPhase.
- Continue to work with the wider Quality team to ensure that themes emerging from learning from deaths are triangulated against data from Patient Experience, Patient Safety and Clinical Effectiveness and that improvement work is undertaken to address the themes.
- Continue to ensure there are proportionate learning responses following the outcomes from mortality reviews in line with the Trust's PSIRP.

3. Shared decision making and goals of care

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



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

We have a 2025/26 Commissioning for Quality and Innovation (CQUIN) indicator focused on achieving high-quality shared decision-making conversations in specific specialised pathways to support recovery.

Aims

We planned to:

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

Progress and achievements

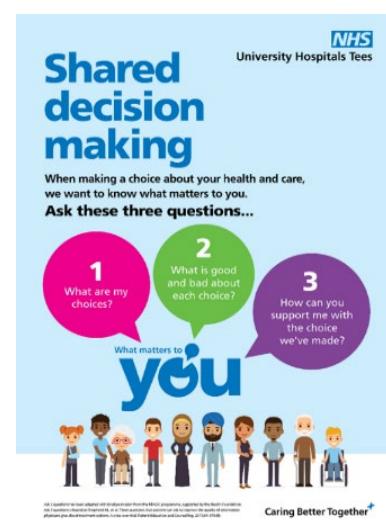
The Digital Consent Project is progressing toward establishing a robust digital solution for informed consent and shared decision-making. A clinical engagement roadshow was held, where over 60 clinical and operational stakeholders reviewed potential suppliers. Four vendors, Bloomsbury Health, Concentric,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

A service-level gap analysis was conducted in palliative chemotherapy, early-stage lung cancer, and renal disease pathways to assess alignment with NICE NG197. Patients attending these clinics completed a nine-item questionnaire assessing shared decision-making discussions with their doctor. A total of 51 responses were collected from each pathway during each audit period. Results showed an average shared decision-making score of 89% in Q2 and 87% in Q4, exceeding the target of 65%. Findings highlighted areas for improvement, including:

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

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

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



Summary and future plans:

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

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

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

Patient experience quality priorities

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

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

Aims

We planned to:

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

We aimed to achieve the following measures of success:

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

Progress and achievements

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

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

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

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

The Patient Information/Experience Teams have completed the How to Write Simply training. Work has commenced with the Regional Health Literacy team, to review all new patient

information and those coming up for review, to ensure the reading age is appropriate to the population. The patient information relating to physiotherapy will be the first speciality to undergo the review.

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

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

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

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

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

It was identified by the Fairer Access Team that many children were missing appointments, therefore missing out on the treatment and care they need. Telephone consultations were made to parents/carers of children who had missed an appointment. This generated a lot of useful feedback which will be used to improve our hospital services and reduce the number of children not brought to appointments. It will also support children who may be vulnerable to missing appointments.

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

Summary and plans for ongoing work

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

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

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

Aims

We planned to:

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

We aimed to achieve the following measures of success:

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

Progress and achievements

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

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

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

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

Summary and plans for ongoing work

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

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

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

Aims

We planned to;

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

We aimed to achieve the following measures of success;

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

Progress and achievements

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

Three priorities were initially agreed as follows;

Suicide Prevention

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

Right Care Right Person – Phase 1 (concerns for welfare and patients who walk out of health care facilities)

A new way of working to support people in mental health crisis. This went live across Teesside on 18 September 2024. At the centre of Right Care, Right Person is a threshold to assist the police in deciding when it is appropriate for them to respond. The threshold for a police response to a mental health-related incident is:

- To investigate a crime that has occurred or is occurring.
- Or to protect people, when there is a real and immediate risk to life, or of a person being subject to or at risk of serious harm.

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

Maternity Mental Health

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

Further priority areas

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

- Maternal Mental Health.
- Suicide Prevention.
- NCEPOD (National Confidential Enquiry into Patient Outcome and Death) Mental Health in Young People and Adults.
- Restraint and aligning the site Restraint Policy.
- Trauma informed care.

The organisation has completed further streams of work, including the development of a mental health communications plan and intranet site. This is available to all Trust staff and provides a wealth of information in one place relating to Mental Health. The Trust has implemented the Mental Health dashboard which provides data relating to Dementia, Delirium, Mental Capacity

Act (MCA) and Deprivation of Liberty Safeguards (DoLS), Eating Disorders and Deliberate Self-Harm. The dashboard will also be used as part of the health inequalities workstream.

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

Summary and future plans

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

The key next steps are to;

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

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

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

Quality Priorities 2025/26		
Patient Safety	Clinical Effectiveness	Patient Experience
Carried forward from 24/25 <p>We will continue to optimise the Trust's ability to respond to and learn from incidents, safeguarding concerns, claims and inquests to improve outcomes for our patients and reduce the risk of reoccurrence.</p>	**Carried forward from 24/25** <p>We will ensure continuous learning and improved patient outcomes following implementation of best clinical practice, using data from clinical audits of compliance against evidence-based standards.</p>	**Carried forward from 24/25** <p>We will develop and implement a Group Mental Health Strategy to improve care and share learning for our patients who are experiencing difficulties with their mental ill health.</p>
Carried forward from 24/25 <p>We will improve medication safety and continue to optimise the benefits of ePMA and evaluate the impact on learning from medication incidents</p>	**Carried forward from 24/25** <p>We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.</p>	**Carried forward from 24/25** <p>We will proactively seek patient feedback and ensure there is continuous improvement in care and treatment because of the feedback we receive</p>
New Quality Priority 25/26 <p>We will reduce the risk of acquiring healthcare associated infections in line with NHS England standard contract objectives such as Clostridioides Difficile, Meticillin Resistant Staphylococcus Aureus, Gram-Negative Blood Stream Infections (ECOLI, Klebsiella, and Pseudomonas) alongside other infections to improve outcomes for our patients whilst embedding IPC practices.</p>	**Carried forward from 24/25** <p>We will develop and implement shared decision making and goals of care.</p>	**Carried forward from 24/25** <p>We will respond in a timely way to complaints, supporting patients and families through difficult circumstances and implement quality improvements as a result of the learning.</p>

2.2 Statement of assurance from the Board

1. Relevant health services

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

2. National clinical audits and national confidential enquiries

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

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

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

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

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

Mandatory National Clinical Audits	Participation	% cases submitted
BAUS Penile Fracture Audit	Yes	100%
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Yes	100%
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes	100%

Breast and Cosmetic Implant Registry	Yes	100%
British Hernia Society Registry	No	
Case Mix Programme (CMP)	Yes	100%
Emergency Medicine QIP: Care of Older People	Yes	50%
Emergency Medicine QIP: Mental Health (Self-Harm)	Yes	100%
Emergency Medicine QIP: Time Critical Medications	Yes	100%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Yes	100%
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Core Audit	No	
National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	Yes	100%
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	Yes	100%
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)	Yes	100%
National Audit of Cardiac Rehabilitation	No	
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (NAD)	Yes	100%
National Bariatric Surgery Registry	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Yes	100%

National Bowel Cancer Audit (NBOCA)	Yes	100%
National Kidney Cancer Audit (NKCA)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	100%
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
National Ovarian Cancer Audit (NOCA)	Yes	100%
National Pancreatic Cancer Audit (NPaCA)	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Adult Cardiac Surgery Audit (NACSA)	Yes	100%
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	100%
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes	100%
UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	100%
Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Yes	100%
National Comparative Audit of Blood Transfusion: Audit of Blood Transfusion against NICE Quality Standard 138	Yes	100%
Bedside Transfusion Audit	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Joint Registry	Yes	100%
National Major Trauma Registry	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%

National Obesity Audit	Yes	100%
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit	No	
National Ophthalmology Database (NOD): Cataract Audit	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review Tool	Yes	100%
National Respiratory Audit Programme (NRAP): COPD Secondary Care	Yes	100%
National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation	Yes	100%
National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	Yes	100%
National Respiratory Audit Programme (NRAP): Children and Young People's Asthma Secondary Care	Yes	100%
National Vascular Registry (NVR)	Yes	100%
Perioperative Quality Improvement Programme	Yes	100%
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology & Reconstruction	No	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	No	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	No	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-melanoma skin cancers	No	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	No	
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT) UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	Yes	100%

Table 2 - national clinical audits

National Confidential Enquiries (NCEPOD):

The Trust participated in all 4 national confidential enquiries (100%) that it was eligible to participate in as shown in Table 3;

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

Table 3 – National Confidential enquiries

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

National Fracture Liaison Service Database

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

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

Key Performance Indicator #2 – non spine case ID is 42% compared to 21% nationally.

Key Performance Indicator #6 – falls risk assessment was 82% compared to 61% nationally.

National Diabetes Foot Care Audit

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

National Lung Cancer Audit (NLCA)

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

Myocardial Ischaemia National Audit Project (MINAP)

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

National Comparative Audit of Bedside Transfusion Practice 2024

Fully compliant with all audit quality standards, therefore there were no improvements required.

3. Local audit

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

Pressure Ulcer Prevention Benchmark – Critical Care Medicine

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

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

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

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

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

Flexible Fibre-Optic Bronchoscopy

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

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

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

4. Clinical Research

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

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

RECRUITMENT by financial year

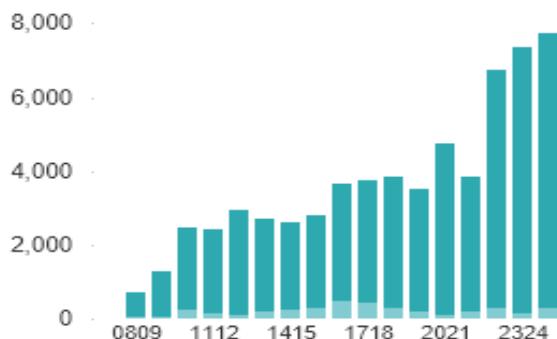


Figure 6 - Recruitment over time

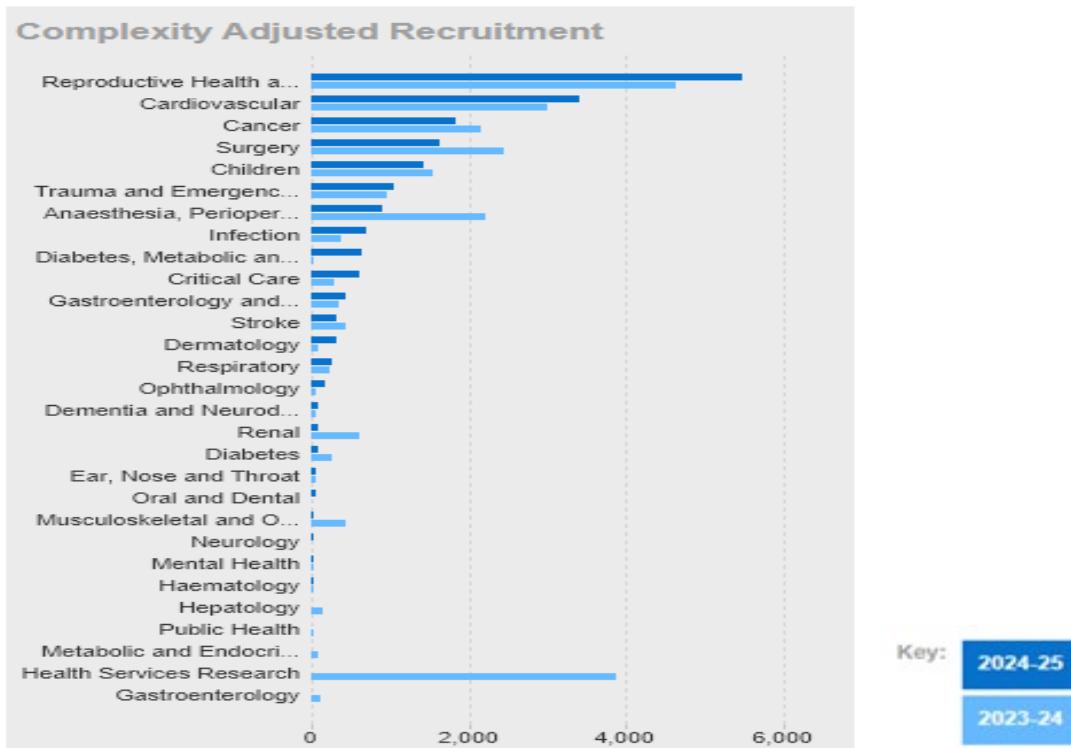


Figure 7 - Recruitment by clinical specialty

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

5. CQC registration, reviews and investigations

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

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

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

The CQC (Care Quality Commission) use a system of ratings to assess the quality of healthcare. These ratings are based on evidence gathered during inspections and are determined by assessing the service against five key areas: safe, effective, caring and supportive, responsive, and well-led. There were no announced or unannounced inspections by the CQC during 2024/25 and South Tees Hospitals NHS Foundation Trust's overall CQC rating remains "Good" (figure 8).

All reports are available at:

[South Tees Hospitals NHS Foundation Trust - Overview - Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk/provider/south-tees-hospitals-nhs-foundation-trust/overview)

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 8 - South Tees Hospitals NHS Foundation Trust overall CQC rating

6. Submission of records to the Secondary Uses Service

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

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

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

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

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

7. Information Governance grading

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

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

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

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

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

Data Security

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

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

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

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

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

We have had no reportable incidents during the reporting period.

8. Clinical coding audit

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

9. Data quality

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

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

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

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

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

10. Learning from deaths

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

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

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

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

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

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

These numbers have been estimated using the adapted version of the Structured Judgement Review Plus tool.

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

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

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

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

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

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

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

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

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

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

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

One 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.

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

2.3 Reporting against core indicators

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

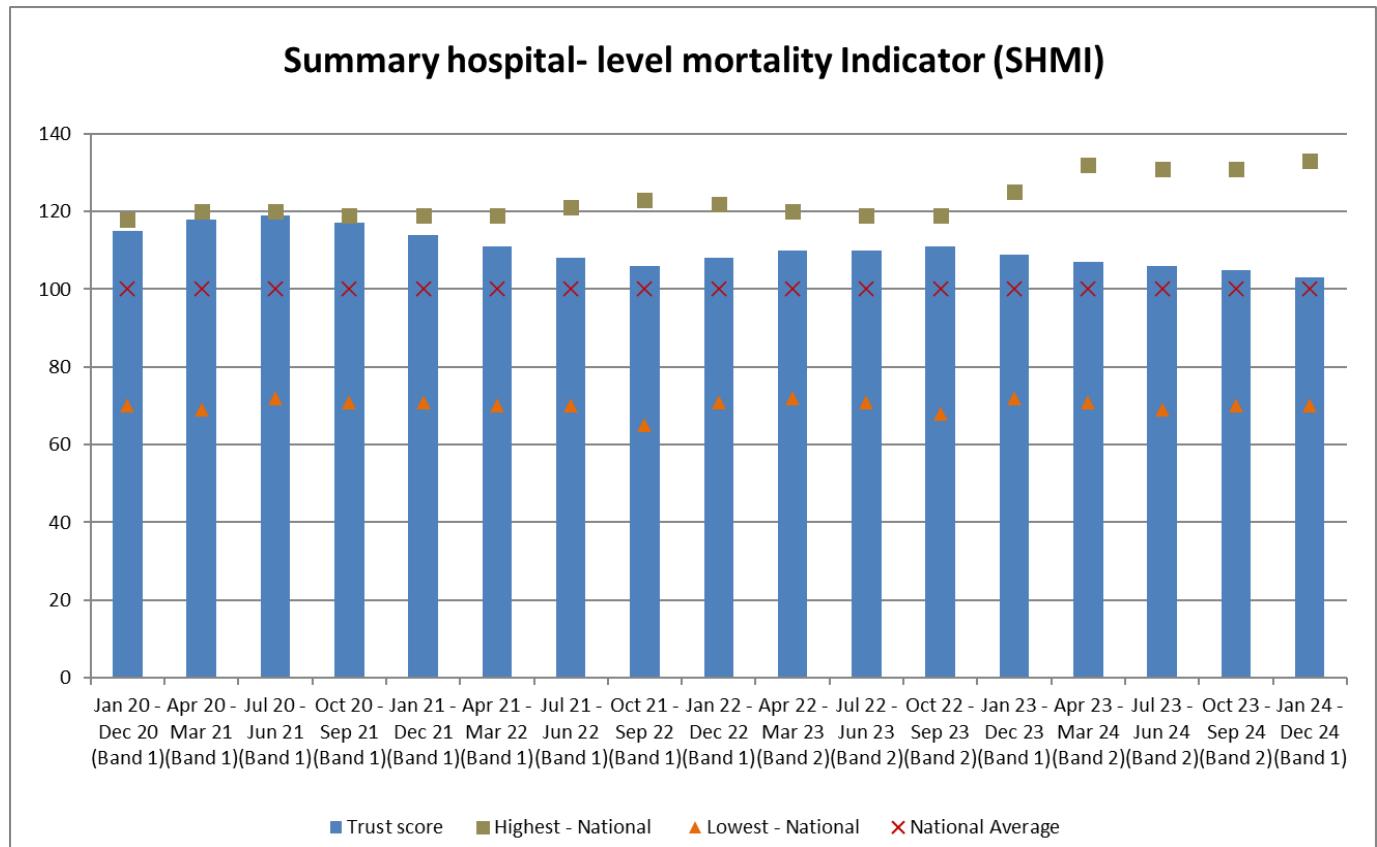
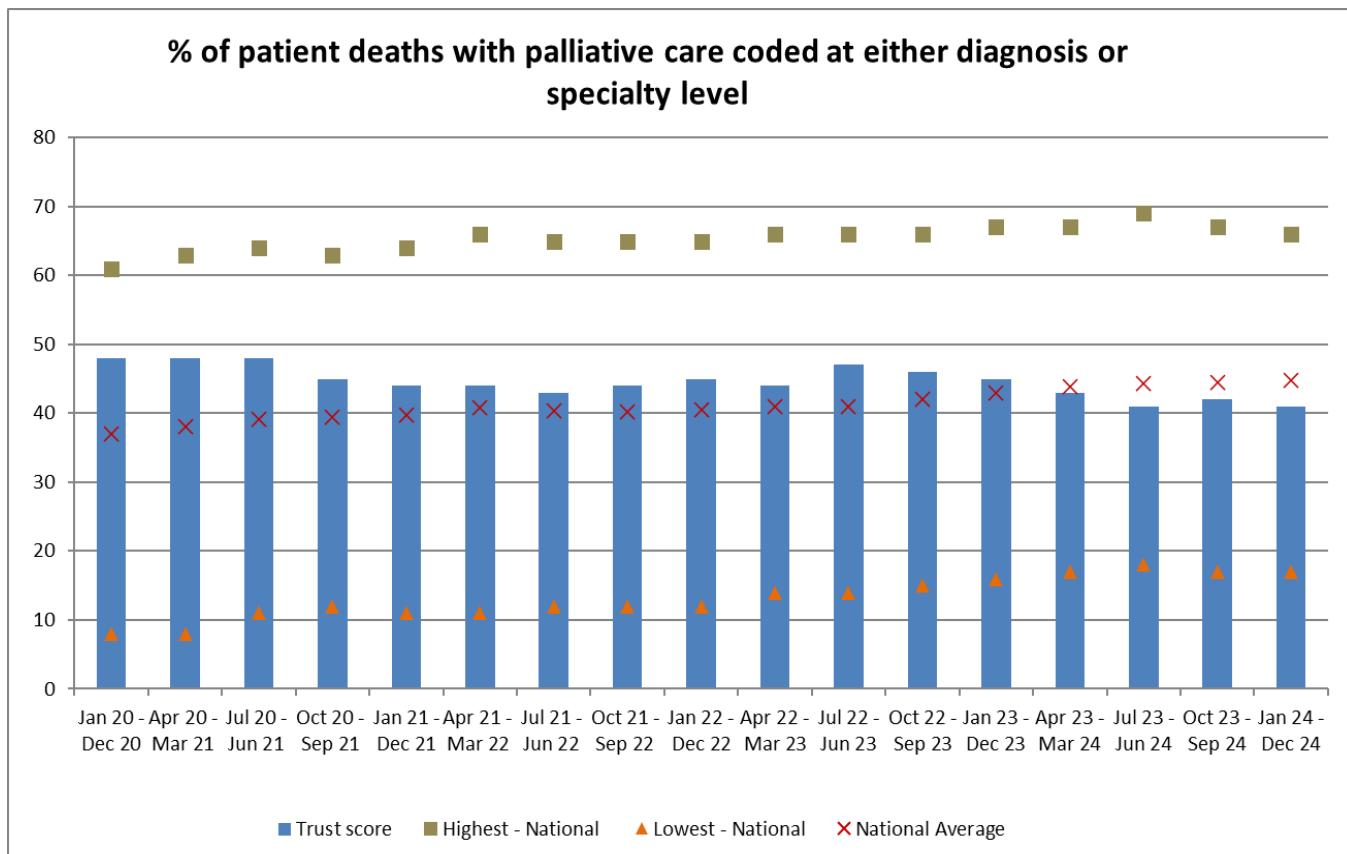


Figure 9 - Summary Hospital Level Mortality Indicator (Data source: NHS Digital)

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

- The SHMI is not designed to account for the COVID-19 pandemic and although spells coded for COVID-19 have been removed by NHS Digital from the indicator calculation, the large reduction in the number of admissions to hospital, particularly during wave 1, has had a substantial impact on the expected number of deaths. Since January to December 2023, spells with COVID-19 are included, with a corresponding small increase in deaths and discharges of around 2%. However, SHMI has fallen compared to the pandemic period and is 'as expected' meaning that the number of observed deaths is within the statistical limits, compared to the estimated number of hospital deaths expected given the population of patients cared for in the Trust. The fall in the number of admissions has not been experienced evenly across the country, with areas that had high levels of COVID-19, such as the North-East, experiencing a greater impact.

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



continued into the current period (October 2023 – September 2024) and the small fall in non-elective (emergency) spells has reversed.

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

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

- The Trust has governance committees which monitor and respond to mortality information and the Group 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. The trend outside the seasonal variations and the pandemic years has remained stable over a long period of time, despite an aging population and increasing complexity of the condition's patients have when admitted to hospital. Work likely to affect mortality rates, particularly in elderly patients admitted to medical wards, includes sustained work on identification and management of deteriorating patients (the National Early Warning Score is electronically recorded in the Emergency Departments and Acute Assessment Units as well as all wards of the hospital), identifying and managing patients with sepsis, prevention of falls, and work identifying patients' level of frailty and providing appropriate support.

2. Patient reported outcome measures

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

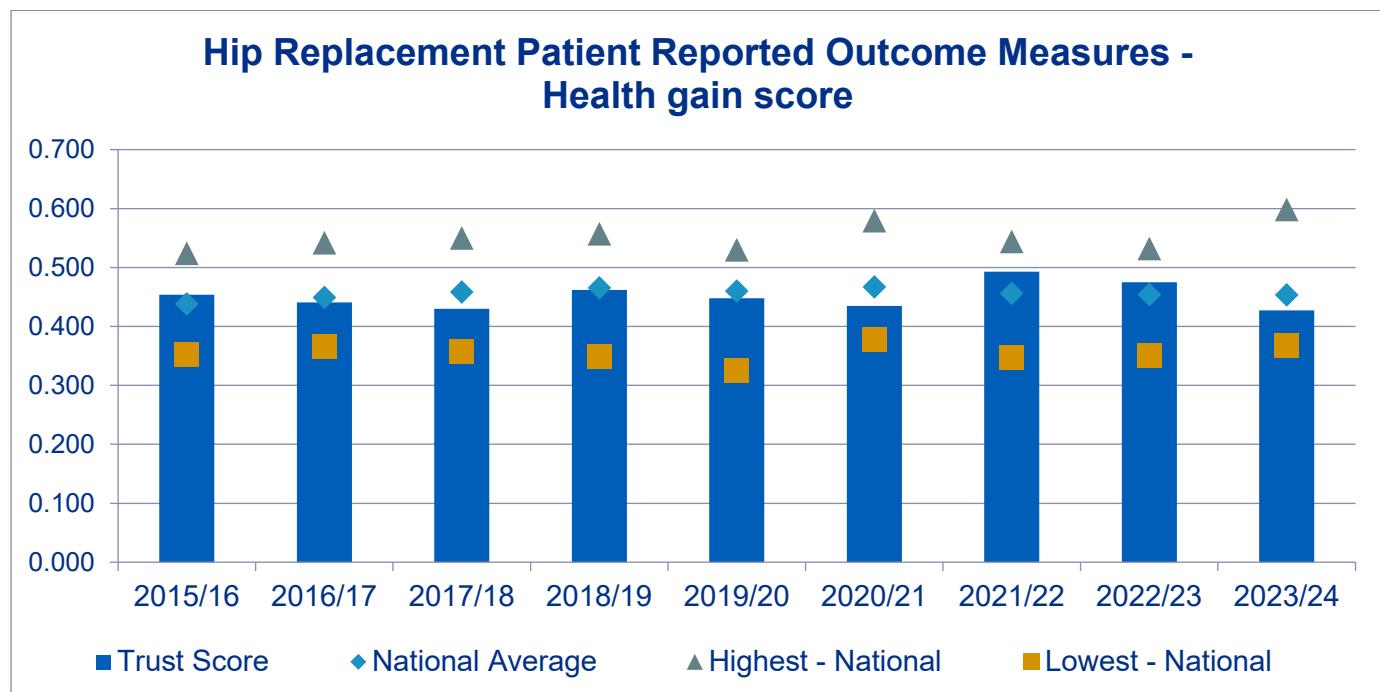


Figure 11 - Hip Replacement Patient Reported Outcome Measures - Health gain score

Knee Replacement Patient Reported Outcome Measures - Health gain score

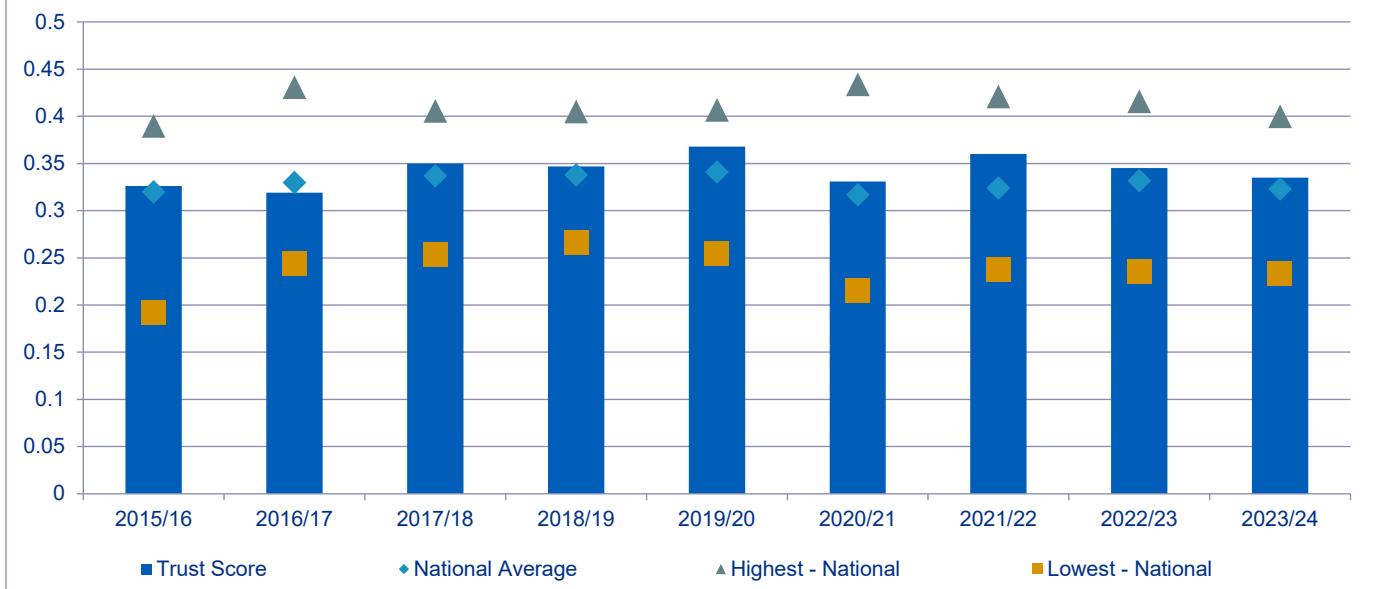


Figure 12 - Knee Replacement Patient Reported Outcome Measures - Health gain score

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

- The specialist review and pre-assessment process ensures that patients are offered the procedure likely to deliver the most benefit and best outcome.
- The health gain scores for hip replacements and knee replacements are in line with the national average.

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

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

3. 30-day readmissions

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

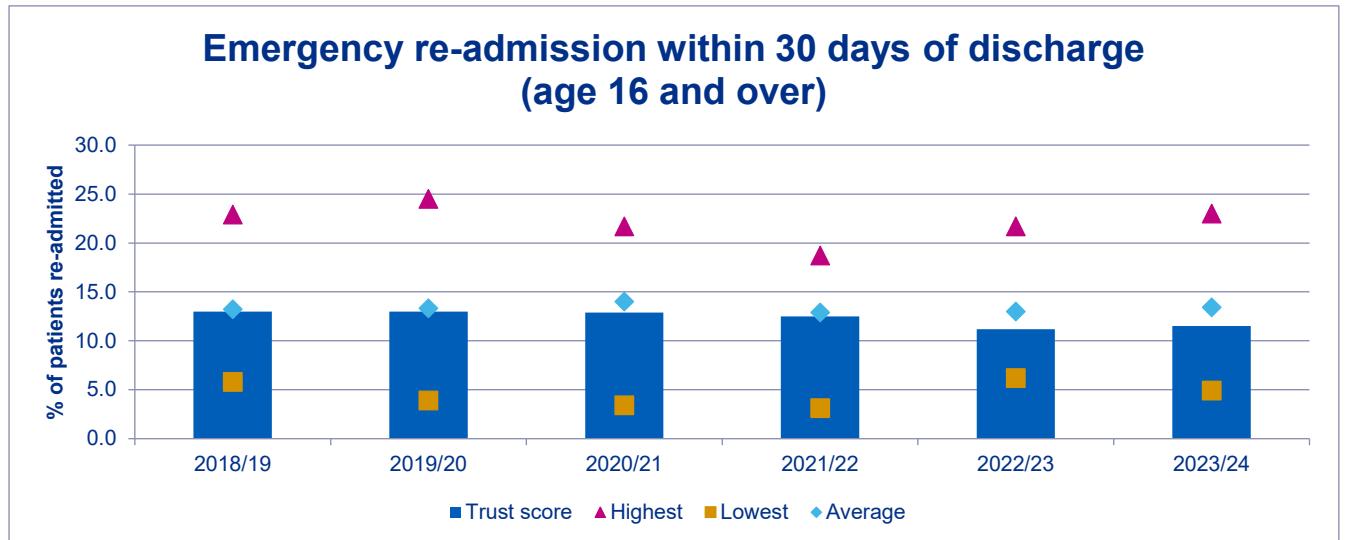


Figure 13 - Emergency re-admission within 30 days of discharge (age 16 and over)

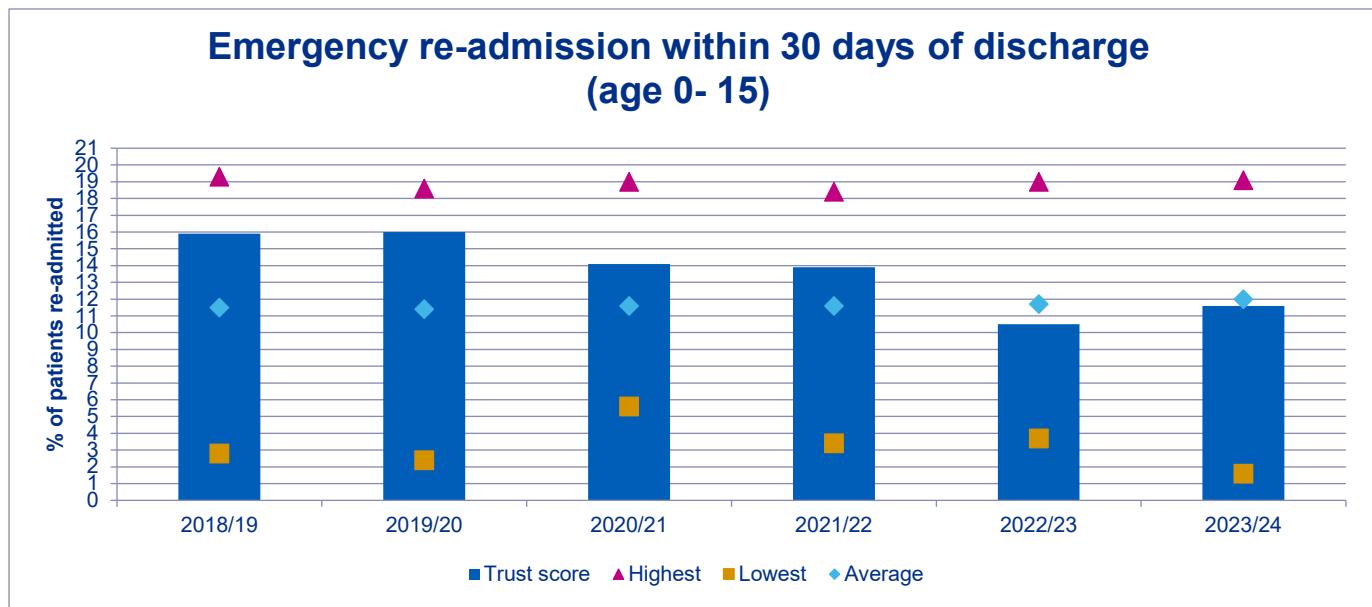


Figure 14 - Emergency re-admission within 30 days of discharge (age 0- 15)

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

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

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

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

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

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

5. National Inpatient Survey

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

We had a response rate of 42%, with 1,250 patients invited to take part and 485 patients participating in the survey. There were slightly more female respondents than male and less than 1% of participants stated they were intersex or preferred not to say. Most respondents were aged over 66 years of age, and the ethnic group was predominantly white (as shown in figures 15-17 below).

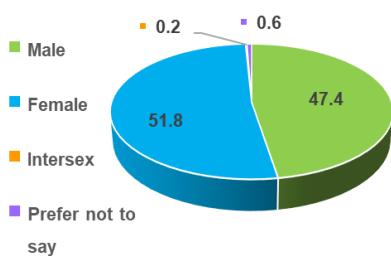


Figure 15 – Sex

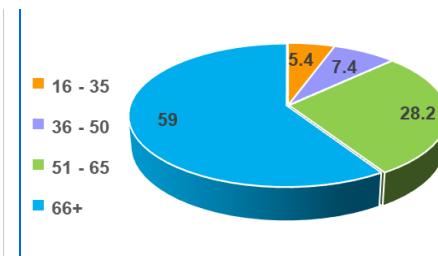


Figure 16 – Age

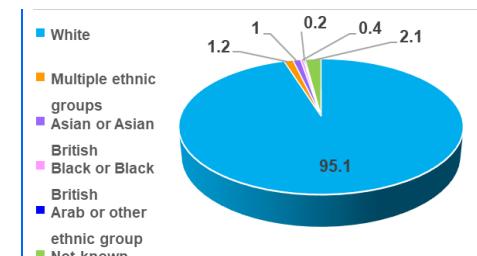


Figure 17 - Ethnicity

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

We scored 'better than most trusts', in one question relating to access to food outside of mealtimes, and 'somewhat better than most trusts' in four questions;

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

Questions showing a decrease in scores, since 2022, were about the length of time on a waiting list before admission to hospital.

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

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

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

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

Our response to the Inpatient survey results

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

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

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

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

Areas for improvement



Figure 18 - Areas for attention following comment analysis

Areas for improvement (identified in Figure 18) have been discussed with clinical staff and included in the action plan. Actions include, the implementation of clinical matron assurance rounds for the discharge process, environment and nighttime assurance rounds. A clinical matron group has been established leading on the pain management workstream, specifically tasked to improve pain re-assessments. The wards now display information relating to pain, pain assessment and re-assessment.

6. Staff Friends and Family Test

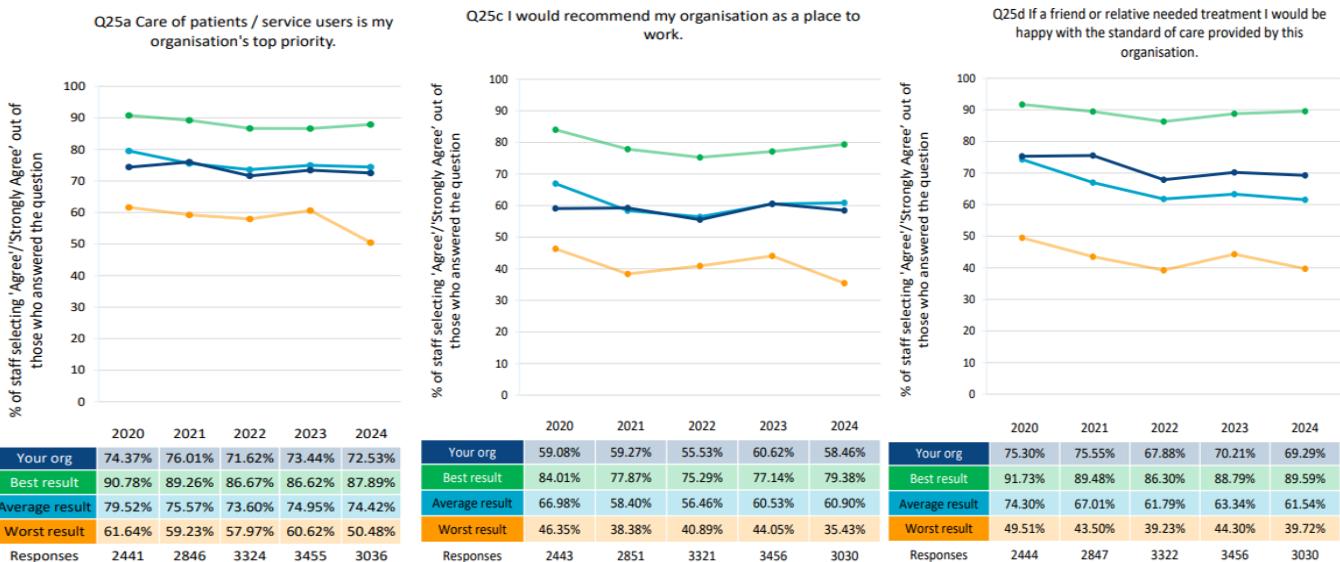


Table 4 - NHS Staff Survey results relevant to staff friends and family test

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

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

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

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

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

7. Venous thromboembolism risk assessments

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

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

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

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

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

8. Clostridioides difficile (C. difficile) Infections rates

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

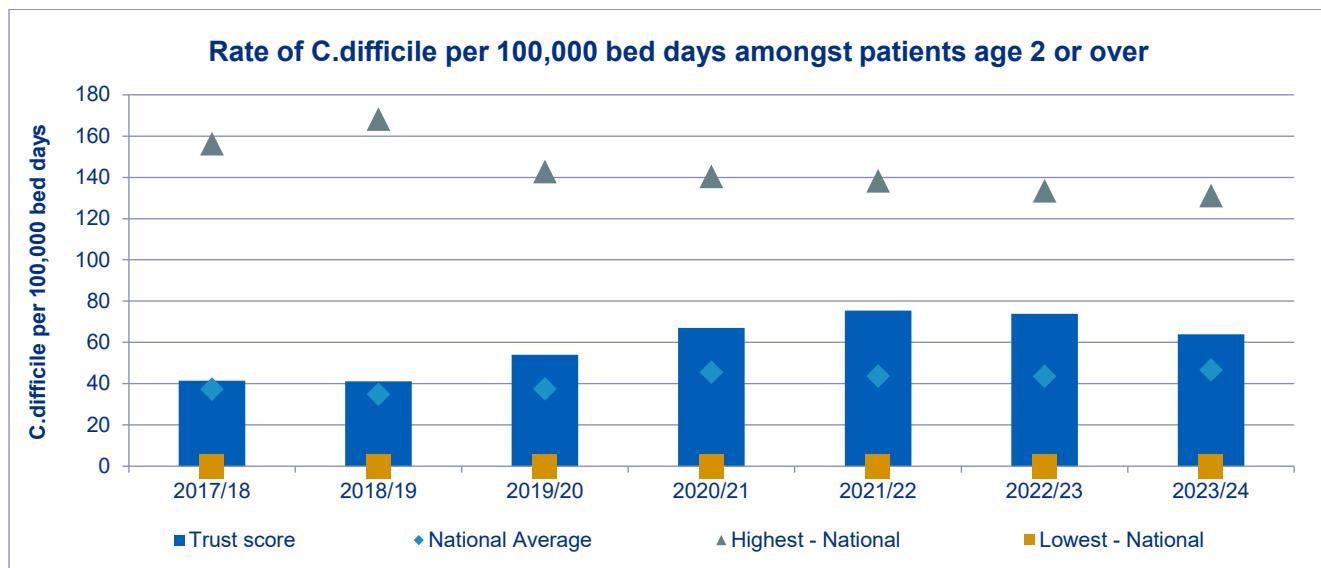


Figure 18: Rate per 100,000 bed days of cases of *C. difficile* infection reported within the Trust amongst patients aged 2 or over.
(Data source: NHS Digital)

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 18 above) reflects the ongoing work within the Trust in relation to *C. difficile* infection. More specific information around performance is reported in section 3.2.

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

- The Trust has a comprehensive action plan for the prevention of all Trust-attributed Healthcare Associated Infections including *C. difficile*, which is monitored through the Infection, Prevention and Control governance route via the Infection Prevention and Control Strategic Group and reported through to the Safe and Effective Care Strategic Group, Quality Oversight Group and Quality Assurance Committee.
- Alongside this recovery plan, each of the clinical collaboratives hold their own *C. difficile* action plan relevant to their area of clinical expertise and report on this through their own appropriate governance structures. The senior team also meet with the Deputy Director of Infection, Prevention and Control twice yearly to discuss progress and actions aligned to this.
- All trust-attributed cases have a Rapid Learning Summary undertaken in line with Patient Safety Incident Response Framework (PSIRF). These reviews are then assessed against a criteria for further discussions and review via a case review which are chaired by the Deputy Director of Infection Prevention and Control (DDIPC) or a senior infection prevention and control (IPC) nurse. All learning from these reviews is shared across the organisation to ensure actions implemented for future improvements. Identifying a single root cause in cases of *C. difficile* is challenging and they are often associated with one or more influencing factors such as patient factors e.g., existing long-term conditions, and/or medical factors such as the requirement for antibiotics or laxatives and/or invasive procedures and investigations.
- Following any Hospital Acquired *C. difficile* case there is a rapid learning review that takes place to identify any immediate learning, this is then shared at the weekly quality and safety panel and senior meetings to ensure actions are completed.
- Continuous update of the *C. difficile* training packages for all staff.
- Membership of the North East and North Cumbria ICB 'Deep Dive' around *C. difficile* continues.

- Membership of NHS England national 'Deep Dive' around C. difficile continues.
- There is an increased focus on antimicrobial prescribing in the organisation including ward rounds and a shared purpose regarding learning, training and education with a particular focus on Co-Amoxiclav as reports suggest that we have increased usage of this antibiotic that can cause C. difficile.

9. Patient safety incidents

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

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

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

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

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

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

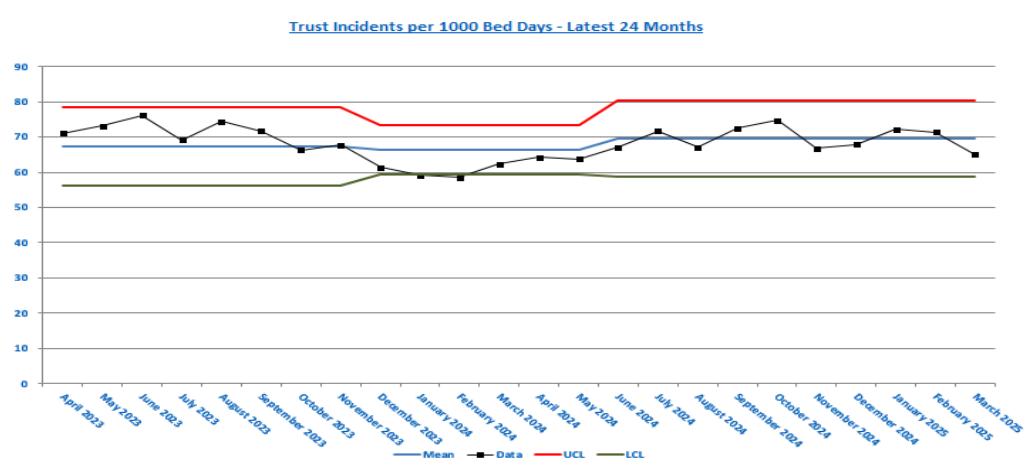


Figure 19 – Trust incidents per 1000 bed days

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

Patient Safety Incident Response Framework (PSIRF)

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

Never Events

We reported five Never Events during 2024/25.

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

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

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

Table 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 2023/24 and 2024/25, however the number of bed days within the Trust has increased by 3000 since September 2023, which has impacted on the data as illustrated in figure 19.

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

- Review Learning from Patient Safety Events thematic and benchmarking data once this is available.

- Continue to encourage high rates of reporting, with a focus on the timely review and management of incidents and providing meaningful feedback to reporters.

10. Patient Friends and Family Test

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

3. Overview of quality of care and performance indicators

3.1 Overview of quality of care

Patient Safety

a. Medication safety

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

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

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

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

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

Our Pharmacy have been adapting and expanding the role and skills of our team to meet the evolving needs of healthcare, with a commitment to improving patients care and supporting the wider healthcare team. In 2024 we have trained our pharmacy technicians to complete transcribing of medication and utilisation of our therapeutic substitution and prescription optimisation



Image: AMS Study Day

policies, which means our skilled staff can assist with ensuring medication charts are accurate for our inpatients.

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

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

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

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

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

The clinical pharmacy team continue to play a crucial role in ensuring the safe use of medication across the organisation, currently 90% of patients are seen by the pharmacy team during their admission and 50% of these are within 24 hours of admission. In August we audited the interventions made by the clinical pharmacy team, and in 1 day 329 interventions were made. 32% of the interventions made would have prevented patient harm, and 93 interventions would have reduced the patient's length of stay.



Image: Beth Mongomerie

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

b. Compassionate Engagement and evaluation of the Family Liaison Officer

The Trust transitioned to the Patient Safety Incident Response Framework (PSIRF) in January 2024. The four key pillars of PSIRF include compassionate engagement and involvement of those affected, a systems-based approach to learning, considered and proportionate responses, and supportive oversight focussed on strengthening response systems.

Learning from patient safety incidents

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

Family Liaison Support

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

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

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

Restorative practice

In addition to Family Liaison Officer training, a further cohort of staff have completed restorative practice training. Restorative practice focuses on relationship building and conflict resolution, addresses the consequences of harm and allows for repair and learning. This practice informs emotional literacy and social skills building, and complements the Family Liaison Officer role

when supporting affected patients and their families. Examples of restorative practice include the facilitation of restorative conversations and supporting patients and their families to access psychological therapies following adverse events.

Patient safety investigation training

A patient safety investigation workshop was facilitated by a patient safety partner, patient safety specialist and patient safety lead. The 4-hour workshop used a case study based on a recent Healthcare Safety Investigation Branch (HSIB) process to develop participants knowledge and skills when undertaking patient safety reviews, based on teaching from the NHSE Patient Safety Syllabus Level 3 and 4 training. The session included the application of human factors models (such as the System Engineering Initiative for Patient Safety and Accident Mapping), Duty of Candour, and the hierarchy of controls in developing meaningful action plans. Over 60 colleagues attended the session, which received positive feedback, and there are plans to deliver further sessions, as part of a regular education programme in 2025.

NHS Patient safety syllabus training

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

Patient Safety Partners

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

c. Martha's Rule

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

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

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

Patient Wellness Questions

How are you feeling?

Very Good Good Fair Poor Very Poor

1 2 3 4 5

How are you feeling compared to the last time we asked you (or compared to yesterday)?

Much better Better No Change Worse Much Worse

1 2 3 4 5

Bradford Teaching Hospitals NHS Foundation Trust

Patient Wellness Score Decision Matrix

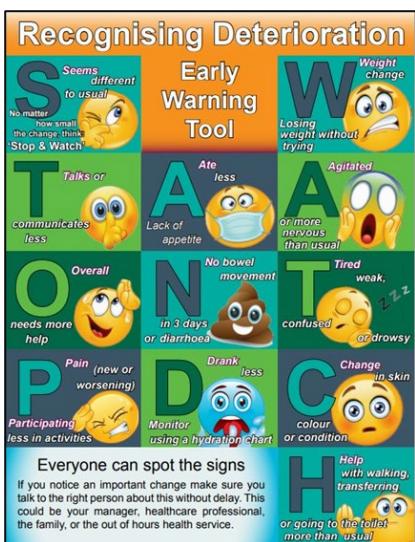
Score	2	3	4	5
2	Green	Green	Yellow	Red
3	Green	Green	Yellow	Red
4	Green	Yellow	Yellow	Red
5	Yellow	Yellow	Red	Red

Action based on PW Score

2-3: Tell the nurse in charge. Repeat PW22. Assess patient for pain. Administer PRN in 2 hours.

4-5: Assess patient for pain. Administer PRN in 2 hours. Contact Critical Care Outreach Team if w/75.

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



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

Step 4

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

- ① The patients name
- ② The ward they are on
- ③ A brief description of the issues and what has already been done about it
- ④ Your contact details and relationship to the patient if not the patient referring.

When NOT to make a C4C call

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

For any general concerns please discuss with the ward team.

Patient Experience

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

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

Critical Care Outreach Team

Are you concerned about a patient?

Call 4 concern®

A patient safety initiative



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

communication between families and the multi professional team and signpost to other services. Since the service has been introduced, it has received over 100 referrals. There is already an established staff route of escalation to the critical care outreach team.

Key Benefits

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

Clinical effectiveness

a. Research and Innovation

Clinical Research

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

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

Achievements of note:

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

Nursing Midwifery and Allied Health Practitioner (NMAHP) Development

The Chief Nursing Officer Research Lead, in collaboration with Teesside University, have secured four Chief Nurse PhD Fellows in 2024/25 with another two planned to start in 2025/26 to develop NMAHP clinical academic careers. In 2024/25 we have four NMAHPs beginning an

INSIGHT funded research masters programme equating to funding of £31,000. Research has now been included into our South Tees Accreditation for Quality of Care (STAQC) programme and we have introduced the [Multi professional Practice Based Research Capabilities Framework](#) to develop practitioners research pillar. To support writing skills for publication/ grants/ research we secured funding for a writer in residence (0.2 WTE) from the [Royal Literary Fund](#). Over 150 staff have accessed workshops or 1:1 writing support since October 2024.

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

Tees Valley Research Alliance (TVRA) Sponsored studies

The Tees Valley Research Alliance has been successful in being awarded over £6.7 million in grant awards in the last year to conduct their own studies. £40,000 of this was for general trust sponsored studies, £4.4 million for Academic Centre for Surgery (ACeS) led studies and £2.3 million for Academic Cardiovascular Unit (ACU) led studies.

We have 20 studies open that have been developed by our own trust researchers that we sponsor and a further 35 under consideration. Further detail is provided in table 6 below.

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

Table 6 – Trust sponsored studies by support team

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

Innovation

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

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

With the appointment of David Ferguson as Director of Innovation, from April 2024, and interim Director of Innovation for University Hospitals Tees from April 2025, an Innovation Strategy is being developed and is expected to be incorporated across the University Hospitals Tees Group considering expected group working. Further work around the strategy will take place in early 2025/26 and overall, the organisation continues to develop a culture of innovation and continues the work needed to progress the ideas that staff have raised.

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

Work is ongoing from previous cohort enquiries, with a breakdown of these provided in figure 20 below.

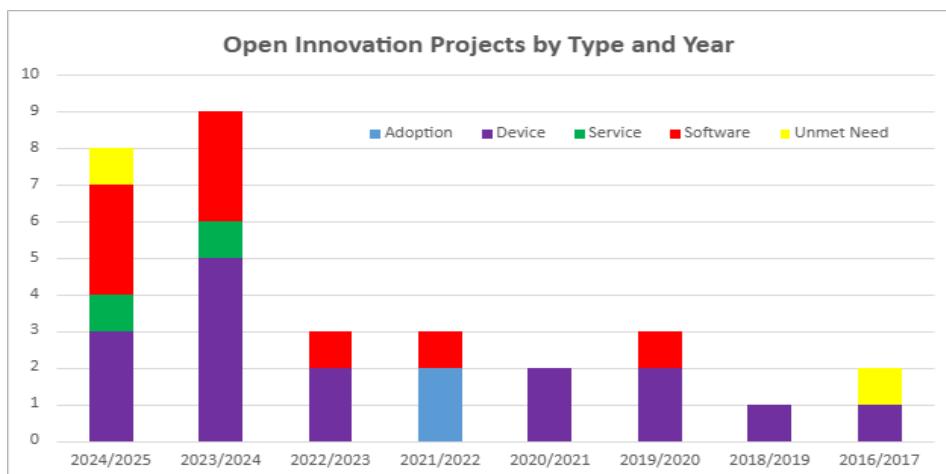


Figure 20 – Open Innovation Projects

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

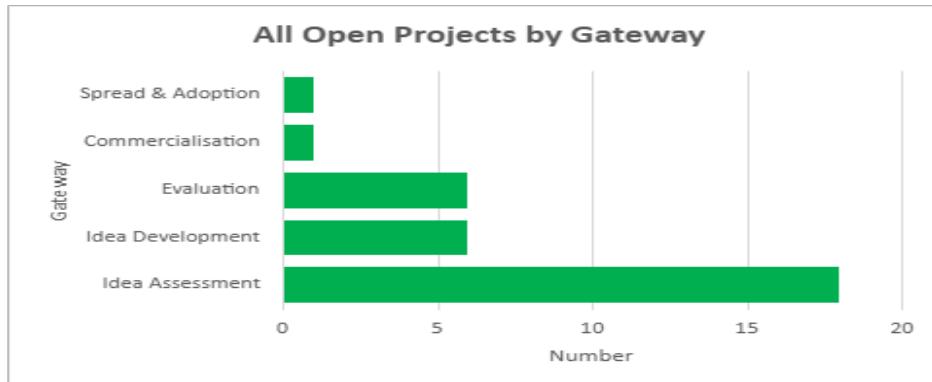


Figure 21 – Open projects by gateway

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

b. STAQC and Ward 12

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

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

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

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

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

There has been a continued focus during 2024 to continue with embedding the STAQC accreditation programme into all clinical areas. Baseline accreditations have continued as a starting point to the formal process, providing clinical areas with a robust action plan and expected timebound actions required to achieve either a gold or diamond accreditation.

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

Total achievements at end of year			Key actions for STAQC team
	2023/24	2024/25	
Diamond accreditations	40	56	<ul style="list-style-type: none"> To maintain a comprehensive work plan, transparent to all teams. To continue to roll out new updated standards aligned to quality statements To maintain a constant focus on shared ownership. To undertake research/service evaluation into the impact of the programme.
Gold accreditations	52	66	
Baseline accreditations	17	34	

Table 7 – STAQC accreditations by level of achievement

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

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

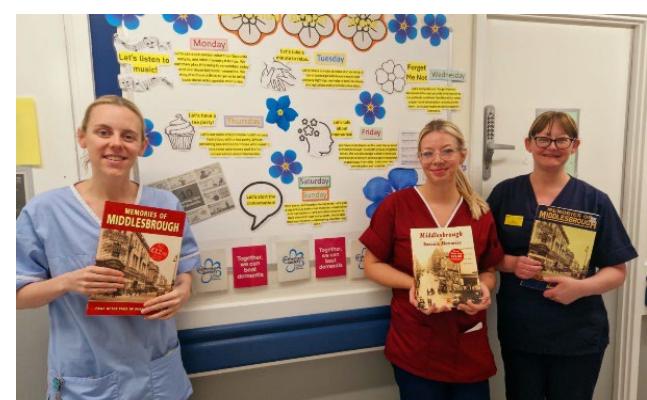
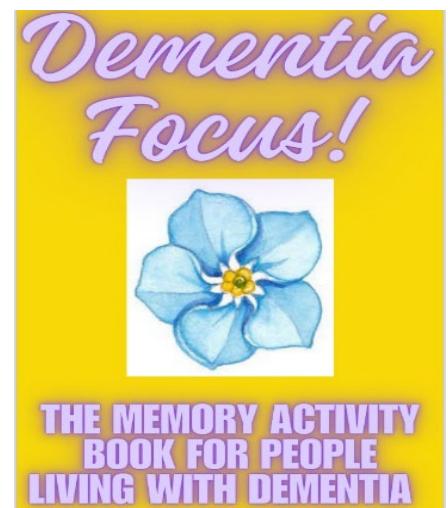
The vision for the ward is to provide the highest quality specialist multidisciplinary care to older people in an environment that is both supportive and friendly but also with an ethos of continuous improvement. The ward has been on a significant journey over the past four years, changing specialities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

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

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

- Excellent environmental work undertaken, to make the ward accessible for patients with dementia, learning disabilities and sensory impairments.
- The investment of the team in terms of learning, development and training to ensure they have the skills needed for providing excellent care for the older person.
- An integrated multi-disciplinary team approach to care was witnessed on the ward with medics, allied health professionals and nurses working closely together to meet the needs of the patient, the multidisciplinary team room at the end of the ward is a positive addition as it helps to facilitate these relationships.
- Robust processes were in place around documentation and all appropriate care plans and risk assessments were witnessed and care was detailed and tailored to the patients' needs.

- The creation and implementation of a patient information leaflet for patients and relatives, to share vital information about the area and ward routine, to help enhance communication and the patients experience.
- Excellent service improvement projects to enhance the safety on the ward, such as the introduction of a triangle in the bedspaces as a visual reminder for all staff the patient is at high risk of falls and the use of clock faces to prompt the regular movement of patients at high risk of pressure ulcers is to be commended upon.
- The inclusivity and diversity of the team; the ward recently won a prize for the cultural diversity board they created, to celebrate this they held a tea party providing the different cuisines from the countries their staff represent and colleagues' dresses in their national dresses.
- Excellent teaching programme created by Advanced Care Practitioners (ACP's), this is held weekly and is tailored around patient safety/training needs identified from the medical team and the ward. This learning is enhanced with SIM and VR headsets.
- One of the ward sisters, Katy, has devised a welcome pack for patients with dementia. This includes a forget me not, carers passport, car parking concessions and a dementia activity book. The dementia activity book helps to encourage family involvement and cognitive stimulation, this is in the process of being rolled out throughout the rest of the organisation and is to be commended upon.
- During Dementia Action Week, the team planned a full week of activities raising awareness of dementia and delirium. They held a tea party to which family members were encouraged to attend and invited a singer to provide entertainment for the patients. This is just another example of how the ward go above and beyond for their patients.



Well done Ward 12!

Summary

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

c. MIYA and Digital Transformation

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

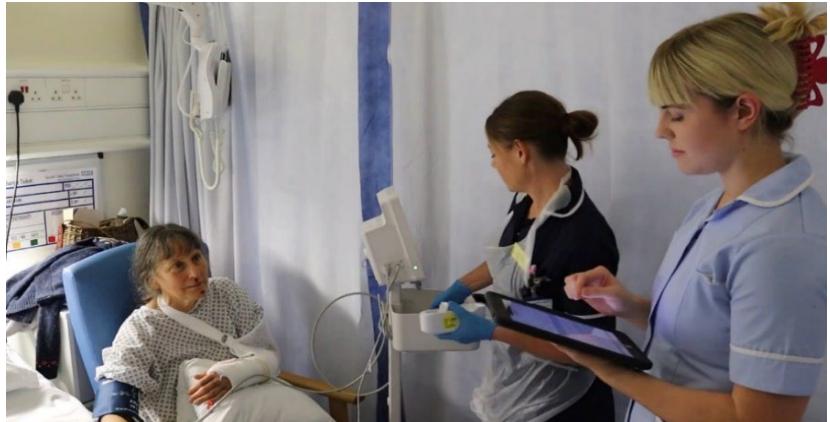
The MIYA Programme team was established in 2021 to drive the digital transformation journey. The multidisciplinary approach towards implementation has contributed to continued success.

Patienttrack

Digital electronic observations have been embedded in adult inpatient services since 2014. However, Patienttrack was introduced in 2021 to supersede the existing platform and introduce further modules and assessments, leading to 22 paper assessments being digitised so far.

Key Benefits

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



<p>Local: T267893 / NHS: - Female, 26-Mar-1967 58y Episode : Inpatient Admission Ward : JC01 Bed : - Flag : -</p> <p>Robinson, Alyson</p> <p>Raise Attendance View Charts Record Observations</p> <p>Record Attendance On Demand Tasks</p>	<p>Obs Profile Initial Observations</p> <p>EWS Regime NEWS2 (SpO2 Scale 1)</p> <p>Observation Due 5 mins ago</p>	<p>Team: - Specialty: GENERAL SURGERY Responsible Clinician: -</p>	<p>Tasks</p> <p>Comfort & Care Rounding 6 mins ...</p> <p>Pressure Ulcer Risk Assessment ...</p> <p>Urinalysis 3 mins ago</p> <p>3 overdue 0 near due</p>
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Image; screenshot of Patienttrack electronic system

Electronic Prescribing and Medicines Administration (ePMA)

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



Key Benefits

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

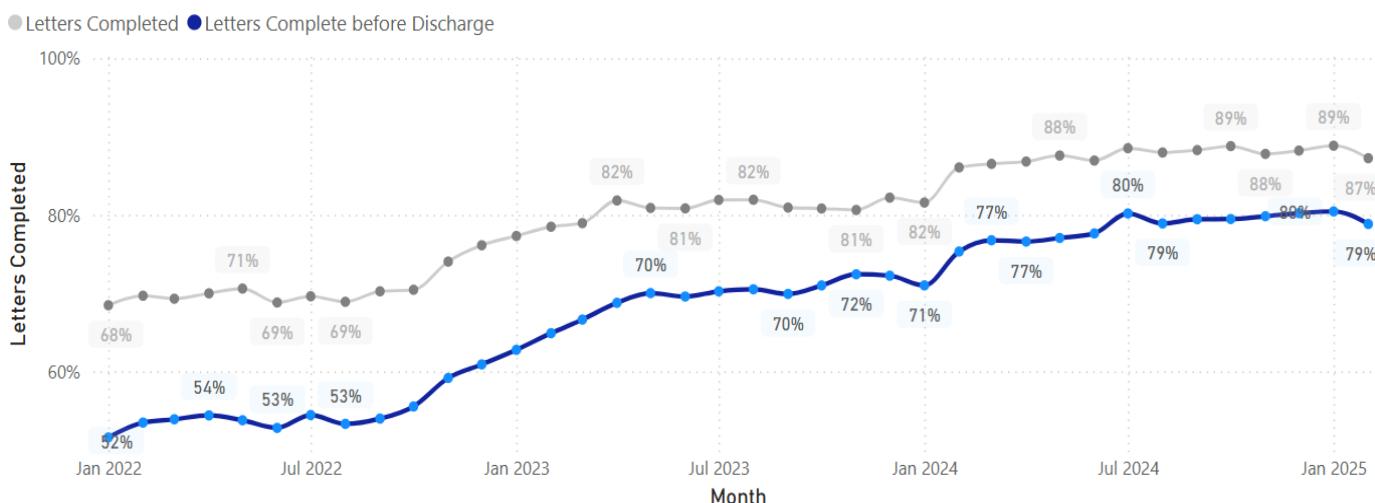
Electronic Discharge

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

Key Benefits

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

Patients Discharged with a Letter (Miya)



Smartpage

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

Key Benefits

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

Clinical Noting

Miya Noting allows for documentation of patient care to be recorded electronically by the multi-disciplinary team. It was introduced into the organisation in October 2023, with 40 areas now live. This includes specialist documentation in areas such as Surgery, Orthopaedics and Cardiology. The remaining areas are planned to go-live over the next 6 months.

Key Benefits

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

Bed Management

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

Key Benefits

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

Patient experience and involvement

a. Patient surveys – national and local

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

Local Trust Surveys and Friends and Family Test (FFT)

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

The family and friends test 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 family and friends test provides a mechanism to highlight both good and poor patient experience, and results can be compared with other trusts.

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

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

Table 8: Inpatient, A&E/UTC, Outpatient, Community and Maternity FFT results benchmarked against national results (April 2024 – January 2025). Data source NHS England.

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

National Surveys

The Trust participates in several national surveys run by the Care Quality Commission (CQC). The published reports are scrutinised to assess trust performance compared to previous

performance, the performance of local trusts, and the national average scores. Action plans are developed to address any areas for improvement, and these are monitored by the Patient Experience Steering Group. The key findings of the most recently published National Adult Inpatient Survey are summarised in Section 2.3.

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

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

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

We scored 'better than most trusts' in one question, 'about the same' as other trusts in 26 questions and 'somewhat worse than most trusts' in two questions. The question we scored 'better than most trusts' in was, "to what extent did you understand the information you were given on how to care for your condition at home"? The 2 questions we scored 'somewhat worse than most trusts' in was, "regarding being able to get food or drinks whilst in A&E".

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

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

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

Patients felt they were not involved in decisions about their care and treatment. Discussions with all the medical and nursing teams have taken place to emphasise the importance of engagement

with patients, carers and family members. The clinical team will continue to review feedback to determine if improvements are being achieved.

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

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

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

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

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

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

- The patient's communication needs were not identified by staff during the booking in process. Communication needs posters are displayed on the doors of reception and reception staff ask the patient if they require any additional communication needs. This is identified on the IT system with any communication needs with symbols (ear – hearing, eyes – visual impairment, butterfly – autism). We procured the services of a new translation and interpretation provider in November 2024, which should improve the timeframe for providing translation and interpretation.
- It was identified that our pain management whilst in the Urgent Treatment Centre was not as good as it could be. The staff have introduced pain score evaluation on triage and pain relief is given. The pain score is evaluated to monitor the effectiveness of the pain relief. The staff use the tannoy to inform patients to ask staff if they require more pain relief.
- The patients identified that that there was no access to food and drinks. A hydration trolley has since been installed in the department, providing water and juice, and a vending machine is available. Signs have been placed around the department informing patients that they can ask for bottles of water.

National Cancer Patient Experience Survey

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

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

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

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

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

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

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

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

National Maternity Survey

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

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

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

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

Following a review of the results and survey comments, an action plan was developed with the clinical staff. Work commenced around personalised care, using the service user voice to create videos to share with staff. The Birth Reflections service was advertised and there was an increase in the availability of this service. The discharge video was updated to ensure that the information provided was relevant. A review of the visiting was undertaken as some of the comments raised were relating to a partner or someone else close to the patient involved in their care being able to stay as much as you wanted. This is managed on an individual basis considering the privacy and dignity for all patients. Pain management after the birth was also raised in the comments and medication 'lock boxes' were ordered. This will allow patients to access pain medication timely, improving staff 'time to care'. Comments were received about the tongue tie service as the patients felt they were not listened to. The Tongue Tie Service is becoming embedded in the organisation and is improving the experience of the patients utilising this service.

b. Patient Experience and Equality, Diversity and Inclusion (EDI)

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

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

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

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

Commitment to Carers

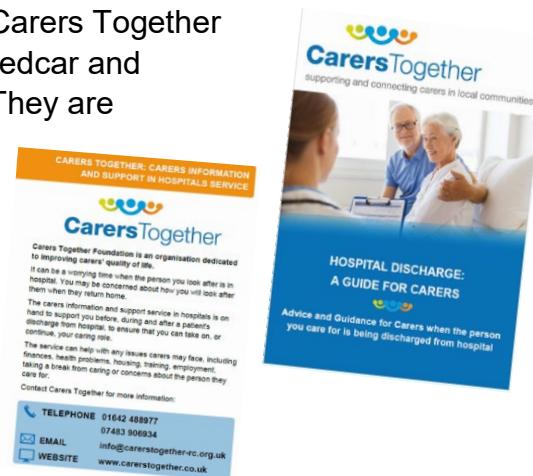
We value the fundamental role carers have in securing the health, comfort and welfare of the people they care for. We identify a carer as a person of any age who provides unpaid help and support because of their illness, frailty or disability. This could be for a parent, child, partner, relative or close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



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

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

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



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

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

NHS
South Tees Hospitals
NHS Foundation Trust

Carer Survey

Ward or Department
Discharge Date (DD/MM/YYYY)

What is this survey for?
A person you care for has recently been discharged from South Tees Hospitals NHS Foundation Trust. This survey will help us understand your experience as a carer of a patient.

There are a few questions to answer. There is also space for you to share your own thoughts and ideas.

Can I complete this survey another way?
Yes, we can help you with the survey over the phone. You can arrange this with the Patient Experience Team. Contact them by email or phone using the details below.

Phone
01642 283 5964
We are open 9am to 4pm, Monday to Friday.

Email
stees.patientsurveys@nhs.net

Patient Transport

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

I have used the transport service for all my chemo appointments. The drivers drop me off in good time. I do have to wait for my return but that is understandable.

I always rely on my father-in-law to take me to appointments. Sometimes, I have to cancel if he can't take me. This service will stop me missing appointments – I can't wait to try it. (Blind patient)

The doctor was able to arrange patient transport for my daughter and I after midnight and we live over 30 miles from the hospital. Thank god for your patient transport.

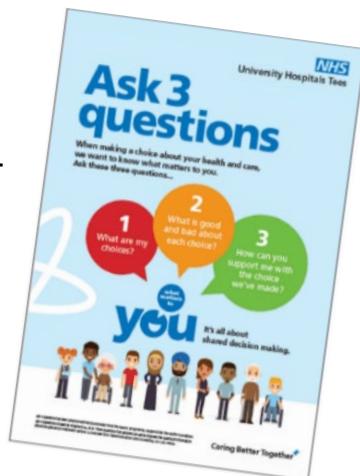
Patient Experience Involvement Bank

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

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

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

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



Emergency Care – Mental Health Study Day

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



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

Supporting our Neurodivergent Patients: A workshop on Autism and ADHD

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

Epilepsy

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



Radiology pre-assessment project

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



Water inflated pessary event

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



Psychology and therapy in Cancer Services leaflets

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

Academic Centre for Surgery

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

The team needed patients to share their views on a research project to improve the care provided for patients with broken hips.

Representatives from the involvement bank and the public at community groups, attended the focus group session. Feedback was very positive; with lots of discussion and ideas generated.



AHP research

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

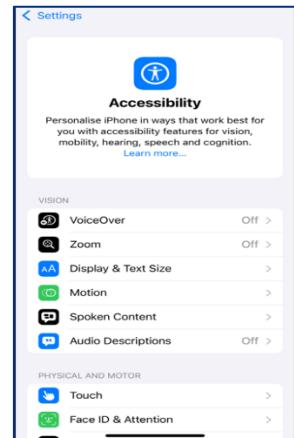
Lung Cancer Expert Patient Panel

A lung cancer expert patient panel has been set up to provide support to patients who are on the pathway to recovery.

Patient menus

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

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



Following the feedback the menus were uploaded to our internet page for patients to access via the website. We shared this with the Teesside Society for the Blind, for them to access the menu via the website. Using the website, they were able to increase the font size, and those who had the accessibility function on their phone were able to listen to the menu being read out. The response to this from the sight impaired community was positive. They felt their input made a change to the accessibility of the menu, which met their needs

Translation and Interpretation Service

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



Patient Engagement Portal

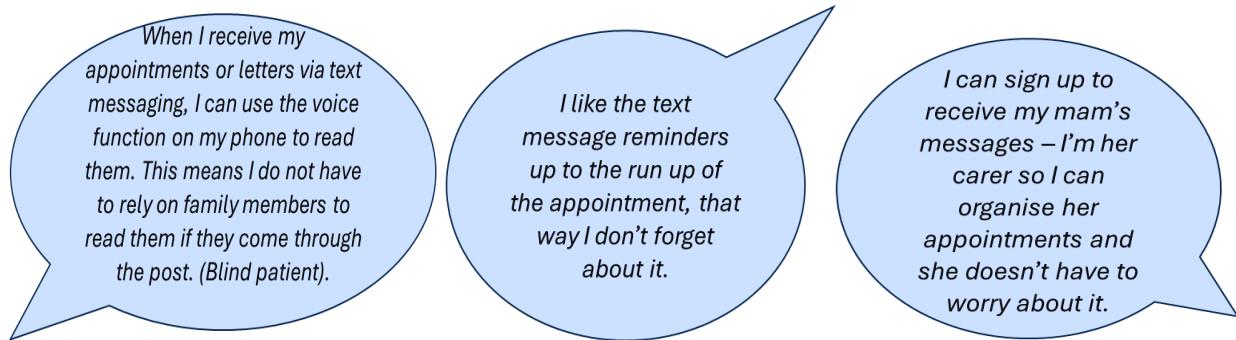
The Patient Engagement Portal (PEP) was rolled out to all patients at the beginning of 2024.

This is a text message service that provides digital letters and communication to patients. It aims to improve patient experience and safety, and reduce use of paper and save time.

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



Feedback has included:



Veteran Aware

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

The role of the Help for Heroes nurse ensures that;

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



Patient Stories

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

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

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

3.2 Performance against key national priorities

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	24/25 Targets
All cancer – 62 day wait for first treatment from											
Urgent GP referral for suspected cancer	79.10%	81.10%	85.44%	82.65%	77.23%	75.52%	73.83%	60.40%	57.8%	57.7%	85%
NHS Cancer screening service referral	89.80%	89.00%	94.55%	87.14%	94.41%	62.77%	50.00%	68.71%	55.0%	32.4%	90%
18 weeks referral to treatment time (RTT)											
Incomplete pathways	93.20%	92.20%	91.45%	89.49%	83.33%	63.20%	65.37%	65.99%	63.78%	60.21%	92%
Accident & Emergency											
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	95.80%	95.33%	95.68%	95.24%	88.35%	87.25%	75.52%	68.22%	67.33%	75.01%	95%
Diagnostic Waits											
Patients waiting 6 weeks or less for a diagnostic test	98.82%	99.15%	97.46%	98.26%	94.04%	72.57%	68.71%	77.57%	76.06%	85%	99%

Table 9: Performance against national priorities

Key findings:

Cancer waiting times

Our 2024/25 year end performance for the all cancer 62-day wait for first definitive treatment for suspected cancer was 61.0% (February 2025). This includes 73.6% compliance for consultant-led upgrades, 56.3% compliance from screening (smaller numbers, average 5 per month), and 52.7% compliance for patients referred from their GP as urgent suspected cancer.

At the end of March 2025, 154 patients were waiting more than 62 days for first definitive treatment. Clinical harm reviews are undertaken for assurance on all patients exceeding 104 days.

In February 2025 South Tees Hospitals NHS Foundation Trust was placed into NHS England (NHSE) performance oversight regime Tier 2 for cancer 62-standard. This provides rigorous oversight of the Trust's improvement plans for this standard.

In addition to accountability to the NHSE tiering performance meeting, cancer action plans are routinely reviewed and monitored through the Cancer Delivery Group, informed by a programme of pathway reviews.

Improvement and sustainability plans are focusing on prostate diagnostic pathways, radiotherapy demand and capacity, histopathology turnaround, amongst other actions. The positive impact of these changes on patient pathway duration will be evident from June 2025.

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

Table 10 - Performance against cancer headline standards

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

Elective care performance

- For elective care (referral to treatment target), the focus is on reducing the number of patients waiting the longest for non-urgent treatment. Few patients waited more than 78 weeks for treatment during the year, and by the end of March 2025 the number of patients waiting more than 65 weeks was reduced to 47. However the number of 52-week waits and overall waiting list remained high and above 2023/24, driven by increasing referrals and capacity constraints in some specialities.
- In 2025/26 we will work to eliminate waits greater than 65 weeks and reduce 52-week waits to less than 1% of the waiting list, as well as improving overall compliance with referral-to-treatment within 18 weeks from 60% to 65%.
- This will be achieved through improvements in productivity (such as theatre and clinic utilisation), booking processes (ensuring patients are seen in date order so far as possible and clinically appropriate) and waiting list validation (ensuring patients are not waiting for an appointment or treatment where there is a more suitable alternative).

Diagnostic performance

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

Urgent and emergency care performance

- Performance against the A&E 4-hour standard improved by over 5% in 2024/25 to 75.5% in March 2025, but fell short of our agreed trajectory to reach 77% by end March 2025. Performance in the three Urgent Treatment Centres consistently exceeded 95%.
- The James Cook University Hospital, Urgent Treatment Centre opened in April 2024 and provides a more appropriate care setting than an emergency department for more minor illness and injury, reducing delays in care for these patients and producing a step change improvement in 4-hour waits overall. However, performance at Trust level dipped during the winter months due to the impact of seasonal pressures leading to a greater volume and acuity of illness than seen in 2023/24. This resulted in high bed occupancy impacting on patient flow despite the implementation of beneficial initiatives such as continuous flow to the receiving wards, additional non-invasive ventilation capacity and patient transfer teams. Work to optimise patient flow, and alternatives to ED for appropriate patient cohorts, will continue in 2025/26 to meet the agreed trajectory of 78% by end March 2026.
- To support the regional ambulance service response times, the Trust has focused on reducing ambulance handover delays. Joint working protocols are embedded and staff allocated to care for patients arriving by ambulance to release the ambulance crews. The focus for 2025/26 will be on minimising any handovers taking longer than 45 minutes.
- For 2025/26 there is continued focus on reducing ambulance handover delays in order to release ambulance crews ready to respond to their next call, supporting ambulance service response times, and ensuring patients do not spend more than 12 hours in the Emergency Department, reducing clinical risk for patients who require admission.
- In community services, urgent response times consistently exceeded the national target throughout the year, and additional hospital at home capacity was created to care for over 100 patients at home in the peak winter months.

3.3 Additional required information

Seven-day services

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

After the challenges of the COVID-19 response, the Board Assurance Framework for Seven Day Services re-focused attention on the four key standards. A full assessment against these standards was completed for South Tees Hospitals NHS Foundation Trust in September 2022.

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

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

Freedom to speak up



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

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

Table 11 shows that a total of 153 concerns were raised with the Guardian Team between April 2024 - March 2025 compared to a total 125 in the previous 12 months. This represents an overall increase of 22.48% year on year. The number of concerns raised anonymously during 2024/25 was 63 which is an increase of 13.16% based on last year's data.

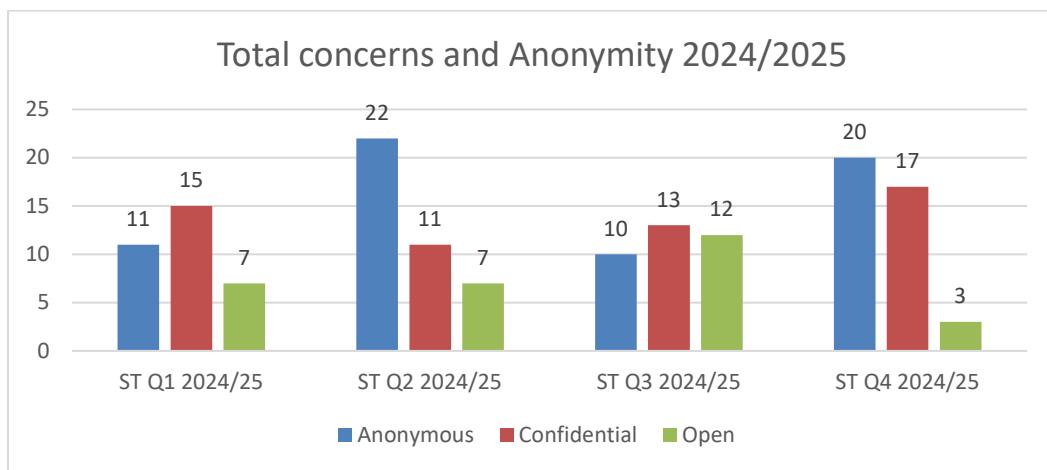


Table 11 – total concerns raised

Table 12 below shows the high-level themes recorded against the concerns received in 2024/25.

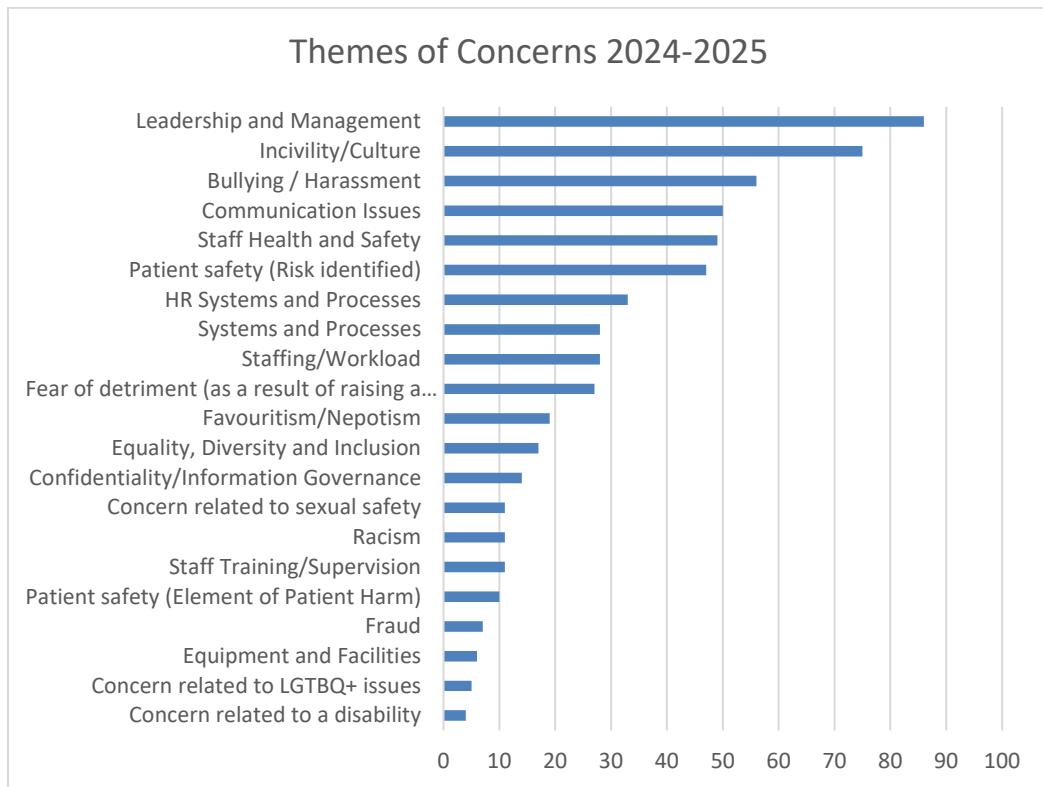


Table 12 – Themes from Freedom to Speak up concerns

Proactive work to date

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

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

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

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



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

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

Future Plans

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

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

Rota gaps for doctors and dentists in training

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

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

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

	<u>No of gaps in establishment by tier of rota</u>	How mitigated
Medical Rotas	0.5 Neurology - T1	Out of hours - backfilled with locum.
	2.5 - Acute - T1	Recruitment
	1 - Chemical Pathology - T1	Recruitment
	1 - Emergency Department - T1	Recruitment/out of hours - backfilled with locum
	1 - Emergency Department - T2	Recruitment to backfill vacancy/locum
	1 - General Psychiatry - T1	Backfill not required
	1 - ICU - T2	Recruitment/out of hours - backfilled with locum
	1 - Infectious Diseases - T1	Out of hours - backfilled with locum.
	2 - Renal - T1	Recruitment/out of hours - backfilled with locum
	2 - Respiratory - T1	Out of hours - backfilled with locum.
	1 - Clinical Oncology	Backfill not required
	1- Dermatology - T2	Recruitment
	1.5 -Trauma & Orthopaedic - T1	Recruitment/out of hours - backfilled with locum
	10 - Neonates - T2	Locum
	14 - Radiology - T1/2	Rota adjustments / locum
	2 - Histopathology - T2	Backfill not required
	2 - ICU - T1	Recruitment/out of hours - backfilled with locum
	2 - Gastroenterology - T1	Out of hours - backfilled with locum.
	2 - Haematology - T2	Backfill not required
	2 - Urgent Treatment Centre - T2	Locum
	2- Spinal Injuries - T2	Locum
	22 - Paediatrics - T1/2	Rota adjustments/Recruitment/Locum.
	3 Clinical Oncology - T2	Backfill not required
	30 - General Internal Medicine - T2	Rota adjustments/Recruitment/Locum
	4 - Trauma & Orthopaedic - T2	Recruitment/out of hours - backfilled with locum

	4 - Obstetrics and Gynaecology - T1/2	Recruitment/out of hours - backfilled with locum
	4.5 - Older People Medicine - T1	Out of hours - backfilled with locum.
	5 - Neurology - T2	Rota adjustments / locum
	5.5 - Diabetes - T1	Out of hours - backfilled with locum.
	6 - General Medicine - T1	Out of hours - backfilled with locum.
	9 - Cardiology - T1	Out of hours - backfilled with locum.
Surgical Rotas	1 - Ear, Nose and Throat - T1	Out of hours - backfilled with locum.
	4 - General Surgery - T2	Out of hours - backfilled with locum.
	1 - Oral Maxillofacial Surgery - T1	Backfill not required
	1 - Urology - T1	Out of hours - backfilled with locum.
	1 - Vascular Surgery - T2	Out of hours - backfilled with locum.
	2 - Plastic Surgery Rota T2	Recruitment
	3.5 - Neurosurgery - T1	Out of hours - backfilled with locum.
	6 - Cardiothoracic Surgery - T2	Rota adjustments/Recruitment/Locum
	8 - Neurosurgery - T2	Recruitment/Locum

Table 13 – rota gaps

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

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

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

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

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

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

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



North East and North Cumbria

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

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

Overview

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

Achievements

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

- The establishment of weekly patient safety and quality panels with Board level representation.
- Increased use of technology to support the recording of key compliance data.
- Continued development of the ePMA system to reduce medication errors, reduce waste, provide education and standardise prescribing.
- Steps made to improve engagement with marginalised groups and reduce health inequalities.

Areas for Further Development

The ICB recognises the additional work required which has been identified within the quality account. In particular, the work required to improve audit compliance and the use of digitalisation to enhance patient safety and effectiveness as well as the increased uptake of awareness and training to support the patient safety and incident response framework. The ICB looks forward to receiving the revised patient safety incident response plan (PSIRP), once the independent review has been completed. The ICB acknowledges the work undertaken to improve complaint response times and recognises the further work that is required to achieve agreed timescales for closure.

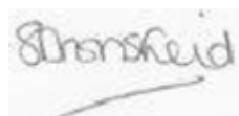
Future Priorities

The ICB is fully supportive of the identified Quality Priorities for 2025/2026. The ICB acknowledges the need to embed processes and improvements across quality priorities rolled over from the previous year. The ICB welcomes the introduction of a new quality priority to reduce the risk of acquiring healthcare associated infections, recognising that this continues to be a challenging area across the hospital group. The sharing of learning across the group can only be of benefit to patients and staff alike.

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

NENC ICB remain committed to working in partnership with the Trust to assure the quality of commissioned services in 2025/26.

Yours sincerely,

A handwritten signature in black ink that reads "Sarah Dronsfield" with a short horizontal line underneath it.

Sarah Dronsfield

Director of Quality
NHS North East and North Cumbria Integrated Care Board

Commissioner Statement from NHS Humber and North Yorkshire Integrated Care Board (HNY ICB) for South Tees Hospitals NHS Foundation Trust Quality Account 2024/25

Humber and North Yorkshire Integrated Care Board (ICB) welcome the opportunity to review the South Tees Hospitals NHS Foundation Trust Quality Account, which as with previous years is reflective of the Trust's values, vision and ambitions for the future.

The account illustrates the progress made and in the continuous commitment to improving patient safety and quality outcomes, above all in meeting the needs of the population we serve including services provided within the Friarage and Friary hospitals and community services covering the Hambleton and Richmondshire area.

Humber and North Yorkshire ICB note the significant progress made in respect of patient safety, and in particular the journey in implementing PSIRF. We welcome the transparency in respect of areas whereby further improvement can be achieved and in detailing the quality priorities for the forthcoming year. As acknowledged the Trust remains committed to delivering a restorative and just culture and continue to develop in a positive way, evidencing collaboration within the Tees Hospital Group and a commitment to learning and sharing both within the Trust and across partnerships.

We note that throughout the Quality account there are many great examples where technology has been used to improve the patient pathway and maintain safe care; successes in applying the use of technology in a number of areas including learning from deaths and patient safety processes within the Trust. We note the transformational nature of the 2025/26 Quality Priorities identified and look forward to seeing the outcomes of further application of technology in supporting patient safety within the Trust.

HNY ICB note the national audits completed by the Trust which evidence positive results in ensuring patients receive excellent quality care with highest regional scores identified. We are pleased to see the presentation of the Trusts structured clinical audit programme, in evidencing the commitment to undertaking effective clinical audit across services. We recognise that this is a key element for providing high quality care and provides assurance and insight in informing targeted continuous quality improvement in developing and maintaining high quality patient-centred services.

We would like to acknowledge the introduction of a new quality priority for the forthcoming year, 2025/26, relating to the reduction of Healthcare Associated Infections and acknowledge the associated risks and challenges for both the system and hospital group.

We also congratulate the Trust on the South Tees Accreditation for Quality of Care (STAQC) model and the improvements Ward 12 have adopted and sustained to achieve Diamond status; in supporting clinical teams to move to outstanding through a culture of continuous improvement, leadership and positive engagement with both staff and patients.

Humber and North Yorkshire ICB confirm that to the best of our knowledge, the report is a true and accurate reflection of the quality of care delivered by South Tees Hospitals NHS Foundation Trust. The Quality Account is a transparent and positive document which demonstrates the Trusts continued commitment to co-production and quality improvement.

Humber & North Yorkshire Integrated Care Board remain committed to working with the Trust and its regulators to improve the quality and safety of services available for the population of each of our places in order to improve patient care, patient safety and outcomes. We note the

transformational nature of the Quality Priorities identified and look forward to seeing the outcomes of this work.

Yours sincerely

A handwritten signature in black ink, appearing to read "Deborah Lowe".

Deborah Lowe,

Director of Nursing (Quality, Safety and Patient Experience), NHS Humber and North Yorkshire Integrated Care Board

Councillor Edward Lynch
Chair, Middlesbrough Council's People Scrutiny Panel
C/o Town Hall
Middlesbrough
TS1 9FT

Diane Palmer – Interim Deputy Director of Quality
Lindsay Garcia – Director of Nursing
Diane Monkhouse – Medical Director
Rachel Scrimgour – Compliance and Regulation Manager

22 May 2025

Dear all

SOUTH TEES HOSPITALS NHS FOUNDATION TRUST DRAFT QUALITY ACCOUNT 2024/25

Thank you for attending the meeting of Middlesbrough Council's People Scrutiny Panel on Monday, 12 May 2025 to present the draft Quality Account 2024/25.

The panel welcomed the opportunity to participate in the consultation process and would like to feedback the points below in respect of the quality of services at the Trust.

As a preliminary, the panel noted the Quality Account Priorities for 2024/25 were as follows:

Patient Safety Priorities

1. Positive, just and restorative safety culture.
2. Learning from incidents, safeguarding concerns, claims and inquests.
3. Medication safety and optimising the benefits of ePMA.

Clinical Effectiveness Quality Priorities

1. Learning and improving patient outcomes from clinical practice and clinical audits.
2. Mortality review processes and learning from deaths.
3. Shared decision making and goals of care.

Patient Experience Quality Priorities

1. Patient feedback and continuous learning in care and treatment.
2. Responding in a timely way to complaints & implementing quality improvements.
3. Development and implementation of a Group Mental Health Strategy.

The panel is supportive of the 2024/25 priorities and looks forward to continuing to receive updates on progress during the year ahead.

In relation to these priorities and publication of the final Quality Account document, the panel wishes to highlight the following:

Martha's Rule

The Committee was pleased to hear about the introduction of Martha's Rule and the Trust being an early implementer of this. Members recognise that Martha's Rule offers a number of positive outcomes for patients and avoids further deterioration of their health. The panel looks forward to the next phase of implementation and receiving an update in due course.

Cancer – Diagnosis and Treatment

Prostate Cancer: Statements regarding the significant progress made in the reduction in timescales around the diagnosis and treatment pathways for patients were received positively by Members. The panel acknowledge the achievements made and the work undertaken to accomplish these reductions, particularly in terms of treatment waiting times – down from 62 days to approximately 25 days, and the efficient communication around benign diagnosis.

Lung Cancer: The panel recognise the value of the Tees Valley Targeted Lung Health Check Programme and the positive outcomes achieved to date. Specifically, the circa. 83% of occurrences, which were found at early stages in comparison to circa. 30% without the screening programme, are positively recognised. Members note that due to improvements in early detection/diagnosis, the pathology turnaround times continue to present challenge, and this is a key area of focus for the Trust over the next 12 months. The panel looks forward to receiving a further update regarding this in due course.

Patient Experience - Hospital Car Parking

A Member highlighted concerns around car parking and the patient experience at the South Tees Hospital site.

The Member explained that, over the last 12 months, he had attempted to gain further insight from the Trust in respect of car parking, with very little success. The following points were raised:

- The only reference to car parking matters in the draft Quality Account document relates to free or discounted car parking for carers visiting regularly (section b of the 'Patient Experience and Involvement Indicators' – 'Patient Experience and EDI'). It is felt that inclusion of only this point does not sufficiently convey the undue distress experienced by patients as a consequence of limited car parking, and the impact this has upon timely attendance at appointments.
- In terms of previous communications with the Trust, it was noted that the Member had made a request for a copy of the hospital's Car Parking Strategy in May 2024. However, to date, despite best efforts by the Member in following this up, this has yet to be received. In addition, communications between the Council and the Trust in respect of car parking could not be evidenced/were not recorded. In light of this, it is felt that the perceived lack of evidence of partnership working between the Trust and the Council dilutes the following statement in the draft document: '...providing consistent feedback to individuals who have taken the time to report events or concerns'.
- It was requested that a copy of the strategy be forwarded to the panel for information, and the issues around car parking be included in the final Quality Account document.

The comments that were made in response to the Members' concerns, which were described as 'reasonable, honest and transparent', were welcomed and it was stated that they would be investigated accordingly.

Mortality Reviews

The panel is appreciative of the data provided in respect of mortality and the explanation provided in respect of mortality and preventable deaths. This included the consideration of the Standardised Hospital Mortality Index (SHMI) and, although performance over 100% is regarded as 'poor', Members were pleased to hear of the improvements made over the last year in bringing this figure down from 110% to 104%. After further discussion around this topic area, it is evident that the Trust takes learning from incidents seriously and is keen to make improvements for patients and their families and/or carers.

The panel wishes to place on record its gratitude for the tremendous amount of work that has taken place over the last year by staff across the Trust, and look forward to welcoming you to future meetings.

Yours sincerely

Councillor Edward Lynch

Chair of Middlesbrough Council's People Scrutiny Panel (2024/2025)



Tees Valley Joint Health Scrutiny Committee

South Tees Hospitals NHS Foundation Trust Quality Account 2024-2025 – Third-Party Declaration

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

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

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

The Committee heard that the Trust had made improvements in Accident and Emergency (A&E), noting that concerted efforts to reduce wait times had resulted in a 1.7% decrease, significantly impacting patient outcomes. Ambulance handover times had also improved, allowing for faster turnaround and reducing delays in community response times.

Martha's Rule and Patient Advocacy

The Committee was pleased to hear about the introduction of Martha's Rule and reflected on its importance in ensuring patients and their families have a mechanism to escalate concerns when they feel their care needs are not being met. The Committee is aware that the next phase of the implementation will be to extend it to mental health trusts and maternity services and the Committee is keen to see progress on patient advocacy in these areas.

The Friarage Hospital

The Committee was impressed to learn that the Getting It Right First Time (GIRFT) programme, a national NHS improvement initiative, had recently conducted an inspection of the Friarage and deemed it to be one of the best surgical centres ever evaluated, with national accreditation

having been achieved. The Committee also welcomes the official opening, on 1 June 2025, of the Friarage's new surgical centre.

Management of Prostate Cancer

The Committee was pleased to hear that significant progress has been made in the management of prostate cancer, with waiting times for treatment reduced from 62 weeks to approximately 25 days. It is evident that the introduction of cancer navigators has proven instrumental in ensuring timely diagnostics and treatment for patients. The Committee was also pleased to learn that in cases where the initial MRI scan results are negative patients are now receiving this information within 10 to 12 days.

Targeted Lung Cancer Screening and Oncology Care Expansion

The Committee was impressed with the update provided in respect of the Targeted Lung Cancer Screening programme. The significant improvements in lung cancer diagnosis rates evident in the shift from 80% of cases being diagnosed at stage 3 or 4, to 80% now being detected at stage 1 or 2, allowing for earlier, more effective treatment.

The Committee acknowledged that these advancements in early diagnosis has placed additional pressure on oncology services and pathology departments, with a rise in demand of 24% since 2020/21. The Committee was pleased to hear that a £1 million funding allocation had been secured to support non-surgical oncology, facilitating enhanced clinical staffing and improve diagnostic pathways.

Vaping and impact on young people

The Committee highlighted its concerns about vaping addiction among young people, emphasising that the current cessation programmes were not effectively addressing nicotine dependency amongst young people. The Committee drew reference to a recent Panorama documentary that highlighted alarming statistics on youth vaping habits and associated health risks. The Committee expressed the view that the scale of addiction amongst young people was being underestimated, with disposable vapes hooking young people at an alarming rate and the long-term impact being greater than anticipated.

Mortality Reviews

The Committee highlighted data provided in respect of mortality reviews and queried the lack of inclusion of Black and Minority Ethnic (BME) patients as a specific criterion for requesting a mortality review, despite emerging national discussions about health outcome disparities in BME populations. The Trust acknowledged the issue and agreed for it to be taken back to the Trust for further evaluation.

Urgent Care Access

The Committee highlighted concerns regarding operational inconsistencies in respect of the Redcar Urgent Treatment Centre (UTC). Reference was made to specific cases where patients had been directed to James Cook University Hospital (JCUH) despite Redcar's UTC being equipped to handle their treatment. The Trust acknowledged the issue and confirmed that there are variations in triage decisions across different UTC sites. The Committee heard that a key factor contributing to these variations is differences in individual risk appetite among clinicians. The Trust agreed that standardising the triage protocols across the different urgent treatment

sites remains a priority and horizontal integration efforts were underway. The Committee is keen to receive further updates in respect of the progress made.

Finally, the Committee wishes to place on record its gratitude for the significant work that has taken place over the last year by staff across the Trust and emphasis on promoting patient safety.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Cooper'.

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

**Healthwatch Middlesbrough &
Healthwatch Redcar and Cleveland**
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Healthwatch South Tees response to South Tees Hospitals NHS Foundation Trust Quality Account 2024-2025

Healthwatch South Tees is pleased to have the opportunity to comment on the South Tees Hospitals NHS Foundation Trust Quality Account.

We appreciate the effort that has gone into compiling this comprehensive Quality Account. The document provides valuable insights into key achievements, ongoing challenges, and areas of improvement across the Trust.

There are some minor grammatical errors which we have listed separately and quite a few abbreviations in need of definition, at least when they are first used.

Key Highlights and Positive Observations

- A well-structured introduction that clearly outlines the full range of services the Trust provides.
- **Antimicrobial Stewardship (AMS) Study Day (Page 12, para 1)**
It is encouraging to see reference to this vitally important topic. Given its significance could greater emphasis be placed on its outcomes and impact?
- **Patient and Carer Involvement (Pages 18-19)**
 - *Shared decision-making and goals of care (Page 18):* The work being done to enhance patient involvement in decision-making is commendable.
 - *Carer involvement (Page 19):* It is reassuring to read of carers becoming more involved in the process of “continuous improvement in care and treatment.” and to improve relevant staff communication skills.
- **Patient Safety (Pages 45-49)**
The emphasis on patient safety is reassuring. It is good to see strong frameworks in place to uphold high standards.
- **Research and Innovation (Page 50)**
It is encouraging to see research and innovation continue to be valued within the Trust. This ongoing commitment helps drive improvements in patient care.

Areas for Consideration and Further Clarification

- **Diagrams and Readability (Pages 13, 14, 51)**

- Some diagrams, particularly on Pages 13 and 14, are difficult to read due to their size. Given the marked improvement in National Clinical Audit achievement, it would be beneficial for these visuals to be enlarged for clarity.
- Similarly, Figures 17 and 18 on Page 51 could be presented in larger type to improve readability.

- **National Clinical Audits (Page 28, Table 2)**

- A brief explanation as to why not all mandatory national clinical audits were completed would be helpful.
- The Trust highlights results from five national audits. If these were selected due to their excellent performance, it would be beneficial to explicitly state this and highlight key successes.

- **CQC Ratings (Page 31)**

A few words explaining how the CQC arrives at its rating of the Trust would provide helpful context.

- **Cancer Waiting Times (Pages 68-69)**

These figures are concerning. Could an explanation be provided regarding the contributing factors to this performance? Is it an issue of service provision, demographic factors within the catchment area, or a combination of elements?

- **Cross-Referencing (Page 45)**

There should be a reference here to the statement made on Page 14, linking to Section 2.13 regarding the Care Quality Commission (CQC) assessment. This would improve coherence within the document.

Overall, this Quality Account provides an informative and thorough overview of the Trust's progress and ongoing initiatives. Strengthening areas such as readability, clarity on audit results, and explanations for key performance metrics would enhance the accessibility and impact of the document. We appreciate the continued commitment to improvement and look forward to seeing the Trust's ongoing progress.

Yours faithfully



Linda Sergeant

HWST Project Lead

Annex 2: Statement of directors responsibilities for the quality report

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

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

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19.
- the content of the quality report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2024 to March 2025.
 - papers relating to quality reported to the board over the period April 2024 to March 2025.
 - feedback from commissioners dated 19 May 2025.
 - feedback from local Healthwatch organisations dated 2 June 2025.
 - feedback from Tees Valley Joint Health Scrutiny Committee dated 3 June 2025.
 - feedback from Middlesbrough People Scrutiny Panel dated 22 May 2025.
 - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2024.
 - the latest national patient survey published November 2024 (Maternity).
 - the latest national staff survey published 13 March 2025.
 - CQC inspection reports dated 24 May 2023 and 19 January 2024 (Maternity).
 - the Internal Auditor (PwC) Audit Opinion report on the adequacy and effectiveness of governance, risk management and control dated 20 May 2025.
- 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



23 June 2025

Derek Bell, Group Chairman



23 June 2025

Stacey Hunter, Group Chief Executive

Annex 3: Glossary of terms

18 Week RTT (Referral to Treatment)

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

A&E

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

Acute

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

Allied Health Professional (AHP)

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

Assurance

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

BadgerNet

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

Black, Asian and minority ethnic (BAME)

All ethnic groups except white ethnic groups; it does not relate to country origin or affiliation.

Board of Directors (of Trust)

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

Care Quality Commission (CQC)

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

CQC Quality Statements

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

Clostridioides difficile infections (CDI)

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

Clinical audit

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

Clinician

Professionally qualified staff providing clinical care to patients.

Commissioners

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

Commissioning for Quality and Innovation (CQUIN)

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

Consultant

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

Council of Governors

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

Datix

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

Duty of Candour

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

Elective

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

Electronic Patient Record (EPR)

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.

Getting it Right First Time (GIRFT)

The Getting It Right First Time (GIRFT) programme is a national NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

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.

Health Services Safety Investigations Body (HSSIB)

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

Inpatient

Patient requiring an overnight stay in hospital.

InPhase

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

Integrated Care Board (ICB)

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

LeDeR

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

Learn from Patient Safety Events (LFPSE)

A national NHS system for the recording and analysis of patient safety events that occur in healthcare.

LocSSIP (Local Safety Standards for Invasive Procedures)

These are local processes/procedures in place to reduce the number of patient safety incidents related to invasive procedures, in which surgical 'Never Events' can occur.

Malnutrition Universal Screening Tool (MUST)

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

Medical Examiners

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

MIYA Noting Electronic Patient Record

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

Multidisciplinary Team (MDT)

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

National Institute for Health and Clinical Excellence (NICE)

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

NCEPOD

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

National Patient Survey Programme

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

NHS England (NHSE)

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

NEQOS (North-East Quality Observatory Service)

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

North Tees and Hartlepool NHS Foundation Trust

Includes University Hospital of North Tees, University Hospital of Hartlepool, Peterlee Community Hospital.

Overview and Scrutiny Committees

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

PALS (Patient Advice and Liaison Service)

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

Patient Reported Outcome Measures (PROMs)

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

Payment by Results

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

PLACE (Patient-led Assessments of the Care Environment)

PLACE assessments are an annual appraisal of the non-clinical aspects of the NHS and independent / private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The team must include a minimum of 50% patient assessors. They provide a framework for assessing quality against common guidelines and standards.

Pressure Ulcer

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

Providers

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

PSIRF (Patient Safety Incident Response Framework)

Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRP (Patient Safety Incident Response Plan)

Sets out how the organisation will respond to patient safety incidents. The PSIRP outlines which patient safety incidents should be reviewed and investigated and which approach should be applied in different scenarios.

Regulations

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

Research

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

Risk

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

Risk Assessment

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

Service user

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

Spell

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

STAQC (South Tees Accreditation for Quality of Care)

STAQC is a ward / department accreditation programme which brings together key measures of nursing and clinical care into one overarching framework.

STRIVE (South Tees Research, innovation and education)

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

Summary Hospital-level Mortality Index (SHMI)

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

South Tees Hospitals NHS Foundation Trust

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

TEWV

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



South Tees Hospitals NHS Foundation Trust

James Cook University Hospital,
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