NHS
North Tees and Hartlepool
NHS Foundation Trust

Quality account

2023-24

Caring
Better
Together

Contents

Part 1. Statement on quality from the Chief Executive

Group Chief Executive's Statement

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

The Quality Account provides the opportunity to showcase many of the innovative practices being carried out across the organisation in support of our chosen quality priorities to help us to meet the needs of our population.

As an organisation we always strive to deliver the best health and care possible through constantly making improvements and acting upon the feedback we receive. Listening to the voices of our patients is a vital part of our work, learning from their lived experiences helps us to continually develop the services we provide.

The priority areas for 2023-24 chosen by our stakeholders were mortality, mental health, infections, learning from deaths, discharge processes, accessibility, violent incidents, safety and quality dashboard, palliative care and measuring if our care is good.

Through our focus this year to better understand the needs of our patients and gain insight into patients' experience of our services, we have spoken with over 20,000 patients in a variety of settings including their own homes, community clinics, and our hospital wards. We have set-up this year a new patient involvement bank, which will enable us to actively engage with patients even more.

Our commitment and dedication to support patients and their families with Dementia continues. It is a stark fact that across Stockton on Tees and Hartlepool we will have the highest projected increase of dementia across the North East by 2025, making this work even more important. Two elements of this are the promotion of John's Campaign which empowers the family or carers of our dementia patients to be involved in the delivery of care to their loved one whilst they are in hospital and provides flexibility around visiting times to ensure the needs of the patient are best met. I am also pleased to report that both North Tees and Hartlepool Hospitals have received the accolade of being Dementia Friendly.

The Trust increasingly cares for patients with mental health conditions and aims to provide high quality mental healthcare to these patients across all our services. By adopting the approach to focus on the whole person, healthcare professionals will be knowledgeable and confident in understanding mental health conditions and know how to access mental health services when required through our successful joint partnership with the mental health trust, Tees Esk and Wear Valleys NHS Foundation Trust.

Protecting the rights of our most vulnerable patients to live in safety, free from abuse and neglect involves the right people and organisations working together to prevent and stop the risks of abuse or neglect from occurring. The Trust's Adult and Children Safeguarding Teams work closely with the relevant agencies to provide the best support to these patients.

During 2023-24 a total of 764 concerns regarding Adult patients were raised compared to 660 the previous year, which reflects an increasing awareness and reporting of such concerns. The Trust continues to promote the importance of listening to children and considering their lived experiences, ensuring for those Children in our Care their wishes and feelings are captured to ensure all of their health needs are being met.

The management of all infection rates remains a priority. The Trust reported 70 cases of Clostridioides difficile against a target of 46 during 2023-24 and is working hard to control and reduce opportunities for infections to spread. Increased cleaning provisions in line with national cleaning standards has been rolled out to help tackle all infections, with additional specific environmental cleaning for Clostridioides difficile. The adherence to high standards of hand hygiene for patients, visitors and staff plays a key role in helping to reduce the incidences of infection.

Our practices around improving hospital discharge and patient flow have improved with the Integrated Coordination Centre now fully embedded ensuring effective management, planning and response of patient flow supported by the OPTICA electronic discharge tool. The Trust's Discharge Flow Facilitator team play an important role liaising with all relevant agencies to support a positive and appropriate discharge journey for our patients. We have continued to gain recognition due to the benefits this is bringing. It has been positive for our teams to welcome visits from national and regional teams to share our effective solutions across these pathways.

Mortality was again a priority area for us during this year because we are committed to reduce avoidable deaths through monitoring and reviewing mortality indicators. During 2023-24, the Trust's Summary Hospital-level Mortality Indicator or 'SHMI' has consistently remained in the 'as expected' range. This reflects the positive impact of the previous improvement work undertaken within clinical coding to ensure the coding records an accurate reflection of the level of sickness for our patients with multiple conditions or 'comorbidities'.

Our journey of improvement is continuous and as we look forward we are already actively working towards the priorities for 2024-25 with a key focus on patient safety, patient experience and clinical effectiveness initiatives, which support the organisations ethos of openness, fairness and accountability.

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.

Stacey Hunter
Group Chief Executive

What is a Quality Report/Accounts?

Quality Accounts are the Trust's annual reports to the public about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to define our priorities for the next year to indicate how we plan to achieve these and quantify their outcomes.

Our Quality Pledge

Our Board of Directors receive and discuss quality, performance and finance at every Board meeting. We use our Quality Committee to provide assurance in relation to patient safety, effectiveness of service, quality of patient experience and to ensure compliance with legal duties and requirements; the Audit Committee is to review our systems of internal control. Non-Executive directors with recent and relevant experience chair both the Quality and Audit Committees, these in turn report directly to the Board of Directors.

The Board of Directors seek assurance on the Trust's performance at all times and recognise that there is no better way to do this than by talking to patients and staff at every opportunity. A departmental visiting programme supports this oversight.

Quality Standards and Goals

The Trust values the contributions made by all members of the organisation to ensure challenging standards and goals are achieved which are set to deliver high quality patient care. The Trust also works closely with commissioners of the services provided to set challenging quality targets. Achievement of these standards, goals and targets form part of the Trust's four strategic quality aims.

Unconditional CQC Registration

During 2022-23 the Trust met all standards required for successful and unconditional registration with the Care Quality Commission (CQC) for services across all of our community and hospital services.

Listening to Patients and Meeting their Needs

We recognise the importance of understanding patients' needs and reflecting these in the Trust values and goals. Patients using the services deserve excellent clinical care delivered with dignity, compassion, and professionalism and these remain our key quality goals.

Over the last year we have spoken with over **20,000** patients in a variety of settings including their own homes, community clinics, and our inpatient and outpatient hospital wards as well as departments. We always ask patients how we are doing and what we could do better.

CQC Rating

The most recent CQC visit took place between the 3 to 26 May 2022. The Trust has been rated as **'Requires Improvement'**, additional detail regarding the recent visit is located in the CQC section on page 95.

Part 2a. 2023-24 Quality Improvement Priorities

Part 2 of the Quality Account provides an opportunity for the Trust to report on progress against quality priorities for 2023-24 that were agreed with external stakeholders in 2022-23.

Stakeholder priorities 2023-24

The quality indicators that our external stakeholders said they would like to see reported in the 2023-24 Quality Accounts were:

Patient Safety	Effectiveness of Care	Patient Experience
Mortality	Learning from Deaths	Palliative care and care for the dying patient (CFDP)
Dementia	Discharge Processes	Is our care good? (Patient experience surveys)
Mental Health	Accessibility	Friends and Family Test
Safeguarding (Adult and Children)	Violent Incidents	
Infections	Safety and Quality Dashboard	

Priority 1: Patient Safety

Mortality

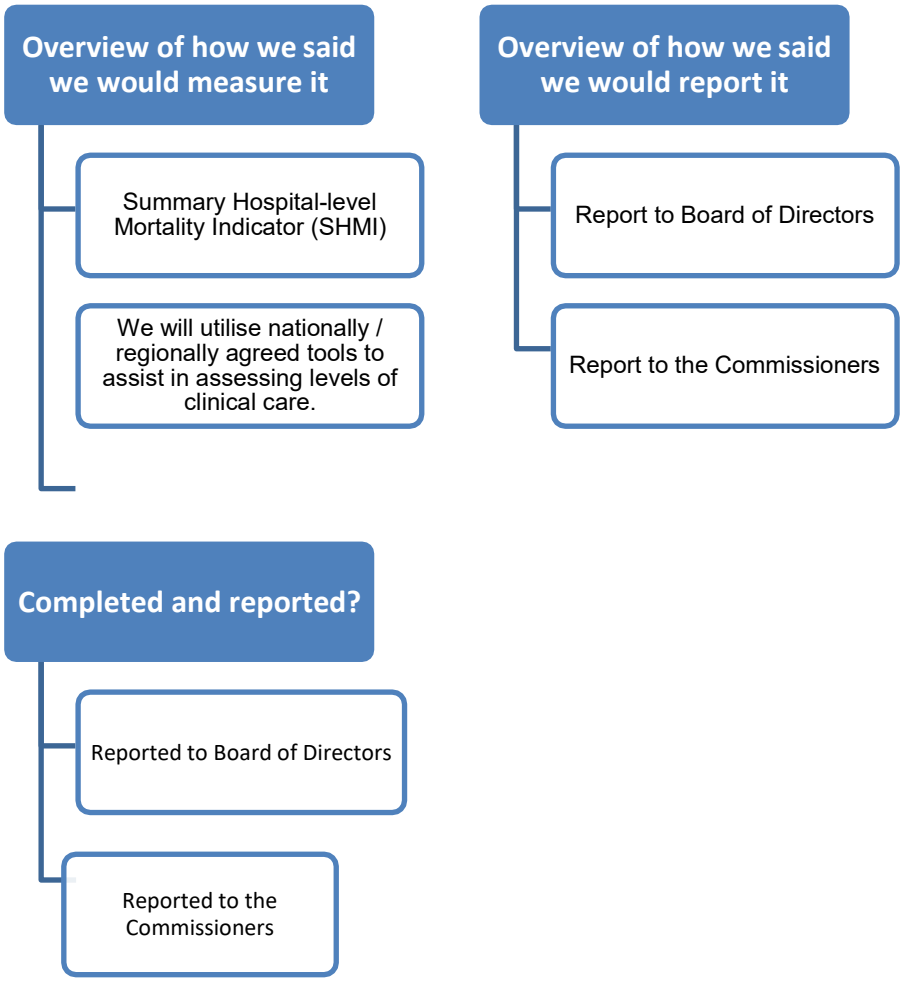
Rationale

To reduce avoidable deaths within the Trust by reviewing all available mortality indicators.

Overview of how we said we would do it

The Trust planned to:

- Monitor the Summary Hospital-level Mortality Indicator (SHMI), the information the data provides and the national comparisons.
- Use the Healthcare Evaluation Data (HED) benchmarking tool to monitor and interrogate the data to determine areas that require improvement.
- Review and improve existing processes involving palliative care, clinical documentation and clinical coding.
- Continue to work with the North East Quality Observatory System (NEQOS) for third party assurance.



Progress in 2023-24

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI indicator provides an indication on whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline in England. The SHMI is released 6 months in retrospect. SHMI includes deaths up to 30 days after discharge and does not take into consideration palliative care.

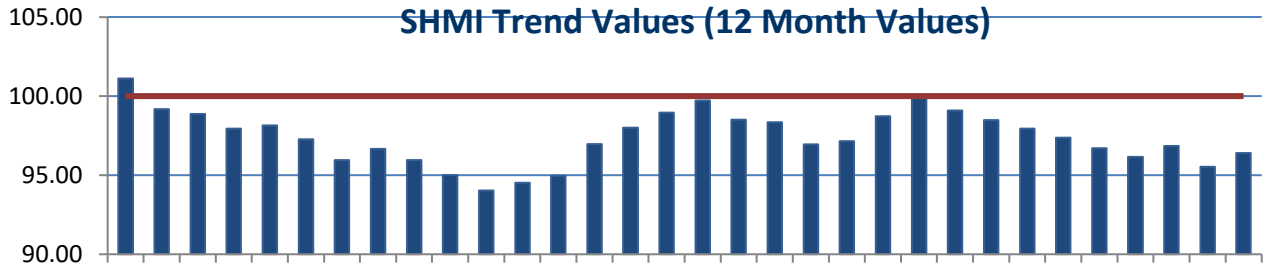
During 2023-24, the Trusts SHMI has consistently been maintained in the **'as expected'** range. This reflects the positive impact of the previous improvement work undertaken within the clincial coding mechanisms to ensure the coding provides an accurate reflection of the level of sickness for our patients with multiple comorbidities.

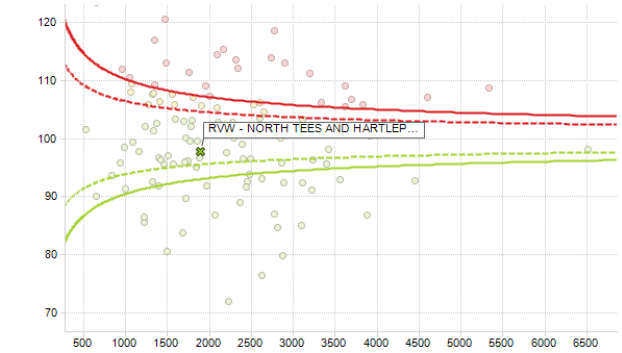
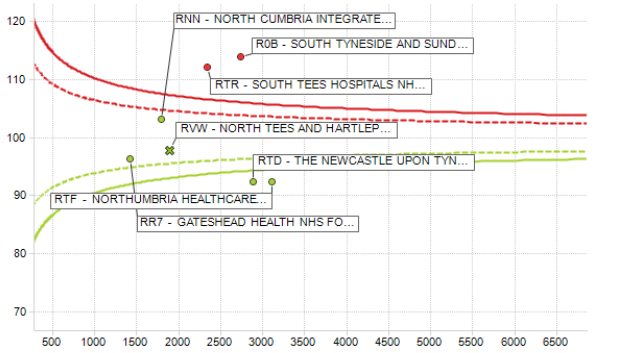
The latest SHMI value of **97.70** **(January 2023 to December 2023)** continues to reside in the **'as expected'** range.

Reporting Period	*CMR	SHMI
Jan 23-Dec 23	-	97.70
Dec 22-Nov 23	-	97.80

Nov 22 - Oct 23	**3.24%**	**96.40**
Oct 22 - Sep 23	**3.24%**	**95.53**
Sep 22 - Aug 23	3.30%	**96.83**
Aug 22 - Jul 23	3.27%	**96.15**
Jul 22 - Jun 23	3.29%	**96.70**

*Crude Mortality Rate (CMR)



National View	Regional View
	

*Data obtained from the Healthcare Evaluation Data (HED)

The top graph shows the variation in the SHMI data since 2021 and highlights that it has stayed within the expected range. The two funnel charts below show where we are placed in comparision to regional and national perfomance. The Trust is well positioned and within the expected range.

Learning from Deaths Improvement Work

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

Recognition of Dying –Recognition of dying is included in palliative care training for all clinical groups. Results from the 2022 National Audit of Care at the End of Life suggest that we are beginning to recognise dying earlier.

This recognition has enabled transfer of some patients to designated end of life hospice beds if that is their wish.Mouth Care – Cases of poor mouth care were identified leading to review of end of life training to ensure that this is included. The importance of good mouth care is promoted regularly by the end of life facilitator.

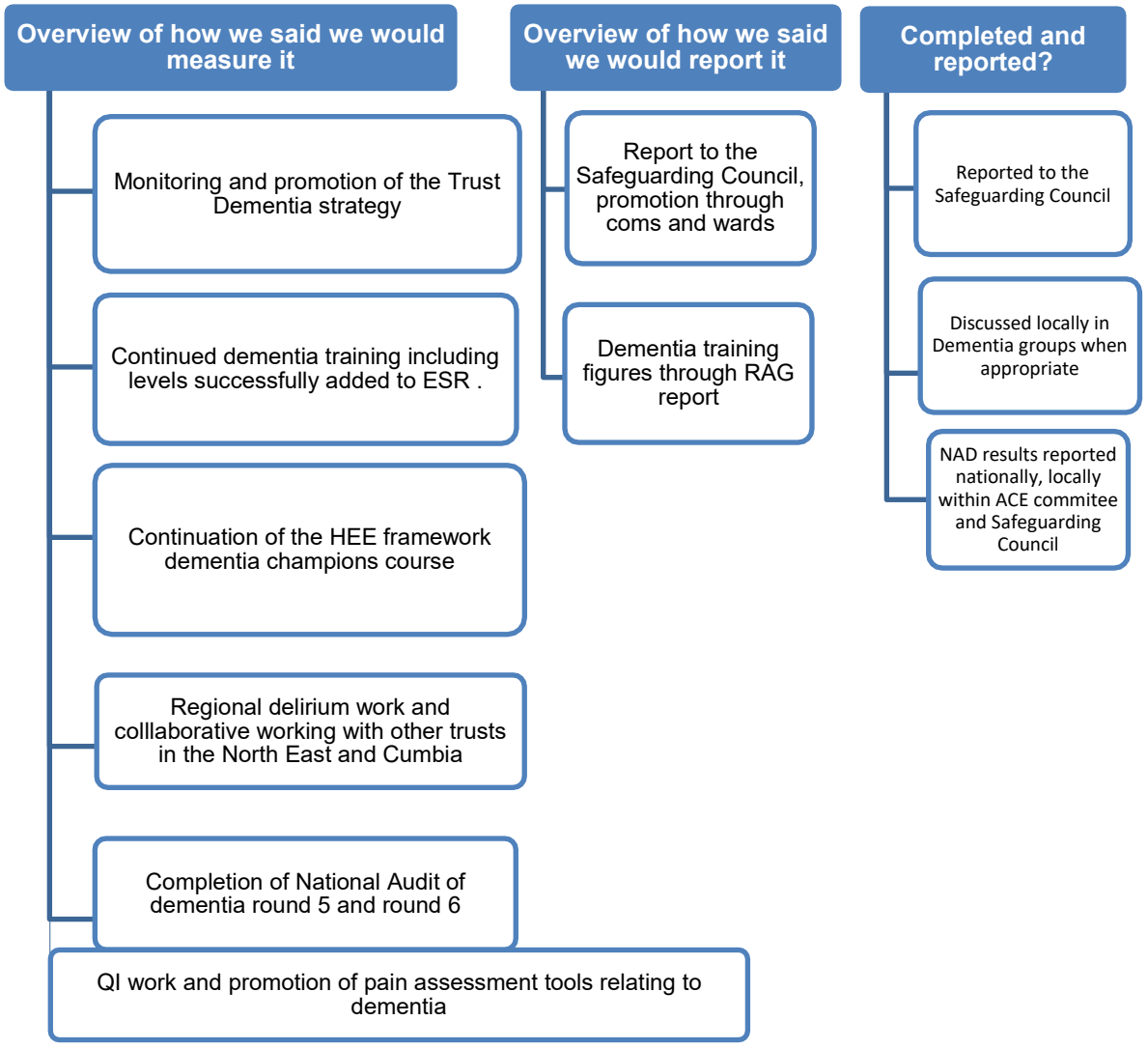
Recognition and escalation of deteriorating patient – The trust has a robust Critical Care Outreach Team and also, now, Deteriorating Patient Nurse Specialists. ‘Call for Care’ (arising from ‘Martha’s Law’) has been introduced across the Trust. The electronic admission document now includes a Treatment Escalation Plan. Community staff have undertaken ‘Soft Signs’ training to improve detection of deteriorating patients in the community.

Priority 1: Patient safety

Dementia

Rationale

NHS Hartlepool/Stockton on Tees has the highest projected increase of dementia across the North East by 2025. All stakeholders identified dementia as a key priority. The region has an 85.8% diagnostic rate. This is significantly higher than the 66.7% national benchmark and shows the progress the region has made in relation to accurate and timely diagnosis.



Round 5 of the national audit of dementia completed in Spring 2023, the results were presented at ACE committee and Safeguarding Council in October 2023.

The National audit of Dementia (NAD) round 6 commenced in September 2023 and concluded January 2024. North Tees and Hartlepool were once again involved. It consisted of 40 patients with a diagnosis of dementia, and was broken down into 3 parts: Part 1 admission, Part 2 inpatient stay and Part 3 discharge. It was a repeat of round 5 with a smaller sample size. There was also a carers and patients questionnaire, and an organisational audit in relation to dementia care, the local and national reports are due to be released during autumn 2024.

What we have achieved in the last year

- Ongoing monitoring of achievements set out in the North Tees and Hartlepool Dementia Strategy have been shared to promote our vision for supporting the people living with dementia that we serve. Improvements are monitored through the national audit of dementia reports and feedback from carers and patients living with dementia.
- Cross-reference of people with a potential dementia diagnosis with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) to check if a clinical diagnosis has been confirmed. If this is the case, an alert is added to Trakcare system. This alert assists all staff including the dementia champion that is available on every ward. This is to continue, and has proved very helpful in terms of identifying patients with a dementia diagnosis.
- The Health Education England (HEE) Tier 2/3 dementia champions' course has continued to support staff to be leaders in their area in dementia care. This has supported more focus on improvements, with more evidence from dementia champions of improved dementia care in their area post course completion.
- Developed update session for existing dementia champions including new content with national and regional updates.
- Ongoing involvement in the regional HEE delirium group, working with regional trusts to improve awareness of delirium in patients with dementia.
- Results from round 5 of the National Audit of Dementia (NAD) were presented at ACE committee and Safeguarding Council in October 2023. 100% of patients were screened for delirium within the first 24 hours of admission.
- Participation in round 6 of the NAD commenced in September 2023 and concluded January 2024. It involved 40 patients with a diagnosis of dementia, and was focused on admission, inpatient stay and discharge. There was also a carers and patients questionnaire, and an organisational audit in relation to dementia care. The local and national reports are due to be released during autumn 2024.
- Analysis of NAD round 5 results identified that our Trust needed to improve the formal assessment of pain in people living with dementia. Pain scales have been added to Trakcare and related quality improvement (QI) work completed. The Trusts Safeguarding team presented at the Royal College of Psychiatry in London in relation to the QI work.
- The Community Dementia Liaison Service (CDLS) is commissioned for Hartlepool only. They had 133 patient referrals during 2023-24 and are supporting 124 carers. The CDLS have developed a resource library where patients and carers they support in Hartlepool community can 'borrow' activity or reminiscence items to try at home, rather than purchasing items and finding they are not appropriate. Items are logged in and out and this has received vey positive feedback from patients and families.

Continuing to improve carers and family support

- Informing carers what services they can access and how through notice boards, carers packs and service improvements from dementia champions.
- Increased information on how they can access individual carer's assessment.
- Both Local Authorities have a detailed directory of services to support people living with dementia and their carers and families.
- Support and advice for financial and social benefit.
- Hartlepool carers regularly visible in UHH concourse.
- Continued involvement in the dementia networks groups and dementia friendly Hartlepool group.
- Community Dementia Liaison Service run carers support sessions through The Bridge at Hartlepool, to support and educate carers of people living with a dementia.
- Continue to promote John's Campaign (www.Johnscampaign.org.uk). This supports carers to outline which elements of care or support they would prefer to do for the patient whilst in hospital, and which elements they would prefer staff to complete. It also outlines allowances for carers and family i.e. if family or carers are spending significant amounts of time visiting, allowing

flexible visiting, and ability to order from the hospital menu for themselves. The Trust now has an agreement with Parking Eye regarding parking allowances for eligible families and carers.

- John's Campaign shows as an alert on Trakcare for staff awareness.
- University Hospital of North Tees has become part of Dementia Friendly Stockton and University Hospital of Hartlepool has also been given this accolade. The aim is to continue to develop close and consistent links with relevant local agencies.

Patients admitted to the Trust with a diagnosis of dementia and/or delirium

The challenges the Trust faces regarding patients admitted with a diagnosis of dementia and/or delirium is an unfortunate increasing trend.

Financial Year	Patients admitted to the Trust with a diagnosis of Dementia/Delirium	Increase or Decrease from Previous Year
2016-17	3,298	+587
2017-18	3,614	+316
2018-19	4,218	+604
*2019-20	3,784	-434
*2020-21	3,253	-531
2021-22	3,624	+371
*2022-23	3,842	+218
*2023-24	3,730	-112

*Data from Information Management Department April 2023 to March 2024
** 2019-20 and 2020-21 affected by Covid-19

Dementia training

Level 1 - Dementia awareness raising
This includes general awareness of what dementia is, different types of dementia and how it may affect the person. Basic skills and approaches are included in this training. This is mandatory to the entire workforce in health and care, involving the completion of 'Essential Dementia Workbooks' at the appropriate level according to job role. This is also available as an e-learning package. There has been an identified training need for the Trust volunteers in relation to dementia. As a result, volunteer training in dementia and delirium is offered regularly and attendance is always good.

Level 2 – Knowledge, skills and attitudes for roles that have regular contact with people living with dementia
This includes all of the content of level 1, but in more detail. It includes treatment options, information on more complex behaviours as a result of cognitive impairment, and provides a variety of options for the staff try to provide the best care possible. The team also provide a 2 hour face to face training session. This is constantly evaluated and updated. It is also delivered to all new recruits to the Trust including overseas nurses, newly qualified staff, students, return to practice nurses, staff attending trust induction, and can be delivered on request for team days. Level 2 e-learning is now also available on the electronic staff record (ESR) system.

Level 3 – Enhancing knowledge, skills and attitudes for key staff in a leadership role
Level 3 can be accessed on ESR, but for a more in depth course we have the dementia champions course available to all staff regardless of role within the Trust. It provides staff with a high level knowledge of dementia, assessment, diagnosis and treatments. It gives the learner opportunities to become confident enough to be a leader in their clinical area. Attendees of level 3 will also get information on carer support, national audits and techniques for managing behaviours that challenge in relation to people living with dementia.

Dementia

Barbara's story is a training programme to raise awareness of how it feels to be a patient with dementia. This training involves support from other multi-disciplinary teams as well as guest speakers where available. It is open to all staff, of any profession or grade, either inpatient or community.

To support this level of training we have the Trust dementia champion programme which, following feedback, has been reviewed and now runs over two consecutive days quarterly. The purpose of the dementia champions is to create an individual with a high level of knowledge of dementia.

We are placing more emphasis on the role of the dementia champions and have compiled a list of expectations which outline their responsibilities following the course, and we request evidence of an improvement in their practice, or in their work area before they receive their certificate.

Dementia champions are required to have update training every 3 years to remain on the champion register. This is delivered in one 2.5 hour session and includes new material as well as recent developments in the Trust, nationally and internationally. This is in line with the Health Education England framework recommendations.

Training compliance 2023-24

Training level	Staff trained
Dementia level 1	96%
Dementia level 2	96%
Dementia level 3	98%

*Data obtained from the Trust dementia training for March 2024.

Priority 1: Patient safety

Mental Health

Rationale

High quality mental healthcare offered to patients across the services we provide is our aim. Integrating mental and physical health and social care will improve patient experience and outcomes, as well as staff experience, and reduce system costs and inefficiencies. However, good integrated care for people with mental health conditions often appears to remain the exception rather than the rule, with physical healthcare and mental healthcare largely disconnected. There has been, and still are, many drivers to try and change the situation, to improve the care for this patient group.

By focusing on the whole person, healthcare professionals will be knowledgeable and confident in understanding and managing mental health conditions and knowing when and how to access mental health services for the patients they see. The integration of all healthcare professionals to provide care as needed for each patient is a crucial part of the solution to providing a higher quality of care to all patients.

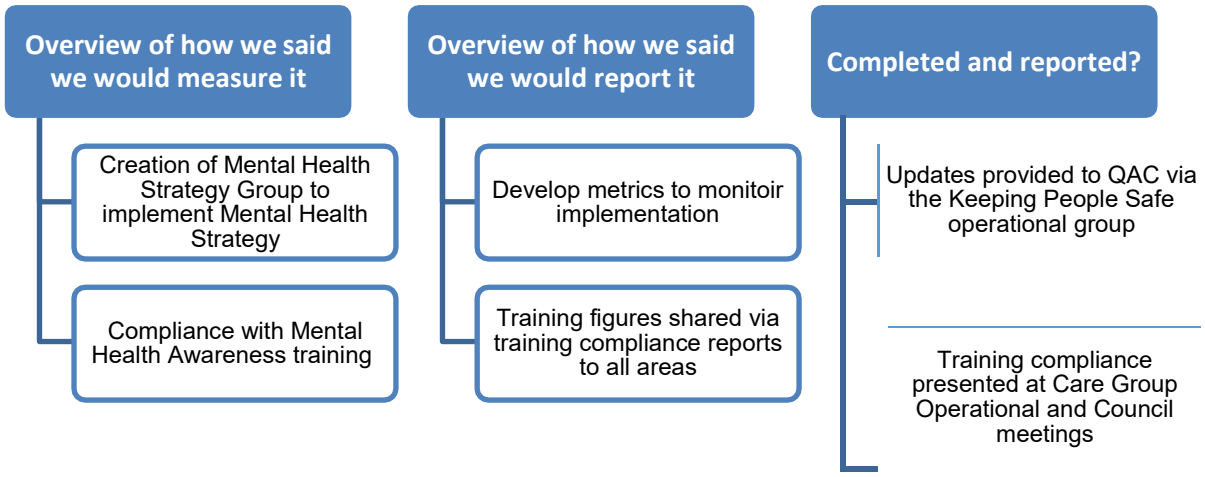
We aimed to:

- Embed integrated mind and body care as common practice, joining up and delivering excellent mental and physical health care, research and education so that we treat the whole person.

- Improve patient care and staff experience through the sustainable provision of effective learning and development of our workforce.
- Provide services where users routinely access care that addresses their physical and mental health needs simultaneously provided by services and staff who feel valued, supported and empowered to do so.

To achieve these aims the objectives were to:

- Foster positive attitudes towards integrated mental and physical health, combatting stigma.
- Improve recognition and support for both the mental and physical health needs of patients.
- Assist staff to access support and resources for working with mind and body.
- Ensure that mind and body care is addressed at all levels of healthcare.
- Engage local partners in improving mind and body training and subsequently care.
- Through Treat as One, develop a 1 day, tier 2 course to ensure that appropriate staff have a more in-depth understanding of how mental health and physical health are linked.



What we have achieved in the last year

During 2023 a Mental Health Strategy was developed to set out our ambitions for the next three years and to demonstrate how the Trust will work alongside Tees, Esk & Wear Valley Mental Health Trust (TEWV) towards delivering an integrated approach to physical and mental health.

This strategy is focussed on the mental health of our patients and how we best support this. The Trust also recognises that good staff mental health is a vital component of ensuring the wellbeing of our workforce. A staff mental health and support programme is delivered by the Workforce and Occupational Health teams in the Trust and supports staff in all areas of health and wellbeing. During 2024-25 the progression of this strategy will be supported by ongoing collaboration with South Tees NHS Foundation Trust as part of the overall Group developments.

Our vision

- Over the next three years, we want to achieve a culture change across our organisation.
- We will aim to further reduce stigma surrounding mental health and enable our staff to embrace conversations about mental health and wellbeing.
- Mental health will be considered in all initiatives and developments Trustwide.

We have three key objectives:

- Improve the quality of care that we deliver to our patients, carers and families who are living with serious mental illness.
- Support patients with long term physical health conditions to identify and manage their mental health needs.

- Ensure our workforce has the right skills, knowledge and attitudes to recognise and care for patients, carers and families with mental illness.

How we will progress this:

- Provide quarterly updates to the Quality Assurance Council. This will include exception reporting for assurance purposes to the Board of Directors.
- Develop metrics to monitor implementation of the strategy.
- Continued participation in local Health and Wellbeing Boards and Integrated Care Partnership forums including evolving Mental Health Partnership Board.Priority 1: Patient safety

Safeguarding - Safeguarding Adults

Rationale

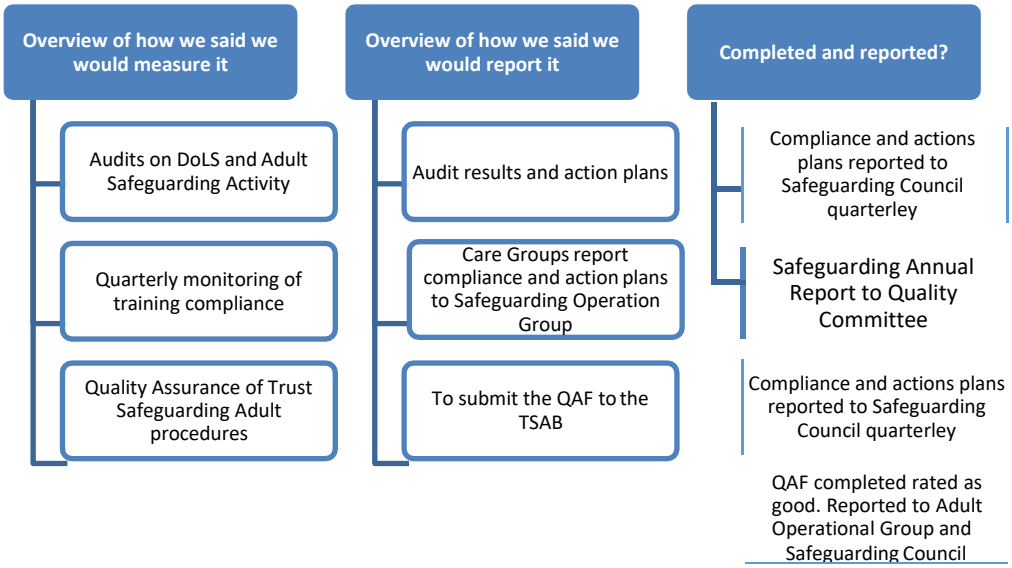
Adult safeguarding protects an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

Adult safeguarding is defined by the Care Act (2014) and is carried out where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect;
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Overview of how we said we would do it

- Ensure staff are well equipped to deal with adult safeguarding issues and have a good understanding of the categories of abuse.
- Ensure staff are aware of how to raise a safeguarding concern.
- Continue to increase the visibility of the Adults Safeguarding Team.
- Development of a work programme that outlines the plans for audit and monitoring of the Trust policy to identify good practice and learning with potential areas for improvement.
- Update the Trusts Quality Assessment Framework (QAF) relating to adult safeguarding. This is an annual requirement of the Trust as a partner within the Tees-wide Safeguarding Adults Board (TSAB).



What we have achieved in the last year

The Trust has continued to work to enhance and develop standards for safeguarding adults across hospital and community services. The Care Act (2014) has been embedded in practice and close working with the Teeswide Safeguarding Adults Board (TSAB) has helped to update policies and procedures in a coordinated approach. The TSAB reviewed the updated QAF and gave an overall rating of GREEN which means it was fully achieved, identifying consistent evidence of good practice. Good practice areas were identified including how senior managers are kept informed and are updated regularly about all safeguarding activity.

The Adults Safeguarding Team continue to raise the profile and visibility of adult safeguarding; this is in the form of walkabouts, teaching activity and attendance at Trust and multiagency meetings.They provide mandatory safeguarding training compliant with intercollegiate requirements.

Trust Adult Safeguarding Governance Arrangements

The Chief Nurse, Director of Patient Safety and Quality, is the executive lead for safeguarding adults, supported by the Associate Director of Nursing and Patient Safety, with the Named Nurse Safeguarding Adults holding the overall operational responsibility. Care Group management teams are responsible for practices within their own teams and individual clinicians are responsible for their own practice.

The Trust Safeguarding Council is a joint (children and adults) strategic group, which reports to the Quality Committee, and includes representatives from key Trust clinical and non-clinical directorates as well as partners from the Local Authority and Harbour (a domestic abuse support provider).

The Adult Safeguarding Operational Group encompasses adult safeguarding, learning disability, dementia, MCA and DoLS, Prevent and mental health as standard agenda items and membership. This supports sharing of information and lessons learnt so that they can be incorporated into relevant work streams relating to the most vulnerable groups.

The Trust is represented at the Tees-wide Safeguarding Adult Board and its subgroups. This ensures co-ordinated multiagency working, which safeguards and protects adults with care and support needs who are at risk of abuse or neglect.

Trust Safeguarding Activity

The Trust produces a quarterly adult safeguarding report with the purpose of providing the Trust Safeguarding Council members with an overview of safeguarding activity. The objective of this is to

disseminate information relevant to their areas of representation. Additionally, the importance of two way communications are recognised as vital to ensure safeguarding adult activity is embedded within practice across adult health and social care. Therefore, this report highlights areas of good practice within all service areas requiring development as well as providing providing an update on actions agreed from discussion within the group

The data contained in the reports includes:

- Number of safeguarding concerns raised
- Number of concerns raised by location
- Number of concerns raised by theme
- Incidents raised by type of abuse, Trust role and outcome
- Number of DoLS applications made by the Trust
- Training compliance figures

Number of Safeguarding Concerns / Enquiries raised within the Trust

The Trust has moved to a new incident reporting system called InPhase which is used to manage and record safeguarding concerns. This helps to collate data and identify trends and themes. The data produced is governed through the quarterly Safeguarding Adults Operational Group, Safeguarding Council and the Quality Committee.

There have been **764** concerns the Trust has been involved with in 2023-24. This reflects a continuing increase in reported concerns which reflects local and national safeguarding activity.

2019-20	2020-21	2021-22	2022-23	2023-24
478	540	565	660	764

Themes of Safeguarding Concerns (top 5)

The following table details the themes of concerns raised to the Local Authorities. The top five themes remain unchanged. It is important to note that there can be multiple allegation types per referral.

Themes of concerns	2022-23	2023-24
Domestic abuse	73	102
Neglect and acts of omission	309	364
Physical	82	109
Psychological	48	68
Self-neglect	161	187

Neglect and acts of omissions remain the main cause for safeguarding concerns, followed by self-neglect. Concerns related to physical and domestic abuse have continued to rise. The rise may indicate greater understanding of when to raise a concern as a result of training and awareness campaigns. The Trust has the services of an Independent Domestic Violence Advisor who continues to raise awareness of domestic abuse.

Number of Safeguarding Concerns raised against the Trust

There have been **99** concerns regarding Trust practice.

2019-20	2020-21	2021-22	2022-23	2023-24
79	80	93	95	99

Themes of Safeguarding Concerns against the Trust (top 5)

Themes of concerns	2022-23	2023-24
Discharge issue	46	30
Communication	28	21
Pressure damage/ulcer	15	20
Medication error	19	18
Documentation	12	9

*note: one concern can cover multiple themes

Work continues within the Trust with the Discharge Team and the tissue viability nurses (TVN) team. Ward pharmacists are continuing to working closely with medical, nursing and midwifery staff to provide support and education.

Deprivation of Liberty Safeguards (DoLS)

DoLS ensure people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests. Representation and the right to challenge a deprivation are part of DoLS. The Trust Safeguarding Team provide specialist advice relating to implementation of the Mental Capacity Act 2005 (MCA) and DoLS. This provides assurance that the Trust is compliant with legislation. The Trust continues to provide education regarding the MCA and DoLS via mandatory safeguarding training and the provision of bespoke sessions on request.

Further improvements have been made to documentation to assist staff in their completion of mental capacity assessments and DoLS forms. Capacity assessments and DoLS authorisation forms are waiting to go 'live' on Trakcare, the Trust electronic patient record system. This year has also seen the appointment of a substantive administrator for MCA and DoLS to ensure timely notifications are made to the CQC of all outcomes of requests for DoLS authorisation.

The Trust auditors, AuditOne, have completed a review of the MCA and DoLS Policy and have given overall GOOD assurance; the recommendations made are to complete the changes described above and ensure the records are active in Trakcare to support staff usage and compliance with policy.

The Trust has requested **1,924** DoLS authorisations for the financial year 2023-24.

2019-20	2020-21	2021-22	2022-23	2023-24
1,810	1,545	1,760	1,697	1,924

*Data as of 31 March 2024

Safeguarding Adults training data 2023-24

Training level	Staff trained
Safeguarding adults level 1	**93%**
Safeguarding adults level 2	**90%**
Safeguarding adults level 3	**81%**

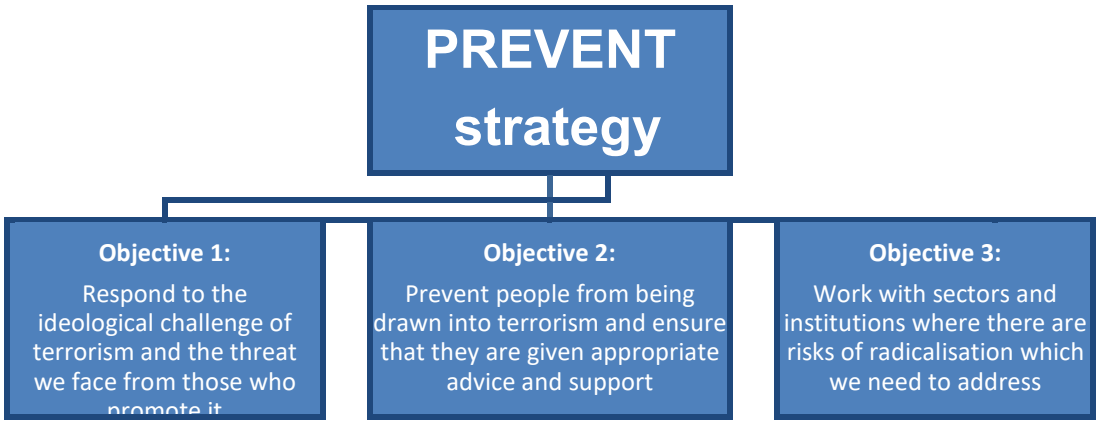
*all training data obtained from Yellowfin April 2024.

Learning Disabilities training data 2023-24

Training	Staff trained
Learning disabilities and autism	95%

Adult Safeguarding - Prevent

The aim of Prevent is to stop people from becoming terrorists or supporting terrorism. Prevent also extends to supporting the rehabilitation and disengagement of those already involved in terrorism.



Global events have continued to ensure the principles of counter terrorism outlined above remain in the NHS workforce agenda. Prevent continues to be addressed within the adult safeguarding portfolio. The Trust facilitates training according to a staff training needs analysis (TNA). Staff requiring level 1 and 2 training complete Preventing Radicalisation-Basic Prevent Awareness via e-learning for health. Staff requiring Level 3 complete Prevent Home Office approved online training.

The 'Named Nurse' for Adult Safeguarding represents the Trust at a multi-disciplinary meeting (Silver command) around Prevent.

Prevent training figures 2023-24

Training type	Staff trained
Preventing Radicalisation - Basic Prevent Awareness	95%
Prevent	94%

Revised safeguarding audits have been planned for the year ahead to assure compliance with training. There is a proposal being developed to combine Children and Adult Safeguarding training to further embed the 'Think Family' approach. This is currently being aligned with provision across the Hospital Group.

Children's Safeguarding

A child/young person is defined as anyone who has not yet reached their 18th birthday.

North Tees and Hartlepool NHS Foundation Trust has a duty in accordance with the Children Act 1989 and Section 11 of the Children Act 2004 to ensure that its functions are discharged with regard to the need to safeguard and promote the welfare of children and young people. The Trust

recognises the importance of partnership working between children/young people, parents/carers and other agencies to prevent child abuse, as outlined in 'Working Together to Safeguard Children and their Families 2023.' In addition, the Trust continues to demonstrate robust arrangements to safeguard and promote the welfare of children within the recommendations set out by NHS England's 'Safeguarding Vulnerable people in the NHS accountability and assurance framework' revised in 2022.

Children & Young People Governance Arrangements

The Trust has maintained Board level oversight of children's safeguarding led at executive level by the Chief Nurse/Director of Patient Safety and Quality. A quarterly Safeguarding Council, chaired by the Associate Director of Nursing and Patient Safety holds responsibility for monitoring the performance of the Children's Safeguarding Operational Group and their work program. The Council also brings together commissioners and providers with representation from key stakeholders including Designated Doctor and Designated Nurse for Safeguarding and Looked after Children and Designated Nurse Safeguarding and Looked after Children from Durham, Darlington, Easington & Sedgefield to ensure our safeguarding priorities align with both national and local learning.

The Chief Nurse/Director of Patient Safety and Quality has delegated authority to the Associate Director of Nursing and Patient Safety who has direct line management of the Safeguarding Children Team.

Representatives from across all Care Groups take a lead role to act as champions for the safeguarding of children and through the safeguarding operational group meet quarterly. Key professionals from Emergency Department and Women's and Children's Services are brought together to ensure momentum of the Safeguarding and Children's Health in Care work program, and ensuring the safeguarding agenda remains central to all aspects of care delivery for children across the Trust. This governance framework provides safeguarding assurance to the Trust and its partners through the Safeguarding Council.

The Trust has made active contributions at senior level to the Hartlepool and Stockton Safeguarding Children Partnership (HSSCP) and the Durham Safeguarding Children Partnership (DSCP).

The Trust has maintained representation on a number of Safeguarding Partnership subgroups including:

- Tees Procedures and Policy group
- HSSCP (Hartlepool and Stockton Children's Partnership) Engine room
- HSSCP Governance meetings and Executive Board
- DSCP (Durham Safeguarding Children's Partnership) Performance and Learning Group
- CHUB Board
- MARAC (Multi Agency Risk Assessment Conference)
- MATAC (Multi Agency Tasking and Co-ordination)
- County Durham Child Exploitation Group (CEG)
- Serious Organised Crime Group

Children's Safeguarding Work Program

The Children's Safeguarding Work Program sets out the work for the year including:

- Action plans from Rapid Reviews / Children's Safeguarding Practice Reviews; Learning Lesson reviews, Domestic Homicide Reviews and any internal trust reviews.
- The safeguarding children annual audit and assurance program.
- The safeguarding forward plan, aligned to Safeguarding DSCP and HSSCP partners business and learning priorities.

Lessons and learning include:

- Continuing to raise awareness around the increasing risks posed to children being exploited by organised crime in our region and for Trust staff to approach every health contact as a reachable moment in identifying and safeguarding our young people.
- Supporting a regional awareness programme and building responsibility within the multiagency network to promote safe sleeping
- Further quality improvement and assurance work related to “Child not Brought” to promote adherence to policy and systems to support practitioners.
- Raising awareness of the impact of Adverse Childhood Experiences on parenting capacity and the challenge to staff to adopt a trauma informed approach to practice that supports further risk assessment, a greater understanding and empathy of the transition from adolescents to adulthood, and the need to approach ‘challenging behaviours’ as indicative of a child in distress rather than a troublesome child.

Part 2 - Development Work

Children Not Brought for Appointments by Parents/Carers’ Policy

The policy and assurance process embedded across the Trust is in response to local children’s safeguarding case reviews and learning lessons review and has been in place for seven years and was updated in June 2022. The policy enables practitioners to understand that when a child has not been brought to appointments this may be an early indicator of neglect and requires a risk and impact assessment that supports an appropriate safeguarding response where required. The Trust now also considers this for children where appointments are frequently rescheduled and cancelled by parents/carers alongside those that do not attend and improvements are monitored through auditing as to how practitioners respond. The additional focused quality improvement work identified in the Trust Patient Safety Incident Response Framework (PSERP) priorities for 2024-25 will strengthen the application and compliance with the policy; which may need a further review following this analysis.

Safeguarding Children’s Policy

The Safeguarding Children’s Policy ensures that Trust staff understand their responsibility under current legislation to safeguard and promote the welfare of children and to enable the Trust to meet its statutory duties in this regard. This policy was updated and ratified in January 2024.

Safeguarding Children Supervision

The local quality and performance indicators include safeguarding children supervision of Trust staff. Children’s safeguarding supervision is recognised as being fundamental to safe practice. The team supports this in the delivery of mandatory 1:1 supervision on a three monthly basis for every staff member who has contact with children and young people within their caseload. These include all Community Midwives and Specialist Paediatric Nurses. Group supervision facilitated by Safeguarding Senior Nurses continues for our Speech and Language Therapists on a rolling program. This provision has been extended to include our allied health professionals from Children’s Physiotherapy, Occupational Therapy, Nutritionists, Diabetes Transition Nurse. Early Pregnancy Assessment Clinics, Assisted reproduction Team, Community Dental Teams. Supervision provides further opportunity to support reflection, challenge bias, and facilitate safeguarding decision-making and safety planning.

Safeguarding Children’s Supervision Policy was updated in January 2023 and provides guidance to practitioners regarding expectations around supervision and support available.

Supervision compliance reported via the quarterly dashboard is demonstrated in the table below which shows very good uptake and the Trust is assured that staff are receiving the supervision they need.

2023-24	Staff supervision
Q1	100%
Q2	100%
Q3	93%
Q4	100%

North of Tees Children's Hub

The Trust is an integral partner of the Local Authorities children's hub and although the senior nurses in the safeguarding team are not co-located within the Hub they continue to provide support and information when and as required.

Child Exploitation (Sexual and Criminal exploitation)

The changing landscape of child exploitation continue to be a significant risk and growing concern for our young people. Both the function and response from Stockton and Hartlepool Multiagency Children Exploitation Group (MACE) practitioners group and the Child Exploited group (CEG) in County Durham has improved significantly to provide a more timely response to children who are at risk from exploitation and although the trust does not directly attend these meeting trust information continues to be provided to support identification of those children and young people most at risk. Information is flagged on records to support trust staff to consider further information sharing and safety planning where ongoing risk is identified. A Child Exploitation risk assessment screening tool is in place for trust staff to complete for all children who attend unscheduled care within the Trust if they fit within an agreed criteria of risk, this is presently being extended to nursing assessment documentation across the trust.

Domestic Violence & Abuse

The Trust is represented at Multi Agency Risk Assessment Conferences (MARAC) in Hartlepool and Stockton where high risk victims of domestic abuse are identified and safety plans put in place. The Trust also contributes to Multi Agency Tasking and Coordination (MATAC) where response to high risk perpetrators are managed.

A Domestic Abuse Policy is in place across the Trust to support staff in responding to indicators that are suggestive of Domestic Abuse. The Policy supports staff on how to use a 'think family' approach, considering not only risk to the vulnerable adult as a victim but considering other victims such as children or other dependent adults in their assessment of an appropriate response, including what to do if a colleague discloses Domestic Abuse. The policy has recently been updated to ensure it reflects guidance to staff on recent changes as a result of the Domestic Abuse Act 2022. This has further informed changes to the Safeguarding training updates.

Local Authority Designated Officer (LADO)

Regular meetings established between the Named Nurse and staff within the Workforce department has improved communication and referrals to the LADO. Additional safeguarding training is delivered to Trust senior managers to increase their awareness of adult risky behaviours that may require safeguarding intervention when supporting staff through sickness/absence or capability issues.

Voice of the Child

Actions in response to recommendations from National and Local learning reviews continue to be reinforced by the Trust and are embedded within the Safeguarding Children's Foundation, yearly update and e-learning training. We continue to promote the importance of listening to children and considering their lived experiences. Promoting working in partnership with the child to understand their felt needs. The wishes and feelings of Children in our Care (LAC) continue to be captured through Initial Health Assessments carried out for children on initially coming into care to ensure all Health needs are being fully met. Electronic health care records for children receiving care within the Trust now incorporate prompts for practitioners to gain the voice of the child during contacts/assessments.

Bruising in Non-mobile baby, infant and children's Procedure

The procedure for non-mobile children who present to A&E with a bruise has been reviewed to support appropriate specialist review, safeguarding decision making and appropriate safe discharge planning, in response to national and local learning around the need for more robust decision making around safeguarding this age group. This is presently being evaluated in response to some improvements identified in piloting this procedure.

Joint working with Adult Safeguarding

Children's Safeguarding trainers continue to support joint working across the Vulnerability Unit in providing training for both children and adult safeguarding across the Trust including Domestic Abuse, Female Genital Mutilation (FGM), Prevent, Forced Marriage and Modern Slavery and Trafficking. The combined Child and Adult Safeguarding Council facilitates the 'Think Family' approach at a strategic level.

Audit

The audit forward plan has a strong focus on quality and improving outcomes for children and young people. Examples include:

- Adult risky behaviours A&E Audit
- Section 11 Audit
- NICE Guideline 89 Audit
- Midwifery Quality Assurance Record Audit
- Paediatrics Child Protection Medical Quality Assurance Record Audit
- Safer referral audit
- Looked after children initial health assessment audit
- Non- mobile children procedure audit
- Children not brought for appointments by parents/carers policy audit

Children's Safeguarding Key Achievements 2023/2024

- Communications and Engagement Strategy to ensure lessons are learned from internal incidents, local and national learning reviews are considered by all staff in how these impact their practice.
- To address the ongoing challenges to ensuring staff maintain the skills and knowledge to be able to identify, assess and respond appropriately to any safeguarding concerns a new safeguarding training proposal has been development and is due to be presented by the trusts safeguarding and operational groups.
- Continue to work with colleagues in Care Groups to support the improvement plans in response to CQC report produced in 2022.
- To review the out of hours multiagency professional challenge pathway.

- Continue to escalate and advocate for support from Designated Safeguarding professionals statutory posts, where there are present vacancies.
- The ongoing development of a rolling program of simulation training for staff around Safeguarding, Sudden Unexpected Death in Children (SUDIC) and Abduction.
- Consideration and collaborative working with our neighbouring South Tees colleagues to ensure that any safeguarding pathway reviews are aligned where possible to support staff working across both Trusts.
- Child Death Overview Panel (CDOP) workshops to support staff in understanding the process and any changes in light of new guidance.

Safeguarding Children Training Programme

Throughout 2023–24 the Trust's in-house Safeguarding Children Training Programme has continued to provide mandatory foundation and update single agency training for all staff employed within the organisation. The training is in-line with the requirements of Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate Document (2019) and the Trust's Safeguarding Children Training Policy.

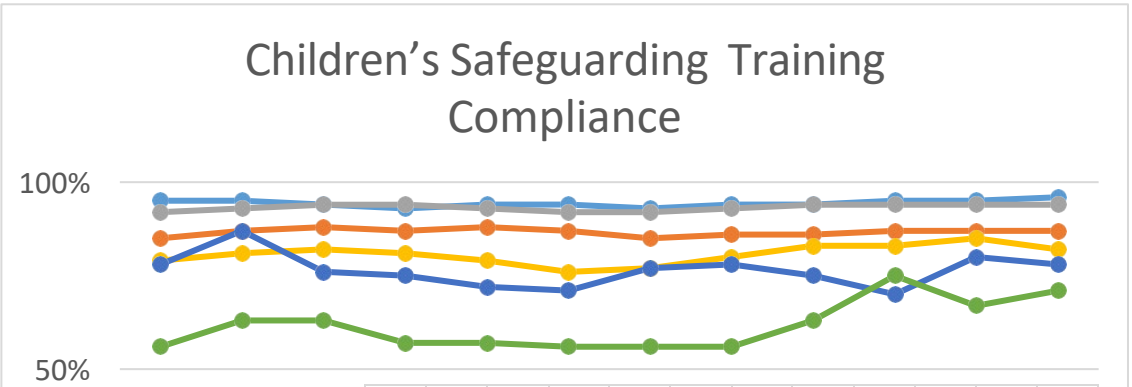
To continue to facilitate a 'think family' approach to safeguarding a training proposal is presently being developed in collaboration with our colleagues at South Tees NHS Foundation Trust to combine children and adult safeguarding training at all levels

Staff are further supported to attend multi-agency training provided by the Safeguarding partnerships and other external providers and is strongly recommended and signposted to those staff groups identified as requiring Level 3 plus competencies.

Bespoke training is developed and provided as required in addition to yearly updates to mandatory in-house training and reviewed in response to learning identified in practice, during supervision, appraisals, event learning themes, Learning Lessons Reviews, LSCPR's, and new and changing national guidance and legislation.

Overall Trust Compliance for Safeguarding Children Training

Training compliance is monitored by the Safeguarding Committee and Operational Group. Care Groups are required to present a quarterly improvement plan to address any compliance issues outside the agreed Local Quality Requirements between the Trust and Integrated Care Board. The Electronic Staff Record (ESR) competency reporting covers compliance for 12 months.



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Level 1	95%	95%	94%	93%	94%	94%	93%	94%	94%	95%	95%	96%
Level 2	85%	87%	88%	87%	88%	87%	85%	86%	86%	87%	87%	87%
Level 3 - Foundation	92%	93%	94%	94%	93%	92%	92%	93%	94%	94%	94%	94%
Level 3 Update	79%	81%	82%	81%	79%	76%	77%	80%	83%	83%	85%	82%
Level 3+	78%	87%	76%	75%	72%	71%	77%	78%	75%	70%	80%	78%
Level 4	56%	63%	63%	57%	57%	56%	56%	56%	63%	75%	67%	71%

*- Level 4 percentage is affected by the small number of staff that is eligible for this training, therefore 1 or 2 non-compliant staff members affects the percentage.

Priority 1: Patient safety

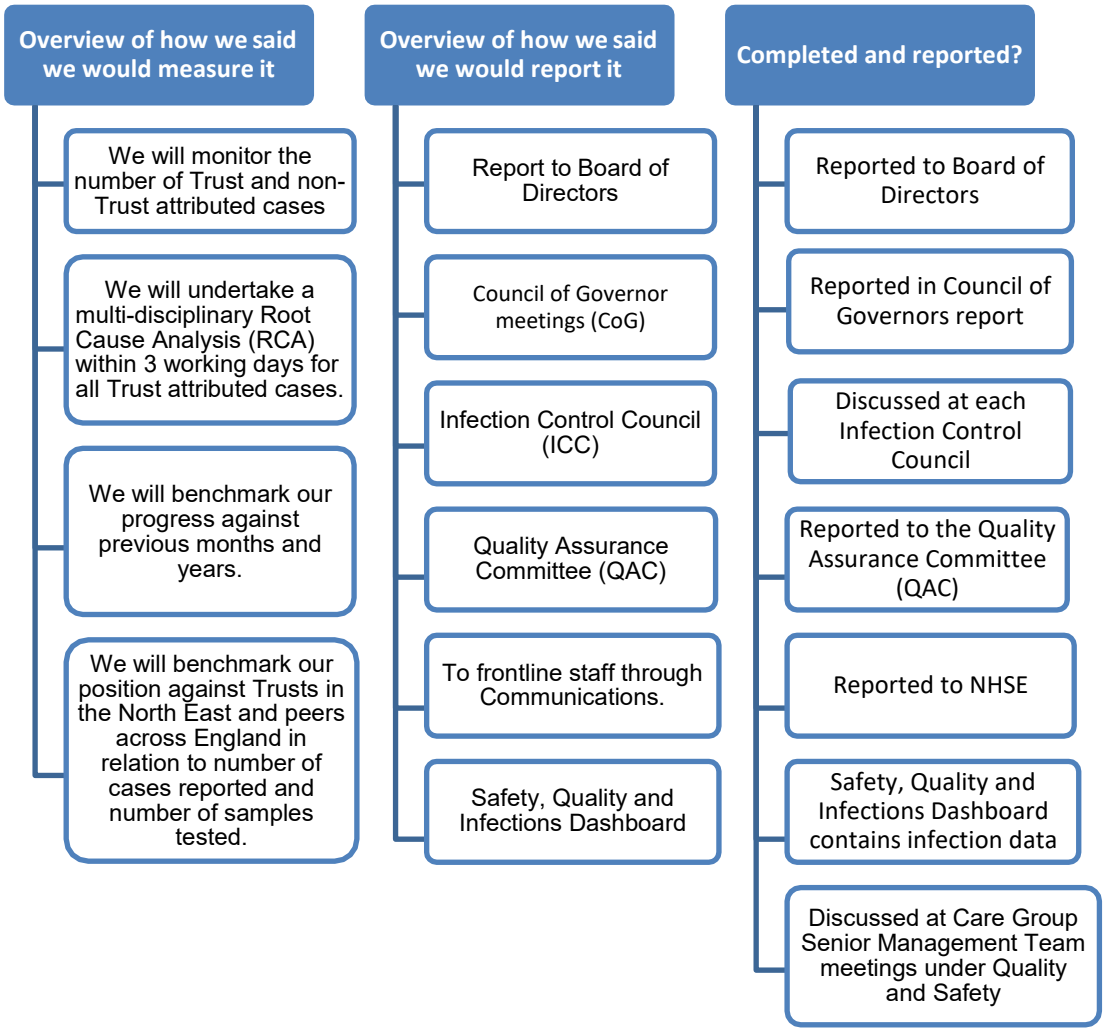
Infections

Rationale: The Trust continues to report on infections of:

- Clostridioides difficile (C.diff),
- Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia;
- Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia; and
- Escherichia coli (E.coli)
- Klebsiella species (Kleb sp) bacteraemia; and
- Pseudomonas aeruginosa (Ps a) bacteraemia.
- Catheter-associated urinary tract infection (CAUTI)
- COVID-19

Overview of how we said we would do it

We planned to closely monitor testing regimes, antibiotic management and repeat cases and ensure we understand and manage the root cause wherever possible.



Due to COVID-19, there was not a trajectory set in 2020-21 for any of the reportable infections. In 2021-2022 trajectories were renewed for all trusts. However, the reporting criteria has changed and we currently report all healthcare-associated cases whether their onset was in hospital or in the community. This is in line with the criteria that is used for *Clostridioides difficile*, which means that data from 2022-23 is the first comparable data that we have.

Clostridioides difficile (C.difficile)

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

The trajectory set for 2023-24 for *C. difficile* was reduced from 54 cases to 46. The Trust is reporting **70** trust-attributable cases for the 2023-24 period. This is a significant increase in cases and is mirrored across the region and nationally.

Staff continue their efforts to control and reduce opportunities for infections to spread, whether we treat people in our clinical premises or in their own homes. The Trust has increased cleaning provision in line with the national cleaning standards which has been rolled out throughout 2023-24. Specific environmental cleaning for *C. difficile*, including enhanced decontamination with triple actichlor plus cleaning and hydrogen peroxide vapour, and the provision of a hygienist team to support additional cleaning remains in place. The importance of adherence to high standards of hand hygiene has continued to be a core element of our strategy.

Actions to reduce *C. difficile* are within the healthcare associated infections (HCAI) plan on a page and the Infection Control Assurance Framework covering all infections and practices and is reviewed quarterly. Progress against the plan is reported to the Healthcare Associated Infection Operational Group and Infection Control Council and is regularly shared and discussed with key stakeholders. The Trust is also a key partner within the integrated care board (ICB) infection control teams and plans to adopt the co-produced plan on a page, implementing shared learning to help reduce the incidence of *C.difficile* throughout 2024/25.

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

- Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission
- Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

***Trust *C. difficile* cases 2021-24**

	2021-22	2022-23	2023-24
Hospital onset-Healthcare-associated	50	48	50
Community- onset associated	55	45	20

*Data obtained from Healthcare Associated Infections (HCAI) data capture system

Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia

Staphylococcus aureus is a bacterium commonly found on human skin which can cause infection if there is an opportunity for the bacteria to enter the body. In serious cases it can cause blood stream infection. MRSA is a strain of these bacteria that is resistant to many antibiotics, making it more difficult to treat.

Many patients carry MRSA on their skin and this is called colonisation. It is important that we screen some groups of high risk patients when they come into hospital so that we know if they are carrying MRSA. Screening involves a simple skin swab. If positive, we can provide special skin wash that helps to get rid of MRSA and reduces the risk of an infection developing.

In 2023-24 we report **4** cases of healthcare-associated MRSA bacteraemia to date.

Each case has undergone a post-infection review and with the development of the Trust Patient Safety Incident Review Framework (PSIRF) we have also completed an intermediate learning thematic review. Key work streams are ongoing to improve our processes in relation to MRSA admission screening and decolonisation in 2024/25.

***Trust MRSA bacteraemia cases 2021-24**

	2021-22	2022-23	2023-24
Hospital-onset healthcare-associated	0	2	2
Community-onset healthcare-associated	0	0	2
Community-onset community-associated	1	2	6

*Data obtained from Healthcare Associated Infections (HCAI) data capture system

Methicillin-Sensitive Staphylococcus Aureus (MSSA)

MSSA is a strain of *Staphylococcus aureus* that can be effectively treated with many antibiotics. It can cause infection if there is an opportunity for the bacteria to enter the body and in serious cases it can cause blood stream infection.

In 2023-24 we currently report **53** cases of healthcare-associated MSSA bacteraemia to date.

***Trust MSSA bacteraemia cases 2021-24**

	2021-22	2022-23	2023-24
Hospital-onset healthcare-associated	29	37	33
Community-onset healthcare-associated	9	10	20
Community-onset community-associated	59	65	60

*Data obtained from Healthcare Associated Infections (HCAI) data capture system

This is an increase of six cases from 2022-23 where we reported 47 hospital-onset cases. Each appropriate case is subject to a root cause analysis and the analysis of these investigations has shown that although a high proportion of cases have been difficult to prevent as they are linked to chest or hepatobiliary sources, there has been an increase in those linked to intravascular devices. Therefore the Trust has undertaken focused work on cannula insertion, maintenance and early removal of devices, which also supports antibiotic stewardship with intravenous (IV) to oral antibiotic switches. A move to non-ported intravascular devices has demonstrated a reduction throughout the year of infections linked to venflons.

Escherichia coli (E.coli)

Escherichia coli is a very common bacterium found in the human gut which can cause serious infections such as blood poisoning. The threshold set for 2023-24 for *E-coli* was reduced from 73 cases to 69.

The Trust is reporting **88** healthcare–associated cases for the 2023-24 period.

***Trust *E.coli* bacteraemia cases 2021-24**

	2021-22	2022-23	2023-24
Hospital-onset healthcare-associated	35	41	55
Community-onset healthcare-associated	42	46	33
Community-onset community-associated	185	213	223

*Data obtained from Healthcare Associated Infections (HCAI) data capture system

An increase of one cases has been noted in 2023-24 compared to 2022-23. Given the significant pressure and increased activity throughout the Trust the numbers of *E-coli* infections have not increased proportionately.

Root cause analysis is completed for cases deemed to have been hospital-onset and healthcare-associated and action plans are developed where learning can be identified. In many cases these infections are related to urine infections and are thought to be not preventable with only a very small percentage of cases being in patients with a urinary catheter where there may be potential for improved practice. Improvements in hydration and educating patients about hydration may support a reduction in *E-coli* infections.

Klebsiella species bacteraemia

Klebsiella species are a type of bacteria that are found everywhere in the environment and also in the human gut, where they do not usually cause disease. These bacteria can cause pneumonia, bloodstream infections, wound and surgical site infections and can be associated with invasive procedures such as venous cannulation or urinary catheterisation.

The threshold set for 2023-24 for *Klebsiella* species was reduced from 21 cases to 20. The Trust is reporting **31** healthcare-associated cases for the 2023-24 period.

***Trust *Klebsiella* species bacteraemia cases 2021-24**

	2021-22	2022-23	2023-24
Hospital-onset healthcare-associated	9	17	19
Community-onset healthcare-associated	6	11	12
Community-onset community-associated	45	43	45

*Data obtained from Healthcare Associated Infections (HCAI) data capture system

Although the threshold was exceeded in 2023/24 an increase of three cases was noted in 2023/24 compared to 2022/23. Given the significant pressure and increased activity throughout the Trust the numbers of *Klebsiella* species infections have not increased proportionately. Hepatobiliary causes remain the highest reported source and improvements made within our surgical pathways to utilise specialist equipment has enabled biliary procedures to be completed in a more timely manner, reducing the number of infections occurring whilst waiting for procedures.

Pseudomonas aeruginosa bacteraemia

Pseudomonas (P) aeruginosa is a bacterium often found in soil and ground water. It rarely affects healthy individuals but can cause a wide range of infections particularly in those with a weakened immune system. P aeruginosa is resistant to many commonly used antibiotics.

The threshold set for 2023-24 for *P. aeruginosa* was reduced from 12 cases to 11. The Trust is reporting **15** healthcare associated cases for the 2023-24 period.

***Trust *P. aeruginosa* bacteraemia cases 2021-24**

	2021-22	2022-23	2023-24
Hospital-onset healthcare-associated	9	8	10
Community-onset healthcare-associated	5	7	5
Community-onset community-associated	13	15	9

Many of these cases are considered unpreventable infections. In the 2023-24 period there was an increase in case numbers in the last two months of the financial year with no links or common themes identified.

Catheter-associated urinary tract infection

A catheter-associated urinary tract infection (CAUTI) is one of the most common infections a person can contract in the hospital. Indwelling catheters are the cause of this infection. An indwelling catheter is a tube inserted into your urethra.

	2021-22	2022-23	2023-24
Hospital onset CAUTI	265	209	186

In 2023-24 the Trust reported **186** cases of CAUTI, demonstrating a good reduction on the previous two years. Work is ongoing to reduce the prevalence of catheters by using alternate urine monitoring devices to be able to measure urine output without relying on catheters There is a focus on promoting early removal of catheters and ensuring that diagnostic testing and antibiotic prescribing is in line with recommended national guidance. There are currently no set targets for trusts but it is recognised that a reduction in CAUTI will have a positive impact on gram-negative bacteraemia cases.

Coronavirus disease (COVID-19)

Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, unvaccinated people and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer remain at a higher risk.

The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes, so it's important that you also practice respiratory etiquette (for example, by coughing into a flexed elbow, and the recommended 'Catch it, bin it kill it').

Numbers of COVID-19 virus have decreased in 2023-24 with 649 positive cases reported. Outbreaks are defined as two linked cases and the Trust has reported 20 outbreaks throughout 2023-24. Outbreaks throughout the last year have been much reduced in length with fewer associated cases.

The Trust has continued to align their testing guidance in line with the national COVID-19 guidance.

Priority 2: Effectiveness of Care

Learning from Deaths

The National Quality Board (NQB, 2017) requires that Trusts have a rigorous approach to Learning from Deaths and has set out standards to ensure this takes place.
Responding to and learning from the deaths of inpatients within our Trust ensures valuable opportunity for improvement is not overlooked. The Trust seeks to do this compassionately and with engagement of families and carers as partners in the process.

During April 2023 to March 2024, 1,373 of North Tees and Hartlepool NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

349 in the first quarter;

299 in the second quarter;

387 in the third quarter;

338 in the fourth quarter.

What we have achieved in the last year.

The Trust has complied with the above guidance by:

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

The Trust has a Medical Examiner (ME) Service scrutinising all inpatient deaths and a growing proportion of out-of-hospital deaths in the locality, in preparation for the service becoming statutory in September 2024. Cases identified from the ME service (or elsewhere) for further review undergo retrospective case note review using the Structured Judgement Review (SJR Plus) tool. Work over the past year has focused on building a panel of trained SJR reviewers and establishing regular review sessions. We now have 20 trained reviewers from a range of disciplines.SJR sessions run

on a monthly basis for a half day with 4-6 reviewers at each session. 21 SJRs have been completed in 2023-2024.

The Trust Mortality Leads have also:

- Reviewed and updated the Trust Learning from Deaths Policy.
- Collaborated with the PSIRF implementation process and the Inphase system

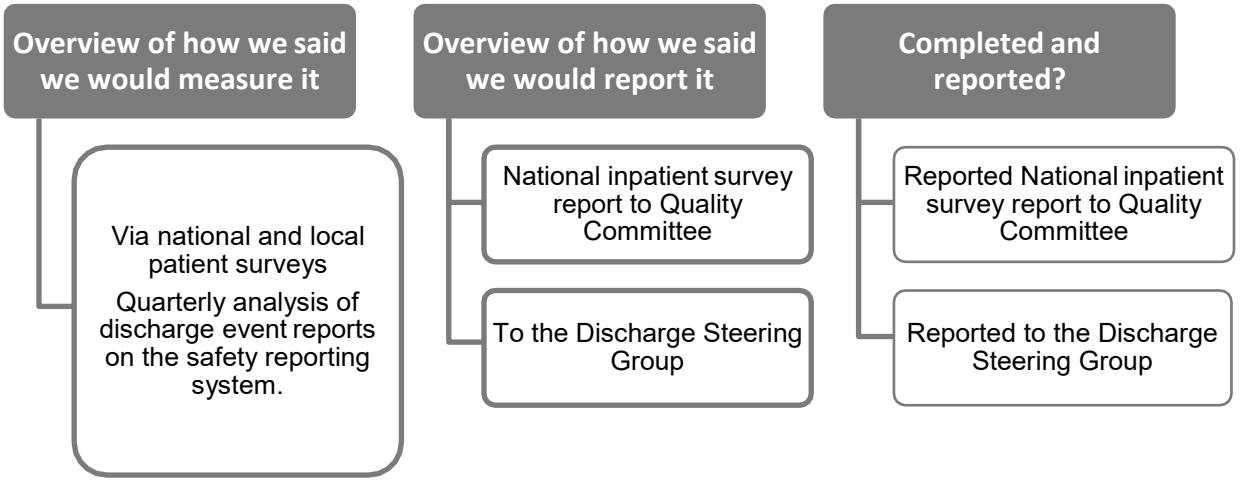
Priorities for the next year:

- Review of speciality mortality reviews with a view to standardisation and robust recording (on InPhase).
- Continue to grow the Learning from Deaths team by appointing administrative support.
- Review the InPhase Mortality Module and adapt for SJR/Learning from Deaths work.
- 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.
- Establish a Mortality Group to oversee the above.
- Work towards a collaborative approach with the South Tees Team.

Priority 2: Effectiveness of Care

Discharge Processes

Rationale: All patients must have a safe and timely discharge once they are able to go back home.



The Trust and partners in Social Care have worked together to implement the changes advised in national discharge guidance and continue to reduce delayed transfers of care supported by the Trust interagency discharge policy. There has been a range of new initiatives/changes that support patient flow across acute to community services working in collaboration with system partners.

Integrated Coordination Centre (ICC)

The ICC continues to support prediction, planning and responding appropriately to patient flow. The ICC brings together:

- The Patient Flow Team (Bed Mangers/Site Managers)
- Discharge Flow Facilitators
- Discharged Transport Scheduler.
- Duty coordinators for discharge pathways
- Discharge operational team lead

The aim is that this integration and the use of our electronic systems support decision-making at the earliest opportunity to maximise our capacity and demand response. These systems include OPTICA (Optimised Patient Tracking and Intelligent Choices Application) and communicate important information to those that need it in a visual and immediate manner, empowering the team to make specific patient-level plans based on 'live' rather than historic data.

Discharge Flow Facilitator role

The Discharge Flow Facilitator (DFF) role was introduced in 2022 to provide overall coordination responsibility of discharges using OPTICA as a supporting digital tool. In 2023 the service was expanded from having two Discharge Flow Facilitators (DFF) to four, that work in the ICC 8.00-17.30 Monday – Friday and 8.00-16.00 Saturday – Sunday. They communicate with all members of the Integrated Discharge Team, the Patient Flow Teams, wards, local authorities and care providers to gather information for patients discharge journey, allocating discharge checklist tasks to the responsible assignee group. The DFF escalates any tasks that extend beyond reasonable timescales (identified within OPTICA) to ensure delays are minimised. Recognising the demand has increased we have also appointed a Band 4 Discharge Flow Facilitator Lead to offer support, education, assist in the development and roll out of OPTICA, and offer supervisory support to the team.

Patient Process Facilitators - base wards

Building on the workforce model of the Discharge Flow Facilitator and Patient Process Facilitators (PPF) at front of house.They are trained and educated by the Integrated Discharge Team on the established discharge processes, and also support the ward in other tasks that facilitate patient flow. We have employed a number of Patient Flow Facilitators to be based on the wards. For example, chasing referrals, requesting bed cleans, liaising with different departments etc. all of which supports clinicians to focus on clinical tasks. They form a conjugate between the wards, the site patient flow team and the discharge team. In 2023 we have increased the number of PPFs to seven, each having a designated ward.

Reduction length of stay in hospital

OPTICA, the ICC, community developments, partner relationships and collaboration have supported the reduction in length of stays where patients no longer meet the criteria to reside in hospital. This means patients are getting home safer sooner. Patients remaining in hospital over 21 days is below the national 12% target for 2023/2024. From October 23-March 24 Average for North Tees is 11.6%).

Volunteer drivers

The volunteer driver service can transport patients home following a period of hospitalisation. Drivers also deliver medication where appropriate and provide transport to outpatient appointments. During 2023-24 the volunteer drivers undertook 5208 journeys.

Help Force – Home but not alone scheme

This is a volunteer led and delivered service to support patients through the discharge process. The programme has been introduced to six wards across the Trust and other discharge areas, including the Discharge Lounge, Emergency Assessment Unit and the Emergency Department. Those patients who live on their own or would like someone to talk to are referred onto the programme. Volunteers meet them whilst they are inpatients or at the point of discharge to discuss their needs upon discharge and post discharge.

The volunteers have access to local Foodbank's emergency food parcels and clothes for those in need. Volunteers follow up for 28 days after discharge to encourage the patients to get involved in local befriending services, community activities, and also to take advice from support networks e.g. Citizens Advice Bureau, etc. The volunteer service has developed good working relationships with local social prescribers and other befriending initiatives.

During 2023-24 this small team have supported 122 patients, with 307 post discharge contacts. As part of the patient survey evaluation, of the 18 patients who answered the question: 'How likely are you to recommend the service'. All 18 said either 'extremely likely' or 'likely'. Examples of cases:

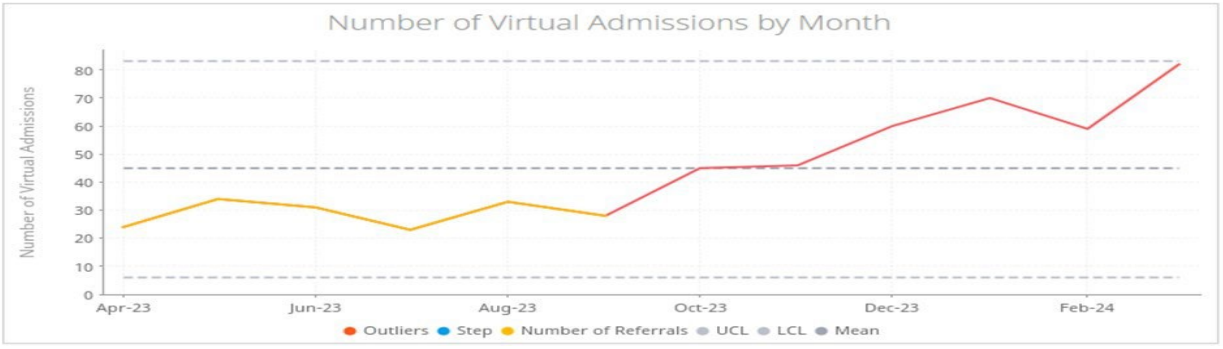
1. A patient was suffering with depression and loneliness with no local friends or family. The volunteer provided a food parcel at discharge and information about local fitness classes, Five Lamps, Community Connect and Aspen Gardens Community Space. The patient was grateful for the information shared and planned to get involved with a local group.
2. A patient was anxious about going home to an empty house after their partner had died. The volunteer provided information about local bereavement services Marie Curie and Cruise, as well as information about Five Lamps and Macmillan Support.
3. A patient with a cancer diagnosis was ready to be discharged but had no fixed abode and was sent to temporary accommodation. They were worried about money and not aware of what benefits they were entitled to. The volunteer shared information about West View Advice Centre and Citizens Advice Bureau.

Hartlepool Carers service

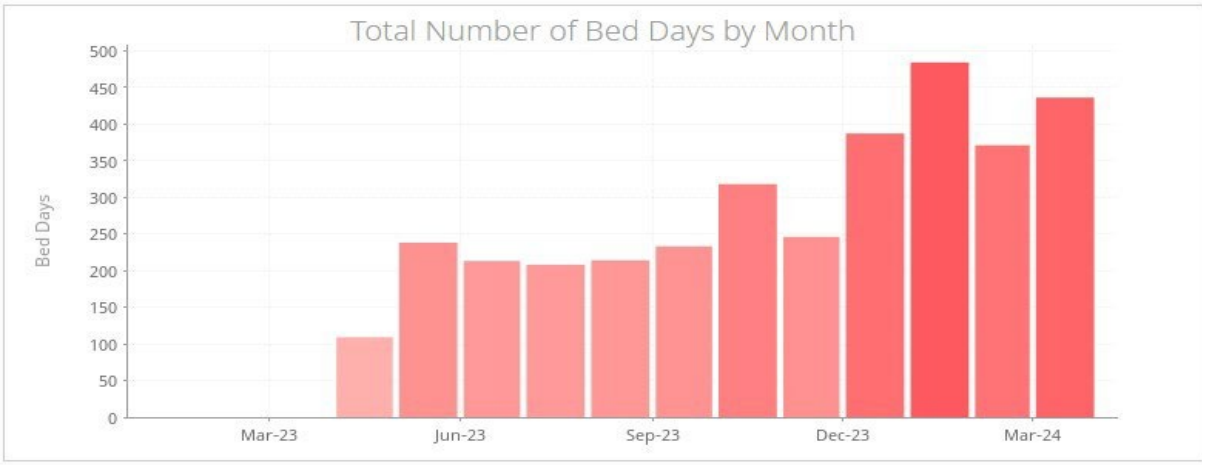
The Trust has been working well with the Hartlepool Carers service and a representative from the organisation is regularly on the hospital site. This has helped carers access support and information on a variety of issues including discharge.

Virtual Frailty Wards

We have continued to increase the numbers of patients accessing virtual wards that utilise community matrons to provide acute care for patients in care homes (see graph 1 below). The virtual wards support admission prevention and discharge, thereby saving acute bed days (see graph 2). This service collaborates with the GP federation and our local authorities to enable us to increase the scope of patients we can manage within this service. Our colleagues in primary care are involved in delivering this service.



Graph 1 Number of admissions to virtual wards by month April 2023-March 2024



Graph 2 Bed days saved per month April 2023-March 2024. Total = 3457

Expansion of the overnight transport

Patient transport is available seven days a week to support patient discharge. The overnight vehicle has now been made permanent. This has allowed us to facilitate up to seven discharges per night from the Emergency Department, meaning the patient does not have an extended stay waiting for the day transport to be available.

Trusted Assessor role expansion

Evidence shows that people recovery better within their own homes yet it has been recognised that discharges from North Tees and Hartlepool discharge a disproportionately high number of people into short term care. Recent data suggests that if a patient is discharged into short term 24 hour care, they have a 50% likelihood of remaining in 24 hour care, reducing independence, and increasing dependency on social care and financial cost.

To ensure the 'Home First' approach is being considered the Trust is working closely with partners and have employed a further two Band 4 Trusted Assessors (with funding from the Better Care Fund). The main role of the Trusted Assessor team is to ensure that every patient referral received from the ward for a short term bed (for rehabilitation or a further period of assessment) has been triaged and assessed to determine if the community services can meet the patient's needs within their own home. From a sample of 373 patients (Stockton residents) who were referred from North Tees Hospital for short term 24 hour care upon discharge, the team have converted 65 (17%) to discharge home with community support.

Introducing new technology - Liberty

The Integrated Discharge Team have adopted the communication system 'Liberty'. This system enables the Discharge Flow Facilitators based in the ICC to direct referrals and queries more efficiently to specific call handlers, for example the transport scheduler and the discharge lounge. There is also the option for more than one staff member to access each line, so more calls can be received, and less clinical time is wasted by staff waiting to get through. It has been introduced to the ward PPFs too so bed managers, ICC, and Integrated Single Point of Access (ISPA) staff can access them easily and communicate with the wards more efficiently. The system also offers the ability to categorise calls so reports can be generated to monitor call management and demand.

Discharge Lounge

During 2023 there has been a drive to increase the use of the Discharge Lounge at North Tees to support patient flow and increase bed availability earlier in the day, supported by the recruitment of a dedicated team which has reduced the need for bank staffing. Data shows a 49% increase in the use of the Discharge Lounge when comparing activity for October 2023-February 2024 with October 2022-February 2023.

Healthwatch Hartlepool have revisited the Discharge Lounge following their initial visit in 2023. They conducted patient and care home surveys and visited the lounge across four dates to interview staff and patients. There were many improvements reported and overall feedback was positive. A follow up action plan has been developed to ensure ongoing improvement of discharge from hospital.

Integrated Single Point of Access (ISPA) developments.

The ISPA has been operational since 2018, however in 2023 a significant step was made to provide a coordinated and integrated response to supporting hospital discharges and community services, by bringing together health and social care teams from Hartlepool and Stockton into one central area at Billingham Health Centre. This move has allowed social care teams within Hartlepool Borough Council and Stockton Borough Council, as well as colleagues within Tees Esk and Wear Valley and Hartlepool and Stockton Health (HASH) to work alongside community services with NTHFT.

Home First Improvement Week

Through a process of continuing improvement we held a 'Home First' improvement week from 28th February 2024 to 6th March 2024. The key focus was to support embedding the Home First approach across all acute and community areas. Community staff worked alongside ED and Emergency Assessment Unit (EAU) colleagues to help identify patients attending the departments who could be treated in the community by the Virtual Frailty Ward. There were a range of education sessions for all professionals to present the Home First strategy and discuss the opportunities and challenges. It also provided a great opportunity for the Acute Frailty Team to work alongside community services and become the 'eyes and ears' for identifying patients over 65 for the Virtual Frailty Ward, ensuring the right care is being delivered in the right place at the right time. During the week over 50 improvements were identified, with four key areas identified for improvement in the coming year. These include education and training, improvements to process and pathways, communication and influence, and developing an IT and digital strategy to support Home First.

Community Integrated Assessment Team support to elderly care therapy teams.

During the 2023-24 winter period the Community Integrated Assessment Team (CIAT) and the elderly care therapy teams have worked together to ensure transfer of care from acute care to the

community is as seamless as possible. This has involved a member of the CIAT team working with the acute therapy teams, supporting with environmental visits, equipment, meeting and greeting patients going into intermediate care beds and being a general advocate of community therapy services. The process has had positive feedback from patients and staff alike since it began in October 2023.

Priority 2: Effectiveness of Care

Accessibility

Rationale

The Trust supports individualised reasonable adjustments for patients across our services:

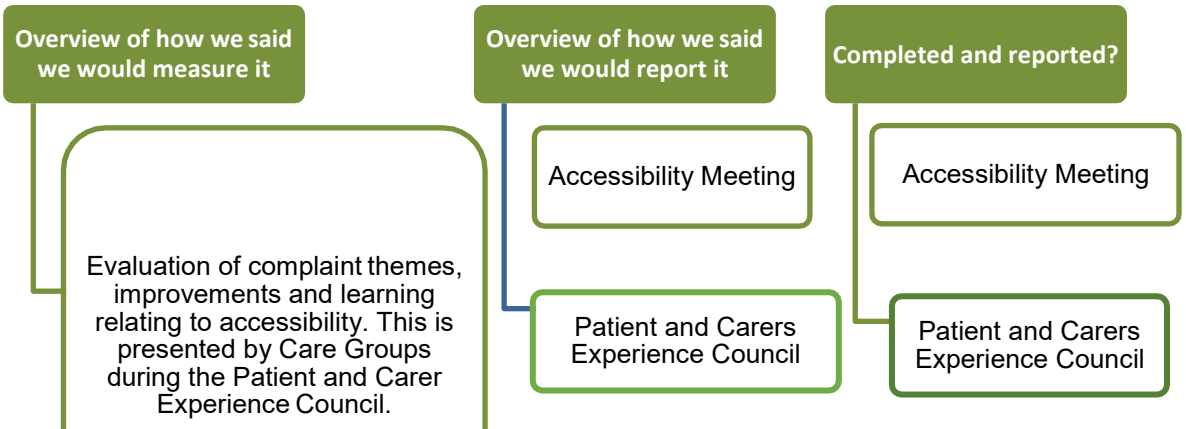
- To ensure that all patients have access to safe and effective healthcare.
- To make person centred reasonable adjustments that are dependent on an individual's needs. Patients who have the same disability, impairment or sensory loss may require different adjustments. Small adjustments can make a significant difference to the experience and health outcomes for the patient.

The Trust is committed to ensuring that it meets its legal duty in making reasonable adjustments under the Equality Act 2010, which explains that "health and social care providers must make reasonable adjustments to remove any barriers – physical or otherwise – that could make it difficult for disabled people to use their services or prevent them from using them altogether". The duty to make reasonable adjustments applies to all patients, family, carers or visitors of any age who are disabled in any capacity (including hidden disabilities, when they are known), have an impairment or sensory loss.

The Trust also continues along its journey to ensure we are compliant with the Accessible Information Standards launched by NHS England in 2016, which builds upon the existing legal duties which public sector bodies and all service providers are already obligated to follow, the aim being to improve healthcare for millions of people with sensory loss and other disabilities.

Overview of how we will do it

The Accessibility Meeting is now incorporated into the Patient and Carer Experience Council. The Patient and Carer Experience Council provides a quarterly focus on accessibility and people with lived experience involvement. The meeting includes representatives from stakeholder organisations, patient experience, dementia and learning disability specialist nurses, quality improvement leads and senior clinical staff. The Patient and Carer Experience Council receives examples of reasonable adjustments and learning in relation to accessibility and shares good practice.



Progress during 2023/24

A baseline audit of staff understanding of the Accessible Information Standard was undertaken in quarter 4 2022-23. Although the return rate was low, the results will be presented in the Patient and Carer Experience Council in quarter 1 2024-25. Any gaps in knowledge identified will be addressed through development of an action plan developed and monitored via the Patient and Carer Experience Council.

Identifying Patients with Information or Communication Needs

The Trust's electronic patient health care record systems allow staff to document a patient's communication needs. This is added to the system on referral if the reasonable adjustments required are known, or at first intervention with the patient. This ensures staff are aware of the patient's communication needs when arranging an appointment or an admission.

A Hospital Passport to assist in meeting communication needs is available for patients, relatives or carers. This can be uploaded to the patient's digital healthcare record for staff to view.

Supporting Patients with Information or Communication Needs

The Trust website has undergone review and improvement. Work is ongoing to replace some PDF and word documents that are essential to providing our services that do not fully meet the Web Content Accessibility Guidelines version 2.1. The site displays contact details to obtain the PDF and word documents in an accessible format. In addition the Patient Experience webpage links to an Accessibility for Patients and Visitors page. This gives guidance as to how to request communication support and support to travel through the hospital, and now includes a British Sign Language video with tips on making a complaint in the NHS. Patient information leaflets are available in a variety of formats including braille upon request.

Accessibility Champions are in place in some wards and departments to help support patients, carers and visitors with a sensory loss whilst on site.

The Interpreter and Translation Policy continues to provide detailed guidance in relation to patients with communication needs eg, sensory loss, dual sensory loss, dementia, learning disability and where their first language is not English. Guidance on working with an interpreter is also included in the policy and a number of training sessions for staff have been carried out by our contracted translation service provider during 2023-24. This includes lip speakers and British Sign Language.

Other work includes:

- The Trust contracted language service provider delivered training courses to Trust staff to share guidance on best practice when working with an interpreter. The courses continue.

- The Disability Discrimination Act (DDA) access audit at North Tees, Hartlepool and Peterlee Hospital sites followed the journey of a patient from the car park/bus stop through to wards and departments. The Trust have been working through the key risks identified within the report and have address the high risk items. The DDA access report and findings continue to be factored into any development work such as ward decants and other refurbishment works to ensure they are addressed whilst undertaking the development work.

- PLACE (Patient-Led Assessment of the Care Environment) audits continue to be undertaken. To ensure that staff, patients and families are aware of the high standard in place in the Trust monthly PLACE lite assessments are also in place.

- The Trust's complaint process was fully reviewed in line with the Parliamentary and Health Service Ombudsman's Complaint Standard Framework which provides a framework for the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The revised process ensures equal access when raising a concern, complaint or providing feedback as well as a more streamlined and efficient service for all.

- The Trust's Patient, Public and People with Lived Experience and Involvement agenda continues. We have successfully recruited two patient involvement partners to ensure patients, service users, carers, families, people with lived experience and other members of the public are involved in the way we design and shape services. The role will promote patient voices across meetings and Boards. We have also launched recruitment opportunities for people with lived experience (patients, their families, carers) and the public into our Trust Involvement Bank. The aim is to encourage local people to get more involved by contributing to our day-to day business of delivering care for example by taking part in visits and inspections, attending meetings, workshops, events, and designing surveys and patient pathways. It is hoped that the involvement bank will include people with communication barriers including sensory loss.

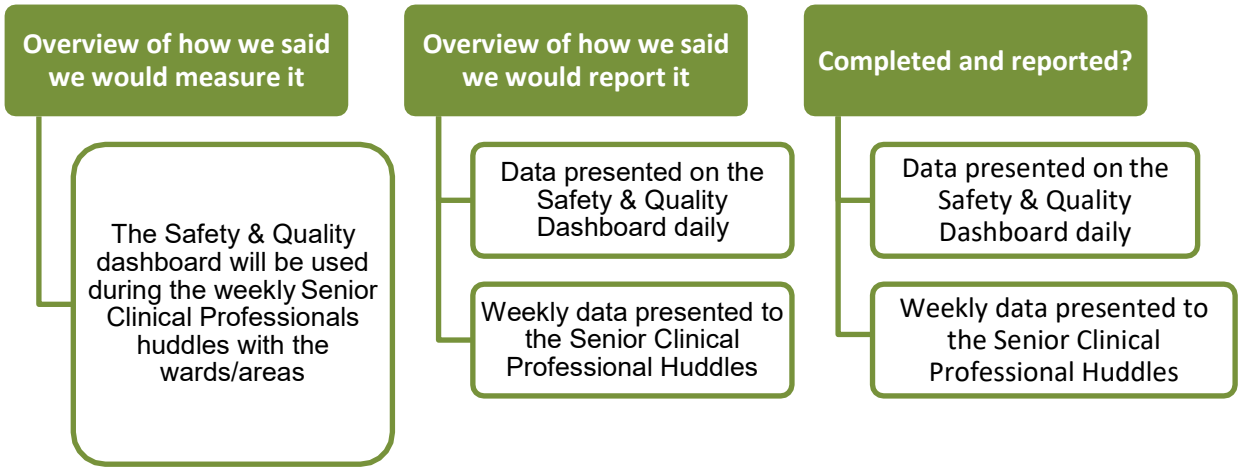
- The Accessibility Champions meetings continue to bring together Accessibility Champions who help support patients in the Trust, and an opportunity to share good practice, request advice and identify any relevant training opportunities.

- A Reasonable Adjustment Policy was developed for staff to ensure reasonable adjustments are in place to reduce barriers to communication for our patients and promotes the importance of consulting with patient's carers and family members.
- The Trust continues to engage with and contribute to Hartlepool Borough Council Joint Sensory Support Plan.
- The Trust supported National Deaf Awareness Week in 2023 by hosting a stall in the Trust highlighting the impact of hearing loss on everyday life and the importance of increasing the visibility and inclusion of Deaf people.

Priority 2: Effectiveness of Care
Violent Incidents

Rationale: There has previously been an increasing number of violent incidents occurring to members of staff from patients and other persons, and the Trust wanted to monitor the numbers of violent incidents and the areas in which they are occurring.

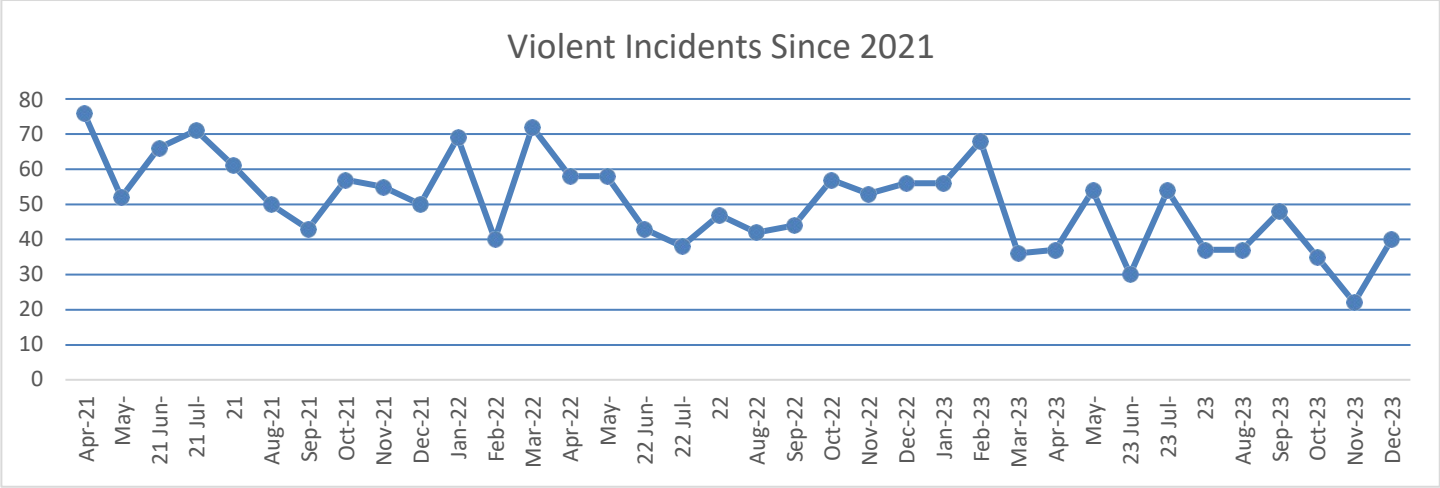
Overview of how we will do it
The Trust planned to utilise the violent incidents data held within the Trust's incident reporting software.



Progress in 2023-24

We have seen a continued downward trend in reported incidents of violence and aggression, with a 20% reduction in 2023-24 compared to 2022-23. The Trusts Keeping People Safe Group has continued to review high risk areas and the underlying causes of violence and aggression. Dementia, delirium and substance misuse have been highlighted as underlying causative factors. Strategies are in place and continue to be implemented to prevent violence and aggression with a specific focus on high impact areas. Work also continues to mitigate any risk to our staff and patients and to support our staff if they are subjected to violent or aggressive behaviour.

	Total Violent Incidents
2023-24	498
2022-23	621
2021-22	690
2020-21	596



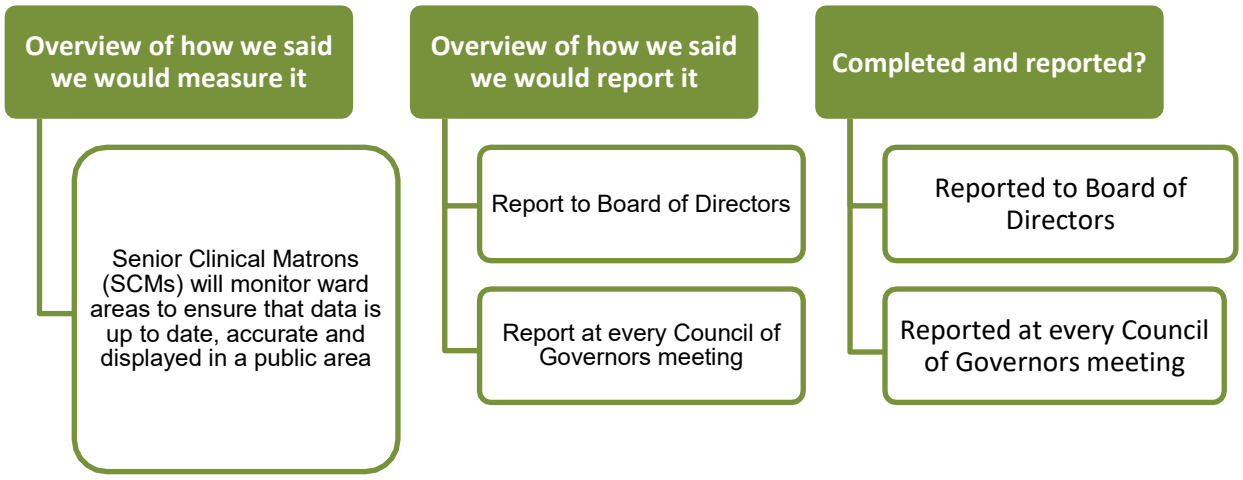
Adverse Event	2021-22	2022-23	2023-24
Verbal abuse or disruption	256	295	129
Physical Abuse, assault or violence - unintentional	125	141	58
Disruptive, aggressive behaviour - other	98	64	71
Concerns to do with personal safety	95	44	12
Need for use of control and restraint with patient	57	28	96
Inappropriate behaviour and/or personal comments	27	25	28
Physical abuse, assault or violence - malicious	11	12	25
Racial	14	7	9
Assault etc with a weapon	6	4	5
Sexual	1	1	6
Behaviour that threatens / appears to threaten personal safety			17
Disruptive / aggressive behaviour (towards an object)			5
Other			3
Physical assault, abuse, or violence (towards a person) with or without a weapon			34
Grand Total	**690**	**621**	**498**

Priority 2: Effectiveness of Care
Safety and Quality Dashboard

Rationale: The Safety and Quality Dashboard contains ten quality key performance indicators. The dashboard provides a quick visual overview to demonstrate where we are doing well and where we may need to focus to make improvements. It supports services to improve decision making, practice and sharing of best practice across the Trust.

Overview of how we said we would do it

Ward matrons display monthly metrics and their analysis in a public area on the safety ward board for patients and staff to see. The data is shared weekly at the Corporate Senior Clinical Professional Huddle, the weekly patient safety meeting within the Care Groups and disseminated to ward staff through staff meetings.



The purpose of the dashboard is for the Trust to have an overview of ward to board assurance. The dashboard statistical process control (SPC) analysis identifies trends if there are variances in practices.

The areas covered by the dashboard are:

- Patient Experience – compliments and complaints
- Patient In-hospital Falls
- Pressure Ulcers Categories 1 to 4
- Medication Errors
- Infection Control
- Hand Hygiene Audit
- Friends and Family Test
- Violent Incidents
- Adult Safeguarding
- Venous thromboembolism (VTE)

The following pictures are a visual display of how the Dashboards look.

Priority 3: Patient Experience

Specialist Palliative Care, End of Life Care and Chaplaincy

Rationale: The 'Ambitions for Palliative and End of Life Care: a national framework for local action 2021-2026' document outlines six key ambitions for the delivery of excellence in palliative and end of life care to help organisations prioritise and continually improve palliative and end of life care. The six ambitions are listed below and further information is available at:

NHS England » Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

1. **Each person is seen as an individual**

   I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible

2. **Each person gets fair access to care**

   I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life

3. **Maximising comfort and wellbeing**

   My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible

4. **Care is coordinated**

   I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night

5. **All staff are prepared to care**

   Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care

6. **Each community is prepared to help**

   I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways

Overview of how we said we would do it

The publication of the Priorities of Care for the Dying Person document in June 2014 provides the Trust with guidance and standards in delivering high quality end of life care. These five priorities provide the fundamental framework of care and support that patients and their families can expect to receive in their last few days and hours of life.

Priority	Description
PRIORITY 1	This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly
PRIORITY 2	Sensitive communication takes place between staff and the dying person, and those identified as important to them
PRIORITY 3	The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
PRIORITY 4	The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible
PRIORITY 5	An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion

Progress in 2023-24

We are participating in the new and revised version of the National Audit of Care at End of Life (NACEL) which began in January 2024. This national audit is a comparative audit of the experiences of dying people and those important to them in acute hospitals. The overarching aim of NACEL is to improve the care of people at the end of life. The new format consists of inputting data from 20 case notes per quarter, a quality survey of bereaved relatives (data collection for a period between January and December 2024) and a staff reported measure (data collection April – June 2024). The first data set is expected in summer 2024.

The End of Life Steering Group continues to meet on a monthly basis to provide strategic leadership and guidance for the organisation. This group reports quarterly to the Quality Assurance Council and onward to Quality Committee on an annual basis. The monthly End of Life Steering Group now reviews compliments and complaints alongside patient safety and quality themes from incident data (InPhase). It also receives regular updates from the Medical Examiner office, local hospices, Chaplaincy and other relevant stakeholders.

The Specialist Palliative Care Team (SPCT) were delighted to win the Royal College of Surgeons Edinburgh prestigious Dundas Medal award which is dedicated to teams that have improved palliative care in hospital. Three members of our team proudly collected the award at a ceremony in Edinburgh during February 2024.

We continue to be involved in multiple quality improvements, audits and research, all of which are discussed and co-ordinated through the SPCT Quality Improvement (QI) subgroup which reports into the monthly SPCT meeting.

Due to the success of the 'End of Life Care Facilitator' role over the past 12 months this role has been made permanent within the team. Key achievements include:

- Promotion of our symbol, the red tree, helping all Trust staff to recognise end of life care so that they can ensure particular attention is paid to respectful, quiet and compassionate care.
- Launch of comfort packs in the hospital. "A little gift of comfort" packs can be offered to families and friends staying at the bedside of dying patients. These packs generously funded through donations contain toiletries, blanket and other essential items designed to improve comfort and support.
- Collaboration with the Royal Voluntary Service (WRVS) to provide ice lollies to enhance patients' mouth care and hydration needs.
- Starting the process of creating an electronic Caring for the Dying Patient document on Trak.
- Ongoing refurbishment of the Oasis Suites through the work of the Oasis task and finish group. This includes the installation of decorative ceiling lights to facilitate a more homely, non-clinical environment, the purchase of new furniture and refreshment facilities.
- Launch of a charitable Just Giving Oasis Suite page to sustain the ongoing provision of the comfort packs.

Following a change to how referrals are managed by the SPCT we are conducting an audit into how well the team are meeting our response targets. The SPC community team have also moved to PCN (primary care network) working to enhance communication, partnership working and build resilience to mitigate absence such as annual leave and sickness. This has been a positive change, welcomed by the team. We are also taking steps to work more efficiently through the use of technology and now routinely send SMS text messages confirming appointment times.

SPCT members have had the opportunity to attend the online Palliative Care Congress in March 2024 to learn, network and share best practice. The team continues to be represented at regular meetings within the North East and North Cumbria working in partnership with other regional organisations to improve palliative and end of life care. We are an active member of the Tees Wide Exemplar work on Palliative and End of Life Care and are represented at the task and finish groups that were initiated following the draft strategy. The Trust's Palliative and End of Life Care Lead chairs the Education task and finish group.

The SPCT collaborated closely during the Home First improvement week with new processes now in place to improve communication between the Integrated Discharge Team, the Inreach District Nurses and SPCT. The purpose of this is to focus attention on the safety, quality and timeliness of end of life care discharges to support achievement of preferred place of care and death.

The SPCT is also research active and represented at regional, national and international forums. Two team members are undertaking PhD studies concurrently with clinical work.

The team continues to offer short and long-term placements to students and qualified staff from a variety of professions to enhance their awareness and knowledge of palliative and end of life care. The delivery of education by the team continues to increase over the past year and has led to the recognition of need for a permanent fulltime Clinical Educator role within the team. We are trying to secure funding to realise this ambition. The education programme includes delivery of a Cancer and Palliative Care study day for qualified staff, ongoing medical education and increased do not attempt cardiopulmonary resuscitation (DNACPR) training for Foundation year 2 doctors, Sage & Thyme communication skills training and the creation of an End of Life simulationeducation day for nursing staff. The nursing SIM sessions have been an overwhelming success and the team have presented this work at various events with much interest from other organisations generated. The SPCTs Education sub-group, which reports into the SPCT monthly team meeting, provides a central forum for discussion and co-ordination for all education that we deliver and receive.

The SPCT have made new links and partnerships with the liver team and virtual frailty wards and now regularly attend their multidisciplinary team meetings (MDTs). This is designed to promote the benefits that early intervention palliative care and advanced care planning can bring these patient groups who have previously had their palliative and end of life care needs underrepresented.

Our specialist therapies team continue to work with Butterwick Hospice at Stockton to provide a physiotherapy clinic with facilities including a rehabilitation gym.

With charitable funding generously donated by Seaton Carew Golf Club the team has hired a Virtual Reality (VR) kit offering patients the chance to experience places and scenes they may not otherwise be able to. It can also help with symptom control, including breathlessness and anxiety management. To date there have been **15** uses of the kit with an average **42.3**% **reduction** in pain, **65.1**% **reduction** in breathlessness and **54.5**% **reduction** in anxiety.

The SPCT continue to work collaboratively with Alice House Hospice in Hartlepool who have two dedicated end of life care beds available to offer patients who are in hospital a rapid transfer to a bed for end of life care. Although the numbers of admissions to date are low (53 patients admitted Oct 2022 – Feb 2024) the feedback from patients, relatives and staff is overwhelmingly positive and this contract has been extended until June 2025. We have also extended the scope of these beds to include direct community admissions and are regularly reviewing processes to improve bed occupancy.

The team has also been successfully working in partnership with Butterwick Hospice Care in Stockton and in August 2023 opened two end of life care beds using a Clinical Nurse Specialist led model with 32 patients admitted from Aug 2023 to Jan 2024. We continue to work in collaboration with the hospice and are hoping to open up more beds in the near future.

Our weekly Nurse Led Clinic at Butterwick Hospice is also going from strength to strength and offers choice for our patients about where and when they would like to be seen. We are in the process of formally evaluating this service.

The chaplaincy team continue to work very closely with the Specialist Palliative Care team and continue to attend the weekly MDT and follow up on patient referrals in the hospital and community. The chaplains have undertaken a staff survey of understanding and satisfaction of chaplaincy services with results to be shared shortly. One of the key priorities for chaplaincy will be to switch to electronic records in the next 12 months.

The Lead Chaplain in his role as Schwartz Lead continues to facilitate a number of successful Schwartz rounds for the Trust. He also chairs a new Trust wide bereavement forum, the aim of which is to provide expert clinical and professional oversight of the delivery of excellent bereavement services across the organisation.

Both teams lead and contribute to the Dying Matters week in May across the organisation; a national initiative encouraging more open discussion about death and dying. Both teams have also taken part in the staff survey with very positive results.

Chaplaincy referral activity data

The following table demonstrates a year-on-year comparison:

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Referrals	401	359	302	400	334	333	372	**409**
Received more than 1 visit	298	244	198	225	176	168	194	**202**
Declined Support	4	2	6	8	1	2	0	**2**

*Data from the Trusts chaplain service

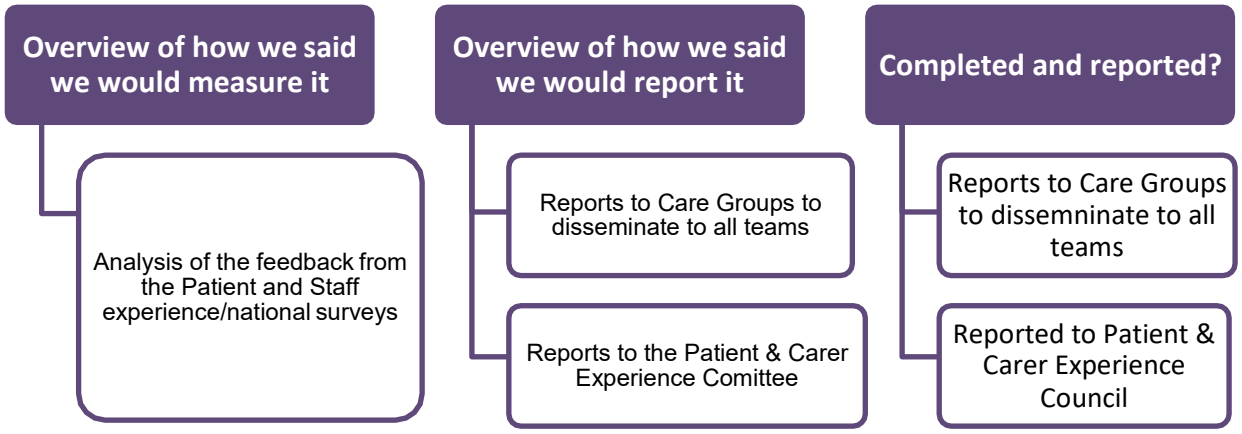
Priority 3: Patient Experience

Is our care good?

Rationale: Trust and key stakeholders believe that it is important to ask this question through internal and external reviews.

Overview of how we said we would do it

- We will ask the question to every patient interviewed in the Patient and Staff Experience Survey visit
- We will ask the question in all Trust patient experience surveys
- We will monitor patient feedback from national surveys



"My experience was most positive, thanks to all staff involved. I am very proud of the NHS."

"Very satisfied with the care and help during my stay in hospital. Thank you NHS!"

"I would like to commend all the staff who treated me for their professionalism and kindness".

"Face to face consultations would be preferable to telephone consultations".

"Departments could communicate a little better. Not good having to chase things yourself whilst you are ill and on treatment".

I was never asked if I would like a shower or help with washing - never asked if I need help.

Progress in 2023-24

National Surveys

Below are a list of the national surveys that the Trust have started between April 2023 and March 2024.

Survey	Published	Response rate
CQC National Inpatient Survey 2022	September 2023	37%
CQC National Maternity Survey 2023	January 2023	41%
CQC National Urgent and Emergency Care Survey	July 2023	20%
National Cancer Patient Experience Survey 2022	July 2023	54%

Local Surveys

Survey	Results	Number of responses
Endoscopy Patient Survey 2023	May 2023	237 patients
Monthly Endoscopy Patient Survey	Monthly	451 patients
Rapid Diagnostic Service 2023	January 2024	96 patients
Family Health Counselling Survey	December 2023	28 patients
Breast Screening Service Survey	December 2023	134 patients
Paediatric Diabetes Service Survey	December 2023	55 patients
Learning Disability Survey	December 2023	20 patients
Maternity Bereavement Survey		3 patients
Patient Controlled Analgesia - Survey	February 2024	10 patients
Pressure Ulcer Project (part of NHSE work)	February 2024	109 patients

National Surveys

We take part in the national survey programme. This is a mandatory Care Quality Commission (CQC) requirement for all acute NHS trusts. Each question is nationally benchmarked so we can understand how we scored when compared with other trusts, please see below:

Better than expected	About the same	Worse than expected

CQC National Inpatient Survey 2022 – Key results

The Trust randomly selected adult inpatients discharged during November 2022. We had a 37% response rate with 432 surveys completed. Results were published in September 2023.

Where we could do better – scores that were significantly worse than in 2021	***2022***
How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	6.5/10
If you brought medication with you to hospital, were you able to take it when you needed to?	8.1/10

In your opinion, were there enough nurses on duty to care for you in hospital?	6.9/10
Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	7.6/10
Were you able to get a member of staff to help you when you needed attention?	7.9/10
Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.2/10

Areas of good practice – scores that were better/ somewhat better than other Trusts nationally	***2022***
How did you feel about the length of time you were on the waiting list before your admission?	8.0/10

"Overall I was quite grateful for the care I was given and the staff were very nice and informative and I received all the follow up treatment required in a relatively short period of time. I value the NHS".

"The doctors who completed my lumbar puncture, listened to my fears and were amazing!"

"Outstanding job by the surgeon and aftercare professionals, it was fantastic".

"My pain went untreated for hours due to no doctor being present or available".

"With today's modern technology surely a more quiet and efficient means of summoning staff for attention other than noisy buzzers going off at all hours could be found".

"The night shift staff were often noisy".

National Cancer Patient Experience Survey 2022 – Key results

This is part of the NHS Cancer Patient Experience Survey Programme and designed to monitor national progress on cancer care to help drive local quality improvements. Our sample consisted of adults with a primary diagnosis of cancer discharged April, May and June 2022. A total of 372 patients returned a questionnaire, a response rate was 54%.

Where we could do better – score lower than expected	***2022***
Patient was always treated with respect and dignity while in hospital	81%

Areas of good practice – score better than expected	***2022***
Patient was told they could have a family member, carer or friend with them when told diagnosis	85%
Patient found it very or quite easy to contact their main contact person	92%
Patient found advice from main contact person was very or quite helpful	98%
Treatment options were explained in a way the patient could completely understand	86%
Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	85%

Patient could get further advice or a second opinion before making decisions about treatment options	60%
Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	83%
Beforehand patient completely had enough understandable information about chemotherapy	91%
Patient completely had enough understandable information about progress with chemotherapy	86%
Patient was always offered practical advice on dealing with any immediate side effects from treatment	75%
Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	65%
Care team gave family, or someone close, all the information needed to help care for the patient at home	67%
Patient has had a review of cancer care by GP practice	26%
After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	47%
Patient was given enough information about the possibility and signs of cancer coming back or spreading	71%

"My chemo is at North Tees fabulous all the beautiful nurses spoil me and the carers I cannot get any better than what I'm getting. I love them so much. Thank you thank you thank you".

"It was quick and professional and sensitive. My operation was successful and my aftercare warm and friendly and reassuring. The whole process was excellent from diagnosis to recovery. A debt of gratitude to the medical team. Thank you NHS".

"Cancer is physically and psychologically challenging. Professionals are there during treatment but one treatment has finished the support falls off the end leaving cancer patients struggling to deal work the aftermath".

"I understand nurses are very busy and don't have lots of time, so it was ok".

"Support/advice for aftercare. More support (i.e. speaking to someone about emotions following treatment). More support from staff after surgery".

CQC National Maternity Survey 2023 – Key results

Women 16 years or over who had a live birth in February 2023 were invited to take part. A total of 123 women responded, a response rate of 41%.

Where we could do better – scored worse/somewhat worse	***2023***

And before you were induced, were you given appropriate information and advice on the risks associated with induced labour?	5.4/10
Were you involved in the decision to be induced?	7.2/10

Areas of good practice – scored better/somewhat better	*2023*
Were you given enough support for your mental health during your pregnancy?	9.4/10
During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	9.2/10
Did you have confidence and trust in the staff caring for you during your antenatal care?	9.1/10
Thinking about your antenatal care, were you treated with respect and dignity?	9.7/10
At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	9.3/10
During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	8.3/10
Thinking about your care during labour and birth, were you treated with kindness and compassion?	9.5/10

“I had a very positive experience during pregnancy and labour. They made me feel heard and comfortable at all stages”.

“I had an amazing team looking after me through pregnancy and birth I had to have growth scans and I was under a consultant at the hospital for this. The team on the ward after I gave birth were amazing with helping me breastfeed all of the staff spent so much time with me and my birth experience was amazing thanks to all of the amazing staff I am very grateful to all of the staff and the amazing job they do every day.

“The midwives during labour were AMAZING. I felt completely at ease with them, even though the pain of labour, and we even managed to have a laugh together during the experience. They made my daughter's birth memorable in the best ways. Also, the midwife who I saw for all of my antenatal checks was fantastic - she really spent time building a relationship/rapportwith us”.

“I only found out that I had low iron and pre-eclampsia when my waters broke at 39 weeks which I wasn’t happy about”.

“I asked for skin to skin and this was not facilitated”.

“Never any consistent answer for the birth of my baby after 32 weeks. This made things very stressful. Inconsistent advice and responses around planned C-sections”.

CQC National Urgent and Emergency Care Survey 2022 – Key results

Patients aged 16 and over were eligible for the survey if they attended A&E or Urgent Care Centre in September 2022. A total of 299 people responded, a response rate of 20%.

Where we could do better – scored worse/somewhat worse than in 2021	*2022*
Sometimes, people will first talk to a health professional and be examined later. From the time you arrived, how long did you wait before being examined? **(UCC)**	5.2
How long did you wait before you first spoke to a nurse or doctor? **(A&E)**	5.5
Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse? **(A&E)**	5.8
Overall, how long did your visit to A&E last? **(A&E)**	5.4
If you needed attention, were you able to get a member of medical or nursing staff to help you? **(A&E)**	7.3
Did a member of staff explain why you needed these test (s) in a way you could understand? **(UCC)**	7.7
While you were in A&E, did you feel threatened by other patients or visitors? **(A&E)**	9.3
Overall, did you feel you were treated with respect and dignity while you were in A&E? **(A&E)**	8.6
Overall experience **(A&E)**	7.7

Areas of good practice – scored better/somewhat better	*2022*
If a family member, friend or carer wanted to talk to a health professional, did they have enough opportunity to do so? **(A&E)**	8.0
Were you given enough privacy when being examine or treated? **(A&E)**	9.4
Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand? **(A&E)**	9.5
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E? **(A&E)**	8.6
Did staff give you enough information to help you care for your condition at home? **(A&E)**	7.6

"My visit was excellent. Could not have treated me better". **(UCC)**

"Fast and efficient service which provide what I needed". **(UCC)**

"Nurses, doctors, hospital staff, ambulance crews all done more and above and I would like to thank them all. Keep up the excellent work and thank God we have them". **(A&E)**

"Keep up the good work! You were fast acting, pleasant and professional". **(A&E)**

"I was originally given an appointment for Urgent Care but when I arrived I was informed I needed to be seen in A&E instead. The waiting time to be seen was immense". **(A&E)**

"I understand that NHS are pushed to the limits but the waiting times and the fact that I was left in a room for more than 12 hours was unnecessary". **(A&E)**

"The waiting time to be examined was completely unacceptable, over 5 hours. I hope I never need to visit again". **(UCC)**

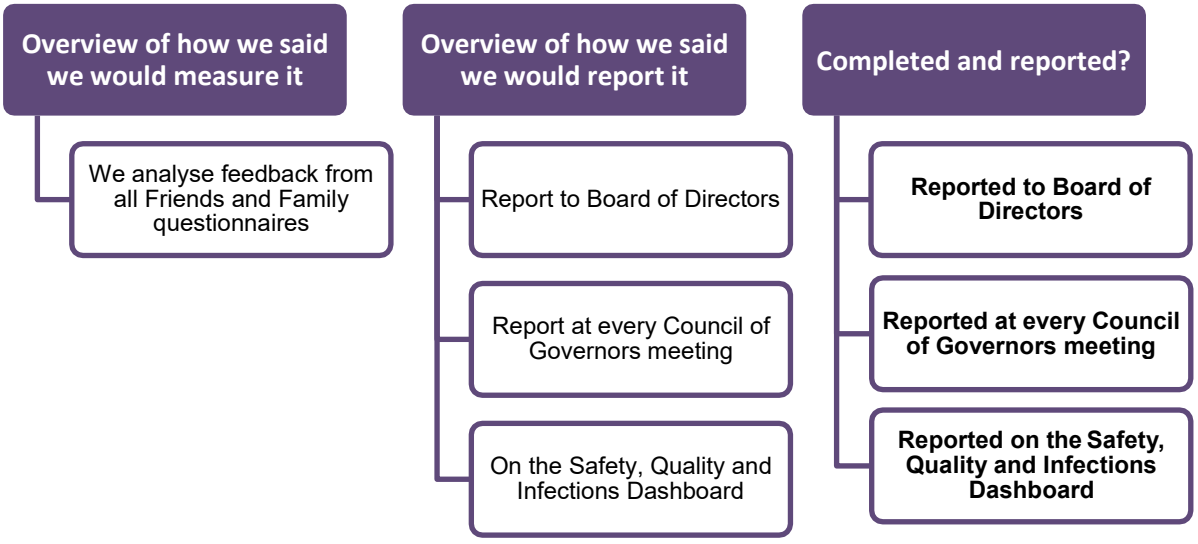
"I would have liked a little more privacy at reception when explaining my condition". **(UCC)**

Action plans
When survey results are published or locally compiled, results are feedback to the clinical teams via senior clinical practitioner meetings, directorate and ward meetings, Trust councils committees and external meetings where patient representatives are present such as the Cancer Patient Group and the Patient and Carer Experience Council. Results are also feedback via clinical governance and education sessions. Action plans are led by the Care Groups who present the results and their action plans to the Patient and Carer Experience Committee.

Priority 3: Patient Experience
Friends and Family Test

Rationale: The Department of Health has required Trusts to ask the Friends and Family recommendation questions from April 2013

Overview of how we said we would do it
We ask patients to complete a questionnaire on discharge from hospital.



"My visit was exceptional from booking in to overall performance. Doctors, nurses, you should be very proud of everyone"

"Used annual leave to attend an appointment that proved to be utterly pointless. No further forward, info given could have been put on a very small leaflet"The FFT question changed a few years ago - "Overall, how was your experience of our service?"

You can rank your answer from "very good" to "very poor".

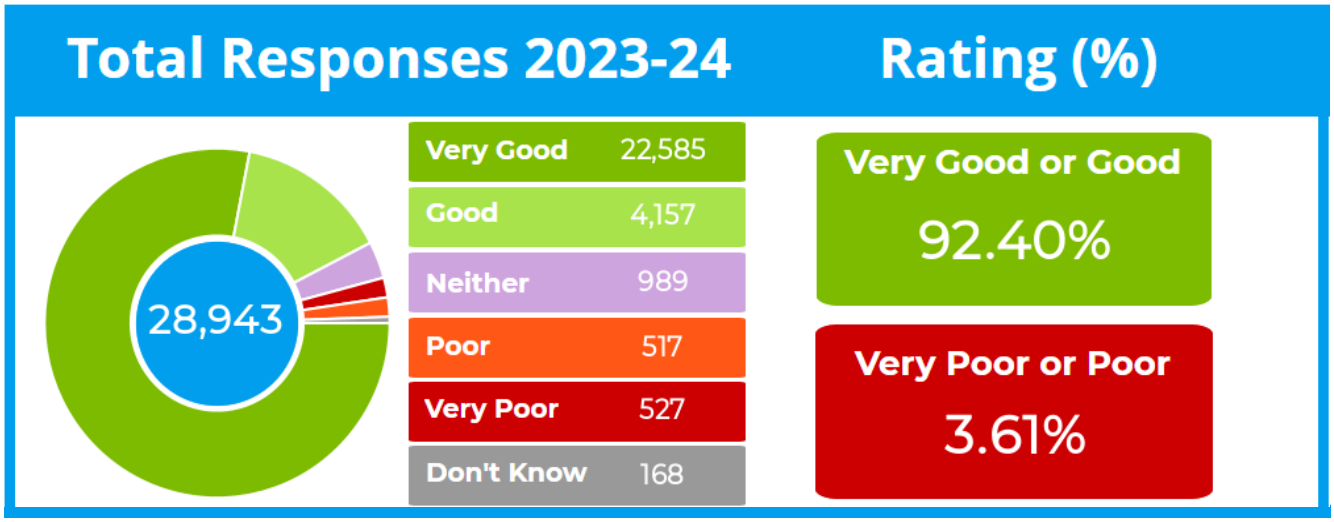
The friends and family data can be found at:
https://www.england.nhs.uk/fft/friends-and-family-test-data/

The Trust has created and developed an in-house data collection and reporting system that covers **70** areas for the Friends and Family Test across both sites and community.

North Tees and Hartlepool NHS Foundation Trust

Returns for 1 April 2023 to 31 March 2024 from all our services

The Trust continuously monitors the positive and negative comments on a weekly basis to ensure that any similar issues or concerns can be acted upon by the ward matrons. This helps in reducing the reoccurrence of similar issues in the future.



Total Responses	Month												
FFT Response	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Total
Very Good	1,547	1,779	1,859	1,883	2,104	1,935	2,021	1,964	1,344	2,392	1,947	1,810	22,585
Good	294	342	339	319	361	358	368	360	257	451	384	324	4,157
Neither Good nor Poor	57	73	79	86	81	85	83	82	73	108	100	82	989
Poor	32	46	42	39	32	44	41	52	35	58	57	39	517
Very Poor	35	34	39	51	53	46	42	35	37	52	57	46	527
Don't know	12	10	13	11	13	18	13	9	14	26	15	14	168
Total	1,977	2,284	2,371	2,389	2,644	2,486	2,568	2,502	1,760	3,087	2,560	2,315	28,943

*Data from Trusts Friends and Family database and Inhealthcare

"I was shocked at how quickly I got seen. The triage and doctor were superb, couldn't of asked for more."

"The care was excellent. All staff were friendly and kind."

"Everything clearly explained and at no point did I feel I was being hurried along. Excellent service."

"The waiting time took 4 hours. This is through no fault of staff as they were understaffed."

"I have waited 4 months for appointment to be told he couldn't deal with my issue."

Part 2b: 2024-25 Quality Improvement Priorities

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

Quality Priorities 2024/25		
Patient Safety	**Clinical Effectiveness**	**Patient Experience**
We will continue to embed our Patient Safety Incident Response Plans, developing a positive, 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 learn from incidents, claims and inquests to improve outcomes for our patients whilst embedding PSIRF.	We will review and strengthen the mortality review processes, ensuring that learning from deaths is used to improve patient outcomes.	We will proactively seek patient feedback and ensure there is continuous improvement in care and treatment because of the feedback we receive.
We will improve medication safety and continue to optimise the benefits of ePMA and evaluate the impact on learning from medication incidents	We will develop and implement shared decision making and goals of care.	We will respond in a timely way to complaints, supporting patients and families through difficult circumstances and implement quality improvements as a result of the learning.

Patient Safety	Effectiveness of Care	Patient Experience
Infections	Mortality / Learning from Deaths	Palliative care and care for the dying patient
Dementia	Discharge Processes	Friends and Family Test
Mental Health	Accessibility	Patient experience surveys
Safeguarding (Adult and Children's)	Safety and Quality Dashboard	
Maternity	Violent Incidents	

The Trust will continuously monitor and report progress on each of the above indicators throughout the year by reporting to the Board.

Part 2c: Statement of Assurance from the Board

Review of Services

During 2023-24, North Tees and Hartlepool NHS Foundation Trust provided and/or subcontracted 103 relevant health services. The majority of our services were provided on a direct basis, with a small number under sub-contracting or joint arrangements with others.

North Tees and Hartlepool NHS Foundation Trust has reviewed all the data available to them on the quality of care in 103 of these relevant health services. The income generated by the relevant health services reviewed in 2023-24 represents 92.1% of the total income generated from the provision of relevant health services by the North Tees and Hartlepool NHS Foundation Trust for 2023-24.

National clinical audits and national confidential enquiries

The Healthcare Quality Improvement Partnership (HQIP) provides a comprehensive list of national audits which collected audit data during 2023-24 and this can be found on the following link:

http://www.hqip.org.uk/national-programmes/quality-accounts/

During 2023-24, **50** national clinical audits and **4** national confidential enquiries covered the relevant health services that North Tees and Hartlepool NHS Foundation Trust provides.

During 2023-24, North Tees and Hartlepool NHS Foundation Trust participated in **92%** of national clinical audits and **100%** of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquires that North Tees and Hartlepool NHS Foundation Trust was eligible to participate in, and those in which the Trust did participate with data collection completed during 2023-24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Mandatory National Clinical Audits	Participation	% cases submitted
Adult Respiratory Support Audit	Yes	100%
Breast and Cosmetic Implant Registry	No	
British Hernia Society Registry	No	
Case Mix Programme (CMP)	Yes	100%
Elective Surgery (National PROMs Programme)	Yes	100%
Emergency Medicine QIP: a) Care of Older People	Yes	100%
Emergency Medicine QIP: b) Mental Health (Self-Harm)	Yes	100%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): a) Fracture Liaison Service Database (FLS-DB)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): b) National Audit of Inpatient Falls (NAIF)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): c) National Hip Fracture Database (NHFD)	Yes	100%
Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	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): a) National Diabetes Footcare Audit (NDFA)	Yes	100%
National Adult Diabetes Audit (NDA): b) National Diabetes Inpatient Safety Audit (NDISA)	Yes	100%
National Adult Diabetes Audit (NDA): c) National Pregnancy in Diabetes Audit (NPID)	Yes	100%
National Adult Diabetes Audit (NDA): d) National Diabetes Core Audit	Yes	100%
National Respiratory Audit Programme (NRAP): a) COPD Secondary Care	Yes	100%
National Respiratory Audit Programme (NRAP): b) Pulmonary Rehabilitation	Yes	100%
National Respiratory Audit Programme (NRAP): c) Adult Asthma Secondary Care	Yes	100%
National Respiratory Audit Programme (NRAP): d) Children and Young People's Asthma Secondary Care	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (NAD)	Yes	100%
National Bariatric Surgery Registry	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Cardiac Audit Programme (NCAP): a) National Heart Failure Audit (NHFA)	Yes	100%
National Cardiac Audit Programme (NCAP): b) National Audit of Cardiac	Yes	100%

Rhythm Management (CRM)		
National Cardiac Audit Programme (NCAP): c) Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Comparative Audit of Blood Transfusion: a) 2023 Audit of Blood Transfusion against NICE Quality Standard 138	Yes	100%
b) 2023 Bedside Transfusion Audit	Yes	100%
National Early Iflammatory Arthritis Audit (NEIAA)	No	
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Gastro-Intestinal Cancer Audit Programme (GICAP): a) National Bowel Cancer Audit (NBOCA)	Yes	100%
National Gastro-Intestinal Cancer Audit Programme (GICAP): b) National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
National Joint Registry	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	100%
Perioperative Quality Improvement Programme	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)[1]	Yes	100%
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit	No	
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	Yes	100%

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

National confidential enquiries (NCEPOD) study	Participation	% cases submitted

Community Acquired Pneumonia	Yes	100%
Testicular Torsion	Yes	100%
Endometriosis	Yes	100%
End of Life Care	Yes	50%

The reports of **23** national clinical audits were reviewed by the provider in 2023-24 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions taken/in progress
National Fracture Liaison Service	Published in January 2023, this annual report presented the results of secondary fracture prevention care received by patients aged 50 and older, following a fragility fracture between January and December 2021. 1747 trust episodes of care were included in the report, representing a significant increase compared to previous audits. Improvements have been made around patients offered and referred for falls risk assessment. There was a slight dip in numbers of patients offered bone protection, linked with requesting DEXA scans. A business case is being developed to increase the resourcing for DEXA scans. This issue has been added to the risk register.
National Hip Fracture Database	This report presented how care since COVID-19 compared with the baseline of 2019 before COVID-19. Local results demonstrated good performance in prompt surgery (which improved from 53% to 64%) and NICE compliant surgery (which improved from 58% to 69%) when compared to the previous year's report. Admission to a specialist ward within four hours required improvement. A working group has been established to discuss the pathway from the Emergency Department to the ward.
NCEPOD "Re-measuring the Units"	Following the original study in 2013, this national re-audit was undertaken in 2019, and published in December 2022, to measure improvements following the original recommendations. The Trust now has an established Alcohol Care Team which has been in place for a year. This has facilitated significant improvement in alcohol screening, implementation of cirrhosis care bundles, and patient escalation. The overall Trust service has improved significantly since the original report.
NHSBT Blood sample collection and labelling	This audit reviewed blood transfusion cases in a calendar month looking for reasons why some samples had been rejected. The results confirmed that in some cases this was because core patient identifiers were not matching on the tube and the form. The audit also looked at sustainable quality improvement because pathology testing is the single highest volume clinical activity in the NHS. An action plan has been completed and a business case for dealing with rejected specimens developed.
National Cardiac Arrest Audit (NCAA)	This audit showed that compared to other trusts nationally, North Tees & Hartlepool have fewer cardiac arrests. Overall results had improved from the previous year and all outcomes were within predicted ranges. Ward survival to discharge is now above what is

	expected and the rate of cardiac arrests is decreasing, showing better use of DNACPR. Future plans include linking in with regional colleagues to share best practice.
National Diabetes Audit	This audit reviewed eight criteria in the care process for diabetic patients. Results were good, but it was noted that documentation of some routine criteria could be improved. Following the audit, a weekly multi-disciplinary team diabetic foot clinic was developed to focus on patients with diabetic foot related problems. In addition, a pilot project with local nursing homes has been initiated identifying support for diabetic patients with the intention of reducing admissions of patients with complications.
RCR Vertebral Fragility Fractures Audit	The audit looked at osteoporotic fractures of the spine and reviewed non-traumatic fractures of the chest, abdomen and pelvis in patients over 70 years of age. Areas for improvement and actions included agreeing a local policy for the standardised use of terminology for vertebral fragility fractures as well as developing a service level agreement to adopt and adhere to vertebral fractures reporting policies.
National Pregnancy in Diabetes Audit	This audit identified an increase in the number of pregnancies complicated by pre-existing diabetes and it was noted that this related to an increasing number of patients with type 2 diabetes in the local population. The audit also identified a low uptake of women taking folic acid in the pre-conception period. The diabetes specialist nurse is communicating with primary care colleagues to emphasise the importance of folic acid use. Another new initiative following the audit is to ensure all pregnant women with diabetes are offered retinal screening.
ICNARC Report	This audit confirmed that all quality indicators in Intensive Care were within the predicted range. The action plan included a requirement to maintain mortality reviews and to engage with the regional dashboard to enhance benchmarking.
MBRRACE-UK Report	This audit on maternal deaths identified two cases, one of which was a case of pulmonary embolism. Actions included a process whereby obstetric colleagues are alerted on a daily basis when pregnant or postnatal women are admitted to surgical or medical wards. This ensures that all relevant information is collected for these patients on the early warning score chart so that any potential complications can be identified and acted upon quickly.
National Audit of Care at End of Life (NACEL)	This audit is based around the five priorities for care that are recognised at the end of life, recognition of dying, sensitive communication, involvement in decision making, the needs of families and an individual plan of care. Results were good, but the audit identified issues with discussing nutrition and hydration with families. An educational intervention has subsequently been initiated to improve this. Work is also being undertaken to improve the provision of an individualised plan of care and making it available in digital format. The related staff survey identified that most staff felt confident communicating with dying patients and those important to them. Staff also felt confident in assessing and managing pain and

	physical symptoms. Staff were slightly less confident responding to spiritual, emotional and cultural needs. Following this national audit, the team have met with patient experience colleagues and bereavement officers to look at receiving more feedback from relatives.
National Emergency Laparotomy Audit (NELA) 8th Annual Report	This audit identified a slight reduction in case ascertainment and low results for CT reporting which were also reflected nationally. Good results were shown in risk documentation before and after surgery. Following the audit, case ascertainment has been reviewed and a plan implemented to improve this.
National Audit of Dementia (Round 5 report)	There was good performance in patients receiving an initial delirium screen. Although carer questionnaire returns were low, there was positive feedback from carers. Patient survey feedback was challenging, as some patients were unable to remember aspects of their care. This was fed back to the national team. Overall, significant improvements were made since round 4, with Trust results being higher than the national average.
National Neonatal Audit Programme annual report 2022 (2021 data)	The previous audit showed the Trust was an outlier for the 2-year follow-up, deferred cord clamping and breast feeding. Several quality improvement projects have been completed since the last audit to address these issues. Overall improvements are now evident in all key areas.
NRAP National COPD (chronic obstructive pulmonary disease) Audit Report	More education is required to encourage patients to attend for spirometry testing to enable the recognition of disease at an earlier stage. This is a wider issue in conjunction with primary care. The Trust cannot currently provide a 7-day service due to staffing levels. Although non-invasive ventilation (NIV) is given correctly, documentation on TrakCare requires improvement. Oxygen prescribing is commendable. A smoking cessation service is now in place. An action plan includes discussion regarding a business case to expand the COPD nursing team, and COPD nurses to provide training to A&E staff.
Royal College of Emergency Medicine QIP Report: Pain in Children	The national inclusion criteria had reduced the potential numbers of patients to include in the audit significantly, by only including patients presenting to Type 1 departments (excluding Type 3 presentations) so only long bone fractures contributed to the data submission. This has been discussed with the College. With this issue in mind, the team is undertaking a local audit, looking at patients presenting to the Children & Young People Emergency Department with any pain. Work is ongoing around this, and will be reported in the coming weeks.
Royal College of Emergency Medicine QIP Report: Infection Control	Good results were shown in patient screening on arrival for COVID symptoms, and patients identified with vulnerability being isolated to a side room. 100% of patients who were potentially infectious were moved to a side room immediately.
Royal College of Emergency Medicine QIP Report: Consultant Sign-off	There was a major problem with the national administration of this audit, whereby the college did not provide any real-time analysis for a long period, hence the intended continuous improvement cycles could not take place until data analysis was restored. Work is ongoing around recording senior reviews. There is now a model in the department, where all patients are discussed with a senior

	clinician, in order to further improve outcomes. A short form on TrakCare is to be added, to allow senior decision makers to record the conversation on the face-to-face review that they have had.
NRAP National Adult Asthma Audit Report	The Trust has seen an improvement in figures for respiratory review, systematic steroids, smoking cessation and inhaled steroids. The Trust has employed a Specialist Asthma Nurse who takes the lead on co-ordination of the discharge bundle and provides education to ward staff on inhaler technique. There currently is not a 7-day service or on-call specialist for respiratory review. The trust is in the process of setting up a Tees Valley Asthma Service which will focus on the most severe forms of asthma.
NRAP National Paediatric Asthma Audit Report	The Trust is working with the digital team to incorporate the discharge care bundle into e-discharges for asthmatic patients to ensure it is better completed at discharge. Smoking cessation advice requires improvement, and a named link nurse is now in place for this. Leaflets will be given to parents and/or carers highlighting the dangers of second hand smoking. The team will be working closely with A&E colleagues to improve the administration of steroids within the 1-hour target.
NRAP National Pulmonary Rehabilitation Audit	The Trust has one of the highest density of patients with COPD and some of the highest rates of morbidity and mortality compared to national data. The pulmonary rehabilitation service is a research active site with current projects including National Institute for Health and Care Research (NIHR) funded clinical trials with the Kings College London and Teesside University. Areas showing good performance include implementation of the repeat walk test and the walking football study, enrolling patients after completion of pulmonary rehabilitation. Waiting times for the initial pulmonary rehabilitation assessment have also improved. The Trust has significantly higher referral rate of 1000 per year versus a national average of 300 a year. We have a challenging context of population, with significant deprivation and severe respiratory disease. Although there are challenges around uptake attendance and completion rates, the Trust has been commended by The Kings College lead who has been in touch to thank the service for their hard work.
Public Health England Surgical Site Infection Audit (NICE NG125/QS49)	The Breast Surgical Site Infection audit is a mandatory audit that commenced in 2021. The UK Health Security Agency (UKHSA) requires one quarter of data per year from all trusts; our Trust submits all four quarters. Mid 2023 results identified an increase in infection rates. Themes identified: • Trend towards higher risk procedures. • No decolonisation prior to surgery. • Variation in practice for prophylactic antibiotics, skin prep, double gloving, double draping for complex surgery. • Theatre etiquette to be addressed, as per policy. Large proportion of agency staff provide scrub team for breast cases.

	Recommendations included: no complex surgery to be carried out in the day case theatres at North Tees; decolonisation for moderate and high risk reconstructive breast surgery; antibiotics for moderate and high risk reconstructive breast surgery; alcoholic chlorhexidine skin prep and double-gloving for implant surgery, and change of glove prior to implantation. Other recommendations included antibiotic cavity wash for implant surgery, tunnelled drains with chlorhexidine drain dressing, negative pressure dressing, bacteriostatic sutures, and theatre etiquette (no entry during implant surgery). Successes included no positive staff testing, quick identification of anomaly, internal investigation initiated well before data submission date, excellent MDT working, open and honest reporting, changes implemented quickly and the implementation of Duty of Candour. Quarter 3 data demonstrated significant improvement.
National Lung Cancer Audit 2023	The "State of the Nation" report relates to patients diagnosed with lung cancer between January and December 2021. The audit used to be co-ordinated by the Royal College of Physicians of London, but has been taken over by the Royal College of Surgeons of England. Some of the data on the report regarding receipt of surgery is incorrect, due to it being recorded against the wrong site, i.e. incorrectly attributed to South Tees Trust, instead of North Tees and Hartlepool Trust. This has been fed back to the national team and is currently under investigation. The team will continue to monitor figures and ensure recording of data is in line with the national report.

All national audit reports are considered by the Audit and Clinical Effectiveness (ACE) Committee which reports to the Quality Assurance Committee, and this reports directly to the Board of Directors.

Local Clinical Audits

The reports of **75** local clinical audits were reviewed by the provider in 2023-24 and North Tees and Hartlepool NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

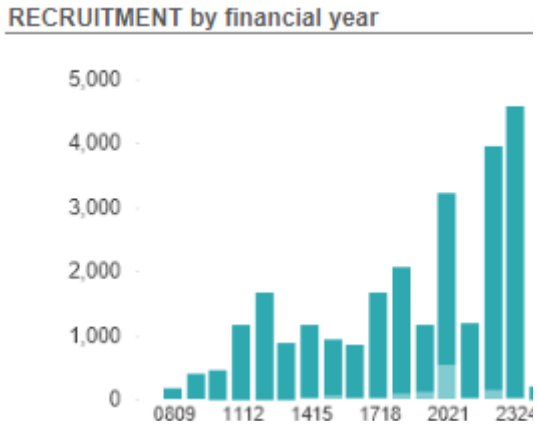
Audit title	Actions taken/in progress
Deep Sedation for Endoscopy (Anaesthetics)	Initial audit identified the need for presence of an anaesthetic nurse to assist the anaesthetist. A recent re-audit confirmed the anaesthetic nurse was in place for 100% of cases.
Head Injury NICE CG 176 & QS 74 (Emergency Care)	Findings identified that many CT scans were being performed unnecessarily in adult patients. Education in relation to current guidelines has been undertaken to improve adherence to recommendations.

Infection Rate - post Flexible Cystoscopy (Surgery & Urology)	Action taken to stop the use of flexible cystoscopy for recurrent urinary tract infections unless there is a strong indication such as visible haematuria, pneumaturia or severe symptoms in the absence of infections or based on imaging findings.
Myeloma: diagnosis and management NICE NG 35 (Haematology)	Audit findings highlighted the need to perform PET-CT (positron emission tomography and computed tomography) / MRI (magnetic resonance imaging) scans to assess for bone lesions.
"Get it on time" – Parkinson's Disease Medication Prescribing (Medicine: Elderly Care)	Action taken to improve frequency of medicines reconciliation including education for staff around time-critical medications.
DEXA Scans in Chronic Pancreatitis NICE NG 104 (Medicine: Gastroenterology)	It was identified that there was insufficient radiological evidence in support of pancreatitis diagnosis. In response to audit findings, the Gastroenterology Consultant has implemented a monthly multi-disciplinary pancreatitis clinic to ensure improved diagnosis and management.
Acute Management of Upper Gastrointestinal Bleeding NICE CG 141 & QS38 (Medicine: Gastroenterology)	Educational presentation to be given at a local Grand Round event for trainees in the Emergency Department and Emergency Assessment Unit around current issues in the documentation of smoking and alcohol intake when clerking patients as well as administration of tranexamic acid and over-transfusion of patients.
Laparoscopic Techniques for Hysterectomy NICE IP 239 (Obstetrics & Gynaecology)	Audit findings identified a low percentage of same-day laparoscopic hysterectomies. An action plan was agreed to address pre-operative selection and priming of patients, increased use of patient information leaflets and patient education around optimising body mass index (BMI) prior to surgery.
Thyroid Protection against Fluoroscopy in Trauma Theatres (Orthopaedics)	The audit identified that the thyroid guards were unhygienic and out of date and inappropriately sized. Some staff were not wearing the guards. New protection equipment was ordered and staff meetings were arranged to ensure new equipment was appropriately sized and properly used in future.
MSK Service Osteoarthritis Audit NICE NG 226 & QS 87 (Out of Hospital Care)	Improved advice to patients required in terms of pharmacological management of pain associated with osteoarthritis and more options for exercise and self-management. The Pharmacy team have planned a presentation to the Musculoskeletal (MSK) Service staff to discuss and support this.
Assessment and Management of Fetal Alcohol Spectrum Disorder (FASD) NICE QS 204 (Paediatrics)	The audit identified the lack of a formal referral pathway and inconsistent use of clinical coding and terminology within doctor's letters. The Paediatric Consultant Leads have made a summary of appropriate clinical coding more accessible to make it more consistent and future audits more robust. A working group has been formed to implement local pathways for referral, diagnosis and management of children with possible FASD.
Lynch Syndrome in Colorectal Cancer NICE DG 27 (Pathology Services)	The audit identified two patients who were not sent for molecular testing for Lynch yndrome (the most common form of hereditary colorectal cancer). These patients have since been tested retrospectively. Additionally, it was noted that molecular testing is currently performed off-site which adds delay to diagnosis. This testing will be moved in-house over the coming months to improve the timeline for the patient.

Clinical Research

The number of patients receiving relevant health services provided or subcontracted by North Tees & Hartlepool NHS Foundation Trust (NTH) in 2023/24 that were recruited during that period to participate in research approved by a research ethics committee was 4,589 (across 89 studies and 20 clinical specialties). This is higher than 2022/23 (3946)

Fig 1 Recruitment over time



Clinical research helps us to improve patient care. Hospitals that are research active have better patient outcomes. Participation in research can help improve current and future care by finding new ways to diagnose, prevent, treat, or cure disease and disability. All research undertaken in the NHS is rigorously reviewed to ensure it is well designed and there are very clear regulations and guidelines to follow to ensure that the safety of patients and their data is paramount. We have dedicated clinical and non-clinical staff employed in our trust to ensure that all research receives the relevant reviews and approvals, is conducted exactly as the research protocol directs and that patient safety is monitored throughout. The Research and Development (R&D) Department employs over 130 members of staff directly supporting research and offers opportunities to clinical staff to work part-time within research to ensure research is embedded across the organisation.

The Trust is a partner organisation within the Clinical Research Network for the North-East and North Cumbria (CRN NENC) and supports the CRN NENC to deliver and lead high quality research as part of the National Institute for Health Research (NIHR) portfolio. In 2019 we joined a strategic alliance with our research and development colleagues in South Tees NHS Foundation Trust to form the Tees Valley Research Alliance (TVRA) to offer an improved, efficient research service that would deliver more research opportunities to the patients of Teesside.

We have refreshed our TVRA Strategy to be delivered across both partner trusts in the Alliance. It is a patient focused strategy to deliver improved outcomes through two main streams ‘Growing Research’ and ‘Supporting Research’ (Fig 2).

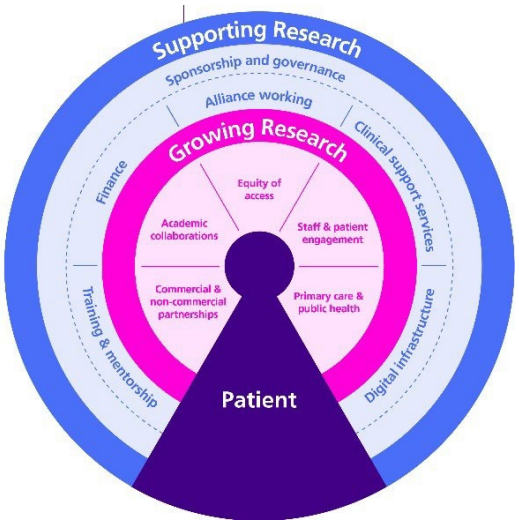


Fig 2 TVRA Strategy 2024

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

Successful contingency funding requests from the CRN NENC have enabled us to fund seven NMAHP posts (2.55 WTE) in seven clinical areas including paediatrics, neonatal care, critical care, stroke, bowel screening, palliative care and coronary heart disease to support patient recruitment creating an embedded research culture within care delivery as part of existing clinical roles.

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

We have extended the "Research Support and Best Practice Council" based in South Tees Hospitals to colleagues from North Tees & Hartlepool Trust. We have worked with the Assistant Director of Nursing to identify "Research link Nurses" in all clinical areas and are in the process of developing a training package and role requirements for these.

We have increased the number of non-medical Principal Investigators this last year in the TVRA from 24 to 43 (31 STH, 12 NTH).

Patient Engagement

Feedback from patients who have participated in NIHR studies within the Trust is sought via the NIHR "Patient Research Experience Survey" (PRES) with feedback reviewed quarterly at our Research and Development Directorate meetings. Due to high recruitment into trials last year our target for responses to PRES survey was significantly increased to 389 for this year. To date 391 responses have been received so the target was met. The responses show that 92% felt their participation had been valued and 89% would consider taking part in research again if asked. We have significantly improved the content of staff facing and patient facing internet sites and have developed a patient and staff facing animation to explain the purpose of research and how patients can get involved.

Commercial Collaborations

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

In February we officially opened the FutureMeds Clinical Trials Facility within the Middlefield Centre on our North Tees site. This collaboration with an external commercial clinical trials provider will ensure more research opportunities can be offered to patients within the Tees Valley

across primary and secondary care. We have put in place a robust oversight group and governance arrangements to ensure we can support the company in a compliant manner in inviting patients to participate in their studies. In time we hope to be able to co-deliver trials within the trials facility in the Middlefield Centre.

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

There was no CQUIN payment received for 2023/24.

The national CQUIN scheme for 2023/24 comprised of the following clinical quality indicators:

Indicator	Description
Flu vaccinations for frontline healthcare workers	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact.
Prompt switching of intravenous to oral antibiotic (**IVOS**)	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.
Timely communication of changes to medicines to community pharmacists via the **Discharge Medicines Service**	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.
Treatment of **non-small cell lung cancer** (stage I or II) in line with the national optimal lung cancer pathway	Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-2) referred for treatment with curative intent, as per the NICE QS17 recommendation. There are a variety of options for treatment with curative intent. This indicator sets out the comprehensive range of treatment modalities that should be considered either individually or in combination. Decisions about treatment options should be taken at cancer multidisciplinary team meetings and involve patients.
Supporting patients to drink, eat and mobilise (**DrEaM**) after surgery	Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.
Compliance with timed **diagnostic pathways** for cancer services	Achieving 55% of referrals for suspected prostate, colorectal, lung, oesophago-gastric, head & neck and gynaecological cancers meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways.
Identification and response to **frailty** in emergency departments	Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.
Recording of and response to **NEWS2** score for unplanned critical care admissions	Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.

Assessment and documentation of **pressure ulcer risk**	Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.
Assessment, diagnosis and treatment of **lower leg wounds**	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.

Within the Trust, clinical teams were appointed to lead on quarterly audits of patient care and development of ongoing improvement plans. Outcomes and improvements were monitored centrally by the establishment of a local CQUIN Steering Group, which provided governance and assurance to the Quality Assurance Council.

The Trust's quarterly performance against all relevant indicators are summarised and colour-coded in relation to their level of achievement against the clinical standards, as follows:

	Standard		Quarter			
	Min	**Max**	**Q1**	**Q2**	**Q3**	**Q4**
Flu vaccinations	75%	80%	N/A	N/A	48.6%	48.0%
IVOS	60%	40%	55%	51%	36%	13%
Discharge Medicines Service	0.5%	1.5%	1.78%	2.02%	1.48%	2.15%
Non-small Cell Lung Cancer	80%	85%	95%	100%	100%	95%
DrEaM	70%	80%	84%	84%	86%	TBC
Cancer diagnostic pathways	35%	55%	55%	59%	66%	TBC
Frailty	10%	30%	41%	45%	11%	27%
NEWS2	10%	30%	44%	46%	62%	TBC
Pressure ulcer risk	70%	85%	48%	46%	67%	63%
Lower leg wounds	25%	50%	66%	34%	48%	TBC

did not meet the standard *partially met the standard* *fully met the standard*

A decision was taken nationally to pause the CQUIN programme during 2024/25, however the Trust has agreed to progress this work locally with its Integrated Care Board in order to continue this valuable quality improvement work.

Care Quality Commission (CQC) registration, review and investigations

North Tees and Hartlepool NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions for all services provided.

The Care Quality Commission (CQC) published a report in September 2022, following the inspection of two core services, maternity and children and young people. The report identified that the ratings for the Trust were 'good' in two of the domains and 'requires improvement' in three domains; safe, effective and well-led. This meant that the Trust's overall rating changed from 'good' to 'requires improvement'. The report outlined 13 'must do' actions and 18 'should do' actions. The Trust has since addressed the CQC must and should do actions from the inspection.

The Trust has focused on improving governance oversight with executive-level ownership to ensure staff and stakeholders have a better understanding of the improvements taking place. Progress is monitored through the Trust CQC Operational Group, Quality Assurance Council with escalation to the Executive Management Team. Progress reports are also provided to the Quality Committee and Board of Directors on a regular basis.

The priority for 23/24 has been to fully understand the new CQC single assessment approach. A ten-week intensive training programme has been completed for senior managers, with on-going training across Care Groups on CQC Quality statements for all staff groups. We have communicated across the organisation in relation to continuous improvement and the ability to demonstrate improvements in practice and delivery of high quality safe care for our patients.

Due to the ratings given at this inspection, the Trust's overall ratings of good across all domains changed to requires improvement in safe, effective and well-led. This meant that the Trust's overall rating changed from good to requires improvement.

Overall rating for this Trust	**Requires Improvement**
Are services at this Trust safe?	Requires Improvement
Are services at this Trust effective?	Requires Improvement
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Good
Are services at this Trust well-led?	Requires Improvement

The full inspection report can be found at: http://www.cqc.org.uk/provider/RVW

CQC Contact and Communication

The Trust has regular engagement meetings with our CQC Relationship Manager. In addition to these meetings, regular telephone contact is maintained. Prior to the engagement meetings, the Trust shares a comprehensive monitoring document. The document is based around the five domains and encompasses details related to incidents, complaints, staffing, and also allows the Trust to share any information it wishes. This has included examples of excellence in practice, awards Trust staff have been short-listed for and major developments within service delivery. As part of the engagement meetings, there has been the opportunity for CQC staff to make informal visits to clinical areas at their request.

Some information related to the Trust's CQC actions is available to the public on the Trust's website http://www.nth.nhs.uk/patients-visitors/cqc/. Quarterly news bulletins are being published and are available to the public on the Trust's website. http://www.nth.nhs.uk/patients-visitors/cqc/news-bulletin/

Duty of Candour

Duty of candour is the regulatory requirement of being open and transparent with people who use the Trust's services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. The legal requirements around duty of candour are defined and

specifically laid out in the CQC Regulation 20. All NHS Trusts are required to fulfil specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The Trust policy has been in place since the regulations were introduced, but has been updated with new CQC guidance and also the changes identified following analysis of the Trusts CQC report in 2022. The policy details for staff how application of the regulations should be communicated to patients and their families and/or carers and then recorded.

On a weekly basis, the Trust's Safety Panel are advised about all events reported with significant harm where the regulations would need to be considered and applied; most of these relate to events where harm has been reported as moderate harm or above. This can also include events linked to formal complaints that have been received, and if the duty of candour regulations are applicable. This sharing of information highlights cases to panel members, provides details of the application of the regulations within clinical areas, and where necessary, identifies any challenges in relation to applying the regulations.

The Trust e-learning package in relation to duty of candour has been updated; and this training has been mandated for all medical staff and other staff, grade 6 and above; at the end of March 2024 92% of the relevant staff have completed the training, this is monitored monthly through the Trusts mandatory training reports and displayed on the Yellowfin dashboard.

Since the publication of its 2022 CQC report, the Trust has undertaken three cycles of a quality audit of cases where the candour regulations have been applied. Cycle three has shown continued improvements that have been identified following quality improvement measures implemented after previous cycles.

The Trust policy has recently been updated and this has strengthened the governance of the regulatory requirements; these changes will be monitored closely over the coming year to ensure there is an ongoing improvement; this will be supplemented by AuditOne review this year.

Commissioners Assurance

There have been no visits during 2023-24.

Freedom to Speak Up (FTSU)

The National Guardian Office (NGO) and the Freedom to Speak Up Guardian (FtSUG) role was established in 2016 following the events at Mid-Staffordshire NHS Foundation Trust and the recommendations from the subsequent inquiry led by Sir Robert Francis. The Francis Report raised 290 recommendations. One of the recommendations was to have a designated person who was impartial and independent working in every Trust. This role would facilitate staff to speak in confidence about concerns at work including any public interest disclosure. It was acknowledged that staff should be listened to, taken seriously and would not suffer detriment as a result of speaking up. The NGO was established to train and support FtSUGs as well as providing appropriate resources to help establish a healthy "Speak Up, Listen Up and Follow Up" culture. All FtSUGs are locally employed but are trained by the NGO.

The Freedom to Speak Up (FtSU) ethos aims to help promote and normalise the raising of staff concerns ultimately for the benefit of patients and workers. Speaking up not only protects patient safety but can also improve the lives of workers by listening to what they need to be able to do their job, so that they can deliver an excellent service. FtSU is about encouraging a positive culture where people feel they can speak up, their voices will be heard and their concerns or suggestions acted upon. In the seven years since Sir Robert Francis recommendations were implemented, the FtSUG role continues to evolve and move away from a whistleblowing culture to one of permission, encouragement, openness and transparency.

> *"If we can get the culture right, benefits will follow, including improving patient safety, innovation for improvement, retaining workers and making the National Health Service a great place to work".* Dr Jayne Chidgey-Clark, National Guardian for the NHS

The Trust positively encourages all employees to speak up if they have a concern about risk, malpractice or wrongdoing. Moreover, if there are any behaviours or acts which harm the services the Trust delivers, we have both a duty and right to speak up. Examples may include (but are by no means restricted to):

- Patient safety concerns, quality of care, unsafe staffing.
- A particular way of working or a process that isn't being followed.
- Professional malpractice.
- You feel you are being discriminated against.
- Working relationships e.g. the behaviours of others is affecting your wellbeing or that of your colleagues.
- A bullying culture (across a team rather than individual instances of bullying).
- A breach of confidentiality, trust policy or procedures.
- Suspicion of fraud.
- A criminal offence has been committed, or is likely to be committed.
- An idea of an improvement or innovation.

Trust progress 2023-2024

A newly appointed full time, trained FtSUG came into post in September 2023. The FtSUG has been formally registered on the NGO database, has completed NGO training and attends the FtSUG network meetings. For resilience and business continuity purposes there is also a contingency FtSUG who has also been formally registered on the NGO database. It has been agreed the contingency FtSUG will cover two days per week in the event of unplanned long term absence of the FtSUG. The contingency FtSUG is also up to date with their training. Cases are not shared between FtSUGs, unless consent has been given to do so.

The FtSUG hosted the first Freedom to Speak Up Champion (FtSUC) network meeting in January 2024. This was attended by FtSUC, FtSUG from South Tees and safeguarding. The FtSUC found the meeting very useful and it has been decided to continue the FtSUC network meetings quarterly. The FtSUC have started to collect data on the high level themes of what workers are speaking up about, before signposting them to the appropriate person, so this can be triangulated as per national guidance.

Currently we have 14 FtSUC in the Trust. To promote the further recruitment of FtSUC, the FtSUG has drafted a FtSUC role summary, application form and line manager sign off. The FtSUG will work with workforce to get these implemented and to ensure a fair recruiting process. The FtSUG has already received a lot of interest about the FtSUC role.

A third FtSU promotion took place in October 2023. This has been an annual event for several years, taking place every October, and forms part of the National FtSU campaign. Promotion of this years "Speak Up Month" focused on the national theme of "breaking barriers". The FTSUG worked alongside the Communications Team to produce a plan to promote the Trusts FtSUC, introduce the new FTSUG and share Executive Team messages.

The FtSU: A Reflection and Planning Tool was completed and presented to Board 1st February 2024 as per national guidance.

The FTSUG continues to attend quarterly North East, Yorkshire and Humberside regional FtSUG network meetings with the aim of learning, sharing best practice, peer support and working collaboratively. As part of the Joint Group Model, the FtSUGs at North and South Tees Hospital have established and sustained a good working alliance to work collaboratively as the Joint Partnership evolves. The FtSUGs have written a joint paper to look at the FtSU arrangements across both sites as part of peer review and sharing best practice, following the Lucy Letby case.

The FtSUG has presented at the FtSU Induction to Allied Healthcare Professional studying at Teesside University to ensure students are aware of FtSU before commencing placements at the Trust.

The new Speaking Up Policy has now been implemented. This is a national policy from NHS England and the NGO in which all Trusts were expected to adopt as minimum standard by January 2024.

As part of the proactive work the FtSUG continues to promote the role via team meetings, floor walking and ward visits and has a high presence within the Trust, which can be demonstrated in the data. The newly appointed FtSUG has had an average of one worker speaking up, per week. Those workers who have spoken up have been from different areas of the organisation and a variety of professional backgrounds including doctors, nursing, allied health care professionals, administration and students.

All staff are actively encouraged to undertake National Guardian Office “Speak Up” (workers) “Listen Up”(middle management) and “Follow Up” (executive leaders), training modules on ESR (the electronic staff record). This is not mandatory training but all training modules are actively promoted by the FtSUG and FtSUC. To encourage staff to do the training the FtSUG has implemented workshops for all three modules.

Regular “Keep in Touch” meetings with the Executive Sponsor, Non-Executive Director for FtSU and all other senior leaders have helped create a relationship approach to speaking up as well progressing any concerns raised. Monthly meetings continue with the CEO and Managing Director whilst the group model evolves. The FTSUG also presents monthly updates at Executive Team Meeting and as required to Board.

The FtSUG has submitted data to the North East and North Cumbria ICB audit for assurance and peer review of Trust Freedom to Speak Up processes. The ICB request that each trust submit an audit of two anonymised (FtSU) cases, to ensure that correct FtSU processes have been followed.

Reflecting on discussions about detriment as a perceived barrier for “Speaking Up” the FtSUG has drafted a feedback survey 3, 6, and 12 months after closing a case to ask if the worker has suffered detriment following “speaking up”. To complement the work on detriment the FtSUG has drafted a presentation and leaflet to educate staff on what detriment is and the importance of reporting it.

The FtSUG has been looking at how to support neurodiversity in the workplace, the sexual safety charter, attends the EDI steering group, the onboarding steering group, Schwartz round steering group and supports the wellbeing framework. The FTSUG also attends the following to promote FTSU:

- Quarterly Patient Safety Council
- Quarterly Care Group Senior Management Team meetings
- Monthly meetings with Care Group Directors.
- Staff network meetings (Ability, Ethic Minority, women and LGBTQ+)
- All staff inductions
- Teesside University

- Joint Forum
- Schwartz Round Steering Group
- NED, SMT Care Group 3 and SMT NTH Solutions “Follow Up” workshop.
- FtSUG Regional Network meeting.
- Quarterly Senior Practitioner Manager Operational Meeting
- Quarterly Matrons Meeting
- Attended Main Outpatients Staff Meeting at UHH
- Attended Obs and Gynae Directorate Meeting
- Community Forum

National Guardian Office 2023 -2024 data submitted:

Q1 – 46 cases (April 2023 – June 2023)
Q2 – 22 cases (July 2023 – September 2023)
Q3 – 11 cases (October 2023 – December 2023)
Q4 – 18 cases (January 2024 – March 2024)

Total number of contacts 97

88 cases have been closed, resolved or have received final outcomes.
9 cases remain open due to awaiting further discussions and / or follow up actions.

Since the new FTSUG commenced in September

96 contacts were received confidentially (99%)
1 contacts were received openly (1%)
0 contacts were received anonymously (0%)

Anonymous reporting at the Trust has come down significantly from last year, from being above the national average of data reported to the NGO at 10.4% to 0%). This gives assurance that workers are happy to speak up confidentially and that they trust their identity will only be shared with their consent. The highest percentage of concerns being raised are done so confidentially at (99%) and this shows there is a long way to go to make speaking up “business as usual” in an open and transparent way.

Please note, as per the NGO guidelines, all Trusts should be working towards a culture where speaking up is “business as usual”. The FtSU ethos is to reduce anonymous reporting where possible and to move into a confidential – open speak up culture. It is important to note that anonymous reporting happens in many organisations and confidentiality remains an important aspect of some cases and processes. Speaking up is accepted in all formats and colleagues are encouraged to report concerns responsibly, with civility and to include any suggested outcomes / improvements if possible.

Of the 96 contacts received, specific themes emerged

- Behavioural / Relationship
- Worker Safety or Wellbeing (including staffing)
- Workload
- Poor System / Process
- Patient Safety
- Health and Safety
- Management and Culture
- Poor communication

- Middle Management
- Bullying and Harassment

The above figures and themes also represent an increased number of individual staff making contact from a wider number of services and professions. This suggests there is a wider awareness of FtSU as an alternative or additional route for speaking up and possibly a growing confidence for staff to raise concerns individually as well as in groups. There have been no reports of detriment but the FtSUG is looking at doing some proactive work around detriment, to stop this from being a perceived initial barrier to speaking up. All open concerns and themes are being progressed or investigated and actioned accordingly. Where applicable, staff have received feedback on follow up recommendations.

Staff Feedback

For quality assurance purposes, staff are invited to provide feedback at the end of the FtSU process. Staff also continue to offer feedback on an ad hoc and voluntary basis during the FtSU process as well as general comments in team meetings. Some examples of staff feedback since commencing the role includes:

> *"Just having someone to listen, already makes me feel better".*
>
> *"Thank you for checking in and thinking about me".*
>
> *"It is good to have someone to talk to and decompress".*
>
> *"Thank you for your continued support, I can't thank you enough".*
>
> *"Thank you again for meeting with me and for the wonderful insight and tips in Freedom to Speak Up."*
>
> *"Just wanted to put ink to paper- so to speak – to say thank you so much for listening to my issues. Sometimes it is good to have an impartial colleague who can help me focus on how to progress and you were that person."*

Speaking up can be a challenging, worrying and sometimes lengthy experience. Timescales for investigations, communication, outcomes as well as the ongoing impact of employment tribunals is challenging for our staff. This means that process and/or psychological support continues to be a requirement which requiresfurther consideration. The FtSUG offers process support to any colleague (or ex-colleague) who have raised a work related concern and signposts staff accordingly for psychological support.

The NHS Staff Annual Survey indicates that staff feel that the follow up aspect of raising a concern could be improved and this is an area that will be looked at in the proactive work of the FtSUG in 2024.

The FtSUG would like to express thanks for the ongoing support from all colleagues who have helped promote and embed the FtSU ethos over the last year as well as continuing thanks to all staff who have spoken up to raise concerns. It takes great courage to speak but this is how as an organisation we learn and grow and become the best version of ourselves.

NHS number and general medical practice validity

North Tees and Hartlepool NHS Foundation Trust submitted records during 2023-24 to the Secondary Uses Service (SUS) for inclusion in the The Data Quality Maturity Index (DQMI which are included in the latest published data.

The percentage of records in the published data as at the end of February 2024:

Which included the patient's valid NHS number was:	%	Which included the patient's valid general medical practice code was:	%
Percentage for admitted patient care	**99.9%**	Percentage for admitted patient care	**100%**
Percentage for outpatient care	**100%**	Percentage for outpatient care	**97.3%***
Percentage for accident and emergency care**	**99.6%**	Percentage for accident and emergency care	**100%**

**This is being investigated as locally we have no missing GP practice.*
*** This includes A&E and urgent care data.*

Information governance (IG) grading

Data Protection Assurance

Assurance continues to be provided to the Board of Directors that systems and processes are being constantly assessed and improved to ensure that information is safe. In accordance with UK GDPR Article 37, we have an appointed Data Protection Officer (DPO) who provides support, advice and assurance to the Board in respect of obligations pursuant to legislation, monitors compliance and acts as a point of contact for data subjects and the supervisory authority (ICO).

The Data Security and Protection Standards for health and care are set out in the National Data Guardian's (NDG) ten standards and are measured though the completion of the Data Security Protection Toolkit (DSPT). All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

The Trust submitted its DSPT submission on the 29 June 2023. The Trust has self-assessed compliance with all 10 standards and all 113 mandatory evidence items were evidenced, meeting all mandatory assertions; therefore, the Trust scored as all 'Standards Met' for the 2023 DSPT.

The 2022-23 DSPT was also subject to external audit, a sample of thirteen of the mandatory assertions taken across the ten standards were audited by External Audit (Audit One) during March /April 2023 prior to the DSPT submission.

The Trusts independent risk assessment scored the Trust as 'Substantial' for eight and 'Moderate' for two of the ten National Data Guardian Standards. All recommended actions for the two moderate areas were completed and verified by the auditor prior to the DSPT submission date providing the Trust with substantial assurance for all 10 standards.

The overall confidence level of the independent assessor in the veracity of the self-assessment was rated as '***Substantial'.***

For the 2023-24 DSPT submission due in June 2024 the current position at the time of this report is that 103 of the 108 mandatory evidence items are complete (95.3%), therefore based on this current position, the Trust remains on plan to complete the full assurance submission by 30 June 2024.

Data Security

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

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

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

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

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

We reported four incidents to the ICO during the 2023-24 reporting period, the same number as in 2022-23. Three were related to 'inappropriate access by staff' and one instance of 'disclosure in error'. All incidents have since been closed without action by the ICO and the Trust has taken appropriate action to mitigate.

In order to further strengthen existing Trust policy and to prevent repeat incidents in areas where incidents have occurred the following key actions were undertaken:

- Review of IG policies and standard operating procedures to ensure they reflect the specific needs and practicalities of each internal department and they reflect the changing needs of legislation and national guidance.
- Continued programme of comprehensive quality assurance and spot checks to ensure all departments are complying with Trust policies relating to the protection of personal data.
- Continue to provide annual Data Security Training inclusive of Cyber Security and the provision of targeted training in areas of non-compliance.
- Robust monitoring of departmental action plans following incidents to ensure appropriate actions have been implemented via the Digital Governance Committee.
- Full annual review of information assets and information flows through the Trust within a redesigned framework to comply with GDPR requirements.
- Regular staff awareness campaigns run via communications team targeting areas of non-compliance.
- HR processes followed where repeated non-compliance has been found.

Freedom of Information (FOI)

The Trust continues to respond to Freedom of Information requests from members of the public on a range of topics across all services and departments, complying with the 20 working day limit to do so. The act is regulated and enforced by the Information Commissioners Office (ICO). The ICO hold powers to enforce penalties against the Trust when it does not comply with the Act, including but not limited to monetary fines. For the year 2023-24 the Trust received 848 requests with a compliance level, as at 31 March 2024, of 95%. This was achieved despite Trust services experiencing significant pressures and demands on services.

The Trust will be taking the following actions to improve data quality

Clinical coding audit

Clinical coding translates medical terms written by clinicians about patient diagnosis and treatment into codes that are recognised nationally.

North Tees and Hartlepool Foundation Trust was *not subject* to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

The Audit Commission no longer audits every Trust every year where they see no issues. The in-house clinical coding audit manager conducts a 200 episode audit every year as part of the Data Security and Protection (DSP) Toolkit and also as part of continuous assessment of the auditor.

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Primary diagnoses correct	91.00%	90.50%	90.50%	91.00%	91.00%	**90.00%**
Secondary diagnoses correct	93.56%	93.72%	85.98%	89.19%	83.13%	**89.94%**
Primary procedures correct	93.75%	90.82%	97.66%	90.42%	91.21%	**94.90%**
Secondary procedures correct	88.33%	91.49%	82.35%	83.10%	90.28%	**90.51%**

The audit is still being carried out but the services reviewed within the sample are 200 finished consultant episodes (FCEs) taken from all specialties and include day cases.

The errors include both coder and documentation errors of which the coding errors will be fed back to the coders as a group and individually. The documentation errors will be taken to directorate meetings.

Depth of coding and key metrics is monitored by the Trust in conjunction with mortality data. Targeted internal monthly coding audits are undertaken to provide assurance that coding reflects clinical management. Any issues are taken back to the coder or clinician depending on the error. The clinical coders are available to attend mortality review meetings to ensure the correct coding of deceased patients.

Our coders organise their work so that they are aligned to the clinical teams. This results in sustained improvements to clinical documentation. This supports accurate clinical coding and a reduction in the number of Healthcare Resource Group changes made. This is the methodology which establishes how much we should get paid for the care we deliver. We will continue to work hard to improve quality of information because it will ensure that NHS resources are spent effectively.

Specific issues highlighted within the audit will be fed back to individual coders and appropriate training planned where required. North Tees and Hartlepool NHS Foundation **Trust** will be taking the following actions to improve data quality. The coding department has undergone a re-structure in order to facilitate coding medical episodes from case notes.

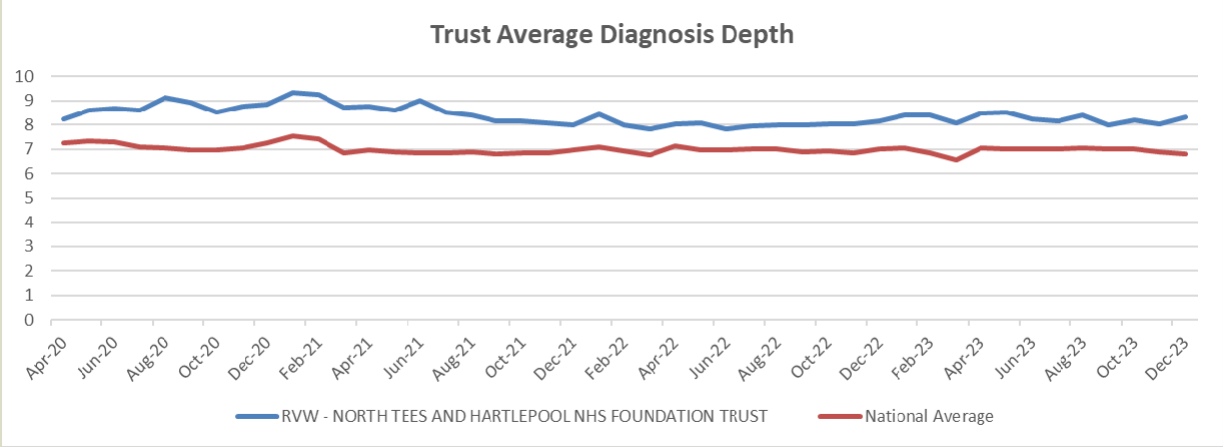
Unfortunately, due to the impact of COVID and losing three WTE coders, the department has failed to code the episodes within the required time scales. This has resulted in a backlog of workload and the difficult decision was taken to pull back from coding all medical episodes from the ACN and case notes and use the discharge summary as the source documentation. There were exceptions, however, to minimise the impact on the mortality indicators and all long stay and deceased patients continue to be coded from the case notes. A contract coder has also been employed to help to reduce the backlog. There is a recovery plan in place and it is hoped the deadlines will be back to the SUS flex deadline in the summer. The HSMR and SHMI mortality indicators are constantly being reviewed and so far, the change in coding practice, has not had a negative impact on them. When the medical coding does return to full ACN and case notes, EAU and ambulatory will still be coded from the discharge summary as the increase in daily workload coupled with the imbalance in the team dynamic means that maintaining coding accuracy while continuing to achieve 100% of coding within the mandatory time deadlines is increasingly challenging. In order to improve the flow of medical case notes being sent to the coding department a temporary red sticker has been piloted on the medical base wards. The sticker instructs whoever has the case notes at that time to send them to the coding department. The pilot was deemed a success, and the system was rolled out to all wards across the Trust.

In July 2020 the Trust went live with Active Clinical Notes (ACN). Active Clinical Notes allows traditional paper-processes and pathways to be made available digitally. This means the clinical details of patient's diagnoses and treatments are now added directly to the patient's Electronic Patient Record (EPR). Nursing pathways are currently not available electronically and are still manually completed and filed within the patient's case notes, but it is hoped nursing notes will be available electronically from the end of June 2023. As a result of this change it has allowed the coding department to introduce an opportunity for some of the coders to work from home. In June 2021 the Coding Department started a twelve week homeworking trial period. After the initial trial period the homeworkers coding was audited and the results showed the quality of coding carried out at home was on a level with the coding carried out within the trust. As a result the home working was made permanent. As more information is made available electronically it means the opportunity for home working increases and coders can spend more of their time coding from home. Continuous audits will be carried out to ensure the levels of accuracy are maintained.

The department carries out monthly reviews of the coding which highlights any 'rule breakers'. The 'rule breakers' are any codes that have been assigned that break the national clinical coding standards. Any 'rule breakers' found are fed back to the clinical coder concerned and the coding is updated before the freeze date.

Diagnosis Coding Depth National and Trust Trend (April 2020 to December 2023)

The Trust has maintained the improvements in accuracy and depth of coding, the following chart demonstrates the Trust average (blue) against the national average (red). The Trust has improved the quality of discharge documentation and actively engaged clinicians to work closely with Clinical Coding. The latest depth of coding shows the Trust having an Average Diagnosis Depth of **8.32** (December 2023) compared with the National average of **6.82.**



Part 2d: Core set of Quality Indicators

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

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

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge.

Summary Hospital-level Mortality Indicator (SHMI). Deaths associated with hospitalisation, England, December 2022 – November 2023. Data source: NHS Digital

Time period	Over-dispersion banding	Trust Score	National Average	Highest – SHMI Trust Value in the country	Lowest – SHMI Trust Value in the country
Sep 2022 – Aug 2023	Band 2 (As Expected)	0.9548	1.00	1.2220	0.7126
Oct 2022 – Sep 2023	Band 2 (As Expected)	0.9540	1.00	1.2293	0.6770
Nov 2022 – Oct 2023	Band 2 (As Expected)	0.9640	1.00	1.2065	0.7215
Dec 2022 – Nov 2023	Band 2 (As Expected)	0.9781	1.00	1.2564	0.7195

SHMI Regional results, December 2022 – November 2023

Trust	Trust Score
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1.2564
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	1.1388
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1.1202
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**0.9781**
GATESHEAD HEALTH NHS FOUNDATION TRUST	0.9637
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	0.9247
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	0.9232

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

- SHMI mortality data when reviewed against other sources of mortality data and when benchmarked against other NHS organisations will provide an overview of overall mortality performance either within statistical analysis or for crude mortality.

North Tees and Hartlepool NHS Foundation Trust is committed to responding to, and learning from, the deaths of those who die in our care. Maintaining the SHMI in the 'as expected' range

forms an integral part of the overall learning from deaths process and is triangulated with information from other sources such as mortality review, audit, surveys, safety events, complaints and compliments.

The CQC and National Quality Board require all trusts to undertake mortality reviews. These are retrospective case note reviews using a validated tool. Mortality review sessions are run on a monthly basis and undertaken by a trained, multidisciplinary panel of staff. The Trust currently uses a mortality review application called SJR Plus to record these reviews and generate reports. The reviews provide a valuable opportunity to assess the quality of care received and to make improvements where indicated.

The Learning from Deaths team within the Trust are making links with South Tees to align processes where possible. The Trust team also meet regularly with regional colleagues to share experience and learning.

Patient reported outcome measures

This section is for the data made available to the trust by NHS Digital with regard to the trust's patient reported outcome measures scores for adjusted average health gain (EQ-5D Index) for:

1. Groin hernia surgery
2. Varicose vein surgery
3. Hip replacement surgery, and
4. Knee replacement surgery during the reporting period

April 21 to March 22	*Groin hernia	*Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement	Knee replacement – Revisions
Trust Score	No data	No data	0.529	0.328	0.464	0.351
National Average	No data	No data	0.462	0.317	0.324	0.308
Highest National	No data	No data	0.768	0.437	0.548	0.351
Lowest National	No data	No data	0.310	0.00	0.303	0.258

Apr 21 to Mar 22, Data from NHS Digital

April 20 to March 21	*Groin hernia	*Varicose vein	Hip replacement – Primary	Hip replacement – Revisions	Knee replacement	Knee replacement – Revisions
Trust Score	No data	No data	0.503	No data	0.389	No data
National Average	No data	No data	0.465	0.336	0.315	0.299
Highest National	No data	No data	0.576	0.336	0.400	0.299
Lowest National	No data	No data	0.392	0.336	0.176	0.299

Apr 20 to Mar 21, Data from NHS Digital

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

- The Trust continues to have a lower than the national average 'adjusted average health gain' score in relation to groin hernia surgery, however the position is improving. In relation to primary knee replacement, the Trust's position continues to demonstrate good results.

The North Tees and Hartlepool NHS Foundation Trust has taken the following actions to improve this score and so the quality of its service.

- The Trust continues to carry out multiple reviews, the reviews occur at 6 weeks and 6 months with the final review being at 12 months. The reviews will be carried out by the joint replacement practitioners unless otherwise identified.
- The Trust continues to use the telephone review clinics, thus ensuring that communication remains open with the patient listening and acting upon any issues/concerns that they may have.

Readmission data

This section is for the data should be made available to the Trust by NHS Digital with regard to the percentage of patients aged (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Age Group	Value	Emergency readmissions within 28 days of discharge from hospital Apr 2022 to Mar 2023	Emergency readmissions within 28 days of discharge from hospital Apr 2021 to Mar 2022
0 to 15	Trust Score	**12.2**	**12.7**
	National Average	14.1	12.5
	Band	W = National average lies within expected variation (95% confidence interval)	W = National average lies within expected variation (95% confidence interval)
	Highest National	302.9	109.6
	Lowest National	3.2	2.7
16 or over	Trust Score	**11.6**	**11.7**
	National Average	13.2	14.7
	Band	B1 = Significantly lower than the national average at the 99.8% level	B1 = Significantly lower than the national average at the 99.8% level
	Highest National	546.6	284.5
	Lowest National	1.4	1.3

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

- The Trust monitors and reports readmission rates to the Board of Directors and Directorates on a monthly basis. The January 2023 position (latest available data) indicates the Trust has an overall readmission rate of 8.73% against the internal stretch target of 7.70%, indicating the Trust's readmission rates have slightly decreased by 1.06% from the same period in the previous year (9.79% - January 2022).

The North Tees and Hartlepool NHS Foundation Trust has taken the following actions to improve the rate and so the quality of its service.

- The Trust recognises further work is required to reduce potential avoidable readmissions and so a revised process has been agreed which has seen the development of a standardised template to capture data which will be clinically led. Results will be presented to the Learning and Improvement Committee and Business Team.
- Patient pathways continue to be redesigned to incorporate an integrated approach to collaboration with health and social care services.

- Initiatives continue including: a discharge liaison team of therapy staff to actively support timely discharge, social workers within the hospital teams to facilitate discharge with appropriate packages of care to prevent readmission; utilisation of ambulatory care and rapid assessment facilities; emergency care therapy team in A&E to facilitate discharge and prevent admissions; community matrons attached to care homes and the community integrated assessment team supporting rehabilitation to people in their own homes including care homes.
- These actions have seen a significant reduction in stranded patients and delayed transfers of care which have assisted in the successful management of winter pressures.

Responsiveness to the personal needs of patients during the reporting period

This section is for the data made available to the Trust by NHS Digital with regard to the trust's responsiveness to the personal needs of its patients during the reporting period.

Period of Coverage	National Average	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (out of 100)
2023-24	Not Available	Not Available
2022-23	Not Available	Not Available
2021-22	Not Available	Not Available
2020-21	Not Available	Not Available
2019-20	67.10	62.60
2018-19	67.20	65.20
2017-18	68.60	68.70
2016-17	68.10	67.20
2015-16	69.60	67.70
2014-15	68.90	68.10

**2020-21 – 2023-24 data not available at the time of print*

Benchmarked against other North East Trusts for 2019-20.

Trust	Overall Score
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	74.80
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	72.60
GATESHEAD HEALTH NHS FOUNDATION TRUST	71.00
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	70.00
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	68.40
SOUTH TYNESIDE NHS FOUNDATION TRUST	68.00
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**62.60**

NB: Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (Score out of 100)

The scores are out of 100. A higher score indicates better performance: if patients reported all aspects of their care as "very good" we would expect a score of about 80, a score around 60 indicates "good" patient experience. The domain score is the average of the question scores within that domain; the overall score is the average of the domain scores. The Trust has worked hard in order to further enhance its culture of responsiveness to the personal needs of patients.

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

- The Trust has developed its Patients First Strategy and understanding patient views in relation to responsiveness and personal needs helps us to understand how well we are performing.

The North Tees and Hartlepool NHS Foundation Trust has taken the following actions to improve this score and the quality of its services.

- By delivering accredited programmes that focus on responsiveness of patient and carers for both registered and unregistered nurses.
- We use human factors training to raise awareness of the impact and of individual accountability on patient outcomes and experience. When compared against the national average score the Trust continues to be rated well by patients.

Staff Friends and Family Test

This section is for the data made available to the trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

The Trust believes that the attitude of its staff is the most important factor in the experience of patients. We will continue to work with staff to develop the leadership and role modeling required to further enhance the experience of patients, carers and staff.

National NHS Staff Survey

Question: If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.

	Survey Year					
Trust Name	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	83	88	87	84	80	81
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	59	61	66	60	52	53
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	**71**	**72**	**74**	**70**	**65**	**65**
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	90	91	91	85	83	77
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	71	64	76	76	68	70
GATESHEAD HEALTH NHS FOUNDATION TRUST	81	82	80	75	73	74
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST		70	71	65	61	63
North East	74	75	78	74	69	64
England	70	71	74	68	63	64
National High	**95**	**-**	**92**	**-**	**-**	**87**
National Low	**41**	**-**	**48**	**-**	**-**	**52**

People Pulse – Staff

	July	*Sep	March
Percentage staff recommending the NHS services they work in to friends and family who need similar treatment or care	57.9%	65.70%	60.8%

**From Staff Survey Data*

	July	*Sep	March
Percentage staff recommending the NHS service they work in to friends and family as a place to work	57.7%	65.6%	52.9%

**From Staff Survey Data*

	July	*Sep	March
Percentage staff agreeing that the care of patients or service users is their organisations top priority	73.2%	80.1%	70.9%

**From Staff Survey Data*

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

- The Trust continues to actively engage with and encourage staff to complete and return the national NHS staff survey along with the quarterly People Pulse survey. The results from these surveys are shared with staff to ensure that two way conversations take place in relation to celebrating successes and considering improvements. Information is provided at Care Group level, line manager level and staff level to ensure there is greater understanding of the information.

The North Tees and Hartlepool NHS Foundation Trust has taken the following actions to further improve this percentage, and so the quality of its services.

- By involving the views of the staff in developing a strategy for care.

- We have a range of opportunities for staff to be involved in develop changes across the organisation which ensures we each have a voice that counts with clear linkage to the NHS People Plan.

Other National Staff Survey results

	2021	2022	2023
In the last 12 months I have not personally experienced harassment, bullying or abuse at work from colleagues	86.08%	**85.65%**	**85.5%**
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	64.88%	**63.24%**	**62.1%**

Venous thromboembolism risk assessment

This section is for the data made available to the Trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

No new updates to this data have been provided by NHS Digital since Q3 2019-20. The VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic. This was communicated via **this letter** on 28th March 2020.

Venous thromboembolism (VTE) mandatory training 2023-24	**91%**

**Data obtained from the Trust training department*

Clostridiodes difficile (C. difficile) infection rates

This section is for the data made available to the trust by NHS Digital with regard to the rate per 100,000 bed days of cases of C difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.

	Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over				
Reporting Period	**Trust C difficile cases**	***Trust Rate**	***National Average**	***Highest National rate**	***Lowest National rate**
***Apr 2023 – Mar 2024**	**Not available via NHS Digital**				
Apr 2022 – Mar 2023	48	25.12	13.34	76.60	0.00
Apr 2021 – Mar 2022	50	28.70	12.67	59.03	0.00
Apr 2020 – Mar 2021	49	16.38	12.27	41.53	0.00
Apr 2019 – Mar 2020	53	13.20	10.71	64.61	0.00
Apr 2018 – Mar 2019	31	16.40	12.20	79.97	0.00
Apr 2017 – Mar 2018	35	17.90	13.70	91.00	0.00
Apr 2016 – Mar 2017	39	18.80	13.20	82.70	0.00

*** 2021-23 numbers include hospital-onset, healthcare associated and community-onset, healthcare associated*

The North Tees and Hartlepool NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services.

- Enhanced ward cleaning in line with the national cleaning standards including the use of hydrogen peroxide fogging.
- The continued use of the mattress decontamination service to reduce the risk of infection and improve quality of service to patients.
- Completion and improvement demonstrated in CQUIN (CCG03) Intravenous (IV) to oral (PO) switch for antibiotics.
- Continued emphasis on high standards of hand hygiene for staff and patients, utilising hand hygiene champions.
- Monitoring of the management of affected patients to support ward staff and ensure guidance is being adhered to.
- The continuation of annual update training in infection prevention and control for all clinical staff. Provision of adhoc training to areas with increased training needs.

The Trust will continue with these measures and will explore every opportunity to minimise C difficile cases in the future.

Patient safety incidents

This section is for data made available to the trust by NHS Digital with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Reporting and understanding patient safety incidents is an important indicator of a safety culture within an organisation.

Acute (non-specialist) provider organisational incident data by organisation in 6-month period.

	Based on occurring dataset (Degree of Harm – All)		National			Our Trust	
			Degree of harm Severe or Death			Degree of harm	
Report period	Number of incidents occurring	Rate per 1000 Bed Days	Average %	Highest %	Lowest %	Number of incidents	%
2020-2024	No recent data						
Oct 19 – Mar 20	3,820	41.60	0.16	0.49	0.01	26	0
Oct 18 – Mar 19	1,580	16.90	0.16	0.49	0.01	15	0
Oct 17 – Mar 18	4,582	44.80	0.15	0.55	0.00	18	0
Oct 16 – Mar 17	3,087	29.80	0.15	0.53	0.01	5	0

Data benchmarked against other North East Trusts for 2019-20.

	October 2019 – March 2020	
Trust	Degree of Harm (All) – Rate per 1,000 bed days	Degree of Harm (Severe or Death) Rate
City Hospitals Sunderland NHS Foundation Trust	45.10	0
North Tees & Hartlepool NHS Foundation Trust	**41.60**	**0**
Northumbria Healthcare NHS Foundation Trust	47.30	0
Gateshead Health NHS Foundation Trust	38.80	0
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	39.80	0
County Durham and Darlington NHS Foundation Trust	49.60	0
South Tees Hospitals NHS Trust	35.00	0
South Tyneside NHS Foundation Trust	44.50	0

**Data for Oct 19 – Mar 20. No recent data available via NHS Digital between 2021-2023.*

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

- During 2023/24 the Trust was preparing for and transitioning to the Patient Safety Incident Response Framework (PSIRF). In line with the ethos of PSIRF the Trust is building a learning and improvement culture where staff, patients, families, carers, and all who engage with the Trust are encouraged to share their experiences and their concerns. The Trust recognises that learning comes from understanding what goes wrong (incidents), what nearly goes wrong but is "saved" by the actions of those involved (near misses) and also what goes well, despite the daily challenges of healthcare (good care). The Trust promotes the reporting of all episodes of care where there is potential for learning and improvement, collectively called 'events'.
- Alongside the transition to PSIRF the Trust has also implemented a new Local Risk Management System (LRMS) which incorporates the new national reporting requirements from the Learning from Patient Safety Events (LFPSE) system, and updated the Trust policy to reflect the changes and promote timely reporting, response and management of safety events, focused on the potential for learning rather than the level of harm.
- The review and investigation of events is focused on identifying opportunities for learning and improvement to prevent future harm, using a systems based approach to investigation, and incorporating human factors analysis and quality improvement methodology. The quality assurance of event data is promoted at all stages of review and response to reflect the most up to date information known about the event.
- All patient safety events reported on the Trust LRMS are shared with the LFPSE. This allows a national view to be obtained in relation to all patient safety events regardless of harm level. Previously, each Trust received regular analysis from the NRLS. This stopped during 2022-23 which has resulted in no new national data being released. The Trust is waiting to see what analysis of event data will be shared from LFPSE to aid analysis and learning.

The North Tees and Hartlepool NHS Foundation Trust has taken the following actions to improve the proportion of this rate and so the quality of its services.

- It is acknowledged that a positive safety culture is associated with increased reporting and as such, the Trust continuously monitors the frequency of event reporting and strives to increase reporting in all areas. The Trust is promoting the reporting all events (incidents, near misses and good care) regardless of the level of harm to ensure awareness of both known and emerging risks, identify themes and trends, and provide valuable insights into preventing future harm. It is acknowledged that during this period of transition there has been a dip in reporting as staff familiarise themselves with the new system and question format. The Trust is supporting staff with a range of training opportunities and expect to see reporting return to previous levels.
- In line with PSIRF, and the Trust Patient Safety Event Response Plan (PSERP) and the Trust Policy, events have been identified that require a learning response to further understand the causes, and those that are well understood and require an improvement response.

Learning response

The Trust will ensure compliance with the national requirements for reporting and investigation as set out in the PSIRF guidance. Additionally, the Trust has identified four local priority areas for focused work over the period of the Trust PSERP and project teams initiated which include a clinical lead, a quality improvement lead and a patient safety lead. The four priority areas are: Child not Brought for Appointment; Delayed recognition and management of the sick child; Management of Diabetes; and Quality of Discharge information.

The Trust has developed a decision making process to identify those events with significant potential for learning. The process details how events will be reviewed at local level and, where appropriate, identified for escalation. The process ensures that those events that require an in-depth response to understand the causal factors and identify learning receive the appropriate

level of investigation and are monitored through to closure. To support this the Trust have developed alternate learning responses for those events that do not meet the national criteria for a Patient Safety Incident Investigation (PSII).

The weekly multidisciplinary Safety Panel reviews all incidents of moderate harm or above, agrees the level of investigation and reviews the application of duty of candour regulations by the clinical directorates. Where there is any discrepancy, the investigating team are asked to provide further details for review and discussion. In complex cases where the identification of the required level of investigation is unclear, the incident, and all evidence collated through the investigation to date is reviewed by senior executives for a decision.

Incidents that meet the national requirements for reporting are managed in line with PSIRF guidance (NHSE, 2022). Any event that is identified as requiring a PSII or a Trust alternate learning response will be presented at a monthly panel on conclusion of the response. The panel will include senior executives and representatives (clinical and non-clinical) from each Care Group to ensure a broad discussion and appropriate challenge. PSIIs will be signed off by a Board member at this meeting. Where safety actions are identified, these will be considered by the appropriate Trust Oversight Group and incorporate into a wider improvement plan to ensure they are SMART and monitored to completion.

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

The national analysis of information undertaken by NHSE / LFPSE identifies where actions need to be taken in relation to national trends. This analysis can initiate a national safety alert. The Trust is fully compliant with all National Patient Safety Alerts that have been published in relation to this analysis. Processes are in place to ensure there is continual review of processes in order to provide on-going assurance.

Improvement response

Where the causal factors of an event are well understood, the burden of undertaking an in-depth investigation can outweigh the learning to be gained. Where possible the Trust has developed event pro formas or checklists to be completed within the LRMS. The data can then be collated and analysed by the relevant Trust Oversight Group and incorporated into their assurance framework or improvement plan. Where new or emerging issues are identified a group or cluster of events can be reviewed using a thematic approach to identify additional learning.

Part 3a: Additional Quality Performance measures during 2023- 24

This section is an overview of the quality of care based on performance in 2023-24. In addition to the three local priorities outlined in Section 2, the indicators below further demonstrate that the quality of the services provided by the Trust over 2023-24 has been positive overall.

The following data is a representation of the data presented to the Board of Directors on a monthly basis in consultation with relevant stakeholders for the year 2023-24. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements.

Patient Safety

Falls

A fall is defined as an unexpected event in which the participant comes to rest on the ground, floor or lower level. Whenever a fall occurs this is recorded on the local incident reporting system. A post falls checklist is completed and is used to help categorise the fall into the classification of no harm, low harm, moderate harm, severe harm or death. The Trust has a robust system in place to understand the background to all falls that result in significant injury; these incidents are shared with staff for future learning.

Falls with no harm

During **2023-24** the Trust has experienced **780** falls resulting in no harm; this has *decreased* from **954** in the 2022-23 reporting period. This is a 22% reduction on falls.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2020-21	59	55	74	74	74	74	91	85	100	91	78	82	**937**
2021-22	64	76	65	97	106	72	86	79	110	90	75	75	**995**
2022-23	**87**	**84**	**84**	**85**	**106**	**65**	**65**	**81**	**88**	**66**	**71**	**72**	**954**
2023-24	**87**	**65**	**53**	**81**	**80**	**60**	**68**	**71**	**72**	**68**	**33**	**42**	**780**

Data obtained via the Trust's Incident Reporting database March 2024.

Falls with low harm

During **2023-24** the Trust has experienced **271** falls resulting in low harm; this has *increased* from **248**
in the 2022-23 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2020-21	15	8	14	14	16	22	13	17	35	17	16	14	**201**
2021-22	16	28	13	8	7	20	13	14	15	22	12	14	**182**
2022-23	**9**	**13**	**22**	**14**	**29**	**21**	**17**	**27**	**26**	**20**	**23**	**27**	**248**
2023-24	**18**	**25**	**19**	**17**	**23**	**14**	**21**	**18**	**15**	**34**	**39**	**28**	**271**

Data obtained via the Trust's Incident Reporting database March 2024.

Falls with moderate harm

During **2023-24** the Trust has experienced **30** falls resulting in moderate harm; this has *increased* from
19 in the 2022-23 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2020-21	0	0	1	1	0	1	1	3	2	1	2	0	**12**
2021-22	5	3	2	0	2	0	3	1	1	1	1	1	**20**
2022-23	**1**	**1**	**0**	**3**	**1**	**0**	**2**	**1**	**4**	**1**	**3**	**2**	**19**
2023-24	**4**	**1**	**0**	**2**	**2**	**0**	**0**	**2**	**2**	**4**	**9**	**4**	**30**

Data obtained via the Trust's Incident Reporting database March 2024.

Falls with severe harm

During **2023-24** the Trust has experienced **0** falls resulting in severe harm; this remains *unchanged* from **0** in the 2022-23 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tota
2020-	0	0	0	0	0	1	1	0	0	0	0	0	**2**
2021-	0	0	0	1	0	0	0	0	0	0	0	0	**1**
2022-	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2023-	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Data obtained via the Trust's Incident Reporting database March 2024.

Falls with death

During **2023-24** the Trust has experienced **2** falls resulting in death; this has increased from ***0*** in the 2022-23 reporting period.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tota
2020-	0	0	0	0	0	0	0	0	0	0	0	0	**0**
2021-	0	0	0	0	0	0	0	0	0	1	0	0	**1**
2022-	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2023-	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**2**

Data obtained via the Trust's Incident Reporting database March 2024.

Whilst the majority of falls result in no or low harm there has been an increase in falls reported as low and moderate harm. Whilst there were two falls with death, investigation and review concluded that the death was not a direct result of the fall.

The impact of the change to the national system LFPSE and the event reporting system Inphase is potentially having an impact on the reporting levels of harm. As these new systems are implemented investigation needs to be completed in the coming months.

Improvements to the falls assessments and documentation have been supported by the digital team to ensure appropriate assessment, care plans and risk mitigation. The recording of lying and standing blood pressure is now embedded using E-Obs, with work on-going to improve the functionality to allow this to be prescribed electronically. InPhase events falls questions have been designed to ensure that key National Hip Fracture Database (NHFD) audit information is included.

Post falls management continues to be supported by the Falls Response Team which is now fully embedded and contributing to the safe manoeuvring and management of the patient post fall.

A review of the Falls Policy and the falls meeting structure and membership is underway.

Never Events

The Trust continues to work hard to improve patient safety therefore stakeholders and the Board wanted to report on the low numbers of never events in the organisation.

Never events are serious safety events that are considered to be wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific safety event occurrence for that event to be categorised as a never event.

Since 2016 the Trust has had **10** never events:

2016- 17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
1	0	1	1	1	3	4	**0**

The NHS England report can be accessed via:
https://improvement.nhs.uk/resources/never-events-data/

Effectiveness of Care

Medication Errors

Work is ongoing to increase awareness of medicines events or error reporting and improve the way we manage the investigation process. The aim of this work is to ensure we learn from medicines events, share good practice and ultimately improve our processes and patient safety.

In **2021-22** there were **628** medicines incident reports via the Trust incident reporting system. In **2022- 23,** there were **782** incident reports. A small number of these incidents originated from external organisations such as GPs and care homes. For **2023-24**, there were **855** medication related patient safety events reported to the Trust. Around 70% of the events occurred on the wards or in clinical areas, with around 26% occurred in the community settings or care homes, and the remaining 3% in other Trusts or organisations.

The Trust is moving from Datix system to InPhase this financial year – an online platform with a suite of apps that help us co-ordinate compliance, assurance and continuous improvement. InPhase is a new way for the staff to record events (formerly incidents), friends and family feedback, mortality data and much more.

As the Trust has also upgraded the local risk management system to a LFPSE (Learn from Patient Safety Events) compliant system, the structure of the questions have changed. LFPSE has a set of mandatory questions when recording patient safety events and this has added to the number of reporting categories on the event page.

Medicines Safety Council (MSC), medication events learning and control measures in place

The aims of the Medicines Safety Council (MSC) are to:

- Improve reporting and learning of medication-related patient safety events in the organisation.
- Analyse events data, audit and other data to identify, prioritise and address medication risks to minimise harm to patients.
- Identify, develop and promote best practice for medication safety.
- Coordinate education and training support to improve the quality of medication error or event reports and safe medication practices, assisting in the development and review of medication- use policies and procedures.

Medication events learning and control measures in place

- Trust medication errors or events are discussed weekly in the Senior Clinical Practitioner (SCP) meeting for awareness and action.
- The quarterly updates of medication events are presented in the Patient Safety Council meeting and MSC meeting to highlight medication errors trends and themes as well as sharing learning points and recommendations.
- Quarterly Medicines Safety Hotspots Bulletin that shares national medication safety updates and safety events learning in the Trust.
- Medication events or relevant medicines safety information or initiatives from national and regional MSO (Medication Safety Officer) network meetings will also be shared in the MSC meeting or other platforms as appropriate.
- Liaised with Medicines Optimisation Pharmacist Lead (NENC ICB Tees Valley) about Trust medicines incidents reported onto Safeguard Incident and Risk Management system (SIRMS)

by primary care providers to understand the medication events occurred at the interface between primary and secondary care.

- Quarterly Trust Controlled Drugs (CD) incident reports submitted to regional CD LIN (local intelligence network) for feedback and monitoring. This provide opportunities for shared learning and support across the locality to work together with the implementation of safety initiatives.
- Review and complete Trust Never event assurance framework/never event proforma around mis-selection of strong potassium solution and insulin overdose due to abbreviation and incorrect device - provides information about current control/risk reduction plan in place (monitoring, planned outcomes and progress evaluation).
- We also collaborate with relevant stakeholders to plan and coordinate actions required by any National Patient Safety Alert (NatPSA) and Central Alerting System (CAS) in relation to medication across their organisation, with executive oversight. This would help to reduce the medication error risk by having appropriate measures in place.
- Analyse medication events themes and prepare Quality and Safety reports for individual ward annually to raise awareness about the key areas of improvements.
- Dissemination of drug alert memo to all clinical areas to communicate risk of medication errors from look-alike sound-alike drugs and supply disruption.
- Contribute to Quality Reference Group (now known as Appreciative Support Programme) review of documents for medicines storage/audit/Controlled Drugs (CD) checks of the wards - provides guidance on safety measures/escalation process.
- 'Focus on Feedback' newsletter- provides information on the lesson learnt from the cases discussed in the Incident Review Panel.

Medicines optimisation nurse was in post to promote safe practice in medicines administration, support ward staff or managers in the analysis of medication events, monitor trends, participate in developing action plans to maximize learning/ reduce recurrence of these errors; and coordinate multidisciplinary work within the trust.

Pharmacy service improvements in promoting medicines safety

Pharmacy have rolled out monthly one-minute medicines optimisation and safety briefings included in ward multidisciplinary team (MDT) huddles. This has recently included changes to warfarin prescribing on EPMA system, antibiotic prescribing issues and complications of SGLT2 inhibitors.

Electronic prescribing and medicines administration continues to be developed further and rolled out in the Trust led by our Informatics Lead Pharmacist. This system has the potential to reduce medicines errors by (including longer-term goals):

- Improving prescribing by encouraging more standardised prescribing (i.e. units, frequencies, formulary choices, tall man lettering etc.)
- Digitisation of the insulin paper chart to reduce the need for dual processes, and missed doses
- Allowing prioritisation of patients for pharmacy review using specific drugs classes or patient alerts.
- Improving data reporting (including missed doses reports etc.) with ongoing work to develop these.
- Supporting integration with the pharmacy system to reduce the amount of transcription required and save time.
- Ability to digitise paper charts - work is ongoing to complete this. Warfarin and insulin prescribing have now been transferred from paper to EPMA.
- The process of transferring ITU onto EPMA has started. They are now using Active Clinical Notes to record contemporaneous medical records, as well as e-observations on TrakCare. Work to integrate prescribing of medication, including infusions, is ongoing.
- Improving in the prescribing of transdermal patches.

Procurement of contracted medicines now includes a quality assessment for high-risk products, and a process has been implemented at Trust level aimed at reducing potential harm from look-alike sound-alike products by highlighting known risk lines with the MSC.

The pharmacy department continues to lead on supporting the rollout of Omnicell cabinets in clinical areas. Omnicell technology provides a real-time solution to support staff in locating critical medicines, with the potential to prevent missed doses and supply medicines in a lean manner.

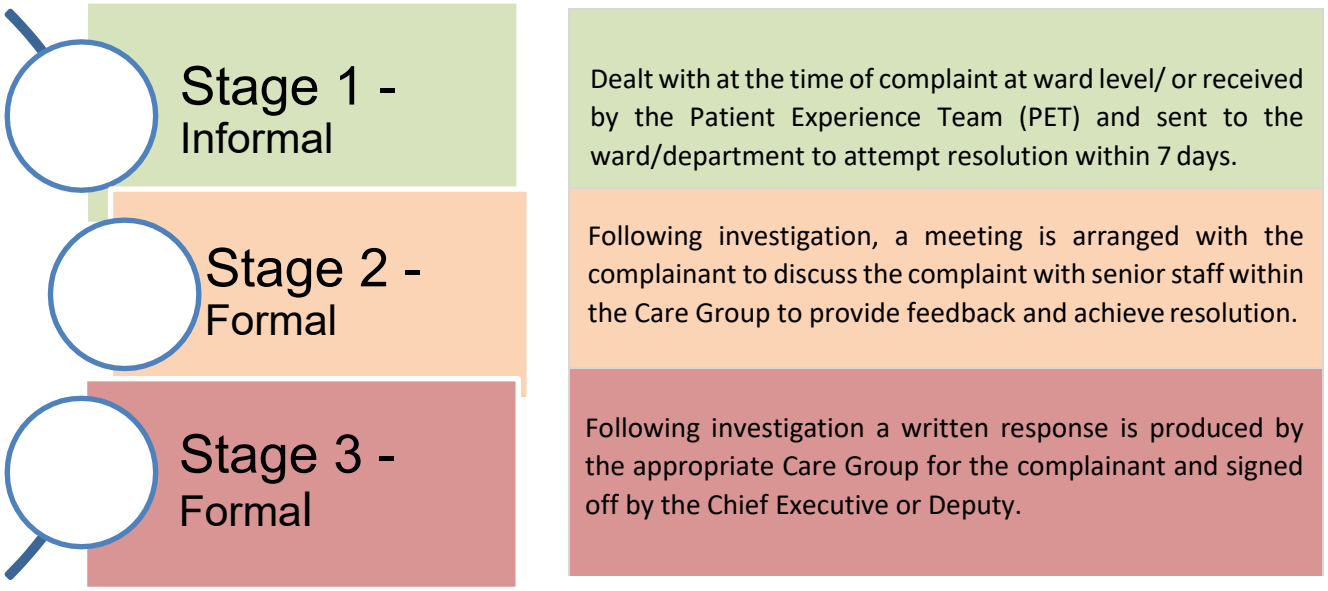
Ward based pharmacy services and other initiatives to improve safe supply of medications:

- Ongoing work with Informatics Lead Pharmacist to support safer prescribing of medicines, e.g. expanding use of order sets/sentences to reducing errors during the prescribing process, additional cautions/warning with regards to high risk medicines, introduction of questionnaires as a prompt/prescribing aid
- Introduction of a full time ICU Pharmacist to support with the complex patients treated on the unit.
- Expanded use of PharmOutcomes to support Discharge Medicines Service project and safer transfer of care back to primary care/community pharmacy where patients have had changes made to their medications.
- New role implemented for a Pharmacist to support the Frailty team. The role is continually growing, but work to date has included active involvement and contribution to the Virtual Frailty Ward round, supporting deprescribing, development of a medication review linked to falls and medication review of frail patients.
- Continuation of and securing of recurrent funding to support the pilot project for ward-based discharge team for Maternity, enabling timely and appropriate discharge, with additional safety checks of VTE scores and appropriate LMWH dose/duration.
- A pilot project to review how a Specialist Pharmacist Prescriber can contribute to the management of patients who are diagnosed/ being treated for a TIA has now been completed and evaluated. We are now investigating how this can be taken forward into a permanent role within the Trust.
- Investigation of Pharmacist Prescriber support into Out-patient Lipid Clinics to help support national initiatives for primary and secondary prevention of CVD.
- Ongoing work to investigate opportunities for service expansion in clinical areas and best use of skill mix to support achievement of KPIs.
- Ongoing work to provide an interface between TrakCare and Ascribe, to remove errors during the transcribing process and make the ordering process more lean.

Patient Experience

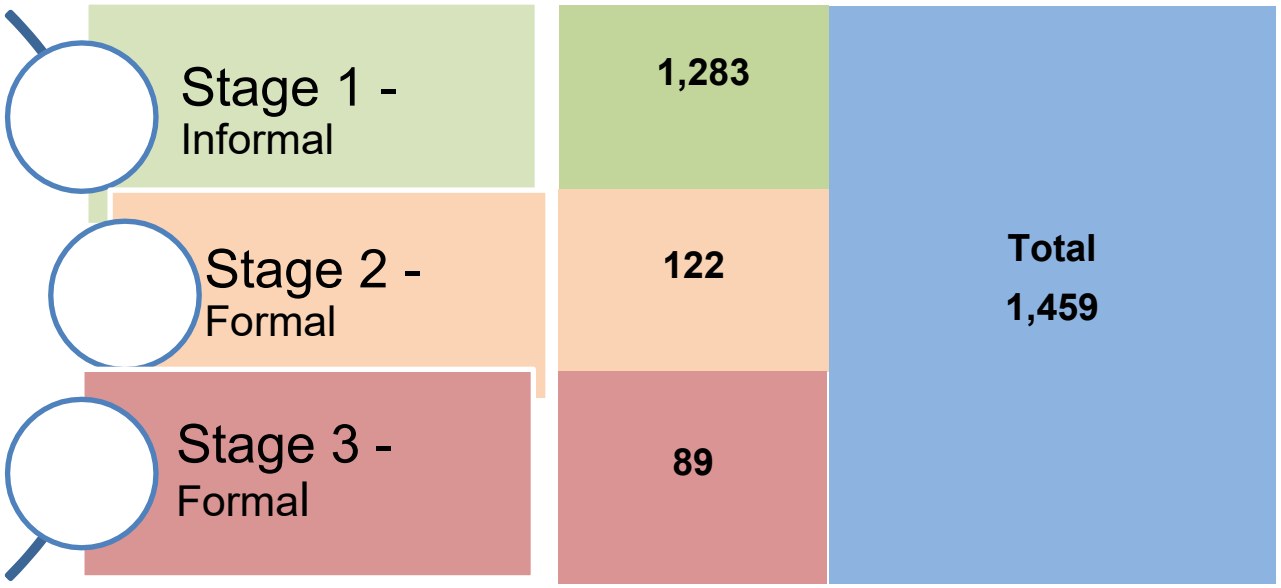
Complaints

The Trust continues to work hard to improve customer satisfaction through patient experience. We do recognise that we don't always get things right and this is why we have a dedicated **patient experience team** to listen to and ensure concerns and complaints are investigated.



Number of Complaints – 2023-24

The Trust received **1,494** complaints in 2023-24.



*Data for 2023-24 obtained from the Trust Business Intelligence Platform - Yellowfin

2023-24 Complaints by complaint type

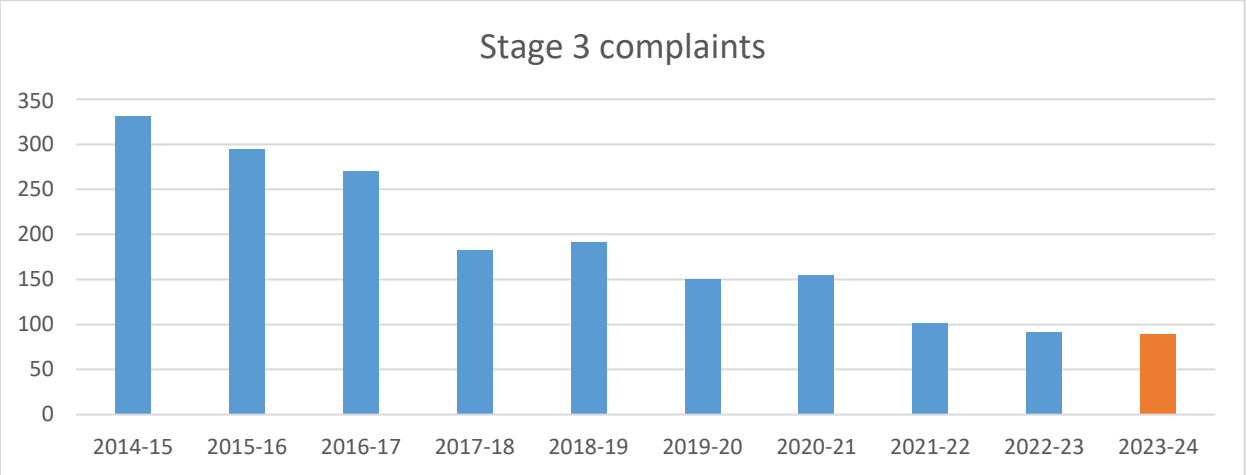
The top 10 primary complaint themes from the **89 stage 3** complaints received in 2023-24 are:

Complaint Sub Subject	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Failure to monitor	2	1	1	2	3	1	2	2	2	0	3	1	**20**
Communication - Verbal	1	2	1	4	1	1	2	3	2	0	0	0	**17**
Delay to diagnosis	0	0	0	4	2	1	3	3	1	0	2	0	**16**
Communication with relatives/carers	0	0	0	0	0	0	0	0	0	2	10	2	**14**
Care and compassion	1	2	1	3	1	3	2	0	1	0	0	0	**14**
Discharge arrangements	0	0	1	3	2	1	1	1	1	0	0	0	**10**
Treatment and procedure delays	0	0	1	5	0	1	2	0	1	0	0	0	**10**
Competence of staff member	1	0	4	1	1	1	1	0	0	0	0	0	**9**
Attitude of staff	0	1	1	4	1	0	1	0	0	0	0	0	**8**
Communication - Written	1	1	0	0	1	1	1	0	1	0	0	0	**6**

*Data obtained from the Trust complaint reporting systems (Datix and Inphase) at end of March 2024 *(for 2024/25 Quality Accounts, this will include themes for complaint Stages 1, 2 and 3).*

Since April 2023, the Trust has received **1,494** complaints of which **89** have requested an executive written complaint response. This equates to **5.96%** of the complaints.

The number of stage 3 complaints received over the last 10 year period is shown in the following table for comparison.



*Data obtained from the Trust complaint reporting systems (Datix and Inphase) up to March 2024 *(for 2024/25 Quality Accounts, this will include data for complaint Stages 1, 2 and 3).*

The number, stage and themes of complaints are viewed weekly during the Safety Panel Meetings held within the Trust. Where there is a concern regarding specific departments or an increase in themes identified, managers are requested to review where services require improvement and provide additional support as required. The complaint themes are collated and aggregated analysis is considered in the Trust's quarterly Patient Experience and Involvement Report.

Number of complaints

The number of complaints received into the Trust has decreased for 2023-24 to 1,494 from 1,573 the previous year. The number of stage 3 complaints has decreased for the year from 125 for 2022-23 to 89 for 2023-24. Stage 1 complaints accounted for 85.87% of the complaints received during 2023-24, stage 2 accounted for 8.17% and stage 3 complaints accounted for 5.96% of the complaints received during 2023-24. This indicates that the vast majority of complaints are managed locally as a stage 1 early resolution complaint.

The number of stage 3 complaints upheld is below:

Upheld – 10
Partly upheld – 34
Not upheld – 27
Open - 18

For 2024/25 Quality Accounts, this will include data for complaint Stages 1, 2 and 3.

Referred to Parliamentary and Health Service Ombudsman (PHSO)

If a complainant feels a complaint is not satisfactorily resolved, the Trust offers a further contact response for issues that have not been previously been responded to, where more information is available or where information has not been understood. Following a complaint response the Trust advise the complainant, if they feel all attempts to resolve have been exhausted that they can go to the PHSO.

During 2023-24 there were four cases upheld or partially upheld.

Action taken to improve services

The Trust takes all complaints raised seriously and actions are taken to improve service issues identified. The most common themes identified from complainants for 2023-24 was failure to monitor and communication.

Patient feedback from the Friends and Family Test, compliments and complaints is available via Yellowfin and InPhase for senior staff from all Care Groups. This ensures areas of concern are visible and can be acted upon quickly. Where there are concerns regarding specific staff such as their attitude or communication with service users and relatives then this is investigated and raised with staff directly via their line manager. Additionally, the Trust have rolled out leadership courses as part of a 3 year leadership strategic plan. The training is for all staff leaders, regardless of role or grade or whether they have a formal position to manage or lead people. The initial session is titled 'It all Starts with me' to develop leadership awareness, skills, knowledge and behaviour.

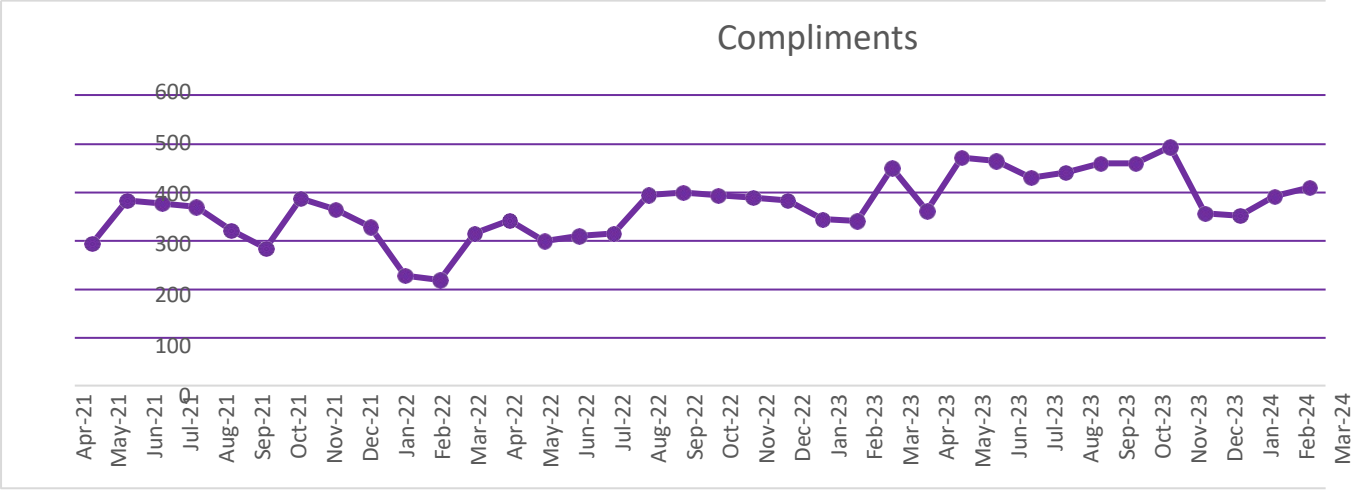
The Trust has undertaken a full review of the complaint process during 2023 based on the PHSO Complaint Standards Framework which aims to improve the process from a patient's perspective. Key changes include a more robust triage of the issues for investigation with the complainant, the introduction of swarm huddles for complex complaints to agree a management plan, and the introduction of a senior quality reviewer for each stage 3 complaint. The revised complaint process ensures the Trust complies with the PHSO Standards which are based on the NHS Complaint Regulations 2009.

Responding to complaints training has been delivered by an external company to key stakeholders within the organisation, including the Trust Board. In addition, all staff involved in complaint management have the opportunity to register and undertaken complaint training via the PHSO website.

Compliments

The Trust records the number of compliments received within each area. The trends in the number of compliments received can be seen in the following table and chart.

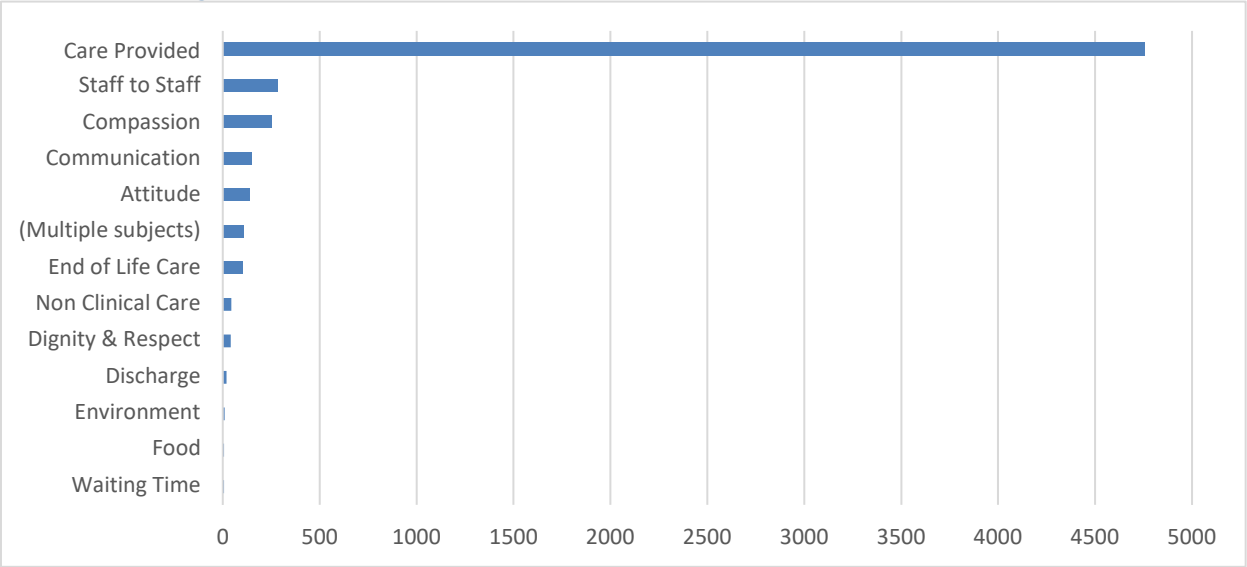
Financial Year	Number of Compliments
2021-22	4,071
2022-23	4,604
2023-24	**5,083**



*Data obtained via the Trusts Compliments (PALS) module within the Trust incident reporting system.

"My whole hospital experience was superb everyone was kind helpful, knowledgeable, empathetic couldn't have wanted anything more excellent
***** 5 star"

Compliment Subject



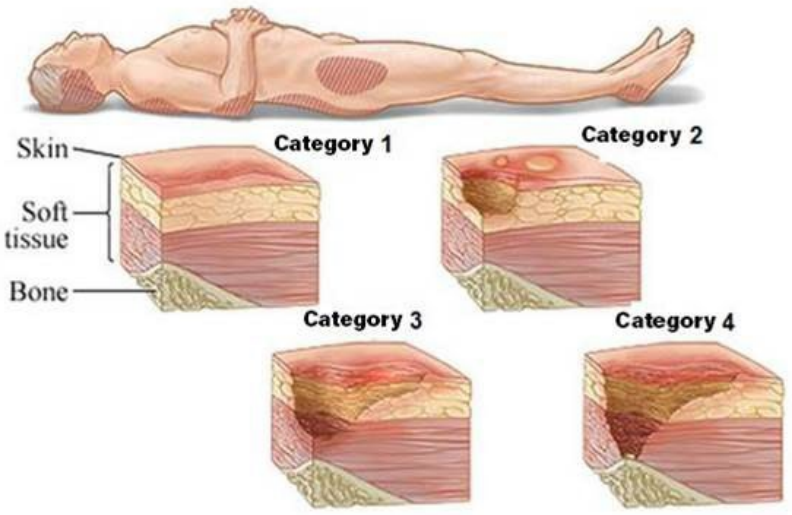
The Trust is exploring ways of continuing to improve data collection and capture.

"Everyone was so kind and helpful and pleasant. They made my stay here feel, so seems odd to say, enjoyable. You all could not have done more was lovely to meet you all thank you"

"We are so grateful for the wonderful treatment we have received from you all over the last five months. you all work so well as a team with sure professionalism dedication and energy, you are an absolute credit to the N.H.S."

Pressure Ulcers

Pressure ulcers, also known as **pressure sores**, **bedsores** and **decubitus ulcers**, are localized damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of **pressure**, or **pressure** in combination with shear and/or friction.



Year on Year Comparison – In-Hospital Acquired

Reporting Period	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Category 1	38	54	92	64	48	74	150
Category 2	189	198	299	233	272	231	308
Category 3	20	35	34	14	16	19	30
Category 4	2	2	3	3	2	0	2
Total	**249**	**289**	**428**	**314**	**338**	**324**	**490**

Data obtained via the Trusts Incident Reporting database. 2023-24 figures (April 2023 - February 2024)

Year on Year Comparison – Out of Hospital Acquired

Reporting Period	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Category 1	159	55	59	50	41	39	48
Category 2	359	173	152	128	153	103	153
Category 3	85	69	75	46	51	40	65
Category 4	21	9	19	12	14	8	8
Total	**624**	**306**	**305**	**236**	**259**	**190**	**274**

Data obtained via the Trusts Incident Reporting database. 2023-24 figures (April 2023 - February 2024)

Actions taken by the Trust

Pressure damage is one of the top five reported incidents within the Trust, with risk assessment, prevention and management being guided through the application of NICE guidelines and quality standards. Any incidents are reported via the Trust event reporting system, utilising a checklist within the system to capture data in relation to omissions in care that may have contributed to pressure ulcer development. The checklist also supports colleagues reviewing such events by providing a consistent approach towards decision making in relation to the level of investigation required and allows for easy identification of learning. All pressure related events are validated, by the Skin Integrity Nurse. The numbers of pressure ulcer events are discussed as part of the monthly quality and safety agenda within each Care Groups senior management team (SMT) meeting and monitored through the Tissue Viability Operational Group and the Quality Assurance Council. The Tissue Viability Operational Group has the remit of reviewing the Trust's programs of improvement, policies, guidelines and information leaflets. Quarterly audit data is undertaken by the Care Groups and presented with a review of cases and shared learning, successes and challenges. An annual pressure ulcer prevalence audit is also undertaken for patients on the community nurse caseload and patients in hospital in-patient beds. This will next take place in June 2024.

A significant increase in reporting of pressure ulcer events has been noted in the period of 2023-24 for both community and in hospital care. This is due to an increase in activity throughout the Trust, but also a positive reporting culture and improved early identification of pressure ulcers, specifically those identified as category 1. The trust report similar numbers of category 3 and 4 ulcers to previous years

which demonstrates that early identification, improved risk assessment and care planning prevents further deterioration and delayed identification.

The Skin Integrity Collaborative has been delivered during 2023-24 and has been supported by the secondment of a Skin Integrity Nurse. The skin integrity collaborative has a focus on quality improvement, education and training, correct validation of pressure ulcers, compliance with risk assessments and care planning and delivery. The Skin Integrity Nurse is able to support clinical staff at the point of care and those areas who have been part of the collaborative have demonstrated improved accuracy of reporting, improved compliance with risk assessment and care planning with a reduction in the level of harm reported. Future plans for 2024-25 include extending the collaborative to more inpatient areas to ensure that harm to patients is reduced across the Trust and patient outcomes are improved. The role of the Skin Integrity Nurse remains integral in this continued progression.

The agenda for pressure ulcer prevention is underpinned by evidence, research and best practice with measurable outcomes ensuring we do the right thing at the right time. The tissue viability nursing (TVN) team have participated in the 2023-24 CQUIN (CCG12) which aimed to continue to evaluate the assessment and documentation of pressure ulcer risk. Although we demonstrated significant improvement throughout the year, especially in evidencing the documentation of patient preference, the Trust wish to continue to review our progress into 2024-25. The annual prevalence audit was completed in June 2023 with an increased submission rate from our community teams. The community teams continue to engage with the TVN teams for specialist wound care advice and manage complex wounds and patients in their own homes successfully.

Education remains a key focus for the Tissue Viability Team. Working with the clinical staff and managers is critical in the maintenance of a network of Tissue Viability Champions who meet for updates on wound care and all matters related to tissue viability. A full day study event is planned for 2024-25 with quarterly meetings to support attendance and allow a full range of topics to be covered.

The annual “Stop the Pressure” event was very successful in November 2023 with a well-circulated campaign. Clinical teams were asked to correctly validate pictures of pressure damage to win a hamper for their team. The “Stop the Pressure” event will be repeated in 2024 with a new focus to help improve patient care.

The tissue viability “Learning Hub” continues to develop with key topics being showcased on the intranet site. The TVN team offer planned and bespoke training events throughout the year on a rolling program to address the needs of the developing workforce.

Implementation of Purpose T, our risk assessment tool has been successfully rolled out Trust wide. A robust training plan has been delivered to staff members across the Trust. The risk assessment tool benefits the patient by delivering patient centred care and allows the assessor to select the appropriate care plans and equipment with the aid of the equipment selection guideline. Specific Purpose T assessment tools have also been implemented in paediatrics and maternity areas. Within our critical care area a specific risk assessment tool has been introduced, CALCULATE. The tool allows for risks associated specifically to critical care patients such as medical devices to be considered and reviewed to reduce the chances of device related pressure damage.

The Trust continues to utilise a pressure ulcer assurance framework which aims to drive and demonstrate progression of excellent practice within pressure ulcer prevention as well as identifying any areas of improvement or action needed. The assurance framework is reviewed quarterly at the tissue viability operational group and identifies key actions and learning to help the Trust to continue to reduce the harm from pressure damage.

Section 3b: Performance from key national priorities

Appendix B of the compliance framework

National NHS objectives form the basis on which the Trusts' Annual Plan and in year reports are presented. Regulation and proportionate management remain paramount in the Trust to ensure patient safety is considered in all aspects of operational performance and efficiency delivery. The current performance against national priorities, existing targets and cancer standards are demonstrated in the table with comparisons to the previous year.

NHS Oversight Framework Indicators	Standard/Trajectory	2023-24 Performance	2022-23 Performance	Achieved (cumulative)
Cancer 31 day wait for second or subsequent treatment – surgery (Apr 23 to Feb 24 Provisional)	94%	90.42%	91.77%	x
Cancer 31 day wait for second or subsequent treatment – anti cancer drug treatments (Apr 23 to Feb 24 Provisional)	98%	99.10%	99.25%	✓
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer) (Apr 23 to Feb 24 Provisional)	85%	54.37%	60.97%	x
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral) (Apr 23 to Feb 24 Provisional)	90%	75.07%	84.84%	x
Cancer 31 day wait from diagnosis to first treatment (Apr 23 to Feb 24 Provisional)	96%	96.34%	95.64%	✓
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) (Apr 23 to Feb 24 Provisional)	93%	88.00%	86.62%	x
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) (Apr 23 to Feb 24 Provisional)	93%	83.72%	92.94%	x
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways (Mar-24)	92%	71.15%	78.36%	x
Referral to Treatment 52 Week Waits (Mar 24)	0	218	38	x
Number of Diagnostic waiters over 6 weeks (Apr 23 to Mar 24)	99%	80.19%	75.04%	x
Community care data completeness – referral to treatment information completeness (Apr 23 to Mar 24)	50%	96.69%	97.61%	✓
Community care data completeness – referral information completeness (Apr 23 to Mar 24)	50%	99.75%	96.81%	✓
Community care data completeness – activity	50%	99.98%	94.61%	✓

information completeness (Apr 23 to Mar 24)				
Community care data completeness – patient identifier information completeness (Shadow Monitoring) (Apr 23 to Mar 24)	50%	99.98%	94.61%	✓
Community care data completeness – End of life patients deaths at home information completeness (Shadow Monitoring) (Apr 23 to Mar 24)	50%	84.21%	84.49%	✓
Other National and Contract Indicators	**Target**	**2023-24 Performance**	**2022-23 Performance**	**Achieved**
Cancelled Procedures for non-medical reasons on the day of op (2023-24)	0.80%	0.48%	0.44%	✓
Cancelled Procedures reappointed within 28 days (Apr 23 to Mar 24)	100%	75.25%	79.52%	x
Eliminating Mixed Sex Accommodation (2023-24)	Zero cases	0	0	✓
A&E Trolley waits > 12 hours (2023-24)	Zero cases	54	172	x
Stroke – 90% of time on dedicated Stroke unit (2023-24)	80%	84.21%	91.93%	✓
Stroke – TIA assessment within 24 hours (Apr 23 to Mar 24)	75%	71.88%	59.06%	x
VTE Risk Assessment (Apr 23 to Mar 24)	95%	95.00%	95.84%	✓
Sickness Absence Rate (Feb 2024)	4.0%	5.44%	5.80%	x
Mandatory Training Compliance (Mar 2024)	90%	90.14%	86.90%	✓
Turnover Rate (Mar 2024)	10.0%	7.61%	9.94%	✓
Operational Efficiency Indicators	**Target**	**2023-24 Performance**	**2022-23 Performance**	**Achieved**
New to Review Ratio (Apr 23 to Mar 24)	1.45	1.97	1.3	x
Outpatient DNA (Combined) (2023-24)	9.20%	9.87%	9.96%	x
Length of Stay Elective (Apr 23 to Mar 24)	3.14	1.96	2.10	✓
Length of Stay Emergency (Apr 23 to Mar 24)	3.35	3.36	3.39	x
Readmission Elective (Apr 23 to Jan 24)	0.00%	4.25%	3.96%	x
Readmission Emergency (Apr 23 to Jan 24)	9.37%	13.46%	12.53%	x
Occupancy (Trust) (Apr 23 to Mar 24)	90%	91.83%	92.96%	x
Quality Indicators	**Standard/Trajectory**	**2023-24 Performance**	**2022-23 Performance**	**Achieved**

Clostridium Difficile – variance from plan (objective) (Apr 23 – Mar 24)	46	70	47	x
Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia (Apr 23 – Mar 24)	0	4	2	x
Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia (Apr 22 – Mar 23)	29	53	46	x
Escherichia coli (E.coli) (Apr 23 – Mar 24)	69	88	86	x
Klebsiella species (Kleb sp) bacteraemia (Apr 23 – Mar 24)	20	31	26	x
Pseudomonas aeruginosa (Ps a) bacteraemia (Apr 23 – Mar 24)	11	15	15	x
Trust Complaints - Formal CE Letter (Stage 3) (Apr 23 – Mar 24)		89	92	
Trust Falls with Moderate Harm (Apr 23 – Mar 24)	<24	30	19	x
Trust Falls with Severe Harm (Apr 23 – Mar 24)	0	0	0	✓
In Hospital Pressure Ulcers Grade 4 (Apr 23 – Mar 24)	0	2	0	x
Medication Error (Apr 23 – Mar 24)	<615	855	782	x
Friends and Family Test - Very Good/Good (Apr 23 – Mar 24)	75%	92.40%	92.87%	✓
Never Events (Apr 23 – Mar 24))	0	0	2	✓
Hand Hygiene (Apr 23 – Mar 24)	95%	97.36	97.31%	✓
Summary Hospital-level Mortality Indicator (SHMI) (Nov 22 – Oct 23)	< 100	96.4	96.56	✓

Additional Assurance:

https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts- requirements-2021-22/

There is no national requirement for NHS trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account; this is a matter for local discussion between the Trust (or governors for an NHS trust) and its auditor. For quality accounts approval from within the Trust's own governance procedures is sufficient.

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30 May 2024

Response from Stockton-on-Tees Healthwatch to the Quality Accounts for North Tees and Hartlepool NHS Foundation Trust – May 2024

Healthwatch Stockton-on-Tees are pleased to provide feedback on the 2023/24 Quality Accounts and note the achievements and the clear useful data explaining how North Tees and Hartlepool NHS Foundation Trust is performing against other Trusts in the region and nationally. As a local Healthwatch we also appreciated the time taken by the Trust to attend our February 2024 Board Meeting and work through the draft report explaining the details known at the time.

This final report is comprehensive and provides an excellent overview of how the Trust demonstrates quality of healthcare, its general performance and how it manages its services. It was pleasing to note that the Trust has maintained ongoing involvement with Healthwatch Stockton-on-Tees and taken account of our thoughts and recommendations where they were helpful.

We were however disappointed to read that the outcome of the most recent CQC inspection in May 2022 was 'requires improvement' focusing on the three domains of safe, effective and well led although the report goes onto advise that the 31 required actions have been addressed.

When reviewing the details in the report, we were pleased to see the Trust has:

- Continued to be in the range of 'as expected' in the hospital mortalityindicator.
- Included mouth care for end-of-life patients in staff training and the role of the End-of-Life Care Facilitator being made permanent.
- Addressed the need to identify and support patients with dementia and delirium through its Strategy, Staff Training and Dementia Champions course and improved its pain management approach for thesepatients.
- Cross-referenced people with a potential dementia diagnosis with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) to check if a clinical diagnosis has been confirmed.
- Continued to promote John's Campaign.
- Developed a mental health strategy to demonstrate how the Trust will work

alongside TEWV to deliver an integrated approach to both physical and mental health over the next three years.

- Produced quarterly adult safeguarding reports with the purpose of providing the Trust Safeguarding Council members with an overview of safeguarding activity. It was noted that although safeguarding concerns have increased year on year, especially domestic abuse, this probably reflects additional staff training and increased reporting trends locally and nationally.
- Focused on Deprivation of Liberty Safeguards (DoLS) authorisations with improvements to paperwork and a positive auditors review of the MCA and DoLS policy.
- Achieved 95% of staff trained in learning disabilities and autism.
- Focused on Children's safeguarding through a revised Communications and Engagement strategy and CQC focused improvement plans, ensuring staff training is highlighted as important.
- Improved performance of catheter associated urinary tract infections through reduced use of catheters and improved urine monitoring devices.
- Continued a focus on managing deaths in hospital by identifying deaths requiring further investigation and ascertaining learning points to change practice.
- Introduced a Medical Examiner Service to scrutinise both inpatient and some community deaths before it is required statutorily.
- An integrated discharge team which has increased in size, working seven days each week, to support timely and effective discharges from hospital.
- The introduction of Patient Flow Facilitators on specific wards to support appropriate clinical and operational tasks, preparing ward beds for new patients.
- Arranged volunteer led teams to assist with patient discharge.
- Worked towards getting more people home from hospital rather than into short term care using the developing Trusted Assessor role.
- Positively improved the Discharge Lounge arrangements by recruiting a dedicated staff team and increased the number of people using it by nearly 50%.
- Supported the development of the Integrated Single Point of Access team based in Billingham.
- Continued to work towards supporting patients with information or communication needs.
- Seen a 20% reduction in the incidents of violence and aggression towards staff and patients, especially around both physical and verbal abuse.
- Focused on safety and quality through the use of an electronic Dashboard which displays useful information on 10 quality standards easily understood by staff and patients.
- Increased referrals to the Chaplaincy service to an all-time high.
- Taken seriously the various local and national patient surveys undertaken during the year and considered the outcome of those surveys to improve overall learning and practice.
- Achieved 92.4% Very Good or Good in the Friends and Family Test.
- Taken seriously both local and national clinical audits and national confidential enquiries to ensure improvement in the quality of healthcare provided to patients. Actions taken show due regard to improving safety and quality.
- Increased the number of patients involved in clinical research and allows clinical staff to work part time within the research department to ensure research is embedded in the organisation.
- Instigated the introduction of the Freedom to Speak Up Guardian role alongside the introduction of the Speaking Up Policy based on the events at Mid-Staffordshire NHS Foundation Trust and recommendations from the

subsequent enquiry led by Sir Robert Francis (previously Chair of Healthwatch England).

- Had no 'never events' during this reporting period.
- Received a reduction (5%) in the number of formal complaints during the year. This includes a 29% reduction of stage 3 complaints of which 50% were upheld or partially upheld.
- Received a 10% increase in compliments to 5,083.

However, we were concerned to see the following negative issues associated with infections:

- Cases of C. difficile increased to 70 trust-attributable cases when the trajectory set was reduced from 54 to 46 cases. It is noted this increase is mirrored across the region and nationally.
- Cases of both MRSA and MSSA (*Staphylococcus aureus*) have increased.
- Cases of E-Coli have increased.
- Cases of *Klebsiella* species have increased.
- Cases of *Pseudomonas (P) aeruginosa* have increased.
- COVID-19 still impacts on patients with 20 outbreaks and 649 positive cases reported.

Also, it was noted that data coding of medical procedures was not meeting the required timescales due to a reduction in staffing within the team of coders. We note there is a recovery plan in place.

Regarding patient safety it was noted that, from the data on patient falls, there has been an increase in the number of falls resulting in low and moderate harm alongside two falls resulting in death (accepting these deaths weren't as a direct result of the fall).

Unfortunately, there had been a nearly 10% increase in the number of reported medication related patient safety events since the previous year (from 782 to 855). As stated, these events are discussed in weekly Senior Clinical Practitioner Meetings and quarterly Patient Safety Council meetings, however it must be concluded these discussions are not having an impact on overall medication safety.

We also noted a significant increase in reported pressure ulcers, up from 324 to 490 (33%) both for in-hospital and community care but accept this could be due to increased activity and improved reporting.

Thank you for the opportunity to review the 2023/24 Quality Account and throughthis work Healthwatch Stockton-on-Tees continues to welcome the strong working relationship we've developed with the Trust over recent years, and we will continue to work with and support the Trust over the coming 12 months with the aim of further improving the quality of services provided and maximising a positive patient experience.

Peter Smith
Peter Smith (Chair)
Healthwatch Stockton-on-Tees

SBC Adult Social Care and Health Select Committee

NTHFT Quality Account 2023-2024 – Third-Party Declaration

(1,000 words max)

The Committee once again welcomes its annual opportunity to comment on key elements of the latest North Tees and Hartlepool NHS Foundation Trust (NTHFT) Quality Account. This statement reflects upon the presentation given to the Committee in March 2024 which outlined NTHFTs performance against its agreed 2023-2024 quality priorities (and its quality improvement priorities for 2024-2025), as well as the content of the delayed draft Quality Account document which was circulated to stakeholders in late-May 2024.

In relation to 'patient safety', NTHFT continued to consistently maintain its Summary Hospital-level Mortality Indicator (SHMI) level within the 'as expected' range. As it has done for several years now, performance in comparison to other Trusts across the region and nationally remains very positive.

Regarding the dementia priority, for many years, this has been seen as an increasing issue for the Trust, yet it is interesting to note that the number of patients admitted with a diagnosis of dementia / delirium in 2023-2024 (3,730) appears to be over 10% lower than the number admitted in the pre-COVID year of 2018-2019 (4,218). Nevertheless, it was good to see the emphasis and range of work around this condition, particularly the specific focus on supporting families and carers (something the Committee frequently advocates). Members note that benefits associated with the Community Dementia Liaison Service (CDLS) which is currently commissioned for Hartlepool only.

Infection control data indicates a mixed performance. The Trust report a significantly increased number of *Clostridium difficile (C Difficile)* cases (mirrored nationally) within the narrative of its draft Quality Account document – however, the accompanying statistics appear to show only a very slight increase (up from 48 to 50) in hospital onset healthcare associated (HOHA) cases and a significant decrease (down from 45 to 20) in community onset healthcare associated (COHA) cases compared to 2022-2023. For other infection types, Members note the increases in some healthcare-associated infections during 2023-2024 and welcome the subsequent assurances given to address this.

The Committee has previously called for more detail on the mental health priority, so it was pleasing to see developments around the mental health strategy (including the recognition of staff wellbeing – so important given the well-documented recruitment and retention challenges within the health sector). From a safeguarding adults perspective, Members observe the increasing trend in safeguarding concerns / enquiries raised both within NTHFT and against the Trust (potentially a cause for alarm, though perhaps reflective of work undertaken to increase awareness of possible safeguarding issues and associated reporting routes). Developments in relation to children's safeguarding are encouraging, particularly the various well-established partnership mechanisms with other local organisations. In other 'patient safety' matters, an absence of 'never events' in 2023-2024 is important, though the rising trend of medication errors appears to demand attention.

Under the 'effectiveness of care' heading, the Committee commends the continued focus on discharge processes (e.g. increases in Discharge Flow Facilitators and Patient Flow Facilitators) which are already the envy of many other NHS Trusts across the country. Getting to a position of strength is not easy – maintaining and even improving this can be even tougher. The volunteer drivers service and 'home but not alone' scheme continue to reap hugely beneficial rewards for the Trust and, more importantly, local people.

Whilst NTHFT reported a 20% reduction in violent incidents compared to 2022-2023, Members once again expressed alarm at recorded cases of violence towards staff, something that may, in part, explain the increased need for the use of control and restraint with a patient (which had significantly risen against the previous year). 34 cases of physical assault, abuse or violence (towards a person) with or without a weapon is simply inexcusable – it is hoped that Trust personnel are appropriately supported both internally and by relevant external powers when (and indeed after) having to deal with those who still find it acceptable to behave in such a deplorable manner.

In terms of 'patient experience', the Committee commend NTHFT for balancing positive outcomes from involvement in various national surveys with more critical statements from patients, demonstrating the Trust's transparency for which Members have become accustomed to. Given well-documented national concerns around midwifery, the Trust's results from the CQC National Maternity Survey 2023 were, broadly speaking, assuring. Maintaining high levels of patient satisfaction via the Family and Friends Test (FFT) is welcome, with the Trust and patients alike deserving praise for the huge increase in FFT responses which appeared to rise by 45% in 2023-2024 (28,943) compared to 2022-2023 (19,923).

Although not formerly added to the 2023-2024 priorities (despite last year's request by the Committee), the specific focus on maternity developments within the March 2024

presentation was appreciated, as was the update on these services (including work undertaken to address the Committee's previous concerns around community midwifery) given to the Committee by the NTHFT Chief Nurse in November 2023.

In staffing matters, Members note the Trust's acknowledgement within the Freedom to Speak Up (FTSU) section that '*there is a long way to go to make speaking up "business as usual" in an open and transparent way*'. National Staff Survey results also show that there is work to do around workforce perceptions of the standard of care being given and the number recommending the Trust as a place to work.

The Committee supports the identified 2024-2025 priorities, though note the apparent absence of a focus around the retention of staff (a well-documented issue which can impact upon the provision of quality care), as well as previous criticism that the Trust had too many plans. The Quality Account document evidences an admirable amount of positive practice, but there is clearly plenty to work on when assessing the 'key national priorities' data.

NTHFT continues to be responsive to requests from the Committee, and its ongoing approach to sharing good quality data and accompanying narrative for analysis is greatly appreciated. Moving forward, the Committee will watch with interest the ramifications on service structure and delivery of the move to more formal partnership-working with neighbouring South Tees Hospitals NHS Foundation Trust.

Fiona McEvoy
North Tees and Hartlepool NHS Foundation Trust
University Hospital of North Tees
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Stockton on Tees
TS19 8PE

Dear Fiona, Tuesday 13th June 2024

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

First, may I put on record our sincere thanks for providing Healthwatch Hartlepool with such a detailed presentation in respect of the Trust's Quality Accounts earlier this year prior to the publication of the Draft Quality Accounts 2023 - 24.

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

Overall members felt that the information provided was incredibly informative. Our members suggested that 'Transfers of Care' would be a welcome addition to future performance monitoring particularly around the Cardio Vascular Pathways given the waiting times some patients experience when requiring a transfer from North Tees to South Tees. This was recommended last year but does not feature again.

One of the long-standing issues we wish to alert the Trust to again is concerns around communication that was accepted when we published our report into hospital discharge. Also, we would again wish to highlight the flaws in respect of 'Friends & Family'. At present these are not issued to patients who have previously had an admission/appointment within 14 days or been subject to a transfer of care. There needs to be some flexibility as to when it may be appropriate to issue such forms especially for in patient care that results in a transfer rather than a discharge. Also, for those patients who may have a dual diagnosis and have multiple appointments but for differing departments.

Our members were also incredibly concerned regarding the 62 day cancer target given we were presented with performance @ 69.23% against a target of 85%. Communication could also be improved around signage at the hospital sites to reflect actual the wards and purpose. There is a need for appropriate & improved signage for patients especially those living with a disability. Access routes should be clearly identified and appropriate signage displayed / use of plain English and easy read where possible; accessible toilets/changing places conveniently located to promote dignity and independence. We also would request that a greater emphasis need to be made on ensuring the availability of patient leaflets and equality of access to patients who may be Deaf/ Blind /Visually impaired or with dual sensory loss.

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

Yours sincerely,

Christopher Akers-Belcher
Chief Executive - Healthwatch Hartlepool

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24th June 2024

Rue Musekiwa
Deputy Chief Nurse
Nursing, Patient Safety & Quality/North Tees and Hartlepool NHS Foundation Trust

Dear Rue

AUDIT AND GOVERNANCE COMMITTEE –THIRD PARTY DECLARATION 2023/24 QUALITY ACCOUNT

Following consideration of the North Tees and Hartlepool NHS Foundation Trust Quality Accounts on 27th February 2024, Hartlepool Borough Council's Audit and Governance Committee agreed the following:

In relation to quality improvement priorities for 2023/24, the Committee was particularly interested in hearing the progress the Trust has made in the following areas:-

Patient Safety; Effectiveness of care; and Patient Experience.

The Committee welcomed the opportunity to comment specifically in relation to:

- Concerns regarding the increase in violent incidents/events and the abuse of NHS staff members.
- Ensuring the reduction of violent incidents/events and a reduction in the abuse of NHS staff members remains a priority in the coming year.

The Committee also supports the quality improvement priorities for 2024/25.

Yours faithfully

Joan Stevens

Joan Stevens
STATUTORY SCRUTINY MANAGER

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Commissioner Statement from North East and North Cumbia Integrated Care Board (NENC ICB) North Tees and Hartlepool NHS Foundation Trust Quality Account 2023/24

The Integrated Care Board (ICB) commissions healthcare services for the local population. The Integrated Care Board take seriously their responsibility to ensure that the needs of patients are met by the provision of safe, high-quality services and therefore welcome the opportunity to submit a statement on the Annual Quality Account for North Tees and Hartlepool NHS Foundation Trust (NTHFT).

Like many organisations across the country, North Tees and Hartlepool NHS Foundation Trust has faced a challenging year post pandemic recovery. The ICB would like to commend the Trust and staff for their commitment and dedication demonstrated throughout these difficult times and for striving to ensure that patient care continues to be delivered to a high standard.

The Integrated Care Board are pleased to note from the 2023/24 Quality Account that the Trust continues to be a strong performer in relation to the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) mortality values. The values continue to report within the 'as expected' range and below the national average. The Trust has demonstrated progress from their Learning from Deaths Improvement Work including the Recognition of Dying training, Recognition, and escalation of deteriorating patient and the implementation of 'Call for Care' (arising from 'Martha's Law').

The Integrated Care Board acknowledges the extensive work the Trust has undertaken in relation to Dementia care including recognition of the condition,

currently the region has an 85.8% diagnostic rate. This is significantly higher than the 66.7% national benchmark and shows the progress the region has made in relation to accurate and timely diagnosis. It is pleasing to note the other important work in relation to supporting carers, raising awareness of delirium in patients with dementia and the increased accessibility of information for both professionals, partners, and family members.

The Trust showcases the progress that has been made in relation to mental health and their three key objectives to improve the quality of care, support patients with long term physical health conditions to identify and manage their mental health needs whilst ensuring that their workforce has the right skills, knowledge, and attitudes to recognise and care for patients, carers, and families with mental illness. The Integrated Care Board congratulates the Trust in their achievements so far and welcome the ambitions set for next year.

The Integrated Care Board notes the ongoing progress that the Trust has made in relation to Safeguarding both adults and children and are pleased to note that there is additional focused quality improvement work identified in the Trust Patient Safety Incident Response Framework (PSERP) priorities for 2024-25. This will help strengthen the application and compliance with the Children not Brought to Appointment policy.

Despite extensive improvement work across the Trust, compliance with the nationally and Trust assigned healthcare associated infection thresholds were not met. The continued focus on reducing harm associated with health care associated infections remains central to patient safety and it is essential that a system wide focus is maintained, particularly as the increasing rates of C. Difficile infection remain a significant challenge both nationally, regionally and within the Trust. It is pleasing to note the decrease of catheter-associated urinary tract infections (CAUTI) and the ongoing work the Trust continues to undertake.

The Trust has made good progress with the Quality Priority 'Learning from Deaths' and this important priority will continue next year to include work on standardisation and robust reporting, establishing a Mortality Group and working more collaboratively with a neighbouring Trust. The Integrated Care Board are also encouraged to note the achievements in other Quality Priorities including 'Discharge Process', 'Accessibility', the reduction in 'Violent Incidents' and the implementation of the Safety and Quality Dashboard providing that visual overview of ten key performance indicators.

The Quality Account demonstrates the work the Trust has undertaken in response to the CQC report September 2022 following the inspection of two core services, maternity and children and young people. Fundamentally the Trust has focused on improving governance oversight with executive-level ownership to certify that staff and stakeholders have an enhanced comprehension of the quality improvements in situ. The Integrated Care Board is pleased to note that maternity services is one of the Trust's Quality Priorities for 2024/25.

The Trust has undertaken significant work with implementation of the Patient Safety Incident Response Framework (PSIRF) and formally transitioned to this new framework in January 2024, following agreement with the Integrated Care Board.
The Integrated Care Board is appreciative of being included from the start in the implementation journey and fully supports the Trust's quality priority for 2024/25 in progressing this further. The Integrated Care Board looks forward to continuing to receive regular updates from the Trust as they continue to fully embed the PSIRF programmes of work.

The Quality Account clearly defines the key priorities for 2024/25, which include detailed explanation of how progress will be measured to deliver safe, clinically effective services and to improve patient and staff experience. The Integrated Care Board welcomes and fully supports these quality priorities as appropriate areas to target for continuous evidence-based quality improvement, which link well with the commissioning priorities.

The Integrated Care Board looks forward to continued partnership working to ensure that there remains a coordinated, collaborative approach towards the quality and safety of services provided to our patient population, whilst developing new ways of working to deliver improvements across pathways of care.

Yours sincerely,

Richard Scott
Director of Nursing
North East and North Cumbria Integrated Care Board

On behalf of

David Purdue

Chief Nurse, AHP and People Officer NHS
North East & North Cumbria ICB

Council of Governors
(third party declaration)

The Council of Governors who are key stakeholders of the Trust, have a duty to hold the Non-Executive Directors to account for the performance of the Board of Directors and to represent the interests of the public at large. In order for the Council of Governors to gain the relevant assurance, detailed compliance, quality and financial information is presented at each Council of Governors meeting, which is supplemented with assurance reports from each of the Board Committees, Quality, People, Resources and Audit demonstrating the challenge and detailed overview the Non-Executive Directors obtain regarding trust performance.

In addition, regular updates regarding the wider system and collaborative working are provided following the requirement in the Health and Care Act 2022 for the provision of greater integrated care for all with multi organisations and partners working together. During 2023-24, this included sharing the development of the group model between the Trust and South Tees Hospitals NHS Foundation Trust and a number of key collaborative projects to improve patient access and care including the Community Diagnostic Centre and Tees Wide Urgent and Emergency Care Service. It is also important that any changes to regulatory requirements and recommendations from inquiry reports are shared with the Council of Governors to provide assurance regarding the Trust's response and subsequent action plans.

As well as the main Council of Governor meetings, which were held regularly throughout the year individually and in common with South Tees Hospitals NHS Foundation Trust, a number of development sessions took place on a range of topics including the Group Model, Joint Council of Governors Collaborative Working, Estates Strategy Update, System Working and Collaboration: Role of Foundation Trust Council of Governors, Portfolio of Chief People Officer & Director of Corporate Affairs, Community Diagnostics, Group Digital Strategy, Group Performance Management and Reporting, Trust Constitution, Trust Improvement Programme Update, and Role of Healthwatch. The provision of these sessions facilitates constructive challenge and discussion between the Council of Governors and members of the Board.

To provide the opportunity for the Council of Governors and Board Members to see service areas and patient care first hand, two joint walkabout sessions were arranged covering a wide range of departments across the University Hospitals of North Tees and Hartlepool, pairing Governors with Non-Executive Directors and senior members of staff. Collective feedback sessions took place after both walkabouts, providing the opportunity to share observations and highlight any areas for improvement.

The schedule of reports provided for Council of Governor meetings are regularly reviewed to ensure relevant information is shared in a timely manner and agendas continue to remain fit for purpose to assist the Council of Governors to hold the Board collectively to account and to support the journey of the Group Model. Governors were engaged in the appointment of the Group Chief Executive and Group Non-Executive Directors as part of the establishment of a Group Board. Governors have also been invited and encouraged to observe the North Tees and Hartlepool Board of Directors meetings throughout the year and the newly formed Group Board meetings. Several governors have attended and have benefited from directly observing the role of the Non-Executive Directors in constructively challenging the Executive Directors and seeking triangulated evidence regarding performance.

Aside from formal meetings, regular communication is maintained with Governors regarding key developments and Trust announcements via bulletins to ensure they remain informed.

June 2024

Annex B: Quality Report Statement

Statement of Directors' Responsibilities in Respect of the Quality Account

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

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

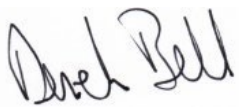
- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2023-24* and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2023 to April 2024
  - papers relating to Quality reported to the Board over the period April 2023 to April 2024
  - feedback from commissioners dated June *2024*
  - feedback from governors dated June *2024*
  - feedback from local Healthwatch organisations dated June *2024*
  - feedback from the Adult Services and Health Select Committee and Audit and Governance Committee dated June *2024*
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,
  - the latest national patient survey *2023*
  - the latest national staff survey *2023*
  - CQC Quality Report – Inspection Report 16 September 2022
  - the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
  - the performance information in the Quality Report is reliable and accurate;
  - there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
  - the data underpinning the measures of performance in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
  - the Quality Report has been prepared in accordance with NHS Improvements annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

Chief Executive

Chairman



Annex C: We would like to hear your views on our Quality Accounts

North Tees & Hartlepool NHS Foundation Trust value your feedback on the content of this year's Quality Account.

Please fill in the feedback form below, tear it off and return to us at the following address:

Patient Experience Team

North Tees & Hartlepool NHS Foundation Trust

Hardwick Road

Stockton-on-Tees

Cleveland

TS19 8PE

.....

Thank you for your time.

Feedback Form (please circle all answers that are applicable to you)

What best describes you: Patient Carer Member of public Staff Other

Did you find the Quality Account easy to read?	Yes	No	
Did you find the content easy to understand?	Yes all of it	Most of it	None of it
Did the content make sense to you?	Yes all of it	Most of it	None of it
Did you feel the content was relevant to you?	Yes all of it	Most of it	None of it
Would the content encourage you to use our hospital?	Yes all of it	Most of it	None of it
Did the content increase your confidence in the services we provide?	Yes all of it	Most of it	None of it

Are there any subjects/topics that you would like to see included in next year's Quality Account?

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In your Opinion, how could we improve Our Quality Account?

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Alternatively you can email us at: nth-tr.PatientExperience@nhs.net with the Subject **Quality Accounts**

Glossary

A&E	Accident and Emergency
ACE Committee	Audit and Clinical Effectiveness Committee – the committee that oversees both clinical audit (i.e. monitoring compliance with agreed standards of care) and clinical effectiveness (i.e. ensuring clinical services implement the most up-to-date clinical guidelines)
ACL	Anterior Cruciate Ligament – one of the four major ligaments of the knee
AKI	Acute Kidney Injury
AHP	Allied Health Professional
AMT	Abbreviated Mental Test
AQuA	Advancing Quality Alliance
BI	Business Intelligence
CAB	Citizens Advice Bureau
CABG	Coronary Artery Bypass Graft (or “heart bypass”)
CAUTI	Catheter-associated urinary tract infection
CFDP	Care For the Dying Patient
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach Team
CDI	Clostridium difficile Infection
CHKS	Comparative Health Knowledge System
CIAT	Community integrated assessment team (CIAT)
Clostridioides Difficile (infection)	A type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It is easily spread and can be acquired in the community and in hospital
CLRN	Comprehensive Local Research Network
CMR	Crude Mortality Rate
CNS	Clinical Nurse Specialist
COHA	Community onset Healthcare Associated
COPD	Chronic Obstructive Pulmonary Disease
CLIP	Complaints Litigation Incidents Performance
CPIS	Child Protection Information System
CPMS	Central Portfolio Management System
CSE	Child Sexual Exploitation
CSP	Co-ordinated System for gaining NHS Permission
CQC	The Care Quality Commission – the independent safety and quality regulator of all health and social care services in England
CQRG	Clinical Quality Review Group

CQUIN	Commissioning for Quality and Innovation – a payment framework introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care
DAHNO	Data for Head and Neck Oncology (Head and Neck Cancer)
DARs	Data Analysis Reports
DH	Department of Health
DLT	Discharge Liaison Team
DNA	Did Not Arrive
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
DSCP	Durham Safeguarding Children Partnership
DSPT	Data Security Protection Toolkit
DToC	Delayed Transfer of Care
DVLA	Driver and Vehicle Licensing Agency
EAU	Emergency Assessment Unit
E coli (infection)	Escherichia coli infection
ED	Emergency Department
EMSA	Eliminating mixed sex accommodation
EPMA	Electronic Prescribing and Medication Administration
EPR	Electronic Patient Record
EOL	End of Life
ESR	Electronic Staff Record
EWS	Early Warning Score – a tool used to assess a patient's health and warn of any deterioration
FCE	Finished Consultant Episode – the complete period of time a patient has spent under the continuous care of one consultant
FGM	Female Genital Mutilation
FICM	Faculty of Intensive Care Medicine
FOI (act)	The Freedom of Information Act – gives you the right to ask any public body for information they have on a particular subject
FFT	Friends and Family Test
FSCO	First Stop Contact officer
FTSU	Freedom To Speak Up

FTSUG	Freedom To Speak Up Guardian
Global trigger tool (GTT)	Used to assess rate and level of potential harm. Use of the GTT is led by a medical consultant and involves members of the multi-professional team. The tool enables clinical teams to identify events through triggers which may have caused, or have potential to cause varying levels of harm and take action to reduce the risk
GCP	Good Clinical Practice
GM	General Manager
HCAI	Health Care Acquired Infection
HED	Healthcare Evaluation Data (A major provider of healthcare information and benchmarking)
HEE	Health Education England
HENE	Health Education North East
HES	Hospital Episode Statistics
HLSCB	Hartlepool Local Safeguarding Children Board
HMB	Heavy Menstrual Bleeding
HOHA	Hospital Onset Healthcare Associated
HQIP	Healthcare Quality Improvement Partnership
HRG	Healthcare Resource Group – a group of clinically similar treatments and care that require similar levels of healthcare resource
HSCB	Hartlepool Safeguarding Children Boards
HSMR	Hospital Standardised Mortality Ratio – an indicator of healthcare quality that measures whether the death rate in a hospital is higher or lower than you would expect
HSSCP	Hartlepool and Stockton Safeguarding Children Partnership
HUG	Healthcare User Group
IBD	Inflammatory Bowel Disease
ICC	Infection Control Council
ICE	
ICNARC	Intensive Care National Audit and Research Centre
ICO	Information Commissioners Office
ICS	Intensive Care Society
IG	Information Governance
IHA	Initial Health Assessment
IMR	Intelligent Monitoring Report tool for monitoring compliance with essential standards of quality and safety that helps to identify where risks lie within an organisation
LD	Learning Difficulties
ICE	Integrated Clinical Environment

IG	Information Governance
Intentional rounding	A formal review of patient satisfaction used in wards at regular points throughout the day
IPB	Integrated Professional Board
IPC	Infection Prevention and Control
ISPA	Integrated Single Point of Access
Kardex (prescribing 120ardex)	A standard document used by healthcare professionals for recording details of what has been prescribed for a patient during their stay
KEOGH	Sir Bruce Keogh
Kleb sp	Klebsiella Species (type of infection)
KPI	Key Performance Indicator
LAC	Looked After Children
LADO	Local Authority Designated Officer
LAR	Looked After Review
LD	Learning disabilities
LeDeR	Learning Disabilities Mortality Review
Liverpool End of Life Care Pathway	Used at the bedside to drive up sustained quality of care of the dying patient in the last hours and days of life
LMS	Local Maternity System
LPMS	Local Portfolio Management Systems
LPS	Liberty Protection Systems
LQR	Local Quality Requirements
LSCB	Local Safeguarding Children's Board
MARAC	Multi Agency Risk Assessment Conferences
MATAC	Multi Agency Tasking and Co-ordination
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
ME	Medical Examiner
MEG	Missing Exploited Group
MHA	Mental Health Act
MHRA	Medicines and Healthcare products Regulatory Agency
MIU	Minor Injuries Unit
MINAP	The Myocardial Ischaemia National Audit Project

MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NCRN	National Cancer Research Network
NDG	National Data Guardian
NEAS	North East Ambulance Service
NEEP	North East Escalation Plan
NEPHO	North East Public Health Observatory
NEQOS	North East Quality Observatory System
NEWS	National Early Warning Score
NHS Improvements	The independent regulator of NHS foundation Trusts
NICE	The National Institute of Health and Clinical Excellence
NICOR	The National Institute for Cardiovascular Outcomes
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
NQB	National Quality Board
NRLS	National Learning and Reporting System
NTHFT	North Tees and Hartlepool Foundation Trust
OD Banding	Overdispersion (statistical indicators)
OFSTED	The Office for Standards in Education
PalCall	Palliative care, out-of-hours telephone helpline for patients and carers registered with our services
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
Patient Safety and Quality Standards (Ps&Qs) Committee	*Now Quality Assurane Committee* - The committee responsible for ensuring provision of high quality care and identifying areas of risk requiring corrective action
PET	Patient Experience Team
PHE	Public Health England
PIC	Patient Identification Centre
PICANet	Paediatric Intensive Care Audit Network
PMRT	Perinatal Mortality Review Tool
PREVENT	the government's counter-terrorism strategy
PROMs	Patient Reported Outcome Measures
Psa	Pseudomonas Aeruginosa (Type of Infection)
Pseudonymisation	A process where patient identifiable information is removed from data held by the Trust

QAF	Quality Assessment Framework
QAC	Quality Assurance Committee – *previously Patient Safety and Quality Standards Committee (PS&QS)* - The committee responsible for ensuring provision of high quality care and identifying areas of risk requiring corrective action
Quality Improvement	
R&D	Research and Development
RA	Recruitment Activity
RAG	Red, Amber, Green chart denoting level of severity
RCA	Root Cause Analysis
RCOG	The Royal College of Obstetricians and Gynaecologists
RCPCH	The Royal College of Paediatric and Child Health
REPORT-HF	International Registry to assess Medical Practice with longitudinal observation for Treatment of Heart Failure
RESPECT	"Responsive, Equipped, Safe and secure, Person centered, Evidence based, Care and compassion and Timely" – a nursing and midwifery strategy developed with patients and governors aimed at promoting the importance of involving patients and carers in all aspects of healthcare
RHA	Review Health Assessments
RMSO	Regional Maternity Survey Office
SBAR	Situation, Background, Assessment and Recommendation – a tool for promoting consistent and effective communication in relation to patient care
SCM	Senior Clinical Matron
SCMOoH	Senior Clinical Matron Out-of-Hours
SCR	Serious Case Review
SEPSIS	Life-threatening reaction to an infection
SHA	Strategic Health Authority
SHMI	Summary Hospital Mortality-level Indicator – a hospital-level indicator which reports inpatient deaths and deaths within 30-days of discharge at Trust level across the NHS
sic	The Latin adverb ***sic*** ("thus"; in full: *sic erat scriptum*, "thus was it written"), inserted immediately after a quoted word or passage, indicates that the quoted matter has been transcribed exactly as found in the source text, complete with any erroneous or archaic spelling, surprising assertion, faulty reasoning, or other matter that might otherwise be taken as an error of transcription.
SINAP	Stroke Improvement National Audit Programme
SLSCB	Stockton Local Safeguarding Children Board
SMPG	Safety Medical Practices Group
SOF	Single Oversight Framework
SOP	Standard Operating Procedures
SPA	Single Point of Access
SPC	Specialist Palliative Care

SPCT	Specialist Palliative Care Team
SPEQS	Staff, Patient Experience and Quality Standards
SPICT	Supportive & Palliative Care Indicator Tools
SPOC	Single point of contact
SSKIN	Surface inspection, skin inspection, keep moving, incontinence and nutrition
SSU	Short Stay Unit
STAMP	Screening Tool for the Assessment of Malnutrition in Paediatrics
STEIS	Strategic Executive Information System
STERLING	Environmental Audit Assessment Tool
SUS	Secondary User Service
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
TIA	Transient Ischemic Attack
TNA	Training Needs Analysis
Tough-books	Mobile computers aim to ensure that community staff has access to up-to-date clinical information, enabling them to make speedy and appropriate clinical decisions
TRAKCARE	Electronic Patient Record System
TSAB	Tees-Wide Safeguarding Board
UCC	Urgent Care Centre
UHH	University Hospital of Hartlepool
UHNT	University Hospital of North Tees
UKST	UK Sepsis Trust
UNIFY	Unify2 is an online collection system used for collating, sharing and reporting NHS and social care data.
UTI	Urinary Tract Infection
UV	Ultra Violet
VEMT	Vulnerable, exploited, missing, trafficked
VSGBI	The Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism
WRAP	Workshop to Raise Awareness of PREVENT
WTE	Whole Time Equivalent - is a unit that indicates the workload of an employed person in a way that makes workloads or class loads comparable
4at delirium assessment tool	Bedside medical scale used to help determine if a person has positive signs for delirium

North Tees and Hartlepool NHS Foundation Trust
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