South Tees Hospitals
NHS Foundation Trust

Board of Directors

2 June 2020
12:00 noon
Microsoft teams

South Tees Hospitals NHS Foundation Trust

MEETING OF THE SOUTH TEES HOSPITALS NHS FOUNDATION TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON TUESDAY 2 JUNE 2020 AT 12:00 NOON MICROSOFT TEAMS

AGENDA

ITEM		PURPOSE	LEAD	FORMAT
CHAIR'S BUSINESS				
1.	Welcome and Introductions	Information	Chair	Verbal
2.	Apologies for Absence	Information	Chair	Verbal
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1
4.	Minutes of the last meetings held on 5 May 2020	Approval	Chair	ENC 2
5.	Matters Arising	Review	Chair	ENC 3
6.	Chairman's report	Information	Chair	Verbal
7.	Chief Executive's report	Information	Chief Executive	ENC 4
QUALITY AND SAFETY				
8.	Safe Staffing Report	Information	Director of Nursing & Midwifery	Verbal
WORKFORCE				
9.	Freedom to speak up report	Information	Guardian	ENC 5
FINANCE AND PERFORMANCE				
10.	Performance Report	Discussion	Chief Operating Officer	ENC 6
GOVERNANCE AND ASSURANCE				
11.	Provider Licence	Approval	Head of Governance	ENC 7
12.	Chair's Logs from Board Committee Meetings	Discussion	Chairs	ENC 8
13.	Any Other Business	Discussion	Chair	Verbal
14.	Risks to be added to the Board Assurance Framework	Discussion	Chair	Verbal

ITEM		PURPOSE	LEAD	FORMAT
15.	Reflections on Meeting	Discussion	Chair / All	Verbal
16.	**DATE OF NEXT MEETING** The next meeting of Board of Directors will take place on Tuesday 7 July 2020			
	Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960)			

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 June 2020			
Register of members interests			**AGENDA ITEM: 3, ENC 1**
Report Author and Job Title:	Jackie White Head of Governance	**Responsible Director:**	Alan Downey Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	The Board of Directors are asked to note interests declared by members of the Committee		
Background	The report sets out membership of the Board of Directors and interests registered by members. Conflicts should be managed in accordance to the Constitution para 32 - If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to other Directors.		
Assessment	There are no specific conflicts identified with the agenda. Members will be reminded at the meeting to raise any if they arise.		
Recommendation	Members of the Board of Directors are asked to note the Register of Interest in relation to the Committee.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Alan Downey	Chairman	1 March 2018 15 April 2014	ongoing 2 April 2019	Wife is Director of PricewaterhouseCoopers working mainly with local government clients in the North of England Neddown Limited (dissolved company) from 2 April 2019 and (dormant) prior to joining the Trust.
Ada Burns	Non-Executive Director	2017 2017 2019	Ongoing Ongoing Ongoing	Role - Governor – Chair of Resources Committee, member of Board of Teesside University. Trustee & Vice Chair – New Local Government Network (NLGN) – Public policy think tank Role – Associate Consultant – Cratus Consultancy, public sector management consultancy
Maureen Rutter	Non-executive Director (Senior Independent Director)	1996	ongoing	Member of Macmillan Cancer Support
Richard Carter-Ferris	Non-executive Director	1 August 2015	ongoing	Director of Yorkshire Area P2P Club – company generates donations for Yorkshire Air Ambulance. Director/No exec Director – Malton & Norton Golf club ltd.
David Heslop	Non-executive Director			No interests declared
Mike Ducker	Non-executive Director	1 December 2017 1 December 2005 1 October 2019	ongoing ongoing ongoing	Advisor to UK Government on Chemicals Industry Trustee of Greenstones Christian Trust Charity – a Charity working with prisons in Ethiopia South Tees Healthcare Management Limited - Company number 10166808
Debbie Reape	Non-executive Director	August 2019 1 October 2019 October 2019	Ongoing Ongoing Ongoing	Associate Director with Northumbria International Alliance (Northumbria NHS Trust and Northumberland County Council) South Tees Healthcare Management Limited - Company number 10166808. School Governor, Ashington Academy.
Adrian Clements	Medical Director	23 January 2012	Ongoing	Director of Clements Medico Legal Consulting Limited.
David Chadwick	Medical Director			No interests declared.
Sath Nag	Medical Director			No interests declared.
Steven Mason	Director of Finance	1 October 2017 13 August 2018 March 2019 1 October 2019 1 April 2020	ongoing ongoing ongoing ongoing ongoing	Children employed at Ernst & Young and Deloitte HM Property Services Ltd (Shareholder) not seeking work in NHS Client representative ELFS Management Board. South Tees Healthcare Management Limited - Company number 10166808. Non-Executive Director – Together for Children

Jackie White	Head of Governance	March 2013	Ongoing	Director – Applied Interim Management Solutions – Company Number 08473345
Sue Page	Chief Executive	May 2018	Ongoing	President of British Red Cross – Cumbria.
Kevin Oxley	Director of Estates, Facilities and Capital Planning	21.02.2020	Ongoing	Trustee with Carbon and Energy Fund Limited (CEF), a private company.
Rachael Metcalf	Director of Human Resources			No interests declared.
Joanne Dobson	Director of Transformation			No interests declared
Mark Graham	Director of Communications			Ad hoc communications support to North Cumbria integrated care NHS Foundation Trust. Registered with IMAS (NHS interim management & support)
Johanna Reilly	Chief Operating Officer	2 October 2019	Ongoing	JRR Consultants Limited – Company number 11600734.
Julie Alderson	Associate Non-Executive Director			Formerly Director of Julie Alderson Interim Management Limited. Company dissolved 14.05.2019. Never did any work for NHS Trusts, just local Government
Ann Wright	Director of Operations - Friarage			No interests declared.
Ros Fallon	Director of Planning & Recovery			Non-Executive Director for Countess of Chester NHS Foundation Trust Trustee – Tarporley War Memorial Hospital
Moira Angel	Director of Clinical Development			Director of Moira Angel consulting Ltd. Director of Arista Associates Ltd. Vice president of the red cross in Cumbria.
Deirdre Fowler	Director of Nursing & Midwifery			No interests declared

South Tees Hospitals NHS
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 5 MAY 2020 AT 2.00 PM USING MICROSOFT TEAMS

Present

Mr A Downey	Chairman
Mr M Ducker	Non-Executive Director
Mrs M Rutter	Non-Executive Director
Ms A Burns	Non-Executive Director
Ms D Reape	Non-Executive Director
Mr D Heslop	Non-Executive Director
Mr R Carter-Ferris	Non-Executive Director
Mrs D Fowler	Interim Director of Nursing & Midwifery
Mr A Clements	Medical Director
Mr D Chadwick	Medical Director
Mr S Mason	Director of Finance
Ms S Page	Chief Executive

In Attendance

Mrs J White	Interim Head of Governance
Ms J Reilly	Interim Chief Operating Officer
Ms J Alderson	Non-Executive Director – Insights Programme
Mr P Kane	Chair of Senior Medical Staff Forum

Action

BoD/20/026 **WELCOME AND INTRODUCTIONS**

The Chairman welcomed members to the meeting which was being held virtually.

BoD/20/027 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Dr Sath Nag. The Chairman noted that, during the Covid-19 crisis and until further notice, non-voting Board members would not necessarily be asked to attend.

BoD/20/028 **QUORUM**

The meeting was quorate in line with the Constitution paragraph 4.39 “Quorum - No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed, (including at least one non-executive director and one executive director) are present”.

BoD/20/029 **DECLARATION OF INTEREST**

The Chairman referred members to the register of interests and asked members if there were any further declarations to be made not already included. There were no further declarations made.

BoD/20/030 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on 7 April 2020 were reviewed and agreed as an accurate record. Mrs White

Action

BoD/20/031 **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

Freedom to speak up – Mrs Fowler reported that she had spoken with Ms Reilly and agreed a proposal which needed to be worked up. The plan would be to devolve Freedom to Speak Up into the Centres: a Guardian would be appointed within each Centre, and the time for this would be ring fenced: Guardians would not be expected to fit their FTSU duties around an existing role. Time commitments for the role were likely to vary from Centre to Centre.

Mrs Rutter welcomed the news as NED Lead for Freedom to Speak Up and looked forward to a more proactive approach to Freedom to Speak Up which the Trust has not been able to achieve with current resources.

Ms Burns asked for a fuller update on the plan at next week's Workforce Committee. The Chairman asked for a report from the committee at the next Board meeting.

Mrs Fowler / Mrs White

BoD/20/032 **CHAIR'S REPORT**

The Chairman wished to record his and the Board's appreciation and gratitude to members of staff across the whole organisation for the outstanding work they have been doing to prepare the Trust for the COVID 19 crisis and for the subsequent recovery phase.

The Chair commented that, as previously reported to the Board, North Yorkshire CCG opened a formal public consultation on 13 September 2019 into the future of urgent care services at the Friarage.

The Chair reminded members that the public were asked to consider two options:

- Option 1: A 24 hour, 7 day a week Urgent Treatment Centre for adults and children with minor injuries and minor illnesses
- Option 2: A 16 hour Urgent Treatment Centre for adults and children with minor injuries and minor illnesses, open 7 days a week from 8am to midnight.

Members noted that the CCG reviewed the responses and feedback from the consultation and agreed at its Governing Body meeting on 30 April that Option 1 is the sustainable way forward for urgent care at the Friarage Hospital.

The Chair said that, from a trust perspective, the decision will ensure this safe model of care continues for the long-term while enabling our clinicians to continue to grow the range of elective services available at the Friarage.

Action

The Chair also commented that Rishi Sunak had welcomed the decision in a local newspaper article and had rightly praised Adrian Clements and James Dunbar for their leadership in relation to the changes at the Friarage. The Chair on behalf of the Board thanked Adrian and James for doing an outstanding job. Mrs White

The Chair reported that he had attended a number of meetings of the Strategic Command and said how impressed he was with the way the group, and indeed the whole command structure, was operating.

Members noted that the Chair continues to hold a weekly video conference call with the NEDs who receive updates from the Chief Executive or Head of Governance with regard to COVID 19.

The Chair commented that he had also had the opportunity to attend a number of meetings of the Clinical Policy Group meetings and reported that it is rewarding to see how this group has developed and how effectively it is now operating.

Finally the Chair reported that he was continuing to hold telephone calls with small groups of governors and the lead governor.

Resolution

The Board of Directors noted the Chair's report.

BoD/20/033 **CHIEF EXECUTIVE'S REPORT**

Ms Page referred members to the slides that she had provided by way of an update specifically focused on COVID 19. Ms Page described the governance structure which wrapped around the Strategic Command and discussed the approach taken and that both she and Mr Clements felt that this was a unique opportunity to fast track a leadership development programme for clinical directors, nursing leadership, professional heads of service and other key individuals within the Trust.

Ms Page specifically referred to the leadership of the Clinical Zoning Group led by Matt Clark which had led on the estate and service changes on dividing the hospital and wards for COVID 19 and non COVID 19 activities.

Ms Page also commented on the Clinical Oversight Group which was made up of "wise owls", a group of senior clinicians who have the responsibility of overseeing the decision making of the trust with regard to the strategic

Action

command.

Mr Clements acknowledged the work undertaken by the Clinical Zoning Group and said that as the Trust move into recovery we need to demonstrate and create a safe environment. Mr Clements commented that the Trust has led the way on how to do this safely and protect our patients and staff in line with guidance issued. Mr Clements commented that it is important to reassure the staff that we are supporting them and this has been demonstrated through the supply of PPE: the Trust has never run out of PPE during the pandemic. He said that it has been amazing how the Clinical Policy Group has pulled together and how the clinicians are engaging with this and coming with solutions rather than problems.

Ms Page then referred to the Trust's three-phase improvement plan. She pointed to two additions to phase 2 of the plan, concerning Outpatients (building on the changes to services implemented during COVID 19) and recovery of the James Cook site for emergency services (recognising that the Trust will be living with COVID 19 for a year or so and we need to be able to manage the shifts in both Covid and non-Covid demand.)

Mr Clements commented that there is an opportunity to treat patients more efficiently, with the most appropriate clinician. We should also embrace same-day emergency care, which is a national directive.

Finally Ms Page commented that the Recovery Group will hold a meeting later today and the focus will be on doing things at pace and building on the momentum and changes already implemented.

Resolution

The Trust Board of Directors noted the Chief Executive's update

BoD/20/034 **SAFE STAFFING MONTHLY REPORT**

Mrs Fowler started by drawing the Board's attention to the International day of the midwife which enables us to celebrate all the fantastic work that is done by midwife colleagues in South Tees. Mrs Fowler commented on the celebratory activities which were underway.

Mrs Fowler reminded members that the Unify submission had been suspended for the current period in accordance with guidance on reducing the burden.

Action

Members noted that there had been a significant increase in registered nurse and healthcare assistant staffing to ensure that 14 COVID 19 wards were opened and to support critical care which was phase 1 of the nursing plan. Phase 2 to meet the demand of COVID 19 and non COVID 19 activity is underway. Mrs Fowler reported that the Trust was engaging in the NHSE/I scheme to get ex-NHS staff back into the workforce. Members noted that initially 41 registered nurses had been allocated to the Trust, but unfortunately only 2 had started work: 24 had declined or withdrawn, 6 are being progressed through the process, and 9 are awaiting decisions.

211 WTE nurses have been re-deployed to critical care to staff phase 1 and this has been a huge success. During Phase 2 staff will need to return to their base wards and areas of expertise. All redeployed staff have been through rigourous procedures to ensure that risks are managed and minimised.

With regard to community staffing, members noted that the Trust has supported palliative care community staff, who have been under significant pressure. The Trust has introduced a variety of digital technology solutions and additional staff. This has been a really positive improvement to meet the COVID 19 challenge.

Mrs Fowler said that the trust has 80 adult students who are in the last 6 months of their programme and 11 aspirant nurses. They can work in a registered nurse capacity with additional support. To match their enthusiasm we need to make sure we support them with additional resources and consider what else we need to do to retain them.

150 second year nurses working have joined the trust as HCAs. The hours they work count towards their training hours.

Finally, with regard to quality and safety, there is good oversight through the EPPR structure of operational, tactical and strategic command. No exceptions have been reported to strategic group but we are seeing an impact on falls and pressure ulcers. Mrs Fowler reported that she is not sure about the reasons and will provide further information to the Quality Assurance Committee for discussion.

Mrs Rutter congratulated the Trust on the number of student nurses and aspirant nurses and asked if there was anything the Board can do to support them. Mrs Fowler thanked Mrs Rutter for the offer and confirmed that a support package has been put in place, but she would consider what further actions we could take.

Action

Mrs Rutter also welcomed the work undertaken with the Palliative care team who have developed a 7 day service – and acknowledged that the Trust has wanted one for 12 years. Mrs Rutter asked if there is anything the Trust can do to support this team with technology or extra kit as they really deserve this.

Ms Burn expressed interest in the number of staff redeployed to support critical care and noted that in the past there have been concerns raised by staff who have been moved into different parts of the Trust. Ms Burns asked Mrs Fowler if she felt the way this had been undertaken had eased this for the future. Mrs Fowler commented that it may have but learning needs to take place. A number of critical care nurses have already gone back to their home areas despite the support in place: we need to do a debrief and ask staff what kept them engaged and what support worked.

Ms Reape commented that the letter from NHSE/I to primary care colleagues was pleasing to read and wondered if there had been any effect on community staff. Mrs Fowler said she had not seen any impact, but the Trust was supporting care homes through the LRF on PPE and train the trainers. Mrs Fowler noted that there will be a benefit for the Trust in the long run. She envisaged that we would work as an ICP, sharing learning on safety, following this.

Mr Kane asked Mrs Fowler how many student nurses did the Trust usually retain and Mrs Fowler advised that the Trust was very successful in retaining student nurses and the percentage was around 99.

Mr Kane also asked regarding how the trust attracted students from other areas to come to the Trust and Mrs Fowler advised that the Trust has increased our commissions of student nurses by 25%, but we are currently at capacity in terms of the number of students we can train and place.

Resolution

The Trust Board of Directors noted the update on staffing

BoD/20/035 **PERFORMANCE REPORT**

Ms Reilly reminded members that NHSE/I had released guidance on 28 March 2020 - Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic. This guidance acknowledged that, although existing performance standards remain in place, the way these are managed will need to change for the duration of the COVID-19 response.

Action

With regard to A&E performance, Ms Reilly advised that a lot of work has occurred in the last month, as a result of performance issues and not meeting the target. The initial evidence is that we don't have enough side rooms and as we are swabbing all patients it takes 6 hours before these can be moved to a base ward. The estate has been looked at and the Trust has converted Ward 19 into more side rooms adjacent to A&E to allow for the flow of patients. We are already seeing an improvement in performance as a result.

Mrs Rutter said that she looked forward to seeing this improvement in the monthly performance report, as it felt wrong that performance had deteriorated when attendances at A&E were down.

Mr Ducker asked if there was any way of speeding up the testing process and Ms Reilly advised that the Trust has looked at the pathway and runners are taking the test from A&E to the lab, so the process is as quick as possible.

Mrs Burns asked about restarting non-urgent services and whether any modelling had been undertaking on the number of procedures cancelled or deferred due to COVID 19 and the impact on performance.

Ms Reilly confirmed that, as part of the recovery process, waiting lists will need to be validated and patients will need to be asked if they want to remain on a waiting list. to add to the complexity, the use of PPE needs to be factored in. Ms Reilly advised that the Clinical Oversight Group will have a role to play in recovery.

Mr Heslop noted that COVID 19 has had a substantial impact on cancer treatment and referrals and asked if the Board can be assured that the Trust are treating all patients with cancer. Mr Chadwick advised that radiotherapy are currently working at 80% of capacity and chemotherapy at 70%. Key to ensuring that all patients who receive appropriate treatment will be the diagnostics and in particular endoscopy which we are just stepping up in a slow and measured way.

Mrs Burns commented that we need to ensure the information Mr Chadwick has shared regarding capacity is factored in, as it is fundamental to knowing how well we are doing with the host of unintended consequences of COVID 19.

Ms Alderson questioned the Delayed Transfers of Care (DTOC) position and advised that she would have expected this figure to have reduced. Ms Reilly confirmed that there had been a significant reduction in April and would share the

Action

figure with members.

Mrs Fowler commented that with regard to patient safety the Trust is seeing an increase in falls and pressure ulcers. Mrs Fowler has instigated a deep dive to understand the detail.

Mr Mason updated on finance and reported that, as at month 12, the Trust is behind plan by £28.2m. This is due to the loss of £8.3m of PSF funding and failure to deliver £22.0m of system savings.

With regard to productivity and efficiency savings, the total achieved for the full year was £9.9m.

Mr Ducker asked Mr Mason to confirm the announcement regarding the conversion of debt. Mr Mason advised that the government has converted the Trust's borrowing into public dividend capital. The trust is not better off from a revenue perspective, but there will be a benefit when the Trust's use of resources is assessed by NHSE/I.

Ms Page left the meeting
Ms Reilly left the meeting
Mr Clements left the meeting

Resolution

The Trust Board of Directors noted the performance report.

BoD/20/036 **ANNUAL FILINGS UPDATE**

Mrs White reported that the Trust has a statutory requirement to produce a number of key documents as part of its annual filings following the end of the financial year. These include the Annual Report, Annual Accounts, Annual Governance Statement and Quality Report (Account).

The monitoring and approval of the annual filings has been delegated by the Trust Board to the Audit Committee.

Mrs White updated that in April 2020, in light of pressures caused by the public sector response to COVID-19, annual filings requirements were changed for 2019/20.

As a result there is no longer a requirement to publish a Quality Report (Account), and the timetable for submission of the accounts and annual report has also been amended. Mrs White commented that there continue to be no issues or risks highlighted with the production of the annual filings, taking into account the revised timetable for submission.

Action

Ms Burns asked Mrs White whether there would be a section on performance included in the annual report as this was deemed as optional in the new guidance. Mrs White advised that there was but it was an abridged version.

Ms Reape commented that she would welcome the opportunity to have a more succinct report on quality as this may be more useful for the general public.

Mrs Fowler said that she agreed completely and that the Trust just need to get the message across which could be undertaken using a number of media.

Mrs White commented that some trusts were producing a report later in the year with an update on quality and performance. Ms Burns said that she would support producing a more public facing report which signals and points to the future and some of the rainbow aspects of COVID 19.

Resolution

The Trust Board of Directors noted the update on the Annual Filings.

BoD/20/037 **BOARD ASSURANCE FRAMEWORK – NEW RISK COVID 19**

Mrs White shared with members a new risk in relation to COVID 19 not currently documented in the BAF. Mrs White confirmed that this was supported by a risk register relating to COVID 19 operational risks which the tactical and strategic command groups would review.

Mrs White reported that the Quality Assurance Committee has reviewed the BAF risk regarding COVID 19 along with the controls and assurances and is recommending that the Board accept the risk.

Mr Heslop asked if the Board should add something on testing and on the impact of COVID 19 on ongoing service delivery.

Mrs Fowler agreed and commented that the BAF is an iterative process and there will be other risks which will need to be added to it.

Resolution

The Trust Board of Directors APPROVED the BAF risk

Action

BoD/20/038 **CHAIRS' LOGS FROM BOARD COMMITTEES**

The Chair offered the Chairs of Committees the opportunity to raise any issues not already covered by the agenda:

Finance & Investment Committee – Mr Ducker referred members to the discussion in the Committee regarding performance and also the disconnect between the strategic improvement plan and the continuous improvement plan. Also that the plan needed to be costed and appropriate KPIs monitored.

Quality Assurance Committee – Ms Reape added that the Committee had reviewed some guidance on what Quality Committees should keep under review during COVID 19 which the Committee will follow along with a focus on community services and vulnerable services.

Ms Reape also reported that the Committee had identified a rise in mortality at Redcar Primary Care hospital. Ms Reape had asked for further information and Mrs Fowler provided an update to members and agreed to circulate further details. DON

BoD/20/039 **ANY OTHER BUSINESS**

There was no other business.

BoD/20/040 **RISKS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK**

No new risks were identified.

BoD/20/041 **REFLECTIONS ON MEETING**

The Chair offered members the opportunity for reflection on the meeting. The Chair commented that whilst virtual meetings were working he looked forward to the resumption of face-to-face board meetings.

Ms Reape commented that she liked that Ms Burns and Mr Ducker had used the chat facility on Microsoft Teams and that commended its use at future meetings.

BoD/20/042 **DATE AND TIME OF NEXT MEETING**

The next meeting of the public Board of Directors will be held on Tuesday 2 June 2020.

Signed: ……

Date: ……

Board of Direction Action Log (meeting held in Public)

Date of Meeting	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
5.11.19	BoD/19/82	HEALTHCARE ASSOCIATED INFECTION MONTHLY REPORT	Mr Heslop advised that the online training for infection control hasn't changed, and perhaps the focus needs to be on behavioural changes going forward. Mrs Hunt agreed to look into the training.	G Hunt	31.7.20	Training slides revewied with the IPC lead and these have been updated in terms of priorities and technical knowledge. They need loading onto the system but that is delayed due to current situation. The next piece of work is to help the team develop more skills around 'nudge theory' and human factors to enhance both formal and informal training methods and we will be planning to do that when the new Band 8 starts (hopefully in approx. 3-4 month) and aligned with the new QI and Leadership Practitioners being more readily available as we lift some restrictions.	open
4.2.20	BoD/19/147	IMPROVEMENT PLAN	Improvement plan needed to be costed and robustly monitored	R Fallon	31.5.20	Date amended	open

South Tees Hospitals
NHS Foundation Trust

CHIEF EXECUTIVE REPORT

COVID 19 – update

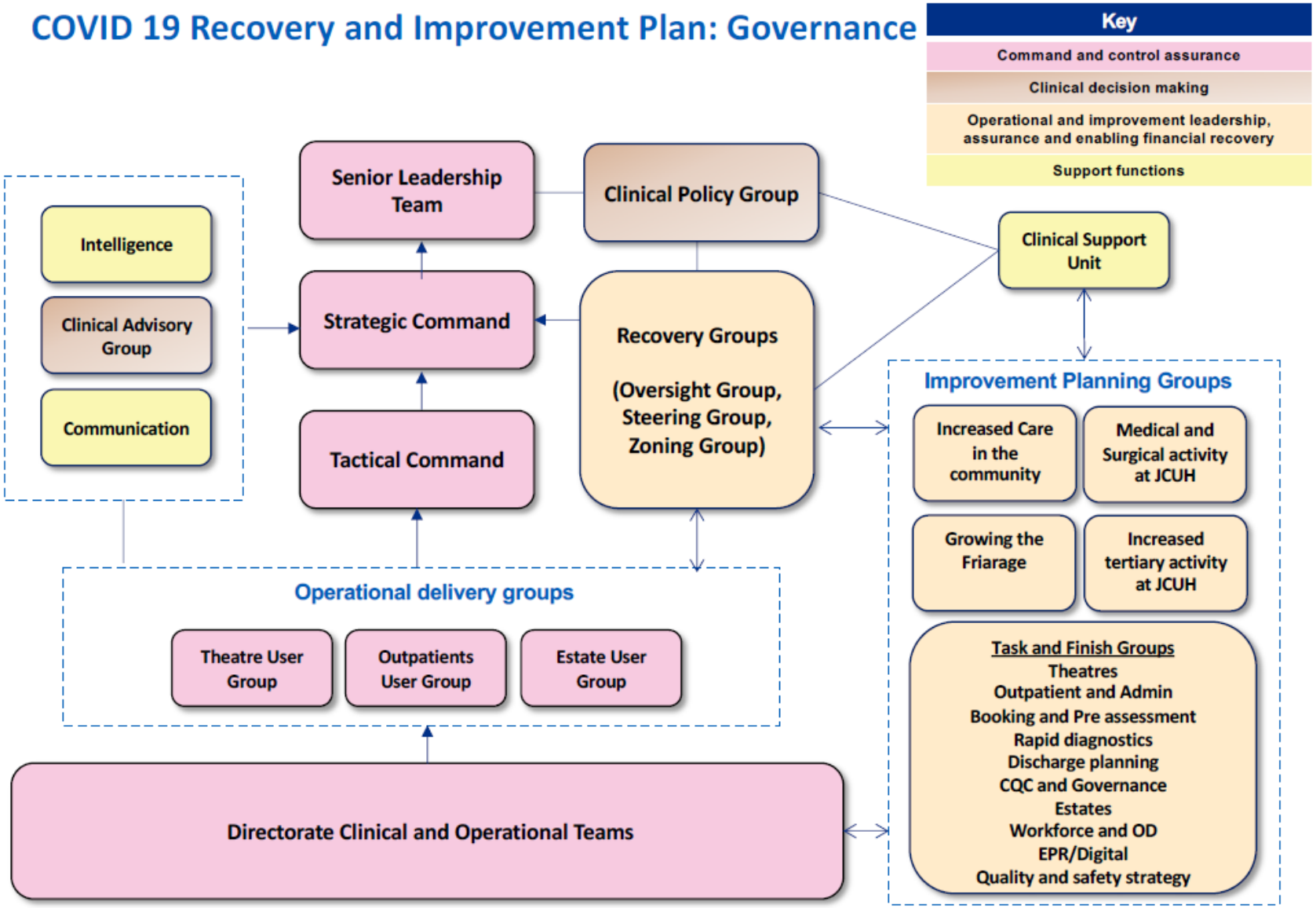
COVID-19 response

- The number of patients with COVID-19 receiving care in our hospitals is continuing to decline.

- In line with this reduction, our clinicians have begun to safely step-down some of our COVID ward areas while maintaining the flexibility to swiftly open them again if cases rise.

- Our clinicians are preparing to gradually deliver more non-COVID-related care where that can be done safely.

COVID 19 Recovery and Improvement Plan: Governance



Wellbeing

Staff Safety

PPE & training

Staff marshals – role to support clinical staff remain safe and confident whilst using PPE, supported by a team of senior nurses and practice educators.

Staff environment rest areas/ catering facilities/ rest breaks/ IT support

Immediate Staff support

Teams/ connections/ conversations

Medical Psychology team - 7 day staff support

Chaplaincy support

Trust 7 day helplines – Psychology/ Counsellors/ Chaplaincy/ Staff helpline

Occupational Health

Unions and Professional bodies

Wobble Room

‘Restful thinking zone’ (Theatres)

‘Living room in a box’

Personal Resilience and Effectiveness Coaching - explore your personal resilience and/or personal performance/impact

Other staff support/ communications

Trust website/ intranet wellbeing resources and signposting/ Intranet banners

Staff daily briefings

Support to colleagues who may be at higher risk e.g. risk assessments

Staff welfare calls to staff who have contacted the COVID-19 helpline

Wellbeing groups

National staff helpline (see slide 4)

https://people.nhs.uk/
- For other national communication/ support resources (see Slide 4)

Assurance

- NHS Level 4 incident response remains in place.
- EPPR support and reporting arrangements.
- Daily SITREPs.
- Updates with stakeholders and partners.
- SFI/SO emergency powers in place.
- Strong clinical input throughout incident response.

Thank you

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 June 2020			
Freedom to Speak Up - Six monthly report			**AGENDA ITEM: 9** **ENC 5**
Report Author and Job Title:	Helen Smithies Assistant Director of Nursing (Safeguarding) Freedom to Speak Up Guardian	**Responsible Director:**	Deirdre Fowler Director of Nursing & Midwifery
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	This paper provides a 6 month update of activity in relation to Freedom to Speak up and data in relation to activity over 2019-20		
Background	Freedom to Speak Up processes form part of the NHS Standard contract and should augment and support usual management practices aimed at promoting an open and transparent culture. This report details action taken under the Freedom to Speak Up agenda within the Trust from September 2019 to March 2020. It further gives details of FTSU issues raised in relation to COVID 19. Finally it considers action needed to further progress the agenda within the organisation.		
Assessment	It identifies that despite the progress to date in relation to structures, policies and personnel there is still much work to be done. This is most notable in addressing the less tangible elements of thinking action and habitual practice and embedding this across the leadership and workforce of the trust and not just in those with a specific FTSU role. The paper considers outline proposals to develop the agenda in the next year.		
Recommendation	Members of the Board of Directors are asked to note the content of this report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risks have been identified with regard to the resource for F2SU which are being addressed.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

South Tees Hospitals
NHS Foundation Trust

Freedom to Speak up at STHFT

1. Introduction

Freedom to Speak Up processes form part of the NHS Standard contract and should augment and support usual management practices aimed at promoting an open and transparent culture. This report details action taken under the Freedom to Speak Up agenda within the Trust from September 2019 to March 2020. It further gives details of FTSU issues raised in relation to COVID 19. Finally it considers action needed to further progress the agenda within the organisation.

2. Freedom to Speak up at STHFT

2.1 Personnel

Role	Name
Non-Executive Director	Maureen Rutter
Executive Director	Gill Hunt (until March 2020)/ Deirdre Fowler
Freedom to Speak Up Guardians	Helen Smithies
	Laura Mills

2.2 Guardian capacity.

Many Trusts have a standalone guardian role, either full or part time. In 2018 STHFT chose an alternative route, asking two existing employees to take on the role of Guardian in addition to their substantive posts. As awareness of the F2SU agenda grows it has been acknowledged within the trust that the demand merely to respond to concerns raised now outstrips the capacity of those in the role, with the majority of the activity falling to one Guardian. Neither Guardian has been able to commit to any development work which has in itself led to challenges. Work is required to strengthen this model and develop a meaningful and accessible culture for all which supports 'speaking up'

2.3 Speaking up.

In 2019-2020

Total number of cases raised	24	
Number raised anonymously	6	
Number element patient safety/quality	8	
Number element bullying or harassment	16	
Number remain open	4	
Professional group	Doctor	1
	Nurse	2
	HCA	1
	AHP	8
	Admin/Clerical	3
	Corporate	1
	Other	2

2.4 Freedom to Speak up during COVID

As lockdown was imposed there were a small number of FTSU concerns on-going. With the agreement of the Director and NED for FTSU each person who had raised a concern was contacted by a Guardian and advised that in order that staff could focus on the needs of organisation to respond to the pandemic all investigations would be paused. This resulted in four investigations being paused. The guardian ensured that this was for the shortest reasonable time and asked all investigators to resume their investigations on 6 May 2020. Two of the four have now been completed and feedback to the individuals and will be closed in due course.

There have been three Freedom to Speak up concerns raised in relation to COVID issues

- A concern raised about staff behaviour in an area identified for COVID positive patients. The concern was that staff from a COVID area were mixing with staff from a non COVID environment. This was quickly addressed by the clinical matron and of note, whilst the area was identified to take COVID positive patients it had not at that point taken any positive patients.
- A concern raised that trust policy in relation to visiting was not be adhered to. This has been addressed and resolved by the ADN.
- Concerns raised that appropriate social distancing is not being facilitated in an office area. This is not yet concluded but pleasingly staff have reported to the Guardian they have been able to make significant progress with managers without the involvement of the Guardian. It is hopeful this will be resolved locally by the end of this week

2.5 Thematic analysis.

It is difficult to draw any firm thematic conclusions from the concluded investigations to date, however the following observations have been noted

- Staff feel valued where they feel listened to and consulted
- In a small number of cases historical concerns have been raised
- Some issues raised have been found to interface with current grievance processes.
- Two linked concerns both with more than one person reporting the concern, with elements of long standing and deep seated cultural issues is to be addressed through organisational development colleagues

2.6 Freedom to speak up Index

The Freedom to Speak up index (2019) is a measure published by the national guardian's office which aims to provide trusts with information on the views of staff on the speaking up culture within their own organisation. It is based on four questions from the staff survey

% of staff responded "agreeing" or "strongly agreeing"

- that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- that their organisation encourages them to report errors, near misses or incidents (question 17b)
- that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- that they would feel secure raising concerns about unsafe clinical practice (question 18b)

The trust scored 73% putting it 207th out of 220 trusts. It is clear that a Freedom to speak up culture is about so much more than having a guardian in post, or having reporting arrangements and relevant policies and governance in place. It is about culture, thinking, action and habitual practice across the organisation.

There may be future benefit in triangulating with outputs from patient and staff surveys to identify overlapping themes

3. Action plans and future developments

3.1 The board development session held on 18 February utilised the National FTSU Guardian's office self-assessment tool to consider

Does the Board behave in a way that encourages workers to speak up?

Can we evidence our commitment as a board to creating an open and honest culture

How well does the Board support the FTSU Guardian

The Board is assured that the FTSU culture is healthy and effective; there is openness and transparency in relation to concerns raised

It was clear from the discussion that whilst good progress has been made to date that within current, resource and structures, further progress around the less tangible elements of culture, thinking and habitual practice poses a real challenge.

3.2 Discussion have commenced within the organisation to review and implement an alternative model for FTSU, which includes:

- Clear leadership and accountability under the Head of Patient Safety and Quality to ensure anonymous triangulation with themes from incident reporting, complaints etc to optimise our learning opportunities

- The redistribution of 2 WTE Band 7 funding, in order to have dedicated FTSU guardians with dedicated time to undertake the role, be visible and accessible to all staff to optimise the opportunity to access 'all voices' and learn from staff concerns proactively.

- A review and relaunch of the FTSU Guardian role, including training/awareness raising, increased visibility and greater involvement from Trust volunteers and champions.

- A revised training plan to ensure all investigators are adequately trained in order to expedite the investigations and optimise learning

4. Conclusion and Recommendations

The Board are asked to:

Note the content of this report.

To ensure that they are cognisant of the challenge facing the organisation in addressing culture thinking and habitual practice.

To note the future developments of the FTSU guardian model across the Trust.

Helen Smithies

Assistant Director of Nursing (Safeguarding) / Freedom to Speak Up Guardian

April 2020/May 2020

South Tees Hospitals
NHS Foundation Trust

Freedom to Speak Up: Concluded cases 2019-20

Number	O/C/A	Issue raised	Findings	Lesson	Feedback where available
19/01/01	O	Historic allegation of bullying not investigated at the time	No evidence of allegation of bullying made at the time	None	
19/01/04	C	Bullying	Concerns about leadership	Development plans put in place	
19/01/05	A	Falsification of time sheet	Not substantiated	None	
19/01/06	A	Communication Process for ordering supplies	Not substantiated	None	
19/01/02 19/02/02 19/02/03 19/02/04 19/02/05 19/02/07	C C C C C O	Bullying/ culture leading to patient safety concerns	Linked to numbers 19/04/04 19/04/05 19/04/06 19/04/07	Historical cultural issues to be identified between two groups of linked staff. For OD response.	
19/01/07	C	Patient safety concerns as a result of team structure/ capacity Person raising the concern no longer worked in the team in question.	OD fully aware of the concerns and comprehensive plans were in place to address the issues. However as the person raising the concern was no longer in the team there was no reason for her to be aware of this	None.	I would like to thank you for the support you have given me in raising my concerns, and the comprehensive plan that has been put in place. I do not have any outstanding patient safety concerns,
19/02/01	O	Cleanliness	Not substantiated		
19/03/02	A	Culture	Perception of unfair practice in relation to recruitment Work load pressures	HR to be involved in all recruitment Work load review	

			Interpersonal relationship breakdown	Interpersonal relationships to be addressed individually	
19/03/03	O	Staff behaviour	Comments, incomplete or taken out of context may be misconstrued and cause distress.	The comments not in line with Trust values should be shut down promptly	
19/03/04	C	Staff behaviour	Different perceptions of the tone of a conversation	1. Importance of considering may overhear conversation 2. ensuring frustration is not displaced onto others	
19/03/06	A	Security management practices	Unsubstantiated	None	
19/04/04 19/04/05 19/04/06 19/04/07	C	Concerns over the response to 19/01/02 19/02/02 19/02/03 19/02/04 19/02/05 19/02/07 (Above)	Historical cultural issues to be identified between two groups of linked staff.	For OD response	

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 June 2020			
Integrated Performance Report			**AGENDA ITEM: 10, ENC 6**
Report Author and Job Title:	Ros Fallon Director of Planning & Recovery	**Responsible Director:**	Various
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	To provide the Board with a detailed assessment of performance against the agreed indicators and measures. The report describes the specific actions that are under way to deliver the required standards.		
Background	The Integrated Performance Report (IPR) will be produced by the Trust on a monthly basis to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance. The IPR provides assurance to the Board that all areas of performance are monitored, allowing the Board to gain assurance regarding actual performance, Trust priorities and remedial actions. Key elements of the report will be discussed by the Board's Quality Assurance Committee, Finance and Investment Committee and Workforce and OD Committee. A summary of discussions will be included in Chair Reports to the Board of Directors.		
Assessment	As this is the first Integrated Performance Report produced in this format, the Board is also asked to provide feedback on the style and content of the report, so that these can be considered for future iterations An executive summary needs to be developed which draws together overall assurance against performance in relation to the key lines of enquiry. Individual assessment against performance is included against each KPI. Gaps in data and commentary need addressing		
Recommendation	Members of the Board of Directors are asked to: a) Receive the Integrated Performance Report for April 2020. b) Note the performance standards that are being achieved. c) Be assured that where performance standards are not currently met, a detailed analysis is being undertaken and actions are in place to ensure an improvement is made.		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 1.5 (new risk) - Risk to Trusts ability to delivery strategic objectives due to diversion of resources of all types required to manage the Covid 19 pandemic. BAF risk 3.1 - A sustained, exceptional level of demand for services that overwhelms capacity resulting in a prolonged, widespread reduction in the quality of patient care and repeated failure to achieve constitutional standards, with possible harm to patients BAF risk 3.2 - Risk of ability to deliver the national access target of 92% for 18 weeks RTT and achievement of the March 19 WTL by March 2020 due to gaps in workforce (T&O, Spinal, General Surgery, Plastics and Urology), increasing demand (ophthalmology, Gastroenterology), transfer of activity from CCDFT, reduction in weekend working and premium pay . BAF risk 3.3 - Risk of ability to deliver the national access target of 85% for 62 Day Cancer Standard	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐
	Drive operational performance ☐	Long term financial sustainability ☐
	Develop clinical and commercial strategies ☐	

South Tees Hospitals
NHS Foundation Trust

Integrated Performance Report

April 2020

Measures

South Tees Hospitals NHS Foundation Trust

	Indicator	Latest Month	Control Limit	Trend	Assurance
SAFE	All Falls Rate	5.34	5		
	Falls with harm rate	0	0		
	Infection control - C-diff	1	0		
	Infection control - MRSA	0	0		
	Serious Incidents	2	0	L	
	Serious Incidents never events	0	0		
	Pressure Ulcers	Work In Progress			
	CHPPD Compliance	Work In Progress			
	Hospital Standard Mortality Rate (HSMR)	91.95	National Target		
	VTE Assessment	Work In Progress			
EFFECTIVE	SEPSIS - Screening	Work In Progress			
	SEPSIS - Treatment	Work In Progress			

	Indicator	Latest Month	Control Limit	Trend	Assurance
CARING	F&F A&E Recommendation Rate	82.4%	85.0%		
	F&F A&E Response Rate (%)	5.1%	12.0%	H	F
	F&F Inpatient Recommendation Rate	96.3%	96.0%		
	F&F Inpatient Response Rate (%)	20.4%	25.0%	H	F
	F&F Maternity Recommendation Rate	100.0%	97.0%		P
	F&F Maternity Response Rate (%)	0.3%	21.0%		F
	Open Complaints > 40 Day Response	0	0		F
	Mixed Sex Accommodation (MSA) Breaches	0	0		

Variation			Assurance		
	H L	H L		P	F
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Measures

South Tees Hospitals NHS Foundation Trust

	Indicator	Latest Month	Control Limit	Trend	Assurance
RESPONSIVE	A&E 4 Hour Wait Standard (%)	91.9%	95.0%	L	?
	RTT Incomplete Pathways (%)	66.0%	92.0%	L	F
	Diagnostic 6 weeks standard (%)	33.8%	99.0%	L	?
	Cancer Treatment - 14 Day Standard (%)	90.6%	93.0%		?
	Cancer Treatment - 31 Day Standard (%)	93.5%	96.0%		?
	Cancer Treatment - 62 Day Standard (%)	66.4%	85.0%	L	?
	Non-Urgent Ops Cancelled on Day	3	0		F
	Urgent Ops Cancelled on Day	0	0		?
	Cancelled Ops not rebooked within 28 days	0	0	H	?
	Delayed Transfers of Care (%)	5.1%	3.5%	H	F
	E-Discharge (%)	93.2%	90.0%	H	?

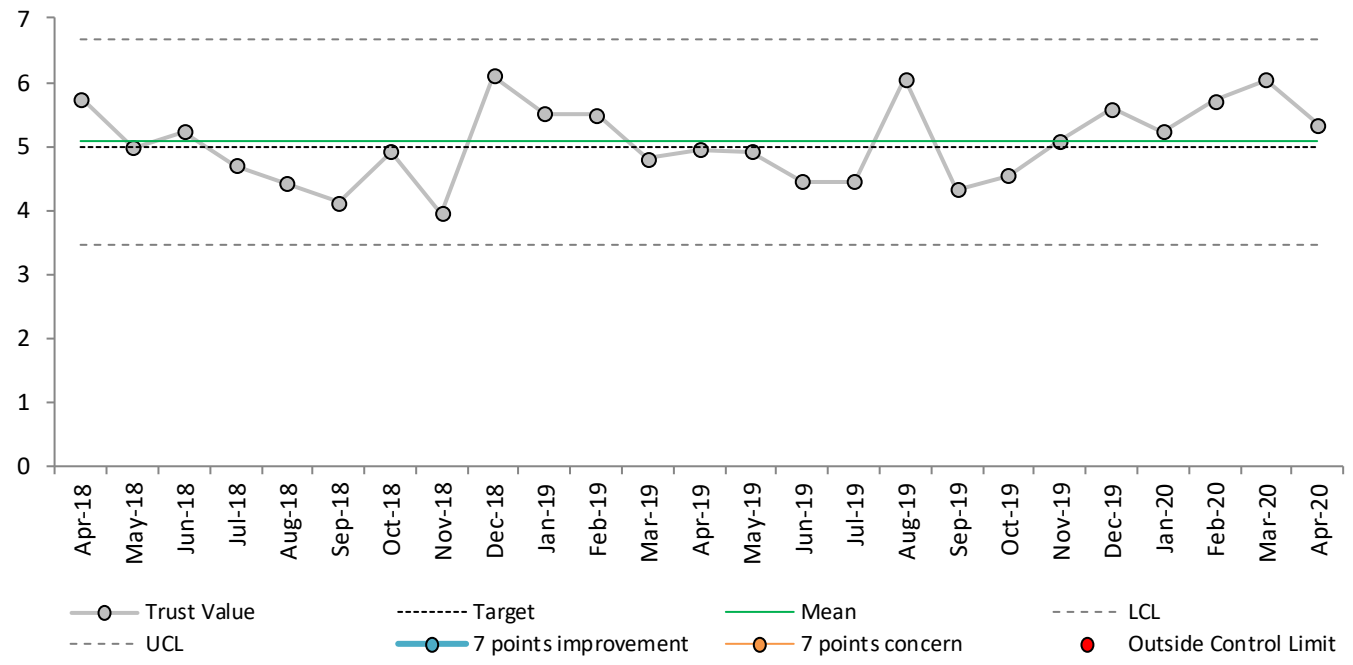
	Indicator	Latest Month	Control Limit	Trend	Assurance
WELL LED	Annual Appraisal (%)	76.3%	80.0%		?
	Mandatory Training (%)	87.2%	90.0%		?
	Sickness Absence (%)	4.5%	4.0%		?
	Staff Turnover (%)	10.2%	10.0%		F
	Year-To-Date Budget (£'millions)	-£1.495			?
	Year-To-Date Budget Position (£'millions)	£0			?
	Year-To-Date Budget Variance (£'millions)	-£1.495			?

Variation			Assurance		
	H L	H L	?	P	F
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Safe

South Tees Hospitals NHS Foundation Trust

All Falls Rate



The Trust falls rate per 1000 bed days

Target	5
Mean	5.06
Last Month	5.34

Executive Lead

Deidre Fowler

Operational Lead

Beth Swanson

Commentary

As a consequence of ward reconfigurations and relocation of specialities some wards with high falls rates have flipped and the reverse has been observed in areas with traditionally lower rates.

Cause of Variation

- Elevated per 1000 rate noted from November 2019. Hospital population is reduced due to covid 19 .
- Significance of increasing acuity levels and increased falls risk factors in the reduced population may be a factor.

Planned Actions

- Review acuity data against falls rate .
- Audit DATIX forms – to confirm if lessons learnt are reflective of the identified contributory factors within the DATIX investigation.
- Monitor the impact of PPE safety on falls rates e.g. delayed response by staff.

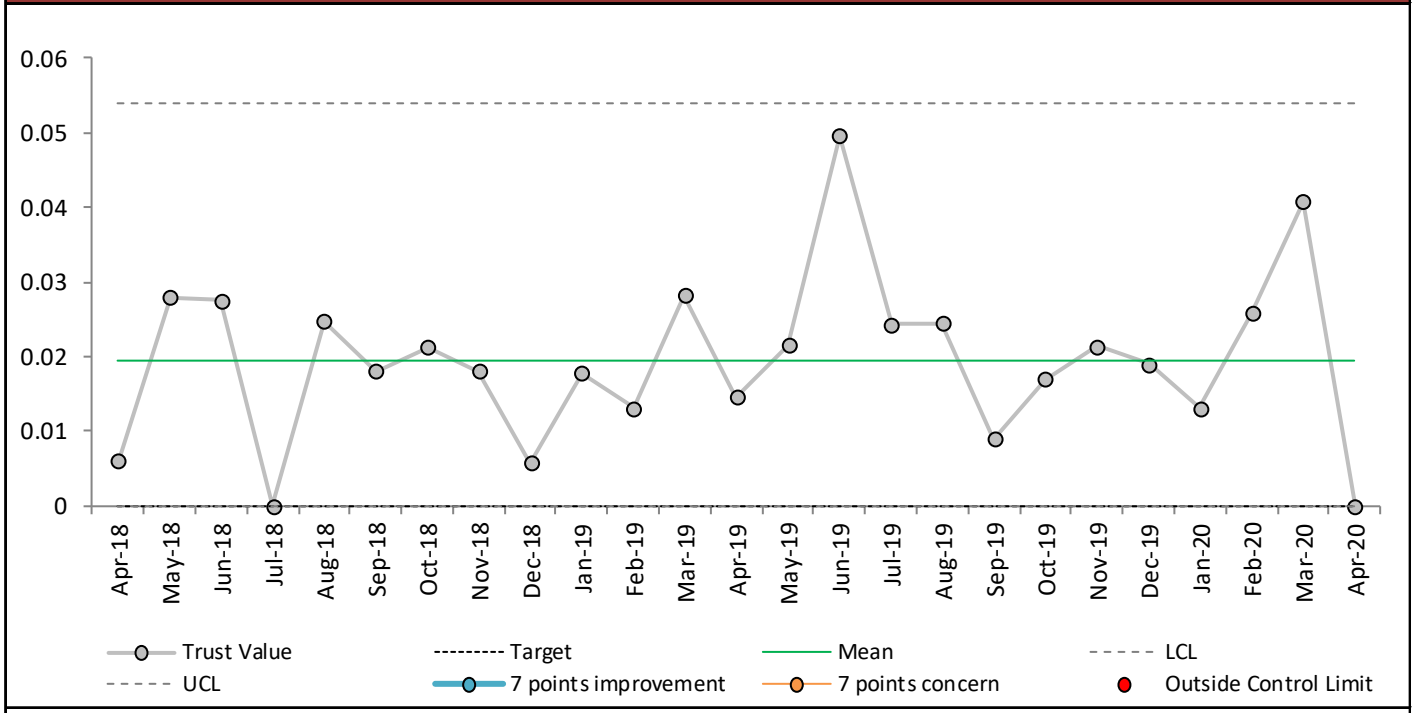
Timescale

- On-going actions

Safe

South Tees Hospitals NHS Foundation Trust

Falls with harm rate



Rate of falls with harm per 1000 bed days

Target	0
Mean	0.02
Last Month	0.00

Executive Lead

Deidre Fowler

Operational Lead

Beth Swanson

Commentary

Cause of Variation

- No falls with fractures in April.

• Planned Actions

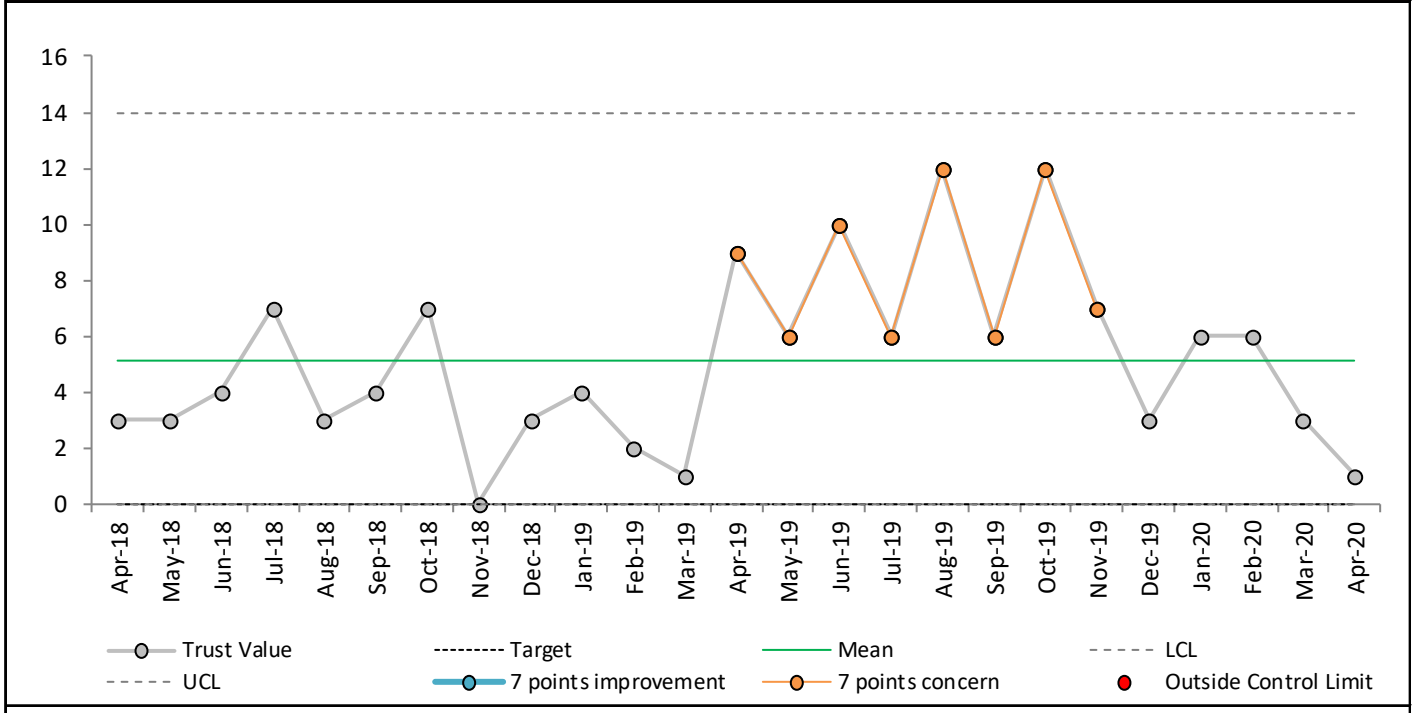
- On going actions to reduce falls continue.

Timescale

Safe

South Tees Hospitals NHS Foundation Trust

Infection control - C-diff



Cases of hospital acquired C. Difficile bacteraemia

Target	0
Mean	5.12
Last Month	1.00

Executive Lead

Deidre Fowler

Operational Lead

Astrida Ndhlovu

Commentary

The Clostridium difficile objective for 19/20 is to have no more than a combined total of 81 community-onset healthcare-associated and/or healthcare-onset healthcare-associated cases among patients aged over 2 years. There have been 89 cases in total in 19/20.

Cause of Variation

- The change in antibiotic guidance released in January 2019 carries a potential risk of increased cases of C. difficile as it could lead to an increase in appropriate prescribing of broad-spectrum antibiotics.
- There has been an increase in carbapenem and piperacillin-tazobactam use and a decrease in co-amoxiclav use. This could have the effect of increasing risk of C. difficile infection.

Planned Actions

- The Medical Director lead for antimicrobial prescribing is undertaking a review of the antimicrobial stewardship programme with the antibiotic pharmacist, in view of the increase in Clostridium difficile infections.
- In response to the increasing rate of C. difficile in 2019/2020 enhanced actions have been put in place and are reviewed in a weekly 'huddle' style meeting with the Clinical Matrons and led by the Deputy Director of Nursing and senior IPC nurse.

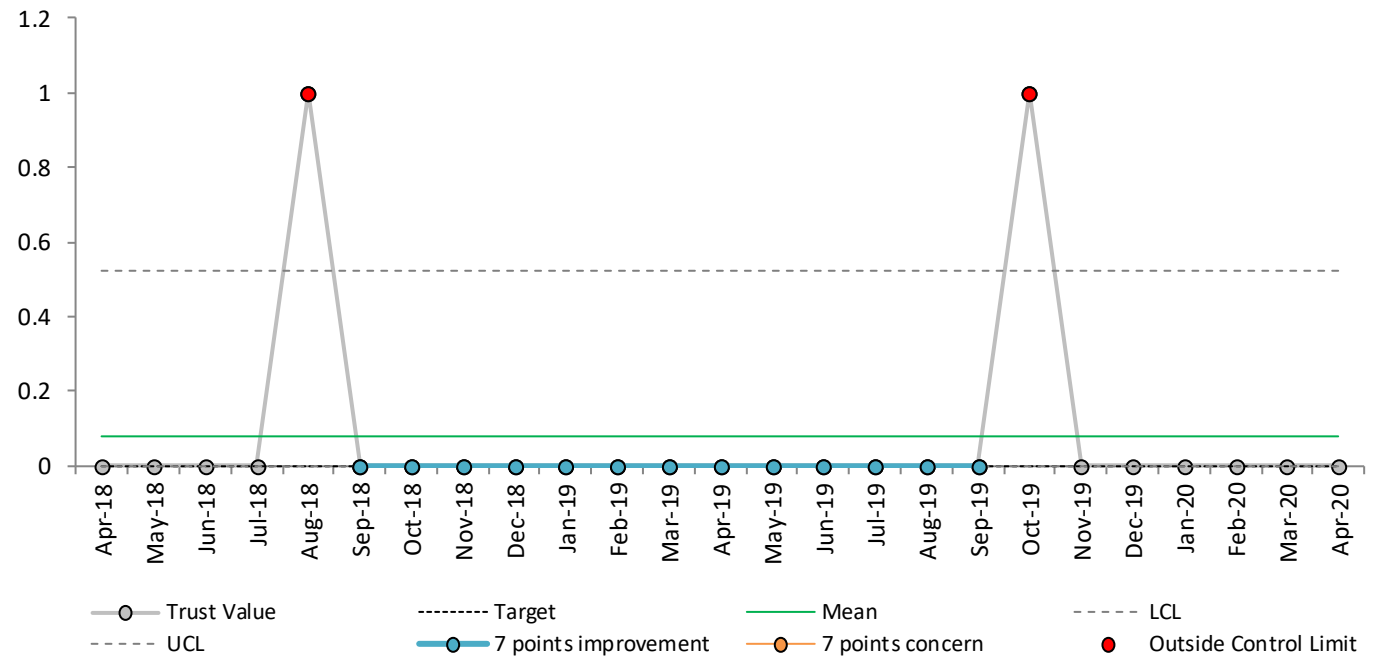
Timescale

- On-going and reviewed monthly at IPAG

Safe

South Tees Hospitals NHS Foundation Trust

Infection control - MRSA



Cases of hospital acquired MRSA bacteraemia

Target	0
Mean	0.08
Last Month	0.00

Executive Lead

Deidre Fowler

Operational Lead

Astrida Ndhlovu

Commentary

The MRSA bacteraemia target is that of zero tolerance. There were 5 cases of MRSA bacteraemia in 2019/20, 1 of which was classed as trust-assigned.

Cause of Variation

- The episode of bacteraemia in October 2019 was investigated and the root cause found to be a peripheral cannula.

Planned Actions

- Enhanced training for Aseptic Non-Touch Technique (ANTT) continues to be implemented across the trust for all relevant staff groups to address avoidable causes related to invasive procedures.
- By February 2020 >95% of staff in augmented care areas had received training in ANTT. The Trust as a whole is between 75-80% compliant with ANTT training.
- In order to enhance training for ANTT an e-learning package was ordered in 2019/20 and is awaiting delivery and implementation in 2020/21.

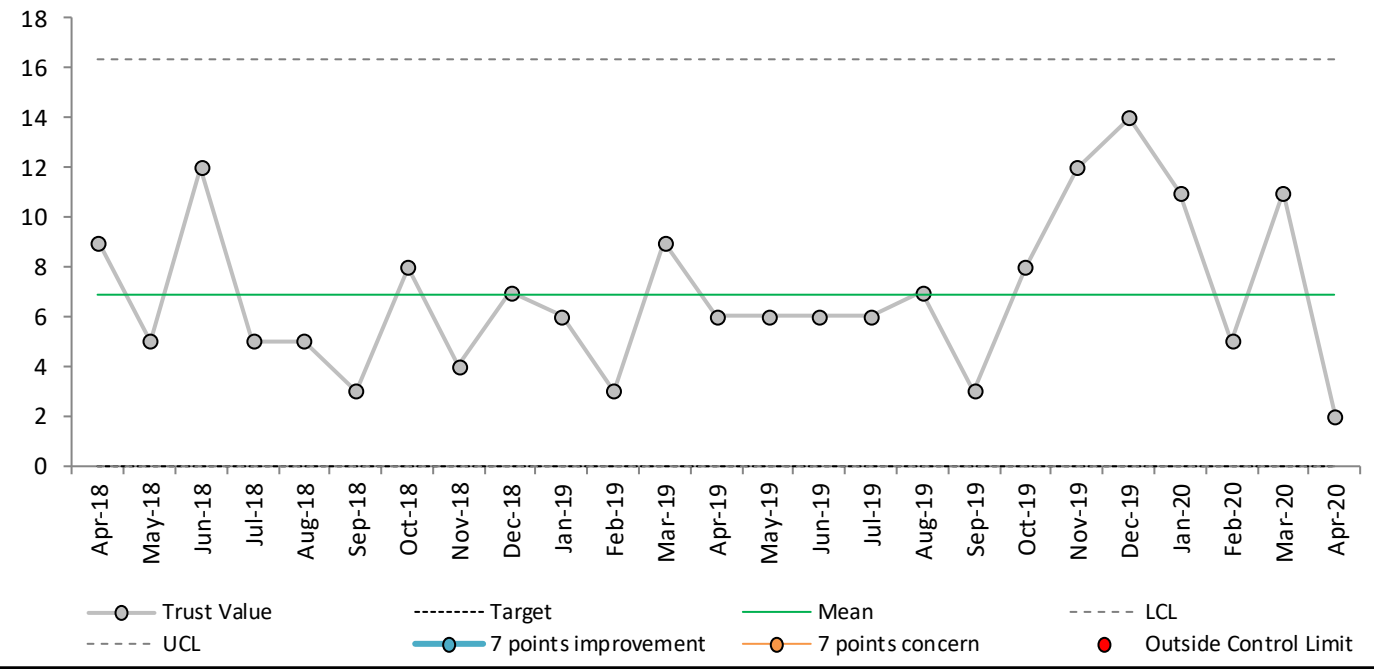
Timescale

- On-going and reviewed monthly at IPAG

Safe

South Tees Hospitals NHS Foundation Trust

Serious Incidents



The number of Serious Incidents

Target	0
Mean	6.92
Last Month	2.00

Executive Lead

Deidre Fowler

Operational Lead

Ian Bennett

Commentary

The Trust continues its focus on Serious Incidents. One of the Trusts Quality Priorities for 2020/2021 is to improve the quality of serious incident investigations.

Cause of Variation

- Serious Incidents are not always reported in the same month that they occur.

Planned Actions

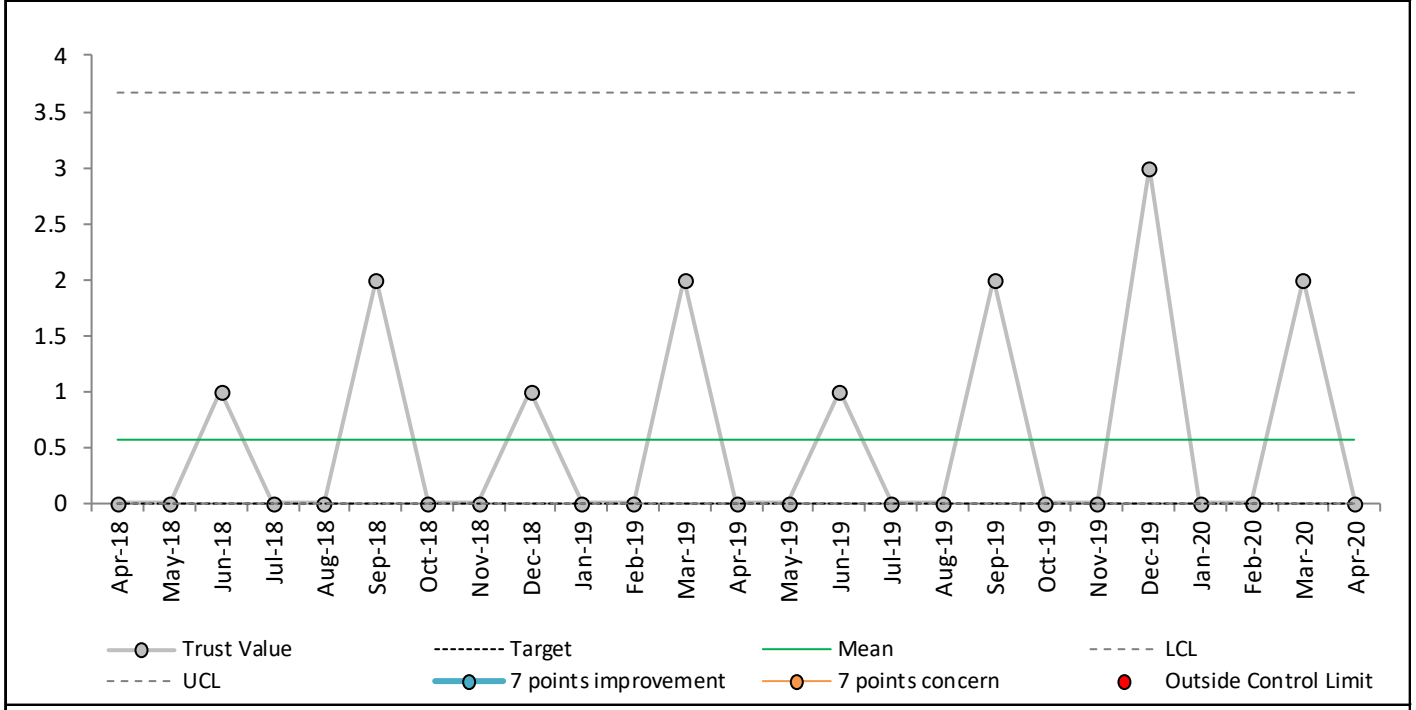
- Director of Nursing and Quality from the CCG has joined the Patient Safety Team one day per week with the aim of reducing the number of open SIs.
- To continue to report and investigate SI's within agreed timescales and ensure lessons learnt are shared across the Organisation.
- Await the publication of the new Patient Safety Incident Response Framework . Commission and deliver training for key staff .

Timescale

Safe

South Tees Hospitals NHS Foundation Trust

Serious Incidents never events



Number of reported Never Events

Target	0
Mean	0.56
Last Month	0.00

Executive Lead

Deidre Fowler

Operational Lead

Ian Bennett

Commentary

The Trust continues its focus on Never Events and Serious Incidents. We have agreed as part of our 'moving to good' programme that our patient safety objective will be to have no surgical never events in the future.

Cause of Variation

- Nationally there is a variation in the number of never events reported of between 28 and 48 per month (2019/20).

Planned Actions

- A working group for this has been established and a Consultant Vascular Surgeon has been identified to lead this important work.
- A safer surgery oversight group has been established and an improvement, incorporating the feedback from the external review of our never events, recent go and see visits to theatres, human factors training and the recommendations from these investigations which have been concluded.

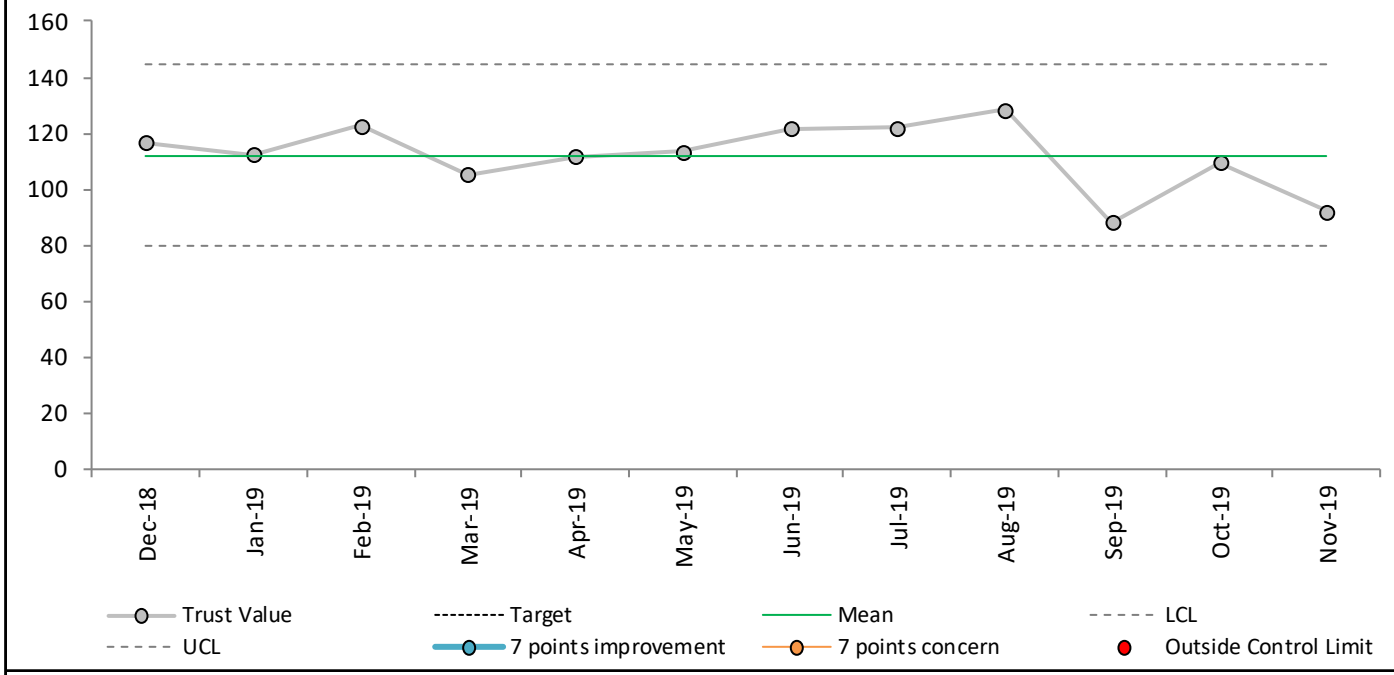
Timescale

- Eliminating Never Events remains a quality priority for 2020/21.

Safe

South Tees Hospitals
NHS Foundation Trust

Hospital Standard Mortality Rate (HSMR)



The HSMR measures the rate of observed deaths divided by predicted deaths

Target	National Average
Mean	111.96
Last Month	91.95

Executive Lead

Sath Nag

Operational Lead

Tony Roberts

Commentary

HSMR is a commercially produced indicator covering approximately 80% of in-hospital deaths. It is sensitive to specialist palliative care coding levels.

Cause of Variation

- All 12 points are within control limits.
- Five rising points between April and September, probably reflecting usual seasonal pattern.

Planned Actions

- Continued monitoring of counts of deaths, unadjusted mortality.
- Summary Hospital-level Mortality Indicator (SHMI) the official NHS hospital mortality indicator which includes all hospital deaths plus deaths within 30 days of discharge. Medical Examiner and Trust level Mortality Reviews and any deaths reported as SI, via nationally mandated Learning from Deaths dashboard.

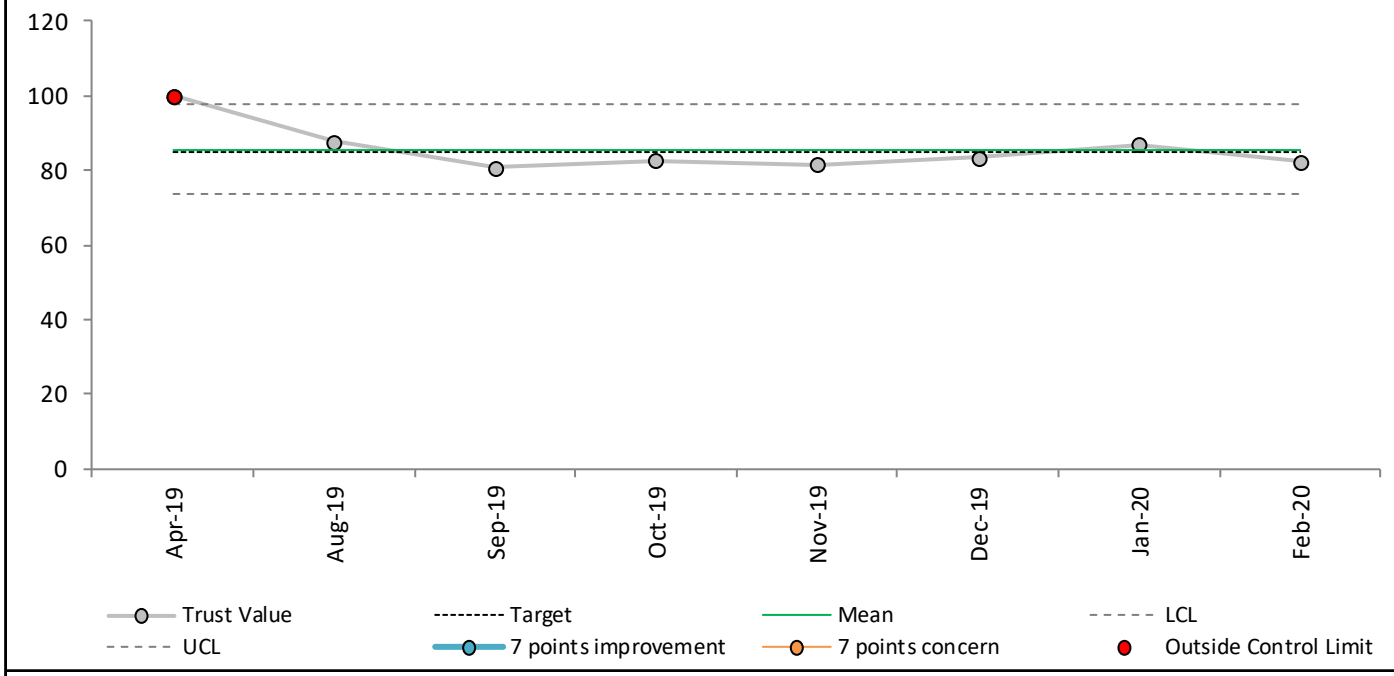
Timescale

- On-going

Caring

South Tees Hospitals NHS Foundation Trust

F&F A&E Recommendation Rate



The friends and family survey/text recommendation rate for A&E

Target	85
Mean	85.73
Last Month	82.36

Executive Lead

Deidre Fowler

Operational Lead

Commentary

Due to the COVID-19 Pandemic NHS England has suspended the uploading of the FFT data from March 2020 for approximately 3 months. Therefore, there is no data for March 2020 at present.

Cause of Variation

- The feedback received from patients is mainly in relation to waiting times in the departments. This was been fed back to the A&E as this concern was also highlighted in the Urgent and Emergency Care National Survey.

Planned Actions

- A review of technology to support information provision was completed to provide patients with a more detailed update in relation to the reasons for the delays in the department.

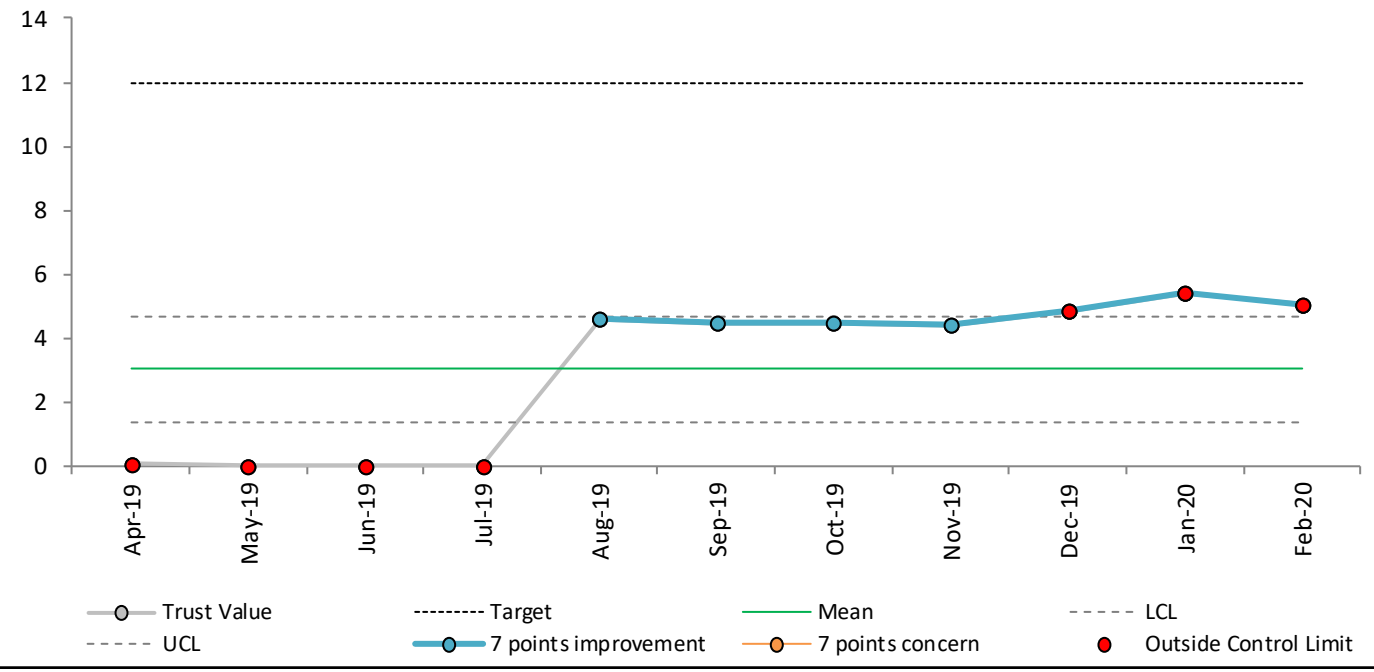
Timescale

- February 2020

Caring

South Tees Hospitals NHS Foundation Trust

F&F A&E Response Rate (%)



The response rate to the friends and family survey/text for A&E

Target	12
Mean	3.02
Last Month	5.07

Executive Lead

Deidre Fowler

Operational Lead

Commentary

The FFT question is sent to all patients, over the age of 16, by text post discharge from the A&E.
The new guidance states that the FFT question can be asked at any point in a patients journey and not just at discharge

Cause of Variation

- The FFT question is asked via text message and is sent to all patients, who are eligible, unless they opt out.

Planned Actions

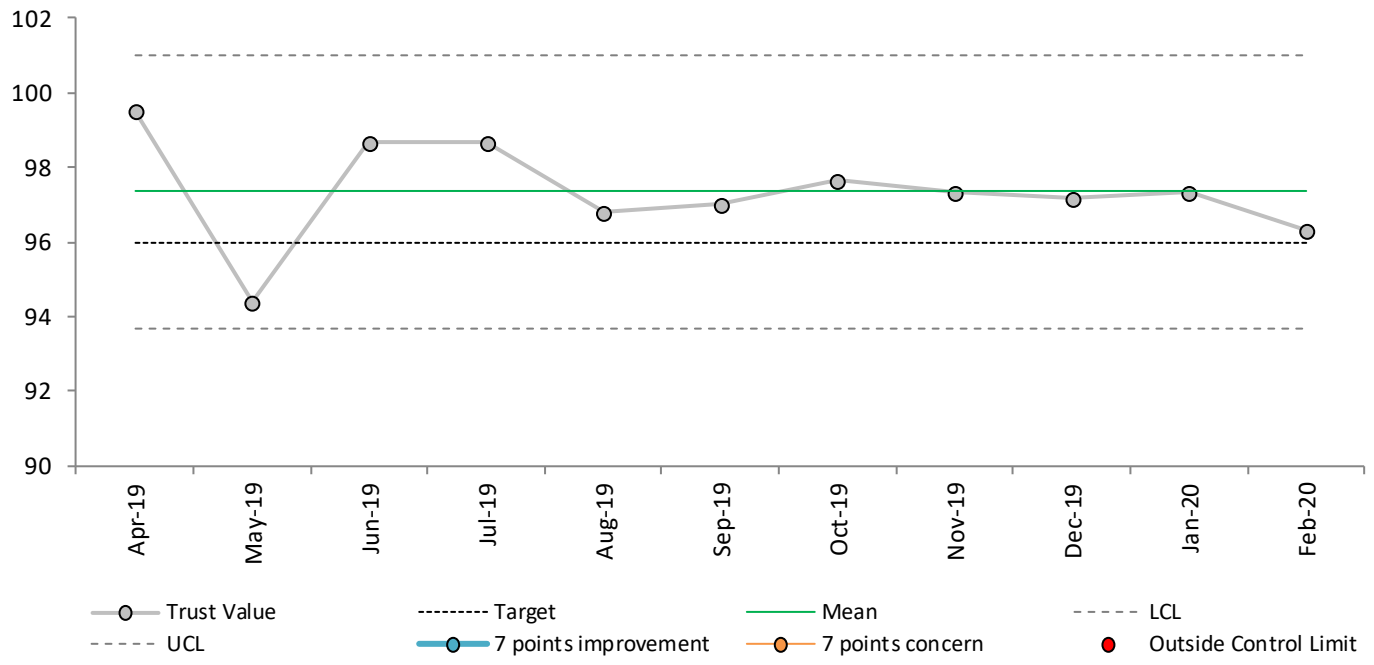
- Include patients who are transferred to a ward in the FFT text message.

Timescale

Caring

South Tees Hospitals NHS Foundation Trust

F&F Inpatient Recommendation Rate (%)



The friends and family survey/text recommendation rate for Inpatient wards

Target	96
Mean	97.35
Last Month	96.31

Executive Lead

Deidre Fowler

Operational Lead

Commentary

Cause of Variation

- Decrease in recommendation rate in February 2020 is possibly due to the an increase in surveys received.

Planned Actions

- Review the comments left on FFT to try and understand the reason for the decrease, along with the data from the inpatient survey.

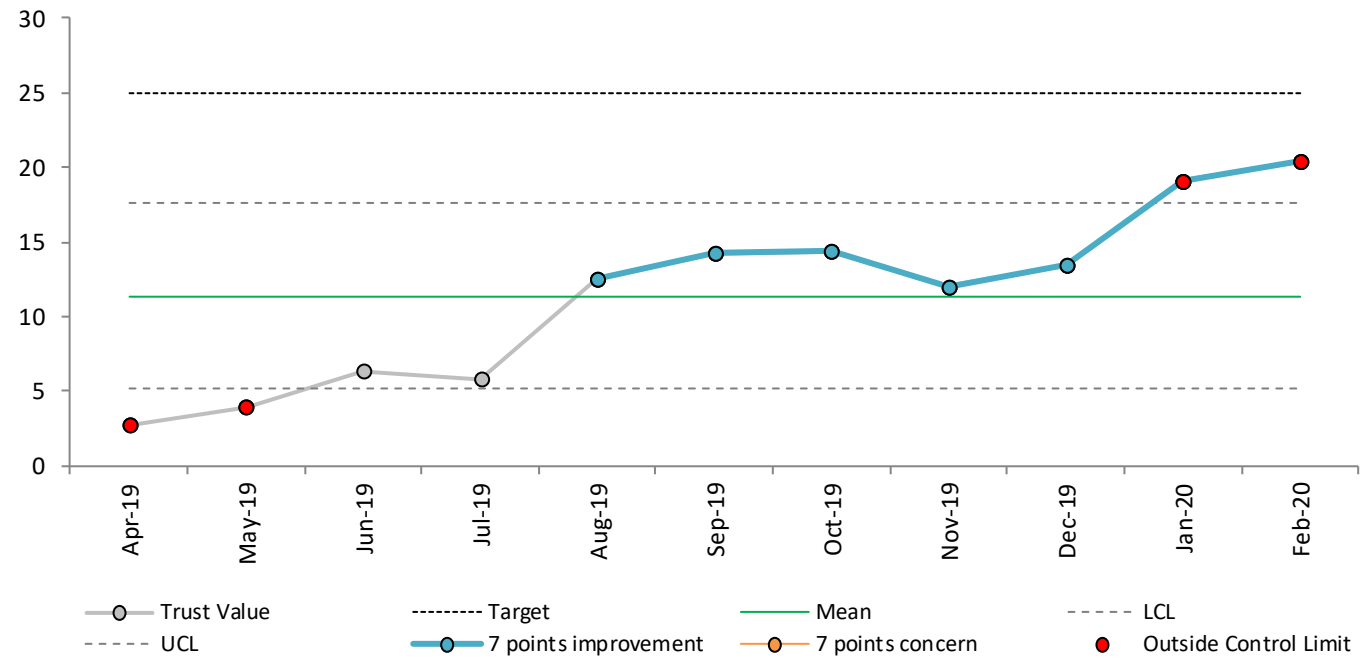
Timescale

- July 2020

Caring

South Tees Hospitals NHS Foundation Trust

F&F Inpatient Response Rate (%)



The response rate to the friends and family survey/text for Inpatient wards

Target	25
Mean	11.37
Last Month	20.43

Executive Lead

Deidre Fowler

Operational Lead

Commentary

The inpatient FFT question is completed by the patient, relative or carer, which is felt to give a more honest response than being completed by a member of staff, whilst on the ward via the iPad.

Cause of Variation

- The increase seen in January / February 2020 response rate was due to the implementation of 'Key Performance Indicators' (KPI) for all wards, dependent on activity.

Planned Actions

- To continue to monitor the wards and departments against the KPI.
- The FFT question and inpatient survey are separate on the iPad's, the FFT question will be added to the inpatient survey

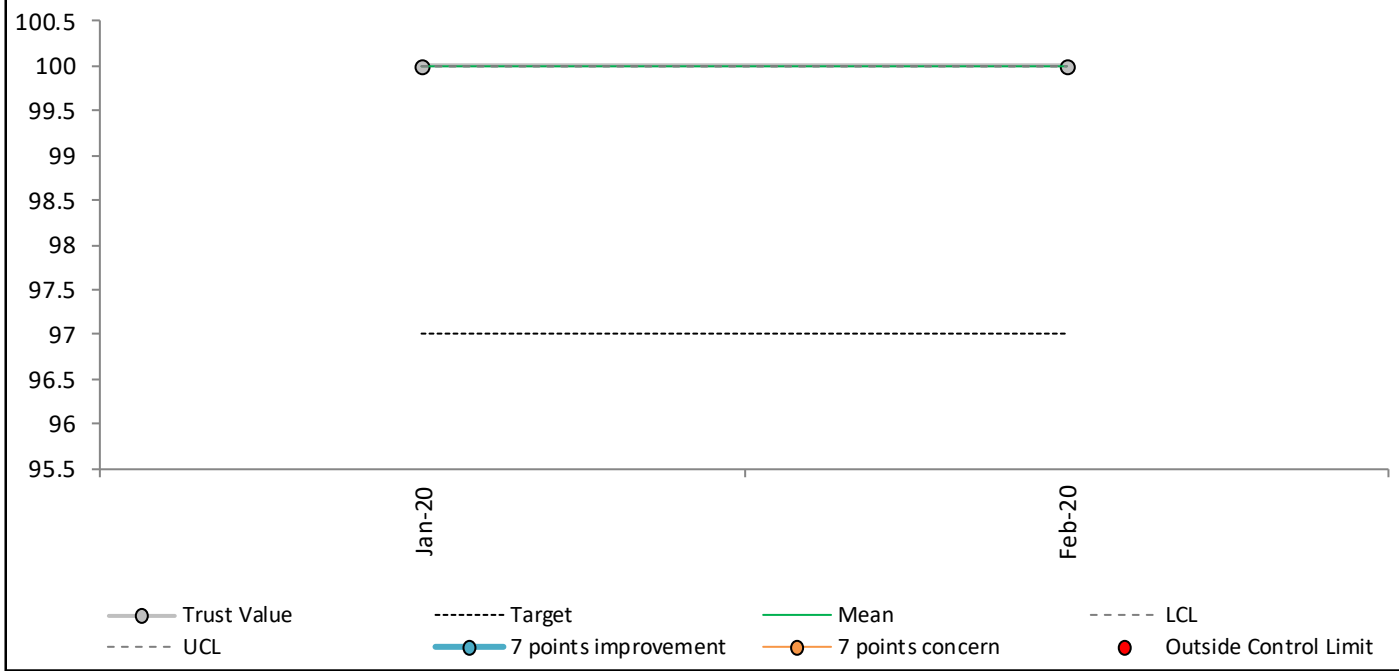
Timescale

- Continuous
- July 2020

Caring

South Tees Hospitals NHS Foundation Trust

F&F Maternity Recommendation Rate (%)



The friends and family survey/text recommendation rate for Maternity services

Target	97
Mean	100.00
Last Month	100.00

Executive Lead

Deidre Fowler

Operational Lead

Commentary

Awaiting update

Cause of Variation

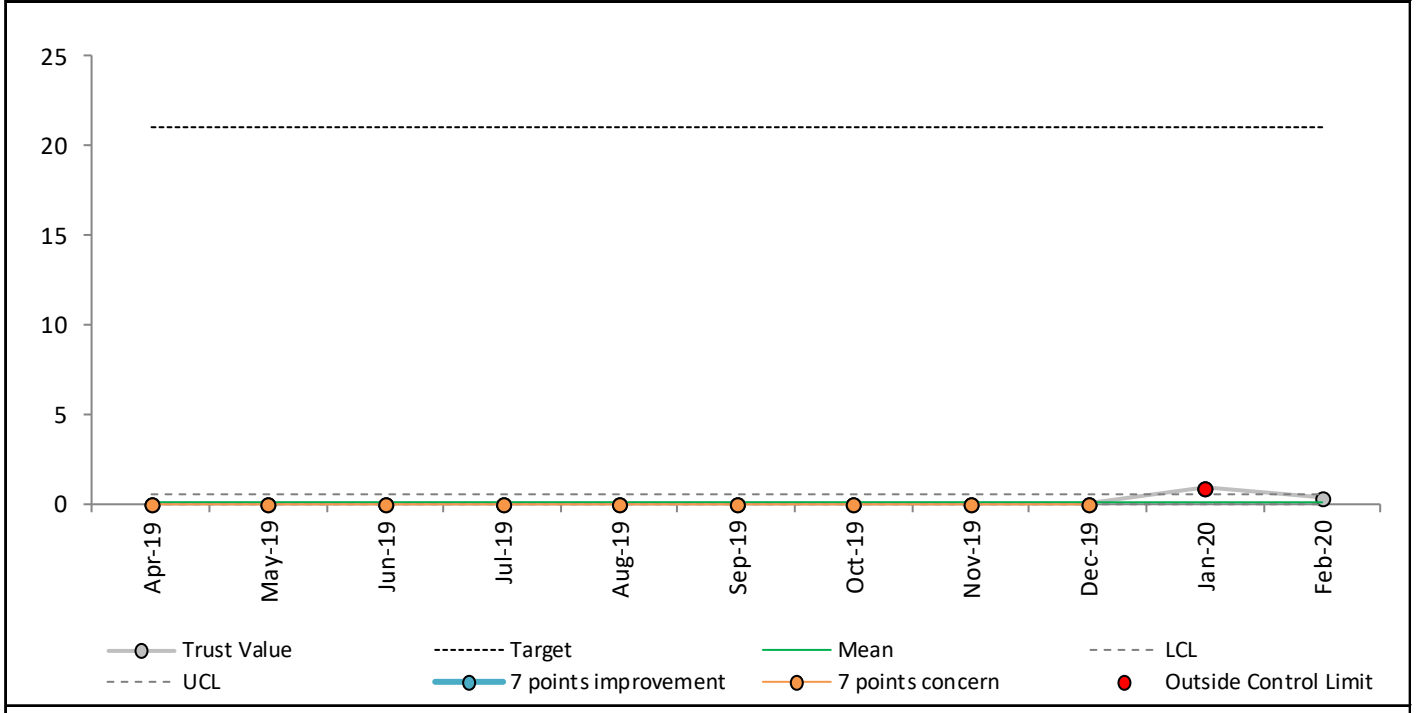
Planned Actions

Timescale

Caring

South Tees Hospitals NHS Foundation Trust

F&F Maternity Response Rate (%)



The response rate to the friends and family survey/text for Maternity

Target	21
Mean	0.11
Last Month	0.33

Executive Lead

Deidre Fowler

Operational Lead

Commentary

Awaiting update

Cause of Variation

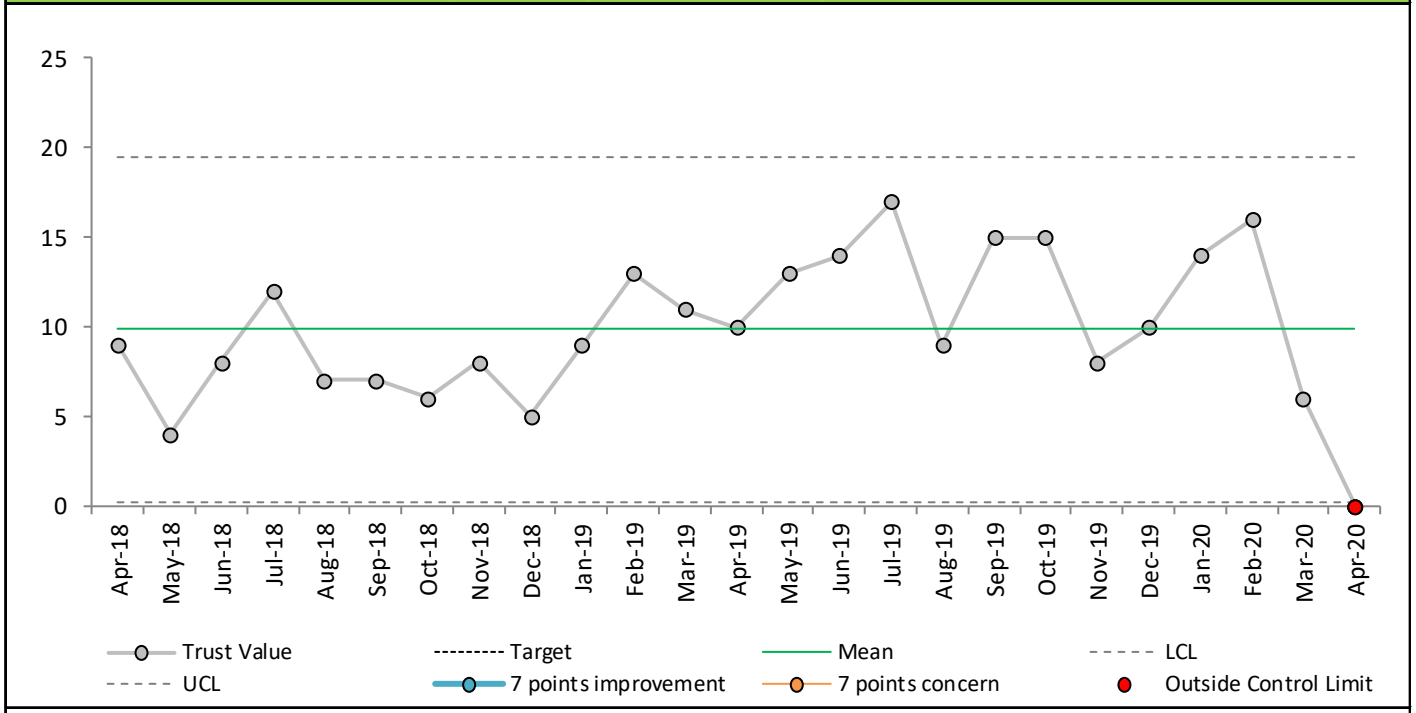
Planned Actions

Timescale

Caring

South Tees Hospitals NHS Foundation Trust

Open Complaints > 40 Day Response



The number of complaints we have past the 40 day response time

Target	0.00
Mean	9.84
Last Month	0.00

Executive Lead

Deidre Fowler

Operational Lead

Commentary

Awaiting Update

Cause of Variation

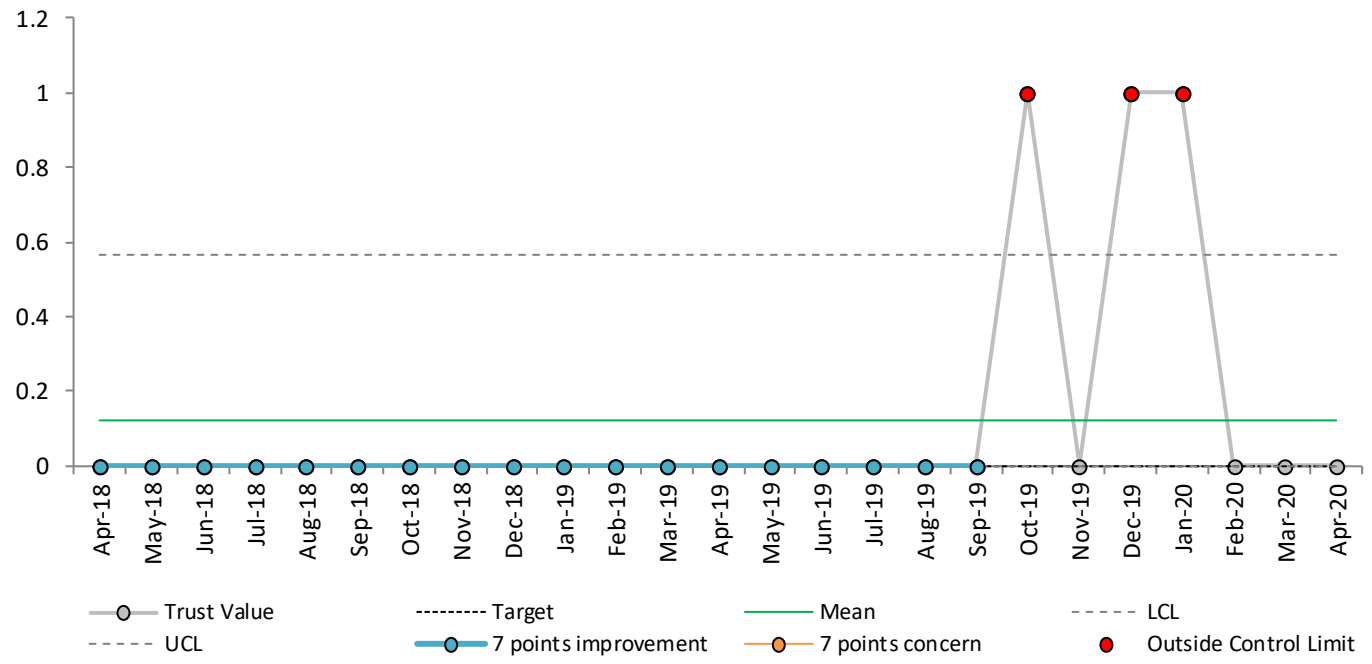
Planned Actions

Timescale

Caring

South Tees Hospitals NHS Foundation Trust

Mixed Sex Accommodation (MSA) Breaches



The number of non-clinically justified breaches of the single sex accomodation standard

Target	0
Mean	0.12
Last Month	0.00

Executive Lead

Deidre Fowler

Operational Lead

Commentary

Oct and Dec breaches were on Ward 9.

Feb breach was in the Endoscopy Unit.

Cause of Variation

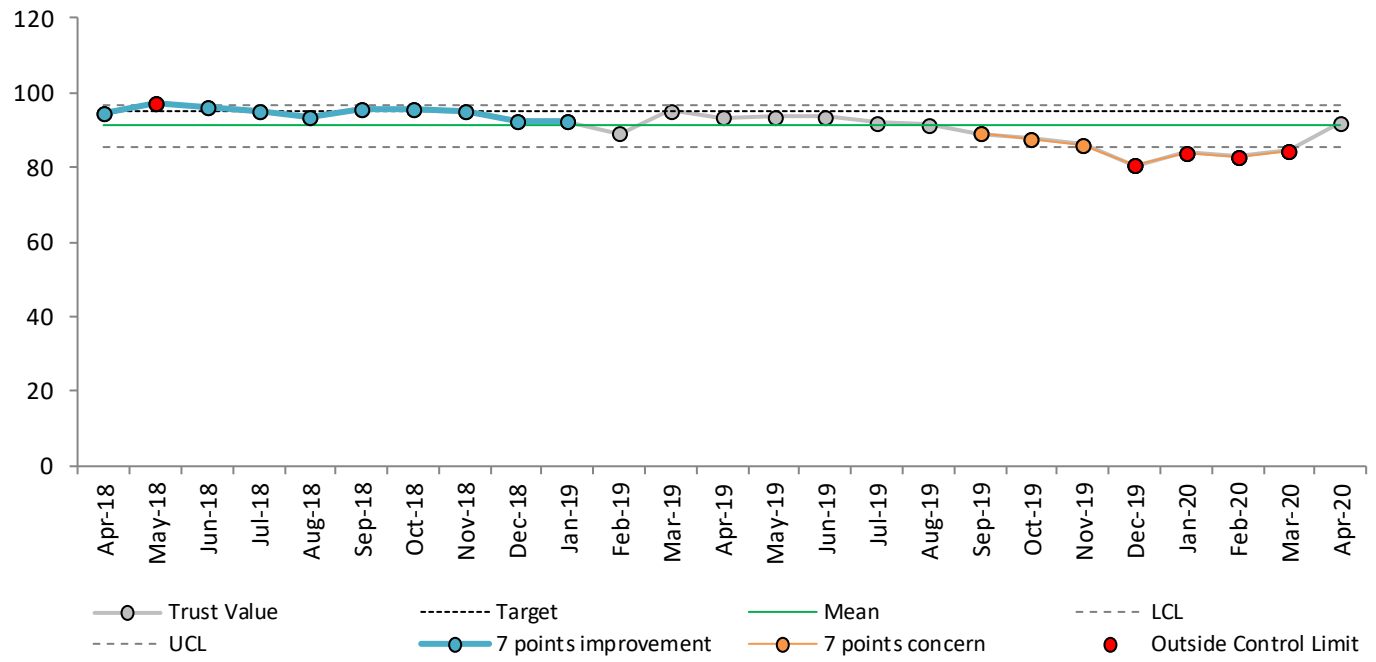
Planned Actions

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

A&E 4 Hour Wait Standard (%)



The Trust figure of A&E attendances who have been discharged within the 4 hour target

Target	95
Mean	91.34
Last Month	91.93

Executive Lead

Johanna Riley

Operational Lead

Penny Bateman

Commentary

Cause of Variation

- Bed availability.
- Increase in attendances.
- 12 hour delays increased capacity.
- Crowding in the ED.
- Exit block.
- Lack of capacity in the main department.
- Lack of resus.
- High number of outliers and delayed discharges across the organisation.

Planned Actions

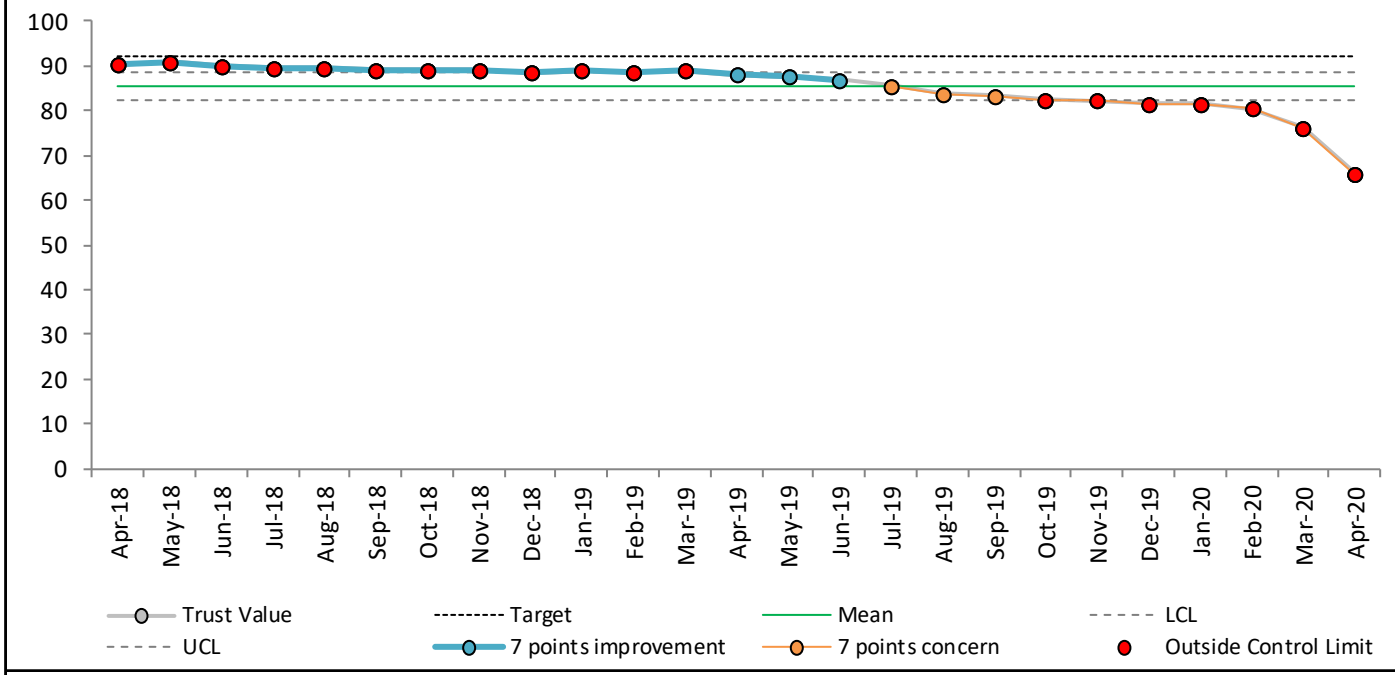
- Trust review of bed base, demand and capacity.
- Pathways to speciality teams.
- Pathology pathways.
- SDEC model to reduce in patient demand.
- Telephone triage to manage demand and provide alternatives.
- Integrated FOH model to enhance pathways.
- FOH CT scanner reducing delays in pathways.

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

RTT Incomplete Pathways (%)



The % of incomplete pathways for patients within 18 weeks

Target	92
Mean	85.60
Last Month	66.04

Executive Lead

Johanna Reilly

Operational Lead

Commentary

April 20 compliance reduced to 66.03%, - 10.14 % in comparison to March 20

Cause of Variation

- In March 2020 the Trust was required to cancel all non-urgent elective activity (by NHSE) for a minimum of three months. RTT compliance has significantly reduced to 66%.
- The number of patients waiting over 52 weeks at the end of April was 111 compared to 15 at the end of March. NHSE plan for waiting list size has been achieved, final position was 2,624 below plan.

Planned Actions

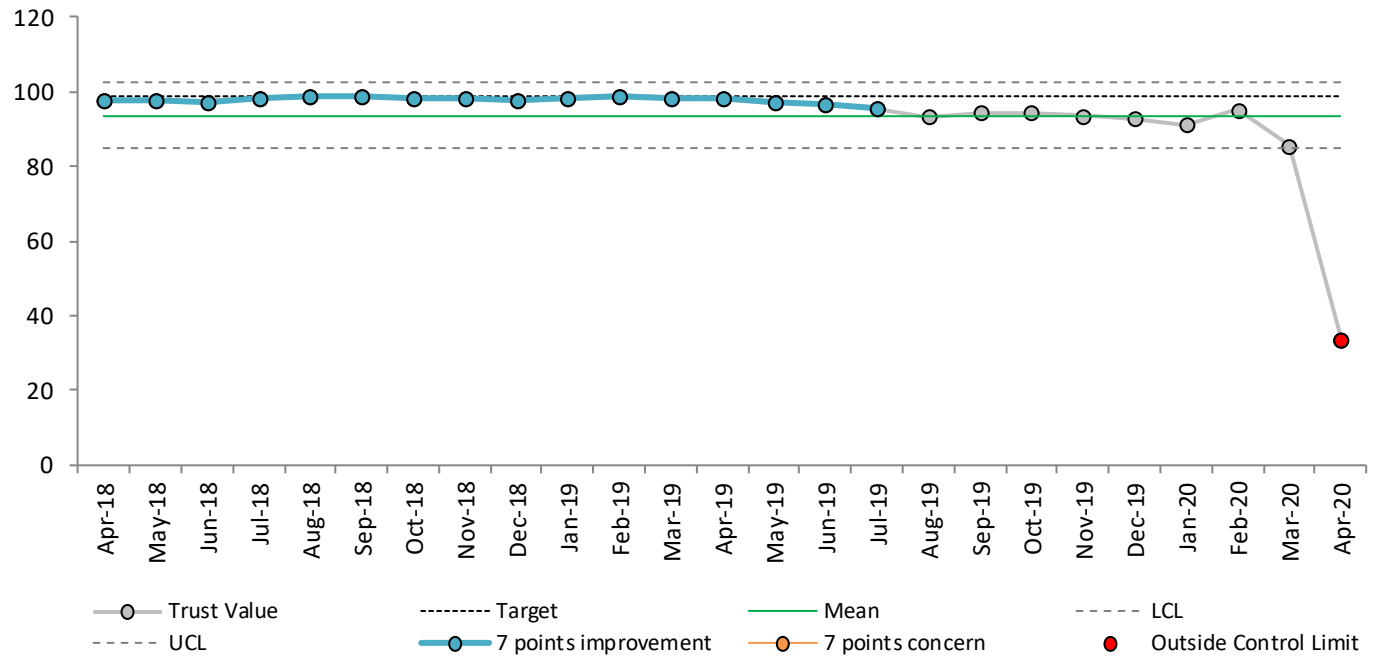
- As the Trust moves into its recovery phase all Directorates have been asked for their recovery plans.
- Consideration of what can be re-started safely will be co-ordinated via the recovery group to ensure sufficient capacity for agreed activity with focus on the patients waiting in excess of 52 weeks where possible.

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

Diagnostic 6 weeks standard (%)



The % of Diagnostic tests that were carried out within 6 weeks of request being received

Target	99
Mean	93.67
Last Month	33.76

Executive Lead

Johanna Riley

Operational Lead

Kelly Smith/Stuart Finn

Commentary

April 20 compliance r educed significantly to 33.76%, due to the COVID 19 pandemic. (2,339 patients waiting over 6 weeks for a diagnostic test.) Top 5 specialties where the breaches have occurred are Audiology, MRI, Neurophysiology and Colonoscopy.

Cause of Variation

- Planning and managing national COVID-19 pandemic has impacted on diagnostic capacity.
- Diagnostic Radiology breaches = 259. 247 of which were MRI breaches. This was due to a failure in following agreed processes in place for re-vetting of referrals during COVID pandemic.

Planned Actions

- Neuroradiology Service Manager has reaffirmed the current process with Neuroradiologists. Patient connect team have been reminded to continue with housekeeping processes for managing filters.
- Meridian working with Radiology to review capacity and demand, room utilisation and associated work plans. It is anticipated this work should reduce the amount of work that is outsourced in the future and clearly identify gaps in workforce.

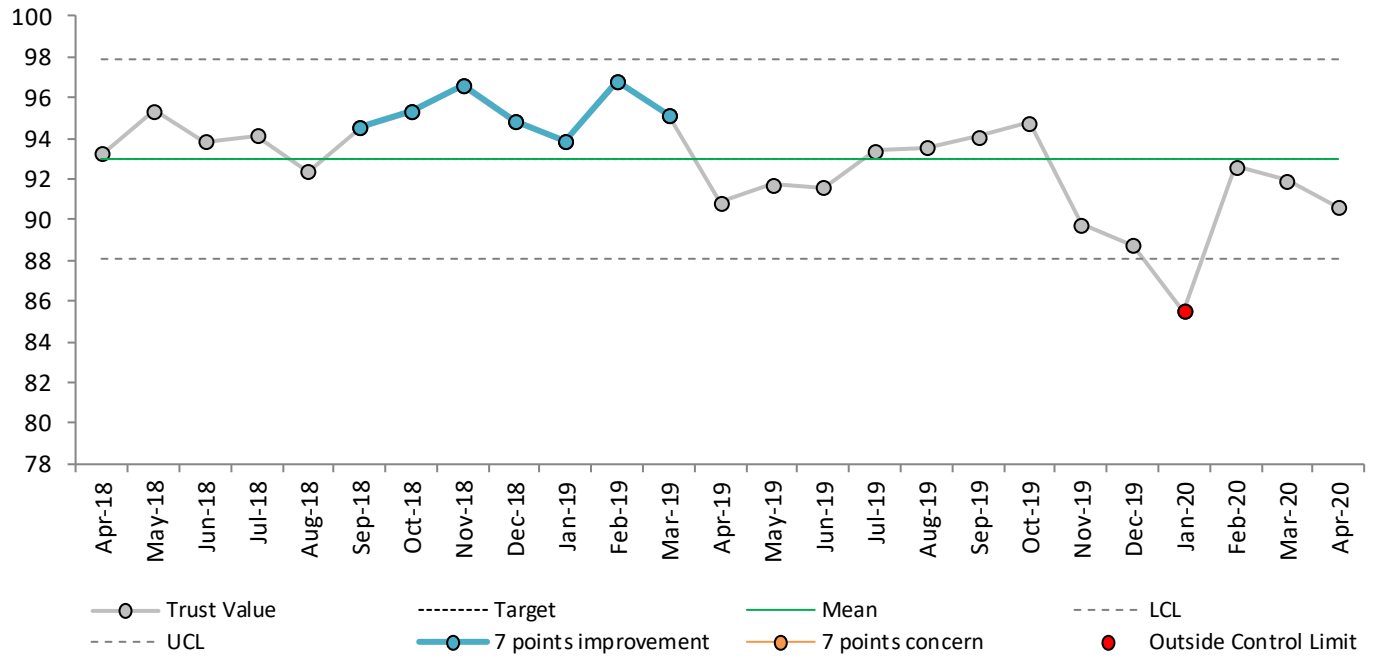
Timescale

- June 2020
- August 2020

Responsive

South Tees Hospitals NHS Foundation Trust

Cancer Treatment - 14 Day Standard (%)



The Trust figure showing number of patients treated within the 14 day target

Target	93
Mean	93.01
Last Month	90.59

Executive Lead

Mr Chadwick

Operational Lead

Commentary

March 20 compliance was 91.91%, breaches occurred in Plastic Surgery, Urology and Gastroenterology.

Cause of Variation

- Full impact of COVID 19 pandemic experience from April onwards with a significant drop in referrals by around 75%.
- Later weeks we have seen this improve following media campaigns etc. to around 50% of our average referrals.

Planned Actions

- 2 week rule clinics re-instated including endoscopy capacity although this remains limited
- Weekly cancer performance wall continues virtually to identify pressures and themes

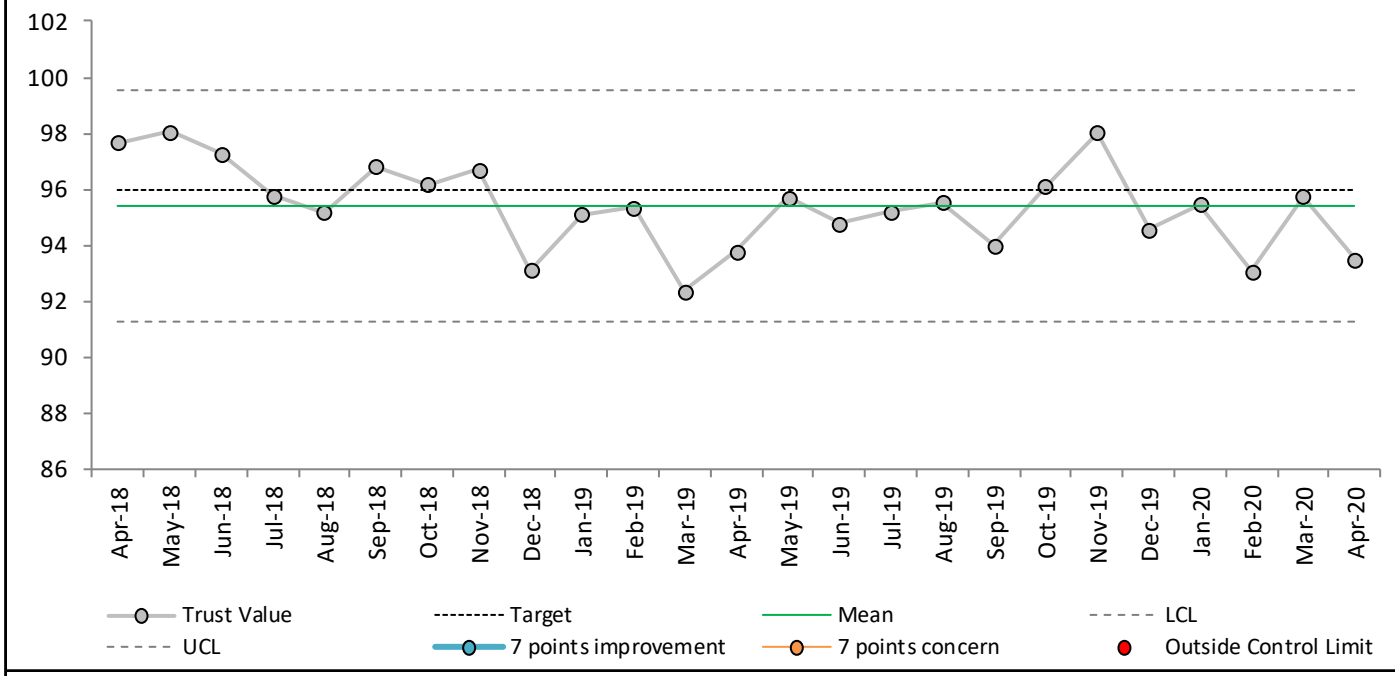
Timescale

- Weekly review – additional capacity approved by Recovery Group

Responsive

South Tees Hospitals NHS Foundation Trust

Cancer Treatment - 31 Day Standard (%)



The Trust figure showing number of patients treated within the 31 day target

Target	96
Mean	95.40
Last Month	93.49

Executive Lead

Mr Chadwick

Operational Lead

Commentary

March 20 compliance was 95.73%, 12 breaches in total 5 Head & Neck, 3 Urological, 2 Upper GI and 1 Haematology.

Cause of Variation

- It should be noted that those who have breached the 62 day standard often carry a 31 day standard as well.
- Diagnostic capacity increasing as COVID 19 demand reduces.

Planned Actions

- Ensure all patients are tracked and expedited where appropriate.
- Weekly cancer performance wall continues virtually
- Operations Directors/Service Managers to implement recommendations from recovery plans.

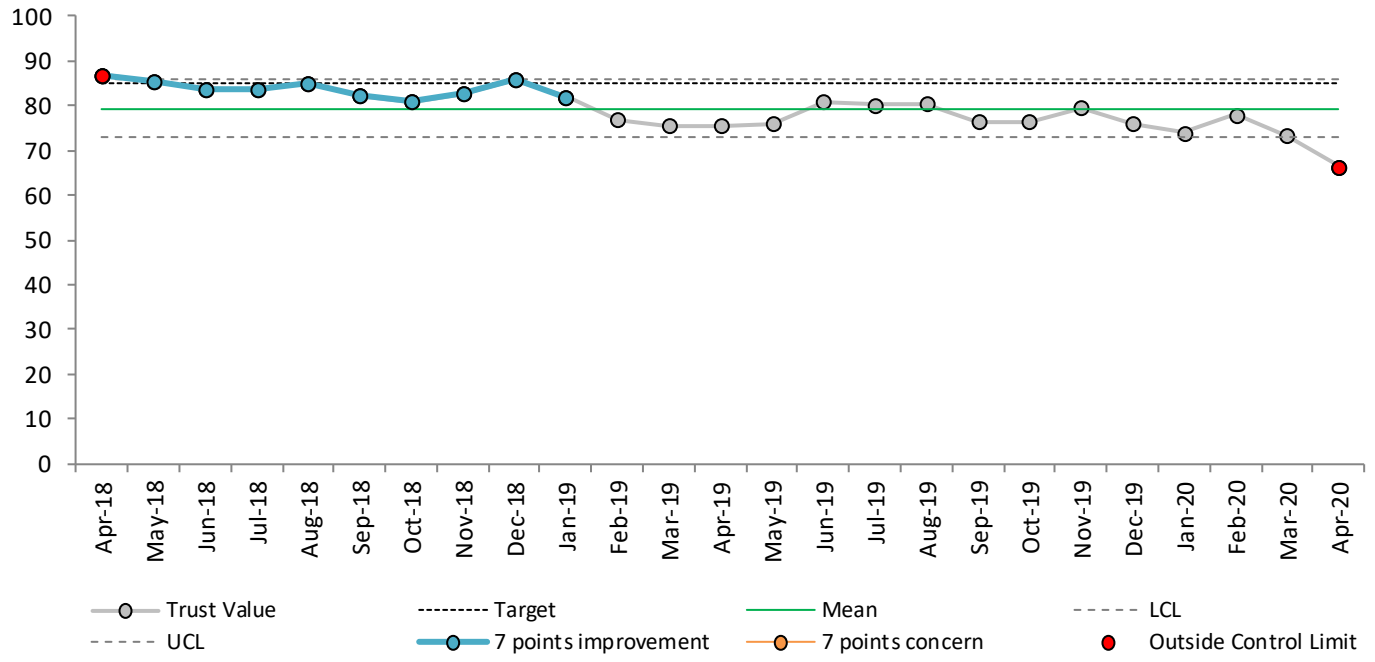
Timescale

- May 2020
- Weekly
- Progress reviewed monthly with escalation to Board through performance report

Responsive

South Tees Hospitals NHS Foundation Trust

Cancer Treatment - 62 Day Standard (%)



The Trust figure showing number of patients treated within the 62 day target

Target	85
Mean	79.37
Last Month	66.37

Executive Lead

Mr Chadwick

Operational Lead

Commentary

March 20 compliance was 73.16%, 51 breaches – main reasons for the breaches were complex pathways – including multiple tests and specialty involvement, medical reason and patients choice.

Cause of Variation

- Overall treatments in March were up in comparison to the same period last year by 8.5% (174.5 v 190 treatments).
- Tees wide cancer cell developed ensuring all priority 2 patients are operated on within a four week period – Trust is managing to consume priority 2 cancer demand .

Planned Actions

- Deep dive reviews carried out with tumour site MDTs – expedite implementation of recommendations where possible.
- STAR chamber reviews with priority MDT tumour site leads planned over the next three weeks.
- Weekly hot clinics in place to review breaches and identify themes..

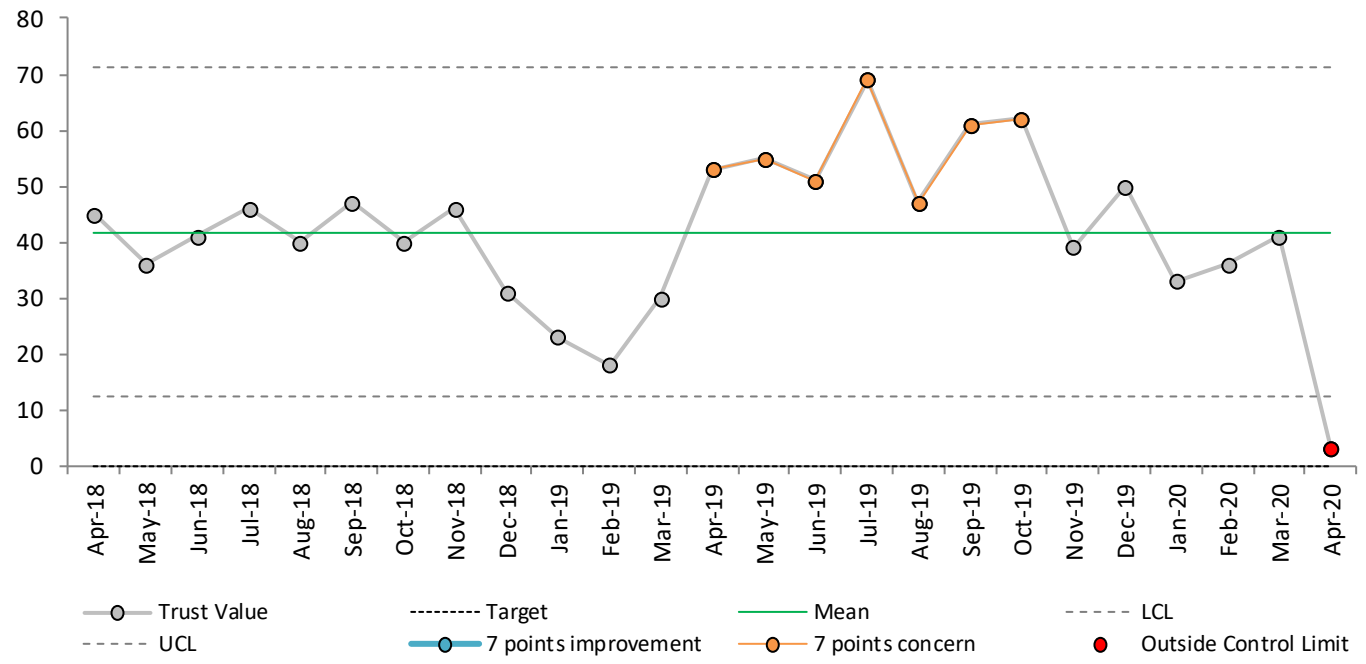
Timescale

- October 2020
- June 2020
- Weekly on-going

Responsive

South Tees Hospitals NHS Foundation Trust

Non-Urgent Ops Cancelled on Day



The number of non-urgent operations that were cancelled on the day of the procedure

Target	0
Mean	41.72
Last Month	3.00

Executive Lead

Johanna Reilly

Operational Lead

Sue Geldart

Commentary

Cause of Variation

- Significant reduction in the number of non-urgent operations cancelled on the day (day of admission or day of procedure) due to limited number of elective / non-urgent procedures going ahead during the COVID-19 pandemic.
- Three patients cancelled during April (1xGynaecology, 2x Urology) versus mean of 41.72 over previous months.

Planned Actions

- Continue to book non-urgent patients as set out in the Trust's Standard Operating Procedure for prioritisation of elective patients during current COVID-19.
- Continue to ensure that patients are suitably consented and pre-assessed prior to admission (and swabbed 48 hours prior to admission) to minimise the likelihood of 'hospital initiated' cancellation.

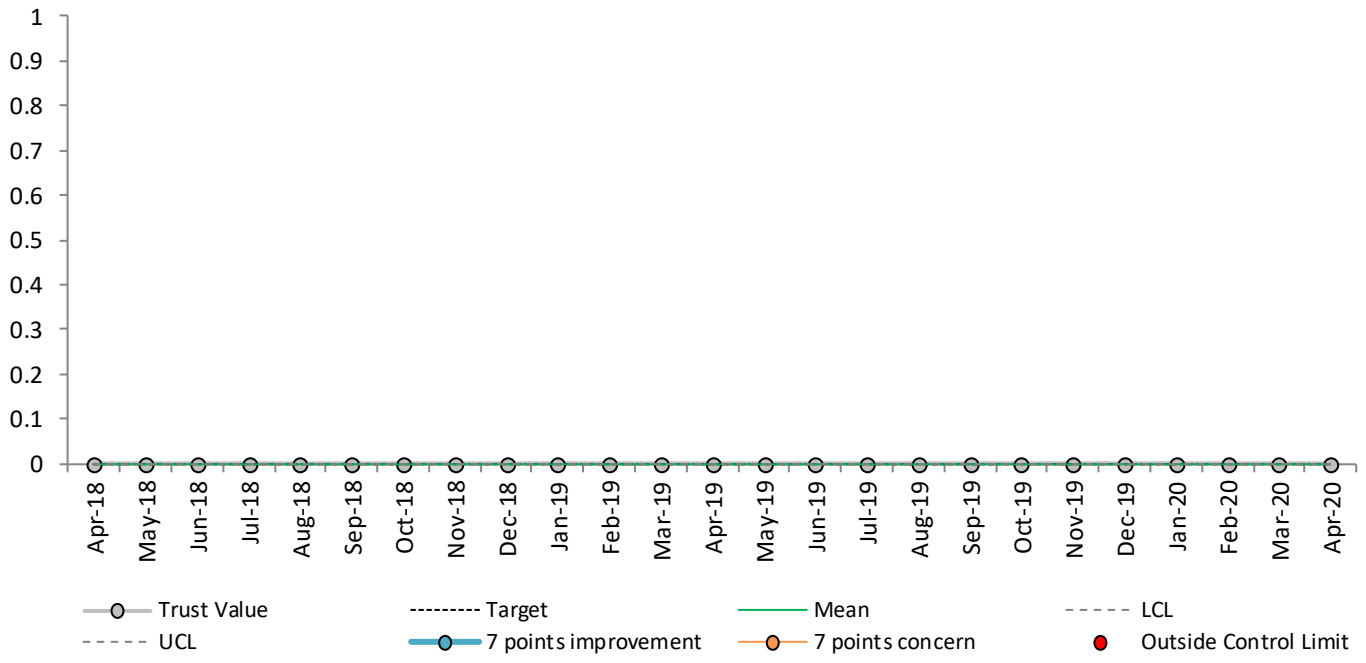
Timescale

- On-going

Responsive

South Tees Hospitals
NHS Foundation Trust

Urgent Ops Cancelled on Day



The number of urgent operations that were cancelled on the day of the procedure

Target	0
Mean	0.00
Last Month	0.00

Executive Lead

Johanna Reilly

Operational Lead

Sue Geldart

Commentary

Cause of Variation

- From the data above this suggests no urgent operations have been cancelled on the day (day of admission or day of procedure) for hospital initiated reasons. No exceptions to report (assuming zero cancellations based on the graph provided above).

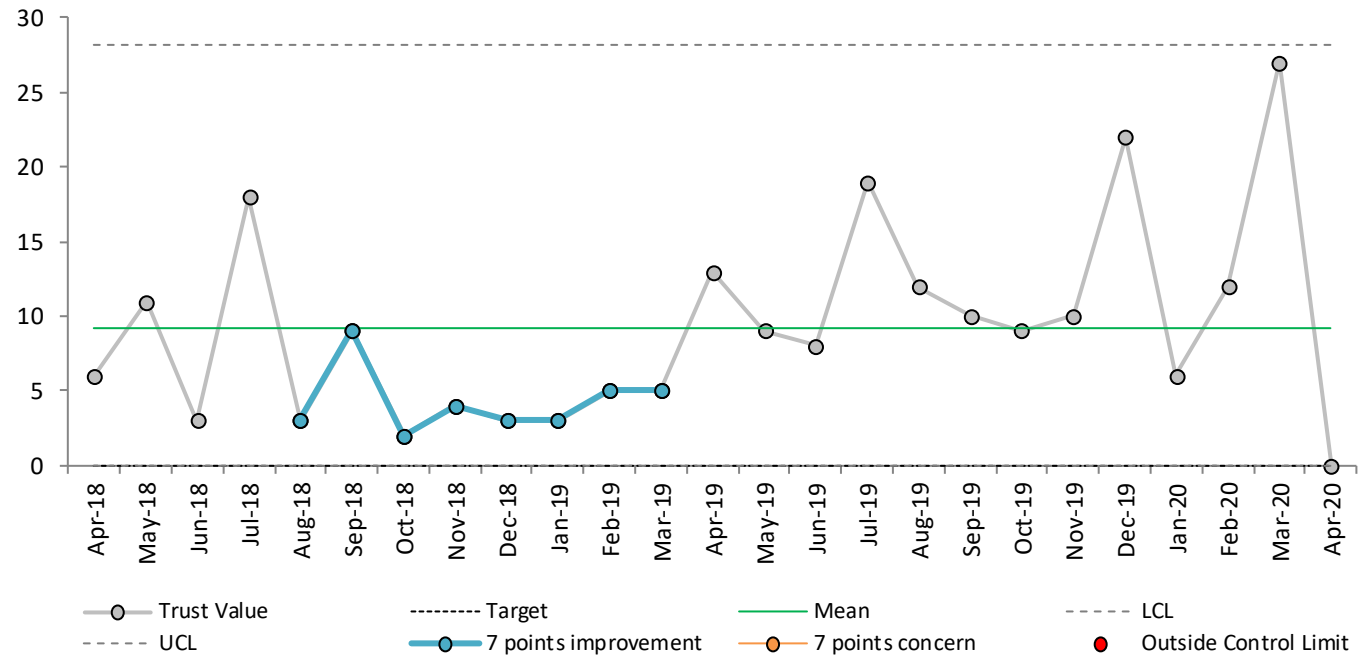
Planned Actions

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

Cancelled Ops not rebooked within 28 days



Cancelled operations for non-clinical reasons not rebooked within 28 days

Target	0.00
Mean	9.16
Last Month	0.00

Executive Lead

Johanna Reilly

Operational Lead

Sue Geldart

Commentary

April 20 the trust had 3 cancelled operations all were re-booked within the 28 day standard.

Cause of Variation

- As per slide 26, the Trust cancelled three non-urgent patients. All patients were re-booked within the 28 day standard.

Planned Actions

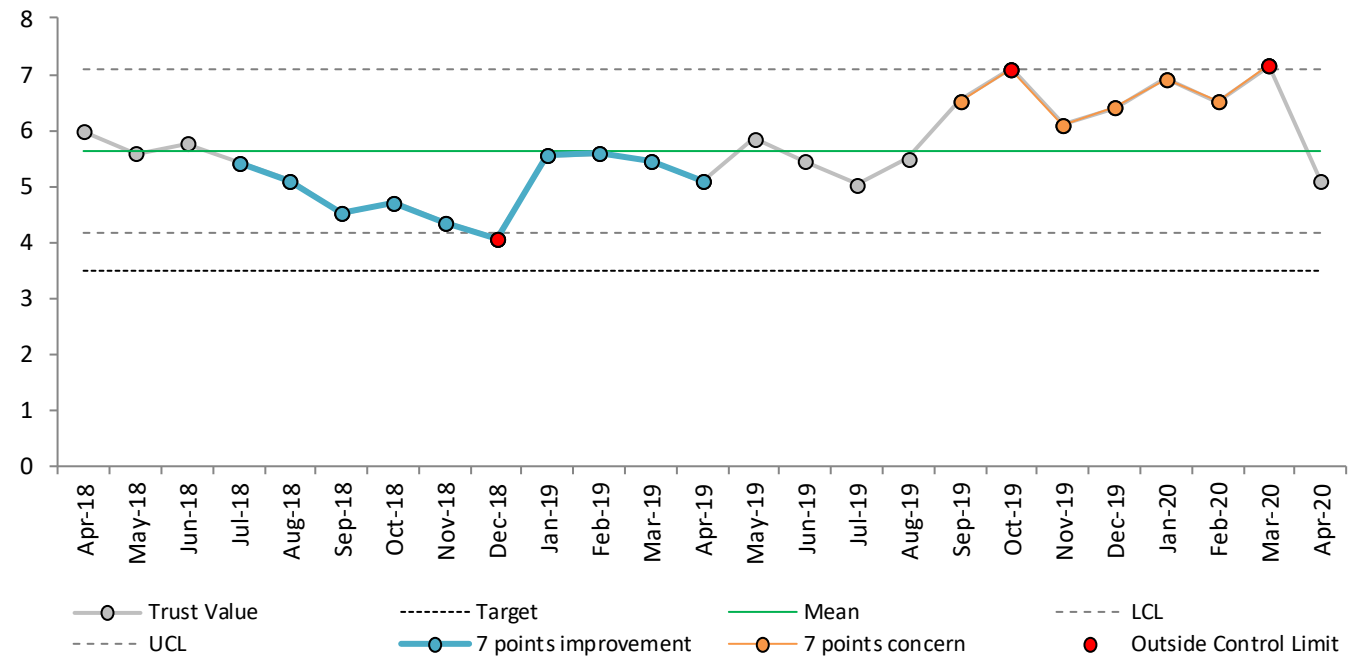
- Continue to monitor the number of non-urgent patients cancelled due to hospital initiated reasons (aim to minimise).
- Actively promote (and provide routine reports) to ensure that short notice cancellations are re-booked within the 28 day standard.

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

Delayed Transfers of Care (%)



Delayed transfers of care compliance

Target	3.5
Mean	5.63
Last Month	5.09

Executive Lead

Joanne Dobson

Operational Lead

Commentary

Significant improvement in DToC rates since March 2020.

Cause of Variation

- COVID 19 discharge guidance facilitated planned changes to DToC.
- Improved working relationships with CCG and Local Authority.
- Streamlined discharge processes.

Planned Actions

- Embed Medworxx across the organisation as a continuous improvement tool to identify themes that delay discharges.
- Continue with > 7 day LoS MDT reviews .
- Ensure 'Home first' ethos across the organisation and embed discharge to assess.
- Organise system wide lessons learned event.

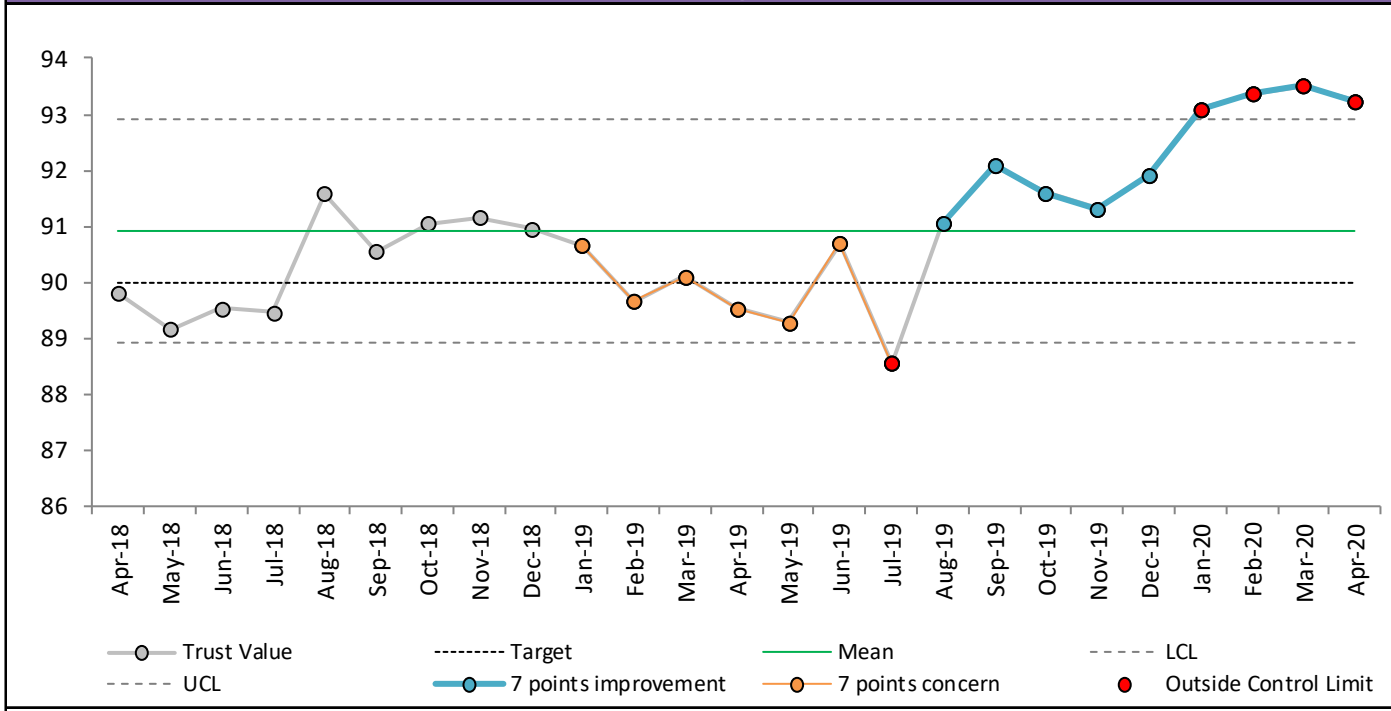
Timescale

- Detailed action plan supporting DToC - targeting wards that require additional support.
- July/August 2020

Responsive

South Tees Hospitals NHS Foundation Trust

E-Discharge (%)



The % of clinical discharge letters which were sent within 24 hours

Target	90
Mean	90.91
Last Month	93.24

Executive Lead

Johanna Reilly

Operational Lead

Commentary

Variable performance completing E-discharges within target – focus on discharge processes has led to an improved position of late.

Cause of Variation

- Improving position as COVID 19 activity decreases.

Planned Actions

- Continue to work with Clinical Directors to ensure e-discharges are prioritised and completed within 72 hours.
- Additional computers on wheels ordered to support timely discharges .

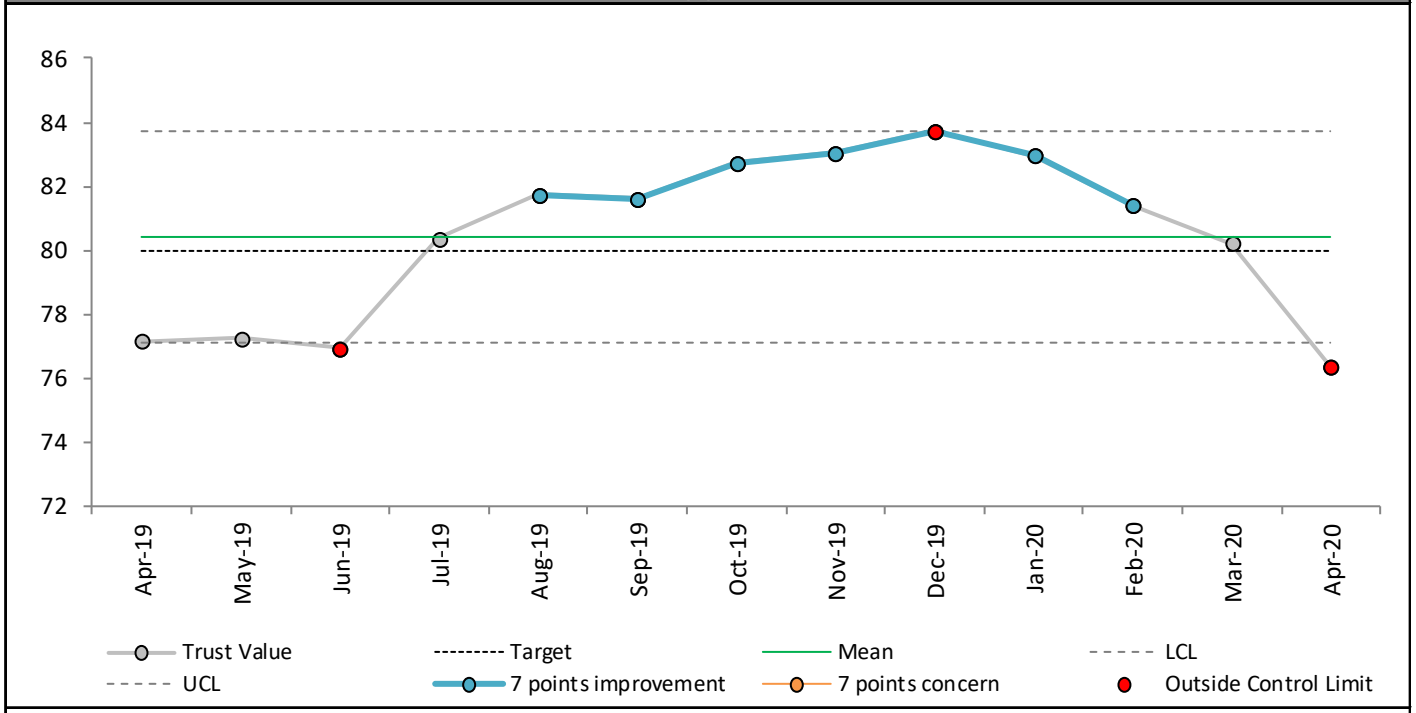
Timescale

- Monthly review of compliance
- August 2020

Well Led

South Tees Hospitals NHS Foundation Trust

Annual Appraisal (%)



Annual Appraisal Rate

Target	80
Mean	80.42
Last Month	76.33

Executive Lead

Rachael Metcalf

Operational Lead

Jane Herdman

Commentary

Cause of Variation

- Planning and managing national COVID-19 pandemic.
- Managers focussed on alternative pressures resulting in non-completion of people related targets.
- HR team realigned to support COVID-19 .

Planned Actions

- Re-distribute SDR overdue data to managers and identify hotspot areas.
- Review the approach to completion of SDRs – provide a tight timescale to reach compliance (4 months)
- HRBPs to discuss outstanding SDRS and prioritisation with OD's for each Centre.

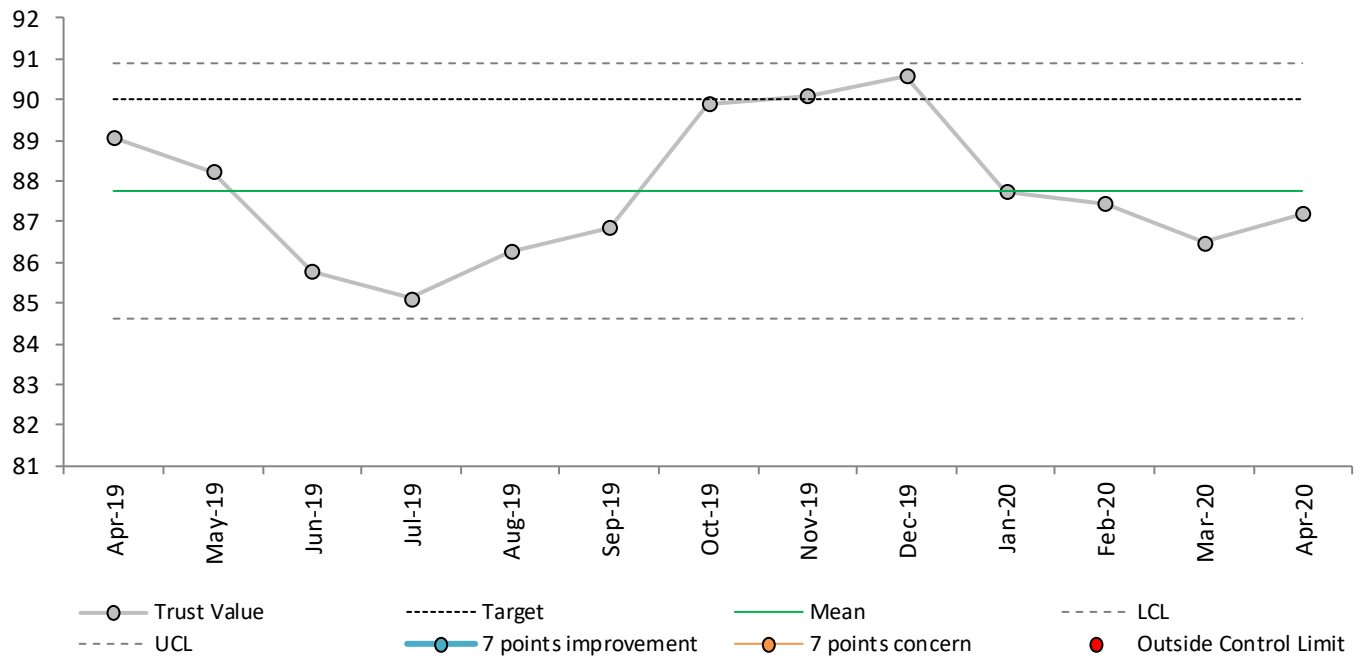
Timescale

- End May 2020
- End May 2020
- End May 2020

Well Led

South Tees Hospitals NHS Foundation Trust

Mandatory Training (%)



The % of Mandatory Training Compliance

Target	90
Mean	87.75
Last Month	87.20

Executive Lead

Rachael Metcalf

Operational Lead

Jane Herdman

Commentary

Cause of Variation

- COVID-19 resulting in staff being redeployed to alternative duties.
- Limited data provision regarding overdue Mandatory Training elements.
- Trust Induction suspended during COVID pandemic.

Planned Actions

- Produce appropriate data and submit to managers.
- Review timescale for completion with a view to reaching compliance within a 4 month timescale.
- Re-establish project group to transfer mandatory training elements onto ESR .

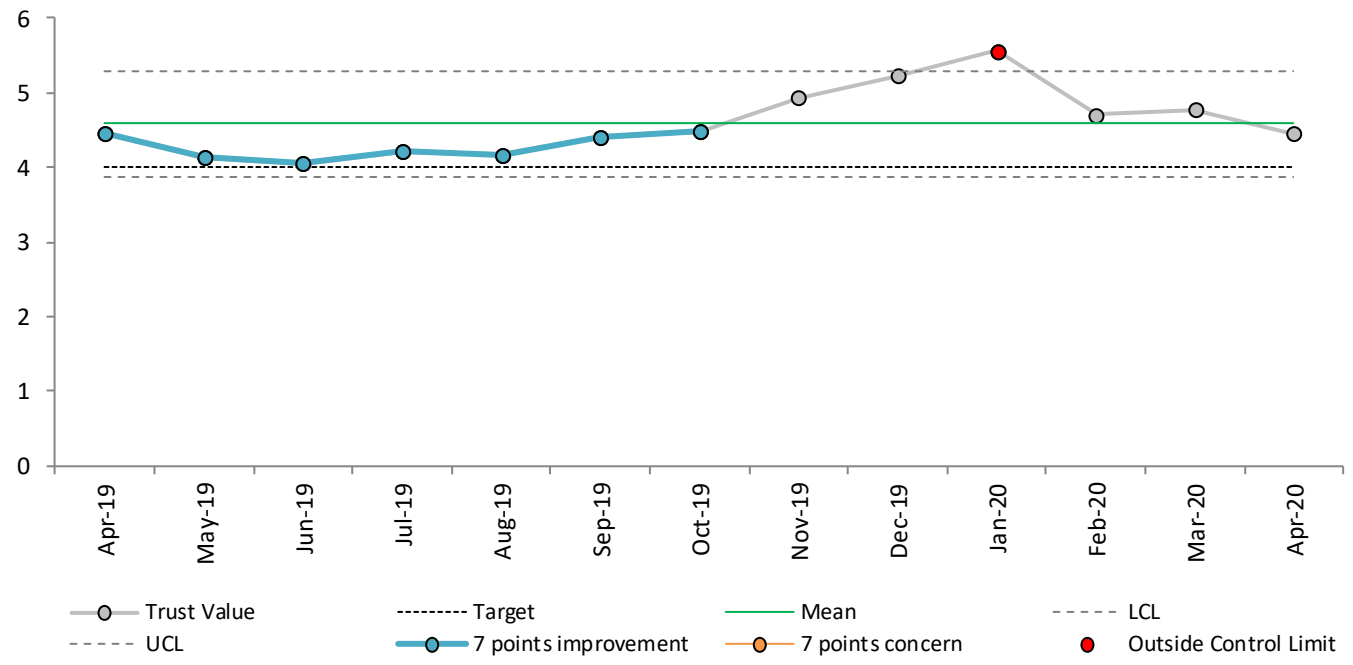
Timescale

- End May 2020
- End May 2020
- End June 2020

Well Led

South Tees Hospitals NHS Foundation Trust

Sickness Absence (%)



The % of monthly sickness absence

Target	4
Mean	4.58
Last Month	4.45

Executive Lead

Rachael Metcalf

Operational Lead

Jane Herdman

Commentary

Cause of Variation

- Focus on COVID-19 pandemic and related absence.
- Limited data provision due to above.
- Formal absence meetings l suspended since March 2020 due to COVID-19 – agreed with Staff Side .

Planned Actions

- Renew focus on BAU absence by providing appropriate data and identifying staff who have reached trigger points etc.
- Re-establishment formal absence meetings .
- HRBPs to discuss absence hotspots within Centre Operational Meetings .

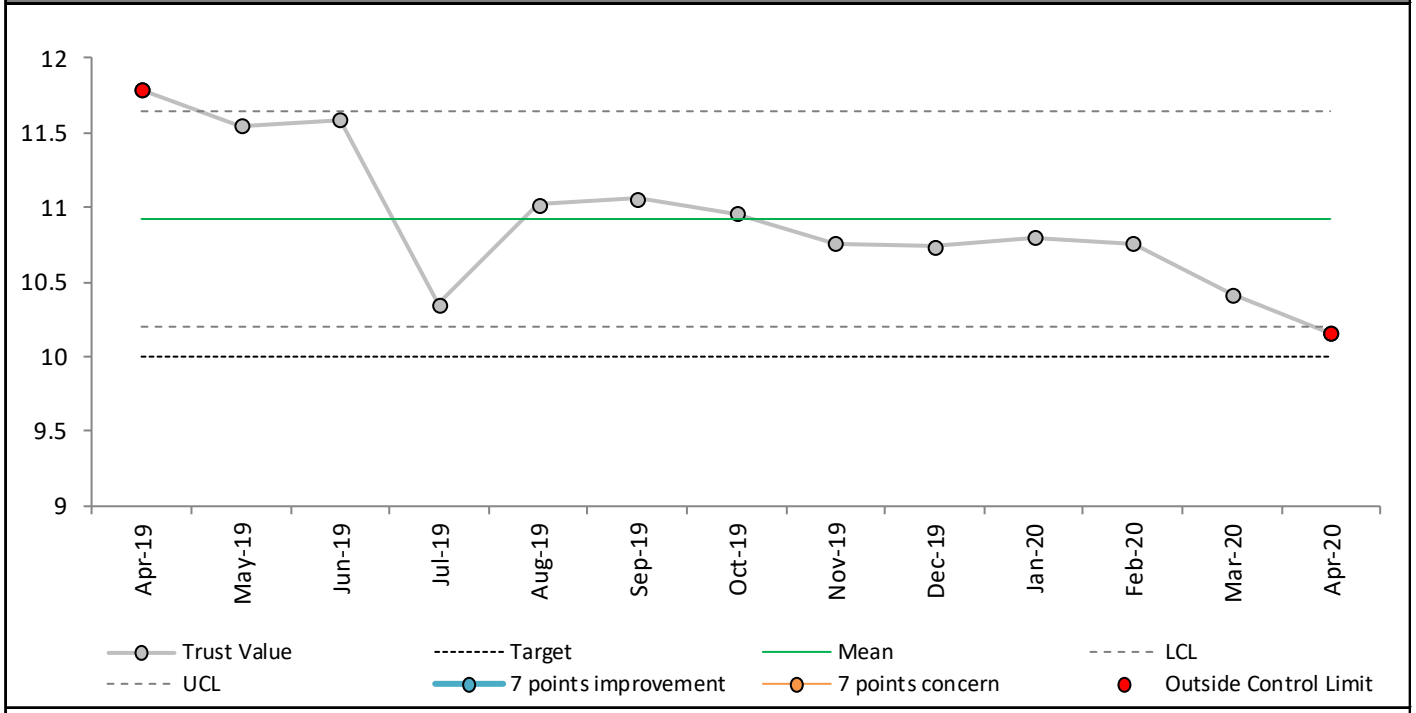
Timescale

- End May 2020
- Mid June 2020
- End May 2020

Well Led

South Tees Hospitals NHS Foundation Trust

Staff Turnover (%)



Staff turnover rate

Target	10
Mean	10.92
Last Month	10.16

Executive Lead

Rachael Metcalf

Operational Lead

Jane Herdman

Commentary

Cause of Variation

- Decrease in staff turnover due to COVID-19 pandemic .
- Increase focus on engagement, well being and retention.

Planned Actions

- Conduct exit interview exercise with all staff who have left organisation since January 2020.
- Review Exit Interview process – discuss at Centre level and agree implementation process.
- Staff Engagement - Re-establish Staff Survey outcomes and support development of action plans.

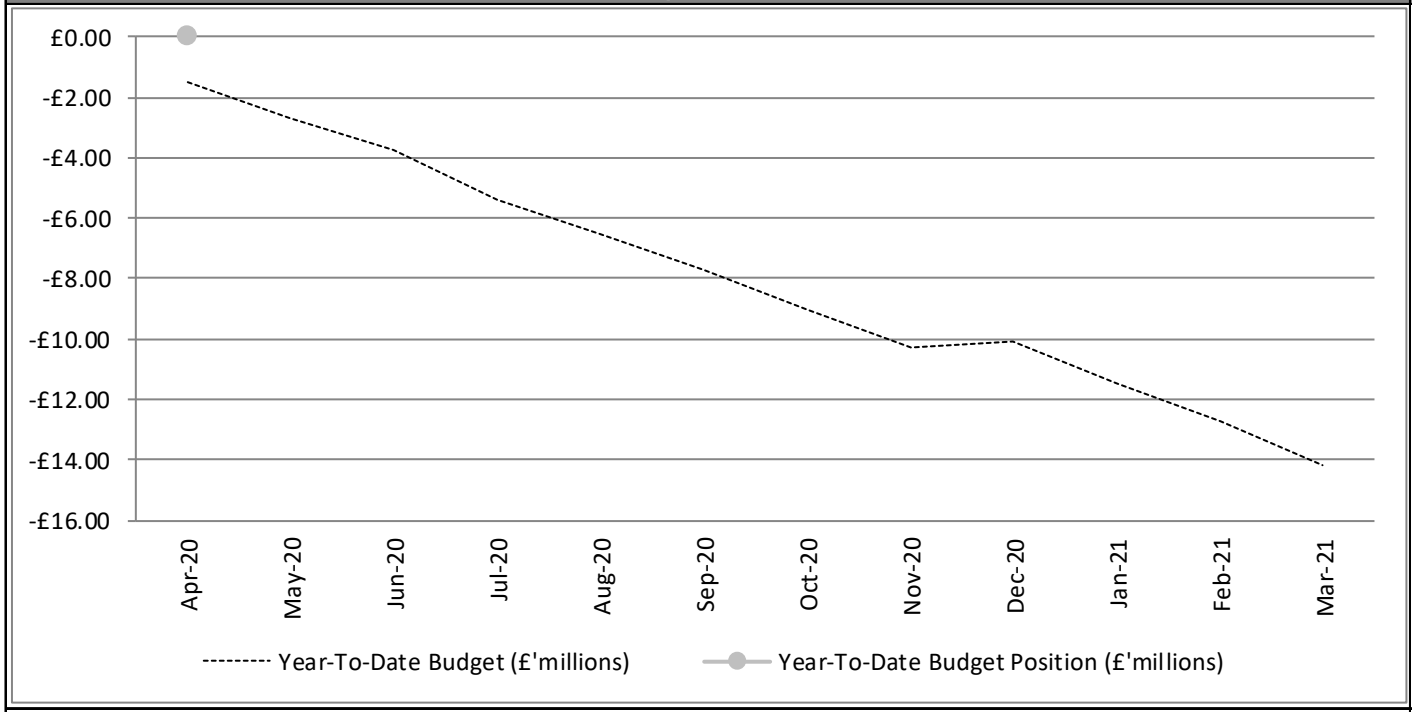
Timescale

- End May 2020
- End June 2020
- End June 2020

Well Led

South Tees Hospitals NHS Foundation Trust

Year-To-Date Budget Position (£'millions)



Year-To-Date Budget Position

Target	-1.50
Mean	N/A
Last Month	0.00

Executive Lead

Steven Mason

Lead

Luke Armstrong

Commentary

The Trust has recorded a break even position for month 1, as required by the new financial arrangements from NSHE/I. Leading to the Trust being £1.5m ahead of its internal budget.

Cause of Variation

- In month Covid-19 specific costs of £0.4m on pay and £2.5m on non pay, these have been assumed as reimbursed by NHSE/I.
- Large underspends noticed on clinical supplies £1.3m and Drugs £0.5m due to reductions in activity.

Planned Actions

- Continuation of detailed monitoring of pay costs to challenge and ensure appropriateness of any additional spend.
- Review of Covid-19 specific expenditure in line with revised NSHE/I guidance for M2.

Timescale

- Review and implementation of new NHSE/I guidance for M2.
- On-going review of pay costs.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 June 2020			
Provider Licence Self Certification			**AGENDA ITEM: 11** **ENC 7**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Alan Downey Chairman Sue Page Chief Executive
Action Required	Approve ☒ Discuss ☐ Inform ☐ (select the relevant action required)		
Situation	An assessment has been undertaken against the NHS provider licence. The results are attached for consideration along with a recommendation to approve the assessment.		
Background	All NHS Foundation Trusts are required to self-certify whether or not they have: i) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the NHS Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012 whilst having regard to the NHS Constitution; and ii) the required resources available if providing commissioner requested services (CRS); and iii) complied with governance requirements.		
Assessment	A review of the provider licence and supporting evidence has been undertaken and the following assessment has been proposed: 1. The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3) – NOT CONFIRMED 2. The provider has complied with the required governance arrangements Condition FT4(8)- PART CONFIRMED. 3. If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver designated services Condition CoS7(3) – CONFIRMED		
Recommendation	Members of the Trust Board are asked to approve the assessment of compliance against the provider licence.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 1.3a - Risk of further breaches to condition 4 of the Trust Provider licence could result in further enforcement undertakings and licence conditions		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust	Excellence in patient outcomes	Excellence in employee	

Strategic objective this report aims to support)	and experience ☒	experience ☒
	Drive operational performance ☒	Long term financial sustainability ☒
	Develop clinical and commercial strategies ☒	

NHS Foundation Trust Self-certification

1. PURPOSE OF REPORT

The purpose of the report is to provide assurance to the Trust Board that the Trust is meeting the conditions set out in the Provider Licence and therefore able to make a declaration of compliance in line with the deadlines identified.

2. BACKGROUND

All NHS Foundation Trusts are required to self-certify whether or not they have: i) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the NHS Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012 whilst having regard to the NHS Constitution; and ii) the required resources available if providing commissioner requested services (CRS); and iii) complied with governance requirements.

3. DETAILS

NHS Improvement (NHSI) guidance requires NHS providers to self-certify after the financial year end. The self-assessment much include 'confirmed' or not 'confirmed' as appropriate for their declaration. For those that choose 'not confirmed' an explanation describing the reasons is required.

The aim of the self-certification is for providers to carry out assurance that they are in compliance against the following three Licence Conditions:

1. The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (**Condition G6(3)**
2. The provider has complied with the required governance arrangements **Condition FT4(8)**.
3. If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver designated services **Condition CoS7(3)**

3.1 Condition G6(3)

Condition G6(2) requires NHS Foundation Trusts to have processes and systems that:

- Identify risks to compliance;
- Take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

3.1.1 Recommendation

In keeping with the return made since 2015/16 self-certification is **"Not Confirmed"** compliance against the licence condition. This is on the basis that the Trust received additional modifications to the licence relating to the lack of financial control and failure to demonstrate a plan for recovery.

A copy of the return is provided at appended.

3.2 Condition FT4(8)

Condition FT4(8) requires NHS Foundation Trusts to:

- review their governance systems to identify if they achieve the objectives set out in their licence condition. There is no set approach to meeting these standards and objectives but NHSI expect a compliant approach would involve effective Board and Committee structures, reporting lines and performance and risk management systems; and
- review whether Governors have received enough training and guidance to carry out their roles.

3.2.1 Recommendation

Provided at Appendix 2 is evidence of assurance against each declaration to support the Trust's self-certification. The Trust is unable to make an overall declaration to support this self-certification as the self-certification identifies one area as **Not Compliant** and one as **Part Compliant.**

3.3 Condition CoS7

Only NHS Foundation Trusts that are designated as providing CRS are required to self-certify under Condition CoS7(3). CRS are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and are subject to regulation by NHS Improvement. Providers can be designated as providing CRS due to:

- There is no alternative provider close enough
- Removing the service would increase health inequalities
- Removing the services would make other related services unviable.

The Trust is required to self-certify to the effect that it 'confirms' to be one of the following three declarations regarding the resources required to provide CRS:

A. The required resources will be available over the next financial year;
   OR
B. The required resources will be available over the next financial year but specific factors may cast doubt on this;
   OR
C. The required resources will not be available over the next financial year.
   Requires resources include: management resources, final resources and facilities, personnel, physical and other assets.

3.3.1 Recommendation

The Trust recommends **"Confirmed"** due to its compliance with Statement (B) on the basis of the Aligned Incentive Contract arrangements established with the Trust's main commissioners and joint working arrangements across the Southern ICP.

A copy of the return is provided at appended.

4. RECOMMENDATIONS

The Trust Board of Directors is asked to:

1. Note evidence and support the sign-off of the Trust's annual self-certification;

APPENDICES

Appendix

Appendix 2

Corporate Governance Statement 2019/20 – Sources of Assurance

(Under NHS FT condition 4 (the governance condition), Boards are required to make a corporate governance statement outlining anticipated compliance (or otherwise) with the governance condition and risks to this).

Licence provision	Enforcement issued (yes/no)	Condition Number	Corporate Governance Statement	Response	Evidence for compliance with licence provision	Enforcement details
FT4	Yes	2	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Not Confirmed**	• Trust's governance enforcement action from 2014 was removed in October 2017; • Annual Governance Statement provides assurance on the strength of Internal Control regarding the risk management process, review and effectiveness; • Head of Internal Audit Opinion for 2019/20; • Internal audit plan agreed and overseen by Audit Committee; • Follow up reviews to check compliance with internal audit recommendations; • Trust Board Committee Structure and revised Terms of Reference were revised; • In July 2019 the Trust received an overall rating of 'requires improvement' and the report contained 26 'must do' recommendations and 22 'should do recommendations. A detailed action plan to address all recommendations is overseen by an Oversight Group. An update is provided to the Quality Assurance Committee and Trust Board. • Throughout January and February 2020 a series of confirm and challenge sessions have been held with operational and director leads. These	Modifications to the existing additional licence condition imposed on the Trust under section 111 of the Health and Social Care Act 2012 ("the Act") on 2 July 2014 made on 30 October 2019. a. The Licensee's failure to apply principles, systems and standards of good corporate governance;

					sessions have focussed on the 'must do' recommendations and have facilitated discussions relating to evidence, action plans, assurance and risk. • Annual Operational Plan 2019/20 (Budget) approved by Board; • Feedback from Board to Board meetings with NHSE/I; • Monthly finance reports to the Board; • Monthly performance reports to the Board; • Programme of regular Board quality reports and monitoring information including patient safety, patient experience including incidents, complaints and infection control; • Board Assurance Framework and SubCommittee review of key strategic risks; • Risk management policy; • DSP Toolkit action plan for compliance; • Revised Constitution to meet 2006 NHS Act and 2012 Health and Social Care Act; • Governor elections held in accordance with model election rules; • Trust Standing Orders and Financial Instructions reviewed annually; • Directors, Governors and Decision Making Staff Register of Interests; and • Fit and Proper Persons Regulation Checks including director insolvency and director baring, DBS and reference checks as well as self-declaration submissions.	
	Yes	3.	The Board has regard to such guidance on good	**Confirmed**	• All guidance issued by NHSI is reviewed by the appropriate members of the	

			corporate governance as may be issued by NHS Improvement from time to time.		Senior Leadership Team/Company Secretary and implemented as appropriate/ relevant. • Audit Committee receives a standing technical update from KPMG identifying action requires/items for information. Declarations are made within Annual Report.	
	Yes	4	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures;	**Confirmed**	Board Committee and Reporting Structure including: • Audit Committee • Nomination Committee • Remuneration Committee • Finance & Investment Committee • Quality Assurance Committee • Workforce & OD Committee • Senior Leadership Team • Clinical Policy Group • Revised Terms of Reference to ensure the Trust meets regulatory, legal requirements and good practice to ensure it is fit for purpose; • Annual review of Committee effectiveness against Terms of Reference; • Board self assessment Well-led governance review carried out; • Revised Annual cycle of business for the Board and Board Committees; • Action Logs for Board and Board Committees; In line with reporting lines between Committees, the Audit Committee reviews Terms of Reference of aligned to Board Committees	
	No		(b) Clear responsibilities	**Confirmed**	• All Board Committees, Clinical Policy	

			for its Board, for Committees reporting to the Board and for staff reporting to the Board and those Committees; and		Group and standing reporting Committees /Groups have Terms of Reference in place; • Responsibilities are in line with Trust Standing Orders, Standing Financial Instructions and Scheme of Delegation reviewed and presented to Audit Committee; • Risk management policy outlines flow of information through organisation regarding risk and the management of corporate and local risk and how these are escalated and de-escalated. A review of the Executive Risk Group was undertaken and it was agreed that the work of this group would be subsumed into the Senior Leadership Team (SLT) who dedicate one meeting per month to review the Corporate Risk Register. SLT holds Centres and Corporate Directorates to account for timely and appropriate management of clinical and non-clinical risk, ensuring the trust has effective systems for the management of risk registers.	
	No		(c) Clear reporting lines and accountabilities throughout its organisation.	**Confirmed**	• Terms of Reference for Committees include purpose, membership, duties and reporting arrangements; • Board Committees Chairs all present summary reports via Chair's Logs to the Board highlighting any escalation items; • Annual Governance Statement is confirmed by Audit Committee to assess consistency with Committee's view on the Trust's system of internal control;	
	Yes	5	The Board is satisfied	**Not**	• As part of its review and approval of the	Modifications to the existing

			that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	**Confirmed**	Operational Plan (Budget) for the forthcoming period the Board has reviewed in detail key areas of potential risk in respect of performance that may impact on compliance with its licence. These relate to the Trust's duties with regard to financial performance; • Areas of potential risk have been reported to the Board through the above processes and are documented in the Operational Plan (Budget report) and Board Assurance Framework; • The Board's Finance and Investment Committee and Quality Assurance Committee provide on-going review, scrutiny and monitoring of required development actions throughout the year – ensuring that the Board has appropriate mechanisms to respond should any concerns develop during the year; • Annual internal audit cycle confirmed by Annual accounts Audit Opinion reported to Audit Committee; • Audit Committee annual work plan including focus on key BAF risks; • Annual Planning arrangements.	additional licence condition imposed on the Trust under section 111 of the Health and Social Care Act 2012 ("the Act") on 2 July 2014, updated in on September 2017 and made on 30 October 2019. b. The Licensee's lack of financial control and failure to demonstrate a plan for recovery;
	Yes		(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	**Not Confirmed**	The Board has access on an on-going basis to inform its assessment of the risks to compliance with its licence: • Monthly performance data is reported to the Board and reviewed in respect of regulatory targets and standards. In addition, the Board receives a programme of regular quality reports and monitoring information in respect of workforce information, patient safety, patient experience including incidents, complaints and infection control;	Modifications to the existing additional licence condition imposed on the Trust under section 111 of the Health and Social Care Act 2012 ("the Act") on 2 July 2014 made on 30 October 2019. d. Any other issues relating to the Licensee's governance, finance and operations, which are causing or contributing to, or

					• Monthly Board finance reports track the overall financial position/performance against efficiency savings and key financial risks; and • Board consideration of financial risk ratings.	which may cause or contribute to breaches, or the risk of breach of the conditions of the licence."
	Yes		(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	**Not Confirmed**	• Quality priorities agreed by the CoG • Quality Dashboard received by Board monthly; • Updates against any CQC Action Plans is reported to Quality Assurance Committee • Reports to Board and Quality Assurance Committee; • Risk Management Policy (risk registers/BAF); • Incident Reporting; • DSP Toolkit submitted annually; • The Trust is fully compliant with the CQC registration requirements. In July 2019 the Trust received an overall rating of 'requires improvement' and the report contained 26 'must do' recommendations and 22 'should do recommendations. A detailed action plan to address all recommendations is overseen by an Oversight Group. A monthly update is provided to the Quality Assurance Committee and Trust Board. • Cleanliness audits / PLACE inspections / Clinical Audit & Effectiveness programme / Infection Control Standards / Complaints monitoring; • CCG contract review meetings; • Routine finance, performance and quality reports to the Board, Board	Modifications to the existing additional licence condition imposed on the Trust under section 111 of the Health and Social Care Act 2012 ("the Act") on 2 July 2014 made on 30 October 2019. c. The Licensee's operational failures relating to quality and safety;

					Committees .	
	Yes		(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	**Not Confirmed**	• SFIs, Standing Orders and scheme of delegation reviewed annually by Audit Committee; • Going concern paper presented to Audit Committee and Board annually confirming Directors agreement to on-going financial viability; • Monthly Board finance reports presented to Finance and Investment Committee and Board, including progress on delivery of efficiency savings programme; • Internal audit reports on financial systems and controls; • Standard financial reporting to Audit Committee; • External audit report, Annual Accounts and Annual Report; and • Approval of financial plan as part of 19/20 Operational Plan submission to NHSI.	Modifications to the existing additional licence conditions imposed on the Trust under section 111 of the Health and Social Care Act 2012 ("the Act") on 2 July 2014, updated on 20 September 2017 and made on 30 September 2019 in relation to financial governance. In June 2019, NHSE/I wrote to the Trust to highlight the concerns regarding the financial position and set out steps in line with the North regional escalation process. As a result of the escalation process a recovery action plan and benchmark review against NHS Improvement Grip and Control checklist was implemented.
	Yes		(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	**Confirmed**	• Annual cycle of business for Board and Board Committees ensures appropriate scheduling of reports.	
	Yes		(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the	**Confirmed**	• Trust risk register and Board Assurance Framework reports key compliance risks for quality and patient safety, finance, performance and reputational risks; • Risks and mitigations identified in Operational Plan/Annual Report;	

			Conditions of its Licence;		• Head of internal audit opinion; • Statutory annual audit; • Annual Governance Statement; • Assessment work as part of Board self-declaration against Board statements – incorporated within annual cycle of business; and • Monthly Board reports cover performance against key performance indicators.	
	No		(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	**Confirmed**	• Annual planning cycle / process to develop business plans with stakeholder involvement; • Finance Investment Board • Finance Investment Committee • Clinical Policy Group clinical decision making on priority of resources • NHSI/E and CQC feedback considered by Board.	
	Yes		(h) To ensure compliance with all applicable legal requirements.	**Confirmed**	• Governance arrangements (constitution, licence, standing orders); • Annual cycle of Board business; • Reporting to NHSE/I; • Audit Committee; • Board Assurance Framework; • Risk Management Policy; • Monthly Chief Executive's report to the Board; • Performance report to the Board; • NHS FT Code of Governance compliance reviews; • Internal Audit reports provide assurance that systems and processes are in place relevant to specific areas audited. When any limited assurance is been provided	

					this is closely monitored and progress monitored against action plans.	
	Yes	6	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	**Confirmed**	• Board composition - membership of the Board is considered balanced, complete and appropriate; • Changes were made to the Board during 2019/20 which included the interim appointment of a Chief Executive a new Non-executive Director both from 1 October 2019. In addition, a Medical Director resigned on 31 December 2019 and the permanent CEO, left the Trust on 30 September 2019. A Non-executive Director, left the Trust on 31 March 2020. All changes were approved by the Nomination and Remuneration Committees and endorsed by the Council of Governors and Board of Directors. • Register of Interests; • Fit & Proper Persons Regulation Policy and Procedure in place and annual review confirming compliance; • Deputy Chair is in place; • Senior Independent Director is in place.	
	Yes		(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	**Confirmed**	• Approved Quality Priorities • Board routinely receives reports on quality, providing details of incidents, complaints, patient feedback and other indicators of quality • Process for quality impact assessment is in place which is required to be reported to the Quality Assurance Committee.	
	No		(c) That the Board	**Confirmed**	• The Trust operates a range of	

			receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;		evaluation, measurement and reporting systems in order to ensure that a wide range of essential quality data is regularly and routinely analysed and challenged; • Internal Auditor reports on quality of data; • Quality Accounts/Report; and there is an appropriate level of high-level reporting to the Board in this area with risk, clinical effectiveness and patient experience reports presented to the Board on a regular and timely basis.	
	No		(d) The collection of accurate, comprehensive, timely and up to date information on quality of care;	**Confirmed**	• Annual Governance Statement – provides assurance on data quality; • Internal Audit Data Quality; • Clinical Audit workplan oversight by Audit Committee. •	
	No		(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	**Confirmed**	• Non-executive Directors are fully engaged with the Trust's quality agenda via their Chairmanship of Board Committees. • Chief Executive, Medical Directors and Director of Nursing regularly meet with Clinical Directors and clinical leaders across the Trust; • The Board actively engages with its key stakeholders on quality through: - analysis of staff survey results and patient survey results (including Friends and Family test)/Open Forum) - Governor involvement in strategic planning - Patient and Staff Stories	

					presented to Board meetings - Local health overview and scrutiny committee. • Governors provide feedback on quality of services through involvement in PLACE assessments and Outpatient assessments.	
	No		(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	**Confirmed**	• Non-executive Directors are fully engaged with the Trust's quality agenda via their Chairmanship of Board Committees. • Chief Executive, Medical Directors and Director of Nursing regularly meet with Clinical Directors and clinical leaders across the Trust; • The Board actively engages with its key stakeholders on quality through: - analysis of staff survey results and patient survey results (including Friends and Family test)/Open Forum) - Governor involvement in strategic planning - Patient and Staff Stories presented to Board meetings - Healthwatch/local health overview and scrutiny committee. • Governors provide feedback on quality of services through involvement in PLACE assessments and Outpatient assessments.	
	No		(f) That there is clear accountability for quality of care throughout the Licensee including but	**Confirmed**	• Committee Structure reporting up to Board and Centre meetings provide a clear framework for overview and escalation;	

			not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		• Risks to quality identified through routine monitoring of key performance indicators. Where necessary quality risks are escalated from ward to Board and through the Risk Register and BAF as necessary; • Quality Assurance Committee Terms of Reference; • Executive Directors job descriptions; • Trust Values	
	Yes	7	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	• Appraisals for Chief Executive and Executive Directors undertaken and overview reported to the Remuneration Committee; • Nominations Committee reviews the Board's balance at the outset of any recruitment campaign; • Board contains appropriately qualified Director of Finance, Medical Director; Director of Nursing and Non-executive Director with accounting qualification; • Board focus on recruitment key performance indicators; • Safe staffing report presented to Board monthly. • Revalidation process for doctors and nurses has been implemented with progress assurances provided to Board.	
Other Declarations						
	No		Training of Governors The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors,	**Confirmed**	• Regular training is provided by Executive Directors on themed topics such as finance, strategic developments, quality and performance; • Development and induction sessions delivered to Governor's regarding their statutory responsibilities;	

			as required within s151(5) of the health and Social Care Act, to ensure that they are equipped with the skills and knowledge they need to undertake their role.			

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

South Tees Hospitals NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

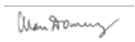
Worksheet "FT4 declaration" | **Financial Year to which self-certif 2019/20**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
2	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Not confirmed	Please see Annual Governance Statement
3	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Please see Annual Governance Statement
4	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Please see Annual Governance Statement
5	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Not confirmed	Please see Annual Governance Statement and note this is part confirmed due to 3 confirmed and 3 not confirmed.
6	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Please see Annual Governance Statement
7	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Please see Annual Governance Statement

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature  **Signature** 

Name Sue Page **Name** Alan Downey

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Worksheet "Training of governors"

Financial Year to which self-certification relates 2019/20

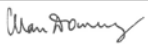
Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sue Page	**Name**	Alan Downey
Capacity	Chief Executive	**Capacity**	Chairman
Date	28 May 2020	**Date**	28 May 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

South Tees Hospitals NHS Foundation Trsut

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2019/20

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Not confirmed

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust continues to face a challenging financial agenda, and is actively working across the Southern ICP System with parties to address the financial challenges of the Tees Valley.

The lack of available capital funding represents a major risk to the Trust given a prolonged period of reduced capital expenditure. The Trust is seeking emergency capital funding via NHS England/Improvement and reviewing/prioritising all capital expenditure bids to minimise clinical and organisational risk.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sue Page	**Name**	Alan Downey
Capacity	Chief Executive	**Capacity**	Chairman
Date	28 May 2020	**Date**	28 May 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

The Trust is currently under regulatory action for issues relating to failure to apply principles, systems and standards of good corporate governance, lack of financial control and failure to demonstrate a plan for recovery; operational failures relating to quality and safety; and issues relating to the Licensee's governance, finance and operations, which are causing or contributing to, or which may cause or contribute to breaches, or the risk of breach of the conditions of the licence. In addition the Head of Audit Opinion on the adequacy and effectiveness of governance, risk management and control for year ending 31 March 2020 is 'Substantial Improvement Required' this is due to the weaknesses in the framework of control which put the achievement of the Trust's objectives at risk.

Workforce Committee
Chair's Log

Meeting: Workforce Committee (Virtual Meeting)	**Date of Meeting** 12 May 2020
Key topics discussed in the meeting	
• Application of the Good Governance Guide to support assurance • Issues for staff from Covid19 – PPE, sickness, well-being, use of volunteers • Impacts for BAME staff from Covid19 and support offered • Mandatory training, education and leadership development • Staff KPI's	
Actions agreed in the meeting	Responsibility / timescale
• Note the data on distribution by Centre of staff isolating and the daily reviews • Noted the welfare checks undertaken every two weeks of staff absent because of Covid19 (shielding) and the support offered to the families of staff receiving hospital care • Noted the work done in liaison with the Chair of the BAME Network to ensure that staff are supported to remain safe • Noted that the recruited volunteers receive DBS checks • Agenda a discussion around nursing numbers and recruitment in view of persistent underspends and likely impacts on safe staffing of Covid 19 recovery planning • Explore the scope to utilise Physician Associates to add capacity to the workforce (and have an offer for current PA placements) • Given persistent low rates of training on Information Governance review how we secure greater ownership and adherence to principles and practice of good IG • Expressed satisfaction and congratulations for the ongoing work to develop and implement the leadership programmes	Deirdre Fowler / Rachael Metcalf David Chadwick / Rachael Metcalf Steven Orley / Rachael Metcalf

Issues for Board escalation/action	Responsibility / timescale
• Low levels of Information Governance training	Steven Orley / Rachael Metcalf by 31 July 2020

Finance and Investment Committee
Chair's Log

Meeting: Finance and Investment Committee (Virtual Meeting)	**Date of Meeting** 21st May 2020
Key topics discussed in the meeting	
• 2020/21 Baseline Budget & Coronavirus Emergency Measures • M1 Monitoring Report • Trust Cashflow and Liquidity • PFI Life Cycle • 2019/20 Financial Statements	
Actions agreed in the meeting	Responsibility / timescale
• The Committee conducted a thorough review of the 2020/21 Baseline Budget as requested by the Board and agreed the proposed budget and recommendations. It was noted that the budget is necessarily somewhat interim in nature and that further work is still needed to clarify the capital position. It was further noted that the Trust does not have credible plans to close the £25.7M deficit highlighted in the budget. • Financial monitoring is being conducted against an adjusted COVID-19 budget which is designed to generate a break-even position for Trusts. This is based on block and top up payments to fund expenditure. It was noted that the scheme currently shows a full year deficit of £14.2M for the Trust and the M1 position was reported as break-even after an additional assumed COVID-19 top up payment of £2.9M. • A review of the PFI Lifecycle scheme has been conducted and indicates a prepayment of £20.2M at 1st April 2020. A plan has been developed to write back to revenue £22.4M over the remaining period to the end of the contract. This needs further challenge to ensure Trust is getting best value.	Director of Finance As per NHSI/E requirements
Issues for Board escalation/action	Responsibility / timescale
• The Board is asked to note that FIC have signed off the 2020/21 Baseline Budget and recommendations, and to note that the Trust continues to carry a structural deficit in excess of £25M. This budget has not been approved by NHSI/E as special measures have been implemented to manage the COVID-19 pandemic.	

• The Board is also asked to note that the Baseline Budget does <u>not</u> include the £3.6M spend identified in Opthalmology to return the service to standard. Approval needs to be granted by NHSI/E for this work. • A detailed review of the content and phasing of the PFI spending plans provided by Endeavour is recommended to ensure that the best possible value is obtained for the Trust.	Senior Leadership Team Q3 2020 Director of Estates Q3 2020

Audit Committee
Chair's Log

Meeting: Audit Committee (by Teams)	**Date of Meeting**: May 21st, 2020
Highlights for: Board Meeting	**Date of Meeting**: June 2nd, 2020

Overview of key areas of work and matters for Board.

Counter- Fraud

1. Meeting reviewed CF progress and received the annual CF Report. Overall improvements identified and very positive outcome.
2. Update from National NHS Counter Fraud Authority following meeting with DoF and AC Chair was very positive – Audit One reported that this was the best seen in the region.
3. Local CF team also highlighted new frauds identified across the NHS occurring in current climate - particularly around changes in payment accounts and quick payments.

Internal Audit

4. Update provided to meeting and draft annual report tabled.
5. Cyber governance and security audit identified high risk areas that need addressing. Actions in place but Board / SLT need to support funding if necessary.
6. The overall IA status has deteriorated to "significant risk" due in main to the increased cyber security risks identified in PWCs audit.

External Audit / Annual accounts

7. KPMG updated year end audit process.
   - No Quality Account / Report audit this year due to Covid
   - There will likely be material uncertainty qualifications due to Valuation of assets and going concern in the current Covid environment. KPMG and other Audit firms are having national discussions with NHSE/I to get consistent approach.
   - VFM will be qualified as still in enforcement.
   - All on track for June 25th delivery of final accounts
   - AC scheduled for June 18th to get final sign off.

Actions to be taken	Responsibility / timescale
• DoF / IT team to action cyber governance and security audit actions and ensure funding where necessary is gained.	DoF / SLT
Board action	**Responsibility / timescale**

• Board to delegate to AC sign off of Annual Accounts • Mazzars have been awarded External Audit contract from next year onwards - this has been ratified by CoG	Board / DoF

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee (by Teams)	**Date of Meeting**: 26th May 2020
Highlights for: Board Meeting	**Date of Meeting**: 2nd June 2020

Overview of key areas of work and matters for Board.

- Covid-19 slide deck
- Monthly Quality Report
- Ophthalmology report
- Gastroenterology progress update report
- Learning Disabilities Standards update
- Monthly Patient Safety & Legal Services Report March 2020
  - Serious Incidents Report
  - Claims
  - Inquests
- Quality Surveillance programme report
- Quality Priorities report
- Pharmacy Aseptic services report
- Children and young people's services during COVID-19 pandemic
- QEIA for whole hospital change managing the pandemic
- Review of Risks and Matters for the Board Assurance Framework

Actions to be taken	Responsibility / timescale
• In response to the reported increased mortality rate at Redcar PCH the committee were told following review that there were no excess deaths. Further explanation was requested.	Deidre Fowler
• QAC received verbal assurance that the trust was compliant with the new NHSE/I Infection Control Framework which is being considered at the trust wide infection control meeting.	Deidre Fowler
• Compliance with the Specialist Services Quality Surveillance (SSQS) standards is a concern. SSQS to have greater awareness across the organisation and to return to QAC quarterly.	Deidre Fowler & Joanna Reilly

• Limited assurance was provided about services for learning disability patients. The committee were advised that an objective and independent review was being sought.	Deidre Fowler
• Evidence to the next QAC to reduce the risks to BAF 2.3 & 2.5	Deirdre Fowler
• Services in Phase 1 of the improvement plan / recovery to come to QAC over the next few months	Jackie White / Johanna Reilly
Board action	**Responsibility / timescale**
• COVID19 - QAC noted that the estate configuration does not lend itself to good IP&C practice at all times.	Deidre Fowler
• A never event was reported to QAC the committee asked for the LOCSIP process and compliance to be looked at by internal audit.	David Chadwick
• The incidence of patient falls and pressure ulcers remain a significant focus on the agenda.	
• QAC were advised that a large working group are reviewing the available bed capacity and the ability to respond to fluctuating demand. That the QEIA process led by the DON and MD is robust in signing off the changes that are required.	Deidre Fowler
• A comprehensive report on the actions in ophthalmology was received. QAC was advised that all notes would be reviewed by end May 2020.	Deidre Fowler & Joanna Reilly
• It was noted that significant progress has been made in reviewing and actioning the issues.	Joanna Reilly
• Concerns continue to be expressed about the risks in GI services including long waits and workforce.	
• 2020/21 Quality Priorities were agreed by QAC.	

	Deidre Fowler and Joanna Reilly
Risks (Include ID if currently on risk register)	Responsibility / timescale
• BAF risk 2.1(2) Due to gaps in compliance in medication practice there is a risk of avoidable patient harm leading to reputational damage. It was agreed to reduce from the BAF to the risk register.	Jackie White