South Tees Hospitals
NHS Foundation Trust

# BOARD OF DIRECTORS (PUBLIC)

Date – 5 October 2021
Time – 13:00 – 13:20 for public access via Microsoft teams
Venue – Board Room, Murray Building and virtually on Microsoft teams

Safety and Quality First

South Tees Hospitals NHS Foundation Trust

**MEETING OF THE SOUTH TEES HOSPITALS NHS FOUNDATION TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON 5 OCTOBER 2021 AT 13:00 IN THE BOARD ROOM AND MICROSOFT TEAMS**

**AGENDA**

| | ITEM | PURPOSE | LEAD | FORMAT |
|---|---|---|---|---|
| **STAFF STORY** | | | | |
| **Access to public and press to the Board of Directors meeting will be available via the following link at 13:20**<br><br>Microsoft Teams meeting<br><br>**Join on your computer or mobile app**<br><br>Click here to join the meeting | | | | |
| **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 7 September 2021 | Approval | Chair | ENC 2 |
| 5. | Matters Arising / action log | Review | Chair | ENC 3 |
| 6. | Chairman's report | Information | Chair | ENC 4 |
| 7. | Chief Executive's Report | Information | Chief Executive | ENC 5 |

| | ITEM | PURPOSE | LEAD | FORMAT |
|---|---|---|---|---|
| 8. | Board Assurance Framework | Discussion | Head of Governance & Company Secretary | ENC 6 |
| **SAFE** | | | | |
| 9. | Safe Staffing Report | Information | Chief Nurse | ENC 7 |
| 10. | Guardian of safe working | Information | Guardian | ENC 8 |
| **EFFECTIVE** | | | | |
| 11. | Consultant appointments | Information | Chief Executive | Verbal |
| **RESPONSIVE & CARING** | | | | |
| 12. | Freedom to speak up report | Information | Guardians | ENC 9 |
| 13. | WRES and WDES | Information | Director of HR | ENC 10 |
| 14. | Learning from deaths report | Information | Chief Medical Officer | ENC 11 |
| **WELL LED** | | | | |
| 15. | Finance Report Month 5 | Information | Chief Finance Officer | ENC 12 |
| 16. | Integrated Performance Report | Discussion | Chief Operating Officer | ENC 13 |
| 17. | CQC update | Information | Chief Nurse | ENC 14 |
| 18. | Committee Reports | Information | Chairs | ENC 15 |
| | | | | |
| | **DATE OF NEXT MEETING**<br>The next meeting of Board of Directors will take place on Tuesday 2 November 2021 | | | |
| | **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** | | | |

| | ITEM | PURPOSE | LEAD | FORMAT |
|---|---|---|---|---|
| | **to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960)** | | | |

South Tees Hospitals
NHS Foundation Trust

| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 October 2021 | | | |
|---|---|---|---|
| Register of members interests | | | **AGENDA ITEM: 3**<br>**ENC 1** |
| **Report Author and Job Title:** | Jackie White<br>Head of Governance & Company Secretary | **Responsible Director:** | Derek Bell<br>Chairman |
| **Action Required** | Approve ☐ Discuss ☐ Inform ☒<br>(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** | The Board of Directors are asked to note the Register of Interest. | | |
| **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) | Best for safe, clinically effective care and experience ☒ | A great place to work ☒ | |
| | Deliver care without boundaries in collaboration with our health and social care partners ☒ | Make best use of our resources ☒ | |
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒ | | |

South Tees Hospitals NHS
NHS Foundation Trust

Board of Directors Register of Interests

| Board Member | Position | Relevant Dates From | to | Declaration Details |
|---|---|---|---|---|
| **Ada Burns** | Non-Executive Director<br>Deputy Chair | 2017<br>2019 | Ongoing<br>Ongoing | Role - Governor – Chair of Resources Committee, member of Board of Teesside University.<br>Role – Associate Consultant – Cratus Consultancy, public sector management consultancy |
| **Richard Carter-Ferris** | Non-executive Director | 1 August 2015 | ongoing | Director of Yorkshire Area P2P Club – company generates donations for Yorkshire Air Ambulance.<br>Director/No exec Director – Malton & Norton Golf club ltd. |
| **Mike Ducker** | Non-executive Director | 1 December 2017<br>1 December 2005<br>1 October 2019 | ongoing<br>ongoing<br>ongoing | Advisor to UK Government on Chemicals Industry<br>Trustee of Greenstones Christian Trust Charity – a Charity working with prisons in Ethiopia<br>South Tees Healthcare Management Limited - Company number 10166808 |
| **Debbie Reape** | Non-executive Director<br>Senior Independent Director | August 2019<br>1 October 2019<br>October 2019 | Ongoing<br>Ongoing<br>Ongoing | Associate Director with Northumbria International Alliance (Northumbria NHS Trust and Northumberland County Council)<br>South Tees Healthcare Management Limited - Company number 10166808.<br>School Governor, Ashington Academy. |
| **Jackie White** | Head of Governance | March 2013 | Ongoing | Registered with IMAS (NHS interim management & support) |
| **Sue Page** | Chief Executive | May 2018 | Ongoing | President of British Red Cross – Cumbria. |
| **Kevin Oxley** | Director of Estates, Facilities and Capital Planning | | | No interests declared |
| **Rachael Metcalf** | Director of Human Resources | | | No interests declared. |
| **Mark Graham** | Director of Communications | | | Ad hoc communications support to North Cumbria integrated care NHS Foundation Trust.<br>Registered with IMAS (NHS interim management & support) |
| **Moira Angel** | Interim Director of Clinical Development | 18 January 2021 | | Director of Moira Angel consulting Ltd - Company number 09529658<br>Director of Arista Associates Ltd. - Company number 09986504<br>Vice president of the red cross in Cumbria. |
| **Robert Harrison** | Managing Director | | | No interests declared |

| | | | | |
|---|---|---|---|---|
| **Maria Harris** | Non-executive Director | 1 January 2021 | Ongoing | Director of Digital Cat Consultancy Ltd – provider of digital transformation and mortgage expertise in financial services - Company number 11967428<br><br>Non-executive Director of United Trust Bank – a regulated specialist bank |
| **David Jennings** | Non-executive Director | 1 January 2021 | Ongoing | Trustee Newcastle University Development Trust and Honorary Treasurer. Unremunerated, voluntary role.<br><br>Chair AuditOne Board NHS internal Audit Consortium. Unremunerated, voluntary role.<br><br>Board member, and Chair of Audit & Risk Committee of Bernicia House Group, a North East Social Housing Company – a remunerated role |
| **David Redpath** | Associate Non-Executive Director | 1 January 2021 | Ongoing | Director of DGR Consultancy - Company number 10340661 |
| **Michael Stewart** | Chief Medical Officer | 1 February 2021 | Ongoing | No interests declared |
| **Hilary Lloyd** | Chief Nurse | 15 February 2021 | Ongoing | No interests declared |
| **Chris Hand** | Chief Finance Officer | 2 July 2021 | Ongoing | South Tees Healthcare Management Limited - Company number 10166808 |
| **Samuel Peate** | Chief Operating Officer | 1 April 2021 | Ongoing | No interests declared |
| **Prof Derek Bell** | Joint Chair | April 2020<br><br>April 2018<br><br>April 2021 | Ongoing<br><br>Ongoing<br><br>Ongoing | Trustee Royal Medical Benevolent Fund – no remuneration<br><br>Chair and Trustee Tenovus Scotland (Edinburgh) – no remuneration<br><br>Centre for Quality in Governance – Dormant Ltd Company |

South Tees Hospitals NHS
NHS Foundation Trust

# UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 7 SEPTEMBER 2021 AT 13:00 IN THE BOARD ROOM, MURRAY BUILDING JAMES COOK AND VIA MICROSOFT TEAMS

**Present**

| | |
|---|---|
| Professor D Bell | Joint Chairman |
| Mrs A Burns | Vice Chair and Non-Executive Director |
| Ms D Reape | Non-Executive Director |
| Mr R Carter-Ferris | Non-Executive Director |
| Mr D Redpath | Associate Non-Executive Director |
| Ms M Harris | Non-Executive Director |
| Mr D Jennings | Non-Executive Director |
| Dr M Stewart | Chief Medical Officer |
| Dr H Lloyd | Chief Nurse |
| Mr C Hand | Chief Finance Officer |
| Mr R Harrison | Managing Director |

**In Attendance**

| | |
|---|---|
| Mrs J White | Head of Governance & Company Secretary |
| Mr K Oxley | Director of Estates, Facilities and Capital Planning |
| Mrs R Metcalf | Director of Human Resources |
| Mrs M Angel | Interim Director of Clinical Development |
| Mr M Graham | Director of Communications |
| Mr M Imiavan | Digital Director |



**Action**

**BoD/20/294** **WELCOME AND INTRODUCTIONS**

The Chairman welcomed members to his first meeting as permanent Joint Chairman for South Tees Hospitals NHS Trust and North Tees & Hartlepool NHS Trust.

The Chairman thanked members of public who had joined the meeting by Microsoft teams and reminded them to put their volume on mute during the meeting. He advised that there would be an opportunity at the end of the meeting for any questions.

**BoD/20/295** **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Ms S Page, Chief Executive, Mr M Ducker, Non Executive Director.

**BoD/20/296** **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/20/297** **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/20/298** **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on Tuesday 7 July 2021 were reviewed and agreed as an accurate record. Mrs White

**BoD/20/299** **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

**BoD/20/300** **CHAIRMAN'S REPORT**

The Chairman reported that it was day four of his official appointment and that he has spent the last 4 weeks involved in an induction programme across the two Trusts. He said it was a great privilege to be appointed to the joint post and welcomed the opportunity to serve the population of the Tees Valley and North Yorkshire, support staff and raise the profile nationally.

The Chairman thanked Ms Burns and Mr Hall, Vice Chair of North Tees & Hartlepool NHS Foundation Trust for their support and everyone who has welcomed him.

He added that on his Board walk today me met staff and thanked them for their support and was pleased to hear positive information. He commented that there are lots of challenges going forward and as a Board we will be looking to minimise challenges with some real positives, but recognised the immediate issues around post covid recovery and the financial challenges of the Trust.

The Chairman advised that he is keen to progress the Joint Strategy Board across the two Trusts and will update members later on the agenda on next steps. He added that he is engaged with the Chairs across the ICS (NENC) to help move forward the Tees Valley and North Yorkshire.

**Resolution**

**The Board of Directors NOTED the Chairman's report.**

**BoD/20/301** **CHIEF EXECUTIVE'S REPORT**

Mr Harrison, Managing Director referred members to the CEO report which he presented on behalf of Ms Page and added that the recruitment for the NENC ICS Chair and CEO has now commenced and we will start to see the posts filled followed by other senior leadership posts which is crucial for the region.

Mr Harrison updated that the Trust had submitted an expression of interest under the Health infrastructure plan (40 hospital bill programme). He added that the Trust had looked at the scope and our future plans meet the definitions of what this requires and therefore the approach the Trust has taken with the submission is that we will re-provide fit for purpose services already reconfigured across the site including major trauma, critical care and radiology, women and children's unit (incorporating a cochlear implant centre).

Mr Harrison was pleased to report that the Trinity Holistic Centre had won a HSJ award for cancer care initiative and congratulated the staff.

He was also pleased to report on the GMC training survey which demonstrated the fantastic outcomes our trainees receive at South Tees Hospitals NHS Trust and a testament to all the teams who work with doctors in training. Dr Stewart added that this has been something we have been focussed on delivering high quality training throughout in terms of the supply train for the doctors we need. We have just opened a new education centre at the Friarage so we can continue to expand the delivery to staff.

Professor Bell commented that it was a good pulse survey and well done to staff in terms of making this happen.

Finally Mr Harrison advised that staff are continuing the recovery work and to deal with the impact of the 4th wave of covid.

**Resolution**

**The Trust Board of Directors NOTED the Chief Executive's update**

**BoD/20/302** **BOARD ASSURANCE FRAMEWORK**

Mrs White referred members to the Board Assurance Framework and reminded members that Board have previously approved the Trust's two-year strategic plan and the improvement and recovery plan and identified the principal risks to achieving the strategic objectives.

Mrs White highlighted that the Board of Directors tasked the Board sub committees to undertake the scrutiny and assurance of the principal risk, controls and gaps. She advised that the Board Sub Committees – People, Quality and Resources have reviewed their BAF risks on two occasions (one for Resources) since the last report to Board and that through the Chair's logs the Board can be assured that the Committees have tested the controls in place; received assurances (some positive and some negative);

reviewed the gaps in controls or assurance and received assurances to mitigate any gaps.

Mrs White highlighted a number of assurance reports which were being received today at Board including:

- CQC update
- Integrated Performance Report
- Safe Staffing Report
- Doctor Revalidation & Appraisal Update Report
- Finance Report Month 4

Mr Jennings, Audit & Risk Committee Chair thanked Mrs White for the update and commented that this was a really positive and helpful report. He added that the BAF is a developmental piece of work and from conversations he has had with Committee Chairs they recognise this and in particularly the work of the Committee being happy to give a level of assurance against any threats.

He added that it also highlights the ongoing developmental work around the IPR as this will become another way we triangulate the work of the BAF.

Ms Burns concurred and added that the comments Mr Jennings has made on direction of travel and as the Chair of the People Committee found the work plan and agenda setting process directly link to the risks and threats that relate to the Committee.

Ms Burns further suggested that there was a new threat to Principal risk 5 in terms of how effectively we in the Tees Valley system and local authority system come together in respect of the new governance arrangements of the ICS and local representatives and suggested this be explored. Mrs White

Ms Reape also commented as Chair of the Quality Assurance Committee and that following the implementation of the Quality sub structure she would be seeking assurances also from these groups on the risks allocated to the Quality Assurance Committee.

Dr Stewart commented that he was pleased to see the BAF at the top of the agenda and endorsed this approach through the Board Committee Structure.

Professor Bell commented that the BAF is a document which is an evolution but does need to be mature enough to guide the decision making. He suggested that assurance could be divided in terms of internal and external and that the Board need to discuss the risk appetite. Referring to the possible new threat suggested by Ms Burns he advised that this is also an opportunity and agreed this should be further explored.

Professor Bell asked that for the next quarterly report the BAF is fully populated.

Mrs White

**Resolution**

**The Trust Board of Directors NOTED the BAF**

**BoD/20/303** **SAFE STAFFING REPORT**

Dr Lloyd referred members to the safe staffing report and highlighted that the percentage of shifts filled against the planned nurse and midwifery staffing across the Trust is 97.3% which demonstrates good compliance with safer staffing.

Staffing has been challenged across the Trust due to the pandemic surge with short notice unavailability and COVID isolation, particularly during mid-July when track and trace was at a peak. This has led to an increased numbers of junior and temporary staff together with frequent redeployment to maintain patient safety.

The Chief Operating Officer and Deputy Operational Chief Nurse took staffing data to CPG at the end of July to enable full and open debate.

There has been one reported episode for lack of supernumerary co-ordinators in ITU during July 2021. Nursing Turnover for July is currently 7.6% with ongoing recruitment to minimise vacant posts. The current nurse/midwifery vacancy rate is 2.7%.

International recruitment has focused on filling vacant theatre posts during July.

Ms Reape thanked Dr Lloyd for the report and commented that there was good information on problem areas and success in some of the recruitment. She added that following her Maternity Champion walk to maternity the staff were very positive around the measures in place for escalation and the support we were providing to staff, however some staff did feel challenged, and Ms Reape asked what else can we do. Dr Lloyd advised that midwifery has experienced high levels of sickness predominately for COVID19 isolation and this is a national issue. She added that we have on occasion closed the Friarage service to manage the situation. Dr Lloyd thanked the staff for their ongoing commitment and support and that the Senior Leadership Team will look at how the Trust can support staff in the ongoing challenging situations.

Professor Bell asked if the ward function could be included in the table to understand which area it related to and that commentary be added to the fill rates section.

Mr Harrison thanked staff who have been great in responding to this need.

Professor Bell advised that in discussions today on his Board walk staff have identified they have had support.

Ms Burns commented that she welcomed this piece of work from Mr Harrison recognising the additional new skills that staff have gained. She reminded Board members around how effective the Trust's Our Hospitals Charity has been in terms of staff support including the provision of staff restrooms, fruit and other goodies to help ease pressures that staff face.

**Resolution**

**The Trust Board of Directors NOTED the safer staffing report**

**BoD/20/304** **CQC**

Dr Lloyd referred members to the previously circulated CQC update report and reminded members that a CQC inspection of the Trust was carried out between the 15th January and the 23rd February 2019, a detailed action plan was developed to address the regulatory breaches ('must do' actions) and also the 'should do' actions.

She commented that the Trust has prepared a high level preparation plan which sets out a process for undertaking a self-assessment and assurance processes for a core services inspection of acute and community services, a well led assessment and a use of resources assessment.

Governance processes for overseeing these assessments including check and challenge and peer review are in place.

The Quality Assurance Committee and sub groups will oversee and monitor the process with appropriate updates to the Board.

Dr Lloyd advised that good progress has been made on delivering of the high level plan since the last report.

Mrs Angel updated that the outstanding must do action relates to mandatory training and that the Board have heard of the impact on staffing throughout July due to COVID-19 and therefore the compliance levels have been approximately around 84%. She added that the Trust have a task and finish group in place and over the next 4 weeks they will look at training levels and the system to ensure this is clear. Finally Mrs Angel advised that the Collaboratives now own the CQC

action plan and will be developing their own actions and trajectories around this.

Ms Burns commented that she welcomed the update on mandatory training and advised that this has been a focus of People Committee for some time and that the Committee are seeing a consistent improvement across the piece. The importance of appraisal is also important.

Mr Harrison added that the Senior Leadership Team have agreed to additional external support to enable PIR preparation (data request); and risk management process. He advised that the Use of resources preparation is also being taken forward through the Resource Committee.

Professor Bell welcomed the external support for PIR preparation and given the timescales this is an important step forward. He added that both mandatory training and appraisal are important and we should not see this as a tick box exercise we should see this as a high quality organisation and business as usual.

**Resolution**

**The Trust Board of Directors NOTED the CQC update**

**BoD/20/305** **SAFEGUARDING ANNUAL REPORT**

Dr Lloyd presented the Safeguarding annual report to the Board for information which provides an overview of the challenges and achievements of the safeguarding, looked after and learning disability services provided by the trust in 2020 -2021 during the Covid pandemic.

**Resolution**

**The Trust Board of Directors NOTED the Annual Report**

**BoD/20/306** **INFECTION PREVENTION AND CONTROL ANNUAL REPORT**

Dr Lloyd presented the Infection Prevention & Control Annual report to the Board for information which provides an overview of HCAI for the year 2020/21.

Ms Reape noted that the report makes reference to surgical site infections and asked if the estate in a better position as we move into winter with regard to isolation and single room facilities. Dr Lloyd reported that there were no concerns regarding surgical site infections and Mr Oxley advised that the Trust do have single room facilities across the site and during COVID 19 we created additional space but the physical estate is an issue and therefore the Trust has developed a business case for a 24 bedded module build.

Dr Stewart added that we don't have side rooms in the right place and this is a sub optimal element that staff have to work around.

Mr Harrison commented that it is really interesting that in previous years there were high levels of diarrhoea and vomiting and asked what learning can we take from our approach during COVID19. Dr Lloyd commented that there are lots of positives about how we have implemented universal precautions during COVID19 which are being shared through clinical groups.

Professor Bell asked if there were any trends we need to know going forward and Dr Lloyd advised that there has been an increase in CDIFF which is highlighted in the IPR and being seen regionally and we are doing some targeted work around this.

**Resolution**

**The Trust Board of Directors NOTED the report**

**BoD/20/07** **CONSULTANT APPOINTMENTS**

Mr Harrison updated members on the following starters in the Trust:

Timothy Brock – Orthopaedics
David Hepple – Anaesthetics
Matthew Horan – Haematology
Prasad Karpe – Spinal Surgery
David Wilson – Oncology

And thanked the following members of staff who have left the Trust:

Kyee Han – A&E
Anchal Puri – Orthodontics

Mr Harrison also advised that the Trust were making a really positive impact to some hard to recruit areas.

Professor Bell welcomed the new recruits.

**Resolution**

**The Trust Board of Directors NOTED the update**

**BoD/20/308** **DOCTOR REVALIATION AND APPRAISAL UPDATE REPORT**

Dr Stewart presented the Doctor Revaluation and Appraisal update report and advised that the report details recent appointments to the Revalidation team, appraisal compliance

figures for the first quarter of the 2021-2022 appraisal year and an update on revalidation recommendations submitted between April 2021 – June 2021.

He added that with the 2020-2021 appraisal year having been significantly impacted by COVID-19 (vast majority of appraisals marked as approved postponements in line with national guidance) re-engagement from Doctors in the appraisal and revalidation process on the whole has been positive. The Trust has now returned to full business as usual, appraisal wise, with effect from 1st April 2021 - having resumed with a soft re-launch of appraisals on 1st October 2020, as suggested by our Regional Responsible Officer

**Resolution**

**The Trust Board of Directors NOTED the report**

**BoD/20/309** **FINANCE REPORT MONTH 4**

Mr Hand presented the month four finance report and highlighted that due to the ongoing Covid-19 pandemic formal annual financial planning has been suspended for the first half of 2021/22. ICS system level planning is in place, with each ICP expected to deliver break-even within a fixed funding envelope.

The Trust's requirement for H1 2021/22 is to deliver a £3.0m deficit.

At Month 4 the Trust reported a deficit of £2.7m at a system control total level. This is in line with the required budget deficit for M4 as agreed within the ICP/ICS.

Mr Jennings asked for clarity on the overspend of £0.7m which was driven by increases in ICT systems costs and phone charges and Mr Hand advised that this related to wider IT contracts.

Mr Harrison asked Mr Hand if the Trust is concerned about being behind on our capital spend and Mr Hand advised that nothing has been flagged in terms of risk and at this stage we are forecasting delivery of this. Mr Oxley confirmed that we have a monthly capital oversight group and its relatively earlier in the year so there is nothing of significance to call out at the moment.

Professor Bell referred to the cost of agency spend and asked if there were any specific areas this was affecting and what the year-end costs were likely to be. Mr Hand advised that it was predominately medical spend and hard to recruit specialities and we are working through this to understand this in more detail and reviewing recruitment processes. He added that the forecast will be the continuation of run rate.

The agency ceiling will come back into play later in the year.

Professor Bell further asked if there were any specific medical spend issues and Dr Stewart advised that there are some areas where nationally there are shortages. He added that the Trust is taking forward a proactive recruitment campaign around these areas, and that we have had a number of enquiries.

Mr Harrison advised that stroke care is one to highlight and we could collaborate across this more.

**Resolution**

**The Trust Board of Directors NOTED the report.**

**BoD/20/310** **INTEGRATED PERFORMANCE REPORT**

Mr Harrison reported on performance for July and highlighted the following key messages:

- Elective outpatient and inpatient recovery reduced, due to COVID-related staff absence and redeployment impacting on theatres and outpatient activity, increased short notice cancellations and DNAs due to COVID-19 in the wider population. Ward reconfiguration to enable covid pathways temporarily reduced elective orthopaedic bed base.
- In line with the pattern seen across the NHS, 4-hour standard performance declined, and ambulance handover times increased with increasing proportions of "Red" pathway patients combined with sustained high volumes of attendances.
- Appraisals rates declined as staff were asked to prioritise direct clinical care in response to patient demand and high levels of absence from work.
- Operational, Tactical and Strategic focus on the demands of the Covid-19 response.

Areas of improved or sustained performance include:

- Safe: Falls rate remains below benchmark, despite staffing challenges; Serious Incidents remain below the mean; all sepsis bundle indicators improved this month;
- Caring: Friends and Family Experience rates for Inpatients, Outpatients above target
- Responsive: Cancer 14-day standard has been above the mean for 7 months.
- Cdif ahead of trajectory

In addition he added that incident reporting has positively exceeded the trajectory for this year which was set for a 10% increase and this is about encouraging an open and learning

culture and at present we are around 30% up on the same period from last year.

With regard to the Emergency Department (ED) Mr Harrison highlighted that both the 4 hour target and Friends and Family response rate declined which mirrors the national position. Mr Harrison advised the Board that the Trust is working with the Emergency Care Improvement Team (ECIS) who are supporting the Trust with improvement work in ED.

Mr Harrison highlighted that the new Paediatric ED opens this month, commented on the great new accommodation which will give us some opportunities in terms of space in main department for adult patients.

He added that the elective recovery for July is below plan due to the COVID surge and national trajectory and RTT position has stabilised and we are anticipating that we should see an increase in this.

Mr Jennings commented that the IPR has been developing month on month and that he acknowledged that this report included a review from SLT which is helpful but that it would benefit from a summary of what that the SLT dialogue was on the emerging issues, an early warning of this would be valuable and for committees in terms of the assurance around this rather than getting into the operational detail. He added that there is still some work to be done on SPC charts which remain unclear.

Mr Harrison thanked Mr Jennings for the comments and advised that the verbal summary provided at Board is what he will see coming through on the front page. He added that SLT went through the report in detail and they are keen to change the format of some graphs and that they want to do this in tandem with NED for assurances and reframing how this talks to the BAF.

Ms Burns asked if the Trust can get the elective / recovery plan back on trajectory and whether there are KPIs that relate to theatre utilisation? Mr Harrison advised that the position is variable in terms of recovery. He added that we should see improvement but there are ongoing challenges around critical care surge and anaesthetic sessions due to COVID-19 which has an impact on delivery of the plan. With regard to theatre utilisation Mr Harrison advised that theatre utilisation reports are produced at a local level and is part of theatre improvement process.

The Friarage elective programme is on track and should continue. The outpatient focus is now around transformation and Mr Peate and Mr Imiavan are getting involved to enable clinicians to see patients face to face or digitally in terms of

helping safely increase the volumes through outpatients.

Dr Stewart reported that the recovery plan is predicated on whether we can increase anaesthetic time. He advised that he was pleased to hear that we have piloted our first anaesthetic nurse practitioner, a new initiative, and it went very well. He added that recovery will be very difficult as he feels that COVID-19 will get worse over the winter.

Professor Bell commented on the elective accumulation in terms of the impact on patient experience and advised that the Trust need to think about the trajectory for this and how this fit into mutual aid.

Ms Burns asked about the cancer performance and the delays because of late transfers from other trusts and asked what mitigations are taking place and what role the CCG takes in terms of whole system improvement; Mr Harrison confirmed that the Cancer Care Alliance strives to support the system and late transfers are not just a local issue: cancer pathways are very complex and the more we can smooth this the better.

Ms Reape advised that the Quality Assurance Committee discuss clinical harm reviews and prioritisation of theatre time from a safety perspective.

Dr Stewart commented that the surgical collaborative meets and reviews waiting list information and competing priorities and are revisiting the theatre allocation on a week-to-week basis to maximise this.

Finally Ms Burns questioned whether complainants are satisfied with the response they receive and Mr Harrison advised that the Trust is much better now. Dr Lloyd added that the Trust are seeing patients and families much more face to face and Dr Stewart and herself read every complaint and if we are not satisfied we ask for further work. She added that the Trust are joining a national pilot on complaints processes.

Professor Bell commented that the IPR is developing and fundamental to how we look at other things including BAF. He added that we need to include a summary report as discussed. In relation to the BAF there is a lot in terms of the need for digital assurance. Mrs White confirmed that digital sites with the Resources Committee.

**Resolution**

**The Trust Board of Directors NOTED the IPR**

**BoD/20/311** **COMMITTEE REPORTS**

The Chairman offered Committee Chairs the opportunity to highlight any issues for escalation to the Board not already covered by the agenda. Ms Reape, Chair of Quality Assurance Committee and Ms Burns, Chair of People Committee confirmed there were no issues for escalation.

**BoD/20/312** **CLOSE OF THE MEETING**

The Chairman offered members of the public the opportunity to raise questions with the Board. There were no questions raised.

**BoD/20/313** **DATE AND TIME OF NEXT MEETING**

The next meeting of the Board of Directors will take place on Tuesday 5 October 2021.



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) |
|---|---|---|---|---|---|---|---|
| 06.04.21 | BoD/20/231 | BOARD ASSURANCE FRAMEWORK (BAF) | Mrs White to include in the standard operating procedure the role of individuals and committees in terms of the Board Assurance Framework to ensure confirming the emphasis placed on the them to review the BAF risks assigned to them. | J White | Jun-21 | BAF SOP developed and agreed at Audit & Risk Committee | Complete |
| 7.9.21 | BoD/20/302 | BOARD ASSURANCE FRAMEWORK | Consideration of a new threat to Principal risk 5 in terms of how effectively we in the Tees Valley system and local authority system come together in respect of the new governance arrangements of the ICS and local representatives and suggested this be explored. | J White & R Harrison & S Page | Dec-21 | To be considered and if appropriate included in quarterly BAF report to Board | Open |
| 7.9.21 | BoD/20/302 | BOARD ASSURANCE FRAMEWORK | BAF is considered by SLT and Committees and is fully populated. | J White | Dec-21 | | Open |
| 7.9.21 | BoD/20/302 | BOARD ASSURANCE FRAMEWORK | Three levels of assurance identified in BAF to be separated into internal and external assurances | J White | Oct-21 | To be considered and included in the BAF next quarter report | Open |
| 7.9.21 | BoD/20/302 | BOARD ASSURANCE FRAMEWORK | Risk Appetite to be undertaken and included on the BAF | J White | Oct-21 | Board development session in November to consider | Open |
| 7.9.21 | BoD/20/304 | CQC | Additional external support to enable a peer review; PIR preparation (data request); and risk management process to be commissioned and undertaken. | H Lloyd / J White | Oct-21 | External support for PIR commissioned and started 28.9.21. Plan for risk management agreed with Exec Leads and will be implemented from 15.10.21. Peer support areas of consideration identified and work underway to commission peer review | part complete |

| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 5 October 2021 | | | |
|---|---|---|---|
| **Joint Chairman's update** | | | **AGENDA ITEM: 6, ENC 4** |
| **Report Author and Job Title:** | Jackie White<br>Head of Governance & Company Secretary | **Responsible Director:** | Professor Derek Bell<br>Joint Chairman |
| **Action Required** | Approve ☐ Discuss ☐ Inform ☒ | | |
| **Situation** | Joint Chairman's update | | |
| **Background** | The following report provides an update from the Joint Chairman. | | |
| **Assessment** | The report provides an overview of the health and wider related issues. | | |
| **Recommendation** | Members of the Trust Board are asked to note the contents of the report | | |
| **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) | Best for safe, clinically effective care and experience ☒ | A great place to work ☒ | |
| | Deliver care without boundaries in collaboration with our health and social care partners ☒ | Make best use of our resources ☒ | |
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒ | | |

# Joint Chairman's Update

## Induction

As I discussed last month, I have continued my induction programme with the Trust and have visited a number of Clinical Collaboratives including the James Cook Cancer Institute and Specialty Medicine Services, Growing the Friarage and Community Services, Clinical Support Services, Cardiothoracic and Vascular Care Services and the Head & Neck, Orthopaedic and Reconstructive Services. It has been great to meet with the Collaborative Chairs, Clinical Directors, nursing colleagues and staff.

## ICS

As board members know, on 6 July 2021, the Health and Care Bill was published, setting out key legislative proposals to reform the delivery and organisation of health services in England.

The Health and Care Bill introduces two-part statutory Integrated Care Systems (ICSs), comprised of an integrated care board (ICB), responsible for NHS strategic planning and allocation decisions, and an integrated care partnership (ICP), responsible for bringing together a wider set of system partners to develop a plan to address the broader health, public health and social care needs of the local population.

ICBs will take on the NHS planning role currently held by NHS clinical commissioning groups (CCGs) and some functions from NHS England.

The Health and Care Bill has received its second reading in parliament and is currently at committee stage. Subject to parliamentary approval the Bill, and its provisions, are planned to come into effect in April 2022.

## HowFit

People across the North East and Cumbria are now able to benefit from a new health and fitness programme launched last month.

Households across the region had the HowFit (Home Wellbeing and Fitness) Plan instructional leaflet delivered to their homes during September. The Plan is designed to help people improve fitness and health which is important at any time but may also need a boost as a result of the COVID-19 pandemic.

With the aid of a website and printed booklet, HowFit encourages users of any ability, from chair based to fairly fit, to undertake a plan of simple exercises that can be carried out at home without the need for any special equipment.

## Council of Governors

On the 14 September 2021 I chaired my first Council of Governors meeting at South Tees. We received a number of updates on finance and performance and received

the Final Quality Account, which a sub group of the Council of Governors had contributed to. We also discussed our preparation for a future CQC inspection.

**Joint Strategic Board**

The Joint Strategic Board met on 22 September 2021 which included new members of the Executive teams across South Tees Hospitals NHS Foundation Trust and North Tees & Hartlepool NHS Foundation Trust. The Board received presentations from the Chief Nurses, Chief Finance Officers and Medical Directors on areas of current joint working and winter planning.

**Board appointments**

I am pleased to report that David Redpath, Associate Non-Executive Director, was appointed to a full Non-Executive Director by the Council of Governors following a successful 6 months and appraisal.

## 2. RECOMMENDATIONS

The board is asked to note the contents of this report.

South Tees Hospitals
NHS Foundation Trust

| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 5 October 2021 | | | |
|---|---|---|---|
| **Chief Executive update** | | | **AGENDA ITEM: 7**<br>**ENC 5** |
| **Report Author and Job Title:** | Mark Graham, Director of Communications | **Responsible Director:** | Chief Executive |
| **Action Required** | Approve ☐ Discuss ☐ Inform ☒ | | |
| **Situation** | Chief Executive update | | |
| **Background** | The following report provides an update from the Chief Executive. | | |
| **Assessment** | The report provides an overview of the health and wider related issues. | | |
| **Recommendation** | Members of the Trust Board are asked to note the contents of the report | | |
| **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) | Best for safe, clinically effective care and experience ☒ | A great place to work ☒ | |
| | Deliver care without boundaries in collaboration with our health and social care partners ☒ | Make best use of our resources ☒ | |
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒ | | |

# Chief Executive Update

## COVID-19 update

At the time of this report's writing, there has been a small but steady increase in community infection rates. The number of patients receiving hospital care for COVID-19 has remained between 59 and 79 for a number of weeks.

Again at the time of this report's writing, critical care colleagues have seen a recent small reduction in the number of critically ill COVID-19 patients.

The majority of patients requiring COVID-19 hospital care have received one or no vaccine dose which is why it is so important to join the millions already vaccination and get double-jabbed.

Since the start of the pandemic, clinical colleagues have provided COVID-care to more than 4,000 patients (patient spells).

Pressures remain as our dedicated clinicians continue to treat COVID patients, and those without COVID whose needs are equally urgent, whilst working to address the needs of anybody whose non-urgent care has been disrupted during the pandemic

## COVID booster vaccine

Following final advice from the independent Joint Committee on Vaccination and Immunisation (JCVI), COVID booster jabs are to be offered to vulnerable groups

The programme will be rolled out to the same priority groups as previously. This means care home residents, health and social care workers, people aged over 50, those aged 16 to 49 years with underlying health conditions that put them at higher risk of severe COVID-19, adult carers, and adult household contacts of immunosuppressed individuals will be prioritised.

Unlike the previous vaccination programme which saw hospitals like the Friarage and James Cook providing jabs for patients and public priority groups, boosters will continue to be delivered in GP surgeries, pharmacies and vaccination centres; and our hospital programme will focus on providing booster jabs for colleagues from 6 months after the date they received their second dose.

The COVID booster programme is being delivered in conjunction with this year's flu immunisation programme.

## Friarage Hospital developments

Building work is underway on the Friarage's new £5 million diagnostic hub.

The new hub, located on the hospital's former ward 15, will provide state-of-the-art facilities for patients undergoing urology and endoscopy procedures,  it is planned to open in the summer of 2022.

The new development is just the latest in a series of clinically-led developments at the Friarage over the last 18-months which have included:

- The creation of a new eye outpatients department
- A new rapid diagnostic centre to support patients with non-specific (vague) symptoms that may be due to cancer.
- A new renal unit to dialyse up to 10 patients, reducing the need for them to travel to Middlesbrough or Darlington for dialysis.

The start of work on the hospital's new diagnostic hub is to be followed by the removal of disused buildings on the site which were built more than 70 years ago.

The redundant buildings (the old physiotherapy and education blocks) were built during the Second World War and, as well as reducing maintenance, heating and other costs which can be recycled into frontline patient services, their removal will clear the way for more developments at the hospital in the future.

These include plans to replace the Friarage's aging theatre block with new modern operating theatres. The plans for the new theatre block will go through regional and national business case development, assurance and approval processes before they can be given the go-ahead.

The commencement of these clinically-led developments at the Friarage, follows the board's approval at its September meeting for the submission of an expression of interest under the government's Health Infrastructure Plan for physical infrastructure investment at The James Cook University Hospital.

**Project Wingman**

The wellbeing of our amazing colleagues is critically important and during September we were delighted to welcome back Project Wingman supported by Our Hospitals Charity.

Project Wingman was set up to support NHS staff during the COVID-19 response. It brings together crews from every UK airline, who have been furloughed, grounded or made redundant due to the pandemic.

It first visited the Trust last year, offering a safe space for staff to talk to someone about their experiences, relax over a tea or coffee or just have some time away from the work environment – all in a lounge setting similar to those enjoyed by first-class passengers at airports.

The team behind Project Wingman has since launched 'Wingman Wheels' – a mobile well-being lounge initiative that allows Project Wingman to reach even more locations, especially those where the usual lounge format would not be possible.

Wingman wheels visited colleagues in the following locations during their time with the Trust:

- Friarage Hospital
- James Cook University Hospital
- Redcar Hospital
- East Cleveland Hospital

**New children's emergency department**

Our new children and young people's emergency department at James Cook welcomed its first patients in September.

The purpose-built department, which is next to the main emergency department, is only the second of its kind in the North East and will provide emergency care to more than 25,000 patients a year, covering all age ranges from neonates up to 18 years.
It provides a number of specialist facilities including:

• Dedicated observation, treatment and resuscitation rooms
• Mental health assessment room
• Sensory room
• Breastfeeding room

Everything from the wall artwork to the patient meals has be designed with children and young people in mind and charitable funds have been used to provide those little extras.

**New Hospital development**

With the support of the Trust Board in September, our Clinical Policy Group has submitted and expression of interest which, if successful, would enable our buildings to catch-up with the high levels of specialist and complex care already delivered at James Cook through the creation of:

The Erimus Teesside & North Yorkshire Women and Children's Centre building (providing modern, purpose-built maternity and paediatric facilities – incorporating our regional Cochlear Implant Centre).

The Teesside & North Yorkshire Regional Major Trauma and Critical Care Centre building (underpinning tertiary, cancer and other specialist services through the construction of a new building on the south west corner of the site incorporating key specialties including regional major trauma, critical care and radiology).

The next stage will be a more detailed national process for the long-listing of schemes later in the year with a decision on the final eight schemes reached nationally by spring 2022.

**Medicines Safety Week**

Our expert pharmacy team are visiting the wards between 27 September and 1 October to offer more useful teaching and advice on medicines safety along with a number of Medicines Safety Events and Non-Medical Prescribing Forums where the team will be discussing all things insulin.

**Organ Donation Week**

Last week was Organ Donation Week and we were encouraging families to get together and talk about organ donation.

Although the law around organ donation has changed to an opt-out system for adults in England, Wales and Scotland, your family will still be consulted if organ donation is a possibility.

Organ Donation Week encourages everyone to start talking about organ donation. Even if someone isn't sure if they want to donate, having that conversation might help them make up their mind.

The Board will receive a report from the team next month.

**National NHS funding settlement**

In September, the government announced an additional £5.4 billion for the NHS to support the COVID-19 response over next 6 months. The £5.4 billion funding is broken down into:

- £2.8 billion for COVID-19 costs including infection control measures
- £600 million for day-to-day costs
- £478 million for enhanced hospital discharge
- £1.5 billion for elective recovery, including £500 million capital funding

At the time of this report's writing, national planning guidance is awaited for H2 (2021/22). It is expected that planning will again take place at an ICS level, within allocations of system-level financial envelopes, and block funding arrangements for providers will continue.

H2 funding allocations are expected to maintain financial support for the COVID-19 response, but overall funding levels will reduce by up to 3 per cent. Additional funding is likely to be available to support winter pressures and elective recovery.

**Winter Planning**

Work is being finalised locally and across the North East and North Cumbria in preparation for the winter ahead.

The Trust recently participated in a preparing for winter virtual event which was chaired by Helen Ray, chief executive of North East Ambulance Service NHS Foundation Trust and included Professor Sir Liam Donaldson as the keynote speaker. The event was an opportunity to come together to take stock so we can plan for the challenges ahead but also to share and learn from the good practice already taking place across the region.

## 2. RECOMMENDATIONS

The board is asked to note the contents of this report.

| MEETING OF THE PUBLIC BOARD OF DIRECTORS – 5 OCTOBER 2021 | | | |
|---|---|---|---|
| **Board Assurance Framework** | | | **AGENDA ITEM: 8**<br>**ENC 6** |
| **Report Author and Job Title:** | Jackie White<br>Head of Governance & Co Secretary | Responsible Director: | Jackie White<br>Head of Governance & Co Secretary |
| **Action Required** | Approve ☐ Discuss ☐ Inform ☒ | | |
| **Situation** | The Board have approved the Trust's two-year strategic plan and the improvement and recovery plan and identified the principal risks to achieving the strategic objectives.<br><br>The Board sub committees undertake on behalf of the Trust Board scrutiny and assurance of the principal risk, controls and gaps each month.<br><br>A BAF Standard Operating Procedure has been developed and agreed by the Audit & Risk Committee which sets out the Committee roles in order to ensure a standard approach to this work. | | |
| **Background** | The Board Assurance Framework is a strategic but comprehensive method for the effective and focused management of the principal risks to meeting an organisation's objectives.<br><br>A structure for the evidence to support the Annual Governance Statement. A method of aggregated board reporting and the prioritisation of action plans which, in turn, allows for more effective performance management.<br><br>A document to help inform decision making and prioritisation of work relating to the delivery of strategic objectives. | | |
| **Assessment** | The Board Sub Committees – People, Quality and Resources have reviewed their BAF risks since the last report to Board.<br><br>Through the Chair's logs the Board can be assured that the Committees have tested the controls in place; received assurances (some positive and some negative); reviewed the gaps in controls or assurance and received assurances to mitigate some of these gaps.<br><br>The Audit & Risk Committee have considered the BAF in full, approved a BAF Standard Operating Procedure and have undertaken a deep dive into the BAF and risk processes in place within the People Committee and can provide assurance that this is working well. | | |

| | | |
|---|---|---|
| | A number of assurance reports are being received today at Board and include:<br><br>Principal risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes<br><br>• CQC update<br>• Integrated Performance Report<br>• Guardian of Safe Working<br>• Freedom to speak up<br>• Learning from Deaths report<br><br>Principal risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain<br><br>• Safe Staffing Report<br>• Integrated Performance Report<br>• Guardian of Safe Working<br>• Freedom to speak up<br>• WRES and WDES<br><br>Principal risk 4 - Failure to deliver as a centre of excellence, resulting in a lack of priority and recognition from commissioners and other stakeholders<br><br>• Integrated Performance Report<br><br>Principal risk 7 - Failure to deliver the Trust's financial recovery plan<br><br>• Finance Report Month 5<br>• Integrated Performance Report | |
| **Recommendation** | Members of the Board of Directors are asked to note the update on the BAF. | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | The risk implications associated with this report are included in the 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) | Best for safe, clinically effective care and experience ☒ | A great place to work ☒ |
| | Deliver care without boundaries in collaboration with our health and social care partners ☒ | Make best use of our resources ☒ |

| | | |
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# Board Assurance Framework (BAF)

## 1. PURPOSE OF REPORT

The purpose of the report is to provide an update on the work of the Board sub Committees on providing assurance to the Board on the principal risks to achieving the strategic objectives.

## 2. BACKGROUND

The role of the BAF is to provide evidence and structure to support effective management of Risk within the organisation. The BAF provides evidence to support the Annual Governance Statement.

The BAF provides this totality of assurance and identifies which of the strategic objectives are at risk of not being delivered. At the same time, it provides positive assurance where risks are being managed effectively and objectives are being delivered. This allows the Board to determine where to make most efficient use of their resources or otherwise take mitigation action and address the issues identified in order to deliver the Trust's strategic objectives.

The process for gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. In order to do this the Board tasks its Board Sub Committee with undertaking scrutiny and assurance of the following:

- Controls in place
- Assurances in place and whether they give positive or negative assurance
- Gaps in controls or assurance
- Actions to close gaps and mitigate risk

Ensuring effective systems are in place to identify, monitor and mitigate risks and providing assurance to Board.

## 3. DETAILS

The BAF has ***7 principal risks*** associated with delivery of the 5 strategic objectives. These 7 principal risks are made up of ***35 threats.***

The risk rating for the 7 principal risks is made up of ***6 extremely high*** and ***1 high risk*** rating. There has been no change to the risk ratings since the last report.

The Board of Directors annual cycle of business has been reviewed to ensure that this is aligned to the BAF and future agenda setting. The Company Secretary has also reviewed all sub Committee cycles of business to ensure there is consistency and aligned to the relevant principal risks for the Committee.

### 3.1 Assurance reports

People Committee received 7 reports of assurance, including one independent

assurance report.

Quality Assurance Committee received 3 reports of assurance and 2 reports which gave assurance on gaps.

Resources Committee received 6 reports of assurance.

3.2 **Trust Board of Directors**

A number of assurance reports are being received today at Board and include:

Principal risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes

- CQC update
- Integrated Performance Report
- Guardian of Safe Working
- Freedom to speak up
- Learning from Deaths report

Principal risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain

- Safe Staffing Report
- Integrated Performance Report
- Guardian of Safe Working
- Freedom to speak up
- WRES and WDES

Principal risk 4 - Failure to deliver as a centre of excellence, resulting in a lack of priority and recognition from commissioners and other stakeholders

- Integrated Performance Report

Principal risk 7 - Failure to deliver the Trust's financial recovery plan

- Finance Report Month 5
- Integrated Performance Report

3.3 **Next quarter report**

New KPIs will be included in the report which set out the following:

- Overall balance between positive and negative assurances
- Balance of internal and external assurances
- % of actions due

New Board front sheets will identify the level of assurance being provided within the report.

The approach to lead committee assurance ratings will be tested out at SLT and a standardised approach will be provided to Committees.

## 4. RECOMMENDATIONS

Members of the Board of Directors are asked to note the report.

| MEETING OF THE TRUST BOARD OF DIRECTORS – 5 October 2021 | | | |
|---|---|---|---|
| Safe Staffing Report for August 2021 – Nursing and Midwifery | | | **AGENDA ITEM: 9**<br>**ENC 7** |
| **Report Author and Job Title:** | Debi McKeown NMAHP Workforce Lead | **Responsible Director:** | Dr Hilary Lloyd Chief Nurse |
| **Action Required** | Approve ☐ Discuss ☒ Inform ☒ | | |
| **Situation** | This report details nursing and midwifery staffing levels for August 2021 | | |
| **Background** | The requirement to publish nursing & midwifery staffing levels on a monthly basis is one of the ten expectations specified by the National Quality Board (2013 and 2016). | | |
| **Assessment** | The percentage of total shifts filled against the planned nurse and midwifery staffing across the trust is 96.51%, and there is a slight decrease the availability of RNs at 86.5%. This continues to demonstrate good compliance with safer staffing.<br>Staffing has been challenged across the trust with short-notice unavailability and COVID isolation, starting in mid-July and continuing.<br>There has been one reported episode for lack of supernumerary co-ordinators during August 2021 in GHDU.<br>Nursing Turnover for August is currently 8.02 % with ongoing recruitment to minimise vacant posts. | | |
| **Recommendation** | 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** | Principal risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes<br>Principal risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain | | |
| **Legal and Equality and Diversity implications** | • Care Quality Commission<br>• NHS Improvement<br>• NHS England | | |
| **Strategic Objectives** (highlight which Trust Strategic objective this report aims to support) | Best for safe, clinically effective care and experience ☒ | A great place to work ☒ | |
| | Deliver care without boundaries in collaboration with our health and social care partners ☒ | Make best use of our resources ☒ | |
| | A centre of excellence, for core and specialist services, | | |

| | | |
|---|---|---|
| | research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒ | |

# Nursing and Midwifery Workforce Exception Report
# August 2021

## Safe Staffing Governance

Safer staffing is maintained through twice daily SafeCare (staffing review) meetings to address any immediate issues and put robust plans in place. All elements of safer staffing are discussed at the Workforce Group which meets weekly on a Wednesday and are escalated to Tactical/Strategic as required. A look forward to the week ahead on Mondays and the weekends on Fridays takes place with Associate Directors of Nursing and Clinical Matrons.

Staff movement takes place to ensure patient safety with Clinical Matron Huddles and Ward Manager Briefings utilised to ensure full communication of plans and to gain feedback from teams to inform decision making.

Planned staffing templates, using professional judgement are reviewed monthly and when patient pathways change and are included in this report as planned versus actual (Table 1 & 2)

Redeployment of staff has taken place on a regular basis to ensure wards are safely staffed with (5347.36) hours logged via SafeCare during August.

Staff COVID unavailability is reported daily from the electronic roster data and is broken down by area and staff group.

**Reporting fill Rate based on planned vs worked hours for August 2021**
There is a slight decrease the availability of RNs at 86.5%

**Table 1 – Trust wide Monthly Fill Rates**

| | | June 2021 | July 2021 | August 2021 |
|---|---|---|---|---|
| Overall Ward Fill Rate | RN/RMs (%) Average fill rate - DAYS | 91.2% | 89.0% | 86.5% |
| | HCA (%) Average fill rate - DAYS | 100.4% | 93.9% | 91.1% |
| | NA (%) Average fill rate - DAYS | 100.0% | 100.0% | 100% |
| | TNA (%) Average fill rate - DAYS | 100.0% | 100.0% | 100% |
| | RN/RMs (%) Average fill rate - NIGHTS | 93.8% | 92.1% | 90.1% |
| | HCA (%) Average fill rate - NIGHTS | 107.9% | 103.8% | 104.4% |
| | NA (%) Average fill rate - NIGHTS | 100.0% | 100.0% | 100% |
| | TNA (%) Average fill rate - NIGHTS | 100.0% | 100.0% | 100% |
| | **Total % of Overall planned hours** | **99.10%** | **97.35%** | **96.51%** |

Table 2 provides details by ward and these are overlaid with bed occupancy and nurse sensitive indicators to triangulate data in table 3.

**Table 2 - Nursing and Midwifery Planned Vs Actual hours % and Care Hours Per Patient Day**

| Wards | Physical Bed Capacity | Open Bed Capacity | Occupied Bed No August | Total CHPPD | Average fill rate - Days RN/ Midwives (%) | Average fill rate - Days HCA (%) | Average fill rate – Days Reg Nursing Associates (%) | Average fill rate – Day Trainee Nursing Associates (%) | Average fill rate - Night RN/ Midwives (%) | Average fill rate - Night HCA (%) | Average fill rate – Night Reg Nursing Associates (%) | Average fill rate - Night Trainee Nursing Associates (%) | Reason for exception (when less than 80%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward 1 (C OVID Assessment) | 28 | 28 | 18 | 11.11 | 109.9% | 85.3% | - | 100.0% | 107.2% | 107.6% | - | 100.0% | |
| Ward 2 AAU (Short Stay Staff) | 28 | 28 | 23 | 7.30 | 88.7% | 115.0% | 100.0% | - | 84.9% | 95.7% | 100.0% | - | |
| Ward 3 (COVID) | 28 | 28 | 13 | 10.38 | 88.1% | 82.6% | - | 100.0% | 93.0% | 117.0% | - | - | |
| Ward 4 | 23 | 23 | 21 | 6.65 | 101.3% | 96.0% | - | - | 81.7% | 109.5% | - | - | |
| Ward 5 | 28 | 22 | 18 | 6.69 | 79.5% | 78.3% | - | 100.0% | 68.8% | 121.0% | - | 100.0% | Bed occupancy reduced. Safe staffing maintained |
| Ward 6 Gastro | 30 | 30 | 27 | 7.08 | 93.5% | 121.6% | - | - | 89.3% | 126.8% | - | - | |
| Ward 7 Colo | 30 | 30 | 27 | 6.26 | 87.1% | 97.2% | 100.0% | 100.0% | 100.0% | 94.6% | - | - | |
| Ward 8 | 30 | 30 | 24 | 6.87 | 86.3% | 101.8% | - | 100.0% | 93.5% | 100.0% | - | 100.0% | |
| Ward 9 | 28 | 28 | 21 | 9.21 | 103.9% | 110.3% | - | - | 115.3% | 142.7% | - | - | |
| Ward 10 (Short Stay RAFAU Staff) | 27 | 27 | 25 | 6.80 | 89.2% | 97.2% | - | - | 90.3% | 109.1% | - | - | |
| OPM (Ward 11) | 28 | 28 | 26 | 6.98 | 93.2% | 85.0% | - | - | 89.2% | 117.7% | - | - | |
| Ward 12 | 26 | 16 | 21 | 6.99 | 127.7% | 125.8% | - | - | 121.9% | 123.6% | - | - | |
| Ward 14 Oncology Staff | 23 | 21 | 18 | 7.41 | 119.2% | 96.1% | - | 100.0% | 74.2% | 130.1% | - | 100.0% | Bed occupancy reduced. Safe staffing maintained for 18 beds |
| Ward 24 | 23 | 23 | 19 | 7.98 | 90.0% | 130.7% | 100.0% | 100.0% | 78.2% | 159.6% | 100.0% | - | Bed occupancy reduced.. Safe staffing maintained for 19 beds with additional HCA support |
| Ward 25 | 21 | 12 | 7 | 11.11 | 62.4% | 51.3% | - | 100.0% | 90.9% | 35.5% | - | 100.0% | 5 days of closed beds. Safe staffing with 2 RN maintained overnight. |
| Ward 26 | 18 | 18 | 17 | 7.71 | 99.1% | 141.2% | - | - | 100.0% | 100.0% | - | - | |
| Ward 27 Neuro Staff | 15 | 15 | 13 | 11.09 | 126.3% | 166.9% | - | - | 103.2% | 124.8% | - | - | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward 28 | 30 | 30 | 20 | 8.75 | 101.6% | 119.4% | - | - | 98.4% | 112.4% | - | - | |
| Ward 29 | 27 | 27 | 23 | 6.87 | 102.5% | 104.2% | 100.0% | - | 97.4% | 145.7% | - | - | |
| Cardio MB | 9 | 9 | 8 | 9.42 | 97.0% | 119.8% | 100.0% | - | 98.4% | - | - | - | |
| Ward 31 Vas | 35 | 19 | 17 | 7.52 | 127.4% | 95.8% | 100.0% | - | 100.0% | 100.0% | - | - | |
| Ward 32 | 22 | 21 | 19 | 7.56 | 104.4% | 106.3% | - | - | 100.0% | 125.6% | - | - | |
| Ward 33 Specialty | 19 | 19 | 16 | 7.92 | 87.1% | 96.7% | - | - | 104.1% | 112.1% | - | - | |
| Ward 34 | 34 | 34 | 30 | 6.55 | 84.0% | 102.6% | - | 100.0% | 92.5% | 102.4% | - | - | |
| Ward 35 | 26 | 26 | 18 | 8.67 | 95.6% | 92.5% | - | - | 90.3% | 89.2% | - | - | |
| Ward 36 Trauma | 34 | 34 | 30 | 6.05 | 88.7% | 116.6% | - | 100.0% | 96.7% | 111.3% | - | 100.0% | |
| Critical Care + Surge | 33 | 33 | 28 | 33.80 | 101.2% | 113.3% | - | - | 100.5% | 104.4% | - | - | |
| CICU JCUH | 8 | 8 | 8 | 33.96 | 84.1% | 96.8% | - | - | 82.1% | 187.1% | - | - | |
| Cardio HDU | 10 | 10 | 6 | 20.38 | 75.6% | 96.8% | - | - | 69.4% | 116.5% | - | - | Bed occupancy reduced. Safe staffing has been maintained for 6 beds and a supernumerary co-ordinator |
| Ward 24 HDU | 8 | 8 | 6 | 19.28 | 96.1% | 87.1% | - | - | 92.1% | 77.4% | - | - | |
| Ainderby FHN | 27 | 22 | 16 | 7.48 | 64.9% | 72.7% | - | - | 98.4% | 82.4% | - | - | Bed occupancy reduced . Safe staffing maintained for 16 beds |
| Romanby FHN | 26 | 26 | 22 | 5.85 | 87.8% | 67.1% | - | - | 98.4% | 125.9% | - | - | Bed occupancy reduced . Safe staffing maintained for 22 beds |
| Gara Orthopaedic FHN | 21 | 16 | 10 | 5.60 | 79.7% | 86.8% | - | - | 90.3% | 81.3% | - | - | Bed occupancy reduced . Safe staffing maintained for 10 beds |
| Rutson FHN | 17 | 17 | 15 | 9.95 | 73.9% | 89.7% | - | - | 100.0% | 95.2% | - | - | Bed occupancy reduced. Safe staffing maintained for 15 beds. |
| Friary Community Hospital | 18 | 18 | 15 | 7.49 | 105.2% | 77.3% | - | - | 99.4% | 97.3% | - | - | Bed occupancy reduced . Safe staffing maintained for 15 beds |
| Zetland | 31 | 29 | 23 | 6.81 | 65.0% | 92.5% | - | 100.0% | 78.5% | 129.0% | - | - | Bed occupancy reduced. Safe staffing maintained with extra HCA support. |
| Tocketts Ward | 30 | 26 | 21 | 8.23 | 77.5% | 83.6% | - | - | 72.1% | 123.7% | - | - | Bed occupancy reduced. Safe staffing maintained with extra HCA support. |
| Ward 21 | 25 | 25 | 11 | 7.92 | 76.1% | 91.3% | - | 100.0% | 71.3% | 57.7% | - | 100.0% | Bed occupancy reduced . Safe staffing maintained for 11 beds. |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward 22 | 17 | 17 | 8 | 12.71 | 98.7% | 78.2% | - | - | 92.1% | 44.1% | - | - | Bed occupancy reduced. Safe staffing maintained for 8 beds |
| JCDS (Central Delivery Suite) | - | - | 10 | 12.61 | 88.7% | 59.2% | - | - | 92.0% | 96.2% | - | - | Bed occupancy reduced. Safe staffing maintained. |
| Neonatal Unit (NNU) | 35 | 35 | 22 | 28.94 | 83.5% | 58.1% | - | - | 86.6% | - | - | - | Bed occupancy reduced. Safe staffing maintained. |
| Paediatric Intensive Care Unit (PCCU) | 6 | 6 | 1 | 14.11 | 70.6% | 55.7% | - | - | 63.7% | - | - | - | Bed occupancy reduced to 1. Safe staffing maintained |
| Ward 17 JCUH | - | - | 24 | 54.70 | 85.6% | 70.2% | - | 100.0% | 90.3% | 68.9% | - | 100.0% | Bed occupancy reduced. Safe staffing maintained |
| Ward 19 Ante Natal | - | - | 5 | 7.04 | 64.9% | 72.7% | - | - | 98.4% | 82.4% | - | - | Average of 5 patients at midnight during August. Safe staffing maintained |
| Maternity Centre FHN | | | | | | | | | | | | - | Unit closed as required to ensure safe staffing on JCUH site |
| Spinal Injuries | 24 | 24 | 21 | 9.95 | 88.6% | 80.2% | - | - | 100.0% | 100.0% | - | - | |
| CCU JCUH | 14 | 14 | 9 | 15.74 | 77.4% | 69.1% | - | - | 81.1% | - | - | - | Bed occupancy reduced to 9. Safe staffing maintained |

The emergency department continues to plan for 19 RNs during the day and 18 RNs overnight during August. Worked RN numbers were 18 and 16 respectively. ED use agency via NHSP interface to support if required.

Zetland Ward and ED have been particularly challenged by staff unavailability and have been supported by redeployment.

Table 3 below shows recorded nurse sensitive indicators during August with 2 Serious Incident (SI) reported during August . No staffing factors were identified as part of the SI review process.

| Ward/Area Name | New or Deteriorating PU 2s (Inpatient) | New or Deteriorating PU 3s (Inpatient) | Medication Incidents | Falls | Complaints | Inpatient Survey | SIs |
|---|---|---|---|---|---|---|---|
| A&E | 9 | 0 | 2 | 0 | 1 | - | |
| Cardio HDU | 0 | 0 | 0 | 0 | 0 | 9.60 | |
| Ainderby Ward | 4 | 0 | 1 | 2 | 0 | 8.81 | |
| Clinical Decisions Unit | 2 | 0 | 3 | 5 | 0 | 9.08 | |
| Gara Ward | 0 | 0 | 3 | 1 | 0 | 9.61 | |
| Romanby Ward | 0 | 0 | 1 | 4 | 1 | - | |
| Ward 2 | 2 | 0 | 4 | 4 | 0 | 9.12 | |
| Ward 3 | 0 | 0 | 1 | 2 | 0 | 9.23 | |
| Ward 4 | 3 | 0 | 2 | 11 | 0 | - | |
| Ward 5 | 1 | 0 | 2 | 1 | 0 | - | |
| Ward 6 | 1 | 0 | 2 | 10 | 0 | - | |
| Ward 7 | 0 | 0 | 5 | 0 | 0 | 8.20 | |
| Ward 8 | 2 | 0 | 2 | 1 | 0 | 9.07 | 1 – Fall |
| Ward 9 | 1 | 0 | 6 | 1 | 0 | 8.94 | |
| Ward 10 | 2 | 1 | 2 | 11 | 0 | 9.45 | |
| Ward 11 | 0 | 2 | 1 | 0 | 2 | 8.55 | |
| Ward 12 | 2 | 0 | 1 | 3 | 0 | 8.66 | |
| Ward 14 | 1 | 0 | 1 | 3 | 0 | 9.41 | |
| Ward 15 | 0 | 0 | 0 | 1 | 0 | - | |
| Ward 16 | 0 | 0 | 0 | 0 | 0 | - | |
| Ward 17 | 0 | 0 | 2 | 0 | 0 | 8.51 | |
| Ward 21 | 0 | 0 | 0 | 0 | 0 | 9.21 | |
| Ward 22 | 1 | 0 | 0 | 0 | 0 | 9.48 | |
| Ward 24 | 1 | 0 | 0 | 10 | 0 | 9.47 | |
| Ward 25 | 0 | 0 | 0 | 0 | 0 | 9.57 | |
| Ward 26 | 1 | 0 | 0 | 7 | 0 | 8.81 | |
| Ward 27 | 0 | 0 | 0 | 4 | 0 | 9.46 | |
| Ward 28 | 1 | 1 | 0 | 8 | 0 | - | |
| Ward 29 | 1 | 0 | 2 | 1 | 0 | - | |
| Ward 31 | 4 | 0 | 1 | 5 | 0 | 9.40 | |
| Ward 32 | 1 | 1 | 0 | 4 | 0 | 9.57 | |
| Ward 33 | 0 | 0 | 6 | 1 | 0 | 8.49 | |
| Ward 34 | 6 | 0 | 3 | 5 | 1 | 8.71 | 1 – Fall |
| Ward 35 | 0 | 0 | 0 | 0 | 0 | 9.38 | |
| Ward 37 | 2 | 1 | 0 | 2 | 0 | 8.21 | |
| Coronary Care Unit | 0 | 0 | 0 | 2 | 0 | 9.63 | |
| Central Delivery Suite | 0 | 0 | 1 | 0 | 0 | - | |
| Maternity Assessment Unit | 0 | 0 | 1 | 0 | 0 | - | |
| Trauma Ward 36 | 2 | 0 | 1 | 4 | 0 | 8.80 | |
| General High Dependency | 15 | 0 | 2 | 0 | 0 | 9.52 | |
| General ICU 2 | 5 | 0 | 3 | 0 | 0 | - | |
| General ICU 3 | 7 | 0 | 0 | 0 | 0 | - | |
| Cardiothoracic ITU | 1 | 0 | 0 | 0 | 0 | - | |
| Special Care Baby Unit | 0 | 0 | 2 | 0 | 0 | 9.78 | |
| Spinal Injury HDU | 0 | 1 | 0 | 1 | 0 | 9.66 | |
| Spinal Injury Rehab Unit | 0 | 0 | 0 | 1 | 0 | - | |
| Neuro HDU | 1 | 0 | 1 | 0 | 0 | 9.47 | |
| Paediatric Critical Care Unit | 0 | 0 | 1 | 0 | 0 | - | |
| Ward 1 | 2 | 0 | 2 | 2 | 1 | - | |
| Friary Victoria Ward | 2 | 0 | 0 | 1 | 0 | 9.14 | |
| Rutson Fhn | 0 | 0 | 0 | 2 | 0 | 8.67 | |
| Zetland Ward | 1 | 0 | 6 | 5 | 0 | 9.45 | |
| Tocketts Ward | 0 | 0 | 0 | 2 | 0 | 9.34 | |

*Table 3 – Nurse sensitive indicators and 1000 voices scores*

A total of 98 red flags were reported during August in table four below, with shortfall of RN being the most common (59).

| Row Labels | Day | Night | Grand Total |
|---|---|---|---|
| AMBER Beds Open | 2 | | 2 |
| Delay in providing pain relief | 2 | 4 | 6 |
| Less than 2 RNs on shift | 6 | 8 | 14 |
| Missed 'intentional rounding' | 7 | 5 | 12 |
| RED Beds Open | 1 | | 1 |
| Shortfall in RN time | 38 | 21 | 59 |
| Vital signs not assessed or recorded | 2 | 2 | 4 |
| **Grand Total** | **58** | **40** | **98** |

*Table 4 Red flag reporting August 2021*

There were 94 DATIX reported relating to staffing during August. DATIX are submitted in advance of any likely staffing issues in areas. The main themes included ED below planned numbers, staff were redeployed from other areas to support. Redeployment decisions were made following safe staffing discussions with Matrons.

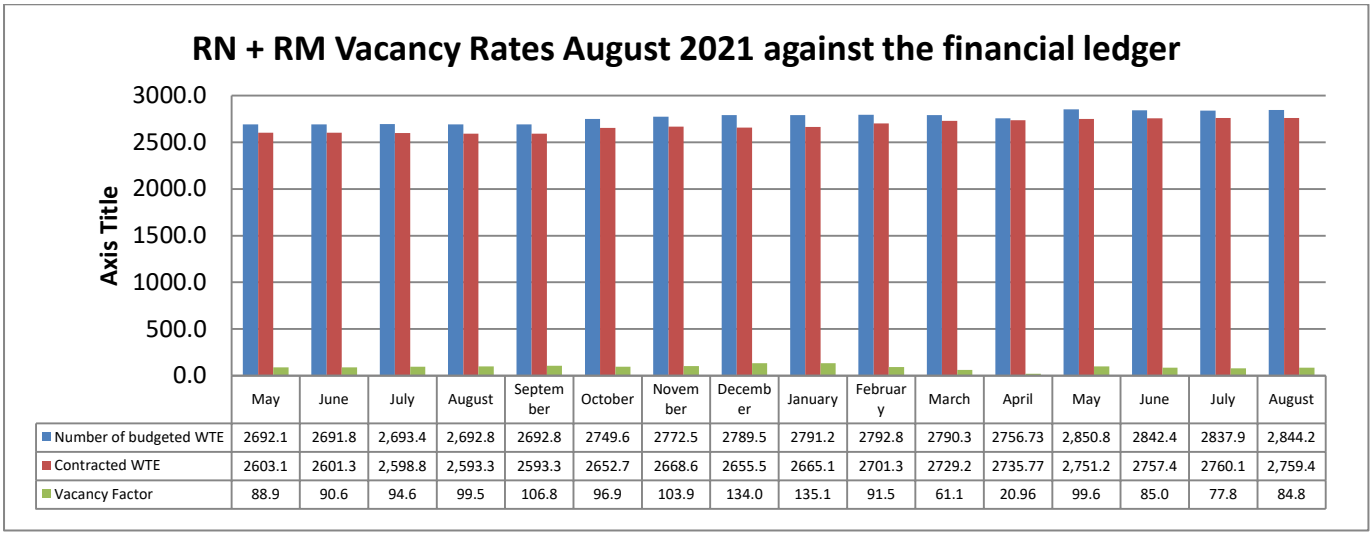
## Vacancy and Turnover

The total nursing and midwifery vacancy rates for RN remained static with HCAs recruited for support.

Recruitment of nursing staff continues as vacancies arise with vacancies being filled quickly. (Fig 1 and 2)

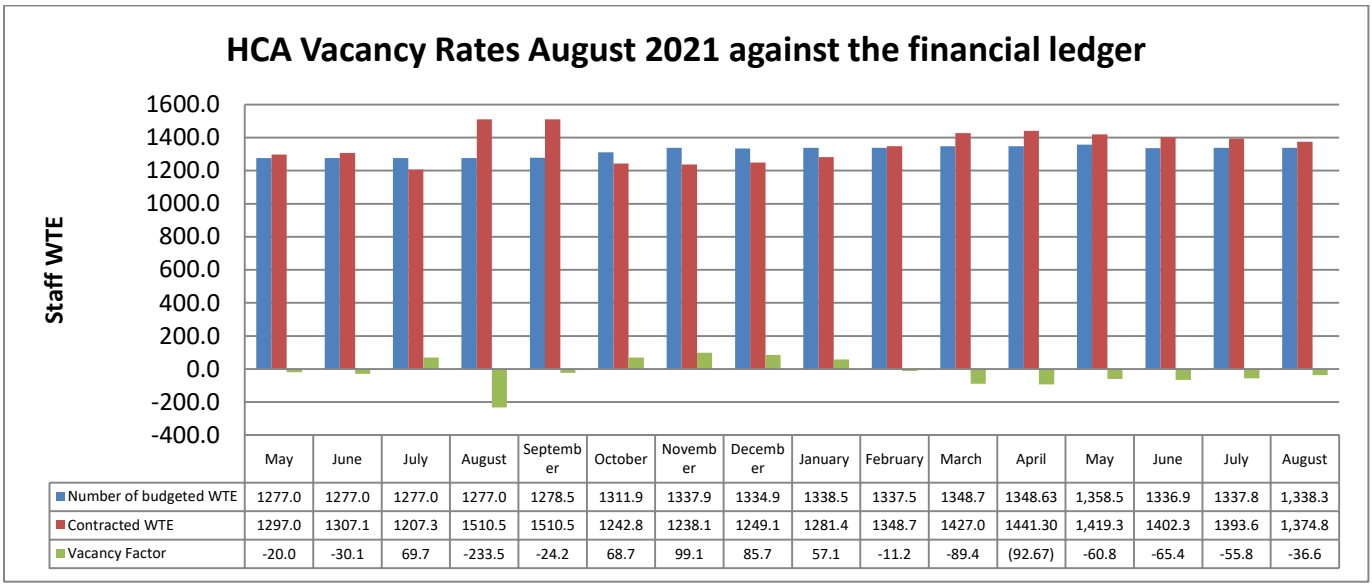
Nursing students interviewed in May group are now transitioning into substantive posts and will all be in post by November 2021.

**Figure 1 Registered Nursing Vacancy Rate August 2021**



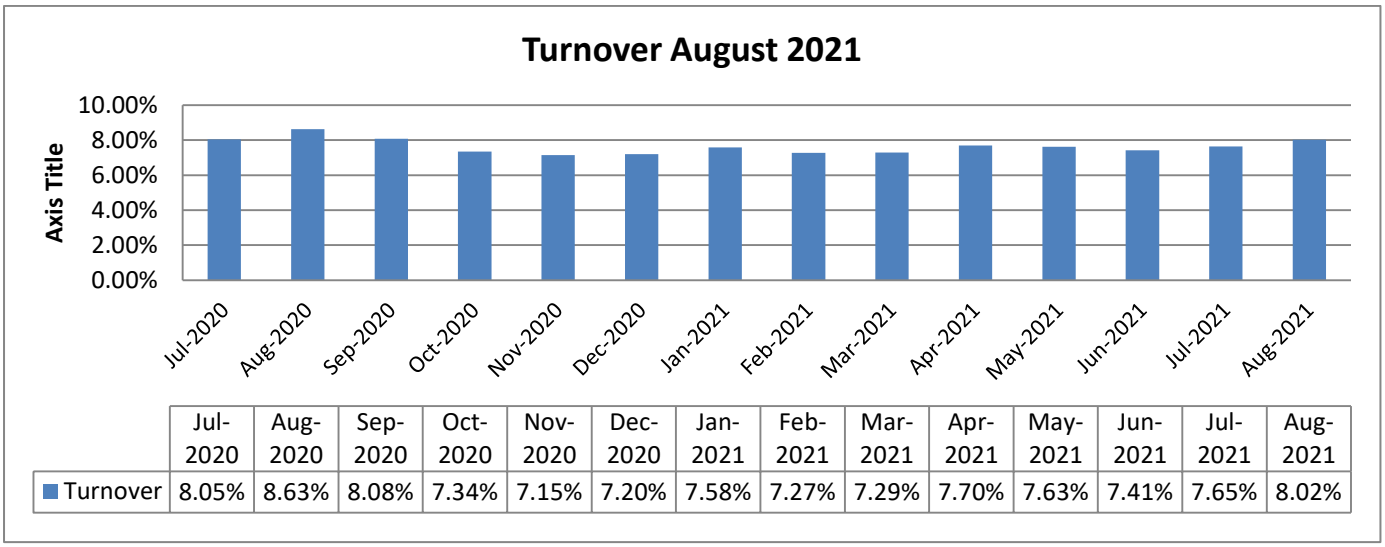

| | May | June | July | August | Septem ber | October | Novem ber | Decemb er | January | Februar y | March | April | May | June | July | August |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of budgeted WTE | 2692.1 | 2691.8 | 2,693.4 | 2,692.8 | 2692.8 | 2749.6 | 2772.5 | 2789.5 | 2791.2 | 2792.8 | 2790.3 | 2756.73 | 2,850.8 | 2842.4 | 2837.9 | 2,844.2 |
| Contracted WTE | 2603.1 | 2601.3 | 2,598.8 | 2,593.3 | 2593.3 | 2652.7 | 2668.6 | 2655.5 | 2665.1 | 2701.3 | 2729.2 | 2735.77 | 2,751.2 | 2757.4 | 2760.1 | 2,759.4 |
| Vacancy Factor | 88.9 | 90.6 | 94.6 | 99.5 | 106.8 | 96.9 | 103.9 | 134.0 | 135.1 | 91.5 | 61.1 | 20.96 | 99.6 | 85.0 | 77.8 | 84.8 |

## Figure 2 - Health Care Assistant Vacancy Rate August 2021




| | May | June | July | August | September | October | November | December | January | February | March | April | May | June | July | August |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of budgeted WTE | 1277.0 | 1277.0 | 1277.0 | 1277.0 | 1278.5 | 1311.9 | 1337.9 | 1334.9 | 1338.5 | 1337.5 | 1348.7 | 1348.63 | 1,358.5 | 1336.9 | 1337.8 | 1,338.3 |
| Contracted WTE | 1297.0 | 1307.1 | 1207.3 | 1510.5 | 1510.5 | 1242.8 | 1238.1 | 1249.1 | 1281.4 | 1348.7 | 1427.0 | 1441.30 | 1,419.3 | 1402.3 | 1393.6 | 1,374.8 |
| Vacancy Factor | -20.0 | -30.1 | 69.7 | -233.5 | -24.2 | 68.7 | 99.1 | 85.7 | 57.1 | -11.2 | -89.4 | (92.67) | -60.8 | -65.4 | -55.8 | -36.6 |

## Figure 3 Nursing Turnover August 2021




| | Jul-2020 | Aug-2020 | Sep-2020 | Oct-2020 | Nov-2020 | Dec-2020 | Jan-2021 | Feb-2021 | Mar-2021 | Apr-2021 | May-2021 | Jun-2021 | Jul-2021 | Aug-2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Turnover | 8.05% | 8.63% | 8.08% | 7.34% | 7.15% | 7.20% | 7.58% | 7.27% | 7.29% | 7.70% | 7.63% | 7.41% | 7.65% | 8.02% |

### Conclusion

Staff absence due to sickness and COVID isolation remain challenging in August. Safe staffing has been maintained through professional judgement, stretch staffing ratios, support from rostering of additional HCAs.

There has been one reported episodes for lack of supernumerary co-ordinators for Critical Care during August 2021.

Recruitment of newly registered nurses and midwives is welcomed.

| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 October 2021 | | | |
|---|---|---|---|
| Guardian of safe working report – Quarter 1 | | | **AGENDA ITEM: 10, ENC 8** |
| **Report Author and Job Title:** | Stacey Dixon – Medical workforce team manager | **Responsible Director:** | Dr Thomas Skeath (GOSW) |
| **Action Required** | Approve ☐ Discuss ☐ Inform ☒ | | |
| **Situation** | This report provides an update of South Tees Hospitals NHS Foundation Trust's participation in the 2016 Junior Doctor Contract. It encompasses the 3 month period between 1st April 2021 and 30th June 2021. | | |
| **Background** | It is a requirement of the 2016 Doctors and Dentists in Training Terms and Conditions that a quarterly report is submitted to Trust Board. The report should include a summary of exception reporting activity and vacancies in the Doctors and Dentists in Training Workforce. | | |
| **Assessment** | Please see body of report for statistics in relation to the quarter ending 30th June 2021.<br><br>The People Committee considered this on the 26th August 2021 and discussed the following points:<br><br>• Junior doctor vacancy rates<br>• Current review of the FlexiShift regional collaborative bank in enrolling LED onto the TempRE system in replace of the current paper claim form process.<br>• Exception reports raised total of 22 in Quarter 1 – April, May, June 2021.<br>• Dr Skeath agreed to meet with Mrs. Metcalf to discuss additional HR support/engagement. | | |
| **Recommendation** | The Trust Board of Directors are asked to note this report. | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | Principal Risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes<br>Principal Risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain | | |
| **Legal and Equality and Diversity implications** | There are no legal or equality & diversity implications associated with this paper. | | |
| **Strategic Objectives** | Best for safe, clinically effective care and experience ☒ | A great place to work ☒ | |
| | Deliver care without boundaries in collaboration | Make best use of our resources ☐ | |

| | | |
|---|---|---|
| | with our health and social care partners ☐ | |
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐ | |

South Tees Hospitals NHS Foundation Trust

**Guardian of safe working report – 1st April 2021 to 30th June 2021**

## 1. PURPOSE OF REPORT

This report provides an update of South Tees Hospitals NHS Foundation Trust's participation in the 2016 Junior Doctor Contract. It encompasses the 3 month period between 1st April 2021 and 30th June 2021.

The report also provides information in relation to rota gaps, recruitment activity and exception reporting activity.

## 2. BACKGROUND

It is a requirement of the 2016 Doctors and Dentists in Training Terms and Conditions that a quarterly report is submitted to Trust Board. The report should include a summary of exception reporting activity and vacancies in the Doctors and Dentists in Training Workforce.

## 3. DETAILS

### Key updates

3.1 The overall vacancy rate has increased slightly to 4.6% as at the end of June 2021. A number of MTIs (medical training initiative) doctors have been appointed to commence later in the year. Gaps on rotas tend to be short term due to sickness, COVID-19 isolation or emergency leave. The medical rota team track junior doctor sickness/leave and any doctors hitting trigger points are picked up by the relevant team (e.g. postgraduate team for foundation doctors, Lead Employer Trust for LET employed doctors). Locum shifts have increased significantly since the 2nd COVID-19 pandemic, by 20% on a monthly basis.

3.2 Advanced Nurse Practitioners are successfully being utilised to cover gaps in some areas and to support medical wards, at hospital at night.

3.3 The medical rota team continue to fill approximately 95% of all locum shifts each month with the majority (approximately 90%) being filled by internal locum cover as opposed to agency.

3.4 The regional collaborative locum bank (FlexiShift) hosted by the LET was well established. Therefore a decision was made to enrol the Trust (LED) doctors onto the system from the 5th August 2020. Due to COVID-19 pressures, this impacted, causing delays to doctors receiving payment for additional shifts which they had covered in such unprecedented times. The medical workforce team manager (Stacey Dixon) is currently seeking/reviewing feedback from the junior doctors with support from the BMA junior doctor representative following on from the last Junior Doctor contract forum meeting (JDCF) which took place on the 13th July 2021 in order to establish if any issues remain outstanding and to

receive confirmation as to whether or not the doctors are in favour of the electronic system (TEMP RE) which we use to assure all pay is made to doctors covering additional hours, Stacey will provide feedback to the relevant senior managers in order for a Trust decision to be made to enrol/not enrol the locally employed doctors onto the system to move away from the current paper claim form process to an established electronic system – further discussions will also take place in October 2021 JDCF meeting.

3.5 Foundation Year 1 & 2 level doctors will be employed by the Lead Employer Trust from August 2021.

3.6 There has been some delay in MTI appointments due to visa/embassy access in home countries.

3.7 The BMA have raised an enquiry with all regional Trusts in relation to prospective study leave allowance for doctors in training, to ensure that doctors have been in receipt of pay for prospective study leave allowance calculation, within their salary, in line with the updated change to the 2016 junior doctor contract TCS from February 2020. Some doctors working within the Trust during this time may have been affected by this change and that we have been instructed by the Lead Employer Trust, Northumbria Healthcare to withhold, along with other regional Trusts from taking any further action to resolve this matter at present. NHS Employers are currently in discussion with the BMA to agree what course of action Trusts will need to take, in order to resolve. The Lead Employer Trust informed that discussions are still undergoing following there meeting with NHS employers on the 17th May 2021, and they will update Trusts accordingly.

3.8 The Junior Doctors Forum has continued to be well attended since the April 2021 rotation.

3.9 Exception reporting submissions continue to be consistently lower than expected.

## 4 Data summary and commentary

### Numbers of doctors in training

**Table 1.1**

| | |
|---|---|
| Number of doctors / dentists in training (total): | **360** |
| Number of doctors / dentists in training on 2016 TCS to date(total): | **360** |

4.1 In addition to the above, the Trust is also allocated up to 37 military doctors in training who are employed on military terms and conditions and who are technically not under the protection of the Guardian of Safe working. Following previous agreement, military colleagues have access to the exception reporting system. This allows military colleagues to highlight any issues with rotas and will provide departments and the guardian with additional information in relation to the safe working of rotas.

4.2 All Local employed Trust Doctors appointed from the 5th August 2020 are employed on a Trust 2016 TCS contract and have access to the exception reporting system, which will replace the monitoring exercise which took place in line with the previous 2002 trust contract TCS, this will also give the opportunity to be able to raise exception reports to highlight any issues with rotas, as stated in the paragraph above.

## 5 Amount of time available in job plan for guardian to carry out duties of the role

6 Hours per week – GOSW
3.5 hours per week – Deputy GOSW

## 6 Exception reports

### Table 2.1

The tables below provides the total number (**22)** Exception Reports (ER) raised in the last quarter between 1st April 2021 and 30th June 2021, and provides the exception reporting category the ER was raised.

| Exception Reports (ER) over past quarter | |
|---|---|
| **Reference period of report** | 01/04/21 - 30/06/21 |
| **Total number of exception reports received** | 22 |
| **Number relating to immediate patient safety issues** | 0 |
| **Number relating to hours of working** | 15 |
| **Number relating to pattern of work** | 1 |
| **Number relating to educational opportunities** | 3 |
| **Number relating to service support available to the doctor** | 3 |

**Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.

**Table 2.2**

Provides an over view of ER outcomes and resolutions and also consists of ER numbers carried over from the previous quarter – 1st January 2021 to the 31st March 2021.

| ER outcomes: resolutions | |
|---|---|
| **Total number of exceptions where TOIL was granted** | 6 |
| **Total number of overtime payments** | 12 |
| **Total number of work schedule reviews** | 0 |
| **Total number of reports resulting in no action** | 8 |
| **Total number of organisation changes** | 0 |
| **Compensation** | 0 |
| **Unresolved** | 33 |
| **Total number of resolutions** | **26** |
| **Total resolved exceptions** | **26** |

**Note**:
* Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.

* Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.

* Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.

**Table 2.3**

Provides an overview of reason for ER raised over the last quarter broken down per speciality and grade, this table also relates to ER's carried over from the previous quarter.

**Reasons for ER over last quarter by specialty & grade**

| ER relating to: | Specialty | Grade | No. ERs carried over from last report | No. ERs raised | No. ERs closed | No. ERs outstanding |
|---|---|---|---|---|---|---|
| **Immediate patient safety issues** | | | | | | |
| **Total** | | | **0** | **0** | **0** | **0** |
| **No. relating to hours/pattern** | Acute Medicine | FY1 | 1 | 0 | 0 | 1 |
| | Diabetes & endocrinology | FY2 | 2 | 0 | 0 | 2 |
| | Gastroenterology | FY1 | 1 | 0 | 0 | 1 |
| | Gastroenterology | FY2 | 0 | 1 | 1 | 0 |
| | General medicine | FY1 | 2 | 0 | 0 | 2 |
| | General medicine | FY2 * | 0 | 6 | 5 | 1 |
| | General surgery | FY1 | 15 | 1 | 3 | 13 |
| | General surgery | FY1 * | 2 | 0 | 0 | 2 |
| | Neurology | FY2 * | 4 | 0 | 4 | 0 |
| | Neurosurgery | FY2 | 0 | 3 | 3 | 0 |
| | Obstetrics and gynaecology | FY2 | 0 | 2 | 2 | 0 |
| | Obstetrics and gynaecology | ST2 | 0 | 1 | 1 | 0 |
| | Trauma & Orthopaedic Surgery | FY1 | 11 | 0 | 4 | 4 |
| | Trauma & Orthopaedic Surgery | FY2 * | 0 | 2 | 0 | 2 |
| **Total** | | | **38** | **16** | **23** | **28** |
| **No. relating to educational opportunities** | Cardio-thoracic surgery | ST5 | 0 | 1 | 0 | 1 |
| | General medicine | FY2 * | 0 | 1 | 1 | 0 |
| | General surgery | FY1 | 0 | 1 | 0 | 1 |
| **Total** | | | **0** | **3** | **1** | **2** |
| **No. relating to service support** | General medicine | FY1 | 1 | 0 | 0 | 1 |
| | General surgery | FY1 | 1 | 0 | 0 | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **available** | Neurology | FY2 * | 0 | 2 | 2 | 0 |
| | Trauma & Orthopaedic Surgery | FY2 * | 0 | 1 | 0 | 1 |
| **Total** | | | **2** | **3** | **2** | **3** |

Exception reports continue to be predominantly for the reason of additional hours being worked which is being compensated with payment or time in lieu.

No ER's have been raised in relation to ISC.

The recent increase of exception reports within general medicine is due to overtime, which has now been resolved.

The x17 general surgery (FY1) ER's is due to natural breaks/over time and there are a total of x10 exception reports raised by x1 doctor, the clinical lead will liaise with the junior doctor in order to resolve and agree the appropriate outcome and close down the ER's within the system to remove the ER's outstanding status.

There has been a recent increase to the number of ER's raised in Trauma & Orthopaedic Surgery and the guardian of safe working is currently liaising with the clinical director/leads to resolve.

**Guardian of safe working fines**

There were no Guardian of Safe working fines issued during the quarter.

## 7 Vacancy information

**Table 3**

Outstanding vacancies as of May 2021 in the run up to/from August 2021 main changeover/rotation

| Specialty | Grade | Vacancies | Comments |
|---|---|---|---|
| Neurosurgery | FY2 | 1 | X1 FY2 gap for four months - OOH being covered with Locum. |
| Neurosurgery | CT1 | 0 | X5 delayed starters - OOH to be covered with locum in the interim. |
| Neurosurgery | ST3 | 1 | x1 Reg post out to advert |
| Cardiothoracic Surgery | FY2 | 1 | Candidates being shortlisted |
| Neuro Rehab | CT1 | 0 | Uzma Nisar appointed – in Pakistan – delayed by one month |

| | | | |
|---|---|---|---|
| Diabetes/Endocrine | FY1 | 1 | Delayed via the LET - Kerry (rota coordinator will ensure the clinical director is updated. |
| Diabetes/Endocrine | MTI | 1 | Appointed 28th May 2021, Dr Arutchelvam aware regarding the delay. |
| Diabetes/Endocrine | Trust Doctor | 3 | Appointed x3 doctors - Dr Gul - awaiting OH clearance, Dr Lee delayed in Malaysia - visa issue, 3rd gap out to advert - C Dixon (Medical recruitment coordinator) will keep both Clinical directors/Rota coordinators updated. |
| Care of the Elderly | FY1 | 1 | Appointed Dr Alfadil - delayed starter awaiting PEC completion - C Dixon (Medical recruitment coordinator) liaising with the Doctor to arrange start date for the 4th August 2021 |
| Care of the Elderly | FY2 | 1 | Delayed starter via the LET due to visa issue, OOH being backfilled with locum in the interim. |
| Care of the Elderly | IMT3 | 1 | Delayed IMT3 starter via the LET - Kerry 9Rota coordinator) awaiting an update - Dr Denham aware as Clinical Director. |
| Infectious diseases | Trust Doctor | 0 | Out to advert - Dr Eleanor Lynch backfilling as locum, in the interim 9-5pm only from the 4th August 2021 |
| Rheumatology | GP Trainee | 1 | Kerry (RC) awaiting update from the LET - Dr Plant is aware. |
| Breast | FY1 | 2 | x2 Trust Doctors appointed to backfill x2 vacancies, potential delayed starters as awaiting completion of PEC - C. Dixon (medical recruitment coordinator) trying to push these through urgently in readiness to commence on |

| | | | |
|---|---|---|---|
| | | | the 4th August 2021. |
| Colorectal | FY1 | 1 | X1 Deferred starter until Dec 2021 - Contingency is that the rota has been reduced - therefore no backfill required for this gap. |
| Colorectal | FY2 | 2 | X2 FY2 doctors delayed due to PEC and being overseas, Lorraine (Rota coordinator) will be liaising with the department to update upon updates of start dates from the LET. The OOH will be covered with locum in the interim as contingency. |
| Upper GI | FY1 | 1 | Deferred start date - rota reduced as a contingency - no backfill to vacancy required. |
| Orthopaedics | FY2 | 1 | 27th July 2021 - Dr Phil Holland appointed Dr Maschal Farooq - has right to work in the UK. The FY2 doctor rotating in from the LET is delayed (Dr Alvin Tan) the department are aware and have agreed to backfill with locum. |
| Cardiology | CT1/2 | 2 | X2 delays due to visa issues - Linda (Rota Coordinator) has updated the department and a contingency is in place. |
| Gastroenterology | FY1 | 1 | Dr Thant Oo appointed Dr Kialash Lallbeeharry on 28th July 2021. OOH to be backfilled with locum in the interim. |

| | | | |
|---|---|---|---|
| Emergency Medicine | Trust Doctor | 1 | x4 Trust doctors appointed, x1 delayed starter - Dr Omer Ahmed, agreed start date with clinical rota lead (Dan Bearn) |
| Emergency Medicine | ST3+ | 0.8 | Vacancy to be backfilled when the EM Registrars commence in September 2021, department running with gap until then and trying to backfill OOH with locum. |
| Acute medicine | Trust Doctor | 1 | Appointed Dr Elhaj - delayed starter due to visa issues |
| Acute medicine | | 2 | Awaiting updates from the LET x1 who is currently off sick - Kerry (Rota coordinator) will be communicating with Dr Oo to update/plan contingency and agree whether or not to advertise the second vacancy. |
| | **TOTAL** | **26.8** | |

## 8 ASSESSMENT
**Summary of risks/issues and next steps**

8.1 Health Roster – The Allocate contract is up for renewal in November 2021, discussions are currently taking place and the implementation of inputting the junior doctor trust rotas (manual excel spreadsheet) is currently on hold, we have the below speciality junior doctor rotas on health roster to date and are currently running with a parallel process in the coordination of the rotas in updating the excel spreadsheet forms and health roster.

1) Paediatrics
2) Trauma & Orthopaedic Surgery
3) Anaesthetics

8.2 No COVID rota has been implemented as we approached the third wave for junior doctors. Regional discussions between guardians have highlighted that there may need to be exemptions to the 2016 contract but some aspects must be adhered to –this is in relation to safety - especially in total hours worked per week and rest between shifts, the other aspects of the 2016 T&C may need to be flexible.

9 **LET Recruitment and rotation timeline August 2021 Update** – All regional Trust DME's have been informed that Health Education England (HEE) have amended the recruitment timelines for Specialty and GP recruitment this year resulting in delays to employers receiving information for new starters. Given this - discussion had been had nationally with HEE, BMA and NHS Employers as the Code of Practice will be difficult to achieve. The LET have reviewed timelines for recruitment locally with HEENE and have agreed the below timeline:-

**Timeline**

9.1 The LET will issue Management Report for **Foundation year 1 on 3rd May** – please note this should follow COP therefore it is expected Trusts will upload Work Schedules for FY1's by 17th May and LET will issue to trainees by 28th May.

9.2 The LET will issue the first Management report **25th May** (10 weeks before changeover) – please note this will **not** include Standalone Foundation Year 2 or IMT Year 3. Difficulties in producing rotations for this timescale have also been raised by ACCS/Anesthetics and Psychiatry but work is ongoing with these specialties. As ever the LET will communicate in full when the first Management Report is available and which specialties are not included on it.

9.3 Further management report will follow on 2nd June with trainees appointed at Round 2 and **possibly** IM3 trainees included.

9.4 The Trusts will provide the LET the Generic Work Schedules by the **8th June** (8 weeks before changeover)

9.5 The LET will issue all Generic Work Schedules received by the **23rd June** (6 weeks before changeover)

9.6 The Trusts will issue all rotas by the **7th July** (4 weeks before changeover)

9.7 The medical rota team will be working on producing work schedules for LET DIT, to meet the deadlines outlined, in the above LET Recruitment and rotation timeline - August 2021, upon receipt of management reports, and will be liaising with speciality clinical leads within the Trust to ensure they are updated with establishment numbers/vacancies in readiness for August 2021.

9.8 The challenge will be in recruiting to backfill vacancies, in a timely manner due to delays in receiving the management report information. The medical workforce team manager (Stacey Dixon) will be liaising with the medical education team lead (Louise Campbell) within the next week to discuss and agree next steps.

9.9 Self-development time – Foundation Doctors, Health Education England's (HEE) foundation programme review recommended that foundation doctors should have dedicated time for self-development. All Trusts with foundation doctors need to ensure that from August 2021, they are provided with two hours per week (self-development time) within the work schedules for both year one and year two foundation doctors.

9.10 The Guardian of Safe working in submitting this report to the Trust Board acknowledges the work which has been undertaken by the medial workforce and postgraduate teams and clinicians within departments to manage the additional work involved in the implementation of the 2016 contract.

9.11 The contract remains work in progress. Currently our issues are centred on the implementation of the changes to the contract from December 2019 and the challenges of ensuring rotas remain compliant with the contractual rules. The main issue is around weekend working but all rotas are now 2016 compliant but there are issues around vacancies and recruitment in readiness for August 2021 junior doctor changeover.

## 10 RECOMMENDATIONS

That the Trust Board acknowledges and accepts the Quarterly Guardian of Safe working Report

**APPENDICES**
(List any appendices)

South Tees Hospitals
NHS Foundation Trust

| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 OCTOBER 2021 | | | |
|---|---|---|---|
| **Freedom to Speak Up Update** | | | **AGENDA ITEM: 12**<br>**ENC 9** |
| **Report Author and Job Title:** | Abbie Silivistris<br>Freedom to Speak Up Guardian<br>Ian Bennett<br>Freedom to Speak Up Guardian & Deputy Director of Quality & Safety | **Responsible Director:** | Dr Hilary Lloyd<br>Chief Nurse |
| **Action Required** | Approve ☐ Discuss ☐ Inform ☒ | | |
| **Situation** | This report provides an update on the work of the Freedom to Speak Up (FTSU) Guardians during Q2. | | |
| **Background** | The Freedom to Speak Up Guardian role was created as a result of recommendations from Sir Robert Francis following his review of the Mid-Staffordshire Hospital.<br><br>A new FTSU model was introduced at the trust in 2020 and continues to be well received by staff.<br><br>FTSU Guardians encourage workers to speak up about concerns with the aim of improving patient safety and staff experience.<br><br>The themes arising from the issues raised can be shared and used to improve learning and improvement within the organisation. | | |
| **Assessment** | Staff continue to speak up within the organisation. The number of issues reported to the FTSU Guardians has decreased slightly from 19 in Q1 to 13 in Q2 (up to 5th September 2021).<br><br>The main themes identified from the 13 issues are:<br>• Management<br>• Incivility<br>• Communication issues<br><br>As a result of staff speaking up a number of organisational learning points have been identified and recommendations have been made on how the trust could improve.<br><br>FTSU Guardians are also taking action to improve FTSU culture and the revised Freedom to Speak Up: Raising Concerns P39 Policy is now available on the intranet.<br><br>Freedom to Speak up training is now part of Trust Induction and also covered as part of the management essentials training. Further work is still required to ensure the National Guardians Office FTSU training for managers is available across the Trust.<br><br>As mentioned in a previous report, the FTSU Guardians have completed a GAP analysis based on the recommendations set out in the 8 National | | |

| | | |
|---|---|---|
| | Guardian Office (NGO) case reviews. To date 94 actions are green and completed and 8 are amber and on track to be completed.<br><br>In July, the trust was visited by Dr Henrietta Hughes, the National Guardian for Freedom to Speak up. The purpose of Dr Hughes' visit was to meet with the trust's FTSU Guardians and to join the Board of Directors development session, in order to hear about our improvements which saw the Trust ranked the 3rd most improved trust in the nation.<br><br>South Tees Hospitals NHS Foundation Trust has been shortlisted in the HSJ Awards 2021 in the 'Freedom to Speak Up Organisation of the Year' category. The live judging day is due to take place on 28th September with the winners announced on the 18th November 2021. | |
| **Recommendation** | Members of the Board of Directors are asked to receive the report | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | Principal risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes<br>Principal risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain | |
| **Legal and Equality and Diversity implications** | There are no legal or equality & diversity implications associated with this paper. | |
| **Strategic Objectives** | Best for safe, clinically effective care and experience ☒ | A great place to work ☒ |
| | Deliver care without boundaries in collaboration with our health and social care partners ☐ | Make best use of our resources ☐ |
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐ | |

# Freedom to Speak Up Update

## 1. PURPOSE OF REPORT

The purpose of the report is to update the Board on the progress made by the Freedom to Speak up (FTSU) Guardian team since the submission of the previous report in June 2021.

The report provides an overview of the themes and issues raised between 1st July 2021 to 5th September 2021 (Q2).

## 2. BACKGROUND

The Freedom to Speak Up Guardian role was created as a result of recommendations from Sir Robert Francis following his review of the Mid-Staffordshire Hospital.

FTSU Guardians help to protect patient safety and quality of care, improve the experience of workers and promote learning and improvement. This is achieved by supporting workers to speak up about concerns, breaking down barriers to speaking up and ensuring that issues raised are used by the trust as opportunities for learning and improvement.

The current Freedom to Speak Up (FTSU) model employed in the Trust has been in place since September 2020 with 2 WTE guardians covering the Trust.

## 3. DETAILS

### 3.1 Assessment of cases in Q2.

Thirteen new issues were raised in Q2, which is a slight decrease in the number of issues raised compared to Q1, when 19 were raised.

With a head count of just under 10,000 staff, South Tees Hospitals NHS Foundation Trust falls under the classification of a medium sized organisation as defined by the NGO (between 5,000 and 10,000 workers). According to the 2020/2021 Annual Speaking Up Data Report from the NGO which reflects on key trends and themes around speaking up across organisations, the average number of cases that were raised with FTSU Guardians per quarter in medium sized organisations in the 2020/2021 calendar year was 26. With 19 issues raised in Q1 and 13 raised in Q2, the trust is slightly below the trend.

As shown in the table below the number of colleagues speaking up confidentially has remaining approximately remained the same over Q1 and Q2. In Q2 two previously closed down cases have been reopened.

<u>Themes</u>

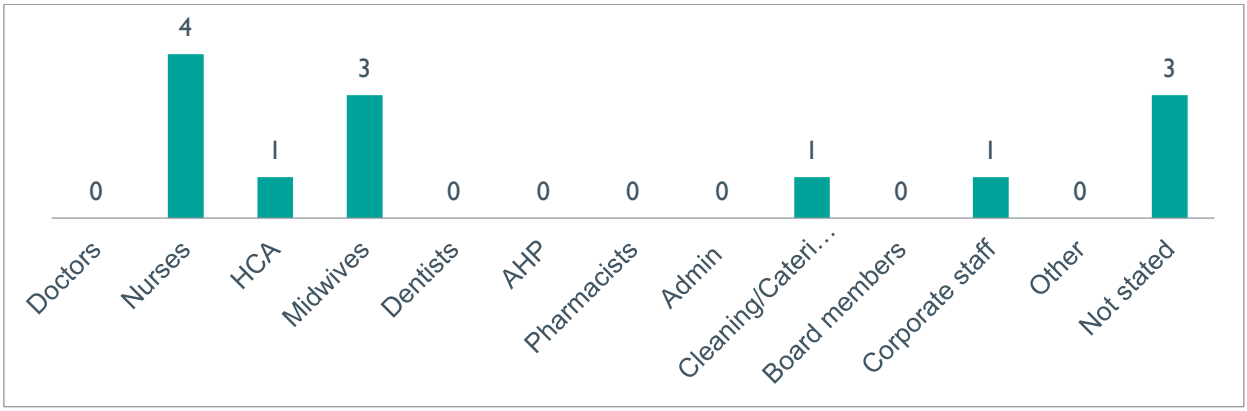
The themes raised are detailed in Table 1 below.

**<u>Table 1</u>**

| Themes | Q2 | Raised | | |
|---|---|---|---|---|
| Incivility/culture | 8 | | Q1 | Q2 |
| | | Openly | 6 (31.6%) | 2 (15.4%) |
| Leadership and management | 8 | Confidentially | 6 (31.6%) | 5 (38.5%) |
| Bullying and harassment | 5 | Anonymously | 7 (36.8%) | 6 (46.2%) |
| Favouritism/Nepotism | 3 | | | |
| Staffing/Workload | 7 | | | |
| HR systems and processes | 5 | | | |
| Systems and processes | 1 | | | |
| Staff training/supervision | 1 | | | |
| Patient Safety | 3 | | | |
| Equipment and facilities | 2 | | | |
| Fraud | 0 | | | |
| Confidentiality/Information Governance | 1 | | | |
| Staff health and safety | 6 | | | |
| Communication issues | 8 | | | |
| Equality, Diversity and Inclusion | 3 | *Note that one concern may include a number of themes. | | |

Char1 below shows the number of concerns raised by staff group in Q2.

**Chart 1.**




Professional Level

Table 2 below shows the professional levels of staff who have spoken up in Q2.

**Table 2.**

| Professional level | Q2 |
|---|---|
| Worker | 6 (46%) |
| Manager | 3 (23%) |
| Senior Leader | 0 |
| Unknown | 4 (31%) |

Concerns raised by Collaboratives

Table 3 below identifies the concerns raised by collaboratives.

**Table 3.**

| Collaborative | Q2 |
|---|---|
| Cardiovascular Care Services | 1 |

| | |
|---|---|
| Clinical Support Services | 1 |
| Medicine and Emergency Care Services | 2 |
| Women and Children's Services | 6 |
| Nursing and Quality | 1 |
| STRIVE | 2 |

### 3.2 Potential patient or worker experience issues

Leadership and management issues tend to originate from poor communication between staff and a line manager or person in seniority. This tends to demonstrate itself by the behaviour of instructing the member of staff 'to do' rather than asking/requesting. Other issues were related to the perceived unfair delegation of work.

Incivility/culture and bullying and harassment-related issues include staff speaking inappropriately to each other, not feeling listened to.

There have been no reports of staff receiving detrimental treatment as a result of speaking up in Q2.

### 3.3 Learning and Improvement

As a result of staff speaking up lessons learnt in the small number of cases described above include:

- The importance of investigations being objective and carried out to a high standard and in a timely manner.
- The importance of compassionate leadership and management styles.
- The importance of feeding back the results of Task and Finish groups and investigations to staff on the front line. If specific suggestions for improvement cannot be accommodated the rationale behind this should be explained to staff.
- Importance of liaising with STRIVE to ensure comprehensive work is done to improve overall organisational working and the accessibility of these services following an issue being raised i.e. multidimensional working.
- Reiteration of the independence and impartiality of the FTSU team.

Due to staff speaking up the following improvements have been made:

- Safety has improved in one area due to staff members being encouraged to complete documentation contemporaneously.
- Regular ward manager meetings are being arranged to improve shared support and learning in another area.
- Newly qualified staff are to be contacted regularly prior to them starting in post to ensure they feel connected and welcomed, with 'drop in' days being organised to support their orientation.
- More managers are being encouraged to attend the Management Essentials Programme, which included an element of FTSU training.
- A Childless Not By Choice (CNBC) staff network has been set up.

- An additional break room has been provided for staff within a specific service.

### 3.3 Action taken to further improve FTSU

All 22 FTSU Champions have now been trained and we have now recruited a number of Champion colleagues from the Military. We plan to have a welcome lunch on 1st October to celebrate the start of 'Speak Up Month' and introduce our Champion colleagues to more senior members of the organisation.

The FTSU Guardians now meet on a bimonthly basis with the Human Resources Business Partners to discuss emerging themes and identify specific areas that may need assistance.

The NGO has completed eight case reviews with numerous recommendations and the FTSU Guardians have performed a GAP analysis to ensure the Trust has been benchmarked against these. It is encouraging to see that the Trust is already implementing most of the recommendations, with 94 being rated green and already in place and 8 being rated amber and expected to deliver, with no recommendations rated RED.

### 3.4 National Guardians Office Developments

As mentioned in our previous report, in May 2021 the NGO published the FTSU index in which South Tees was ranked as the 3rd most improved trust overall and the most improved acute Trust. Our position FTSU score increased by 4.5% and improved our positioning from 224th out of 230 in 2019 to 161st out of 219 in 2020.

In July 2021, Dr Henrietta Hughes The National Guardian for Freedom to Speak Up visited South Tees to learn more about our improvement journey and to suggest ways in which the organisation can further improves its speaking up culture. She is retiring from her role and recruitment is underway to appoint her successor.

Dr Henrietta Hughes' suggestions included:

- 'Speak Up' (for workers) and 'Listen Up' online training (for managers) is currently available and 'Follow Up' training (for Senior Leaders) is due to be published in October 2021. Senior leaders can role model this by undertaking the training themselves.
- Speak Up Month in October is a great way to increase engagement and to do some 'you said, we did' in your communications.
- A quarterly steering group , bringing together FTSU Guardians, HR, Staff Side, Complaints, Incidents, Staff Networks etc is an excellent way to bring themes together to identify hotspots of culture.
- We discussed anonymous cases, the possible causes and steps to understand in more detail.
- We discussed investigations and how workers and investigators could be supported with some principles of a good investigation and training and a support network for investigators.
- Drilling down into your data is a way that some trusts learn more about vulnerable groups and then address barriers they face to speaking up.

As mentioned in our previous report, the FTSU guardians have put forward a submission to the Health service Journal (HSJ) Awards in the Freedom to Speak Up Organisation of the Year category. It was announced in August 2021 that South Tees Hospitals Foundation Trust has been shortlisted and live judging is due to take place online on 28th September 2021, with the winners being announced on 18th November 2021

**As a result of Dr Hughes' observations we will**

- Review the Quality Assurance process following concerns being raised and closed, in order to provide greater assurance on the quality of investigations.

- Develop 'principles of an effective FTSU investigation' in collaboration with the HRBPs.

- Strengthen the process so that front line staff are kept up to date with the results of investigations and any planned changes or improvements to their area of work.

- Discuss and consider making management essentials training mandatory for all new and existing managers, in order to enhance their soft skills and reduce issues arising due to poor communication.

- Encourage managers all levels in the Trust to use the 'You Said, We Did' approach and review the working practices in their areas to see if small changes can be made to reduce the pressure on staff e.g. ensure documentation is not repetitive.

- Discuss with HRBPs the issue of requests for re banding and the delay some staff have experienced in the process being concluded

**Recommendations**

Members of the Board of Directors are asked to receive the report

| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 OCTOBER 2021 | | | |
|---|---|---|---|
| **Workforce Disability Equality Scheme (WDES) Update report** | | | **AGENDA ITEM: 13, ENC 10** |
| **Report Author and Job Title:** | Denise Curtis-Haigh<br>HR Business Partner | **Responsible Director:** | Rachael Metcalf,<br>Director of HR |
| **Action Required** | Approve ☐ Discuss ☒ Inform ☒ | | |
| **Situation** | The purpose of the reports is to provide an update regarding the Trust WDES data reporting for 2020/21, reported across 10 key metrics. | | |
| **Background** | The WDES is integrated as part of the South Tees Hospitals NHS Foundation Trust People Plan 2021-23.<br><br>Embedding Equality Diversity and Inclusion (EDI) is a national priority and this forms one of our five key strategic enablers. Data from 6 metrics is taken from the NHS national Staff Survey. | | |
| **Assessment** | The metrics data has been reviewed and findings have been summarised along with current strategic objectives and actions. | | |
| **Recommendation** | Members of the Trust are asked to note the report | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | Principal risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain | | |
| **Legal and Equality and Diversity implications** | The report is written as part of the Equality, Diversity and Inclusion Strategy. | | |
| **Strategic Objectives** | Best for safe, clinically effective care and experience ☐ | A great place to work ☒ | |
| | Deliver care without boundaries in collaboration with our health and social care partners ☐ | Make best use of our resources ☐ | |
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐ | | |

South Tees Hospitals NHS
NHS Foundation Trust

# NHS Workforce Disability Equality Standard (WDES)

## Annual Report 2021

South Tees Hospitals NHS Foundation Trust

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## Executive Summary

The Workforce Disability Equality Standards (WDES) is a set of ten measures (metrics) that will enable NHS organisations to compare the experience of disabled and non-disabled staff. The submission was new for 2019 and like the Workforce Race Equality Standard (WRES) its an opportunity for NHS Trusts to hold up the mirror to organisational performance on the equality agenda and develop action plans to facilitate progress in each metric, to improve the experience of disabled staff with in the Trust

There is still additional work to be done to improve the number of staff who declare themselves as disabled. Our ESR data set shows that 254 members of staff 2.62% have declared a disability. 6292 members of staff have said they do not have a disability which equates to 65.01% of the workforce. However 3133 members of staff which is 32.3% of our workforce are currently unknown.

## Introduction

The Workforce Disability Equality Standard (WDES) is a set of ten measures (metrics) that will enable NHS organisations to compare the experience of disabled and non-disabled staff. This information will then be used to develop a local plan which will enable the Trust to demonstrate progress against the indicators of disability equality

The WDES has been commissioned by the Equality and Diversity Council (EDC). It is mandated through the NHS Standard Contract and is restricted to NHS Trusts and Foundation Trusts for the first two years on implementation. The WDES comprises ten metrics. The metrics have been developed to capture information relating to the experiences of disabled staff in the NHS.

Metrics 4, 5, 6, 7, 8 and 9 are based on staff survey results. As a Trust we opt for a full census approach which resulted in the 2020 response rate producing 2,452 returned questionnaire will equates to a 28% return rate.

At South Tees NHS Foundation Trust we have a workforce of 9,679 staff. Our Electronic Staff Records (ESR) data shows 254 staff (2.62%) have declared themselves as disabled. 6292 staff members (65.01%) have declared as not having a disability and 3133 staff (32.37%) of the workforce have not declared their disability status.

Declaration rates for disability is a national issue, we are working locally with other Trusts in the North East and Yorkshire region to look at how we can encourage staff to update their information. If a significant proportion of staff are not declaring their disability status this can call into question all the information, analysis and subsequent action plan that has being based on these figures. It is therefore important that further work is undertaken during 2021/22 to improve declaration rates.

In addition we need to encourage a higher uptake of our annual staff survey. With a return rate of 28% mapped against 2.62% of our total workforce declaring themselves as disabled it is challenging to provide fully representative analysis and assurance.

## Data Summary

### Workforce

| | |
|---|---|
| 1. Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. | At 31st March 2021<br><br>**Non-Clinical**<br><br>Disability /No Disability/ Unknown<br><br>Band 1 0.00% /100% /0%<br>Band 2 3.7% /67.50% /28.8%<br>Band 3 3.8% /73.1% /23.1%<br>Band 4 2.5% /53.20% /44.30%<br>Band 5 3.7% /69.50% /26.8%<br>Band 6 1.3% / 67.90% /30.80%<br>Band 7 1.5% / 78.8% /19.70%<br>Band 8a 0.0% /88.70% / 11.30%<br>Band 8b 0.0% / 75.0% / 2.5%<br>Band 8c 0.0% / 80.0% / 20.0%<br>Band 8d 0.0% / 71.4%/ 28.6%<br>Band 9 0.0% / 64.70% / 35.30%<br><br>VSM 0.0% / 64.7% / 35.30%<br>Other 0.0% /100% / 0.0%<br><br>**Cluster 1**<br>Band 1 -4 3.5% / 65.7% / 30.8%<br><br>**Cluster 2**<br>Band 5-7 2.6% / 71.1% /26.3%<br><br>**Cluster 3**<br>Band 8a-8b 0% / 84.4% / 15.6%<br><br>**Cluster 4**<br>Band 8c -9 & VSM 0% / 72.5% / 27.5% |

| | | |
|---|---|---|
| | **Clinical**<br><br>Disability /No Disability /Unknown<br><br>Band 1 0.0% / 75.0% / 25%<br>Band 2 2.67% / 72.05% /25.28%<br>Band 3 1.76% / 54.29% / 43.96%<br>Band 4 4.63% / 58.29% / 37.07%<br>Band 5 3.49% / 71.37% / 25.14%<br>Band 6 2.82% / 61.87% / 35.31%<br>Band 7 1.13% / 60.20% / 38.66%<br>Band 8a 0.53% / 57.67% / 41.80%<br>Band 8b 0.0% / 39.47% / 60.53%<br>Band 8c 0.0% / 55.0% / 45.0%<br>Band 8d 10.0% / 90.0% /0.0%<br>Band 9 0.0% / 0.0% /0.0%<br><br>VSM 0.0% / 60.0% / 40.0%<br>Other 0.0% / 0.0% /100%<br><br>**Cluster 1**<br>Band 1 -4 2.8% / 66.3% / 30.9%<br><br>**Cluster 2**<br>Band 5-7 2.8% / 66.2% / 31.0%<br><br>**Cluster 3**<br>Band 8a-8b 0.4% / 54.6%/ 45.0%<br><br>**Cluster 4**<br>Band 8c -9 & VSM 2.9% /65.7% / 31.4%<br><br>**Medical & Dental**<br><br>Disability /No Disability /Unknown<br><br>Consultants 0.56% / 48.04% /51.4%<br><br>Non Consultants 1.15% /54.02% /44.83%<br><br>Trainee 0.82% / 63.9% /35.28% | |
| 2. Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. | At March 2020 non-disabled staff were 1.55 more times likely to be appointed from shortlisting compared to disabled staff. | At March 2021 non-disabled staff are now 2.13 times more likely to be appointed from shortlisting<br><br>This is a further reduction in the likelihood of disabled staff being appointed compared to non-disabled staff during the last 12 month period. |

| | | |
|---|---|---|
| 3. Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. | This metric was voluntary in the first year and the calculation is based on a two year rolling average.<br>At March 2020 the likelihood was 6.12% compared to non-disabled staff. | It is important to note that there has only being 1 case of formal capability with a disabled member of staff in a rolling two year period.<br>At March 2021 the likelihood was 2.48% compared to non-disabled staff. |
| 4a) Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:<br>Patients /service users, their relatives or other members of the public. | At March 2020<br>Disabled 31.7%<br>Non-disabled 25.3% | At March 2021<br>Disabled 28.4%<br>Non-disabled 22.8% |
| 4b) Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers. | At March 2020<br>Disabled 15.9%<br>Non-disabled 10.7% | At March 2021<br>Disabled 17.0%<br>Non-disabled 10.8% |
| 4c) Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues. | At March 2020<br>Disabled 26.4%<br>Non-disabled 16.3% | At March 2021<br>Disabled 28.2%<br>Non-disabled 16% |
| 4d) Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. | At March 2020<br>Disabled 42.8%<br>Non-disabled 40.4% | At March 2021<br>Disabled 49.6%<br>Non-disabled 41.6% |
| 5) Percentage of disabled staff compared to non-disabled staff believing that the Trust provided equal opportunities for career progression or promotion. | At March 2020<br>Disabled 80.8%<br>Non-disabled 87.7% | At March 2021<br>Disabled 79.2%<br>Non-disabled 87.1% |
| 6) Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from | At March 2020<br>Disabled 35.8% | At March 2021<br>Disabled 30.5% |

| | | |
|---|---|---|
| their manager to come to work, despite not feeling well enough to perform their duties. | Non-disabled 25% | Non-disabled 23.1% |
| 7) Percentage of disabled staff compared to non-disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. | At March 2020<br>Disabled 22.9%<br>Non-disabled 37.7% | At March 2021<br>Disabled 29.2%<br>Non-disabled 41.8% |
| 8) Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. | At March 2020<br>66.5% | At March 2021<br>77.3% |
| 9)The staff engagement score for disabled staff compared to non-disabled staff and the overall engagement score for the organisation | At March 2020<br>Disabled 6.1<br>Non-disabled 6.6 | At March 2021<br>Disabled 6.4<br>Non-disabled 6.9 |

## Summary of Data:

**1 Percentage of staff in AfC pay band or medical and dental sub groups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce**

Analysis:

The percentage of staff whose disability is unknown in each cluster requires improvement. It is recognised there is a significant amount of work to be done to ensure our workforce data is accurate and representative of the entire workforce and staff feel able to declare their disability status.

Action:

Write out to all staff and encourage our workforce to update their disability status through the ESR self-service portal

We need to improve declaration rates so that we can undertake deeper data analysis to understand and achieve disability equality within our workforce in each of the pay band.

**2 Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.**

Analysis:

Non-disabled candidates are 2.13 times more likely than disabled staff to be appointed from shortlisting and this represents an overall reduction in the likelihood of disabled candidates being appointed within a 12 month period.

It is acknowledged that we have a number of candidates who have not declared their disability status during the recruitment stage. This will affect the accuracy of the relative likelihood of disabled staff being appointed.

Action:

Undertake a review of recruitment information from a disability view point to ensure candidates are aware of why we ask for this information.

Development of targeted recruitment drives and activities aimed at disabled members of our existing workforce in terms of career progression and within our local communities in terms of joining the Trust.

Undertake discussion with other Trusts across our ICS to explore areas of best practice and potential joint working around recruitment practices in relation to staff with disabilities.

Undertake a deep dive analysis of all the disability data we hold and develop both recruitment and local action plans for existing staff to address the gaps in data.

Continue to review recruitment training material to strengthen disability and reasonable adjustment best practices to share with Trust appointing managers.

**3 Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure**

Analysis:

To the year end March 2020, staff were 6.12 more times likely to enter a formal process than non-disabled staff. It is important to note that there has only being 1 case of formal capability with a disabled member of staff in a rolling two year period. However when compared to non-disabled staff there has been an improvement during 2020/21.

Over the last 12 month period to the year end March 2021 this reduced to 2.48% more times likely.

The HR operational team have been working closely with managers to support staff with disabilities and when issues arise and policies and training materials have been updated.

Action:

Continue to enhance best practice around employee relations issues, disabled staff and reasonable adjustments

Continue to update training material around working with disables colleagues

4) **Percentage of disabled staff compared to non-disabled staff experiencing harassment, bulling or abuse from: a) patients /service users, their relatives or other members of the public b) managers c) other colleagues**

Analysis:

The percentage of staff with a disability compared to staff without a disability experiencing some sort of harassment, bullying or abuse from patients has decreased but in regards to the same behaviour from managers of colleagues has seen an increase.

Action:

The Trust has a zero policy on bullying and harassment. Further work through both the disability network and staff engagement network needs to be undertaken, to further increase the staff reporting such instances and education for the workforce around what it means to live with a disability

**4d) Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it**

Analysis:

It is encouraging there has been an increase in the percentage (6.8%) of staff with a disability who have reported such instances.

Action:

The Trust has a zero-tolerance approach to bullying and harassment and are reviewing reporting mechanisms to ensure we encourage staff to report unacceptable behaviour

whether it is from patients, colleagues or managers. Continue to promote the routes through which such instances can be raised and the support that is available

**5) Percentage of disabled staff compared to non-disabled staff felt the trust provides equal opportunities for career progression promotion.**

Analysis:

79.2% of disabled staff compared 87.1% of non-disabled staff felt the Trust provides equal opportunities. This represents small reduction of 1.6% from the previous year

Action:

This will be addressed under the Trusts equality initiatives that are in process across the Trust.

**6) Percentage of disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties**

Analysis:

30.5% of disabled staff compared to 23.1% of non-disabled staff have felt pressure to work for their manager despite not feeling well enough to do so. This represents a 5.3% improvement on the previous year, but it is recognised there is still work to do around improvement.

Action:

The HR Operations team are introducing a range of HR clinics to support managers, wellbeing and absence being a large part of this. This will assist in upskilling managers to support the health and wellbeing of their staff as well as enhance manager's confidence and understanding of health related issues at work and more specifically how disabled employees can be supported.

The Trust is updating the local induction arrangements providing both new staff and managers with signposting on where information and support can be sought.

**7) Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent the organisation values their work**

Analysis

The Trust has seen an improvement of 6.3% in this metric compared to the previous year, of the number of disabled staff that feel the Trust values their work.

Action:

The Trust values the contribution of all its staff and each service area have developed their own staff survey actions plans which includes the contribution that staff made.

Further work is being done around how the Trust reward and recognise its staff contribution as part of the overarching People Plan.

Our cultural and engagement ambassadors will play a key role to broaden our methods of acknowledging staff performance and contribution increasing informal acts of kindness and recognition alongside more formal mechanisms such as Staff Awards.

**8) Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work**

Analysis:

The Trust seen an improvement of 10.8% in this metric in the number of staff who fell that the Trust made adequate adjustments to enable them to carry out their work. This may be reflected in the change of working practices during the pandemic and supporting redeployment of colleagues through the risk assessment process.

Action:

To review the range of reasonable adjustments the Trust have on offer to ensure they are still affective to support staff

The HR Operations team are introducing a range of HR clinics to support managers, wellbeing and absence being a large part of this. This will assist in upskilling managers to support the health and wellbeing of their staff enhancing manager's confidence and understanding of health related issues at work and specifically how disabled employees can be supported.

**9) The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation**

Analysis:

There has been an overall improvement in this metric from the previous year and the gap between disabled and non-disabled staff is currently recorded as 0.50%

Action:

The Trust has an engagement strategy as part of the overarching People Plan which will address this.

## Staff Network Groups

The Trust is actively taking steps to facilitate the voices of our disabled staff and had introduced a disability and long term health conditions staff network in 2019. Unfortunately the group has not meet for some time during the Covid pandemic. The EDI Steering group are now in the process of relaunching this network group which will be instrumental in seeking the views of disabled colleagues and developing appropriate support initiatives.

## Conclusion

This is the Trust third data submission for the WDES. Acknowledging there is room for improvement, the Trust has improved many of the metric's over the previous 12 month period.

As an organisation with a fundamental aim of the People Strategy to “Make South Tees the best place to work” we are keen to improve within each metric over the next 12 months and will create an action plan to improve representation and the experience of disabled staff across the Trust.

An area we must focus on as a Trust is encouraging our staff to update their monitoring information on ESR, 32.3% of staff have not declared their disability status. We are also aware that disability status may change throughout a staff member’s career and the information on ESR may not be reflective of staff members change of circumstances, furthermore we need to raise awareness that long-term conditions (hidden disabilities) may be included in this data (though a staff member may not deem this as a disability). We know this is a national problem and will share best practice with other NHS organisations to improve in this area.

A specific task for the year ahead is to encourage our staff to update their monitoring information in ESR along with the rest of the actions set out above. The actions are to be monitored on a regular basis and reported against at March 31, 2022.

The National Staff Survey plays an integral part in our Disability Equality Scheme with 6/9 questions taken directly from our staff survey. We have a detailed communication strategy to support our staff survey launch for 2020 to encourage take up and develop more meaningful disability analysis for future action plans.

# APPENDIX 2 - WDES action plan 2021/22

| No. | Objective | Action | Timescales | Leads |
|---|---|---|---|---|
| 1. | Improve health & wellbeing and staff Engagement | Introduce and work to achieve the Better Health at Work Award during. | Spring 2022 | Occupational Health Manager |
| 2. | Improve health & wellbeing and staff engagement | Achieve the Menopause Accreditation Standard. | Spring 2022 | Menopause Working Group |
| 3. | Improve fairness and equality | Ensure all HR policies undertake an EIA and incorporate reasonable adjustments that will enable fairness and equal treatment for staff with a disability and long term health conditions. | Spring 2022 | Head of HR Operations |
| 4. | Improve staff engagement | Encourage further improvement of declaration rates through staff engagement, including using Health and Wellbeing Champions to encourage staff feedback and engagement. | Ongoing | EDI Steering Group |
| 5. | Improve staff engagement | Include health and wellbeing questions into the new annual appraisal and career conversation process supporting staff who may experience a change in their disability of long term health status. | December 2021 | HRBP - Strategy |
| 6. | Improve fairness and equality | Make plans to ensure all recruiting managers have attended unconscious bias training. | December 2022 | Recruitment Manager |
| 7. | Improve staff engagement | Relaunching the Disability and Long-term | October 2021 | EDI Steering Group |

| | | | | |
|---|---|---|---|---|
| | | Condition Staff Network Group. | | |
| 8. | Improve leadership and staff development | Continue to invest in leadership and staff development programmes which support the embedding of equality, diversity and inclusion. | Ongoing | Director of Education and Organisational Development |
| 9. | Improve staff engagement | Raise awareness of disability and health and wellbeing through an annual calendar of events. | Ongoing | EDI Steering Group |
| 10. | Improve fairness and equality | The Trust will take steps to ensure that our workforce is broadly representative of the communities we serve at all levels of our organisation by 2023. | By 2023 | Head of Workforce |
| 11. | Improve staff engagement | Set up a strategic Health & Wellbeing Group that will meet monthly and will focus on activities aligned to the Better Health at Work Award that will identify good practice that will support our disabled workforce. | July 2021 | Health and Wellbeing Board |
| 12. | Improve fairness and equality | The Trust will monitor and take steps to ensure that our workforce is broadly representative of the communities we serve at all levels following the release of the next census information. | April 2023 | EDI Steering Group |

| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 OCTOBER 2021 | | | |
|---|---|---|---|
| **Workforce Race Equality Scheme (WRES) Update report** | | | **AGENDA ITEM: 13, ENC 10** |
| **Report Author and Job Title:** | Denise Curtis-Haigh<br>HR Business Partner | **Responsible Director:** | Rachael Metcalf,<br>Director of HR |
| **Action Required** | Approve ☐ Discuss ☐ Inform ☒ | | |
| **Situation** | The purpose of the reports is to provide an update regarding the Trust WRES data reporting for 2020/21, reported across 9 key metrics. | | |
| **Background** | The WRES is integrated as part of the South Tees Hospitals NHS Foundation Trust People Plan 2021-23. Embedding Equality Diversity and Inclusion (EDI) is a national priority and this forms one of our five key strategic enablers.<br><br>Data from 4 metrics is taken from the NHS national Staff Survey. | | |
| **Assessment** | The metrics data has been reviewed and findings have been summarised along with current strategic objectives and actions. | | |
| **Recommendation** | Members of the Trust Board are asked to note the report | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | Principal risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain | | |
| **Legal and Equality and Diversity implications** | The report is written as part of the Equality, Diversity and Inclusion Strategy. | | |
| **Strategic Objectives** | Best for safe, clinically effective care and experience ☐ | A great place to work ☒ | |
| | Deliver care without boundaries in collaboration with our health and social care partners ☐ | Make best use of our resources ☐ | |
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐ | | |

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# NHS Workforce Race Equality Standard (WRES)

## Annual Report 2021

South Tees Hospitals NHS Foundation Trust

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# 1 Introduction

The Workforce Race Equality Standard (WRES) was introduced in 2015 and reviews the treatment of Black, Asian and Minority Ethnic (BAME) staff in NHS organisations and aims to improve the workplace and career experiences of BAME colleagues in the NHS. The annual national WRES reporting reviews a series of 9 measures (metrics). This includes representation, experience of discrimination and access to senior roles, with the aim to enable continuous improvement to ensure fairness and equality of BAME staff in the NHS.

The purpose of this report is to provide an update regarding the Trust WRES data reporting for 2020/21 and the actions taken and progress made by the Trust including the next steps. The data provided is for the period April 2020 to March 2021. The timescale for completion of WRES data reporting has continued to be extended this year due to the COVID-19 pandemic and data collection was completed by the 31 August 2021 deadline.

An overview of the data from the national NHS Staff Survey 2020 (4 metrics) is included as part of this report.

The WRES Metrics are in Appendix 1 and the Trust's Action Plan is in Appendix 2.

The Trust will publish the WRES on their Trust Website following ratification by the Board.

# 2 Executive summary

The information provided within this report includes the data for the 9 key WRES metrics and describes the actions taken during 2020/21 and those planned for 2021/22. These actions have been based on areas for further development identified and informed through the WRES metrics and action plan, through staff survey findings and through the Trust's and NHS People Plans.

The Trust has taken a number of important actions during 2020/21, which has been without doubt one of the most difficult and challenging years in the history of the NHS. The pressure on our entire workforce both in work and out of work, due to the impact of the Covid-19 pandemic has created at times overwhelming pressure on all individuals' physical and mental wellbeing. It has increased the focus on the importance of supporting our BAME workforce, as the pandemic progressed there was clear evidence that BAME colleagues where disproportionally affected if they contracted Covid-19.

Throughout this challenging period we have stepped up our support mechanisms across all of our staff health and wellbeing services, trying to ensure that we could provide both proactive and reactive support to the whole workforce but more specifically to those staff who have identified as being of a BAME background. Indirectly linked to this we have also seen an increase in self-declaration of BAME status from 799 staff (8.8%) in 2020 up to 933 staff (9.6%) in 2021 through our Electronic Staff Record (ESR) system, which potentially may have been influenced by the adverse impact on the BAME workforce due to Covid-19.

Despite the impact of Covid-19 throughout 2020/21 we have continued to deliver a range of activities that have been identified within the WRES action plan, as well as adapting and introducing additional activities that would specifically support our BAME workforce with new and emerging issues associated with the Covid-19 pandemic. In light of this the following activities where undertaken:

**Key Activities 2020/21**

- Further development of the BAME Staff Network Group.
- Improving self-declaration rates of BAME staff
- Development and roll out of the new Trust Values and Behaviours of supportive, caring and respectful
- Implementing and improving fair recruitment and selection processes
- Introduction of values based selection training
- Introducing unconscious bias training
- Raising awareness of BAME related issues and events through the Equalities Diversity and Inclusion (EDI) calendar of events
- Risk assessments and support plans relating to Covid-19 for all BAME staff
- Covid-19 vaccination programme
- Development of the Reciprocal Mentoring Programme
- Leadership and staff development programmes for BAME colleagues
- Review of employee relations processes to ensure they are fair and equitable
- Development of the Trust People plan which includes the EDI strategy and plan
- Development and delivery of a Staff Engagement strategy and plan

# 3 WRES progress in 2020/21

In 2020/21 the Trust took the following steps to support our BAME workforce to improve race equality, reduce discrimination and create an inclusive culture.

3.1 There has been further development of the BAME Staff Network Group which reports into the Equality Diversity and Inclusion (EDI) Steering Group and People Committee. The network has significantly increased their membership during the year, starting the year with approximately 10 members and it now has approximately 57 members. Awareness of the network group was significantly increased following the launch of the Reciprocal Mentoring Programme. The network provides peer group support through sharing experiences, as well as providing feedback and ideas to support delivery of organisational improvements that will support our BAME colleagues. The network has recently developed a terms of reference and now actively links with other BAME networks within the region.

3.2 During 2020/21 we have experienced an improvement in self-declaration rates from 8.8% in 2020 up to 9.6% in 2021. In part this improvement occurred as a result of supporting BAME colleagues during the early stages of the Covid-19 pandemic. The Trust was encouraging BAME colleagues to undertake risk assessments with the aim of agreeing support plans to keep people safe, in light of the disproportionate impact Covid was having on the BAME workforce. As a result we experienced an increase in self-declaration. However, there is still room for improvement in self-declaration rates, as we have 500 staff members (4.4%) of the workforce who have still not declared their ethnicity.

3.3 Following engagement with the workforce the new Trust Values and Behaviours have been developed and rolled out across the Trust. The three values established through this work are supportive, caring and respectful. By threading the values across a range of people management processes we will ultimately develop an inclusive and supportive culture for all our staff, including those within our BAME workforce.

3.4 The Trust continues to implement fair and transparent recruitment processes for all positions at all levels across the organisation. The Trust also offers recruitment and selection training, enabling appointing managers to structure and conduct the process in a non-discriminatory, positive, objective and constructive manner. At least one member of each interview panel must have attended recruitment and selection training.

3.5 Values based selection has been introduced based on the new Trust values. Training has been incorporated into the management essentials recruitment and selection module. This new approach to selection not only focuses on technical ability but also on the ability to demonstrate the right behaviours. Introduction of this approach should help to ensure that people, who join the organisation or are promoted, actively demonstrate the organisations values which will help to support an inclusive culture.

3.6 A module specifically relating to unconscious bias has been developed and delivered, with full support from the EDI steering group, including the network chairs. This has been incorporated into the Management Essentials Day 1 Programme linked with recruitment and selection training. It has also being delivered as a standalone training module. The activities in 3.4, 3.5 and 3.6 did not go live until February 2021, with relatively low attendance numbers at these initial training events, in part due to overall staffing pressures during wave

2 of Covid. This is reflected in the WRES data that in 2020/21 white colleagues were 2.6% more likely to be shortlisted during recruitment than BAME colleagues, which is an increase 0.8% on the previous year.

3.7 The EDI Steering Group continues to meet on a monthly basis with representation from the BAME network. The EDI Steering Group have developed and rolled out a calendar of events helping to raise awareness of race related issues. Key events such as Chinese New Year, Commonwealth Day, Ramadan, Eid, Diwali and Black History month to name but a few, have been focused upon across the year to increase staff awareness of the rich diversity we have within our workforce and to foster greater understanding of difference and inclusion.

3.8 Following receipt of a letter from NHS Chief Operating Officer, highlighting the emerging evidence that BAME communities are disproportionately affected by COVID-19, the Trust offered and completed risk assessments for all BAME colleagues. It encouraged staff to have a discussion with their line manager to risk assess health needs and ensure all staff felt safe and supported in their current role. One-to-one meetings with our internal Occupational Health Department were offered to those colleagues who had more serious health concerns or anxieties regarding their current role. As a result redeployment options were provided, which included changes to the working environment to ensure BAME staff felt sufficiently safe to remain at work. Redeployment or working from home where possible were also offered where appropriate.

3.9 From November 2020 the provision of an in house Covid vaccination service was established to enable all staff across the Trust to access the new Covid vaccine provision. Initially there was below average take up rates form our BAME workforce compared to white workforce colleagues. Through working in partnership with our BAME Network and senior BAME Clinicians, specific advice and guidance was given to provide assurance of the benefits of the vaccine. As a result the vaccine take up level for BAME colleagues significantly improved and was above the national average take up rates for BAME staff within the NHS.

3.10 In February 2021 the Trust gained confirmation that they have been accepted onto the new nationally lead Reciprocal Mentoring Programme. Work commenced in partnership with the NHS Leadership Academy and the Trust, to develop and commence the roll out of the Reciprocal Mentoring Programme. The Trust, through the EDI steering group and in partnership with the BAME network and senior leadership representatives, decided that the programme would target establishing reciprocal mentoring partnerships between senior leaders across the Trust and BAME colleagues. A programme implementation plan, which will take 18 months, was developed by March 2021 for implementation throughout 2021/23.

3.11 A staff development programme for BAME colleagues and other protected characteristics called the ‘Opening Opportunities Programme’, has been designed and delivery of the programme has commenced. However attendance at the initial events was low and further work needs to be undertaken to raise awareness and interest of the programme, especially in light of the 2020 staff survey result whereby only 70% of BAME colleagues felt they were provided with equal opportunities and career progression in comparison to 86.8% of white colleagues

3.12 Following a review of employee relations processes involving BAME colleagues there were a total of 12 disciplinary cases held in 2020/21, of which 83.3% (10 cases) were with white colleagues and 16.7% (2 cases) were with BAME colleagues. This is a disproportionate increase in percentage terms of cases taken against BAME colleagues

compared to white colleagues on the previous year. However, it is important to note that the overall number of disciplinary cases for the whole workforce reduced by 74% against the previous year. Moving forward we need to look for improvements with training in unconscious bias, human factors and 'Just Culture' to enable cases to be proportionally representative of the workforce.

3.13 The Trust has developed and commenced delivery of an EDI strategy and plan to underpin its overall People Plan, with the aim to engender a sense of belonging for all by creating an environment where we value unique differences. This work will directly support the WRES and our BAME colleagues with improvement plans that will ensure the delivery of the WRES action plan with regular engagement with our BAME network and EDI steering group.

3.14 Also supporting the delivery of the People Plan is the Trust's Staff Engagement strategy and plan containing objectives to help build trust, involvement and a sense of common purpose and identity. Staff are actively encouraged to maximise opportunities to influence and contribute to the Trust's success. We have continued to engage with BAME colleagues through the staff survey, EDI Steering Group and the BAME Staff Network. The feedback the Trust has received is informing our workforce improvement plans and actions.

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# 4 Conclusion and next steps

During 2020/21 we have continued to recognise the importance of supporting our BAME workforce more than ever before, especially in light of the Covid-19 pandemic and the pressure this placed on the whole workforce. We recognise that we are stronger working together and supporting each other to be the best we can be.

To enable the Trust in its journey of improvement we must continue to identify both short and long term actions within the WRES, underpinned by data within the metrics and feedback from our BAME workforce, to enable our BAME staff to experience a sense of belonging by creating an environment where we value unique differences.

We will embrace diversity and promote inclusion. We will strive to ensure our workforce is representative of the communities that we serve, and recognises the contribution of all colleagues and be supportive, fair and free from discrimination and ensure there is psychological safety for all.

In light of the WRES data and reflecting on activities undertaken over previous years, as well as new activities identified within the People Plan, the Trust will focus on delivering the new WRES action plan for 2021/22 over the next 12 months. The aim is to support our BAME workforce to flourish through gaining fair treatment through actions that will create a supportive and inclusive environment.

The next steps will be incorporated into the WRES action plan for 2021/22. The Trust will:

4.1 To work to deliver the overhauling recruitment and promotion action plan to increase the likelihood of appointing candidates from BAME backgrounds, to enable our workforce to be broadly representative of the communities we serve at all levels of our organisation by 2023.

4.2 Make plans to ensure all recruiting managers have attended unconscious bias training by 2022.

4.3 Continue to invest in leadership and staff development programmes which support the embedding of equality, diversity and inclusion.

4.4 Continue with the roll out and awareness of the ‘Opening Opportunities Programme’ targeting the BAME workforce to support with career development and promotion.

4.5 Continue to raise awareness across the Trusts workforce of race related issues through an annual calendar of events.

4.6 Commence the roll out of the Reciprocal Mentoring Programme to increase understanding of issues related to race to inform and improve future decision making of senior leaders across all systems and processes, to improve EDI for both staff and patients.

4.7 Continue to develop and grow the BAME Staff Network to ensure there is an opportunity for our BAME colleagues to access peer support, providing a forum for staff to share their experiences, views and ideas to support themselves and to also influence culture change across the Trust, making it a more diverse and inclusive place to work.

4.8 Achieve a reduction in the % of BAME staff that are experiencing bullying and harassment from colleagues in the workplace, through a range of initiatives such as raising awareness of behaviours via appraisal, staff and leadership EDI awareness training, better use of mediation to enable reflective learning around impact of bias behaviour

4.9 Achieve a reduction in the % of BAME staff who are experiencing discrimination from managers or team leaders.

4.10 Improve ethnicity declaration rates to ensure we accurately reflect the diversity within our workforce.

# Appendix 1  WRES metrics report

Detailed below is the organisation's WRES data

**1. WRES INDICATOR 1 – Workforce Data**

The following table shows the top three staff groups with the highest BAME representation, with comparison data from 2019 and 2020.

| | Non-Clinical staff 2019 | Non-Clinical staff 2020 | Non-Clinical staff 2021 | Clinical staff 2019 | Clinical staff 2020 | Clinical staff 2021 | Medical staff 2019 | Medical staff 2020 | Medical staff 2021 |
|---|---|---|---|---|---|---|---|---|---|
| 1st | Band 2 (11 staff) | Band 2 (18) | Band 2 (34) | Band 5 (167) | Band 5 (183) | Band 5 (237) | Consultants (161) | Consultants (166) | Consultants (183) |
| 2nd | Band 1, Band 3, Band 5 (all 7 staff) | Band 3 (9) | Band 5 (7) | Band 6 (54) | Band 6 (61) | Band 2 (77) | Trainee Grades (152) | Trainee Grades (163) | Trainee Grades (169) |
| 3rd | Band 4 (5 staff) | Band 5 (7) | Band 3 (6) | Band 2 (38) | Band 2 (50) | Band 6 (76) | Non-consultant career grade (30) | Non-consultant career grade (32) | Non-consultant career grade (33) |

**WRES INDICATOR 2 - Relative likelihood of appointment from shortlisting**

The following table demonstrates the likelihood of appointing BAME applicants from shortlisting.

| | White | BAME | Ethnicity unknown/ NULL | Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants |
|---|---|---|---|---|
| 2020/21 | 35.43% | 13.62% | 47.8% | 2.6% |
| 2019/20 | 20.25% | 11.18% | 23.46% | 1.81% |
| 2018/19 | 22.40% | 16.99% | 17.35% | 1.32% |

**WRES INDICATOR 3 - Relative Likelihood of staff entering the formal disciplinary process**

The following table shows the likelihood of staff entering for formal disciplinary process which is calculated based on the number of staff declaring their ethnicity.

| | White | BAME | Ethnicity unknown/ NULL | Relative likelihood of BME staff entering a formal disciplinary process compared to white staff |
|---|---|---|---|---|
| 2022/21 | 0.12% | 0.22% | 0% | 1.80% |
| 2019/20 | 0.48% | 0.63% | 0.75% | 1.31% |
| 2018/19 | 1.01% | 0.28% | 0.55% | 0.28% |

From 1 April 2020 to March 2021, 12 staff entered a formal disciplinary process. Of those staff, 10 were of white ethnicity (83.3%), 2 were of BAME ethnicity (16.7%).

From 1 April 2019 to 31 March 2020, 46 staff entered a formal disciplinary process.  Of those staff, 37 were of white ethnicity (80%), 5 were of BME ethnicity (11%) and 4 staff chose not to disclose their ethnicity (9%).

**WRES INDICATOR 4 – Relative Likelihood of staff accessing non-mandatory training and CPD**

The following table shows the likelihood of staff accessing non-mandatory training and CPD which is calculated as compared based on the number of staff declaring their ethnicity.

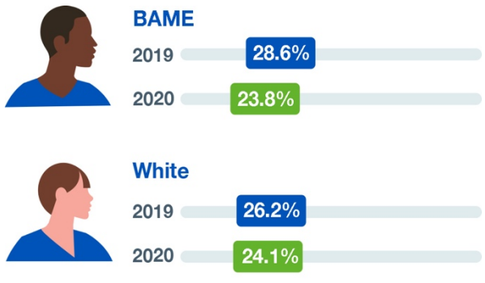
| | White | BAME | Ethnicity unknown/ NULL | Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff |
|---|---|---|---|---|
| 2020/21 | 91.17% | 83.35% | 87.94% | 1.09 |
| 2019/20 | 99.09% | 96.46% | 98.31% | 1.03 |
| 2018/19 | 86.47% | 79.07% | 89.76% | 1.10 |

From 1 April 2020 to 31 March 2021, of 8738 staff accessing non-mandatory training and CPD, 86.8 % were of white ethnicity, 8.8% were of BAME ethnicity and 4.3% of applicants chose not to disclose their ethnicity.

From 1 April 2019 to 31 March 2020, of 8,896 staff accessing non-mandatory training and CPD, 85.5% were of white ethnicity 8.5% were of BME ethnicity and 6% of applicants chose not to disclose their ethnicity.

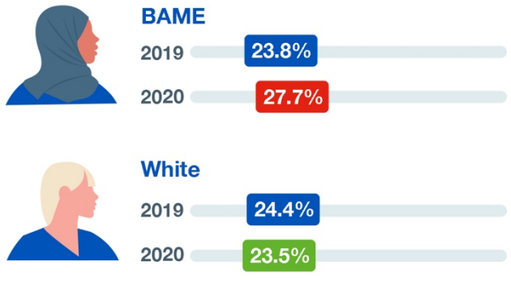
## Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



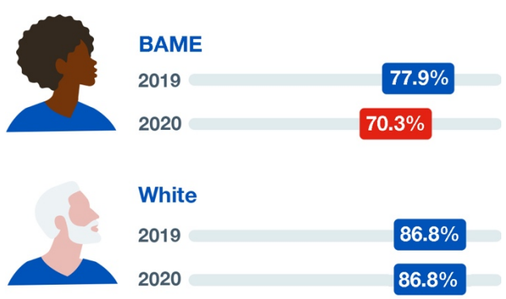

## Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



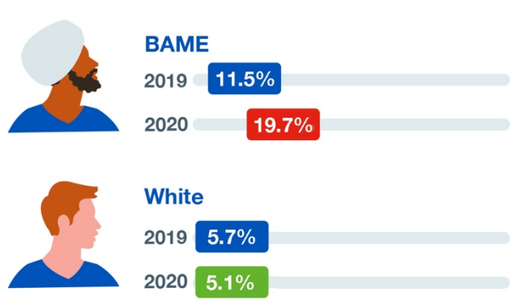

## Indicator 7

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion




## Indicator 8

Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months



## WRES INDICATOR 9 – Percentage difference between the organisations' board voting membership and its overall work force

The final WRES metric relates to BAME representation within the Trust's Board of Directors.

| | 2019 | | | 2020 | | | 2021 | | |
|---|---|---|---|---|---|---|---|---|---|
| | **White** | **BME** | **Ethnicity unknown** | **White** | **BME** | **Ethnicity unknown** | **White** | **BME** | **Ethnicity unknown** |
| Total Board members (% by ethnicity) | 93% | 6.7% | 0% | 76.9% | 7.7% | 15.4% | 100% | 0% | 0% |
| Voting board members (% by ethnicity) | 93% | 6.7% | 0% | 76.9% | 7.7% | 15.4% | 100% | 0% | 0% |
| Executive board members (% by ethnicity) | 87.5% | 12.5% | 0% | 66.7% | 16.7% | 16.7% | 100% | 0% | 0% |
| Non-Executive board members (% by ethnicity) | 100% | 0 | 0% | 85.7% | 0% | 14.3% | 100% | 0% | 0% |
| Overall workforce | 85.3% | 8.2% | 6.5% | 85.3% | 8.8% | 5.9% | 86% | 9.6% | 4.4% |

# APPENDIX 2 - WRES action plan 2020/21

| No. | Objective | Action | Timescales | Lead/s |
|---|---|---|---|---|
| **1.** | Improve fairness and equality | To deliver the overhauling recruitment and promotion action plan | 2021/23 | Head of Workforce |
| **2.** | Improve fairness and equality | Make plans to ensure all recruiting managers have attended unconscious bias training by 2022. | December 2022 | Head of Workforce |
| **3.** | Improve fairness and equality | Continue to invest in leadership and staff development programmes which support the embedding of equality, diversity and inclusion. | March 2022 (Review) | Director of Education and Organisational Development |
| **4.** | Improve fairness and equality | Continue with the roll out and awareness of the 'Opening Opportunities Programme' targeting the BAME workforce to support with career development and promotion. | March 2022 (Review) | Director of Education and Organisational Development |
| **5.** | Improve staff engagement | Continue to raise awareness across the Trusts workforce of race related issues through an annual calendar of events. | March 2022 (Review) | EDI Steering Group |
| **6.** | Improve staff engagement<br><br>Improve fairness and equality<br><br>Improve leadership and staff development | Commence the roll out of the Reciprocal Mentoring Programme to increase understanding of issues related to race to inform and improve future decision making of senior leaders across all systems and processes to improve EDI for both staff and patients. | 2021/23 | HR Director |
| **7.** | Improve staff engagement | Continue to develop and grow the BAME Staff Network | March 2022 (Review) | Chair of BAME Network |
| **8.** | Improve fairness and equality<br><br>Improve staff engagement | Achieve a reduction in the % of BAME staff who are experiencing bullying and harassment from colleagues in the workplace. | March 2023 – progress review March 2022 | Senior Leadership Team |
| **9.** | Improve fairness and equality<br><br>Improve staff engagement | Achieve a reduction in the % of BAME staff who are experiencing discrimination from managers or team leaders. | March 2023 – progress review March 2022 | Senior Leadership Team |
| **10.** | Improve staff engagement | Improve ethnicity declaration rates to ensure we accurately reflect the diversity within our workforce. | March 2022 (Review) | Head of Workforce |

South Tees Hospitals NHS Foundation Trust

| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 October 2021 | | | |
|---|---|---|---|
| Learning from Deaths Monthly Dashboard August 2021 | | | **AGENDA ITEM: 14, ENC 11** |
| **Report Author and Job Title:** | Jo Raine, Data Analyst Mortality Surveillance and Tony Roberts, Deputy Director (Clinical Effectiveness) | **Responsible Director:** | Dr Michael Stewart Chief Medical Officer |
| **Action Required** | Approve ☐ Discuss ☐ Inform ☒ | | |
| **Situation** | This report provides assurance on the overall quality of care, as measured by hospital mortality and other clinical effectiveness indicators, delivered by the organisation. | | |
| **Background** | Overview of mortality within the Trust, relevant mortality indicators and coverage of the Medical Examiner service and Mortality Surveillance activity including lessons learned. | | |
| **Assessment** | Following the peak in mortality figures over the initial COVID-19 pandemic, and subsequent reduction during the summer, rates are beginning to normalise. The Medical Examiner team coverage of mortality continues to be in excess of 95% of all deaths. Mortality Surveillance is continuing though has been affected by the pandemic. | | |
| **Recommendation** | Members of Trust Board are asked to note this report. | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | Principal risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes | | |
| **Legal and Equality and Diversity implications** | There are no legal or equality & diversity implications associated with this paper. | | |
| **Strategic Objectives** | Best for safe, clinically effective care and experience ☒ | A great place to work ☐ | |
| | Deliver care without boundaries in collaboration with our health and social care partners ☐ | Make best use of our resources ☐ | |
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and | | |

| | | |
|---|---|---|
| | beyond ☐ | |

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# Learning From Deaths Monthly Dashboard August 2021

## 1 Responding to Deaths

1.1 In March 2017 the National Quality Board published *Guidance on Learning from Deaths* (LFD)[1] and a national work programme has been established for LFD. NHS Improvement hosted a conference on 14 December 2017 LFD: One Year On and have published case studies[2].

1.2 The Trust published its *Responding to Deaths* Policy (in line with the national LFD requirements) in September 2018 and updated it in October 2020. It sets out the Trust's approach to learning from deaths in care: https://www.southtees.nhs.uk/about/trust/responding-deaths-policy/ There are broadly three opportunities to learn:

- at the time of certification of death. The Trust has established a Medical Examiner Service which commenced work in May 2018. Most deaths receive A *Medical Examiner Review* (a small number of 'unnatural' deaths may go directly to Coroners without discussion with an ME) and this includes review of the case records, discussion with the attending team and a discussion with the bereaved family

- a *Trust Mortality Review,* is conducted, usually within weeks of a death, if any potential concerns are identified during the Medical Examiner Review and also for all deaths of patients with learning disabilities, serious mental illness, where an incident or complaint has been reported, within 30 days of a surgical procedure or where a 'mortality alert' from a range of sources has occurred.

- at the time of investigation when a death has occurred where an incident has been reported through the Trust's incident reporting system (Datix).

1.3 39 reviews were completed between April and August 2021 (activity affected by the ongoing COVID-19 pandemic and a change in personnel with two consultants resigning and four new consultant reviewers joining). 97% were Expected deaths, care was judged to be Good-Excellent in 74% of cases. In 74% of cases, death was judged to be definitely not preventable, with 13% of cases showing slight evidence for preventability and 10% case no preventability. Five reviews identified learning from good care (*Very good preoperative assessment of risk and optimisation of intercurrent problems*), including good communication with family. 18 reviews identified learning from problems in care. The most frequently identified were around quality of documentation including patient identifiers, medication and pathway records or filed paperwork. Co-ordination of care/l senior input. anticoagulation (stopping/starting) also featured.

1.4 The Learning From Deaths dashboard reports the number of deaths, the number of Medical Examiner Reviews, the number of deaths with a Trust Level Mortality Review or investigation and the number of those deaths judged to show evidence of preventability. Numbers are reported separately for patients with learning disabilities and known serious mental health illnesses. For the year to end of August 2021, there were 1,940 deaths, of which 1,919 (98.9%) received a review or investigation and one death was considered to be potentially avoidable. In the same period 97% of deaths

[1] https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
[2] https://improvement.nhs.uk/uploads/documents/Learning_from_deaths_case_studies_Web_version.pdf

in patients with a learning disability and 99.4% of cases where the patient had a pre-existing mental health condition were reviewed with no deaths considered potentially avoidable.

1.5 The Medical Examiner Service has been operational since May 2018, and 94.0% of deaths have received a medical examiner review (April 2021 – August 2021). 88.8% of deaths were judged to be definitely not preventable with 4.8% of cases judged to show some preventability. One case was judged 'Definitely Preventable' but the element of preventability occurred before the patient reached hospital. 86.5% of deaths were judged to be Expected, 12.3% of deaths judged Unexpected, the remainder ungraded. In that period, 73 have been recommended for Trust Mortality Review, 15 reviews have so far been undertaken with the rest scheduled. The acumination of cases requiring review by Mortality Surveillance from this and the previous year are currently being addressed. Four new consultant reviewers have been appointed and will begin reviewing in September 2021.

1.6 National implementation of the Medical Examiner reforms set out in the 2009 Coroners Act is in two phases (as described by the impact assessment for the Introduction of Medical Examiners and Death Certification reform in England by the Department of Health and Social Care . Resources about Medical Examiners are available. During 2021/22 expansion of the service towards reviewing deaths in the community will be encouraged by the National Medical Examiner and work is underway to implement this in stages from September 2021 onwards.

| Medical Examiner Service Statistics: Month of Death | No. In-Hospital Deaths | Other Deaths (A&E/OOHosp) | ME Review | % Review | Recommended Trust Mort Rev | Received TMR | Specialty Review | Discussed with Coroner | Noted as Coroner Case |
|---|---|---|---|---|---|---|---|---|---|
| May 2018 - Mar 2019 | 1698 | 44 | 1432 | 82.2% | 230 | 221 | 265 | 275 | 137 |
| Apr 2019 - Mar 2020 | 1902 | 138 | 1822 | 89.3% | 192 | 171 | 393 | 381 | 296 |
| April 2020 - Mar 2021 | 1994 | 112 | 2041 | 96.9% | 153 | 88 | 224 | 330 | 279 |
| | | | | | | | | | |
| **Medical Examiner Service Statistics: Month of Death Apr 2021 -Mar 2022** | No. In-Hospital Deaths | Other Deaths (A&E/OOHosp) | ME Review | In hospital % Review | Recommended Trust Mort Rev | Received TMR | Specialty Review | Discussed with Coroner | Noted as Coroner Case |
| Apr-21 | 141 | 4 | 141 | 97.2% | 17 | 7 | 12 | 22 | 23 |
| May-21 | 155 | 6 | 154 | 95.7% | 16 | 8 | 8 | 25 | 26 |
| Jun-21 | 129 | 9 | 134 | 97.1% | 11 | | 8 | 20 | 21 |
| Jul-21 | 155 | 11 | 151 | 91.0% | 15 | | 5 | 18 | 29 |
| Aug-21 | 150 | 9 | 143 | 89.9% | 14 | | 15 | 29 | 26 |
| | 730 | 39 | 723 | 94.0% | 73 | 15 | 48 | 114 | 125 |
| | | | | | | | | | |
| | 6324 | 333 | 6018 | 90.4% | 648 | 495 | 930 | 1100 | 837 |

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# Learning from Deaths Monthly Dashboard - August 2021

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**Total number of deaths reviewed and deaths judged preventable from the case notes**

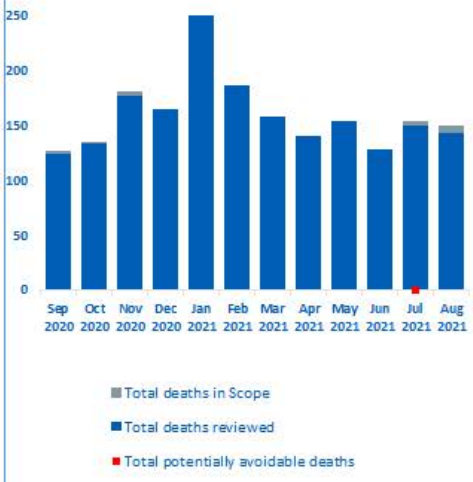
(includes patients with identified learning disabilities or serious mental illness) Note: This dashboard shows deaths that have received a review. In practice, some deaths may have received more than one review but they are only counted once for this dashboard

| | Total deaths in scope | Total deaths Reviewed | Ungraded Medical Examiner Review | Definitely not Preventable | Slight evidence of preventability | Possibly preventable (<50:50 but close call) | Probably preventable (>50:50 but close call) | Strong evidence for preventability | Definitely Preventable | Total potentiallly avoidable deaths |
|---|---|---|---|---|---|---|---|---|---|---|
| Previous 12 months | 1940 | 1919 | 98 | 1753 | 2 | 65 | 0 | 0 | 1 | 1 |

Trust Mortality Review

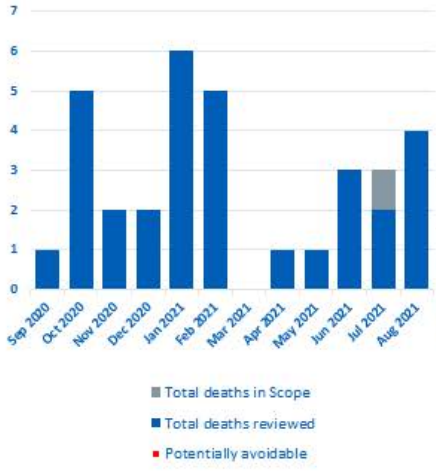
**All patients:**

Mortality over time, total deaths and deaths considered potentially preventable




**Patients with learning disabilities:**

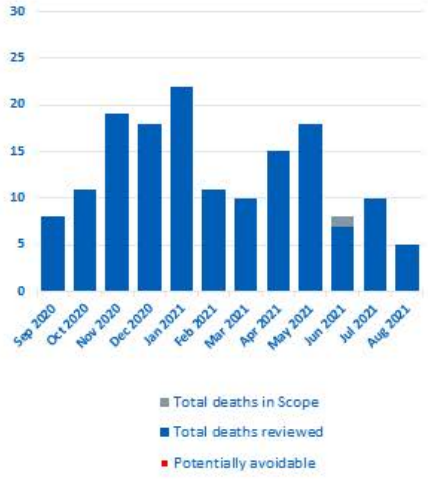
Mortality over time, total deaths and deaths considered potentially avoidable




| YEAR TO DATE | |
|---|---|
| Total Deaths in scope | 33 |
| Deaths reviewed | 32 |
| Potentially avoidable (learning disabilities) | 0 |

**Patients with a serious mental illness:**

Mortality over time, total deaths and deaths considered potentially avoidable




| YEAR TO DATE | |
|---|---|
| Total Deaths in scope | 155 |
| Deaths reviewed | 154 |
| Potentially avoidable (learning disabilities) | 0 |

## 2 Mortality indicators

2.1 The dashboard includes the number of deaths from April 2009 to August 2021. 129 deaths were recorded in June 2021, 155 in July 2021, and 150 in August, all within normal range. The unadjusted mortality rate is reducing to pre-pandemic levels. Rolling 12 month average is 1.58 compared to 1.24 pre-pandemic.

2.2 The Summary Hospital-level Mortality Indicator (SHMI) includes all in-hospital deaths plus deaths within 30 days of discharge. It is published on a quarterly basis (including 12 months of data in each release) by NHS Digital and is an official government statistic. Current reporting is April 2020 – March 2021. The SHMI is the ratio of observed mortality rate/expected mortality rate (based on a statistical estimate of expected mortality). The SHMI is 118 and is 'higher than expected' (i.e. outside the variation expected statistically). The indicator has been impacted by the pandemic with 30% fewer discharges included. In addition, as previously reported, the Trust continues to be lower than average in the recording of comorbidities which also affects the SHMI. NHS Digital are removing any spell containing a COVID-19 Confirmed or Suspected code. In this release this amounts to 1,012 spells or 1.33% of spells. The indictor is also affected by the fall in non-covid activity during the outbreak.

2.3 633 patients were coded as being in receipt of palliative care since April 2021 of whom 294 (46.4%) died (40.3% of all deaths in the period). It should be noted that August 2021's data was not complete at time of reporting.

2.4 Work on producing statistics by Collaborative group is currently being developed. 41.8% of deaths were in Medicine and Emergency Care Services and 11.6% in Growing the Friarage and Community Services.

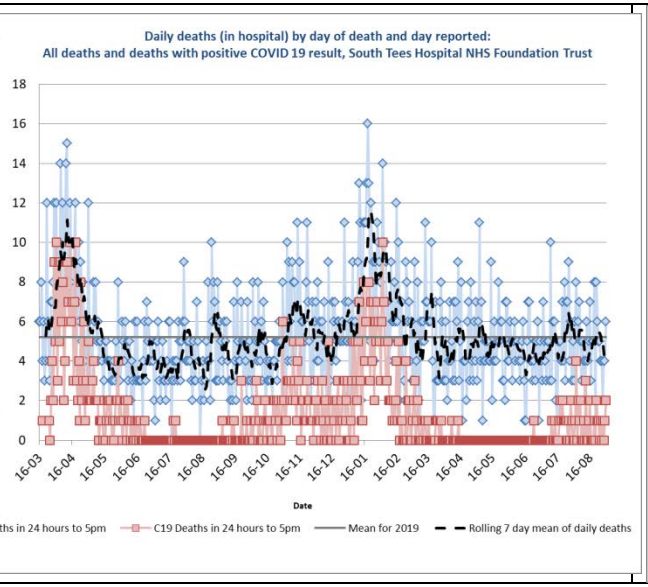
| Collaborative | Apr 2021 | May 2021 | Jun 2021 | Jul 2021 | Aug 2021 | Total | % |
|---|---|---|---|---|---|---|---|
| Cardiovascular Care services | 15 | 13 | 7 | 11 | 9 | 55 | 7.6% |
| Digestive Diseases, Urology and General Surgery services | 14 | 12 | 18 | 11 | 9 | 64 | 8.8% |
| Head and Neck, Orthopaedic and Reconstructive services | 5 | 4 | 3 | 5 | 3 | 20 | 2.8% |
| James Cook Cancer Institute and Speciality Medicine services | 11 | 13 | 8 | 15 | 18 | 65 | 8.9% |
| Medicine and Emergency Care services | 60 | 61 | 52 | 65 | 66 | 304 | 41.8% |
| Neurosciences and Spinal Care services | 10 | 5 | 14 | 6 | 8 | 43 | 5.9% |
| Perioperative and Critical Care services | 12 | 21 | 13 | 17 | 20 | 83 | 11.4% |
| Women and Children services | | 6 | 1 | 1 | | 8 | 1.1% |
| Clinical Support services | | | | | 1 | 1 | 0.1% |
| Growing the Friarage and Community services | 13 | 20 | 12 | 24 | 15 | 84 | 11.6% |
| **Grand Total** | **140** | **155** | **128** | **155** | **149** | **727** | **100%** |

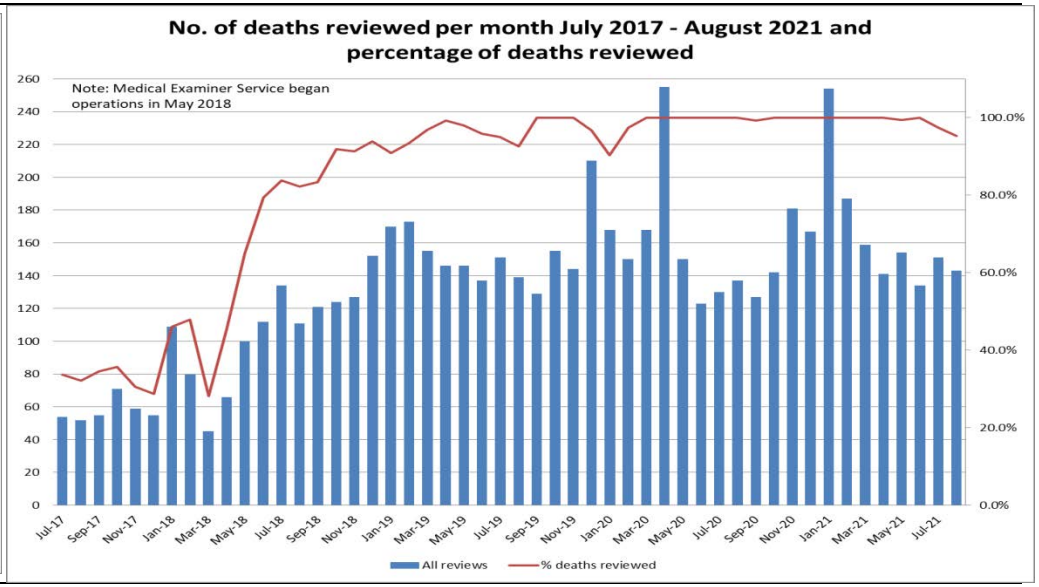
## 3 COVID-19

3.1 The first in-hospital death in a patient with Covid-19 occurred on the 19th March 2020. The trust established reporting mechanisms to the Covid-19 Patient Notification System (CPNS) and the Covid-19 Hospitalisations in England Surveillance System (CHESS) in line with national guidance. Between March and the end of June 2020 there were 257 Covid-19 deaths reported in the Trust (41% of all deaths reported). Nine further Covid-19 deaths occurred between July and September 2020 taking the total to 266. In October 2020 during the second wave between October – December 2020 there were a further 142 Covid-19 deaths (29% of all deaths in the period). 408 deaths in 2020 were Covid-19 related.

3.2 In January 2021, during the the third wave and new variants of Covid-19, and there were 133 further Covid-19 deaths (52% of all deaths) taking the total number of Covid-19 deaths to 541. There were a further 71 Covid-19 deaths in February (32% of all deaths in the month) taking the overall total above 600. There were a further 18 COVID deaths recorded in March. In April 2021 less than five COVID-19 deaths were recorded. There were no COVID-19 deaths recorded in May 2021 and less than five in June 2021. The third wave (mainly Delta variant) began in early July with 16 COVID-19 deaths in July and a further 27 deaths in August. The total COVID-19 deaths is 676.

| Total Deaths | C19 Deaths | C19 Reported deaths |
|---|---|---|
| 16 March - 30 June 2020 | | |
| 621 | 257 | 257 |
| July - September 2020 | | |
| 389 | 9 | 7 |
| October - December 2020 | | |
| 482 | 142 | 137 |
| january - March 2021 | | |
| 606 | 222 | 226 |
| April - June 2021 | | |
| 425 | 3 | 4 |
| July 2021 | | |
| 155 | 16 | 12 |
| August 2021 | | |
| 149 | 27 | 21 |
| 16 March 2020 to date | | |
| 2827 | 676 | 664 |
| Last 24 hours | | |
| 6 | 2 | 0 |
| All deaths are reported to 5pm | | |



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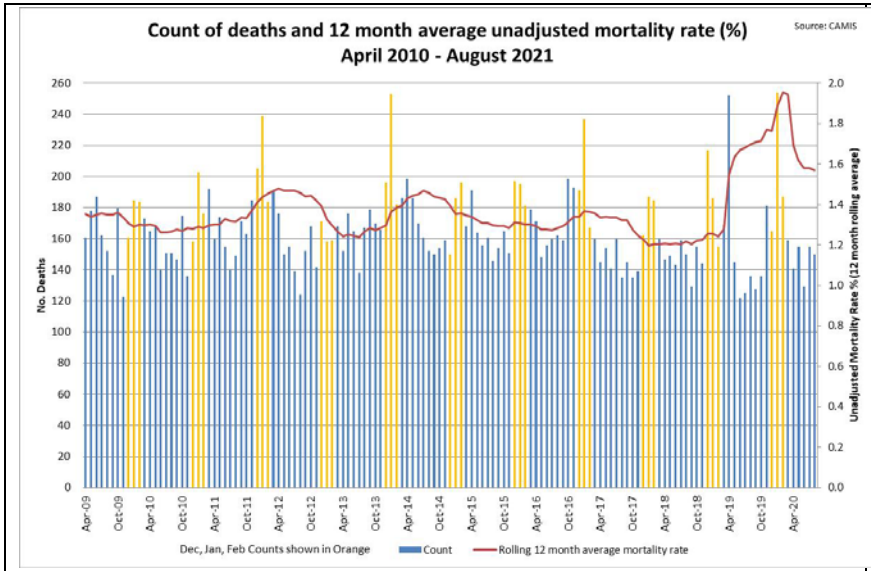
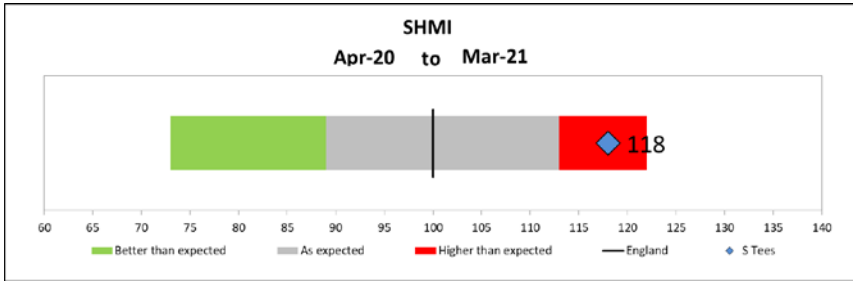
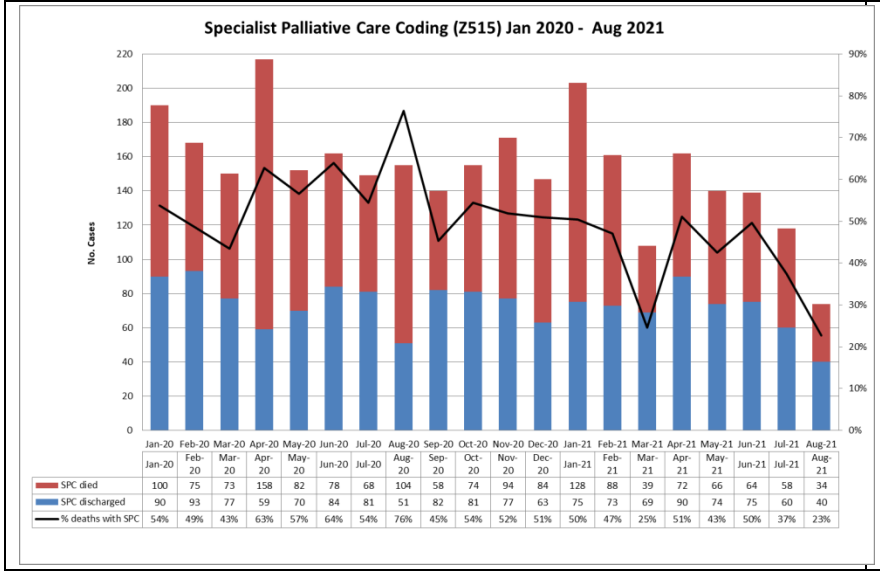
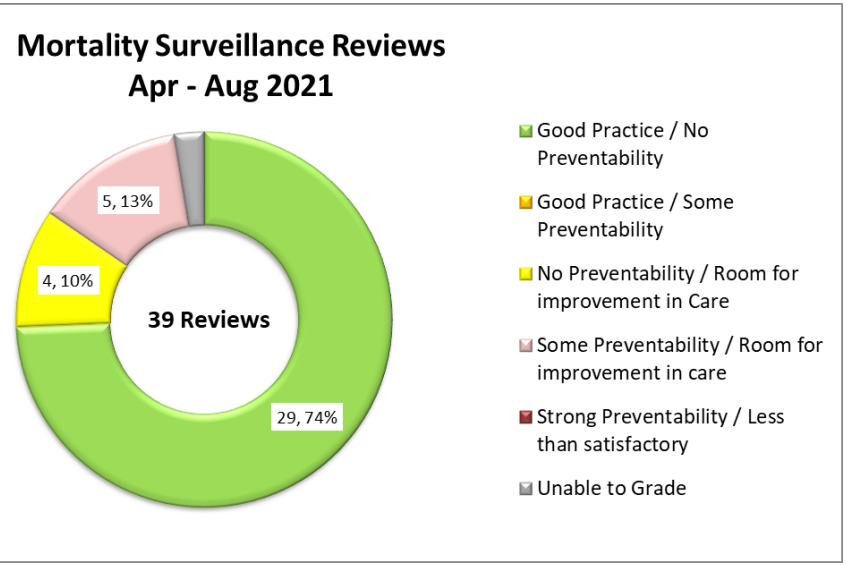



| | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SPC died | 100 | 75 | 73 | 158 | 82 | 78 | 68 | 104 | 58 | 74 | 94 | 84 | 128 | 88 | 39 | 72 | 66 | 64 | 58 | 34 |
| SPC discharged | 90 | 93 | 77 | 59 | 70 | 84 | 81 | 51 | 82 | 81 | 77 | 63 | 75 | 73 | 69 | 90 | 74 | 75 | 60 | 40 |
| % deaths with SPC | 54% | 49% | 43% | 63% | 57% | 64% | 54% | 76% | 45% | 54% | 52% | 51% | 50% | 47% | 25% | 51% | 43% | 50% | 37% | 23% |



| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 5 October 2021 | | | |
|---|---|---|---|
| Month 5 2021/22 Financial Performance | | | **Agenda Item 15, ENC 12** |
| **Report Author and Job Title:** | Luke Armstrong<br>Deputy Chief Finance Officer | **Responsible Director:** | Chris Hand<br>Chief Finance Officer |
| **Action Required** | Approve ☐ Discuss ☒ Inform ☒ | | |
| **Situation** | This report outlines the Trust's financial performance as at Month 5. | | |
| **Background** | Due to the ongoing COVID-19 pandemic formal annual financial planning has been suspended for the first half of 2021/22. ICS system level planning is in place, with each ICP expected to deliver break-even within a fixed funding envelope. The Trust's requirement for H1 2021/22 is to deliver a £3.0m deficit. | | |
| **Assessment** | At Month 5 the Trust reported a deficit of £2.8m at a system control total level. This is in line with the required budget deficit for M5 as agreed within the ICP/ICS.<br><br>The underlying structural deficit remains recurrently outwith the revised funding arrangements for the start of the current financial year. Detailed planning guidance for the second half of 2021/22 is awaited and the recurrent impact of COVID is currently unknown. | | |
| **Recommendation** | Members of the Trust Board are asked to note the financial position for Month 5. | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | Principal Risk 6 - Inability to agree financial plan with the regulator<br>Principal Risk 7 - Failure to deliver the Trust's financial plan | | |
| **Legal and Equality and Diversity implications** | There are no legal or equality & diversity implications associated with this paper. | | |
| **Strategic Objectives** | Best for safe, clinically effective care and experience ☐ | A great place to work ☐ | |
| | Deliver care without boundaries in collaboration with our health and social care partners ☐ | Make best use of our resources ☒ | |
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐ | | |

# Month 5 2021/22 Financial Performance

## 1. PURPOSE OF REPORT

The purpose of the report is to update the Board of Directors on the financial position of the Trust as at Month 5.

## 2. BACKGROUND

Following the suspension of the NHS Planning Process for the first half of 2021/22 the Trust and wider ICP / ICS has a fixed level of income to cover its total costs. The ICP and ICS have an overall requirement to break even at the end of the 6 month period.

The Trust is required to deliver an overall deficit position of £3.0m for the 6 month period, in order to support the wider ICP / ICS system financial balance.

In the final 6 months of 2020/21, a number of items of specific reasonable COVID-19 expenditure are reclaimable from NHS England centrally, including the costs of swabbing and vaccinations. The income in relation to these costs is shown in the PSF, MRET and top-up line, and the resulting variance has been normalised by adjusting budgets for both the additional income received and expenditure incurred.

The financial position included within this report is shown on a group basis including both the Trust and the Trust's subsidiary company South Tees Healthcare Management. The Trust is required to report on a group basis each Month to NHSE/I.

The Month 5 YTD actual performance is a £2.8m deficit at a control total level. This has resulted in the Trust being in line with its financial plan.

## 3. DETAILS

### Trust position

The Month 5 position is outlined below; the following sections outline key variances and risks for divisional income, pay, non-pay and technical items.

| | YTD Budget £'000 | YTD Actual £'000 | YTD Variance £'000 | Adjustments £'000 | Revised YTD Variance £'000 |
|---|---|---|---|---|---|
| Nhs Clinical Income | 286,638 | 290,217 | **3,579** | (3,575) | **03** |
| Other Income | 20,755 | 21,327 | **572** | (396) | **176** |
| Pay | (177,627) | (180,038) | **(2,411)** | 1,789 | **(622)** |
| Non Pay | (116,354) | (118,917) | **(2,563)** | 1,735 | **(828)** |
| Depreciation & Amt | (7,896) | (7,287) | **609** | 416 | **1,026** |
| Finance Income | 34 | 0 | **(34)** | 01 | **(33)** |
| Finance Expense | (6,163) | (6,153) | **10** | (01) | **09** |
| Profit / (Loss) on Sale | 0 | 102 | **102** | 29 | **131** |
| Public Dividend Capital | (2,175) | (1,926) | **249** | 01 | **250** |
| Corporation Tax | 0 | (02) | **(02)** | 01 | **(01)** |
| Donated Asset Inc / Depr | (291) | (1,207) | **(916)** | 0 | **(915)** |
| Impairments | 0 | 0 | **0** | 0 | **0** |
| Surplus / (Deficit) for Period | **(3,079)** | **(3,883)** | **(804)** | **0** | **(804)** |
| | | | | | |
| *Reconciliation to system Control Total* | | | | | |
| | | | | | |
| Less: Donated Asset Inc/Depreciation | 291 | 1,105 | **814** | | **814** |
| Impairments | | 0 | **0** | | **0** |
| System Control Total | **(2,788)** | **(2,779)** | **10** | **0** | **10** |

Overall the Trust is on plan for Month 5 of 2021/22.

- Adjustments are shown to normalise the NHSE/I submitted plan to the Trust's working budget. Adjustments relate to high cost drugs and devices, net neutral budget realignments along with additional income and costs in relation to the Elective Recovery Fund.
- Within the year to date position the Trust has recognised income and cost in relation to the Elective Recovery Fund of £7.1m.
- The Other Income over achievement of £0.2m is being driven by increased Estates income from Car Parking along with increased RTA and Private Patients income.
- The £0.6m overspend on pay has been driven by the recognition of the year to date element of the flowers legal case and increased agency spend.
- Non pay is overspent by £0.8m for Month 5 with this overspend driven by additional drugs and ICT systems spend, offset by lower depreciation charges.

## Clinical Income

Under the revised financial arrangements for 2021/22, the Trust's previous aligned incentive contractual arrangement with its commissioners continues to be suspended as in 2020/21. Instead, the Trust is paid under a block arrangement with income fixed for the first half of the year, with the exception of the below items:

- HEPC and CDF Drugs
- High cost devices from NHS England
- Elective Recovery Fund income

The Trust's block payments are shown below split by Commissioner:

| Commissioner Code | Commissioner Name | Block Payment |
|---|---|---|
| 16C | NHS Tees Valley CCG | 154,126 |
| 84H | NHS County Durham CCG | 5,943 |
| 00P | NHS Sunderland CCG | 306 |
| 01H | NHS North Cumbria CCG | 273 |
| 13X | NHS England - North East and Yorkshire Commissioning Hub | 85,054 |
| 13Q | NHS England - Central (CDF, HepC & C&V Variance) | 3,050 |
| Y63 | NHS England - North East and Yorkshire Commissioning Region | 3,043 |
| Y58 | South West Regional Office (MoD) | 724 |
| 42D | NHS North Yorkshire CCG | 37,040 |
| 03Q | NHS Vale of York CCG | 612 |
| | Prior Year Adjustments | 47 |
| | **Total Income Month 5** | **290,217** |

Clinical income is shown below split by income type in order to highlight variable elements.

| | YTD Budget £'000 | YTD Actual £'000 | YTD Variance £'000 |
|---|---|---|---|
| **Blocks** | 248,846 | 248,904 | **58** |
| **Top Up** | 12,440 | 12,440 | **0** |
| **Covid-19** | 11,255 | 11,255 | **0** |
| **Lost non NHS Income** | 1,050 | 1,050 | **0** |
| **CDF** | 2,785 | 2,243 | **(542)** |
| **HEPC** | 320 | 290 | **(30)** |
| **High Cost Devices** | 6,460 | 6,460 | **0** |
| **Cost and volume drugs** | 0 | 518 | **518** |
| **ERF** | 7,057 | 7,057 | **0** |
| **YTD M5** | **290,213** | **290,217** | **04** |

Variances shown on CDF, HEPC cost and volume drugs and high cost devices income are counteracted by cost movements within expenditure.

At Month 5 the Trust has recognised income in relation to the Elective Recovery Fund of £7.1m, with a corresponding expenditure value within pay and non-pay.

## Other Income

Other income is £0.2m ahead of plan at Month 5.

| | Budget to M6 £'000 | YTD Budget £'000 | YTD Actual £'000 | YTD Variance £'000 |
|---|---|---|---|---|
| Education & Training Income | 10,079 | 8,408 | 8,367 | (41) |
| Estates Income | 1,102 | 918 | 965 | 46 |
| Misc. Other Income | 6,528 | 5,623 | 5,539 | (84) |
| Non Patient Care Income | 1,317 | 1,136 | 1,371 | 234 |
| Other Clinical Income | 1,487 | 1,239 | 1,340 | 100 |
| Psf, Mret & Top Up | 1,745 | 1,699 | 1,724 | 24 |
| Research & Development Income | 2,451 | 2,125 | 2,022 | (104) |
| Total | 24,708 | 21,151 | 21,327 | 176 |

- Misc. Other income is behind plan by £0.1m driven by lower income generation from testing services within Pathology from external customers, this lower income is matched to lower non pay costs.
- Non patient care income is overachieving by £0.2m from higher receipts year to date of maternity pathway income.
- Other clinical income is overachieving by £0.1m, this is being driven by higher income receipts for both RTA income and Private Patient income, as both income streams recover following the pandemic.

## Pay

In the year to date position, pay is overspent by £0.6m, as outlined in the below table.

| | Budget to M6 £'000 | YTD Budget £'000 | YTD Actual £'000 | YTD Variance £'000 |
|---|---|---|---|---|
| Ahp'S, Sci., Ther. & Tech. | (31,027) | (25,827) | (25,919) | (92) |
| Hca'S & Support Staff | (22,328) | (18,825) | (19,771) | (946) |
| Medical And Dental | (64,488) | (53,796) | (54,159) | (363) |
| Nhs Infrastructure Support | (30,127) | (25,119) | (25,315) | (196) |
| Nursing & Midwife Staff | (66,197) | (55,216) | (54,213) | 1,003 |
| Other Pay Costs | (760) | (633) | (661) | (28) |
| Total | (214,927) | (179,416) | (180,038) | (622) |

- Within the YTD pay position a budget for additional Covid costs of £5.4m is included, assigned to the specific staff group and directorate where costs are being incurred.
- Spending on HCAs, Support Staff and Nursing has seen a combined net £0.1m underspend position. Within both pay categories £1.8m of year-to-date funding for covid sickness is included, increasing the overall underspend.

- Medical and Dental staff show a year to date overspend of £0.4m. Junior staffing is overspent by £0.2m and £0.2m for senior medical staffing, driven by the premium pay cost of agency and additional activity payments.
- Cost have been recognised in relation to the year to date element of the flowers legal case of £0.3m, split to the relevant pay category.

Total year to date agency spend is £3.4m. Work is ongoing within each collaborative to recruit to hard to fill posts where possible and reduce overall cost. Agency spend will continue to be monitored monthly moving forward.

**Non-Pay**

Non-pay is underspent by £0.8m at Month 5.

| | Budget to M6 £'000 | YTD Budget £'000 | YTD Actual £'000 | YTD Variance £'000 |
|---|---|---|---|---|
| Clinical Negligence Cost | **(9,120)** | (7,600) | (7,600) | **(0)** |
| Clinical Supplies And Services | **(50,159)** | (43,970) | (41,873) | **2,097** |
| Drugs | **(35,736)** | (29,917) | (31,473) | **(1,556)** |
| Establishment | **(3,373)** | (2,758) | (3,571) | **(812)** |
| Ext. Staffing & Consultancy | **(208)** | (179) | (98) | **81** |
| General Supplies & Service | **(1,558)** | (1,287) | (1,134) | **154** |
| Healthcare Service Purchase | **(6,324)** | (5,348) | (5,444) | **(96)** |
| Miscellaneous Services | **(1,378)** | (1,160) | (1,125) | **34** |
| Pfi Unitary Payment | **(14,833)** | (12,376) | (12,544) | **(168)** |
| Premises & Fixed Plant | **(12,090)** | (10,137) | (10,832) | **(695)** |
| Research, Education & Training | **(1,848)** | (1,624) | (1,579) | **45** |
| Transport | **(2,066)** | (1,732) | (1,644) | **88** |
| Total | **(138,692)** | **(118,089)** | **(118,917)** | **(828)** |

- Clinical supplies and services are showing a year to date underspend of £2.0m with this being driven by reduced activity levels within clinical directorates.
- Drugs have a YTD overspend of £1.6m. This overspend is due to increased drugs costs within Gastroenterology, Neurology, Haematology and Ophthalmology, with costs being linked to increased activity levels.
- Establishment costs have a year to date overspend of £0.8m with this driven by increases in ICT systems costs.
- The £0.7m overspend on premises has been driven by increases in charges from NHS Property Services with these costs anticipated to be funded by the CCG in future months coupled with increased minor new works and estates costs for covid building alterations.

**Non-Operating Costs**

Non-operating costs are underspent year to date, largely relating to PDC dividends and reflecting the Trusts current strong liquidity position during the H1 covid funding arrangements.

**CIP**

For the first 6 months of the year the Trust has a £5.0m CIP target. The programme is shown in the below table. Work is ongoing to embed efficiency planning and delivery arrangements through the Clinical Collaboratives, as part of the Trust's financial recovery planning, with the recent introduction of the Collaborative Improvement Planning Group weekly meetings to further monitor and support delivery.

| | Plan to M6 £'000 | | YTD Target £'000 | YTD Actual £'000 | YTD Variance £'000 |
|---|---|---|---|---|---|
| **Corporate** | **2,430** | | 1,936 | 2,771 | **835** |
| **Procurement** | **740** | | 583 | 269 | **(314)** |
| **Pharmacy** | **485** | | 346 | 0 | **(346)** |
| **Clinical Services** | **275** | | 225 | 0 | **(225)** |
| **Estates** | **450** | | 367 | 511 | **144** |
| **ICT** | **80** | | 68 | 0 | **(68)** |
| **Workforce** | **540** | | 417 | 467 | **50** |
| **Total** | **5,000** | | **3,941** | **4,018** | **77** |

In month savings have been formally recognised in relation to:

- Procurement contractual savings
- Estates

## Capital

The Trust's capital expenditure at the end of August amounted to £8.3m as detailed below:

| | YTD Budget £'000 | YTD Actual £'000 | YTD Variance £'000 | Full Year Budget £'000 | Full Year Forecast £'000 | Full Year Variance £'000 |
|---|---|---|---|---|---|---|
| PFI Lifecycle | 3,908 | 3,911 | 03 | 9,380 | 9,380 | 0 |
| Site Reconfiguration | 6,167 | 2,473 | (3,694) | 19,729 | 19,729 | 0 |
| Replacement of Medical Equipment | 984 | 1,316 | 332 | 2,036 | 2,036 | 0 |
| Network Replacement and Clinical Noting | 2,200 | 633 | (1,567) | 3,750 | 3,750 | 0 |
| **Total** | **13,259** | **8,333** | **(4,926)** | **34,895** | **34,895** | **0** |

| | YTD Budget £'000 | YTD Actual £'000 | YTD Variance £'000 | Full Year Budget £'000 | Full Year Forecast £'000 | Full Year Variance £'000 |
|---|---|---|---|---|---|---|
| Financing | | | | | | |
| Depreciation | 13,259 | 8,333 | (4,926) | 13,203 | 13,203 | 0 |
| Internal Reserves | 0 | 0 | 0 | 9,547 | 9,547 | 0 |
| Charitable Funding | 0 | 0 | 0 | 0 | 0 | 0 |
| PDC | 0 | 0 | 0 | 12,145 | 12,145 | 0 |
| **Total Financing** | **13,259** | **8,333** | **(4,926)** | **34,895** | **34,895** | **0** |

The programme includes the following identified schemes:

- PFI Lifecycle - £10.4m contractual commitment (£9.4m) to Endeavour SCH LLP with the payment based on the Financial Model and PFI Enhancements and Change in Law (£1.0m);

- Estates – Friarage Rationalisation and Redevelopment (£12.1m), SDEC (£1.5m), Pathology Development (£1.2m), Elective Recovery (£1.4m) and Friarage Critical Backlog maintenance (£1.0m);

- IT – Alcidion and Digital Aspiration investment for e-prescribing and licencing (£1.2m), Data Centre Upgrade (£0.8m) and Cyber Investment (£0.5m); and

- Medical equipment – Emergency replacement of medical equipment including committed items from 2020/21.

Capital investment to date largely relates to contractual PFI Lifecycle payments and investment in emergency Business As Usual (BAU) replacements. The capital programme is currently underspent by £4.9m and this mainly includes variances on the Same Day Emergency Care (SDEC) scheme £0.9m, Interventional Radiology £0.3m, Pathology CAT3 £0.3m, PFI Enhancements and Change in Law £0.4m, FHN Theatre development and maintenance schemes £1.2m and the Alcidion project £0.7m. These are timing delays at this stage based on the forecast profile at the time of submitting the plan. It is anticipated that the plan will largely be delivered in full by 31 March and the Trust will continue to closely monitor the position over the coming months. The FHN Theatre business case is subject to regulatory approval.

The Trust submitted the annual capital plan for 2021/22 to NHSE/I on 12 April amounting to £33.4m. The Trust will utilise internally generated (depreciation) funds of £16.9m and sought to access PDC funding of £21.7m to support the capital programme, and to provide cash for contractual principal repayments on PFI and finance leases (£3.7m).

The Trust will look to utilise available cash to deliver the programme as outlined in the table above. The Trust will continue to review its liquidity forecasts with NHSE/I.

The Trust will look to utilise PDC to deliver the Friarage Rationalisation and Theatre Redevelopment and this will amount to a request of £12.1m. The PDC funding for Friarage is ring-fenced to FHN and will not be available for other purposes.

**Liquidity**

The cash balance at 31 August 2021 was £64.5m.

It is anticipated that the Trust's cash position will worsen in September following the second quarterly PFI payment. The Better Payment Practice Code (BPPC) performance for the Trust (target 95%) on cumulative invoices paid to date is detailed as follows:

- April 95.8%;
- May 96.4%;
- June 95.7%;
- July 95.7%;and
- August 95.3%.

To 31 August the Trust has paid 38,518 invoices (total value £187.9m) with 36,724 invoices (total value £173.4m) paid within the 30 day target.

## Statement of Financial Position (SOFP)

The following table compares the SOFP position between 31 July and 31 August 2021.

| | 31 July<br>£000 | 31 August<br>£000 | Movement between months<br>£000 |
|---|---|---|---|
| Property, Plant and Equipment | 243,816 | 244,122 | 306 |
| Long Term Receivables | 1,666 | 1,666 | 0 |
| **Total Non-Current Assets** | 245,482 | 245,788 | 306 |
| **Currents Assets** | | | |
| Inventories | 13,894 | 13,948 | 54 |
| Trade and other receivables (invoices outstanding) | 5,040 | 4,944 | (96) |
| Trade and other receivables (accruals) | 26,108 | 18,588 | (7,520) |
| Prepayments including PFI | 16,694 | 13,050 | (3,644) |
| Cash | 54,088 | 64,457 | 10,369 |
| **Total Current Assets** | 115,824 | 114,987 | (837) |
| **Current and Non-Current Liabilities** | | | |
| Borrowings | (91,795) | (91,481) | 314 |
| Trade and other payables | (93,668) | (93,690) | (22) |
| Provisions | (2,445) | (2,386) | 59 |
| **Total Current and Non-Current Liabilities** | (187,908) | (187,557) | 351 |
| **Net Assets** | **173,398** | **173,218** | **(180)** |
| **Equity:** | | | |
| Income and Expenditure Reserve | (234,343) | (234,523) | (180) |
| Revaluation Reserve | 33,643 | 33,643 | 0 |
| Public Dividend Capital | 347,622 | 347,622 | 0 |
| Other Reserves | 26,476 | 26,476 | 0 |
| **Total Equity** | **173,398** | **173,218** | **(180)** |

The major points of note on changes between July and August are:

- Property, Plant and Equipment – movement in month of £0.3m arising from spend on PFI lifecycle and emergency replacements, offset by depreciation.
- Trade and other receivables – £7.5m reduction relating to ERF funding received in August (£2.8m) and a £4.2m movement on VAT Control.
- Prepayments – decrease for 1 month following the advanced quarterly contractual PFI payment in June.
- Income and Expenditure Reserve – movement relates to the deficit on the revenue position delivered in August.

| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 OCTOBER 2021 | | | |
|---|---|---|---|
| Integrated Performance Report | | | **AGENDA ITEM: 16**<br>**ENC 13** |
| **Report Author and Job Title:** | Emma Moss<br>Management Information Lead<br>Business Intelligence Unit | **Responsible Director:** | Various |
| **Action Required** | Approve ☐ Discuss ☐ Inform ☒ | | |
| **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) is produced monthly to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance.<br><br>The IPR demonstrates areas of performance are monitored and provides assurance to the Board regarding actual performance and, where necessary, remedial actions.<br><br>Key elements of the report are discussed at the Trust Quality Assurance Committee, Resources Committee and People Committee. A summary of discussions are included in Chair Reports to the Board of Directors. | | |
| **Assessment** | The following changes have been implemented in August's IPR:<br><br>• Senior Leadership Team have reviewed content and format, further changes are to be implemented in subsequent months.<br><br>**Our key messages for August are:**<br><br>The escalated C-19 response continued through August. Clinical teams treated patients with COVID-19 in two dedicated wards, a dedicated critical care unit and specialist beds as required across JCUH. Patients without COVID whose needs are equally urgent were prioritised while we continued to address the backlog of patients whose care has been disrupted by the pandemic.<br><br>The surge of Covid-19 patients and infection rates in our community impacted in many areas:<br><br>• Elective inpatient activity remained below plan, due to critical | | |

<table>
<tr><td></td><td colspan="2">care capacity, continued COVID-19 inpatients and DNAs due to COVID-19 in the wider population.<br>• As seen across the NHS, the 4-hour standard performance declined as our A&E services dealt with COVID-19 pathway patients and sustained high demand in ED and our two UTCs.<br>• Appraisals and mandatory training rates declined as we continue to see high levels of absence from work.<br>• In addition, ongoing challenges in recruitment to specific specialties continue to impact on activity recovery, for example Anaesthetic Consultants and Theatre registered nursing.<br><br>Despite these challenges safety and quality remained the number one priority.<br><br>• Safe: Falls rate remains below benchmark, despite staffing challenges; Serious Incidents remain below the mean; most sepsis bundle indicators continued to improve;<br>• Caring: Patient satisfaction for Inpatients and Outpatients remain above target<br>• Responsive: Outpatient activity back to plan; Cancer 14-day standard above mean for 7 months.<br><br>Benchmarking sets our performance in context, reflecting that of comparable Trusts.</td></tr>
<tr><td>Recommendation</td><td colspan="2">The Board of Directors are asked to:<br><br>• Receive the Integrated Performance Report for August 2021.<br><br>Note the performance standards that are being achieved and the remedial actions being taken where metrics are outside expected parameters.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="2">All principal risks identified in the BAF</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="2">There are no legal or equality and diversity implications associated with this paper</td></tr>
<tr><td rowspan="2">Strategic Objectives</td><td>Best for safe, clinically effective care and experience ☒</td><td>A great place to work ☒</td></tr>
<tr><td>Deliver care without boundaries in collaboration with our health and social care partners ☒</td><td>Make best use of our resources ☒</td></tr>
</table>

| | | |
|---|---|---|
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒ | |

South Tees Hospitals
NHS Foundation Trust

# Integrated Performance Report

August 2021

# Changes to IPR

South Tees Hospitals
NHS Foundation Trust

The following changes have been implemented in August 2021 IPR:

- Senior Leadership Team have reviewed content and format, further changes are to be implemented in subsequent months.

# Key Messages

South Tees Hospitals NHS Foundation Trust

The escalated C-19 response continued through August. Clinical teams treated patients with COVID-19 in two dedicated wards, a dedicated critical care unit and specialist beds as required across JCUH. Patients without COVID whose needs are equally urgent were prioritised while we continued to address the backlog of patients whose care has been disrupted by the pandemic.

The surge of Covid-19 patients and infection rates in our community impacted in many areas:
- **Elective inpatient activity** remained below plan, due to critical care capacity, continued COVID-19 inpatients and DNAs due to COVID-19 in the wider population.
- As seen across the NHS, the **4-hour standard** performance declined as our A&E services dealt with COVID-19 pathway patients and sustained high demand in ED and our two UTCs.
- **Appraisals** and **mandatory training** rates declined as we continue to see high levels of absence from work.

In addition, ongoing challenges in recruitment to specific specialties continue to impact on activity recovery, for example Anaesthetic Consultants and Theatre registered nursing.

Despite these challenges safety and quality remained the number one priority.

- Safe: **Falls** rate remains below benchmark, despite staffing challenges; **Serious Incidents** remain below the mean; most **sepsis bundle indicators** continued to improve;
- Caring: **Patient satisfaction** for Inpatients and Outpatients remain above target
- Responsive: **Outpatient activity** above plan; **Cancer 14-day standard** above mean for 7 months.

Benchmarking sets our performance in context, reflecting that of comparable Trusts.

# Summary

South Tees Hospitals NHS Foundation Trust

| | Indicator | Latest Month | Target/ Benchmark | Month Reported | Trend | Assurance |
|---|---|---|---|---|---|---|
| SAFE | All Falls Rate | 4.61 | 6.6 | 08/2021 | | |
| | Falls With Harm Rate | 0.07 | TBD | 08/2021 | | |
| | Infection Control - C-Difficile (YTD) | 46 | 73 | 08/2021 | N/A | N/A |
| | Infection Control - MRSA (YTD) | 1 | 0 | 08/2021 | N/A | N/A |
| | All DATIX Incidents | 2047 | 2070 | 08/2021 | | |
| | Serious Incidents | 5 | 5 | 08/2021 | | |
| | Never Events (YTD) | 2 | 0 | 08/2021 | N/A | N/A |
| | Category 2 Pressure Ulcers | 5.53 | TBD | 08/2021 | | |
| | Category 3 & 4 Pressure Ulcers | 0.74 | TBD | 08/2021 | | |
| | SHMI | 111.81 | 100 | 05/2021 | | |
| | Hospital Standard Mortality Rate (HSMR) | 86.42 | 100 | 06/2021 | | |
| | Palliative Care Coding | 0.004 | TBD | 06/2021 | | |
| | Comorbidity Coding | 3.63 | TBD | 06/2021 | | |
| | VTE | 79.74% | 95% | 08/2021 | L | F |
| | Maternity - Caesarean Section Rate (%) | 34.87% | 30.0% | 08/2021 | | |
| | Maternity - Induction of Labour Rate (%) | 46.97% | 44.0% | 08/2021 | | |
| | Maternity - Still Births (YTD) | 11 | 17 | 08/2021 | N/A | N/A |
| | Maternity - PPH 1500ml Rate (%) | 3.75% | 0.00% | 08/2021 | | |

| | Indicator | Latest Month | Target/ Benchmark | Month Reported | Trend | Assurance |
|---|---|---|---|---|---|---|
| EFFECTIVE | Sepsis - Targeted oxygen delivered within 1 hour | 98.00% | 95% | 07/2021 | | |
| | Sepsis - Blood cultures taken within 1 hour | 75.50% | 95% | 07/2021 | | |
| | Sepsis - Empiric IV antibiotics administered | 79.60% | 95% | 07/2021 | H | |
| | Sepsis - Serum lactate taken within 1 hour | 81.60% | 95% | 07/2021 | | F |
| | Sepsis - IV fluid resuscitation initiated | 85.70% | 95% | 07/2021 | H | F |
| | Sepsis - Urine measurement started | 57.10% | 95% | 07/2021 | | F |
| CARING | F&F A&E Overall Experience Rate (%) | 80.79% | 85% | 08/2021 | L | |
| | F&F Inpatient Overall Experience Rate (%) | 96.30% | 96% | 08/2021 | | |
| | F&F Outpatient Overall Experience Rate (%) | 96.39% | 95% | 08/2021 | | |
| | F&F Maternity Overall Experience Rate (%) | 93.10% | 97% | 08/2021 | L | |
| | Complaints Closed Within Target (%) | 80.77% | 80% | 08/2021 | | |
| | All New Complaints | 26 | TBD | 08/2021 | | |

| 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 |

# Summary

South Tees Hospitals NHS Foundation Trust

| | Indicator | Latest Month | Target | Month Reported | Trend | Assurance |
|---|---|---|---|---|---|---|
| RESPONSIVE | A&E 4 Hour Wait Standard (%) | 78.08% | 95% | 08/2021 | L | F |
| | Ambulance Handovers - over 30 mins | 195 | TBD | 08/2021 | H | ? |
| | Ambulance Handovers - over 60 mins | 132 | TBD | 08/2021 | H | ? |
| | RTT Incomplete Pathways (%) | 62.50% | 92% | 08/2021 | L | F |
| | Diagnostic 6 Weeks Standard (%) | 76.26% | 99% | 08/2021 | | F |
| | Cancer Treatment - 14 Day Standard (%) | 88.74% | 93% | 08/2021 | H | ? |
| | Cancer Treatment - 31 Day Standard (%) | 88.44% | 96% | 08/2021 | L | ? |
| | Cancer Treatment - 62 Day Standard (%) | 74.65% | 85% | 08/2021 | | ? |
| | Cancer Treatment - 62 Day Screening (%) | 83.33% | 90% | 08/2021 | L | F |
| | Non-Urgent Ops Cancelled on Day | 32 | 0 | 08/2021 | | F |
| | Cancer Operations Cancelled On Day (YTD) | 7 | 0 | 08/2021 | N/A | N/A |
| | Cancelled Ops Not Rebooked Within 28 days | 11 | 0 | 08/2021 | | ? |
| | E-Discharge (%) | 94.30% | 90% | 08/2021 | H | P |

| | Indicator | Latest Month | Target | Month Reported | Trend | Assurance |
|---|---|---|---|---|---|---|
| WELL LED | Year-To-Date Budget Variance (£'millions) | -2.79m | -2.78m | 08/2021 | N/A | N/A |
| | Annual Appraisal (%) | 67.46% | 80% | 08/2021 | L | F |
| | Mandatory Training (%) | 84.35% | 90% | 08/2021 | L | F |
| | Sickness Absence (%) | 5.62% | 4% | 08/2021 | H | ? |
| | Staff Turnover (%) | 11.59% | 10% | 08/2021 | H | F |

| 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 |

# Elective Recovery Summary

South Tees Hospitals NHS Foundation Trust

**Context: Performance in 2021 against service plans**

**Recovery: Elective & Theatres**

## SUMMARY MONTHLY ACTIVITY AGAINST PLAN

| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YtD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outpatient First | Plan | 15,268 | 15,806 | 15,315 | 16,547 | 14,328 | 15,799 | 16,679 | 15,511 | 13,614 | 15,901 | 14,845 | 12,644 | 77,264 |
| | 2021 | 15,405 | 15,792 | 17,697 | 16,074 | 14,500 | 5,288 | 0 | 0 | 0 | 0 | 0 | 0 | 79,468 |
| | Var | 137 | -14 | 2,382 | -473 | 172 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,204 |
| | *2019* | *17,697* | *18,080* | *17,611* | *19,045* | *16,375* | *17,918* | *18,886* | *17,570* | *15,401* | *17,929* | *16,818* | *14,357* | *88,808* |
| Outpatient Follow-up | Plan | 41,017 | 42,743 | 40,250 | 44,050 | 39,046 | 41,180 | 44,839 | 41,926 | 36,893 | 44,513 | 39,462 | 34,651 | 207,106 |
| | 2021 | 44,288 | 43,100 | 47,757 | 44,030 | 41,335 | 14,672 | 0 | 0 | 0 | 0 | 0 | 0 | 220,510 |
| | Var | 3,271 | 357 | 7,507 | -20 | 2,289 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13,404 |
| | *2019* | *48,556* | *50,322* | *47,362* | *51,972* | *45,819* | *48,316* | *52,500* | *49,158* | *42,991* | *51,908* | *46,101* | *40,435* | *244,031* |
| **Outpatient Total** | **Plan** | **56,286** | **58,550** | **55,566** | **60,597** | **53,375** | **56,980** | **61,518** | **57,438** | **50,507** | **60,415** | **54,308** | **47,295** | **284,374** |
| | **2021** | **59,693** | **58,892** | **65,454** | **60,104** | **55,835** | **19,960** | **0** | **0** | **0** | **0** | **0** | **0** | **299,978** |
| | **Var** | **3,407** | **342** | **9,888** | **-493** | **2,460** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **15,604** |
| | ***2019*** | ***66,253*** | ***68,402*** | ***64,973*** | ***71,017*** | ***62,194*** | ***66,234*** | ***71,386*** | ***66,728*** | ***58,392*** | ***69,837*** | ***62,919*** | ***54,792*** | ***332,839*** |
| Outpatient virtual | Plan | 16,748 | 17,161 | 16,108 | 17,568 | 15,719 | 16,671 | 17,804 | 16,644 | 14,451 | 17,583 | 15,760 | 13,922 | 83,304 |
| | 2021 | 17,754 | 16,519 | 17,718 | 15,844 | 14,581 | 4,712 | 0 | 0 | 0 | 0 | 0 | 0 | 82,416 |
| | Var | 1,006 | -642 | 1,610 | -1,724 | -1,138 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -888 |
| | *2019* | *1,517* | *1,653* | *1,542* | *1,600* | *1,405* | *1,485* | *1,594* | *1,497* | *1,428* | *1,787* | *1,564* | *7,147* | *7,717* |
| Outpatient FtF | Plan | 39,537 | 41,389 | 39,458 | 43,028 | 37,655 | 40,308 | 43,713 | 40,794 | 36,055 | 42,831 | 38,547 | 33,373 | 201,067 |
| | 2021 | 41,939 | 42,373 | 47,736 | 44,260 | 41,254 | 15,248 | 0 | 0 | 0 | 0 | 0 | 0 | 217,562 |
| | Var | 2,402 | 984 | 8,278 | 1,232 | 3,599 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 16,495 |
| | *2019* | *64,736* | *66,749* | *63,431* | *69,417* | *60,789* | *64,749* | *69,792* | *65,231* | *56,964* | *68,050* | *61,355* | *47,645* | *325,122* |

# Elective Recovery Summary

South Tees Hospitals NHS Foundation Trust

## Context: Performance in 2021 against service plans

## Recovery: Elective & Theatres

| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YtD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Elective SD | Plan | 4,733 | 5,208 | 5,067 | 5,736 | 5,298 | 5,288 | 5,931 | 5,533 | 5,116 | 5,934 | 5,169 | 4,440 | 26,042 |
| | 2021 | 4,793 | 4,964 | 5,542 | 5,330 | 5,174 | 2,013 | 0 | 0 | 0 | 0 | 0 | 0 | 25,803 |
| | Var | 60 | -244 | 475 | -406 | -124 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -239 |
| | *2019* | *5,809* | *5,977* | *5,608* | *6,309* | *5,633* | *5,627* | *6,327* | *5,931* | *5,443* | *6,320* | *5,512* | *4,728* | *29,336* |
| IP Elective Overnight | Plan | 678 | 852 | 989 | 1,026 | 1,071 | 1,035 | 1,120 | 1,159 | 918 | 944 | 995 | 833 | 4,616 |
| | 2021 | 636 | 867 | 906 | 904 | 894 | 380 | 0 | 0 | 0 | 0 | 0 | 0 | 4,207 |
| | Var | -42 | 15 | -83 | -122 | -177 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -409 |
| | *2019* | *1,037* | *1,076* | *1,147* | *1,143* | *1,120* | *1,077* | *1,167* | *1,193* | *945* | *970* | *1,020* | *852* | *5,523* |
| **IP Elective Total** | **Plan** | **5,411** | **6,060** | **6,056** | **6,762** | **6,369** | **6,323** | **7,051** | **6,692** | **6,034** | **6,878** | **6,164** | **5,273** | **30,658** |
| | **2021** | **5,429** | **5,831** | **6,448** | **6,234** | **6,068** | **2,393** | **0** | **0** | **0** | **0** | **0** | **0** | **30,010** |
| | **Var** | **18** | **-229** | **392** | **-528** | **-301** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **-648** |
| | ***2019*** | ***6,846*** | ***7,053*** | ***6,755*** | ***7,452*** | ***6,753*** | ***6,704*** | ***7,494*** | ***7,124*** | ***6,388*** | ***7,290*** | ***6,532*** | ***5,580*** | ***34,859*** |

## Summary

- Note the August figures are provisional; finalised activity will be slightly higher.
- Outpatient activity was above plan in August and remains ahead of plan overall.
- Inpatient elective activity was below plan, though better than July. The year-to-date position has now dropped below plan.

## Cause of Variation

- Covid-19 pressure reduced during August but was still significant particularly for theatre and anaesthetic staffing due to absence.
- Continuing deployment of Anaesthetic resource to Critical Care – impacting on the number of GA theatre sessions.
- Theatres 5 & 6 re-opened but COVID-19 related absence meant they could not be fully utilised.

## Planned Actions

- Expectation that Covid-19 activity will remain at current levels for some time, including Red wards and Critical Care impact.
- Regular review of isolation policy to minimise staff absence while retaining safe care
- Eye theatre team recruitment continuing
- Increase number of lists at Redcar Primary Care Hospital.
- Recovery Oversight Group meetings restarted with a rolling programme of service reviews
- Winter Plan in prep. Aims to protect elective activity as far as possible (presented to Clinical Policy Group)

## Timescale

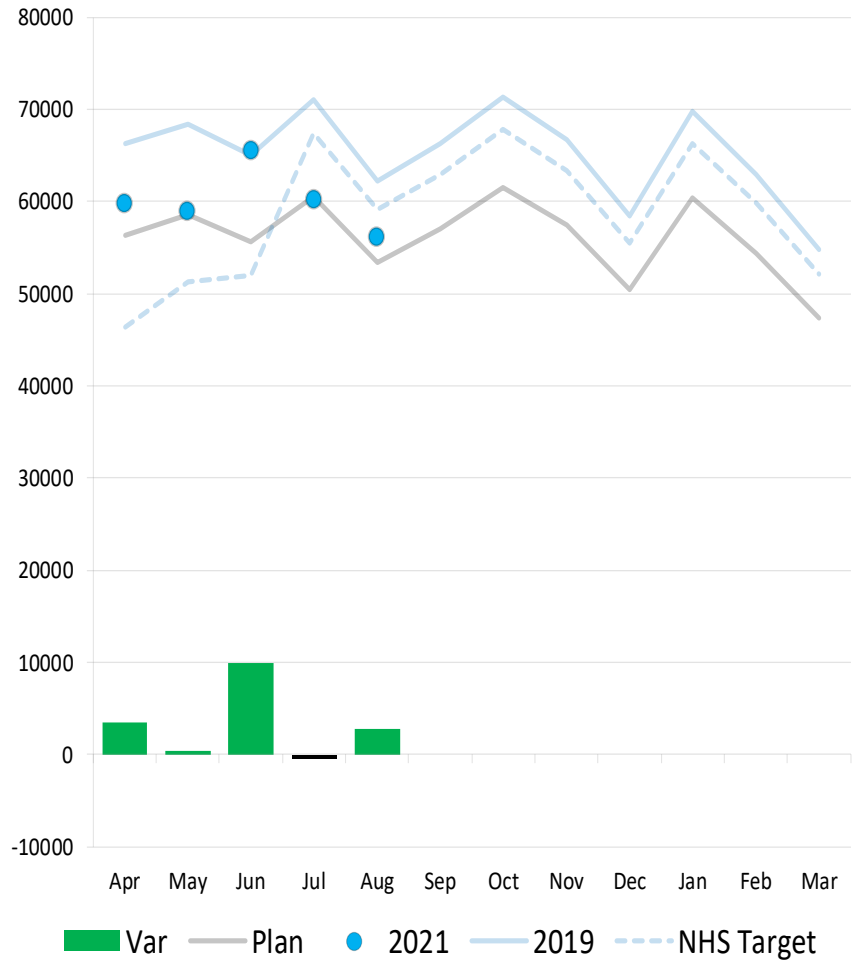
Weekly review and challenge at Recovery Oversight Group, reporting to Clinical Strategy & Improvement Group

# Responsive

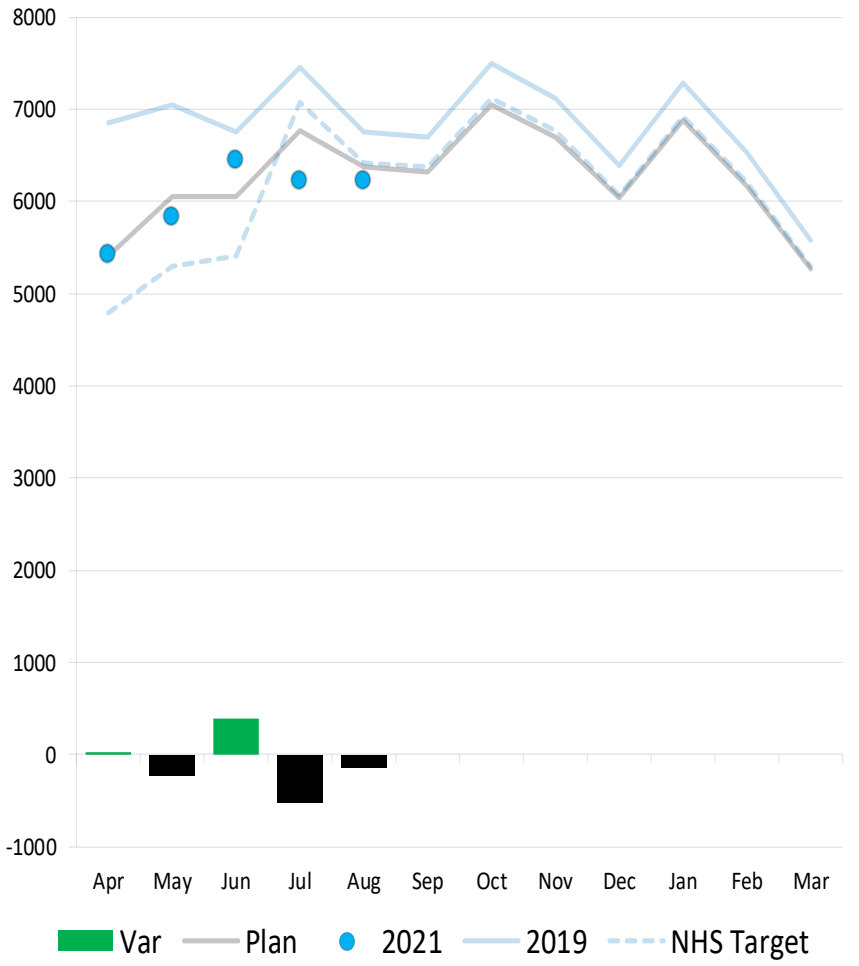
South Tees Hospitals NHS Foundation Trust

## SUMMARY MONTHLY ACTIVITY AGAINST PLAN

### Total Outpatient Attends

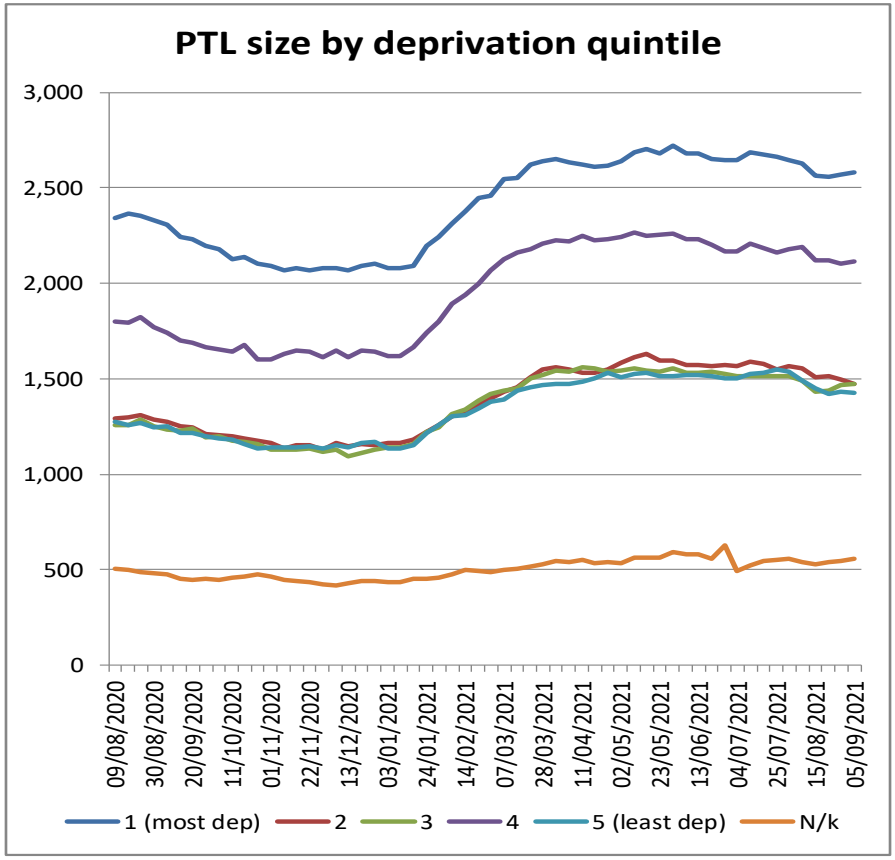



### Total Elective Spells

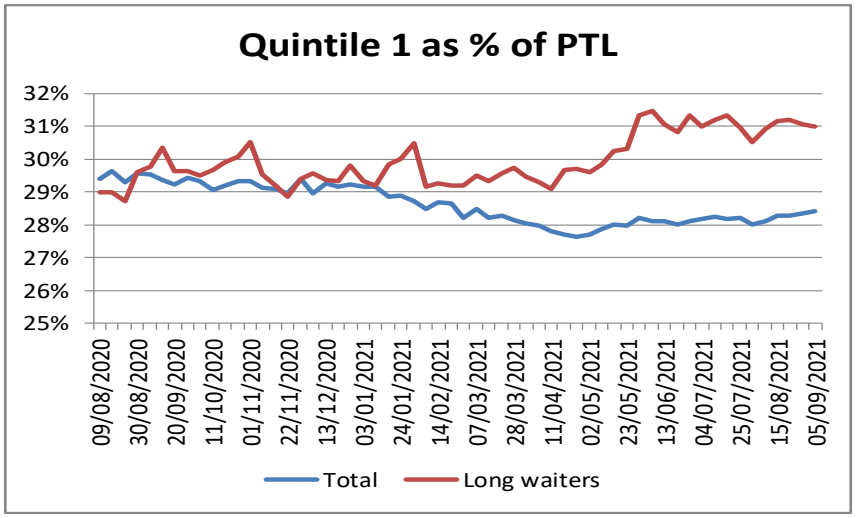


South Tees Hospitals
NHS Foundation Trust

# INPATIENT PTL: INEQUALITIES - DEPRIVATION (IMD from postcode of residence)




| 05/09/2021 | Total | | Long waiters | | Ratio |
|---|---|---|---|---|---|
| 1 (most dep) | 2,579 | 28% | 880 | 31% | 1.09 |
| 2 | 1,474 | 16% | 484 | 17% | 1.05 |
| 3 | 1,476 | 16% | 449 | 16% | 0.97 |
| 4 | 2,116 | 23% | 608 | 21% | 0.92 |
| 5 (least dep) | 1,428 | 16% | 420 | 15% | 0.94 |
| N/k | 560 | | 168 | | |

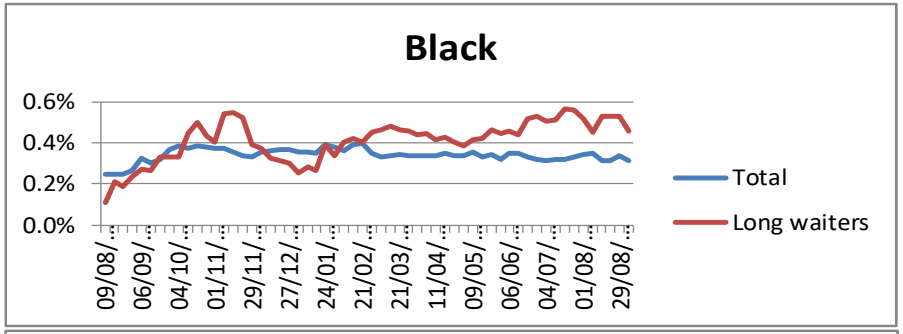


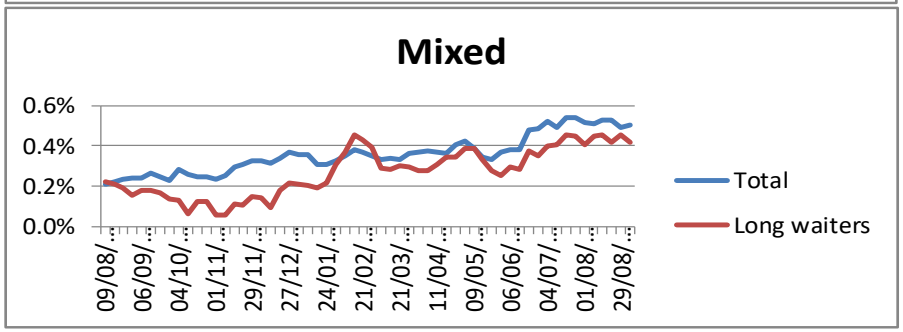

Patients in the most deprived quintile continue to be over-represented in the cohort of long waiters.

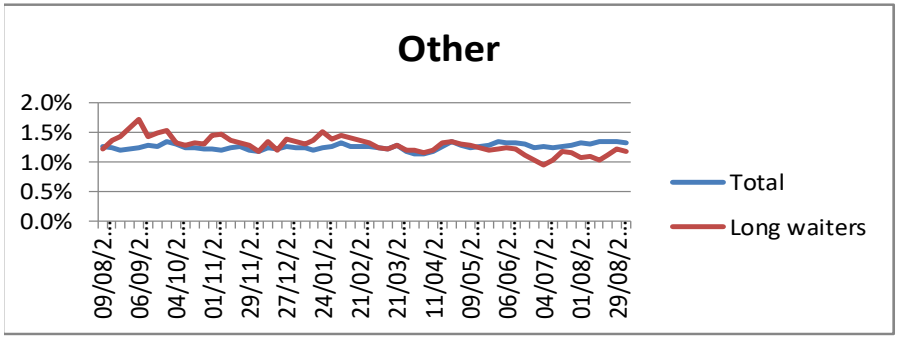
IMD – Index of multiple deprivation

South Tees Hospitals
NHS Foundation Trust

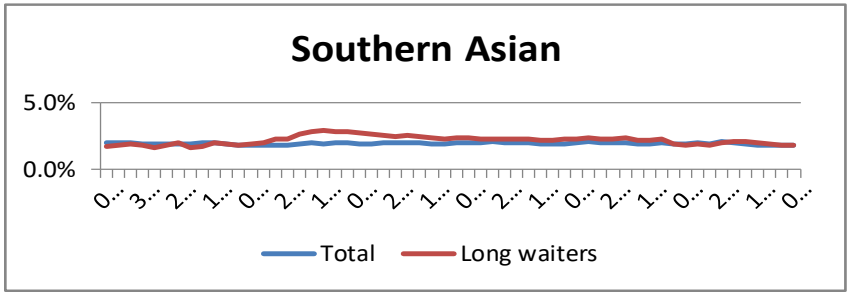
# INPATIENT PTL: INEQUALITIES - ETHNICITY

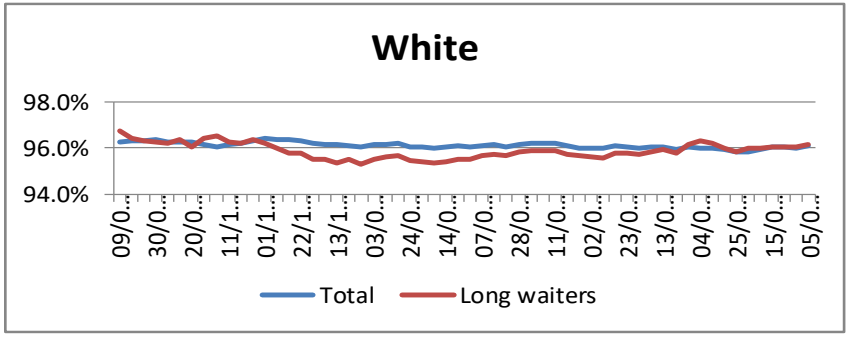



| 05/09/2021 | Total | | Long waiters | | Ratio |
|---|---|---|---|---|---|
| Black | 26 | 0.3% | 12 | 0.5% | 1.46 |
| Mixed | 42 | 0.5% | 11 | 0.4% | 0.83 |
| Southern Asian | 150 | 1.8% | 47 | 1.8% | 0.99 |
| White | 8,010 | 96.1% | 2,532 | 96.2% | 1.00 |
| Other | 110 | 1.3% | 31 | 1.2% | 0.89 |
| N/k | 1,295 | | 376 | | |



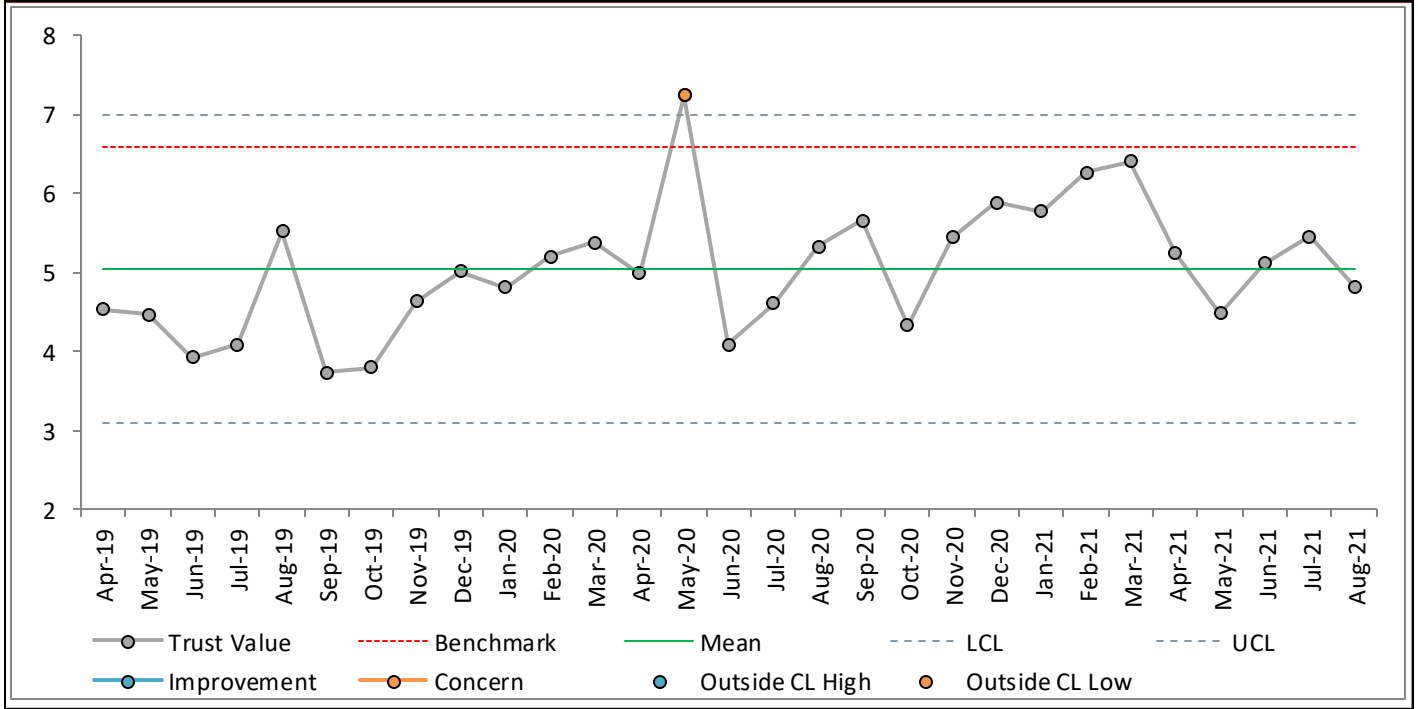




The proportion of the long waiters on the PTL who are White has fallen showing an overall increase in the proportions of Non-White. Action: NENC ICS Health Inequalities toolkit launch in September 2021.

# Safe

South Tees Hospitals NHS Foundation Trust

## All Falls Rate




The Trust falls rate per 1000 bed days

| | |
|---|---|
| Benchmark | 6.6 |
| Mean | 5.03 |
| Last Month | 4.61 |

**Executive Lead**

Hilary Lloyd

**Lead**

Ruth Mhlanga

## Commentary

The Trust had a rate of 4.61 falls per 1000 bed days in August., which is below the 2-year average.

The most common cause of falls remain poor balance with patients falling mostly whilst mobilising slips deconditioning and memory loss or a combination of all 4.

## Cause of Variation

- This metric is within normal variation and rate has now reduced in the second quarter of this year
- The Trust is not an outlier for its reporting of falls

## Planned Actions

- Communication around themes of contributors to falls to continue.
- Joint regular reviews of falls with harm with Safeguarding team to identify hotspots and develop action plans.
- Bespoke ward interventions where high levels of falls have been identified.
- Refreshing patient falls leaflet.

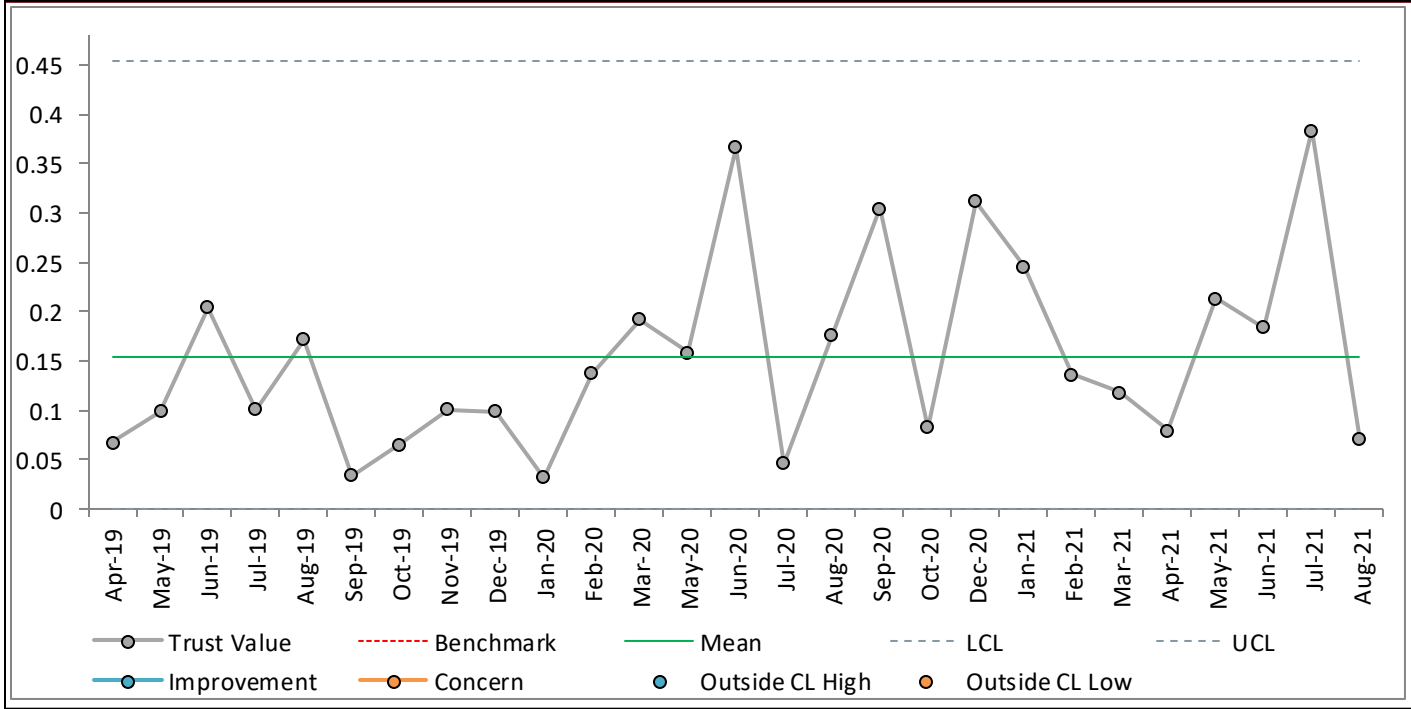
## Timescale

- October 2021
- Inpatient falls lead will continue to foster the sharing of good practice and quality improvement work.

# Safe

South Tees Hospitals NHS Foundation Trust

## Falls With Harm Rate




Rate of falls with harm per 1000 bed days

| | |
|---|---|
| Benchmark | TBD |
| Mean | 0.16 |
| Last Month | 0.07 |

**Executive Lead**

Hilary Lloyd

**Lead**

Ruth Mhlanga

## Commentary

We have seen a reduction on falls with harm this month, below the 2-year average.

## Cause of Variation

- The rate of harm is within normal variation

## Planned actions

- Communication around themes of contributors to falls to continue.
- Joint regular reviews of falls with harm with Safeguarding team to identify hotspots and develop action plans.
- Bespoke ward interventions where high levels of falls have been identified.
- Refreshing patient falls leaflet.

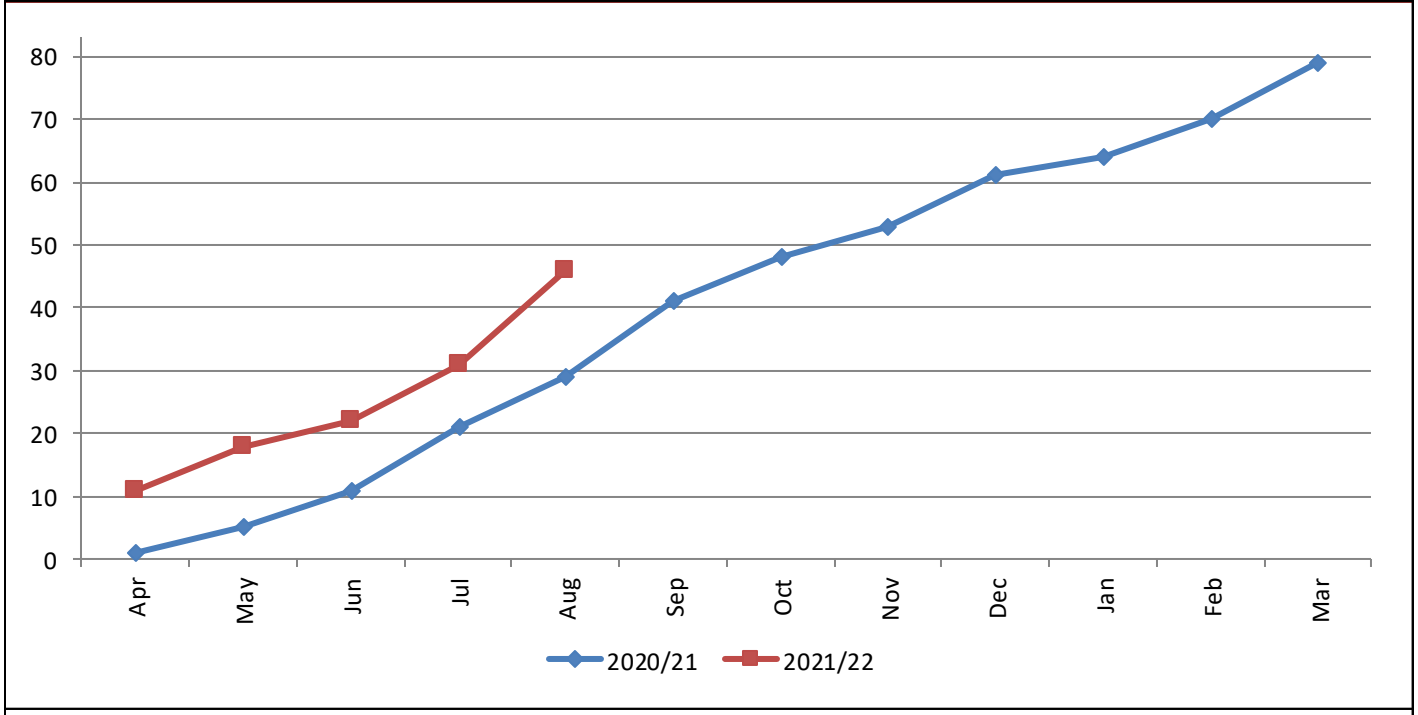
## Timescale

- October 2021
- Inpatient falls lead will continue to foster the sharing of good practice and quality improvement work.

# Safe

South Tees Hospitals NHS Foundation Trust

## Infection Control - C-Difficile (YTD)




Cases of hospital acquired C. Difficile bacteraemia

| | |
|---|---|
| Outturn | 73 |
| Mean | N/A |
| YTD | 46 |

**Executive Lead**

Hilary Lloyd

**Lead**

Sharon Lance

## Commentary

We have seen an increase in C Difficile, both month on month and in comparison to the previous year and which is also reflected in the regional and national position.

## Cause of Variation

- This indicator is not in control chart format because numbers. reported are small and therefore variation is not being assessed.
- The Trust trajectory is to have no more than a combined total of 82 community onset healthcare associated (COHA) and healthcare onset healthcare associated (HOHA) cases amongst patients aged over 2 year.
- There were 15 cases of CDI in August 2021, 3 of which were classed as COHA and 12 HOHA. .

## Plan

- CDI recovery plan developed and update presented to IPC Strategic group September '21 – Focus on Diarrhoea control, Hand Hygiene, Ownership & Learning.
- Implemented weekly CDI escalation group meeting (mandatory attendance) – 8am Monday – to include heatmap, areas of focus and intensive support programme for areas of concern.
- 6 week intense programme focus areas include = toolbox teachings, commode competencies and commode audit and hand hygiene competencies.

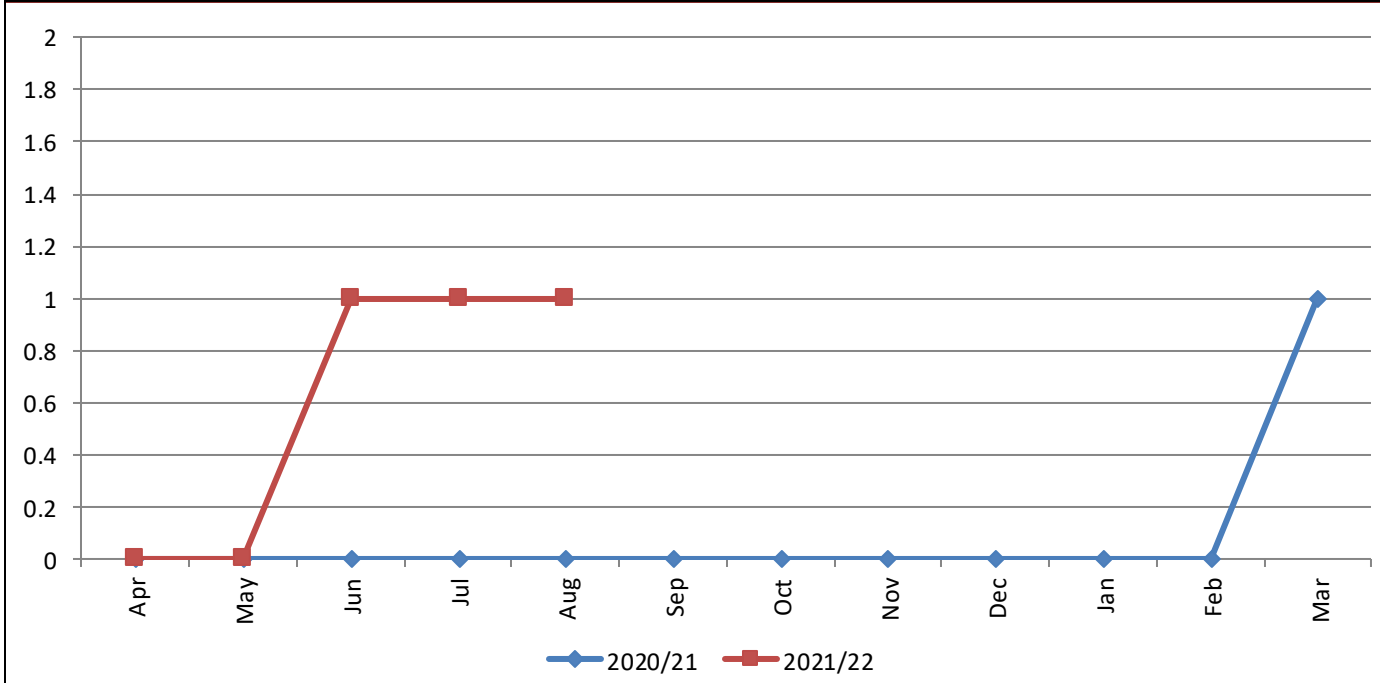
## Timescale

- November 2021
- November 2021
- November 2021

# Safe

South Tees Hospitals NHS Foundation Trust

## Infection Control - MRSA (YTD)




Cases of hospital acquired MRSA bacteraemia

| | |
|---|---|
| Target | 0 |
| Mean | N/A |
| YTD | 1 |

**Executive Lead**

Hilary Lloyd

**Lead**

Sharon Lance

## Commentary

No new cases this month. A case panel has been held for TA MRSA from June 2021, with an agreement from the CCG that this case does meet the national definition of 'non-trust assigned'

## Cause of Variation

- This indicator is not in control chart format because numbers reported are small and therefore variation is not being assessed.
- There was 0 Trust Assigned case in August 2021.

## Planned Actions

- Aseptic non touch technique training and audit programs continue
- Line care and infection prevention included in annual plan 2021/22
- Development of patient pathway for line care in early discussions, utilising previous work to move forward, this is to be presented at the IPC Strategy group
- Request to join a Nurse Antimicrobial Stewardship group working across NE & Cumbria.

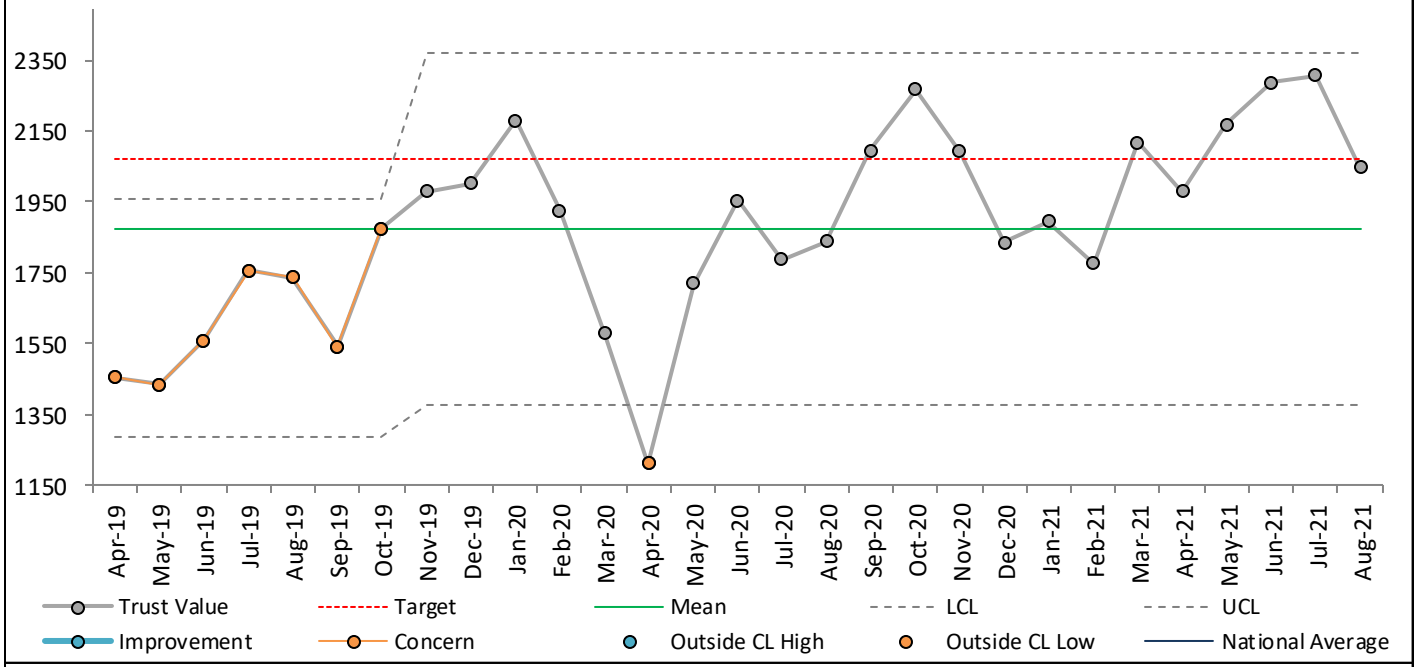
## Timescale

- November 2021

# Safe

South Tees Hospitals NHS Foundation Trust

## All DATIX Incidents




All incidents recorded on DATIX

| | |
|---|---|
| Target | 2070 |
| Mean | 1875.69 |
| Last Month | 2047.00 |

**Executive Lead**

Hilary Lloyd

**Lead**

Kay Davies

## Commentary

The Trust has a Quality Priority for 2021/22 to Increase Incident Reporting by 10%. This will also mean an increase in incidents reported to NRLS

The Trust has been above the 10% target since April 2020

## Cause of Variation

- The reporting remains within normal variation
- Special cause variation is noted in August 2021

## Planned Actions

- The implementation of Datix Cloud IQ commenced in August 2021 and the associated Datix Anywhere App will rolled out by March 2022
- Request for Datix Champions to be identified and trained to improve Datix experience for all users.

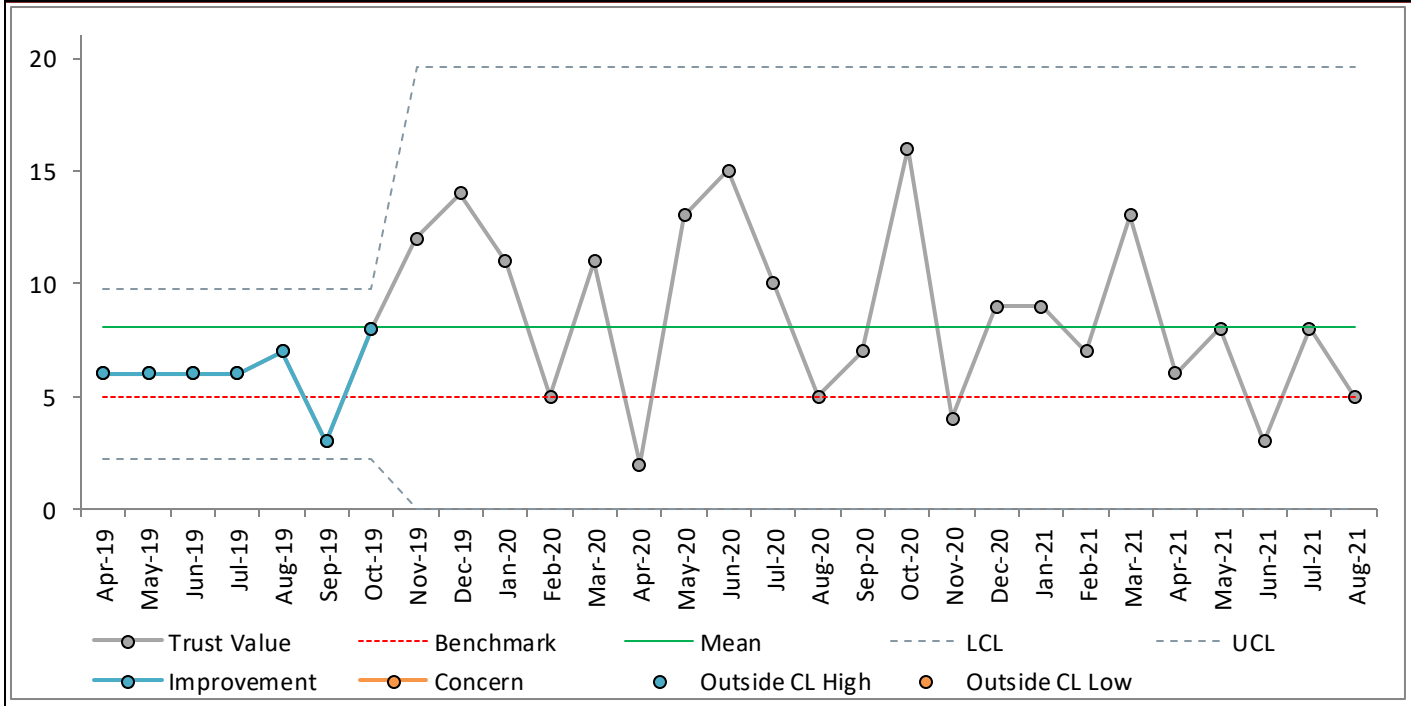
## Timescale

- This is a three year plan which commenced in April 2019 and will run to March 2022.

# Safe

South Tees Hospitals NHS Foundation Trust

## Serious Incidents




The number of Serious Incidents

| | |
|---|---|
| Benchmark | 5 |
| Mean | 8.10 |
| Last Month | 5.00 |

**Executive Lead**

Hilary Lloyd

**Lead**

Kay Davies

## Commentary

The number of Serious Incidents reported remains below the mean. In August 2021 and reached benchmark of 5. 100% were reported in the month that they occurred.

## Cause of Variation

- This metric is within normal variation from November 2019.

## Planned Actions

- Develop Trust wide approach to the new Patient Safety Framework
- Implementing Patient Safety Action Plan
- Trust wide work on Just culture
- Prioritise overdue SI actions

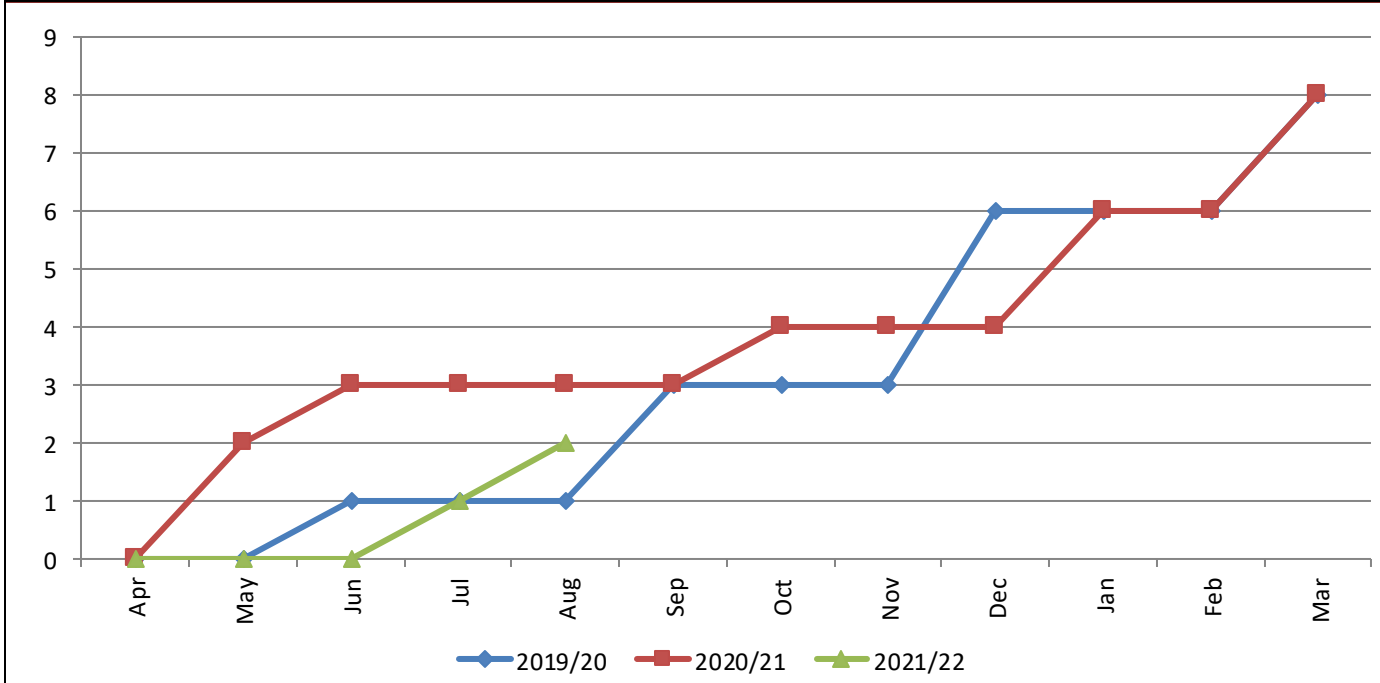
## Timescale

- March 2022
- January 2022

# Safe

South Tees Hospitals NHS Foundation Trust

## Never Events (YTD)




Number of reported Never Events

| | |
|---|---|
| Target | 0 |
| Mean | N/A |
| YTD | 2 |

**Executive Lead**

Hilary Lloyd

**Lead**

Kay Davies

## Commentary

There was one Never Event reported in August 2021. This incident related to a retained guidewire within a Nasogastric tube, and there was no harm caused to the patient.

## Cause of Variation

- This indicator is not in control chart format because numbers reported are small and therefore variation is not being assessed.

## Planned Actions

- Auditing of the LocSSIPs relating to previous NEs is being carried out
- Never Events working group establishing from CPG to review previous NE's
- Developing the Trust approach to the National Patient Safety Strategy
- Developing the Trusts Quality and Safety Strategy
- Establish a learning culture supported by the Leadership and Safety Academy.

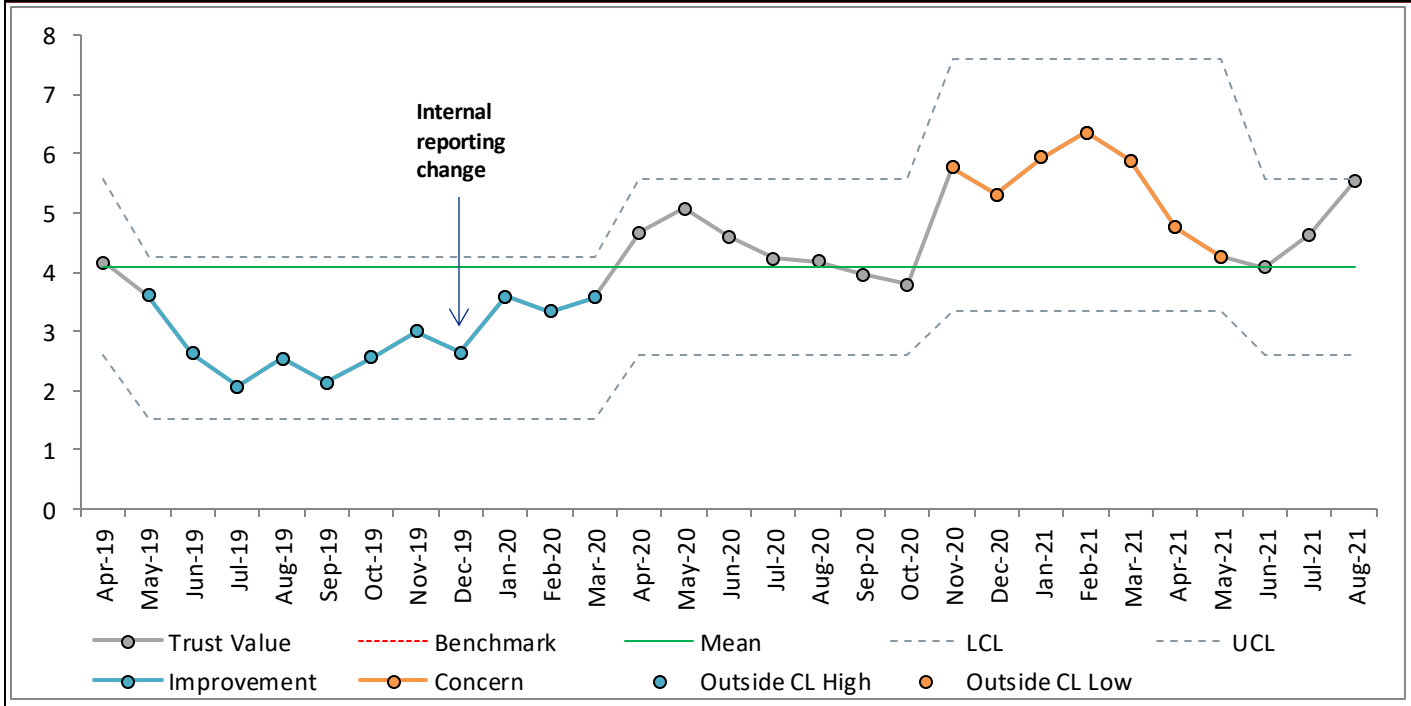
## Timescale

- October 2021
- December 2021
- October 2021
- March 2022

# Safe

South Tees Hospitals NHS Foundation Trust

## Category 2 Pressure Ulcers




Rate of Category 2 Pressure Ulcers - Trust Acquired per 1000 bed days

| | |
|---|---|
| Benchmark | TBD |
| Mean | 4.10 |
| Last Month | 5.53 |

**Executive Lead**

Hilary Lloyd

**Lead**

Louise Fleming

## Commentary

Whilst the Trust is not an outlier for PUs, this remains one of our Quality Priorities and we are leading the Tees Valley Pressure Ulcer Collaborative

## Cause of Variation

- The majority of the increase is due to the high acuity in Q4 in the critical care areas as a result of Covid.
- Whilst not statistically significant the upward trend in Category 2 pressure ulcers is being closely monitored with actions in place.

## Planned Actions

- Update and launch the Tissue Viability action plan 2021/22.
- Trust wide Pressure Ulcer Collaborative (PUC)
- New risk assessment tool (Purpose T) trial completed in July 2021 in Community with positive impact on 'no lapses of care'. To be rolled out.

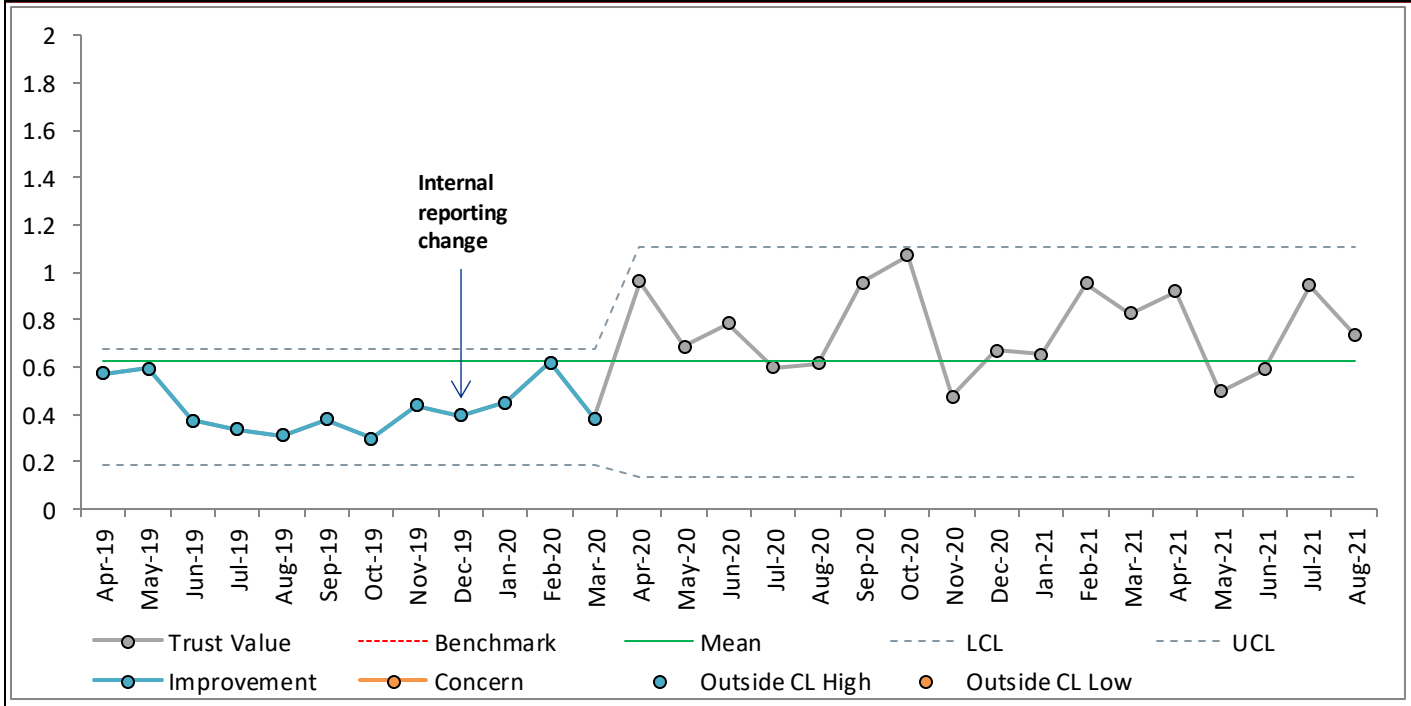
## Timescale

- December 2021

# Safe

South Tees Hospitals NHS Foundation Trust

## Category 3 & 4 Pressure Ulcers




Rate of Category 3 & 4 Pressure Ulcers per 1000 bed days

| | |
|---|---|
| Benchmark | TBD |
| Mean | 0.62 |
| Last Month | 0.74 |

**Executive Lead**

Hilary Lloyd

**Lead**

Louise Fleming

## Commentary

7 category 3 Pressure Ulcers were observed in the acute setting, 13 category 3's within community.

1 Category 4 Pressure Ulcer was reported in Spinal due to rapid deterioration, full MDT meeting took place.

## Cause of Variation

- The rate is within normal variation, with fewer Category 3 and 4 Pressure Ulcers this month.

## Planned Actions

- Ongoing Intensive support for critical care with Action Plan.
- 12 month planned programme of Teaching and PU improvement programme for Community Services
- Monitor impact of 'structured review' learning conversation replacing RCA and panel process
- Agree improvement Trajectory
- New risk assessment tool (Purpose T) trial completed in July 2021 in Community with positive impact on 'no lapses of care'. To be rolled out.

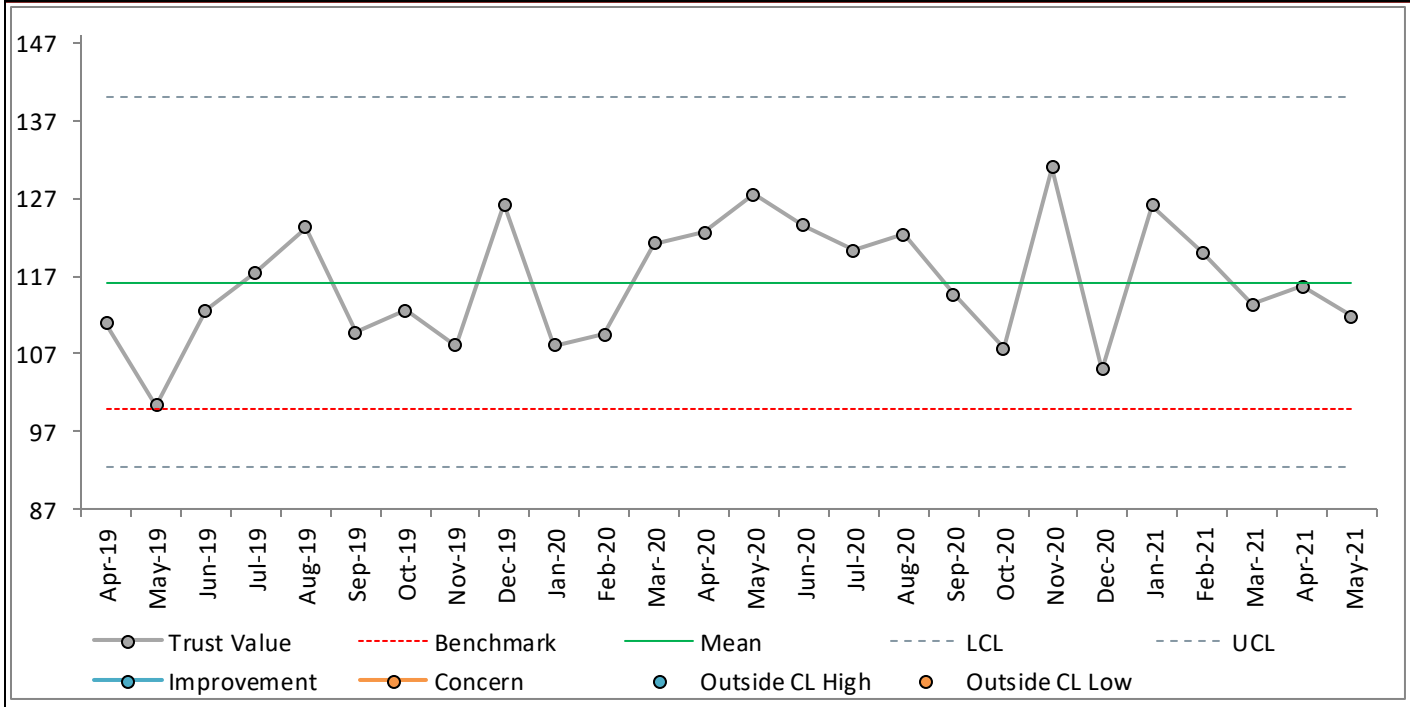
## Timescale

December 2021

# Safe

South Tees Hospitals NHS Foundation Trust

## SHMI




Summary Hospital-Level Mortality Indicator

| | |
|---|---|
| Benchmark | 100 |
| Mean | 116.23 |
| Last Month | 111.81 |

**Executive Lead**

Mike Stewart

**Lead**

Tony Roberts

## Commentary

SHMI is the official NHS hospital mortality indicator and relies on correct primary diagnosis and comorbidity capture at admission. It does not adjust for specialist palliative care coding.

Although the two measures differ, the lower HSMR and review of data from medical examiners office and mortality reviews provides some reassurance that avoidable mortality is not driving high SHMI

## Cause of Variation

- Mean SHMI is stable with normal variation but high (national average is set to 100). This reflects the relatively low level of comorbidity capture.
- SHMI for Apr 2020 to Mar 2021 is outlying (officially 118, 3 points higher than the previous period). Pneumonia and septicaemia remain high.
- SHMI is impacted by the pandemic as COVID-19 spells are removed (5%) and the fall in discharges of other patients is substantial (30%) this will result in higher SHMI given relatively lower mortality expected in the lower risk emergency and elective cases not presenting in this time period. Hospitals where this impact is greater will see a relatively greater effect on this indexed measure"

## Planned Actions

- More analysis commissioned from NEQOS.
- Review the impact of the Clinical Coding Strategy which was launched in April and agree further roll out.
- Clear the backlog of mortality reviews requested by MEs, with newly appointed reviewers, to note that continued clinical pressures have delayed training and additional sessions required to progress this

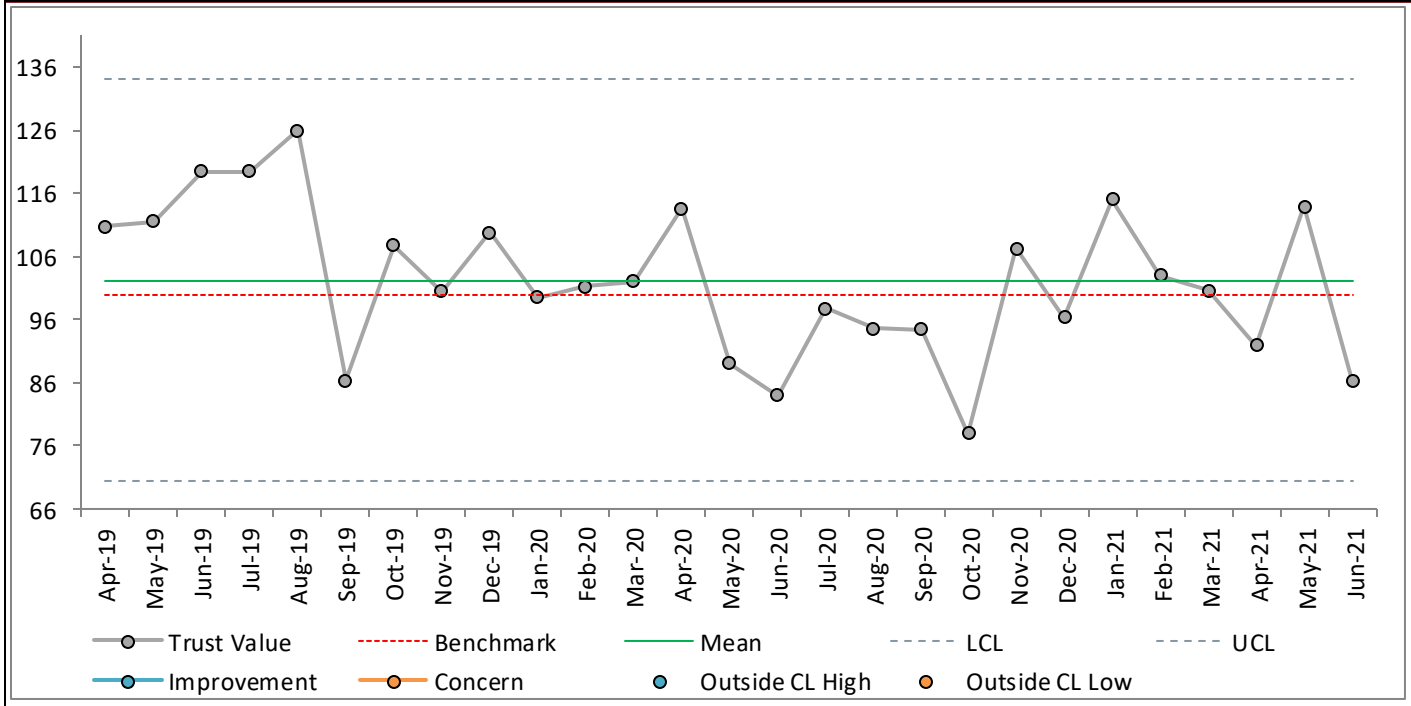
## Timescale

- October 2021
- April 22
- – December 21

# Safe

South Tees Hospitals NHS ation Trust

## Hospital Standard Mortality Rate (HSMR)




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

| | |
|---|---|
| Benchmark | 100 |
| Mean | 102.24 |
| Last Month | 86.42 |

**Executive Lead**

Mike Stewart

**Lead**

Tony Roberts

## Commentary

HSMR is ''as expected'. It is a commercially produced indicator used by the CQC. It is sensitive to specialist palliative care coding levels, and since the Trust has improved this coding HSMR has remained close to 100.

## Cause of Variation

- HSMR is stable with normal variation and reflects the improvement in accuracy of specialist palliative care coding, following implementation of a new process checking SystmOne recording from May 2019.

## Planned Actions

- Continued monitoring of deaths, unadjusted mortality, SHMI, HSMR, Medical Examiner and Trust Mortality Reviews and any deaths reported as a Serious Incident, via nationally mandated Learning from Deaths dashboard.
- Improvements to coding (outlined on SHMI slide) will impact on HSMR.

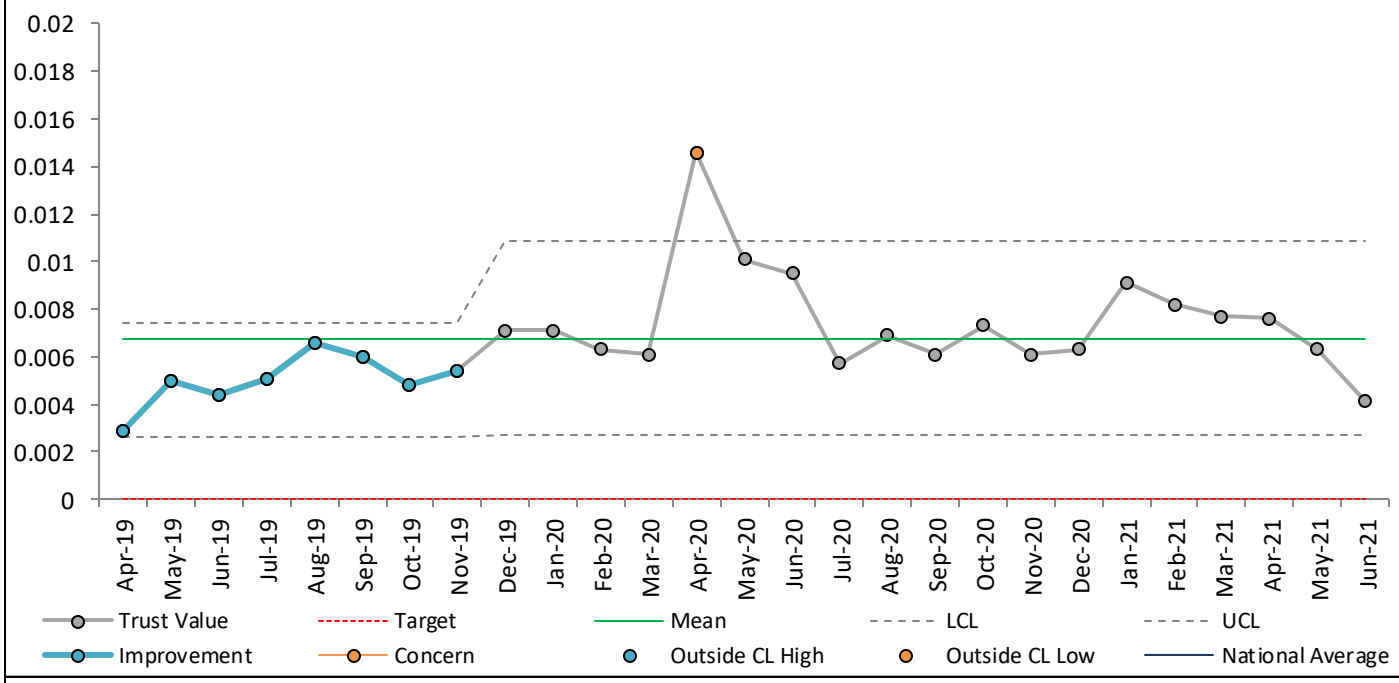
## Timescale

- October 2021

# Safe

South Tees Hospitals NHS Foundation Trust

## Palliative Care Coding




Average no. of First Finished Consultant Episodes (FFCEs) recorded with Palliative Care diagnosis (Z515)

| | |
|---|---|
| Target | |
| Mean | 0.01 |
| Last Month | 0.00 |

**Executive Lead**

Mike Stewart

**Lead**

Allison Davis

## Commentary

Coding of Specialist Palliative Care is reported as a contextual indicator alongside SHMI and is used as a risk adjustment factor in HSMR. The Trust is recording at a higher level than the national average and thus HSMR is lowered.

## Cause of Variation

- The indicator has been stable with normal variation since May 2020. The special cause in April 2020 was due to the first wave of the covid pandemic.
- There has been a downward trend on palliative care coding from a peak in January 2021, reflecting a reduction in covid patients in the period to June 2021.

## Planned Actions

- The current process of cross-checking recording of contacts with patients by the specialist palliative care team in SystmOne by the clinical coding team will continue.

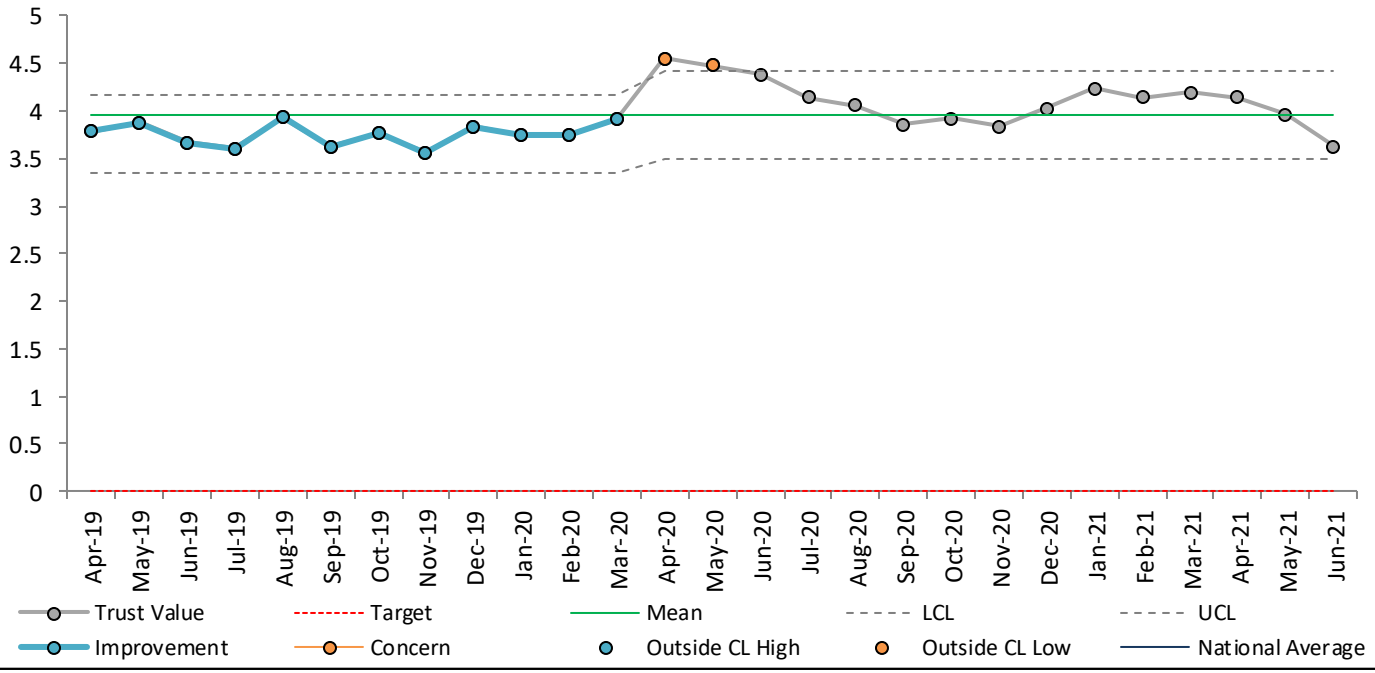
## Timescale

- Ongoing.

# Safe

South Tees Hospitals NHS Foundation Trust

## Comorbidity Coding




Average Comorbidity score on First Finished Consultant Episode (FFCE)

| | |
|---|---|
| Target | |
| Mean | 3.95 |
| Last Month | 3.63 |

**Executive Lead**

Mike Stewart

**Lead**

Allison Davis

## Commentary

Charlson Comorbidity Index (which includes 15 major comorbidities) is used to risk-adjust both SHMI and HSMR. The trust is well below national average (which adversely raises both indictors) and has the lowest rate in the North East.

## Cause of Variation

- The indicator has been stable with normal variation since June 2020. The special cause in April and May 2020 was due to the first wave of the covid pandemic. The final point for May 2021 probably reflects incomplete coding at the time this indicator was generated and is likely to be higher once refreshed.

## Planned Actions

- The Clinical Coding Strategy presented to CPG includes implementation of a new comorbidity coding sheet.
- A Renal ward pilot showed the form increases capture of comorbidities. Several wards have offered to pilot. The key is the admission areas where pilot occurring. In due course, Miya will allow digital recording.
- The Full Action Plan is being reviewed and new timescales agreed for further improvement work.

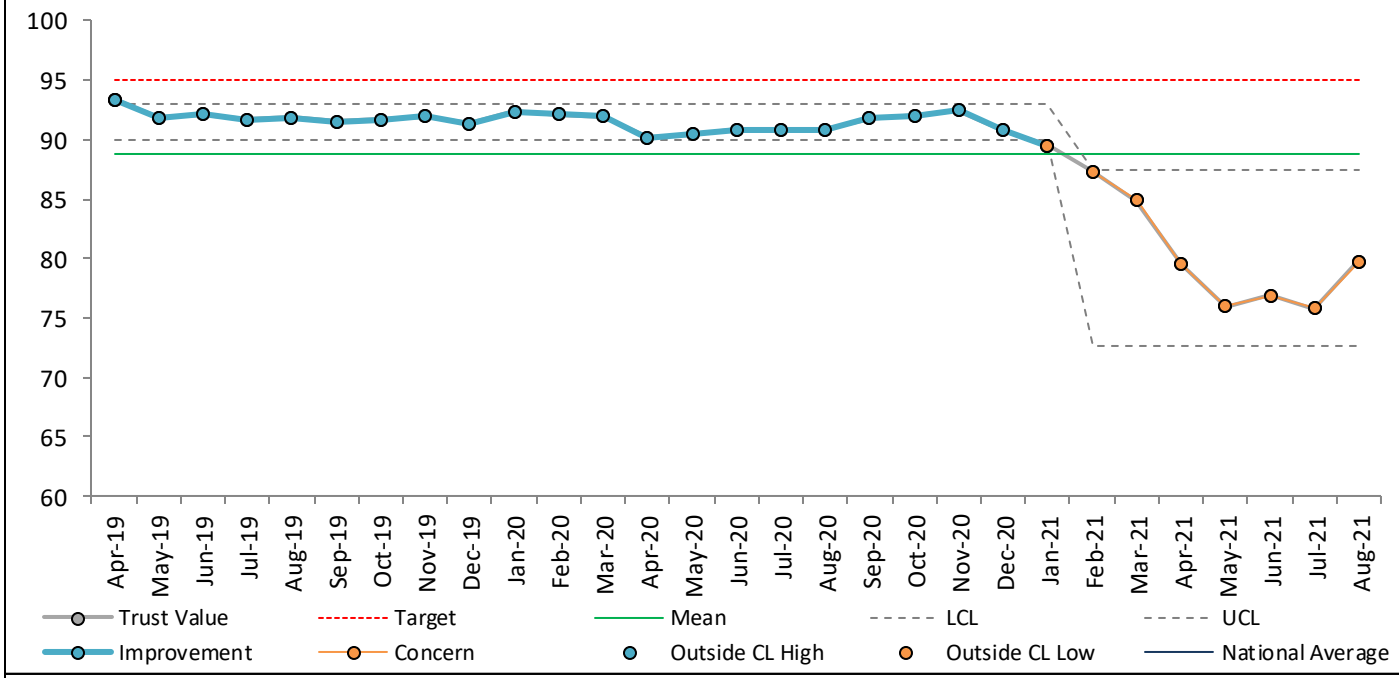
## Timescale

- Further pilots conducted in July and August, although impact not apparent yet as data to June.
- Miya implementation for this purpose is at least 18 months away.

# Safe

South Tees Hospitals NHS Foundation Trust

## VTE Assessment




The proportion of eligible admissions, who are being risk assessed for VTE (venous thromboembolism)

| | |
|---|---|
| Target | 95 |
| Mean | 88.76 |
| Last Month | 79.74 |

**Executive Lead**

Mike Stewart

**Lead**

Jamie Maddox

## Commentary

Compliance with VTE assessment has reduced significantly and is now outside the control limits.

## Cause of Variation

- The last 6 points (Jan - August), display the impact of changing the recording method and incomplete data.
- There are delays with recording and completing investigations.

## Planned Actions

- Have re-established VTE Working Group - first meeting May 2021.
- Increase VTE reporting into Safe & Effective Care Group
- Revise CAMIS VTE data entry to ensure easier and accurate data recording.
- Addition of visual indicator, to prompt outstanding assessments.
- Anticoagulant specialist nurses to receive monthly ward level data to support wards.
- Long term goal would be to have VTE risk assessment as in essential requirement within the electronic medical record.

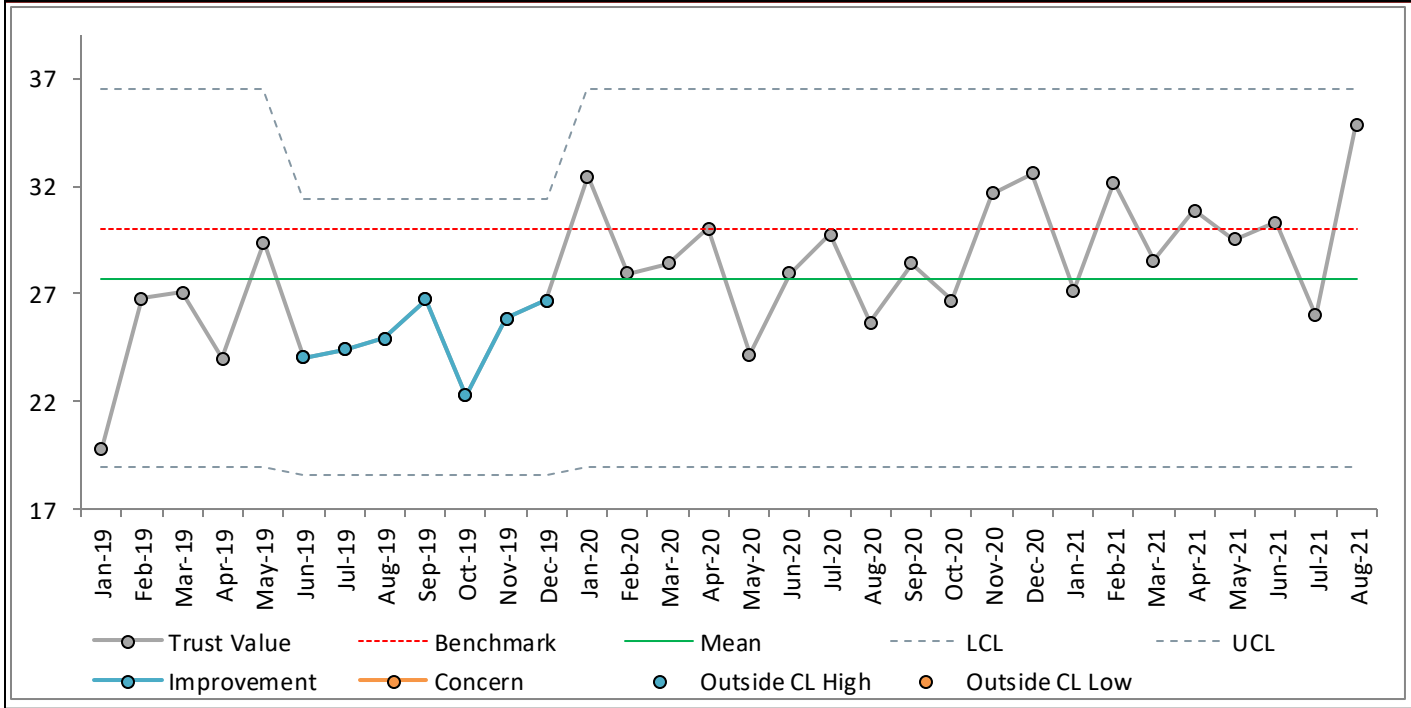
## Timescale

November 2021

# Safe

South Tees Hospitals NHS Foundation Trust

## Maternity - Caesarean Section Rate (%)




The % of Patients Delivering via Caesarean Section

| | |
|---|---|
| Benchmark | 30 |
| Mean | 27.73 |
| Last Month | 34.87 |

**Executive Lead**

Hilary Lloyd

**Lead**

Heather Gallagher

### Commentary

This metric is measured against a national benchmark. The Trust Caesarean Section rate is currently 27.5% and is within the control limits. Lower threshold for LSCS throughout COVID-19

### Cause of Variation

- This metric is a stable from January 2020 and within normal variation.

### Planned Actions

- CS rates should not be used as a quality metric as NICE advocates maternal choice.
- COVID-19 is resulting in an increase in CS rates nationally.

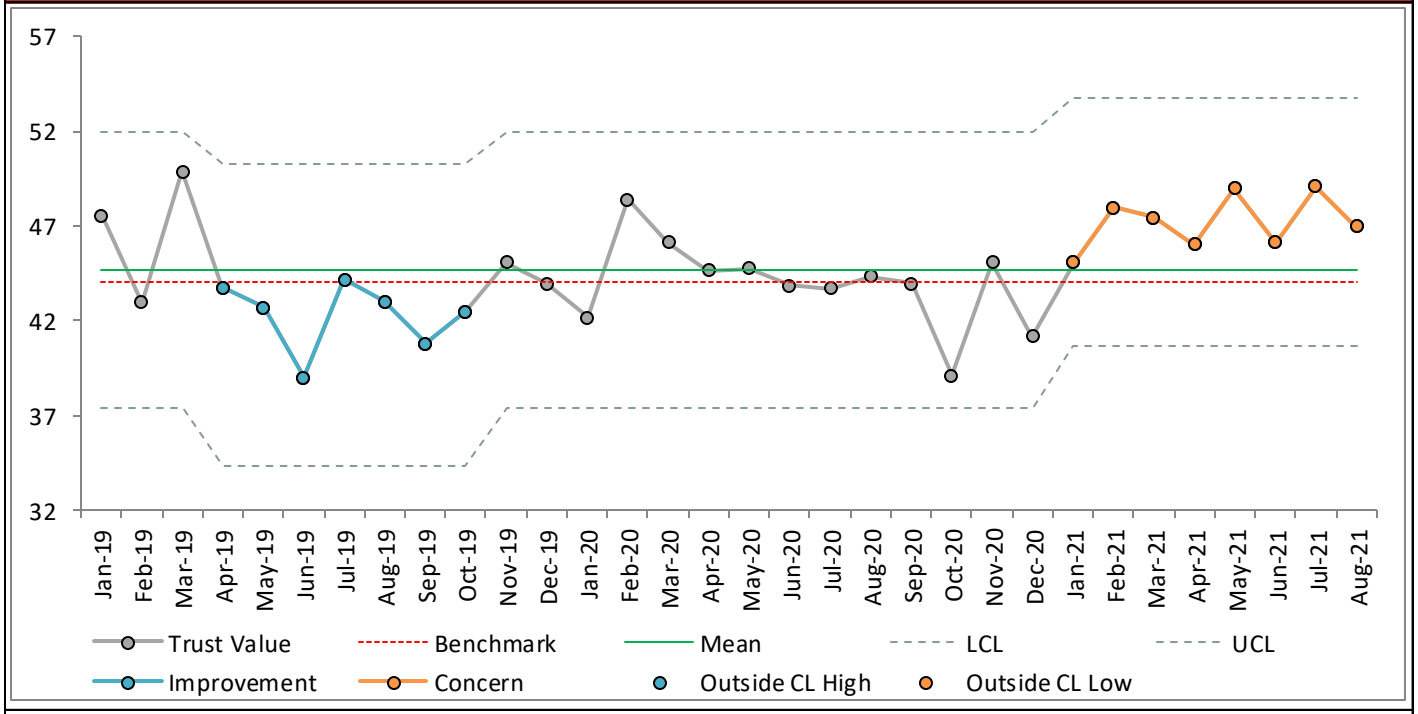
### Timescale

- On-going review

# Safe

South Tees Hospitals NHS Foundation Trust

## Maternity - Induction of Labour Rate (%)




The % of Patients Delivering via Caesarean Section

| | |
|---|---|
| Benchmark | 44 |
| Mean | 44.70 |
| Last Month | 46.97 |

**Executive Lead**

Hilary Lloyd

**Lead**

Heather Gallagher

### Commentary

Maternity report when to QAC in September and further work is required to understand this metric.

### Cause of Variation

- This metric is a stable process with normal variation since November 2019.

### Planned Actions

- No specific actions are required.
- Continue current processes.

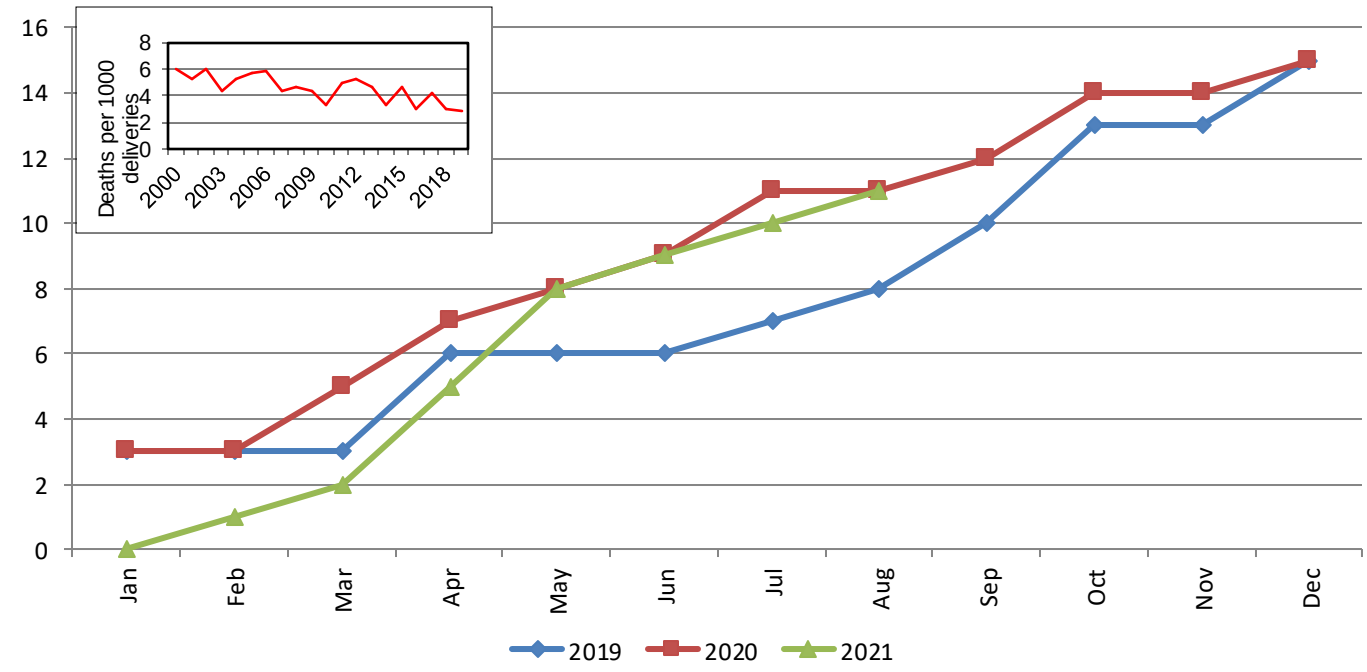
### Timescale

- Not applicable

# Safe

South Tees Hospitals NHS Foundation Trust

## Maternity - Still Births (YTD)




Still births

| | |
|---|---|
| Outturn | 17 |
| Mean | N/A |
| YTD | 11 |

**Executive Lead**

Hilary Lloyd

**Lead**

Heather Gallagher

## Commentary

National target 4 per 1000 births
Target of 50% reduction in stillbirths by 2025
Note: UKOSS data showing an outcome 1 in 100 stillbirth for pregnant women admitted with COVID-19

## Cause of Variation

- This indicator is not in control chart format because numbers reported are small and therefore variation cannot be assessed.

## Planned Actions

- Deliver all aspects of the Saving Babies Lives Care Bundle V2
- Implementation of Ockenden report recommendations
- Continued review and analysis through patient safety processes ie PMRT
- Monitored quarterly through maternity safety champions and LMS regional board.

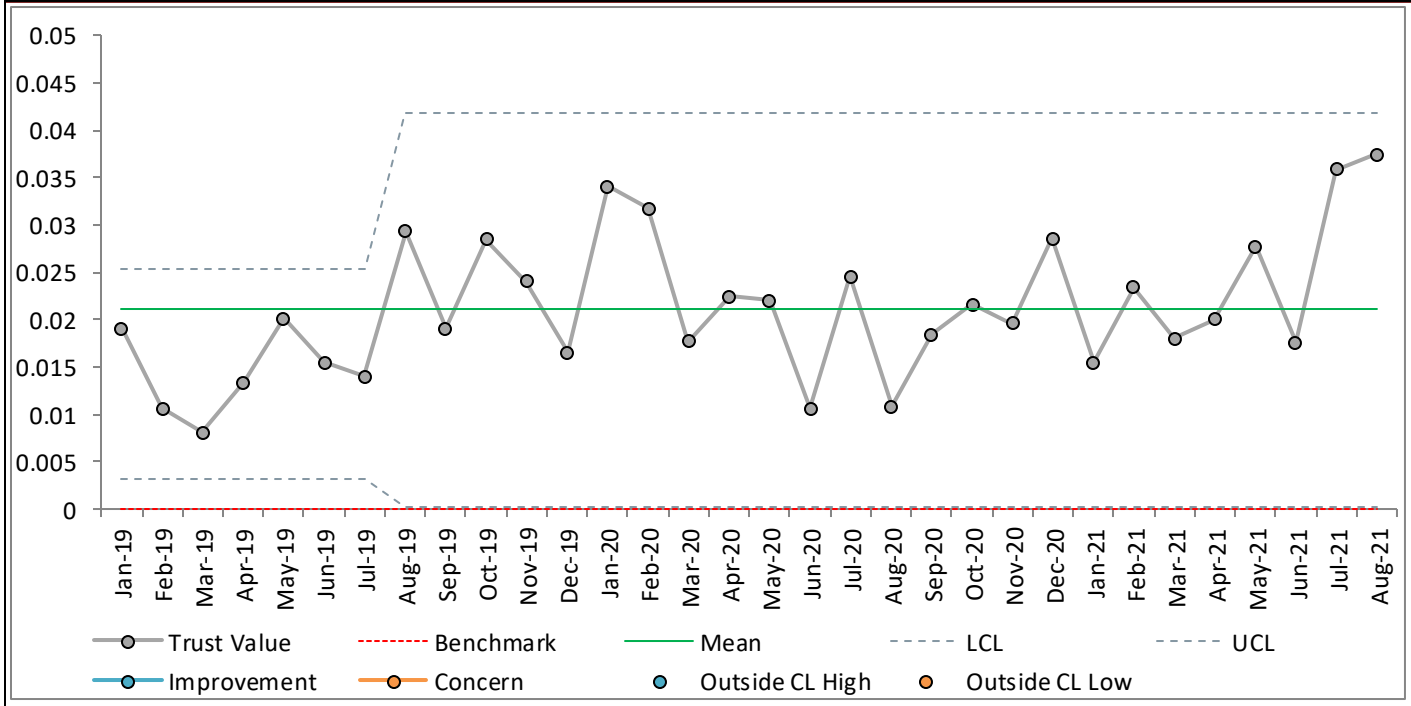
## Timescale

- December 2021

# Safe

South Tees Hospitals NHS Foundation Trust

## Maternity - PPH 1500ml Rate (%)




Postpartum Haemorrhage Rate over 1500ml

| | |
|---|---|
| Benchmark | |
| Mean | 0.02 |
| Last Month | 0.04 |

**Executive Lead**

Hilary Lloyd

**Lead**

Heather Gallagher

## Commentary

Target based on National Maternity & Perinatal Audit (NMPA) data 2017 (data based on vaginal birth only)

## Cause of Variation

- This metric is a stable process with normal variation.

## Planned Actions

- Continue current processes.

## Timescale

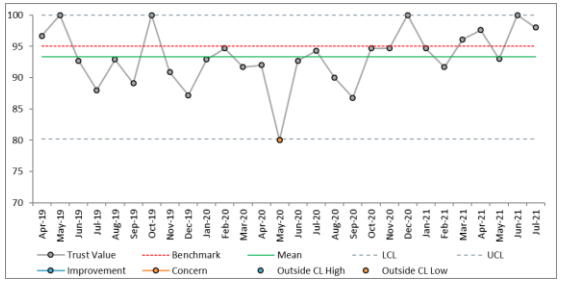
- December 2021

# Effective

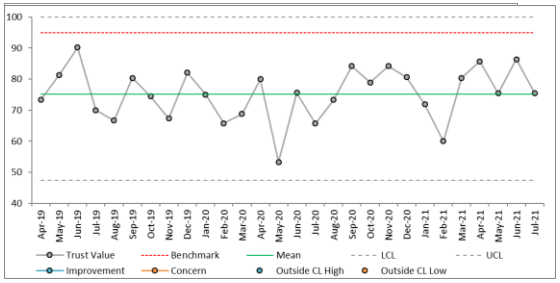
South Tees Hospitals NHS Foundation Trust

| Sepsis | | | |
|---|---|---|---|
| **Executive Lead** | Mike Stewart | **Lead** | Lindsay Garcia |

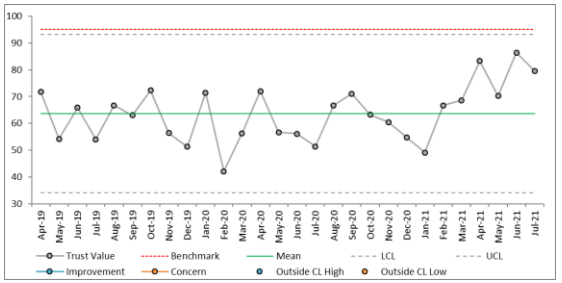
### Targeted oxygen delivered within 1 hour



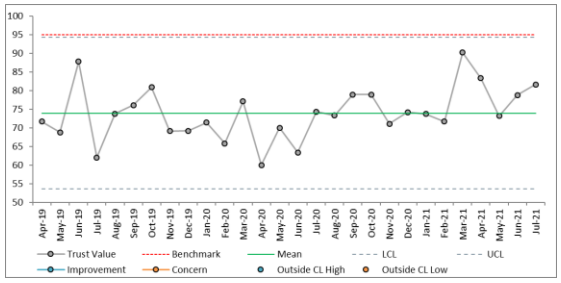

### Blood cultures taken within 1 Hour



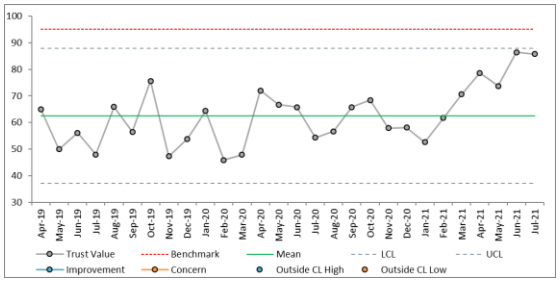

### IV antibiotics administered within 1hr



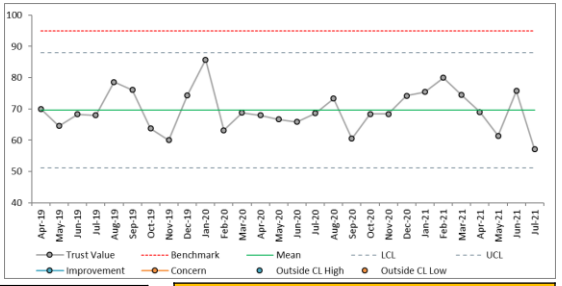

### Serum lactate taken within 1 hour




### IV fluid resuscitation initiated within 1 hour




### Urine output measurement started within 1hr




## Cause of Variation

- 2 of the 6 Sepsis indictors have been achieved
- Normal variation with improvement seen in all 6 elements
- On occasions the Sepsis Assessment tool is not getting launched appropriately in ED
- On occasions the sepsis assessment is not completed in ward based areas when the criteria is met
- Theme identified blood cultures not taken in normothermic patients
- Lack of electronic decision support and management tools
- Poor compliance with completion of fluid balance chart
- Capacity reached in ED, leading to delays in treatment
- Record of trigger not being used in ward environments
- Difficulty to release staff for training

## Planned Actions

- Electronic workflow to be introduced throughout the organisation with 'close the loop' configuration.
- Introduction of electronic fluid balance to increase compliance to the urineoutput element
- Clinical audit trial underway with coding allowing timely access to HCRs for audit
- Daily record of trigger audit in ward based locations
- Sepsis competency update & relaunch
- ED to participate in clinical audit
- World Sepsis Day 13th September 2021 – promotional campaign

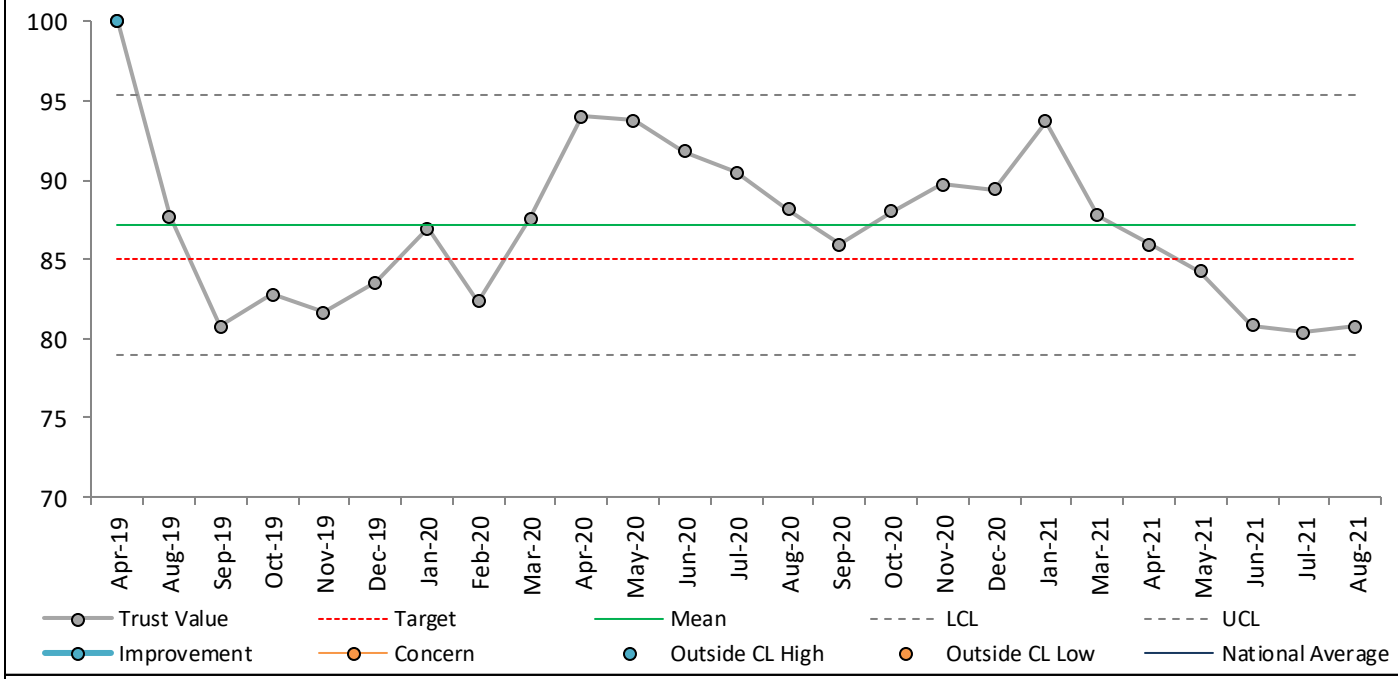
## Timescale

- July - October 2021
- October20 21 -
- August 2021 3 month audit with coding - reporting November 2021

# Caring

South Tees Hospitals NHS Foundation Trust

## F&F A&E Overall Experience Rate (%)




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

| | |
|---|---|
| Target | 85 |
| Mean | 87.14 |
| Last Month | 80.79 |

**Executive Lead**

Hilary Lloyd

**Lead**

Jen Olver

## Commentary

This target has been met consistently since April 2020.

A downward trend has been noted since January.

## Cause of Variation

- This metric is within normal variation.
- The metric has seen a downward trend since January 21.
- The metric has fallen below the target this month, for the fourth time since February 2020.

## Planned Actions

- Continue to monitor.
- Following a review of feedback, Urgent and Emergency Care National Survey results and a triangulation of other A&E data sources has been undertaken.
- T & F group established with an action plan is in place monitored by the PESG.

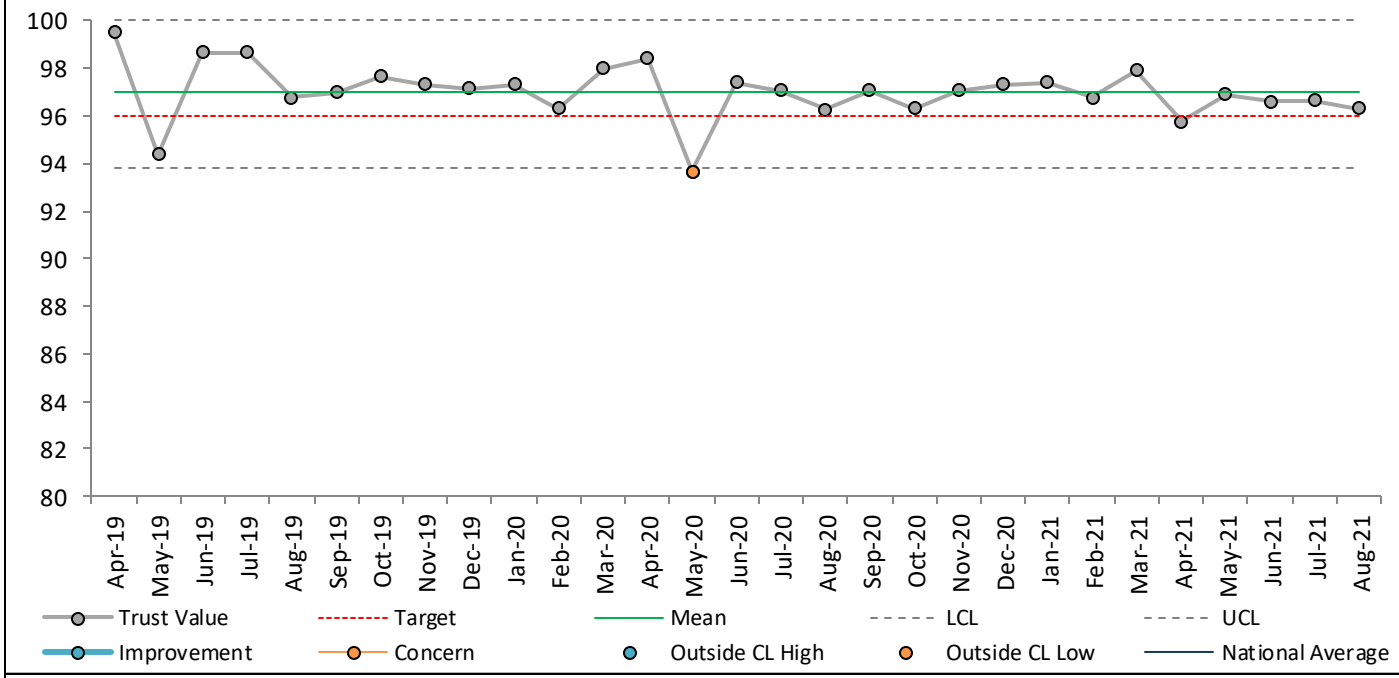
## Timescale

- November 2021.

# Caring

South Tees Hospitals NHS Foundation Trust

## F&F Inpatient Overall Experience Rate (%)




The friends and family survey/text overall experience rate for Inpatient wards

| | |
|---|---|
| Target | 96 |
| Mean | 97.03 |
| Last Month | 96.30 |

**Executive Lead**

Hilary Lloyd

**Lead**

Jen Olver

## Commentary

This metric is within normal variation and the mean is above the target

Inpatient feedback remains consistently high

## Cause of Variation

- The mean remains above the target.

## Planned Actions

- Continue with current process.

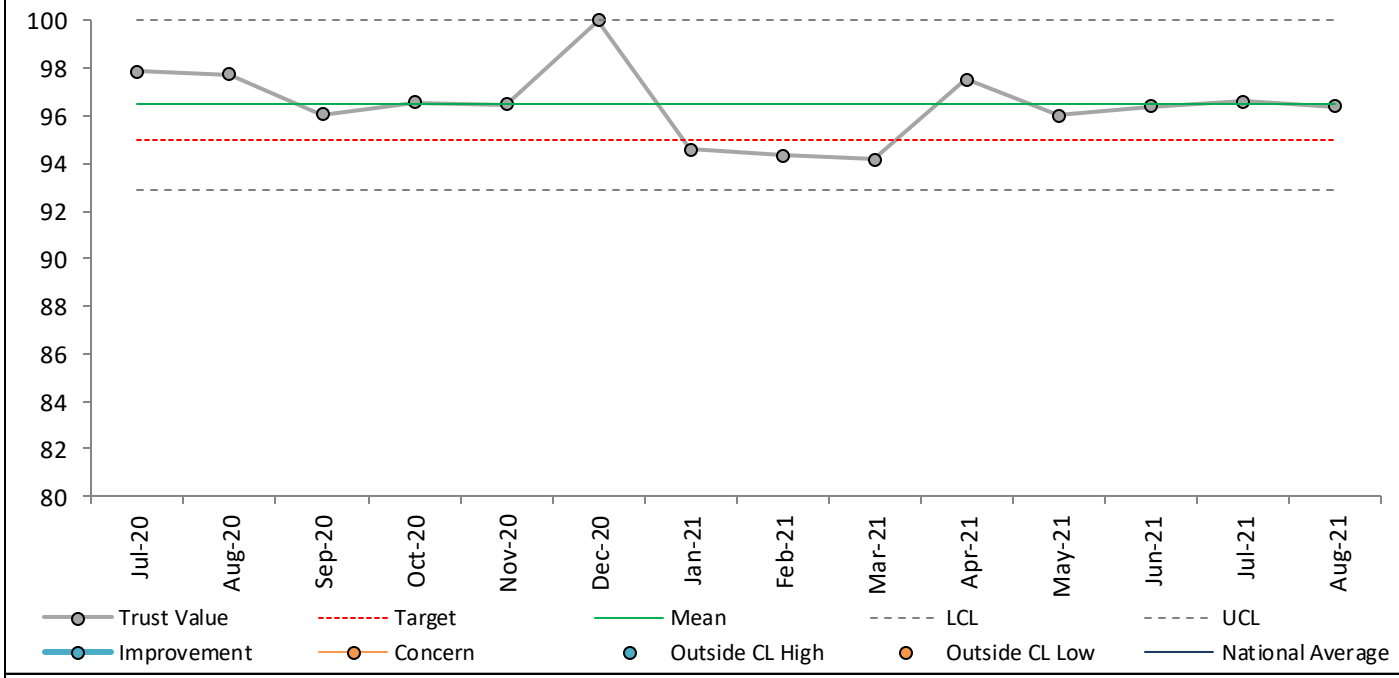
## Timescale

- Ongoing.

# Caring

South Tees Hospitals NHS Foundation Trust

## F&F Outpatient Overall Experience Rate (%)




The friends and family survey/text overall experience rate for Outpatients

| | |
|---|---|
| Target | 95 |
| Mean | 96.48 |
| Last Month | 96.39 |

**Executive Lead**

Hilary Lloyd

**Lead**

Jen Olver

## Commentary

This is a new indicator and data is available from July 2020.

Patient experience in outpatients remains high

## Cause of Variation

- This metric is within normal variation and the mean is above the benchmark.
- Compliance continues to be achieved.

## Planned Actions

- Continue to monitor the overall experience.
- To increase patient feedback in outpatient areas.

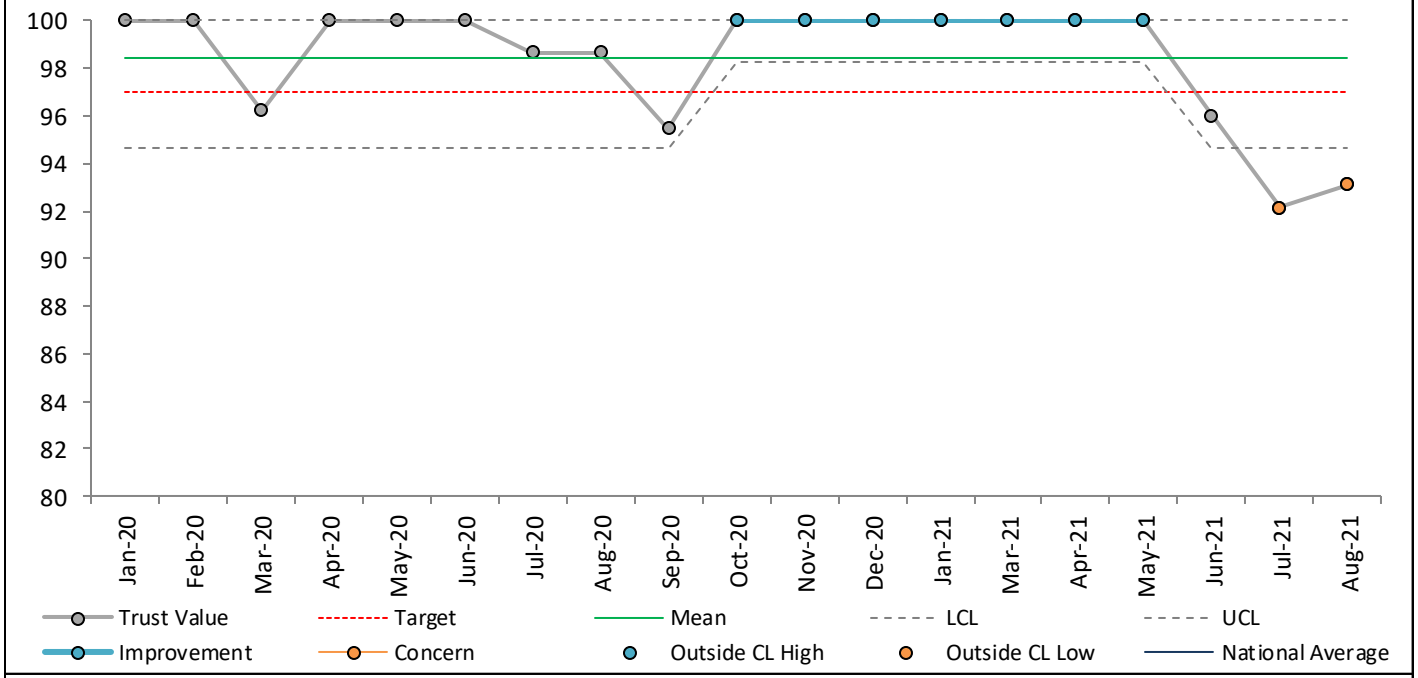
## Timescale

- Ongoing

# Caring

South Tees Hospitals NHS Foundation Trust

## F&F Maternity Overall Experience Rate (%)




The friends and family survey/text overall experience rate for Maternity services

| | |
|---|---|
| Target | 97 |
| Mean | 98.44 |
| Last Month | 93.10 |

**Executive Lead**

Hilary Lloyd

**Lead**

Jen Olver

## Commentary

The target has consistently been met up to May 2021 and has fallen below the mean for the last three months.

Current Covid restrictions on visiting continue to impact of Womens experience

## Cause of Variation

- The mean is below the target, for the third month, however a slight increase is noted in August.
- Low numbers are returned, with the number of surveys completed at birth, post natal ward and community being very low.

## Planned Actions

- Unprecedented operational challenges in maternity services nationally.
- Review undertaken of the surveys completed at the four touch points in the maternity pathway.
- The new surveys will go live on 1 October 2021.

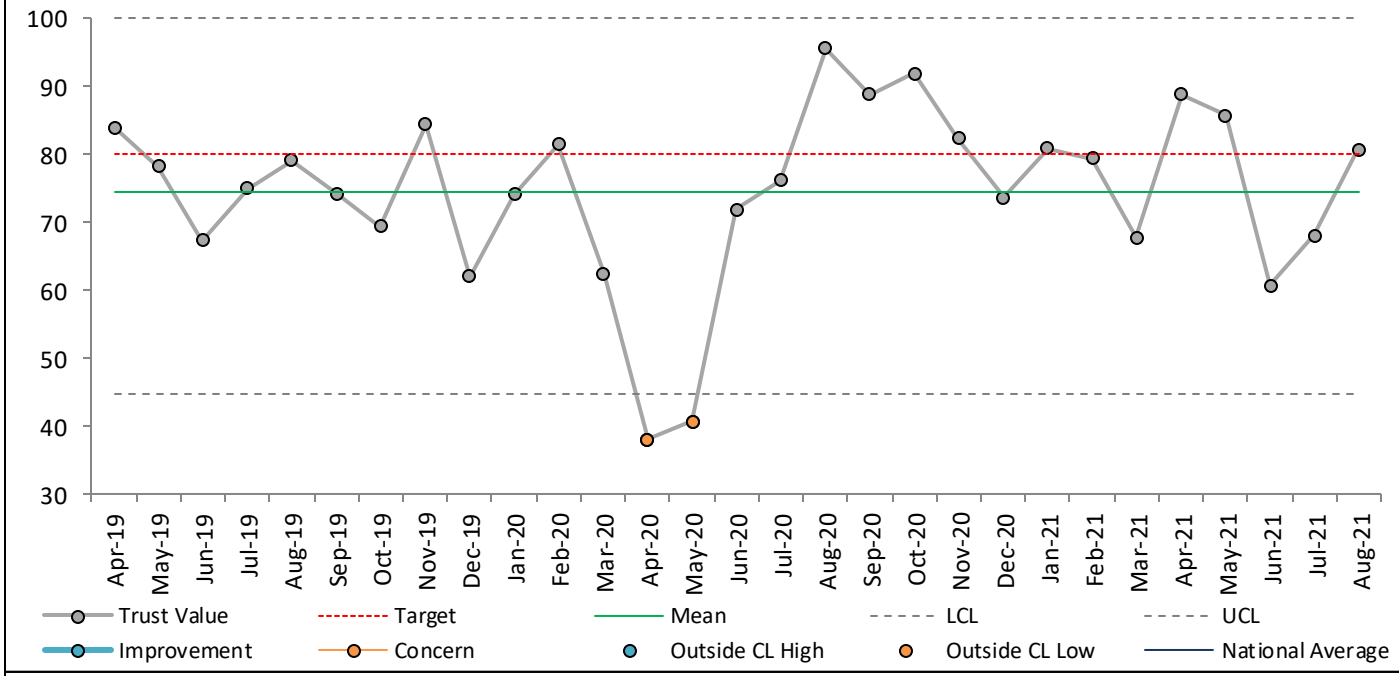
## Timescale

- October 2021

# Caring

South Tees Hospitals NHS Foundation Trust

## Complaints Closed Within Target (%)




The percentage of complaints closed within the target

| | |
|---|---|
| Target | 80 |
| Mean | 74.62 |
| Last Month | 80.77 |

**Executive Lead**

Hilary Lloyd

**Lead**

Jen Olver

## Commentary

The target has been met for the first time since April 2021.

There were 29 complaints closed in August, of which 24 were within the agreed timeframe.

## Cause of Variation

- Compliance for this metric is above the target.

## Planned Actions

- Monitor current process and quality assurance processes.
- Continue to meet weekly to discuss actions for off target complaints.
- Escalation process in place for complaints off target.
- Detailed complaints paper to QAC
- T & F group establish to address recommendations from internal audit

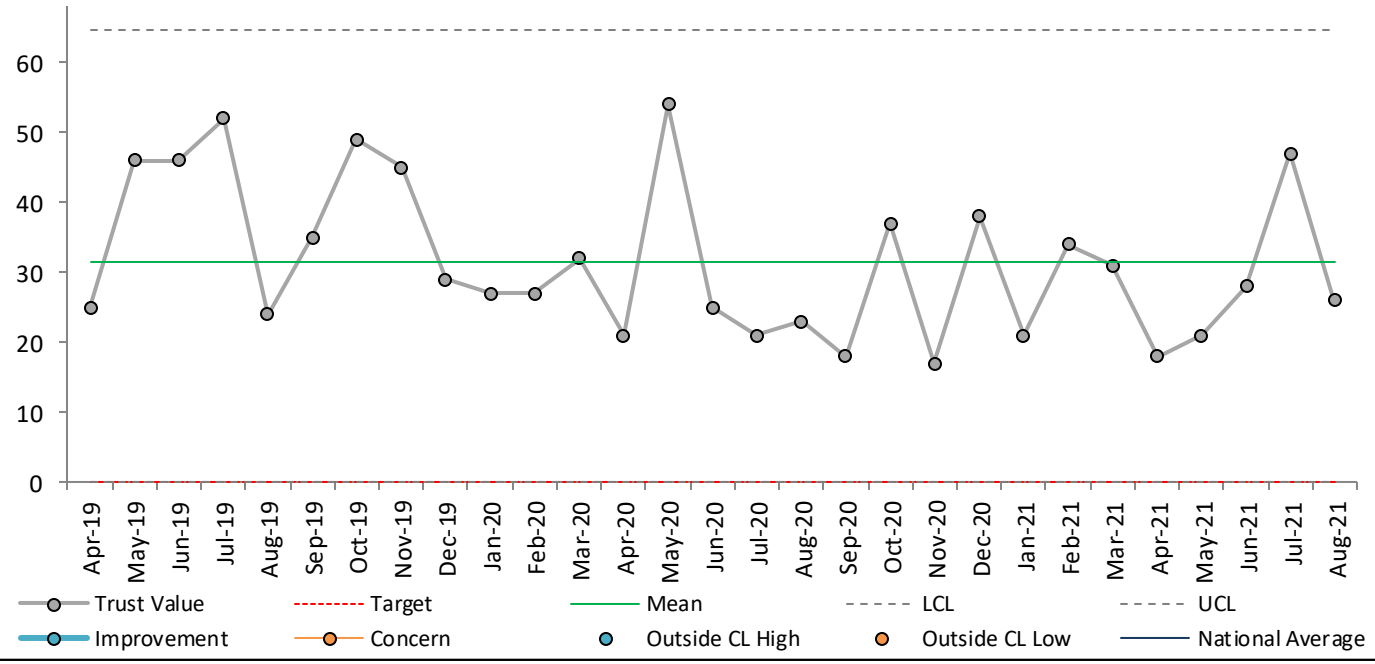
## Timescale

- October 2021
- December 2021

# Caring

South Tees Hospitals NHS Foundation Trust

## All New Complaints




All new complaints recorded on DATIX

| | |
|---|---|
| Target | |
| Mean | 31.62 |
| Last Month | 26.00 |

**Executive Lead**

Hilary Lloyd

**Lead**

Jen Olver

## Commentary

There was 20 formal complaints received in August, a decrease on the previous month.

## Cause of Variation

- Variation of common cause within confidence limits.

## Planned Actions

- Themes from complaints are fed back to the collaboratives.
- Actions from complaints are monitored monthly.
- Detailed paper to QAC

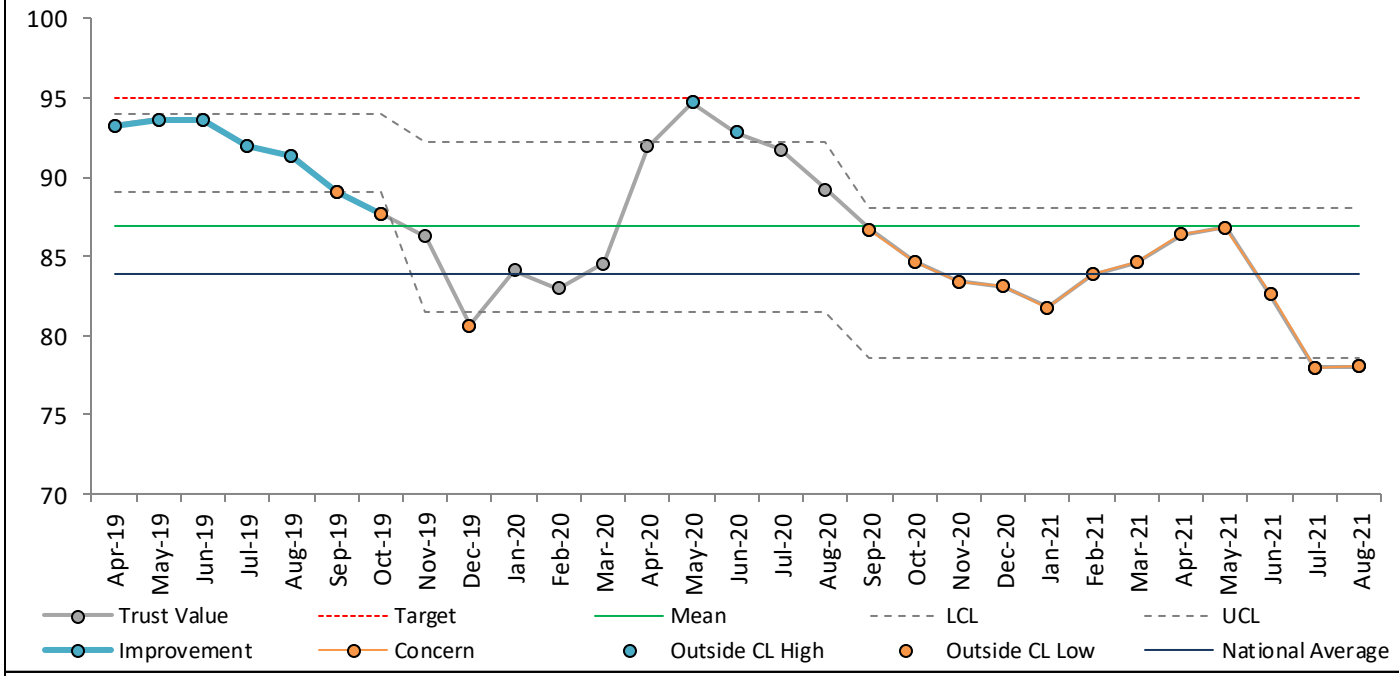
## Timescale

- October 2021

# 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 | 86.89 |
| Last Month | 78.08 |

**Executive Lead**

Sam Peate

**Lead**

Cheryl Burton

## Commentary

Activity in excess of pre pandemic levels. Impact on performance in August 21. COVID staff isolation and sickness impact. Performance for August was slightly above the national average for the same month.

## Cause of Variation

- Since August 2020 4-hour performance has been below the 2-year average, and In July and August fell below the control limits.
- This is dure to sustained increased demand across all emergency and urgent care settings
- In July and August the department has been impacted with significant levels of staff isolation and absence due to Covid-19 impacting medical and nursing rosters impacting on turnaround.

## Planned Actions

- Children's and Young Persons Emergency Department development.
- Speciality level SDEC pathways agreed across organisation
- ED recovery plan developed in line with ECIST recommendations.
- Clinically ready to proceed to be implemented September 2021.
- Estate's strategy to optimise use of ED footprint.
- Regional 111 online, GP and pharmacy first message amplification.

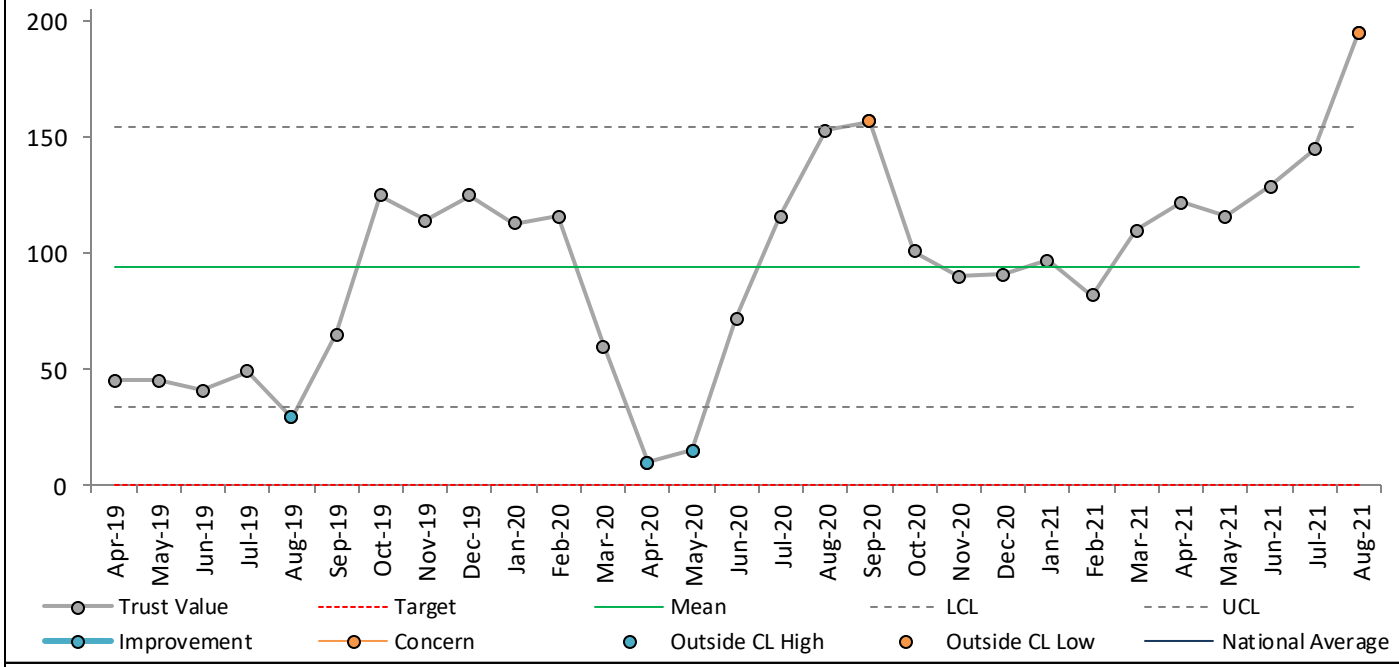
## Timescale

- 21 September 2021
- Implemented clinical pathways mid Aug with audit on-going.
- August 2021
- Ongoing
- End Sep 2021

# Responsive

South Tees Hospitals NHS Foundation Trust

## Ambulance Handovers - over 30 mins




Ambulance A&E handover delays greater than 30 minutes

| | |
|---|---|
| Target | 0 |
| Mean | 94.07 |
| Last Month | 195.00 |

**Executive Lead**

Sam Peate

**Lead**

Cheryl Burton

### Commentary

Increasing levels of activity impacting on ability to receive ambulance handover in line with measure. It has been identified that in some cases access to IT for the provider to complete episode (PIN) delays the turnaround KPI.

### Cause of Variation

- Handover delays have been above the 2-year average since March 2021 and in August 2021 were above the control limit.
- This is due to sustained high levels of demand (non-ambulance) impacting on patient throughput and cubicle space to take handover.
- Staffing resource has also been impacted by COVID-19 absence.

### Planned Actions

- Activity follow with NEAS and YAS to identify delays in total turnaround times.
- Weekly meetings with NEAS to validate data and utilise business intelligence to streamline pathways/process.
- Access to IT for ambulance PIN for .accurate completion of episode
- Collaborative communications between NEAS and ED in relation to roles and responsibilities regarding ambulance handover and process.
- Exploring Paramedic Transformation role with NEAS to identify areas for improvement.

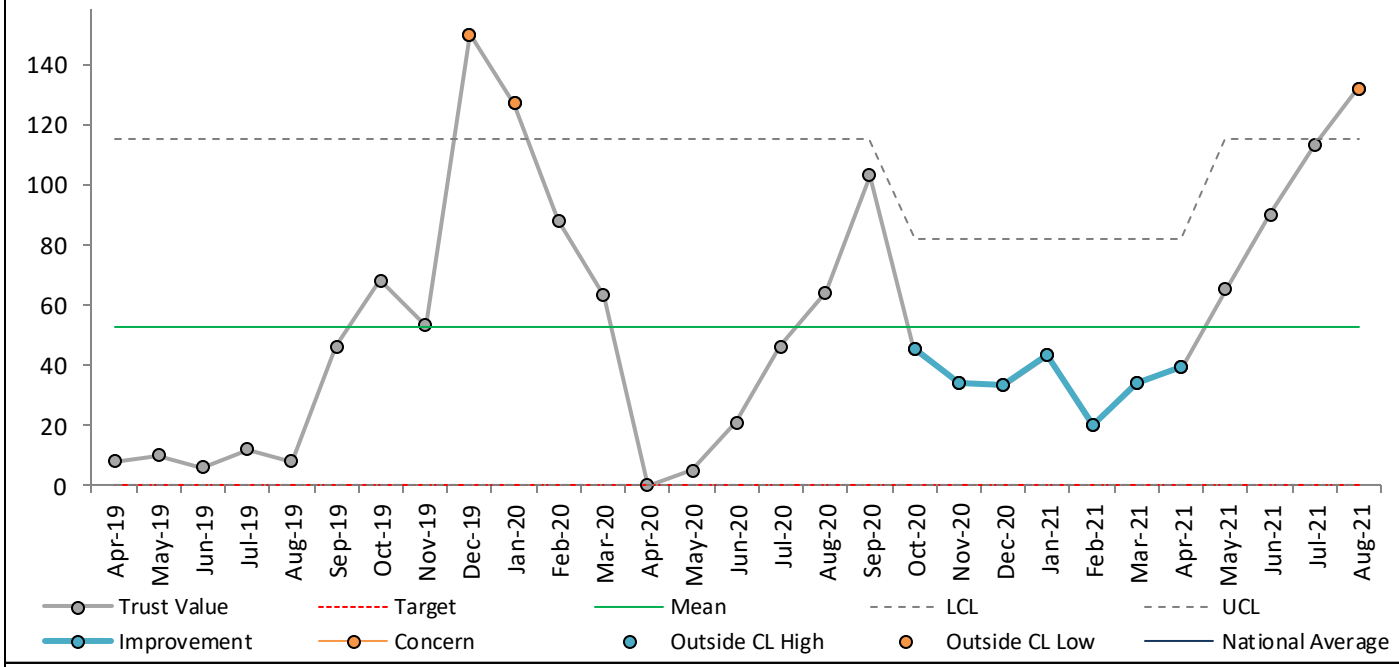
### Timescale

- Completed
- Ongoing
- October 2021
- Ongoing
- September 2021

# Responsive

South Tees Hospitals NHS Foundation Trust

## Ambulance Handovers - over 60 mins




Ambulance A&E handover delays greater than 60 minutes

| | |
|---|---|
| Target | 0 |
| Mean | 52.62 |
| Last Month | 132.00 |

**Executive Lead**

Sam Peate

**Lead**

Cheryl Burton

## Commentary

Increasing levels of activity impacting on ability to receive ambulance handover in line with measure. It has been identified that in some cases access to IT for the provider to complete episode (PIN) delays the turnaround KPI.

## Cause of Variation

- Handover delays have been above the 2-year average since May 2021 and in August 2021 were above the control limit.
- This is due to sustained high levels of demand (non-ambulance) impacting on patient throughput and cubicle space to take handover.
- Staffing resource has also been impacted by COVID-19 absence.

## Planned Actions

- Activity follow with NEAS and YAS to identify delays in total turnaround times.
- Weekly meetings with NEAS to validate data and utilise business intelligence to streamline pathways/process.
- Access to IT for ambulance PIN – completion of episode
- Collaborative communications between NEAS and ED in relation to roles and responsibilities regarding ambulance handover and process.
- Exploring Paramedic Transformation role with NEAS to identify areas for improvement.

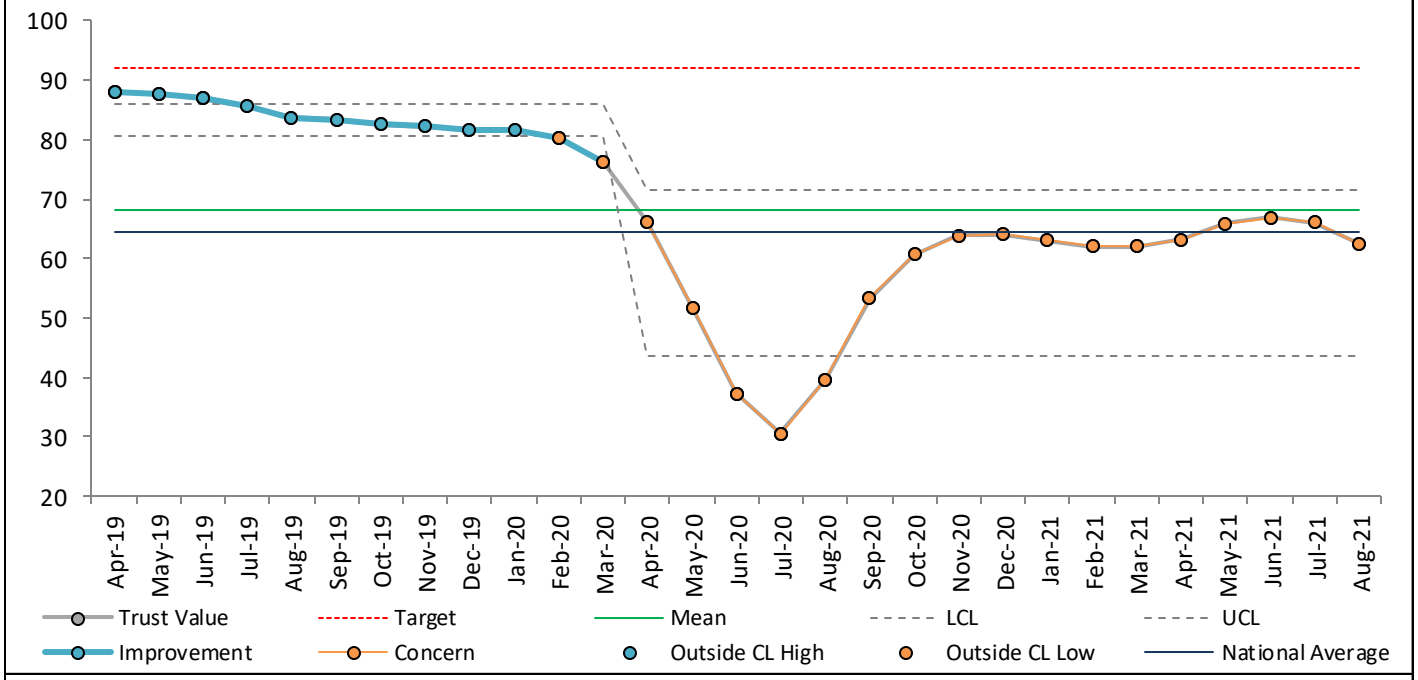
## Timescale

- Completed
- Ongoing
- October 2021
- Ongoing
- September 2021

# Responsive

South Tees Hospitals NHS Foundation Trust

## RTT Incomplete Pathways (%)




The % of incomplete pathways for patients within 18 weeks

| | |
|---|---|
| Target | 92 |
| Mean | 68.25 |
| Last Month | 62.50 |

**Executive Lead**

Sam Peate

**Lead**

Joanne Evans

## Commentary

Existing RTT improvement Trajectory expecting improvement to 74% by March 22.

Over 52 week waits improvement trajectory 2,817 for July 21 reducing to 1,470 by March 22.

National standard sets out that more than 92% of patients on incomplete pathways should have been waiting no more than 18 weeks from referral.

## Cause of Variation

- Special cause variation within the system from July 2020 to December 2020 as a result of COVID. Improvements within the system can be seen, however the target is still not being achieved.
- August position not yet confirmed, Over 52-week waiters for July 21: 2,360 (June 21 2,591)
- Significant impact on theatre and anaesthetic provision through July and August due to staff isolation.

## Planned Actions

- Outpatient transformation programme.
- Orthopaedic weekend working is in place.
- Distribution of activity to IS.
- Focus on clinical need first, then longest waiters
- 104 week wait trajectory and action plan.
- Elective Recovery and theatre utilisation overseen by Recovery Oversight Group and supported by Surgical Improvement Group.

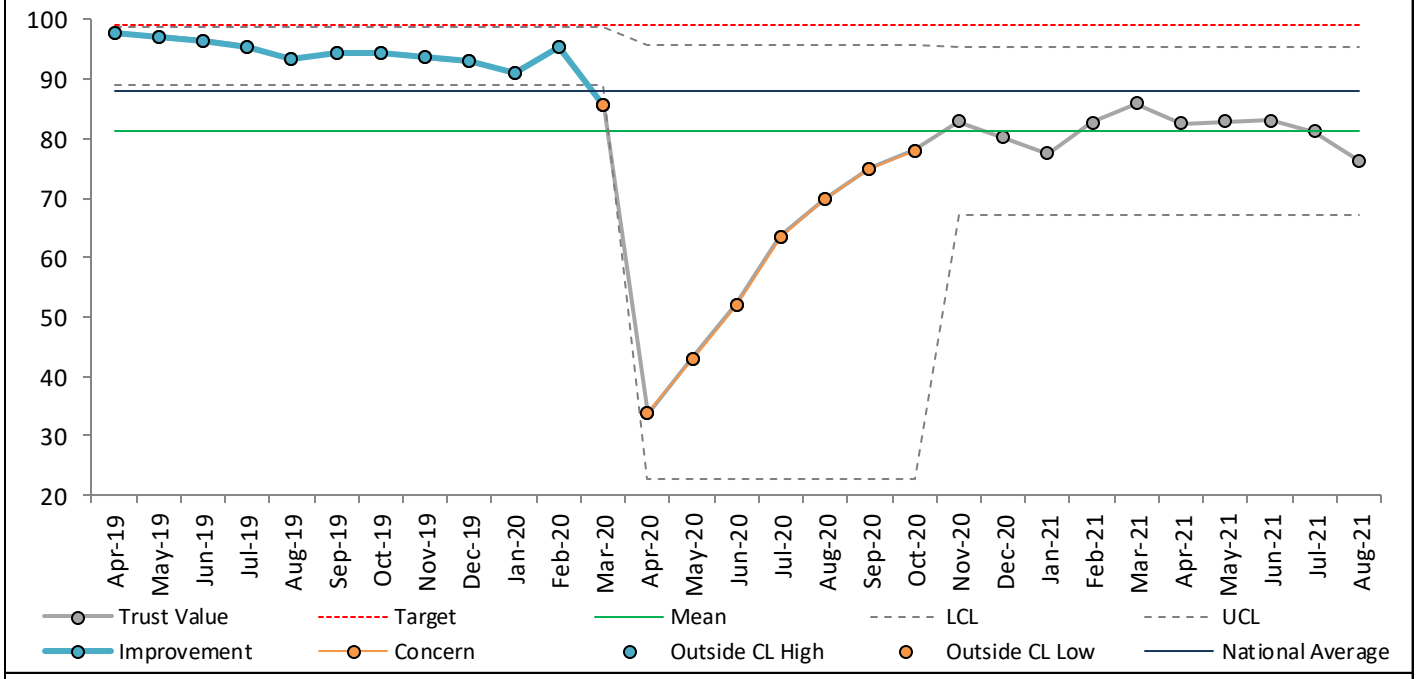
## Timescale

- 18 months to deliver standard.
- Individual plans have specific target dates.
- Improvement trajectory will be determined with clinical teams.
- October 2021

# 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 | 81.34 |
| Last Month | 76.26 |

**Executive Lead**

Sam Peate

**Lead**

Sam Peate

## Commentary

The monthly diagnostics waiting times collection is the primary source for diagnostics waiting times and activity for 15 key diagnostics tests. It is used to measure performance against the operational standard, that less than 1% of patients should wait 6 weeks or more for a diagnostics test.

## Cause of Variation

- The process is showing common cause variation following special cause variation in March 2020 due to Covid 19 pandemic.
- Demand for routine diagnostic tests for Neurophysiology, Audiology, Dexa Scanning and Urodynamics are causing the deterioration in performance.

## Planned Actions

- Continue to review and maximise utilisation of capacity.
- Replacement Dexa scanner being installed
- Administrative and clinical prioritisation and validation of waiting lists, including surveillance patients.
- Book according to priority and chronological order.
- Work with ICP and ICS partners on demand and capacity, including business cases for community diagnostic hubs.
- Service review and improvement trajectories.

## Timescale

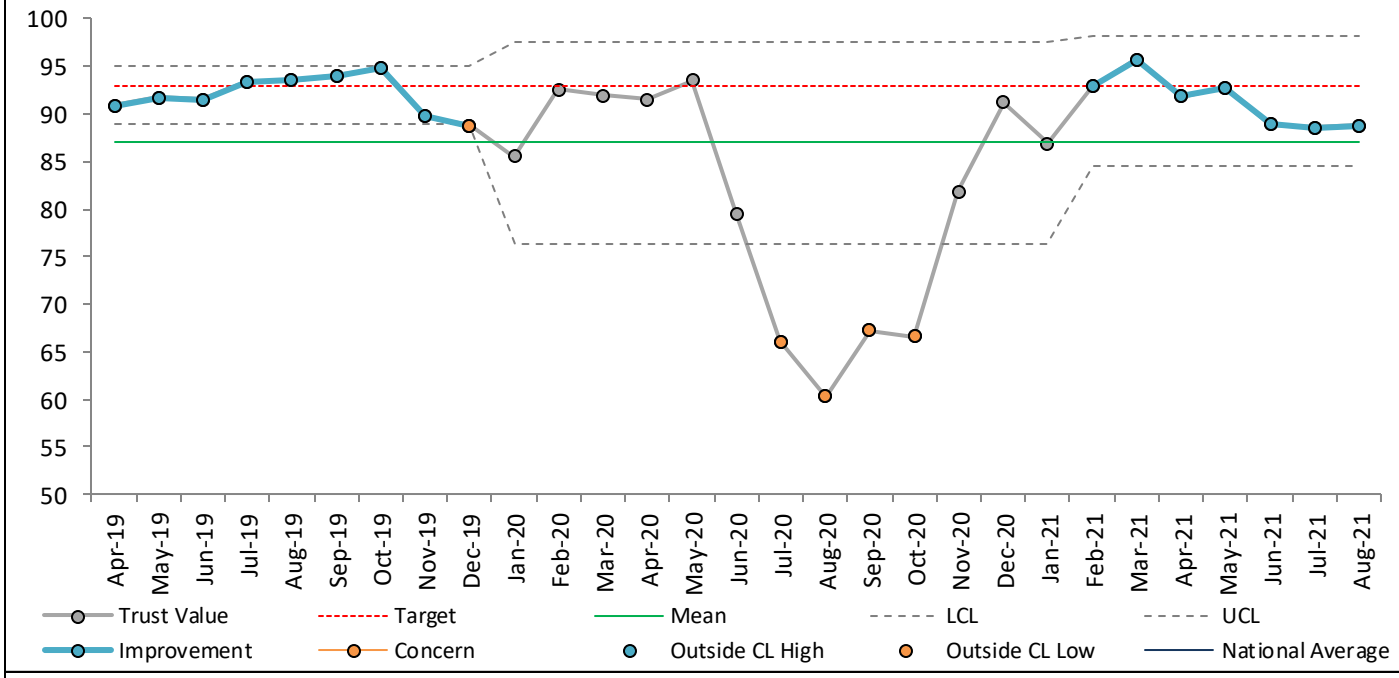
- Weekly
- September / October 21
- 31st July 2021

- Weekly
- Q1/Q2
- As required by Strategic Recovery Group.

# 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 | 86.99 |
| Last Month | 88.74 |

**Executive Lead**

Sam Peate

**Lead**

Carol Taylor

## Commentary

National Standard - 93% This standard covers patients seen by a specialist following an urgent GP referral for suspected cancer.

August 21 indicative. Last achieved in March 21.

28 day faster diagnostic target achieved in July 21 – compliance 82% (National Target 75%)

## Cause of Variation

- Special cause variation within the system from Jun 2020 to November 2020, as a result of COVID and a marked reduction in referrals across all cancer sites. Improvements within the system can be seen, however the target is still not being achieved consecutively.

## Planned Actions

- Continuation of triage of 2ww referrals on receipt.
- Daily Escalation of unutilised slots to ensure these are filled.
- Weekly cancer performance wall continues virtually to identify themes.

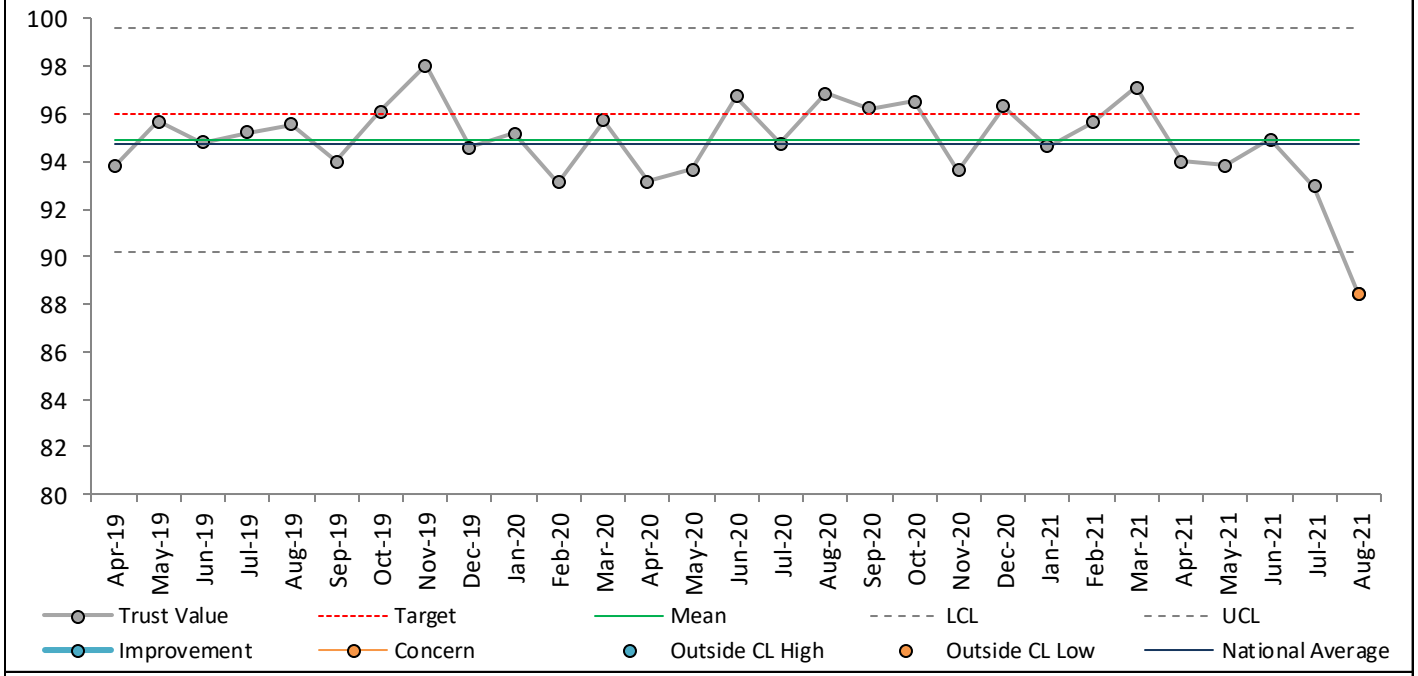
## Timescale

- Ongoing

# 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 | 94.87 |
| Last Month | 88.44 |

**Executive Lead**

Sam Peate

**Lead**

Carol Taylor

## Commentary

National Target - a maximum one month (31-day) wait from the date a decision to treat (DTT) is made to the first definitive treatment for all cancers.

August 21 position is indicative – 63 day plus backlog reducing.

## Cause of Variation

- Process within normal variation, although within control limits this target is not being met consistently.
- Significant reduction in referrals received in Lung and Urological tumour groups in comparison to Pre COVID.

## Planned Actions

- Ensure all patients are tracked and expedited where appropriate.
- Weekly cancer performance wall continues virtually.
- Detailed Cancer improvement trajectories to be established by tumour group.

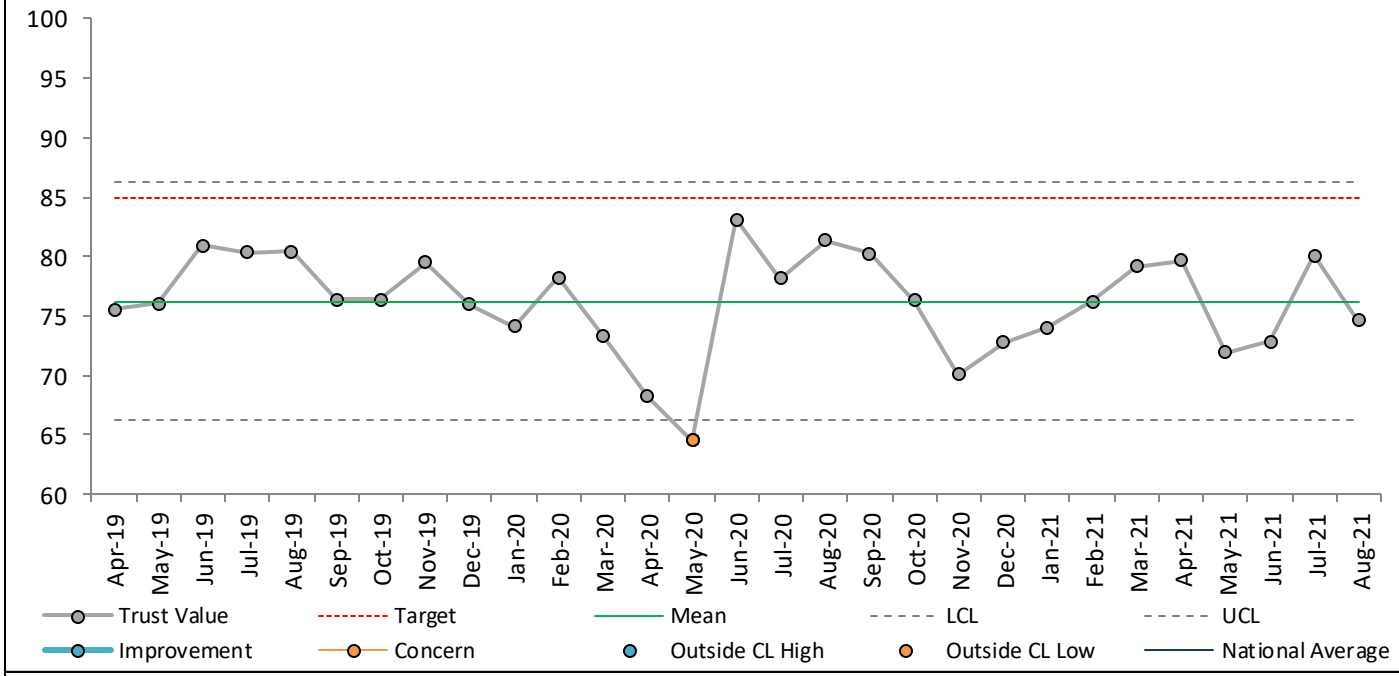
## Timescale

- Weekly.
- Weekly.
- Progress reviewed monthly through collaborative performanc e reports.

# 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 | 76.23 |
| Last Month | 74.65 |

**Executive Lead**

Sam Peate

**Lead**

Carol Taylor

## Commentary

National Target - maximum two month (62-day) wait from urgent referral for suspected cancer to the first definitive treatment for all cancers
Whilst within the control limit the mean is at 76.23% therefore the target is unlikely to be met.

62 day plus backlog reducing which will lead to overall improvement in performance

## Cause of Variation

- Late transfers from other organisations continues to impact on the trust's ability to achieve the 62 days cancer standard. In order to achieve the standard transfers need to take place by day 38 of the patient pathway. In line with the Inter Provider transfer rules those transferred after day 38 47% were treated by the trust within 24 days of receipt.
- Increased level of demand – returning to pre pandemic levels.

## Planned Actions

- South Tees Surgical Cell in place to support the delivery of Cancer Surgeries across the patch.
- Weekly PTL meetings in place to aid patients through their pathway and mitigate breaches where possible.
- Weekly Cancer Wall forum – provides an opportunity to discuss current performance and updates from specialties on current state of play.
- Improvement trajectories to be developed at tumour group level
- Work in ongoing with the cancer network to seek to resolve delays in transfer of patients.

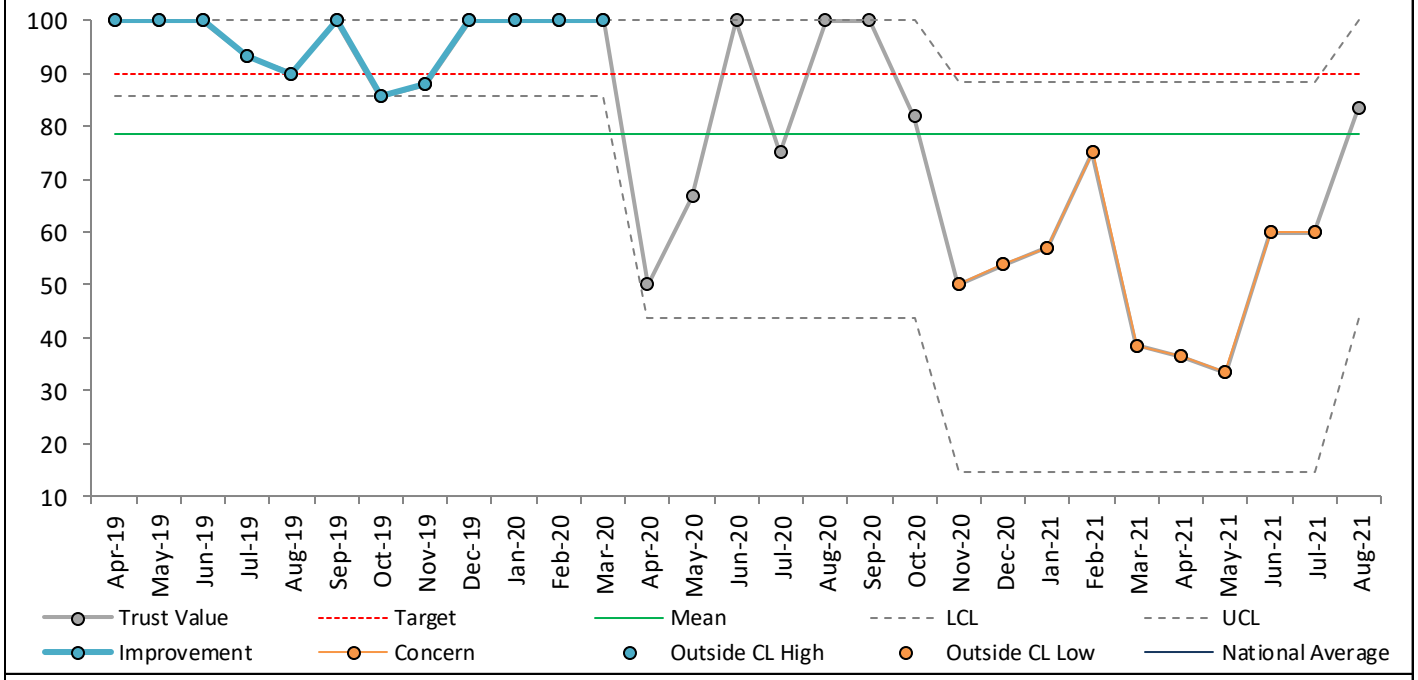
## Timescale

- Due to the impact of Covid this metric is unlikely to get back to target for many months.
- Once the effects from the COVID pandemic subside, and the process reviews are all completed. The '62 day' KPI performance would start to improve to an average of circa. 85%, usually varying between 82% and 88% each month.

# Responsive

South Tees Hospitals NHS Foundation Trust

## Cancer Treatment - 62 Day Screening (%)




| | |
|---|---|
| Target | 90 |
| Mean | 78.55 |
| Last Month | 83.33 |

**Executive Lead**

Sam Peate

**Lead**

Carol Taylor

## Commentary

National Screening Target - maximum two month (62-day) wait from urgent referral for suspected cancer to the first definitive treatment for all cancers

Whilst just within the control limit the means is at 78.55% therefore the target is unlikely to be met.

## Cause of Variation

- Process within normal variation, note due to the low volumes of screening referrals this does impact on the overall compliance significantly. Majority screening patients commence their pathway at a tertiary provider and are transferred in for further investigations and treatment. It should be noted that the transfer rules within 62 day first also stand for screening patients.

## Planned Actions

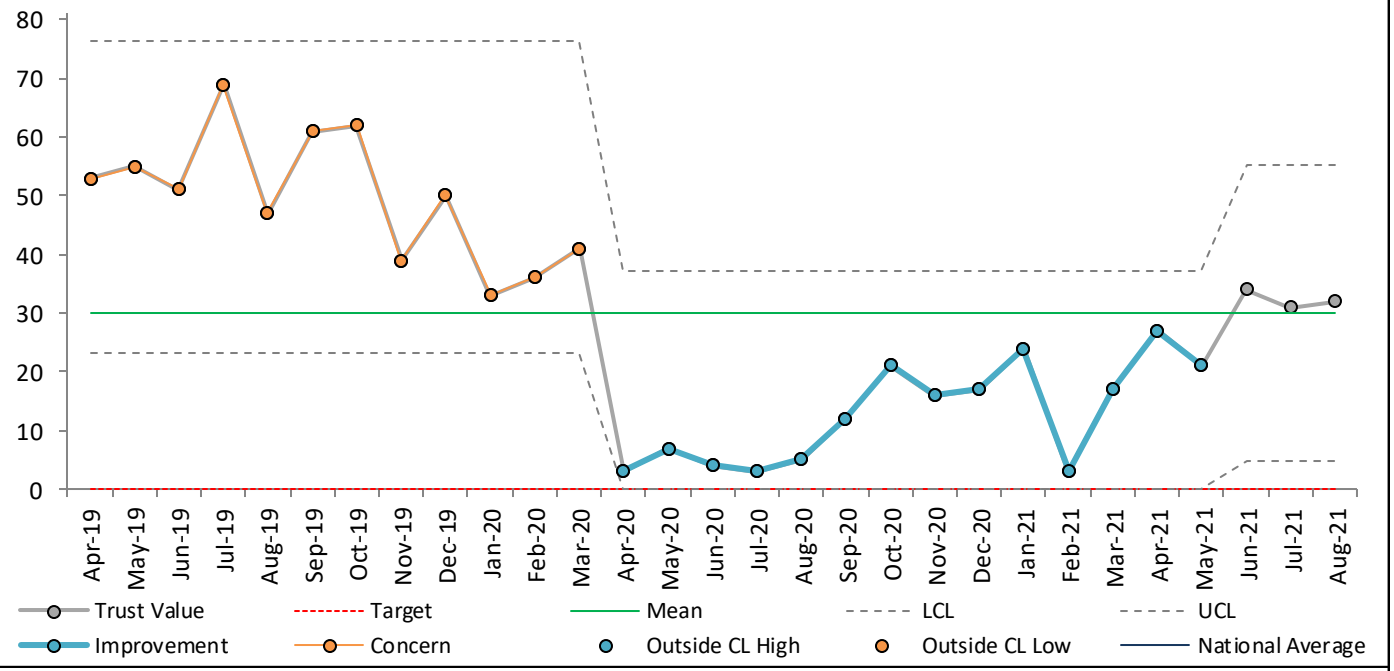
- Actions as per 62 day first standard (previous slide)

## Timescale

# 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 | 30.14 |
| Last Month | 32.00 |

**Executive Lead**

Sam Peate

**Lead**

Joanne Evans

## Commentary

Improvement in the system due to COVID and reduced elective programme.

Theatre improvement plan being developed to address late cancellation of patients due to hospital factors.

## Cause of Variation

- Process within normal variation, not reduced volumes of cancellations between April 2020 and August 2020 due to the reduction in elective activity being undertaken.

## Planned Actions

- Continue to ensure that patients are appropriately consented and pre-assessed prior to admission to minimise the likelihood of 'hospital initiated' cancellation.
- Focus on improved pre-assessment service.
- Weekly review to take place in clinical recovery meeting.
- Established waiting list managers forum to tackle performance.
- Implementation of new Theatre SOP to support reduction in cancellations.

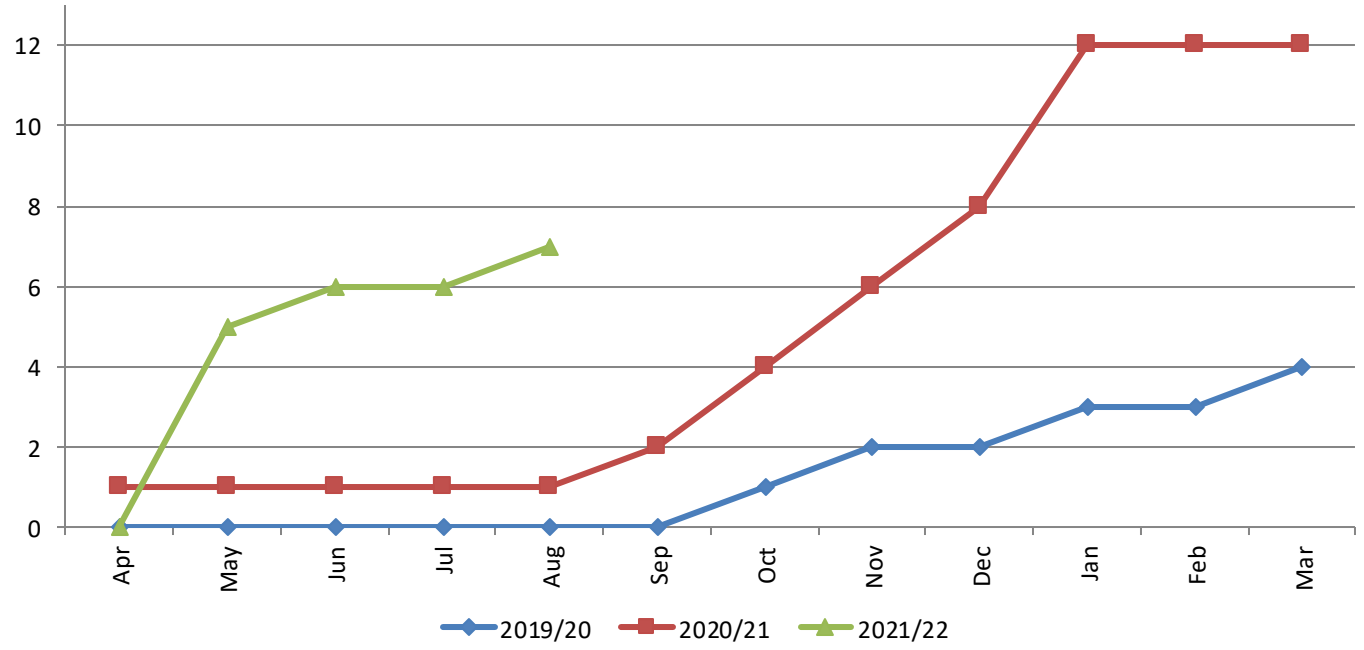
## Timescale

- Ongoing.

# Responsive

South Tees Hospitals NHS Foundation Trust

## Cancer Operations Cancelled On Day (YTD)




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

| | |
|---|---|
| Target | 0 |
| Mean | N/A |
| YTD | 7 |

**Executive Lead**

Sam Peate

**Lead**

Joanne Evans

## Commentary

Cancer cancelled Operations have only been reported since the end of 2019.

## Cause of Variation

- Limited access to critical care throughout pandemic.

## Planned Actions

- Cancellation reasons to be reviewed in weekly clinical recovery meeting.

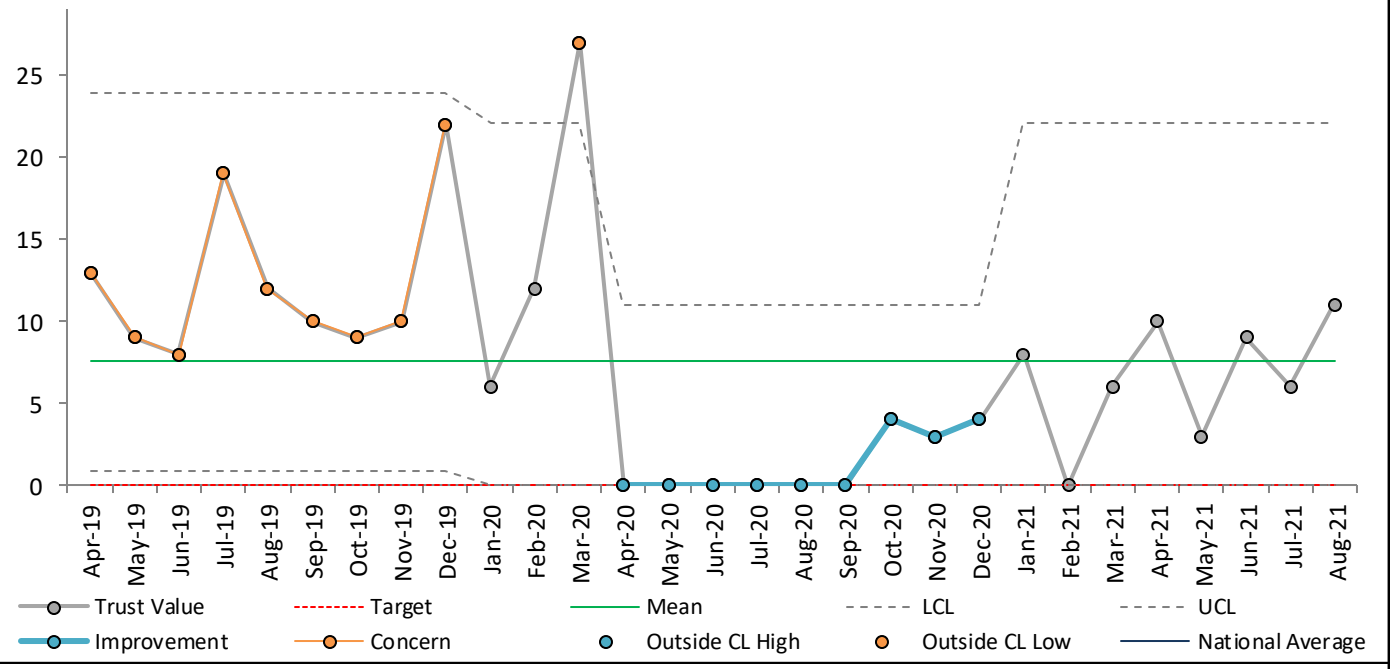
## Timescale

- Ongoing monitoring.

# 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 |
| Mean | 7.62 |
| Last Month | 11.00 |

**Executive Lead**

Sam Peate

**Lead**

Joanne Evans

## Commentary

National standard - When a patient's operation is cancelled by the hospital at the last minute for non clinical reasons, the hospital will have to offer another binding date within a maximum of the next 28 days

This metric improved significantly following the onset of Covid. Cancellations started to increase during the recovery phase however they have not increased to pre Covid levels.

## Cause of Variation

- Process within normal variation.

## Planned Actions

- Continue to escalate for dates to be re-booked within 28 day standard if dates not yet booked or booked outside of the 28 day standard.
- Increase in theatre access implemented throughout April.
- Weekly monitoring via clinical recovery meeting.

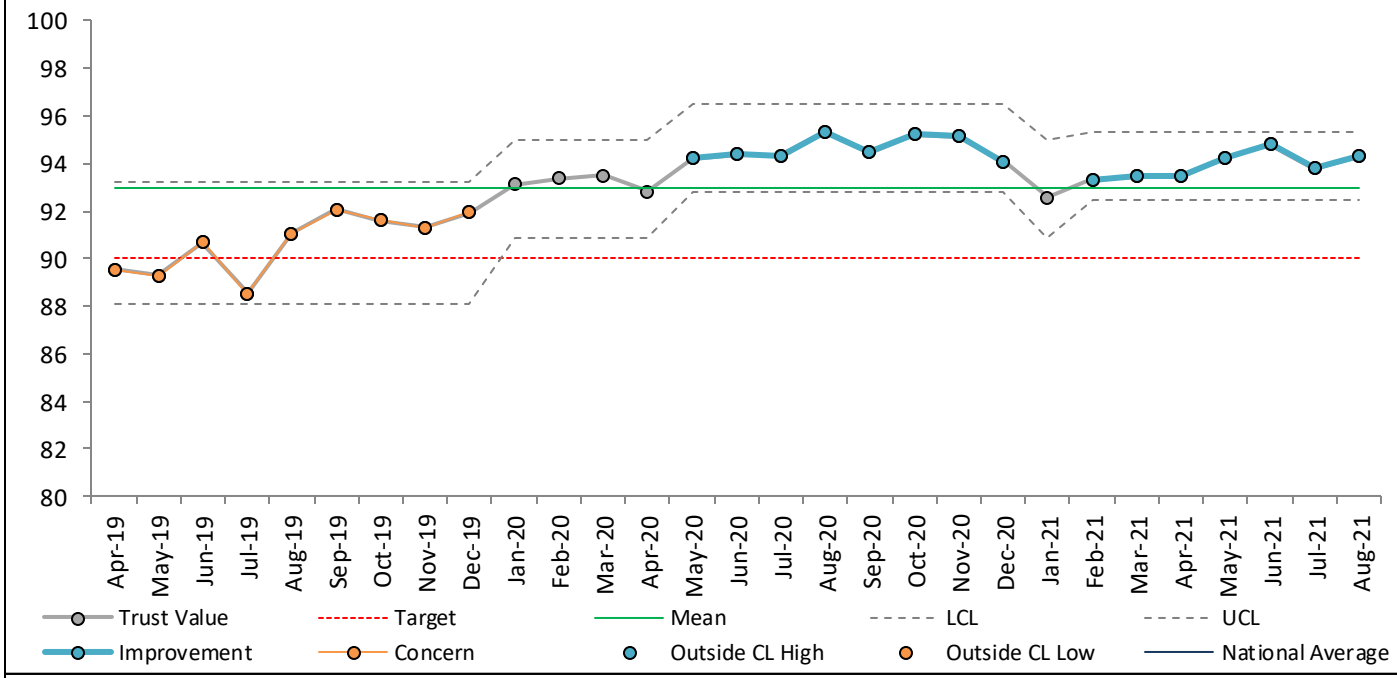
## Timescale

- Ongoing

# Responsive

South Tees Hospitals NHS Foundation Trust

## E-Discharge (%)




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

| | |
|---|---|
| Target | 90 |
| Mean | 92.96 |
| Last Month | 94.30 |

**Executive Lead**

Sam Peate

**Lead**

Moira Angel

## Commentary

This target has been met consistently since August 2019.

## Cause of Variation

- No significant variation.

## Planned Actions

- There are some data quality issues that are being explored to check for accuracy. The definition for the metric is being checked to make sure that the denominator only includes the areas of the organisation that should be completing e-discharges within 24 hours.
- A task & finish group will review the data for accuracy and address any areas where the performance is lower than the 90% target.

## Timescale

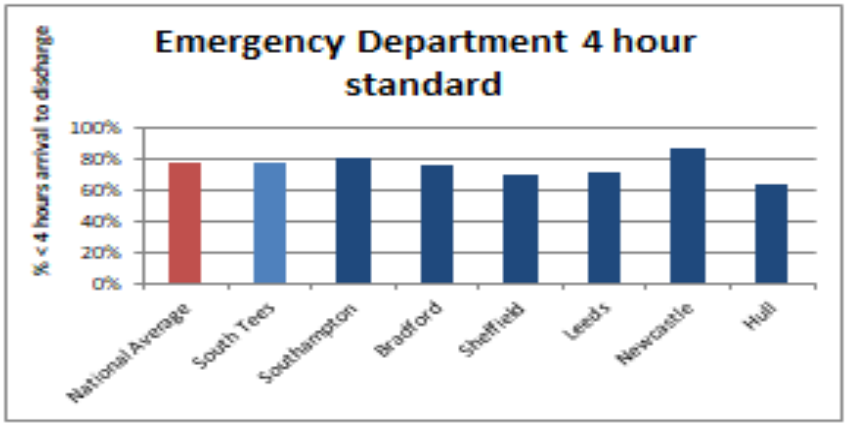
- Ongoing

# Responsive

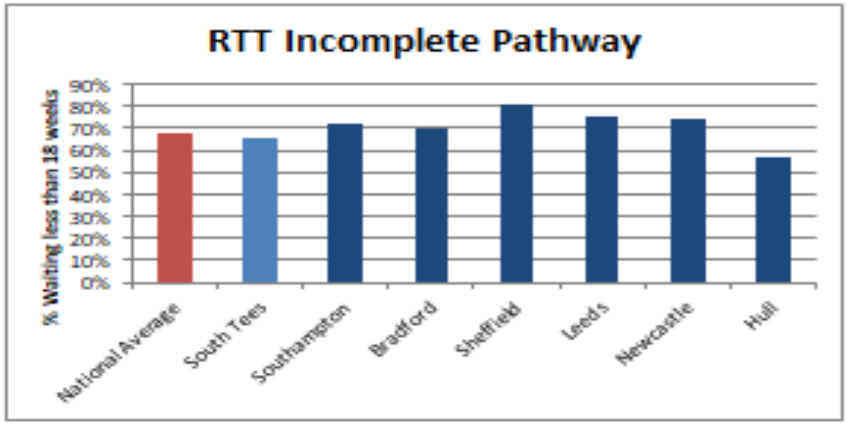
South Tees Hospitals NHS Foundation Trust

## Benchmarking against National Average and Other Providers

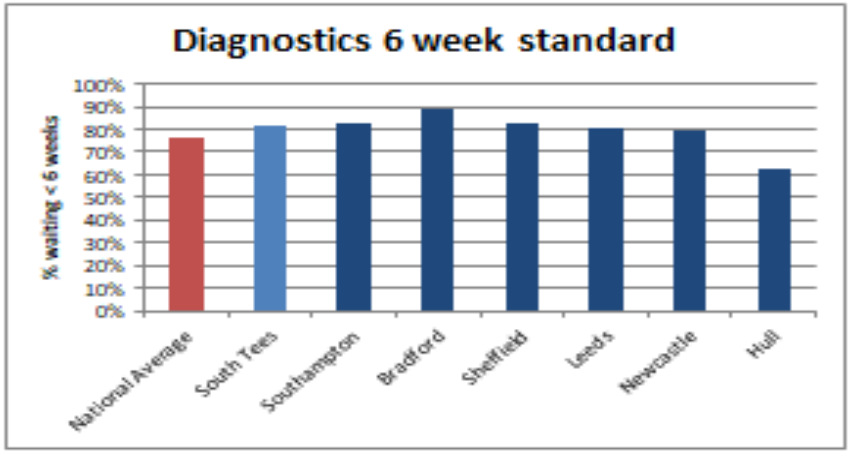
**July 2021**



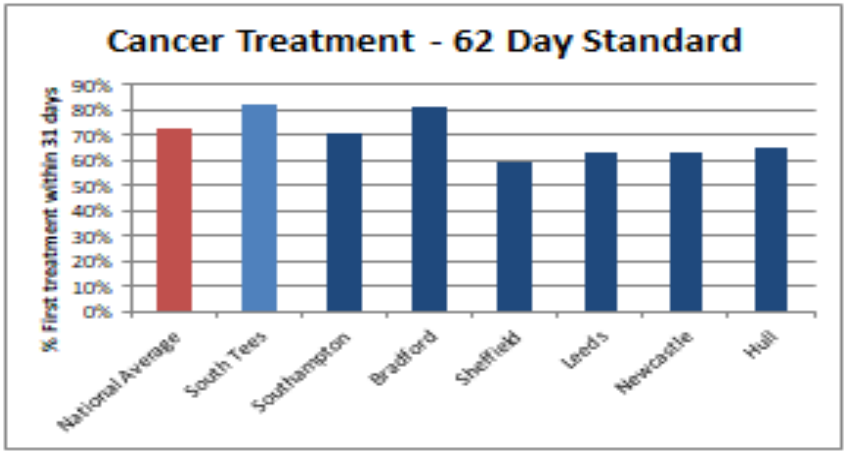

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2021-22/




Source: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2021-22/



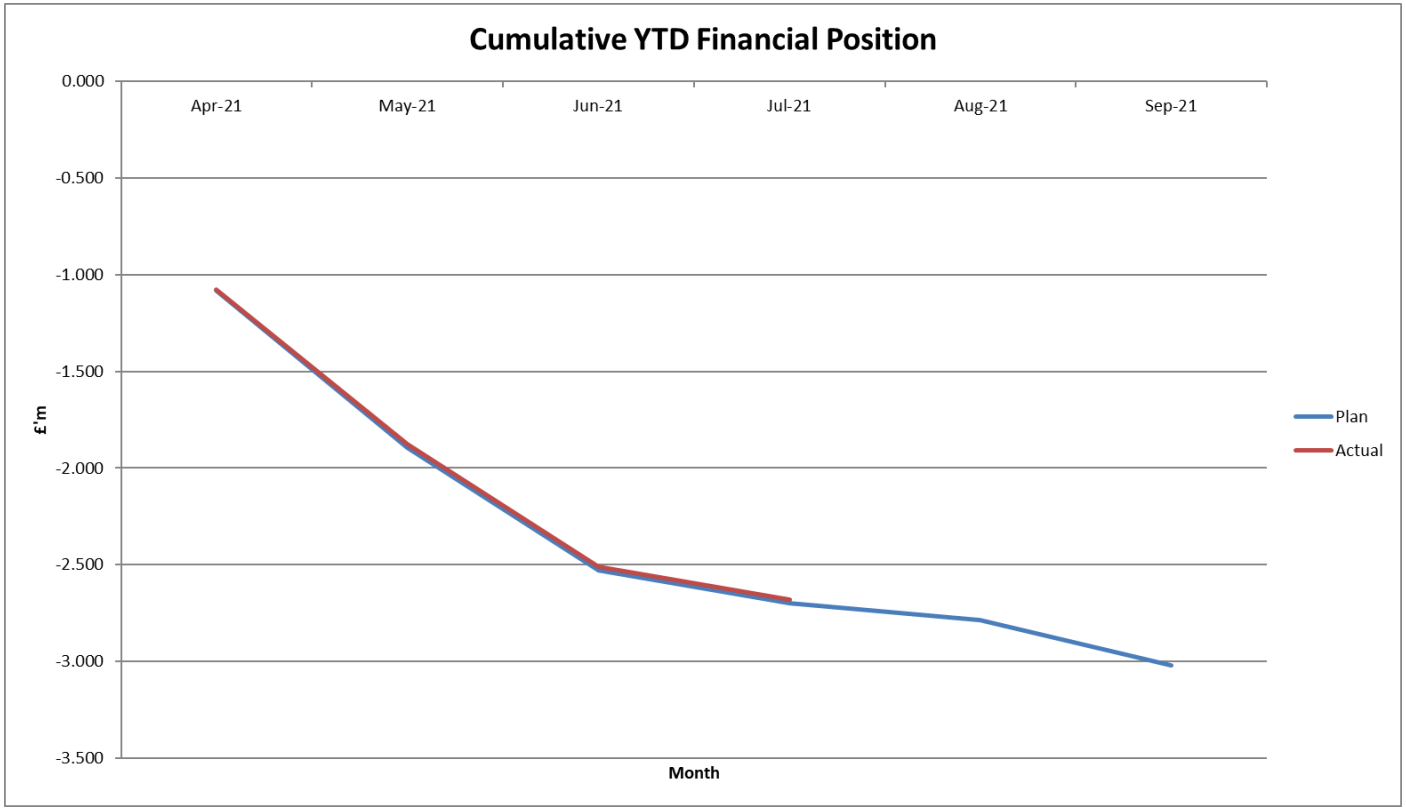

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/monthly-diagnostics-data-2021-22/




Source: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

# Well Led

South Tees Hospitals NHS Foundation Trust




| | |
|---|---|
| Target | -2.78m |
| Mean | N/A |
| Last Month | -2.79m |

**Executive Lead**

Chris Hand

**Lead**

Luke Armstrong

**Commentary**

The deficit at month 5 was £2.8m, in line with plan. Budget statements are provided to managers each month, and each Collaborative Board reviews its financial position. Resources Committee and Trust Board receive a financial report at each meeting.

## Cause of Variation

- No cause of variation.

## Planned Actions

- Understanding of revised financial arrangements for H2 of 2021/22.
- Review of ongoing Covid-19 costs.
- H2 Planning Submission

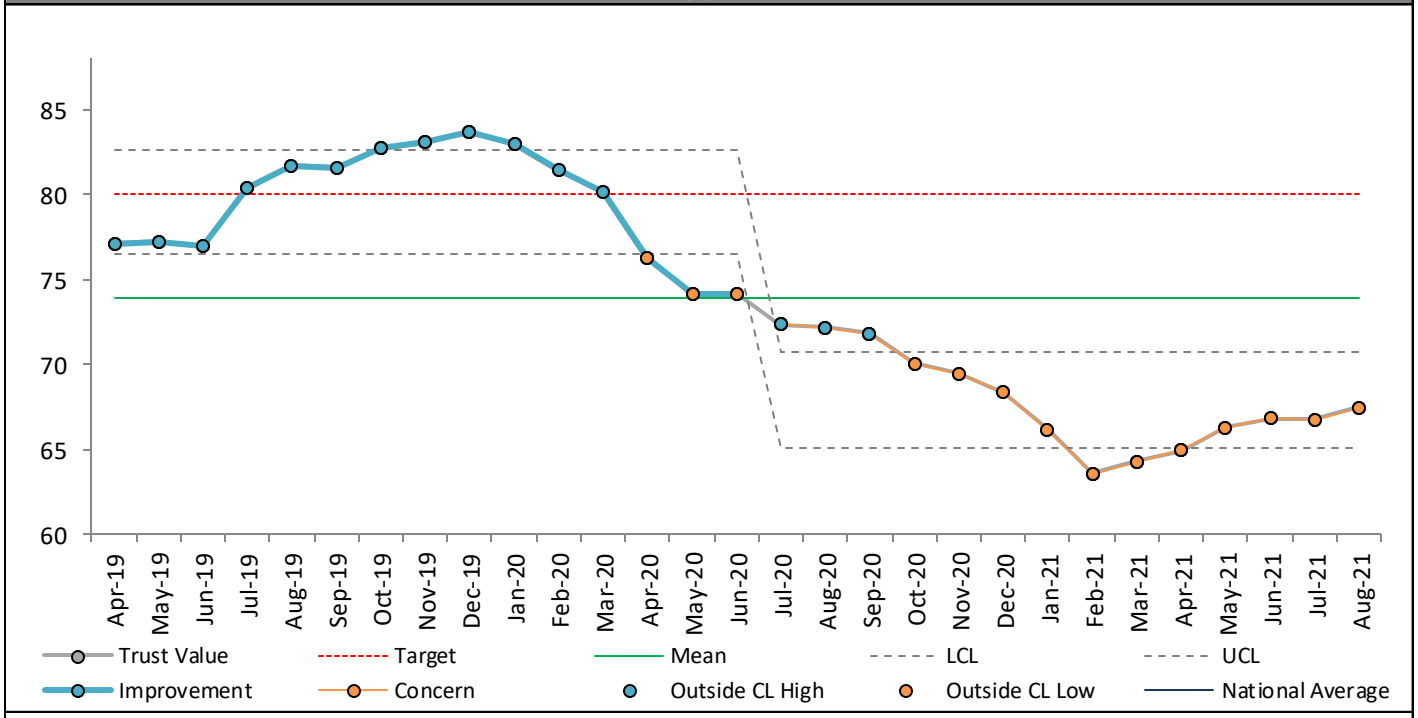
## Timescale

- 31 October 2021
- Ongoing
- November 2021

# Well Led

South Tees Hospitals NHS Foundation Trust

## Annual Appraisal (%)




Annual Appraisal Rate

| | |
|---|---|
| Target | 80 |
| Mean | 73.94 |
| Last Month | 67.46 |

**Executive Lead**

Rachael Metcalf

**Lead**

Jane Herdman

## Commentary

This metric has had a slight increase in the month of August. It has increased from 66.81% to 67.46%.
HR clinics with managers throughout August have been greatly received. Further work has been focused on medical appraisals and how this is reported so that the data is more accurate.

## Cause of Variation

- Managers requiring them to focus on operational requirements as a result of Covid pressures and staff isolating remain a pressure during the month August.
- Lowest areas of compliance include Growing the Friarage and Community at 53.54%, Women and Children at 58.78% and Head & Neck, Orthopaedic and Reconstructive Services at 63.26%.
- Cardiovascular Care services remain above target at 81.10% but Neurosciences & Spinal Care Services has shown improvement at 79.50% .

## Planned Actions

- HR Operations Team are working in partnership with the medical recruitment team to ensure the medical appraisals are recorded accurately.
- A total of 85 HR clinics have been held with managers in the month of August, focusing on lowest compliance areas. This will continue throughout September and October.
- Corporate compliance data has shown the highest improvement from 69.84% to 76.25% which is a 6.41% improvement.. Drop in clinics and focussed management meetings have been undertaken to support managers and will continue throughout the forthcoming months.

## • Timescale

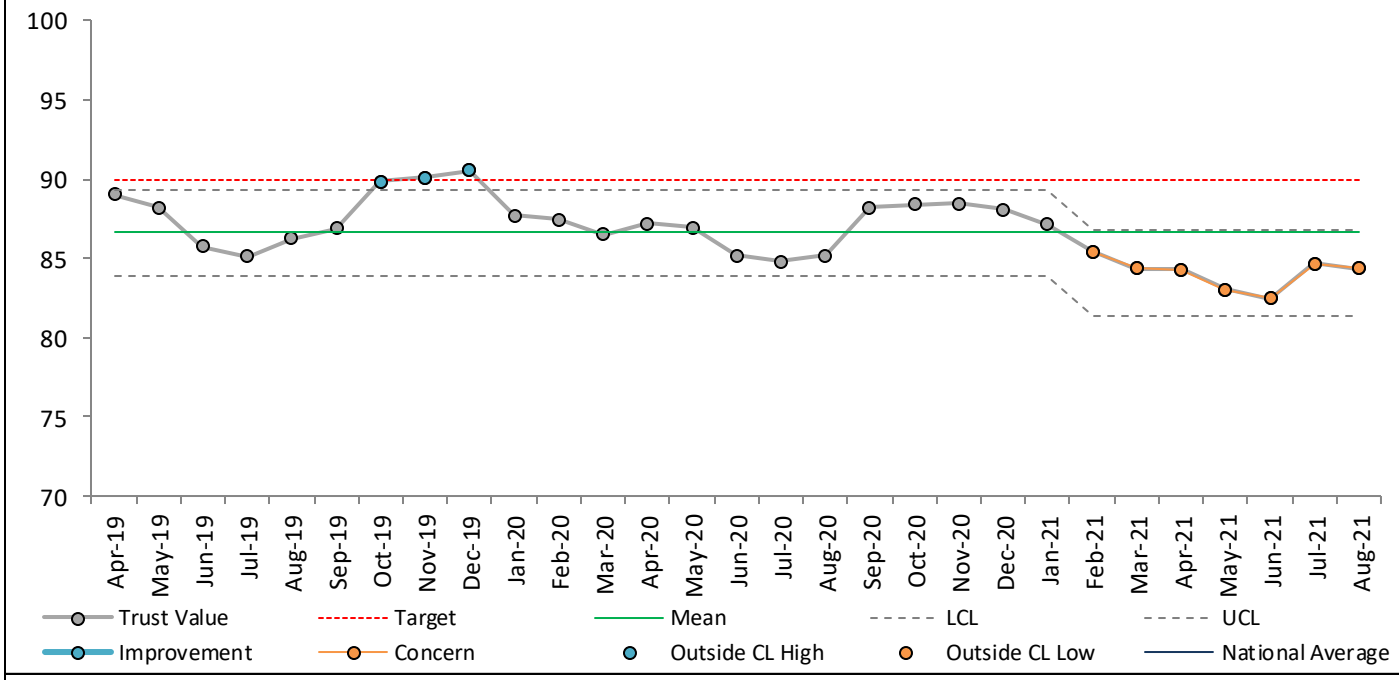
* September/October 21

- September/October 21
- September/October 21

# Well Led

South Tees Hospitals NHS Foundation Trust

## Mandatory Training (%)




The % of Mandatory Training Compliance

| | |
|---|---|
| Target | 90 |
| Mean | 86.62 |
| Last Month | 84.35 |

**Executive Lead**

Rachael Metcalf

**Lead**

Jane Herdman

## Commentary

Mandatory Training has decreased slightly from 84.67 to 84.35%
HR clinics have continued to take place during August to discuss compliance against KPI for worst performing areas.

## Cause of Variation

- Capacity in the organisation has continued to be been under pressure with staff isolation figures rising and also annual leave commitments.
- Lowest areas of compliance are Women and Children at 81.22%, Medicine & Emergency care services 80.48 % & Digestive Disease, Urology & General Surgery at 82.61%. Remaining areas in 80 – 86%.

## Planned Actions

- 85 HR clinics have been held across the organisation during August 2021 to focus on compliance with our managers.
- Further support for managers will be provided in the form of a more detailed reports which will focus on overdue and outstanding training.
- Drop in clinics have been arranged with managers in all collaboratives to support the improvement of KPIs and will be included as part of the overall HR/manager meeting structure.

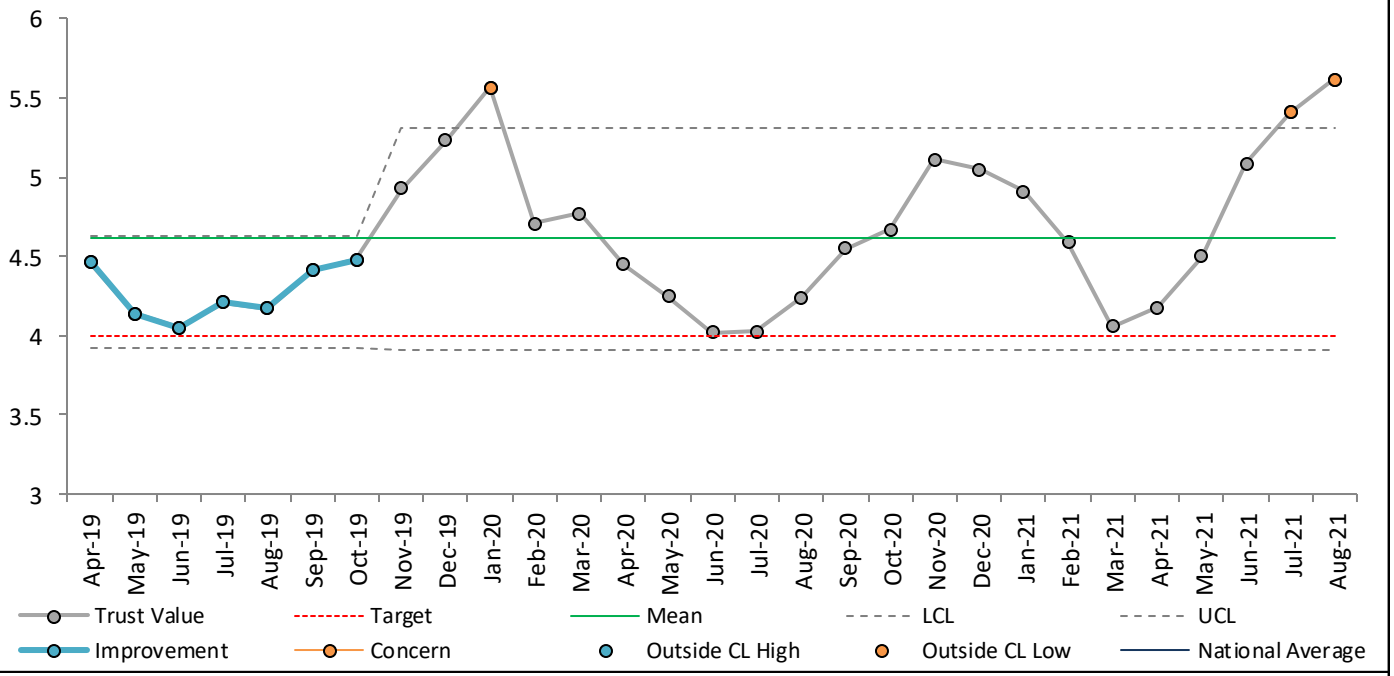
## Timescale

- August 2021 onwards
- August 2021 onwards

# Well Led

South Tees Hospitals NHS Foundation Trust

## Sickness Absence (%)




The % of monthly sickness absence

| | |
|---|---|
| Target | 4 |
| Mean | 4.62 |
| Last Month | 5.62 |

**Executive Lead**

Rachael Metcalf

**Lead**

Jane Herdman

## Commentary

General sickness absence has increased for the last 4 months in a row.
Staff absence figures have increased from 5.41% in July to 5.61% in August.
85 HR clinics have taken place across the organisation, including highlighting absence management refresher training and case conferences

### Cause of Variation

- Absence rates have been above the upper control limit in July and August 2021.
- Staff absence figures have increased from 5.41% in July to 5.61% The key areas of concern are stress, anxiety and depression.
- The highest recorded sickness is Medicine & Emergency Care with 7.49%, but this is a reduction from 7.72% in July 2021.
- Short term sickness is down from 1.83% to 1.72%. Long term sickness has increased from 3.58% to 3.89%.

## Planned Actions

- Cardiovascular Care had the most improvement, reducing absence by 0.85% within August 2021.
- HR Clinics are continuing, with 85 occurring in August 2021 across the Trust. In additional to HR clinics, monthly case conferences between HR, OH and managers have been introduced to focus on areas with highest absence

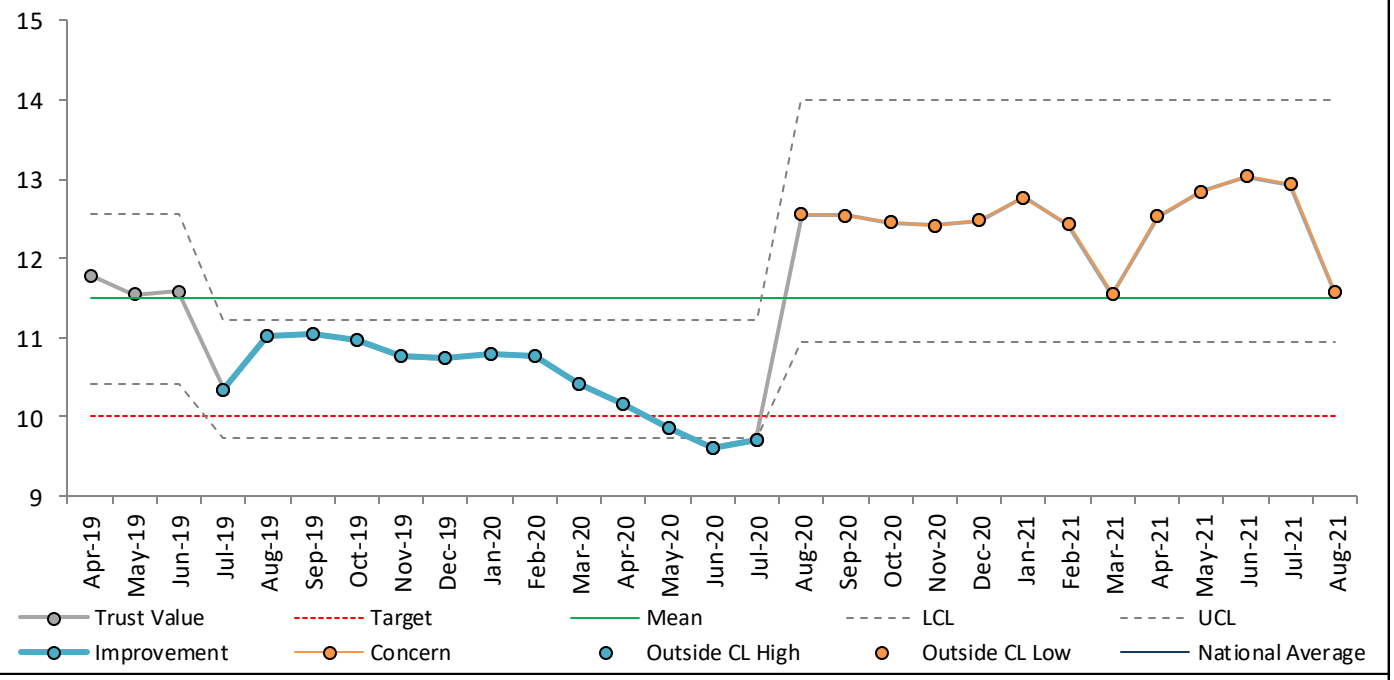
## Timescale

- August 2021 ongoing
- September 2021

# Well Led

South Tees Hospitals NHS Foundation Trust

## Staff Turnover (%)




Staff turnover rate

| | |
|---|---|
| Target | 10 |
| Mean | 11.49 |
| Last Month | 11.59 |

**Executive Lead**

Rachael Metcalf

**Lead**

Jane Herdman

## Commentary

HR have introduced an overarching Retention Strategy which recognises the importance of retaining and developing our highly skilled and dedicated workforce and also reflects the trust's values of being Caring, Supportive and Respectful.

## Cause of Variation

- Turnover has decreased by 1.34% to 11.59%
- Highest rate of turnover is in the following areas: Medicine & emergency Care Services - 15.53% but has decrease by 1.80%, Digestive Diseases – 13.42% and Women and Children – 13.20%
- James Cook Cancer institute & Specialist Medicine Services are at 7.87%, Clinical Support Services are at 7.65% and Neurosciences & Spinal Care Services at 8.68% - all below target of 10%

## Planned Actions

- As part of the HR Clinics the operations team will be discussing the retention strategy and working with managers to hold "itchy feet" conversations and "stay/exit" conversations.
- Detailed action plan to underpin the People Plan is in development, which includes focus on staff engagement and retention.
- There is ongoing work on the workforce plan to be developed for each Clinical Collaborative, which provides a detailed forecast of staff requirements form a 5 year period, Clinical Collaboratives to develop action plan by November 2021.

## Timescale

- September 2021
- September 2021
- October 2021

# Glossary of Terms

South Tees Hospitals NHS Foundation Trust

| Term | Description |
|---|---|
| ED | Emergency Department |
| EPRR | Emergency Preparedness, Resilience and Response |
| HDU | High Dependency Unit |
| HILT | Hospital Intervention Liaison Team |
| HRBP | HR Business Partner |
| IPAC | Infection Prevention and Control |
| IPAG | Infection Prevention Assurance Group |
| IPCN | Infection Prevention Control Nurse |
| ITU | Intensive Therapy Unit |
| LocSSIP | Local Safety Standards for Invasive Procedures |
| OPAT | Outpatient Parenteral Antibiotic Therapy |
| PTL | Patient Tracking List |
| RTA | Ready To Assemble |
| SI | Serious Incident |
| STACQ | South Tees Accreditation for Quality of Care |
| TCI Date | To Come In Date |

# Future Changes

South Tees Hospitals
NHS Foundation Trust

- Continue review of IPR, including relevant targets in line with Improvement Plan, trajectories for improvement and page layout.

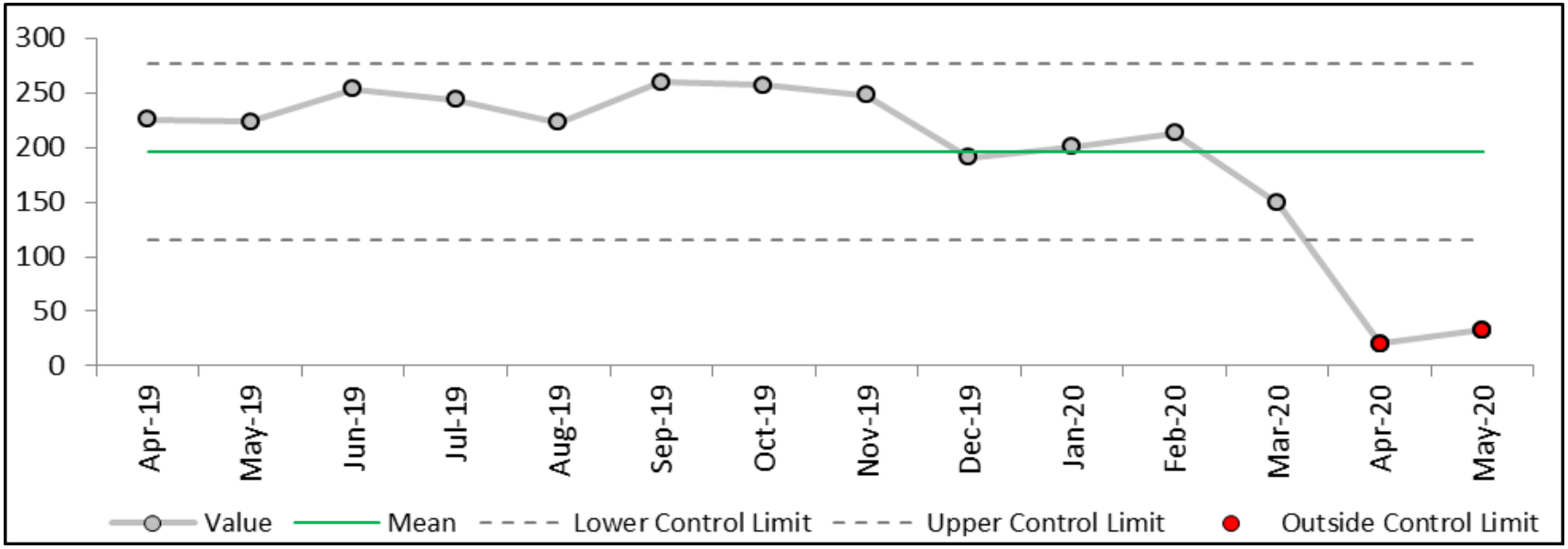
# Introduction to Statistical Process Control

South Tees Hospitals NHS Foundation Trust

Statistical process control (SPC) charts can help to understand the scale of a problem, gather information and identify possible causes.

An SPC chart has an average line (mean) and two control lines above and below the average line.
The control lines are a function of the data, and provide an indication as to whether the process exhibits common cause (predictable) variation or whether there are special causes.

In the example below, activity falls outside of the control limits in April, indicating a potential issue that requires further analysis.



South Tees Hospitals
NHS Foundation Trust

| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 October 2021 | | | |
|---|---|---|---|
| CQC Update Report | | | **AGENDA ITEM: 17, ENC 14** |
| **Report Author and Job Title:** | David Bell<br>Quality, Governance & Mortality Reporting Manager (CQC Project Lead) | **Responsible Director:** | Dr. Hilary Lloyd<br>Chief Nurse<br><br>Moira Angel<br>Interim Director of Clinical Development |
| **Action Required** | Approve ☐ Discuss ☐ Inform ☒ | | |
| **Situation** | This paper provides an update on the progress the Trust is making in preparation for its next CQC inspection. | | |
| **Background** | Following the last CQC inspection of the Trust, a detailed action plan was developed to address the regulatory breaches 26 'must do' actions and 23 'should do' actions. | | |
| **Assessment** | This paper outlines the significant progress the Trust is making as well as future plans in respect of preparing for the next CQC inspection.<br><br>**Achievements**<br>• Creation of the CQC Compliance Group that meets monthly to assure the Quality Assurance Committee<br>• CQC Emergency framework, solid preparation around IBAF and first meeting held with positive outcome<br>• All Directorates have completed their CQC self-assessments and have attended a check and challenge meeting with the CQC project team<br>• Further meetings have commenced in relation to Directorate updates after initial check and challenge meetings<br>• Task and finish group has been established focusing on mandatory training (Core 11). Giving this focused attention and traction is expected to move this one remaining must do red action, swiftly to amber and then to green during the coming months.<br>• Creation and commencement of PIR (Provider Information Request) action plan<br>• Regular triangulation meetings in respect of CQC, STAQC and GIRFT happening fortnightly<br>• Trust Board Well Led Self-Assessment completed<br>• Additional senior resources secured for the CQC Project Team<br>• Completion of Notes Trolley Audit<br>• Engagement meeting with a focus on Clinical Support services with good feedback.<br><br>**Risks**<br>• Recognition that the COVID-19 pandemic has affected appraisals and mandatory training compliance (M6).<br>• Recognition of establishment of new clinical digital tools which will bring together important patient and service user information in one place. In the meantime, with an electronic e-prescribing due to | | |

| | | |
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| | commence this year. | |
| **Recommendation** | The Trust Board of Directors are asked to note the progress which has been made. | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | Principal risk 1.1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes | |
| **Legal and Equality and Diversity implications** | There are no legal or equality & diversity implications associated with this paper. | |
| **Strategic Objectives** | Best for safe, clinically effective care and experience ☒ | A great place to work ☒ |
| | Deliver care without boundaries in collaboration with our health and social care partners ☒ | Make best use of our resources ☒ |
| | A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒ | |

# Care Quality Commission Update Report

## PURPOSE OF REPORT

This paper provides an update on the progress the Trust is making in preparation for its next CQC inspection. The Trust Board members are asked to note progress.

## BACKGROUND

Following the last CQC inspection of the Trust a detailed action plan was developed to address the regulatory breaches 26 'must do' actions and 23 'should do' actions.

The Quality Assurance Committee has received regular reports on the action plan and are kept informed of areas of focus. The action plan is now 'owned and monitored' by the Collaboratives.

The Trust is now in preparation phase for a forthcoming CQC visit whilst continuing to embed actions from the original report and improve quality standards.

## KEY HIGHLIGHTS

### Provider Information requests

- The purpose of the PIR is to provide a general overview of the provider, its quality, comment on changes since the last inspection, and provide data for ongoing monitoring
- The Provider Information Request (PIR) is completed by each Trust and submitted to CQC
- Data will be updated by October
- Work is ongoing in respect of the Community PIR

### Triangulating Evidence

Table 1 and 2 below give examples of how we are triangulating CQC self-assessment data, STAQC and GIRFT. Additional regulatory and other key information will be added. The STAQC accreditation programme has been brought forward and additional support has been provided by STRIVE to help wards and departments prepare for their accreditation.

**Table 1**

# Triangulation Dashboard – Work in Progress

CQC SELF-ASSESSMENT SUMMARY

DIRECTORATE: RADIOLOGY

COLLABORATIVE: CLINICAL SUPPORT SERVICES

| Category | Self-Assessed Rating |
|---|---|
| SAFE | Good |
| EFFECTIVE | Good |
| CARING | Good |
| RESPONSIVE | Good |
| WELL-LED | Good |
| OVERALL RATING | Good |

CQC SELF-ASSESSMENT SUMMARY

DIRECTORATE: PHARMACY

COLLABORATIVE: CLINICAL SUPPORT SERVICES

| Category | Self-Assessed Rating |
|---|---|
| SAFE | Good |
| EFFECTIVE | Good |
| CARING | Good |
| RESPONSIVE | Good |
| WELL-LED | Good |
| OVERALL RATING | Good |

CQC SELF-ASSESSMENT SUMMARY

DIRECTORATE: PATHOLOGY

COLLABORATIVE: CLINICAL SUPPORT SERVICES

| Category | Self-Assessed Rating |
|---|---|
| SAFE | Good |
| EFFECTIVE | Good |
| CARING | Good |
| RESPONSIVE | Good |
| WELL-LED | Good |
| OVERALL RATING | Good |

CQC SELF-ASSESSMENT SUMMARY

DIRECTORATE: MEDICAL PHYSICS

COLLABORATIVE: CLINICAL SUPPORT SERVICES

| Category | Self-Assessed Rating |
|---|---|
| SAFE | Good |
| EFFECTIVE | Good |
| CARING | Good |
| RESPONSIVE | Good |
| WELL-LED | Good |
| OVERALL RATING | Good |

Safety and Quality First

**Table 2**

## Radiology

| CQC Self-assessment | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL-LED | OVERALL RATING |
|---|---|---|---|---|---|---|
| | Good | Good | Good | Good | Good | Good |

| STAQC Accreditation | Radiology |
|---|---|
| | Accreditation Visit November 2021 |

| GIRFT | Initial deep-dive 11/03/2019. Implementation plan meeting 06/04/2021 |
|---|---|

## Pathology

| CQC Self-assessment | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL-LED | OVERALL RATING |
|---|---|---|---|---|---|---|
| | Good | Good | Good | Good | Good | Good |

| STAQC Accreditation | Pathology |
|---|---|
| | Accreditation Visit February 2022 |

| GIRFT | Initial deep-dive 11/03/2019 - meeting postponed |
|---|---|

### Actions and next steps

- Further meetings have been arranged with each Directorate to support, discuss and track progress against their self-assessment
- Work is ongoing with the Estates team to address environment actions as they arise
- Finalise and action the PIR plan
- Directorates have been asked to provide a comprehensive list of external bodies/accreditation for compliance
- Finalise the data triangulation dashboards (CQC, STAQC, GIRFT etc.) for each Directorate
- Creation of the Core 11 Task and Finish Group focusing on mandatory training to provide focused attention and traction to move this one remaining must do red action, swiftly to amber and then to green during the coming months.
- The Consent policy was approved at the healthcare records group on 23/09/21
- CQC engagement meeting – first meeting held in the new format which focused on Clinical Support Services Collaborative, with plans underway for next meeting with a focus on Medicine, Older People, Stroke and Frailty
- Additional resource secured to oversee the Trust's CQC preparations from 27/9/21.

- Well Led Self Assessment completed with Trust Board 21/09/2021 and planned self-assessment with the Clinical Policy Group
- The monthly CQC compliance group will oversee a communications plan

## Recommendations

The Trust Board to note the report.

South Tees Hospitals NHS Foundation Trust

# People Committee
# Chair's Log

| **Meeting**: People Committee | **Date of Meeting**: 23 September 2021 |
|---|---|
| **Connecting to:** Board of Directors | |

**Key topics discussed in the meeting**

- BAF and assurance reports in respect of threats related to Principle Risk 3
- People Plan - Health and Wellbeing
- Workforce Race Equality and Disability Equality Scheme Annual Reports
- Freedom to Speak Up
- Staff survey campaign
- Flu campaign
- Pilot approach to workforce planning – James Cook Cancer Institute & Specialist Medicine
- Performance data

| Actions | Responsibility / timescale |
|---|---|
| • To review the wording around threat 3.3, making clearer the distinction between enablers for an effective agile workforce, and to closer working with North Tees. | R Metcalf/J White |
| • To keep under review the threat level in respect of staff absence related to COVID-19 and fatigue | R Metcalf/J White |
| • Ensure that People Plan reports with metrics on outcomes wherever available, including quality data from surveys, staff networks | R Metcalf |
| • To explore ICS and other options to reduce waiting times for counselling and physiotherapy services and to progress delivery of wellbeing interventions in wards and via short videos to support staff unable to come off for support | J Cooper |
| • To provide numerical data alongside percentage data for the WRES and WDES reports to Board, to enable better | D Curtis-Haigh |

| | |
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| understanding of the experience of colleagues when sample sizes are very low | |
| • To continue a focus on encouraging colleagues to declare any disability and/or ethnic origin in ERS | D Curtis-Haigh |
| • Noted the positive approach to securing maximum takeup of Flu and Covid booster immunisation, building on excellent performance in previous years | J Cooper |
| • Noted the approach to improving participation in the staff survey and asking NEDS and Board members to join in the distribution of paper copies to areas and services where access online is constrained | Board |
| • Noted the improvements to process and culture emerging from the work of the FTSU team and offered congratulations for their shortlisting in the HSJ Awards | |
| **Escalated Items** | |
| • No new threats or matters to escalate but a very useful and thorough discussion at Committee on the health and wellbeing challenges felt across the Trust and the potential impact on risk | |
| **Risks (Include ID if currently on risk register)** | **Responsibility / timescale** |
| | |

South Tees Hospitals NHS Foundation Trust

# Quality Assurance Committee
# Chair's Log

| | |
|---|---|
| **Meeting**: Quality Assurance Committee | **Date of Meeting**: 28th September 2021 |
| **Connecting to**: Board of Directors | |

| Key topics discussed in the meeting |
|---|
| • BAF discussion<br>• STAQC progress update<br>• CQC update<br>• Monthly IPR<br>• Maternity Services Report<br>• Monthly SI / NE report<br>• GIRFT / Benchmarking<br>• Single Sex Accommodation update - deferred |

| Actions | Responsibility / timescale |
|---|---|
| Review of the BAF | JW/HL/MS |
| Quality & Safety risks with regard to the Alcidion programme to be considered by QAC | MI |
| Ongoing preparation for the CQC including support to fragile services. | JW HL |
| Further enhance the commentary in the IPR with regard to the Quality and Safety indicators | HL/MS |
| Maternity reports to highlight the national steer on performance to link to the IPR | HG |
| Further work on SI/NE and closing down actions and providing evidence on trust wide learning from the incidents. | HL/MS |
| Further work on non-compliance in relation to GIRFT relates workforce issues that are being mitigated. | IB |

| Escalated items |
|---|

| There are no items to escalate. | |
|---|---|
| **Risks (Include ID if currently on risk register)** | **Responsibility / timescale** |
| The Committee undertook a thorough review of the BAF including reviewing all gaps in assurance. No change in BAF risk rating<br><br>Two principle risks remain.<br><br>Assurance reports received IPR threat 1.1, 1.3 & 1.5, SI/NE update threat 1.1 7 1.3, CQC update threat 1.1.<br><br>No new threats to add.<br><br>Threats 1.5 and 1.6 to be updated to reflect current risks around critical services. | JW/MS |

South Tees Hospitals NHS Foundation Trust

# Audit & Risk Committee
# Chair's Log

| | |
|---|---|
| **Meeting**: Audit & Risk Committee | **Date of Meeting**: 21 September 2021 |
| **Connecting to**: Board of Directors | |
| Key topics discussed in the meeting | |

- Terms of Reference
- Assurance Matrix
- Counter Fraud Progress Report, Counter Fraud Policy and Strategy
- Internal Audit Progress Report  including audit reports on Patient Experience and
- Waiting List Patient Flow Final Report
- External Audit Progress Report, 2020/21 Final Annual Report, Charitable Funds Audit update, Subsidiary Audit update
- Review of Standing Financial instructions, Standing Orders, Scheme of Delegation
- Freedom to Speak Up report
- Clinical Audit Annual Plan
- Review Losses & Special Payments
- Review Tender Waivers
- Accounting Policies Update
- BAF – Standing Operating Procedure
- Review of BAF
- Deep dive into People Committee review of BAF and risk processes, including scoring of assurance column of BAF for People Committee risks.

| Actions | Responsibility / timescale |
|---|---|

| | |
|---|---|
| Update TOR to include invite for Chair and CEO (Managing Director) as observers, to include all Committees including Provider Committee (CIC), role of audit committee in terms of receiving assurance and financial reporting via Internal Audit and CFO | JW |
| Clarify reporting arrangements for EPRR | JW |
| Consider Risk Appetite at next meeting | JW/KO |
| Launch Gifts and Hospitality staff briefing before next meeting | JW |
| Circulate Mazars report on national publications to Board members | JW/Paul Bevan |
| Review subsidiary company SFI, SO re approval for audit | JW |
| Updated report on FTSU at next meeting | JW/CH |
| | HL |

| Escalated items |
|---|
| There are no items to escalate. |

| Risks (Include ID if currently on risk register) | Responsibility / timescale |
|---|---|
| PWC Audit report on Patient Experience includes a number of High Risks. Assurance assessment to be done via Quality Committee. | HL |
| PWC Audit report on Waiting Lists includes medium risks. Assurance assessment to be done via Resources Committee. | SP |
| Outcome of subsidiary audits dispensation request still to be clarified | Mazars / CH |
| The BAF Standard Operating Procedure was approved and a deep dive into the People Committee was undertaken to seek assurance on the scrutiny of the BAF and risks. Assurance was provided. | |

South Tees Hospitals NHS
NHS Foundation Trust

**AUDIT AND RISK COMMITTEE : Remit Assurance Matrix**

**Purpose:** to show that we have covered each element of our ARC remit throughout the year, and have sufficient assurance for each element at year-end.

| AR&C Remit & Constitution | September 2021 | November 2021 | February 2022 | May 2022?? |
|---|---|---|---|---|
| **16.1 Governance, Risk Management and Internal Control** | | | | |
| The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. | | | | |
| In particular, the Committee will review the adequacy and effectiveness of: | | | | |
| • all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors of Directors; | | | | |
| • the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements; | | | | |

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| • the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reviews, reporting and self certifications; | | | | |
| • the policies and procedures for all work related to counter fraud and security as required by NHS Protect. | | | | |
| In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. | | | | |
| As part of its integrated approach, the Committee will have effective relationships with other Trust Board Sub Committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable review and oversight of the other Sub Committee's governance of risk. This will include the exchange of their chair's action logs and highlight reports to the Trust Board | *Plan for formal exchanges with Chair of RC, PC, QC?* | | | |
| **16.2 Internal Audit** | | | | |
| The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards 2013* and provides appropriate | | | | |

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| independent assurance to the Committee, Accountable Officer and Board of Directors of Directors. This will be achieved by: | | | | |
| • consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal | | | | |
| • review and approval of the internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework | | | | |
| • consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources | | | | |
| • ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation | | | | |
| • monitoring the effectiveness of internal audit and carrying out an annual review. | | | | |
| **16.3 External Audit** | | | | |
| The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external | | | | |

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| auditors and consider the implications and management's responses to their work. This will be achieved by: | | | | |
| • consideration of the appointment (in conjunction with the Council of Governors) and performance of the external auditors, as far as the rules governing the appointment permit, including the formation of an Audit Appointment Panel as set out in the Local Audit and Accountability Act 2014 | | | | |
| • discussion and agreement with the external auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan and ensuring coordination, as appropriate, with other external auditors in the local health economy | | | | |
| • discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee; | | | | |
| • reviewing all external audit reports, including the report to those charged with governance (before its submission to the Governing Body) and any work undertake outside the annual audit plan, together with the appropriateness of management responses. | | | | |
| • Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services. | | | | |

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| **16.4 Other Assurance Functions** | | | | |
| The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. | | | | |
| These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Litigation Authority etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.). | | | | |
| In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality and Assurance Committee the Finance and Investment Committee and Workforce Committee. | | | | |
| **16.5 Clinical Audit Function** | | | | |
| In reviewing the work of the Quality Assurance Committee the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function and issues around clinical risk management. | | | | |
| The Audit Committee will review the Clinical Audit Strategy and Plan each year and monitor through the Quality | | | | |

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| Assurance Committee. | | | | |
| **16.6 Counter Fraud** | | | | |
| The Committee will review the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these meet the NHS counter Fraud Authority's standards and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service. | | | | |
| **16.7 Freedom to speak up** | | | | |
| To review the adequacy of the Trust's arrangements (whistleblowing arrangements) by which Trust staff and other individuals where relevant, may raise, in confidence, concerns about possible improprieties in matters of: financial reporting and control; clinical quality; patient safety or other matters or any other matters of concern. The Committee shall receive its assurance that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action through the Non-Executive Freedom to Speak up champion. | | | | |
| **16.8 Management** | | | | |
| The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. | | | | |
| They may also request specific reports from individual | | | | |

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| functions within the organisation (e.g. clinical audit). | | | | |
| **16.9 Financial Reporting** | | | | |
| The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. | | | | |
| The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided. | | | | |
| The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors of Directors, focusing particularly on: | | | | |
| • the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee | | | | |
| • changes in, and compliance with, accounting policies, practices and estimation techniques | | | | |
| • unadjusted mis-statements in the financial statements | | | | |
| • significant judgements in preparation of the financial statements | | | | |
| • significant adjustments resulting from the audit | | | | |

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| • Letters of representation | | | | |
| • Qualitative aspects of financial reporting. | | | | |
| **16.10 Risk Management** | | | | |
| The Committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the Committee considers it is appropriate to do so. This will include: | | | | |
| • Reviewing the Trust's risk management strategy and recommending its approval to the Board of Directors | | | | |
| • Provide assurance to the Board of Directors that the organisation is compliant with the NHS England EPRR core standards and has an effective business continuity process in place. | | | | |
| • Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks | | | | |
| • Overseeing actions plans relating to regulatory requirements in terms of the Single Oversight Framework and Use of Resources | | | | |

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| • Providing the Board with assurance over developing partnership arrangements (e.g. accountable care organisations) and mitigation of risks which may arise at the borders between such organisations | | | | |
| • To agree the strategy in place to manage risks on the organisational risk register, including identification of appropriate risk owners, and monitoring the satisfactory operation of the risk management policy. | | | | |
| • Review the Trust's Risk Appetite statement. Ensure that risk is identified and managed proactively in accordance with the Board's risk appetite | | | | |
| • Ensure through the Trust's governance and divisional structures that risk management systems and processes are adhered to across the Trust. | | | | |
| • Ensure that each Division, Care Group and Corporate Department maintains a robust risk register and risk management processes in line with the Trust's Risk Management Strategy by receiving and testing the risk registers. | *Collaboratives ??* | | | |
| The Board will however retain the responsibility for routinely reviewing specific risks. | | | | |