South Tees Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS (PUBLIC)

Date – 7 September 2021

Time – 13:20
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 7 SEPTEMBER 2021 AT 13:00 IN THE BOARD ROOM AND MICROSOFT TEAMS

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT
PATIENT STORY				
Access to public and press to the Board of Directors meeting will be available via the following link at 13:20 Microsoft Teams meeting **Join on your computer or mobile app** 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 6 July 2021	Approval	Chair	ENC 2
5.	Matters Arising / action log	Review	Chair	ENC 3
6.	Chairman's report	Information	Chair	Verbal
7.	Chief Executive's Report	Information	Chief Executive	ENC 4
8.	Board Assurance Framework	Discussion	Head of Governance & Company	ENC 5

	ITEM	PURPOSE	LEAD	FORMAT
			Secretary	
QUALITY AND SAFETY				
9.	Safe Staffing Report	Information	Chief Nurse	ENC 6
10.	CQC update	Information	Chief Nurse	ENC 7
11.	Safeguarding Annual Report including Learning Disabilities	Information	Chief Nurse	ENC 8
12.	Infection prevention & control annual report	Information	Chief Nurse	ENC 9
PEOPLE				
13	Consultant appointments	Information	Managing Director	Verbal
14.	Doctor Revalidation & Appraisal Update Report	Information	Chief Medical Officer	ENC 10
FINANCE AND PERFORMANCE				
15.	Finance Report Month 4	Information	Chief Finance Officer	ENC 11
16	Integrated Performance Report	Discussion	Chief Operating Officer	ENC 12
GOVERNANCE AND ASSURANCE				
17.	Committee Reports	Information	Chairs	ENC 13
	DATE OF NEXT MEETING The next meeting of Board of Directors will take place on Tuesday 5 October 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 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 – 7 September 2021			
Register of members interests			**AGENDA ITEM: 3** **ENC 1**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Derek Bell Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	The Board of Directors are asked to note interests declared by members of the Committee		
Background	The report sets out membership of the Board of Directors and interests registered by members. Conflicts should be managed in accordance to the Constitution para 32 - If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to other Directors.		
Assessment	There are no specific conflicts identified with the agenda. Members will be reminded at the meeting to raise any if they arise.		
Recommendation	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 Deputy Chair	2017 2019	Ongoing Ongoing	Role - Governor – Chair of Resources Committee, member of Board of Teesside University. 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. Director/No exec Director – Malton & Norton Golf club ltd.
Mike Ducker	Non-executive Director	1 December 2017 1 December 2005 1 October 2019	ongoing ongoing ongoing	Advisor to UK Government on Chemicals Industry Trustee of Greenstones Christian Trust Charity – a Charity working with prisons in Ethiopia South Tees Healthcare Management Limited - Company number 10166808
Debbie Reape	Non-executive Director Senior Independent Director	August 2019 1 October 2019 October 2019	Ongoing Ongoing Ongoing	Associate Director with Northumbria International Alliance (Northumbria NHS Trust and Northumberland County Council) South Tees Healthcare Management Limited - Company number 10166808. School Governor, Ashington Academy.
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. 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 Director of Arista Associates Ltd. - Company number 09986504 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 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. Chair AuditOne Board NHS internal Audit Consortium. Unremunerated, voluntary role. 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	1 March 2021	Ongoing	No interests declared
Samuel Peate	Chief Operating Officer	1 April 2021	Ongoing	No interests declared
Prof Derek Bell	Joint Chair	April 2020 April 2018 April 2021	Ongoing Ongoing Ongoing	Trustee Royal Medical Benevolent Fund – no remuneration Chair and Trustee Tenovus Scotland (Edinburgh) – no remuneration 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 6 JULY 2021 AT 13:00 IN THE BOARD ROOM, MURRAY BUILDING JAMES COOK AND VIA MICROSOFT TEAMS

Present

Mr N Mundy	Interim Joint Chairman
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
Mr M Ducker	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
Ms S Page	Chief Executive

In Attendance

Mrs J White	Head of Governance & Company Secretary
Mr K Oxley	Director of Estates, Facilities and Capital Planning
Mr S Peate	Chief Operating Officer
Mrs R Metcalf	Director of Human Resources
Mrs R Fallon	Interim Director of Planning & Recovery

Members of the public

Action

STAFF STORY

The Chairman welcomed Mr Chris Hunter from the simulation team and STRIVE, and advised that he was presenting the staff story today. Mr Hunter thanked the Board for allowing him to present his story and explained that he joined the Trust about 4 1/2 years ago and has enjoyed every moment of this so far. He described his learning journey following being placed with the undergraduate department as part of the prospect scheme. This is where he achieved his level 2 apprenticeship and on the job working picking up a lot of new skills. Following a family bereavement in which he was supported well from the Trust and colleagues he returned to work on a period of graduated return and then had the opportunity to undertake a Level 3 apprenticeship and at the same time a new role was advertised in the team for a simulation technician and was encouraged to apply, however he was not successful at that time but was supported to apply for a support role in simulation and was successful. He continued with his Level 3 apprenticeship in this new role which he achieved. During COVID he had to retrain and refocus his skills into other areas due the reduction in face to face contact and contributed to the production of over 50 hours of educational videos.

The Chairman thanked Mr Hunter again most warmly for attending and for sharing his inspirational story . He wished him well in his future career with the Trust. He encouraged Board colleagues to visit the Simulation Team at STRIVE.

BoD/20/274 **WELCOME AND INTRODUCTIONS**

The Chairman welcomed members to the meeting which was held in the Board Room and virtually. He reminded members that the NHS was celebrating its 73rd anniversary and it was great that the queen, recognised this by awarding the NHS the George Cross. It was a great accolade and recognition of everyone involved in the health service who have worked so hard throughout the last year during the pandemic.

The Chairman reminded those in attendance that there will be an opportunity during the meeting for questions and he will invite this at the end of the meeting.

BoD/20/275 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Ms A Burns, Vice Chair, Mr D Heslop, Non-Executive Director and Mr M Graham, Director of Communications.

BoD/20/276 **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/20/277 **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/20/278 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on Tuesday 1 June 2021 were reviewed and agreed as an accurate record. Mrs White

BoD/20/279 **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

BoD/20/280 **CHAIRMAN’S REPORT**

The Chairman referred members to his report which had been previously circulated and highlighted several points. He asked to record his and the Boards thanks to staff across the organisation for their efforts and dedication in planning and

delivering healthcare at the Trust . He wished to record grateful thanks.

The Chairman reported that sadly, there is a very sharp increase in the incidence of COVID-19 Delta variant, particularly in this region and that the Trust was preparing for dealing with the impact. He added that at this stage the Prime Minister is still optimistic about opening up on the 19th, The Chairman was keen to emphasize staff achievements and mentioned the Trust had received the most improved trust in terms of the Freedom to speak up in the latest National Guardian's report and the Board was delighted that Dr Henrietta Hughes had attended the Trust this morning and given a presentation on her work. She is stepping down this year after achieving so much to strengthen an open culture in the NHS.

The Chairman added that the Trust was awarded the international Environment Management award. It's the first of any trust in in England to receive this accreditation and thanked Mr Kevin Oxley and his team for this remarkable achievement.

The Chairman congratulated Mr Ben Murphy, Head of our Hospitals Charity for completing his sponsored skydiving challenge for the charity.

Referring to the integrated care system legislative changes the Chairman reminded members that it is important that we as a trust together with our partners in the Tees Valley and North Yorkshire take every opportunity to be strongly represented. This twill undoubtedly in the long run be reflected in the way in which the system is managed.
The Chairman was pleased to report that the Council of Governors working with North Tees & Hartlepool NHS Foundation Trust Council of Governors had unanimously approved the appointment of Professor Derek Bell, OBE as permanent joint chairman who will take up the role from the beginning of September. He added that Derek Bell is a eminent physician and clinical leader. The Chairman advised that it has been a very complex recruitment and appointment process, which involved very close working between the Council of Governors and Nomination Committees of both Trusts.

Mrs Seward spoke on behalf of the Council of Governors to thank the Chairman for helping lead them through the recruitment process for the permanent appointment of a Joint Chair.

Resolution

The Board of Directors NOTED the Chairman’s report.

BoD/20/281 **CHIEF EXECUTIVE'S REPORT**

Mr Harrison on behalf of Ms Page referred members to the CEO report and added that there is a report on the agenda on CQC and it is really important for us to see where we're seeing improvements in the Trust and how that then fits to the revised improvement plan. A number of enabling plans / strategies are on the agenda today for Board approval, the People Plan, which has been through the people committee and the second one being the communications and engagement plan. So again, we should start to see how these things are coming together, and how they support delivery of the 2 year strategic plan.

Mr Harrison reported that the CQC visited the Trust and inspected the radiotherapy department and that was a really positive visit. We're waiting for the full final written feedback but initial feedback on the day was very positive and the team should be really proud of the work that they put in.

Mr Harrison referred members to the update in the CEO report regarding the Pill-sized cameras which are now being used at The James Cook University Hospital to investigate and diagnose bowel abnormalities.

Previously, patients would need to undergo a colonoscopy procedure at the hospital but now, thanks to state-of-the-art cameras, suitable patients are being given the option to undergo the examination from the comfort of their own home.

He advised that this is not new technology and has been used for a number of years but higher up in the bowel.

Mr Harrison reported the position with COVID in the Trust and reminded members that we have seen an increase over the last week as a result of the higher rates of community prevalence of COVID and in the last week we've gone from a relatively low number of inpatients up to 30 in patients. He added that senior clinicians continue to lead our response to two COVID to make sure that pathways are supporting both staff and patient safety throughout.

Finally Mr Harrison thanked Mrs Fallon, Interim Director of Planning & Recovery who has been with the Trust for around 18 months and has done a huge amount of work including developing the Integrated Performance Plan, 2 year strategic plan and improvement plan.

Mr Harrison also thanked the Chairman for stepping in for last six months and fulfilling the brief to appoint a permanent chair.

Resolution

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

BoD/20/282 **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 99.36% as per table 1 demonstrating good compliance with safer staffing.

Critical Care move back to their pre COVID footprint but have a higher number of level 3 patients requiring 35 -37 nurses per shift. There have been no reported episodes for lack of supernumerary co-ordinators during May 2021.

Staffing during May has effectively supported the acuity and dependency of patients based on data from the SafeCare staffing tool.

Nursing Turnover for May is currently 7.6%

Monthly International RN recruitment continues with the last 6 arrivals travelling in early July, which includes the three nurses from India delayed due to escalating cases across the country.
Student nurse interviews have taken place and are in the process of being appointed to posts.

Dr Lloyd highlighted that ED and critical care are busy and being supported by other departments. This is mainly due to sickness. There were no staffing factors identified as part of a review of incidents.

Compliant for birth rate plus for midwifery.

Ms Reape asked whether the Trust are retaining most of the student nurses and Dr Lloyd advised that everyone wants to come and work for us which is really good. She added that these students have had quite some months now of not traditional nurse training because they have been deployed in supporting us with COVID. Ms Reape thanked Dr Lloyd and commented that this is most commendable.

Mr Jennings thanked Dr Lloyd for the report and assurances given. He asked if there were any issues the Board need to further focus in on in preparation for CQC. Dr Lloyd advised that the Trust have high levels of compliance with staffing levels which is pleasing. She added that she will be presenting to the Board later in the year the staffing establishment review to be compliant with NQB recommendations.

Dr Stewart commented that the last CQC visit highlighted a lack of compliance with GPIC standard. However it he can give assurance that staffing is safe for patients and specialist high level areas are staffed to our model of care.
Mr Jennings asked if we have plans in place. Dr Stewart commented that he is happy we have the staffing to provide the right standards of care for patients.

The Chairman commented that there are a number of ward areas where there are levels of pressure ulcers if there were any issues relating to staffing, patient acuity etc. Dr Lloyd advised that as she had explained last month the numbers relate to A&E and assessment areas and these are patients who attend with pressure damage on admission and this accounts for the numbers in these areas.
The Chairman acknowledged this but numbers had increased asked he if any cases related to patients admitted from Care home settings where the Trust could consider support with staff training. Mrs Angel added that there are plans to extend the enhanced care home offer beyond covid across the care home sector and this should support the work in the Trust on pressure damage through good integrated working.

Resolution

The Trust Board of Directors NOTED the safer staffing report

BoD/20/283 **CQC UPDATE**

Dr Lloyd presented an update on CQC and reminded members that there had been a robust discussion in the mornings Board development session. She reminded members that 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. Dr Lloyd was pleased to report that good progress has been made on the action plan, with a small number of issues still to resolve, with clear risks identified and mitigation in place. Alignment of all CQC action to Collaboratives for awareness, sign off and focus on trust wide actions as part of improvement plans has been undertaken and awareness sessions held throughout June for all clinical collaborative chairs, clinical policy groups members, senior professional forum and allied healthcare professionals forum around CQC

Dr Lloyd advised that preparation for the next inspection paper had been shared and agreed at the Trust Board on 4 May 2021.

Finally that recognition that the Covid-19 pandemic has affected the appraisals and mandatory training compliance (M6) which is an outstanding action.

The Chairman commented on the new approach the CQC are taking around support and risk based and was encouraged by this.

Dr Lloyd was also pleased to report that the Trust had received an ERMRE inspection and feedback on the day was positive.

The Chairman asked Dr Lloyd when amber actions will be resolved. Dr Lloyd advised that this should be in the next couple of months. Mr Redpath asked for timescales to be included in reports going forward.

Resolution

The Trust Board of Directors NOTED the CQC update

BoD/20/284 **FREEDOM TO SPEAK UP REPORT**

The Chairman reported that the National Freedom to Speak Up Guardian had kindly attended the Trust today and had presented the latest national position with regard to Freedom to Speak up and her views on what the Trust could do further at the Board Development session in the morning. The Freedom to Speak up Guardians also took the opportunity to present this quarter's report to the Board. For completeness Dr Lloyd reported that the new FTSU model continues to work well across the trust and staff have a greater awareness of the freedom to speak up ethos which is evident in the FTSU index score published last month.

Staff continue to speak up within the organisation and the number of concerns reported have remained constant over the last quarter.

More staff from a variety of backgrounds are speaking up and raising concerns within the organisation. There were 16 concerns raised between 1st April 2021 and 10th June 2021, with one concern being reopened. In the last quarter (1st January 2021 to 31st March 2021) there were 17 cases. The main themes identified from the 16 concerns are:

- Leadership and Management (7)
- Incivility/Culture (6)
- Bullying and Harassment (5)
- Favouritism/Nepotism (4)

To support the development of the 13 FTSU champions we have re-established training and have also recruited a further two new champions, which will complement the diversity of our champions across the Trust.

The team has forged links with Teesside University and have

delivered two sessions to the health care students, raising the awareness and profile of FTSU, with this due to become a regular event.

The NGO published the FTSU index in May 2021 in which we were asked to contribute a case study due to South Tees being the 3rd most improved trust overall and the 1st most improved acute Trust.

Resolution

The Trust Board of Directors NOTED the FTSU report

BoD/20/285 **STAFF HEALTH AND WELLBEING UPDATE**

Mrs Metcalf was pleased to share an update with the Board on the work to support staff with health and wellbeing. Members noted that this is one of the workstreams of the People Plan which the Board were due to receive this afternoon and had considered at the morning Board Development Session. The People Committee have oversight of this work.

Mrs Metcalf advised that there have been many achievements for health and wellbeing in the last year with initiatives and activities increasing as we continue to focus on supporting the people who work in our organisation, highlighting a number of these included in the report. She advised that we want to make South Tees a great place to work and looking after the health and wellbeing of our workforce is a key component of this. We are aiming to create a wellbeing culture with a range of initiatives that are available and relevant both to our current and future workforce.

Good health and wellbeing of our workforce is a key focus of our People Plan as is providing support for mental, physical and financial wellbeing.

The Chairman thanked Mrs Metcalf for the update and asked if there is anything more as a Trust we should be doing to support our colleagues . Mrs Metcalf advised that we are doing a lot and its important we take forward the initiatives we have agreed to do so, so we can embed them in the organisation.

The Chairman also added that we are not yet free of COVID 19 and staff having been through so much any further challenges will be demanding on them. As a Board we need to review this routinely and with emphasis on listening.

Mrs Metcalf advised that the new appraisal document which was launched last month is underpinned by a health and wellbeing conversation in line with the people plan.

Resolution

The Trust Board of Directors NOTED the health and wellbeing update

BoD/20/286 **FINANCE REPORT**

Mr Hand presented the 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 2 the Trust reported a deficit of £1.9m at a control total level. This is in line with the required budget deficit for M2 as agreed within the ICP/ICS.

Mr Jennings asked Mr Hand where the Trust is with the cost improvement programme (CIP). Mr Hand advised that we are largely on track with savings identified of around £1.1m and a number of savings which need further validation, and we should see an improvement in this next month. He added that CIP becomes more challenging as the year progresses.

The Chairman commented that there is generally national uncertainty at the end of the year. He asked Mr Hand how he sees things progressing. Mr Hand advised that there is a national finance briefing this week so anticipated a more gradual return. He added that there are discussions in the ICS around how we allocate capital resource.

Ms Reape asked if there were any quality or safety issues in relation to the capital programme underspent on FHN Critical Backlog maintenance £0.2m. Mr Oxley advised that everything was fine and all on track now.

Resolution

The Trust Board of Directors NOTED the update

BoD/20/287 **FINANCIAL PLAN**

A meeting had been held to discuss the plan and further work was progressing on the next stage. Mr Hand asked that the Board delegate authority to the Resources Committee to have oversight and sign off the next stage iteration on behalf of the Board.

Resolution

The Trust Board of Directors AGREED to delegate

responsibility to the Resource Committee for oversight and sign off of the next stage in the financial plan

Mrs White / Mr Hand / Mr Ducker

BoD/20/288 **INTEGRATED PERFORMANCE REPORT**

Mr Peate referred members to the Integrated Performance Report which had been previously circulated and highlighted that the Trust has continued its COVID-19 response during May alongside maintaining emergency, urgent and other non-COVID-related care. Clinical teams are now focused on addressing the needs of patients whose non-urgent care has been disrupted or delayed by the pandemic.

Areas of improved or sustained performance include:

- Caring domain indicators: Complaints closed within target timescale, and Friends and Family Experience rates for Inpatients, Outpatients and Maternity all remain above target
- Cancer standards for 14 days and 31 days achieved the provisional target in March.

Areas for focus include:

- ED performance continues to improve in month, however it is still below the expected level.
- RTT and diagnostics are still below the constitutional standard due to the pandemic, however the planned activity has been delivered.
- VTE compliance following changes to recording methods and steps in place to improve completeness of data
- To support operational focus on Annual Appraisals and Mandatory Training to improve compliance.

Mr Peate also discussed that yesterday was one of our busiest day in ED. Referral rates into the Trust are at pre COVID 19 rates, which is positive but give us another set of challenges. Further we are being impacted by staff absences due to test and trace and other activities COVID 19 related.

Dr Stewart commented that a decision has been made at in Strategic Command today to reinstate the COVID 19 pathways (red, amber, green) to protect staff and patients however cautioned that and this will slow down recovery and elective work. He added that the Trust is seeing an impact on staffing numbers due to family members being ill and staff isolating. Dr Stewart advised that we are watching what is happening North of the patch as we are normally a couple of weeks behind their trend.

The Chairman commented that this will create uncertainty with regard to the national announcement to open up the Country and will need careful management. Dr Stewart

concurred and commented that we will need to protect our staff and patients during this time.

Ms Reape asked whether the CCG will issue some communications to the public regarding the impact the pandemic is having as the public may believe the NHS is back to normal despite the pressures and if staff are met by the public making demands on services it is important to recognise this.

Dr Stewart advised that the Trust are putting some communications out to staff and working with partners on a community response. He added that staffing shortages is the main issue for us. Dr Stewart also updated the Board that the other impact of Strategic Command's decision today is that staff will be returning into PPE during the summer / hotter months and the impact this will have on staff morale will need to be considered. The Chairman thanked Dr Stewart for providing this update and advised that staff have the support from the Board and we must do whatever is necessary to protect staff and patients.

The Chairman asked for further information on VTE, Dr Stewart reported that the situation remained the same as last month and the issue relates to recording and the Trust has not been doing this accurately. He advised that the Clinical Lead is working with the ward clerks to improve the accuracy of recording and once we get the new electronic prescribing system we should start to see some improvement.

The Chairman asked for further information on the 62 day cancer target. Mr Peate advised that the Trust has focussed on P2 and P3 as part of the ongoing work through COVID 19 and recovery which has caused some disruption in patients requiring surgical intervention. We are working through this in terms of access to theatre time and should see this improving over the coming weeks.

The Chairman asked Mr Peate regarding the number cancelled ops and asked if this was due to access to critical care. Mr Peate advised that the Trust has seen an increase in acuity and the number of level 3 patients we have in the organisation. He added that we are bringing patients in as quickly as possible where care has been disrupted during the pandemic. Dr Stewart added that we are seeing more on the day cancelations – this is due to critical care requirements and the complexity of the work we undertake at South Tees Hospitals NHS Trust.

Ms Reape asked if there anything we do in critical care which isn't deemed as good practice. Mr Harrison advised that the ICNARC data for the Trust is good and the readmission data is good. Mr Harrison suggested that the Board delegate

authority to the Resources Committee to discuss and agree the nest steps. Mr Ducker, Chair of Resources Committee agreed this was a sensible approach.

The Chairman was pleased to see sepsis metrics recorded in more detail and asked Dr Stewart if there was any more progress with this. Dr Stewart advised that the system roll out starts this month. He has asked ED to do a separate analysis on our sepsis 6 compliance on patients presenting with sepsis to ED and will update Quality Committee on behalf of the Board on the outcome.

Mr Ducker commented that he would like to place on record his thanks to Mrs Fallon on behalf of the Resource Committee with regard to the Integrated Performance Report which she had taken a lead on producing which Mr Ducker felt had come on leaps and bounds.

Mr Ducker noted the slight uptick on number of positive patients in the Trust and asked if we record age profile for the patients or vaccination status so we know who are coming in. Dr Stewart advised that the Trust doesn't record vaccination data to allow us to analysis this; we do record age profile, and we are seeing more younger patients and more needing admitted to critical care. This included younger patients unvaccinated, older patients with other illnesses / frail elderly who have significant mortality despite being vaccinated.

Resolution

The Trust Board of Directors NOTED the update

BoD/20/289 **OPERATIONAL AND IMPROVEMENT PLAN**

Mrs Fallon presented the Operational and Improvement plan which had been presented to the Board in the mornings Board Development Session in detail. Mrs Fallon reminded members that the Improvement Plan sets out a two year Trust strategy and operational plan to drive our recovery and getting back to our best.

In February 2020 following the CQC inspection and subsequent changes in leadership an Improvement Plan was approved by the Clinical Policy Group and Trust Board. Following the clinically led response to the Covid 19 pandemic the Improvement Plan has been refreshed. The Improvement Plan sets out our vision for a clinically driven organisation that puts safety and quality first. The trust strategy was developed with wide clinical engagement and will be delivered through nine enabling strategies.

The Chairman thanked Mrs Fallon for presenting the improvement plan in such detail also in the earlier Board

Development session.

Mr Ducker suggested that the document would benefit from section on the main risks we see to implementation and the mitigation we intend to take. He noted that the BAF captured the principal risks but it might be useful to start thinking about the key operational risks driving some of these strategic plans.

Mrs Metcalf shared the People Plan with members of the Board and advised that the Plan had been signed off on behalf of the Board by the People Committee. She advised members that this is also a two year plan focussing on making significant improvements around culture, values and behaviours of the organisation.

The Chairman commented that one of potential benefits of working collaboratively as organisations in the NHS is to remove unhelpful competition for recruitment and retaining staff and to create more resilience. Mrs Metcalf advised that this will be covered gaps in the areas of specialist recruitment.

Mr Jennings commented that it was a really good plan and makes sense and he liked the clarity in which it is set out; he added that he was expecting to see a plan, who, what, when, how and what all the actions are in terms of delivering this. Mrs Metcalf confirmed that there are 5 action plans underpinning the People plan which have all the detail in terms of when is being delivered and when.

Resolution

The Trust Board of Directors APPROVED the Operational and Improvement Plan, Communications and Engagement Strategy and People Plan

BoD/20/290 **BOARD ASSURANCE FRAMEWORK**

Mrs White referred members to her previously circulated report and highlighted that the Board received at its last meeting a first draft of the revised Board Assurance Framework identifying the process which has been undertaken to identify the principal risks and next steps in the process.

Since the last meeting all Board Sub Committees have reviewed the BAF again in its new format and agreed the principal risk and threats. Gaps have been identified including clarity on actions, responsibilities and implementation dates and Chairs of Board Sub Committees have agreed to sign off their element of the BAF.

The standard operating procedure for the BAF has been drafted and over the next couple of weeks this will be tested out with the Chairs of Committees and Executive Leads for their BAF risks by the incoming Audit & Risk Committee Chair and Company Secretary to further refine and agree the level of assurances.

The Chairman thanked Mrs White for the progress made and commented on the escalation process to ensure that this includes an exception report to the Board each meeting. Mr Harrison commented that this could be included in the CEO report to Board.

Mr Jennings thanked Mrs White for the work and agreed with the next steps in developing the assurance process. He added that it would be good also for Committees to consider the threats that we don't know about and that we should be worried about and highlight this in meetings.

Resolution

The Trust Board of Directors NOTED the update

BoD/20/291 **COMMITTEE REPORTS**

The Chairman offered Chairs of Committees the opportunity to update members on any issues not already covered by the agenda:

Resource Committee – Mr Ducker updated that the Committee had received a thorough update on Digital and considered the digital investment plans which are significant and far reaching. He advised that these need to be carefully managed and have significant resource requirements on a stretched organisation. Mr Ducker confirmed that the Friarage Theatre plan was supported by the Committee but recognised this will require support from partners.
Mr Hand updated on the financial recovery plan which had been submitted to NHSE/I.

People Committee – Mr Carter Ferris on behalf of Ms Burns updated that the Freedom to speak up Guardians had presented their report to the Committee and there had been a thorough discussion on the issues raised.

Quality Assurance Committee – Ms Reape advised that the Committee had received update reports on ophthalmology and gastroenterology which were quality and safety risk areas. She advised that a tremendous amount of work had been undertaken but there was further work to be completed around the risk level for Ophthalmology. The Draft Quality Account had been circulated and would be considered at the next meeting for sign off.

With regard to Ophthalmology Mr Peate advised that the team are working to reduce waiting, but pressures remain around social distancing. Fortnightly meetings with the directorate continue. Significant improvement in this service has been undertaken over last 18 months. .

BoD/20/292 **QUESTIONS FROM THE PUBLIC**

The Chairman offered members of the public and observers the opportunity for questions. There were no questions raised.

BoD/20/293 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Public Board of Directors will take place on Tuesday 7 September 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	Draft standard operating procedure in place - shared with D Jennings and comments received. Slippage in completion date due to further check and challenge on BAF with committee chairs and executive leads taking place during July. Should be complete for August.	open

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 7 September 2021			
Chief Executive update			**AGENDA ITEM: 7, ENC 4**
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 update

The fall in community infection rates has been followed by a gradual decline in the number of patients needing COVID-care in hospital.

The patients receiving COVID-care continue to be younger than those seen in previous waves and most have had no vaccine or only one dose. That is why it is so important for people who have not yet received their vaccine to join the millions already jabbed.

The NHS has been asked to prepare for the third phase of the vaccination programme and the details on who will receive a booster jab and when, will be made nationally when the Joint Committee on Vaccination and Immunisation (JCVI) makes its final recommendation.

In the meantime, our vaccination team and occupational health colleagues are preparing for this year's staff flu immunisation programme and planning for COVID booster jabs which (at the time of this report's writing) are being considered by the Joint Committee on Vaccination and Immunisation (JCVI).

GMC training survey 2021

The GMC training survey for 2021 has been published which shows the trust in the top-quartile nationally for overall satisfaction. The trust has been ranked the second highest hospital trust in the region for overall satisfaction by doctors in training.

Health and Care Bill

The Health and Care Bill received its second reading in the House of Commons on Wednesday 14 July and is expected to go through to Common's committee stage in autumn 2021. The majority of the Bill focuses on establishment of Integrated Care Systems on a statuary footing from April 2022, with responsibility for overseeing health services in 42 regions including the North East and North Cumbria.

Emergency care standards

In March 2019, the Review of NHS Access Standards was published, which proposed that the current four-hour A&E target should be replaced by a set of access standards, including the average waiting time in A&E, time to initial clinical assessment, and time to emergency treatment for critically ill and injured patients.

NHS England has subsequently confirmed its intention to replace the 4-hour waiting time target with a proposed bundle of indicators. Under the proposed new measures, patients will need to be seen within 15 minutes of arriving at A&E for an initial assessment and hospitals will be monitored based on an average time in the department.

The proposed measures also include response times for ambulances, reducing avoidable trips to Emergency Departments by ambulances, the percentage of ambulance handovers within 15 minutes, and the percentage of patients spending more than 12 hours in A&E.

The trust's medicine and emergency care services clinical collaborative chair Ramamurthy Sathyamurthy is working with clinical directors to develop new clinical pathways to support the new model in anticipation of its national adoption.

New laparoscopic theatres open

Two new laparoscopic theatres were officially opened at The James Cook University Hospital in August.

The purpose-built operating theatres feature advanced imaging technologies with multiple flat-screen monitors and leading edge laparoscopic equipment. They are also the first in the region with ICG technology which uses a special dye to pin-point the exact location of a tumour in relation to adjacent vital organs.

Laparoscopic surgery has been performed at James Cook for many years, but for the first time surgeons at the Middlesbrough hospital can now carry out their life-saving work in a dedicated facility.

Organ donation

Figures published by NHS Blood and Transplant show The James Cook University Hospital as one of the top 20 organ donor hospitals in England. The figures show that hospital increased its donors last year despite a fall nationally in the number of patients receiving transplants.

New Friarage academic centre

A new academic centre which will benefit medical students for generations to come has officially opened its doors at the Friarage Hospital in July.

The centre, located above the Gara ward, will put the Northallerton hospital at the forefront for providing cutting-edge training facilities for undergraduate and postgraduate medical students as well as for staff.

It will also provide a range of training opportunities for healthcare staff across North Yorkshire, Hambleton and Richmondshire in the future.

Thanks to a £400,000 donation from the Friends of the Friarage the new STRIVE centre features an immersive simulation teaching space, a library, three teaching rooms, and a computer room, a common room, offices and a video wall.

Robotic exoscope

The James Cook University Hospital has become theis the first in the north east, and the second in the country, to benefit from a robotic exoscope which allows neurosurgeons unprecedented 4K-3D views of the brain and spine during surgery.

Unlike a traditional microscope, that requires surgeons to endure hours looking into an eyepiece, the new ORBEYE exoscope gives medical teams the ability to see the finest anatomical structures in deep parts of the brain on a large 3D monitor in real-time.

Patient check-in kiosks introduced

Kiosks have been installed outside main outpatients, at retinal therapy, near Costa and in the small atrium near eye outpatients, to help reduce queues in reception areas and wasted appointments as part of a new pilot scheme to improve patient experience and go live in September.

Patients will need to enter details such as date of birth and surname to gain access to the system and volunteers will be close by to give assistance if required.

The kiosks will go live week commencing Monday 13 September and will be piloted in four areas once access testing and staff training is completed:

- Main outpatients
- Trauma outpatients
- Eye outpatients
- Retinal therapy

Only patients using these four areas will be able to check-in using the kiosks.

The state-of-the-art kiosks will link to our patient information system and will enable colleagues to track patients, complete digital forms and have easy access to audit data.

They will be able to quickly see if a patient is still with another specialty or has cancelled their appointment.

The 12-month pilot will be regularly reviewed and if successful it could be rolled out across more areas on a permanent basis.

Friarage clinic helps children suffering from long COVID

Children suffering with long term coronavirus symptoms in Tees Valley and North Yorkshire are now accessing a specialist service at the Friarage.

The new paediatric clinic is the second specialist long COVID service set up by the trust. A clinic for adults was set up at Redcar Primary Care Hospital in December 2020.

The clinic, which is looking after children who are experiencing fatigue, anxiety, 'brain fog' and other debilitating symptoms, is one of the two hubs in North East and North Cumbria and one of the 15 hubs in England specifically for children and young people suffering from long COVID.

Our Hospitals Charity

Our Hospitals Charity held its first Charity golf day at Middlesbrough golf club on Friday 20 August 2021. The Charity was overwhelmed by the generosity of companies and individuals who supported the day, taking part and donating gifts and prizes for the event.

Freedom to Speak Up

The trust has been shortlisted for this year's HSJ Freedom to Speak Up Organisation of the Year Award which will be announced on 18 November 2021.

2. RECOMMENDATIONS

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

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 7 SEPTEBER 2021			
Board Assurance Framework			**AGENDA ITEM: 8 ENC 5**
Report Author and Job Title:	Jackie White Head of Governance & Co Secretary	Responsible Director:	Jackie White Head of Governance & Co Secretary
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	The Board have previously approved the development and composition of the Trust's two-year strategic plan and the improvement and recovery plan which sets out the strategic objectives of the Trust. Following this the Board identified the principal risks to achieving the strategic objectives. The Board of Directors tasked the Board sub committees to undertake the scrutiny and assurance of the principal risk, controls and gaps.		
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. 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. 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 on two occasions (one for Resources) since the last report to Board. 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. 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 Principal risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain • Safe Staffing Report • Doctor Revalidation & Appraisal Update Report • Integrated Performance Report 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 4 • 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 ☒
	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 ☒	

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.

All three Committees acknowledged the increased ***threat*** to staff health and wellbeing, impact on delivery of services and quality and safety with the increase in COVID activity. No other threats were identified during this period.

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 8 reports of assurance and 1 report which gave part assurance on a gap.

Quality Assurance Committee received 8 reports of assurance and 3 reports which gave assurance on gaps.

Resources Committee received 5 reports of assurance and 2 reports which gave assurance on gaps and 1 part 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

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

- Safe Staffing Report
- Doctor Revalidation & Appraisal Update Report
- Integrated Performance Report

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 4

- 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.

3.4 Standard Operating Procedure

A standard operating procedure has been drafted which describes the integrated governance and internal control processes within the Trust and the way the Board and the management of the Trust receive its assurance they are operating effectively. It takes account of best practice guidance.

4. RECOMMENDATIONS

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

APPENDICES
BAF

South Tees Hospitals
NHS Foundation Trust

Board Assurance Framework (BAF): August 2021

This BAF includes the following Principal Risks (PRs) to the Trust's strategic priorities:

- 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
- A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water, IT), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period and compromises ability to deliver high quality care
- Failure to recruit to full establishment, retain and engage our workforce
- Failure to deliver as a centre of excellence, resulting in a lack of priority and recognition from commissioners and other stakeholders
- Working more closely with local health and care partners does not fully deliver the required benefits
- Failure to agree with the system and achieve the Trust's financial strategy resulting in regulatory action and inability to delivery strategic objectives

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level)
- Risk ratings – initial, current and target levels
- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (**Averse** = aim to avoid the risk entirely; **Minimal** = insistence on low risk options; **Cautious** = preference for low risk options; **Open** = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment strategy identified for each threat and opportunity, each assigned to an executive lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance functions** (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers)
- Clearly identified gaps in the primary control framework, with details of planned responses each assigned to a member of the Senior Leadership Team (SLT) with agreed timescales risk

Key to lead committee assurance ratings:

Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity
- no gaps in assurance or control AND current exposure risk rating = target
OR
- gaps in control and assurance are being addressed

Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

Red = Negative assurance: the Committee is satisfied that there is sufficient reliable evidence that the current risk treatment strategy is not appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

South Tees Hospitals
NHS Foundation Trust

Principal risk - 1 (what could prevent us achieving this strategic priority)	**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**	**Strategic Objective**	**Best for safe, clinically effective care and experience**

Lead Committee	Quality Assurance Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk type**	
Executive Lead	Chief Nurse/Chief Medical officer	**Likelihood**	4. Likely	4. Likely	3. Possible	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	4. Major	4. Major	3. Moderate	**Risk treatment strategy**	
Last reviewed	23.8.21	**Risk Rating**	16. Extreme	16. Extreme	9. High		
Last changed							

Threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / action to address gaps inc timescales and lead** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
1.1 Significant reduction in patient satisfaction due to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality	Corporate, Collaborative and Directorate structures, accountability & quality governance arrangements at Trust including: • Tier 1 Board Sub Committee and sub structure review undertaken and implemented July 2021. • Nursing and Midwifery and AHP meeting • Clinical policies, procedures, guidelines, pathways • Clinical audit programme & monitoring arrangements considered at QAC and Audit Committee • Clinical staff recruitment, induction, mandatory training, registration & re-validation • Defined safe nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) • Ward accreditation programme - STACQ • Nursing & Midwifery Strategy • Sign-off process for incidents and Sis and Never Events • Established and robust QEIA process • Freedom to speak up process in place • Patient Experience sub group in place • Shared learning on quality and safety via weekly, monthly briefings Trust wide and at CPG/SLT • Medical Examiner's office in place	**Management:** Learning from deaths Report to QAC and Board quarterly EoLC Strategy and Annual Report to QAC Senior leadership walk arounds weekly Deep Dives of critical services at QAC (ED, Ophalmology, Gastroenterology, Critical Care) Guardian of Safe Working report to Board quarterly Safeguarding Annual Report to QAC Medical Education update report to People Committee quarterly Freedom to Speak up report to People Committee quarterly Medicines Optimisation Report to QAC quarterly Revised structure for mortality / learning from deaths report to QAC July 2021 CQC preparation plan for future inspection report July 2021 **Risk & compliance:** IPR - Quality Dashboard Monthly QAC and Board Quality Priorities Report Qtrly to QAC Incidents and SI report to QAC monthly CQC report to QAC monthly Health & Safety meeting escalation report to QAC Urgent items for escalation at QAC monthly **Independent assurance:** CQC Rating and oversight (monthly relationship)	Develop AHP Strategy – Ms Mhalanga – November 2021 (People Committee) Identify requirements for Children & Young People Annual report for QAC – Ms Brammer – July 2021 Review portfolio arrangements for clinical and non-clinical risk – Dr Lloyd/Dr Stewart/Mr Oxley / Mr Bennett – July 2021 Review recommendations and develop a plan for implementation of NHSE/I never events critical friend – Dr Lloyd – September 2021 Review the CQC insights tool to establish the key safety concerns as highlighted by the report and develop a plan to address these issues and provide assurance through QAC – Mr Bennett – July 2021	

		ICNARC Quarterly Report to Clinical Effectiveness Group Audit Inpatient Survey 2019 GMC Feedback to People Committee Care Quality Commission / External Regulation Care Quality Commission / External Regulation Report to QAC CCG Directors of Nursing in attendance at QAC Internal Audit reports PWC (in line with the Internal Audit Plan -; SIs, Prescribing)		
1.2 An increase in the incidences of infectious disease (such as CDIF, influenza; Coronavirus; norovirus; infections resistant to antibiotics) that forces closure of one or more areas of the hospital	Infection prevention & control programme, policies, procedures, staff training and audits PFI arrangements and cleaning standards Review panels of all trust apportioned of all infection disease incidents Clinical Audit programme and monitoring arrangements. Ward accreditation programme - STAQ Weekly IPC huddles Antibiotic stewardship programme in line with revised QAC reporting structure Daily outbreak report aligned to COVID Weekly regional outbreak meeting 14 HCA/PPE marshals / Fit testers and in place Matron for IPC appointed and team capacity increased Cohorting and isolation of patients in line with best practice	**Management** IPC reporting in line with revised QAC governance structure Reports to IPC Group IPC Annual report to QAC IPC breaches report – IPC Group **Risk and Compliance** IPC Committee escalation report to QAC IPR quality metrics report to QAC and Board monthly Cleaning standards report to IPC group **Independent Assurance** IBAF CQC review PLACE assessment and scores	Capital funding to support IPC initiatives and equipment replacement – Mrs Lance June 2021 (Resources Committee) Review of estate in order to consider the ability to increase side room facilities – Mr Oxley – August 2021 (Resources Committee) Compliance with SOP and Policies - further work required to ensure compliance being explored – ongoing monitoring Implement recommendations from Table top exercise with HR and OH on resilience within the team – Mrs Lance September 2021	
1.3 Lack of IT and administrative systems and processes for organisational learning from events such as incidents, complaints and claims, resulting in patient harms and poorer outcomes	Serious Incident Report (monthly) Serious Incident Investigations (root cause) Safety Bulletins – weekly and monthly Quarterly Patient Experience Report Real time patient experience reporting Clinical Audit programme and monitoring Collaborative Board meetings Review panels (Serious Incident, Pressure Ulcers, Falls, Deteriorating Patients, C. Difficile) Mortality Reviews Medical Examiner reviews Safety@stees collaborative Induction and education sessions for staff Patient Safety Faculty Clinical support unit development Regional Getting to good programme Weekly quality and safety wall Regular EQIA panels considering service changes and impact on safety	**Management** Monthly SI and Never event report to Quality Assurance Committee Implementation of the revised quality governance structure and sub groups Integrated Quality Report to QAC **Risk and compliance** IPR quality report to QAC and Board monthly Quarterly Health & Safety group review of incidents DATIX incident reporting levels monitored against NRLS Freedom to speak up Guardians quarterly report to People Committee Patient safety promises campaign **Independent Assurance** NRLS Benchmarking National Staff Survey to People Committee External Audit Independent assessment of Quality Report	Train key staff on incident investigation techniques to support increase in reporting culture – commenced – Mr Bennett – January 2022 Embed a sustained learning culture in line with trust vision, values and behaviours , civility and a just culture – Dr Connolly/ Mr Bennett – January 2022 Develop metrics for measuring the impact of learning and culture change – Mr Bennett / Dr Connolly – September 2021 Incident reporting upgrade - DATIX cloud – Mr Bennett – July 2021 Development of patient safety faculty	

		Internal audit report on Sis (PWC) CQC engagement meeting Internal and External Risk Summits on critical services NHSE/I Quality Board (stood down) NHSE/I Peer review on never events Quality Report (Account) July 2021 to QAC	– commenced – Dr Connolly – June 2021 Develop a patient safety and quality Strategy – Mr Bennett – October 2021 Increase number of staff who are training in human factors (linked to 21/22 Quality Priority) – Mrs Winnard / Mr Bridle – January 2022 (People Committee) Prepare organisation for the implementation of the patient safety incident report framework – Mr Bennett/Dr Connolly – January 2022	
1.4 Arising from a lack of engagement with staff at all levels around cultures and behaviours required to embed best practice, continuously learn and deliver high quality patient care.	Trust vales and behaviours agreed and shared with staff Just culture training – roll out Civility and Human factors training – roll out Ward accreditation programme Reciprocal mentorship programme – roll out Freedom to speak up guardians Patient Safety Faculty Patient Safety Champions / Ambassadors Weekly / monthly safety and quality briefings Revised QAC governance sub group structure Appointment of Clinical Collaborative Chairs CPG Constitution Falls and Pressure Ulcers Structure Judgement Reviews - weekly Senior Leadership Visibility programme Incident investigation and complaints training – roll out	**Management** Report and feedback on training for just culture, civility and human factors to People Committee Implementation of new Freedom to speak up model Roll out plan for ward accreditation programme agreed with QAC and CPG CPG constitution agreed and roll out Quarterly report to People Committee culture and leadership **Risk and Compliance** **Independent** National Staff survey results Freedom to speak up national survey Feedback from NHSE/I on review of never events	Implementation of revised QAC sub group reporting structure in relation to learning and embeddness from events – Mr Bennett – September 2021 Implement reciprocal mentorship programme fully across the Trust – August 2021 – Mrs Metcalf (People Committee) Develop roll profile for patient safety ambassadors/champions – Dr Connolly – August 2021 Prepare organisation for the implementation of the patient safety incident report framework – Mr Bennett/Dr Connolly – January 2022	
1.5 Lack of responsive and accessible services due to inability to deliver national performance standards	Patient Flow process in place Standard operating procedures and policies in place Trust and System escalation process Trust leadership of and attendance at A&E Board Deep dive into high risk areas, risk assessment and recovery plans monitored on a weekly basis as part of an incident control methodology Working with primary care and other stakeholders to manage demand through diversion and re-provision Single QSG review of constitutional standards and escalation of high risk areas SI process Clinical Harm review process Intensive support package agreed with NHSE/I and lead Director and network for support in place Emergency capital funding received and SDEC	**Management** Reports to Board on Winter preparedness (x to x) Monthly reports on COVID strategic decision to Board (x to x) Improvement Plan Phase 1 and reports to Board Recovery plans for high risk services and updates to Board and Committees and CPG Response to NHSE/I letter of 31 July 2020 (updated 7 August 2021) about the third phase of the NHS response to COVID-19 through CPG/SLT Response to NHSE/I letter of 20 August on Elective through CPG/SLT **Risk and compliance** QAC review and deep dive into critical areas Clinical Policy group addressing key issues and	Implement recommendations from the Internal audit on flow and waiting times – Mr Peate – September 2021 (Resources Committee) Implement the recommendations from the improvement work identified by ECIS – Mr Peate – September 2021 (Resources Committee) Recovery and Improvement Plan phase 2 to be completed and presented to the Board – Mrs Fallon – July 2021 (Resources Committee) Agree the revised process for	

	implemented, Paediatric ED being established Weekly touchpoint meeting with Commissioners Daily touchpoint meeting on patient flow	deterring the allocation of resources based on clinical priorities Improvement recovery plan Phase 2 - capacity and demand updates to CPG IPR report to Board monthly and sub committees Strategic Command structure and recovery structures in place **Independent Assurance** ECIS improvement work on patient flow Internal audit of patient flow (to be received)	managing and monitoring implementation of the recovery plan through the revised Assurance Framework model- Ms Tullock – July 2021 (Resources Committee)	
1.6 Current estate, lack of capital investment and infrastructure compromises the ability to consistently delivery safe, caring, responsive and efficient patient care, world class services	Improved access now in place for lifecycle investment (not available due to COVID restrictions currently Feb 21) Capital planning group in place Planned maintenance processes in place Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Low levels of back log maintenance Available wards for decanting (not available due to COVID restrictions currently Feb 21) Emergency capital bid 2020/21 Prioritised 5 year Capital plan developed and submitted to ICS for consideration	**Management** 5 year prioritised Capital Plan received by Resources Committee and Board and submitted Regionally January 2021 **Risk and Compliance** Report on lifecycle to Resources Committee Report on capital to Resources Committee quarterly **Independent Assurance** PLACE assessments ISO accreditation for medical engineering CQC report from July 2019 Visit by David Black and Alan Foster re Critical Care investment	Inability to release wards and theatres for lifecycle investment due to operational pressures. Issue being reviewed at Strategic and Tactical estates groups and being considered by the Clinical Strategy and Improvement Group. (Resources Committee)	

Principal risk - 2	**A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period and compromises ability to deliver high quality care**	**Strategic Objective**	**Best for safe, clinically effective care and experience**

Lead Committee	Quality Assurance	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk type**	
Executive Lead	Director of Estates	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	5. Catastrophic	5. Catastrophic	5. Catastrophic	**Risk treatment strategy**	
Last reviewed	23.8.21	**Risk Rating**	20. Extremely High	15. Extremely High	10. High		
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
2.1 A large-scale cyber-attack that shuts down the IT network and severely limits the availability of essential information for a prolonged period	Information Governance Assurance Framework Cyber security programme Major incident plan in place Spam and malware email notifications circulated	**Management** Data Protection and Security Toolkit submission 19/20 **Risk and compliance** **Independent assurance** Cyber internal audit report – weaknesses identified	Internal Audit report recommendations on cyber to be implemented – S Orley – date (Resources Committee) Date protection and security toolkit for 2020/21 to be completed – S Orley – date (Resources Committee)	
2.2 A critical supply chain failure that severely restricts the availability of essential goods, medicines or services for a prolonged period (EU exit)	EU Exit task and finish group review of operational response plan for monitoring issues following Brexit SRO for EU Exit appointed Premises Assurance Model (PAM) Estates Governance arrangements with PFI partner Emergency preparedness, resilience and response (EPRR) arrangements at regional, Trust, Centre and service level Operational strategies and plans for specific types of major incident, business continuity and critical incidents Strategic, tactical and operational command for major incidents Trust Resilience Forum and EPRR operational group EPRR Strategy in line with National EPRR framework Training and testing exercises undertaken annually Annual assessment against EPRR core standards On call arrangements in place	**Management** Health & Safety Annual report Condition survey report **Risk and compliance** **Independent assurance** Premises Assurance Model report to xxx EPRR report EPRR Core Standards compliance report Water safety report		

South Tees Hospitals NHS Foundation Trust

Principal risk - 3	**Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain**	**Strategic Objective**	**A great place to work**

Lead Committee	People Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk type**	
Executive Lead	Director of HR	**Likelihood**	5. Almost Certain	4. Likely	3. Possible	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	4. Major	3. Moderate	3. Moderate	**Risk treatment strategy**	
Last reviewed	19.7.21	**Risk Rating**	20. Extreme	12. High	9. High		
Last changed							

Threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / action to address gaps inc timescales and lead** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
3.1 Ability to attract and retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources. Failure to have effective workforce plans that anticipate and prevent shortages arising from retirements, shortfalls in all recruitment and retention plans	Vacancy management and recruitment systems and processes Safe nurse staffing levels for all wards and departments managed through daily huddles and escalation through to tactical and strategic Temporary staffing approval and recruitment process in place Specialist recruitment campaigns Work / link with university medical school and Memorandum of Understanding Nurse recruitment days AHP recruitment days International nurse recruitment programme Return to practice programme for nursing vacancies Flexible retirement and return process Increased apprenticeship workforce People Plan work stream on addressing workforce shortages HR Policies and procedures Engagement strategy (including rewards and recognition; engagement tools) Staff Engagement Group Visibility of leadership Board walk rounds Health and Wellbeing Strategy Exit interviews Workforce metrics contained in IPR STAR awards Partnership working compact with medical and staff side Pulse survey and staff survey (national) Freedom to speak up process Staff networks in place for some protected characteristics Contracting arrangements in place for SERCO and sub	**Management** Quarterly reports to People Committee on the 5 key workstreams in the People Strategy – ED&I, Health & Wellbeing, Leadership and Culture, Workforce Shortages, Sense of Belonging Safe Nursing Staffing levels report to Board monthly Use of resources in relation to staff reported to Resource Committee Disciplinary Report quarterly **Risk and compliance** Guardian of Safe Working report to Board May 2020 Freedom to speak up report quarterly People Committee review of risks on a monthly basis IPR workforce metrics reviewed by People Committee and Board monthly **Independent Assurance** NHSI use of resources report 2018 CQC inspection report July 2018 NHS staff survey 2020 results showing improvement in a number of areas	Medical and APH safe staffing levels report to People Committee – Dr Lal and Ruth Mhlanga - date _____ Directorate and Collaborative ownership and accountability and understanding of their workforce issues – output – workforce plan and accountability framework - Workforce tool kit to be developed by September 2021 – Jane Herdman Collaborative Chair to analyse and develop plans – November 2021 Collaborative Chairs to share workforce plans with People Committee – December 2021 _____ Establish clear report and visibility of collaborative agency spend and overtime – to be reported to Resource Committee – Dr Lal, Dr Lloyd – date September 2021 Dr Lal and Dr Lloyd supported by Luke Armstrong _____ Independent assurance required on e	**Amber**

	contractor workforce at the Trust Year on year increase in volunteer workforce Nursing & Midwifery Strategy		roster & allocate system to establish best use of resources – Resources Committee – Director of HR, Dr Lal, Dr Lloyd - date Independent audit review to be commissioned January 2022 _____ Further develop relationships with higher education and further education sectors to develop a talent pipeline and also enable our colleagues to develop into new roles. – Director of HR / Dr Lloyd Mrs R Metcalf and Hilary Lloyd November 2021	
3.2 Poor health and absence within our workforce creating service pressures impacting their ability to deliver a high quality service	Welfare calls to staff who are absent Health & wellbeing support programme Staff weekly briefing Psychology support and mental health support Occupational Health and counselling and physio service Wobble rooms established across sites for staff to recover and recoup Project Wingman (staff rest and support programme) Long covid clinics for staff Menopause programme insomnia intervention programme and fatigue support Flu and covid vaccination programme Hardship fund for staff	**Management** Quarterly reports to People Committee on the Health & Wellbeing Staff survey action plans at Collaborative level presented to the People Committee **Risk and compliance** Occupational Health accreditation award in 2021 **Independent Assurance** NHS staff survey 2020 results showing improvement in a number of areas	Embed wellbeing into leadership and management programmes – Ms J Winnard – 31 October 2021 _____ Embed conversations about flexible and agile working as standard practice – through embedding the culture Mrs R Metcalf November 2021 _____ Ensure health and wellbeing conversations occur as part of the annual appraisal system and as part of the return to work process following a period of absence Mrs R Metcalf December 2021 _____ Work towards the Better Health at Work Award which will assist in embedding health and wellbeing into the workplace. Mrs R Metcalf April 2022	**Amber**

			Support financial wellbeing by implementing a programme of workshops for colleagues who are considering retirement and require support with pension planning. Mr Emerson February 2022 _____ Implement policies relating to absence management and report on outcomes Ms Herdman January 2022	
3.3 Lack of an embedded agile workforce does not allow culture change and utilise technology to change work practices and to work differently which should increase the effectiveness of the service and deliver benefits to staff and patients.	Agile working policy with 'flexible choice' for working hours and ensuring our staff had adequate rest, recuperation and support. Staff Side colleagues to embed wellbeing into our HR Covid-19 Policy Pulse surveys Trust vales and behaviours agreed and shared with staff Freedom to speak up guardians	**Management** Freedom to speak up report quarterly Quarterly reports to People Committee on Health & Wellbeing **Risk and compliance** **Independent Assurance**	Establish evidence that policy and flexible choice has been embedded in the organisation Ms Herdman December 2021 _____ Establish home working group to support staff who remain at home or choose to work from home long term – Mrs Metcalf October 2021 _____ Ensure appropriate training programmes in effectiveness of technology and investment are implemented Mrs Metcalf and Mr Imiavan February 2021	**Amber**
3.4 Our culture and organisational development programme is not progressed leading to poor staff morale, less empowered teams, lack of progress of the equality and diversity agenda and less positive engagement.	BAME risk assessments ED&I strategy Workshop and roll out of values and behaviours Learning and development programme for staff development Weekly staff communications Schwartz rounds Collaborative staff survey action plans STAR awards and local GEM awards Freedom to speak up champions Improvement Plan with OD interventions linked to	**Management** ED&I Annual report WRES and WDES report to People Committee Quarterly report to People Committee on ED&I Reciprocal mentorship programme in development **Risk and compliance** Freedom to speak up self-review Board 2019 Freedom to Speak Up Guardian report quarterly to Board	Embed values based recruitment process Mr Emerson November 2021 _____ Develop on-board programme to continuously engage and retain staff during their recruitment and early stages of employment	**Amber**

	critical services Affina programme Human factors training Leadership and development programme Just culture and civility saves lives programme Culture workshops and values agreed and launched across the Trust Staff networks in place for some protected characteristics	Guardian of Safe Working report to Board; Gender Pay Gap report to People Committee **Independent Assurance** NHS staff survey 2020 results showing improvement in a number of areas Critical Care junior doctor survey discussed at People Committee 2021	Mr Emerson December 2021	

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

Lead Committee	Trust Provider Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk type**	
Executive Lead	Chief Medical Officer	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	4. Major	4. Major	4. Major	**Risk treatment strategy**	
Last reviewed		**Risk Rating**	16. Extreme	16. Extreme	8. High		
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
4.1 Lack of a clear vision for the improvement journey which engages staff and development the improvement capability leading to a failure to deliver sustainable change and the improvements required.	2 Year Strategic plan and objectives agreed and nine enabling strategies and plans identified Improvement plan Phase 1 People Plan Nursing & Midwifery Strategy Communications & Engagement Strategy Leadership development plan and programmes including quality improvement, team and service support, coaching and human factors CPG constitution Collaborative Chairs in place Mission, Vision and Values agreed and rolled out Leadership and Safety Academy developing Integrated performance report	**Management** Clinical Strategy & improvement Group Recovery groups meeting 3 times per week 2 year strategic plan signed off by Board in May 2021 Board development sessions on 2 year strategic plan CPG constitution signed off Improvement & recovery plan - phase 2 **Risk and Compliance** **Independent Assurance** One of the highest ranked medical training organisations Top 100 Apprenticeship Employer	Enabling Plans to be finalised – lead Directors - date	
4.2 Failure to deliver a programme of change in support of fragile or vulnerable services leading to a loss of quality, efficiency, outcomes and workforce shortages	Improvement Plan phase 1 Recovery plan including trajectories for improvement Thrombectomy service development OD programme Collaborative structure in place from April 2021 Clinical Strategy and Improvement Group Quality Improvement programme Medical and Nursing leadership changes implemented Medical Management Structure implemented ICS/ICP workstreams on vulnerable services	**Management** Recovery plan reported monthly to Resources Committee, Recovery Group and Board IPR monthly to Committees and Board CPG oversight and sign of of recovery trajectories Monthly reports to QAC on critical services, eg ophthalmology Deep dives by QAC on critical services **Risk and Compliance** **Independent Assurance**	ICS review of vulnerable service – M Stewart – date Stroke workforce resilience gaps in assurance – M Stewart - date	
4.3 Failure to be a leading centre for research and innovation centre	STRIVE centre for innovation Research Network across Tees Valley R&D Director and team in post	**Management** Reports to QAC on R&D and Board quarterly	R&D plan to be reviewed and updated – Director of R&D – date	

	Medical Management Model Research programme People Committee Leadership development programmes	**Risk and compliance** MOU with Teesside University for strategic links Collaborations with HEIs **Independent Assurance**	Estate available for regional centre (eg Cochlear implants, Cardiac Critical Care) inadequate for long term service sustainability – plan to be developed – Mr Oxley – date No fit for purpose estate for R&D – Mr Oxley - date	
4.4 Inability to recruit clinicians in specialist and sub speciality fields	Consultant recruitment panels with NED Chair Recruitment process now managed by CMO office Clear systems and processes on recruitment gaps and risks Alternative workforce development plan discussed at CPG	**Management** Report on new consultants and leavers to People Committee, SMSC and Board monthly Weekly report on consultants to CEO/CMO **Risk and compliance** **Independent Assurance** Actions completed from internal audit report on recruitment	Explore CESR program to establish in house training of consultant staff – Dr Lal - date	
4.5 Failure to adopt best practice or develop innovative practice due to inadequate systems and process	Clinical Strategy and Improvement Group Improvement and Recovery plan Phase 2 Clinical effectiveness group Getting to Good NHSE/I support group	**Management** Clinical Effectiveness quarterly report to QAC **Risk and compliance** **Independent Assurance**	Routine use of benchmark and / or information used by regulators such as CQC insight report consider by Governance Structures in Trust – Who – Date (QAC) Implement outstanding actions as identified in the clinical effectiveness / audit action plan – Mr Bennett (September 2021)	

Principal risk - 5	**Working more closely with local health and care partners does not fully deliver the required benefits**	**Strategic Objective**	**Deliver care without boundaries in collaboration with our health and social care partners**

Lead Committee	Trust Provider Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk type**	
Executive Lead	Chief Executive / Managing Director	**Likelihood**	5. Almost Certain	4. Likely	2. Unlikely	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	4. Major	4. Major	4. Major	**Risk treatment strategy**	
Last reviewed		**Risk Rating**	20. Extreme	16. Extreme	8. High		
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
5.1 Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	ICS CEO meeting ICS Management Meeting Joint development of plans at ICS level Provider Collaborative meetings and workstreams Representation on ICP/ICS and Provider Collaborative work streams Tees Valley ICP Executive Group Tees Valley ICP Compact Exec to Exec meetings with CCG and Trust Finance Directors Group Capital Plan amended June 2020	**Management** Partnership reports including Chairs log from JSB to Board Resources Committee Chairs log to Board Planning update to Board **Risk and Compliance** **Independent Assurance** Provider licence modifications lifted in relation to governance	Work with the ICP to further the expectations to strengthen ICP working - Managing Director – date June 2021 Consider further opportunities for joint appointments – Managing Director – June 2021	
5.2 Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	Improvement Recovery Plan Continued engagement with commissioners and ICS/ICP developments in clinical service strategies Partnership working with NTHT TV Clinical Services Strategy	**Management** Partnerships including Chairs log from JSB to Board Resources Chairs log to Board Planning update to Board **Risk and Compliance** **Independent Assurance**	Development of a co-produced clinical services strategy for the ICP – Chief Medical Officer – August 2021	
5.3 Failure to modernise the workforce profile to deliver integrated working and efficient use of resources for care across boundaries	ICS/ICP Workforce work stream JSB MOU	**Management** Partnerships including Chairs log from JSB to Board **Risk and Compliance** **Independent Assurance**		
5.4 The Trust will not maximise its potential to	Joint Strategic Board Objective of the JSB included in the MOU	**Management** Partnerships including Chairs log from JSB to Board	Further explore the opportunity to combine the resources of NTHT Public Health post	

contribute to the public health agenda if it does not coordinate its focus on prevention and healthy living with the wider health and social care system		**Risk and Compliance** **Independent Assurance**	– Managing Director – July 2021	
5.5 Joint working with North Tees & Hartlepool NHS Trust through Joint Strategic Board does not work effectively to deliver the benefits to the local population including the effectiveness of the Joint Strategic Board and Joint Chair	Interim Joint Chair and appointment process for Joint Chair Memorandum of Understanding, vision and values Joint Strategic Board (Committees in Common) including TOR Joint Board to Board, Council of Governors to Council of Governor development sessions Joint Nomination Committee (Committees in Common) Vice Chair job role supporting joint chair role Stakeholder Engagement with Local Authorities , MPs and local population, CCGs Clinical Policy Group Improvement Recovery Plan Capital Plan amended June 2020 Tees Valley ICP Executive Group Tees Valley ICP Compact Exec to Exec meetings with CCG and Trust Finance Directors Group Representation on ICP work streams	**Management** Joint Strategic Board and governance framework in place and approved by Trust Board Chairs log from JSB to Trust Board Interim Joint Chair update **Risk and Compliance** **Independent Assurance**		

South Tees Hospitals
NHS Foundation Trust

Principal risk - 6	Inability to agree financial recovery plan with the regulator	Strategic Objective	Make best use of our resources

Lead Committee	Resources	Risk Rating	Initial Rating	Current Rating	Target	Risk type	
Executive Lead	Chief Finance Officer	Likelihood	5. Almost Certain	5. Almost Certain	3. Possible	Risk appetite	
Initial date of assessment	21.5.21	Consequence	4. Major	4. Major	4. Major	Risk treatment strategy	
Last reviewed	23.08.21	Risk Rating	20. Extreme	20. Extreme	12. High		
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
6.1 Inability to demonstrate to the regulator the causes of the deficit and a credible recovery plan to address those elements within the Trust's control	Medium Term Financial Plan Resources Committee Trust Board Joint Strategy Board ICP Finance Directors ICS Finance Directors Tees Valley CEO meeting ICS Management Executive Reference Costs and PLICS Clinical Strategy and Improvement Group	**Management** Ongoing updates to SLT, CPG and CSIG Annual report and accounts Annual Governance Statement Medium Term Financial Assessment plan agreed by Resources Committee & Board and submitted to NHSE/I **Risk and compliance** Updates to Board and Resources Committee monthly Updates to ICP DoFs Financial recovery meeting with NHSE/I held July 2021 B2B meeting outcome letter from R Barker re MTFA August 2021 **Independent assurance** Review of PFI costs – Deloitte External audit of annual account NHSE/I monthly finance monitoring Provider licence restrictions – Letter from Tim Savage	A fully developed recovery plan underpinned by detailed analysis and detailed recovery proposals with clear timelines, and a governance and programme framework for implementation and delivery. – Mr Hand - 31 August 2021 PLICs development plan – Mr Hand – date	
6.2 Insufficient time afforded by the regulator to develop and implement a recovery plan	Medium Term Financial Plan Resources Committee Trust Board Joint Strategy Board ICP Finance Directors ICS Finance Directors Tees Valley CEO meeting ICS Management Executive Clinical Strategy and Improvement Group	**Management** Ongoing updates to SLT, CPG and CSIG Annual report and accounts Annual Governance Statement **Risk and compliance** Updates to Board and Resources Committee monthly Updates to ICP DoFs Financial recovery meeting with NHSE/I held July 2021 B2B meeting outcome letter from R Barker re MTFA August 2021 **Independent assurance**	Inability to agree within the system a credible and appropriately challenging CIP programme – Mr Hand – date Implement recommendations from Provider licence letter – Tim Savage – 18 June 2021 and 31 August 2021 Ongoing discussions with reginal NHSE/I colleagues – Mr Hand – date	

		Review of PFI costs – Deloitte External audit of annual account NHSE/I monthly finance monitoring Provider licence restrictions – Letter from Tim Savage		
6.3 Insufficient revenue resources available across the ICS to support the phasing of the Trust's proposed recovery plan	Resources Committee Trust Board Joint Strategy Board ICP Finance Directors ICS Finance Directors Tees Valley CEO meeting ICS Management Executive	**Management** ICS/ICP updates through Finance report and CEO report to Committees and Board JSB MOU **Risk and compliance** Regional Directors (2019) review of system savings report **Independent** ICP/ICS Plan submission approval by NHSE/I	Lack of recognition of PFI costs on revenue and the provision within ICS to meet the structural costs – Mr Hand - date Establish and receive external support to address the structural deficit - Mr Hand – date Establish joint contracting group with NTHT – Mr Hand – date Agree with the Commissioner the additional investment to address the cost of the safety issues – Mr Hand - date	
6.4 Insufficient capital resources available across the ICS to support the phasing of the Trust's capital investment requirements	PFI Contract management Capital planning group Planned maintenance programme Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Emergency capital bid 2021/22 1 year Capital Plan agreed Prioritised 5 year Capital plan developed and submitted to ICS for consideration Medical Devices Group Fixed Asset register Risk register	**Management** Chairs log from H&S Group to QAC regarding Medical **Risk and compliance** PFI contract management Lifecycle report to Resources Committee Capital update report to Resources Committee **Independent assurance** Internal audit reports	Inability to release estate for lifecycle due to COVID restrictions - additional planned maintenance works and condition assessments being undertaken routinely – Mr Oxley – date Agree with ICS sufficient capital resource to address the Trust investment requirements over the short and medium term - Mr Hand - date	
6.5 Lack of cooperation from ICS partners to support allocation of ICS resources to the Trust	ICS/ICP Director of Finance meeting ICS Capital Planning / Estates Managers meeting Joint working with NTHT TV Clinical Services Strategy and Board TV CEO meeting ICS Executive Management Meeting Joint Strategy Board ICS/ICP plan	**Management** ICS/ICP updates through Finance report and CEO report to Committees and Board JSB MOU **Risk and compliance** Regional Directors (2019) review of system savings report **Independent** ICP/ICS Plan submission approval by NHSE/I	Agree risk share agreement across ICS – Mr Hand - date Delivery of the regional directors (2019) system savings to be reviewed by ICP – Mr Hand – date	

Principal risk - 7	Failure to deliver the Trust's financial recovery plan	Strategic Objective	Make best use of our resources

Lead Committee	Resources	Risk Rating	Initial Rating	Current Rating	Target	Risk type	
Executive Lead	Chief Finance Officer	Likelihood	5. Almost Certain	5. Almost Certain	3. Possible	Risk appetite	
Initial date of assessment	21.5.21	Consequence	4. Major	4. Major	4. Major	Risk treatment strategy	
Last reviewed	23.8.21	Risk Rating	20. Extreme	20. Extreme	12. High		
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
7.1 Insufficient capacity to identify and deliver the required level of savings opportunities	Resources Committee Budget setting principles and budgets in place CIP planning CIP monitoring programme and infrastructure Clinical Collaborative framework CPG Clinical Strategy and Improvement Group PLICS GIRFT	**Management** Directorate level finance reports Annual report and accounts Annual Governance Statement National Cost Collection report to Resources Committee July 2021 **Risk and compliance** Finance report to Board and Resources Committee monthly including CIP progress IPR report to Board and Committees Provider licence self-assessment **Independent assurance** Internal audit External audit NHSE/I monthly finance monitoring	Delivery of the regional directors (2019) system savings to be reviewed by ICP – Mr Hand – date Review of finance structure to ensure fit for purpose to support directorates and Collaboratives financial management – Mr Hand – date Develop PLICS, Model hospital reporting and interpretation of data – Mr Hand - date	
7.2 Potential loss of grip and control during transition to new clinically led structure	Day to day budget management processes in place Finance business partners - qualified Policies and procedures for managing financial control Cash flow forecast Finance Investment Board in place quality assuring business cases for revenue Capital Planning Group in place quality assuring business cases for capital Business case process in place Corporate Governance Framework (SFI/SO, Scheme of delegation in place) Vacancy control plan in place CPG Constitution Collaborative Chairs meeting Agency and locum sign off process Purchasing via procurement frameworks and NHS supply chain	**Management** Directorate level and department level finance reporting Cost centre level finance reports Business cases reviewed by FIB / Capital Planning CPG decision making on budgets and capital planning Budget sign off Annual accounts **Risk and compliance** Finance report to Board, Resources Committee Procurement report to Resources Committee **Independent** Going concern and financial controls audit as part of External and Internal audit programme Regional finance returns monthly (H1/H2)	Review of finance structure to ensure fit for purpose to support directorates and Collaboratives financial management – Mr Hand – date Develop PLICS, Model hospital reporting and interpretation of data – Mr Hand - date Update SFI/SOs in line with Collaborative Structure – Mr Hand / Mrs White – date Contract uncertainty – agree with Commissioners – Mr Hand – date	
7.3 Unexpected cost	Day to day budget management processes in place	**Management**	Review of finance structure to ensure fit	

pressures leading to unplanned overspends	Finance business partners - qualified Policies and procedures for managing financial control Cash flow forecast Corporate Governance Framework (SFI/SO, Scheme of delegation in place) Vacancy control plan in place CPG Constitution Collaborative Chairs meeting Agency and locum sign off process Purchasing via procurement frameworks and NHS supply chain ICS/ICP Director of Finance meeting Joint working with NTHT	Directorate level and department level finance reporting Budget sign off ICS/ICP updates through Finance report and CEO report to Committees and Board **Risk and compliance** Finance report to Board, Resources Committee Procurement report to Resources Committee **Independent** Going concern and financial controls audit as part of External and Internal audit programme Regional finance returns monthly (H1/H2)	for purpose to support directorates and Collaboratives financial management – Mr Hand – date Enhancement of CIP and delivery programme – Mr Hand – date Agree risk share agreement across ICS – Mr Hand - date	
7.4 Inability to agree contracts with commissioners to provide the planned levels of clinical income	Resources Committee Contracting team BIU team NHS Standard Contract and guidance Costing information Joint NTHT Contract Contract meetings	**Management** Finance report Contracting guidance **Risk and compliance** Finance report to Board, Resources Committee **Independent** NHSE/I independent costing assurance audits	Contract uncertainty – agree with Commissioners – Mr Hand – date Establish joint contracting group with NTHT – Mr Hand – date	
7.5 Insufficient capital resources available to support innovation and transformation	Capital planning group in place Planned maintenance processes in place Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Emergency capital bid 2021/22 1 year Capital Plan agreed Prioritised 5 year Capital plan developed and submitted to ICS for consideration Medical Devices Group Fixed Asset register	**Management** Chairs log from H&S Group to QAC regarding Medical **Risk and compliance** PFI contract management Lifecycle report to Resources Committee Capital update report to Resources Committee **Independent assurance** Internal audit reports	Inability to release estate for lifecycle due to COVID restrictions - additional planned maintenance works and condition assessments being undertaken routinely – Mr Oxley – date Agree with ICS sufficient capital resource to address the Trust investment requirements over the short and medium term - Mr Hand - date	
7.6 Inability of system partners to support or implement system wide opportunities	ICS/ICP Director of Finance meeting ICS Capital Planning / Estates Managers meeting Joint working with NTHT TV Clinical Services Strategy and Board TV CEO meeting ICS Executive Management Meeting Joint Strategy Board ICS/ICP plan	**Management** ICS/ICP updates through Finance report and CEO report to Committees and Board JSB MOU **Risk and compliance** Regional Directors (2019) review of system savings report **Independent** ICP/ICS Plan submission approval by NHSE/I	Agree risk share agreement across ICS – Mr Hand - date Delivery of the regional directors (2019) system savings to be reviewed by ICP – Mr Hand – date	
7.7 Failure of key infrastructure (equipment, IT and Estates) impacting on operational delivery	Capital planning group in place Planned maintenance processes in place Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Emergency capital bid 2021/22 1 year Capital Plan agreed Prioritised 5 year Capital plan developed and submitted	**Management** Chairs log from H&S Group to QAC regarding Medical **Risk and compliance** PFI contract management Lifecycle report to Resources Committee Capital update report to Resources Committee	Agree with ICS sufficient capital resource to address the Trust investment requirements over the short and medium term - Mr Hand - date Inability to release estate for lifecycle due to COVID restrictions - additional planned	

	to ICS for consideration Medical Devices Group Fixed Asset register Digital Director appointment made and commenced in post August 2021	**Independent assurance** Internal audit reports	maintenance works and condition assessments being undertaken routinely – Mr Oxley – date Update to digital strategy – Mr Harrison – date	
7.8 Failure to advance digital maturity will impact on efficiency, care quality and safety	Business case for MIYA IT Business Continuity and Incident Management plans Programme for upgrade to Network infrastructure Capital Investment approved and programme of delivery for identified capital plan including infrastructure and desk top hardware Digital Strategy group MIYA programme board Engagement on GNCR SIRO Digital leadership meeting in place fortnightly NED and Associate NED appointed with digital skills background Digital Director appointment made and commenced in post August 2021	**Management** Business Case for MIYA approved by Board **Risk and compliance** Digital updates to Resource Committee quarterly **Independent assurance** NHS digital review of Tees Valley PWC have completed audits of Cyber Security and the Data Security & Protection toolkit.	Update to digital strategy – Mr Harrison – date Complete implementation of recommendations from NHS digital review – Mr Harrison - date Complete the delivery of MIYA roll out – Mr Harrison – date Internal audit review of digital governance – Mr Harrison – autumn	

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 7 SEPTEMBER 2021			
Safe Staffing Report for July 2021 – Nursing and Midwifery			**AGENDA ITEM: 9, ENC 6**
Report Author and Job Title:	Eileen Aylott, Associate Chief Nurse - Education and Workforce	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report details nursing and midwifery staffing levels for July 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 shifts filled against the planned nurse and midwifery staffing across the trust is 97.3% as per table 1 which demonstrates good compliance with safer staffing. Staffing has been challenged across the trust with short notice unavailability and COVID isolation, particularly during mid July when track and trace was at a peak. Increased numbers of junior and temporary staff together with frequent redeployment to maintain patient safety has led to a significant increase in datix reporting during the month. The Chief Operating Officer and Deputy Operational Chief Nurse took staffing data to GPG 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.		
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	BAF risk 5.1 Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit. Threat - Ability to attract and retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources. Failure to have effective workforce plans that anticipate and prevent		

	shortages arising from retirements, shortfalls in all recruitment and retention plans	
Legal and Equality and Diversity implications	• Care Quality Commission • NHS Improvement • 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
July 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 the Tactical/Strategic Group 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.

Staff movement has been higher than usual in July due to COVID sickness and isolation. Redeployment of staff has taken place to ensure wards are safely staffed with 526 shifts/5642.29 hours logged via SafeCare during July which was a significant increase on June hours.

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 July 2021

The breakdown by ward is in Table 2

Table 1 – Trust wide Monthly Fill Rates

		May 2021	June 2021	July 2021
Overall Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	92.7%	91.2%	89.0%
	HCA (%) Average fill rate - DAYS	99.6%	100.4%	93.9%
	NA (%) Average fill rate - DAYS	100%	100.0%	100.0%
	TNA (%) Average fill rate - DAYS	100%	100.0%	100.0%
	RN/RMs (%) Average fill rate - NIGHTS	93.8%	93.8%	92.1%
	HCA (%) Average fill rate - NIGHTS	108.8%	107.9%	103.8%
	NA (%) Average fill rate - NIGHTS	100%	100.0%	100.0%
	TNA (%) Average fill rate - NIGHTS	100%	100.0%	100.0%
	Total % of Overall planned hours	**99.36%**	**99.10%**	**97.35%**

Although the average fill rate remains excellent, staff at ward level have verbalised feeling ‘stretched’. This has been highlighted by the number of datix submitted during the month relating to staffing.

Staff are feeling tired and increased numbers of junior and temporary staff together with frequent redeployment to maintain patient safety has proved difficult for some wards/departments. Psychology colleagues have been out visiting staff daily during the week to offer support and have also reiterated the comments made by staff.

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 June	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	10.29	124.9%	89.1%			101.0%	102.2%			
Ward 2 AAU (Short Stay Staff)	28	28	22	8.31	95.2%	123.6%	100.0%	-	76.6%	93.6%	100.0%	-	Bed occupancy reduced by 6 beds in July. Planned 5 RN on nights and working 4 (1:5.5 ratio) Safe staffing maintained for 22 beds
Ward 3 (COVID)	28	28	13	12.14	93.2%	111.4%	-	100.0%	89.6%	90.4%	-	100.0%	
Ward 4	21	21	21	6.59	83.8%	94.9%	-	-	74.4%	103.9%	-	-	Bed occupancy at maximum for July. Planned 3 RN on nights working 2 (1:10.5 ratio). Safe staffing maintained with additional HCA support.
Ward 5	28	22	22	7.29	110.7%	105.8%	-	100.0%	130.6%	145.8%	-	100.0%	
Ward 6 Gastro	30	30	27	6.53	90.2%	153.7%	-	100.0%	90.5%	166.5%	-	-	
Ward 7 Colo	30	30	26	6.14	88.4%	86.0%	100.0%	100.0%	85.6%	98.9%	-	-	
Ward 8	30	30	24	6.83	85.8%	98.1%	100.0%	100.0%	89.5%	101.7%	-	100.0%	
Ward 9	28	28	22	8.62	108.4%	86.8%	-	-	102.6%	97.5%	-	-	
Ward 10 (Short Stay RAFAU Staff)	27	27	25	6.98	89.3%	100.7%	-	-	90.4%	106.9%	-	-	
OPM (Ward 11)	28	28	26	7.08	86.9%	93.0%	-	-	82.8%	98.9%	-	-	
Ward 12	26	24	12	8.84	81.9%	105.2%	-	-	86.1%	92.2%	-	-	
Ward 14 Oncology Staff	23	21	17	7.46	92.6%	82.1%	-	100.0%	75.3%	95.9%	-	100.0%	Bed occupancy reduced by 4 beds in July. Planned 3 RN on nights working 2 (1:8.5 ratio) safe staffing maintained for 17 beds
Ward 24	23	23	20	7.17	90.0%	115.6%	100.0%	100.0%	76.2%	139.0%	100.0%	-	Bed occupancy reduced by 3 beds in July. Planned 3 RN on nights working 2 (1:10 ratio). Safe staffing maintained for 20 beds with additional HCA support
Ward 25	21	21	8	8.49	85.2%	77.7%	-	100.0%	73.4%	54.6%	-	-	5 days of closed beds. Safe staffing with 2 RN maintained overnight.

Ward 26	18	18	18	7.44	96.8%	126.1%	-	-	100.0%	123.7%	-	-	
Ward 27 Neuro Staff	15	15	11	14.27	131.1%	201.2%	-	-	95.2%	147.7%	-	-	Additional staffing required during the day due to relocation of the day unit away from the ward. High levels of enhanced observation to maintain patient safety.
Ward 28	30	30	21	8.28	86.3%	113.8%	-	-	78.4%	104.5%	-	-	Bed occupancy reduced by 9 beds in July. Safe staffing maintained for 21 beds
Ward 29	27	27	21	4.89	96.9%	86.5%	100.0%	-	88.2%	114.5%	100.0%	-	
Cardio MB	9	9	7	8.65	98.6%	117.8%	-	-	93.5%	-	-	-	
Ward 31 Vas	35	26	7	7.76	80.8%	75.8%	100.0%	-	95.2%	97.4%	-	-	Bed occupancy reduced by 9 beds in July. Safe staffing maintained for 26 beds
Ward 32	22	21	21	7.70	108.3%	101.7%	-	-	100.0%	111.3%	-	-	
Ward 33 Specialty	19	19	17	7.57	92.1%	85.0%	-	-	107.4%	91.8%	-	-	
Ward 34	34	34	34	6.40	82.8%	111.6%	-	-	93.5%	104.7%	-	-	
Ward 35	26	26	26	8.24	97.1%	106.9%	-	100.0%	87.5%	110.2%	-	-	
Ward 36 Trauma	34	34	34	6.87	88.5%	120.5%	-	100.0%	95.8%	121.6%	-	100.0%	
Critical Care + Surge	32	32	26	33.35	92.6%	101.8%	-	-	95.3%	109.8%	-	-	
CICU JCUH	12	11	8	33.56	79.1%	101.4%	-	-	78.0%	206.5%	-	-	Bed occupancy reduced by 3 beds in July. Planned 11 RN days and nights worked 9 (1:1 ratio). Safe staffing maintained for 8 beds and a supernumerary co-ordinator. HCA Planned for 1 overnight worked 2.
Can Cardio HDU	10	10	6	20.18	71.9%	98.4%	-	-	65.2%	93.5%	-	-	Bed occupancy reduced by 4 beds in July. Planned 6 RN Days working 5 (1:1.5 Ratio) Planned 5 RN nights working 4 (1:2 Ratio) safe staffing has been maintained for 6 beds and a supernumerary co-ordinator
Ward 24 HDU	8	8	6	18.18	104.6%	83.7%	-	-	95.5%	103.2%	-	-	
Ainderby FHN	27	27	17	6.14	68.0%	88.8%	-	-	100.4%	90.2%	-	-	Bed occupancy reduced by 10 beds in July. Planned 4 RN days working 3 (1:6). Safe staffing maintained for 17 beds
Romanby FHN	26	20	22	5.68	92.5%	68.9%	-	-	103.2%	76.3%	-	-	Bed occupancy reduced by 6 beds in July. Safe staffing maintained for 20 beds
Gara Orthopaedic FHN	16	16	10	9.24	125.8%	124.8%	-	-	94.0%	137.3%	-	-	

Rutson FHN	17	15	**14**	7.90	73.3%	93.5%	-	-	100.0%	90.4%	-	-	Bed occupancy reduced by 1 bed in July. Planned 3 RN days working 2 (1:7 ratio). Safe staffing maintained for 14 beds.
Friary Community Hospital	18	18	13	7.70	74.6%	78.2%	-	-	100.1%	178.9%	-	-	Bed occupancy reduced by 5 in July. Planned 3 RN working 2 (1:6.5 ratio) Safe staffing maintained for 13 beds
Zetland	31	29	26	7.47	97.5%	77.3%	-	-	58.8%	132.3%	-	-	Bed occupancy reduced by 5 in July. Planned 4 RN nights working 2 (1:13 ratio) with extra HCA support. This staffing was extreme stretch due to unavailability resulting from track and trace and short term sickness.
Tocketts Ward	30	30	22	7.15	75.9%	80.2%	-	-	73.1%	92.7%	-	-	
Ward 21	25	25	10	12.63	68.4%	84.3%	-	100.0%	64.1%	61.3%	-	100.0%	Bed occupancy reduced by 15 in July. Planned 6 RN day and night working 4 (1:2.5 ratio) Safe staffing maintained for 10 beds.
Ward 22	17	17	6	14.29	90.8%	75.2%	-	-	82.1%	35.5%	-	-	Bed occupancy reduced to only 6 beds in July. Safe staffing maintained
JCDS (Central Delivery Suite)	-	-	7	19.17	85.4%	64.4%	-	-	89.7%	86.6%	-	-	
Neonatal Unit (NNU)	35	35	27	12.10	84.6%	80.0%	-	-	87.7%	-	-	-	
Paediatric Intensive Care Unit (PCCU)	6	6	2	43.34	67.8%	61.9%	-	-	66.7%	-	-	-	Bed occupancy reduced by 4 in July. Planned 4 RN Day and night working 3 (1:1 ratio) Safe staffing maintained
Ward 17 JCUH	-	-	27	6.73	81.7%	82.2%	-	-	91.1%	74.3%	-	-	
Ward 19 Ante Natal	-	-	5	9.30	63.1%	77.4%	-	-	70.8%	-	-	-	Average of 5 patients at midnight during July. Safe staffing maintained
Maternity Centre FHN	-	-	0	-	54.5%	28.2%	-	-	46.9%	-	-	-	Unit staffing reduced as redeployment required to ensure safe staffing on JCUH site.
Spinal Injuries	24	24	22	8.81	89.3%	63.8%	-	-	100.0%	98.9%	-	-	
CCU JCUH	14	14	8	17.21	80.4%	51.3%	-	-	94.3%	-	-	-	Bed occupancy reduced by 6 beds in July. Safe staffing maintained for 8 beds

The emergency department continues to plan for 19 RNs during the day and 18 RNs overnight during July. Worked RN numbers were 18 and 17 respectively. Increased staff sickness and COVID isolation was significant during mid July.

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

Ward/Area Name	New or Deteriorating PU 2's (Inpatient)	New or Deteriorating PU 3's (Inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey	SI's
A&E	1	0	2	2	4	-	
Cardio HDU	0	0	0	1	0	9.10	
Ainderby Ward	3	0	0	2	2	9.17	
Clinical Decisions Unit	0	0	0	8	0	9.37	
Gara Ward	1	0	1	1	0	9.57	
Romanby Ward	5	1	0	2	1	9.17	
Ward 2	1	0	5	10	0	8.97	
Ward 3	0	0	0	1	1	9.10	
Ward 4	5	0	2	4	0	9.00	
Ward 5	1	0	0	3	1	-	
Ward 6	4	1	5	4	0	7.30	
Ward 7	1	0	6	6	0	9.06	
Ward 8	2	3	1	5	1	9.27	
Ward 9	2	0	0	2	0	8.90	
Ward 10	3	0	1	8	1	8.88	1
Ward 11	2	1	3	9	0	8.42	
Ward 12	0	1	0	0	0	8.84	
Ward 14	0	0	0	2	1	9.29	
Ward 15	0	0	0	0	0	-	
Ward 16	0	0	1	0	0	-	
Ward 17	0	0	2	1	1	9.18	
Ward 21	0	0	2	0	0	9.30	
Ward 22	0	0	0	0	0	9.55	
Ward 24	1	0	3	2	0	9.04	
Ward 25	2	0	0	6	1	9.76	
Ward 26	0	0	1	11	0	8.59	
Ward 27	0	0	1	2	0	9.25	
Ward 28	3	0	0	9	0	-	
Ward 29	2	0	0	10	0	-	
Ward 31	0	0	1	2	0	8.21	
Ward 32	0	0	0	2	0	9.14	
Ward 33	0	0	0	1	0	9.41	
Ward 34	4	1	1	2	0	-	
Ward 35	2	0	2	5	0	9.27	
Ward 37	1	0	2	7	0	8.86	
Coronary Care Unit	0	0	0	0	1	9.48	
Central Delivery Suite	0	0	3	0	1	-	
Maternity Assessment Unit	0	0	0	0	0	-	
Trauma Ward 36	1	0	1	3	0	8.61	
General High Dependency	2	2	7	1	0	-	
General ICU 2	11	3	1	0	0	-	
General ICU 3	4	0	0	0	0	-	
Cardiothoracic ITU	5	0	0	0	0	9.21	
Special Care Baby Unit	0	0	5	0	0	-	
Spinal Injury HDU	0	0	1	0	0	9.70	
Spinal Injury Rehab Unit	0	1	0	0	1	-	
Neuro HDU	0	0	2	0	0	9.47	
Paediatric Critical Care Unit	0	0	0	0	0	-	
Ward 1	2	0	6	1	1	9.63	
Friary Victoria Ward	1	0	1	4	0	8.82	
Rutson Fhn	0	0	1	2	0	9.07	
Zetland Ward	0	0	2	9	0	-	
Tocketts Ward	0	0	1	8	0	9.25	

Table 3 – Nurse sensitive indicators and 1000 voices scores

A total of 125 red flags were reported during July in table four below, with shortfall of RN being the most common (106). Short notice unavailability across the whole trust was significant during mid July when track and trace notifications were at a peak. This is a significant increase from the 53 reported during June.

Red Flags Reported	Day	Night	Grand Total
AMBER Beds Open		1	1
Delay in providing pain relief	2	3	5
Missed 'intentional rounding'	10	1	11
Shortfall in RN time	58	48	106
Vital signs not assessed or recorded	2		2
Grand Total	**72**	**53**	**125**

Table 4 Red flag reporting July 2021

Retrospective red flags have been raised for missing intentional rounding and delays in pain relief. These can be due to short periods of increased acuity and dependency and should be reported through datix if likely to cause patient harm. There were no Datix reported against these flags.

There were 118 datix reported relating to staffing during July. The majority were from ED (38). Redeployment decisions were made following safe staffing discussions with Matrons to ensure areas are safely staffed.

Vacancy and Turnover

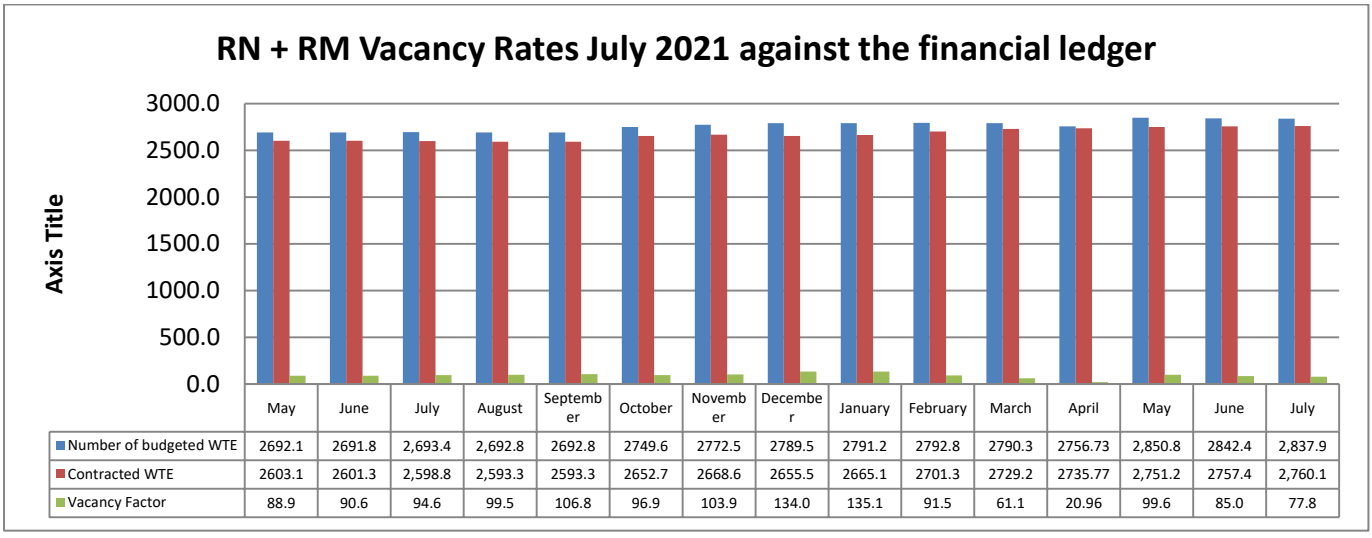
The total nursing and midwifery vacancy rates for RN remain fairly static at 2.7% with HCAs over recruited for COVID support.

Recruitment of nursing staff continues as vacancies arise with vacancies being filled quickly. (Fig 1 and 2) Approximately 85 student nurses and 6 student midwives are due to take up first destination posts in September.

An open day is planned at FHN in September with all staff groups supporting this event. The Communications team will be publicising the event through social media and students will be informed through the university blackboard system.

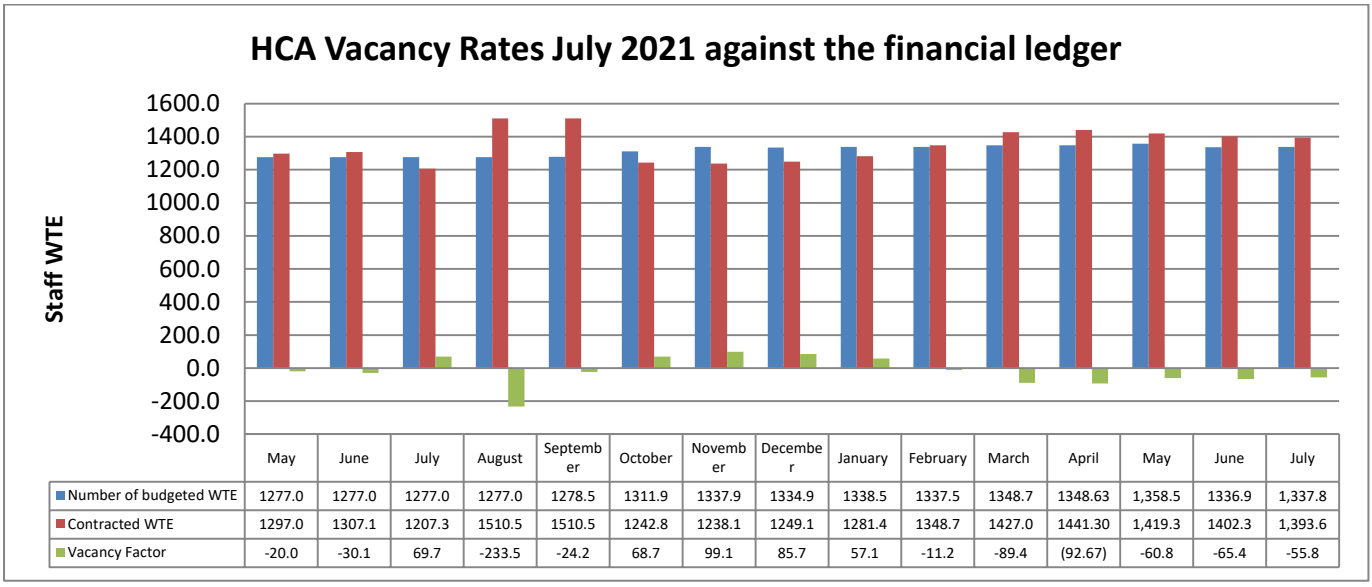
Midwifery

Midwifery has experienced high sickness and self isolation rates during July. The team have been working differently to support these shortfalls with management time converted to clinical with some unit closures at FHN to maintain patient safety.



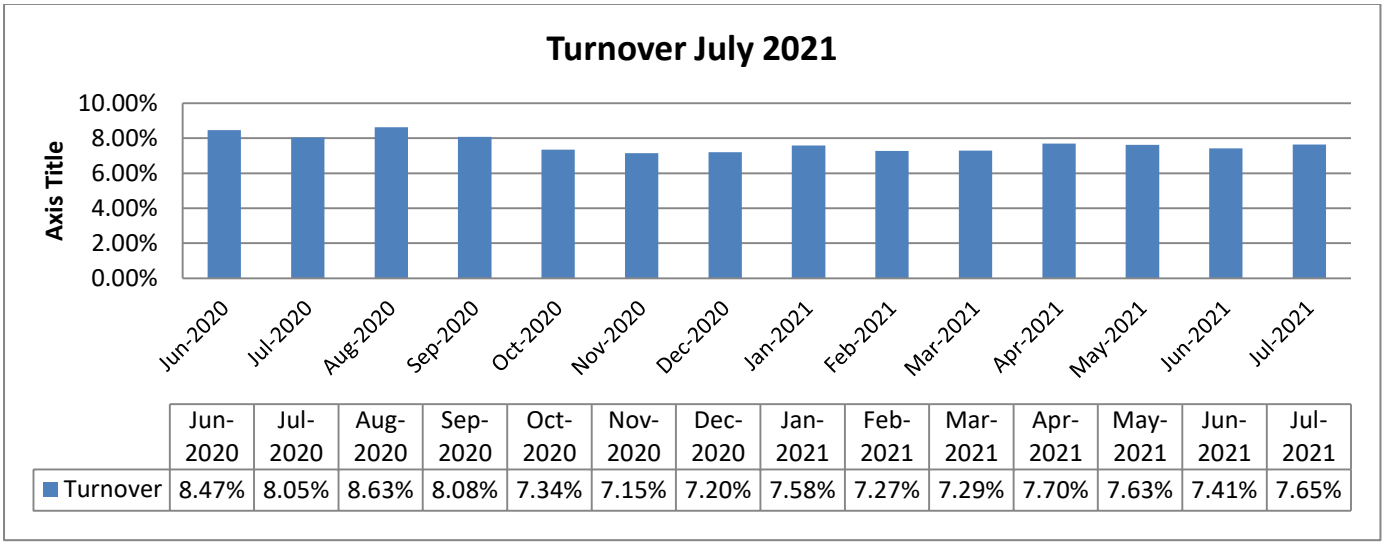
	May	June	July	August	September	October	November	December	January	February	March	April	May	June	July
Number of budgeted WTE	2692.1	2691.8	2,693.4	2,692.8	2692.8	2749.6	2772.5	2789.5	2791.2	2792.8	2790.3	2756.73	2,850.8	2842.4	2,837.9
Contracted WTE	2603.1	2601.3	2,598.8	2,593.3	2593.3	2652.7	2668.6	2655.5	2665.1	2701.3	2729.2	2735.77	2,751.2	2757.4	2,760.1
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

Figure 2 - Health Care Assistant Vacancy Rate July 2021



	May	June	July	August	September	October	November	December	January	February	March	April	May	June	July
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	1,337.8
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	1,393.6
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

Figure 3 Nursing Turnover July 2021



	Jun-2020	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
Turnover	8.47%	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%

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 7 SEPTEMBER 2021			
CQC Update Report			**AGENDA ITEM: 10** **ENC 7**
Report Author and Job Title:	David Bell Quality, Governance & Mortality Reporting Manager (CQC Project Lead) Moira Angel Interim Director of Clinical Development	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This paper provides an update on progress the Trust has made against the CQC high level preparedness plan and outstanding action plan from the 2019 inspection.		
Background	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. In line with the CQC regulatory framework a Trust which is graded as "Requires improvement" will normally be inspected within two years of publishing the last core service inspection report, which for the Trust was July 2019. Therefore the Trust is preparing for a CQC inspection.		
Assessment	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 has been set out in the report. On behalf of the Board the Quality Assurance Committee and sub groups will oversee and monitor the process with appropriate updates to the Board. Good progress on delivering of the high level plan has been made since the last report.		
Recommendation	For the Board of Directors to receive this report for information.		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF threats - 1.1 Significant reduction in patient satisfaction due to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality 1.2 An increase in the incidences of infectious disease (such as CDIF, influenza; Coronavirus; norovirus; infections resistant to antibiotics) that forces closure of one or more areas of the hospital 1.3 Lack of IT and administrative systems and processes for organisational learning from events such as incidents, complaints and claims, resulting in patient harms and poorer outcomes	
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 ☒	

CQC Update Report

1. PURPOSE OF REPORT

The purpose of this report is to provide an update against the high level preparation plan for a CQC inspection at the Trust and on the CQC action plan

2. BACKGROUND

A CQC inspection of the Trust was carried out between the 15 January and the 23 February 2019, a detailed action plan was developed to address the regulatory breaches ('must do' actions) and also the 'should do' actions.

In line with the CQC regulatory framework a Trust which is graded as "Requires improvement" will normally be inspected within two years of publishing the last core service inspection report, which for the Trust was July 2019.

Therefore the Trust is preparing for a CQC inspection.

3. DETAILS

3.1 Governance arrangements

The Quality Assurance Committee on behalf of the Trust Board receives updates on progress the Trust has made against the CQC action plan following the last visit which covers the 26 regulatory notices (the 'Must Do's) and the 23 'Should Do's' from the inspection report.

Regular updates are also provided to the Senior Leadership Team and CPG. This along with a new meetings structure to QAC provides the necessary governance and assurance to the Board going forward.

3.2 CQC action plan 2019

Since the last report, the CQC action plan has been discussed and handed over to the collaborative Chairs, who are now responsible for final completion.

The tables below show the number of actions that have been completed and the number of actions rated red due to either, action not being completed by the required time, or lack of evidence to demonstrate that the action has been completed.

The actions have also been separated into the 'must do' actions and the 'should do' actions and the actions that have a financial implication. A breakdown is provided below: -

Overview	
1	Off track

19	Expected to deliver actions
112	Completed actions
21	Embedding in practice

Table 1: *Summary status of all 153 detailed CQC actions*

Currently there is 1 Must Do action currently classed as 'Off track', including the mitigations in place and progress made to date: -

CQC "must do" Requirement	Actions taken to mitigate	Progress	Anticipated Timescale
• M6 - The Trust must ensure that staff training compliance with mandatory training, especially resuscitation training, safeguarding children (level 2) and safeguarding vulnerable adults (including mental capacity act and deprivation of liberty safeguard training) meets the Trust target of 90% (Reg 18)	• Trust current rate for mandatory training is 83.04% (May 2021).	• Mandatory Training date has been transferred onto ESR to enable real time reporting. • Training packages within ESR are more challenging than our previous packages and the system will require staff to develop familiarisation with the platform. • HR Workforce Team continues to provide training for managers and staff on the new ESR platform. • Continued focus on non-compliant areas and elements of mandatory training via HR Business Partners and collaborative managers. All centres to develop trajectories to improve position by July.	All collaboratives to develop trajectories to improve position
Red (off track)			

3.3 Moving to Good

The Trust signed up to the Moving to Good Programme which is offered and facilitate by NHSE/I. The programme has been suspended during Covid 19, however work has continued throughout the Trust to progress the areas identified as part of the programme, including the safety project.

3.4 CQC National Update

On 24 March 2021 the CQC published a statement on their future approach to regulation and having an active role in encouraging system-wide recovery and how they can support this.

From 1 April 2021 the CQC advised that they will continue to have on-site inspection as a core part of their activity however they will also develop tools to inspect quality and risk proportionately.

The CQC will continue with their current risk-based approach to regulation, undertaking inspection activity where there is clear patient safety risk.

3.5 Preparations for the next inspection

No date has been announced for the Trust's next CQC inspection, however we are anticipating this will be sometime soon, based on the fact that Trusts rated as requires improvement are inspected approximately every 2 years.

3.5.1 Trust-wide CQC Compliance Group

As we are entering the next phase of the CQC preparation process, the Trust has established a CQC Compliance Group that meets monthly.

The key function of the group is to provide assurance to the Board and QAC in respect of the preparedness of the Trust's response to an expected CQC visit. This is chaired by the Chief Nurse and is made up of multi professional colleagues with relevant experience.

3.5.2 Check & Challenge meetings

The CQC project team have held check and challenge meetings with all Directorates in the Trust. At these meetings, the Directorate CQC self-assessment submission was reviewed and key themes have been identified in terms of where further assistance from the Trust may be required to ensure that they are prepared for a CQC visit.

Further meetings to review progress will be held with each Directorate during September and October.

3.6 Timeline update

Timeframe	Actions	Lead	Reporting	Update
May	Review and sign off previous action plan	Moira Angel	Monthly to QAC	One outstanding must do as documented above.

				This continues to be monitored.
May	Presentation to CPG	Hilary Lloyd / Moira Angel	CPG	Completed
May - June	Complete self - assessment for well led domains	Jackie White	Board	Delayed to ensure new Joint Chair participates – self assessment for Board scheduled for 21 September 2021
May – June	Gap analysis against PIR internally and develop action plan	Ian Bennett	Safe and Effective Care Strategic Group	Making good progress against data collection for PIR
May – June	Collaborative teams complete self-assessment against fundamental standards and KLOES	Collaborative Chairs	CPG	Completed – heat map produced and considered at QAC. Check and challenge meetings undertaken and self assessments updated
June	Merge self-assessments into CQC service lines and develop action plans	Ian Bennett	CPG	Delayed - revised completion date end of September
May - June	Embed CQC governance structure in to new quality governance structure	Hilary Lloyd / Moira Angel	QAC	New governance structure in place
May	Review CQC insights report at Safe and Effective Care Strategic Group (SECG)	Ian Bennett	Report progress to QAC Group.	Reviewed and reported considered at SECG. This will be considered routinely and used as a basis for further targeted work
June	Carry out 'hot' topic reviews. E.g. LD, mental health, safeguarding, discharge etc.	Moira Angel / Ian Bennett	CQC & Compliance Group	Completed as part of corporate KLOE self assessment
June – July	Agree communication strategy – roadshows, presentations, posters etc.	Mark Graham		Communications strategy reviewed and approved by CQC compliance group. This will be rolled out throughout

				the Trust
July – August	Capture areas of outstanding practice	Hilary Lloyd Moira Angel		Ongoing – progress in place as part of check and challenge
July – September	Plan supportive visits, peer reviews, CQC huddles, confirm and challenge with the collaboratives	Moira Angel Ian Bennett		Part complete – confirm and challenge meetings held with Collaboratives, huddles in place and taking place weekly, CQC compliance group established
June -July	Prepare for potential use of resources review (UOR)	Chris Hand Jackie White	Resources Committee	Preparation for UOR is well underway with a self assessment undertaken and further work on benchmarking taking place. Routine reports are received by Resources Committee
August – September	Plan CQC inspection oversight during inspection	Hilary Lloyd Moira Angel		CQC compliance group established with supporting project group and key individuals with a range of experience supporting the preparation. This is being led by the Chief Nurse.

4. IR(ME)R Inspection – Initial feedback from the visit on 22nd June 2021

On the 8th June the Trust was notified that the CQC would be inspecting the Radiotherapy department for an IR(ME)R inspection on the 22nd June.

An information request was also received with the notification and requested that information to support the inspection process was sent to the CQC by 12 noon the following day. 84 pieces of information was sent to the CQC before the deadline.

On the 22nd June the inspection took place and at the end of the process an informal feedback session took place, where verbal feedback was provided that there were no enforcement actions for the Trust. Many areas of positive work were highlighted, with a small number of areas for improvement being noted.

5. WELL LED

A date has now been agreed to undertake the self-assessment exercise which will take place on 21 September 2021. The action plan from the previous self-assessment will be reviewed along with the key lines of enquiry, prompts and ratings characteristics document to agree a rating for each key line of enquiry and an updated action plan.

In addition a self-assessment exercise will take place at Clinical Policy Group (CPG). The format of the self-assessment will be the same as the Board. An action plan will be developed at the meeting and will be routinely updated and reviewed by CPG. This should take place by the end of September 2021.

6. COMMUNICATION PLAN

A communications approach to support colleagues during the inspection phase has been developed and will be rolled out across the Trust in the coming weeks.

As part of the plan, the following documents have been created: -

- Pre-inspection Plan
- Booklet for Staff
- Staff Toolkit

7. CONCLUSION

Good progress has been made across a number of different areas with regards to delivering the CQC action plan from the last inspection and preparations are well underway within the organisation for our next CQC inspection.

The Board of Directors should receive assurance that robust systems and processes are in place, with areas where risks have been identified, being escalated quickly, with mitigation and recovery plans being put in place.

The currently level of engagement, focus and scrutiny must continue, in order that the Trust to achieve its ambition of getting back to its best**.**

8. RECOMMENDATIONS

For the Board of Directors to:

- Note the progress which has been made.

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 7 SEPTEMBER 2021			
Safeguarding Children & Adults Annual Report			**AGENDA ITEM: 11, ENC 8**
Report Author and Job Title:	Jo Gamble Assistant Director of Nursing (Safeguarding)	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☒ Discuss ☐ Inform ☒		
Situation	This annual report 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; it also identifies priority areas for 2021 – 2022.		
Background	The Trust has statutory duties to promote safeguarding and the welfare of vulnerable patients of all ages. This report provides assurance across the range of this activity including: • The Care Act (2014) • The Mental Capacity Act (2005) & Deprivation of Liberty Safeguards (2007). • The Children's Act (1989 / 2004); section 22 (1989) Looked After Children • Working Together to Safeguard Children (2018). • Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHSE 2019). • Multi-agency risk assessment conferences (MARAC) and Domestic Homicide Reviews (Domestic Violence, Crime and Victims Act 2004). • Counter-Terrorism and Security Act 2015 (PREVENT) • Modern Slavery and Human Trafficking Act (2015). • Mandatory reporting of Female Genital Mutilation (FGM Act 2003)		
Assessment	**SUCCESS**: 1. ICON has been well embedded across the Trust to help prevent abusive head trauma in babies and infants. 2. Quarterly 'Areas of Focus' have been successfully introduced across A&E and pediatrics. 3. Safeguarding adult reviews, domestic homicide reviews and child safeguarding practice reviews have continued throughout the pandemic. 4. LeDeR reviews have continued. 5. The delivery of safeguarding mandatory training has been updated and streamlined and a new training matrix has been developed. **AREAS FOR CONTINUED FOCUS:** 6. Support the new continuity of care teams in maternity services. 7. Staff within paediatrics and the emergency department will be upskilled to work with young people in respect of the MCA / DoLS for 16 and 17 year olds. 8. An MCA Steering Group will be set up to support MCA / DoLS &		

	preparation for the Liberty Protection Safeguards (LPS) in 2022. 9. Facilitate the development of mandatory learning disability training for all clinical staff.	
Recommendation	Members of 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	Threat - 1.1 Significant reduction in patient satisfaction due to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality	
Legal and Equality and Diversity implications	The activity included in this report contributes to the Trusts duties under safeguarding and equality legislation.	
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

Safeguarding Annual Report 2020 – 2021

KEY FACTS

4604	Contacts for advice & support to the safeguarding children / maternity team.
227	Child Protection Medicals completed
351	Initial Health Assessments completed for children in care
598	Review Health Assessments completed for children in care
1246	Incidents reported as a safeguarding adult concern
577	Deprivation of Liberty Safeguards applications made
630	Safeguarding adult concerns reported to the local authorities
26	Mental Health Act Detentions
163	Safeguarding concerns reported relating to Trust practice
8	Local Child Safeguarding Practice Reviews (LCSPRs) [1]
5	Domestic Homicide Reviews (DHRs)[2]
55	MARAC referrals made by the Trust
6	Safeguarding Adult Reviews (SARs) / Learning Lessons Review[3]
933	Learning Disability patients with a flag on electronic patient records

[1] This includes all LSCPRs subject to review in 2020/21 including 3 that were reported in March 2020. This excludes an Independent Mental Health Review commissioned by NHSE.
[2] There have been 9 DHRs in Middlesbrough and Redcar & Cleveland since 2016 that the Trust has actively contributed to. The most recent DHR that occurred in December 2019 includes a review of safeguarding concerns regarding the children in the family instead of undertaking a spate LSCPR.
[3] SARs / Learning Lessons Review are examined on a Tees wide footprint under the auspices of Tees Safeguarding Adults Board (TSAB). Not all of the cases are specific to the South of Tees locality.

CONTENTS

INTRODUCTION

South Tees Hospitals NHS Foundation Trust is the largest hospital Trust in the Tees Valley and provides services from The James Cook University Hospital in Middlesbrough and the Friarage Hospital in Northallerton to over 1.5m patient a year; an additional 1.2 million patient are seen by our community services. The Trust recognises that patient experience is a fundamental component of quality healthcare and is committed to providing patients with the very best care across all of our services; safeguarding is at the heart of what we do. This annual report provides a summary of key issues and activities in relation to trust safeguarding responsibilities in 2020/21 for:

- Safeguarding the unborn baby / maternity care
- Safeguarding children
- Looked after Children
- Safeguarding adults including mental capacity act and deprivation of liberty safeguards
- Services to patients with learning disabilities.
- Safeguarding training

This report also details the statutory, regulatory and contractual obligations of the organisation and gives an overview of the governance arrangements as defined by:

- Care Act 2014
- Children Act 1989 & 2004
- Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHSE 2019).
- Multi-agency risk assessment conferences (MARAC) and Domestic Homicide Reviews (Domestic Violence, Crime and Victims Act 2004).
- Counter-Terrorism and Security Act 2015 (PREVENT agenda).
- Modern Slavery and Human Trafficking Act (2015).
- Mandatory reporting of Female Genital Mutilation (FGM Act 2003 section 5b).
- NHS Standard Contract Requirements

THE SAFEGUARDING TEAMS

Dr Hilary Lloyd (Chief Nurse) is the Executive Lead for safeguarding supported by Jo Gamble (Assistant Director of Nursing for Safeguarding) who attends interagency statutory safeguarding boards on behalf of the Trust. The Named Nurse Safeguarding Children / Looked after Children, Named Midwife and Named Doctor Child Protection are statutory roles. The safeguarding team structure is shown in appendix 1 (page 13).

GOVERNANCE ARRANGEMENTS

The Strategic Safeguarding Group reports to Quality Assurance Committee meets quarterly and is chaired by the Chief Nurse. The Terms of Reference of this group were reviewed in March 2021 and its functions include, but are not limited to:

- Agreeing Trust safeguarding policies procedures and processes.
- Receiving feedback from interagency strategic safeguarding partnerships.
- Monitoring action plans developed as a result of statutory processes.
- Reviewing Trust practice in relation to national guidance and statutory requirments.

The safeguarding strategy 2020 – 2022 is shown in appendix 3 (page 15) was approved in September 2020 by the Strategic Safeguarding group; this will be developed further in 2021 to include a dynamic work plan to monitor workload and to support service improvement.

Additionally, the Safeguarding Operational Groups for adults and children (including looked after children) are held each quarter and are chaired by the Assistant Director of Nursing [Safeguarding]. These groups are shown in appendix 2 (page 14) and

- Receive quartely reports of safeguarding activity within the organisation.
- Monitor progress against actions plans for safeguarding case reviews (adults and children).
- Escalate operational issues to the strategic group where necessary.

COVID

- Throughout the pandemic and subsequent societal ‘lockdowns’ and restrictions on social contact, the nursing and admin staff within the safeguarding teams, looked after children’s team and learning disability nurse have maintained a high level of functioning in terms of both physical and mental health.
- IT improvements have facilitated the ability for the team to continue delivering a robust service by providing opportunities for working from home and virtual meetings.
- The time saved by not having to travel to and from external meetings or supervision sessions created some additional capacity within the team. This supported some members to be released into clinical areas to support direct patient care.

SAFEGUARDING MATERNITY SERVICES

2020 / 2021 CHALLENGES:

- Some antenatal care was offered by telephone resulting in a lack of face-to-face contact with community midwives (CMW); some booking appointments were completed by a CMW who would not be providing on-going care (staff shielding or isolating were completing these). The CMW booking would not always have access to the medical records or be aware of previous safeguarding concerns. Initially the 16 week appointment was also by phone and possibly by a different CMW so there was a risk that safeguarding concerns could be missed. There was also minimal contact, if any, with fathers of UBB so ICON message was unlikely to be discussed.
- There have been several very late bookings/concealed pregnancies where mothers have reported that they were scared to access, or found it difficult to access, services due to COVID.
- There was reduced capacity when the specialist midwife was temporarily re-deployed to support maternity services during the pandemic.

2020 / 2021 ACHIEVEMENTS:

- Visibility with maternity services has been maintained during the pandemic.
- ICON has been well embedded across James Cook Hospital and The Friarage to help prevent abusive head trauma in babies and infants.
- Electronic system for sharing antenatal alerts with maternity services (SOP in place)
- Safeguarding supervision with community midwives has continued and compliance has remained high due to the use of Microsoft Teams
- There is a strong interface between the safeguarding midwives and the children's safeguarding nurses.
- Safeguarding supervision with community midwives has continued and compliance has remained high due to the use of MS Teams WebEx and telephone contact.
- The 16 week appointment was reinstated face to face as soon as it was safely possible.
- Communication with GP's regarding safeguarding concerns was highlighted with the CMW's and the use of the GP liaison forms was reinforced.
- Face-to-face appointments were offered to women with known concerns where possible.

2020 / 2021 PRIORITIES:

- The concealed pregnancy standard operating procedure (SOP) is to be reviewed and implemented.
- Support the community midwives to attend more Initial Child Protection Conferences.
- Support the new continuity of care teams in maternity services.
- Promote increased awareness of FGM
- Refresh the focus on male partners and the significance of the role they have in caring for babies and young children.

SAFEGUARDING CHILDREN

2020 / 2021 CHALLENGES:

- Ensuring the high quality of multiagency safeguarding practice whilst working with partner agencies in 'special measures'.
- Review of administrative processes within the team.
- There were significant changes to practice in March 2020 due to restrictions visiting wards. The team worked hard to maintain a visible presence throughout the Trust and quickly adapted working practices to keep in contact with wards/departments and to be as 'virtually visible' as possible during this time.

2020 / 2021 ACHIEVEMENTS:

- The team have continued duty rounds and have maintained visibility during the pandemic. This includes visits to A&E each morning and quality assures safeguarding referrals made in the previous 24 hours (or over the weekend).
- The team respond to calls for advice and support from practitioners or to calls from partners for Trust information.
- Continued attendance at same day child protection strategy meetings
- Processes for safeguarding supervision have been adapted by using MS Teams and this has supported compliance which remains compliance remains at 99% - 100%.
- Quarterly Areas of Focus have been successfully introduced (Paeds Q4 Jan – Exploitation 50 staff – Feb SAFER Referrals 41 staff)
- The high number of CSPR and DHR's have been completed within timescales
- Participated in Middlesbrough Local Authority improvement plan through membership on groups such as MACH Operational Group.
- Business as usual has been maintained and the team continue to participate in South Tees safeguarding partnership arrangements.
- The team continue to actively contribute to MATAC, MARAC and safeguarding strategy meetings via Microsoft Teams.
- Child protection medicals are completed within 24 hours of referral except in a few cases where it has been agreed between the paediatrician and the social worker.
- The team supports the child death review process where there are safeguarding concerns.

2021 / 2022 PRIORITIES:

- The Named Nurse Safeguarding Children will be a member of the MCA Steering Group in preparation for the implementation of LPS.
- There is a task and finish group led by the Named Doctor to review and implement the newly published FII Procedures.
- Staff within paediatrics and the emergency department will be upskilled to work with young people in respect of the MCA / DoLS for 16 and 17 year olds.
- A continuous cycle of service improvement will be developed to include additional data collection and monitoring.
- Supervision documentation will move to an electronic system.

LOOKED AFTER CHILDREN

2020 / 2021 CHALLENGES:

- The looked after children system is complex and highly interdependent on the timely actions of multiple agencies and multiple professionals within those agencies. Additionally a number of local children are placed in areas outside of the Trust footprint, and a number of children from outside our area are placed within South Tees. The looked after team has a role in statute and contract in relation to all of these children. Additionally the number of children becoming looked after can vary dramatically each quarter leading to peaks and troughs of activity which can impact on performance.
- The Trust should be notified the child has become looked after and be provided with parental consent for the assessment within 5 working days. The initial health assessment is then carried out by a paediatrician.

2020 / 2021 ACHIEVEMENTS:

- Initial health assessments moved to a virtual model during the first lockdown but returned to face to face assessments when this was lifted; unlike other areas that continued with virtual contacts. This is better for children and avoids the need for re-assessment as recommended by RCPCH.
- Challenges with partner agencies working from home which has impacting on co-location arrangements and the practicality of SW's working from home getting documents into the health team in a timely manner which has in turn impacted on IHA compliance. Despite this:
  - 100% of all review health assessments where children have been placed out of area have been quality assured by the team.
  - The Looked after Team have consistently achieved 100% compliance for IHAs within 15 days of receiving official notifications from the local authorities.
- The team have proactively managed workload despite an increase in the overall number of children in care who require review health assessments.
- The team have maintained their own health and well-being during a time when their local authority colleagues vacated the co-located office base and the Looked after Children Team have had to work in isolation.

2021 / 2022 PRIORITIES:

- Continue to pro-actively improve systems and processes to manage increasing workload due to higher numbers of children remaining in care for longer.
- Work with multi-agency partners to improve the notification process for when children or young people become looked after or when they change foster placement.
- Seek to transfer the team from their current location in a local authority building into an NHS office base to improve working environment.
- Work with colleagues to develop a new service for review health assessments across the Tees Valley footprint.

SAFEGUARDING ADULTS

2020 / 2021 CHALLENGES:

- Resources to the adult safeguarding team were reduced when a full-time member of the team was re-deployed to critical care during the pandemic.
- There has been an increase in safeguarding concerns around discharges. "Discharge to Assess" is creating challenges in relation to patients being discharged before being assessed by a social worker.
- The dissemination of shared learning has been more challenging due to the cancellation of corporate events such as safety@southtees, Nursing Leadership days and other forums.
- Tees Safeguarding Adults Board stood down Board meetings and sub-groups for several months. Despite this, safeguarding adults work continued within the Trust by introducing virtual means to contact staff and other organisations. Other meetings such as MAPPA continued via teleconferencing and/or Teams.
- There is no Named Doctor for safeguarding adults in the Trust.

2020 / 2021 ACHIEVEMENTS:

- The adult safeguarding team received a stars award for their incredible support to the Therapeutic Care Team.
- There is an improvement in compliance with Making Safeguarding Personal (MSP as evidenced by the audit process.
- The operational model for the delivery of adult safeguarding within the Trust was revised to support clinical services during the pandemic.
- Compliance with safeguarding training and safeguarding supervision has been maintained despite intense pressure on clinical services.
- Safeguarding investigations including safeguarding adult reviews and domestic homicide reviews have continued throughout the pandemic.
- The adult safeguarding team have continued to contribute to multi-agency work including the work of the Safeguarding Adults Boards and sub-groups in Teesside and North Yorkshire.

2021 / 2022 PRIORITIES:

- Prepare for the implementation of Liberty protection Safeguards in 2022 and set up a new Steering / Operational Group for the Trust to support MCA / DoLS & LPS.
- Improve the application of the MCA into clinical practice to support a positive patient experience when individuals access Trust services.
- Explore new opportunities for conducting thematic learning reviews and sharing lessons that arise from safeguarding investigations; safeguarding adult reviews and domestic homicide reviews.
- Develop systems and process to capture data that reflects the work of the adult safeguarding team.
- Promote increased awareness of modern slavery and human trafficking and equip staff with the skills and knowledge to identify concerns and act responsively.

LEARNING DISABILITY

2020 / 2021 CHALLENGES:

Challenges arose when the learning disability nurse was re-deployed into a clinical role to support the Covid pandemic. A delay in national Covid-19 guidance for patients with learning disabilities also meant some patients were not supported by family or carers. Policies have since been developed to ensure patients with a learning disability can have someone with them during an out-patient, emergency department or in patient stay.

Covid related deaths for patients with a learning disability were not noted in the first lockdown of 2020; however there has been a notable increase in Covid-19 deaths in quarter 4. All deaths have been notified to LeDeR and are being reviewed under the LeDeR process.

2020 / 2021 ACHIEVEMENTS:

- Accessible information (videos and easy read documents) has been produced and made available on the Trust website. Updates have also been posted regularly with advice on keeping well and links to useful support groups.
- Learning disability training has been developed to be accessed via e-learning.
- The Diamond Standard Pathway is ready to launch in Learning Disability week 2021; this includes care pathways for inpatient, outpatient, emergency admission and discharge as developed by NECLD.
- A report on the outcomes from the national LeDeR 2020 Annual Report was presented to the Learning Disability Partnership Group, Patient Safety Sub-Group and Quality Assurance Committee.
- Additional funding has been received from the CCG to support improving the care of people with a learning disability in the Trust.
- Work has progressed to improve the number of patients with a learning disability & autism to be flagged on the Trust's electronic systems.
- LeDeR reviews have continued during the pandemic (Appendix 9).
- The national learning disability audit for NHSI was completed for the third consecutive year.
- 'Ask Listen Do' posters have been developed.
- The learning disability nurse has supported some complex patients to access Trust services.

2021 / 2022 PRIORITIES:

- Learning Disability Diamond Pathway to be introduced in June 2021 to coincide with national Learning Disability week.
- Set up a RNLD Forum to generate Ideas and inspiration about how RNLD nurses can support the learning disability agenda in the Trust
- Set up a task and finish group to improve the use of hospital passports.
- Facilitate the development of mandatory learning disability training for all clinical staff.

SAFEGUARDING TRAINING

OVERVIEW:
The Trust has a statutory responsibility to ensure its workforce is trained to meet the needs of children, young people and adults who come into contact with Trust services by ensuring staff have the appropriate skills and competencies achieved through safeguarding training. In order to support compliance with our legal duty, the Royal Colleges and professional health bodies have published intercollegiate guidance for safeguarding children[1] (2019) and safeguarding adults[1] (2018) which sets out the knowledge, skills and training requirements for healthcare staff in the UK.

2020 / 2021 CHALLENGES:
- The COVID-19 pandemic restrictions and subsequent immunisation programme have resulted in all face-to-face training being postponed for the majority of the past year.
- The safeguarding trainer was temporarily re-deployed on a part-time basis to support the Covid vaccination hub.
- Completion of mandatory training has been a challenge for staff within the Trust due to the pressures of the pandemic.
- Challenges associated with transferring to a new training system
- Ongoing issues with the accuracy of the training data, due to errors in the creation and amending of records, resulting in significant amounts of time by the safeguarding team to correct the errors.

2020 / 2021 ACHIEVEMENTS:
- Maintained high compliance across each level of safeguarding training despite the ongoing pandemic and service pressures within clinical areas (Appendix 9 page 21).
- Significant preparations to support with the transfer to a new Trust training system
- A review and streamlining of the training requirements, with publication of a new training strategy. (Appendix 4 page 16).

2021 / 2022 PRIORITIES:
- To support staff with the new training system to ensure all staff can access their mandatory safeguarding and Prevent training.
- To embed the new training strategy across the organisation by raising awareness.
- To endeavour to raise compliance for safeguarding and Prevent training.
- To facilitate enhanced learning by developing bespoke safeguarding training packaged to supplement mandatory training requirements and encourage staff to attend to embed a culture of safeguarding across the Trust.
- Explore new opportunities to deliver training using virtual technology.

PARTNERSHIP WORKING

Cleveland Police are committed to work in collaboration with health providers to protect children and adults from harm. The Trust representative has been critical in support of the revision of VEMT strategy 2021. The strategy recognises the critical importance of strong partnership working to protect those who might be at risk of exploitation, the need to support victims and to disrupt and prosecute suspected offenders. The Trust representative has been a key player in this and continues to support the strategy in the role of deputy chair and lead of the VEMT sub-group. **Detective Chief Inspector Shaun Page**

Middlesbrough Council's Access Safeguarding Team works closely with the Trusts Safeguarding Adults Team and value the established partnership working that supports the effective coordination of enquiries and timely information sharing. Joint working also enables safeguarding concerns to be shared with the Trust keeping them informed of vulnerable adults in their care. The Safeguarding Team effectively manage enquiries on behalf of the local authority, providing us with a detailed analysis of the concern raised whilst identifying lessons learnt and monitoring the completion of action plans. Partnership working is further embedded as the Council's Access Safeguarding Lead Officer is a member of the Trust's Safeguarding Adults Operational Meeting which allows us to reflect on safeguarding practice and to pick up on any themes and issues that need to be addressed at a strategic level. **Ruth Musicka (Access Safeguarding Lead Officer) Middlesbrough Adult Social Care**

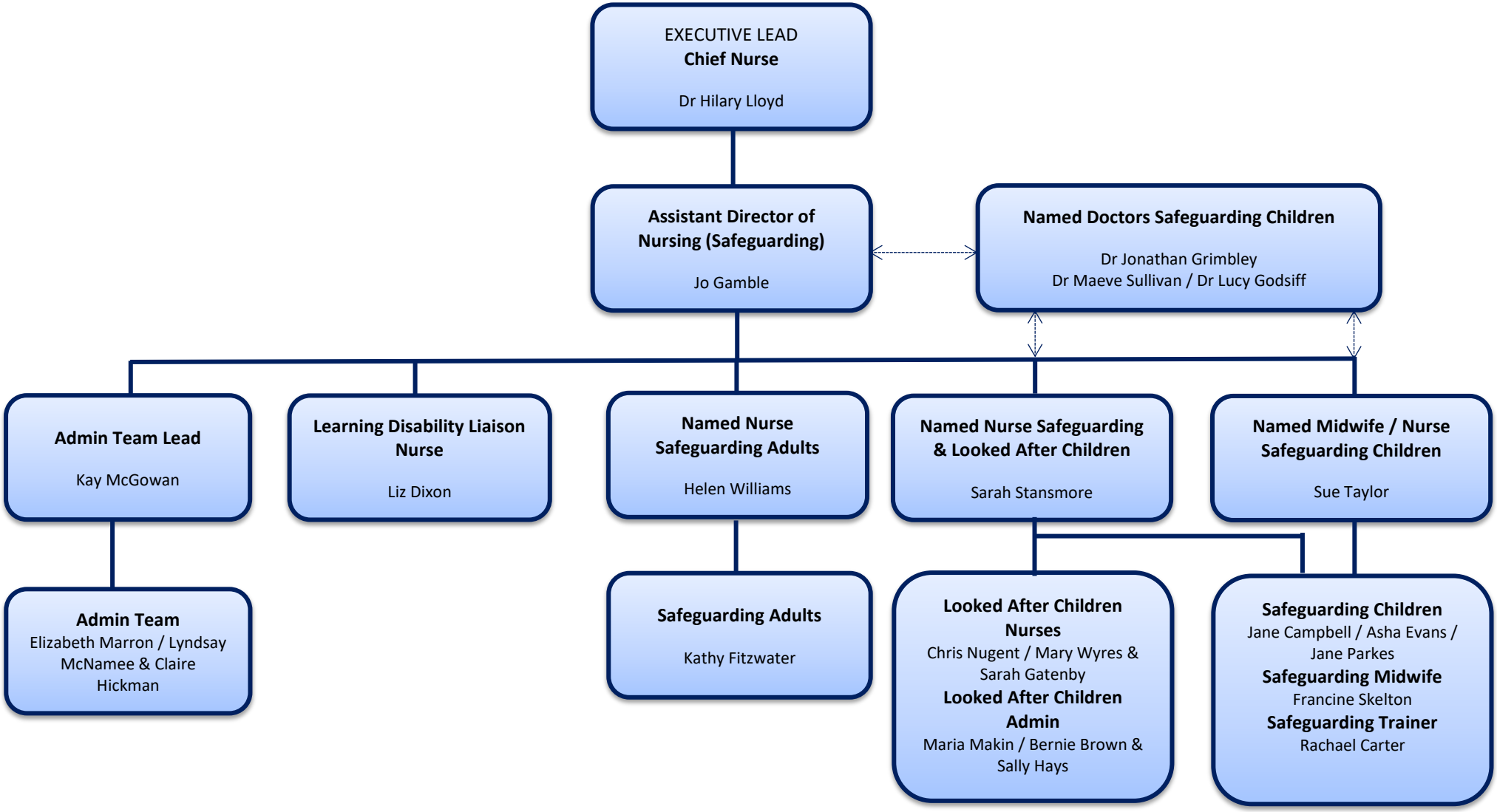
The Trust has worked closely with Tees Valley CCG which has provided assurance of appropriate safeguarding activities and enabled strong partnership engagement and support related safeguarding developments and initiatives. **Alison Peevor (Head of Quality & Adult Safeguarding) NHS Tees Valley CCG**

South Tees NHST have been receptive to the feedback raised by Tees Valley CCG, to safeguarding queries and concerns and the new in post Assistant Director for Safeguarding has worked hard over a relatively short period of time to maintain relationships with multi-agency partners, as well as forge new ones. The AD is aware that there is still much to do to maintain the assurance that there is already as well continuing the build on this. **Nicki Ayres Interim Designated Nurse LAC/CIC NHS Tees Valley Clinical Commissioning Group**

APPENDIX 1
Safeguarding Management Structure

South Tees Hospitals NHS
NHS Foundation Trust

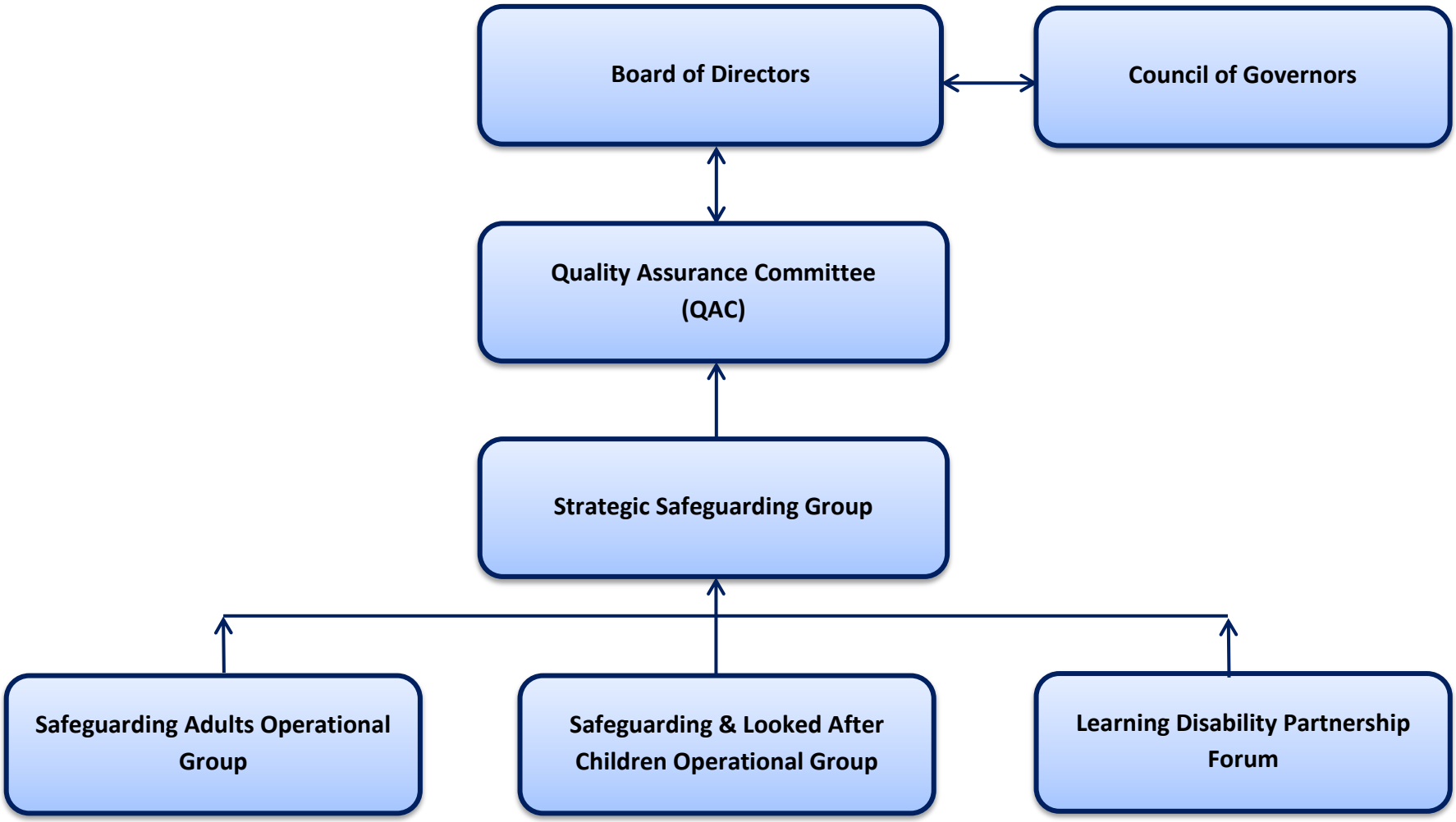
SAFEGUARDING MANAGEMENT STRUCTURE 2020 - 2021



APPENDIX 2
Safeguarding Governance Structure

South Tees Hospitals NHS
NHS Foundation Trust

SAFEGUARDING GOVERNANCE STRUCTURE 2020 - 2021



APPENDIX 3
Safeguarding Strategy

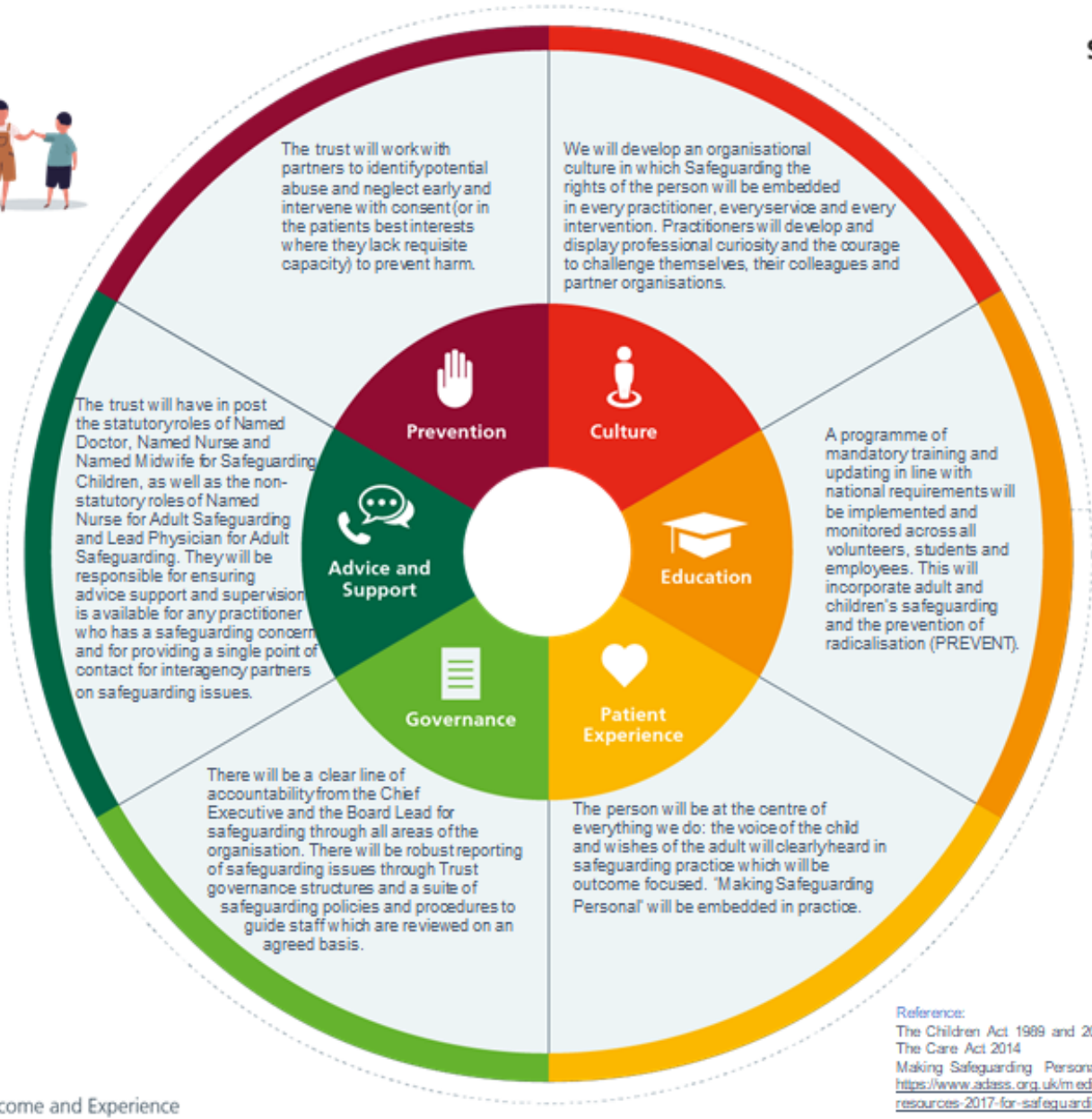
South Tees Hospitals NHS
NHS Foundation Trust

Safeguarding Strategy 2020-2023

NHS
South Tees Hospitals
NHS Foundation Trust

Background

Safeguarding is a positive duty placed on all of us to promote the wellbeing of vulnerable people and protect them from harm whether or not the harm is intentional and irrespective of whoever causes the harm. Safeguarding duties are rooted in law and whilst legislation differs between adults and children, human rights run as a golden thread through both. As a public authority the trust must follow the Human Rights Act 1989 in everything we do. We are obliged to treat people in accordance with their rights.



Aim

- Every unborn baby child and young person will be enabled to grow up free from abuse and neglect.
- Every adult will be supported to live the life they choose safe from harm.
- Every trust practitioner will be supported by the organisation to promote this aim.

Reference:
The Children Act 1989 and 2004
The Care Act 2014
Making Safeguarding Personal
https://www.adass.org.uk/media/6137/msp-resources-2017-for-safeguarding-adults-boards.pdf

Excellence in Patient Outcome and Experience

APPENDIX 4
Safeguarding Mandatory Training Matrix

South Tees Hospitals NHS
NHS Foundation Trust

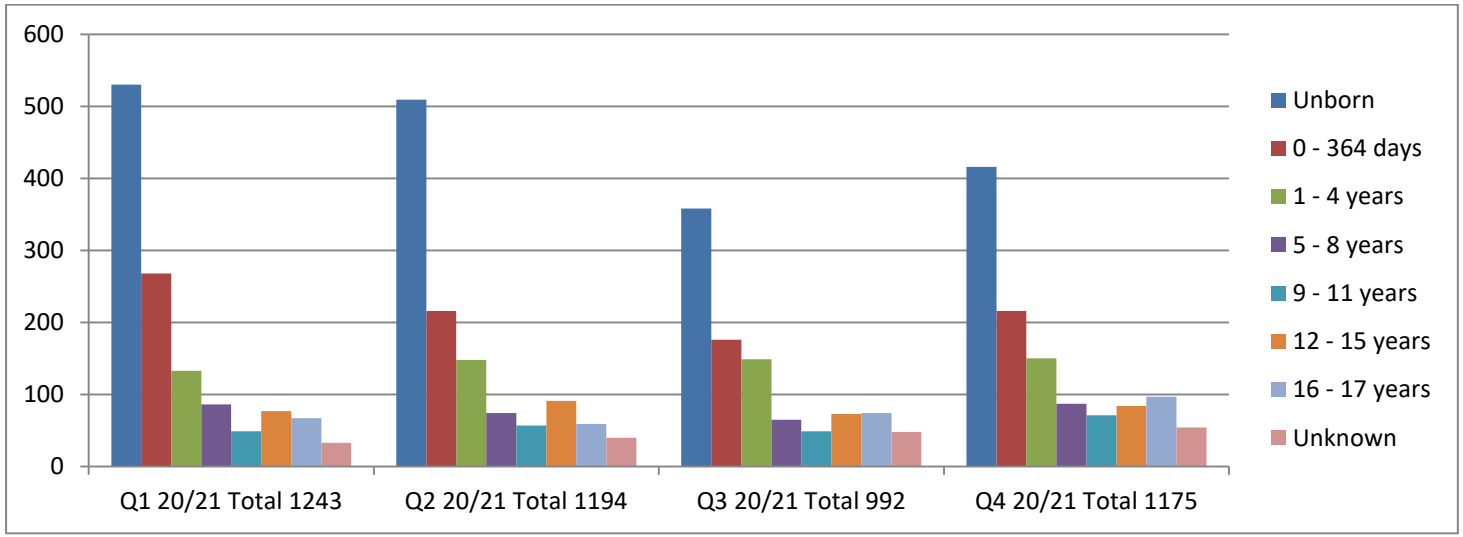
Level	Staff Groups	Safeguarding Level	Method & frequency	Mandatory Requirement	Prevent[4] Requirement	Method & Frequency
Level 1	**All non-clinical staff + clinical staff with no patient contact** e.g. receptionists, admin & clerical, lab staff /healthcare scientists/ technicians, catering staff, domestic staff, porters, maintenance staff, Board members[5], Non-executive Directors and volunteers	Adults Level 1	Combined eLearning Every 3 years	Adults = 2 hours / 3 yearly	**BPAT**	eLearning (one off)
		Children Level 1		Children = 2 hours / 3 yearly		
Level 2	**All clinical staff** with any patient contact including medical, nursing, AHPs, pharmacy, chaplains, radiologists, students, phlebotomy and nursing associates	Adults level 2	Combined eLearning Every 3 years	Adults = 3-4 hours / 3 yearly	**WRAP**	eLearning (one off)
		Children Level 2		Children = 4 hours / 3 yearly		
Level 3	**Staff working predominantly with children or with adults where there may be safeguarding concerns** e.g. ED & Urgent Care Staff, Paediatric Staff, Learning Disability Nurses, Specialist Nurses for Safeguarding Adults / Children, Midwives & Obstetricians, neonatologists, paediatric intensivists, diagnostic radiographers (those undertaking imaging for suspected physical abuse)	Adults level 3	Combined Face to face (3 hours annually)	Adults = 8 hours / 3 yearly	**WRAP**	eLearning (one off)
		Children Level 3		Children = 8 hours / 3 yearly		
		Children Level 3+[6]		Children = 12-16 hours / 3 yearly		
Level 4	Named Nurses & Named Doctors + ADoN Safeguarding	Adults Level 4	Combination of eLearning / face to face training and self-directed learning	Adults = 24 hours / 3 yearly	**WRAP**	eLearning (one off)
		Children Level 4		Children = 24 hours / 3 yearly		

[4] There is a requirement for NHS staff to complete the national PREVENT training packages developed by the Home Office. Training needs to be refreshed every 3 years and will be included in the Trust's training at every level. An annual briefing will also be distributed to all staff.
[5] The Intercollegiate Guidance for Safeguarding Adults (2018); Safeguarding Children (2019) and Looked After Children (2020) all state that Board members including chief executive officers, executive and non-executive board members need a tailored package to encompass level 1 skills and competencies with additional board level specific knowledge.
[6] Guidance will be issued to staff requiring level 3+ safeguarding children training to advise how this may be completed; for nurses and midwives this will evidence knowledge and skill to support revalidation with the NMC.

APPENDIX 5
Safeguarding Children Data

South Tees Hospitals NHS
NHS Foundation Trust

ADVICE AND SUPPORT



Child Protection Medicals				
	TOTAL NO.	SEEN IN 24 HOURS	EXCLUDED*	% COMPLIANCE
Q1 20/21	53	47	5	98%
Q2 20/21	60	59	0	98%
Q3 20/21	75	71	0	95%
Q4 20/21	39	38	1	100%

Safeguarding Supervision	
COMPLIANCE	%
Q1 20/21	100%
Q2 20/21	100%
Q3 20/21	99%
Q4 20/21	99%

APPENDIX 6
Looked after Children Data

South Tees Hospitals NHS
NHS Foundation Trust

			17/18	18/19	19/20	20/21	% Increase
Initial Health Assessments	M[7]	TOTAL CHILDREN	138	195 (↑41%)	290 (↑49%)	225 (↓22%)	↑63% overall
	RC[8]	TOTAL CHILDREN	120	120 (↔)	154 (↑29%)	126 (↓18%)	↑5% overall
		TOTAL	**258**	**315 (↑22%)**	**444 (↑41%)**	**351 (↓21%)**	**↑36% overall**
Review Health Assessments undue 5 years	M	TOTAL CHILDREN	146	161 (↑10%)	200 (↑24%)	267 (↑34%)	↑83% overall
	RC	TOTAL CHILDREN	66	80 (↑21%)	105 (↑31%)	120 (↑14%)	↑82% overall
		TOTAL	**212**	**241 (↑13%)**	**305 (↑27%)**	**387 (↑27%)**	**↑83% overall**
Review Health Assessments over 5 years	M	TOTAL CHILDREN	267	316 (↑18%)	332 (↑5%)	377 (↑2%)	↑41% overall
	RC	TOTAL CHILDREN	178	189	211	221 (↑5%)	↑24% overall
		TOTAL	**445**	**505 (↑13%)**	**543 (↑8%)**	**598 (↑10%)**	**↑34% overall**

TOTALS	**IHAs**	258	315 (↑22%)	444 (↑41%)	351 (↓21%)	↑36% overall
	TOTAL RHAs	657	746 (↑14%)	848 (↑14%)	985 (↑16%)	↑% overall
	OVERALL TOTAL	**915**	**1061 (↑16%)**	**1292 (↑22%)**	**1336 (↑3.5%)**	**↑50% overall**

[7] M = children who are looked after by Middlesbrough Local Authority
[8] RC = children who are looked after by Redcar & Cleveland Local Authority

South Tees Hospitals NHS
NHS Foundation Trust

APPENDIX 7
Adult Safeguarding Data

Safeguarding Adults Activity 2020 - 2021						
	2019 - 20	**Q1 20-21**	**Q2 20-21**	**Q3 20-21**	**Q4 20-21**	**TOTAL**
Datix incidents coded as safeguarding adults	1100	277	323	324	322	1246 ↑
Safeguarding concerns submitted to local authority	573	149	154	170	157	630 ↑
Safeguarding concerns relating to Trust practice	115 (20%)	31 (21%)	38 (25%)	42 (25%)	52 (33%)	163 (26%)↑
Top 3 themes	Discharge Medication Communication	Pressure ulcers Medication Staff behaviour	Pressure ulcer Discharge Medication	Discharge Medication Communication	Discharge Pressure ulcer Medication	Medication Pressure ulcer Discharge
MHA detentions	17	6	3	10	7	26 ↑
Urgent DOLS authorisation and application for Standard Authorisation	489	120	163	141	153	577 ↑

APPENDIX 8
Summary of Trust LeDeR Reviews

South Tees Hospitals NHS
NHS Foundation Trust

Trust LeDeR Reviews:

2020/21	Number of deaths	Cause of Death
Q1 20/21	5	2 deaths due to Covid-19 pneumonitis 1 respiratory failure 2 no cause of death noted
Q2 20/21	3	SI Investigation Coroner Community acquired pneumonia
Q3 20/21	6	1 advanced ovarian cancer 3 Covid 19 Pneumonitis 2 multi organ failure
Q4 20/21	8	7 Covid 19 Pneumonitis 1 aspiration pneumonia

Outcome of the mortality review:

No of patients	Score	Outcome
16	1 – 1	Good practice in healthcare Death definitely not preventable
2	2-1	Room for improvement in clinical care Death definitely not preventable
1	1-2	Good practice in healthcare Slight evidence death could have been preventable (acquired Covid-19 as an in-patient)
1	5-3	Less than satisfactory healthcare Possibly preventable less than 50-50 This will be subject to a more detailed review as an SLE.
2	No score	1 mortality review has not been completed yet 1 mortality review did not include an outcome score

APPENDIX 9
Safeguarding Training Compliance 2020 - 2021

South Tees Hospitals NHS
NHS Foundation Trust

CHILDREN								
	L1	L2	L3 Initial	Level 3 Update	L3+ Initial	L3+ Update	L 4	Total compliance
Q1 20/21	90%	89%	92%	96%	94%	88%	100%	89%
Q2 20/21	90%	91%	93%	84%	93%	80%	100%	90%
Q3 20/21	91%	92%	93%	87%	90%	73%	89%	90%
Q4 20/21	88%	88%	97%	93%	89%	77%	100%	88%

ADULTS						PREVENT[9]		
	L1	L2	L3 update	Level 4	Total Compliance	Prevent BPAT	Prevent WRAP	Total compliance
Q1 20/21	92%	89%	100%	100%	90%	83%	90%	88%
Q2 20/21	93%	91%	94%	100%	92%	88%	91%	90%
Q3 20/21	93%	92%	50%	75%	92%	88%	92%	91%
Q4 20/21	91%	89%	77%	100%	89%	86%	88%	88%

LEGEND	
90 – 100%	GREEN
80 – 89%	AMBER
79% or lower	RED

[9] Prevent training compliance is above the national target of 85%

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 7 SEPTEMBER 2021			
HCAI Annual Report			**AGENDA ITEM: 12** **ENC 9**
Report Author and Job Title:	Richard Bellamy, Infection Control Doctor, JCUH Sharon Lance, Deputy DIPC	**Responsible Director:**	Hilary Lloyd, Director of Nursing & Quality/ DIPC
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	The members of the Trust Board of Directors are asked to note the current position in respect of HCAI for the year 2020/21 and for their support for the actions being taken.		
Background	The report summarises surveillance information on the following for the year 2020/21, • *Clostridium difficile*-associated diarrhoea • *Methicillin Resistant Staphylococcus aureus* (MRSA) and *Methicillin Sensitive Staphylococcus aureus* (MSSA) bacteraemia • Bacteraemia due to *glycopeptide-resistant Enterococci* • Bacteraemia due to three Gram negative bacteria *Escherichia coli* (*E. coli*), *Klebsiella* species and *Pseudomonas aeruginosa* • Extended Spectrum Beta Lactamase (ESBL)-producing coliform infections and other important healthcare-associated infections. The report also highlights antimicrobial stewardship and environmental cleaning in relation to HCAI management. Measures undertaken for COVID-19 in this time period are also described.		
Assessment	All infection prevention and control activities are monitored by The Infection Prevention Assurance Group (IPAG) which reported to the Quality Assurance Committee (QAC). This report is presented to IPAG and QAC prior to the Board of Directors. The Clostridium difficile-associated diarrhoea objective for 2020/21 was the same as it was for 2019/20 which was to have no more than a combined total of 81 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There have been 79 COHA + HOHA cases in the current financial year. This		

	compares to 89 cases in 2019/20. MRSA bacteraemia target is that of zero tolerance. There has been 1 Trust-assigned case for the 2020/21 financial year, which is the same as in 2019/20. There was no official MSSA bacteraemia target for 2020/21. There were 21 Trust-apportioned MSSA bacteraemia cases in the current financial year. This compares to 43 in 2019/2020. Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in avoidable bacteraemia by 2022/2023. There were 497 cases of the three GNBSI organisms which are part of national surveillance, 104 of which were classed as trust-apportioned. This is a 22% decrease in total cases compared to 2019/20 and a 32% decrease compared to 2018/19. For hospital-apportioned cases this is a 20% decrease compared to 2019/20 and a 42% decrease compared to 2018/19. The Trust had 5 cases of bacteraemia due to Glycopeptide-resistant Enterococci in 2020/21, compared to 6 cases in 2019/20. ESBL-producing coliforms cause a large number of infections and they are the commonest multi-drug resistant Gram negative organisms affecting patients in the Trust and in the local community. In 2020/21 the Trust had 14 cases of bacteraemia due to ESBL-producing coliforms, compared to 24 in 2019/20. One further case of multi-drug-resistant GES-carbapenemase-producing Pseudomonas aeruginosa was identified in 2020/21. This is part of an ongoing outbreak which was first identified in 2014, but there is no evidence of ongoing spread. In total 26 patients have been affected by the GES carbapenemase-producing strain. This continues to be monitored. Over the last 3-4 years several patients across Teesside have been found to carry the same strain of oxa-48 carbapenemase-producing Klebsiella pneumoniae. We have not detected any cases of transmission within our trust during 2020/21, despite extensive contact-tracing and screening. During the winter months, outbreaks of Norovirus infection have previously caused severe disruption both nationally and to our Trust. During 2020/21 there was 1 cluster which met our definition of an outbreak and it affected a total of 11 patients and 8 staff members. During the winter months of 2020/21 a total of 0 patients with influenza who required critical care.

	An international pandemic of a novel coronavirus began in December 2019. COVID-19 started to affect our trust during February and March 2020 and caused significant challenges during 2020/2021. A number of antimicrobial stewardship initiatives are in place in the trust. Due to changes in our antibiotic guidelines we have seen an increase in total antibiotic use and carbapenem use. There have been significant improvements in endoscope decontamination practices and traceability, over the last 5-6 years. An international issue was identified in 2016 with regard to patients who have had cardiac surgery who have subsequently developed endocarditis due to Mycobacterium chimerae. To date no patients who have had cardiac surgery in our Trust have been found to be affected. However we have had Mycobacterium chimaera isolated from one of our heater-cooler units. The overall average of compliance with the 5 moments of hand hygiene as reported by self-audit is 99% compared with average peer audit scores of 89%. Cleaning standards have been maintained on all of the trust hospital sites over 2020/21 with the majority of cleaning scores above the required threshold. Joint monitoring with the trusts Environmental Monitoring Team continues and cleaning scores are monitored through IPAG. The IPC team have continued to develop and use 'tool box teaching' packages. This approach has enabled a more flexible approach to training and education.	
Recommendation	Members of the Trust Board of Directors are asked to note the year end position in respect of HCAI.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF threat - 1.2 An increase in the incidences of infectious disease (such as CDIF, influenza; Coronavirus; norovirus; infections resistant to antibiotics) that forces closure of one or more areas of the hospital	
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	Make best use of our resources ☐

	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 ☐	

INFECTION PREVENTION AND CONTROL ANNUAL REPORT
APRIL 2020 TO MARCH 2021

1. INTRODUCTION

This annual report summarises information on healthcare-associated infections for the period 1st April 2020 to 31st March 2021 including a summary of alert organisms and conditions. It includes information on Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia, Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and *Clostridium difficile*-associated diarrhoea.

2. SURVEILLANCE DATA

2.1 C. difficile-associated diarrhoea

The 2020/21 *C. difficile* definitions are as follows:

a) Hospital onset healthcare associated (HOHA): cases detected in the hospital ≥2 days after admission.

b) Community onset healthcare associated (COHA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.

c) Community onset indeterminate association (COIA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks.

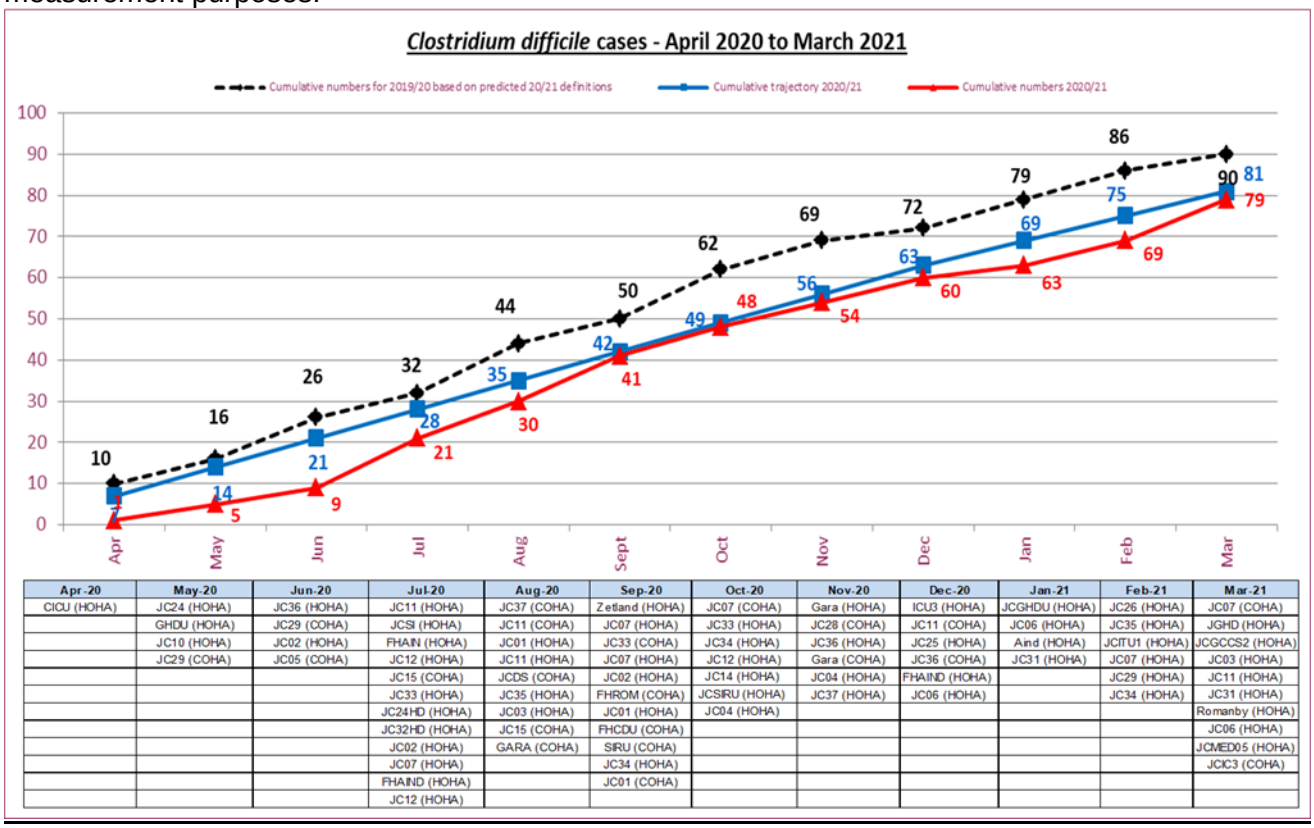
d) Community onset community associated (COCA): cases that occur in the community (or within <2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

The *Clostridium difficile*-associated diarrhoea objective for 2020/21 was the same as it was for 2019/20 which was to have no more than a combined total of 81 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. In 2020/21 there have been 79 trust-apportioned cases (COHA = 21; HOHA = 58) so the target has been met. In comparison, between April 2019 and March 2020 the Trust had 89 cases of Trust-apportioned *C. difficile* infection so there has been an 11% decrease compared to last year.

A cluster of *C. difficile* is described as two or more cases which may be linked. During 2020/2021 the Trust had no confirmed clusters.

Root Cause Analysis (RCA) and panel reviews are undertaken for all trust-apportioned *C. difficile* cases. Panel reviews are chaired by the DIPC or Deputy DIPC and are attended by CCG colleagues. These panels were postponed during the COVID-19 emergency period whilst RCAs have continued.

These panels have been reinstated in 21/22 whereby, if the panel agrees that there were no lapses in care, then the case may be discounted from the total for performance measurement purposes.



Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
CICU (HOHA)	JC24 (HOHA)	JC36 (HOHA)	JC11 (HOHA)	JC37 (COHA)	Zetland (HOHA)	JC07 (COHA)	Gara (HOHA)	ICU3 (HOHA)	JCGHDU (HOHA)	JC26 (HOHA)	JC07 (COHA)
	GHDU (HOHA)	JC29 (COHA)	JCSI (HOHA)	JC11 (COHA)	JC07 (HOHA)	JC33 (HOHA)	JC28 (COHA)	JC11 (COHA)	JC06 (HOHA)	JC35 (HOHA)	JGHD (HOHA)
	JC10 (HOHA)	JC02 (HOHA)	FHAIN (HOHA)	JC01 (HOHA)	JC33 (COHA)	JC34 (HOHA)	JC36 (HOHA)	JC25 (HOHA)	Aind (HOHA)	JCITU1 (HOHA)	JCGCCS2 (HOHA)
	JC29 (COHA)	JC05 (COHA)	JC12 (HOHA)	JC11 (HOHA)	JC07 (HOHA)	JC12 (HOHA)	Gara (COHA)	JC36 (COHA)	JC31 (HOHA)	JC07 (HOHA)	JC03 (HOHA)
			JC15 (COHA)	JCDS (COHA)	JC02 (HOHA)	JC14 (HOHA)	JC04 (HOHA)	FHAIND (HOHA)		JC29 (HOHA)	JC11 (HOHA)
			JC33 (HOHA)	JC35 (HOHA)	FHROM (COHA)	JCSIRU (HOHA)	JC37 (HOHA)	JC06 (HOHA)		JC34 (HOHA)	JC31 (HOHA)
			JC24HD (HOHA)	JC03 (HOHA)	JC01 (HOHA)	JC04 (HOHA)					Romanby (HOHA)
			JC32HD (HOHA)	JC15 (COHA)	FHCDU (COHA)						JC06 (HOHA)
			JC02 (HOHA)	GARA (COHA)	SIRU (COHA)						JCMED05 (HOHA)
			JC07 (HOHA)		JC34 (HOHA)						JCIC3 (COHA)
			FHAIND (HOHA)		JC01 (COHA)						
			JC12 (HOHA)								

Graph 1: Cumulative Trust-apportioned *C. difficile* cases 2020/21 compared to trajectory

Identifying a single root cause in cases of *C. difficile* is challenging and is often associated with one or more influencing factors; patient factors e.g. existing long term conditions, and/or medical factors such as the requirement for antibiotics or laxatives and/or process concerns, e.g. delays in isolation.

C. difficile death certificate audit

During 2007 the Healthcare Commission published a report on an investigation into deaths which had occurred at Maidstone and Tunbridge Wells NHS Trust caused by *C. difficile*. In response to this, in 2007/8 we review all deaths where *C. difficile* was recorded on the death certificate.

In 2020/21, there were 2 JCUH cases and 0 cases at FHN. The death certificate counterfoils indicated that for 1 of these patients *C. difficile* or toxic megacolon was recorded as the primary cause of death (under Ia). For 1 patient, *C. difficile* was recorded as a contributing/ predisposing factor in the patient's death. In the infection control doctor's assessment concurs, *C. difficile* was the main cause of death for 1 patient and was a contributing/ predisposing factor for 1 patient.

2.2 MRSA bacteraemia

The approach to MRSA bacteraemia is that of zero tolerance. There were 4 cases of MRSA bacteraemia in 2020/21, 1 of which was classed as trust-assigned. In comparison, there were 5 cases in 2019/2020, 1 of which was classed as Trust-assigned.

Since June 2006 every episode of MRSA bacteraemia has been investigated as a clinical incident to help identify lessons to be learnt and to guide improvements in practice. The DIPC or deputy DIPC chairs the case review panel with the appropriate clinical staff. This has enabled a number of lessons to be learnt and has helped the Trust to focus attention on avoidable causes of MRSA bacteraemia.

2.3 MSSA bacteraemia

Between April 2020 and March 2021 there were 104 episodes of MSSA bacteraemia. 21 of these cases were classified as Trust-apportioned (defined as all cases occurring in inpatients other than those where the blood culture was taken on admission or on the day after admission). Compared to 2019/2020 this is a 34% decrease in total cases and a 51% decrease in trust-apportioned cases.

There is no external target for MSSA bacteraemia. However, the trust set an internal target for a 15% reduction from the 2016/17 baseline of 41 trust-assigned MRSA and trust-apportioned MSSA cases combined. This gives an upper threshold of 35. We have achieved this target as we had a combined total of 22 trust-apportioned MSSA and provisionally trust-assigned MRSA cases during 2020/21.

A case review meeting should be held within the relevant clinical centre/ directorate for every Trust-apportioned MSSA bacteraemia.

The cause of each MSSA bacteraemia is assessed by the infection control doctor and in 2020/21 the causes assigned were:

- Pneumonia: 39 cases.
- Skin and soft tissue infection: 19 cases.
- Tunnelled central venous lines including haemodialysis: 16 cases.
- Non-tunnelled central venous lines: 5 cases
- Infected discitis: 5 cases
- Catheter-associated urinary tract infection: 4 cases.
- Prosthetic joint infection: 4 cases.
- Septic arthritis: 3 cases.
- Peripheral venous cannulae: 1 case.
- Surgical site infection: 1 case.
- Contaminant: 3 cases.
- Other causes: 4 cases.

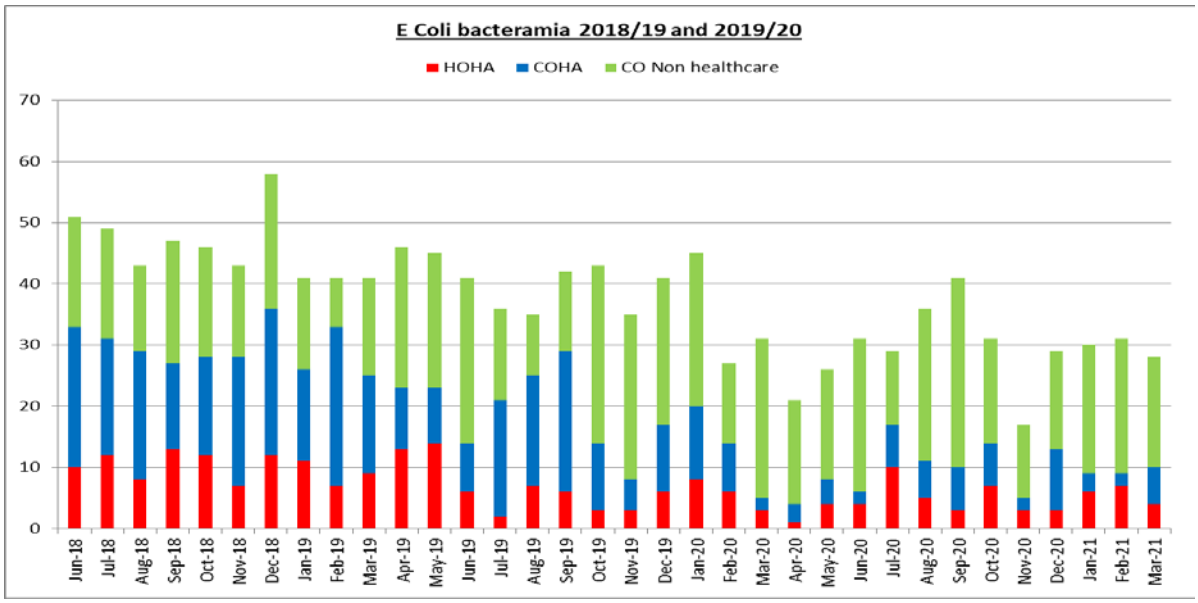
Bacteraemia can be related to invasive procedures (excludes prosthetic joint infection). Enhanced training for Aseptic Non-Touch Technique (ANTT) continues to be implemented across the trust for all relevant staff groups to address avoidable causes related to invasive procedures.

2.4 Surveillance for other alert organisms

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in avoidable bacteraemia by 2022/2023. During 2020/2021, the trust reported a total of 497 cases of the three GNBSI organisms which are part of national surveillance (*E.coli* 350; *Klebsiella* species 114; *Pseudomonas aeruginosa* 33). Of these, 104 cases were classed as trust-apportioned (21%). This is a 22% decrease in total cases compared to 2019/20 and a 32% decrease compared to 2018/19. For hospital-apportioned cases this is a 20% decrease compared to 2019/20 and a 42% decrease compared to 2018/19. The trust is working in collaboration with the wider health community on a large number of initiatives to reduce Gram negative infections including improving hydration and urinary catheter care.

Other alert organisms detected in 2020/21 compared to 2018/19 and 2019/20	**Total for 2020/21**	**Total for 2019/20**	**Total for 2018/19**
Bacteraemia due to glycopeptide-resistant enterococci	5	6	10
Bacteraemia due to E. coli • Trust-apportioned • Not trust-apportioned	350 57 293	468 81 387	550 129 421
ESBL producing coliform infections • sample taken in community • sample taken in our trust • bacteraemias	610 409 201 14	810 520 290 24	953 599 354 28
Bacteraemia due to Klebsiella species • Trust-apportioned • Not trust-apportioned	114 29 85	117 34 83	134 37 97
Bacteraemia due to Pseudomonas aeruginosa • Trust-apportioned • Not trust-apportioned	33 18 15	47 15 32	37 12 25
Other alert organisms • invasive group A streptococcus	0	1	1

Table 1: Surveillance of GNBSI and other alert organisms



Graph 2. E.coli bacteraemia for 2018 to 2021

ESBL-producing coliforms are highly antibiotic-resistant Gram-negative bacteria. The majority of isolates of these organisms are from the urinary tract, but they also cause wound infections, biliary and gastrointestinal tract infections, pneumonia and bacteraemia. The majority of infections are community-acquired. ESBL producing coliforms are not included in mandatory national surveillance, however, prevalence data regarding bacteraemias enables the most effective comparison year on year. In 2020/21 there were 14 bacteraemia due to ESBL-producing coliforms, compared to 24 in 2019/20 and 28 in 2018/19.

Glycopeptide-resistant Enterococci are highly antibiotic-resistant Gram-positive bacteria. The majority of infections are healthcare-associated. They are included in mandatory national surveillance. In 2020/21 there were 5 bacteraemias caused by glycopeptide-resistant Enterococci, compared to 6 in 2019/20 and 10 in 2018/19.

In 2012/13 we introduced monitoring for *Pseudomonas aeruginosa* in the water supply in critical care areas supported by active monthly surveillance. *Pseudomonas aeruginosa* has been detected periodically in several areas and action plans developed.

We have had an outbreak of GES-carbapenemase-producing, multi-drug-resistant *Pseudomonas aeruginosa* over the last 7 years, originally linked to critical care and the renal dialysis unit and urology ward. In total 26 patients have been affected by the GES carbapenemase-producing strain. The 1 case that was identified during 2020/21, probably acquired the organism several years previously. A large number of actions have been taken. We believe that cases have occurred due to patient-to-patient transmission rather than due to water-borne infection or another environmental source.

Acute trusts in the North and South locality across Teesside have seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing *Klebsiella pneumoniae* over the last 3-4 years. The major risk factors have been inpatient admissions to other trusts or residences in particular care homes. We do not believe transmission has occurred unknowingly in our trust. An extensive contact screening programme has only identified one case of transmission.

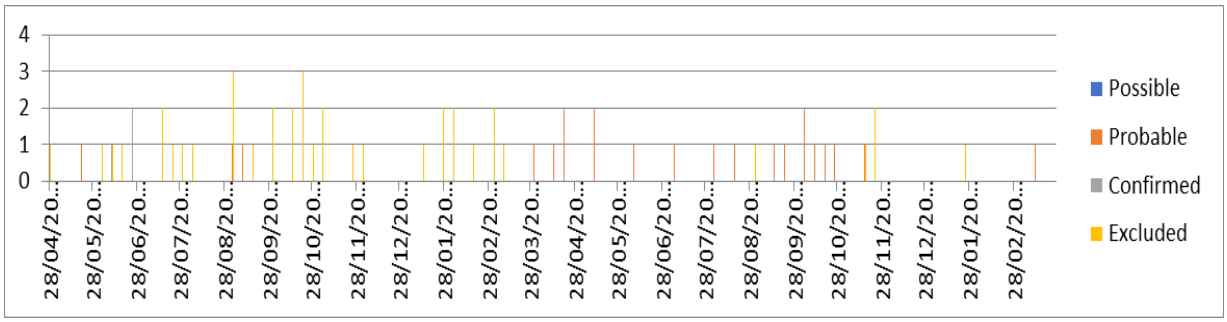
An international issue was identified in 2016 with regard to patients who have had cardiac surgery who have subsequently developed endocarditis due to *Mycobacterium chimaera*. To date no patients who have had cardiac surgery in our Trust have been found to be affected. However we have had *Mycobacterium chimaera* isolated from one of our heater-cooler units. The procedures to minimise the risk of heater-cooler contamination during cardiac surgery remain in place. The manufacturer has produced modifications to the design of the heater-coolers to minimise the risk of patient exposure.

2.5 Outbreak of *Serratia marcescens* within the cardiothoracic surgical service

In July 2019 our surveillance system for potential clusters of gram negative bacteria had identified 4 patients who had been treated in Cardiothoracic ICU and/or HDU had been colonised or infected with the same strain of *Serratia marcescens*. Further investigations have determined (as of 4th March 2021) we have had a total of 5 patients who are confirmed as affected by the outbreak strain, 22 cases classed as ‘probable’ and 38 cases which have

subsequently been found to be unlinked to each other. The timeline of outbreak cases indicates cases are now less frequent. Environmental sampling has identified *Serratia marcescens* from a sink area where there was damage to the wall behind the sink.

The Cardiothoracic ICU, HDU and ward 32 underwent a deep clean and hydrogen peroxide fogging and replacement of the contaminated sink in August 2019. The outbreak is monitored by IPAG. It appears that in recent months there has been a fall in cases of people developing *Serratia marcescens* colonisation and/or infection (see graph 3).



Graph 3: Timeline of *Serratia marcescens* cases

2.6 Surveillance for other alert conditions

No cases of any of the other alert conditions included in the surveillance policy (HIC 29) have been identified in 20/21.

Legionella has not been detected in the water supply in 20/21. Our most recent culture results were all negative. There have been no cases of Legionnaires' disease acquired in our Trust.

2.7 Orthopaedic surgical site infection surveillance

The trauma and orthopaedic directorate conduct mandatory surgical site infection surveillance following elective hip and knee replacement surgery at both the JCUH and FHN sites.

2.8 Outbreaks of diarrhoea and vomiting

During the winter months each year there have been outbreaks of Norovirus infection, which have caused significant disruption to the Trust.

Year	Patients affected	Staff affected
2019/20	82	54
2020/2021	11	8

Table 2: Comparison of patients and staff affected by winter vomiting disease during outbreaks at South Tees Hospitals 2019/20 and 2020/21

2.9 Influenza

Influenza had a much smaller impact on the trust in 2020/21 than in previous years probably because of the interventions being used to prevent the spread of COVID-19. The trust contributes to the national reporting of influenza cases in critical care and there were no cases in the winter of 2020/21. In comparison 11 patients with influenza were reported from critical care areas in 2019/20.

The trust achieved over 92.5% vaccination rate for clinical staff this year. This was the highest ever achieved and the highest in our region. It was a great achievement given the competing demands created by COVID-19.

2.10 Other critical care surveillance

Isolation capacity for patients with infection continues to pose a challenge particularly in ICU areas. Processes to mitigate risk of transmission of infection continue to be put in place including increased presence of the IPC team to support staff. Critical care teams work with IPC to ensure all risk reduction strategies are put in place. This includes appropriate use of PPE, strict hand hygiene, equipment decontamination and any condition-specific devices (e.g. faecal collector) are put in place.

2.11 COVID-19 pandemic

A brief summary of the response to COVID-19 by South Tees FT is listed below:

- Daily planning meetings occurred since Monday 3rd February 2020. There are now workstreams, tactical and strategic groups meeting regularly.
- All inpatients being admitted with or without symptoms of COVID-19 infection are screened. Those testing negative are re-screened on days 3 and 5.
- Staff with symptoms of COVID-19 infection are tested for infection.
- Staff members' relatives who have symptoms of COVID-19 infection can also be tested.
- South Tees inpatient areas were divided into red, amber and green pathways. The red pathway had included a "previous COVID-19-suspect" ward but this was stood down in early April 2021.
- A regular and detailed Trust briefing is produced to inform staff of the management of all potential patient pathways and admission routes and associated education and cleaning requirements.
- Between June and October 2020, a greater range of outpatient visits and elective procedures were reintroduced as part of the recovery process.
- In early 2021 we were in a national lockdown. This was due to rising cases and concern that a new variant was more transmissible than other strains. This variant was found in almost 100% of cases in the North East.
- Further concerns about new variants led to organised genotyping of several hundred positive COVID-19 swabs from the JCUH microbiology laboratory and none had the new variant.
- We commenced widespread staff asymptomatic lateral flow testing in late November 2020.
- Over 70,000 vaccinations have been given at South Tees Hospitals and we were highlighted as an exemplar of good practice by NHSE&I.

COVID-19

An outbreak is classed as two or more patients and/or staff members with COVID-19 which occur in the same clinical or non-clinical area within a 14-day period.

Outbreaks are managed by regular outbreak control meetings. All staff and all patients who are believed to have potentially been exposed to COVID-19 infection are tested. This enables assessment of the number of people who have been affected and the size of the area. In conjunction we assess many factors which may potentially have caused or contributed to transmission. The following factors are believed to have been relevant to COVID-19 transmission:

- *Patient pathways*
- *Ventilation*
- *Social distancing*
- *Use of PPE*
- *Close contact in rehabilitation wards*

3. ANTIMICROBIAL STEWARDSHIP

The trust is continuing with a number of antimicrobial stewardship initiatives including the ARK (antibiotic review kit) project. The antibiotic guidelines app was launched at the end of September 2019 and complements the “Antibiotic Sepsis/ Infection (not sepsis)” poster. The change in guidance carries a potential risk of increased cases of *C. difficile* as it could lead to an increase in appropriate prescribing of broad-spectrum antibiotics.

Antimicrobial ward rounds were suspended at the start of COVID-19 and re-commenced in May 2020. The ward rounds continue to show high compliance with the antimicrobial formulary. Audit of antibiotic prescribing levels has shown an increase in total antibiotics, carbapenems and piperacillin/tazobactam use throughout the COVID-19 period but the significance of this is difficult to interpret due to the change in patient mix. The proportion of ACCESS antibiotics has remained stable.

International EUCAST guidelines for the reporting of antimicrobial sensitivities have the potential to change clinical practice and increase carbapenem prescribing. When the EUCAST guidelines are implemented we will need an accompanying programme of education and monitoring to prevent this having an adverse impact on antimicrobial stewardship.

4. DECONTAMINATION

The majority of the key decontamination issues identified over recent years have been resolved or significantly improved. Governance is provided through the Decontamination Steering Group which reports to the Infection Prevention Action Group. There have been significant improvements in endoscope decontamination practices and traceability, over the last 5-6 years.

Building work for the decontamination room in theatres remains an important infection control priority.

5. HAND HYGIENE

The average hand hygiene self-assessment score between April 2020 and March 2021 was 99% and peer review average was 89%. Peer reviews are conducted by IPCNs and Clinical Matrons and independent reviews carried out by the PPE Champions.

6. CLEANING

The trust continues to monitor monthly cleaning scores through IPAG.

The James Cook Site:

Risk Category	NSC Target	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Very high Risk	**95%**	Score unavailable due to COVID19			99%	99%	99%	99%	99%	99%	99%	99%	99%
Significant Risk	**85%**				99%	98%	98%	98%	98%	97%	98%	98%	98%
Low Risk	**75%**				97%	97%	97%	97%	97%	97%	97%	98%	98%

Table 3: Cleaning scores for James Cook site for 2020/2021

Cleaning scores have been maintained on the JCUH site. Maintaining cleaning standards remains an area of continued focus in conjunction with our service provider SERCO. The monthly cleaning standards review meetings continue to be led by the Director of Estates and cleaning scores continue to be monitored via IPAG.

The Friarage, Friary, East Cleveland and Redcar Primary Care Hospital:

Risk Category	NSC Target	FHN Site	Friary	East Cleveland	Redcar PCH
Very High Risk	98%	99.87%	100%		99%
High Risk	95%			96%	98.6%
Significant Risk	85%	98.72%		95%	93.8%
Low Risk	75%	98.48%		93%	98.2%

Table 4: Cleaning scores for community sites for 2020/2021

The scores on the Friarage, Friary, East Cleveland and Redcar Primary Care Hospital site are an aggregated monthly score.

7. TRAINING AND EDUCATION

Infection prevention and control teaching includes formal teaching, e-learning, opportunistic ward-based education and toolbox teaching.
The toolbox teaching includes:

- Antibiotic Guardian toolbox teaching
- Clostridium difficile toolbox teaching
- ANTT toolbox teaching
- MRSA toolbox teaching
- Multi Drug resistant toolbox teaching
- Peripheral intravenous cannula toolbox teaching

- Urinary Catheter toolbox teaching

In total 155 members of staff have received training from the IPC team in 2020/21.

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 7 SEPTEMBER 2021			
Doctor Revalidation & Appraisal Update Report			**AGENDA ITEM: 14, ENC 10**
Report Author and Job Title:	James Auty Revalidation, Job Planning & Medical Recruitment Manager	**Responsible Director:**	Michael Stewart Chief Medical Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Bi-annual update to Trust Board on Doctor's revalidation and appraisals presented by the Trust's Responsible Officer (RO)		
Background	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		
Assessment	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		
Recommendation	Members of the Trust Board of Directors are asked to receive this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF threat 3.1 Ability to attract and retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources. Failure to have effective workforce plans that anticipate and prevent shortages arising from retirements, shortfalls in all recruitment and retention plans		
Legal and Equality and Diversity implications	- NHS England - General Medical Council		
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 ☐		

1. PURPOSE OF REPORT

The purpose of the report is to provide the Board of Directors with assurance that annual appraisals are being undertaken by Doctors to allow for revalidation recommendations to be made, in accordance with GMC guidance, for Doctors holding a prescribed connection to South Tees Hospitals NHS Foundation Trust and Teesside Hospice Care Foundation. 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.

2. BACKGROUND

Medical revalidation was launched in 2012 to strengthen the way that Doctors are regulated with the aim of improving the quality of care provided to patients, improving patient safety and increasing the public trust and confidence in the medical system. Provider organisations have a statutory duty to support their RO in discharging their duties under the Responsible Officer Regulations and it is expected that the Board of Directors will oversee compliance by:-

- Monitoring the frequency and quality of medical appraisals in their organisations
- Checking there are effective systems in place for monitoring the conduct and performance of their Doctors
- Confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their Doctors

Dr Michael Stewart - Chief Medical Officer - was appointed as the Trust's RO on 1st February 2021, taking over from Dr Sath Nag who had been in the role since January 2019. The RO has a statutory and professional responsibility for all Doctors in the organisation holding a prescribed connection to South Tees Hospitals NHS Foundation Trust as well as Teesside Hospice Care Foundation for which the Trust holds a service level agreement for the South Tees RO to take on the role of its RO. The RO's statutory responsibility is to ensure Doctors are fit to practice and maintain their licence to practice.

For revalidation purposes, the RO is supported by the individuals listed below. Members of the team represent the Trust at the Revalidation North quarterly meetings where Trusts across the region share best practice:-

- Dr Mithilesh Lal – Associate Medical Director (People & Governance)
- Dr Mike Ingram – Medical Lead for Appraisal & Revalidation
- Mr James Auty – Revalidation, Job Planning & Medical Recruitment Manager
- Miss Katie Honeywell – Revalidation & Job Planning Advisor
- Dr Simon Baker – Lead Appraiser
- Mr Sanjay Rao – Lead Appraiser
- Mr Anil Reddy – Lead Appraiser
- Dr Nicola Barham – Lead for Locally Employed Doctors (Trust Doctors)

3. DETAILS

3.1 Revalidation Team – Recent Appointments

Dr Mike Ingram, former Lead Appraiser, was successfully appointed to the Medical Lead for Appraisal & Revalidation role vacated by Dr Mithilesh Lal (now Associate Medical Director – People & Governance) with effect from 1st March 2021.

Dr Simon Baker was appointed to the role of Lead Appraiser, vacated by Dr Mike Ingram, with effect from 15th April 2021.

Dr Ruth Barron is due to take up the position of Lead Appraiser in October 2021 in line with the planned handover of this role from Dr Nicola Barham.

Miss Katie Honeywell has now secured permanent employment within the Revalidation team as Revalidation & Job Planning Advisor.

3.2 Annual Organisational Audit (AOA) / Statement of Compliance

The designated body annual report was last presented to Board in October 2020, confirming the intended submission of our Annual Organisational Audit (AOA) to NHS England at the end of November 2020 - detailing our appraisal compliance for the 2019-20 appraisal year - with the subsequent sign off by the Board of our Annual Statement of Compliance - providing assurances to NHS England that our policies and processes within the Trust underpinning the revalidation and appraisal process continued to be reliable and effective.

Due to pressures associated with COVID-19 and with the majority of appraisals classed as approved postponements in line with national guidance, the AOA and Statement of Compliance covering the 2020-21 appraisal year has not yet been requested of the organisation by NHS England. Members of the team will continue to engage as usual with any requests for information by our regional support team.

3.3 Appraisal Compliance Figures Q1 21-22

The Trust are usually required to submit quarterly appraisal figures to NHS England, culminating in the end of year report – AOA. NHS England have not requested these figures for Q1 of 2021-22, presumably allowing Trust's the time to re-adjust to appraisal business as usual from 1st April 2021. However, compliance figures for Doctors holding a prescribed connection to South Tees Hospitals NHS Foundation Trust and Teesside Hospice Care Foundation for Q1 are detailed below:-

- Drs due to have an appraisal in Q1 = **113**
- Drs who have had their 21/22 appraisal meeting = **86 (76%)**
- Drs who have not had their 21/22 appraisal meeting = **27 (24%)**
- Drs who the RO considers postponement of appraisal reasonable = **19**

- Drs who the RO doesn't consider postponement of appraisal reasonable = **8**

Compliance for Q1 is slightly lower than the last, uninterrupted appraisal year (2019-2020) where the percentage completed was 85%. However, a great deal of encouragement can be taken from the fact that three quarters of Doctors have had their appraisal within the reporting period and if reasonable postponements are taken in to account, the compliance percentage would be 93%.

Routine reminders concerning appraisal have resumed from April 2021 with the Trust's policy and escalation process for non-participation in appraisal enforced where deemed appropriate. Whilst the expectation of a return to business as usual has been communicated, the team fully appreciates individual circumstances where completion of appraisal within the desired timeframe has not been possible with each situation considered on a case by case basis.

3.4 Revalidation Recommendations

Revalidation recommendation dates are set by the GMC with Doctors coming 'under notice' four months prior to their revalidation date. The number of revalidation recommendations made so far in the 2021-22 appraisal year are detailed below:-

- 57 Positive Recommendations
- 12 Deferrals

Doctors can be deferred for a number of reasons but it is usually because they have provided insufficient evidence to allow the RO to make a positive recommendation for revalidation. This is not to be seen to be detrimental to the Doctor or their practice however, when a Doctor is deferred twice - the GMC automatically contacts the RO for further information as to the reasons why a second deferral has been made - these cases are always discussed with the Trust's appointed GMC Employer Liaison Adviser.

In response to the COVID-19 pandemic, the GMC took the decision to defer revalidation dates for one year for all Doctors due to revalidate between 17th March 2020 and 16th March 2021. ROs still have the option of submitting positive revalidation recommendations for these individuals if they had already presented the required supporting information in order to successfully revalidate without having to wait until their deferred revalidation date. As we effectively have two years' worth of revalidation recommendations to submit between 2021-2022 i.e. all those originally due to revalidate during this time and those that were deferred until then, the Revalidation team continue to actively review appraisal portfolios of all Doctors currently 'under notice' in order to advise the RO of positive recommendations that can be submitted where appropriate to do so.

3.5 Patient Feedback and COVID-19

One of the main challenges of being able to successfully revalidate in the current climate is the continued requirement for Doctors to complete patient

feedback – this exercise must be completed once in each five year revalidation cycle and is one of the GMC's six key requirements of demonstrable supporting information. This has always proved challenging for particular departments such as Anaesthesia and Critical Care given the nature of the speciality concerned. Furthermore, the additional pressures associated with COVID-19 have made this all the more difficult (appropriateness of requesting feedback from seriously ill patients / significant decrease in foot fall of family members/visitors to gather feedback from / increased usage of virtual clinics meaning less face to face contact with patients). Therefore, revalidation deferrals are considered where deemed appropriate to do so in order to allow colleagues the additional time required in order to gather the necessary patient feedback responses prior to revalidating.

3.6 Quality Assurance Process

From 1st April 2021, the Revalidation and Appraisal team have been delivering an enhanced role in appraiser quality assurance in line with NHS England Quality Assurance of Appraisal guidance. As such, all active appraisers are now receiving annual feedback in line with the published PROGRESS audit tool. Appraiser feedback is provided from a Trust appointed lead appraiser, designed to support appraisers in delivering excellence through a constructive and supportive model. As well as supporting individuals in their appraiser role, this provides personalised evidence for individuals to include in their own appraisal as part of whole scope of practice. This is also in keeping with the direction of travel within our North East Medical Appraisal Leads Network – we had been an outlier in this regard as our attention had previously focussed on quality assuring appraisal forms from an appraisee perspective rather than appraiser.

3.7 Medical Appraisal for Revalidation Policy – P57

The Trust's Medical Appraisal for Revalidation Policy is scheduled for review in Q2 2021-22; members of the team will ensure the policy is updated in line with changes to the Trust's new medical leadership structure as well as updated national guidance on the format of appraisals – particularly concerning the updates to the Medical Appraisal Guide (MAG) form in the context of COVID-19.

4. RECOMMENDATIONS

Members of the Trust Board of Directors are asked to receive this report and its contents.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 7 SEPTEMBER 2021			
Month 4 2021/22 Financial Performance			**Agenda Item 15, ENC 11**
Report Author and Job Title:	Luke Armstrong Deputy Chief Finance Officer	**Responsible Director:**	Chris Hand Chief Finance Officer
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report outlines the Trust's financial performance as at Month 4.		
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 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.		
Recommendation	Members of the Trust Board are asked to note the Trust position for Month 4.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF threat 7.1 Insufficient capacity to identify and deliver the required level of savings opportunities BAF threat 7.2 Potential loss of grip and control during transition to new clinically led structure BAF threat 7.3 Unexpected cost pressures leading to unplanned overspends BAF threat 7.4 Inability to agree contracts with commissioners to provide the planned levels of clinical income		
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 ☐		

Month 4 2021/22 Financial Performance

1. PURPOSE OF REPORT

The purpose of the report is to update the Committee on the financial position of the Trust as at Month 4.

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.

As with 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 4 YTD actual performance is a £2.7m 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 4 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	229,491	232,930	**3,439**	(3,439)	**0**
Other Income	16,756	17,357	**601**	(324)	**277**
Pay	(142,482)	(144,185)	**(1,703)**	1,311	**(392)**
Non Pay	(93,506)	(96,372)	**(2,866)**	2,093	**(773)**
Depreciation & Amt	(6,315)	(5,949)	**366**	335	**701**
Interest	(4,903)	(4,921)	**(18)**	0	**(18)**
PDC	(1,741)	(1,541)	**200**	0	**200**
Profit / (Loss) On Sale	0	93	**93**	23	**116**
Restructuring Costs	0	0	**0**	0	**0**
Corporation Tax	0	0	**0**	01	**01**
Donated Asset Inc & Depr	(233)	(1,113)	**(880)**	0	**(880)**
Impairments	0	0	**0**	0	**0**
Surplus / (Deficit) for period	**(2,933)**	**(3,701)**	**(768)**	**0**	**(768)**
Reconciliation to system Control Total					
Profit on Sale	0	(93)	**(93)**		**(93)**
Donated Asset Inc / Depr	233	1,113	**880**		**880**
Impairments	0	0	**0**		**0**
System control total	**(2,700)**	**(2,681)**	**18**	**0**	**18**

Overall the Trust is on plan for Month 4 of 2021/22.

- Adjustments are shown to normalise the NHSE/I submitted plan to the Trusts working budget, adjustments relate to high cost drugs and devices, net neutral budget realignments, along with additional income and cost 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 £6.5m.
- The other income over achievement of £0.3m is being driven by increased Estates income from Car Parking along with increased RTA and Private Patients income.
- The £0.4m 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 4 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	124,142
84H	NHS County Durham CCG	4,767
00P	NHS Sunderland CCG	245
01H	NHS North Cumbria CCG	218
13X	NHS England - North East and Yorkshire Commissioning Hub	68,295
13Q	NHS England - Central (CDF, HepC & C&V Variance)	2,110
Y63	NHS England - North East and Yorkshire Commissioning Region	2,434
Y58	South West Regional Office (MoD)	579
42D	NHS North Yorkshire CCG	29,632
03Q	NHS Vale of York CCG	489
	Prior Year Adjustments	20
	Total Income Month 4	**232,930**

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	199,111	199,111	**0**
Top Up	9,952	9,952	**0**
Covid-19	9,004	9,004	**0**
Lost non NHS Income	840	840	**0**
CDF	2,228	1,789	**(439)**
HEPC	256	178	**(78)**
High Cost Devices	5,047	5,422	**375**
Cost and volume drugs	0	142	**142**
ERF	6,492	6,492	**0**
YTD M4	**232,930**	**232,930**	**0**

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

At Month 4 the Trust has recognised income in relation to the Elective Recovery Fund of £6.5m, with a corresponding expenditure value within pay and non-pay.

Other Income

Other income is £0.3m ahead of plan at Month 4.

	Budget to M6 £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Education & Training Income	10,021	6,689	6,724	35
Estates Income	1,102	735	785	51
Misc. Other Income	6,344	4,536	4,427	(109)
Non Patient Care Income	1,246	892	1,039	146
Other Clinical Income	1,487	992	1,150	158
Psf, Mret & Top Up	1,527	1,436	1,460	24
Research & Development Income	2,451	1,800	1,772	(28)
Total	24,177	17,080	17,357	277

- 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 £0.1m from higher receipts year to date of maternity pathway income.
- Other clinical income is overachieving by £0.2m, 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 £0.4m, as outlined in the below table.

	Budget to M6 £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Ahp'S, Sci., Ther. & Tech.	(30,946)	(20,601)	(20,640)	(39)
Hca'S & Support Staff	(22,275)	(15,289)	(15,917)	(628)
Medical And Dental	(64,426)	(43,029)	(43,320)	(291)
Nhs Infrastructure Support	(30,237)	(20,232)	(20,336)	(104)
Nursing & Midwife Staff	(66,014)	(44,135)	(43,443)	692
Other Pay Costs	(760)	(507)	(529)	(23)
Total	(214,656)	(143,793)	(144,185)	(392)

- Within the YTD pay position a budget for additional Covid costs of £4.4m 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 £1.7m 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 £0.3m. Junior staffing is overspent by £0.2m and £0.1m 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 £0.2m, split to the relevant pay category.

Non-Pay

Non-pay is overspent by £0.8m at Month 4. This overspend is predominantly driven by increases in drugs costs from high cost drugs and increases in ICT systems costs.

	Budget to M6 £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Clinical Negligence Cost	**(9,120)**	(6,080)	(6,080)	**(0)**
Clinical Supplies And Services	**(48,602)**	(36,244)	(34,862)	**1,382**
Drugs	**(35,597)**	(23,959)	(25,165)	**(1,206)**
Establishment	**(3,317)**	(2,108)	(2,763)	**(655)**
Ext. Staffing & Consultancy	**(220)**	(163)	(104)	**60**
General Supplies & Service	**(2,047)**	(1,345)	(1,191)	**154**
Healthcare Service Purchase	**(6,266)**	(4,315)	(4,356)	**(41)**
Miscellaneous Services	**(809)**	(566)	(624)	**(57)**
Pfi Unitary Payment	**(14,812)**	(9,899)	(10,006)	**(108)**
Premises & Fixed Plant	**(12,009)**	(8,103)	(8,548)	**(445)**
Research, Education & Training	**(1,835)**	(1,388)	(1,399)	**(11)**
Transport	**(2,119)**	(1,428)	(1,273)	**154**
Total	**(136,754)**	**(95,599)**	**(96,372)**	**(773)**

- Clinical supplies and services are showing a year to date underspend of £1.3m with this being driven by reduced activity levels within clinical directorates.
- Drugs have a YTD overspend of £1.2m. 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 £0.7m with this driven by increases in ICT systems costs and phone charges. A full detailed review of this cost will be conducted.
- The £0.4m 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.

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.

	Plan to M6 £'000		YTD Target £'000	YTD Actual £'000	YTD Variance £'000
Corporate	**2,430**		1,442	2,143	**701**
Procurement	**740**		427	214	**(213)**
Pharmacy	**485**		208	0	**(208)**
Clinical Services	**275**		175	0	**(175)**
Estates	**450**		283	280	**(03)**
ICT	**80**		54	0	**(54)**
Workforce	**540**		333	394	**61**
Total	**5,000**		**2,922**	**3,031**	**109**

In month savings have been formally recognised in relation to:

- Procurement contractual savings
- Estates
- Workforce

Capital

The Trust's capital expenditure at the end of July amounted to £6.3m 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	3,127	3,129	02	9,380	9,380	0
Site Reconfiguration	4,883	1,209	(3,674)	19,729	19,729	0
Replacement of Medical Equipment	834	1,449	615	2,036	2,036	0
Network Replacement and Clinical Noting	1,800	548	(1,252)	3,750	3,750	0
Total	**10,644**	**6,335**	**(4,309)**	**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	10,644	6,335	(4,309)	13,203	13,203	0
Internal Reserves	0	0	0	0	0	0
Charitable Funding	0	0	0	0	0	0
PDC	0	0	0	21,692	21,692	0
Total Financing	**10,644**	**6,335**	**(4,309)**	**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 £4.3m and this mainly includes variances on the Same Day Emergency Care (SDEC) scheme £0.9m, Interventional Radiology £0.3m, FHN Theatre development and maintenance schemes £1.6m and the Alcidion project £0.6m.

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 submitted a request for Emergency PDC amounting to £9.6m in July but this was not accepted based on the Trust's liquidity. In this case the Trust will look to utilise available cash to deliver the programme and will only look to review the request should the liquidity deteriorate significantly. The

Trust's actual and forecast liquidity position will continue to be monitored as outlined in this report.

The Trust will therefore only 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 July 2021 was £54.1m.

The Trust's cash position will be maintained in August, with the next significant commitment on liquidity in September following the second quarterly PFI payment to Endeavour SCH Plc.

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%; and
- July 95.7%.

Statement of Financial Position (SOFP)

The following table compares the SOFP position between 30 June and 31 July 2021.

	30 June £000	31 July £000	Movement between months £000
Property, Plant and Equipment	243,119	243,816	697
Long Term Receivables	1,666	1,666	0
Total Non-Current Assets	244,785	245,482	697
Currents Assets			
Inventories	13,716	13,894	178
Trade and other receivables (invoices outstanding)	4,302	5,040	738
Trade and other receivables (accruals)	22,934	26,108	3,174
Prepayments including PFI	21,619	16,694	(4,925)
Cash	50,086	54,088	4,002
Total Current Assets	112,657	115,824	3,167
Current and Non-Current Liabilities			
Borrowings	(92,111)	(91,795)	316
Trade and other payables	(90,010)	(93,668)	(3,658)
Provisions	(1,632)	(2,445)	(813)
Total Current and Non-Current Liabilities	(183,753)	(187,908)	(4,155)
Net Assets	**173,689**	**173,398**	**(291)**
Equity:			
Income and Expenditure Reserve	(234,052)	(234,343)	(291)
Revaluation Reserve	33,643	33,643	0
Public Dividend Capital	347,622	347,622	0
Other Reserves	26,476	26,476	0
Total Equity	**173,689**	**173,398**	**(291)**

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

- Property, Plant and Equipment – movement in month of £0.7m arising from spend on PFI lifecycle and emergency replacements, offset by depreciation.
- Trade and other receivables – £3.2m increase relating to ERF funding due to be received in August (£3.0m).
- Prepayments – decrease for 1 month following the advanced quarterly contractual PFI payment in June.
- Payables – receipts in advance relating to a payment from HENE (£3.2m).
- Provisions - provision for VAT recovered on the Alcidion project pending a HMRC ruling.
- Income and Expenditure Reserve – movement relates to the deficit on the revenue position delivered in July.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 7 September 2021			
Integrated Performance Report			**AGENDA ITEM: 16, ENC 12**
Report Author and Job Title:	Emma Moss Management Information Lead Business Intelligence Unit	**Responsible Director:**	Various
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	To provide the Board with a detailed assessment of performance against the agreed indicators and measures. The report describes the specific actions that are under way to deliver the required standards.		
Background	The Integrated Performance Report (IPR) is produced monthly to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance. The IPR demonstrates areas of performance are monitored and provides assurance to the Board regarding actual performance and, where necessary, remedial actions. 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 July's IPR:** • Senior Leadership Team have reviewed content and format, further changes are to be implemented in subsequent months. **Key messages relating to performance this month include**: The Trust escalated its C-19 response during July. Clinical teams focused on treating patients with COVID-19, and those without COVID whose needs are equally urgent, while working to address the needs of anybody whose non-urgent care has been disrupted by the pandemic. **Impacts of July Covid-19 surge:** • 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.
Recommendation	The Board of Directors are asked to receive the Integrated Performance Report for June 2021.
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF threat – 1.5 Lack of responsive and accessible services due to inability to deliver national performance standards

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 Foundation Trust

Integrated Performance Report

July 2021

Changes to IPR

South Tees Hospitals
NHS Foundation Trust

The following changes have been implemented in July 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 Trust escalated its C-19 response during July. Clinical teams focused on treating patients with COVID-19, and those without COVID whose needs are equally urgent, while working to address the needs of anybody whose non-urgent care has been disrupted by the pandemic.

Impacts of July Covid-19 surge:

- 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

Summary

South Tees Hospitals NHS Foundation Trust

	Indicator	Latest Month	Target/ Benchmark	Month Reported	Trend	Assurance
SAFE	All Falls Rate	5.47	6.6	07/2021		
	Falls With Harm Rate	0.34	TBD	07/2021		
	Infection Control - C-Difficile (YTD)	31	73	07/2021	N/A	N/A
	Infection Control - MRSA (YTD)	1	0	07/2021	N/A	N/A
	All DATIX Incidents	2307	2070	07/2021		
	Serious Incidents	8	0	07/2021		
	Never Events (YTD)	1	0	07/2021	N/A	N/A
	Category 2 Pressure Ulcers	4.58	TBD	07/2021		
	Category 3 & 4 Pressure Ulcers	0.86	TBD	07/2021		
	SHMI	112.39	100	04/2021		
	Hospital Standard Mortality Rate (HSMR)	104.46	100	05/2021		
	Palliative Care Coding	0.004	TBD	05/2021		
	Comorbidity Coding	3.39	TBD	05/2021		
	VTE	74.31%	95%	07/2021	L	F
	Maternity - Caesarean Section Rate (%)	26.56%	30.0%	07/2021		
	Maternity - Induction of Labour Rate (%)	48.96%	44.0%	07/2021		
	Maternity - Still Births (YTD)	10	17	07/2021	N/A	N/A
	Maternity - PPH 1500ml Rate (%)	3.70%	0.00%	07/2021		

	Indicator	Latest Month	Target/ Benchmark	Month Reported	Trend	Assurance
EFFECTIVE	Sepsis - Targeted oxygen delivered within 1 hour	100.00%	95%	06/2021		
	Sepsis - Blood cultures taken within 1 hour	83.00%	95%	06/2021		
	Sepsis - Empiric IV antibiotics administered	80.90%	95%	06/2021		F
	Sepsis - Serum lactate taken within 1 hour	80.90%	95%	06/2021		
	Sepsis - IV fluid resuscitation initiated	85.10%	95%	06/2021		F
	Sepsis - Urine measurement started	74.50%	95%	06/2021		F
CARING	F&F A&E Overall Experience Rate (%)	80.40%	85%	07/2021	L	
	F&F Inpatient Overall Experience Rate (%)	96.64%	96%	07/2021		
	F&F Outpatient Overall Experience Rate (%)	96.62%	95%	07/2021		
	F&F Maternity Overall Experience Rate (%)	92.16%	97%	07/2021	L	
	Complaints Closed Within Target (%)	68.89%	80%	07/2021		
	All New Complaints	45	TBD	07/2021		

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 (%)	78.01%	95%	07/2021	L	F
	Ambulance Handovers - over 30 mins	145	TBD	07/2021		?
	Ambulance Handovers - over 60 mins	113	TBD	07/2021		?
	RTT Incomplete Pathways (%)	64.20%	92%	07/2021	L	F
	Diagnostic 6 Weeks Standard (%)	81.27%	99%	07/2021		F
	Cancer Treatment - 14 Day Standard (%)	88.26%	93%	07/2021	H	?
	Cancer Treatment - 31 Day Standard (%)	92.47%	96%	07/2021		?
	Cancer Treatment - 62 Day Standard (%)	77.35%	85%	07/2021		?
	Cancer Treatment - 62 Day Screening (%)	50.00%	90%	07/2021	L	F
	Non-Urgent Ops Cancelled on Day	31	0	07/2021		F
	Cancer Operations Cancelled On Day (YTD)	6	0	07/2021	N/A	N/A
	Cancelled Ops Not Rebooked Within 28 days	6	0	07/2021		?
	E-Discharge (%)	94.43%	90%	07/2021	H	P

	Indicator	Latest Month	Target	Month Reported	Trend	Assurance
WELL LED	Year-To-Date Budget Variance (£'millions)	-2.68m	-2.7m	07/2021	N/A	N/A
	Annual Appraisal (%)	66.73%	80%	07/2021	L	F
	Mandatory Training (%)	84.67%	90%	07/2021	L	F
	Sickness Absence (%)	5.41%	4%	07/2021	H	?
	Staff Turnover (%)	12.93%	10%	07/2021	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	46,389
	2021	15,405	15,792	17,670	15,266	36	0	0	0	0	0	0	0	48,867
	Var	137	-14	2,355	-1,281	0	0	0	0	0	0	0	0	2,478
	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*	*53,388*
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	124,010
	2021	44,288	43,100	47,671	41,769	20	0	0	0	0	0	0	0	135,059
	Var	3,271	357	7,421	-2,281	0	0	0	0	0	0	0	0	11,049
	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*	*146,240*
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**	**170,402**
	2021	**59,693**	**58,892**	**65,341**	**57,035**	**56**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**183,926**
	Var	**3,407**	**342**	**9,775**	**-3,562**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**13,524**
	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***	***199,628***
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	50,017
	2021	17,754	16,519	17,663	14,744	15	0	0	0	0	0	0	0	51,936
	Var	1,006	-642	1,555	-2,824	0	0	0	0	0	0	0	0	1,919
	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*	*4,712*
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	120,384
	2021	41,939	42,373	47,678	42,291	41	0	0	0	0	0	0	0	131,990
	Var	2,402	984	8,220	-737	0	0	0	0	0	0	0	0	11,606
	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*	*194,916*

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
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	15,008
	2021	4,793	4,964	5,541	5,062	35	0	0	0	0	0	0	0	15,298
	Var	60	-244	474	-674	0	0	0	0	0	0	0	0	290
	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*	*17,394*
IP Elective Overnight	Plan	678	852	989	1,026	1,071	1,035	1,120	1,159	918	944	995	833	2,519
	2021	636	867	906	880	10	0	0	0	0	0	0	0	2,409
	Var	-42	15	-83	-146	0	0	0	0	0	0	0	0	-110
	2019	*1,037*	*1,076*	*1,147*	*1,143*	*1,120*	*1,077*	*1,167*	*1,193*	*945*	*970*	*1,020*	*852*	*3,260*
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**	**17,527**
	2021	**5,429**	**5,831**	**6,447**	**5,942**	**45**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**17,707**
	Var	**18**	**-229**	**391**	**-820**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**180**
	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***	***20,654***

Summary

- Note the July figures are provisional and will be incomplete so the position will be slightly better than shown here.
- July inpatient activity, both overnight and day case was well below plan.
- The year to date inpatient position is just above plan.

Cause of Variation

- Covid-19 pressure reached a peak during July. This included pressure on general and critical care beds and staff absence from isolation.
- Continuing deployment of Anaesthetic resource to Critical Care – impacting on the number of GA theatre sessions.
- High vacancy rate in Eye theatres.

Planned Actions

- Reduction in Covid-19 committed wards as soon as practicable.
- Re-enforced isolation guidance has reduced staff absences by half.
- Theatres 5 & 6 to re-open in August.
- Eye theatre team recruitment – underway. Agency nursing team contracted from end of July onwards increasing provision to plan.
- Increase number of lists scheduled at Redcar Primary Care Hospital.
- Re-establishment of Strategic Recovery Group meetings once Covid-19 incident can be stood down.

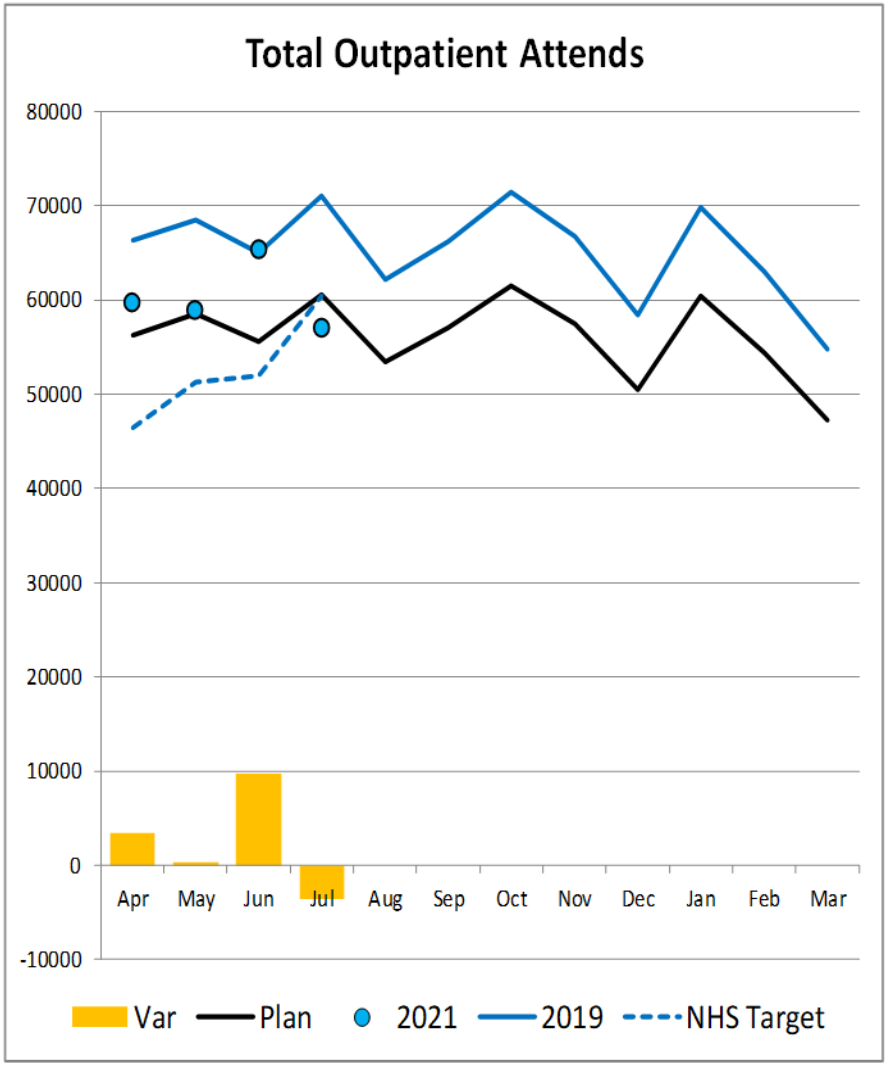
Timescale

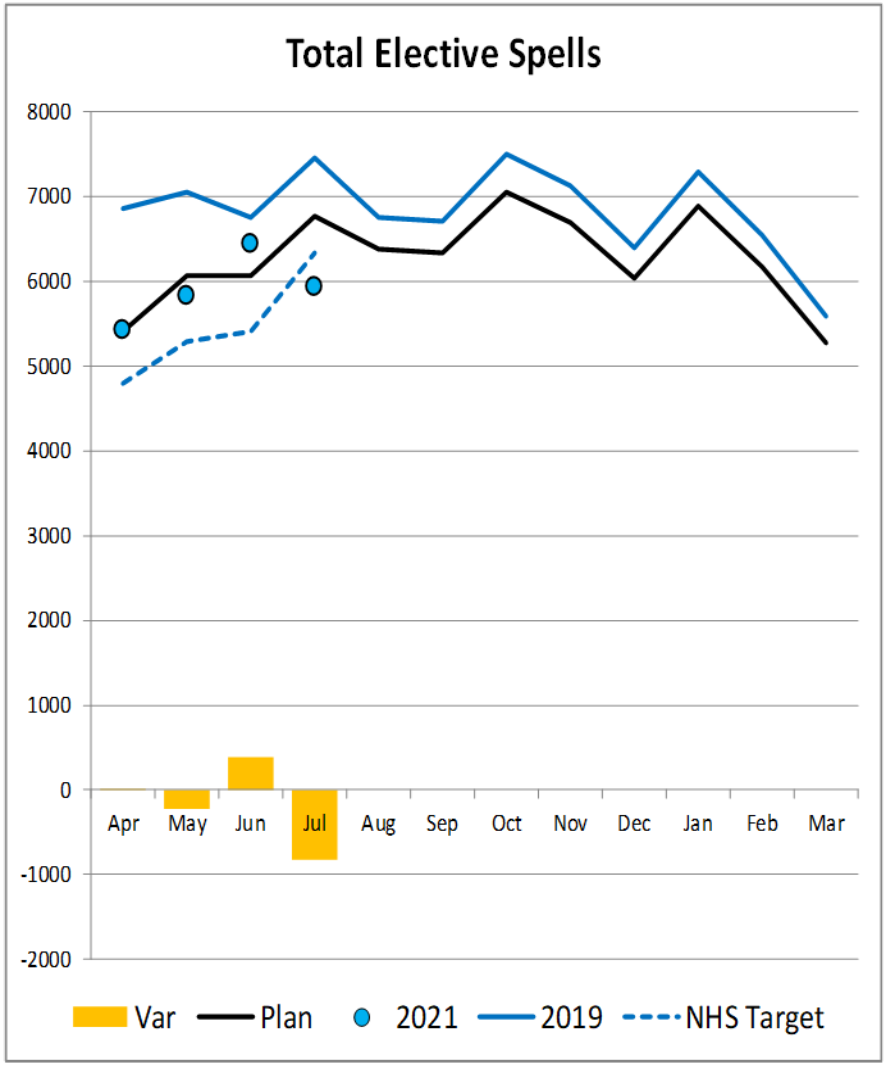
- Weekly review and challenge at Strategic Recovery Group.

Responsive

South Tees Hospitals NHS Foundation Trust

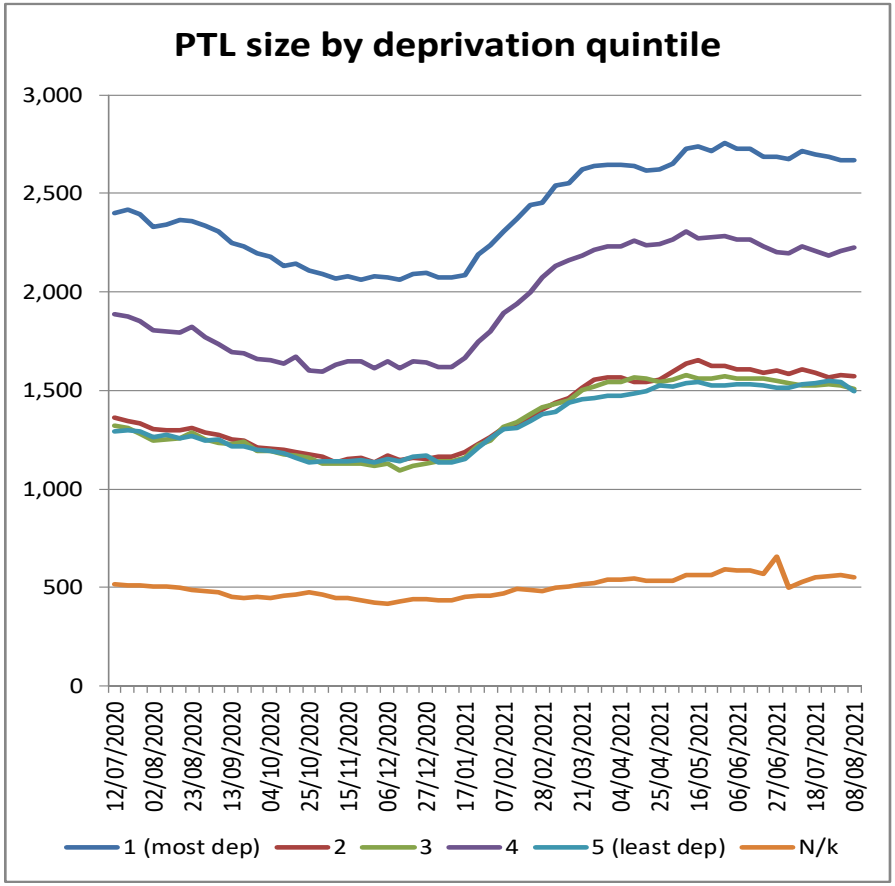
SUMMARY MONTHLY ACTIVITY AGAINST PLAN



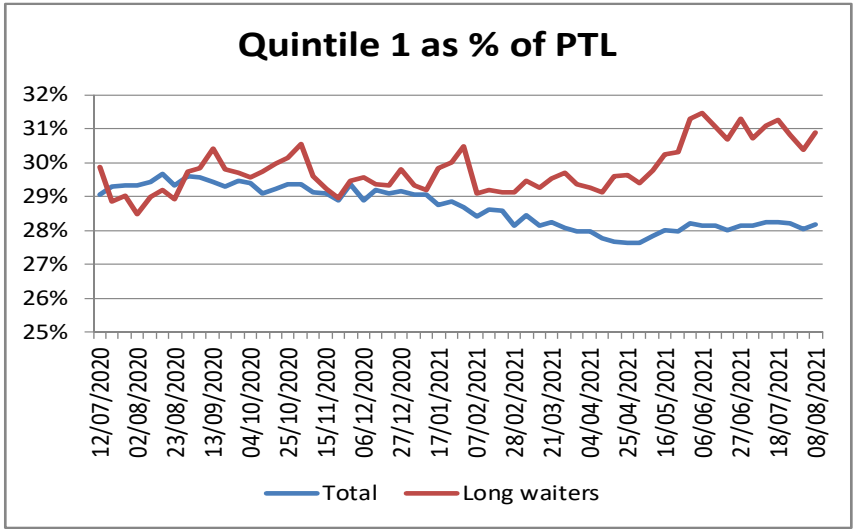


South Tees Hospitals
NHS Foundation Trust

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



08/08/2021	Total		Long waiters		Ratio
1 (most dep)	2,669	28%	920	31%	1.10
2	1,571	17%	498	17%	1.01
3	1,507	16%	476	16%	1.00
4	2,226	24%	633	21%	0.90
5 (least dep)	1,497	16%	451	15%	0.96
N/k	549		166		

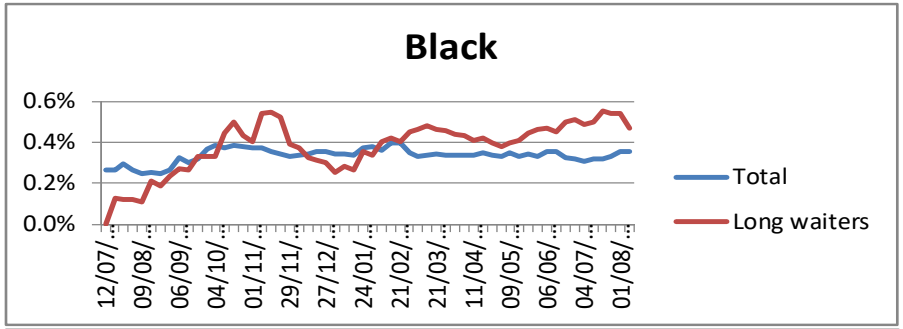


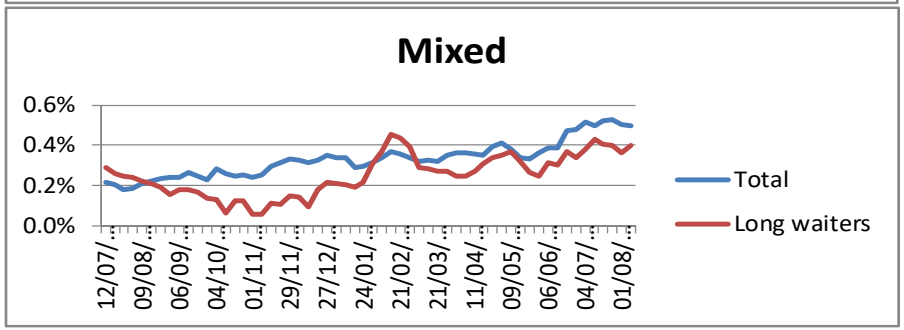
The separation of the overall position and the long waiter position for the most deprived quintile has continued.

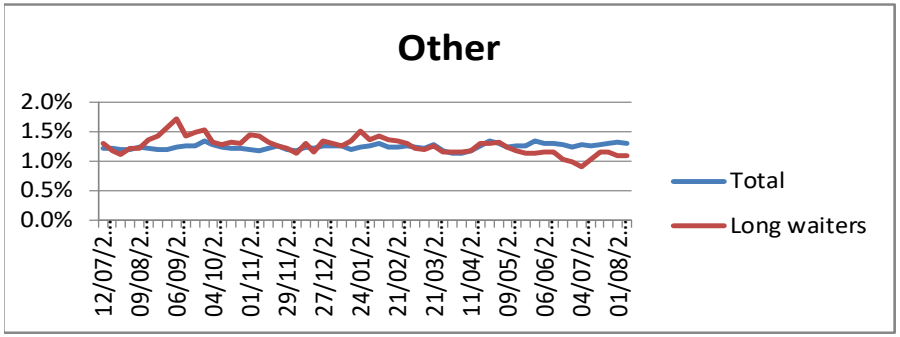
IMD – Index of multiple deprivation

South Tees Hospitals
NHS Foundation Trust

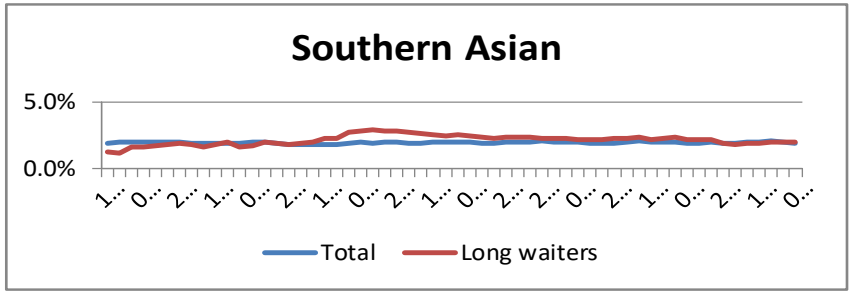
INPATIENT PTL: INEQUALITIES - ETHNICITY

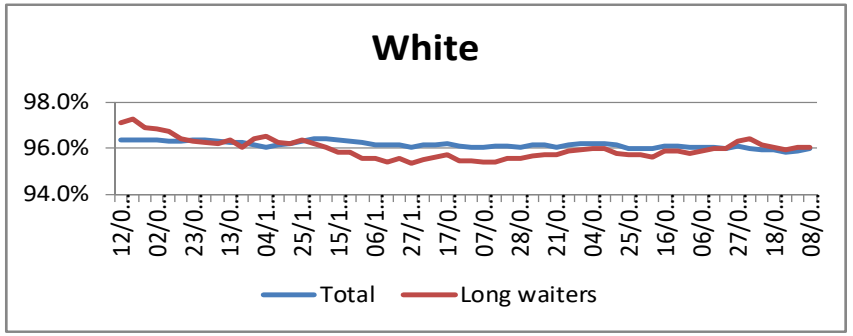






08/08/2021	Total		Long waiters		Ratio
Black	31	0.4%	13	0.5%	1.31
Mixed	43	0.5%	11	0.4%	0.80
Southern Asian	164	1.9%	55	2.0%	1.05
White	8,307	96.0%	2,656	96.1%	1.00
Other	112	1.3%	30	1.1%	0.84
N/k	1,362		379		



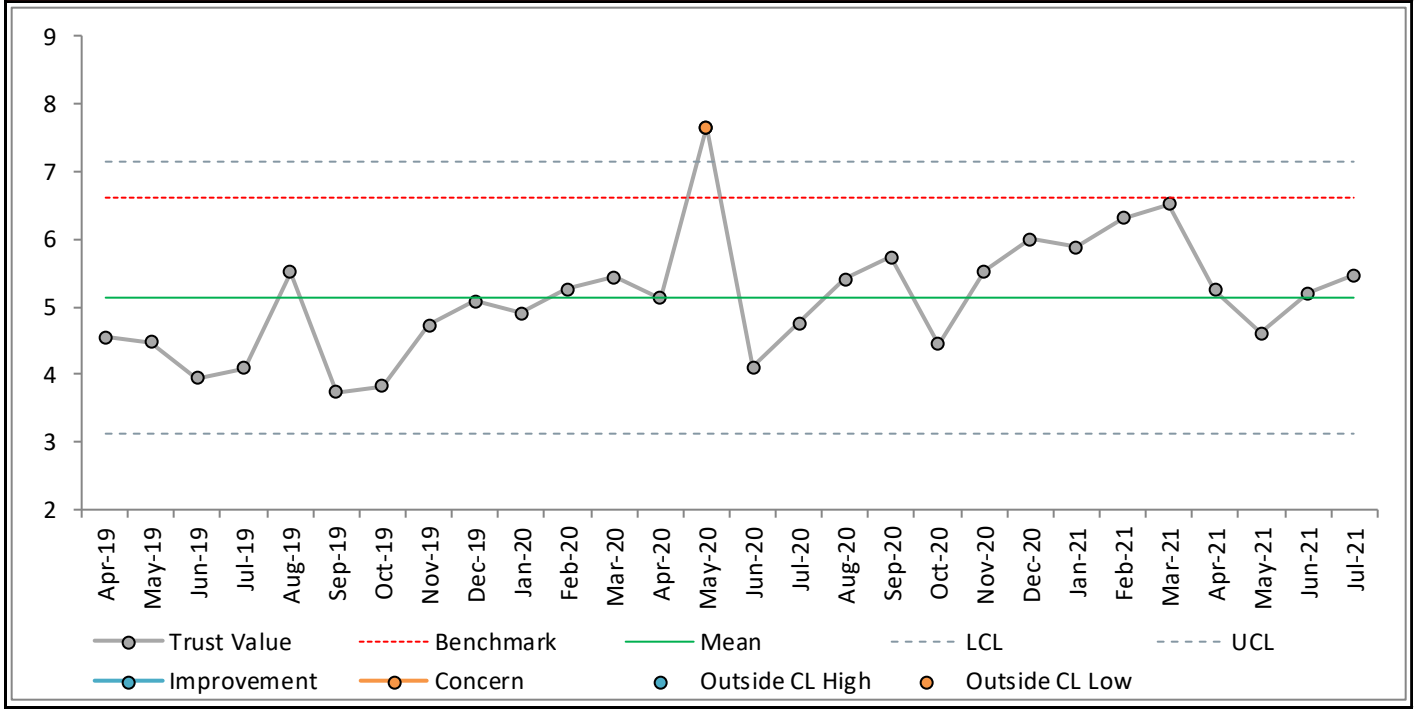


The proportion of the long waiters on the PTL that are white has fallen showing an overall increase in the proportions of non-white

Safe

South Tees Hospitals NHS Foundation Trust

All Falls Rate



The Trust falls rate per 1000 bed days

Benchmark	6.6
Mean	5.13
Last Month	5.47

Executive Lead

Hilary Lloyd

Lead

Ruth Mhlanga

Commentary

The Trust has a mean of approx 130 falls per month. This metric is consistent and is below the national benchmark., which means we have less falls.

The most common cause of falls remain poor balance , slips deconditioning and memory loss or a combination of all 4.

Working collaboratively with TEWV for shared learning.

Cause of Variation

- This metric is within normal variation, although the rate of falls seems to have increased during the first quarter of 2021. Likely linked to seasonal variation and possible increased risk of falls due to deconditioning for those self isolating during the year.
- Potential correlation between changes in ward functionality and increase in falls during Covid-19.

Planned Actions

- Issue safety alerts around themes of contributors to falls.
- 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.

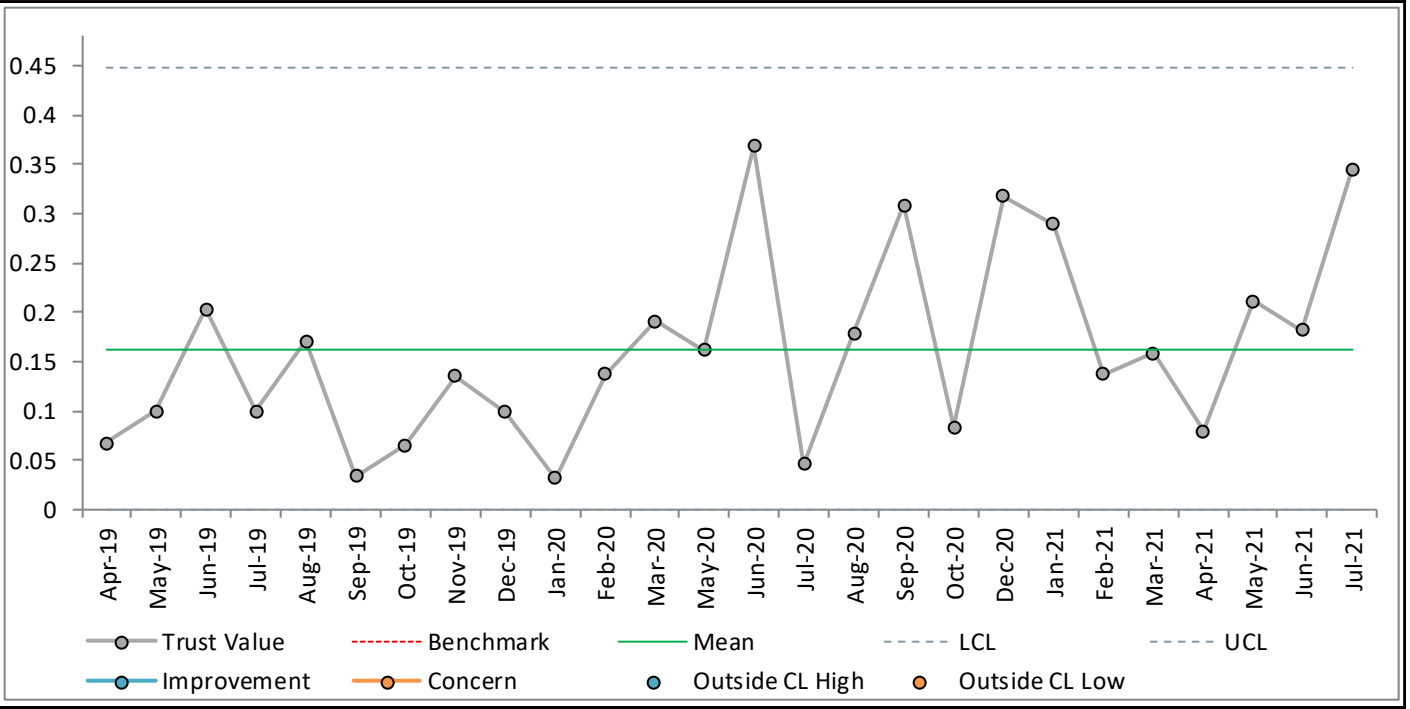
Timescale

- September 2021
- STAQC team 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	0.34

Executive Lead

Hilary Lloyd

Lead

Ruth Mhlanga

Commentary

There are 5 falls with harm per month.

Cause of Variation

- The rate of harm is within the expected range.

Planned actions

- Refresh safety alert around themes that have been identified as contributing to falls.
- Shared learning from within collaboratives and organisation.
- Refreshing Falls leaflet.
- Joint regular reviews of falls with harm with safeguarding team to facilitate shared learning.

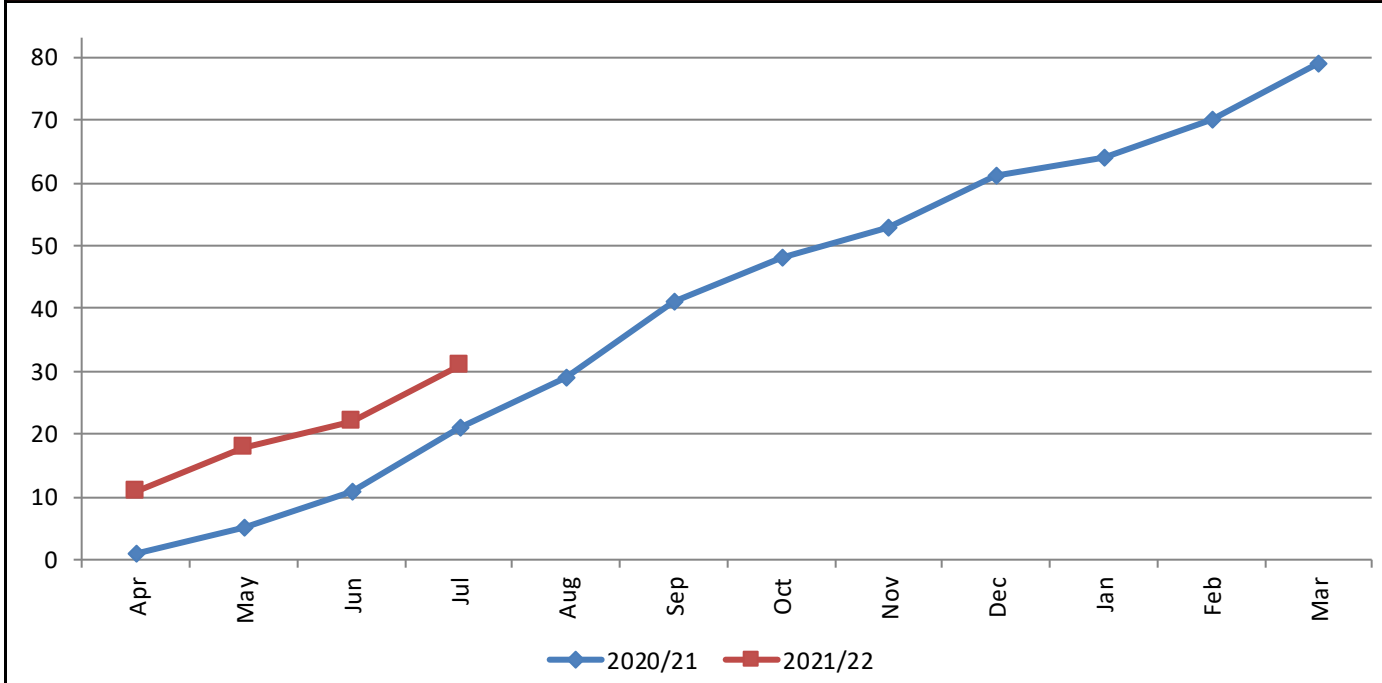
Timescale

- September 2021
- STAQC team 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	31

Executive Lead

Hilary Lloyd

Lead

Sharon Lance

Commentary

This metric is benchmarked against the number of C Difficile cases at the Trust during 2019/20.

Cause of Variation

- This indicator is not in control chart format because numbers. reported are small and therefore variation is not being assessed.
- This is a national reporting requirement and the Trust were to have no more than a combined total of community onset healthcare associated (COHA) and healthcare onset healthcare associated (HOHA) cases amongst patients aged over 2 year, the target for 2021/22 is currently unknown but is assumed to be the same.
- There were 15 cases of CDI in July 2021, 4 of which were classed as COHA and 9 HOHA, totalling 13 cases as Trust Apportioned – total TA up to end of July = 40.

Plan

- All areas with increased prevalence of CDI or cluster of cases would result in ribotyping requested.
- New CDI Process revamped again to strengthen process regarding completion of detailed RCA and attendance at a panel.
- Development of electronic system for side room allocation to facilitate prompt isolation – ongoing support from BIU needed.
- New Matron council in development with IPC focus embedded.
- CDI recovery plan developed and presented to IPC Strategic group July '21 – Focus on Diarrhoea control, Hand Hygiene, Ownership & Learning.
- Collaboration with H&R CCG regarding RCA panels for community cases.
- Implemented weekly CDI escalation group meeting (mandatory attendance) – 8am Monday – to include heatmap, areas of focus and intensive support programme for areas of concern.

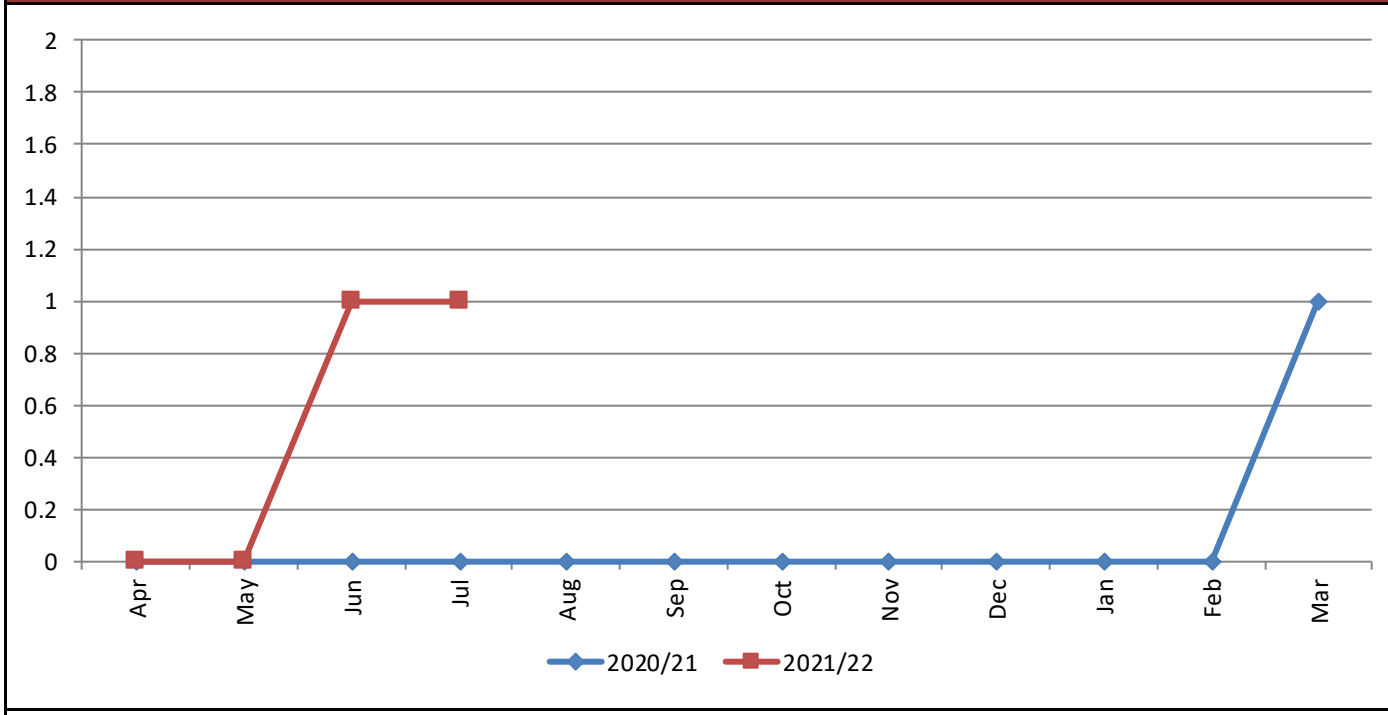
Timescale

- Ongoing as constant unless detailed otherwise in Plan.

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

There has been one case identified in June 2021.

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 July 2021. In the first 4 months of 2021/2022 there have been 1 trust-assigned case.

Planned Actions

- Aseptic non touch technique training and audit programs continue to be refreshed and supported in new collaboratives with train the trainers key to the continued assurance of this.
- Line care group developed with IPC, Procurement and OPAT.
- Line care and infection prevention included in annual plan 2021/22.
- Review of current MRSA/MSSA RCA/Lessons learned process to follow
- Development of patient pathway for line care in early discussions, utilising previous work to move forward.
- Request to join a Nurse Antimicrobial Stewardship group working across NE & Cumbria

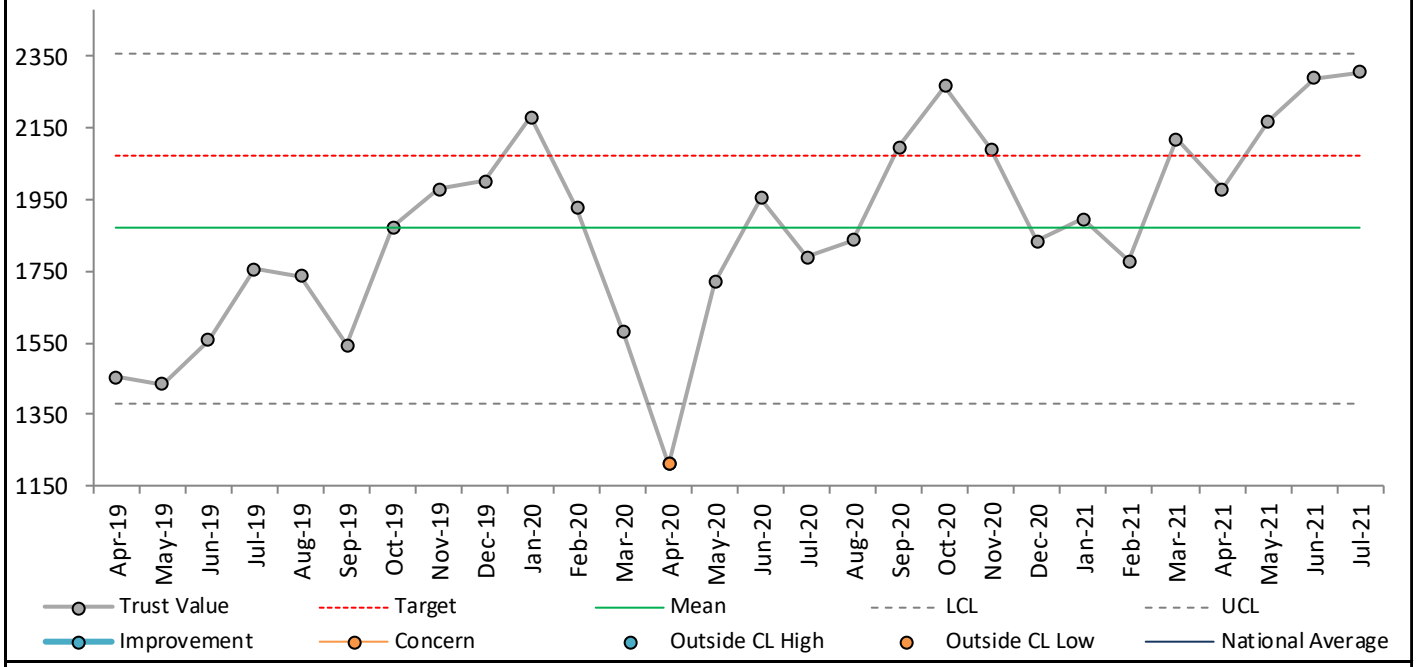
Timescale

- Ongoing.

Safe

South Tees Hospitals NHS Foundation Trust

All DATIX Incidents



All incidents recorded on DATIX

Target	2070
Mean	1869.57
Last Month	2307.00

Executive Lead

Hilary Lloyd

Lead

Kay Davies

Commentary

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

Cause of Variation

- The reporting remains within normal variation and has shown an increase in the previous 3 months.

Planned Actions

- Implementation of Datix Cloud IQ in August 2021 and associated Datix Anywhere App for mobile devices in coming months.
- Request for Datix Champions to be identified and trained to improve Datix experience for all users.
- Implementing Patient Safety Action Plan.
- Trust wide work on Just culture.

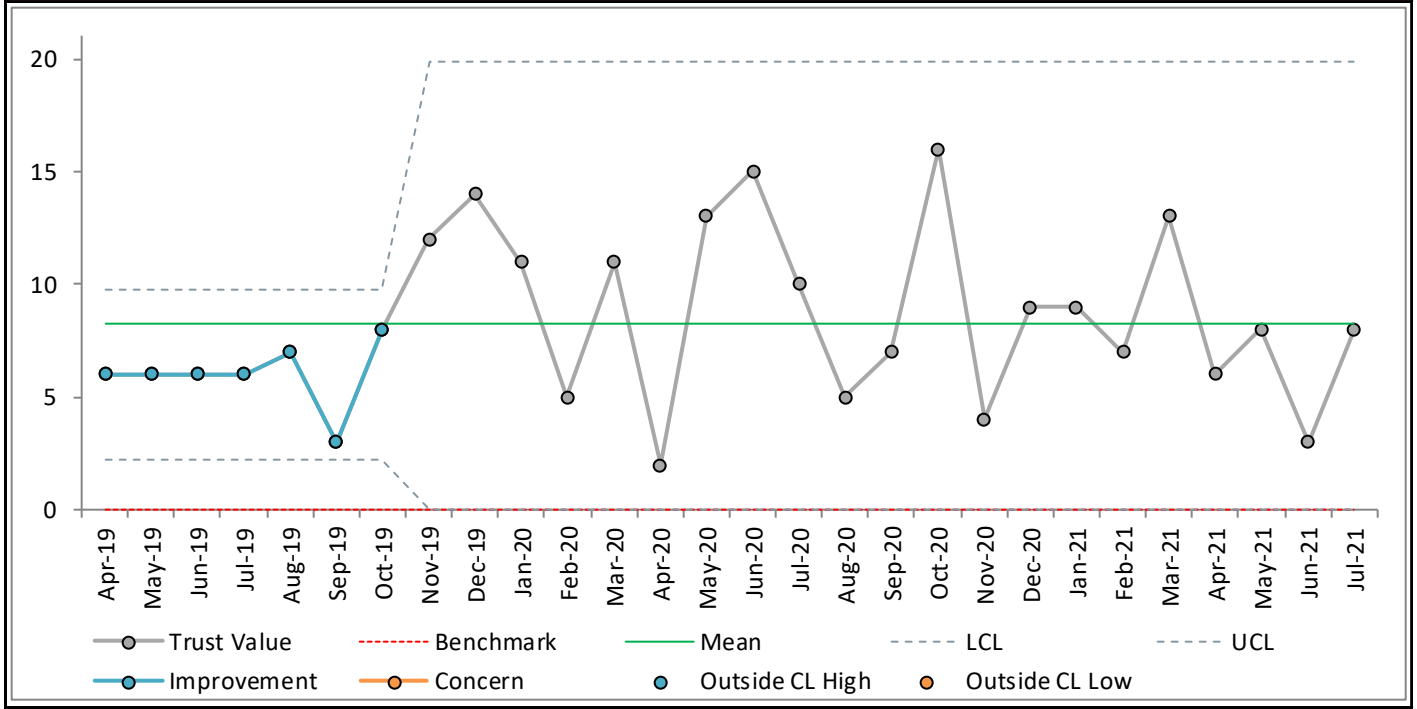
Timescale

- 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	0
Mean	8.21
Last Month	8.00

Executive Lead

Hilary Lloyd

Lead

Kay Davies

Commentary

In July 2021, 87.5% were reported in the month that they occur.

Cause of Variation

- This metric is within normal variation from November 2019 .

Planned Actions

- Continue to report and investigate SIs within agreed timescales and ensure lessons learnt are shared across the Organisation.
- Focus on outstanding actions from previous SIs to ensure evidence is provided and learning is being embedded. Data has been added to monthly SI report and a spreadsheet will be shared with Collaboratives.
- Await the publication of the new Patient Safety Incident Response Framework.
- Training needs analysis to be carried out.
- Establish a learning culture with support from the Leadership and Safety Academy.

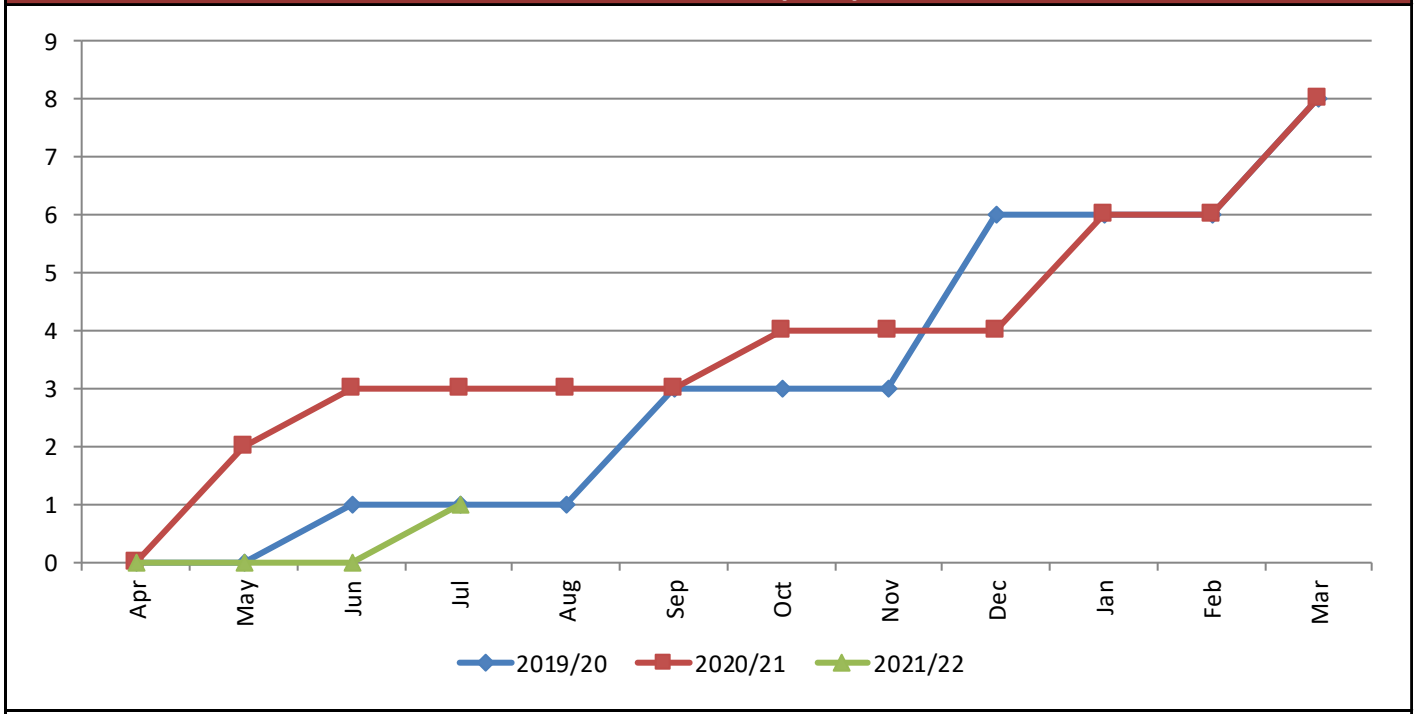
Timescale

- Ongoing

Safe

South Tees Hospitals NHS Foundation Trust

Never Events (YTD)



Number of reported Never Events

Target	0
Mean	N/A
YTD	1

Executive Lead

Hilary Lloyd

Lead

Kay Davies

Commentary

Eliminating never events remains a priority. There was 1 Never Event in July.

This related to a retained clip following neurosurgery

Cause of Variation

- This indicator is not in control chart format because numbers reported are small and therefore variation is not being assessed.
- Nationally there is a variation in the number of never events reported of between 28 and 48 per month.

Planned Actions

- A three month project to fully coordinate and establish the LocSSIP process has concluded and an audit programme commenced in May 2021.
- Regional data released and local action plan developed and presented to the Quality Assurance Committee in November 2020 and updated in March 2021 shared with our CCG.
- Internal Audit carried out a site visit in September to review the design and operating effectiveness of key controls in place relating to patient safety. Draft report received, action plan has been developed.
- Establish a learning culture supported by the Leadership and Safety Academy
- Critical friend review by NHSE/I is been completed and a gap analysis completed which is shared in the July SI & Never Event Paper.

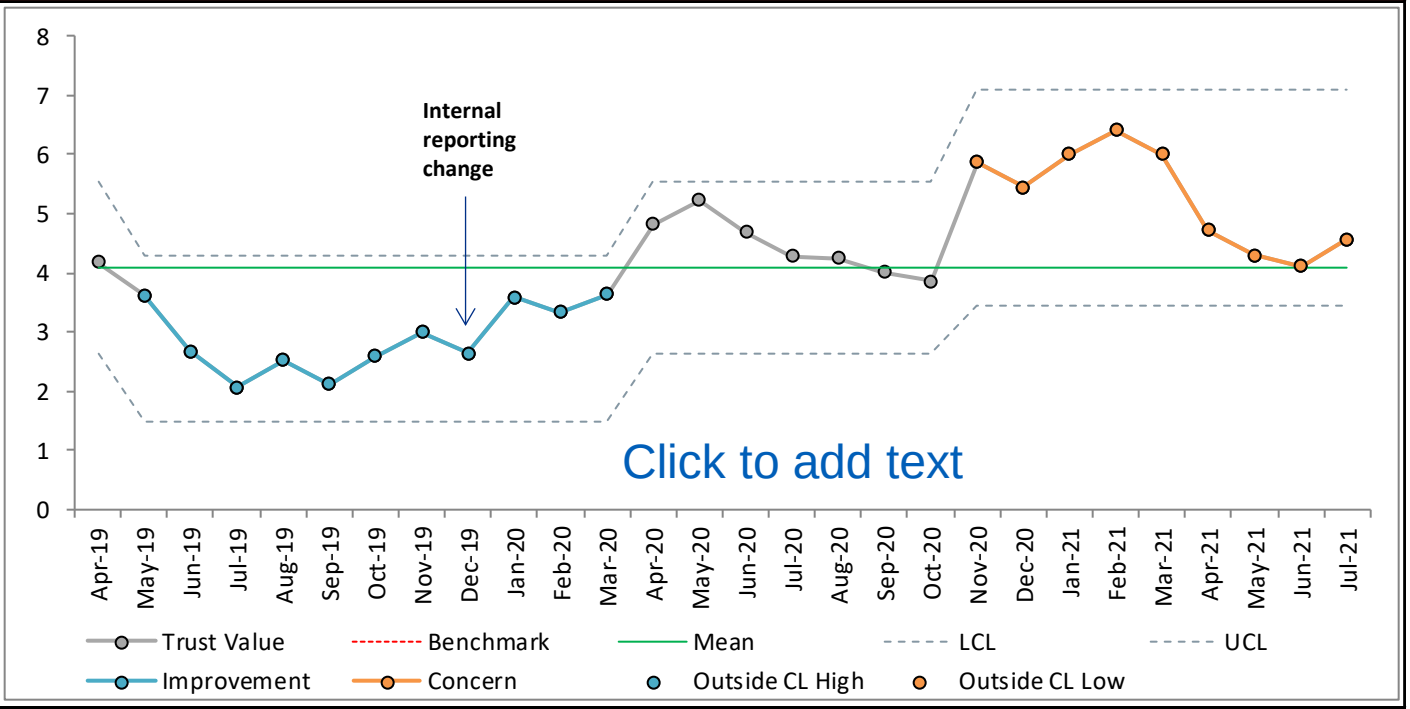
Timescale

- Eliminating Never Events remains a quality priority for 2021/22.
- The recommendations from the critical friend report will be added to the NE action plan.

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	4.09
Last Month	4.58

Executive Lead

Hilary Lloyd

Lead

Helen Day

Commentary

There were a total of 136 category 2 pressure ulcers reported, 60 in the community setting and 76 in the acute setting.

Cause of Variation

- Confidence limits have been recalculated from November 2020.
- The majority of the increase in Q4 20/21 was observed in the critical care areas and was Covid related.
- Slight increase in July 2021 potentially related to stretch staffing ratios on wards ('pingdemic'), no specific ward hotspots and Covid ICU specifically.

Planned Actions

- Update and launch the Tissue Viability action plan 2021/22. Examples of specific work includes;
- 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'. Review to launch across Trust.
- Peer conversations with subject matter experts.
- Data collection in progress to commence research into patient compliance in the community setting.

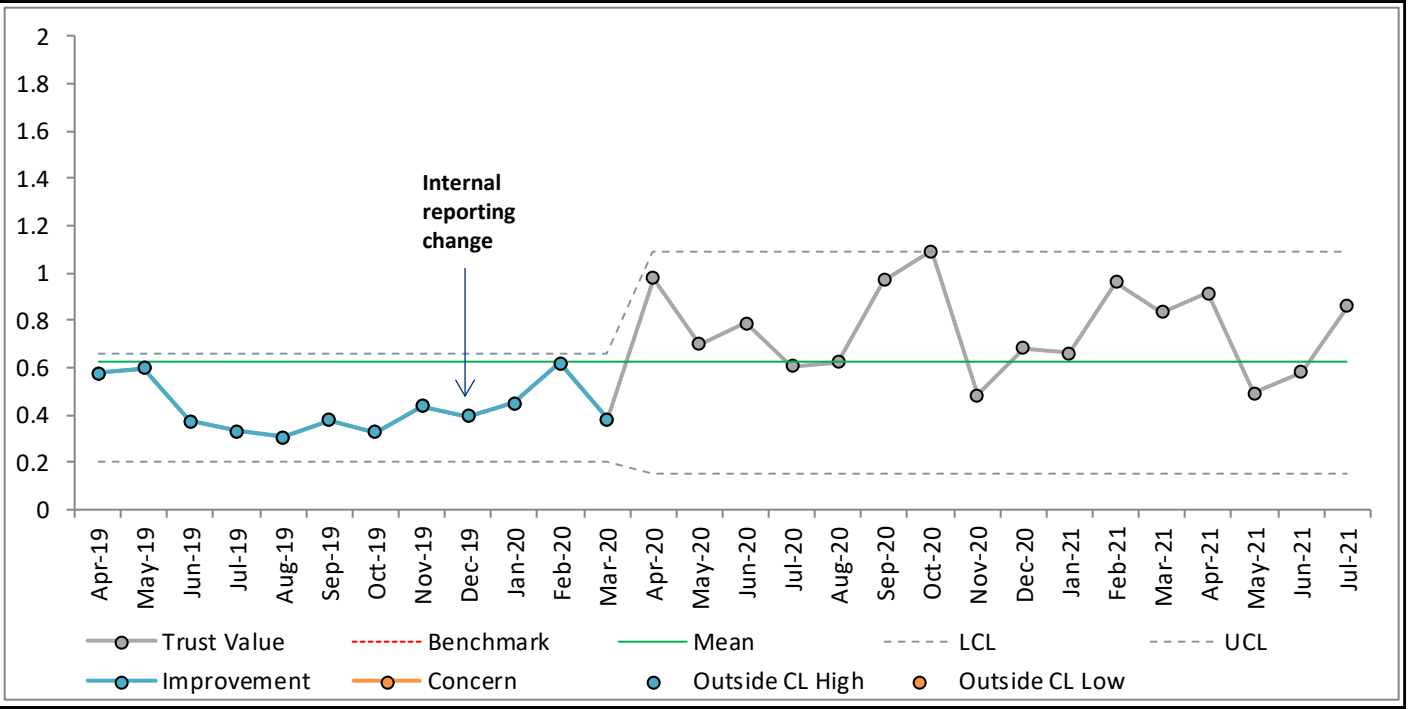
Timescale

- All actions are ongoing and linked to the pressure ulcer reduction action plan & improvement timescales are being built into this PUC commenced 12/04/2021.

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	0.86

Executive Lead

Hilary Lloyd

Lead

Helen Day

Commentary

16 category 3s were observed in the acute setting, 6 were in Critical Care. No ward 'hot spots' identified for the remaining 10 and no significant lapses in care with 2 of the 16 were declared as SIs.
No SIs in the community for 2 months running.

Cause of Variation

- The rate is within normal variation from February 2020, with the exception of October 2020.

Planned Actions

- Update and launch the Tissue Viability action plan 2021/22 as per previous slide.
- Intensive support commenced for critical care.
- Report to Quality Assurance Committee.
- Commenced 'structured review' learning conversation replacing RCA and panel process.

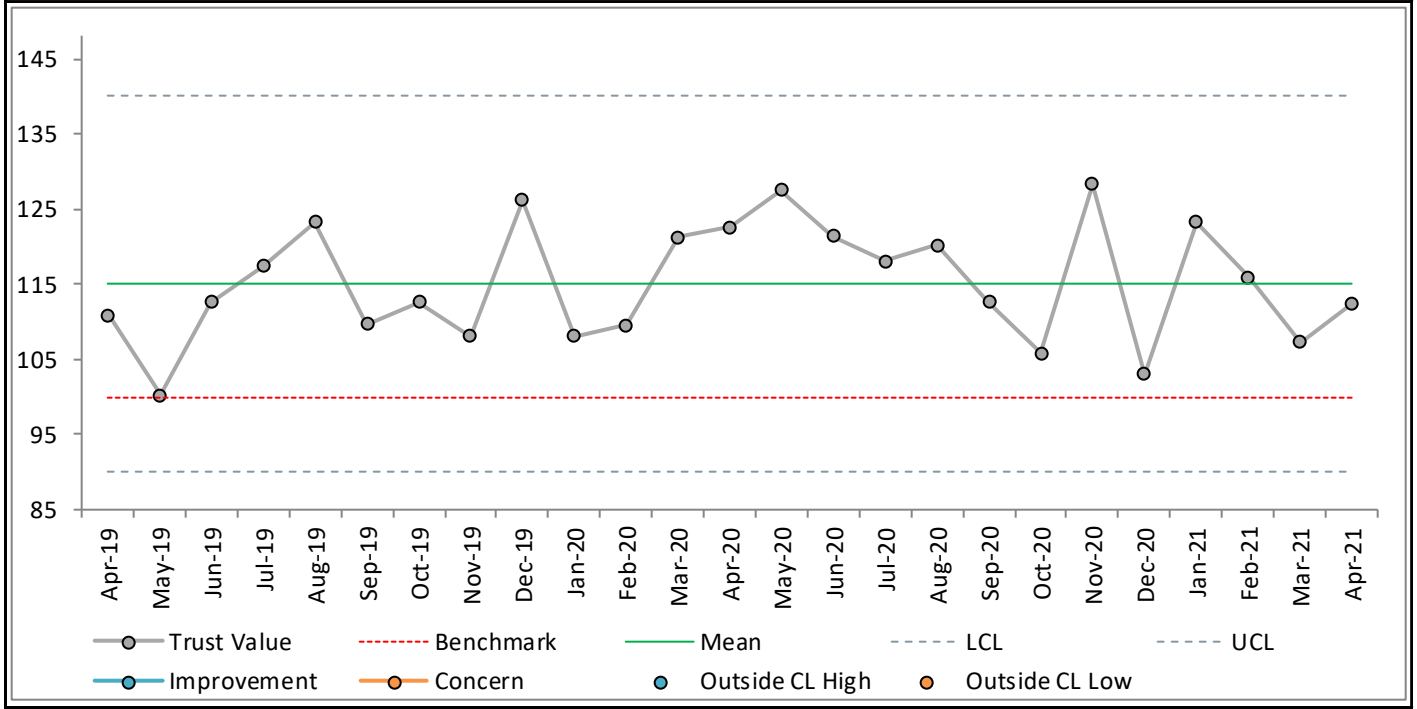
Timescale

- All actions are ongoing and linked to the pressure ulcer reduction action plan & improvement timescales are being built into this.

Safe

South Tees Hospitals NHS Foundation Trust

SHMI



Summary Hospital-Level Mortality Indicator

Benchmark	100
Mean	115.15
Last Month	112.39

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.

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 septicemia 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%).

Planned Actions

- The trust has fallen behind national average for capture of comorbidities. More analysis commissioned from NEQOS.
- A new Clinical Coding Strategy was launched in April and a number of specialties are piloting a refreshed approach.
- Medical Examiner scrutiny has been sustained at high levels (>95% of deaths are reviewed) and preventable deaths have not been identified, although there is a backlog for mortality reviews requested by MEs.

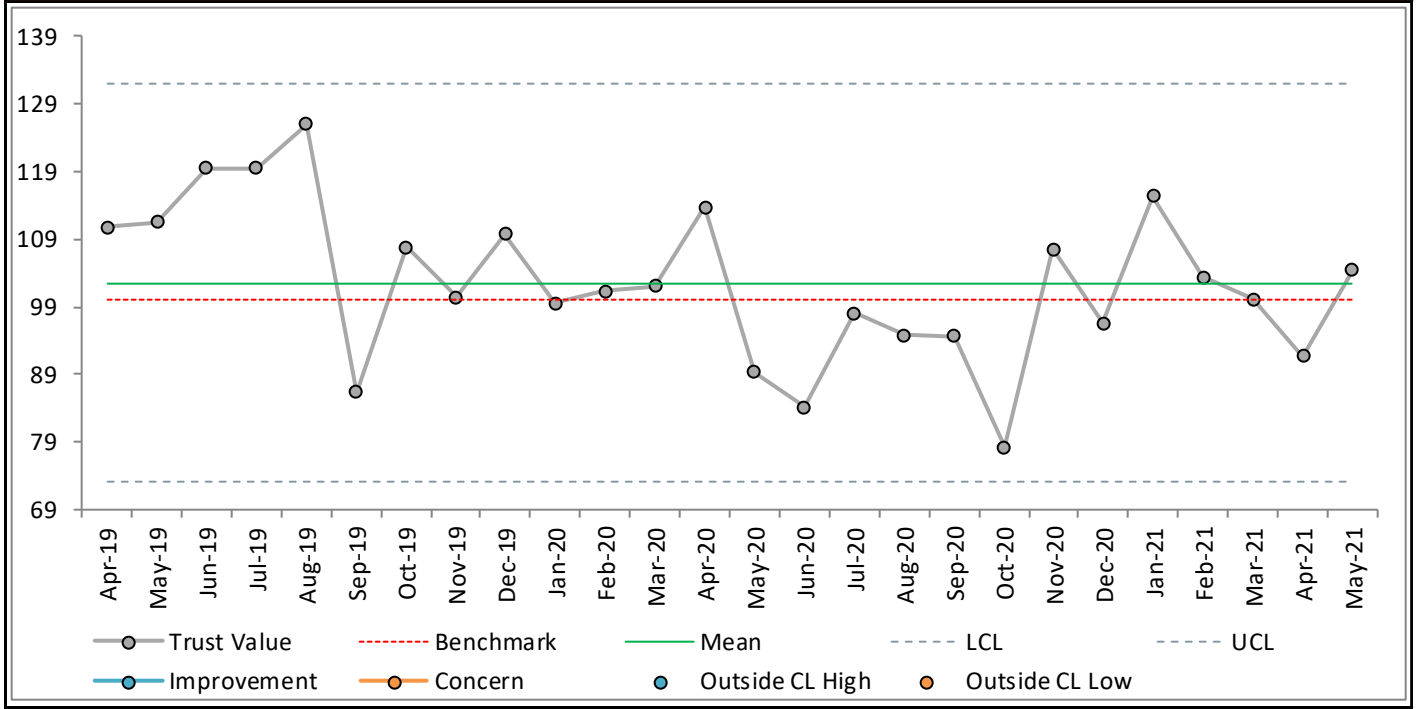
Timescale

- Coding work on-going. Quarterly review of the impact of COVID-19 on SHMI needed throughout 2021/2022.
- NEQOS Quarterly report in September 2021 will include further analysis.

Safe

South Tees Hospitals NHS Foundation Trust

Hospital Standard Mortality Rate (HSMR)



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

Benchmark	100
Mean	102.56
Last Month	104.46

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.

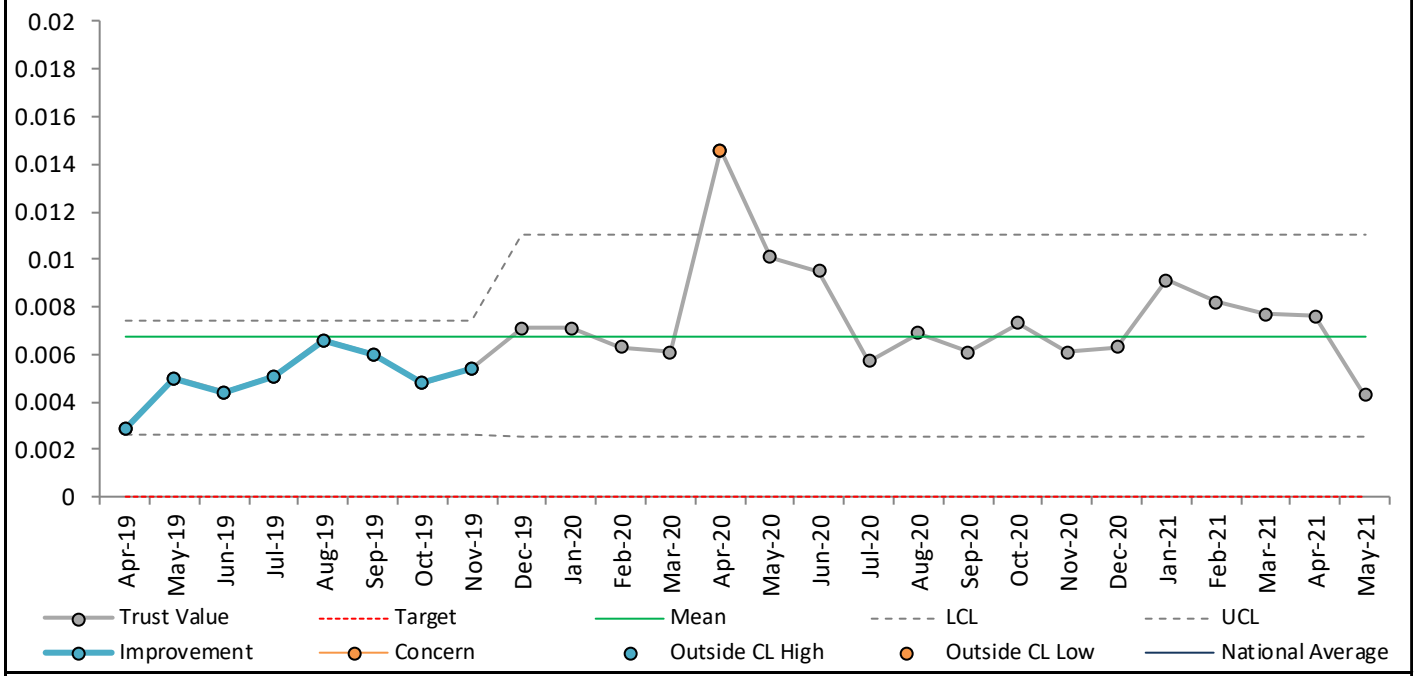
Timescale

- On-going. Comparison of SHMI and HSMR continues to be important, given the difference between them.

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.

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.

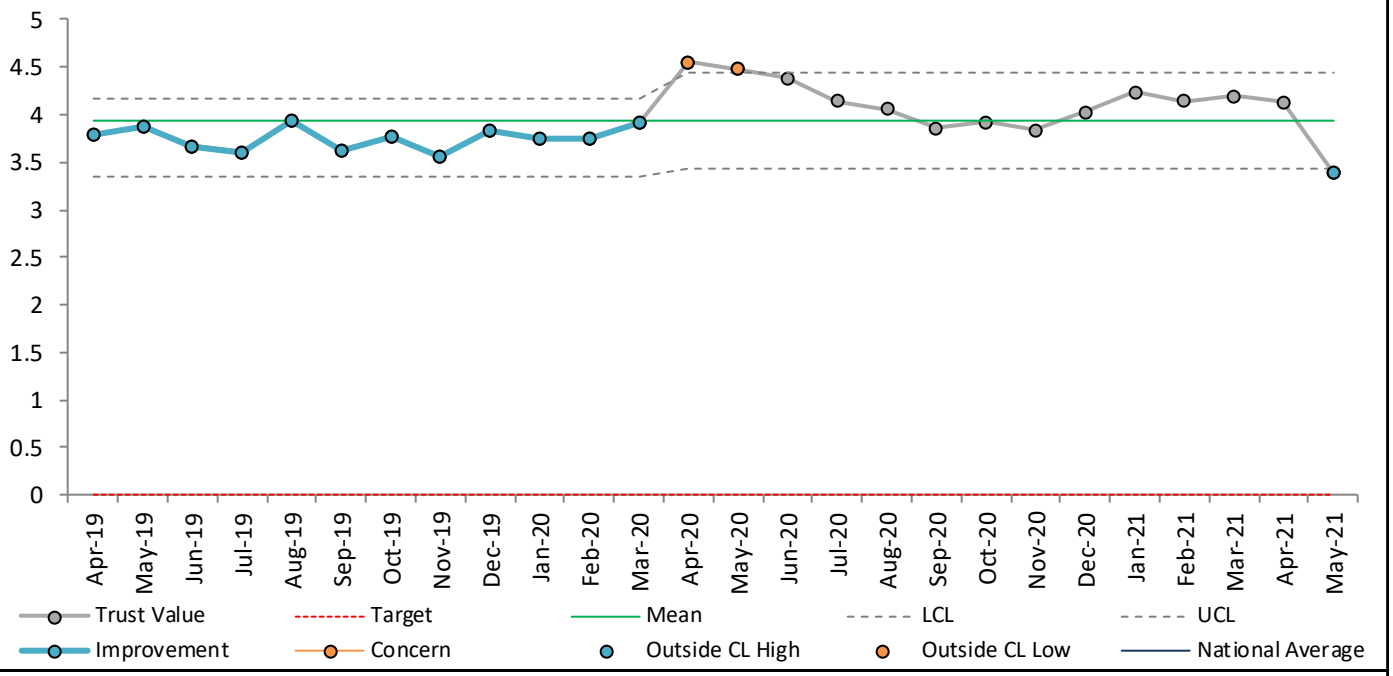
Timescale

- Ongoing.

Safe

South Tees Hospitals NHS Foundation Trust

Comorbidity Coding



Average Comorbidity score on First Finished Consultant Episode (FFCE)

Target	
Mean	3.94
Last Month	3.39

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 shows the use of the form increases capture of comorbidities. A number of other wards have offered to pilot. The key is the admission areas where piloting is underway. In due course, Miya will allow digital recording.

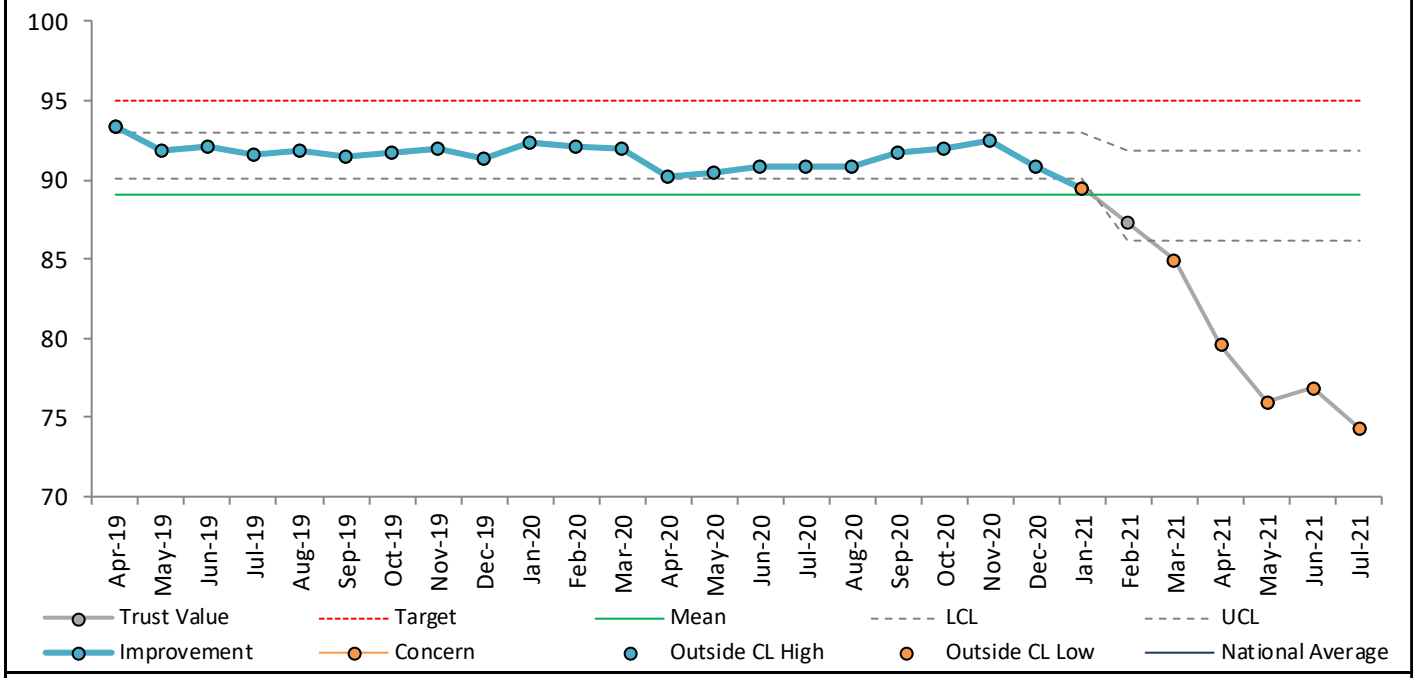
Timescale

- Further pilots planned July and August, although may be delayed.
- 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	89.03
Last Month	74.31

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 - June), 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
- 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 – this data is still awaited.
- Long term goal would be to have VTE risk assessment as in essential requirement within the electronic medical record.

Timescale

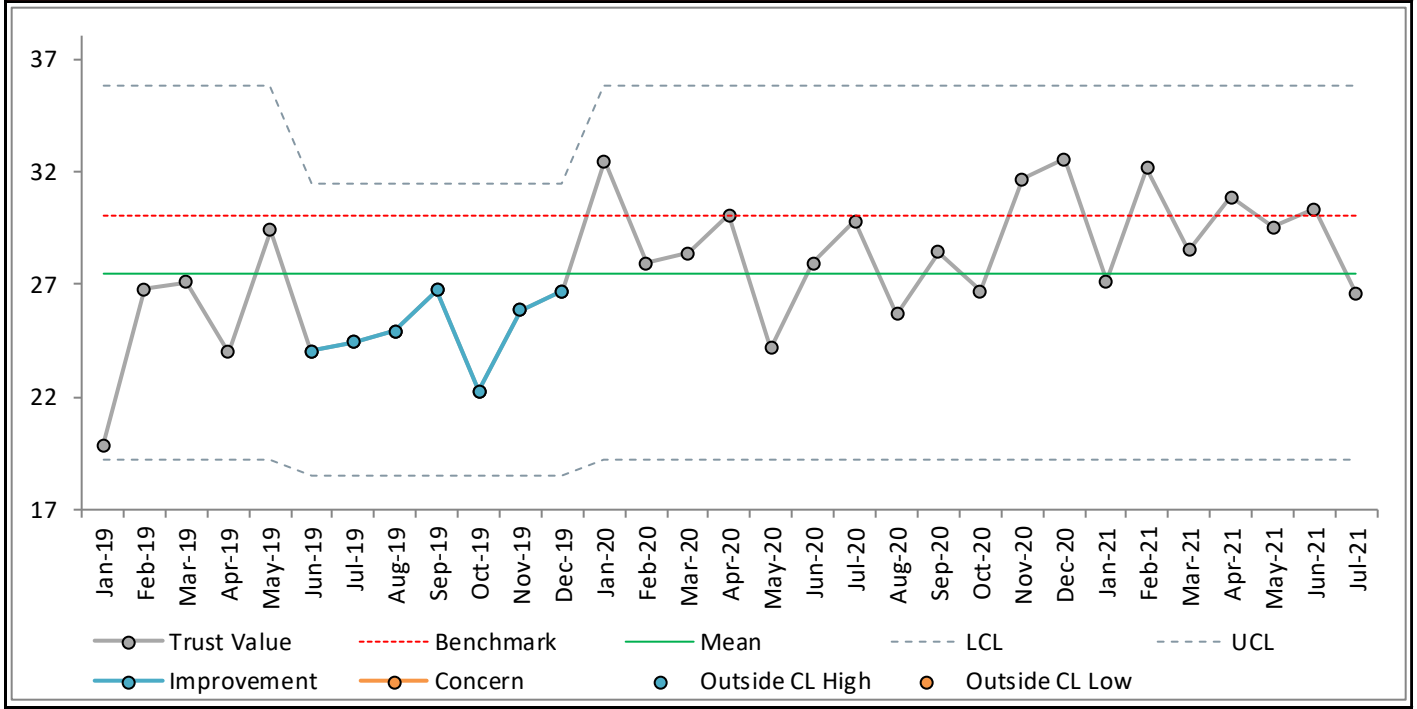
Q1 – VTE Working Group to agree trajectory.
Q3 – Improved compliance

- Meeting took place on the 14th May 2021.

Safe

South Tees Hospitals NHS Foundation Trust

Maternity - Caesarean Section Rate (%)



The % of Patients Delivering via Caesarean Section

Benchmark	30
Mean	27.52
Last Month	26.56

Executive Lead

Hilary Lloyd

Lead

Kay Branch

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

- An annual labour ward report has been produced since 2004 which tracks changes and identifies areas of practice change.
- Lower Segment Caesarean Section rates are monitored quarterly via patient safety and the Local Maternity System regional board.

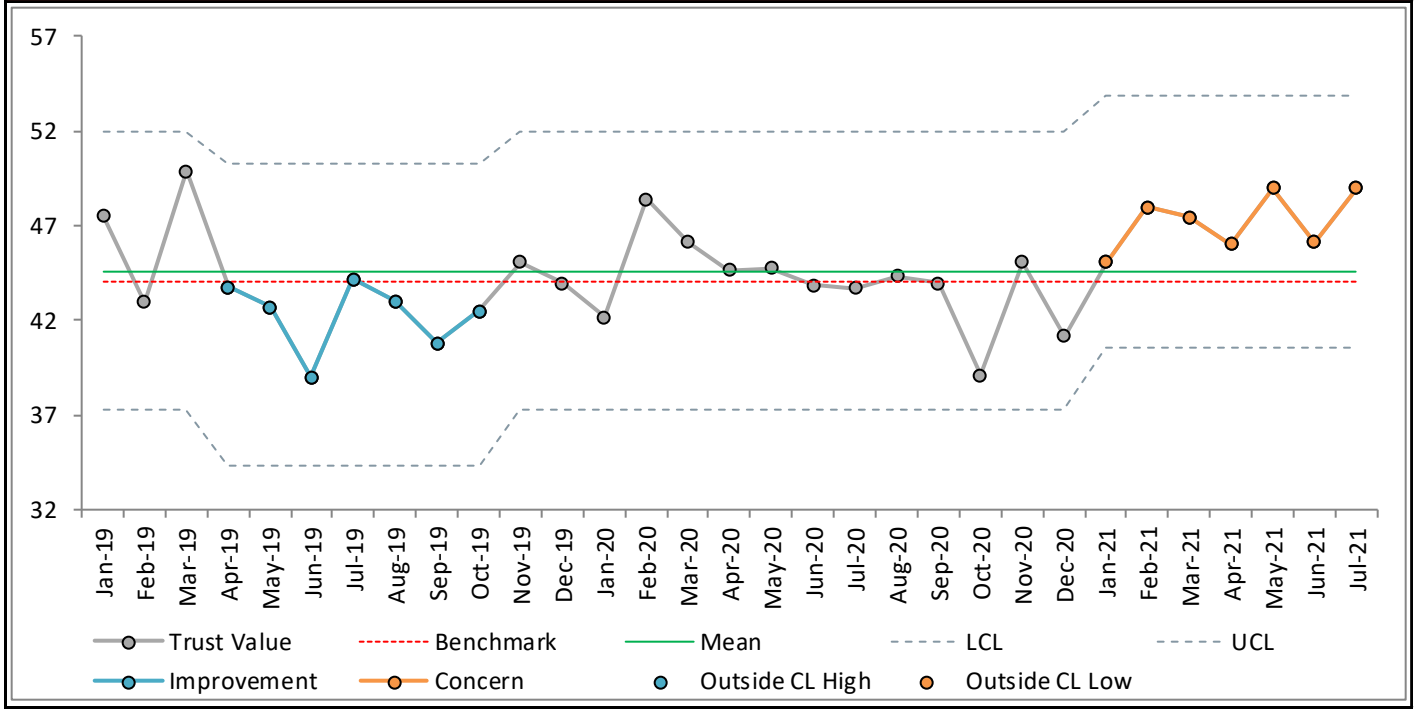
Timescale

- On-going review – no specific time scale.

Safe

South Tees Hospitals NHS Foundation Trust

Maternity - Induction of Labour Rate (%)



The % of Patients Delivering via Caesarean Section

Benchmark	44
Mean	44.62
Last Month	48.96

Executive Lead

Hilary Lloyd

Lead

Kay Branch

Commentary

National benchmark

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.

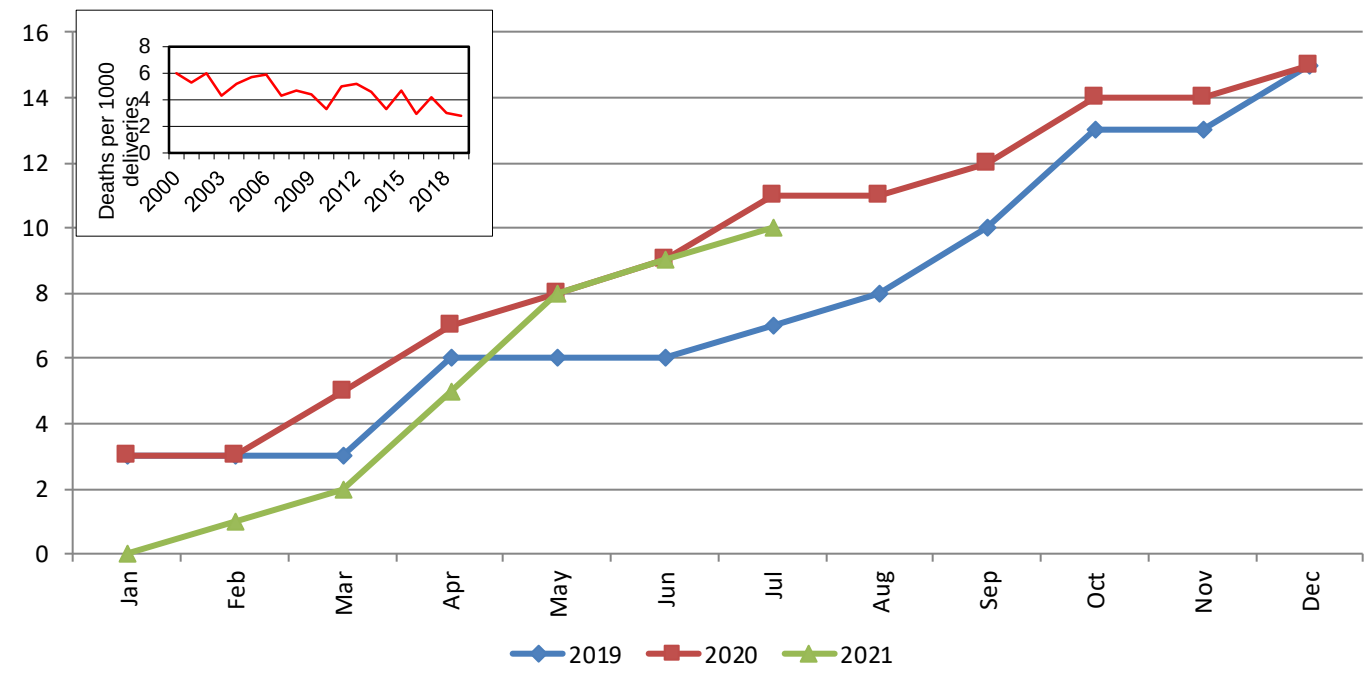
Timescale

- Not applicable

Safe

South Tees Hospitals NHS Foundation Trust

Maternity - Still Births (YTD)



Still births

Outturn	17
Mean	N/A
YTD	10

Executive Lead

Hilary Lloyd

Lead

Kay Branch

Commentary

National target 4 per 1000 births
Target of 50% reduction in stillbirths by 2025

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.
- Implementation of Ockenden report recommendations
- Continued review and analysis through the labour ward reporting and risk management case reviews.
- Monitored quarterly through patient safety and LMS regional board.

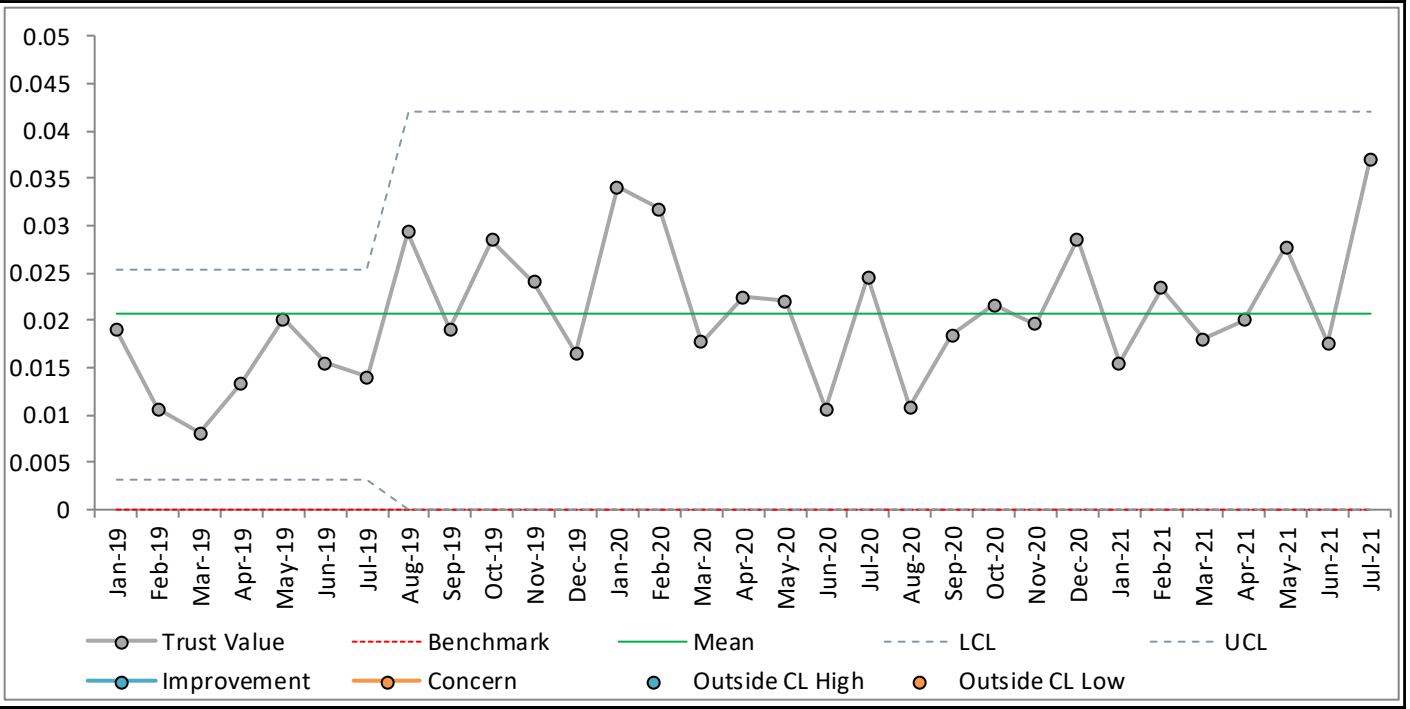
Timescale

- Ongoing

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

Kay Branch

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.
- Introduction of measured blood loss at Elective Caesarean Section is being trialled with a view to rolling out to Emergency Caesarean Sections.

Timescale

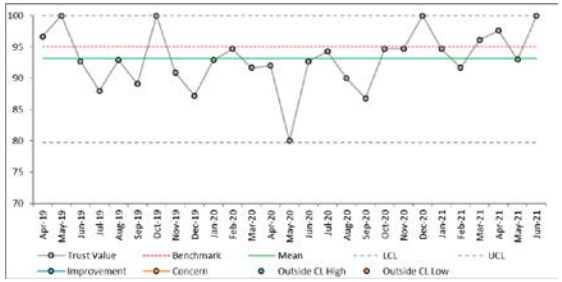
- Timescale to be determined.

Effective

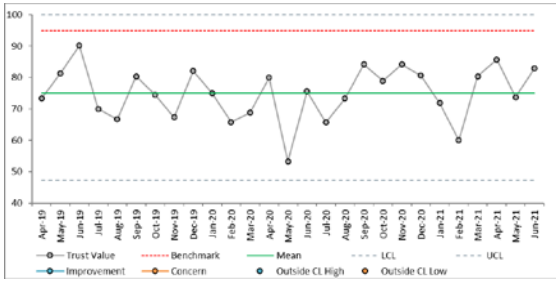
South Tees Hospitals NHS Foundation Trust

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

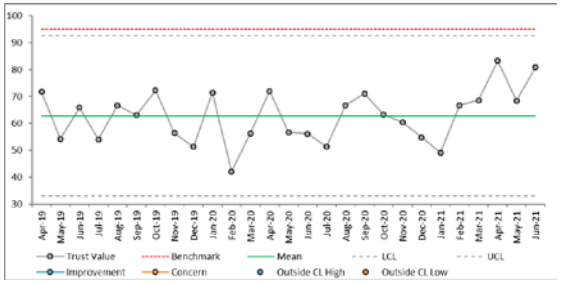
Targeted oxygen delivered within 1 hour



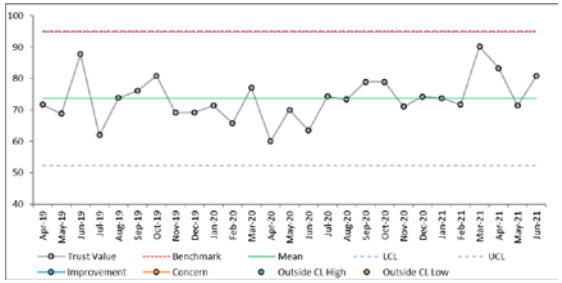
Blood cultures taken within 1 Hour



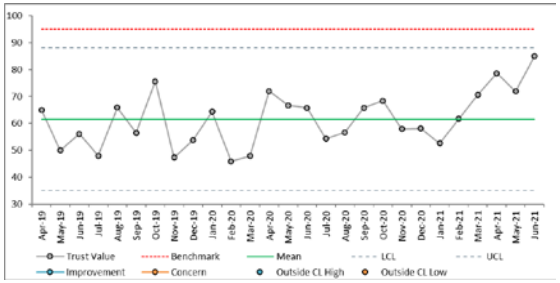
IV antibiotics administered within 1hr



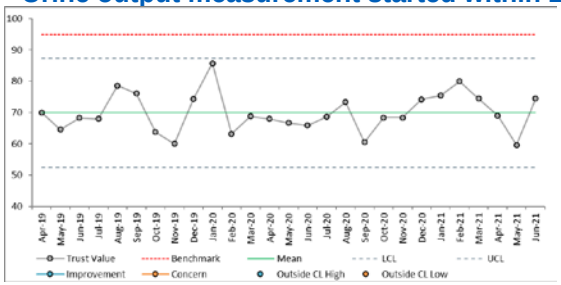
Serum lactate taken within 1 hour



IV fluid resuscitation initiated within 1 hour



Urine output measurement started within 1hr



Cause of Variation

- Normal variation with improvement seen in all elements.
- On occasions the Sepsis Assessment tool is not getting launched appropriately in ED - immediate action undertaken
- Difficulty in obtaining venous access has been documented - which has an impact on 3 elements of the bundle
- Lack of electronic decision support and management tools
- Poor compliance with completion of fluid balance chart
- Increase in ED activity
- Staffing shortages reported

Planned Actions

- Electronic workflow to be introduced throughout the organisation with 'close the loop' configuration. This will;
  -open the sepsis six pathway and produce a visual timer
  -reduce the time required locating and reviewing HCRs for audit
  -allow further clinical support from the educators
  -identify areas for improvement and exemplary practice
- The introduction of electronic fluid balance will also increase compliance to the urine output element of the sepsis six - second phase of implementation
- Final stage user acceptance testing complete
- Clinical audit trial underway with coding allowing timely access to HCRs for audit
- Daily record of trigger audit
- Daily educator presence in every clinical area – guided by elevated NEWS on VitalPAC
- ED to participate in clinical audit, allowing ownership of data and analysis

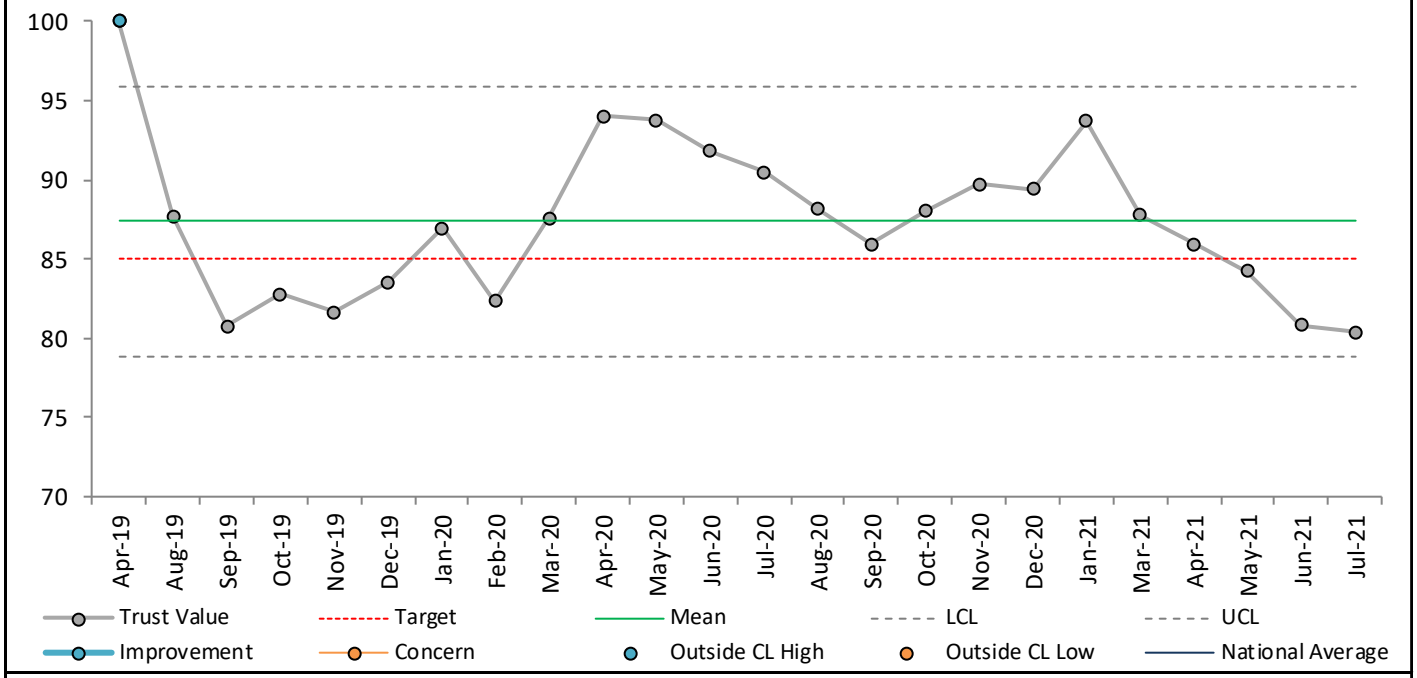
Timescale

- July - September 2021 - educational rollout and promotional campaign
- September 2021 - Patientrack 'Go-live' implementation - including sepsis
- August 2021 - 1 month audit with coding - reporting September 2021
- Clinical Education team in post and inductions complete
- One vacancy remaining interviews 17/08/21
- Daily education in ED
- Weekly engagement with the ED Clinical Matron

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	87.41
Last Month	80.40

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 second time since February 2020.

Planned Actions

- Continue to monitor.
- Review of the feedback to identify cause for deterioration.
- Triangulate with other A & E data sources.
- Review Urgent and Emergency Care National Survey results.

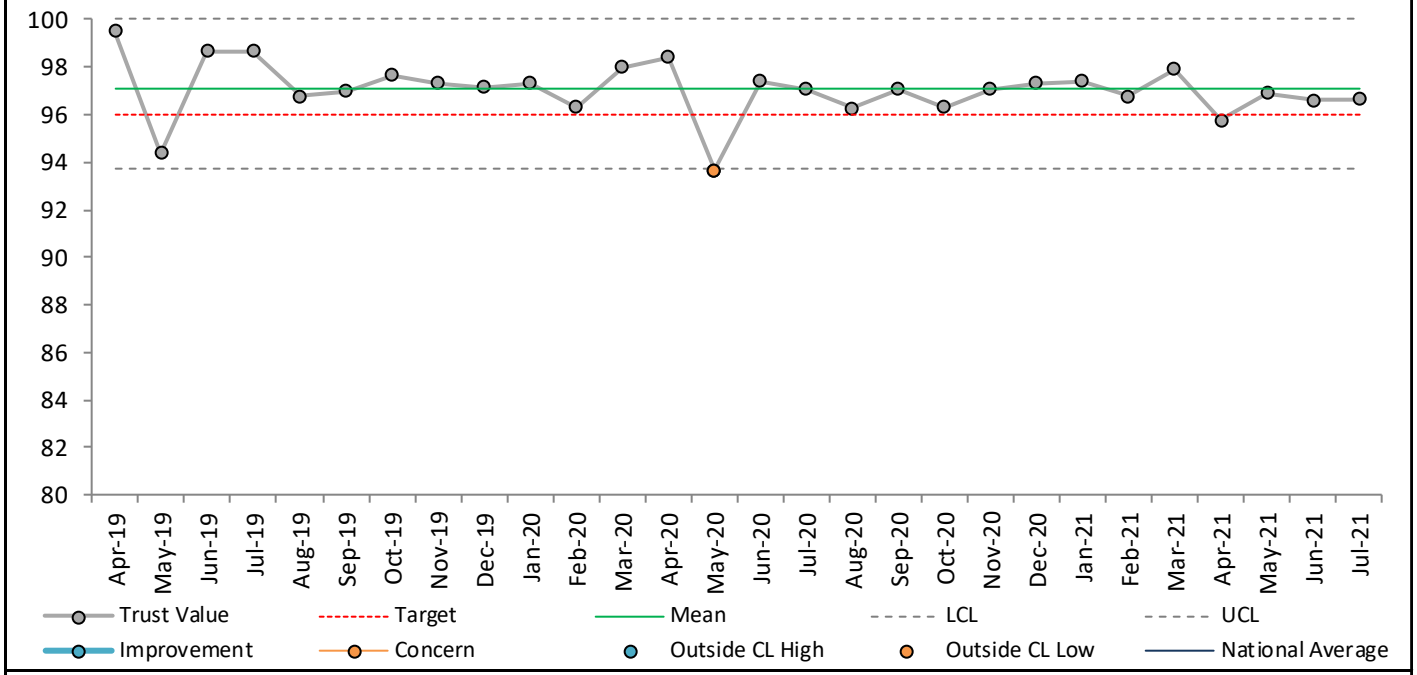
Timescale

- October 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	97.05
Last Month	96.64

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.

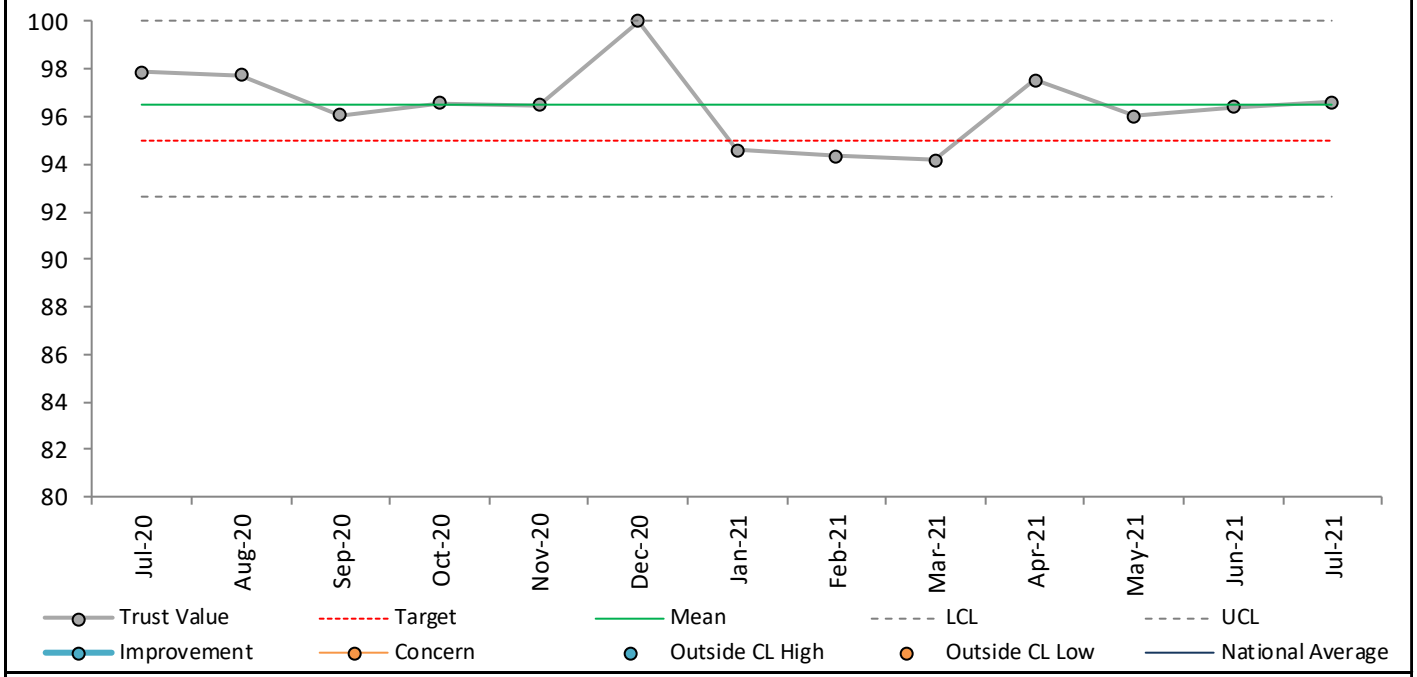
Timescale

- 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	96.49
Last Month	96.62

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.

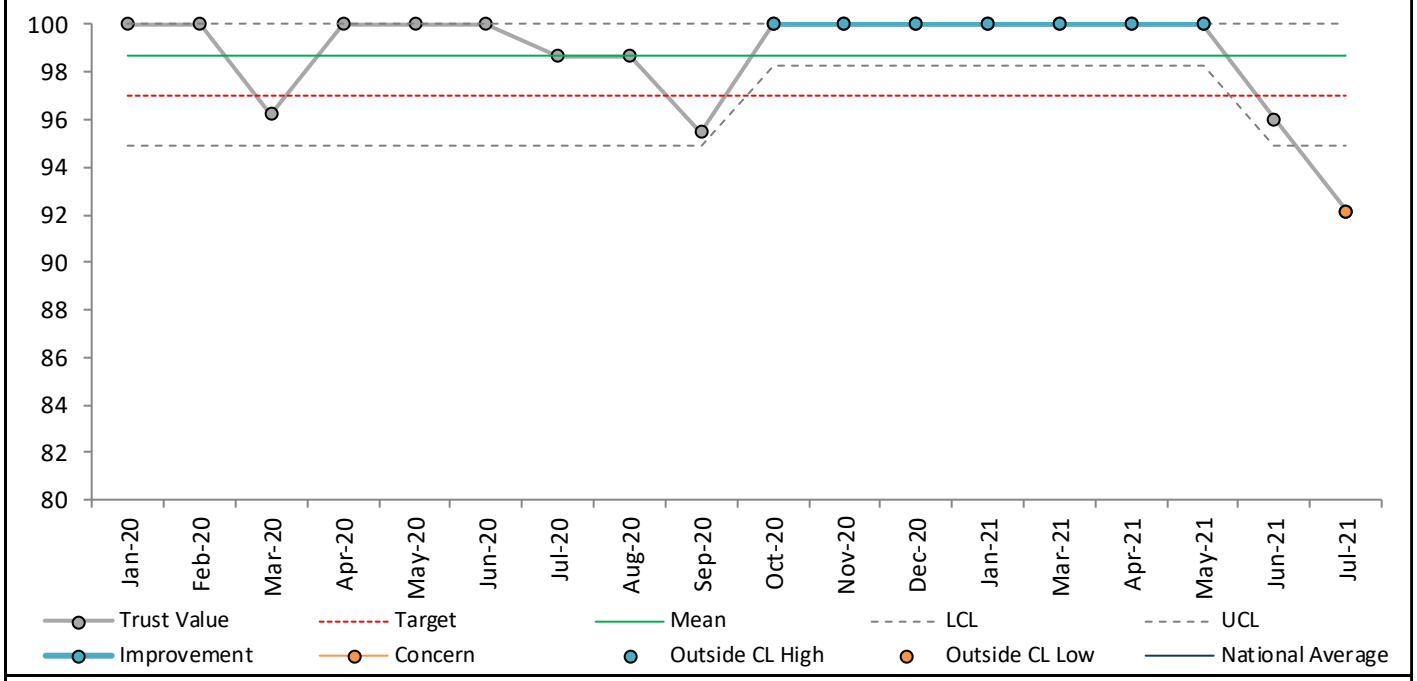
Timescale

- 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	98.73
Last Month	92.16

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 two months .

Cause of Variation

- The mean is below the target, for the second month.
- Low numbers are returned, with the number of surveys completed at birth, post natal ward and community being very low.

Planned Actions

- Review survey compliance with Maternity Lead for patient experience, to understand causes of variation.
- Review of the surveys completed at the four touch points in the maternity pathway.

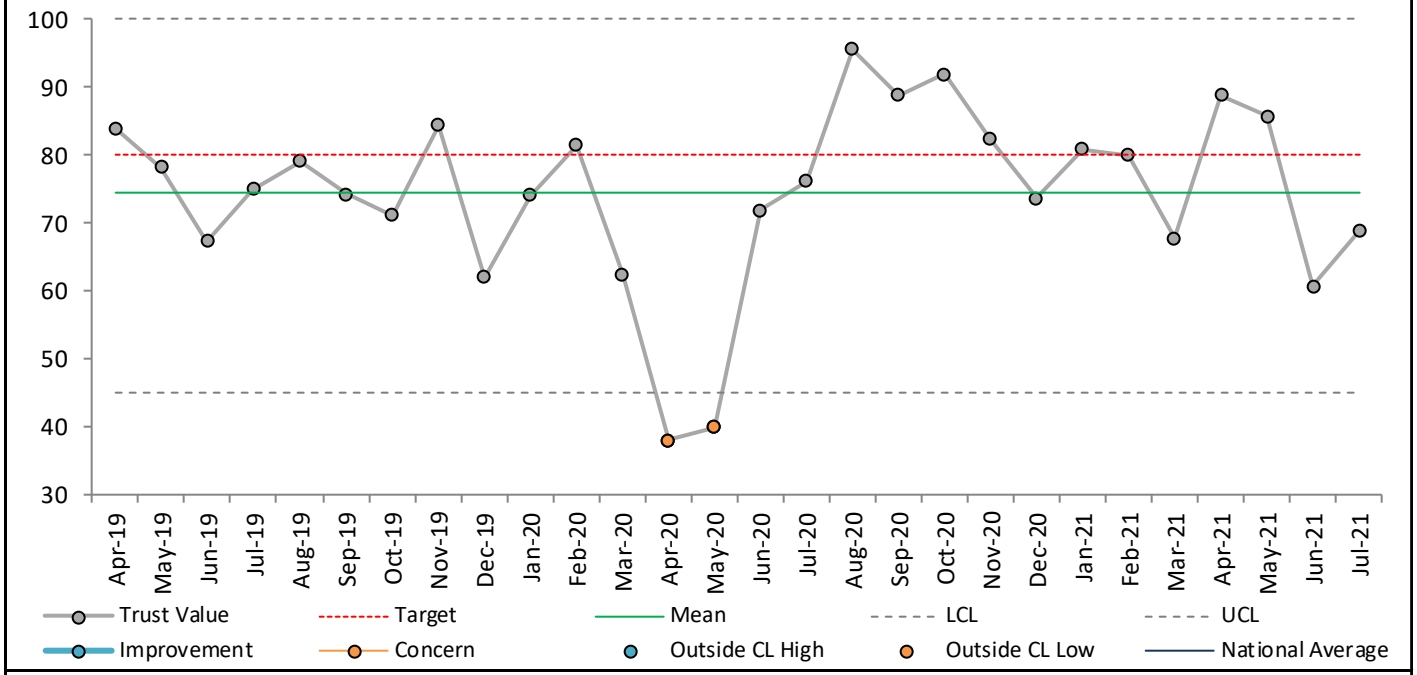
Timescale

- October 2021

Caring

South Tees Hospitals NHS Foundation Trust

Complaints Closed Within Target (%)



The percentage of complaints closed within the target

Target	80
Mean	74.48
Last Month	68.89

Executive Lead

Hilary Lloyd

Lead

Jen Olver

Commentary

There were 47 complaints closed in July , 8 of which were closed following a meeting.

Cause of Variation

- Compliance for this metric is below the target.
- Annual leave, staff sickness, availability of healthcare records. and clinicians' availability to input into responses .

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.

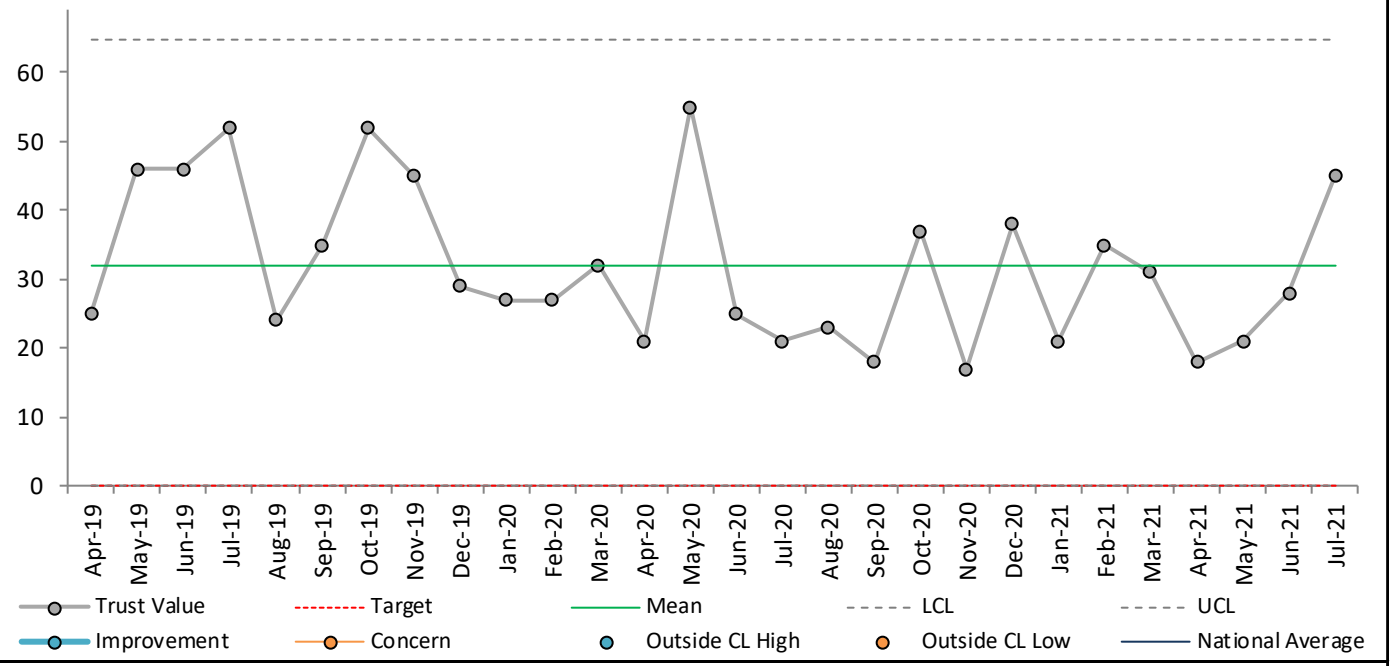
Timescale

- September 2021

Caring

South Tees Hospitals NHS Foundation Trust

All New Complaints



All new complaints recorded on DATIX

Target	
Mean	31.93
Last Month	45.00

Executive Lead

Hilary Lloyd

Lead

Jen Olver

Commentary

There was 35 formal complaints received in July a significant increase 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.

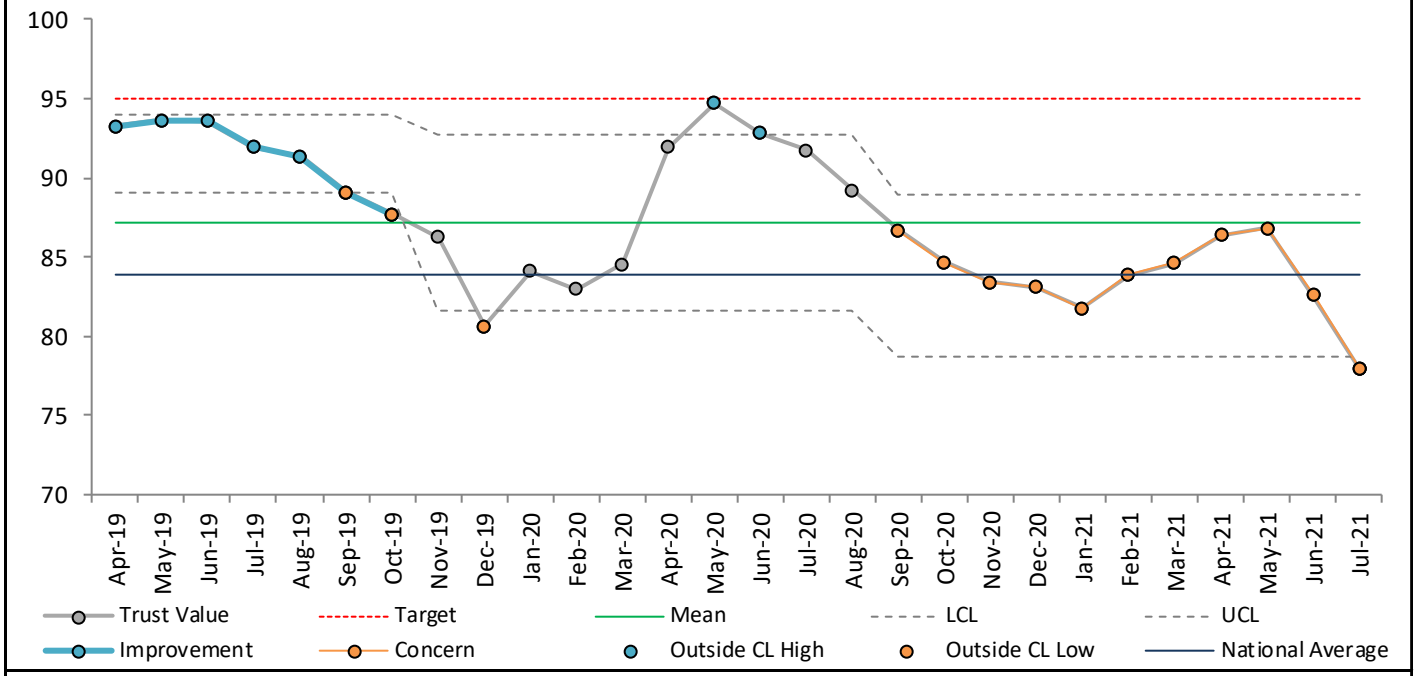
Timescale

- Ongoing

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	87.20
Last Month	78.01

Executive Lead

Sam Peate

Lead

Cheryl Burton

Commentary

Activity in excess of pre pandemic levels. Significant impact on performance in July 21. COVID staff isolation and sickness impacting on ability to meet demand.

Cause of Variation

- Sustained increased demand across all emergency and urgent care settings.
- Throughput challenged at times of high attendances.
- Staff isolation and absence due to outbreak significantly impacting medical and nursing rosters
- Lack of cubicle space.
- Sustained increase in Resus and Paediatric activity
- F2F GP appointments.

Planned Actions

- Operationalisation of Children's and Young Persons Emergency Department. (September 2021)
- Organisational approach to SDEC pathways to remove crowding and delays for non elective patients.
- Review of ED operational model to improve dwell times and processing – meetings in progress.
- ED recovery plan developed in line with ECIST recommendations.
- Clinically ready to proceed to be implemented end August 2021

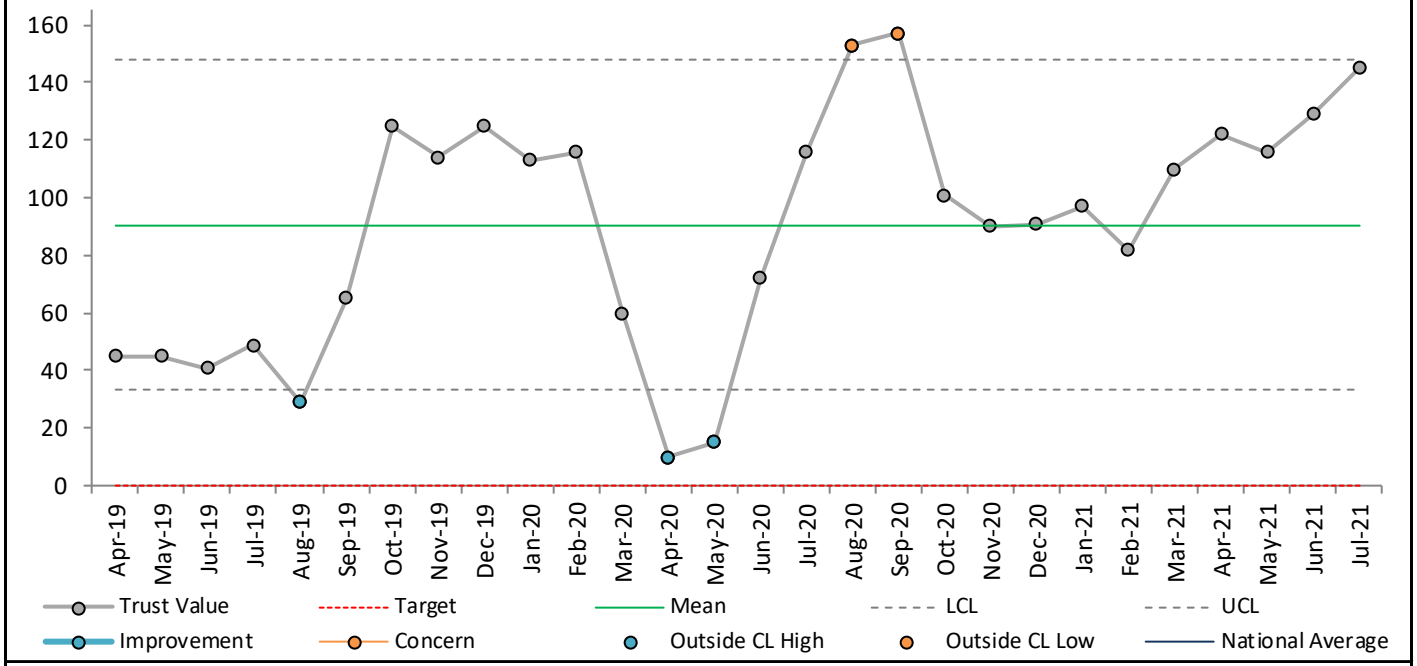
Timescale

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

Responsive

South Tees Hospitals NHS Foundation Trust

Ambulance Handovers - over 30 mins



Ambulance A&E handover delays greater than 30 minutes

Target	0
Mean	90.46
Last Month	145.00

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

- High volume of self presentations to ED .
- Reduced ability to meet demand due to increased levels of presentation.
- Exit block from department leading to overcrowding and lack of capacity to take handovers.
- PIN completion at point of contact.
- Handover delays.
- Staffing resource not available to take handover.

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.

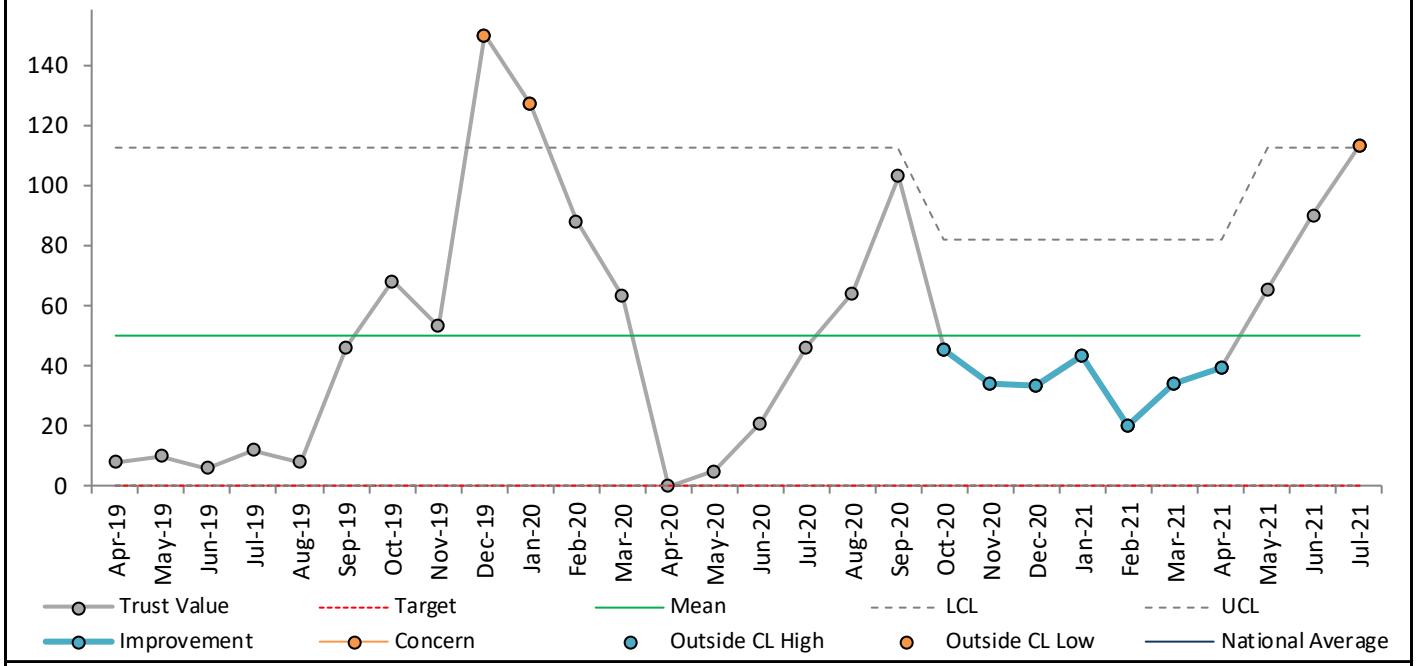
Timescale

- Completed
- Ongoing
- August 2021
- August 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	49.79
Last Month	113.00

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

- High volume of self presentations to ED .
- Reduced ability to meet demand due to increased levels of presentation.
- Exit block from department leading to overcrowding and lack of capacity to take handovers.
- PIN completion at point of contact.
- Handover delays.
- Staffing resource not available to take handover.

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.

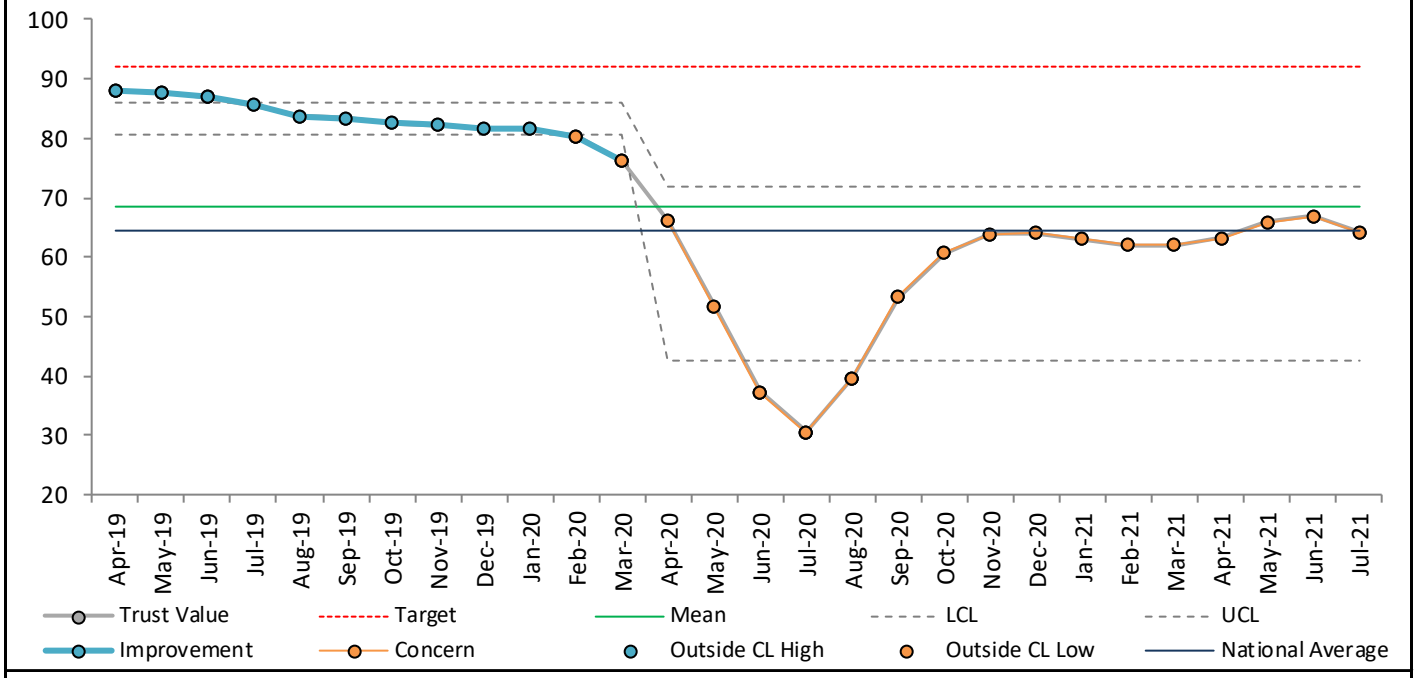
Timescale

- Completed
- Ongoing
- August 2021
- August 2021

Responsive

South Tees Hospitals NHS Foundation Trust

RTT Incomplete Pathways (%)



The % of incomplete pathways for patients within 18 weeks

Target	92
Mean	68.39
Last Month	64.20

Executive Lead

Sam Peate

Lead

Joanne Evans

Commentary

Existing RTT improvement Trajectory expecting performance to 68% by July 21 with further 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.
- June position not yet confirmed, Over 52 week waiters for June 21: 2,591 (May 21 : 3,167).

Planned Actions

- Orthopaedic weekend working commenced.
- Distribution of activity to IS.
- Focus on clinical need first, then longest waiters.
- Further increase in access planned in May ensuring all available theatre estate being utilised.
- Plan being established for opening additional sessional activity in August on completion of lifecycle works to Theatres 5 & 6.

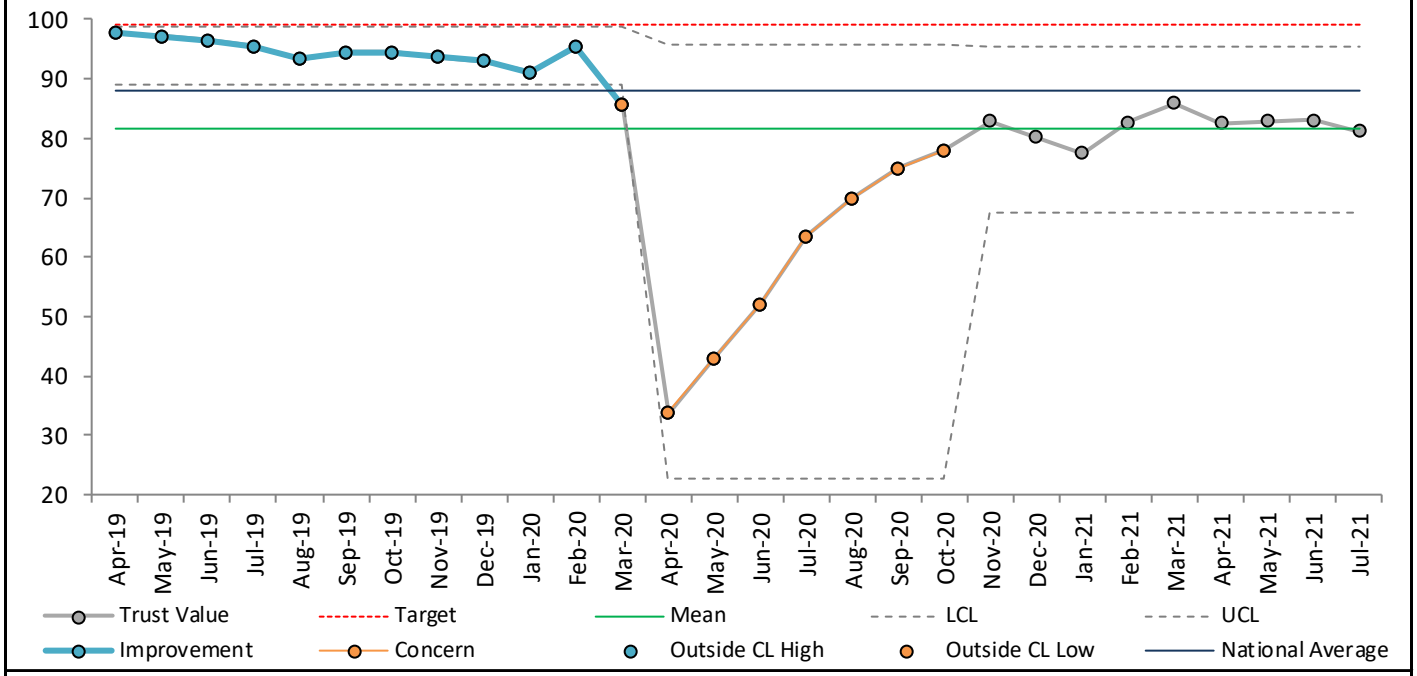
Timescale

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

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	81.52
Last Month	81.27

Executive Lead

Sam Peate

Lead

Ann Wright

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.
- Accumulation of routine diagnostic tests for Neurophysiology, Audiology, Dexa Scanning and Urodynamics.

Planned Actions

- Continue to review and maximise utilisation of capacity.
- Replacement Dexa scanner being progressed
- 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

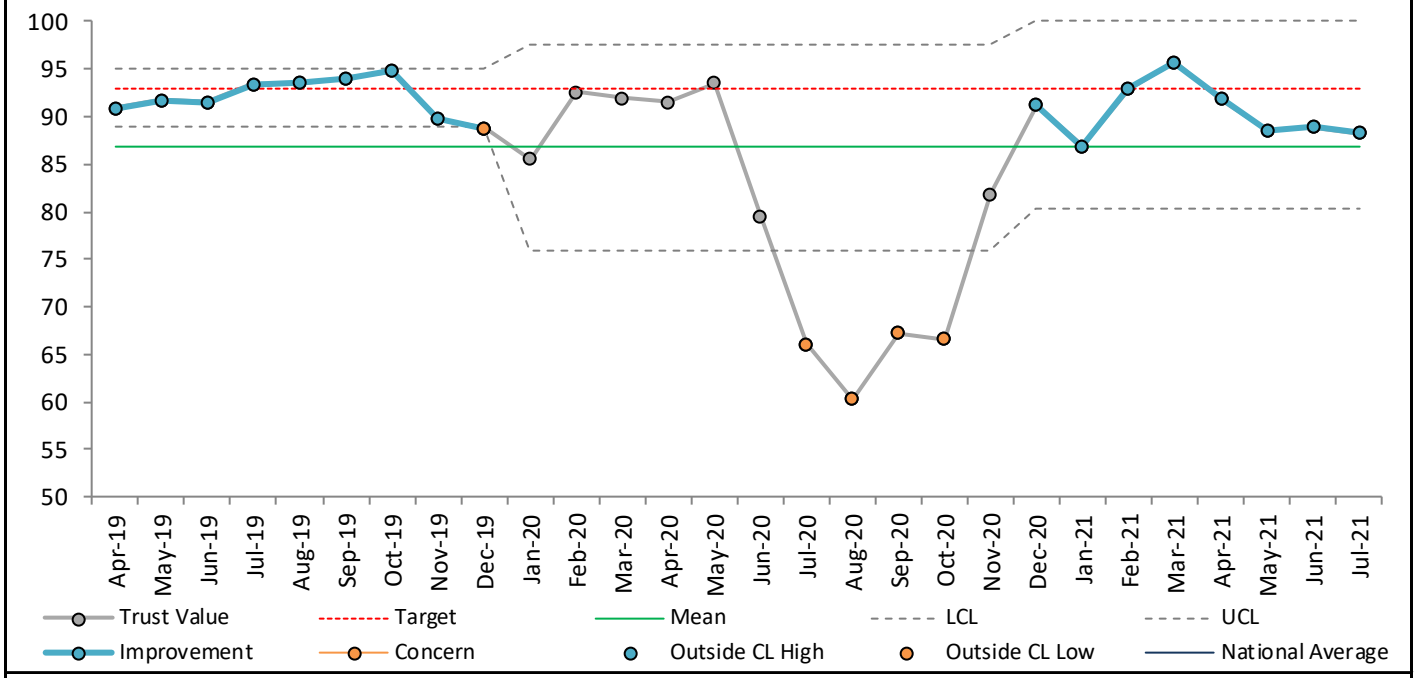
- Weekly
- August 2021
- 31st July 2021

- 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	86.76
Last Month	88.26

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.

July 21 indicative. Last achieved in March 21.

28 day faster diagnostic target achieved in June 21 – compliance 78% (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 pressures and themes.

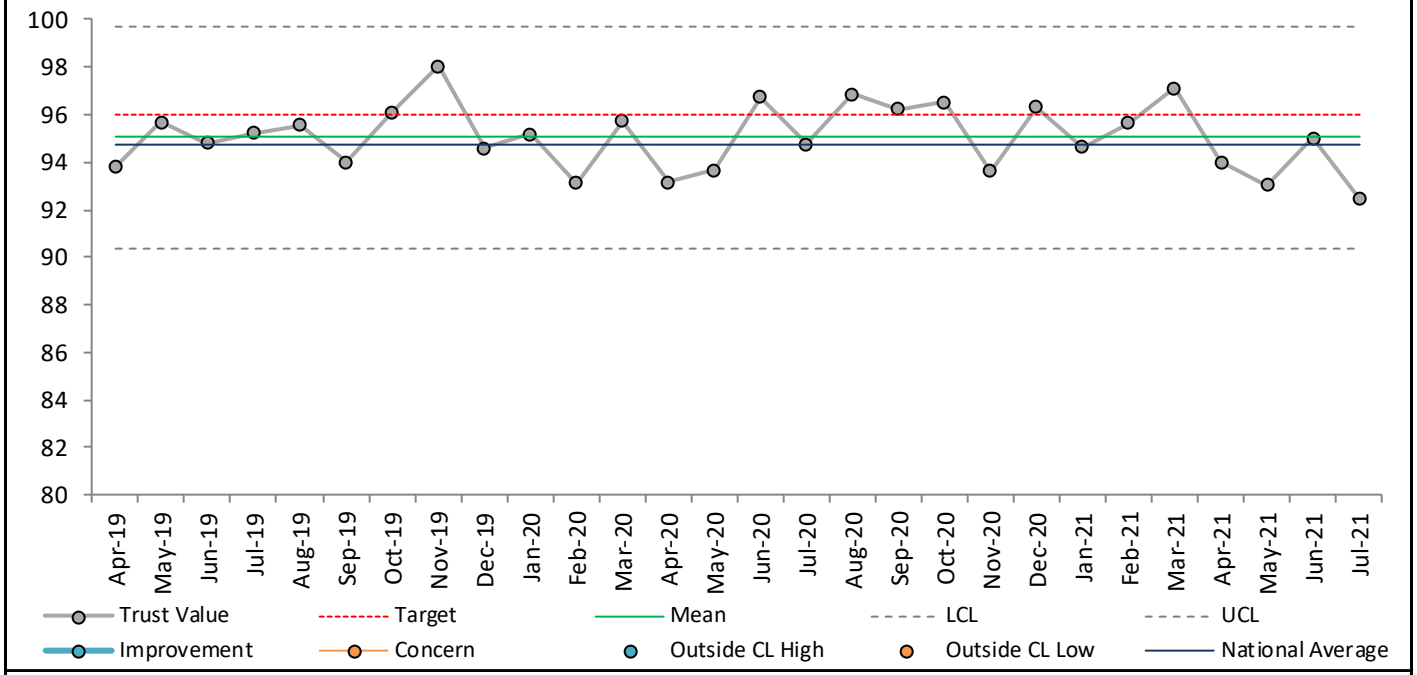
Timescale

- 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	95.05
Last Month	92.47

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.

July 21 indicative. Last achieved in March 21.

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 in June 21.

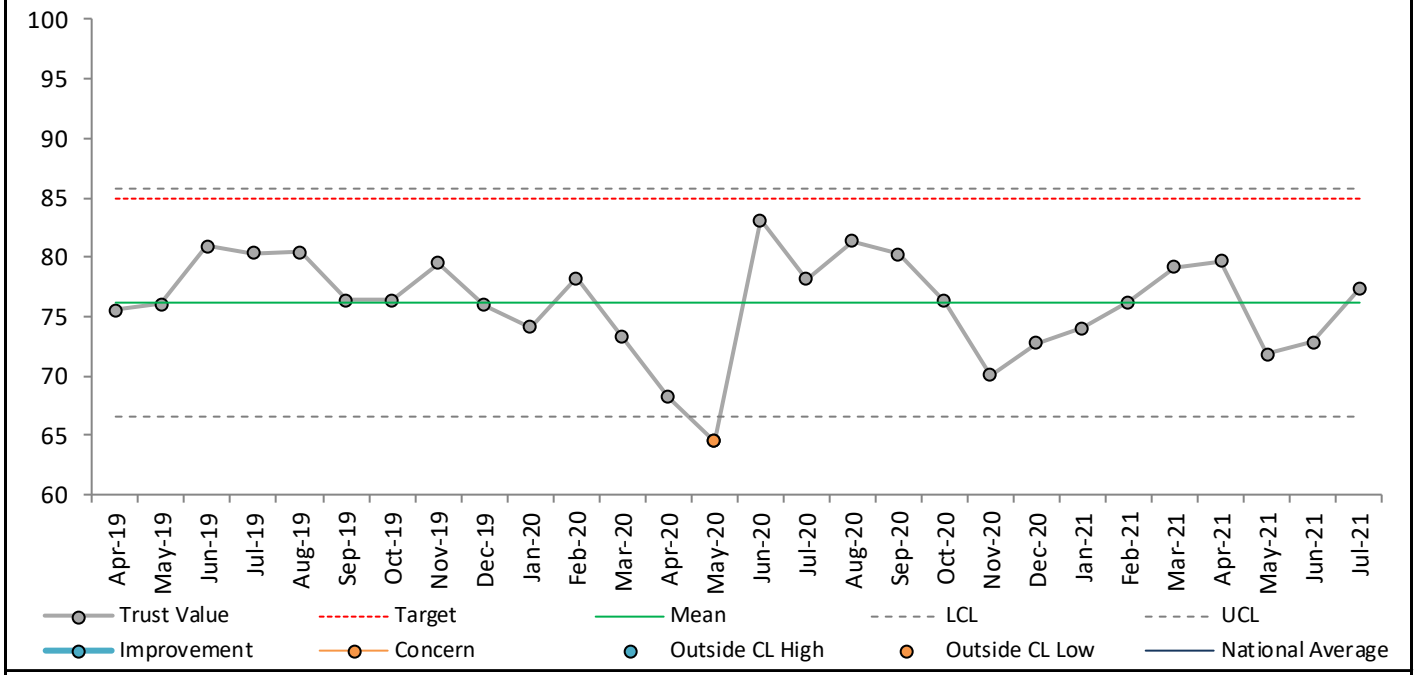
Timescale

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

Responsive

South Tees Hospitals NHS Foundation Trust

Cancer Treatment - 62 Day Standard (%)



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

Target	85
Mean	76.18
Last Month	77.35

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 just within the control limit the means is at 75.99% therefore the target is unlikely to be met.

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. June 21 - 35% of transfers have taken place after 38 days. In line with the Inter Provider transfer rules those transferred after day 38 25% 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.

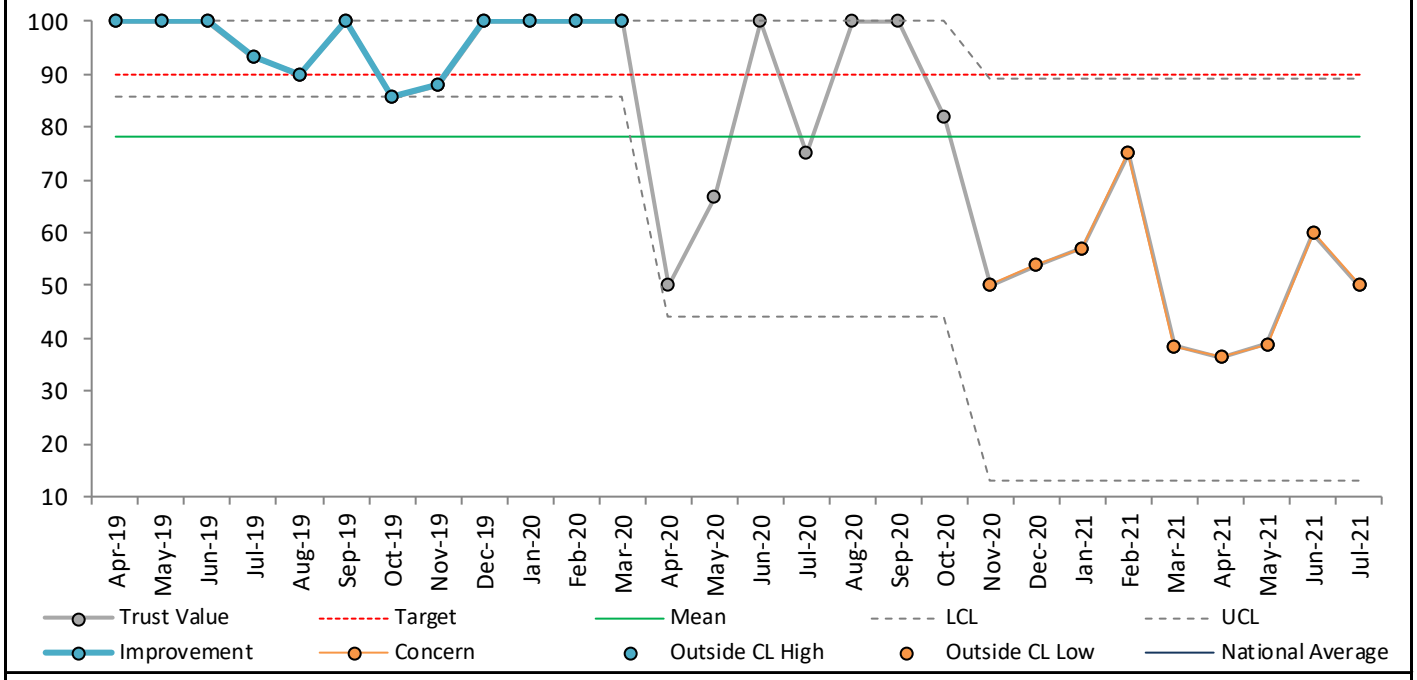
Timescale

- 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	78.22
Last Month	50.00

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 78.22% 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

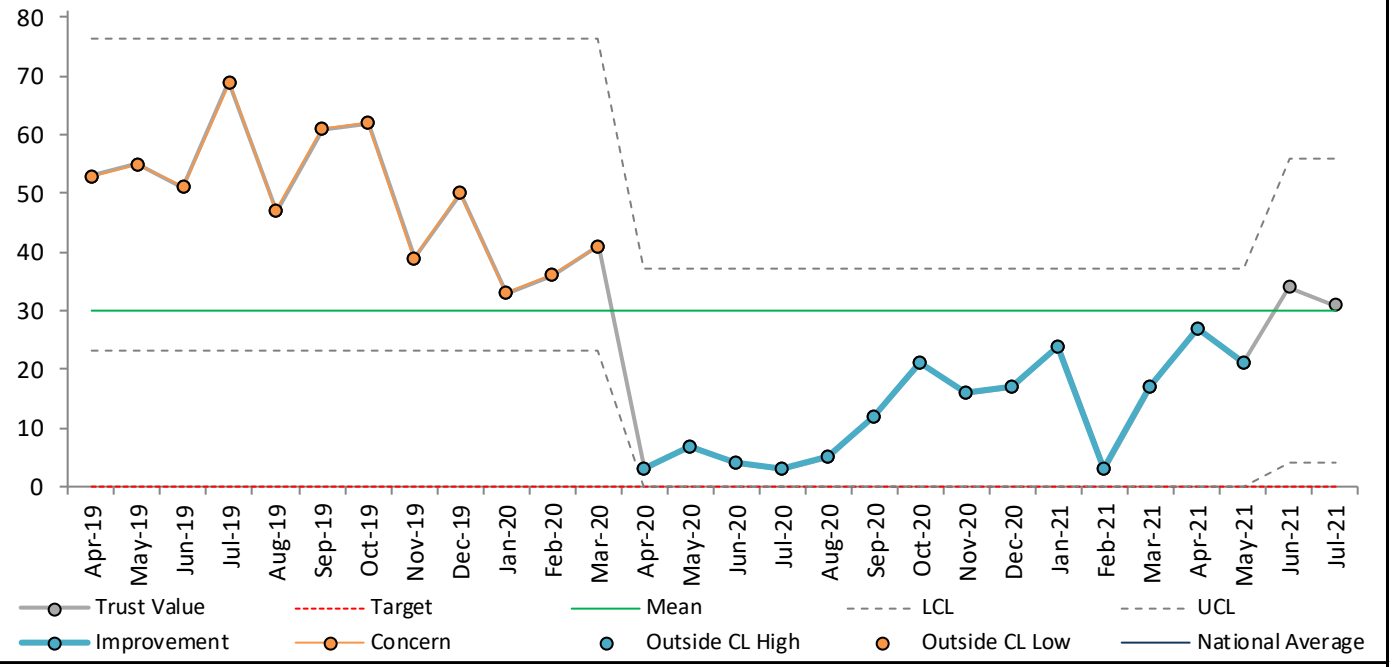
- Actions as per 62 day first standard (previous slide)

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	30.07
Last Month	31.00

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.

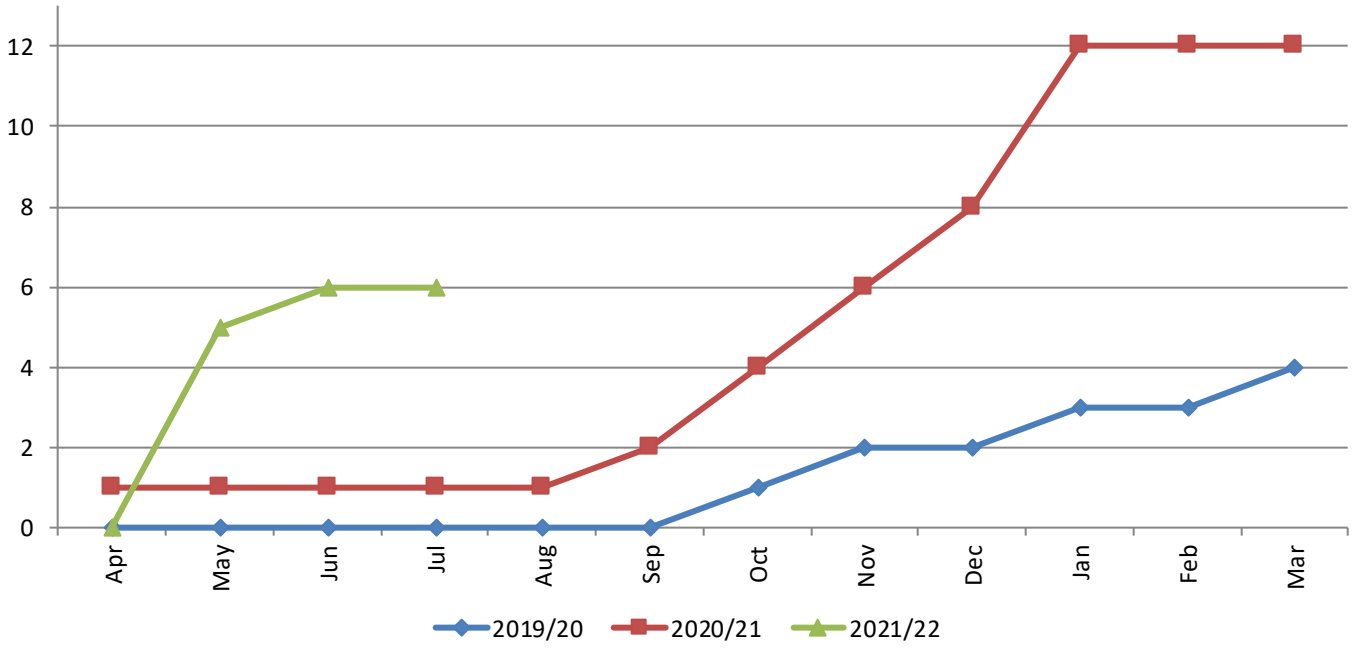
Timescale

- 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	6

Executive Lead

Sam Peate

Lead

Joanne Evans

Commentary

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

There have been 6 cancer operations cancelled this financial year.

Cause of Variation

- There was 1 short notice cancer operation cancelled in June for non clinical reasons.
- Limited access to critical care throughout pandemic.

Planned Actions

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

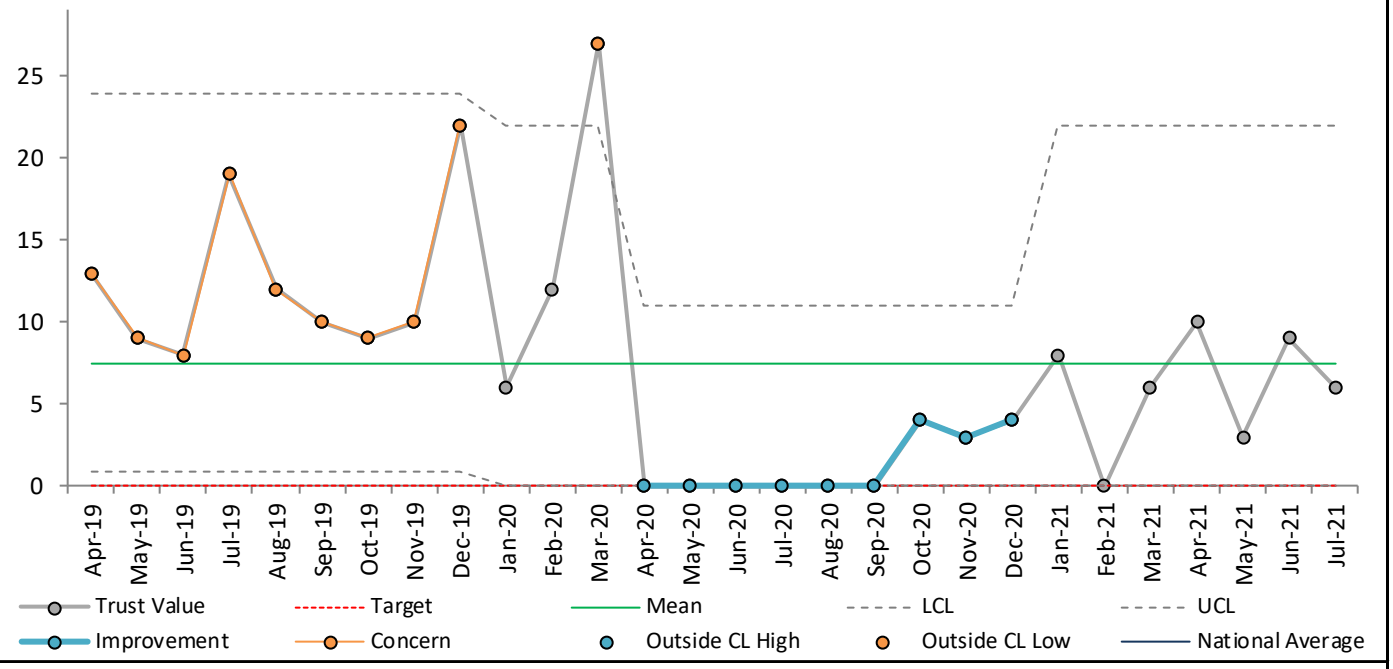
Timescale

- 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	7.50
Last Month	6.00

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.

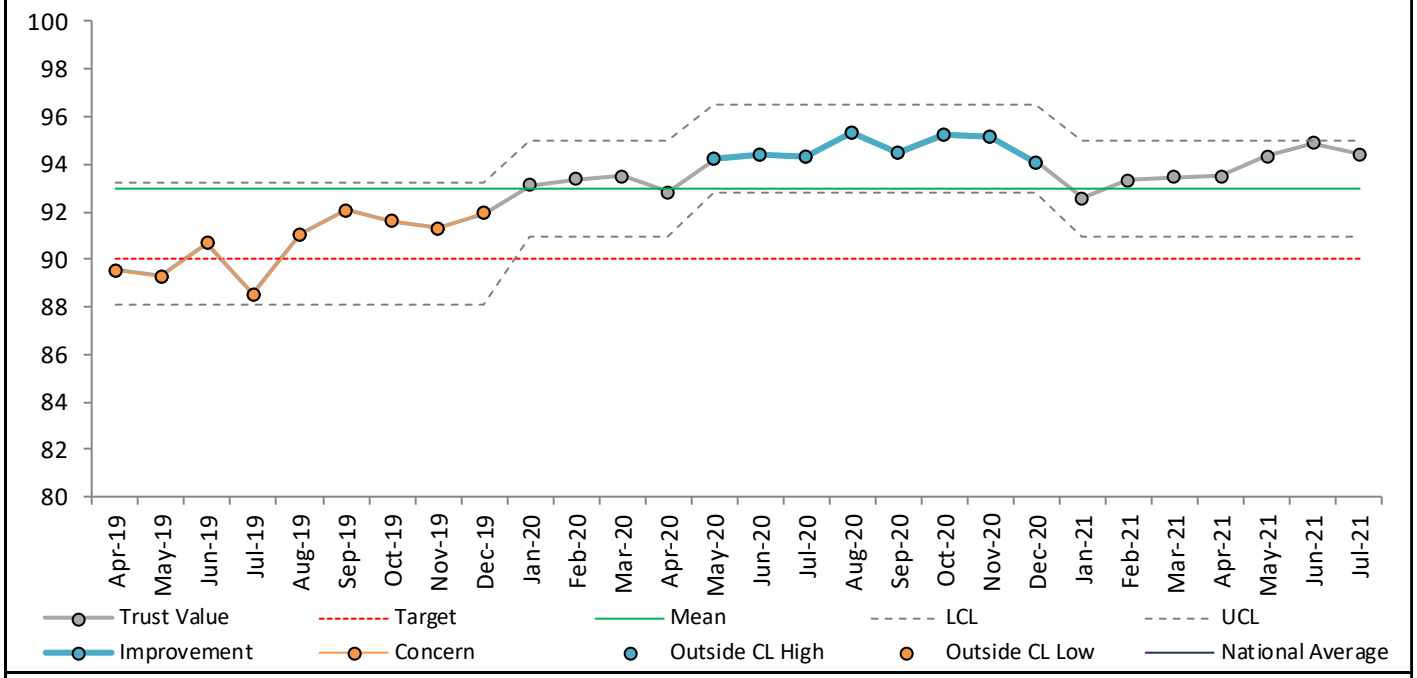
Timescale

- Ongoing

Responsive

South Tees Hospitals NHS Foundation Trust

E-Discharge (%)



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

Target	90
Mean	92.94
Last Month	94.43

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.

Timescale

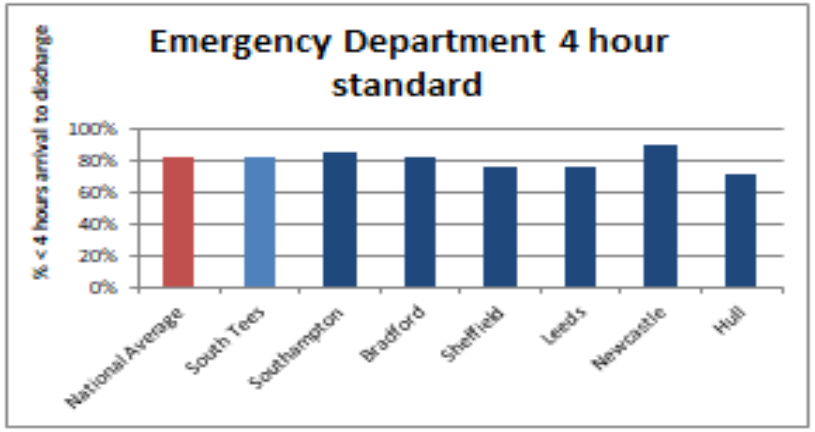
- Ongoing

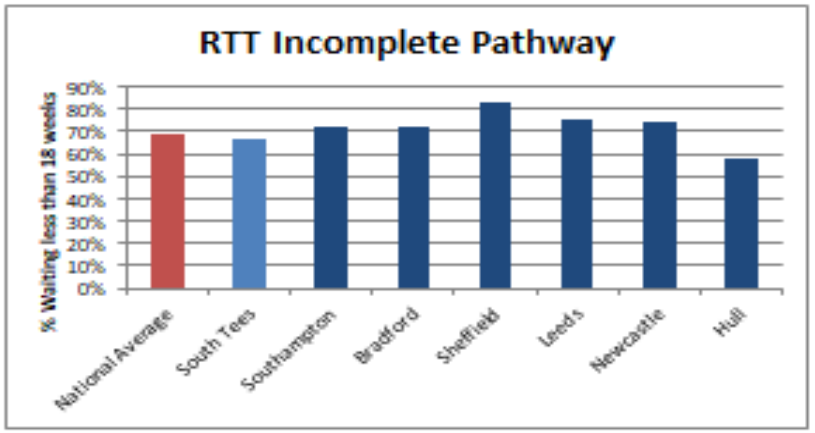
Responsive

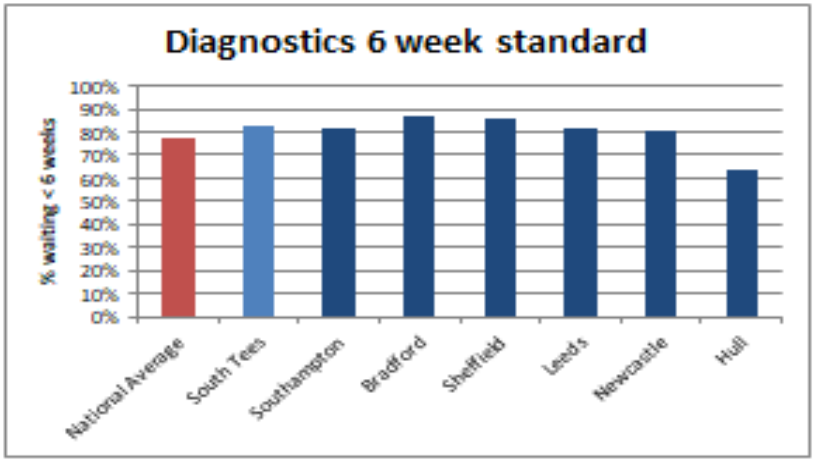
South Tees Hospitals NHS Foundation Trust

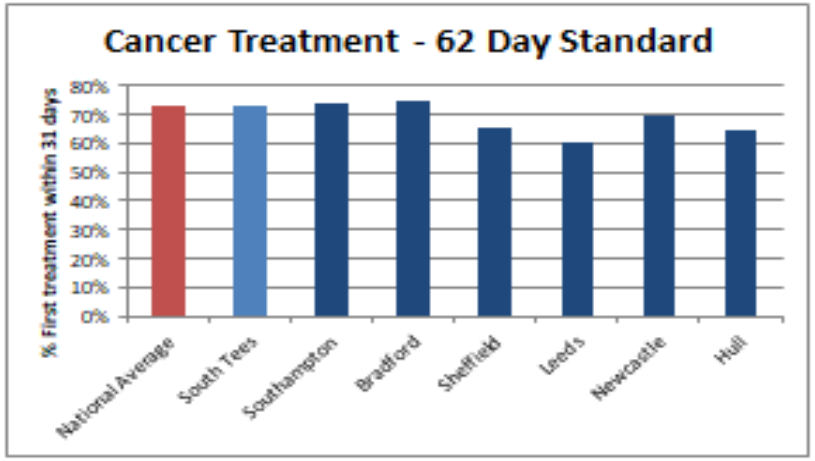
Benchmarking against National Average and Other Providers

June 2021









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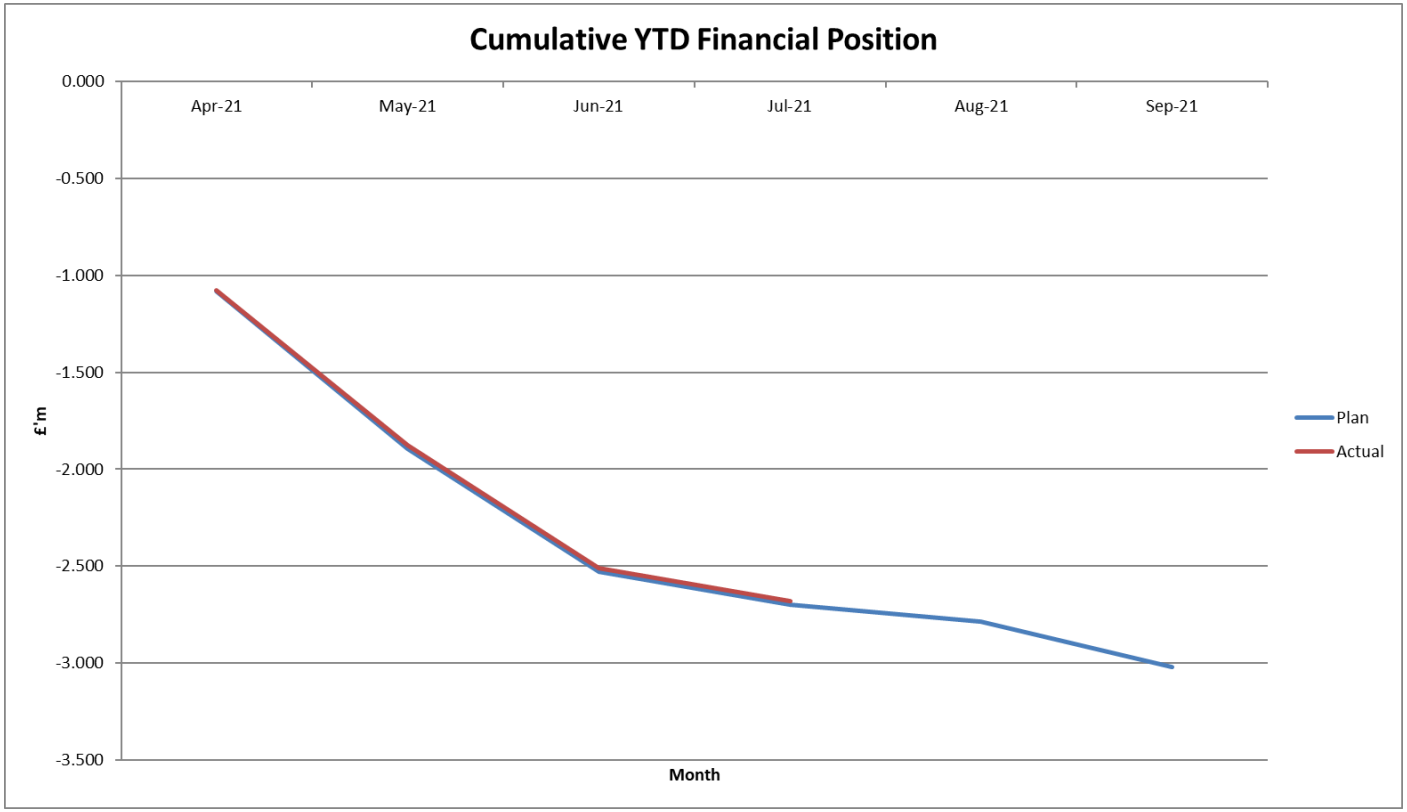

Target	-2.68m
Mean	N/A
Last Month	-2.7m

Executive Lead

Chris Hand

Lead

Luke Armstrong

Commentary

The Trust's financial performance is a deficit of £2.7m at month 4, in line with the submitted H1 plan.

Cause of Variation

- No cause of variation.

Planned Actions

- Rebase and detailed review of high cost drugs and devices baseline budget, including HCTED items.
- Review of ongoing Covid-19 costs for H1.

Timescale

- 31 August 2021
- 30 September 2021

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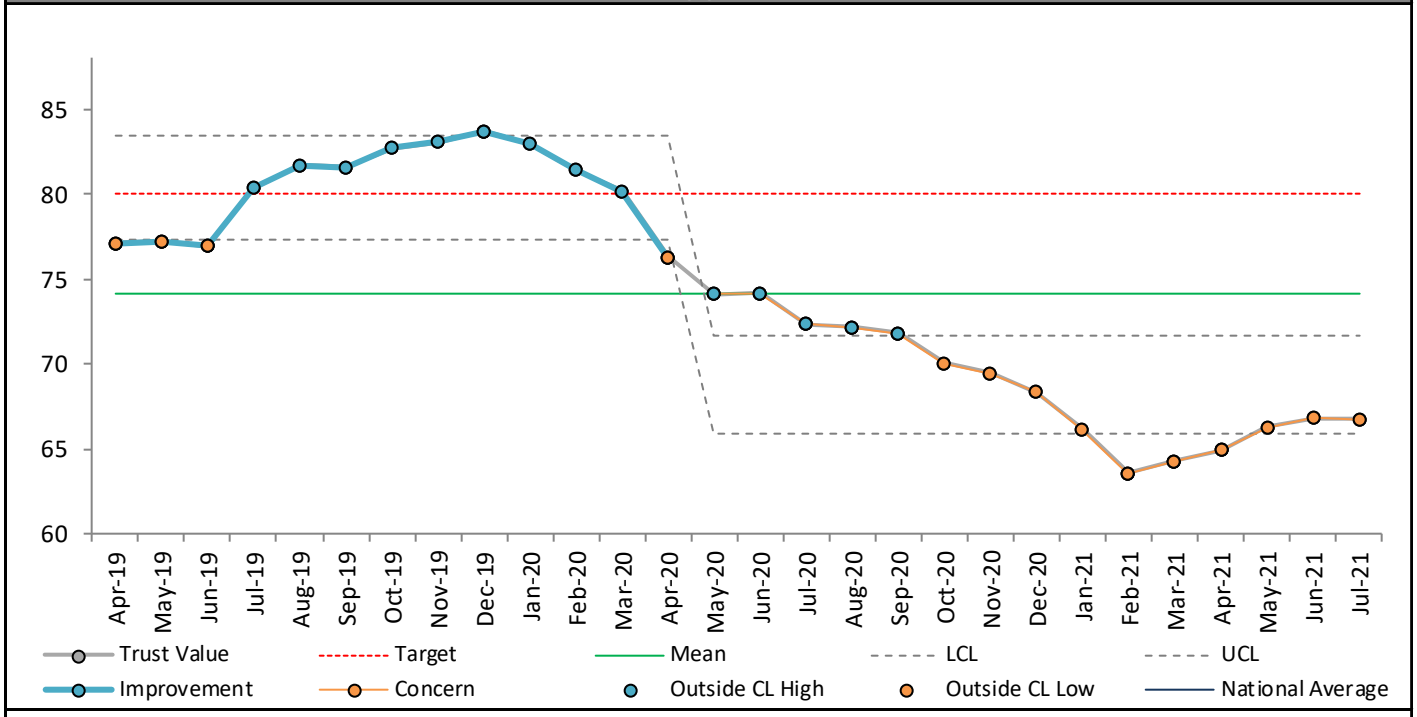
Annual Appraisal (%)



Annual Appraisal Rate

Target	80
Mean	74.17
Last Month	66.73

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

This metric has had a slight drop in month of July. It has dropped from 66.81% to 66.73%.
The introduction of HR clinics with managers throughout the organisation has received positive comment. Introduction of real time data has enabled a data cleanse to take place, which will support more accurate HR data being provided to managers.

Cause of Variation

- Additional pressures on managers requiring them to focus on operational requirements a as a result of Covid pressures and staff isolating during the month July.
- Lowest areas of compliance include Growing the Friarage and Community at 57.33%, Women and Children at 57.37% and Perioperative and Critical Care services at 60.93%.
- Cardiovascular Care services above target of 82.67%.

Planned Actions

- HR Operations Team now have access to real time data which has enabled them to provide improved data to management teams which is now in use to inform discussion with managers to improve performance.
- A total of 37 HR clinics have been held with manager in the month of July.
- Digestive Diseases showed highest improvement from 67.9 to 71.92 – 3.98% improvement
- HR clinics to address areas of lowest compliance are planned through August 2021.
- Corporate compliance data is currently 75 % with additional support being provided by HR to reach 80% by end August 2021.

• Timescale

- August 2021
- August 2021
- August 2021

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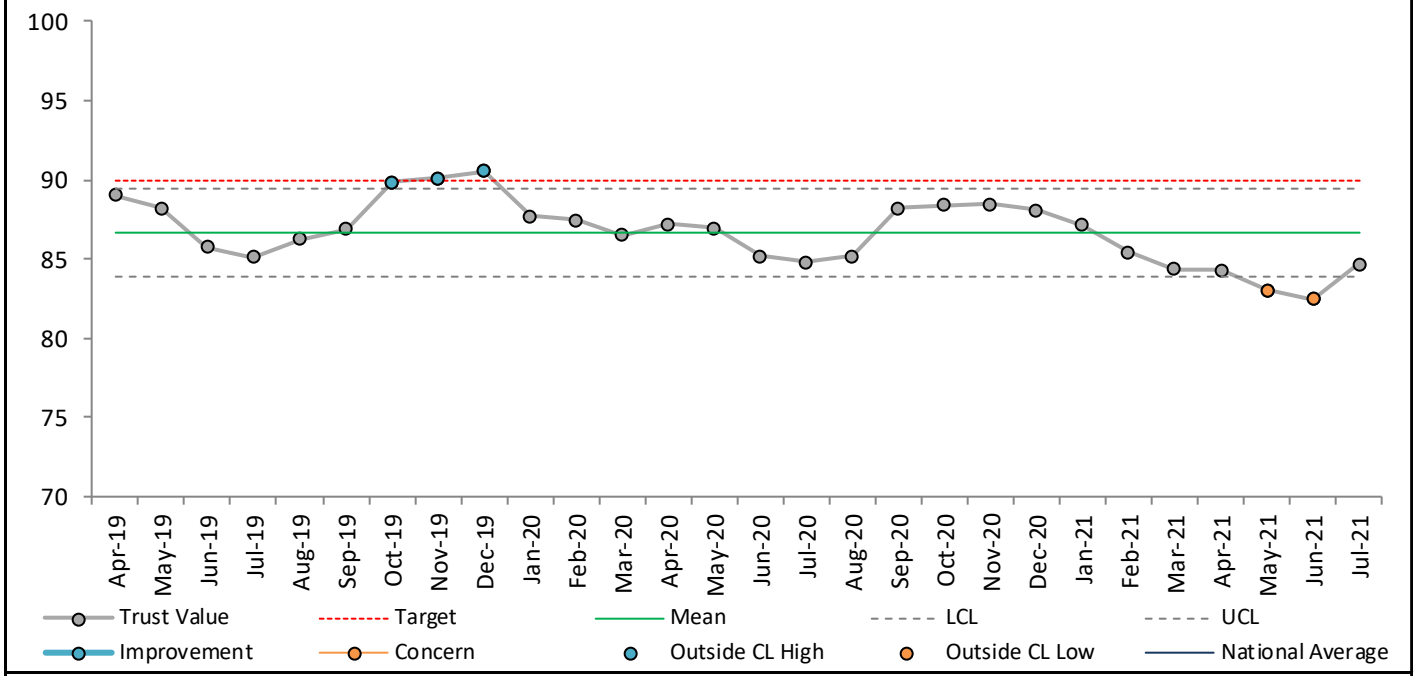
Mandatory Training (%)



The % of Mandatory Training Compliance

Target	90
Mean	86.70
Last Month	84.67

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

Mandatory Training has increased slightly to from 84.29 to 84.67%
Briefing sessions have taken place for staff regarding the transfer of training onto ESR and HR clinics introduced to discuss compliance against KPI for worst performing areas.

Cause of Variation

- Mandatory Training data has been transferred onto ESR to enable real time reporting. Training packages within ESR are more challenging. Therefore some of the training programmes will take more time to complete.
- Capacity in the organisation has been under significant pressure with staff isolation figures rising.
- Lowest areas of compliance Women and Children at 79.26%, Medicine & Emergency care services 81.21% & Head and Neck at 83.18%. Remaining areas in 80 – 90%.
- Growing the Friarage & Community Service is above target at 90.02%

Planned Actions

- HR Clinics introduced between HR and managers and focusses on those areas with lowest compliance of KPI. 37 clinics held across the organisation within July/August 2021.
- Mini data cleanse underway, data is updated following every HR clinic which will provide more accurate HR data with managers.
- Significant Increase in compliance within Growing the Friarage and Community Services currently at 90.2% James Cook Cancer Institute showed greatest improvement in compliance from 86.9 to 88.17% - a 1.27% improvement
- Meetings have taken place with the Resus Team to support the introduction of this role specific training to be available on ESR

Timescale

- August 2021 onwards
- August 2021 onwards
- August 2021

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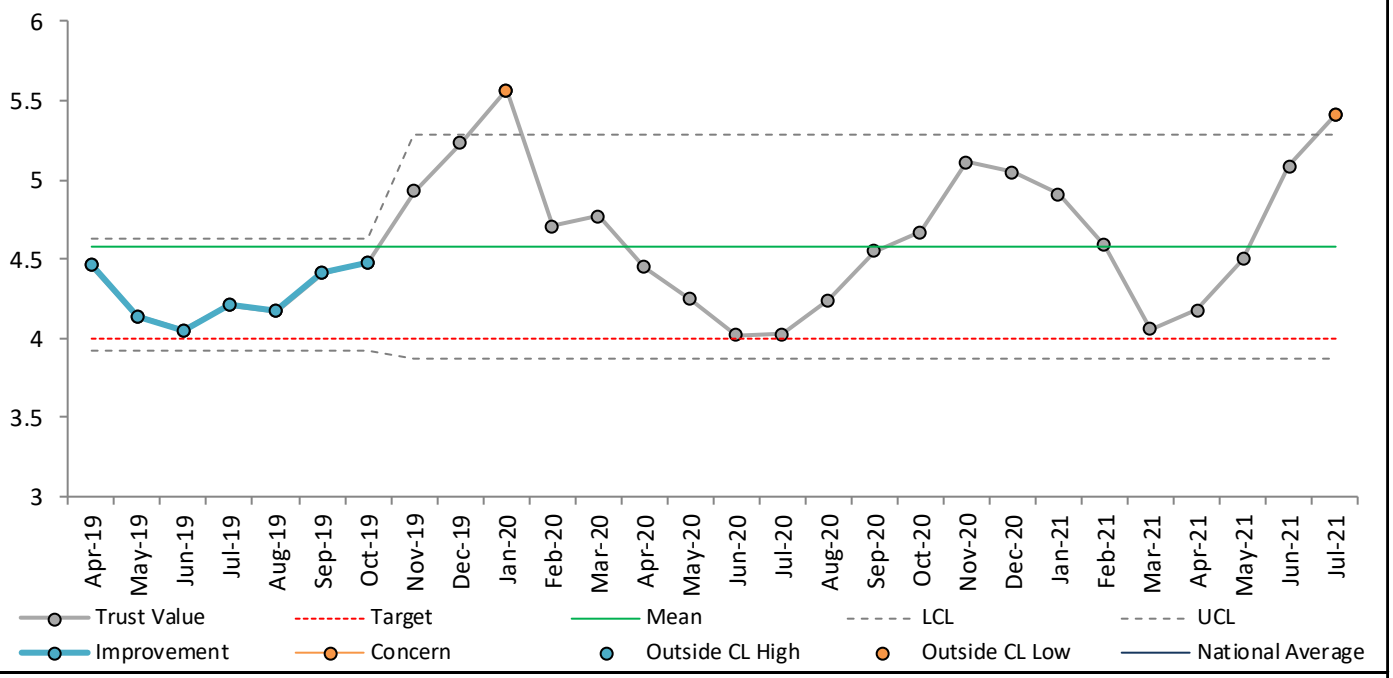
Sickness Absence (%)



The % of monthly sickness absence

Target	4
Mean	4.58
Last Month	5.41

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 5.09% in June to 5.41% in July.
Various HR clinics introduced across the organisation, including absence management refresher training and case conferences

Cause of Variation

- Staff absence figures have increased from 5.09% in June to 5.41% in July. The key areas of concern are stress, anxiety and depression.
- The highest recorded sickness is Neurosciences and Spinal Care Services at 6.24% closely followed by Perioperative and Criticar Care Services at 6.01% and Cardiovascular Care Services at 5.99%.
- Medicine and Emergency Care Services last month were recorded the highest sickness rate with 8.02% this has now reduced to 7.72 % this month.

Planned Actions

- In additional to HR clinics, monthly case conferences between HR, OH and managers to be introduced by end of August 2021 to focus on areas with highest absence
- Support provided to Critical Care to recruit to a number of vacant posts within Critical Care which is having an impact on absence management.
- Digestive Diseases area with most improvement, reducing absence by 0.38% within July 2021.
- Refresher session on absence process being provided in Corporate and Clinical services to support managers with high levels of absence.

Timescale

- August 201 ongoing
- August 2021
- August 2021

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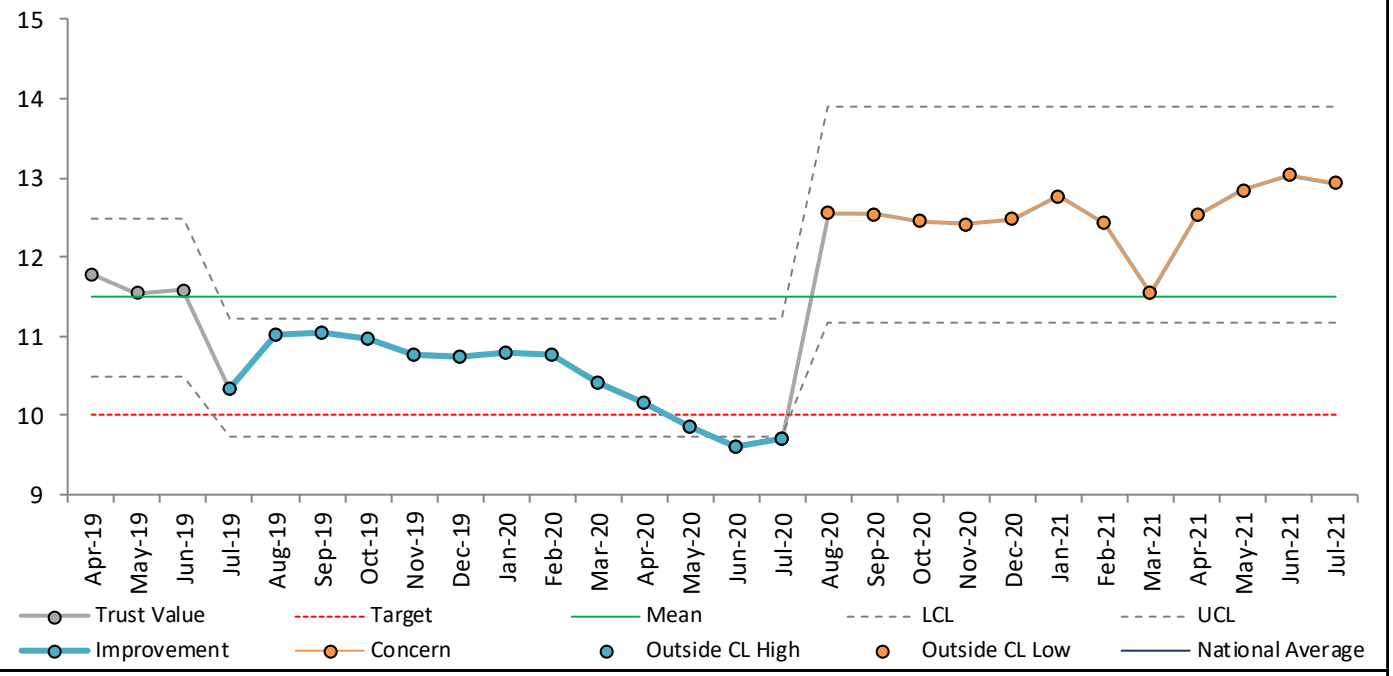
Staff Turnover (%)



Staff turnover rate

Target	10
Mean	11.49
Last Month	12.93

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

Various initiatives to be introduced to support staff engagement and workforce planning , focussing on staff wellbeing and retention.

Cause of Variation

- Turnover has decreased by 0.11% to 12.93%
- Highest rate of turnover is in the following areas: Medicine & emergency Care Services - 17.33%, Cardiovascular Care Services - 15.42% and Perioperative and Critical Care – 15.40%
- James Cook Cancer institute and specialist Medicine Services are at 9.09% and Neurosciences and Spinal care at 9.94% - both below target of 10%

Planned Actions

- Partnership working with Staff Side and HR to finalise the Retention Strategy, which includes a number of early interventions to retain staff. These will be introduced within operational areas in August/September 2021
- Detailed action plan to underpin the People Plan is in development, which includes focus on staff engagement and retention.
- A 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.
- Development of a succession planning document to be implemented in every department
- Growing the Friarage and Community Services are holding a recruitment day

Timescale

- September 2021
- September 2021
- August 2021
- October 2021
- September 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.

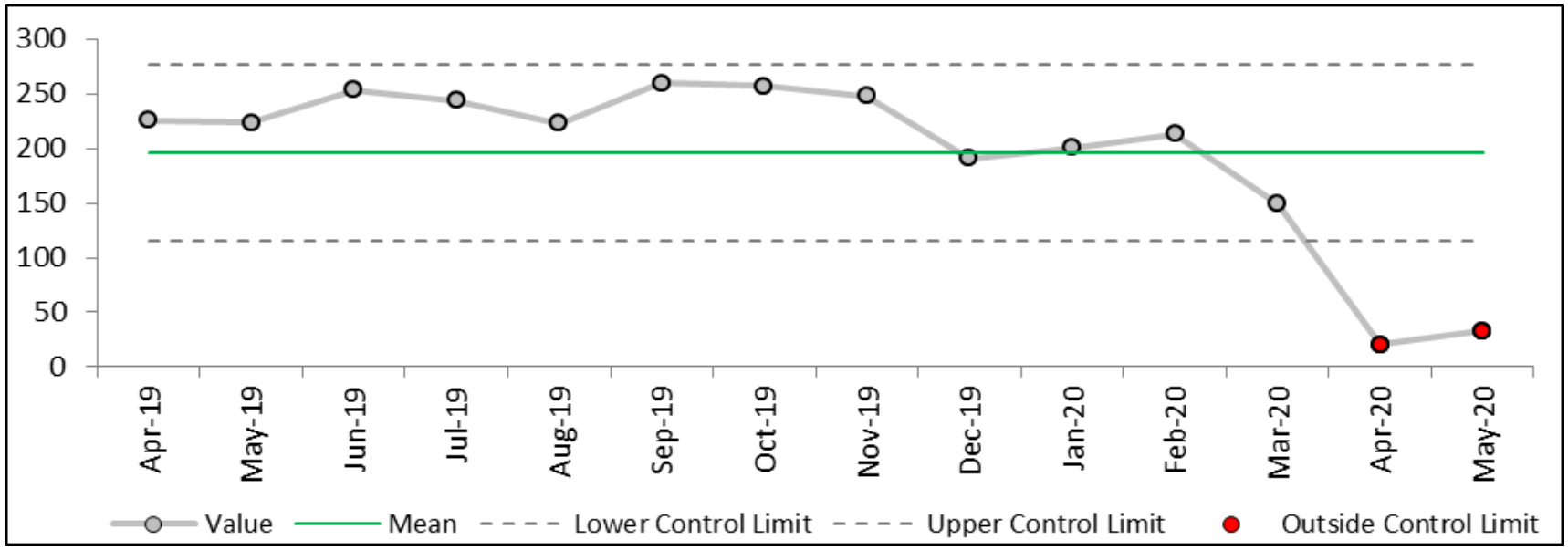
Introduction to Statistical Process Control

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

People Committee
Chair's Log

Meeting: People Committee	**Date of Meeting**: 26 August 2021
Connecting to: Board of Directors	7th September 2021

Key topics discussed in the meeting

- Next phase of development and the risks within the BAF
- Education update
- Organisational development and management training update
- Outcome of Ofsted inspection of apprenticeship provision and ongoing work to determine the best provider to deliver excellent education
- Proposals related to the development of medical apprenticeships for information
- Report of the Guardian of Safe Working
- HEENE Update report
- Allied Health Professionals workforce review
- Performance report

Actions	Responsibility / timescale
• The value of leadership and management development to safety and quality is noted with encouragement to explore mechanisms to maximise attendance	Ms Winnard / share with QAC as assurance
• The Director of Education was encouraged to investigate how to undertake an evaluation of the whole OD and Leadership Programme to give assurance that the investment in time and money is contributing to improvement in safety and quality and resource management	Ms Winnard
• The continued programme of the Schwarz rounds was welcomed	
• Work to develop a response to the delivery of apprenticeships to continue	Ms Winnard
• Noted the timeline and process for the AHP workforce review	
• Noted the performance report and asked for an "exception" comment in future on areas where a trajectory of improvement is not apparent	Mrs Metcalf

Escalated items

- There were no matters to escalate to Board

Risks (Include ID if currently on risk register)	Responsibility / timescale
The People Committee reviewed the BAF. A number of assurance documents were received. The Committee rated the overall assurances as Amber. • Timelines for the BAF were noted, but in respect of the ongoing risks for the medical and AHP workforce the Committee asked for an interim report on current shortages and risks associated • Congratulations offered to the Medical Education team for the very positive feedback from the quality visits from Newcastle Medical School and the Northern Foundation School • Welcomed the report from the (relatively) new Guardian of Safe Working Dr Skeath and his observations on how the system can be further improved	Dr Lal and Ms Mhalanga

South Tees Hospitals NHS Foundation Trust

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 31 August 2021
Connecting to: Board of Directors	7th September 2021

Key topics discussed in the meeting	
• CQC update • Never Events and SI report • BAF • IPR • Cycle of business • COVID update	

Actions	Responsibility / timescale
• Clinical Harm review – Ophthalmology update in September; • Clinical Harm review – process would be reported through DATIX • Never events – thematic review being undertaken with clinical engagement of new patient safety ambassadors • IPR – further explore use of SPC within IPR • Level of assurance process to be proposed by SLT	Sam Peate Hilary Lloyd Rob Harrison Jackie White, Hilary Lloyd & Michael Stewart

Escalated items
• National Blood bottle shortage – risk to Trust being managed effectively

Risks (Include ID if currently on risk register)	Responsibility / timescale
The Quality Assurance Committee reviewed the BAF. A number of assurance documents were received. • Timelines for the BAF were noted, with a number of gaps outstanding • The number of gaps had been reduced since the last report	