South Tees Hospitals
NHS Foundation Trust

Board of Directors

1 June 2021
10:00
Microsoft teams & Board Room, Murray Building

South Tees Hospitals NHS Foundation Trust

MEETING OF THE SOUTH TEES HOSPITALS NHS FOUNDATION TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON 1 JUNE 2021 AT 10:00 IN THE BOARD ROOM AND MICROSOFT TEAMS

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT
PATIENT STORY				
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 4 May 2021	Approval	Chair	ENC 2
5.	Matters Arising / action log	Review	Chair	ENC 3
6.	Chairman's report	Information	Chair	ENC 4
7.	Chief Executive's Report	Information	Chief Executive	ENC 5
QUALITY AND SAFETY				
8.	Safe Staffing Report	Information	Chief Nurse	ENC 6
9.	Research & Development update	Information	Director of R&D	ENC 7
10.	Infection Prevention & Control Report	Information	Chief Nurse	ENC 8
FINANCE AND PERFORMANCE				
11.	Finance Report Month	Information	Chief Finance Officer	ENC 9
12	Integrated Performance Report	Discussion	Chief Operating Officer	ENC 10

	ITEM	PURPOSE	LEAD	FORMAT
GOVERNANCE AND ASSURANCE				
13.	Provider Licence self assessment	Approval	Head of Governance & Co Secretary	ENC 11
14.	Board Assurance Framework	Discussion	Head of Governance & Co Secretary	ENC 12
15.	Committee Reports	Information	Chairs	ENC 13
16.	**DATE OF NEXT MEETING** The next meeting of Board of Directors will take place on Tuesday 6 July 2021			
17.	**Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960)**			

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 June 2021			
Register of members interests			**AGENDA ITEM: 3** **ENC 1**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Neil Mundy 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)	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
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.
David Heslop	Non-executive Director			No interests declared
Mike Ducker	Non-executive Director	1 December 2017 1 December 2005 1 October 2019	ongoing ongoing ongoing	Advisor to UK Government on Chemicals Industry Trustee of Greenstones Christian Trust Charity – a Charity working with prisons in Ethiopia South Tees Healthcare Management Limited - Company number 10166808
Debbie Reape	Non-executive Director 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	Director – Applied Interim Management Solutions – Company Number 08473345 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)
Ros Fallon	Interim Director of Planning & Recovery			Non-Executive Director for Countess of Chester NHS Foundation Trust Trustee – Tarporley War Memorial Hospital
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. 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
Neil Mundy	Interim joint Chair	2 February 2021		Director and Trustee Northumberland Theatre Company Director of N Mundy Ltd (Charitable Trusteeships) - Company number 11136507 Member of the North East Working Group for Medilink North Ltd Board Member of Medilink North of England Ltd - Healthcare and Life sciences technology membership organisation For completeness - Chair of the Joint Independent Audit Committee for the Police and Crime Commissioner and Chief Constable of Northumbria Police. Son Philip Mundy and Daughter in Law Dr. Lydia Mundy are Founders and major shareholder in Pando Ltd a Clinical Communications Platform company conducting business with the NHS .
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

South Tees Hospitals NHS
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 4 MAY 2021 AT 10:00 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
Ms A Burns	Vice Chair / Non-Executive Director
Mr R Carter-Ferris	Non-Executive Director
Mr M Ducker	Non-Executive Director
Mr D Redpath	Associate Non-Executive Director
Ms M Harris	Non-Executive Director
Mr D Jennings	Non-Executive Director
Dr M Stewart	Chief Medical Officer
Dr H Lloyd	Chief Nurse
Mr C Hand	Chief Finance Officer
Mr R Harrison	Managing Director

In Attendance

Mrs J White	Head of Governance & Company Secretary
Mr K Oxley	Director of Estates, Facilities and Capital Planning
Mrs R Metcalf	Director of HR
Mr S Peate	Chief Operating Officer
Mrs R Fallon	Interim Director of Planning & Recovery
Mrs M Angel	Interim Director of Clinical Development
Mr M Graham	Director of Communications

Members of the public

Action

BoD/20/235 **WELCOME AND INTRODUCTIONS**

The Chairman welcomed members to the meeting which was held in the Board Room and virtually.

The Chairman gave a special welcome to Governors from North Tees and Hartlepool NHS Trust, members of the Public and members of the press.

He added that he wished to provide his condolences to the family and friends of the patient who sadly passed away who was due to provide a patient story at the Board today.

BoD/20/236 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Mr D Heslop Non-Executive Director and Ms S Page, Chief Executive.

BoD/20/237 **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/20/238 **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/20/239 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on Tuesday 6 April 2021 were reviewed and agreed as an accurate record. Mrs White

BoD/20/240 **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

BoD/20/241 **CHAIRMAN'S REPORT**

The Chairman reported that a great deal has happened since the Board last met. He started by expressing profound thanks and admiration to Sue Page, the Directors and all of the staff of the Trust for what they have achieved in the most difficult of circumstances.

The Chairman added his heartfelt support to India and those communities and courageous Healthcare staff. He expressed his strong support colleagues who may have relatives who are affected by this crisis.

The Chairman commented that the UK has seen a steady reduction in the case numbers of COVID 19, with the further rapid roll out of vaccines here and throughout the country. He offered grateful thanks to staff in the NHS, partners within local authorities and third sector for all they have done over the past year to make this possible.

On the governance front, the Chairman was pleased to report that the Trust received encouraging news last week that NHS Improvement had updated the Trust's provider license giving the Trust greater autonomy through the removal of an additional condition which had been in place for some time. This reflects the clear progress the Trust and its staff are making in recovery and improvement.

Referring to today's Board of Directors meeting the Chairman directed the Board of Directors to focus on Agenda item 9 which sets out the process CQC will follow and the steps the Trust is taking to assess progress and to prepare for that inspection, Agenda Item 10 on the Finance update and the need to look beyond that short term position and develop a 3-5 year medium term improvement and recovery plan to accommodate the 2 year strategic aims, the Trust's to PFI financial requirements to resolve the structural deficit and

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performance.

The Chairman updated members that he had attended the first meeting of the Joint Strategy Board which was held on the 8th April which enabled both Trusts with the support of their respective Boards to put in place terms of reference and memorandum of understanding and to start to set the Agenda for future collaborative working. The next meeting is on 18 May Dr Mike Bramble ICS Medical Director and David Gallagher from Tees Valley CCG will join us.

Members noted that in May, the Trusts will appoint jointly a Director of Strategy and Partnerships to work to the Joint Strategy Board to strengthen partnership working between the two Trusts and with other partners within the Integrated Care System. The recruitment and appointment process for of the substantive Joint Chair is now underway and was launched on 30th April with the closing date of 24th May. The aim is to invite applications during May and hold selection events on the 29th and 30th June in order to make an appointment of a substantive Joint Chair for the two Trusts by July.

The Chairman reflected on his visits to staff areas during April including Pathology and Radiology and the Durham and Tees Valley Research Alliance, and with the Chief Executive attending the Star Awards for outstanding compassionate care. He attended a Staff side meeting to provide an update and answered questions on progressing his Joint role.

With regard to external meetings, the Chairman reported that he had met with the Chair of Tees Valley CCG and discussed future developments within the ICP and ICS, and also the Healthwatch Project Lead for South Tees to listen to her views and experience on behalf of patients and how Healthwatch wishes to continue to engage with the Trust.

Resolution

The Board of Directors NOTED the Chairman's report.

BoD/20/242 **CHIEF EXECUTIVE'S REPORT**

Mr Harrison referred members to the CEO report and added that at the last Board meeting Ms Page outlined the position with regard to COVID patients which at the time were around 30 inpatients and now Mr Harrison advised the Trust have round 12 patients which continues to fall.

Mr Harrison advised members that the Trust have been focussing on recovery and the teams are working hard to work through the opportunities to recover and focus on patients who have been waiting for planned care. He added

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that he was pleased to report that the Trust will have hit the trajectories of 70% recovery in April and the remaining of the year looks like we should continue along these lines.

Mr Harrison took the opportunity to thank Mr Hand and his team for the work they have been undertaken. He commented that it has been a complex financial year end, and thanks to Mr Hand and his team we have brought it to a conclusion.

Mr Harrison commented that the Board of Directors will be receiving the 2 year strategic plan later on the agenda and in July the operational plan will be received. In relation to the Digital enabling plan Mr Harrison confirmed that the closing date for Digital Director post was today and reminded members of this critical area of focus for the Trust and that the post will be critical in supporting the leadership of IM&T and wider Digital agenda going forward.

Mr Jennings asked Mr Harrison if the Trust is preparing for a potential 3rd wave. Mr Harrison advised that the Trust is maintaining the critical infrastructure so that if there is any future waves it is prepared to cope with them. In addition the Trust continues to learn from previous waves and has adjusted plans accordingly and our response has been adapted to manage this. In particular we are looking at the robustness of critical care and looking at ancillary care support such as PPE, testing and the ability to vaccinate staff if booster vaccines are required.

Resolution

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

BoD/20/243 **SAFE STAFFING REPORT**

Dr Lloyd referred members to the safe staffing report and highlighted that the percentage of shifts filled against the planned staffing across the trust is 96.6%, demonstrating good compliance with safer staffing.

The demand for critical care beds remain high with surge areas still open and staff from other areas supporting. There have been no reported episodes for lack of supernumerary co-ordinators during March 2021.

Nursing and Midwifery Turnover for March is currently 7.29% with the vacancy rate at 2.1% (61 whole time equivalents) excluding the international nurses yet to arrive. The HCA rapid recruitment has been successful with 246 HCA's recruited since the beginning of November against a target of 150.

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Red flags are dealt with promptly when reported with good systems in place for managing day to day staffing issues as they arrive.

Ms Reape commented that the report was really positive and the recruitment of qualified nurses and HCA is excellent. Ms Reape asked if there are any issues with regard to quality and safety in regard to the closed beds. Dr Lloyd advised that the beds were closed due to social distancing and covid issues not in relation to staffing. She added that the Trust are looking at the bed reconfiguration to ensure we have the right number of beds open at the right time.

Mr Jennings also commented that the report was really helpful and the section on triangulation on incidents was insightful. Referring to the table in relation to fill rate he referred members to the downward trend and asked Dr Lloyd if this was a cause for concern. Dr Lloyd confirmed that it wasn't, the change reflected a small number of shifts each day and Dr Lloyd advised she thought it related to annual leave and down time.

The Chairman referred also to the staffing levels and incidents of harm section and asked if there was any correlation with the ward configuration from an environmental perspective and the levels of falls and other aspects of harm. Dr Lloyd confirmed that where there have been incidents of harm it has not been due to staffing levels. She added that the Trust do have some wards which will have higher levels of falls such as rehab areas as the opportunity for falls increase and it's about the acuity and dependency of patients.

The Chairman asked if the Trust was applying the best falls prevention nursing principles to minimise harm to patients. Dr Lloyd confirmed that it was and sharing this information collaboratively across the system. Ms Reape added that both falls and pressures ulcers are discussed routinely at the Quality Assurance Committee (QAC) and that both the CCG Chief Nurses sit on this Committee and they commented that the approach the Trust is taking is the right approach and they were really pleased that the Trust is taking the initiative and encouraged the Trust to share this across the system for others to learn.

Resolution

The Trust Board of Directors NOTED the safer staffing report

BoD/20/244 **CQC UPDATE**

Dr Lloyd referred members to her previously circulated report which set out that the Trust has prepared a high level plan which sets out a process for undertaking a self-assessment

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and assurance processes for a core services inspection of acute and community services, a well led assessment and a use of resources assessment.

Members noted that governance processes for overseeing these assessments including check and challenge and peer review has been set out in the report and include the Quality Assurance Committee and sub groups overseeing and monitor the process with appropriate updates to the Board.

Mrs Angel added that the plan is robust and the Trust now needs to look forward; this is about starting now with some of the actions we have identified through to when we get the inspection. There is about 12 weeks lead in time once inspection is notified. It's about a conversation with our staff around continuing to improve standards.

The Chairman thanked Dr Lloyd for her report and commented that it is a really positive opportunity to have these conversations with our staff.

Ms Burns also thanked Dr Lloyd for setting out a really helpful report. She added that it would be helpful for the Board to have feedback on the self-assessments undertaken and important to include the Council of Governors in terms of the engagement plan as they have felt previously blindsided. Ms Burns asked Dr Lloyd to consider how we will engaging wider partnerships and how we engaging as NEDs with services and how best we do this.

Mr Jennings echoed Ms Burns comments on sharing the self-assessment with Board members and developing a plan for use of resources with the Resource Committee. Mr Jennings added that the self assessment should contain the issues that were raised previously by the CQC to ensure they have closed off.

Resolution

The Trust Board of Directors NOTED the update on CQC

BoD/20/245 **FINANCE REPORT MONTH 12**

Mr Hand presented the month 12 finance report and highlighted that the Trust is reporting a defect of £11.6m at a system control total level. This is £6.4m higher than the financial plan due primarily to the PFI Lifecycle, but in-line with the year-end forecast position agreed with the ICS.

Mr Jennings asked Mr Hand to confirm the plan for the use of resources and the cost impact. Mr Hand advised that it has been a complex year and the Trust needs to establish the run rate and medium term strategy. In terms of use of resources

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the Trust needs to do a piece of work on efficiencies using information such as model hospital and use this across all areas of the Trust.

The Chairman referred to the overspends reported in the finance report on pay and non-pay and asked to what extent they are attributable to covid or other issues such as the effectiveness of budgetary control. Mr Hand advised that due to the complexities with covid adjustments the figures are distorted. He added that there is a piece of work being undertaken to understand the cause of the issues.

The Chairman advised that it is important to re-base the budgets for any medium-term plan but also to recognise that if the budget control systems are strong enough. The Chairman asked Mr Hand if he felt this was something that could be achieved in the next few months. Mr Hand discussed that this piece of work is already underway to allow the Collaboratives to understand the budgets they have which are challenging but deliverable.

The Chairman commented that it is important for delivering the 2 year strategic plan which Mr Harrison will discuss later on the agenda, and because of the structural deficit of the Trust that we have this in place an understanding of budgets and what would be our resource requirements going forward. The Board need to understand the timescales and road map on how this will be taken forward.

Mr Harrison agreed and confirmed that the Trust is undertaking a piece of work to understand what is required recurrently following COVID and what H2 will look like including contract negotiations, capital round and preparing for financial plan.

The Chairman reported that the NENC Provider Collaborative has declared that one of its priorities is on getting capital investment in a more structured way to ensure hospitals and services have the right equipment and environment to deliver the right care to patients. He added that this is a huge opportunity for the Trust to get our position clear and working with our colleagues in the Tees Valley we need to share this understanding.

Mr Hand confirmed that the ICS have agreed the Trust settlement; the discussions in the various ICS groups are well advanced on the rules of the allocation basis going forward. Separately to this we as a Trust need to make sure we engage with the ICS at the right time on emergency capital to be ready to address any capital priorities as and when any slippage becomes apparent. Mr Oxley and the team are looking at this to identify opportunities.

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Mr Oxley added that the Directors of Estates have been asked by the Provider Collaborative to map out 5 year aspirations and have been asked to develop criteria on how we will priorities these. Mr Oxley confirmed that a report will go to the Provider Collaborative in June which sets out this approach and how the ICS would do this.

The Chairman advised that the Joint Strategic Board should consider the deployment of investment in the Tees Valley later in the year and it is important we share this with colleagues in North Tees & Hartlepool NHS and not go this alone.

Mr Harrison commented that it is critical for the Joint Strategic Board that there is clarity around the clinical strategy so this underpins and provides the framework for finance and capital. He added that we need to work with colleagues in Tees Valley to ensure that this strategy is fit for purpose and gives us the principles on resource allocation and this is important that we submit the right application for the right resource.

Mr Harrison advised that he and Dr Stewart have had meetings with North Tees & Hartlepool NHS Trust so we can clarify the underpinning plans.

Dr Stewart commented that it is important that a clinical strategy informs the estates plan and 5 year capital plan. The PFI burden is significant and we hope we will be able to address this within the Region but in this current year £22m was paid to revenue from the PFI pre-payment burden.

Resolution

The Trust Board of Directors NOTED the update on Finance

BoD/20/246 **INTEGRATED PERFORMANCE REPORT**

Mr Peate referred members to the Integrated Performance Report and highlighted that the Trust has continued its COVID-19 response during March alongside maintaining emergency and urgent care, this included significant levels of critical care bed occupancy and the delivery of urgent surgical treatment.

Areas of improved performance include:

- A reduction in cases of C Difficile compared to 2019/20.
- Complaints closed within target.
- Compliance with Friends and Family Maternity Experience rate.
- Cancer standards for 14 days and 31 days have provisionally achieved target in March.

Areas for focus include:

- An increase in the incidence of Category 2 Pressure Ulcers in March, linked to extended critical care LOS and COVID-19 admissions.
- ED performance has improved 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.
- Two further Never Events have been recorded in March.

The Chairman thanked Mrs Fallon for the work she has undertaken on the Integrated Performance Report since last September noting that each month the report gets better and clearer especially the narrative.

Mr Jennings echoed the Chairman's comments and thanked Mrs Fallon for all the work she is doing. He commented that in relation to the governance structure the integrated performance report had been considered at the Board Sub Committees over the last week and Mr Peate had touched on the planning which is underway in terms of attaining the constitutional targets, and advised that within the Resources Committee there had been a discussion with regard to the extent to which we have in place the recovery plan, timescales and for some of standards this may be 12-18 months and for others it may be shorter. Mr Jennings asked whether this plan was could be shared with the Board. Mrs Fallon commented that a full recovery and improvement plan will be shared with the Board in July.

Mr Peate added that there are a number of things being undertaken; we are starting to develop clear improvement plans against constitutional targets and an initial report will be discussed at the next Recourse Committee. In addition the implications of the pandemic and restrictions on theatre capacity and additional support into critical care have had an impact and this is also being looked at.

Ms Burns commented that she was encouraged that the data is being collected and developed for the recovery plan. She added that she was not clear on when the clock started and whether the Trust inherited a risk due to delays elsewhere in the system. Mr Peate advised that the process was very complicated but that in the main it starts at referral point from primary care into the organisation.

The Chairman commented on the falls performance which was broadly in line with national trends, he asked when the Trust was re-establishing the falls improvement work. Dr

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Lloyd confirmed that the work had already commenced.

The Chairman referred Dr Stewart to the section on never events and asked what learning was expected to come out of the engagement with NHSE/I. Dr Stewart advised that he expects that the learning will be around how we share the learning from reviews of never events into the organisation and completing the circle on actions to ensure these are embedded into practice.

The Chairman commented on sepsis and that it was helpful to see this included in the report. He asked how this is being taken forward within the Trust. Dr Stewart advised that Lindsey Garcia was the lead for the Trust but she had been involved in critical care during the pandemic and had just recently returned to her substantive role and plans to start working on the plan shortly. Ms Reape advised that Ms Garcia had attended the Quality Assurance Committee to present a plan which involved a large scale education programme and linked in with the roll out of MIYA.

The Chairman asked Dr Stewart if there was an update on SHIM. Dr Stewart advised that there is still a need to do a deep dive into areas of concern. CPG recently received a presentation on coding but we need to do some more work on coding of deaths.

Resolution

The Trust Board of Directors NOTED the update

BoD/20/247 **FREEDOM TO SPEAK UP ANNUAL REPORT**

Abbie Silivistris Freedom to Speak Up Guardian attended and presented the annual report. Members noted that significant progress has been made in the 6 months since the new model was launched with more staff than ever now speaking up through FTSU channels. It was reported that the Trust have seen a significant improvement within the 2020 Staff Survey results in regards to our safety culture and have also seen an improvement in our FTSU Index score.

Ms Burns congratulated the team on the report and amount of work and improvement the Trust are seeing on being able to speak up and its clear from her conversations that the Executive are supporting and engaging on developing this culture. Ms Burns added that the audit recommendations which were included in the report were helpful and confirmed that the report has been discussed at the People Committee.

Ms Burns also reported that she was pleased to see the engagement with staff networks in particular equality and diversity. Good progress and well done.

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Mr Jennings referred members to the section on protected time for the Guardians and asked if this was enough to do the role. Ms Silivistris reported that it was but that she was keeping this under review. She had undertaken a benchmarking exercise with other colleagues and the Trust was around the middle of the pack with regard to hours.

Mr Jennings also referred to the July 2020 FTSU Index which STHFT was ranked 224th out of 230 organisations and asked when this would be updated to reflect this years staff survey results. Ms Silivistris advised that this should happen around June. Ms Silivistris also added that the Trust are one of the most improved Trusts nationally as notified by the national guardians office.

The Chairman commented that it was a real delight to see the work and progress the Guardians are making and asked if there was anything more the Board could do. Ms Silivistris advised that there is good support and engagement from the Executive Team and if the Board could continue to be supportive of the role and model that would be fine.

Resolution

The Trust Board of Directors NOTED the update

BoD/20/248 **GUARDIAN OF SAFE WORKING QUARTER 4 REPORT**

Dr Stewart presented the Guardian of Safe Working on behalf of the Guardian and advised that the report sets out the work which has been undertaken by the medial workforce and postgraduate teams and clinicians within departments to manage the additional work involved in the implementation of the 2016 contract.

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

Ms Reape asked Dr Stewart what the view of his colleagues were on how attractive it is to work in South Tees. Dr Stewart referred Ms Reape and colleagues to the GMC report on medical trainees experience and highlighted that the Trust is a top training placement for a number of specialities; individual specialities do go up and down and we need to look at this but generally this is seen as a popular Trust with high quality training offered.

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Resolution

The Trust Board of Directors NOTED the update

BoD/20/249 **2 YEAR STRATEGIC PLAN**

Mr Harrison referred members to the previously circulated 2 year strategic plan which set out the next-steps regarding the development of underpinning enabling strategies and plans. Board members have previously approved the development and composition of the Trust's two-year strategic plan and the following components have been introduced across the Trust:

- Mission
- Vision
- Values and behaviours
- Strategic intent
- Strategic objectives

A programme of enabling strategies and plans is set out in the two-year strategy which will be developed and submitted to future meetings of the Board for approval. Members were reminded that the two-year strategic plan has been developed through engagement with members of the Board, the Trust's Clinical Policy Group (CPG), patient and service user feedback, stakeholders and staff. In doing so, it supports the Trust's clinically-led improvement journey and overarching improvement plan.

Ms Reape thanked Mr Harrison for the report and congratulated colleagues for putting the plan together. She added that it has been an engaging process right from the values and behaviours and latterly with the Collaboratives – it feels like a really good document. Ms Burns concurred with Ms Reapes comments.

Mr Jennings welcomed the report and in particularly the work on culture and behaviours. However expressed that it is important that with this being a 2 year plan on getting back to our best we continue to develop a longer term vision and view and the plan doesn't stand alone. In addition Mr Jennings commented that the Mission and Vision are long statements and he will not be able to remember them and suggested the longer term plan needs to include statements which differentiate the ambition and mission.

The Chairman added that we need to focus on the tertiary services and other elements of getting back to our best and this will play through into a number of areas such as capital and finances etc. Mr Harrison confirmed that these are happening in parallel with each other and there is a reality to timescales that this is happening.

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Resolution

The Trust Board of Directors APPROVED the 2 year strategic plan

BoD/20/250 **ANNUAL FILINGS UPDATE**

Mrs White provided an update to the Board of Directors on the annual filings. She advised that guidance has been received on production of these documents and a programme management approach has been established to oversee this work which has been overseen by the Audit & Risk Committee.

In light of pressures caused by the public sector response to COVID-19, some annual report requirements were changed for 2019/20. These revisions were made in April 2020, mirroring changes made to The Government Financial Reporting Manual by HM Treasury. In December 2020 HM Treasury confirmed that these relaxations will continue to be available in 2020/21 reports. A summary of these changes are included in the report.

Mrs White added that there continues to be no issues or risks highlighted with the production of the annual filings, taking into account the revised timetable for submission and asked for the Board of Directors approval to delegate monitoring and approval of the Annual filings to the Audit & Risk Committee with support from the Quality Assurance Committee and Remuneration Committees as appropriate.

Mr Carter Ferris commented that if any issues get highlighted through the audit process, Mrs White will seek to set up an Extra Ordinary Board.

Resolution

The Trust Board of Directors NOTED the update and APPROVED delegated authority to the Audit & Risk Committee for approval of the Annual Report and Accounts on behalf of the Board of Directors

BoD/20/251 **USE OF THE SEAL**

Mrs White shared for information a report on the documents affixed under seal between 1 November 2020 and 31 March 2021, advising that there were no underlying issues for discussion regarding this report.

Resolution

The Trust Board of Directors NOTED the report

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BoD/20/252 **BOARD ASSURANCE FRAMEWORK**

Mrs White referred members to her previously circulated report and updated that the Board have previously approved the development and composition of the Trust's two-year strategic plan and the next stage in the process is to identify and understand the principal risks to achieving the strategic objectives.

The report sets out an update on identifying the principal risks to achieving the strategic objectives as set out in the two year strategic plan which will form the Board Assurance Framework (BAF).

The Chairman thanked Mrs White for updating on progress and confirmed that it was important that everyone has ownership of that report and the BAF risks.

Resolution

The Trust Board of Directors NOTED the update

BoD/20/253 **COMMITTEE REPORTS**

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

Resources Committee – Mr Ducker highlighted that the Committee had discussed key issues around the capital plan, IPR and digital investment plan that is underway within the Trust and recognised a number of implementation risks with the plan which the Board need to remain sighted on. There is more work being done within SLT that the priorities are appropriate and to which the correct resources have been allocated.

People – Ms Burns confirmed that there had been a good first People Committee meeting. Further assurance had been received around the effective arrangements on fire safety which had come up at the previous meeting,

QAC – Ms Reape highlighted that pressure ulcers are a quality priority for the Trust for the coming year. The Chief Nurses from the CCGs are fully on board and we are monitoring the plan in terms of delivery. The Committee discussed that staff had been under pressure over the last 12 months but received a presentation on mortality for critical care showing good outcomes. Discussion on lost to follow up incidents concluded that there is more work to do and we are keeping an eye on this.

Audit Committee – Mr Cater Ferris highlighted that the Trust has applied for and been given an extension of audit deadline which is unlikely to be needed but available if required.

DRAFT

BoD/20/254 **QUESTIONS FROM THE PUBLIC**

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

Mr Graham reminded members that the Board were briefed in April on the Safety Promise which staff were embarking on. He advised that the patient safety team will be producing the outputs of this in the coming weeks and the opportunity for the Board to make a promise back to colleagues. The Board welcomed this opportunity and agreed the following:

'We promise to support our colleagues to always put safety and quality first, and to foster the South Tees Way: Respectful, Supportive, Caring.'

BoD/20/255 **DATE AND TIME OF NEXT MEETING**

Mr Mundy confirmed that the date of the next meeting is 1June 2021.

DRAFT

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. On track to be completed	open
06.04.21	BoD/20/231	BOARD ASSURANCE FRAMEWORK (BAF)	Mrs White to ensure the role of the Committee in terms of the BAF is included in their terms of reference to clarify the way in which the Committees drill down into risk and what they look for in terms of risk and how this is covered in the chairs log.	J White	Jun-21	the role of the Committees in terms of the BAF is included in the standard operating procedure which is on track to be complete in June 2021	open

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 1 June 2021			
Interim Joint Chairman update			**AGENDA ITEM: 4, ENC4**
Report Author and Job Title:	Neil Mundy Interim Joint Chairman	**Responsible Director:**	Neil Mundy Interim Joint Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Interim Joint Chairman update		
Background	The following report provides an update from the Interim Joint Chairman.		
Assessment	The report provides an overview of the health and wider related issues.		
Recommendation	Members of the Trust Board are asked to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒	
	Drive operational performance ☒	Long term financial sustainability ☒	
	Develop clinical and commercial strategies ☒		

Interim Joint Chairman update

Introduction

In introducing my report on behalf of my Non Executive colleagues and myself I offer our grateful thanks to Sue Page and the Teams within the Trust for their remarkable efforts on behalf of our patients in the recovery stage from the Pandemic. During May we have seen a continued reduction in cases, but we are mindful of the risks linked to COVID-19 variants which are affecting some areas so seriously.

Working with our partners within an Integrated Care System

You will hear in the reports later in the meeting the progress being made to return to the levels of services pre Covid 19 and how waiting lists are being reduced which is the priority of our Trust and other Trusts in the Region. It is imperative that we reduce the number of patients waiting more than 52 weeks as soon as possible The Integrated Care System (ICS) in North East and North Cumbria is working collectively with the support of additional funding to address those pressures.

We have worked with our partners in the Tees Valley and North Yorkshire to make as compelling a case as possible case for a basis of future funding to be administered by the ICS, that better takes account of the needs of our area and the health inequalities that are present within our population.

This situation has been accentuated by COVID 19 and there are clear signs that this priority for resources is being recognised and the Trust and its partners are actively working together to secure a satisfactory outcome.

It is necessary to put in place a recovery and improvement plan to support the case and resources but also the requirement of our license. The Trust is now preparing a medium term plan to be submitted to NHS England / Improvement (NHSE/I) by 31st August. The Trust will be working with NHSE/I and the ICS to put this in place.

Developing our partnership and joint working

A second joint Board-to-Board Meeting was held on 10th May to enable the members from both Trusts to join together to discuss areas of current collaboration and mutual priority.

The Team from the Durham and Tees Valley Research Alliance, which undertakes outstanding joint research projects and clinical testing, presented to the meeting. The Alliance Team has been prominent during the Pandemic in supporting the national programme to tackle COVID 19.

We also received a powerful presentation on Health Inequalities from Public Health Consultants on the priorities for addressing health inequalities and the importance of working together with our Local Authority, Voluntary Sector and other partners urgently support our communities .

Recruitment of the Joint Chair

Regarding the recruitment and appointment of the substantive Joint Chair for North Tees and Hartlepool and South Tees Hospital NHS Foundation Trusts the process is now well underway.

The closing date for applications was the 24th May. The Nominations Committees of both Trusts are working closely together to take this forward. The Governors have appointed independent recruitment consultants to support the process and the coproduction of the recruitment pack.

Shortlisting and stakeholder engagement will be carried out on 9th June with stakeholder events and final the interviews at the end of June with the aim of appointing a substantive Joint Chair by July.

Visiting and thanking staff

This month I have had the opportunity to visit a number of Departments in the Trust including Maternity, Paediatrics, Neonatal, Cardiology, Volunteers, Renal, Endeavor, Oncology, Radiology Surgical Wards and our Bereavement Team all of whom have achieved so much during the pandemic. It was a great privilege to meet those dedicated staff and to thank them on behalf of us all.

Staff meetings

I was delighted to join the staff representatives at a meeting on 4th May. We discuss our joint working with our partners in North Tees and Hartlepool NHS Foundation Trust and within the ICP and ICS as well as answering questions on the recruitment process for the substantive Joint Chair.

Council of Governors Meeting

The Council of Governors met on the 11th May with a busy agenda covering the various aspects of the Trust's performance both clinical and financial performance. It was a very constructive meeting at which Governors participated strongly and I was delighted that we were joined by a number of Governors from North Tees and Hartlepool NHS Foundation Trust.

Board Development

The North East and Yorkshire Leadership Academy has agreed to provide consultancy support and facilitation for the Trust and our partners to develop our approach to closer collaboration within the Integrated Care System.

Next month

I am looking forward to supporting our Governors in the next stage of recruitment and appointment of the substantive Joint Chair and the further developing partnership and collaborative relationships.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 1 June 2021			
Chief Executive update			**AGENDA ITEM: 7, ENC 5**
Report Author and Job Title:	Mark Graham, Director of Communications	**Responsible Director:**	Chief Executive
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Chief Executive update		
Background	The following report provides an update from the Chief Executive.		
Assessment	The report provides an overview of the health and wider related issues.		
Recommendation	Members of the Trust Board are asked to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒	
	Drive operational performance ☒	Long term financial sustainability ☒	
	Develop clinical and commercial strategies ☒		

Chief Executive Update

COVID-19 vaccination programme update

Since becoming some of the the world's first COVID vaccination hubs in December (2020) the hubs at James Cook University Hospital and the Friarage Hospital have delivered more than 70,000 jabs.

As the national programme has progressed with the majority of vaccines now being delivered to priority groups through primary care and mass vaccination centres, the hubs at James Cook and the Friarage have now been stood-down.

Over the coming weeks and months, the Trust's vaccination team will be working on a smaller scale to support the national vaccination programme through the opportunistic delivery of the Oxford/AstraZeneca vaccine to priority groups on a peripatetic basis.

COVID update

The Trust has continued to see stable COVID inpatient numbers and the experienced clinicians who continue to guide our response to the pandemic have no plans at this time to move away from our current pathways, which were introduced on 19 April.

Our specialist clinicians will continue to monitor community infection rates, inpatient numbers, new variants of concern and other factors as they continue to guide our response to the pandemic.

International Day of the Midwife, International Nurses Day and National ODP Day

On 5 May, colleagues celebrated International Day of the Midwife and on 12 May our nursing colleagues showcased what it means to be a nurse and how they have led patient care during the pandemic for International Nurses Day.

Friday 14 May was National ODP (operating department practitioners) Day and a chance to reflect and say an enormous thank you for the unfailing support which ODP colleagues have provided to our critical care team during the pandemic alongside their role as essential members of our theatre teams.

Nursing Strategy

In May, our Chief Nurse published the Trust's new model of professional practice which is consistent with the Nursing & Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) Code, the Care Quality Commission (CQC) key lines of enquiry, and quality priorities.

The model comprises:

- Professional excellence

- Collective leadership
- Investing in our people

Key focus is on accreditation of our quality of care, compassionate culture, transformational leadership, research and innovation, exemplary professional practice and clinical education.

Wards and departments are undergoing their STAQC (South Tees Accreditation for Quality of Care) assessments. Wards and departments are assessed against multiple standards grouped under the four core competencies:

- Culture of compassionate care
- Well led
- Avoidable harm
- Effective care

Once wards and departments have had their accreditation visit they are awarded one of the following accreditation levels:

- Diamond – meets all of the standards all of the time (outstanding)
- Gold– meets most of the standards the majority of the time (good)
- In development – meets some of the standards with variable compliance

Congratulations to ward 32 at James Cook University Hospital and the Redcar Urgent Treatment Centre who were awarded Diamond accreditation, during May.

Digital programme

Experienced clinicians and information technology (IT) colleagues are working to introduce a new range of smart technologies to support patient care and make work simpler.

As well as electronic prescribing, which is due to go live before the end of 2021, teams are introducing MIYA - a single platform which will enable clinical colleagues to access critical patient clinical data from one place.

Separate projects will run over the next 18 months. The first of these projects will replace VitalPAC with a new system for E-Observations called Patientrack which is expected to become operational this summer. Smartpage - a web-based secure messaging system for hospital communication and task management - is also planned to go live this summer.

The introduction of these new systems is being supported by a programme to replace aging equipment including more than 3,600 new PCs, 800 laptops and2,250 monitors and keyboards.

Board Assurance Framework

Work has continued through May to refine the principal risks and threats to delivery of the strategic objectives. A new Board Assurance Framework (BAF) format been developed which meets the national requirements for BAFs setting out the risk rating, three lines of assurance and provides the opportunity for the Board Sub Committees and the Board to rate the level of assurance. A report on progress is being shared with the Board today and will be considered at the People Committee and Resources Committee.

Clinical Strategy and Improvement Group

As we continue to move through the COVID-19 recovery phase, the Trust has stood down its strategic command structure and set up a number of groups. The Clinical Strategy and Improvement Group will focus on providing strategic oversight for the delivery of the Trust's Improvement Plan; the Recovery Programme and oversight of the following work programmes:

- Clinical Strategy
- Safety and Quality Strategy
- Nursing and midwifery strategy
- Estates Plan
- Digital Plan
- People plan
- Financial strategy
- Research and innovation strategy
- Communication and engagement strategy

Local and regional partnerships

The Boards of North Tees & Hartlepool NHS Trust and South Tees Hospitals NHS Trust met on 10 May for their second joint meeting and received two very good presentations; one from the Tees Valley Research Network and one on health inequalities in the Tees Valley.

I also attended the second meeting of the Joint Strategic Board which was held on 18 May 2021 with the Vice Chair and Chief Medical Officer.

I met on 19 May with Col Timothy Steele who has taken over on an interim basis from Lt Col Fran Daive as Commanding Officer, JHG(N). I am very grateful for everything the military have done with us during the pandemic – it is such a privilege to have them with us side by side. We discussed our ongoing joint working and the recent changes at the Trust with regard to Medical Leadership, CPG and Nurse Leadership.

Visibility

I am very lucky to be able to spend time with colleagues throughout the Trust and this month have visited Diabetes, Theatres and Pathology. I am continuing my 3rd round of 1:1 CD meetings and spending some time with our newly appointed CDs. I have also participated in the recruitment panels for consultants for restorative dentistry and radiology.

Clinical Policy Group constitution

Since the autumn of 2019 we've been empowering our clinicians to take the decisions about how we manage our resources and deliver care across our hospitals and services – supported by our amazing scientific teams, administrative, support staff and volunteers.

We have done this through our Clinical Policy Group (CPG) which draws its membership from our clinical directors, chief medical officer and executive team and joined by our nursing and allied health professional leaders, chairs of staff-side, our senior medical staff forum, and our BMA representative.

This clinically-led approach has been at the heart of the way we have responded to COVID-19 together and the overriding priority set by our clinicians to help keep patients, service users and one another safe. In May the Clinical Policy Group agreed to adopt a constitution – a set of principles and goals that guide how it works to support colleagues to always put safety and quality first.

Improvement work

Work is progressing on developing the *Leadership and Safety Academy* which will support key areas and teams across the organisation requiring support and development.

The team recently received a presentation from ECIS who have been undertaking work in the Trust looking at patient flow through ED and out into the community. The outputs of this work are being shared with the teams involved and built into the recovery improvement plan which Board will receive at the July 2021 meeting.

2. RECOMMENDATIONS

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

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 JUNE 2021			
Safe Staffing Report for April 2021 – Nursing, Midwifery and Allied Health Professionals (AHP)			**AGENDA ITEM: 8** **ENC 6**
Report Author and Job Title:	Eileen Aylott, Assistant Director of Nursing Education and Workforce	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report details nursing, midwifery staffing levels for April 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 staffing across the trust is 97.7%, demonstrating good compliance with safer staffing. Critical care is beginning to retract into their pre COVID footprint with staff from other areas still supporting activity. There have been no reported episodes for lack of supernumerary co-ordinators during April 2021. Staffing during April has effectively supported the acuity and dependency of patients. Nursing Turnover for April is currently 7.7% and the vacancy rate is 1% (20.96 whole time equivalents) against the financial ledger. Monthly International RN recruitment continued however, three nurses due to arrive from India have been delayed due to the country being added to the 'Red travel list' HCA rapid recruitment targets were achieved and redeployment of temporary COVID staff has begun starting with ED with Critical Care requirements currently being reviewed. Student nurses who entered the workforce as HCAs during the last surge have now returned to supernumerary placements. Interviews are planned for May for student nurse who qualify in September		
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	BAF risk 5.1 Demographic changes, shifting cultural attitudes to careers, capacity and capability of staff combined with employment market factors resulting in critical workforce gaps in some clinical and non clinical services		

outline		
Legal and Equality and Diversity implications	• Care Quality Commission • NHS Improvement • NHS England	
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒
	Drive operational performance ☐	Long term financial sustainability ☐
	Develop clinical and commercial strategies ☐	

Nursing and Midwifery Workforce Exception Report
April 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 three times weekly 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.

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

Redeployment of staff has taken place on a regular basis with:

272 shifts/2886.88 hours logged via SafeCare showing staff transferring to ITU roster to support the COVID response.

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

COVID vaccination programme has scaled following over 70,000 doses administered through the James Cook and Friarage Hospital Hubs since December 2020.

Table 1 – Overall UNIFY fill Rate based on planned vs worked hours for April 2021

		January 2021	February 2021	March 2021	April 2021
Overall Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	95.1%	93.6%	90.7%	90.8%
	HCA (%) Average fill rate - DAYS	96.4%	94.2%	90.3%	94.8%
	NA (%) Average fill rate - DAYS	100%	100%	100%	100%
	TNA (%) Average fill rate - DAYS	100%	100%	100%	100%
	RN/RMs (%) Average fill rate - NIGHTS	98.7%	95.5%	90.2%	91.8%
	HCA (%) Average fill rate - NIGHTS	109.3%	104.6%	102.0%	104.7%
	NA (%) Average fill rate - NIGHTS	100%	100%	100%	100%
	TNA (%) Average fill rate - NIGHTS	100%	100%	100%	100%
	Total % of Overall planned hours	**99.9%**	**98.7%**	96.6%	**97.7%**

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

Nursing and Midwifery Planned Vs Actual hours % and Care Hours Per Patient Day

Wards	Physical Bed Capacity	Open Bed Capacity	Occupied Bed No April 2021	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 2 AAU (Short Stay Staff)	28	28	25		94.3%	87.6%	100.0%	-	80.8%	100.5%	100.0%	-	
Ward 3	28	27	10		83.9%	91.4%	-	100.0%	80.2%	78.3%	-	100.0%	
JC04	21	21	19		104.2%	96.0%	-	-	80.9%	107.0%	-	-	
Ward 5	28	22	11		87.9%	54.5%	-	100.0%	70.0%	51.1%	-	100.0%	Bed occupancy reduced by 11 beds in April. Planned 3 RN on nights and working 2 (1:6)
JC06 Gastro	30	30	27		97.5%	154.3%	-	-	73.4%	169.2%	-	-	Bed occupancy reduced by 3 beds in April Planned 3 RN working 2 (1:14) with additional HCA support.(4)
Ward 7 Colo	30	30	26		113.4%	90.2%	100.0%	100.0%	100.0%	98.9%	-	-	
Ward 8	30	30	19		82.4%	92.2%	-	100.0%	94.6%	82.5%	-	100.0%	
JC09	28	28	22		96.5%	78.6%	-	100.0%	88.0%	104.7%	-	-	
Ward 10 (Short Stay RAFAU Staff)	27	27	22		104.5%	100.2%	-	-	94.4%	109.5%	-	-	
OPM (Ward 11)	28	28	25		124.3%	148.5%	-	-	104.5%	143.6%	-	-	
Ward 12	26	20	16		111.3%	125.8%	-	100.0%	106.9%	159.1%	-	-	
JC14 Oncology Staff	23	21	17		94.2%	91.1%	-	100.0%	83.3%	123.4%	-	100.0%	
JC24	23	23	18		98.3%	104.4%	100.0%	100.0%	98.9%	119.4%	100.0%	-	
Ward 25	21	21	6		71.3%	70.1%	-	100.0%	96.3%	63.1%	-	-	Opened on 5th April Bed occupancy reduced by 15 beds in April Planned 3 RN working 2 (1:3)
JC26	18	18	16		99.6%	134.6%	-	-	98.7%	116.8%	-	-	
JC27 Neuro Staff	15	15	14		142.9%	204.8%	-	-	100.3%	149.4%	-	-	Day case unit staffed at 2 RN and 1 HCA 8am – 6pm on top of ward establishment of 3 RN and 3 HCA

JC28	30	30	21		99.3%	89.2%	-	-	99.2%	79.8%	-	-	
JC29	27	27	25		98.5%	88.4%	100.0%	100.0%	96.6%	100.0%	100.0%	-	
Cardio MB	9	9	7		100.0%	107.6%	-	-	100.0%	-	100.0%	-	
JC31 Vas	35	26	20		86.7%	112.0%	100.0%	-	88.9%	122.4%	100.0%	-	
JCCT (Ward 32)	22	21	19		114.1%	93.1%	-	-	100.0%	103.2%	-	-	
JC33 Specialty	19	19	16		86.0%	115.5%	-	-	87.3%	70.1%	-	-	
JC34	34	34	30		99.5%	216.3%	-	-	101.1%	154.1%	-	-	
JC35	26	26	17		106.6%	135.9%	-	100.0%	80.0%	159.9%	-	-	
JC36 Trauma	34	34	27		97.1%	120.1%	-	100.0%	99.1%	111.7%	-	100.0%	
Critical Care + Surge	32	32	26		92.6%	90.8%	-	-	94.6%	110.9%	-	-	
CICU JCUH	8	8	9		90.3%	98.4%	-	100.0%	92.2%	160.0%	-	-	
Cardio HDU	10	10	5		70.0%	98.8%	-	-	64.0%	96.7%	-	-	Bed occupancy reduced by 5 beds in April Planned 6 RN Days working 4 (1:2 Ratio) Planned 5 RN nights working 3 (1:2 Ratio)
JC24 HDU	8	8	5		102.1%	96.7%	-	-	95.9%	109.7%	-	-	
Ainderby FHN	27	27	17		78.5%	103.7%	-	-	103.3%	101.7%	-	-	Bed occupancy reduced by 10 beds in April Planned 4 RN days working 3 (1:6)
Romanby FHN	26	27	19		94.5%	68.9%	-	-	70.0%	62.7%	-	-	Bed occupancy reduced by 3 beds in April Planned 3 RN Nights working 2 (1:10 Ratio)
Gara Orthopaedic FHN	16	16	8		74.2%	133.0%	-	-	100.0%	61.5%	-	-	Opened on 26th April with an average of 8 patients over the 5 days.
Rutson FHN	17	15	15		83.3%	74.3%	-	-	100.0%	98.5%	-	-	
Friary Community Hospital	18	18	13		78.6%	72.3%	-	-	100.3%	167.4%	-	-	Bed occupancy reduced by 5 in April. Planned 3 RN working 2 (1:7 ratio)
Zetland	31	29	21		100.3%	81.6%	-	100.0%	64.5%	138.9%	-	-	Bed occupancy reduced by 8 in April. Planned 4 RN nights working 2 (1:11 ratio) with extra HCA support
Tocketts Ward	30	30	22		79.0%	83.4%	-	-	78.9%	99.9%	-	-	Bed occupancy reduced by 8 in April. Planned 4 RN days working 3 (1:7) 3 RN nights working 2 (1:11) with 3-5 HCA
JC21	25	25	11		68.7%	87.8%	-	100.0%	72.2%	84.5%	-	100.0%	Bed occupancy reduced by 14 in April. Planned 6 RN day and night working 4 (1:3 ratio)

JC22	17	17	7		96.7%	78.0%	-	-	97.6%	48.3%	-	-	
JCDS (Central Delivery Suite)	-	-	4		91.7%	59.6%	-	-	95.7%	98.3%	-	-	
Neonatal Unit (NNU)	35	35	19		90.2%	86.7%	-	-	85.6%	-	-	-	
Paediatric Intensive Care Unit (PCCU)	6	6	2		79.4%	48.0%	-	-	75.8%	-	-	-	Bed occupancy reduced by 4 in April. Planned 4 RN day and night working 3 (1:1 ratio)
Ward 17 JCUH	-	-	22		92.0%	82.2%	-	-	68.8%	85.5%	-	-	Bed occupancy reduced by 7 in April. Planned 4 RN night working 3 (1:7 ratio)
Ward 19 Ante Natal	-	-	4		70.5%	96.7%	-	-	80.0%	-	-	-	Average of 4 patients at midnight during April
Maternity Centre FHN	-	-	0		73.6%	25.7%	-	-	92.6%	-	-	-	Average 1 patient at midnight during April
Spinal Injuries	24	24	19		87.9%	80.9%	-	100.0%	100.0%	98.9%	-	-	
CCU JCUH	14	14	9		75.2%	58.7%	-	-	83.3%	-	-	-	Bed occupancy reduced by 5. Planned 8 RN working 6 (1:2 ratio)

During the month of April 2021 Ward 9 maintained staffing ratio of 1:2 RNs for level 2 patients with two Assistant Practitioners (Band 4) experienced in NIV supporting the ward.

The emergency department continues to require 18 RNs during the day as building work takes place. A safe staffing review is being undertaken as part of the new ED SNCT work.

Nurse Sensitive Indicators April 2021

Ward/Area Name	New or Deteriorating PU 2's (Inpatient)	New or Deteriorating PU 3's (Inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey	Reported Serious Incidents
A&E JCUH	49	4	3	1	3	-	
CARDIO HIGH DEPENDENCY	0	0	0	0	0	9.48	
AINDERBY WARD	0	0	1	5	0	8.77	
CDU	12	0	1	2	1	9.01	
GARA WARD	0	0	0	0	0	9.84	
ROMANBY WARD	0	0	0	3	0	8.72	
WARD 2 COVID	0	0	2	5	0	-	
WARD 3	0	0	0	6	0	8.60	
WARD 4	1	0	4	9	0	8.73	
WARD 5	0	0	0	0	0	-	
WARD 6	1	0	1	4	0	8.30	
WARD 7	0	0	1	3	2	9.08	
WARD 8	1	1	0	1	1	8.72	Grade 3 new or deteriorating PU
WARD 9	0	0	4	2	1	9.29	
WARD 10	2	0	0	13	1	9.29	
WARD 11	1	0	4	6	0	8.76	
WARD 12	0	0	5	6	1	9.27	
WARD 14	0	0	2	0	0	-	
WARD 15	0	0	0	0	0	-	
WARD 17	0	0	1	0	0	9.26	
Ward 19 ANTENATAL WARD	0	0	0	0	0	-	
WARD 21	0	0	1	0	0	9.45	
WARD 22	0	0	1	0	0	9.30	
WARD 24	1	0	0	3	0	9.11	
WARD 25	2	0	2	2	0	8.63	
WARD 26	0	0	0	3	0	8.52	
WARD 27	0	0	0	4	0	9.30	
WARD 28	1	0	1	12	0	9.33	
WARD 29	2	0	1	2	0	9.31	
WARD 31	1	1	4	6	0	7.94	Grade 3 new or deteriorating PU
WARD 32	0	0	0	1	0	9.03	
WARD 33	1	1	0	4	0	9.15	
WARD 34	1	0	3	4	2	9.26	
WARD 35	0	0	1	3	0	9.33	
WARD 37 (AAU)	14	0	4	1	1	9.01	
CORONARY CARE	1	0	0	2	0	9.91	
CENTRAL DELIVERY	0	0	3	0	0	-	
TRAUMA WARD 36	1	0	4	2	0	9.09	
GENERAL HIGH DEPENDENCY	0	1	3	1	0	-	
GENERAL ICU2	0	0	0	0	0	-	
GENERAL ICU3	1	0	1	0	0	-	
CARDIOTHORACIC ITU	0	0	0	0	0	-	
SPECIAL CARE BABY UNIT	0	0	4	0	0	-	
SPINAL INJURY HDU	2	1	1	0	0	8.38	
WARD 1	22	2	6	9	0	-	
VICTORIA WARD (Friary)	3	0	0	0	0	8.89	
RUTSON WARD	0	0	0	1	0	8.41	
ZETLAND WARD	0	0	0	2	0	9.24	
TOCKETTS WARD	0	0	3	1	0	9.34	
TOTAL	**128**	**10**	**129**	**133**	**28**	**8.94**	

Good progress is being made with the reduction in pressure ulcers through the pressure ulcer collaborative. Focused work on falls is also ongoing with the STAQC team.

SI reports have been made by two wards (Ward 8 and Ward 31) for grade 3 new/deteriorating pressure ulcers during April. Staffing factors are always considered as part of the SI review process.

Red flag reporting April 2021

Red Flags	Early	Late	Long Day	Night	Grand Total
AMBER Beds Open				1	1
Delay in providing pain relief	1			3	4
Less than 2 RNs on shift				3	3
Missed 'intentional rounding'	4	4		4	12
Shortfall in RN time	5	5	2	9	21
Grand Total	**10**	**9**	**2**	**20**	**41**

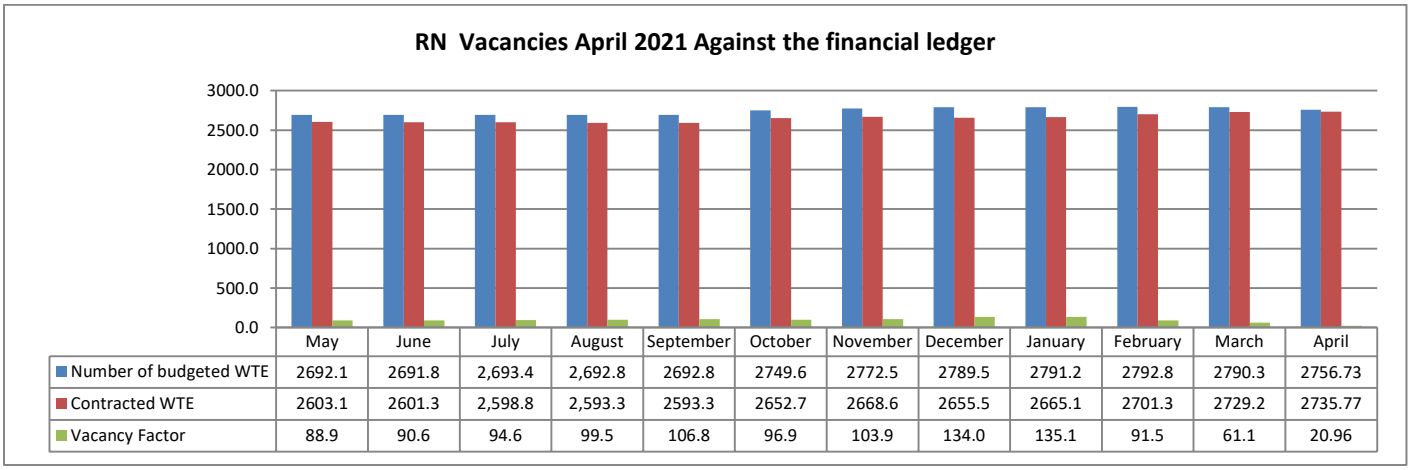
A total of 41 red flags were reported during April with shortfall of RN being the most common (21). No wards were left with less than two RNs on duty at any time as these flags were resolved by Matrons or patient flow.

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 datix.

Vacancy and Turnover

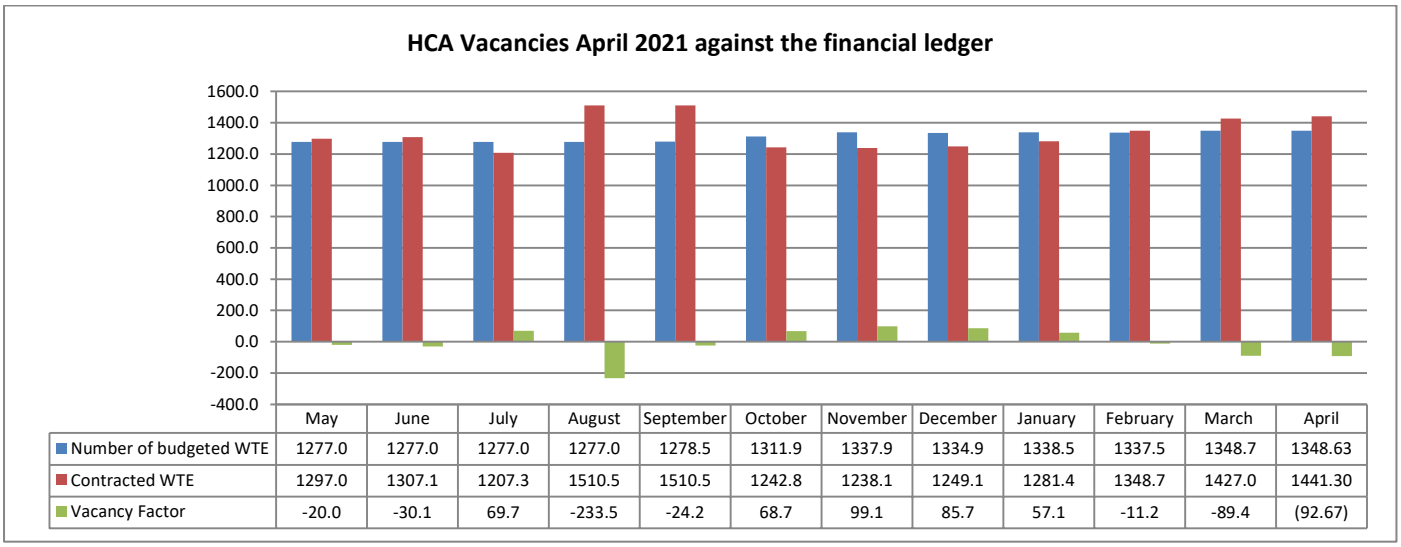
The total current nursing and midwifery vacancy rate for all nursing and midwifery staff is currently at 1% at the end of April 2021 against the financial ledger which equates to 20.9 WTE (Figure 1). Critical Care and ED are currently over established. ED has a large number of staff going on parenting leave.

Figure 1 Registered Nursing Vacancy Rate



	May	June	July	August	September	October	November	December	January	February	March	April
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
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
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

Figure 2 - Health Care Assistant Vacancy Rate



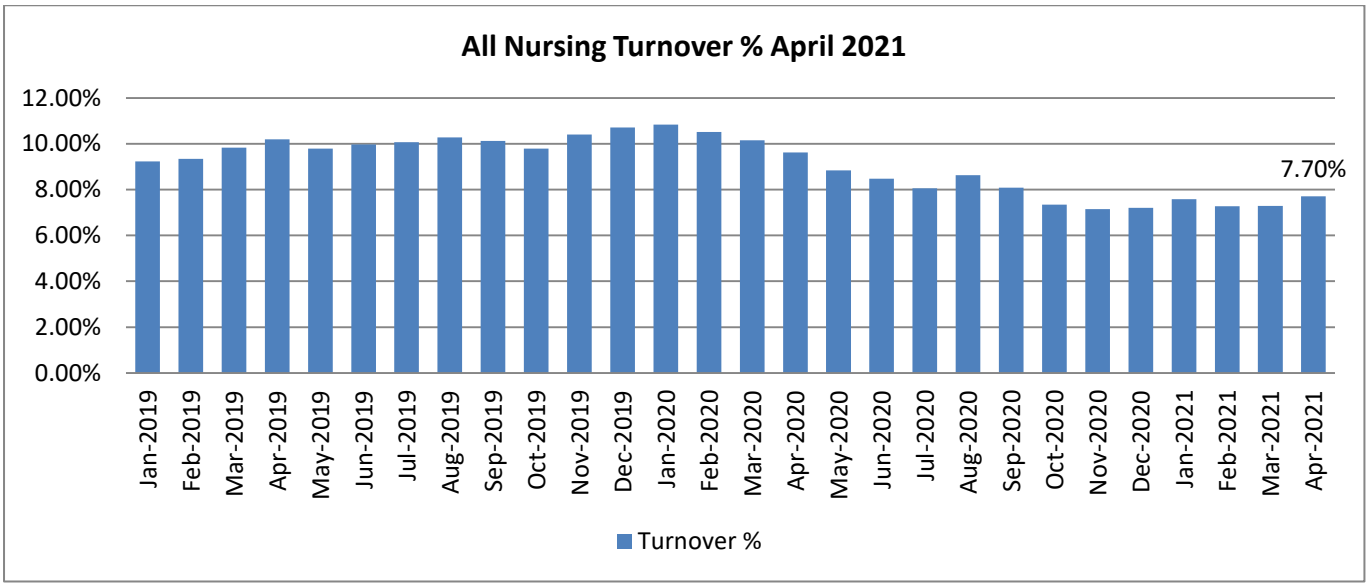
	May	June	July	August	September	October	November	December	January	February	March	April
Number of budgeted WTE	1277.0	1277.0	1277.0	1277.0	1278.5	1311.9	1337.9	1334.9	1338.5	1337.5	1348.7	1348.63
Contracted WTE	1297.0	1307.1	1207.3	1510.5	1510.5	1242.8	1238.1	1249.1	1281.4	1348.7	1427.0	1441.30
Vacancy 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)

Health Care Assistant (HCA) vacancy rates are showing as over recruited by 92.7 WTE at the end of April 2021 (Figure 2). This is due to 60.8 student nurses on short term paid placements as part of the national COVID response until 25th April and extra COVID HCA appointments to ED and Critical Care.

Rapid HCA recruitment centres achieved the planned target to recruit to all vacant posts by 31st March.

Nursing Turnover

Turnover for April 2021 was 7.7% which is lower than the National average.



Conclusion

During April nurse and midwifery staffing has mostly matched the acuity and dependency of the patients within agreed staffing ratios. The highest impact on staffing during the month has been sickness and increased critical care activity resulting in the requirement for redeployment from other areas to support particularly overnight.

There have been no reported episodes for lack of supernumerary co-ordinators during April 2021.

Monthly International RN recruitment continued with 11 arrivals due in April reduced by 3 as the RNs from India were unable to travel.

HCA rapid recruitment to achieve a 0% vacancy by 31st March 2021.

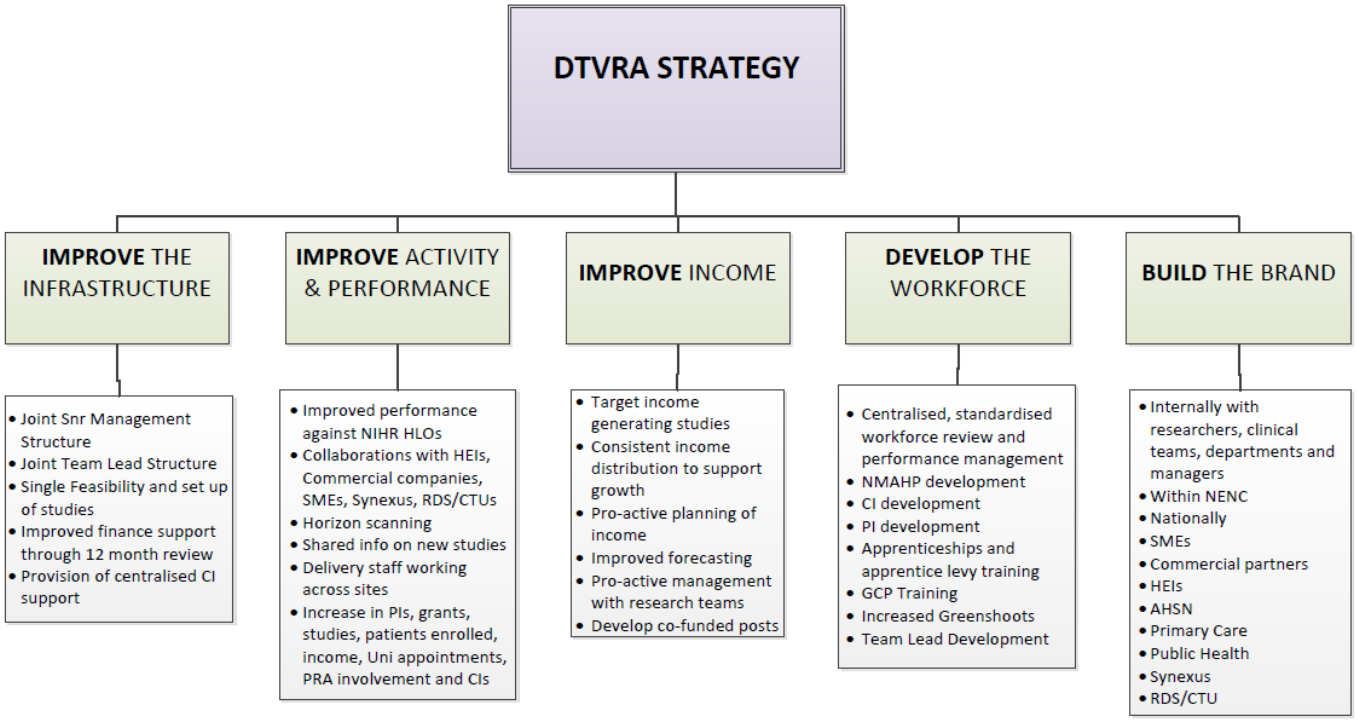
One hundred and five (105) adult branch student nurses have applied for posts within the trust for September/October and interviews are underway.

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 1 JUNE 2021			
Bi-annual Update of Research and Development			**AGENDA ITEM: 9** **ENC 7**
Report Author and Job Title:	Dr Paul Baker Director for Research and Innovation / Consultant Orthopaedic Surgeon / NJR clinician lead Dr Jane Greenaway	**Responsible Director:**	Dr Mike Stewart Chief Medical Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Report from the Trust Director for Research		
Background	Report covering the following aspects of R&D activity: 1) Strategic aims 2) Governance and Reassurance 3) Patient safety and Risks 4) Performance 5) Academic growth and CI support 6) Finance 7) CQC domains for research		
Assessment	No active concerns with R&D. Strong performance throughout COVID.		
Recommendation	Members of the Board of Directors are asked to note the report for information and reassurance		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	R&D Finance listed in Trust risk register Finance section of the report aims to provide assurances about R&D finances and that there are processes in place to deal with any shortfall in R&D income.		
Legal and Equality and Diversity implications	There are no legal or equality diversity implications		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☐	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☒		

Bi-annual update to the Quality Assurance Committee
Research & Development: May 2021

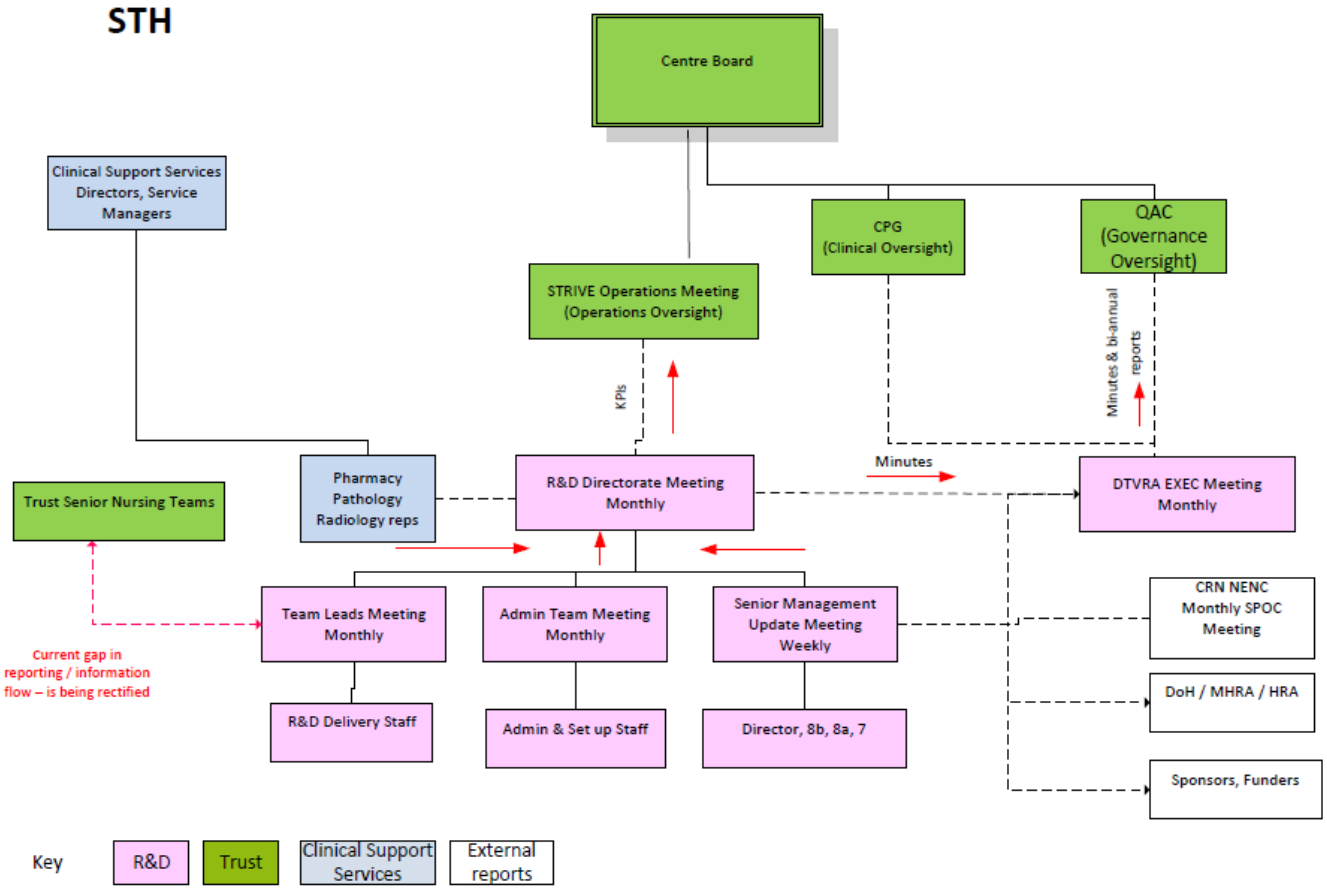
1.1 Strategic Aims

The agreed strategic aims for the Durham Tees Valley Research Alliance (DTVRA) are shown below (See Appendix 3 for details about progress against strategic aims):



2.1 Governance & Reassurance

Governance Structure & reporting for South Tees R&D department:



3.1 Patient Safety & Risks

Patient safety and risk reporting is now part of the core R&D Directorate agenda and discussed monthly (See Appendix 1)

DATIX events reported and lessons learned

Reviewed as part of the R&D Directorate agenda and discussed monthly in the Team Leader meetings for sharing within each team.

17 DATIX incidents were reported between 1st April 2020 and 31st March 2021

Sub category	Description
Equipment - Including Pain Management devices	Lack of adequate facilities / equipment
Pressure Ulcer	New or Deteriorating Pressure Ulcer - Category 2
Information Governance	Data Integrity
Medication	Pharmacy Dispensing Error
Infrastructure e.g. buildings, utilities	Unsafe/Inapp building
Medication	Ward stock discrepancy - not controlled drugs
Information Governance	Loss of paper information (accidental or malicious)
Research Project - medicinal study	Protocol Violation
Fall/slip/trip	Fall from bed
Medication	Medication - not ordered from pharmacy
Security Incident (Not LDT or Violence)	Miscellaneous – security
Research Project - medicinal study	Protocol Violation
Fall/slip/trip	Fall whist mobilising
Research Project - medicinal study	Protocol Violation
Medication	Prescribing error - delay in prescribing
Health Records	HCR - Clinic Prep - any issues
Information Governance	Inappropriate disclosure of patient information

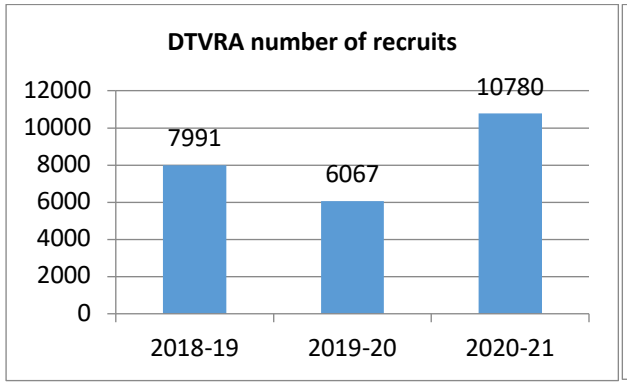
Durham Tees Valley Research Alliance (DTVRA)

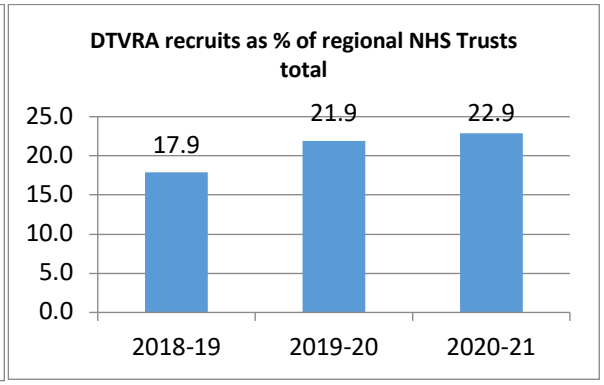
South Tees Hospitals NHS
NHS Foundation Trust

4.1 Performance Overview

Research activity as part of Durham Tees Valley Research Alliance (DTVRA)

Year-on-year comparison:



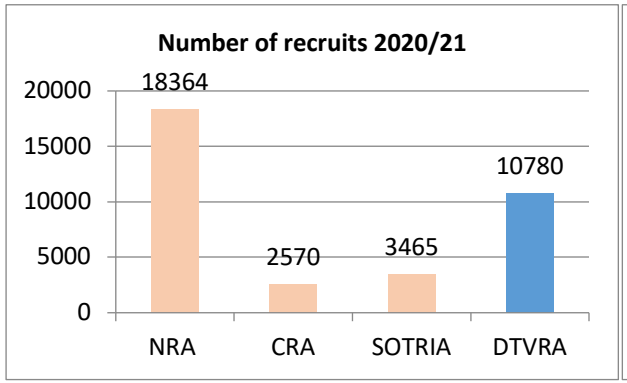


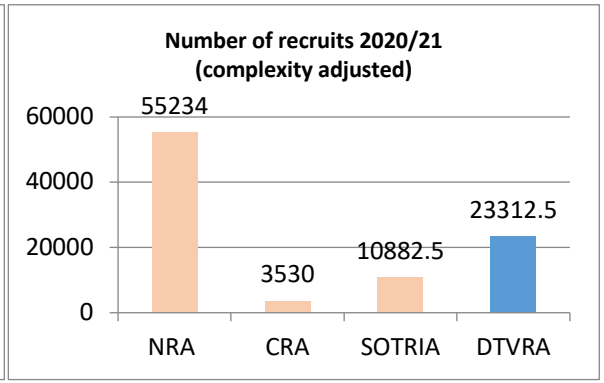
Combined recruitment for the three DTVRA NHS Trusts* is higher in 2020-21 than the previous two years and demonstrate yearly growth since the advent of the DTVRA.

Changes in research activity in response to COVID-19 (e.g. focus on supporting 'urgent public health' studies) have not negatively affected our standing.

*STHFT / NTFT / CDDFT
(Data downloaded from NIHR ODP on 08th April 2021)

Comparison with other research alliances:





DTVRA is the second highest recruiting research alliance in the region

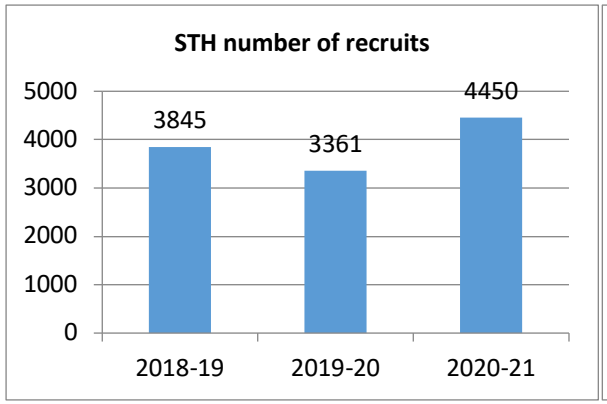
Key:
NRA: Newcastle, Gateshead, Northumbria
CRA: Cumbria
SOTRIA: South Tyneside, Sunderland
(Data downloaded from NIHR ODP on 08th April 2021)

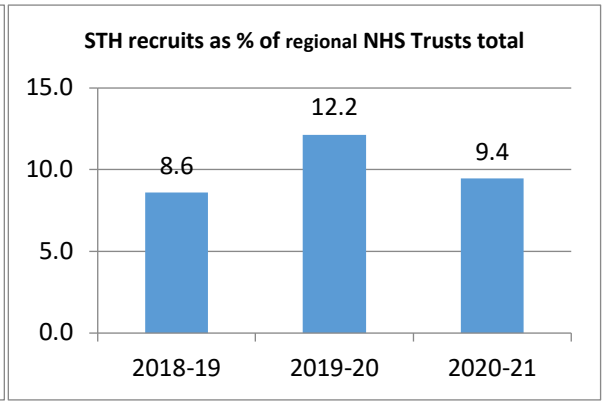
Durham Tees Valley Research Alliance (DTVRA)

South Tees Hospitals NHS
NHS Foundation Trust

Focus on South Tees Hospitals NHS FT performance

Year-on-year comparison:



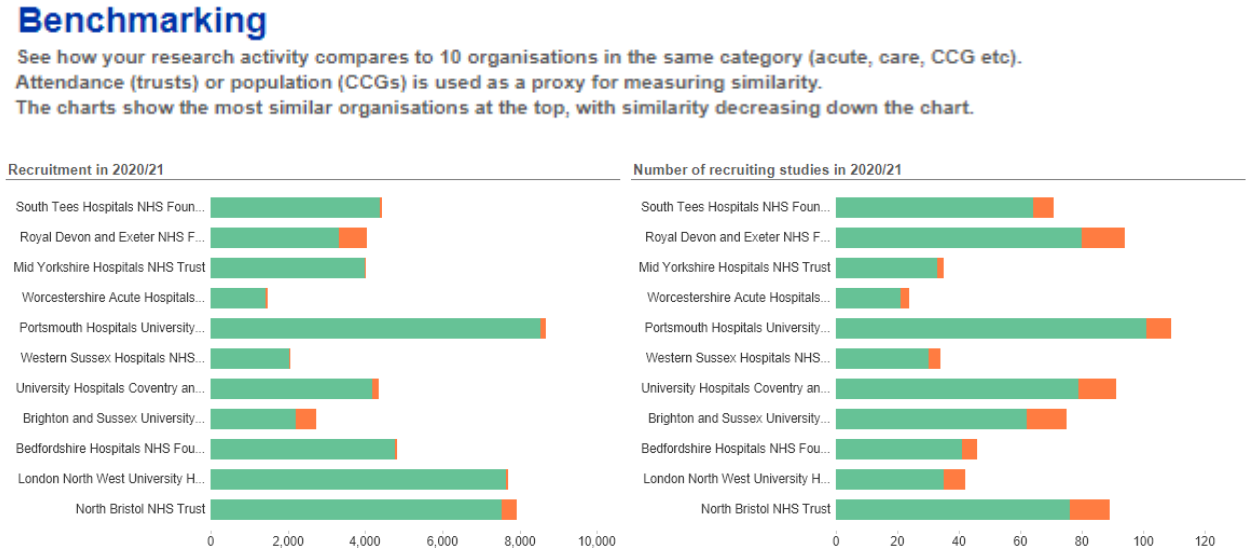


Recruitment is higher in 2020-21 than the previous two years.

The % regional share is lower than last year but this figure does not account for South Tees contribution to the NOVAVAX COVID 19 vaccine trial for which Hartlepool (NTFT) was the recruiting site; local team significantly over-achieved against agreed target recruiting 532 participants to date.

(Data downloaded from NIHR ODP on 08th April 2021)

<u>Activity comparison with similar Trusts nationwide</u>



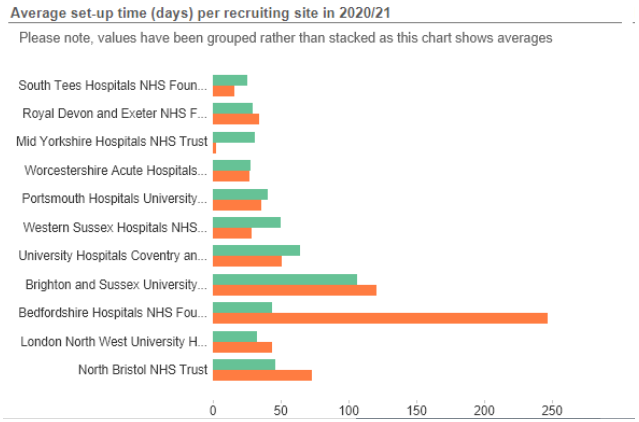
When compared to similar Trusts nationwide, STH compares particularly favourably in terms of both overall recruitment and the number of recruiting research studies.

(Data downloaded from NIHR ODP on 08th April 2021)

Durham Tees Valley Research Alliance (DTVRA)

South Tees Hospitals NHS
NHS Foundation Trust

Study set-up performance



Our average set up time is excellent compared to other Trusts against which we are benchmarked. **82%** of studies achieved the NIHR target* for study set-up in 2020-21.

*'Confirmation of capacity and capability' issued within 40 days of receiving complete study document pack
(Data take from NIHR C&C report dated 07th April 2021)

Performance against STRIVE KPIs 2020/21 (See Appendix 2 for list of STRIVE KPIs)

Number of patients recruited	4260
Median time to approval for studies	12.5 days
Number of commercial trials open	17
Total number of all trials open	74
Number of PI's from NMAHPs	1

Durham Tees Valley Research Alliance (DTVRA)

South Tees Hospitals NHS
NHS Foundation Trust

STH performance by clinical specialty 2020/21

Raw recruitment

Managing Specialty	STH	Total
Anaesthesia, Perioperative Medicine and Pain Mar	135	**135**
Cancer	47	**47**
Cardiovascular Disease	130	**130**
Children	43	**43**
Critical Care	563	**563**
Dementias and Neurodegeneration	117	**117**
Dermatology	2	**2**
Diabetes	14	**14**
Ear, Nose and Throat	72	**72**
Gastroenterology	86	**86**
Health Services Research	338	**338**
Hepatology	2	**2**
Infection	1,682	**1,682**
Metabolic and Endocrine Disorders	11	**11**
Musculoskeletal Disorders	2	**2**
Neurological Disorders	2	**2**
Renal Disorders	4	**4**
Reproductive Health and Childbirth	388	**388**
Stroke	2	**2**
Surgery	146	**146**
Trauma and Emergency Care	462	**462**
Total	**4,248**	**4,248**

Complexity Adjusted Recruitment (CAR). A weighting is applied to account for some studies being more complex in their trial design and delivery.

Managing Specialty	STH	Total
Anaesthesia, Perioperative Medicine and Pain	933	**933**
Cancer	365	**365**
Cardiovascular Disease	1,228	**1,228**
Children	293	**293**
Critical Care	2,383	**2,383**
Dementias and Neurodegeneration	455	**455**
Dermatology	2	**2**
Diabetes	72	**72**
Ear, Nose and Throat	792	**792**
Gastroenterology	184	**184**
Health Services Research	1,183	**1,183**
Hepatology	7	**7**
Infection	2,210	**2,210**
Metabolic and Endocrine Disorders	121	**121**
Musculoskeletal Disorders	22	**22**
Neurological Disorders	7	**7**
Renal Disorders	4	**4**
Reproductive Health and Childbirth	741	**741**
Stroke	22	**22**
Surgery	1,576	**1,576**
Trauma and Emergency Care	1,342	**1,342**
Total	**13,938**	**13,938**

5.1 Academic growth and researcher support

There were 56 different Principal Investigators across 76 recruiting studies in 2020-21. It is difficult to compare to other years as most non-COVID research was paused in line with national guidance.

Of the studies that recruited participants in 2020-21 for which 'recruitment to time and target' data is available, 34 studies achieved a 'positive' green, hatched green or blue rating while 12 received a 'negative' (in terms of not currently achieving local recruitment target) red or amber rating.

Research grant activity

Grant Holder	**Grant Type** (NIHR, Commercial, NHS)	**Specialty**
David Austin	NIHR and Other	Cardiology
Enoch Akowuah	NIHR and Other	Cardiology
Amar Rangan	NIHR and Other	Orthopaedics
Paul Baker	NIHR and Commercial	Orthopaedics
David Chadwick	Other	Infectious Diseases
Sam Eldabe	NIHR and Commercial	Pain
Vicky Ewan	NIHR	Community Geriatric Medicine
James Durrand	Other	Peri-operative Medicine
Gerry Danjoux	Other	Peri Operative Medicine
Mr Jeremy Twigg	Commercial	Cancer & Surgery
Mr Manjunath Prasad	Commercial	Renal Medicine
Mr Anil Reddy	Commercial	Surgery
Dr Saladin Sawan	Other	Cancer
Vrinda Nair	Commercial	Neonates
Prakash Loganathan	Commercial	Neonates

Our CI and grants support staff have supported a number of grant submissions in the last six months across the DTVRA. Below are the grants that have been successfully awarded in the last 6 months:

Grant funder	**Speciality**	**Trust**	**CI / Trust lead**
Innovate UK	Gynae-oncology	STHFT	Mr Saladin Sawn
National Institute for Health Research: HTA	Trauma & Orthopaedics	STHFT / Northumbria	Prof Mike Reed / Mr Paul Baker
National Institute for Health Research: RfPB	Orthopaedics / Elderly medicine	STHFT	Dr Vicky Ewan
AOUK research grant	Orthopaedics	STHFT	Prof Amar Rangan
Sport England	Anaesthetics	STHFT	Prof Gerry Danjoux
National Institute for Health Research: Fellowship		STHFT / Teesside University	Dr Sam Harrison
External Commercial Research Funding	Neonates	STHFT	Dr Vrinda Nair
External Commercial Research Funding	Neonates	STHFT	Dr Prakash Loganathan
External Commercial Research Funding	Stroke / A&E	STHFT	Dr Chris Price / Dr Lisa Shaw

6.1 Finance – Overview and 20/21 Financial Performance

Background:
Historically, full costs have not been allocated to R&D projects which has presented problems with ascertaining profitability. Work is ongoing to correct this issue to provide better management information. Income and expenditure were never allocated against one another and no reporting was available as income may not have been coded to R&D and expenditure could be attributed to other directorates.

What Changed?

- All staff are now paid from R&D cost centres.
- Income & Expenditure are allocated to each individual trial in R&D. Improving the financial transparency and allowing a more granular understanding of the financial position.
- Income is deferred between financial periods for each trial until trial completion, unless R&D is not covering its own costs. In this situation deferred income may be used to make sure staffing budgets are met.
- Financial reporting is available at every R&D directorate meeting.

<u>Overview of Income Streams</u>

a) Local Clinical Research Network (LCRN)

This is an allocation we receive from the National Institute for Health Research (NIHR). It funds research staff, research support staff (Pathology, Pharmacy), Research Delivery Awards for PIs (PAs), Greenshoot awards for new and aspiring researchers and some of the research support staff. We are allocated an amount at the beginning of the financial year based on a number of factors such as past performance and proportionate share of the regional allocation. This can increase throughout the year depending on access to additional in-year funding opportunities. It represents approximately 50-60% of our operating budget.

b) Commercial Income

This is generated through income from commercially funded clinical trials – usually drug trials. The income from commercial trials through the year is helps to ensure we hit our income target in the cost centre 8043SA, the remaining monies (profit) is kept in the trial cost centre and can be utilised by the clinical trial leads.

c) Grants

Experienced trust researchers can submit applications to a number of grant funding bodies to fund the costs of running clinical trials. Some of these are funded by the NIHR and others might be funded by the government (MRC). They can range in scope from a few thousand pounds to multi million pound grants for complex interventional trials.

d) Research Capacity Funding (RCF)

RCF is an additional allocation to Trusts largely based on research grant activity as some grant schemes attract additional RCF funding.

The aims of RCF funding are to:

- help research-active NHS organisations to act flexibly and strategically to maintain research capacity and capability
- support the appointment, development and retention of key staff undertaking or supporting people and patient-based based research
- contribute towards the costs of hosting NIHR-funded or 'adopted' research that are not currently fully covered across NIHR's programmes, and that are not met in other ways.

e) Charitable Funding

Certain staff members are funded through charity funds, expenditure is agreed with charity fund holder.

f) Legacy Funds

This is a set amount (£500k for 5 financial years) which has been agreed with the trust to recoup money which was previously used in non R&D areas. Legacy Funds are available until 2024.

g) Deferred income

Deferral of income can only be considered if a trial is operating across 2 financial periods'. Any balance of income greater than expenditure at the end of the trial must be utilised by the end of the financial period in which the trial ends. Any commercial trial which is ongoing and has had all costs allocated against it (i.e. Pay & Non Pay expenditure) will have a 'profit' sitting in the trial cost centre. Every month this income is deferred until the trial is complete, unless if at year end we are overspending, discussions will then take place to allocate some of the deferred income against costs. In 20/21 we deferred a total of £264,000.

Overview of LCRN Income 20-21

LCRN Summary 20-21	WTE	YTD £
LCRN Income		(2,069,667)
LCRN Pay	44.72	2,039,542
LCRN Non Pay		30,125
TOTAL	**44.72**	**0**

Overview of Non LCRN (Commercial) income 20-21

Salary costs of staff 20-21 funded through Non-LCRN income

Clinical Area	WTE	YTD £
Admin	12.45	301,231
Anaesthetics	2.00	89,237
Cancer	2.11	110,983
Cardio	6.83	258,649
Medicine	3.27	110,143
Pain	3.37	119,732
Pathology	1.27	17,506
Pharmacy	0.80	27,414
Trauma & Ortho	2.64	55,439
Women & Children	3.85	61,093
Grand Total	**38.58**	**1,151,426**

R&D broke even in 20/21 as we generated enough Non LCRN (Commercial) income to cover all the above staff costs.

Budget setting - Income and Expenditure 21-22

Projected expenditure	£3,476,294
Base CRN income	£2,043,862
RCF income	£ 242,142

This leaves an income target for 21-22 of £1,190,290, based on the costings of 33.54 WTE's. This is before the reinvestment of the years legacy funding, staff funding from grants and use of deferred income from the previous financial year

Financial risk to organisation

The risk to the organisation will be if R&D cannot cover its own staff costs. For 21-22 we have the ability to use some of the deferred income from 20-21 (in discussion with the relevant research teams) and the Legacy funds which could also be utilised, if it becomes a risk during the financial year. Key to mitigating this risk is robust financial forecasting of income and expenditure to enable management action at an early stage.

7.1 CQC domains for research

The R&D CQC action plan is being developed and reviewed by Jane Greenaway, Tarn Green and the Team Leads. We report progress against this twice a year at the R&D Directorate meeting.

W8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?
Measures Are divisional staff aware of research undertaken in and through the Trust, how it contributes to improvement and the service level needed across departments to support it?
How do senior leaders support internal investigators initiating and managing clinical studies?
Does the vision and strategy incorporate plans for supporting clinical research activity as a key contributor to best patient care?
Does the Trust have clear internal reporting systems for its research range, volume, activity, safety and performance?
How are patients and carers given the opportunity to participate in or become actively involved in clinical research studies in the trust?

Our CQC action plan will be presented to QAC during the November reporting submission.

Durham Tees Valley Research Alliance (DTVRA)

South Tees Hospitals NHS
NHS Foundation Trust

Appendix 1

Monthly Directorate Meeting agenda items

R&D Directorate Monthly meetings			Frequency of Agenda items											
	Person responsible for Agenda item reports/info	Freq.	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Finance update	MH, DM	Monthly	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of Previous Meeting and Matters arising	PB	Monthly	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Performance update	JM	Monthly	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governance update	JM	Monthly	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Risk/Incidents	JM/TN	Monthly	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Support services update	Pathology, Pharm, Radiology	Monthly	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Team leads updates	TLs	Monthly	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Update from 70@70 Lead (Nicky Cunningham)	NC	Bi-annually			✓						✓			
CQC Action plan review & update	JG	Bi-annually		✓						✓				
Update on CI sponsored studies (planned, open)	JM	Bi-annually	✓						✓					
Whole team attendance (include update on "Care and Safety" in R&D as agenda item for TN to update		Bi-annually			✓						✓			
Overview of strategy and vision		Bi-annually			✓						✓			
Grant finances update	HC	Bi-annually				✓						✓		
FDA report/MHRA update	JM	Quarterly		✓			✓			✓				✓
Lessons learned from DATIX/ audits/ inspections	JM TN	Quarterly		✓			✓			✓				✓
HR Update	TN, HL	Quarterly	✓			✓			✓			✓		
Communications / PR	TBC	Quarterly			✓			✓			✓			✓
Feedback from TScs/TMGs for sponsored studies	JM	Quarterly	✓			✓			✓			✓		

Appendix 2

STRIVE KPI items for R&D

HEALTH AND SAFETY
Number of PALS complaints received
Number of formal complaints received
Number of DATIX's received
Number of departmental STARS received
RESEARCH AND DEVELOPMENT
Number of patients recruited per month
% share of patients recruited per month in region
% of studies approved within NIHR target period
Number of recruiting commercial trials each month
Number of recruiting trials each month
Number of new studies with PI's from NMAHPs
HUMAN RESOURCES
Percentage of sickness leave taken
Percentage of study leave taken
Percentage of special leave taken (C/L, M/L)
Percentage of annual leave taken
WTE
Percentage of Mandatory training completed
Percentage of SDR's completed

Durham Tees Valley Research Alliance (DTVRA)

South Tees Hospitals NHS
NHS Foundation Trust

Appendix 3

Performance against strategic aims

Strategic Aim	Performance in last 12 months
Improve the infrastructure	Joint Senior Management Structure complete and operational Joint DTVRA Team lead meetings operational (daily during COVID, now twice a week) Single feasibility and set up process operational Centralised CI support now operational – new Grants and costings post in place, MedConnect North Support in place, additional CI support admin role planned
Improve Activity & Performance	Recruitment into NIHR portfolio trials increased from 3361 to 4450 for STHFT despite many of our non-COVID trials being paused in the last 12 months. 82% of new studies in 2020-21 at STHFT were opened within 40 days of receiving a document pack (former NIHR metric), with a median time of 12.5 days. Expedited approval was offered for Urgent Public Health and commercial research. A Memorandum of Understating (MoU) is being drafted to formalise strategic links with Teesside University relating to Research, Education and Innovation. Thereafter we will have regular strategy meetings to plan and further develop our partnership and collaborations. NTHFT have a collaborative agreement with Synexus, a commercial research provider and provide services to support their studies when required. We have now begun to contract with Synexus for STH service provision for some studies (liver biopsies and radiology support). This brings additional income to the Trust at commercial rates **Collaborations with HEIs** We hold numerous academic posts and partnerships with University partners – Oxford University (Orthopaedics), York University (Orthopaedics), Hull York Medical School (Peri-operative medicine), Newcastle (Peri-operative medicine , Anaesthetics, Cardiothoracics, Rheumatology, Infectious Diseases, Neonates), Manchester University (Cancer) and Teesside University (Peri-operative medicine, Plastic surgery). We have completed a scoping exercise of our existing Chief Investigators (CIs) and grant holders and hosting a workshop in June to develop an aspirational plan for the development of academic research and partnerships. We hold regular strategic meetings with the National Horizons biosciences centre from Teesside University where we look for opportunities to link clinical colleagues with their academic staff and external commercial partners to develop new trials. We held an online joint COVID symposium and have developed a flyer disseminated trust-wide to raise the profile of the opportunities that this partnership offers. **Horizon scanning**: we have improved our process of responding to “expressions of interest” for new commercial studies and review the pipeline of studies and offers weekly with our local Clinical research network colleagues. **Delivery staff working across sites** The NOVAVAX COVID vaccine trial was the first trial to use staff from across the DTVRA and was a huge success. Feedback from staff was very positive. The trial over recruited and has brought significant income to all three trusts which otherwise would not have bene possible by one trust working alone.

	Pharmacy and pathology staff are now routinely assisting with cross-site studies when needed and we're looking to develop a joint Pharmacy study feasibility review process. **Opportunities to increase PIs** have been limited as we've focussed most of our efforts on the CMO Urgent Public Health (UPH) COVID studies. However, the RECOVERY trial required broad trust clinical engagement with recruitment and resulted in over 600 patients being recruited into this treatment trial.
Improve Income	**Targeting of income generating studies** in this last year has been difficult as we've had to prioritise UPH COVID studies over all others –most of which didn't attract any additional income. The NOVAVAX COVID vaccine trial was a significant income generating study and would not have been possible without a DTVRA approach. All three DTVRA trusts now have the same **agreed principles for the distribution of income** for commercially sponsored studies in line with NIHR guidance. Significant work has been undertaken within the last 12 months to understand **R&D financial position** and bring them to a state of absolute transparency – not only for the R&D Senior Management Team (SMT) but for the PIs and CIs across the trust who generate research income. We now know our detailed financial position and forecast and can budget and plan accordingly. Regular financial reports are now being produced for all cost centres and shared with the Team leads and PIs/CIs for those cost centres. The support of Mark Hutchinson, Danielle Melton and Mia Appleton has been instrumental in getting to this position. **Co-Funded posts** All of the SMT posts are joint funded between the Trusts to provide the centralised management team. We have committed to funding centralised Chief Investigator (CI) support, R&D reporting and R&D comms posts. For the growth in the CI support team, part funding has been secured from NTHFT Research Capacity Funding (RCF) with a paper being submitted to CDDFT for the same.
Develop the workforce	**Centralised, standardised workforce review** T Limited development of this strategic aim due to the focus on COVID research studies in the last 12 months. Team Leaders hold regular research team meetings, 1:1's with team members. Opportunities for learning shared across the DTVRA. Workforce related projects to be agreed for each T/L to work on as part of Leadership training. The aim is for all Band 6/7 workforce staff to have completed some form of formal leadership training within the next 5 years with Band 7 T/L's to have either completed or commenced Level 5 Leadership Apprenticeship in the next 12 months. All Band 6's to have completed the Trusts management study days in the next 12 months **NMAHP development** TN- Limited development of this strategic aim due to the focus on COVID research studies in the last 12 months. Work in partnership with NIHR 70@70 NMAHP Lead for South Tees to develop DTVRA NMAHP Leaders and to attend South Tees Research Council. Encourage NIHR Green Shoots applications and none medical PI's. Currently 1 NMAHP PI and 2 Clinical Research Practitioner Investigators. **CI/PI development**

	Limited development of this strategic aim due to the focus on COVID research studies in the last 12 months. We have completed a CI scoping exercise to understand our academic affiliations and aspirations and will be holding an afternoon workshop with key CIs to develop aspirational plans which we would aim to roll out across the DTVRA. **Apprentices** Limited development of this strategic aim due to the focus on COVID research studies in the last 12 months however and jointly funded STRIVE apprentice comms post is being developed for 2021/22. DTVRA Team Leaders are currently undertaking apprenticeships in leadership or business management with coaching apprenticeship starting in Sept 2021 **GCP** Limited development of this strategic aim due to the focus on COVID research studies in the last 12 months **Green shoots** We were successful in obtaining 6 "green shoot" RDA awards from the Clinical Research Network for 200/21 which will be continued into 2021/22 **Team Leader Development** We hold regular DTVRA wide Team Leader huddles, these were daily during the height of the pandemic to understand the studies, plan how they could be supported and troubleshoot issues. These are now twice weekly and amongst general oversight there is dedicated time to review study pipelines and our response rates to Expressions of Interest for commercial studies, sharing of good practice. Once a month include support services to discuss study capacity and agree priority list of study opening. Quarterly DTVRA Team Leader resilience days are held, the first at UHH with the second planned for June.
Build the brand	There has been limited development of this strategic aim due to the focus on COVID research studies in the last 12 months and our need to be internally focussed on delivering these vital public health pandemic studies. We ensured that Trust Tactical Command and CEO received regular updates on our COVID research activity. We have recently begun regular meetings with some of our strategic partners (National Horizons Centre, Public Health) and are setting up an MoU with Teesside University. We are appointing a new communications assistant in STRIVE to help with raising the profile of research activity and it's impact on patient care to everyone both inside and outside of the trust.

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 1 June 2021			
Healthcare-associated infection (HCAI) report for April 2021			**AGENDA ITEM: 10, ENC 8**
Report Author and Job Title:	Dr Richard Bellamy, Infection Control Doctor, JCUH Sharon Lance, Deputy DIPC	Responsible Director:	Dr Hilary Lloyd, Chief Nurse and DIPC
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	The Board of Directors are asked to note the current position in respect of HCAI and for their support for the actions being taken.		
Background	This report summarises surveillance information on the following: • *Clostridium difficile* • *Methicillin Resistant Staphylococcus aureus* (MRSA) bacteraemia • *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 for the month of April 2021. The report also highlights antimicrobial stewardship and environmental cleaning in relation to HCAI management.		
Assessment	The *Clostridium difficile*-associated diarrhoea objective for 2019/20 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. The target for 2021/2022 is unknown but is assumed to be the same. There were 2 COHA + 7 HOHA cases in April 2021. We are currently above trajectory. The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There were 0 trust-assigned cases in April 2021. There is no official MSSA bacteraemia target for 2021/22. There were 3 trust-apportioned cases in April 2021. An outbreak of *Serratia marcescens* infection commenced in May 2019, affecting patients who have been treated in cardiothoracic ICU and/or cardiothoracic HDU. At the time of writing (5th May		

	2021) there have been 5 confirmed cases, 24 probable cases and 40 excluded cases. Discussions are to take place at the next IPAG regarding the official closure of the outbreak; however continued reporting and monitoring will remain. The average hand hygiene self-assessment score in April 2021 was 99%. The average hand hygiene peer assessment score for April 2021 was 99%. The Trust has undertaken a number of measures to manage patients with COVID-19 infection and clear admission pathways are in place with associated screening protocols. The former red/amber/green 3-pathway system was replaced by a red/standard 2-pathway system in April 2021. The IPC team have been involved in a Rapid-Process Improvement Workshop (RPIW) looking at systems and processes within the team. The key requirement to make this successful is information technology support from the Business Intelligence Unit (BIU)	
Recommendation	The Board of Directors are asked to note the current position in respect of HCAI and for their support for the actions being taken.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 2.1 - An infection outbreak (such a influenza; norovirus; infections resistant to antibiotics and CDiff) may result in avoidable patient harm and could adversely impact on delivery of key performance indicator	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☐
	Drive operational performance ☒	Long term financial sustainability ☐
	Develop clinical and commercial strategies ☐	

1.SURVEILLANCE

1.1 Clostridium difficile

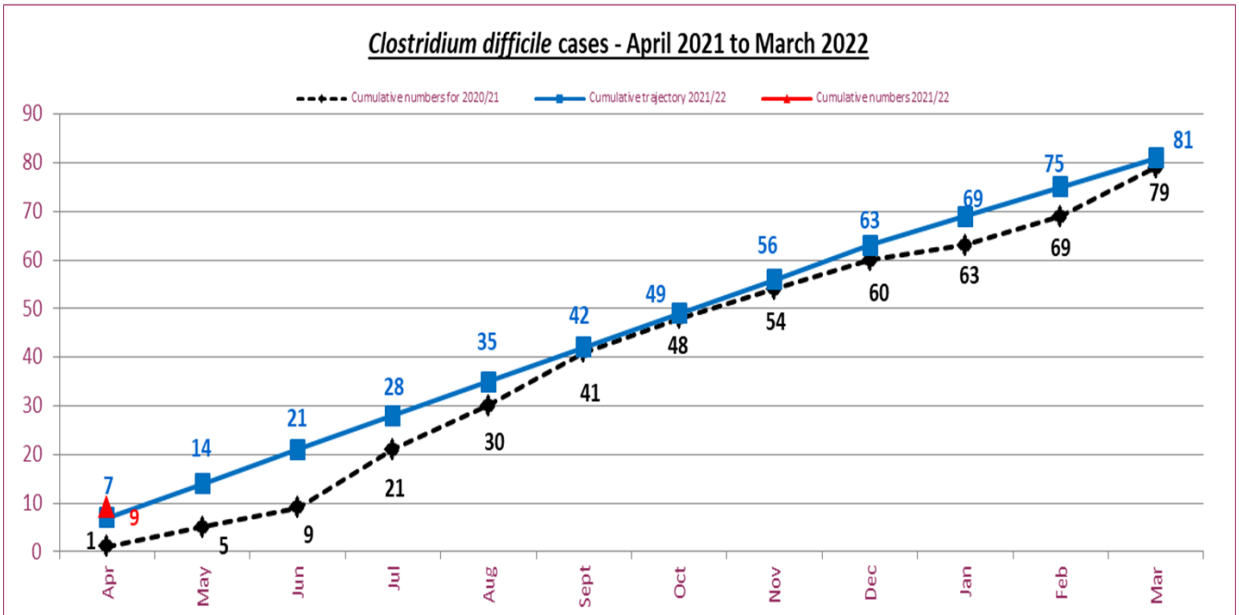
There were 12 cases of *C. difficile* infection in April 2021, 2 of which were classed as COHA and 7 were classed as HOHA, totalling 9 cases as trust-apportioned according to the definitions (table 1). The trust 2021/22 annual objective is to have no more than 81 COHA + HOHA cases. All actions to ensure that robust controls are in place are actioned in weekly 'huddle' style meetings with Clinical Matrons, weekly patient safety meetings and at monthly Collaborative meetings and monitored through IPAG.

Definition	Criteria
Hospital onset healthcare associated (HOHA)	Cases detected in the hospital ≥2 days after admission.
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.
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.
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.

Table 1: 2019/20 *C. difficile* definitions

Root Cause Analysis (RCA) and panel reviews are undertaken for all trust-apportioned *C. difficile* cases. Panel reviews are chaired by the Deputy DIPC and are attended by CCG colleagues. If the panel agrees that there were no deficiencies in care then the case may be discounted from the total for performance measurement purposes. These panels were postponed during the COVID-19. The Trust has recently reviewed the CDI process in collaboration with the CCGs and agreed through IPAG a new format.

Identifying 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.



Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
JC33 (COHA)											
RZET (COHA)											
ICU2 (HOHA)											
JC01 (HOHA)											
JC06 (HOHA)											
JC10 (HOHA)											
JC09 (HOHA)											
AIND (HOHA)											
CCSURG1 (HOHA)											

Graph 1: Cumulative Trust-apportioned *C. difficile* cases 2021/22 compared to trajectory

1.2 MRSA bacteraemia

In April 2021 there was 1 case of MRSA bacteraemia in, which is classed as not trust-assigned and a total of 0 trust-assigned cases.

1.3 MSSA bacteraemia

There were 9 cases of MSSA bacteraemia in April 2021; 3 of which were classed as trust-assigned.

Whilst there is no external target for MSSA, the trust has set an internal annual target to maintain the 15% reduction of trust-apportioned *Staphylococcus aureus* bacteraemia episodes based on the 2016/17 baseline.

This means no more than 35 combined MRSA and MSSA trust-apportioned cases in total. The trust is approximately on target as we have had 3 cases after 1 month.

Enhanced training for Aseptic Non-Touch Technique (ANTT) is being implemented across the trust for all relevant staff groups to address avoidable causes of MRSA and MSSA bacteraemia related to invasive procedures and remains as a priority on the IPC Annual Plan.

1.4 Surveillance for other healthcare-associated infections

Reducing gram negative blood stream infections (GNBSI) is a national priority with the aim of a 50% reduction in healthcare associated GNBSI by 2022/2023.

In 2020/2021 we achieved a 22% decrease in total cases compared to 2019/20 and a 32% decrease compared to 2018/19 overall.

For hospital-apportioned cases this was a 20% decrease compared to 2019/20 and a 42% decrease compared to 2018/19.

	Total for 20/21	April 2021	Total for 21/22
Bacteraemia due to glycopeptide-resistant enterococci	5	1	1
Bacteraemia due to E. coli	350	28	28
• Trust-apportioned	57	4	4
• Not trust-apportioned	293	24	24
ESBL producing coliform infections	610	78	78
• sample taken in community	409	57	57
• sample taken in our trust	201	21	21
• bacteraemias	14	0	0
Bacteraemia due to Klebsiella species	114	6	6
• Trust-apportioned	29	2	2
• Not trust-apportioned	85	4	4
Bacteraemia due to Pseudomonas aeruginosa	33	0	0
• Trust-apportioned	18	0	0
• Not trust-apportioned	15	0	0
Other alert organisms	0	0	0
• invasive group A streptococcus			

Table 2

In April 2021, the trust reported a total of 34 cases of three GNBSI organisms which are part of national surveillance (*E. coli, 28; Klebsiella sp. 6, Pseudomonas aeruginosa* 0) (table 2).

Of these, 6 cases were classed as trust-assigned as per Department of Health definition. We have previously worked and are supporting again with the Tees-wide collaborative which supports a number of initiatives within the community setting.

1.5 Antimicrobial Stewardship

The trust is continuing with a number of antimicrobial stewardship initiatives including the Antibiotic Review Kit (ARK) project.

The antibiotic guidelines app was launched at the end of September 2019. To continue using the app after October 2021 the Trust needs to purchase the ongoing software license, however pharmacy have confirmed they can provide the budget for this. We are also working with North Tees staff to explore developing a common guideline.

Antimicrobial 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. The ACCESS refers to a group of 48 antibiotics, 19 of which are included individually on the WHO Model List of Essential Medicines as first or second choice empiric treatment options for specified infections.

The European Committee on Antimicrobial Susceptibility Testing (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 have an accompanying programme of education and monitoring to prevent this having an adverse impact on antimicrobial stewardship.

It is unclear if the antimicrobial CQUINs which were paused due to COVID-19, will recommence in 2021/2022.

1.6 Environmental cleaning

The average cleaning scores by month are as follows for the James Cook Site, The Friarage, Friary, East Cleveland and Redcar Primary Care Hospitals:

The James Cook Site													
Risk Category	**NSC Target**	**Apr 21**	**May 21**	**June 21**	**July 21**	**Aug 21**	**Sept 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 21**	**Feb 21**	**Mar 21**
Very high	**95%**	99%											
Significant	**85%**	98%											
Low	**75%**	97%											

The Friarage Hospital													
Risk Category	**NSC Target**	**Apr 21**	**May 21**	**June 21**	**July 21**	**Aug 21**	**Sept 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 21**	**Feb 21**	**Mar 21**
Very high	**95%**	99.87%											
Significant	**85%**	98.72%											
Low	**75%**	98.48%											

The Friary Hospital													
Risk Category	**NSC Target**	**Apr 21**	**May 21**	**June 21**	**July 21**	**Aug 21**	**Sept 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 21**	**Feb 21**	**Mar 21**
Very high	**98%**	100%											

East Cleveland Hospital													
Risk Category	**NSC Target**	**Apr 21**	**May 21**	**June 21**	**July 21**	**Aug 21**	**Sept 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 21**	**Feb 21**	**Mar 21**
High	**95%**	96%											
Significant	**85%**	95%											
Low	**75%**	93%											

Redcar Primary Care Hospital													
Risk Category	**NSC Target**	**Apr 21**	**May 21**	**June 21**	**July 21**	**Aug 21**	**Sept 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 21**	**Feb 21**	**Mar 21**
Very high	**95%**	99%											
High	**95%**	98.6%											
Significant	**85%**	93.8%											
Low	**75%**	98.2%											

Cleaning scores have been maintained on the sites as detailed with maintaining cleaning standards remaining an area of continued focus in conjunction with our service providers.

The frequency of cleaning standards review meetings are now monthly and continue to be led by the Director of Estates with cleaning scores monitored via IPAG.

2. OUTBREAKS

2.1 Diarrhoea and Vomiting

There were no outbreaks of diarrhoea and vomiting in April 2021.

2.2 Outbreak of GES – Carbapenemase producing, multi-drug resistant Pseudomonas Aeruginosa infection in ICU2/3, GHDU, Wards 4 and 24HDU and other areas

During April 2021, we have not identified any further patients who have the *GES*-carbapenemase-producing *Pseudomonas aeruginosa* infection.

2.3 OXA-48-Carbapenemase-producing Klebsiella Pneumoniae

Acute trusts across Teesside have seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing *Klebsiella pneumoniae* over the last 2-3 years. In April 2021 we did not identify any further cases that carried the strain which has been linked to this cluster.

2.4 Outbreak of Serratia Marcescens within the Cardiothoracic Surgical service

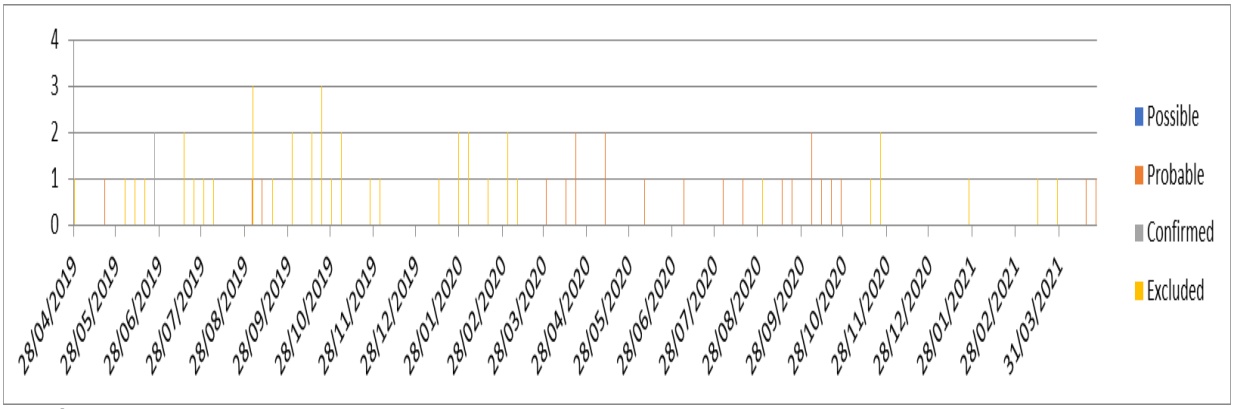
In July 2019 we found a potential cluster of gram negative bacteria had identified that 4 patients who had been treated in Cardiothoracic ICU and/or HDU had been colonised or infected with the same strain of *Serratia marcescens*.

Further investigations have determined (as of 6th April 2021) we have had a total of 5 patients who are confirmed as affected by the outbreak strain, 24 cases classed as 'probable' and 40 cases which have subsequently been found to be unlinked to each other.

The timeline of outbreak cases shown in graph 3 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. On subsequent environmental sampling the environmental strain was isolated from another clinical area. This isolate had the same strain type as one of the patients supporting our hypothesis that at least some of the patients have been infected from an environmental source.

The Cardiothoracic ICU, HDU and ward 32 underwent a deep clean and hydrogen peroxide fogging and replacement of the contaminated ICU sink in August 2019. 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).

There will be a discussion at IPAG regarding the official closure of the outbreak as all actions are now completed, however further reporting and monitoring will continue.



Graph 3

3. COVID19

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

- All inpatients being admitted with or without symptoms of COVID-19 infection are screened. Those testing negative are re-screened on days 3, 5 and every 7 days if required.

- 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 previously divided into red, amber and green zones. The red pathway had included a "previous COVID-19-suspect" ward. In April 2021 we stood down the previous COVID-19 suspect ward due to the decreased community prevalence and switched to a 2-pathway model, red (high risk of COVID-19) and blue/standard (low risk of COVID-19).

- 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.

- In early 2021 we were in a national lockdown but restrictions are currently being relaxed.

- There are concerns about new variants from Brazil, South Africa and India. The Pfizer vaccine is believed effective against all strains but the Astra-Zeneca vaccine is possibly not effective against the South African variant. There was a patient with the South African variant admitted to JCUH in January. Subsequently we have organised genotyping of several hundred positive COVID-19 swabs from the JCUH microbiology laboratory and none had the South African variant.

- We commenced widespread asymptomatic lateral flow testing for staff in late November 2020.

- Vaccination of the population has commenced and over 70,000 vaccinations have now been given at South Tees Hospitals. Almost all Trust staff have already had two vaccine doses.

- An outbreak is now classed as two or more cases of COVID-19 which occur in the same clinical or non-clinical area within a 14-day period. As an example, if two colleagues test positive for coronavirus through the Trust's testing regime within 14 days of one another, as well as providing immediate support to self-isolate our infection prevention team works with them to trace their movements. Even if that tracing shows they have not come into contact with one another inside a hospital but may have been near one another in a car park, we record and treat this in exactly the same way we would if they had been working together in an office or clinical setting.

4. AREAS OF NOTE

- Our CDI cases within the Trust continue to rise and alongside the review of the CDI review panels the IPC team are developing a robust CDR recovery plan that will align to the IPC Annual Plan.

- As identified above there have been increased cases of Pseudomonas aeruginosa in CICU. The CICU team attended the last IPAG to share learning around this and continued support is being offered to the Matron, Manager and staff around this.

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 1 June 2021			
Month 1 2021/22 Financial Performance			**Agenda Item 11 ENC 9**
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 Trusts financial performance as at Month 1.		
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 with a fixed funding envelope. The Trusts requirement for H1 2021/22 is to deliver a £3.0m deficit.		
Assessment	At Month 1 the Trust reported a deficit of £1.0m at a control total level. This is in line with the required budget deficit for M1 as agreed within the ICP/ICS.		
Recommendation	Members of the Trust Board are asked to note the report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 4.1 - Lack of robust financial information and grip and control may result in poor financial governance and decision making lead to the inability to deliver the annual control total impacting on cash flow and long term sustainability as a going concern		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐	
	Drive operational performance ☒	Long term financial sustainability ☒	
	Develop clinical and commercial strategies ☒		

Month 1 2021/22 Financial Performance

1. PURPOSE OF REPORT

The purpose of the report is to update the Board on the financial position of the Trust as at Month 1.

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 have been normalised by adjusting budgets for both the additional income received and expenditure incurred.

Within both the actual and budget position any variance from both cost and income is removed in order to better show the true underlying position of the Trust. Income to cover these costs are shown on the PSF, MRET and Top up line in the I and E.

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 1 YTD actual performance is a £1.0m 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 1 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	Adjustment £'000	Revised YTD Variance £'000
Nhs Clinical Income	55,557	55,381	(177)	**(177)**	**0**
Other Income	4,074	4,758	684	**587**	**97**
Pay	(35,443)	(36,083)	(641)	**(265)**	**(376)**
Non Pay	(21,938)	(21,760)	178	**(145)**	**323**
Depreciation And Interest	(2,721)	(2,735)	(14)		**(14)**
Other Non Operating	(608)	(600)	09		**09**
Corporation Tax	(0)	0	0		**0**
Control Total	**(1,079)**	**(1,039)**	**40**	**0**	**40**

Overall the Trust is on plan for month 1 of 2021/22.

- Adjustments are shown to normalise high cost drugs and devices along with claimed income to cover vaccinations, swabbing and student nurses.
- For clinical income the Trust is under achieving by £0.2m, linked to lower income for pass through items of drugs and devices, with corresponding reductions in non-pay expenditure. The adjusted variance is nil.
- The £0.6m overspend on pay has been driven by premium pay costs within medical and dental staffing, largely within Diabetes, Respiratory and Radiotherapy and Oncology and by additional costs for vaccinations, swabbing and student nurses. Once the impact of additional claimable costs are adjusted the resulting variance is £0.4m
- Non pay is underspent by £0.2m for Month 1, with this underspend driven by both lower clinical supplies and services costs and drugs costs linked to lower levels of activity, compared to pre Covid-19 levels. An additional variance of £0.1m is shown for pass through items, once removed the resulting variance is a £0.3m underspend.

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

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

Commissioner Code	Commissioner Name	Block Payment
16C	NHS Tees Valley CCG	29,349
84H	NHS County Durham CCG	1,176
00P	NHS Sunderland CCG	61
01H	NHS North Cumbria CCG	55
85J	NHS England - North East and Yorkshire Commissioning Hub	16,010
13Q	NHS England - Central (CDF & HepC)	472
Y63	NHS England - North East and Yorkshire Commissioning Region	609
Y58	South West Regional Office (MoD)	145
42D	NHS North Yorkshire CCG	7,382
03Q	NHS Vale of York CCG	122
	Prior Year Adjustments	0
	Total Income Month 1	**55,381**

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	49,612	49,612	0
Top Up	2,488	2,488	0
Covid-19	2,251	2,251	0
Lost non NHS Income	210	210	0
CDF	557	467	(90)
HEPC	64	03	(61)
High Cost Devices	375	349	(26)
YTD M1	**55,557**	**55,380**	**(177)**

Variances shown on CDF, HEPC and high cost devises income are counteracted by lower costs within expenditure.

At Month 1 the Trust hasn't recognised any additional income in relation to the elective recovery fund, under which the ICS will receive additional income if key activity trajectories are achieved at a system level. Work is ongoing within the Trust and wider ICP/ ICS to plan activity recovery trajectories and to understand the achievement of gateway points for the recognition of income, along with how income received at an ICS level will be distributed between Trusts.

The position will be closely monitored by the Trust to ensure that any premium costs associated with delivering additional activity are met by additional ERF income.

Other Income

Other income is £0.1m ahead of plan at month 1.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Budget to M6 £'000
Education & Training Income	1,509	1,538	**29**	**9,053**
Estates Income	184	201	**17**	**1,102**
Misc. Other Income	1,085	899	**(186)**	**6,246**
Non Patient Care Income	223	239	**16**	**1,199**
Other Clinical Income	248	163	**(85)**	**1,487**
Psf, Mret & Top Up	587	587	**(0)**	**587**
Research & Development Income	826	1,132	**306**	**2,453**
Total	**4,661**	**4,758**	**97**	**22,128**

- Misc other income is under achieving by £0.2m. Pathology income is £0.1m less than plan, driven by lower testing income with corresponding lower expenditure within non pay. The remainder of the variance relates to planned income expected from Tees Valley CCG for the Stoma service. Discussions are ongoing with Tees Valley CCG in order to receive this income via variation to the Trust core blocks.
- Other clinical income is underachieving by £0.1m, relating to planned income for overseas visitors and private patients. Income is below plan in month, reflecting the ongoing impact of Covid on activity levels. This will be closely monitored over the next few months to ensure the assumed return of income in this category following Covid-19 is achievable.
- R and D income is over achieving by £0.3m linked to additional research funds for increased costs within pay and non-pay. The R and D budget is currently being rebased to reflect the latest assumptions for research activity.
- Within the top up income line the Trust has accrued income of £0.6m to cover the costs of both the vaccinations and swabbing programmes in month along with additional student nurses cost. This is included in addition to the core blocks and claims are subject to validation by NHSE/I; receipt of income is expected in July 2022.

Pay

In the year to date position pay is overspent by £0.4m, as outlined in the below table.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Budget to M6 £'000
Ahp'S, Sci., Ther. & Tech.	(5,058)	(5,138)	**(81)**	**(30,294)**
Hca'S & Support Staff	(4,092)	(4,052)	**40**	**(22,942)**
Medical And Dental	(10,466)	(10,893)	**(427)**	**(62,497)**
Nhs Infrastructure Support	(5,029)	(5,069)	**(40)**	**(29,652)**
Nursing & Midwife Staff	(10,935)	(10,802)	**133**	**(64,976)**
Other Pay Costs	(127)	(128)	**(01)**	**(760)**
Total	**(35,708)**	**(36,083)**	**(376)**	**(211,121)**

- Within the pay position a budget for additional Covid costs of £1.2m is included, notionally split between Medical and Dental, HCA's and Nursing Staff. The provisional allocation of this budget will be updated in Month 2 to reflect the latest agreed additional Covid-19 pressures, including additional pathology costs within the AHP pay category.
- Medical and Dental staff show a year to date overspend of £0.4m. Junior staffing is overspent by £0.1m and £0.3m for senior medical staffing, with both elements driven by premium pay of agency and bank costs. Key areas of premium agency spend relate to Diabetes, Respiratory and Radiotherapy and Oncology to cover current vacancies.
- The work to recalculate the junior doctor's budget is now complete with funding for the expected budget pressure currently held corporately and reflected in the above position. Rota calculations are undergoing verification with individual service areas, with the funding to be allocated to individual directorate budgets from Month 2.

Non-Pay

Non-pay is underspent by £0.5m at Month 1, as outlined in the table below.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Budget to M6 £'000
Clinical Negligence Cost	(1,520)	(1,520)	**(0)**	**(9,120)**
Clinical Supplies And Services	(6,908)	(6,366)	**541**	**(39,230)**
Drugs	(6,033)	(5,951)	**82**	**(35,820)**
Establishment	(682)	(688)	**(07)**	**(4,090)**
Ext. Staffing & Consultancy	(29)	(43)	**(14)**	**(176)**
General Supplies & Service	(349)	(229)	**120**	**(2,072)**
Healthcare Service Purchase	(913)	(956)	**(43)**	**(5,479)**
Miscellaneous Services	(92)	(173)	**(81)**	**(554)**
Pfi Unitary Payment	(2,483)	(2,506)	**(23)**	**(14,766)**
Premises & Fixed Plant	(2,175)	(2,169)	**05**	**(12,126)**
Research, Education & Training	(726)	(887)	**(162)**	**(1,855)**
Transport	(352)	(272)	**80**	**(2,110)**
Total	**(22,260)**	**(21,760)**	**500**	**(127,398)**

- Clinical supplies and services are showing a year to date underspend of £0.5m. Underspends are apparent in a number of clinical directorates, due to reductions in activity levels compared to pre Covid-19 levels. This underspend is expected to reduce as activity trajectories increase during 2021/22.
- Drugs have a YTD underspend of £0.1m, driven by lower costs for both Cancer Drug fund and HEPC.
- General supplies and services has a year to date underspend of £0.1m due to a credit note being received for PPE items relating to 2020/21.
- Research, Education and Training is overspending by £0.1m due to clinical trials, with this cost covered by additional income.

Non-Operating Costs

Technical items are in line with budgeted amounts, with both Deprecation and PDC in line with the rebased budget for 2021/22.

CIP

For the first 6 months of the year the Trust has a £5.0m CIP target. The outline programme is shown in the below table, with work ongoing to finalise delivery arrangements, as part of the Trust's financial recovery planning.

CIP Scheme	YTD M1	YTD M6
Corporate	244	2,430
Procurement	42	740
Pharmacy	18	485
Clinical	25	275
Estates	58	450
ICT	14	81
Workforce	83	540
Totals	**483**	**5,000**

Capital

The Trust's capital expenditure at the end of April amounted to £1.1m as detailed below:

	YTD Actual £'000	Full Year Forecast £'000
PFI Lifecycle	782	10,380
Site Reconfiguration	127	17,114
Replacement of Medical Equipment	170	2,181
Network Replacement and Clinical Noting	32	3,750
Total	**1,111**	**33,425**

	YTD Actual £'000	Full Year Forecast £'000
Financing		
Depreciation	1,111	11,733
Internal Reserves	0	0
Charitable Funding	0	0
PDC	0	21,692
Total Financing	**1,111**	**33,425**

The annual 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) 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.

The Trust submitted the Annual Pan for 2021/22 to NHSE/I on 12 April amounting to £33.4m and will look to utilise PDC funding amounting to £21.7m to support this programme.

Liquidity

The Trust carried over a cash balance amounting to £57.4m at 31 March 2021. The following table outlines the actual position at the end of each month and the monthly forecast going forward.

The Trust's cash position at the end of April amounted to £70.1m and it is anticipated that this position will be maintained for the end May, prior to the payment of the first quarterly PFI payment in June. This year end cash balance is forecast to be £15m.

The Better Payment Practice Code (BPPC) performance for the Trust (target 95%) equated to 95.8% on invoices paid in the month of April.

Statement of Financial Position (SOFP)

The following table compares the SOFP position between 31 March and 30 April:

	31 March £000	30 April £000	Movement between months £000
Property, Plant and Equipment	244,904	243,535	(1,369)
Long Term Receivables	1,766	1,766	0
Total Non-Current Assets	246,670	245,301	(1,369)
Currents Assets			
Inventories	13,054	13,445	391
Trade and other receivables (invoices outstanding)	5,774	5,309	(465)
Trade and other receivables (accruals)	13,990	14,619	629
Prepayments including PFI	23,809	17,055	(6,754)
Cash	58,402	70,105	11,703
Total Current Assets	115,029	120,533	5,504
Current and Non-Current Liabilities			
Borrowings	(93,060)	(92,744)	316
Trade and other payables	(89,937)	(95,528)	(5,591)
Provisions	(1,602)	(1,632)	(30)
Total Current and Non-Current Liabilities	(184,599)	(189,904)	(5,305)
Net Assets	**177,100**	**175,930**	**(1,170)**
Equity:			
Income and Expenditure Reserve	(230,641)	(231,811)	(1,170)
Revaluation Reserve	33,643	33,643	0
Public Dividend Capital	347,622	347,622	0
Other Reserves	26,476	26,476	0
Total Equity	**177,100**	**175,930**	**(1,170)**

The major points of note on changes between March and April are:

- Property, Plant and Equipment – movement in month of £1.4m arising from depreciation, partly offset by spend on PFI lifecycle and emergency replacements.
- Prepayments – reduction for one month of the quarterly contractual PFI charge paid in advance in March. The next quarterly PFI payment is due in June 2021.
- Cash – increase in liquidity based on ongoing funding arrangements in preparation for the first quarterly PFI payment
- Payables – change of £5.6m arising from treatment of income in advance mainly relating to Heath Education England 2021/22 quarter 1 Learning Development Agreement (LDA) income (£3.1m) for May and June.
- Income and Expenditure Reserve – movement relates to the deficit on the revenue position delivered in April.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1st June 2021			
Integrated Performance Report			**AGENDA ITEM: 12, ENC 10**
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	A new format for the IPR was introduced in September 2020 with further improvements added in the following months. The following changes have been implemented in April's IPR: • Benchmark data against other Trusts. • Implementation of recalculating the control limits within charts where special cause variation has been detected. . Key messages relating to performance this month include: The Trust has continued its COVID-19 response during April alongside maintaining emergency, urgent and other non-COVID-related care. Treating over 4,000 patients with COVID-19 during the pandemic to-date has inevitably had an impact. Clinical teams are now focused on addressing the needs of anybody whose non-urgent care has been disrupted by the pandemic.		

	Areas of improved or sustained performance include: • Complaints closed within target. • Compliance with Friends and Family Experience rates for, A&E, Outpatients and Maternity. • 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.	
Recommendation	The Board of Directors are asked to: • Receive the Integrated Performance Report for April 2021. • Note the performance standards that are being achieved and the remedial actions being taken where metrics are outside expected parameters.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 1.5 - Risk to Trusts ability to delivery strategic objectives due to diversion of resources of all types required to manage the Covid 19 pandemic. BAF risk 3.1 - A sustained, exceptional level of demand for services that overwhelms capacity resulting in a prolonged, widespread reduction in the quality of patient care and repeated failure to achieve constitutional standards, with possible harm to patients BAF risk 3.2 - Risk of ability to deliver the national access target of 92% for 18 weeks RTT and achievement of the March 19 WTL by March 2020 due to gaps in workforce (T&O, Spinal, General Surgery, Plastics and Urology), increasing demand (ophthalmology, Gastroenterology), transfer of activity from CCDFT, reduction in weekend working and premium pay . BAF risk 3.3 - Risk of ability to deliver the national access target of 85% for 62 Day Cancer Standard	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐
	Drive operational performance ☐	Long term financial sustainability ☐

	Develop clinical and commercial strategies ☐	

South Tees Hospitals
NHS Foundation Trust

Integrated Performance Report

April 2021

New Additions to IPR for April

South Tees Hospitals
NHS Foundation Trust

The following changes have been implemented in April's IPR:

- Benchmark data against other Trusts.
- Implementation of recalculating the control limits within charts where special cause variation has been detected.

Key Messages

South Tees Hospitals
NHS Foundation Trust

Our key messages are:

The Trust has continued its COVID-19 response during April alongside maintaining emergency, urgent and other non-COVID-related care. Treating over 4,000 patients with COVID-19 during the pandemic to-date has inevitably had an impact. Clinical teams are now focused on addressing the needs of anybody whose non-urgent care has been disrupted by the pandemic.

Areas of improved or sustained performance include:

- Complaints closed within target.
- Compliance with Friends and Family Experience rates for, A&E, Outpatients and Maternity.
- 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.

Summary

South Tees Hospitals NHS Foundation Trust

	Indicator	Latest Month	Target/ Benchmark	Month Reported	Trend	Assurance
SAFE	All Falls Rate	5.29	6.6	04/2021		
	Falls With Harm Rate	0.04	TBD	04/2021		
	Infection Control - C-Difficile (YTD)	11	81	04/2021	N/A	N/A
	Infection Control - MRSA (YTD)	0	0	04/2021	N/A	N/A
	Serious Incidents	6	0	04/2021		
	Never Events (YTD)	0	0	04/2021	N/A	N/A
	Category 2 Pressure Ulcers	4.81	TBD	04/2021	H	
	Category 3 & 4 Pressure Ulcers	0.72	TBD	04/2021		
	SHMI	121.58	100	01/2021		
	Hospital Standard Mortality Rate (HSMR)	101.67	100	02/2021		
	VTE Assessment	86.55%	95%	04/2021	L	F
	Maternity - Caesarean Section Rate (%)	31.47%	30.0%	04/2021		
	Maternity - Induction of Labour Rate (%)	45.59%	44.0%	04/2021		
	Maternity - Still Births (YTD)	5	17	04/2021	N/A	N/A
	Maternity - PPH 1500ml Rate (%)	2.06%	0.00%	04/2021		

	Indicator	Latest Month	Target/ Benchmark	Month Reported	Trend	Assurance
EFFECTIVE	Sepsis - Targeted oxygen delivered within 1 hour	93.90%	95%	03/2021		
	Sepsis - Blood cultures taken within 1 hour	78.80%	95%	03/2021		
	Sepsis - Empiric IV antibiotics administered	60.60%	95%	03/2021		F
	Sepsis - Serum lactate taken within 1 hour	90.90%	95%	03/2021		F
	Sepsis - IV fluid resuscitation initiated	66.70%	95%	03/2021		F
	Sepsis - Urine measurement started	72.70%	95%	03/2021		F
CARING	F&F A&E Overall Experience Rate (%)	85.97%	85%	04/2021		
	F&F Inpatient Overall Experience Rate (%)	95.77%	96%	04/2021		
	F&F Outpatient Overall Experience Rate (%)	97.56%	95%	04/2021		
	F&F Maternity Overall Experience Rate (%)	100.00%	97%	04/2021		
	Complaints Closed Within Target (%)	88.89%	80%	04/2021		

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 (%)	86.40%	95%	04/2021	L	F
	RTT Incomplete Pathways (%)	61.14%	92%	04/2021	L	F
	Diagnostic 6 Weeks Standard (%)	82.65%	99%	04/2021		F
	Cancer Treatment - 14 Day Standard (%)	91.84%	93%	04/2021		?
	Cancer Treatment - 31 Day Standard (%)	92.30%	96%	04/2021		?
	Cancer Treatment - 62 Day Standard (%)	79.66%	85%	04/2021		?
	Non-Urgent Ops Cancelled on Day	27	0	04/2021	L	F
	Cancer Operations Cancelled On Day (YTD)	0	0	04/2021	N/A	N/A
	Cancelled Ops Not Rebooked Within 28 days	10	0	04/2021		F
	E-Discharge (%)	94.1%	90%	04/2021		P

	Indicator	Latest Month	Target	Month Reported	Trend	Assurance
WELL LED	Year-To-Date Budget Variance (£'millions)	0.40	0	04/2021	N/A	N/A
	Annual Appraisal (%)	64.93%	80%	04/2021	L	F
	Mandatory Training (%)	84.32%	90%	04/2021	L	?
	Sickness Absence (%)	4.18%	4%	04/2021		?
	Staff Turnover (%)	11.55%	10%	03/2021	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

Activity Summary

South Tees Hospitals NHS Foundation Trust

Context: Performance from August 2020/21 vs 2019/20

Point of Delivery	Activity as % of 2019/20							as % of 2019	
	Aug-20 (Actual)	Sep-20 (Actual)	Oct-20 (Actual)	Nov-20 (Actual)	Dec-20 (Actual)	Jan-21 (Actual)	Feb-21 (Actual)	Mar-21 (Actual)	Apr-21 (Actual)
Outpatients First Attendances	72%	82%	77%	85%	89%	78%	81%	94%	86%
Outpatient Follow Up Attendances	76%	89%	81%	88%	93%	79%	87%	99%	90%
Elective Day Case	71%	90%	86%	85%	86%	63%	69%	79%	82%
Elective Inpatient	66%	77%	80%	68%	82%	56%	46%	42%	61%
Diagnostics	79%	101%	98%	95%	99%	88%	92%	102%	102%

Point of Delivery	Aug-20 (Actual)	Sep-20 (Actual)	Oct-20 (Actual)	Nov-20 (Actual)	Dec-20 (Actual)	Jan-21 (Actual)	Feb-21 (Actual)	Mar-21 (Actual)	Apr-21 (Actual)
Accident and Emergency	91%	87%	79%	71%	72%	69%	72%	87%	99%
Non elective: zero length of stay	89%	83%	73%	66%	67%	67%	76%	96%	96%
Non elective: 1+ night length of stay	83%	89%	83%	81%	77%	78%	85%	82%	90%

Recovery: Elective & Theatres

SUMMARY ELECTIVE ACTIVITY vs 2019

April activity: Provisional numbers as at 9/5/2021

Elective activity	2019	2020	2021	2021 as % of 2019
Same day	5,809	1,916	4,615	79%
Overnight	1,037	229	616	59%
Sub-total inpatient	**6,846**	**2,145**	**5,231**	**76%**
New	17,697	5,736	15,000	85%
Review	48,556	20,299	43,378	89%
Sub-total outpatient	**66,253**	**26,035**	**58,378**	**88%**
Total Elective	**73,099**	**28,180**	**63,609**	**87%**
			NHS Plan expectation *	70%

* The plan target is by tariff value. Compared to activity this will be weighted towards inpatients

April elective theatre cases: all theatres (included in activity above)

Same day	2,088	366	1,145	55%
Overnight	852	172	494	58%
Total	**2,940**	**538**	**1,639**	**56%**

Summary

- After peaking in Autumn (highest absolute month shown in red) activity fell in all areas during the January / February wave.
- From March onwards activity has started to increase and the April elective activity is above the 70% expectation by value.
- Non-elective activity increased as Covid-19 reduced meaning that overall pressure on services was maintained during March and April.

Cause of Variation

- Reduced capacity in some services due to some workforce still being re-deployed.
- Increased numbers of high clinical priority complex cases on the PTL is leading to a richer case-mix than previous years.
- Activity transferred to IS.

Planned Actions

- Final revisions to Specialty's activity and capacity plans following review and challenge with COO and Planning team.
- Continue with planned opening of capacity.
- Assessment of impact of plans on PTL positions and support to challenged services.
- Ongoing monitoring of plans through Recovery.

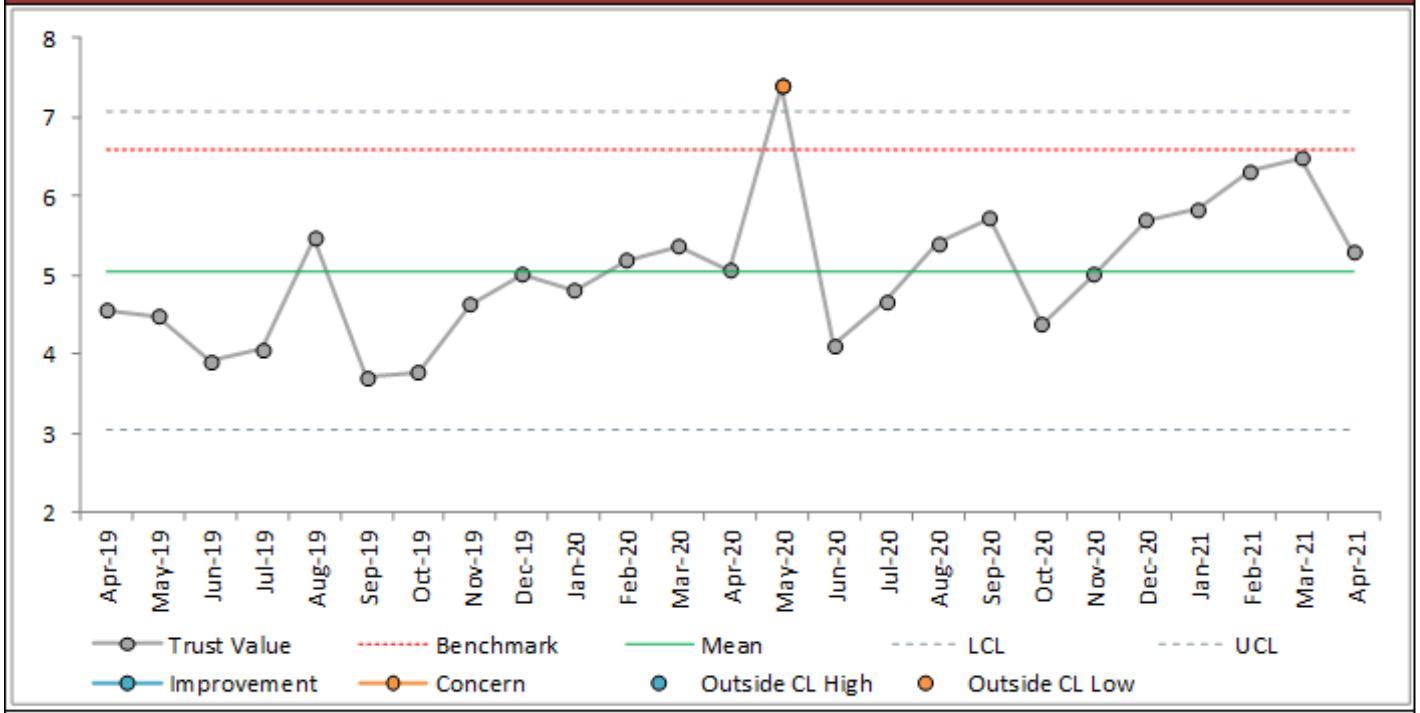
Timescale

- Final submission in early June.

Safe

South Tees Hospitals NHS Foundation Trust

All Falls Rate



The Trust falls rate per 1000 bed days

Benchmark	6.6
Mean	5.05
Last Month	5.29

Executive Lead

Hilary Lloyd

Lead

Helen Day

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.

TVCCG commenced regional scoping work for consistency of reporting, assessment and prevention.

Cause of Variation

- This metric is within normal variation, except for a special cause in May 2020, which may be related to a reduction in the number of bed days.
- Potential correlation between changes in ward functionality and increase in falls during Covid-19.

Planned Actions

- Review multi disciplinary resource to enable Trust wide action group and update and launch the Falls Prevention action plan 2021/22 aligned with the ethos 'every contact counts '

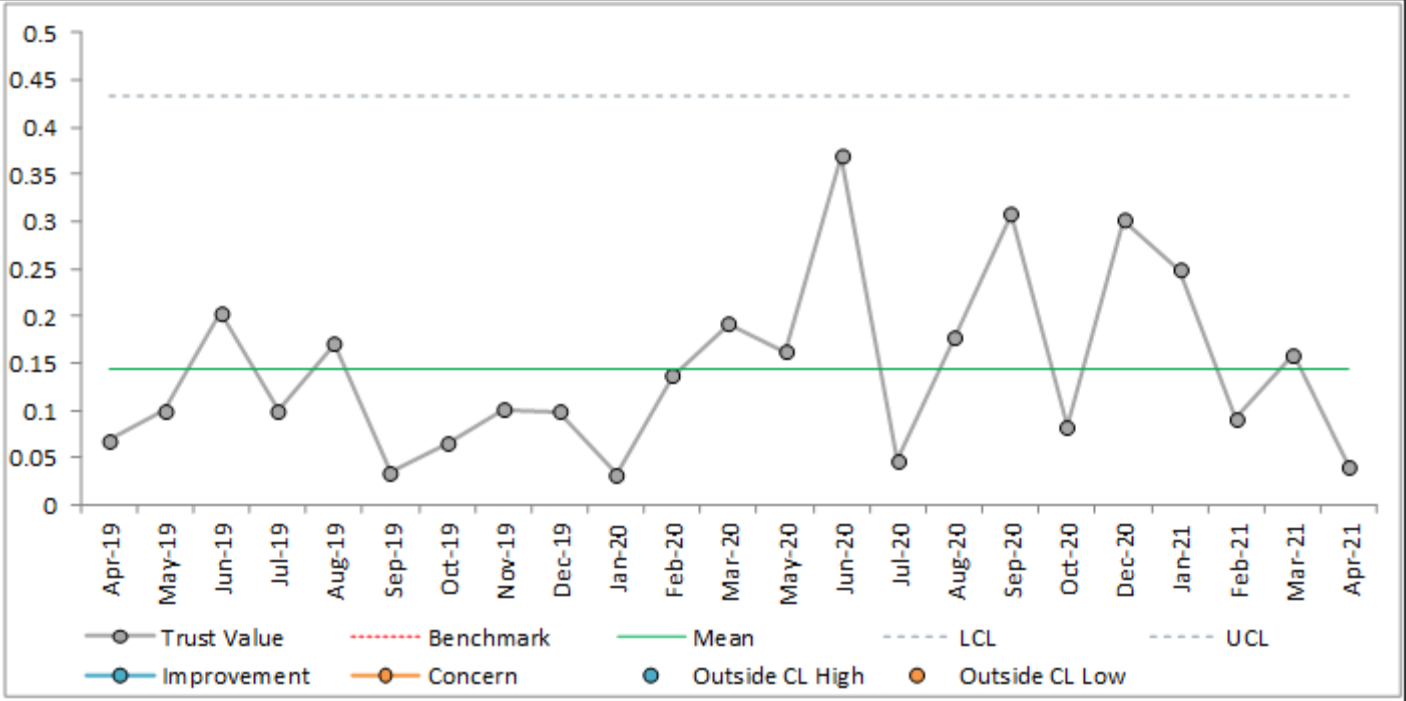
Timescale

- July 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	0.14
Last Month	0.04

Executive Lead

Hilary Lloyd

Lead

Helen Day

Commentary

There are less than 2 falls with harm per month.

Cause of Variation

- This metric is within normal variation .

Planned actions

- Review multi-disciplinary resource to enable Trust wide action group and update and launch the Falls Prevention action plan 2021/22 aligned with the ethos 'every contact counts '

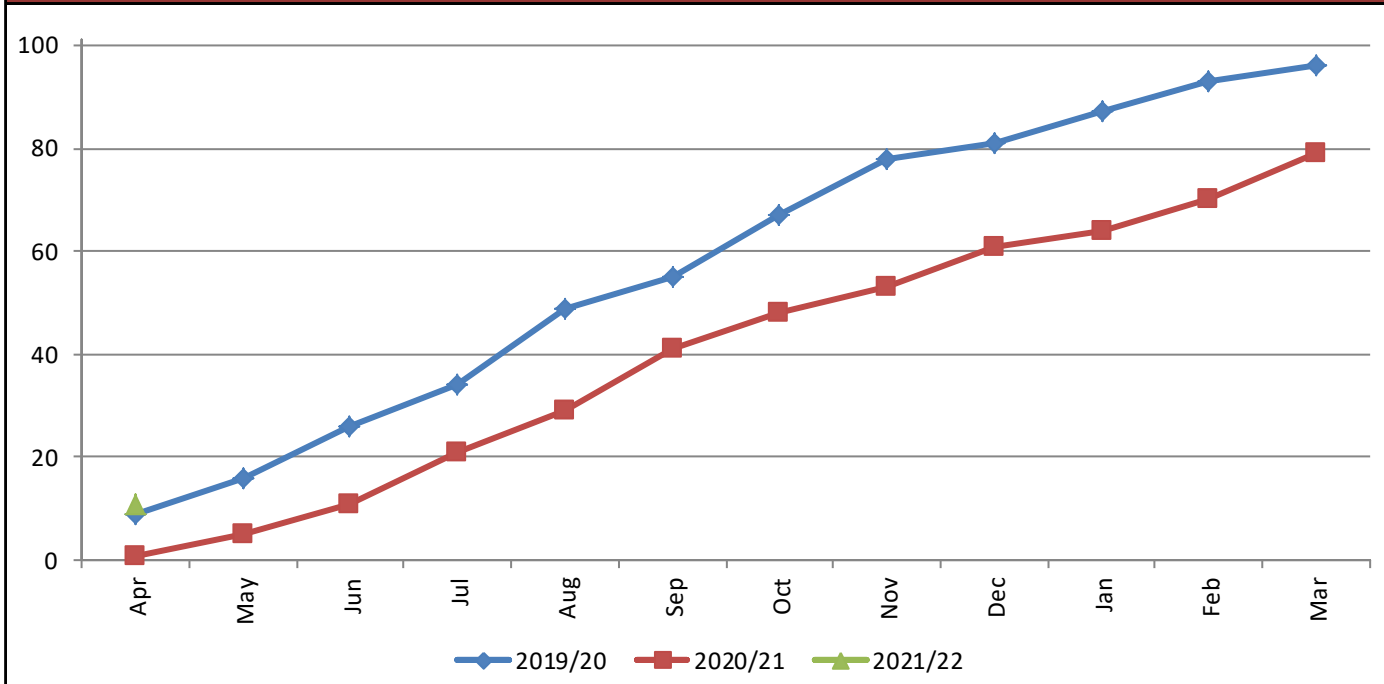
Timescale

- July 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	81
Mean	N/A
YTD	11

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 11 cases of CDI in April 2021, 2 of which were classed as COHA and 7 HOHA, totalling 9 cases as Trust Apportioned

Plan

- Review of ALL 10 March CDI cases with findings to IPAG reported
- Review of current RCA process for CDI with both CCGs, initial agreement of proposal at IPAG with implementation in April – this has commenced with positive feedback
- Reporting and learning to be enhanced in IPAG with new meeting structure - Agreed May 2021
- Development of electronic system for side room allocation to facilitate prompt isolation – ongoing support from BIU
- Reinstate IPC Matron Huddle as combined currently with weekly matron/ward manger huddles from April 2021 with clear focus
- Review of IPC input to Collaborative meetings at Board etc.
- Annual plan focus around CDI with a clear recover plan to present at IPAG

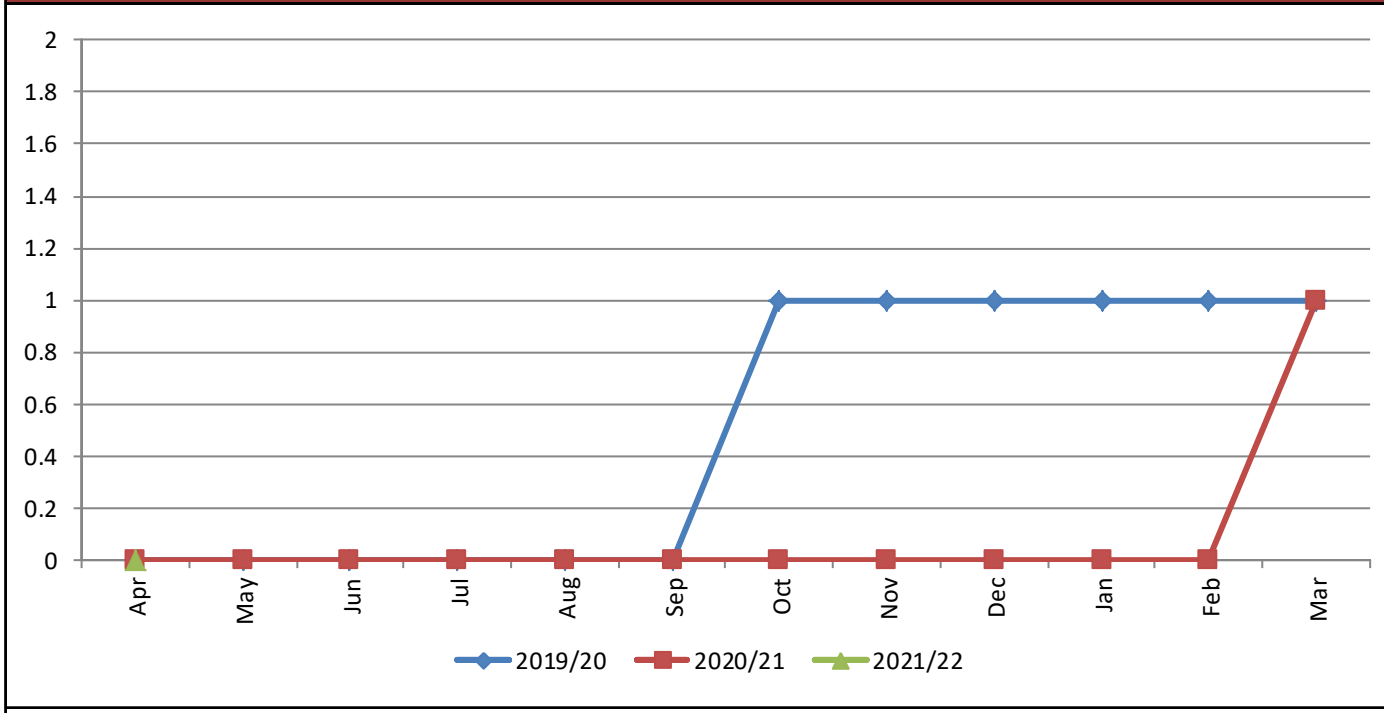
Timescale

- 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	0

Executive Lead

Hilary Lloyd

Lead

Sharon Lance

Commentary

There has been no cases identified in April 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 one case of MRSA Bacteraemia in April 2021, which is classed as non-trust assigned.

Planned Actions

- Aseptic non touch technique training and audit programs for indwelling device insertion and care remain in place and continue.
- Dedicated IPCN input for OPAT and line care support to commence from April 2021 as part of collaborative work
- Review of 'hot spot' areas for focussed work with matron alignment
- Align action areas and education plan in relation to bacteraemia management into 2021/22 IPC Annual Plan.
- Review of current MRSA/MSSA RCA/Lessons learned process to follow recent CDI review to follow same format from May 2021

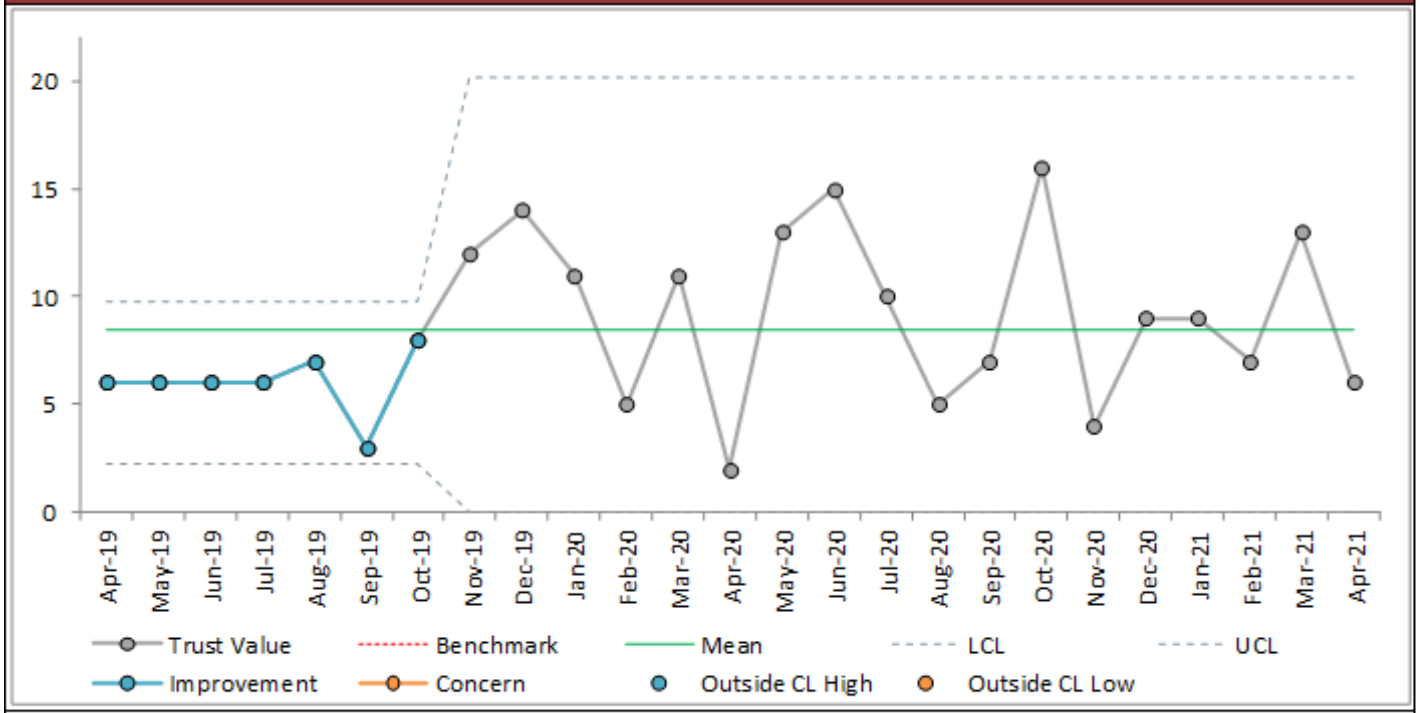
Timescale

- Ongoing.

Safe

South Tees Hospitals NHS Foundation Trust

Serious Incidents



The number of Serious Incidents

Benchmark	0
Mean	8.44
Last Month	6.00

Executive Lead

Hilary Lloyd

Lead

Kay Davies

Commentary

In April 2021, 67% were reported in the month that they occur. (4 out of 6).

Cause of Variation

- This metric is within normal variation from November 2019 .
- Establishing the facts and the incident not coming to light until the Trust received a complaint were the causes of late reporting

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. Add data to monthly SI report.
•Await the publication of the new Patient Safety Incident Response Framework.
•Training needs analysis to be carried out.
•Establish a learning culture through the Leadership and Safety Academy.

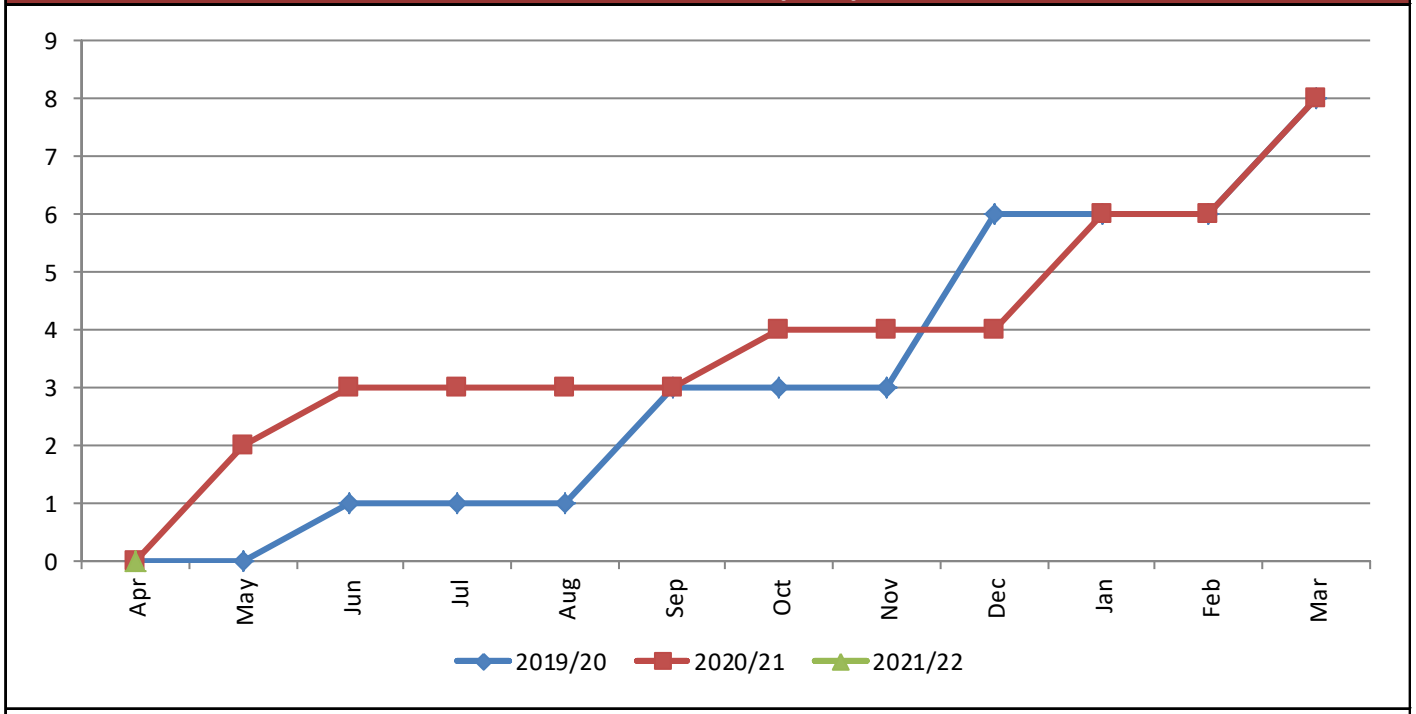
Timescale

- Ongoing

Safe

South Tees Hospitals NHS Foundation Trust

Never Events (YTD)



Number of reported Never Events

Target	0
Mean	N/A
YTD	0

Executive Lead

Hilary Lloyd

Lead

Kay Davies

Commentary

Eliminating never events remains a priority. There were 0 Never Events in April.

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 safer surgery oversight group has been established.
- A three month project to fully coordinate and establish the LocSSIP process has concluded and an audit programme commences in May 2021.
- Regional data released and local action plan developed and presented to the Quality Assurance Committee in November 2020 and updated in January 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 through the Leadership and Safety Academy
- Critical friend review by NHSE/I is underway with interviews of key staff being undertaken.

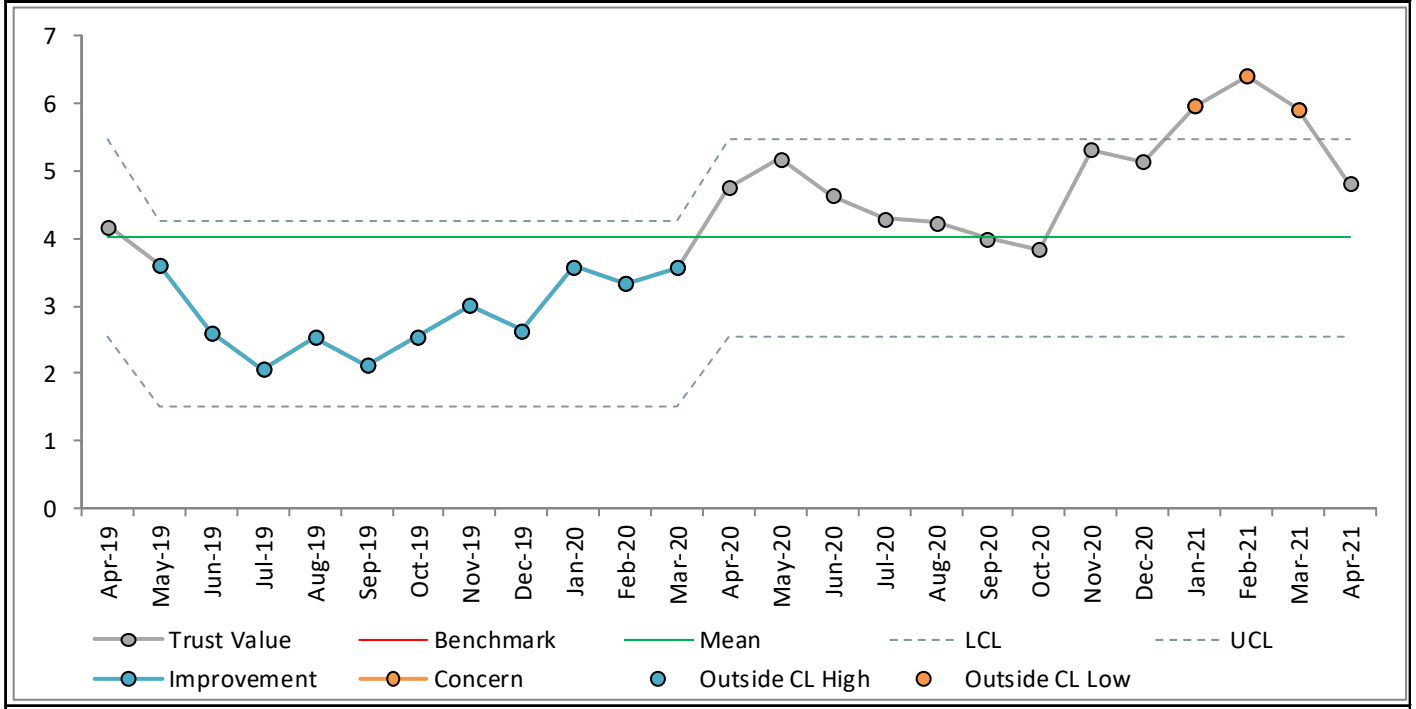
Timescale

- Eliminating Never Events remains a quality priority for 2020/21.
- The report from the critical friend review is due end of May 2021.

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	4.01
Last Month	4.81

Executive Lead

Hilary Lloyd

Lead

Helen Day

Commentary

- In April we observed 70 Cat 2 in the acute setting (88 in March)
- In April we observed 51 Cat 2 in the community setting (69 in March)

Cause of Variation

- This metric has returned to normal variation after a 3 month period outside.
- The majority of the increase in Q4 20/21 was observed in the general and cardiothoracic critical care areas and was Covid related.

Planned Actions

- Update and launch the Tissue Viability action plan 2021/22 to enable continuous improvement. Examples of specific work includes;
- Trust wide Pressure Ulcer Collaborative (PUC)
- New risk assessment tool (Purpose T) to be trialled from April 2021 in the community setting.
- Peer conversations with subject matter experts.

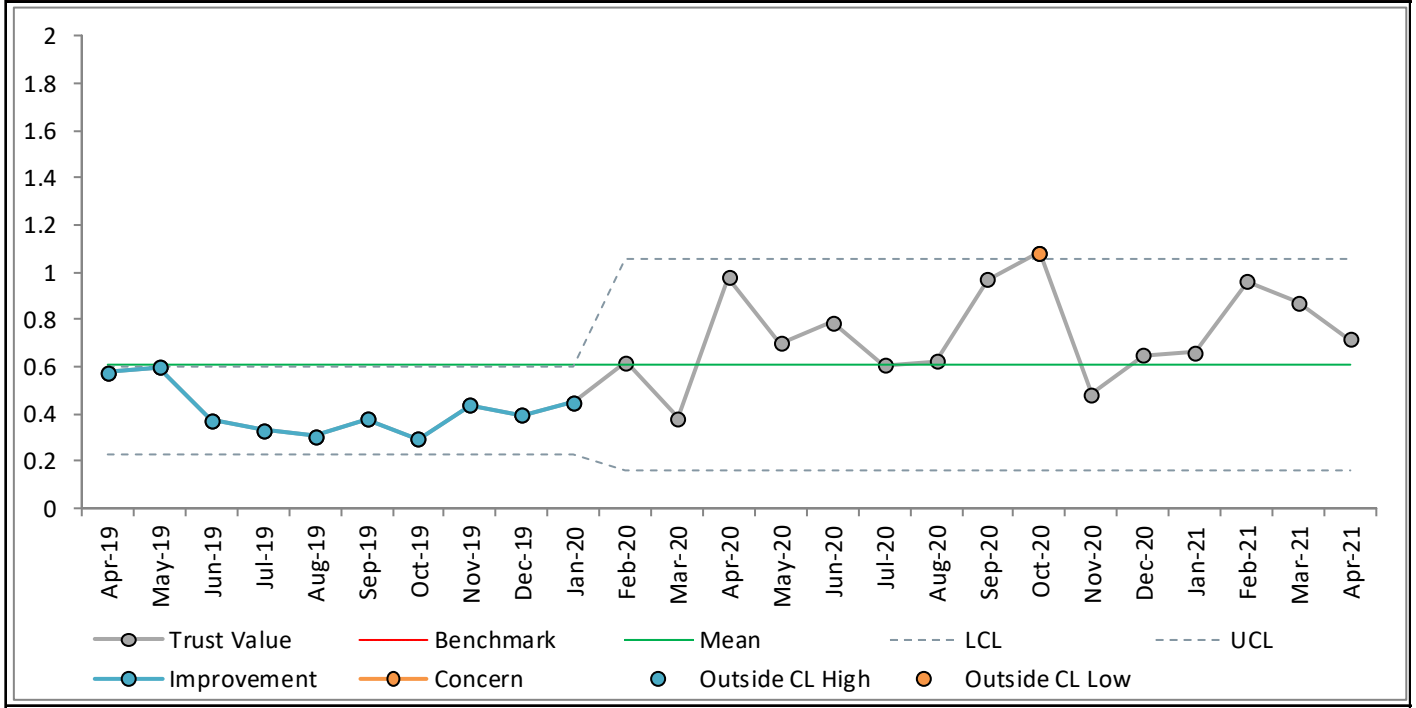
Timescale

- 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	0.61
Last Month	0.72

Executive Lead

Hilary Lloyd

Lead

Helen Day

Commentary

- In April there were 19 Cat 3 PUs with 3 meeting SI reporting criteria
- 12/19 were observed in the Community setting with no SIs
- 7/19 were observed in the acute setting

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.
- Report to Quality Assurance Committee.
- Commenced 'structured review' learning conversation replacing RCA and panel process.

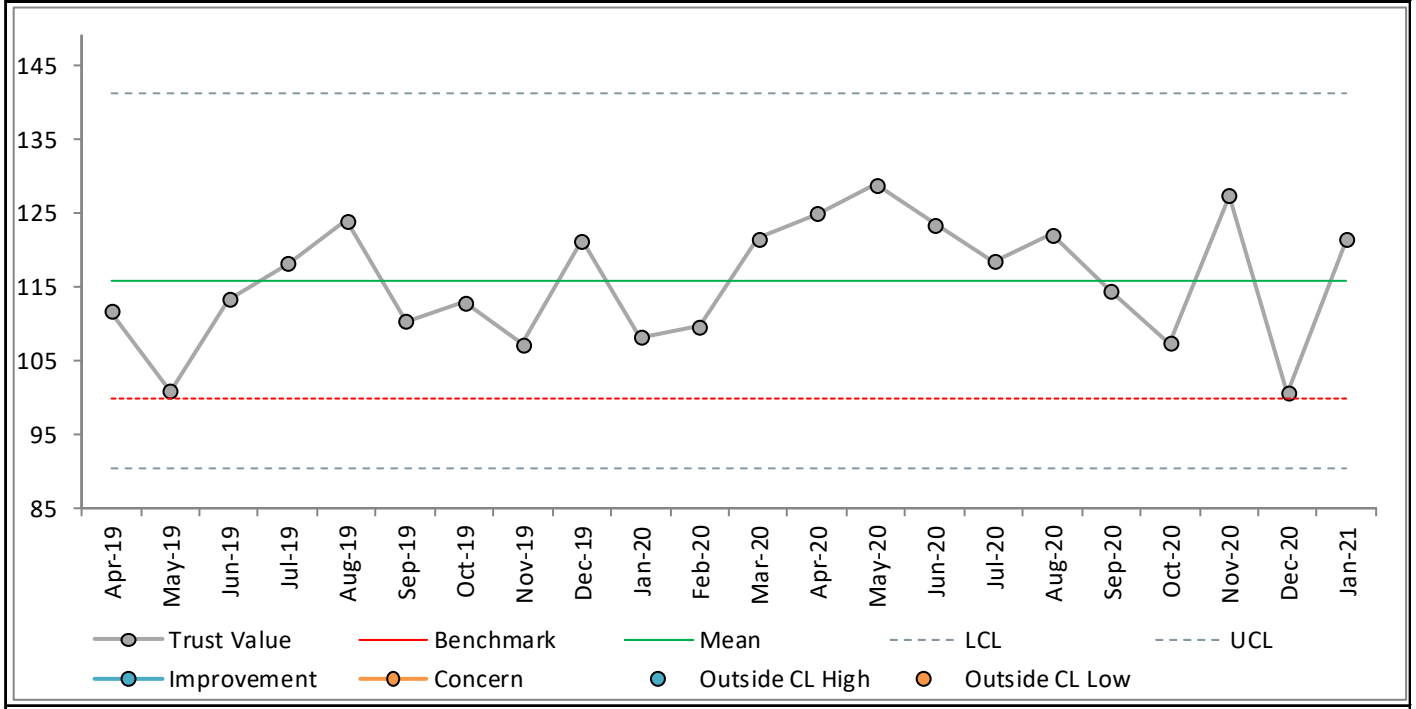
Timescale

- 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	115.85
Last Month	121.58

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 Jan 2020 to Dec 2020 is outlying (officially 115, the same as the last release). Pneumonia and septicemia mortality is high.
- SHMI is impacted by COVID-19 as spells are removed and the fall in discharges of other patients is substantial.

Planned Actions

- The trust is gradually falling behind national averages for capture of comorbidities.
- 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.

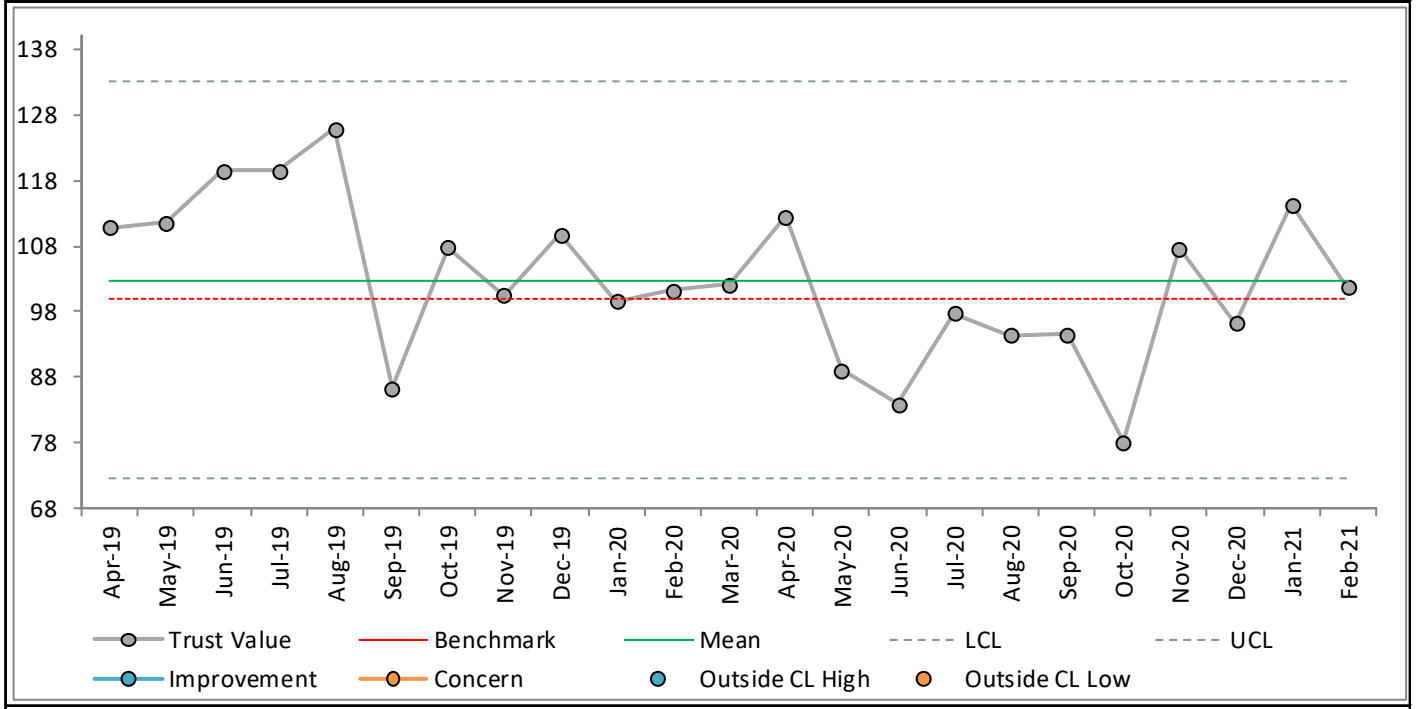
Timescale

- Coding work on-going. Quarterly review of the impact of COVID-19 on SHMI needed throughout 2021/2022.
- HED report delivered Jan 2021.

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	102.82
Last Month	101.67

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.

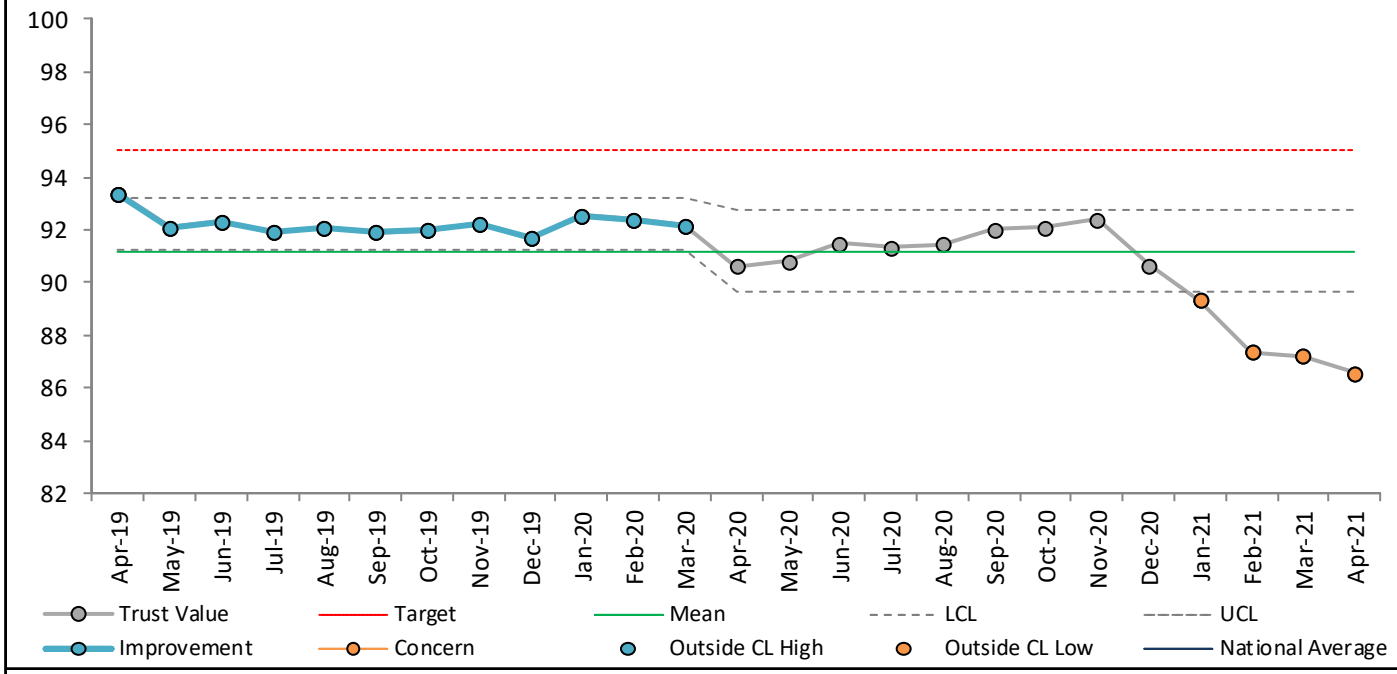
Timescale

- On-going. Comparison of SHMI and HSMR will be important, given the discrepancy between them.

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	91.21
Last Month	86.55

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 4 points (Jan, Feb, Mar, April) display the impact of changing the recording method and incomplete data.
- There are delays with recording and completing investigations.

Planned Actions

- General medical and critical care colleagues have reviewed national COVID guidance in this area to ensure that appropriate management policies are in place across the Trust.
- Re-establish a Working Group to focus on VTE Assessment.
- 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.

Timescale

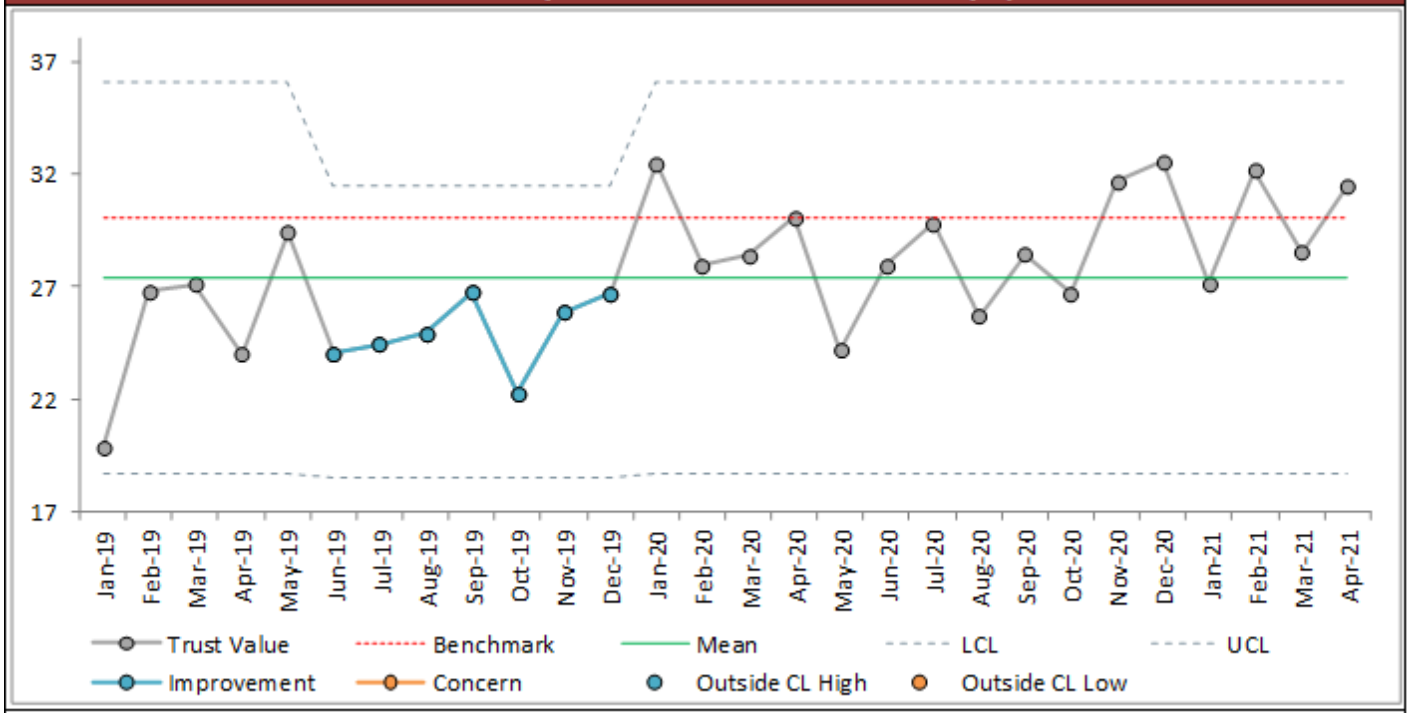
Q1 – VTE Working Group to agree trajectory
Q3 – Improved compliance

- 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	27.40
Last Month	31.47

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.

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

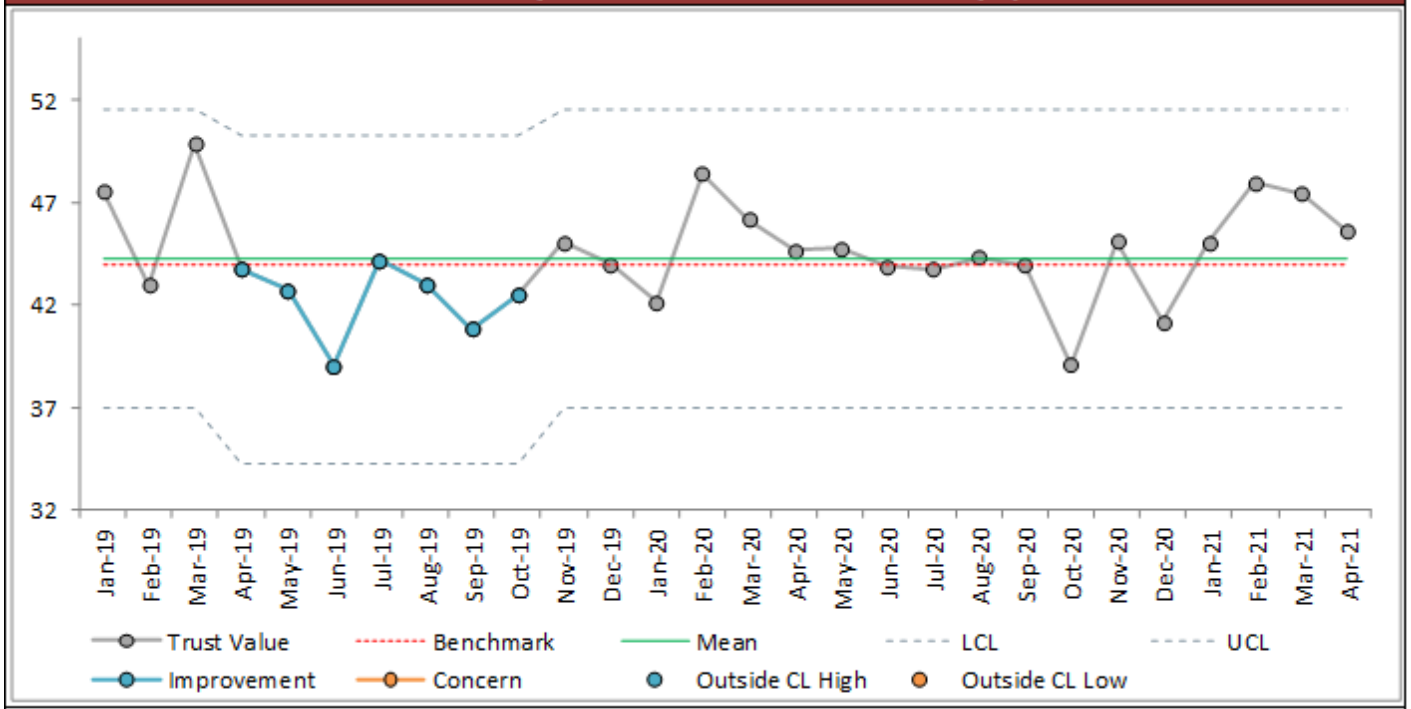
Timescale

- 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	44.24
Last Month	45.59

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.

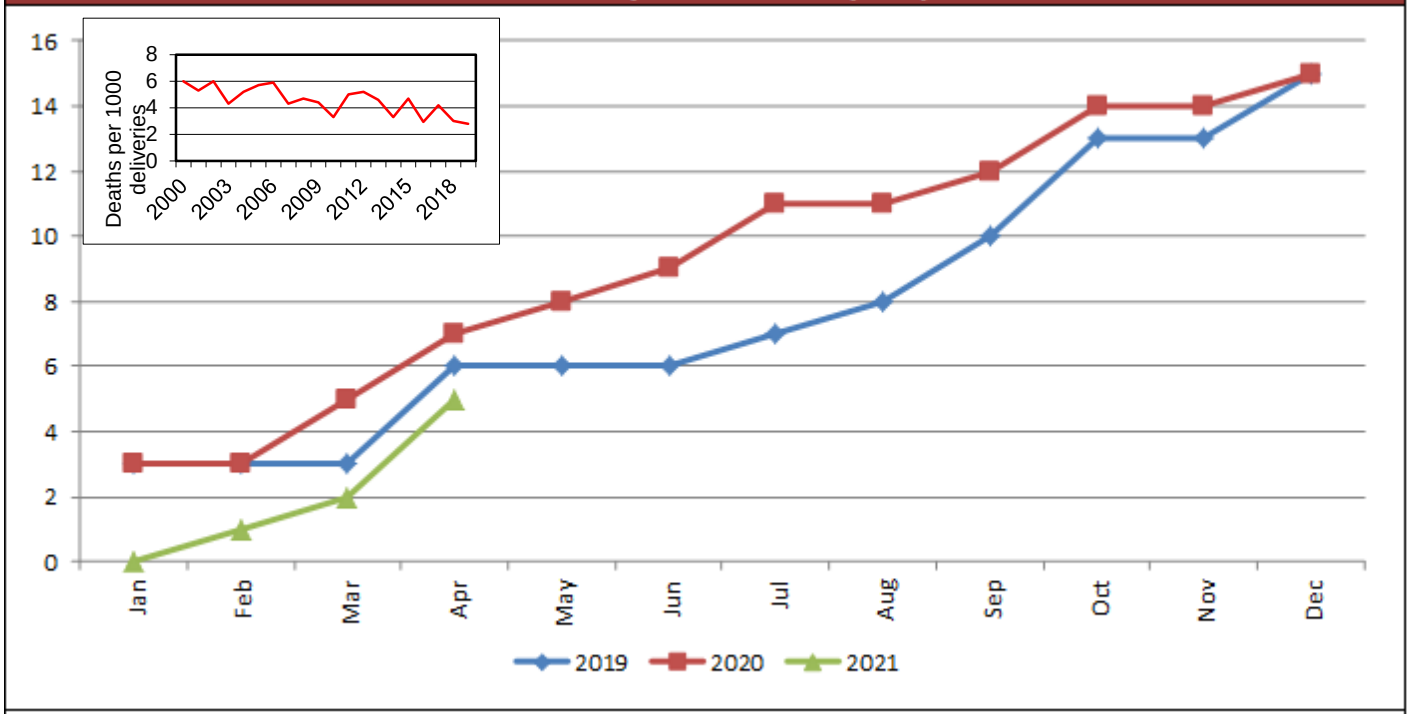
Timescale

- Not applicable

Safe

South Tees Hospitals NHS Foundation Trust

Maternity - Still Births (YTD)



Still births

Outturn	17
Mean	N/A
YTD	5

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.

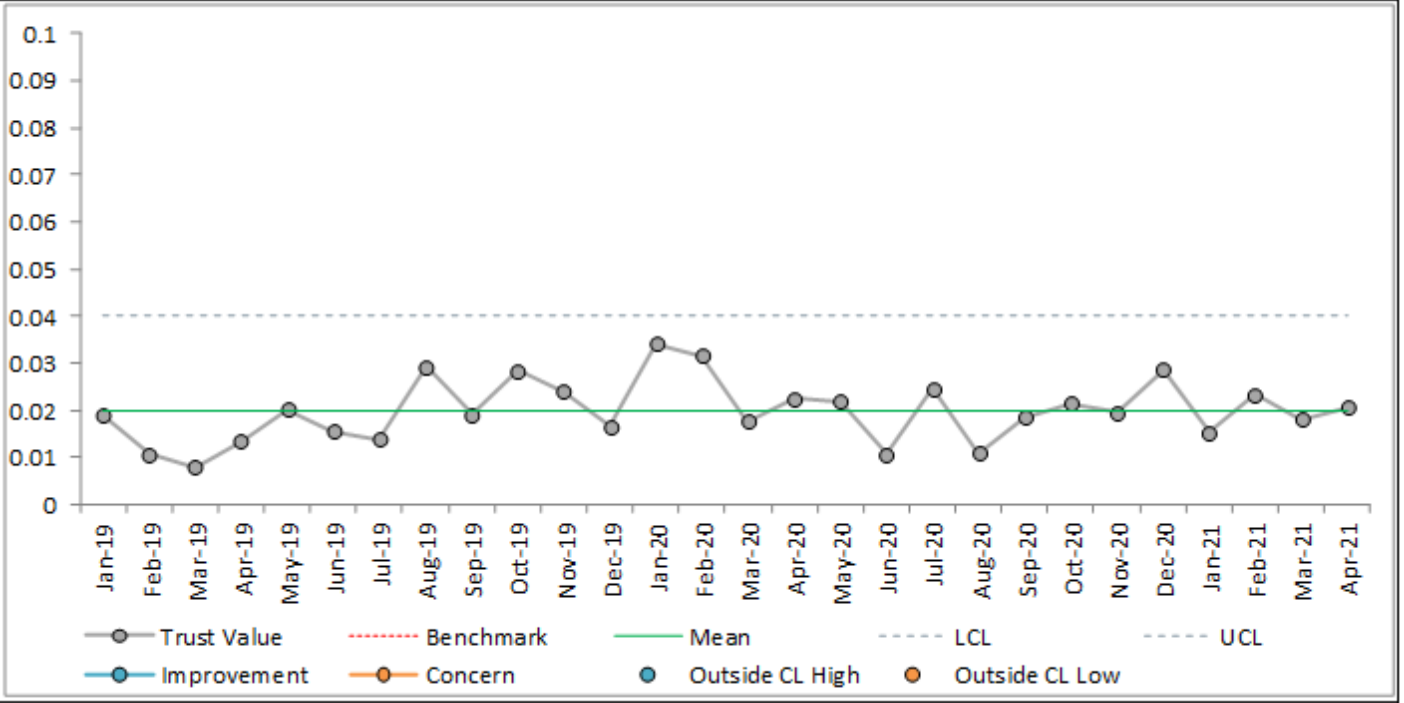
Timescale

- Ongoing

Safe

South Tees Hospitals NHS Foundation Trust

Maternity - PPH 1500ml Rate (%)



Postpartum Haemorrhage Rate over 1500ml

Benchmark	
Mean	0.02
Last Month	0.02

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

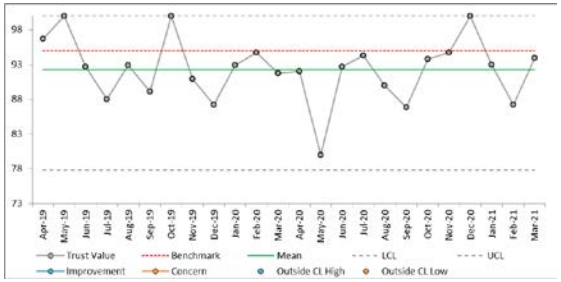
- Timescale to be determined.

Safe

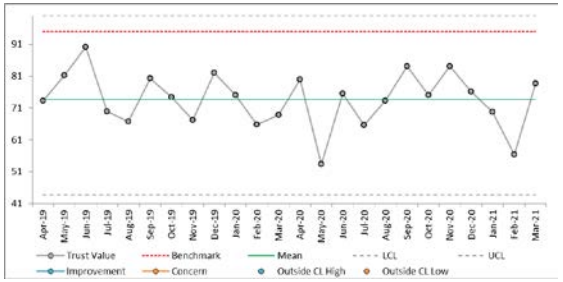
South Tees Hospitals NHS Foundation Trust

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

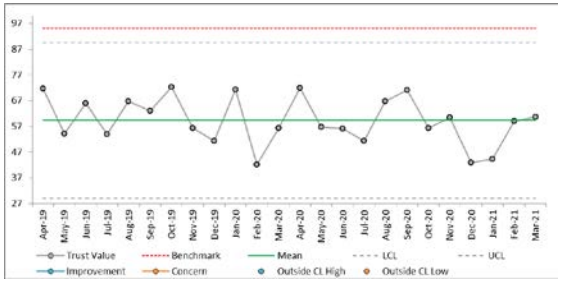
Targeted oxygen delivered within 1 hour



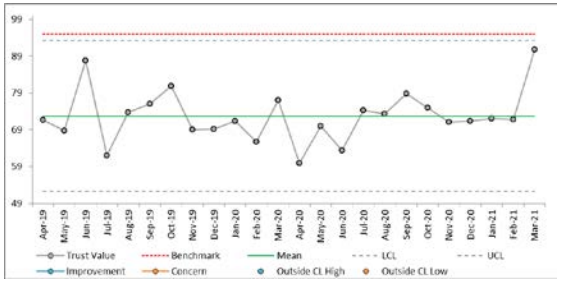
Blood cultures taken within 1 Hour



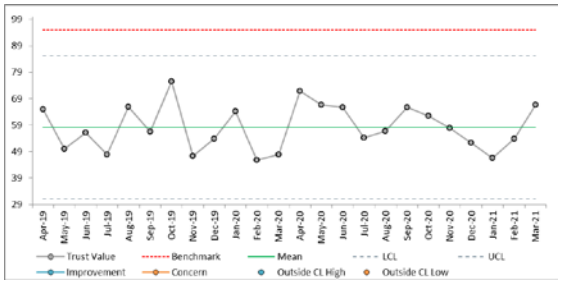
Empiric IV antibiotics administered within 1hr



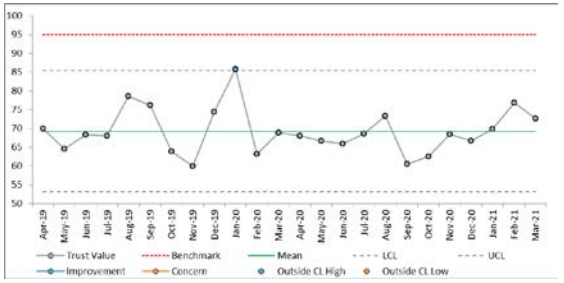
Serum lactate taken within 1 hour



IV fluid resuscitation initiated within 1 hour



Urine output measurement started within 1hr



Cause of Variation

- Normal variation, but the means are below the targets for a number of elements and therefore will continue to follow improvement plan.

Reasons include:

- Covid (Jan data)
- Sepsis assessment tool not being utilised.
- Lack of compliance with escalation policies.
- Waiting for AGB sample to obtain lactate.

Planned Actions

- Triage team introduced in ED – early feedback positive.
- To add grey blood bottle used for venous lactate into blood culture pack. In discussion with microbiologist.
- Electronic workflow being implemented across the organisation with 'close the loop' configuration, so uncomplete tasks highlighted.
- Timescale for audit in real time explored.
- Vacant Clinical Educator post – interviews scheduled.
- Reintroduction of sepsis champions.

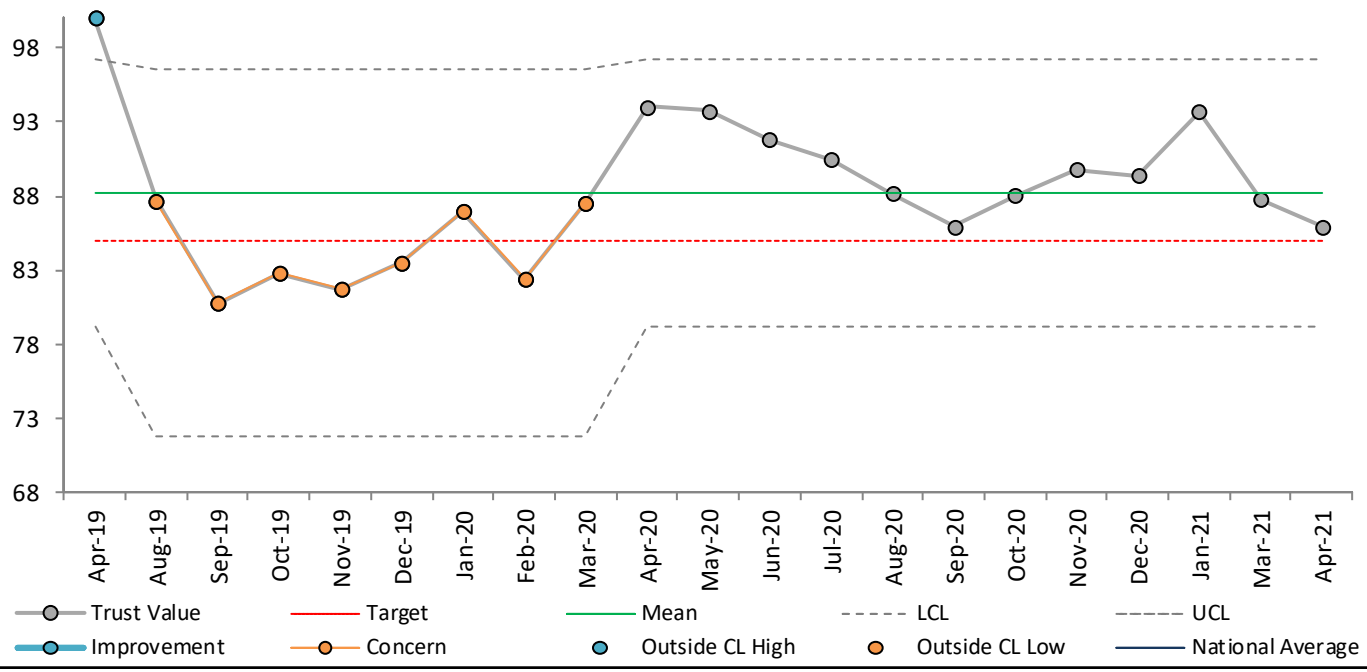
Timescale

- July 2021 for electronic system.
- Informatics being explored at present.
- Clinical Educator post Interview date 20th May.

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	88.20
Last Month	85.97

Executive Lead

Hilary Lloyd

Lead

Jen Olver

Commentary

This target has been met consistently since April 2020.
Patient feedback in A and E remains high

Cause of Variation

- This metric has been within normal variation since April 2020.

Planned Actions

- Continue current processes.

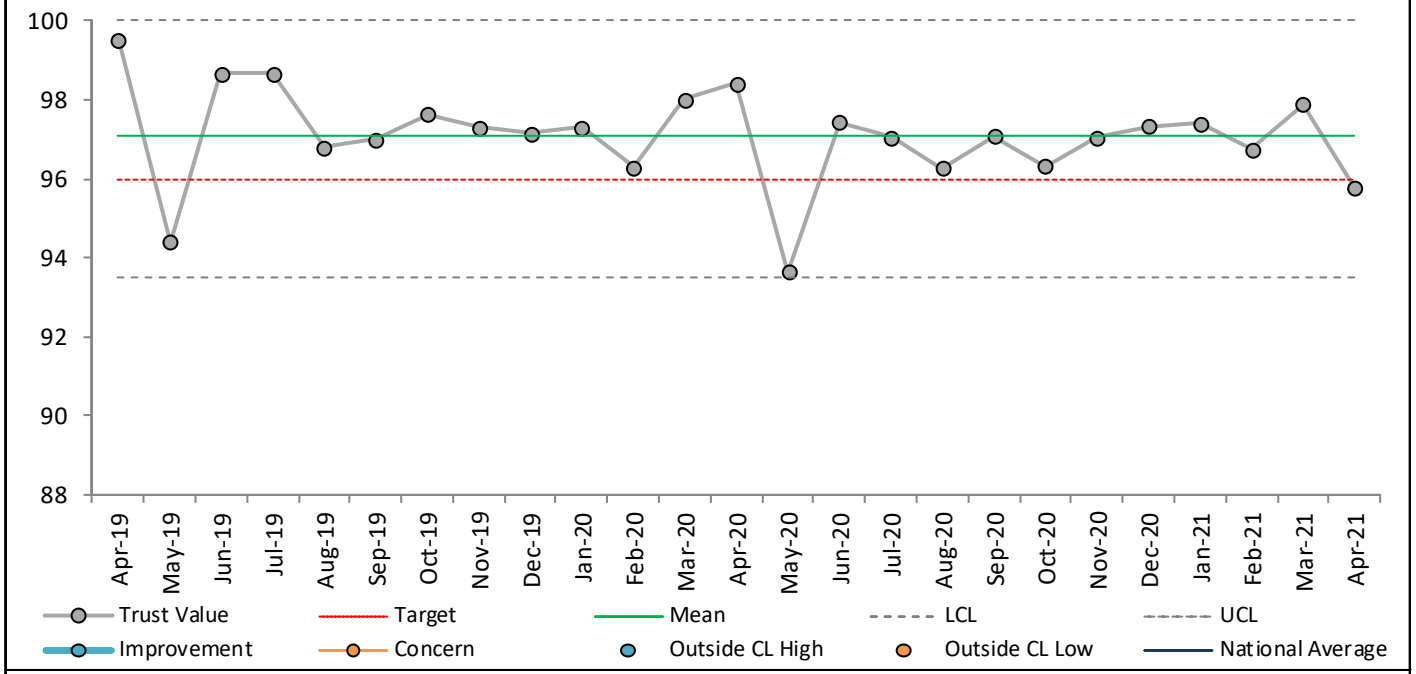
Timescale

- Ongoing.

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	97.09
Last Month	95.77

Executive Lead

Hilary Lloyd

Lead

Jen Olver

Commentary

This metric has fallen below the target for the first time since June 2020

Inpatient feedback remains high

Cause of Variation

- This metric is within normal variation and the mean is above the target.
- An increase in completion of the survey

Planned Actions

- Continue with current process.

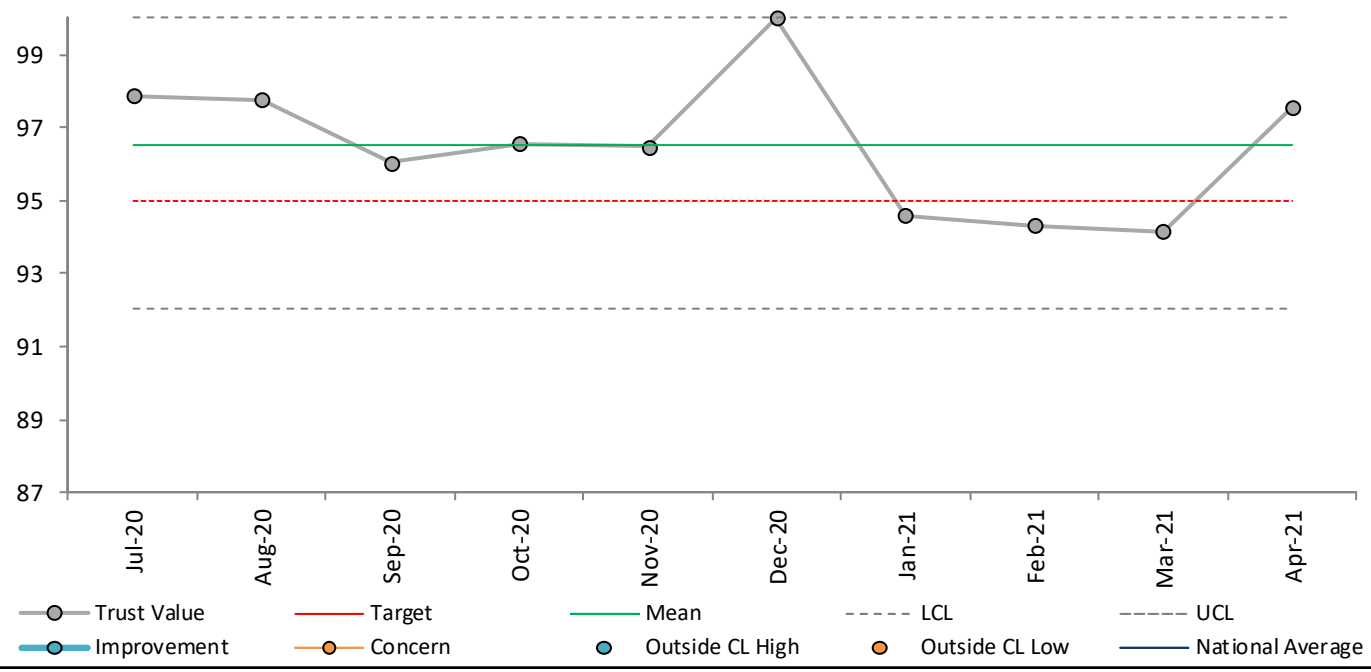
Timescale

- 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	96.54
Last Month	97.56

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.
- Excellent progress as good compliance continues to be achieved.

Planned Actions

- Continue to monitor the overall experience.

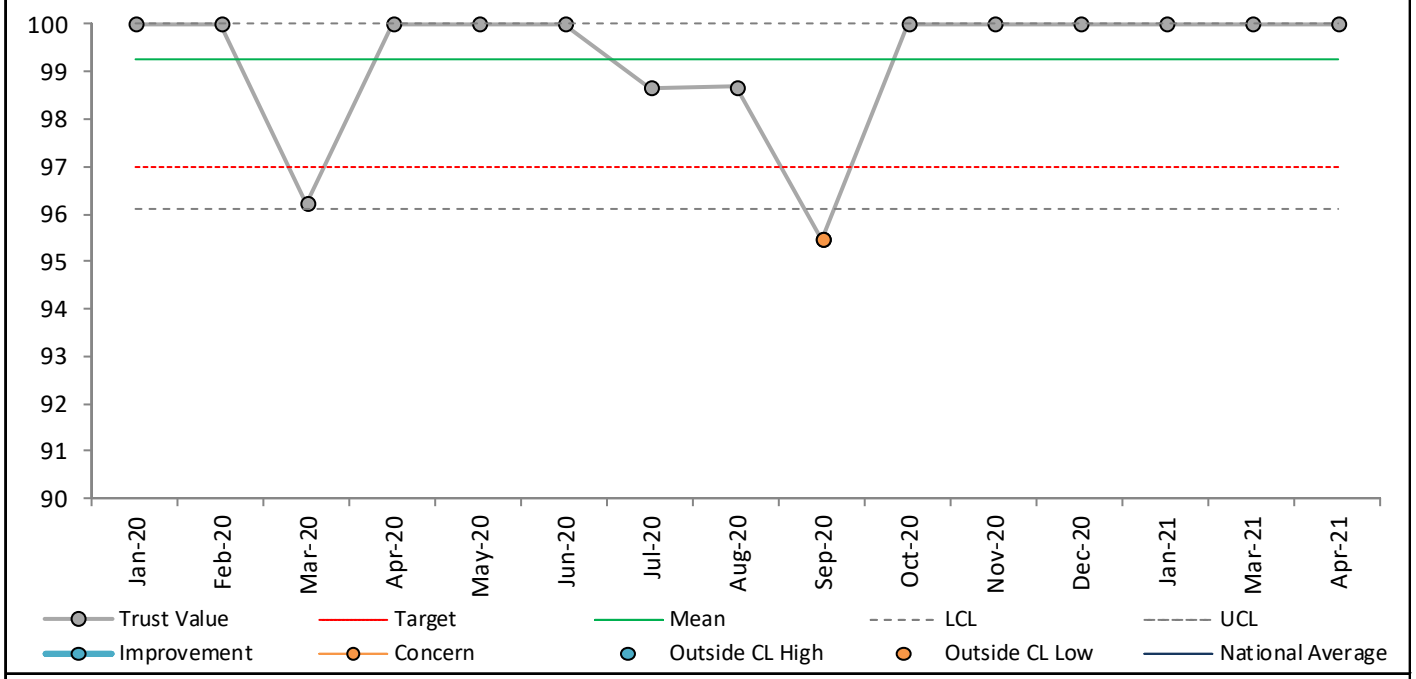
Timescale

- 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	99.27
Last Month	100.00

Executive Lead

Hilary Lloyd

Lead

Jen Olver

Commentary

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

Patient feedback in maternity remains high

Cause of Variation

- This is within normal variations, with the exception of September 2020
- The mean is above the target.
- Excellent progress as 100% compliance has been achieved for six months.

Planned Actions

- Continue with current process.

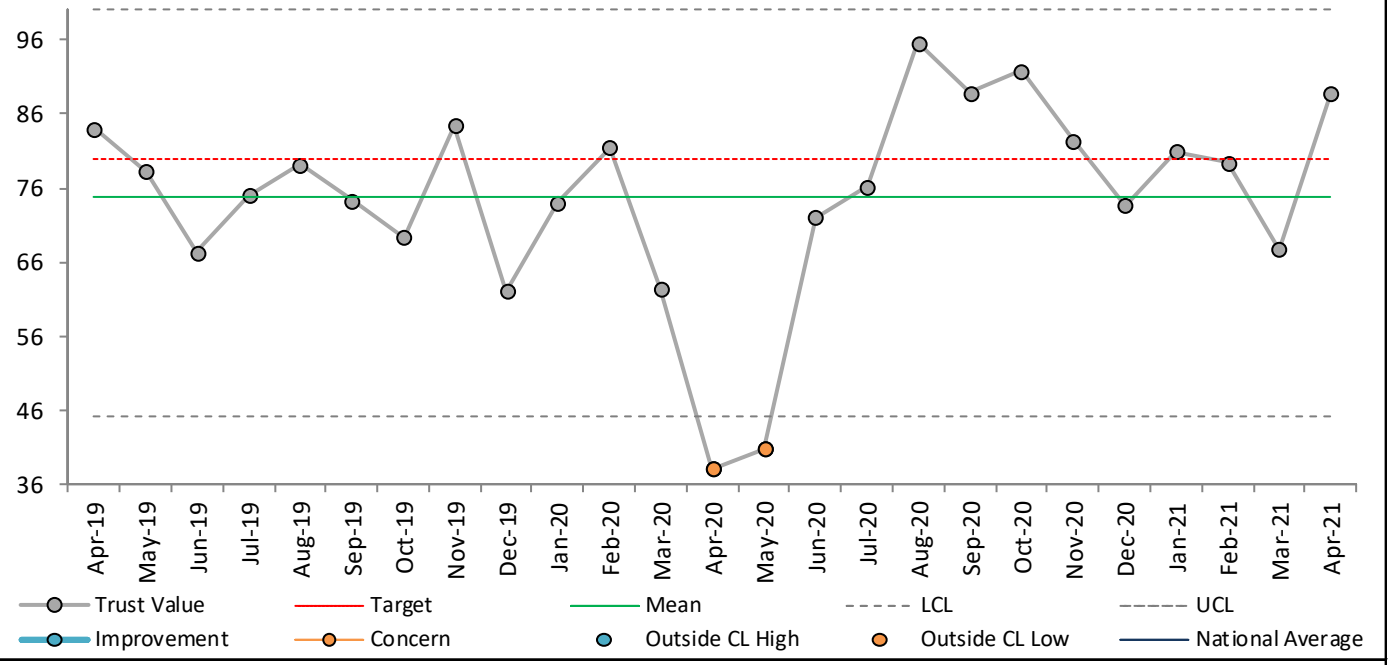
Timescale

- Ongoing

Caring

South Tees Hospitals NHS Foundation Trust

Complaints Closed Within Target (%)



The percentage of complaints closed within the target

Target	80
Mean	74.74
Last Month	88.89

Executive Lead

Hilary Lloyd

Lead

Jen Olver

Commentary

There were 22 complaints closed in April.

The number of complaints has been very variable through the year and this has contributed to the variation in performance.

Cause of Variation

- This mean is below the target, which is affected by COVID-19.
- Availability of healthcare records

Planned Actions

- Weekly reviews of complaints that are outstanding and off target.
- Timely escalation to Associate Directors of Nursing, Service Managers, Clinical Directors and Clinical Chairs.
- Review at patient experience steering group
- Report to QAC on progress in May
- Report delays accessing healthcare records

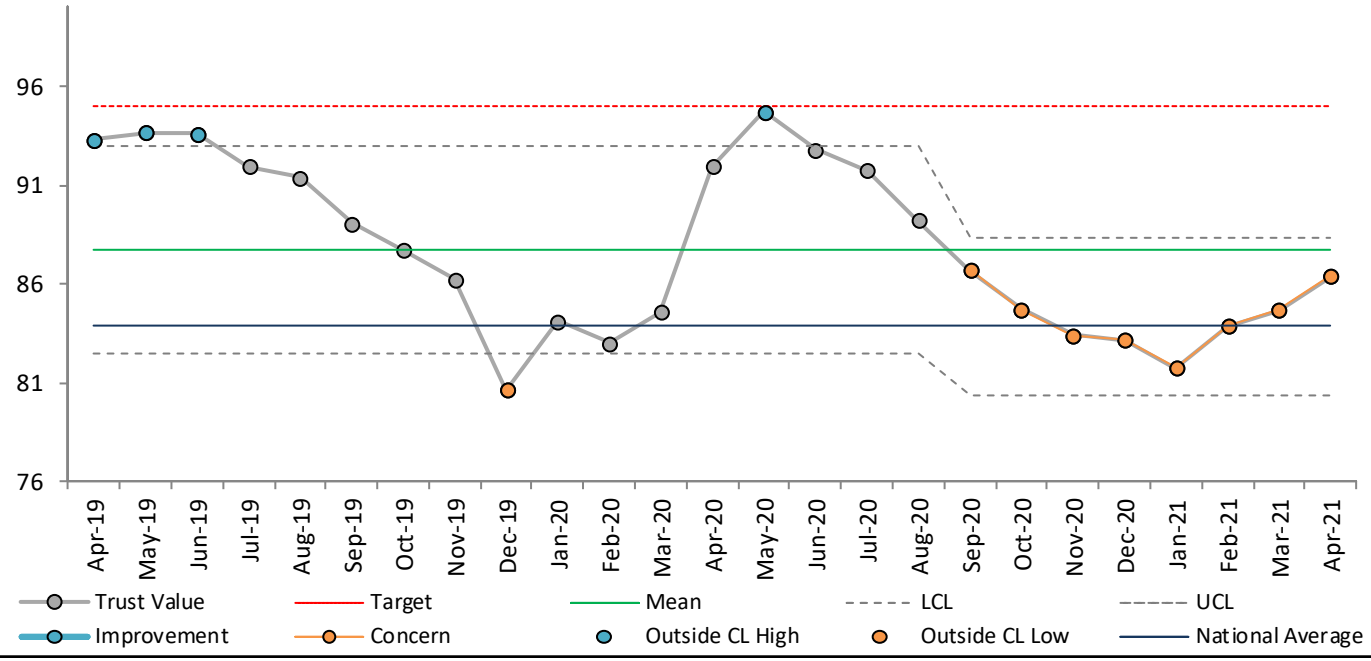
Timescale

- July 2021

Responsive

South Tees Hospitals NHS Foundation Trust

A&E 4 Hour Wait Standard (%)



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

Target	95
Mean	87.77
Last Month	86.40

Executive Lead

Sam Peate

Lead

Cheryl Burton

Commentary

Improving performance but outside control limits.

Activity levels are returning to pre-pandemic levels with higher acuity patients and fewer see and treat.

Cause of Variation

- Increased demand especially at Redcar UTC.
- Improving performance.
- Throughput.
- Delays in processing of patients.
- Lack of cubicle space at times of continued demand.
- Resus activity increased.
- Transfers to both internal and external pathways delayed.
- Lack of F2F GP appointments.

Planned Actions

- Review of service model in JCUH ED.
- Communication to SLT regarding CRoS implementation plan.
- Ready to proceed (R2P) implemented and embedded across the organisation before winter.
- Organisational approach to SDEC pathways to remove crowding and delays for non elective patients.
- Escalation process to be reviewed with actions and response targets.
- Focus on ambulance conveyance and alternative pathways.
- Activity follow with ambulance providers to improve handover times.
- ED recovery plan developed in line with ECIST recommendations.

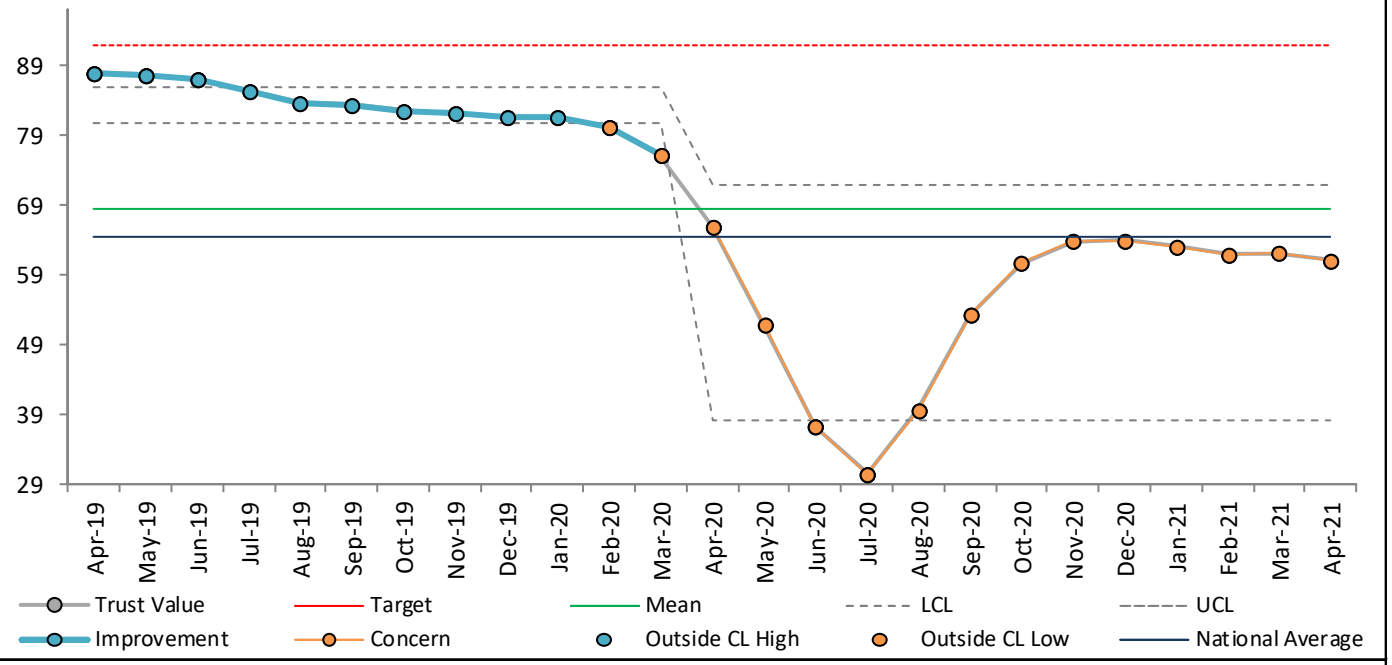
Timescale

- June 2021
- May 2021
- June 2021
- June 2021
- June 2021
- May 2021 – completed
- May 2021
- May 2021

Responsive

South Tees Hospitals NHS Foundation Trust

RTT Incomplete Pathways (%)



The % of incomplete pathways for patients within 18 weeks

Target	92
Mean	68.63
Last Month	61.14

Executive Lead

Sam Peate

Lead

Joanne Evans

Commentary

Compliance has been below target since April 18 and decreased early in pandemic.

Existing RTT improvement Trajectory expecting performance to 68% by July 21 with further improvement to 74% 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.
- April position not yet confirmed, Over 52 week waiters for March 21, 4258.

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

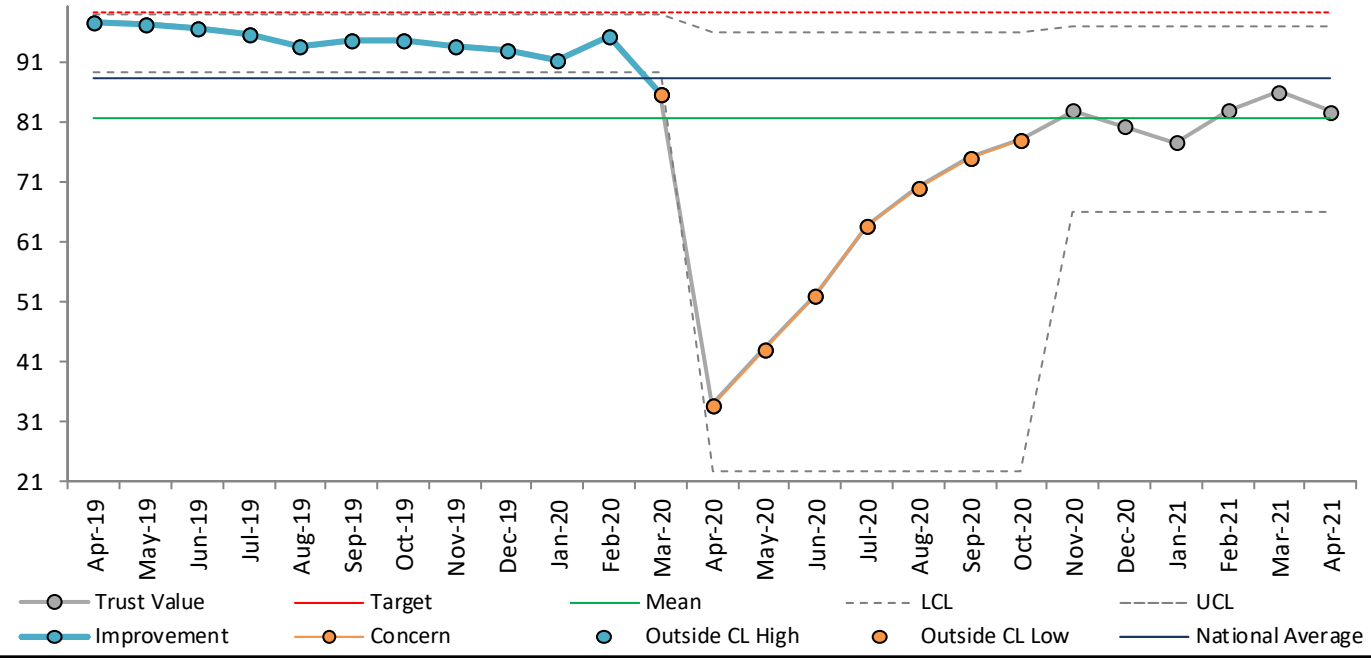
Timescale

- 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	81.41
Last Month	82.65

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.

Planned Actions

- Weekend working in place and to continue.
- Weekly review of diagnostic performance and waiting lists via Clinical Recovery Group
- Recovery plans established in non performing areas including Dexa Scanning, Audiology, Sleep Studies and Endoscopy
- Improvement trajectories to be developed in May 2021

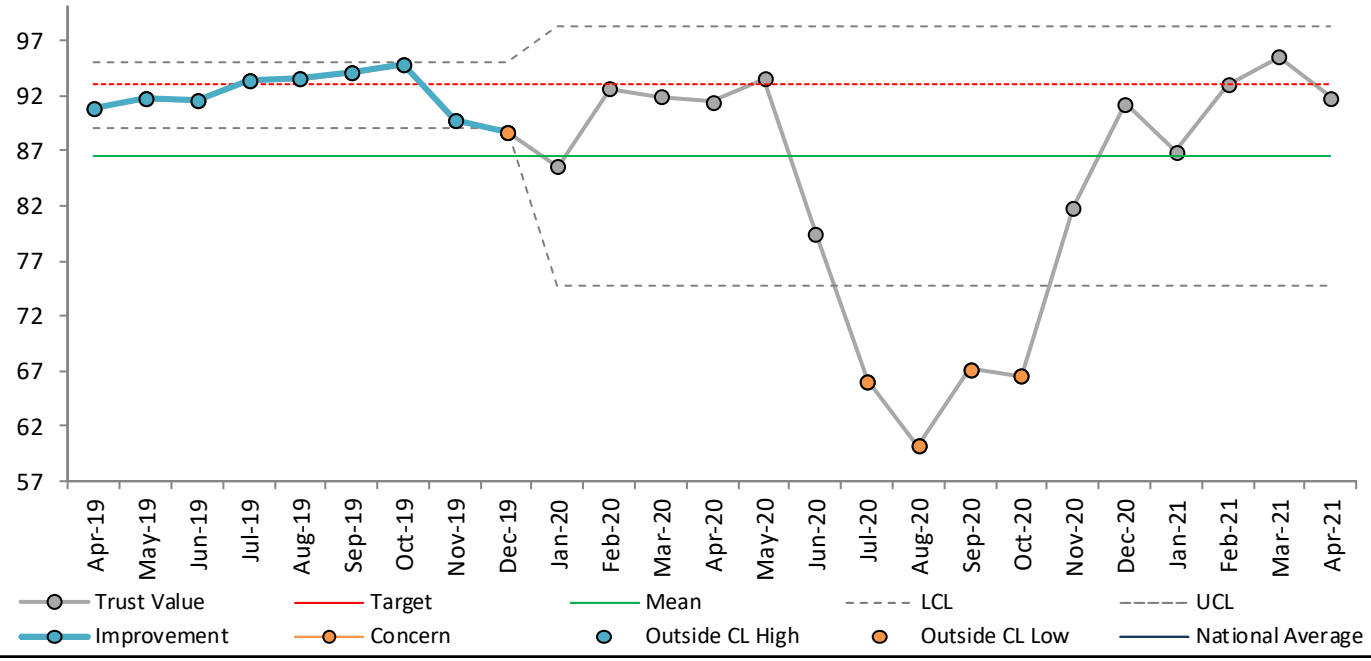
Timescale

- Due to the impact of Covid this metric is unlikely to get back to target for many months.
- Improvement trajectory will be determined with clinical teams.

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	86.54
Last Month	91.84

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.

Target achieved March 2021. April 21 indicative. 28 day faster diagnostic target achieved in March 21 – compliance 83.7% (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.

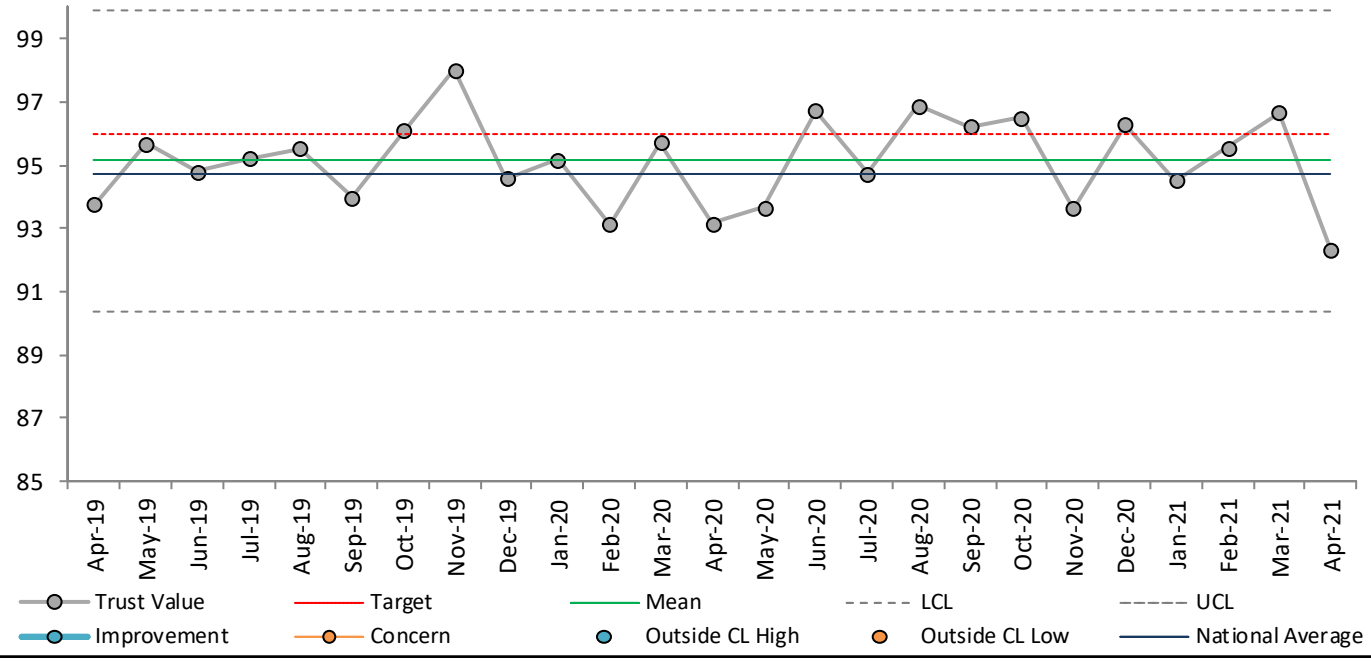
Timescale

- 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	95.15
Last Month	92.30

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.

Target achieved March 2021. April 21 indicative

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.

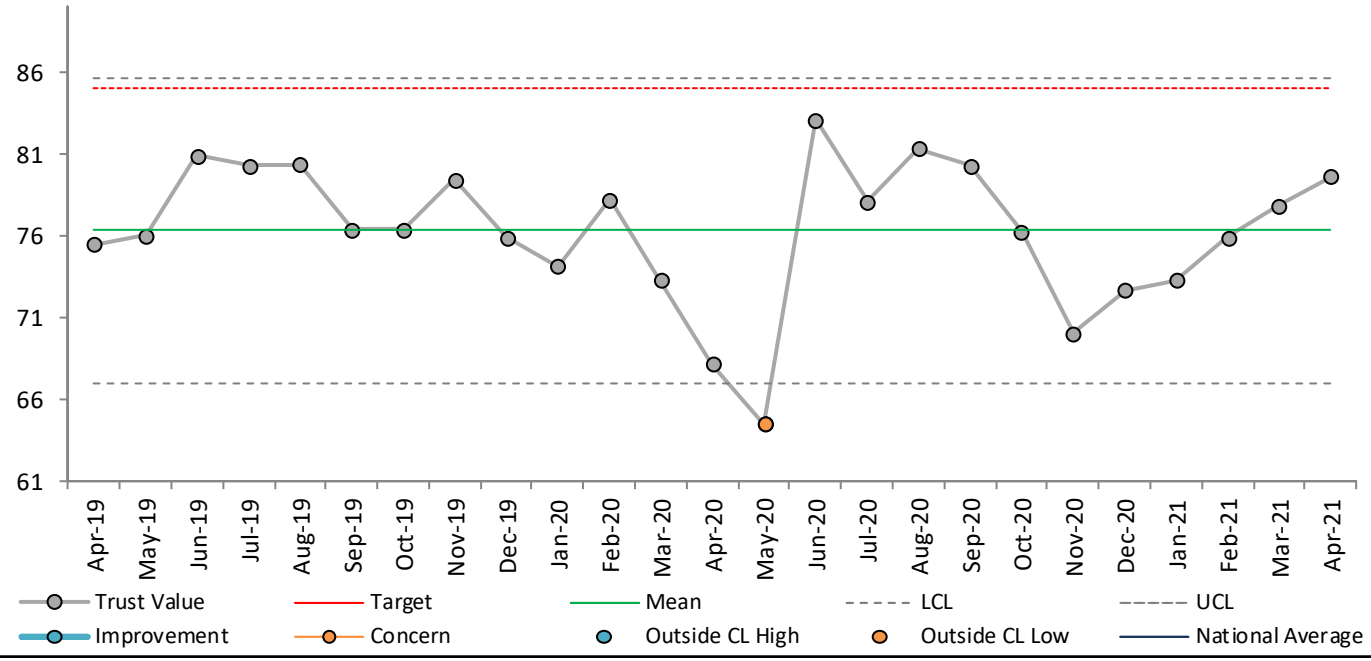
Timescale

- 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	76.35
Last Month	79.66

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 76.07% therefore the target is unlikely to be met.

Cause of Variation

- Late transfers from other organisations has impacted 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. Over the last year 66.5% of transfers have taken place after 38 days. In line with the Inter Provider transfer rules those transferred after day 38 42 % were treated by the trust within 24 days of receipt.

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

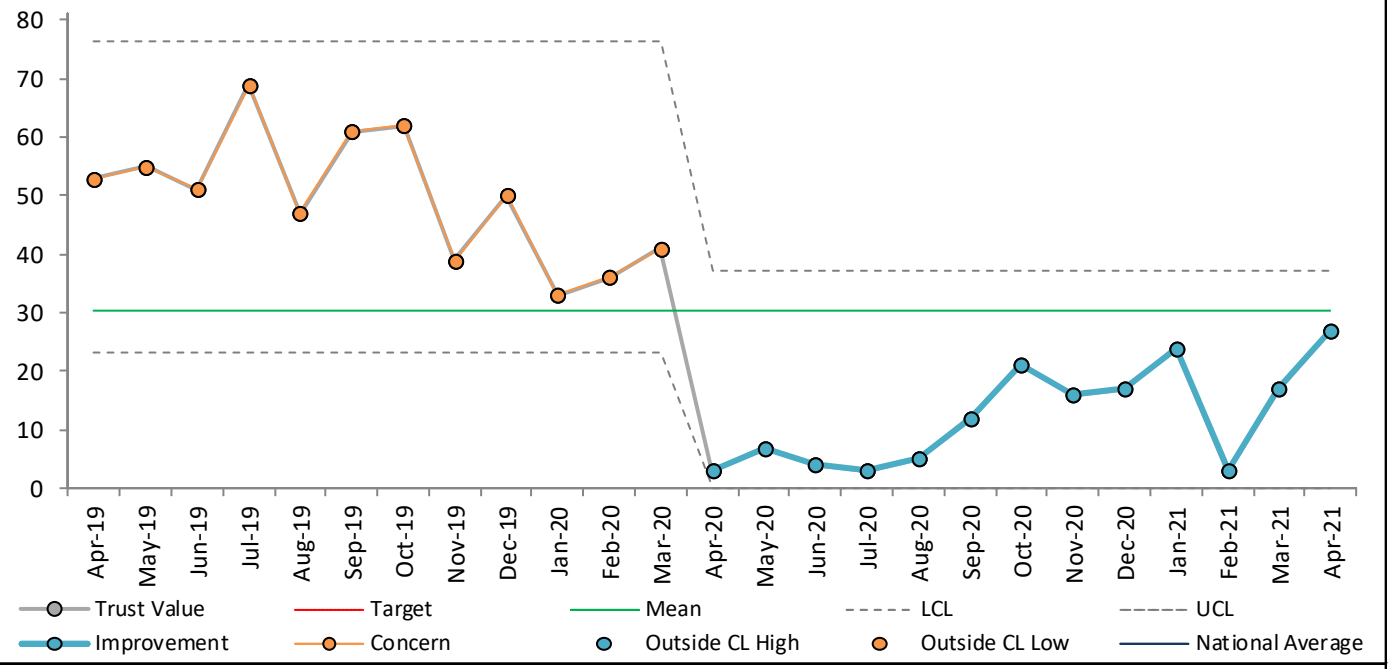
Timescale

- 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

Non-Urgent Ops Cancelled on Day



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

Target	0
Mean	30.24
Last Month	27.00

Executive Lead

Sam Peate

Lead

Joanne Evans

Commentary

Significant improvement in the system due to COVID and reduced elective programme.

Assurance given that theatre capacity will return t0 100% by the end of May 2021.

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.

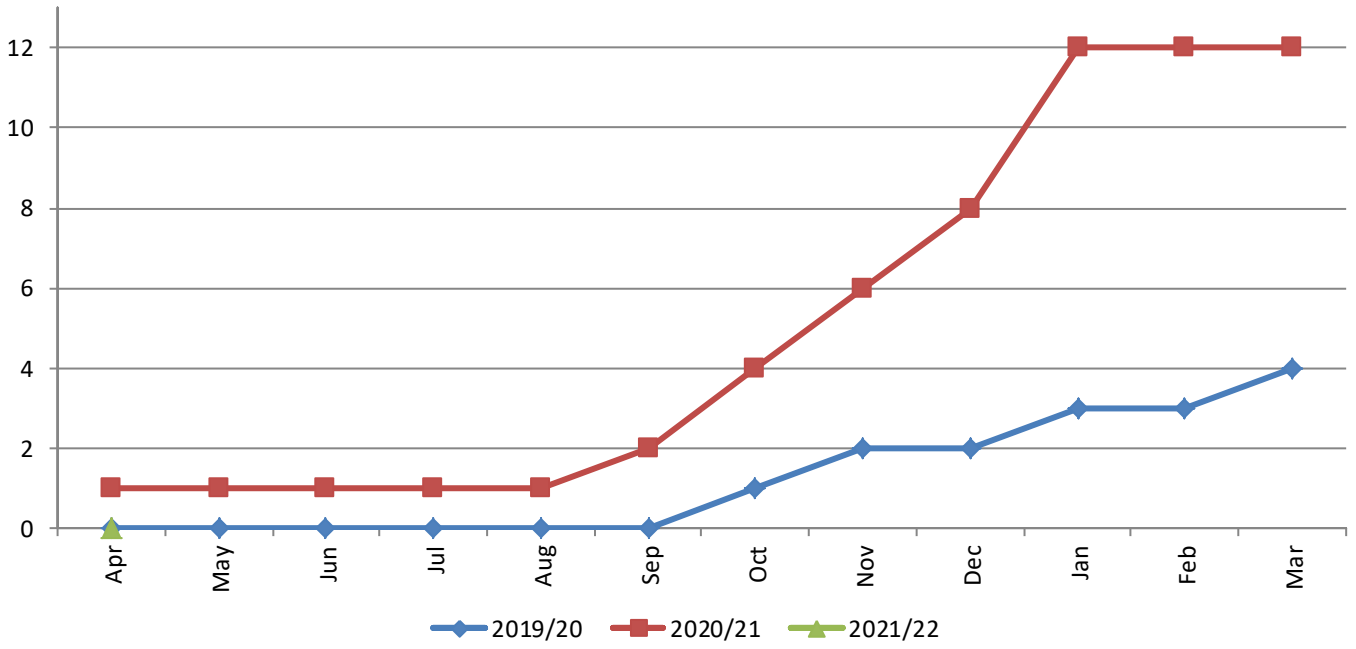
Timescale

- 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	0

Executive Lead

Sam Peate

Lead

Joanne Evans

Commentary

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

There have been 12 cancer operations cancelled this financial year.

Cause of Variation

- There were 0 short notice cancer operations cancelled in March for non clinical reasons.
- Limited access to critical care throughout pandemic

Planned Actions

- Cancellation reasons to be reviewed in weekly clinical recovery meeting

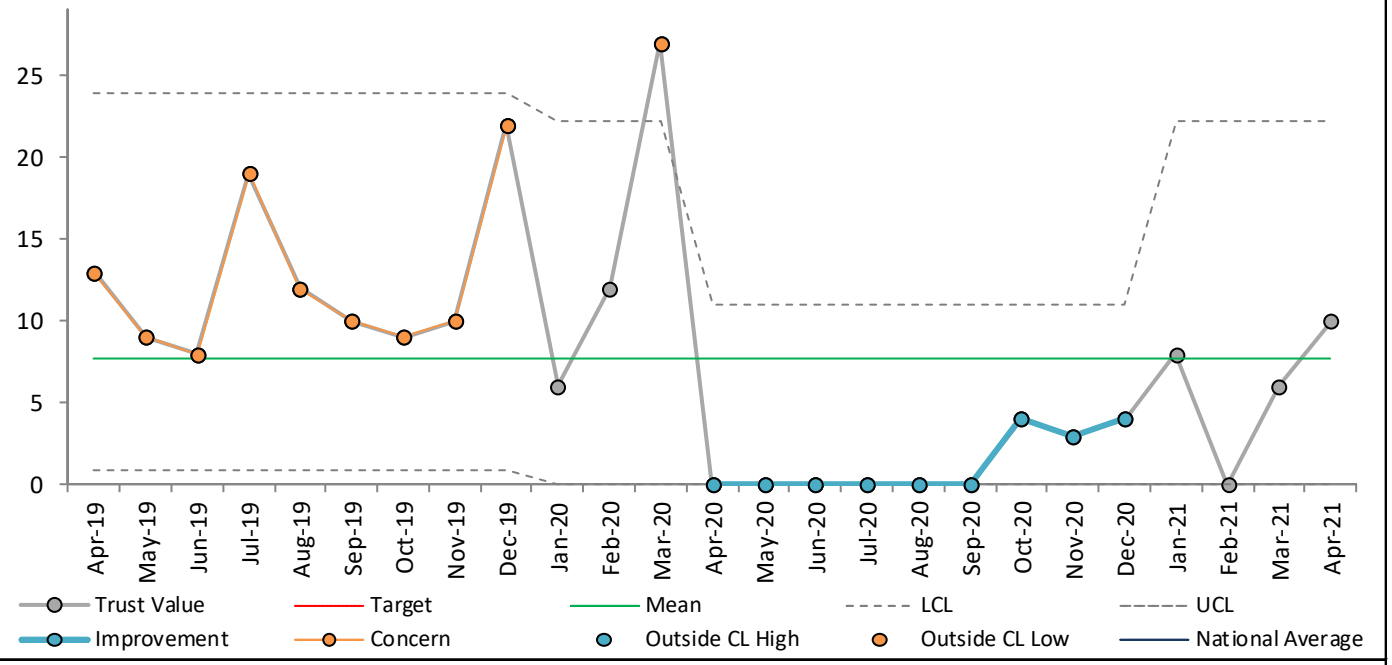
Timescale

- 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	7.68
Last Month	10.00

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

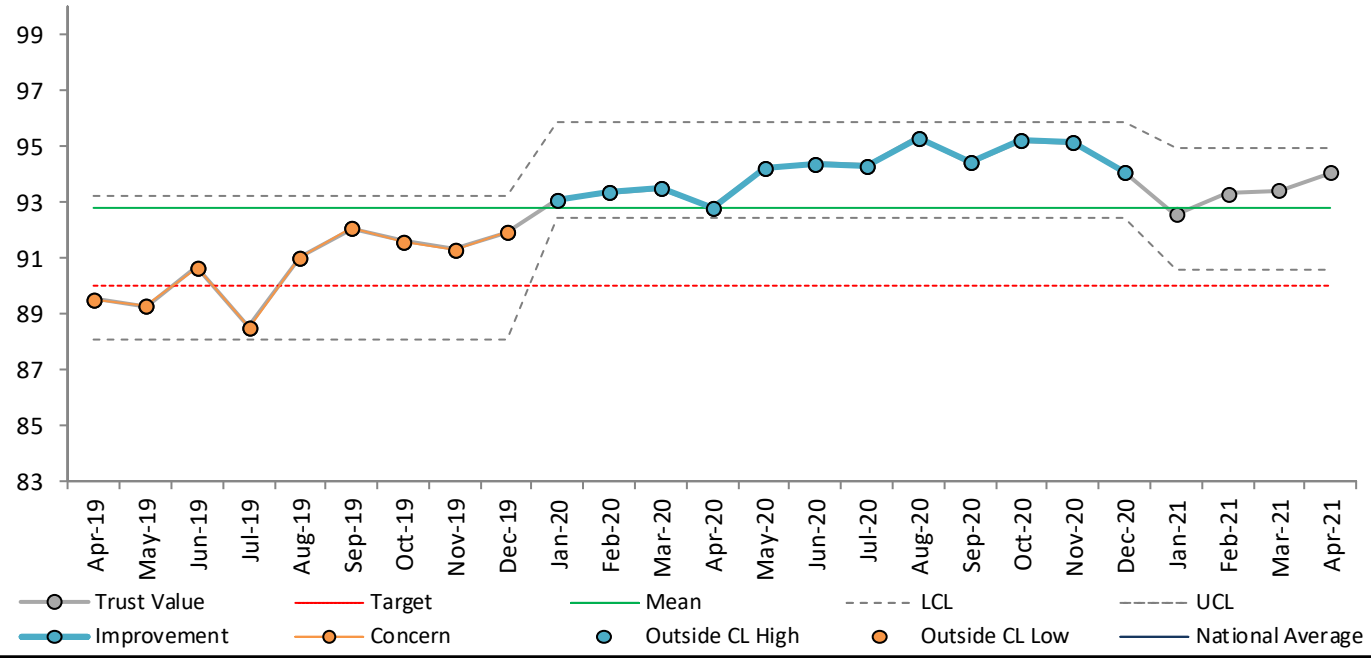
Timescale

- Ongoing

Responsive

South Tees Hospitals NHS Foundation Trust

E-Discharge (%)



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

Target	90
Mean	92.77
Last Month	94.07

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.

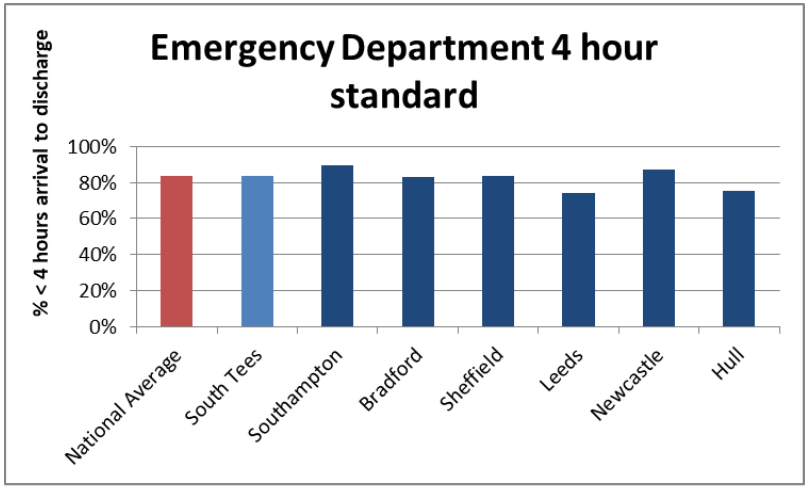
Timescale

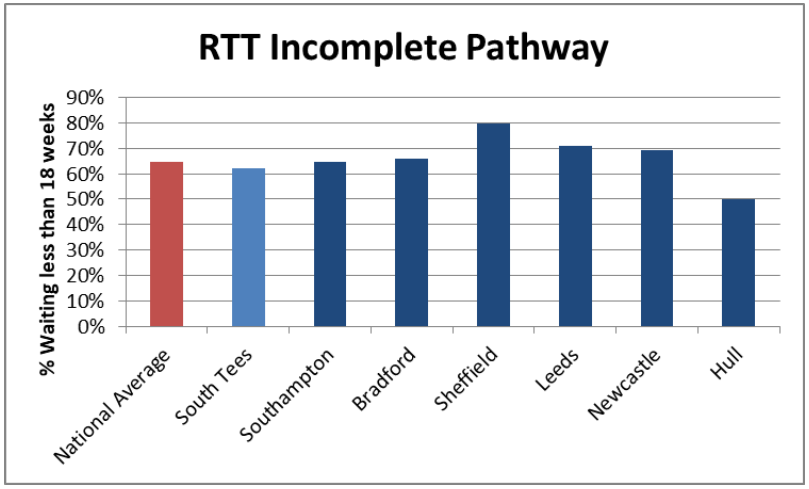
- May 2021

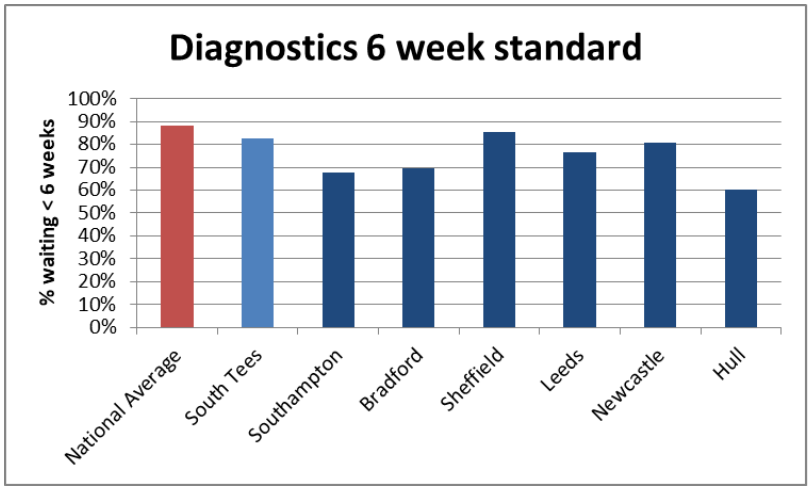
Responsive

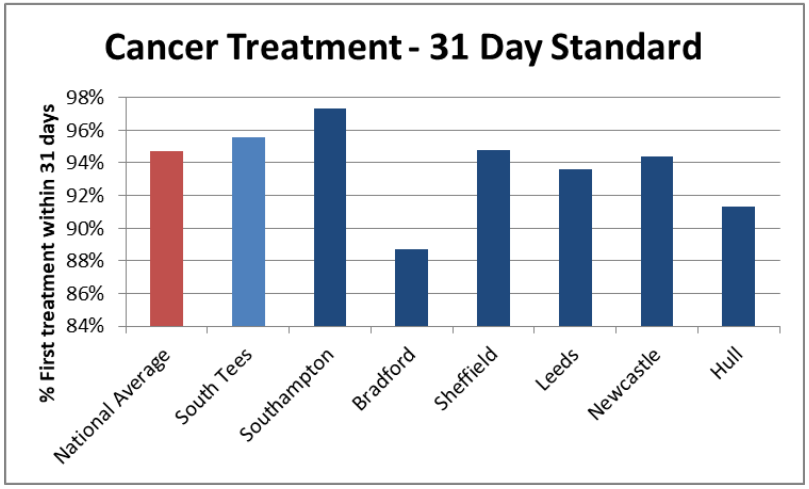
South Tees Hospitals
NHS Foundation Trust

Benchmarking against National Average and other Providers





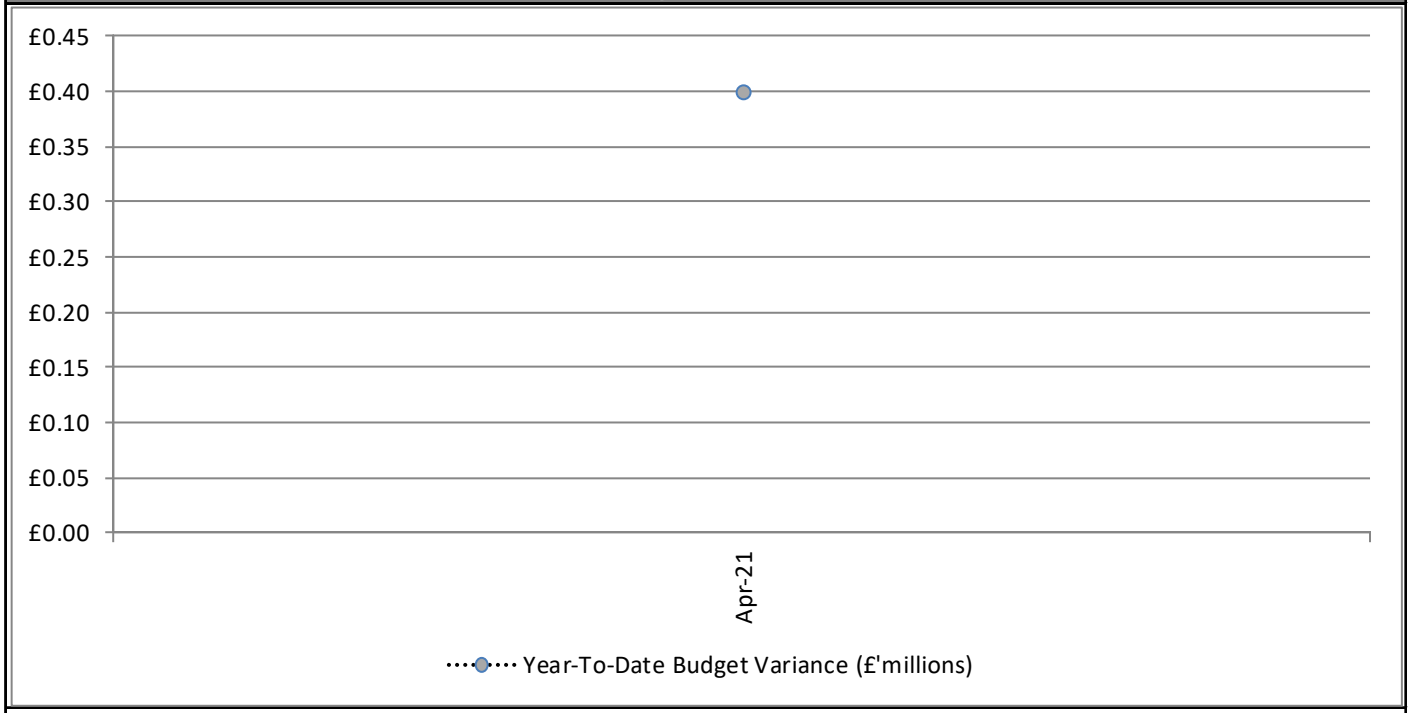




Well Led

South Tees Hospitals NHS Foundation Trust

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



Year-To-Date Budget Variance

Target	0.00
Mean	N/A
Last Month	0.40

Executive Lead

Chris Hand

Lead

Luke Armstrong

Commentary

The Trust's financial performance is a deficit of £1.0m, in line with the recently submitted H1 plan.

Cause of Variation

- No cause of variation.

Planned Actions

- Review of forecast Covid-19 costs for the first six months of 2021/22.
- Rebase of Junior Doctors budget at a Directorate level

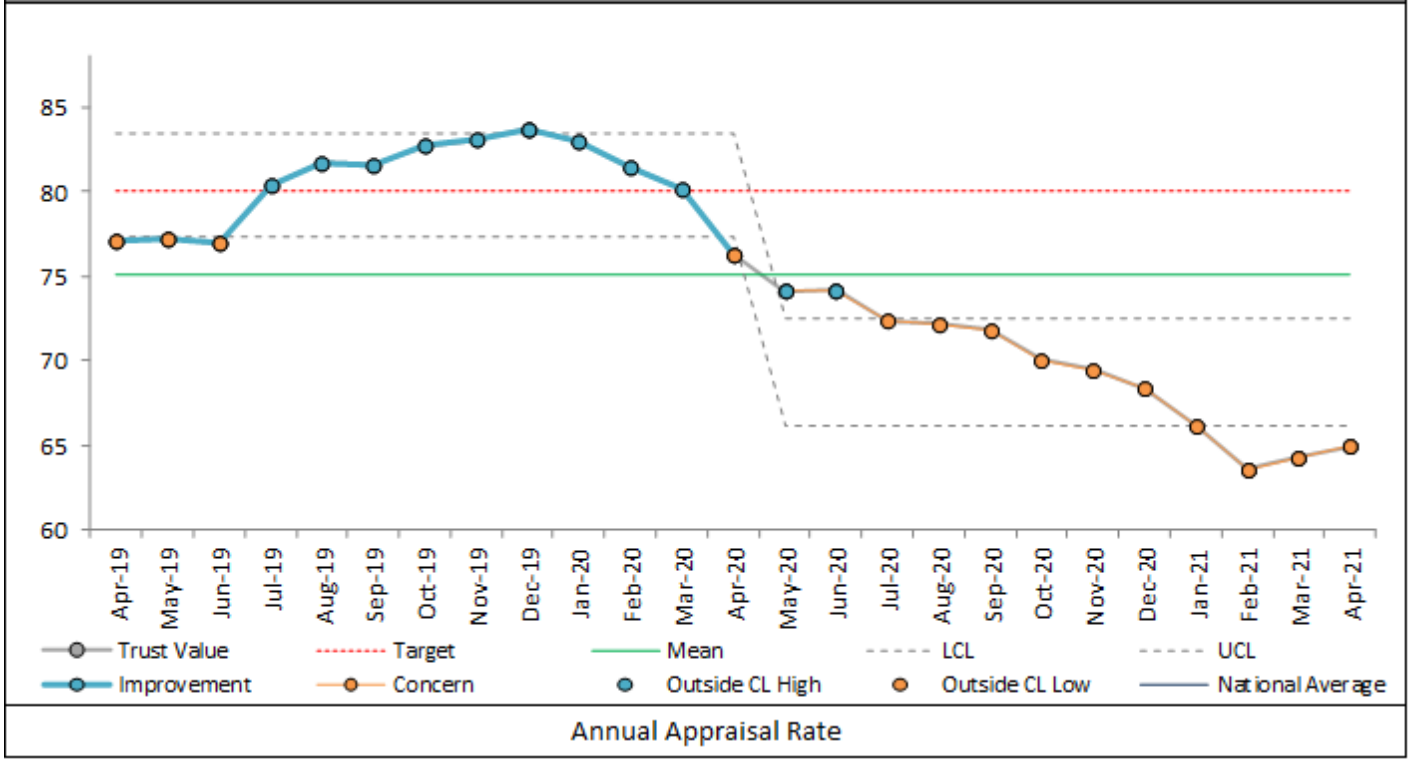
Timescale

- 31 May 2021
- 31 May 2021

Well Led

South Tees Hospitals NHS Foundation Trust

Annual Appraisal (%)



Annual Appraisal Rate

Target	80
Mean	75.08
Last Month	64.93

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

This metric is starting to improve and trajectories are in place to ensure we continue to improve month on month. Launch of new appraisal process and formation of collaboratives should enable a swift increase. Focus on reaching 80% compliance by September 2021

Cause of Variation

- Increased volume of staff absence due to COVID over last 12 months, including absence and isolation.
- Medical staff not required to complete annual appraisals until April 2021.
- Additional pressures on managers requiring them to focus on operational requirements.

Planned Actions

- New Appraisal document complete and agreed with Staff Side. To be rolled out to organisation April 2021.
- Corporate Services to pilot new appraisal document to complete all appraisals by the end of the 1st Quarter (April to June).
- Working party set up to develop a Retention Strategy which commences with recruitment and incorporates the importance of the appraisal process.
- 80% appraisals completed by end of Quarter 2.

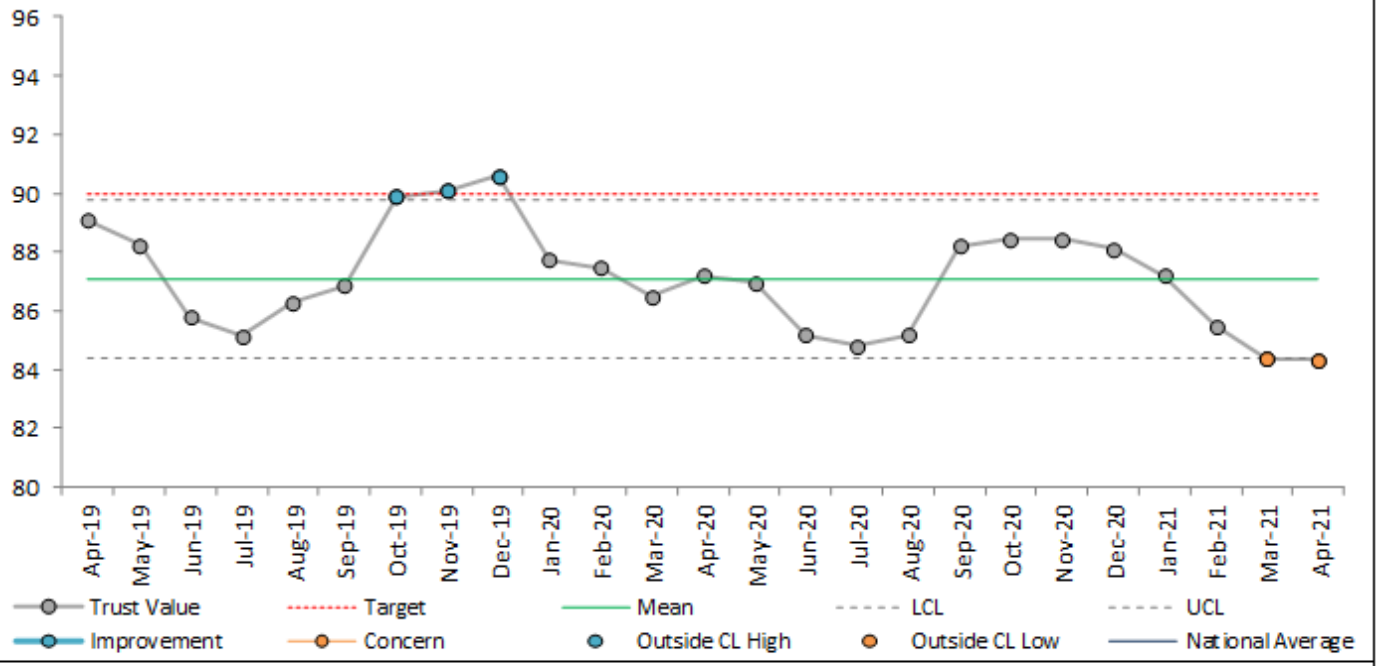
Timescale

- May 21
- June 2021
- September 2021

Well Led

South Tees Hospitals NHS Foundation Trust

Mandatory Training (%)



The % of Mandatory Training Compliance

Target	90
Mean	87.10
Last Month	84.32

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

The transfer of mandatory training onto ESR has taken place and briefing sessions for staff in place.

Cause of Variation

- Data cleanse of mandatory training data now complete and accuracy of data has vastly improved. Mandatory Training date has been transferred onto ESR to enable real time reporting

Planned Actions

- Core 11 Mandatory Training modules now available on ESR.
- ESR to be aligned to support new Clinical Collaboratives which will ensure data provision will support the organisational restructure.
- HR Workforce Team continue to provide training for managers and staff on the new ESR platform.
- Continued focus on non-compliant areas and elements of mandatory training via HRBPs and Centre/Department managers.

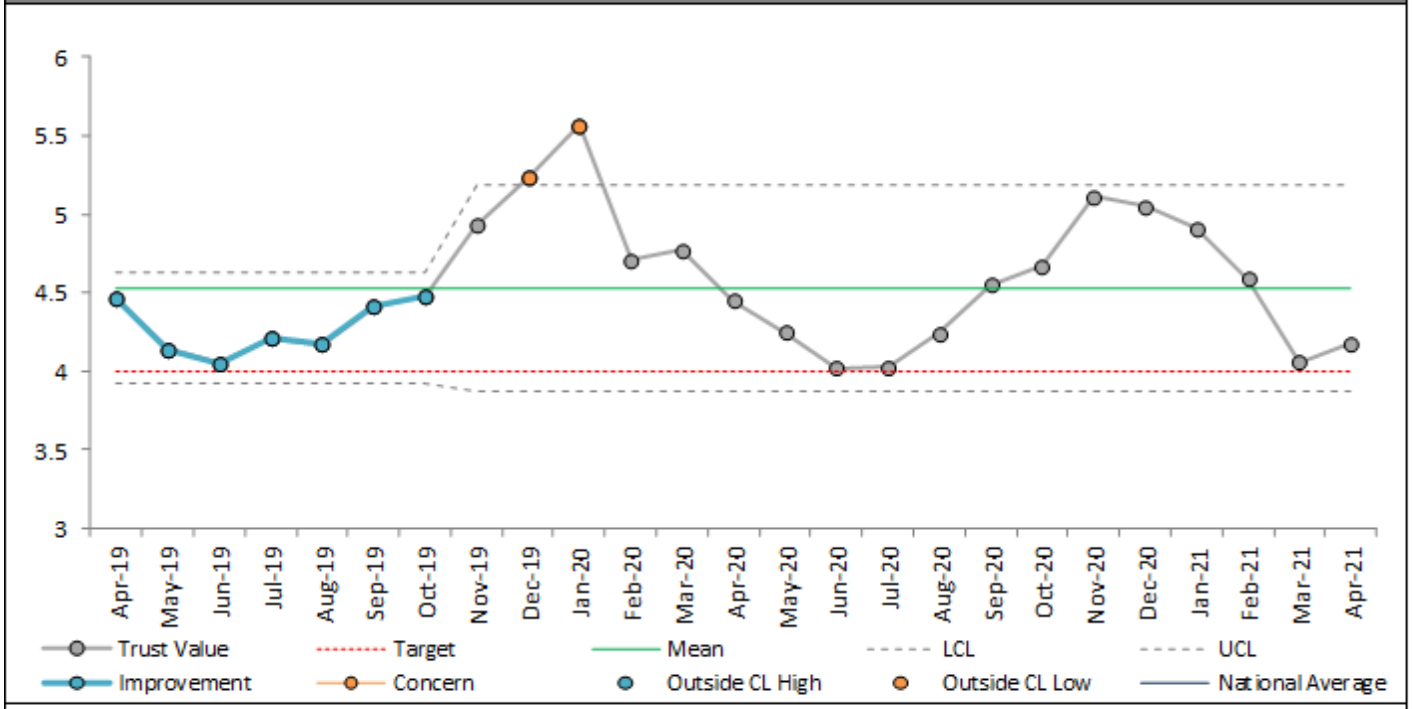
Timescale

- May 2021
- Ongoing

Well Led

South Tees Hospitals NHS Foundation Trust

Sickness Absence (%)



The % of monthly sickness absence

Target	4
Mean	4.53
Last Month	4.18

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

General sickness has reduced over the recent months with most Clinically Extremely Vulnerable staff now returned to work.
A number of support mechanisms have been developed for colleagues to support their return to work and health and wellbeing. .

Cause of Variation

- Staff absence figures have increased slightly from 4.06% in March to 4.18% in April.
- Covid related absence has reduced from a March position of 0.28% to an April position of 0.14%.

Planned Actions

- Appointment of a Mental Health Nurse to take a proactive lead in health and wellbeing across the Trust.
- Case Conferences recommenced between HR and Collaborative Managers to focus on long term absence.
- OH supporting managers with redeployment for staff who return from shielding and have developed a referral process for staff with long-covid who require additional clinical support.
- Discussions underway regarding the procurement of health and wellbeing hubs to be placed at JCUH, FHN and within the wider community hospitals.

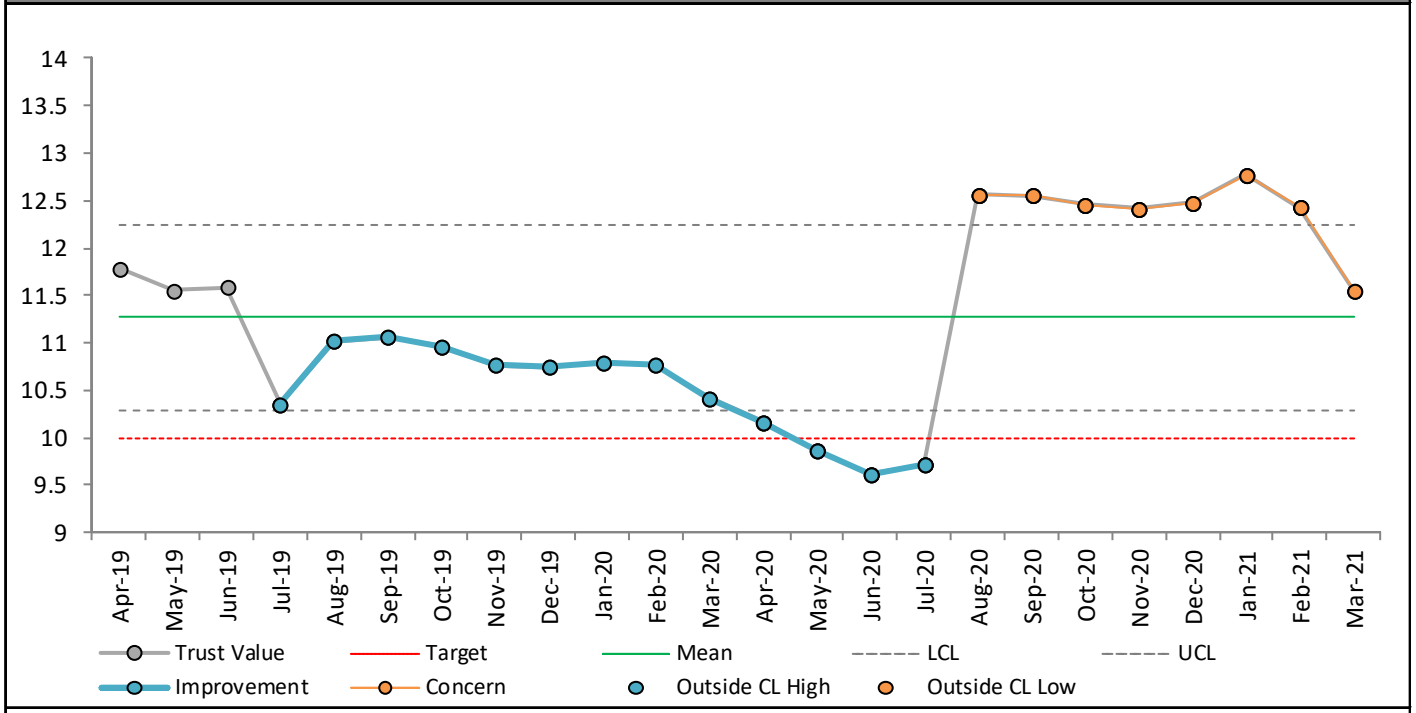
Timescale

- June 20
- Ongoing
- June 2021

Well Led

South Tees Hospitals NHS Foundation Trust

Staff Turnover (%)



Staff turnover rate

Target	10
Mean	11.27
Last Month	11.55

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

Staff turnover reduced over the last 3 months.

Cause of Variation

- Turnover has reduced over the last quarter, as short and fixed term contracts expire, resulting in more stability within in staff groups.

Planned Actions

- Draft Retention Strategy developed and discussed at JPC. to be developed in partnership with Staff Side and includes six stages, commencing at the recruitment stage. Also presented and agreed at People Committee in May 21.
- Continued support provided by Health and Wellbeing Nurse for those staff returning from shielding, with a focus on psychological and wellbeing.
- Continue to promote agile and flexible working to support staff develop better worklfe balance.

Timescale

- July 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

- From next month we will include clinical prioritisation and associated processes as a result of COVID 19.
- Elective recovery trajectories.
- Further revisions following publication of planning guidance.
- Review structure of IPR, including trajectories for improvement and page layout.
- Review of C-difficile and MRSA and Finance chart presentation.
- Review of targets in line with refreshed improvement plan.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 June 2021			
Provider Licence Self Certification			**AGENDA ITEM: 13, ENC 11**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary Chris Hand Chief Finance Officer	**Responsible Director:**	Neil Mundy Interim Joint Chairman Sue Page Chief Executive
Action Required	Approve ☒ Discuss ☐ Inform ☐ (select the relevant action required)		
Situation	An assessment has been undertaken against the NHS provider licence. The results are attached for consideration along with a recommendation to approve the assessment.		
Background	All NHS Foundation Trusts are required to self-certify whether or not they have: i) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the NHS Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012 whilst having regard to the NHS Constitution; and ii) the required resources available if providing commissioner requested services (CRS); and iii) complied with governance requirements.		
Assessment	A review of the provider licence and supporting evidence has been undertaken and the following assessment has been proposed: 1. The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6) – **CONFIRMED** 2. The provider has complied with the required governance arrangements Condition FT4(8)- **NOT CONFIRMED**. 3. If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver designated services Condition CoS7(3) – **CONFIRMED**		
Recommendation	Members of the Trust Board are asked to approve the assessment of compliance against the provider licence.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 1.3a - Risk of further breaches to condition 4 of the Trust Provider licence could result in further enforcement undertakings and licence conditions		

Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒
	Drive operational performance ☒	Long term financial sustainability ☒
	Develop clinical and commercial strategies ☒	

NHS Foundation Trust Self-certification

1. PURPOSE OF REPORT

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

2. BACKGROUND

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

3. DETAILS

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

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

- effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
- complied with governance arrangements (condition FT4);
- for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7).

3.1 Condition G6

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

- identify risks to compliance with the licence, NHS acts and the NHS Constitution
- guard against those risks occurring.

Providers must complete a self-certification after reviewing whether their processes and systems were implemented in the previous financial year and were effective (condition G6(3)).

Providers must publish their self-certification by 30 June (condition G6(4)).

It is recommended that there is appropriate evidence to confirm that the Trust declares **"Confirmed"** with this condition.

3.2 Condition FT4(8)

Condition FT4 is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4.

It is recommended that this is not sufficient evidence to confirm that the Trust has complied with this condition therefore is declaring **"Not Confirmed"**

3.3 Condition CoS7

The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. This only applies to foundation trusts that are providers of CRS.

It is recommended that the Trust declares **"Confirmed"** due to its compliance with Statement (B) which is that:

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

In making this decision the Trust has taken the following into account:

- agreement of financial recovery plan
- ongoing deficit support
- emergency PDC capital support
- COVID pandemic funding

4. RECOMMENDATIONS

The Trust Board of Directors is asked to note the above and support the sign-off of the Trust's annual self-certification.

APPENDICES

Appendix 1 – self assessment

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2020/21**

Corporate Governance Statement (FTs and NHS trusts)

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

	Corporate Governance Statement	Response	Risks and Mitigating actions
2	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Please see Annual Governance Statement
3	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Please see Annual Governance Statement
4	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Please see Annual Governance Statement
5	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Not confirmed	Modifications to the existing additional licence condition imposed on the Trust under section 111 of the Health and Social Care Act 2012 ("the Act") made on 11 November 2019.

6	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Please see Annual Governance Statement
7	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Please see Annual Governance Statement

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

Signature 

Name Sue Page

Signature

Name Neil Mundy

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2020/21

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

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

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

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed

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

EITHER:

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

OR

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

OR

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

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

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

agreement of financial recovery plan
ongoing deficit support
emergency PDC capital support
COVID pandemic funding

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

Signature		**Signature**	
Name	Sue Page	**Name**	Neil Mundy
Capacity	Chief Executive	**Capacity**	Interim Joint Chairman
Date		**Date**	

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

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 1 June 2021			
Board Assurance Framework			**AGENDA ITEM: 14, ENC 12**
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. At the last meeting of the Board an update was provided on progress with regard to establishing the principal risks and threats to achieving the strategic objectives. The attached report includes a **first draft** of the Board Assurance Framework and the report identifies the process which has been undertaken to identify the principal risks and proposes the next steps in the process.		
Background	This paper provides an update on developing the Board Assurance Framework (BAF) for the Board. Members are reminded that 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 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 what level of assurance they give • Gaps in controls or assurance, and • Actions to close gaps and mitigate risk Ensuring effective systems are in place to identify, monitor and mitigate risks and providing assurance to Board.		
Assessment	The Board received an update at the last meeting setting out progress to date on identifying the principal risks and threats to delivery of the strategic objectives. Since then discussions have taken place with the Executive Leads, Managing Director and Board Sub Committees to review and refine the principal risks and threats. The Board should be advised that this is a **first draft** and further work is required. This should be undertaken at Board Sub Committee level and should be complete and signed off by Chairs of Committees at the next meeting of the Board.		

Recommendation	Members of the Board of Directors are asked to note the progress with the development of 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)	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☐
	Drive operational performance ☒	Long term financial sustainability ☐
	Develop clinical and commercial strategies ☐	

Board Assurance Framework

1. PURPOSE OF REPORT

The purpose of the report is to attached a first draft of the BAF and to set out the process which has been undertaken to identify the principal risks to the 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 Board received an update at the last meeting setting out progress to date on identifying the principal risks and threats to delivery of the strategic objectives. Since then discussions have taken place with the Executive Leads, Managing Director and Board Sub Committees to review and refine the principal risks and threats.

The Company Secretary has reviewed the format of the BAF, this meets the national requirements for BAF. The key elements of the updated BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework
- Risk ratings – initial, current and target levels

- Clear identification of primary strategic threats 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

An additional step has been added in to the revised BAF in which the lead committee will provide a level of assurance ratings to the evidence provided. This is rag rated as follows:

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

Next Steps

- All Board Sub Committees to review the BAF in its new format and provide a level of assurance against each of the threats
- Agree the plans to take corrective action where gaps have been identified including clarify expectations on responsibilities and implementation / action dates
- Chairs of Board Sub Committees to sign off agreement of their element of the BAF prior to the July 2021 Board of Directors meeting

4. RECOMMENDATIONS

Members of the Board of Directors are asked to note the progress with the development of the BAF, receive the first draft of the BAF and agree to the next steps.

APPENDICES
BAF

South Tees Hospitals
NHS Foundation Trust

Board Assurance Framework (BAF): June 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.

FIRST DRAFT

South Tees Hospitals
NHS Foundation Trust

Principal risk (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		**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**
A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction	Corporate, Collaborative and Directorate structures, accountability & quality governance arrangements at Trust including: • Tier 1 Board Sub Committee – Quality Assurance Committee with sub groups – just reviewed • 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 • 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 QAC quarterly Freedom to Speak up report to QAC and People Committee quarterly Medicines Optimisation Report to QAC quarterly **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 report quarterly to QAC Urgent items for escalation at QAC monthly **Independent assurance:** CQC Insight tool to QAC CQC Rating and oversight (monthly relationship) ICNARC Quarterly Report to QAC Audit Inpatient Survey 2019 Maternity Inpatient Survey 2019 GMC Feedback to People Committee Care Quality Commission / External Regulation	Following review of QAC sub groups implement Monthly meeting of Safe and Effective Care Strategic Group – Mr Bennett – June 2021 Develop AHP Strategy – Ms Mhalanga – November 2021 Following review of QAC sub groups realign mortality and morbidity groups within the sub structure of QAC – Dr Monkhouse – June 2021 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 Implement the CQC action plan following 2019 inspection – Dr Lloyd/Mrs Angel – July 2021 Implement the CQC preparation plan for future inspection – Dr Lloyd/Mr Bennett – September 2021	

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		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 - Freedom to speak up; SIs, Prescribing)		
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 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 Review of estate in order to consider the ability to increase side room facilities – Mr Oxley – August 2021 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	
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 Quarterly & Annual Claims and Litigation report to QAC **Risk and compliance** IPR quality report to QAC and Board monthly Monthly Risk Validation Group review of 16+ new risks Quarterly Health & Safety group review of incidents DATIX incident reporting levels monitored against NRLS Freedom to speak up Guardians quarterly report to QAC Patient safety promises campaign **Independent Assurance** NRLS Benchmarking National Staff Survey External Audit Independent assessment of Quality Report 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	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 Incident reporting upgrade - DATIX cloud – Mr Bennett – July 2021 Development of patient safety faculty – 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 Prepare organisation for the	

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			implementation of the patient safety incident report framework – Mr Bennett/Dr Connolly – January 2022	
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 embeddedness from events – Mr Bennett – September 2021 Implement reciprocal mentorship programme fully across the Trust – August 2021 – Mrs Metcalf 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	
Ability to deliver national performance standards resulting in a lack of responsive and accessible services	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 implemented, Paediatric ED being established Weekly touchpoint meeting with Commissioners Daily touchpoint meeting on patient flow	**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 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)	Implement recommendations from the Internal audit on flow and waiting times – Mr Peate – September 2021 Implement the recommendations from the improvement work identified by ECIS – Mr Peate – September 2021 Recovery and Improvement Plan phase 2 to be completed and presented to the Board – Mrs Fallon – July 2021 Agree the revised process for managing and monitoring implementation of the recovery plan through the revised Assurance Framework model- Ms Tullock – July 2021	
Current estate, lack of	Improved access now in place for lifecycle investment	**Management**	Inability to release wards and theatres	

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capital investment and infrastructure compromises the ability to consistently delivery safe, caring, responsive and efficient patient care, world class services	(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	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	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.	

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South Tees Hospitals
NHS Foundation Trust

Principal risk	**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		**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
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 Date protection and security toolkit for 2020/21 to be completed – S Orley - date	
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		

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Principal risk	**Failure to recruit to full establishment, retain and engage our workforce**	**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		**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**
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 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	**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 **Risk and compliance** Guardian of Safe Working report to Board May 2020 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 Lack of Directorate and Collaborative ownership and accountability and understanding of their workforce issues – Collaboratives Chairs – date Establish clear report and visibility of collaborative agency spend and overtime – to be reported to Resource Committee – Dr Lal, Dr Lloyd – date Independent assurance required on e roster & allocate system to establish best use of resources – Resources Committee – Director of HR, Dr Lal, Dr Lloyd - date	
Poor health and absence	Welfare calls to staff who are absent	**Management**	Embed wellbeing into leadership and	

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within our workforce creating service pressures impacting their ability to deliver a high quality service	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	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	management programmes – Ms J Winnard - date Embed conversations about flexible and agile working as standard practice – through embedding the culture – Ms J Winnard - date 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 - date Work towards the Better Health at Work Award which will assist in embedding health and wellbeing into the workplace. Mrs R Metcalf - date Support financial wellbeing by implementing a programme of workshops for colleagues who are considering retirement and require support with pension planning. – Mrs R Metcalf date	
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	**Management** **Risk and compliance** **Independent Assurance**	Establish evidence that policy and flexible choice has been embedded in the organisation – Mrs Metcalf – date Establish home working group to support staff who remain at home or choose to work from home long term – Mrs Metcalf - date	
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 critical services Affina programme	**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 Guardian of Safe Working report to Board; Gender Pay Gap report to People Committee	Embed values based recruitment process – Mrs Metcalf – date Develop on-board programme to continuously engage and retain staff during their recruitment and early stages of employment – Mrs Metcalf – date	

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	Human factors training Leadership and development programme Just culture and civility saves lives programme Culture workshops and values agreed and launched across the Trust	**Independent Assurance** NHS staff survey 2020 results showing improvement in a number of areas Critical Care junior doctor survey discussed at People Committee 2021		

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South Tees Hospitals
NHS Foundation Trust

Principal risk	**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	Quality Assurance	**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
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 **Risk and Compliance** **Independent Assurance** One of the highest ranked medical training organisations Top 100 Apprenticeship Employer	Development of Improvement plan - phase 2 – Ms Fallon – July 2021 Enabling Plans to be finalised – lead Directors - date	
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	
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 Medical Management Model	**Management** Reports to QAC on R&D and Board quarterly **Risk and compliance**	R&D plan to be reviewed and updated – Director of R&D – date Estate available for regional centre (eg	

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	Research programme People Committee Leadership development programmes	MOU with Teesside University for strategic links Collaborations with HEIs **Independent Assurance**	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	
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	
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	

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South Tees Hospitals NHS Foundation Trust

Principal risk	**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	Board	**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
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	
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	
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**		
The Trust will not maximise its potential to contribute to the public	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 – Managing Director – July 2021	

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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**		
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**		

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South Tees Hospitals
NHS Foundation Trust

Principal risk	**Failure to deliver Trust financial strategy, due to the inability to establish and agree with the system the capital and revenue resource requirements And/or Failure to deliver the internal and shared system efficiency and cost reduction plans resulting in regulatory action**	**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		**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
Threat - failure to deliver a credible financial plan over the medium to long term	Resources Committee System based contracting approach ICP Finance Directors ICS Finance Directors Tees Valley CEO meeting ICS Management Executive Corporate governance framework (SFI/SO/SoD) Finance policies and procedures Vacancy control process in place Budget setting principles and budgets in place Existing CIP plans	**Management** Directorate level finance reports Cost centre level finance reports Annual report and accounts Annual Governance Statement **Risk and compliance** Finance to Board and Resources Committee monthly IPR report to Board and Committees Provider licence self-assessment **Independent assurance** Internal audit report on BAF Review of PFI costs – Deloitte External audit of annual account NHSE/I monthly finance monitoring Provider licence restrictions – Letter from Tim Savage	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 Agree with the Commissioner the additional investment to address the cost of the safety issues – Mr Hand - date Inability to agree within the system a credible and appropriately challenging CIP programme – Mr Hand - date Agree with ICS sufficient capital resource to address the Trust investment requirements over the short and medium term - Mr Hand - date Establish joint contracting group with NTHT – Mr Hand – date Implement recommendations from Provider licence letter – Tim Savage – 18 June 2021 and 31 August 2021	
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	**Management** Business Case for MIYA approved by Board Digital updates to Resource Committee quarterly **Risk and compliance**	Digital Director appointment process – Mr Harrison – 2.7.21 Update to digital strategy – Mr Harrison – date	

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	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	**Independent assurance** NHS digital review of Tees Valley PWC have completed audits of Cyber Security and the Data Security & Protection toolkit.	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	
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 Board to Board meetings and ongoing concerns discussed with NHSE/I CPG Constitution Operational Management Group Collaborative Chairs meeting Agency and locum sign off process NHS supply chain and procurement framework in place	**Management** Directorate level and department level finance reporting 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	
Lack of system resources and financial flexibility to invest in service transformation resulting in an inability to deliver required cost reduction	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	Review of finance structure to ensure fit for purpose to support directorates and Collaboratives financial management – Mr Hand – date Enhancement of CIP lifecycle and delivery programme – Mr Hand – date Delivery of the regional directors (2019) system savings to be reviewed by ICP – Mr Hand – date Agree risk share agreement across ICS – Mr Hand - date	
Failure to utilise and develop systems and process to identify future efficiency and transformation programmes through the use of tools such as model	Resources Committee Individual GIRFT review meetings CPG BIU team Collaborative Chairs Directorate meetings Annual PLICS report	**Management** Finance report including PLICS information to Resources Committee Costing guidance **Risk and compliance** Benchmarking update given to Resources Committee	Systematic approach to using benchmarking data – Mr Hard – date Theatre efficiency plan to be developed – Mr Peate - date	

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hospital, GIRFT, HED data, PLICS	Finance Business Partner - Costing	**Independent** NHSE/I independent costing assurance audits		
Current estate, lack of capital investment in equipment and infrastructure compromises the ability to consistently deliver safe, caring, responsive and efficient patient care.	Improved access now in place for lifecycle investment 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	

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Audit Committee
Chair's Log

Meeting: Audit Committee	**Date of Meeting**: May 19th, 2021
Summary for Board : Jun 1st, 2021	

Quorum

The meeting was held by teams. Chair Richard Carter-Ferris (RJCF) and NED David Jennings (DJ) were present giving quorum to the Committee

In attendance were Hilary Lloyd (HL), Chris Hand (CH), Jackie White (JW) and Brian Simpson (BS) from the Trust and representatives from Mazars (External Audit), PWC (Internal Audit)

The meeting was primarily to discuss the Annual report so no CF representatives were present

Internal Audit

Susan McNair (SMc) and Paul Charnock (PC) from PWC provided an update of their work and annual internal audit report. The overall internal audit position is "Generally satisfactory with some improvements required". This is one level better than last year and PWC complimented the trust on an improved internal control framework.

The key weaknesses identified were regarding IT infrastructure and controls. Kevin Oxley (KO) and Steven Orley attended the session and gave updates on the actions to mitigate the high risk findings. The AC were informed that most if not all of the actions would be complete by end of June and RJCF requested that KO inform the committee if any issues with resources or otherwise would cause delivery dates to me missed.

External Audit

Cameron Waddell (CW) and Cath Andrew (CA) briefed AC on the year end Audit progress. The work is on plan to be complete and meet reporting deadlines.

CW detailed the new process for VfM review which has been introduced this year.

Annual report and governance statements

JW presented the draft Annual governance statement which is substantially complete. Final tweaks to ensure readiness for deadline day. She also reviewed the narrative for the annual report which is in final draft state. Some comments and discussions will lead to final changes. AC happy that the reports are accurate and will be ready for final deadline.

BW walked the AC through the financials and as with remainder of process they are substantially complete subject to final audit. A few points are still to be completed in particular a couple of pension data points.

The Committee reviewed the register of gifts and hospitality, schedule of losses and tender waivers and identified no abnormal items. The committee reviewed the BAF and identified that there are no matters to be added to the BAF

Key	Actions
• SLT to ensure adequate support to KO/SO to ensure completion of internal Audit reviews so that the year end report can be issued on time.	KO / SLT
• Finalisation of Annual reports to me monitored and report if any delay	JW/BW

South Tees Hospitals
NHS Foundation Trust

Charitable Funds
Chair's Log

Meeting: Charitable Funds Committee	**Date of Meeting:** 18th May 2021
Connecting to: Board of Directors / Corporate Trustee	**Date of Meeting**: 10th August 2021
Key topics discussed in the meeting	
Quarterly review of income and expenditure Performance of investments Draft Charity annual review and accounts 2021 Fundraising update Trinity Holistic Centre review of income and fundraising plan Charity re-brand Finances, good progress made but still more to do Trustee training development need identified around roles and responsibilities	
Actions agreed in the meeting	Responsibility / timescale
Arrange a governance session to Trustees on the role and responsibilities of Trustees in relation to the charity.	Ben Murphy, head of charity – complete by the next committee meeting.
The Chair remarked on the level of charitable funds at £7m and suggested the guidance be drafted to circulate to fund holders setting out the criteria for managing funds including a reminder that funds should be used appropriately within a reasonable period and not merely accumulated	Ben Murphy, head of charity – complete by next committee meeting.
Nine business cases were considered and approved with conditions around capital spend and trust business case requirements needed. Head of charity to contact business case authors and inform them of	Ben Murphy, head of charity – complete by next committee meeting.

the outcome and conditions if any for action. Work with the new Collaboratives to explore the scope to rationalise the number of smaller and dormant funds to support more extensive and innovative spend	Ben Murphy, head of charity and Jackie White, head of governance to meet with Collaboratives and explore options and a way forward to reduce funds - complete by next committee meeting.
Escalation of issues for action by connecting group	**Responsibility / timescale**
Board / Corporate Trustee to note that charitable funding was agreed for a number of business cases that supported staff health and wellbeing and advancing health for our patients. Projects included; renovation of ward 17 outdoor garden, mobile project wingman, digital white boards for theatres, the children and young person's emergency department and the fixed term appointment of a palliative care pharmacist and a bereavement counsellor.	To note
Chair noted the progress made to date with regards to financial governance and that the outstanding items to be addressed will be focused on as a priority.	To note
Discuss future options for the Trinity Holistic Centre with the executive team following the options appraisal and risks associated with each option. Executive team to agree a sustainable way forward for the Trinity Holistic Centre. The Chair asked if for a long term plan to be agreed within 6 months.	Head of Governance and Director of Finance By the next committee meeting.
Committee endorsed the Charity rebrand rollout.	To note
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
There were no matters to consider	

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 25/05/2021
Connecting to: Board of Directors	**Date of Meeting**: 01/06/2021

Key topics discussed in the meeting	

- Maternity Services Quarterly report
- Falls update - **Deferred**
- Nursing, Midwifery & Healthcare Professional Model of Professional Practice
- Research & Development 6 monthly report
- QAC Reporting & Connecting Group Structure
- QAC effectiveness review and ToR **(ToR Deferred)**
- CQC action plan update report
- Monthly IPR – Quality
- Clinical Audit Annual Report
- Quality Priorities report (metrics, monitoring and progress)
- 2020/21 Quality account timescales and submission
- Monthly SI/NE report (including learning slides)
- Patient Safety & Legal Services Annual report
- Health & Safety & Fire Annual Report
- Review of Risks and Matters for the Board Assurance Framework
- Chairs log of any sub group reporting to the committee

Actions	Responsibility / timescale
• **Maternity Services Quarterly Report** Outstanding risks continue to be the continuity of carer project, the stop smoking project and the lack of digital systems to support data capture. Action plans are in place for both the continuity of carer project and stop smoking. A business case has been agreed in principle for the software to support data capture however this is going to CPG and the Resources Committee in the next month. • **Bi-annual Update of the Research and Development** A very positive report from the Durham, Tees Valley Research Alliance demonstrating a strong performance throughout COVID. DTVRA is the second highest recruiting alliance in the region, high numbers of recruits in the NOVAVAX COVID 19 vaccine trial, and positive research grant activity. Income from COVID studies and how this might be used to sustain R&D in future years is under discussion. • **Ophthalmology Update** QAC received an update on the effects of COVID on the ophthalmology service and waiting list. The trust is implementing the Medisight, a bespoke ophthalmology IT system, and upgrading CAMIS to e-CAMIS which will support the tracking of patients who have been cancelled or have open follow up appointments, both part of the digital strategy. The COO has stood up three specific trust wide	Kay Branch

recovery groups. Each has a different focus which include drilling down waiting lists and waiting times, embedded learning and will also focus on administration and training programmes. The risk rating in ophthalmology has been reduced. QAC requested an update on open SI's in future reports.	Hilary Lloyd & Ian Bennett
• **IPR and cancer targets** The reports narrative has been expended which was welcomed. QAC heard that there are a number of things being worked on around trajectories, activity levels and performance and that a draft plan of work is being developed for cancer and diagnostics to be shared at the June meeting. QAC noted that the Trust is in a better position regarding RTT and long waiters. QAC requested that the work plan as well as being presented to the Resource committee, also comes to QAC for assurance.	Sam Peate

• A number of annual plans were received
  • The Clinical Audit Annual Plan
  • The Patient Safety and Legal Services Annual Report	

• **Health and Safety Annual Report** The H&S Annual Report was received and demonstrated the importance of the H&S group work in the last year. The team and wider team were congratulated on their achievements in this important area. The report contained a comprehensive workplan for 2021/2022 which will be monitored quarterly via QAC.	
• **Quality Account** Timescales for publishing the Quality Account is the end of July 2021. QAC was asked sign this off on behalf of trust board.	Hilary Lloyd and Ian Bennett
• **BAF** A verbal report was received on the new BAF which will be circulated for comment and sign off at the June meeting.	Jackie White

Escalated items
Board to note: • The success's of the Durham Tees Valley Research Alliance (DTVRA) • The position in ophthalmology services

Risks (Include ID if currently on risk register)	Responsibility / timescale
N/A	

Extra-ordinary People Committee:
Chair's Log

Meeting: Extra-ordinary People Committee	**Date of Meeting**: 26 May 2021
Highlights for: Board of Directors	**Date of Meeting**: 1 June 2021

Overview of key areas of work and matters for Board.

The agenda for this extraordinary meeting was to hear input from each of the Collaboratives and Corporate Services on their responses to the Staff Survey and their improvement plans for 2021.

Each had submitted an overview of their specific areas of focus and there was a discussion and questions with a particular emphasis on plans for improvement on Appraisals and mandatory training.

There will be further discussion within the Committee at the ordinary meeting on the 27th May.

Summary

This is the second time this exercise has been undertaken and the Committee noted the increase in good engagement from senior leaders in each area. The plans in the main were sharp and well evidenced and discussion drew out the timescales which services and directorates are working to. There were good ideas and evidence of learning being shared.

Discussion around embedding the Trust values, the safety culture, civility and organisational development were recurrent themes in the plans and priorities.

There is evidence of a time lag in data shared with HR to inform reporting to the Committee and Board. In a number of cases Managers updated the data, particularly on appraisals.

There was evidence of engagement with the equality and diversity strategy and priorities for the Trust.

The experience of working through the pandemic emerged as a constant theme, both in terms of the challenges – for staff shielding, working in critical care, and also for support services such as Finance where home working presented both opportunities and challenges.

It was encouraging to hear an awareness of the likely re-inspection this year, and the ambition services have to demonstrate their progress back to good.

The sessions provided a good level of assurance for the Committee that across the Trust senior leaders are both aware of the views of staff expressed in the survey, and keen to effect improvement and enhance engagement. They also offered HR

opportunities to identify those services likely to benefit from some additional support.

It was agreed to invite services back later in the year for an update on the progress against the plans.

The Committee thanked all those who participated for their participation and input.

People Committee
Chair's Log

Meeting: People Committee	**Date of Meeting**: 27 May 2021
Highlights for: Board of Directors	**Date of Meeting**: 1 Jun 2021

Overview of key areas of work and matters for Board.

- Board Assurance Framework risks
- Gender pay gap report
- Staff health and wellbeing
- People plan
- CQC preparation
- Disciplinary policy
- Workforce performance metrics
- Medical assurance and establishment review

Actions to be taken	Responsibility / timescale
Reviewed and acknowledged the new format of the BAF risk framework. Detailed walk through of the threats, controls, assurance sources and gaps. Some minor wording changes proposed around the principal risk title and capturing the importance of partnerships, education, networks, and 3rd parties as part of our workforce. Discussed the alignment to safe staffing levels and the impact of our talent management programme. Further thoughts to be added on measuring agile working effectiveness and culture improvements throughout the year. Reviewed the gender pay gap data and proposed next steps. Increasing the number and successful attainment of Clinical excellence awards is a key focus area for 2022 following national changes and ensuring diversity of applications for key vacancies and talent management pipeline. Highlighted the need for benchmarking, setting a measurable improvement target and embedding best practise. Heath and wellbeing have seen an improvement in the number and quality of return to work processes. A calendar of lifestyle and wellbeing events to be shaped around the staff response to needs and priorities. Wellbeing pods arriving soon with mobile support for community and Friarage sites. Discussed need for a 'Cycle to Work' champion, walking routes, and completing the refurb of staff break out areas. Walked through the proposed People Plan. Discussed alignment to strategy, recovery plan and board risk	

framework. Challenged whether sufficient resources to deliver the plan and the role of the collaborative chairs in owning the policy and bringing it to life. Some additional metrics agreed around payroll and invoice issues. Final version to be approved in June committee before July board meeting. Assurance gained on the CQC preparation and that all departments involved in the plan. Request to add measures and evidence around improvements made to quality and culture especially where organisation development has taken place. Reviewed the updated disciplinary policy and acknowledged the need for more people to have formal training on investigations. Next update to include any trends around timescale failures and evidence of diversity and inclusion considerations, proportionality of policy application, and capturing the improvements achieved in relationship effectiveness with staffside. Good improvement seen in attendance with most sickness now long-term illness and repeat cases. Support for absence management increasing post pandemic. Agreed review of the procedure between teams and HR to ensure data on mandatory training is accurate and aligned and potential for real-time reporting. Agreed to review the target and benchmark for training with proposal to be presented in June committee including a plan to tackle recurring non-compliance and key focus areas. Work underway to identify the key gaps in medical and workforce assurance. Initial findings are lack of diversity on interview panels, consultant staff turnover, alignment of vacancies with e-roster, gaps in training posts to enable specialist recruitment, and timing of vacancies to student graduation. Discussed the impact on safe staffing. Assurance timetable to be drawn up and reviewed by committee in 3 and 6 months. The committee noted its thanks to all team members who presented their staff survey results feedback and next steps. Reverse mentoring activity underway with local familiarisation sessions, and network member involvement in recruitment, staff support, etc. Plans in place for LGBT+ network and next month's Pride event Freedom to speak up results confirmed South Tees has seen the highest improvement across the country.	

Board action	Responsibility / timescale
There were no matters for escalation to the board.	
Risks (Include ID if currently on risk register)	Responsibility / timescale
No new risks identified.	