South Tees Hospitals
NHS Foundation Trust

Board of Directors

7July 2020
10:30 am
Microsoft teams

South Tees Hospitals NHS Foundation Trust

MEETING OF THE SOUTH TEES HOSPITALS NHS FOUNDATION TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON TUESDAY 7 JULY 2020 AT 10:30 AM IN THE BOARD ROOM, MURRAY BUILDING, JAMES COOK UNVERSITY HOSPITAL AND MICROSOFT TEAMS

AGENDA

ITEM		PURPOSE	LEAD	FORMAT
STAFF 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 2 June 2020	Approval	Chair	ENC 2
5.	Matters Arising	Review	Chair	ENC 3
6.	Chairman's report	Information	Chair	Verbal
7.	Chief Executive's report	Information	Chief Executive	Verbal
QUALITY AND SAFETY				
8.	Safe Staffing Report for May 2020	Information	Director of Nursing & Midwifery	ENC 4
9.	NHSE/I Covid19 Infection, Prevention and Control Board Assurance Framework	Approval	Director of Nursing & Midwifery	ENC 5
10.	Safeguarding Annual Report 2019/20	Approval	Director of Nursing & Midwifery	ENC 6
FINANCE AND PERFORMANCE				
11.	Integrated Performance Report	Discussion	Chief Operating Officer	ENC 7
12.	Month 2 2020/21 Financial Performance	Information	Director of Finance	ENC 8
GOVERNANCE AND ASSURANCE				

ITEM		PURPOSE	LEAD	FORMAT
13.	Board Assurance Framework	Information	Head of Governance	ENC 9
14.	Corporate Risk Register	Information	Head of Governance	ENC 10
15.	Chair's Logs from Board Committee Meetings	Discussion	Chairs	ENC 11
16.	Any Other Business	Discussion	Chair	Verbal
17.	Risks to be added to the Board Assurance Framework	Discussion	Chair	Verbal
18.	Reflections on Meeting	Discussion	Chair / All	Verbal
	DATE OF NEXT MEETING The next meeting of Board of Directors will take place on Tuesday 1 September 2020.			
	Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960)			

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 7 JULY 2020			
Register of members interests			**AGENDA ITEM: 3, ENC 1**
Report Author and Job Title:	Jackie White Head of Governance	**Responsible Director:**	Alan Downey Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	The Board of Directors are asked to note interests declared by members of the Committee		
Background	The report sets out membership of the Board of Directors and interests registered by members. Conflicts should be managed in accordance to the Constitution para 32 - If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to other Directors.		
Assessment	There are no specific conflicts identified with the agenda. Members will be reminded at the meeting to raise any if they arise.		
Recommendation	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
Alan Downey	Chairman	1 March 2018 15 April 2014	ongoing 2 April 2019	Wife is Director of PricewaterhouseCoopers working mainly with local government clients in the North of England Neddown Limited (dissolved company) from 2 April 2019 and (dormant) prior to joining the Trust.
Ada Burns	Non-Executive Director	2017 2017 2019	Ongoing Ongoing Ongoing	Role - Governor – Chair of Resources Committee, member of Board of Teesside University. Trustee & Vice Chair – New Local Government Network (NLGN) – Public policy think tank Role – Associate Consultant – Cratus Consultancy, public sector management consultancy
Maureen Rutter	Non-executive Director (Senior Independent Director)	1996	ongoing	Member of Macmillan Cancer Support
Richard Carter-Ferris	Non-executive Director	1 August 2015	ongoing	Director of Yorkshire Area P2P Club – company generates donations for Yorkshire Air Ambulance. Director/No exec Director – Malton & Norton Golf club ltd.
David Heslop	Non-executive Director			No interests declared
Mike Ducker	Non-executive Director	1 December 2017 1 December 2005 1 October 2019	ongoing ongoing ongoing	Advisor to UK Government on Chemicals Industry Trustee of Greenstones Christian Trust Charity – a Charity working with prisons in Ethiopia South Tees Healthcare Management Limited - Company number 10166808
Debbie Reape	Non-executive Director	August 2019 1 October 2019 October 2019	Ongoing Ongoing Ongoing	Associate Director with Northumbria International Alliance (Northumbria NHS Trust and Northumberland County Council) South Tees Healthcare Management Limited - Company number 10166808. School Governor, Ashington Academy.
Adrian Clements	Medical Director	23 January 2012	Ongoing	Director of Clements Medico Legal Consulting Limited.
David Chadwick	Medical Director			No interests declared.
Sath Nag	Medical Director			No interests declared.
Steven Mason	Director of Finance	1 October 2017 13 August 2018 March 2019 1 October 2019 1 April 2020	ongoing ongoing ongoing ongoing ongoing	Children employed at Ernst & Young and Deloitte HM Property Services Ltd (Shareholder) not seeking work in NHS Client representative ELFS Management Board. South Tees Healthcare Management Limited - Company number 10166808. Non-Executive Director – Together for Children

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

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 2 JUNE 2020 AT 12.00 IN THE BOARD ROOM, JAMES COOK UNIVERSITY HOSPITAL AND MICROSOFT TEAMS

Present

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

In Attendance

Mrs J White	Interim Head of Governance
Ms J Reilly	Interim Chief Operating Officer
Ms J Alderson	Non-Executive Director – Insights Programme
Mr M Graham	Interim Director of Communications

Action

BoD/20/043 **WELCOME AND INTRODUCTIONS**

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

BoD/20/044 **APOLOGIES FOR ABSENCE**

There were no apologies for absence. The Chairman noted that, during the Covid-19 crisis and until further notice, non-voting Board members would not necessarily be asked to attend.

BoD/20/045 **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/20/046 **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/20/047 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on 5 May 2020 were — Mrs White

Action

reviewed and agreed as an accurate record subject to the following change:

Page 5, Bod/20/34, para 6, 2nd line, replace EPPR with EPRR

BoD/20/048 **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

BoD/20/049 **CHAIR'S REPORT**

The Chair commented that he had attended a number of meetings of the Strategic Command and continued to be impressed with the way the group, and indeed the whole command structure, was operating.

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

Finally the Chair reported that he had attended a number of Board Committee meetings this month including meetings of the Finance & Investment Committee and Audit Committee

Resolution

The Board of Directors noted the Chair's report.

BoD/20/050 **CHIEF EXECUTIVE'S REPORT**

Ms Page referred members to the slides that she had provided by way of an update on COVID 19. Ms Page described the governance structure that had been put in place and expressed her confidence that the Trust was on the right track, with the right clinical expertise to lead the Trust through recovery.

A review of phase 1 had been undertaken and the lessons learnt from this will be used in preparing for the next phase.

The Chairman commented that the Council of Governors had asked him to convey their gratitude and appreciation to the Trust Board and all staff for the work that had been undertaken. The Chairman added his thanks, on behalf of the board, to the staff on the fantastic job they had done, rising to the occasion and supporting each another through the pandemic.

Ms Burns commented that it was good to see early thinking around recovery and asked how the Trust was linking in with

Action

the wider system. Mr Mason confirmed that the Trust is working within two ICPs who are coordinating meetings twice a week on recovery to ensure synergy and coordination of activity across the system. In addition work was being led by the CCGs on engagement with primary care and maintaining the momentum going forward.

Mr Heslop was pleased to hear we are planning well and preparing for another surge and asked how the Trust is screening patients who attend A&E. Mr Clements advised that the Trust has been testing every patient admitted to the Trust, whether through A&E or through other pathways. Patients are screened before being placed with other patients to maintain safety. Patents admitted for elective procedures, are asked to isolate for two weeks prior to attendance and then screened. The Trust maintains clear pathways to protect staff and patients.

Mr Graham advised that community services have supported the Trust during the pandemic, and the Emergency Department is changing the way patients engage at front of house, and we will be taking forward "talk before you walk" to ensure patients are managed and get to the right place for treatment by encouraging patients to contact NHS 111 if they have an urgent but non-life-threatening medical need and are unsure what to do..

Resolution

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

BoD/20/051 **SAFE STAFFING MONTHLY REPORT**

Mrs Fowler reported that she has shared a new look safe staffing report with a number of Non-Executive Directors for comment and that she will present the new look report to the next meeting.

In terms of the current safe staffing report, members noted that the fill rate is good against plan at 89.5% at a 50% bed occupancy rate. 91 aspirant nurses have started with the Trust and a number of registered nurses and OPDs who were redeployed to critical care are now back at their base and others will follow.

Resolution

The Trust Board of Directors noted the update on staffing

Action

BoD/20/052 **FREEDOM TO SPEAK UP**

Ms Smithies, Freedom to Speak Up Guardian, presented an update on Freedom to Speak Up. Members noted that the process forms part of the NHS Standard contract and should augment and support usual management practices aimed at promoting an open and transparent culture. Her report details action taken under the Freedom to Speak Up agenda within the Trust from September 2019 to March 2020. It further gives details of FTSU issues raised in relation to COVID 19. Finally it considers action needed to further progress the agenda within the organisation.

Ms Smithies reported that, despite the progress to date in relation to structures, policies and personnel, there is still much work to be done. This is most notable in addressing the less tangible elements of thinking, action and habitual practice and embedding these across the leadership and workforce of the trust, not just in staff with a specific FTSU role.

Mrs Fowler added that the report also considers outline proposals to develop the agenda in the next year. The service will transfer to Mr Bennett's portfolio, and a proposal for development of the service was due to be considered further at the Workforce Committee.

Mr Heslop asked whether the resource devoted to FTSU will be increased, and Mrs Fowler confirmed that there will be funding for the equivalent of two full-time Band 7 posts. The model will ensure there are visible and accessible FTSU Guardians in both clinical and corporate parts of the Trust.

The Chairman asked Mrs Fowler if she has a view on how many Guardians will be appointed to make up the equivalent of two full-time posts. Mrs Fowler advised that this had not yet been worked out, but she expected there to be a relatively small number of Champions, each with ring-fenced time for the role.

Ms Reilly commented that the centres are currently looking at how to utilise FTSU and Mrs Angel has linked with the National Guardian's office who is willing to support the Trust in this.

The Chairman asked how the new service will be launched and Mrs Fowler reported that the new service will be launched in conjunction with the new values and behaviour framework. Ms Burns said she was encouraged to hear this.

The Chairman thanked Ms Smithies on behalf of the Trust Board and wished her well on her retirement.

		Action
	Resolution **The Trust Board of Directors noted the update on Freedom to Speak up**	
BoD/20/053	**PERFORMANCE REPORT** Mrs Fallon presented to members the latest iteration of the new performance report for the Trust. Members were reminded of the work Mrs Fallon has been undertaking on developing the new report and associated KPIs. Going forward Mrs Fallon advised members that a summary pulling together all the key issues into a front sheet will be produced. Mrs Fallon thanked the BI team for pulling the report together. Mrs Fallon reported that the Board was due to receive some board development support on "making data count" prior to launching the new report, but this had been postponed due to COVID-19. Mrs White is liaising with the team to reschedule this session. Mrs Fallon added that she is reviewing the KPIs in relation to tertiary and community services which needed adding along with the links to people and quality. Finally Mrs Fallon advised that each of the Committees will receive the report in order to interrogate their element of the report. Ms Reape thanked Mrs Fallon for the report and asked whether the report will pick up the trajectory for recovery. Mrs Fallon confirmed that most areas in the report will include a trajectory using the capacity and demand model from the recovery improvement plan. Mr Heslop commented that it was good to see the upper and lower limits but that the mean was not relevant and perhaps the average would be more appropriate to include. Mrs Fallon noted this request. Mr Ducker noted that there were around 40 measures already included in the report, referring to Mrs Fallon's comment on looking at additional KPIs. He suggested that these would might need slimming down for reporting to the Board. Mrs Fallon agreed and suggested the report is built up and the Board then agree which KPIs it wishes to see and which will be monitored by a Board Committee. Ms Reilly referred members to the responsive measures and in particular the Cancer 62 day standard. Members noted that the Trust had established the Southern Cancer cell ensuring all priority 2 patients are operated on within a four week period. In addition star chamber reviews with priority MDT tumour site leads were planned over the next three	Mrs White Mrs Fallon

Action

weeks. Ms Reape commented that she was pleased to hear about the work on the star chambers and looked forward to hearing the output of these in the near future.

Mr Heslop raised concern regarding the reduction in cancer activity due to COVID-19. Ms Reilly advised that work continues to review referrals first before bringing the patient into the hospital for the safety of the patient which does reduce the amount of activity the Trust is seeing.

The Chairman thanked Mrs Fallon and the BI team for the report.

Mrs Fowler reported that the Trust is seeing an increase in pressure ulcers and falls which are being looked at. A paper will be considered at the next meeting of the Quality Assurance Committee on the detail.

Mr Mason reported that there will be a detailed finance report at the next Board meeting.

Resolution

The Trust Board of Directors noted the performance report.

BoD/20/054 **PROVIDER LICENCE SUBMISSION**

Mrs White reported on the Trust assessment against the NHS provider licence following a review of the evidence against the licence conditions. Mrs White recommended that the Trust submit as follows:

1. The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3) – NOT CONFIRMED
2. The provider has complied with the required governance arrangements Condition FT4(8)- 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

Resolution

The Trust Board of Directors APPROVED the provider licence submission

Action

BoD/20/055 **CHAIRS' LOGS FROM BOARD COMMITTEES**

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

Workforce – Ms Burns referred members to the risk regarding IG training and advised that she has asked for a fresh eyes review on how we could do this differently to enable staff to be compliant.

Finance & Investment Committee – Mr Ducker reported that the Committee looked at the 2021 baseline budget and approved the budget on behalf of the Board. Mr Ducker advised that the committee noted the impact of the special Covid arrangements. He added that the Committee noted that £ Ophthalmology was not included in the budget but recognised further discussion was required. Finally Mr Ducker confirmed that the Committee would explore the issue of PFI lifecycle maintenance and payments at its next meeting.

Quality Assurance Committee – Ms Reape confirmed that the Committee had reviewed the additional information following a rise in mortality at Redcar Primary Care hospital and did not wish to escalate anything to the Board.

Audit Committee – Mr Carter Ferris reported that there had been a useful report on counter fraud: internal audit had identified a number of high risk issues which will be reported in the Annual Governance Statement. Finally the Committee reminded the Board of its delegated authority to approve the accounts at its next meeting.

BoD/20/056 **ANY OTHER BUSINESS**

There was no other business.

BoD/20/057 **RISKS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK**

No new risks were identified.

BoD/20/058 **REFLECTIONS ON MEETING**

The Chair commented on the very sad loss of Mr Mark Lowe a member staff and asked members to observe a minute's silence in his memory and to reflect on his contribution to the Trust..

BoD/20/059 **DATE AND TIME OF NEXT MEETING**

The next meeting of the public Board of Directors will be held on Tuesday 7 July 2020.

Signed: ……

Date: ……

Board of Direction Action Log (meeting held in Public)

Date of Meeting	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
5.11.19	BoD/19/82	HEALTHCARE ASSOCIATED INFECTION MONTHLY REPORT	Mr Heslop advised that the online training for infection control hasn't changed, and perhaps the focus needs to be on behavioural changes going forward. Mrs Hunt agreed to look into the training.	D Fowler	31.7.20	Training slides revewied with the IPC lead and these have been updated in terms of priorities and technical knowledge. They need loading onto the system but that is delayed due to current situation. The next piece of work is to help the team develop more skills around 'nudge theory' and human factors to enhance both formal and informal training methods and we will be planning to do that when the new Band 8 starts (hopefully in approx. 3-4 month) and aligned with the new QI and Leadership Practitioners being more readily available as we lift some restrictions.	open
4.2.20	BoD/19/147	IMPROVEMENT PLAN	Improvement plan needed to be costed and robustly monitored	R Fallon	31.5.20	Date amended	open
2.6.20	BoD/20/053	PERFORMANCE REPORT	Mrs White to liaising with the team to reschedule the "making data count" session.	J White	31.9.20	Contact made and awaiting agreement on date	open
2.6.20	BoD/20/053	PERFORMANCE REPORT	Mrs Fallon to support the Board to agree which KPIs it wishes to see and which will be monitored by a Board Committee.	R Fallon	31.12.30	Further interation of the Board report being received at the July meeting and during August the KPIs will be finalised and agreed with the Committees and Board for September	open

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 7 JULY 2020			
Safe Staffing Report for May 2020 – Nursing, Midwifery and Allied Health Professionals (AHP)			**AGENDA ITEM: 8** **ENC 4**
Report Author and Job Title:	Eileen Aylott, Assistant Director of Nursing Education and Workforce	**Responsible Director:**	Deirdre, Director of Nursing and Quality
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report details nursing, midwifery and AHP staffing levels for the month of May 2020.		
Background	The requirement to publish nursing, midwifery and AHP staffing levels on a monthly basis is explicit and is one of the ten expectations specified by the National Quality Board (2013 and 2016).		
Assessment	Staffing has matched patient acuity and dependency throughout May. Patient harms have increased in terms of fall and pressure ulcers. This may be related to changes in the patient pathway ie Ward 25 elective orthopaedic and gastro and Tocketts taking stroke rehab, staff redeployment to unfamiliar areas and locations, use of PPE and proning of patients within critical care.		
Recommendation	The Board of Directors are asked to note the content of this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 5.1 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		
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, Midwifery and AHP Workforce Report

June 2020 based on May 2020 Data

Safe Staffing Governance

A more accurate measure of safe staffing has been against professional judgement templates created during the physical splitting of the hospital sites into COVID and Non-COVID pathways. Due to the unknown aspects of the disease, clinical judgement was based on the need for staff in the COVID areas to don and doff Personal Protective Equipment (PPE), the estimated respiratory requirements of infected patients and the psychological impact of increased end of life care of staff.

Daily Senior Nursing Workforce meetings were held to review safe staffing across the patient pathways with staffing requirements adjusted as the month progressed. The frequency of these meetings has been reduced to three times weekly and includes HR, an Ops Director, finance and Medical Consultant Colleagues.

Clinical Matron Huddles and Ward Manager Briefings have been utilised to ensure full communication of plans and to gain feedback from teams to inform decision making.

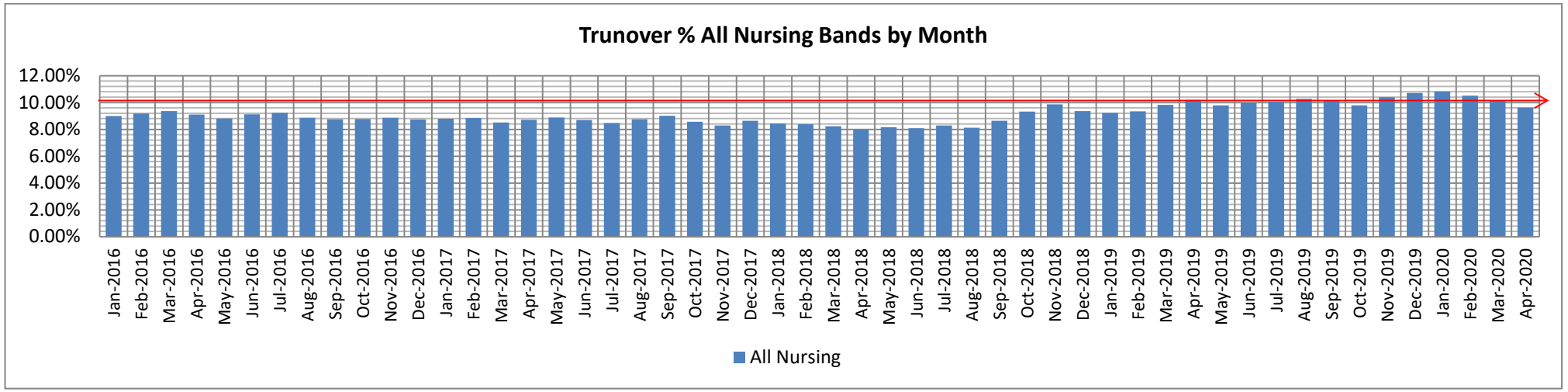
Staff redeployment has taken place to ensure patient safety with twice daily SafeCare meetings to address any immediate issues and robust plans for overnight and weekend staffing shared with patient flow.

Table 1 – Overall UNIFY fill Rate based on planned vs worked hours for May 2020

		April 2020	May 2020	
Overall Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	81.1%	87.2%	The UNIFY safe staffing report has now been requested by NHSI for retrospective submission of March Data by 17th May and then April, May and June data by 15th July Bed occupancy during May across the Trust has remained reduced with COVID positive numbers reducing and Non-COVID emergency and planned admissions increasing. 140 second year Student Nurses commenced paid placements across the Trust on 18th May and would have been in their supernumerary period and not been included in the fill rate %. Theatre staff have returned from Critical Care to FHN to begin surgical procedures.
	HCA (%) Average fill rate - DAYS	72.4%	105%	
	NA (%) Average fill rate - DAYS	100.0%	100.0%	
	TNA (%) Average fill rate - DAYS	100.0%	100.0%	
	RN/RMs (%) Average fill rate - NIGHTS	81.3%	86.9%	
	HCA (%) Average fill rate - NIGHTS	80.7%	96.8%	
	NA (%) Average fill rate - NIGHTS	100.0%	100.0%	
	TNA (%) Average fill rate - NIGHTS	100.0%	100.0%	
	Total % of Overall planned hours	**89.44%**	**96.99%**	

Nursing Vacancy and Turnover

The current nursing and midwifery vacancy rate against the financial ledger is 3.3% for May 2020. Turnover for the month of April for all Nursing and Midwifery is at 9.62%.



Approximately 100 adult, 6 midwifery and 11 paediatric student nurses are being recruited to commence band 5 posts in September/October. Potential COVID effects on student placements have been minimised by the Trust offering extended paid placements although there may be some lag in registration which will be clarified over the next two months.

Due to increased student capacity built up over the past 4 years the vacancy rate for band 5 RN's should be minimal by September 2020 and by January 2021 we are predicted to be over recruited. There are still 35 international nurses waiting to travel who have been recruited before travel restrictions came into force. The arrival of these nurses is dependent on a number of factors including the need for self-isolation, our ability to provide accommodation to enable this safely, international travel restrictions being lifted and the reopening of the OSCE test centres.

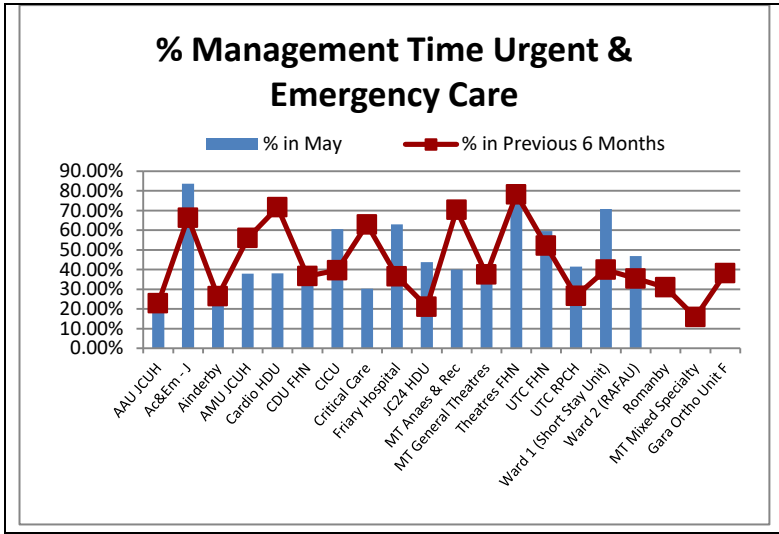
Band 7 RN/RM turnover has included a number of specialist nurses at retirement age and these posts are likely to create some movement through internal progression of band 6 and band 5 staff.

This situation will be dependent on the effects of COVID working on our current workforce and will require dedicated work through our Nursing, Midwifery and AHP workforce strategy around retention.

Urgent and Emergency Care Centre actual worked hours against planned and professional judgement template numbers for May 2020

May 2020 Data	Planned Day	Worked Day	Planned N	Worked N	Bed Occ	PU 2's	PU 3's	Medication Incidents	Patient Falls	Formal Complaints	Quality Impact
Critical Care	70	36 + 7	69	33 + 3	22	24	1	3	1	0	Increase in pressure ulcers possibly due to proning of ventilated patients
Critical Care Surge		4 + 4		3 + 3		0	0	0	0	0	
RAFAU	5 + 5	4 + 4	4 + 4	3 + 3	7	0	0	2	9	0	
Short Stay (JC02)	5 + 5	5 + 4	4 + 4	3 + 3	8	1	0	1	3	0	
AMU JCUH	4 + 3	5 + 5	4 + 3	5 + 3	10	0	0	1	1	0	
Ward 38	3 + 2	3 + 2	2 + 2	2 + 2	-	0	0	0	0	0	
AAU JCUH	5 + 3	7 + 4	4 + 3	4 + 3	5	0	0	1	3	0	
CDU FHN	5 + 3	4 + 4	3 + 2	3 + 2	5	3	0	2	2	0	
Ainderby FHN	5 + 5	4 + 6	3 + 4	3 + 3	5	1	0	1	1	0	
Romanby FHN	4 + 3	4 + 4	2 + 2	2 + 2	11	1	0	2	1	0	
Ac&Em -J	17 + 7	16 + 8	15 + 7	15 + 6	-	0	0	3	1	0	

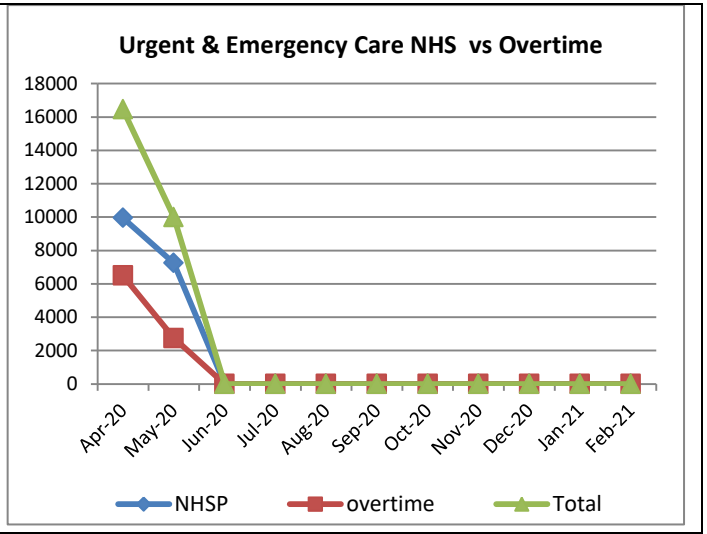
Critical Care requirement for staffing has been extensive with a large number of ex critical care nurses returning to the units to complete refresher training and shadowing. Theatre staff have also been working within critical care as the footprint increased into theatre, PICU, FSAU and CICU. A full paper has been submitted with surge plan details by Critical Care.



Ward Managers are budgeted 80% supervisory time on the roster. The use of this time versus clinical time varies by ward/department and as can be seen from the adjacent chart demonstrates continued variation during COVID.

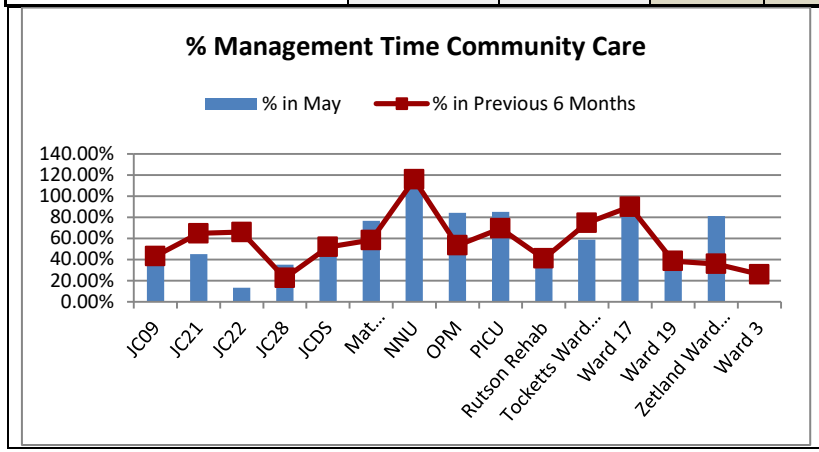
Romanby manager has had sickness and leave whilst Gara and MT Mixed Speciality have been closed.

NHSP and overtime are on a downward trend. Data will be discussed with managers to understand how further reductions can be made.



Community Care Centre actual worked hours against planned and professional judgement template numbers for May 2020

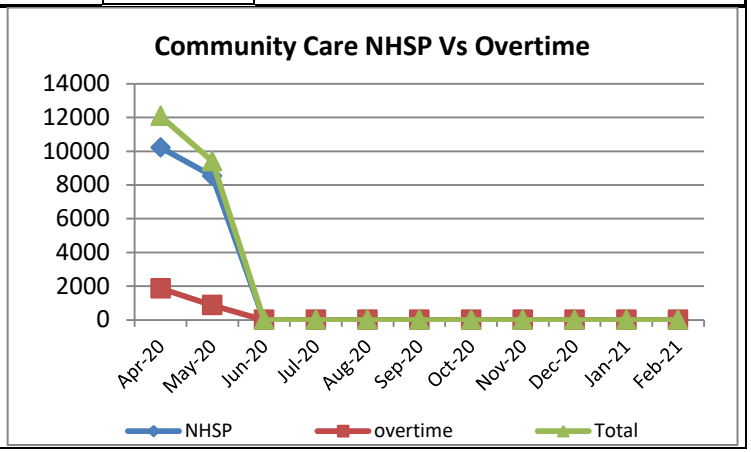
May 2020 Data	Planned Day	Worked Day	Planned N	Worked N	Bed Occ	PU 2's	PU 3's	Medication Incidents	Patient Falls	Complaints	Quality Impacts
Ward 3	4 + 4	4 + 5	4 + 3	3 + 3	9	0	1	1	2	0	Serious Incident PU
JC09 (Ward 9)	5 + 5	4 + 5	4 + 4	3 + 4	10	0	0	1	0	0	
OPM (Older Persons Medicine)	4 + 4	4 + 6	3 + 3	3 + 4	8	0	0	0	2	0	
Rutson FHN	2 + 4	3 + 4	2 + 2	2 + 2	9	0	0	0	0	0	
Tocketts Ward	4 + 6	4 + 6	3 + 3	3 + 4	27	3	1	1	5	0	Now taking Stroke patients from Zealand Ward. Optional AP/HCA each shift. Serious Incident PU jointly with Hambleton & Rich & Ward 36
Zetland	5 + 6	3 + 6	3 + 3	2 + 3	7	0	0	0	1	0	
Friary Community Hospital	3 + 4	2 + 2	2 + 2	2 + 2	6	0	0	2	0	0	
JC21 (Ward 21)	5 + 2	5 + 2	5 + 2	4 + 2	4	0	0	2	0	0	
JC22 (Ward 22)	5 + 2	4 + 2	4 + 1	4 + 2	7	1	0	1	0	0	
JCDS (Central Delivery Suite)	10 + 2 M- F	10 + 2	11 + 2	11 + 2	16	0	0	0	0	0	
Neonatal Unit	15 + 1	14 + 2	15 + 1	13 + 1	22	0	0	2	0	0	
Paediatric Intensive Care Unit currently on Ward 21 a and b	4 + 0	4 + 0	4 + 0	4 + 0	4	0	0	0	0	0	
Ward 17 JCUH	6 + 2	6 + 2	4 + 2	4 + 2	19	0	0	1	1	0	
Ward 19 Ante Natal	3 + 1	3 + 1	2 + 0	2 + 0	6	0	0	0	0	0	
Maternity FHN	2	3 + 1	2	2 + 0	1	0	0	0	0	0	
Mat Assessment Unit	4 +1	4 + 1	2 + 0	2 + 0	1	0	0	0	0	0	



Ward Managers are budgeted 80% supervisory time on the roster.

Ward 3 has remained in the COVID footprint with the Ward Manager taking no management time during May.

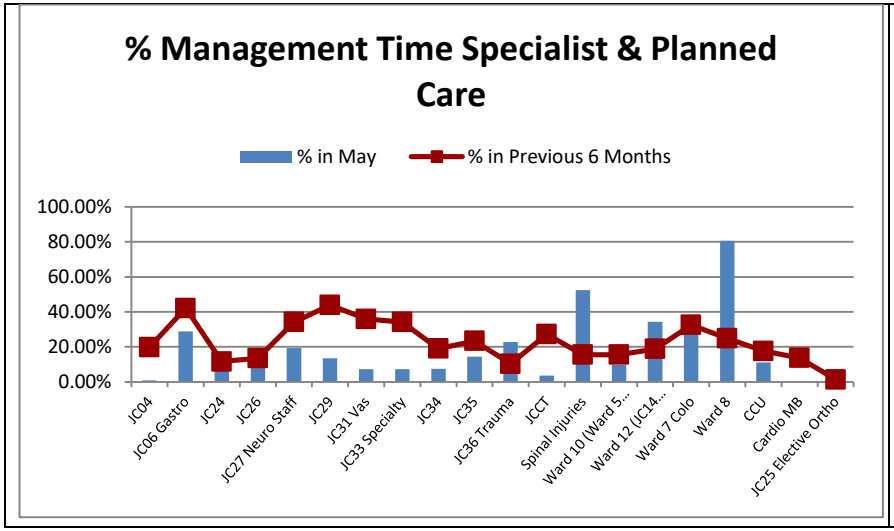
Overtime and NHSP usage for May has seen a downward trend from April figures



Specialist and Planned Care Centre actual worked hours against planned and professional judgement template numbers for May 2020

May 2020 Data	Planned Day	Worked Day	Planned N	Worked N	Bed occ	PU 2's	PU 3's	Medication Incidents	Falls	Complaints	Quality Impacts
JC04 (Ward 4)	5 + 4	4 + 3	3 + 3	3 + 2	5	2	0	0	1	0	Serious Incident Pressure Ulcer
Ward 5 Surgery (on Ward 10)	4 + 4	5 + 6	3 + 3	3 + 4	6	1	0	1	5	0	
JC06 Gastro	5 + 5	Closed	4 + 4	Closed	-	0	0	1	1	0	
Ward 7 Colo	4 + 4	4 + 5	3 + 3	3 + 4	14	1	0	1	10	0	
Ward 8	4 + 4	4 + 4	3 + 3	3 + 4	14	0	0	2	3	0	Serious Incidents # Neck of Femur + Pressure Ulcer
Ward 12 (JC14 Oncology Staff)	5 + 5	4 + 3	4 + 4	3 + 2	7	0	0	0	3	0	
JC24 (Ward 24)	4 + 3	5 + 4	3 + 2	3 + 2	19	1	0	3	8	1	
Neuro HDU	4 + 3	4 + 1	3 + 2	4 + 1	3	0	0	0	1	0	
JC25 Elective Ortho	4 + 3	4 + 6	3 + 3	3 + 4	19	0	0	2	5	0	
JC26 (Ward 26)	3 + 3	4 + 4	2 + 3	2 + 3	16	0	0	1	4	0	
JC27 Neuro Staff	3 + 3	4 + 4	2 + 2	2 + 3	10	0	0	0	4	0	
JC28 (Ward 28)	5 + 3	4 + 4	3 + 2	4 + 2	14	2	0	0	8	0	
JC29 (Ward 29)	4 + 3	4 + 4	3 + 2	3 + 3	21	0	0	1	10	0	Serious Incidents # Neck of Femur
Cardio MB	2 + 2	2 + 1	2 + 1	2 + 0	6	0	0	0	1	0	
JC31 Vas	5 + 5	5 + 6	4 + 4	3 + 4	13	1	0	5	5	1	
JCCT (Ward 32)	6 + 3	4 + 3	4 + 2	2 + 2	14	1	0	0	3	0	
CADU	2 + 1	2 + 2	0 + 0	2 + 1	-	0	0	0	0	0	
JC33 Specialty	4 + 4	4 + 4	3 + 3	3 + 2	15	0	0	3	2	0	
JC34 (Ward 34)	5 + 5	4 + 1 + 6	4 + 3	3 + 1 + 4	26	0	0	0	6	0	Serious Incidents Pressure Ulcer. Red flags raised re missed intentional rounding.
JC35 (Ward 35)	4 + 4	4 + 6	3 + 3	3 + 4	13	0	0	0	1	0	
JC36 Trauma	6 + 6	5 + 7	4 + 4	3 + 4	28	3	0	0	10	0	Serious Incident # Neck of Femur and Pressure Ulcer jointly with Hambleton & Rich & Tocketts. Mixed specialties of patients on ward.
Spinal Injuries	8 + 5	6 + 5	7 + 5	4 + 3	17	0	0	0	1	0	
CCU JCUH	8 + 2	6 + 2	6 + 0	5 + 0	7	0	0	0	3	0	
CICU JCUH	11	10 + 3	11	10 + 2	7	5	0	0	0	0	
Cardio HDU	6	5 + 1	5	4 + 1	5	0	0	0	0	0	
Gara Orthopaedic FHN		Closed		Closed	-	-	-	-	-	-	

Specialist and Planned Care (SPCC) have mixed specialities on the non-COVID side of the hospital to accommodate the trusts pathway redesign. Redeployed staffs from outpatient areas have joined ward teams to support these moves. CICU and CHDU have moved into SPCC from UECC but still support the critical care surge plans. Staffing based on professional judgement across SPCC was considered due to the unfamiliarity of redeployed staff working on wards and current ward teams caring for patients from unfamiliar specialities. Aspirant nurses (Band 4) Assistant Practitioners (Band 4) and Registered Nursing Associates (Band 4) support the RN workforce.

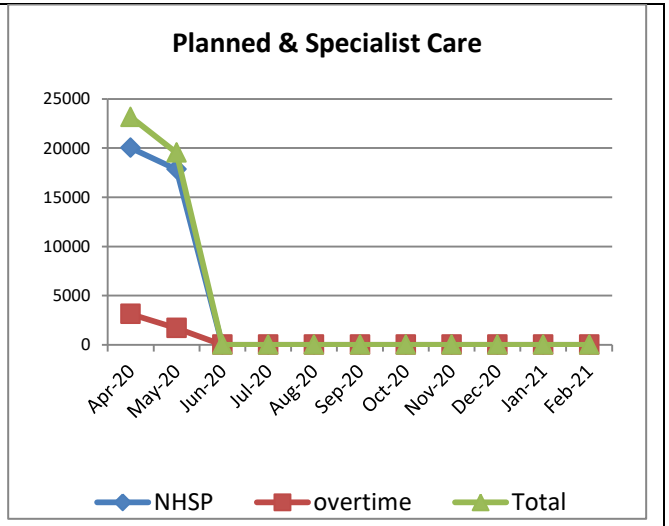


Ward Managers are budgeted 80% supervisory time on the roster.

A few ward managers within centre have taken minimal amounts of management time during COVID. Where possible time should be supported to ensure managers are able to maintain their workload.

Ward 8 was the only ward to utilise the whole management allowance and may be in a position to help colleagues with some management activity.

NHSP and overtime are on a downward trend



Red Flags raised during May 2020

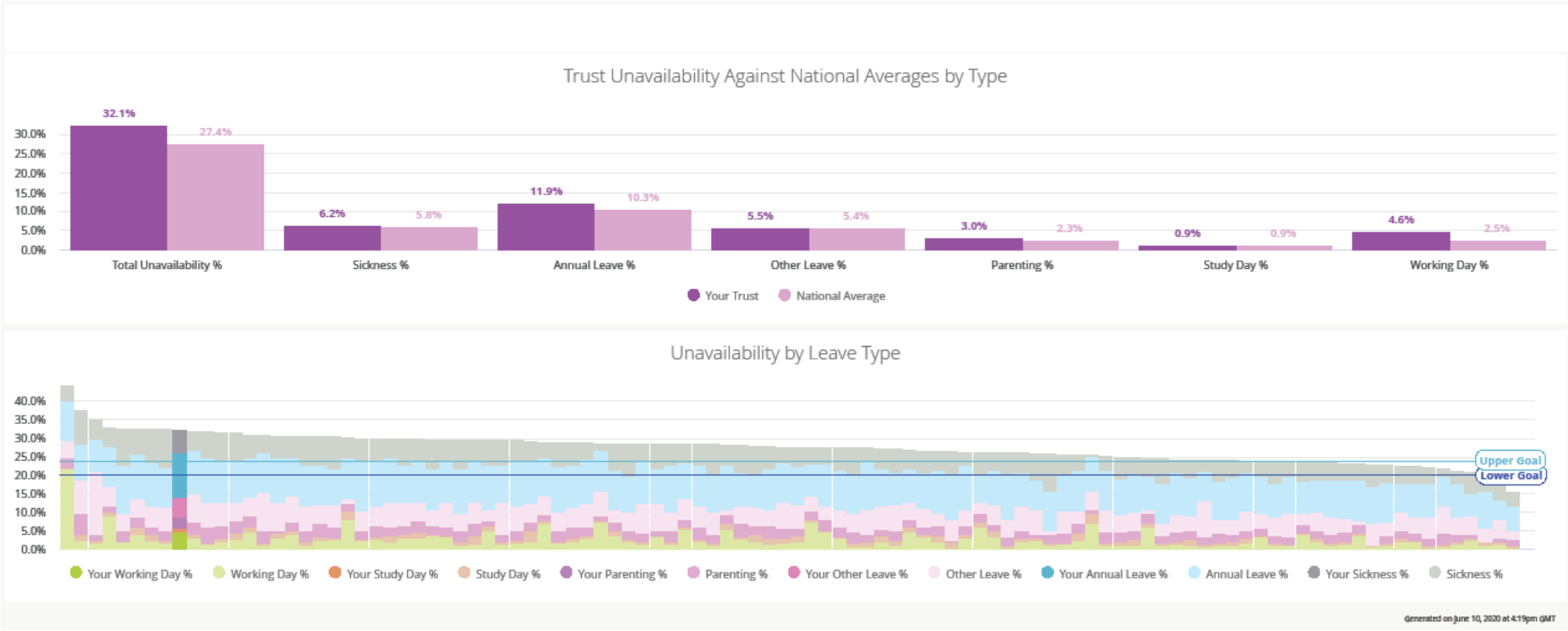
Red Flags Raised	Missed 'intentional rounding'	Grand Total
JC26	2	2
JC34	3	3
Grand Total	5	5

Matrons reviewed all red flags and solutions sought through in centre redeployment or professional discussion considering patient acuity and dependency and bed occupancy. Any unresolved issues were taken to SafeCare meetings for escalation to ADoN and group support for cross centre redeployment.

Missed international rounding's have been logged retrospectively and cannot therefor be resolved

A total of hours 550 hours were redeployed through SafeCare during May to maintain safe staffing.

Unavailability Compared to Allocate National Average 11th May – 7th June 2020

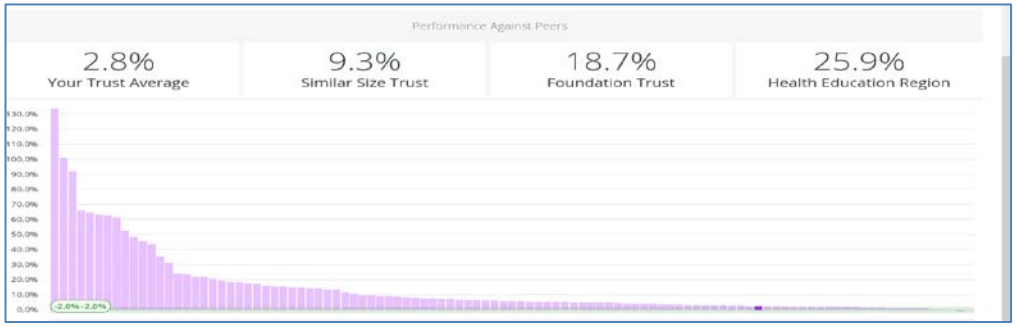


Overall unavailability of staff was 32.1% (36% last report) against standard Trust 21% headroom.

Sickness and other leave remains high due to COVID related absence. Annual leave remains constantly well managed at 12%.which is slightly lower than the 14% KPI target but still very good in the current climate. Staff working from home or shielding are encouraged to take leave as planned during this period.

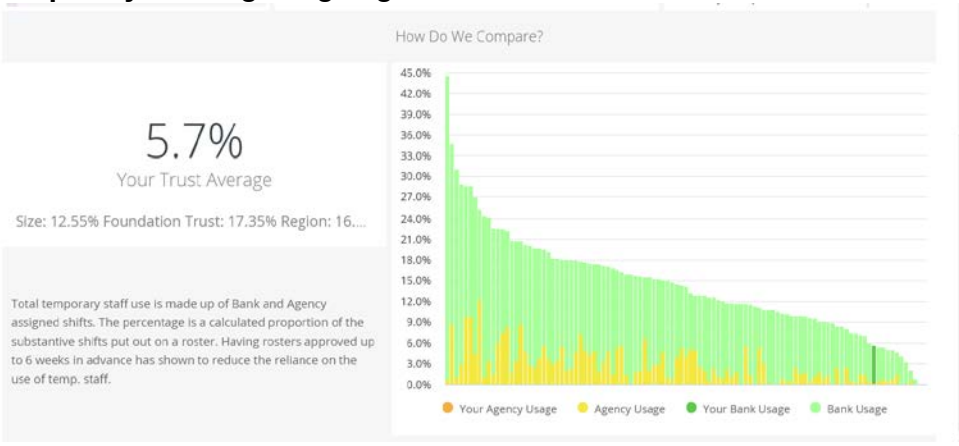
Working Day for May includes all of the supernumerary time for the 140 student nurses starting on paid placement from 18th of the month. The Aspirant Nurses (end of 3rd year) who started in critical care on 20th April have also been in their 6 week supernumerary period during May but will be counted in the numbers from June.

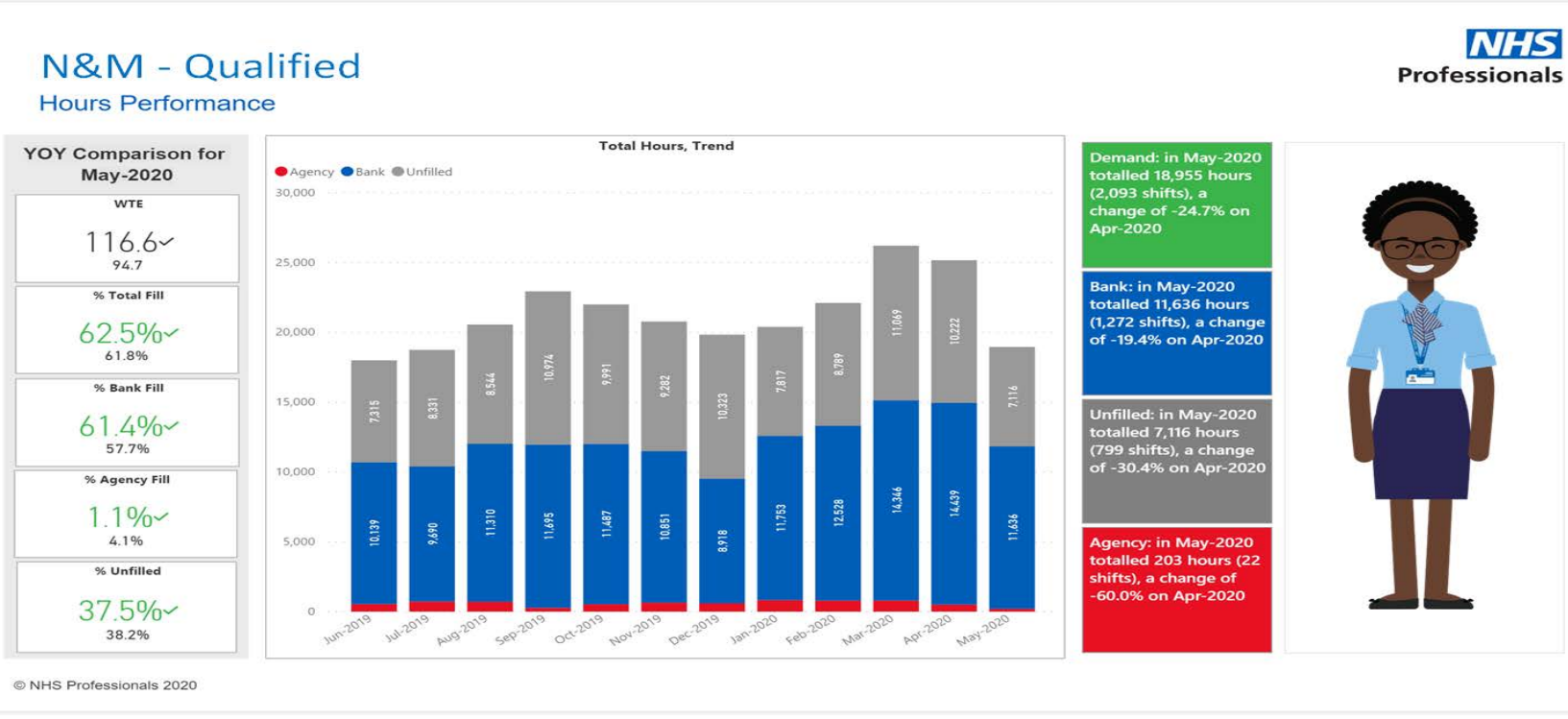
4 Weekly Hours Balance Against Peers



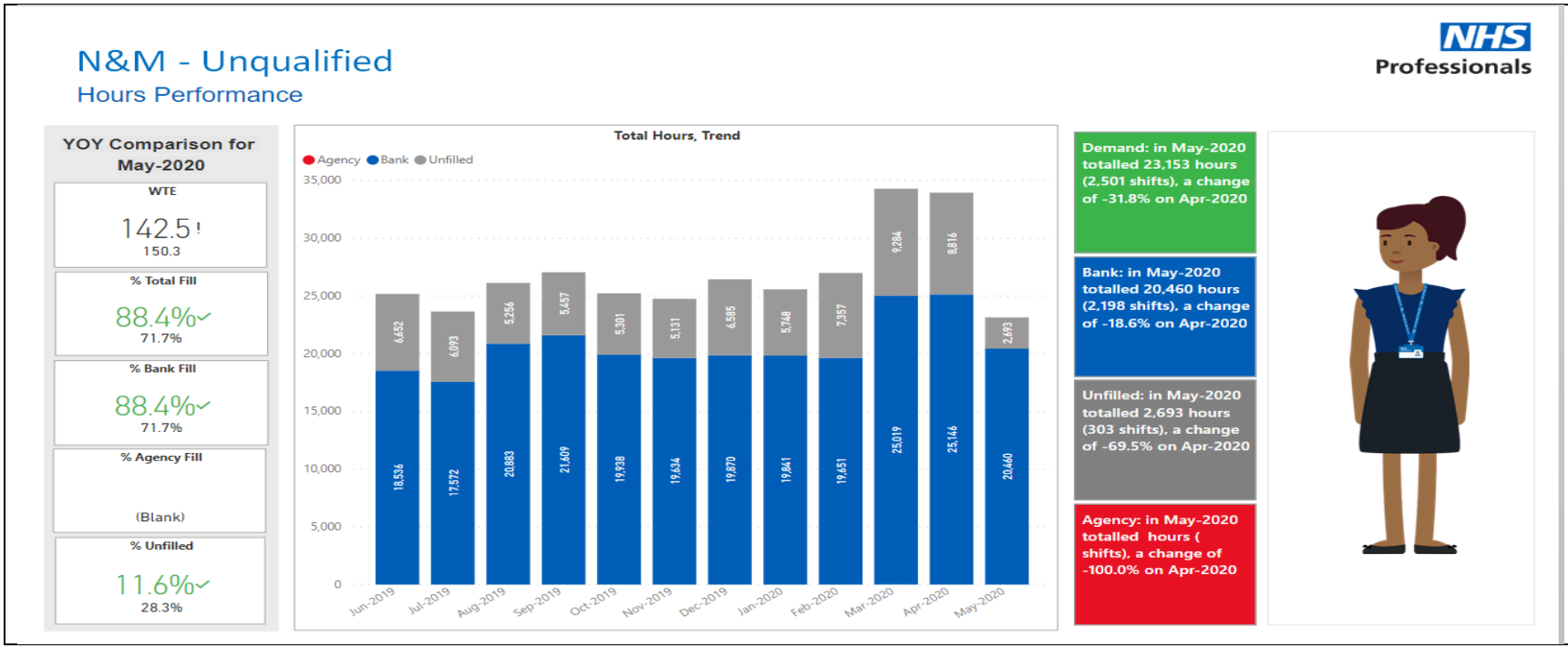
Best practice is to maintain the 4 weekly hours balance between + and – 2%. Although there has been an increase in our % to 2.8% (2.1% last report) it is still well managed compared to our Peers and has been highlighted as a focused area with Ward Managers and Matrons.

Temporary Staffing usage against other Allocate Peers





RN hours worked through NHSP and agency was 62.5% against a reduced demand of 18,955 hours. Agency (22 shifts) have been utilised at JCUH to support anaesthetic increased overnight staffing to provide cover teams for intubating.



HCA hours worked through NHSP has increased to 88.4% against a decreased demand of 23,153 hours.

There was no agency usage for HCA.

Second and 3rd year student nurses continue on paid extended placements and have contributed to reduced demand.

AHP Staffing

AHP staffing throughout May has matched the demands placed on the various services.

The COVID pandemic led to some services being significantly reduced as face to face out-patient contacts were limited, the primary examples being Out Patient Physiotherapy and Podiatry. There was also an increased demand on acute services who operated across specialities as COVID or non-COVID teams. Throughout this period the required staffing establishment was agreed for each area and staff provided up to this establishment each day. Appropriate training was provided to staff members who were supported in working within different areas of practice.

To ensure suitable allocation senior leads held staffing reviews twice daily and allocated staff accordingly depending on availability which at times was significantly affected by COVID related absence. The Head of Professions and Professional leads led daily operational meetings so any staffing issues could be escalated promptly for review and this provided assurance that the staffing establishment was maintained in an appropriate manner.

Summary

Nurse Staffing throughout May has matched the acuity, dependency and numbers of patients. There does not appear to be any direct correlation between patient harms and safe staffing levels although these two areas have seen a significant increase during COVID.

In May, the falls rate remains above target at 7.8 falls per 1000 bed days (139 falls) against 5.4 (84 falls) in March. As a consequence of ward reconfigurations and relocation of specialities some wards with high falls rates have flipped and the reverse has been observed in areas with traditionally lower rates. In May there were 3 falls with harm (x 3 Neck of femur fractures) on wards 36, 29 & 8

The mainstay of our improvement strategy remains on-going although challenged by COVID-19: effective management of delirium, lighting and signage effective continence management, improved compliance with risk reduction interventions and response to patient individual risk factors.

In Month actions include: Ward manager / matron to provide assurance that risk assessments are completed and risks actioned and to reinstate bay nursing.

Reducing the number of pressure ulcers remains an on-going challenge for the Trust. In May, the rate of new or deteriorated pressure ulcers was 118 (category 1-4) with 6 declared serious incidents on Wards 8, 4, 34, 3 and Hambleton & Rich & Tocketts / 36 jointly.

During May the TVN team have supported additional roles within the trust in response to COVID-19. This includes redeployment to critical care, PPE marshalling and discharge team support. On-going actions include: support to areas with increased incidence (critical care, community nursing, wards 8, 4, 3, 34 and community nursing).

In Month actions include: Restarting clinical standards meetings, audit of compliance with the comfort and pressure chart conducted and results feedback to clinical matrons and managers and a focussed safety at south tees meeting.

Bed reconfiguration continues to enable COVID recovery and as such professional judgement around planned safe staffing has been paramount. Discussions occur through Senior Policy Group (CPG) and three times weekly COVID19 Staffing meetings.

Six monthly staffing reviews will not be carried out in the usual way during June due to COVID and will be based on the Planned Staffing Through COVID paper and will include all staffing areas previously covered by separate reports for Midwifery, Paediatrics, Theatres, A+E, Community Nursing and Adult Inpatients. The first OPD review was due in June and will be formulated as part of a task and finish group around recovery.

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

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NQB (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing. https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

Safe, sustainable and productive staffing in maternity services https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_Maternity_final_2.pdf

Safe, sustainable and productive staffing for neonatal care and children and young people's services https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_Neonatal_mYLJCHm.pdf

Safe, sustainable and productive staffing in urgent and emergency care https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_urgent_and_emergency_care.pdf

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 7 JULY 2020			
Trust compliance with a specific NHSE/I Covid19 Infection, Prevention and Control Board Assurance Framework			**AGENDA ITEM: 9, ENC 5**
Report Author and Job Title:	Helen Day, Deputy Director Nursing	**Responsible Director:**	Deidre Fowler Director of Nursing, and Midwifery
Action Required	Approve ☒ Discuss ☒ Inform ☒		
Situation	This paper provides a summary of Trust compliance with a specific Covid19 Infection, Prevention and Control Board Assurance Framework		
Background	Effective infection prevention and control is fundamental to our efforts to manage Covid19. NHSE/I developed a board assurance framework in May 2010 with updates added in June 2020 to support healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards and regulatory bodies. NHSE state that using this framework is not compulsory, however the trust have chosen to use as a source of internal assurance and it will help support the organisation to maintain quality standards.		
Assessment	This report outlines the current compliance with the BAF and the mitigations in place • Satisfactory assurance is in place for 52/59 items • There are no items with no assurance and no mitigations • Mitigation for gaps in assurance are in place for 7/59 from 5 BAF sections and these are summarised in in the table below A full review of this assessment has been undertaken by the Quality Assurance Committee.		
Recommendation	The Board of Directors are asked to note the update.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 2.1 (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 indicators		
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 ☐	

Trust compliance with a specific NHSE/I Covid19 Infection, Prevention and Control Board Assurance Framework

1. PURPOSE

1.1 This paper provides a summary of Trust compliance with a Covid19 IPC board assurance framework published by NHSE/I in May 2020 and an updated version in June 2020. The key components of the report are a summary table providing an overview position for each section of the BAF and a summary table of those areas where have self-assessed ourselves as non-compliant and associated mitigations and actions.

2. BACKGROUND

2.2 Novel coronavirus (SARS-CoV-2) is a new strain of coronavirus first identified in Wuhan City, China. The clinical infection caused by this virus is called COVID-19. In early March the UK government declared a 'command and control' approach to the management of SARS-CoV-2. UK has the second highest number of deaths globally and the chief scientific officer states 10% of people in London and 4% of people in the rest of the UK have been infected. COVID-19 has had a significant impact on the NHS and our trust has been divided into COVID-19 and non-COVID-19 areas.

2.3 Effective infection prevention and control is fundamental to the management of Covid19. NHSE/I developed a board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards. NHSE/I state that using this framework is not compulsory, however South Tees Trust will use as a source of internal assurance and maintain quality standards. The BAF will be monitored in IPAG, reporting to QAC.

3. PROGRESS

3.1 A gap analysis has been completed against the BAF framework. The BAF is formed of 10 sections:

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users (8 items)
2. Provide and maintain a clean and appropriate environment in managed premises (12 items)
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance (2 items)
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion (4 items).

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people (7 items).
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection (11 items).
7. Provide or secure adequate isolation facilities (3 items)
8. Secure adequate access to laboratory support as appropriate (2 items)
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections (3 items)
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection (7 items)

TOTAL: 59 items assessed

3.2 Describing the evidence

The key finding of this review is that robust evidence is not always available, due to the number of changes being made in quick succession in response to evolving guidance and the changing face of our clinical services. The overall success of our IPC and related operational interventions should be viewed in terms of other key factors including, positive feedback from staff, and the extremely low rate of covod19 infection developed by patients in hospital, and very low numbers of Covid19 related incidents or complaints. We will continue to monitor the embeddeness of the evidence and monitor through IPAG to QAC

BAF	Overview		
Assessed w/c 1st June 2010		**0**	**Unable to deliver/no mitigation**
		6	**Gaps in assurance but mitigations in place**
		53	**Satisfactory assurance**

Table 1: Overview of BAF compliance

- Satisfactory assurance is in place for 53/59 items
- There are no items with no assurance and no mitigations
- Mitigation for gaps in assurance are in place for 6/59 from 5 BAF sections and these are summarised in in the table below

4. RECOMMENDATIONS

- Acknowledge the work done so far and approve the regular review of the BAF at monthly IPAG meetings
- Approve the use the BAF as an ongoing assurance tool reporting to IPAG and on to the Board.

BAF Section:	Evidence gaps	Mitigation
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Challenges in A&E waiting areas We are assured of specific air changes and ventilations in critical care and theatres but not in all in patient areas	• Signage • Streaming to alternative environments including self-care • Risk register highlighted to 20 • ED Escalation plan includes Social distancing • A detailed estates review is underway with national ventilation engineering lead to assess all areas and scope any improvement work that is required
7. Provide or secure adequate isolation facilities	Some ward bays have air changes less than 6 per hour Isolation capacity recognised as limited pre covid (negative and neutral)	• Fans and ante rooms have been installed in 4 bays on 4 wards to increase negative pressure capacity • A detailed estates review is underway with national ventilation engineering lead to assess all areas and scope any improvement work that is required

Table 2 BAF items without full assurance

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 June 2020			
Safeguarding Annual Report			**AGENDA ITEM: 10 ENC 6**
Report Author and Job Title:	Helen Smithies Assistant Director of Nursing (Safeguarding)	**Responsible Director:**	Deirdre Fowler Interim Director of Nursing & Midwifery
Action Required	Approve ☒ Discuss ☐ Inform ☒		
Situation	This report details activity across the adult and children's safeguarding agenda during 2019-2020		
Background	The Trust has statutory duties to safeguarding and promote the welfare of vulnerable patients across the age range. This report provides assurance across the range of this activity.		
Assessment	This report presents information about adults at risk for whom safeguarding referrals were opened during the reporting period, and case details for safeguarding referrals which concluded during the reporting period. A safeguarding referral is where a concern is raised with a council about a risk of abuse, which instigates an investigation under the local safeguarding procedures. The Quality Assurance Committee has recommended approval of the Annual Report.		
Recommendation	The Board of Directors are asked to note and approve the contents of this report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Work is currently underway to refine risk and identify mitigation posed by 1.The trusts current learning disability offer 2. Management of detentions under the Mental health act 3. The trusts offer to victims of domestic abuse		
Legal and Equality and Diversity implications	The activity included in this report contributes to the trusts duties under safeguarding and equality legislation.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	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

Annual Report 2019-2020

Introduction

This annual report provides assurance to the Board of Directors on the discharge of the trusts statutory duties in relation to a range of safeguarding legislation encompassing

- Adults and children at risk of abuse or neglect
- Adults with a learning disability or autism
- Patients who are deprived of their liberty whilst receiving care either through lack of capacity or through the Mental Health Act
- Children who are looked after by the local authority
- Victims of Domestic abuse
- Individuals who are at risk of being radicalised into terrorism
- Victims of Modern Slavery

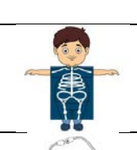
Governance

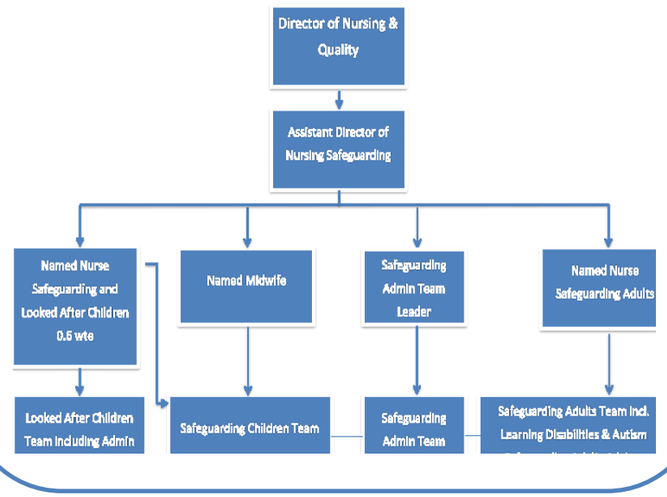
Director of Nursing and Governance	Board Lead	Gill Hunt
Assistant Director of Nursing (safeguarding)	Strategic Lead. Represents trust at interagency safeguarding boards and partnerships	Helen Smithies
Named Professionals	Named Nurse Safeguarding Adults Named Nurse Safeguarding and Looked after Children Named Midwife Named Doctor Child Protection	Helen Williams Sarah Stanmore Sue Taylor Dr Maeve O'Sullivan Dr Allison Morrison (until 10/19) Dr Jonathan Grimbley (from 10/19)
Allegations against Staff	Senior Designated Officer	Rachael Metcalf
Safeguarding Strategic Group	Chair: Gill Hunt	Meetings held each quarter (Q4 not held due to COVID 19) Reports to Quality Assurance Committee
Safeguarding Operational Groups (Adult/Children)	Chair: Helen Smithies	Meetings held each quarter (Q4 not held due to COVID 19). Reports to Safeguarding Strategic Group

What is Safeguarding?

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

Year at a Glance

			18/19
	**5563**	Safeguarding Children Team - advice and support	↑16%
	**573**	Safeguarding Adults Concern forms submitted to local authorities	↑37%
	**115**	Safeguarding Adults Concern forms submitted about Trust practice	↑5%
	**5**	Trust involvement in Domestic Homicide Reviews	↔
	**761**	Number of patients flagged on hospital systems as having a learning disability	↑16%
	**9**	Interagency Reviews relating to children	↑3
	**6**	Interagency reviews relating to adults	N/A
	**489**	Deprivation of Liberty Safeguard Applications (DoLS) made by the Trust	↓4%
	**252**	Child protection medicals undertaken	↑38%
	**402**	Children became looked after by Middlesbrough/Redcar & Cleveland local authorities during 19/20	↑28%
	**987**	Children who were looked after by Middlesbrough/Redcar & Cleveland local authorities on 31 March 2020	↑19%



Advice Support and Supervision

Providing advice support and supervision are key functions of a safeguarding service. Advice and support from the safeguarding team is available 8.30-4.30 Mon-Fri. Outside these hours this would come from the Local Authority Emergency Duty team when needed. Contact details are included in training and on the trust intranet. 92% of staff know where to seek advice and support Safeguarding Supervision is provided to staff with on-going role in safeguarding by a named supervisor on a quarterly basis and compliance is monitored via CCG

SAFEGUARDING - 'A WICKED PROBLEM'

'Ill structured, with an evolving set of interlocking issues and constraints. There are so many factors and conditions, all embedded in dynamic social context that no two wicked problems are alike and the solutions to them will always be custom designed and fitted. There may be no solutions or there may be a host of potential solutions and another host that are never even thought of'

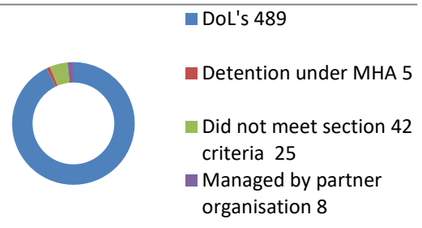
(Grint 2005).

Adult Safeguarding

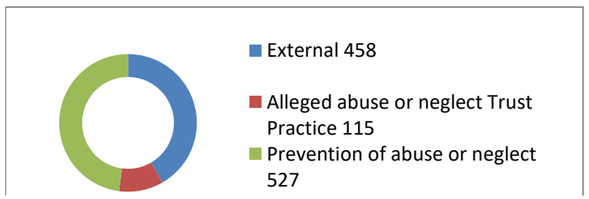
MODEL OF SAFEGUARDING ADULT PRACTICE

The Safeguarding adult team triage all safeguarding concerns raised and allocate to an appropriate clinical matron taking into account work load and complexity. Those concerns most complex, reputationally risky or involing multilple services are managed by the team themselves. These include allegations of organisational or discriminatory abuse, where there are potential criminal charges or disciplinary processess against staff members**.** This includes working with the ward/department team to undertake an investigation providing evidence to the safeguarding meeting and working with those involved to instigate any resulting action plan.

PREVENTION OF ABUSE OR NEGLECT Total 527



REPORTED ADULT SAFEGUARDING INCIDENTS Total 1,100

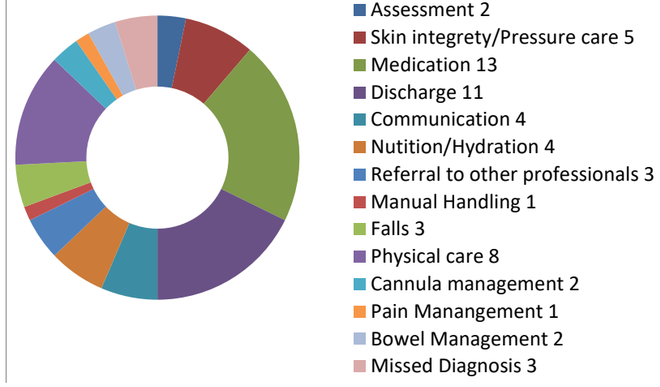


John – Reasonable adjustment

John has severe learning disability, autism and behaviours that challenge. He required surgical intervention and a range of reasonable adjustments were put in place. Blood tests were carried out his GP where John was more comfortable, he was admitted at the time of day least likely distress him, he was cared for in a side ward, community staff John knows and trusts were enabled to stay by his side whilst awake, John was first on the list to avoid him having to wait, general anaesthesia was utilised rather than local, local anaesthetic cream used for a cannula and sedation was used.

CONCLUDED S42 BY THEME Total 121

Not substantiated 28 (23%)
HR Process 5



Sophie - Preventative safeguarding in the Community setting

Sophie lives with David her husband who is her main carer. Sophie has Parkinson's disease and a recent diagnosis of terminal cancer. She has difficulties communicating and a fluctuating cognitive ability and relies on David to maintain a safe environment for her. The Integrated Therapy Team (ITT) were contacted by David because of a rapid decline in Sophie's physical condition and had concerns around the equipment provided for her.

The Physiotherapist (PT) and Occupational therapist (OT) arranged a visit for that day to reassess Sophie and provide equipment appropriate to Sophie's current needs. Sophie had been independently mobile the previous week but was in bed when the team arrived. David described the variability of Sophie's mobility ranging from requiring his assistance to David having to lift Sophie out of bed into the chair. The alternative equipment was installed and demonstrated to David who was then assessed on his manual handling techniques, some of which put Sophie at a high risk of falling and joint damage requiring the PT and OT to intervene and return Sophie back to bed. They observed old bruising on Sophie's limbs from previous transfers. The PT and OT advised David that Sophie would need to remain in bed for her safety and would benefit from the use of a hospital bed and daily input from care workers. David was reluctant to take this advice on board and was determined that he would manage to care for his wife.

At this point the concern for Sophie would meet the criteria for submitting an adult safeguarding concern for the Local Authority procedure to identify and reduce the level of risk. The PT and OT however spent many hours over the next 24 hours providing Sophie and David with information, encouragement and arrangement in being supported. Support was accepted from District Nurses, McMillan and Carer services to prevent further risk to Sophie for the last weeks of her life.

MODEL OF LEARNING DISABILITY PRACTICE

The trust believes that every member of staff should be able to meet the basic care needs of any patient they come into contact with and to ensure that reasonable adjutments are made for people with learning disabilities to enable them to receive parity of care and treatment . With this in mind the role of the Learning Disabilit/ Autism Adult Safeguarding Advisor is not that of a liason nurse. The role is to focuse on educating staff, supporting reasonable adjustments in line with the disabiltiy discrimination act, reviewing deaths of adults with learning disabilties and supporting the embedding of hosptials passports. Key to all of these roles is increasing the number of adults lawfully flagged on CAMIS as requring reasonable adjustment.

MAKING SAFEGUARDING PERSONAL

The focus of the Making Safeguarding Personal (MSP) agenda is on safeguarding processes supporting the individual to develop or maintain a private life in safety and free from abuse. At its heart it is about people being enabled to live the life they choose.

Adults should be asked what outcome they would like from safeguarding procedures. This is audited on a quarterly basis. This has shown a significant improvement over the year from 44% in Q1 to 84% in Q4 with overall compliance across the year of 61%

LEARNING DISABILITY ASSURANCE

Practitioners know what a learning disability is	64%
Practitioners can demonstrate knowledge of a hospital passport	71%
Practitioners know how to access hospital communication book?	44%
Practitioners can articulate who can provide them with information about a patient	98%
Practitioners know why anticonvulsant medication must be given at the correct time	90%
Practitioners know what to do if a patient with a learning disability refuses treatment	81%
Practitioners know what tools to use to recognise pain	97%
Practitioner know who to contact for additional support with a patient with a learning disability	71%
Staff can provide 3 examples of reasonable adjustments	92%
Practitioners can explain the difficulties faced by people with autism in hospital	98%

Josh – Safeguarding Adult Review

Josh was in his late 20's, he was homeless and diabetic. He had a history of being in care as a child and of substance misuse. He had self neglected by taking multiple overdoses of insulin leading to hospital admissions and ultimately a life changing brain injury. Three months later Josh died unexpectedly in hospital. Josh's case met the criteria for a multiagency safeguarding adult review. A number of areas of good practice were identified including effective joint working between the acute and mental health trust and the flexible service offered by the diabetic team to keep Josh engaged. However a number of recommendations were made to improve practice particularly around multi agency working with housing providers, improvements in capacity assessments and understanding of working with self neglect. The full report can be accessed at https://www.tsab.org.uk/wp-content/uploads/2019/12/TSAB-Adult-B-FINAL-1.pdf

All age Safeguarding

DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

DoLS is the statutory framework for approving the deprivation of liberty of those patients who lack the mental capacity to consent to being in a hospital or care home. The Supreme Court has determined that deprivation of liberty occurs when:

- The person is under continuous supervision and control and
- is not free to leave,
- and the person lacks capacity to consent to these arrangements.

DoLS ensure that people are only deprived of their liberty in a safe and lawful way. This is only done when it is in the persons' best interests and there is no other way to provide necessary care and treatment. Increasing number of DoLs shows improved practice. DoLS safeguards consist of six separate assessments by designated professionals, and subsequent rights of review.

DoLS Audit

Every inpatient clinical area is visited each quarter. The safeguarding nurse and the nurse in charge identify any patient who meet DoLS criteria but have not had the appropriate authorisation/ application. Wards who's practice is rated as inadequate are 'red rated' and are revisited weekly until the achieve green rating.

	Q1	Q2	Q3	Q4	Total
19/20	82%	74%	72%	92%	80%
18/19	↑19%	↑7%	↑38%	↑53%	↑15%

DoLS Applications

	Q1	Q2	Q3	Q4	Total
19/20	122	109	134	124	489
18/19	↑85%	↑63%	↑123%	↑59%	↑80%

Percentage of staff that can identify what amounts to DoLs and the process to follow

Q1	Q2	Q3	Q4	Total
82%	74%	72%	92%	80%

HUMAN TRAFFICKING AND MODERN SLAVERY

In 2019, 10,627 potential victims of modern slavery were referred to the National Referral Mechanism; a 52% increase from 2018. Just over half of referrals were for individuals exploited as adults, whilst 43% were for individuals exploited as children. The most common type of exploitation for both adults and children was labour exploitation. The most common places victims came from were the UK, Albania and Vietnam

For those exploited as children, criminal exploitation is driven by an increase in the identification of 'county lines' cases. 'County lines' is used to describe drug gangs from large cities expanding their reach to smaller towns. In many cases, vulnerable individuals are exploited to transport substances, and mobile phone 'lines' are used to communicate drug orders. Overall, female potential victims were most commonly referred for sexual exploitation, whilst males were most often referred for labour and criminal exploitation.

The ADN (Safeguarding) attends the Cleveland Antislavery Network hosted by the Office of the Police and Crime Commissioner. In 2019-2020 the trust worked with the CCG in establishing pathways of health care for individuals rescued from Slavery.

Additionally the Safeguarding team attend multiagency meetings where children at risk of sexual and criminal exploitation are discussed. Relevant trust information is shared and plans to safeguard the young person are drawn up at these Vulnerable Exploited Missing and Trafficked meetings (VEMT).

PREVENT

The national PREVENT strategy aims to reduce the threat to the UK from terrorism by stopping vulnerable people from becoming radicalised into terrorism. The key challenge for health care providers is ensure that workers are trained to recognise the signs correctly and they know how to access support for the person at risk. This is a form of exploitation

PREVENT (BPAT)	PREVENT (WRAP)	TOTAL
84↑	92 ↑	90 ↑

MANAGING ALLEGATIONS AGAINST STAFF

Arrangements for managing allegations against staff in relation to children's safeguarding have been embedded for many years. Arrangements came into place in relation to adults in North Yorkshire this year. Known as PIPOT (Person in position of trust) they are expected to be replicated across Tees in the coming months

RESTRAINT

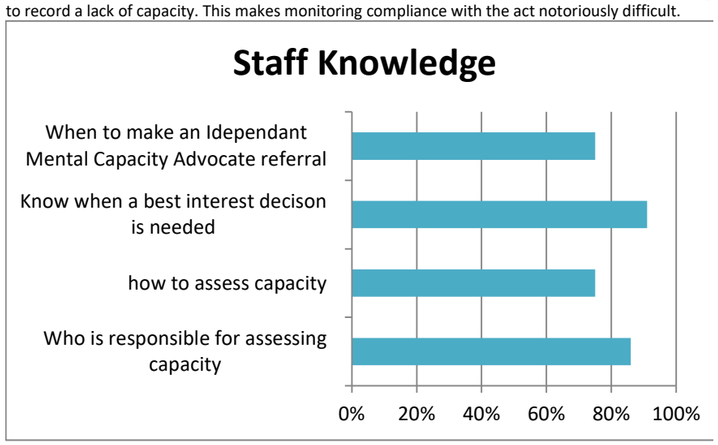
The Mental Capacity Act (2005) defines restraint as ' the use of force or the threat of the use of force to make someone do something they are resisting or, the restriction on a person's freedom of movement, whether they are resisting or not.' It is wider than physically controlling somebody's movement and can include the use of bed rails, sedation and continuous observation which restricts the individual's movement. For restraint to be lawful under the MCA staff must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity and the amount and type of restraint used, and the time it lasts must be a proportionate response to the likelihood and seriousness of harm. Failing to use restraint where necessary can lead to neglect of a patient. It is important therefore that staff know how and when to use restraint.

84% of staff can identify lawful restraint

62% of Medical and Nursing staff were aware of the Covert Medication policy

MENTAL CAPACITY ACT (MCA)

A central tenet of the MCA is the presumption of capacity which results in practitioners only needing to record a lack of capacity. This makes monitoring compliance with the act notoriously difficult.



MENTAL HEALTH ACT

The assessment or treatment of individuals under the Mental Health Act (MHA) is known as regulated activity and can only be carried out on sites registered for this with CQC. The trust has two such sites, JUCH and FHN. When caring for someone detained under the MHA it is vital that the trust acts lawfully so as to avoid infringing the patients Human Rights. Additionally any infringement would risk financial or other sanctions.

When a person is detained under the Mental Health Act it is the managers of this trust that have detained them, the responsibility does not sit with the mental health trust. However the legislative requirements around detentions are complex and to protect the patient and the organisation the trust has a Service Level agreement with TEWV trust to manage this process. Each person detained is entitled to have their rights as a detained person explained to them. This function is carried out by 'Designated Staff Members' (Clinical Matrons and the Safeguarding adult team). Designated Staff members are required to undertaken annual training compliance at the end of 2019-20 was 86%. Detention under the Mental Health Act within the trust remains a relatively rare occurrence and perhaps unsurprisingly therefore it is clear staff knowledge of requirements is patchy. Only 40% of staff knew who to contact when a patient is detained under the act.

It has become apparent that despite a clear policy being in place not all detentions have been reported in the required manner. An audit of all known detentions from 2019/20 is underway and will inform a review of the process.

DOMESTIC ABUSE

Domestic abuse affects both adults at risk of abuse and neglect and children. Care Act guidance recognises domestic abuse as a category in its own right in relation to adults and whilst this is not the case for children, statute recognises hearing or seeing the abuse of another (such as a parent) as a form of abuse.

Interagency management of the risks posed by domestic abuse is through two processes Multiagency Risk Assessment Conferences (MARAC) which focus on high risk victims and Multiagency Tasking and Coordination (MATAC) which focus on high risk serial offenders.

Attendance at the fortnightly MARAC meeting is through the safeguarding children team. Prior to the meeting the safeguarding nurse reviews the Trust records for the perpetrator, victim and any associated children to enable relevant information to be shared in preparation for a multiagency safety plan being devised. The Safeguarding nurse is deputy chair of MARAC.

MATAC meetings are relatively new and are held monthly. The trust began sharing relevant information in 2019-20. This has proven beneficial and on more than one occasion a high risk perpetrator has been identified as the putative father of an unborn baby, this has enabled early intervention to protect the unborn.

During 2019-20 the trust was involved in one domestic homicide review with which was completed. The single agency review undertaken by the trust evidenced the important role the Hospital Intervention and Liaison Team (HILT) had played in care of both the victim and perpetrator. Unfortunately this service is no longer commissioned. The only recommendation from the review was for gap in service following the decommissioning of the HILT service in April 2019 to be highlighted to the DPH.

A further domestic homicide review was completed. The trust had no involvement with the subjects within the timescale of the review. A request for patient information from outside the timescale was declined by the Caldecott guardian as not relevant or proportionate. The trust did however provide assurance around policy and procedure within the organisation being in line with NICE guidance and the UK national screening committee.

Children Safeguarded and Looked After/Training

TRAINING

Safeguarding training requirements are set nationally and are part of NHS standard contract, and CCG quality standards. Compliance with training formed part of the CQC action plan. Significant changes were made to training delivery to enable 90% compliance to be achieved. Training is delivered as part of trust induction and Level 2 adult and children training are available in a combined eLearning package. At the end of August overall compliance for children was 84% and for adults 74%.

In last year's annual report the trusts difficulty in accurately recording and reporting on training compliance was highlighted. This continued to be a challenge for the workforce team throughout 2019/2020; it is one commissioners are well sighted on.

'Thank you very much, I found the safeguarding training very useful, it was great having examples to help understand and support what was being discussed'

THE IMPACT OF TRAINING

After attending safeguarding training a staff nurses developed a particular interest in MCA/DOLS and safeguarding. She created a monthly focus board in April 2019 to raise awareness of process and policy of applying for DoLs. The area submitted 2 DoLs in 18-19 and 13 in 2019-20

MODEL OF SAFEGUARDING CHILDREN PRACTICE

The safeguarding children team operates a model of duty nurse system (Mon-Fri) who visits ED, Paediatric and post natal inpatient areas each moring and attend any child protection strategy meetings called for that day . Each member of the the team has a caseloead of practitioners for whom they provide safeguarding supervision. In addition they represent the organisation at iteragency safeguarding meetings, contirbute to training and professionally challedge interagency partners when necesasary.

During part of 2019-2020 a team member was located each day in the South Tees Multiagency Children's Hub (MACH) After a 6 month period it was apparent this was not proportion as many of the children discussed at the MACH were not know to the trust. The trust reamins a virtual partner.

KRISTINA – PROFESSIONAL CHALLENGE

Kristina aged 5 week was observed have a bruise on her face. When this was discussed with parents they said it had been caused when Dad had been kissing the baby.
A referral was made and a Police Officer and a Social Worker visited the home - they were satisfied with explanations. This decision challenged by the safeguarding team using the 'Bruising on Non-Mobile Babies Procedure' (Tees Procedures, 2018) and the baby was admitted for assessment by a Paediatrician.

A Strategy meeting was convened and the Safeguarding Team worked with the Consultant Paediatricians to promote the voice of the child. The baby was admitted to the ward and contact with Father was supervised

Further investigations revealed that the baby had a bleed to the brain as well as the bruising to the face.Bruising in non-mobile children is rare and is a strong indicator of abuse or neglect. Bruising is not always responded to appropriately by Practitioners. In a significant number of deaths of babies from physical abuse a previous physical injury has been overlooked or explained away.

'The assessment provided an excellent insight into what the child was suffering and what needed to change and ensured that the voice of the child was heard'

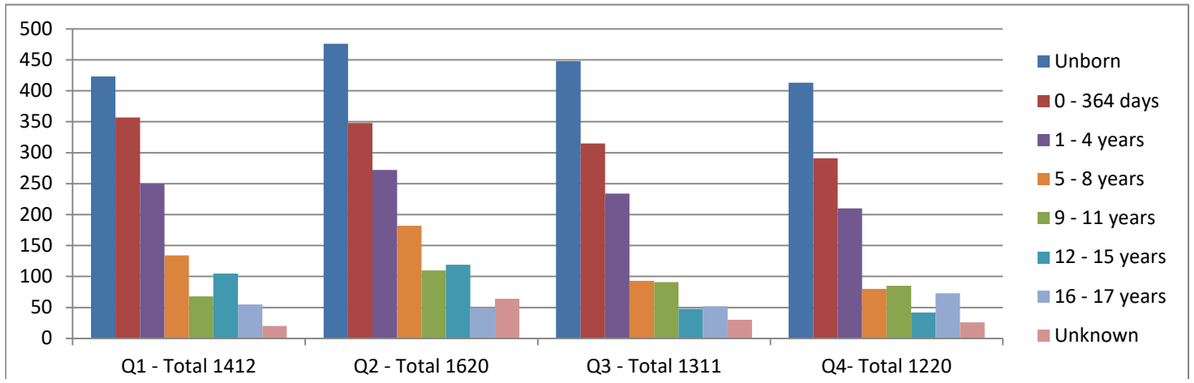
Feedback to staff from social care manager

MARC – A CHILD IN CARE

Marc was 12 years old and has complex health needs. There were concerns about poor weight gain and sleep difficulties. Marc had not been taken for appointments; however he was seen at school paediatrician clinic. A urine specimen was obtained and toxicology requested as part of consideration to reason weight loss. The result was positive for cocaine. Parents were requested to bring Marc into hospital where it was discussed that the urine toxicology had been positive for cocaine. Paediatrician was prompt in making a referral and Marc remained on ward for medical treatment whilst social care undertook an assessment and investigation. This led to legal proceedings being initiated, Marc was taken into care where he began to gain weight and his health began to generally improve.

SAFEGUARDING CHILDREN ADVICE AND SUPPORT

Total 5563 (↑16% on 18/19)



MODEL OF LOOKED AFTER CHILDREN PRACTICE

A child is looked after by a local authority if a court has granted a care order to place the child in care, or a council's children's services department has cared for the child for more than 24 hours. Within 5 working days the Trust should be notified the child has become looked after and be provided with parental consent for an initial health assessment to be carried out by a paediatrician. The initial health assessment must be carried out by 20 working days. These are statutory time scales.

Following their initial health assessment, each child will have a review health assessment at a statutory interval for their period of time in care. Children under 5 years are reviewed every six months and children over that age annually. These reviews are requested, collated, distributed and quality assured by the LAC team but carried out by other provider Trust's.

The looked after children system is complex and highly interdependent on the timely actions of multiple agencies and multiple professionals within those agencies. Additionally a number of local children are placed in areas outside of the Trust footprint, and a number of children from outside our area are placed here. The looked after team has a role in statute and contract in relation to all of these children. Where a child is looked after by North Yorkshire County Council their health needs are coordinated by Harrogate District Foundation Trust. Data provided in the report therefore is in relation to South Tees Children. Middlesbrough has some of this highest numbers of children looked after in the country and numbers are growing

TOTAL NUMBER OF LOOKED AFTER CHILDREN 31.03.2020 987 ↑19% on 31.03.19

TRAINING 31 MARCH 2020

	Level 1	Level 2	Level 3 Initial	Level 3 Update	Level 3+ Initial	Level 3+ Update	Level 4	Total compliance
Children	89% ↓	91% ↑	95% ↓	97%↑	91%↓	91%↑	100% ↔	91%↑
Adults	91%	89%	100%		N/A		100%	90%↑

Safeguarding adults not recorded by level in 2018-19

INITIAL HEALTH ASSESSMENTS

	Q1	Q2	Q3	Q4
Total number of children became looked after	107	104	109	124
Offered an appointment within 15 days of notification consent	100%	100%	100%	93%
% IHA's completed within statutory timescales	63%	87.5%	85.3%	78%

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 7 JULY 2020			
Integrated Performance Report			**AGENDA ITEM: 11, ENC 7**
Report Author and Job Title:	Ros Fallon Director of Planning & Recovery	**Responsible Director:**	Various
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	To provide the Board with a detailed assessment of performance against the agreed indicators and measures. The report describes the specific actions that are under way to deliver the required standards.		
Background	The Integrated Performance Report (IPR) will be produced by the Trust on a monthly basis to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance. The IPR provides assurance to the Board that all areas of performance are monitored, allowing the Board to gain assurance regarding actual performance, Trust priorities and remedial actions. Key elements of the report will be discussed by the Board's Quality Assurance Committee, Finance and Investment Committee and Workforce and OD Committee. A summary of discussions will be included in Chair Reports to the Board of Directors.		
Assessment	Key messages relating to performance this month include: • Falls rate has increased in May (from 5.34 to 7.84). This is due to a decrease in bed days against which fall are measured. Actual number of falls is consistent with previous months. • Two 'never events' have occurred. • A number of complaints were not completed to target, due to backlog. • A&E 4 hour wait is continuing to improve, although is still just below target • Diagnostics,18 week and cancer compliance continue to be impacted by COVID-19. (Entering into Recovery stage and implementing recovery plans) • Annual appraisal compliance has decreased as a result of the COVID 19 pandemic • Financially the trust has recorded a break even position		
Recommendation	The Board of Directors are asked to: a) Receive the Integrated Performance Report for May 2020.		

	b) Note the performance standards that are being achieved. c) Be assured that where performance standards are not currently met, a detailed analysis is being undertaken and actions are in place to ensure an improvement is made.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 1.5 - 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

May 2020

Key Messages

South Tees Hospitals NHS Foundation Trust

- Falls rate has significantly increased in May (from 5.34 to 7.84). This is due to a decrease in bed days, which is what falls are measured against. Actual number of falls is consistent with previous months.
- Two ‘never events’ have occurred.
- A number of complaints were not completed to target, due to backlog.
- A&E 4 hour wait is continuing to improve, although is just below target
- Diagnostics,18 week and cancer compliance continue to be impacted by COVID-19. (Entering into Recovery stage and implementing recovery plans)
- Annual appraisal compliance has continued to decrease since December 2019
- Financially the trust has recorded a break even position

Measures

South Tees Hospitals NHS Foundation Trust

	Indicator	Latest Month	Control Limit	Trend	Assurance
SAFE	All Falls Rate	7.84	5	H	?
	Falls with harm rate	0	0		?
	Infection control - C-diff	4	0		?
	Infection control - MRSA	0	0	L	?
	Serious Incidents	13	0		?
	Serious Incidents never events	2	0		?
	Grade 2 Pressure Ulcers	95	TBD		?
	Grade 3 & 4 Pressure Ulcers	13	TBD		?
	CHPPD Compliance	Data Validation Required			
	Hospital Standard Mortality Rate (HSMR)	91.16	National Target		?
	VTE Assessment	Data Validation Required			
EFFECTIVE	SEPSIS - Screening	Work In Progress			
	SEPSIS - Treatment	Work In Progress			

	Indicator	Latest Month	Control Limit	Trend	Assurance
CARING	F&F A&E Recommendation Rate	93.7%	85.0%		?
	F&F A&E Response Rate (%)	Unavailable - NHS Digital currently not publishing this data			
	F&F Inpatient Recommendation Rate	93.7%	96.0%		?
	F&F Inpatient Response Rate (%)	Unavailable - NHS Digital currently not publishing this data			
	F&F Maternity Recommendation Rate	100.0%	97.0%		?
	F&F Maternity Response Rate (%)	Unavailable - NHS Digital currently not publishing this data			
	Complaints Closed Within Target (%)	30.8%	80.0%	L	?
	Mixed Sex Accommodation (MSA) Breaches	0	0		?

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

Measures

South Tees Hospitals NHS Foundation Trust

	Indicator	Latest Month	Control Limit	Trend	Assurance
RESPONSIVE	A&E 4 Hour Wait Standard (%)	94.7%	95.0%		?
	RTT Incomplete Pathways (%)	51.8%	92.0%	L	F
	Diagnostic 6 weeks standard (%)	43.0%	99.0%	L	?
	Cancer Treatment - 14 Day Standard (%)	93.7%	93.0%		?
	Cancer Treatment - 31 Day Standard (%)	92.9%	96.0%		?
	Cancer Treatment - 62 Day Standard (%)	64.0%	85.0%	L	?
	Non-Urgent Ops Cancelled on Day	7	0	L	F
	Cancer Operations Cancelled on Day	0	0		?
	Cancelled Ops not rebooked within 28 days	0	0		?
	Delayed Transfers of Care (%)	6.4%	3.5%		F
	E-Discharge (%)	94.5%	90.0%	H	?

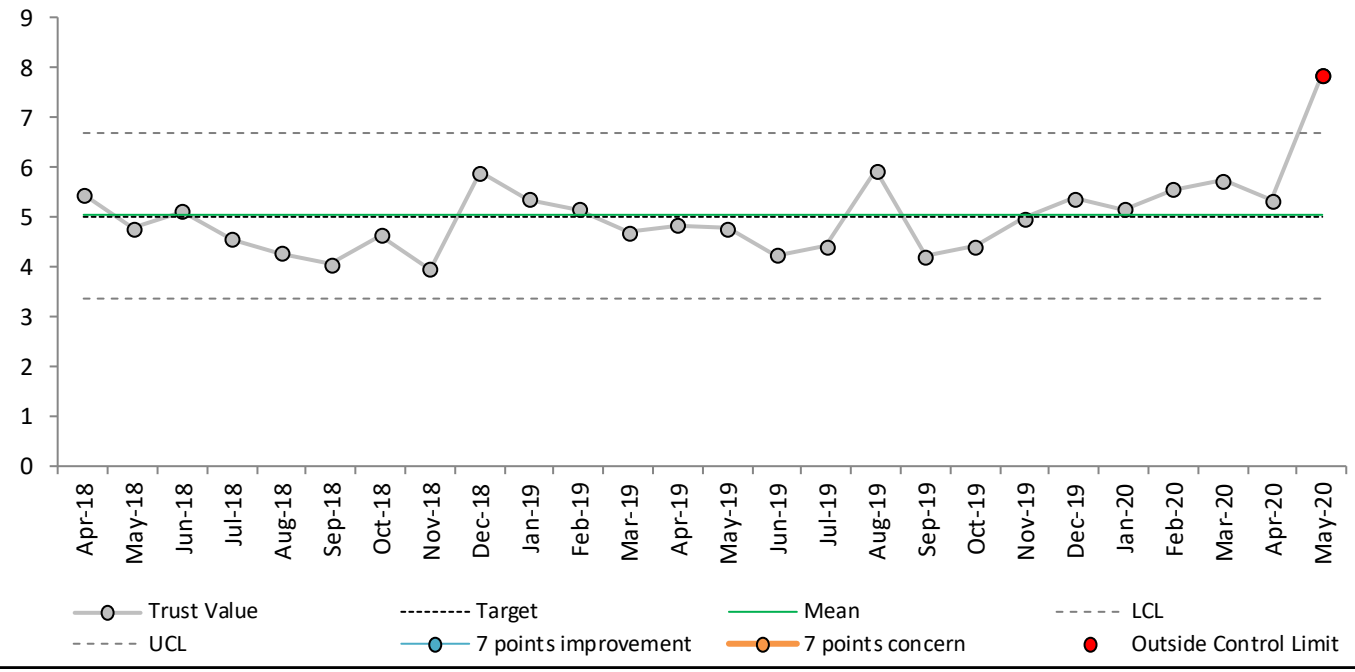
	Indicator	Latest Month	Control Limit	Trend	Assurance
WELL LED	Annual Appraisal (%)	74.1%	80.0%	L	?
	Mandatory Training (%)	87.0%	90.0%		?
	Sickness Absence (%)	4.3%	4.0%		?
	Staff Turnover (%)	9.9%	10.0%	L	F
	Year-To-Date Budget (£'millions)	-£0.991	Within Budget		?

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

Safe

South Tees Hospitals NHS Foundation Trust

All Falls Rate



The Trust falls rate per 1000 bed days

Target	5
Mean	5.03
Last Month	7.84

Executive Lead

Deirdre Fowler

Lead

Beth Swanson

Commentary

In May, the falls rate remains above target at **7.8** falls per 1000 bed days (139 falls) against 5.4 (84 falls) in March. As a consequence of ward reconfigurations and relocation of specialities some wards with high falls rates have flipped and the reverse has been observed in areas with traditionally lower rates.

Cause of Variation

- Covid 19 related, number of bed days reducing has resulted in a higher rate despite falls figure being consistent.
- Hospital population changes (no electives)
- A number of patients falling multiple times.

Planned Actions

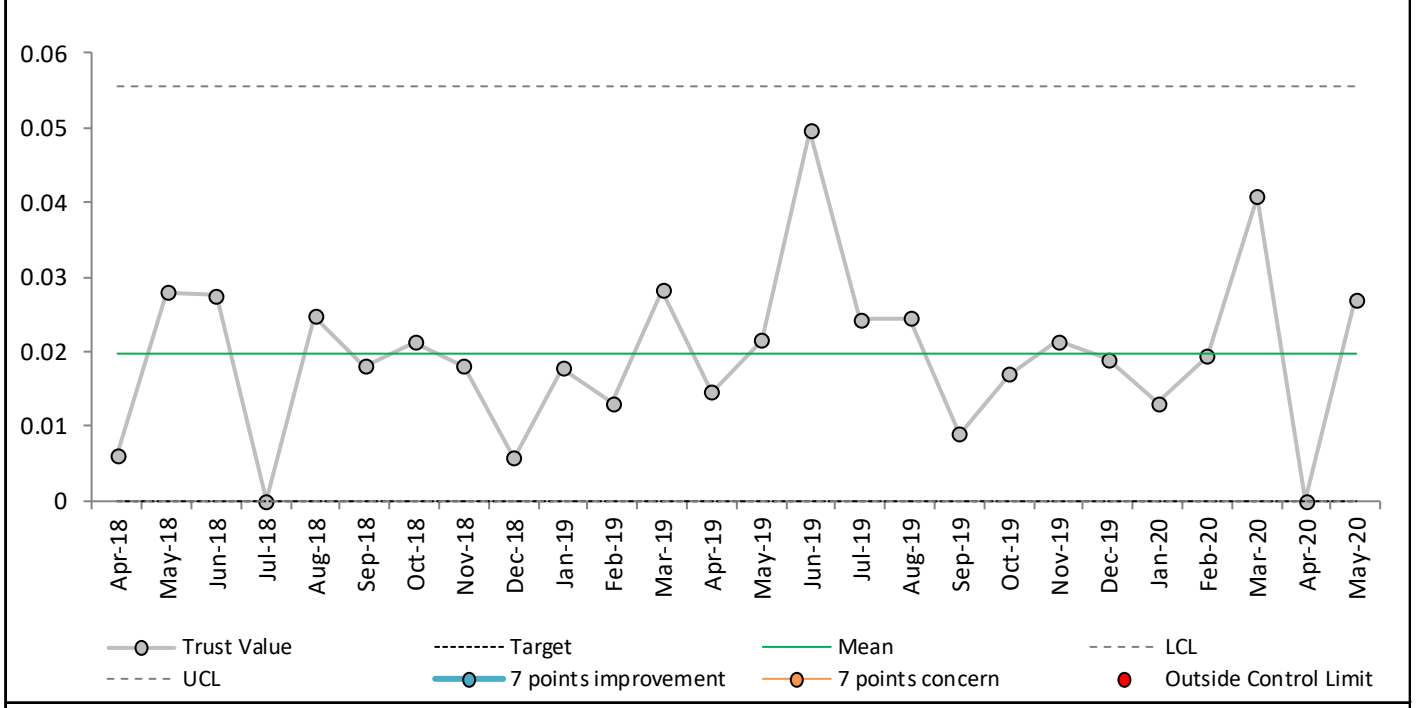
- Ward manager / matron to provide assurance that risk assessments are completed and risks actioned.
- Reinstate bay nursing.
- Matrons to ensure patients who fall multiple times are reviewed and confirm that risk reduction strategies are in place.

Timescale

Safe

South Tees Hospitals NHS Foundation Trust

Falls with harm rate



Rate of falls with harm per 1000 bed days

Target	0
Mean	0.02
Last Month	0.03

Executive Lead

Deirdre Fowler

Lead

Beth Swanson

Commentary

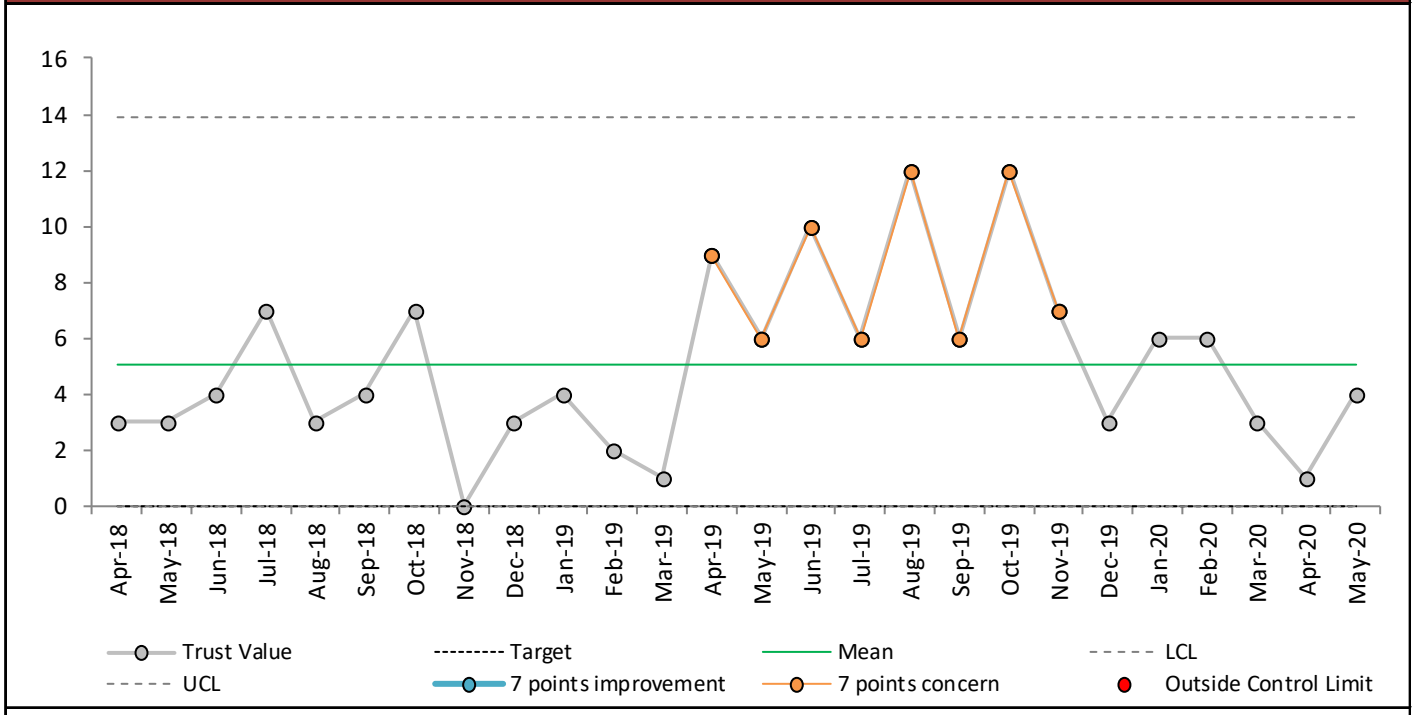
In May there were 3 falls with harm (x 3 Neck of femur fractures).
A number of patients fell multiple times (1x6, 1x5, 1x3 & 8 x2) = 30 falls.

Cause of Variation	Planned Actions	Timescale

Safe

South Tees Hospitals NHS Foundation Trust

Infection control - C-diff



Cases of hospital acquired C. Difficile bacteraemia

Target	0
Mean	5.08
Last Month	4.00

Executive Lead

Deirdre Fowler

Lead

Astrida Ndhlovu

Commentary

There is currently no set objective for C.difficile for 2020/21. It is assumed that the 2020/21 target will be the same as for 2019/20 which was 81 cases.

Cause of Variation

- There were 8 cases of C. difficile infection in May 2020, 1 of which was classed as COHA and 3 were classed as HOHA, totalling 4 cases classed as trust-apportioned according to the new definition.

Planned Actions

- Continue to undertake enhanced mandatory surveillance of C.difficile in the over 2yr olds through data collection and data entry via HCAI DCS using the new reporting definitions for 2019/20.
- Support clinical staff daily to optimise the appropriate use of limited isolation facilities by triangulation of information from patient flow, microbiology and IPC.

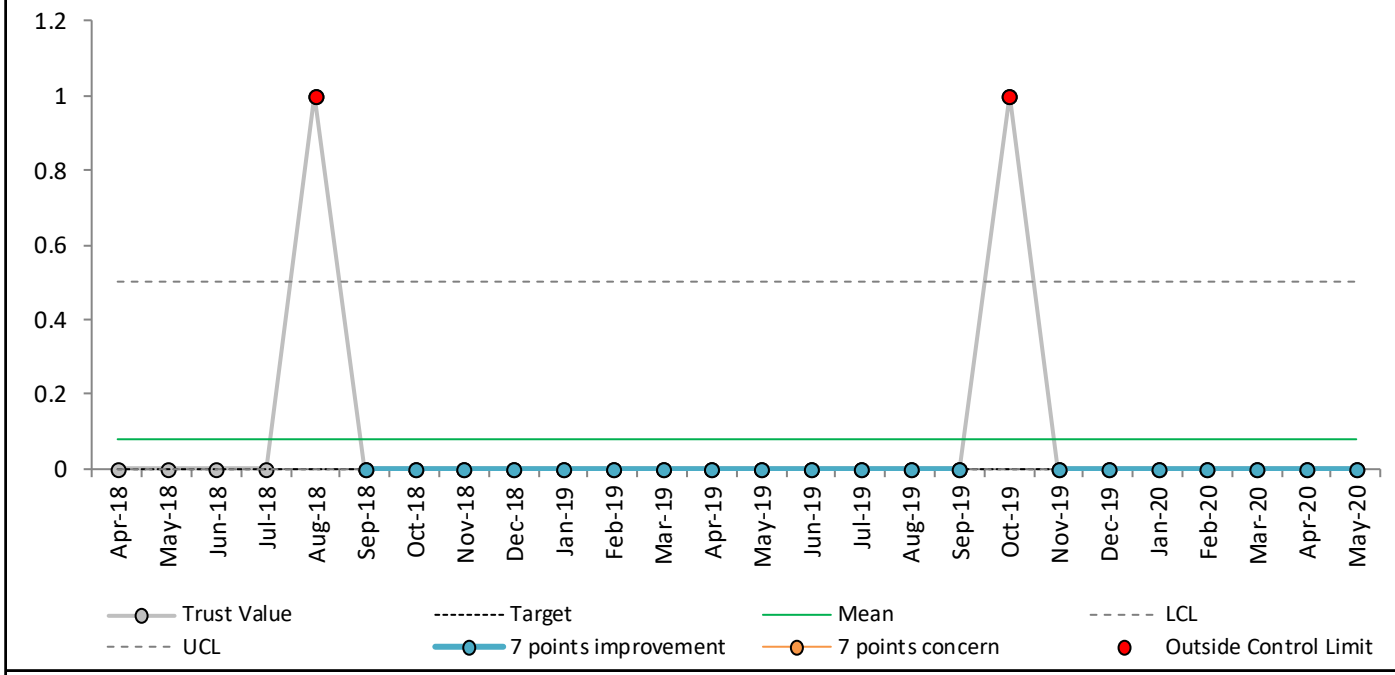
Timescale

- On-going until end of March 2021.

Safe

South Tees Hospitals NHS Foundation Trust

Infection control - MRSA



Cases of hospital acquired MRSA bacteraemia

Target	0
Mean	0.08
Last Month	0.00

Executive Lead

Deirdre Fowler

Lead

Astrida Ndhlovu

Commentary

The Trust approach to MRSA bacteraemia is one of 'zero tolerance'.

Cause of Variation

- There were 0 cases of MRSA bacteraemia in May 2020.
- In the first 2 months of 2020/21 there have been a total of 0 trust-assigned cases and 0 cases which are not trust assigned.

Planned Actions

- Resume MRSA weekly audits that were paused due to COVID and attendance at Clinical Standards meetings to provide feedback.
- Continue to implement Aseptic Non-Touch Technique to ensure appropriate management of invasive devices.

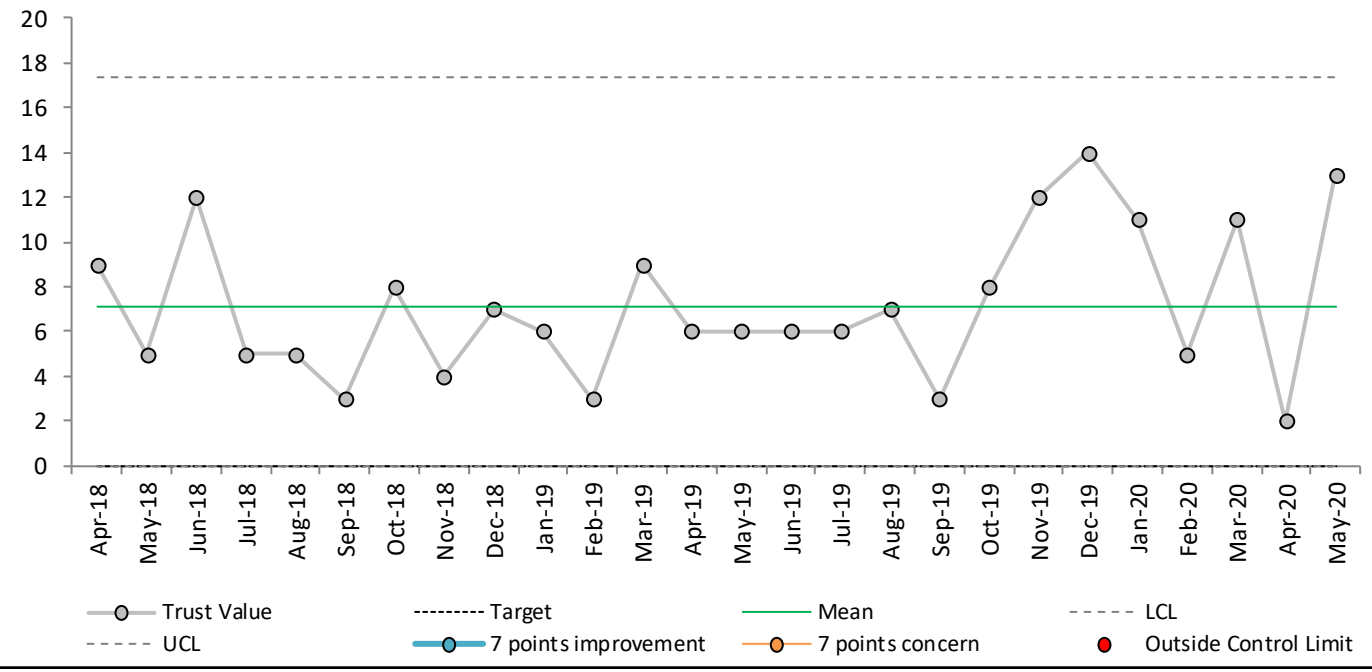
Timescale

- On-going until end of March 2021.

Safe

South Tees Hospitals NHS Foundation Trust

Serious Incidents



The number of Serious Incidents

Target	0
Mean	7.15
Last Month	13.00

Executive Lead

Deirdre Fowler

Lead

Ian Bennett

Commentary

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

Cause of Variation

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

Planned Actions

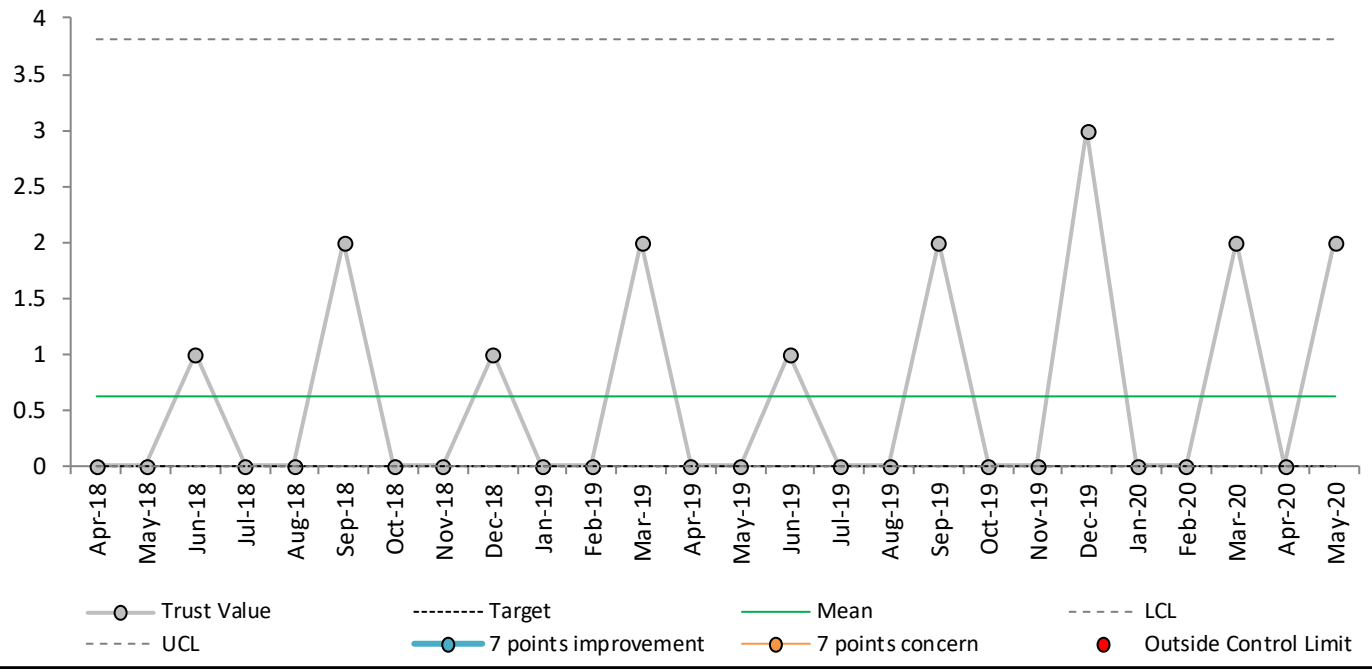
- A focussed piece of work is underway to close down all historic actions from Serious Incidents within the next 4 weeks. To continue to report and investigate SI's within agreed timescales and ensure lessons learnt are shared across the Organisation.
- Await the publication of the new Patient Safety Incident Response Framework. Commission and deliver training for key staff .

Timescale

Safe

South Tees Hospitals NHS Foundation Trust

Serious Incidents never events



Number of reported Never Events

Target	0
Mean	0.62
Last Month	2.00

Executive Lead

Deirdre Fowler

Lead

Ian Bennett

Commentary

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

Cause of Variation

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

Planned Actions

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

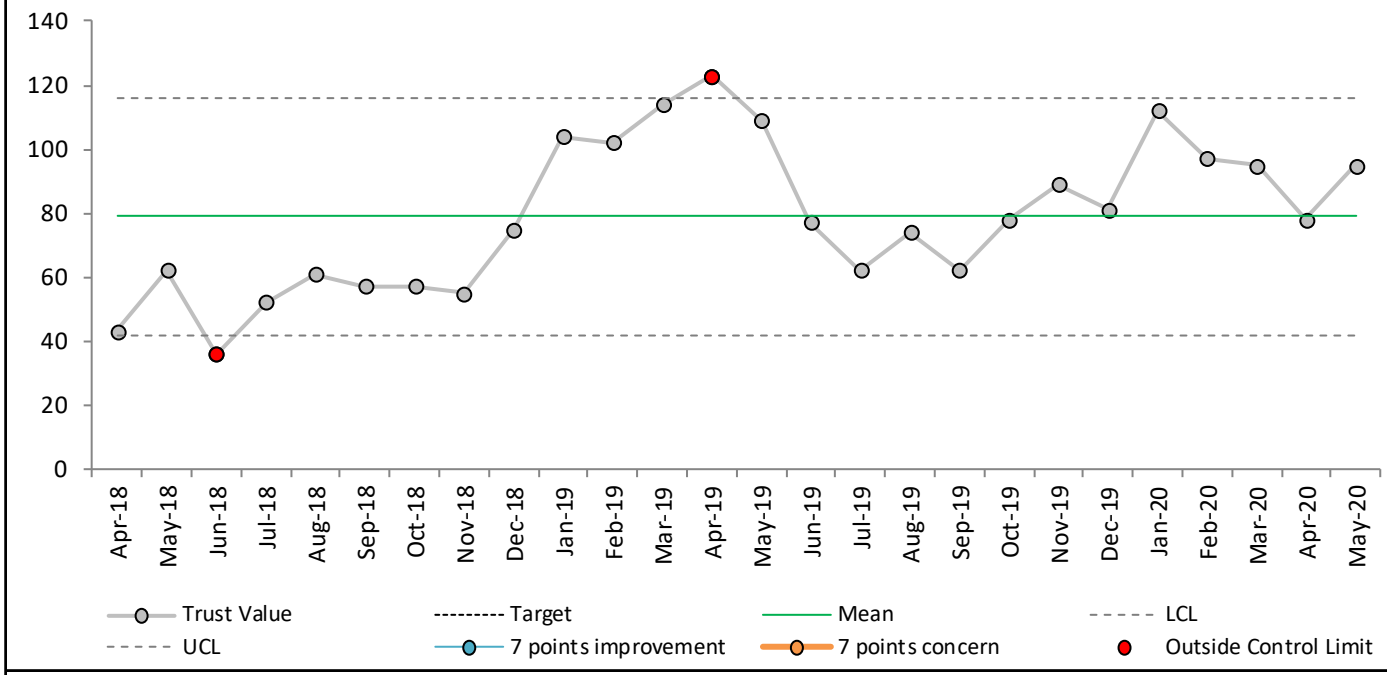
Timescale

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

Safe

South Tees Hospitals NHS Foundation Trust

Grade 2 Pressure Ulcers



Number of Grade 2 Pressure Ulcers - Trust Acquired

Target	TBD
Mean	78.85
Last Month	95.00

Executive Lead

Deirdre Fowler

Lead

Beth Swanson

Commentary

Increased incidence in critical care related to devices and proning.

Cause of Variation

- Impact of Covid 19.
- Poor compliance with comfort and pressure chart.

Planned Actions

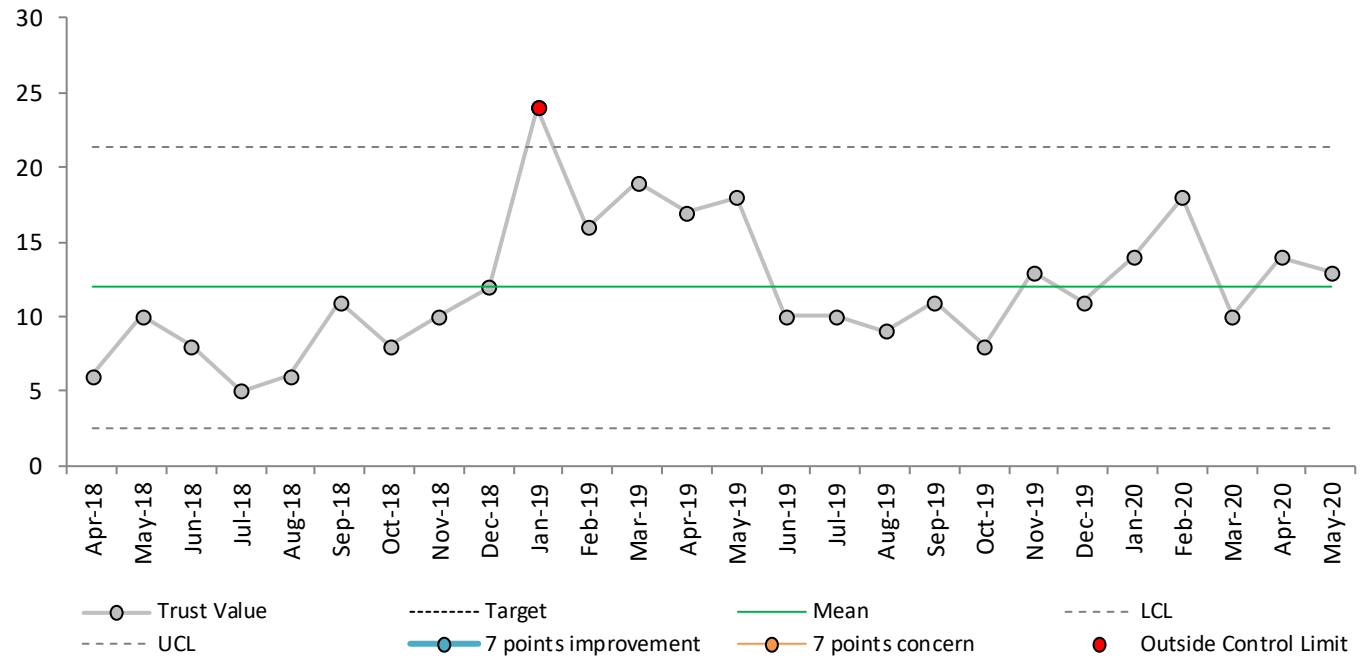
- Reinstate bay nursing .
- Restart clinical training (class room and via teams) – focus included interventions to reduce risk and documentation to support.
- Community nursing H&R and ward 34 pulling together an overarching action plans.
- Conduct a deep dive and report analysis to QAC June 2020.

Timescale

Safe

South Tees Hospitals NHS Foundation Trust

Grade 3 & 4 Pressure Ulcers



Number of Grade 3 & 4 Pressure Ulcers - Trust Acquired

Target	TBD
Mean	11.96
Last Month	13.00

Executive Lead

Deirdre Fowler

Lead

Beth Swanson

Commentary

In May the trust declared 6 serious incidents relating to gaps and lapses in care.

Increased incidence in critical care related to devices and proning.

Cause of Variation

- Impact of Covid 19.
- Poor compliance with comfort and pressure chart.

Planned Actions

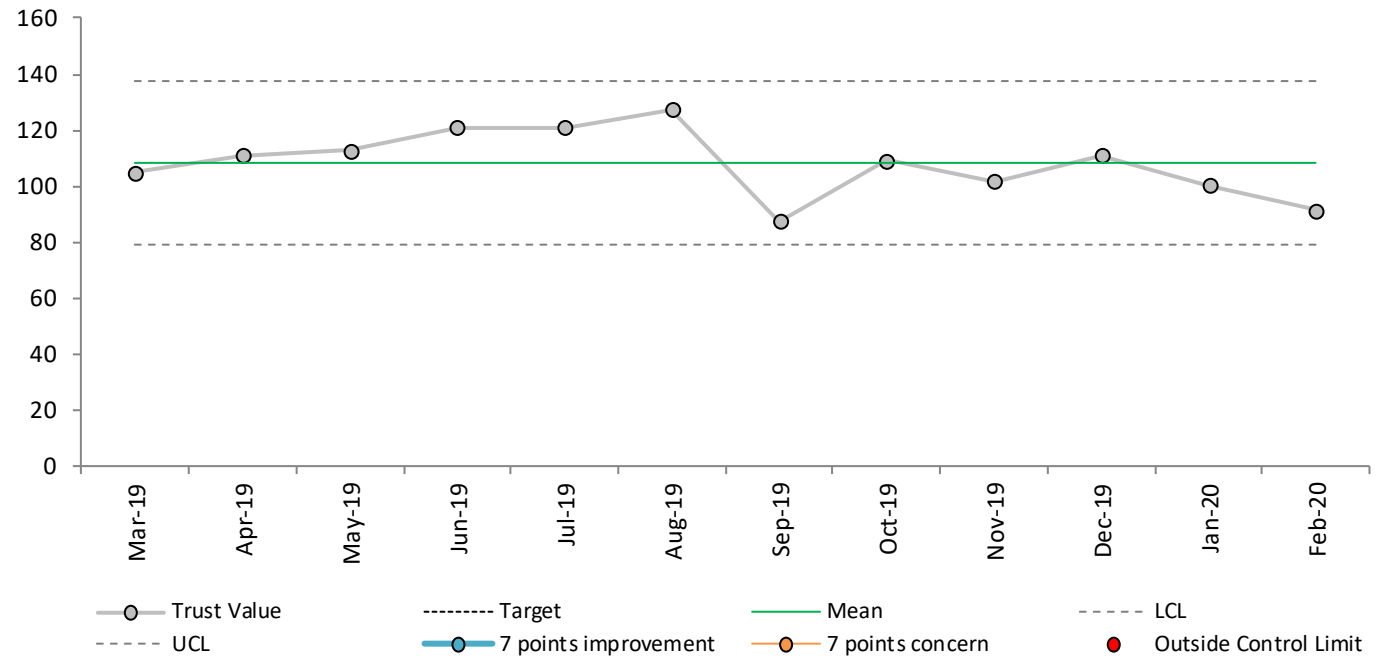
- Reinstate bay nursing .
- Restart clinical training (class room and via teams) – focus included interventions to reduce risk and documentation to support.
- Community nursing H&R and ward 34 pulling together an overarching action plans.
- Conduct a deep dive and report analysis to QAC June 2020.

Timescale

Safe

South Tees Hospitals NHS Foundation Trust

Hospital Standard Mortality Rate (HSMR)



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

Target	National Average
Mean	108.12
Last Month	91.16

Executive Lead

Sath Nag

Lead

Tony Roberts

Commentary

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

Cause of Variation

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

Planned Actions

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

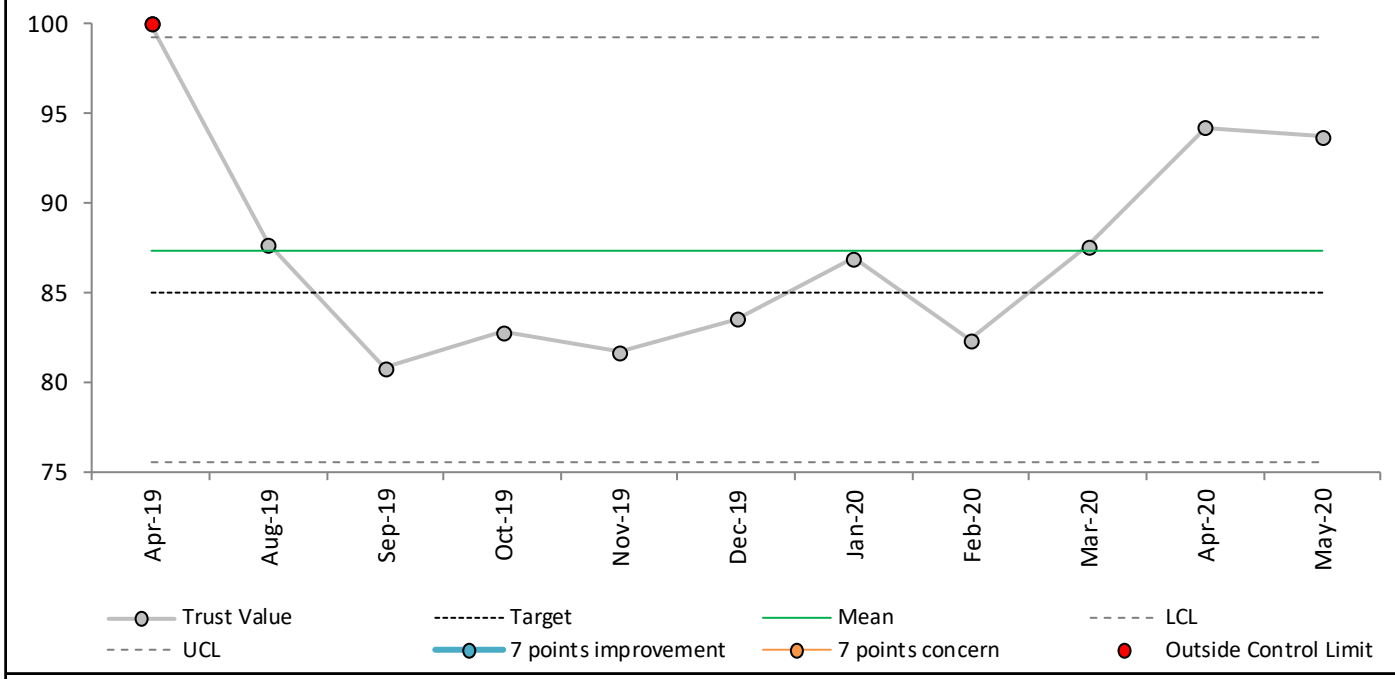
Timescale

- On-going

Caring

South Tees Hospitals NHS Foundation Trust

F&F A&E Recommendation Rate



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

Target	85
Mean	87.39
Last Month	93.73

Executive Lead

Deirdre Fowler

Lead

Jen Olver

Commentary

The uploading of the FFT data was suspended by NHS England at the end of March.
The data has been pulled from the Meridian program rather than NHS Digital.

Cause of Variation

- Increased response rate to text messaging service from the previous month.

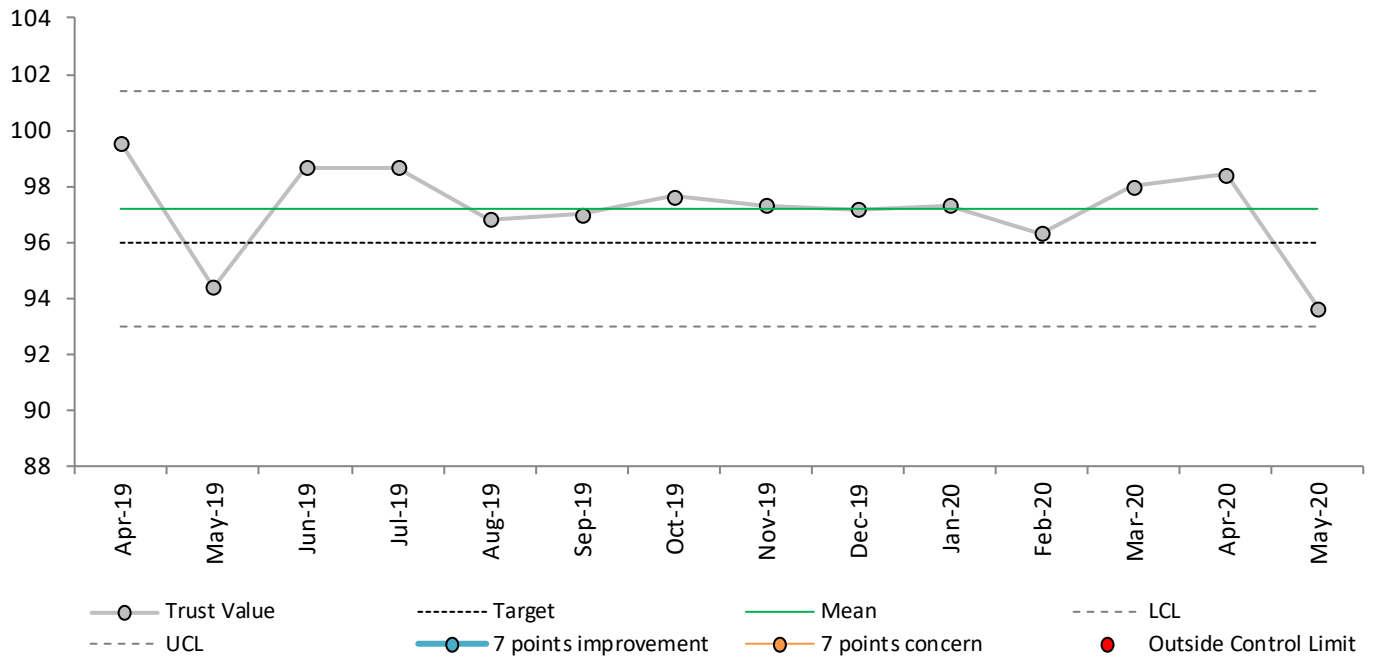
Planned Actions

Timescale

Caring

South Tees Hospitals NHS Foundation Trust

F&F Inpatient Recommendation Rate (%)



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

Target	96
Mean	97.20
Last Month	93.65

Executive Lead

Deirdre Fowler

Lead

Jen Olver

Commentary

The inpatient recommendation rate has dropped below target but remains within the control limits.

Cause of Variation

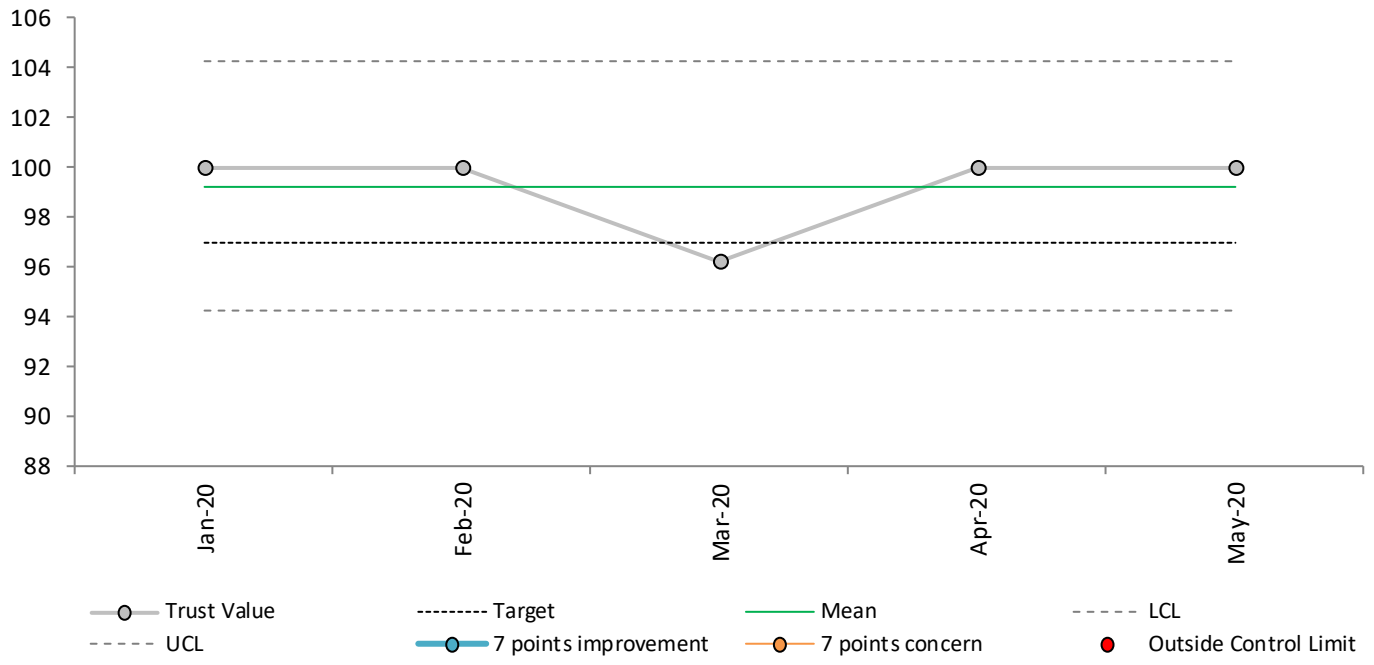
Planned Actions

Timescale

Caring

South Tees Hospitals NHS Foundation Trust

F&F Maternity Recommendation Rate (%)



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

Target	97
Mean	99.25
Last Month	100.00

Executive Lead

Deirdre Fowler

Lead

Jen Olver

Commentary

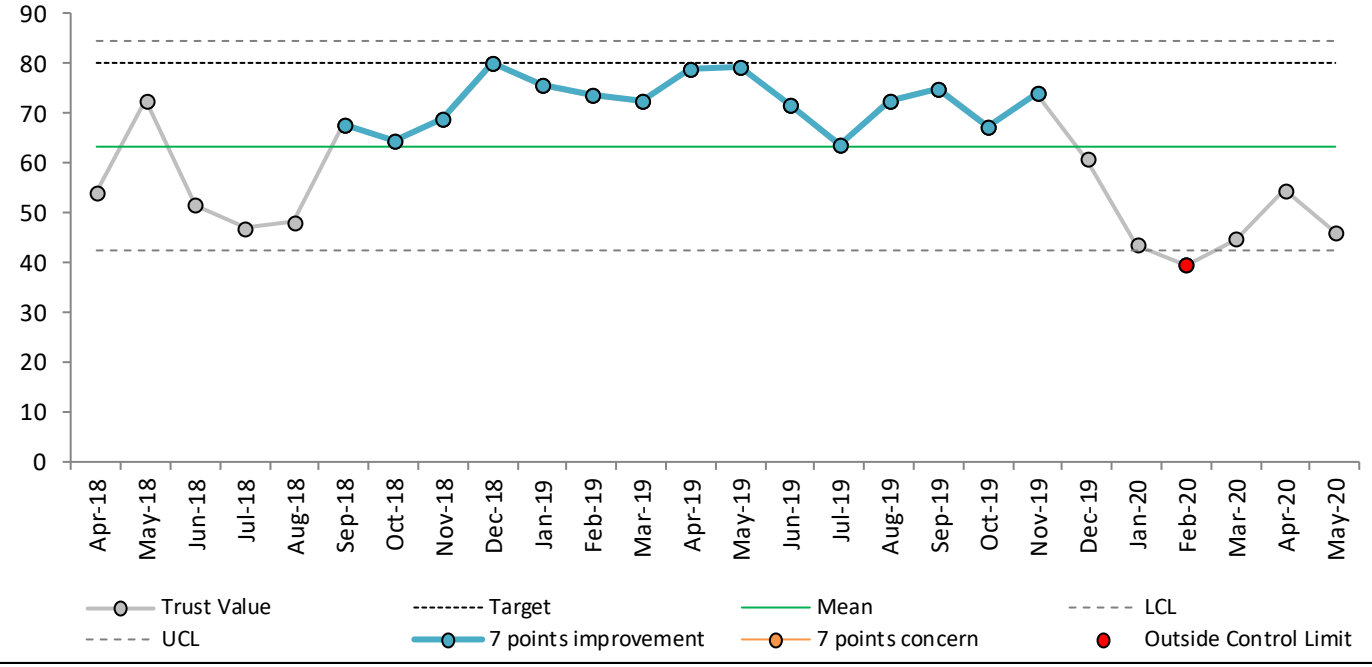
The recommendation rate has remained at 100% for the second month running.

Cause of Variation	Planned Actions	Timescale

Caring

South Tees Hospitals NHS Foundation Trust

Complaints Closed Within Target (%)



The percentage of complaints closed within the target

Target	80
Mean	63.41
Last Month	46.15

Executive Lead

Deirdre Fowler

Lead

Jen Olver

Commentary

Cause of Variation

- There was a significant reduction in the complaints closed within target response rate and this was due to the 'off target' complaints that were being cleared.
- There are now 7 'off target' complaints compared to 58 in January.

Planned Actions

- Weekly complaint review meeting to discuss the written complaint responses coming 'off target' in the next 14 working days.
- Escalation procedure, as per the Trust policy, to be routinely followed by the teams in the Centre.
- Review of all written complaint responses that do not meet the agreed timeframe.

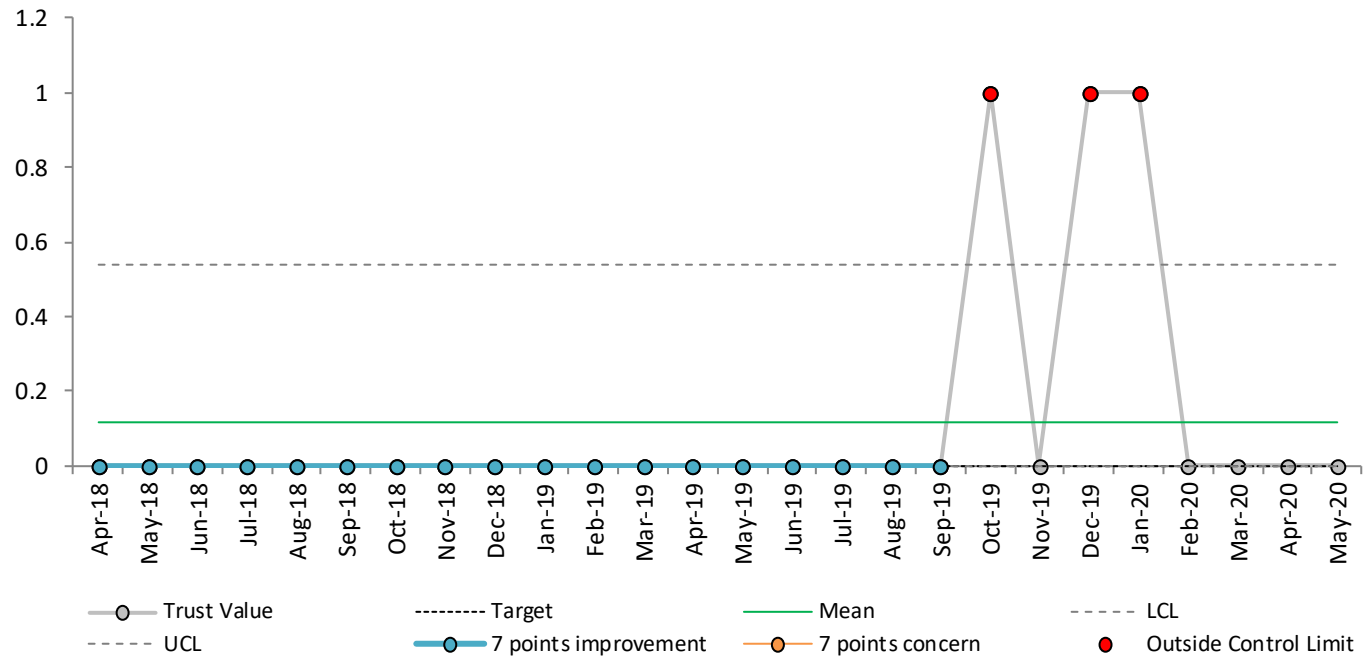
Timescale

- On-going
- On-going
- On-going

Caring

South Tees Hospitals NHS Foundation Trust

Mixed Sex Accommodation (MSA) Breaches



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

Target	0
Mean	0.12
Last Month	0.00

Executive Lead

Deirdre Fowler

Lead

Jen Olver

Commentary

No significant change this month. We are hitting the target but we are not doing this consistently.

Cause of Variation

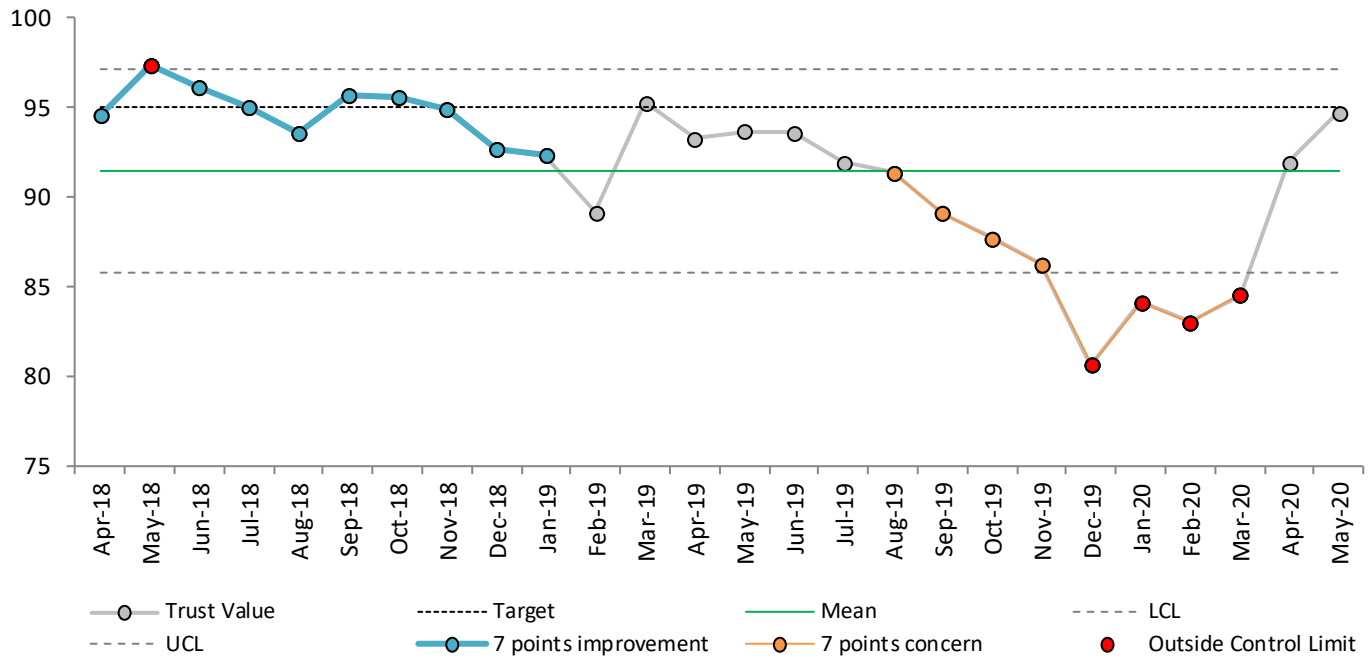
Planned Actions

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

A&E 4 Hour Wait Standard (%)



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

Target	95
Mean	91.47
Last Month	94.72

Executive Lead

Johanna Riley

Lead

Penny Bateman

Commentary

A&E 4 hour compliance has increased for the fourth consecutive month, although remains just below the target.

Cause of Variation

- Bed availability for non – covid pathway.
- Increase in activity including over 65's.
- Limited options for external navigation.
- Exit block.

Planned Actions

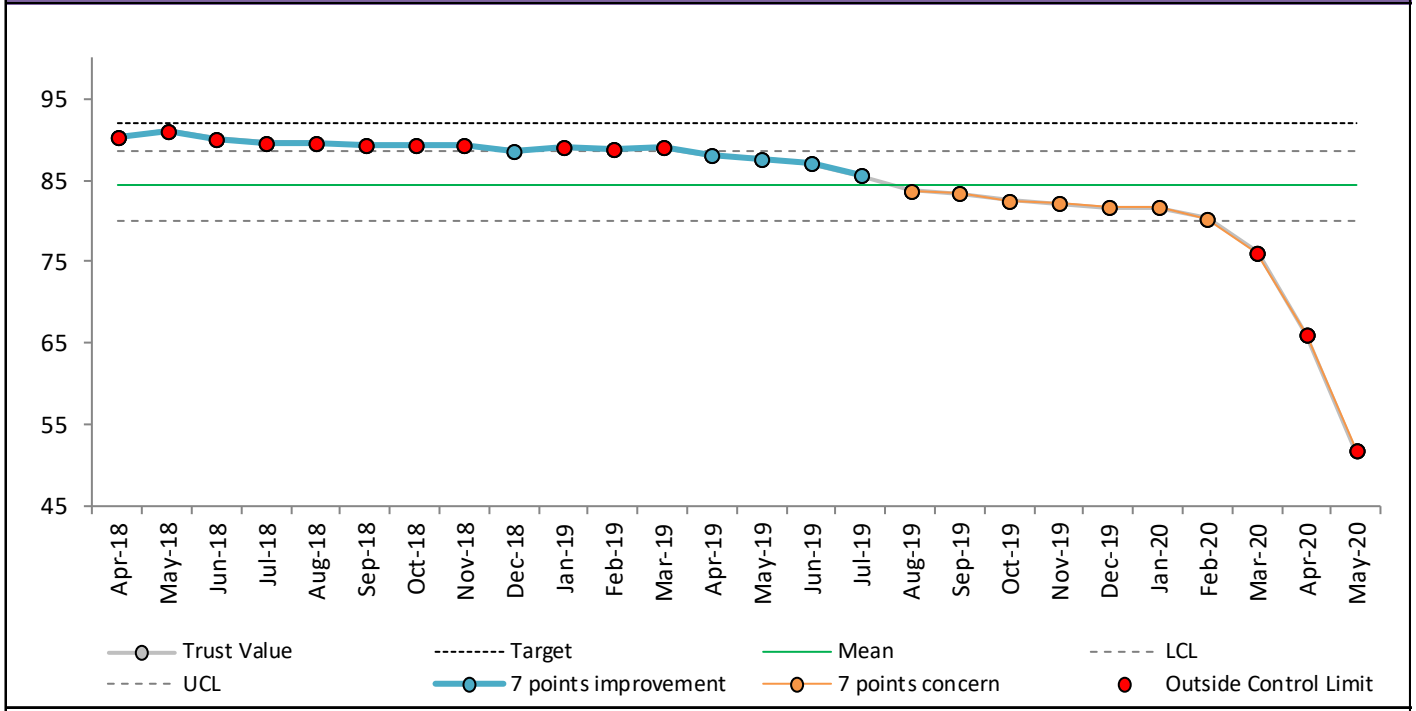
- Daily breach validation process.
- 3 x weekly breach analysis meeting.
- Provision of enhanced navigation and triage process occupied in the red shed area adjacent to ED.
- Collaborative working with CCG and primary care to stream externally.
- Review of radiology KPI's to support timely decision making.
- Admission avoidance options.

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

RTT Incomplete Pathways (%)



The % of incomplete pathways for patients within 18 weeks

Target	92
Mean	84.30
Last Month	51.79

Executive Lead

Johanna Riley

Lead

Sue Geldart

Commentary

RTT Compliance has been off target since Nov 17 and has been outside of the lower control limit for the last 3 months.

May 2020 compliance reduced to 51.79%, a reduction of 14.24% on April 2020 position.

Cause of Variation

- In March 2020 the Trust was required to cancel all non-urgent elective activity (by NHSE/I) for a minimum of three months. RTT compliance has significantly reduced to 51.79%. The number of patients waiting over 52 weeks at the end of May was 339 compared to 111 at end of April. NHSE plan for waiting list size has been achieved, final position was 5,003 below plan.

Planned Actions

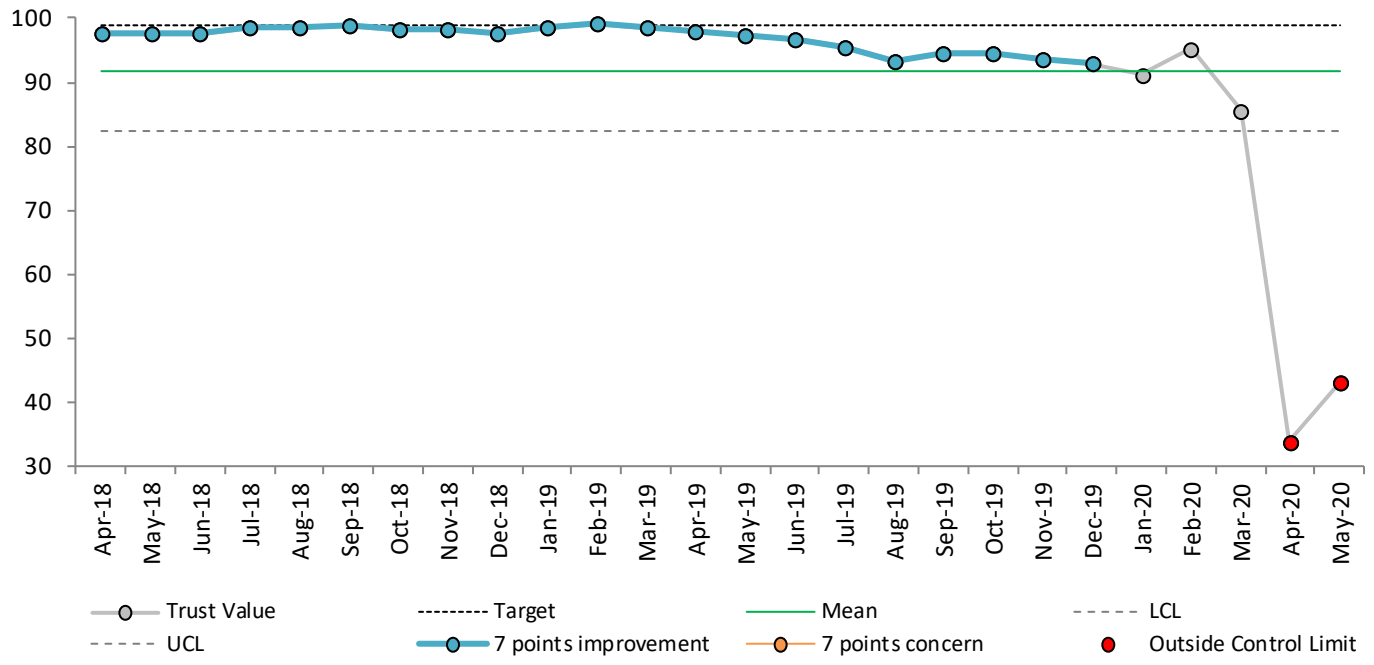
- As the Trust moves into its recovery phase all Directorates have been asked to submit recovery plans. Consideration of what can be re-started safely will be co-ordinated via the Recovery Group to ensure sufficient capacity for agreed activity with focus on the patients of (a) greatest clinical need and (b) those waiting in excess of 52 weeks. Increased theatre availability comes on line w/c 6th July 2020 and a supporting theatre scheduler has been shared with surgical Directorates.

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

Diagnostic 6 weeks standard (%)



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

Target	99
Mean	91.72
Last Month	43.02

Executive Lead

Johanna Riley

Lead

Kelly Smith

Commentary

Special cause variation for April and May due to the impact of Covid -19.

Cause of Variation

- Reduced capacity.
- Tentative appointments as part of surveillance scanning .

Planned Actions

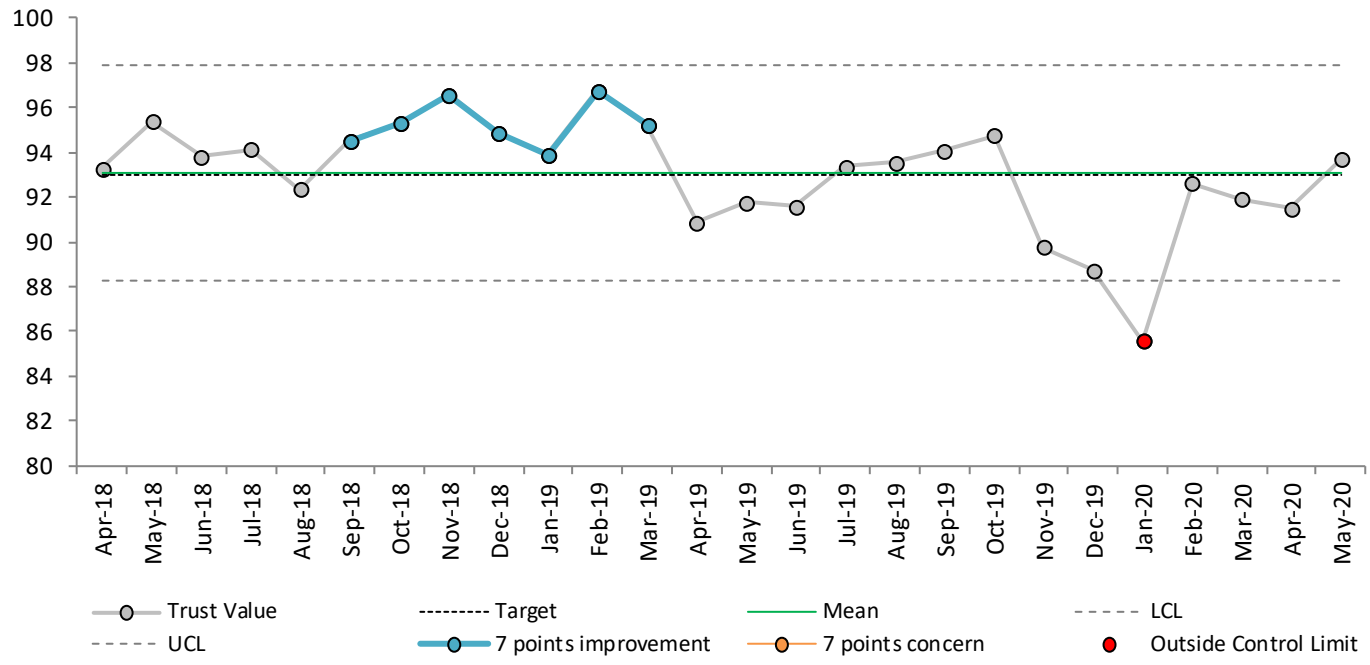
- Capacity has been increased across all modalities as part of our recovery phase 1.
- Ramsey Health are providing 4 days of MRI capacity until 31st August, Mobile CT scanner on site until 31st July.
- House-keeping required on patients waiting 6 weeks plus.

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

Cancer Treatment - 14 Day Standard (%)



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

Target	93
Mean	93.07
Last Month	93.67

Executive Lead

David Chadwick

Lead

Nicki Hurn

Commentary

April 20 compliance was 91.49%, breaches occurred in Plastic Surgery, Urology and Gastroenterology.

Cause of Variation

- Full impact of COVID 19 pandemic experience from April onwards with a significant drop in referrals by around 75%.
- Later weeks we have seen this improve following media campaigns etc. to around 64% of our average referrals..

Planned Actions

- 2 week rule clinics re-instated including endoscopy capacity although this remains limited.
- Weekly cancer performance wall continues virtually to identify pressures and theme.
- Exploring options to continue triage of all 2ww referrals. Looking at processes available through eRS.

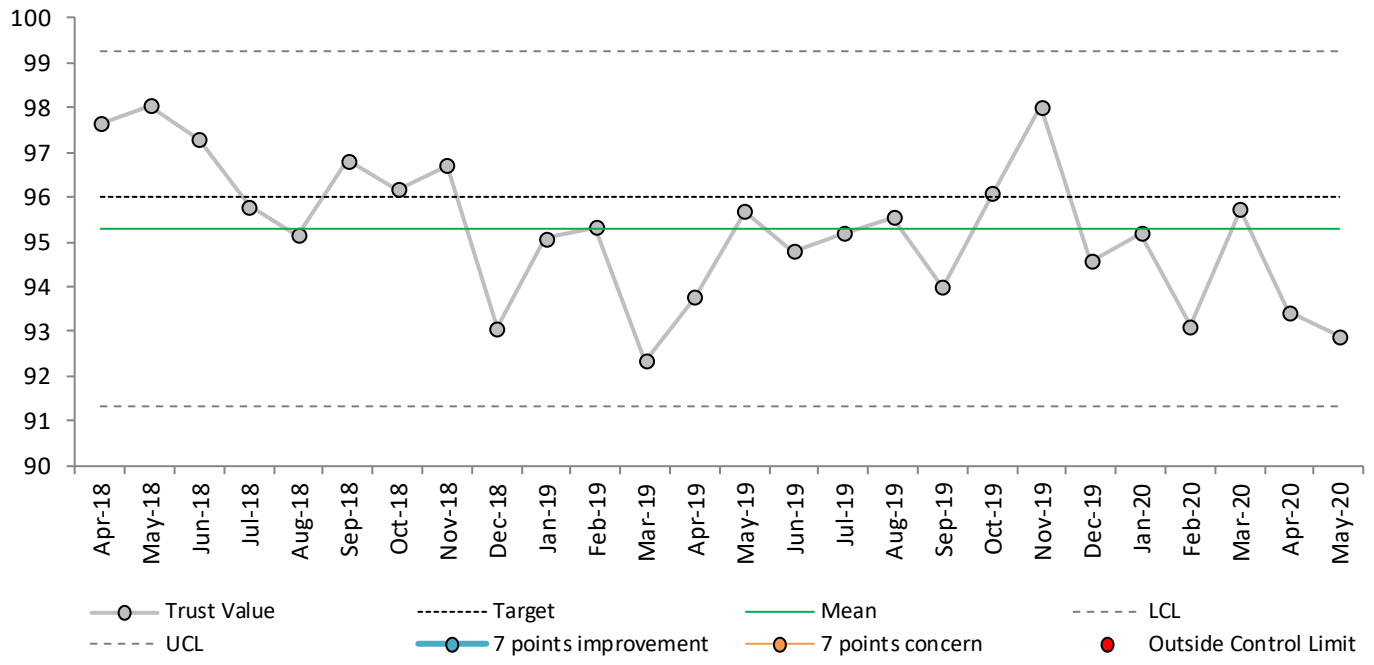
Timescale

- Weekly review – additional capacity approved by Recovery Group.

Responsive

South Tees Hospitals NHS Foundation Trust

Cancer Treatment - 31 Day Standard (%)



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

Target	96
Mean	95.29
Last Month	92.90

Executive Lead

David Chadwick

Lead

Nicki Hurn

Commentary

April 20 compliance was 93.44%, 12 breaches in total 3 Head & Neck, 4 Gynaecology, 2 Colorectal, 1 Breast, 1 Urological and 1 Skin.

Cause of Variation

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

Planned Actions

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

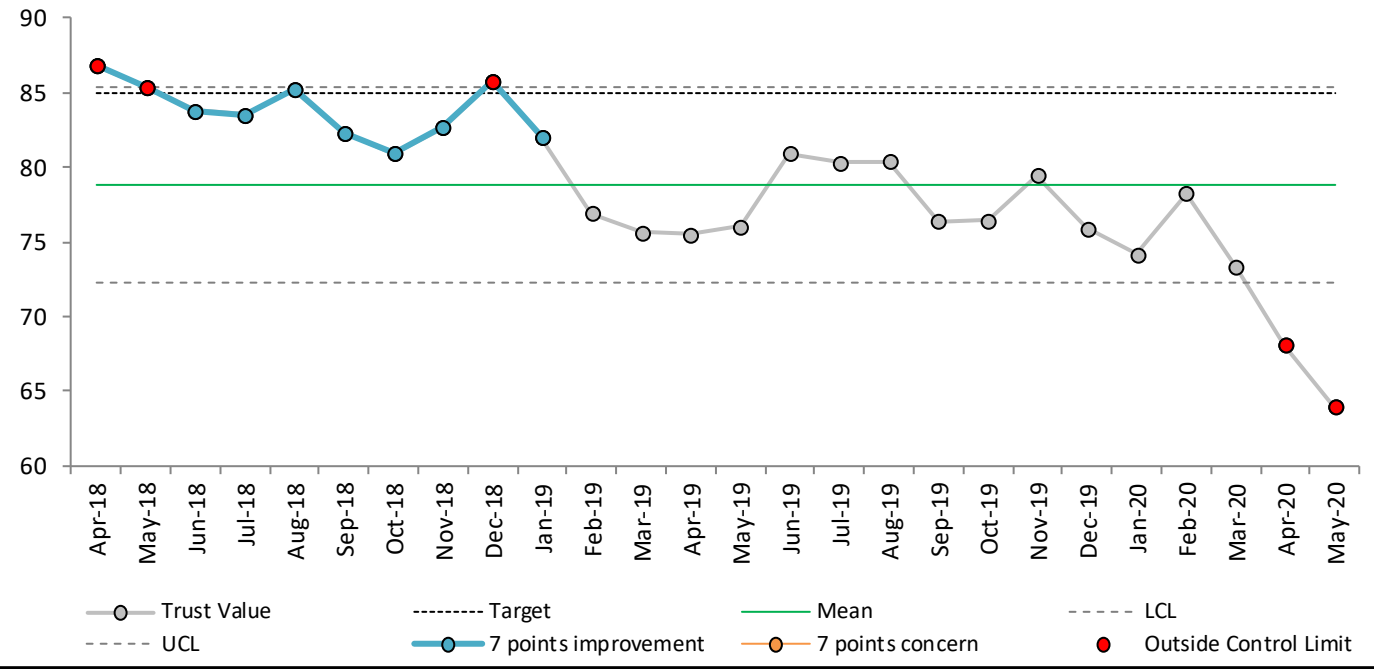
Timescale

- 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	78.86
Last Month	63.96

Executive Lead

David Chadwick

Lead

Nicki Hurn

Commentary

April 20 compliance was 68.10%, 37 breaches – main reasons for the breaches were complex pathways – including COVID risk, multiple tests and specialty involvement, medical reason and patients choice.

Cause of Variation

- Overall treatments in April were down in comparison to the same period last year by 33.14% (116 v 173.5 treatments).
- Tees wide cancer cell developed ensuring all priority 2 patients are operated on within a four week period – Trust is managing to consume priority 2 cancer demand .

Planned Actions

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

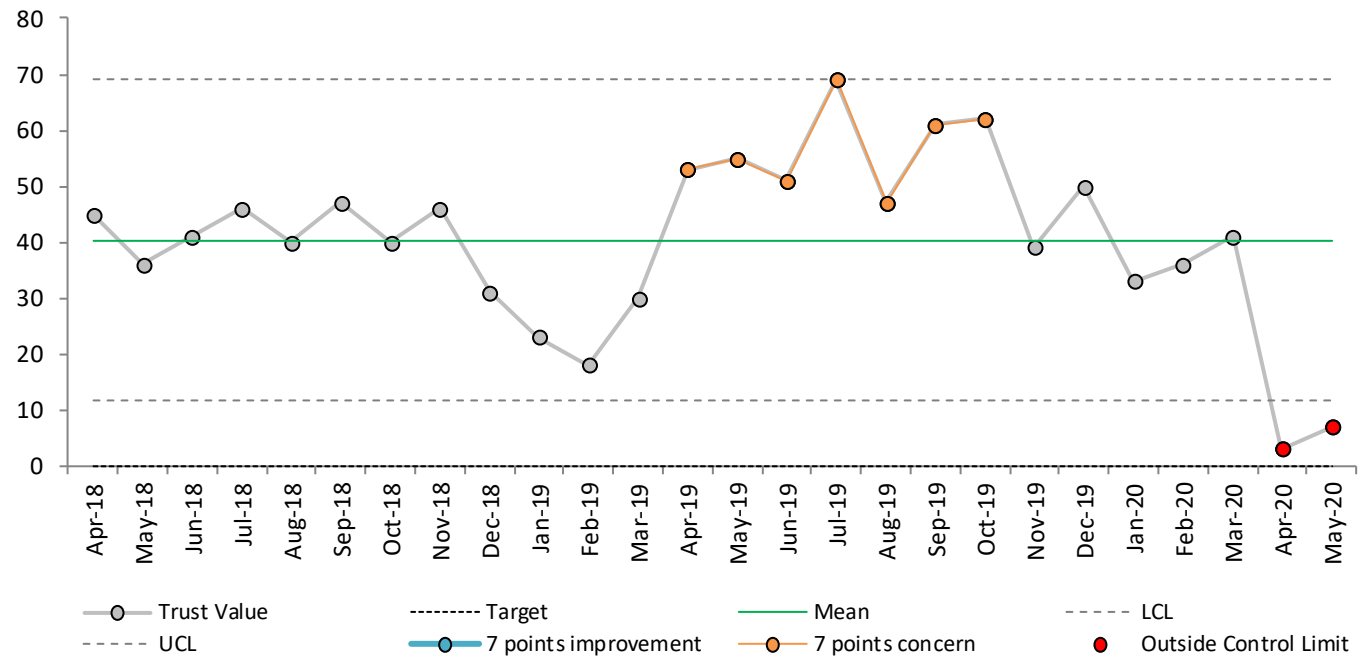
Timescale

- October 2020
- June 2020
- Weekly on-going

Responsive

South Tees Hospitals NHS Foundation Trust

Non-Urgent Ops Cancelled on Day



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

Target	0
Mean	40.38
Last Month	7.00

Executive Lead

Johanna Riley

Lead

Sue Geldart

Commentary

Variation outside control limits due to reduced elective program.

In May 2020, 7 patients had their operation cancelled on the day. These were all due to lack of theatre time. All 7 patients were given a new TCI date with the 28 day standard.

Cause of Variation

- Significant reduction in the number of non-urgent operations cancelled on the day (day of admission / day of procedure) due to limited number of elective / non urgent procedures going ahead during the COVID-19 pandemic. 7 patients cancelled during May (2 Cardiothoracic Surgery, 1 General Surgery, 1 Gynaecology, 3 Urology). All patients were given new TCI dates within 28 day standard.

Planned Actions

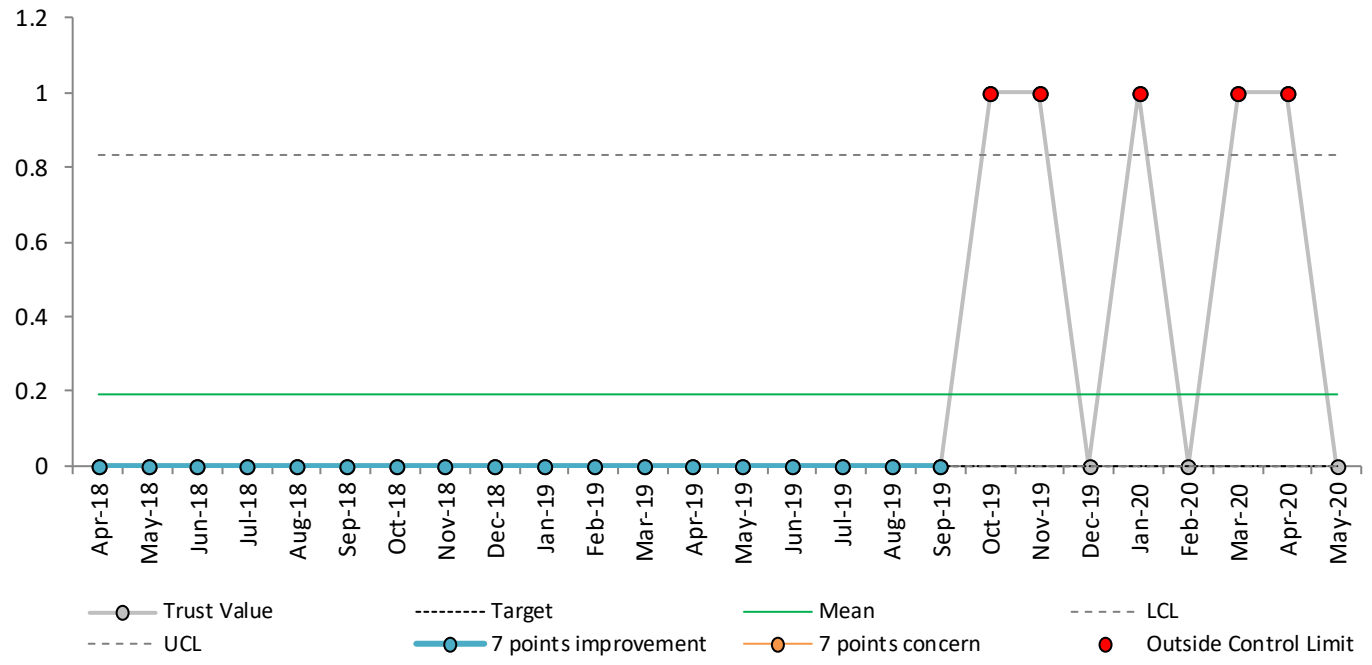
- Continue to book non-urgent patients as set out in the Trust's Standard Operating Procedure for prioritisation of elective patients during current COVID-19 pandemic. Continue to ensure that patients are appropriately consented and pre-assessed prior to admission (including swabbed 48 hours prior to admission) to minimise the likelihood of 'hospital initiated' cancellation. Increased theatre capacity coming on line w/c 6th July 2020.

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

Cancer Operations Cancelled on Day



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

Target	0
Mean	0.19
Last Month	0.00

Executive Lead

Johanna Riley

Lead

Sue Geldart

Commentary

There were no cancelled cancer operations in May.

Cause of Variation

- From the data above this suggests no urgent operations were cancelled on the day (day of admission / day of procedure) during May 2020 for 'hospital initiated' reasons. No exceptions to report (assuming zero cancellations based on data provided in graph above

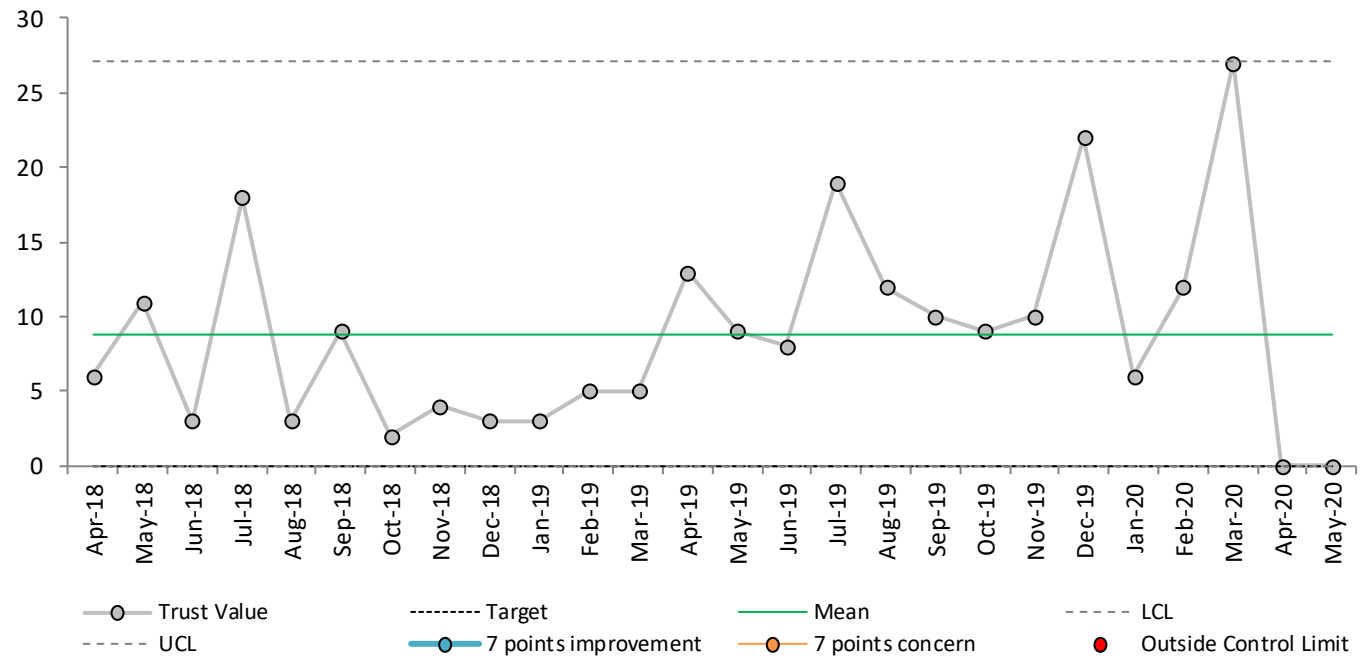
Planned Actions

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

Cancelled Ops not rebooked within 28 days



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

Target	0
Mean	8.81
Last Month	0.00

Executive Lead

Johanna Riley

Lead

Sue Geldart

Commentary

In May 2020, 7 patients had their operation cancelled on the day. All 7 patients were given a new TCI date with the 28 day standard.

Cause of Variation

- The Trust cancelled 7 non-urgent operations on the day in May 2020. All patients were given a new TCI date within the 28 day standard (therefor no exceptions to report).

Planned Actions

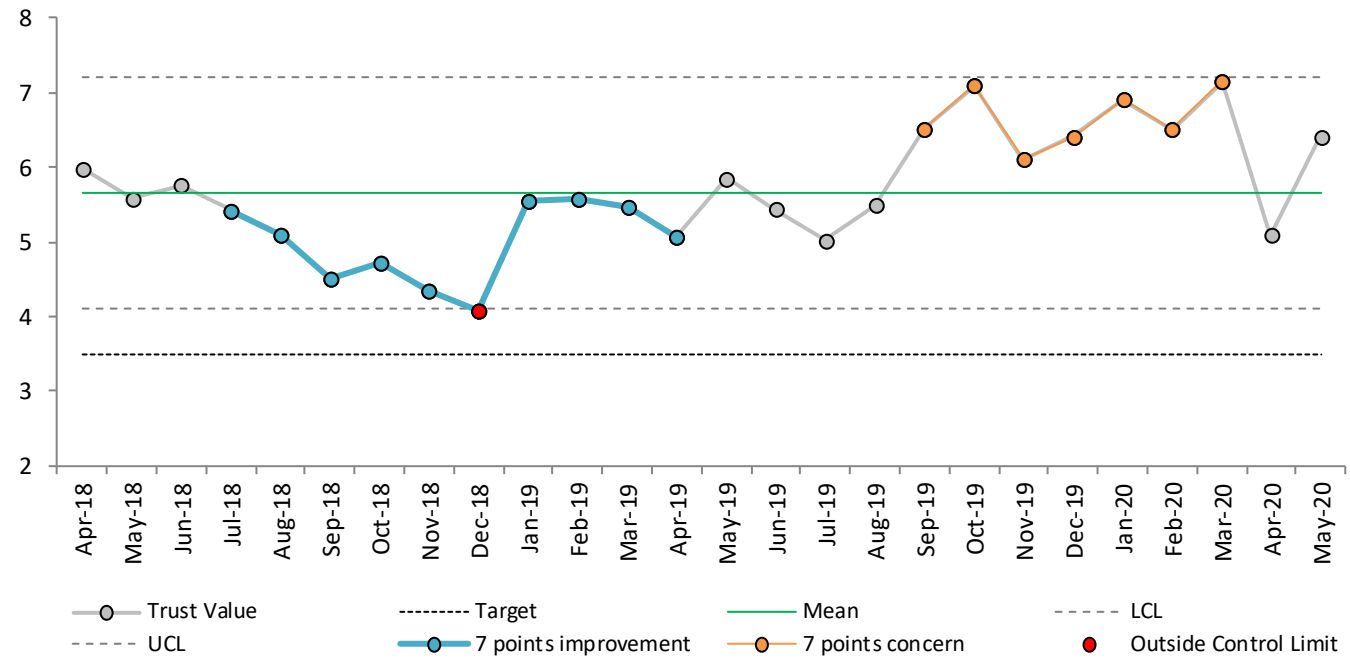
- Continue to monitor the number of non-urgent patients cancelled due to hospital initiated reasons (aim to minimise). Actively promote (and provide routine reports) to ensure that short notice cancellations are re-booked within the 28 day standard.

Timescale

Responsive

South Tees Hospitals NHS Foundation Trust

Delayed Transfers of Care (%)



Delayed transfers of care compliance

Target	3.5
Mean	5.66
Last Month	6.41

Executive Lead

Johanna Riley

Lead

Joanne Dobson

Commentary

Significant improvement in DToC rates since March 2020 .

As of April the data source was changed from local data collection to Medworxx.

Cause of Variation

- DToC within tolerance.
- Improved working relationships with CCG and Local Authority .
- Streamlined discharge processes

Planned Actions

- Continue to embed Medworxx across the organisation as a continuous improvement tool.
- Continue with > 7 day LoS MDT reviews.
- Ensure 'Home first' ethos across the organisation and embed discharge to assess – work will continue through Medicine and Emergency Improvement Collaborative linking with Community Improvement Collaborative.

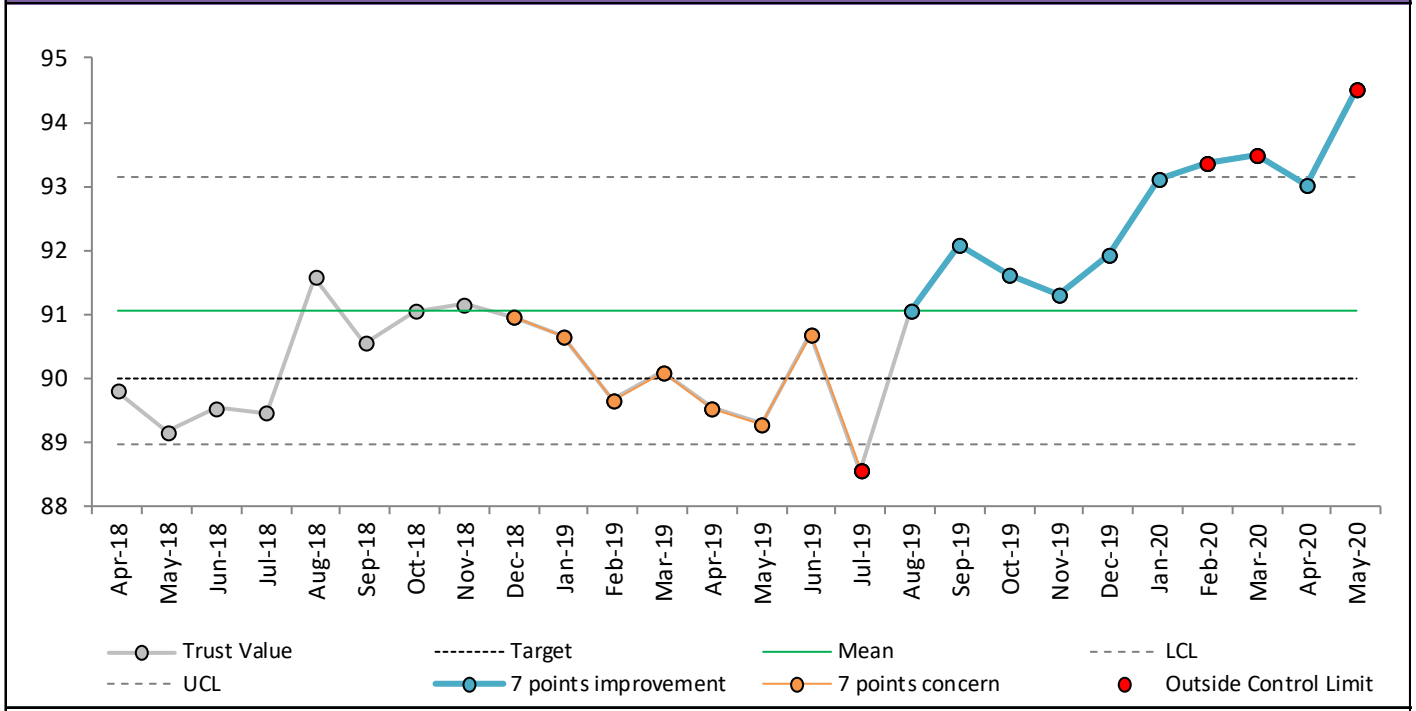
Timescale

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

Responsive

South Tees Hospitals NHS Foundation Trust

E-Discharge (%)



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

Target	90
Mean	91.04
Last Month	94.52

Executive Lead

Johanna Riley

Lead

Joanne Dobson

Commentary

10 point improvement and compliance is now above the upper control limit. Do we need to change target or do we need to check data completeness as there is variable performance completing E-discharges although the position is improving

Cause of Variation

- Position appears to be improving this may be in some part to wards and teams being re-organised as we de-escalate COVID19.

Planned Actions

- Continue to work with Clinical Directors to ensure E-discharges are prioritised and completed within 72 hours.
- Continue to wait for deployment of computers on wheels ordered to support timely discharges .

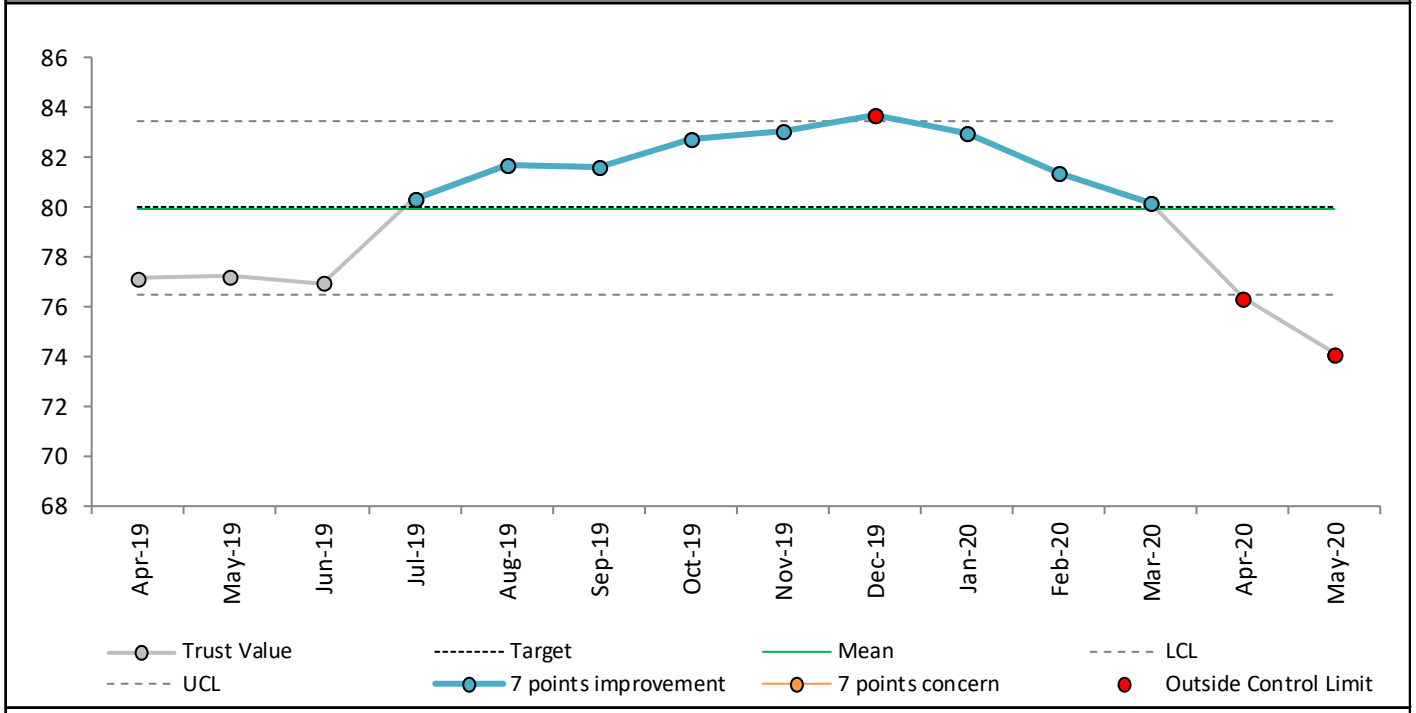
Timescale

- Monthly review of compliance.
- August 2020

Well Led

South Tees Hospitals NHS Foundation Trust

Annual Appraisal (%)



Annual Appraisal Rate

Target	80
Mean	79.97
Last Month	74.12

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

Special cause variation outside of the control limit. for the last 2 months.

Cause of Variation

- Enhanced focus needed on completion rates and areas of high non compliance due to various factors including COVID-19 and a national agreement to extend timescales for appraisal requirements and accountability of operational managers.

Planned Actions

- Targeted focus on departments/wards who have dropped below 80% compliance rate.
- Discussions with OD's to highlights areas above and agree action plan to rectify .
- Discussions to commence about the feasibility of all appraisals to be completed in Q1 each year

Timescale

- 10 July 2020
- 3 July 2020
- 6 July 2020

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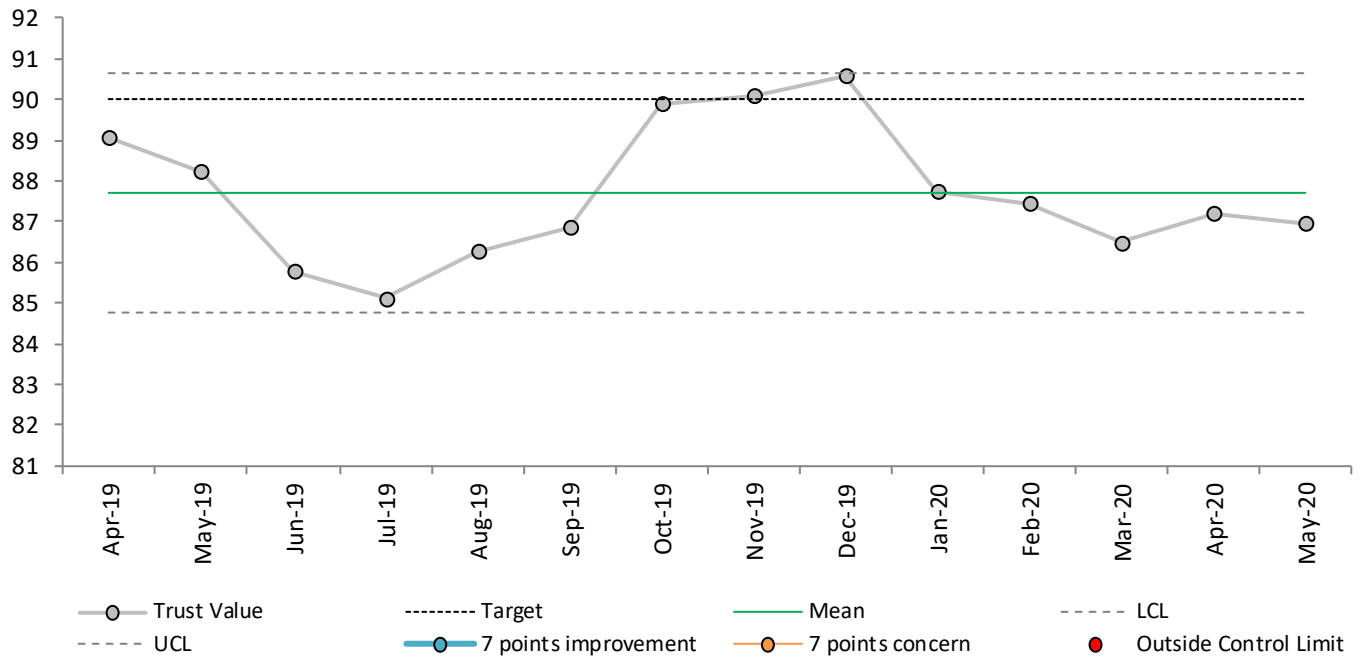
Mandatory Training (%)



The % of Mandatory Training Compliance

Target	90
Mean	87.70
Last Month	86.96

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

Consistently missing the target for 4 consecutive months.

Cause of Variation

- Operational focus on COVID and national agreement to extend timescales for mandatory training.
- Local Induction on hold from March impacted on Mandatory training compliance.

Planned Actions

- Analysis of available mandatory training data to identify areas/subjects of non compliance, with Operations Directors and Service Managers
- Agree action plan to improve compliance

Timescale

- July 2020
- July 2020

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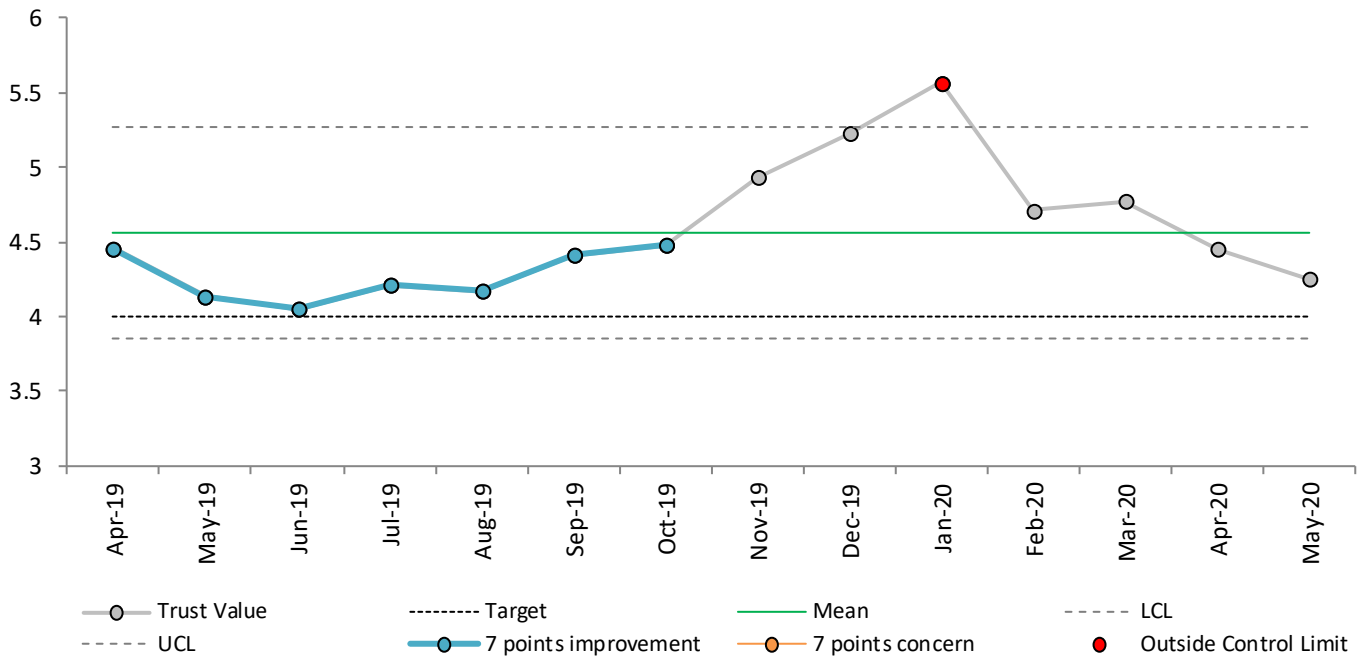
Sickness Absence (%)



The % of monthly sickness absence

Target	4
Mean	4.56
Last Month	4.25

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

Sickness absence has improved for the second consecutive month, although we're not achieving the target.

Cause of Variation

- Formal absence management cases following COVID-19 pressures.
- More accurate absence recording for COVID and non-COVID related absences.

Planned Actions

- Continue with introduction of formal absence monitoring, working with managers to identify non-COVID related absence and monitoring procedures

Timescale

- Immediate

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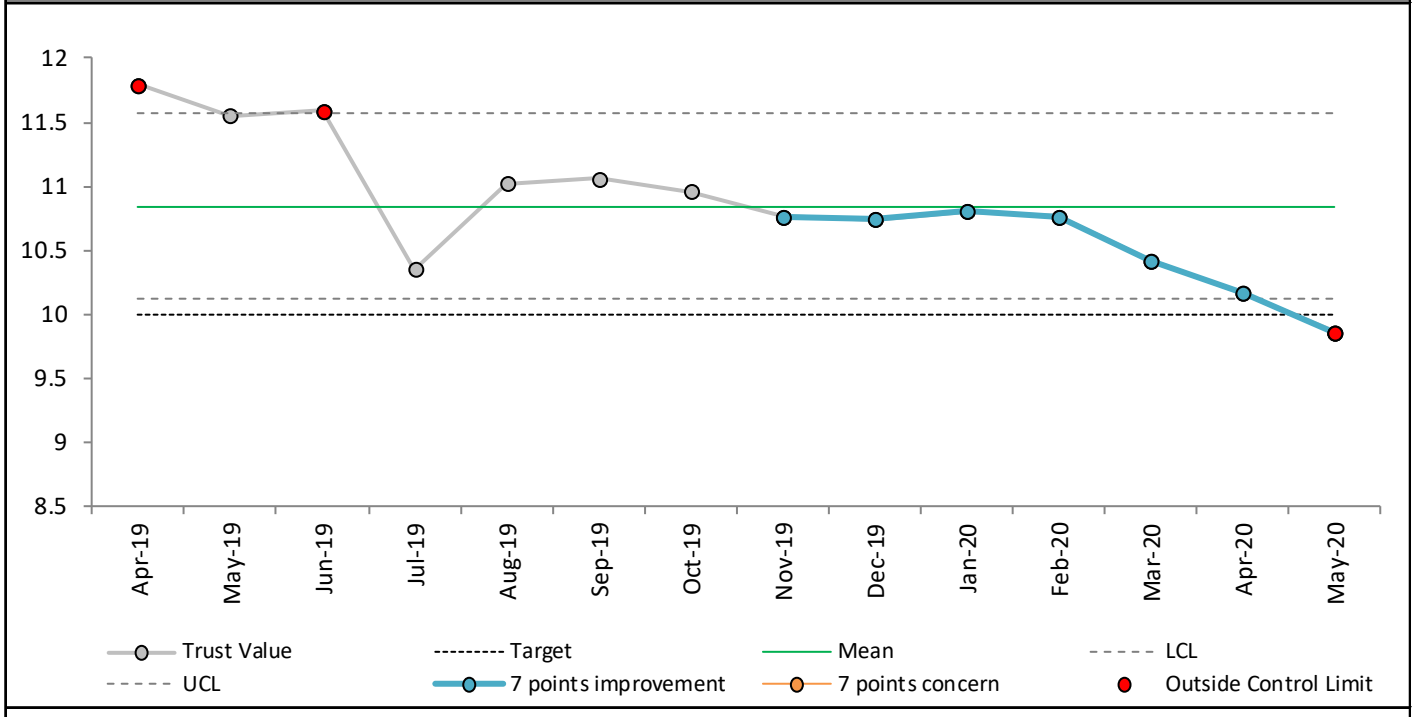
Staff Turnover (%)



Staff turnover rate

Target	10
Mean	10.84
Last Month	9.86

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

Special cause outside of lower control limit, although May's value now meets the target.

Cause of Variation

- Additional well being support offered to staff during COVID-19 pandemic.
- Focus on Trust values and behaviours .

Planned Actions

- Introduce a series of retention solutions, including reinvigorating the exit interview procedures to include:
  - offer online and face to face exit interviews
  - Itchy feet conversations, for those staff who express a desire for alternative employment within the Trust
  - Stay conversations – what makes individuals want to stay with the Trust and ensuring good practice is shared to support retention.

Timescale

* To be presented to Workforce Committee in July 2020 for sign off. Implementation to follow ,

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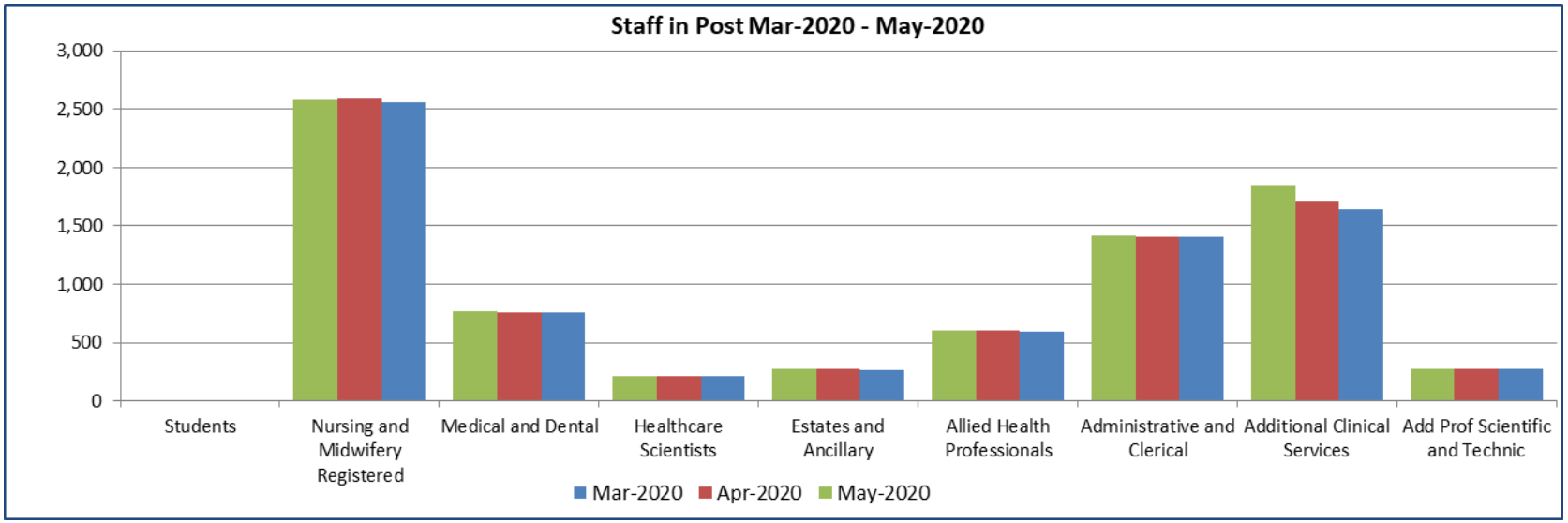
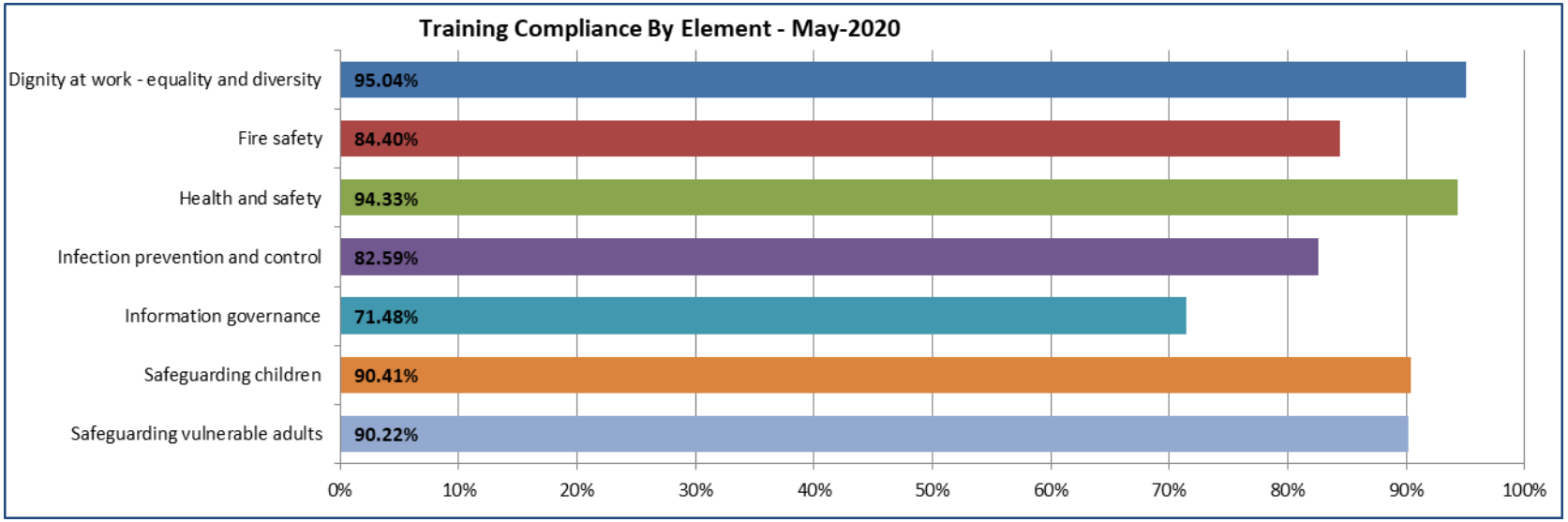
NHS Foundation Trust





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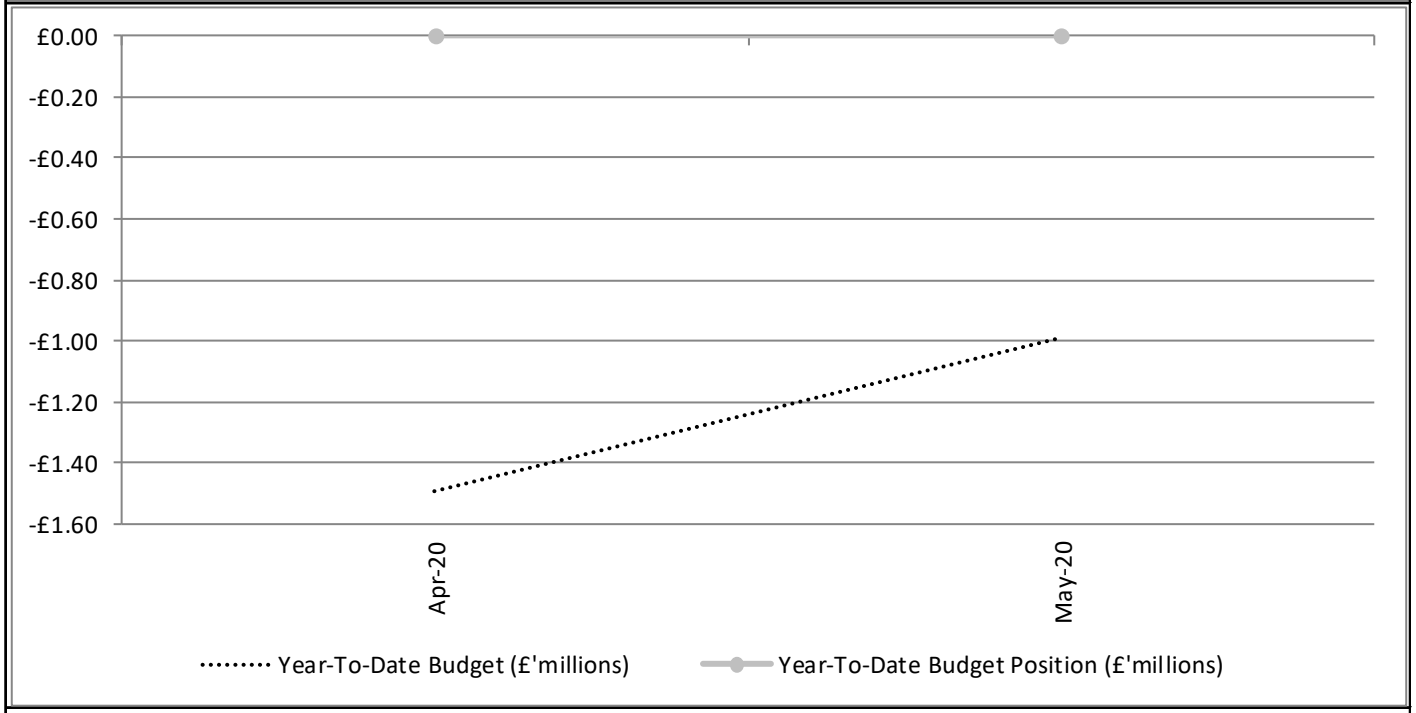
Year-To-Date Budget Position (£'millions)



Year-To-Date Budget Position

Target	-0.99
Mean	N/A
Last Month	0.00

Executive Lead

Steven Mason

Lead

Luke Armstrong

Commentary

The Trust has recorded a break even position for month 2, as required by the financial arrangements from NSHE/I. Leading to the Trust being £2.5m ahead of its internal budget.

Cause of Variation

- Year to date Covid-19 specific costs of £2.5m on pay and £3.9m on non pay, these have been assumed as reimbursed by NHSE/I.
- Large year to date underspends noticed on clinical supplies £2.4m and Drugs £1.7m due to reductions in activity.

Planned Actions

- Continuation of detailed monitoring of pay costs to challenge and ensure appropriateness of any additional spend.
- Review of future funding guidance for months 5 to month 12 when issued by NHS England / Improvement.

Timescale

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

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 7 JULY 2020			
Month 2 2020/21 Financial Performance			**AGENDA ITEM: 12, ENC 8**
Report Author and Job Title:	Luke Armstrong Head of Financial Management	**Responsible Director:**	Steven Mason Director of Finance
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report outlines the Trust's financial performance as at Month 2.		
Background	The Trust is required to break-even during the Covid-19 period which will be determined by NHSE/I. The Trust is underspent by £2.5m year to date against our own internal budget as amended to reflect the Covid-19 interim financial arrangements. The Trust has assumed additional Covid-19 revenue support of £3.5m in month 2 and £6.4m year to date for specific costs as outlined within the report.		
Assessment	The Trust has achieved the Month 2 position as required by NHSE/I to break even. The underlying structural deficit has remained unchanged throughout 2019/20 and has been carried forward into 2020/21. The Trust remains in an extremely challenging position once the current Covid-19 interim funding arrangements come to an end.		
Recommendation	The Board of Directors are asked to: • Note the Trust position for Month 2 • Note the additional revenue claim for Covid-19 expenditure in order to achieve a breakeven position • Note that the Trust continues to have anstructural deficit of c £25 m. Excess costs from the Trust's historic PFI scheme remain the largest single contributory factor to the organisation's structural deficit position. • Note the capital position including the level of Covid-19 related commitments.		
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 2 2020/21 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 2.

2. BACKGROUND

Due to the suspension of the national NHS planning process for 2020/21, the NHS is operating under a different financial regime. This includes the payment to Trusts of both block and top up income to fund expenditure. Each Trust has a requirement to break-even with funding provided by NHSE/I to reach this required outcome. These new arrangements are in place until at least the end of July 2020, with the expectation they will continue into 2020/21.

For the purpose of this report and internal reporting, the Trust is monitoring financial performance against an internal budget that was developed as part of the budget setting process for 2020/21. As a result of the national suspension this budget was not submitted to NHSE/I and the Trust will not be monitored externally against this during 2020/21.

This budget shows a full year deficit of £14.2m at a control total level. Further guidance on the NHS financial arrangements post month 4 are expected during June and July.

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 2 YTD actual performance is a break-even position. This has resulted in the Trust being ahead of its internal plan by £2.5m. In order to achieve a break-even position, the Trust has assumed an additional top up payment for Covid-19 expenditure of £6.4m year to date.

3. DETAILS

Trust position

The Month 2 full year position is outlined below; the following section outlines key variances and risks for divisional income, pay, non-pay and technical items.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Nhs Clinical Income	98,350	98,154	**(196)**	**590,100**
Education And Training Income	2,693	2,763	**71**	**16,157**
Estates Income	902	214	**(688)**	**5,414**
Misc Other Income	2,206	1,463	**(742)**	**13,667**
Non Patient Care Income	424	327	**(98)**	**2,547**
Other Clinical Income	618	292	**(326)**	**3,705**
Psf, Mret, Top Up	3,817	10,244	**6,427**	**22,901**
Research & Development Income	812	701	**(111)**	**4,874**
Total Other Income	**109,822**	**114,158**	**4,336**	**659,364**
Ahp'S, Sci, Ther & Tech	(9,661)	(9,627)	**34**	**(58,736)**
Apprentice Levy	(228)	(250)	**(21)**	**(1,370)**
Hca'S And Support Staff	(6,685)	(7,457)	**(772)**	**(40,293)**
Medical And Dental	(19,078)	(20,858)	**(1,780)**	**(112,165)**
Nhs Infrastructure Support	(9,362)	(9,434)	**(72)**	**(57,037)**
Nursing & Midwife Staff	(20,367)	(20,749)	**(383)**	**(122,917)**
Total Pay	**(65,380)**	**(68,375)**	**(2,994)**	**(392,518)**
Clinical Negligence Cost	(2,900)	(2,900)	**0**	**(17,401)**
Clinical Supplies And Services	(12,182)	(9,782)	**2,401**	**(73,229)**
Drugs	(11,327)	(9,603)	**1,724**	**(67,960)**
Establishment	(1,380)	(1,486)	**(106)**	**(8,061)**
Ext Staffing And Consultancy	(161)	(150)	**11**	**(502)**
General Supplies And Service	(691)	(2,991)	**(2,300)**	**(4,139)**
Healthcare Service Purchase	(1,792)	(1,605)	**187**	**(10,754)**
Miscellaneous Services	(149)	(131)	**18**	**(893)**
Pfi Unitary Payment	(5,302)	(6,997)	**(1,695)**	**(31,813)**
Premises & Fixed Plant	(4,233)	(3,966)	**267**	**(25,273)**
Research, Education & Training	(434)	(338)	**96**	**(2,573)**
Transport	(703)	(609)	**94**	**(4,390)**
Total Non Pay	**(41,255)**	**(40,558)**	**697**	**(246,987)**
Depreciation	(2,517)	(2,234)	**282**	**(15,100)**
Interest Payable	(2,008)	(1,902)	**106**	**(12,048)**
Interest Receivable	17	07	**(09)**	**100**
Other Non Operating	(1,165)	(1,096)	**69**	**(6,987)**
Corporation Tax	(01)	0	**01**	**(03)**
Control Total	**(2,486)**	**(0)**	**2,486**	**(14,179)**

Clinical Income

Under the revised financial arrangements for 2020/21, the Trust's previous contractual arrangements under an aligned incentive scheme with its commissioners no longer stands. Instead, the Trust is paid under a block arrangement as agreed by NHSE/I, which is intended to cover the Trust's usual cost base. Any shortfall in the block arrangement is covered by top up payments claimed by the Trust on a monthly basis. This additional top up payment is recorded within other income as per NHSE/I guidance.

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

Commissioner Code	Commissioner Name	Block Payment
16C	NHS Tees Valley CCG	(47,723)
84H	NHS County Durham CCG	(2,341)
85J	NHS England - North East and Yorkshire Commissioning Hub	(31,644)
Y63	NHS England - North East and Yorkshire Commissioning Region	(1,314)
42D	NHS North Yorkshire CCG	(14,690)
15F	NHS Leeds CCG	(42)
13T	NHS Newcastle Gateshead CCG	(52)
01H	NHS North Cumbria CCG	(109)
03J	NHS North Kirklees CCG	(35)
00L	NHS Northumberland CCG	(36)
00P	NHS Sunderland CCG	(122)
03Q	NHS Vale of York CCG	(244)
	Prior Year Adjustments	196
	Total Income Month 2	**(98,154)**

The prior year adjustment of £0.2m relates to differences between accruals made for NCAs in M11 and M12 of 2019/20 and actual billing within 2020/21.

Other Income

Other income is £4.5m ahead of plan, to deliver a break-even position for the Trust, additional top up payments of £6.4m have been assumed, £3.5m within M2.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Education And Training Income	2,693	2,763	**71**	**16,157**
Estates Income	902	214	**(688)**	**5,414**
Misc Other Income	2,206	1,463	**(742)**	**13,667**
Non Patient Care Income	424	327	**(98)**	**2,547**
Other Clinical Income	618	292	**(326)**	**3,705**
Psf, Mret, Top Up	3,817	10,244	**6,427**	**22,901**
Research & Development Income	812	701	**(111)**	**4,874**
Total Other Income	**11,472**	**16,004**	**4,532**	**69,264**

- Education and Training income is over achieving by £0.1m due to revised payment arrangements from Health Education for training support during Covid-19. The Trust's budget is set on payments received in 2019/20. The Trust's Education income budget will be updated once confirmation is received of the revised funding model for 2020/21 expected at the start of Q2.
- Estates income is behind plan by £0.7m due to the loss of car parking income, catering income and staff accommodation income due to the Covid-19 response.
- Misc other income is behind plan by £0.7m. £0.4m of this under recovery against budget relates to income previously billed to NHS England for national CEA awards and salary recharges. These payments are now covered by the block arrangements in place for funding and cannot be billed separately. The remaining underperformance relates to lower rental income receipts and lower income generation within pathology from testing services provided to other bodies, this is offset by lower costs.
- Other clinical income is behind plan by £0.3m due to no private patient procedures taking place within April or May, due to Covid-19 restrictions.
- R and D income is behind plan by £0.1m. Within month 2 the full R and D budget has been realigned with the income and expenditure budget now recorded fully within R and D and not within individual directorates. This allows the overall costs of R and D to be more appropriately understood and monitored.
- Additional top up income has been assumed to cover the Trust's Covid-19 specific costs.

Pay

In the year to date position pay is overspent by £3.0m and increase of £2.4m on month 1, which is being driven by increased pay costs for Covid-19.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Ahp'S, Sci, Ther & Tech	(9,661)	(9,627)	**34**	**(58,736)**
Apprentice Levy	(228)	(250)	**(21)**	**(1,370)**
Hca'S And Support Staff	(6,685)	(7,457)	**(772)**	**(40,293)**
Medical And Dental	(19,078)	(20,858)	**(1,780)**	**(112,165)**
Nhs Infrastructure Support	(9,362)	(9,434)	**(72)**	**(57,037)**
Nursing & Midwife Staff	(20,367)	(20,749)	**(383)**	**(122,917)**
Total Pay	**(65,380)**	**(68,375)**	**(2,994)**	**(392,518)**

- HCAs are overspent by £0.8m with nursing staff £0.4m overspent giving a combined overspend of £1.2m. £0.2m of this additional cost is due to student

nurses who have entered employment with the Trust early due to Covid-19 this additional cost is reclaimable as a Covid-19 response cost.

- A large increase has been notedin month 2 from enhancements paid for the working of un-social hours over the usual run rate. This has been caused due to nursing staff who usually work a 9 – 5 shift pattern in outpatients being asked to work a 24 hour shift pattern on wards. An increase in spend has also been noted for overtime, being linked to the increase in staffing within wards and critical care. For both overtime and enhancements the increase in costs within month 2 are for shifts worked in April, with payments through ESR made a month in arrears. Both of these increased costs for overtime and enhancements have been claimed as additional Coivid-19 costs.
- Year to date increased bank and agency costs for Nursing and HCA's over the usual run rate have increased, again with this increase cost being from the staffing up of additional shifts for Covid-19. A drop of 16% in cost has been noticed between M1 and M2.. Further reductions in bank spend are expected in June due to the recruitment of Student nurses.
- Medical and Dental staff show a year to date overspend due to increases in costs for both junior staffing and senior medical staff. Increases in both costs are linked to increased staffing costs from Covid-19, with additional bank spend for junior staff and increased additional payment claims and agency costs for senior staff. Controls have are in place on additional spend with all senior medical staffing claims for Covid-19 subject to Medical Director approval.

Non-Pay

Non-pay is £0.7m underspent. Reductions in spend on both clinical supplies and drugs noticed in month 1 have continued in to month 2 reflecting cancelled activity as a consequence of Covid-19 which are offset by increased costs for personal protective equipment and estates charges

Given the revised funding model and the Trust being funded on a month to month basis, key underspends within non pay must be protected and not spent in future months.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Clinical Negligence Cost	(2,900)	(2,900)	**0**	**(17,401)**
Clinical Supplies And Services	(12,182)	(9,782)	**2,401**	**(73,229)**
Drugs	(11,327)	(9,603)	**1,724**	**(67,960)**
Establishment	(1,380)	(1,486)	**(106)**	**(8,061)**
Ext Staffing And Consultancy	(161)	(150)	**11**	**(502)**
General Supplies And Service	(691)	(2,991)	**(2,300)**	**(4,139)**
Healthcare Service Purchase	(1,792)	(1,605)	**187**	**(10,754)**
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Research, Education & Training	(434)	(338)	**96**	**(2,573)**
Transport	(703)	(609)	**94**	**(4,390)**
Total Non Pay	**(41,255)**	**(40,558)**	**697**	**(246,987)**

- Clinical supplies and services are showing a year to date underspend of £2.4m. This has been driven by reductions in activity in key surgical directorates with lower patient numbers reducing the need to purchase clinical consumables across the Trust. The underspend noticed in April has continued in to May and is expected to continue until services across the Trust recommence clinical activity.
- Drug costs are underspent by £1.7m, being driven by reductions in clinical activity across the Trust.
- General supplies and services show a large overspend of £2.3m. This is due to the purchase of Personal Protective equipment; this cost has been recorded on the Trusts Covid-19 cost return to be fully reimbursed by NHSE/I.
- PFI costs are overspent by £1.7m. This additional cost is from the additional write-off of lifecycle payments for 2020/21. Additional write-offs of lifecycle are being posted to the Trust's income and expenditure account, as the lifecycle work cannot currently be completed due to Covid-19 restrictions.

Non-Operating Costs

Depreciation is showing an underspend due to lower capital spending at the end of 2019/20. Interest charges are also underspent due to the write-off of a number of capital loans. The Trust's interest and PDC budgets will be re-based by NHSI/E during this financial year, removing the underspend.

Other technical items are broadly in line with budgeted amounts.

Covid-19 Costs

In line with the new financial regime for 2020/21 the Trust is able to claim additional income to cover costs incurred specific to Covid-19. In line with the national guidance these costs are the incremental cost to the Trust of delivering Covid-19,

and not the overall total cost. These are summarised below in line with the national requirements.

	Month 1 £'000	Month 2 £'000
Catering	35	0
Decontamination	415	283
IT Equipment	10	1
PPE	1,654	824
Printing / Stationary	9	12
Security Costs	7	0
Testing / Swabbing	133	108
Transport	13	5
Ward equipment	172	153
Rental costs	0	62
Incremental additonal pay cost	448	1,869
Student Nurses	0	215
Total	**2,895**	**3,532**

As outlined within the body of this report. the increased pay costs within month 2 are for shifts worked in April and are expected to reduce in June. Additional pay costs have been calculated based on the increase in bank, agency and additional overtime payments compared to the run rate of 2019/20, with this increase being due to increased shift requests due to sickness or increased staffing for Covid-19 patient areas.

Catering costs have not been claimed as a Covid-19 cost within month 2 due to national guidance.,

On the current reclaim model from NHSE/I it is only possible to recover additional spend by the Trust, not lost income. Within the year to date position, the Trust has seen reductions in other income from lost estates income and reductions in private patients. The Trust has covered this loss of income through natural by un-derspends in other areas.

NHSI/E are due to issue further guidance defining what reasonable costs will be reimbursed associated with the Covid-19 response.

Capital

The Trust's capital expenditure at the end of May amounted to £4.7 million as detailed below:

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
PFI Lifecycle	1,766	1,766	**0**	10,600	10,600	**0**
Site Reconfiguration	0	102	**102**	0	42	**42**
Replacement of Medical Equipment	66	159	**93**	400	559	**159**
Network Replacement and Clinical Noting	0	236	**236**	0	207	**207**
PDC						
- COVID 19 Medical gases	0	0	**0**	352	352	**0**
- HSLI Radiology and	0	0	**0**	966	966	**0**
COVID-19	0	2,461	**2,461**	0	2,461	**2,461**
Total	**1,832**	**4,724**	**2,892**	**12,318**	**15,187**	**2,869**

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Financing						
Depreciation	1,766	4,724	**2,958**	10,600	13,469	**2,869**
Charitable contributions	66	0	**(66)**	400	400	**0**
PDC - COVID 19, HSLI	0	0	**0**	1,318	1,318	**0**
Total Financing	**1,832**	**4,724**	**2,892**	**12,318**	**15,187**	**2,869**

The expenditure at the end of May includes contractual PFI lifecycle payments to Endeavour SCH plc, medical equipment relating to COVID-19 and schemes that have carried over from 2019/20. Due to the on-going structural deficit pressures caused by the trust's historic PFI scheme, in 2020/21, the only funding sources available to the Trust, excluding PDC and assuming emergency support is not available, includes depreciation (£14.8 million) and potential charitable contributions amounting to £0.4 million. Contractual commitments for the year incorporate PFI Lifecycle (£10.6 million) and principal repayments on loans, PFI and finance leases of £5.4 million.

The Trust submitted a revised capital plan to NHSE/I at the end of May for 2020/21. . To prepare this plan each scheme included in the draft plan submitted in March was risk-assessed in conjunction with IT and the Estates Team. In line with national and regional guidelines the Trust prepared the revised plan. The Trust is also now in the process of drafting a further request capital request.

One risk associated with this revised plan include the Trust's position on committed COVID-19 expenditure, where funding is awaiting externl approval. The Trust has received approval for PDC funding a further application is with NHSE/I in the review and approval process. It is anticipated that any un-funded COVID related expenditure will be drawn from within the revised capital plan.

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 7 JULY 2020			
Board Assurance Framework			**AGENDA ITEM: 13, ENC 9**
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	Updated BAF following review by the Executive Lead, Head of Governance and Sub Committees		
Background	The BAF risks have been reviewed and updates made as appropriate over the last quarter.		
Assessment	The Executive Lead, Head of Governance and Sub Committees have reviewed the BAF risks relevant to the Committee. Gaps in controls, assurances and target dates have been amended to reflect the review.		
Recommendation	Members of the Public Board of Directors are asked to note the update of the BAF risks		
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 ☐		

1. PURPOSE OF REPORT

The purpose of the report is to update members on the Board Assurance Framework principal risks affecting the Trust and the control measures which have been introduced.

This report includes

- A summary of both the overall number and grade of risks contained in the Board Assurance Framework (BAF)
- A description of the high risks included on the BAF
- A description of any changes made to the Board Assurance Framework.
- A description of any BAF reviewed and agreed risks to close.

2. BACKGROUND

The BAF must meet the requirements of the DoH Guidance on Building an Assurance Framework and is reviewed annually by Internal Audit. The Trust Board reviews the Board Assurance Framework (BAF) on a quarterly basis.

The BAF is the means by which the Trust holds itself to account and assures the safety of patients, visitors and staff. It does this by clarifying the risks to not achieving the Strategic Objectives. The Board has the responsibility for ensuring that there is assurance identified against the risks and ensures that the controls are appropriate and up to date.

The Board must also assess the assurance, which could be internally generated, external, evidence based, or potential assurance. It is important that actual examples of assurance in the BAF are drawn from a broad spectrum of evidence, noting that some evidence is stronger than other, eg external audit report will be stronger evidence than an internally generated review. By including a wide range of assurance, the BAF will be a more robust and effective tool.

3. DETAILS

3.1 A summary of both the overall number and grade of risks contained in the Board Assurance Framework (BAF)

The BAF currently contains 24 risks. There is 1 very high risk, 15 high risks and 8 moderate risks.

3.2 A description of the very high risks included on the BAF

The very high risk (25) relates to the following Strategic risk:

BAF 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, leading to:

- Failure to deliver constitutional standards
- Associated reduced / compromised outcomes
- Patient Harm

- Reduced patient experience
- Increased costs
- Failure to meet financial trajectories
- Workforce issues such as stress, recruitment and retention

3.3 A detailed description of any changes made to the Board Assurance Framework

Risk scores have been updated on 7 risks with 3 risks increasing (Operations 3.1, 3.2 and 3.3) and 4 decreasing (Quality 2.2, Finance 4.1 and 4.2 and Workforce 5.3).

3.3.1 Updated risks

Updates to BAF risks were agreed by the Board sub committee's as follows:

- Quality 2.1, 2.2 and 2.4
- Workforce 5.1, 5.2, 5.3 and 5.4
- Finance 4.1, 4.2, 4.4, 4.5 and 4.5
- Operations 3.1, 3.2 and 3.3

3.3.2 Risks requiring an update

There are two quality BAF risks which require updating (Quality 2.3 and Quality 2.5) one operations BAF risk (Operations 3.4) and five strategy risks (BAF 1.1, 1.2, 1.3(a) 1.3 (b), 1.4).

3.3.3 New Risks added

No new risks added.

3.3.4 Risks closed

One BAF risk closed (Quality 2.1) following review at the Quality Assurance Committee.

4. RECOMMENDATIONS

It is recommended that members note the changes to the BAF since the last report.

APPENDICES
BAF

Board Assurance Framework

1. STRATEGIC OBJECTIVE: Develop clinical and commercial strategies to ensure long term sustainability																	
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Action**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Change to Rating since last Review**	**Date Reviewe**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
1.1	Delivery of Trust's strategic aims and sustainable healthcare services across North Yorkshire and the Tees Valley (ICP Footprint)	A fundamental breakdown in one or more strategic partnerships, resulting in long term disruption to plans for transforming local health and care services	**3**	**4**	**Moderate Risk 12**	**Low Risk 2x3=6**	NHSE/I Engagement ICS/ ICP Leadership Stakeholder Engagement with Local Authorities , MPs and local population, CCG ICS MOU Clinical Policy Group Tees Valley Hospitals Group Board Interim Independent Chair Tees Valley Group Board Improvement Recovery Plan Capital Plan amended June 2020	**Internal** Clinical Policy Group agenda and papers, Reports to Board, SLT, Council of Governors **External** NHSI QRM ICS/ICP groups CEO meetings (South Tees FT, County Durham and Darlington NHS FT, North Tees and Hartlepool FT) **Sir Ian Caruthers, Independent Review** supported by NHSI Strategic Oversight Group	Clinical Policy Group agenda and action notes, Board minutes Council of Governor minutes	ICS / ICP meetings Sir Ian Caruthers Review NHSI QRM Tees Valley Hospitals Group Board papers	Group Structure Board paper to be considered on 3/12/19	3.12.19	to be agreed	Chief Executive	Board of Directors		⟷	12.11.19

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

Quarter 1 (1 April - 31 July 2019)
- May 2019 - no changes made
28 August 2019 - principal risk updated

1. STRATEGIC OBJECTIVE: Develop clinical and commercial strategies to ensure long term sustainability

Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Change to Rating since last Review	Date Reviewed
			LH	Conseq	Rating				Internal	External								
1.2	Delivery of a sustainable future for the Friarage Hospital	Due to the unavoidable accelerated implementation timescale of the preferred clinical model there is a risk that we will not be able to fully deliver all elements of the change, which could adversely impact on patient outcome and experience leading to reputational damage.	**3**	**4**	**Moderate Risk 12**	**Low Risk 2x4 = 8**	Urgent Temporary Changes to the services we provide at the Friarage Hospital including Implementation/Operational Plans / Standard Operating Procedures Quality Impact Assessments for all affected services continued to be reviewed and updated Operational Risk Registers Human Resources Retention Plan Communication and engagement plan	Communication briefings held with: Clinical Senate, Yorkshire Ambulance Service, Harrogate NHS FT, York NHS FT, ICR North Yorkshire, ICP Tees Valley, Health Education England, Local University Partners, All Staff, Unions/Staff side, Governors, Local Medical Committee, Medical Advisory Committee, Friends of Friarage, Local Authorities, Catterick Garrison/Military, GP Practices, Pharmacy, Dental Practices, Health Watch, McMillan, Health Engagement Network, Town councils, Parish Councils, MPs, Media Real time daily patient flow tracker Daily documented review of variance from SOP's Case review of any patient transfers from the FHN site Monthly assurance report to OMB & QAC Daily Assurance Calls with Strategic, Tactical, Surgical and Medical On-call Weekly assurance report provided to SLT and NHSE Medical Director	Board approval of preferred Clinical Model agreed 4 September 2018 submitted to NHS Hambleton, Richmondshire and Whitby CCG to take forward to NHSE and N&Y Clinical Senate Board approval of Urgent Temporary Change (5 February 2019) to move to Urgent Service Change model on 27 March 2019 Quality Assurance Committee reviewed QIAs, SOPs and potential risks approved proposal to move to urgent temporary change for ratification by the Board Board approved the Urgent Service Change Implementation Plan (including communication plan) on 5 March 2019 to mobilise the Urgent Service Change Model on 27 March 2019	North Yorkshire Scrutiny of Health Committee minutes NHS England Medical Director Site Visit prior to 27 March 2019 Clinical Senate Review 21 May 2019 Consultation events ongoing	Outcome of consultation event	Jan-20		Medical Director (Emergency & Urgent Care)	Operational Management Board Workforce Committee Quality Assurance Committee	1664	⟷	28.8.19

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved
Quarter 1 (1 April - 30 June 2019)
May 2019:
Added:
Assurances received: 1. continuing to review and update QIAs and SOPs; Clinical Senate Review 21 May 2019
Assurances effective: 1. regular briefings with Yorkshire Ambulance Service; 2. daily assurance calls with strategic, tactical, surgical and medical on-call; 3. weekly assurance report to SLT and NHSE Medical Director
Deleted:
deleted gaps in operational plans QIAs and SOPs from gaps in controls/assurances due to them now being in place and reviewed and updated continuously
28 August 2019 - no change

Propose to Risk Committee no longer a risk as outcome has been received.

1. STRATEGIC OBJECTIVE: Develop clinical and commercial strategies to ensure long term sustainability																	
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Action**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Change to Rating since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
1.3a	Regulatory Compliance with the Health and Social Care Act 2008 and Regulations 2014	Risk of further breaches to condition 4 of the Trust Provider licence could result in further enforcement undertakings and licence conditions	4	5	**High Risk 20**	**Low Risk 3x3=9**	SFI/SO Scheme of Delegation Constitution Board and Committee structures Provider Licence self assessment Internal control arrangements Trust Strategic Plan Additional short term senior interim support in specialist areas Board to Board meeting held with NHSE/I (2) Single item QSG Quality Risk Profile	SLT and Board review of provider licence Quality Assurance Committee Finance & Investment Committee Workforce Committee Board agenda and minutes CQC action plan Single item QSG minutes of meeting Review of governance and effectiveness of committees	Quality Assurance Committee Minutes / Chairs log Finance & Investment Committee Minutes / Chairs Log	External NHS QRM CQC Inspection Internal and External Audit Reports Annual Governance Statement Quality Report Annual Report Finance Single item QSG minutes of meeting and level of assurance	Operational concerns on quality & safety Financial recovery plan, governance and assurance - reduction in conditions on provider licence	Review again with NHSE/I in February 2020	Feb-20	Chief Executive	Board		⟷	27.11.19
1.3b		Prolonged adverse publicity or regulatory attention resulting in a fundamental loss of confidence in the Trust amongst regulators, partner organisations, patients, staff and the general public	4	5	**High risk 20**	**Low Risk 3x3=9**	Conflicts of interest & whistleblowing management arrangements Counter Fraud arrangements Internal Audit Established relationships with regulators Stakeholder engagement meetings Forum for Public Involvement meetings Internal control arrangements	A&E Patient Survey results	Quality Assurance Committee Minutes / Chairs log Finance & Investment Committee Minutes / Chairs Log	External NHS QRM CQC Inspection Internal and External Audit Reports Annual Governance Statement Quality Report Annual Report Finance	Improving the understanding of stakeholder confidence in the Trust	to be agreed	to be agreed	Chief Executive	Board		⟷	12.11.19

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved
Quarter 1 (1 April - 30 June 2019)
May 2019: Recommend this risk is removed and a new risk is added at 2.2 overseen by the Quality Assurance Committee with regards to ongoing compliance with the CQC (compliance with the Health and Social Care Act 2008 and Regulations 2014)
28 August 2019 - new risk added 1.3b; 1.3 principal risk updated;
27.11.19 - update to assurance and gaps

1. STRATEGIC OBJECTIVE: Develop clinical and commercial strategies to ensure long term sustainability																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Action**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Change to Rating since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
1.4	Regulatory Compliance with the Health and Social Care Act 2008 and Regulations 2014	A major incident (cyber attack, critical infrastructure failure, supply chain failure etc) resulting in temporary hospital closure or a prolonged disruption to the continuity of care services across the Trust, which also impacts significantly on the local health service community	3	4	**Moderate Risk 12**	**Low Risk 2x4=8**	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 Estates Governance arrangements with PFI partner Trust Resilience Forum 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 EU Exit task and finish group review of operational response plan for monitoring issues following Brexit	EPPR self assessment - partial compliance Information Governance Assurance Framework (IGAF) Debriefs following local testing shared with Trust resilience forum	Board report on EPPR self assessment IG Assurance Framework submission Annual report to Board on EPRR	Validated EPPR assessment - partial compliance Regional assurance visit undertaken in October External audit (2017) Peer Review undertaken (December 2019)	Actions to address self assessment to increase compliance contained within EPPR work plan External review of escalation and EPPR Actions to address peer review outcome Board cyber training booked for February Cyber exercise to be planned Strategic leadership in a crisis course being developed (2020) Participation in regional exercise (May) HMIMMS course for all staff on call	30.9.20 31.3.20 31.1.20 4.2.20 31.3.20 31.3.21 31.5.20 31.3.20	31.5.20	Director of Estates, ICT and Healthcare Resources	FIC		⟺	27.11.19

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved
28 August 2019 - new risk added
27.11.19 - update to controls, gaps and assurance
11.12.19 - update to full risk

1. STRATEGIC OBJECTIVE: Develop clinical and commercial strategies to ensure long term sustainability																		
	Principle Objective	Principle risks to delivery of objective	Grade (including change in			Target	Existing Key Controls	Possible Sources of Assurance	Assurances Received		Gaps in control/assurance and	Target date for completion of	Target date score will be	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings	Date Reviewed by
			LH	Conseq	Rating				Internal	External								
1.5	Delivery of safe care	Risk to Trusts ability to delivery strategic objectives due to diversion of resources of all types required to manage the COVID19 19 pandemic, leading to: Failure to deliver constitutional standards Associated reduced / compromised outcomes Patient Harm Reduced patient experience Increased costs Failure to meet financial trajectories Workforce issues such as stress, recruitment and retention	5	5	**Very High Risk 25**	**Low Risk - 1 x 5 = 5**	EPPR incident management processes in place with tactical and strategic command meeting daily Communication briefings and meetings with staff HR systems and processes to enable tracking of staff, welfare calls and psychological support / OH support to staff Implementation of national guidance Implementation of business continuity plans Stopping elective activity Redeployment and retraining of staff Training for staff in relation to PPE and redeployment duties IT facilities to enable patient contact/appointments/reviews to be undertaken IT facilities in place to enable staff to work from other places Liaison with partners and stakeholders LRF coordination in place Government financial support to manage COVID 19 Reducing the burden guidance on managing performance and governance processes	Board reporting Real time reporting to tactical and strategic command through daily SITREP Task and finish groups	Daily reporting to strategic command through SITREP Clinical Oversight group (ethical)	LRF coordination process in place ICS/ICP coordination processes in place NHSE/I reducing the burden guidance	Availability of staffing for the continuation of front line services Availability of appropriately trained staff Availability of equipment from NHS supply chain Loss of staff through self isolation / ill health	Ongoing		Chief Executive	Board			01.04.20
New risk added																		

2. STRATEGIC OBJECTIVE: Delivering excellence in patient outcomes and experience

	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed by Committee
			LH	Conseq	Rating				Internal	External								
2.1 (1)	Delivery of safe care	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 indicators	4	4	**High risk - 16**	**Very Low Risk 2x3=6**	1. IPAG 2. Monthly performance meeting with clinical matrons. 3. Cleaning standards meetings 4. Handwashing audits 5. Environmental Audits 6. Review panels of all trust apportioned CDIF 7. HPV fogging 8. Antibiotic stewardship programme 9. Centre Board meetings 10. QAC and sub group structure 11. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 12. clinical Audit programme and monitoring arrangements 13. Defined safe medical and nurse staffing levels for all wards and departments 14. Ward assurance and accreditation programme 15. • As part of agreed contracts external suppliers are supporting with refresher training in relation to equipment cleaning and ANTT for clinical staff. 16. • Weekly DIPC / Dep. DIPC Matron IPC huddles 17. • additional assurance of	IPAG meeting minutes Audit findings Panel outcomes Regulator oversight Capital and FIB minutes of meetings Reduction in HCAIs since COVID19 19 pandemic	IPAG QAC Board Antimicrobial Group	TIPC NHSI review of outbreak action plan CCG oversight CQC oversight	• Peer review assessment of cleaning has not yet been agreed • Develop a more collaborative approach with Serco in terms of education delivery and audits including hand hygiene and IPC and Serco joint monitoring in augmented care areas (this is a recent development and we will review effectiveness). Capital funding to support IPC initiatives and equipment replacement Compliance with SOP and Policies - further work required to ensure compliance being explored implement STACQ Employ Deputy DIPC post	31.12.19 31.3.20 2020/21 31.3.20 June 2020 June 2020	31.06.20	Director of Nursing & Midwifery	Quality Assurance Committee			25.5.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

28 August 2019 - Principal risk updated and risk score, additional controls and external assurance
29.10.19 - updated gaps in control / assurance and target date
20.11.19 - update to risk score, controls, assurance and gaps
25.5.20 - update to existing key controls, sources of assurances, assurances and gaps.

2. STRATEGIC OBJECTIVE: Delivering excellence in patient outcomes and experience

	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed by Committee
			LH	Conseq	Rating				Internal	External								
2.1 (2)	Delivery of safe care	2. Due to gaps in compliance in medication practice there is a risk of avoidable patient harm leading to reputational damage	2	4	**Moderate Risk 8**	**Very Low 1x4=4**	1. Pharmacist staff allocated to priority wards 2. Specific medication incident reporting system on Datix 3. Medicines policies are fit for purpose 4. Monthly omitted doses audits	Controlled drugs audit Omitted doses audit NHS protect audit Medicines reconciliation audit	Safer Medication Practice Group QAC		1. Limited pharmacist cover at weekends. Insufficient technical staff on ward to deliver at times of staff shortage 2.Automated cabinets not fully implemented 3. Current pharmacy establishment insufficient to achieve 80% medicines reconciliation - business case in progress 4. EPR system would provide assurance on medicine reconciliation	31.12.19 28.02.19	28.02.20	Director of Nursing	Quality Assurance Committee		⟺	29.10.19

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

29.10.19 - added additional gap and updated gaps in control / assurance
25.5.20 - suggest reduce from BAF to risk register - no specific incidents or issues

2. STRATEGIC OBJECTIVE: Delivering excellence in patient outcomes and experience

	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed by Committee
			LH	Conseq	Rating				Internal	External								
2.2	Ensuring on-going compliance with the Care Quality Commission Regulations and Standards (Health and Social Care Act 2008 and Regulations 2014)	Risk that failure to comply with the CQC Health and Social Care Act could lead to restrictions on service provision leading to reputational damage and/or financial penalties	4	4	**High Risk - 16**	**Low Risk 3x3=9**	1. Performance management systems 2. Monthly performance dashboards 3. Risk management process 4. Centre governance meetings 5. Monthly quality and safety report 6. Monthly safe staffing report (nursing and midwifery) 7. Quarterly patient experience report 8. Monthly health care associated infection report 9. Monthly mandatory training report 10. Quality and Equality Impact Assessment process 11. CQC Action plan 12. CQC oversight group 13. Quality risk profile and implementation plan 14. Business case process established 15. Improvement Recovery Plan in place 16. Interim Director of Clinical Development 17. Moving to Good programme	1. Performance against national standards 2. Key outcome measure in relation to patient outcome and experience 3. Audit results 4. Risk registers 5. reports to QAC sub group including patient safety and patient experience 6. Capital Planning Group and FIB 7. Oversight by Strategic Nurse	Quality Assurance Committee Annual Operational Plan Quality Report and Account Integrated Performance Report	NRLS benchmarking CQC engagement meetings Clinical Quality Review Group - Single item quality surveillance group meeting NHSI Quarterly Review meetings National Staff Survey Quality risk profile report out from NHSE/I Bi weekly clinical governance and risk oversight group NHSE/I	Embed workforce safeguard standards for all professional groups Embed QEIA process across the organisation Embed the risk management process across the organisation Review processes to ensure compliance with mandatory and essential training Capital equipment and prioritisation required	31.12.20 30.9.20 30.9.20 30.9.20 30.7.20	31.12.20	Director of Nursing & Midwifery	Quality Assurance Committee		↓	25.5.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

28 August 2019 - risk rating and target risk rating updated, additional controls added
29 October 2019 - updated assurances received
20.11.19 - update to key control, sources of assurances
25.5.20 - update to risk grade, key controls, assurances and gaps

2. STRATEGIC OBJECTIVE: Delivering excellence in patient outcomes and experience

	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed by Committee
			LH	Conseq	Rating				Internal	External								
2.3	Ability to learn from Serious Incidents, complaints, clinical audits and external reviews to improve on quality and patient safety	Due to the quantity and complexity of clinical quality information there is a risk that areas for improvement are not identified leading to missed opportunities	3	3	**Moderate Risk 9**	**Low Risk 2x3=6**	1. Serious Incident Report 2. Serious Incident Investigations 3. Safety Bulletins 4. Learning Bulletins 5. Monthly Quality Report 6. Quarterly Patient Experience Report 7. Quarterly & Annual Claims 8. Real time patient experience reporting 9. Clinical Audit 10. Centre Governance Meetings 11. Review panels (Serious Incident, Pressure Ulcers, Falls, Deteriorating Patients, C. Difficile) 12 .Mortality Review 13. Medical Examiner reviews 14. Safety@stees collaborative 15. Clinical assurance rounds 16. Risk Validation Group to meet monthly to review Centre/Corporate Risks with consideration of 15+ new risks 17. Patient Safety Sub-group 18. cross-centre learning through QBP structure 19. Induction and education sessions Monthly SI report	**Internal** Monthly report to Quality Assurance Committee Clinical Standards Sub Group Clinical Intelligence Unit and electronic solution to support triangulation of data	Quality Report Serious Incident Report Patient Experience Report Quality Account Internal Audit Report	CCG SI Monitoring of complaints Benchmarking Safety Thematic National Clinical Audit Outcomes	**Gaps** Triangulation of quality metrics to be included in monthly quality and safety report Lack of availability of resource in the BIU to support accurate and timely data Requirement to train more investigators to support increase in reporting culture Evidence of embedded and sustained learning Ensure	31.12.19 31.3.20 31.3.20 31.3.20	31.3.20	Director of Nursing/Medical Director Corporate Clinical and Support Services	Quality Assurance Committee		⇔	29.10.19

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

Quarter 1 (1 April - 30 June 2019)

May 2019: Updated target dates for completion of actions. December 2018 changes to 31 October 2019 for completion of actions listed under gaps; Develop mechanisms for cross centre learning and embed induction and education sessions (completed March 2019); Establishment of Patient Safety Group (completed September 2018); Establish Patient Experience Group (date added by June 2019)

29.10.19 - updated gaps in control / assurance actions

20.11.19- updated controls, assurance and gaps

25.5.20 - reduce risk to risk register and remove from BAF

2. STRATEGIC OBJECTIVE: Delivering excellence in patient outcomes and experience																		
	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed by Committee
			LH	Conseq	Rating				Internal	External								
2.4	Ensure an open and transparent safety culture that supports organisational learning and quality improvement	Due to under reporting of incidents could indicate a safety culture that is not open and transparent leading to an increase in mortality and/or patient harm	4	4	**High risk - 16**	**Moderate Risk 2x4=8**	1. Quality Report 2. Safety@stees collaborative 3. Review panels (Serious Incident, Pressure Ulcers, Falls, Deteriorating Patients, C. Difficile) 4. Centre governance meetings 5. Incident reporting system 6. Daily review of moderate and above incidents 7. SI panels 8. Serious incident investigation 9. Serious Learning event investigations 10. Patient Safety Sub-group cross-centre learning through QBP structure 19. Induction and education sessions QAC report demonstrating month on month increase in reporting DATIX incident reporting levels monitored against NRLS Getting to good programme Weekly safety wall	**Internal** Quality Assurance Committee Patient Safety Sub-group Serious Incident report Annual Operating Plan Quality Report and Account integrated performance **External** NRLS Benchmarking CQC engagement meeting Clinical Quality Review Group NHSI Quarterly Review meetings National Staff Survey External Audit Independent assessment of Quality Report Internal Audit	performance report Board Quality and patient safety performance update to Quality Assurance Committee monthly Serious incidents/Never Events report to Board	National Staff Survey - annually External Audit Quality Report review Independent Audit reports presented to Quality Assurance Committee and Audit Committee Serious Incident Report Bi weekly clinical governance and risk oversight group NHSE/I Single item QSG / risk summit	Incident reporting upgrade - DATIX cloud	31.6.20	31.6.20	Director of Nursing & Midwifery	Quality Assurance Committee		⟺	25.5.20
Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved 29.10 19 - no change 20.11.19 - update to controls and gaps 25.5.20 - update to risk score, key controls, assurances and gaps in assurance																		

2. STRATEGIC OBJECTIVE: Delivering excellence in patient outcomes and experience

	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed by Committee
			LH	Conseq	Rating				Internal	External								
2.5	Delivery of continuous safe maternity and new-born care	Due to changes in maternity services there is a risk of inability to provide continuous, safe maternity and neonatal care posing a risk to the mortality and morbidity of women and babies. As a result of: increase in birth numbers, increase in maternity acuity and complexity, tees wide change of neonatal intensive care increasing high risk pregnancies attending workforce gaps in midwives (birth-rate assessed) workforce gaps in junior medical staff increasing demand on consultants out of hours environmental pressure and space increasing unit closure and transfer of care	4	5	20 High Risk	**1x4 =4 Low Risk**	1. Daily staffing/bed huddle 2.Delivery Suite acuity tool 3.Midwife led pathways 4.Classification of Transitional Care (TC) Babies 5.Safe discharge criteria introduced for TC 6.Daily review of EL LSCS lists to reallocate vacant slots 7.EL LSCS carried out on a Friday with emergency team 8.Rostered day off for Consultants when possible following on call 9.Buddy`support for the consultant team 10. Skill mixing of midwifery and support staff 11. Birth-rate plus Midwifery and Support Worker staffing assessment undertaken in Feb 2019 . 12.ECA SOP to be followed in times of excess clinical activity and closure of unit if at capacity to maintain safety 13.Emergency staffing action plan in place 14. Internal escalation plan (including use of community and acute midwives)	**Internal;** **1**. Daily staffing Huddle 2. Maternity Patient Safety meeting (weekly). 3.Community Care Centre Board meeting 4. Risk Validation Group 5. Internal escalation plan (including use of community and acute midwives) **External** 1. Maternity CNST assessment. 2. HSIB investigations. 3. National maternity Dataset 4. MBRRACE reports 5.Perinatal Mortality Review Tool submission. 6. Every Baby Counts Reports 7. RCOG National Maternity and Perinatal Audit.	1. Maternity Patient Safety Group Quarterly Report to PSSG 2.Community Care Centre Board Action Log minutes. 3. Risk Validation To QAC. 4.Board.	1. Maternity CNST Assessment 2.HSIB Investigations. 3.MBRRACE Reports 4.Every Baby Counts reports 5.CCG - SI /HSIB feedback. 6. RCOG National Maternity and Perinatal Audit	Agree regional escalation plan	Mar-20	Mar-20	Medical Director (Community Care)	Quality Assurance Committee		⟺	29.10.19

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

Quarter 1 (1 April - 30 June 2019)
May 2019: New risk added
29.10.19 - updated sources of assurance, gaps in control / assurance and target dates
25.5.20 - reduce to risk register - remove from BAF - not supported by QAC

3. STRATEGIC OBJECTIVE: Drive operational performance to deliver responsive cost effective care																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Action**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Ratings since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
3.1	Achievement of key access standards/NHSI investigation	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	5	4	**High Risk - 20**	**Low risk 2x3 = 6**	Patient Flow process in place Urgent Care monitoring A&E Delivery Board Standard operating procedures Performance management process in place 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 Clinical Policy group addressing key issues and deterring the allocation of resources based on clinical priorities Single QSG review of constitutional standards and escalation of high risk areas QAC review and deep dive into critical areas SI process Clinical Harm review process High risk patients identified and have been allocated appointment and theatre capacity using T100	Clinical Policy Group agenda and action notes A&E Delivery Board agenda and notes Improvement recovery plan - capacity and demand Recovery plans for high risk services and updates to Board and Committees Risk register Outcome of QSG Internal risk summit	Centre Board management of constitutional standards Weekly incident control meetings for high risk areas	LADB NHSE/I External review of DTOC CQC inspection report Monthly management of RTT 52 week waiters Single Item QSG Risk Summit 2/52 oversight with regulators	Compliance with SAFER standards, Patient Flow SOPs Review of 111 Directory of Service Recruitment of medical and nursing workforce to manage demand with appropriate skill mix Limitation of current Estate with increased demand - outcome of emergency capital bid and 2020/21 capital bid	31.03.20 31.1.21 Ongoing 2021	31.11.20	COO	FIC		↑	23.6.20

28 August 2019 - 3.1 principal risk updated, controls and gaps in controls added;
27.11.19 - update to controls, gaps and assurances
23.6.20 update to risk grade, key controls, assurances, gaps

3. STRATEGIC OBJECTIVE: Drive operational performance to deliver responsive cost effective care																	
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that**	**Assurances Received**		**Gaps in control/assurance and description of**	**Target date for completion**	**Target date score will**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Ratings since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
3.2	Achievement of key access standards/NHSI investigation	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 .	5	4	**High Risk - 20**	**Low risk 3x3 = 9**	Recovery Plan in place for overall RTT Weekly Performance Meetings Speciality specific level recovery plans have been developed Patient Flow process in place Standard operating procedures Deep dive into high risk areas, risk assessment and recovery plans monitored on a weekly basis as part of an incident control methodology Clinical Policy group addressing key issues and deterring the allocation of resources based on clinical priorities Single QSG review of constitutional standards and escalation of high risk areas QAC review and deep dive into critical areas	RTT Recovery Plan Regular meeting with NHSE/I regarding position Clinical Policy Group agenda and action notes Improvement recovery plan - capacity and demand Recovery plans for high risk services and updates to Board and Committees Risk register Outcome of QSG Internal risk summit	Performance report to Board and Centre boards Outcome of QSG Weekly incident control meetings for high risk areas	NHSE/I weekly / monthly Return Regular meeting with NHSE/I External review of DTOC CQC inspection report Monthly management of RTT 52 week waiters Single Item QSG Risk Summit 2/52 oversight with regulators	Waiting list system inefficient due to underdeveloped informatics infrastructure - capital and revenue bids for emergency funds	31.03.21	31.3.20	COO	FIC		⇧	23.6.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

Quarter 1 (1 April - 30 June 2019)

May 2019:

Changed Risk description March 18 WTL by March 19 to March 19 WTL to March 20; and deleted service manager capacity (additional service managers now in post);

Added to key controls: Directorate level recovery plans have been developed

27.11.19 - update to risk rating, controls, assurances and target dates

23.6.20 update to risk grade, key controls, assurances, gaps

3. STRATEGIC OBJECTIVE: Drive operational performance to deliver responsive cost effective care																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Ratings since last**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
3.3	Achievement of key access standards/NHSI investigation	Risk of ability to delivery the national access target of 85% for 62 Day Cancer Standard	5	4	**High Risk - 20**	**Low risk 3x3 = 9**	Recovery Plan in place for overall Cancer target Weekly Performance Meetings Speciality specific level recovery plans have been developed Weekly cancer wall including medical director input Cancer delivery group meeting monthly Standard operating procedures Performance management process in place Deep dive into high risk areas, risk assessment and recovery plans monitored on a weekly basis as part of an incident control methodology Clinical Policy group addressing key issues and deterring the allocation of resources based on clinical priorities Single QSG review of constitutional standards and escalation of high risk areas QAC review and deep dive into critical areas SI process Clinical Harm review process High risk patients identified and have been allocated appointment and theatre capacity using T100 Cancer Cell in place (Southern) STAR chamber MDT reviews with COO Repatriation to local unit policy in place	Cancer Recovery Plan Outcome of QSG RTT Recovery Plan Regular meeting with NHSE/I regarding position Clinical Policy Group agenda and action notes Improvement recovery plan - capacity and demand Recovery plans for high risk services and updates to Board and Committees Risk register Outcome of QSG	Performance report to Board and Centre boards Outcome of QSG Weekly incident control meetings for high risk areas	NHSE/I weekly / monthly Return Regular meeting with NHSE/I External review of DTOC CQC inspection report Monthly manaement of RTT 52 week waiters Single Item QSG Risk Summit 2/52 oversight with regulators	Roll out of automated tracking system across all relevant specialities identifying patients who have high risk of cancer Continue to outsource pathology and radiology services	31.03.21 ongoing	31.03.21	COO	FIC		↑	23.5.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

Quarter 1 (1 April - 30 June 2019)
May 2019:
Deleted under Gaps in control - Cancer Delivery Group to be formed
Added to Existing controls - Trust wide Cancer Delivery Group (this is now in place and Chaired by the Medical Director, Specialist and Planned)
27.11.19 - update to risk score, controls, gaps, assurance and action scores
23.5.20 - update to risk grade, key controls, gaps

3. STRATEGIC OBJECTIVE: Drive operational performance to deliver responsive cost effective care																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Action**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Ratings since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
3.4	Achievement of key access standards/NHSI investigation	Risk that patients deteriorate or actual harm materialises due to patients being moved from list to accomodate cancelled surgical procedures due to inadequate capacity in critical care	4	5	**High Risk 20**	**Moderate risk 2x5 = 10**	Monitoring and tracking patients DATIX report if operation is cancelled Clinical review to determine the level of harm that may have occurred as a result PACU opened Planned surgery has been smoothed across the week ensuring the demand on critical care capacity is balanced Deep dive into high risk areas, risk assessment and recovery plans monitored on a weekly basis as part of an incident control methodology Single QSG review of constitutional standards and escalation of high risk areas	Clinical Policy Group action notes updates to Board and Committees Risk register Outcome of QSG	Report to Board Sub Committees and Centre boards	NHSE/I	Ensure critical care capacity is fully utilised across the Network Ensure community services are fully utilised to enable appropriate step-down care Review of patient flow and the standardisation of pre-assessment processes Patient DNA rates are high and require further investigation to understand the cause	31.3.20 31.3.20 31.12.19 31.12.19	31.3.20	COO	FIC		⇔	23.5.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

28 August 2019 - New Risk
27.11.19 - update to controls, assurance, gaps and target dates
23.5.20 - no change - due to COVID19 position will change when restarting activity

4. STRATEGIC OBJECTIVE: Deliver long term financial sustainability to invest in our future																	
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Actions**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Rating since last Review**	**Date Reviewed**
			LH	**Consq**	**Rating**				**Internal**	**External**								
4.1	Delivery of Annual Plan including Control Total	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	**2**	**4**	**Moderate Risk - 8**	**Low risk 1 x 4 - 4**	**Internal** FIB driving cost improvement programme with Executive Risk Owners linked to schemes Capital Planning Group in place Monthly defunding of budgets for completed schemes Monitoring through Board, Senior Leadership Team, FIC and FIB SFI/SO, Scheme of delegation FIB established to control expenditure vacancy controls established Business case process re-establish **External** Aligned incentive contact agreed with NHSI, NHSE and Trust's commissioners. Integrated Care Provider work stream delivery dependent for circa £20m of efficiency savings. Initial programme of work in development. NHSI performance review meetings (PRM) Board to Board meetings and ongoing concerns discussed with NHSE/I Dialogue with National Cash Management Team	Audit report on going concern Reports to FIC and Board FIC report month 9 revised forecast Agreed return submitted to NHSE/I	Board minutes Finance and Investment Committee minutes Audit Committee work programme Standing Orders/Standing Financial Instructions presented and approved by September 2018 Audit Committee and ratified by the Board Trust Productivity and Efficiency programme developed.	PWC Audit reports on DSPT available Revised forecast month 9 agreed by NHSE/I	Current NHSI Single Oversight Use of Resource rating '3' primarily due to Capital service cover rating of '4' which limits the maximum score to '3'. - keep under-review as funding for capital starts to be received by Trust System decisions to approve progression of system productivity and efficiency work streams. Financial governance and control gaps - NHSI review being undertaken - report awaited	Review end of 2020/21 On hold pending ongoing system discussions Report due in February 2020	31.3.20	Director of Finance	Finance and Investment Committee	1774 1775	↓	19.3.20
Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved **Quarter 1 (1 April - 31 July 2019)** **- May 2019 - no changes made** **28 August 2019 - principal risk updated, risk rating updated, target risk updated,** **21 January 2020 - principal risk objective updated, risk reduced, key controls and assurances updated** **19.3.20 - update to risk objective, score, controls and objectives**																		
4.2	Eradicating debt	Risk of ability to repay the Trust's debt of £90m. Loans were taken from NHSI which need to be repaid from 2019/20. Failing to have sufficient funds could result in the Trust becoming financially unsustainable with regulatory enforcement and intervention	**2**	**2**	**Low Risk - 4**	**Low Risk 2x2=4**	Annual review of governance linked to Annual Governance Statement **External** Regional NHSI team National review by NHSI Chief Executive due to current arrangements being unsustainable and it has been acknowledged such debt cannot be repaid External audit going concern	Reports to FIC FIC report month 9 revised forecast Agreed return submitted to NHSE/I	FIC minutes	Outcome of National Review awaited NHSE/I proposal to commit to PDC in 2020/21 Borrowing approval	No further actions envisaged that can mitigate this risk further internally. The Trust to continue engagement where practical/feasible. Risk mitigated as far as feasible. Unsure of repayment options	30.9.19	30.3.20	Director of Finance	Finance and Investment Committee	1774	↓	24.1.20
Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved **Quarter 1 (1 April - 31 July 2019)** **- May 2019 - no changes made** **26.11.19 - no changes** **21 January 2020 - principal risk objective updated, risk reduced, key controls and assurances updated** **19.3.20 - update to risk objective, score, controls and assurances**																		

4. STRATEGIC OBJECTIVE: Deliver long term financial sustainability to invest in our future																	
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Actions**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Rating since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
4.4	IT infrastructure fit for current and future organisational needs	Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care resulting in a potential impact of being unable to deliver an Electronic Patient Record and interoperability with the Great North Care Record	**4**	**4**	**HIGH - 16**	**Moderate Risk 2x4=8**	IT strategy presented to Board in November 2018 Business Case for Electronic Patient Records (EPR) approved by the Board in December 2018 and has subsequently been submitted to NHSI/E for review/approval. IT Business Continuity and Incident Management plans have been updated. A desktop of the BCPs for IT undertaken May 2019. Upgrade to Network infrastructure completion. IT Capital Investment approved and spent for replacement hardware. Business case for new backup solution approved at Capital & Investment Committee. Digital Strategy group reviewing risks Approval to bid for digital project which would fund both infrastructure and medicines management £6m Emergency capital funding Cyber findings	Action Plan in response to Internal Audit report DSP Action Plan Update reports to Digital Strategy Group, and Board Audit Committee and Digital Strategy Group minutes **External** NHS Digital Audit PWC Audit IG Toolkit re unsupported systems	Chief Clinical Information Officer (CCIO) and Deputies appointed Business Continuity testing commenced EPR Programme Board in place Board minutes evidence approved EPR Business Case	PWC Audit reports on DSPT NHS Digital Audit	Outcome of Business Case for EPR - following bid for digital project Future strategy subject to independent review	31.03.20	31.3.20	Director of Finance	Finance and Investment Committee	1728	⟷	19.3.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

Quarter 1 (1 April - 30 June 2019)
- May 2019 - no changes made
12.11.19 - update to principal risk, controls and assurances
19.3.20- update to principal risk, sources of assurance and responsible Director

4. STRATEGIC OBJECTIVE: Deliver long term financial sustainability to invest in our future																		
Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Actions	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Rating since last Review	Date Reviewed
			LH	Conseq	Rating				Internal	External								
4.5	Ensuring secure IT infrastructure is in place	Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care resulting in a potential impact of a Cyber Attack which could result in access to electronic information being inaccessible, breach of standards, reputational damage and 3rd party costs to repair and resolve issues	5	4	High Risk 20	Low Risk 2x4=8	Executive Director SIRO in place A monthly Cyber Security group has been established which reports through to the re-established Information Governance Steering Group. S monthly meeting with SIRO and reps from IT and IG has been established Business continuity plans and incident management plans have been developed. Desktop testing of a sample of the Incident Plans took place in May. The Trust participated in a patch wide incident exercise related to Cyber security in March 2019. PWC have completed audits of Cyber Security and the Data Security & Protection toolkit. Action plans have been developed to mitigate identified risks, business cases to be drafted for key recommendations that require investment NHS Digital have completed a technical assessment, results pending. £1.5m cyber funding Appointed interim cyber security manager to work with IG Completed 14 business cases considered by digital strategy group and awaiting funding stream Revenue improvements elements of business case due to be considered 2020 by FIB	Action Plan in response to Internal Audit report DSP Action Plan Update reports to Digital Strategy Group Board Audit Committee and Digital Strategy Group minutes Board development session - Cyber Security **External** NHS Digital reviews x 2 PWC reviews x 2	Digital Strategy Group minutes Board minutes	PWC Audit reports on DSPT available	Actions identified in PWC audit report Capital and revenue investment required for business cases to be considered by FIB	31.03.20 31.1.20	31.3.20	Director of Finance	Finance & Investment Committee	1728 1733	⇔	19.3.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

Quarter 1 (1 April - 30 June 2019)
- May 2019 - no changes made
12.11.19 - change to risk rating, key controls and sources of assurance
19.3.20 - update to principal risk, sources of assurance, gaps in control, target dates and responsible director

4. STRATEGIC OBJECTIVE: Deliver long term financial sustainability to invest in our future																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Actions**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Rating since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
4.6	Trust estate developed and maintained to meet regulatory requirements and aligned to strategic plans	Current estate, lack of capital investment and infrastructure compromises the ability to consistently deliver safe, caring, responsive and efficient patient care. Potential impact on delivery of service, backlog maintenance, patient safety potentially impacted by lack of capacity (space & resources) to meet operational demands and mandated standards. Environment provides poor patient experience and infection risk.	**4**	**4**	**High Risk 16**	**Moderate Risk 2x5=10**	Improved access now in place for lifecycle investment Capital planning group in place Planned maintenance processes in place Undertake Premises assurance model (PAM) Regular risk assessments and environmental audits Low levels of back log maintenance Available wards for decanting £2.5m emergency capital bid 2019/20 received to address immediate priorities £22m emergency capital bid 2020/21	Emergency capital funding bid Audit on cleaning Internal audit report on estates & facilities Health & Safety Group consideration of audit information	Lifecycle work now commenced at James Cook University Hospital Available wards across sites	Audit of H&S function by PWC	Prioritised funded Capital Programme currently in place PFI contract limited to 'like for like' replacement - change in Law	31.3.20	to be agreed	Director of Finance	Finance and Investment Committee		⟷	19.302

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

Quarter 1 (1 April - 30 June 2019)
- May 2019 - no changes made

28 August 2019 - principal risk updated - new one added
12.11.19 - updated principle risk, risk rating, controls, actions and assurances
19.3020 - update to objective, key controls and sources of assurance and responsible director

5. STRATEGIC OBJECTIVE: Delivering excellence in employee experience to be seen as an employer of choice																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target dates for completion of Actions**	**Target date score will be met/closed**	**Changes to Ratings since last Review**	**Responsible Director**	**Responsible Committee**	**Associated Corporate Risk**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
5.1	Recruit high calibre people and offer a flexible, patient centred and family friendly work environment	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 (radiology, anaesthetics, critical care)	3	4	**Moderate Risk - 12**	**Low Risk 3x3=9**	Internal: Reports to Workforce Committee Board of Directors Vacancy management and recruitment systems and processes Safe medical and nurse staffing levels for all wards and departments Temporary staffing approval and recruitment process in place Specialist recruitment campaigns Work / link with university medical school Nurse recruitment days AHP recruitment days External: Care Quality Commission National Staff Survey	National Staff Survey results reported to Workforce Committee, Board of Directors and Exit interviews Vacancy report for hard to recruit gaps discussed at SLT and Workforce Committee Timeline for recruitment report to SLT Staff survey split down into staffing groups	Staff Survey You said we did action plan and presentation to Board / Workforce Committee co produced with Staff Side and Staff Engagement	National Staff Survey CQC inspection report	People Plan (bring together all plans) Robust workforce plan including roles and skill mix Safe staffing (medical workforce) for high risk areas On boarding plan for high risk / all areas Working across Tees Valley - workforce gaps and learning 1st 5 years consultant plan	31.7.20 30.6.20 31.7.20 30.9.20 31.8.20	01.06.20	⇔	Director of Human Resources	Workforce Committee		01.06.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

Quarter 1 (1 April - 30 June 2019)
May 2019: No changes made
28 August 2019 - principal risk updated
28 October 2019 - updates to principal risk, key controls, possible sources of information, internal assurances and gaps in control
12.11.19 - update to assurances and target dates
3.2.20 - update to risk rating score, key controls, sources of assurance and gaps
01.06.20 - update to gaps in control and target dates

5. STRATEGIC OBJECTIVE: Delivering excellence in employee experience to be seen as an employer of choice																	
Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target dates for completion of Actions	Target date score will be met/closed	Changes to Ratings since last Review	Responsible Director	Responsible Committee	Associated Corporate Risk	Date Reviewed
			LH	Conseq	Rating				Internal	External								
5.2	Recruit high calibre people and offer a flexible, patient centred and family friendly work environment	Ineffective engagement with the workforce may result in low staff morale, leading to poor outcomes & experience for patients; less effective teamwork; reduced compliance with policies and standards; high levels of staff absence; and high staff turnover.	4	4	High Risk-16	Low Risk 3x3=9	Reports to Workforce Committee Board of Directors Policies and procedures Staff Wellbeing and Occupational Health Draft Engagement strategy (including rewards and recognition; engagement tools) Staff Engagement Group Visibility of leadership Board walk rounds Roadshows COVID19 Draft Wellbeing Strategy Exit interviews Workforce metrics Draft ED&I strategy Workshop on values and behaviours STAR awards Partnership working compact with medical and staff side CPG established - decision making forum Staff weekly briefing Psychology support Health & Wellbeing Group Pulse survey Welfare calls BAME risk assessments	National Staff Survey results reported to Workforce Committee, Board of Directors and Council of Governors Exit interviews Staff survey split down into staffing groups Pulse survey	Staff Survey You said we did action plan and presentation to Board / Workforce Committee co produced with Staff Side and Staff Engagement	National Staff Survey CQC inspection report	Launch of People Strategy Trends from exit interviews Reduction in absence and turnover (<10%)	July 2020 July 2020 April 2020	Aug-20	⟷	Director of Human Resources	Workforce Committee		01.06.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

28 August 2019
New risk
28.10.19 - update to existing controls, gaps in control and target dates
12.11.19 - update to target dates
3.2.20 - update to existing control, sources of assurance and gaps in control and target dates
01.06.20 - update to risk grade, existing controls, sources of assurance, gaps in control

5. STRATEGIC OBJECTIVE: Delivering excellence in employee experience to be seen as an employer of choice																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target dates for completion of Actions**	**Target date score will be met/closed**	**Changes to Ratings since last Review**	**Responsible Director**	**Responsible Committee**	**Associated Corporate Risk**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
5.3	Recruit high calibre people and offer a flexible, patient centred and family friendly work environment	A loss of workforce productivity arising from individual decisions taken in response to the pension implications	1	4	**Low Risk - 4**	**Low Risk 3x3=9**	Job Planning Engagement / support and advice for affected colleagues Options available to address the short fall in session External individual advice for those affected National guidance Local policy	Numbers withdrawing from pension Provision of External financial advice Small % reduction in Pas	Local Policy Rem Com agenda and minutes of discussions regarding pension policy	HR network group on pension NHSE/I winter letter regarding implementing local pension policy National guidance				↓	Director of Human Resources	Rem Com		01.06.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

28 August 2019
New risk
28.10.19 - updated principal risk, existing control and assurances and gaps in control
12.11.19 - updated controls and assurance
3.2.20 - update to risk score and gaps in controls and target dates

5. STRATEGIC OBJECTIVE: Delivering excellence in employee experience to be seen as an employer of choice																	
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target dates for completion of Actions**	**Target date score will be met/closed**	**Changes to Ratings since last Review**	**Responsible Director**	**Responsible Committee**	**Associated Corporate Risk**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
5.4	Recruit high calibre people and offer a flexible, patient centred and family friendly work environment	Failure to comply with national guidance regarding funded establishments in Stroke, Maternity, Paediatric inpatient wards, Cardiothoracic HDU and Neurosurgery HDU could impact on the quality and safety of patient care and / or regulatory action	4	4	**High Risk 16**	**Low Risk 3x3=9**	Internal: Reports to Workforce Committee Reports to SLT Board of Directors Vacancy management and recruitment systems and processes Safe nurse staffing levels for all wards and departments Temporary staffing approval and recruitment process in place External: Care Quality Commission	Safe staffing report monthly to QAC and Board Risk assessment and registers identifying mitigation of failure to comply with guidance		CQC inspection report Royal College guidelines	Baseline audit of which specialities are covered by national guidance Plan to address gaps identified in baseline audit Safe staffing (medical workforce) for high risk areas	31.10.20 31.11.20 30.6.20	31.3.21	⟺	Director of Human Resources Director of Nursing and Quality Medical Directors Corporate Executive Directors	Workforce Committee		01.06.20

Reviewed principle risk, current and target risk rating, existing key controls, possible sources of assurances, assurances received, gaps in control, target date for completion of actions, target date score will be achieved

Quarter 1 (1 April - 30 June 2019)
May 2019: No changes made
28 August 2019 - new risk
12.11.19 - update to assurances and target actions
01.06.20 - update to gaps in control

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 7 JULY 2020			
Corporate Risk Register			**AGENDA ITEM: 14, ENC 10**
Report Author and Job Title:	Jackie White Head of Governance	**Responsible Director:**	Kevin Oxley Director of Estates, ICT and Healthcare Records
Action Required	Approve ☐ Discuss ☒ Inform ☐ (select the relevant action required)		
Situation	The Trust has a number of risk registers which provide a comprehensive picture of all risks that affect the Trust. The mechanism for escalating risks to the Board of Directors is through the Risk Validation Group, Senior Leadership Team a Board Committee or the Risk Committee.		
Background	In line with the Risk Management Policy the attached report sets out the risks which have been brought together into the Corporate Risk Register which are risks facing the Trust and scored 16 and above and are brought to the attention of the Committee		
Assessment	On 9 June 2020 (report extracted from DATIX) there are 36 risks on the corporate risk register graded 16 and above. There has been a reduction in the number of incidents graded 16 and above and the general themes remain the same as the previous quarter. All risks have an action plan, however 18 risks are overdue a review, 3 of these risks relate to an overdue review in 2019 with one of these risks due a review in 2018.		
Recommendation	The Trust Board of Directors are asked to note the risk report and full risk register which has been previously circulated to members.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risk implications associated with this report are contained within 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 ☒		

Risk Register Report

1. PURPOSE OF REPORT

The purpose of the report is to provide the Trust Board with an update on the risks monitored at Board level. These are risks which are graded as 16 and above which are high or extreme risk and contained on the Trust corporate risk register.

2. BACKGROUND

The corporate risk register is an active tool through which the Trust manages its risks. Its purpose is to log all risks identified in the high or extreme categories and the controls in place or planned to manage the risk to its lowest possible level (residual risk). The corporate risk register is built up from the Centre registers and the organisation-wide and strategic risks identified by corporate committees and the Senior Leadership Team. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.

The Risk Validation Group is responsible for reviewing locally approved new and existing risks scored as 16 and above (the Corporate Risk Register), to validate the risk score and grade; to scrutinise and challenge the adequacy of the risk description, the controls and the mitigating action plan; and to consider any cross-cutting issues and the implications for risk aggregation.

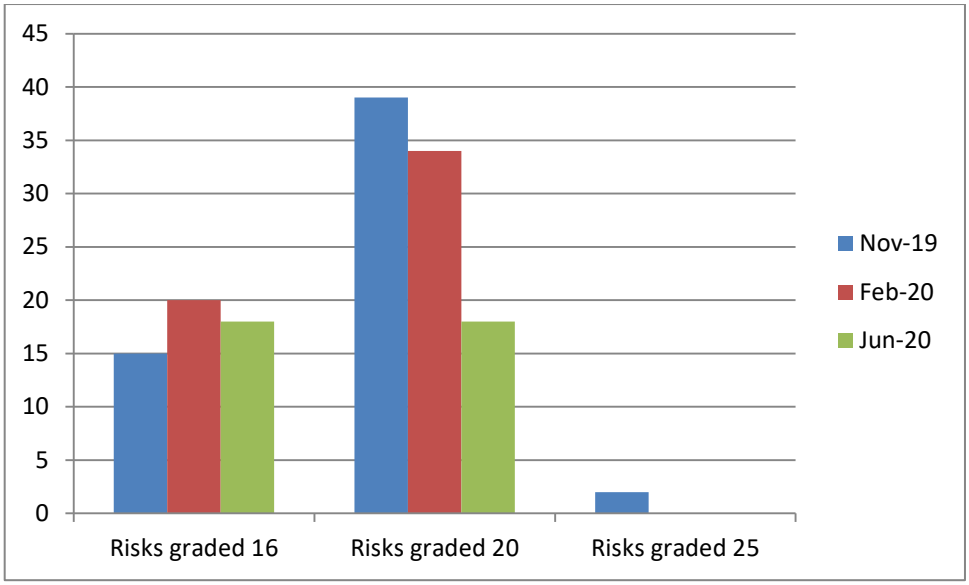
The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a Directorate risk register to a Centre register, or from the Centre risk register to the Corporate risk register reviewed by the Senior Management Team, Finance and Investment, Audit, Workforce and Quality Assurance Committees, and finally the Board.

3. DETAILS

As of 9 June 2020 there are 36 risks on the corporate risk register of 16 and above which are broken down by centre/corporate Directorate below. This is a reduction of 18 risks from the last quarter.

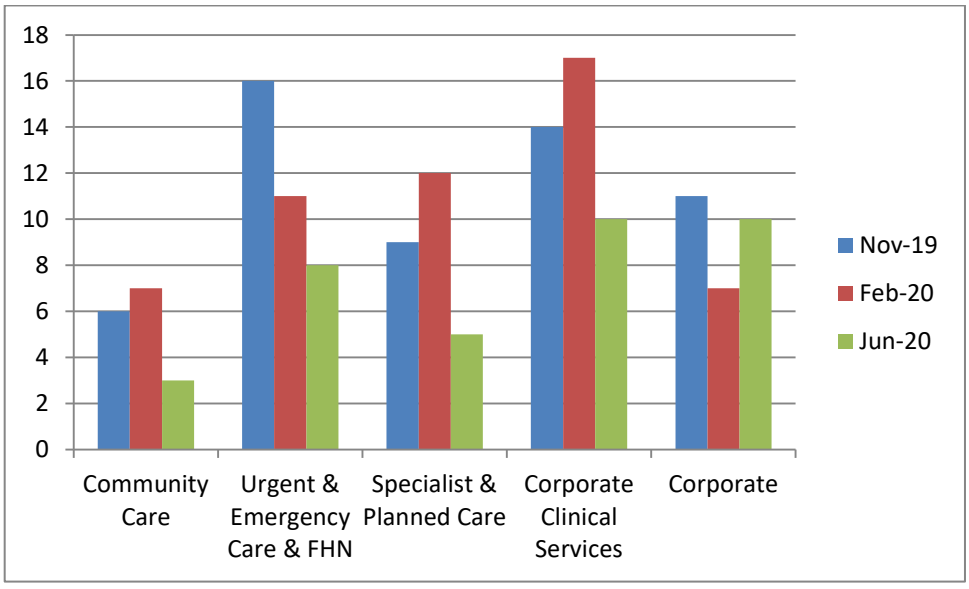
All 16 and above risks relating to the clinical Centres were reviewed by the Senior Leadership Team at its meeting on 14 May 2020 and corporate Directorate risks graded 16 and above were reviewed by the Risk Committee at its meeting held on 17 June 2020.

Further work on corporate Directorate risk registers is underway which includes development or enhancement of processes for development and monitoring of risk registers, and development of actions to mitigate the risk to as low as possible. This should be complete by mid July 2020.

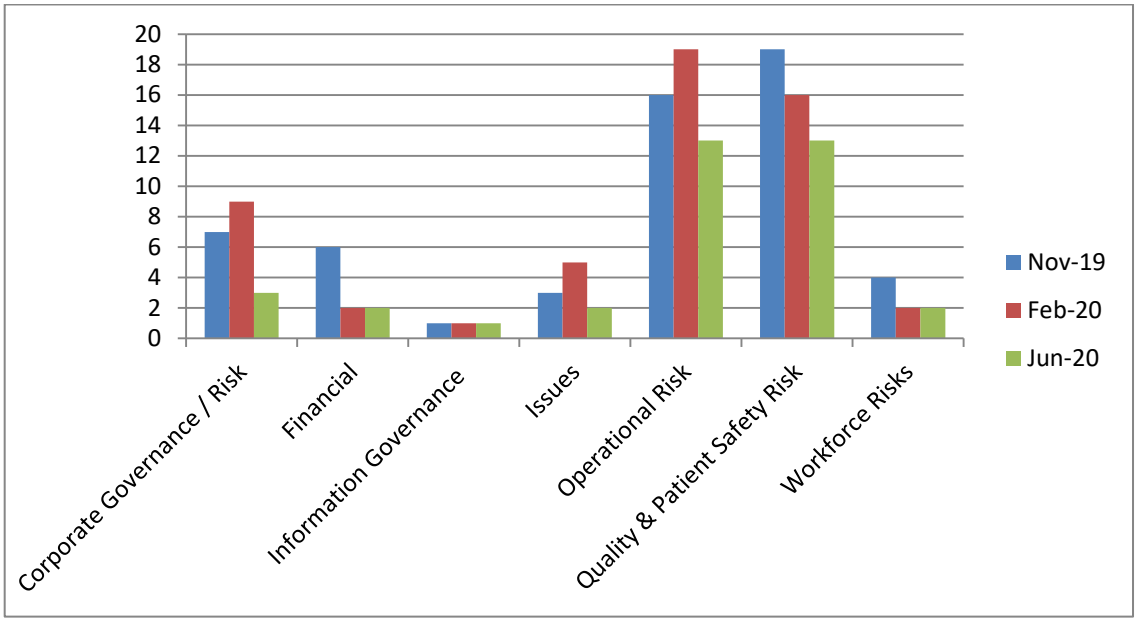


In the last quarter the risks graded 20 and above have reduced by 16 risks with the number of risks graded 16 reducing by 2.

All centres and corporate areas have seen a reduction in incidents graded 16 and above this quarter.



The main themes continue to be operational risks and quality and patient safety risk.



Of the 34 risks on the risk register all risks have an action plan to mitigate the risk

4. RECOMMENDATIONS

The Trust Board of Directors are asked to note the corporate risk register.

APPENDICES
Corporate Risk Register (previously circulated)

Audit Committee
Chair's Log

Meeting: Audit Committee	**Date of Meeting**: June 23rd, 2020
Summary for Board	

Audit Committee was held to review and approve Annual report and accounts including Internal and External Audit reports

DoA

At the Board meeting held by Teams on June 2nd the Board gave delegated authority to the Audit Committee to review and approve the Annual Report and Accounts.

Attendees

NEDs Richard Carter-Ferris and Debbie Reape were present giving quorum to the AC.

In attendance were Steven Mason, Jackie White and Brian Simpson from the Trust, Rashpal Khangura (Partner KPMG), Susan McNair (Partner PWC) and Paul Charnock (Manager PWC)

Internal Audit

1. PWC provided a summary of reviews completed since the last meeting. Final reports for 3 completed reviews were received covering :
   - DSP (Data Security and Protection) Toolkit.
   - GDPR
   - Procurement

2. PWC then presented their Annual Internal Audit report. They are satisfied that sufficient work has been performed to enable them to form their opinion.

3. The overall opinion remains unchanged from 2018/19 at Substantial Improvement.

4. Key areas identified:
   - IT and DSP toolkit
   - Procurement
   - Cyber Security
   - H&S
   - Waste Management

5. An underlying thread through the key areas of risks is the IT infrastructure.

6. All areas are being addressed by management.

External Audit / Annual accounts

7. KPMG delivered their ISA 260 Annual Report on their Audit of the Accounts and Annual report.

- There is a clear opinion on the Annual report and Accounts except for material uncertainty qualifications due to valuation of assets and going concern in the current COVID environment.
- The Value for Money (VFM) audit is necessarily qualified
- There is no Quality Account Audit this year due to COVID
- KPMG identified a non-adjusting difference of £2.5million in relation to the PFI prepayment which is below the overall materiality level
- KPMG also reported differences between South Tees and other NHS entities all of which will be reviewed by the finance team going forward with a view to inter-company amounts.
- There are a couple of small areas of work to complete but KPMH do not forsee any changes to the reports before delivery on 25th June

Governance

8. The Committee reviewed the Annual Self Certification statement previously presented to the Board.

9. The Committee reviewed the Letter of representation to KPMG on behalf of the Board and agreed that all matters included therein were correct.

10. There are no matters to be added to the BAF

Conclusion and Recommendations	Actions
• The Audit Committee reviewed and agreed the wording of the letter of representation to KPMG. The Committee approved the signing of the letter by DoF on behalf of the trust Board.	Steven Mason to sign and deliver to KPMG
• The Audit Committee agreed that the Annual Report and Accounts were complete and ready to be approved by Chair/CEO (subject to any last minute material corrections identified which DoF will advise to CEO/Chair).	DoF / CEO / Chair
• Finally a huge vote of thanks to all involved (KPMG, PWC, DoF, Brian Simpson and the finance team and Jackie White) in getting the Annual Report and Accounts to a deliverable state given the current remote working environment.	

Finance and Investment Committee
Chair's Log

Meeting: Finance and Investment Committee (Virtual Meeting)	**Date of Meeting** 18th Jun 2020
Key topics discussed in the meeting	
• M2 Financial Report • Orthopaedics • PFI Life Cycle • Integrated Performance Report	
Actions agreed in the meeting	**Responsibility / timescale**
• The Committee noted that the M1 financial report had been accepted by NHSE/I and that the M2 report showed break-even performance using the new COVID-19 approach. • A detailed review of the proposal for Orthopaedics was conducted. While the direction of travel was supported by the committee, more work is required, and this will be submitted to FIC following further discussion at SLT and CPG. • Recent review by Endeavour has identified a potential PFI lifecycle maintenance underspend. A thorough review of the Endeavour proposal will be conducted when they release their recent condition survey findings, and an independent condition survey may be commissioned. Asset availability for maintenance will also be considered and proposals made.	Director of Finance July 2020 Director of Estates Sept 2020
Issues for Board escalation/action	**Responsibility / timescale**
• The Board is asked to note the significant progress made in establishing the operational processes around Orthopaedics. A business case will now be developed and approved before Trust authorisation.. • A detailed review of the content and phasing of the PFI spending plans provided by Endeavour is recommended to ensure that the best possible value is obtained for the Trust.	Director of Finance July 2020 Director of Estates Sept 2020

Risk Committee
Chair's Log
Date: 10 October 2019

Meeting: Risk Committee	**Date of Meeting**: 17/06/20
Connecting to: Board of Directors	**Date of Meeting**: 07/07/20
Key topics discussed in the meeting	

The meeting was quorate and received the following inputs to discuss:

- The current Board Assurance Framework and a paper outlining changes
- An update on 16+ risk register
- A summary of the SLT risk meeting held on 14/5/20 prepared by Head of Governance
- Short presentations by each area in the "corporate" functions

The committee reviewed the Board Assurance Framework and in particular the items "owned" by the Board. All other items had been scrutinised by the relevant committee. It was noted that the document was now in a much better shape.

The committee looked at the proposed changes to the risks on the BAF and agreed with the following observations:

1. Risk 4.2. This requires further scrutiny by FIC as it is not clear that the proposed changes in the structure of the debt will ultimately lead to a reduction in risk.

2. Risks 4.4/4.5. It is not clear that risks relating to other aspects of IT relating to hardware, operating systems and data security are reducing, given the future vision heavily relies on digitisation it. Further scrutiny by SLT required.

The committee considered the strength of the risk management processes and concluded that improvements had been made except in some "corporate" areas (see below). SLT and Risk Validation Group scrutiny was improved. Continued focus on reviewing risks by these groups is required and ensure that an auditable trail is apparent.

Each of the "corporate" functions gave a short presentation. It is clear that they all require some assistance from a risk expert and Mr Greener will assist.

The committee considered any emerging risks in a horizon scanning session. Those discussed included:

1. Organisational recovery and the impact on services post (current) Covid issue.

2. Lifecycle maintenance and the impact of Covid (distancing) on the use of the estate.

3. Possible personal litigation from arising from Covid.

There were no specific escalations to be made to the Board.	
Actions agreed in the meeting	**Responsibility / timescale**
FIC/SLT to review BAF risks 4.2/4.4/4.5 as appropriate. ToR for an audit of the BAF in connection with CQC to be provided to the committee for review. Emerging risks to be referred for review by appropriate body. MR Greener to assist “corporate” function in risk management.	• Jackie White/asap • Jackie White/asap • Jackie White/asap • Jackie White/asap
Escalation of issues for action by connecting group	**Responsibility / timescale**
None	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
None	

Workforce Committee
Chair's Log

Meeting: Workforce Committee	**Date of Meeting**: 4/6/20
Connecting to: Board of Directors	**Date of Meeting**: 07/07/20

Key topics discussed in the meeting	
A range of themes associated with Covid19. These included infection prevention control measures, FPPE and advice to staff, safe staffing, continuing engagement with BAME colleagues to supplement occupational health and HR contacts; and the positive response from the very comprehensive package of support during the pandemic. The Pulse survey as a very encouraging indicator of morale and how this, with other evidence is supporting a reduction in the risk score for poor staff engagement. The Trust response to the advice on improving the engagement of BAME staff in leadership and decision making. Progress on developing a fresh set of values. The first iteration of a simplified People Plan and its interface with re-energising action around the Staff Survey action plan. Progress and plans to re-launch a stronger approach to Freedom to Speak Up. KPI's	

Actions agreed in the meeting	Responsibility / timescale
In agreeing to recommend a reduction in the BAF risk score for staff engagement, the evidence needs to be documented.	Jackie White
To make strong representations that the annual Staff Survey should take place in 2020 (and a local approach be taken if the national survey does not run)	Rachael Metcalf
The People Plan to be made more explicit in terms of what will change, and how this would be evidenced in terms of how it contributes to the Trust goal to enhance patient care.	Rachael Metcalf
Every effort to be made to ensure that the new Freedom to Speak model is in place from	Deirdre Fowler

September. To work towards a goal and model for appraisal that sees all completed within the first four months of each year, to enable stronger alignment between Trust quality and strategic objectives and the contribution of all staff. To refresh the process around mandatory training to ensure that it is likewise complete within the first four months. That the clinical excellence awards are distributed for 2020/21 amongst all eligible consultants in line with the recommended approach and neighbouring Trusts.	Rachael Metcalf Rachael Metcalf Rachael Metcalf
Escalation of issues for action by connecting group	Responsibility / timescale
None	
Risks (Include ID if currently on risk register)	Responsibility / timescale
None	

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 30th June 2020
Connecting to: Board of Directors	**Date of Meeting**: 7th July 2020

Key topics discussed in the meeting	

• Escalations
  • EPRR
  • COVID-19
• Updated Terms of Reference
• Covid-19 slide deck
• Monthly Quality Report
• Maternity Services update
• Gap analysis against NHSE/I IPC BAF
• Monthly Patient Safety & Legal Services Report March 2020
  • Serious Incidents Report
  • Claims
  • Inquests
• LocSSIP's audit update
• Quality Account update
• Health & Safety & Fire Annual Report report
• Safeguarding annual report
• Mortality:
  • Survey of patients with Covid-19 (EoL) at JCUH
  • Zetland Ward patient mortality review
• QEIA Panel update report
• Review of Risks and Matters for the Board Assurance Framework	

Actions agreed in the meeting	**Responsibility / timescale**
• Never Event actions and learning	• Mrs Fowler, Mr Chadwick and Miss Reilly
• Noted that there are demand pressures in gastroenterology and endoscopy resulting in extented waiting times. Noted that the demand pressures were not escalated in the first six months of 2019. Demand pressures have increased due with C-19.A clear risk stratification process is in place and all patient referrals have been triaged with no serious incidents identified. Action planning has been shared	
• QAC to receive updates on other priority services in Phase 1 of the improvement / recovery plan each month.	
• Noted that the CQC will be assessing the organisation in line with the Emergency Support Framework in the coming weeks focusing initially on the NHSEI Infection Prevention and Control Board Assurance Framework, which is a dynamic document currently and changing. .	• Mrs Fowler, Mr Chadwick and Miss Reilly

• Reported and noted that the Trust's CQC action plan has five actions off-track, seven items expected to deliver actions, thirteen items completed and one item embedded. Performance against the action plan is discussed fortnightly with the CQC.	
• Noted that the South Tees Accreditation for Quality of Care (STAQC) is being re-launched in July which will give assurance on the embedding of improvement actions / the CQC action planning.	• Mrs Fowler and Miss Reilly
• Patient falls and pressure ulcers.. QAC were informed this trend is happening throughout the region due to a change in patient case mix. A number of additional interventions have been put in place. .	• Mrs Fowler
• QAC membership now includes the Head of Midwifery (from June 2020) and an invite will go to the directors of nursing from both Middlesborough CCG and North Yorkshire CCG to attend as 'observers' from July 2020.	
• The maternity CNST and Saving Babies Lives dashboard was presented and outstanding actions discussed.	
• Noted the position of current outstanding Local Safety Standards for Invasive Procedures (LocSSIPs) and the importance of the trust having a LocSSIP for every invasive procedure.. Assurance was given that all LocSSIPs are in place. Consequently the timetable for audit is to be reviewed to make sure all LocSSIPs can be audited in a 12-18 month period (or more frequently if required) for compliance. The profile of LocSSIPs in the organisations is to be raised.	
• Noted that a Quality Account for 2019/20 is required and revised timescales agreed. The report will be completed for publication on 1st October 2020.	
• The following annual reports were received: o Health and Safety and Fire o Safeguarding	
• The following annual reports are delayed due to COVID 19 and completion dates are being reviewed: o Annual reports from sub groups o NICE Compliance o Serious Incidents o Mandatory training o Clinical audit	• Mr Chadwick

Escalation of issues for action by connecting group	Responsibility / timescale
• Board to note that another never event concerning a 'retained swab' has been reported. • Board to note the position and risks in the gastroenterology and endoscopy services.	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Ensure risks around endoscopy are included on appropriate risk registers.	• Jackie White/Johanna Reily