South Tees Hospitals
NHS Foundation Trust

Board of Directors

3 March 2020
2.00 pm
Board Room, Langbaurgh House, Guisborough

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 3 MARCH 2020 AT 2.00 PM IN THE BOARD ROOM, LANGBAUGH HOUSE, GUISBOROUGH

AGENDA

ITEM		PURPOSE	LEAD	FORMAT
1.	Staff Story	Discussion	Director of HR	Presentation
CHAIR'S BUSINESS				
2.	Welcome and Introductions	Information	Chair	Verbal
3.	Apologies for Absence	Information	Chair	Verbal
4.	Quorum and Declarations of Interest	Information	Chair	ENC 1
5.	Minutes of the last meetings held on 4 February 2020	Approval	Chair	ENC 2
6.	Matters Arising	Review	Chair	ENC 3
7.	Chairman's report	Information	Chair	Verbal
8.	Chief Executive's report	Information	Director of Finance	Verbal
PEOPLE				
9.	Values and Behaviours update	Discussion	Director of HR	ENC 4
QUALITY AND SAFETY				
10.	Safe Staffing Monthly Report	Information	Director of Nursing & Quality	ENC 5
11.	Healthcare Associated Infections report	Information	Director of Nursing & Quality	ENC 6
12.	CNST maternity standards update	Information	Medical Director	Presentation
PERFORMANCE AND FINANCE				
13	Performance Report	Discussion	Chief Operating Officer	ENC 7
14.	Month 10 2019/20 Financial Performance	Information	Director of Finance	ENC 8
STRATEGY AND PLANNING				

ITEM		PURPOSE	LEAD	FORMAT
15.	Strategic Issues Affecting the Trust and Wider Health Economy update	Information	Chair	Verbal
16.	Friarage Hospital Northallerton	Information	Medical Director	Verbal
GOVERNANCE AND ASSURANCE				
17.	Board Assurance Framework and Risk Register	Discussion	Head of Governance	ENC 9 and 10
18	CQC update	Information	Director of Nursing & Quality	ENC 11
19.	Chair's Logs from Board Committee Meetings	Discussion	Chairs	ENC 12
20.	Any Other Business		Chair	Verbal
21.	Risks to be added to the Board Assurance Framework	Discussion	Chair	Verbal
22.	Reflections on Meeting	Discussion	Chair / All	Verbal
	DATE OF NEXT MEETING The next meeting of Board of Directors will take place on Tuesday 7 April 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 – 4 February 2020			
Register of members interests			**AGENDA ITEM: 4, ENC 1**
Report Author and Job Title:	Jackie White Head of Governance	**Responsible Director:**	Alan Downey Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	The Board of Directors are asked to note interests declared by members of the Committee		
Background	The report sets out membership of the Board of Directors and interests registered by members. Conflicts should be managed in accordance to the Constitution para 32 - If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to other Directors.		
Assessment	There are no specific conflicts identified with the agenda. Members will be reminded at the meeting to raise any if they arise.		
Recommendation	Members of the Board of Directors are asked to note the Register of Interest in relation to the Committee.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Alan Downey	Chairman	1 March 2018 15 April 2014	ongoing 2 April 2019	Wife is Director of PricewaterhouseCoopers working mainly with local government clients in the North of England Neddown Limited (dissolved company) from 2 April 2019 and (dormant) prior to joining the Trust
Amanda Hullick	Non-executive Director (Deputy Chair)	1 June 2018	ongoing	Husband employed as Supply Chain and Operations Director at Brakes UK (Sysco Plc) – supplier to the Trust.
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
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 (Urgent and Emergency Care & Friarage Hospital) and Deputy Chief Executive	23 January 2012	Ongoing	Director of Clements Medico Legal Consulting Limited
David Chadwick	Medical Director (Specialist and Planned Care)	21 August 2006	ongoing	Member of Team Health LLP (dormant)
Sath Nag	Medical Director (Community Care)			No interests declared
Gill Hunt	Director of Nursing and Quality			No interests declared
Steven Mason	Director of Finance	1 October 2017 1 September 2018 13 August 2018 March 2019 1 October 2019	ongoing ongoing ongoing ongoing ongoing	Child employed at Deloitte Children employed at Ernst & Young HM Property Services Ltd (family company) Client representative ELFS Management Board South Tees Healthcare Management Limited - Company number 10166808
Jackie White	Head of Governance	March 2013	Ongoing	Director – Applied Interim Management Solutions – Company Number 08473345

		February 2017 September 2018	Ongoing Ongoing	Specialist Governance Advisor – CQC The Northern School of Art Director – DevCo Ltd – Company Number 11574517
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
Sue Page	Interim Chief Executive	May 2018	Ongoing	President of British Red Cross – Cumbria
Kevin Oxley	Director of Estates, ICT and Healthcare Records			No interests declared
Rachael Metcalf	Director of Human Resource Operations			No interests declared
Joanne Dobson	Director of Transformation			No interests declared
Mark Graham	Director of Communications			No interests declared
Johanna Reilly	Chief Operating Officer	2 October 2019	Ongoing	JRR Consultants Limited – Company number 11600734

South Tees Hospitals NHS
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 4 FEBRUARY 2020 AT 2.00 PM IN THE BOARD ROOM, MURRY BUILDING, JAMES COOK UNIVERSITY HOSPITAL

Present

Mr A Downey	Chairman
Mr M Ducker	Non-Executive Director
Mr R Carter-Ferris	Non-Executive Director
Ms A Hullick	Non-Executive Director
Mrs M Rutter	Non-Executive Director
Ms A Burns	Non-Executive Director
Mr D Heslop	Non-Executive Director
Mrs G Hunt	Director of Nursing & Quality
Mr A Clements	Medical Director
Dr S Nag	Medical Director
Mr D Chadwick	Medical Director
Mr S Mason	Director of Finance

In Attendance

Mrs J White	Interim Head of Governance
Mr M Graham	Interim Director of Communications
Mr K Oxley	Director of Estates, ICT and Healthcare Records
Mrs R Metcalf	Director of HR
Ms J Reilly	Interim Chief Operating Officer
Ms J Alderson	Non-Executive Director – Insights Programme

Action

BoD/19/125 **PATIENT AND STAFF STORY**

The Chairman welcomed Emma, Simon and their son Ben Howard to the Board along with Dr English from the Trust. Dr English presented Ben's story. Ben was 14years old when he presented with a diagnosis of keratoconus in June 2017: a non-inflammatory, usually progressive, eye condition. The cornea (normally round, dome-shaped clear window of the eye) progressively thins causing a cone-like bulge to develop. This eventually impairs the ability of the eye to focus properly, causing poor vision even with glasses or normal contact lenses. Following treatment with the Ophthalmology service Ben now has good vision supported by a combination of specially designed contact lenses.

Mrs Howard took the opportunity to thank the Trust and in particular Lynne Welham who had supported Ben during his treatment. Mrs Howard had nominated Lynne for an award which she won. Mrs Howard said Lynn was an amazing help to Ben and the family.

The Chairman thanked Dr English for an interesting and uplifting presentation and expressed the Board's thanks and good wishes to Ben and his family.

Action

BoD/19/126 **WELCOME AND INTRODUCTIONS**

The Chairman welcomed Julie Alderson who was joining the Board for 6 months on the Gatenby Sanderson insights programme for aspiring Non-Executive Directors.

BoD/19/127 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Ms Reape Non-Executive Director, and Ms Page, Interim CEO, and Mrs Dobson, Director of Transformation.

BoD/19/128 **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/19/129 **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/19/130 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on 3 December 2019 were reviewed and agreed as an accurate record. — Head of Governance

BoD/19/131 **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

BoD/19/132 **CHAIR'S REPORT**

The Chair reported that he had had a number of internal meetings with Non-Executive Director colleagues and staff and had met the new Joint Hospital Group North Commanding Officer. In addition he had met with Healthwatch and a representative of the National Guardian's Office.

Members noted that following a nomination process a new lead governor had been appointed – Plym Auty.

The Board had received an update on role of regulators and NED responsibilities and the Corporate Trustees had met and approved the accounts and annual report for the Charity.

Finally the Chair advised he had attended the Finance and Investment Committee this month as part of his routine attendance at sub-committees.

Action

Resolution

The Board of Directors noted the Chair's report.

BoD/19/133 **CHIEF EXECUTIVE'S REPORT**

Mr Mason, Director of Finance, updated members on behalf of the Chief Executive.

Mr Mason briefed members on expanding the range of elective services provided for patients at the Friarage including a new dedicated arthroplasty (joint-replacement) service. Clinical directors James Dunbar and Andy Gray have been the driving forces behind the new dedicated service, which is already carrying out around 20 procedures each week.

Again linked to the improvement plan, the Trust has submitted a bid for £6 million in funding which, if successful, will enable the organisation to commence the preparatory work and IT infrastructure upgrades necessary prior to the adoption and roll-out of an Electronic Patient Record system.

The Trust has achieved its highest ever staff flu vaccination rate with the week 16 position confirmed at 81.2% of colleagues immunised. Enormous thanks are due to colleagues throughout the Trust who have made this possible and, in particular, our Flu Champions who promote and deliver vaccinations alongside their substantive roles.

As the biggest hospital trust - and one of the biggest employers - in the Tees Valley, the Trust has more than 3,500 nurses and midwives working across our hospitals and community health services. 2020 has been internationally recognised as the Year of the Nurse and Midwife to mark the bicentenary of Florence Nightingale's birth. As part of this year's events, the Trust is offering 20 of our young leaders the opportunity to sign up to a bespoke distance learning programme to attain a Master's in Management Practice from Manchester Business School.

The Trust is also encouraging patients and members of the public to nominate a South Tees nurse, healthcare assistant or midwife who has gone that extra mile, for a Nightingale Award through the Trust website or by picking up a form at the South Tees Hospitals Charity Hub.

Resolution

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

Action

BoD/19/134 **SUMMER STAFF SURVEY – YOU SAID WE DID**

Roaqah Shaher, Kat Evan and Holly Scrafton attended and presented the "You said, we did" co-authored action plan in response to the summer staff survey.

Mrs Burns welcomed the presentation and action plan and advised that she will be taking the Chair of the Workforce Committee and would be delighted for staff side to attend and provide updates on progress. Mrs Burns said that there were lots of actions within the plan, some complex, and asked what were the top three impacts and changes they would like to see. Roaqah commented that visibility of senior management was key along with support and interaction with staff. Roaqah said that this did not just relate to Board, but also to Senior Leaders across the Trust. There was a need to improve relationships between teams and across the organisation in relation to bullying and harassment. Finally Roaqah commented that all actions are achievable if both sides work together.

The Chair thanked Roaqah Shaher, Kat Evan and Holly Scrafton for attending and commented that the Board are committed to working together to deliver the plan.

Resolution

The Board of Directors noted the 'You Said, We Did' action plan.

BoD/19/135 **HEALTHCARE ASSOCIATED INFECTION REPORT**

Mrs Hunt referred members to her previously circulated report. Members noted that in response to the high incidence of *C.difficile* enhanced actions have been implemented. The *C difficile*-associated diarrhoea objective for 2019/20 is to have no more than a combined total of 81 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There were 0 COHA + 3 HOHA cases in December 2019. There have been 72 COHA + HOHA cases in the first 9 months of 2019/20. We are currently over trajectory.

The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There were 0 trust-assigned cases in December 2019. There has been 1 trust-assigned case and 1 potentially trust-assigned case in the first 9 months of 2019/20.

There is no official MSSA bacteraemia target for 2019/20. There were 3 trust-apportioned cases in December 2019. There have been 35 trust-apportioned cases in the first 9

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months of 2019/20.

There has been an outbreak of *Serratia marcescens* infection affecting patients who have been treated in cardiothoracic ICU and/or HDU and/or Ward 32. At the time of writing (8th January 2020) there have been 5 confirmed cases, 3 probable cases and 25 excluded cases.

Mrs Hunt also assured members that the Trust is working with NHS Public Health England with regard to preparedness for the coronavirus. Appropriate measures have been taken to protect staff and the public and training and equipment has been provided to staff.

Mr Oxley updated that following concerns regarding cleaning standards potentially linked to an increase in HCAIs at the James Cook Hospital a request was made to our PFI partners, Endeavour and their contractor, Serco FM, to commission an independent audit of cleaning standards at the JCUH site. In agreement with the Trust they commissioned an independent company, Environmental Excellence Training and Development Ltd (EETD Ltd), led by its director Delia Canning. This individual is a recognised expert in the healthcare cleaning field and the Trust was supportive of her engagement. The audit took place between 25th November 2019 and 27th November 2019.

The report found that the current position is generally good for in-patient areas. However public areas and some departments require attention and have been identified as needing improvement to meet the expected standard.

A number of recommendations have been identified and are being monitored by the Trust and the Quality Assurance Committee.

Mrs Rutter commented that it was good to hear that this work has been undertaken and that Serco have revised the decision on the way they clean. Mr Oxley confirmed that the change in cleaning will need quality impact assessing and further discussing at the Quality Assurance Committee.

Mrs Burns said that she noted in the report the impact *C difficile* had on older people and wondered if there was a correlation between this and acuity and length of stay on the wards. Mrs Hunt advised that there is a correlation but the Trust is not seeing *C difficile* particularly on the wards.

Resolution

The Board of Directors noted the Healthcare associated infection report

Action

BoD/19/136 **SAFE STAFFING REPORT**

Mrs Hunt presented the Safe Staffing report and members noted that the fill rate against planned rosters for the month of December 2019 at an overall level was:

- RN / RM day shift 87.1% night shift 90.0%
- Nursing Associates (NA) day and night shift 100%
- HCSW day shift 95.1% night shift 111.1%
- Trainee NA day and night shift 100%

Mr Kane referred Mrs Hunt to page 3, table 1 which provided data on average fill rate and then specifically page 4, which provided further information in relation to wards with an RN fill rate of less than 80% and asked for further clarity. Mrs Hunt advised that it was important to show the number of planned versus actual and bed occupancy in order to understand the full picture. Mrs Hunt advised that there are areas which are more challenged in the Trust; however the Trust does undertake a review of staffing on a daily basis.

Ms Hullick asked when community nursing and primary care networks would be included in the report and Mrs Hunt advised that a new safer nursing care tool for community nursing is being introduced shortly which factors in contact with patients and geographical spread.

Resolution

The Board of Directors noted the safer staffing report

BoD/19/137 **NURSE STAFFING REVIEWS**

Mrs Hunt referred members to her previously circulated report which had been considered and recommended by Workforce Committee. Members noted that the Director of Nursing and Assistant Director of Nursing Education and Workforce delivered a presentation to the Workforce Committee, with an overview of the Shelford Group Safer Nursing Care Tool (SNCT) and how this tool calculates staffing requirements based on the acuity and dependency of the patients during the time frame agreed. The use of Care Hours per Patient Day (CHPPD) as a measure was also presented. This information is overlaid with professional judgement and nurse sensitive outcome measures.

The Committee noted that the Trust agreed and budgeted headroom is 21%, with national guidance generally recommending 25%.

Resolution

The Board approved the Nurse Staffing Reviews

Action

BoD/19/138 **NHS BLOOD AND TRANSPLANT 6 MONTHLY REPORT**

Lisa Tombling, Specialist Organ Donation Nurse, attended and presented the six month report into Actual and Potential deceased donation activity 2019/2020. Lisa highlighted that it had been a fantastic first 6 months of the year, with 8 actual donations and 20 patients receiving lifesaving transplants. There were 40 potential organ donors, although some were not suitable. In addition there had been two heart donations and successful transplantations.

Mrs Rutter commented that it was a quality service and wondered about the impact of the new legislation on activity going forward and whether the Trust would meet the potential demand. Lisa advised that the legislation had already been implemented in Wales where there had not been a huge increase in demand, although there had been increased awareness among families.

Resolution

The Board of Director noted the 6 monthly report

BoD/19/139 **PERFORMANCE REPORT**

Ms Reilly presented the performance report. Members noted that the position in A&E had deteriorated and the Trust was experiencing problems in line with the national position. Members noted that the main concerns were around acuity of patients, lack of flow in the hospital and too many beds having been taken out of the system at the beginning of 2019/20. Ms Reilly advised that Jo Dobson Director of Transformation is working on flow to see if the Trust can increase throughput.

Ms Reilly confirmed she would bring recovery plans to the next meeting.

Mrs Rutter asked whether there was a plan to re-open closed beds and Ms Reilly commented that if the Trust did open additional beds, it would not be able to staff them following the decision of the Trust at the beginning of 2019/20 to reduce its bed capacity. However next year's winter plan will look at options around opening a ward and fully staffing it.

Mrs Hullick commented that the issue with performance is not just a winter issue.

Mr Graham advised members that last year 49 beds were removed. In correlation to the removal of those, beds there has been a steady decline in performance. The Trust has already taken steps to manage the impact and has introduced the full capacity protocol to escalate internally to deal with

Action

high pressure times.

Mrs Burns commented that there is a need to look at Delayed Transfers of Care (DTOC) numbers in conjunction with flow. Ms Reilly advised that some of the plans the Trust are putting in place should reduce the number of DTOCs. Mrs Rutter said that for more than 2 years DTOC numbers have been rising and the Trust does not seem to be making any impact on this. Ms Reilly said that she chairs a group of stakeholders who are looking at how we can do things differently in this area.

Mr Heslop asked if the Trust was aware of best practice in other Trusts on managing these issues and Ms Reilly confirmed that the Trust is learning lessons from the peer review which had been undertaken.

Mrs Hunt confirmed that the Trust has introduced a virtual diagnostic pathway and, although it is early days, patients are being referred onto this pathway. In addition ambulatory care is working well.

Mrs Hunt referred members to the patient safety section of the performance report and highlighted that the Trust had seen a slight increase in falls which were up to 5.5 per 1000 bed days, predominately associated with patient dependency. However, there are a number of hot spots, and this is being looked into. In terms of pressure ulcers, work in community services is ongoing, as is dialogue with NHSI in terms of system wide learning. The 1,000 voices programme continues, and QAC will receive an update at their next meeting on work that is also ongoing on patient experience.

Mrs Metcalf referred members to the workforce section of the report and highlighted that staff sickness had increased last month. The Trust had achieved a 90.58% performance on mandatory training and 83.74% of appraisals had been completed. There had been a 1% reduction in turnover compared to last year. 67 disciplinary investigations had been undertaken to date. Mrs Metcalf commented that the Trust is holding a workshop next week to discuss and define the values and behaviours for the Trust: members of the Board were invited to attend. Following this the Trust would be looking to introduce a new values-based recruitment process and a new appraisal process.

Mrs Burns commented on overdue appraisals and asked Mrs Metcalf which year they related to. Mrs Metcalf advised that the overdue appraisals related to staff that haven't had an appraisal for over two years. Members noted that action is being taken to follow this up.

Action

Mrs Burns commented that there had been a discussion in Workforce Committee on sickness and she felt that short-term sickness was the greatest concern for the Trust.

Mr Heslop referred members to the Board Development session held in the morning and asked Mrs Metcalf whether there needed to be sanctions put in place for staff who have not undertaken their information governance training. Mrs Metcalf advised that this need further consideration and she would raise it in Workforce Committee.

Mr Kane raised the need to understand the feedback from exit interviews conducted with consultants who leave the Trust. Mrs Hullick confirmed that the Workforce Committee reviews information from exit interviews, although further work is required on making effective use of the information.

Finally Mr Mason referred members to the Finance section. Members noted that the Trust is behind its revenue spending target by £18.3m. The shortfall is made up of £4.9m of lost Provider Sustainability Funding, £14.3m of undelivered system savings and an underlying underspend, attributable to the Trust, of £0.9m. The full year plan is for a surplus of £3.2m. With regard to productivity and efficiency savings the year to date savings are £7.5m.

Resolution

The Trust Board of Directors noted the performance report

BoD19/140 **MONTH 9 2019/20 FINANCIAL PERFORMANCE**

Mr Mason advised members that the Trust has a year to date overspend of £18.3m driven by the loss of PSF and non-delivered system savings. This is forecast to increase to a full year overspend of £28.3m. Included within the full year forecast are costs of £4.0m due to an exceptional cost from lifecycle prepayments. The Trust has agreed its year-end position with NHSE/I. Residual finance risks will be managed within this forecast. Excess costs of £17.5 million per year from the Trust's PFI contract remain the largest single contributory factor to the organisation's structural deficit.

The Trust's current run rate has continued from month 8 into month 9 and is likely to continue for the remainder of the financial year. Month 9 performance was in line with the forecast at month 8.

Resolution

The Trust Board of Directors noted the financial

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performance.

BoD/19/141 **ANNUAL PLAN UPDATE**

Mr Mason updated members on the annual plan. Members noted that the Trust has received a revised control total which appears to be revenue neutral but needs further exploration. Mr Mason advised that the most significant area is the clinical negligence scheme for trusts which will worsen the Trust position by £1.5m. There is another adjustment which appears to benefit the Trust by £1.6m, but this may be withdrawn through specialist commissioning. Mr Mason advised that the budget process is ongoing and finance staff are in dialogue with individual budget holders. Members noted that a draft budget report will be presented to the Board in due course. Take-away messages are that next year will be challenging, with a requirement to deliver significant savings without a solution to the Trust's historic PFI burden.

The Chairman commented that there had been a discussion at the Finance & Investment Committee. The likely shortfall is of the order of £20m, and we need a recovery plan. However, the Chairman advised that the plan must be a realistic and must be owned by the Board and the Senior Leadership Team. There is no appetite on the part of the Board to sign up to unrealistic savings that can only be delivered by cutting essential services or by one-off measures which deliver no long-term benefit.

Dr Nag left the meeting.

Ms Reilly referred to the application of Getting It Right first time (GIRFT) principles and to ongoing work to ensure the safety of services: these activities should lead to some savings in due course. The Trust needs to strike a balance between patient safety and financial recovery.

Mr Heslop commented that the Trust should ask the regulator to help the Trust identify areas of savings, whether through use of Model Hospital data or using other benchmarking tools. Mr Mason confirmed that the Trust is looking at various sources of information, but it seems unlikely that NHSE/I will make specific recommendations about areas in which they believe savings could safely be made.

Resolution

The Trust Board of Directors noted the update on the annual plan

Action

BoD/19/142 **STRATEGIC ISSUES AFFECTING THE TRUST**

The Chairman updated members on issues affecting the Trust and advised that there are ongoing discussions regarding managed clinical networks across the Tees Valley. He recognised that members were frustrated at the slow progress.

Resolution

The Trust Board of Directors noted the update on issues affecting the Trust

BoD/19/143 **FRIARAGE HOSPITAL NORTHALLERTON**

Mr Clements referred members to his previously circulated report and members noted that the urgent temporary change to services at the Friarage continues to be delivered safely. The consultation has been completed, and Hambleton, Richmondshire & Whitby CCG are now analysing the feedback. The Trust will move forward with work to sustain the urgent and acute care model and, whilst this process concludes, to develop the elective programmes on site and integrate the hospital with community services in this locality.

Mrs Hullick noted that the change that has been implemented has resulted in no harm to patients, and all the staff need thanks and support from the Board.

The Chairman noted that there had been some positive local publicity regarding the shift of elective services to the Friarage.

Ms Reilly advised that phase 2 of the improvement plan sets out the plan to maximise and expand the range of elective services provided at the Friarage and that additional orthopaedic services have already started to be provided, and plans are in place to provide ophthalmology services at the Friarage.

Mrs Hullick welcomed these developments and stressed the need to keep under review the risk of increased pressure on nurse staffing levels at the Friarage.

Resolution

The Trust Board of Directors noted the update on the Friarage Hospital

BoD/19/144 **ANNUAL FILINGS REPORT**

Mrs White updated members on the plan to deliver the annual filings for the Trust. Members noted that the Trust has a statutory requirement to produce a number of key documents as part of its annual filings following the end of the financial

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year. These include the Annual Report, Annual Accounts, Annual Governance Statement and Quality Report (Account).

Guidance has been received on production of the annual report and accounts. Guidance relating to the Quality Report and Annual Governance Statement is still outstanding.

A programme management approach has been established to oversee this work and a programme plan is attached which includes the key timeline of deliverables.

Mrs White commented that at this stage there are no issues or risks highlighted with the production of the annual filings. Whilst guidance is still outstanding the Quality Report and Annual Governance Statement will be drafted in line with previous guidance to ensure no delay.

However, in order to meet the drafting and final publication timetable, the Board of Directors is requested to delegate approval to the Quality Assurance Committee and Audit Committee for ongoing monitoring and approval.

Mr Mason commented that the external auditor has confirmed that they will stay on for next year and discussions are ongoing regarding the audit fee.

Mrs Hullick advised that the remuneration element of the annual report will need to be overseen by the Remuneration Committee.

Resolution

The Trust Board of Directors approved the delegation of ongoing monitoring and approval to the Audit Committee, Quality & Assurance Committee and Remuneration Committee

BoD/19/145 **CQC UPDATE**

Mrs Hunt presented the update on the CQC action plan to the Board. Members noted that there are now 161 actions, down from 164 due to one action being removed and other actions being combined. There are 15 red, 12 amber and 78 green actions as at the end of January 2020.

The Huddles and the Confirm and Challenge meetings continue with each action owner which means that a new level of scrutiny and rigour is being applied to the evidence. RAG ratings have been updated accordingly.

Mrs Hullick asked when DATIX cloud roll out will occur and Mr Oxley confirmed that the roll out is scheduled to last 9

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months, but that the DATIX incident and risk reporting will be implemented in the next couple of months. Mrs Hunt confirmed that a project group for the roll out was in place and associated training and engagement plans are being developed.

Mr Heslop asked Mrs Hunt about management of the relationship management with the CQC. Mrs Hunt confirmed that the Trust meets with the CQC every 8 weeks in additiona to a monthly conference call. A relationship meeting was held last week and the Trust invited the CCG and NHSE/I to the meeting.

Mrs Rutter reported that she had met with Mrs Angel regarding the ongoing assurance processes for CQC. Mrs Rutter advised that the South Tees Accreditation Process (STAQC) was being rolled out across the Trust which would provide this evidence. A paper is expected at the Quality Assurance Committee next month.

Resolution

The Trust Board of Directors noted the CQC update

BoD/19/146 **WELL LED SELF REVIEW ACTION PLAN AND UPDATE**

Mrs White referred members to the well led self-review action plan paper and reminded members that in December 2019, the Board undertook a self-review against the well led key lines of enquiry. The well led framework suggests that Trust should undertake an annual self-review against performance, three yearly external developmental reviews and a detailed review will be undertaken by the CQC.

The Board undertook a self-review in December 2019 and the review set out actions to move the Trust to good, taking into account the self-review of performance and CQC detailed review actions from February 2019.

Mr Ducker, referring to KLOE 3 (culture), commented that it would be useful to develop some indicators of the culture in the Trust. Mrs White confirmed that the staff survey, along with a number of other tools such as exit interviews, would be used as a baseline indicator for culture, and then a set of KPIs would be agreed to monitor this.

The Chairman welcomed the report and commented that it was good to see the output of the Board development session and that work had already progressed on the actions which had been agreed.

Resolution

Action

The Trust Board of Directors approved the Well Led self-review and received the update

BoD/19/147 **IMPROVEMENT PLAN**

Ms Fallon attended the meeting to present the improvement plan for the Trust. Members noted that the plan describes three phases of work that will provide stability to services requiring focussed support, alongside systematically reviewing each service and developing more integrated services across the Tees Valley, North Yorkshire and beyond. The Trust has undergone a number of leadership changes since the CQC Report and the 2019 Staff Survey. The Improvement Plan will be delivered in three concurrent phases and has been developed with lead clinicians through the recently established Clinical Policy Group. Phase 1 runs from now to March 2020, Phase 2 from now to March 2021 and Phase 3 from now until March 2022.

To support delivery of the Plan a significant degree of operational, cultural, learning and performance support will be provided to enable existing teams to deliver a range of early and measurable improvements.

Mrs Hullick commented that she felt the electronic patient record (EPR) was more than an enabler and asked where did it fit into the plan. Ms Fallon advised that the EPR was covered by IM&T in phase 1 but recognised that this part of the plan needed expanding.

Mrs Burns confirmed that the plan captured what the CEO had previously discussed with members: the plan should drive the agenda for both the Board and its sub committees, and this assurance model should be described in the accountability structure.

Mr Carter Ferris expressed concern about the large number of plans and actions for the Trust: the improvement plan should become the overarching strategy for improvement. Delivery plans, such as the CQC action plan, should sit within it. Ms Fallon confirmed that this was the approach which the Trust had agreed.

Mrs Rutter commented that the plans needed to be costed and robustly monitored which Ms Fallon agreed.

Resolution

The Trust Board of Directors received the improvement plan

Action

BoD/19/148 **COMMUNICATIONS AND ENGAGEMENT STRATEGY – UPDATE**

Mr Graham referred members to his previously circulated report and advised that, following approval in February 2019 of the Trust's Communication and Engagement Strategy, an updated communications and engagement strategy has now been developed to support the Trust's improvement journey.

Effective communication and engagement has formed a central part of the improvement plan's development and will be required to remain a key enabler throughout each phase of the plan's implementation,

The Chairman thanked Mr Graham for the updated Strategy.

Resolution

The Trust Board of Directors approved the Communication and Engagement Strategy

BoD/19/149 **CHAIRS LOGS FROM BOARD SUB COMMITTEES**

The Chairs of Committees referred members to their highlight reports and the following issues were escalated:

Workforce – the regional passport pilot will have significant implications for Tees Valley working and the Trust have asked for ED staff to be included in the pilot.

FIC – the committee had stressed the importance of developing a credible financial recovery plan for next year. FIC has been reviewing its terms of reference,and is in the final stages of drafting broader terms of reference to include estates, IT and broader performance metrics.

BoD/19/150 **ANY OTHER BUSINESS**

Mrs Hullick commented that as part of the Board walk round she had visited the refurbished theatres and thanked Mr Oxley for taking this forward.

BoD/19/151 **RISKS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK**

The Chair asked Mrs White to check whether cyber security risks were adequately reflected in the Board Assurance Framework.

BoD/19/152 **REFLECTIONS ON THE MEETING**

The Chair offered members the opportunity for reflections on the meeting. There was general agreement that there had been a good debate and discussion.

Action

BoD/19/153 **DATE AND TIME OF NEXT MEETING**

The next meeting will be on Tuesday 3 March 2020 and will be held at Langbaurgh House, Guisborough

Signed: ……

Date: ……

Board of Direction Action Log (meeting held in Public)

Date of Meeting	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
5.11.19	BoD/19/82	HEALTHCARE ASSOCIATED INFECTION MONTHLY REPORT	Mr Heslop advised that the online training for infection control hasn't changed, and perhaps the focus needs to be on behavioural changes going forward. Mrs Hunt agreed to look into the training.	G Hunt	31.3.20		open
3.12.19	BoD/19/114	CANCELLED OPERATIONS	The Chair asked that additional information on how well the Trust is doing compared to others would be useful. Mrs Dobson agreed to look in into this.	J Dobson	4.2.20 31.3.20	Work underway, extended deadline.	open
4.2.20	BoD/19/147	IMPROVEMENT PLAN	Improvement plan needed to be costed and robustly monitored	R Fallon	31.3.20		open
	BoD/19/144	ANNUAL FILINGS	The Trust Board of Directors approved the delegation of ongoing monitoring and approval to the Audit Committee, Quality & Assurance Committee and Remuneration Committee	J White	31.7.20		open

MEETING OF THE PUBLIC BOARD OF DIRECTORS - 3 March 2020			
VALUES AND BEHAVIOURS UPDATE			**AGENDA ITEM: 9, ENC 4**
Report Author and Job Title:	Rachael Metcalf HR Director	**Responsible Director:**	Rachael Metcalf HR Director
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	The report sets out an update for members on the work to revise and agree the Trust values and develop a behaviours framework associated with the Values.		
Background	The Trust values have been in place for some time and it was agreed by the staff engagement group that a review be undertaken. In support of the values the Trust needs to develop a set of behavioural standards which will help us to be more consistent in what we do and say to help people to feel cared for, safe and confident in their treatment.		
Assessment	Following review of the Trust values it has been recommended that the NHS Values which are described in this report be adopted. An initial workshop involving 40 staff from across the Trust has been held to look at the behaviours associated with the values. It is acknowledged that this process needs to involve as many staff as possible and therefore further workshops are being held during March and April. Following this the values and behaviours will be launched across the Trust.		
Recommendation	Members of the Trust Board are asked to acknowledge the progress so far and support the on-going work.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 5.1 (recruitment) - 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 BAF risk 5.2 (retention)- 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.		
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 ☐		

Values and behaviours update report

1. PURPOSE OF REPORT

The purpose of the report is to provide an update to Board regarding the work to review the Trust values and develop a set of behaviours.

With the values in place, teams, groups and organisations need to identify what behaviours support and contradict the values so that each of us can be clear about what's expected of us. Behaviours which demonstrate the values need to be reinforced whilst those that contradict them need to be challenged.

Being clear about the behaviours we commit to as an organisation will support us to become an employer of choice and help to ensure that whenever anyone engages with South Tees NHS Hospitals Foundation Trust, they have a consistent, positive experience.

2. BACKGROUND

The staff engagement group was established in the summer of 2019 and part of the work the group were asked to consider was the current Trust values which have not been reviewed for some time.

Alongside this, the Trust supported the national NHS pledges day in July 2019 and colleagues were asked to reflect on the NHS values and make a local pledge.

The feedback received from colleagues is that the Trust should adopt the NHS values rather than have individual Trust ones.

The current Trust Values

- Putting patients at the centre of everything we do
- Supporting, respecting and valuing each other
- Continuously improving quality
- Using our resources to the benefit of the wider community

NHS Core Values

Respect and dignity

We value each person as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

Commitment to quality of care

We earn the trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.

Compassion

We respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care.

Improving lives

We strive to improve health and well-being and people's experiences of the NHS. We value excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation.

Working together for patients

We put patients first in everything we do, by reaching out to staff, patients, carers, families, communities, and professionals outside the NHS. We put the needs of patients and communities before organisational boundaries.

Everyone counts

We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste others' opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier.

3. Values Workshop

An initial values workshop was held on 12 February 2020, the open invite went to all colleagues across the Trust and 40 participants attended from a variety of roles and areas.

Participants were asked to identify their top 3 values from a list of over 200. The results are shown below, with compassion being a value shared by all.

The second part of the session was a series of facilitated group discussions, where delegates considered both the positive and negative behaviours associated with each NHS core values.

The information from the session is being collated and will be shared via staff briefing.

4. Next Steps

Feedback received from the values workshop was positive and it has been recognised that the values workshop needs to be repeated across a number of Trust locations to ensure as many colleagues as possible have the opportunity to be involved to shape the Trust behaviours. These sessions will run throughout March and April.

Following full consultation with colleagues, the agreed Trust behaviours will then:

- be incorporated into individuals personal objectives and appraisals
- be developed into our values based recruitment
- be developed into a ‘brand’ and communicated in both our internal and external communications activities

- encourage dialogue about our behaviours during leadership interactions with colleagues, including walkrounds, to raise awareness and support opportunities for improvement

5. Recommendation

The Board are asked to acknowledge the progress so far and support the on-going work. Successfully embedding our values and behaviours in to all that we do and supporting NHS England to live its six behaviours requires a commitment from everyone, individually, as teams, as directorates and centres and as an organisation of 9000 people working in a matrix.

MEETING OF THE TRUST BOARD OF DIRECTORS – 3 March 2020			
Safe Staffing Report for January 2020 – Nursing, Midwifery and Allied Health Professionals (AHP)			**AGENDA ITEM: 10, ENC 5**
Report Author and Job Title:	Eileen Aylott, Assistant Director of Nursing Education and Workforce	**Responsible Director:**	Gill Hunt, Director of Nursing and Quality
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report details nursing, midwifery and AHP staffing levels (planned versus actual) for the month of January 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	The fill rate against planned rosters for the month of January 2020 at an overall level was: • RN / RM day shift 90.5% night shift 93.4% • Nursing Associates (NA) day and night shift 100% • HCSW day shift 99.2% night shift 112.2% • Trainee NA day and night shift 100%		
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 ☐		

Executive Summary

South Tees Hospitals NHS Foundation Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses (RN), Midwives (RM), Nursing Associates (NA) and Health Care Support Workers (HCSW), matches the acuity and dependency needs of patients within the organisation. To ensure there is an appropriate level and skill mix of staff to provide safe and effective high quality care.

The requirement to publish nursing and midwifery staffing levels on a monthly basis is explicit and is one of the ten expectations specified by the National Quality Board (2013 and 2016).

From April 2019 all staffing reports presented to the Board must comply with NHSI Workforce Safeguards and require a signed declaration by the Director of Nursing or appropriate Director for the staff group (s).

The fill rate against planned rosters for the month of January 2020 at an overall level was:

- RN / RM day shift 90.5% night shift 93.4%
- Nursing Associates (NA) day and night shift 100%
- HCSW day shift 99.2% night shift 112.2%
- Trainee NA day and night shift 100%

Monitoring of AHP workforce levels is included for the first time within this report and is based on planned v actual fill rates to align with the nursing report. More meaningful KPI's need to be developed for future months so that the report provides the detail required for this staff group.

1. Recommendation

The Board of Directors are asked to note the content of this report .

1. UNIFY Safe Staffing Return

The Trust's safer staffing submission to UNIFY for January 2020 was submitted on 17th February 2020 with the summary of overall fill rate in the table below with the full report in Appendix 1.

Table 1 – Overall UNIFY Return fill Rate 2019

2019	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
January 2019	96.8%	94.0%	96.0%	106.4%
February 2019	93.7%	94.7%	94.3%	108.4%
March 2019	92.8%	91.2%	94.2%	106.6%
April 2019	94.2%	94.7%	95.8%	105.8%
May 2019	92.7%	92.3%	95.4%	110.3%
June 2019	92.1%	96.5%	95.6%	111.6%
July 2019	89.2%	90.9%	94.3%	107.6%
August 2019	89.3%	95.5%	93.8%	109.2%
September 2019	88.1%	96.1%	91.8%	109.1%
October 2019	88.0%	94.7%	91.8%	110.5%
November 2019	88.9%	95.9%	90.8%	111.6%

Trust Average	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)
December 2019	87.1%	95.1%	100.0%	100.0%	90.0%	111.1%	100.0%	100.0%
January 2020	90.5%	99.2%	100.0%	100.0%	93.4%	112.2%	100.0%	100.0%

Centre Associate Directors of Nursing lead the twice daily SafeCare meetings Monday to Friday with Clinical Matrons providing weekend leadership in this area. Temporary staffing requirements are reviewed daily together with acuity, dependency and clinical judgement to ensure safe and efficient staffing.

Specialist Nurses, Critical Care Outreach and Corporate Nurses have all supported wards with complex patients and those with higher acuity and dependency but do not appear in the fill rate. Matrons provide oversight and assurance across their areas addressing red flags and supporting decision making.

Paediatric and Midwifery teams meet daily to review staffing across the floor and move staff accordingly. Unavailability is adjusted to meet the needs of the service with managers working

clinically as required to maintain safe staffing. The Paediatric wards and the Neonatal unit have been added to SafeCare to improve visibility.

Appendix 1. Details staffing fill rate by ward (i.e. planned versus actual), parenting and sickness percentage and a range of quality metrics by ward.

Further information in relation to wards with an RN fill rate of less than 80% is below:

1. Ward 9 Planned staffing for days were 5 RN and they have worked with 4 RN. Nights were 4 RN and they have worked with 3 RN's and 1 AP as the RSU did not require the 4th RN due to patient acuity (28 patients)
2. OPM planned staffing for days was 5 RN and they have worked with 3 RN's for 26 patients (RN:Pt ratio 1:9) Nights were planned 3 RN but worked with 2 RN and 4 HCA. There are also two international nurses on the ward, one has just obtained NMC registration and one is studying for OSCE
3. Ward 5 currently have closed beds with 2 RN working nights for an average of 24 patients (RN:Pt ratio 1:12)
4. CCU planned staffing for RN days was 7 RN and they have worked with 5 RN for 7 patients
5. Ainderby ward planned RN staffing for days were 4 RN and they have been working with 3 RN for 20 patients with Nursing Associate support and two international nurses studying for OSCE who worked during the last week of January (RN:Pt ratio 1:7)
6. Romanby ward planned staffing was 4 RN and they have worked with 3 RN for an average of 20 patients (ratio 1:7).
7. Rutson Ward planned staffing for days were 3 RN, they have worked with 3 RN mornings and 2 RM afternoons for an average of 13patients (RN:Pt ratio 1:7).

Critical Care

Nurse staffing is monitored on a daily basis and reported on a weekly basis to ensure compliance with safe staffing. There were no occasions in January where there were less than the required 3 supernumerary coordinators in the general critical care units.

Stroke Ward (W28)

If safe staffing cannot be maintained and all other options have been exhausted the escalation policy includes an option to temporarily reduce capacity. Due to RN workforce shortages 6 beds were reduced on ward 28 in July and remained closed. Three International Nurses have joined the team and have now all gained their NMC registration.

2. Temporary Staffing

The total number of hours requested for RN and HCA increased during January with a 68.5% fill rate overall. Agency staff have provided 836 hours of Nursing/ODP agency hours across Critical Care (ITU/GHDU), theatres and winter escalation beds.

Daily review of all shifts continues to take place during the morning SafeCare meeting with ADoN's to ensure both safe and efficient allocation of staff.

3. Red Flag Reporting

A total of 161 red flags have been reported during January. These are investigated by Clinical Matrons prior to the morning SafeCare meeting on a daily basis and action to address taken in real time. The predominant themes are Shortfall in RN time (77) and opening of 'amber' beds (51). Action taken to mitigate risk is captured on the system providing an audit trail or response to the alert.

Red Flags raised during December

Red Flag	Day	Night	Grand Total
AMBER Beds Open	38	13	51
Delay in providing pain relief	3	1	4
Less than 2 RNs on shift	4	3	7
Missed 'intentional rounding'	4	1	5
RED Beds Open	9	5	14
Shortfall in RN time	62	15	77
Vital Signs not assessed or recorded	3		3
Grand Total	**123**	**38**	**161**

Amber beds are used as part of routine escalation during surge and are managed within planned staffing levels. The system alerts the matron to the opening of amber beds which ensures the matron can support patient flow as required.

Any occasion where there are less than 2 RN's on a shift is always immediately addressed with staff redeployed to support.

4. Redeployed staff

SafeCare gives the Trust the ability to redeploy staff from an area with excess hours to one which is short using the acuity and dependency calculation to support patient care and ensure effective use of resource. During the month of January 2020 a total of 1103 hours were redeployed across adult inpatient areas via SafeCare.

5. Care Hours Per Patient Day (CHPPD)

CHPPD is a national measurement recorded monthly through the UNIFY safe staffing report and is a Model Hospital metric. Triangulation between hours planned vs hours worked in this report should be considered with CHPPD and professional judgement to ensure areas have safe and efficient levels of staffing. The Model Hospital metric also provides the Trust with a peer review option to enable us to compare with hospitals of a similar size and complexity as well as the National trend. The latest Trust result published on the Model Hospital website are from November 2019 and was 8.9 against a peer group median of 7.9 and a national median of 8

.

6. Recruitment Activity

The forth cohort of 8 international RN's arrived on 31st January 2020 and were deployed to Cardiac Catheter Lab, Ward 26, Ward 9 (x2), Ward 7 and Critical Care (x3).

A task and finish group met in January to review the nurse recruitment process and literature to form a new recruitment campaign. Teesside University have kindly offered 2/3 media students to help produce new recruitment video's and media materials to promote nursing and midwifery.

7. Workforce Safeguards

Adult inpatient wards, Paediatrics, Theatres and Community Nursing have completed Safe Staffing reviews during January as required in accordance with National Quality Board Guidance and reports will be written during February to present to The Nursing, Midwifery and AHP Workforce Assurance Group and then to Workforce Committee.

Meetings have been undertaken with Service Managers and will continue throughout February 2020 to review staffing in OPD's which will be reported as part of the June 2020 cycle.

Emergency Department Safe staffing is based on yearly attendance figures so will be completed in April to ensure it includes a full data set. NHSI will support with data analysis if the SNCT tool has not been published at this point.

Dates for Midwifery Birthrate+ and Neonatal Safe Staffing reporting will be agreed with Head of Midwifery.

8. Community Nursing

The Community SNCT was undertaken during January 2020 and the first report will be written and submitted with all the other reports mentioned above. The ADoN for Community Care is currently working with the Primary Care Networks to align services.

9. AHP Staffing Review for UNIFY report

In October 2018 NHS Improvement published 'Developing Workforce Safeguards' which includes mandatory guidance for NHS providers to follow. Trusts are required to confirm in an annual statement that staffing governance processes are safe and sustainable, inclusive of a multi-disciplinary approach including the whole workforce required to deliver the activity. Further to this CHPPD guidance in July 2019 advised that 'all clinical staff within the ward establishment and budget who are rostered and contribute to care provision' solely to that ward should be included.

Within the organisation budgets are not aligned to include all clinical staff who provide care to a ward area, however we do have specific teams who provide staff who solely work on specific ward areas. As such to monitor compliance areas where AHP staff work solely to a designated

ward e-roster groups have been aligned to those ward areas for monitoring purposes. These areas are General Critical Care, Critical Care Cardiothoracic, Acute Stroke, Spinal Injuries, East Cleveland, Friary and Rutson. The staff groups included for these areas are Physiotherapists, Occupational Therapists and their unregistered support staff.

To consider the staffing required for these areas the actual registered and unregistered staffing has been compared to the planned staffing as indicated in the table below. The parameters used for RAG rating of fill rates in this report are based on the nursing targets of less than 80% being red, 80-95% amber and above 95% green. However in areas outside registered critical care there is no headroom allocation for the therapy teams, this is not uncommon is the AHP workforce and may warrant further review.

As AHP reporting evolves refinement of data in addition to fill rates will be required, many teams are small in terms of Wte (particularly in unregistered staff) meaning percentage compliance is potentially not the most meaningful measure. The Head of Professions has joined the CNO 'Safe Staffing Faculty' and in the coming months is working to establish meaningful KPI's.

Initial review of the table below shows relatively poor compliance against the parameters with on average less than two thirds of shifts filled across the clinical areas. The low level of unregistered staffing in a number of areas should be noted as small changes will have a significant impact on actual staffing. In particular when viewing unregistered staffing within both critical care areas, Spinal Injuries and the Friary the planned hours are based on 1 or 2 individuals with no headroom for cover. As such any one individual's absence from work will significantly affect the fill rate.

Clinical leads are reviewing planned staffing levels to ensure these are realistic in relation to actual budgeted establishment. Another point to highlight is that vacancies are not routinely covered as temporary staffing is not readily available so this will impact areas where vacancies are apparent.

						< 80	80-95	> 95
		Hours				Average fill rate -Reg (%)		Average fill rate - Unreg (%)
		Planned Reg Hours	Actual Reg Hours	Planned Unreg Hours	Actual Unreg Hours			
UEC	**UECC Therapists Critical Care - ICU**	1,289.00	1,055.75	171.50	85.50	81.9%		49.9%
UEC	**UECC Therapists Critical Care - Cardio**	1,080.50	691.25	172.50	165.00	64.0%		95.7%
SP&PL	**SPCT Acute Stroke**	1,267.50	700.50	675.00	450.00	55.3%		66.7%
SP&PL	**SPCT Spinal Injuries**	1,350.00	1,011.00	157.50	150.00	74.9%		95.2%
COMM	**Community Therapists ECPCH**	1,275.00	577.50	810.00	475.00	45.3%		58.6%
COMM	**Community Therapists Friary**	315.00	189.63	97.50	6.00	60.2%		6.2%
COMM	**Community Therapists Rutson**	765.00	605.90	307.50	148.25	79.2%		48.2%
	Totals	7342	4831.53	2391.5	1479.75	65.8%		60.1%

Further detail for each area is provided below;

UEC Therapists Critical Care ICU

The low compliance with unregistered shifts was due to one therapy assistants unavailability. The total hours lost were 85 and the team were supported from other resource to maintain safety.

UEC Critical Care Therapists Cardiothoracic

The planned staffing levels have been reset on e-roster and this will not take effect until this month, therefore compliance does not reflect appropriately.

SPCT Acute Stroke

The fill rate of registered Occupational Therapy (OT) shifts has been negatively affected due to unplanned leave and vacancies. Due to the shortage of staff in the team occupational therapy provision has been temporarily reduced from 6 days to Monday to Friday 5 day service. Total shortfall in physiotherapy and OT staff is 2.7wte excluding. This is equivalent to 27.8% vacancy rate for the team. The stroke team are closely monitoring the impact against the national standards with a report expected March 2020. In its anticipated that the team will be fully staffed by May 2020.

SPCT Spinal Injuries

The team has 1wte Band 7 vacancy and 0.6wte unregistered staff vacancy. The unregistered vacancy has already been recruited into and we are now awaiting a start date. The band 7 post is awaiting interviews. The unregistered vacancy has been filled using additional hours and hence the 95% fill rate despite the vacancy.

Current vacancy rate for team is 17%. The team should be fully staffed by May 2020.

Community Therapists

The low fill rate within community teams is being monitored with recruitment in progress. It is noted that current compliance against the target of providing 95% new patient assessment within 24hrs is not achieved due to current staffing levels. Assessments are prioritised and the target is achieved within 72hrs however this is an on-going pressure.

East Cleveland PCH

At ECPCH as well as carrying vacancies and long term sickness the staffing model is subject to a consultation. Changes in the e-roster model will be applied when fully agreed post-consultation. This is expected to be complete in March.

Friary

The Friary has the smallest team in this review with total planned hours of only 412.5 as such any leave will give large fluctuations as is noted by the only unregistered staff member not being available and as such showing a fill rate of only 6%. The team is supported by community based colleagues to ensure care needs are met in priority order.

Rutson

The team at Rutson is comprised of small groups of staff. The Rutson registered staff total 4.27wte and unregistered 1.5wte with no headroom for cover. Current registered staff vacancy of 0.5wte equates to 11% of the workforce. The unregistered staffing is based on 2 staff so large fluctuations in fill rate occur with any absence. Mitigation to ensure safety is provided through all in-patient therapy teams based at FHN working collectively and prioritising care across the site through the designated lead.

Eileen Aylott, Assistant Director of Nursing Workforce and Rob Goddard, Head of Professions
February 2020

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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

Appendix 1 JCUH

	James Cook																	< 80	80-95	> 95																			
		Hours																DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)	Parenting	Sickness	Parenting	Sickness	Formal Complains	Inpitent Falls	Trust acquired grade 2 PU	Trust Aquired Grade 3 PU	CHPPD	Registered Midwives/ Nurses	Care Staff	Overall
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned NA Days	Actual NA Days	Planned TNA Days	Actual TNA Days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	Planned NA Nights	Actual NA Nights	Planned TNA Nights	Actual TNA Nights																						
UEC	Critical Care	10,398.67	10,093.83	2,267.83	1,991.83					10,416.00	10,206.33	984.00	845.33					97.1%	87.8%	-	-	98.0%	85.9%	-	-	8.40%	6.20%	4.30%	8.50%			17	1	826	24.6	3.4	28.0
UEC	RAFAU	2,141.17	1,996.50	1,639.07	1,737.58	132.00	132.00			1,115.50	1,092.17	1,288.50	1,350.83					93.2%	106.0%	100.0%	-	97.9%	104.8%	-	-	6.60%	4.40%		5.50%		10		1	851	3.6	3.6	7.2
SP&PL	JC06 Gastro	1,069.00	1,176.25	1,419.08	1,412.42					1,069.50	931.92	713.08	978.00					110.0%	99.5%	-	-	87.1%	137.2%	-	-		3.30%		19.00%	1	5	2		749	2.8	3.2	6.0
COM	JC09 (Ward 9)	1,849.50	1,473.75	1,418.17	1,369.67			72.00	72.00	1,488.00	1,079.83	1,083.75	1,129.25			24.00	24.00	78.7%	96.6%	-	100.0%	72.6%	104.2%	-	100.0%	4.90%	4.20%		16.60%		3	1	1	787	3.2	3.2	6.4
COM	OPM (Older Persons Medicine)	1,904.47	1,453.32	2,230.90	2,054.33					1,116.00	768.00	1,116.00	1,782.17					76.3%	92.1%	-	-	68.8%	159.7%	-	-	8.60%	9.00%	2.20%	12.30%		9	2		832	2.7	4.6	7.3
COM	JC28 (Ward 28)	1,484.10	1,348.93	1,116.33	960.08					1,488.00	1,404.00	744.00	760.67					90.9%	86.0%	-	-	94.4%	102.2%	-	-	4.50%	3.00%	4.60%	10.50%		6			439	6.3	3.9	10.2
COM	Ward 3	1,421.83	1,336.58	1,782.75	1,919.50					1,081.83	903.50	722.50	966.00					94.0%	107.7%	-	-	83.5%	133.7%	-	-		15.10%	5.80%	4.90%		6			845	2.7	3.4	6.1
UEC	Short Stay (JC02)	1,845.67	1,768.00	1,436.33	1,448.33			48.00	48.00	1,476.00	1,284.00	1,116.00	1,169.33					95.8%	100.8%	-	100.0%	87.0%	104.8%	-	-		15.70%		12.30%		8	2		813	3.8	3.2	7.0
SP&PL	Ward 5 Surgery	1,857.25	1,647.25	1,860.00	1,738.33					1,116.00	780.00	1,116.00	1,036.67					88.7%	93.5%	-	-	69.9%	92.9%	-	-	10.50%	1.20%	5.50%	7.10%		3			620	3.9	4.5	8.4
SP&PL	JC35 (Ward 35)	1,489.25	1,396.92	1,856.58	1,618.25					1,116.00	1,032.00	1,116.00	1,200.00					93.8%	87.2%	-	-	92.5%	107.5%	-	-	5.60%	1.60%		3.30%		6			746	3.3	3.8	7.0
SP&PL	JC31 Vas	1,042.75	1,070.75	1,423.50	1,395.50	90.00	90.00	30.00	30.00	720.00	720.00	672.00	696.00	36.00	36.00	60.00	60.00	102.7%	98.0%	100.0%	100.0%	100.0%	103.6%	100.0%	100.0%	12.20%	7.20%		4.40%		3	1		483	3.7	4.3	8.0
SP&PL	Ward 7 Colo	1,860.00	1,316.42	1,858.00	1,691.58					1,116.00	984.00	744.00	1,147.33					70.8%	91.0%	-	-	88.2%	154.2%	-	-	5.10%	12.10%		13.40%		4	1		782	2.9	3.6	6.6
SP&PL	JC04 (Ward 4)	1,642.25	1,496.08	1,116.00	1,288.83					1,110.83	1,074.83	740.33	790.33					91.1%	115.5%	-	-	96.8%	106.8%	-	-	5.30%	2.30%	8.00%	7.70%			4		700	3.7	3.0	6.6
SP&PL	JC14 Oncology (Ward 14)	1,867.83	1,599.50	1,014.50	1,228.17			96.00	96.00	1,111.50	1,099.17	744.00	873.33					85.6%	121.1%	-	100.0%	98.9%	117.4%	-	-	4.50%	18.80%	6.90%	5.60%		2	1		671	4.0	3.1	7.2
SP&PL	JC33 Specialty (merger of ward 18 and ward 27)	1,486.00	1,316.50	1,342.75	1,076.25			144.00	144.00	1,115.50	1,103.50	738.00	764.83					88.6%	80.2%	-	100.0%	98.9%	103.6%	-	-		5.30%		6.70%		1			575	4.2	3.2	7.4
SP&PL	JC34 (Ward 34)	1,446.67	1,473.83	1,965.08	1,545.58	54.00	54.00	96.00	96.00	1,068.00	1,080.00	1,479.33	1,455.33	48.33	48.33	12.00	12.00	101.9%	78.7%	100.0%	100.0%	101.1%	98.4%	100.0%	100.0%	5.50%	2.30%		12.90%		3	6	1	980	2.6	3.1	5.7
SP&PL	JC25 Elective Ortho	1,072.20	921.37	1,083.47	1,127.13					717.00	707.67	358.17	764.83					85.9%	104.0%	-	-	98.7%	213.5%	-	-		24.10%		12.60%	1	3			614	2.7	3.1	5.7
SP&PL	JC36 Trauma	1,849.00	1,569.00	1,870.15	1,898.32					1,118.00	1,081.67	1,122.50	1,388.17					84.9%	101.5%	-	-	96.8%	123.7%	-	-	4.30%	8.00%		21.80%		6	2		1001	2.6	3.3	5.9
SP&PL	Spinal Injuries	2,519.75	2,346.27	1,937.53	1,671.08					1,488.00	1,488.00	1,116.00	1,088.67					93.1%	86.2%	-	-	100.0%	97.6%	-	-	12.70%	7.90%	8.10%	8.90%		1			364	10.5	7.6	18.1
SP&PL	Cardio MB	744.00	762.00	371.00	401.75					744.00	720.00	0.00	180.67					102.4%	108.3%	-	-	96.8%	-	-	-		8.90%		65.40%					248	6.0	2.3	8.3
SP&PL	CCU JCUH	2,652.00	1,962.00	370.17	580.00					1,860.00	1,848.00	0.00	0.00					74.0%	156.7%	-	-	99.4%	-	-	-	3.20%	1.00%		5.10%		1			305	12.5	1.9	14.4
UEC	CICU JCUH	3,682.17	3,571.08	651.00	624.00					3,660.00	3,483.00	600.00	504.00					97.0%	95.9%	-	-	95.2%	84.0%	-	-	5.30%	4.30%	8.60%	20.10%		1	5		274	25.7	4.1	29.9
SP&PL	JC24 (Ward 24)	1,483.58	1,377.00	1,083.00	1,435.17			93.00	93.00	1,118.00	1,046.50	720.00	956.67			24.00	24.00	92.8%	132.5%	-	100.0%	93.6%	132.9%	-	100.0%		6.10%		2.80%		6			670	3.6	3.6	7.2
SP&PL	JC27 Neuro	1,443.92	1,389.75	1,146.92	1,124.50					744.00	733.08	960.00	1,108.67					96.2%	98.0%	-	-	98.5%	115.5%	-	-		7.40%		31.40%		1	1		488	4.4	4.6	8.9
SP&PL	JC26 (Ward 26)	1,138.25	946.25	737.67	1,514.08					744.00	745.33	372.00	1,166.33					83.1%	205.3%	-	-	100.2%	313.5%		-	3.40%	8.70%				7			384	4.4	7.0	11.4
SP&PL	JC29 (Ward 29)	1,486.00	1,420.00	1,112.67	1,071.33					1,104.00	1,032.00	744.00	781.33	12	12			95.6%	96.3%	-	-	93.5%	105.0%	100.0%	-		5.80%	0.80%	7.60%		6	3		727	3.4	2.5	5.9
SP&PL	JCCT (Ward 32)	1,850.08	1,579.92	1,248.00	1,216.83					1,115.33	935.33	743.33	936.83					85.4%	97.5%	-	-	83.9%	126.0%	-	-	8.40%	8.30%		5.20%		1			620	4.1	3.5	7.5
UEC	Cardio HDU	2,112.25	2,002.33	312.00	317.67			60.00	60.00	1,740.00	1,548.00	348.00	348.00			24.00	24.00	94.8%	-	-	100.0%	89.0%	-	-	100.0%	3.30%	3.40%							228	15.6	2.9	18.5
SP&PL	Ward 8	1,864.08	1,641.92	1,746.00	1,449.33					1,110.25	1,110.25	743.42	1,079.42					88.1%	83.0%	-	-	100.0%	145.2%	-	-	4.00%	9.20%		30.70%	1	3	1		885	3.1	2.9	6.0
UEC	JC24 HDU	1,491.58	1,447.50	372.00	360.00					1,488.00	1,407.75	372.00	374.00					97.0%	96.8%	-	-	94.6%	100.5%	-	-	1.70%	4.00%		11.10%					184	15.5	4.0	19.5
COM	JC21 (Ward 21)	2,232.00	2,118.00	744.00	696.00					2,232.00	2,004.00	516.00	366.00					94.9%	93.5%	-	-	89.8%	70.9%	-	-	4.60%	4.10%		1.90%	1				436	9.5	2.4	11.9
COM	JC22 (Ward 22)	1,114.00	1,199.50	594.00	576.00					1,020.00	996.00	216.00	228.00					107.7%	97.0%	-	-	97.6%	105.6%	-	-		5.00%							271	8.1	3.0	11.1
COM	JCDS (Central Delivery Suite)	3,899.50	3,663.25	1,043.00	778.50					4,083.67	3,987.42	744.00	740.00					93.9%	74.6%	-	-	97.6%	99.5%	-	-	1.50%	4.50%		7.80%					623	12.3	2.4	14.7
COM	Neonatal Unit	5,745.48	5,162.48	372.00	282.00					5,204.50	4,900.00	0.00	120.00					89.9%	75.8%	-	-	94.1%	-	-	-	6.90%	11.40%	15.50%	27.40%					661	15.2	0.6	15.8
COM	Paediatric Intensive Care Unit (PICU)	1,860.00	1,489.50	229.50	160.50					1,860.00	1,447.00	0.00	0.00					80.1%	69.9%	-	-	77.8%	-	-	-	6.00%	7.30%							76	38.6	2.1	40.8
COM	Ward 17 JCUH	2,229.17	2,106.92	888.00	717.00			60.00	60.00	1,487.67	1,499.67	1,031.67	863.67			36.00	36.00	94.5%	80.7%	-	100.0%	100.8%	83.7%	-	100.0%	12.10%	9.30%	5.50%	11.30%	1				806	4.5	2.0	6.4
COM	Ward 19 Ante Natal	1,257.00	1,108.00	316.00	301.00					744.00	732.00	0.00	0.00					88.1%	-	-	-	98.4%	-	-	-		2.30%		27.00%					306	6.0	1.0	7.0
																	Site average	91.3%	99.9%	100.0%	100.0%	92.7%	120.5%	100.0%	100.0%												

	FHN	Hours																< 80	80-95	> 95																	
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned NA Days	Actual NA Days	Planned TNA Day	Actual TNA Days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	Planned NA Nights	Actual NA Nights	Planned TNA Night	Actual TNA Nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)	Parenting	Sickness	Parenting	Sickness	Formal Complaints	Inptient Falls	Turst aquired grade 2 PU	Trust Aquired Grade 3 PU	CHPPD	Registered Midwives/Nurses	Care Staff	Overall
UEC	Ainderby FHN	1,235.33	933.83	1,070.50	1,094.17	172.50	172.50			713.00	717.00	714.33	761.33					75.6%	102.2%	100.0%	-	100.6%	106.6%	-	-	7.80%	11.60%		3.70%		4	1		630	2.6	2.9	5.6
UEC	Romanby FHN	1,552.98	1,178.65	1,101.00	1,230.00					713.00	713.00	713.00	816.50					75.9%	111.7%	-	-	100.0%	114.5%	-	-		1.50%	6.60%	4.00%		2	2		630	3.0	3.2	6.3
COM	Rutson FHN	1,136.45	875.48	1,646.08	1,171.13					713.00	713.00	713.00	713.00					77.0%	71.1%	-	-	100.0%	100.0%	-	-	12.90%	9.50%	6.30%	4.40%			1		481	3.3	3.9	7.2
SP&PL	Gara Orthopaedic FHN	791.25	789.25	728.00	705.00					714.33	702.83	357.52	357.52					99.7%	96.8%	-	-	98.4%	100.0%	-	-	8.70%	1.70%		3.80%			1		295	5.1	3.6	8.7
COM	Maternity FHN	1,036.50	1,038.00	148.50	167.50			24.00	24.00	744.00	732.00	0.00	0.00					100.1%	112.8%	-	100.0%	98.4%	-	-	-	3.50%	5.20%							11	160.9	15.2	176.1
																	Site Average	85.7%	98.9%	100.0%	-	99.5%	105.3%	-	-												

	East Cleveland	Hours								< 80	80-95	> 95													
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	Parenting	Sickness	Parenting	Sickness	Formal Complaints	Inptient Falls	Turst aquired grade 2 PU	Trust Aquired Grade 3 PU	CHPPD	Registered Midwives/Nurses	Care Staff	Overall
COM	Tocketts Ward East Cleveland Hospital	1,460.98	1,250.73	1,768.88	1,721.63	1,087.50	889.50	1,450.33	1,234.75	85.6%	97.3%	81.8%	85.1%		19.20%		21.20%		7	2		795	2.7	3.7	6.4
									Site Average	85.6%	97.3%	81.8%	85.1%												

	Redcar	Hours																< 80	80-95	> 95																	
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned NA Days	Actual NA Days	Planned TNA Day	Actual TNA Days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	Planned NA Nights	Actual NA Nights	Planned TNA Night	Actual TNA Nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)	Parenting	Sickness	Parenting	Sickness	Formal Complaints	Inptient Falls	Turst aquired grade 2 PU	Trust Aquired Grade 3 PU	CHPPD	Registered Midwives/Nurses	Care Staff	Overall
COM	Zetland	1,519.75	1,449.25	2,656.82	2,470.82					1,116.00	1,056.00	1,116.00	1,140.83					95.4%	93.0%	-	-	94.6%	102.2%	-	-		7.20%		6.50%		3	3		877	2.86	4.12	6.97
																	Site Average	95.4%	93.0%	-	-	94.6%	102.2%	-	-												

	Friary Community Hospital	Hours																< 80	80-95	> 95																	
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned NA Days	Actual NA Days	Planned TNA Day	Actual TNA Days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	Planned NA Nights	Actual NA Nights	Planned TNA Night	Actual TNA Nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)	Parenting	Sickness	Parenting	Sickness	Formal Complaints	Inptient Falls	Turst aquired grade 2 PU	Trust Aquired Grade 3 PU	CHPPD	Registered Midwives/Nurses	Care Staff	Overall
COM	Friary Community Hospital	1,028.25	968.42	1,366.83	1,126.08			12.00	12.00	623.75	625.25	626.75	596.75					94.2%	82.4%	-	100.0%	100.2%	95.2%	-	-		3.80%							439	3.63	3.92	7.55
																	Site Average	94.2%	82.4%	-	100.0%	100.2%	95.2%	-	-												

	James Cook	Hours																< 80	80-95	> 95																	
		Planned RN days	Actual RN days	Planned HCA days	Actual HCA days	Planned NA Days	Actual NA Days	Planned TNA Day	Actual TNA Days	Planned RN Nights	Actual RN nights	Planned HCA nights	Actual HCA nights	Planned NA Nights	Actual NA Nights	Planned TNA Night	Actual TNA Nights	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)	Parenting	Sickness	Parenting	Sickness	Formal Complaints	Inptient Falls	Turst aquired grade 2 PU	Trust Aquired Grade 3 PU	CHPPD	Registered Midwives/Nurses	Care Staff	Overall
UEC	Ac&Em -J	7,052.83	6,806.83	2,467.17	1,491.67	94.00	94.00	42.00	42.00	5,484.00	5,683.17	1,961.67	1,449.67	189.00	189.00	63.00	63.00	96.5%	60.5%	100.0%	100.0%	103.6%	73.9%	100.0%	100.0%	2.50%	3.90%	5.90%	15.50%	3	1						
UEC	AMU JCUH	2,592.67	2,232.67	1,482.00	1,702.17					2,232.00	1,980.00	1,488.00	1,812.00					86.1%	114.9%	-	-	88.7%	121.8%	-	-	6.60%	8.30%		1.70%		6	1	1	775	5.44	4.53	9.97
UEC	AAU JCUH	2,976.00	2,943.50	1,752.83	1,707.08					1,854.00	1,806.00	1,116.00	1,267.33					98.9%	97.4%	-	-	97.4%	113.6%	-	-	9.60%	5.90%		15.50%		7	2		667	7.12	4.46	11.58
COM	Mat Assessment Unit	1,547.33	1,470.08	279.00	207.00					837.50	777.50	0.00	0.00					95.0%	74.2%	-	-	92.8%	-	-	-	5.70%	4.20%		11.20%					48	46.82	4.31	51.14
	Theatres																																				
UEC	MT Mixed Specialty	3,778.92	3,656.42	2,758.25	2,519.65					310.00	310.00	310.00	300.00					96.8%	91.3%	-	-	100.0%	96.8%	-	-		6.70%		3.20%								
UEC	MT Orthopaedics	2,116.25	1,738.50	1,894.75	1,823.00			10.00	10.00	310.00	310.00	310.00	310.00					82.2%	96.2%	-	100.0%	100.0%	96.8%	-	-	5.40%	10.70%		6.70%								
UEC	MT General Theatres	3,843.00	3,499.25	3,368.50	2,630.50	143.00	143.00	31.00	31.00	930.00	930.00	620.00	620.00					91.1%	78.1%	100.0%	100.0%	100.0%	100.0%	-	-	3.00%	9.40%	1.40%	9.40%								
UEC	MT Anaes & Rec	9,707.25	7,605.25	996.50	1,392.50					930.00	930.00	0.00	0.00					78.3%	139.7%	-	-	100.0%	-	-	-	1.40%	14.20%		7.90%								
UEC	Theatres FHN	5,696.03	4,996.95	2,831.25	1,865.25	142.50	142.50			0.00	0.00	0.00	0.00					87.7%	65.9%	100.0%	-	-	-	-	-	2.00%	3.70%		7.40%								
	FHN																																				
UEC	Clinical Decisions Unit FHN	1,782.83	1,367.50	1,071.33	1,325.17					1,069.50	1,003.83	713.00	713.00					76.7%	123.7%	-	-	93.9%	100.0%	-	-	15.70%	5.90%	1.80%	8.00%		7		1	531	4.47	3.84	8.30

	< 80	80-95	> 95					
	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	DAYS Average fill rate - NA (%)	DAYS Average fill rate - TNA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)	NIGHTS Average fill rate - NA (%)	NIGHTS Average fill rate - TNA (%)
Trust Average								
Community Care	90.4%	87.8%	100.0%	100.0%	90.8%	103.5%	100.0%	100.0%
Specialist & Planned Care	91.2%	106.2%	100.0%	100.0%	94.8%	131.3%	100.0%	100.0%
Urgent and Emergency Care	89.8%	103.7%	100.0%	100.0%	94.7%	101.7%	100.0%	100.0%
Trust Average	90.5%	99.2%	100.0%	100.0%	93.4%	112.2%	100.0%	100.0%

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PULBIC BOARD OF DIRECTORS – 3 March 2020			
Healthcare-associated infection (HCAI) report for January 2020			**AGENDA ITEM: 11, ENC 6**
Report Author and Job Title:	R Bellamy, Infection Control Doctor, JCUH A Ndhlovu, Lead Nurse, IPC Helen Day, Deputy Director of Nursing/Deputy DIPC Gill Hunt, Director of Nursing and Quality/ DIPC	**Responsible Director:**	Gill Hunt, Director of Nursing and Quality/ DIPC
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	The Board of Directors are asked to note the current position in respect of HCAI and for their support for the actions being taken.		
Background	The report summarises surveillance information on healthcare-associated infections for the month of January 2020; and also highlights antimicrobial stewardship and environmental cleaning in relation to HCAI management. Enhanced actions that have been put in place as a response to an increased number of *C. difficile* cases have been summarised in appendix 1 of this report. National reporting of Influenza cases started week commencing 30th September 2019, focusing on critical care areas and this report provides an update.		
Assessment	The organisation remains above trajectory for Clostridium difficile infection. The report provides an update on the recent outbreaks and assurance that robust action has been taken and policy followed.		
Recommendation	The Board of Directors are asked to: note the current position in respect of HCAI and for their support for the actions being taken.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 2.1 - An infection outbreak (such a influenza; norovirus; infections resistant to antibiotics and CDiff) may result in avoidable patient harm and could adversely impact on delivery of key performance indicators		
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 ☐		

1. Executive Summary

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, *Methicillin Resistant Staphylococcus aureus* (MRSA) and *Methicillin Sensitive Staphylococcus aureus* (MSSA) bacteraemia, bacteraemia due to *glycopeptide-resistant Enterococci,* bacteraemia due to three Gram negative bacteria *(Escherichia coli* (*E. coli*), *Klebsiella* species. and *Pseudomonas aeruginosa)*, Extended Spectrum Beta Lactamase (ESBL)-producing coliform infections and other important healthcare-associated infections for the month of January 2020. The report also highlights antimicrobial stewardship and environmental cleaning in relation to HCAI management.

In response to the high incidence of *C. difficile* enhanced actions have been implemented. These actions have been summarised in appendix 1 of this report and include:

- Weekly cleaning standards meetings with Serco
- Weekly action focussed IPC 'huddle' with matrons
- Launch of 'glove awareness' campaign to reduce overuse (associated audit)
- Actions to support the use of patient hand hygiene wipes at mealtimes
- Review and respond to the external cleaning audit on the JCUH site

- The *Clostridium difficile*-associated diarrhoea objective for 2019/20 is to have no more than a combined total of 81 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There were 2 COHA + 5 HOHA cases in January 2020. There have been 79 COHA + HOHA cases in the first 10 months of 2019/20. We are currently over trajectory.

- The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There were 0 trust-assigned cases in January 2020. There has been 1 trust-assigned case and 1 potentially trust-assigned case in the first 10 months of 2019/20.

- There is no official MSSA bacteraemia target for 2019/20. There were 3 trust-apportioned cases in January 2020. There have been 38 trust-apportioned cases in the first 10 months of 2019/20.

- There has been an outbreak of *Serratia marcescens* infection affecting patients who have been treated in cardiothoracic ICU and/or HDU and/or Ward 32. At the time of writing (4th February 2020) there have been 5 confirmed cases, 5 probable cases and 26 excluded cases.

- The Trust has responded to instruction by NHSE/I to set up COVID-19 (Novel Wuhan Coronavirus) assessment and screening 'pods' which are now in place at JCUH and a 111 facility at FHN. At the time of writing (14 February 2020) there have been nine confirmed cases to date in the UK, there have been no positive results of the patients screened to date within the Trust.

2. Recommendation

The Board of Directors are asked to note the current position in respect of HCAI.

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1. SURVEILLANCE DATA

The 2019/20 *C. difficile* definitions are as follows:

a) Hospital onset healthcare associated (HOHA): cases detected in the hospital ≥2 days after admission.
b) Community onset healthcare associated (COHA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
c) Community onset indeterminate association (COIA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks.
d) Community onset community associated (COCA): cases that occur in the community (or within <2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

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

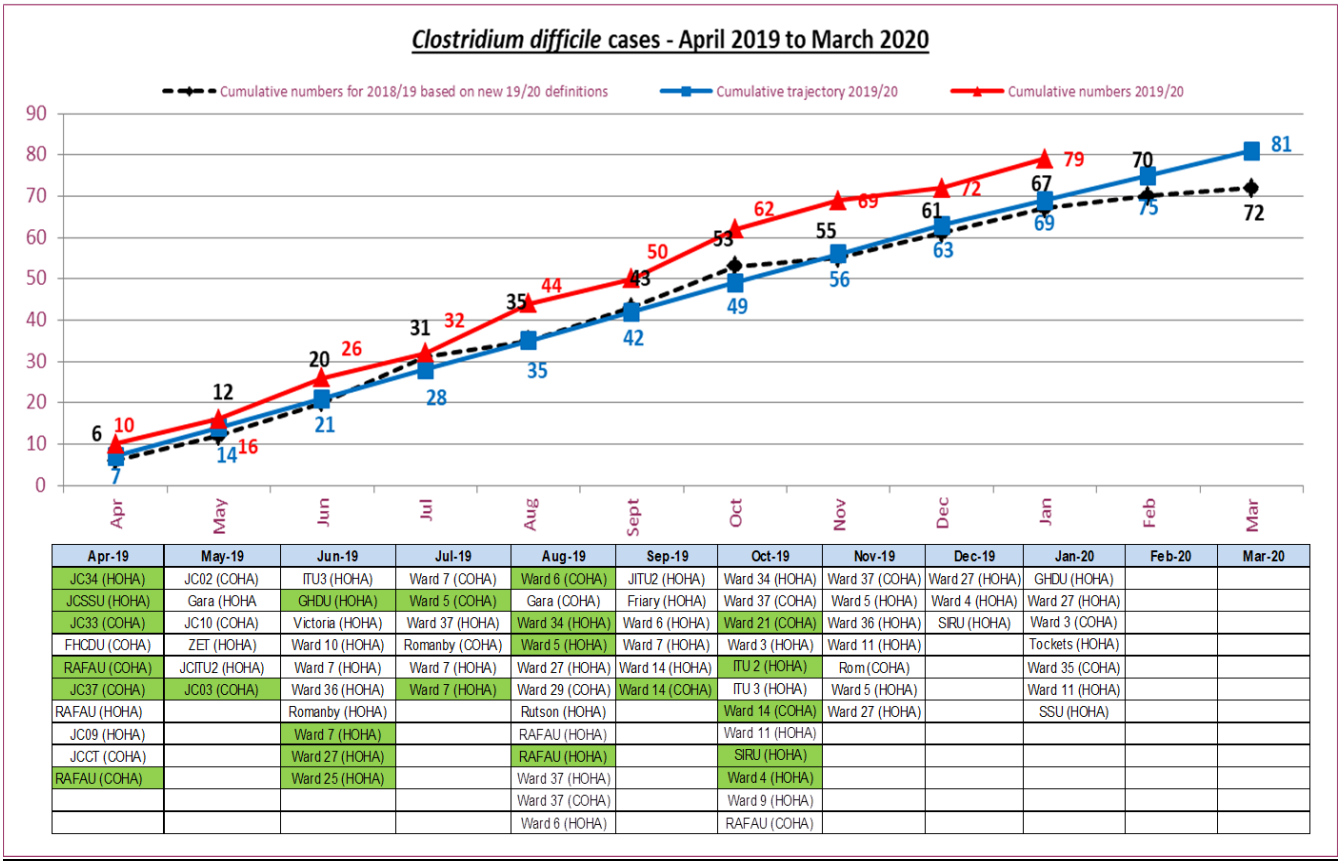
1.1 Clostridium difficile

C diff	Total 2018/19	Feb 19	Mar 19	Apr 19	May 19	June 19	July 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Total 2019/ 20 to date	Target for 2019/20
Total cases	120	5	6	18	7	14	14	19	10	23	12	8	11	136	NA
Not trust apportioned	79	3	5	8	1	4	8	7	4	11	5	5	4	57	NA
Trust-apportioned	41	2	1	10(4)	6(3)	10(10)	6(3)	12(8)	6(5)	12(8)	7(5)	3(3)	7(5)	79(54)	**81**
- JCUH	33	1	1	10	4	8	4	10	5	11	6	3	6	67	
-FHN	3	0	0	0	1	1	2	1	0	1	1	0	0	7	
-Redcar	2	0	0	0	1	0	0	0	0	0	0	0	0	1	
-East Cl	1	0	0	0	0	0	0	0	0	0	0	0	1	1	
-Guis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Rutson	0	0	0	0	0	0	0	1	0	0	0	0	0	1	
-Friary	2	1	0	0	0	1	0	0	1	0	0	0	0	2	

Table 2 (numbers in brackets denote HOHA cases)

There were 11 cases of *C. difficile* infection in January 2020, 2 of which were classed as COHA and 5 were classed as HOHA, totalling 7 classed as trust-apportioned according to the new definition (table 2). The 2019/20 annual objective is to have no more than 81 COHA + HOHA cases. In the first 10 months of 2019/20 there have been 79 trust-apportioned cases (COHA = 25; HOHA = 54). All actions to ensure that robust controls are in place are actioned in weekly 'huddle' style meetings with Clinical Matrons and at monthly Centre Clinical Standards meetings held with Matrons and monitored through IPAG.

Deaths within 30 days after *C. difficile* diagnosis: for December 2019, two patients died during this period. Since April 2009, 318/1761 patients (18%) have died during the 30 day follow-up period.



Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
JC34 (HOHA)	JC02 (COHA)	ITU3 (HOHA)	Ward 7 (COHA)	Ward 6 (COHA)	JITU2 (HOHA)	Ward 34 (HOHA)	Ward 37 (COHA)	Ward 27 (HOHA)	GHDU (HOHA)		
JCSSU (HOHA)	Gara (HOHA	GHDU (HOHA)	Ward 5 (COHA)	Gara (COHA)	Friary (HOHA)	Ward 37 (COHA)	Ward 5 (HOHA)	Ward 4 (HOHA)	Ward 27 (HOHA)		
JC33 (COHA)	JC10 (COHA)	Victoria (HOHA)	Ward 37 (HOHA)	Ward 34 (HOHA)	Ward 6 (HOHA)	Ward 21 (COHA)	Ward 36 (HOHA)	SIRU (HOHA)	Ward 3 (COHA)		
FHCDU (COHA)	ZET (HOHA)	Ward 10 (HOHA)	Romanby (COHA)	Ward 5 (HOHA)	Ward 7 (HOHA)	Ward 3 (HOHA)	Ward 11 (HOHA)		Tockets (HOHA)		
RAFAU (COHA)	JCITU2 (HOHA)	Ward 7 (HOHA)	Ward 7 (HOHA)	Ward 27 (HOHA)	Ward 14 (HOHA)	ITU 2 (HOHA)	Rom (COHA)		Ward 35 (COHA)		
JC37 (COHA)	JC03 (COHA)	Ward 36 (HOHA)	Ward 7 (HOHA)	Ward 29 (COHA)	Ward 14 (COHA)	ITU 3 (HOHA)	Ward 5 (HOHA)		Ward 11 (HOHA)		
RAFAU (HOHA)		Romanby (HOHA)		Rutson (HOHA)		Ward 14 (COHA)	Ward 27 (HOHA)		SSU (HOHA)		
JC09 (HOHA)		Ward 7 (HOHA)		RAFAU (HOHA)		Ward 11 (HOHA)					
JCCT (COHA)		Ward 27 (HOHA)		RAFAU (HOHA)		SIRU (HOHA)					
RAFAU (COHA)		Ward 25 (HOHA)		Ward 37 (HOHA)		Ward 4 (HOHA)					
				Ward 37 (COHA)		Ward 9 (HOHA)					
				Ward 6 (HOHA)		RAFAU (COHA)					

Graph 1: Cumulative Trust-apportioned *C. difficile* cases 2019/20 compared to trajectory

Appeal successful

Root Cause Analysis (RCA) and panel reviews are undertaken for all trust-apportioned *C. difficile* cases. Panel reviews are chaired by the DIPC or her Deputy and are attended by CCG colleagues. If the panel agrees that there were no deficiencies in care then the case may be discounted from the total for performance measurement purposes.

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

These factors are captured in the below table 3. In addition practices relating to hand hygiene, PPE and ward cleanliness must be optimum to prevent cross infection. Table 3 demonstrates that antibiotics are clearly a key risk factor for the development of *C.difficile.* However in terms of practice, the documentation of 'normal bowel habit on admission' is also evident as a process failure and is then often associated with a delay in sampling. The key action to address this has been the introduction of new Trust nursing documentation in December 2019 which specifically prompts the admitting nurse to ask about 'usual' stool type and frequency on admission which can then inform on-going monitoring and need for sampling. The documentation and the diarrhoea algorithm chart will be audited together in March 2020.This action forms part of a wider selection of actions that are summarised in APPENDIX I.

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	Apr-19										May-19						Jun-19				
Were the following assessment and management elements completed?	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8	Case 9	Case 10	Case 11	Case 12	Case 13	Case 14	Case 15	Case 16	Case 17	Case 18	Case 19	Case 20	Case 21	Case 22
The patient has received Antibiotics in previous 12 weeks to this episode of care	Y	Y	Y	N	Y	Y	Y	Y		Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y
Normal Bowel habit assessment on admission	N	Y	Y	Y	N	Y	N	N		Y	N	N	N	Y	N	Y	N	Y	Y	N	Y	N
Was the sample obtained timely	N	Y	Y	Y	Y	Y	Y	N		N	N	N	Y	Y	N	Y	N	Y	N	N	N	Y
Bristol Stool score recorded	N	Y	Y	Y	Y	Y	Y	Y		Y	N	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y
Was the patient Isolated within 2 hours of suspicion of infected diarrhoea?	Y	Y	Y	Y	Y	Y	Y	Y		Y	N	NA	Y	Y	Y	Y	Y	Y	N	N	Y	Y
Patient commenced appropriate pathway and bundle for isolation eg PPE (full length fluid repellent gowns), chlorine based products for cleaning, signage, single use equipment etc.	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was the patient given the appropriate information leaflet and given advice about hand hygiene?	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reviewed by medic and severity assessment completed	Y	Y	N	Y	Y	Y	Y	N		Y	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Appropriate antibiotics based on severity assessment prescribed and administered in line with trust guidelines?	Y	Y	Y	Y	Y	Y	Y	N		Y	Y	Y	Y	Y	Y	Y	Y	Y	U	Y	Y	Y
Previous hospital admission in the last 12 weeks	Y	Y	Y	Y	Y	N	Y	Y		Y	Y	N	Y	Y	N	Y	N	Y	Y	Y	N	Y
Does the patient have the following risk factors?	Apr-19										May-19						Jun-19					
>65 years old	Y	Y	Y	N	Y	Y	Y	Y		Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	N	Y
Taking protein pump inhibitors (PPI)	N	Y	Y	Y	Y	N	Y	Y		Y	Y	y	N	N	Y	Y	Y	Y	Y	N	N	N
Known history of Clostridium Difficile infection (CDI)	N	Y	N	Y	Y	Y	N	N		Y	N	N	N	N	Y	N	N	N	Y	N	N	N
Link to CDI case	N	N	N	N	N	N	N	N		N	N	N	N	N	N	N	N	N	N	N	N	N
Immune supressed	N	Y	Y	N	N	N	Y	Y		N	N	N	N	N	N	Y	N	N	N	N	N	N
Underlying oncology	N	Y	Y	N	Y	N	Y	N		Y	N	N	N	N	N	Y	N	N	N	N	N	N
Care Home resident	N	N	N	N	Y	Y	N	N		Y	N	N	N	N	N	N	N	N	N	N	N	N
History of abdominal surgery	N	N	N	N	N	N	N	N		N	N	N	N	N	N	N	N	N	N	N	Y	N
Admission to critical care	N	N	N	N	N	N	N	N		N	N	N	N	N	Y	N	Y	Y	N	N	Y	Y
PEG tube and feed	N	N	N	N	N	N	N	N		N	N	N	N	N	Y	N	Y	N	Y	N	N	N

	Jun-19				Jul-19							Aug-19										
Were the following assessment and management elements completed?	Case 23	Case 24	Case 25	Case 26	Case 27	Case 28	Case 29	Case 30	Case 31	Case 32	Case 33	Case 34	Case 35	Case 36	Case 37	Case 38	Case 39	Case 40	Case 41	Case 42	Case 43	Case 44
The patient has received Antibiotics in previous 12 weeks to this episode of care	Y	Y	Y	Y	Y	N	Y		Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	Y
Normal Bowel habit assessment on admission	N	Y	Y	N	N	Y	Y		Y	Y	Y	Y	Y	Y	N	Y	N	Y	N	Y	Y	N
Was the sample obtained timely	Y	Y	Y	Y	Y	N	Y		Y	Y	Y	Y	NA	Y	Y	Y	N	N	Y	Y	Y	N
Bristol Stool score recorded	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was the patient Isolated within 2 hours of suspicion of infected diarrhoea?	Y	Y	Y	Y	Y	Y	Y		Y	Y	N	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	N
Patient commenced appropriate pathway and bundle for isolation eg PPE (full length fluid repellent gowns), chlorine based products for cleaning, signage, single use equipment etc.	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	NA	Y	Y	Y	Y	Y	Y	NA	Y	Y
Was the patient given the appropriate information leaflet and given advice about hand hygiene?	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA
Reviewed by medic and severity assessment completed	Y	Y	Y	N	Y	N	Y		Y	Y	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	N
Appropriate antibiotics based on severity assessment prescribed and administered in line with trust guidelines?	Y	Y	Y	Y	Y	Y	N		Y	Y	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y
Previous hospital admission in the last 12 weeks	N	N	Y	Y	Y	Y	Y		Y	Y	N	Y	N	N	Y	Y	Y	Y	Y	N	Y	N
Does the patient have the following risk factors?	Jun-19				Jul-19							Aug-19										
>65 years old	Y	N	Y	Y	Y	N	Y		Y	N	Y	N	Y	Y	N	Y	Y	Y	Y	N	Y	N
Taking protein pump inhibitors (PPI)	N	N	Y	Y	Y	Y	Y		N	Y	N	Y	Y	N	Y	N	Y	N	N	Y	N	Y
Known history of Clostridium Difficile infection (CDI)	N	N	N	N	N	Y	N		Y	N	N	N	N	N	N	N	N	N	N	Y	N	N
Link to CDI case	N	N	N	N	Y	N	N		N	N	N	N	N	N	N	N	N	N	N	N	N	N
Immune supressed	N	N	N	N	N	N	Y		Y	Y	N	N	N	N	N	N	N	Y	N	N	N	N
Underlying oncology	N	N	N	N	N	N	Y		N	Y	N	N	N	N	N	N	N	N	N	N	N	N
Care Home resident	Y	N	Y	N	N	N	N		N	N	N	N	N	N	N	N	N	N	N	N	N	N
History of abdominal surgery	N	Y	N	N	N	N	Y		N	Y	Y	N	N	N	Y	N	N	N	N	N	N	N
Admission to critical care	N	N	N	N	N	N	N		N	Y	N	N	N	Y	N	N	Y	N	N	N	N	Y
PEG tube and feed	N	N	Y	N	N	N	N		N	N	Y	N	N	N	Y	N	N	N	N	N	N	Y

	Aug-19	Sep-19					Oct-19												Nov-19		
Were the following assessment and management elements completed?	Case 45	Case 46	Case 47	Case 48	Case 49	Case 50	Case 51	Case 52	Case 53	Case 54	Case 55	Case 56	Case 57	Case 58	Case 59	Case 60	Case 61	Case 62	Case 63	Case 64	Case 65
The patient has received Antibiotics in previous 12 weeks to this episode of care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y
Normal Bowel habit assessment on admission	N	N	N	N	N	N	N	N	N	Y	N	N	Y	N	N	Y	N	Y		Y	N
Was the sample obtained timely	N	N	N	Y	N	Y	Y	Y	Y	N	Y	Y	N	N	Y	Y	N	N		N	Y
Bristol Stool score recorded	NA	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y
Was the patient Isolated within 2 hours of suspicion of infected diarrhoea?	NA	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y		Y	N
Patient commenced appropriate pathway and bundle for isolation eg PPE (full length fluid repellent gowns), chlorine based products for cleaning, signage, single use equipment etc.	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y
Was the patient given the appropriate information leaflet and given advice about hand hygiene?	Y	Y	N	Y	Y	N	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y		Y	Y
Reviewed by medic and severity assessment completed	NA	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y		Y	Y
Appropriate antibiotics based on severity assessment prescribed and administered in line with trust guidelines?	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y
Previous hospital admission in the last 12 weeks	N	N	N	Y	Y	Y	N	Y	Y	N	N	N	Y	N	N	Y	Y	Y		Y	Y
Does the patient have the following risk factors?																					
>65 years old	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	N	Y	N	Y	Y	Y		Y	Y
Taking protein pump inhibitors (PPI)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	N	Y		N	N
Known history of Clostridium Difficile infection (CDI)	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	Y	N	N		N	Y
Link to CDI case	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N		N	N
Immune supressed	N	Y	N	N	Y	Y	N	N	N	N	N	N	Y	N	N	Y	N	N		Y	N
Underlying oncology	Y	N	N	N	Y	Y	N	N	N	N	N	N	Y	N	N	Y	N	N		Y	N
Care Home resident	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N		N	N
History of abdominal surgery	N	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N		Y	N
Admission to critical care	N	N	Y	N	N	N	N	N	Y	N	Y	Y	N	N	Y	N	N	N		N	N
PEG tube and feed	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	N	N	N	N		N	N

Table 3 *Clostridium difficile* cases 19/20 (HOHA / COHA) summary of risk factors and compliance with best practice

The average hand hygiene self-assessment score in January 2020 was 86% and the peer review average was 86%.

1.2 MRSA bacteraemia

MRSA	Total 2018/19	Feb 19	Mar 19	Apr 19	May 19	June 19	July 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Total 2019/20 to date	Target for 2019/20
Total cases	9	1	0	0	0	0	0	0	0	2	2	0	0	4	NA
Not trust assigned	8	1	0	0	0	0	0	0	0	1	1	0	0	2	NA
Trust assigned	1	0	0	0	0	0	0	0	0	1	1	0	0	2	**NA**

Table 4

There were 0 cases of MRSA bacteraemia in January 2020 (table 4); The case reviews for the two cases from November were postponed. These are both provisionally classed as not trust-assigned, but for one case this is likely to change after the case review.

In the first 10 months of 2019/20 there has been a total 1 trust-assigned case and three cases which are not trust assigned.

1.3 MSSA bacteraemia

There were 12 cases of MSSA bacteraemia in January 2020; 3 of which were classed as trust-apportioned (table 5). In the first 10 months of 2019/20 there have been 38 trust-apportioned MSSA bacteraemia cases.

MSSA	Total 2018/19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	July 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Total 2019/20 to date	Target for 2019/20
Total cases	134	8	11	12	12	17	18	17	15	13	13	15	12	144	NA
Not trust apportioned	92	5	7	9	11	12	14	11	11	11	6	12	9	106	NA
Trust apportioned	42	3	4	3	1	5	4	6	4	2	7	3	3	38	NA

Table 5

Whilst there is no external target for MSSA, the trust has set an internal target to maintain the 15% reduction of Staphylococcus aureus infections based on the 2016/17 baseline. This means no more than 35 combined MRSA and MSSA trust-apportioned cases in total. The trust has already exceeded this number as we have had 39 cases after 10 months. Enhanced training for Aseptic Non-Touch Technique (ANTT) is being implemented across the trust for all relevant staff groups to address avoidable causes of MRSA and MSSA bacteraemia related to invasive procedures.

1.4 Surveillance for other healthcare-associated infections

	Total for 18/19	January 2020	Total for 19/20
Bacteraemia due to glycopeptide-resistant enterococci	10	0	6
Bacteraemia due to E. coli	550	45	411
• Trust-apportioned	128	8	73
• Not trust-apportioned	422	37	338
ESBL producing coliform infections	953	85	691
• sample taken in community	599	62	446
• sample taken in our trust	354	23	245
• bacteraemias	28	2	21
Bacteraemia due to Klebsiella species	134	7	100
• Trust-apportioned	37	3	29
• Not trust-apportioned	97	4	71
Bacteraemia due to Pseudomonas aeruginosa	37	3	42
• Trust-apportioned	12	1	13
• Not trust-apportioned	25	2	29
Other alert organisms	1	0	1
• invasive group A streptococcus			

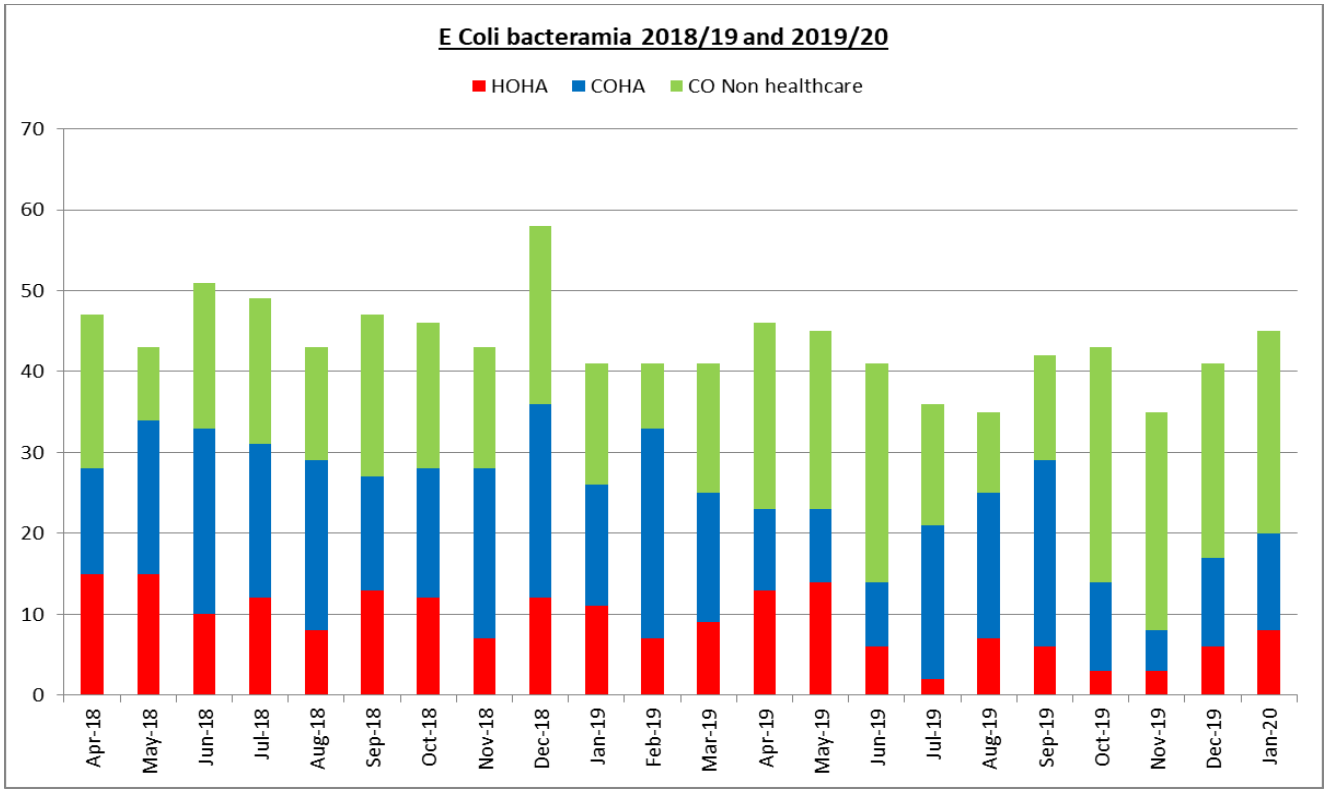
Table 6

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

In January 2020, the trust reported a total of 55 cases of three GNBSI organisms which are part of national surveillance (*E. coli, 45; Klebsiella sp. 7; Pseudomonas aeruginosa* 3). Of these, 12 cases were classed as trust-apportioned as defined by the Department of Health definition. In the first 10 months of 2019/2020 there have been a total of 553 cases of the three GNBSI cases (*E.coli,* 411*; Klebsiella sp.*100*; Pseudomonas aeruginosa* 42) and of these 115 are classed as trust-apportioned 20%. This demonstrates the need to continue working with the wider community as part of the Tees-wide collaborative which supports a number of initiatives within the community setting. In addition a detailed retrospective audit of 5 sets of notes per month is being performed to ascertain patient-related contributory themes in the challenge to identify causes of *E. Coli* infections.

The trust's GNBSI annual plan is on track with initiatives and reduction strategies to reduce rates of GNBSIs including promotion of hydration, central venous catheter care and training and education for staff.

Graph 2 – E Coli bacteraemia cases 2018/19 and 2019/20



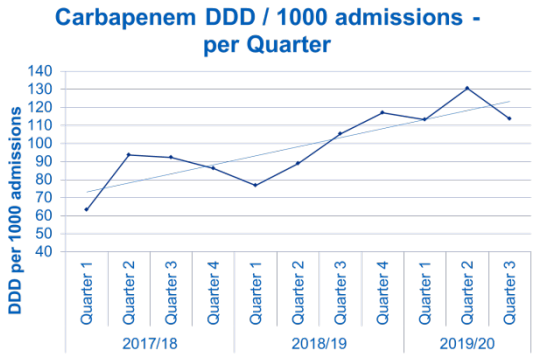
Graph 2: note that the definition of cases above is based upon information available to the infection control team. Information around community healthcare interventions may be incomplete overestimating the proportion of CO non-healthcare-associated cases as defined by the PHE definition.

Antimicrobial Stewardship

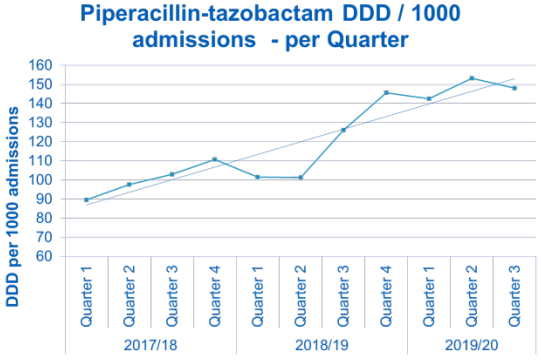
The trust is continuing with a number of antimicrobial stewardship initiatives including the ARK project.

The antibiotic guidelines app was launched at the end of September 2019. This complements the "Antibiotic Sepsis/ Infection (not sepsis)" poster which was released in January 2019. The change in guidance carries a potential risk of increased cases of *C. difficile* as it could lead to an increase in appropriate prescribing of broad-spectrum antibiotics.

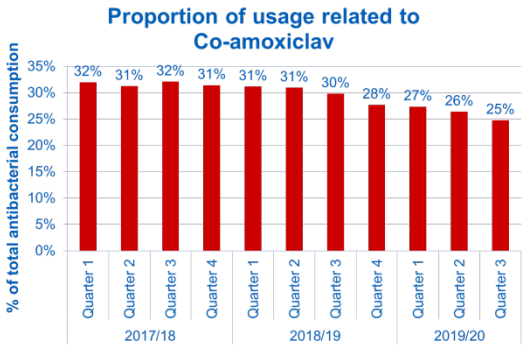
Graphs 3-6 below show that we have seen an increase in carbapenem and piperacillin-tazobactam use and a decrease in co-amoxiclav use. This could have an effect on increasing risk of *C. difficile* infection. We have also seen an increase in the proportion of "Access" antibiotics which should reduce selection for C. difficile and multi-resistant organisms.



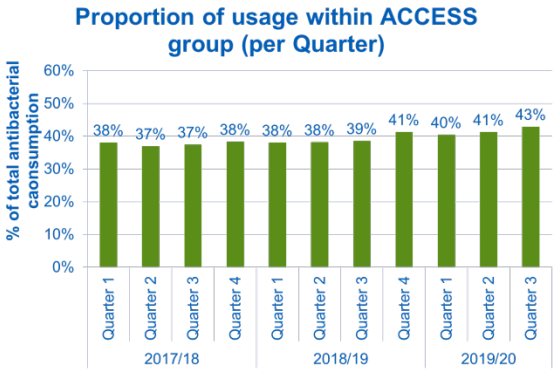
Graph 3



Graph 4



Graph 5



Graph 6

The antimicrobial CQUIN for 2019/20 focuses on 3 areas:

1. Diagnosis and antibiotic prescribing for lower urinary tract infections.

2. Antibiotic prophylaxis for colorectal surgery.

3. Diagnosis and antifungal prescribing for systemic fungal infections.

The antimicrobial pharmacy team perform audits for these CQUINs. There has been considerable improvement with performance for the colorectal surgery prophylaxis audit but achievement of the full urinary tract infection CQUIN remains challenging.

The Medical Director lead for antimicrobial prescribing is undertaking a review of the antimicrobial stewardship programme with the antibiotic pharmacist, in view of the increase in *Clostridium difficile* infections.

Environmental Cleaning

The average cleaning scores by month are as follows (table 6):

The James Cook Site:

Risk Category	NSC Target	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20
High Risk	**95%**	98%	99%	99%	99%	99%	98%	98%	99%	99%	99%	99%	99%
Significant Risk	**85%**	97%	98%	97%	97%	98%	97%	97%	98%	98%	98%	98%	98%
Low Risk	**75%**	95%	96%	96%	95%	96%	96%	95%	97%	96%	97%	97%	98%

Table 6

Cleaning scores have been maintained on the JCUH site (table 6). Maintaining cleaning standards remains an area of continued focus in conjunction with our service provider SERCO. Concerns from clinical staff about the standard of cleaning versus the cleaning scores have been raised with Serco colleagues and escalated to IPAG and actions put in place where required. For example, the frequency of cleaning standards review meetings have been increased from monthly to weekly and continue to be led by the Director of Estates with cleaning scores monitored via IPAG.

The Friarage, Friary, East Cleveland and Redcar Primary Care Hospital (table 7):

Risk Category	NSC Target	FHN Site	Friary	East Cleveland	Redcar PCH
Very High Risk	**98%**	99.43%			99.2%
High Risk	**95%**			96%	100%
Significant Risk	**85%**	98.71%		95%	100%
Low Risk	**75%**	100%		94%	100%

Table 7

2. OUTBREAKS OF DIARRHOEA AND VOMITING

Diarrhoea & vomiting outbreaks	Annual total 18/19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Total 19/20 to date
Total number	*1*	1	0	0	0	0	0	0	0	1	2	1	0	4
Total number of patients affected	*1*	1	0	0	0	0	0	0	0	6	28	8	0	42
Total number of staff affected	*12*	12	0	0	0	0	0	0	0	3	25	3	0	31

Table 8

There were no outbreaks of diarrhoea and vomiting during January 2020.

3. OUTBREAK OF GES – CARBAPENEMASE-PRODUCING MULTI-DRUG-RESISTANT PSEUDOMONAS AERUGINOSA INFECTION IN ICU2/3, GHDU, WARDS 4 AND 24HDU AND OTHER AREAS

During January 2020, we have identified no further patients who have the *GES-carbapenemase-producing Pseudomonas aeruginosa* infection.

In total there have been 25 confirmed patients identified who are colonised or infected with a GES carbapenemase-producing strain of *Pseudomonas aeruginosa* in our trust since November 2014.

4. OXA-48-CARBAPENEMASE-PRODUCING KLEBSIELLA PNEUMONIAE

Acute trusts across Teesside have seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing *Klebsiella pneumoniae* over the last 2 years. In January 2020 we did not identify any further cases that carried the strain which has been linked to this cluster. We do not believe transmission has occurred unknowingly in our trust. An extensive contact screening programme has only identified one case. We have devised a brief protocol for a pilot project to screen patients for carbapenemase-producing enterobacteria, if they have been an inpatient in a North East hospital during the preceding 12 months.

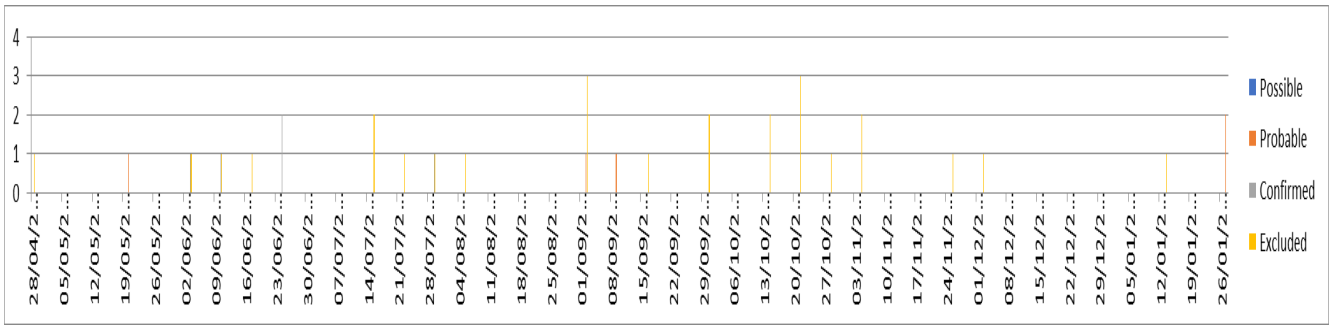
5. OUTBREAK OF SERRATIA MARCESCENS WITHIN THE CARDIOTHORACIC SURGICAL SERVICE

In July we found that our surveillance system for potential clusters of gram negative bacteria had identified that 4 patients who had been treated in Cardiothoracic ICU and/or HDU had been colonised or infected with the same strain of *Serratia marcescens*. Further investigations have determined (as of 4th January 2020) we have had a total of 5 patients who are confirmed as affected by the outbreak strain, 5 cases classed as ‘probable’ and 26 cases which have subsequently been

found to be unlinked to each other (but may have had an environmental source). The timeline of outbreak cases is shown in graph 3. Environmental sampling has identified *Serratia marcescens* from a sink area where there was damage to the wall behind the sink. On subsequent environmental sampling the environmental strain was isolated from another clinical area. This isolate had the same strain type as one of the patients supporting our hypothesis that at least some of the patients have been infected from an environmental source.

In addition we have identified 6 patients who had been treated in Cardiothoracic ICU and/or HDU, between August 2019 and November 2019, who have been infected or colonised with the same strain of *Stenotrophomonas maltophilia.* The organism was not isolated from multiple environmental samples and probably represents patient-to-patient transmission which is a consequence of inadequate isolation facilities. No further linked cases were identified in January 2020.

The Cardiothoracic ICU, HDU and ward 32 underwent a deep clean and hydrogen peroxide fogging and replacement of the contaminated sink in August 2019. Outbreak meetings are ongoing and a detailed action plan is in place addressing potential influencing variables relating to clinical practice and the environment. The 'Dangers in Damp' awareness campaign commenced in September 2019. The outbreak status remains 'open' until assurance is provided that we have returned to a background rate of *Serratia* colonisation.



Graph 3

6. OTHER CRITICAL CARE SURVEILLANCE

Isolation capacity for patients with infection continues to pose a challenge particularly on ICU2, ICU3 and Cardiothoracic ICU. Processes to mitigate risk of transmission of infection continue to be put in place including increased presence of the IPC team to support staff.

When isolation becomes challenging critical care staff work with IPC staff to ensure all risk reduction strategies are put in place. This includes appropriate use of aprons, gloves, gowns and other personal protective equipment, with the visual prompt of the PPE trolley displaying a 'STOP' sign alerting staff, who need to enter the bed space. Strict hand hygiene, equipment decontamination and any condition-specific devices (e.g. faecal collector) are put in place. For patients with infections in sputum, these measures may not be sufficient as demonstrated by the cluster of *Stenotrophomonas maltophilia* cases in cardiothoracic services.

In January 2020, 30 patients across the critical care footprint (including specialist areas) were not isolated in a side room, all mitigating actions were implemented.

- In January 2020, we have identified one case of MRSA acquisition of colonisation or infection while on Critical Care. This case was in the neonatal unit, which is highly unusual for our trust.

- In January 2020, we had 1 case of HOHA *C. difficile* infection on Critical Care.

- In January 2020, 3 healthcare-onset GNBSI bacteraemia (due to the 3 organisms which are part of national surveillance) have been identified 2 or more days after admission to Critical Care.

7. INFLUENZA REPORTING

National reporting of Influenza cases started week commencing 30 September 2019 focusing on critical care areas. All patients admitted to ICU/HDU with a laboratory-confirmed influenza result (A, H1, H3 or Novel) or B will be reported. If two influenza types are detected in the same patient, this will be reported as influenza A. In the month of January 2020, 1 case of influenza was admitted to a critical care area.

8. WUHAN NOVEL CORONAVIRUS (COVID-19)

Novel coronavirus (COVID-19) is a new strain of coronavirus first identified in Wuhan City, China. COVID –19 is classified as an airborne high consequence disease. This specific virus has only just been identified so there is limited information about the precise routes of transmission. However based on previous experience with other coronaviruses such as Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV) it is likely that COVID-19 is transmitted by respiratory droplets and direct or indirect contact with infected secretions. This infection has now spread beyond China and to date there have been 9 confirmed cases in the UK.

Public Health England has issued guidance on the assessment and screening of potential patients and on Friday 31st January requested that acute Trusts set up 'pods' to screen patients that have been referred by 111 after telephone assessment and confirmation of meeting case definition (dependent on travel history). A summary of the response to COVID-19 by South Tees FT is summarised below:

- Daily planning meetings from Monday 3rd February which enabled opening of the 'pod' on Friday 8th February 2020 at JCUH and a 'pod' at FHN on 13th February 2020
- Operational and adult and paediatric clinical standard operating procedures have been produced for the pods by relevant subject matter experts and in line with NHSE instruction and PHE guidance
- Patients attending the pod at FHN will be referred for screening at JCUH if required
- Patients attending JCUH are assessed and screened by a registered nurse and all cases discussed with the Consultant for Infectious Diseases.
- A detailed Trust briefing is updated every 48hours or as required which outlines the management of all potential patient pathways and admission routes and associated education and cleaning requirements.
- A daily 8.30am briefing meeting takes place in the Incident Coordination Centre which has been set up and staffed to take any queries and manage on-going requirements. A more detailed meeting is held every 48 hours to review a detailed action plan addressing patient's pathways, equipment and training and Communications.

Healthcare workers who have travelled to a high risk area

There is clear guidance is available from PHE and any queries are being managed by Occupational Health.

Appendix 1

Enhanced actions -*Clostridium difficile*

In response to the increasing rate of *C. difficile* in 2019/2020 enhanced actions have been put in place and are reviewed in a weekly 'huddle' style meeting with the Clinical Matrons and led by the Deputy Director of Nursing and senior IPC nurse. A summary of the key actions are provided below:

Hand Hygiene

- External peer review of process and practice in hand hygiene was performed by Ecolab in 2019. The report highlighted an overuse of non-sterile gloves. The response to this has been to add glove use to the hand hygiene audit tool and launch a 'gloves awareness' education link on the intranet. Whilst not relating directly to *C.difficile*, this action is also picked up with the aseptic non touch technique (ANTT) training program providing a second source of educational assurance. Follow up quarterly external peer hand hygiene audits from Ecolab have been requested.

- Patient hand hygiene is encouraged with the use of hand hygiene wipes before meals. Matrons informal scoping in February 2020 identified varying practice around mealtime routines. Therefore the IPC surveillance practitioner will observe and audit practice so a definitive practice guideline can be implemented by end March 2020.

- The Infection Prevention and Control Team (IPCT) is working collaboratively with Serco Service managers to train domestic staff in hand hygiene; training in the Critical Care areas is now complete and is being further cascaded across key clinical areas. Audit results can be filtered by staff group and will be reviewed at new Clinical Standards and Cleaning Standards meetings form March 2020.

Environment and equipment

- Commodes - Two commode audits have been conducted in 2019 and revealed a small number of commodes that were no longer fit for purpose. Commode checks now form part of the daily nurse in charge checklist and a new central store or commodes ensures easy replacement of damaged commodes.

- Environmental audits - The Infection Prevention and Control Team (IPCT) have started to join Serco staff during their cleaning audits, promoting teamwork and to ensure consistent and accurate reporting and escalation of findings. Further work to merge the IPCT and Serco cleaning audit tool is being undertaken, expected completion end February 2020 and will be monitored via Cleaning Standards Group.

- External review of Serco cleaning processes was undertaken by Environmental Excellence training and development limited (EETD) in December 2019. A report has been received and an associated action plan is being developed.

- The use of Ultra Violet (UV) light to monitor effectiveness of terminal cleaning was introduced in October 2019 by the IPC lead for decontamination, capturing 5 areas per month and auditing at least 5 high touch points within the immediate patient area. Feedback is given in real time and captured in a monthly Decontamination report for IPAG and via Cleaning Standards Group.

- Vernaclean was introduced to the trust in August 2019 to use in small rooms such toilets and bathrooms where Hydrogen Peroxide Vapour (HPV) could not be deployed.

Process, reporting and assurance

- Diarrhoea management – RCA thematic analysis review and staff feedback resulted in replacing the diarrhoea assessment tool with a simplified diarrhoea algorithm which advises stool sampling at first episode of diarrhoea. The new document was launched in September 2019, staff report ease of use and further work is underway to empower nursing staff to sample all type 5 stools.

- Situational reporting - From November 2019 a situational report of all current *C.difficile* in-patients with active symptoms is being shared with clinical matrons and the site team on a daily basis to ensure that efforts are concentrated first and foremost in these areas of risk.

- Staff training – Records are being compiled by the IPC team and will be held centrally to ensure compliance can be tracked relating to bed cleaning, commode cleaning, hand hygiene competencies and C. difficile tool box teaching.

- Weekly DIPC / Dep. DIPC Matron IPC huddles with actions to reinforce hand hygiene for staff and patients, environmental and equipment cleaning and staff training have been put in place.

- Weekly *C.difficile* audits have continued since their introduction in April 2019 and results are shared at Clinical Standards meetings.

- Weekly *C.difficile* ward rounds conducted by the IC Doctor, IPCN, and pharmacy staff remain ongoing with opportunities to highlight antibiotic usage.

- Clinical Standards meetings will have a dedicated IPC section from March 2020.

South Tees Hospitals
NHS Foundation Trust

Quality, Operational & Finance Performance Report

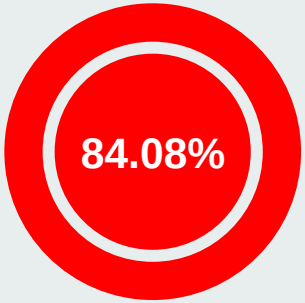
25th February 2020

Must Do’s

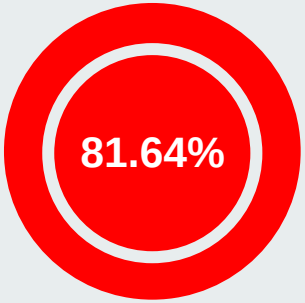
Must Do's 2019/20 – January 2020

Deliver Excellence in Patient Outcome and Experience….

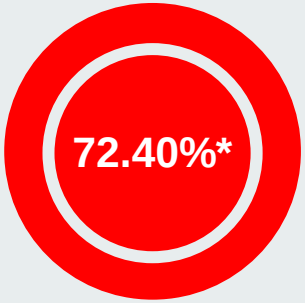
A&E
4hr Target



RTT
18 Week Target



Cancer
62 Day Target



Operating Surplus

* Indicative

…and ensure our long term financial sustainability

Performance - A&E

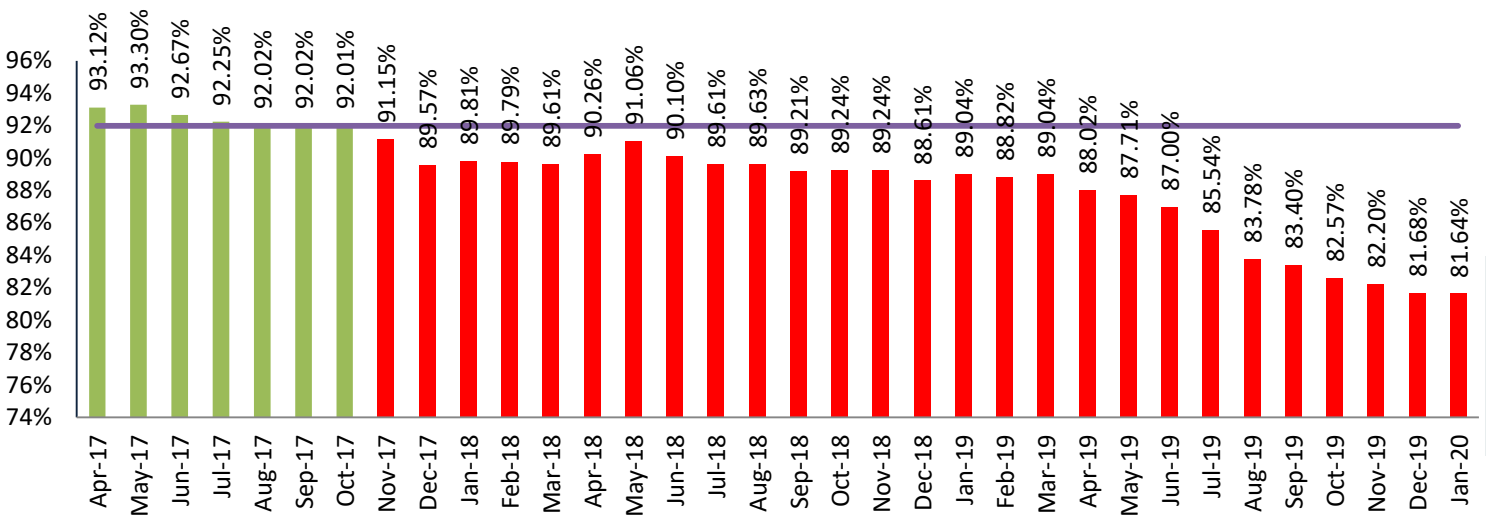
95%
TARGET

Jan 20
84.08%

Regional Rank	Trust	Jan-20
1	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	94.49%
2	Northumbria Healthcare NHS Foundation Trust	93.72%
3	Harrogate and District NHS Foundation Trust	88.74%
4	**South Tees Hospitals NHS Foundation Trust**	**84.08%**
5	Gateshead Health NHS Foundation Trust	84.01%
6	South Tyneside And Sunderland NHS Foundation Trust	78.94%
7	North Cumbria University Hospitals NHS Trust	78.79%
8	York Teaching Hospitals NHS Foundation Trust	75.21%
9	County Durham and Darlington NHS Foundation Trust	69.67%
-	North Tees and Hartlepool NHS Foundation Trust	
	ENGLAND	**81.68%**

Jan 20
Ranked 4th in the region

Referral to Treat



92%
TARGET

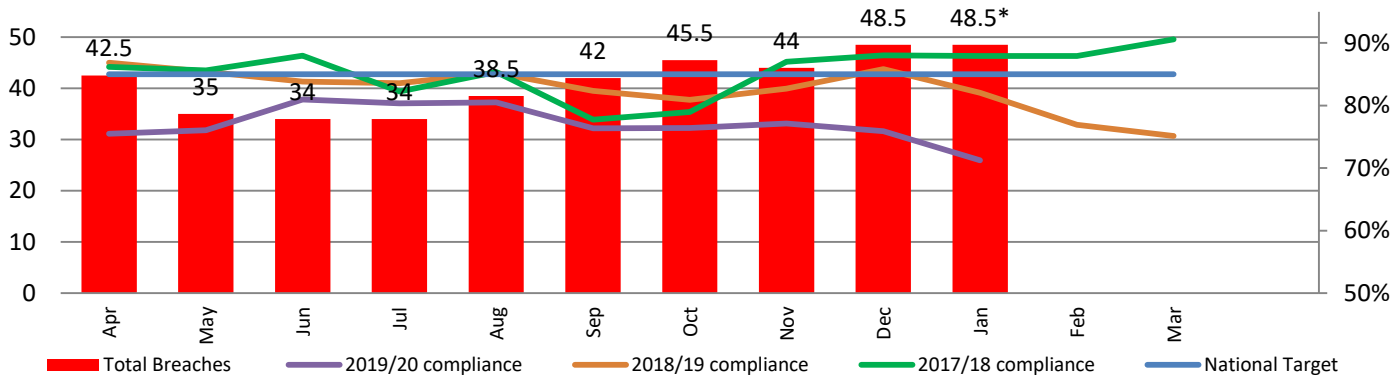
Jan 20

81.64%

Regional Rank	Trust	Dec-19
1	North Tees and Hartlepool NHS Foundation Trust	92.62%
2	South Tyneside And Sunderland NHS Foundation Trust	92.07%
3	Gateshead Health NHS Foundation Trust	92.06%
4	Northumbria Healthcare NHS Foundation Trust	92.01%
5	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	88.68%
6	County Durham and Darlington NHS Foundation Trust	87.87%
7	**South Tees Hospitals NHS Foundation Trust**	**81.68%**
8	York Teaching Hospital	74.77%
9	North Cumbria University Hospitals NHS Trust	73.13%
10	Harrogate and District NHS Foundation Trust	-
	ENGLAND	**83.66%**

Dec 19
Ranked 7th in the region

Performance – 62 Day Cancer Standard



% compliance and number of breaches

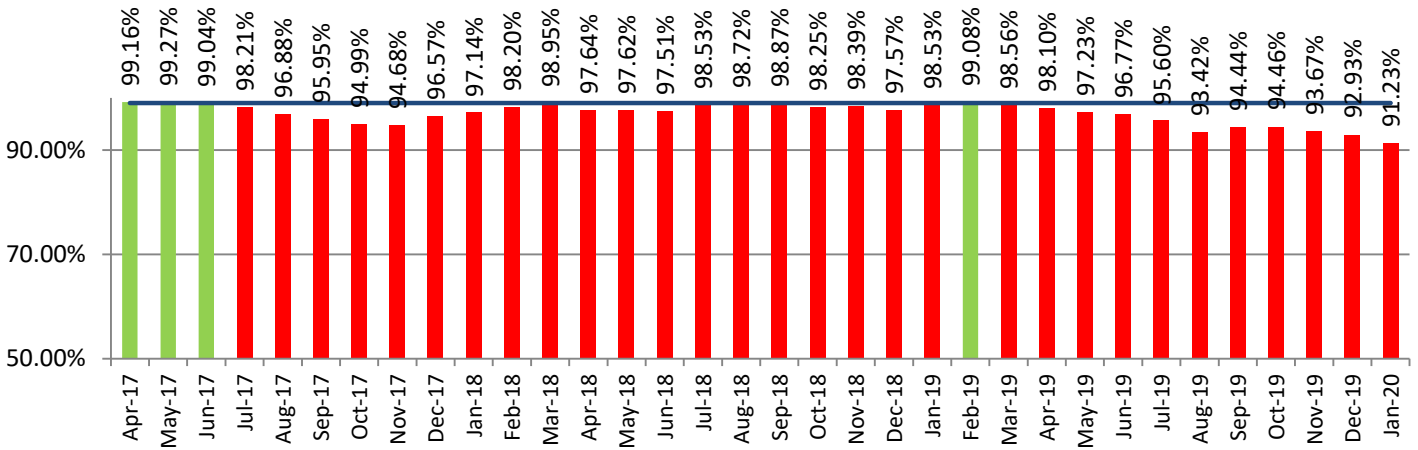
* Indicative

Jul 19	Aug 19	Sep 19	Oct 19	Nov19	Dec 19	Jan 20*
80.35%	80.41%	76.34%	76.42%	79.43%	75.87%	72.40%*

Regional Rank	Trust	Dec-19
1	Harrogate and District NHS Foundation Trust	98.98%
2	Northumbria Healthcare NHS Foundation Trust	96.55%
3	County Durham and Darlington NHS Foundation Trust	84.25%
4	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	83.19%
5	North Cumbria University Hospitals NHS Trust	80.54%
6	York Teaching Hospitals NHS Foundation Trust	76.50%
7	Gateshead Health NHS Foundation Trust	76.42%
8	South Tyneside and Sunderland NHS Foundation Trust	76.17%
9	**South Tees Hospitals NHS Foundation Trust**	**75.87%**
11	North Tees and Hartlepool NHS Foundation Trust	70.16%
	ENGLAND	**77.99%**

Dec 19 Ranked 9th in the region

6 Week Diagnostic



99% TARGET

Jan 20

91.23%

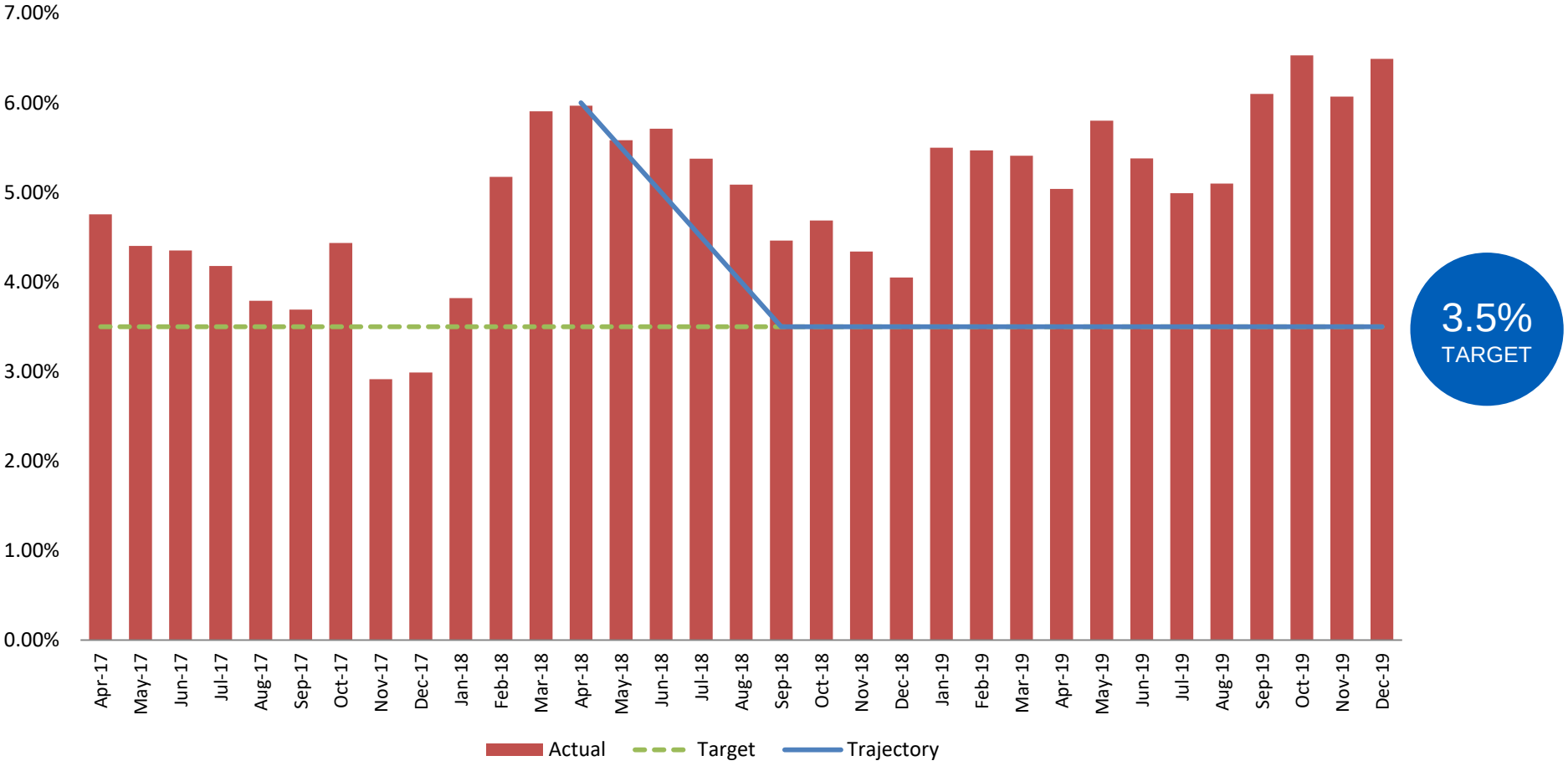
6 Week Diagnostic Performance (Target 99%)	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Magnetic Resonance Imaging	99.69%	99.75%	99.83%	99.64%	98.81%	99.78%	99.96%	99.73%	99.89%	99.60%	97.75%	92.26%
Computed Tomography	99.79%	99.92%	99.85%	99.94%	99.93%	99.93%	99.80%	99.93%	99.30%	99.46%	99.84%	99.93%
Non-obstetric ultrasound	100.00%	100.00%	100.00%	99.90%	99.97%	99.90%	99.92%	99.97%	99.93%	100.00%	99.76%	99.97%
Barium Enema												
DEXA Scan	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Audiology Assessments	98.55%	98.83%	96.22%	98.11%	97.99%	94.86%	88.51%	87.10%	86.57%	86.49%	86.28%	83.33%
Cardiology - echocardiography	92.50%	93.62%	92.31%	88.24%	69.70%	83.78%	97.62%	96.88%	100.00%	97.44%	90.63%	94.59%
Cardiology - electrophysiology												
Neurophysiology	95.21%	91.30%	84.09%	70.74%	72.06%	70.64%	66.53%	73.38%	79.23%	88.38%	86.89%	84.34%
Sleep studies	67.31%	50.00%	44.44%	14.29%	22.64%	34.92%	40.00%	49.06%	62.75%	65.96%	46.30%	51.06%
Urodynamics - pressures & flows	47.37%	18.52%	48.00%	52.08%	73.91%	79.07%	85.29%	70.45%	76.47%	55.26%	49.09%	42.86%
Gastro - Colonoscopy	98.41%	94.30%	93.75%	94.86%	89.72%	71.53%	62.66%	64.38%	62.86%	59.13%	56.85%	54.08%
Gastro - Flexi sigmoidoscopy	96.77%	94.12%	92.75%	89.47%	91.49%	74.38%	60.63%	69.51%	65.00%	53.26%	45.98%	46.82%
Urology - Cystoscopy	95.95%	97.18%	100.00%	94.62%	96.07%	96.83%	92.68%	91.84%	95.60%	98.14%	94.44%	93.84%
Gastroscopy	98.32%	95.95%	96.48%	98.11%	90.87%	88.85%	77.52%	83.81%	87.66%	79.51%	82.47%	77.39%
Trust Total	99.08%	98.56%	98.10%	97.23%	96.77%	95.60%	93.42%	94.44%	94.46%	93.67%	92.93%	91.23%

Operational Management

2

Delayed Transfer of Care (DToC)

Percentage DToC against Midnight Bed Occ

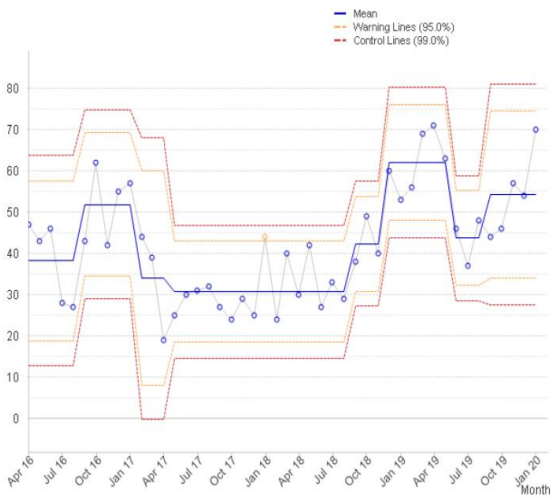


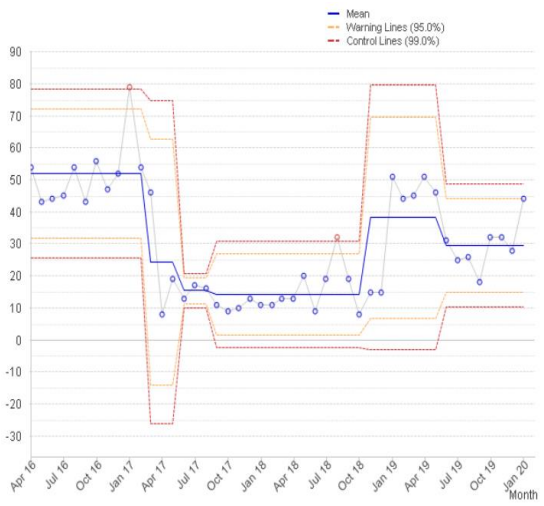
Patient Safety, Outcome and Experience

3

Delivering Safe Care 19/20

New or deteriorating category 2 pressure ulcers January 2020

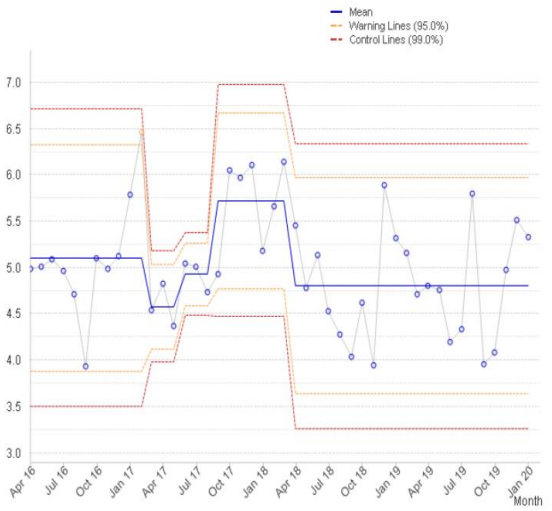




Inpatient rate is 2.4 per 1000 bed days.

44 community category 2 pressure ulcers

Falls January 2020



Rate 5.3 per 1000 bed days.

Focus required on prevention strategies to secure improvements

1. Incident reporting - Current position

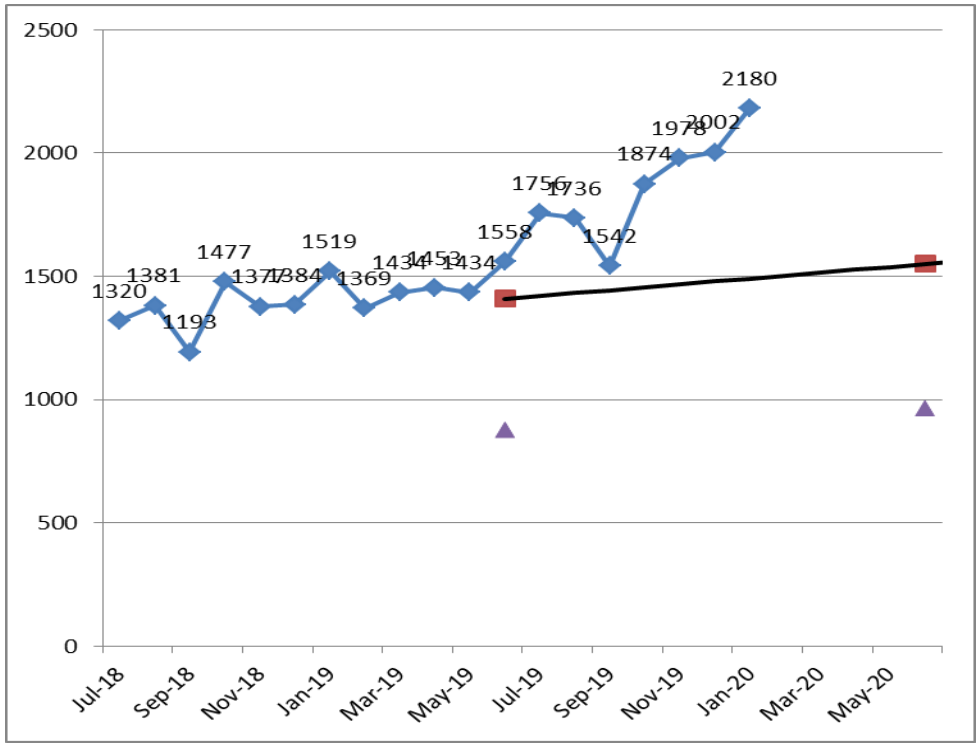
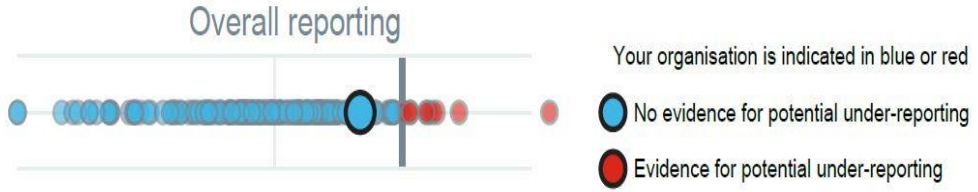


Figure 1: Potential under-reporting of incidents to the NRLS, October 2018 to March 2019



- 16 per cent increase in incident reporting across the Trust from Quarter 2 (19/20) to Quarter 3 (19/20).
- January 2020, 2,180 incidents reported on Datix (highest number of incidents ever reported on Datix in the Trust).
- Improvement trajectory of a 10 per cent year-on-year increase over the next three years set (quarterly monitoring).
- T&F group convened with CD's to improve connectivity with frontline colleagues to share and embed learning.

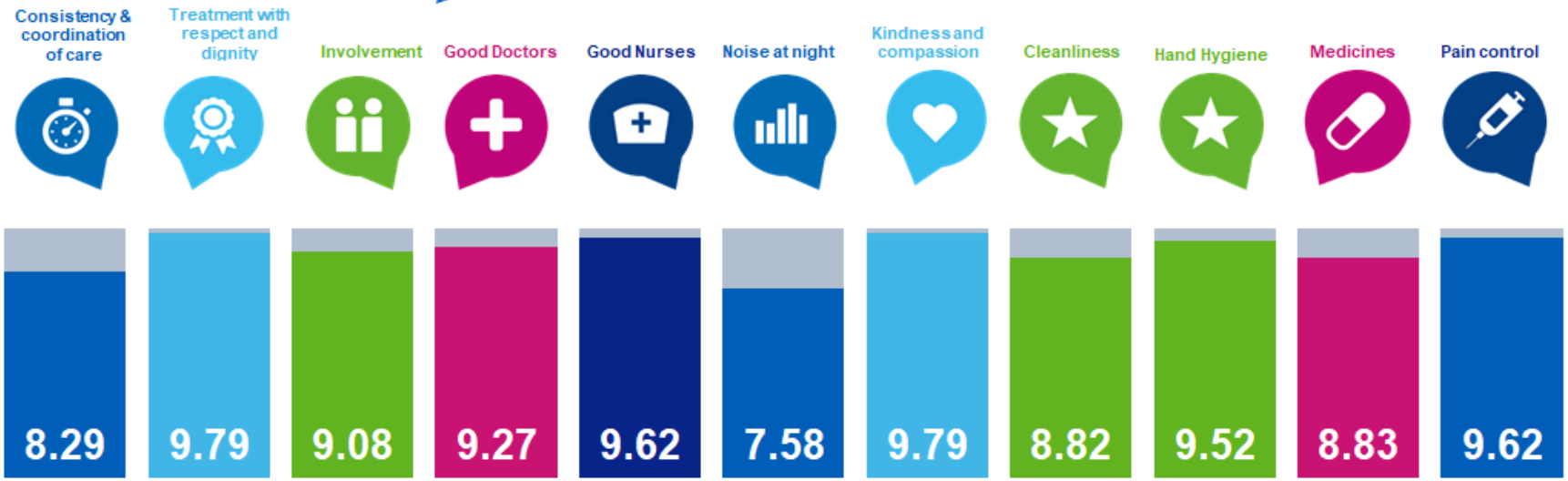
Incidents reported as Serious Incidents in January 2019

	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Total
Anaesthetics / Theatre / Surgery / Recovery	0	0	0	0	2	0	0	0	1	2	1	3	**9**
Breach /Cancellation of Treatment	0	0	1	0	0	1	1	1	1	2	4	0	**11**
COSHH (Contact with a harmful substance)	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Death of Person	0	0	2	0	0	0	0	0	0	0	0	0	**2**
Nutrition Related	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Fall/slip/trip	0	3	2	2	2	1	2	0	1	1	3	2	**19**
Manual handling of patients	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Infection Control	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Obstetrics related	3	1	0	0	1	0	0	0	1	0	1	1	**8**
Medication	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Treatment, procedure	0	2	0	1	1	1	1	0	1	2	2	1	**12**
Pressure Ulcer	0	3	1	2	0	0	1	0	3	3	2	4	**19**
Radiology investigations	0	0	0	0	0	0	0	0	1	2	1	0	**4**
Infrastructure e.g. buildings, utilities	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Safeguarding Adults (18 yrs. and over)	0	0	0	0	0	0	0	2	0	0	0	0	**2**
Totals:	3	9	6	6	6	6	7	3	9	12	14	11	**92**

Patient Experience Trust

How do patients rate us out of 10…?

NHS
South Tees Hospitals
NHS Foundation Trust

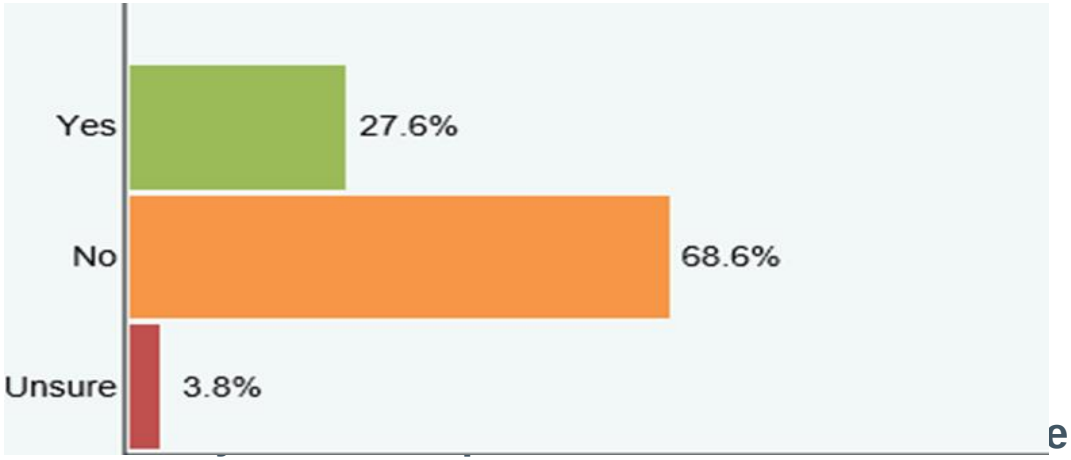


In January 2020 patients gave us an overall rating of... **9.02** out of 10

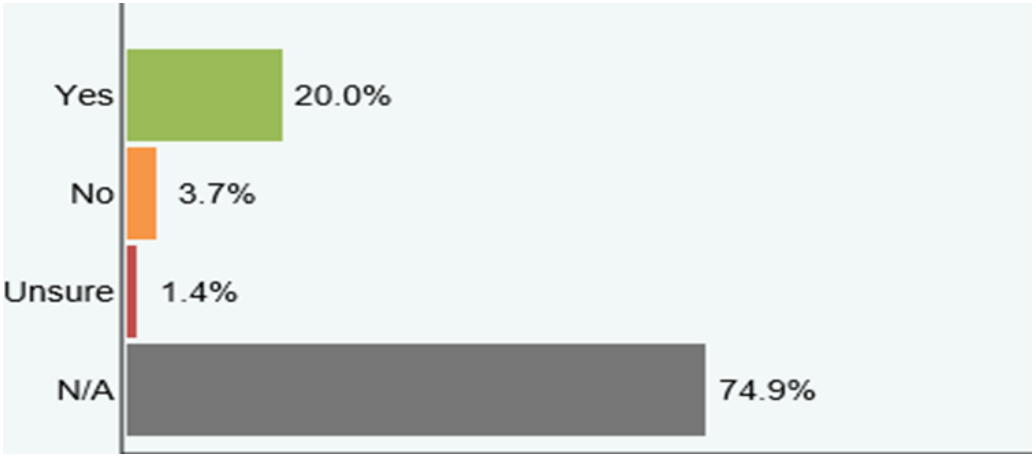
% of patients surveyed would highly likely or likely recommend this ward to their families and friends	98%	No of patients on new medication	440	No of respondents	864

Real-time inpatient survey responses relating to pre-admission communication, January 2020

- **10. Was this admission planned?**

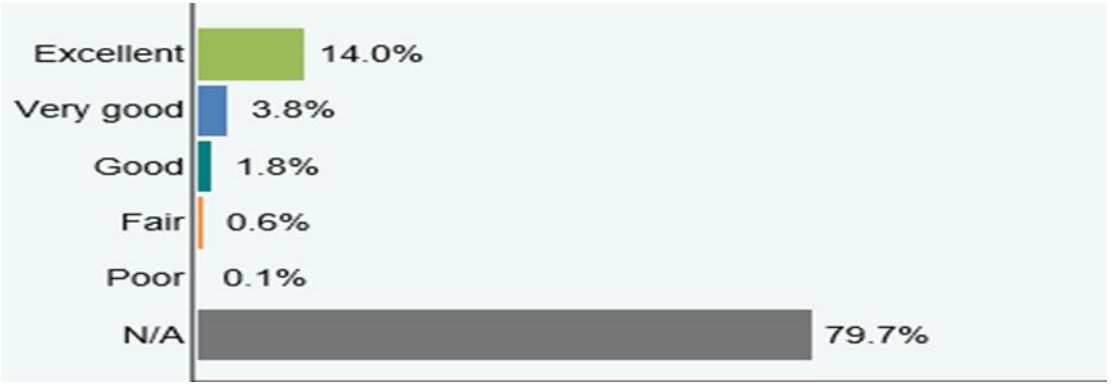


e Trust regarding your admission (e.g. a letter / phone call / text message)?



Real-time inpatient survey responses January 2020

- **12. How would you rate the information you received?**



- **<u>Comments regarding the information received prior to admission</u>**
- “Information received was complete and always delivered well”.
- “Received in a timely manner”.
- “Information given on operation before starting”

People

4

HR Workforce Data

Jan-2020

Sickness

Our overall sickness absent rate is 5.57% which is a 0.34% increase on December.

Short Term is 2.15% which is up 0.27% on our December position.
Long Term is 3.43%, which is up by 0.08% on our December position.

Stress/Anxiety accounts for the most FTE days lost at 3929.97 days and accounts for almost a third of all sickness.

In January, 260 staff were absent with Stress/Anxiety with an average of 15 days per employee.

Other musculoskeletal is next highest with 1500.38 FTE days lost.

Training

Our overall mandatory training compliance is 87.74% which is a 2.84% decrease on our December position.

Information Governance has the lowest compliance at 71.57% followed by Infection Control at 83.92%.

The portfolio with the highest concern is Trauma & Orthopaedics at 78.93% followed by General Surgery & Urology at 81.87%.

Paediatrics & Neonatology is the best performing portfolio at 93.60% followed by Theatres, Anaesthetics & Pain at 92.72%.

Appraisals

Our overall Target for appraisals is 82.96% which is a decrease by 0.78% on our December position.

However is compliant against our 80% compliance target which has been consistently achieved for 7 months.

The portfolio with the highest concern is Trauma & Orthopaedics with 69.96% compliance followed by Finance with 70.80%.

Reminders continue to be sent by HR to all staff and managers that are overdue. We currently have1437 overdue appraisals, 910 are from 2018, 372 from 2017 and105 from previous years.

Turnover

76 colleagues left the Trust in January 2020.

1 Dismissal – sickness absence
1 End of a fixed term contract
3 retire and returns
10 retirements
61 voluntary leavers

All leavers have been sent an exit interview questionnaire and a number of face to face interview have taken place. Data is being collated and analysis will go to workforce committee in March 2020.

Employee Relations

1 new grievance was received in January 2020 relating to cultural issues, raised as a FTSU concern.

5 new disciplinaries were opened in January 2020
1 x consultant – inappropriate comments
1 x Nurse - IG breach
1 x HCA – Patient care
1 x Nurse – registration renewal lapse
1 x HCA – working whilst on sick leave

Strategic Matters

Equality, diversity and inclusion network chair will be attending a Staff Networks Development Workshop - Thursday, 19 March 2020.

Values and Behaviours workshop took place on 12 February with 40 delegates in attendance.

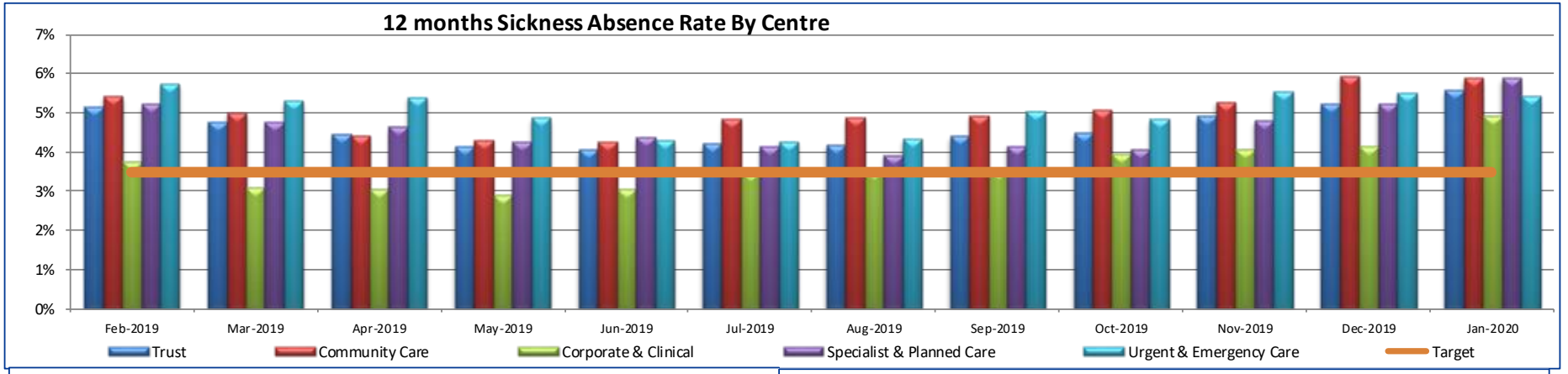
Our flu vaccination rate at the end of week 20 is 82.5%

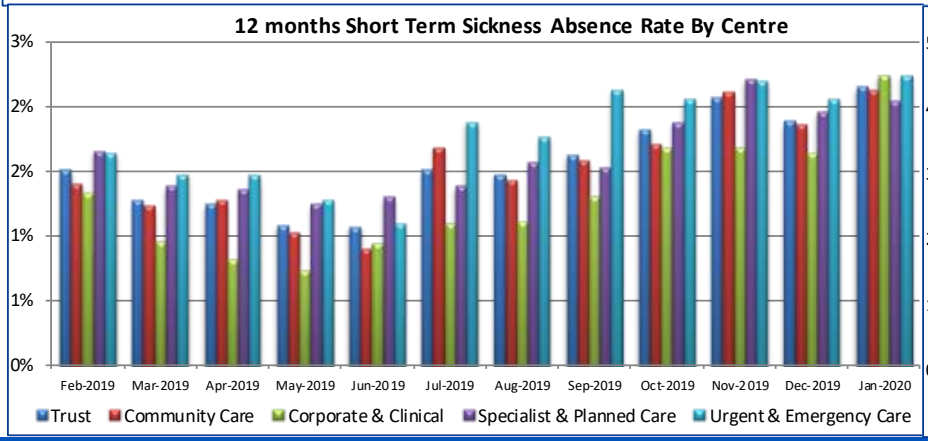
61 staff excellence reports were received in January 2020.

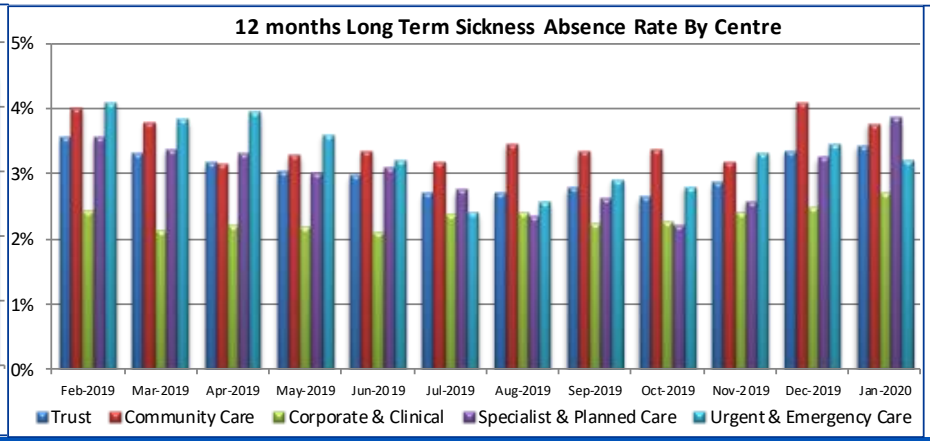
Sickness

Jan-2020

Trust	Community Care	Corporate	Specialist & Planned Care	Urgent & Emergency Care
5.57%	5.88%	4.94%	5.89%	5.43%
↑ 0.34%	↓ -0.05%	↑ 0.80%	↑ 0.67%	↓ -0.08%
5.23%	5.94%	4.14%	5.22%	5.52%







Top 10 Sickness by Ward/Department

Jan-2020

All Sickness

Rank	Ward/Department	FTE	% Rate
1	2204AD ICU JCUH	132.52	8.39%
2	7106AE Neonatal Unit	97.37	10.36%
3	6356FG Anaesthetics And Recovery JCUH	91.89	11.18%
4	2129AG Tocketts Ward ECH	51.23	15.21%
5	1051IF Pharmacy Department	128.11	5.83%
6	2019OA District Nursing Middlesbrough	85.95	6.71%
7	6400DA A & E Department JCUH	176.80	5.11%
8	5047AD Cardiothoracic ITU	67.16	6.84%
9	2027AA Ward 2 Acute Medicine	44.55	11.53%
10	2127OA District Nursing Redcar & Cleveland	82.95	12.95%

Short Term

Rank	Ward/Department	FTE	% Rate
1	2127OA District Nursing Redcar & Cleveland	82.95	5.80%
2	1051IF Pharmacy Department	128.11	3.42%
3	7106AE Neonatal Unit	97.37	4.22%
4	6356FG Anaesthetics And Recovery JCUH	91.89	4.37%
5	6400DA A & E Department JCUH	176.80	2.10%
6	2204AD ICU JCUH	132.52	2.42%
7	8157QI Medical Records JCUH	77.11	4.10%
8	7008AA Ward 8 Urology, Gynae & Ugi	44.42	5.88%
9	4211CA Ophthalmology Outpatients JCUH	35.56	7.02%
10	2207AD HDU	65.17	3.59%

Long Term

Rank	Ward/Department	FTE	% Rate
1	2204AD ICU JCUH	132.52	5.97%
2	2129AG Tocketts Ward ECH	51.23	12.62%
3	6356FG Anaesthetics And Recovery JCUH	91.89	6.80%
4	7106AE Neonatal Unit	97.37	6.14%
5	2127OA District Nursing Redcar & Clevelan	82.95	7.15%
6	5126AA Ward 27 Neurology	32.68	17.31%
7	6400DA A & E Department JCUH	176.80	3.01%
8	8157QI Medical Records JCUH	77.11	6.31%
9	7008AA Ward 8 Urology, Gynae & Ugi	44.42	11.06%
10	4217FB Ophthalmology Theatre JCUH	25.28	18.20%

Includes only Wards/Departments with greater than 5.0 WTE

Scoring is calculated by taking the FTE and multiplying by the % Absence Rate

Top 10 Sickness Reasons By FTE Days Lost

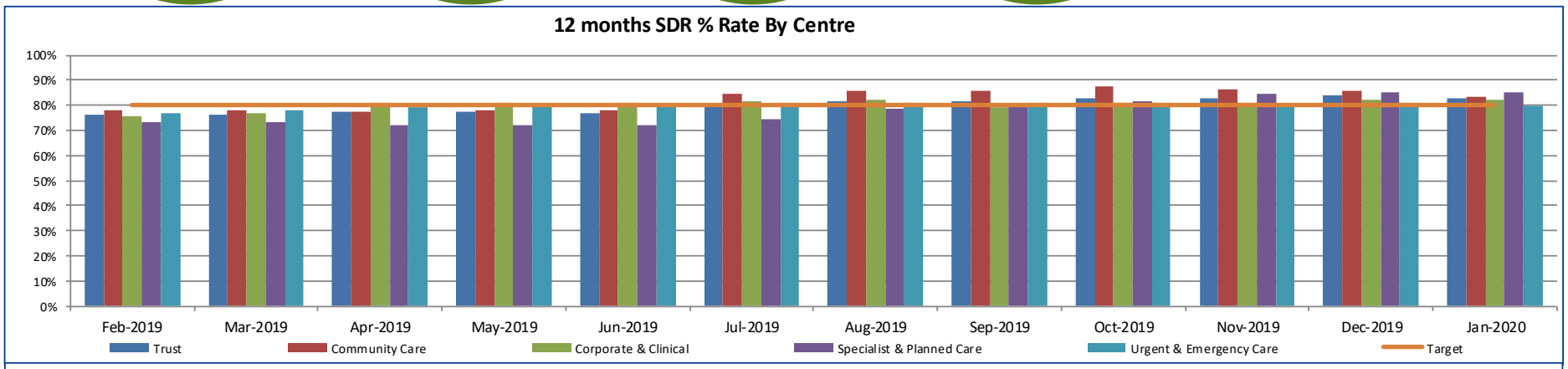
Absence Reason	Headcount	FTE Days Lost	Abs Estimated Cost	% of All Sickness
Stress/Anxiety	260	3,929.97	£333,461.06	30.9
Other musculoskeletal	111	1,500.38	£126,585.79	11.8
Cold, Flu	307	1,231.55	£120,778.64	9.7
Gastrointestinal	256	957.01	£75,919.24	7.5
Injury, fracture	69	945.77	£74,920.96	7.4
Back Problems	64	760.85	£64,791.78	6.0
Genitourinary & gynae	61	499.54	£40,627.16	3.9
Chest & respiratory	77	496.83	£44,181.90	3.9
Pregnancy related	42	400.64	£36,221.70	3.1
Unknown causes / Not specified	26	317.77	£35,439.87	2.5

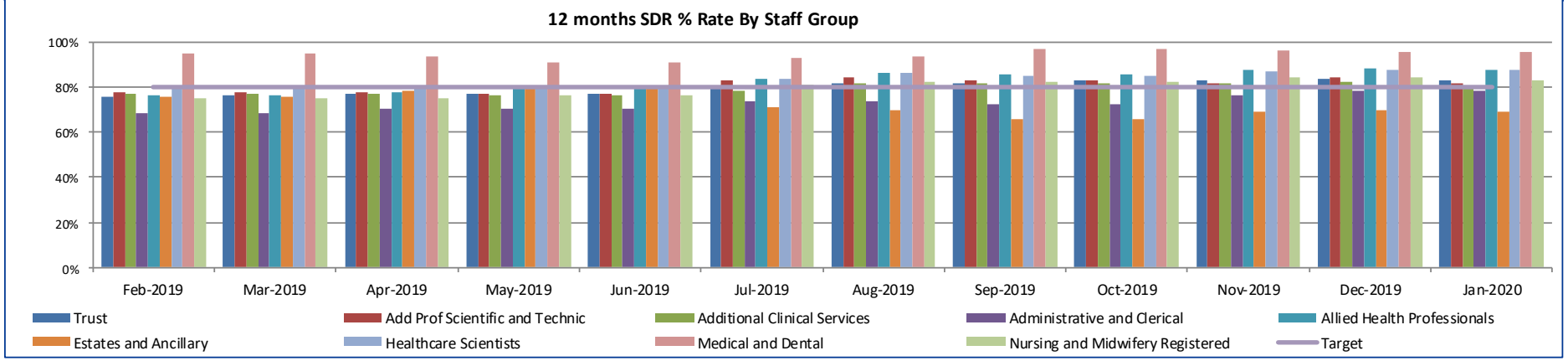
Total estimated cost = Salary Based Absence Cost OSP OMP Adjusted + Employers Cost OSP OMP Adjusted.
Please note, because ESR does not record shift patterns, this is only an estimate using the assignment FTE and calendar days.

SDR

Jan-2020

Trust	Community Care	Corporate	Specialist & Planned Care	Urgent & Emergency Care
82.96%	83.63%	82.31%	85.43%	79.56%
↓	↓	↑	↑	↓
-0.78%	-2.35%	0.34%	0.34%	-1.52%
83.74%	85.98%	81.96%	85.08%	81.09%

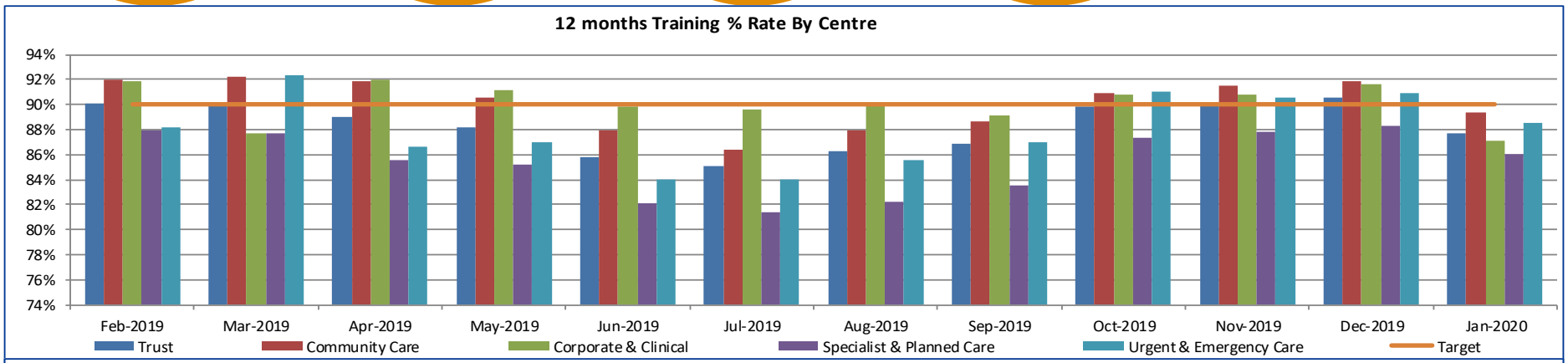


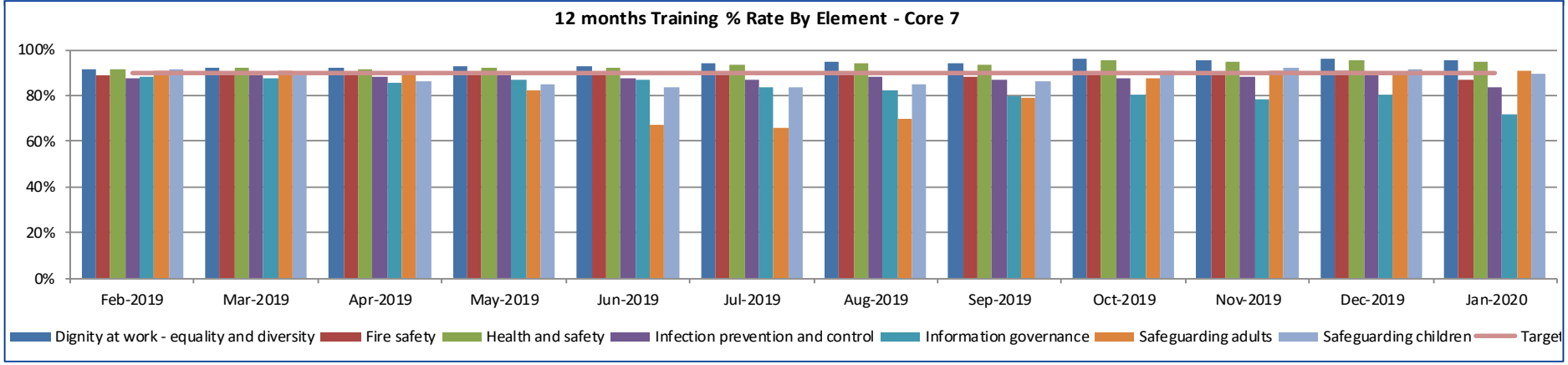


Training

Jan-2020

Trust	Community Care	Corporate	Specialist & Planned Care	Urgent & Emergency Care
87.74%	89.40%	87.14%	86.03%	88.53%
-2.84%	-2.48%	-4.55%	-2.23%	-2.41%
90.58%	91.88%	91.69%	88.26%	90.94%





Employee Relations

Jan-2020

Employee Relations Cases received

Month	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Jan-2020
Grievance	5	1	1	2	1	0	0	2	2	1	0	1
Disciplinary	11	6	4	4	4	6	4	5	5	2	1	5
Capability	0	1	1	0	0	2	0	1	0	0	0	0
Dignity at Work	2	0	0	1	2	1	1	0	1	0	0	0
Total	18	8	6	7	7	9	5	8	8	3	1	6

Reasons for Disciplinary Cases

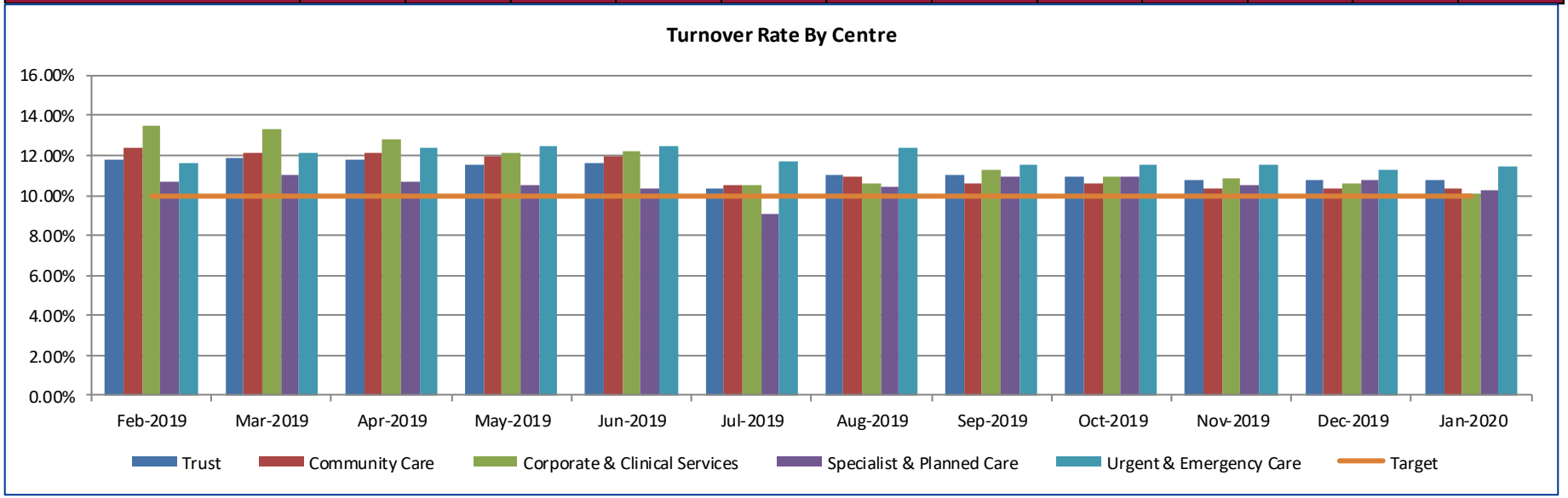
Nature of Allegation	Community Care	Corporate & Clinical Services	Specialist & Planned Care	Urgent & Emergency Care	Grand Total
Breach of confidentiality	1	1		2	4
Breach of Health and Safety Requirements		2			2
Disregard of instructions		2		3	5
Failure to Renew Prof Reg	2		2		4
Falsification of records	1				1
Fraud	2				2
Inappropriate Behaviour	4	4	4	4	16
Inappropriate use of NHS resources			1		1
Maltreatment of other Worker				1	1
Maltreatment of Patient / Client	5		1		6
Misconduct	6	1			7
Negligence	2		1		3
Other Allegation	3		2		5
Theft of Money or materials		2			2
Total	26	12	11	10	59

Staff in Post & Turnover

Jan-2020

Staff in Post by FTE

Centre	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Jan-2020
Community Care	2097.484	2101.994	2091.718	2000.513	1919.106	1929.45	1896.123	1915.062	1931.976	1928.669	1924.852	1927.502
Corporate & Clinical Services	1598.209	1596.729	1590.189	1595.536	1611.906	1634.873	1645.453	1650.902	1676.77	1685.463	1689.717	1699.022
Specialist & Planned Care	2093.291	2079.771	2081.957	2133.907	2163.39	2175.83	2187.016	2200.399	2226.834	2225.011	2216.271	2230.958
Urgent & Emergency Care	1612.835	1619.224	1616.664	1645.874	1667.481	1671.026	1664.8	1717.848	1722.771	1726.108	1728.521	1733.556
Trust	**7401.819**	**7397.719**	**7380.528**	**7375.83**	**7361.883**	**7411.178**	**7393.392**	**7484.212**	**7558.35**	**7565.251**	**7559.36**	**7591.038**



Leavers By Reason

Reasons	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Total
Dismissal	3	4	2	4	1	2	2	4	2	1		1	26
End of Fixed Term	8	2	1	4	1	5	50	8	4	1	1	1	86
Flexi Retirement	3	6	4	8	9	4	2	10	4	8	11	3	72
Redundancy	4	1	1	1				1					8
Retirement	7	20	19	15	11	12	9	10	13	9	11	10	146
Voluntary Resignation	38	60	42	37	51	48	65	69	31	47	35	61	584
Grand Total	**63**	**93**	**69**	**69**	**73**	**71**	**128**	**102**	**54**	**66**	**58**	**76**	**922**

Finance

5

Summary Financials - YTD January 2019

Community Care	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Other Income	3,673	3,960	**288**
Pay	(77,744)	(78,284)	**(540)**
Non Pay	(32,408)	(32,717)	**(309)**
Total	**(106,479)**	**(107,040)**	**(561)**

Corporate Clinical Services	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Other Income	19,130	20,270	**1,140**
Pay	(31,424)	(31,568)	**(144)**
Non Pay	(14,718)	(15,898)	**(1,180)**
Total	**(27,012)**	**(27,196)**	**(184)**

Specialist & Planned Care	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Other Income	2,954	2,944	**(10)**
Pay	(99,103)	(99,653)	**(551)**
Non Pay	(70,984)	(70,802)	**183**
Total	**(167,133)**	**(167,510)**	**(377)**

Urgent & Emergency Care	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Other Income	888	838	**(50)**
Pay	(72,750)	(74,050)	**(1,300)**
Non Pay	(10,849)	(11,125)	**(276)**
Total	**(82,712)**	**(84,338)**	**(1,626)**

Corporate	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Nhs Clinical Income	479,741	479,064	**(677)**
Other Income	15,148	9,342	**(5,806)**
Pay	(30,263)	(28,022)	**2,241**
Non Pay	(56,385)	(72,692)	**(16,307)**
Depreciation And Interest	(19,897)	(19,572)	**325**
Other Non Operating	(5,191)	(5,107)	**83**
Restructuring Costs	(417)	(365)	**52**
Total	**382,736**	**362,647**	**(20,089)**

Shm Pharmacy	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Other Income	28	41	**13**
Pay	(154)	(126)	**28**
Non Pay	(23)	(44)	**(21)**
Total	**(149)**	**(129)**	**20**

Total	**(749)**	**(23,565)**	**(22,817)**

- **Trust headlines YTD M10**
- **Control total**
- Behind plan by £22.8m
- Loss of PSF funding £6.0m, £16.8m being undelivered system savings, underlying on plan.
- Full year plan is a control total surplus of £3.2m
- **Productivity and Efficiency savings**
- YTD savings of £8.6m

Summary Financials – FY Forecast

Community Care	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Other Income	4,387	4,695	**308**
Pay	(93,455)	(94,125)	**(670)**
Non Pay	(38,901)	(39,343)	**(442)**
Total	**(127,970)**	**(128,773)**	**(803)**

Corporate Clinical Services	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Other Income	22,933	23,800	**867**
Pay	(37,783)	(38,014)	**(231)**
Non Pay	(17,541)	(19,578)	**(2,037)**
Total	**(32,390)**	**(33,792)**	**(1,402)**

Specialist & Planned Care	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Other Income	3,547	3,618	**71**
Pay	(118,897)	(119,881)	**(984)**
Non Pay	(85,202)	(85,149)	**53**
Total	**(200,553)**	**(201,412)**	**(859)**

Urgent & Emergency Care	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Other Income	1,065	1,001	**(64)**
Pay	(87,410)	(88,832)	**(1,422)**
Non Pay	(13,057)	(13,356)	**(299)**
Total	**(99,401)**	**(101,187)**	**(1,786)**

Corporate	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Nhs Clinical Income	576,242	575,571	**(671)**
Other Income	19,260	19,313	**53**
Pay	(36,555)	(33,505)	**3,050**
Non Pay	(64,605)	(90,356)	**(25,751)**
Depreciation And Interest	(23,876)	(24,138)	**(262)**
Other Non Operating	(6,229)	(6,229)	**0**
Restructuring Costs	(500)	(365)	**135**
Total	**463,737**	**440,291**	**(23,446)**

Shm Pharmacy	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Other Income	43	62	**20**
Pay	(231)	(195)	**36**
Non Pay	(29)	(52)	**(23)**
Total	**(217)**	**(185)**	**32**

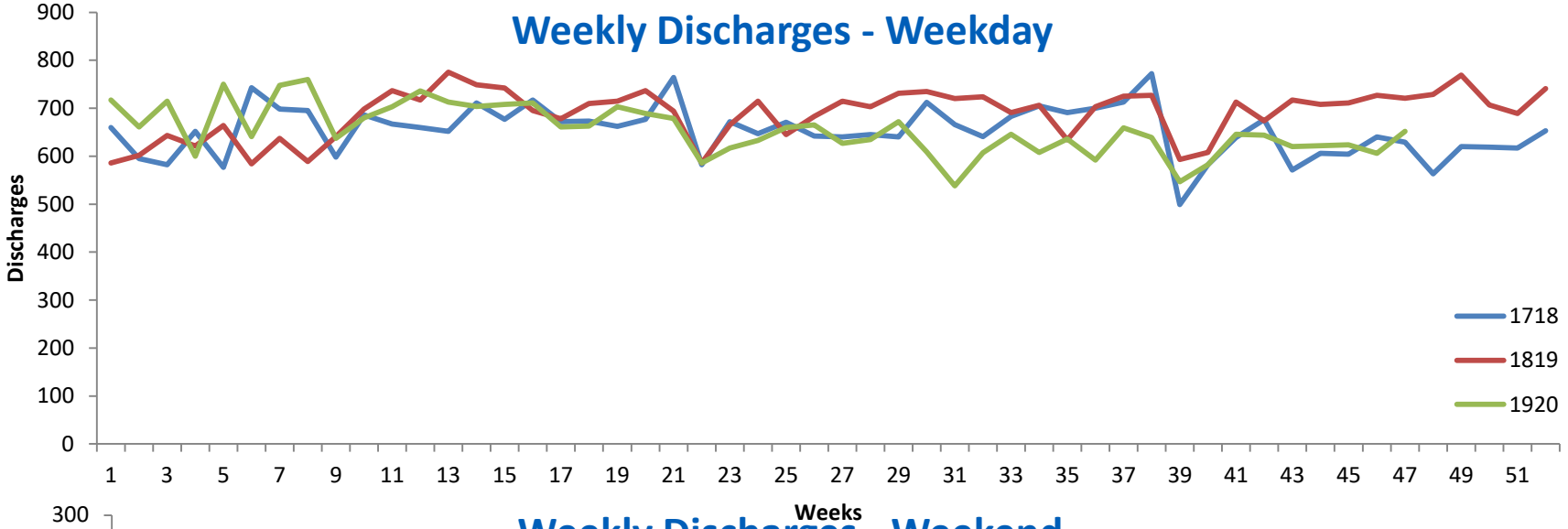
Total	**3,206**	**(25,058)**	**(28,264)**

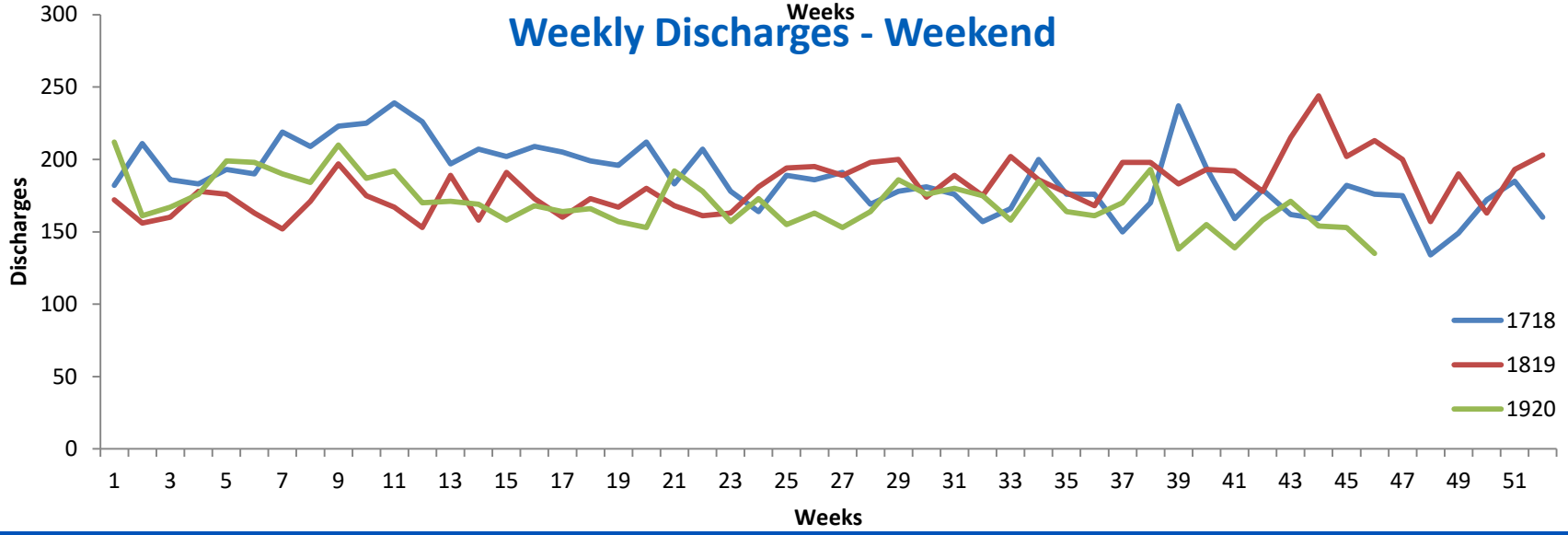
- **Control total**
- Behind plan by £28.3m
- Key variance being £22.0m being undelivered system savings, underlying Trust overspend of £6.3m
- Full year plan is a control total surplus of £3.2m
- **Productivity and Efficiency savings**
- Full year forecast savings of £9.9m

Appendices

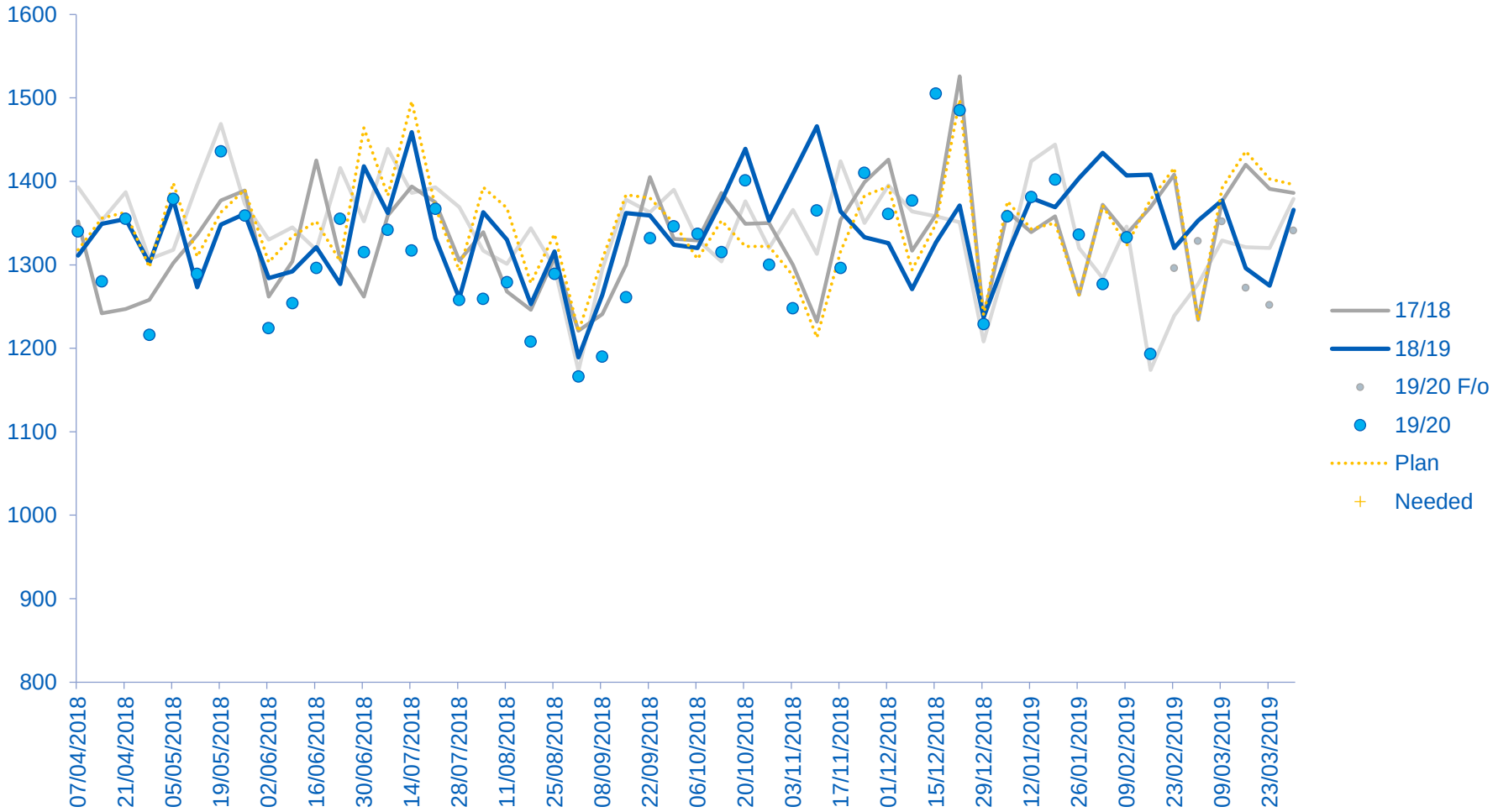
6

JCUH Adult Ward Discharge Rates



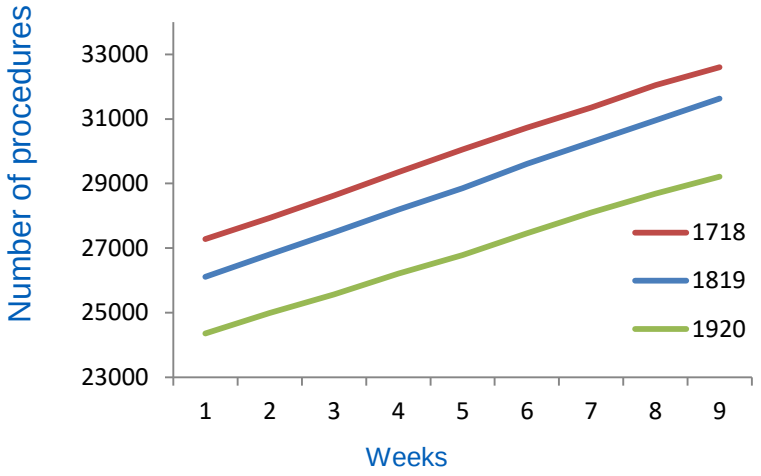


Non-Elective Delivery - All



Elective – Theatre Throughput

Elective overnight and day case - 9 week delivery period from 22/12/2019 FY19/20 compared with FY17/18 & FY18/19

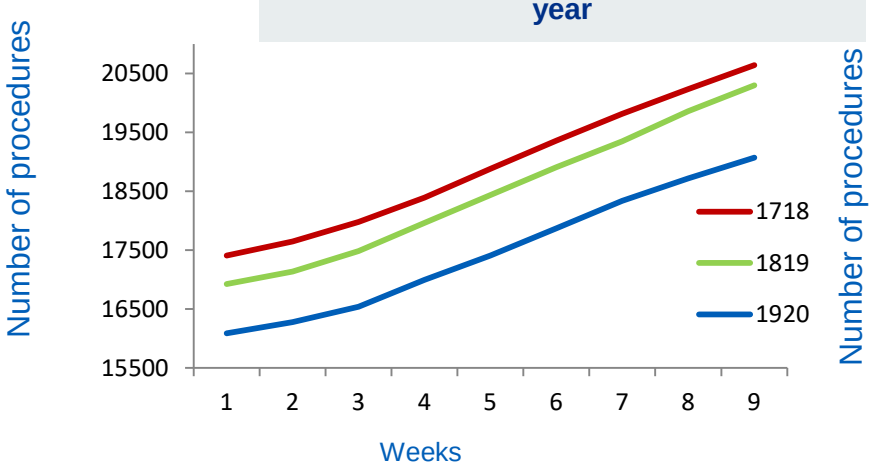


7.6% *less* cases undertaken in last 9 week period this year when compared to last.

YTD 12.6% *less* than last year

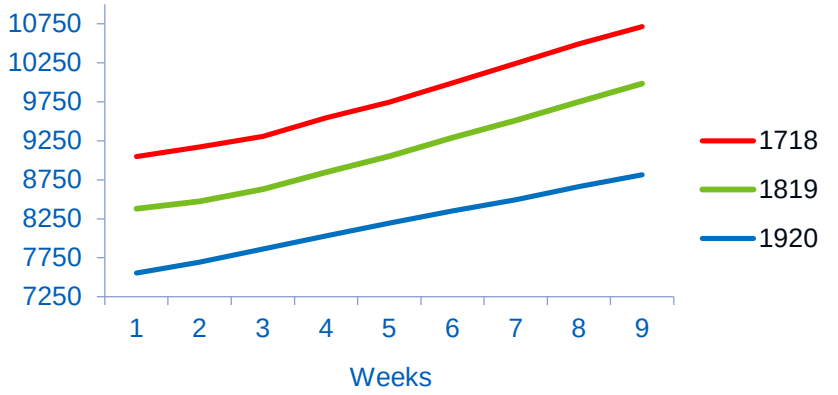
Elective day case

YTD 6.0% *less* when compared with last year



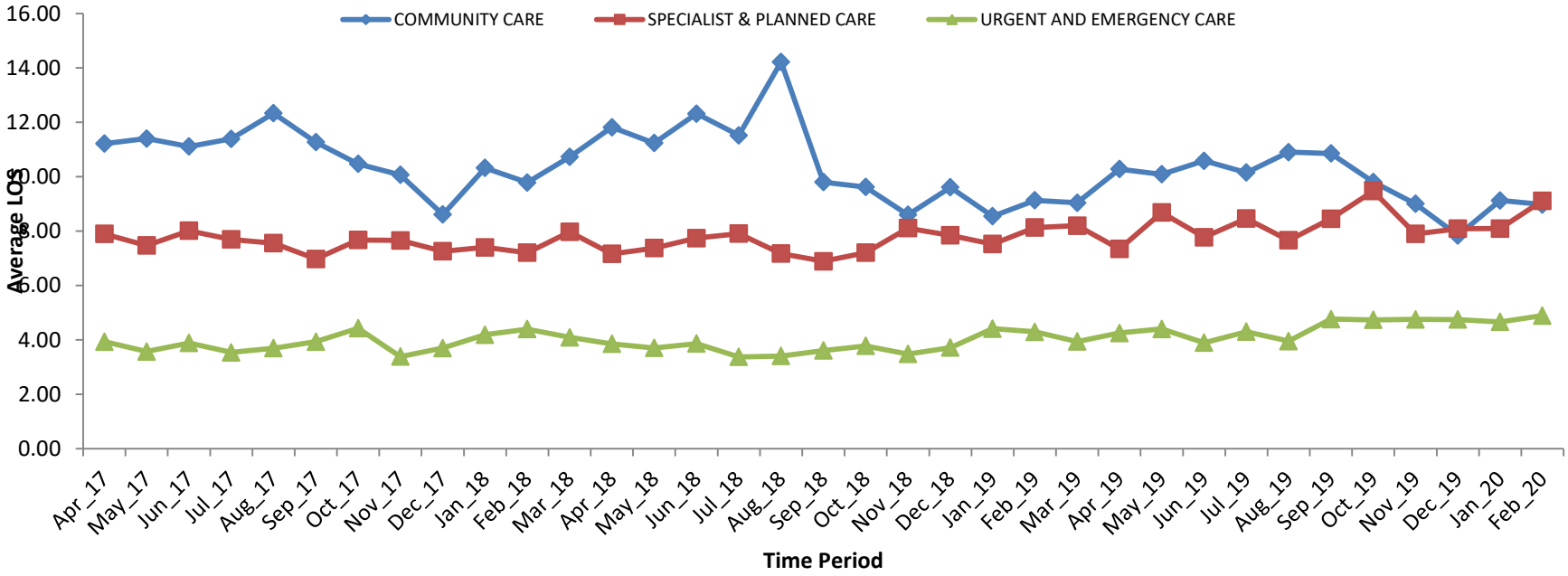
Elective overnight

YTD 11.7% *less* when compared with last year



Emergency Length of Stay by Centre

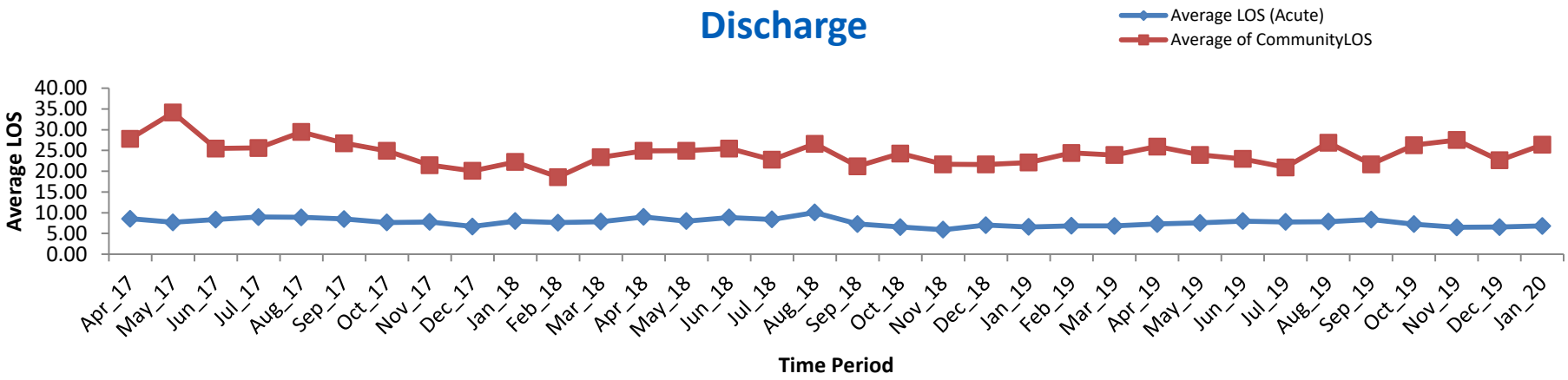
Emergency LOS by Centre at Discharge - 1st April 17 - 22nd Feb 2020



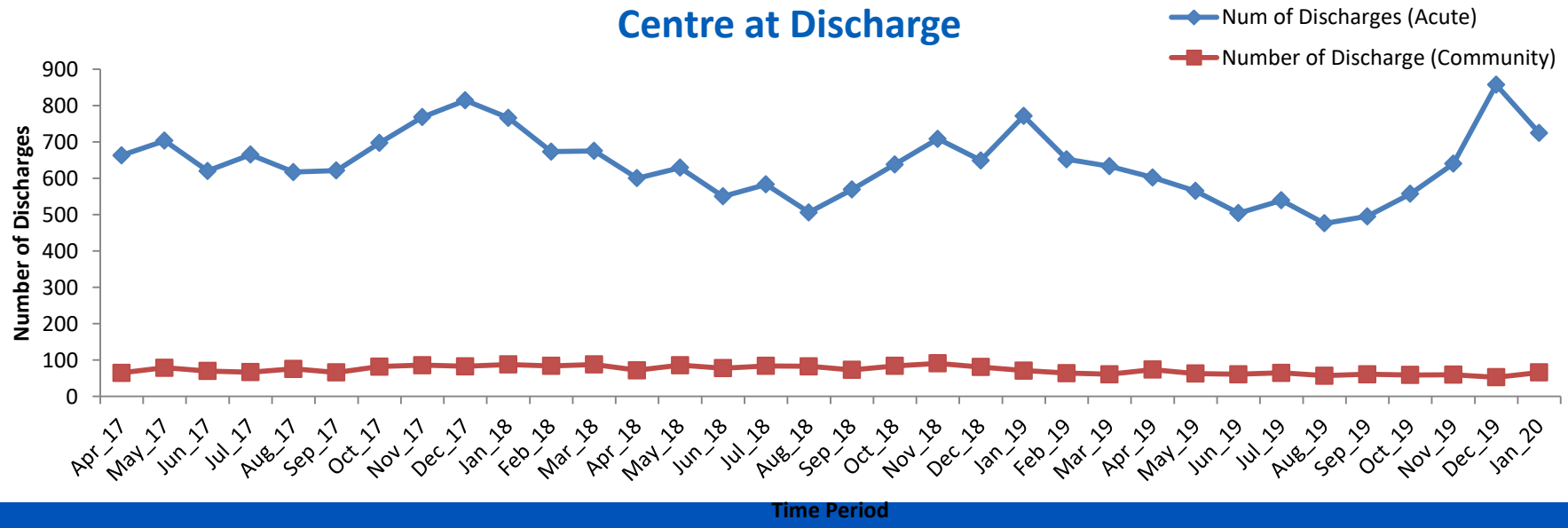
AVG LOS				
Centre	Community Care	Specialist & Planned Care	Urgent & Emergency Care	Grand Total
1718	10.7	7.6	3.9	7.2
1819	10.4	7.6	3.8	6.9
1920	9.7	8.2	4.4	7.3

Emergency LOS for Community Centre by Site Type

Average LOS by Site Type for Patients Under Community Care Centre at Discharge



Number of Discharges by Site Type for Patients Under Community Care Centre at Discharge



MEETING OF THE PUBLIC BOARD OF DIRECTORS – 3 MARCH 2020			
Month 10 2019/20 Financial Performance			**AGENDA ITEM: 14, 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 Trusts financial performance as at month 10.		
Background	The Trust has a year to date overspend of £22.8m driven by the loss of PSF and non-delivered system savings. This is forecast to increase to a full year overspend of £28.3m, included within the full year forecast are costs of £4.0m due to an exceptional cost from lifecycle prepayments. Excess costs of £17.5 million per year from the Trust's historical PFI scheme remain the largest single contributory factor to the organisation's structural deficit position.		
Assessment	Month 10 performance was behind what was forecast at month 9 due to a number of one off pressures, as outlined in the body of this report.		
Recommendation	Members of the Trust Board are asked to: • Discuss and Consider the contents of this report • Note that the Trust has agreed a year-end position with NHSE/I. • Note the liquidity position, capital plan and the proposed utilisation of revenue and capital borrowing.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The main risk from this report relates to the ongoing Trust overspend both year to date and full year forecast and the required actions that need to be taken to reduce this. A year end forecast position of a variance of £28.3m cannot be exceeded.		
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 ☒		

South Tees Hospitals
NHS Foundation Trust

Month 10 2019/20 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 10.

2. BACKGROUND

The Trust Control Total for 2019/20 is a £3.2m surplus, inclusive of £9.7m PSF funding.

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 NHSI.

The month 10 YTD budget is a £0.7m deficit position. The month 10 YTD actual performance is a £23.6m deficit. This has resulted in the Trust being behind plan by £22.8m. Of this, £6.0m is due to the loss of PSF funding giving an underlying position of £16.8m behind plan. The saving required from the system CIP of £22.0m has been phased into the Trust's position with a year to date budget reduction of £16.8m. The Trust is therefore on plan out-with the system saving target and PSF. The system saving is the responsibility of the Trust unless additional funding is agreed.. The original risk sharing agreement is unlikely to deliver an in- year contribution. The Trust will therefore continue to look for in-year savings to mitigate any deficit.

Full year the Trust is forecasting a deficit of £25.1m showing a variance to plan including PSF of £28.3m.

Key risks remain within the year to date and full year position in relation to:

- NHS property services and confirmation of current and prior year charges.
- Medical premium pay for additional sessions and IPAs.
- Capacity within Radiology and the switch off costs from outsourcing and agency to substantive staffing.

The Trust is exploring the feasibility of a capital to revenue transfer to mitigate these risks.

3. DETAILS

Trust position

The month 10 YTD and full year forecast position is outlined below; the following section outlines key variances and risks for divisional income, pay, non-pay and technical items.

Performance per directorate is shown in appendix 1 along with detailed reconciliations on forecast movements in appendix 2.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Nhs Clinical Income	479,741	479,064	**(677)**	576,242	575,666	**(576)**
Education And Training Income	13,465	13,995	**530**	16,120	16,616	**496**
Estates Income	4,112	4,402	**290**	4,936	5,262	**326**
Misc Other Income	7,862	7,558	**(304)**	9,754	17,408	**7,654**
Non Patient Care Income	2,020	2,558	**538**	2,419	2,939	**520**
Other Clinical Income	2,737	2,552	**(184)**	3,278	3,081	**(197)**
Psf And Mret	8,092	2,094	**(5,998)**	10,487	2,221	**(8,266)**
Research & Development Income	3,534	4,238	**704**	4,241	4,868	**627**
Total Income	**521,562**	**516,460**	**(5,102)**	**627,477**	**628,061**	**584**
Ahp'S, Sci, Ther & Tech	(45,890)	(45,036)	**853**	(55,179)	(54,099)	**1,080**
Apprentice Levy	(1,110)	(1,154)	**(44)**	(1,332)	(1,384)	**(52)**
Hca'S And Support Staff	(30,830)	(32,656)	**(1,825)**	(37,082)	(39,219)	**(2,137)**
Medical And Dental	(90,326)	(93,862)	**(3,537)**	(108,765)	(113,137)	**(4,372)**
Nhs Infrastructure Support	(43,187)	(43,784)	**(597)**	(51,725)	(52,397)	**(672)**
Nursing & Midwife Staff	(100,095)	(95,211)	**4,884**	(120,247)	(114,316)	**5,931**
Total Pay	**(311,438)**	**(311,703)**	**(265)**	**(374,332)**	**(374,552)**	**(220)**
Clinical Negligence Cost	(14,560)	(13,917)	**642**	(17,472)	(16,829)	**643**
Clinical Supplies And Services	(59,105)	(59,881)	**(777)**	(70,763)	(71,486)	**(723)**
Drugs	(56,217)	(55,611)	**606**	(66,691)	(66,832)	**(141)**
Establishment	(6,166)	(6,777)	**(612)**	(7,475)	(8,396)	**(921)**
Ext Staffing And Consultancy	(285)	(624)	**(339)**	(341)	(795)	**(454)**
General Supplies And Service	(3,635)	(3,173)	**463**	(4,373)	(3,807)	**566**
Healthcare Service Purchase	(4,384)	(4,940)	**(556)**	(5,286)	(5,822)	**(536)**
Miscellaneous Services	(5,824)	(6,270)	**(446)**	(6,907)	(7,646)	**(739)**
Pfi Unitary Payment	(24,850)	(25,036)	**(186)**	(29,746)	(34,014)	**(4,268)**
Premises & Fixed Plant	(21,645)	(21,623)	**23**	(25,661)	(25,775)	**(114)**
Research, Education & Training	(1,642)	(1,858)	**(216)**	(1,934)	(2,042)	**(108)**
System Savings	16,846	0	**(16,846)**	22,000	0	**(22,000)**
Transport	(3,902)	(3,568)	**334**	(4,686)	(4,391)	**295**
Total Non Pay	**(185,369)**	**(203,278)**	**(17,910)**	**(219,334)**	**(247,835)**	**(28,501)**
Depreciation	(10,668)	(10,229)	**438**	(12,801)	(12,806)	**(05)**
Interest Payable	(9,313)	(9,514)	**(202)**	(11,175)	(11,507)	**(332)**
Interest Receivable	83	172	**89**	100	175	**75**
Other Non Operating	(5,191)	(5,107)	**83**	(6,229)	(6,229)	**0**
Restructuring Costs	(417)	(365)	**52**	(500)	(365)	**135**
Control Total	**(749)**	**(23,565)**	**(22,817)**	**3,206**	**(25,058)**	**(28,264)**

Clinical Income

The NHS Clinical YTD income position has improved from month 9 by £0.1M. The month 10 YTD position is behind plan by £0.7m this is due to underperformance against the non AIC contracts of £0.3m and the finalisation of the income position from 2018/19, which is showing a variance of £0.4m.

The Trust is currently forecasting an adverse variance of £0.6m, which is a £.01M improvement on last month's forecast. This is based on improving the year to date variance from the non-aligned incentive income. As shown below the estimated impact of the aligned incentive contract is an overall benefit of £5.4m in the YTD position and £4.2m in the forecast. If any challenges were recognised this would increase the overall benefit up to £22.2m in the full year position. The forecast below assumes that activity is delivered in the same trend as in 2018/19.

The HRW CCG plan now reflects a reduction in income relating to the reconfiguration of services at the Friarage hospital. All additional income received in month has been added to the income position and the expenditure has been matched in the forecast position.

Aligned Incentive Contract Performance YTD to Month 10 - 12ths and Forecast Outturn

Code	Commissioner Name	Price Plan	Price Actual	Price Diff	Indicative Challenges	Revised Actual	Revised Variance	Price Plan	Price Actual	Price Diff	Indicative Challenges	Revised Actual	Revised Variance
00C	NHS DARLINGTON CCG	(6,230)	(5,859)	371	348	(5,511)	719	(7,482)	(7,073)	409	418	(6,655)	827
00D	NHS DURHAM DALES EASINGTON AND SEDGEFIELD CCG	(10,167)	(9,670)	497	464	(9,205)	961	(12,200)	(11,682)	518	557	(11,125)	1,075
00J	NHS NORTH DURHAM CCG	(1,233)	(1,083)	150	56	(1,028)	206	(1,480)	(1,313)	167	67	(1,246)	234
00K	NHS HARTLEPOOL AND STOCKTON-ON-TEES CCG	(31,283)	(31,246)	37	963	(30,283)	1,000	(37,540)	(37,598)	(58)	1,156	(36,442)	1,098
00M	NHS SOUTH TEES CCG	(193,955)	(194,529)	(574)	10,127	(184,402)	9,553	(233,301)	(235,022)	(1,721)	12,152	(222,870)	10,431
00N	NHS SOUTH TYNESIDE CCG	(138)	(83)	55	2	(82)	57	(166)	(102)	64	2	(100)	67
00P	NHS SUNDERLAND CCG	(455)	(367)	88	9	(359)	97	(546)	(445)	101	10	(435)	112
01H	NHS NORTH CUMBRIA CCG	(528)	(454)	73	0	(454)	73	(633)	(547)	86	0	(547)	86
03D	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	(68,675)	(68,587)	88	2,730	(65,857)	2,818	(82,410)	(82,965)	(555)	3,276	(79,689)	2,721
03M	NHS SCARBOROUGH AND RYEDALE CCG	(833)	(669)	164	0	(669)	164	(1,000)	(804)	196	0	(804)	196
03Q	NHS VALE OF YORK CCG	(1,185)	(1,097)	88	0	(1,097)	88	(1,422)	(1,325)	97	0	(1,325)	97
13T	NHS NEWCASTLE GATESHEAD CCG	(251)	(364)	(113)	0	(364)	(112)	(302)	(440)	(138)	1	(440)	(138)
13X	NHS ENGLAND - Specialised	(148,396)	(143,944)	4,452	300	(143,644)	4,753	(178,076)	(173,043)	5,033	360	(172,682)	5,394
	Grand Total	**(463,331)**	**(457,955)**	**5,376**	**15,000**	**(442,955)**	**20,376**	**(556,558)**	**(552,359)**	**4,199**	**18,000**	**(534,359)**	**22,199**
	AIC Adjustment	0	(5,376)	(5,376)				0	(4,199)	(4,199)			
	Non AIC Income	(16,410)	(16,159)	251				(19,684)	(19,534)	151			
	Prior Year	0	425	425				0	425	425			
	NHS Clinical Income	**(479,741)**	**(479,064)**	**677**				**(576,242)**	**(575,667)**	**576**			

The detail by contract of the £0.3m YTD underperformance and the expected £0.2m forecast under performance on non AIC contracts is shown in the table below. The forecast is mainly driven by an underperformance on Hep C and MOD activity. The Hep C drugs variance can be offset by an underspend in the expenditure position.

Non Aligned Incentive Contract Performance YTD to Month 10 - 12ths and Forecast Out Turn

Code	Commissioner Name	Price Plan	Price Actual	Price Diff	Price Plan	Price Actual	Price Diff
03E	Harrogate and Rural CCG	(2,152)	(2,121)	32	(2,583)	(2,559)	24
13Q	Ministry of Defence	(1,845)	(1,402)	442	(2,214)	(1,691)	523
Q72	NHS England - Yorkshire & Humber	(1,092)	(956)	136	(1,310)	(1,163)	147
Q74	NHS England - Cumbria & North East	(4,583)	(4,701)	(118)	(5,499)	(5,713)	(214)
CBF	Cross Boarder Flows	(199)	(136)	63	(239)	(164)	75
NCA	Non Contract Activity	(2,330)	(2,579)	(248)	(2,796)	(3,126)	(330)
CDF	Cancer Drug Fund	(2,906)	(3,386)	(480)	(3,487)	(4,063)	(576)
AQP	AQP Audiology	(100)	(124)	(24)	(120)	(151)	(30)
HepC	Hepatitis C Drugs	(1,052)	(651)	401	(1,263)	(781)	482
MPK	Micro Processor Knees	(144)	(103)	41	(173)	(124)	50
	Grand Total	**(16,410)**	**(16,159)**	**251**	**(19,684)**	**(19,534)**	**151**

Other Income

YTD other income is £4.4m behind plan. Within this position YTD PSF funding of £6.0m has been removed. As a result, Trust income variance excluding PSF funding is £1.6m ahead on income. Full year, the Trust is forecast to be ahead of plan on income by £1.2m, with a PSF loss of £8.3m Excluding this income loss the Trust is forecast to be ahead on other income by £9.5m. This over achievement is due to additional forecast income being confirmed of £8.0m.

From the forecast that was completed at month 9, expected YTD other income for month 10 was £37.2m, with actual YTD income being £37.4m showing a variance to forecast of £0.2m. The key driver for this being additional Education and Training Income from HENE.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Education And Training Income	13,465	13,995	**530**	16,120	16,616	**496**
Estates Income	4,112	4,402	**290**	4,936	5,262	**326**
Misc Other Income	7,862	7,558	**(304)**	9,754	17,408	**7,654**
Non Patient Care Income	2,020	2,558	**538**	2,419	2,939	**520**
Other Clinical Income	2,737	2,552	**(184)**	3,278	3,081	**(197)**
Psf And Mret	8,092	2,094	**(5,998)**	10,487	2,221	**(8,266)**
Research & Development Income	3,534	4,238	**704**	4,241	4,868	**627**
Total Other Income	**41,821**	**37,397**	**(4,424)**	**51,234**	**52,395**	**1,161**

- Education and Training income is over achieving by £0.5m YTD due to additional one off income being received from HENE and the confirmation of Q3 payments. This position is expected to continue to the full year forecast.
- Non patient care income is over achieving by £0.5m due to increases in maternity pathway income, this is expected to continue for the rest of the year with a full year forecast variance of £0.5m.
- Other clinical income is behind plan YTD by £0.2m due to lower private patient and overseas visitor's income, the forecast assumes that this underachievement will not be recovered but the current rates of income will continue with a full year forecast variance of £0.2m.
- R and D income is over achieving both YTD £0.7m and full year £0.6m this additional income is covering increased costs within non pay.

Pay

In the year to date position pay is overspent by £0.3m, with a full year forecast variance of an overspend of £0.2m. This increase in pay cost is being driven by additional recruitment in the latter part of the financial year for example PACU, additional medical consultants and increases in administration staff.

Compared to the month 9 forecast for month 10 pay was forecast to be £311.5m with actual pay costs being £0.2m higher at £311.7 m.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Ahp'S, Sci, Ther & Tech	(45,890)	(45,036)	**853**	(55,179)	(54,099)	**1,080**
Apprentice Levy	(1,110)	(1,154)	**(44)**	(1,332)	(1,384)	**(52)**
Hca'S And Support Staff	(30,830)	(32,656)	**(1,825)**	(37,082)	(39,219)	**(2,137)**
Medical And Dental	(90,326)	(93,862)	**(3,537)**	(108,765)	(113,137)	**(4,372)**
Nhs Infrastructure Support	(43,187)	(43,784)	**(597)**	(51,725)	(52,397)	**(672)**
Nursing & Midwife Staff	(100,095)	(95,211)	**4,884**	(120,247)	(114,316)	**5,931**
Total Pay	**(311,438)**	**(311,703)**	**(265)**	**(374,332)**	**(374,552)**	**(220)**

Non-Pay

Year to date non pay is £17.9m behind plan. the month 9 forecast for month 10 was non pay spend of £202.5m, with actual non-pay costs being £0.8m over forecast.
The full year forecast for non-pay is anoverspend of £28.5m largely driven by the non-achievement of systems savings of £22.0m and PFI pressures.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Clinical Negligence Cost	(14,560)	(13,917)	**642**	(17,472)	(16,829)	**643**
Clinical Supplies And Services	(59,105)	(59,881)	**(777)**	(70,763)	(71,486)	**(723)**
Drugs	(56,217)	(55,611)	**606**	(66,691)	(66,832)	**(141)**
Establishment	(6,166)	(6,777)	**(612)**	(7,475)	(8,396)	**(921)**
Ext Staffing And Consultancy	(285)	(624)	**(339)**	(341)	(795)	**(454)**
General Supplies And Service	(3,635)	(3,173)	**463**	(4,373)	(3,807)	**566**
Healthcare Service Purchase	(4,384)	(4,940)	**(556)**	(5,286)	(5,822)	**(536)**
Miscellaneous Services	(5,824)	(6,270)	**(446)**	(6,907)	(7,646)	**(739)**
Pfi Unitary Payment	(24,850)	(25,036)	**(186)**	(29,746)	(34,014)	**(4,268)**
Premises & Fixed Plant	(21,645)	(21,623)	**23**	(25,661)	(25,775)	**(114)**
Research, Education & Training	(1,642)	(1,858)	**(216)**	(1,934)	(2,042)	**(108)**
System Savings	16,846	0	**(16,846)**	22,000	0	**(22,000)**
Transport	(3,902)	(3,568)	**334**	(4,686)	(4,391)	**295**
Total Non Pay	**(185,369)**	**(203,278)**	**(17,910)**	**(219,334)**	**(247,835)**	**(28,501)**

- Clinical supplies and services are showing a year to date variance of £0.8m and full year overspend of £0.7m. Within the full year forecast a saving of £0.5m has been included within the category for additional grip and control. Excluding this the full year position would be an overspend of £1.2m the key driver for this being costs for infusion pumps in diabetes of £1.1m.
- A benefit is shown against CNST for £0.6m linked to a rebate due to maternity.
- Drug costs are forecast to be overspent by the year end by £0.1m being driven by increase in costs for Ophthalmology, HEPC and increased activity.
- Establishment costs are overspending YTD by £0.6m with this forecast to increase to £0.9m by the year end. The key causes of both the YTD and full year variances being postage and carriage costs.
- PFI costs are forecast to be overspent by £4.3m by the year end. This being the required write off of underutilised lifecycle prepayments. Following discussions with the Trust's external auditor and PFI partner, the total cost for this financial year is £4.9m. A provision has been made within the annual

2019/20 budget of £0.9m for this resulting in a cost pressure of £4.0m. The remaining overspend has been driven by increases in contract variations.

- Transport costs are showing a YTD and full year underspend.

Non-Operating Costs

A budget of £0.5m has now been provided for restructuring costs provided from reserves phased across the full year with 10 months shown within the YTD position. YTD spend on restructuring has been £0.4m. No further spend is anticipated for the remaining months of the year.

Depreciation is showing a YTD underspend of £0.5m=.

Other technical items are broadly in line with budgeted amounts.

Efficiency programme

The Trust's overall savings requirement for 2019/20 is a savings programme of £31.9m. In order to mitigate savings that have not progressed from the original CIP plan, for example PFI savings, other schemes have been developed.

The YTD savings target is £24.7m and the Trust has delivered £8.6m. The key variance is the system saving requirement of £16.8m. YTD the Trust has exceeded the internal plan to mitigate an element of the system saving requirement. By year end the Trust is forecasting to achieve CIP of £9.9m being the CIP plan less the systems savings target of £22.0m.

CIP Scheme	YTD Target £'000	YTD Delivery £'000	YTD Variance £'000	Full Year Target £'000	Full Year Delivery £'000	Full Year 2020/21 £'000
Admin Review	1,667	1,667	-	2,000	2,000	2,000
Therapies	1,583	1,583	-	1,900	1,900	1,900
Estates	389	508	**119**	500	550	203
Procurement	672	472	**(200)**	860	497	325
PFI Review	778		**(778)**	1,000	-	-
GIA Review	1,083	1,083	-	1,300	1,300	1,300
Drugs	820	1,389	**569**	1,100	1,582	1,156
Commercial Review	-	-	-	200	-	-
Community Savings	833	573	**(260)**	1,000	680	617
Other Savings	-	1,299	**1,299**	-	1,375	453
System Savings	16,846	-	**(16,846)**	22,000	-	-
Total	**24,671**	**8,574**	**(16,097)**	**31,860**	**9,884**	**7,953**

Cash and Working Capital

Liquidity

The Trust held £11.9 million at the end of January (£10.1 million ahead of plan). The Trust continues to retain a higher than planned cash balance as reported in earlier

months and this will be utilised during February and March to cover aged payable balances..

March will these the quarterly PFI, Department of Health and Social Care debt repayments and the Trust's obligation to augment available cash for supplier payments. It is anticipated that the higher than planned level of liquidity carried through from January, supported by deficit funding and Capital Support utilised from February, will provide sufficient funding to cover these pressures.

The Trust's planned cash holdings are set at £1.8 million based on the recommendation of NHS Improvement.

Working capital

Payables update

During January the Trust spent £30.3 million on payments to suppliers and the Trust will have approximately £22.5 million available to spend on suppliers in February.

The age profile of payments, as reported in line with the Better Payment Practice Code (BPPC target 95%), currently stands at 79%. There continues to be a gradual improvement in the BPPC during the financial year from April when it stood at 67%.

Outstanding debt and accrued income

The value of aged outstanding debt at the end of December amounted to £9.1 million.. During February and March the Trust will continue to concentrate recovery on the aged and higher value debt.

The Trust has a balance on accrued income at the end of January amounting to £11.3 million, an increase of £1.7 million from the end of December. The balance mainly consists of Commissioner income including work in progress (£6.8 million).

Capital

The following table provides a summary of the position on capital expenditure, the full year forecast and funding position.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
PFI Lifecycle	7,767	9,020	(1,253)	10,824	10,824	0
Site Reconfiguration	0	4,585	(4,585)	70	4,963	(4,893)
Replacement of Medical Equipment	1,047	1,655	(608)	1,690	2,120	(430)
Network Replacement and Clinical Noting	0	1,952	(1,952)	0	5,809	(5,809)
Cancer Transformation	0	200	(200)	200	200	0
£1.4m Bid	0	299	299	0	1,172	1,172
£2m Winter Pressures	0	111	102	0	1,186	1,186
£3m Bid	0	183	183	0	3,492	3,492
Total	8,814	18,005	(8,014)	12,784	29,766	(5,282)

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Financing						
Depreciation	5,918	5,918	0	5,918	5,918	0
Capital - LRI	2,430	11,373	(8,943)	6,266	12,875	(6,609)
Macmilan	0	0	0	0	0	0
Charitable contributions including Newcastle University contribution towards LRI	266	514	(248)	400	1000	(600)
Interim Support	0	0	0	0	3,935	(3,935)
PDC (received in 2018/19)	200	200	0	200	6,038	(5,838)
Total Financing	**8,814**	**18,005**	**(9,191)**	**12,784**	**29,766**	**(16,982)**

As at 31 January the Trust has spent £18.0 million on its capital programme with a forecast spend of £29.8 million In agreement with NHSE/I. A detailed analysis of the capital schemes within this programme is included in the attached annex.

The major areas of expenditure included in the forecast include:

- Contractual PFI lifecycle payment to the PFI Provider (£10.8 million);
- Medical equipment - £6.0 million allocation of which £2.3 million is currently committed;
- Estate schemes – allocations for the LRI refurbishment, PACU/SAU and further allocations for Community Premises, Trust lifecycle works within Ward 12 and Theatre 3 and the Pharmacy refit following Board approval of the formation of the wholly owned subsidiary;
- Information Technology - £7.4 million included to cover Voice Recognition, Pharmacy LIMS server replacement, UPS, backups and an allocation for equipment replacement. This allocation covers the planned replacement programme of desktops, servers and laptops given the age and condition of the existing infrastructure.

To finance the above programme the Trust has gained approval for a bid for Capital Support amounting to £2.5 million and is awaiting the loan documentation from the Department of Health and Social Care to support a further bid for £1.4 million. The Trust will draw the funding to support the initial bid of £2.5 million in February and the borrowing for the £1.4 million will be utilised in March.

A further bid has been prepared and submitted to NHSE/I to support the delivery of the capital programme for 2020/21. In 2020/21 the capital plan amounts to £30.6 million and the financing request amounts to £21.1 million.

5 Year Long Term Capital Plan

A 5 year plan was submitted to NHS England in October to support a programme over 4 years from 2020/21 to 2023/24 amounting to £125.6 million. The delivery of a programme of this size will require capital borrowing support of £93.8 million. It is not anticipated, however, that a significant level of borrowing will be approved or that borrowing will be given for non-essential spend.

The detail of the programme can and will continue to be reviewed and updated as part of the submission process. The Trust's Capital Planning Group will manage both the programme and Long Term Capital Planning moving forward.

Borrowing Update

The Trust did not utilise any funding in January. The Trust utilised £4.6 million in February in the form of deficit funding (£2.3 million) and PSF due for January and February of a further £2.3 million. The Trust is now working with NHSE/I on a request for support in March.

The Trust's current position on future borrowing and the repayment of existing borrowing is as follows:

- Revenue borrowing support will continue to be available for deficit funding and lost/due PSF with a further drawdown occurring in March in line with the existing process.

- A process is now in place to provide 1 year extensions to revenue loans at the end of their existing terms. The Trust is in receipt of confirmations from the Department of Health and Social Care to support these annual extensions. NHSE/I has also outlined that the Trust's borrowing relating to Interim Revenue Support and Revolving Working Capital could transfer to Public Dividend Capital in 2020/21.

- The Trust has submitted 2 bids for Interim Capital Support, the funding for the first will be drawn down in February and the Trust is awaiting the loan documentation to support the second from the Department of Health and Social Care. The Trust has held further discussions with NHS Improvement around the timing of the utilisation of support to cover the use of the cash received from the sale and leaseback of the LRI.

4. RECOMMENDATIONS

- Discuss and consider the contents of thus report.
- Note the liquidity position, capital plan and the proposed utilisation of revenue and capital borrowing.

APPENDICES

Appendix 1 – Performance per Centre and Directorate
Appendix 2 – Month to month forecast bridge
Appendix 3 – Capital Programme 2019/20

Appendix 1 – Performance per Centre and Directorate

Urgent & Emergency Care

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Acute Medicine	(18,097)	(19,764)	**(1,668)**	(21,710)	(23,708)	**(1,998)**
A&E	(11,086)	(10,554)	**531**	(13,302)	(12,664)	**638**
Anaesthetics	(10,558)	(10,538)	**21**	(12,741)	(12,703)	**38**
Critical Care	(10,753)	(10,967)	**(214)**	(12,937)	(13,127)	**(190)**
Hdu	(2,150)	(2,195)	**(45)**	(2,579)	(2,632)	**(53)**
Icu	(6,075)	(5,890)	**185**	(7,291)	(7,065)	**226**
Miu	(676)	(666)	**10**	(822)	(798)	**24**
Operational Management	(2,853)	(2,927)	**(74)**	(3,422)	(3,519)	**(97)**
Pain	(136)	(87)	**49**	(164)	(104)	**60**
Social Workers	(195)	(319)	**(124)**	(234)	(382)	**(148)**
Theatres	(16,927)	(17,018)	**(91)**	(20,302)	(20,393)	**(91)**
Urgent & Emergency Care Cm	(3,206)	(3,412)	**(206)**	(3,897)	(4,092)	**(195)**
Total	**(82,712)**	**(84,338)**	**(1,626)**	**(99,401)**	**(101,187)**	**(1,786)**

Specialist & Planned Care

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Admin - Cardio, Thoracic & Vas	(1,036)	(1,017)	**19**	(1,249)	(1,219)	**30**
Admin - Ent, Audiology & Omfs	(504)	(481)	**23**	(617)	(577)	**40**
Admin - Gastro & Urology	(502)	(470)	**32**	(614)	(563)	**51**
Admin - Neurosciences	(1,002)	(1,092)	**(90)**	(1,191)	(1,309)	**(118)**
Admin - Radonc & Haematology	(923)	(878)	**45**	(1,120)	(1,052)	**68**
Admin - Trauma & Orthopaedics	(626)	(636)	**(11)**	(749)	(763)	**(14)**
Appointments Team	(16)	0	**16**	(19)	0	**19**
Cardiology	(19,031)	(17,788)	**1,243**	(22,822)	(21,275)	**1,547**
Cardiothoracic	(9,964)	(9,432)	**533**	(11,946)	(11,344)	**602**
Ent	(9,317)	(9,630)	**(312)**	(11,201)	(11,649)	**(448)**
Gastroenterology	(9,659)	(8,819)	**840**	(11,582)	(10,717)	**865**
General Surgery	(11,231)	(11,742)	**(511)**	(13,471)	(14,084)	**(613)**
Haematology	(12,123)	(12,080)	**43**	(14,548)	(14,583)	**(35)**
Neurology	(12,934)	(13,253)	**(319)**	(15,519)	(15,923)	**(404)**
Neuro Rehab & Spinal Injuries	(5,497)	(5,824)	**(327)**	(6,594)	(6,947)	**(353)**
Neurosurgery, Spinal & Pain	(7,557)	(7,801)	**(244)**	(9,063)	(9,348)	**(285)**
Oral Surgery	(2,510)	(2,904)	**(394)**	(3,012)	(3,528)	**(516)**
Orthodontics	(944)	(904)	**40**	(1,132)	(1,084)	**48**
Outpatients	(1,071)	(872)	**199**	(1,284)	(1,045)	**239**
Planned Care Centre Management	(828)	(700)	**128**	(994)	(840)	**154**
Radiotherapy & Oncology	(16,434)	(16,450)	**(16)**	(19,701)	(19,794)	**(93)**
Renal	(9,182)	(9,895)	**(713)**	(11,010)	(11,844)	**(834)**
Specialist Care Cm	(1,056)	(1,068)	**(11)**	(1,273)	(1,303)	**(30)**
Spec Therapies	(8,785)	(8,953)	**(168)**	(10,564)	(10,758)	**(194)**
Trauma And Orthopaedics	(15,512)	(16,295)	**(784)**	(18,611)	(19,606)	**(995)**
Urology	(5,757)	(5,658)	**99**	(6,915)	(6,797)	**118**
Vascular	(3,131)	(2,868)	**263**	(3,752)	(3,459)	**293**
Total	**(167,133)**	**(167,510)**	**(377)**	**(200,553)**	**(201,411)**	**(858)**

Shm Pharmacy

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Op Pharmacy	(149)	(129)	**20**	(217)	(184)	**33**
Total	**(149)**	**(129)**	**20**	**(217)**	**(184)**	**33**

Corporate Clinical Services

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Bacteriology	(2,654)	(2,679)	**(25)**	(3,183)	(3,255)	**(72)**
Blood Sciences - Biochemistry	(1,706)	(1,567)	**139**	(2,041)	(1,913)	**128**
Blood Sciences - Haematology	(4,266)	(4,319)	**(53)**	(5,104)	(5,187)	**(83)**
Cell Path	(2,962)	(3,205)	**(243)**	(3,554)	(3,895)	**(341)**
Clinical Support Cm	(1,005)	(919)	**85**	(1,219)	(1,119)	**100**
Cor Therapies	(2,221)	(2,170)	**51**	(2,680)	(2,624)	**56**
Fhn & Community	(1,285)	(1,259)	**25**	(1,554)	(1,496)	**58**
Lri Institute	10,329	11,236	**907**	12,401	12,586	**185**
Neuroradiology	(651)	(714)	**(63)**	(795)	(856)	**(61)**
Pathology	(3,769)	(3,684)	**85**	(4,543)	(4,467)	**76**
Pharmacy	(4,702)	(4,662)	**40**	(5,596)	(5,569)	**27**
Radiology	(10,706)	(11,780)	**(1,075)**	(12,820)	(14,229)	**(1,409)**
Ultrasound	(834)	(874)	**(40)**	(1,006)	(1,047)	**(41)**
Virology	(580)	(598)	**(18)**	(696)	(721)	**(25)**
Total	**(27,012)**	**(27,196)**	**(184)**	**(32,390)**	**(33,792)**	**(1,402)**

Corporate

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Capital Charges	(24,827)	(24,699)	**127**	(29,792)	(30,337)	**(545)**
Corporate Affairs Directorate	(3,234)	(3,517)	**(282)**	(3,886)	(4,223)	**(337)**
Estates And Facilities	(47,800)	(47,044)	**757**	(57,402)	(56,752)	**650**
Finance Directorate	(29,377)	(29,502)	**(125)**	(35,261)	(35,523)	**(262)**
Hr Directorate	(2,950)	(3,018)	**(68)**	(3,540)	(3,648)	**(108)**
Nursing Directorate	(4,951)	(5,222)	**(271)**	(5,947)	(6,539)	**(592)**
Central	495,875	475,649	**(20,226)**	599,565	577,311	**(22,254)**
Total	**382,736**	**362,647**	**(20,089)**	**463,737**	**440,289**	**(23,448)**

Community Care

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Admin - Community	(789)	(748)	**40**	(958)	(897)	**61**
Admin - Obstetrics & Gynae	(587)	(599)	**(12)**	(710)	(718)	**(08)**
Admin - Paeds & Neonatology	(681)	(664)	**17**	(825)	(795)	**30**
Admin - Plastics, Ophth, Derm	(853)	(759)	**94**	(1,044)	(909)	**135**
Admin - Specialist Medicine	(714)	(676)	**37**	(871)	(810)	**61**
Community Care Cm	(501)	41	**542**	(600)	(79)	**521**
Community Services Therapies	(6,321)	(5,913)	**408**	(7,592)	(7,085)	**507**
Com Services - Management	(854)	(1,045)	**(190)**	(1,025)	(1,253)	**(228)**
Dermatology	(4,289)	(4,087)	**203**	(5,138)	(4,907)	**231**
Diabetes	(5,151)	(6,410)	**(1,259)**	(6,175)	(7,727)	**(1,552)**
Gynaecology	(2,499)	(2,426)	**73**	(2,997)	(2,934)	**63**
Infectious Diseases	(3,477)	(3,242)	**235**	(4,166)	(3,886)	**280**
Medicine - Management	(315)	(280)	**35**	(362)	(339)	**23**
Middlesbrough Com. Services	(4,484)	(4,169)	**315**	(5,393)	(5,027)	**366**
Neonatology	(5,633)	(5,380)	**253**	(6,752)	(6,452)	**300**
North Yorkshire Com. Services	(4,754)	(4,581)	**173**	(5,701)	(5,493)	**208**
Obstetrics	(9,809)	(9,446)	**363**	(11,783)	(11,288)	**495**
Obstetrics & Gynaecology	(3,652)	(4,256)	**(604)**	(4,373)	(5,119)	**(746)**
Older Persons Medicine	(6,400)	(6,327)	**74**	(7,679)	(7,593)	**86**
Ophthalmology	(13,628)	(14,769)	**(1,141)**	(16,423)	(17,770)	**(1,347)**
Paediatrics	(11,394)	(11,670)	**(276)**	(13,713)	(14,199)	**(486)**
Paediatrics & Neonatology	133	(01)	**(135)**	163	(05)	**(168)**
Palliative Care	(1,200)	(1,166)	**34**	(1,439)	(1,400)	**39**
P And N Therapies	(1,906)	(1,971)	**(65)**	(2,291)	(2,361)	**(70)**
Plastic Surgery/Burns	(2,631)	(2,809)	**(177)**	(3,155)	(3,371)	**(216)**
Redcar And Cleveland Com. Ser.	(3,073)	(2,986)	**87**	(3,699)	(3,536)	**163**
Respiratory	(4,183)	(4,470)	**(287)**	(5,069)	(5,446)	**(377)**
Rheumatology	(6,834)	(6,232)	**602**	(8,198)	(7,374)	**824**
Total	**(106,479)**	**(107,040)**	**(561)**	**(127,970)**	**(128,773)**	**(803)**

Appendix 2 – Centre Forecast Bridges

Forecast Bridge COM			
	Forecast £'000	Budget £'000	Variance £'000
Month 9 forecast	(128,446.9)	(127,892.1)	(554.8)
Education & Training Income - increase in HENE funding (new schedule received)	95.7		
Other Clinical Income - Private Patient accrual not actioned Month 10	(63.7)		
Misc Income behind plan (Lease Cars, Salary recharges and Sale of Goods)	(57.6)		
Forecast adjustments was higher than actual costs for Agency Consultants (Ophthalmology)	51.4		
Nursing & Midwife Staff - vacancies not yet filled	42.2		
NHS Infrastructure Support - vacancies filled and Manpower for Porter cover.	(23.3)		
AHP, Scientific, Therapeutic and Technical - vacancies filled	(18.0)		
HCA & Support Staff - vacancies filled/NHSP spend	(18.9)		
Drugs - High Cost Drugs £290k (mainly due to ID, Ophthalmology & Paeds (Paeds due to change to National Criteria changes in Cystic Fibrosis). Rheumatology fav reducing overspend)	(312.7)		
Transport - Lease cars underspend (offsets against income behind plan)	17.1		
Clinical Supplies & Services - reduced spend on Dressings, Patient Appliances & Implants & M&SE	62.2		
Healthcare Service Purchase - Skin Clinics Ltd - additional funding for new contract (passthrough)	(46.7)	(77.5)	
Establishment - Computer spend and licences	(23.9)		
Various - Balancing figure to match new forecast	(30.0)		
Revised M10 forecast	(128,773.1)	(127,969.6)	(803.4)
Monthly Change	(326.2)	(77.5)	(248.7)

Forecast Bridge CSD			
	Forecast £'000	Budget £'000	Variance £'000
Month 9 forecast	(33,390.3)	(32,390.3)	(1,000.0)
Med physics pay vacancies	21.0		
Pathology North tees income for salary recharges	90.0		
Pathology Other sale of goods income	64.0		
Pathology Pay worse offset by income	(56.0)		
Pathology microbiology additional locum	(21.0)		
Pathology Clinical supplies and services lower spend	61.0		
Pathology blood credit note	11.0		
Pathology establishment fees, dropped accrual for haemonetics	17.0		
Pathology increase fuel	(10.0)		
Radiology sale of goods income improvement	21.0		
Radiology pay improvement less additional work	58.0		
Radiology nonpay outsourcing offset by jawad	(55.0)		
Radiology York SLA breast service at Northallerton	(279.0)		
Radiology Meridian Fees 19/20 50% added to M10 forecast	(155.0)		
Radiology m&se worse	(7.6)		
LRI - SIFT Expected expenditure not materialised	142.5		
LRI - Innovation income to be deferred into 20/21	(95.6)		
LRI - WP & L Training expenditure	(9.0)		
LRI - Institute Events Income lower than forecast	(9.8)		
LRI - LCRN Income more than forecast	25.8		
LRI - PGMC additional income from HENE Qtr 3 Schedule	138.5		
LRI - R and D additional deferral of Income into 20/21	(488.1)		
LRI - NMET Income more than forecast	134.4		
Revised M10 forecast	(33,792.2)	(32,390.3)	(1,401.9)
Monthly Change	(401.9)	0.0	(401.9)

Forecast Bridge U and E			
	Forecast £'000	Budget £'000	Variance £'000
Month 9 forecast	(101,138.3)	(99,401.3)	(1,737.0)
Increased M and D pay costs	(48.7)		
Revised M10 forecast	(101,187.0)	(99,401.3)	(1,785.7)
Monthly Change	(48.7)	0.0	(48.7)

Forecast Bridge SPE

	Forecast £'000	Budget £'000	Variance £'000
Month 9 forecast	(201,362.0)	(200,529.2)	(832.8)
Admin & Clerical post transfer from Corporate	(23.0)	(23.0)	0.0
Therapies - net effect of rotational posts corrections with UEC	15.0		15.0
Centre - Private Patients income - credit notes raised & accrual not auctioned in month	(116.0)		(116.0)
Centre - Agency Administration support	(138.0)		(138.0)
Centre - reduction in substantive Admin & Clerical spend	74.0		74.0
Centre wide increase in Junior Doctors overspend	(32.0)		(32.0)
Centre wide increase in HCA & Nursing spend	(69.0)		(69.0)
Centre wide decrease in Consultant spend	174.0		174.0
Centre wide - decrease in Clinical Supplies & Services spend	178.0		178.0
Trauma & Orthopaedics - increase in implant expenditure	(145.0)		(145.0)
Cardiology - Abbott rebate received	75.0		75.0
ENT -Cochlear implants (CSS) forecast movement	36.0		36.0
Neuro Rehab & SI - Increase forecast for expected Ottobock contract spend	24.0		24.0
Neurology - Increased High Cost Drugs spend	(36.0)		(36.0)
Neurology - decreased high Cost Devices spend	28.0		28.0
Renal - increasing satellite clinic expenditure	(30.0)		(30.0)
SPEC Therapies - staff vacancies	44.0		44.0
Radiology/Oncology - increase in Cancer Drug Fund expenditure	(55.0)		(55.0)
Balancing reduction	(53.0)		(53.0)
Revised M10 forecast	(201,411.0)	(200,552.2)	(858.8)
Monthly Change	(49.0)	(23.0)	(26.0)

Forecast Bridge COR

	Forecast £'000	Budget £'000	Variance £'000
Month 9 forecast	439,461.0	463,636.8	(24,175.8)
CorAf - Senior Management Pay reduction to FO	19.7		
CorAf - Cancer Services income utilisation reduction	(57.5)		
E&F - Carpark income increase at FHN, reallocation	12.1		
E&F - Carpark income decrease at JCUH, reallocation	(20.2)		
E&F - Utilities JCUH gas expenditure increase for winter	(51.2)		
E&F - Utilities JCUH water credit note stopped M10	(58.6)		
E&F - Med Eng contract forecast decrease correction	273.7		
E&F - Med Eng non-contract parts forecast decrease as actuals reduce	21.7		
Finance - HCR budget and actuals for 1wte B3 moved from COR to SPEC/PLAN FYE	23.0	23.0	
Finance - IT additional licences for new IT hardware from M10	(29.6)		
Finance - IT forecast reduction for phone rental	18.2		
Finance - FG & C forecast reduction Band 7	13.0		
Nursing - International recruitment	20.0		
Clinical Income additional income re SKIN moved to Community	46.7	77.5	
Clinical Income improvement re Drugs	599.6		
Depreciation change re revised capital programme	(370.0)		
RTA Income improvement	127.0		
Reduction in centrally forecast grip and control	(1,412.0)		
Reserves funding removal	1,661.0		
Other small movements	(8.6)		
Revised M10 forecast	440,289.0	463,737.3	(23,448.3)
Monthly Change	828.0	100.5	727.5

Forecast Bridge South Tees Healthcare Management

	Forecast £'000	Budget £'000	Variance £'000
Month 9 forecast	(183.0)	(217.0)	34.0
Pay forecast change	(1.0)		
Revised M10 forecast	(184.0)	(217.0)	33.0
Monthly Change	(1.0)	0.0	(1.0)
Trust Total	1.2	0.0	1.2

Appendix 3 – Capital Programme 2019/20

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Estates						
PFI Lifecycle	7,767	9,020	1,253	10,824	10,824	**0**
Task 218 - CT scanner	0	97	**97**	0	97	**97**
Ward 4 refurbishment	0	56	56	0	56	**56**
LRI	0	2,021	**2,021**	0	2,021	**2,021**
PACU/SAU	0	1,605	1,605	0	1,727	**1,727**
Cheriton House	0	33	**33**	0	33	**33**
Omnicell	0	382	**382**	0	382	**382**
Lifecycle enhancements (Theatres 1-6, Ward 11-12 and Medical Gases)	0	19	19	0	300	**300**
Endoscopy – JAG Accreditation	0	0	0	0	0	**0**
Cancer Centre (Friarage)	0	41	**41**	70	41	**(29)**
Critical infrastructure risk (FHN)	0	26	26	0	26	**26**
PFI change of law (Emergency Lighting)	0	0	**0**	0	0	**0**
Pre- Assessment	0	2	2	0	2	**2**
Critical Care Expansion	0	143	**143**	0	143	**143**
VAT on Capital	0	(31)	(31)	0	(56)	**(56)**
Replacement Programme - Radio	0	24	**24**	0	24	**24**
3T in the Current MRI 2	0	12	12	0	12	**12**
Hardstanding for Mobile MRI at FHN	0	56	**56**	0	56	**56**
Microscope	0	9	9	0	9	**9**
Linac Bunker 2	0	24	**24**	0	24	**24**
Car Parking Improvements	0	26	26	0	26	**26**
CSSD AHU Replace/Refurb (FHN)	0	40	**40**	0	40	**40**
Estates Total	7,767	13,605	5,838	10,894	15,787	4,893
Medical Equipment						
Chief Executive Emergency Replacement	1,047	0	(1,047)	1,690	0	**(1,690)**
- Manometry solar trolley system	0	51	**51**	0	51	**51**
- Cannon Megacool	0	63	63	0	63	**63**
- Hemosphere monitoring systems	0	180	**180**	0	180	**180**
- Endoscopic imaging	0	255	255	0	255	**255**
- Birthing beds	0	0	**0**	0	100	**100**
- BIPaps	0	108	108	0	108	**108**
- YSIO Detector	0	110	**110**	0	110	**110**
- Natus Embla Amplifier	0	46	46	0	66	**66**
- Irradiation booth	0	0	**0**	0	47	**47**
- Neonatal incubators	0	0	0	0	55	**55**
- Pathology labelling machine	0	0	**0**	0	138	**138**
- Home Haemodialysis machine	0	80	80	0	81	**81**
- Slidemate as on demand printing system A8390(	0	138	**138**	0	138	**138**
- Dual server dual san upgrade	0	0	0	0	0	**0**
- Trilogy 202 Ventolator	0	108	**108**	0	108	**108**
- Opthalmology equipment	0	0	0	0	0	**0**
- High risk investment	0	0	**0**	0	0	**0**
- Other replacements	0	390	390	0	390	**390**
Emergency Breakdown contingency	0	0	**0**	0	0	**0**
Endoscopy PDC	0	0	0	0	104	**104**
Emergency Replacement	0	0	0	0	0	**0**
X Ray tubes	0	126	**126**	0	126	**126**
Total Medical Equipment	1,047	1,655	608	1,690	2,120	**430**

Information Technology						
Telephones (VOIP)	0	857	857	0	857	**857**
Clinical Noting	0	34	**34**	0	34	**34**
MFD printers	0	86	86	0	86	**86**
Lloyds Pharmacy	0	47	**47**	0	47	**47**
Symphony expansion to Redcar Primary	0	10	10	0	10	**10**
Patient WiFi	0	1	**1**	0	1	**1**
Voice recognition	0	451	451	0	353	**353**
IT discretionary	0	192	**192**	0	192	**192**
Pervasive BYOD	0	15	15	0	18	**18**
LIMS server	0	231	**231**	0	344	**344**
Radiology PACS PDC	0	0	**0**	0	365	**365**
Digital Pathology	0	28	28	0	96	**96**
Web ice upgrade	0	0	**0**	0	37	**37**
Cyber PDC	0	0	0	0	79	**79**
IT kit replacement	0	0	0	0	3,000	**3,000**
Integration Engine PDC	0	0	0	0	290	**290**
Total Information Technology	0	1,952	1,952	0	5,809	**5,809**
Cancer Transformation PDC	0	200	**200**	200	200	**0**
£1.4m Bid						
Bladder Scanner FHN	0	160	160	0	160	**160**
Ultrasounds	0	45	**45**	0	45	**45**
Hemodialysis & Hemofiltration Machine	0	94	94	0	94	**94**
Other schemes	0	0	0	0	873	**873**
Total £1.4m Bid	**0**	**299**	**299**	**0**	**1,172**	**1,172**
£2m Winter Pressures						
Defribrillator - Pain Clinic	0	07	**07**	0	07	**07**
EMG Equipment	0	38	38	0	38	**38**
Orbital Drill	0	11	**11**	0	11	**11**
Paediatric Coloscope	0	30	30	0	30	**30**
Mosaiq Hardware & Software	0	02	02	0	02	**02**
Ward Equipment	0	14	**14**	0	14	**14**
Spinal Stimulation Machine	0	09	0	0	09	**09**
Other schemes	0	0	0	0	1,075	**1,075**
Total £2m Winter Pressures	0	111	102	0	1,186	1,186
£3 Bid						
Micropath Digital Imaging	0	23	**23**	0	23	**23**
JCUH Ophthalmic Consulting Rooms	0	30	30	0	30	**30**
IT Kit Replacement	0	05	**05**	0	05	**05**
Jackson Table	0	28	28	0	28	**28**
Drager Fabius CE Machines	0	54	54	0	54	**54**
Endotoxin Testing System	0	06	06	0	06	06
Bladder Scanner FHN	0	09	09	0	09	**09**
Other schemes	0	0	0	0	3,057	**3,057**
Community premises	0	28	28	0	280	**280**
Total £3 Bid	0	183	183	0	3,492	3,492
Total	8,814	18,005	9,182	12,784	29,766	**16,982**
Financing						
Depreciation	5,918	5,918	0	5,918	5,918	0
Capital - LRI	2,463	11,373	(8,910)	6,266	12,875	(6,609)
Macmilan	0	0	0	0	0	0
Charitable contributions including Newcastle University contribution towards LRI	233	514	(281)	400	1,000	(600)
Interim Support	0	0	0	0	3,935	(3,935)
PDC (received in 2018/19)	200	200	0	200	6,038	(5,838)
Total Financing	**8,814**	**18,005**	**(9,191)**	**12,784**	**29,766**	**(16,982)**

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 3 March 2020			
Board Assurance Framework			**AGENDA ITEM: 17, ENC 9**
Report Author and Job Title:	Jackie White Head of Governance	Responsible Director:	
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.		
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 are 15 high risks and 9 moderate risks.

3.2 A description of the high risks included on the BAF

A breakdown of the 15 high risks are as follows:

Strategy

1.3a - Risk of further breaches to condition 4 of the Trust Provider licence could result in further enforcement undertakings and licence conditions

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

Quality

2.1 (1) - An infection outbreak (such as influenza; norovirus; infections resistant to antibiotics and CDiff) may result in avoidable patient harm and could adversely impact on delivery of key performance indicators

2.2 - 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

2.4 - 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

2.5 - 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.

Operations

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

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 .

3.3 - Risk of ability to deliver the national access target of 85% for 62 Day Cancer Standard

3.4 - Risk that patients deteriorate or actual harm materialises due to patients being moved from list to accommodate cancelled surgical procedures due to inadequate capacity in critical care

Finance

4.4 - 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

4.5 - 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 issue

4.6 - 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.

Workforce

5.2 - 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.
5.4 - 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

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

3.3.1 Updated risks

21 BAF risks have been updated. Seven (7) risks have had a change to the risk score as follows:

Strategy 1.4 - 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 – Risk increase to Moderate

Quality 2.1 (1) - An infection outbreak (such as influenza; norovirus; infections resistant to antibiotics and CDiff) may result in avoidable patient harm and could adversely impact on delivery of key performance indicators – Risk increase to High

Operations 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 - Risk increase to High

Operations 3.3 - Risk of ability to delivery the national access target of 85% for 62 Day Cancer Standard – Risk increase to High

Finance 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 – Risk reduced to Moderate

Finance 4.2 - 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 – Risk reduced to Moderate

Workforce 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 – Risk reduced to Moderate

Workforce 5.3 - A loss of workforce productivity arising from individual decisions taken in response to the pension implications – Risk reduced to Moderate

3.3.2 No change

Three (3) BAF risks have not been updated. These relate to:

Strategy 1.1 - A fundamental breakdown in one or more strategic partnerships, resulting in long term disruption to plans for transforming local health and care services and 1.2 - 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, and

Quality 2.5 - 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.

3.3.3 New Risks added

No new risks have been added to the BAF.

3.3.4 Risks closed

One risk has been closed and this relates to Quality 2.1 (3) Due to abnormal variation in mortality rates there is a risk of unrecognised harm and outlier flags leading to increased regulatory scrutiny, following consideration by 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**	NHSI / NHS Engagement ICS Engagement - Health Strategy Group, Health Strategy Board ICP Leadership - ICP Provider Lead, Stakeholder Engagement with Local Authorities , MPs and local population, ICP Leadership, CCG partnering, ICS MOU, Clinical Policy Group	**Internal** Clinical Policy Group agenda and papers, Reports to Board, SLT, Council of Governors **External** NHSI QRM ICS Health Strategy Group ICS Health Strategy Board ICP Monthly Meetings 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	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

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 Qualit 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 itme 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, govrnance and assurance - reduction in conditions on provider licence	Review again w	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 Resilence Forum EPRR Strategy in line with National EPRR framework Training and testing exercices undertaken annually Annual assessment against EPRR core standards Oncall 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 resilence forum	Board report on EPPR self assessment IG Assurance Framework submission Annual report to Board on EPRR	Validated EPPR assessment - partical 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 exercice 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 Healthare 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

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 adversly impact on delivery of key performance indicators	4	4	**Moderate Risk 16**	**Very Low Risk 2x3=6**	1. IPAG 2. Monthly performance meeting with clinical matrons. 3. Front of house IPC model 4. Cleaning standards meetings including Serco 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	IPAG meeting minutes Audit findings Panel outcomes Regulator oversight Capital and FIB minutes of meetings	IPAG QAC Board Antimicrobial Group	TIPC NHSI review of outbreak action plan	• Ecolab have undertaking an external review of hand hygiene compliance on the JCUH site, we are awaiting their report. 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	31.12.19 31.3.20 2020/21 31.3.20	31.03.20	Director of Nursing/DIPC	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 - Principle risk description fully re-written
Current risk rating increased from 6 to 9

Added:
1. No agreed mechanism for appeals process across all CCGs. Solution being sought across ICO - to Gaps in control/assurance column
2. Appeals panel process to be agreed by 30.06.19 to - Target date for completion of action
3. Date 31.03.20 added as the target date score will be met/closed

28 August 2019 - Principal risk updated and risk score, additional controls and external assurance
29.10.19 - updatedgaps in control / assurance and target date
20.11.19 - update to risk score, controls, assurance 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

Quarter 1 (1 April - 30 June 2019)

May 2019:

1. Amended target risk from 3 to 4
2. Added 31.12.19 for completion of pharmacy cover at weekends; and automated cabinets to completion of action by 28.02.20
3. Added 28.02.20 for the Target date score will be met/closed

29.10.19 - added additional gap and updated gaps in control / 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								
2.2	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	5	**High Risk 20**	**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	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 NHSI Quarterly Review meetings National Staff Survey Quality risk profile report out from 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 Single item quality surveilliance group meeting Capital equipment and prioritisation required	31.12.19	31.12.19	Director of Nursing/ Medical Directors	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
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 asurances

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

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	**Internal** Quality Assurance Committee Patient Safety Sub-group Serious Incident report Annual Operating Plan Quality Report and Account Chief Executive Report on 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	Chief Executive - 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	Target to: Clinical Intelligence unit and electronic solution to support triangulation of data to be fully implemented Incident reporting upgrade - DATIX cloud	31.3.20 31.12.19	30.04.20	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:
1. updated description of risk
2. deleted SI review and learning group from 'possible sources of assurance that controls are effective'
3. added patient safety sub-group to 'possible sources of assurance that controls are effective'
4. added target date for completion of actions of 31.10.19 and June 2019
5. added target date for completion of action of 30.04.20
29.10 19 - no change
20.11.19 - update to controls 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								
2.5	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

Risk Rating Key

Key to Risk Assessment	Consequence				
Likelihood	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic/ Tragic 5
1 rare	Very low risk (green) 1	Very low risk (green) 2	Very low risk (green) 4	Low risk (yellow) 4	Low risk (yellow) 5
2 Unlikely	Very low risk (green) 2	Low risk (yellow) 4	Low risk (yellow) 6	Moderate risk (orange) 8	Moderate risk (orange) 10
3 Possible	Very low risk (green) 3	Low risk (yellow) 6	Moderate risk (orange) 9	Moderate risk (orange) 12	High risk (red) 15
4 Likely	Low risk (yellow) 4	Moderate risk (orange) 8	Moderate risk (orange) 12	High risk (red) 16	Very high risk (red) 20
5 Certain/almost certain	Low risk (yellow) 5	Moderate risk (orange) 10	High risk (red) 15	Very high risk (red) 20	Very high risk (red) 25

Changes to ratings:

⟷ No change in risk rating from previous version of assurance framework
Risk rating has been downgraded from previous version of assurance framework
Risk rating has been increased from previous version of assurance framework

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	4	4	**High Risk 16**	**Low risk 2x3 = 6**	Patient Flow and model ward 'walls' Urgent Care monitoring Investment in Front of House model as a defence to prevent increased activity to back of house A&E Delivery Board Standard operating procedures Performance management arrangements between Centres, Specialities and Departments and OMB 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	Clinical Policy Group action notes A&E Delivery Board agenda and notes Recovery plans for high risk services and updates to Board and Committees Risk register Outcome of QSG	Urgent and Emergency Care Centre Board Centre Boards Weekly incident control meetings for high risk areas	LADB NHSI External review of DTOC CQC inspection report	Compliance with SAFER standards, Patient Flow SOPs Review of 111 Directory of Service 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 Planned system wide actions may not have the desired outcomes of reducing ED attendances and delays in discharging or transferring patients	31.03.20 31.1.20 Ongoing 2021 ongoing	31.06.20	COO	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

Quarter 1 (1 April - 30 June 2019)
May 2019:
Changed target risk score from 9 to 6 (likelihood 2; consequence 3 = 6)
Added: 1. Sustainable medical and nursing workforce and skill mix; and 2. limitation of current Estate with increased demand - to Gaps in control/assurance;
Changed: Target date for completion of action from 31.03.19 to 31.03.20

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

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**	**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 (opthalmology, Gastroenterology), transfer of activity from CCDFT, reduction in weekend working and premium pay .	4	4	**High Risk 16**	**Low risk 3x3 = 9**	Recovery Plan in place for overall RTT Deep dive into high risk areas Weekly Performance Meetings Speciality specific level recorvery plans have been developed	RTT Recovery Plan Regular meeting with NHSI regarding position	Performance report to Board and Centre boards Wall weekly report out in Specialist and Planned Outcome of QSG	NHSI weekly / monthly Return Regular meeting with NHSI	Waiting list system inefficient due to underdeveloped informatics infrastructure - capital and revenue bids for emergency funds	31.03.21	31.03.20	COO	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

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

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	4	4	**High Risk 16**	**Low risk 3x3 = 9**	Recovery Plan in place for overall Cancer target Deep dive into high risk areas Weekly Performance Meetings Speciality specific level recovery plans have been developed Weekly cancer wall including medical director input Cancer delivery group meeting monthly	Cancer Recovery Plan Regular meeting with NHSI regarding position Outcome of QSG	Performance report to Board and Centre boards Wall weekly report out	NHSI Regular meeting with NHSI	Roll out of automated tracking system across all relevant specialities identifying patients who have high risk of cancer Demand for oncology provision / chemotherapy - explore repatriation to local unit Continue to outsource pathology and radiology services Implement a process to ensure accurate rallocation of cancer breaches	31.03.20 31.3.20 ongoing 31.12.19	31.03.20	Coo	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

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

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	NHSI	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			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
27.11.19 - update to controls, assurance, gaps and target dates

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								
4.1	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	Moderate Risk 3x5=15	**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 workstream 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 workstreams. 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	↓	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** **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**																	
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	Moderate Risk - 4	Moderate Risk 2x4=8	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 comit 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**																	

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 2x5=10**	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 iundertaken 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 fundings	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	⟷	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 - 30 June 2019)
- May 2019 - no changes made
12.11.19 - update to principal risk, controls and assurances
21.1.20- update to principal risk, risk score, 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 4x2=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	⇔	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 - no changes made
12.11.19 - change to risk rating, key controls and sources of assurance
26.11.19 - 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**	**5**	**High Risk 20**	**Low Risk 2x3=6**	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 consdieration of audit information	Lifecycle work now commenced at James Cook University Hospital Availble 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		⇔	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 - 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
26.11.19 - 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	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 Council of Governors 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	PeoplePlan (bring together all plans)	31.3.20	01.06.20		Director of Human Resources	Workforce Committee	1577 2049 2066 2067 2068 1977 1875 1434 1499 1574 1763 2071	3.2.20

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

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 Draft Wellbeing Strategy Policies and procedures Exit interviews Workforce metrics Draft ED&I strategy Workshop on values and behaviours	National Staff Survey results reported to Workforce Committee, Board of Directors and Council of Governors Exit interviews 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 Engagemen	National Staff Survey CQC inspection report	Launch of Engagement Strategy Launch of wellbeing strategy EDI Strategy launch Trends from exit interviews Reduction in absence and turnover (<10%)	April 2020 March 2020 April 2020 April 2020 April 2020	Apr-20	⟺	Director of Human Resources	Workforce Committee		3.2.20

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

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	2	4	**Moderate Risk - 8**	**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 Exeternal financial advice % 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	Review of local policy Await outcome of national review	Mar-20	Apr-20	↓	Director of Human Resources	Rem Com		3.2.20

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 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 External: Care Quality Commission	Safe staffing report monthly to QAC and Board Quality outcomes identified and monitored in workforce committee Risk assessment and registers identifying mitigation of failure to comply with guidance	Human Resources 'Wall' Scoreboard	CQC inspection report Royal College guidelines	Workforce Plan (bring together all plans) Workforce strategy Deep dive into staffing	31.3.20 30.6.20 December 2019	to be agreed	⟺	Director of Human Resources Director of Nursing and Quality Medical Directors Corporate Executive Directors	Workforce Committee		28.10.19

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: No changes made
28 August 2019 - new risk
12.11.19 - update to assurances and target actions

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 March 2020			
Corporate Risk Register			**AGENDA ITEM: 17, 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 Management Group.		
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 Board of Directors		
Assessment	Of the 54 risks, there are 5 risks with an overdue risk review. This is low risk as the reviews were due in January and plans are in place to review these risks in the next 2 weeks. There are no risks to escalate to Board.		
Recommendation	Members of the 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

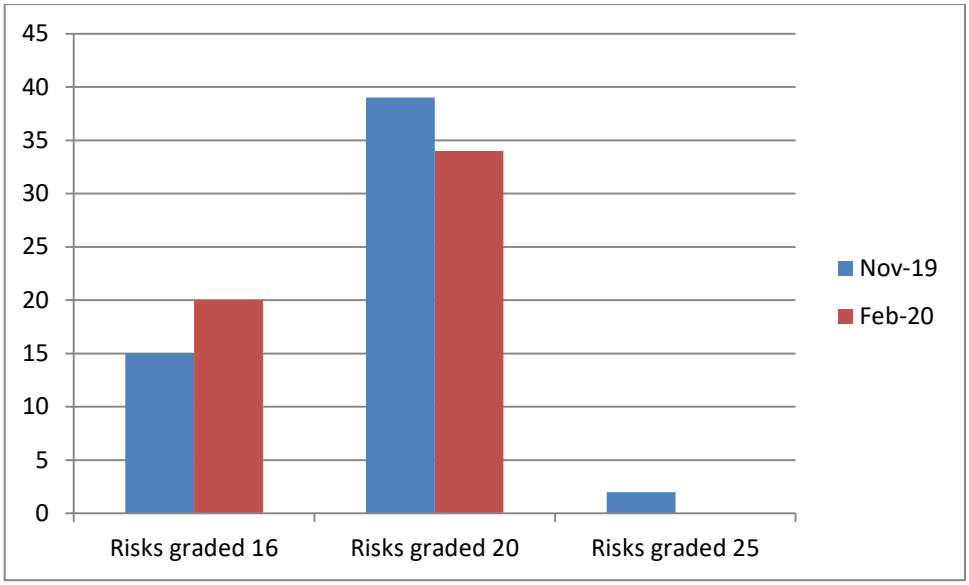
The corporate risk register is an active tool through which the Trust manages its risks. Its purpose is to log all risks identified in the high or extreme categories and the controls in place or planned to manage the risk to its lowest possible level (residual risk). The corporate risk register is built 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.

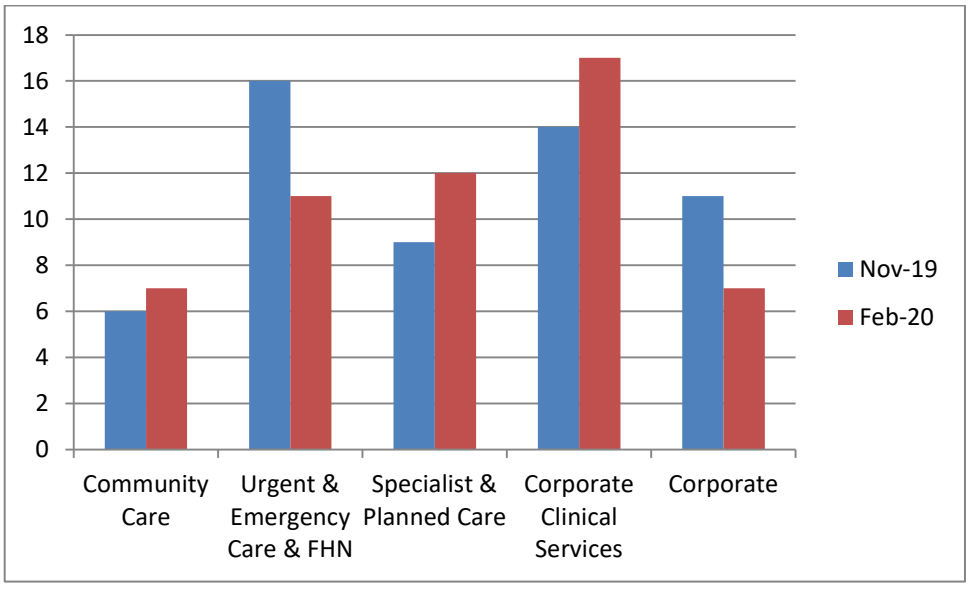
3. DETAILS

As of 24 February 2020 there are 54 risks on the corporate risk register of 16 and above which are broken down by centre below. This is a reduction of 2 risks from the last quarter.

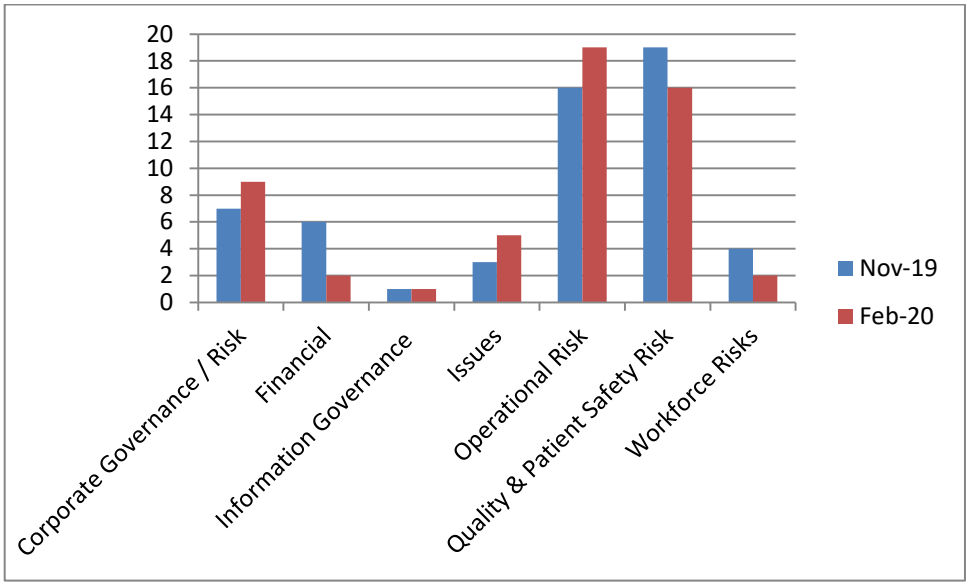


In the last quarter the risks graded 20 and above have reduced by 5 risks with the number of risks graded 16 increased by 5 risks.

There has been an increase in the number of incidents graded 16 and above across Community, Specialist & Planned, and Corporate Clinic centres.



The main themes of the risks have changed since the last report with operational risks being the top area and quality and patient safety risk second.



Of the 54 risks on the risk register all risks have an action plan to mitigate the risk and only 5 of the 54 risks have an overdue review date.

4. RECOMMENDATIONS

The Board are asked to note the corporate risk register and discuss the two risks which are brought to the attention of the Board in further detail.

APPENDICES
Corporate Risk Register

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 3 MARCH 2020			
Care Quality Commission (CQC) action plan update			**AGENDA ITEM: 18, ENC 11**
Report Author and Job Title:	Moira Angel Senior Nurse Advisor, Nursing and Quality	**Responsible Director:**	Gill Hunt Director of Nursing and Quality
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This paper provides an update on progress with delivery of the CQC action plan		
Background	Following the CQC inspection of the Trust which was carried out between the 15th January and the 23rd February 2019, a detailed action plan was developed to address the regulatory breaches ('must do' actions) and also the 'should do' actions.		
Assessment	This report outlines the progress since the last report to the Board of Directors		
Recommendation	Members of the Trust Board are asked to note the update.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 2.2 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		
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 ☐		

South Tees Hospitals
NHS Foundation Trust

CARE QUALITY COMMISSION ACTION PLAN UPDATE

1. PURPOSE OF REPORT

This paper provides an update on progress against the Care Quality Commission (CQC) action plan and builds upon other updates received regularly by the Quality Assurance Committee and the Trust Board. Key components of the report include an overview position for each area of improvement, supporting metrics, remedial action where plans are off track and refreshed governance arrangements.

2. BACKGROUND

In July 2019 South Tees NHS Hospitals Foundation Trust received a report from the CQC following an inspection in January and February 2019. The Trust received an overall rating of 'requires improvement' and the report contained 26 'must do' recommendations and 22 'should do recommendations. A detailed action plan has been developed for all recommendations and this has been submitted to CQC. Delivery of the action plan is overseen by a fortnightly Oversight Group and a small Huddle Group meets daily to review and challenge sources of evidence.

3. PROGRESS

Throughout January and February 2020 a series of confirm and challenge sessions have been held with operational and director leads. These sessions have focussed on the 'must do' recommendations and have facilitated discussions relating to evidence, action plans, assurance and risk.

The sessions have also provided the opportunity to identify where support is required to progress specific actions. Whilst each 'must do' recommendation is made up of a series of specific actions the confirm and challenge sessions have concluded with an overall assessment of where the Trust is against the entire CQC recommendations. Appendix 1 sets out the assessment for each individual recommendation and Table 1 contains an overview of progress.

Assessment date	Overview		
20 February 2020		5	Off track
		10	Expected to deliver actions
		10	Completed actions
		1	Embedded in practice

Table 1: Overview of progress against CQC 'must do' recommendations.

Good progress has been made for 21 of the 26 recommendations.

Five (5) recommendations are deemed to be off track however this is mainly due to specific actions and not the entire CQC recommendation. Mitigating actions are in place for each action that is deemed off track. Table 2 sets out a summary of the metrics that are off track and the mitigating actions. The five 'off track' recommendations are included as workstreams within Phase 1 of the Improvement Plan under the main CQC

Ref	CQC Recommendation	Reason for 'off track' assessment	Mitigation

workstream. This involves a weekly level of scrutiny by the Medical Directors, Director of Nursing & Quality and Chief Operating Officer.

M6	The Trust must ensure that staff training compliance with Mandatory Training especially resuscitation training, safeguarding children (level 2) and safeguarding vulnerable adults (including mental capacity act and deprivation of liberty) safeguarding training meets the target of 90%	Achievement of Centre trajectories for resuscitation training	Additional training being delivered Trajectories due for completion by May 2020
M8	The Trust must take action to ensure that the environment is suitable for the purpose being used and is secure and compliant with current standards especially for paediatric patients and patients with mental health needs (Urgent & Emergency Care Centre & FHN)	Constraints associated with the Emergency Department Paediatric environment	Immediate improvement actions undertaken and Estates business case submitted
M11	The Trust must ensure that there are at all times sufficient numbers of suitably skilled and qualified nursing and medical staff in line with best practice and national guidance (Emergency Department)	24/7 Consultant presence not available in ED (links to M9, compliance with Major Trauma Standards for which we are currently non-compliant)	Work with Specialised Commissioning to review funding to externally mandated model CCG funding for integrated Primary Care/ED assessment
M14	The Trust must review the role of supernumerary coordinators and the level of specialist pharmacy provision in Critical Care so they are in line with GPICS recommendations	Sufficient pharmacists to deliver GPICs compliance and 80% medicines reconciliation	Patient prioritisation Electronic prescribing funding secured for 2021
M26	The Trust must ensure there are sufficient numbers of suitably qualified staff, especially radiologists	Workforce review completed however not yet implemented	3 Additional radiologists in post from March 2020

Table 2: Summary of 'off track' recommendations and mitigating action

4. QUALITY ASSURANCE FRAMEWORK

NHS England and NHS Improvement (NHSE/I) have highlighted organisations that are excelling at ward accreditation. When used effectively ward accreditation can drive continuous improvement in standards and increase patient and staff experience. The South Tees Accreditation for Quality of Care (STAQC) is a methodology that has been developed and the CQC key Lines of Enquiry are embedded in the methodology.

The revised STAQC framework is currently being piloted in Critical Care and two ward areas. A deep dive into Critical Care using the STACQ methodology was undertaken on 20 January 2020. This enabled the process and standards to be tested and gave the Critical Care Team an assessment of what they need to do to commence their accreditation journey.

STAQC will be launched formally in April 2020 with publicity and a Trust wide workshop to ensure clinical teams are engaged in the development of a Strategy and Assurance Framework for quality, safety and continuous improvement.

The first phase of STAQC implementation commences April 2020 and accreditation visits include:

- Critical Care including Cardiac
- Diagnostic and Imaging
- Theatres
- Wards

5. WELL LED REVIEW

A review of governance processes, including a board development workshop, was undertaken during September to December 2019 and this resulted in the development of a 'Well Led' Action Plan. Progress to date includes:

- Leadership Programme due to commence March 2020
- 6 Clinical Directors attending the Northumbria Leadership Training programme
- Staff currently on Manchester MBA programme
- Board Development Programme commenced
- Senior Leadership Portfolios realigned
- Clinical Policy Group (CPG) has been established to strengthen clinical decision making and engagement including making decisions about how the organisation uses its resources and delivers care.
- 3 Phase Improvement Plan approved by the Trust Board
- Communication and Engagement Strategy aligned to the Improvement Plan
- Staff engagement to define Trust Values
- Accountability Framework and supporting metrics under development
- Development of STAQC and a Quality Assurance Strategy
- Risk management policy updated subject to final approval
- Datix Cloud implementation to commence April 2020
- New Integrated Performance report to be implemented from April 2020

6. MOVING to GOOD

'Moving to Good' is a collaborative improvement programme organised by NHSI/E. Through this programme South Tees NHS Hospitals Foundation Trust has identified three objectives which are embedded in the overarching QCQ Action Plan and include:

- Increase incident reporting and learning throughout the Trust
- To identify, develop and implement a Quality Strategy for the Trust and embed an agreed approach to Quality Improvement Methodology
- To implement safe surgery practices across the Trust in order to eliminate never events

The programme includes a series of workshops to support Trusts in developing their improvement plans. A 'Moving to Good' workshop focussing on governance was attended by the Director of Nursing & Quality, the Head of Governance and other team members. The programme addressed quality and corporate governance, accountability, assurance and reassurance and performance management. Included in the workshop were examples of board assurance frameworks and risk registers along with discussion on risk management processes and structures. There was also a discussion about the themes and lessons learnt from CQC well led inspections. Two further workshops focussing on CQC and Staff engagement are to be held imminently and will be attended the appropriate team members.

7. MONITORING PROGRESS

Whilst the CQC action plan is grounded in the delivery of specific actions, quantitative and qualitative outcome metrics provide evidence that improvement is sustained and embedded in the culture of the organisation.

Work is underway to develop an Integrated Performance Framework for Directorates, Centres and the Trust Board. From the start of 2020/21 the Trust Board will see a new style Integrated Performance Report bringing together clinical quality, operational delivery, workforce and financial metrics aligned to the CQC Key Lines of Enquiry.

These quantitative metrics are supplemented by qualitative metrics which have been scrutinised during the confirm and challenge sessions. Whilst the detailed focus has been on the 'must do' recommendations action plans have been developed to deliver the 'should do' actions. A series of confirm and challenge sessions are now planned for the 'should do' recommendations whilst maintaining focus on the 'must do's. As each recommendation is assessed as 'completed' further plans will be developed to ensure sustainability right across the Trust. Confirm and challenge will become an integral part of the emerging Performance Framework and further scrutiny will be applied through the Improvement Programme Board.

8. SYSTEM ENGAGEMENT

Engagement meetings continue to take place between the Trust and the CQC. The most recent meeting in January 2020 focussed on the 'off track' recommendations outlining the reasons, mitigation and financial implications.

The Single Item Quality Surveillance Group led by NHSE/I continues to provide oversight, system monitoring and support. The next meeting is scheduled for 25th February 2020. The system is providing support for a number of areas including Never Events.

9. RECOMMENDATIONS

For the Trust Board to:

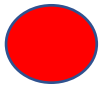
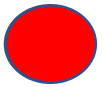
- Be made aware and to discuss the exceptions identified from the action tracker
- Be aware of the actions that have not been delivered within agreed timescales and what the mitigating actions are to bring these back on track.
- Acknowledge the update on the Moving to Good Programme
- To discuss the CQC action plan as part of the overarching improvement plan and development of an assurance framework

Appendix 1: CQC Inspection Action Plan Progress Report

Assessment date	Overview		
20 February 2020		5	Off track
		10	Expected to deliver actions
		10	Completed actions
		1	Embedded in practice

Ref	Requirement notice	Area for improvement	Assurance	Outcome Metrics	Risk, Mitigation and sustainability
M1	MUST DO	The Trust must ensure that there are effective systems and processes to identify, assess, monitor and mitigate risks relating to the health, safety and welfare of patients and staff; especially within Critical Care		Delivery of Well Led Action Plan Datix Cloud implementation Patient safety training Serious incidents reported within 48 hours 10% Increase in incident reporting year on year over 3 years	Intense focus on incident reporting Progress on training and learning Develop a comprehensive plan across the organisation to embed learning
M2	MUST DO	The Trust must ensure that there is effective engagement to seek and action on feedback for the purpose of continually evaluating and improving services; particularly in relation to improving engagement with all staff groups and external stakeholders including ensuring that Senior Managers are visible, accessible and provide the necessary support to staff		Staff engagement strategy Staff Surveys (Summer and October 2019) Disaggregated themes Discussed at CPG, Healthcare Professionals Group, SMFS, Staff Side, Directorate meetings	Vision and values to be agreed
M3	MUST DO	The Trust must ensure that the quality of record keeping is consistent and that staff maintain accurate and contemporaneous records for all patients and that patient records on the wards are stored securely when unattended		Record keeping audits STAQC assessments	Document review to be extended to medical notes/staff

Appendix 1: CQC Inspection Action Plan Progress Report

Ref	Requirement notice	Area for improvement	Assurance	Outcome Metrics	Risk, Mitigation and sustainability
M4	MUST DO	The Trust must ensure that all risks within Departments are recorded on the risk register		Risk Management Policy Communication and engagement Strategy, good progress on identification and management of risk at all levels, focus on escalation and de-escalation	Risk Management Policy to be approved Requires standardised Documentation Focus on training and embedding
M5	MUST DO	The Trust must ensure that it meets all aspects of the Duty of Candour regulation and that the Trust policy is always followed		Monthly compliance audit Annual notes audit	
M6	MUST DO	The Trust must ensure that staff training compliance with Mandatory Training especially resuscitation training, safeguarding children (level 2) and safeguarding vulnerable adults (including mental capacity act and deprivation of liberty safeguard training meets the target of 90%		Mandatory training compliance	ESR accuracy
M7	MUST DO	The Trust must ensure that all staff have an up to date appraisal completed		80% against appraisal target	Requires an agreed stretch target
M8	MUST DO	The Trust must take action to ensure that the environment is suitable for the purpose being used and is secure and compliant with current standards especially for paediatric patients and patients with mental health needs		Paediatric and Mental Health Pathways	Requires a Trust wide plan for Paediatric and Mental Health
M9	MUST DO	The Trust must take action to ensure that James Cook University Hospital is able to meet all requirements of the major trauma standards		Major Trauma Lead appointment Business case Compliance against Major Trauma Standards	Requires funding to deliver full compliance

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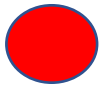
Ref	Requirement notice	Area for improvement	Assurance	Outcome Metrics	Risk, Mitigation and sustainability
M10	MUST DO	The Trust must take action to ensure that staff have the required paediatric competencies at the urgent and emergency care services at the Friarage Hospital		Safeguarding training in ED Paediatric competencies in ED	Maintaining competencies monitored as part of integrated performance report
M11	MUST DO	The Trust must ensure that there are at all times sufficient numbers of suitably skilled and qualified nursing and medical staff in line with best practice and national guidance		Staffing levels (ED)	Risk associated with 24/7 Consultant cover in ED Work with Specialised Commissioning to review funding to externally mandated model to achieve Major Trauma Compliance CCG funding for integrated Primary Care/ED assessment
M13	MUST DO	The Trust must ensure that nurse staffing is in line with GPICS recommendations of 1:1 care for level three patients and 1:2 patients for level two care		Daily staffing levels Weekly staffing levels	48 additional nurses recruited between April and September 2019. An additional 21 nurses recruited through international recruitment campaigns Patient numbers, acuity and staffing

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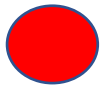
Ref	Requirement notice	Area for improvement	Assurance	Outcome Metrics	Risk, Mitigation and sustainability
					levels assessed daily and reported monthly to the Board.
M14	MUST DO	The Trust must review the role of supernumerary coordinators, the provision of clinical educators and the level of specialist pharmacy provision in Critical Care so they are in line with GPICS recommendations		Number of Clinical Educators in post Number of Specialist Pharmacists in post	Specialist Pharmacists
M15	MUST DO	The Trust must ensure that staff follow the appropriate IPC protocols to manage patients on the units with infections and to reduce the number of units acquired infections		HCAI rate for Critical Care Audit compliance	Monthly detailed report Board
M16	MUST DO	(Critical Care) The Trust must ensure Trust Policy is followed in relation to spot checks and the recording of these checks of controlled drugs		Monthly audits	Entire Trust audit required
M17	MUST DO	The Trust must review incidents related to pressure damage and take appropriate action to reduce the numbers		Reduce the incidence of new or deteriorated pressure damage year on year Improved compliance with interventions known to reduce risk	Requires escalation plan and sustainability plan
M18	MUST DO	The Trust must improve incident reporting and the mechanism for sharing learning when incidents are reported (Linked to M1 and M25)		Delivery of Well Led Action Plan Datix Cloud implementation Patient safety training Serious incidents reported within 48 hours 10% Increase in incident reporting year on year over 3	Requires plan for sustainable learning

Appendix 1: CQC Inspection Action Plan Progress Report

Ref	Requirement notice	Area for improvement	Assurance	Outcome Metrics	Risk, Mitigation and sustainability
				years	
M19	MUST DO	The Trust must ensure that up to date critical care policies and guidance can be accessed by staff		Induction training numbers Evidence of discussion at appraisal	
M20	MUST DO	The Trust must improve the quality and safety of services by ensuring that capacity and demand is appropriately managed including following their own standard operating procedure in relation to elective patients requiring critical care beds after surgery		Standard Operating Procedure Analysis of daily checklist	Bed capacity
M21	MUST DO	The Trust must review the Critical Care Outreach Team capacity to ensure there is adequate service provision for patients cared for outside the unit requiring critical care support in line with best practice guidance		Increase establishment Practitioners 24/7 on site availability	Requires a sustainability plan
M22	MUST DO	The Trust must review the findings of the national laparotomy report regarding the use of critical care beds and ensure appropriate actions are identified and taken		Compliance with North East Leadership Academy Report Other national standards	
M23	MUST DO	The Senior Management Team must be assured that information reviewed on performance is accurate and reliable and they must consider collecting ICNARC data for areas other than general ICU and HDU		Regular internal review of ICNARC report	Requires plan to maintain outcomes
M24	MUST DO	The Trust must be able to provide assurance that nursing staff in critical care are trained in equipment and have the appropriate knowledge and skills to provide level two and level three care		Training records	Requires greater increase and trajectory
M25	MUST DO	The Trust must ensure there is a robust system to ensure that incidents are reported, managed, and use for ongoing improvements according to Trust Policy. Links to M1 and M18		Delivery of Well Led Action Plan Datix Cloud implementation Patient safety training Serious incidents reported	Requires a Trust wide plan

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Ref	Requirement notice	Area for improvement	Assurance	Outcome Metrics	Risk, Mitigation and sustainability
				within 48 hours 10% Increase in incident reporting year on year over 3 years	
M26	MUST DO	The Trust must ensure there are sufficient numbers of suitably qualified staff, especially radiologists		Agreed Radiologist establishment Numbers of Radiologists in post against plan	External review of workforce planning completed Three additional radiologists will be in post March 2020
M27	MUST DO	The Trust must ensure the diagnostic service at the Friarage Hospital is compliant with good infection prevention and control practices at all times		Hand hygiene compliance self assessment and peer review audits Outcome of spot checks	Requires sustainable plan to improve compliance

Notes:

- **M12 has been removed at it was identified as a SHOULD DO requirement**
- **A separate report will be provided on should do actions**

Charitable Funds Committee
Chair's Log

Meeting: Charitable Funds Committee	**Date of Meeting**: 11th February 2020
Connecting to: Board meeting	**Date of Meeting**: 3rd March 2020

Key topics discussed in the meeting	

• Review of expenditure requests between £25,000 and £99,999 for authorisation:
  o Transport incubator to be purchased from Special Care Baby Fund
  o Funding of Smoke Free post for another year
• Review of charitable income and expenditure
• Report on administration of charitable funds
• Review of Holistic Centre finances
• Report on updated charity governance
• Update of committee terms of reference
• Update of committee's annual cycle of businesst	

Actions agreed in the meeting	**Responsibility and timescale**
• Purchase of transport incubator approved.	
• Further information requested before funding of Smoke Free post is approved.	Kevin Oxley/Laura Mills, March 2020
• Ongoing issues with administration of charitable funds were noted, as was the need to recruit new Head of Charity.	Alan Downey/Jackie White March 2020
• Updated committee terms of reference approved (subject to further discussion by corporate trustee – see below).	
• Revised cycle of business approved.	
• Corporate trustee to hold development session on charity strategy, governance and leadership	Session held on 18 Feb 2020
Escalation of issues to the Board	**Responsibility / timescale**
Board to note the ongoing issues with the administration of charitable funds and the urgency of appointing a new Head of Charity to address these issues, stabilise the charity team and rebuild relationships with fund managers and fund holders across the Trust.	Board Meeting 3rd March 2020
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
No new risks identified.	

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 28 January 2020
Connecting to: Board	**Date of Meeting**: 3 March 2020

Key topics discussed in the meeting	
Monthly Quality Report Mortality / Learning from Patient Deaths Report HCAI monthly report Cleaning review report Monthly Serious Incident Report Ophthalmology Updated QAC ToR & Annual cycle of business QEIA Report Quality Account plan 20/21 CQC Action Plan update	
Actions agreed in the meeting	**Responsibility / timescale**
QAC to receive service recovery plans for discussion and challenge and plan a programme of 'deep dive' quality surveillance into services in line with safety and quality priorities and the Trust Recover Plan. Timetable for QAC to be drawn up.	Gill Hunt and Joanna Reilly. Feb 2020
Escalation of issues for action by connecting group	**Responsibility / timescale**
Mortality: Advised SHMI likely to increase and STees to become an outlier due to others trusts coding substantially improving and STees unable to improve the quality of the coding due to a lack of EPR.	T Roberts
QA Framework: Emphasis on the relaunch of the STAQC to provide assurance of standards in wards and departments. Programme to be supported by an Organisational Development Programme for those teams.	M Angel
Coronovirus: All plans and policies in the trust are in place. No reported UK cases.	G Hunt
External cleaning review: Completed and all recommendations have been agreed and will be implemented with reporting to QAC.	G Hunt / K Oxley

SI and Never Events: NHSE/I completed their table top review. An external review of surgical practices to be carried out by an ENT surgeon from Airdale NHS Trust Ophthalmology: update received . CQC actions plan: Financial and recruitment issues remain a hurdle in improvement however improvement is slowly happening.	G Hunt J Reilly M Angel
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
None	

Workforce Committee
Chair's Log

Meeting: Workforce Committee	**Date of Meeting**: 10 February 2020
Connecting to: Board	**Date of Meeting**: 3 March 2020
Key topics discussed in the meeting	
Review of Education delivery Education Strategy Mandatory training compliance (by exception areas only) Health & Wellbeing Strategy Engagement Strategy Annual staff survey Local Clinical Excellence Awards Values & Behaviours Review workforce performance data and metrics Equalities objectives, EDS2 and WRES Update Equality Diversity and Inclusion Group Draft Strategy	
Actions agreed in the meeting	Responsibility / timescale
Concern regarding the outstanding action of safe monitoring of medical staffing. It was agreed that this issue be escalated to the Medical Director for a report at the next meeting. A People Plan be developed underpinned by a number of delivery plans including Health & Wellbeing, Education, ED&I and Engagement	J White / D Chadwick R Metcalf
Escalation of issues for action by connecting group	Responsibility / timescale
FTSU - Committee is concerned at the delay in taking action/identifying the resource needed to give assurance that we are compliant with our obligations and good practice on FTSU. Embracing this programme will make an important contribution to demonstrating to staff that the Board is listening and keen to engage. Workforce Strategies - there may be a delay in bringing forward to Board the workforce strategies as the Committee agreed to reframe these, not as separate Strategies (for health and well-being, engagement, equalities etc), but as themes within a unified People Strategy. A plan on a page for each, with a small number of	A Burns / G Hunt R Metcalf

priorities for 2020/21, will enable the Executive to balance off available capacity, and give the Board assurance that the most critical things to respond to the staff survey outcomes and our obligations are being delivered. The Committee would like the Executive to give consideration to aligning the SDR timetable with the financial year, enabling staff to be set objectives consistent with the Strategic improvement Plan and Financial Plan early enough in the relevant year (ideally within the first quarter)	R Metcalf / SLT
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
None	