South Tees Hospitals NHS Foundation Trust

Board of Directors Meeting (to be held in PUBLIC)

Tuesday, 5 February 2019 at 1pm in the Boardroom

Murray Building, James Cook University Hospital

		Enclosure	Led By
1.	**Opening Items**		
1.1	Welcome and Apologies for Absence (*information*)	*Verbal*	Chairman
1.2	Declarations of Interest (*information*/**approval**) *(Any new conflict of interest and any actual or potential conflict of interest in relation to any matter to be discussed*)	*Verbal*	Chairman
1.3	Minutes of Previous Meeting (**approval**)	***5***	Chairman
1.4	Matters Arising (*discussion/information/***approval**)	*Verbal*	Chairman
1.5	Action Log (*information*) - no open actions to report	***13***	Chairman
1.6	Patient Experience	*Presentation*	Chief Executive
1.7	Chairman's Report (*discussion/information*)	*Verbal*	Chairman
1.8	Chief Executive Report (*discussion/information*)	*Verbal*	Chief Executive
2.	**Strategy and Planning**		
2.1	Strategic Issues Affecting the Trust and Wider Health Economy update	Verbal	Chief Executive/ Chairman
2.2	Research and Innovation Strategy (*discussion*/**approval**)	***15***	Medical Director
2.3	Communication and Engagement Strategy(*discussion*/**approval**)	***23***	Chief Executive
3.	**Quality, Safety, Performance and Finance**		
3.1	Quality, Safety, Performance and Finance Exception Report (*discussion/information*)	***39***	Deputy Chief Executive/ Director of Nursing and Quality/ Medical Directors/ Director of Finance
3.2	Healthcare Associated Infection Report (/*information*/**approval**)	***51***	Director of Nursing and Quality
3.3	Safe Staffing Monthly Report (*discussion/information*)	***59***	Director of Nursing and Quality
3.4	Learning from Deaths Q3 Report 2018-19 (*discussion/information*)	***65***	Medical Director

3.5	Guardian of Safe Working Hours Q3 Report 2018-19 (*discussion/information*)	***73***	Medical Director
4.	**Governance/Assurance**		
4.1	Board Committee Terms of Reference (**approval**)	***81***	Committee
4.1.1	Quality Assurance Committee	***82***	Chairs
4.1.2	Finance and Investment Committee	***89***	
4.1.3	Audit Committee	***95***	
5.1	Chair's Logs from Board Committee Meetings (*discussion/information/action*)		Committee Chairs
5.1.1	Quality Assurance Committee – 27 November 2018 and 29 January 2019	***101-102***	
5.1.2	Finance and Investment Committee – 27 November 2018 and 24 January 2019	***103-104***	
5.1.3	Risk Committee – 25 October 2018 and 13 December 2018	***105-106***	
5.1.4	Workforce Committee – 13 December 2018	***107-110***	
5.1.5	Operational Management Board – 29 November 2018 and 24 January 2018	***111-114***	
5.	**Closing Items**		
5.1	Any Other Business	*Verbal*	Chairman
5.2	*Risks* *Any Risks discussed during meeting for consideration of adding to Risk Registers or Board Assurance Framework (discussion/***approval***)*	*Verbal*	Chairman
5.3	Evaluation of Meeting (*discussion*)	*Verbal*	Chairman
5.4	Date and Time of Next Meeting (*information*) The next meeting is scheduled to take place on Tuesday, 7 May 2019 (*information*)		

Board of Directors Meeting (held in PUBLIC)
held on 6 November 2018
Boardroom, Murray Building, James Cook University Hospital

Present:

Mr A Downey	Chairman
Ms A Hullick	Non-executive Director/Deputy Chair
Mrs M Rutter	Non-executive Director/Senior Independent Director
Mr R Carter-Ferris	Non-executive Director
Mr M Ducker	Non-executive Director
Mrs S McArdle	Chief Executive
Mr D Chadwick	Medical Director (Planned and Specialist Care)
Mr A Clements	Deputy Chief Executive/Medical Director (Urgent and Emergency & Friarage)
Mrs G Hunt	Director of Nursing and Quality
Mr S Mason	Director of Finance.
Dr S Nag	Medical Director (Community Care)
Professor A Owens	Medical Director (Corporate Clinical Support Services)

In attendance:

Mrs H Edwards	Director of Communications
Ms L Hughes	Company Secretary
Mr K Oxley	Director of Estates, ICT and Health Records
Mr A Adair	Consultant in Accident and Emergency/Chief Clinical Information Officer (*item BoD/11/09 only)*
Mr I Willis	Mr I Willis Head of Digital Programmes (*item BoD/11/09 only)*
D Macafee	Director of Medical Education (*item BoD/11/08 only***)**

Observing:

Mrs A Seward	Lead Governor (Elected Governor for Rest of England)
Mr G Davidson	Business Development Manager, Cannon UK

BoD/11/01 **Apologies for Absence**

1.1 Apologies for absence were received from Mr D Heslop, Non-executive Director and Mr J Tompkins, Non-executive Director.

BoD/11/02 **Declaration of Interests**

2.1 The Chairman requested that Directors declared any actual or potential conflict of interest relevant to their role as a member of the Board of Directors and in particular to any matter to be discussed at the meeting. There were no interests declared in relation to open items on the agenda.

BoD/11/03 **Minutes of Previous Meeting**

3.1 **Resolved:** the minutes of the previous meeting held on 4 September 2018 were accepted as a true record.

BoD/11/04 **Matters Arising**

4.1 There were no matters arising in addition to those included on the agenda.

BoD/11/05 **Action Log**

5.1 There were no open actions.

BoD/11/06 **Chairman's Report**

6.1 The Chairman reported on the work that was progressing as part of the Sir Ian Carruthers's Independent review looking at the reconfiguration of services across the Tees Valley which was progressing with the support of the Chief Executive, Medical Directors and senior leaders/management involvement.

6.2 **Resolved:** the Chairman's report was noted.

BoD/11/07 **Chief Executive Report**

7.1 The Chief Executive was pleased to report on the:

- Successful introduction of patient-centred visiting on all wards and sites
- 1,000th baby born had been at the maternity centre, Friarage Hospital Northallerton
- 10,000th pacemaker implanted
- Winter plan had been submitted to NHS England with continuous monitoring taking place in place to respond to demand and times of surge
- Influenza staff vaccination scheme was progressing well
- Launch of the green energy heating initiative with the Tees Valley Combined Authority
- NHS national staff survey was underway
- CQC inspection had announced with the Trust responding to the CQC's Provider Information Return
- Ongoing management of the waste management contractor continued

7.2 She was pleased to report on the following Trust success gaining National awards:

- 'Team of the Year' awarded by the Heart Rhythm Congress to the cardiology team at the Friarage Hospital Northallerton for service developments within cardiac rhythm management
- 'Putting Care Needs First' awarded by the Allocate Awards to the e-roster team for the therapeutic care provided on enhanced observations and specialing

7.3 There had been a number of changes to the Board and senior leadership at the Trust following the three year review of Medical Directors with Mr Simon Kendall stepping down from his Medical Director (non-voting) position; Dr Sath Nag taking on the role of Responsible Officer; Professor Andrew Owens taking on the responsibility of EPRR lead and joint lead with Gill Hunt for the Clinical Intelligence Unit; Mr Adrian Clements taking the lead for operational performance and Mrs Rachael Metcalfe appointed as Director of Human Resources (non-voting). The Council of Governors also approved the Appointment of Debbie Reape as Non-executive Director who joined the Board with Professor Andrew Owens as voting members.

7.4 The Chief Executive also provided an update on stakeholder engagement which included the work that continued with Sir Ian Carruthers which was looking at the clinical pathways across the Cumbria and North East Integrated Care System; the Annual General/Annual Members meeting had been held on 9 October 2019; and a meeting held with Rishi Sunak, MP for Richmondshire.

7.5 **Resolved:** the Chief Executive's Report was noted.

BoD/11/08 **Medical Education Strategy**

8.1 The Medical Director (Medical Workforce, Research and Innovation & Clinical Diagnostics) and Director of Medical Education presented the Medical Education Strategy. The Director of Medical Education drew reference to the

mission and vision, the eight high impact actions which aimed to improve the working environment for junior doctors and their work looking forward to increased collaboration with higher education institutions such as Newcastle University, Hull-York Medical school, Imperial College and Teesside University.

8.2 The Board were pleased to endorse the eight high impact actions and the development work ongoing with regards to the education facilities Hub at Friarage.

8.3 The Chairman praised the innovative work and aspirations presented to the Board. He stressed the importance of medical education to the Trust.

8.4 The Chief Executive explained that there had been extensive work taking place in the background with regards to medical education. The GMC had visited the Trust at the end of October 2018 and had been sighted on this work. She confirmed that Operational Management Board had received the strategy prior to it being presented at the Board which had been well received by all those present.

8.5 A Hullick, Non-executive Director (Deputy Chair) requested that the high level action plan referenced in the strategy was shared with the Board following the meeting which was agreed. **ACTION (A Owens)**

8.6 R Carter-Ferris, Non-executive Director queried how the milestones would be monitored. In response it was agreed that arrangements would be made for progress made against the action plan to be presented to the Board or Workforce Committee at six monthly intervals. **ACTION (A Owens)**

8.7 The Board thanked the Medical Director (Medical Workforce, Research and Innovation & Clinical Diagnostics), Director of Medical Education and their team for the excellent work and innovation demonstrated with regards to medical education at the Trust.

8.8 **Resolved:**
i) the Board supported and approved the direction of the Medical Education Strategy;
ii) Endorsed the eight high impact actions to improve the working environment for junior doctors; and
iii) Supported the plans to pursue working with Hull-York Medical School Undergraduates, Trust Postgraduates and the wider North Yorkshire health service.

BoD/11/09 Information Technology Strategy

9.1 The Director of Estates, ICT and Health Records explained that the previous ICT Strategy (2014-2019) had focussed on maximising the use of the Trust's current systems whilst providing small scale improvements in clinical systems and the underlying infrastructure.

9.2 Chief Clinical Information Officer and Head of Digital Programmes explained that regional and national drivers were focussing on the need to share patient records across all healthcare settings. They explained that the ICT Strategy had been updated to incorporate national and regional priorities with the Electronic Patient Record forming the heart of the strategy.

9.3 The Board were asked to approve the strategy noting the ambition to procure an Electronic Patient Record with work taking place to enable presentation of the business case to the Board at its December 2018 meeting.

9.4 A Hullick, Non-executive Director (Deputy Chair) queried if the current

infrastructure would support the Electronic Patient Record plans. In response the Chief Information Officer explained that plans would need to be in place to support the success of implementation.

9.5 Following discussion the Board approved the Information Technology strategy and supported the commitment for the implementation of the Electronic Patient Record subject to consideration of the business case and capital funding being available.

9.6 **Resolved:** i) the Information Technology strategy was approved; and
ii) the Board supported commitment for the implementation of the Electronic Patient Record subject to consideration of the business case and capital funding being available.

BoD/11/10 Emergency Preparedness Resilience and Response Core Standards

10.1 It was noted that NHS Trusts are required to undertake an annual self-assessment against the NHS England Emergency Preparedness Resilience and Response (EPRR) Core Standards and provide a statement of compliance to the Board.

10.2 The Director of Estates, ICT and Health Records explained that a self-assessment review of the 2018/19 EPRR Core Standards had identified that six of the 64 standards were rated amber. Those six rated amber were not compliant but evidence had shown progress had been made against the EPRR work plan which had resulted in the Trust declaring *substantial compliance* in line with the national reporting levels. An action plan had been developed to continue to address the areas of partial compliance.

10.3 A Hullock, Non-executive Director (Deputy Chair) queried if the six standards rated amber were the same as reported the previous year. In response the Director of Estates, ICT and Health Records explained that some of the standards from the previous year had changed, which prevented a full comparative analysis, but he assured members that the Trust had coped with the global cyber-attack and Carillion changes with lessons learned and adjustments made to EPRR plans.

10.4 **Resolved:** the submission to NHS England of 'substantial compliance' with the 2018/19 EPRR Core Standards was noted.

BoD/11/11 Quality, Safety, Performance and Finance Assurance Report

11.1 The quality, safety, finance and operational performance by exception for the period ending 30 September 2018 was noted with reference drawn to:

11.2 Accident and Emergency 4 hour performance was reported as 96.33% against the 95% target with the Trust ranked fourth in the region.

11.3 Referral to Treatment 18 week target was reported below trajectory at 89.21% against the 92% target with the Trust ranked ninth out of 12 local Trusts. It was noted that a review of the patient list had found 208 patients should not have been included on the Trust's lists and have recently been removed. In response to A Hullock, Non-executive Director (Deputy Chair) query, the Medical Director (Planned and Specialist Care) explained that the Trust was working with primary care to ensure that the patients removed were transferred to the correct pathway within primary care.

11.4 M Rutter, Non-executive Director sought assurance around the timescale to comply with the RTT target. In response the Deputy Chief Executive/Medical

Director (Urgent and Emergency & Friarage) explained that plans were in place to meet the trajectory target by the financial year end (31 March 2019). The Chief Executive explained that some behavioural issues had been noted which were seen as a barrier to meeting the target. Work with medics was being taken forward to remove those barriers.

11.5 Cancer 62 Day Standard was reported at 82.5% which was below the 85% target with the continued underlying issues noted to be attributable to tertiary referrals with work continuing to drive forward improvements via close monitoring of the cancer wall. The Board noted that the Trust continued to perform well against all other cancer targets.

11.6 The Director of Nursing spoke to the Healthcare Associated Infection Report. The Clostridium difficile cases were noted as one trust-apportioned case over trajectory for the position as at 31 October 2018. She explained that a full review had taken place and there was no evidence to suggest there had been a drop in the standards of cleanliness or other infection prevention and control measures. Robust measures of assurance would continue.

11.7 It was noted that there has also been a noted increase in category two pressure ulcers, but the rate per 1000 bed days was within normal variation. The Board were pleased to note that the falls rate was the lowest rate since October 2016.

11.8 With regards to patient experience in September 2018 the Trust's patients gave the Trust an overall rating of 9.65 out of 10.

11.9 Sickness absence was reported at 4.3% against the 3.5% target. The Chief Executive explained that a recent restructure of the Human Resources department would de-centralise the hub to give direct support to Centres with staff working to drive down sickness absence levels.

11.10 Financial performance as at 30 September 2018, was noted as £0.7m ahead of the Trust's control total plan. The Board noted that the Trust was in receipt of PSF funding as a result of it being on track at the end of quarter 2 and that progress continued to be made against the Trust's productivity and efficiency savings plan with £18.8m achieved against the £35.6m year-end plan with work continuing to identify new schemes.

11.11 **Resolved:** the Quality, Safety, Performance and Finance Assurance Report as at 30 September 2019 was noted.

BoD/11/12 **Learning from Deaths Q2 Report**

12.1 The Medical Director (Medical Workforce, Research and Innovation & Clinical Diagnostics spoke to the Learning from Deaths Q2 Report.

12.2 The Trust published its *Responding to Deaths* Policy (in line with the national LFD requirements) in September 2018 which set out the Trust's approach to learning from deaths in care. It was noted that the Learning From Deaths dashboard had been redesigned and reported the number of deaths, the number deaths with first stage reviews (by Medical Examiners), number of deaths with second stage reviews or investigations and the number of those deaths judged to show evidence of preventability. (It was also noted that numbers were reported separately for patients with learning disabilities.)

12.3 The Summary Hospital-level Mortality Indicator (SHMI) which includes all in-hospital deaths plus deaths within 30 days of discharge was reported as expected.

12.4 The Hospital Standardised Mortality Ratio (HSMR) includes approximately 80% of in-hospital deaths and uses different risk adjustment methods. The most current report was noted to cover the period July 2017 – June 2018 with HSMR reported as 114 (higher than expected.) This had resulted in a deep dive exercise being carried out. The Chair of the Quality Assurance Committee (QAC) confirmed that QAC had asked the Patient Safety Group to carry out a deep dive exercise on the Serious Incidents and also the HSMR results to gain a greater understanding of the underlying factors.

12.5 The Board noted the planned next steps with reference specifically drawn to: i) the Medical Examiner Service at the Trust which was now operational; ii) 68% of deaths had received a stage one review with 55 deaths being recommended for second stage review; iii) the new service would also impact on the number of second stage reviews completed which would be monitored through the Learning From Deaths dashboard; iv) Mortality indicators would continue to be monitored with issues around recording of comorbidities and specialist palliative care coding being addressed through Trust departments; v) the Learning From Deaths Quarterly Dashboard would continue to be developed with an in-depth report presented to the Patient Safety Group which reports to Quality Assurance Committee (QAC) following each of its meetings.

12.6 **Resolved:** the Learning from Deaths Q2 Report was noted.

BoD/11/13 **Healthcare Associated Infection Report**

13.1 The Trust's performance against its Clostridium difficile target was covered in the Quality, Safety, Performance and Finance Report above at BoD/11/11 above.

13.2 The Director of Nursing and Quality explained there had been zero MRSA bacteraemia trust-assigned cases in September 2018 with one Trust assigned case from 1 April to 30 September 2018; and four trust-apportioned MSSA bacteraemia cases in September 2018 which totalled 22 for April to 30 September 2018.

13.3 **Resolved:** the Healthcare Associated Infection Report as at 30 September 2018 was noted.

BoD/11/14 **Safe Staffing Monthly Report**

14.1 **Nurse Establishment Review (Adult In-patient)**

The Director of Nursing and Quality presented the report on the safe staffing levels across all adult inpatient bed holding areas. She explained that each centre Associate Director of Nursing (ADoN) had reviewed data and had contributed to actions resulting in the formation of the report.

14.1.2 She drew reference to Critical care areas which are staffed in line with mandatory staffing levels of 1:1 for Intensive Care (ICU) and 1:2 for High Dependency Units (HDU). It was noted that a staffing review was planned in line with the critical care strategy. Care Hours per Patient Day (CHPPD) were reported to be within mid-range of the Trust's model hospital peer group at a median of 8.7 (range 6.9 – 10.6).

14.1.3 Work was noted to be ongoing with Allocate as part of the Insights package to drill into the data sets provided for roster efficiencies and SafeCare metrics including acuity and dependency scoring and CHPPD in line with the Lord Carter NHSI recommendations to improve efficiencies and reduce variation and waste.

14.1.4 **Resolved:** the Nurse Staffing Review for Adult Inpatient Areas was approved.

14.2 **Nurse Establishment Review (Paediatrics In-patient)**
The Director of Nursing spoke to the Safe Staffing Report for Paediatric Inpatient Areas (Ward 21 and 22) acute paediatric medical and surgical wards within the Community Care Centre which have 25 and 17 beds respectively. It was noted that this was the Trust's first staffing establishment review of the inpatient paediatric wards on the James Cook University Hospital site using the newly published Children and Young People's Safer Nursing Care Tool (CYP SNCT, Shelford Group 2018).

14.2.1 M Rutter, Non-executive Director queried if moving staff across wards had any impact on staff morale. In response the Director of Nursing and Quality explained that significant progress had been made over the last 18 months and there is a full process of communication with affected staff before any move.

14.2.2 **Resolved:** the Board noted the assurance of safe staffing levels across the paediatric ward areas (Ward 21 and 22 JCUH) for the period of the data collection (June 2018).

BoD/11/15 **Revised Board Corporate Governance Structure**

15.1 The Board noted the review of the Trust's corporate governance structure had resulted in a number of changes to the reporting lines with the aim of providing clear lines of accountability and assurance to the Board. It was noted that the operational groups were planned to report to Operational Management Board with a dotted line of assurance to Board Committees.

15.2 Following discussion the revised Board Corporate Governance Structure, including Board Committees and operational groups was approved. It was noted that following a review of the Board Committee Terms of Reference the updated Terms of Reference would be presented to the Board for approval.

15.3 **Resolved:** the revised Board Corporate Governance Structure including Board Committees and operational groups were approved

BoD/11/16 **Standing Financial Instructions and Corporate Policies**

16.1 The Director of Finance reported that the Standing Financial Instructions and Corporate Policies (inclusive of Standing Orders and Decisions Reserved for the Board – Scheme of Delegation) had been updated to incorporate changes to the senior management structure and had been reviewed by the Senior Leadership Team and the Audit Committee who supported the changes. The Board considered and approved all changes to the Standing Financial Instructions and Corporate Policies for uploading on the Trust's intranet site.

(ACTION) S Mason

16.2 **Resolved:** the updated Standing Financial and Corporate Policies (inclusive of Standing Orders and Decisions Reserved for the Board – Scheme of Delegation) were approved.

BoD/11/17 **Any Other Business**

17.1 There was no other business.

BoD/11/18 **Risks**

18.1 There were no additional risks raised in addition to those included on the Risk Registers or Board Assurance Framework.

BoD/11/19 **Evaluation of Meeting**

19.1 It was noted that the content of the meeting had included strategic, governance, risk management, quality and patient safety, and operational and financial performance.

BoD/11/20 **Date and Time of Next Meeting**

20.1 The Board meeting to be held in Public was arranged to take place on Tuesday, 5 February 2019.

Board of Direction Action Log (meeting held in Public)

Date of Meeting	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
6.1.18	BoD/11/08.5	**Medical Education Strategy**	At the request of A Hullick, Non-executive Director (Deputy Chair) it was agreed that the high level action plan referenced in the strategy is shared with the Board following the meeting	Medical Director (Corporate Clinical Support Services)	4.12.18	Completed	Completed
6.1.18	BoD/11/08.6	**Medical Education Strategy**	Agreed that arrangements would be made for progress made against the action plan to be presented to the Board or Workforce Committee at six monthly intervals	Medical Director (Corporate Clinical Support Services)	4.12.18	Completed - added to Workforce Committee workplan for May 2019	Completed
6.1.18	BoD/11/16.1	**Standing Financial Instructions and Corporate Policies**	the updated Standing Financial Instructions and Corporate Policies to be uploaded on the Trust's internat site	Director of Finance	4.12.18	Completed	Completed

Board of Directors	
Agenda item	2.2
Title of Report	Research and Innovation Interim Strategy (*including mid year review*)
Date of Meeting	5 February 2019
Presented by	Medical Director (Corporate Clinical Support Services)
Author	Director of Research and Innovation
Approved by	Medical Director (Corporate Clinical Support Services)
Previous Committee/Group Review	Operational Management Board
Purpose	Approval ☑ Decision ☐ Discussion ☐ Information ☑
Alignment to Trust's Strategic Objectives	☑ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements	NHS Improvement NHS England
Recommendation(s)	The Board is asked to support the Interim Research and Innovation Strategy.

1. Executive Summary

The most significant development in 2018/19 is the Durham Tees Valley Research Alliance (DTVRA). This alliance has the potential to bring significant improvements in performance, quality and accessibility of research opportunities across the Durham Tees Valley. Of the 4 alliances in North East and North Cumbria the DTVRA is the most developed and is recognised as an example of innovative collaboration by the Local Clinical Research Network.

South Tees Hospitals NHS Foundation Trust R&I department achieved the following year to date (data cut 1st December) 2018/19:

RESEARCH

- Recruited 1942 patients to 148 research trials
- 3rd in the region and in the top 10% of NHS Trusts for number of recruits
- 2nd in the region and in the top 5% of NHS Trusts for number of studies open
- Sustained increase in Chief Investigator numbers
- Research grants awarded; Mr Enoch Akowuah, Heart Research UK £147k-pre-habilitation in elderly patients undergoing cardiac surgery. Prof Gerry Danjoux, Macmillan £76k-prehabilitation platform for Cancer patients.
- Introduced Specialty specific R&I reports

INNOVATION

- Innovation grants awarded: Socektwizard, Mr Barney Green and team, H2020- £167k for the development of smart limb prosthesis
- Dr David Chadwick & the Infectious Diseases team won the Bright Idea in Health Award for technology developing a test to prompt GP's to check for blood borne virus
- The 'Universal Medical Handbook' developed by Shane Lester, ENT Consultant, is now available for all NHS trusts to access via NHS Digital OpenSource

Key risks identified include:

- **Finance:** Income remains at risk due to the nature of funding received from NIHR (5% reduction equating to 280k overspend in 2019/20 –a plan to address this overspend is currently being ratified with the R&I senior management team)
- **Governance:** A trial we delivered in 2016 was inspected by the FDA (US Federal Drugs Authority) in June 2018. The department failed the inspection due to inconsistencies in data collection. The FDA accepted our corrective action plan and the outcome has been downgraded. The department had a UK MHRA inspection and passed in December 2018. This is a reflection of the significant commitment to quality and training led by the Research clinical lead Alison Chilvers and Orthopaedic Research Trial Coordinator Lucksy Kottam.
- **HR:** Due to the expanding portfolio and innovation grants issues have been identified about the capacity and skill set to deliver current and new grants. This will be addressed by strengthening managerial and grant writing support in Q4.

1.1 Research Activity

Each quarter the Trust submits performance on the following metrics, these data refer to end Q2:

Metric	Achievement
Recruiting the first patient to a clinical trial as soon as possible	32nd out of all 203 providers (and 1st in our league of 18 Trusts with similar levels of activity) for how quickly the first patient was recruited
Recruiting the target number of participants within the agreed time for closed commercial trials (National league table)	54.5%+ of reported studies achieved this metric, placing the Trust 73rd out of all 159 providers that provided data (and joint 10th in our league of 20 Trusts with similar levels of activity).
Trial set up within 40 days of receiving documentation (national target)	100%

+Approximately 25% of these are related to external factors the rest are related to internal factor which the R&D Manager and team lead research nurses are reviewing in Q4.

Rise in New Chief Investigator (CI) S Tees sponsored studies opened:

Year	2015/16	2016/17	2017/18	2018/19
Number of CI's (NIHR sponsored)	4 (0)	8 (2)	10 (2)	16 (3)

For example: Professor Amar Rangan – PROFHER 2 trial: This is a major clinical trial funded by the National Institute of Health Research, to the value of £2.32M. The research is looking at whether reverse shoulder arthroplasty is more effective than hemiarthroplasty at restoring use of the shoulder and arm, whether shoulder replacement surgery is more effective than non-surgical treatment for these fractures (three or four part fractures of the proximal humerus), and which treatment is best value for money. This study will recruit 380 patients across 3 years working with 40 different NHS Trusts to recruit patients.

1.2 Innovation Activity

Innovation grant activity from 1st April 2018

Project title	**Status**	**Total value of grant**	**STees allocation**	**Date Submitted**	**Funding from**
SocketWizard	Grant Awarded	£ 3,521,400.00	**£ 167,000.00**	17/04/2018	H2020
Parkinson's Intelligence App	Seeking grant	£ 1,000,000.00	**£ 50,000.00**	30/03/2018	MRC
SkinDetector	interview stage	£ 1,000,000.00	**£ 52,355.00**	18/04/2018	Innovate UK
AI Lung Cancer	Unsuccessful	£ 975,000.00	**£ 127,020.00**	18/04/2018	Innovate UK
Smart & Healthy Living at Home	Seeking grant	£ 15,500,000.00	**€50-150K**	14/11/2018	H2020
iHome	Seeking grant	£ 13,500,000.00	**£ 265,000.00**	13/11/2018	H2020
Pain Response Wristband	Unsuccessful	~£ 3,000,000.00	**£ 215,000.00**	25/10/2018	H2020

Royalty payments/sales of Trust innovations:

Sales of the Cervix Visual Assessment Guide from April - October 2018 are at £1,120 with marketing of the guide continuing. Royalty payments continue to be received for Smart System and the Left Radial Support Sling, but are currently allocated to the innovator until they are worth >£1000.

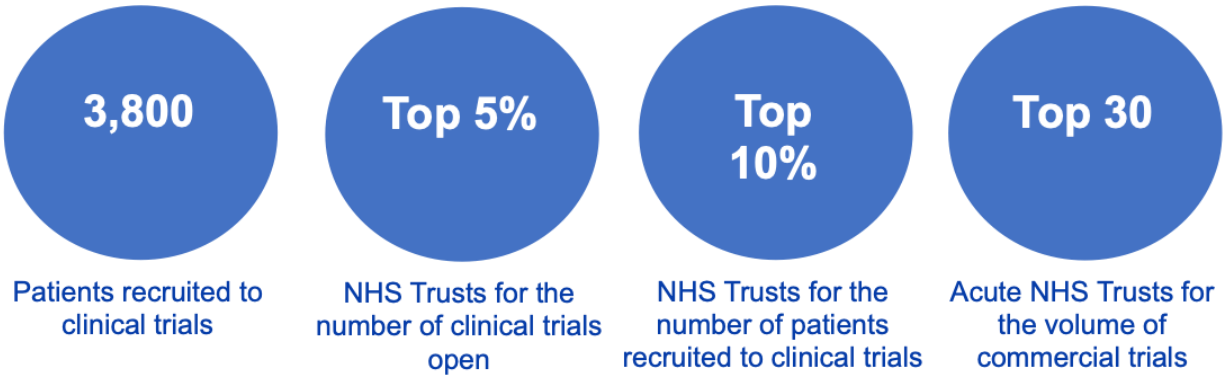
2. Next Steps

Plans for Q3&4 2018/19

- Smooth handover to new R&I Director Mr Paul Baker
- Develop DTVRA senior management team (led by Mrs Jane Greenaway)
- Pilot STees sponsored Primary care study
- Develop the Research patient ambassador group to reflect regional representation

3. Recommendation

The Board is asked to support the Interim Research and Innovation Strategy.



Purpose of strategy document

There a government mandate for NHS Trusts to engage in research through the National Institutes of Health and Research (NIHR). South Tees Hospitals NHS Foundation Trust has consistently articulated a commitment to promoting research and innovation.

The aim of this document is to articulate a strategy whereby the Trust can further develop its engagement in research and innovation. This strategy replaces the 2013-2018 strategy and is a 1-2 year interim strategy as it is anticipated to be replaced following the creation of the Durham Tees Valley Research Alliance (DTVRA) strategy.

The DTVRA creates a single Research & Development service covering County Durham & Darlington NHS FT, North Tees & Hartlepool NHS FT and South Tees Hospitals NHS FT. The proposed alliance is currently coming to the end of a 6 month scoping project and plans to formalise the alliance are at respective Trust boards for agreement. It is anticipated that the alliance will be formalised by 1st April 2019 and established and developed in 2019-20.

There are 4 strands to the South Tees interim strategy.

1. Increase the opportunities for patients and staff to participate in health research and innovation at all sites and in all clinical areas.

2. Provision of high quality research and innovation services

3. Support and development of research and innovation staff

4. Develop new and strengthen existing regional and national relationships with research and innovation partners.

1. Increase the opportunities for patients and staff to participate in health research and innovation at all sites and in all clinical areas

All clinical areas-research engagement will be promoted across the trust. Research and Innovation engagement and performance will be reported quarterly by specialty and disseminated by research and clinical teams.
All sites-Research opportunities will be developed at community sites and within the Friarage expanding on the work based at The James Cook University Hospital.
All patients- Increase the number and breadth of research opportunities for patients.

In addition the Trust will maintain its position as a UK research lead in Orthopaedics, Cardiothoracics and Pain/perioperative care Research and support research with out military colleagues.

2. Provision of high quality research and innovation services

Communication-The R&I Directorate will be an easily accessed source of the information needed by the leadership within the Trust and investigators to understand, develop, fund and manage research activity and projects.
Research Governance-Investigators are supported with timely and appropriate trial support, with regular performance management from successful set up to the support of failing trials. The R&I department will monitor and meet performance targets set by the NIHR and the LCRN.
Innovation pathway- staff will be signposted through the innovation pathway and supported with advice over intellectual property and commercial engagement.
Patient and Public Involvement-Our patient and carer experience of participating in research will be evaluated and supported by the Patient Research Ambassadors group. This information will be used to help inform strategies to improve research engagement and clinical trial design where appropriate.

3. Support and development of research and innovation staff

This includes the following strands:

(a) Development of Principle Investigator role with NMAHP and medical PI's
(b) Mentoring and training of new CI's
(c) Increase in the number of existing Trust staff engaged in research and innovation
(d) Establishment of substantive University appointments, both Medical and NMAHP
(e) Externally funded Fellowships
(f) Provide leadership and professional development opportunities to support research staff in delivering clinical research.

4. Develop new and strengthen existing regional and national relationships with research and innovation partners.

These partners include the LCRN, AHSN, Teeside, York, Durham and Newcastle Universities, the Tees Health Improvement Partnership and commercial SMEs.

Board of Directors	
Agenda item	2.3
Title of Report	Communication and Engagement Strategy
Date of Meeting	5 February 2019
Presented by	Director of Communications
Author	Director of Communications
Approved by	Chief Executive
Previous Committee/Group Review	Organisational Management Board Senior Leadership Team
Purpose	Approval ☑ Decision ☐ Discussion ☐ Information ☐
Alignment to Trust's Strategic Objectives	☑ 1. We will deliver excellence in patient outcomes and experience ☑ 2. We will drive operational performance to deliver responsive, cost effective care ☑ 3. We will deliver long term financial sustainability to invest in our future ☑ 4. will deliver excellence in employee experience to be seen as an employer of choice ☑ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	NHS 2006 Act
Recommendation(s)	The Board is asked to approve the proposed Communication and Engagement Strategy.

South Tees Hospitals
NHS Foundation Trust

Communication and Engagement Strategy

1. Executive summary

The communications and engagement strategy for South Tees Hospitals NHS Foundation Trust sets out how the Trust will communicate and engage with its audiences and supports of the delivery of its mission, vision, values and strategic objectives.

The need to communicate and engage well with our staff, the public, patients, partners and key stakeholders is essential for the delivery of safe and effective patient care and central to the success of the Trust. It needs to be what we do, every day, and involves everyone within the Trust.

We are committed to improving how we communicate and engage, and understand the importance of clear, open, timely and relevant communication and meaningful engagement.

Meeting the challenges of improving quality of care and improving patient experience, while ensuring services meet growing demands and are sustainable, puts an increased importance on communicating and engaging effectively.

This strategy aims to build on our reputation and make the Trust an attractive place to work, for our existing workforce and for prospective staff. It recognises the need to listen to, and involve, patients, the public, our partners and external stakeholders, with emphasis on improving communication and engagement with our staff to create a well-informed and engaged workforce that is proud to work here and represent the Trust.

It describes the communication and engagement tools the Trust uses, and will develop these based on research and feedback and it sets out how we will measure and review their effectiveness.

The strategy supports the other Trust strategies, including the HR strategy, Equality and Diversity strategy, as well as strategies being developed for staff engagement and membership engagement.

It reflects a renewed focus by the Trust on communication and engagement with the development of a communications team covering a range of skills in internal and external communications, as well as complementing the commitment required of every member of staff, at all levels of the organisation to communicate and engage well.

2. Communication and engagement objectives

The objectives of this strategy are to;

- Engage staff in the Trust's mission, vision, values and strategic objectives, and communicate these effectively with our patients and external stakeholders, so everyone knows what the Trust is aiming to achieve;
- Listen to, engage and involve staff, and people who use our services, to improve the quality of care we provide;
- Develop and use our communications channels to promote the Trust as a place to be treated, to learn and to work;
- Work collaboratively with our partners to communicate the changes needed to improve health and social care in the Tees valley and the importance of people being cared for in the right place, at the right time;
- Support those staff who manage others, to listen to and engage their staff in decisions about service improvement; and
- Make the most of our Trust membership, supported by working with our governors.

We will deliver these objectives using the communications principles and key messages identified and deliver them through the channels and tools outlined below.

Appendix 3 sets out our mission, vision, values and strategic objectives, to which these communications objectives are aligned.

3. Communications and engagement principles

- Every communication contributes to our reputation, and should be at all times be consistent with our values and what we want to be known for. Managing our reputation is essential to recruiting, retaining and engaging with staff, as well as maintaining the confidence of our patients and commissioners, and ensuring support from our external stakeholders.
- We are open and transparent about how the Trust is performing and observe our duty of candour.
- We work to meet the communication needs of our diverse and hard-to-reach groups, to ensure the voices of all our audiences are heard.

All our communication and engagement activity should be;

- Clear, timely and accurate;
- Targeted and relevant to the audience's needs;
- Planned, consistent and professional;
- Accountable, purposeful and measured;
- Consistent with a clear narrative of the organisation's mission, vision and values;

- Using the relevant channels and techniques that are appropriate to the audience;
- Providing a feedback mechanism; and
- Using resources efficiently and effectively.

4. Key messages

We;

- deliver excellence in patient outcomes and experience;
- provide good access to health care services for our local population, for the wider Tees valley and region;
- run efficient operational services and provide long-term financial sustainability for the Trust;
- provide excellence in education and teaching;
- provide innovative services and cutting edge clinical research;
- involve and engage with the public and their representatives in decisions about their care and the services we provide;
- are an employer of choice and provide excellent employee experience that listens to its staff and responds to feedback, is a great place to work, where people feel valued and motivated;
- work collaboratively with partners, commissioners and stakeholders, to provide integrated health and community services; and
- develop commercial strategies to ensure our long term sustainability.

5. Situation analysis

The Trust operates in a changing and challenging environment. The Trust needs to build a strong reputation as a provider of great healthcare, an employer of choice and a key partner in integrated care. The Trust needs to engage and involve all our internal and external stakeholders in the future of our organisation and health system across the region, along with the services it runs to deliver the transformation expected and needed of the NHS.

The national context of rising demand for healthcare and increased expectations of patients, along with pressure on our workforce and the need to reconfigure our services across the region requires effective support from communications and engagement. The context for the communications strategy is summarised as;

- **Political** – NHS long term plan (prevention, community services, integrated care and integrated working); Brexit; ICP/ICS plans; technological expectations; engagement and consultation; social care reform.
- **Economic** – Deficit and funding pressures (locally and nationally); NHS long term plan; financial investment; aligned incentive contracts (three year financial agreements with CCG commissioners); local authority savings

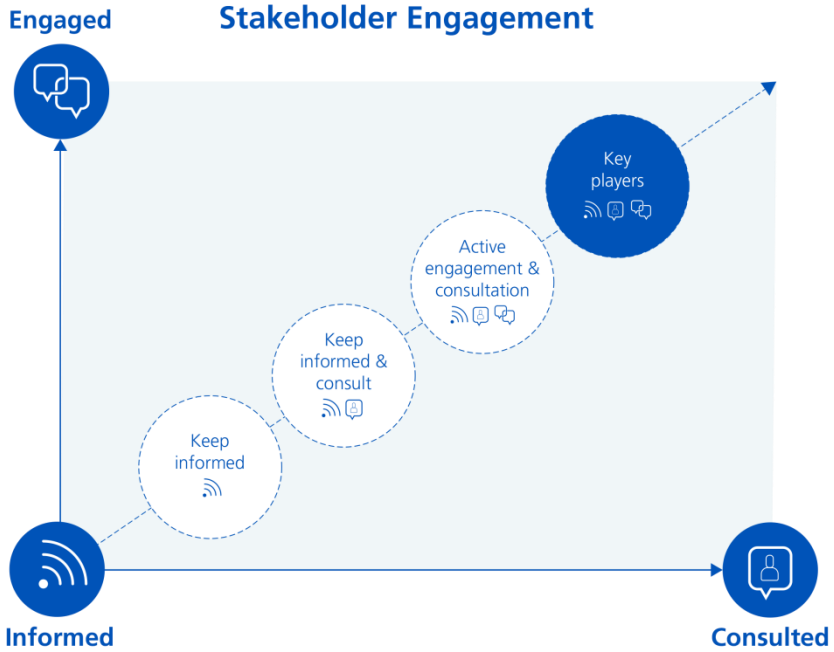
- **Social** – Growing/ageing population with new health challenges; public pride and concern over NHS future; public health initiatives; rising public expectations.
- **Technological** – Digital and IT innovations (including patient records, use of data and business intelligence); medical innovations; customer service, social media and digital; self-diagnosis and information access.
- **Legal** – 'must do' access and quality targets, governance, CQC and inspection requirements, transformation and improvement programmes, consultation and engagement for service change.
- **Environmental** – estate investment, use and development of estate, transport connections/patient access, energy and environmental impact.

6. Stakeholders

The Trust works hard to develop and maintain good relationships with its stakeholders (*list in Appendix 2*). Support of stakeholders is integral to successfully meeting our aims and objectives, as well as delivering our strategy. We need to listen to, communicate with and engage with our stakeholders in a clear, open, timely and relevant way.

Recognising that stakeholders have differing priorities and needs, we have identified stakeholders in the following categories;

- ❖ Key player (regular and ongoing engagement, through a variety of channels, on a wide range of issues).
- ❖ Active engagement and consultation (seeking out views and responses, often to specific issues)
- ❖ Keep informed and consult (regular communication and opportunities for feedback)
- ❖ Keep informed (provision of regular information)



6.1 The public and our patients

- Encompasses defined communities, identifying strongly with their local area and local hospital (James Cook local communities; Friarage communities; wider Tees Valley and North Yorkshire footprint).
- Ensure we provide a good understanding of what the Trust does and services we provide – through a variety of formats and channels; clear and easy to understand.
- Encourage people to seek help early, looking after their own health and use NHS services appropriately (e.g. use of A&E).
- Opportunity to be involved when services need to change, explaining why (engagement that is clear, open, timely).
- Open when things go wrong; apologise and explain.
- Work with the media to reflect the compliments and successes of our staff and services, using stories, case studies and interviews.
- Opportunities for involvement through volunteering, fundraising.

6.2 Staff

- A large proportion of our staff are also users of our services, local residents and important communicators of our messages at work and at home (with influence on friends, family and partners on public perception of the Trust).
- Staff continue to face a period of significant change and transformation, with reconfiguration of services, meeting operational targets and increased demands for services; the role of staff in making successful service change is fundamental (making services sustainable, improving quality, meeting standards); communicate clearly and effectively.
- Communications needs to be accessible for all groups of staff (in offices, at all sites, on wards, in the community)
- Our staff survey results have identified key areas for improvement, with communications and engagement a key area of focus.
- We recognise and have pride in the achievements of our staff; promote the Trust as a great place to work (recruitment and retention).
- We need staff awareness of opportunities for feedback, raising concerns (freedom to speak up), safety, quality and patient care and a culture of learning from mistakes.

6.3 Governors

- Our governors represent the views of their constituency and residents.
- They provide a focus on patients and link between the communities and the Board.
- We need our governors to be well informed and aware of what is happening in the Trust, with the opportunity to engage with constituents, and provide the Trust with valuable feedback about services.

6.4 Members

- Members need to know how to contact their local governor, meet them in their locality and access to information about the Trust
- Involvement of members varies; includes events, representing patients, joining specific groups
- A strategy for member engagement is being developed to improve the opportunities for engagement.
- Our members have an important role in electing governors, to represent their area on Council of Governors, in turn holding the Board to account through non-executive directors.

6.5 Partners

- Networks and structures exist at a range of levels for partnership working. Partners have a key role in enabling the Trust deliver its objectives, in providing good quality and sustainable healthcare to our public.
- Communicating and engaging with partners in ways which are clear, open, timely and relevant will support partnership working.
- The development of integrated care partnerships, within a wider integrated care system, will continue a focus on more effective partnership working, which will need to be supported by effective communications and engagement with all audiences.

7. Channels and tools

We use a range of channels and tools to communicate and engage with our audiences. These channels will be developed to meet our objectives, ensuring the delivery of our key messages to our audiences. These are corporate channels and are supplemented by the cascade of information by centres and by services, led by clinical directors, associate directors of nursing, matrons and ward managers, operation and service managers, who deliver face to face information, alongside relevant clinical issues.

7.1 Internal channels:

Intranet, which will be available to all staff and the place for staff to go to find a wide range of information, policies and updates, to help them in their roles. All corporate communications will be available for staff in one place that is easy to use and accessible. It will include opportunities for engagement via forums and blogs and will be a trusted source of information.

Staff weekly bulletin, produced each Tuesday at midday, is a brief newsletter for all staff, delivered via email and available as a pdf, (to enable printing for staff not desk

based). Its content aims to keeps staff informed of the Trust's news, performance and operational updates, changes to processes and includes staff notices and information about events and activities and signposts to the intranet for further detailed information.

Chief executive's briefing is provided on a regular basis, via email, to all staff and includes key messages on performance, operational direction, wider partner and health system developments and staff changes and recognises achievements and successes. It highlights areas for focus, progress against targets and is available on the intranet and via pdf, as a focus for managers in team meetings as part of the key messages to be delivered alongside service information and updates from managers. Comments and feedback are received via the intranet or email.

Performance briefing focuses on our key performance targets, including mandatory service and patient access targets as well as performance on infection control, finance, patient feedback and key measures for staffing. The briefing follows the monthly updates to the Operational Management team and to the Board, from the Deputy Chief Executive, with a brief commentary provided and trends identified, along with actions expected. It is issued via email and available on the intranet and is aimed at managers for regular discussion with staff on performance and targets.

Consultant briefing is provided electronically each month via email from the medical directors, with specific messages for clinical directors and consultants. It provides service updates, system developments, and messages on operational and financial performance that are relevant for consultants, along with staff related updates.

Leadership events / Strategic Dialogue Days held twice yearly in September and May to engage the senior leaders in the organisation face to face on the organisation's strategy and vision and overall performance and direction. The event is led by senior leaders, covering performance and targets, system developments and transformation and change updates. It includes opportunities for feedback and discussion.

Clinical forums are held twice yearly to engage the consultant body, on strategic and operational priorities, with an opportunity for engagement and feedback.

Talking Point, our quarterly staff magazine, covers a range of news and features, on Trust services, developments and staff achievements, along with a celebration of success and focus on charity and fundraising activities. Available electronically and with limited printed copies, it is available in Trust sites, and for governors, members and partners.

Digital tools such as screensavers are used to raise awareness of key campaigns, issues or events, (e.g. patient centred visiting, smoke free Trust campaign), with key messages for staff. Changed monthly in line with key campaigns, they are produced in line with other **printed material**, which are included on noticeboards, via leaflets and posters.

Member/Governor briefings and events are provided to give members the opportunity to hear about, or visit, a specific aspect of the Trust's service and provide further detail on a specific issue or hear directly from staff.

7.2 External channels:

The **Trust's website** provides information for patients and the public about the Trust, its services and its performance. It provides information, advice and guidance on services, along with news and updates, promotion of the Trust as an employer, as well as publishing statutory governance information for regulators and stakeholders.

Through **media relations**, we use relationships with the local and regional media to highlight news, campaigns and activities, as well as manage issues and deal with criticisms and any service failures. Both printed and online news provide a channel to highlight our key messages, with a particular focus on how our services impact the public.

We use **social media** to reach our audiences through a variety of digital channels to engage and communicate, to share news about our services, to highlight successes, to respond to feedback, and to provide information, as well as to recruit. A variety of social media channels are used to widen the opportunities for engagement and feedback.

Through **specific stakeholder bulletins**, we provide external stakeholders with information on specific issues (e.g. Friarage bulletin, waste management).

Patients provide us with regular feedback through our 1,000 voices programme (reported as part of our performance monitoring), as well as through our Patient Advice and Liaison Service (PALS) and through social media. We review the feedback and respond (e.g. our noise at night campaign). We also provide patients and carers with a wide range of information on our services and the care we provide, through our **patient information**, available in a variety of forms.

Public meetings, including board meetings are publicised and held in public five times a year, with the opportunity for the public, governors and members to attend Our annual members' meeting provides an opportunity to present key information on the Trust, its performance and services, and gives members the opportunity to ask questions

Communication and engagement projects and campaigns are developed to support the Trust's strategic objectives, service changes and other initiatives, which may involve the produce of material such as posters or leaflets and incorporate other external communications channels.

8. Branding and corporate identity

The NHS branding, updated in 2017, sets out clear guidance on how Trusts are expected to use the NHS brand and how this is used in conjunction with individual Trust branding. This guidance ensures that the NHS brand is used consistently and continues to provide patients and the public with the reassurance they expect from the NHS in terms of quality, excellence and peace of mind.

Within these guidelines, the Trust will update its own branding and corporate identity in 2019, to reflect its strategic objectives and the transformation and change underway within the Trust. The branding will focus on the strapline of 'Excellence in Patient Outcome and Experience' and will use a complimentary colour palette, font and typeface, with clear graphical devices. This branding will be incorporated into a new intranet, which will be redesigned alongside a content review, with a focus on accessibility and usability. The branding will also be used to create a new website and will be introduced into all other channels of internal and external communications.

9. Monitoring and evaluation

The critical success factors for this strategy will be;

- Improvement of staff engagement, with increased opportunity for feedback, across a range of channels (linked to the staff engagement strategy); measured by response to bulletins, intranet news; comments on the intranet, responses to the NHS staff survey; Trust specific survey; adhoc service or department surveys; NHS staff friends and family test; discussion and attendance at events, with follow up feedback;
- The delivery of a new intranet, with improved staff engagement, accessibility and usability.
- Production of regular internal communications publications on schedule (staff weekly bulletin, briefings, Talking Point) including key messages.
- Improving the relationship with the local and regional media, via regular discussions, identifying media opportunities for the Trust (covering key messages) and improving media coverage; measured by feedback from editors and analysis of coverage (including measurement of audience reached, key messages covered)

- Patient and public engagement – feedback via governors and members; feedback from patient experience and PALs; social media content analysis and growth of followers etc.
- External stakeholder engagement – feedback on briefings, via face to face, metrics on bulletins sent digitally

Appendix 1 - Roles and responsibilities

Everyone in the Trust has a role to play in supporting the delivery of this strategy to ensure good and effective communication and engagement takes place within the Trust with staff and governors and externally with partners and the public.

There are specific roles for individuals and groups;

Trust Board
The role of the Trust Board is to provide leadership. Board members represent the organisation, to staff and the public, and how they communicate supports the reputation of the Trust.

Council of Governors
Governors provide a vital link between the communities they represent, and we serve, and the Board. Governors need to be well informed and aware of what is happening in the Trust and engage with their constituents so they can feed their views into the Trust's strategy.

Executive directors and senior leadership team
Executive directors have an ongoing day to day responsibility for delivering the organisation's strategic objectives which includes this strategy.

Medical Directors, Associate Directors of Nursing and Management Board
The senior management team has responsibility to directly support the delivery of this strategy and to encourage their teams to do so, and has a responsibility in ensuring this strategy is delivered and information is cascaded throughout the organisation.

All staff
All members of staff need to keep themselves informed on updates, initiatives and information from the Trust using the variety of different channels of communication available. They should ask for information and discuss ideas or issues with their manager.

Communications and engagement team
The communications and engagement team provide dedicated, professional communications leadership, technical expertise, advice and guidance. It provides the lead role in protecting the Trust's brand and reputation, developing communication channels, co-ordinating media relations and providing information for staff, patients, the public and stakeholders.

Appendix 2 - Stakeholder engagement

Patients and public

- General public
- Service user groups
- GP Patient Participation Groups
- HealthWatch
- Charitable organisations, voluntary and community groups, third sector
- Foundation Trust members

Partners

- CCGs
- Councils CExs / DASS / portfolio holders /leaders in relevant councils
- Local Medical Committee
- GPs
- Pharmacists
- NHS Trusts (neighbouring and ICP/ICS partners)
- SERCO

Governance and regulators

- NHS England
- NHSI
- Care Quality Commission
- CCG Governing bodies

Internal

- All staff
- Non-Executive Directors
- Specific leadership groups (CDs, ODs, ADNs)
- Senior clinical staff
- Staff-side representatives/ Trade unions
- Medical staffing committee
- Trust Governors

Politicians

MPs

- Andy McDonald, Labour, Middlesbrough
- Simon Clarke, Conservative, Middlesbrough and SE Cleveland
- Anna Turley, Labour, Redcar and Cleveland
- Rishi Sunak, Conservative, Richmond
- Alex Cunningham, Labour, Stockton North
- Paul Williams, Labour, Stockton South
- Helen Goodman, Labour, Bishop Auckland
- Jenny Chapman, Labour, Darlington

- Phil Wilson, Labour, Sedgefield
- Mike Hill, Labour, Hartlepool
- Kevan Jones, Labour, North Durham
- Laura Pidcock, Labour, North West Durham

Local Councillors

- Overview and Scrutiny Committees – joint for Tees /N Yorks; Tees Valley; Middlesbrough and Redcar joint and separate
- Joint Health and Wellbeing Boards – Tees and North Yorkshire
- Tees Valley Combined Authority and Mayor

Business

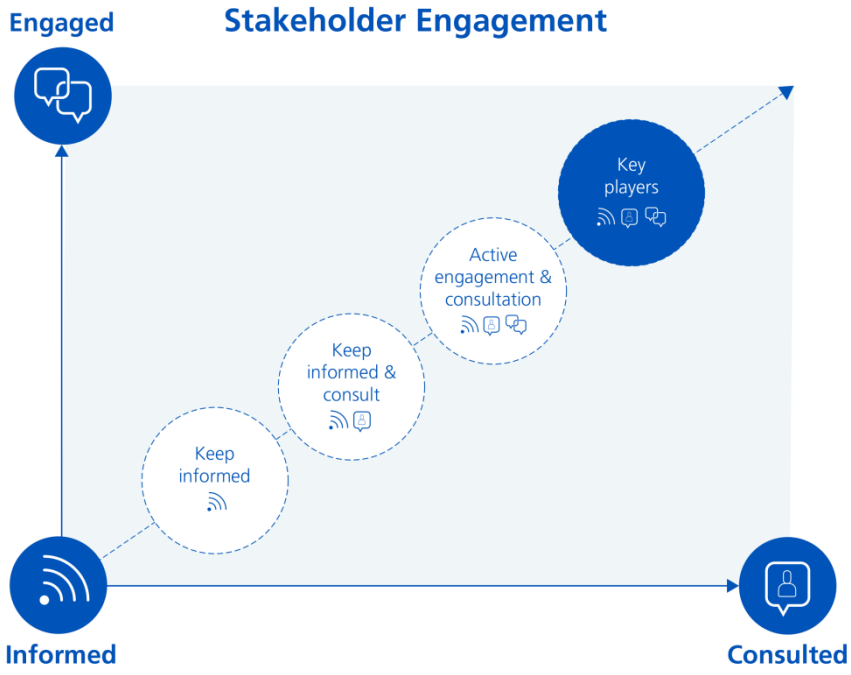
- Local Enterprise Partnership, LEP

Research and Education

- Universities (Newcastle, Teesside, Hull/York)

Local, regional and national media (newspapers, radio, TV, professional/trade press)

- Regional broadcast – TV (BBC Look North (Newcastle and Leeds), ITV (Tyne Tees and Calendar)
- Regional broadcast – Radio (BBC Radio Tees, BBC Radio York, Independent radio (TFM, Heart, Zetland)
- Print and online – regional, local and national (Northern Echo, Teesside Gazette, Darlington and Stockton Times, Hambleton/Richmondshire Today, Hartlepool Mail)
- Trade press and media (HSJ, Nursing Times)



Appendix 3

Our Mission The Trust's mission is to provide seamless, high quality, safe healthcare for all.

Our Vision

Our vision is to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement and continuous improvement.

Our 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.

Our Strategic Objectives

We have five strategic objectives to help us deliver our mission, vision and values which include:

We will deliver excellence in patient outcomes and experience

We will deliver long-term financial sustainability to invest in our future

We will deliver excellence in employee experience to be seen as an employer of choice

We will develop clinical and commercial strategies to ensure our long term sustainability

We will drive operational performance to deliver responsive, cost effective care

South Tees Hospitals
NHS Foundation Trust

Quality, Performance, Safety, Finance Exception Report

Board of Directors Meeting

5 February 2019

Excellence in Patient Outcome and Experience

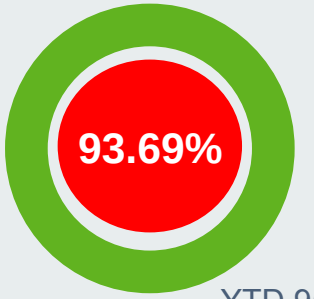
NHS
South Tees Hospitals
NHS Foundation Trust

Must Do's

Must Do's 2018/19 – December 2018

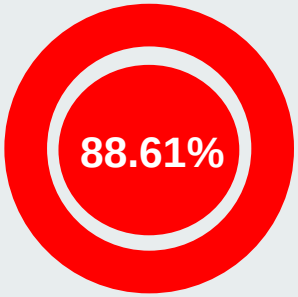
Deliver Excellence in Patient Outcome and Experience….

A&E
4hr Target



YTD 95.7%

RTT
18 Week Target



Cancer
62 Day Target

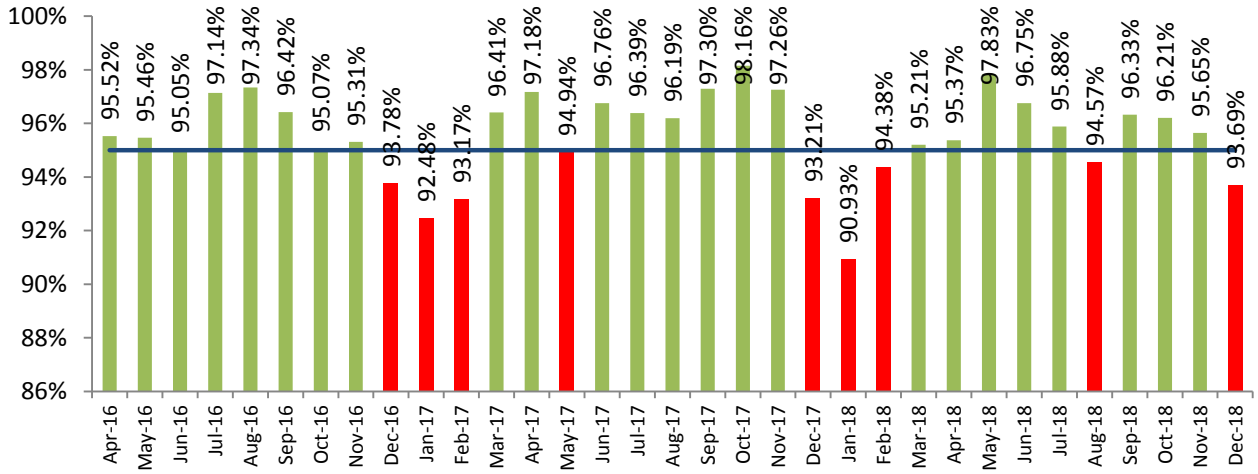
* Indicative

CDiff
HCAI Threshold

Operating Surplus

…and ensure our long term financial sustainability

Performance - A&E



95% TARGET

Dec 18

93.69%

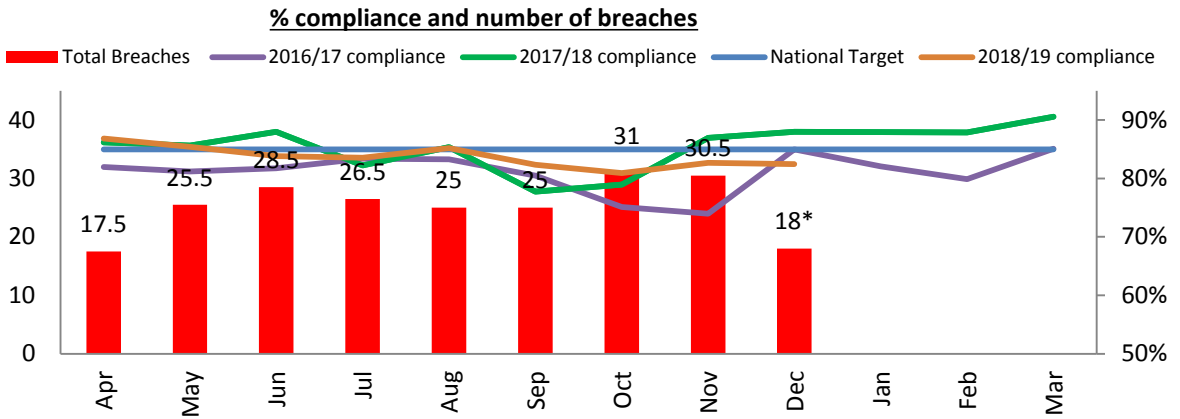
Regional Rank	Trust	Dec-18
1	North Tees and Hartlepool NHS Foundation Trust	97.09%
2	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	95.24%
3	Northumbria Healthcare NHS Foundation Trust	93.82%
4	**South Tees Hospitals NHS Foundation Trust**	**93.69%**
5	Harrogate and District NHS Foundation Trust	92.23%
6	South Tyneside NHS Foundation Trust	92.05%
7	North Cumbria University Hospitals NHS Trust	91.75%
8	Gateshead Health NHS Foundation Trust	91.63%
9	County Durham and Darlington NHS Foundation Trust	88.59%
10	City Hospitals Sunderland NHS Foundation Trust	88.52%
11	York Teaching Hospitals NHS Foundation Trust	87.57%
	ENGLAND	**86.43%**

December 18 Ranked 4th in the region

January to date
92.97%

Improvement on last year but still non-compliant in December…

Performance – 62 Day Cancer Standard



% compliance and number of breaches

*** Indicative**

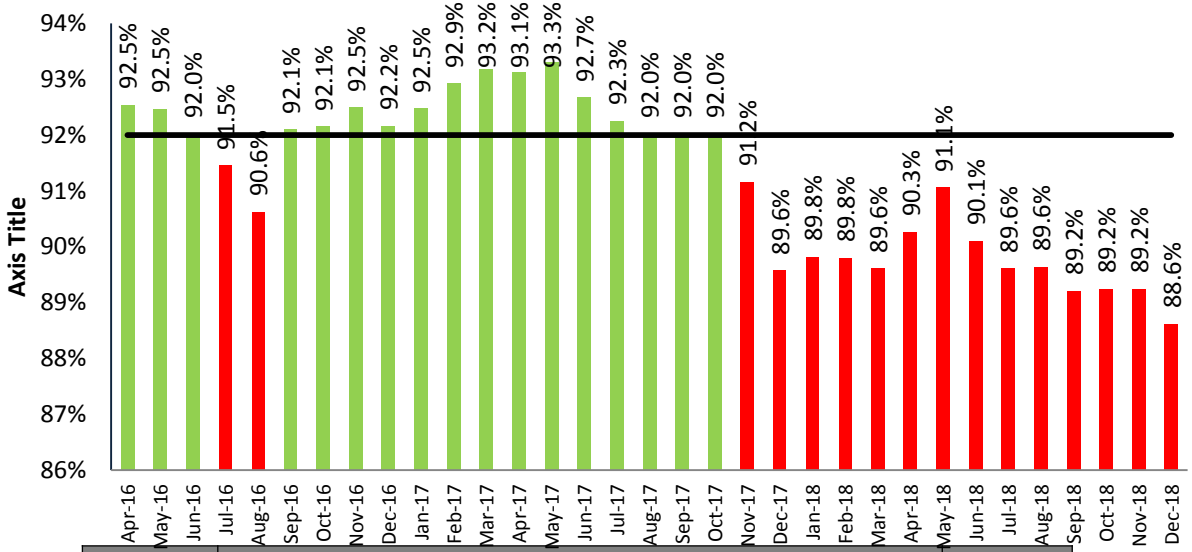
Oct 18	Nov 18	Dec 18*
80.92%	82.67%	84.97%

Regional Rank	Trust	Nov-18
1	South Tyneside NHS Foundation Trust	94.44%
2	North Tees and Hartlepool NHS Foundation Trust	89.92%
3	Gateshead Health NHS Foundation Trust	89.19%
4	County Durham and Darlington NHS Foundation Trust	88.44%
5	City Hospitals Sunderland NHS Foundation Trust	86.47%
6	Harrogate and District NHS Foundation Trust	84.89%
7	**South Tees Hospitals NHS Foundation Trust**	**82.67%**
8	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	81.38%
9	Northumbria Healthcare NHS Foundation Trust	77.20%
10	North Cumbria University Hospitals NHS Trust	75.80%
11	York Teaching Hospitals NHS Foundation Trust	75.29%
	ENGLAND	**79.19%**

November 18 Ranked 7th in the region

21% less treatments in December 2018 when compared to December 2017…

Referral to Treat



92% TARGET

Dec 18

88.61%

Regional Rank	Trust	Nov-18
1	South Tyneside NHS Foundation Trust	95.41%
2	North Tees and Hartlepool NHS Foundation Trust	94.62%
3	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	93.94%
4	Northumbria Healthcare NHS Foundation Trust	93.83%
5	City Hospitals Sunderland NHS Foundation Trust	93.20%
6	Gateshead Health NHS Foundation Trust	92.38%
7	County Durham and Darlington NHS Foundation Trust	91.38%
8	Harrogate and District NHS Foundation Trust	90.49%
9	**South Tees Hospitals NHS Foundation Trust**	**89.24%**
10	North Cumbria University Hospitals NHS Trust	82.17%
11	York Teaching Hospital	82.04%
	ENGLAND	**87.29%**

Percentage

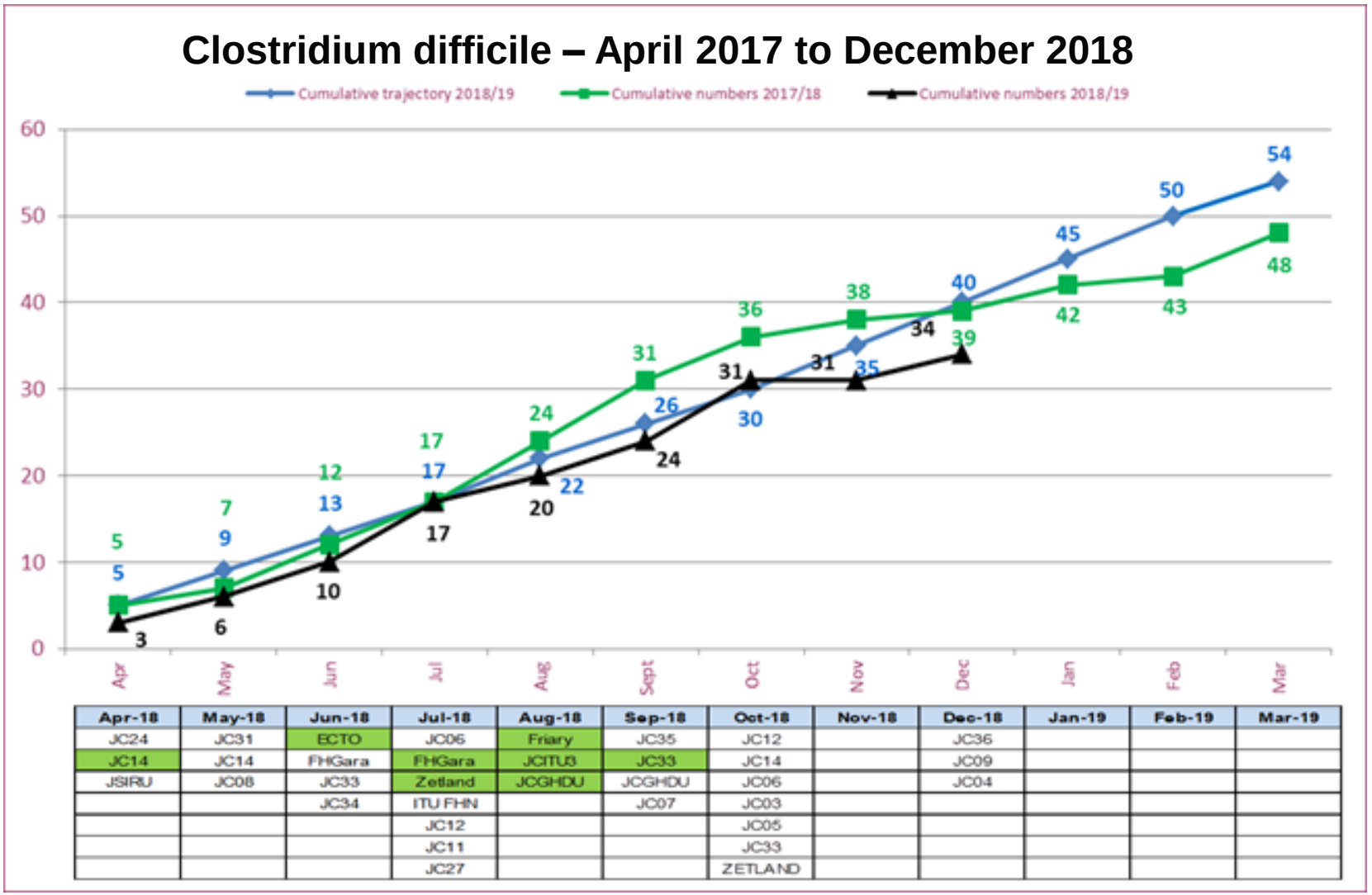
Waiting time	Mar	Sep	Oct	Nov	Dec
<18 weeks	89.61%	89.21%	89.24%	89.24%	88.61%
18-24	5.98%	5.73%	5.93%	5.88%	5.97%
24-30	2.77%	2.64%	2.63%	2.73%	3.15%
30-40	1.40%	1.78%	1.75%	1.68%	1.81%
40-50	0.24%	0.61%	0.43%	0.46%	0.45%
50+	0.00%	0.01%	0.03%	0.01%	0.01%

Lowest compliance in nearly three years…

South Tees Hospitals
NHS Foundation Trust

Patient Outcome and Experience

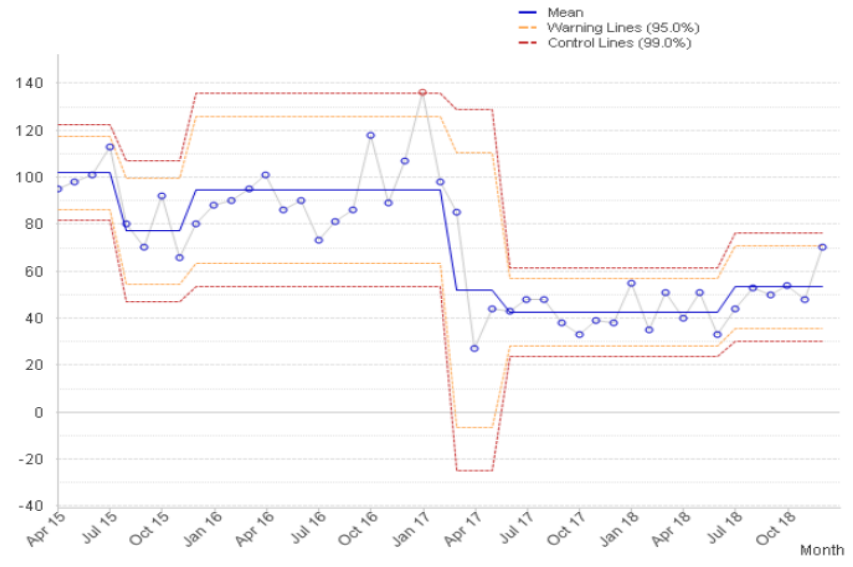
Trust apportioned Clostridium difficile



Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
JC24	JC31	ECTO	JC06	Friary	JC35	JC12		JC36			
JC14	JC14	FHGara	FHGara	JCITU3	JC33	JC14		JC09			
JSIRU	JC08	JC33	Zetland	JCGHDU	JCGHDU	JC06		JC04			
		JC34	ITU FHN		JC07	JC03					
			JC12			JC05					
			JC11			JC33					
			JC27			ZETLAND					

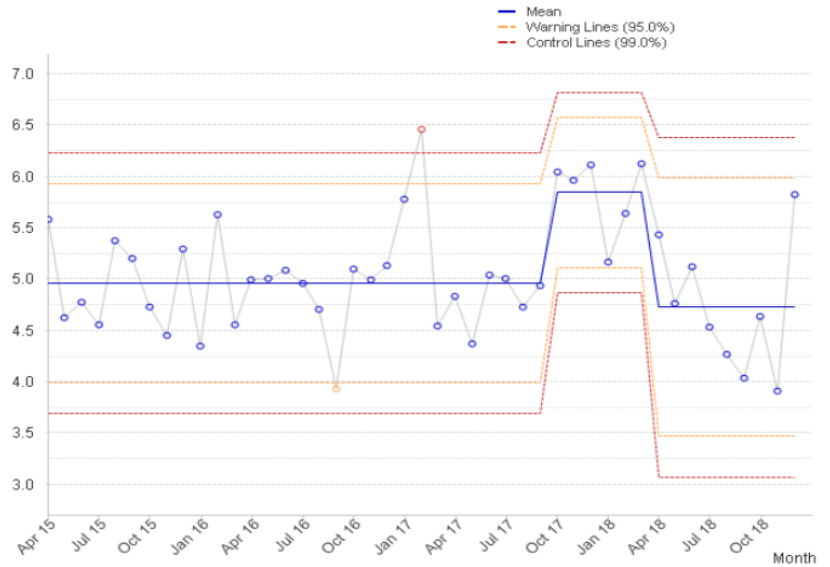
Delivering Safe Care 18/19

Trust attributed category 2 pressure ulcers December 2018



Rate 2.5 per 1000 bed days.
Rate within normal variation

Falls December 2018



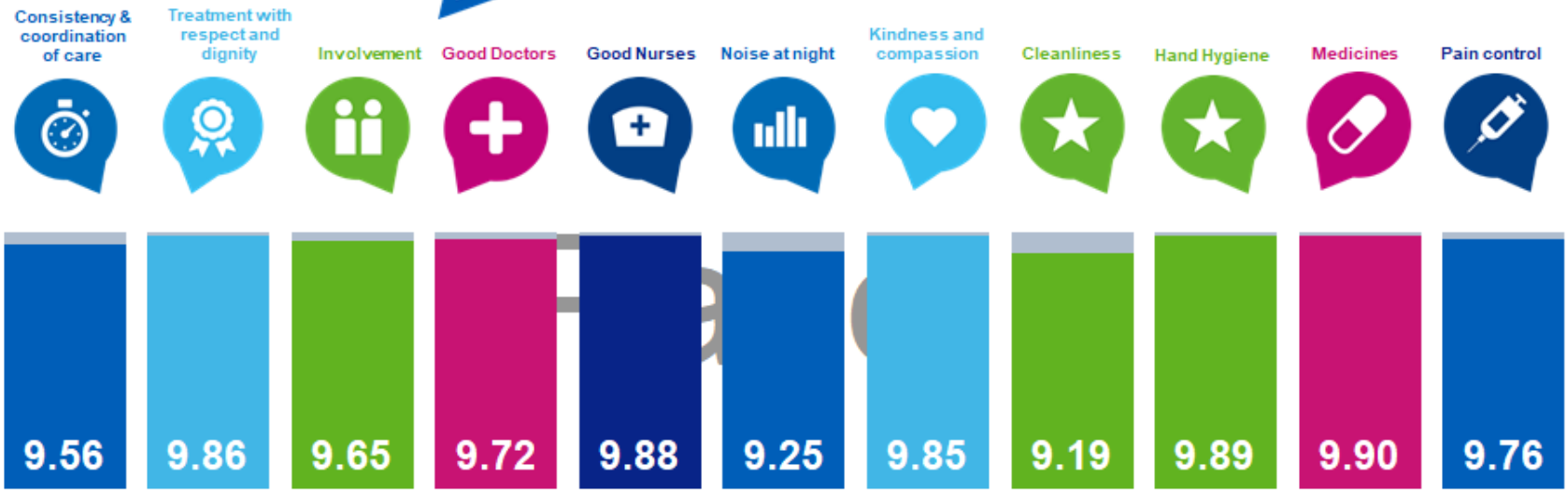
5.8 per 1000 bed days.
Rate within normal variation

Continued Focus on Falls Prevention Strategies

Patient Experience Trust

How do patients rate us out of 10…?

NHS
South Tees Hospitals
NHS Foundation Trust



In December 2018 patients gave us an overall rating of... **9.67 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	152	No of respondents	335

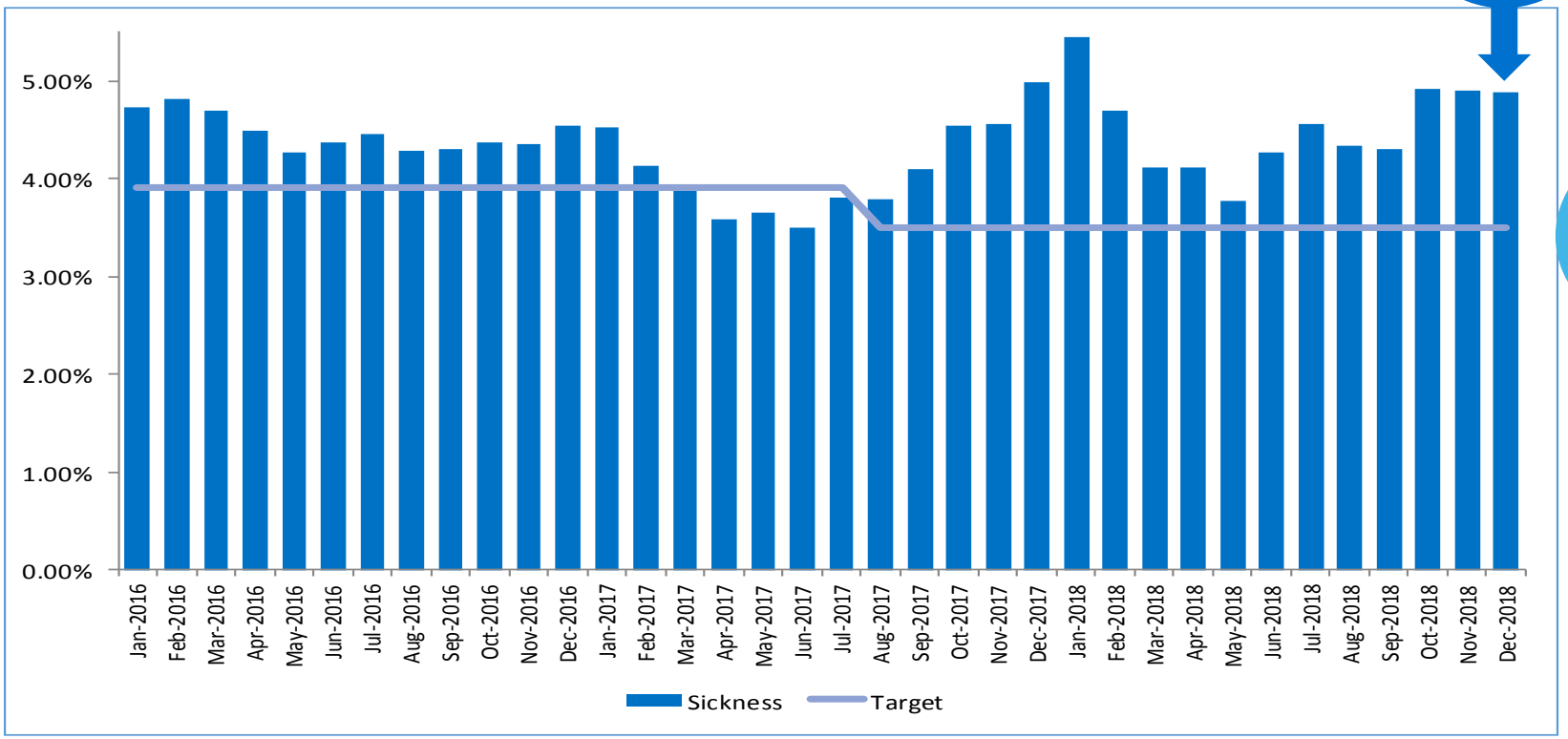
Excellence in Patient Outcome and Experience

NHS
South Tees Hospitals
NHS Foundation Trust

People

People

Sickness % Rate



SDR % Rate - 74.28% (Target 80%)

2015/16	2016/17	2017/18	2018/19
68.58%	71.27%	84.70%	78.39%

Training % Rate 89.17% (Target 90%)

2015/16	2016/17	2017/18	2018/19
79.75%	89.35%	92.38%	90.40%

NHS
South Tees Hospitals
NHS Foundation Trust

Finance

Summary Financials by Centre – December 2018

Summary Financials	Year to Date		
	Plan £'000	Actual £'000	Variance £'000
Community Care			
Income	90,714.4	90,758.1	43.7
Pay expenditure	(54,795.8)	(52,854.2)	1,941.6
Non-Pay expenditure	(17,950.3)	(18,117.8)	(167.5)
EBITDA	**17,968.3**	**19,786.1**	**1,817.8**
Clinical Support			
Income	31,666.0	30,185.3	(1,480.7)
Pay expenditure	(51,657.1)	(50,657.1)	1,000.0
Non-Pay expenditure	(18,902.9)	(18,994.2)	(91.3)
EBITDA	**(38,894.0)**	**(39,466.0)**	**(572.0)**
Urgent and Emergency Care			
Income	56,027.4	56,341.8	314.4
Pay expenditure	(46,252.5)	(46,985.1)	(732.6)
Non-Pay expenditure	(4,418.0)	(4,481.0)	(63.0)
EBITDA	**5,356.9**	**4,875.7**	**(481.2)**
Specialist and Planned Care			
Income	236,197.8	230,553.5	(5,644.3)
Pay expenditure	(90,368.9)	(90,981.8)	(612.9)
Non-Pay expenditure	(68,341.7)	(69,596.0)	(1,254.3)
EBITDA	**77,487.2**	**69,975.7**	**(7,511.5)**
Corporate	**(71,868.1)**	**(65,101.7)**	**6,766.4**
Control Total	**(9,949.7)**	**(9,930.2)**	**19.5**

Trust Headlines Month 9 YTD

Control Total

£20k ahead of plan

Productivity and Efficiency savings

£26.7m YTD Plan
£30.4m YTD Actual

£35.6m Plan for year

Board of Directors	
Agenda item	3.2
Title of Report	Healthcare-associated infection report for December 2018
Date of Meeting	5 February 2019
Presented by	Gill Hunt, Director of Nursing and Quality/DIPC
Authors	Richard Bellamy, Infection Control Doctor, JCUH Helen Day, Deputy Director of Nursing Gill Hunt, Director of Nursing and Quality/DIPC
Approved by	Gill Hunt
Previous Committee/Group Review	Operational Management Board
Purpose	Approval ■ Decision ☐ Discussion ☐ Information ■
Alignment to Trust's Strategic Objectives	■ 1. We will deliver excellence in patient outcomes and experience ■ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	BAF 2.1
Legal/Regulatory Compliance Requirements (if applicable)	• Care Quality Commission • NHS Improvement • NHS England
Recommendation(s)	The Board is asked to note the current position in respect of HCAI and for their support for the actions being taken.

1. Executive Summary

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, MRSA and MSSA bacteraemia, bacteraemia due to glycopeptide-resistant enterococci, E.coli, ESBL-producing coliform infections and other important healthcare-associated infections for the month of December 2018. The report also highlights antimicrobial stewardship and environmental cleaning in relation to HCAI management.

- The *Clostridium difficile*-associated diarrhoea objective for 2018/19 is to have no more than 54 trust-apportioned cases among patients aged over 2 years. There were 3 trust-apportioned cases in December 2018. In the first 9 months of 2018/19 there have been 34 trust-apportioned cases, we remain under trajectory.

- The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There were 0 trust-assigned cases in December 2018. In the first 9 months of 2018/19 there has been 1 trust-assigned case.

- There is no official MSSA bacteraemia target for 2018/19. There were 4 trust-apportioned cases in December 2018. In the first 9 months of 2018/19 there have been 32 trust-apportioned cases.

2. Recommendation

The Board is asked to note the current position in respect of HCAI and for their support for the actions being taken.

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1. SURVEILLANCE DATA

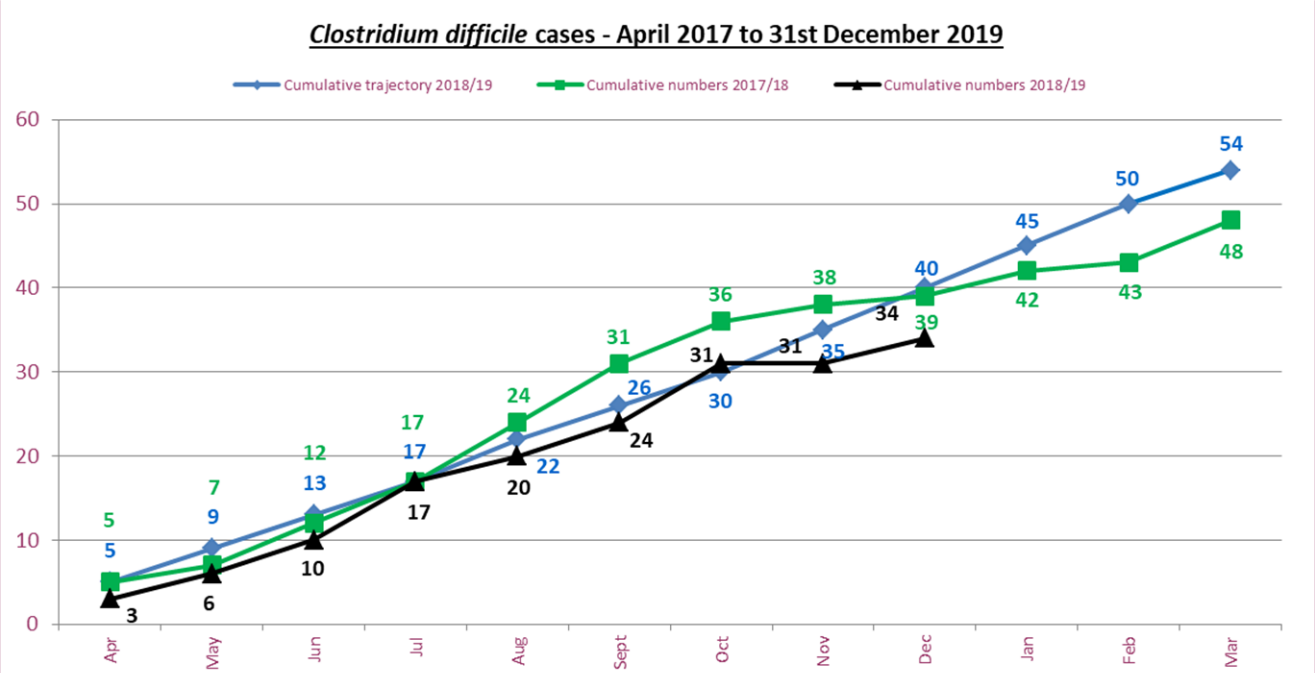
1.1 Clostridium difficile

C diff	Total 2017/18	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Total 2018/19 to date	Target for 2018/19
Total cases	125	10	6	8	8	11	12	14	8	11	17	9	8	98	NA
Not apportioned	77	7	5	3	5	8	8	7	5	7	10	9	5	64	NA
Trust apportioned	48	3	1	5	3	3	4	7	3	4	7	0	3	34	54
- JCUH	45	2	1	5	3	3	2	4	2	4	6	0	3	27	
-FHN	3	1	0	0	0	0	1	2	0	0	0	0	0	3	
-Carters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Redcar	0	0	0	0	0	0	0	1	0	0	1	0	0	2	
-East Cl	0	0	0	0	0	0	1	0	0	0	0	0	0	1	
-Guis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Rutson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Friary	0	0	0	0	0	0	0	0	1	0	0	0	0	1	
-Lambert	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

There were 8 cases of *C. difficile* infection in December 2018, 3 of which were classed as Trust-apportioned. The annual objective is to have no more than 54 Trust-apportioned cases. There have been 34 Trust-apportioned cases in the first 9 months of 2018/19. All actions to ensure that robust controls are in place are monitored through both IPAG and the monthly 'Performance Wall' held with Matrons.

Deaths within 30 days after *C. difficile* diagnosis: for November 2018, 0 patients died during this period. Since April 2009, 290/1621 patients (18%) have died during the 30 day follow-up period.

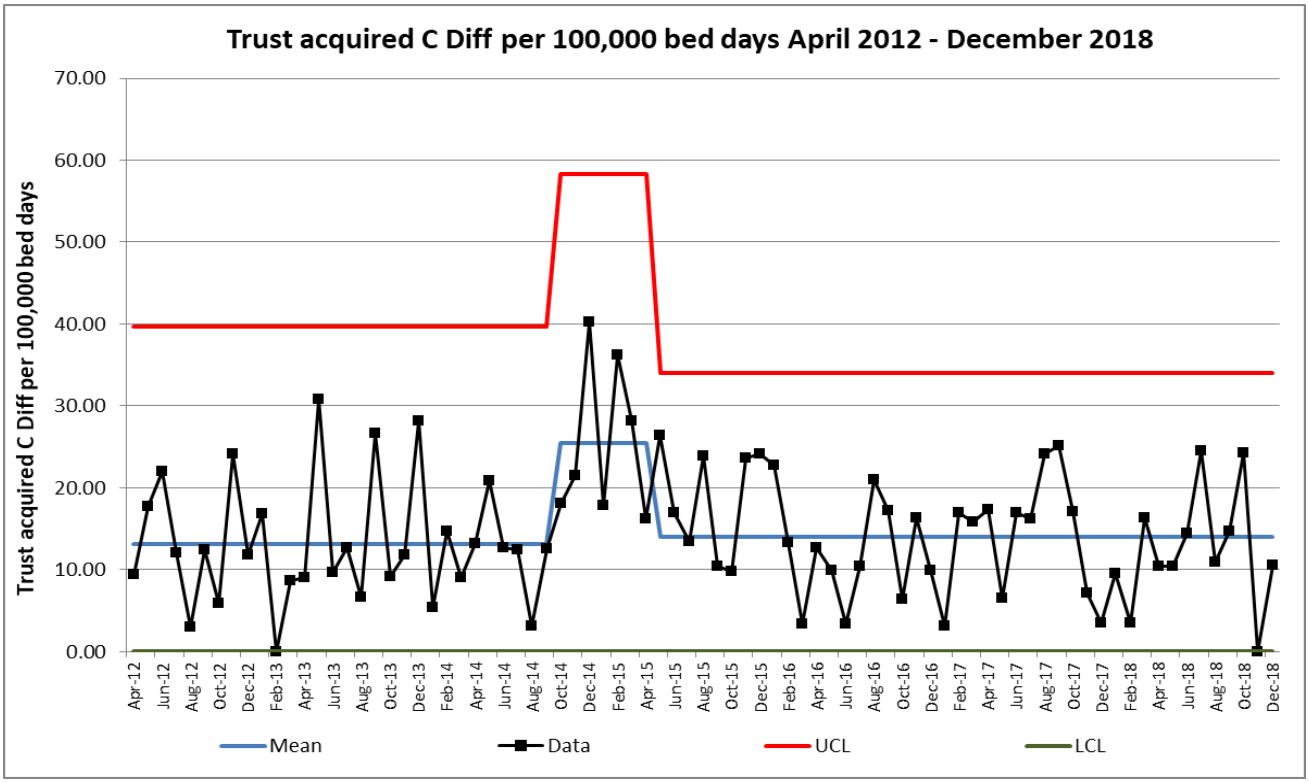
Graph 1: Cumulative Trust-apportioned *C. difficile* cases 2018/19 compared to 2017/18 trajectory:

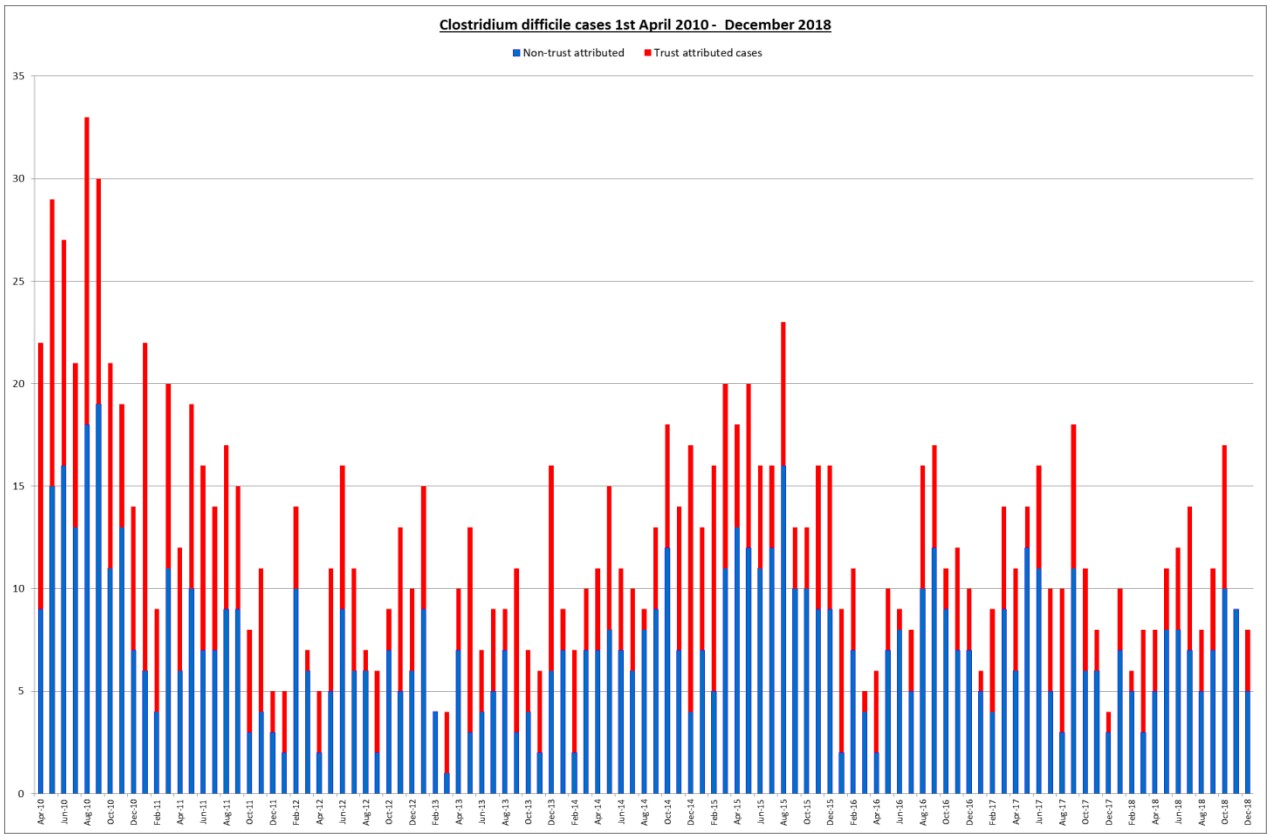


Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
JC24	JC31	ECTO	JC06	Friary	JC35	JC12		JC36			
JC14	JC14	FHGara	FHGara	JCITU3	JC33	JC14		JC09			
JSIRU	JC08	JC33	Zetland	JCGHDU	JCGHDU	JC06		JC04			
		JC34	ITU FHN		JC07	JC03					
			JC12			JC05					
			JC11			JC33					
			JC27			ZETLAND					

Requested appeal	

Graph 2: Rate of Clostridium *difficile* infection per 100,000 bed days.





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. There have been no episodes of linked cases by ribotype identified since June/July 2017.

The average hand hygiene self-assessment score in December 2018 was 95% and the peer review average was 98%.

Antimicrobial Stewardship

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

The antibiotic guidelines are being developed into a user-friendly app in conjunction with North Tees Hospitals. The “Antibiotic Sepsis/ Infection (not sepsis)” poster will be released in January 2019. The proposed changes are important from a clinical perspective although they may make the CQUIN harder to achieve (as multiple antibiotics are sometimes needed).

Environmental Cleaning

The average cleaning scores by month are as follows:

The James Cook Site:

Risk Category	NSC Target	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
High Risk	**95%**	98%	99%	98%	99%	99%	99%	98%	98%	98%	98%	98%	98%
Significant Risk	**85%**	98%	98%	98%	97%	98%	97%	97%	97%	97%	97%	97%	97%
Low Risk	**75%**	95%	96%	96%	95%	95%	96%	95%	94%	94%	95%	95%	95%

Cleaning scores have been maintained on the JCUH site. No areas failed the C4C inspection in December on the James Cook site. Maintaining cleaning standards remains an area of continued focus in conjunction with our new service provider SERCO. The monthly cleaning standards review meetings continue to be led by the Director of Estates and cleaning scores continue to be monitored via IPAG. The Trust will be adopting the new cleaning standards in 2019; the red, amber and green risk categories.

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

Risk Category	NSC Target	FHN Site	Friary	East Cleveland	Redcar PCH
Very High Risk	**98%**	98.70%	99.85%		99.9%
High Risk	**95%**			96%	99.6%
Significant Risk	**85%**	98.28%		95%	100%
Low Risk	**75%**	92.56%		95%	99.9%

1.2 MSSA bacteraemia

MSSA	Total 2017/18	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Total 2018/19 to date	Target for 2018/19
Total cases	130	10	9	21	9	23	8	13	13	10	9	8	12	105	NA
Not Trust apportioned	96	5	6	17	6	16	6	11	9	6	5	6	8	73	NA
Trust apportioned	34	5	3	4	3	7	2	2	4	4	4	2	4	32	NA

There were 12 cases of MSSA bacteraemia in December 2018; 4 of which were classed as Trust-apportioned. There have been 32 Trust-apportioned cases in the first 9 months of 2018/19.

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 16/17 baseline. This means no more than 35 combined MRSA and MSSA Trust-apportioned cases in total. The Trust is not currently on trajectory to achieve this as we have had 33 cases in 9 months. A further thematic review is planned but currently no recurring themes are apparent.

1.3 MRSA bacteraemia

MRSA	Total 2017/18	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Total 2018/19 to date	Target for 2018/19
Total cases	4	2	0	0	0	2	0	2	1	0	0	2	0	7	NA
Not Trust assigned	3	2	0	0	0	2	0	2	0	0	0	2	0	6	NA
Trust assigned	1	0	0	0	0	0	0	0	1	0	0	0	0	1	NA

There were 0 cases of MRSA bacteraemia in December 2018. There has been 1 Trust-assigned case in the first 9 months of 2018/19. Case reviews have been held for the two cases from November. These cases were judged not Trust assigned and no lessons were learned for the Trust.

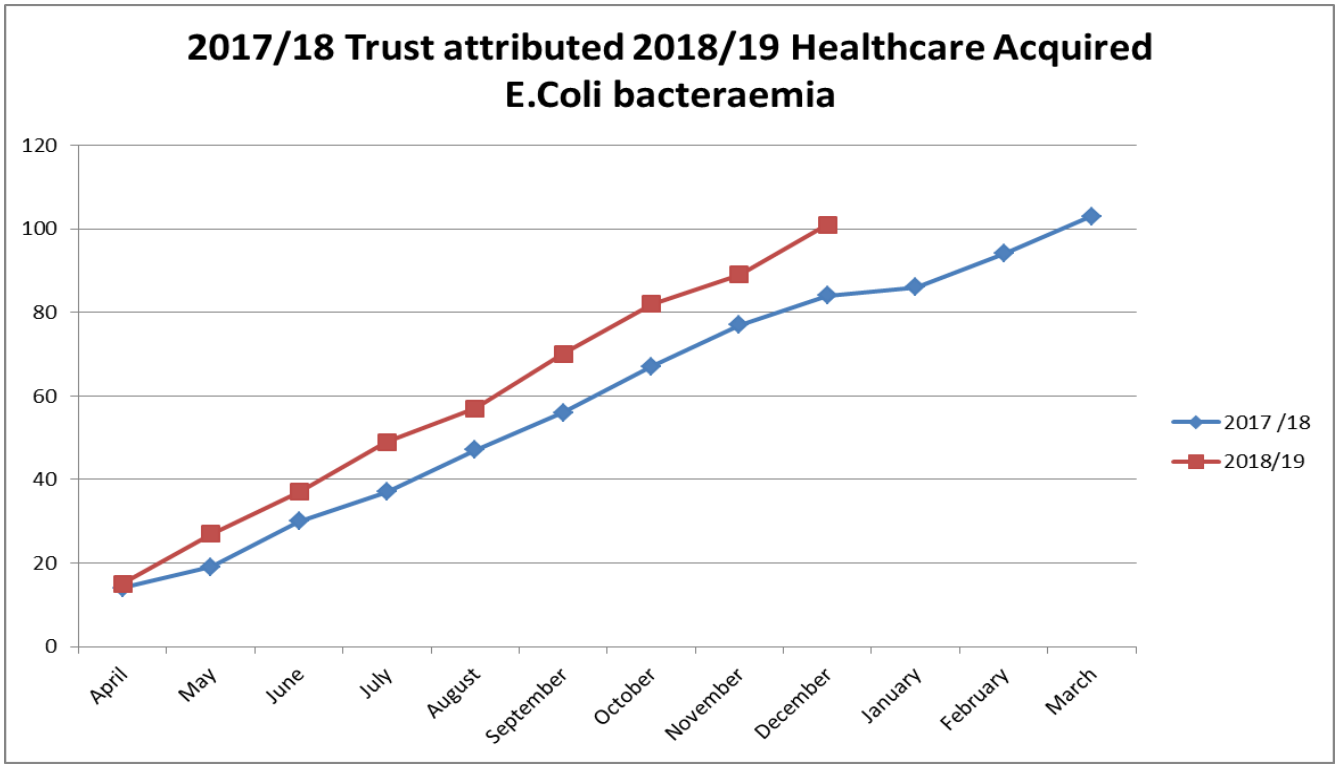
1.4 Surveillance for other healthcare-associated infections

	Total for 17/18	December 2018	Total 18/19
Bacteraemia due to glycopeptide-resistant enterococci	7	0	8
Bacteraemia due to E. coli	500	58	427
• Trust-apportioned	106	12	101
• Not Trust-apportioned	394	46	326
ESBL producing coliform infections	798	74	703
• sample taken in community	490	44	442
• sample taken in our Trust	304	30	261
• bacteraemias	25	3	19
Bacteraemia due to Klebsiella species	131	16	106
• Trust-apportioned	41	4	29
• Not Trust-apportioned	90	12	77
Bacteraemia due to Pseudomonas aeruginosa	41	3	26
• Trust-apportioned	19	0	10
• Not Trust-apportioned	22	3	16
Other alert organisms	1	0	0
• invasive group A streptococcus			

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in healthcare associated infections by 2021.

In December 2018 the Trust reported a total of 77 cases of the three GNBSI organisms which are part of national surveillance (E.coli, 58; Klebsiella sp. 16; Pseudomonas aeruginosa 3). Of these, 16 cases were classed as Trust-apportioned (21%) as defined by the Department of Health definition. This demonstrates the need to continue working in collaboration with the wider community as part of the Tees-wide collaborative which supports a number of initiatives within the community setting.

Initiatives in the community will be emulated and implemented within the acute Trust in order to reduce these infections. The Trust is taking part in the second wave of the national GNBSI urinary tract infection collaborative hosted by NHS Improvement/NHS England. The second meeting took place in October. The focus of this improvement programme will be hydration in both the community setting in the older population and care home setting with a number of resources being made available as well as a specific hydration campaign within 2 care homes. This work is being led by the IPC post currently hosted by the Trust and funded through health and social care funding the 'Better Care Fund'.



2. OUTBREAKS

Diarrhoea & vomiting outbreaks	Annual total 17/18	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Total 18/19 to date
Total number	*3*	0	0	0	2	0	0	0	0	0	0	0	0	0
Total number of patients affected	*42*	0	0	0	31	0	0	0	0	0	0	0	0	0
Total number of staff affected	*15*	0	0	0	13	0	0	0	0	0	0	0	0	0

There were no significant outbreaks of diarrhoea and vomiting in the Trust in December 2018.

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

There have been no new patients identified with GES carbapenemase-producing Pseudomonas aeruginosa since October 2017. In December 2018 and January 2019, we identified a further two patients who may have this organism and strain typing has been requested to investigate this possibility.

In total there have been 21 confirmed patients (and 2 patients under investigation) 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 in North and South locality across Teesside have seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing Klebsiella pneumoniae. We had no new cases linked to this cluster in December 2018. We do not believe transmission has occurred unknowingly in our Trust. An extensive contact screening programme has only identified one case.

Board of Directors	
Agenda item	3.3
Title of Report	Safe Staffing Report – Nursing and Midwifery
Date of Meeting	5 February 2019
Presented by	Gill Hunt, Director of Nursing and Quality
Author	Eileen Aylott, Assistant Director of Nursing Workforce
Approved by	Gill Hunt, Director of Nursing and Quality
Previous Committee/Group Review	Operational Management Board
Purpose	Approval ☐ Decision ☐ Discussion ■ Information ■
Alignment to Trust's Strategic Objectives	■ 1. We will deliver excellence in patient outcomes and experience ■ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ■ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	
Legal/Regulatory Compliance Requirements (if applicable)	• Care Quality Commission • NHS Improvement • NHS England
Recommendation(s)	The Board is asked to receive and note the content of this report.

1. Executive Summary

South Tees Hospitals NHS Foundation Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses (RN), Midwives (RM) 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).

The fill rate against planned rosters for the month of December 2018 at an overall level was:

- RN / RM day shift 94.6%, night shift 94.8%
- HCSW day shift 92%, night shift 104.2%

2. Recommendation

The Board is asked to note the content of the report and to be assured that staffing levels are sufficient to deliver safe, high quality care with systems and processes in place should staffing levels fall short of those planned.

1. UNIFY Safe Staffing Return

The Trust's safer staffing submission to UNIFY for December 2018 was submitted on 17th January 2019 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 2017/2018

2017/2018	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
April 2017	92.7%	99.0%	95.3%	111.9%
May 2017	91.0%	97.4%	95.0%	109.5%
June 2017	91.5%	98.3%	93.5%	109.1%
July 2017	88.7%	97.4%	93.9%	111.0%
August 2017	87.2%	96.9%	92.1%	113.1%
September 2017	88.3%	100.3%	91.7%	113.9%
October 2017	88.7%	96.6%	93.1%	116.0%
November 2017	88.5%	95.1%	93.6%	109.6%
December 2017	87.1%	92.8%	92.6%	107.9%
January 2018	90.7%	91.2%	93.0%	109.1%
February 2018	89.4%	89.2%	93.1%	107.4%
March 2018	91.1%	92.6%	94.2%	109.2%
April 2018	91.0%	94.7%	96.4%	110.9%
May 2018	92.1%	91.4%	96.2%	112.1%
June 2018	92.7%	93.1%	94.6%	109.5%
July 2018	91.4%	92.3%	94.3%	107.3%
August 2018	91.3%	91.3%	94.5%	108.1%
September 2018	93.7%	92.4%	95.6%	109.4%
October 2018	94.0%	94.9%	95.4%	107.0%
November 2018	95.7%	94.2%	96.8%	105.5%
December 2018	94.6%	92.0%	94.8%	104.2%

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 with both full and part shifts. 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. These areas are not currently on SafeCare and changes may not always be captured on the roster.

Ward 9 RN night shifts have been monitored, safety has been maintained in relation to both the number of patients in the Respiratory Support Unit (RSU) and their clinical need. Ward 34 night shifts have been supplemented with extra HCA to support the number of dependent patients and ward 25 days have been monitored in terms of patient acuity / dependency and bed occupancy during each SafeCare meeting.

Staff have been redeployed to maintain safe staffing and professional judgment used to triangulate staffing ratios, CHPPD and conversations with the nurse in charge of each shift.

2. Temporary Staffing

The number of temporary staffing hours during December reduced with a combined RN/HCA fill rate of 69%, this is in line with the National seasonal trend. Daily review of all shifts continues to take place during the morning SafeCare meeting to ensure both safe and efficient allocation of staff.

3. Red Flag Reporting

A total of 105 red flags have been reported during December. 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 (42) and opening of 'amber' beds (32) Action taken to mitigate risk is captured on the system providing an audit trail or response to the alert.

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. Red beds are staffed outside of the normal ward establishment. The system records 3 counts per day so an escalation bed may only be open for part of a day and then reclosed.

Flag Type	Count of Shift Type
AMBER Beds Open	32
Delay in providing pain relief	4
Less than 2 RNs on shift	8
Missed 'intentional rounding'	12
RED Beds Open	6
Shortfall in RN time	41
Vital signs not assessed or recorded	2
Grand Total	**105**

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 December a total of 1485 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.

There has been a review undertaken of the data reported on the monthly mandated safe staffing return (UNIFY) in line with updated guidance and admission units and any day units have now been removed from this data set. The latest Trust results published on the Model Hospital website are from October 2018 and were 8.6 against a peer group median of 8.7 and a national medium of 8.0.

6. Band 5 Vacancy Rate and Recruitment Activity

The Nursing and Midwifery turnover rate remains fairly static at 9.7%. There are currently 50 band 5 Wte vacancies.

The next Nursing and ODP recruitment open day is planned for Saturday 26 January with over 100 expressions of interest received. Theatres will also host an open door event during this morning to enable a full view of the department for those interested in applying for posts.

The final 3 overseas nurses have been confirmed to arrive at the end of January. All previously deployed nurses have now passed their OSCE and have registered with the NMC.

We have interviewed 5 Return to practice applicants who will be starting their programme with Teesside University in January with 3 choosing FHN to complete their practice hours and be interviewed for RN posts once registered later in the year.

Eileen Aylott
Assistant Director of Nursing Workforce
January 2019

References

Department of Health (2016) **Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. An independent report for the Department of Health by Lord Carter of Coles** *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf*

National Quality Board (2016) **How to ensure the right people, with the right skills are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability.**
London Safe, sustainable and productive staffing in maternity services
https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_Maternity_final_2.pdf

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

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

Appendix 1 JCUH

Copy of staffing report for UNIFY Dec

Board of Directors	
Agenda item	3.4
Title of Report	Learning From Deaths Monthly Dashboard January 2018
Date of Meeting	5 February 2019
Presented by	Mr Andrew Owens, Medical Director, Corporate Clinical Support Services
Author	Jo Raine, Data Analyst Mortality Surveillance and Tony Roberts, Deputy Director (Clinical Effectiveness)
Approved by	Operational Management Board
Previous Committee/Group Review	Quality Assurance Committee
Purpose	Approval ☐ Decision ☐ Discussion ☐ Information ☒
Alignment to Trust's Strategic Objectives	☒ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	Care Quality Commission NHS Improvement
Recommendation(s)	The Board is asked to note that the Trust will continue to monitor and Learning From Deaths data, and act accordingly.

Learning From Deaths Monthly Dashboard December 2018

1 Responding to Deaths

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

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

- at the time of certification of death. The Trust has established a Medical Examiner Service which commenced work in May 2018. All deaths receive some scrutiny and for those deaths not referred to the Coroners this includes a 'stage one' case record review, discussion with the attending team and a discussion with the bereaved family

- at a 'stage two' case record review, usually conducted within weeks of a death, any death identified by a 'stage one' case record review plus all deaths of patients with learning disabilities, serious mental illness, where an incident or complaint has been reported, within 30 days of a surgical procedure or where a 'mortality alert' from a range of sources has occurred.

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

1.3 The Learning From Deaths dashboard has been redesigned to make it more easily interpreted and reports the number of deaths, the number deaths with 1st stage reviews (by Medical Examiners), number of deaths with 2nd stage reviews or investigations and the number of those deaths judged to show evidence of preventability. Numbers are reported separately for patients with learning disabilities and known mental health issues. For the year to end of December 2018, there were 1,880 deaths, of which 1,030 received a review or investigation (720 1st stage only) and 8 deaths were considered to be potentially avoidable. In the same period there were 10 deaths in patients with learning disabilities, of which 8 received a review or investigation and 0 deaths were considered to be potentially avoidable. For patients with a mental health issue, 158 were identified of which 38 have been reviewed, with 0 deaths considered potentially avoidable. Potential learning from both good care and from problems in care are outlined. Changes that are being implemented relate to better coordination and documentation of care and these will be easier to address as enhancement to the use of electronic patient records occur and the impact of these changes will also become easier to assess from digital records.

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

2 Mortality indicators

2.1 The dashboard includes the number deaths from April 2008 to December 2018. Since the winter peak the number of deaths per month has averaged 150 – about what would be expected for the Trust at this time of year. The total for December was 162 deaths, lower than expected (in December 2017 there were 191 deaths and in December 2016 197 deaths). This was the lowest December total since 2011 (158 deaths).

2.2 Two risk-adjusted mortality indicators are included in the dashboard. The Summary Hospital-level Mortality Indicator (SHMI) includes all in-hospital deaths plus deaths within 30 days of discharge. It is published on a quarterly basis (including 12 months of data in each release) by NHS Digital and is an official government statistic. Current reporting is July 2017 – June 2018. The SHMI is the ratio of observed mortality rate/expected mortality rate (based on a statistical estimate of expected mortality). The SHMI is 109 and is 'as expected' (ie within the variation expected statistically). The Hospital Standardised Mortality Ratio (HSMR) includes approximately 80% of in-hospital deaths and uses different risk adjustment methods. Current reporting is October 2017 – September 2018. The HSMR is 114 and is 'higher than expected'.

2.3 SHMI and HSMR risk-adjust deaths in diagnostic groups based on the primary diagnosis coded in the first Finished Consultant Episode (FCE), risk-adjusted for age, sex, method of admission and comorbidities (ie other clinical conditions coded in secondary positions). The Comorbidity score for South Tees and England is shown in quarters from January 2015 to June 2018. This shows the broadly static coding level for South Tees and the higher and rising rate for England. The relative difference is adversely affecting the HSMR and accounts for part of the difference in value between the SHMI and HSMR (as HSMR is more sensitive to this issue than SHMI). HSMR (but not SHMI) also adjusts for specialist palliative care coding and the chart for Palliative Care Coding for January 2016 to December 2018 shows that the number of cases with the relevant codes is static or falling slightly. This is adversely affecting the HSMR by about 4.3 points.

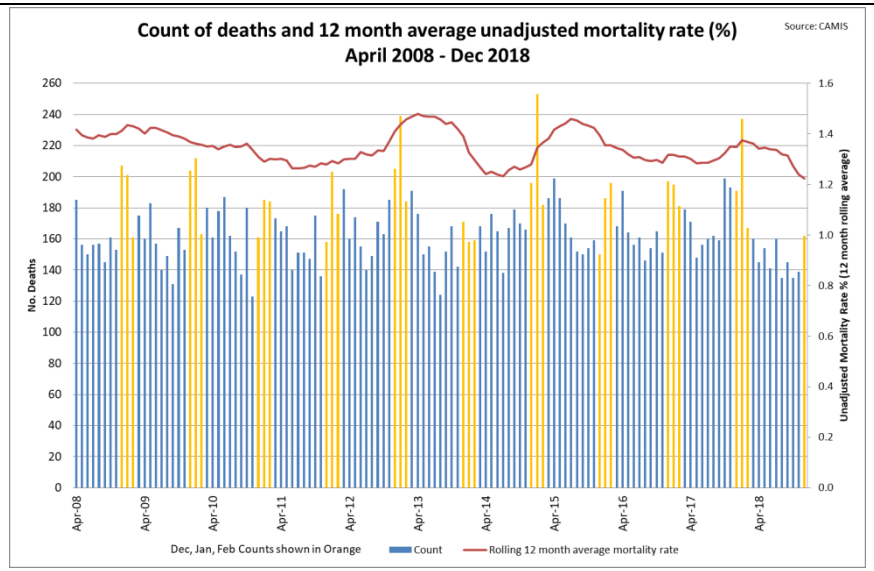
3 Next steps

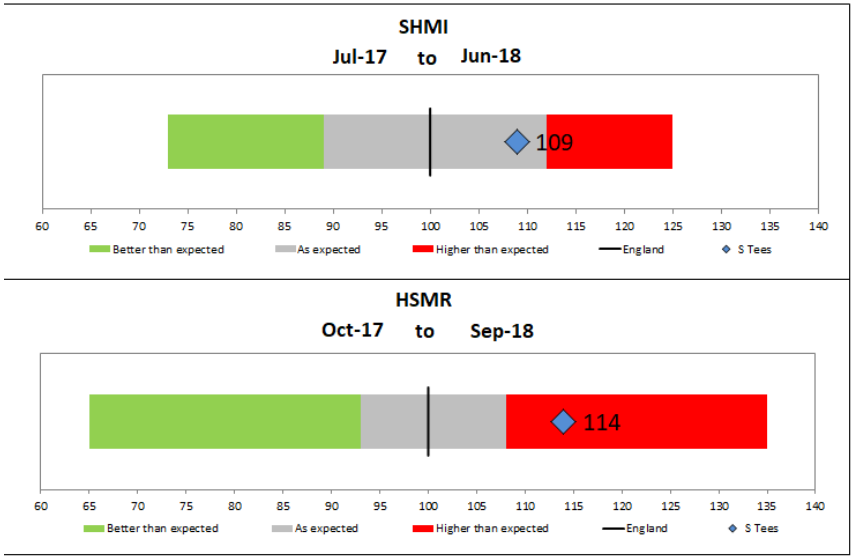
3.1 The Learning From Deaths work was reported in the annual Quality Account which was published in June 2018.

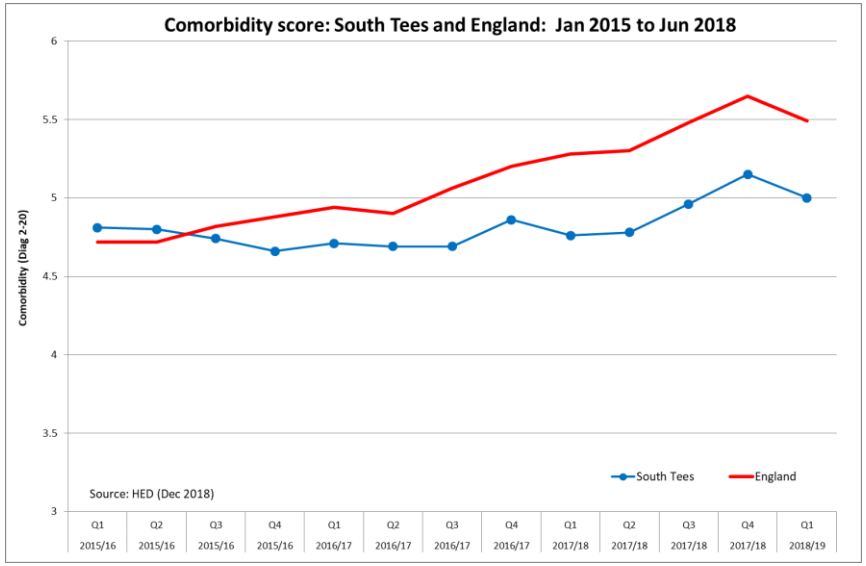
3.2 The Medical Examiner Service is now operational, and 49% of deaths have received a stage one review with 124 deaths being recommended for 2nd stage review. The new service will also impact on the number of second stage reviews completed and this will be monitored through the Learning From Deaths dashboard.

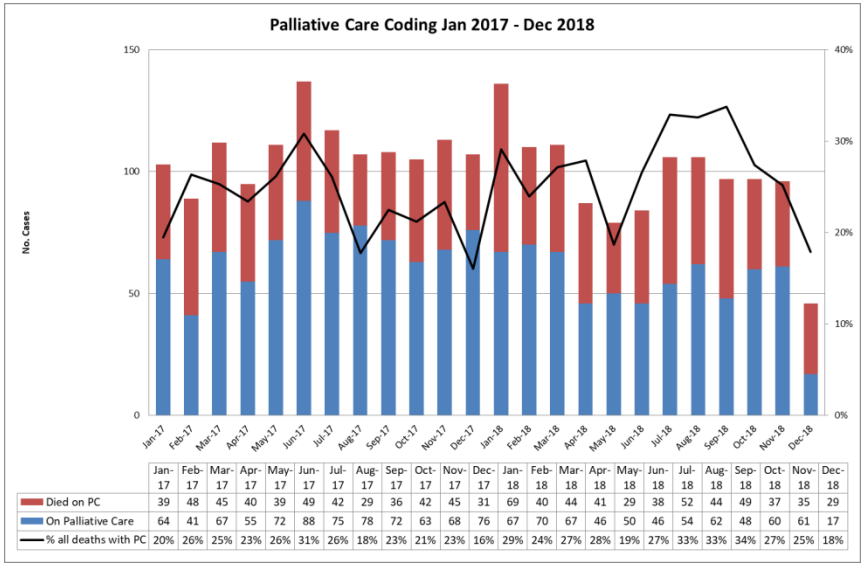
3.3 Mortality indicators will continue to be monitored. Issues around the recording of comorbidities and specialist palliative care coding are being addressed through relevant departments of the Trust.

3.4 This Learning From Deaths Quarterly Dashboard is a development of previous Board reporting and will continue to evolve. A longer report is considered by the Patient Safety Group who report to the Quality Assurance Committee (QAC) who report to the Board of Directors.









	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Died on PC	39	48	45	40	39	49	42	29	36	42	45	31	69	40	44	41	29	38	52	44	49	37	35	29
On Palliative Care	64	41	67	55	72	88	75	78	72	63	68	76	67	70	67	46	50	46	54	62	48	60	61	17
% all deaths with PC	20%	26%	25%	23%	26%	31%	26%	18%	23%	21%	23%	16%	29%	24%	27%	28%	19%	27%	33%	33%	34%	27%	25%	18%

Learning from Deaths Monthly Dashboard - December 2018

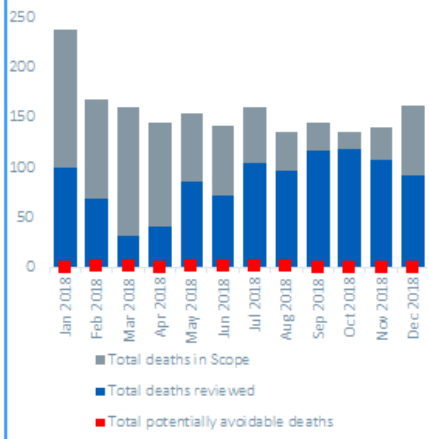
South Tees Hospitals NHS Foundation Trust

Total number of deaths reviewed and deaths judged preventable from the case notes
(includes patients with identified learning disabilities or serious mental illness)

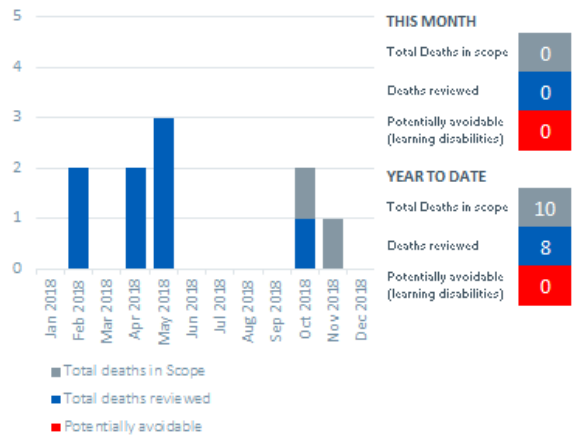
	Total deaths in scope	Total deaths Reviewed	1st stage review only	Definitely not Preventable	Slight evidence of preventability	Possibly preventable (<50:50 but close call)	Possibly preventable (>50:50 but close call)	Strong evidence for preventability	Definitely Preventable	Total potentiallly avoidable deaths
This month	162	91	88	3	0	0	0	0	0	0
Previous 12 months	1880	1030	720	280	17	5	2	6	0	8

2nd Stage Review

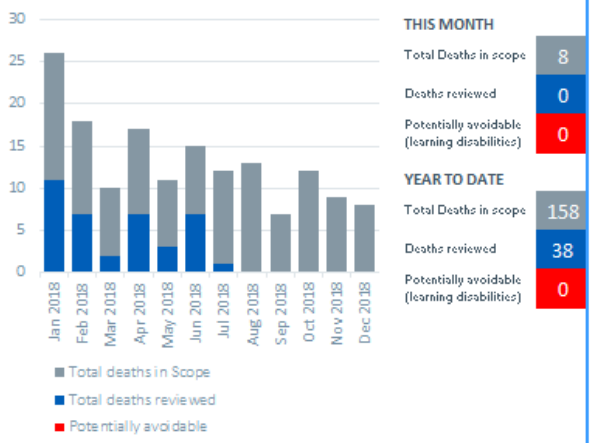
All patients:
Mortality over time, total deaths and deaths considered potentially preventable

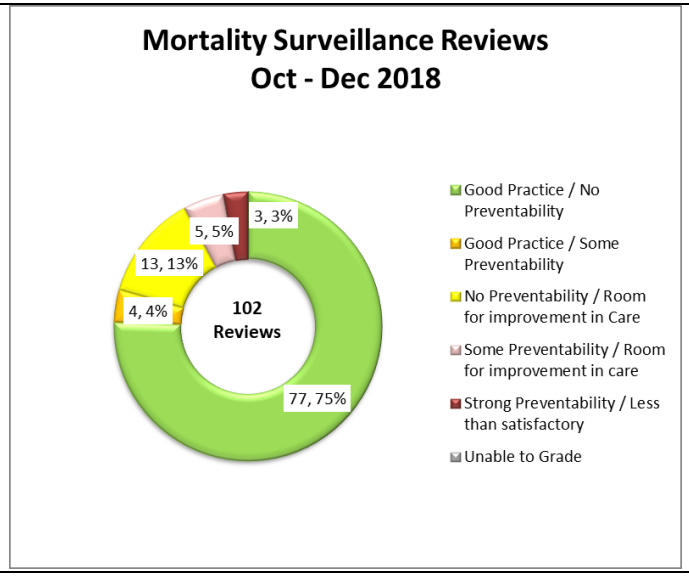


Patients with learning disabilities:
Mortality over time, total deaths and deaths considered potentially avoidable



Patients with a serious mental illness:
Mortality over time, total deaths and deaths considered potentially avoidable





Of the 102 deaths reviewed in the quarter, 75% of patients were judged to have received good care with no preventability.5 cases were judged to show strong preventability with room for improvement in care and 3 cases to show strong preventability with less than satisfactory care. 87% of deaths were Expected.

20 cases were highlighted as identifying learning from good care (cases can appear in more than one category) and 35 cases were highlighted as identifying learning from problems in care.

Positive lessons were around communication with family around patient's wishes for treatment, advanced decision making and palliative care. Negatives reflected incomplete or unsigned DNACPR forms, lack of timings and designations in paperwork and uncompleted forms and pathway documentation.

REVIEWS IDENTIFYING LEARNING FROM GOOD CARE	20
Good communication with family	13
Good coordination of clinical care / senior input / advanced decision making	9
High quality treatment	5
Palliative care instituted appropriately	5
Good quality of documentation	3
Patient's stated wishes were followed	3
Appropriate diagnosis	2
Appropriate Referral to Critical Care	2
Test results / tests being undertaken appropriately	2
Appropriate medications given	1
Complete physiological observations / deterioration escalated appropriately	1
Good quality clerking	1
ICU Bed made available	1
successfully completed surgery	1
Treatment of complex patient in appropriate ward,	1

REVIEWS IDENTIFYING LEARNING FROM PROBLEMS IN CARE	35
Poor quality of documentation	13
DNACPR not in place or invalid or not acted on and CPR undertaken	11
Availability of appropriate bed (nonICU) compromising care	3
Inappropriate admission from nursing home / community hospital / community setting	3
Incomplete physiological observations / deterioration not escalated	3
Patient fall not escalated properly	2
Rapid readmission following earlier (inappropriate?) discharge	2
Anticoagulation: administration error	1
Chest Drain not fitted properly	1
CVC Complications: infection	1
Delay in test results / tests being undertaken	1
Medication Error	1
Mis- or Missed Diagnosis	1
Patient's nutritional needs not met	1
Patient's stated wishes not followed	1
Poor communication with family	1
Poor coordination of clinical care / lack of senior input / advanced decision making	1
Possible poorer standard of care over weekend	1

Board of Directors	
Agenda item	3.5
Title of Report	Guardian of Safeworking – Quarter 3 Report
Date of Meeting	5 February 2019
Presented by	Medical Director (Community Care)
Author	Guardian of Safeworking and HR Business Partner
Approved by	Medical Director (Community Care)
Previous Committee/Group Review	Operational Management Board
Purpose	Approval ☐ Decision ☐ Discussion ■ Information ■
Alignment to Trust's Strategic Objectives	■ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ■ 4. will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements	NHS Improvement NHS England
Recommendation(s)	The Board is asked to note the Guardian of Safeworking – Quarter 3 Report and the work that will continue to be provided during 1209/20 as per the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

1. Executive Summary

This report provides an update of South Tees Hospitals NHS Foundation Trust's participation in the 2016 Junior Doctor Contract. It encompasses the 3 month period between 1 October 2018 and 31 December 2018.

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

As at 31 December 2018 there were 254 out of 363 doctors in training on the 2016 terms and conditions. This number will increase from August 2019 as doctors come to the end of existing contracts and move onto the new terms.

To increase engagement it was agreed with junior doctor forum representatives to add the meeting onto the Foundation Programme generic skills teaching days. This will help to engage the foundation trainees. Higher trainees have also been invited to attend and further discussion is planned with the forum to find ways to continue to improve engagement.

One GoSW fine has been issued to date due to a breach of the 72 hour weekly maximum over 7 days. It has been agreed that the fine money will be spent on resources for the junior doctor mess.

Exception reporting submissions continue to be at a lower level than was originally anticipated. A recent survey conducted by the GMC at the Trust provided some insight into potential reasons for this although it should be noted that the sample size was small (21 respondents)

Briefing sessions for Educational and Clinical Supervisors on the 2016 contract and exception reporting have been arranged for January to March 2019.

The overall vacancy rate for junior doctors has dropped from 10% to 6.4%.

2. Recommendation

The Board is asked to note the Guardian of Safeworking – Quarter 3 Report and the work that will continue to be provided during 1209/20 as per the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

Guardian of Safeworking Quarter 3 Report (1 October 2018 to 31 December 2018)

1. Purpose

This report provides an update of South Tees Hospitals NHS Foundation Trust's participation in the 2016 Junior Doctor Contract. It encompasses the 3 month period between 1 October 2018 and 31 December 2018.

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

2. Introduction

The Contract came into force on 7 December 2016, initially applying to Foundation Year 1 doctors. On 2 August 2017 it was rolled out to all Training Grades of Junior Doctors. The main differences between the new and previous contract are the tighter limits on junior doctors' hours and protection of educational opportunities.

The Guardian of Safe Working (GoSW) is a role in every Trust in the UK to ensure safe and correct implementation of the new contract. A junior doctor on the new contract can raise an 'Exception Report' if they have worked beyond their agreed hours or have missed Educational Events in order to care for patients. These require discussion regarding the necessity of the excess hours and then need to be 'signed off' by the Clinical Director or Educational Lead, either with the agreement to have Time Off in Lieu (TOIL) or payment.

The benefit of this system is that it provides 'real time' information and can help identify and rectify issues with rotas at an early stage.

In certain circumstances outlined in the contract (e.g. breach of 48 hour average working week over the rota cycle, breach of the absolute limit of 72 hours over any consecutive 7 day period or certain breaches of daily rest periods) the GoSW has the power to fine the department concerned.

We currently have 254 doctors in training on the 2016 contract and registered to submit exception reports. This accounts for 70% of all funded training posts.

3. Key updates

- The Junior Doctors Forum has been established as per the contract terms and conditions. The forum continues to be slow to engage and this seems to be a common finding across Trusts. All doctors who have moved onto the new contract to date are now being sent regular reminders about the forum. To increase engagement it was agreed with junior doctor forum representatives to add the meeting onto the Foundation Programme generic skills teaching days. This will help to engage the foundation trainees. Higher trainees have also been invited to attend and further discussion is planned with the forum to find ways to continue to improve engagement.

- Exception reporting submissions continue to be at a lower level than was originally anticipated. A recent survey conducted by the GMC at the Trust provided some insight into potential reasons for this. It should be noted however, that the sample size was small (21 respondents) and was almost exclusively Foundation Year One doctors (20 out of 21 respondents)

- 42% of the respondents rated their knowledge of the exception reporting process as poor or very poor. This is despite exception reporting being covered at induction and quarterly reminders on the process being sent out to all doctors on the new contract.

- 50% of respondents reported that they have felt under pressure not to exception report in their current post. 25% were concerned about the potential impact of reporting on their career and reputation.

- 32% of respondents said they had not reported as exceptions are ‘every day’ occurrences

- The GoSW has planned a programme of refresher sessions for Clinical and Educational Supervisors for quarter 4. This will cover the importance of exception reporting and encouraging trainees to exception report.

- One GoSW fine has been issued to date due to a breach of the 72 hour weekly maximum over 7 days. It has been agreed that the fine money will be spent on resources for the junior doctor mess.

- The overall vacancy rate has dropped from 10% to 6.4%. Gaps on rotas tend to be short term gaps due to sickness or emergency leave. The Medical Rota Team track junior doctor sickness and any doctors hitting trigger points are picked up by the relevant team (e.g. postgraduate team for foundation doctors, Lead Employer Trust for LET employed doctors).

    - Advanced Nurse Practitioners are successfully being utilised to cover gaps in some areas
    - The medical rota team continue to fill approximately 95% of all locum shifts each month with the majority (approximately 91%) being filled by internal locum cover as opposed to agency
    - The contract for the regional locum bank (Flexishift) hosted by the Lead Employer Trust has been extended following a successful pilot. The possibility of adding Trust employed doctors to the bank is now being explored
    - The employment of MTI doctors though the Royal Colleges schemes. These are fixed two year appointments

4. Data summary and commentary

4.1 Numbers of doctors in training

Table 4.1.1

Number of doctors / dentists in training (total):	**363**
Number of doctors / dentists in training on 2016 TCS to date(total):	**254**

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

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

1 PA / 4 hours per week.

4.3 Exception reports

The tables below give a breakdown and analysis of the 11 exception reports raised between 1 October 2018 and 31 December 2018

Table 4.3.1

Exception reports raised October to December 18			
Specialty	**No. Exceptions Raised**	**No. Exceptions Closed**	**No. Exceptions Outstanding**
Obstetrics	1	1	0
Neonates	6	5	1
Diabetes	1	1	0
General Surgery	2	2	0
A&E	1	1	0
Total	**11**	**10**	**1**

Table 4.3.2

Exception report category			
Specialty	**Education**	**Hours & Rest**	**Other**
Obstetrics	0	1	0
Neonates	0	6	0
Diabetes	0	1	0
General Surgery	0	1	1
A&E	0	1	0
Total	**0**	**10**	**1**

Table 4.3.3

Exception report type							
Specialty	**Early Start**	**Early Start & Late Finish**	**Late Finish**	**Late Finish & Unable To Achieve Breaks**	**Working pattern does not match work schedule**	**Unable To Attend Scheduled Teaching / Training**	**Other**
Obstetrics	0	0	1	0	0	0	0
Neonates	0	0	4	1	0	0	1 – concerns raised re numbers of junior doctors
Diabetes	0	0	1	0	0	0	0
General Surgery	0	0	1	0	0	0	1 – concerns re shift allocations
A&E	0	0	1	0	0	0	0
Total	**0**	**0**	**8**	**1**	**0**	**0**	**2**

Table 4.3.4

Exception report action taken					
Specialty	**No Action Required**	**Payment For Additional Hours**	**Time Off In Lieu**	**Work Schedule Review and payment**	**Other**
Obstetrics	0	0	1	0	0
Neonates	1	0	3	1	0
Diabetes	1	0	0	0	0
General Surgery	1	0	1	0	0
A&E	1	0	0	0	0
Total	**4**	**0**	**5**	**1**	**0**

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

4.5 Vacancy data

Outstanding vacancies by month October 18 to December 18					
Specialty	**Grade**	**Oct 18**	**Nov 18**	**Dec 18**	**Comments**
Diabetes	ST3+	1	1	1	Out to advert
Care of the elderly	ST3+	1	1	1	Rota adjusted to accommodate
Obs and Gynae	ST1/2/3	4	4	4	Pending interviews
Paediatrics	CT1/2	1	1	1	Rota adjusted to accommodate
Neonatology	CT1/2	1	1	1	Rota adjusted to accommodate
Neonatology	Trust Doctor	1	1	1	Rota adjusted to accommodate
General Surgery FHN	Trust Registrar	2	2	2	Appointed 1, expected start date March 2019. Second post back out to advert
Colorectal	ST3+	1	1	1	Rota adjusted to accommodate
Oral and orthodontics	DC2	1	1	1	Appointed, to commence November 18
ENT	CT1/2	1	1	1	Currently covered with agency locum, until next rotation in Feb 2019
Upper GI	Trust Doctor	1	1	1	Appointed, expected to commence January 19
Urology	Research Fellow	1	1	1	Appointed, pending exam results and GMC registration, expected start date February 19
Ophthalmology	ST3+	1	1	1	Rota adjusted to accommodate, out of hours covered by locum
Orthopaedics	Trust Doctors	1	1	1	Appointed candidate withdrew, recruitment liaising with department re next steps
Orthopaedics	Teaching Fellow	1	1	0	Appointed, commenced November 18
Spinal Surgery	ST3+	1	1	1	Appointed, to commence January 19
Neurosurgery	FY2	1	1	0	Appointed, commenced December 18
Cardiothoracic Surgery	Clinical Fellow	1	1	1	Appointed, to commence January 19
Infectious Diseases	CT1/2	1	1	0	Appointed, commenced December 18
Gastroenterology	CT1/2	1	1	1	Appointed, to commence December 18
Oncology	Trust Doctor	1	1	1	Appointed, to commence December 18
Acute Medicine	Trust Registrar	1	1	1	Specialty do not wish to fill currently
A&E	FY2	2	2	2	Covered by supernumery MOD doctors
A&E	CT1/2	2	2	2	Rota adjusted to accommodate
Totals		**30**	**30**	**27**	

Vacancies continue to be actively recruited to and are also covered via a variety of methods including internal locum, use of the master vendor agency HCL, use of Advanced Nurse Practitioners (ANPs) or by redesign of rotas where possible to accommodate lower number of doctors.

4.6 Guardian of safeworking fines

There has been one GOSW fine issued to date. This was due to a breach of the 72 hour absolute weekly maximum in Cardiology. The concern was raised during the rotation but not paid until after the end of the placement due to a prolonged investigation into the issue. The fine had the potential to have been far larger. However, the other doctors on the rota did not exception report and did not pursue a retrospective claim after the initial fine was levied.

4.7 Risks/issues and next steps

There are a number of risks and issues to bring to the attention of the Workforce Committee.

- Not all junior doctors across the region have transferred to the new contract as many are employed on existing run through training contracts which do not expire for some time (in some cases as late as 2023). This has resulted in doctors being employed on differing terms and conditions which leads to rotas being composed of a hybrid workforce. For example, doctors on the new contract are under the protection of the Guardian of Safeworking for rota and training breaches where as those on the old contract are not. Also, doctors on the new contract will be entitled to claim for additional hours where rota hours are exceeded whereas those on the old contracts are not.

  To date this does not appear to have impacted on morale; however this will continue to be monitored via the junior doctor forum.

- Further guidance regarding non-resident on call rotas is still awaited from NHS Employers and the BMA as this is a potentially problematic area for a number of areas within the Trust. NHS Employers and the BMA made a joint statement in June 2018 that a joint review of the contract will take place. It is hoped that non-resident on call is picked up as part of this review. In the meantime discussions have taken place with Clinical Directors in affected areas and local solutions have been put into place.

5. Conclusion

The Guardian of Safeworking in submitting this report to the Board acknowledges the work which has been undertaken by the medial workforce and postgraduate teams and clinicians within departments to manage the increase in numbers of junior doctors who have moved onto the new contract from August 2018.

The contract remains work in progress, locally our issues are centred on:

- Non Resident on call posts, with guidance still outstanding as negotiations between BMA & NHS Employers still ongoing.

- Reluctance of trainees to exception report. Further work to take place with supervisors to encourage trainees as to the benefits of exception reporting.

Board of Directors	
Agenda item	4.1
Title of Report	Board Committee Terms of Reference
Date of Meeting	5 February 2019
Presented by	Committee Chairs
Author	Company Secretary
Approved by	Associated Board Committees
Previous Committee/Group Review	Quality Assurance Committee Finance and Investment Committee Audit Committee Committee
Purpose	Approval ☑ Decision ☐ Discussion ☐ Information ☐
Alignment to Trust's Strategic Objectives	☑ 1. We will deliver excellence in patient outcomes and experience ☑ 2. We will drive operational performance to deliver responsive, cost effective care ☑ 3. We will deliver long term financial sustainability to invest in our future ☑ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☑ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements	NHS 2006 Act as amended by 2012 Health and Social Care Act NHS Improvement Care Quality Commission
Recommendation(s)	The Board is asked to 1. *note* that the Terms of Reference for Quality Assurance Committee; Finance and Investment Committee; and Audit Committee have been updated to align with regulatory requirements and the Trust's Corporate Governance Structure which was approved by the Board at its 6 November 2018 meeting; 2. *note* that the updated Terms of Reference have been approved by the associated Board Committee; and 3. endorse the approval of the Terms of Reference

South Tees Hospitals NHS Foundation Trust

Quality Assurance Committee

Terms of Reference

1. Constitution

1.1 The Quality Assurance Committee (the Committee) has been established by the South Tees Hospitals NHS Foundation Trust in accordance with its Standing Orders and Standing Financial Instructions and will report to the Board of Directors.

1.2 The Committee is authorised to act within its Terms of Reference with escalation to the Board of Directors for consideration and decision as appropriate.

1.3 All members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised to instruct professional advisors following consultation with the Board of Directors and request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

1.5 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Membership

2.1 The core membership of the Committee will consist of:

- Three Non-executive Directors (one of whom shall be the Committee Chair)
- Medical Director/(Medical Education, Research and Innovation/Corporate and Clinical Centre) (who will act as the joint executive lead)
- Director of Nursing and Quality(who will act as the joint executive lead)
- Director of Human Resources
- Chief Pharmacist
- Director of Estates, ICT and Health Records

2.1 In the absence of the Chair of the Committee one other Non-executive Director present shall Chair the meeting.

2.2 There is an open invitation for the Chief Executive and any of the Non-executive Directors to attend meetings.

3. Attendance at Meetings

3.1 The Committee may require the attendance of any of its employees or agents to attend its meetings such as the Assistant Director of Nursing for Safeguarding; Head of PALS; Deputy Director of Clinical Effectiveness or equivalent, Head of Quality.

3.2 However, only members of the Committee are entitled to attend and present at meetings. In addition to 3.1 above other members of staff may be invited to attend meetings as required to provide assurance and assist in its deliberations.

3.3 For the avoidance of doubt, Trust employees who serve as members of the Committee do not do so to represent or advocate their respective Centre, department, directorate or service area but to act in the interest of the Trust as a whole and as part of the Trust-wide governance structure.

4. Duties of the Chair

4.1 The Chair will be appointed by the Board of Directors. In the absence of the nominated Chair a Non-executive Director amongst those present will Chair the meeting.

4.2 The Chair will lead a review of the effectiveness of each meeting and on an annual basis undertake a formal review of effectiveness and report the outcome to the Board of Directors.

5. Frequency of Meetings

5.1 The Committee shall meet monthly at least 10 times per annum and at any other time as deemed necessary. Seminars and similar events may also be held in addition to the formal business meetings. These will be at the discretion of the Chair of the Committee and be used to accommodate specific issues which either warrant the involvement of staff beyond the core membership or when a topic specific meeting is required.

5.2 Papers shall be circulated by the Secretary of the meeting at least 5 days prior to each meeting and shall not be tabled unless this is agreed by the Chair of the meeting on an exceptional basis.

6. Quorum

6.1 No business should be transacted at the meeting unless one third of members are present, which must include at least:

- Two Non-executive Directors
- One Medical Director
- Director of Nursing and Quality

7. Main Priority and Objective

7.1 To enable the Board to obtain assurances that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- Promote safety and excellence in patient care;
- Identify, prioritise and manage risk arising from clinical care;
- Ensure the effective and efficient use of resources through evidence-based clinical practice;
- Protect the health and safety of Trust employees; and
- Ensure compliance with legal, regulatory and other obligations.

7.2 The Committee will identify areas that require more detailed scrutiny arising from: internal metrics, including the Board Assurance Framework, national reports, NHS Regulators, patient /service user feedback and public interest issues.

8. Scope and Duties

8.1 The Committee has delegated powers from the Board of Directors in respect of general governance arrangement to:

- To review information on the Board Assurance Framework where exceptions and/or emerging issues have been identified; paying particular attention to the Patient Safety, Patient Experience Strategic Aims and Key Priorities.
- To make recommendations to other forums on action required in response to the Assurance Framework and/or Corporate/High Level Risk Register.
- To receive summary reports of the key findings and recommendations of level 5 actual harm incidents and seek assurance on Clinical Services action plans.
- To consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee, or Board of Directors as appropriate.
- To undertake a regular (annual as a minimum) review of the Board Safety and Quality metrics to ensure the right areas of concern are presented.
- To receive progress reports on key safety and quality work programmes.
- To receive summary information on themes arising from complaints and concerns and consider the responses by centre and corporately as determined by the committee.
- To monitor centre scrutiny of complaints twice a year, and more frequently if required (by exception).
- To approve the Annual Quality Report.
- Oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust (eg. Licences granted by the Human Tissue Authority or any successor organisation), receiving such reports as the Committee considers necessary;
- Ensure the requirements of registration with the Care Quality Commission continues to be met;
- Support the Board to promote within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's policy on reporting issues of concern/freedom to speak up and monitoring the implementation on such policy;
- Ensure that robust arrangements are in place for the review of patient safety incidents (including near misses, complaints, claims reports from HM Coroner) from within the Trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning;
- Ensure that actions for improvement identified in incident reports, reports from HM Coroner and other similar documents are addressed;
- Approve Terms of Reference and membership of Sub-committees/Groups that report to the Committee.

9. Authority

9.1 The Committee is empowered to examine and investigate any activity pursuant to the above scope and duties.

10. Reporting and Minutes

10.1 The Quality Assurance Facilitator shall be Secretary to the Committee and shall attend to take minutes of meetings and provide appropriate support to the Chair and members.

10.2 Minutes shall be submitted after each of its meetings for consideration by the next meeting.

10.3 The Committee will receive minutes/Chair's Logs from all of the Sub Committees/Groups that report to it.

10.4 The following shall report to the Committee:

- Patient Safety Sub Group

- Safeguarding Adults and Children's Strategic Group
- Patient Experience Sub Group
- Medical Devices Group
- Clinical Standards Sub Group
- Safer Medical Practice Group
- Infection Prevention Action Group
- Health and Safety Group

11. Review

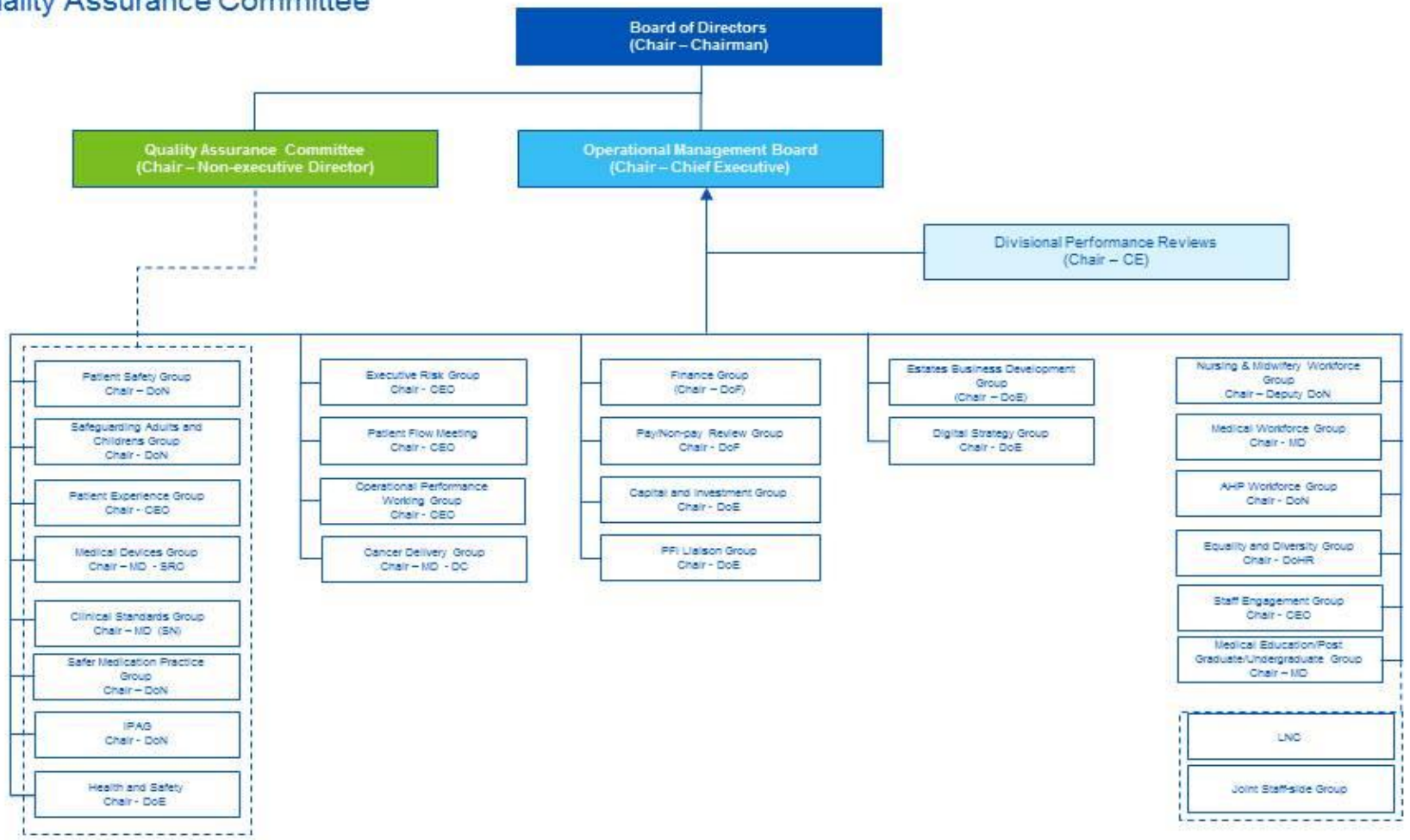
11.1 These Terms of Reference will be reviewed formally on an annual basis and periodically as required to incorporate national and local guidance.

11.2 Committee members will be required to attend at least 75% of meetings with attendance included within the annual report of the Committee.

Approved by Board of Directors:

Date of Next Formal Review: January 2020

Quality Assurance Committee



Excellence in Patient Outcome and Experience

South Tees Hospitals NHS Foundation Trust

Finance and Investment Committee

Terms of Reference

1. Constitution

1.1 The Finance and Investment (the Committee) has been established by the South Tees Hospitals NHS Foundation Trust in accordance with its Standing Orders and Standing Financial Instructions and will report to the Board of Directors. The Board of Directors has given authority for the Finance and Investment Committee to assume the role of Finance Improvement Board. This Board will be decommissioned by the Finance and Investment Committee once the work has been completed.

1.2 The Committee is authorised to act within its Terms of Reference with escalation to the Board of Directors for consideration and decision as appropriate.

1.3 All members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised to instruct professional advisors following consultation with the Board of Directors and request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

1.5 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Membership

2.1 The core membership of the Committee will consist of:

- Three Non-executive Directors (one of whom shall be the Committee Chair)
- Director of Finance and/or Deputy Director Finance Director
- Medical Director
- Director of Nursing and Quality

2.2 In the absence of the Chair of the Committee one other Non-executive Director present shall Chair the meeting.

2.3 There is an open invitation for the Chief Executive and any of the Non-executive Directors to attend meetings.

3. Attendance at Meetings

3.1 The Committee may require the attendance of any Trust employees or agents to attend its meetings.

3.2 However, only members of the Committee are entitled to attend and present at meetings. In addition to 3.1 above other members of staff may be invited to attend meetings as required to provide assurance and assist in its deliberations.

3.3 For the avoidance of doubt, Trust employees who serve as members of the Committee do not do so to represent or advocate their respective Centre, department, division or service area but to act in the interest of the Trust as a whole and as part of the Trust-wide governance structure.

4. Duties of the Chair

4.1 The Chair will be appointed by the Board of Directors. In the absence of the nominated Chair a Non-executive Director amongst those present will Chair the meeting.

4.2 The Chair will lead a review of the effectiveness of each meeting and on an annual basis undertake a formal review of effectiveness and report the outcome to the Board of Directors.

5. Frequency of Meetings

5.1 The Committee shall meet at least quarterly and at any other time as deemed necessary. Seminars and similar events may also be held in addition to the formal business meetings. These will be at the discretion of the Chair of the Committee and be used to accommodate specific issues which either warrant the involvement of staff beyond the core membership or when a topic specific meeting is required.

5.2 Papers shall be circulated by the Secretary of the meeting at least 5 days prior to each meeting and shall not be tabled unless this is agreed by the Chair of the meeting on an exceptional basis.

6. Quorum

6.1 No business should be transacted at the meeting unless one third of members are present, which must include at least:

- Two Non-executive Directors
- Director of Finance
- One other Director of Nursing or Medical Director

7. Main Priority and Objective

7.1 The role of the Committee is to seek assurance, on behalf of the Board that the Trust's finances are being soundly managed, and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust by monitoring financial performance against budget, reviewing any remedial measures to bring performance back into line with budget and making recommendations to the Board as appropriate. The Committee will also:

- Provide the Board with assurance on financial management, governance and control.
- Review and escalate significant issues and risks.
- Ensure that long-term financial planning is undertaken and long-term financial sustainability is maintained.

7.2 **Duties of the Committee include:**

Review of Financial Performance - monthly

- To review Income and Expenditure for the latest month, year to date and forecast.
- To review the Trust's cash-flow position.
- To assess the Trust's financial risk profile.

Financial Performance Management – monthly

- To monitor delivery of Trust activity against key financial performance indicators (capacity, demand and efficiency) and consider trends.
- To review information on performance within the Centres and to receive assurance on implementation of Board priorities.
- To review any remedial measures needed to bring financial performance back into line with budget.

Financial Transformation - monthly

- To review performance against strategic transformation objectives.
- To monitor CIP performance against plan and prior year.
- To review financial issues and challenges in the Tees Valley health economy.

Commissioning and Contracting – bi-monthly

- To receive updates on contractual issues.
- To review the Trust's contractual performance in relation to both CCGs and national commissioners.
- To assess any contractual risks and potential opportunities.

Long-term financial performance - quarterly

- To review funding requirements and any emerging issues.
- To review capital expenditure requirements and any emerging issues.

Annual Financial Planning – February through April

- To review budget approach and structure.
- To review assurance that the budget is both stretching and achievable.

Capital Expenditure - biannually

- Review of approved Capex programme (April)
- Review of proposed Capex programme (January)

Single Oversight Framework ratings will be reported to this Committee and to the Operational Management Board

Review of business cases, as required (as outlined at item 8 below)

Annual review of Finance Department Effectiveness

Matters delegated by the Board

8. Delegated Authority and Decision Making Powers

8.1 The Committee is empowered to examine and investigate any activity pursuant to the above scope and duties, including:

- Approve cost pressure business cases, as recommended by the Trust Executive Directors, up to £1.0m.
- Approve contribution generating or marginal cost business cases, as recommended by the Trust Executive Directors, up to £5.0m (disaggregated).
- Approve changes in the Board approved Capital Programme, as recommended by the Trust Executive Directors, up to £1.0m.

9. Reporting and Minutes

9.1 The Company Secretary shall nominate a Secretary to the Committee to attend to take minutes of meetings and provide appropriate support to the Chair and members.

9.2 Minutes shall be submitted after each of its meetings for consideration by the next meeting.

9.3 The Committee will receive minutes/Chair's Logs from all of the Sub Committees/Groups that report to it.

9.4 The following shall report to the Committee:

- Capital and Investment Group
- PFI Liaison Group

10. Review

10.1 As part of the Board's annual performance review process, the Committee shall review its collective performance.

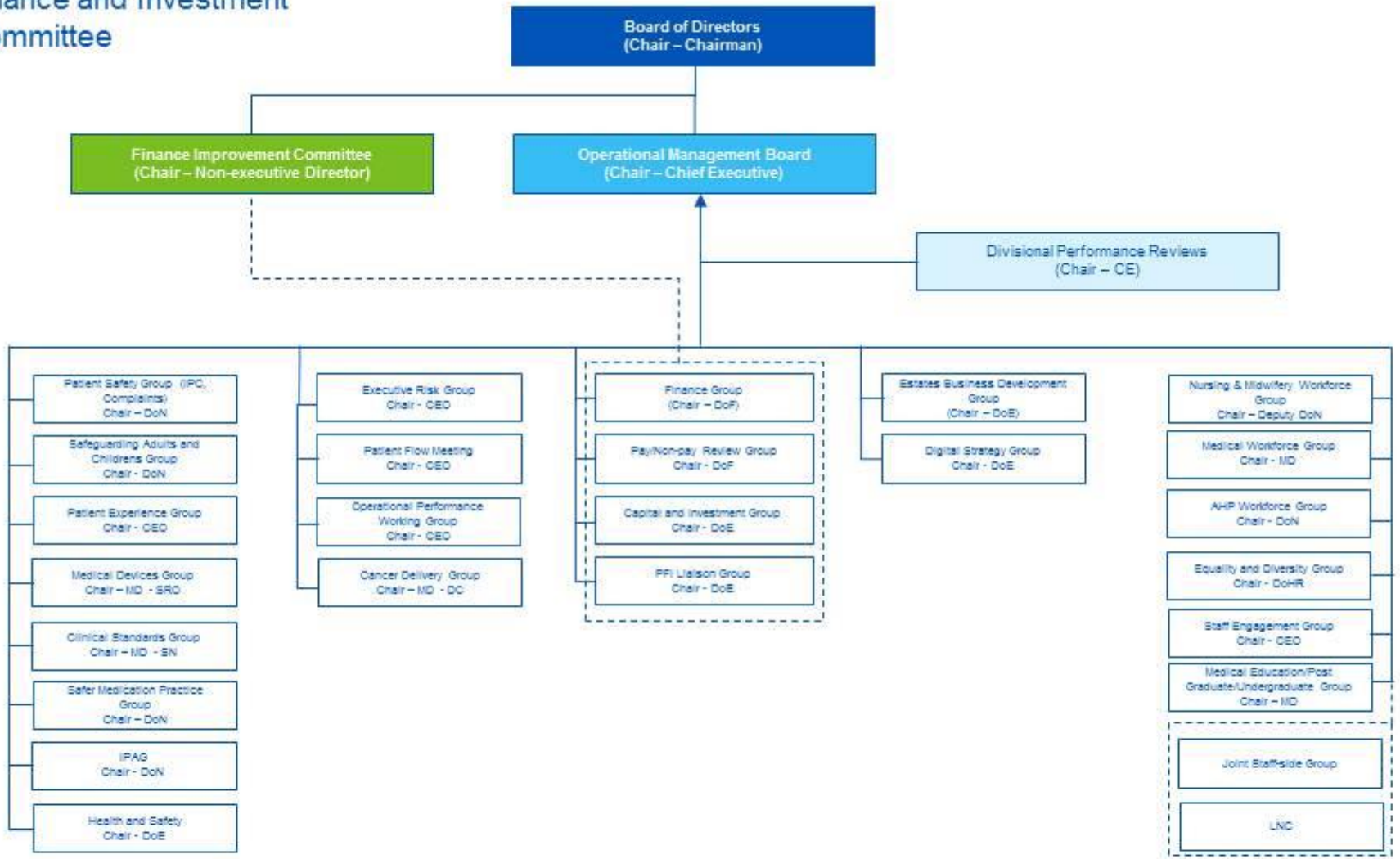
10.2 These Terms of Reference will be reviewed formally on an annual basis and periodically as required to incorporate national and local guidance.

10.3 Committee members will be required to attend at least 75% of meetings with attendance included within the annual report of the Committee.

Approved by Board of Directors:

Date of Next Formal Review: January 2020

Finance and Investment Committee



South Tees Hospitals NHS Foundation Trust

Audit Committee

Terms of Reference

1. Constitution

1.1 The Audit Committee (the Committee) has been established by the South Tees Hospitals NHS Foundation Trust in accordance with its Standing Orders and Standing Financial Instructions and will report to the Board of Directors.

1.2 The Committee is a Non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

1.3 All members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

1.5 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Membership

2.1 The Committee shall be appointed by the Chairman of the Board from amongst its independent Non-executive Directors of the Trust and shall consist of not less than three members (Non-executive Directors).

2.2 The Board should satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.3 The Chairman of the Trust shall not be a member of the Committee.

3. Attendance at meetings

3.1 The Committee will be supported by the following officers of the Trust:
Director of Finance
Director of Nursing and Quality
Company Secretary
Internal and External Audit representatives
The Counter Fraud Specialist will attend a minimum of two Committee meetings per financial year.

3.2 The Chief Executive (Accountable Officer) shall be invited to attend meetings to discuss at least annually with the Audit Committee the process for assurance that supports the annual governance statement. The Chief Executive shall also attend when the Committee considers the Draft Annual Governance Statement and the Annual Report and Accounts.

3.3 Other Executive Directors/Managers will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director/Manager.

3.4 At least once a year the Committee will meet privately with the External and Internal Auditors.

4. Quorum

4.1 No business should be transacted at the meeting unless three members are present.

5. **Duties of the Chair**

5.1 The Chair of the Committee will be appointed by the Board of Directors. In the absence of the nominated Chair a Non-executive Director amongst those present will Chair the meeting.

5.2 The Chair of the Committee will lead a review of the effectiveness of each meeting and on an annual basis undertake a formal review of effectiveness and report the outcome to the Board of Directors.

5.3 The Chair of the Committee will provide an annual report to describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

6. Aims, Objectives and Duties

6.1 Integrated governance, risk management and internal control

6.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives.

6.1.2 In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to submission to the Board.

- The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.

- The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA.

6.1.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

6.1.4 As part of its integrated approach, the Committee will have effective relationships with other key Board Committees in order that it understands processes and linkages. However, these other Committees must not usurp the Committee's role.

6.2 Internal Audit

6.2.1 The Committee shall ensure that there is an effective internal audit function and provides appropriate independent assurance to the Committee, Chief Executive (Accounting) Officer and Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.

- Reviewing and approving the annual audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework.

- Considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources.

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust.

- Monitoring the effectiveness of internal audit and carrying out an annual review.

6.3 ***External audit***

6.3.1 The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

6.3.2 Considering the appointment (in conjunction with the Council of Governors) and performance of the external auditors, as far as the rules governance the appointment permits.

6.3.3 Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.

6.3.4 Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee.

6.3.5 Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

6.3.6 Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

6.4 ***Other assurance functions***

6.4.1 The Committee shall review the findings of other significant functions, both internal and external to the Trust, and consider the implications for the governance of the Trust.

6.4.2 These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors – for example, the Care Quality Commission, NHS Resolution, etc. and professional bodies with responsibility for the performance of staff or functions – for example, Royal Colleges, accreditation bodies, etc

6.4.3 In addition, the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established.

6.4.4 In reviewing the work of any Clinical Governance Committee or equivalent Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

6.5 ***Counter fraud***

6.5.1 The Committee shall satisfy itself that the Trust has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

6.5.2 In accordance with 3.2 of the NHSCFA's *Fraud Commissioners Standards*, the Audit Committee has:

6.5.3 'stated its commitment to ensuring commissioners achieve these standards and therefore requires assurance that they are being met via NHSCFA's quality assurance programme'.

6.5.4 The Committee will refer any suspicions of fraud, bribery and corruption to the NHSCFA.

6.6 ***Management***

6.6.1 The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

6.6.2 The Committee may also request specific reports from individual functions within the Trust (for example, clinical audit).

6.7 ***Financial reporting***

6.7.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

6.7.2 The Committee shall ensure that the systems for financial reports to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

6.7.3 The Committee shall review the Annual Report and financial statements before submission to the Board, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Explanations for significant variances.

6.8 Arrangements by which staff raise concerns

6.8.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff and contractors to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

7. Access

7.1 The Head of Internal Audit and representative of External Audit have a right of direct access to the Chair of the Committee.

8. Frequency of meetings

8.1 The Committee will meet at least four times a year.

8.2 The Board, Chief Executive (Accountable) Officer, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

8.3 Papers shall be circulated by the Secretary of the meeting at least five days prior to each meeting and shall not be tabled unless this is agreed by the Chair of the meeting on an exceptional basis.

9. Authority

9.1 The Committee is empowered to examine and investigate any activity pursuant to the above aims, objectives and duties.

10. **Reporting and Minutes**

10.1 The Company Secretary shall nominate a Secretary to the Committee who shall attend to take minutes of meetings and provide appropriate support to the Chair and members.

10.2 The Committee shall report to the Board on how it discharges its responsibilities.

10.3 The minutes meetings shall be formally recorded The minutes and/or Chair's log shall be submitted to the Board following each meeting. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure, or require executive action.

10.4 The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on:

- The fitness for purposes of the assurance framework.
- The completeness and 'embeddedness' of risk management in the Trust.
- The integration of governance arrangements.
- The appropriateness of the evidence that shows the Trust is fulfilling regulatory requirements relating to its existence as a functioning business.
- The robustness of the processes behind the quality accounts.

11. Review

11.1 These Terms of Reference will be reviewed formally on an annual basis and periodically as required to incorporate national and local guidance.

11.2 Committee members will be required to attend at least 75% of meetings with attendance included within the annual report of the Committee.

Approved by Board of Directors:

Date of Next Formal Review: January 2020

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 27/11/2018
Key topics discussed in the meeting	
• CQC inspection update • End of Life Strategy – progress update • Mortality review – update • Monthly Quality Report • Monthly SI report • Board Assurance Framework / Quality Risks	
Actions agreed in the meeting	Responsibility / timescale
• Mortality reviews – Data received – Palliative care; Coding and Specific clinical groups likely to be the main issues. Panel to convene to examine further. • Medication Errors increasing • Dr Foster Alert regarding Intracranial Injuries • End of Life Care Strategy	• T. Roberts – January 2019 • Safer Medication Practice Group – January 2019 • T. Roberts – January 2019 • G. Hunt/ S. Nag – February 2019
Escalation of issues for action by connecting group	Responsibility / timescale
None	
Risks (Include ID if currently on risk register)	Responsibility / timescale
• Medication Practice (BAF 2.1) • HTA regulations (BAF 2.2) - backlog being progressed	• G. Hunt – November 2018 • G. Hunt & Medical Directors – January 2019

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 29 January 2019
Key topics discussed in the meeting	
• Proposed Terms of Reference and Annual Business Cycle • End of Life Group and Strategy Update • HSMI Data Examination Task and Finish Group Update • Monthly Serious Incident Report • Monthly Quality Report • Patient Experience Report Quarter 2 and Quarter 3 • Board Assurance Framework – review of risks aligned to Quality Assurance Committee • Chairs Logs from Reporting Sub Groups • Serious Hazards of Transfusion (SOT) Annual Report 2017 – for events reported in 2017	
Actions agreed in the meeting	Responsibility / timescale
• Terms of Reference – Approved • End of Life Care Strategy • Friary Hospital Richmond – No Mortality Concerns • Internal Audit to Examine Serious Incident Process	• Implement from February 2019 • C Ward/S Nag (March 2019) • G Hunt (2019/20)
Escalation of issues for action by connecting group	Responsibility / timescale
None	
Risks (Include ID if currently on risk register)	Responsibility / timescale
• No new risks added to Risk Register. • Board Assurance Framework - Controls strengthened for Risk 2.3 (Learning from Serious Incidents)	

Finance and Investment Committee Chair's Log

Meeting: Finance and Investment Committee	**Date of Meeting** 27 November 2018
Key topics discussed in the meeting	
• Month 7 and YTD financial performance • 2018/19 end-of-year forecast • 2018/19 capital & liquidity position • 2018/19 productivity & efficiency programme • Additional financial improvement opportunities	
Actions agreed in the meeting	Responsibility / timescale
• YTD performance shows costs under control but income behind plan. • Clinical income is £6.9M behind plan YTD principally due to below target performance in Specialised Commissioning and Independent Sector volumes. • Urgent focus is required on driving operational efficiency in Specialised & Planned Care. • Further Board discussion required on additional financial improvement opportunities.	Senior Leadership Team
Issues for Board escalation/action	Responsibility / timescale
• Report to Board on additional financial opportunities • Year-end forecast deteriorated slightly since last month – Board to note	Director of Finance 4 December 2018

Finance and Investment Committee Chair's Log

Meeting: Finance and Investment Committee	**Date of Meeting** 24 January 2019
Key topics discussed in the meeting	
• Month 9 and YTD financial performance • 2018/19 end-of-year forecast • 2018/19 capital & liquidity position • Control Total Notification and budget plan for 2019/20 • Review of Board Assurance Framework – consideration of recommendation from Workforce Committee and agreed to recommend to the Board that the risk is removed from the BAF • Review of Finance and Investment Committee Terms of Reference - approved	
Actions agreed in the meeting	Responsibility / timescale
• The Committee noted the income adjustment of £1.75M leading to a Q3 performance which is £0.02M ahead of plan. • Full year forecast is £8.7M behind target and a gap closure plan with associated risks is urgently required for review by the Board. • A financial summary of the impact of the new Aligned Incentive Contracts in 2018/19 will be prepared for the next Finance and Investment Committee meeting.	Senior Leadership Team 5 February 2019 Director of Finance 21 February 2019
Issues for Board escalation/action	Responsibility / timescale
• Year-end forecast still showing a deficit of £8.7M against plan – Board to note • Gap closure plan (with associated risks) to hit 2018/19 Control Total to be provided to Board	Senior Leadership Team 5 February 2019

Risk Committee
Chair's Log

Meeting: Risk Committee	**Date of Meeting**: 25 October 2018
Key topics discussed in the meeting	
Executive Risk Group (ERG) Terms of Reference – agreed EPPR should be agreed by the ERG Risk Escalation Structure – agreed Risk Validation group proposal – agreed Risk Committee Terms of reference – agreed Chairs log Executive Risk Group - noted BAF development – format and validation principles discussed with amends	
Actions agreed in the meeting	Responsibility / timescale
Amend documents and liaise with relevant committee owners BAF strategic risk 2.1 relating to Cdiff discussed in detail (by way of example)	• Company Secretary • Director of Nursing and Quality - to work through example prior to Exec away day
Escalation of issues for action by connecting group	Responsibility / timescale
Format risk statements to consider following best practice with three parts: As a result of … There is a risk that…. Leading to …. That format will then clearly assist in assessing what controls are currently in place and establish what gaps need to be closed to bring the grade within appetite.	• Exec Risk Group for discussion at away day based on example provided by Gill Hunt
Risks (Include ID if currently on risk register)	Responsibility / timescale
None	

Risk Committee
Chair's Log

Meeting: Risk Committee	**Date of Meeting**: 13 December 2018
Key topics discussed in the meeting	
Risk Escalation Structure – minor amend agreed Risk Validation Group – discussion of functionality and processes for inclusion of risks on register 15+ risk register - content discussed and suggestions made around process content and format Board Assurance Framework development – format and validation principles discussed with amends Chairs log Executive Risk Group – noted	
Actions agreed in the meeting	Responsibility / timescale
Amend Escalation Structure recommend minor amendment	Company Secretary
Continue to work on format of 15+ risk register in particular ensuring gaps in controls and actions are consistent. Ensure emerging risks are captured pending validation work	Director of Estates, ICT and Health Records (Chair of Risk Validation Group) ongoing
Board Assurance Framework noted review by risk owner and responsible committee	Company Secretary
Board Assurance Framework reconsider the risk to be included in section 5 with Workforce Committee	Director of Human Resources/Company Secretary
Escalation of issues for action by connecting group	Responsibility / timescale
None	
Risks (Include ID if currently on risk register)	Responsibility / timescale
None	

Workforce Committee
Chair's Log

Meeting: Workforce Committee	**Date of Meeting:** 13 December 2018

Key topics discussed in the meeting

- Local Clinical Excellence Awards
- Staff Survey Action Tracking
- Review of Mandatory Training 2018/9 Approach
- Guardian of Safeworking Report 1/4/18-30/9/18
- *Guardian of Safeworking Report Q3 circulated to Committee members for review and noting of questions/concerns – January 2019*

Actions agreed in the meeting	**Responsibility / timescale**
• Local Clinical Excellence Awards process to be undertaken in March 2019. Review to be reported to Committee October 2019	Medical Director (Corporate Clinical) - October 2019
• Complete and detailed Staff Survey results will be available March 2019. A further year of using the sample survey process had raised some concerns. Further the Trust needs to consider use of technology to increase return rate	Director of HR - April 2019
• Issues raised with the Trust's current bespoke learning system re connectivity with ESR. Recommendation that the Trust revert to using ESR system to be taken to SLT for discussion and sign-off. Update in April 2019	Director of HR - April 2019
• Apprenticeship Levy financial Performance to be discussed at next Committee meeting	Director of HR - April 2019
• *Having read the Q3 report and noting the finding of the GMC survey members of the Committee struggled to think of what more the team can do to improve reporting – the team should be commended on their efforts to date. More work to be done on high number of respondents who felt under pressure not to report. The reduction in the vacancy rate was welcomed with a note that the Trust manage to fill nearly all gaps internally from a list of staff willing to do locum work. Committee to discuss further at next meeting*	Medical Director (Corporate Clinical) - April 2019

issues for Board escalation or action by connecting group	**Responsibility / timescale**

Given the Trust has now undertaken sample Staff Surveys for the last 3 years the Committee recommends a full staff survey for 2019. Board to note letter from Minister of State for Apprenticeships and Skills to the Trust on being one of the top performing apprenticeship employers in the country.	OMB to consider recommendation following review of 2018 results. Director of HR - June 2019
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
None	

Rt Hon Anne Milton MP
Minister of State for Apprenticeships and Skills
Sanctuary Buildings Great Smith Street Westminster London SW1P 3BT
tel: 0370 000 2288 www.education.gov.uk/help/contactus

Dave Morris
Head of Learning & Development
South Tees Hospitals NHS Foundation Trust

11 December 2018

Dear Dave

As one of the top performing apprenticeship employers in the country, I wanted to write to thank you personally for your commitment, enthusiasm and drive for apprenticeships.

You have clearly taken advantage of the reforms by growing high quality apprenticeship programmes over the past year, benefitting your company, your apprentices, and indeed the economy as a whole. I know from talking to employers that building large scale, high quality apprenticeship programmes is a significant investment. I have met hundreds of apprentices over the last year, and they all speak incredibly highly of the employers that have given them this opportunity. I know that they more than repay the investment you have made with their loyalty, enthusiasm and skills they bring to your business.

We continue to listen to you individually and collectively. At the recent budget, the Chancellor announced a package of reforms to strengthen the role of employers and increase flexibility in the apprenticeship programme, in response to your requests. Included in that was confirmation that from April 2019, employers that pay the apprenticeship levy will be able to transfer up to 25% of their levy funds to other employers to help pay for apprenticeship training (up from 10% now). We will also provide additional funding to the Institute for Apprenticeships and the National Apprenticeship Service to identify gaps in the training provider market and increase the number of employer-designed apprenticeship standards. New apprentices will all start on these new, higher-quality apprenticeship standards from September 2020. I hope that you take advantage of the increase in transfers and welcome our continuing focus on ensuring that you get more choice of quality standards to meet your needs.

At the One Year On Celebration event you attended at the House of Commons during the summer we launched the Vacancy Snapshot website. The site (https://vacancies.amazingapprenticeships.com/) was commissioned to promote vacancies and help students and teachers to understand the recruitment cycle of apprenticeship employers in England. By bringing businesses together with some specially selected Teacher Champions (a network created by the National Apprenticeship Service) from across England,

we can share understanding on employer recruitment methods. We can also help teachers better prepare students for apprenticeship opportunities. I believe it is important to raise awareness of the kind of opportunities you are creating. I urge you to use the opportunity to get involved.

I hope you enjoyed the event. Please do consider joining the Apprenticeship Diversity Champions Network (ADCN) and the Apprenticeship Ambassador Network (AAN). I would also encourage your apprentices to join the Young Apprenticeship Ambassador Network (YAAN). Your involvement in these groups will undoubtedly help spread the word about the huge benefits apprenticeships can bring.

Once again, thank you for your continued support. I know that building apprenticeship programmes into your workforce planning takes time and investment. My grateful thanks for all you have done and continue to do in helping us grow the skilled workforce we need.

With my best wishes,

Best wishes

Anne Milton

Rt Hon Anne Milton MP
Minister of State for Apprenticeships and Skills

(Operational Management Board)
Chair's Log

Meeting: Operational Management Board	**Date of Meeting**: 29 November 2018
Key topics discussed in the meeting	Action by:
The following items were covered during the meeting: • Strategic Issues Affecting the Trust and Wider Health Economy • Quality and Operational Performance Report - noted • Lung Pathway Review – supported the improvement plan • Healthcare Associated Infection Update Report – noted • Typing Review and Development – development plan approved for staff IT training • Influenza Immunisation Action Plan - noted • Guardian of Safe Working Quarter One and Quarter Two Report – noted update and approved for submission to Board • Smoke Free Site Update - noted • Electronic Patient Record Business Case – approved for submission to Board for consideration subject to capital funding being available • Serious Incident Report - noted • Monthly Quality Report - noted • Information Governance (IG) Update – compliance against IG agreed to continue as a high priority with monitoring by the IG Steering Group and areas of non-compliance/risk escalated to the Digital Strategy Group /OMB • Delayed Transfer of Care update and progress noted • Safe Staffing - noted • Policies Approved: Remediation Policy;	Medical Directors (Community Care) and (Specialist and Planned) Operations Directors Medical Director (Community Care) Director of Estates, ICT and Health Records

Improving Data Quality Across the Trust	
Issues for Board escalation/action	Responsibility/timescale
None	

(Operational Management Board)
Chair's Log

Meeting: Operational Management Board	**Date of Meeting**: 24 January 2019
Key topics discussed in the meeting	Action by:
The following items were covered during the meeting: • Strategic Issues Affecting the Trust and Wider Health Economy – noted	
• Research and Innovation Strategy – approved for submission to the Board	Medical Director (Corporate Clinical Support Services)
• Communication and Engagement Strategy – approved for submission to the Board	Director of Communications
• Quality and Operational Performance Report – noted and approved for submission to Board	Medical Director/Deputy Chief Executive/Director of Nursing and Quality/Director of Finance
• Winter Plan Progress against Plan – plan to continue to be implemented with lessons learned to be translated to Easter/Surge Plans	Operations Directors/Medical Directors
• Healthcare Associated Infection Report – noted • Typing Review and Modelling – progress noted agreed modelling to be updated	Operations Director (Community Care)
• Smoke Free Site Update – noted	
• Learning from Deaths Quarter 3 Report – approved for submission to Board	Executive Risk Owners
• Guardian of Safe Working Quarter 3 Report – approved for submission to Board	
• Board Assurance Framework – updates made to key risks, mitigating actions and assurances noted for consideration by associated Board Committees and Board	
• CQC Inspection update from unannounced visit – noted	
• Serious Incident Report – noted	
• Monthly Quality Report – noted	

• Delayed Transfer of Care – update and progress noted • Safe Staffing update – noted Centre Board Chairs Logs noted for: Specialist and Planned Community Services Urgent and Emergency Care • Policies approved: Induction Policy Use and Approval of Non-emergency patient transport	
Issues for Board escalation/action	Responsibility/timescale
None