Board of Directors

2 February 2021
14:00
Microsoft teams & Board Room, Murray Building

MEETING OF THE SOUTH TEES HOSPITALS NHS FOUNDATION TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON TUESDAY 2 FEBRUARY 2021 AT 14:00 MICROSOFT TEAMS AND THE BOARD ROOM, MURRAY BUILDING

AGENDA

ITEM			PURPOSE	LEAD	FORMAT
PATIENT STORY					
CHAIR'S BUSINESS					
1	Welcome and Introductions		Information	Chair	Verbal
2	Apologies for Absence		Information	Chair	Verbal
3	Quorum and Declarations of Interest		Information	Chair	ENC 1
4	Minutes of the last meetings held on 1 December 2020		Approval	Chair	ENC 2
5	Matters Arising		Review	Chair	ENC 3
6	Chairman's report		Information	Chair	Verbal
7	Chief Executive's Report		Information	Chief Executive	Verbal
QUALITY AND SAFETY					
8	CQC update		Information	Interim Director of Nursing	Verbal
9	Safe Staffing Report		Information	Interim Director of Nursing	ENC 4
10	Organ Donation report		Information	Specialist Nurse Organ Donation	ENC 5
11	Maternity Services update				
	11.1	Ockenden Review	Information	Head of Midwifery	ENC 6a

ITEM			PURPOSE	LEAD	FORMAT
	11.2	Continuity of Care	Information	Head of Midwifery	ENC 6b
WORKFORCE					
12	Guardian of Safe Working		Discussion	Guardian	ENC 7
FINANCE AND PERFORMANCE					
13	Month 9 Finance Report		Discussion	Director of Finance	ENC 8
14	Operational priorities for winter and 2021/22		Information	Interim Director of Planning	ENC 9
15	Integrated Performance Report		Discussion	Chief Operating Officer	ENC 10
GOVERNANCE AND ASSURANCE					
16	Winter preparedness update		Information	Chief Operating Officer	Verbal
17	Board Assurance Framework and Corporate Risk register		Discussion	Head of Governance	ENC 11a and 11b
18	Committee Chair Reports		Information	Chair	ENC 12
	DATE OF NEXT MEETING The next meeting of Board of Directors will take place on Tuesday 2 March 2021				
	Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960)				

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 February 2021			
Register of members interests			**AGENDA ITEM: 3, ENC 1**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Alan Downey Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	The Board of Directors are asked to note interests declared by members of the Committee		
Background	The report sets out membership of the Board of Directors and interests registered by members. Conflicts should be managed in accordance to the Constitution para 32 - If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to other Directors.		
Assessment	There are no specific conflicts identified with the agenda. Members will be reminded at the meeting to raise any if they arise.		
Recommendation	The Board of Directors are asked to note the Register of Interest.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Alan Downey	Chairman	1 March 2018	ongoing	Wife is Director of PricewaterhouseCoopers working mainly with local government clients in the North of England
Ada Burns	Non-Executive Director Deputy Chair	2017 2019	Ongoing Ongoing	Role - Governor – Chair of Resources Committee, member of Board of Teesside University. Role – Associate Consultant – Cratus Consultancy, public sector management consultancy
Richard Carter-Ferris	Non-executive Director	1 August 2015	ongoing	Director of Yorkshire Area P2P Club – company generates donations for Yorkshire Air Ambulance. Director/No exec Director – Malton & Norton Golf club ltd.
David Heslop	Non-executive Director			No interests declared
Mike Ducker	Non-executive Director	1 December 2017 1 December 2005 1 October 2019	ongoing ongoing ongoing	Advisor to UK Government on Chemicals Industry Trustee of Greenstones Christian Trust Charity – a Charity working with prisons in Ethiopia South Tees Healthcare Management Limited - Company number 10166808
Debbie Reape	Non-executive Director Senior Independent Director	August 2019 1 October 2019 October 2019	Ongoing Ongoing Ongoing	Associate Director with Northumbria International Alliance (Northumbria NHS Trust and Northumberland County Council) South Tees Healthcare Management Limited - Company number 10166808. School Governor, Ashington Academy.
Sath Nag	Medical Director			No interests declared.
Steven Mason	Director of Finance	1 October 2017 13 August 2018 March 2019 1 October 2019 1 April 2020	ongoing ongoing ongoing ongoing ongoing	Children employed at Ernst & Young and Deloitte HM Property Services Ltd (Shareholder) not seeking work in NHS Client representative ELFS Management Board. South Tees Healthcare Management Limited - Company number 10166808. Non-Executive Director – Together for Children
Jackie White	Head of Governance	March 2013	Ongoing	Director – Applied Interim Management Solutions – Company Number 08473345
Sue Page	Chief Executive	May 2018	Ongoing	President of British Red Cross – Cumbria.
Kevin Oxley	Director of Estates, Facilities and Capital Planning			No interests declared
Rachael Metcalf	Director of Human Resources			No interests declared.

Mark Graham	Director of Communications			Ad hoc communications support to North Cumbria integrated care NHS Foundation Trust. Registered with IMAS (NHS interim management & support)
Johanna Reilly	Chief Operating Officer	2 October 2019	Ongoing	JRR Consultants Limited – Company number 11600734.
Ros Fallon	Director of Planning & Recovery			Non-Executive Director for Countess of Chester NHS Foundation Trust Trustee – Tarporley War Memorial Hospital
Moira Angel	Interim Director of Nursing	18 January 2021		Director of Moira Angel consulting Ltd. Director of Arista Associates Ltd. Vice president of the red cross in Cumbria.
Robert Harrison	Managing Director			No interests declared
Maria Harris	Non-executive Director	1 January 2021	Ongoing	Director of Digital Cat Consultancy Ltd – provider of digital transformation and mortgage expertise in financial services Non-executive Director of United Trust Bank – a regulated specialist bank
David Jennings	Non-executive Director	1 January 2021	Ongoing	Trustee Newcastle University Development Trust. Unremunerated, voluntary role. Chair AuditOne Board NHS internal Audit Consortium. Unremunerated, voluntary role. Board member, and Chair of Audit & Risk Committee of Bernicia House Group, a North East Social Housing Company – a remunerated role
David Redpath	Associate Non-Executive Director	1 January 2021	Ongoing	Director of DGR Consultancy
Neil Mundy	Interim joint Chair	2 February 2021		Director and Trustee Northumberland Theatre Company Director of N Mundy Ltd (Charitable Trusteeships) Member of the North East Working Group for Medilink North Ltd Board Member of Medilink North of England Ltd - Healthcare and Life sciences technology membership organisation For completeness - Chair of the Joint Independent Audit Committee for the Police and Crime Commissioner and Chief Constable of Northumbria Police. Son Philip Mundy and Daughter in Law Dr. Lydia Mundy are Founders and major shareholder in Pando Ltd a Clinical Communications Platform company conducting business with the NHS .

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 1 DECEMBER 2020 AT 14:00 VIA MICROSOFT TEAMS

Present

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

In Attendance

Mrs J White	Head of Governance & Company Secretary
Mr M Graham	Director of Communications
Mr K Oxley	Director of Estates, Facilities and Capital Planning
Mrs R Metcalf	Director of HR
Ms J Reilly	Interim Chief Operating Officer

STAFF STORY

The Chairman welcomed and introduced Jill Hunton to the meeting. Members noted that Jill had worked for the NHS for over 44 years, working across Teesside, starting as a student nurse at the age of 18. Her first qualified post was at Hemlington hospital followed by North Ormesby and Poole hospitals, eventually joining South Tees Hospital where she spent many happy years before joining the community nursing team.

Jill thanked the Chairman for his introduction and went on to share her experiences working as a nurse in a rural area from the Stokesley District Nursing team for almost 18 years having retired at the end of November.

The Chairman thanked Jill for sharing her story with the Board and advised that she will be truly missed by all her colleagues and patients. He went ton to wish her a very well deserved long and happy retirement.

Ms Reape commented that Jill had a tremendous amount of experience that will be missed and asked Jill what advice she would give to new registrants starting with the Trust. Jill said that it is important to take every day in your stride and enjoy every day, but keep learning, that is key.

Mrs Fowler gave her congratulations to Jill and asked her if she planned to keep her hand in a little and join the bank; Jill explained that she had put her name forward to support the

Trust in the vaccination hub.

The Chairman once again thanked Jill for her contribution to the Trust and wished her every success in her retirement and thanked her for helping the Trust with the vaccinations roll out.

Action

BoD/20/148 **WELCOME AND INTRODUCTIONS**

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

BoD/20/149 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Ms Burns.

BoD/20/150 **QUORUM**

The meeting was quorate in line with the Constitution paragraph 4.39 “Quorum - No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed, (including at least one non-executive director and one executive director) are present”.

BoD/20/151 **DECLARATION OF INTEREST**

The Chairman referred members to the register of interests and asked members if there were any further declarations to be made not already included. There were no further declarations made.

BoD/20/152 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on Tuesday 3 November 2020 were reviewed and agreed as an accurate record. — Mrs White

BoD/20/153 **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

BoD/20/154 **CHAIR’S REPORT**

The Chair gave a brief update on meetings and events since the last Board meeting. He mentioned that he had participated in a number of interviews for senior posts including that of Chief Financial Officer, to which Chris Hand was appointed, Chief Nurse, to which Hilary Lloyd was appointed, and in conjunction with the Governors and Deputy Chair the appointment of 3 new Non-Executive Directors which will be recommended to the Council of Governors for final appointment.

The Chairman welcomed Ben Murphy who joined the Trust as new Head of South Tees Hospitals Charity and has already made a very positive impression and is ensuring that the Charity is at the centre of activities in the Trust and Community.

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The Chairman mentioned that there had been positive and discussions with the NEDs and Senior Leadership Team in order to ensure that we are doing everything we can to make the trust a safe and secure place for patients and staff during the Covid-19 pandemic. As a result of these discussions, the Board has a high level of assurance concerning the steps that have been taken to ensure the safety of staff and patients.

Mr Carter-Ferris updated members that he had participated in an interview panel for a number of consultant posts and was pleased to report the extremely high calibre of individuals being appointed into these role.

Resolution

The Board of Directors noted the Chair's report.

BoD/20/156 **<u>CHIEF EXECUTIVE'S REPORT</u>**

Ms Page updated on the Board on the Trust's preparations for delivery of COVID vaccinations. There are several potential vaccines for COVID-19 in the later stages of phase 3 trials. If one or more is approved and authorised as safe and effective by the Medicines and Healthcare Regulatory Authority (MHRA), the NHS want to begin vaccination straight away, fully deploying whatever scale of supply may be available. All NHS Trusts have been asked to have a plan to vaccinate their staff and our own plans are in place and ready to begin the moment a vaccine is available.

Ms Page highlighted that the surgical teams at James Cook now have access to three da Vinci robots which means the number of patients benefitting from minimally invasive surgery will be doubling. The installation of a third robot means James Cook now has the potential to become a national Centre of Excellence for robotic surgery and teaching. By 2021 it is hoped heart specialists at the hospital will be the first in the region – and only the second in the UK – to offer robotics for cardiac surgery. We have a higher number of different specialities that can now use robotic surgery compared to other hospitals in the country and its enhanced precision helps reduce side effects and the length of time patients have to stay in hospital, which is important at any time but particularly during the COVID pandemic.

Ms Page updated members on national awards and recognition and mentioned that a number of colleagues including Sarah Baker and our theatre teams were highly commended in the HSJ Patient Safety Awards for their work in helping to keep surgical patients safe during COVID. Nursing colleagues reached the finals in five categories at this year's Nursing Times Awards including Vicki Davidson who just missed out on the Florence Nightingale Nurse of the Year

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Award. And Paul Wilkinson, one of our occupational therapists, who earlier this year was chosen from hundreds of other first-year OTs, to be part of a national team developing resources to support the wellbeing of newly qualified OTs. Paul was one of ten OTs who were selected nationally to form the project team which has now produced six pocket guides under the series title ‘Thriving not Surviving’ which are freely available at elizabethcasson.org.uk

Finally Ms Page said that over the last few weeks, when she has been out and about, she has been asking our nurses, midwives, doctors, allied health professionals, scientific teams, administrative and support staff what we can do as a trust to go some small way to recognising what they have achieved together. What lots of them have asked for is extra time to spend with family once winter is out of the way
So in recognition of all that they have done, and continue to do, everyone will receive an extra day’s annual leave which can be taken next year or, if colleagues already have lots of days to carry over, the following year. The choice will be theirs.

Resolution

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

BoD/20/157 **CQC UPDATE**

Mrs Angel, Interim Director of Clinical Development provided an update on the delivery of the CQC action plan. Members were reminded that the CQC visited the Trust in January 2019 and the Trust developed an action plan to deal with the requirements. Mrs Angel advised that good progress has been made on all areas for improvement within the action plan especially given that this is a particularly challenging year.

Members noted that there were 26 requirements which were assessed as ‘must do’ and currently there is only one off track. 11 are expected to deliver, 13 are ongoing and one has been fully embedded. 23 ‘should do’ requirements were assessed, 11 expected to deliver and 11 completed, one off track.

Mrs Angel commented that there was a need to move forward now with the action plan and focus on learning from all requirements placed upon us as a Trust and make sure that we embed those and that evidence is available across the trust and that we are compliant across the whole trust not just the area highlighted in the report.

Mrs Angel reported that staff training requirements are off track. Mitigation is in place and all data is being cleansed to

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ensure we have this input accurately into ESR.

With regard to patient consent a great deal of work has been undertaken. Guidance has now been received and a task and finish group has been established.

With regard to monitoring the action plan Mrs Angel reminded members that weekly huddles and 'confirm and challenge' meetings are taking place. This involves cross checking evidence, and assurance is provided to the Quality Assurance Committee and Senior Leadership Team through the operational assurance meetings. At ward level, the South Tees Accreditation process will provide oversight and assurance and at Centre level, Boards make sure they understand the areas they need to be complaint against and measure this.

Mrs Angel confirmed that the next steps on the journey include sharing good practie using the STAQC process and making sure that wards and departments can work towards this process.

Members noted that the Trust had recently held a 'confirm and challenge' meeting with the CQC on the IBAF. No concerns were raised and the Trust was congratulated on the response to COVID 19 and IPC. In addition the CQC undertook a deep dive using a Patient First assessment of ED at the Trust, the result of which is awaited.

Moving forward Mrs Angel noted that the focus is on leadership at all levels, making sure we have the right leadership throughout with clinical leadership at the heart of what we do and a focus on getting back to good and hopefully on to excellent.

The Chairman thanked Mrs Angel for her update and commented that the Trust has struggled with achieving the compliance levels with mandatory training and wondered what other Trusts do to ensure compliance.

Mrs Metcalf informed the Board that the Trust is looking to encourage staff to undertake their training in the first quarter of the year as some other trusts have done. It is likely however that rates will increase from April as full compliance with mandatory training will be a requirement for moving through pay bands for Agenda for Change staff.

Ms Shaher, Staff Side chair, pointed out that there are still inconsistencies in the time given to staff to complete mandatory training, and this needs looking at.

Mr Carter-Ferris commented that there had been a discussion at the Workforce Committee and there are some issues in the

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data which need to be explored further. He added that we need to make sure that staff are undertaking their mandatory training, but we also need to ensure the data is correct.

Resolution

The Trust Board of Directors NOTED the CQC update

BoD/20/158 **<u>SAFE STAFFING MONTHLY REPORT</u>**

Mrs Fowler reported that mandated levels of safe staffing have been maintained where possible within the RSU, Stroke, Oncology and Midwifery. COVID outbreaks and short notice unavailability have on occasions led to stretch staffing ratios. There have been no reported episodes for lack of supervisory co-ordinator shifts across ITU/GHDU and CICU. COVID cases in Critical Care have increased, requiring surge plans to be enacted and the return of former critical care staff to provide support. Emergency Department staffing requirements have increased due to a red ED pathway being opened.

Members noted that nurse staffing throughout October has generally matched the acuity, dependency and numbers of patients as new RNs took up post.

Ward managers' supervisory time remains a challenge and Clinical Matrons have begun to work a shift per week to support clinical areas.

Rapid recruitment of HCAs was undertaken at the end of October and a Care Support Worker Programme to bolster NHSP temporary workforce is planned for November. NHSE/I bids have been successful for Strand A and B funding with Strand C still to be finalised. 41 international nurses will arrive between September and January 2021.

Ms Reape commented that there is pressure on staff asked how the Trust is supporting staff during and at the end of a very difficult shift. Mrs Fowler responded to confirm that the psychology team are in and around ward areas to listen and support staff along with Freedom to Speak Up Champions. In addition the Trust has instigated Matrons working clinically in 1 shift per week since October.

Mr Ducker raised staffing levels in the critical care areas. Mrs Fowler advised that therapy compliance levels are being monitored.

Resolution

The Trust Board of Directors noted the update on staffing

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BoD/20/159 **<u>RESEARCH AND DEVELOPMENT UPDATE</u>**

Mr Baker, Research and Development Director attended and provided the Board with an update on the following:

- Development of the Durham Tees Valley Research Alliance (DVTRA)
- DTVRA strategy
- R&D Governance
- R&D Performance
- R&D COVID Response
- R&D Finance

Members noted that over the last 12 months the R&D department has made significant progress relating to its infrastructure, strategy, governance and finance. These changes will support a more robust and comprehensive research offering across the organisation and wider Tees Valley. High levels of performance have been maintained in both research delivery and research development. The R&D department has adapted well to the challenges of COVID, delivering a portfolio of COVID research as requested by the CMO / secretary of state for health.

Ms Reape commented that she had spent time with the team recently and it was clear that the work the team are undertaking and have managed to continue with through covid is a real success.

The Chairman thanked Mr Baker for his comprehensive report

Resolution

The Trust Board of Directors NOTED the update on R&D

BoD/20/160 **<u>FREEDOM TO SPEAK UP GUARDIANS REPORT</u>**

The Chairman welcomed Abbie Silivistris, Freedom to Speak up Guardian, who referred members to her report which set out an update of the work undertaken following the newly appointed Freedom to Speak Up Guardians commencing in post. The report outlines the future priorities of the team and the work carried out since the last report.

Members were reminded that due to changes in personnel a revised model was developed in June 2020 which culminated in the appointment of four new FTSU Guardians with a different reporting structure in place. Following the last update the Trust has employed four Freedom to Speak Up Guardians (equivalent to 2 whole time equivalents) with the model now falling under Ian Bennett's (Head of Patient Safety and Quality) portfolio.

The majority of work carried out so far has centred around promoting the new model. October was the 'National

Freedom to Speak Up Month' and was used as an opportunity to raise the profile further.

Ms Silivistris reported that 10 new FTSU contacts have been made, of which 3 have been closed down. This shows that the profile of Freedom to Speak Up has already increased and it is hoped these contacts will continue to increase over the coming months as the new model is further embedded.

Mr Carter-Ferris commented that the Guardians had attended the Workforce Committee recently and there had been a good discussion, with support being offered by the Committee Members should the Guardians need it.

Ms Reape commented that it was good to see the Guardians now in post and asked how it felt and whether the team were able to get to all areas of the Trust. Rick commented that the main area of focus has been on raising awareness and they have had the opportunity to visit most departments in James Cook, Redcar Hospital, Friarage, Friary, East Cleveland; visits to other areas were planned. Abi added that there were drop-in sessions scheduled. Members noted that the Guardians were linking in with other staff in the Trust including the Military Freedom to Speak up team, medical psychology team, and staff side.

Mrs Metcalf thanked Abi for attending and presenting the update. She mentioned that Abi had also attended the EDI Steering Group to link into to the networks.

Mr Harrison asked the Guardians what the Board can do to help them in their roles and they advised that they are keen to create a robust communication strategy and staff bulletins. It would also be helpful to have support in developing links with universities and newly recruited staff.

Mrs Fallon commented that in the first 7 weeks that the team have been in post in the new model there was a 60% increase in conversations and therefore the need was definitely there and illustrates a different approach that the team are taking in being visible and approachable.

The Chairman thanked the Guardians for attending and commented that it was good to see the new approach working and thanked the team for the update.

Resolution

The Board of Directors NOTED the Freedom to Speak Up report

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BoD/20/161 **FINANCE REPORT**

Mr Mason commented on the month 7 Finance report and members noted that the Trust is £0.5m underspend against its revised financial plan. The key drivers for this underspend are improved other income and COVID funding, as outlined further in the report. It is, however, anticipated that expenditure will increase during the winter months.

Mr Harrison asked Mr Mason about Medical and Dental staff pay which was showing an overspend and whether this was caused by historic overspends or underspends due to vacancies. Mr Mason advised that additional work is being carried out on this area.

Resolution

The Trust Board of Directors NOTED the Finance Report

BoD/20/162 **CAPITAL UPDATE**

Mr Mason referred members to his previously circulated report and members were reminded that the Trust is generally limited in the investments it can make because of the impact of the James Cook University Hospital's historic PFI scheme. As a consequence, the Trust relies on emergency capital from the Department of Health and Social Care (DHSC) support to fund investment. The Capital Plan for 2020/21 amounts to £45.6 million.

He advised that:

- The trust has a Capital Programme which stands at £45.6 million; and £25.4 million to spend in the remaining 5 months of the financial year;
- The Programme will be mainly financed through external support in the form of PDC amounting to £34.4 million;
- PDC awaiting approval amounts to £19.4 million.

Mr Mason also confirmed that the Trust has received the emergency bid for capital which was signed off by the Department of Health for £14m.

Resolution

The Board of Directors NOTED the update on Capital

BoD/20/163 **INTEGRATED PERFORMANCE REPORT**

Ms Reilly presented the integrated performance report and highlighted the key messages relating to performance this month:

- Last month grade 3 and 4 pressure ulcers were high and outside expected range.

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- Increased demand, higher acuity and reduced capacity have led to A and E compliance to continue to be below target.
- Implementation of recovery plans have seen RTT and diagnostic compliance continue to improve, although both are still below target.
- Cancer compliance against the 14 day standard: although referrals are still below pre-COVID levels, reduced capacity has limited throughput. The weekly cancer performance wall continues to identify pressures and themes.
- There has been significant deterioration in annual appraisal compliance due to COVID-19.
- The target of 4% for sickness and absence is currently not achievable.
- The Trust is £0.5m ahead of revised plans.

Mrs Fowler added that October had been an exceptional month with pressure ulcers category 3 and 4. She reassured the Board that there had been a discussion at the Quality Assurance Committee, and a full analysis paper with actions would be received by the Committee in December. Work had been taken forward immediately on working with social care colleagues, families and carers in their own homes, and looking at system approaches with the voluntary sector.

The Chairman asked how learning is share from those areas of the Trust where there is good practice in managing pressure ulcers and falls. Mrs Fowler confirmed that all staff providing care are now involved in the learning, and ward managers and staff are reporting at @safetyatsouthtees; and learning is starting to be shared through this route.

Ms Reape commented that ongoing work is required regarding pressure ulcers, as they are difficult and painful wounds for patients and we need to work with other partners to prevent them.

Ms Page commented that she spent a lot of time with community teams in the summer and came across some teams with high standards of pressure ulcer care and we need to be learning from each other. We do have areas of outstanding practice in our community services.

Mr Harrison commend on the challenges which continue with A&E performance, referring members to the winter plan and RTT position which is impacting on the amount of activity which can be undertaken.

Mr Harrison reported that the Trust is working across outpatients, making better use of the digital infrastructure and we are starting to see some improvements in diagnostic 6-week waits.

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Ms Reape discussed the vulnerable patients when the 4 hour standard is not met and asked for some assurance regarding this group of patients. Mr Harrison reminded members that Mrs Fowler had already commented on the staffing changes to meet the peak periods in ED to ensure that patients are not waiting longer than we would wish them to. He added that the delays tend to be waiting for a bed and the focus for the patients and staff whilst in ED would be on pressure care. Mrs Fowler added that ED undertake a process of intentional rounding and sepsis screening and she suggested that a report to QAC on these areas would be beneficial.

Dr Nag commented that medical assessment of patients in ED is not delayed: triage and care begin as soon as the ambulance hits ED, whilst patient may be on a trolley the assessment occurs on point of entry.

The Chairman asked that information relating to our comparison with other Trusts in terms of this target is included in future reports. Mr Harrison confirmed that this is possible and that we are currently meeting the rolling 6 week average and median in the north east.

Resolution

The Trust Board of Directors NOTED the integrated performance report

BoD/20/164 **<u>WINTER PREPAREDNESS UPDATE</u>**

Ms Reilly provided a verbal update to the Board with regard to the Trust's preparedness for winter. Members noted that the Trust is providing two pathways in ED: one for Covid 19 patients and one for non covid. Ms Reilly advised members that operating the two pathways for streaming means we are not clearing the department as quickly as we would ideally like, as we need to wait for covid results. She added that during wave 1 the footfall fell significantly in ED and we could manage better, but the number of attendances is higher now that in April. On 18 December the Trust will open its SDEC to stream patients who need extended assessment and don't need a bed, and that will cover both surgical and medical.

Ms Reilly reported that additional measures have been put in place to support the Trust with winter preparedness including extending the opening hours at Redcar Urgent Treatment Centre, introducing navigator roles at James Cook to divert patients to the right place, additional consultant medical staff and additional surge capacity for critical care with staff who have agreed to work in critical care and who have worked there before.

Resolution

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The Trust Board of Directors NOTED the update on winter preparedness

BoD/20/165 EU EXIT UPDATE

Mr Oxley referred members to the previously circulated report and reminded members that following the implementation of the European Union (Withdrawal Agreement) Act 2020 on 23rd January 2020 there was an 11 month implementation (transition) period during which time work is being undertaken to put arrangements in place for a full withdrawal.

Mr Oxley advised that this transition period is due to end at 11pm on 31st December 2020 and currently no formal deal has been agreed on future trade or other arrangements including freedom of movement

Members noted that the Trust has assessed its preparedness for EoTP against the seven key risks identified by the Department of Health and Social Care plus local risks identified internally. No major issues of concern have been noted at this time but this will be monitored via the Tactical Oversight Group in the period before and after EoTP.

Resolution

The Trust Board of Directors NOTED the update on EU Exit

BoD/20/166 COMMITTEE CHAIRS' REPORTS

The Chairman offered Chairs of Committees the opportunity to highlight any issues from the Board sub committees which have not already been discussed on the agenda.

Audit Committee – Mr Carter-Ferris advised that the Committee had received updates from Audit One on their Counter Fraud work, Internal and External Audit. The accounts for South Tees Hospitals Charity, South Tees Healthcare Management and the LLP were reviewed and given clean audits.

QAC – Ms Reape reported that the Committee received a report on by maternity services in response to the Embrace report.

Workforce – Mr Carter-Ferris reported that there had been a good discussion and information shared by the Freedom To Speak Up Guardians.

FIC – Mr Ducker reported that he was delighted to note the recent approval of the emergency capital bid, but the approval process makes it difficult to plan investment. He added that

the Committee had discussed some constitutional targets not being met which required more work on steps that are being taken to improve. Finally that the Committee were seeking further clarity on Medical pay.

BoD/20/167 **QUESTIONS FROM THE PUBLIC**

The Chairman offered the opportunity for questions from the public:

Mrs Auty raised an issue regarding the recovery plan for managing staffing levels in maternity. Mrs Fowler advised that the issues is regularly monitored and had decreased significantly in frequency over the last year.

Mrs Auty referring to the Safer Staffing report and noted that nothing was included for MSK. Mrs Fowler advised that not all teams are yet on EROSTER and these should be added once they are on.

Mr Holmes asked whether patient delays should be included in the integrated performance report. Mr Harrison advised that although not directly referred to as patient delays, KPIs such as referral to treatment times (RTT) and the percentage of patients being treated in 18 weeks, cancer waiting times and diagnostic waiting times all reflect delays in patient care.

The Chairman thanked members for attending the meeting and on behalf of the Board sent thanks and appreciation to everyone in the Trust working extremely hard over the year.

BoD/20/168 **DATE AND TIME OF NEXT MEETING**

The date of the next Public Trust Board meeting is Tuesday 2 February 2021

Signed: ………………………………………………………………………………….

Date: ………………………………………………………………………………………

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Board of Direction Action Log (meeting held in Public)

Date of Meeting	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
4.2.20	BoD/19/147	IMPROVEMENT PLAN	Improvement plan needed to be costed and robustly monitored	R Fallon	31.3.21	on hold due to Covid however it should be picked up as we go	open
2.6.20	BoD/20/053	PERFORMANCE REPORT	Mrs Fallon to support the Board to agree which KPIs it wishes to see and which will be monitored by a Board Committee.	R Fallon	31.12.20	All Committees with the exception of Workforce Committee have received their KPIs. Further work continues	open

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 February 2021			
Safe Staffing Report for September 2020 – Nursing, Midwifery and Allied Health Professionals (AHP)			**AGENDA ITEM: 9, ENC4**
Report Author and Job Title:	Eileen Aylott, Assistant Director of Nursing Education and Workforce	**Responsible Director:**	Deirdre, Director of Nursing and Quality
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report details nursing, midwifery and AHP staffing levels for the months of November and December 2020.		
Background	The requirement to publish nursing, midwifery and AHP staffing levels on a monthly basis is explicit and is one of the ten expectations specified by the National Quality Board (2013 and 2016).		
Assessment	Mandated levels of safe staffing have been monitored within the RSU, Stroke, Oncology and Midwifery. During November and December the number of patients requiring BIPAP/CPAP has increased significantly and staffing levels have been stretched ‘Black Beds’ – unfunded winter pressure beds remain open Ward 31 has seen increased nurse sensitive indicators around inpatient falls and regular monitoring and review of staffing levels to maintain patient safety is taking place Nursing and Midwifery Turnover is currently 7.15% Vacancy against the financial ledger is 4% /106wte against an increased budgeted WTE There have been two reported episodes for lack of a second co-ordinator on GHDU One on 16th November and a 4 hour period on 8th December. The risk to safe staffing remains from COVID self-isolation and sickness for all staff groups and increased COVID activity Close monitoring and agile actions will be required to mitigate risks.		
Recommendation	The Board of Directors are asked to note the content of this report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 5.1 Demographic changes, shifting cultural attitudes to careers, capacity and capability of staff combined with employment market factors resulting in critical workforce gaps in some clinical and non clinical services		

<table>
<tr><td rowspan="1">Legal and Equality and Diversity implications</td><td colspan="2">Care Quality Commission
NHS Improvement
NHS England</td></tr>
<tr><td rowspan="3">Strategic Objectives</td><td>Excellence in patient outcomes and experience ☒</td><td>Excellence in employee experience ☒</td></tr>
<tr><td>Drive operational performance ☐</td><td>Long term financial sustainability ☐</td></tr>
<tr><td>Develop clinical and commercial strategies ☐</td><td></td></tr>
</table>

Nursing, Midwifery and AHP Workforce Report

January 2021 based on November and December 2020 Data

Safe Staffing Governance

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

Staff redeployment has taken place to ensure patient safety with twice daily SafeCare meetings to address any immediate issues and robust plans for staffing oversight introduced to look forward to the week ahead on Monday's and the weekends on Friday with Associate Directors of Nursing and Clinical Matrons. All elements of safe staffing are discussed at the Workforce Assurance Group which meets three times weekly and are escalated to the Strategic Group as required.

Professional judgement planned staffing templates are reviewed monthly or if patient pathways change and are included in this report as planned versus actual. These are depicted as numbers of staff and are overlaid with occupied bed numbers and nurse sensitive indicators.

Critical Care and Emergency Department Staffing has been reviewed using a one week look back and a two week forward view to ensure patient safety. Redeployment of staff has taken place on a regular basis with 5000 hours logged via SafeCare with other staff members transferring to ITU roster to support the COVID response.

An SNCT data collection was undertaken in November and will be repeated in February to triangulate the Professional Judgement Templates in line with the rapid staffing review through COVID regional document agreed by the Directors of Nursing.

Midwifery and AHP staffing reviews have been included in this report provided by the Head of Midwifery and AHP Lead.

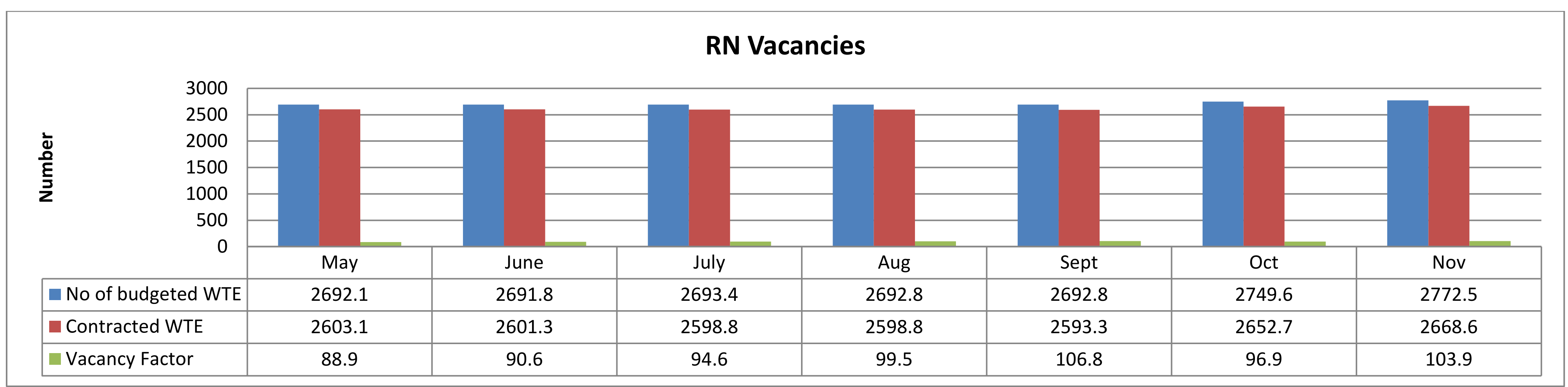
Staff COVID unavailability is reported daily via Allocate broken down by area and staff group. COVID vaccination programme began on 7th November and has increased in intensity throughout December, only closing for Christmas Eve, Christmas Day and Boxing Day.

Table 1 – Overall UNIFY fill Rate based on planned vs worked hours for November and December 2020

Overall Ward Fill Rate		November 2020	December 2020	
	RN/RMs (%) Average fill rate - DAYS	91.2%	91.1%	HCA % includes Registered Nursing Associates (Band 4), Assistant Practitioners (Band 4), Trainee Nursing Associates (Band 3) and HCA's Bands 2 and 3. Therapeutic Care Support Workers (TCSW Band 2) support wards on the JCUH site with enhanced observation for level 3 patients presenting with challenging behaviour.
	HCA (%) Average fill rate - DAYS	93.1%	96.2%	
	NA (%) Average fill rate - DAYS	100.0%	100.0%	
	TNA (%) Average fill rate - DAYS	100.0%	100.0%	
	RN/RMs (%) Average fill rate - NIGHTS	99.1%	99.3%	
	HCA (%) Average fill rate - NIGHTS	103.9%	101.7%	
	NA (%) Average fill rate - NIGHTS	100.0%	100.0%	
	TNA (%) Average fill rate - NIGHTS	100.0%	100.0%	
	Total % of Overall planned hours	**98.5%**	**98.5%**	

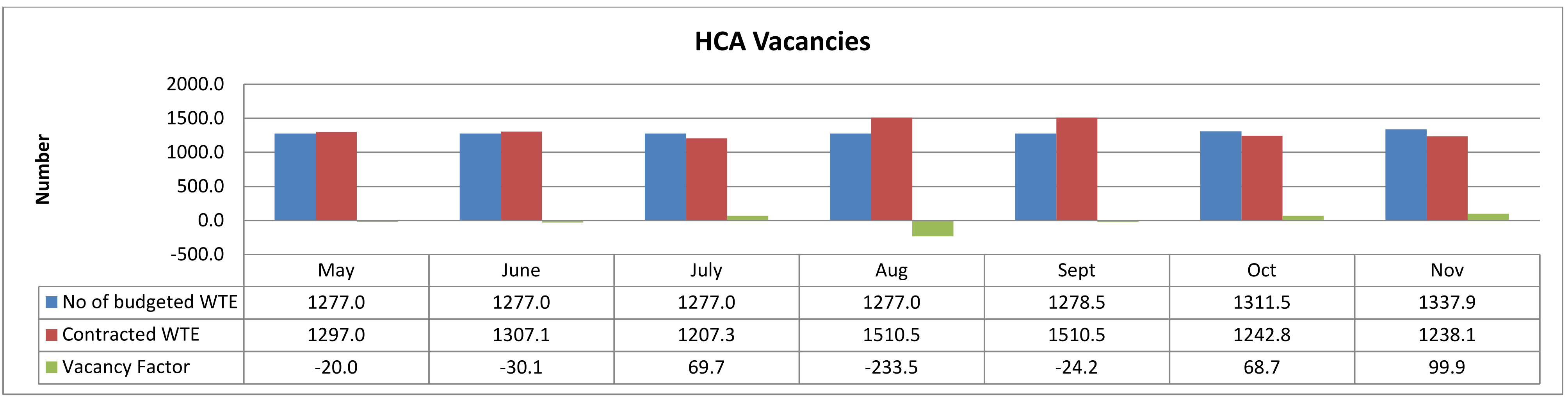
Vacancy and Turnover

The total current nursing and midwifery vacancy rate against the financial ledger for all nursing and midwifery is currently at 4% at the end of November 2020 this equates to 103.9 WTE. The latest publicised Care Hours per Patient Day (CHPPD) for Nursing, Midwifery and AHP on the Model Hospital was in October 2020 and was11.4 against a Peer of 9.1 and a National of 9.0.



	May	June	July	Aug	Sept	Oct	Nov
No of budgeted WTE	2692.1	2691.8	2693.4	2692.8	2692.8	2749.6	2772.5
Contracted WTE	2603.1	2601.3	2598.8	2598.8	2593.3	2652.7	2668.6
Vacancy Factor	88.9	90.6	94.6	99.5	106.8	96.9	103.9

HCA vacancy rates have risen due to an increase in budgeted number, partially due to the increased demand from Critical Care and the red and amber pathways in ED.



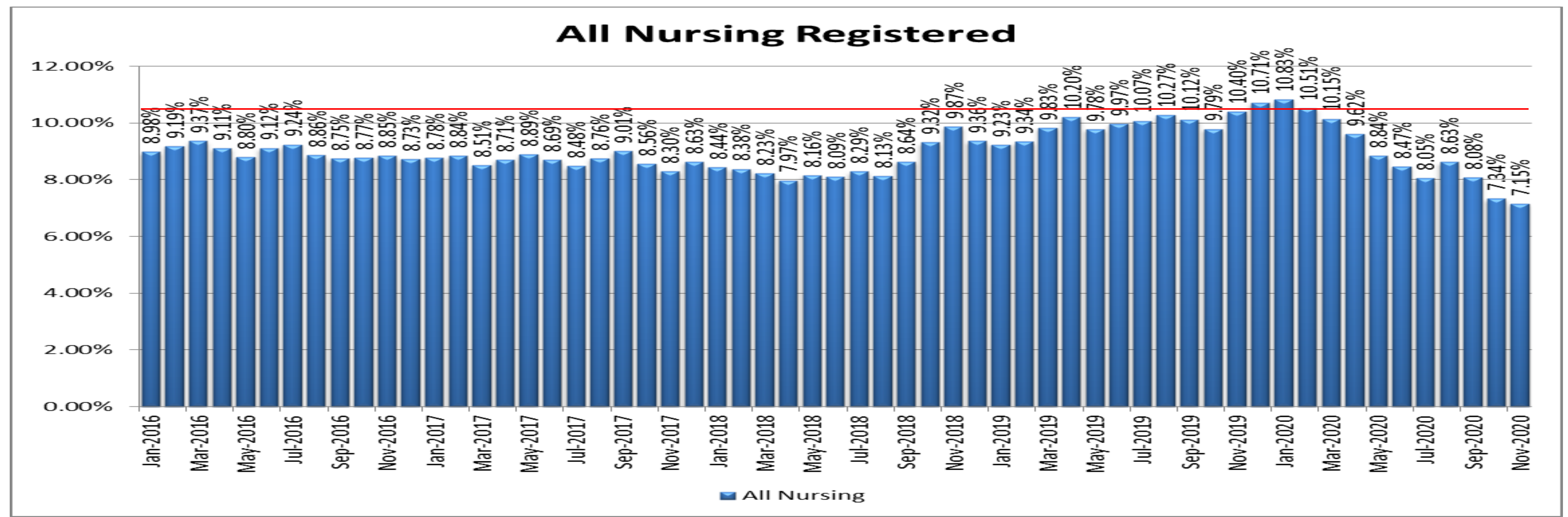
	May	June	July	Aug	Sept	Oct	Nov
No of budgeted WTE	1277.0	1277.0	1277.0	1277.0	1278.5	1311.5	1337.9
Contracted WTE	1297.0	1307.1	1207.3	1510.5	1510.5	1242.8	1238.1
Vacancy Factor	-20.0	-30.1	69.7	-233.5	-24.2	68.7	99.9

International recruitment continues with the successful Strand B funding approved to recruit 60 nurses by October 2021. Our September and October nurses are all now through their OSCE exams and in process of registering with the NMC. The new process takes up to 35 days which is adding a delay for the Trust. Help has been requested to expedite this process and the NMC have reopened the temporary COVID 19 register to support Trusts and future cohorts arriving over the next few months.

Sixty five newly qualified nurses will be taking up posts between January and March and 20 Nursing Associates/ Assistant Practitioners begin their conversion courses to transition to RN in January. Some will complete a full time 2 year programme whist others will work part time over an 18 month period. 20 HCA's will also commence a 4 year part time BSc apprenticeship in March.

Funding to support HCA recruitment has been made available to enable the Trust to reach a 0% vacancy rate by 31st March – rapid recruitment will begin shortly with pastoral support to on-board these groups.

Nursing and Midwifery Turnover for November has reduced to 7.15% which is significantly lower than the National average.

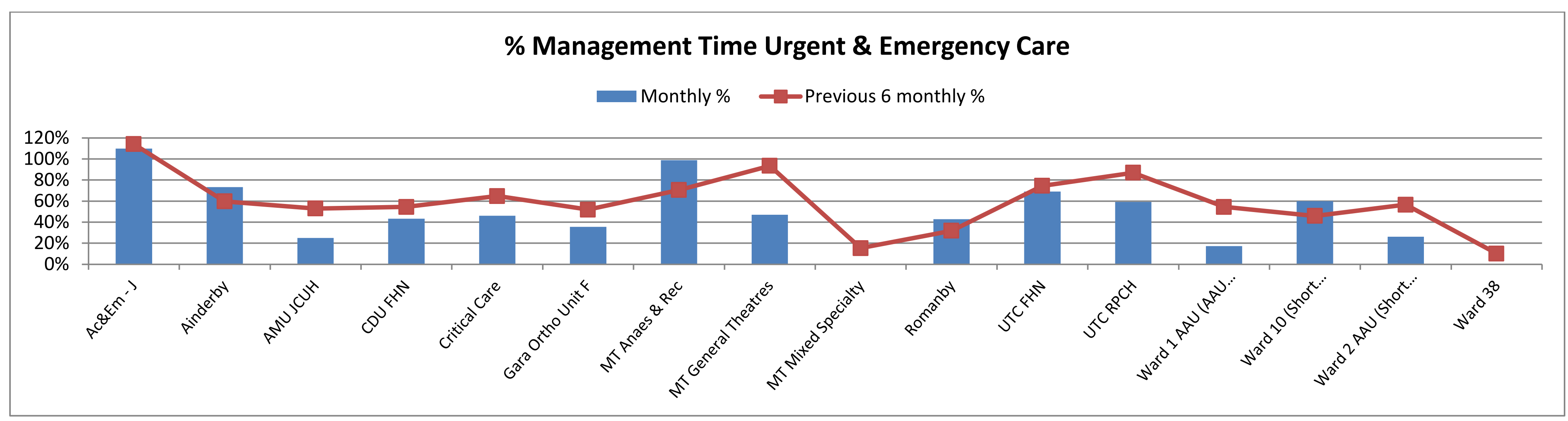


Urgent and Emergency Care Centre actual worked hours against planned and professional judgement template numbers for November and December 2020

	Bed Occ	Planned Day Nov	Worked Day	Planned N Nov	Worked N	Bed Occ	Planned Day Dec	Worked Day	Planned N Dec	Worked N
Critical Care	25	35 + 12	34 + 8	35 + 8	32 + 6	24	35 + 12	31 + 6	35 + 8	31 + 5
Critical Care Surge			2 + 1		1 + 1	4		2 + 1		1 + 1
RAFAU (On Ward 10)	19	3 + 2	4 + 4	2 + 2	3 + 3	18	3 + 2	3 + 3	2 + 2	2 + 3
Short Stay (On Ward 2)	13	4 + 4	4 + 3	3 + 3	3 + 3	16	4 + 4	4 + 3	3 + 3	3 + 3
AMU JCUH	18	5 + 4	5 + 3	5 + 4	5 + 3	18	5 + 4	5 + 3	5 + 4	5 + 3
AAU JCUH (On Ward 1)	12	5 + 3	7 + 4	4 + 3	5 + 3	11	5 + 3	7 + 4	4 + 3	4 + 3
CDU FHN	7	5 + 3	3 + 3	3 + 2	2 + 2	8	5 + 3	4 + 3	3 + 2	2 + 2
Ainderby FHN	16	4 + 3	3 + 3	2 + 2	2 + 2	18	4 + 3	3 + 4	2 + 2	2 + 2
Romanby FHN	11	4 + 3	3 + 4	2 + 2	2 + 2	14	4 + 3	3 + 3	2 + 2	2 + 2
Ac&Em -J	/	17 + 7	17 + 7	15 + 7	17 + 5	/	17 + 7	17 + 7	15 + 7	16 + 6

Nurse Sensitive Indicators November and December Data

	PU 2's	PU 3's	Medication Incidents	Patient Falls	Formal Complaints	Quality Impact
Critical Care	18 + 13 = 31	0 + 1 =1	3 + 3 = 6	0 + 1 = 1	1 + 1 = 2	Increased PU due to proning
RAFAU (On Ward 10)	0 + 2 = 2	0	4 + 4 = 8	5 + 2 = 7	1	
Short Stay (On Ward 2)	1	0	0	2 + 8 + 10	0	
AMU JCUH	2 + 1 = 3	1	6 + 6 = 12	11 + 3 = 14	0 + 1 = 1	
AAU JCUH	0	0	0	0	0	
CDU FHN	1	0	2 + 2 =4	0 + 4 = 4	0	
Ainderby FHN	2	0	2 + 2 = 4	2 + 7 = 9	0	
Romanby FHN	0	0	2 + 2 = 4	1 + 3 = 4	0	
Ac&Em -J	0 + 1 = 1	0	5 + 5 = 10	2 + 2 = 4	2 + 3 = 5	



Critical Care Staffing

Critical care staffing continues to be monitored on a daily basis with 2 supervisory co-ordinators required on each shift to support activity. There was one occasion where this number dropped to one on GHDU during both November and December.

Staff have returned to support staffing from across the trust and more recently theatres. A one week look back and two week look forwards is undertaken weekly to support the staffing requirements against patient need and capacity modelling.

Clinical Psychology are supporting staff and the health and wellbeing of staff is paramount. International nursing activity has been focused to support the increased critical care requirement.

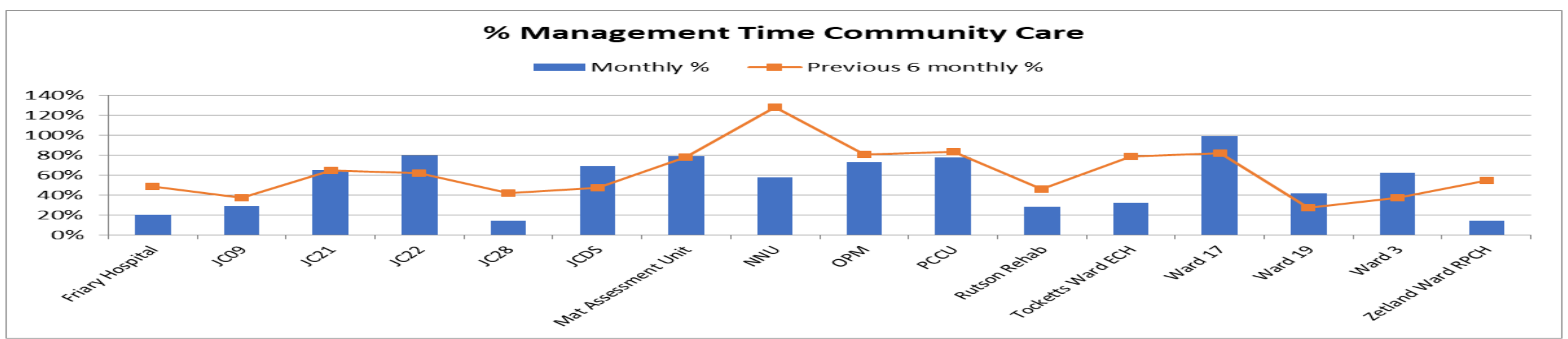
Community Care Centre actual worked hours against planned and professional judgement template numbers for November and December 2020

	Planned Day	Worked Day	Planned N	Worked N	Bed Occ	Planned Day	Worked Day	Planned N	Worked N	Bed Occ
Ward 3	4 + 5	4 + 4	3 + 3	3 + 3	20	4 + 5	4 + 5	3 + 3	3 + 3	19
JC09 (Ward 9)	5 + 4	5 + 3	4 + 3	3 + 3	21	5 + 4	5 + 4	4 + 3	4 + 3	21
Ward 11 (Older Persons Medicine OPM)	4 + 4	4 + 5	3 + 3	3 + 4	21	4 + 4	4 + 5	3 + 3	3 + 3	20
Rutson FHN	3 + 4	3 + 4	2 + 2	2 + 2	14	3 + 4	3 + 4	2 + 2	2 + 2	15
Tocketts Ward	4 + 5	3 + 5	3 + 4	3 + 4	20	4 + 5	3 + 5	3 + 4	2 + 3	18
Zetland Ward	4 + 8	4 + 6	4 + 3	3 + 4	13	4 + 8	4 + 6	4 + 3	3 + 3	15
Friary Community Hospital	3 + 4	2 + 3	2 + 1	2 + 2	9	3 + 4	2 + 2	2 + 1	2 + 1	5
Ward 21 – Paeds	5 + 2	5 + 2	5 + 2	5 + 2	11	5 + 2	5 + 3	5 + 2	5 + 2	10
Ward 22 – Paeds	5 + 2	3 + 1	3 + 1	3 + 1	5	5 + 2	3 + 1	3 + 1	3 + 1	5
Central Delivery Suite	10 + 2 M- F	10 + 2	11 + 2	10 + 2	5	10 + 2 M- F	10 + 2	11 + 2	10 + 2	6
Neonatal Unit	15 + 1	13 + 1	15 + 1	13 + 0	22	15 + 1	12 + 1	15 + 1	12 + 0	21
Paediatric Intensive Care Unit (PICU)	4 + 0	4 + 1	4 + 0	3 + 0	2	4 + 0	3 + 1	4 + 0	3 + 0	2
Ward 17 JCUH	6 + 2	6 + 3	4 + 2	4 + 3	23	6 + 2	6 + 3	4 + 2	4 + 2	20
Ward 19 Ante Natal	3 + 1	3 + 1	2 + 0	2 + 0	6	3 + 1	3 + 1	2 + 0	2 + 0	6
Maternity FHN	2 + 0	3 + 1	2 + 0	2 + 0	0	2 + 0	3 + 0	2 + 0	2 + 0	0
Mat Assessment Unit	4 +1	4 + 2	1 + 0	2 + 0	1	4 +1	4 + 2	1 + 0	2 + 0	1

Nurse sensitive indicators November and December

Wards	PU 2's	PU 3's	Medication Incidents	Patient Falls	Complaints	1000 voices	Quality Impacts
Ward 3	1 + 5 = 6	0	0	4 + 7 = 11	0	8.54	
JC09 (Ward 9)	3 + 1 = 4	0	2 + 2 = 4	2 + 4 = 6	2	9.03	
Ward 11 (Older Persons Medicine OPM)	1 + 2 = 3	0	3 + 4 = 7	1	2	9.24	
Rutson FHN	0	0	1 + 1 = 2	2 + 5 = 7	0	9.23	
Tocketts Ward	3 + 1 = 4	0	0	2 + 3 = 5	0	8.93	
Zetland Ward	0	0 + 1 = 1	1 + 1 = 2	3 + 4 =7	0 + 1 = 1	9.80	

Friary Community Hospital	0	0	0	1	0	8.50	
Ward 21 – Paeds	0	0	3 + 3 = 6	0	0	9.65	
Ward 22 – Paeds	0	0	1 + 1 = 2	0	0	9.32	
Central Delivery Suite	0	0	0	0	0 + 1 = 1		
Neonatal Unit	0	0	8 + 8 = 16	0	0	9.46	
Paediatric Intensive Care Unit (PICU)	0	0	0	0	0		
Ward 17 JCUH	0	0	0	0	0	9.25	
Ward 19 Ante Natal	0	0	0	0	0 + 2 = 2		
Maternity FHN	0	0	0	0	0		
Mat Assessment Unit	0	0	0	0	0		



Maternity

Maternity is facing a number of issues with recruitment and has a recruitment gap of 16.15 WTE (16%) Band 5 & 6 and 12.14 WTE (24%) Bands 2,3 and 4. This gap is in part due to the national shortage of midwives from insufficient numbers of midwives in training/qualifying and high levels of staff reaching retirement age. Newly qualified midwives have not been retained on qualification due to a number returning to their home localities out of area to work.

Work has been ongoing with Teesside University to ensure that a fair distribution of out of area home trust students is allocated and practice placements have been increased.

There has been high COVID sickness/unavailability, maternity leave and short term sickness which have caused some staffing pressures. An action plan is in place to mitigate the risks to service provision and minimise any risk to patients and are managed through clear escalation processes which include unit closures.

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

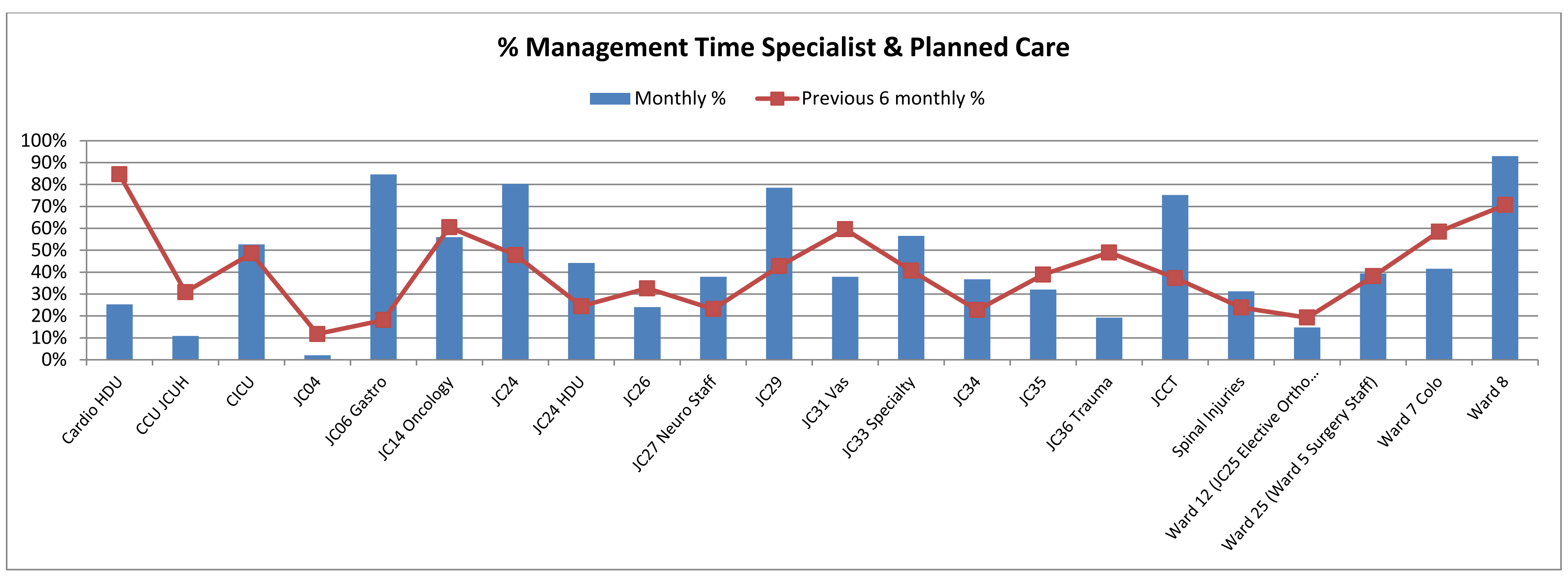
Wards	Planned Day Nov	Worked Day Nov	Planned N Nov	Worked N Nov	Bed occ	Planned Day Dec	Worked Day Dec	Planned N Dec	Worked N Dec	Bed occ
JC04 (Ward 4)	4 + 3	4 + 3	3 + 2	3 + 2	19	4 + 3	4 + 3	3 + 2	3 + 2	17
Ward 5 Surgery (on Ward 25)	3 + 4	4 + 3	3 + 3	2 + 2	6	3 + 4	2 + 2	3 + 3	2 + 2	14
JC06 Gastro	4 + 3	3 + 4	3 + 2	2 + 3	23	4 + 3	3 + 4	3 + 2	3 + 3	22
Ward 7 Colo	5 + 4	5 + 5	3 + 3	3 + 3	28	5 + 4	5 + 4	3 + 3	3 + 3	25
Ward 8	3 + 3	4 + 3	2 + 3	2 + 3	16	3 + 3	4 + 4	2 + 3	2 + 3	17
Ward 12 (Ward 25 Staff)	4 + 3	4 + 3	4 + 3	3 + 3	17	4 + 3	4 + 4	4 + 3	3 + 3	18
Ward 14	3 + 3	3 + 3	2 + 2	2 + 2	12	3 + 3	3 + 2	2 + 2	2 + 2	12
JC24 (Ward 24)	4 + 3	4 + 4	3 + 2	3 + 3	18	4 + 3	4 + 4	3 + 2	3 + 3	20
Neuro HDU	4 + 1	4 + 1	4 + 1	4 + 1	6	4 + 1	4 + 1	4 + 1	4 + 1	6
JC26 (Ward 26)	3 + 3	3 + 3	2 + 2	2 + 2	15	3 + 3	3 + 4	2 + 2	2 + 3	15
JC27 Neuro Staff	3 + 2	3 + 3	2 + 2	2 + 2	12	3 + 2	4 + 4	2 + 2	2 + 3	12
JC28 (Ward 28)	5 + 3	5 + 3	4 + 2	4 + 3	18	5 + 3	5 + 2	4 + 2	4 + 2	19
JC29 (Ward 29)	4 + 3	4 + 3	3 + 2	3 + 2	23	4 + 3	3 + 3	3 + 2	3 + 2	20
Cardio MB	2 + 1	2 + 1	2 + 0	2 + 0	6	2 + 1	2 + 1	2 + 0	2 + 0	5
JC31 Vas	3 + 3	5 + 4	2 + 2	3 + 3	23	3 + 3	4 + 4	2 + 2	3 + 3	20
JCCT (Ward 32)	4 + 3	4 + 3	3 + 2	2 + 2	18	4 + 3	5 + 3	3 + 2	2 + 2	18
JC33 Specialty	4 + 3	3 + 3	3 + 3	3 + 2	14	4 + 3	4 + 3	3 + 3	3 + 2	16
JC34 (Ward 34)	4 + 5	4 + 4	3 + 2	3 + 4	25	4 + 5	5 + 4	3 + 2	3 + 4	25
JC35 (Ward 35)	4 + 4	4 + 3	3 + 3	2 + 2	19	4 + 4	4 + 4	3 + 3	3 + 3	17
JC36 Trauma	5 + 4	5 + 5	3 + 3	3 + 4	28	5 + 4	5 + 4	3 + 3	3 + 3	28
Spinal Injuries	8 + 5	4 + 3	7 + 5	3 + 2	10	8 + 5	5 + 3	7 + 5	3 + 2	12
CCU JCUH	8 + 2	6 + 1	6 + 0	5 + 0	8	8 + 2	6 + 1	6 + 0	5 + 0	8

CICU JCUH	11 + 2	8 + 2	11 + 1	8 + 1	7	11 + 2	9 + 2	11 + 1	8 + 2	7
Cardio HDU	6 + 1	4 + 1	5 + 1	3 + 1	5	6 + 1	4 + 1	5 + 1	4 + 1	5
Gara Orthopaedic FHN	2 + 2	2 + 2	2 + 1	2 + 1	9	2 + 2	2 + 2	2 + 1	2 + 1	7

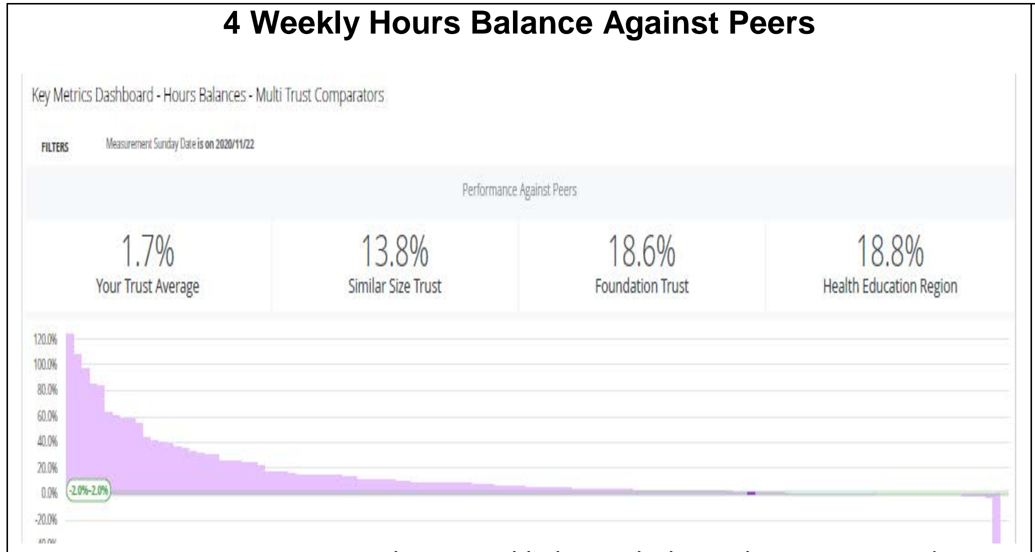
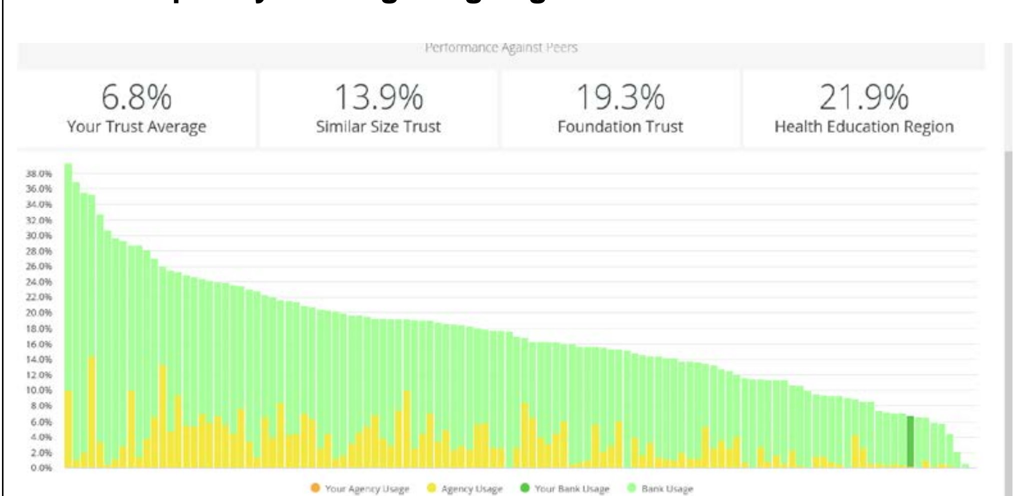
Nurse Sensitive Indicators November and December 2020

Wards	PU 2's	PU 3's	Medication Incidents	Falls	Complaints		Red Flags	Quality Impacts
JC04 (Ward 4)	5 + 4 = 9	0	0 + 4 = 4	1	0	9.05		
Ward 5 Surgery (on Ward 25)	1 + 3 = 4	0	2 + 2 = 4	3	0			
JC06 Gastro	1	0	2 + 2 = 4	6 + 2 = 8	1	8.28		
Ward 7 Colo	2	0 + 1 = 1	0	2 + 5 = 7	1	9.91		
Ward 8	1	0	1 + 1 = 2	9 + 6 = 15	0			
Ward 12 (Ward 25 Staff)	1 + 4 = 5	0	0	7 + 5 = 12	0	9.28		
Ward 14	0	0	1 + 1 = 2	1 + 3 = 4	1			
JC24 (Ward 24)	1 + 1 = 2	0	0	3 + 10 = 13	0	8.93		
Neuro HDU	0	0	0	0	0	9.42		
JC26 (Ward 26)	0 + 2 = 2	0	0	2 + 5 = 7	0	8.52		
JC27 Neuro Staff	2	0 + 1 = 1	1	1 + 3 = 4	0 + 1 = 1			
JC28 (Ward 28)	1 + 2 = 3	0 + 2 = 2	1 + 1 = 2	2 + 8 = 10	1	9.54		
JC29 (Ward 29)	1	0	1 + 1 = 2	2 + 7 = 9	1	8.96		
Cardio MB	0	0	0	0	0			
JC31 Vas	0 + 2 = 2	0	3 + 3 = 6	11 + 8 = 19	1	9.14	30	Extra beds have been opened
JCCT (Ward 32)	0	0	0	1	1	8.82		
JC33 Specialty	1	0	0	2 + 2 = 4	0	9.12		
JC34 (Ward 34)	2	0	5 + 5 = 10	8 + 5 + 13	0	9.07		

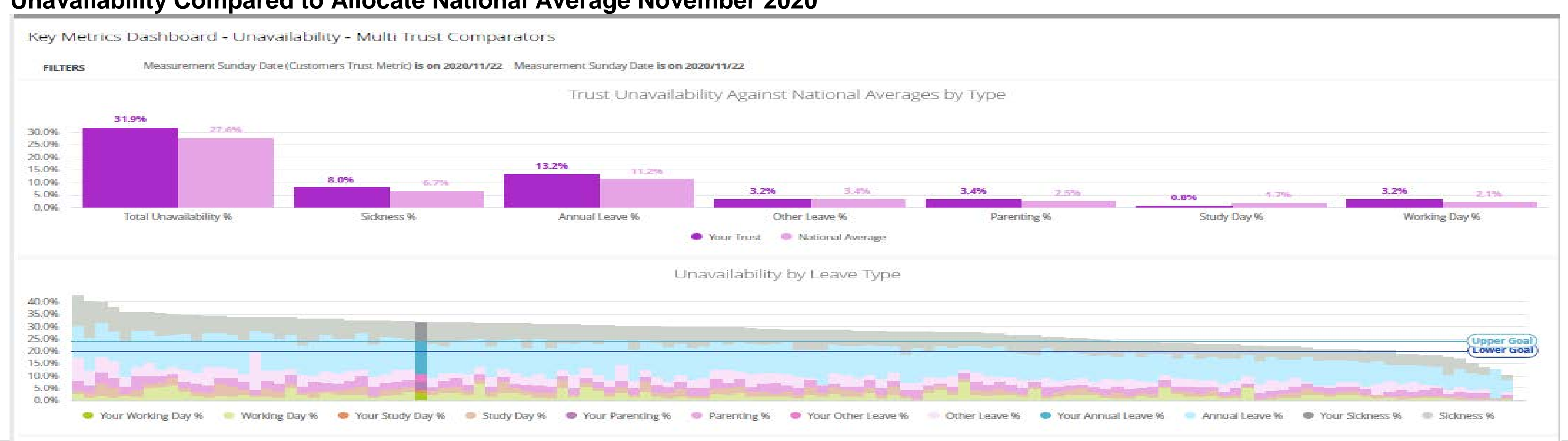
JC35 (Ward 35)	0 + 2 = 2	0	2 + 2 = 4	4	1	8.93		
JC36 Trauma	0	0	5 + 8 = 13	8 + 4 = 12	0 + 1 = 1	8.92		
Spinal Injuries	0 + 1 = 1	0	0	1	0 + 1 = 1			
CCU JCUH	0	0	1 + 1 = 2	2 + 1 = 3	0	9.69		
CICU JCUH	0	0	1 + 1 = 2	0	0	9.79		
Cardio HDU	0	0	3 + 3 = 6	0	0	9.47		
Gara Orthopaedic FHN	0	0	1 + 1 = 2	0	0	9.67		



Ward 31 have increased bed numbers into the previous SDU footprint Staffing numbers have been increased and require monitoring as nurse sensitive indicators have also shown an increase particularly around inpatient falls.

4 Weekly Hours Balance Against Peers	Temporary Staffing usage against other Allocate Peers
 Best practice is to maintain the 4 weekly hours balance between + and – 2%. This demonstrates good management of staff hours	 Although higher than norm al our temporary staffing remains well managed

Unavailability Compared to Allocate National Average November 2020

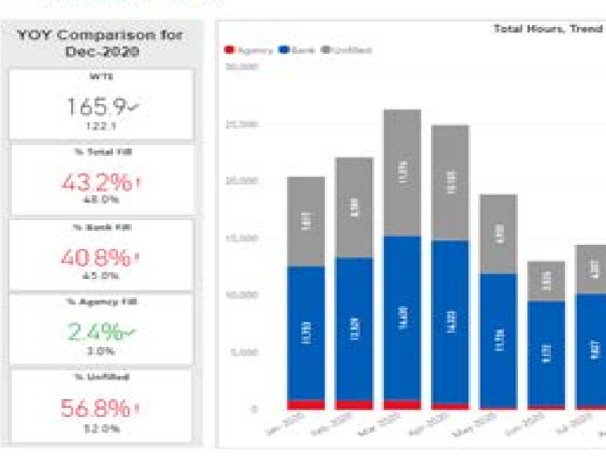


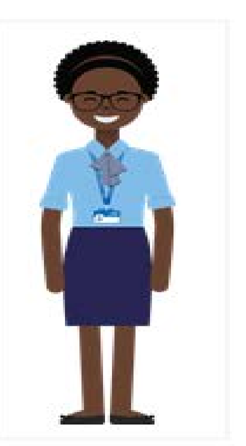
Overall unavailability of staff was 31% against standard Trust 21% headroom. Parenting leave is not included in the headroom. Sickness % remains slightly higher. Annual leave remains well managed at 13.2% against a 14% -16% KPI target.

N&M - Registered

Hours Performance

NHS Professionals





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4

The number of RN hrs worked in November was 15,075, the highest all year. Demand however was 27,000 hrs making the fill rate 57%

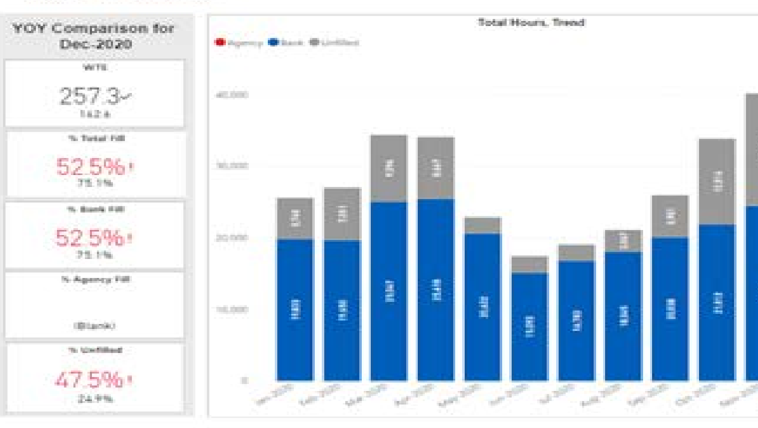
As per the National trend December saw a reduced number of hours filled at 10,900 hrs. Demand remained high resulting in a 43% fill rate.

550 -655 hrs of Agency was worked

N&M - Unregistered

Hours Performance

NHS Professionals



Demand: in Dec-2020 totalled 41,819 hours (4,775 shifts), a change of 4.7% on Nov-2020

Bank: in Dec-2020 totalled 21,946 hours (2,366 shifts), a change of -10.3% on Nov-2020

Unfilled: in Dec-2020 totalled 19,873 hours (2,409 shifts), a change of 26.6% on Nov-2020

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5

HCA worked hours increased in November to 24,600 but reduced back to 21,700 in December as per the National Trend.

There was no agency usage for HCA.

A programme has been running to recruit 27 new Care Support Workers who will be ready in January to work a minimum of 30hrs per week for 12 weeks to support Winter Pressures.

AHP Staffing report.

The following is a redacted AHP Unify report. Of note is that the JCUH has been better staffed than all other Therapy teams. This is in line with the demand for therapies for covid patients who are in need of oxygen therapy, the majority of whom are managed by this team. The service and professional leads meet three times a week to allocate appropriately skilled staff to the areas with the highest need whilst also ensuring that other organisational priorities including patient flow are accommodated.

Due to the prioritising of recruitment into nursing and healthcare assistant posts, there has been a delay in the recruitment into some of the professions including dietetics. The team has struggled to recruit into some of the specialist posts and is now planning to recruit into locum posts to enable them to provide safe care to patients. The teams are currently working on a priority list to ensure those in most need of care are provided with care.

AHPS		Total monthly planned staff hrs	Total monthly actual staff hrs	Total monthly planned staff hrs	Total monthly actual staff hrs	Average fill rate - Reg AHP (%)	Average fill rate - Non-AHP (%)
UEC	**UECC Therapists Critical Care - ICU**	1,304.50	1,088.00	157.50	135.00	83.4%	85.7%
UEC	**UECC Therapists Critical Care - Cardio**	764.50	546.50	157.50	97.50	71.5%	61.9%
UEC	UECC Therapists Front of House	2,307.50	1,509.75	743.50	479.00	65.4%	64.4%
UEC	UECC Therapists JCUH Inpatients	2,110.25	2,075.25	1,447.50	950.17	98.3%	65.6%
SP&PL	SPCT Acute Outpatients	4,063.50	2,966.60	345.00	282.00	73.0%	81.7%
SP&PL	**SPCT Acute Stroke**	1,170.00	738.75	637.50	447.00	63.1%	70.1%
SP&PL	SPCT H&R MSK & Outpatient Physiotherapy	1,985.00	1,172.75	0.00	0.00	59.1%	-
SP&PL	SPCT Neuro	2,451.50	1,669.50	1,307.25	650.75	68.1%	49.8%
SP&PL	**SPCT Spinal Injuries**	1,313.00	1,031.75	247.50	154.50	78.6%	62.4%
SP&PL	SPCT Tees MSK	727.50	506.75	0.00	0.00	69.7%	-
SP&PL	SPCT Trauma & Orthopaedics	3,254.00	1,900.25	2,354.50	936.25	58.4%	39.8%
COMM	Community Therapists Elderly	795.00	538.50	727.50	358.00	67.7%	49.2%
COMM	Community Therapists FHN Inpatients	1,005.00	636.83	885.00	526.75	63.4%	59.5%
COMM	**Community Therapists Stroke & RPCH**	3,022.50	1,849.00	1,590.00	1,057.00	61.2%	66.5%
COMM	Community Therapists Falls H&R	247.50	221.50	315.00	236.50	89.5%	75.1%
COMM	**Community Therapists Friary**	382.50	37.50	90.00	60.00	9.8%	66.7%
COMM	**Community Therapists Rutson**	670.00	520.40	285.00	186.75	77.7%	65.5%
COMM	Community Therapists South Tees	6,223.00	4,507.50	3,787.25	2,087.25	72.4%	55.1%
COMM	**Community Therapists ECPCH**	1,260.00	870.00	622.50	327.25	69.0%	52.6%
SP&PL	Speech & Language Therapy	2,232.78	1,626.75	315.00	69.08	72.9%	21.9%
SP&PL	Dietitians FHN	930.00	708.00	0.00	0.00	76.1%	-
SP&PL	Dietitians JCUH	3,365.50	2,483.33	0.00	0.00	73.8%	-
SP&PL	Dietitians Langbaurgh	1,837.50	695.08	0.00	0.00	37.8%	-
						67.8%	60.8%

Due to vacancies and sickness absences, some teams, including stroke remain short staffed. Staff continues to be moved daily in order to accommodate operational pressures. It has not been always possible to move staff out of the outpatients due to ongoing elective work and associated skill sets to work in areas with a high acuity level.

The critical care team will be recruiting more band 5 physiotherapy posts to assist with winter pressures. These posts will be recruited into on a permanent

basis and the service is confident that this will absorbed through staff turnover during the year. Consideration needs to be taken into account for all the other professions including dietetics and Speech and language therapy services which have not always been able to provide cover into critical care

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

<table>
<tr><td colspan="5">MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 February 2021</td></tr>
<tr><td colspan="4">Actual and Potential Deceased Organ Donation 1st April 2020- 30th Sept 2020 South Tees Hospital NHS Foundation Trust</td><td>AGENDA ITEM:10, ENC 5</td></tr>
<tr><td>Report Author and Job Title:</td><td>Janine Langthorne
Specialist Nurse Organ Donation
NHS Blood and Transplant</td><td colspan="2">Responsible Director:</td><td>Sath Nag Medical Director & Chair Trust Donation Committee Clinical Leads for Organ Donation Professor Stephen Bonner and Dr Steven Williams</td></tr>
<tr><td>Action Required</td><td colspan="4">Approve ☐ Discuss ☐ Inform ☒</td></tr>
<tr><td>Situation</td><td colspan="4">Actual and Potential Deceased Organ Donation</td></tr>
<tr><td>Background</td><td colspan="4">Six month report into Actual and Potential deceased donation activity 2020</td></tr>
<tr><td>Assessment</td><td colspan="4">Goal : Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplants Organ Donation Service.

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families.</td></tr>
<tr><td>Recommendation</td><td colspan="4">The Board of Directors are asked to note this report for information.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="4">There are no risk implications associated with this report.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="4">There are no legal or equality & diversity implications associated with this paper.</td></tr>
<tr><td rowspan="3">Strategic Objectives (highlight which Trust Strategic objective this report aims to support)</td><td colspan="2">Excellence in patient outcomes and experience ☒</td><td colspan="2">Excellence in employee experience ☒</td></tr>
<tr><td colspan="2">Drive operational performance ☒</td><td colspan="2">Long term financial sustainability ☐</td></tr>
<tr><td colspan="2">Develop clinical and commercial strategies ☐</td><td colspan="2"></td></tr>
</table>

Actual and Potential Deceased Organ Donation
1 April 2020 - 30 September 2020

South Tees Hospitals NHS Foundation Trust

Taking Organ Transplantation to 2020

In the first six months of 2020/21, from 12 consented donors the Trust facilitated 12 actual solid organ donors resulting in 35 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

Best quality of care in organ donation

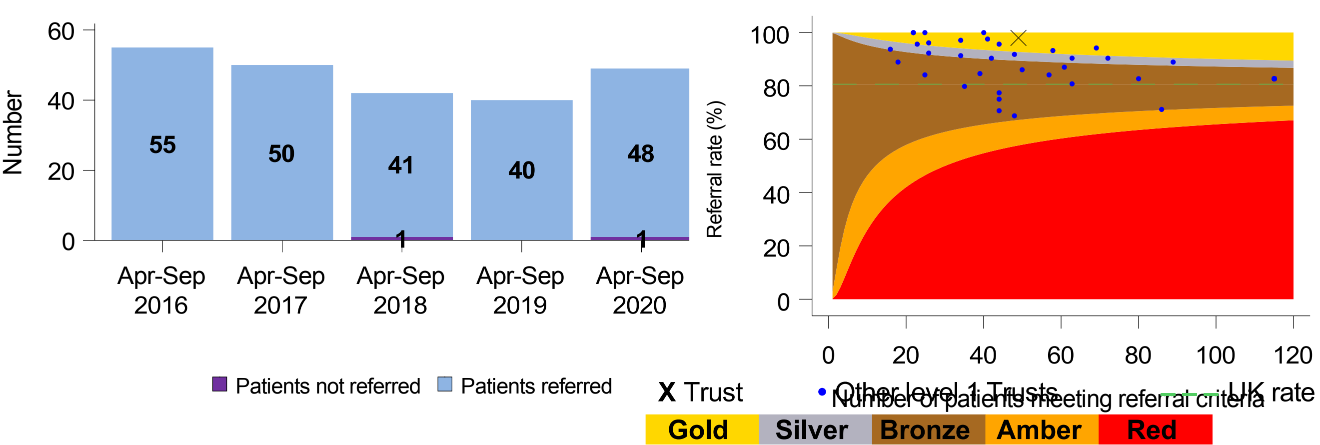
We acknowledge that the data presented in this section includes the period most significantly impacted by COVID-19 and appreciate that the COVID-19 pandemic affected Trusts/Boards differently across the UK.

Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart

Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



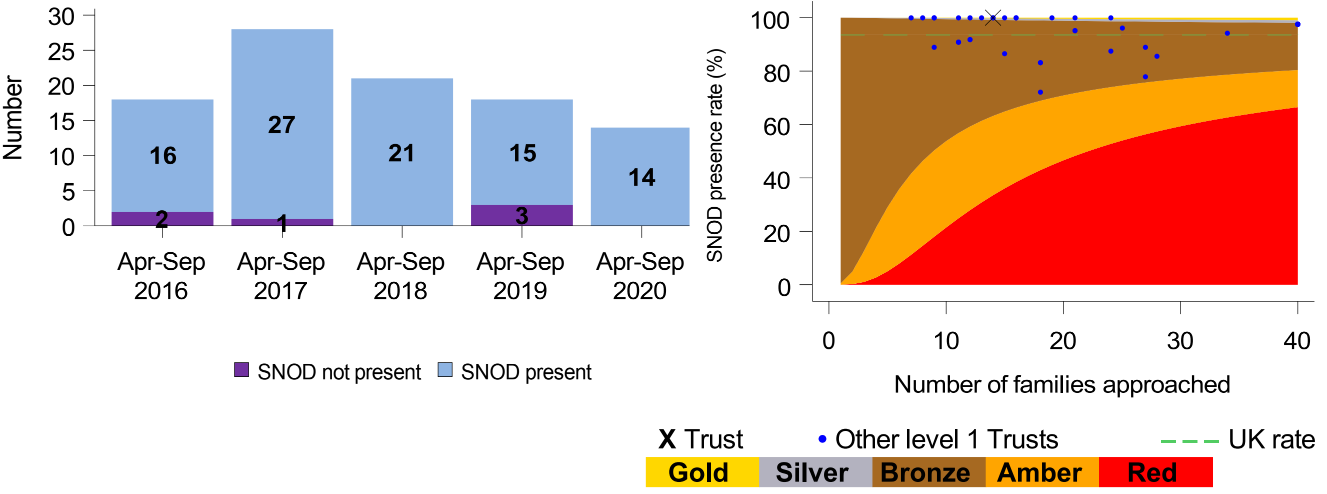
The Trust referred 48 potential organ donors during the first six months of 2020/21. There was 1 occasion where a potential organ donor was not referred.

Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart

Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 14 organ donation discussions with families during the first six months of 2020/21. There were no occasions where a SNOD was not present.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	North East*	UK
1 April 2020 - 30 September 2020		
Deceased donors	35	587
Transplants from deceased donors	71	1,498
Deaths on the transplant list	19	229
As at 30 September 2020		
Active transplant list	232	4,621
Number of NHS ODR opt-in registrations (% registered)**	1,030,580 (39%)	26,331,015 (40%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 2.62 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers, rates and comparison with UK data, 1 April 2020 - 30 September 2020

	DBD Trust	DBD UK	DCD Trust	DCD UK	Deceased donors Trust	Deceased donors UK
Patients meeting organ donation referral criteria[1]	16	895	35	2932	49	3695
Referred to Organ Donation Service	16	880	34	2221	48	2979
Referral rate %	G *100%*	*98%*	G *97%*	*76%*	G *98%*	*81%*
Neurological death tested	15	750				
Testing rate %	B *94%*	*84%*				
Eligible donors[2]	13	691	13	1587	26	2277
Family approached	11	605	3	477	14	1081
Family approached and SNOD present	11	591	3	421	14	1011
% of approaches where SNOD present	G *100%*	*98%*	G *100%*	*88%*	G *100%*	*94%*
Consent ascertained	9	453	3	300	12	752
Consent rate %	B *82%*	*75%*	G *100%*	*63%*	B *86%*	*70%*
Actual donors (PDA data)	9	406	3	183	12	588
% of consented donors that became actual donors	*100%*	*90%*	*100%*	*61%*	*100%*	*78%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold	Silver	Bronze	Amber	Red

For further information, including definitions, see the latest Potential Donor Audit report at www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 February 2021			
Ockenden Report into Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust- Maternity services assessment and assurance tool against the 7 Immediate and Essential Actions (IEAs).			**AGENDA ITEM:11, ENC 6**
Report Author and Job Title:	Yvonne Regan Quality Assurance Lead, Obstetrics and Gynaecology	**Responsible Director:**	Moira Angel Interim Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Following the publication of the Ockenden review at the beginning of December 2020, all Trusts were written to by NHSe/i on the 14 December 2020 asking for assurance on the quality and safety of maternity services. The Trust undertook a gap analysis against the 7 Immediate and Essential Actions (IEAs) of the Ockenden review and specifically the 12 urgent clinical priorities within these. This analysis has been undertaken as a multidisciplinary team led by the Clinical Director for Obstetrics, in conjunction with the Quality & Safety lead for maternity services and the Head of Midwifery. The gap analysis and evidence has also been reviewed by the Interim Director of Nursing and Midwifery (Executive Lead and Maternity Safety Champion) and Associate Medical Director for Quality and Safety through a confirm and challenge process. The analysis had also been considered and approved by the LMS, prior to being submitted to NHSe/i on the 21st December 2020. In which, the Chief Executive confirmed that the Trust is meeting these standards and have the relevant action plans in place for further improvement and mitigation. Subsequently, all maternity services were asked to complete an assessment and assurance tool to be submitted by 15.01.2021. This submission has since been delayed until 15.02.2021 and following a further confirm and challenge meeting which took place on the 14.01.2021, the Trust is on track to submit this.		
Background	In 2017 and independent review into maternity services at the Shrewsbury and Telford hospital NHS Trust was commissioned by NHSI following instruction from the Secretary of State. This was as a result of concerns raised by parents and families.		

<table>
<tr><td></td><td colspan="2">The initial terms of reference included 23 cases. This has been subsequently amended to include 1 862 maternity cases.

So far, 250 cases have been reviewed. The emerging 1st report was published on 10.12.2020</td></tr>
<tr><td>Assessment</td><td colspan="2">Maternity services have completed the assessment and assurance tool and a GAP analysis including the current evidence of compliance.

There are some identified gaps for national, regional and local implementation. However, there is adequate mitigation against these actions in place across the Trust until they can be fully implemented.</td></tr>
<tr><td>Recommendation</td><td colspan="2">Members of the Board are asked to

• Note the content of the report
• Receive assurance that the Trust is meeting these standards and have the relevant action plans in place for mitigation and further improvement
• Receive a further update one the assessment of assurance has been submitted in February 2021</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="2">All risks are logged on the risk register and aligned with the BAF under 2.3 and 2.5</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="2">There are no legal or equality & diversity implications associated with this paper.</td></tr>
<tr><td rowspan="3">Strategic Objectives</td><td>Excellence in patient outcomes and experience ☒</td><td>Excellence in employee experience ☐</td></tr>
<tr><td>Drive operational performance ☐</td><td>Long term financial sustainability ☐</td></tr>
<tr><td>Develop clinical and commercial strategies ☐</td><td></td></tr>
</table>

South Tees Hospitals
NHS Foundation Trust

Ockenden Report into Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust- Maternity services assessment and assurance tool against the 7 Immediate and Essential Actions (IEAs).

1. PURPOSE OF REPORT

The purpose of the report is to brief the Trust on the assessment of South Tees maternity services against the implementation of the 7 IEAs and the actions needed to be compliant.

2. BACKGROUND

In 2017 and independent review into maternity services at the Shrewsbury and Telford hospital NHS Trust was commissioned by NHSI following instruction from the Secretary of State. This was a result of concerns raised by parents and families. The initial terms of reference included 23 cases.

This has been subsequently amended to include 1 862 maternity cases. So far, 250 cases have been reviewed. The emerging 1st report was published on 10.12.2020 9appendix 1) with 7 IEAs to be implemented by 21.12.2020 (chairs letter- Appendix 2). This was assessed and evidenced by the maternity team and confirmation of completion of these actions was ratified by the DON/M and the Assistant Medical Director and also the Local Maternity System (LMS). This was submitted to the regional Chief Midwife on 21.12.2020.

Maternity Units have now been requested to complete an assurance and assessment tool by 15.02.2021. A portal is to be opened in February for Trusts to upload their evidential documents to support this assessment and assurance tool.

3. DETAILS

The completed self-assessment and assurance tool is included in Appendix 3 and the GAP analysis including the evidence to be uploaded onto the portal is in Appendix 4.
There are some identified gaps for national, regional and local implementation. However, there is adequate mitigation against these actions until they can be implemented. The actions are detailed in both documents.

4. RECOMMENDATIONS

The Quality Assurance Committee are asked to:

- Note the content of the report
- Receive assurance that the Trust is meeting these standards and have the relevant action plans in place for mitigation and further improvement

- Receive a further update one the assessment of assurance has been submitted in February 2021

APPENDICES

Appendix 1- Ockenden Review of Maternity Services

Appendix 2- Chairs letter re. 7 IEAs

Appendix 3- completed assessment and assurance tool

Appendix 4- GAP analysis against tool including evidence documents

OCKENDEN REPORT

Emerging Findings and Recommendations from the Independent Review of

MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Our First Report following 250 Clinical Reviews

10 December 2020

OCKENDEN REPORT

Return to an Address of the Honourable the House of Commons dated 10 December 2020 for

Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust

Our First Report following 250 Clinical Reviews

HC 1081

Ordered by the House of Commons to be printed on 10 December 2020

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Letter to the Secretary of State for Health and Social Care from Donna Ockenden

10 December 2020

Dear Secretary of State

I publish this emerging findings report at a time when the NHS is facing further challenging months ahead as a result of the Covid 19 pandemic. We are all aware that frontline NHS staff have, day after day, risen to these challenges, demonstrating their commitment to providing excellent care in what are often seen and described as the most difficult of circumstances.

Whilst this year, especially, has been about the pride our country has quite rightly in our NHS, this independent maternity review is about those families who have suffered harm as a result of their NHS care at a time when they had planned for a joyous event. Families have told us of their experiences of pregnancies ending with stillbirth, newborn brain damage and the deaths of both babies and mothers. These families have shared with us their accounts of the overwhelming pain and sadness that never leaves them.

We have met face to face with families who have suffered as a result of the loss of brothers and sisters or, from a young age, have also been carers to profoundly disabled siblings. We have met many parents where there have been breakdowns in relationships as a result of the strain of caring for a severely disabled child, the grief after the death of a baby or resultant complications following childbirth.

Following the review of 250 cases we want to bring to your attention actions which we believe need to be urgently implemented to improve the safety of maternity services at The Shrewsbury and Telford Hospital NHS Trust as well as learning that we recommend be shared and acted on by maternity services across England.

Your predecessor, the former Secretary of State Jeremy Hunt, requested an *'independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm at The Shrewsbury and Telford NHS Trust'*. When I started work as chair of this review, 23 cases had been identified after considerable efforts by the parents of Kate Stanton Davies and Pippa Griffiths who both died just after their births in 2009 and 2016, respectively. Since the review commenced, the number of families who have directly contacted my team, together with cases provided by the Trust for review, has now reached 1,862. When the review is completed, this is likely to be the largest number of clinical reviews conducted as part of an inquiry relating to a single service in the history of the NHS.

Understandably, examining the details of 1,862 cases is taking time and we continue to face many challenges which are out of our control, including adapting to new ways of working during the COVID19 pandemic.

Due to the significant increase in numbers, I was asked by the Minister of State for Mental Health, Suicide Prevention and Patient Safety to do my utmost to enable initial learning for The Shrewsbury and Telford Hospital NHS Trust and the wider NHS in this calendar year. Therefore, I publish this first emerging first report arising from the 250 cases reviewed to date. The number of cases considered so far include the original cohort of 23 cases.

My team and I have also held conversations with more than 800 families who have raised serious concerns about their care. These are in addition to the 250 cases considered in this

report and have also informed our findings in this report. We would like to pay tribute to all the families who have approached us to share their experiences.

We have identified a number of important themes which we believe must be shared across all maternity services as a matter of urgency. Therefore, with the full support of the Department of Health and Social Care and NHS England and Improvement we are sharing emerging findings and themes, have formed **Local Actions for Learning** and make early recommendations which we see as **Immediate and Essential Actions**. We appeal for these to be implemented at The Shrewsbury and Telford Hospital NHS Trust as soon as practically possible and recommend these for thorough consideration within all maternity units across England.

Secretary of State, through our work to date we have recognised a need for critical oversight of patient safety in maternity units. This oversight must be strengthened by increasing partnerships across trusts within local networks of neighbouring trusts. Neighbouring trusts and their maternity services **must** work together with immediate effect to ensure that local investigations into all serious incidents declared within their maternity services are subject to external oversight by trusts working together. This is essential to ensure that effective learning and impactful change to improve patient safety in maternity services can take effect using a system wide approach and in a timely manner.

We have no doubt that, had a similar structure of partnership working been in place, The Shrewsbury and Telford Hospital NHS Trust would have been alerted much earlier for the need to scrutinise its governance processes and learn from its serious incidents.

For this structure to be effective we have identified the need to give increased authority and accountability to Local Maternity Systems (LMS) to ensure safety and quality in the maternity services they represent. They must have knowledge of all serious maternity incidents within their LMS with input to and oversight of these investigations and their resultant outcomes and recommendations. Of significance is that we are convinced that an LMS cannot function effectively when limited to one maternity service only. We also consider it imperative that family voices are strongly and effectively represented in each LMS through the Maternity Voices Partnerships.

This is just one of seven **Immediate and Essential Actions** we outline in this first report. We will add to and strengthen these recommendations in our final report following completion of this review as per the terms of reference. We are certain that these **Local Actions for Learning** and **Immediate and Essential Actions** will improve safety in the maternity service at The Shrewsbury and Telford Hospital NHS Trust and across all maternity services in England provided that implementation is approached with urgency and determination.

Thank you Secretary of State for your ongoing support.

Yours sincerely,

Donna Ockenden
Chair of the Independent Maternity Review

Acknowledgements

This first report and the work that will follow owes its origins to Kate Stanton Davies and her parents Rhiannon Davies and Richard Stanton and to Pippa Griffiths and her parents Kayleigh and Colin Griffiths.

Kate's death in 2009 and Pippa's death in 2016 were avoidable. Their parents' unrelenting commitment to ensuring their daughters' lives were not lost in vain continues to be remarkable. In a void described by the families as 'incomprehensible pain', they undertook their own investigations to highlight the deaths of their newborn daughters, and to insist upon meaningful change in maternity services that would save other lives.

Rhiannon, Richard, Kayleigh and Colin persisted in their call for an independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust; through their tenacity and efforts this review was instigated.

We remain indebted to all the families contributing to this maternity review. Their experiences continue to shape the learning which will transform maternity care for the better. Finally, we convey our sincere gratitude to the many families who tried to raise serious concerns about maternity care and safety at the Trust who have told us they were not listened to.

Why This Report is Important

Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones.

The families who have contributed to this review want answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They are concerned by the perception that clinical teams have failed to learn lessons from serious events in the past.

The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future.

After reviewing 250 cases and listening to many more families, this first report identifies themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

CONTENTS

Letter to the Secretary of State for Health and Social Care iii

Acknowledgements v

Why this Report is Important vi

Explanation of Maternity specific terminology used in this report viii

Chapters:

1. Introduction 1
2. How we Approached this Review 4
3. Executive Oversight and External Reviews 7
4. Multidisciplinary Review: Our Findings following Review of 250 Cases 11

   Local Actions for Learning:
   Maternity Care 18
   Maternal Deaths 20
   Obstetric Anaesthesia 22
   Neonatal Services 24
5. Immediate and Essential Actions to Improve Care and Safety in Maternity Services 25

   Our ongoing Work 31

Appendices:

Appendix 1: Terms of Reference 32

Appendix 2: Glossary of Terms 36

Explanation of Maternity specific terminology used in this report

Throughout the text this report sometimes uses terms and words that may be unfamiliar to some readers. Although use of these are kept to a minimum, on occasions they are essential because this is a report about maternity services. These terms and words are highlighted in ***bold italics*** at the first use with further explanations for them found in the Glossary at the end of this report.

Chapter 1

Introduction

1.1 In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

1.2 The first terms of reference in 2017 were written for a review comprising 23 families. They were amended in November 2019 to encompass a much larger number of families. The current terms of reference can be found in Appendix 1.

1.3 Since the commencement of this review many more families have directly approached the review team, voicing similar concerns to those raised by the original cohort of 23 families. Intermittent publicity regarding the work of the review led to a continual increase in families wanting their stories and voices to be heard and their questions and concerns answered. Between June 2018 and the summer of 2020 a further 900 families directly contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. These included a number of maternal and baby deaths and many cases where babies suffered brain damage possibly as a result of events that took place around the time of their birth.

1.4 In addition, The Shrewsbury and Telford Hospital NHS Trust , supported by NHS Improvement and NHS England, undertook its own two-stage review of electronic and paper records of cases of ***stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3)*** and ***maternal deaths.*** Through these reviews, known as the 'Open Book', which first occurred in October 2018 as an electronic review and then in July 2020 with paper records included, the review team were notified by NHS Improvement and subsequently the Trust of over 750 cases of poor outcomes across these 4 categories in the period 2000 to the end of 2018. The review team were first able to make contact with these families in April and July 2020.

1.5 Direct contact from families together with the Trust's referrals led to us reporting in July 2020 that the review numbers had increased to encompass 1,862 families. We are aware that a number of families made multiple attempts, sometimes over many years to raise concerns with the Trust, but at this stage we are unable to say whether all of the poor outcomes reported to us occurred as a result of poor care.

1.6 It is likely that, when completed, this review of 1,862 families will be the largest number of clinical reviews undertaken relating to a single service, as part of an inquiry, in the history of the NHS. The majority of cases are from the years 2000 to 2019. However, where families contacted us directly with concerns preceding the year 2000, we agreed to review those cases where records exist as per the revised terms of reference. Throughout the review, the care and treatment provided and the quality of any internal reviews, investigations and learning undertaken by the Trust will be considered with reference to the guidance and standards of the day by experienced clinicians who were in clinical practice at the time.

1.7 It is important that we explore the experiences of staff working in the maternity units at The Shrewsbury and Telford Hospital NHS Trust. To do this we will scrutinise staff surveys where available and are working towards a process to hearing from staff directly. In addition we aim to examine past and current governance procedures within maternity services at the Trust that are applicable for the core period of this review.

1.8 To carry out a review of this size and to give each case the attention it deserves will take some time. It is important that expert clinicians lead the process, ensuring that each case is considered carefully and consistently using a standardised methodology. With the review now at 1,862 families, we anticipate a publication date for the second and final report in 2021.

1.9 To date, the review team have already identified emerging themes that should be addressed by the Trust and the wider maternity community across England as soon as possible. Therefore we have decided to publish this first report of important emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** for the Trust and the wider maternity system in advance of the completion of the final report, with the full support of NHS England and Improvement, the Department of Health and Social Care and the Secretary of State for Health and Social Care.

1.10 For this first report 250 cases were investigated which are drawn from the entire period of the review and include the original cohort of 23 families. We also refer to in depth conversations and contact with a further 800 families, but we are mindful that these cases have not yet been subject to systematic and independent review by our team.

1.11 Our first objective in publishing these emerging themes and findings and their corresponding **Local Actions for Learning** is to support the improvement work currently underway in the maternity services at the Trust. A second objective is to ensure that these emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** are carefully considered by all maternity services in England. We strongly believe we have identified a need for structural changes which, if implemented nationwide with our recommendations will reduce cases of harm to mothers and babies.

1.12 It is important to note that we would not have been able to identify these objectives without carefully considering the voices of families which underpin this report.

1.13 Over the years, many important recommendations from previous national maternity reviews[1 2 3] and local investigations which might have made a significant difference to the safety of mothers and babies receiving care at the Trust have either not been implemented or the implementation has failed to create the intended effect of improving maternity care. From this review of 250 cases we can confirm that we have identified missed opportunities to learn in order to prevent serious harm to mothers and babies. However, we are unable to comment any further on any individual family cases until the full review of all cases is completed.

1.14 Having listened to families we state that there must be an end to investigations, reviews and reports that do not lead to lasting meaningful change. This is our call to action. We expect to see real change and improved safety in maternity services as a result of

1 Northwick Park (2008) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1557922/ https://www2.harrow.gov.uk/documents/s30776/Maternity%20Review%20Report.pdf

2 Morecambe Bay (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

3 Saving Babies Lives (2019) https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

findings from these 250 case reviews and our resultant **Local Actions for Learning** and **Immediate and Essential Actions** whilst we continue to work towards completion of the full and final report.

1.15 Furthermore, we recommend that the **Immediate and Essential Actions** which we have identified should also inform the decision-making of those who lead maternity services at local, regional and national levels.

1.16 Everyone has a part to play. The Shrewsbury and Telford Hospital NHS Trust Board and local commissioners must urgently focus on expediting implementation of the **Local Actions for Learning** and **Immediate and Essential Actions** outlined within this first report. This will ensure that consistently safe maternity care is provided to its local population.

1.17 The NHS England and Improvement regional improvement team must ensure that they give appropriate support and oversight to the Trust. Regulators and professional bodies including the **Care Quality Commission**, The Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives, The Royal College of Anaesthetists and The Royal College of Paediatrics and Child Health must strengthen their collective efforts to work collaboratively to ensure rapid action and implementation of these **Local Actions for Learning** and **Immediate and Essential Actions** in order that they translate into safer maternity care across England. To do nothing is not an option.

1.18 Repeatedly, families have told us of two key wishes. Firstly, they want questions answered in order that they understand what happened during their maternity care. Secondly, they want the system to learn, so as to ensure that any identified failings from their care are not repeated at the Trust or occur at any other maternity service in England. The scale of this review has reinforced their perceptions that their cases were not thoroughly investigated and that there may have been missed opportunities for learning and change and thereby a failure to prevent future harm.

1.19 We owe it to the 1,862 families who are contributing to this review to bring about rapid, positive and sustainable change across the maternity service at The Shrewsbury and Telford Hospital NHS Trust. Implementation of the recommendations from this first report and the final report in 2021 will be their legacy.

Chapter 2:

How we approached this Review

What kind of clinical incident is this review considering?

2.1 This independent maternity review is focusing on all reported cases of maternal and neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.

2.2 In addition, a small number of earlier cases have emerged where families have raised significant concerns with the review team. These are being reviewed by the independent team wherever medical records are available from which it may then be possible to answer family questions. These earlier cases are those proactively reported to us by families, rather than systematically provided to us by the Trust. In all likelihood these are not the actual number of events. The earlier cases which occurred in the years immediately prior to 2000 are of importance to this review to establish whether there is evidence of embedded learning in subsequent cases.

2.3 The total number of families to be included in the final review and report is 1,862. The original plan was to publish one complete report, when the reviews of all the cases had been completed. However, as numbers of affected families continued to grow, in July 2020 it was agreed with the Minister of State for Mental Health, Suicide Prevention and Patient Safety, that early learning from the review of cases so far be shared with the Trust and the wider maternity services this calendar year. This has led us to publish this first report whilst our work continues towards completion of the remaining cases.

Methodology

2.4 For this first report the care that 250 mothers and their babies received has been reviewed as fully as possible on the evidence available. All clinical reviews have been undertaken by a team of independent expert clinicians. All review team members work outside the Trust and region and have no current or previous association with the Trust.

2.5 All reviews have been undertaken to date with benchmarking and consideration of the standards of care, policies and practice that would have been considered acceptable at the time the incident or concern occurred. The review team have had access to a range of local and national policies and guidance whilst undertaking their work. All the team members reviewing each case are experienced in clinical practice at the time the issue or incident of concern occurred.

2.6 The review team comprises obstetricians, midwives and neonatologists working collaboratively. Where specialist advice is required, for example in obstetric anaesthesia, maternal medicine, or other medical specialities such as adult cardiology or neurology, appropriate clinicians are available in the review team.

Listening to family voices

2.7 Family voices have been heard by the review team, either through face to face individual interviews held in Shrewsbury in a non-NHS location or via telephone or a

videoconferencing platform. Interviews are recorded electronically and typed up using a transcribing service of which a copy of the transcript is then shared with the family. There is a comprehensive support service available to all families in the review following initial assessment with a trained professional. The review team works in collaboration with SANDS, Child Bereavement UK and Bereavement Training International in offering this service. From early 2021 this will be extended to include support from the Midlands Partnership NHS Foundation Trust.

Listening to the views and voices of staff working at the Trust

2.8 Arrangements are under way to ensure that staff voices of current and former employees within the maternity and neonatal services at the Trust will be heard and carefully considered. We will review the information already available about staff views over the years from a number of sources, including staff surveys undertaken by the Care Quality Commission, the ***'Mat Neo' Collaborative***[4] and the NHS annual staff survey[5]. Following analysis of this information we will offer both former and current employees of the Trust the opportunity to speak with members of the review team in confidence.

Review of the Trust's maternity governance processes

2.9 The maternity review team has received a large volume of governance documentation from the Trust that is of importance and is of relevance to the review. It is now believed that the Trust have provided us with all the governance documentation that they have available that refers to the main time period under review. Findings following consideration of this documentation will be included in our final report.

2.10 For the governance documentation considered so far for this report the review team have found inconsistent governance processes for the reporting, investigation, learning and implementation of maternity-wide changes.

2.11 To date, the review team have also found inconsistent multiprofessional engagement with the investigations of maternity serious incidents at the Trust. There is evidence that when cases were reviewed the process was sometimes cursory. In some serious incident reports the findings and conclusions failed to identify the underlying failings in maternity care. The review team has also seen correspondence and documentation which often focussed on blaming the mothers rather than considering objectively the systems, structures and processes underpinning maternity services at the Trust.

2.12 Further, whilst the action plans and recommendations that the review team have seen so far provide some limited evidence of feedback to staff, we have found clear examples of failure to learn lessons and implement changes in practice. This is notable in the selection of, or advice around, place of birth for mothers, the management of labour overall, the injudicious use of oxytocin, the failure to escalate concerns in care to senior levels when problems became apparent, with continuing errors in the assessment of fetal wellbeing.

2.13 This indicates that opportunities for valuable learning to improve care and the prevention of similar occurrences in the future were lost. The frequency with which particular issues have re-occurred, even within the limited group of cases reviewed so far, is entirely consistent with that conclusion. In the sections below we have provided anonymised

4 https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/

5 From 2003 to 2019 and provided by the Trust to the review team 10.11.20

vignettes of some of the mothers' and babies' stories; these are illustrative of the types of incidents which have occurred, and which might have been avoided had lessons been learned from previous events and changes in practice been implemented accordingly.

2.14 Within the 250 cases reviewed to date, we have also found that a number of the earlier cases of significant concern were not investigated at the time, although this appears to improve over the period under review. The Trust underwent external review and scrutiny by the CQC in 2015, 2018 and 2020[6], and by The Royal College of Obstetricians and Gynaecologists (RCOG)[7] in 2017. However, even within this later timeframe, there is evidence that some serious incidents were not investigated using a systematic and multiprofessional approach, and evidence is lacking that lessons were learned and applied in practice to improve care.

6 https://www.cqc.org.uk/sites/default/files/new_reports/AAAA3868.pdf CQC report 2015

7 https://www.rcog.org.uk/en/news/statement-regarding-an-invited-review-by-royal-college-of-obstetricians-and-gynaecologists-rcog-into-maternity-services-at-shrewsbury-and-telford-hospital-nhs-Trust/

Chapter 3

Trust Board oversight and External Reviews

3.1 As we have progressed with this review a number of apparent themes have emerged in the 250 cases and family interviews considered to date. These themes will be further scrutinised as we review the remaining cases, but the following are noted by the maternity review team at this early stage:

Turnover of Executive leadership at The Shrewsbury and Telford Hospital NHS Trust impacting organisational knowledge and memory

3.2 We understand from documents supplied to us by the Trust that there have been ten Chief Executive Officers (CEOs) from 2000 to early 2020, with eight in post between 2010 and the current day. Four of those eight were employed as interim CEOs[8]. Since 2000 there have been ten Executive Board Chairs. There has also been considerable Board level turnover amongst both Executive and Non-Executive Directors since the year 2000.

3.3 We have concluded that, it is probable that this lack of continuity at Board level has resulted in a loss of organisational memory. As new CEOs started at the Trust there was a tendency, until at least 2019, to regard problems at the Trust as *'historical'* or as a *'legacy'* from previous years. Indeed, one of the groups of cases of potentially significant concern submitted to the review team by the Trust, ranging from between 1998 and 2017 and therefore, includes some relatively recent cases, was titled *'The Legacy'* cohort by the Trust.

What the Care Quality Commission (CQC) said about the Trust

CQC Reports

3.4 The CQC reports in 2015[9], 2018[10] and 2020[11] vary considerably. We note that the two later reports are critical of leadership at the Trust. The 2015 CQC report graded the maternity and gynaecology services *'good'* across all five domains of safe, effective, caring, responsive and well led, with an overall rating of *'good'*. (CQC 2015, page 21). Oswestry, Ludlow and Bridgnorth Midwifery Led Units (MLUs) were also rated *'good'* across all 5 domains. The 2015 report noted that *'The Trust had recently opened the new Shropshire Women and Children's Centre at the Princess Royal [hospital] site. This had seen all consultant led maternity services and inpatient paediatrics move across from the Royal Shrewsbury [hospital] site. We found that this had had a positive impact on these services.'* (CQC 2015, page 2)

The CQC reports in 2018 and 2020

3.5 We note that in the 2018 and 2020 reports the Trust's overall rating of the domain *'well led'* was *'inadequate'*. The 2020 report states that there is a lack of stability in the Executive team. Overall, the CQC told the Trust they must *'ensure that there are effective governance systems and processes in place to effectively assess, monitor and improve the quality and safety of services'.* (CQC 2020, page 6).

8 'Who's Who at the Trust – internal document – received by the review team 9th September 2020

9 https://www.cqc.org.uk/sites/default/files/new_reports/AAAA3868.pdf CQC report January 2015

10 https://www.cqc.org.uk/provider/RXW CQC report 29th November 2018

11 https://www.cqc.org.uk/provider/RXW CQC report January 2020

3.6 In respect of maternity services at the Princess Royal Hospital, the CQC advised that the Trust must:

- *Ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults*
- *Ensure high risk women are reviewed in the appropriate environment by the correct member of staff*
- *Ensure grading of incidents reflects the level of harm, to make sure the duty of candour is carried out as soon as reasonably practical*
- *Ensure all women receive one to one care when in established labour* (CQC 2020, page 8)

The review team will further consider these CQC reports of the maternity service and the Trust's responses to them in its final report.

MBRRACE (Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries)

Overview of MBRRACE reports: perinatal mortality rates at the Trust 2013-2017

3.7 Stillbirths, neonatal deaths and perinatal mortality rates for the UK are published by MBRRACE-UK in Perinatal Mortality Surveillance Reports[12]. These reports publish stabilised and adjusted mortality rates to adjust for chance variation due to small numbers and for key factors known to increase the risk of perinatal mortality such as mother's age, socio-economic deprivation, baby's ethnicity, baby's sex, multiple births and gestational age at birth (for neonatal deaths only).

3.8 MBRRACE issues individual reports to NHS Trusts indicating the local perinatal mortality rates. These Trust-specific reports recommend that Trusts should review existing records regarding the deaths to ensure any avoidable factors have been identified and appropriate changes to care have been implemented.

3.9 MBRRACE reports show that for the years 2013-2016 stabilised and adjusted extended perinatal mortality rates at The Shrewsbury and Telford Hospital NHS Trust were up to or more than 10% higher than comparable UK NHS Trusts. For the year 2017 stabilised and adjusted extended perinatal mortality rates at The Shrewsbury and Telford Hospital NHS Trust were reported as up to 5% higher or up to 5% lower than the UK average (suggesting roughly comparable rates with other UK Trusts). Perinatal mortality rates for 2018 were not published at the time of writing this report.

Clinical Commissioning Group (CCG) oversight of the Trust

3.10 There are two CCGs in the local area, Telford and Wrekin CCG and Shropshire CCG. They were formally established in April 2013 and from 2019 have engaged in *'bringing their decision-making processes closer together'*[13].

12 https://www.npeu.ox.ac.uk/mbrrace-uk/reports

13 https://www.healthwatchtelfordandwrekin.co.uk/news/new-board-members-join-shropshire-ccg-and-telford-and-wrekin-ccg/

3.11 The Maternity review team will have the opportunity to consider a range of maternity specific documentation from the two CCGs. As commissioners, the interactions with the Trust and the CCGs and the ***Primary Care Trusts (PCTs)*** before them, will provide valuable insight into the local external oversight the Trust's maternity services received during the timespan of the maternity review.

3.12 We note that during the inaugural Telford and Wrekin CCG Board meeting in April 2013[14] there appeared to have been some concerns raised about maternity services at the Trust, leading to the CCG intending to write to the Trust *'with regards to concerns with Midwifery numbers.'* (page 4).

3.13 In June 2013 the Telford and Wrekin CCG Quality and Safety report[15] describes that, following concerns raised by both CCGs, a 'Risk Summit' led by the NHS England Area Team had been held in May 2013. Concerns specific to maternity services were: *'Maternity services model and the number of SIs reported (in particular 1 high profile case and coroner's inquest and a 2nd SI...'* (page 5). In July 2013 a CCG led review of maternity services at the Trust[16] was commenced with the stated *'Lack of improvement in maternity services'* recorded as a 'risk' as follows:

'Risk 3 - Lack of Improvement in Maternity Services
External review of maternity services across the local health economy has now formally commenced and will report to Boards by September 2013.' (page 4)

3.14 The resulting report[17] published jointly by both CCGs in October 2013 will be considered more fully in the final report, as will further documentation received from the CCGs.

The role of the Local Supervisory Authority and statutory supervision of midwives at the Trust

3.15 Prior to its demise in 2017 the purpose of statutory supervision of midwives was to protect the public by ensuring a safe standard of midwifery practice through enhanced quality and safety.

3.16 As a consequence of family complaints there were a number of independent reviews commissioned into the quality of supervisory investigations undertaken by supervisors of midwives at the Trust. The review team will continue to consider all available supervisory governance documentation relating to any individual cases in this maternity review.

14 See Telford and Wrekin CCG, Minutes of Governing Board Meeting 090413 –page 4 https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/may-3/444-03-ccg-board-minutes-9th-april-2013-v1/file

15 https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/june-3/542-10-5-twccg-board-quality-and-safety-june-2013-report/file

16 https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2013/july-3/585-11-3-ccg-board-quality-and-safety-report-9th-july-2013/file

17 https://shropshireccg.nhs.uk/media/1197/maternity-services-review-msr-report-281013.pdf

Review of Maternity Services 2007- 2017

3.17 In June 2017 the Trust conducted an internal review of maternity services[18]. It considered the history of maternity services between 2007 and 2017, focussing on issues of patient safety, learning, and engagement with bereaved parents. The report concluded that '*all patient safety actions should be in one plan against a framework that makes sense to the staff that run the service.*' The report further stated that the service must '*create a coordinated approach to the maternity safety improvement plan*' and that '*safety in maternity is protected by the efforts of the staff and supported by leaders.*' (2017, page 28.)

18 https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

Chapter 4

Multidisciplinary Review: Our findings following review of 250 cases

Midwifery and Obstetric issues identified in the review of 250 cases at the Trust

The roles of midwives and obstetricians in the multidisciplinary maternity team

4.1 Midwives and obstetricians work closely together providing maternity care. Midwives are specialists in the provision of normal pregnancy care throughout the pregnancy pathway. Obstetricians are the lead clinicians providing care for complex pregnancies and births in an obstetric unit working in collaboration with midwives and other health care professionals including obstetric anaesthetists. The following is a reflection of emerging themes identified from the 250 cases reviewed to date by the independent review team.

4.2 The midwifery and obstetric issues identified from these cases are merged for the purposes of this report, which recognises the close working relationship that is required between midwives and obstetricians for the benefit of mothers and babies within their collective care.

Compassion and kindness

4.3 One of the most disappointing and deeply worrying themes that has emerged is the reported lack of kindness and compassion from some members of the maternity team at the Trust. Healthcare professionals are in a privileged position caring for women and their families at a pivotal time in their lives. Many of the cases reviewed have tragic outcomes where kindness and compassion is even more essential. The fact that this has found to be lacking on many occasions is unacceptable and deeply concerning.

4.4 Evidence for this theme was found in the women's medical records, in documentation provided by the Trust and families, in letters sent to families by the Trust and from through the families' voices heard through the interviews with the review team. Inappropriate language had been used at times causing distress. There have been cases where women were blamed for their loss and this further compounded their grief. There have also been cases where women and their families raised concerns about their care and were dismissed or not listened to at all.

4.5 *Follow up letter sent after discharge which states: 'If you would like to come and have a chat with me about the death of your baby…' There were no words of condolences or sympathy within the body of the letter. (2001)*

4.6 *A woman was in agony but told that it was 'nothing'; staff were dismissive and made her feel 'pathetic'. This was further compounded by the obstetrician using flippant and abrupt language and calling her 'lazy' at one point. (2011)*

4.7 *A woman was in great pain after delivery and left screaming for hours before it was identified that there were problems that needed intervention. The attitude of some of the midwives also made the situation worse. (2013)*

4.8 There are several examples from the cases reviewed to date indicating that minimal learning has occurred and that this lack of compassion and kindness has persisted. There are some examples of midwives and doctors who have made a huge difference to the women and families due to the care they provided and kindness they showed. However, kind and compassionate care is something that every woman, baby and family deserve and should expect from all midwives, doctors and members of the maternity team.

Place of birth: Assessment of risk

4.9 At the booking appointment all women should have a risk assessment to decide on the most appropriate place of birth. This can be at home, a midwifery led unit or an obstetric-led unit. Once the decision on place of birth has been made, there should be a risk assessment at each antenatal appointment to ensure the decision remains appropriate. In many cases reviewed there appears to have been little or no discussion and limited evidence of joint decision making and informed consent concerning place of birth. There is evidence from interviews with women and their families, that it was not explained to them in case of a complication during childbirth, what the anticipated transfer time to the obstetric-led unit might be.

4.10 *A woman was considered appropriate for birth in a remote stand-alone birth centre despite developing known risk factors in the weeks leading up to her delivery. There were then errors in the fetal monitoring in labour. After birth the baby was not monitored appropriately despite clear warning signs, and was transferred, too late, to a specialist unit where the baby died. (2009)*

4.11 *A woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in a very poor condition having suffered a brain injury. The baby subsequently died. (2016)*

4.12 *A woman who delivered in a stand alone birth centre suffered a catastrophic haemorrhage requiring transfer to the consultant unit, where she died. Her family stated that there had not been an explanation of the risks of birth in a midwifery led unit, nor information on the need for transfer if complications arose. (2017)*

Clinical care and competency: management of the complex woman

4.13 At the point of registration a midwife will have achieved competency in the required academic and clinical subject areas and therefore qualify for entry to the Nursing and Midwifery Council register. In a significant number of cases the review team found evidence that the clinical care and decision making of the midwives did not demonstrate the appropriate level of competence, with consequences for the mothers and babies in their care. One aspect is failure to recognise deviation from the norm and so failure to escalate appropriately.

4.14 In some cases the review team has found evidence of poor consultant oversight of mothers with high-risk pregnancies; they either remained under midwifery-led care or were managed by obstetricians in training without appropriate and timely escalation.

4.15 *A woman in the early third trimester of her pregnancy was admitted to the antenatal ward with severe pre-eclampsia, characterised by new onset hypertension and proteinuria. Shortly after her discharge home she had an eclamptic seizure and was taken to a neighbouring unit, where she delivered. (2011)*

4.16 *A woman developed severe high blood pressure and was managed on the labour ward. There was a delay in treating her high blood pressure and, following delivery, there was a further delay in seeking senior clinical advice. She subsequently died in another hospital. (2011)*

4.17 *A pregnant woman who was known to have large uterine fibroids had midwifery led care and was not referred to an obstetrician as her condition should have required. There were errors in the interpretation of the baby's growth and an obstetric opinion or ultrasound scan was not obtained. The baby was delivered around ten weeks early, was growth restricted and died the same day from a severe hypoxic birth injury. (2016)*

Escalation of concerns

4.18 In the cases reviewed so far, concerns regarding escalation have evolved as an overarching theme. The cases show repeated failures to escalate for further opinion and review. This is a key element of the role of the midwife and an integral part of safe practice. There is also evidence that when concerns were escalated they were not then acted upon appropriately or escalated further to the appropriate level. This may indicate a lack of multidisciplinary communication and collaboration and/or senior clinical supervision, both of which are key to providing safe care.

4.19 The reviewers found a significant number of instances both of failure to recognise and escalate the management of deteriorating mothers by midwives to obstetricians, and by obstetricians in training to consultants. From the 250 cases reviewed to date these problems appear to continue across the review period, suggesting a failure to learn from other previous serious incidents which had resulted in stillborn or severely brain damaged babies.

4.20 *A woman was induced for raised blood pressure at 37 weeks. The fetal heart rate was normal on arrival on labour ward. After artificial rupture of the membranes there was a failure by the midwife to record the fetal heart rate or escalate any concern and the baby was subsequently stillborn. The family did not feel that they were involved in the investigation and did not receive an apology. (2015)*

4.21 *A woman who was admitted with contractions and early signs of infection late in her second trimester of pregnancy was seen by a junior doctor and discharged without higher level assessment. Her management was not subsequently discussed with a senior colleague. Several hours later she was re-admitted and delivered a premature baby. (2015)*

Management of labour: monitoring of fetal wellbeing, use of oxytocin

4.22 Fetal heart rate (FHR) monitoring is an essential component of the safe management of labour. When labour is managed in a midwife-led setting the FHR is monitored using intermittent auscultation (IA). On the labour ward setting the FHR is usually monitored continuously with the ***cardiotocograph*** (CTG). The review team found significant problems with the conduct of intermittent auscultation and in the interpretation of CTG traces.

4.23 Oxytocin is an intravenous infusion commonly used in obstetric labour wards to increase the frequency, strength and length of uterine contractions. There are guidelines for its use and it should be used carefully and reduced or discontinued in the presence of excessive uterine contractions or fetal heart rate concerns. Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour.

4.24 Long labour exacerbated by use of oxytocin can result in an obstructed labour leading to fetal distress and also difficult caesarean delivery because the fetal head is deeply in the pelvis. Long labours can also increase the risks of infection and excessive haemorrhage after birth. The review team noted many examples where oxytocin was used injudiciously; these cases occurred across the time period of the 250 cases reviewed, which suggests a failure to learn from previous cases where the outcome was poor.

4.25 *A woman who had a previous caesarean section was induced and had a long labour using oxytocin. The baby's head was in the occiput posterior position and this made the delivery by caesarean section difficult. The mother said afterwards that she had the impression that the Trust were trying to keep the caesarean section rate low. (2000)*

4.26 *A mother, admitted in labour with a breech presentation, had inappropriate use of oxytocin for her long labour with CTG concerns. Standard obstetric teaching is to avoid the use of oxytocin in breech labour and especially in this case, where there was the added complication of FHR abnormalities. Her baby was born in very poor condition and died a few days later. (2006)*

4.27 *A woman presented in labour at 39 weeks. There were CTG abnormalities in labour, which were not escalated. Oxytocin was used despite an abnormal CTG. The baby was delivered normally but developed a hypoxic brain injury and cerebral palsy. (2006)*

4.28 *A woman had a prolonged labour at a birth centre despite earlier concerns over abnormal CTG tracings during the antenatal period. She was transferred to the labour ward but her baby was stillborn shortly afterwards. Despite the failure to adequately monitor both the mother and the baby there was no investigation or learning. The mother and father did not receive an apology. (2007)*

4.29 *A woman was in labour and there were fetal heart rate concerns. Despite the abnormal CTG oxytocin use was continued throughout the labour. At the caesarean section there was evidence that there had been an obstructed labour. The baby suffered from hypoxic brain injury and died some months after birth. (2009)*

4.30 *A woman had oxytocin commenced in the later stage of delivery with CTG abnormalities. There was a ventouse delivery and the baby was delivered in poor condition and developed a hypoxic brain injury. (2010)*

4.31 *A woman who had a previous caesarean section was in active labour. Despite FHR abnormalities, oxytocin was commenced and was continued despite evidence of deterioration of the baby's condition. The baby was born in poor condition and died a few months later. A case review was undertaken but it failed to identity or address the errors in the management of the mother's labour thus leading to a complete failure to learn lessons or change clinical practice in future. (2014)*

4.32 *A woman had a previous caesarean section followed by a normal delivery. The following pregnancy she was induced at term. Oxytocin was used in the presence of CTG*

abnormalities and there was excessive uterine action (hyper stimulation). There was also a failure to monitor the fetal heart during siting of epidural. An emergency caesarean section was performed and the baby was delivered in a poor condition. The investigation did not address the management of labour and CTG interpretation or the injudicious use of oxytocin. (2014)

4.33 *A woman was admitted in normal labour. There were CTG abnormalities in the second stage, which were not recognised and later it was also not recognised that the maternal heart rate was being recorded rather than the fetal heart. The baby was born in poor condition, developed hypoxic brain injury, and died several months later. (2015)*

4.34 *A woman had a failed ventouse delivery and emergency caesarean section in a previous pregnancy. In the next pregnancy the baby was found to be macrosomic (large) on scan at 36 weeks. The woman was admitted in labour and despite requests for a caesarean section she was persuaded to attempt a vaginal birth. This was complicated by a pathological CTG in labour with inappropriate use of oxytocin and shoulder dystocia. The baby died a few days later from hypoxic brain injury and complications of the shoulder dystocia. The family were dissatisfied with the investigation. The investig*ation failed to acknowledge omissions in care, which prevented future learning. (2015)

4.35 *A woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in very poor condition and hypoxic ischaemic encephalopathy (HIE) was later confirmed. The baby subsequently died. The family were critical of the ensuing investigation, and correspondence with the Trust, and said during a meeting with the Review Chair that they had been 'put off, fobbed off and had obstacles put in our way'. (2016)*

Traumatic birth

4.36 Some cases involving long labour with injudicious use of oxytocin resulted in women becoming fully dilated and consequently being assessed for instrumental vaginal delivery. The review team found evidence in a number of cases of repeated attempts at vaginal delivery with forceps, sometimes using excessive force; all with traumatic consequences. There was clear evidence that the operating obstetricians were not following established local or national guidelines for safe operative delivery.

4.37 *A woman laboured and had repeated attempts at forceps delivery. The baby sustained multiple skull fractures and subsequently died. (2007)*

4.38 *A woman who was known to have a big baby was refused her request for a caesarean section and encouraged to labour. She had a forceps delivery and the baby had* **shoulder dystocia** *with a resulting fractured* ***humerus****. In her letter to the Trust afterwards the mother wrote that she felt her request for a caesarean section was refused because the Trust wanted to keep their caesarean section rates low. There was no incident form or investigation. (2012)*

4.39 *A baby died following a traumatic forceps delivery. There were repeated attempts by two doctors to deliver the baby with forceps. (2013)*

4.40 *A woman had repeated attempts to deliver the baby using forceps. The baby was found to have skull fractures after birth and subsequently developed cerebral palsy. There was no investigation. The family were very dissatisfied with the Trust's response to their concerns. (2017)*

4.41 The reviews of these and other cases indicate that efforts to ensure a vaginal delivery either should not have been attempted or should have been abandoned and the baby delivered by caesarean section. Some of these deliveries were undertaken by consultant obstetricians, which was particularly concerning.

Caesarean section rates at The Shrewsbury and Telford Hospital NHS Trust

4.42 Caesarean section rates have risen in the UK over the two decades of this review. It is notable that for this period the caesarean section rate at The Shrewsbury and Telford Hospital NHS Trust has consistently been 8%-12% below the England average and those of its neighbouring units (Table 1). Over the years this has been positively reported in the local press with it widely known in the local community.

Table 1. Comparison of Caesarean section rates between The Shrewsbury and Telford Hospital NHS Trust, neighbouring Hospital Trusts, and the rates in England.

	The Shrewsbury and Telford Hospitals NHS Trust	University Hospitals of North Midlands NHST	Royal Wolverhampton Hospitals Trust	NHS Hospitals England
2006-2007	11.8%	24.3%	25.5%	24.2%
2007-2008	15.5%	23.5%	26.1%	24.6%
2008-2009	16.8%	24.1%	25.0%	24.6%
2009-2010	15.8%	25.6%	24.9%	24.8%
2010-2011	No data	-	-	-
2011-2012	14.9%	26.3%	25.9%	24.4%
2012-2013	16.3%	25.4%	25.4%	24.8%
2013-2014	16.3%	27.6%	27.9%	26.2%
2014-2015	16.3%	26.0%	28.0%	26.5%
2015-2016	19.5%	29.0%	28.2%	27.1%
2016-2017	20.8%	29.8%	26.6%	27.3%
2017-2018	21.0%	30.0%	28.0%	29.0%

(Data from NHS Maternity Statistics NHS Digital)

4.43 The review team came across many cases where women said that they had been aware The Shrewsbury and Telford Hospital NHS Trust wished to keep caesarean section rates low. A typical quote during interviews was that *'they didn't like to do caesarean sections'*. The review team observed that women who accessed the Trust's maternity service appeared to have little or no freedom to express a preference for caesarean section or exercise any choice on their mode of delivery.

4.44 The review team have the clear impression that there was a culture within The Shrewsbury and Telford Hospital NHS Trust to keep caesarean section rates low, because this was perceived as the essence of good maternity care in the unit. Whereas it is not possible to correlate this culture with overall poor obstetric outcomes, the previous vignettes show that in some individual cases earlier recourse to a caesarean delivery would have avoided death and injury.

Overall there did not seem to be a consideration of whether this culture contributed to unnecessary harm.

Bereavement care

4.45 It is well known that the provision of support following a bereavement makes a significant difference to the family and how supported they feel. The quality of bereavement care can have a significant effect on the wellbeing of parents and their families in the time immediately following the loss and in the longer term.

4.46 The Stillbirth and Neonatal Death Society (SANDS)[19] states that high quality bereavement care involves a recognition of parenthood using sensitive and effective communication, whilst enabling informed choice in all aspects of care and decision making. This may be decision making with regards to delivery, seeing their baby, funerals and post mortem, to name a few aspects. Midwives and obstetricians need to have an awareness of these key issues and also an awareness of the grief and trauma that families may be going through. Compassion and kindness in care and communication by midwives, obstetricians and all members of the maternity team parents may encounter is essential. Such compassion can have a positive and long lasting influence on the experience families have at this time.

4.47 Whilst there is some limited evidence that parents were supported to spend time with their baby after death and to create memories from the very limited time they were able to spend together, there is also little evidence of follow up support being provided as would be expected and recommended. There are several instances where the bereavement care was either inadequate or non-existent, which had a negative impact on the wellbeing of the parents and their overall experiences.

4.48 Not only was bereavement care poor in a number of the 250 cases reviewed to date, there are also examples of completely inappropriate comments made to some family members after the loss of their baby. There are several examples where mothers say that they were made to feel responsible by Trust staff for the loss of their babies.

4.49 *One mother complained about the consultant obstetrician's attitude when seen on the neonatal ward. She described the consultant as being rude and completely dismissive of the family's concerns. She also complained about postnatal care saying that the staff were not aware of the issues and she had to keep explaining distressing details at every shift change. There was no investigation or learning. (2009*)

4.50 *A woman whose baby died after a particularly traumatic delivery was seen by the consultant afterwards. The consultant was described as having 'no compassion or understanding of the trauma experienced'. (2013)*

4.51 *The family had received limited bereavement support on Day 17 after birth. The family found this unhelpful and unprofessional. …….bereavement care was lacking to the point of being completely inadequate. The Trust's bereavement service should have made contact much sooner. There is no record that any follow up support and advice was given. (2016)*

4.52 *A mother experienced a neonatal death at 17 hours of age. She and her partner described the bereavement service 'as offering no support, lacking in compassion and actually making it so many times worse'. (2016)*

19 https://nbcpathway.org.uk/about-nbcp/national-bereavement-care-pathway-background-project

4.53 *A woman had an apparently uncomplicated homebirth. Later the same day and overnight she repeatedly rang the midwifery unit to say that she was concerned that the baby wasn't feeding properly. She was reassured but the baby collapsed and died the next day. The family felt they had to 'push for an investigation' and that the Trust did not listen to them. They believed that the bereavement care they received was inadequate. (2016)*

LOCAL ACTIONS FOR LEARNING: MATERNITY CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- **4.54** A thorough risk assessment must take place at the booking appointment and at every antenatal appointment to ensure that the plan of care remains appropriate.
- **4.55** All members of the maternity team must provide women with accurate and contemporaneous evidence-based information as per national guidance. This will ensure women can participate equally in all decision making processes and make informed choices about their care. Women's choices following a shared decision making process must be respected.
- **4.56** The maternity service at The Shrewsbury and Telford Hospital NHS Trust must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of fetal monitoring. Both colleagues must have sufficient time and resource in order to carry out their duties.
- **4.57** These leads must ensure that the service is compliant with the recommendations of Saving Babies Lives Care Bundle 2[20] (2019) and subsequent national guidelines. This additionally must include regional peer reviewed learning and assessment. These auditable recommendations must be considered by the Trust Board and as part of continued on-going oversight that has to be provided regionally by the Local Maternity System (LMS) and Clinical Commissioning Group.
- **4.58** Staff must use NICE Guidance (2017)[21] on fetal monitoring for the management of all pregnancies and births in all settings. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.
- **4.59** The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.
- **4.60** The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse

20 https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

21 https://www.nice.org.uk/guidance/cg190

outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015[22].

- **4.61** Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour.
- **4.62** There must be a minimum of twice daily consultant-led ward rounds and night shift of each 24 hour period. The ward round must include the labour ward coordinator and must be multidisciplinary. In addition the labour ward should have regular safety huddles and multidisciplinary handovers and in-situ simulation training[23].
- **4.63** Complex cases in both the antenatal and postnatal wards need to be identified for consultant obstetric review on a daily basis.
- **4.64** The use of oxytocin to induce and/or augment labour must adhere to national guidelines and include appropriate and continued risk assessment in both first and second stage labour. Continuous CTG monitoring is mandatory if oxytocin infusion is used in labour and must continue throughout any additional procedure in labour.
- **4.65** The maternity service must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion the development and improvement of the practice of bereavement care within maternity services at the Trust.
- **4.66** The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway.

Maternal Deaths

4.67 Between the years 2000 and 2019, there were 13 maternal deaths at The Shrewsbury and Telford Hospital NHS Trust. The review team were also contacted by two families who had experienced the death of their mothers whilst under maternity care at the Trust before 2000. These will be reviewed if clinical records become available.

4.68 The review team identified recurrent themes in the care of some mothers who died, which present opportunities for important learning from the initial evaluation of these occurrences.

4.69 In the cases reviewed from 2000 onwards there appears to have been a lack of antenatal multidisciplinary team planning for women with significant pre-existing comorbidities and/or other medical risk factors. Whilst the women appear to have been correctly identified as ‘high risk’ at booking, the review team were unable to identify the lead clinician with overall responsibility for the care of the woman in the majority of cases. Whilst pathways seem to have existed for referral to other medical specialities, once referred for specialist care, the resultant assessments were frequently conducted by junior doctors. There appear to have been no joint clinics and multidisciplinary care planning for antenatal monitoring, labour, delivery or postnatal care.

22 https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

23 https://www.hsib.org.uk/documents/261/HSIB_Delays_to_intrapartum_intervention_once_fetal_compromise_is_suspected_Report.pdf

4.70 In some cases there was poor completion of the ***maternal early warning score (MEWS)*** which might have prompted escalation if completed appropriately, and there was frequently a failure to recognise the deteriorating patient. High risk and significantly sick women on the delivery suite were reviewed by junior medical staff without involvement of consultant obstetricians or consultant obstetric anaesthetists for lengthy time periods. There were delays in initiating appropriate investigations and treatment which also led to delayed escalation. These delays impacted on timely transfers to a higher level facility such as high dependency or intensive care.

4.71 The review team is further concerned about the rigour and quality of investigations after serious incidents such as a maternal death. In some cases no investigation was initiated. Some cases were investigated internally by a small governance team, no learning appears to have been identified and the cases were subsequently closed with it deemed that no further action was required. A number of investigations lacked visibility and input from the wider multidisciplinary team, resulting in missed opportunities for important learning.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- **4.72** The Trust must develop clear Standard Operational Procedures (SOP) for junior obstetric staff and midwives on when to involve the consultant obstetrician. There must be clear pathways for escalation to consultant obstetricians 24 hours a day, 7 days a week. Adherence to the SOP must be audited on an annual basis.

- **4.73** Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.

- **4.74** There must be a named consultant with demonstrated expertise with overall responsibility for the care of high risk women during pregnancy, labour and birth and the post-natal period.

Obstetric Anaesthesia

4.75 Obstetric anaesthetists are an integral part of the labour ward team. Over 60 % of all women entering the labour ward require anaesthetic interventions, and many more are assessed by an obstetric anaesthetist in the antenatal or postnatal period[24]. The Royal College of Anaesthetists (RCoA) and the Obstetric Anaesthetist Association (OAA) have issued clear guidance for staffing on the labour ward which includes a duty anaesthetist available for maternity services 24 hours a day and appropriate consultant cover for emergency and elective work[25].

24 RCoA Guidelines for the Provision of Anaesthesia Services (GPAS); Chapter 9: Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2020 "Raising the Standards", RCoA Quality Improvement Compendium, 4th Edition, May 2020, page 241-268; www.rcoa.ac.uk

25 OAA/AABGI Guidelines for Obstetric Anaesthesia Services 2013

4.76 The number of women requiring advanced levels of medical and anaesthetic care from maternity services has risen over the last 20 years, due to a number of factors including increasing levels of maternal obesity and its associated co-morbidities such as Type 2 diabetes, high blood pressure and cardiac disease. More women conceive with pre-existing medical problems and/or are delaying motherhood until they are older and may therefore have developed more underlying medical conditions[26].

4.77 The trend towards an older obstetric population with increasing morbidities and significant levels of maternal obesity means obstetric anaesthetists are increasingly required to take on the role of peri-partum physician dealing with the management of these underlying medical conditions in labour and in acute settings, as well as providing their traditional services such as pain relief in labour and anaesthesia for operative delivery or immediate surgery postpartum. The support of a consultant anaesthetist on the labour ward is crucial, in addition to consultant anaesthetist availability 'around the clock', as maternity is a 24 hours a day and 7 days a week service.

4.78 In considering the cases for this first report, the review team have identified several areas of concern relating to obstetric anaesthesia practice. The reviewers found a tendency towards simple task focus, e.g. siting an epidural, or administering anaesthesia, without a holistic assessment of the patient and appreciation of the wider clinical picture.

Poor obstetric anaesthesia practice

4.79 *A woman with severe and rapidly progressive pre-eclampsia and uncontrolled blood pressure (BP) was taken to theatre for an emergency caesarean section. The labour ward team failed to control her blood pressure and the duty anaesthetist compounded the issue when inducing general anaesthesia without administration of any drugs to attenuate the potential BP rise during intubation. This failure exposed the woman to an increased risk of cerebrovascular accident (CVA) or a stroke. (2011)*

4.80 *A woman requested epidural analgesia in labour. She had frequent contractions and felt the urge to push, although diagnosed as being in the first stage of labour. There were significant concerns about fetal wellbeing on the basis of the cardiotocograph (CTG). Despite this, the CTG was discontinued for a significant time to site the epidural. When the CTG was recommenced immediately after siting of the epidural, the fetal heart rate was difficult to obtain and an emergency caesarean section was indicated. The anaesthetist did not seek clarification on the CTG and possible urgency of delivery before siting the epidural. The baby was born in poor condition, requiring neonatal resuscitation. (2014)*

Lack of escalation to, and involvement of, senior anaesthetists

4.81 We also found several examples of lack of senior involvement from the consultant anaesthetists on call. Even in periods of high workload there was limited support by the consultant anaesthetist responsible for the delivery suite out-of-hours. Complex obstetric complications, for example severe sepsis or pre-eclampsia, or women with significant pre-existing underlying co-morbidities, were treated by very junior staff for extended periods of time even when the complexity of work clearly required senior input. There were some cases where there was an evident delay in escalating to the

26 Knight M et al on behalf of MBRRACE-UK. Saving Lives, Improving Mother's Care- Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013 – 2015. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2017

consultant anaesthetist on call. However, when requested by junior doctors, we also found instances where the consultant anaesthetist failed to attend in a timely manner.

4.82 *A woman who had an epidural for pain relief in childbirth developed a significant headache and unspecific neurological symptoms after birth. She was seen over several days by a junior doctor. Only one review was documented in the notes. There was a significant delay requesting further diagnostic tests and involving the consultant anaesthetist. Subsequent imaging showed significant pathology that should have been detected earlier. The delay put the woman at significant risk for further complications. (2012)*

Limited consultant anaesthetist representation in incident investigation and multidisciplinary team meetings after significant incidents

4.83 The review team found instances of maternal deaths or cases of severe complications, where the obstetric anaesthesia team was requested by the obstetric risk management team to 'perform their own incident investigation' and not participate in any wider investigation or contribute recommendations to prevent such occurrences in future. Sometimes only junior anaesthetic staff attended initial root cause analysis meetings or obstetric anaesthetists were not represented at all in investigation panels or team meetings. This undermines the concept of multidisciplinary team working and indicates to the external review team that obstetric anaesthetists were not perceived as an integral part of the maternity team.

4.84 As late as 2016 the review team saw serious incident investigations without input from obstetric anaesthetists or relevant other sub-specialities. The lack of a well-functioning multidisciplinary team represented a significant weakness in the structure of the Trust's maternity services with a significant impact on wider learning from adverse events and ultimately a detrimental impact on patient safety.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

- **4.85** Obstetric anaesthetists are an integral part of the maternity team and must be considered as such. The maternity and anaesthetic service must ensure that obstetric anaesthetists are completely integrated into the maternity multidisciplinary team and must ensure attendance and active participation in relevant team meetings, audits, Serious Incident reviews, regular ward rounds and multidisciplinary training.

- **4.86** Obstetric anaesthetists must be proactive and make positive contributions to team learning and the improvement of clinical standards. Where there is apparent disengagement from the maternity service the obstetric anaesthetists themselves must insist they are involved and not remain on the periphery, as the review team have observed in a number of cases reviewed.

- **4.87** Obstetric anaesthetists and departments of anaesthesia must regularly review their current clinical guidelines to ensure they meet best practice standards in line with the national and local guidelines published by the RCoA and the OAA.

Adherence to these by all obstetric anaesthetic staff working on labour ward and elsewhere, must be regularly audited. Any changes to clinical guidelines must be communicated and necessary training be provided to the midwifery and obstetric teams.

- **4.88** Obstetric anaesthesia services at the Trust must develop or review the existing guidelines for escalation to the consultant on-call. This must include specific guidance for consultant attendance. Consultant anaesthetists covering labour ward or the wider maternity services must have sufficient clinical expertise and be easily contactable for all staff on delivery suite. The guidelines must be in keeping with national guidelines and ratified by the Anaesthetic and Obstetric Service with support from the Trust executive.

- **4.89** The service must use current quality improvement methodology to audit and improve clinical performance of obstetric anaesthesia services in line with the recently published RCoA 2020 'Guidelines for Provision of Anaesthetic Services', section 7 'Obstetric Practice' [27].

- **4.90** The Trust must ensure appropriately trained and appropriately senior/ experienced anaesthetic staff participate in maternal incident investigations and that there is dissemination of learning from adverse events.

- **4.91** The service must ensure mandatory and regular participation for all anaesthetic staff working on labour ward and the maternity services in multidisciplinary team training for frequent obstetric emergencies.

Neonatology

4.92 From our review of patient clinical records in 250 cases to date, for most babies the quality of neonatal care at the Trust appears to have been satisfactory or good and at times excellent. The period 2000 - 2019 includes the time when services across England and Wales were moving from a situation where many units delivered intensive care to one where all units became part of networks within which certain units were designated intensive care units and others were not.

4.93 Prior to 2006, the neonatal unit at the Royal Shrewsbury Hospital regularly delivered neonatal intensive care, as was appropriate at that time. From 2009 the unit was designated as a Local Neonatal Unit (LNU). LNUs are not expected to deliver ongoing neonatal intensive care. It appears that there was a period between 2006 and 2011 when the local network was transitioning from one model of neonatal care to another.

4.94 We have found a small number of cases where the neonatal care was substandard. However, these were very much the exception and we have to date found no evidence of systemic poor practice or lack of care in the neonatal service.

4.95 It appears from the majority of the 250 medical records reviewed to date that involvement of the consultant neonatologists in the provision of neonatal care and in communication with parents was of a very high quality. The medical records invariably record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents.

27 http://www.csen.com/GPAS.pdf

4.96 Review of the medical records show that advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. It appears that their practice has been sound and likely to have contributed to the maintenance of good standards of neonatal practice within the Trust.

LOCAL ACTIONS FOR LEARNING: NEONATAL SERVICE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their neonatal services.

- **4.97** Medical and nursing notes must be combined; where they are kept separately there is the potential for important information not to be shared between all members of the clinical team. Daily clinical records, particularly for patients receiving intensive care, must be recorded using a structured format to ensure all important issues are addressed.
- **4.98** There must be clearly documented early consultation with a neonatal intensive care unit (often referred to as tertiary units) for all babies born on a local neonatal unit who require intensive care.
- **4.99** The neonatal unit should not undertake even short term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit.
- **4.100** There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit.

Chapter 5

Immediate and Essential Actions to Improve Care and Safety in Maternity Services

We include these **Immediate and Essential Actions** because the Minister of State for Mental Health, Suicide Prevention and Patient Safety has expressly asked us, as part of this first report, to make recommendations which will help to improve safety in maternity services across England. We are aware that to date, there has been a mixed approach to implementing change from national safety reports and reviews into maternity services triggered by concerns relating to safety, such as this review.

Recommendations are of limited use if they are not implemented; indeed, had earlier recommendations been followed at The Shrewsbury and Telford Hospital NHS Trust some of the adverse outcomes we are investigating might not have occurred. Relying on the strength of our collective clinical experience we have named our conclusions as **Immediate and Essential Actions** – i.e. these are things which we say must be implemented now if not already done so.

As a team of clinicians we are engaged in practice across eleven Trusts in London and the South East and South West of England. In addition to clinical practice, our current roles, or those we have held in the recent past include midwifery, clinical and divisional director roles, consultant midwives, leads for governance, labour ward coordinators, clinical matrons and educational leads. Many of us have been active in leading and supporting regional and national maternity safety initiatives and have published their expertise in maternal and child health on a national and international level[28].

Many of our **Immediate and Essential Actions** are not newly developed; they are largely formed from recommendations made in previous reports and publications, to which we have referred below. We have formed our 'musts' from recurrent themes we have identified from investigating the selected 250 cases of concern referred to in this first report, with the objective being to positively impact safety in all maternity services across England.

28 http://www.ockendenmaternityreview.org.uk/

1: ENHANCED SAFETY

Essential Action

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.

Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.
- An LMS cannot function as one maternity service only.
- The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2: LISTENING TO WOMEN AND FAMILIES	
Essential Action **Maternity services must ensure that women and their families are listened to with their voices heard.**	• Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. • The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. • Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions. • CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.

3: STAFF TRAINING AND WORKING TOGETHER	
Essential Action **Staff who work together must train together.**	• Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. • Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. • Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

4: MANAGING COMPLEX PREGNANCY	
Essential Action **There must be robust pathways in place for managing women with complex pregnancies** **Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.**	• Women with complex pregnancies must have a named consultant lead. • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team. • The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians. • This must also include regional integration of maternal mental health services.

5: RISK ASSESSMENT THROUGHOUT PREGNANCY	
Essential Action **Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.**	• All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

6: MONITORING FETAL WELLBEING

Essential Action

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

- The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:
  - Improving the practice of monitoring fetal wellbeing
  - Consolidating existing knowledge of monitoring fetal wellbeing
  - Keeping abreast of developments in the field
  - Raising the profile of fetal wellbeing monitoring
  - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported
  - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on he review of cases of adverse outcome involving poor FHR interpretation and practice.
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

7: INFORMED CONSENT

Essential Action	
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	• All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care • Women must be enabled to participate equally in all decision making processes and to make informed choices about their care. • Women's choices following a shared and informed decision making process must be respected.

Our Ongoing Work

I am grateful to my Independent Review Team who continue to support me with this review. We have taken these initial steps, through the publication of this first report, towards making a significant difference in helping to improve safety in maternity services. This review of 250 cases at the Trust can now impact positively on the maternity care provision for women and their families in Shropshire with the Trust working with their commissioners to ensure this happens.

As our work continues, we implore maternity services across England to also carefully consider this first report, and to make ambitious plans to ensure timely implementation of these **Local Actions for Learning** and **Immediate and Essential Actions** takes place.

Donna Ockenden

Appendix 1: Terms of Reference

Revised Terms of Reference - November 2019

1. This document sets out the revised Terms of Reference for the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which was commissioned in 2017 by the Secretary of State for Health. These updated Terms of Reference reflect changes to the scope of the review.

2. The original Terms of Reference set out an 'independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospital (the Trust). The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry.' Terms of Reference, May 2017.

3. Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review as outlined in the original Terms of Reference.

Background

4. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:

   a. appropriate investigations were conducted; and

   b. the assurance processes relating to investigations in the maternity service were adequate.

Governance

5. The review was commissioned by the Secretary of State for Health.

6. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who will periodically update the Department of Health and Social Care on progress.

7. The review will continue to be led by independent Chair, Donna Ockenden and the final report will be presented to the Department of Health and Social Care.

8. The Chair will be supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

Revised scope

9. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be review

Review approach

10. The multidisciplinary Review Team will:

    a. Review the quality of the investigations and subsequent reports into the identified cohort of incidents;

    b. Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;

    c. Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;

    d. Consider how the parents, patients and families of patients were engaged with during these investigations;

    e. Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the National Medical Director of NHS Improvement and NHS England; and

    f. The review team will present cases internally, and on an as required basis seek further external advice

11. If the Review Team identifies any material concerns that need further immediate investigation or review, the National Medical Director of NHS Improvement and NHS England must be notified immediately.

12. All relevant case notes and other information will be passed by the Trust to the Chair and the Review Team and will be treated confidentially by them. Every effort will be made to contact families to let them know whether their case forms part of the review and to ask how they wish to be engaged, if at all. In the interests of conducting a comprehensive review and maximising the clinical learning, it is necessary for the Chair and Review Team to consider all cases within the scope of the review but no patient or family member will be identified by name in the final published report unless they have consented to this.

13. Directions to the Review Team:

    a. Did the Trust have in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?

b. Were incidents and investigations reported and conducted in line with national and Trust policies, that were relevant at the time?

c. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?

d. Were families involved in the investigation in an appropriate and sympathetic way?

Key Principles

14. The review will be expected to:

a. Engage widely, openly and transparently with all relevant parties participating in the review process;

b. Be respectful when dealing with individuals who have been impacted by the incidents being investigated;

c. Adopt an evidence-based approach;

d. Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and babies;

e. Consider links to national policy and best practice in relation to midwifery, maternity, neonatal and obstetric care and investigation management that were relevant at the time; and

f. Consider the challenge of implementing proposals, including the workforce.

g. Handle data and information with care and in accordance with good information governance practice

15. For families who have contacted the Chair of the Secretary of State commissioned Independent Review directly, and whose cases were originally investigated by the Trust, the investigations of these cases will be reviewed. The review process will consider the investigations and associated action plans from each incident investigation to ensure these appropriately addressed the relevant concerns and were implemented by the Trust at the time.

16. All cases will be reviewed in relation to Trust policy and national guidance that was relevant at the time.

17. In 2018 NHS Improvement commissioned an ‘Open Book’ review of Trust records. Shrewsbury and Telford Hospital NHS Trust was requested to ‘open its books’ in relation to specific maternity data held by the organisation from 1 January 1998, when national incident reporting on the Strategic Executive Information System (STEIS) began, to 27 September 2018. The scope included patients from England and Wales (Powys).

18. The purpose of the review was to determine as far as reasonably practical with the available data, the number of cases and associated incident reporting and investigation practices over the time period in relation to:

a. Maternal deaths

b. Stillbirths

c. Neonatal deaths

d. Babies diagnosed with hypoxic ischemic encephalopathy (Grade 2 & 3)

19. This has identified over 300 cases which don't appear to overlap with many other cases known to the review team. The independent review will now consider how to incorporate these cases, and any others which arise through the investigation, into its scope to assess whether their outcomes were the result of failings.

Resources

20. Resource requirements will be agreed between the Chair of the review, NHS Improvement and NHS England and the Department of Health and Social Care to ensure the review is adequately supported.

Timeframe

21. The overall timeline will be agreed between the Chair of the review, NHS Improvement and NHS England and Department of Health and Social Care, in light of the extended scope of the review.

22. The final review report and proposals should be available within one month of the review being completed.

Appendix 2: Glossary

Definitions and Medical and Midwifery terms used throughout this Report

Glossary of terms used

Birthing centre	A birth centre staffed by midwives, they may be 'stand alone', (some distance from a Consultant led unit) or alongside- often in the same building/ on the same floor as a Consultant led unit
Cardiotocograph (CTG)	A technical means of recording the fetal heart rate and the uterine contractions during pregnancy and labour
Care Quality Commission (CQC)	An executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England
Clinical Commissioning Groups (CCG)	Groups of general practices (GPs) which come together in each area to commission the best services for their patients and population
Consultant obstetric unit	A place to give birth staffed by obstetricians, midwives and anesthetists. They have a neonatal unit staffed by neonatologists and nurses
Executive Director	A member of a board of directors who also has managerial responsibilities
Extended perinatal death	A stillbirth or neonatal death
Fibroids	A benign tumour of muscular and fibrous tissue which develops in the wall of the uterus
Forceps	An instrument shaped like a pair of large spoons which are applied to the baby's head in order to guide the baby out of the birth canal
HSIB	The Healthcare Safety Investigation Branch. They investigate incidents that meet the Each baby Counts criteria and their defined criteria for maternal deaths https://www.hsib.org.uk/maternity/what-we-investigate/

Hypoxic ischaemic encephalopathy (HIE)	A newborn brain injury caused by oxygen deprivation to the brain. Graded into HIE grades 1-3 depending on severity
Humerus	The long bone in the arm
Intermittent auscultation (IA)	The technique of listening to and counting the fetal heart rate (FHR) for short periods during active labour
Local Maternity System (LMS)	The Local Maternity Systems are the mechanism through which it is expected that a Sustainability and Transformation Partnership (STP) will collaboratively transform maternity services with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes for women and their families. The LMS's are overseen by the Maternity Transformation Board
Maternal Death	Defined as the death of a woman while pregnant or within 42 days of termination of pregnancy
Maternity Voices Partnerships (MVP)	A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
MatNeo collaborative	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
MEWS or MEOWS	An early warning score or guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs. The MEOWS is a 'Modified Early Obstetric Warning System'
MBRRACE-UK	(Mothers and Babies: Reducing Risk though Audits and Confidential Enquiries across the UK) – a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths
Neonate	Refers to an infant in the first 28 days after birth
Neonatal death	An infant who dies in the first 28 days of life - Early neonatal death – a liveborn baby who died before 7 completed days after birth - Late neonatal death – a liveborn baby who died after 7 completed days but before 28 completed days after birth
Non Executive Director (NED)	A board member without responsibilities for daily management or operations of the organisation

Nursing and Midwifery Council (NMC)	The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Occipito posterior position	Common malpresentation in labour, which can be associated with a prolonged labour
Oxytocin	A hormone commonly used in obstetric practice to increase uterine activity
Perinatal death	A stillbirth or early neonatal death
Pre-eclampsia	A disease of high blood pressure, proteinuria and organ dysfunction occurring in pregnancy
Primary Care Trust or PCT	were part of the National Health Service in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups or CCGs.
Shrewsbury and Telford Hospital NHS Trust or the Trust	
Stillbirth	A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks
Ventouse delivery	A suction cap is applied to the baby's head in order to deliver the baby through the birth canal

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OCKENDEN REPORT

Skipton House
80 London Road
London
SE1 6LH

To: NHS Trust and Foundation Trust Chief Executives

CC: Trust Chairs, STP and ICS Leaders, CCGs

14 December 2020

Dear colleague,

OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11th December 2020, this letter sets out the immediate response required of all Trusts providing maternity services, and next steps to be taken nationally.

You will have read the report and recognise the deep and lasting impact on those families who have lost loved ones, and those who continue to live with the injury and trauma caused.

Despite considerable progress having been made in improving maternity safety, there continues to be too much variation in experience and outcomes for women and their families. We must use this report and its 7 Immediate and Essential Actions (IEA) to redouble efforts to bring forward lasting improvements in our maternity services.

Immediate Actions

You should proceed to implement the full set of the Ockenden IEAs. However, we have identified 12 urgent clinical priorities from the IEAs which we are asking you to confirm you have implemented by **5pm on 21st December 2020**. The priorities are:

1) **Enhanced Safety**
   a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly
   b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

2) **Listening to Women and their Families**
   a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services
   b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.

3) **Staff Training and working together**
   a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
   b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.
   c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

4) **Managing complex pregnancy**
   a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place
   b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

5) **Risk Assessment throughout pregnancy**
   a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

6) Monitoring Fetal Wellbeing
   a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

7) Informed Consent
   a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

Workforce - the report is clear that safe delivery of maternity services is dependent on a Multidisciplinary Team approach. The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment.

Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by 31 January 2020 confirming timescales for implementation.

Please send confirmation of your compliance with these immediate actions signed off by you, as the CEO, along with confirmation of sign off from the Chair of your local LMS to your Regional Chief Midwife, by 21 December. They are available to support you with this request. Your individual responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term actions will be considered.

We are also asking every trust providing maternity services to review the report at your next public board. The Board should reflect on whether the assurance mechanisms within your Trust are effective and, with your local maternity system (LMS), you are assured that poor care and avoidable deaths with no visibility or learning cannot happen in your own organisation. To support these discussions, we are asking Trusts to complete and take to your board the **assurance assessment tool,** which will be published shortly and draws together elements including:

1) All 7 IEAs of the Ockenden report,
2) NICE guidance relating to maternity,
3) compliance against the CNST safety actions, and
4) a current workforce gap analysis

Your assurance assessment tool should also be reported through your LMS and shared with regional teams by the **15th January 2021**, in order to complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Boards.

We undertake to work with regions, systems and Royal Colleges to implement the Ockenden 7 IEAs including: those for LMS; the independent senior advocate role in Trusts; and ensuring that networked maternal medicine is implemented across all regions. We will also review the MTP, now entering its final year, to ensure future plans are in line with the Ockenden 7 IEAs.

We are planning a webinar this week with Amanda Pritchard (Chief Operating Officer, NHS England and NHS Improvement and Chief Executive, NHS Improvement), Sarah-Jane Marsh (Chair, Maternity Transformation Programme, Chief Executive, Birmingham Women's and Children's NHS Foundation Trust) and Ruth May (Chief Nursing Officer, NHS England and NHS Improvement) to discuss and answer any questions you may have about this letter and the requests contained herein.

As you will no doubt agree our women and families deserve the best of NHS care and we must therefore act without delay to make further improvements. Thank you in advance in your collective support in responding to this.

Yours sincerely

Amanda Pritchard
Chief Operating Officer, NHS England and NHS Improvement
Chief Executive, NHS Improvement

Ruth May
Chief Nursing Officer, England

Professor Steve Powis

National Medical Director

NHS England and NHS Improvement

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?

1. Maternity dashboard is reported and reviewed quarterly by the Obstetric Patient Safety (PS) Group (PSSG), Trust Patient Safety Sub Group and the Quality Assurance Committee (QAC) (subsidiary of TB and chaired by a NED). Quarterly data is shared with the regional maternity network for the regional dashboard.	1. Action plans are implemented and monitored for all dashboard anomalies and outcome parameters outside of national or regional benchmarking.	1. Tracking and trending of incidents. Maternity dashboard monitoring	1. Review of new national dashboard and alignment of Trust and regional	April 2021 PS team	1. National dashboard. Process for dashboard reporting to LMS	Continue with current processes
2. External clinical opinion is requested for all maternal deaths, IP and AN IUDs, NNDs and cases of HIE facilitated by the regional network. Formal written reviews are requested in specific cases. In addition, all cases are reported to HSIB for external investigation.	2. External reviews are incorporated into case reviews and action plans implemented and monitored. All feedback from HSIB reviews is reviewed and actioned by the Obstetric PS group. All learning communicated to staff via established processes and included in TNA as appropriate	2. Monitoring of themes within case reviews and Sis. national and regional benchmarking	2. Audit of compliance with external reviewer for past 12 months	March 2021 PS team	2. Guidance from network/LMS	2. Continue with current processes
3. All SIs reported to TB via the Integrated Performance Report report. Process for reporting of all maternity SIs to Trust Board 4. Trust statement of commitment to	3. All SIs and implementation of related actions plans are reviewed and monitored by the Obstetric PS group and Trust groups as	3. Monitoring of themes of SIs	3. Participation in LMS/network sharing process when implemented	3. TBC	3. Guidance from network/LMS	3. Continue with current processes

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

1. Currently all women and families who have an adverse outcome are all allocated a single point of contact midwife for support and information 2. NED maternity Champion in post. Meets bi-monthly with local champions 3. Active local MVP with lead professional. Liaison with LMS MVP.	1. SPOC midwife attends the MDT case review where possible to address any concerns from them and feeds back the outcome. 2. Issues discussed as appropriate and escalated if needed. 3. Meeting minutes, national CQC survey result and action plan. Demonstration of co-production	1. All learning is included in the action plans 2. Joint working with Executive Maternity Champion to address issues of concern 3. Feedback from women and families	1. Review of national guidance for independent advocate and implement as appropriate 2. Implementation of new guidance for the role and monthly reporting to TB using recommended dashboard 3. Explore ways of increasing co-production with local MVP.	TBC 2. April 2021 3. 2021	1.National guidance on the role of the independent advocate 2. None 3. Link with LMS MVP	1. Continue with current processes 2. Continue as present until actions completed. 3. Continue as present until actions completed

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

1. All midwives, medical staff and support workers within maternity services attend a mandatory 3 obstetric course which is facilitated and monitored by the Clinical Educator. Annual review of TNA in accordance with national guidance and local and regional influences.	1. Training attendance monitored quarterly and reported via Obstetric PS group	1. Obstetric PS group, Trust PSSG and QAC	1. Compliance with external validation by LMS	TBC	1. Guidance on process for this from LMS	1. Continue with current processes
2. MDT labour ward rounds occur 4 x per day 7 days per week.	2. Recently implemented monitoring via acuity tool completed 4 hourly by CDS team leader	2. A quarterly compliance report from the acuity tool is reported to obstetric PS group.	2. Ensure inclusion of ward round monitoring in quarterly report	2. April 2021	2. Interactive whiteboard for CDS	2. Continue with current processes
3. Ensure audit trails available for all monies allocated for maternity training form external sources. 2020-21 MIS reimbursements utilised within maternity services. Verification of commitment to utilise MIS reimbursement for 2021-22 within maternity services	3. Audit trail for utilisation of 2020-21 funds	3. TB	3. None	3. As applicable	3. Continued Trust support for maternity services	3. Continue with current processes

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

1. SOP for referral to tertiary centre Participation in reginal maternal medicine group 2. All women referred to a consultant clinic are assigned a named consultant 3. Maternal medicine Consultant team of 4 consultants and 1 specialist MW+ specialist MW for public health NICE compliant clinical guidance for pathways of care and involvement of MDT	1. Annual report form maternal medicine team 2. Monitored via monthly Quality Indicator Checks (QIC) audits 3. Annual report form maternal medicine team	1. Obstetric PS group 2. Obstetric PS group 3. Obstetric PS group	1. Ensure all action plans are implemented 2. Ensure all action plans are implemented 3. Ensure all action plans are implemented	1. Maternal Medicine Team 2. Maternity managers Quarterly 3. Maternal Medicine Team	1. Regional MIS. Digital maternity records 2. Digital maternity records 3. Digital maternity records	1. Continue with current processes 2. Continue with current processes 3. Continue with current processes	

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.						
What do we have in place currently to meet all requirements of IEA 5?	**What are our monitoring mechanisms and where are they reported?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
1. PHR template for all AN reviews with community MW PHR template for all attendances at ANC and MAU and admission to AN ward. 2. Intended POB reviewed by community MWs at AN reviews	1. Audited monthly as part of QIC audit process 2. Audited monthly as part of QIC audit process	1. Quarterly reports reviewed by obstetric PS Group 1. Quarterly reports reviewed by obstetric PS Group	1. Ensure all action plans from audits are implemented 2. Ensure all action plans from audits are implemented	1. Maternity managers Quarterly 2. Maternity managers Quarterly	1. Digital maternity records 2. Digital maternity records	1. Continue with current processes 2. Continue with current processes

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

1. Consultant lead for fetal monitoring in post and time allocated within job plan Appointment of Lead Midwife currently in progress Job roles agreed. QA lead for maternity and gynaecology currently ensures implementation and monitoring of SBLv2	1. Annual review of job plans Appraisal Quarterly report to obstetric PS group KPIs of SBLv2 monitored quarterly	1. Maternity dashboard data. Quarterly KPI monitoring for SBLv2 National and regional benchmarking Maternity CNST compliance	1. Successful recruitment to Lead Midwife role. Implementation of the role within clinical practice Implementation of reporting processes	1. Lead Consultant/Clinical Educator/PS team	1. None	1. Continue with current training and PS processes

Immediate and essential action 7: Informed Consent

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Patient held records (PHRs) Birth choices information on internet with links to regional and national information Personalised care plans within PHRs Integrated care pathways for FGR (regional) and twins	Participation in National CQC maternity survey Ad hoc survey monkeys facilitated by MVP Monthly QIC patient feedback audits	Results of survey reviewed by service and MVP and action plan implemented and monitored.	Review of website with MVP- align with C&W Review of PCP in PHR in conjunction with MVP- align with C&W	PH Specialist MW, MVP/Community Manager	Increased use of digital technology for women and families	Continue with current processes

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
BR+ assessment completed January 2019 Midwifery staffing reviewed quarterly by Obstetric PS group, PSSG and QAC	Reviewed and approved by workforce committee and TB	All action monitored by workforce committee. All actions completed.	6 monthly midwifery staffing report reviewed by workforce committee. BR+ assessment to be repeated in Jan 2022	HOM	Support for BR+ review 3 yearly and implementation of staffing recommendations	Continue with current processes

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The Head of Midwifery is directly accountable to the Director of Nursing and Midwifery who is also an Executive Director and Board level Maternity Champion.

A gap analysis against the RCM document has been undertaken and is planned for discussion with the DON.

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Comply with current Trust processes for implementation of NICE guidance.	Monthly by the clinical audit NICE Evaluation Group	All guideline development follows Trust processes All obstetric guidelines are ratified by the Obstetric PS group. Monitoring against quality standards is facilitated by the NICE evaluation Group	Review of all current local guidelines to ensure in line with NICE guidance and quality standards.	QA Lead April 2021	None	Continue with current processes

Name of Guidance/Report: Ockenden Review of Maternity Services- Urgent Actions	Date published: December 2020	Lead: Yvonne Regan	Date at Obs Risk Mgt	Date for review (3 monthly)

Report recommendations	Fully, partially or non-compliant	GAP/Deficiency	Action plan	Lead person responsible	Target date	Evidence required
1. Enhanced Safety						
a) A plan to implement the Perinatal Clinical Surveillance Quality Model			Await final document and consult with wider team on achievement of compliance	**Y Regan/J Lappin**		Perinatal Quality Surveillance Preparat
b) All maternity Sis are shared with Trust Boards at least monthly **and the LMS**, in addition to reporting as required to HSIB			To review Board processes for notification of Sis to further strengthen transparency and oversight	**J Lappin/K Branch/D Meneni**		QAC Maternity Quarterly Report Apı AUgust 2020 Monthly PSSG Matern PSSG October 2020 Maternity Report usir Septemeber 2020 PSSG Maternity Repo 20201216 NENC Trust LMS Ockenden I Quality Assurance Committee (QAC) is a delegated

Report recommendations	Fully, partially or non-compliant	GAP/Deficiency	Action plan	Lead person responsible	Target date	Evidence required
						authority of the Trust Board and receives a monthly presentation of all Sis including any that occur in Maternity Services.
2. Listening to women and their Families						
a) Evidence of a robust mechanism for gathering service user feedback and of working with service users through the MVP to co-produce maternity services			Further develop working with the MVP using a co-production model	**K Branch/A Temke**	March 2021	ST MVP TOR - draft YR ASW 9Nov20 - Co 5. Parents feedback for inclusion and cons South Tees JCUH MVP Annual Report 2(National Maternity Survey 2019 - update Pateint experience process.docx

Report recommendations	Fully, partially or non-compliant	GAP/Deficiency	Action plan	Lead person responsible	Target date	Evidence required
b) In addition to the identification of an executive Director with specific responsibility for maternity services, confirmation of a non-executive Director who supports the Maternity Champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.			Review the maternity champions role in line with new guidance once published To further raise the profile of the maternity Champion Role with all staff with posters in clinical areas and social media information	**K Branch/D Meneni/D Fowler/D Reape**		letter re maternity champions.pdf Process and Pathway for Sharing
3. Staff training and working together						
a) Implement Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week			Review of operational policy to reflect new on call rota for consultant cover on CDS and include roles and responsibilities of obstetric and anaesthetic teams	**J Matthews/ H Simpson**	Feb 2021	4. OPERATIONAL POLICY FOR HIGH DE
b) Assurance that an MDT training schedule is in place			Implementation of on line training for specific training and identified staff	**S Evans**	Jan 2021	TNA 2020-2021.doc
c) Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST maternity incentive scheme refund is used exclusively for improving maternity safety				**D Fowler/DOF**		Confirmation of CNST monies for mat

Report recommendations	Fully, partially or non-compliant	GAP/Deficiency	Action plan	Lead person responsible	Target date	Evidence required
4. Managing complex pregnancy						
a) All women with complex pregnancy must have a named Consultant lead and mechanism to regularly audit compliance must be in place			Full implementation and embedding of QIC audit process	**J Matthews/ A Himsworth**	Jan 2021	A2 Antenatal Assessment of Care F Process for QIC audits.docx Documentation of lead midwife and consultant is included in the QIC audit process
b) Understand what further steps are required to support the development of maternal medicine centres			Continue with engagement in network process	**D Meneni**		20201216 NENC Trust LMS Ockenden I
5. Risk assessment throughout pregnancy						
a) A risk assessment must be completed at every contact, including an ongoing review and discussion of place of birth as part of the personalised care and support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance			Full implementation and embedding of QIC audit process	**J Matthews/ A Himsworth**	Jan 2021	Guideline A2 (in section 4) 6.MAU Operational Policy 2020.docx Documentation of PCSP is included in the QIC audit process (section 4)

Report recommendations	Fully, partially or non-compliant	GAP/Deficiency	Action plan	Lead person responsible	Target date	Evidence required
6. Monitoring fetal well being						
a) Implement the SBL bundle, ensuring there is a Lead Obstetrician and Lead midwife in place to lead best practice, learning and support, including regular training sessions, review of cases and ensuring compliance with SBLv2 and national guidelines b)			Integration of lead midwife role into current training processes and clinical practice.	**K Branch/Y Regan**		Lead Midwife- Fetal Monitoring.docx Lead consultant - FM.docx
7. Informed consent						
a) Ensure pathways of care are clearly described in written information in formats consistent with NHS policy and posted on the Trust website			Updating of some pathways and patient information on website. Review of The Friarage Maternity services (FMLU) website to ensure services provided are clear Link to LMS and pregnancy and birth choices website/app to be added to Trust website	**L Hand**		Guidelines and pathways all in Trust format- accessible to all obstetric staff South Tees maternity website. All clinical guidance and pathway documentation monitored by the Clinical guidance and Audit Monitoring Group TOR July 2020.docx

Report recommendations	Fully, partially or non-compliant	GAP/Deficiency	Action plan	Lead person responsibl e	Target date	Evidence required
						20201216 NENC Trust LMS Ockenden

Project Plan v2 Nov 2020

Midwife Continuity of Carer Implementation – South Tees Hospitals NHS Foundation Trust

Project Lead Lucy Findlay	LMS Network Lead Kathryn Hardy

Aims:

- The following proposal for maternity services at South Tees Hospitals NHS Foundation Trust is to achieve progress toward implementation of the Continuity of Carer (CoC) recommendations outlined in Better Births (2016)
- Better Births, the report of the National Maternity Review, the Five Year Forward View for NHS maternity services in England (National Maternity Review, 2016) and Safer Maternity Care – The National Maternity Safety Strategy (Department of Health, 2017), sets out a vision for maternity services in England which are safe and personalised.
- At the heart of this vision is the ambition that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth.
- There is increasing evidence to show the benefits of midwifery continuity of carer with positive outcomes for women who receive care from a midwife they know during the antenatal and intrapartum period. These models have also been shown to improve job satisfaction, autonomy, and more effective collaboration between agencies.
- The aims of the MCoC pathway will underpin all of the elements of the Maternity Transformation Programme including Better Births and the Saving Babies Lives care bundle.
- In 2019/20 there were 5219 maternity bookings at South Tees. The target is to achieve 35% of all women of 29/40 gestation to be booked onto a CoC pathway by March 2021.

Objectives:

To establish continuity teams to offer greater continuity of the healthcare professional supporting the woman, her baby and the family. Including:

- A midwife who will normally provide continuity throughout a woman's journey, if that is what she and her partner want;
- The midwife will usually work in and be supported by a small teams of six to eight midwives, one of whom could be a buddy and take responsibility for the woman's care if her midwife is not available;
- The team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate;
- Having a midwife the woman knows at the birth. Ideally this will be her own midwife, but if that is not possible, a midwife from the same team of eight;
- Where a woman needs on-going obstetric support, this should be from a single

obstetric team and the care should be fully integrated across the midwifery and Obstetric services.

- Provision of extra antenatal and postnatal support as required
- Provision of tailored antenatal education
- Provision of infant feeding advice and support

The NHS ten-year plan also aims to ensure that most women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period by 2024 (NHS England, 2019) These groups have been shown to benefit disproportionately from the effects of MCoC. Therefore the first integrated CoC teams at JCUH will be developed to focus on this population within 2 postcode areas which include vulnerable groups such as

- Women aged 19 and under
- Women smoking at time of booking
- Women on treatment for current mental health problems
- Women from BAME populations, with particular focus on asylum seekers, refugees and none English speakers.

Providing CoC to this specific group of women with the first 2 caseloading teams would achieve CoC for approximately16% of the local target population.

At the Friarage Maternity Centre the aim is for all low dependency women to receive CoC by 2021 (approx. 300= 6% of total)

Outcomes	Expected Benefits
• Shared vision to be disseminated throughout the division. • Movement towards implementation monitored and disseminated to national review board. • Share proposed model within STP and amongst the LMS • Models identified trialled and widely shared within LMS. • Sharing of model and feedback to influence future planning. • Women and families will be able to access individualised care and support which wraps around them • Evaluation and reporting of KPIs met through the implementation of the model • Reconfiguration of the workforce and the implementation of cross department working across the division. • Evaluation of the evidence through the Maternity Data Set • The implementation of this project plan supports the overall strategic direction of the division.	• Improved maternal satisfaction • Encourage engagement with health care professionals • It has been found that women who received MCoC were more likely to be looked after in labour by midwives they already knew (63-98% vs. 0.3- 21%) and were less likely to have an epidural, episiotomy or instrumental birth. • Women's chances of a spontaneous vaginal birth were increased. • Women were less likely to experience preterm birth, fetal loss before and after 24 weeks, and neonatal death. • Women were more likely to report a better experience with various aspects of care. • Improve outcomes in perinatal mental health, smoking cessation and weight management • Improve interprofessional collaborative working • Improved breast feeding rates • Long term costing improvement • Cost effective use of skill mix • Professional autonomy • Reduction in staff sickness and absence • Professional retention • Professional satisfaction • Professional development of allied health professionals

Action Plan Key Milestones and Deliverables - Overall Trust Position

(RAG Rating - RED no progress Amber progress Green Achieved)	20/21 Q1	20/21 Q2	20/21 Q3
1. Engagement of Key Stakeholders Key actions • Formal engagement of key stakeholders – Staff Side/ Regulators/ Service Leads • Engage with Estates to identify clinical base hubs • Engage with Workforce to map staffing • Engagement with local authority Barriers • Estates - Availability / cost of hubs and engagement • GP Surgeries – Antenatal clinics traditionally ran from surgeries, some GPs reluctant to change arrangement.			
2. Development of Case for Change & Investment Appraisal Form Key Actions Barriers			
3. Capture the perceptions of Service Users Key Actions • Co-production of all communication with MVP • Working with Public Relations Dept. for Social Media/ Local Press launch and ongoing updates • Liaise with health/local council/ other agencies to engage with service users • Link in with roll out of new initiatives for vulnerable families from local authority services. Barriers • Current Covid-19 pandemic- difficulty in reaching service user groups regularly • Inclusion of vulnerable groups including BAME communities not always well represented through MVP			
4. Development and identification of Teams Key Actions • Engage with Workforce to implement new maternity staffing tool • Engage with Staff Side/ Unions Barriers • Change to current staffing structures • Financial implications/ Uplift for movement of staff • Staff reluctance to work in new model • Current Covid-19 pandemic – staffing			

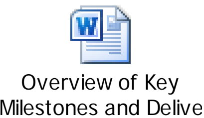
• Unknown workforce requirements			
5. Training Programme Key Actions • Standardisation and roll-out of universal programme for training/upskilling of staff Barriers • Funding for back-fill of staff released for training • Maintaining safe staffing levels when staff undergoing shadowing shifts.			
6. Estates/ IT & Communication Key Actions • Updating of MSDS system to capture CoC data requirement • Remote access to System One GP records • Staff training to use generic team diaries via Microsoft Office • Need to develop virtual platforms to support remote working/engagement during Covid-19 pandemic Barriers • Availability of laptop computers • Time for IT Training and ongoing support • Engagement from Estates			
7. Implementation of Teams Key Actions • Utilisation of new workforce mapping tool • Involvement of Staffside/HR/ Unions • Ongoing programme of staff engagement Barriers • Safe staffing/ maintaining core skill mix in all areas • Involvement of specialist roles • Inclusion of part-time workforce • Inclusion of MSWs • Lack of available base hubs • Capacity to undertake workforce assessment			
8. Health & Safety Key Actions • Updated loan worker policy • Procurement of Loan Worker Devices for teams • Development of SOPs for escalation policy / midwife attending unit Barriers • Remote working during Covid-19 pandemic – could be detrimental to CoC relational model			

9. **Evaluation & Sustainability** Key Actions • Development of staff/service user evaluation tool • Development of data capture on financial sustainability of model Barriers • Delay in MSDS update to accurately capture data relating to CoC			

Current projects for provision of Continuity by site since project start date (updated Nov 2020)

FHN

Current workforce transformation currently on-going to redesign current working practices for community & hospital midwives to provide integrated care through four caseloading teams across the geographical area. One team to focus on supporting military families, who are often socially isolated and experience high levels of mental health issues.
Due to delay in HR consultation throughout Covid 19 pandemic two pilot teams staffed with midwives volunteering to work in the new models have been formed. This has bypassed the need for full staff consultation at this time.
The first team of 7 Midwives – The Heather Team are due to launch 23/11/20. The midwives within the team will care for a caseload of low dependency women aiming to deliver at the Friarage Maternity Centre. The midwives will deliver care throughout the pregnancy journey and be rota'd or on call to staff the midwifery lead unit. These arrangements would ensure a known midwife was available to provide intrapartum care to the caseload.


Overview of Key Milestones and Delive

JCUH
Up scaling vulnerabilities pathway explored. Successful staff engagement and recruitment of new CoC team. Team of 8 x midwives (7.6 WTE) and 1 x MCA (1 WTE) To provide CoC via team caseloading model. Options for cohort of geographical areas including areas of deprivation and vulnerable groups. Work on-going to identify geographical base. Team to provide intrapartum cover to delivery suite 24 hrs. via 1 x mw on night shift 19.00-07.00 and one mw on 07.00-19.00 shift where they were available to come into unit to provide care in labour to the caseload. Exploring creative team working to ensure meet the team/ joint antenatal appointments/ tailored antenatal education etc.
Training package developed and utilised to allow new team training to up skill for cross area working in high dependency care. Predicted start date by March 2020 – delayed due to COVID 19, team successfully launched 26/10/20. Social Media / Local Press launch in the community supported by trust public relations/communications department.

Second team- scoping of targeted area, working with local council statistician to identify vulnerable areas and BAME community areas of greatest need. TS1 (Central Middlesbrough) population identified. Expressions of interest now out for interested midwives to join team, close working with Public Health specialist midwife and new maternity BAME task & Finish group.

Key Milestones and Deliverables JCUH Pr(

Communication Strategy

•Milestones established

•Progress monitored by project lead midwife and shared monthly with HoM, regional leads, LMS SRO and LMS programme Lead.

•Communication internally at regular team meetings – fortnightly once teams recruited.

•Stakeholder engagement groups involved and updated via standing agenda item to be included at all meetings

•Progress reported regionally and nationally via LMS Programme Lead on monthly basis, attendance to report quarterly at regional sub-group

•Project lead to engage MVP via MVP lead to promote the model to service users.

•Media presence development: newsletters, social media platforms, web site local press, celebrate successes and promote model once established.

Data analysis of current models- Project Scope

Low dependency women choosing to deliver at FHN now included in CoC analysis totalling **6%** of overall trust bookings.

Prediction of further 383 women included in first CoC pathway with JCUH geographical team – **approx. 8%** of overall trust bookings.

Similar figures expected in second JCUH team – **8**%

Expected achievement of CoC with proposed models – 22% of bookings by trust

On-going plans toward achievement of 35% CoC by March 2021

Continuing staff engagement and promotion of implementation on Continuity aims. Exploration of some hybrid models (i.e. Community midwives attending elLSCS to care for women in their caseload).

On-going work with the Regional LMS transformation project, maternity observations and data analysis.

Strategic Fit – Describe how the national/regional / local strategic / policy drivers support this proposal

Better Births set out the Five Year Forward View for NHS Maternity services in England (2016) through the NHS Transformation Plan for Maternity and lead by the Local Maternity System (LMS). This includes

- All women to be able to make choices about their maternity care during pregnancy, birth and postnatally.

- Most women receiving continuity of the person caring for them during pregnancy, birth and postnatally.
- More women able to give birth in midwifery settings (at home or in midwifery-led units).
  Local Maternity System Transformation Plans currently under development. The specific ambition of this work is to create a conceptual, regional design of service that will describe the working patterns and resources needed to provide a practicable and sustainable means of providing continuity of carer for all women – thereby, aiming to support trusts by providing them with an overarching model that can be used to inform (and enhance the co-ordinated development of) individual service-level proposals.

Governance (Legal & Clinical) – Provide details of any requirement or recommendation that this proposal id undertaken
There is no legal requirement to implement this proposal. The clinical requirements and benefits are outlined by NHS England within the National Maternity Transformation Plan and Long Term Plan.

Inequalities & Access – What impact will this proposal have on health inequalities and what will be the impact of this scheme on patient access?
The proposal at JCUH will be delivered in the central urban area due to the current demographic data related to poor maternal outcomes including higher rates of maternal smoking and obesity. The first team will be based in a vulnerable area highlighted within the National Indices of Deprivation Report 2019. The second proposed team launching from JCUH will again focus on a vulnerable target area which includes a high proportion of BAME communities, including refugees, asylum seekers and none English speakers.
The proposal at FHN will cover a wide and varied geographical location including isolated communities and families of military background. The service will evidence improved healthcare outcomes for women, babies and their families.

Estates/ Facilities Impact
The JCUH CoC team will require a base within the local community facility such as North Ormesby Health Village or The Cleveland Health Centre – Work ongoing via CCG to scope hubs.
FHN teams have established community bases so no further estates requirements are envisaged.
IT Systems will be required for agile working requirements. Essential equipment would include lap tops with 4G provision for areas with no Wi-Fi.

Budget
Initial bid successful for £200,000 of LMS funding toward CoC implementation - budgeted by April 2020. See Investment Appraisal Form - Business Case appendix i
Second Bid funding secured for 20/21 of £81,813 toward CoC trajectory, to include funding for band 7 project lead and remaining monies (£25,960) to focus primarily on vulnerable groups and the BAME community.

Impact on organisational 'Running Costs'
There will need to be review to ensure these models can be sustained within the trust and external facilities to host clinics. The National Maternity Transformation Programme is reviewing how continuity of carer will be funded as part of the NHS Long Term Plan.

Risk Management plan

Predicted possible pitfalls – workforce, budget, resistance of staff to transformational changes, equipment, Primary Care Network Hub provision.

Support Requirements

Human resources support- Staffing requirements, protected pay, quarterly hours

Estates – Identification of available community base hubs

CCG – Financial support with community base hubs

IT support – Costs with reoccurring connectivity, MSDS updates, equipment, training and support

MVP and clinical lead – Publicising and promoting transformation, surveys, service user involvement.

RCM/ Union representation/ Staff side

LMS lead – consistent feedback from regional/ national reporting.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 February 2021			
Maternity Continuity of Carer (MCoC) update			**AGENDA ITEM: 11, ENC 6b**
Report Author and Job Title:	Kay Branch – Head of Midwifery	**Responsible Director:**	Moira Angel Interim Chief Nurse
Action Required	Approve ☐ Discuss ☒ Inform ☐		
Situation	This report provides an update to the Trust Board on the current position of the Continuity of Carer implementation in Maternity Services at South Tees Hospitals NHS Foundation Trust at the end of November 2020. The Board received the last update in March 2020, ahead of the last years CNS submission.		
Background	Better Births, the report of the National Maternity Review, the Five Year Forward View for NHS maternity services in England (National Maternity Review, 2016) and Safer Maternity Care, The National Maternity Safety Strategy (Department of Health, 2017), all sets out a vision for maternity services in England which are safe and personalised. At the heart of this vision is the ambition that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth. The aims of the MCoC pathway will underpin all of the elements of the Maternity Transformation Programme including Better Births and the Saving Babies Lives care bundle		
Assessment	This paper provides a summary and the action plan which South Tees Maternity Services will use to work towards the target of 35% in order that all women have the continuity of carer pathway in place by March 2021. The Trust is currently falling short of the target an is only offering this to 11% of women. A comprehensive action plan has been developed and in place, which is tracked and monitored through the Maternity Services Governance Group and QAC. The actions which are currently off target are: Estates and IT Communication, evaluation and sustainability of the MCoC model.		
Recommendation	For The Trust Board to: Note the current level of compliance against the target Note the Actions which are of track Not the actions which have been put in place to improve compliance		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	The risk of not meeting the 35% target is reflected in risk 2365 on the Trust risk Register and is aligned to the BAF via 2.3, 2.5		

please outline		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒
	Drive operational performance ☒	Long term financial sustainability ☒
	Develop clinical and commercial strategies ☒	

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 February 2021			
Guardian of Safeworking – Quarter 3 report October 2020 to December 2020			**AGENDA ITEM: 12, ENC 7**
Report Author and Job Title:	Tom Skeath, Guardian of Safe working and Stacey Dixon, Medical Workforce Team Manager	**Responsible Director:**	Sath Nag, Medical Director
Action Required	Approve ☐ Discuss ☐ Inform X		
Situation	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 1st October 2020 and 31st December 2020.		
Background	It is a requirement of the 2016 Doctors and Dentists in Training Terms and Conditions that a quarterly report is submitted to Trust Board. The report should include a summary of exception reporting activity and vacancies in the Doctors and Dentists in Training Workforce.		
Assessment	Please see body of report for statistics in relation to the quarter ending 31st December 2020.		
Recommendation	The Trust Board of Directors are asked to note this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives)	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

Guardian of Safeworking report 1st October 2020 to 31st December 2020

Report to Trust Board

Prepared by Thomas Skeath, Guardian of Safe working and Deputy Guardian of Safe working – Anu Kansal, and Stacey Dixon – Medical Workforce Team Manager.

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 1st October 2020 and 31st December 2020.

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

2. Key updates

- The overall vacancy rate has increased slightly to 2.3% as at the end of December 2020. A number of MTIs (medical training initiative) doctors have been appointed to commence later in the year. Gaps on rotas tend to be short term due to sickness, COVID-19 isolation or emergency leave. The medical rota team track junior doctor sickness/leave 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). Locum shifts have increased significantly since the 2nd COVID-19 pandemic, by 20% on a monthly basis.
    - Advanced Nurse Practitioners are successfully being utilised to cover gaps in some areas and to support medical wards, at hospital at night.
    - The medical rota team continue to fill approximately 95% of all locum shifts each month with the majority (approximately 90%) being filled by internal locum cover as opposed to agency
    - The regional locum bank (Flexi shift) hosted by the LET was well established. Therefore a decision was made to enrol the Trust (LED) doctors onto the system from the 5th August 2020. Unfortunately due to COVID-19 pressures, this impacted, causing delays to doctors receiving payment for additional shifts which they had covered in such unprecedented times. In order to rectify this issue urgently the Trust re-verted back to the previous locum claim form process to ensure all doctors receive payment, in a timely manner. The Trust is currently working on resolving these issues and will provide an update to all in the next JDCF meeting on the 9th February 2021.
    - Foundation Year doctors will be employed by the Lead Employer Trust from August 2021.
    - There has been some delay in MTI appointments due to visa/embassy access in home countries.

- The Junior Doctors Forum has continued to be well attended since the August 2020 changeover.

- Exception reporting submissions continue to be consistently lower than expected.

- Following the recent amendments to the Terms and Conditions, all remaining Training Grade doctors on the 2002 terms will transfer to the 2016 contract (with salary protection where eligible) from February 2020, except for those training doctors coming towards the end of their training contracts, who had been given the option to remain on the 2002 TCS until the end.

- A new Guardian of Safe working and deputy guardian of safe working have been employed into position from the 5th August 2020 – please see their details below, they have re-placed the previous guardian – Dr Suzie Peatman.

  - Dr Thomas Skeath – GOSW
  - Dr Anu Kansal – Deputy GOSW

3. Data summary and commentary

3.1 Numbers of doctors in training

Table 3.1.1

Number of doctors / dentists in training (total):	**413**
Number of doctors / dentists in training on 2016 TCS to date(total):	**363**

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.

All Local employed Trust Doctors appointed from the 5th August 2020 are employed on a Trust 2016 TCS contract and have access to the exception reporting system, which will replace the monitoring exercise which took place in line with the previous 2002 trust contract TCS, this will also give the opportunity to be able to raise exception reports to highlight any issues with rotas, as stated in the paragraph above.

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

6 hours per week.

4. Exception reports

The tables below give a breakdown and analysis of the 41 exception reports raised between 1st October 2020 and 31st December 2020

Table 4.1

Exception reports raised October to December 2020			
Specialty	**No. Exceptions Raised**	**No. Exceptions Closed**	**No. Exceptions Outstanding**
Accident & Emergency	1	0	1
Acute medicine	2 (x1 carried over from previous quarter)	1	1 (from previous quarter)
Gastroenterology	4 (x2 carried over from previous quarter)	2	2 (from previous quarter)
General Medicine	30	30	0
General Surgery	8 (x2 carried over from previous quarter)	0	8
Obstetrics & Gynaecology	1	1	0
Trauma & Orthopaedics	26 (carried over	**4**	**11** (from previous

	from previous quarter)		quarter)
Vascular Surgery	**1**	**1**	**0**
Total (based on new raised this quarter)	**41**	**9**	**39**

Table 4.2 - figures based on New ER raised in current Quarter (Oct – Dec 2020)

Exception report category				
Specialty	**Education**	**Hours & Rest**	**Service Support**	**Pattern**
Accident & Emergency	0	0	0	0
Acute Medicine	0	0	0	0
Gastroenterology	0	0	0	0
General Medicine	0	30	0	0
General Surgery	0	6	0	0
O & G	0	1	0	0
T & O	**0**	1	**0**	0
Vascular Surgery	**0**	1	**0**	0
Total	**0**	**39**	**0**	**0**

*although categorised under hours/rest – it also states pattern category

Table 4.3

Exception report type							
Specialty	**Early Start**	**Early Start & Late Finish**	**Late Finish**	**Unable To Achieve Breaks**	**Working pattern does not match work schedule**	**Unable To Attend Scheduled Teaching / Training**	**Other**
Accident & Emergency	0	0	1	0	0	0	0
Acute Medicine	0	0	2	0	0	0	0
Gastroenterology	0	0	2	0	0	0	0
General Medicine	0	0	2	0	0	0	28
General Surgery	0	0	5	0	0	0	1
O & G	0	0	1	0	0	0	0
T & O	0	0	0	0	0	0	0
Vascular Surgery	0	0	1	0	0	0	1
Total	**0**	**0**	**14**	**0**	**0**	**0**	**30**

Table 4.4

Exception report action taken					
Specialty	**No Action Required**	**Payment For Additional Hours**	**Time Off In Lieu**	**Work Schedule Review and payment**	**Other**
Accident & Emergency	0	0	0	0	1
Acute Medicine	0	0	1	0	0
Gastroenterology	0	0	0	0	2

General Medicine	0	0	0	0	30
General Surgery	0	3	0	0	2
O & G	0	0	1	0	0
T&O	0	0	0	0	0
Vascular Surgery	0	1	0	0	0
Total		**4**	**2**	**0**	**35**

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

The recent increase in exception reports from general medicine (FY2 mainly) is due to an indifference in hours between the GP practice rota's, the doctor affected raised multiple duplicate exception reports against each shift date. The GOSW helped to resolve this issue in order to gain parity of rota hours for the FY2 doctors carrying out there four month rotation in GP practice. There are a total of 28 ER relating to this issue which have been resolved and closed down.

Outstanding vacancies as at 31.12.2020			
Specialty	**Grade**	**31.12.2020**	**Comments**
Rheumatology	GP Trainee	0	Department do not wish to backfill
Obsterics & Gynecology	GP Trainee	0	Dept. does not wish to backfill - running with vacancy.
Pediatrics	GP Trainee	1	Rota has been adjusted
Neonatal	MTI	1	Recruited x1 MTI Doctor - ESD has been delayed due to visa issues until 2021 - Caroline will provide an update the end of Jan 2020
Neonatal	ST3 +	4	Recruited x2 MTI doctors to backfill - x1 to commence ESD - 2021 and x1 Caroline is chasing up to confirm a start date with the MTI doctor - update will be provided from Caroline (Recruitment Co-ordinator) the end of Jan 2021.
Colorectal	FY1	4	Rota has been adjusted
Urology	Research Fellow	1	Department do not wish to backfill
Ophthalmology	ST3 +	4	Recruited x2 Doctors - x1 MTI (ESD 3 months from Dec 2020) and x1 Trust Reg level - has commenced in Nov 2020.
Vascular	ST3 +	3	Interviews are taken place – x3 Trust Registrar doctors have been appointed – ESD – end of February 2021.
A&E	FY2	7	Caroline Dixon (Recruitment co-ordinator to provide a recruitment update - by end of Jan 2021
A&E	FY2	2	Caroline Dixon (Recruitment co-ordinator to provide a recruitment update - by end of Jan 2021.
A&E	CT1/2	4	Caroline Dixon (Recruitment co-ordinator to provide a

			recruitment update - by end of Jan 2021.
A&E	ST3 +	1	Caroline Dixon (Recruitment co-ordinator to provide a recruitment update - by end of Jan 2021.
ICU	ST3 +	5	Caroline organising interviews to take place - week commencing the 25th January 2021.
Totals		**20%**	

5. Guardian of safe working fines

There were no Guardian of Safeworking fines issued during the quarter.

6. Summary of risks/issues and next steps

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

- The school of Medicine have asked that HEE NE Neurology trainees join the medicine speciality and be removed from Neurosciences (Neurosurgery). It is unclear at present if this will take place from the April 2021, as informed by the DME – South Tees NHS Foundation Trust. Discussions are taking place around re-configuration of the junior doctor rotas and an update will be provided at the next JDCF meeting on the 9th February 2021.

- Health Roster – engagement sessions began on the 9th December 2020, organised by Tracy Glennen - programme manager, involving the rostering and medical rota team to engage with senior clinicians/rota leads and the DME/postgraduate education department and junior doctors, to plan the implementation of unavailability (annual/study leave) and rostering/shift management, on the health roster system. Discussions are continuing, regarding proposed implementation timeline.

- No COVID rota has been implemented during the second wave for junior doctors. Regional discussions between guardians have highlighted that there may need to be exemptions to the 2016 contract but some aspects must be adhered to –this is in relation to safety - especially in total hours worked per week and rest between shifts, the other aspects of the 2016 T&C may need to be flexible.

  Transition to the use of electronic locum claims via Tempre workforce system; due to the implementation of the Tempre system a temporary backlog of locum payments, this has subsequently been addressed by the rota team and reverted to the paper version which will remain in place until review of the process.

7. 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 additional work involved in the implementation of the 2016 contract.

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

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 February 2021			
Month 9 2020/21 Financial Performance			**Agenda Item 13, ENC 8**
Report Author and Job Title:	Luke Armstrong Head of Financial Management	**Responsible Director:**	Steven Mason Director of Finance
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report outlines the Trusts financial performance as at Month 9.		
Background	From Month 7 of 2020/21 revised financial arrangements have been put in place, replacing the previous arrangements of a break even requirement with retrospective expenditure claims. The Trust now has a fixed income level as agreed within the ICP, and is expected to manage resources within this funding envelope.		
Assessment	At month 9 the Trust is £0.4m underspend against its revised financial plan.		
Recommendation	Members of the Trust Board are asked to note the Finance position for month 9.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 4.1 - Lack of robust financial information and grip and control may result in poor financial governance and decision making lead to the inability to deliver the annual control total impacting on cash flow and long term sustainability as a going concern		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Excellence in patient outcomes and experience ☐	Excellence in employee experience ☐	
	Drive operational performance ☒	Long term financial sustainability ☒	
	Develop clinical and commercial strategies ☒		

Month 9 2020/21 Financial Performance

1. PURPOSE OF REPORT

The purpose of the report is to update the Board on the financial position of the Trust as at Month 9.

2. BACKGROUND

Following the suspension of the NHS Planning Process for 2020/21 the Trust had operated under a break even arrangement up to month 6. The Trust has received top up income from NHS England to cover its increased expenditure and achieve a break even position.

From month 7 a revised financial framework has been implemented. This new framework allows for greater system working across the ICP and ICS. The Trust now has a fixed financial plan for the remainder of 2020/21, with a fixed level of Clinical Income.

The Trust and the ICP, like others nationally, have a requirement to achieve an overall system break even position at the year end. Two items have been identified both regional and nationally as potentially allowable deviations from the breakeven requirement. This being lost non NHS income and an allowance for a year end annual leave provision. The amounts involved being £1.3m and £3.8m for the Trust.

As part of the new financial arrangements for month 7 onwards the Trust has reset its budget to align to the revised NHSI financial plan. Previous variances up to month 6 have been reset and the revised agreed budget profiled for month 7 onwards.

The revised budget includes a fixed budget allocation for Covid-19, outlined further in the report.

The financial position included within this report is shown on a group basis including both the Trust and the Trust’s subsidiary company South Tees Healthcare Management. The Trust is required to report on a group basis each month to NHSE/I.

The Month 9 YTD actual performance is a £0.4m deficit. This has resulted in the Trust being ahead of its financial plan by £0.4m. The Trust expects this variance to reduce as the year progresses to cover increased Covid-19 costs and winter pressures.

3. DETAILS

Trust position

The Month 9 position is outlined below; the following sections outline key variances and risks for divisional income, pay, non-pay and technical items.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Nhs Clinical Income	459,175	459,493	**318**	**623,901**
Education & Training Income	13,047	13,811	**764**	**17,402**
Estates Income	1,357	1,417	**60**	**1,908**
Misc. Other Income	6,672	6,987	**315**	**9,506**
Non Patient Care Income	1,906	2,008	**102**	**2,483**
Other Clinical Income	644	1,114	**470**	**885**
Psf, Mret & Top Up	38,472	38,541	**69**	**39,245**
Research & Development Income	3,505	3,823	**318**	**4,529**
Total Other Income	**524,778**	**527,195**	**2,417**	**699,857**
Ahp'S, Sci., Ther. & Tech.	(44,379)	(44,311)	**67**	**(60,195)**
Apprentice Levy	(1,141)	(1,141)	**0**	**(1,521)**
Hca'S & Support Staff	(34,162)	(34,299)	**(137)**	**(45,406)**
Medical And Dental	(93,490)	(95,309)	**(1,820)**	**(124,713)**
Nhs Infrastructure Support	(43,631)	(43,722)	**(91)**	**(58,991)**
Nursing & Midwife Staff	(93,368)	(92,902)	**466**	**(126,770)**
Total Pay	**(310,170)**	**(311,685)**	**(1,515)**	**(417,596)**
Clinical Negligence Cost	(13,050)	(13,050)	**0**	**(17,400)**
Clinical Supplies And Services	(49,203)	(47,022)	**2,182**	**(68,015)**
Drugs	(49,824)	(50,829)	**(1,005)**	**(66,906)**
Establishment	(6,916)	(7,187)	**(272)**	**(8,818)**
Ext. Staffing & Consultancy	(480)	(450)	**30**	**(567)**
General Supplies & Service	(7,342)	(7,408)	**(65)**	**(8,340)**
Healthcare Service Purchase	(8,796)	(9,157)	**(360)**	**(11,451)**
Miscellaneous Services	(1,052)	(1,375)	**(323)**	**(1,270)**
Pfi Unitary Payment	(29,459)	(29,440)	**19**	**(37,926)**
Premises & Fixed Plant	(18,884)	(19,329)	**(445)**	**(25,196)**
Research, Education & Training	(3,369)	(3,719)	**(349)**	**(4,217)**
Transport	(2,977)	(2,942)	**35**	**(4,032)**
Total Non Pay	**(191,352)**	**(191,907)**	**(555)**	**(254,139)**
Depreciation	(10,368)	(10,488)	**(120)**	**(14,994)**
Interest Payable	(8,702)	(8,708)	**(07)**	**(11,663)**
Interest Receivable	32	07	**(25)**	**57**
Other Non Operating	(5,007)	(4,832)	**175**	**(6,668)**
Corporation Tax	(01)	0	**01**	**(02)**
Control Total	**(789)**	**(418)**	**371**	**(5,148)**

Clinical Income

Under the revised financial arrangements for 2020/21, the Trust's previous contractual arrangement under an aligned incentive scheme with its commissioners no longer stands. Instead, the Trust is paid under a block arrangement as agreed by NHSE/I, these had been fixed for the first half of the year and then re set for the second.

For the second half of the year the Trust does have a number of key variable areas of clinical income that are not under a block arrangement, this covers

- HEPC and CDF Drugs

The Trust's block payments are shown below split by Commissioner. The prior year adjustment of £0.5m relates to differences between accruals made for NCAs in M11 and M12 of 2019/20 and actual billing within 2020/21.

Commissioner Code	Commissioner Name	Block Payment
16C	NHS Tees Valley CCG	231,731
84H	NHS County Durham CCG	10,534
85J	NHS England - North East and Yorkshire Commissioning Hub	141,356
85J	NHS England - CDF & HepC (months 7-12)	1,418
Y63	NHS England - North East and Yorkshire Commissioning Region	5,757
42D	NHS North Yorkshire CCG	66,104
15F	NHS Leeds CCG	127
13T	NHS Newcastle Gateshead CCG	181
01H	NHS North Cumbria CCG	489
03J	NHS North Kirklees CCG	105
00L	NHS Northumberland CCG	109
00P	NHS Sunderland CCG	548
03Q	NHS Vale of York CCG	1,096
Y58	South West Regional Office (MoD)	432
	Prior Year Adjustments	(494)
	Total Income Month 9	**459,493**

Clinical income is shown below split by income type in order to highlight variable elements.

In month 8 the Trust had a £0.3m adverse variance on blocks that was driven by the recognition of a funding reduction from Specialised Commissioning for high cost devices. This adjustment was in dispute with the national team and has now been repaid and reversed.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
YTD M6	294,554	294,554	0
M7 Onwards			
Blocks	149,264	149,354	90
Top Up	7,470	7,470	0
Covid-19	6,696	6,696	0
CDF	999	1,298	299
HEPC	192	121	(71)
YTD M7	**459,175**	**459,493**	**318**

In line with national guidance the Trust has assumed no income loss from the elective incentive scheme. A calculation has been done at a national level that shows the Trust has achieved the required activity level for September and October and as such will not be penalised.

Other Income

Other income is £2.1m ahead of plan, with key drivers of this variance being improved Education and Training income, RTA income and a VAT rebate from NHS Fleet Solutions. As part of the re setting of the Trust budget from month 7 a number of adjustments have been made to the other income budget to take account of lower income due to Covid-19, particularly in relation to Estates income, Private Patients and Overseas visitors income.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Education & Training Income	13,047	13,811	**764**	**17,402**
Estates Income	1,357	1,417	**60**	**1,908**
Misc. Other Income	6,672	6,987	**315**	**9,506**
Non Patient Care Income	1,906	2,008	**102**	**2,483**
Other Clinical Income	644	1,114	**470**	**885**
Psf, Mret & Top Up	38,472	38,541	**69**	**39,245**
Research & Development Income	3,505	3,823	**318**	**4,529**
Total Other Income	**65,603**	**67,701**	**2,098**	**75,956**

- Education and Training income is overachieving by £0.8m, this is a continuation from month 7 and is being driven by the revised education income received from Health Education North East for quarter 3. This income is linked to the increase in the number of educational placements across the Trust for Trainee Doctors. The finance team are working with the operational lead for Education to understand the recurrent nature of this income.
- Other clinical income is ahead of plan by £0.5m, this variance is largely RTA income along with a small element of private patients income that had not been budgeted for.

- Misc. other income is showing a favourable variance to plan of £0.3m driven by the £0.6m received from NHS Fleet Solutions as part of a historic VAT settlement with HMRC, offsetting against credits being issued for rental income from the Royal Volunteers Service along with reductions in salary recharge income.
- R and D income is over achieving by £0.3m linked to increased costs within non pay.

Pay

In the year to date position pay is overspent by £1.5m, due to an overspend on Medical and Dental employees, with non-medical staff groups showing a year to date underspend.

Graphs showing year to date premium pay costs and trends are included in Appendix 1.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Ahp'S, Sci., Ther. & Tech.	(44,379)	(44,311)	**67**	(60,195)
Apprentice Levy	(1,141)	(1,141)	**0**	(1,521)
Hca'S & Support Staff	(34,162)	(34,299)	**(137)**	(45,406)
Medical And Dental	(93,490)	(95,309)	**(1,820)**	(124,713)
Nhs Infrastructure Support	(43,631)	(43,722)	**(91)**	(58,991)
Nursing & Midwife Staff	(93,368)	(92,902)	**466**	(126,770)
Total Pay	**(310,170)**	**(311,685)**	**(1,515)**	**(417,596)**

- HCAs are overspent by £0.1m with nursing staff £0.5m underspent giving a combined underspent budget position. Within the budget is a YTD allowance of Covid sick pay of £0.3m and additional winter funding of £0.3m from the CCG. Bank spend for both staff groups has in the current month decreased compared to month 8 by £0.2m with lower fill rates noticed over the Christmas holidays.
- Medical and Dental staff show a year to date overspend of £1.8m. £1.2m of this overspend relates to junior doctors and £0.6m consultants. The overspend on consultants relates to increased premium costs for agency staffing within a number of directorates, particularly older person medicine, oral surgery, respiratory and Radiotherapy /Oncology.
- Within Medical and Dental costs a provision has been made for the payment of local CEA awards to consultants in line with guidance for 2020/21 of £1.3m. This was fully budgeted as part of the M7 – M12 budget setting exercise.
- Additional work is required within the medical workforce team to complete the review of junior doctor rotas and align these to budgets held within Finance. The Trust needs to ensure appropriate controls are in place for the deployment of staff across the Trust. Work is being arranged to add rotas to the allocate rostering system and review the individual specialty detail.

Non-Pay

Non-pay is overspent by £0.6m at month 9.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Clinical Negligence Cost	(13,050)	(13,050)	**0**	**(17,400)**
Clinical Supplies And Services	(49,203)	(47,022)	**2,182**	**(68,015)**
Drugs	(49,824)	(50,829)	**(1,005)**	**(66,906)**
Establishment	(6,916)	(7,187)	**(272)**	**(8,818)**
Ext. Staffing & Consultancy	(480)	(450)	**30**	**(567)**
General Supplies & Service	(7,342)	(7,408)	**(65)**	**(8,340)**
Healthcare Service Purchase	(8,796)	(9,157)	**(360)**	**(11,451)**
Miscellaneous Services	(1,052)	(1,375)	**(323)**	**(1,270)**
Pfi Unitary Payment	(29,459)	(29,440)	**19**	**(37,926)**
Premises & Fixed Plant	(18,884)	(19,329)	**(445)**	**(25,196)**
Research, Education & Training	(3,369)	(3,719)	**(349)**	**(4,217)**
Transport	(2,977)	(2,942)	**35**	**(4,032)**
Total Non Pay	**(191,352)**	**(191,907)**	**(555)**	**(254,139)**

- Clinical supplies and services are showing a year to date underspend of £2.2m. £0.5m of this relates to the phasing of the Covid-19 budget, £0.4m from underspends within Medical Engineering on maintenance contracts and the residual £1.3m from underspends in a number of clinical directorates arising from reductions in activity levels.
- Drugs has seen an increase in cost in month leading to a YTD overspend of £1.0m. This increase in cost is from increased activity in a number of directorates including Paediatrics, Gastro, Rad/Onc and Neurology. The pharmacy team are investigating the increases in cost and dispensing to understand the recurrent nature of the spend.
- Healthcare Service purchase is overspending by £0.4m year to date with £0.1m of this within Ophthalmology from outsourcing work to New Medica, £0.2m within Trauma and Orthopaedics for outsourcing to the T and O LLP and an overspend within renal of £0.1m from the satellite renal clinics.
- Premised and Fixed Plant is overspending by £0.4m due to the purchases of furniture and fittings, minor new works and estates work for Covid-19. Where relevant for vaccinations and swabbing this cost is being recovered from NHSE/I.
- Research, Education and Training is overspending by £0.3m due to clinical trials, with this cost covered by additional income.

Non-Operating Costs

Technical items are broadly in line with budgeted amounts, following the rephrasing of the Trusts annual budget and delays to the Trust capital programme. The revised full year deprecation charge for the Trust has now been calculated and is shown within the YTD position. The level of PDC dividend is being reviewed with NHSE/I to ensure an accurate full year forecast.

Covid-19 Costs

In line with the revised financial arrangement for the second half of 2020/21 the Trust now has a fixed financial plan; within this the Trust has allocated specific budgets for Covid-19 expenditure.

Following discussions with operational colleagues and CPG the below envelopes of funding have been provided. Although underspent currently at month 9 the Trust expects to fully utilise the full budget allocation by year end.

Actual month 9 spend is outlined below within these categories.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Sickness	(1,150)	(1,150)	
Facilities	(500)	(500)	
Ward	(250)	(250)	
Critical Care	(291)	(291)	
IPC & Winter	(31)	(31)	
Redcar	(68)	(68)	
Emergency Department	(232)	(232)	
PPE		(118)	**118**
Christmas Staff Meals		(100)	**100**
Other		(77)	**77**
Contingency	(544)		**(544)**
Total	**(3,066)**	**(2,817)**	**(249)**

The full allocation for sickness costs has been shown as utilised due to the Trust over spending in month on pay expenditure. Provisions have been made within Facilities for anticipated spend with Serco. PPE spend has been noticed in month, this category is not expected to incur extra cost as the year progresses as all required PPE should be centrally provided.

The Trust has also incurred cost in relation to Covid-19 swabbing YTD of £0.4m, covering increased staffing and consumables along with the hire of swabbing facilities. This cost has been fully reclaimed from NHSE/I and the Trust is awaiting confirmation that these costs will be covered and fully reimbursed.

Within month 9 the Trust has also started its vaccination programme. Like swabbing the Trust is able to claim the incremental cost increase associated with the vaccination programme from NHS England. For month 9 this has been £0.2m for pay costs and £0.1m for non-pay costs.

The Trust has received feedback on its final retrospective top up claim for month 6, the Trust is being deducted £0.3m for the provision made in respect of the backdating of expense payments and £0.4m for system development funding, with this adjustment being made within the month 9 position. The Trust will look to manage both losses within its current funding envelope. Overall the level of reimbursement was significant and has enabled the Trust to break even despite a significant underlying deficit caused by the historic PFI scheme on James Cook University Hospital.

Forecast outturn

The Trust is continuing to monitor and plan its expected outturn positon, with discussions ongoing within the ICP and Tees Valley CCG. The Trust planned deficit for the year end as part of the planning process was £5.1m driven by lost other income due to Covid-19 and annual leave accruals. The Trust has agreed to move its forecast deficit to £2.5m showing an improvement of £2.6m, being driven by increased funding from the CCG.

Further work is being conducted in January to understand the extend of the required year end annual leave provision including the specific cost of Covid-19 and the additional days holiday awarded to all employees.

Capital

The Trust's capital expenditure at the end of December amounted to £24.5m as detailed below:

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
PFI Lifecycle	7,950	7,733	(218)	10,310	10,310	0
Site Reconfiguration	807	933	126	8,247	8,292	45
Replacement of Medical Equipment	4,479	4,338	(141)	8,574	8,402	(172)
Network Replacement and Clinical Noting	2,544	3,243	699	9,963	10,090	127
COVID Phase 1	8,482	8,286	(196)	8,482	8,482	0
Total	**24,262**	**24,533**	**271**	**45,576**	**45,576**	**0**

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Financing						
Depreciation	6,359	6,359	0	9,539	9,539	0
Internal Reserves	0	0	0	472	472	0
Charitable Funding	305	08	(297)	1,181	1,181	0
PDC	17,598	18,165	568	34,384	34,384	0
Total Financing	**24,262**	**24,533**	**271**	**45,576**	**45,576**	**0**

The expenditure at the end of December includes:

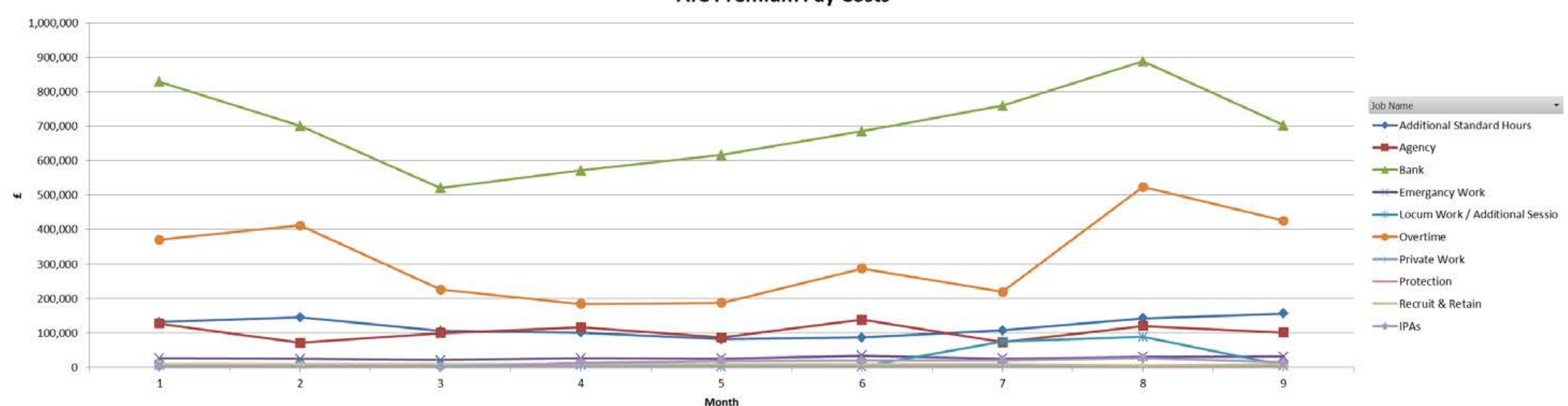
a) PFI Lifecycle - contractual payments to Endeavour SCH plc (£7.7m),
b) COVID-19 - £8.3m on medical equipment to support delivery of services;
c) Information Technology - £3.2m on essential IT equipment replacement and the delivery of the Alcidion project;
d) Medical equipment - £4.3m on emergency replacements including £2.8m on the expansion of robotic surgery; and

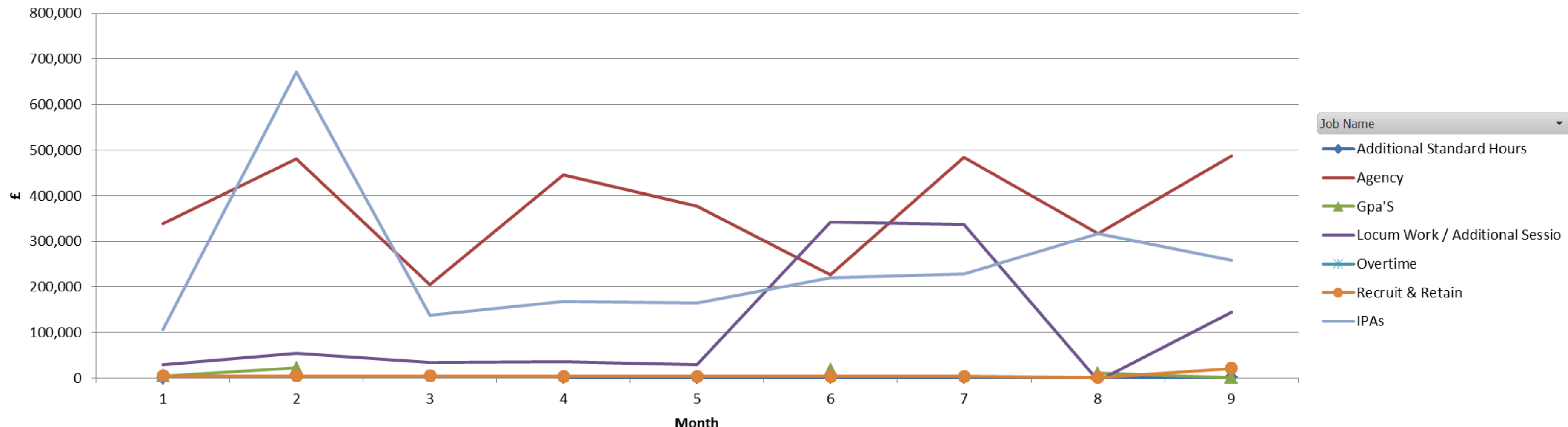
e) Estate Rationalisation - £0.9m on the investment in the estate infrastructure including Community premises and PFI lifecycle enhancements.

As it stands for 2020/21 the only funding sources available to the Trust, excluding PDC, includes depreciation and internal reserves (£10.0m) and potential charitable contributions amounting to £1.2m. Contractual commitments for the year include PFI Lifecycle (£10.3m) with £3.3m charged to revenue in line with the agreed recharge profile from the Lifecycle Fund. In addition, further contractual commitments concern the principal repayments on loans, PFI and finance leases of £5.4m. On that basis and without support, the existing funding sources are not sufficient to cover these contractual commitments.

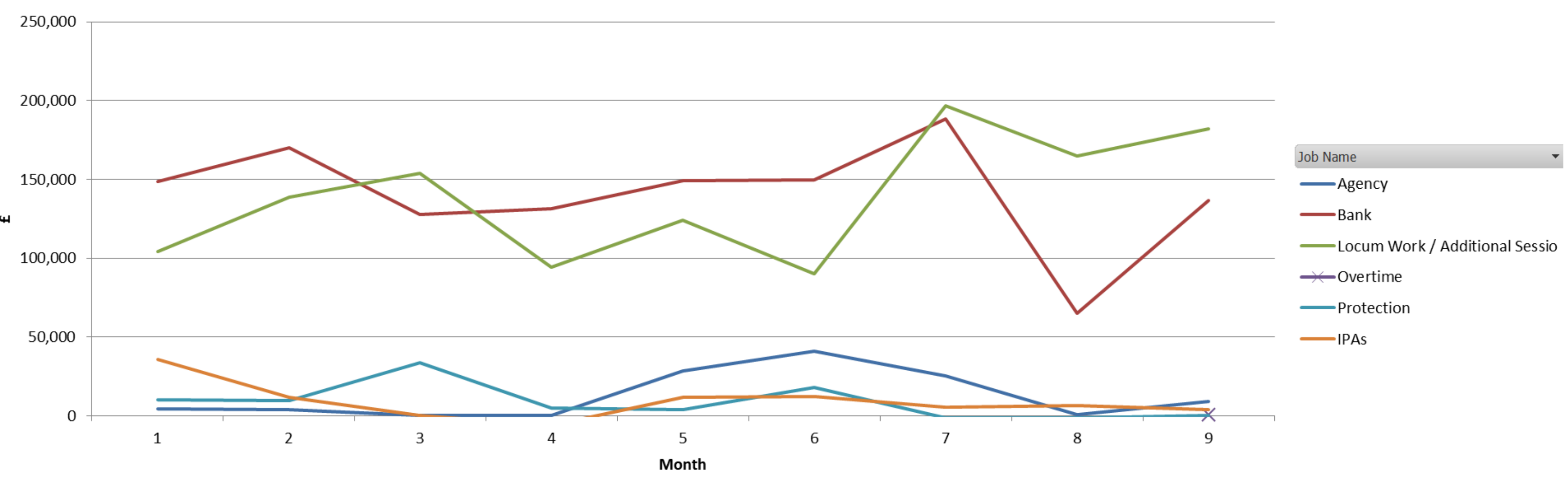
To support the submission of the Trust's capital plan to NHSE/I in July for 2020/21, the Trust drafted an emergency request for support amounting to £14.6m. This request has now been approved by DHSC and all other outstanding PDC allocations, apart from £0.8m relating to COVID-19 Phase 1, have also been approved. The approved allocations include Urgent and Emergency Care (£3.2m), Digital Aspiration (£3.0m) and FHN Rationalisation (£1.0m). The latter bid relating to FHN Rationalisation was a 2 year request including £4.1m in 2021/22 and this portion is also still going through the approval process. The Trust will start to draw funding on all approved PDC funded schemes in January.

Appendix 1





NHS
South Tees Hospitals
NHS Foundation Trust


Medical and Dental Trainee Grades Premium Pay Costs
250,000
200,000
150,000
100,000
50,000
0
£
1
2
3
4
5
6
7
8
9
Month
Job Name
Agency
Bank
Locum Work / Additional Sessio
Overtime
Protection
IPAs

<table>
<tr><td colspan="4">MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 February 2021</td></tr>
<tr><td colspan="3">Approach to Improvement Planning for 2021/21 and beyond</td><td>AGENDA ITEM: 14,
ENC 9</td></tr>
<tr><td>Report Author and Job Title:</td><td>Ros Fallon
Director of Planning and Recovery</td><td>Responsible Director:</td><td>Ros Fallon
Director of Planning and Recovery</td></tr>
<tr><td>Action Required</td><td colspan="3">Approve ☐ Discuss ☐ Inform ☒</td></tr>
<tr><td>Situation</td><td colspan="3">Whilst Covid 19 has impacted on the Trust waiting list position it has also provided opportunities for improvement right across the Trust. We now need to look beyond Covid 19 and plan for recovery of services over the next 1,2 and 5 years.</td></tr>
<tr><td>Background</td><td colspan="3">In February 2020 The Trust Board approved an Improvement Plan. On 23 December 2020 the Trust received a letter from the Chief Operating Officer of NHS England setting out the NHS Priorities for winter and for 2021/22.</td></tr>
<tr><td>Assessment</td><td colspan="3">The Trust needs to assess progress and refresh the Improvement Plan originally published in February 2020. The intention is that over the coming months a single refreshed Improvement Plan is developed which will set out strategic and operational priorities for the Trust for the next 2 to 3 years.

Discussions have started to take place around the approach we will take to planning, ensuring it is led by the new medical structure, the emerging 10 Collaboratives and the Leadership and Safety Academy.

The approach to planning is still emerging as the new medical leadership becomes established and, whilst the NHS letter is contained in this report, the committee will receive a detailed presentation on the approach at the meeting on 28 January 2021</td></tr>
<tr><td>Recommendation</td><td colspan="3">Members of the Trust Board of Directors are asked to note the approach to Improvement Planning for 2021/22 and beyond</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="3">There are no risk implications associated with this report.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="3">There are no legal or equality & diversity implications associated with this report.</td></tr>
<tr><td rowspan="2">Strategic Objectives</td><td colspan="2">Excellence in patient outcomes and experience ☐</td><td>Excellence in employee experience ☐</td></tr>
<tr><td colspan="2">Drive operational performance</td><td>Long term financial sustainability</td></tr>
</table>

	☒	☐
	Develop clinical and commercial strategies ☐	

To:
- STP and ICS Leaders
- Chief executives of all NHS trusts and foundation trusts
- CCG Accountable Officers
- GP practices and Primary Care Networks
- Providers of community health services
- NHS 111 providers

Skipton House
80 London Road
London
SE1 6LH

23 December 2020

CC:
- NHS Regional Directors
- Regional Incident Directors & Heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of adult social care
- Chairs of Local Resilience Forums

Dear colleague

Important – for action – Operational priorities for winter and 2021/22

As we near the end of this year, we are writing to thank you and your teams for the way you have responded to the extraordinary challenge of Covid-19 and set out the key priorities for the next phase.

An extraordinary 2020

In the past year we have cared for more than 200,000 of those most seriously ill with Covid-19 in our hospitals. At the same time NHS staff have also worked incredibly hard to keep essential services such as cancer, mental health, general practice, urgent, emergency and community healthcare running and restore non-urgent services that had to be paused. Community nurses, pharmacists, NHS 111 staff and other NHS workers have cared for countless others, and been supported by the wider NHS team, from HR and finance to admin and clerical staff. The number of cancer treatments is above the level at the same time last year. GP appointments are back to around pre-pandemic levels. Mental health services have remained open and more than 400,000 children have accessed mental health services, above the target for 2020/21. Community services are supporting 15 per cent more people than they were at the same point last year. And we have had a record number of people vaccinated against flu, including a higher percentage of NHS staff than in the last three years. It has been an incredible team effort across our health and care system.

The response to the pandemic has also demonstrated our health service's enormous capacity for innovation with rapid development and implementation of new treatments, such as dexamethasone, rolling out of pulse oximetry and at-home patient self-monitoring, and the move to virtual and telephone consultations. We are already in the third week of our world-leading vaccination programme – the largest in NHS history.

We know that this relentless pressure has taken a toll on our people. Staff have gone the extra mile again and again. But we have lost colleagues as well as family and friends to the virus; others have been seriously unwell and some continue to

experience long-term health effects. The response of the NHS to this unprecedented event has been magnificent. We thank you and your teams unreservedly for everything that you have given and achieved and the support you continue to give each other.

You have asked us for a short statement of operational priorities going forward. This letter is therefore intended to help you and your staff over the next few months by:

- ensuring we have a collective view of the critical actions for the remainder of this financial year, and
- signalling the areas that we already know will be important in 2021/22.

Managing the remainder of 2020/21

Given the second wave and the new more transmissible variant of the virus, it is clear that this winter will be another challenging time for the NHS. Our task is five-fold:

A. Responding to Covid-19 demand
B. Pulling out all the stops to implement the Covid-19 vaccination programme
C. Maximising capacity in all settings to treat non-Covid-19 patients
D. Responding to other emergency demand and managing winter pressures
E. Supporting the health and wellbeing of our workforce

In addition, as the UK approaches the end of the transition period with the European Union on 31 December 2020, we will provide updates as soon as the consequences for the NHS become known. We are following a single operational response model for winter pressures, including Covid-19 and the end of the EU transition period. All CCGs and NHS trusts should have an SRO to lead the EU/UK transition work and issues should be escalated to the regional incident centre established for Covid-19, EU transition and winter.

A. Responding to ongoing Covid-19 demand

With Covid-19 inpatient numbers rising in almost all parts of the country, and the new risk presented by the variant strain of the virus, you should continue to plan on the basis that we will remain in a level 4 incident for at least the rest of this financial year and NHS trusts should continue to safely mobilise all of their available surge capacity over the coming weeks. This should include maximising use of the independent sector, providing mutual aid, making use of specialist hospitals and hubs to protect urgent cancer and elective activity and planning for use of funded additional facilities such as the Nightingale hospitals, Seacole services and other community capacity. Timely and safe discharge should be prioritised, including making full use of hospices. Support for staff over this period will need to remain at the heart of our response, particularly as flexible redeployment may again be required.

Maintaining rigorous infection prevention and control procedures continues to be essential. This includes separation of blue/green patient pathways, asymptomatic testing for all patient-facing NHS staff and implementing the ten key actions on infection prevention and control, which includes testing inpatients on day three of their admission.

All systems are now expected to provide timely and equitable access to post-Covid assessment services, in line with the commissioning guidance.

B. Implementing the Covid-19 vaccination programme

On 8 December, after the MHRA confirmed the Pfizer BioNTech vaccine was safe and effective, the biggest and most ambitious vaccine campaign in NHS history began.

The Joint Committee for Vaccination and Immunisation (JCVI) priorities for roll out of the vaccine have been accepted by Government, which is why the priority for the first phase of the vaccination is for individuals 80 years of age and over, and care home workers, with roll out to care home residents now underway. It is critical that vaccinations take place in line with JCVI guidance to ensure those with the highest mortality risk receive the vaccine first. To minimise wastage, vaccination sites have been ensuring unfilled appointments are used to vaccinate healthcare workers who have been identified at highest risk of serious illness from Covid-19. Healthcare providers have been undertaking staff risk assessments throughout the pandemic to identify these individuals and it remains important that this is organised across the local healthcare system to ensure equitable access.

If further vaccines are approved by the independent regulator, the NHS needs to be prepared and ready to mobilise additional vaccination sites as quickly as possible. In particular, Covid-19 vaccination is the highest priority task for primary care networks including offering the vaccination to all care home residents and workers. All NHS trusts should be ready to vaccinate their local health and social care workforce very early in the new year, as soon as we get authorisation and delivery of further vaccine.

C. Maximising capacity in all settings to treat non-Covid-19 patients

Systems should continue to maximise their capacity in all settings. This includes making full use of the £150m funding for general practice capacity expansion and supporting PCNs to make maximum use of the Additional Roles Reimbursement Scheme, in order to help GP practices maintain pre-pandemic appointment levels. NHS trusts should continue to treat as many elective patients as possible, restoring services to as close to previous levels as possible and prioritising those who have been waiting the longest, whilst maintaining cancer and urgent treatments.

To support you to maximise acute capacity, as set out in Julian Kelly and Pauline Phillip's letter of 17 December, we have also extended the national arrangement with the independent sector through to the end of March, to guarantee significant access to 14 of the major IS providers. NHS trusts have already been notified of the need for a Q4 activity plan for their local IS site by Christmas; this should be coordinated at system level. If you need it, we can also access further IS capacity within those providers subject to the agreement of the national team. However, we will need to return to local commissioning from the beginning of April and local systems, in partnership with their regional colleagues, will need to prepare for that.

The publication of the Ockenden Review of maternity services is a critical reminder of the importance of safeguarding clinical quality and safety. As set out in our letter of 14 December there are twelve urgent clinical priorities that need to be implemented. All Trust Boards must consider the review at their next public meeting along with an assessment of their maternity services against all the review's immediate and essential actions. The assessment needs to be reported to and assured by local systems, who should refresh their local programmes to make maternity care safer, more personalised and more equitable.

D. Responding to emergency demand and managing winter pressures

Alongside providing £80m in new funding to support winter workforce pressures, we are asking systems to take the following steps to support the management of urgent care:

- Ensure those who do not meet the 'reasons to reside' criteria are discharged promptly. We know that maximising capacity over the coming weeks and months is essential to respond to seasonal pressures. We are asking all systems to improve performance on timely and safe discharge, as set out in today's letter, as well as taking further steps that will improve the position on 14+ and 21+ day length of stay, aided by 100% completion of discharge and reasons to reside data.

- Complete the flu vaccination programme, including vaccinating our staff against flu and submitting vaccination uptake data to the National Immunisation and Vaccination system (NIVS).

- To minimise the effects of emergency department crowding, continue to develop NHS 111 as the first point of triage for urgent care services in your locality, with the ability to book patients into the full range of local urgent care services, including urgent treatment centres, same day emergency care and speciality clinics as well as urgent community and mental health services.

- Maximise community pathways of care for ambulance services referral, as a safe alternative to conveyance to emergency departments. Systems should also ensure sufficient arrangements are in place to avoid unnecessary conveyance to hospital, such as the provision of specialist advice, including from emergency departments, to paramedics as they are on scene.

E. Supporting the health and wellbeing of our workforce

Our NHS people continue to be of the utmost importance, and systems should continue to deliver the actions in their local People Plans. Please remind all staff that wellbeing hubs have been funded and will mobilise in the new year in each system.

Planning for 2021/22

The Spending Review announced further funding for the NHS for 2021/22 but in the new year, once we know more about the progress of the pandemic and the impact of the vaccination programme, the Government will consider what additional funding will be required to reflect Covid-19 cost pressures.

In the meantime, systems should continue to:

- **Recover non-covid services**, in a way that reduces variation in access and outcomes between different parts of the country. To maximise this recovery, we will set an aspiration that all systems aim for top quartile performance in productivity on those high-volume clinical pathways systems tell us have the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/orthopaedics. The Government has provided an additional £1bn of funding for elective recovery in 2021/22. In the new year we will set out more details of

how we will target this funding, through the development of system-based recovery plans that focus on addressing treatment backlogs and long waits and delivering goals for productivity and outpatient transformation. In the meantime we are asking you to begin preparatory work for this important task now, through the appointment of a board-level executive lead per trust and per system for elective recovery.

- Strengthen delivery of local **People Plans**, and make ongoing improvements on: equality, diversity and inclusion of the workforce; growing the workforce; designing new ways of working and delivering care; and ensuring staff are safe and can access support for their health and wellbeing.
- Address the **health inequalities** that covid has exposed. This will continue to be a priority into 2021/22, and systems will be expected to make and audit progress against the eight urgent actions set out on 31 July as well as reduce variation in outcomes across the major clinical specialties and make progress on reducing inequalities for people with learning disabilities or serious mental illness, including ensuring access to high-quality health checks.
- Accelerate the planned expansion in **mental health** services through delivery of the Mental Health Investment Standard together with the additional funding provided in the SR for tackling the surge in mental health cases. This should include enhanced crisis response and continuing work to minimise out of area placements.
- Prioritise investment in **primary and community care**, to deal with the backlog and likely increase in care required for people with ongoing health conditions, as well as support prevention through vaccinations and immunisations. Systems should continue to focus on improving patient experience of access to general practice, increasing use of online consultations, and supporting the expansion of capacity that will enable GP appointments to increase by 50 million by 2023/24.
- Build on the development of effective **partnership working at place and system level**. Plans are set out in our Integrating Care document.

These priorities should be supported through the use of data and digital technologies, including the introduction of a minimum shared care record in all systems by September 2021 to which we will target some national funding, and improved use of remote monitoring for long term conditions.

The 2021/22 financial framework

For the reasons set out above, we won't know the full financial settlement for the NHS until much closer to the beginning of the new financial year, reflecting, in particular, uncertainty over direct Covid-19 costs. We will, however, need to start work early in the new year to lay the foundation for recovery. The underlying financial framework for 2021/22 will therefore have the following key features:

- Revenue funding will be distributed at system level, continuing the approach introduced this year. These **system revenue envelopes will be consistent with the LTP financial settlement**. They will be based on the published CCG allocation and the organisational Financial Recovery Fund each system would

have been allocated in 2021/22. There will be additional funding to offset some of the efficiency and financial improvements that systems were unable to make in 2020/21.

- Systems will **need to calculate baseline contract values to align with these financial envelopes** so there is a clear view of baseline financial flows. Our planning guidance will suggest that these should be based on 2019/20 outturn contract values adjusted for non-recurrent items, 2020/21 funding growth and service changes, not on the nationally-set 2020/21 block contracts.

- Systems and organisations should start to develop plans for **how Covid-19 costs can be reduced and eliminated** once we start to exit the pandemic.

- **System capital envelopes** will also be allocated based on a similar national quantum and using a similar distributional methodology to that introduced for 2020/21 capital planning.

We will aim to circulate underlying financial numbers early in the new year. We will then provide fuller planning guidance once we have resolved any further funding to reflect the ongoing costs of managing Covid-19. Further detail of non-recurrent funding announced in the recent Spending Review for elective and mental health recovery will also be provided at that point.

Conclusion

This year has arguably been the most challenging in the NHS's 72-year history. But even in these most testing times, people across the service have responded with passion, resilience and flexibility to deal with not only the virus but also the needs of patients without Covid-19. The rollout of the vaccine will bring hope to 2021 and we will need to maintain the energy and effort to meet the needs of all we serve throughout the year. Thank you for all that you have done and continue to do to achieve this.

With best wishes,

Amanda Pritchard
Chief Executive, NHS Improvement and
NHS Chief Operating Officer

Julian Kelly
NHS Chief Financial Officer

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 2 February 2021			
Integrated Performance Report			**AGENDA ITEM: 15, ENC 10**
Report Author and Job Title:	Emma Moss Business Intelligence Unit	**Responsible Director:**	Various
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	To provide the Board with a detailed assessment of performance against the agreed indicators and measures. The report describes the specific actions that are under way to deliver the required standards.		
Background	The Integrated Performance Report (IPR) will be produced by the Trust on a monthly basis to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance. The IPR provides assurance to the Board that all areas of performance are monitored, allowing the Board to gain assurance regarding actual performance, Trust priorities and remedial actions. Key elements of the report will be discussed by the Board's Quality Assurance Committee, Finance and Investment Committee and Workforce and OD Committee. A summary of discussions will be included in Chair Reports to the Board of Directors.		
Assessment	Key messages relating to performance this month include: • There have been no reports of MRSA for the past 14 months, demonstrating a capable process. • Data quality issues are being investigated for Mixed Sex Accommodation and E-Discharge metrics. • Higher acuity, reduced capacity and swabbing delays have led to A and E compliance being below target and continuing to be an area of concern. • RTT and diagnostic compliance continue to improve through the implementation of recovery plans, although both are still below target. • 62 day target Cancer compliance was below the lower control limit for December, although ratification is still on going. • There has been significant deterioration in annual appraisal compliance due to staff absence as a result of COVID and the need to focus on operational duties. • Although staff turnover has stabilised statistically it is an area for concern.		

<table>
<tr><td></td><td colspan="2">

- The Trust is £0.4m ahead of revised plans.

The following metrics are being worked through and will be included in from next month's report:
VTE
Sepsis – NEWS score taken within one hour of arrival
Sepsis – Antibiotics administered within one hour of sepsis diagnosis
Maternity outcomes – details to be discussed with the service</td></tr>
<tr><td>Recommendation</td><td colspan="2">The Board of Directors are asked to:

a) Receive the Integrated Performance Report for December 2020.
b) Note the performance standards that are being achieved.
c) Be assured that where performance standards are not currently met, a detailed analysis is being undertaken and actions are in place to ensure an improvement is made.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="2">BAF risk 1.5 - Risk to Trusts ability to delivery strategic objectives due to diversion of resources of all types required to manage the Covid 19 pandemic.
BAF risk 3.1 - A sustained, exceptional level of demand for services that overwhelms capacity resulting in a prolonged, widespread reduction in the quality of patient care and repeated failure to achieve constitutional standards, with possible harm to patients
BAF risk 3.2 - Risk of ability to deliver the national access target of 92% for 18 weeks RTT and achievement of the March 19 WTL by March 2020 due to gaps in workforce (T&O, Spinal, General Surgery, Plastics and Urology), increasing demand (ophthalmology, Gastroenterology), transfer of activity from CCDFT, reduction in weekend working and premium pay .
BAF risk 3.3 - Risk of ability to deliver the national access target of 85% for 62 Day Cancer Standard</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="2">There are no legal or equality & diversity implications associated with this paper.</td></tr>
<tr><td rowspan="3">Strategic Objectives
(highlight which Trust Strategic objective this report aims to support)</td><td>Excellence in patient outcomes and experience ☐</td><td>Excellence in employee experience ☐</td></tr>
<tr><td>Drive operational performance ☐</td><td>Long term financial sustainability ☐</td></tr>
<tr><td>Develop clinical and commercial strategies ☐</td><td></td></tr>
</table>

Integrated Performance Report

December 2020

Key Messages

Our key messages are:

- There have been no reports of MRSA for the past 14 months, demonstrating a capable process.
- Data quality issues are being investigated for Mixed Sex Accommodation and E-Discharge metrics.
- Higher acuity, reduced capacity and swabbing delays have led to A and E compliance being below target and continuing to be an area of concern.
- RTT and diagnostic compliance continue to improve through the implementation of recovery plans, although both are still below target.
- 62 day target Cancer compliance was below the lower control limit for December, although ratification is still on going.
- There has been significant deterioration in annual appraisal compliance due to staff absence as a result of COVID and the need to focus on operational duties.
- Although staff turnover has stabilised statistically it is an area for concern.
- The Trust is £0.4m ahead of revised plans.

Quality Summary

Domain	Indicator	Latest Month	Target	Trend	Assurance
SAFE	All Falls Rate	5.75	5		
SAFE	Falls With Harm Rate	0.26	0		
SAFE	Infection Control - C-Difficile	5	6.75		
SAFE	Infection Control - MRSA	0	0	L	
SAFE	Serious Incidents	9	0		
SAFE	Never Events	0	0		
SAFE	Category 2 Pressure Ulcers	125	TBD	H	
SAFE	Category 3 & 4 Pressure Ulcers	14	TBD		
SAFE	SHMI	121.80	N/A		
SAFE	Hospital Standard Mortality Rate (HSMR)	101.26	N/A		
SAFE	VTE Assessment	Data Validation Required - metric isn't currently being reported nationally			
EFFECTIVE	SEPSIS - Screening	Data Validation Required			

Domain	Indicator	Latest Month	Target	Trend	Assurance
CARING	F&F A&E Overall Experience Rate (%)	89.42%	85.0%		
CARING	F&F A&E Response Rate (%)	Unavailable - NHS Digital currently not publishing this data			
CARING	F&F Inpatient Overall Experience Rate (%)	97.34%	96.0%		
CARING	F&F Inpatient Response Rate (%)	Unavailable - NHS Digital currently not publishing this data			
CARING	F&F Outpatient Overall Experience Rate (%)	100.00%	95.0%		
CARING	F&F Maternity Overall Experience Rate (%)	100.00%	97.0%		
CARING	F&F Maternity Response Rate (%)	Unavailable - NHS Digital currently not publishing this data			
CARING	Complaints Closed Within Target (%)	72.97%	80.0%		
CARING	Mixed Sex Accommodation (MSA) Breaches	Data Validation Required			

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

Safe

All Falls Rate

The Trust falls rate per 1000 bed days

Target	5
Mean	4.98
Last Month	5.75

Executive Lead

Deirdre Fowler

Lead

Beth Swanson

Commentary

Overall compliance against this metric has not changed in the last 2 ½ years, therefore we do not have confidence we will consistently achieve the target.

Cause of Variation

- The falls rate per 1000 bed days remains susceptible to changes in patient dependency, work force and location.
- In December, there were 134 falls. This included: 10 falls from the toilet or commode, 38 from bed, 28 chairs, 1 trips and 54 while mobilising.
- The most common cause of falls remain poor balance (30), slips (16), deconditioning (12), memory loss (10), alcohol / drug toxicity (5).

Planned Actions

- New falls improvement work has been suspended due to Covid-19:
- November actions remain ongoing: There is now dedicated a project facilitator within the STAQC team leading multiple PDSA cycles with ward staff. This includes a trial of the "falling star" visual indicator and work to improve patient mobilisation.
- Review of high low bed provision and use of bed rails
- Ward 3, 9 and 11 – are completing a new training package which includes fall's assessment completion and "what now" and L&S BPs, fall's specific exercise prescription.

Timescale

- All actions are ongoing and linked to the falls reduction strategy.
- STAQC team continue to foster the sharing of good practice and quality improvement work.

Safe

Falls With Harm Rate

Rate of falls with harm per 1000 bed days

Target	0
Mean	0.12
Last Month	0.26

Executive Lead

Deirdre Fowler

Lead

Beth Swanson

Commentary

This metric has not significantly changed over time.
There is evidence during COVID that there was an increase in falls (likely due to bed moves.)
As the target is 0 there is no evidence we can consistently achieve it.

Cause of Variation

In December, 4 patients sustained a fractured NOF. All 4 occurred following falls from bed

Time	Location	Type	Confused	Why did the patient fall (observed or recalled reason)?
03:00	Ward 29	Fall from bed	N	Alcohol/drug intoxication/withdrawal, Dizziness or light-headedness - black outs, fainting or loss of consciousness
11:30	Ward 12	Fall from bed	Y	Alcohol/drug intoxication/withdrawal, Dizziness or light-headedness - black outs, fainting or loss of consciousness, Slip
14:15	Zetland Ward	Fall from bed	Y	Alcohol/drug intoxication/withdrawal, Poor balance, causing unsteadiness
20:15	Ainderby Ward - FHN	Fall from bed	N	Alcohol/drug intoxication/withdrawal, Slip, Some bladder or bowel conditions (incontinence or urgency)

Planned Actions

- New falls improvement work has been suspended due to Covid-19.
- November actions remain ongoing: There is now dedicated a project facilitator within the STAQC team leading multiple PDSA cycles with ward staff. This includes a trial of the "falling star" visual indicator and work to improve patient mobilisation.
- Review of high low bed provision and use of bed rails
- Ward 3, 9 and 11 – are completing a new training package which includes fall's assessment completion and "what now" and L&S BPs, fall's specific exercise prescription.

Timescale

- All actions are ongoing and linked to the falls reduction strategy.
- STAQC team continue to foster the sharing of good practice and quality improvement work.

Safe

Infection Control - C-Difficile

16
14
12
10
8
6
4
2
0

Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value | Target | Mean | LCL | UCL
Improvement | Concern | Outside CL High | Outside CL Low

Cases of hospital acquired C. Difficile bacteraemia

Target	6.75
Mean	6.09
Last Month	5.00

Executive Lead

Deirdre Fowler

Lead

Sharon Lance

Commentary

Except for April – Nov 19 there is no significant change over time.
A monthly target of 6.75 has been added to support monitoring against last years upper threshold of 81.
Currently the process is not capable of consistently meeting target.

Cause of Variation

- Further thematic review of RCA's required
- There were 6 areas with a CDI case identified in November (4 HOHA & 2 COHA); JC06, JC11, JC25, JC36, ICU3 and Ainderby.
- Therefore in the first 9 months of 2020/2021 there have been 60 trust-apportioned cases. We are currently above trajectory, and we note the higher number of cases during July, August and September.
- Increased focus when discussing at IPAG, safety huddle and matron huddles.

Planned Actions

- Continue reintroduction of RCA'S and panel reviews, proving difficult due to Covid.
- Reporting to be strengthened into IPAG with new meeting structure in 2021.
- Development of electronic system for side rooms to aid prompt isolation.
- Senior IPCN review of all RCA cases to identify thematic analysis.
- Review of IPC Matron Huddle, to be strengthened in the future.

Timescale

- Ongoing

Safe

Infection Control - MRSA

Target	0
Mean	0.06
Last Month	0.00

Executive Lead

Deirdre Fowler

Lead

Sharon Lance

Chart axis labels: 0, 1, 2; Apr-18, May-18, Jun-18, Jul-18, Aug-18, Sep-18, Oct-18, Nov-18, Dec-18, Jan-19, Feb-19, Mar-19, Apr-19, May-19, Jun-19, Jul-19, Aug-19, Sep-19, Oct-19, Nov-19, Dec-19, Jan-20, Feb-20, Mar-20, Apr-20, May-20, Jun-20, Jul-20, Aug-20, Sep-20, Oct-20, Nov-20, Dec-20

Legend: Trust Value, Target, Mean, LCL, UCL, Improvement, Concern, Outside CL High, Outside CL Low

Cases of hospital acquired MRSA bacteraemia

Commentary

14 months of consecutive compliance shows the current process is a capable process.

Cause of Variation

- Not applicable

Planned Actions

- Aseptic non touch technique training and audit programs for indwelling device insertion and care remain in place.
- Further implementation of annual plan regarding line care across the organisation.
- Attendance at IPAG in December by Dr Williams regarding raising profile of the OPAT line service.
- Dedicated IPCN input for OPAT and line care support, meeting arranged for 13.01.2021.

Timescale

- Not applicable

Safe

Serious Incidents

Target	0
Mean	7.64
Last Month	9.00

Executive Lead

Deirdre Fowler

Lead

Kay Davies

Legend: Trust Value, Target, Mean, LCL, UCL, Improvement, Concern, Outside CL High, Outside CL Low

The number of Serious Incidents

Commentary

There is some evidence that the variation has increased although this is not statistically significant.

This variation could be linked to improved DATIX reporting.

Cause of Variation

- Serious Incidents are not always reported in the same month that they occur.
- In December, 100% were reported within 48 hours of knowledge of the incident.

Planned Actions

- Continue to report and investigate SIs within agreed timescales and ensure lessons learnt are shared across the Organisation.
- Focus on outstanding actions from previous SIs to ensure evidence is provided and learning is being embedded
- Await the publication of the new Patient Safety Incident Response Framework.
- Training for key staff continues.

Timescale

Safe

Never Events

Trust Value · Target · Mean · LCL · UCL · Improvement · Concern · Outside CL High · Outside CL Low

Number of reported Never Events

Target	0
Mean	0.55
Last Month	0.00

Executive Lead

Deirdre Fowler

Lead

Kay Davies

Commentary

Eliminating never events is a priority for 2020. However there is no evidence of a significant reduction.

Cause of Variation

- Nationally there is a variation in the number of never events reported of between 28 and 48 per month.

Planned Actions

- A safer surgery oversight group has been established.
- A three month project to fully coordinate and establish the LocSSIP process has commenced in November 2020.
- Regional data has been released and a local action plan has been developed and was presented to the Quality Assurance Committee in November 2020 and shared with our CCG.
- Internal Audit carried out a site visit in September to review the design and operating effectiveness of key controls in place relating to patient safety. Closing meeting January 2021.

Timescale

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

Safe

Category 2 Pressure Ulcers

Target	TBD
Mean	94.38
Last Month	125.00

Executive Lead

Deirdre Fowler

Lead

Beth Swanson

Number of Category 2 Pressure Ulcers - Trust Acquired

Commentary

Although there was a reduction between June-Dec 19, we are now observing a system of around 90 a month.

There is no current target so data can only be measured against the mean.

Cause of Variation

- The number of reported category 2 pressure ulcers has increased in December .
- There has been a continued heightened incidence in reporting of category 2 pressure ulcer in critical care (13). This is most likely linked to increased activity and high numbers of Covid+ve admissions.
- 59 category 2 pressure ulcers were reported in the community 71 in the acute.

Planned Actions

- The Pressure ulcer safety huddle (push) has been rolled out. This aims to prevent deterioration of pressure ulcers by ensuring all aspects of the ASSKING bundle are in place.
- Targeted training and support continues in areas with heightened incidence.
- Tissue viability policy has been ratified.
- Community nursing collaborative met in December and are creating guidance for EOL pressure area care and management.
- Compliance with the ASSING bundle remains good (measured via PPA audit).

Timescale

- All actions are ongoing and linked to the pressure ulcer reduction strategy.
- STAQC team continue to foster the sharing of good practice and quality improvement work.

Safe

Category 3 & 4 Pressure Ulcers

Target	TBD
Mean	14.83
Last Month	14.00

Executive Lead

Deirdre Fowler

Lead

Beth Swanson

Y-axis: 0, 5, 10, 15, 20, 25

X-axis: Jan-19, Feb-19, Mar-19, Apr-19, May-19, Jun-19, Jul-19, Aug-19, Sep-19, Oct-19, Nov-19, Dec-19, Jan-20, Feb-20, Mar-20, Apr-20, May-20, Jun-20, Jul-20, Aug-20, Sep-20, Oct-20, Nov-20, Dec-20

Legend: Trust Value, Target, Mean, LCL, UCL, Improvement, Concern, Outside CL High, Outside CL Low

Number of Category 3 & 4 Pressure Ulcers - Trust Acquired

Commentary

In October we observed a significantly higher number of pressure ulcers.

We would normally expect between 6 and 24 as variance within range.

Cause of Variation

- In November, there were x12 category 3 pressure ulcer and 0 category 4.
- 6 of the 12 pressure ulcers occurred in the community (x1 resident of a care home) and 6 in the acute.
- Of the 12 reported pressure ulcers an internal review determined that x 3 met SI reporting criteria (ward 7, 27 and 28. Ongoing learning focuses on heel off loading and documentation of pressure relief.

Planned Actions

- The Pressure ulcer safety huddle (push) has been rolled out. This aims to prevent deterioration of pressure ulcers by ensuring all aspects of the ASSKING bundle are in place.
- Targeted training and support continues in areas with heightened incidence.
- Tissue viability policy has been ratified.
- Community nursing collaborative met in December and are creating guidance for EOL pressure area care and management.
- Compliance with the ASSING bundle remains good (measured via PPA audit).

Timescale

- All actions are ongoing and linked to the pressure ulcer reduction strategy.
- STAQC team continue to foster the sharing of good practice and quality improvement work.

Safe

SHMI

Summary Hospital-Level Mortality Indicator

Target	N/A
Mean	117.22
Last Month	121.80

Executive Lead

Sath Nag

Lead

Tony Roberts

Commentary

SHMI is 'higher than expected'. It is the official NHS hospital mortality indicator and relies on correct primary diagnosis and comorbidity coding at admission. It does not adjust for specialist palliative care coding.

Cause of Variation

- SHMI has remained stable but high (national average is set to 100). This reflects the Trust's relatively low level of comorbidity coding.
- SHMI is reported quarterly and for June 2019 to July 2020 is outlying (officially 115). Pneumonia and septicemia mortality is high.
- SHMI is impacted by COVID-19 as spells are removed and the fall in discharges of other patients is substantial.

Planned Actions

- The trust is gradually falling behind national averages for coding. Work to change documentation of comorbidities at admission to enable better coding is progressing. An independent review of SHMI data has been commissioned from University Hospitals Birmingham NHS FT's HED service and the report is expected w/c 11/01/2021.

Timescale

- Coding work on-going, although a quarterly review of the impact of COVID-19 on SHMI will be needed throughout 2020/2021.
- HED report delayed to early January 2021.

Safe

Hospital Standard Mortality Rate (HSMR)

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

Target	N/A
Mean	103.63
Last Month	101.26

Executive Lead

Sath Nag

Lead

Tony Roberts

Commentary

HSMR is ''as expected' It is a commercially produced indicator, but used by the CQC. It is sensitive to specialist palliative care coding levels, and since the Trust has increased the rate of this coding HSMR has remained close to 100.

Cause of Variation

- HSMR is stable and reflects the improvement in accuracy of specialist palliative care coding, following implementation of a new process checking SystmOne recording from May 2019

Planned Actions

- Continued monitoring of counts of deaths, unadjusted mortality, SHMI, HSMR, Medical Examiner and Trust Mortality Reviews and any deaths reported as a Serious Incident I, via nationally mandated Learning from Deaths dashboard.
- Improvements to coding (outlined on SHMI slide) will impact on HSMR.

Timescale

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

Caring

F&F A&E Overall Experience Rate (%)

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

Target	85
Mean	88.05
Last Month	89.42

Executive Lead

Deirdre Fowler

Lead

Jen Olver

Commentary

There has been an overall improvement since March 2020 but the change is not yet statistically significant.

Cause of Variation	Planned Actions	Timescale

Caring

F&F Inpatient Overall Experience Rate (%)

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20

Legend: Trust Value, Target, Mean, LCL, UCL, Improvement, Concern, Outside CL High, Outside CL Low

Y axis: 88, 90, 92, 94, 96, 98, 100

The friends and family survey/text overall experience rate for Inpatient wards

Target	96
Mean	97.12
Last Month	97.34

Executive Lead

Deirdre Fowler

Lead

Jen Olver

Commentary

Compliance is good although we may not consistently meet the target.

Cause of Variation	Planned Actions	Timescale

Caring

F&F Outpatient Overall Experience Rate (%)

The friends and family survey/text overall experience rate for Outpatients

Target	95
Mean	97.46
Last Month	100.00

Executive Lead

Deirdre Fowler

Lead

Jen Olver

Commentary

Compliance is good, although more data needed to allow comment that it is a capable process.

Cause of Variation	Planned Actions	Timescale

Caring

F&F Maternity Overall Experience Rate (%)

Month	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20

Legend: Trust Value, Target, Mean, LCL, UCL, Improvement, Concern, Outside CL High, Outside CL Low

The friends and family survey/text overall experience rate for Maternity services

Target	97
Mean	99.09
Last Month	100.00

Executive Lead

Deirdre Fowler

Lead

Jen Olver

Commentary

Compliance is good but it is unlikely that we will hit the target consistently.

Cause of Variation	Planned Actions	Timescale

Caring

Complaints Closed Within Target (%)

The percentage of complaints closed within the target

Target	80
Mean	71.54
Last Month	72.97

Executive Lead

Deirdre Fowler

Lead

Jen Olver

Commentary

There was an improvement in the metric in August, September and October. However the response rate has been significantly impacted by COVID-19 and availability of clinical staff to respond timely.

Cause of Variation	Planned Actions	Timescale

Responsive Summary

RESPONSIVE

Indicator	Latest Month	Target	Trend	Assurance
A&E 4 Hour Wait Standard (%)	83.14%	95.0%	L	?
RTT Incomplete Pathways (%)	63.99%	92.0%	L	F
Diagnostic 6 Weeks Standard (%)	80.21%	99.0%		F
Cancer Treatment - 14 Day Standard (%)	91.09%	93.0%	H	?
Cancer Treatment - 31 Day Standard (%)	93.19%	96.0%		?
Cancer Treatment - 62 Day Standard (%)	68.45%	85.0%	L	?
Non-Urgent Ops Cancelled on Day	17	0	L	F
Cancer Operations Cancelled On Day	0	0	L	?
Cancelled Ops Not Rebooked Within 28 days	4	0	L	?
E-Discharge (%)	95.31%	90.0%	H	?

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

Responsive

A&E 4 Hour Wait Standard (%)

Target	95
Mean	90.60
Last Month	83.14

Executive Lead

Johanna Reilly

Lead

Penny Bateman

96
91
86
81
76
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value · Target · Mean · LCL · UCL · Improvement · Concern · Outside CL High · Outside CL Low

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

Commentary

Significant deterioration can be seen from April 18 – March 20.

COVID period showed improvement, however as attendance numbers increase again compliance continues to drop.

Cause of Variation

- Pressure on segregation capacity.
- Delays in transfers awaiting swab results.
- Limited number of rapid swabs.
- Social distancing measures continually impacting upon efficiency of service delivery.
- Exit block – limited isolation capacity.
- Higher acuity.

Planned Actions

- Operationalisation of the ED segregation surge plan.
- Updated ED escalation plan.
- Development of separate Paediatric ED (4 Jan)
- Extended hours at RUTC allows for flow and navigation away from the JCUH site.
- Expansion of back of house segregation pathways to improve capacity to meet demand.
- Direct access to red pathway assessment areas.
- Implement transfer team

Timescale

- Immediate
- Immediate
- April 2021
- Ongoing and reviewed weekly
- Daily reviews - EPRR

Responsive

RTT Incomplete Pathways (%)

The % of incomplete pathways for patients within 18 weeks

Target	92
Mean	77.01
Last Month	63.99

Executive Lead
Johanna Reilly

Lead
Sue Geldart

Commentary

Compliance has been below target since April 18 and then decreased significantly since March 2020 due to COVID.

Compliance is improving but is still not capable of meeting the target.

Cause of Variation

- RTT compliance has marginally increased to 63.99% (from 63.94% in November). The number of patients waiting over 52 weeks at the end of December has increased to 2,597 from 2,254 at the end of November. The number of patients waiting in excess of 78 weeks has increased from 134 at the end of November to 237 at the end of December.

Planned Actions

- Due to critical care surge plans and need to staff additional critical care beds theatre capacity has had to be reduced to release theatre staff to support critical care. Focus remains on patients of greatest clinical need and therefore the longest waiters will continue to increase. Further planned reduction in elective theatre capacity will exacerbate RTT compliance and elective patients will continue to wait longer.
- Working on recovery plans across the ICS/ICP

Timescale

Responsive

Diagnostic 6 Weeks Standard (%)

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

Target	99
Mean	81.27
Last Month	80.21

Executive Lead

Johanna Reilly

Lead

Ann Wright

Commentary

Compliance across all diagnostics has been below target since April 19 and decreased significantly due to COVID. Radiology & Cardio Echo procedures are now back above target. Compliance for all other diagnostics, although increasing month on month are areas for concern.

Cause of Variation

- See Appendix for individual responses.

Planned Actions

- See Appendix for individual responses.

Timescale

Responsive

Cancer Treatment - 14 Day Standard (%)

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

Target	93
Mean	88.86
Last Month	91.09

Executive Lead

Johanna Reilly

Lead

Nicki Hurn

Commentary

Prior to COVID the system was consistent although not always meeting the target.

The system is now showing an area of concern and is currently not capable of meeting the target.

Cause of Variation

- 2ww referrals continue to rise towards pre – COVID levels, with the exception of the Christmas period (inline with seasonal trend). Currently referral levels are currently down by 18%.
- Reduction in Outpatient capacity due to requiring social distancing for some specialties.

Planned Actions

- Continuation of triage of 2ww referrals on receipt
- Weekly cancer performance wall continues virtually to identify pressures and theme.

Timescale

Responsive

Cancer Treatment - 31 Day Standard (%)

Trust Value, Target, Mean, LCL, UCL, Improvement, Concern, Outside CL High, Outside CL Low

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

Target	96
Mean	95.33
Last Month	93.19

Executive Lead

Johanna Reilly

Lead

Nicki Hurn

Commentary

This metric has not significantly changed over time.

The current process is unlikely to consistently meet the target.

Cause of Variation

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

Planned Actions

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

Timescale

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

Responsive

Cancer Treatment - 62 Day Standard (%)

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

Target	85
Mean	78.45
Last Month	68.45

Executive Lead

Johanna Reilly

Lead

Nicki Hurn

Commentary

The current process is not capable of meeting the target.

Confirmed November 20 compliance was 70.10%, 43.5 breaches in total.

Cause of Variation

- Overall treatments in November were down in comparison to the same period last year by 7% (145.5 v 157 treatments).
- Tees wide cancer cell developed ensuring all priority 2 patients are operated on within a four week period – Trust is managing to consume priority 2 cancer demand .

Planned Actions

- South Tees Surgical Cell in place to support the delivery of Cancer Surgeries across the patch
- Weekly PTL meetings in place to aid patients through their pathway and mitigate breaches where possible.
- Exploring IS capacity to support delivery of cancer standard

Timescale

Responsive

Cancer Operations Cancelled On Day

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

Target	0
Mean	0.15
Last Month	0.00

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

The process is showing evidence of being capable and this is now statistically significant as the target has been met for 8 consecutive months.

Cause of Variation

Planned Actions

Timescale

Responsive

Non-Urgent Ops Cancelled on Day

70
60
50
40
30
20
10
0

Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value | Target | Mean | LCL | UCL
Improvement | Concern | Outside CL High | Outside CL Low

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

Target	0
Mean	34.18
Last Month	17.00

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

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

Cancellations are increasing as activity resumes towards pre-COVID levels.

Cause of Variation

- 17 patients cancelled (6 Cardiothoracic Surgery, 3 ENT, 2 Orthopaedics, 1 General Surgery, 2 Urology, 1 Gynaecology, 1 Vascular Surgery and 1 Oral Surgery). Predominate reasons for the cancellations are lack of theatre time or ITU/HDU bed. The likelihood of short notice cancellations may increase as we have escalated into Covid surge plans in critical care impacting on delivery of elective patients requiring critical care.

Planned Actions

- Continue to book non-urgent patients as set out in the Trust's Standard Operating Procedure for prioritisation of elective patients during current COVID-19 pandemic. Continue to ensure that patients are appropriately consented and pre-assessed prior to admission (including swabbed 48 hours prior to admission) to minimise the likelihood of 'hospital initiated' cancellation.

Timescale

Responsive

Cancelled Ops Not Rebooked Within 28 days

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

Target	0
Mean	7.27
Last Month	4.00

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

As the target is 0 there is no significant evidence that the target can be consistently met.

Compliance was met during COVID due to a reduced elective programme.

Cause of Variation

- 17 patients had their operation cancelled on the day of admission or procedure mainly due to lack of HDU/ITU bed or lack of theatre time. 12 patients were given dates within the 28 day, 4 dated outside the 28 day standard, 1 patient still requires a TCI date.

Planned Actions

- Continue to escalate for dates to be re-booked within 28 day standard if dates not yet booked or booked outside of the 28 day standard (1 patient in December).

Timescale

Responsive

E-Discharge (%)

100
98
96
94
92
90
88
86
84

Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value | Target | Mean | LCL | UCL
Improvement | Concern | Outside CL High | Outside CL Low

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

Target	90
Mean	91.87
Last Month	95.31

Executive Lead

Johanna Reilly

Lead

Moira Angel

Commentary

The process has shown significant improvement.

Are we confident in the quality of the information recorded?

Cause of Variation

- There are some data quality issues that are being explored to check the increase in performance is accurate.

Planned Actions

Timescale

Well-Led Summary

WELL LED	Indicator	Latest Month	Target	Trend	Assurance
	Year-To-Date Budget Variance (£'millions)	£0.37	Within Budget		?
	Annual Appraisal (%)	68.34%	80.0%	L	?
	Mandatory Training (%)	88.12%	90.0%		?
	Sickness Absence (%)	5.05%	4.0%	H	?
	Staff Turnover (%)	12.48%	10.0%	H	F

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

Well Led

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

Year-To-Date Budget Variance

Target	0.00
Mean	N/A
Last Month	0.37

Executive Lead

Steven Mason

Lead

Luke Armstrong

Commentary

For December the Trust is £0.4m ahead of its revised annual plan.

Cause of Variation

- £2.0m positive variation to plan on income, linked to RTA, Education and Training Income and a VAT rebate.
- £1.5m overspend on pay driven by Medical and Dental Pay
- £0.6m overspend on non pay caused by increased drugs costs.

Planned Actions

- Ongoing review of Covid-19 non pay costs via operational, tactical and strategic group meetings.
- Challenge over workforce costs via workforce meetings.

Timescale

- Ongoing
- Ongoing

Well Led

Annual Appraisal (%)

Target	80
Mean	77.05
Last Month	68.34

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Annual Appraisal Rate

Commentary

Significant deterioration in the system can be seen.

This can be attributed to the COVID pandemic.

Cause of Variation

- Increased volume of staff absence due to COVID, including absence and isolation.
- Medical staff not required to complete annual appraisal due to COVID-19 pandemic.
- Focus on operational requirements and managers deployed to operational duties.

Planned Actions

- Development of new Review and Career Conversation document and process to replace existing SDR documentation.
- Focus on top 100 overdue SDR’s via HR Business Partners and Centre/Departmental Managers.

Timescale

- April 2021
- Ongoing

Well Led

Mandatory Training (%)

Target	90
Mean	87.44
Last Month	88.12

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

The % of Mandatory Training Compliance

Commentary

There is no evidence of significant change in compliance of mandatory training.

Without a new initiative the process is incapable of achieving the target.

Cause of Variation

- Operational focus on mandatory training compliance limited due to workforce pressures.
- Ongoing challenge regarding accuracy of mandatory training data.

Planned Actions

- Project to transfer mandatory training elements onto ESR underway and on track. Target date March 2021. This will ensure more accurate data monitoring and assist in provision of up to date data for managers.
- Continued focus on non-compliant areas and elements of mandatory training via HRBPs and Centre/Department managers.

Timescale

- April 21
- Ongoing

Well Led

Sickness Absence (%)

Target	4
Mean	4.55
Last Month	5.05

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

The % of monthly sickness absence

Commentary

This process cannot meet the target of 4%.

Cause of Variation

- Improvement in staff absence.

Planned Actions

- Meeting in place to discuss with Strive Team the feasibility of culture champions working in partnership with HR to undertake Exit interviews as part of the ongoing Value and Behaviours and Staff Engagement workstreams. This will support introduction of the ‘stay’ and ‘itchy feet’ conversations between managers and staff who are considering employment external to the Trust.

Timescale

- Feb 2021

Well Led

Staff Turnover (%)

Staff turnover rate

Target	10
Mean	11.12
Last Month	12.48

Executive Lead

Rachael Metcalf

Lead

Jane Herdman

Commentary

From October 19 to July 20 there was a significant improvement in turnover reduction.

In August 20 there was a significant increase - was this as a result of student nurses leaving the organisation.

Cause of Variation

- Turnover has stabilised over the last quarter.

Planned Actions

- Meeting in place to discuss with Strive Team the feasibility of culture champions working in partnership with HR to undertake Exit interviews as part of the ongoing Value and Behaviours and Staff Engagement workstreams. This will support introduction of the 'stay' and 'itchy feet' conversations between managers and staff who are considering employment external to the Trust.

Timescale

- Feb 2021

Future Changes

The following changes are to be implemented in January's IPR:

- New metrics:
  - VTE
  - Sepsis – NEWS score taken within one hour of arrival
  - Sepsis – Antibiotics administered within one hour of sepsis diagnosis
  - Maternity outcomes – details to be discussed with the service
- Following metrics will change from an SPC chart to a cumulative graph:
  - Never Events
  - MRSA metrics

Diagnostics Summary

	Indicator	Latest Month	Target	Trend	Assurance
DIAGNOSTICS	Diagnostic 6 Weeks Standard (%) - Audiology	47.9%	99.0%		
	Diagnostic 6 Weeks Standard (%) - Bone Densitometry	41.6%	99.0%		
	Diagnostic 6 Weeks Standard (%) - Cardiology Echo	100.0%	99.0%		
	Diagnostic 6 Weeks Standard (%) - Colonoscopy	49.7%	99.0%		
	Diagnostic 6 Weeks Standard (%) - CT	99.7%	99.0%		
	Diagnostic 6 Weeks Standard (%) - Cystoscopy	19.3%	99.0%		
	Diagnostic 6 Weeks Standard (%) - Flexible Sigmoidoscopy	66.7%	99.0%		
	Diagnostic 6 Weeks Standard (%) - Gastroscopy	64.8%	99.0%		
	Diagnostic 6 Weeks Standard (%) - MRI	99.4%	99.0%		
	Diagnostic 6 Weeks Standard (%) - Neurophysiology	56.8%	99.0%		
	Diagnostic 6 Weeks Standard (%) - Sleep	20.1%	99.0%		
	Diagnostic 6 Weeks Standard (%) - Urodynamics	3.7%	99.0%		
	Diagnostic 6 Weeks Standard (%) - Ultrasound	98.9%	99.0%		

Responsive

Diagnostic 6 Weeks Standard (%)

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20

Y-axis: 32, 42, 52, 62, 72, 82, 92

Legend: Trust Value, Target, Mean, LCL, UCL, Improvement, Concern, Outside CL High, Outside CL Low

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

Target	99
Mean	81.27
Last Month	80.21

Executive Lead

Johanna Reilly

Lead

Ann Wright

Commentary

Compliance across all diagnostics has been below target since April 19 and decreased significantly due to COVID. Radiology procedures are now back above target with the exception of ultrasound (only marginally below target). Compliance in some other areas remains a concern.

Cause of Variation

- See appendix for individual responses.

Planned Actions

- See appendix for individual responses.

Timescale

Responsive

Diagnostic 6 Weeks Standard (%) - Audiology

97
87
77
67
57
47
37
27
17
7

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value · Target · Mean · LCL · UCL
Improvement · Concern · Outside CL High · Outside CL Low

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

Target	99
Mean	62.13
Last Month	47.95

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

The system has been falling from the target since July ‘19 and decreased significantly in April ‘20 due to Covid.

Compliance has increased since August ‘20 but remains an area of concern.

Cause of Variation

- Lack of capacity over summer (due to Covid) has created a backlog and as such, team are prioritising work as best they can.
- Two members of staff have also left the department.

Planned Actions

- Weekend working has been approved between now and the end of March 2021 to support catch up (due to vacancies).

Timescale

- March 2021

Responsive

Diagnostic 6 Weeks Standard (%) - Bone Densitometry

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

Target	99
Mean	71.61
Last Month	41.57

Executive Lead

Johanna Reilly

Lead

Fran Toller

Commentary

The system was running consistently at 100% compliance but significantly dropped in March '20 due to Covid. The system is still an area of concern and is currently incapable of returning above target.

Cause of Variation

- Diagnostic service paused at the outset of Covid-19 first wave.
- Staff redeployed to Radiology to support clinically prioritised Covid-19 response.
- Referral system not closed in line with local guidance so referrals continued to be received.

Planned Actions

- Review of service provision including:
- Continue to explore ability to deliver additional sessions.
- Administration support for managing of patients.
- Review of templates for new : review balance.
- Ask partners in the ICS if they have capacity to support.
- Request approval for a trainee radiographer.

Timescale

- Ongoing, regular updates to be provided.

Responsive

Diagnostic 6 Weeks Standard (%) - Cardiology Echo

92
82
72
62
52
42
32
22
12
2

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value
Target
Mean
LCL
UCL
Improvement
Concern
Outside CL High
Outside CL Low

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

Target	99
Mean	72.44
Last Month	100.00

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

Compliance has continued to improve following the significant drop due to Covid in April '20 and is now above target.

Cause of Variation

- Apart from inpatients (based on risk) these diagnostic procedures stopped during COVID first wave – TOEs are an AGP procedure.

Planned Actions

- Reinstated 4 sessions per week but throughput slower as some are AGP procedures and are taking longer in full PPE plus cleaning between procedures.
- Additional consultant time is supporting this service, with concerted efforts to try and address the backlog and maintain the service.

Timescale

- Ongoing as per job plans.
- Ongoing monitoring.

Responsive

Diagnostic 6 Weeks Standard (%) - Colonoscopy

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

Target	99
Mean	56.01
Last Month	49.74

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

Compliance has continued to improve following the significant drop due to Covid in April '20.

From March to December compliance remains a cause for concern.

Cause of Variation

- The current number of patients who do not want to attend for their test until after the pandemic is causing the % compliance to remain below target.

Planned Actions

- All deferred patients are being re-assessed by the Consultant to see if alternative diagnostics can be arranged so patients do not need to come onto site.

Timescale

- Q1 2021/2022

Responsive

Diagnostic 6 Weeks Standard (%) - Gastroscopy

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

Target	99
Mean	67.87
Last Month	64.78

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

Compliance has been below target since April '19 and then decreased significantly in April '20 due to COVID.

Compliance although increasing month on month remains an area of concern.

Cause of Variation

- The current number of patients who do not want to attend for their test until after the pandemic is causing the % compliance to remain below target.

Planned Actions

- All deferred patients are being re-assessed by the Consultant to see if alternative diagnostics can be arranged so patients do not need to come onto site.

Timescale

- Q1 2021/2022

Responsive

Diagnostic 6 Weeks Standard (%) - Flexible Sigmoidoscopy

99
89
79
69
59
49
39
29
19

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value
Target
Mean
LCL
UCL
Improvement
Concern
Outside CL High
Outside CL Low

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

Target	99
Mean	54.39
Last Month	66.67

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

Compliance has been below target since April '19 and continued to fall before a significant decrease in March '20 due to COVID.

From March to October compliance was a cause for concern but is on an improving trend since Sept.

Cause of Variation

- The current number of patients who do not want to attend for their test until after the pandemic is causing the % compliance to remain below target.

Planned Actions

- All deferred patients are being re-assessed by the Consultant to see if alternative diagnostics can be arranged so patients do not need to come onto site.

Timescale

- Q1 2021/2022.

Responsive

Diagnostic 6 Weeks Standard (%) - Neurophysiology

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

Target	99
Mean	63.50
Last Month	56.84

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

Compliance has shown some improvement following the significant drop due to Covid in April ’20 but has not been maintained in October and December.

Cause of Variation

- Covid-19 backlog
- Deterioration in performance due to reduced capacity due to Christmas / New Year period

Planned Actions

- Clinics re-opened June 2020
- Continue to book in chronological order
- Fully utilise lists

Timescale

Responsive

Diagnostic 6 Weeks Standard (%) - Sleep

92
82
72
62
52
42
32
22
12
2

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value | Target | Mean | LCL | UCL
Improvement | Concern | Outside CL High | Outside CL Low

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

Target	99
Mean	29.97
Last Month	20.14

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

Compliance has been below target since April ‘19 and decreased significantly in April ‘20 due to Covid.

Compliance has increased since April ‘20 but is still an area of concern, not capable of reaching the target.

Cause of Variation

- Covid 19 backlog
- Access to 2 x diagnostic beds (adult) on W27 currently compromised as side rooms need allocating to Neurology IP with higher clinical need. Endeavouring to improve patient flow to avoid this.
- Currently experiencing higher DNA rate / patients reluctant to come in.

Planned Actions

- Recommenced IP diagnostics May 2020.
- Continue to book in chronological order.
- Ensure that all available capacity is fully utilised.

Timescale

Responsive

Diagnostic 6 Weeks Standard (%) - CT

Target	99
Mean	98.64
Last Month	99.67

Executive Lead

Johanna Reilly

Lead

Ann Wright

99
97
95
93
91
89
87
85
83

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value · Target · Mean · LCL · UCL
Improvement · Concern · Outside CL High · Outside CL Low

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

Commentary

There was a drop in compliance during March – June ‘20 due to Covid.

Compliance returned to above target in July ‘20 but requires monitoring to ensure compliance is sustainable.

Cause of Variation

Planned Actions

- Continue to monitor weekly.

Timescale

Responsive

Diagnostic 6 Weeks Standard (%) - MRI

98
88
78
68
58
48
38

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value | Target | Mean | LCL | UCL
Improvement | Concern | Outside CL High | Outside CL Low

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

Target	99
Mean	94.53
Last Month	99.40

Executive Lead

Johanna Reilly

Lead

Ann Wright

Commentary

Compliance dropped below target in Dec ‘19 and has mainly remained below with a significant drop in April ‘20 due to Covid.

Although target has been met this month it needs to be monitored further to confirm this is sustainable.

Cause of Variation

Planned Actions

- Continue to monitor weekly.

Timescale

Responsive

Diagnostic 6 Weeks Standard (%) - Ultrasound

Target	99
Mean	99.25
Last Month	98.91

Executive Lead

Johanna Reilly

Lead

Ann Wright

Chart axis: 84–100; months Apr-19 to Dec-20. Legend: Trust Value, Target, Mean, LCL, UCL, Improvement, Concern, Outside CL High, Outside CL Low.

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

Commentary

Prior to March '20, compliance was consistently above target.

Compliance has returned and does not show any significant areas of concern.

Cause of Variation

- Significant pressures within patient connect leading to lists not being fully appointed to. High DNA rate ? Due to short notice of appointment.

Planned Actions

- Continue to monitor DNA rate – audit underway.

.

- More resource provided specifically to ultrasound appointment team in patient connect.

Timescale

Responsive

Diagnostic 6 Weeks Standard (%) - Cystoscopy

Target	99
Mean	64.31
Last Month	19.27

92
82
72
62
52
42
32
22
12

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value, Target, Mean, LCL, UCL, Improvement, Concern, Outside CL High, Outside CL Low

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

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

Compliance dropped significantly in April '20 due to Covid.

Compliance, although increasing month on month, is below the mean and an area of concern.

Cause of Variation

- During December there was a reduction in sessions available resulting in a significant reduction in compliance.

Planned Actions

- Bookings for cystoscopy have now been moved to the admissions hub with streamlined processes and more procedures per session.

Timescale

- With the new processes there should be a gradual improvement in compliance.

Responsive

Diagnostic 6 Weeks Standard (%) - Urodynamics

92
82
72
62
52
42
32
22
12
2

Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20

Trust Value | Target | Mean | LCL | UCL
Improvement | Concern | Outside CL High | Outside CL Low

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

Target	99
Mean	45.60
Last Month	3.70

Executive Lead

Johanna Reilly

Lead

Sue Geldart

Commentary

Compliance has been inconsistent and falling since November '19, accentuated by the impact of Covid in April '20.

Recovery since May '20 has been variable month on month but has significantly deteriorated Sept '20.

Cause of Variation

- Urodynamics sessions were not available during December.

Planned Actions

- Sessions are dependent on available staffing and this is being reviewed monthly to provide Urodynamics.
- Aiming to have regular FHN sessions.

Timescale

- Establish regular sessions by March 2021 to improve position.

<table>
<tr><td colspan="4">MEETING OF THE PUBLIC BOARD OF DIRECTORS – 2 February 2021</td></tr>
<tr><td colspan="3">Board Assurance Framework</td><td>AGENDA ITEM: 17, ENC 11</td></tr>
<tr><td>Report Author and Job Title:</td><td>Jackie White
Head of Governance & Co Secretary</td><td>Responsible Director:</td><td>Jackie White
Head of Governance & Co Secretary</td></tr>
<tr><td>Action Required</td><td colspan="3">Approve ☐ Discuss ☐ Inform ☒</td></tr>
<tr><td>Situation</td><td colspan="3">Updated BAF following review by the Executive Lead, Head of Governance and Sub Committees</td></tr>
<tr><td>Background</td><td colspan="3">This paper presents the current Board Assurance Framework (BAF) for 2020/21, following discussions at Board and subcommittees since consideration at the last Board meeting.</td></tr>
<tr><td>Assessment</td><td colspan="3">The BAF comprises of 19 strategic risks, as attached. Since the last report, there have been no BAF risk score changes.

There have been no new BAF risks added since the last report.

Since the last Trust Board, the BAF (or elements of it) have been presented once to the Quality Assurance Committee (January 2021), once to the Finance and Investment Committee (October) and Workforce Committee (September).

Finally, PWC have reviewed the Trust’s Governance Framework (including the BAF) and as part of their review and categorised the outcome as low risk. The following areas of good practice have been identified:
• Each individual centre / corporate directorate maintains their own operational risk register, which they report on to the Senior Leadership Team (SLT);
• Operational risk registers have been updated to reflect the CQC action plan;
• The BAF has been updated to reflect the impact of covid-19, specifically in relation to the delivery of safe care objective; and
• The BAF is reported and discussed at the following:
- Finance and Investment committee;
- Quality Assurance committee;
- Risk committee;
- Workforce committee; and
- Board of Directors</td></tr>
<tr><td>Recommendation</td><td colspan="3">Members of the Public Board of Directors are asked to note the update of the BAF risks</td></tr>
</table>

<table>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="2">The risk implications associated with this report are included in the report.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="2">There are no legal or equality & diversity implications associated with this paper.</td></tr>
<tr><td rowspan="3">Strategic Objectives (highlight which Trust Strategic objective this report aims to support)</td><td>Excellence in patient outcomes and experience ☒</td><td>Excellence in employee experience ☐</td></tr>
<tr><td>Drive operational performance ☒</td><td>Long term financial sustainability ☐</td></tr>
<tr><td>Develop clinical and commercial strategies ☐</td><td></td></tr>
</table>

Board Assurance Framework

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

Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Change to Rating since last Review	Date Reviewe
			LH	Conseq	Rating				Internal	External								
1.1	Delivery of Trust's strategic aims and sustainable healthcare services across North Yorkshire and the Tees Valley (ICP Footprint)	A fundamental breakdown in one or more strategic partnerships, resulting in long term disruption to plans for transforming local health and care services	3	4	**Moderate Risk 12**	**Low Risk 2x3=6**	NHSE/I Engagement ICS/ ICP Leadership Stakeholder Engagement with Local Authorities , MPs and local population, CCG ICS MOU Clinical Policy Group Tees Valley Hospitals Group Board initial meetings Improvement Recovery Plan Capital Plan amended June 2020 ICP compact N&Y CEO Call ICP Executive Management Group Vice Chair job role supporting joint chair role Action plan for joint working with North Tees including establishment of a CIC in place	**Internal** Clinical Policy Group agenda and papers, Reports to Board, SLT, Council of Governors **External** NHSI QRM / System and oversight groups ICS/ICP groups CEO meetings (South Tees FT, County Durham and Darlington NHS FT, North Tees and Hartlepool FT) **Sir Ian Caruthers, Independent Review** supported by NHSI	Clinical Policy Group agenda and action notes, Board minutes supporting proposals Council of Governor minutes supporting proposals	Sir Ian Caruthers Review ICS / ICP meetings NHSI QRM/system and oversight Tees Valley Hospitals Group Board papers considering partnerships NHSE/I letters from Amanda Prichard and Richard Barker regarding joint working with NTHT NTHT letter supporting proposal to joint Chair Confirmation of timeframe agreed			03.02.21	Chief Executive	Board of Directors			26.01.21

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

Quarter 1 (1 April - 31 July 2019)
- May 2019 - no changes made
28 August 2019 - principal risk updated
29.9.20 - update to Sources of assurance and gaps in control
26.1.21 - update to controls, assurances and actions

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

Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Change to Rating since last Review	Date Reviewed
			LH	Conseq	Rating				Internal	External								
1.3a	Regulatory Compliance with the Health and Social Care Act 2008 and Regulations 2014	Risk of further breaches to condition 4 of the Trust Provider licence could result in further enforcement undertakings and licence conditions	3	5	High Risk 15	Low Risk 3x3=9	SFI/SO; Scheme of Delegation review September 2020 Constitution update August 2020 Board and Committee structures Provider Licence self assessment 2020 Internal control arrangements Trust Strategic Plan Additional short term senior interim support in specialist areas Board to Board meeting held with NHSE/I (2) Single item QSG Quality Risk Profile	Board and Sub committees review of BAF risks and internal assurances Board agenda and minutes CQC action plan Single item QSG minutes of meeting Review of governance and effectiveness of committees Annual Governance Statement	Quality Assurance Committee Minutes / Chairs log Finance & Investment Committee Minutes / Chairs Log	External NHS QRM CQC Inspection Internal and External Audit Reports Annual Governance Statement Quality Report Annual Report Finance Single item QSG minutes of meeting and level of assurance B2B September 2020 Quality Board November 2020	Need to establish what further assurance is required for addressing provider licence conditions	31.12.20	31.3.21	Chief Executive	Board			26.01.21
1.3b		Prolonged adverse publicity or regulatory attention resulting in a fundamental loss of confidence in the Trust amongst regulators, partner organisations, patients, staff and the general public	3	5	High risk 15	Low Risk 3x3=9	Conflicts of interest & whistleblowing management arrangements Counter Fraud arrangements Internal Audit Established relationships with regulators Stakeholder engagement meetings Forum for Public Involvement meetings Internal control arrangements Staff briefings and forums Public Board and AGM Ongoing engagement with local MPs, OSC	Fraud and Internal Audit Reports to FIC and Audit Committee Pulse Surveys Staff survey National patient survey reports	Board and Sub Committees	External NHS QRM CQC Inspection Internal and External Audit Reports Annual Governance Statement Quality Report Annual Report Finance B2B Quality Board November 2020	Stakeholder relationship management plan	31.12.20	31.3.21	Chief Executive	Board			26.01.21

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

1. STRATEGIC OBJECTIVE: Develop clinical and commercial strategies to ensure long term sustainability																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Action**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Change to Rating since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
1.4	Regulatory Compliance with the Health and Social Care Act 2008 and Regulations 2014	A major incident (cyber attack, critical infrastructure failure, supply chain failure etc) resulting in temporary hospital closure or a prolonged disruption to the continuity of care services across the Trust, which also impacts significantly on the local health service community	4	4	**High Risk 16**	**Low Risk 2x4=8**	Emergency preparedness, resilience and response (EPRR) arrangements at regional, Trust, Centre and service level Operational strategies and plans for specific types of major incident, business continuity and critical incidents Strategic, tactical and operational command for major incidents Estates Governance arrangements with PFI partner Trust Resilience Forum and EPRR operational group EPRR Strategy in line with National EPRR framework Training and testing exercises undertaken annually Annual assessment against EPRR core standards On call arrangements in place EU Exit task and finish group review of operational response plan for monitoring issues following Brexit SRO for EU Exit appointed - S Mason	EPPR self assessment - partial compliance for 2019/20 Information Governance Assurance Framework (IGAF) Debriefs following local testing shared with Trust resilience forum, report to Board, SLT and Sub Committee	Board report on EPPR self assessment IG Assurance Framework submission Annual report to Board on EPRR Board cyber training February 2020 Internal audit report on cyber (September 2020)	Validated EPPR assessment - partial compliance Regional assurance visit undertaken in October External audit (2017) Peer Review undertaken (December 2019) Digital review	Actions to address self assessment to increase compliance contained within EPPR work plan Cyber exercise to be planned Strategic leadership in a crisis course being developed (2020) HMIMMS course for all staff on call Oncall refresher training Address cyber risks internal audit report	30.10.20 31.9.20 2021 31.4.21 31.12.20 31.12.20	31.5.21	Director of Estates, Facilities and Capital Planning	FIC			26.01.21

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

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

	Principle Objective	Principle risks to delivery of objective	Grade (including change in			Target	Existing Key Controls	Possible Sources of Assurance	Assurances Received		Gaps in control/assurance and	Target date for completion of	Target date score will be	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings	Date Reviewed by
			LH	Conseq	Rating				Internal	External								
1.5	Delivery of safe care	Risk to Trusts ability to delivery strategic objectives due to diversion of resources of all types required to manage the COVID19 19 pandemic, leading to: Failure to deliver constitutional standards Associated reduced / compromised outcomes Patient Harm Reduced patient experience Increased costs Failure to meet financial trajectories Workforce issues such as stress, recruitment and retention	5	5	Very High Risk 25	Low Risk 1 x 5 = 5	EPPR incident management processes in place with tactical and strategic command meeting daily Communication briefings and meetings with staff HR systems and processes to enable tracking of staff, welfare calls and psychological support / OH support to staff Implementation of national guidance Implementation of business continuity plans Stopping elective activity Redeployment and retraining of staff Training for staff in relation to PPE and redeployment duties IT facilities to enable patient contact/appointments/reviews to be undertaken IT facilities in place to enable staff to work from other places Liaison with partners and stakeholders LRF coordination in place Government financial support to manage COVID 19 Reducing the burden guidance on managing performance and governance processes COVID 19 mandatory training staff package Weekly outbreak meeting regionally held (COVID 19) Risk assessment of staff - clinically vulnerable and extremely clinically vulnerable, welfare calls and packages of care including hardship fund in place for staff Level 5 command and control in place Revised governance processes in place for Board and Sub committees including business as usual and mandatory training	Board reporting Real time reporting to tactical and strategic command through daily SITREP Task and finish groups NED weekly meetings and assurance around outbreaks, mortality and welfare of staff	Daily reporting to strategic command through SITREP Clinical Clinical Oversight group (ethical)	LRF coordination process in place ICS/ICP coordination processes in place NHSE/I reducing the burden guidance	Availability of staffing for the continuation of front line services Availability of appropriately trained staff Loss of staff through self isolation / ill health	Ongoing		Chief Executive	Board			26.01.21

26.01.21 - update to controls

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

	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed by Committee
			LH	Conseq	Rating				Internal	External								
2.1 (1)	Delivery of excellence in patient outcomes and experience	An infection outbreak (such a influenza; norovirus; infections resistant to antibiotics and CDiff) may result in avoidable patient harm and could adversely impact on delivery of key performance indicator	4	4	**High risk - 16**	**Very Low Risk 2x3=6**	IBAF Cleaning standards meetings Review panels of all trust apportioned CDIF Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems Clinical Audit programme and monitoring arrangements. Ward assurance and accreditation programme - STAQ Weekly Dep. DIPC Matron IPC huddles Performance management systems Centre Assurance and Improvement Committee (performance reviews) Handwashing audits Environmental Audits HPV fogging Antibiotic stewardship programme As part of agreed contracts external suppliers are supporting with refresher training in relation to equipment cleaning and ANTT for clinical staff. Daily outbreak report aligned to COVID introduced Outbreak meetings convened at initial onset and then weekly Weekly regional outbreak meeting 14 HCA/PPE marshalls / Fit testers recruited and in place Matron for IPC appointed - Jo Tait	QAC and sub group meeting agenda and minutes IPAG meeting minutes Audit findings Panel outcomes Regulator oversight Capital and FIB minutes of meetings Nosocomial rates Key quality metrics	Board, QAC and sub committee structure CQC confirm and challenge STACQ Clinical Standards Group	Tees Infection Prevention & Control Committee CCG oversight through Chief Nurses CQC oversight / bi weekly calls IBAF review and feedback report Improvement IBAF feedback November 2020 to IPAG NHSEI Quality Board assurance received 021220	Capital funding to support IPC initiatives and equipment replacement Compliance with SOP and Policies - further work required to ensure compliance being explored Develop a more collaborative approach with Serco in terms of education delivery and audits including hand hygiene and IPC and Serco joint monitoring in augmented care areas (this is a recent development and we will review effectiveness). Recruitment of IPC specialists to increase capacity and expertise across the Trust -, linked to action below Table top exercise with HR and OH to provide assurance on resilience in conjunction with DON	30.3.21 ongoing 31.12.20 31.1.21 31.1.21	31.3.21	Director of Nursing	Quality Assurance Committee			18.01.21

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

28 August 2019 - Principal risk updated and risk score, additional controls and external assurance
29.10.19 - updated gaps in control / assurance and target date
20.11.19 - update to risk score, controls, assurance and gaps
25.5.20 - update to existing key controls, sources of assurances, assurances and gaps.
18.8.20 - no change
29.9.20 - no change
18.1.21 - update to controls

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

	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed by Committee
			LH	Conseq	Rating				Internal	External								
2.1 (2)	Delivery of excellence in patient outcomes and experience	2. Due to gaps in compliance in medication practice there is a risk of avoidable patient harm leading to reputational damage	3	4	**Moderate risk - 12**	**Very Low 1x4=4**	1. Pharmacist staff allocated to priority wards 2. Specific medication incident reporting system on Datix 3. Medicines policies are fit for purpose 4. Monthly omitted doses audits 5. Medication Safety Alerts 6. World Café Educational events 7. DON/MD visibility in clinical areas 8. Omnicel	Controlled drugs audit Omitted doses audit NHS protect audit Medicines reconciliation audit Clinical standards group QAC and sub group oversight EPR report on mitigations to SLT and QAC	Safer Medication Practice Group QAC review of mitigations	Digital review and proposal for E prescribing system	Limited pharmacist cover at weekends. Business case part 2 is going to FIB on Thursday. The pharmacist covering the wards at the weekend has been pulled to support the vaccination hub. Over recruit band 6 pharmacists Insufficient technical staff on ward to deliver at times of staff shortage - Due to the problems recruiting to grade, we are recruiting to training posts and developed a training program to train the staff in house. Automated cabinets not fully implemented - 15 Omnicell cabinets in place across the Trust. One removed from ward 15 due to building work, this is to be relocated along with 1 other cabinet.	31.12.19 28.02.19 31.12.20 ongoing	28.02.20	Director of Nursing	Quality Assurance Committee	1572- Risk of patient harm due to medicine related errors due to no electronic prescribing system		18.1.21

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

29.10.19 - added additional gap and updated gaps in control / assurance
25.5.20 - suggest reduce from BAF to risk register - no specific incidents or issues - not supported by Committee
18.8.20 - update to risk score, controls and sources of assurance
29.9.20 - update to gap in control, controls and assuance
18.1.21 - update to actions

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

	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed by Committee
			LH	Conseq	Rating				Internal	External								
2.2	Delivery of excellence in patient outcomes and experience	Risk that failure to comply with the regulations / regulators could lead to restrictions on service provision leading to reputational damage and/or financial penalties	3	4	High Risk - 16	Low Risk 3x3=9	Risk management process Centre governance meetings Monthly quality and safety report Monthly safe staffing report (nursing and midwifery) Quarterly patient experience report Monthly health care associated infection report Monthly mandatory training report Quality and Equality Impact Assessment process CQC Action plan CQC confirm and challenge meetings Quality risk profile and implementation plan Business case process established Improvement Recovery Plan in place Interim Director of Clinical Development Moving to Good programme MD/DON visibility in clinical areas Safeguarding structure Clinical policy group oversight STACQ program	QAC and sub group meeting agenda and minutes Audit findings Panel outcomes Regulator oversight Capital and FIB minutes of meetings Key quality metrics	Board, QAC and sub committee structure CQC confirm and challenge STACQ evidence	TIPC CCG oversight through Chief Nurses CQC oversight / bi weekly calls IBAF and Patient First review and feedback report Improvement Board Single item quality surveillance group meeting Risk Summits for critical services B2B September 2020 NHSe/I Quality Board assurance on CQC	Implement CQC improvement report Undertake a self assessment and preparedness for CQC inspection from Board to Ward	31.12.20 31.3.21	31.3.21	Director of Nursing	Quality Assurance Committee		⟺	18.01.21

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

28 August 2019 - risk rating and target risk rating updated, additional controls added
29 October 2019 - updated assurances received
20.11.19 - update to key control, sources of assurances
25.5.20 - update to risk grade, key controls, assurances and gaps
18.8.20 - update to existing key controls, sources of assurance, assurances and gaps
29.9.20 - update to gaps in control and risk score
18.1.21 - no change

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

	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed by Committee
			LH	Conseq	Rating				Internal	External								
2.3	Delivery of excellence in patient outcomes and experience	Ability to learn from Serious Incidents, complaints, clinical audits and external reviews to improve on quality and patient safety	3	3	**Moderate Risk 9**	**Low Risk 2x3=6**	1. Serious Incident Report (monthly) 2. Serious Incident Investigations 3. Safety Bulletins 4. Learning Bulletins 5. Monthly Quality Report 6. Quarterly Patient Experience Report 7. Quarterly & Annual Claims 8. Real time patient experience reporting 9. Clinical Audit 10. Centre Governance Board meetings 11. Review panels (Serious Incident, Pressure Ulcers, Falls, Deteriorating Patients, C. Difficile) 12 .Mortality Review 13. Medical Examiner reviews 14. Safety@stees collaborative 15. Clinical assurance rounds 16. Risk Validation Group to meet monthly to review Centre/Corporate Risks with consideration of 15+ new risks 17. Patient Safety Sub-group 18. cross-centre learning through QBP structure 19. Induction and education sessions 20. Patient Safety Faculty 21. Clinical support unit development 22. Getting to good programme 23. Weekly safety wall	Monthly report to Quality Assurance Committee Clinical Standards Sub Group Clinical support Unit QAC report demonstrating month on month increase in reporting DATIX incident reporting levels monitored against NRLS NRLS Benchmarking CQC engagement meeting National Staff Survey External Audit Independent assessment of Quality Report Internal Audit	Quality Report to QAC monthly Serious Incident Report to QAC monthly Patient Experience Report Quality Account Internal Audit Report Performance report Board Serious incidents/Never Events report to Board	CCG SI oversight by Chief Nurses National Clinical Audit Outcome National Staff Survey - annually External Audit Quality Report review Independent Audit reports presented to Quality Assurance Committee and Audit Committee Serious Incident Report Bi weekly clinical governance and risk oversight group NHSE/I Single item QSG / risk summit NHSE/I Quality board	Requirement to train more investigators to support increase in reporting culture - commenced Evidence of embedded and sustained learning Incident reporting upgrade - DATIX cloud Development of patient safety faculty - commenced	31.3.21 31.3.21 31.3.21 March 2021	31.3.21	Director of Nursing	Quality Assurance Committee		⟺	18.01.21

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

Quarter 1 (1 April - 30 June 2019)

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

29.10.19 - updated gaps in control / assurance actions

20.11.19- updated controls, assurance and gaps

25.5.20 - reduce risk to risk register and remove from BAF - not agreed by QAC

18 08 20 - update to key controls assurances and gaps - suggest merge with 2.4

29.9.20 - no change

18.1.21 - no change

3. STRATEGIC OBJECTIVE: Drive operational performance to deliver responsive cost effective care																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Action**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Ratings since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
3.1	Achievement of key access standards/NHSI investigation	A sustained, exceptional level of demand for services that overwhelms capacity resulting in a prolonged, widespread reduction in the quality of patient care and repeated failure to achieve constitutional standards, with possible harm to patients	5	4	**High Risk - 20**	**Low risk 2x3 = 6**	Patient Flow process in place Urgent Care monitoring A&E Delivery Board Standard operating procedures Performance management process in place Deep dive into high risk areas, risk assessment and recovery plans monitored on a weekly basis as part of an incident control methodology Working with primary care and other stakeholders to manage demand through diversion and re-provision Clinical Policy group addressing key issues and deterring the allocation of resources based on clinical priorities Single QSG review of constitutional standards and escalation of high risk areas QAC review and deep dive into critical areas SI process Clinical Harm review process High risk patients identified and have been allocated appointment and theatre capacity using T100 Intensive support package agreed with NHSE/I and lead Director and network for support in place Emergency capital funding received and SDEC implemented, Paediatric ED being established review of patient flow undertaken and additional resources added Directory of services compelted	Clinical Policy Group agenda and action notes A&E Delivery Board agenda and notes Improvement recovery plan - capacity and demand Recovery plans for high risk services and updates to Board and Committees Risk register Outcome of QSG Internal risk summit Assurance and Improvement committee oversight of all delivery and risk areas within Centres Joined Improvement network with NHSE/I	Centre Board management of constitutional standards Weekly incident control meetings for high risk areas Deep dive into critical services at QAC SLT review of risks to delivery of critical services	LADB NHSE/I External review of DTOC CQC inspection report Monthly management of RTT 52 week waiters Single Item QSG Risk Summit 2/52 oversight with regulators B2B September 2020 Quality Board November & February	Recruitment of medical and nursing workforce to manage demand with appropriate skill mix	Ongoing		COO	FIC		⟺	26.01.21

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

3. STRATEGIC OBJECTIVE: Drive operational performance to deliver responsive cost effective care																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Action**	**Target date score will be met/clos**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Ratings since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
3.2	Achievement of key access standards/NHSI investigation	Risk of ability to deliver the national access target of 92% for 18 weeks RTT and achievement of the March 19 WTL by March 2020 due to gaps in workforce (T&O, Spinal, General Surgery, Plastics and Urology), increasing demand (ophthalmology, Gastroenterology), transfer of activity from CCDFT, reduction in weekend working and premium pay .	5	4	**High Risk - 20**	**Low risk 3x3 = 9**	Recovery Plan in place for overall RTT Weekly Performance Meetings Speciality specific level recovery plans have been developed Patient Flow process in place Standard operating procedures Deep dive into high risk areas, risk assessment and recovery plans monitored on a weekly basis as part of an incident control methodology Clinical Policy group addressing key issues and deterring the allocation of resources based on clinical priorities Single QSG review of constitutional standards and escalation of high risk areas QAC review and deep dive into critical areas Intensive support package to be arranged with NHSE/I - undertaken a review of waiting list information Level 5 command and control in place due to pandemic Agreed sharing of P2 cancer work across Tees Valley using IS	RTT Recovery Plan Regular meeting with NHSE/I regarding position Clinical Policy Group agenda and action notes Improvement recovery plan - capacity and demand Recovery plans for high risk services and updates to Board and Committees Risk register Outcome of QSG Internal risk summit	Performance report to Board and Centre boards Outcome of QSG Weekly incident control meetings for high risk areas Deep dive into critical services at QAC SLT review of risks to delivery of critical services	NHSE/I weekly / monthly Return Regular meeting with NHSE/I External review of DTOC CQC inspection report Monthly management of RTT 52 week waiters Single Item QSG Risk Summit 2/52 oversight with regulators B2B September 2020	Implement out come of review of waiting list information from NHSEI Ongoing System discussion regarding shared PTIs for critical services	31.03.21 Ongoing	31.3.20	COO	FIC			27.01.21

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

Quarter 1 (1 April - 30 June 2019)

May 2019:

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

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

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

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

29.9.20 - update to sources of assurance

3. STRATEGIC OBJECTIVE: Drive operational performance to deliver responsive cost effective care																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Ratings since last**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
3.3	Achievement of key access standards/NHSI investigation	Risk of ability to delivery the national access target of 85% for 62 Day Cancer Standard	5	4	**High Risk - 20**	**Low risk 3x3 = 9**	Recovery Plan in place for overall Cancer target Weekly Performance Meetings Speciality specific level recovery plans have been developed Weekly cancer wall including medical director input Cancer delivery group meeting monthly Standard operating procedures Performance management process in place Deep dive into high risk areas, risk assessment and recovery plans monitored on a weekly basis as part of an incident control methodology Clinical Policy group addressing key issues and deterring the allocation of resources based on clinical priorities Single QSG review of constitutional standards and escalation of high risk areas QAC review and deep dive into critical areas SI process Clinical Harm review process High risk patients identified and have been allocated appointment and theatre capacity using T100 Cancer Cell in place (Southern) STAR chamber MDT reviews with COO Repatriation to local unit policy in place	Cancer Recovery Plan Outcome of QSG RTT Recovery Plan Regular meeting with NHSE/I regarding position Clinical Policy Group agenda and action notes Improvement recovery plan - capacity and demand Recovery plans for high risk services and updates to Board and Committees Risk register Outcome of QSG	Performance report to Board and Centre boards Outcome of QSG Weekly incident control meetings for high risk areas STAR chamber report to QAC Deep dive into critical services at QAC SLT review of risks to delivery of critical services	NHSE/I weekly / monthly Return Regular meeting with NHSE/I External review of DTOC CQC inspection report Monthly management of RTT 52 week waiters Single Item QSG Risk Summit 2/52 oversight with regulators National patient experience report	Roll out of automated tracking system across all relevant specialities identifying patients who have high risk of cancer Continue to outsource pathology and radiology services	31.03.21 ongoing	31.03.21	COO	FIC			27.01.21

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

Quarter 1 (1 April - 30 June 2019)

May 2019:

Deleted under Gaps in control - Cancer Delivery Group to be formed

Added to Existing controls - Trust wide Cancer Delivery Group (this is now in place and Chaired by the Medical Director, Specialist and Planned)

27.11.19 - update to risk score, controls, gaps, assurance and action scores

23.5.20 - update to risk grade, key controls, gaps

29.9.20 - update to assurances

3. STRATEGIC OBJECTIVE: Drive operational performance to deliver responsive cost effective care

Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk			Target	Existing Key Controls	Possible Sources of Assurance (that controls are	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Action	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Ratings since last Review	Date Reviewed
			LH	Conseq	Rating				Internal	External								
3.4	Achievement of key access standards/NHSI investigation	Risk that patients deteriorate or actual harm materialises due to patients being moved from list to accommodate cancelled surgical procedures due to inadequate capacity in critical care	4	5	**High Risk 20**	**Moderate risk 2x5 = 10**	Monitoring and tracking patients DATIX report if operation is cancelled Clinical review to determine the level of harm that may have occurred as a result PACU opened Planned surgery has been smoothed across the week ensuring the demand on critical care capacity is balanced Deep dive into high risk areas, risk assessment and recovery plans monitored on a weekly basis as part of an incident control methodology Single QSG review of constitutional standards and escalation of high risk areas Reviewing daily lists and moving to T800 list where appropriate Network actively decompressing sites Social work teams in hospital identifying approrpriate patients for discharging on daily basis	Clinical Policy Group action notes updates to Board and Committees Risk register Outcome of QSG Tactical and Strategic command review	Report to Board Sub Committees and Centre boards	NHSE/I B2B September 2020	Ensure critical care capacity is fully utilised across the Network Ensure community services are fully utilised to enable appropriate step-down care Ongoing work with developing business case for pre-assessment Patient DNA rates are high and require further investigation to understand the cause	ongoing ongoing 31.3.21 ongoing	31.3.21	COO	FIC			27.01.21

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

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

5. STRATEGIC OBJECTIVE: Delivering excellence in employee experience to be seen as an employer of choice

Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target dates for completion of Actions	Target date score will be met/closed	Changes to Ratings since last Review	Responsible Director	Responsible Committee	Associated Corporate Risk	Date Reviewed
			LH	Conseq	Rating				Internal	External								
5.1	Recruit high calibre people and offer a flexible, patient centred and family friendly work environment	Demographic changes, shifting cultural attitudes to careers, capacity and capability of staff combined with employment market factors resulting in critical workforce gaps in some clinical and non clinical services (radiology, anaesthetics, critical care)	3	4	**Moderate Risk - 12**	**Low Risk 3x3=9**	Internal: Reports to Workforce Committee Board of Directors Vacancy management and recruitment systems and processes Safe medical and nurse staffing levels for all wards and departments Temporary staffing approval and recruitment process in place Specialist recruitment campaigns Work / link with university medical school Nurse recruitment days AHP recruitment days External: Care Quality Commission National Staff Survey	National Staff Survey results reported to Workforce Committee, Board of Directors and Exit interviews Vacancy report for hard to recruit gaps discussed at SLT and Workforce Committee Timeline for recruitment report to SLT Staff survey split down into staffing groups ACP further development (report to CPG 08.09.20) Turnover report Locum costs report	Staff Survey You said we did action plan and presentation to Board / Workforce Committee co produced with Staff Side and Staff Engagement	National Staff Survey CQC inspection report B2B with NHSE/I 2.9.20	People Plan (bring together all plans) Robust workforce plan including roles and skill mix Safe staffing (medical workforce) for high risk areas On boarding plan for high risk / all areas - developed by the new AMD for People Working across Tees Valley - workforce fops and learning - Clinical Services Strategy cross cutting groups 1st 5 years consultant plan CSU leadership development training for clinicians	31.12.20 30.12.20 31.10.20 30.12.20 ongoing 31.8.20 31.12.20	01.06.21		Director of Human Resources	Workforce Committee		05.10.20

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

3.2.20 - update to risk rating score, key controls, sources of assurance and gaps
01.06.20 - update to gaps in control and target dates
09.09.20 - update to sources of assurance, external and gaps in assurance
05.10.20 - update to assurances and gaps in control

5. STRATEGIC OBJECTIVE: Delivering excellence in employee experience to be seen as an employer of choice

Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target dates for completion of Actions	Target date score will be met/closed	Changes to Ratings since last Review	Responsible Director	Responsible Committee	Associated Corporate Risk	Date Reviewed
			LH	Conseq	Rating				Internal	External								
5.2	Recruit high calibre people and offer a flexible, patient centred and family friendly work environment	Ineffective engagement with the workforce may result in low staff morale, leading to poor outcomes & experience for patients; less effective teamwork; reduced compliance with policies and standards; high levels of staff absence; and high staff turnover.	3	4	**Moderate Risk - 12**	**Low Risk 3x3=9**	Reports to Workforce Committee Board of Directors Policies and procedures Staff Wellbeing and Occupational Health Draft Engagement strategy (including rewards and recognition; engagement tools) Staff Engagement Group Visibility of leadership Board walk rounds Road shows Covid Draft Wellbeing Strategy Exit interviews Workforce metrics Draft ED&I strategy Workshop on values and behaviours STAR awards Partnership working compact with medical and staff side CPG established - decision making forum Staff weekly briefing Psychology support Health & Wellbeing Group Pulse survey Welfare calls BAME risk assessments	National Staff Survey results reported to Workforce Committee, Board of Directors and Council of Governors Exit interviews Staff survey split down into staffing groups Pulse survey National People Plan report to Workforce committee Engagement Strategy on a page	Staff Survey You said we did action plan and presentation to Board / Workforce Committee co produced with Staff Side and Staff Engagement 12 months on You Said We Did report October 2020	National Staff Survey CQC inspection report B2B with NHSE/I 2.9.20	Reduction in absence and turnover (<10%) CSU leadership development training for clinicians	April 2020 31.12.20	Aug-21		Director of Human Resources	Workforce Committee		05.10.20

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

3.2.20 - update to existing control, sources of assurance and gaps in control and target dates
01.06.20 - update to risk grade, existing controls, sources of assurance, gaps in control
09.09.20 - update to assurances external and gaps in assurance
05.10.20 - update to assurances

5. STRATEGIC OBJECTIVE: Delivering excellence in employee experience to be seen as an employer of choice

Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target dates for completion of Actions	Target date score will be met/closed	Changes to Ratings since last Review	Responsible Director	Responsible Committee	Associated Corporate Risk	Date Reviewed
			LH	Conseq	Rating				Internal	External								
5.4	Recruit high calibre people and offer a flexible, patient centred and family friendly work environment	Failure to comply with national guidance regarding funded establishments in Stroke, Maternity, Paediatric inpatient wards, Cardiothoracic HDU and Neurosurgery HDU could impact on the quality and safety of patient care and / or regulatory action	4	4	High Risk 16	Low Risk 3x3=9	Internal: Reports to Workforce Committee Reports to SLT Board of Directors Vacancy management and recruitment systems and processes Safe nurse staffing levels for all wards and departments Temporary staffing approval and recruitment process in place External: Care Quality Commission	Safe staffing report monthly to QAC and Board Risk assessment and registers identifying mitigation of failure to comply with guidance		CQC inspection report Royal College guidelines	Baseline audit of which specialities are covered by national guidance Plan to address gaps identified in baseline audit Safe staffing (medical workforce) for high risk areas	31.10.20 31.11.20 30.6.20	31.3.21		Director of Human Resources Director of Nursing and Quality Medical Directors Corporate Executive Directors	Workforce Committee		05.10.20

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

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

4. STRATEGIC OBJECTIVE: Deliver long term financial sustainability to invest in our future

Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Actions	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Rating since last Review	Date Reviewed
			LH	Conseq	Rating				Internal	External								
4.1	Delivery of Annual Plan including Control Total	Lack of robust financial information and grip and control may result in poor financial governance and decision making lead to the inability to deliver the annual control total impacting on cash flow and long term sustainability as a going concern	**2**	**3**	**Moderate Risk - 6**	**Moderate Risk 1 x 4 - 4**	**Internal** FIB driving cost improvement programme with Executive Risk Owners linked to schemes Capital Planning Group in place Monthly defunding of budgets for completed schemes Monitoring through Board, Senior Leadership Team, FIC and FIB SFI/SO, Scheme of delegation FIB established to control expenditure vacancy controls established Business case process re-establish **External** Aligned incentive contact agreed with NHSI, NHSE and Trust's commissioners. Savings. Initial programme of work in development. NHSI performance review meetings (PRM) Board to Board meetings and ongoing concerns discussed with NHSE/I Dialogue with National Cash Management Team Ongoing discussions regarding Group structure and addressing PFI ICP Finance Director Group	Audit report on going concern Reports to FIC, Audit Committee and Board Achieved revised forecast in 2019/20 Agreed return submitted to NHSE/I - suspended COVID19 Interim COVID19 arrangements - Trust currently breakeven Year end accounts	Board minutes Finance and Investment Committee minutes Audit Committee work programme Finance Improvement Board minutes Senior Leadership Team action notes Standing Orders/Standing Financial Instructions presented and approved by September 2020 Audit Committee and ratified by the Board	PWC Audit report Revised financial envelop next 6 months Revised financial framework (Covid) Financial governance and control gaps - NHSI review being undertaken - report received and further controls implemented	Savings need to be identified to bridge underlying deficit - Board to revisit in light of financial settlement for 2021/22 Draft PFI business case to be updated and follow up with Jim Mackey November with a view to review by Board in Februray 2021	31.2.21 30.9.21	31/09/2021	Director of Finance	Finance and Investment Committee			22.01.21

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

Quarter 1 (1 April - 31 July 2019)
- May 2019 - no changes made
28 August 2019 - principal risk updated, risk rating updated, target risk updated,
21 January 2020 - principal risk objective updated, risk reduced, key controls and assurances updated
15.6.20 Update to key controls, sources of assurance and gaps in control
01.07.20 update to assurances and gaps in controls
29.9.20 - update to assurances and gaps
12.10.20 - update to risk score
22.1.21 - no change

4. STRATEGIC OBJECTIVE: Deliver long term financial sustainability to invest in our future

Risk ID	Principle Objective	Principle risks to delivery of objective	Grade (including change in risk rating)			Target	Existing Key Controls	Possible Sources of Assurance (that controls are effective)	Assurances Received		Gaps in control/assurance and description of mitigating actions	Target date for completion of Actions	Target date score will be met/closed	Responsible Director	Responsible Committee	Associated Risk	Changes to Rating since last Review	Date Reviewed
			LH	Conseq	Rating				Internal	External								
4.4	IT infrastructure fit for current and future organisational needs	Underdeveloped informatics infrastructure compromises ability to deliver safe, responsive and efficient patient care.	**4**	**4**	**HIGH - 16**	**Moderate Risk 2x4=8**	IT strategy presented to Board in November 2018 Business Case for Electronic Patient Records (EPR) approved by the Board in December 2018 and has subsequently been submitted to NHSI/E for review/approval. IT Business Continuity and Incident Management plans have been updated. A desktop of the BCPs for IT undertaken May 2019. Upgrade to Network infrastructure completion. IT Capital Investment approved and spent for replacement hardware. Business case for new backup solution approved at Capital & Investment Committee. Digital Strategy group reviewing risks Approval to bid for digital project which would fund both infrastructure and medicines management £6m - successful Emergency capital funding Cyber funding's Funded GNCR Executive Director SIRO in place A monthly Cyber Security group has been	Action Plan in response to Internal Audit report DSP Action Plan Update reports to Digital Strategy Group, and Board Audit Committee and Digital Strategy Group minutes FIC agenda and minutes Trust Board agenda and minutes Cyber and IT risk papers discussed at SLT **External** NHS Digital Audit PWC Audit IG Toolkit re unsupported systems	Chief Clinical Information Officer (CCIO) and Deputies appointed Business Continuity testing commenced EPR Programme Board in place Board minutes evidence approved EPR Business Case	PWC Audit reports on DSPT NHS Digital Audit PWC cyber report	Future strategy subject to independent review commissioned by ICS / NHSE/I Address high risk audit reports Trust commissioned independent review of IT infrastructure	31.11.20 in line with audit recommendations 30.9.20	31.3.21	Director of Finance	Finance and Investment Committee			22.01.21

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

Quarter 1 (1 April - 30 June 2019)
- May 2019 - no changes made
12.11.19 - update to principal risk, controls and assurances
21.1.20- update to principal risk, risk score, sources of assurance and responsible Director
15.6.20 - update to key controls and gaps
01 07 20 -update to assurances, key control and actions
29.9.20 - update to assurances
22.1.21 - no change

4. STRATEGIC OBJECTIVE: Deliver long term financial sustainability to invest in our future																		
Risk ID	**Principle Objective**	**Principle risks to delivery of objective**	**Grade (including change in risk rating)**			**Target**	**Existing Key Controls**	**Possible Sources of Assurance (that controls are effective)**	**Assurances Received**		**Gaps in control/assurance and description of mitigating actions**	**Target date for completion of Actions**	**Target date score will be met/closed**	**Responsible Director**	**Responsible Committee**	**Associated Risk**	**Changes to Rating since last Review**	**Date Reviewed**
			LH	**Conseq**	**Rating**				**Internal**	**External**								
4.6	Trust estate developed and maintained to meet regulatory requirements and aligned to strategic plans	Current estate, lack of capital investment in equipment, IT and infrastructure compromises the ability to consistently deliver safe, caring, responsive and efficient patient care. Potential impact on delivery of service, backlog maintenance, unplanned equipment failure leading to a patient safety risk.	**4**	**4**	**High Risk 16**	**Moderate Risk 2x5=10**	Improved access now in place for lifecycle investment Capital planning group in place Planned maintenance processes in place Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Low levels of back log maintenance Available wards for decanting Emergency capital bid 2020/21 Prioritised Capital plan developed and submitted to ICS for consdieration	Emergency capital funding bid Commissioned a condition survey of the estate Health & Safety Group consideration of audit information	PFI Lifecycle - £7.9 million contractual commitment to Endeavour SCH Plc. Payment to Endeavour based on the Financial Model amounts to £10.5 million with the difference charged direct to revenue in line with the agreed profiling of the Providers Lifecycle investment gap Estates – PFI Enhancements and change in law for lifecycle (£0.8 million), Pathology development, relocation across sites including blood sciences hub (£0.4 million), Paediatric Emergency Department (£3.2 million), critical infrastructure investment at FHN (£1.2 million), Critical Care Isolation and Surge Capacity (£2.9 million) and FHN Rationalisation (£1.0 million);	PLACE assessments ISO accreditation for medical engineering CQC report	PFI contract limited to 'like for like' replacement - change in Law is a Trust liability External review commissioned to look at physical infrastructure (condition survey)	ongoing 30.9.20	31.3.22	Director of Estates, Facilities and Capital Planning	Finance and Investment Committee			22.1.21

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

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

28 August 2019 - principal risk updated - new one added
12.11.19 - updated principle risk, risk rating, controls, actions and assurances
26.11.19 - update to objective, key controls and sources of assurance and responsible director
15.6.20 - update to gaps in control
12.10.20 - update to risk score and assurances
22.1.21 - update to assurances

<table>
<tr><td colspan="4">MEETING OF THE PUBLIC BOARD OF DIRECTORS – 2 February 2021</td></tr>
<tr><td colspan="3">Corporate Risk Register</td><td>AGENDA ITEM: 17,
ENC 11</td></tr>
<tr><td>Report Author and Job Title:</td><td>Jackie White
Head of Governance</td><td>Responsible Director:</td><td>Kevin Oxley
Director of Estates, Facilities and Capital Planning</td></tr>
<tr><td>Action Required</td><td colspan="3">Approve ☐ Discuss ☒ Inform ☐
(select the relevant action required)</td></tr>
<tr><td>Situation</td><td colspan="3">The Trust has a number of risk registers which provide a comprehensive picture of all risks that affect the Trust. The mechanism for escalating risks to the Board of Directors is through the Risk Validation Group, Senior Leadership Team a Board Committee or the Risk Committee.</td></tr>
<tr><td>Background</td><td colspan="3">In line with the Risk Management Policy the attached report sets out the risks which have been brought together into the Corporate Risk Register which are risks facing the Trust and scored 16 and above and are brought to the attention of the Committee</td></tr>
<tr><td>Assessment</td><td colspan="3">On 27 January 2021 (report extracted from DATIX) there are 68 risks on the corporate risk register graded 16 and above. There has been an increase in the number of incidents graded 16 and above the majority of which are within Urgent and Emergency Care. All but one risk have an action plan, however 21 risks are overdue a review, 1 of these risks relate to an overdue review in 2019 and 20 due for review in 2020, the majority of which are within the corporate directorates.</td></tr>
<tr><td>Recommendation</td><td colspan="3">The Trust Board of Directors are asked to note the risk report and full risk register which has been previously circulated to members.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="3">Risk implications associated with this report are contained within the report.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="3">There are no legal or equality & diversity implications associated with this paper.</td></tr>
<tr><td rowspan="3">Strategic Objectives
(highlight which Trust Strategic objective this report aims to support)</td><td>Excellence in patient outcomes and experience ☒</td><td colspan="2">Excellence in employee experience ☒</td></tr>
<tr><td>Drive operational performance ☒</td><td colspan="2">Long term financial sustainability ☒</td></tr>
<tr><td>Develop clinical and commercial strategies ☒</td><td colspan="2"></td></tr>
</table>

Risk Register Report

1. PURPOSE OF REPORT

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

2. BACKGROUND

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

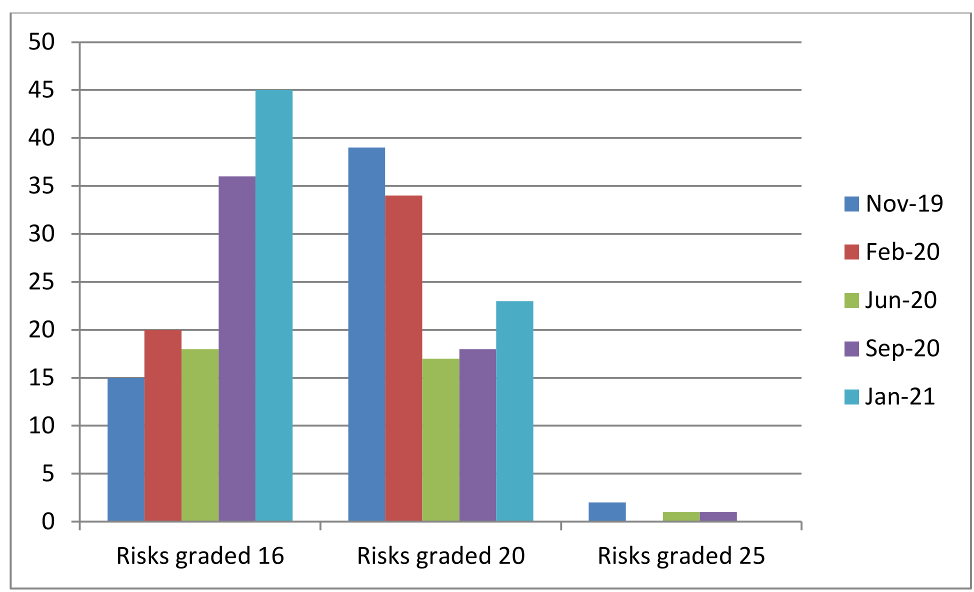
The Risk Validation Group is responsible for reviewing locally approved new and existing risks scored as 16 and above (the Corporate Risk Register), to validate the risk score and grade; to scrutinise and challenge the adequacy of the risk description, the controls and the mitigating action plan; and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

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

3. DETAILS

As of 27 January 2021 there are 68 risks on the corporate risk register of 16 and above which are broken down by centre/corporate Directorate below. This is an increase of 13 since the last quarter.

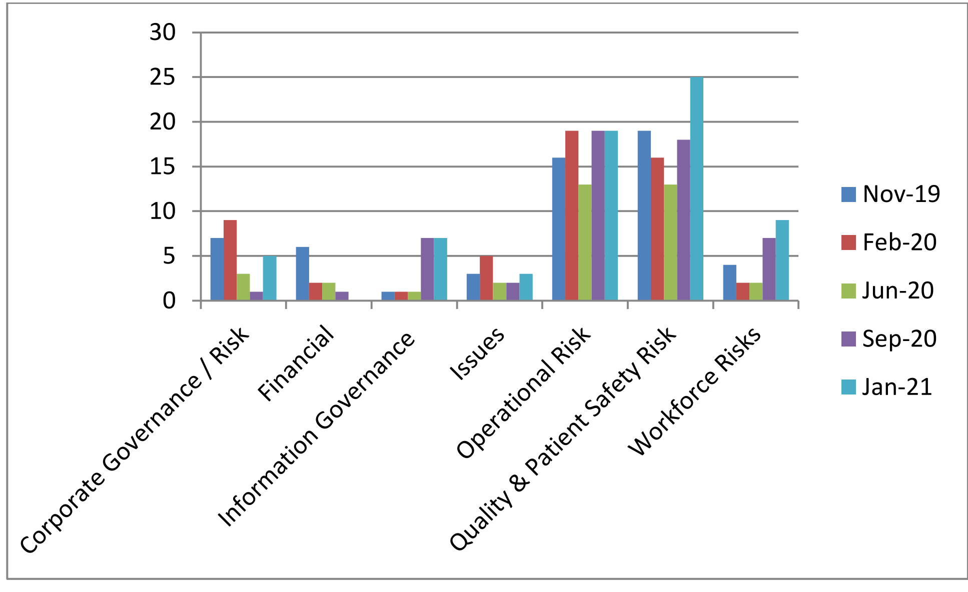
All 16 and above risks relating to the clinical Centres were reviewed by the Senior Leadership Team at meetings during October and November through the newly formed Assurance and Improvement Committee.



In the last quarter the risks graded 16 and above have increased by 13, this was predominately within the Urgent and Emergency Services Centre.

The risk graded 25 within Specialist and Planned which has been escalated within the system has been reduced and there are no risks at 25 to highlight to the Board.

The main themes this quarter relate to governance and patient safety due to COVID19 related issues such as staff absence and social distancing impact on delivery of services.



Of the 68 risks on the risk register all but one risk have an action plan to mitigate the risk

4. RECOMMENDATIONS

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

APPENDICES

Corporate Risk Register (previously circulated)

Charitable Funds Committee Chair's Log

Meeting: Charitable Funds Committee	**Date of Meeting**: 3/12/2020
Connecting to: Board of Directors / Corporate Trustee	**Date of Meeting**: 02/02/2021
Key topics discussed in the meeting	
Quarterly review of charitable income and expenditure Update by fund manager on performance of the charity's financial investments Proposal to fund a Band 8 psychologist post Acceptance of annual report and accounts Extension of staff hardship fund	
Actions agreed in the meeting	Responsibility / timescale
The committee reviewed and approved the approach to authorisation of charitable expenditure. The committee noted that the charity's investments had decreased in value during the course of the year, but had subsequently recovered to just under £6m. The committee agreed to fund an additional Band 8 psychologist post for a period of 12 months. The committee noted the content of the annual report and accounts. The committee agreed to fund an extension of the staff hardship fund, with a review in 12 months' time.	

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**: 21 January 2021
Highlights for: Board of Directors	**Date of Meeting**: 2 February 2021

Overview of key areas of work and matters for Board.
• Committee terms of reference • Covid update for staff including health and wellbeing • Workforce performance data • Education update • Initial findings from staff survey 2019 • Accreditation of Occupational Health

Actions to be taken	Responsibility / timescale
• Note and congratulate the education team for the positive feedback on continuation of face to face medical education • Endorsed approach to maintain and enhance targeted psychology support to staff impacted by Covid and support review of support needed medium term as part of a staff recovery plan • Reinforced the importance of managers complying with policy and procedures in respect of staff who are extremely clinically or clinically vulnerable • Congratulate Clinical Support for their consistent good performance in respect of workforce KPI's • Note the initial findings from the staff survey from 2019	

Board action	Responsibility / timescale

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

Quality Assurance Committee
Chair's Log

Meeting: Quality Assurance Committee	**Date of Meeting**: 26/01/2021
Connecting to: Board of Directors	**Date of Meeting**: 02/02/2021
Key topics discussed in the meeting	

- Pressure Ulcer update
- (Appendices under silent papers)
- Sepsis update
- Maternity Services update
  - Continuity of Carer action plan
  - Ockenden Report update
- Cancer Priorities Pathways update
- Medication Incidents Action Plan Update
- Clinical prioritisation / Harm review process for patients on waiting lists
- Urgent Escalations
  - Single Sex Accommodation
  - Nursing documentation and SI investigations during Covid-19 surge
  - Never Events & SI's
  - Covid-19
- Monthly Integrated Performance Report – Quality indicators
- QEIA's
  - Covid vaccination programme
  - ED segregation
  - Red, Amber, Green pathways
- Patient Safety Incident Response Framework
- LocSSIPs Update Report
- QAC and Workforce Committee alignment, issues and dates of joint meetings
- Review of Risks and Matters for the Board Assurance Framework
- Items for escalation from Chairs log of any sub group reporting to the committee

Actions	Responsibility / timescale
• QAC received a report on the incidence of pressure ulcers, actions to reduce tissue damage, benchmarking data with other organisations and the outcome of the recent external review. Actions are being monitored however the incidence remains an area of increased scrutiny. Pressures on staff due to COVID cannot be excluded as a reason for the increased incidence. However, there are many examples of good practice. The action plan is supported by both CCG Chief Nurses and the CQC. The joint approach across the Tees Valley is welcome. NEQOS have been asked to develop a regional dashboard.	Ian Bennett / February 2021
• A paper on compliance against the sepsis bundle was shared. Compliance against the sepsis bundle is 37% however this is not a straight-forward measure and the evidence behind the standards is being reviewed. There is a Sepsis Working Group with an action plan. Timescales are dependent on COVID-related	Lindsey Garcia, Moira Angel and Ros Fallon

pressures. This work is being led by the critical care and outreach teams.. Sepsis reporting will be pulled through into the IPR on a monthly basis. QAC noted that previously there was no adverse feedback due to non-compliance with sepsis standards, reported to QAC from the medical examiner review process.	
• QAC heard the monthly Maternity update, progress against the continuity for carer standards and the response to the Ockenden Report. Limited compliance was reported against the maternity services dataset due to national IT issues concerning the Euroking System. This affects all NHS organisations. CNST mandatory training targets will not be achieved until training is transferred. Maternity staffing remains a challenge due to vacancies and difficulty with recruitment. By March 2021 the trust is expected to have 35% of women on the continuity of carer pathway. Current performance is 11%.. This risk is on the risk register. QAC heard that there are no gaps against the minimum recommendations in the Ockenden Report. A report is coming to Trust Board. Final submission mid-February. The IPR is to include maternity standards.	Kay Branch and Ian Bennett Kay Branch Kay Branch Ros Fallon
• Prior to the meeting it was agreed that the verbal reports scheduled for cancer priorities update and the medication incidents action plan would not be heard at this meeting to allow the leads to remain focussed on clinical and operational issues. QAC will continue to receive detailed updates as per the meeting cycle of business. Board will hear the cancer services position on 2nd February.	
• QAC heard how the review process for patients affected by COVID-19 will take place. The process is at the final stages of being agreed and tested. A report will come to the next meeting.	Ian Bennett / February 2021
• Due to COVID pressures QAC received a paper describing the process to maximise staff time while maintaining good governance processes Assurance was given that any immediate fact-finding and necessary learning and actions from incidents will not be delayed.	
• QAC Discussed patient safety learning. The QAC discussed the continuing work around safety and quality and how pace can be maintained against the backdrop of COVID-19. This will remain on the QAC and Board agenda.	
• Monthly IPR: The clinical detail of performance was discussed throughout the meeting. From a reporting point of view the IPR will be altered for SI & Never Events and a review of mean or target measures as appropriate.	
• QEIA's: QAC were assured by the process of QEIA for operational changes due to COVID and the monitoring in place. QEIA's shared were: the vaccination programme, ED segregation and the red,	Ros Fallon

amber and green pathways. The process continues to be led by the medical and nurse directors. • QAC received a paper on progress on the LocSSIPs project which has been very successful in streamlining, standardising and agreeing LocSSIPs, plus engaging with clinical directors. A further update on embedding the use of LocSSIPs and how this is supported by the wider work to improve the safety culture and the work of the safety and leadership faculty will remain on the QAC agenda	
Escalated items	
Board to note: • The QAC agenda and attendance list for this meeting was reduced owing to the current COVID pressures. Discussions were reduced to try to reduce the time spent in the meeting. • It was clear from the discussions in the meeting that the staff are working extraordinarily hard. Therefore, timescales for delivery in some areas will necessarily need to slip. QAC fully support the members of the committee. • The incidence of pressure ulcers and steps to take a Tees Valley approach, with support from the CCG and NEQOS support to benchmark between trusts. • The maternity update, including the expected low compliance against the continuity of carer standards. In addition, to note that there were no gaps reported against the Ockenden recommendations. • Assurance was given that any immediate fact- finding and necessary learning and actions from incidents will not be delayed.The investigation and reporting of incidents including serious incidents will be delayed due to COVID. • Never Events, Sis and learning were discussed. • Assurance was received from the QEIA process for changes necessary due to COVID. • Progress with LocSSIPs work.	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
Updated of 2.1(2) Medication practice has been updated and it is expected as the Trust moves forward with the electronic prescribing the risk score will decrease. 2.3 & 2.4 – remain unchanged. 2.1(1) - Covid - includes all covid risks.	