South Tees Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS (PUBLIC)

Date – 3 May 2022
Time – 13:00 – 13:20 for public access via Microsoft teams
Venue – Board Room, Murray Building and virtually on Microsoft teams

Safety and Quality First

NHS
South Tees Hospitals
NHS Foundation Trust

MEETING OF THE SOUTH TEES HOSPITALS NHS FOUNDATION TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON TUESDAY 3 MAY 2022 AT 13:00 IN THE BOARD ROOM MURRAY BUILDING JAMES COOK UNIVERSITY HOSPTIAL FOR BOARD MEMBERS ONLY

Members of the public to observe via Microsoft Teams

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT
STAFF STORY				
CHAIR'S BUSINESS				
1.	Welcome and Introductions	Information	Chair	Verbal
2.	Apologies for Absence	Information	Chair	Verbal
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1
4.	Minutes of the last meetings held on 5 April 2022	Approval	Chair	ENC 2
5.	Matters Arising / action log	Review	Chair	ENC 3
6.	Chairman's report	Information	Chair	ENC 4
7.	Chief Executive's Report	Information	Chief Executive	ENC 5
8.	Board Assurance Framework	Discussion	Head of Governance & Company Secretary	ENC 6
9.	Integrated Performance Report	Discussion	Chief Operating Officer	ENC 7
SAFE				
10.	Safe Staffing Report	Information	Chief Nurse	ENC 8
11.	Ockenden report	Information	Chief Nurse	ENC 9

	ITEM	PURPOSE	LEAD	FORMAT
EXPERIENCE				
12.	Freedom to speak up report	Information	Guardians & Chief Nurse	ENC 10
EFFECTIVE				
13.	Consultant appointments	Information	Chief Executive	Verbal
WELL LED				
14.	Finance Report	Information	Chief Finance Officer	ENC 11
15.	CQC update	Information	Chief Nurse	ENC 12
16.	Annual filings update	Information	Head of Governance & Company Secretary	ENC 13
17.	Annual Compliance with Provider Licence	Information	Head of Governance & Company Secretary	ENC 14
18.	Committee Reports	Information	Chairs	Verbal
	DATE OF NEXT MEETING The next meeting of Board of Directors will take place on TBC			

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 MAY 2022			
Register of members interests			**AGENDA ITEM: 3** **ENC 1**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Derek Bell 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.		
Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐		
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)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Ada Burns	Non-Executive Director Vice 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.
Debbie Reape	Non-executive Director Senior Independent Director	August 2019 1 October 2019 October 2019	Ongoing Ongoing Ongoing	Associate Director with Northumbria International Alliance (Northumbria NHS Trust and Northumberland County Council) South Tees Healthcare Management Limited - Company number 10166808. School Governor, Ashington Academy.
Jackie White	Head of Governance & Company Secretary	March 2013	Ongoing	Registered with IMAS (NHS interim management & support)
Sue Page	Chief Executive	May 2018	Ongoing	President of British Red Cross – Cumbria.
Kevin Oxley	Director of Estates, Facilities and Capital Planning			No interests declared
Rachael Metcalf	Director of Human Resources			No interests declared.
Mark Graham	Director of Communications			Ad hoc communications support to North Cumbria integrated care NHS Foundation Trust. Registered with IMAS (NHS interim management & support)
Moira Angel	Interim Director of Clinical Development	18 January 2021		Director of Moira Angel consulting Ltd - Company number 09529658 Director of Arista Associates Ltd. - Company number 09986504 Vice president of the red cross in Cumbria.
Robert Harrison	Managing Director			No interests declared
David Jennings	Non-executive Director	1 January 2021	Ongoing	Trustee Newcastle University Development Trust and Honorary Treasurer. Unremunerated, voluntary role. Chair AuditOne Board NHS internal Audit Consortium. Unremunerated, voluntary role.
David Redpath	Non-executive Director	1 January 2021	Ongoing	Director of DGR Consultancy - Company number 10340661
Michael Stewart	Chief Medical Officer	1 February 2021	Ongoing	No interests declared
Hilary Lloyd	Chief Nurse	15 February 2021	Ongoing	No interests declared

Chris Hand	Chief Finance Officer	2 July 2021	Ongoing	South Tees Healthcare Management Limited - Company number 10166808
Samuel Peate	Chief Operating Officer	1 April 2021	Ongoing	No interests declared
Prof Derek Bell	Joint Chair	April 2020	Ongoing	Trustee Royal Medical Benevolent Fund – no remuneration
		April 2018	Ongoing	Chair and Trustee Tenovus Scotland (Edinburgh) – no remuneration
		April 2021	Ongoing	Centre for Quality in Governance – Dormant Ltd Company

South Tees Hospitals NHS
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 5 APRIL 2022 AT 13:00 IN THE BOARD ROOM, MURRAY BUILDING JAMES COOK AND VIA MICROSOFT TEAMS

Present

Professor D Bell	Joint Chairman
Ms A Burns	Vice Chair / Non-Executive Director
Ms D Reape	Non-Executive Director
Mr R Carter-Ferris	Non-Executive Director
Mr D Redpath	Non-Executive Director
Mr D Jennings	Non-Executive Director
Dr M Stewart	Chief Medical Officer
Dr H Lloyd	Chief Nurse
Mr C Hand	Chief Finance Officer
Mr R Harrison	Managing Director
Ms S Page	Chief Executive

Directors – non-voting

Mrs J White	Head of Governance & Company Secretary
Mrs R Metcalf	Director of Human Resources
Mr M Graham	Director of Communications
Mr K Oxley	Director of Estates, Facilities & Capital Planning

BoD/22/001 **WELCOME AND INTRODUCTIONS**

The Chairman welcomed members to the meeting and thanked members of public who had joined the meeting by Microsoft teams and reminded them to put their volume on mute during the meeting.

The Chairman gave thanks to Ms Harris and Mr Ducker, Non-executive Directors who had recently left the Trust for personal reasons and work pressures. He wished to acknowledge collective thanks for their contribution to the Trust.

BoD/22/002 **APOLOGIES FOR ABSENCE**

There were no apologies for absence.

BoD/22/003 **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/22/004 **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/22/005 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on Tuesday 3 March 2022 were reviewed and agreed as an accurate record. Mrs White

BoD/22/006 **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

BoD/22/007 **CHAIRMAN'S REPORT**

The Chairman referred members to his previously circulated report and drew members attention to a number of issues including COVID rates remain high which is having an impact on staff both professionally and personally with an increasing level of sickness absence. That he had chaired the Council of Governors meeting recently which was very productive. A joint Board to Board development session had been held on cyber security and that he had attended a Trust wide Safety day on 8 March which was a very well attended and organised event. The Chairman reported that Sam Allen, CEO of North East and North Cumbria ICS had attended the Trust who had found her visit to be engaging and she was excited by the progress of improvement and innovation observed. Finally the Chairman highlighted that the Terms of reference for the COVID public inquiry had been developed.

Ms Burns as Vice Chair reported that she had attended the Tees Valley Health Summit which was focussed on health inequalities and shared some dispiriting data on what has happened around life expectancy in the Tees Valley. Ms Burns updated that having made some really good progress over recent years the gap in life expectancy is closer to where we were 15 years ago. She added that the Trust has set up an internal group looking at health inequalities and the Nomination Committee have agreed when we recruit NEDs we will look for candidates with public health / health inequalities experience.

Ms Burns also added that the Board undertook their walkrounds prior to Board and without exception all the wards we visited we were impressed with leadership, team spirt and care for patients. She added that this reinforces what we see in the staff survey about the shift and the morale, notwithstanding all the challenges.

RESOLUTION

The Board of Directors NOTED the Chairman's report.

BoD/22/008 **CHIEF EXECUTIVE'S REPORT**

The Chief Executive referred the previously circulated report and highlighted a number of areas for consideration including the group of cardiothoracic surgeons in Ghana doing some amazing work teaching new techniques. Enoch Akowuah had been made a Professor of Cardiothoracic care and that the Trust in conjunction with Cleveland Heart Foundation had launched their joint appeal "Hearts and Minds" to raise funds to establish a research facility at James Cook Hospital.

Dr Stewart commented that he was really proud of the team, they held a significant national reputation and were developing international reputation and across the world and the research facility will enable them to look at gaps in knowledge.

The Chief Executive highlighted that the LINAC accelerator had been recently installed and we need 2 more over the next couple of years.

The BBC had run a programme last week "This is England" which Barney Green, Consultant Vascular Surgeon had contributed to relating to knife crime in Middlesbrough which demonstrated the work of James Cook. Following this it was announced that Middlesbrough will receive a Violence Reduction Unit and received £3.5m from the Home Office.

Finally in relation to COVID, the Chief Executive commented that the Trust had observed the most difficult weekends over the last couple of years due to the pandemic, with problems across the whole (regional) system.

RESOLUTION

The Board of Directors NOTED the Chief Executive's update

BoD/22/009 **BOARD ASSURANCE FRAMEWORK**

Mrs White referred members to the report on the Board Assurance Framework report and highlighted the Board Sub Committees – People, Quality and Resources continue to review their BAF each meeting.

Through the Chair's logs the Board can be assured that the Committees have tested the controls in place; received assurances (some positive and some negative); reviewed the gaps in controls or assurance and received assurances to mitigate some of these gaps.

A number of assurance reports are being received today at

Board.

The Finance report and IPR discuss the financial position for month 11 drawing on the work of the Collaboratives and Improvement Councils established to support the CIP for the Trust.

COVID-19 continues to have an impact on areas across the Trust including performance as identified in the IPR and staffing as identified in the IPR and safer staffing report. This is also highlighted in the learning from deaths report with regard to the unadjusted and risk adjusted mortality rates. In addition the year to date pay position is impacted by the additional Covid costs of £10.2m.

Staffing continues to be highlighted in a number of assurance reports including the IPR and safer staffing report due to the ongoing nature of the COVID-19 pandemic, sickness absences remained high, reflected in HR KPI's.

Medicine and Emergency care services are highlighted in a number of reports including the IPR around the 4-hour standard and A&E patient experience in line with trends across the region. .

Each of the Committees have reviewed their Risk Appetite during March and final statement will come back to the May Board,

RESOLUTION

The Board of Directors NOTED the BAF

BoD/22/010 **INTEGRATED PERFORMANCE REPORT**

The Chairman introduced Mr Peate to present on the Integrated Performance Report (IPR). He reported that the report has been changing over the last few months and thanked those who had contributed to its development including the Non-Executive and Executive Directors.

Mr Peate highlighted the key messages:

- Trust performance in December 2021-February 2022 reflects a significant increase in COVID-19 infections in our communities due to the COVID-19 Omicron variant. This placed additional demands on primary, emergency and acute care and social care, with COVID-19 related staff absences adding substantial pressures to service delivery across the system.
- Due to the ongoing nature of the COVID-19 pandemic, sickness absences remained high, reflected in HR KPI's, however mandatory compliance improved

markedly in February. Changes to national guidance on COVID-19 isolation guidance were adopted to safely minimise the impact of staff isolation on absence levels.

- Compared to January, the falls rate reduced in February. The rate of falls with harm also remains low. Pressure ulcers of category 2 in the community have increased: targeted and systematic support has been put in place.
- The increase in C. difficile cases at the Trust is reflective of the national and regional picture. A structured review process has been implemented to identify any themes and learning.
- Emergency care access as reported by the 4-hour standard and ambulance handover delays continued to be challenging due to the higher volumes of attendance seen across the system and continued pressures caused by COVID-19, and this is reflected in A&E patient experience. Maternity services patient experience: use of technology to increase response rates will help provide more insight into trends.
- Despite challenges of COVID-19, elective inpatient activity exceeded our plan and the reduction in numbers of patients waiting the longest was sustained.
- The financial position remains on plan.

Mr Peate added that in relation to 104 week waits there will be zero by end of March.

Mr Jennings commented that it is important to remind members that the detailed deep dives into the IPR are undertaken in the Board Sub Committees. He asked in relation to the Equitable section and inpatient PTL how the Trust are responding to the health inequalities. Mr Harrison advised that the work in relation to this area is about improving our data around ethnic groups ensuring we are monitoring access across the Trust to ensure people have access and we are not treating those who should not be on our books. In addition the Trust has established a group working with colleagues in public health which is pulling together a work programme and our contribution to addressing health inequalities; in terms of direct care and as a major employer. Aligned to this we are advertising a joint appointment for public health consultant with the local authority.

Ms Burns commented that she welcomed the news on health inequalities. She referred to the safe section and maternity services with regard to Caesarean Section and post-partum haemorrhage rates which remain in line with the longer-term average and the commentary which identified that this indicator was impacted by changing clinical practice and adhering to NICE guidance through the Covid-19

pandemic where an increase in some indicators reflected the impact of COVID on pregnancy and births and whether the Trust felt there were other things which have impacted this such as the needs of the communities we serve. Dr Lloyd commented that COVID has been the biggest impact – mums have seen premature births and there has been some evidence around still births during the pandemic. With regard to the communities, the Trust continues to work with families and communities and that's where the Continuity of Carer teams are focussing on. Having a dedicated team should have a positive impact on health.

Mr Carter Ferris asked regarding the Effective slide and sepsis indicators with regard to the action around - Electronic workflow was introduced in November 2021 which is predicted to further increase timely responses. Dr Stewart updated that the electronic prescribing project will take around 12 to 18 month to implement.

The Chairman asked regarding the cancer targets and how many of them are going to compress to 62 days. Mr Peate commented that the 62 day target will stay, there is some movement on others including the faster diagnostic.

The Chairman commented that the position regarding 104 weeks position is excellent and well done for achieving this.

The Chairman referred to the Safe section and Health Care Associated Infections in particular C. difficile cases which remain higher than last year. The Chairman asked Dr Lloyd regarding the detailed plan which has been implemented and where and when this will be reported on Dr Lloyd advised that IPC will report to Board through QAC at a future meeting.

RESOLUTION

The Board of Directors NOTED the update

BoD/22/011 **SAFE STAFFING REPORT**

Dr Lloyd referred members to the safe staffing report and highlighted that the percentage of shifts filled against the planned nurse and midwifery staffing across the trust is 97.7% demonstrating good compliance with safer staffing.

Staffing has continued to be a challenge across the trust with short notice unavailability associated with Covid isolation and Covid related absence.

Stretch staffing ratios have been implemented where necessary based on skill mix, acuity and occupancy levels, all of these actions agreed by senior nurse through safe care.

The introduction of allocate on arrival shifts for RNs and HCAs (5 per day and night at JCUH and FHN) has seen improved pick up in February, these shifts are promoted daily via ward manager platforms and NHSp text messaging. This model has been followed in community with impactful pick up Nursing Turnover for February has increased slightly to 8.67%

Dr Lloyd reported that a successful recruitment event had been held on Saturday with students from Tees Valley attending. There was lots of positive social media and publicity demonstrating staff were proud of what they were presenting. Mrs Metcalf advised that 40 students turned up and all would want to come to South Tees for a role.

Ms Reape asked if there were any students from outside the area and Mrs Metcalf confirmed that it was just local Teesside university students on this occasion.

Mr Jennings commented on a national report which set out that not all international nurses have a good experience within Trusts and asked how the Trust is supporting our international nurses. Dr Lloyd advised that the international recruitment is straight through from NHSE led by Ruth May, Chief Nurse – we are signed up to this programme rather than going on our own. This gives us good assurance on quality recruitment and looking after them. When they arrive we have an international nurse's facilitator and other support packages.

Ms Burns commented on the reciprocal mentorship programme and the focus on our international nurses and how they access the opportunities to progress into management roles.

RESOLUTION

The Board of Directors NOTED the safer staffing report

BoD/22/012 **CONSULTANT APPOINTMENT**

The Chief Executive updated members on the new consultant appointments and the following staff were welcomed to the Trust:

Charlotte Ashton – Neonatology
Emma James – A&E
Dilani Perera – Older Person's Medicine

And said farewell to Mike Tremlett – Anaesthetics

RESOLUTION

The Board of Directors NOTED the update

BoD/22/013 **LEARNING FROM DEATHS REPORT**

Dr Stewart presented the learning from deaths report and highlighted that following the high peak in mortality figures over the initial COVID-19 pandemic, and then the subsequent dip in mortality over the summer, numbers are beginning to normalise again. SHMI at 117 remains higher than expected.

The Medical Examiner team coverage of mortality continues to be in excess of 95% of all deaths.

Mortality Surveillance is continuing though has been affected by the pandemic. New reviewers have been recruited to address outstanding of reviews and these been reduced from 150+ to 118

Ms Burns asked if is there correlation with Serious Incidents or never events and Dr Stewart advised that yes they will be a criteria for a more detailed surveillance review by the team.

The Chairman commented on coding and the work which is required and Dr Stewart reported that this will is around 12 months away from seeing the impact however we are seeing progress on coding but that work has some way to go.

RESOLUTION

The Board of Directors NOTED the update

BoD/22/014 **PATIENT EXPERIENCE AND INVOLVEMENT REPORT**

Dr Lloyd presented the patient experience and involvement report and highlighted that there has been a marginal decrease in the number of complaints received compared to the previous quarter.

The timeframe to respond to complaints is an area of focus. A plan is in place to escalate complaints early to prevent them becoming 'off target'.

The number of re-opened complaints has decreased to 13%.

The number of PALS (advice/enquiry/concerns) rose above the average in October and November but decreased quite significantly in December.

Ms Burns commented on the assurance from identifying themes and learning from complaints and asked regarding the systems which allow the Trust to triangulate this information. Dr Lloyd advised that the information is discussed and shared with the Patient Experience Steering

Group and shared across Collaboratives. A good practice bulletin is produced in addition to a social media facebook post called 60 seconds. There is more we can do around triangulation.

RESOLUTION

The Trust Board of Directors NOTED the report

BoD/22/015 **FINANCE REPORT**

Mr Hand referred members to the previously circulated report and highlighted that due to the ongoing Covid-19 pandemic formal annual financial planning has been suspended for 2021/22. ICS system level planning is in place, with each ICP expected to deliver break-even within a fixed funding envelope. The Trust has recently agreed its H2 plan. The Trust's requirement for 2021/22 is to deliver a £5.0m deficit. At Month 11 the Trust reported a deficit of £4.7m at a system control total level. This is in line with the required budget deficit for M11 as agreed within the ICP/ICS.

Mr Jennings asked regarding the agency spend and what potential there was to reduce the overall cost. Mr Hand confirmed that the Trust has strong systems and processes in place to manage this area and all locums are tracked through the Trust and there are plans in place to monitor this to ensure we have the best value for money.

The Chairman asked regarding the pipeline of consultants and whether some of those joining the Trust will off set this spend. Dr Stewart confirmed that they would but that there are a number of hard to recruit areas which are national issues.

Mr Oxley commented that the service managers are bringing to the table the high cost locums and what they are doing with recruitment and recognise the opportunity for real change.

RESOLUTION

The Board of Directors NOTED the report

BoD/22/016 **CQC UPDATE**

Dr Lloyd referred members to the previously circulated report which set out the ongoing work to prepare for the next full CQC inspection and an update on the initial feedback and actions taken following its focused visit which was carried out in February 2022.

The CQC attended the trust on the 9th February and 10th to undertake a focussed visit. Initial feedback has been received and the Trust is working with the CQC prior receipt of a final report.

The Chairman asked regarding the quality and safety dashboard and Dr Lloyd updated that we are further developing the triangulation of data including safety, complaints, and enquiries to look at feeding these into the ward level self-assessments and ward to board governance and learning from these this.

RESOLUTION

The Board of Directors NOTED the report

BoD/22/017 **STAFF SURVEY UPDATE**

Mrs Metcalf updated members on the staff survey results and confirmed that the 2021 NHS Staff Survey saw a return of a 31.3% with 2,877 surveys completed. In the 2020 NHS Staff Survey the trust was ranked as the most improved in the country. The 2021 NHS Staff Survey results show that, in comparison to 2020, the trust has improved or maintained across the vast majority of questions, while overall national average scores have declined.

On the core questions, the trust's 2021 NHS Staff Survey results are:

- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (increase to 75.7 per cent and now above the 66.9 per cent national average).
- Care of patients / service users is my organisation's top priority (increase to 76 per cent and now above the 75.5 per cent national average).
- I would recommend my organisation as a place to work (increase to 59.5 per cent and now above national 58.4 per cent average).

Mr Jennings commented that it was really positive to read and referred to two specific indicators - Learning and Flexible Working which are slightly below national benchmark. Mrs Metcalf advised that the Trust is planning feedback and workshops on the themes of the staff survey over the next 12 months and will pick up these along with the verbatim comments through that engagement.

Mr Redpath commented on the positive report and asked regarding any information on what the Trusts who score over 80% compliance do differently. Mrs Metcalf advised that most organisations do a sample survey which involves much fewer staff.

Mr Redpath commented that we might be getting more responses that those who do a sample from a total number of responses. Mrs Metcalf agreed and confirmed that we have a higher response rate in terms of numbers.

The Chairman commented that lots of organisations have seen a reduction and we have seen an improvement in such a context.

Ms Burns commented that part of the proof of this is seeing improvement in the areas from 2019 we can see the areas which have been tackled – the cultural aspects – teams need to be congratulated on this.

RESOLUTION

The Board of Directors NOTED the update

BoD/22/018 **ANNUAL FILINGS**

Mrs White shared with members an update on the requirement to produce a number of key documents as part of its annual filings following the end of the financial year. These include the Annual Report, Annual Accounts, Annual Governance Statement and Quality Report (Account).

Guidance has been received on production of the key documents and a small project group has been established to oversee this work on behalf of the Trust Board of Directors.

At this stage there are no issues or risks highlighted with the production of the annual filings.

In order to meet the drafting and final publication timetable the Board of Directors are requested to delegate approval to the Quality Assurance Committee and Audit & Risk Committee for ongoing monitoring and approval.

RESOLUTION

The Board of Directors AGREED to delegate to the Quality Assurance Committee and Audit & Risk Committee approval of the Quality Report and Annual Report, Accounts and Annual Governance Statement

BoD/22/019 **COMMITTEE REPORTS**

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

QAC – Ms Reape updated that the Committee had signed off the quality priorities and noted an improved position with the SI outstanding actions

People – Ms Burns updated that the Committee reviewed its risk appetite statement, and considered the staff survey report

Resources – Discussed the planned refresh of digital strategy

JPB – agreed two facilitated sessions in May to discuss future progress and plans

Charitable Funds Committee – important part of the life of the hospital and staff and patients – pleased to say we are in a reasonable good financial position but need to use all funds across the Charity. Supporting the Hearts and Minds Campaign.

BoD/22/020 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Board of Directors will take place on 3 May 2022.

Signed: ……

Date: ……

Board of Direction Action Log (meeting held in Public)							
Date of Meeting	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
7.9.21	BoD/20/302	BOARD ASSURANCE FRAMEWORK	Risk Appetite to be undertaken and included on the BAF	J White	Mar-22	All Committees in March discussed their risk appetite - verbal update to be given as part of Chairs logs; further discussion in Committees during April - still work to do	Open

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 MAY 2022			
Joint Chairman's update			**AGENDA ITEM: 6, ENC 4**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Professor Derek Bell Joint Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Joint Chairman's update		
Background	The following report provides an update from the Joint Chairman.		
Assessment	The report provides an overview of the health and wider related issues.		
Recommendation	Members of the Trust Board are asked to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

Joint Chairman's Update

1. Introduction

This report provides information to the Board of Directors on key local, regional and national issues.

2. Key Issues and Planned Actions

2.1 North East Chairs Meeting

A meeting of the North East Chairs took place on 7 April, which was a positive well attended meeting. There was a broad discussion and the issue was raised about the importance of recognising and addressing the health and wellbeing requirements for staff following the impact of winter pressures and the ongoing effects of the COVID-19 pandemic.

2.2 Joint Partnership Board

The Joint Partnership Board between this Trust and South Tees Hospitals NHS Foundation Trust continues to meet regularly to progress collaborative and joint working relationships with partners across the Tees Valley for the benefit of the local population. To further develop this work, two facilitated sessions have been scheduled for May and June 2022, which will be attended by the Boards from both trusts

2.3 Non Executive Director recruitment

We have now commenced the process for recruiting an additional Trust Non-Executive Directors (NED) and Associate Non-Executive Directors (ANED). I am pleased to report that GatenbySanderson is support us with this following agreement with the Nominations Committee who met in February to agree the recruitment process to be undertaken and the skills to be sought in the new NED.

2.4 Departmental visits

A programme of visits across the Trust continue and during March and April the areas visited included wards and departments at the Friarage and Critical Care at James Cook. It was great to be able to meet staff who were all enthusiastic and proud of the services they are delivering.

3. Recommendation

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

Professor Derek Bell Joint Chair

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 May 2022			
Chief Executive update			**AGENDA ITEM: 7** **ENC 5**
Report Author and Job Title:	Mark Graham, Director of Communications	**Responsible Director:**	Chief Executive
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Chief Executive update		
Background	The following report provides an update from the Chief Executive.		
Assessment	The report provides an overview of the health and wider related issues.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

Chief Executive Update

COVID-19 update

The rise in COVID-19 community infection rates during April saw an increase in in the number of patients requiring care with the virus.

Around two fifths of COVID-19 patients are receiving care in hospital because the virus has made them poorly enough to need treatment.

However, the remaining three fifths of patients with the virus still need to be isolated and cared for by our clinicians wearing protective equipment, to avoid spreading the virus to other vulnerable patients.

As a result, during April our clinical colleagues were caring for patients with the virus on three wards at the James Cook Hospital.

Despite the rise in the number of patients with COVID-19, over the five weeks to 14 April, our surgical teams delivered almost 3,400 operations, of which more than 2,500 were planned procedures.

At the same time, more than 70,000 outpatient appointments took place and more than 17,700 people attended our urgent and emergency care services - an increase of almost 5,000 on the same period last year.

Separately, our experienced clinicians been very careful around our patient visiting arrangements since the beginning of the pandemic in order to help protect our patients and service users.

Due the success of the vaccination programme our experienced clinicians have eased restrictions and up to two people are now able to visit a non-COVID patient at the same time for up to one hour a day on an appointment basis which can be booked directly through the relevant hospital ward.

Although this is another step in the right direction, our clinicians are asking people to help keep their loved ones and other visitors safe by not visiting if they have COVID-19 symptoms, have tested positive for COVID-19, have identified as a close contact or have symptoms of another infectious disease.

When am I going home?

The trust is supporting a national NHS campaign to help patients prepare for leaving hospital as soon as they are medically ready to do so.

The ‘when am I going home?’ campaign encourages patients and their families to ask questions about their care and recovery beyond the hospital setting, either at home or a care location suitable for their needs.

It is focused on patients and their families / carers and is centred around these four questions that patients can ask so they understand everything they need to know about their care and recovery plan:

- What is wrong with me?
- What is going to happen next?
- What can I do to help myself get better?
- When am I likely to go home?

Asking questions helps us all, staff, patients and family alike and answering those questions is crucial for a smooth transition and getting the right level of care in place away from hospitals, so we can reduce the number of prolonged stays.

Environmentally friendly wound care initiative

During April the trust launched a new wound care initiative which is good for both patients and the environment.

Eligible patients at The James Cook University Hospital are being given bags to help support them, hospital colleagues and community teams with managing their dressings when they are discharged home.

The trial, funded by Our Hospitals Charity, makes it easier for patients and teams to keep their dressings and wound care together in one place while promoting continuity of care and communication between the patient, ward staff and the community teams or care homes staff.

The bags are made of potato starch meaning patients are able to put them in their compost bin or in their green waste bin when they have reached the end of their usable life span.

Unlike normal plastic or biodegradable plastic bags, that still allow for micro plastics to leach into the environment, these 100% compostable bags will fully decompose within a few months when exposed to soil.

Menopause friendly employer

The trust is now officially a menopause friendly employer.

Being a menopause friendly employer means the trust been recognised by an independent panel as having in place a culture of support for our colleagues, sufficient and reliable training and evidence of ongoing sustainable help for those colleagues who need it.

It also shows the trust has created an environment where menopause can be spoken about easily.

As part of this the trust has introduced awareness training for staff; including sessions for our male colleagues and a Women-o-Pause support group, which is a

safe space for female colleagues to share experiences with expert guest speakers who discuss different subjects each month relating to menopause.

Simulation training

The Trust's trainee nurses are gaining vital practical placement experience through simulation as part of a ground-breaking training pilot.

Rather than using traditional methods of learning, the trust's future nurses are using state-of-the-art immersive simulation suites and virtual reality headsets to gain virtual practical working experience in real life hospital ward environments and scenarios.

The 12-week programme has been partly funded through the Northern Enabling Effective Learning Environments team and Health Education England to provide placements for up to 20 student nurses at a time, delivered over six two-week blocks.

The trust's trainers are using a combination of innovative teaching and assessment methods and strategies to inspire student nurses to apply evidence-based practice to clinical settings.

Through this they are encouraged to problem-solve to develop decision making skills and demonstrate effective leadership.

2. RECOMMENDATIONS

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

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 3 MAY 2022			
Board Assurance Framework			**AGENDA ITEM:**
Report Author and Job Title:	Jackie White Head of Governance & Co Secretary	Responsible Director:	Jackie White Head of Governance & Co Secretary
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	The Board have previously approved the development and composition of the Trust's two-year strategic plan and the improvement and recovery plan which sets out the strategic objectives of the Trust. Following this the Board identified the principal risks to achieving the strategic objectives. The Board of Directors tasked the Board sub committees to undertake the scrutiny and assurance of the principal risk, controls and gaps.		
Background	The Board Assurance Framework is a strategic but comprehensive method for the effective and focused management of the principal risks to meeting an organisation's objectives. A structure for the evidence to support the Annual Governance Statement. A method of aggregated board reporting and the prioritisation of action plans which, in turn, allows for more effective performance management. A document to help inform decision making and prioritisation of work relating to the delivery of strategic objectives.		
Assessment	The Board Sub Committees – People, Quality and Resources continue to review their BAF each meeting. Through the Chair's logs the Board can be assured that the Committees have tested the controls in place; received assurances (some positive and some negative); reviewed the gaps in controls or assurance and received assurances to mitigate some of these gaps. A number of assurance reports are being received today at Board. The Finance report and IPR discuss the financial position for month 12 drawing on the work of the Collaboratives and Improvement Councils established to support the CIP for the Trust. COVID19 continues to have an impact on areas across the Trust including performance and experience of patients as identified in the IPR and staffing as identified in the IPR and safer staffing report.		

	Staffing continues to be highlighted in a number of assurance reports including the IPR and safer staffing report due to the ongoing nature of the COVID-19 pandemic, sickness absences remained high, reflected in HR KPI's. Medicine and Emergency care services are highlighted in a number of reports including the IPR around the 4-hour standard and A&E patient experience. In addition the patient experience report highlights that Medicine and Emergency Care Services received the highest number of complaints in the last quarter. Each of the Committees have reviewed their Risk Appetite during March and April.	
Recommendation	Members of the Board of Directors are asked to note the update on the BAF.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The risk implications associated with this report are included in the report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒	

Board Assurance Framework (BAF)

1. PURPOSE OF REPORT

The purpose of the report is to provide an update on the work of the Board sub Committees on providing assurance to the Board on the principal risks to achieving the strategic objectives.

2. BACKGROUND

The role of the BAF is to provide evidence and structure to support effective management of Risk within the organisation. The BAF provides evidence to support the Annual Governance Statement.

The BAF provides this totality of assurance and identifies which of the strategic objectives are at risk of not being delivered. At the same time, it provides positive assurance where risks are being managed effectively and objectives are being delivered. This allows the Board to determine where to make most efficient use of their resources or otherwise take mitigation action and address the issues identified in order to deliver the Trust's strategic objectives.

The process for gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. In order to do this the Board tasks its Board Sub Committee with undertaking scrutiny and assurance of the following:

- Controls in place
- Assurances in place and whether they give positive or negative assurance
- Gaps in controls or assurance
- Actions to close gaps and mitigate risk
- Ensuring effective systems are in place to identify, monitor and mitigate risks and providing assurance to Board.

3. DETAILS

The BAF continues to have ***7 principal risks*** associated with delivery of the 5 strategic objectives. These 7 principal risks are made up of ***35 threats.***

The risk rating for the 7 principal risks is made up of ***6 extremely high*** and ***1 high risk*** rating. There has been no change to the risk ratings since the last report.

All Committees continue to have time on their agenda to horizon scan for new threats or risks.

A number of assurance reports are being received today at Board.

Assurance levels for each of the threats and principal risks have now been agreed by Committees following the initial agreement with Lead Executives and Chairs.

3.1 **Assurance reports Trust Board of Directors**

A number of assurance reports are being received today at Board and include:

Principal risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes

- CQC update
- Integrated Performance Report

Principal risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain

- Safe Staffing Report
- Integrated Performance Report
- CQC update

Principal risk 4 - Failure to deliver as a centre of excellence, resulting in a lack of priority and recognition from commissioners and other stakeholders

- Integrated Performance Report

Principal risk 7 - Failure to deliver the Trust's financial recovery plan

- Finance Report
- Integrated Performance Report

3.2 Additional assurances to highlight

Quality Assurance Committee

Cancer breaches – this report gave moderate assurance to the Committee on the current position regarding Trust compliance with the 62 day CWT target and to activities in place to support compliance with the standard throughout 2022/23.

Lost to follow up – this report provided moderate assurance on the summarised the on the progress against the actions with the governance framework put in place to monitor the compliance and sustainability of the agreed actions.

STACQ – this report provided moderate assurance on the South Tees Accreditation of Quality Care (STAQC) programme which commenced in September 2020 along with an update on progress to date and outlines the recovery and ongoing plan.

3.3 **Assurance levels**

During **April 2022** assurance levels were reported for each report being submitted to a Board Committee (note the Resources Committee have not met in April 2022). The breakdown is as follows:

None	Limited	Moderate	Significant
	2	10	

The balance between internal and external assurances was as follows:

Internal	External
12	0

4. RECOMMENDATIONS

Members of the Board of Directors are asked to note the report.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 MAY 2022			
Integrated Performance Report			**AGENDA ITEM: 9, ENC 7**
Report Author and Job Title:	Emma Moss Management Information Lead Business Intelligence Unit	**Responsible Director:**	Various
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	To provide the Board with a detailed assessment of performance against the agreed indicators and measures. The report describes the specific actions that are under way to deliver the required standards.		
Background	The Integrated Performance Report (IPR) is produced monthly to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance. The IPR demonstrates areas of performance are monitored and provides assurance to the Board regarding actual performance and, where necessary, remedial actions. Key elements of the report are discussed at the Trust Quality Assurance Committee, Resources Committee and People Committee. A summary of discussions are included in Chair Reports to the Board of Directors.		
Assessment	There are no changes to metrics for March 2022 IPR. Review of metrics for IPR for 2022/23 is being finalised, including identifying the appropriate targets or standards, where applicable. **Our key messages for March are:** • Trust performance in **February to March 2022** reflected changing levels of COVID-19 infections in our communities. This placed significant additional demands on primary, emergency and acute care and social care, with COVID-19 related staff absences adding considerable pressures to service delivery across the system. In April, there has again been a significant increase in the number of people testing positive for COVID-19. • **Sickness absences** remained high in some staff groups despite an overall improvement. Changes to national guidance on COVID-19 isolation guidance were adopted to safely minimise the impact of staff isolation on absence levels. **Mandatory training** and **appraisal rates** continued to improve but did not meet target duer to the impact of the		

	pandemic; continued improvement is expected to meet targets Quarter 1 22/23. • **Rate of falls** and **falls with harm** remains low. **Pressure ulcers rates** are within normal variation and targeted and systematic support is in place. There has been 1 Never Event reported in month. • The increase in **C. difficile** cases at the Trust compared to last year is reflective of the national and regional picture. A structured review process has been implemented to identify any themes and learning, and scrutinise attributable cases, and an improvement group is established. Established IPC precautions for C. difficile have remained in place throughout the pandemic. • Emergency care access as reported by the **4-hour standard** and **ambulance handover** continued to be challenging due to the higher volumes of attendance seen across the system and continued pressures caused by COVID-19, and this is reflected in **A&E patient experience**. 4-hour standard performance was in the top 50% of Trusts nationally (February position). • **Maternity services patient experience** has improved in March, with 100% overall satisfaction this month, **outpatient and inpatient experience** also remains very positive. • **Outpatient activity** and **elective inpatient activity** exceeded our plan and the reduction in numbers of patients waiting the longest was sustained. Referral-to-treatment and diagnostic waits are expected to improve as agreed activity plans are implemented in 2022/23. Cancer access standards were not met, but 62-day standard is within upper 50% of Trusts, and the number of long waiters reduced. • The **financial position** remains on plan.
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐
Recommendation	Members of the Public Trust Board of Directors are asked to receive the Integrated Performance Report for January 2022.
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	All principal risks
Legal and Equality and Diversity implications	There are no legal or equality and diversity implications associated with this paper.

Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒	

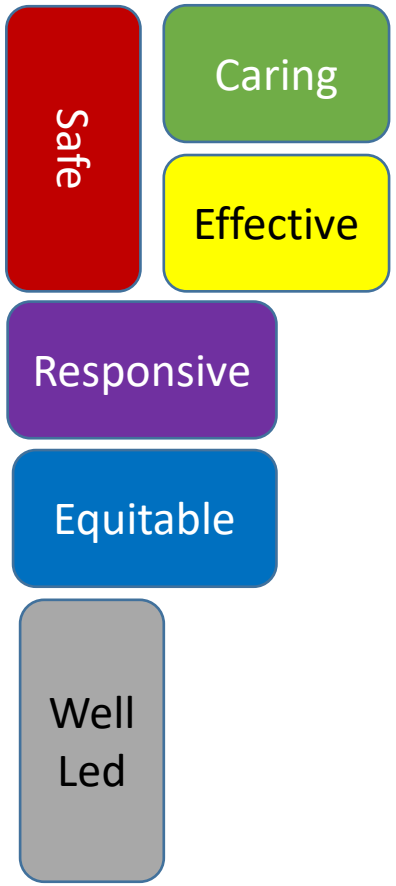
South Tees Hospitals
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT

March 2022

OVERSIGHT

RESPONSIBLE DIRECTORS	BOARD SUB COMMITTEE
Dr Hilary Lloyd, Chief Nursing Officer	Quality Assurance Committee
Dr Michael Stewart, Chief Medical Officer	Quality Assurance Committee
Samuel Peate, Chief Operating Officer	Resources Committee
Robert Harrison, Managing Director	Resources Committee
Chris Hand, Finance Director	Resources Committee
Rachael Metcalf, Human Resources Director	People Committee



Audit and Risk Committee

INTRODUCTION

OVERSIGHT

The Integrated Performance Report has been reviewed by the Senior Leadership Team to ensure that it clearly represents the Trust's performance against key indicators of Single Oversight Framework, Compliance, Quality, People and Resources. The IPR domains are owned by the responsible Director and accountable to the relevant Committee of the Board. In addition, significant risks are reviewed by Audit and Risk Committee.

The IPR is reviewed and signed off by the Senior Leadership Team prior to publication, to ensure connectivity and triangulation between the domains.

Performance metrics follow through from ward or specialty, to Directorate, Collaborative and Trust level. They are owned, reviewed and challenged at relevant meetings which may include Directorate meetings, Collaborative Boards and their Groups in operational services; and the Trust-wide Groups that report into the Committees of the Board providing corporate assurance through the Trust governance structure.

INTRODUCTION

ASSURANCE

The IPR is a key element of the Board Assurance Framework, as it evidences our performance and management of risks to safety, quality, patient access and experience, and resource utilisation.

The IPR includes a summary of metrics monitored by NHSE&I in the NHS Single Oversight Framework matrix; this informs the System Oversight Framework which reflects and reinforces system-led delivery of care. The Framework seeks to identify NHS providers' potential support needs from NHSI across five themes: quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability. NHSE&I use the outcome from the themes to 'segment' individual trusts according to the level of support each trust requires. It then signposts, offers or mandates tailored support as appropriate.

Metrics are mapped to the five CQC domains of Safe Effective Caring, Responsive and Well Led. Together these demonstrate the Trust achieves its Licence to Operate. A sixth domain, Equitable, reflects the NHS focus on reducing inequalities in access and outcomes, as set out in the Operational Priorities and Planning Guidance for 2021/22.

CHANGES NEXT MONTH

Review of metrics for IPR for 2022/23 is being finalised, including identifying the appropriate targets or standards, where applicable.

NATIONAL CONTEXT

The policy context for the second half of financial year 2021/22 as set out in the *Operational Planning Guidance* continues to focus on

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention.
B. Delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19.
C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (EDs), improve timely admission to hospital for ED patients and reduce length of stay.
F. Working collaboratively across systems to deliver on these priorities

Planning guidance for 2022/23 reiterates and expands upon these priorities, going further with outpatient transformation , and emphasises the system delivery overseen by Integrated Care Boards (from July 2022).

The NHS Chief Medical Officer declared a Level 4 National Incident on 12 December 2021 in response to the threat from Omicron, in recognition of the impact on the NHS of both supporting the vital increase in the vaccination programme and the significant increase in COVID-19 cases. This continues and the Trust operates a Command & Control structure, to manage our clinically-led response to the changing phases of the pandemic.

REGIONAL AND LOCAL CONTEXT

Across the North East and North Cumbria Integrated Care System (NENC ICS) the focus for acute Trusts is on achieving elective recovery, whilst addressing clinical priorities such as cancer and emergency care. The Trust is engaged in the NENC ICS Provider Collaborative to ensure elective access targets are met and is a leader in Tees Valley Managed Clinical Networks to drive quality and sustainability of key services. We also work closely with Yorkshire and North East Ambulance Services, and Local Authorities. The Trust also provides services within Humber Coast and Vale ICS, and is engaged in local partnership working to develop services in North Yorkshire.

In response to the 22/23 planning guidance and national submission timetable, final draft finance, workforce, performance and activity projections for 22/23 have now been submitted. This included our intent to develop virtual wards, urgent community response and reduce lengths of stay, in partnership with local authorities and commissioners in Tees Valley and North Yorkshire.

During March-April 2022, the Trust Improvement Plan has been refreshed to reflect the achievements and progress over the last 12 months and the service improvement and transformational change priorities required for 22/23. Improvement Councils are being embedded to provide a support mechanism and methodology to prioritise and deliver Collaborative Improvement Plans.

The Trust remains focused on CQC fundamental standards, and learning lessons and spreading good practice, in response to a focused CQC visit in February 2022 (in advance of formal feedback).

EXECUTIVE SUMMARY

- Trust performance in **February to March 2022** reflected changing levels of COVID-19 infections in our communities. This placed additional demands on primary, emergency and acute care and social care, with COVID-19 related staff absences adding pressures to service delivery across the system. In April, there has again been a significant increase in the number of patients testing positive for COVID-19.
- **Sickness absences** remained high in some staff groups despite an overall improvement. Changes to national guidance on COVID-19 isolation guidance were adopted to safely minimise the impact of staff isolation on absence levels. **Mandatory training** and **appraisal rates** continued to improve but did not meet target; continued improvement is expected to meet targets Quarter 1 22/23.
- **Rate of falls** and **falls with harm** remains low. **Pressure ulcers rates** are within normal variation and targeted and systematic support is in place. There has been 1 **Never Event** reported in month.
- The increase in **C. difficile** cases at the Trust compared to last year is reflective of the national and regional picture. A structured review process has been implemented to identify any themes and learning, and scrutinise attributable cases, and an improvement group is established. Established IPC precautions for C. difficile have remained in place throughout the pandemic.
- Emergency care access as reported by the **4-hour standard** and **ambulance handover** continued to be challenging due to the higher volumes of attendance seen across the system and continued pressures caused by COVID-19, and this is reflected in **A&E patient experience**. 4-hour standard performance was in the top 50% of Trusts nationally (February position).
- **Maternity services patient experience** has improved in March, with 100% overall satisfaction this month, **outpatient and inpatient experience** also remains very positive.
- **Outpatient activity** and **elective inpatient activity** exceeded our plan and the reduction in numbers of patients waiting the longest was sustained. Referral-to-treatment and diagnostic waits are expected to improve as agreed activity plans are implemented in 2022/23. Cancer access standards were not met, but 62-day standard is within upper 50% of Trusts, and the number of long waiters reduced.
- The **financial position** remains on plan.

SINGLE OVERSIGHT FRAMEWORK

Provider	A&E 4 hour standard Feb-22	RTT - 18 week standard Jan-22	Cancer 62 day - GP referral Jan-22	Cancer 62 day - screening services Jan-22	Diagnostic 6 week waits Jan-22	Single Oversight Framework triggers			12 hour delay from DTA Feb-22	Ambulance handovers 30-60 mins Feb-22	Ambulance handovers 60+ mins Feb-22	52 week waits Jan-22	104 week waits Jan-22	Total Waiting List Jan-22
	95%	92%	85%	90%	=<1%	This month	Last month	This month triggers	Zero			Zero	Zero	
South ICP														
South Tees Hospitals NHS Foundation Trust	70.6%	64.9%	65.9%	58.3%	47.4%	5	5	A&E; RTT; Cancer 62 (GP); Cancer 62 (Screening); Diagnostics	10	170	172	1,350	66	41,267
North East & Yorkshire	74.4%	70.6%	63.5%	69.7%	28.8%									
National	73.3%	62.8%	61.8%	65.4%	30.0%									

The Trust was non-compliant with the mandated Single Oversight Framework metrics and access standards in **January/February**. March month end position not yet published. Across the themes of the SOF (quality of care, finance and use of resources, operational performance, strategic change, leadership and improvement capability) the Trust is placed in **segment 3, mandated support for significant concerns**, under the NHSI Regulatory Approach (Support Regime). The Trust is currently gaining external support on emergency care pathways and cost improvement and transformation.

Performance was generally in line with the regional and national position, reflecting the challenges faced by many Trusts in recovering patient access given the impacts of the Covid pandemic. The Trust had a poorer position for elective referral to treatment standard than the region, although the longest waits are reducing. Note that cancer 62-day screening standard is typically a low-volume pathway (<10 per month) so percentage performance fluctuates. Diagnostic access standard breaches remains above the regional position, however data quality has been impacted in this period, associated with implementation of new imaging information system, being resolved with the supplier. 12-hour breaches from decision to admit reduced in February.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
DATIX Incidents	2329	2070	Mar 2022		
Serious Incidents	11	13	Mar 2022		
Never Events (YTD)	5	0	Mar 2022	N/A	N/A
Falls	168	N/A	Mar 2022		N/A
Falls Rate	5.31	6.6	Mar 2022		
Falls With Harm	4	N/A	Mar 2022		N/A
Falls With Harm Rate	0.13	TBC	Mar 2022		N/A
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	2.94	TBC	Mar 2022		N/A
Category 2 Pressure Ulcers Community Rate (Per 1000 Bed Days)	1.96	TBC	Mar 2022		N/A
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	0.13	TBC	Mar 2022		N/A
Category 3&4 Pressure Ulcers Community Rate (Per 1000 Bed Days)	0.38	TBC	Mar 2022		N/A
Medication Incidents	115	TBC	Mar 2022		N/A
Medications Reconciled Rate %	63%	80%	Mar 2022		
C-Difficile (YTD)	138		Mar 2022	N/A	N/A
MRSA (YTD)	1	0	Mar 2022	N/A	N/A

Incidents

Reporting of incidents remains high since March 2021, setting a new positive norm of around 2100 incident reports per month. This has increased by 12.3% against a target of 10% since April 2021. High levels of reporting are typically a feature of a positive safety culture. There was 1 Never Event reported in March.

The rate of inpatient falls in March is comparable to our running average. There were more falls resulting in patient harm although this remains within normal parameters. Targeted support continues to be provided to areas as needed.

The number of category 4 pressure ulcers remains low across both the acute and community setting. The last Category 4 Pressure Ulcer reported in the community occurred in November 2021 and in the acute setting in January 2022. March month end has seen a further reduction in Category 3 pressure ulcers in both community and acute settings but a slight increase in Category 2s.

The PURPOSE T tool is currently being piloted on wards 28, 31, 37 and CDU with the intent to roll out further upon digitalising onto Patientrack. The PUSH tool has now been incorporated into DATIX to allow prompt assessment and intervention to avoid any gaps in care.

Medication incidents remain within normal variation. Medications reconciliation has been impacted by staffing. A business case for seven-day working, which is required to meet the 80% standard, is in preparation.

Healthcare acquired infections

There were no new MRSA reported this month. C. difficile cases reported remain higher than last year with the year total 61% above trajectory. IPC precautions for isolating patients with C. difficile have been maintained. Although the increase is reflective against some of the national and regional picture an improvement group has been established. The structured review process was implemented in March 2022 and we had successfully appealed 28 cases in the last few months of 2021/22 due to this robust process. A detailed plan has also been implemented. This is also recorded on the Trust risk register to capture the organisational risk and the patient safety risk with clear tracking and reporting with regular updates and reporting.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
Caesarean Section (%)	32.63%		Mar 2022		N/A
Induction of Labour (%)	46.84%	44%	Mar 2022		
Still Births (YTD)	5	17	Mar 2022	N/A	N/A
PPH 1500ml (%)	0.03		Mar 2022		N/A

Maternity services

Caesarean Section and post-partum haemorrhage rates remain in line with the longer-term average.

Induction of labour rates are above the target, although have reduced slightly from last month. This indicator was impacted by changing clinical practice and adhering to NICE guidance through the Covid-19 pandemic where an increase in some indicators reflected the impact of COVID on pregnancy and births. In addition, the Trust is a tertiary centre, taking some of the most complex patients in the region. This is in addition to a greater number of women with a high BMI or from a deprived background, both of which are risk factors to having a Caesarean Section or Induction of Labour.

Still births reflects the complexity of case mix as a tertiary centre, where pregnancies with foetal anomalies are managed, as appose to other local maternity units.

The Maternity Improvement Board continues to oversee quality, safety and performance against the suite of national maternity indicators and Ockenden Review Part 1 essentials.

EFFECTIVE

Metric	Latest Month	Target	Month	Trend	Assurance
Readmission Rate %	5.24%	TBC	Jan 2022		N/A
Sepsis - Oxygen delivered within 1hr	89.3%	95%	Jan 2022		
Sepsis - Blood cultures within 1hr	60.7%	95%	Jan 2022		
Sepsis - Empiric IV antibiotics within 1hr	71.4%	95%	Jan 2022	H	
Sepsis - Serum lactate within 1hr	71.4%	95%	Jan 2022		F
Sepsis - IV fluid resuscitation within 1hr	78.6%	95%	Jan 2022	H	
Sepsis - Urine measurement within 1hr	75%	95%	Jan 2022	H	F
Hospital Standard Mortality Rate	91.77	100	Dec 2021		
Summary Hospital-Level Mortality Indicator	94.61	100	Dec 2021	L	
Comorbidity Coding	4.11	TBC	Dec 2021		N/A
Palliative Care Coding	0.01	TBC	Dec 2021	L	N/A

Readmission rates

There has been variability in emergency readmission rates as the impact of the Covid 19 pandemic varies across time. The rate remains below that seen pre-pandemic and an apparent downward trend continues in January 2022. Contributory factors include community services rapid response, and data quality improvements.

Sepsis

A reduction in compliance has been observed for 5 of the 6 elements. This has been impacted by the data period up to the end of January, when the organisation was experiencing significant operational and staffing challenges related to winter pressures and covid. A time lag of approximately 6 – 8 weeks occurs to receive the patient level data to facilitate audit. Further actions include:

- Acutely Ill Patient (AIP) champion study days have been planned for 2022
- Adult and paediatric sepsis competencies available on staff intranet
- Sepsis study days planned for 2022/23
- Targeted education to ward-based areas – driven by Patientrack
- Audit compliance to sepsis bundle via digital solution
- Progress work with BIU to develop effective ward level reporting strategies to improve performance.

Mortality

SHMI and HSMR are both stable but divergent. For latest official reporting period, Oct 2020 to Sep 2021, SHMI is 'higher than expected' at 117 (3 points better than the previous period), whilst HSMR is 'as expected' at 100 (please note the IPR graphs contain longer periods to show trends). Both metrics are impacted by COVID-19 which has reduced their reliability because of the reduction in the spells (by a fifth in this period), and they are improving as this factor reduces in the data. In addition, the mortality metrics are impacted by the recording of comorbidities which is the lowest in the region and substantially below the national average despite the population we serve. The pattern is currently stable, following the unusual pattern caused by the first wave of the pandemic. Specialist palliative care coding is higher than the national average and stable (apart from the first month of the pandemic). It is not used to adjust SHMI but is used to adjust HSMR.

CARING

Metric	Latest Month	Target	Month	Trend	Assurance
A&E Experience (%)	78.98%	85%	Mar 2022		
Inpatient Experience (%)	96.08%	96%	Mar 2022		
Maternity Experience (%)	100%	97%	Mar 2022		
Outpatient Experience (%)	97.36%	95%	Mar 2022		
New Complaints	32		Mar 2022		N/A
Closed Within Target (%)	70.3%	80%	Mar 2022		

Patient experience

Patient experience in A&E remains below target which is likely to reflect longer wait times within JCUH ED due to the impact of COVID-19. Review work is underway with the support of the NHS Emergency Care Intensive Support Team to improve patient flow in the JCUH ED and into the wider hospital. This includes remodelling of the ambulatory care pathway and developing pathways for the Same Day Emergency Care (SDEC).

The recent changes to visiting guidance allowing the patient's carer or family member to stay with them whilst they are in ED, may improve the patient experience. Staff levels were reduced in all disciplines in ED due COVID 19 related absence.

The return rate for the Maternity survey at the four touch points (ante-natal, birth, post -natal and community) has improved. The trust is waiting for the external company to add the Maternity surveys to the Meridian system by April 2022.

Trends continue to be monitored and action taken locally on review of the surveys. National benchmarking data is published monthly up to February 2022 and the Trust remains above the national average in all surveys.

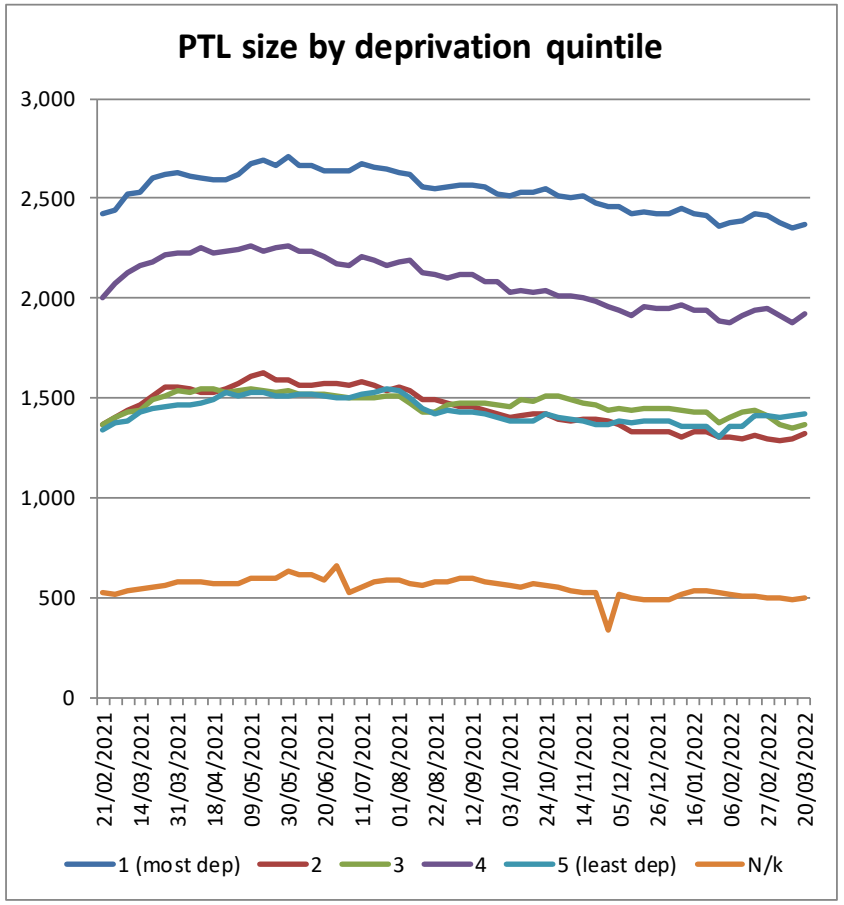
Learning from complaints

The number of formal complaints received has remained stable. Target timeframe for closure has not been met for 4 months, this is due to availability of healthcare records, multiple speciality involvement, the coordination of the records across the specialities and COVID-related staff absence. Monitoring and an escalation plan to achieve the target continues through the Patient Experience Steering Group, and an improved position is noted for March 2022.

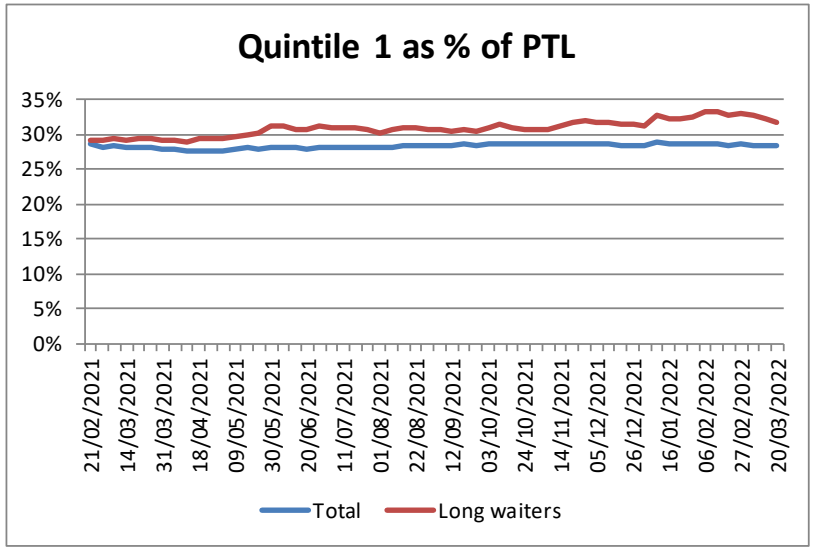
Themes and learning from closed complaints for March 2022, include training relating to communication and clinical practice. Further work will be carried out in this areas to strengthen the narrative.

EQUITABLE

INPATIENT PTL: INEQUALITIES - DEPRIVATION (IMD from postcode of residence)



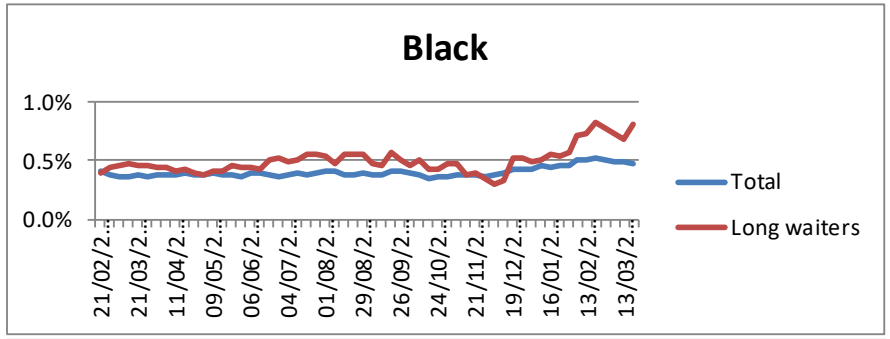
20/03/2022	Total		Long waiters		Ratio
1 (most dep)	2,372	28%	633	32%	1.12
2	1,320	16%	330	17%	1.05
3	1,368	16%	333	17%	1.02
4	1,919	23%	407	20%	0.89
5 (least dep)	1,422	17%	297	15%	0.88
N/k	499		117		

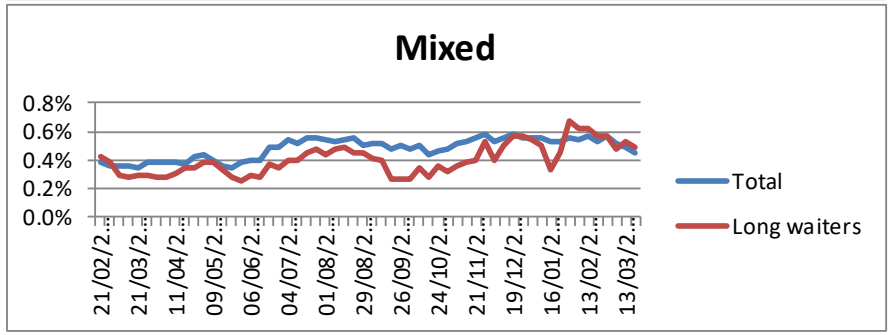


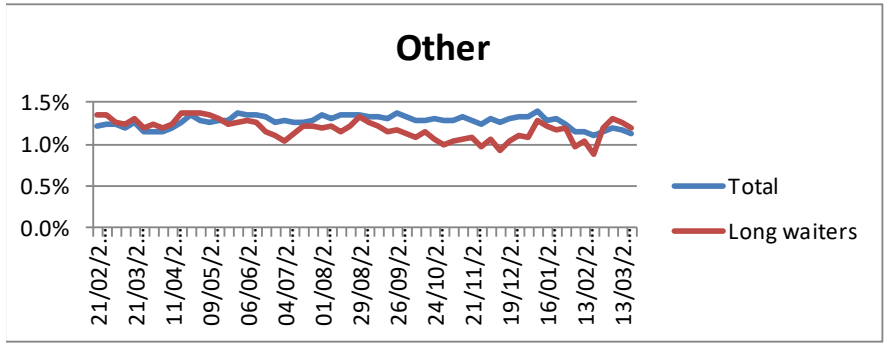
Whilst the inpatient waiting list size has reduced, the separation of the overall position and the long waiter position for the most deprived quintile has been resistant. This is in the context of lower uptake of COVID vaccination, which may lead to cancellation/DNAS of appointments/treatments and multiple indicators of poorer health in more deprived populations which can lead to more complex care pathways. The Trust is working with the Local Authority on a joint Public Health role to inform, lead and guide our response. The Trust Health Inequalities Group convened in March 2022 to identify priorities, next steps and interventions such as targeted 'Waiting Well' and pre-habilitation, with advice and input offered from Public Health colleagues.

IMD – Index of multiple deprivation

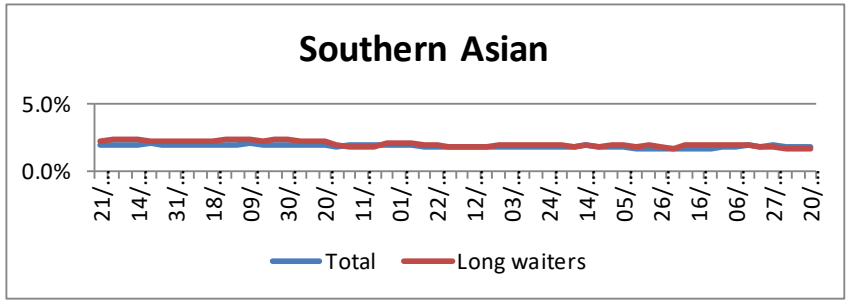
INPATIENT PTL: INEQUALITIES - ETHNICITY

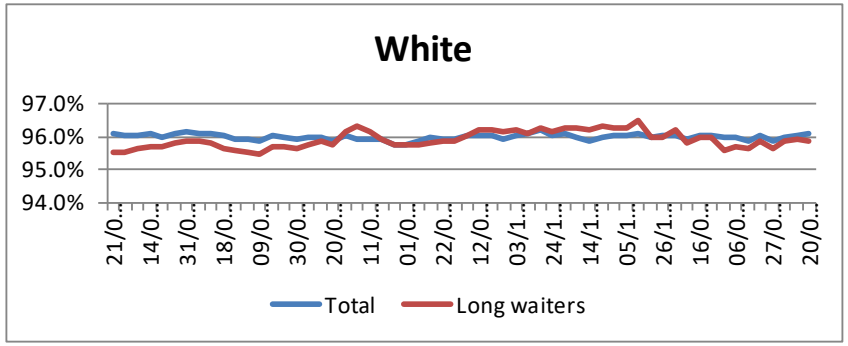






20/03/2022	Total		Long waiters		Ratio
Black	37	0.5%	15	0.8%	1.69
Mixed	35	0.5%	9	0.5%	1.07
Southern Asian	145	1.9%	31	1.7%	0.89
White	7,459	96.1%	1,781	95.9%	1.00
Other	88	1.1%	22	1.2%	1.04
N/k	1,136		259		





We have seen a widening in the proportion of long waiting patients in black ethnic groups, this had started to reduce, but has increased again recently, will be closely monitored and actions taken to bring this back into line with all patient groups on the waiting list through individual patient tracking. Note that small numbers lead to fluctuations in the position. There is also a high proportion of patients for whom ethnicity is not known, this is being addressed through initiatives such as prompting at self-check-in kiosks, for which there is now good evidence of the data quality improvement.

RESPONSIVE

Metric	Latest Month	Target	Month	Trend	Assurance
4 Hour Wait Standard (%)	71.25%	95%	Mar 2022	L	F
Handovers - Over 30 Mins	210	0	Mar 2022	H	F
Handovers - Over 60 Mins	270	0	Mar 2022	H	F
RTT Incomplete Pathways (%)	64.67%	92%	Feb 2022	L	F
RTT 52 week waiters	1256	2451	Feb 2022	N/A	N/A
RTT 104 week waiters	36	19	Feb 2022	N/A	N/A
Diagnostic 6 Weeks Standard (%)	60.16%	99%	Feb 2022		F
Cancer 14 Day Standard (%)	80.8%	93%	Feb 2022		?
Cancer 31 Day Standard (%)	92.65%	96%	Feb 2022		?
Cancer 62 Day Standard (%)	71.01%	85%	Feb 2022		?
Cancer 62 Day Screening (%)	50%	90%	Feb 2022		?
Cancelled Ops - Non-Urgent Cancelled on Day	22	0	Mar 2022		F
Cancelled Ops - Not Rebooked Within 28 days	4	0	Mar 2022		?
Cancer Operations Cancelled On Day (YTD)	7	0	Mar 2022	N/A	N/A

Urgent and emergency care

4-hour standard performance remains below previous average as seen across the region. The impact of COVID-19 on staffing levels in this staff group and patient flow (segregation of pathways) continues to be challenging. Increased levels of urgent and emergency care activity continued throughout March impacting on 4 hour standard and ambulance handover – both areas remain an area of focus in partnership with North East Ambulance Service. Specific actions are being monitored through the Emergency Care Improvement Group and the Trust continues to be supported by ECIST.

Elective waiting times

Elective waiting times overall RTT remained at 65%. This is expected to improve as we move into 22/23 with renewed focus on outpatient and elective activity and completing patient pathways. The diagnostics 6-week wait performance increased to 60% and is expected to increase further following further data validation in the extracts from the new imaging information system. The number of patients waiting more than 52 weeks continues to decrease steadily and is significantly better than plan. Patients waiting 104 weeks returned to trajectory in March, ending the year with one reportable breach, however, this was due to the patient being unable to be treated due to COVID-19. The focus has now shifted to eliminating waits of more than 78 weeks.

Cancer waiting times

14-day standard was below target in February 2022. 31-day and 62-day treatment performance remains within normal variation, and whilst below target it is within the upper 50% of Trusts. The actual number of patients waiting more than 62-days decreased during March and is now in line with plan. Weekly PTL Assurance meeting and Cancer Wall remain in place to support delivery of targets.

Cancelled operations

Zero tolerance of cancer operation cancellations on the day of surgery has been sustained (7 year to date, but zero in month for most recent 7 months), and non-urgent cancellations and re-booking are within normal variation.

RESPONSIVE

Metric	Latest Month	Target	Month	Trend	Assurance
New Attendances	17617	12644	Mar 2022		
Review Attendances	46114	34651	Mar 2022		
Day Case admissions	5337	4440	Mar 2022		
Ordinary Elective admissions	1669	833	Mar 2022		N/A
NEL admissions with 0 LOS	1763	1860	Mar 2022		
NEL admissions with 1+ LOS	3732	3853	Mar 2022		
Length of Stay - Elective	2.17	N/A	Mar 2022		N/A
Length of Stay - Emergency	5.44	N/A	Mar 2022		N/A
Length of Stay - Non-Elective	4.76	N/A	Mar 2022		N/A

Activity

Outpatient New and Review activity continued to exceeded Trust plan in March 2022.

Elective inpatient admissions exceeded plan, with ongoing focus on reducing the longest inpatient waiters. Day case activity also exceeded plan in March 2022.

Non-elective admissions are in line with expected levels, after a winter peak. However, we have also experienced a resurgence of COVID-19 and increased acuity of emergency presentations which impacted on patient flow (as seen in the UEC metrics).

Length of Stay

The reduction in elective length of stay since April 2021 is positive, and has been sustained. Non-elective length of stay is within normal variation, despite the challenges of covid (long lengths of stay for clinical treatment of covid, capacity constraints in social care leading to delays in hospital discharge).

WELL LED

Metric	Latest Month	Target	Month	Trend	Assurance
Cumulative YTD Financial Position (£'millions)	-£23.368m	-£23.368m	Mar 2022	N/A	N/A
Annual Appraisal (%)	76.13%	80%	Mar 2022		
Mandatory Training (%)	88.79%	90%	Mar 2022		
Sickness Absence (%)	4.96%	4%	Mar 2022		
Staff Turnover (%)	14.28%	10%	Mar 2022		

Finance and use of resources

The deficit at Month 12 is in line with the year-end forecast position agreed with the NHSE/I Regional Team, supporting the wider ICP / ICS to deliver overall financial balance at system level.

Assurance is obtained through the budgetary framework, with budget statements provided to managers each month and each Collaborative Board reviewing its financial position. Resources Committee and Trust Board receive a financial report at each meeting.

People

The Trust sickness absence has reduced by 0.03% to 4.96%. Long term absence has reduced by 0.02% to 2.99%. Short term absence has seen a decrease of 0.01% to 1.97%. Covid-19 absence for March was 1.33%, and therefore the total absence was 6.92%. The HR team continue to work with each Collaborative to embed sickness absence improvement plans. The recently implemented stress and anxiety absence process providing early intervention and support is receiving a positive reception from manager and employees and will be analysed for efficacy in the coming months as the impact works through into attendance trends and metrics.

Mandatory training throughout the Trust has had a positive increase of 0.29% to 88.79% and Appraisals have increased by 1.87% and are now 76.13%, this is the highest level for both of these key indicators in the last 2 years. Both KPI's continue to be a focus at monthly HR Clinics and Collaborative Boards.

Turnover has seen an increase of 0.72% to 14.28% across the Trust. The HR team continues to promote the Trust's Retention Strategy. The Strategy provides a range of tools for managers to engage with employees to have conversations tailored to the situation relevant to the individual and develop appropriate plans to encourage retention.

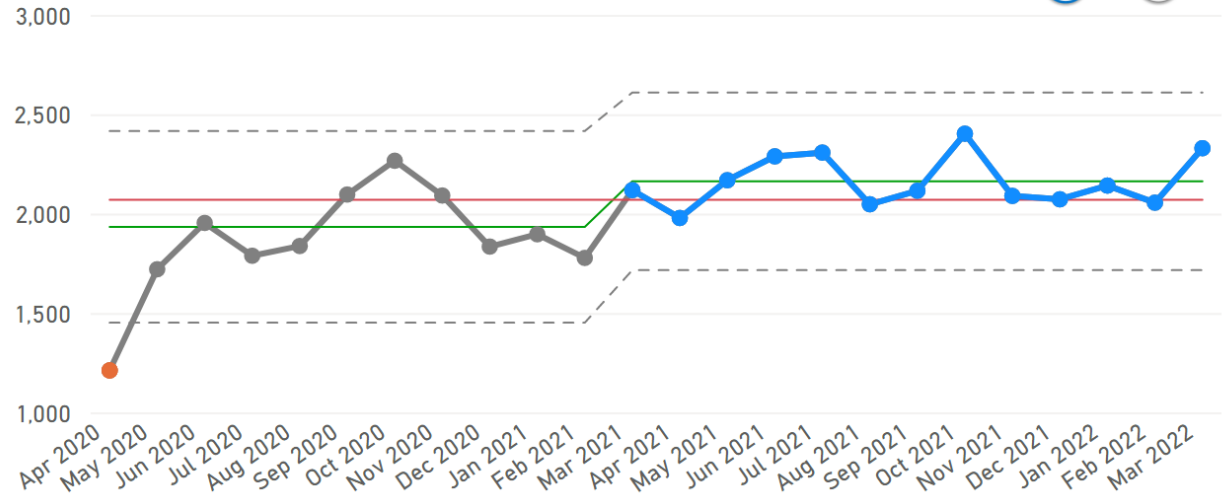
APPENDICES

SPC charts for the metrics summarised above, by domain.

SAFE

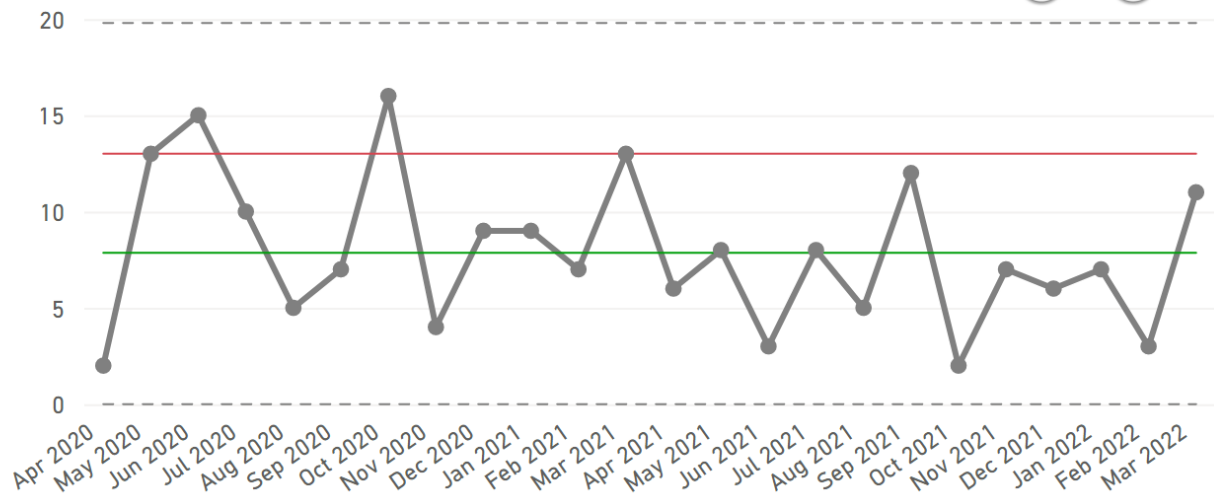
DATIX Incidents

Month	Performance	Target	Trend	Assurance
Mar 2022	2329	2070		



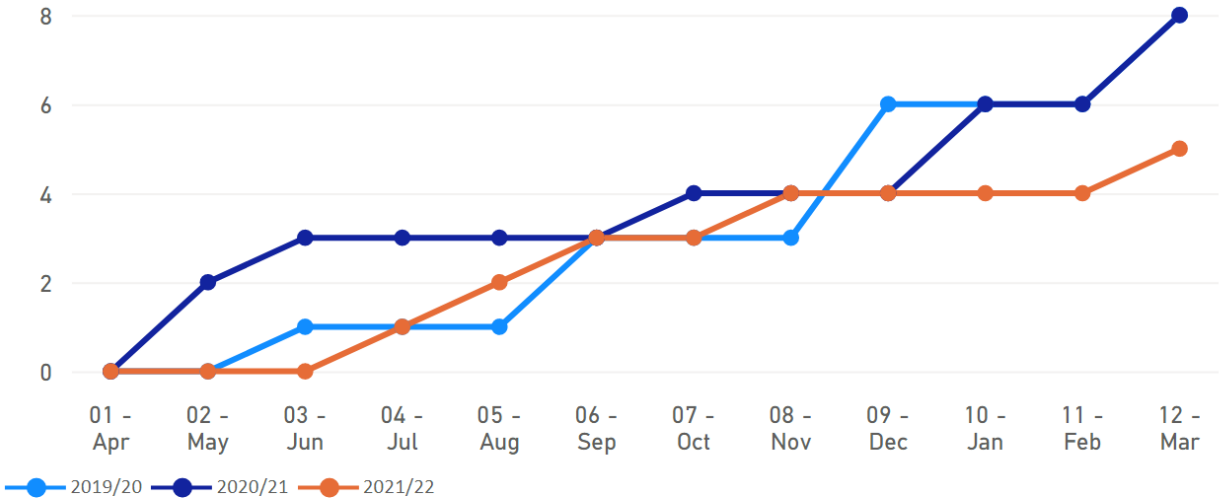
Serious Incidents

Month	Performance	Target	Trend	Assurance
Mar 2022	11	13		



Never Events (YTD)

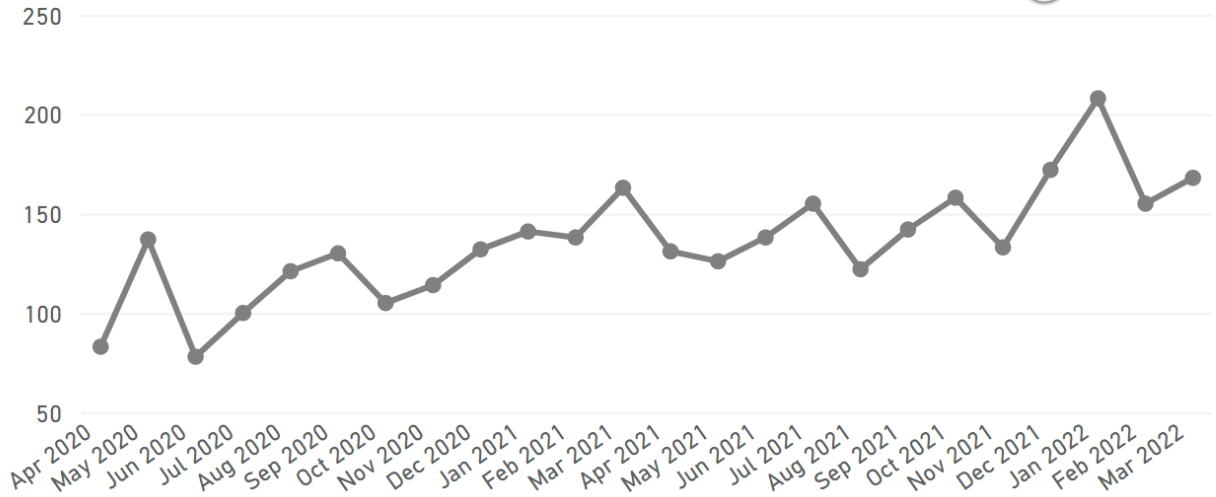
Month	Performance	Target	Trend	Assurance
Mar 2022	5	0	N/A	N/A



SAFE

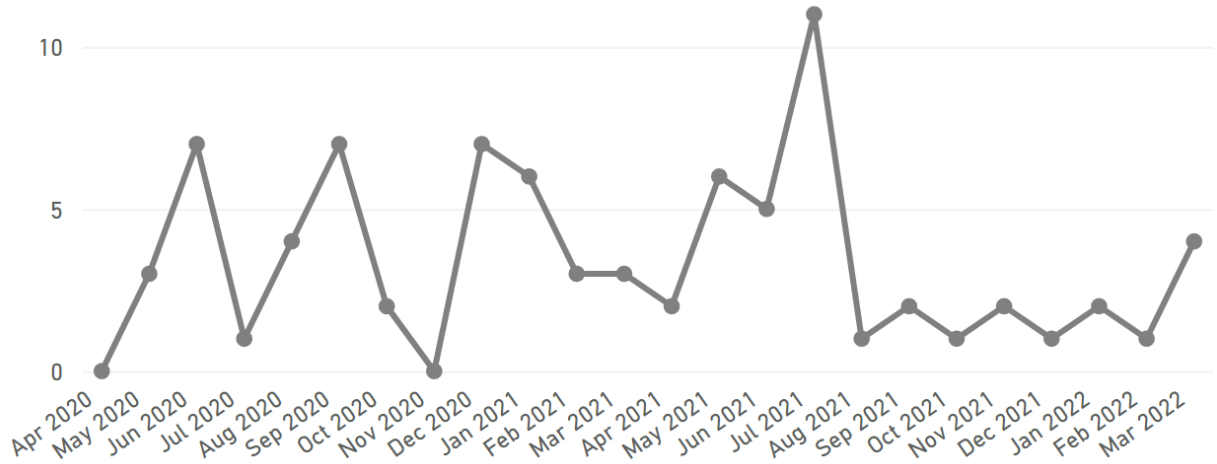
Falls

Month	Performance	Target	Trend	Assurance
Mar 2022	168	N/A		N/A



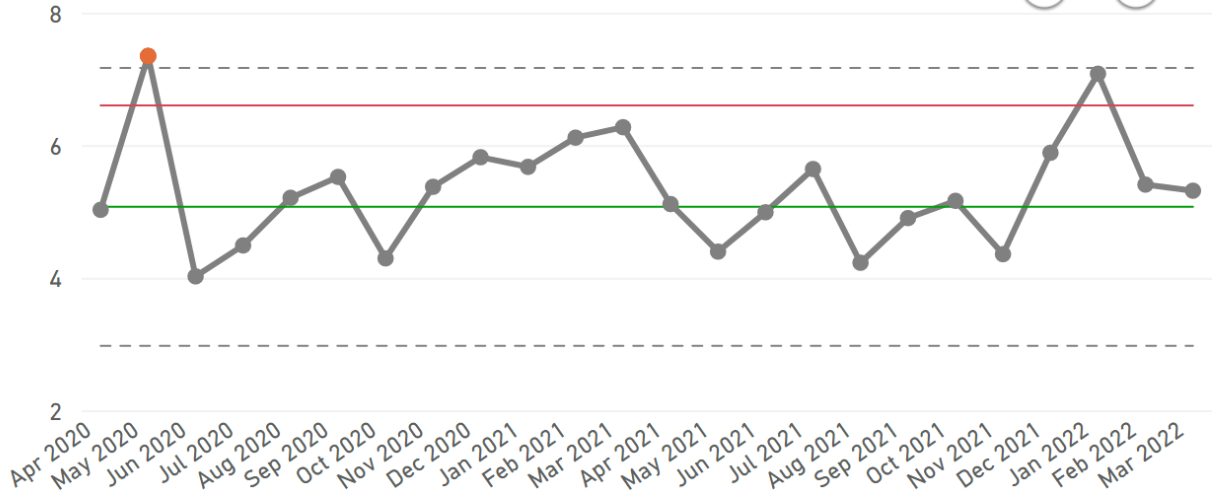
Falls With Harm

Month	Performance	Target	Trend	Assurance
Mar 2022	4	N/A		N/A



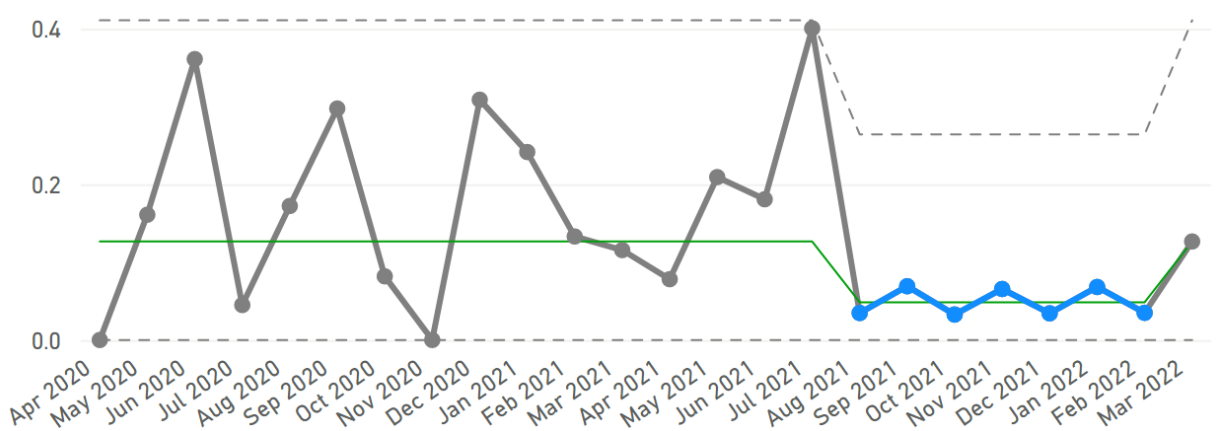
Falls Rate

Month	Performance	Target	Trend	Assurance
Mar 2022	5.31	6.6		



Falls With Harm Rate

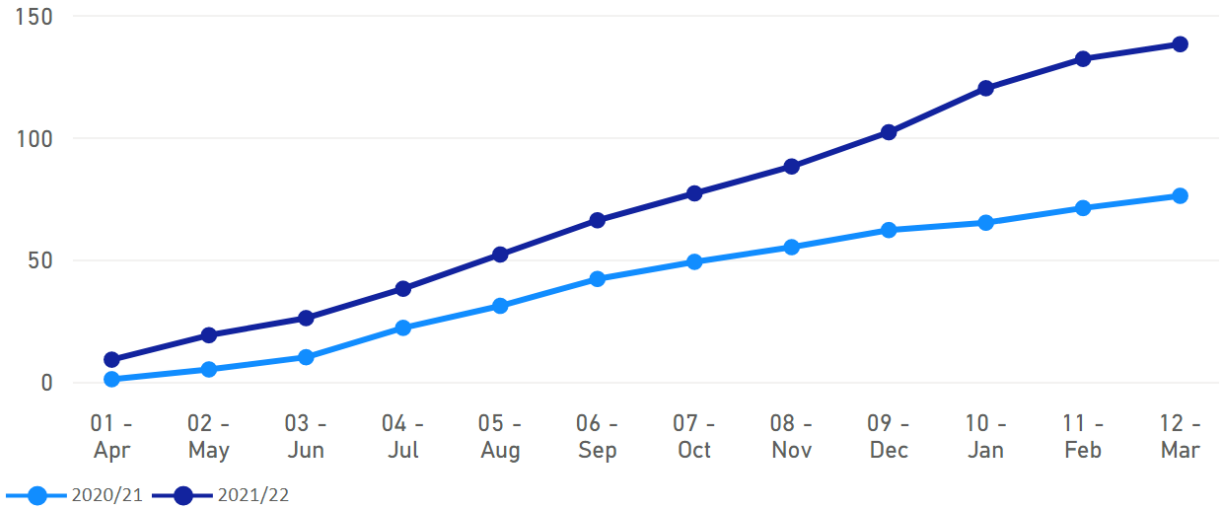
Month	Performance	Target	Trend	Assurance
Mar 2022	0.13	TBC		N/A



SAFE

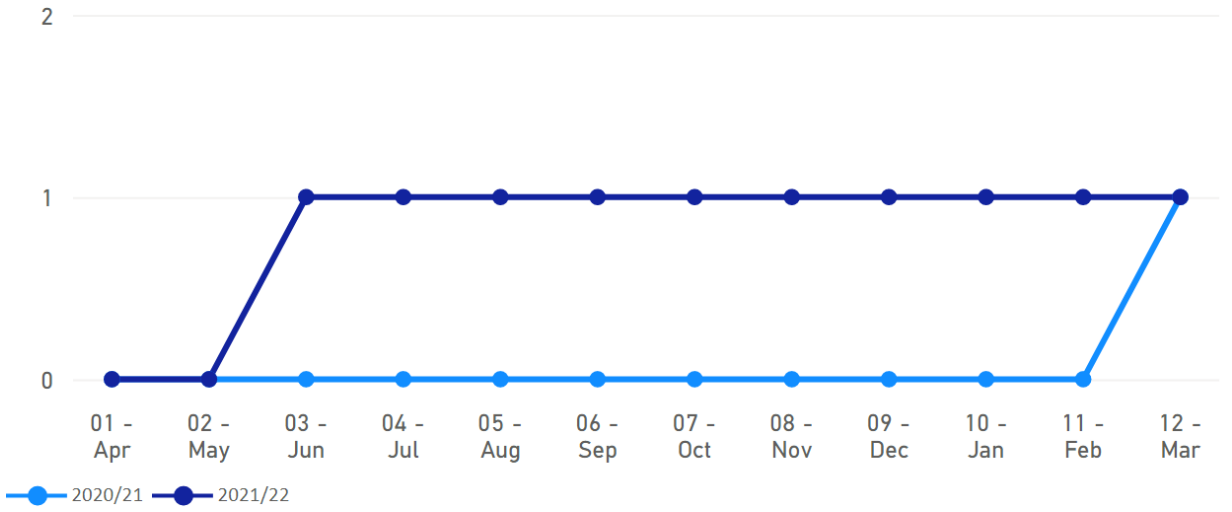
C-Difficile (YTD)

Month	Performance	Target	Trend	Assurance
Mar 2022	138		N/A	N/A



MRSA (YTD)

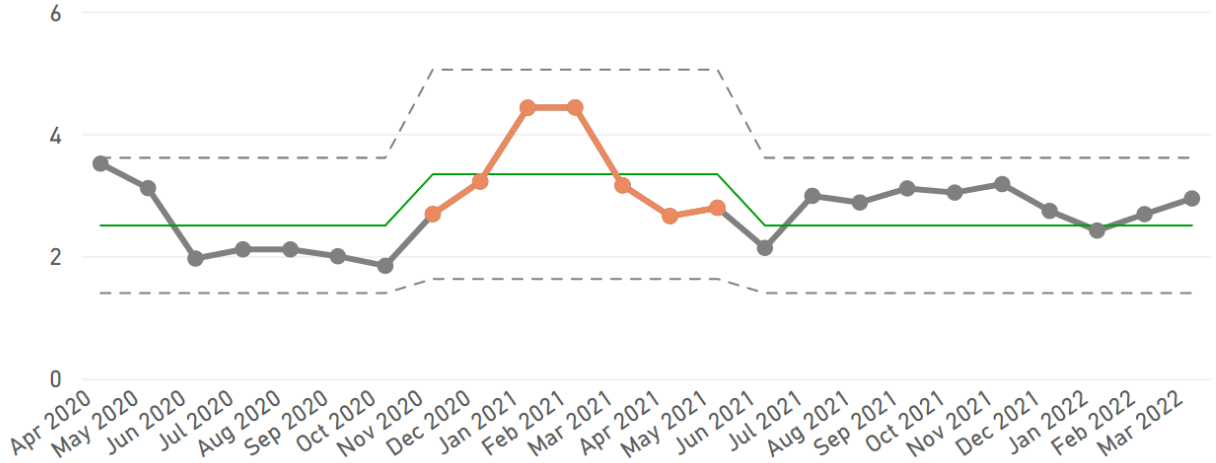
Month	Performance	Target	Trend	Assurance
Mar 2022	1	0	N/A	N/A



SAFE

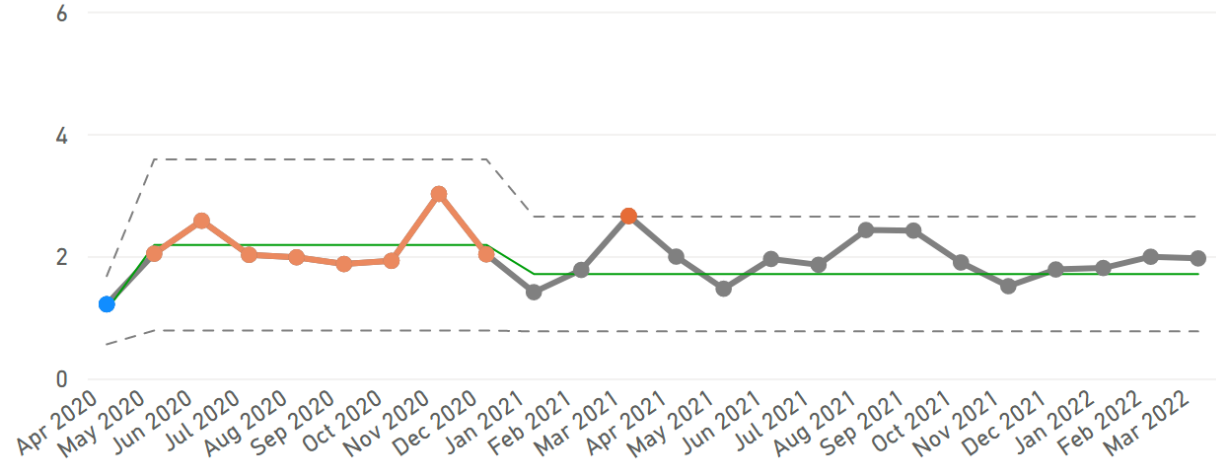
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Mar 2022	2.94	TBC		N/A



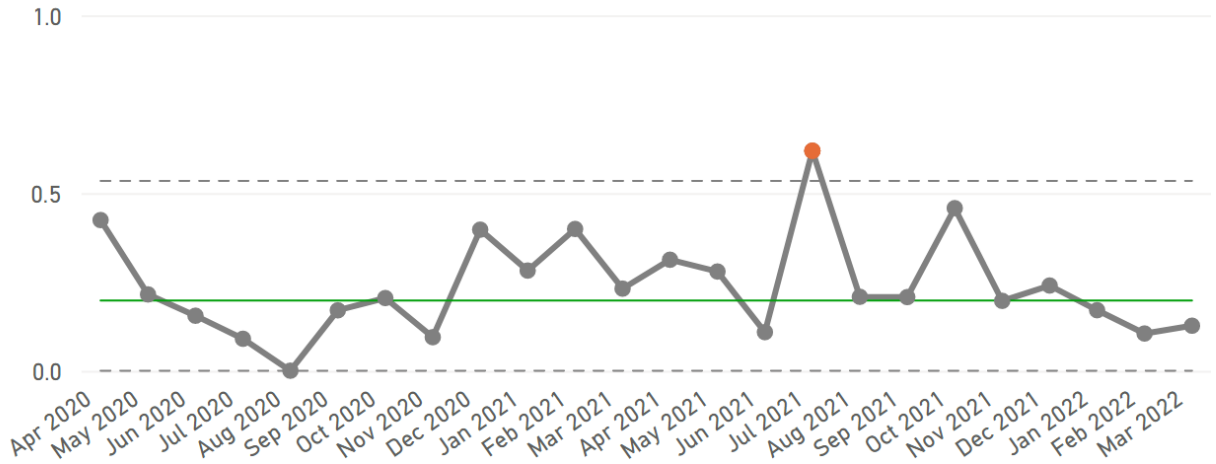
Category 2 Pressure Ulcers Community Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Mar 2022	1.96	TBC		N/A



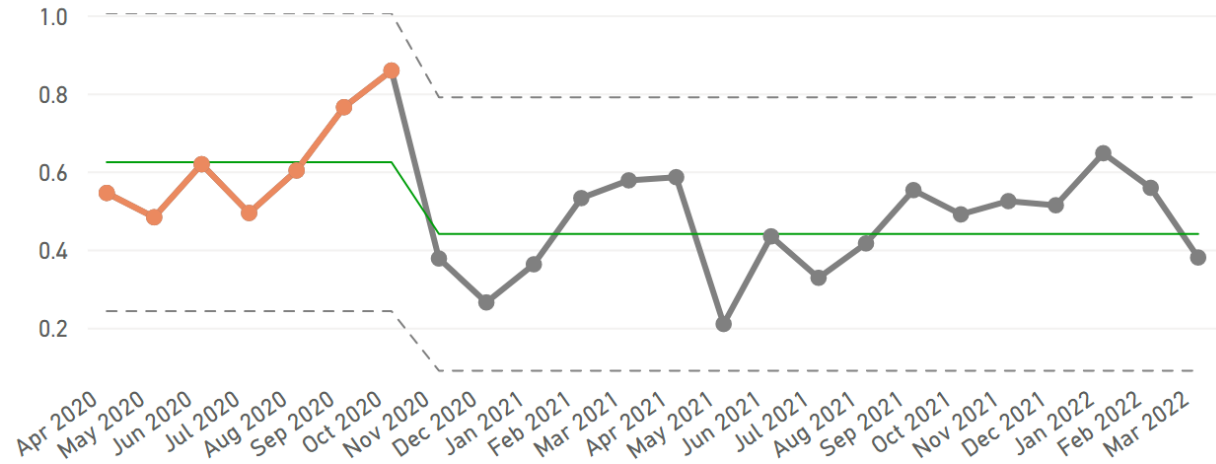
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Mar 2022	0.13	TBC		N/A



Category 3&4 Pressure Ulcers Community Rate (Per 1000 Bed Days)

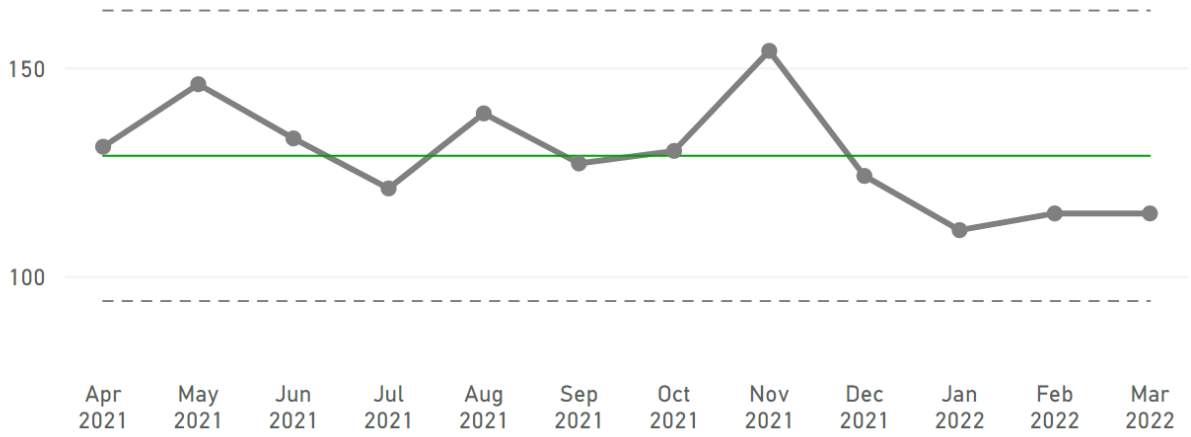
Month	Performance	Target	Trend	Assurance
Mar 2022	0.38	TBC		N/A



SAFE

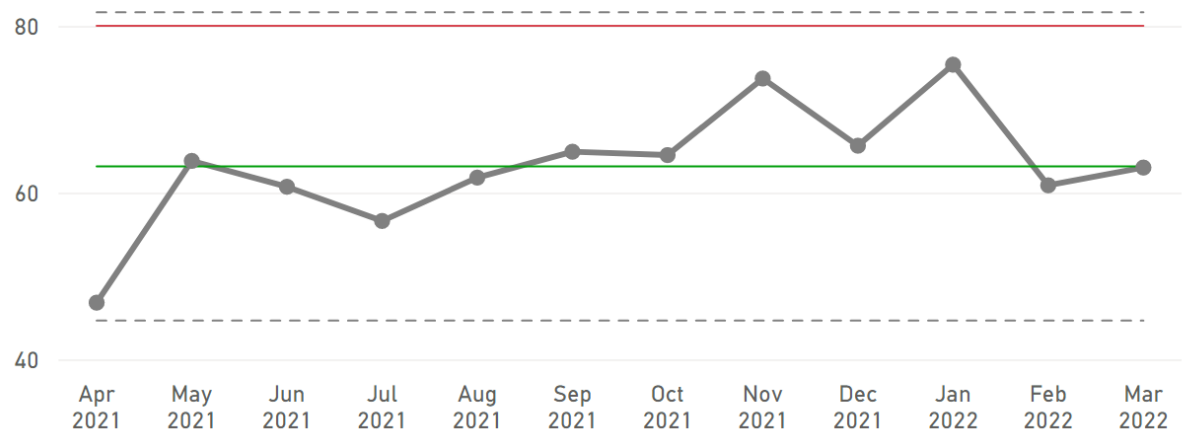
Medication Incidents

Month	Performance	Target	Trend	Assurance
Mar 2022	115	TBC		N/A



Medications Reconciled Rate %

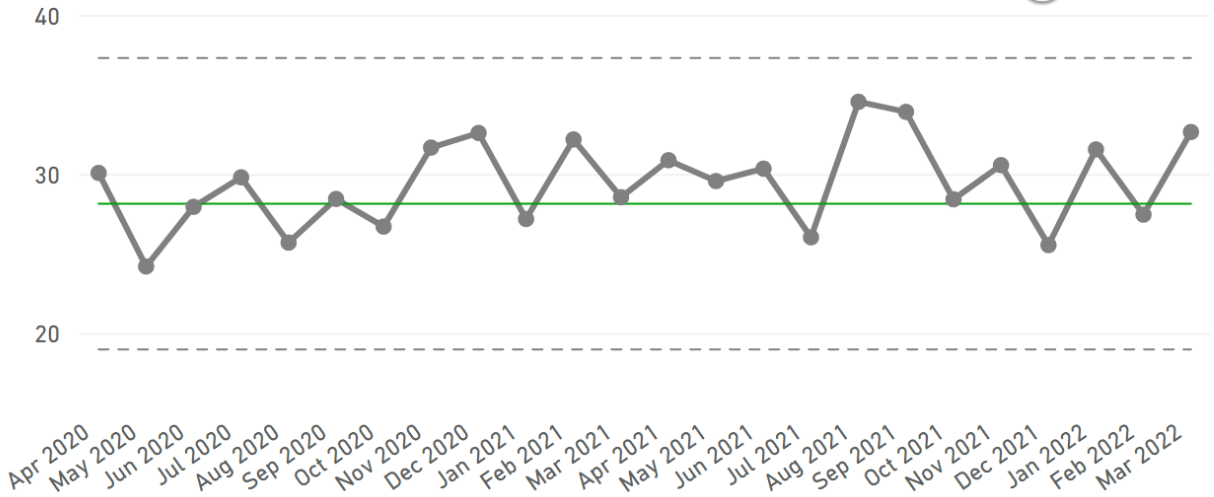
Month	Performance	Target	Trend	Assurance
Mar 2022	63%	80%		



SAFE

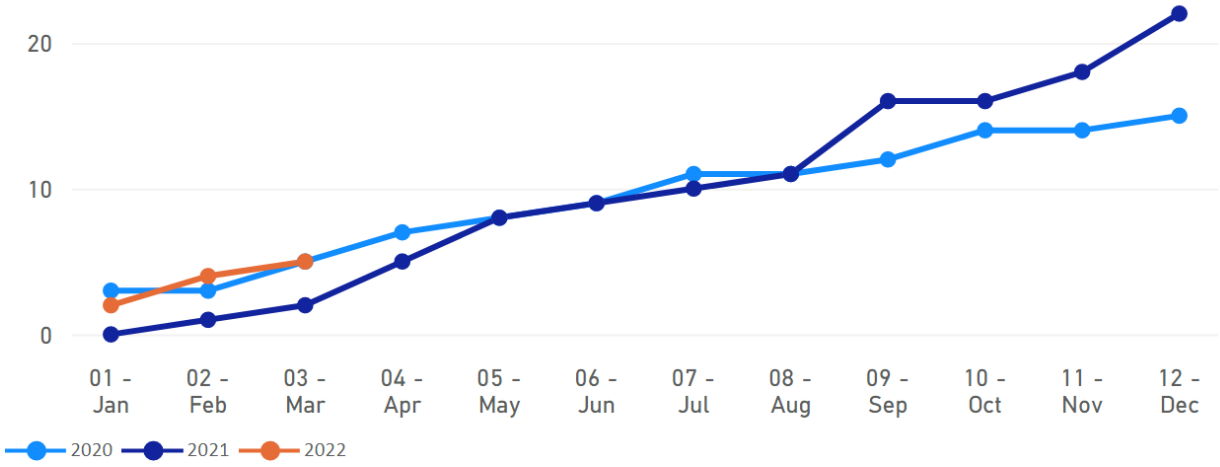
Caesarean Section (%)

Month	Performance	Target	Trend	Assurance
Mar 2022	32.63%			N/A



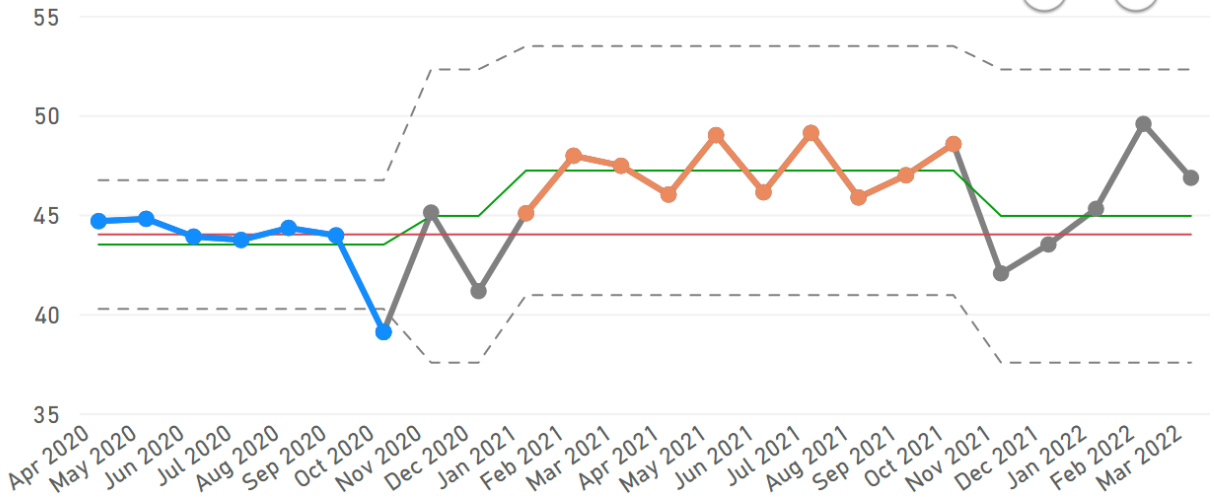
Still Births (YTD)

Month	Performance	Target	Trend	Assurance
Mar 2022	5	17	N/A	N/A



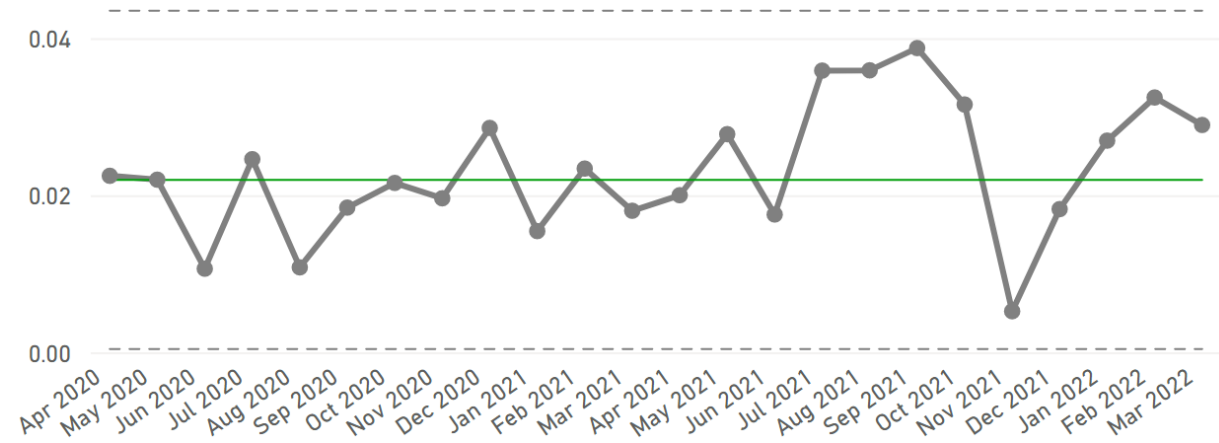
Induction of Labour (%)

Month	Performance	Target	Trend	Assurance
Mar 2022	46.84%	44%		



PPH 1500ml (%)

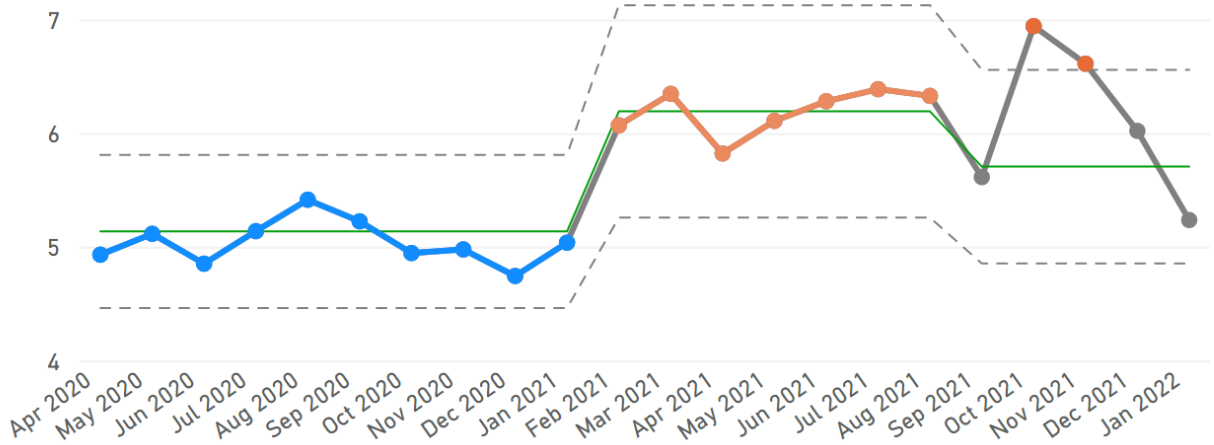
Month	Performance	Target	Trend	Assurance
Mar 2022	0.03			N/A



EFFECTIVE

Readmission Rate %

Month	Performance	Target	Trend	Assurance
Jan 2022	5.24%	TBC		N/A



Readmission logic

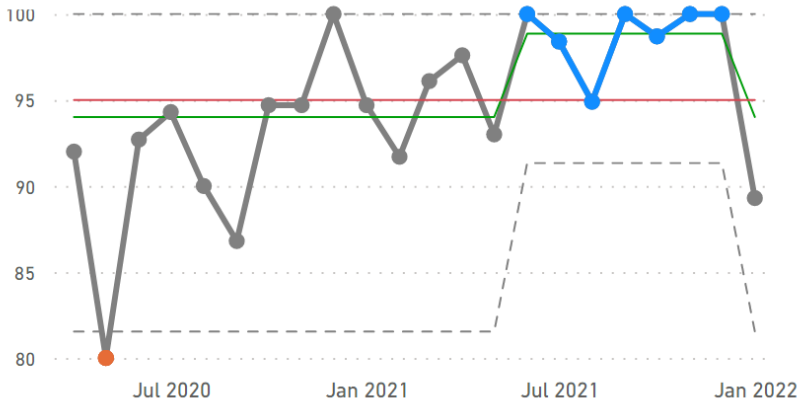
All emergency readmissions within 30 days of discharge, where the admission doesn't meet the national exclusion criteria:

- Unclassified HRG (Readmission)
- Cancer Diagnosis
- Cancer Unbundled HRG
- Child Under 4yrs
- Non-Mandatory HRG
- Obstetric HRG
- Renal Dialysis Patient
- Self Discharge
- Transplant Patient

EFFECTIVE

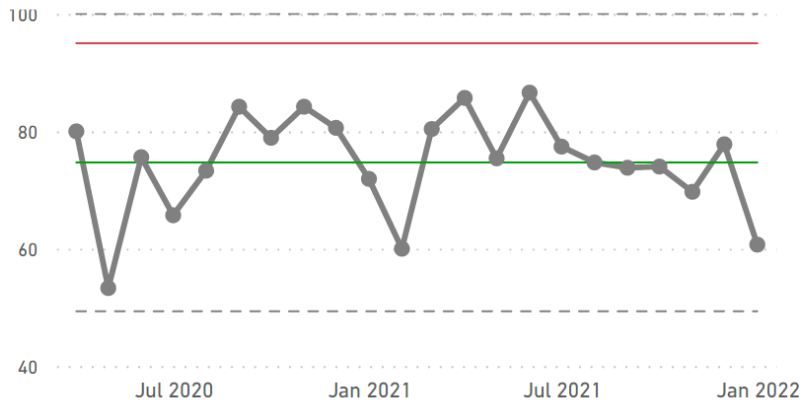
Sepsis - Oxygen within 1hr

Month	Performance	Target	Trend	Assurance
Jan 2022	89.3%	95%		



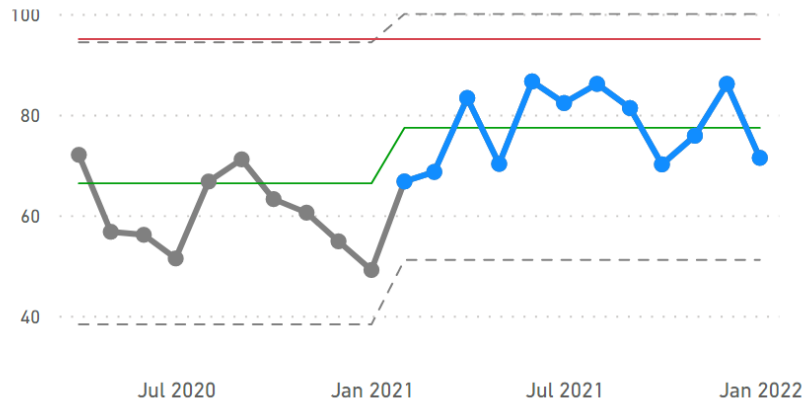
Sepsis - Blood cultures within 1hr

Month	Performance	Target	Trend	Assurance
Jan 2022	60.7%	95%		



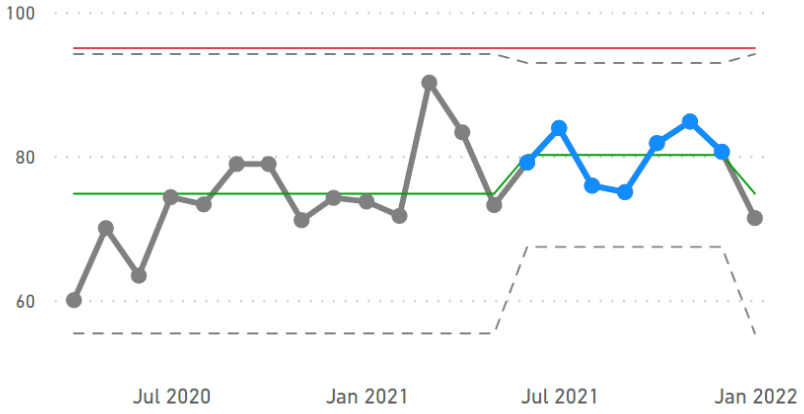
Sepsis - IV antibiotics within 1hr

Month	Performance	Target	Trend	Assurance
Jan 2022	71.4%	95%	H	



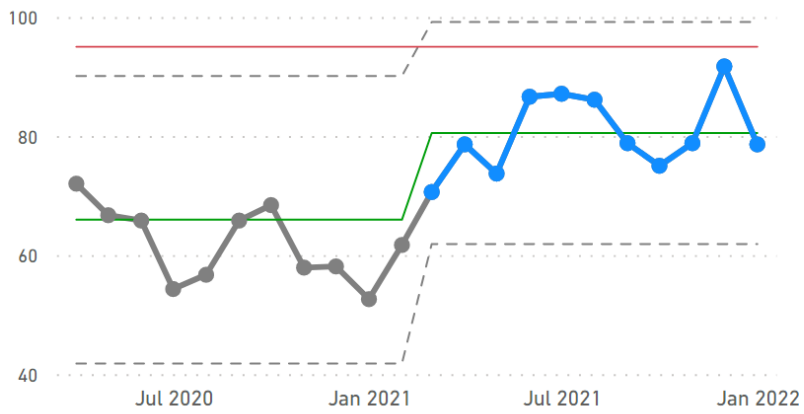
Sepsis - Serum lactate within 1hr

Month	Performance	Target	Trend	Assurance
Jan 2022	71.4%	95%		F



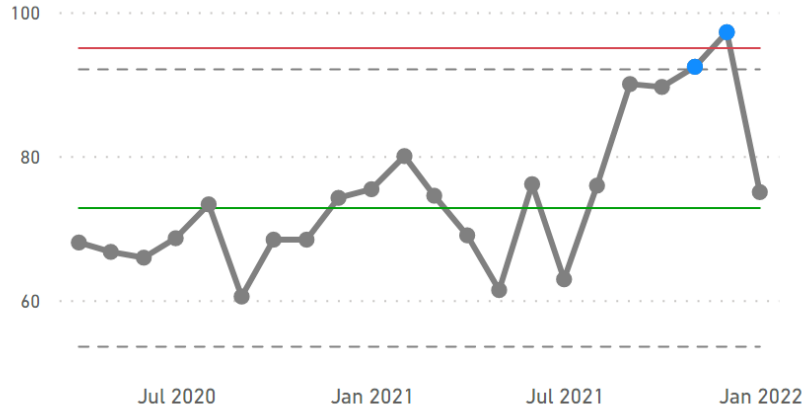
IV fluid resuscitation within 1hr

Month	Performance	Target	Trend	Assurance
Jan 2022	78.6%	95%	H	



Sepsis - Urine measurement within 1hr

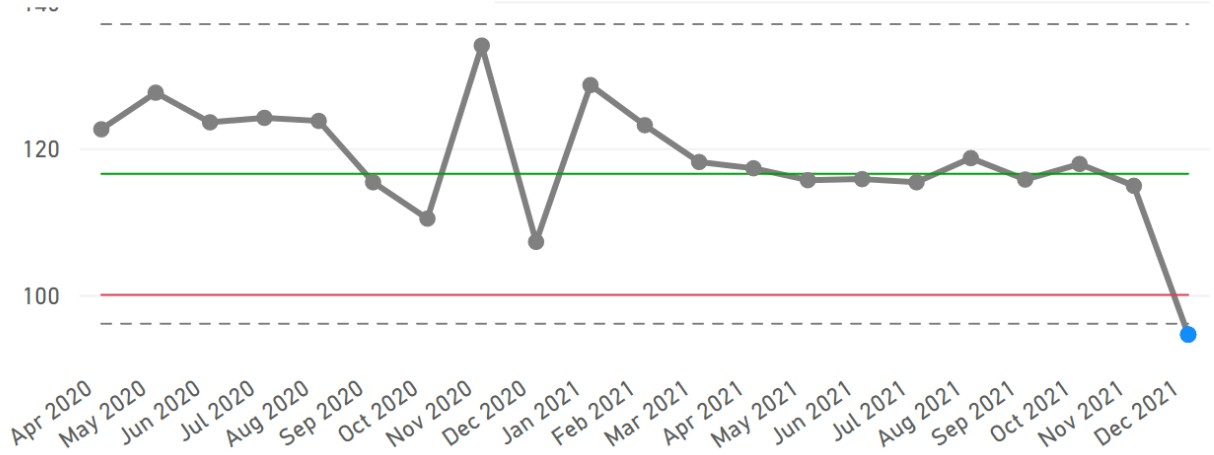
Month	Performance	Target	Trend	Assurance
Jan 2022	75%	95%	H	F



EFFECTIVE

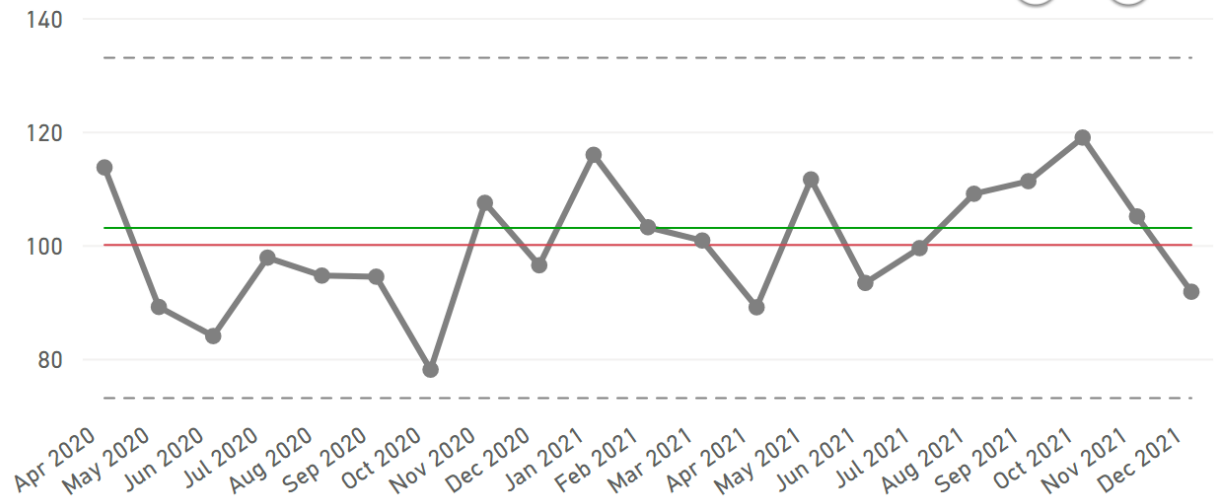
Summary Hospital-Level Mortality Indicator

Month	Performance	Target	Trend	Assurance
Dec 2021	94.61	100		



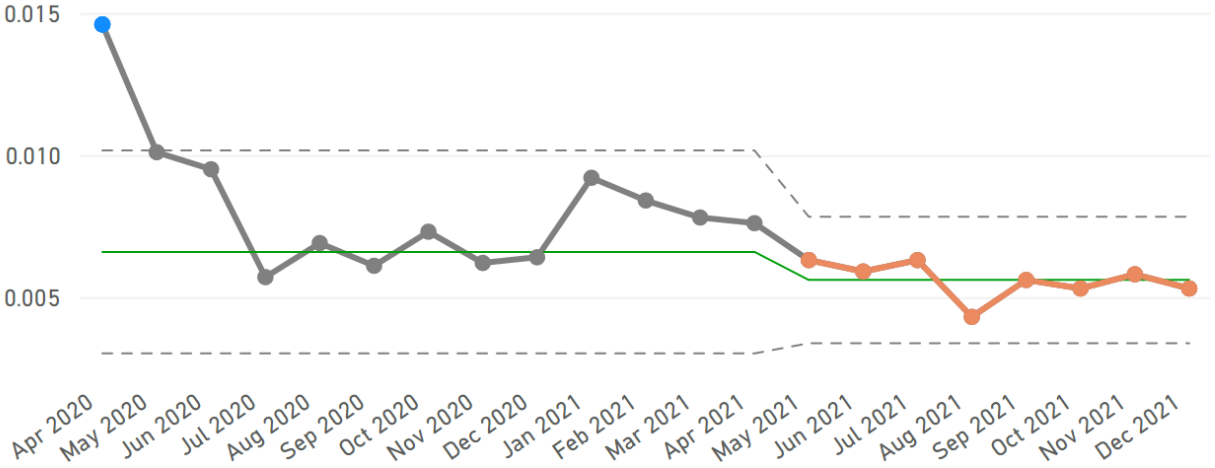
Hospital Standard Mortality Rate

Month	Performance	Target	Trend	Assurance
Dec 2021	91.77	100		



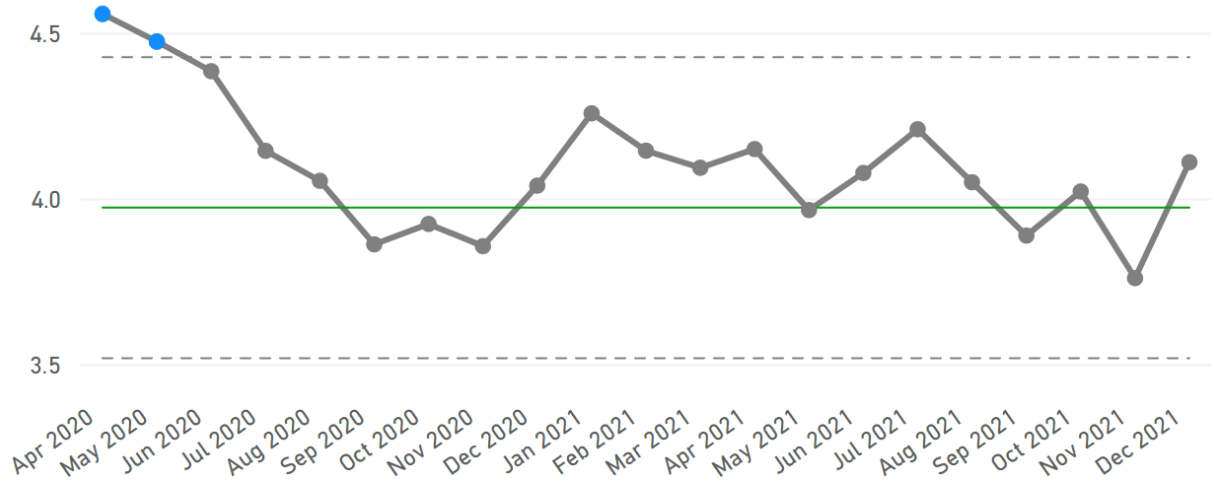
Palliative Care Coding

Month	Performance	Target	Trend	Assurance
Dec 2021	0.01	TBC		N/A



Comorbidity Coding

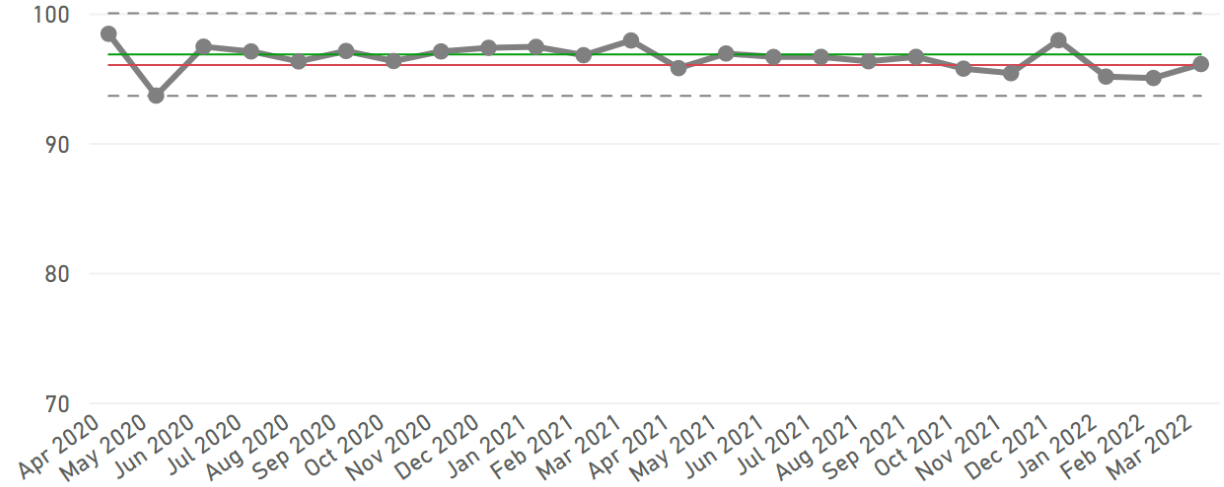
Month	Performance	Target	Trend	Assurance
Dec 2021	4.11	TBC		N/A



CARING

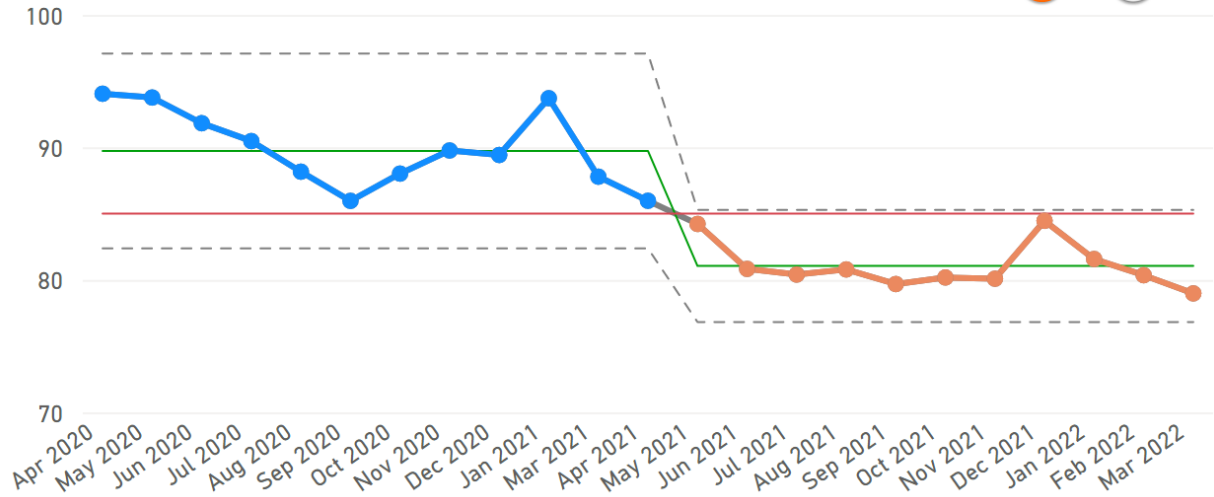
Inpatient Experience (%)

Month	Performance	Target	Trend	Assurance
Mar 2022	96.08%	96%		



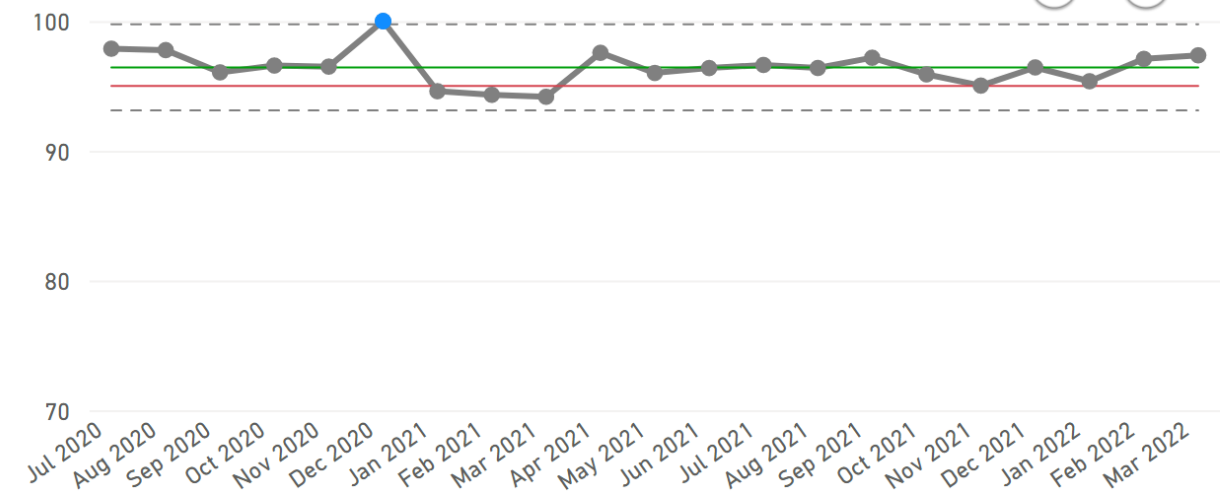
A&E Experience (%)

Month	Performance	Target	Trend	Assurance
Mar 2022	78.98%	85%		



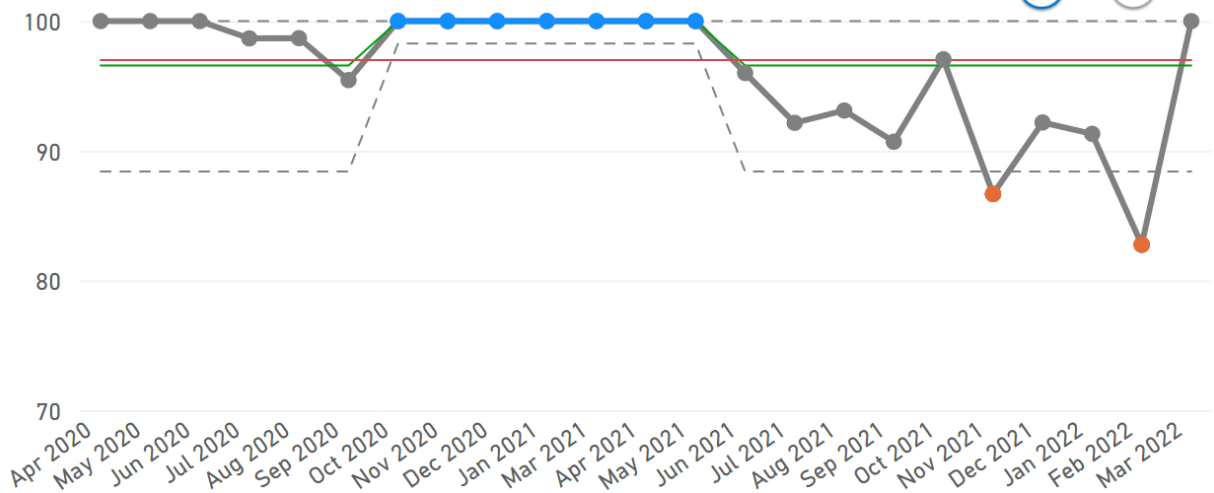
Outpatient Experience (%)

Month	Performance	Target	Trend	Assurance
Mar 2022	97.36%	95%		



Maternity Experience (%)

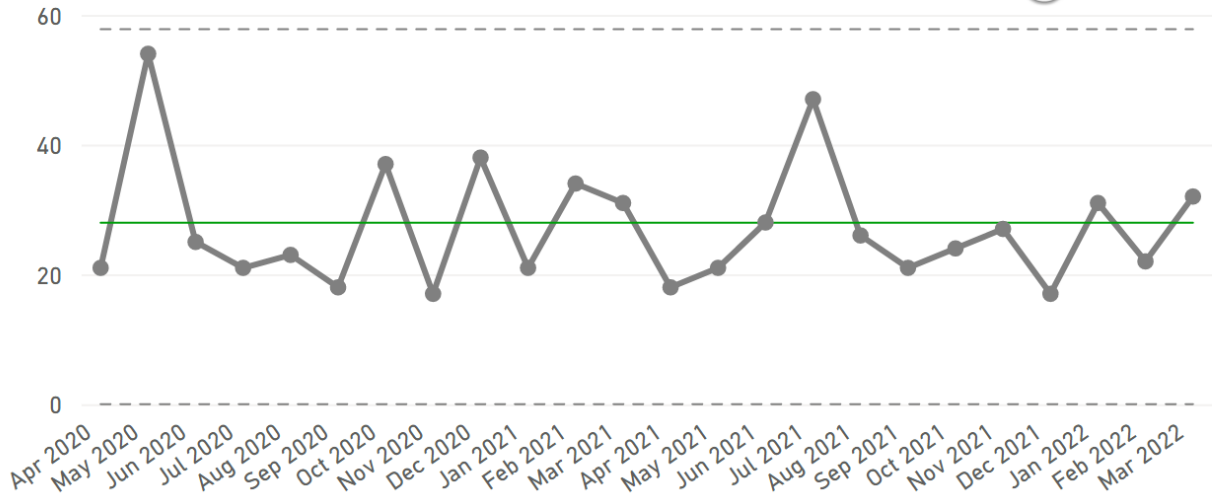
Month	Performance	Target	Trend	Assurance
Mar 2022	100%	97%		



CARING

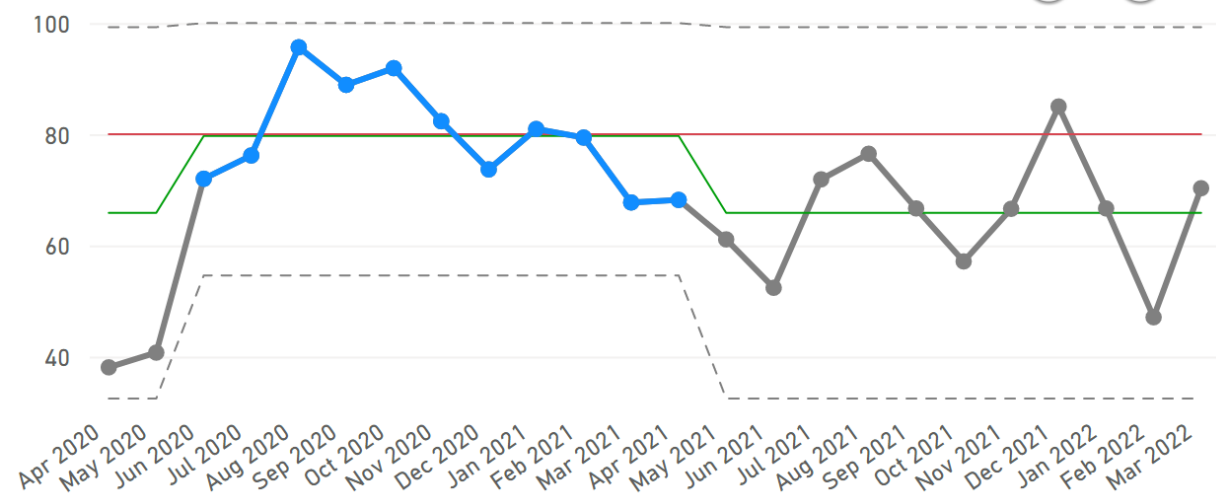
New Complaints

Month	Performance	Target	Trend	Assurance
Mar 2022	32			N/A



Closed Within Target (%)

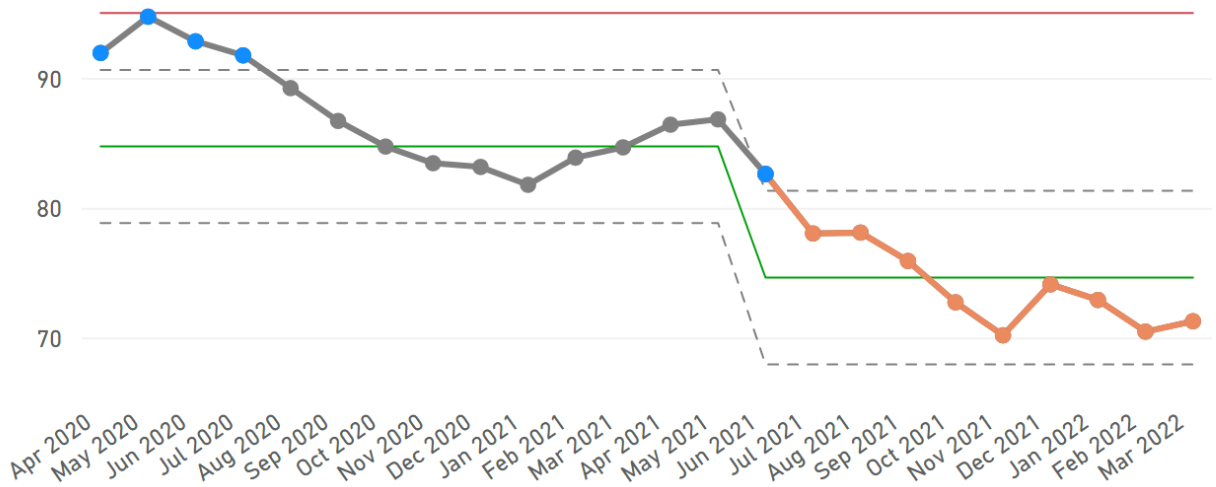
Month	Performance	Target	Trend	Assurance
Mar 2022	70.3%	80%		



RESPONSIVE

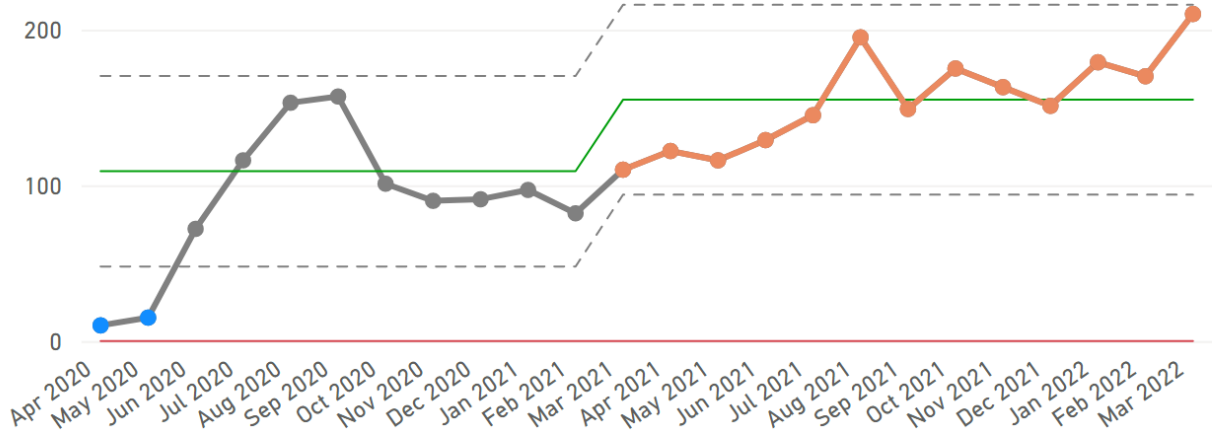
4 Hour Wait Standard (%)

Month	Performance	Target	Trend	Assurance
Mar 2022	71.25%	95%	L	F



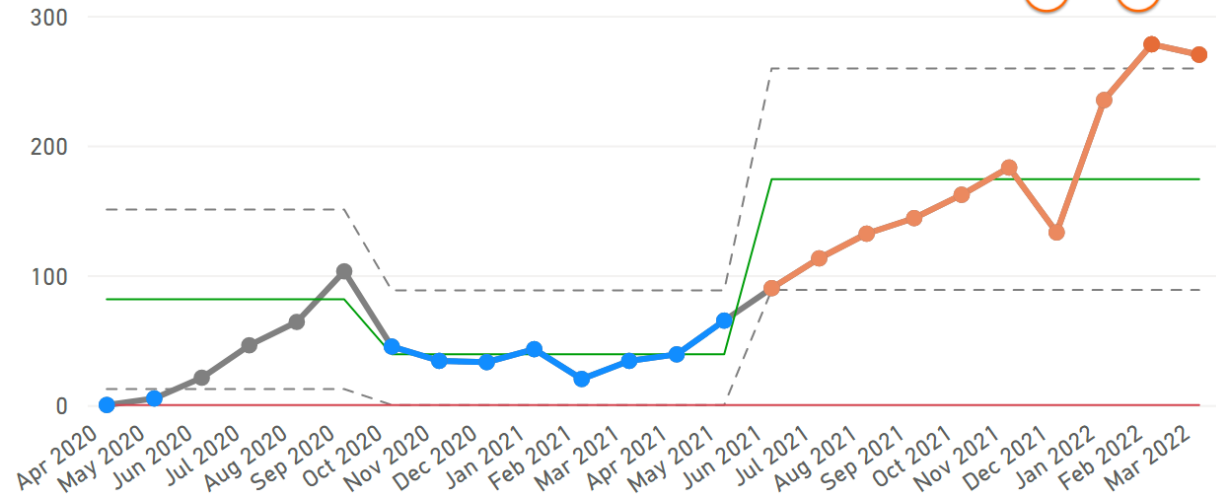
Handovers - Over 30 Mins

Month	Performance	Target	Trend	Assurance
Mar 2022	210	0	H	F



Handovers - Over 60 Mins

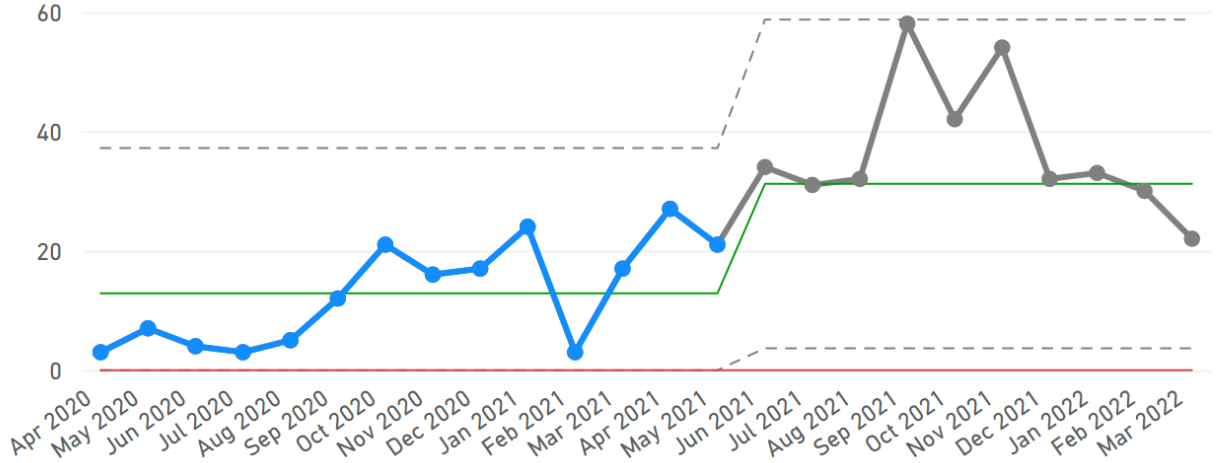
Month	Performance	Target	Trend	Assurance
Mar 2022	270	0	H	F



RESPONSIVE

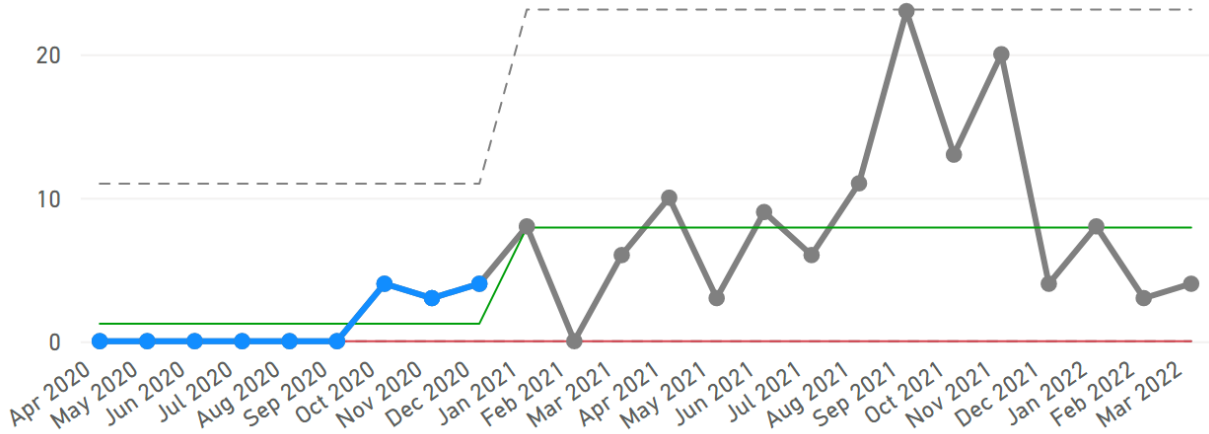
Cancelled Ops - Non-Urgent Cancelled On Day

Month	Performance	Target	Trend	Assurance
Mar 2022	22	0		



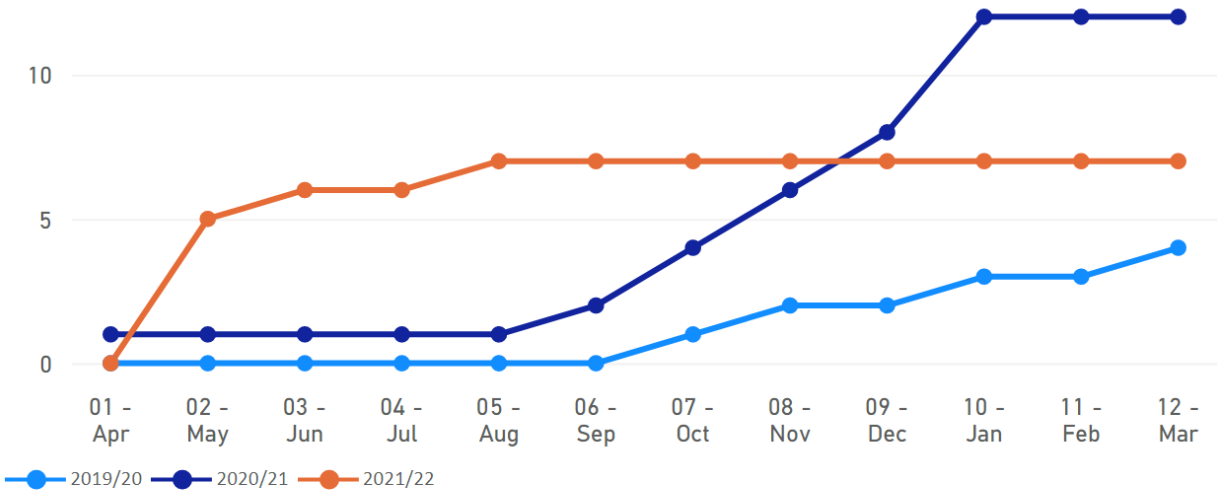
Cancelled Ops - Not Rebooked Within 28 days

Month	Performance	Target	Trend	Assurance
Mar 2022	4	0		



Cancer Operations Cancelled On Day (YTD)

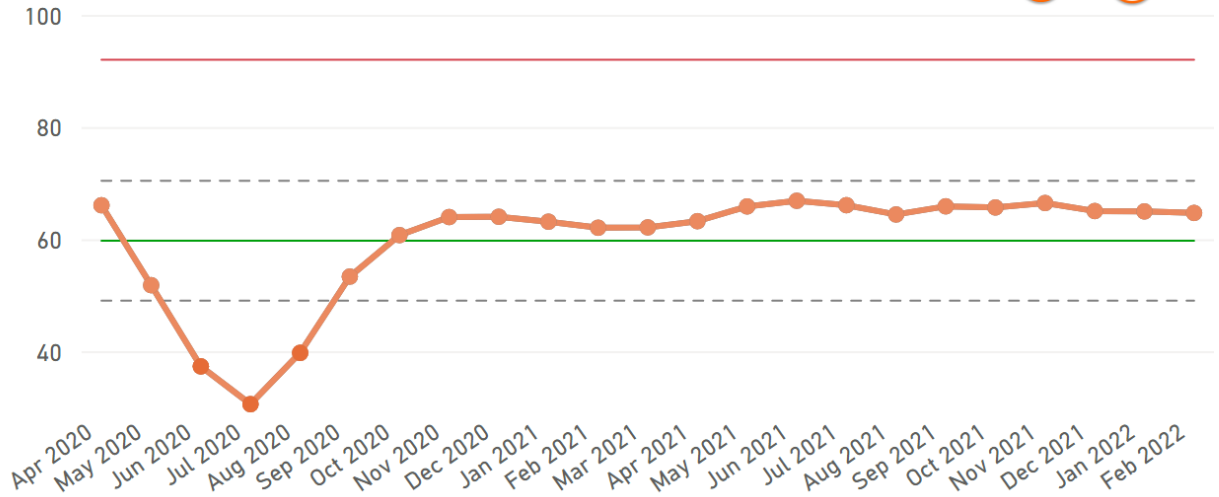
Month	Performance	Target	Trend	Assurance
Mar 2022	7	0	N/A	N/A



RESPONSIVE

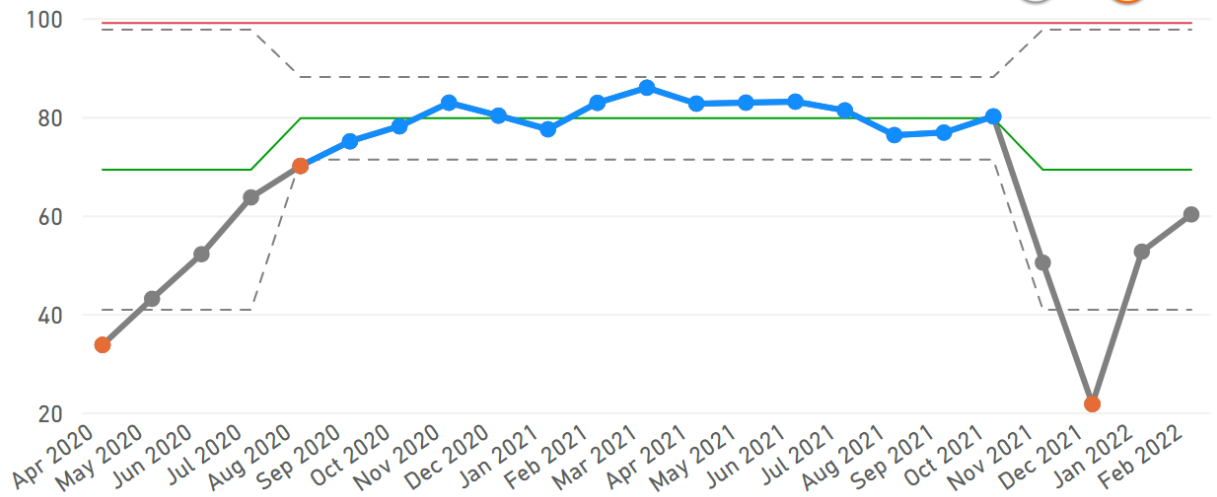
RTT Incomplete Pathways (%)

Month	Performance	Target	Trend	Assurance
Feb 2022	64.67%	92%		



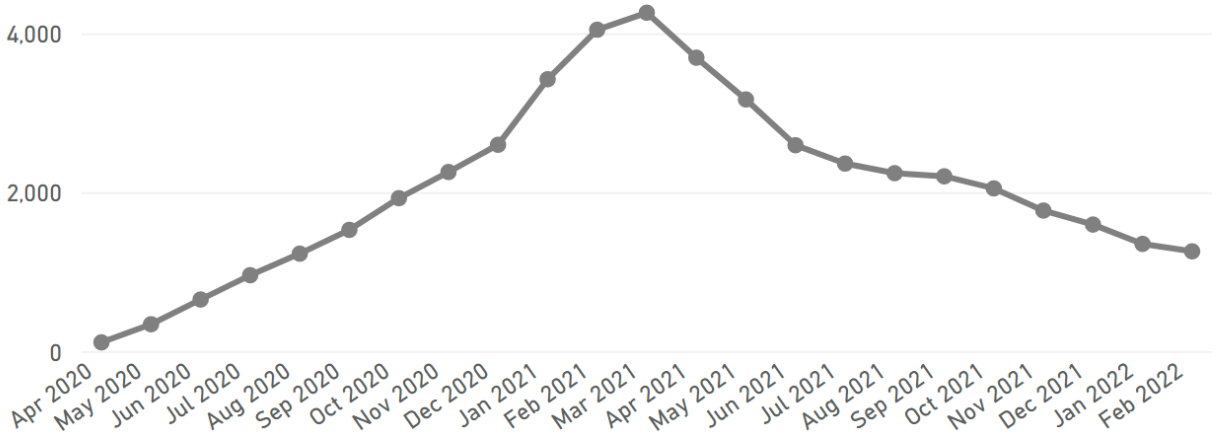
Diagnostic 6 Weeks Standard (%)

Month	Performance	Target	Trend	Assurance
Feb 2022	60.16%	99%		



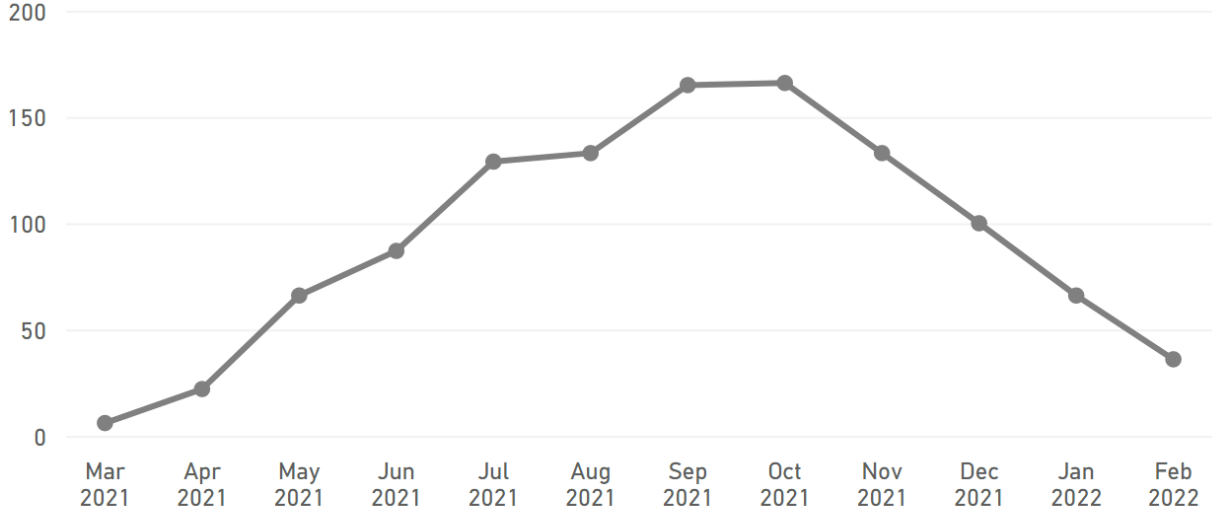
RTT 52 week waiters

Month	Performance	Target	Trend	Assurance
Feb 2022	1256	2451	N/A	N/A



RTT 104 week waiters

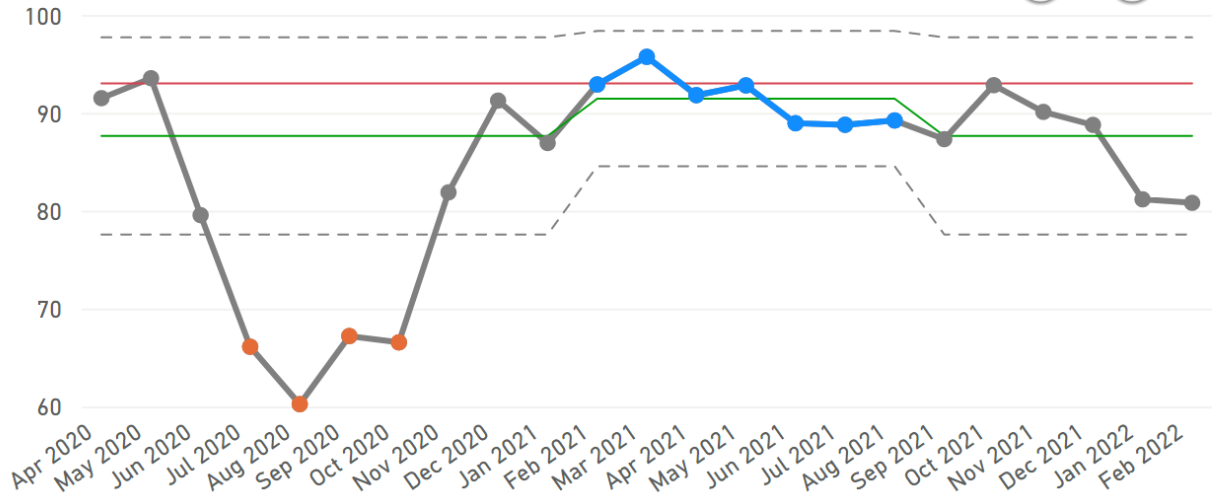
Month	Performance	Target	Trend	Assurance
Feb 2022	36	19	N/A	N/A



RESPONSIVE

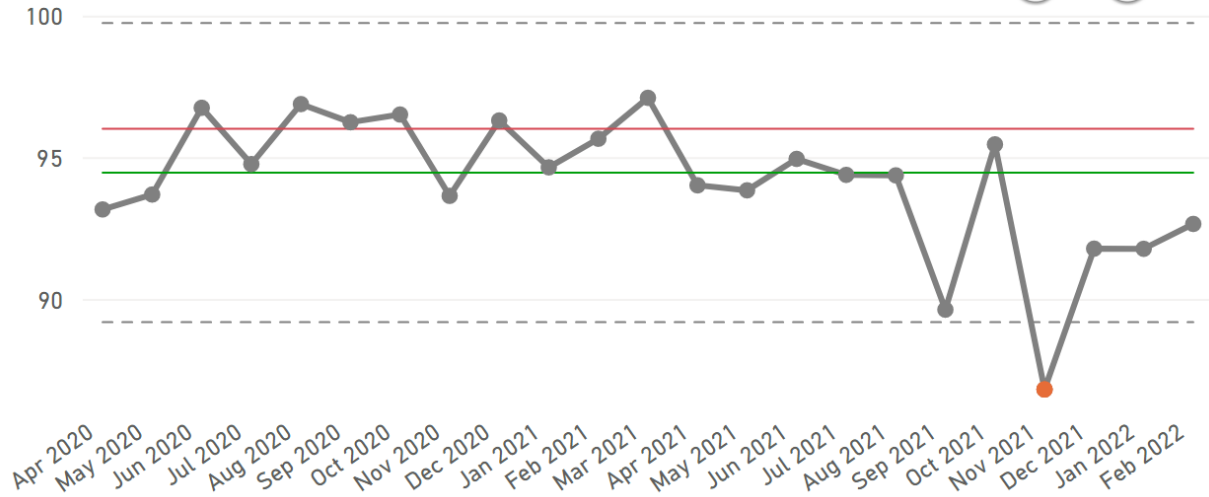
Cancer 14 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Feb 2022	80.8%	93%		



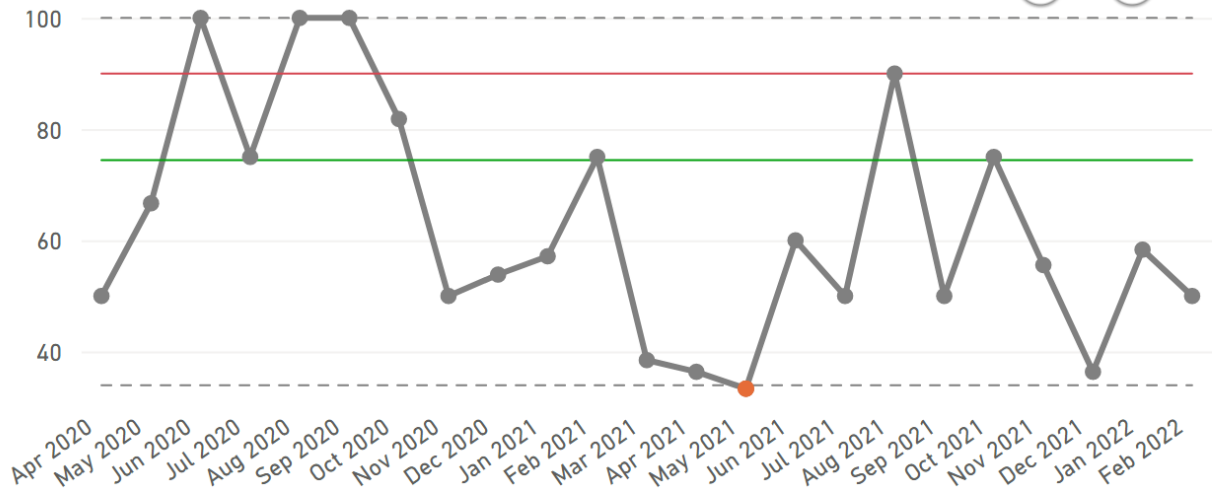
Cancer 31 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Feb 2022	92.65%	96%		



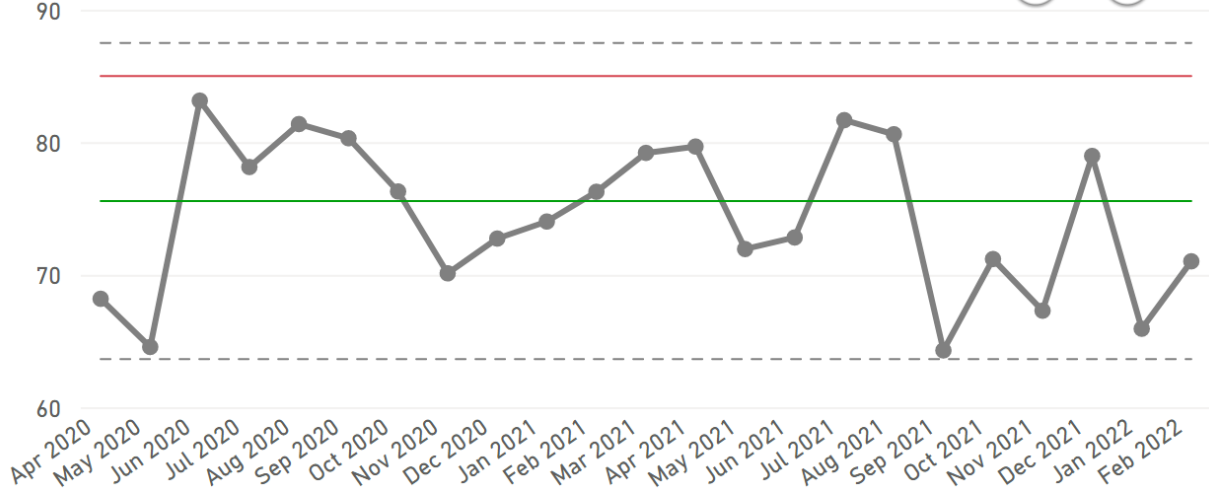
Cancer 62 Day Screening (%)

Month	Performance	Target	Trend	Assurance
Feb 2022	50%	90%		



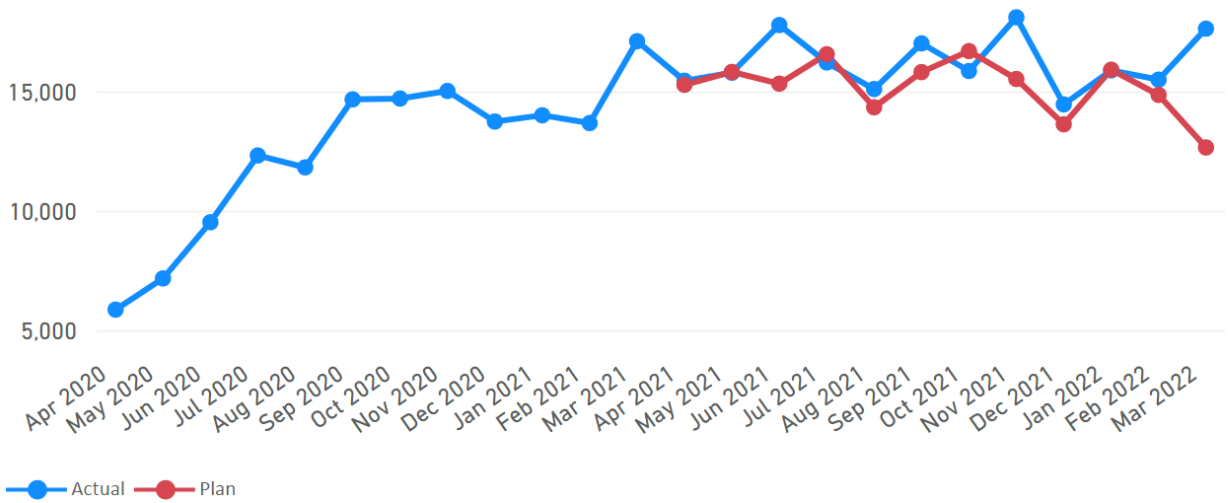
Cancer 62 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Feb 2022	71.01%	85%		

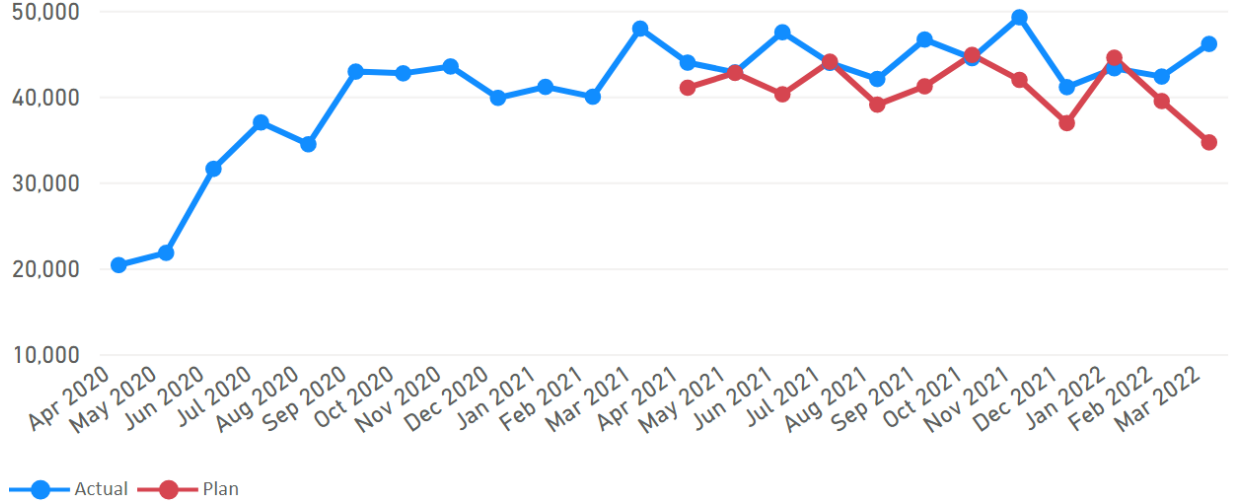


RESPONSIVE

Outpatient New Attendances

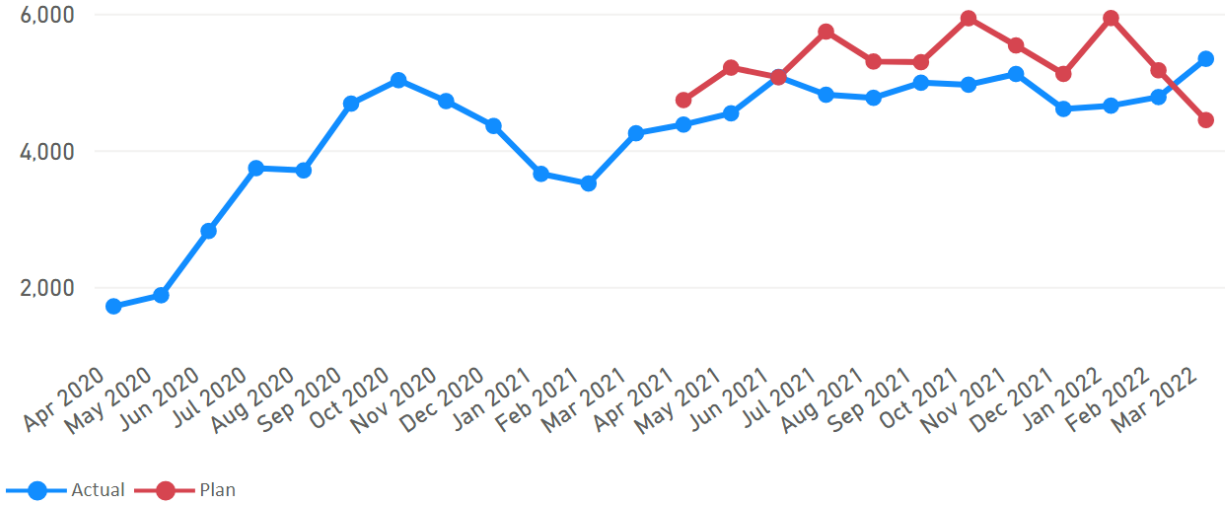


Outpatient Follow-Up Attendances

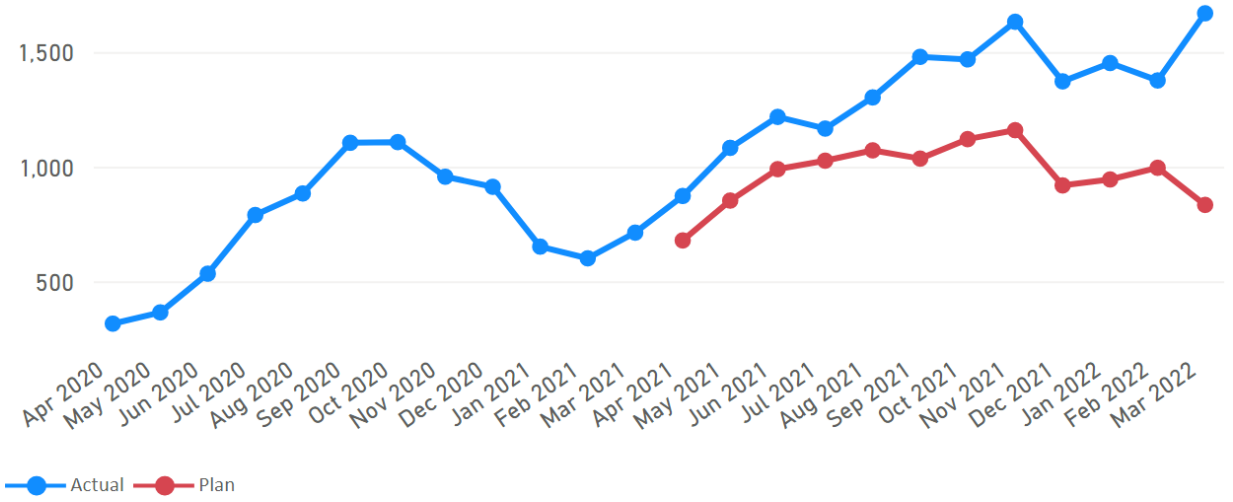


RESPONSIVE

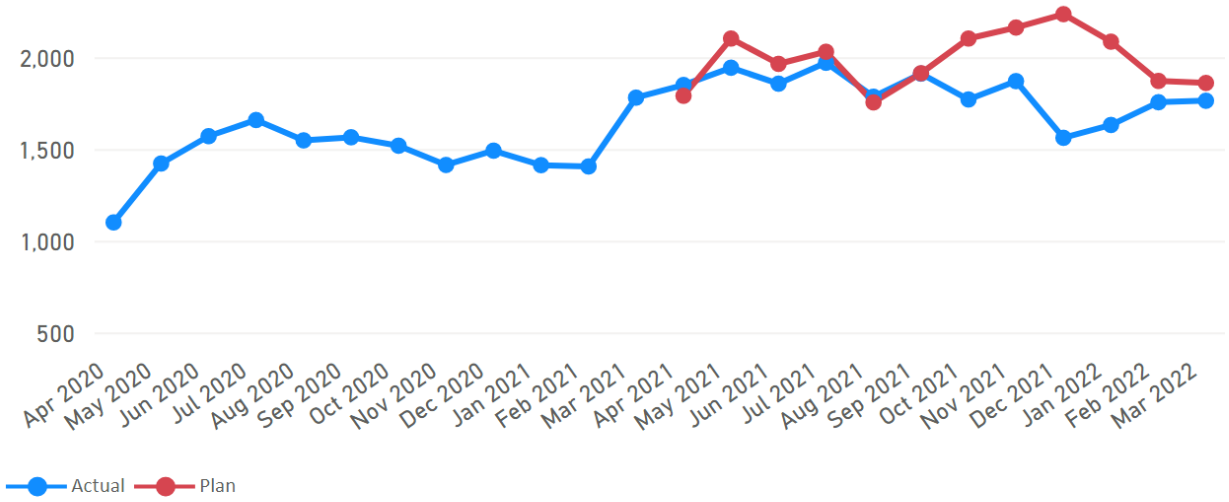
Day Case admissions



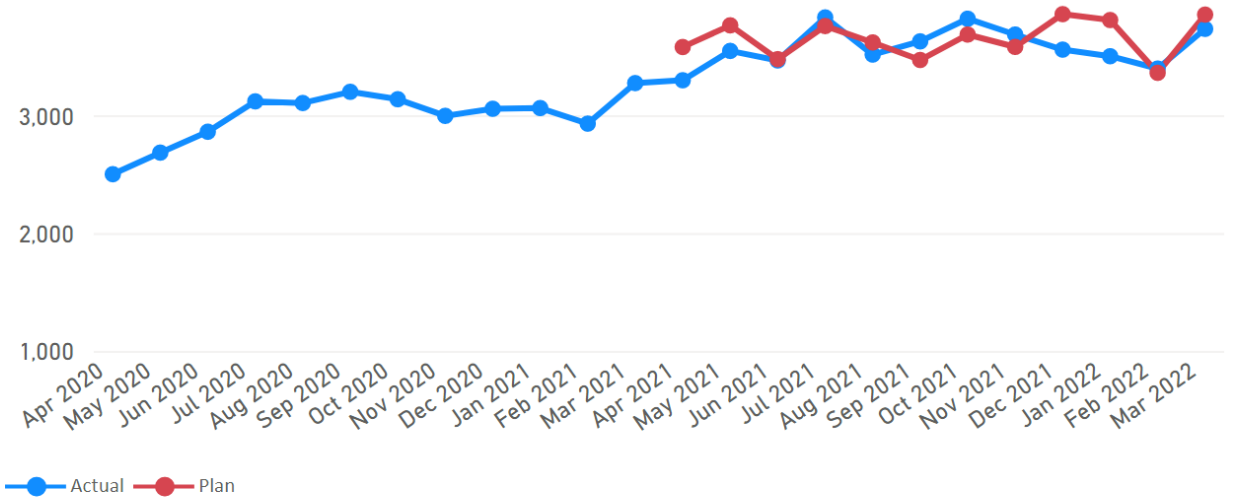
Ordinary Elective admissions



NEL admissions with 0 LOS



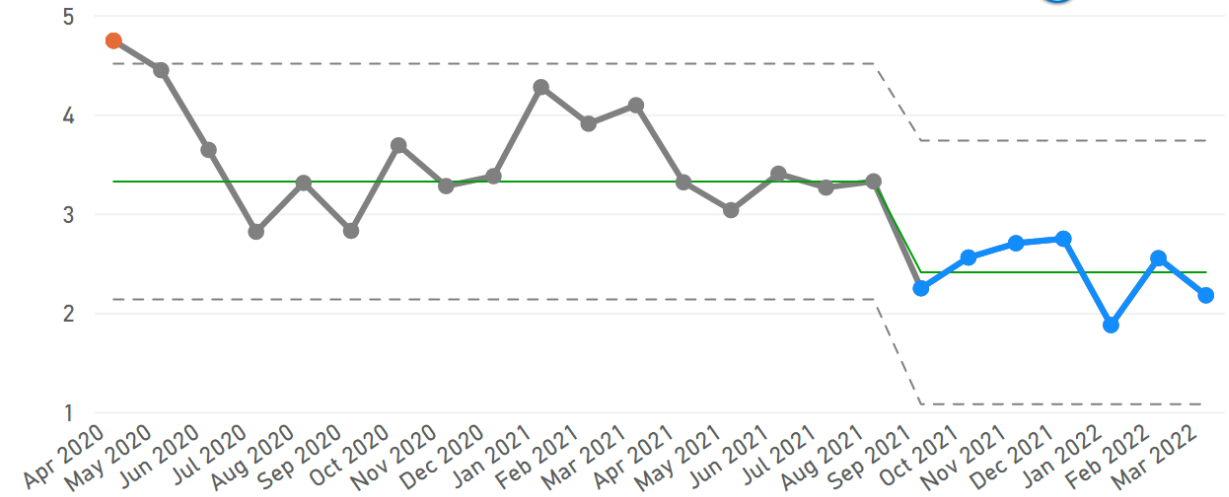
NEL admissions with 1+ LOS



RESPONSIVE

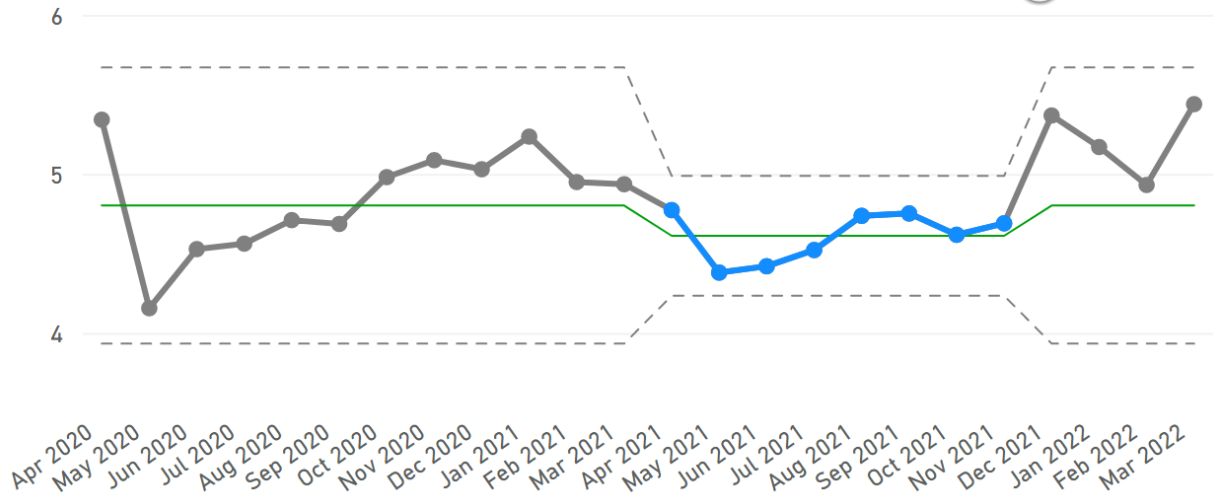
Length of Stay - Elective

Month	Performance	Target	Trend	Assurance
Mar 2022	2.17	N/A		N/A



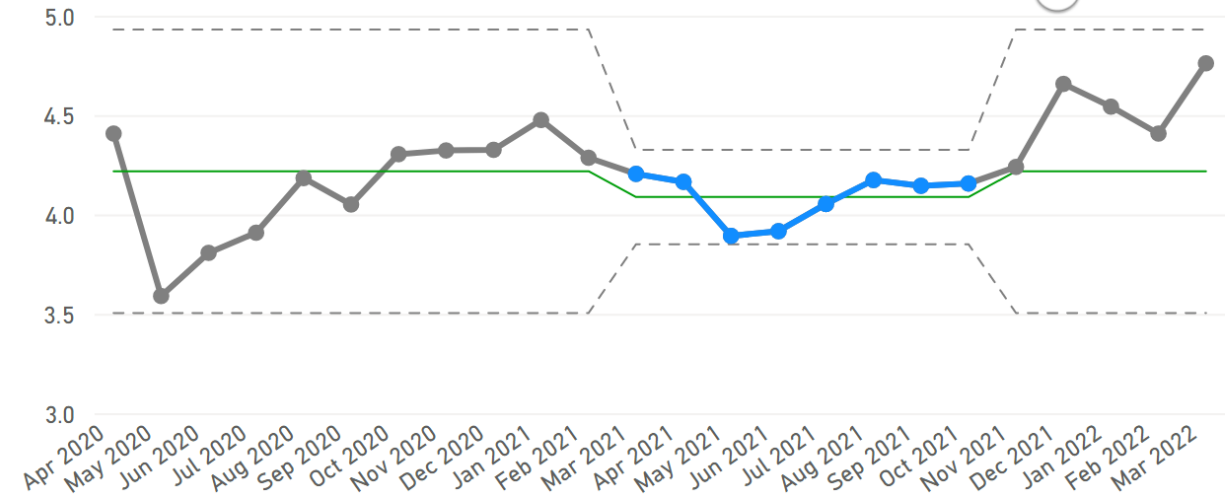
Length of Stay - Emergency

Month	Performance	Target	Trend	Assurance
Mar 2022	5.44	N/A		N/A



Length of Stay - Non-Elective

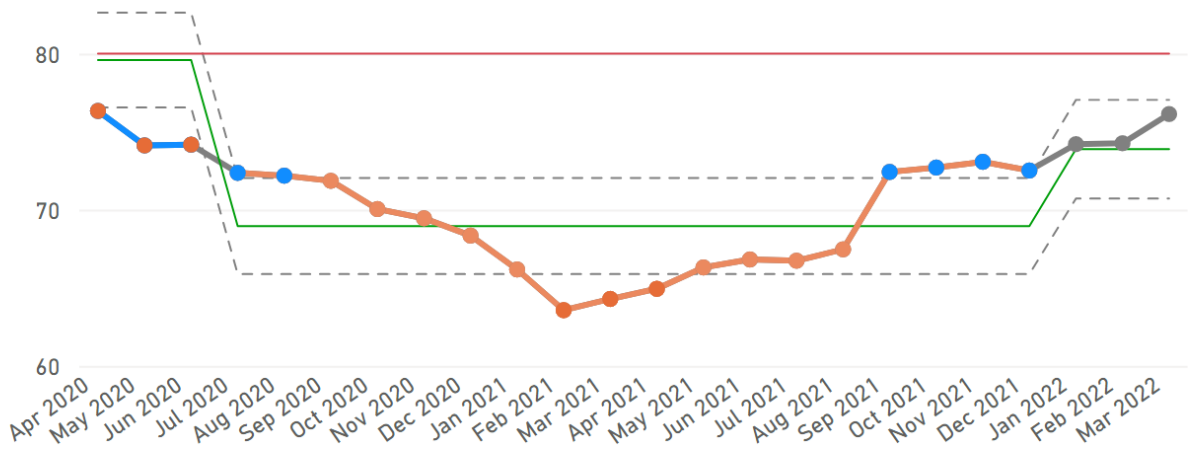
Month	Performance	Target	Trend	Assurance
Mar 2022	4.76	N/A		N/A



WELL-LED

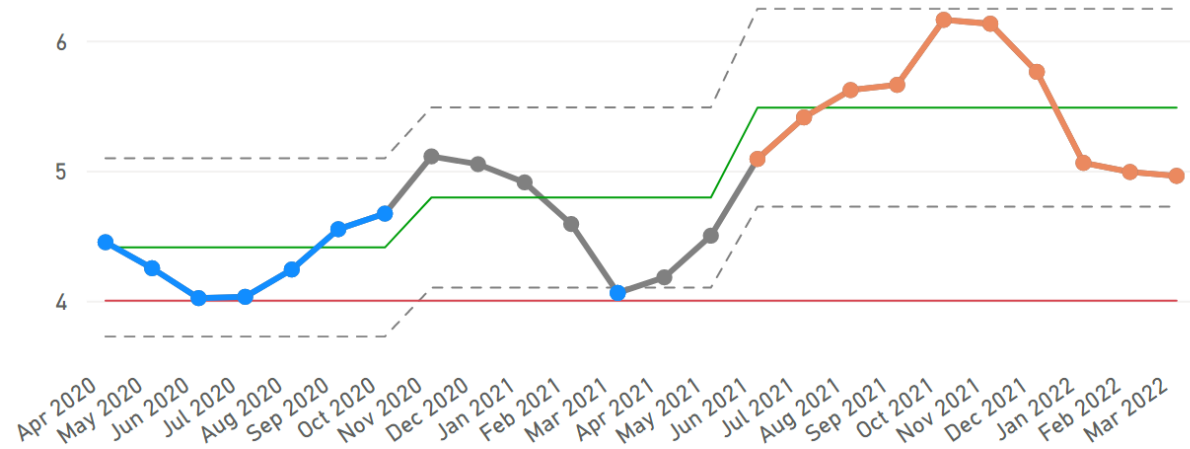
Annual Appraisal (%)

Month	Performance	Target	Trend	Assurance
Mar 2022	76.13%	80%		F



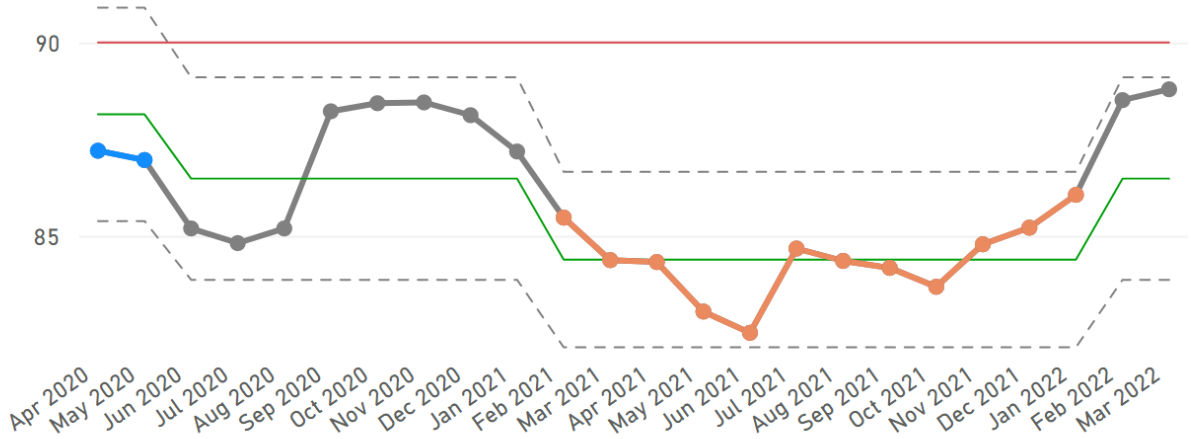
Sickness Absence (%)

Month	Performance	Target	Trend	Assurance
Mar 2022	4.96%	4%		F



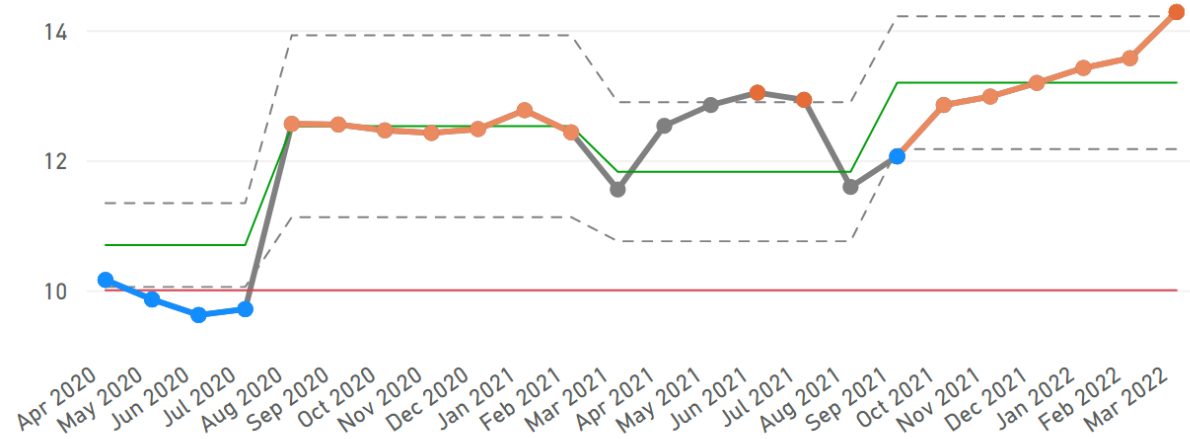
Mandatory Training (%)

Month	Performance	Target	Trend	Assurance
Mar 2022	88.79%	90%		F



Staff Turnover (%)

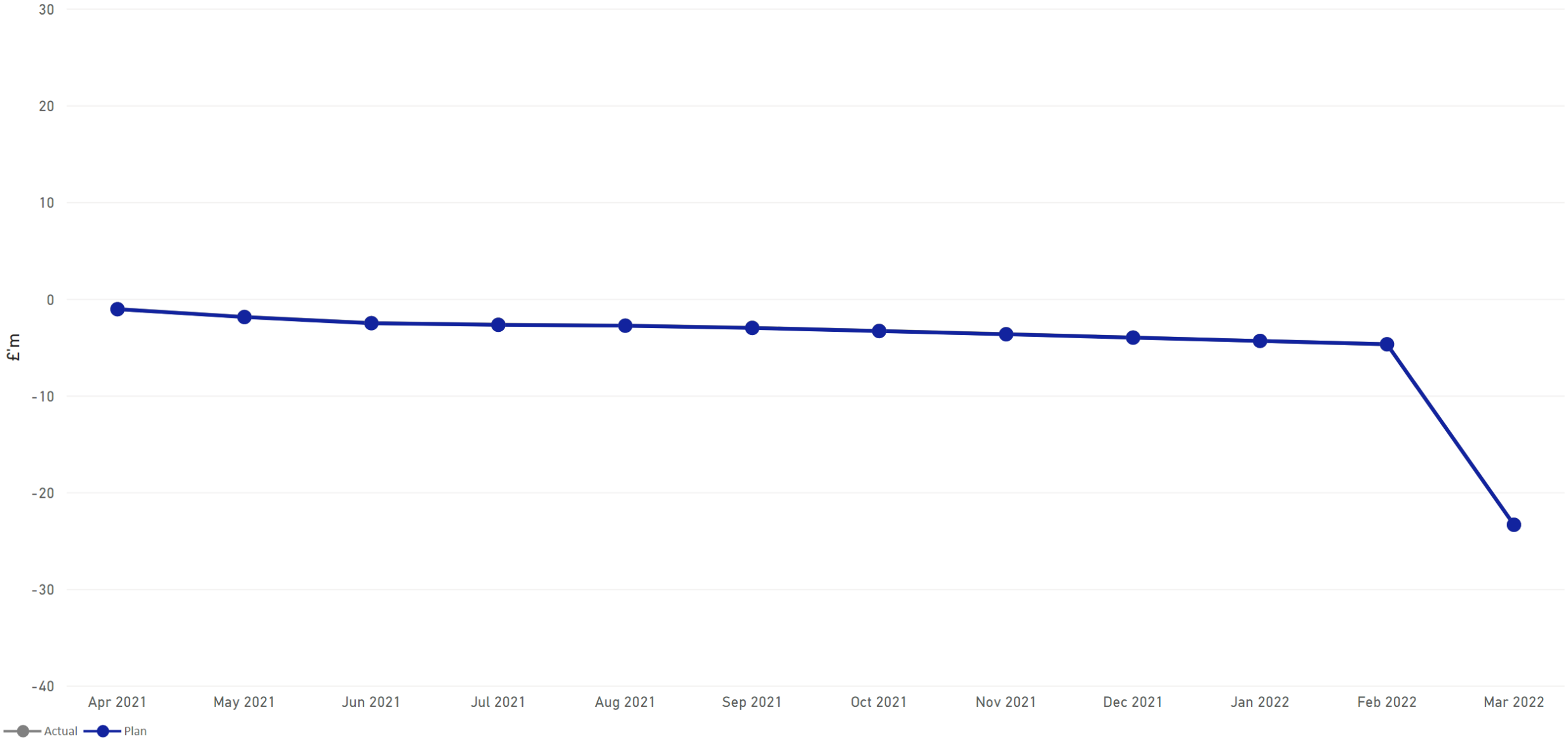
Month	Performance	Target	Trend	Assurance
Mar 2022	14.28%	10%		F



WELL-LED

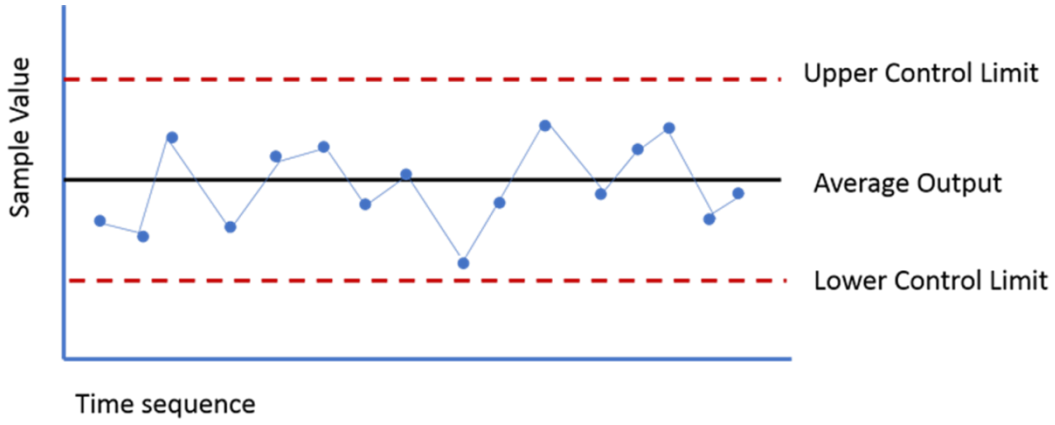
Cumulative YTD Financial Position (£'millions)

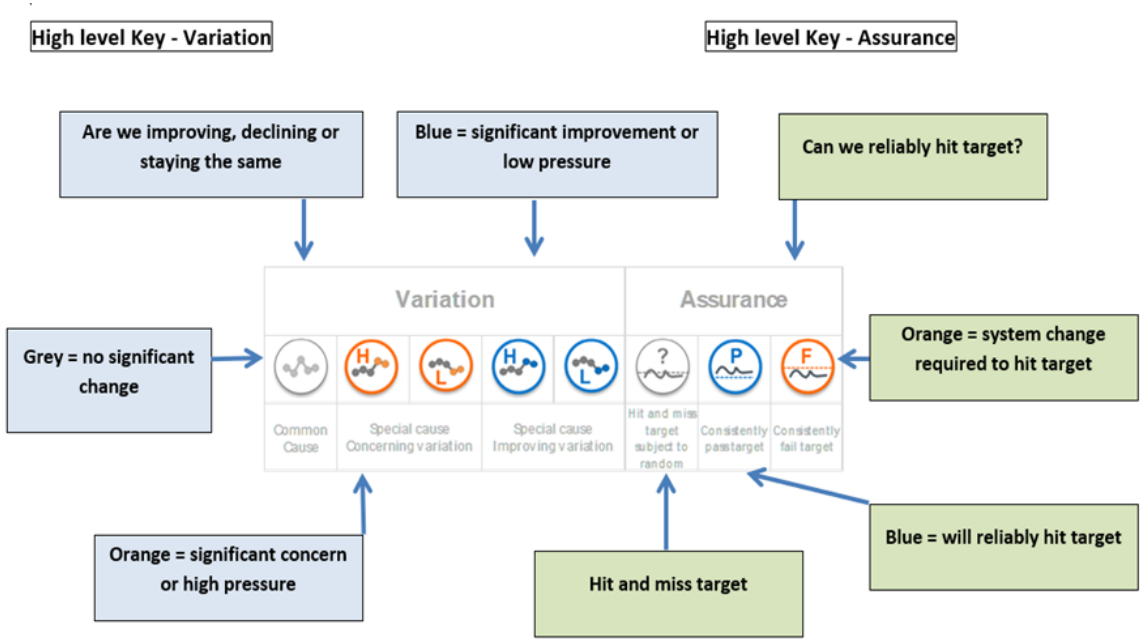
Month	Performance	Target
Mar 2022	-£23.368m	-£23.368m



SPC CHARTS

Statistical Process Control (SPC) charts with indicators of variation and assurance, are utilised where applicable, in line with the best practice standards of *Making Data Count*.





MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 May 2022			
Safe Staffing Report for March 2022 – Nursing and Midwifery			**AGENDA ITEM:10 ENC 8**
Report Author and Job Title:	Debi McKeown Interim NMAHP Workforce Lead	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This report details nursing and midwifery staffing levels for March 22		
Background	The requirement to publish nursing & midwifery staffing levels on a monthly basis is one of the ten expectations specified by the National Quality Board (2013 and 2016).		
Assessment	The percentage of shifts filled against the planned nurse and midwifery staffing across the trust remains at 97.7% as per table 1 demonstrating good compliance with safer staffing. Staffing has continued to be a challenge across the trust with short notice unavailability associated with Covid isolation and Covid related absence. Stretch staffing ratios in line with national guidance have been implemented where necessary based on skill mix, acuity and occupancy levels, all of these actions agreed by senior nurse through safe care. The introduction of allocate on arrival shifts for RNs and HCAs (5 per day and night at JCUH and FHN) has seen improved pick up in March, these shifts are promoted daily via ward manager platforms and NHSp text messaging. This model has been followed in community with impactful pick up Nursing Turnover for March has increased slightly to 8.78%, there has been an increase number of retirements in March.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
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	Principal risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain		
Legal and Equality and Diversity implications	• Care Quality Commission • NHS Improvement • NHS England		

Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☐	Make best use of our resources ☒
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐	

Nursing and Midwifery Workforce Exception Report

March 2022

Safe Staffing Governance

Safer staffing is maintained through twice daily SafeCare (staffing review) meetings to address any immediate issues and put robust plans in place. All elements of safer staffing are discussed at the Workforce Group which meets weekly on a Wednesday and are escalated to the Tactical/Strategic Group as required. A look forward to the week ahead on Mondays and the weekends on Fridays takes place with Associate Directors of Nursing and Clinical Matrons.

Staff movement takes place to ensure patient safety with Clinical Matron Huddles and Ward Manager Briefings utilised to ensure full communication of plans and to gain feedback from teams to inform decision making.

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

Redeployment of staff has taken place on a regular basis to ensure wards are safely staffed with 390 total shifts (3929.75 hours) logged via SafeCare during March which was a slight decrease on February hours.

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

Reporting fill Rate based on planned vs worked hours for March 2022

The breakdown by ward is in Table 2

Table 1 – Trust wide Monthly Fill Rates

		January 22	February 22	March 22
Overall Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	85.4%	87.5%	87.3%
	HCA (%) Average fill rate - DAYS	94.3%	99.0%	93.4%
	NA (%) Average fill rate - DAYS	100%	100%	100%
	TNA (%) Average fill rate - DAYS	100%	100%	100%
	RN/RMs (%) Average fill rate - NIGHTS	87.7%	90.3%	89.4%
	HCA (%) Average fill rate - NIGHTS	98.9%	105.1%	103.4%
	NA (%) Average fill rate - NIGHTS	100%	100%	100%
	TNA (%) Average fill rate - NIGHTS	100%	100%	100%
	Total % of Overall planned hours	**95.8%**	**97.7%**	**97.7%**

Table 2 provides details by ward and these are overlaid with bed occupancy and nurse sensitive indicators to triangulate data in Table 3.

Table 2 - Nursing and Midwifery Planned Vs Actual hours % and Care Hours Per Patient Day

Wards	Physical Bed Capacity	Open Bed Capacity	Total CHPPD	Occupied Bed No – March (at midnight)	Average fill rate - Days RN/ RM (%)	Average fill rate - Days HCA (%)	Average fill rate – Days NA (%)	Average fill rate – Days TNA (%)	Average fill rate - Nights RN/ RM (%)	Average fill rate - Nights HCA (%)	Average fill rate – Nights NA (%)	Average fill rate - Nights TNA (%)	
Ward 1	28	28	802	26	80.1%	107.5%	-	100.0%	74.2%	104.4%	-	-	
Ward 2	28	28	775	25	83.1%	92.6%	100.0%	100.0%	85.0%	105.4%	100.0%	100.0%	
Ward 3	28	28	601	19	96.6%	159.3%	100.0%	100.0%	91.4%	120.6%	100.0%	100.0%	
Ward 4	23	23	659	21	82.0%	106.3%	-	-	76.8%	139.8%	-	-	
Ward 5	28	22	427	14	81.6%	67.8%	-	100.0%	74.3%	100.5%	-	100.0%	Redeployment to other areas due to low occupancy
Ward 6	30	30	872	28	95.1%	118.2%	-	-	92.6%	105.3%	-	-	
Ward 7	30	30	862	28	87.6%	94.4%	100.0%	100.0%	97.2%	98.7%	-	-	
Ward 8	30	30	838	27	86.4%	108.0%	-	100.0%	95.6%	97.8%	-	100.0%	
Ward 9	28	28	723	23	82.9%	141.6%	-	-	78.6%	106.1%	-	100.0%	Amber RSU - low occupancy staffing adapts to demand
Ward 10	27	27	773	25	73.8%	75.5%	-	-	65.4%	109.0%	-	-	Short Term Sickness - 2 RNs on overnight
Ward 11	28	28	785	25	80.1%	77.0%	-	100.0%	82.2%	99.6%	-	-	
Ward 12	26	26	762	25	95.5%	117.9%	-	-	70.8%	128.8%	-	-	Increased HCA Support
Ward 14	23	21	542	17	100.0%	98.0%	-	100.0%	67.0%	133.0%	-	100.0%	Increased HCA Support
Ward 24	23	23	637	21	93.1%	123.6%	-	100.0%	77.8%	173.7%	-	-	Increased HCA Support
Ward 25	21	21	263	8	150.2%	195.7%	-	-	90.6%	182.1%	-	-	
Ward 26	18	19	558	18	88.9%	142.7%	-	-	98.5%	175.7%	-	-	
Ward 27	15	15	610	20	65.3%	47.0%	-	100.0%	92.3%	53.5%	-	-	Low occupancy of elective pathway - staffing reduced in response

Ward 28	30	30	664	21	76.8%	90.9%	-	-	94.6%	100.6%	-	-	Short term sickness and reduced beds
Ward 29	27	27	762	25	92.3%	92.0%	-	-	82.7%	130.5%	100.0%	100.0%	
Cardio MB	9	9	248	8	99.7%	103.0%	-	-	98.1%	-	-	-	
Ward 31	35	31	796	26	112.1%	99.4%	100.0%	-	87.1%	138.3%	100.0%	-	
Ward 32	22	21	600	19	105.3%	99.1%	-	-	100.0%	99.9%	-	-	
Ward 33	19	19	474	15	69.2%	102.0%	-	-	69.9%	90.3%	-	-	
Ward 34	34	34	960	31	86.8%	99.5%	-	100.0%	71.7%	112.0%	-	-	
Ward 35	26	26	632	20	95.4%	106.2%	-	-	79.6%	101.1%	-	-	
Ward 36	34	34	864	28	94.9%	92.6%	-	100.0%	75.1%	105.8%	-	100.0%	
Ward 37	30	30	799	26	89.2%	87.0%	-	100.0%	81.7%	94.7%	-	-	
Critical Care + Surge	33	33	871	28	97.5%	101.3%	-	-	98.1%	97.3%	-	-	
CICU JCUH	12	10	209	7	74.0%	66.1%	-	-	71.0%	112.9%	-	-	Full adherence to GPIX standards
Cardio HDU	10	10	188	6	77.4%	96.4%	-	-	74.2%	100.0%	-	-	Full adherence to GPIX standards
Ward 24 HDU	8	8	218	7	98.2%	83.9%	-	-	98.3%	106.5%	-	-	
Ainderby FHN	27	22	551	18	77.1%	91.9%	-	-	90.5%	88.0%	-	-	
Romanby FHN	26	26	669	22	60.6%	54.6%	-	-	96.8%	51.7%	-	-	
Gara Orthopaedic FHN	21	16	211	7	80.8%	81.9%	-	-	96.8%	34.5%	-	-	
Rutson FHN	17	17	478	15	80.8%	110.9%	-	-	100.1%	91.9%	-	-	
Friary Community Hospital	18	18	412	13	99.1%	96.3%	-	-	90.9%	72.8%	-	-	
Zetland	31	29	911	29	90.6%	81.0%	-	100.0%	89.2%	116.0%	-	100.0%	
Tocketts Ward	30	26	827	27	83.9%	106.1%	-	-	79.4%	118.1%	-	-	
Ward 21	25	25	397	13	78.3%	71.4%	-	-	77.3%	87.1%	-	-	Staff redeployed due to reduced acuity on base ward

Ward 22	17	17	216	7	91.5%	64.5%	-	-	83.6%	46.8%	-	-	
JCDS (Central Delivery Suite)	-	-	330	11	93.8%	79.8%	-	-	93.3%	83.3%	-	-	
Neonatal Unit (NNU)	35	35	591	19	79.3%	75.3%	-	-	78.4%	-	-	-	
Paediatric Intensive Care Unit (PCCU)	6	6	53	2	73.3%	35.9%	-	-	67.7%	-	-	-	Staff redeployed due to reduced acuity on base ward
Ward 17	-	-	797	26	78.5%	76.9%	-	100.0%	88.0%	83.8%	-	100.0%	
Ward 19 Ante Natal	-	-	306	10	79.9%	86.7%	-	-	98.4%	-	-	-	
Maternity Centre FHN	-	-	8	0	105.1%	29.6%	-	-	78.5%	-	-	-	
Spinal Injuries	24	24	610	20	118.9%	128.6%	-	-	196.8%	98.8%	-	-	
CCU JCUH	14	14	313	10	84.6%	126.7%	-	-	82.2%	-	-	-	

Increased staff sickness and COVID isolation continues to be significant during March. Nursing turnover increased slightly from 8.67% to 8.78%.

Nurse Sensitive Indicators

No staffing factors were identified as part of the SI review process in March 2022

Red Flags

143 red flags relating to workforce, with shortfall in RN time being the most common (104).

In relation to red flags for less than 2 RNs on shift the SafeCare log provides a documented resolution to this particular red flag to ensure no shifts had less than 2 RNs throughout March.

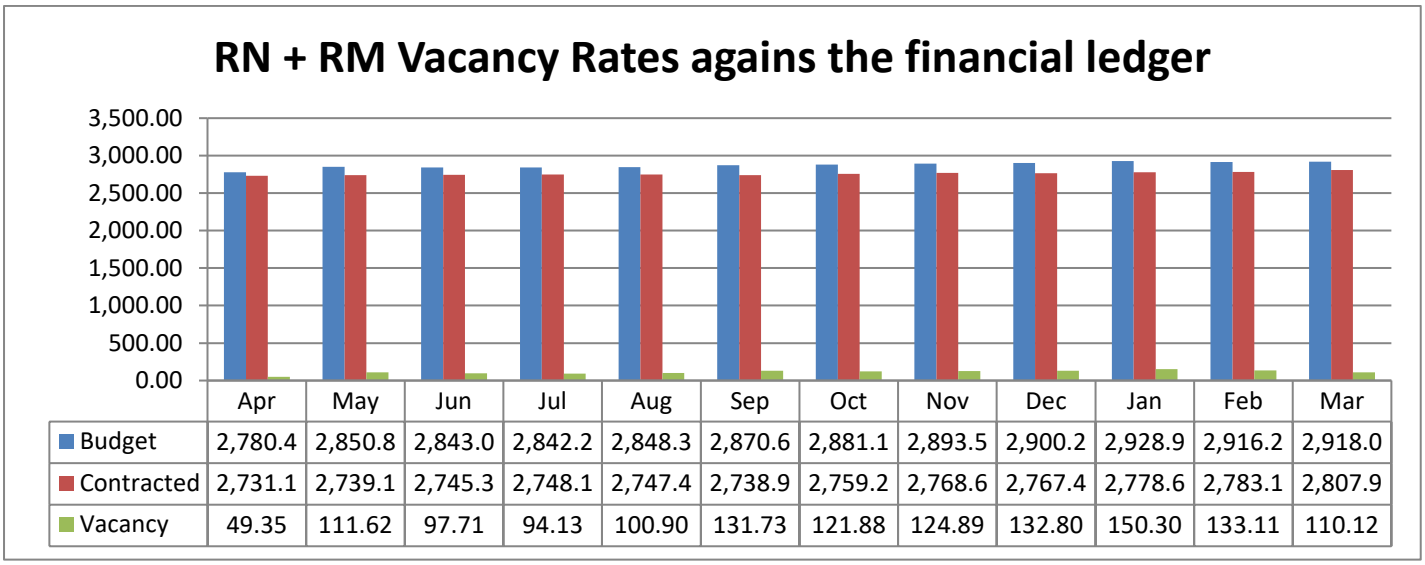
There were 51 DATIX submissions relating to staffing in March. The majority were for staff shortages within Critical Care Outreach and Friarage inpatient areas (Ainderby and Romanby), all were escalated through the SafeCare call and logged by a daily SafeCare chair.

Redeployment decisions were made following safe staffing discussions with Matrons chaired by a Senior Nurse.

Vacancy and Turnover

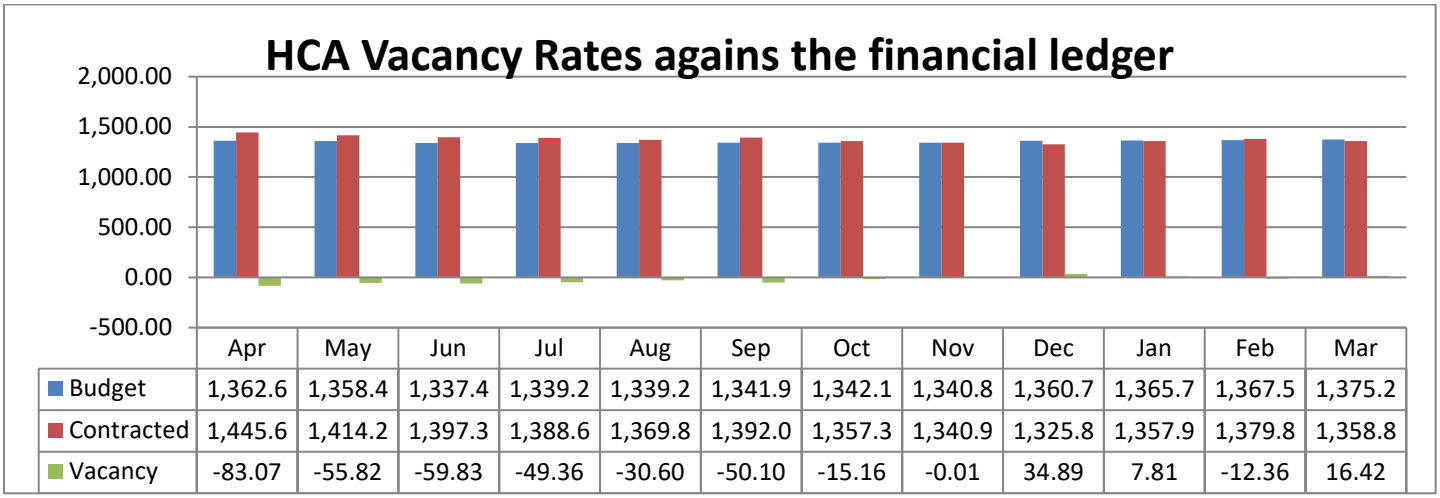
Recruitment of nursing staff continues as vacancies arise. (Fig 1 and 2)

Figure 1 Registered Nursing Vacancy Rate March 2022



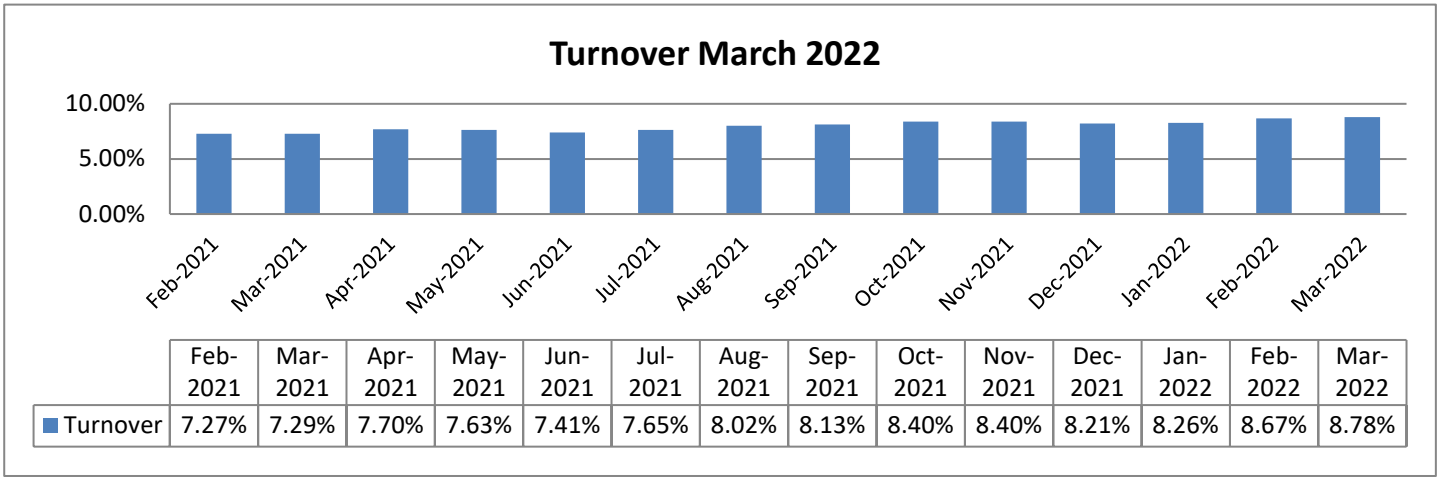
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget	2,780.4	2,850.8	2,843.0	2,842.2	2,848.3	2,870.6	2,881.1	2,893.5	2,900.2	2,928.9	2,916.2	2,918.0
Contracted	2,731.1	2,739.1	2,745.3	2,748.1	2,747.4	2,738.9	2,759.2	2,768.6	2,767.4	2,778.6	2,783.1	2,807.9
Vacancy	49.35	111.62	97.71	94.13	100.90	131.73	121.88	124.89	132.80	150.30	133.11	110.12

Figure 2 Health Care Assistant Vacancy Rate March 2022



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Budget	1,362.6	1,358.4	1,337.4	1,339.2	1,339.2	1,341.9	1,342.1	1,340.8	1,360.7	1,365.7	1,367.5	1,375.2
Contracted	1,445.6	1,414.2	1,397.3	1,388.6	1,369.8	1,392.0	1,357.3	1,340.9	1,325.8	1,357.9	1,379.8	1,358.8
Vacancy	-83.07	-55.82	-59.83	-49.36	-30.60	-50.10	-15.16	-0.01	34.89	7.81	-12.36	16.42

Figure 3 Nursing Turnover March 2022



	Feb-2021	Mar-2021	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Mar-2022
Turnover	7.27%	7.29%	7.70%	7.63%	7.41%	7.65%	8.02%	8.13%	8.40%	8.40%	8.21%	8.26%	8.67%	8.78%

Summary

Staffing remains a priority focus on a daily basis, the twice daily SafeCare meetings identifies redeployment to support safe care across the sites. Registered nurse vacancies have decreased in March

The trust held a successful recruitment event in March for soon to be qualified nurses. This refreshed recruitment process and early on boarding will provide a boost to the nursing workforce from September onwards.

Allocate on arrival shifts continue to provide an essential resource that gives additional support for critical shifts across the sites.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 May 2022			
Ockenden Final Report			**AGENDA ITEM: 11** **ENC 9**
Report Author and Job Title:	Lynne Staite – Head of Midwifery	**Responsible Director:**	Dr Hilary Lloyd, Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	The purpose of the report is to provide an update on the Trusts maternity service following the Donna Ockenden's final report		
Background	Donna Ockenden was asked to review Maternity Services in the Shrewsbury and Telford Hospital Trust by the Secretary of State. The team reviewed 1,592 clinical incidents, between 2000 and 2019, involving 1,486 families. The interim Ockenden report required providers to submit evidence to NHSE/I in June 2021, to show they had enacted the 7 immediate and essential actions (IEAs), covering 41 minimum standards. The Trusts Ockenden action plan was presented to board in February 2022 and positively all actions had either been completed or were in the process of being completed. The final report was released on 30th March 2022 and in addition to actions from the interim report, the final report proposes 15 areas for national action, with 90 plus individual points. NHSE/I sent a letter to all Trusts on 01st April stating that the Ockenden report should be taken to the next public Board meeting		
Assessment	Immediately following the report an action plan was commenced and will be completed following further guidance from NHSE/I, see Appendix 1. All trusts were urged to review their position in relation to Midwifery Continuity Of Career (MCoC) with immediate effect. This is in light of the current staffing challenges within services nationally and the need to provide stability and concentrate resource in order to meet staffing standards. We are recommending that we do not continue to move forward with the roll out of MCoC until we are in a position to do so safely. We will of course continue to work towards a review of workforce to ensure we have a flexible responsive staffing structure and also to ensure we have training plans in place to support changes for the future. Further will be submitted to Board in June 2022		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the report		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Principal Risk 4 - Failure to deliver as a centre of excellence, resulting in a lack of priority and recognition from commissioners and other stakeholders Principal Risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain	
Legal and Equality and Diversity implications	CQC NHS England/Improvement	
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☐
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☐
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐	

Maternity Services – Ockenden Final Report

1. PURPOSE OF REPORT

The purpose of the report is to provide an update on the Trusts maternity service following the Donna Ockenden's final report.

2. BACKGROUND

Donna Ockenden was asked to review Maternity Services in the Shrewsbury and Telford Hospital Trust by the Secretary of State. The team reviewed 1,592 clinical incidents, between 2000 and 2019, involving 1,486 families.

The interim Ockenden report required providers to submit evidence to NHSE/I in June 2021, to show they had enacted the 7 immediate and essential actions (IEAs), covering 41 minimum standards.

The Trusts Ockenden action plan was presented to board in February 2022 and positively all actions had either been completed or were in the process of being completed.

The final report was released on 30th March 2022 and in addition to actions from the interim report, the final report proposes 15 areas for national action, with 90 plus individual points.

NHSE/I sent a letter to all Trusts on 01st April stating that the Ockenden report should be taken to the next public Board meeting.

3. ACTIONS TAKEN

Immediately following the publication of the report a gap analysis was conducted and initial actions were agreed and will be completed, for some we are awaiting further guidance from NHSE/I, see Appendix 1.

All trusts were urged to review their position in relation to Midwifery Continuity of Carer (MCoC) with immediate effect. This is in light of the current staffing challenges within services nationally and the need to provide stability and concentrate resource in order to meet staffing standards.

The Senior Maternity Team are recommending that we do not continue to move forward with the roll out of MCoC until we are in a position to do so safely and have written to staff to inform them of this position.

Plans are in place to continue to work towards a review of workforce to ensure we have a flexible and responsive staffing structure as well as ensuring training plans are in place to support the actions and changes required within the recommendations of the report.

4. RECOMMENDATIONS

The Board are asked to:

Acknowledge the Final Ockenden and the initial actions put in place to address the immediate and essential actions.

Essential and Immediate Actions	Requirements	Initial Actions
1: WORKFORCE PLANNING AND SUSTAINABILITY Financing a safe maternity workforce- The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	Funding maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England	Undertake full BR+ assessment for midwifery and support staffing Review of obstetric Consultant staffing in line with RCOG standards Review of NN staffing against BAPM standards Budget realignment for recurrent funding Undertake review of all maternity and NN staff absence (including mandatory training) Calculate additional staffing uplift required against current provision
	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements	
	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave	
	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH	
Training- We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this	Review of preceptorship progamme to ensure standards are met Implementation and monitoring of programme Continue with current practice where compliance is achieved
	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical	

Essential and Immediate Actions	Requirements	Initial Actions
	practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife	Identify appropriate education modules/packages Continue to ensure all members of the team continue with clinical and theoretical updates Continue to recruit, train and support new members to the team to ensue 24 hour cover Identify process for time allocation GAP analysis of all leadership roles within maternity and NN services Agreed action plan for continuous development
	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce	
	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development	
	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7	
	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience	
	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	
2: SAFE STAFFING All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS	Check new LMNS policy in line with local policy To continue with separate rotas Labour ward coordinator JD to be reviewed and updated
	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level	
	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification	

Essential and Immediate Actions	Requirements	Initial Actions
	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain	Review of current provision and agreed plan going forward Formal mentorship programme to be agreed and implemented Review of communication guidance
	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	
	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	
	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings	
	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles	
	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication	
	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	
3. ESCALATION AND ACCOUNTABILITY Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals	Review of escalation guidance Continue with implementation of standards within the RCOG `role of the Obstetric consultant ` document and monthly monitoring Check new LMNS policy in line with local policy
	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role	
	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	

Essential and Immediate Actions	Requirements	Initial Actions
must be clear guidelines for when a consultant obstetrician should attend.	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit	
	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit	
4. CLINICAL GOVERNANCE-LEADERSHIP Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans	Good compliance in place Review process for Trust reporting as required. Re-visit and review self assessment tool Appoint to Governance lead post Review formulation of guidelines and SOPs guidance Review of obstetric audit process
	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board	
	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services	
	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	
	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement	
	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	
	All maternity services must ensure they have midwifery and obstetric co-leads for audits	
5.CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS Incident investigations must be meaningful for families and staff and lessons must be learned and	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms	Review process for lessons learned being incorporated into training Ensure process in place for audit of all SI actions where applicable to be included in action plan and completion monitored by MSQEC group
	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan	
	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred	

Essential and Immediate Actions	Requirements	Initial Actions
implemented in practice in a timely manner.	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred. All trusts must ensure that complaints which meet SI threshold must be investigated as such All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent Complaints themes and trends must be monitored by the maternity governance team	Ensure all SI actions have a timescale under 6 months and completion is monitored by MSQEC group Audit of complaints against SI investigations Review of complaints process by MVP Formulation of process for quarterly presentation to MSQEC group
6. LEARNING FROM MATERNAL DEATHS Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required. Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	National requirements To be facilitated by LMNS
7. MULTIDISCIPLINARY TRAINING Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Good compliance Process for more robust monitoring of attendance at governance and audit meetings to be developed Review of time allocation for MW attendance at governance and audit

Essential and Immediate Actions	Requirements	Initial Actions
CTG training and emergency skills training	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Need to clarify process for agreement with LMNS Review skills drill programme Continue to monitor effectiveness of PMA programme
	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care	
	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills	
	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	
8. COMPLEX ANTENATAL CARE Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have	Good Compliance
	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019	
	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes	
	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	
	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019)	

Essential and Immediate Actions	Requirements	Initial Actions
9. PRETERM BIRTH The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability	Good Compliance
	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	
	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability	
	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit	
10. LABOUR AND BIRTH Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	Clarify RA process with LMNS Complete annual risk assessment and present to MQSEC group Review of content and frequency of skills drills Review of information and homebirths in conjunction with MVP and NEAS and YAS Review of previous BC for centralised monitoring Identify funding Implementation and training
	Midwifery-led units must complete yearly operational risk assessments	
	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan	
	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	
	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing	
	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	
11. OBSTETRIC ANAESTHESIA In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Review of obstetric anaesthetic local guidance to ensure process in place

Essential and Immediate Actions	Requirements	Initial Actions
up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	
	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	
	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	
	Obstetric anaesthesia staffing guidance to include: • The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. • The competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments. • Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	
12. : POSTNATAL CARE Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward.	Review of guidelines/SOPs Develop processes Undertake full BR+ assessment for midwifery and support staffing Review of NN staffing input into transitional care in line with BABM Budget realignment for recurrent funding
	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum	
	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	
	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies	
13. BEREAVEMENT CARE	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	Good compliance

Essential and Immediate Actions	Requirements	Initial Actions
Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Ensure enough staff trained to provide an appropriate service Develop monitoring process to ensure that process is timely
	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	
	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	
14. : NEONATAL CARE There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Good compliance Review processes and action being developed
	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	
	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	
	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation	
	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation	
	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	
	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given	

Essential and Immediate Actions	Requirements	Initial Actions
	to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm	
	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	
15. SUPPORTING FAMILIES Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate	Review processes and actions being developed
	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	
	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	

Official
Publication approval reference: B1523

To:

- NHS Trust and Foundation Trust:
  - Chief Executives
  - Chairs
  - Chief Nurses
  - Chief Midwives
  - Medical Directors
- ICS leads and Chairs
- LMNS/LMS leads
- CCG Accountable Officers

CC:

- Regional chief nurses
- Regional chief midwives
- Regional medical directors
- Regional obstetricians

Skipton House
80 London Road
London
SE1 6LH

1 April 2022

Dear colleagues

OCKENDEN – Final report

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

Donna Ockenden and her team have set out the terrible failings suffered by families at what should have been the most special time of their lives. We are deeply sorry for the loss and the heartbreak they have had to endure.

This report must act as an immediate call to action for all commissioners and providers of maternity and neonatal services who need to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

We have announced significant investment to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. This will fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support. We will set out further information in the coming weeks.

Your Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system. The Ockenden report should be taken to your next public Board meeting and be shared

with all relevant staff – we strongly recommend everyone reads it, regardless of their role. After reviewing the report, you should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up.

Staff in maternity services may need additional health and wellbeing support. Please signpost colleagues to local support services or national support for our people.

The report highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

It includes a specific action on continuity of carer: *'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (*IEA 2, Safe Staffing page 164)

In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway. We are committed to consolidating actions to ensure a coherent national delivery plan.

However, there can be no delay in implementing local action that can save lives and improve the care women and their families are receiving now.

In the 25 January 2022 letter we asked you to set out at a Public Board your organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. Your position should be discussed with your LMS and ICS and reported to regional teams by 15 April 2022. We will be publishing a detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs at NHSE/I public Board in May. Your trust also needs to provide reliable data to the regular provider workforce return, with executive level oversight.

For organisations without maternity and neonatal services, this report must still be considered, and the valuable lessons digested.

We know you will be as determined as we are to ensure the NHS now makes the changes that will prevent other families suffering such devastating pain and loss.

Yours sincerely

Amanda Pritchard

NHS Chief Executive

Ruth May

Chief Nursing Officer

Professor Stephen Powis

National Medical Director

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS - 3 May 2022			
Freedom to Speak Up Q4 Update			**AGENDA ITEM: 12** **ENC 10**
Report Author and Job Title:	Rick Betts/Afshan Ali/Jim Woods Freedom to Speak Up Guardians Ian Bennett Freedom to Speak Up Guardian & Deputy Director of Quality & Safety	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This report provides an update on the work of the Freedom to Speak Up (FTSU) Guardians during the last month of Q3 (from 13th December), and the end of Q4 (31st March) and for the year April 1st 2021 to March 31st 2022		
Background	The Freedom to Speak Up Guardian role was created as a result of recommendations from Sir Robert Francis following his review of the Mid Staffordshire Hospital. The FTSU model has now been in operation for 18 months and continues to be well received by staff and managers. South Tees FTSU Guardians encourage colleagues to speak up about concerns in the workplace with the aim of improving patient safety and staff experience. Themes arising from concerns raised are shared and used to improve learning and improvement within the organisation.		
Assessment	Staff continue to speak up within the organisation, with the number of issues reported to the FTSU Guardians in Q4 decreasing from 32 in Q3 to 22 in Q4. As a result of our staff speaking up a number of organisational learning points have been identified, with recommendations made on how the Trust should continue to improve. The FTSU Guardians will triangulate this data with the recent staff survey results. The Guardians are also taking action to improve FTSU culture throughout the organisation and beyond, with stronger links being forged with our colleagues in both NHS Professionals, Military and North Tees.. This positive culture is highlighted in the 2021 NHS Staff Survey results which show continued improvement across the board for our speaking up culture which is in contrast to the national trend.		

Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐	
Recommendation	Members of the Board of Directors are asked to note and receive the paper	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Principal Risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes Principal Risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☐	Make best use of our resources ☐
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐	

Freedom to Speak Up Q4 Update

1. PURPOSE OF REPORT

The purpose of the report is to update the Board on progress made by the Freedom to Speak up (FTSU) Guardians since the submission of the previous report in December 2021.

The report provides an overview of the themes and issues raised between 13th December 2021 (Q3) and up to March 31st 2022 (Q4) and the results of the 2021 NHS Staff Survey.

2. BACKGROUND

The Freedom to Speak Up Guardian role was created as a result of recommendations from Sir Robert Francis. FTSU Guardians help to protect patient safety and quality of care, improve the experience of workers and promote learning and improvement. This is achieved by supporting our colleagues to speak up about issueds, breaking down barriers to speaking up and ensuring that issues raised are used by the trust as opportunities for feedback, learning and improvement.

The current Freedom to Speak Up (FTSU) model employed in the Trust has now been in place for a full 18 months with 2 WTE guardians covering the Trust.

3. DETAILS

3.1 Assessment of issues

During Q4, the Guardians received 22 new issues representing a decrease when compared to the previous report submitted in December 2021 and as set out in Table 1 below.

The 2020/2021 Annual Speaking Up Data Report from the NGO, reflects on key trends and themes around speaking up across organisations. The average number of cases that were raised with FTSU Guardians per quarter in medium sized organisations (which is the category our Trust falls into) in the 2020/2021 calendar year being 26. Therefore the 22 issues raised in our trust are marginally below the national average for Trusts of our size for Q4.

Yearly figures show that 56.07% of staff are speaking up openly or confidentially with 43.92% speaking up anonymously. The last quarter has seen an overall reduction in the trend of anonymous reporting as set out in Table 1 below.

Table 1

Number Issues Raised					
	Q1	**Q2**	**Q3**	**Q4**	**Yearly**
Open	6 (30%)	5 (15.62%)	6 (18.75 %)	8 (36.36%)	25 (23.58%)
Confidential	6 (30%)	12 (37.5%)	9 (28.12 %)	8 (36.36%)	35 (33.01%)
Anonymous	8 (40%)	15 (46.87%)	17 (53.12 %)	6 (27.27%)	46 (43.39%)
Total	20	32	32	22	106

Themes

The themes from the issues raised in Q4 are detailed in Table 2. It must be highlighted that issues raised can often have multiple themes related to them.

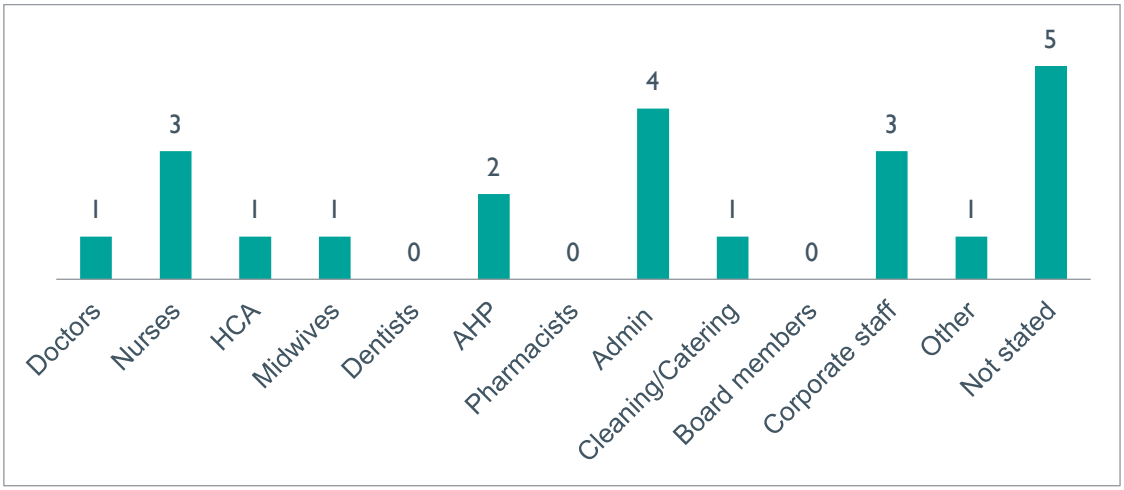
Table 2

Themes	Q4
Management	16
Staff health and safety	15
Staffing/Workload	13
Communication issues	13
Incivility/Culture	12
Bullying and harassment	11
HR systems and processes	9
Safety	7
Equality, Diversity and Inclusion	7
Staff training/supervision	5
Systems and processes	4

Staff Groups

Chart 1 below shows the staff groups who have raised issues in Q4.

Chart 1.



Professional Level

Table 3 shows the numbers and percentage of professional levels of all staff who have spoken up in Q4.

Table 3

Professional level	Q4

Worker	13 (59.09%)
Manager	3 (13.63%)
Senior Leader	2 (9.09%)
Unknown	4(18.18%)

High level themes raised in Q4

Further analysis of the data shows that management issues often originate from poor communication between staff and line managers.. It is important to note that communication issues are reported from and regarding all grades of staff.

- Incivility–related issues can relate to behaviours.
- This includes colleagues' interactions or not feeling listened to.
- Safety is often linked to processes and interactions.

3.1 Learning and Improvement

As a result of staff speaking up some of the lessons learned include:

- The importance of investigations being objective and carried out to a high standard and in a timely manner
- The importance of compassionate management
- The importance of escalating cases in a timely manner

3.4 2021 NHS Staff Survey Results

The FTSU Guardians use the NHS Staff Survey results to triangulate themes and update the FTSU action plan.

The results of the 2021 survey were released at the end of March 2022 and show encouraging trends across the organisation, when compared both nationally and regionally.

There were 4 questions relating to speaking up in the survey as seen in table 4

Table 4

Staff Survey Question		2020/21 results	2021/22 results	Comparison to 2021/22 national benchmarking
Q17A	If you were concerned about unsafe clinical practice, would you know how to report it?	72.2%	76.9%	73.9% ↑ (3%)
Q17B	I would feel secure raising concerns about unsafe clinical practice. Those responding Strongly Agree	58.6%	60.7%	57.6% ↑ (3.1%)
Q21E	I feel safe to speak up about anything that concerns me in this organisation	63.8%	64.7%	60.7% ↑ (4%)
Q21F	If I speak up about something that	N/A	49.6%	47.9%

	concerns me, I am confident that my organisation would address my concern			(1.7%)

In the North East and North Cumbia region, South Tees was the only Trust to record an overall increase in responses to the questions relating to speaking up. Returns from other Trusts varied widely but all showed decreases overall of between -2.5% to -10.6%.

Since the autumn of 2019 the trust has undergone a number of significant changes an now empowers clinicians to take the decisions about how we manage our resources and deliver care across our hospitals and services.

By enabling clinicians to come together to shape and deliver the care they want for their patients and service users.

The results from the 2021 NHS Staff Survey are testament to this approach, the hard work of colleagues and the awareness raising that has taken place over the last 12 months by the FTSU Guardians and Champions, along with the continued support from the CPG, Executive and non-Executive teams for FTSU.

3.5 National Guardians Office Developments

New Guidance is available from the National Guardians Office on how we should record cases as an organisation. These change requests were sent to the Trust I.T. Department and were all implemented from the beginning of April.

Follow Up FTSU Training for Senior Leaders

The final module of the Freedom to Speak Up e-learning from the National Guardians Office was launched on 12th April.

The Freedom to Speak Up training - ‘Speak Up, Listen Up, Follow Up’ - is available for everyone who works in healthcare. Divided into three modules, it helps people understand the vital role we all play in a healthy speaking up culture which protects patients and service users and enhances worker experience.

The latest session “Follow Up” has been developed for senior leaders throughout healthcare - including executive and non-executive directors, lay members and governors – this module aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to and action taken.

Recommendations

Members of the Board of Directors are asked to note and receive the paper.

South Tees Hospitals
NHS Foundation Trust

MEETING OF PUBLIC BOARD OF DIRECTORS – 3 May 2022			
Finance Report			**Agenda Item 14, ENC 11**
Report Author and Job Title:	Chris Dargue Deputy Chief Finance Officer	**Responsible Director:**	Chris Hand Chief Finance Officer
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report outlines the Trust's financial performance as at Month 12 of 2021/22 and the plan for the 2022/23 financial year.		
Background	Due to the ongoing Covid-19 pandemic formal annual financial planning was suspended for 2021/22. ICS system level planning is in place, with each ICP expected to deliver a break-even position within a fixed funding envelope.		
Assessment	At Month 12 the Trust reported a deficit of £23.4m, which was in line with the year-end forecast position agreed with the NHSE/I Regional Team, supporting the wider ICS to deliver overall financial balance at a system level		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board of Directors are asked to note the financial position for Month 12 2021/22 and the financial plan for 2022/23.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Principal Risk 7 - Failure to deliver the Trust's financial recovery plan		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Best for safe, clinically effective care and experience ☐	A great place to work ☐	
	Deliver care without boundaries in collaboration with our health and social care partners ☐	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐		

Month 12 2021/22 Financial Performance

1. PURPOSE OF REPORT

The purpose of the report is to update the Board of Directors on the Trust's financial performance as at Month 12 of 2021/22 and the plan for the 2022/23 financial year.

2. BACKGROUND

Following the suspension of the NHS Planning Process for 2021/22 the Trust and wider ICP / ICS has a fixed level of income to cover its total costs. The ICP and ICS have an overall requirement to break even at the end of the 12 month period.

A number of items of specific reasonable Covid-19 expenditure are reclaimable from NHS England centrally, including the costs of swabbing and vaccinations.

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.

At Month 12 the Trust reported a deficit of £23.4m, which was in line with the year-end forecast position agreed with the NHSE/I Regional Team, supporting the wider ICS to deliver overall financial balance at a system level

3. DETAILS

Trust Position Month 12 2021/22

The Month 12 position is outlined in the table below.

STATEMENT OF COMPREHENSIVE INCOME	Actual £000
Operating income from patient care activities	740,285
Other operating income	59,308
Employee expenses	-475,440
Operating expenses excluding employee expenses	-327,200
OPERATING SURPLUS/(DEFICIT)	-3,047
FINANCE COSTS	
Finance income	36
Finance expense	-24,912
PDC dividends payable/refundable	-3,123
NET FINANCE COSTS	-27,999
Other gains/(losses) including disposal of assets	107
Corporation tax expense	-3
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	-30,942
Add back all I&E impairments/(reversals)	12,756
Remove capital donations/grants/peppercorn lease I&E impact	-5,183
Adjusted financial performance surplus/(deficit)	-23,369

The Trust's operating deficit for the financial year was £3.0m and the overall deficit for the financial year 2021/22 was £30.9m. The adjusted financial position for the purpose of system performance was a deficit of £23.4m.

Operating Income from Patient Care Activities

Under the revised financial arrangements for 2021/22, the Trust's previous aligned incentive contractual arrangement with its commissioners was suspended as in 2020/21. Instead, the Trust was paid under a block arrangement with the exception of the below items:

- HEPC and CDF Drugs
- High cost devices from NHS England
- Elective Recovery Fund income

The Trust's operating income from patient activities is shown in the table below.

INCOME FOR PATIENTS CARE ACTIVITIES	Actual £000
NHS England	243,497
Clinical commissioning groups	493,671
Non-NHS: private patients	931
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	2
Injury cost recovery scheme	2,102
Non-NHS: other	82
TOTAL INCOME FOR PATIENTS CARE ACTIVITIES	**740,285**

Other Operating Income

Other income received during 2021/22 totalled £59.3m and includes all non-direct patient care income.

OTHER OPERATING INCOME	Actual £000
Research & Development	5,262
Education and Training	20,698
Non Patient Care Income	3,404
Reimbursement & Top-Up funding	3,853
Donations - (Assets, Equipment & COVID consumables)	9,675
Other	16,416
TOTAL OTHER OPERATING INCOME	59,308

Employee Expenses (Pay)

The Trusts total expenditure on pay for 2012/23 was £475.4m and a breakdown is included in the table below. Other pay costs include the increased employer pension contribution which is paid centrally by NHSE but reported at an organisation level.

PAY	Actual £000
Ahp'S, Sci., Ther. & Tech.	-66,425
Hca'S & Support Staff	-49,624
Medical And Dental	-137,561
Nhs Infrastructure Support	-63,056
Nursing & Midwife Staff	-137,014
Other Pay Costs	-21,760
TOTAL PAY	-475,440

Operating Expenses excluding Employee Expenses (Non-Pay)

The Trusts total expenditure on operating non-pay for 2012/23 was £327.2m and a breakdown is included in the table below. Expenditure includes all cost relating to clinical delivery and the Trust's response to the COVID pandemic . This includes the costs of swabbing and vaccinations which was reclaimable from NHS England centrally.

NON PAY	Actual £000
Purchase of Healthcare	-12,987
Clinical Supplies & Services	-95,250
Drugs	-78,672
External Staff & Consultancy	-888
Establishment	-12,728
Premises & Fixed Plant	-30,567
Transport	-4,485
Depreciation & Amortisation	-33,042
Research Training & Education	-4,176
PFI Unitary Payment	-31,113
Other	-5,846
Clinical Negligence	-17,446
TOTAL NON PAY	-327,200

Finance Costs

The Trust finance costs totalled £28.0m, including PDC dividends payable of £3.1m, finance costs relating to the PFI contract and a further lifecycle prepayment write off.

Efficiency Savings

For the 2022/23 financial year the Trust has a delivered a efficiency saving of £13.1m which was £1.3m higher than plan. The performance against the efficiency programme is shown in the below table.

CIP	YTD Target £'000	YTD Actual £'000	YTD Variance £'000
Coporate	6,074	7,583	1,509
Procurement	1,582	1,568	-14
Pharmacy	502	214	-288
Clinical Supplies	528	550	22
Estates	1,360	1,898	537
Workforce	1,773	1,288	-485
TOTAL CIP	11,818	13,099	1,281

Capital

The Trust's capital expenditure at the end of March amounted to £47.1m as detailed below:

Scheme	**Capital Plan £000's**	**Outturn £000's**	**Variance £000's**
PFI Lifecycle	3,040	3,040	0
Estates	18,256	18,251	(5)
Medical Equipment	10,554	11,673	1,119
Information Technology	15,200	14,086	(1,114)
Total Spend	**47,050**	**47,050**	**0**
Financed by:			
Depreciation	11,699	10,570	(1,129)
PDC	34,951	19,478	(15,473)
Internal Reserves	0	9,547	9,547
Charitable contributions:			
South Tees Charity	400	400	0
DHSC COVID donations	0	633	633
Other contributions	0	6,422	6,422
Total Financing	**47,050**	**47,050**	**0**

The capital programme reflects the Trust's awards of additional national PDC funding amounting to £19.5m in relation to diagnostics, IT and elective recovery. The Trust delivered its capital programme to plan and in line with the ICS capital allocation which amounted to £17.0 million.

Statement of Financial Position (SOFP)

The following table details the SOFP at the 31 March 2022.

	31 March 2022 **£000**
Property, Plant and Equipment	267,975
Long Term Receivables	3,662
Total Non-Current Assets	271,637
Currents Assets	
Inventories	14,426
Trade and other receivables (invoices outstanding)	13,060
Trade and other receivables (accruals)	14,460
Prepayments including PFI	21,220
Cash	70,554
Total Current Assets	133,720
Current and Non-Current Liabilities	
Borrowings	(89,501)
Trade and other payables	(137,975)
Provisions	(3,147)
Total Current and Non-Current Liabilities	(230,623)
Net Assets	**174,734**
Equity:	
Income and Expenditure Reserve	(258,617)
Revaluation Reserve	39,775
Public Dividend Capital	367,100
Other Reserves	26,476
Total Equity	**174,734**

Liquidity

The cash balance at 31 March amounted to £70.6m.

To 31 March the Trust had paid 92,919 invoices (total value £475.3m) with 87,866 invoices (total value £437.6m) paid within the 30 day target. The Trust's performance against the Better Payment Practice Code (BPPC) target (95%) on cumulative invoices paid to date is detailed as follows:

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
95.8%	96.4%	95.7%	95.3%	95.3%	95.5%	95.4%	95.1%	95.0%	95.0%	94.6%	94.6%

2022/23 Annual Plan

Each year the Trust is required to submit an annual financial plan. The NHS national planning guidance for 2022/23 was published on the 24 December 2021, outlining the priorities and financial arrangements for the NHS for the new financial year, with detailed planning and financial guidance issued from the 14th January. The objectives set out in the planning guidance are based on a scenario where Covid-19 returns to a low level.

For 2022/23, the system-based approach to planning and delivery continues, with each provider trust fully mapped to a single ICS system, and all systems have a breakeven requirement. Trusts are still required to submit organisational plans and these plans must be consistent with their system plan submission.

Under the national planning timetable, provider and system draft plan submissions were required on the 17 March 2022, followed by submission of final plans on 28 April 2022.

The Trust's plan for the 2022/23 financial year is a deficit of £29.6m, measured on a system financial performance basis. The plan has been developed in conjunction with the NHS North East and North Cumbria ICB, with internal review and oversight of provided through the Resources Committee and private meetings of the Trust Board.

STATEMENT OF COMPREHENSIVE INCOME	Plan £000

Operating income from patient care activities	719,031
Other operating income	52,032
Employee expenses	(471,457)
Operating expenses excluding employee expenses	(313,231)
OPERATING SURPLUS/(DEFICIT)	(13,625)
FINANCE COSTS	
Finance income	0
Finance expense	(17,330)
PDC dividends payable/refundable	(4,189)
NET FINANCE COSTS	(21,519)
Other gains/(losses) including disposal of assets	0
Corporation tax expense	(5)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	(35,149)
Add back all I&E impairments/(reversals)	3,974
Remove capital donations/grants/peppercorn lease I&E impact	1,618
Adjusted financial performance surplus/(deficit)	(29,557)

The financial plan has been prepared incrementally from the 2021/22 forecast outturn baseline, and assumes receipt of clinical income in line with the indicative contract envelopes provided by the Trust's commissioners. All contract envelopes include uplifts for National Tariff inflation and for demographic and non-demographic activity growth. The NENC ICB and NHSE envelopes also include additional Elective Recovery Funding, to support post-Covid elective recovery and the delivery of elective and outpatient first attendance activity at 104% of 2019/20 levels (on a tariff value basis). The plan assumes a further £3.8m of ERF funding from NHS Humber and North Yorkshire ICB, which is expected to be included in the final contract offer from the ICB, in line with national planning guidance.

The National Tariff uplift for 2022/23 includes 1.1% efficiency requirement. In addition, the funding available to the ICS for 2022/23 has been reduced by a convergence factor, as the NHS moves away from the temporary Covid-19 financial framework towards a fair share target allocation for each ICS. The additional block funding to support the Covid-19 pandemic response has also been significantly reduced nationally from 2021/22 levels, with an expectation that non-clinical income receipts are restored to pre-pandemic levels. These efficiency requirements are reflected in the Trust's contract envelopes for clinical income and have been reflected in the plan. The Trust's 2022/23 plan assumes delivery of efficiency savings of £23.8m (3% of operating expenses), including expected reductions in non-recurrent Covid-19 operational costs.

The plan includes expenditure inflation assumptions in line with National Tariff inflation rates, adjusted to reflect known local inflation rates for PFI, energy and CNST. The marginal cost of delivering the additional planned activity for 2022/23, including elective recovery, has been included in the plan.

The plan assumes a gross capital programme of £33.1m for 2022/23, as outlined below:

- PFI Lifecycle £12.8m
- Friarage Development (Year 1) £5.0m
- Estates schemes £9.5m
- Medical equipment £3.0m
- Digital £2.8m

Planning and delivery of the Trust's capital programme will be overseen by the Clinical Policy Group and the Capital Planning Oversight Group.

The Trust's allocation from the ICS capital envelope is £15.0m, with the Friarage Development schemed assumed to be funded with capital PDC support. Capital charges have been calculated to reflect the full year effect of 2021/22 capital expenditure, the part-year effect of the 2022/23 capital programme and the impact of implementing accounting standard IFR16 during the year.

The Trust's opening cash position for 2022/23 is £70.6m, reflecting the Covid-19 financial framework that was in place throughout 2021/22. However, due to the Trust's underlying deficit position and PFI contract obligations, the plan assumes receipt of PDC cash support totalling £27.2m over the course of the financial year. The reduced average cash balances during 2022/23 will have an adverse impact on PDC Dividend payable, which has been reflected in the plan.

Internal operational budgets for 2022/23 have been prepared following the budget-setting principles agreed through the Board and Resources Committee, in line with the Trust's financial plan submission. The Covid-19 pandemic has had a significant impact on the Trust's activity, cost base and configuration of services. In order to realign budgets to current operational delivery and expenditure levels, a budgetary 'control total' has been calculated for each Clinical Collaborative and Corporate Directorate, based on current recurrent expenditure run rates, inflation, activity growth and efficiency requirements. Detailed operational budgets are calculated for each service area, within the affordability envelope of the overall relevant Collaborative budget control total.

The Trusts 2022/23 plan is outlined in the table below.

		Budget £000
INCOME FOR PATIENTS CARE ACTIVITIES	NHS England	236,206
	Clinical commissioning groups	479,835
	Non-NHS	1,051
	Injury cost recovery scheme	1,939
Sub Total		719,031
OTHER OPERATING INCOME	Research & Development	4,635
	Education and Training	22,421
	Non Patient Care Income	2,824
	Other	22,152
Sub Total		52,032
PAY	Ahp'S, Sci., Ther. & Tech.	-67,613
	Hca'S & Support Staff	-52,857
	Medical And Dental	-140,442
	Nhs Infrastructure Support	-64,355
	Nursing & Midwife Staff	-144,162
	Other Pay Costs	-2,028
Sub Total		-471,457
NON PAY	Clinical Supplies & Services	-109,495
	Drugs	-81,691
	Establishment	-11,283
	Premises & Fixed Plant	-21,552
	Transport	-4,023
	Depreciation & Amortisation	-30,516
	PFI Operating Expenditure	-31,902
	Clinical Negligence Scheme	-17,230
	Other	-5,539
Sub Total		-313,231
FINANCING	Finance Income	0
	Finance Expenses	-17,330
	PDC Dividend	-4,189
	Corporation Tax	-5
Sub Total		-21,524
FINANCIAL PERFORMANCE ADJUSTMENTS	Add back all I&E impairments/(reversals)	3,974
	Remove capital donations I&E impact	1,618
	Less gains on disposal of assets	0
Sub Total		5,592
Adjusted financial performance surplus/(deficit)		-29,557

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 3 MAY 2022			
Care Quality Commission (CQC) Update Report			**AGENDA ITEM: 15** **ENC 12**
Report Author and Job Title:	Dr Sylvia Wood Interim CQC Compliance Professional	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This paper provides an update on the plans for ongoing work to develop preparedness for future CQC inspections.		
Background	The Trust has an overall rating of "Requires Improvement" given at the last CQC inspection of the Trust in 2019. A detailed action plan was developed to address the regulatory breaches, 26 'must do' actions and 23 'should do' actions.		
Assessment	This paper outlines the ongoing work to prepare for the next full CQC inspection and an update on the initial feedback and actions taken following their unannounced focused inspection which was carried out in February 2022. The CQC attended the trust on the 9th February and 10th to undertake a focussed visit. Initial feedback has been received and the Trust is working with the CQC prior receipt of a final report.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Board of Directors are asked to note the progress that has been made, ongoing and planned work.		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	Principal Risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes Principal Risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☒	

	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒	

Care Quality Commission (CQC) Update Report

1. PURPOSE OF REPORT

This paper provides an update on the unannounced focused CQC inspection which took place across Medicine and Surgery at both the James Cook and Friarage Hospital sites on the 9th and 10th February 2022 and plans for ongoing work to develop preparedness for future CQC inspections.

2. BACKGROUND

The CQC monitors, inspects and regulates NHS trusts. They monitor the quality of care provided using feedback from staff, patients, and partners, and changes to information held in CQC Insight. CQC Insight brings together in one place the information CQC holds about services, and analyses it to monitor services at provider, location, or core service level. Together with the ongoing relationship management between key members of the Trust and the CQC relationship holder, this enables CQC to decide what, where and when to inspect.

CQC attended the trust on the 9th and 10th February to undertake a focussed unannounced visit.

The Trust is preparing for any future full inspection whilst continuing to embed actions from the 2019 report to address the 'must do' actions and 'should do' actions.

3. DETAILS

a. CQC Focused Inspection

The CQC attended the trust on the 9th February and 10th to undertake a focussed visit. Initial feedback has been received and the Trust is working with the CQC prior to receipt of a final report.

b. CQC Project Team

There has been a reassessment of ongoing work and changes made to the team structure. The aim is to embed quality assurance regarding CQC standards into the day to day delivery, reporting and learning of the organisation in a responsive and timely way using a variety of sources. The team will liaise with colleagues and utilise resources within patient safety, clinical effectiveness, patient experience, quality assurance, STAQC, collaboratives, STRIVE etc. Weekly and monthly meetings are being adjusted to support new and ongoing work.

The weekly meeting has been revised to focus on triangulating the hard and soft intelligence about quality; identifying areas of concern, ensuring actions are in place and implemented effectively across the organisation to address deficiencies, with escalation to the monthly meetings.

c. CQC action plan

The CQC action plan from the last full inspection in 2019 has been reviewed and a number of actions have been updated, closed or revised. This is being monitored and reported through the weekly CQC huddle and monthly CQC compliance group. This plan will be reviewed once the final report is received from the unannounced focused inspection.

d. CQC enquiries

When the CQC receive information, they share this with Trusts as a specific enquiry and ask for a response. There are a number of sources of CQC enquiries including from incident reporting to STEIS, NRLS and RIDDOR, complaints from patients, families and carers, whistleblowing, inter-agency safeguarding concerns, Local Authority concerns etc. Themes and learning from recent enquiries are shared at various forms across the Trust.

This is a standing agenda item on the Senior Leadership Team meeting, with discussion and escalation as appropriate.

e. CQC Engagement Meetings

There continues to be ongoing dialogue with the CQC with the last engagement meeting held on 25 April 2022 with the relationship manager.

4. RECOMMENDATIONS

Members of the Board of Directors are asked to note the progress that has been made, ongoing and planned work.

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 MAY 2022			
Annual Filings 2021-22			**AGENDA ITEM: 16** **ENC 13**
Report Author and Job Title:	Jackie White Head of Governance	**Responsible Director:**	Chris Hand Chief Finance Officer Hilary Lloyd Chief Nurse
Action Required	Approve ☒ Discuss ☐ Inform ☐ (select the relevant action required)		
Situation	The Trust has a statutory requirement to produce a number of key documents as part of its annual filings following the end of the financial year. These include the Annual Report, Annual Accounts, Annual Governance Statement and Quality Report (Account).		
Background	Guidance has been received on production of the key documents and a small project group has been established to oversee this work on behalf of the Trust Board of Directors. The timetable for submission of the Annual Report and financial statements has been released by NHS England/Improvement (NHSE/I). This includes a final submission date for the Trusts signed and audited Annual Report and Accounts of 22 June. NHSE/I and the Department of Health and Social Care (DHSC) have also issued draft accounting policies for providers, as outlined in the Group Accounting Manual (GAM).		
Assessment	At this stage there are no issues or risks highlighted with the production of the annual filings.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the progress in developing the key annual filings documentation		
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	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care	Make best use of our resources ☒	

	partners ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒	

South Tees Hospitals
NHS Foundation Trust

Annual Filings 2021-22

1. PURPOSE OF REPORT

- The purpose of the report is to update members of the Trust Board on the preparation of the annual filings for 2021-22:
  - Quality Report (Account)
  - Annual Accounts
  - Annual Report
  - Annual Governance Statement

2. BACKGROUND

The Trust has a statutory requirement to produce a number of key documents as part of its annual filings following the end of the financial year. A programme management approach has been established to oversee this work. A task and finish group has been established and will meet every two weeks to review progress.

3. DETAILS

3.1 Annual report and accounts

The Trusts external auditors, Mazars, will continue to undertake the majority of the audit remotely and similar to how the audit was performed for 2020/21. A number of amendments have been made to the Trusts Accounting Policies following the release of the draft guidance and the GAM and these are outlined in the report.

The Annual report narrative is on track, there are a number of changes to the report for 2021/22 which were highlighted previously to Board – no risks identified.

3.2 Quality Report (Account)

The Quality Report priorities for 2021-22 have been overseen by the Quality Assurance Committee throughout the year.

With regard to 2022-23 an initial engagement event has been held with a sub group of the Council of Governors. The quality priorities were developed using quality indicators from national, regional and local level intelligence, ensuring that the measures are relevant to our population and this has been developed in conjunction with the Governors and approved by the Quality Assurance Committee.

There is no requirement for external audit review.

3.3 Annual Governance Statement

This is on track, there are no changes to the requirements for 2021/22 – no risks to identify at this stage.

4. TIMETABLE

Wednesday 22 June 2022 – NHS providers submit month 12 PFR form (including audited TACs) and audited accounts to NHS Improvement including Annual report

TBC - Laying NHS foundation trust annual report and accounts before Parliament

4. RECOMMENDATIONS

The Board of Directors are asked to note the progress in developing the key annual filings documentation and to seek assurance from the Audit & Risk Committee and Quality Assurance Committee.

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 3 MAY 2022			
Provider Licence Self Certification			**AGENDA ITEM: 17** **ENC 14**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary Chris Hand Chief Finance Officer	**Responsible Director:**	Derek Bell Chairman Sue Page Chief Executive
Action Required	Approve ☒ Discuss ☐ Inform ☐ (select the relevant action required)		
Situation	An assessment has been undertaken against the NHS provider licence. The results are attached for consideration along with a recommendation to approve the assessment.		
Background	All NHS Foundation Trusts are required to self-certify whether or not they have: i) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the NHS Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012 whilst having regard to the NHS Constitution; and ii) the required resources available if providing commissioner requested services (CRS); and iii) complied with governance requirements.		
Assessment	A review of the provider licence and supporting evidence has been undertaken and the following assessment has been proposed: 1. The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6) – **CONFIRMED** 2. The provider has complied with the required governance arrangements Condition FT4(8)- **NOT CONFIRMED**. 3. If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver designated services Condition CoS7(3) – **CONFIRMED**		
Recommendation	Members of the Trust Board are asked to approve the assessment of compliance against the provider licence.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Does this report mitigate risk included in the BAF or Trust Risk	All principal risks		

Registers? please outline		
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)	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒	

South Tees Hospitals
NHS Foundation Trust

NHS Foundation Trust Self-certification

1. PURPOSE OF REPORT

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

2. BACKGROUND

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

3. DETAILS

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

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

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

3.1 Condition G6

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

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

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

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

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

3.2 Condition FT4(8)

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

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

3.3 Condition CoS7

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

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

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

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

- agreed financial plan
- agreed deficit plan with ICS
- planned PDC cash support
- COVID pandemic funding

4. RECOMMENDATIONS

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

APPENDICES

Appendix 1 – self assessment – circulated separately