South Tees Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS (PUBLIC)

Date –1 March 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

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 1 MARCH 2021 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
PATIENT STORY				
CHAIR'S BUSINESS				
1.	Welcome and Introductions	Information	Chair	Verbal
2.	Apologies for Absence	Information	Chair	Verbal
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1
4.	Minutes of the last meetings held on 1 February 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
EFFECTIVE				

	ITEM	PURPOSE	LEAD	FORMAT
11.	Consultant appointments	Information	Chief Executive	Verbal
WELL LED				
12.	Maternity quarterly update	Information	Head of Midwifery	ENC 9
13.	Finance Report	Information	Chief Finance Officer	ENC 10
14.	CQC update	Information	Chief Nurse	ENC 11
15.	Committee Reports	Information	Chairs	Verbal
	DATE OF NEXT MEETING The next meeting of Board of Directors will take place on Tuesday 5 April 2022			

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 February 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 ☒		

South Tees Hospitals NHS
NHS Foundation Trust

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Ada Burns	Non-Executive Director Deputy Chair	2017 2019	Ongoing Ongoing	Role - Governor – Chair of Resources Committee, member of Board of Teesside University. Role – Associate Consultant – Cratus Consultancy, public sector management consultancy
Richard Carter-Ferris	Non-executive Director	1 August 2015	ongoing	Director of Yorkshire Area P2P Club – company generates donations for Yorkshire Air Ambulance. Director/No exec Director – Malton & Norton Golf club ltd.
Mike Ducker	Non-executive Director	1 December 2017 1 December 2005 1 October 2019	ongoing ongoing ongoing	Advisor to UK Government on Chemicals Industry Trustee of Greenstones Christian Trust Charity – a Charity working with prisons in Ethiopia South Tees Healthcare Management Limited - Company number 10166808
Debbie Reape	Non-executive Director Senior Independent Director	August 2019 1 October 2019 October 2019	Ongoing Ongoing Ongoing	Associate Director with Northumbria International Alliance (Northumbria NHS Trust and Northumberland County Council) South Tees Healthcare Management Limited - Company number 10166808. School Governor, Ashington Academy.
Jackie White	Head of Governance	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

Maria Harris	Non-executive Director	1 January 2021	Ongoing	Director of Digital Cat Consultancy Ltd – provider of digital transformation and mortgage expertise in financial services - Company number 11967428 Non-executive Director of United Trust Bank – a regulated specialist bank
David Jennings	Non-executive Director	1 January 2021	Ongoing	Trustee Newcastle University Development Trust 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 April 2018 April 2021	Ongoing Ongoing Ongoing	Trustee Royal Medical Benevolent Fund – no remuneration Chair and Trustee Tenovus Scotland (Edinburgh) – no remuneration 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 1 FEBRUARY 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
Ms M Harris	Non-Executive Director
Mr M Ducker	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 M Imiavan	Digital Director
Mr K Oxley	Director of Estates, Facilities & Capital Planning

Action

PATIENT STORY

Dr Lloyd introduced Ms J Axon who attended to present her story on her experience of care. Ms Axon had recently had a bilateral uni condylar knee replacement undertaken at the Friarage Northallerton, first one in April 2021 second on 22/1/22. On both occasions Ms Axon was discharged home on the same day of surgery.

Ms Axon named a number of staff who had provided exceptional care and support to her.

The Chairman thanked Ms Axon for attending and presenting her story.

BoD/20/379 **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.

BoD/20/380 **APOLOGIES FOR ABSENCE**

There were no apologies for absence.

BoD/20/381 **QUORUM**

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

BoD/20/382 **DECLARATION OF INTEREST**

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

BoD/20/383 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on Tuesday 4 December 2021 were reviewed and agreed as an accurate record. Mrs White

BoD/20/384 **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

BoD/20/385 **CHAIRMAN'S REPORT**

The Chairman firstly thanked all staff working in the Trust and across the NHS and care sector for their contribution to care during the pandemic and throughout the winter period.

He referred members to his previously circulated report and highlighted a number of areas for consideration including his visits to departments across the Trust. Adding that he had visited the Estates and Facilities teams today as part of the Board Walkrounds and that generally feedback was positive but that there were some common themes in relation to support on training.

The Chairman updated that he had met with stakeholders with the Vice Chair.

He attended the Tees Valley Chairs meeting and discussed access to health digitally across Teesside and North Yorkshire, particularly for those who find it more difficult to do so and that health inequalities remain a main focus of interest in particular the elective recovery programme to ensure that those patients who may be disadvantaged are not.

Referring to Same Day Emergency Care (SDEC) the Chairman commented on the exemplar support the Trust's SDEC provided to accident and emergency services and one stop service for emergency care. Dr Stewart added that the Trust's SDEC is developing well and staff and patients are satisfied with the service it provides and that it is definitely impacting on flow into the Trust. He added that over the last month SDEC medicine has opened overnight and processes and pathways working well.

The Chair referred to the Council of Governors meeting which was held in private last week due to reducing the burden the public meeting had been postponed. However there was a good development session held for governors.

The Chairman reported that he had participated in a meeting with General Sir Gordon Messenger on the Review of Health and Social Care Leadership and was pleased to say that the message was inclusive and supportive of NHS leadership going forward. He added that they want to push on a sustainable approach to NHS leadership, local, regional and national will be key recommendation and systems and processes should be consistent across the NHS.

The Chairman handed over to Ms Burns, Vice Chair who reported that he had visited three wards as part of her Health & Wellbeing Guardian role which have been stretched supporting work on COVID and she was encouraged about the messages of support by managers and wellbeing initiatives that are in place within the Trust which staff had discussed with her. She added that there was also a sense of a growing level of confidence working in the challenges of COVID and in many ways some colleagues feeling up skilled as part of this experience. She commented that this was enormously challenging but encouraging.

Ms Burns advised that she had met with the Freedom to Speak Up Guardians to receive their quarterly update and was pleased to report that staff continue to speak up and there continues to be positive outcomes and feedback for staff who had taken up the opportunity to speak up in a timely fashion. The team have been providing advice and support to the newly appointed Guardian and North Tees & Hartlepool NHS Trust around processes and systems.

RESOLUTION

The Board of Directors NOTED the Chairman's report.

BoD/20/386 **CHIEF EXECUTIVE'S REPORT**

The Chief Executive referred to her previously circulated report and highlighted a number of areas for consideration including the ongoing high levels of staff sickness due to COVID-related absence and the high volumes of patient attendance. She advised that this winter has seen huge pressures. There is tiredness on the shop floor and hopefully those staff will get some time off over Easter and half term. She added that this is an extraordinary time for community and hospital based staff and gave a heartfelt thank you for staff.

The Chief Executive updated that the vaccination program is continuing extremely high staff vaccination rates

Finally the Chief Executive updated that we have seen a strong development of clinical leadership through the Trust's Clinical Policy Group and collaborative chairs and this group has now stepped up to make sure all the right decisions are taken at the right time. This has made such a difference, very calm and collective.

RESOLUTION

The Board of Directors NOTED the Chief Executive's update

BoD/20/387 **BOARD ASSURANCE FRAMEWORK**

Mrs White referred members to the report on the Board Assurance Framework report and highlighted that 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.

Four assurance reports are being considered today in the Public Board of Directors meeting which contribute to the assurance received in the Board Sub Committees.

Mrs White highlighted that the level of assurance this month as dropped to limited due to reducing the burden and impact on Board Sub Committee agendas.

The Chairman thanked Mrs White for the update and advised that it was important for the positive assurances to be highlighted in the report.

RESOLUTION

The Board of Directors NOTED the BAF

BoD/20/388 **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 that the Trust performance for December 2021 reflects a significant increase in COVID-19 infections in our communities due to the COVID-19 Omicron variant. This has placed demands on primary, emergency and acute care and social care, with COVID-19 related staff absences adding pressures to service delivery across the system.

- Sickness absences (5.76%) remained high
- Access targets including 4-hour and ambulance handover delays have been challenging across the region, work continues with ECIST and focus on emergency care pathways and reducing ambulance handover delays.
- Validated elective activity returned closer to pre-Covid levels, with outpatient activity and day case activity exceeding our plan.
- The financial position remains on plan
- Incident reporting has maintained consistently increased levels which reflects a positive reporting culture.
- The falls rate in December remained within normal variation limits,
- There is a sustained improvement in prescribing antibiotics, and improvement in serum lactate and urine measurement, in the sepsis care bundle.
- There was an improvement in overall waiting times in November, and a reduction in the total patients waiting over 52 and 104 weeks for treatment, where our improvement trajectory was met. We are over 800 patients lower than trajectory with less than 1600 patients at the end of December.
-

- With regard to patients who have waited more than 2 years we are very close to our plan with 70 patients waiting and a plan to have no patients waiting by the end of March longer than 2 years.
- November validated Cancer 14-day access has maintained the shift to pre-COVID-19 levels. 31-day access standard continues to be monitored. Zero tolerance of cancellation of cancer surgery on the day of surgery was maintained.

Ms Reape asked if there had been any moderate or serious incidents around elective programme and Mr Peate confirmed that the staffing and demand pressures have not translated into a reduction in the quality of patient care being delivered.

The Chairman asked regarding health inequalities and Mr Peate confirmed that the policy context for the second half of the financial year as set out in the Operational Planning guidance continues to focus on local health outcomes and addressing health inequalities. He added that we are routinely providing the data into Collaborative chairs and CDs to monitor all activity and deprivation around protected characteristics.

Mr Harrison added that we are working with our Local Authorities colleagues regarding a joint public health post which will focus on access to secondary care for areas of the population most deprived.

Ms Burns commented that she was pleased to see the introduction of a metric on readmission rates and asked for further information regarding the commentary in the report regarding the 3.85% and whether this is good or where would we like it to be. Dr Stewart commented that this is really good and a new one for us to explore further. Typically readmission rates run around 12% in health systems, but we need to be cognisant around the impact of outreach services and how much of it links to COVID and the public's continued reluctance to attend hospital..

Ms Burns thanked Dr Stewart for his update and asked if other Trusts were measuring this indicator. Mr Peate advised that we haven't done any benchmarking across Trusts as yet, but GIFRT reports at speciality level generally tend to show favourable against peers.

The Chairman asked if it related to emergency and elective and Mr Harrison advised that it was all emergency readmissions and elective and that the December figure and will need to include validated information which might have tipped into January.

Mr Jennings thanked colleagues for the work on developing the IPR and advised that external colleagues who had received a copy of it had also commented that it was a much better report. He added that we acknowledge things that go well and what's required to getting back to our best. The commentary and numbers align well and key themes are supported by data. We can use Committees to delve into the detail of individual metrics and scrutinise them in more detail and what comes to Board is the helpful summary you provide and this feels the right balance.

RESOLUTION

The Board of Directors NOTED the update

BoD/20/389 **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 95.4% as per table 1 demonstrating good compliance with safer staffing. Actual registered nurses on both days (84.9%) and nights (85.8%) have seen a reduction against planned. Staffing has continued to be a challenge across the trust with short notice unavailability associated with Covid isolation and Covid related absence.

In-line with national pandemic guidance, stretch ratios have been implemented where necessary based on skill mix, acuity and occupancy levels, with all of these actions agreed by senior nurse through safe care.

The introduction of allocate on arrival shifts for RNs and HCAs (6 per day and night at JCUH and 1 per day and night at FHN) has seen improved take-up in January, these shifts are promoted daily via ward manager platforms and NHSP messaging.

Nursing Turnover for December has reduced to 8.21%.

Ms Reape commented that nursing turnover has decreased and asked what the national benchmark is. Dr Lloyd advised that this is around 10% although it may have changed recently.

Ms Burns asked colleagues how it feels at the moment with regard to nurse staffing and are we seeing an improvement with the challenges. Dr Lloyd advised that we are seeing improvement and have seen the sickness levels reduce, staff are anxious when the numbers of COVID patients went up as high as they did, staff are tired and need time to rest and recuperate.

RESOLUTION

The Board of Directors NOTED the safer staffing report

BoD/20/390 **CONSULTANT APPOINTMENT**

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

Christopher Lawrence – Infectious Diseases
Glen Pinto – Anaesthetics

The Chief Executive thanked the following staff who have left the Trust:

Adrian Clements - ED
Gill Ingram – Older Person's Medicine / Stroke
Dave Ryall – Anaesthetics
Nicola Storey – Radiotherapy & Oncology
Nick Stratford – Cardiac Anaesthesia

RESOLUTION

The Board of Directors NOTED the update

BoD/20/391 **MATERNITY QUARTERLY UPDATE**

Dr Lloyd on behalf of the Head of Midwifery presented the maternity quarterly update which highlights the current position of maternity services, confirms the work that has been carried out to date and areas where further focus is required with regards the Ockenden, CNST, and maternity transformation.

Ms Reape confirmed that as Maternity Board Champion she regularly undertakes walk rounds and has noted that staff are tiered but are well supported. She added that staff will welcome the digital investment.

Ms Reape asked Dr Lloyd was the Trust continuing to support and keep fathers involved post COVID. Dr Lloyd advised that there is clear guidance in place with visiting and we have implemented this as close as possible, in delivery the fathers have been supported to attend.

RESOLUTION

The Board of Directors NOTED the maternity update

BoD/20/392 **FINANCE REPORT MONTH 9**

Mr Hand presented the month 9 finance report and advised 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 9 the Trust reported a deficit of £4.0m at a system control total level. This is in line with the required budget deficit for M9 as agreed within the ICP/ICS.

Mr Hand referred members to his report and highlighted that the clinical income is under achieving of £0.5m is due to the HEPC and CDF drugs income being less than plan, offset by a corresponding underspend in the expenditure position.

With regard to pay this is overspent by £0.8m, Medical and Dental staff show a year to date overspend of £1.5m. Additional costs relate to increases in premium pay for IPA claims and internal locum shifts, along with increases in headcount for junior doctors.

Highlighting operating Non-pay expenditure Mr Hand confirmed this is overspent by £1.8m at Month 9, Drugs have a year to date overspend of £5.0m. This overspend is due to increased drugs costs within Gastroenterology, Neurology, Haematology and Ophthalmology, with costs being linked to increased activity levels.

Establishment costs have a year to date overspend of £1.8m, largely driven by increases in ICT systems costs of £1.2m.

Finally the Trust's capital expenditure at the end of December amounted to £15.2m. These are timing delays at this stage based on the forecast profile at the time of submitting the plan. It is currently anticipated that the plan apart from one scheme will largely be delivered in full by 31 March and the Trust will continue to closely monitor the position over the coming months

The Chairman referred to the increased maternity pathway income and Mr Hand advised that this related to activity and more births.

Ms Burns commented on the CIP report and confirmed that she now attends as non executive Director. She advised that there has been good level of engagement and good work being done to establish the plans and challenges of delivery.

Ms Burns further added that she had visited the Collaborative Chairs as part of the Board Walkrounds today and commented that there had been a good discussion on the CIP and noted that we need to remember that when we are looking at the issues some financial pressure are as a result of positive developments in treatments and length and complexity of conditions. She added that digital investment is clearly a significant enabler for eliminating waste and the Chairs were keen to see that the Board is supporting in making effective bids for improving digital connectivity.

Mr Oxley advised that they are very keen to eliminate waste and the digitisation agenda will see them have the tools to make them more efficient in the way they provide treatment.

Dr Stewart added that the Collaborative Chairs have matured a lot in a short time and are having the right level of debate and it is gratifying to see the quality of debate being held.

Mr Harrison commented that there was a presentation at CPG on the planning guidance and implications for next year. It was well attend and looked at opportunities and what needs to be done.

RESOLUTION

The Trust Board of Directors NOTED the report

BoD/20/393 **CQC UPDATE**

Dr Lloyd referred members to the previously circulated report and highlighted the completed and ongoing work to prepare for the next CQC inspection.

The Chairman thanked Dr Lloyd for the update and advised that it is important to recognise that the Trust want to make this as business as usual.

RESOLUTION

The Board of Directors NOTED the report

BoD/20/394 **COMMITTEE REPORTS**

The Chairman offered the Chairs of Committees an opportunity to highlight any other business not already covered by the agenda.

Quality Assurance Committee – Ms Reape referred members to the previously circulated Chairs logs for December and January. She added that the Committee remains focussed on SIs and learning from Never Events and at the last meeting there was a discussion around how some of the open actions will be closed and learning taking place. She added that the Committee signed off the quality strategy and received a

report on the HSE visit held in September.

People Committee – Ms Harris referred members to the December and January Chairs logs and added that the Committee had discussed Mandatory vaccine timescales and how the Trust was working with staff to encourage vaccine uptake, assurance was also sought around long term sickness absence and supporting staff in terms of mandatory training.

Mr Carter Ferris added that the Committee gave its thanks to the teams in the Trust supporting staff with the vaccination.

The Chair added that he had raised the vaccination programme with the Tees Valley Chairs and with local MPs who recognised the work the Trust had undertaken.

Resources Committee – Mr Ducker advised that there was no meeting in December, however January focussed on CIP and noted that it is currently weighting towards non recurrent and this needs to move towards recurring. High level information on planning guidance was received and Finance teams are working through budget setting and we will see gradual tightening on finance position.

The Chairman commented that next year will be a tough year for the NHS in general.

Mr Hand concurred and added that the glide path position is to get back to sustainable funding levels so COVID funding will be significantly reduced again next year and we will work through the position with the guidance issued.

Joint Partnership Board – The Chairman verbally updated that the Committee had established a sub group which had met recently involving lead governors.

BoD/20/395 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Board of Directors will take place on 1 March 2022. Close

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	Board development session in November to consider - action to be taken forward by Board Sub Committees - March 2022	Open
7.11.21	BoD/20/350	patient experience and involvement report	Patient Experience report to include the reasons for re-opened cases.	H Lloyd	Mar-22	Next report due in April and will be covered then	Open
7.11.21	BoD/20/350	patient experience and involvement report	Benchmarking report of re-opened complaints	H Lloyd	Mar-22	Next report due in April and will be covered then	Open

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 March 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 NHS COVID-19 Pressures

In line with the NHS as a whole, the trust has continued to face high demand across its services due to surge in COVID-19. Despite the pressures, the trust is able to deliver good, safe care for patients. As I write this report the Trust has started to see a drop in COVID positive patients with currently 97 inpatients with a positive PCR result within their hospital stay.

2.2 Department and site visits

Since the last Board meeting, I have continued to undertake site and departmental visits including meeting with colleagues in Research & Development, ED, Estates and Friarage ward based services.

2.3 Meeting with MPs

As part of my broader induction programme, I am continuing to meet with MPs and Local Authorities.

2.4 ICB development

Interviews have started for the executive roles for the ICB and information on the appointments should be briefed in March by Samantha Allen, chief executive designate for the North East and North Cumbria Integrated Care System.

The Department of Health and Social Care (DHSC) published the integration white paper, Joining Up Care for People, Places and Populations, outlining the government's ambition to accelerate the delivery of joined-up health and social care at place level.

It sets out an expectation for each place to: have a single accountable person by Spring 2023; develop a set of shared outcomes by April 2023; and move towards a "significant" proportion of NHS and social care funding pooled/aligned at place level.

It also sets out how progress will be made to support the key enablers to integration such as digital, data and workforce.

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 – 1 March 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 and winter update

The sharp increase in COVID-19 community infections this winter saw a peak of 176 patients receiving hospital care with the virus in January.

The reduction in community infection rates which began in January saw a gradual reduction in the the number of patients with COVID-19 receiving hospital care.

Despite the enormous success of the vaccination programme, screening pathways and infection prevention control measures to reduce the risk to vulnerable patients and service users have remained in place.

The sharp increase in COVID-19 community infections this winter inevitably impacted on our colleagues as well as the wider public. As services recover from this winter's COVID-19 Omicron surge, the STAQC (South Tees Accreditation for Quality of Care) programme, developed by clinical colleagues, will continue to be rolled out across our wards and services.

Separately, in the five weeks (to 3 February) surgical teams delivered more than 3,300 operations, of which almost 2,500 were planned procedures. At the same time, over 70,000 outpatient appointments took place.

In the same period, urgent and emergency care services remained very busy with 18,000 people attending services – an increase of more than 5,000 on the same period last year.

COVID Medicines Delivery Unit

The results from the latest REACT coronavirus monitoring study (published in January) show that that around two thirds of people with Omicron had previously had COVID-19.

The same study also found that vaccination and improved treatment options have led to a reduced risk of being admitted to hospital, and a consistently lower risk of death.

This winter, our infectious diseases team became one of the first in our region to offer new antibody and antiviral treatments to eligible patients when they first test positive for coronavirus.

When eligible patients in the community with a range of conditions including cancer, liver disease, immune deficiencies and neuro disorders report a positive PCR test, they are clinically assessed by and invited to receive appropriate medication as an outpatient. Since beginning, more than 800 people have accessed the service.

COVID-19 vaccination as a condition of deployment

On 31 January, the Secretary of State for Health and Social Care announced a consultation to remove vaccination as a condition of deployment.

Vaccination rates for our colleagues remain extremely high and remain the best defence against COVID-19.

Novavax vaccine approval

The Novavax vaccine was given official approval in February by the Medicines and Healthcare products Regulatory Authority.

The Durham Tees Valley Research Alliance, consisting of South Tees Hospitals NHS Foundation Trust, North Tees and Hartlepool NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust, contributed to the research.

The Novavax study is the largest ever double blind, placebo-controlled trial to be undertaken in the UK.

It recruited over 15,000 participants from 35 research UK sites – including more than 500 from the Durham Tees Valley area.

2. RECOMMENDATIONS

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

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 1 March 2022			
Board Assurance Framework			**AGENDA ITEM: 8, ENC 6**
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. Staffing continues to be highlighted in a number of reports due to COVID-19 impacting (isolation and sickness) on well led and cqc must do actions including mandatory training. However there is no impact on delivery of care to patients as identified in the IPR and safer staffing report. The Finance report and IPR discuss the financial position for month 10 drawing on the work of the Collaboratives and Improvement		

	Councils established to support the CIP for the Trust. Maternity report on Ockenden highlights the work which has been undertaken and how assurance is gained through the newly established Maternity Assurance Board and Quality Assurance Committee.	
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 assurance**

Assurance reports have been received in the operational decision making structure of the Trust and closed Board sessions which provide further assurances against gaps in assurance in the BAF. These include:

- Estates update
- Medium Term Financial plan
- Performance meeting established with Collaboratives
- CIP Steering group established with NED representation
- Improvement Councils established across Collaboratives
- Clinical Policy Group check in reports from Collaboratives
- Elective recovery programme report to Clinical Services and Improvement Group and CPG
- Health inequalities group established
- Reports on digital operability, Pathology, clinical services strategy development and joint working across the Tees Valley to the Joint Partnership Board
- Board development session on 15 February to agree CIP

3.3 **Assurance levels**

During **February 2022** assurance levels were reported for each report being submitted to a Board Committee. The breakdown is as follows:

None	Limited	Moderate	Significant
1	3	20	2

The balance between internal and external assurances was as follows:

Internal	External
26	0

4. RECOMMENDATIONS

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

APPENDICES
BAF

South Tees Hospitals
NHS Foundation Trust

Board Assurance Framework (BAF): February 2022

This BAF includes the following Principal Risks (PRs) to the Trust's strategic priorities:

- 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
- A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water, IT), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period and compromises ability to deliver high quality care
- Failure to recruit to full establishment, retain and engage our workforce
- Failure to deliver as a centre of excellence, resulting in a lack of priority and recognition from commissioners and other stakeholders
- Working more closely with local health and care partners does not fully deliver the required benefits
- Failure to agree with the system and achieve the Trust's financial strategy resulting in regulatory action and inability to delivery strategic objectives

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level)
- Risk ratings – initial, current and target levels
- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (**Averse** = aim to avoid the risk entirely; **Minimal** = insistence on low risk options; **Cautious** = preference for low risk options; **Open** = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment strategy identified for each threat and opportunity, each assigned to an executive lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance functions** (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers)
- Clearly identified gaps in the primary control framework, with details of planned responses each assigned to a member of the Senior Leadership Team (SLT) with agreed timescales risk

Key to lead committee assurance ratings:

Green (significant) = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity
- no gaps in assurance or control AND current exposure risk rating = target
OR
- gaps in control and assurance are being addressed

Amber (moderate) = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

Red (limited) = Negative assurance: the Committee is satisfied that there is sufficient reliable evidence that the current risk treatment strategy is not appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

South Tees Hospitals
NHS Foundation Trust

Principal risk - 1 (what could prevent us achieving this strategic priority)	**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**	**Strategic Objective**	**Best for safe, clinically effective care and experience**

Lead Committee	Quality Assurance Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk type**	
Executive Lead	Chief Nurse/Chief Medical officer	**Likelihood**	4. Likely	4. Likely	3. Possible	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	4. Major	4. Major	3. Moderate	**Risk treatment strategy**	
Last reviewed	17.02.22	**Risk Rating**	16. Extreme	16. Extreme	9. High		
Last changed							

Threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / action to address gaps inc timescales and lead** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
1.1 Significant reduction in patient satisfaction due to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality	Corporate, Collaborative and Directorate structures, accountability & quality governance arrangements at Trust including: • Tier 1 Board Sub Committee and sub structure review undertaken and implemented July 2021. • New governance structure for Risk Management identified and implemented October 2021 • Nursing and Midwifery and AHP meeting • Clinical policies, procedures, guidelines, pathways • Clinical audit programme & monitoring arrangements considered at QAC and Audit Committee • Clinical staff recruitment, induction, mandatory training, registration & re-validation • Defined safe nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) • Ward accreditation programme - STACQ • Nursing & Midwifery Strategy • Sign-off process for incidents and Sis and Never Events • Established and robust QEIA process • Freedom to speak up process in place • Patient Experience sub group in place • Shared learning on quality and safety via weekly, monthly briefings Trust wide and at CPG/SLT	**Management:** Learning from deaths Report to QAC and Board quarterly SI/NE report to QAC and Board monthly EoLC Strategy and Annual Report to QAC Senior leadership walk arounds weekly Deep Dives of critical services at QAC (ED, Ophalmology, Gastroenterology, Critical Care) Guardian of Safe Working report to People Committee and Board quarterly Safeguarding Annual Report to QAC December 2021 Medical Education update report to People Committee quarterly Freedom to Speak up report to People Committee and Board quarterly Medicines Optimisation Report to QAC quarterly Revised structure for mortality / learning from deaths report to QAC July 2021 CQC preparation plan for future inspection report to QAC and Board monthly AHP Strategy drafted and action plan in place – received by People Committee CQC insights report reviewed by QAC October 2021 Thematic review of never events QAC December 2021 **Risk & compliance:** IPR - Quality Dashboard Monthly QAC and Board Quality Priorities Report Qtrly to QAC Health & Safety meeting escalation report to QAC	Develop AHP Strategy – Ms Mhalanga – revised date *March 2022* (People Committee) In order to improve the depth and quality of our clinical coding in general, and mortality KPIs (e.g. SHMI, HSMR, RAMI etc.) in particular, our Trust has embarked on a clinical coding improvement plan – Mr Imiavan – May 2022	**Moderate**

	• Medical Examiner's office in place	Urgent items for escalation at QAC monthly **Independent assurance:** CQC Rating and oversight (monthly relationship) ICNARC Quarterly Report to Clinical Effectiveness Group Audit Inpatient Survey 2019 and 2020 GMC Feedback to People Committee Care Quality Commission / External Regulation Care Quality Commission / External Regulation Report to QAC CCG Directors of Nursing in attendance at QAC Internal Audit reports PWC (in line with the Internal Audit Plan -; SIs, Prescribing) NHSE/I Never Events critical friend report considered by Safe & Effective Care Group August 2021 CQC monthly deep dives (Clinical support services; Medicine, Surgery) verbal feedback CQC insights report		
1.2 An increase in the incidences of infectious disease (such as CDIF, influenza; Coronavirus; norovirus; infections resistant to antibiotics) that forces closure of one or more areas of the hospital	Infection prevention & control programme, policies, procedures, staff training and audits PFI arrangements and cleaning standards Review panels of all trust apportioned of all infection disease incidents Clinical Audit programme and monitoring arrangements. Ward accreditation programme - STAQ Weekly IPC huddles Antibiotic stewardship programme in line with revised QAC reporting structure Daily outbreak report aligned to COVID Weekly regional outbreak meeting 14 HCA/PPE marshals / Fit testers and in place Matron for IPC appointed and team capacity increased Cohorting and isolation of patients in line with best practice Increased Critical Care single rooms by 2 in recent months as part of Covid monies	**Management** IPC reporting in line with revised QAC governance structure Reports to IPC Group IPC Annual report to QAC December 2021 IPC breaches report – IPC Group Bid for the elective recovery fund for a modular decant ward with 24 single rooms submitted – Board report EOI in the New Hospitals Programme submitted COVID19 nosocomial rate reporting **Risk and Compliance** IPC Committee escalation report to QAC IPR quality metrics report to QAC and Board monthly Cleaning standards report to IPC group **Independent Assurance** IBAF CQC review PLACE assessment and scores	Compliance with SOP and Policies - further work required to ensure compliance being explored – ongoing monitoring	**Moderate**
1.3 Lack of IT and administrative systems and processes for organisational learning from events such as incidents, complaints and claims, resulting in patient harms and poorer outcomes	Serious Incident Report (monthly) Serious Incident Investigations (root cause) Safety Bulletins – weekly and monthly Quarterly Patient Experience Report Real time patient experience reporting Clinical Audit programme and monitoring Collaborative Board meetings Review panels (Serious Incident, Pressure Ulcers, Falls, Deteriorating Patients, C. Difficile) Mortality Reviews Medical Examiner reviews	**Management** Monthly SI and Never event report to Quality Assurance Committee Implementation of the revised quality governance structure and sub groups Integrated Quality Report to QAC Patient Experience Quarterly report Digital update to QAC on quality & safety issues November 2021 **Risk and compliance**	Train key staff on incident investigation techniques to support increase in reporting culture – commenced – Mr Bennett – January 2022 Embed a sustained learning culture in line with trust vision, values and behaviours , civility and a just culture – Dr Connolly/ Mr Bennett – January 2022	**Moderate**

	Safety@stees collaborative Induction and education sessions for staff Patient Safety Faculty Clinical support unit development Regional Getting to good programme Weekly quality and safety wall Regular EQIA panels considering service changes and impact on safety Incident reporting upgrade - DATIX cloud	IPR quality report to QAC and Board monthly Quarterly Health & Safety group review of incidents DATIX incident reporting levels monitored against NRLS Freedom to speak up Guardians quarterly report to People Committee Patient safety promises campaign Patient Safety and Quality Strategy December 2021 **Independent Assurance** NRLS Benchmarking National Staff Survey to People Committee External Audit Independent assessment of Quality Report Internal audit report on Sis (PWC) CQC engagement meeting Internal and External Risk Summits on critical services NHSE/I Quality Board (stood down) NHSE/I Peer review on never events Quality Report (Account) July 2021 to QAC Patient Experience Audit Report	Identify and agree which existing metrics would provide evidence for measuring the impact of learning and culture change (eg staff survey; FTSU; SI report on incident reporting; moderate and above incident reporting) – Mr Bennett / Dr Connolly – *date changed to 2 months after publication of staff survey – tbc (shared report to QAC and People)* Development of patient safety faculty – commenced – Dr Connolly – *date changed* December 2021 Increase number of staff who are training in human factors (linked to 21/22 Quality Priority) – Mrs Winnard / Mr Bridle – January 2022 (People Committee) Prepare organisation for the implementation of the patient safety incident report framework – Mr Bennett/Dr Connolly – January 2022 Implement recommendations from Patient Experience audit report February 2022	
1.4 Arising from a lack of engagement with staff at all levels around cultures and behaviours required to embed best practice, continuously learn and deliver high quality patient care.	Trust vales and behaviours agreed and shared with staff Just culture training – roll out Civility and Human factors training – roll out Ward accreditation programme Reciprocal mentorship programme – roll out Freedom to speak up guardians Patient Safety Faculty Patient Safety Champions / Ambassadors Weekly / monthly safety and quality briefings Revised QAC governance sub group structure Appointment of Clinical Collaborative Chairs CPG Constitution Falls and Pressure Ulcers Structure Judgement Reviews - weekly Senior Leadership Visibility programme Incident investigation and complaints training – roll out Patient Safety Ambassadors recruitment and appointment process	**Management** Report and feedback on training for just culture, civility and human factors to People Committee Implementation of new Freedom to speak up model Roll out plan for ward accreditation programme agreed with QAC and CPG CPG constitution agreed and roll out Quarterly report to People Committee culture and leadership QAC sub structure implemented **Risk and Compliance** Reciprocal mentorship programme agreed and roll out for training commencing October 2021 – reported through People Committee **Independent** National Staff survey results	Prepare organisation for the implementation of the patient safety incident report framework – Mr Bennett/Dr Connolly – January 2022	**Moderate**

		Freedom to speak up national survey Feedback from NHSE/I on review of never events		
1.5 Lack of responsive and accessible services due to inability to deliver national performance standards	Patient Flow process in place Standard operating procedures and policies in place Trust and System escalation process Trust leadership of and attendance at A&E Board Deep dive into high risk areas, risk assessment and recovery plans monitored on a weekly basis as part of an incident control methodology Working with primary care and other stakeholders to manage demand through diversion and re-provision Single QSG review of constitutional standards and escalation of high risk areas SI process Clinical Harm review process Intensive support package agreed with NHSE/I and lead Director and network for support in place Emergency capital funding received and SDEC implemented, Paediatric ED being established Weekly touchpoint meeting with Commissioners Daily touchpoint meeting on patient flow	**Management** Reports to Board on Winter preparedness Monthly reports on COVID strategic decision to Board (Wave 1 and 2) Improvement Plan Phase 1 and reports to Board Recovery plans for high risk services and updates to Board and Committees and CPG Response to NHSE/I letter of 31 July 2020 (updated 7 August 2021) about the third phase of the NHS response to COVID-19 through CPG/SLT Response to NHSE/I letter of 20 August on Elective through CPG/SLT Assurance Framework for managing the implementation of the recovery plan with Collaboratives agreed by SLT **Risk and compliance** QAC review and deep dive into critical areas Clinical Policy group addressing key issues and deterring the allocation of resources based on clinical priorities Improvement recovery plan Phase 2 - capacity and demand updates to CPG IPR report to Board monthly and sub committees Strategic Command structure and recovery structures in place Recovery and Improvement Plan phase 2 presented to the Board **Independent Assurance** ECIS improvement work on patient flow Internal audit of patient flow (to be received)	Implement recommendations from the Internal audit on flow and waiting times – Mr Peate –April 2022 (Resources Committee) Implement the recommendations from the improvement work identified by ECIS – Mr Peate – review initial work January 2022 (Resources Committee)	**Limited**
1.6 Current estate, lack of capital investment and infrastructure compromises the ability to consistently delivery safe, caring, responsive and efficient patient care, world class services	Improved access now in place for lifecycle investment (not available due to COVID restrictions currently Feb 21) Capital planning group in place Planned maintenance processes in place Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Low levels of back log maintenance Available wards for decanting (not available due to COVID restrictions currently Feb 21) Emergency capital bid 2020/21 Prioritised 5 year Capital plan developed and submitted to ICS for consideration	**Management** 5 year prioritised Capital Plan received by Resources Committee and Board and submitted Regionally January 2021 Expression of Interest (EOI) – New Build Hospital Programme Elective Recovery Programme – Targeted Investment Fund (TIF) Friarage Hospital Estates Update Capital Programme for this financial year 21/22 Quarterly updates on Capital to Resources Committee Estates paper to Board January 2022 **Risk and Compliance** Report on lifecycle to Resources Committee Report on capital to Resources Committee quarterly		**Limited**

		Independent Assurance PLACE assessments ISO accreditation for medical engineering CQC report from July 2019 Visit by David Black and Alan Foster re Critical Care investment Elective Recovery Programme – Targeted Investment Fund (TIF)		

Principal risk - 2	**A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire or security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period and compromises ability to deliver high quality care**	**Strategic Objective**	**Best for safe, clinically effective care and experience**

Lead Committee	Quality Assurance	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk type**	
Executive Lead	Director of Estates	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	5. Catastrophic	5. Catastrophic	5. Catastrophic	**Risk treatment strategy**	
Last reviewed	17.02.22	**Risk Rating**	20. Extremely High	15. Extremely High	10. High		
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
2.1 A large-scale cyber-attack that shuts down the IT network and severely limits the availability of essential information for a prolonged period	Information Governance Assurance Framework Cyber security programme Major incident plan in place Spam and malware email notification ns circulated	**Management** Data Protection and Security Toolkit submission 19/20 **Risk and compliance** Board cyber training 2019 **Independent assurance** Cyber internal audit report – weaknesses identified	Internal Audit report recommendations on cyber to be implemented – S Orley – October 2021 (Resources Committee) Date protection and security toolkit for 2020/21 to be completed – S Orley – October 2021 (Resources Committee) Board cyber training scheduled for March 2022	**Moderate**
2.2 A critical supply chain failure that severely restricts the availability of essential goods, medicines or services for a prolonged period (EU exit)	EU Exit task and finish group review of operational response plan for monitoring issues following Brexit SRO for EU Exit appointed Premises Assurance Model (PAM) Estates Governance arrangements with PFI partner Emergency preparedness, resilience and response (EPRR) arrangements at regional, Trust, Centre and service level Operational strategies and plans for specific types of major incident, business continuity and critical incidents Strategic, tactical and operational command for major incidents Trust Resilience Forum and EPRR operational group EPRR Strategy in line with National EPRR framework Training and testing exercises undertaken annually Annual assessment against EPRR core standards On call arrangements in place	**Management** Health & Safety Annual report Condition survey report Procurement Strategy reviewed at Resources Committee Procurement report quarterly to Resources Committee **Risk and compliance** Business Continuity Plan report to Audit & Risk Committee February 2022 **Independent assurance** Premises Assurance Model report EPRR report EPRR Core Standards compliance report Water safety report	Commission independent report into supply chain issues which are being identified nationally regarding demand and impact on delivery of capital programmes (Resources Committee)	**Significant**

South Tees Hospitals NHS Foundation Trust

Principal risk - 3	**Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain**	**Strategic Objective**	**A great place to work**

Lead Committee	People Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk type**	
Executive Lead	Director of HR	**Likelihood**	5. Almost Certain	4. Likely	3. Possible	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	4. Major	3. Moderate	3. Moderate	**Risk treatment strategy**	
Last reviewed	16.02.22	**Risk Rating**	20. Extreme	12. High	9. High		
Last changed							

Threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / action to address gaps inc timescales and lead** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
3.1 Ability to attract and retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources. Failure to have effective workforce plans that anticipate and prevent shortages arising from retirements, shortfalls in all recruitment and retention plans	Vacancy management and recruitment systems and processes Safe nurse staffing levels for all wards and departments managed through daily huddles and escalation through to tactical and strategic Temporary staffing approval and recruitment process in place Specialist recruitment campaigns Work / link with university medical school and Memorandum of Understanding Nurse recruitment days AHP recruitment days International nurse recruitment programme Return to practice programme for nursing vacancies Flexible retirement and return process Increased apprenticeship workforce People Plan work stream on addressing workforce shortages HR Policies and procedures Engagement strategy (including rewards and recognition; engagement tools) Staff Engagement Group Visibility of leadership Board walk rounds Health and Wellbeing Strategy Exit interviews Workforce metrics contained in IPR STAR awards Partnership working compact with medical and staff side Pulse survey and staff survey (national) Freedom to speak up process Staff networks in place for some protected characteristics Contracting arrangements in place for SERCO and sub	**Management** Quarterly reports to People Committee on the 5 key workstreams in the People Strategy – ED&I, Health & Wellbeing, Leadership and Culture, Workforce Shortages, Sense of Belonging Safe Nursing Staffing levels report to Board monthly Use of resources in relation to staff reported to Resource Committee Disciplinary Report quarterly Finance report to Resources Committee on collaborative agency spend Report on new roles November 2021 – quarterly updates Impact of strike action considered at December 2021 **Risk and compliance** Guardian of Safe Working report to Board May 2020 Freedom to speak up report quarterly People Committee review of risks on a monthly basis IPR workforce metrics reviewed by People Committee and Board monthly **Independent Assurance** NHSI use of resources report 2018 CQC inspection report July 2018 NHS staff survey 2020 results showing improvement in a number of areas	AHP workforce plan to be implemented – R Mhalanga March 2002 Report on Junior Doctors rota gaps and risk, establishment and mitigation – Dr Lal – February 2022 . Implement and then review the impact of the hard to recruit medical workforce campaign – L Lucas Hartley – March 2022 Collaborative Chairs to share workforce plans with People Committee – *updated date January 2022* Workforce plan for Nursing; Workforce plan for Medical and Workforce Plan for AHP to be presented – D McKeown, Dr Lal and R Mhalanga – May 2022 Independent assurance required on e roster & allocate system to establish best use of resources – Resources Committee – Director of HR, Dr Lal, Dr Lloyd - Independent audit review to be	**Moderate**

	contractor workforce at the Trust Year on year increase in volunteer workforce Nursing & Midwifery Strategy Workforce plan and accountability framework		commissioned- February 2022 _____ Assess the level of risk on implementing Mandatory vaccinations across the workforce – initial update December 2021; further update required once guidance issued _____ Establish the metrics which the Trust will use to review resilience of staff during the pandemic Mrs Metcalf – March 2022	
3.2 Poor health and absence within our workforce creating service pressures impacting their ability to deliver a high quality service	Welfare calls to staff who are absent Health & wellbeing support programme Staff weekly briefing Psychology support and mental health support Occupational Health and counselling and physio service Wobble rooms established across sites for staff to recover and recoup Project Wingman (staff rest and support programme) Long covid clinics for staff Menopause programme insomnia intervention programme and fatigue support Flu and covid vaccination programme Hardship fund for staff Policies and procedures in place for managing absence	**Management** Quarterly reports to People Committee on the Health & Wellbeing Staff survey action plans at Collaborative level presented to the People Committee Leadership update report regarding embedding wellbeing Report on Workforce Retention regarding health and wellbeing conversations Health & wellbeing conversations embedded in Appraisal documentation and appraisal documentation rolled out across Trust **Risk and compliance** Occupational Health accreditation award in 2021 Bronze **Independent Assurance** NHS staff survey 2020 results showing improvement in a number of areas	Embed wellbeing into leadership and management programmes – 3 month review of feedback programme Ms J Winnard – February 2022 _____ Embed conversations about flexible and agile working as standard practice – through embedding the culture; quarterly review of grievances to be reviewed as assurance *Mrs R Metcalf – date amended March 2022* _____ Work towards the Better Health at Work Award which will assist in embedding health and wellbeing into the workplace. Mrs R Metcalf - April 2022 --- Support financial wellbeing by implementing a programme of workshops for colleagues who are considering retirement and require support with pension planning. *Lead and date amended - Ms Herdman – March 2022* _____	**Limited**

			Staff redeployment – output of pulse surveys undertaken with staff following redeployment to be shared – *Mrs McKeown – date and lead amended to March 2022*	
3.3 Lack of an embedded agile workforce does not allow culture change and utilise technology to change work practices and to work differently which should increase the effectiveness of the service and deliver benefits to staff and patients.	Agile working policy with 'flexible choice' for working hours and ensuring our staff had adequate rest, recuperation and support. Staff Side colleagues to embed wellbeing into our HR Covid-19 Policy Pulse surveys Trust vales and behaviours agreed and shared with staff Freedom to speak up guardians Home working forum in place	**Management** Freedom to speak up report quarterly Quarterly reports to People Committee on Health & Wellbeing Report on grievances – quarterly Report on staff retention – home working **Risk and compliance** **Independent Assurance**	*Implement flexible working workstream programme including training package, refresh of policy and engagement conversations and undertake a review of impact – Ms Herdman – April 2022* _____ Ensure appropriate training programmes in effectiveness of technology and investment are implemented Mrs Metcalf and Mr Imiavan February 2022	**Limited**
3.4 Our culture and organisational development programme is not progressed leading to poor staff morale, less empowered teams, lack of progress of the equality and diversity agenda and less positive engagement.	BAME risk assessments ED&I strategy Workshop and roll out of values and behaviours Learning and development programme for staff development Weekly staff communications Schwartz rounds Collaborative staff survey action plans STAR awards and local GEM awards Freedom to speak up champions Improvement Plan with OD interventions linked to critical services Affina programme Human factors training Leadership and development programme Just culture and civility saves lives programme Culture workshops and values agreed and launched across the Trust Staff networks in place for some protected characteristics	**Management** ED&I Annual report WRES and WDES report to People Committee Quarterly report to People Committee on ED&I Reciprocal mentorship programme in development Values based recruitment process roll out January 2022 **Risk and compliance** Freedom to speak up self-review Board 2019 Freedom to Speak Up Guardian report quarterly to Board Guardian of Safe Working report to Board; Gender Pay Gap report to People Committee **Independent Assurance** NHS staff survey 2020 results showing improvement in a number of areas Critical Care junior doctor survey discussed at People Committee 2021	*Review feedback from onboard programme and include in quarterly report to People Committee – Ms Herdman – next engagement report*	**Moderate**

South Tees Hospitals NHS Foundation Trust

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

Lead Committee	Trust Provider Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk type**	
Executive Lead	Chief Medical Officer	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	4. Major	4. Major	4. Major	**Risk treatment strategy**	
Last reviewed	25.02.22	**Risk Rating**	16. Extreme	16. Extreme	8. High		
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
4.1 Lack of a clear vision for the improvement journey which engages staff and development the improvement capability leading to a failure to deliver sustainable change and the improvements required.	2 Year Strategic plan and objectives agreed and nine enabling strategies and plans identified Improvement plan Phase 1& 2 People Plan Nursing & Midwifery Strategy Communications & Engagement Strategy Estates Plan R&D Plan Leadership development plan and programmes including quality improvement, team and service support, coaching and human factors CPG constitution Collaborative Chairs in place Mission, Vision and Values agreed and rolled out Leadership and Safety Academy Integrated performance report CQC project group STACQ accreditation Improvement Councils established Performance Meetings with Collaboratives Patient Safety Ambassadors Clinical Strategy & improvement Group Recovery groups meeting 3 times per week Maternity Assurance Group Emergency Care Group Outpatient Improvement group Surgical improvement group	**Management** 2 year strategic plan signed off by Board in May 2021 Board development sessions on 2 year strategic plan CPG constitution signed off Improvement & recovery plan signed off by Board Reports to People Committee on delivery of the People Plan Reports to Quality Assurance Committee on safety and quality Report to Resources Committee on CIP and sustainability CQC deep dives – Medicine and Surgery CQC self-assessment of Directorates **Risk and Compliance** B2B feedback on improvement strategy CQC insights and NQS data received and analysed by BIU and reviewed in QAC sub structure GIRFT reports and external visits including HSE September 2002, CQC focussed visit reviewed at Directorate and Committee level **Independent Assurance** One of the highest ranked medical training organisations HEE Annual Report Wellbeing national award - Bronze Top 100 Apprenticeship Employer Other external regulator such as UCAS for Urology; Anaesthetic ACSA	Refresh Digital Strategy to be approved by the Resources Committee – Mr Imiavan – June 2022 To ensure all appropriate areas have undertaken a STACQ by 31.3.22 - Dr Lloyd Establish and identify trajectories for improvement aligned to the revised IPR – Mr Peate – 31 March 2022 Refresh improvement strategy - Lucy Tulloch – 31 March 2022	**Moderate**
4.2 Failure to deliver a programme of change in	Improvement Plan phase 1 and 2 Recovery plan including trajectories for improvement	**Management** Recovery plan reported monthly to Resources	ICS review of vulnerable service – M Stewart – date	**Limited**

support of fragile or vulnerable services leading to a loss of quality, efficiency, outcomes and workforce shortages	Winter Plan Strategic & Winter weekly meeting Elective recovery programme Bespoke programmes of support to critical / fragile services Collaborative structure in place from April 2021 Clinical Strategy and Improvement Group Quality Improvement programme Medical and Nursing leadership changes implemented Medical Management Structure implemented ICS/ICP workstreams on vulnerable services SROs & SLT leads for all Collaborative and critical services (CCU, ED and Maternity) Surgery Tees Valley workstream with SRO in place Maternity Assurance Group Emergency Care Group Outpatient Improvement group Surgical improvement group Implement a recruitment campaign and support package for hard to recruit areas	Committee, Winter & Strategic Group IPR monthly to Committees and Board CPG oversight and sign of of recovery trajectories Monthly reports to QAC on critical services, eg ophthalmology Deep dives by QAC on critical services CPG check in reports from Collaboratives **Risk and Compliance** Output of Surgery Tees Valley workstream report into Tees Clinical Strategy Group and then Joint Partnership Board ECIS improvement package of support and assurance **Independent Assurance**	ECIS improvement package of support implement recommendations (Resources Committee) Mr Peate – 31.3.22 Regional maternity assurance visit scheduled – Dr Lloyd	
4.3 Failure to be a leading centre for research and innovation centre	STRIVE centre for innovation Research Network across Tees Valley R&D Director and team in post R&D Strategy Medical Management Model Research programme	**Management** Reports to QAC on R&D and Board quarterly EOI for capital development **Risk and compliance** MOU with Teesside University for strategic links Collaborations with HEIs **Independent Assurance** Elective Recovery Programme – Targeted Investment Fund (TIF)	Develop Individual research units in conjunction with R&D Director across specialities, eg Cardiology – R&D Director / M Stewart – ongoing Innovation database to be shared and understood – S Brown	**Limited**
4.4 Inability to recruit clinicians in specialist and sub speciality fields	Consultant recruitment panels with NED Chair Recruitment process now managed by CMO office Clear systems and processes on recruitment gaps and risks Alternative workforce development plan discussed at CPG Implement a recruitment campaign and support package for hard to recruit areas	**Management** Report on new consultants and leavers to People Committee, SMSC and Board monthly Weekly report on consultants to CEO/CMO Report to people committee on alternative roles for hard to recruit to roles Workforce plans by Collaboratives developed and reviewed at people Committee February 2022 **Risk and compliance** **Independent Assurance** Actions completed from internal audit report on recruitment	Explore CESR program to establish in house training of consultant staff – Dr Lal – date Consider further opportunities for joint appointments – Managing Director – ongoing	**Moderate**

4.5 Failure to adopt best practice or develop innovative practice due to inadequate systems and process	Clinical Strategy and Improvement Group Improvement and Recovery plan Phase 2 Clinical effectiveness group Getting to Good NHSE/I support group Improvement Councils to deliver quality improvement opportunities	**Management** Clinical Effectiveness quarterly report to QAC GIRFT report by speciality and quarterly report to QAC on quality CQC insights report reviewed in sub structure of QAC CQC deep dives into Medicine and Surgery **Risk and compliance** CQC insights report **Independent Assurance**	Routine use of benchmark and / or information used by regulators such as CQC insight report consider by Governance Structures in Trust – Who – I Bennett 31.12.21 (QAC)	**Limited**

Principal risk - 5	**Working more closely with local health and care partners does not fully deliver the required benefits**	**Strategic Objective**	**Deliver care without boundaries in collaboration with our health and social care partners**

Lead Committee	Trust Provider Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk type**	
Executive Lead	Chief Executive / Managing Director	**Likelihood**	5. Almost Certain	4. Likely	2. Unlikely	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	4. Major	4. Major	4. Major	**Risk treatment strategy**	
Last reviewed	25.02.22	**Risk Rating**	20. Extreme	16. Extreme	8. High		
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
5.1 Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	ICS CEO meeting ICS Management Meeting Joint development of plans at ICS level Provider Collaborative meetings and workstreams Representation on ICP/ICS and Provider Collaborative work streams Tees Valley ICP Executive Group Tees Valley ICP Compact Exec to Exec meetings with CCG and Trust Finance Directors Group Capital Plan Joint Partnership Board MOU and TOR	**Management** Partnership reports including Chairs log & Chairs update from JPB to Board Resources Committee Chairs log to Board Planning update to Resource Committee & Board Finance update to Resource Committee & Board **Risk and Compliance** **Independent Assurance** Provider licence modifications lifted in relation to governance	Work with the ICP to further the expectations to strengthen ICP working - Managing Director – 31.3.22 Consider further opportunities for joint appointments – Managing Director – ongoing Consider the impact of the ICS/ICB in terms of system decision and risks – Managing Director & Head of Governance – 31.3.22 Work with the ICB and stakeholders to influence the opportunities with the new financial formula and transition – Mr Hand and Mr Harrison – end March 2022	**Moderate**
5.2 Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	Improvement Plan Phase 1 and 2 Continued engagement with commissioners and ICS/ICP developments in clinical service strategies Partnership working with NTHT and CDD TV Clinical Services Strategy Board TV & ICS Population Health workstreams Health Inequalities Group JPB MOU and TOR	**Management** Partnerships including Chairs log from JSB to Board Resources Chairs log to Board Planning update to Board Elective recovery programme report to Strategic and recovery groups, Clinical Services and Improvement Group **Risk and Compliance** **Independent Assurance**	Development of a co-produced clinical services strategy for the ICP – Chief Medical Officer – 31.3.22 Consider the impact of the ICS in terms of system decision and risks – Managing Director & Head of Governance – 31.3.22 Consider the impact of Spec Com in light of ICS structure and governance – Mr Hand – 31.3.22 Recruitment of Joint Director of Public Health with LA colleagues – end of March 2022 – Mr Harrison	**Limited**

5.3 Failure to modernise the workforce profile to deliver integrated working and efficient use of resources for care across boundaries	ICS/ICP Workforce work stream JPB MOU and TOR Agreement of joint posts as they arise in JPB Digital operability mobilisation across Trusts	**Management** Partnerships including Chairs log from JPB to Board Pathology integration updates to JPB Digital operability report to JPB Nursing and Medical joint working report to JPB **Risk and Compliance** **Independent Assurance**	Fully implement the passport to work across Trusts – Mrs Metcalf – 31.3.22 Implementation of digital connectivity across Trust sites – Mr Imiavan – 31.3.22	**Limited**
5.4 The Trust will not maximise its potential to contribute to the public health agenda if it does not coordinate its focus on prevention and healthy living with the wider health and social care system	Joint Partnership Board Objective of the JPB included in the MOU Representation on Live Well (South Tees) Board Population Health workstreams at ICP/ICS IPR monitoring impact of deprivation levels and access Health inequalities Group	**Management** IPR report to sub committee and board monthly Elective recovery plan report to Clinical Services and Improvement Group and updates provided at Resources Committee and Board **Risk and Compliance** **Independent Assurance**	Recruitment of Joint Director of Public Health with LA colleagues – end of March 2022 – Mr Harrison Identify at speciality level the impact of health inequalities – Mr Hand 31.3.22	**Limited**
5.5 Joint working with North Tees & Hartlepool NHS Trust through Joint Strategic Board does not work effectively to deliver the benefits to the local population including the effectiveness of the Joint Strategic Board and Joint Chair	Joint Chair appointed Memorandum of Understanding, vision and values Joint Partnership Board (Committees in Common) including TOR Joint Board to Board, Council of Governors to Council of Governor development sessions Joint Nomination Committee (Committees in Common) Vice Chair job role supporting joint chair role Stakeholder Engagement with Local Authorities , MPs and local population, CCGs Tees Valley ICP Executive Group Tees Valley ICP Compact Exec to Exec meetings with CCG and Trust Finance Directors Group Representation on ICP work streams	**Management** Joint Partnership Board and governance framework in place and approved by Trust Board Chairs log & chairs update from JPB to Trust Board Interim Joint Chair update Expression of Interest (EOI) – New Build Hospital Programme joint with NTHT **Risk and Compliance** B2B feedback on joint working positive **Independent Assurance** Elective Recovery Programme – Targeted Investment Fund (TIF)	Development of a co-produced clinical services strategy for the ICP – Chief Medical Officer – 31.3.22 Development of a communications strategy – Mr Graham 31.12.21	**Moderate**

South Tees Hospitals
NHS Foundation Trust

Principal risk - 6	Inability to agree financial recovery plan with the regulator	Strategic Objective	Make best use of our resources

Lead Committee	Resources	Risk Rating	Initial Rating	Current Rating	Target	Risk type	
Executive Lead	Chief Finance Officer	Likelihood	5. Almost Certain	5. Almost Certain	3. Possible	Risk appetite	
Initial date of assessment	21.5.21	Consequence	4. Major	4. Major	4. Major	Risk treatment strategy	
Last reviewed	12.10.21	Risk Rating	20. Extreme	20. Extreme	12. High		
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
6.1 Inability to demonstrate to the regulator the causes of the deficit and a credible recovery plan to address those elements within the Trust's control	Medium Term Financial Assessment Plan Resources Committee Trust Board Joint Strategy Board ICP Finance Directors ICS Finance Directors Tees Valley CEO meeting ICS Management Executive Reference Costs and PLICS Clinical Strategy and Improvement Group Improvement Councils established CIP steering group established	**Management** Ongoing updates to SLT, CPG and CSIG Annual report and accounts Annual Governance Statement Medium Term Financial Assessment plan agreed by Resources Committee & Board and submitted to NHSE/I Final Medium Term Financial Assessment plan agreed by Resources Committee & Board and submitted to NHSE/I **Risk and compliance** Updates to Board and Resources Committee monthly Updates to ICP DoFs Financial recovery meeting with NHSE/I held July 2021 B2B meeting outcome letter from R Barker re MTFA August 2021 *Board Development session 15 February 2022 to agree CIP and response to NHSE/I* **Independent assurance** Review of PFI costs – Deloitte External audit of annual account NHSE/I monthly finance monitoring Provider licence restrictions – Letter from Tim Savage	PLICs development plan – Mr Hand – 31 March 2022	**Moderate**
6.2 Insufficient time afforded by the regulator to develop and implement a recovery plan	Medium Term Financial Plan Resources Committee Trust Board Joint Strategy Board ICP Finance Directors ICS Finance Directors Tees Valley CEO meeting ICS Management Executive Clinical Strategy and Improvement Group	**Management** Ongoing updates to SLT, CPG and CSIG Annual report and accounts Annual Governance Statement Final Medium Term Financial Assessment plan agreed by Resources Committee & Board and submitted to NHSE/I CIP reports to Resources Committee quarterly CIP programme established	Agree within the system a credible and appropriately challenging CIP programme – Mr Hand – ongoing discussions through JSB and ICP – November 2021	**Limited**

	CIP Group established with weekly meetings in place PMO and programme management established Improvement Councils established Additional resource provided and Kingsgate commissioned to support CIP process Improvement Councils established CIP steering group established	*CIP Steering Group established with NED input* *Board Development session 15 February 2022 to agree CIP and response to NHSE/I* **Risk and compliance** Updates to Board and Resources Committee monthly Updates to ICP DoFs Financial recovery meeting with NHSE/I held July 2021 B2B meeting outcome letter from R Barker re MTFA August 2021 and November 2021 Kingsgate assurance report **Independent assurance** Review of PFI costs – Deloitte External audit of annual account NHSE/I monthly finance monitoring Provider licence restrictions – Letter from Tim Savage		
6.3 Insufficient revenue resources available across the ICS to support the phasing of the Trust's proposed recovery plan	Resources Committee Trust Board Joint Strategy Board ICP Finance Directors ICS Finance Directors Tees Valley CEO meeting ICS Management Executive Contracting working group established across NT and ST MTFA Delivery Plan	**Management** ICS/ICP updates through Finance report and CEO report to Committees and Board JSB MOU & TOR COVID financial framework **Risk and compliance** Regional Directors (2019) review of system savings report Ongoing discussions with NHSE/I *Board Development session 15 February 2022 to agree CIP and response to NHSE/I* **Independent** ICP/ICS Plan submission approval by NHSE/I	Lack of recognition of PFI costs on revenue and the provision within ICS to meet the structural costs – Mr Hand – ongoing discussion – resolve December 2021 Agree with the Commissioner the additional investment to address the cost of the safety issues – Mr Hand – ongoing discussions – need to agree as part of the ICS handover March 2022	**Limited**
6.4 Insufficient capital resources available across the ICS to support the phasing of the Trust's capital investment requirements	PFI Contract management Capital planning group Planned maintenance programme Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Emergency capital bid 2021/22 1 year Capital Plan agreed Prioritised 5 year Capital plan developed and submitted to ICS for consideration Medical Devices Group Fixed Asset register Risk register	**Management** Chairs log from H&S Group to QAC regarding Medical Quarterly update to Resources Committee on Capital PFI contract management Lifecycle report to Resources Committee **Risk and compliance** Expression of Interest Capital Planning agreed by Resources Committee LINAC report to Resources Committee Community Diagnostic Hub report recommended by Resources Committee and approved by Board *Estates report to Board February 2022* **Independent assurance** Internal audit reports	Agree with ICS sufficient capital resource to address the Trust investment requirements over the short and medium term - Mr Hand – March 2022 subject to planning guidance	**Limited**

6.5 Lack of cooperation from ICS partners to support allocation of ICS resources to the Trust	ICS/ICP Director of Finance meeting ICS Capital Planning / Estates Managers meeting Joint working with NTHT TV Clinical Services Strategy and Board TV CEO meeting ICS Executive Management Meeting Joint Strategy Board ICS/ICP plan	**Management** ICS/ICP updates through Finance report and CEO report to Committees and Board JSB MOU & TOR **Risk and compliance** Regional Directors (2019) review of system savings report Expression of Interest Capital Planning agreed by Resources Committee LINAC report to Resources Committee Community Diagnostic Hub report recommended by Resources Committee and approved by Board *Board Development session 15 February 2022 to agree CIP and response to NHSE/I* **Independent** ICP/ICS Plan submission approval by NHSE/I	Agree risk share agreement across ICS – Mr Hand – March 2022 Delivery of the regional directors (2019) system savings to be reviewed by ICP – Mr Hand – as part of ICS handover March 2022	**Limited**

South Tees Hospitals
NHS Foundation Trust

Principal risk - 7	Failure to deliver the Trust's financial recovery plan	Strategic Objective	Make best use of our resources

Lead Committee	Resources	Risk Rating	Initial Rating	Current Rating	Target	Risk type	
Executive Lead	Chief Finance Officer	Likelihood	5. Almost Certain	5. Almost Certain	3. Possible	Risk appetite	
Initial date of assessment	21.5.21	Consequence	4. Major	4. Major	4. Major	Risk treatment strategy	
Last reviewed	18.02.22	Risk Rating	20. Extreme	20. Extreme	12. High		
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
7.1 Insufficient capacity to identify and deliver the required level of savings opportunities	Resources Committee Budget setting principles and budgets in place CIP planning CIP monitoring programme and infrastructure Clinical Collaborative framework CPG Clinical Strategy and Improvement Group PLICS pilot in General Surgery GIRFT Improvement Councils established CIP steering group established	**Management** Directorate level finance reports Annual report and accounts Annual Governance Statement National Cost Collection report to Resources Committee September 2021 **Risk and compliance** Finance to Board and Resources Committee monthly including CIP progress IPR report to Board and Committees Provider licence self-assessment *Board Development session 15 February 2022 to agree CIP and response to NHSE/I* **Independent assurance** Internal audit External audit NHSE/I monthly finance monitoring	Delivery of the regional directors (2019) system savings to be reviewed by ICP – Mr Hand – as part of ICS handover March 2022 Review of finance structure to ensure fit for purpose to support directorates and Collaboratives financial management – Mr Hand – interim posts September 2021, full review by December 2021 Develop PLICS, Model hospital reporting and interpretation of data – Mr Hand - initial reporting started to Resources Committee August 2021, pilot for collaboratives established with General Surgery August 2021 – full roll out to be agreed	**Moderate**
7.2 Potential loss of grip and control during transition to new clinically led structure	Day to day budget management processes in place Finance business partners - qualified Policies and procedures for managing financial control Cash flow forecast Finance Investment Board in place quality assuring business cases for revenue Capital Planning Group in place quality assuring business cases for capital Business case process in place Corporate Governance Framework (SFI/SO, Scheme of delegation in place) Vacancy control plan in place CPG Constitution Collaborative Chairs meeting Agency and locum sign off process	**Management** Directorate level and department level finance reporting Cost centre level finance reports Business cases reviewed by FIB / Capital Planning CPG decision making on budgets and capital planning Budget sign off Annual accounts Update SFI/SOs in line with Collaborative Structure agreed by Audit Committee **Risk and compliance** Finance report to Board, Resources Committee Procurement report to Resources Committee *Board Development session 15 February 2022 to agree CIP and response to NHSE/I*	Review of finance structure to ensure fit for purpose to support directorates and Collaboratives financial management – Mr Hand – interim posts September 2021, full review by December 2021 Develop PLICS, Model hospital reporting and interpretation of data – Mr Hand - initial reporting started to Resources Committee August 2021, pilot for collaboratives established with General Surgery August 2021 – full roll out to be agreed Contract uncertainty – agree with	**Limited**

	Purchasing via procurement frameworks and NHS supply chain Improvement Councils established CIP steering group established	**Independent** Going concern and financial controls audit as part of External and Internal audit programme Regional finance returns monthly (H1/H2)	Commissioners – Mr Hand – ICS handover March 2022	
7.3 Unexpected cost pressures leading to unplanned overspends	Day to day budget management processes in place Finance business partners - qualified Policies and procedures for managing financial control Cash flow forecast Corporate Governance Framework (SFI/SO, Scheme of delegation in place) Vacancy control plan in place CPG Constitution Collaborative Chairs meeting Agency and locum sign off process Purchasing via procurement frameworks and NHS supply chain ICS/ICP Director of Finance meeting Joint working with NTHT CIP group in place with agreed governance and reporting structure	**Management** Directorate level and department level finance reporting Budget sign off ICS/ICP updates through Finance report and CEO report to Committees and Board **Risk and compliance** Finance report to Board, Resources Committee Procurement report to Resources Committee **Independent** Going concern and financial controls audit as part of External and Internal audit programme Regional finance returns monthly (H1/H2)	Review of finance structure to ensure fit for purpose to support directorates and Collaboratives financial management – Mr Hand – interim posts September 2021, full review by December 2021 Agree risk share agreement across ICS – Mr Hand – March 2022	**Limited**
7.4 Inability to agree contracts with commissioners to provide the planned levels of clinical income	Resources Committee Contracting team BIU team NHS Standard Contract and guidance Costing information Joint NTHT Contract Contract meetings Contracting working group established across NT and ST	**Management** Finance report Contracting guidance **Risk and compliance** Finance report to Board, Resources Committee **Independent** NHSE/I independent costing assurance audits	Contract uncertainty – agree with Commissioners – Mr Hand – ICS handover March 2022	**Limited**
7.5 Insufficient capital resources available to support innovation and transformation	Capital planning group in place Planned maintenance processes in place Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Emergency capital bid 2021/22 1 year Capital Plan agreed Prioritised 5 year Capital plan developed and submitted to ICS for consideration Medical Devices Group Fixed Asset register	**Management** Chairs log from H&S Group to QAC regarding Medical Quarterly update to Resources Committee on Capital PFI contract management Lifecycle report to Resources Committee **Risk and compliance** Expression of Interest Capital Planning agreed by Resources Committee LINAC report to Resources Committee Community Diagnostic Hub report recommended by Resources Committee and approved by Board *Estates update to Board February 2022* **Independent assurance**	Agree with ICS sufficient capital resource to address the Trust investment requirements over the short and medium term - Mr Hand – March 2022 subject to planning guidance	**Limited**

		Internal audit reports		
7.6 Inability of system partners to support or implement system wide opportunities	ICS/ICP Director of Finance meeting ICS Capital Planning / Estates Managers meeting Joint working with NTHT TV Clinical Services Strategy and Board TV CEO meeting ICS Executive Management Meeting Joint Strategy Board ICS/ICP plan	**Management** ICS/ICP updates through Finance report and CEO report to Committees and Board JSB MOU Finance report to JSB on opportunities across the TV **Risk and compliance** Regional Directors (2019) review of system savings report **Independent** ICP/ICS Plan submission approval by NHSE/I	Agree risk share agreement across ICS – Mr Hand – March 2022 Delivery of the regional directors (2019) system savings to be reviewed by ICP – Mr Hand – as part of ICS handover March 2022	**Limited**
7.7 Failure of key infrastructure (equipment, IT and Estates) impacting on operational delivery	Capital planning group in place Planned maintenance processes in place Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Emergency capital bid 2021/22 1 year Capital Plan agreed Prioritised 5 year Capital plan developed and submitted to ICS for consideration Medical Devices Group Fixed Asset register Digital Director appointment made and commenced in post August 2021	**Management** Chairs log from H&S Group to QAC regarding Medical supplies PFI contract management Lifecycle report to Resources Committee Capital update report to Resources Committee **Risk and compliance** Expression of Interest Capital Planning agreed by Resources Committee LINAC report to Resources Committee Community Diagnostic Hub report recommended by Resources Committee and approved by Board *Estates paper to Board February 2022* **Independent assurance** Internal audit reports	Agree with ICS sufficient capital resource to address the Trust investment requirements over the short and medium term - Mr Hand – March 2022 subject to planning guidance Update to digital strategy – Mr Imiavan – *date updated in line with audit June 2022*	**Limited**
7.8 Failure to advance digital maturity will impact on efficiency, care quality and safety	Business case for MIYA IT Business Continuity and Incident Management plans Programme for upgrade to Network infrastructure Capital Investment approved and programme of delivery for identified capital plan including infrastructure and desk top hardware Digital Strategy group MIYA programme board Engagement on GNCR SIRO Digital leadership meeting in place fortnightly NED and Associate NED appointed with digital skills background Digital Director appointment made and commenced in post August 2021	**Management** Business Case for MIYA approved by Board Digital updates to Resource Committee monthly **Risk and compliance** Digital roadmap produced and included in Improvement Recovery Plan for Board Digital operability report to JPB **Independent assurance** NHS digital review of Tees Valley PWC have completed audits of Cyber Security and the Data Security & Protection toolkit. Digital governance audit by PWC – high risk	Update to digital strategy – Mr Imiavan – *date updated in line with audit recommendation – June 2022* Complete implementation of recommendations from NHS digital review – *Mr Imiavan – June 2022* Complete the delivery of MIYA roll out – Mr Imiavan – September 2022	**Limited**

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 March 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	The following changes have been implemented in January's IPR: Single Oversight Framework summary slide included. Caesarean section rate target removed as peer NHSE&I letter 15 February 2022. Emergency readmission rate reporting one month behind (November 2021 this month) due to the impact of incomplete coding on this indicator. Palliative care coding and comorbidity coding reporting period aligned to mortality index reporting period. **Our key messages for January are:** • Trust performance in **December 2021-January 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 pressures to service delivery across the system.		

	• Due to the ongoing nature of the COVID-19 pandemic, **sickness absences** remained high, reflected in **training** and **appraisal** compliance. Staff well-being has been at the forefront of the trust's clinically-led response to the pandemic, and changes to national guidance on COVID-19 isolation guidance have been adopted to minimise the impact of staff isolation on absence levels. • The **falls** rate in January increased, however, the rate of falls with harm, remained low. • As seen across the NHS region, **Access targets** including **4-hour** and **ambulance handover delays** have been challenging due to the higher volumes of attendance seen across the system and continued pressures caused by COVID-19, and this is reflected in **patient experience**. • Despite challenges of COVID-19, **elective inpatient activity** exceeded our plan. • The **financial position** remains on plan and the team is focussing on preparing for the next financial year and delivery of the Coding Action Plan. Collaborative leadership teams have been asked to focus on confirming normal cost improvement plan delivery for 2021/22, plans for 2022/23 in-line with milestone expectations and longer term and transformational changes to achieve operational excellence and sustainability. HR, Finance, Business Intelligence and Service Improvement support is aligned to this through the Collaborative Improvement Councils. The Board sub committees have reviewed their specific elements of the IPR.	
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐ (select the relevant assurance level)	
Recommendation	Members of the Public Trust Board of Directors are asked to note the Integrated Performance Report for January 2022.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	All BAF 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	Make best use of our resources ☒

	with our health and social care 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 ☒	

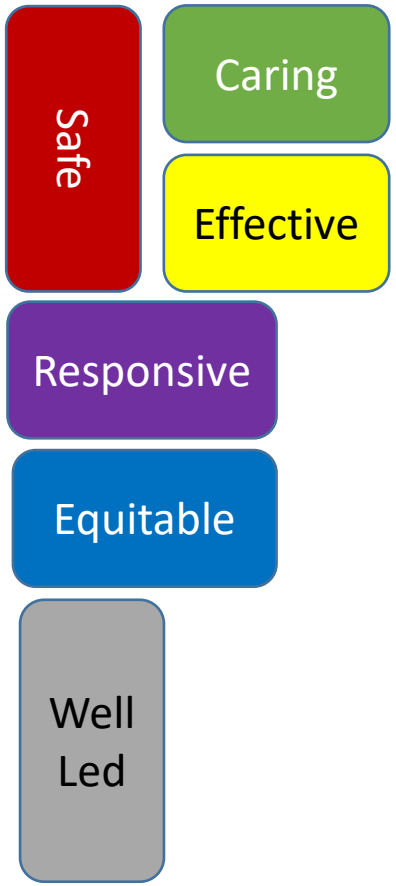
South Tees Hospitals
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT

January 2021

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 THIS MONTH

Single Oversight Framework summary slide included.

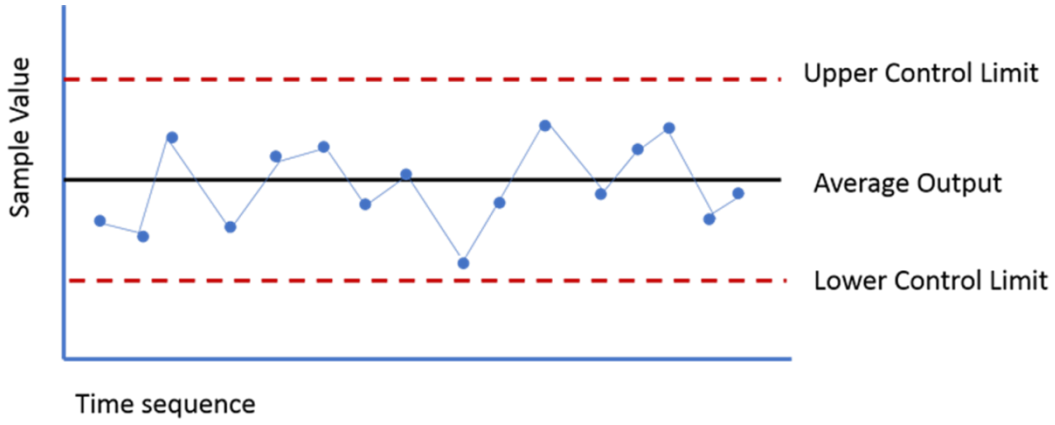
Caesarean section rate target removed as peer NHSE&I letter 15 February 2022.

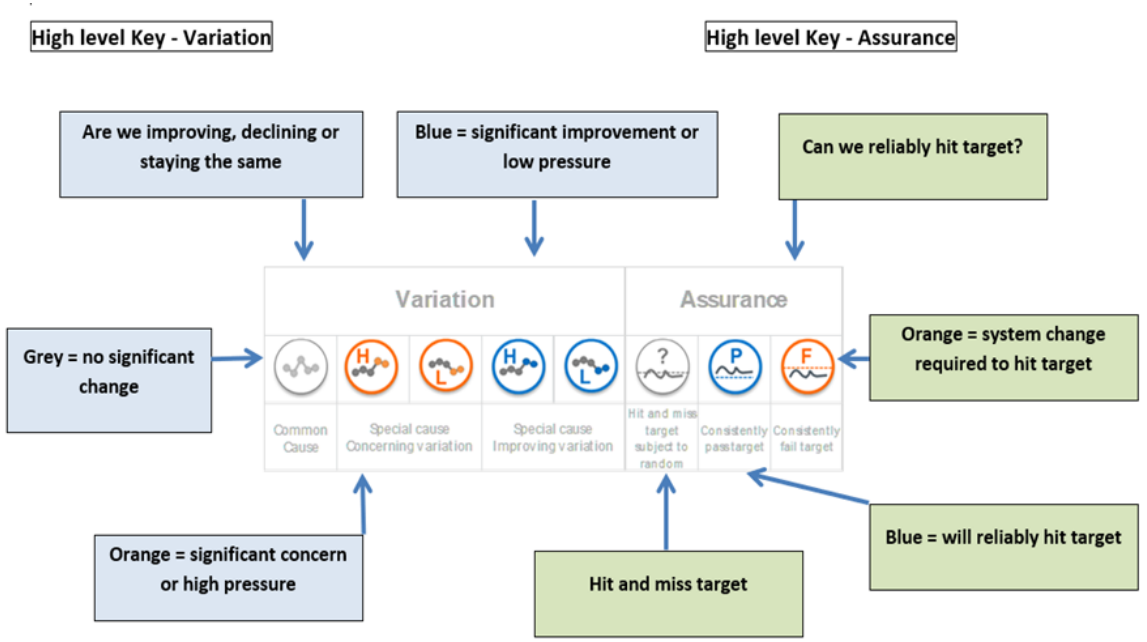
Emergency readmission rate reporting one month behind (November 2021 this month) due to the impact of incomplete coding on this indicator.

Palliative care coding and comorbidity coding reporting period aligned to mortality index reporting period.

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*.





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. The Trust therefore operates a Command & Control structure, to manage our clinically-led response to 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.

EXECUTIVE SUMMARY

- Trust performance in **December 2021-January 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 pressures to service delivery across the system.
- Due to the ongoing nature of the COVID-19 pandemic, **sickness absences** remained high, reflected in **training** and **appraisal** compliance. Staff well-being has been at the forefront of the trust's clinically-led response to the pandemic, and changes to national guidance on COVID-19 isolation guidance have been adopted to minimise the impact of staff isolation on absence levels.
- The **falls** rate in January increased, however, the rate of falls with harm, remained low.
- As seen across the NHS region, **Access targets** including **4-hour** and **ambulance handover delays** have been challenging due to the higher volumes of attendance seen across the system and continued pressures caused by COVID-19, and this is reflected in **patient experience**.
- Despite challenges of COVID-19, **elective inpatient activity** exceeded our plan.
- The **financial position** remains on plan and the team is focussing on preparing for the next financial year and delivery of the Coding Action Plan. Collaborative leadership teams have been asked to focus on confirming normal cost improvement plan delivery for 2021/22, plans for 2022/23 in-line with milestone expectations and longer term and transformational changes to achieve operational excellence and sustainability. HR, Finance, Business Intelligence and Service Improvement support is aligned to this through the Collaborative Improvement Councils.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
DATIX Incidents	2141	2070	Jan 2022		
Serious Incidents	7	9	Jan 2022		
Never Events (YTD)	4	0	Jan 2022	N/A	N/A
Falls	211	N/A	Jan 2022		N/A
Falls Rate	7.16	6.6	Jan 2022		
Falls With Harm	2	N/A	Jan 2022		N/A
Falls With Harm Rate	0.07	TBC	Jan 2022		N/A
Category 2 Pressure Ulcers Rate (Per 1000 Bed Days)	4.48	TBC	Jan 2022		N/A
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	2.55	TBC	Jan 2022		N/A
Category 2 Pressure Ulcers Community Rate (Per 1000 Bed Days)	1.93	TBC	Jan 2022		N/A
Category 3&4 Pressure Ulcers Rate (Per 1000 Bed Days)	0.71	TBC	Jan 2022		N/A
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	0.1	TBC	Jan 2022		N/A
Category 3&4 Pressure Ulcers Community Rate (Per 1000 Bed Days)	0.61	TBC	Jan 2022		N/A
Medication Incidents	109	TBC	Jan 2022		N/A
Medications Reconciled Rate %	65.63%	80%	Dec 2021		
C-Difficile (YTD)	120		Jan 2022	N/A	N/A
MRSA (YTD)	1	0	Jan 2022	N/A	N/A

Incidents

Reporting of incidents remains high since March 2021, setting a new positive norm of around incident reports per month. The target 10% increase has been achieved since April 2021. High levels of reporting are typically a feature of a positive safety culture. There were 7 Serious Incidents reported in January 2022; none of which were Never Events.

The rate of inpatient falls increased in January 2022. However, falls resulting in patient harm remained below the running average.

An overall reduction in pressure ulcers has been observed in all categories other than a small increase (0.12) in community category 3&4. The pressure ulcer improvement group is embedded in practice. Pressure ulcer prevalence is reviewed by area and targeted support is directed as necessary with increased visibility and responsiveness by the TVN team. This has proved to gain a positive reduction in key areas such as critical care. The Purpose T tool has been rolled out throughout the community setting and is currently being piloted within a number of the acute wards. The intentional rounding chart is currently under review alongside the placement of it in existing nursing documentation.

Medication incidents decreased again in January and remain within normal variation.

Healthcare acquired infections

There were no new MRSA reported this month. C. difficile cases reported remain higher than last year. IPC precautions for isolating patients with C. difficile have been maintained. The increase is reflective of the national and regional picture, however an improvement group has been established.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
Caesarean Section (%)	31.54%	TBC	Jan 2022		
Induction of Labour (%)	45.28%	44%	Jan 2022		
Still Births (YTD)	2	17	Jan 2022	N/A	N/A
PPH 1500ml (%)	0.03	TBC	Jan 2022		N/A

Maternity services

Caesarean Section and post-partum haemorrhage rates remain in line with the longer-term average. Induction of labour rates have returned to the average and benchmark in November after a ten-month period of higher rates. 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.

The Maternity Assurance Board continues to oversee quality, safety and performance against the suite of national maternity indicators and Ockenden review essentials.

EFFECTIVE

Metric	Latest Month	Target	Month	Trend	Assurance
Readmission Rate %	6.61%	TBC	Nov 2021		N/A
Sepsis - Oxygen delivered within 1hr	100%	95%	Nov 2021		
Sepsis - Blood cultures within 1hr	62.2%	95%	Nov 2021		
Sepsis - Empiric IV antibiotics within 1hr	77.8%	95%	Nov 2021		
Sepsis - Serum lactate within 1hr	82.2%	95%	Nov 2021		
Sepsis - IV fluid resuscitation within 1hr	77.8%	95%	Nov 2021		
Sepsis - Urine measurement within 1hr	95.6%	95%	Nov 2021		
Hospital Standard Mortality Rate	115.94	100	Oct 2021		
Summary Hospital-Level Mortality Indicator	120.59	100	Oct 2021		
Comorbidity Coding	4.02	TBC	Oct 2021		N/A
Palliative Care Coding	0.01	TBC	Oct 2021		N/A

Readmission rates

Emergency readmission rates reduced from March 2020 to Jan 21 due to overall reduction in admission. Much greater variability in rate has been apparent over last year as impact of pandemic varies across time - this pattern has been seen nationally. The rate remains below that seen pre-pandemic. Contributory factors may include use of Virtual Ward, community services rapid response, and data quality improvements (particularly around recording of SDEC activity).

Sepsis

Improvement strategies have driven 5 elements above 75%. Further actions include:

- Electronic workflow was introduced in November 2021 which is predicted to further increase timely responses.
- Midwifery consultant working alongside AIP team to support the inclusion and analysis of maternal sepsis data and identify areas for ongoing education.
- AIP champion study days have been planned for 2022. Adult and paediatric sepsis competencies available on staff intranet.
- Maternity sepsis competencies under development.
- Digital workstreams have commenced for both maternity and paediatrics.
- Circulate a safety briefing related to the requirement for blood cultures in normothermic / hypothermic patients
- Audit compliance to sepsis bundle via digital solution

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 (%)	81.57%	85%	Jan 2022		
Inpatient Experience (%)	95.11%	96%	Jan 2022		
Maternity Experience (%)	91.3%	97%	Jan 2022		
Outpatient Experience (%)	95.36%	95%	Jan 2022		
New Complaints	31		Jan 2022		N/A
Closed Within Target (%)	43.75%	80%	Jan 2022		

Patient experience

Patient experience in A&E remains slightly below target which is likely to reflect longer wait times within JCUH ED. 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.

The return rate for the Maternity survey at the four touch points (ante-natal, birth, post -natal and community) remains variable. The survey has been reviewed by the Maternity Voices Partnership (MVP) group and the Maternity leads and will be added to Meridian system.

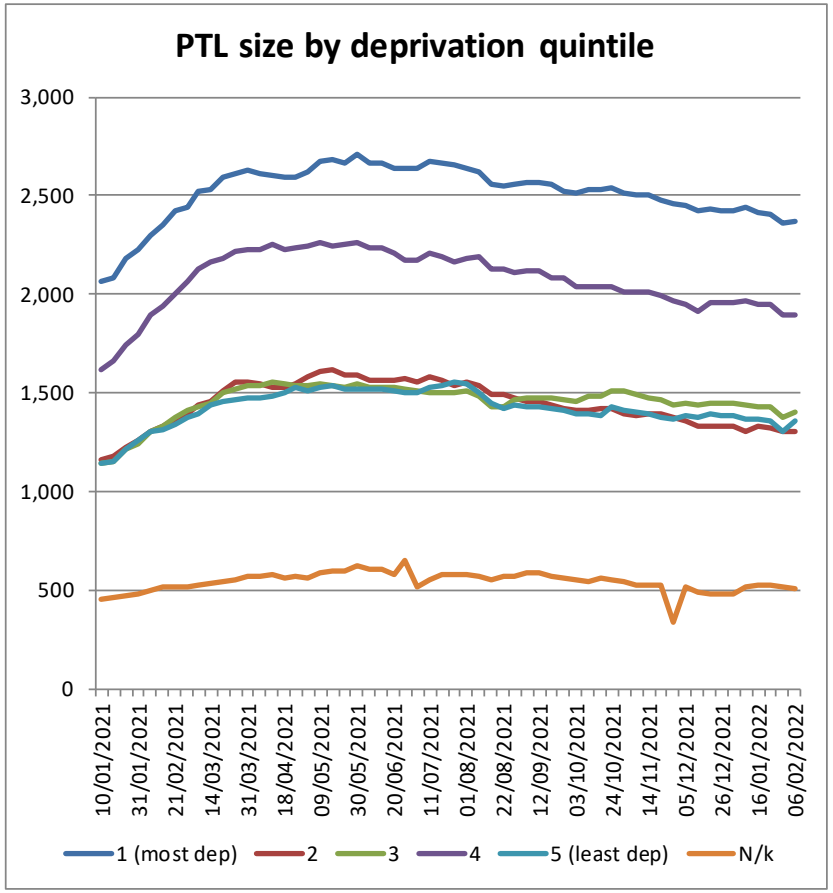
Trends continue to be monitored and action taken locally on review of the surveys. National benchmarking data is published monthly up to December 2021 and the Trust remains above the national average in all surveys and the Maternity antenatal survey.

Learning from complaints

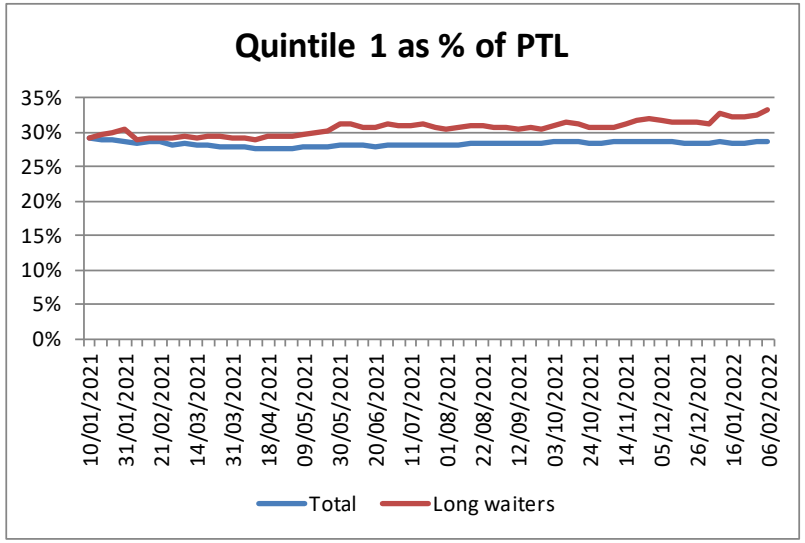
In January, the number of new complaints increased. The timeframe for closure did not meet the target, this was due increased activity in the organisation. Monitoring and escalation to achieve the target continues.

EQUITABLE

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



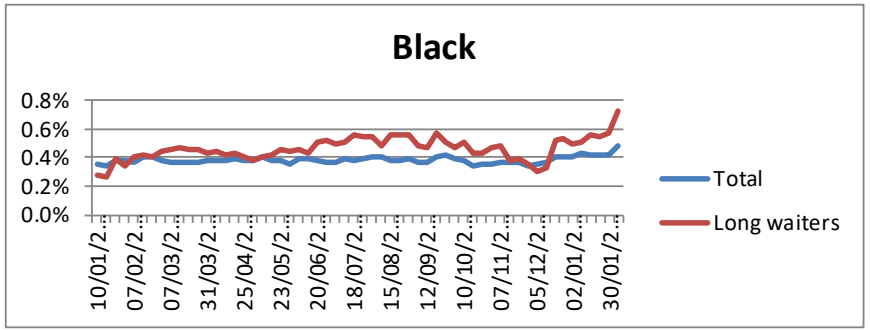
06/02/2022	Total		Long waiters		Ratio
1 (most dep)	2,371	28%	687	33%	1.17
2	1,300	16%	333	16%	1.03
3	1,404	17%	333	16%	0.96
4	1,893	23%	434	21%	0.92
5 (least dep)	1,359	16%	281	14%	0.83
N/k	509		127		



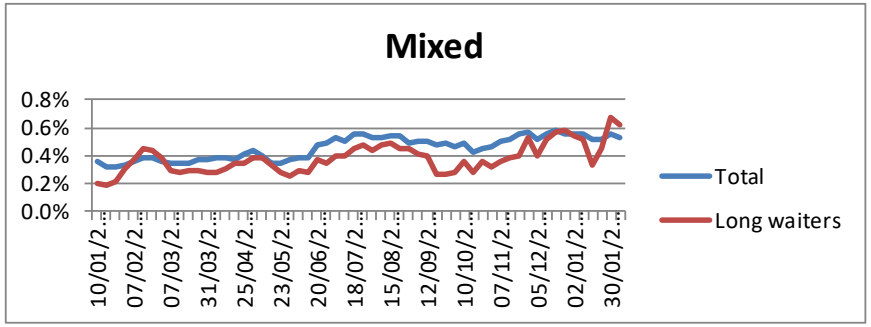
Whilst the inpatient waiting list size has reduced, the separation of the overall position and the long waiter position for the most deprived quintile has continued. This is in the context of lower uptake of COVID vaccination (discussed with Trust's clinical leaders) and multiple indicators of poorer health in more deprived populations. The Trust is working with the Local Authority on a joint Public Health role to inform, lead and guide our response.

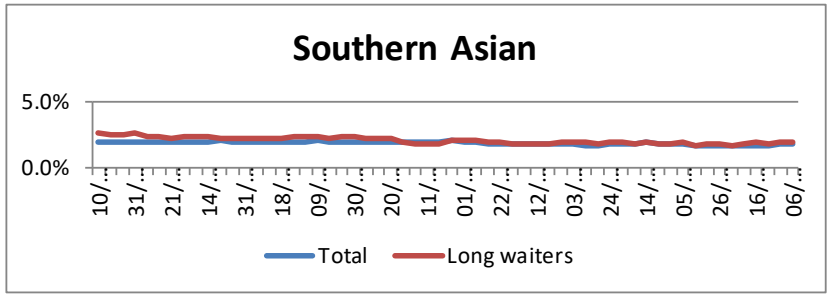
IMD – Index of multiple deprivation

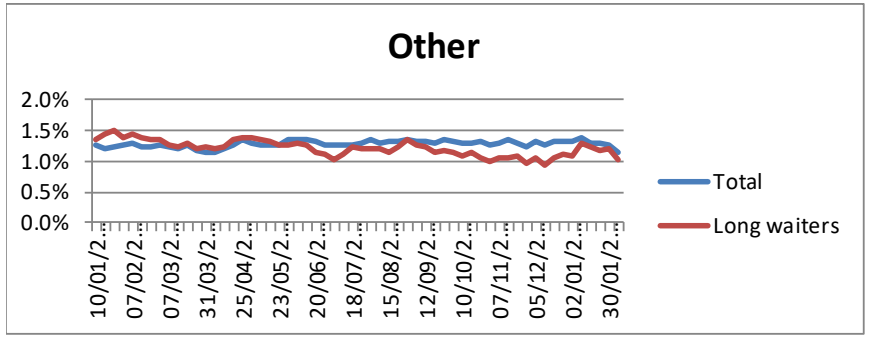
INPATIENT PTL: INEQUALITIES - ETHNICITY

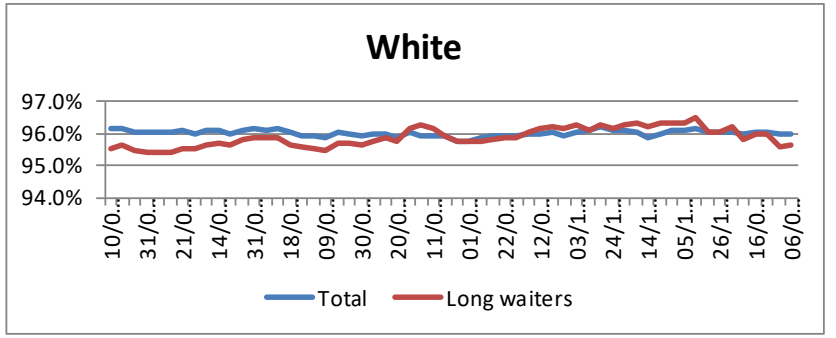


06/02/2022	Total		Long waiters		Ratio
Black	37	0.5%	14	0.7%	1.51
Mixed	41	0.5%	12	0.6%	1.17
Southern Asian	143	1.9%	38	2.0%	1.06
White	7,397	96.0%	1,843	95.6%	1.00
Other	89	1.2%	20	1.0%	0.90
N/k	1,129		268		









We have seen a widening in the proportion of long waiting patients in a number of ethnic groups, this will be closely monitored and actions taken to bring this back into line with all patient groups on the waiting list

RESPONSIVE

Metric	Latest Month	Target	Month	Trend	Assurance
4 Hour Wait Standard (%)	72.89%	95%	Jan 2022	L	F
Handovers - Over 30 Mins	179	0	Jan 2022	H	F
Handovers - Over 60 Mins	235	0	Jan 2022	H	F
RTT Incomplete Pathways (%)	65.01%	92%	Dec 2021	L	F
RTT 52 week waiters	1593	2512	Dec 2021	N/A	N/A
RTT 104 week waiters	100	94	Dec 2021	N/A	N/A
Diagnostic 6 Weeks Standard (%)	21.68%	99%	Dec 2021	L	F
Cancer 14 Day Standard (%)	88.76%	93%	Dec 2021		?
Cancer 31 Day Standard (%)	91.77%	96%	Dec 2021		?
Cancer 62 Day Standard (%)	78.96%	85%	Dec 2021	H	?
Cancer 62 Day Screening (%)	36.36%	90%	Dec 2021	L	?
Cancelled Ops - Non-Urgent Cancelled on Day	33	0	Jan 2022		F
Cancelled Ops - Not Rebooked Within 28 days	8	0	Jan 2022		?
Cancer Operations Cancelled On Day (YTD)	7	0	Jan 2022	N/A	N/A

Urgent and emergency care

4-hour standard performance remains below previous average. The impact of COVID-19 and segregation of pathways continues to be challenging. Increased levels of Non Elective activity throughout January has had a significant impact on 4 Hour Standard and Ambulance handover delays – both areas remain an area of focus. 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 static at 65%, and the diagnostics 6-week wait standard decreased. There was special-cause variation impacting on this, due to incomplete reporting from the new imaging information system. This is being resolved during January 2022. The number of patients waiting more than 52 weeks continues to decrease steadily and is significantly better than plan, and 104 weeks reduced in line with plan. These trends continued through January with ongoing prioritisation of capacity, and validation of waiting lists.

Cancer waiting times

14-day standard was below target in December. 31-day and 62-day standards improved but continue to be areas of focus. 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 5 months), and non-urgent cancellations and re-booking are within normal variation.

RESPONSIVE

Metric	Latest Month	Target	Month	Trend	Assurance
New Attendances	15499	15901	Jan 2022		
Review Attendances	42381	44513	Jan 2022		
Day Case admissions	4643	5934	Jan 2022		N/A
Ordinary Elective admissions	1439	944	Jan 2022		N/A
NEL admissions with 0 LOS	1625	2085	Jan 2022		
NEL admissions with 1+ LOS	3498	3807	Jan 2022		
Length of Stay - Elective	1.86	N/A	Jan 2022		N/A
Length of Stay - Emergency	5.2	N/A	Jan 2022		N/A
Length of Stay - Non-Elective	4.58	N/A	Jan 2022		N/A

Activity

Outpatient New and Review activity exceeded Trust plan in December but was below plan in January.

Elective inpatient admissions exceeded plan. Efforts have focused on maximising forward planning and booking to improve utilisation of lists that go ahead and reduce avoidable cancellations. Despite COVID-related pressures, protected elective capacity was maintained as far as it was possible and safe to do so.

Non-elective same day and overnight admissions are below expected levels. Emergency care recovery group is working on maximising the use of same day emergency care (SDEC) pathways, as an alternative to both ED attendances and inpatient admissions. 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 has been sustained. Non-elective length of stay is consistent, 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).

Reported **diagnostic** performance has been significantly impacted through the changeover of the Radiology reporting system in November 21. Transition to new systems is now complete with a full validation exercise being undertaken. Actual performance is in line with previous months, once data validation audits are complete and performance will be reflected in future months Integrated Performance Reports.

WELL LED

Metric	Latest Month	Target	Month	Trend	Assurance
Cumulative YTD Financial Position (£'millions)	-£4.362m	-£4.363m	Jan 2022	N/A	N/A
Annual Appraisal (%)	74.2%	80%	Jan 2022		
Mandatory Training (%)	86.06%	90%	Jan 2022		
Sickness Absence (%)	5.06%	4%	Jan 2022		
Staff Turnover (%)	13.42%	10%	Jan 2022		

Finance and use of resources

The deficit at month 10 is in line with the Trust Financial Plan and continuing the trend seen in the previous 9 months. Assurance is obtained by budget statements being 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 0.7% to 5.06%. This reduction is made of a decrease in short term and long term absence rates., short term absence has decreased by 0.08% and long term absence has decreased by 0.62%. Covid absence for January was 3.46%, and therefore the total absence was 8.52%. The new stress and anxiety absence process has been implemented and will identify those staff who go absent with stress and anxiety on their first day and enable early intervention with a view to helping them return to work sooner. This and other attendance management procedures are continued to be discussed at HR Clinics throughout the Collaboratives and a sickness absence action plan is being developed for each Collaborative.

Mandatory training has increased throughout the Trust to 86.06% and Appraisals have also increased and are now 74.20%. Both KPI's continue to be a focus at monthly HR Clinics.

Turnover has seen a small increase of 0.23% to 13.42% across the Trust and, along with implementing the Trust's Retention Strategy, HR are continuing to work with collaboratives in regard to the development of the overarching Collaborative Workforce Plans.

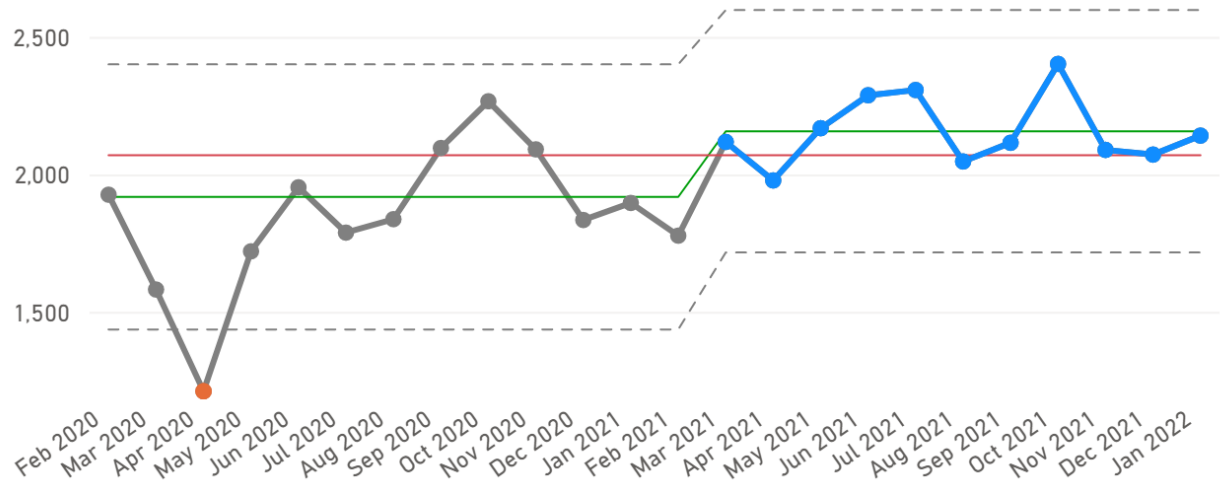
APPENDICES

SPC charts for the metrics summarised above, by domain.

SAFE

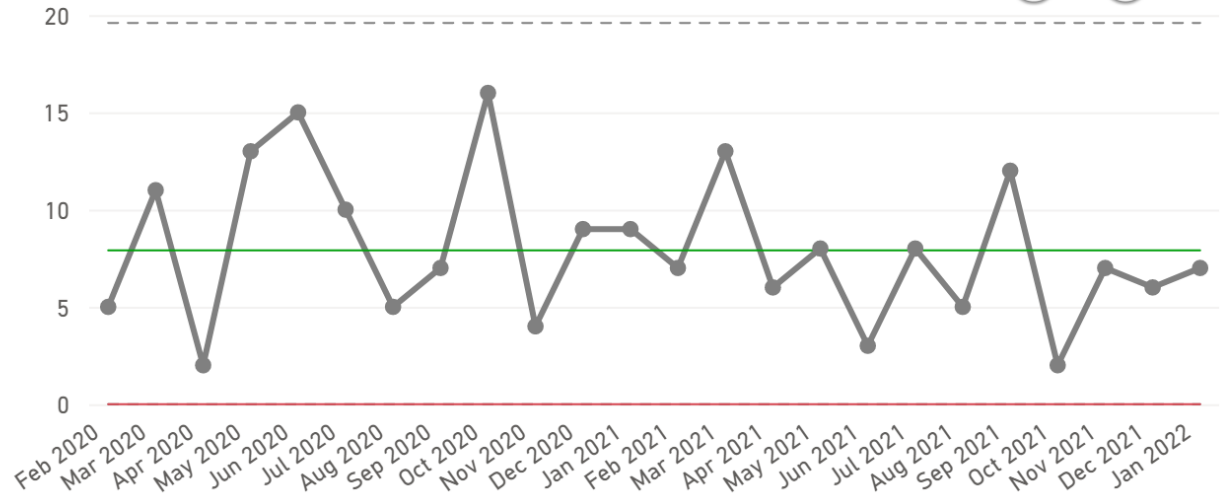
DATIX Incidents

Month	Performance	Target	Trend	Assurance
Jan 2022	2141	2070		



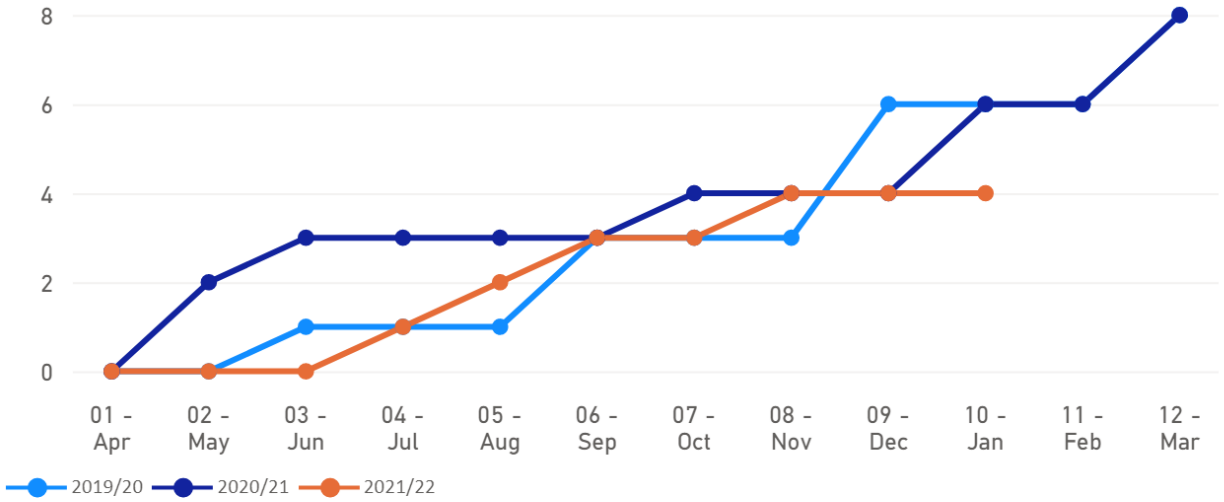
Serious Incidents

Month	Performance	Target	Trend	Assurance
Jan 2022	7	0		



Never Events (YTD)

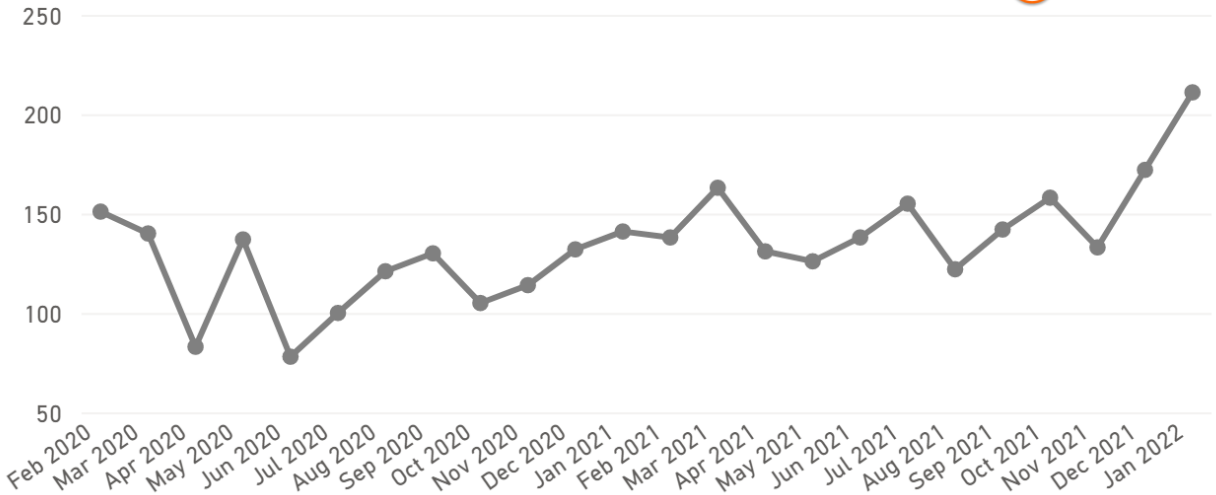
Month	Performance	Target	Trend	Assurance
Jan 2022	4	0	N/A	N/A



SAFE

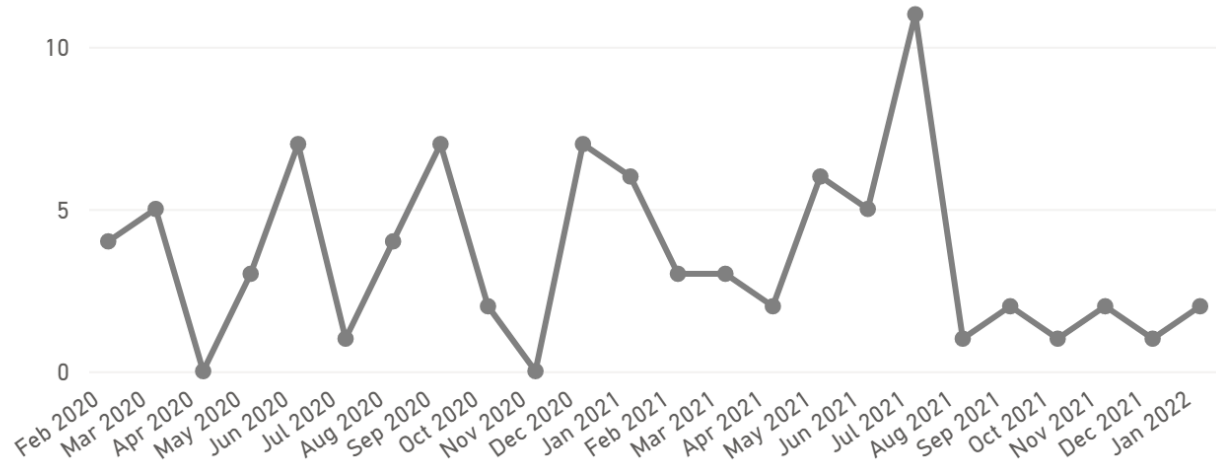
Falls

Month	Performance	Target	Trend	Assurance
Jan 2022	211	N/A		N/A



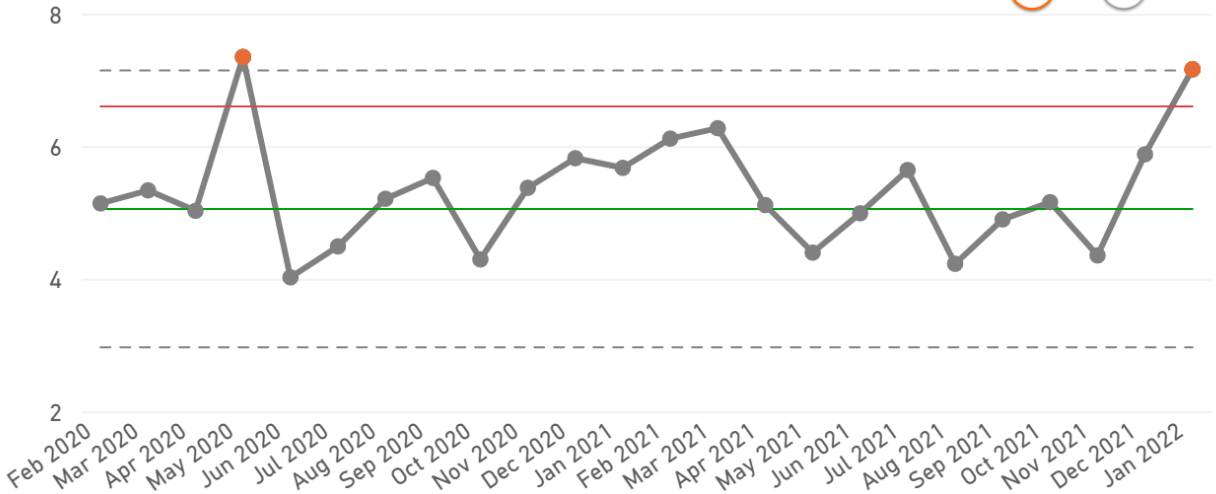
Falls With Harm

Month	Performance	Target	Trend	Assurance
Jan 2022	2	N/A		N/A



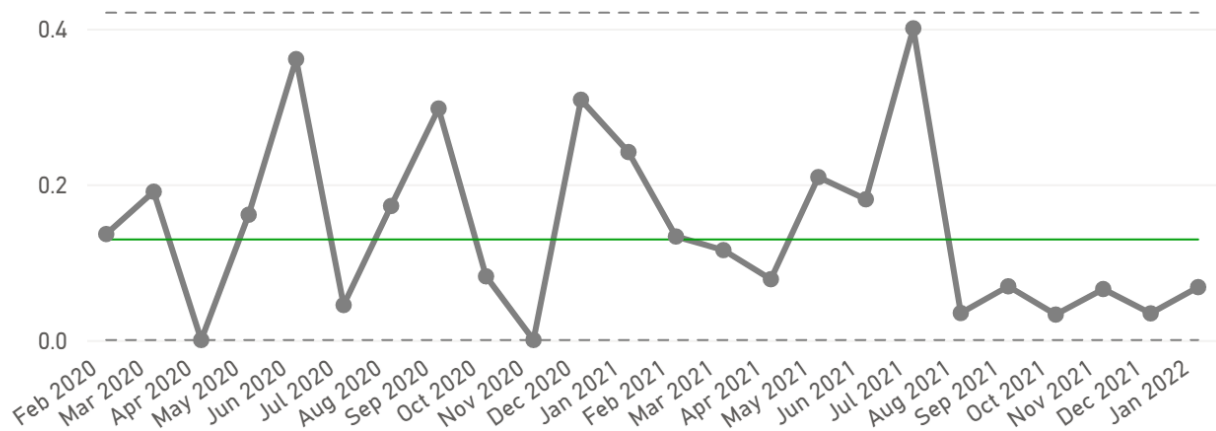
Falls Rate

Month	Performance	Target	Trend	Assurance
Jan 2022	7.16	6.6		



Falls With Harm Rate

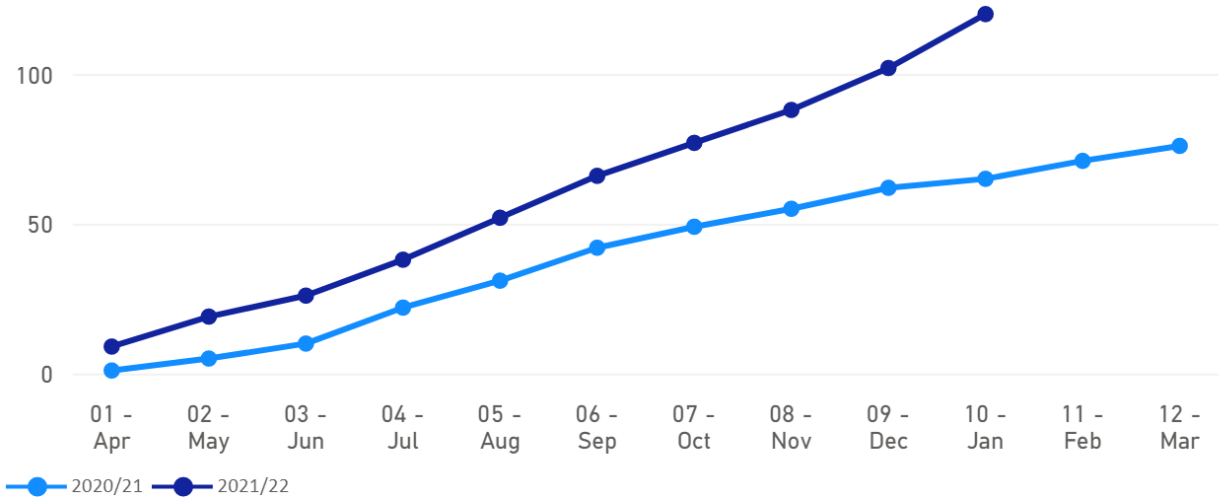
Month	Performance	Target	Trend	Assurance
Jan 2022	0.07	TBC		N/A



SAFE

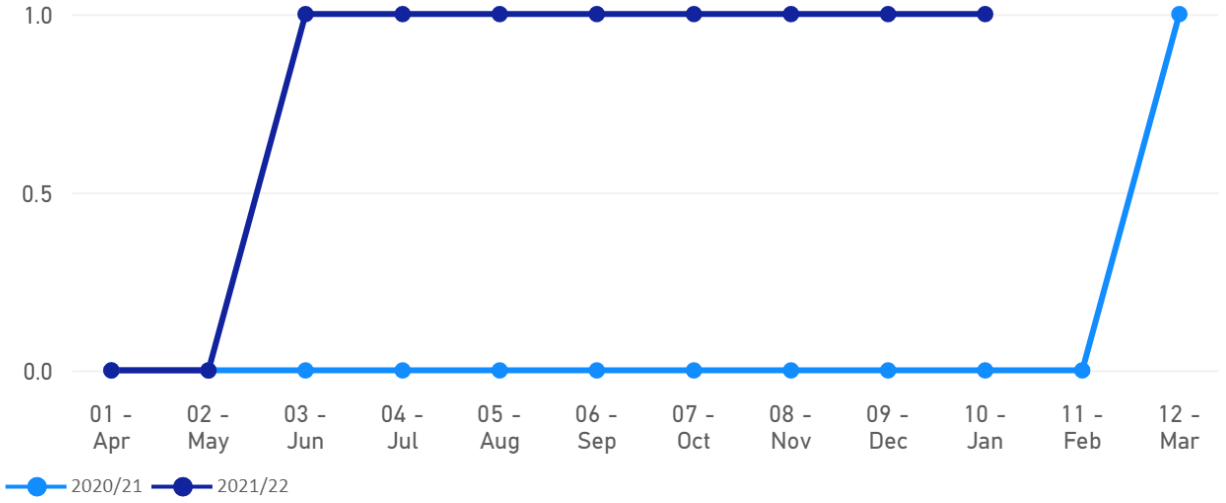
C-Difficile (YTD)

Month	Performance	Target	Trend	Assurance
Jan 2022	120		N/A	N/A



MRSA (YTD)

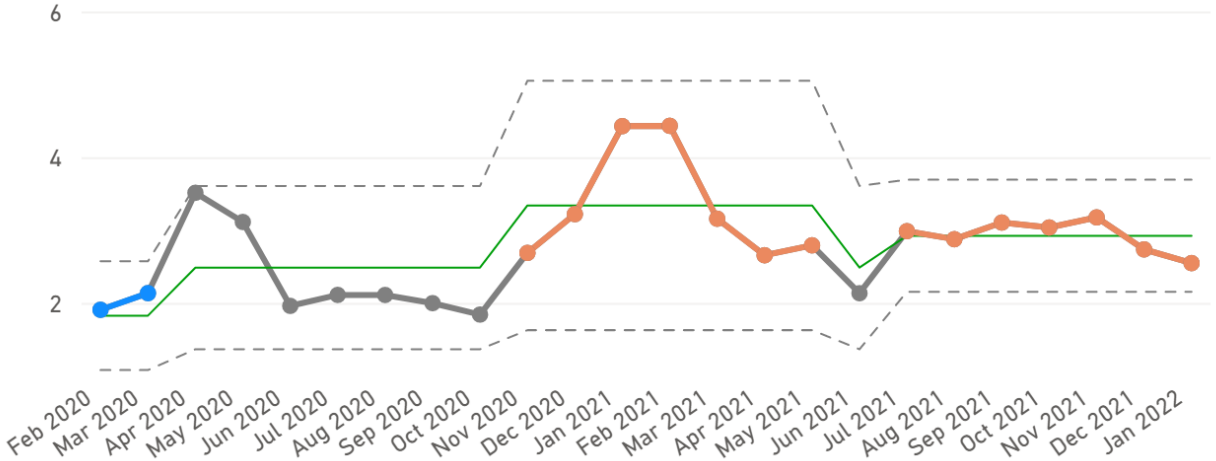
Month	Performance	Target	Trend	Assurance
Jan 2022	1	0	N/A	N/A



SAFE

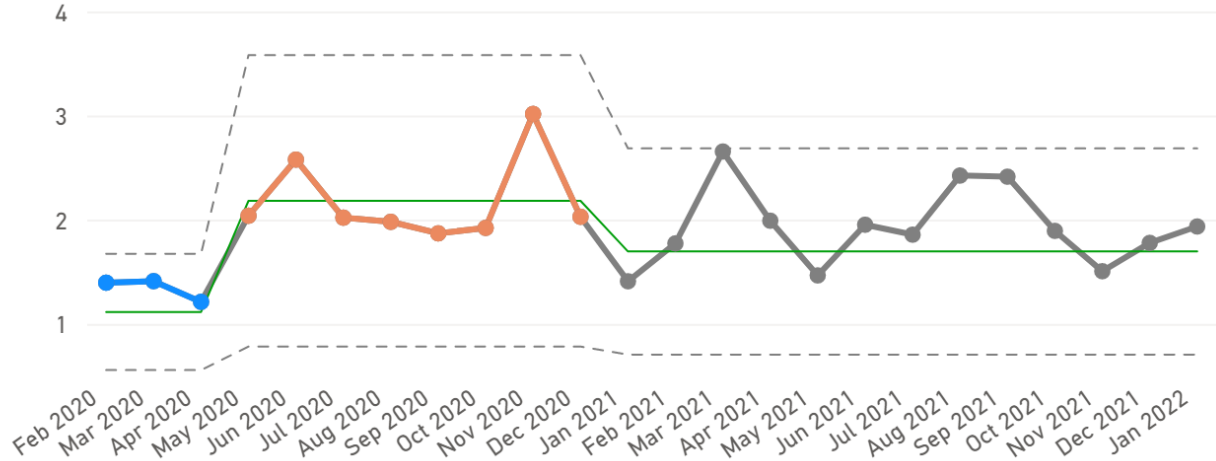
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Jan 2022	2.55	TBC		N/A



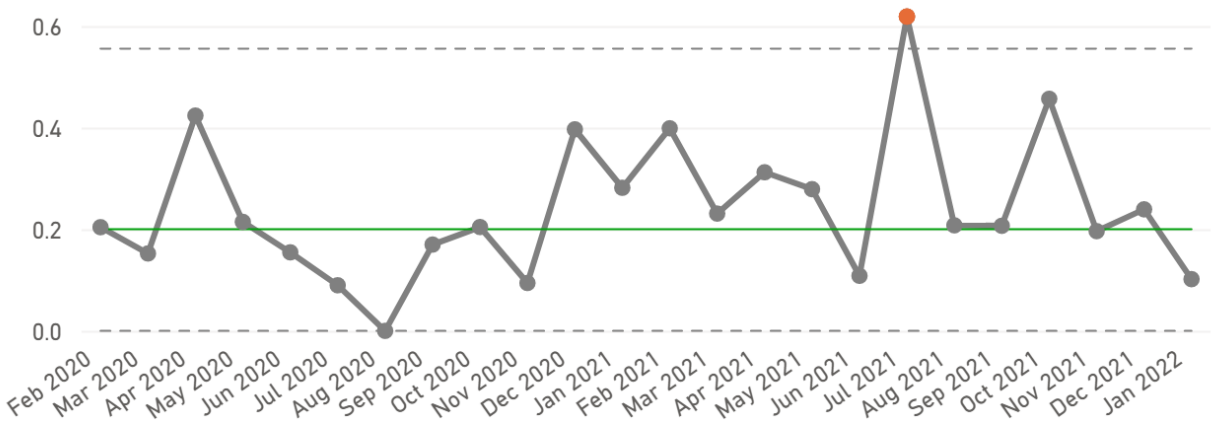
Category 2 Pressure Ulcers Community Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Jan 2022	1.93	TBC		N/A



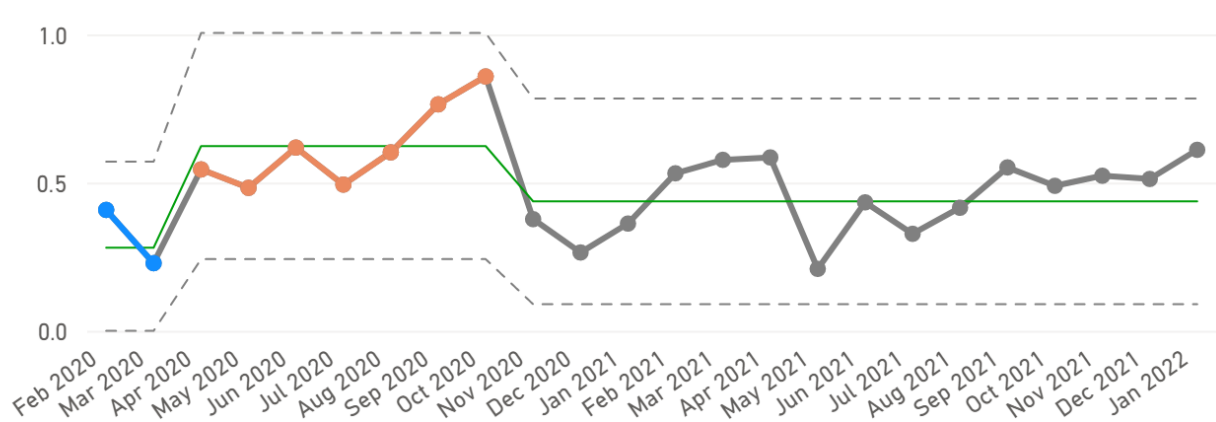
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Jan 2022	0.1	TBC		N/A



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

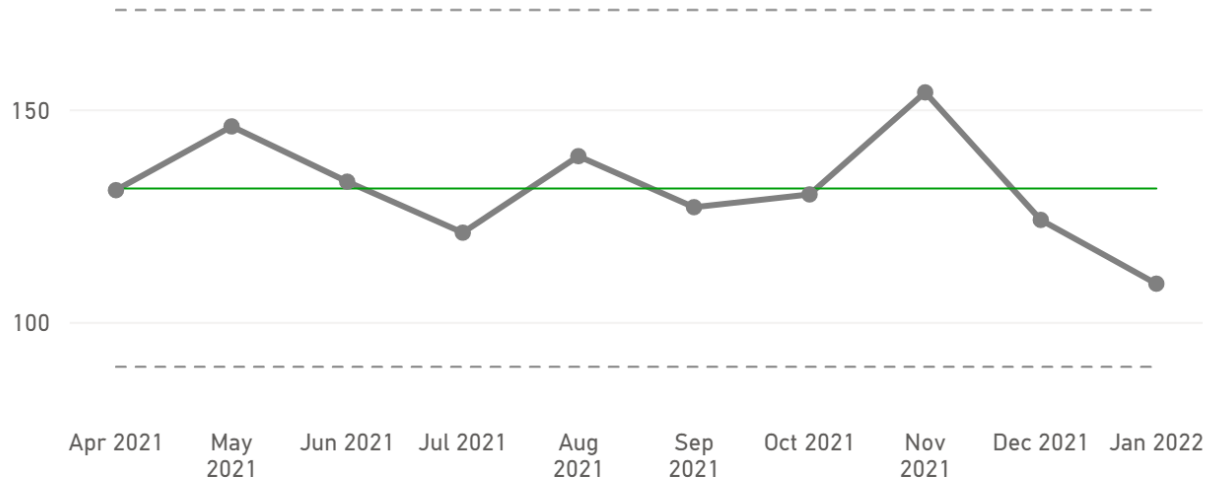
Month	Performance	Target	Trend	Assurance
Jan 2022	0.61	TBC		N/A



SAFE

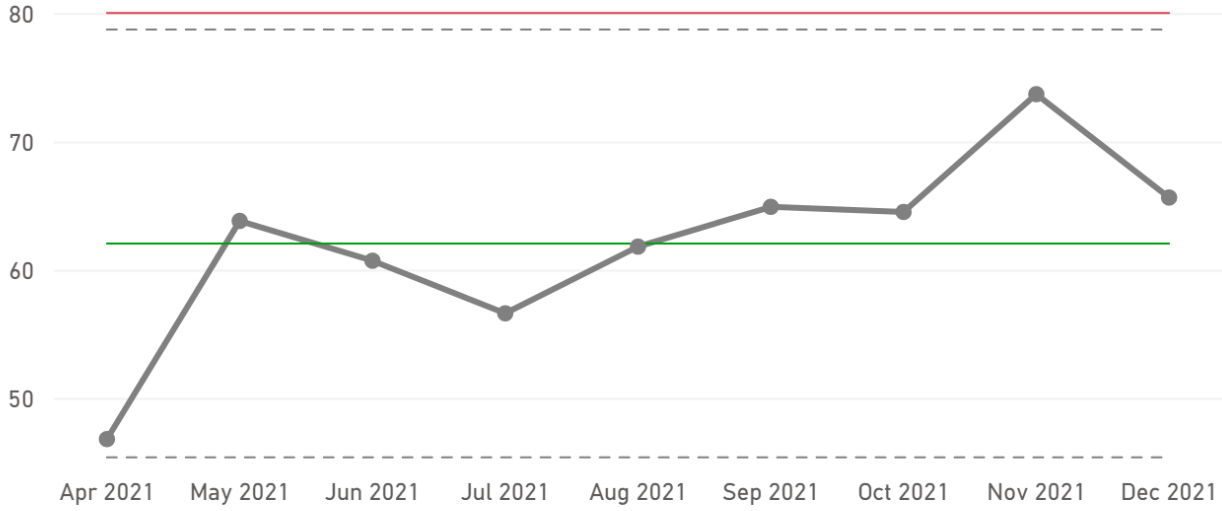
Medication Incidents

Month	Performance	Target	Trend	Assurance
Jan 2022	109	TBC		N/A



Medications Reconciled Rate %

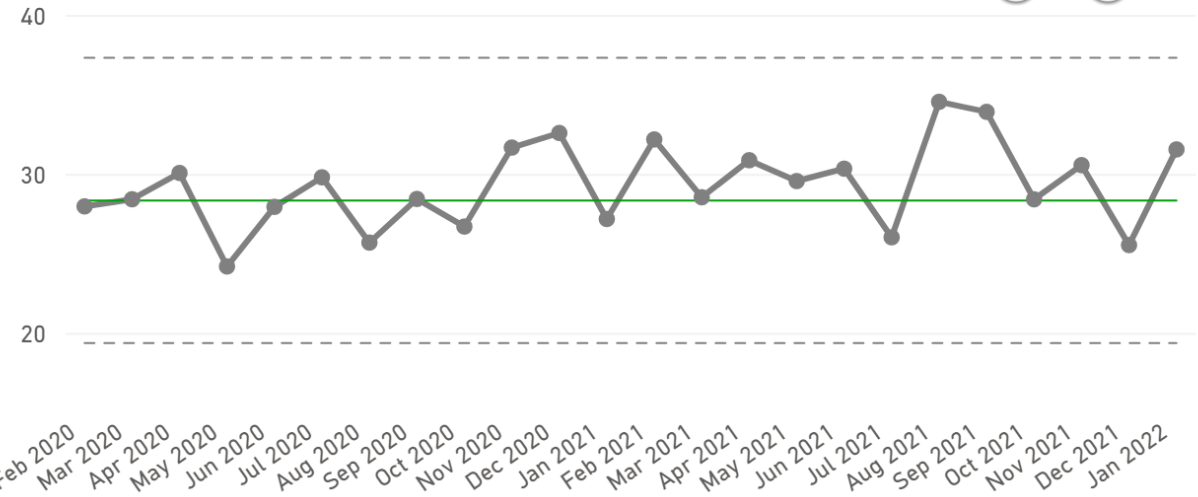
Month	Performance	Target	Trend	Assurance
Dec 2021	65.63%	80%		



SAFE

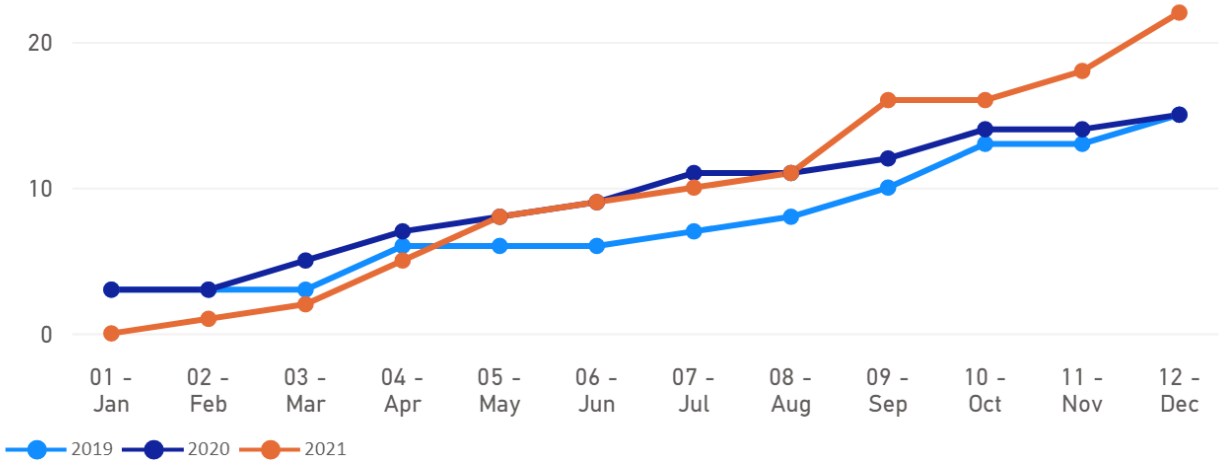
Caesarean Section (%)

Month	Performance	Target	Trend	Assurance
Jan 2022	31.54%	TBC		



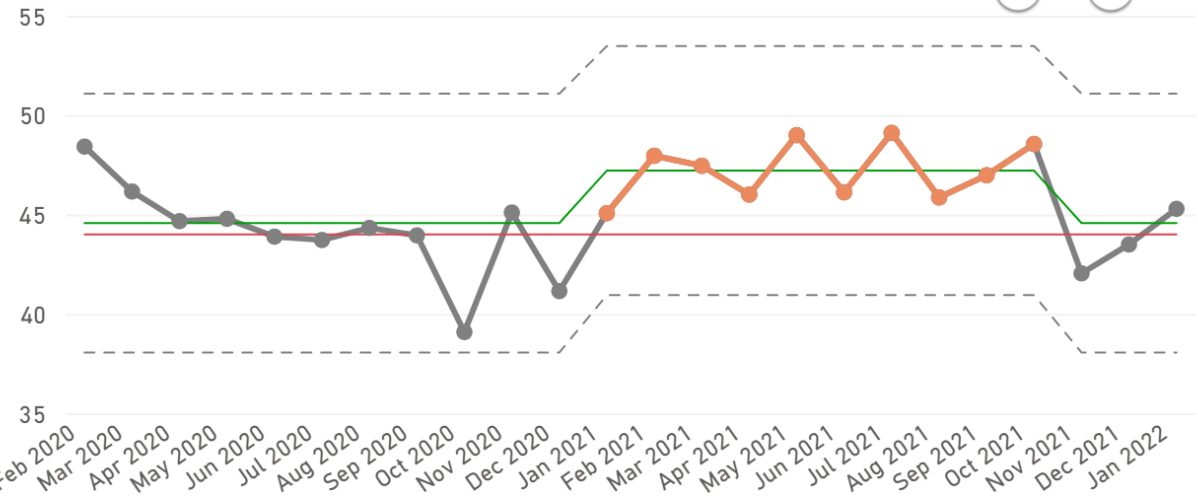
Still Births (YTD)

Month	Performance	Target	Trend	Assurance
Jan 2022	2	17	N/A	N/A



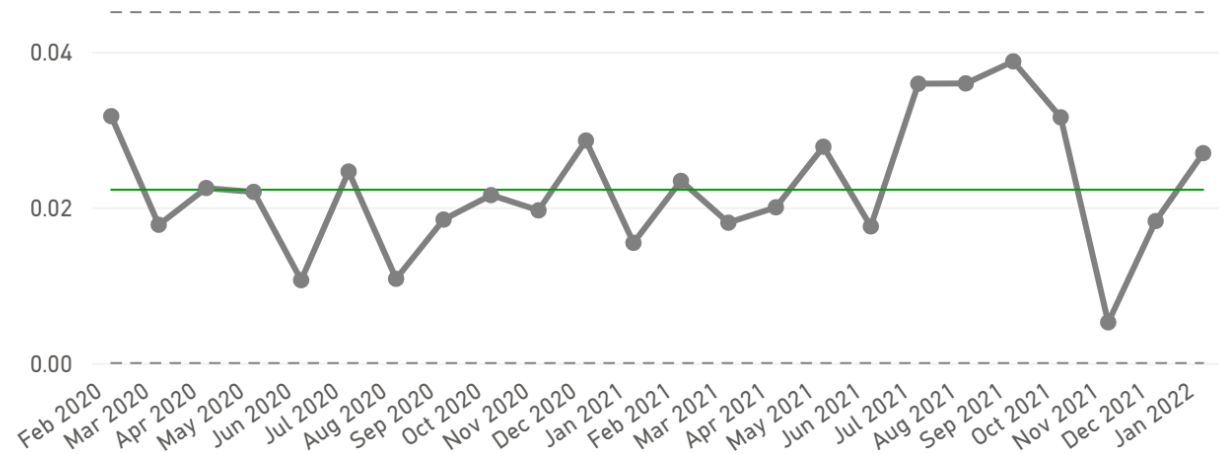
Induction of Labour (%)

Month	Performance	Target	Trend	Assurance
Jan 2022	45.28%	44%		



PPH 1500ml (%)

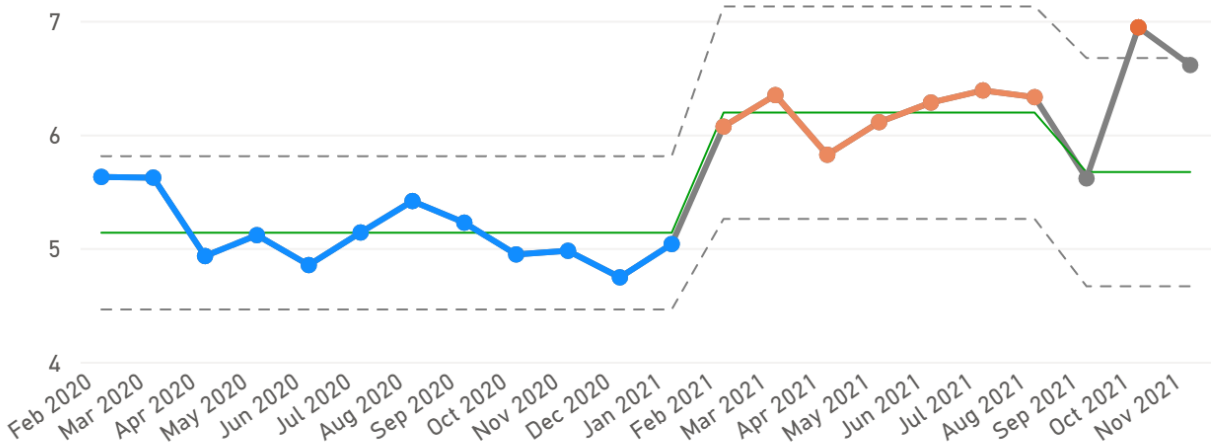
Month	Performance	Target	Trend	Assurance
Jan 2022	0.03	TBC		N/A



EFFECTIVE

Readmission Rate %

Month	Performance	Target	Trend	Assurance
Nov 2021	6.61%	TBC		N/A



Readmission logic

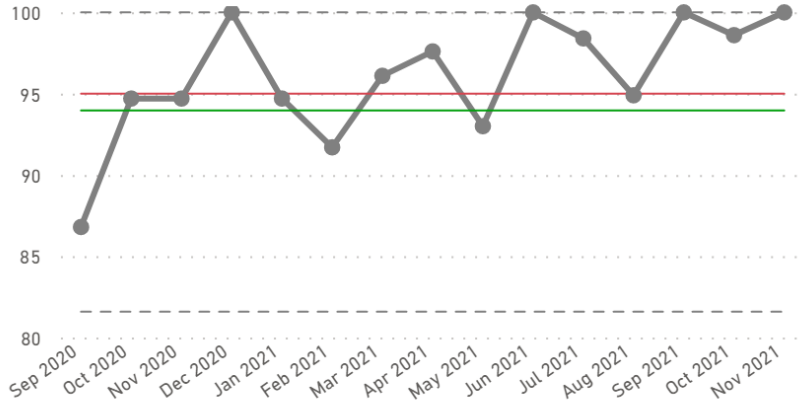
All emergency readmissions within 30 days of discharge, where the admission doesn't meet the national exclusion criteria:

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

EFFECTIVE

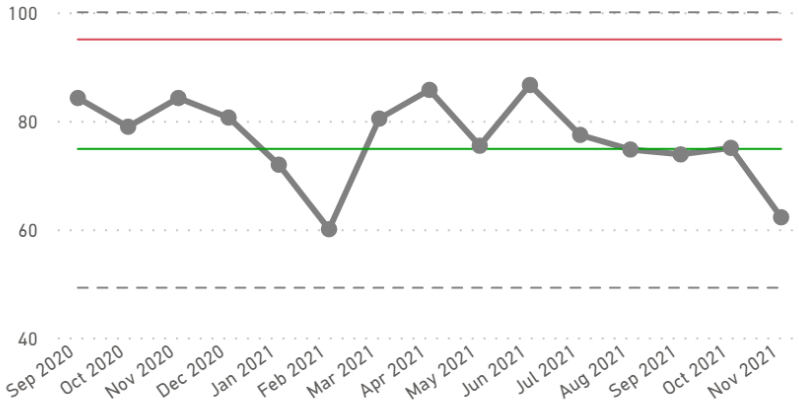
Sepsis - Oxygen within 1hr

Month	Performance	Target	Trend	Assurance
Nov 2021	100%	95%		



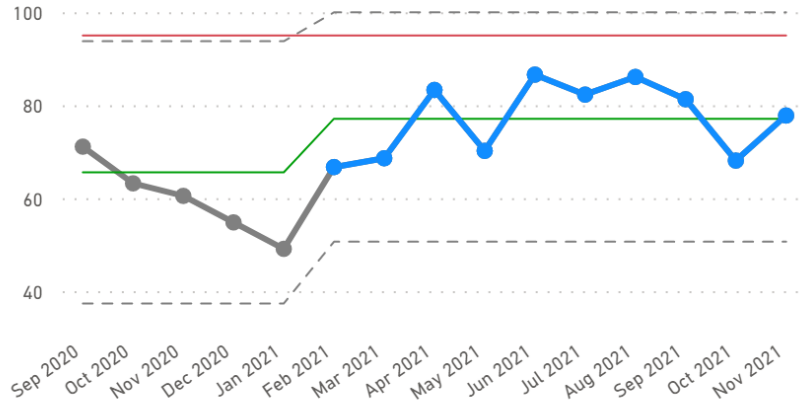
Sepsis - Blood cultures within 1hr

Month	Performance	Target	Trend	Assurance
Nov 2021	62.2%	95%		



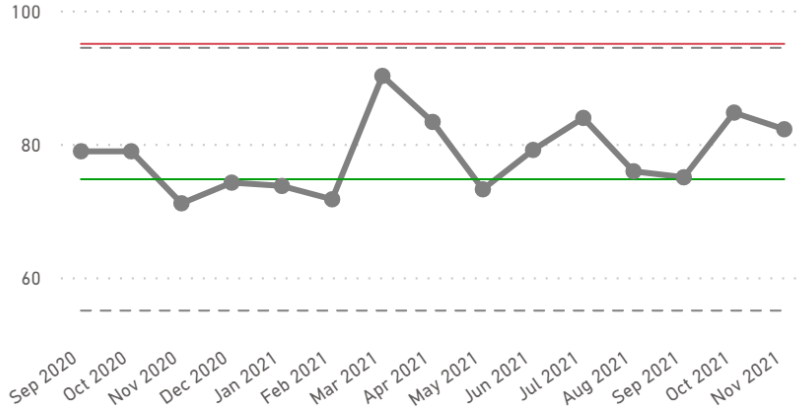
Sepsis - IV antibiotics within 1hr

Month	Performance	Target	Trend	Assurance
Nov 2021	77.8%	95%		



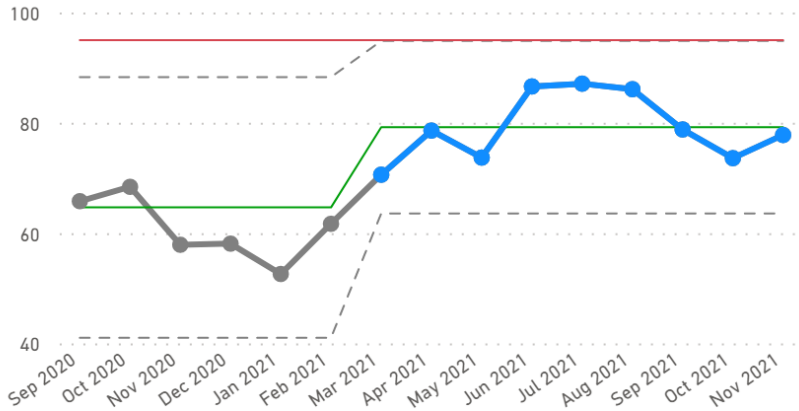
Sepsis - Serum lactate within 1hr

Month	Performance	Target	Trend	Assurance
Nov 2021	82.2%	95%		



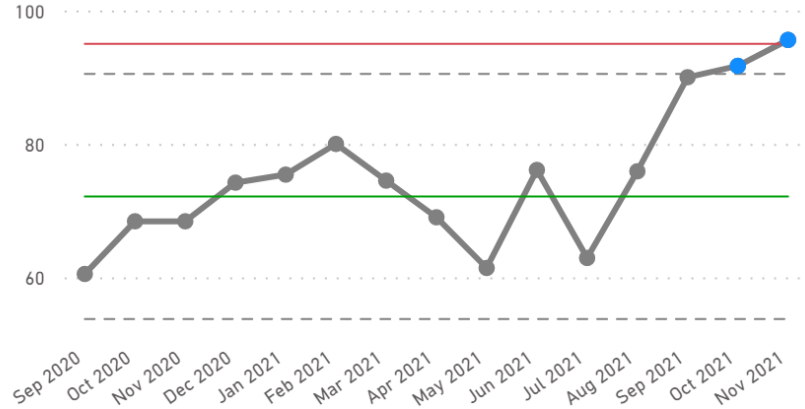
IV fluid resuscitation within 1hr

Month	Performance	Target	Trend	Assurance
Nov 2021	77.8%	95%		



Sepsis - Urine measurement within 1hr

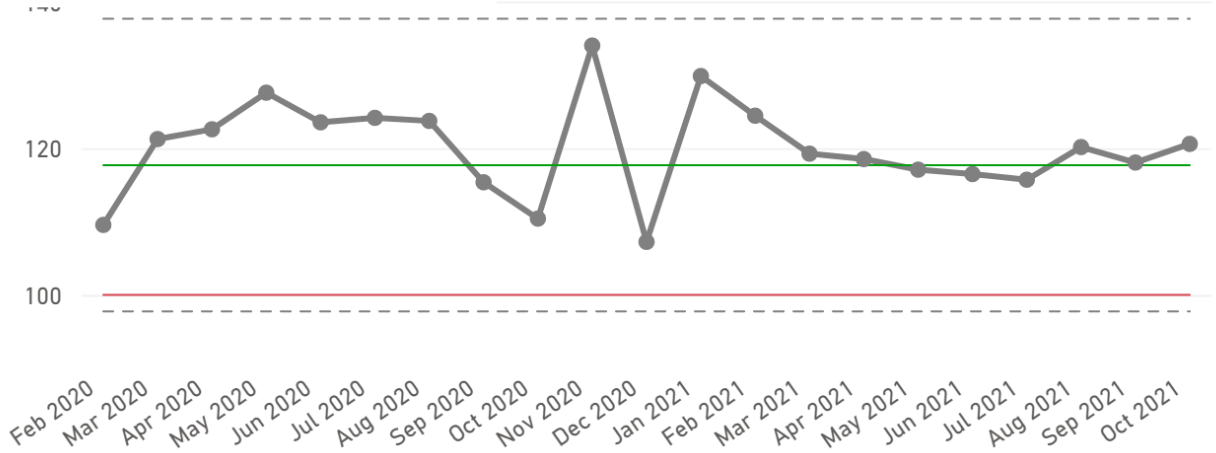
Month	Performance	Target	Trend	Assurance
Nov 2021	95.6%	95%		



EFFECTIVE

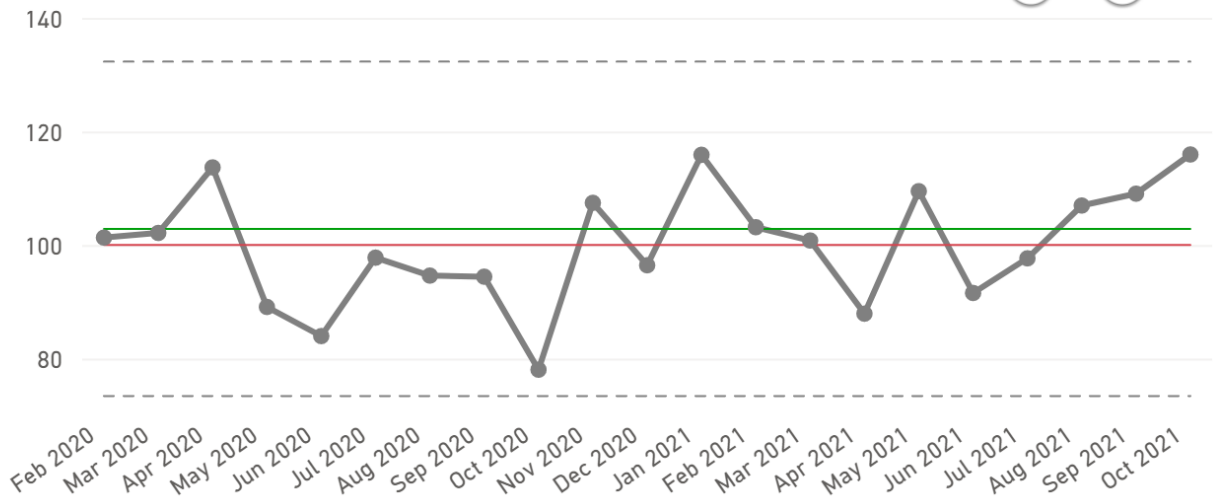
Summary Hospital-Level Mortality Indicator

Month	Performance	Target	Trend	Assurance
Oct 2021	120.59	100		



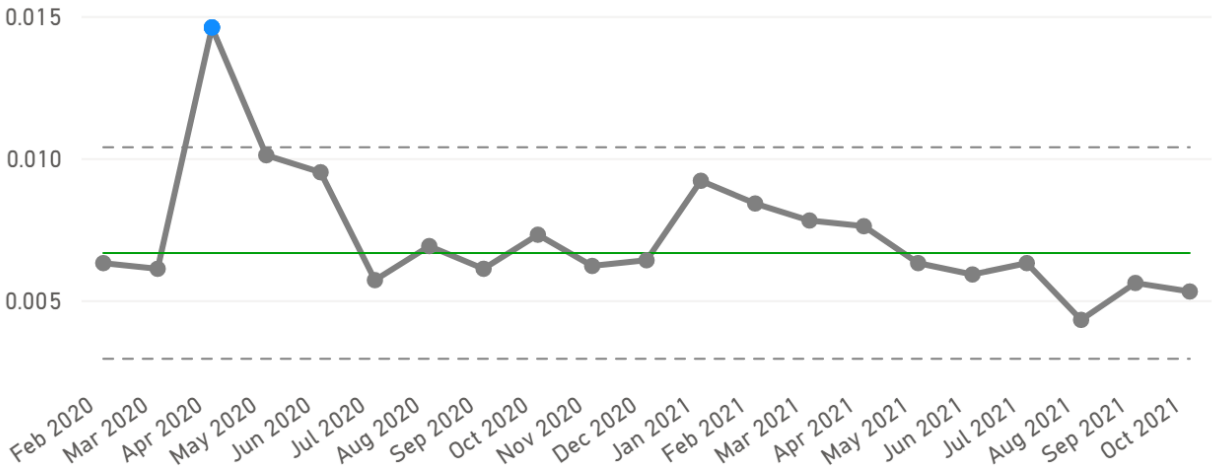
Hospital Standard Mortality Rate

Month	Performance	Target	Trend	Assurance
Oct 2021	115.94	100		



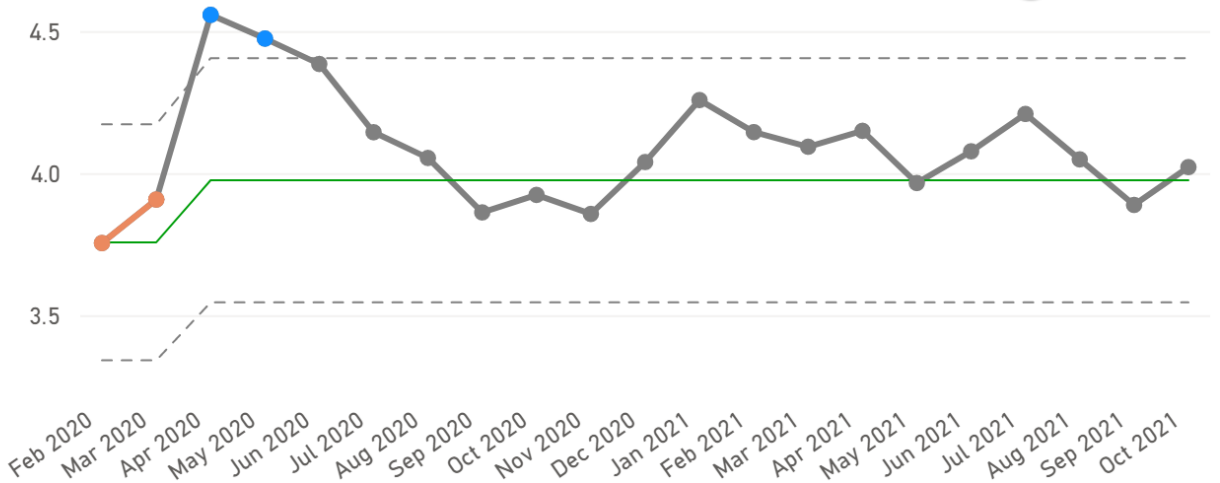
Palliative Care Coding

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



Comorbidity Coding

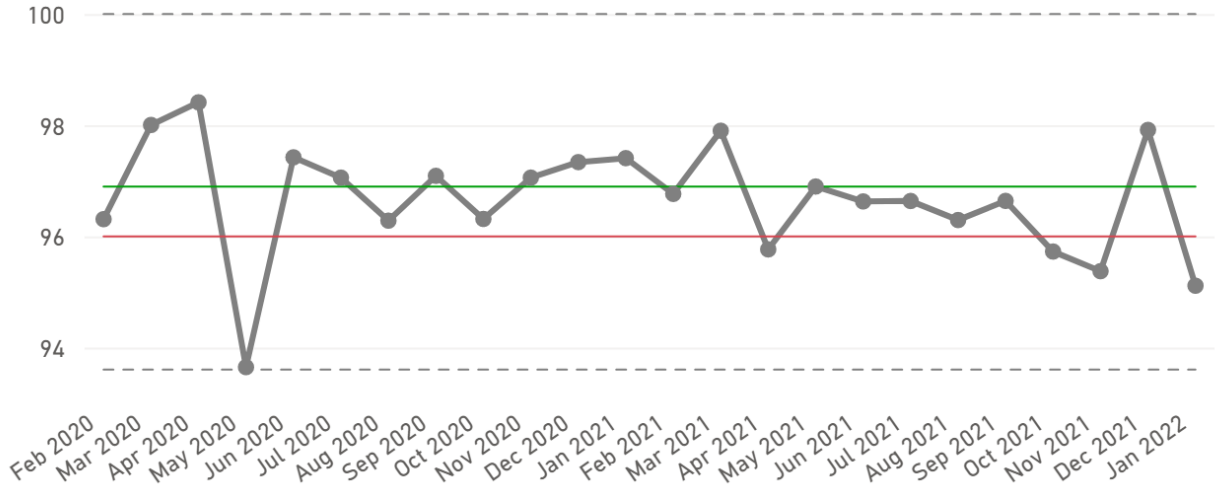
Month	Performance	Target	Trend	Assurance
Oct 2021	4.02	TBC		N/A



CARING

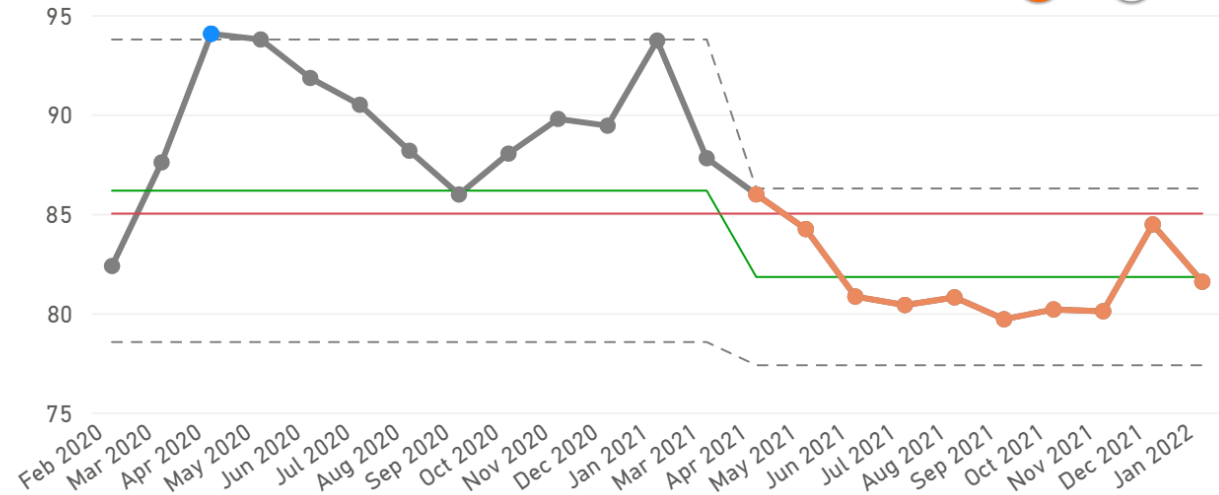
Inpatient Experience (%)

Month	Performance	Target	Trend	Assurance
Jan 2022	95.11%	96%		



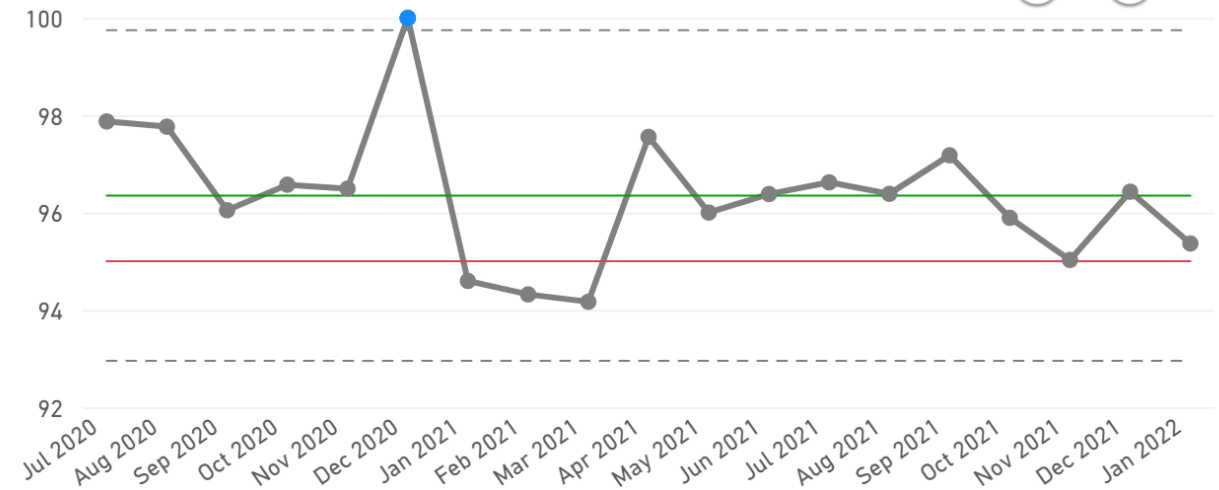
A&E Experience (%)

Month	Performance	Target	Trend	Assurance
Jan 2022	81.57%	85%		



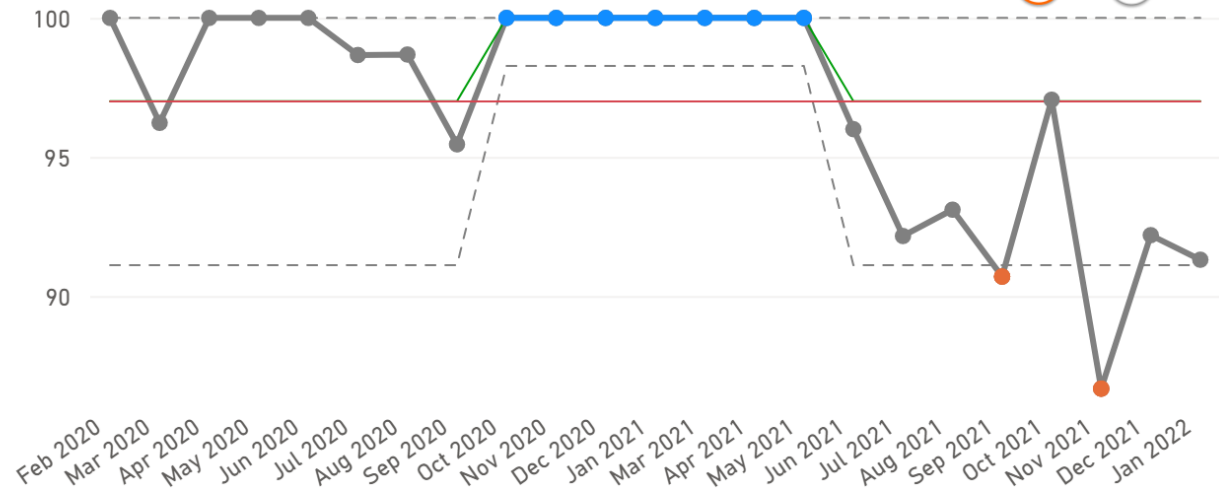
Outpatient Experience (%)

Month	Performance	Target	Trend	Assurance
Jan 2022	95.36%	95%		



Maternity Experience (%)

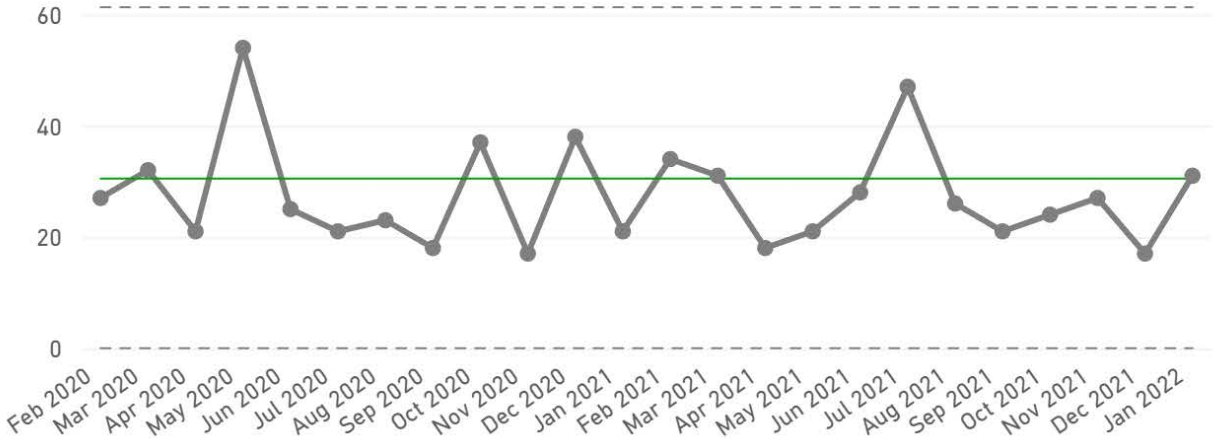
Month	Performance	Target	Trend	Assurance
Jan 2022	91.3%	97%		



CARING

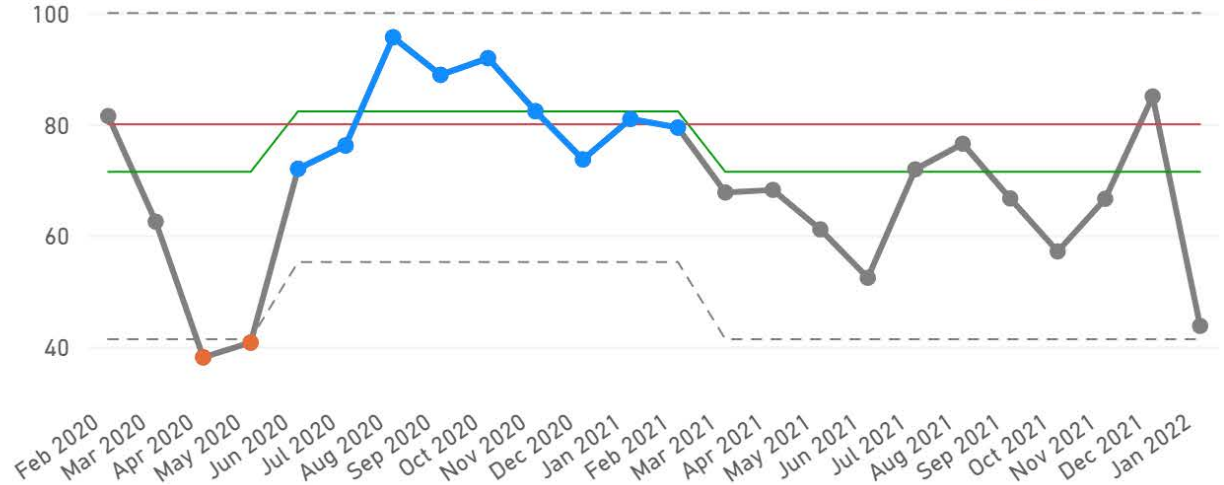
New Complaints

Month	Performance	Target	Trend	Assurance
Jan 2022	31			N/A



Closed Within Target (%)

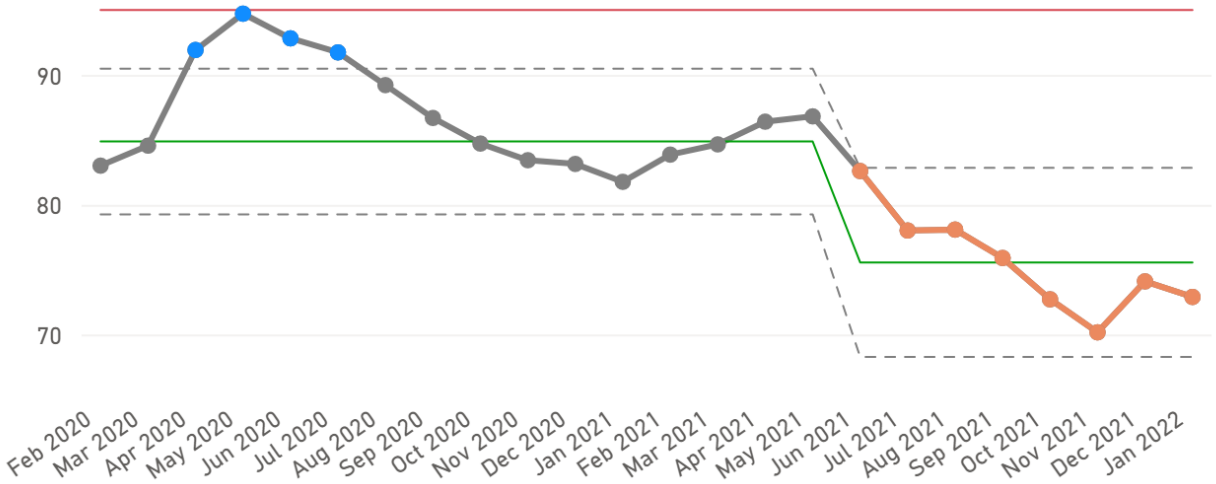
Month	Performance	Target	Trend	Assurance
Jan 2022	43.75%	80%		



RESPONSIVE

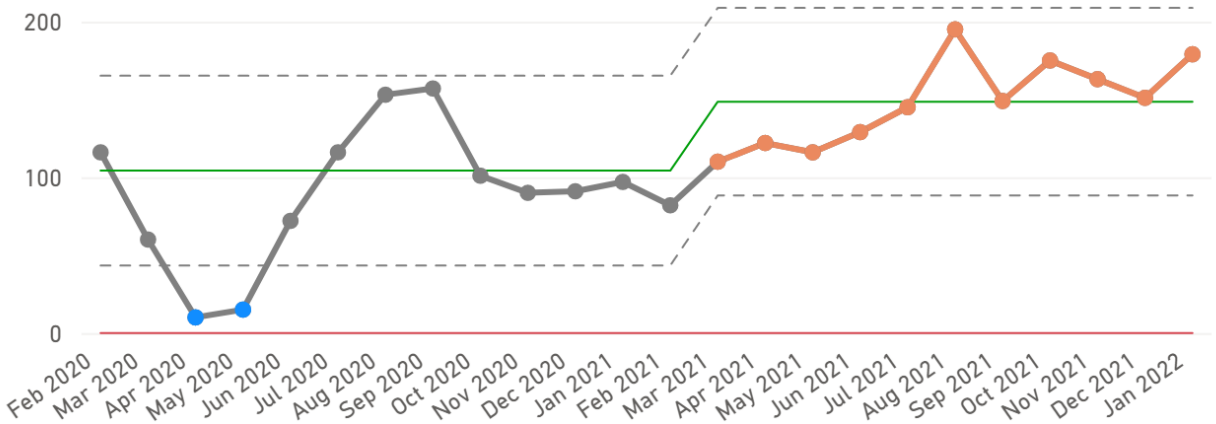
4 Hour Wait Standard (%)

Month	Performance	Target	Trend	Assurance
Jan 2022	72.89%	95%		



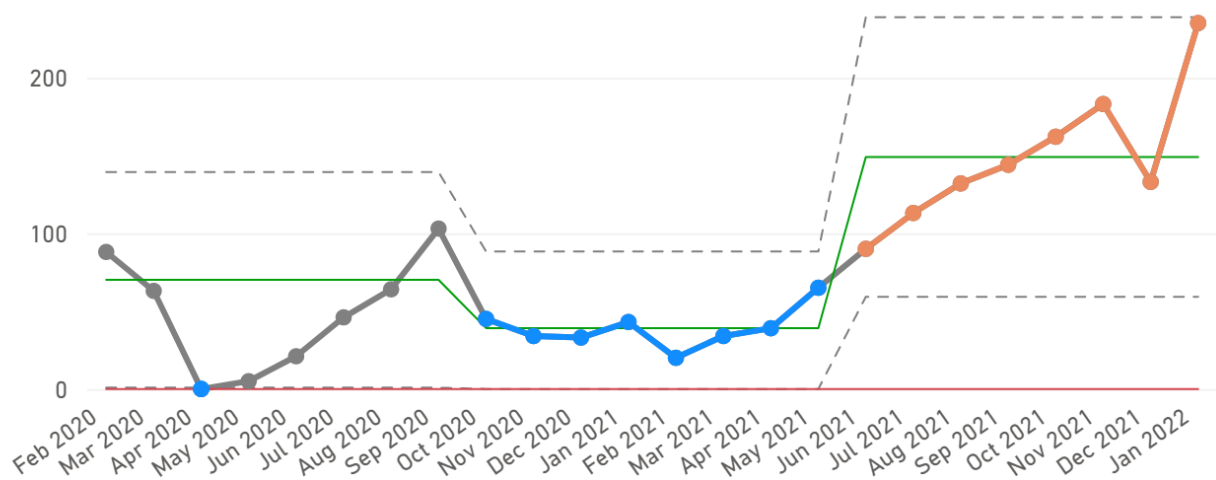
Handovers - Over 30 Mins

Month	Performance	Target	Trend	Assurance
Jan 2022	179	0		



Handovers - Over 60 Mins

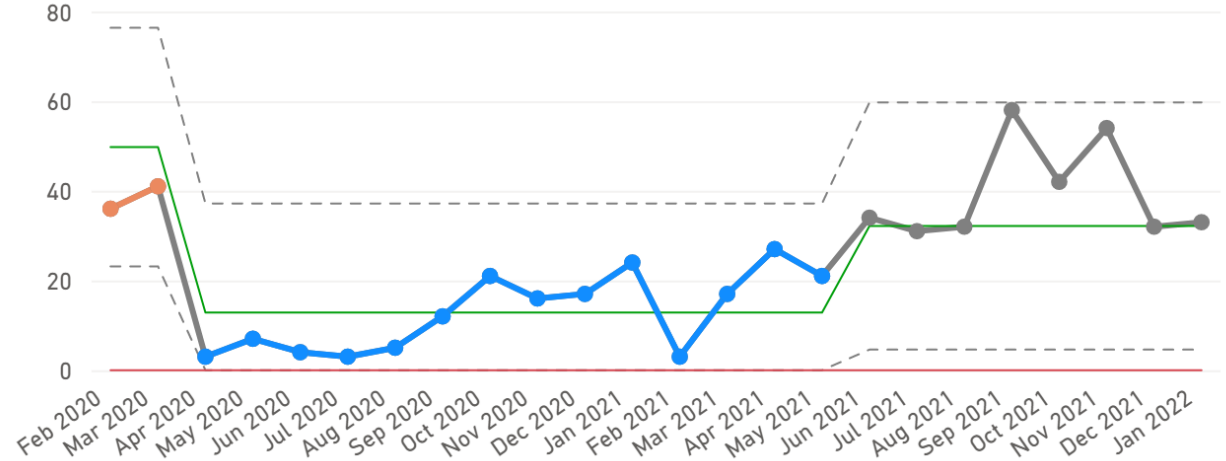
Month	Performance	Target	Trend	Assurance
Jan 2022	235	0		



RESPONSIVE

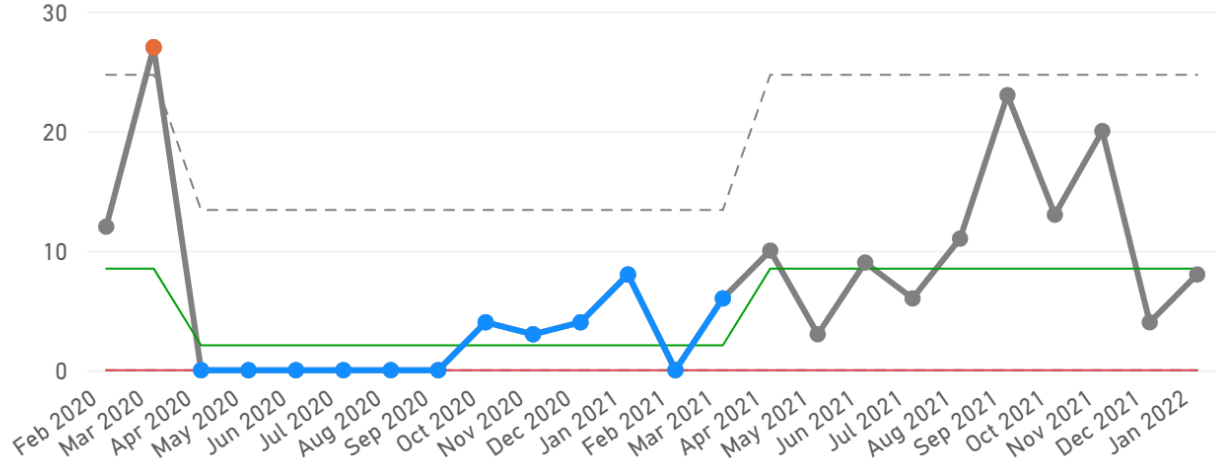
Cancelled Ops - Non-Urgent Cancelled On Day

Month	Performance	Target	Trend	Assurance
Jan 2022	33	0		



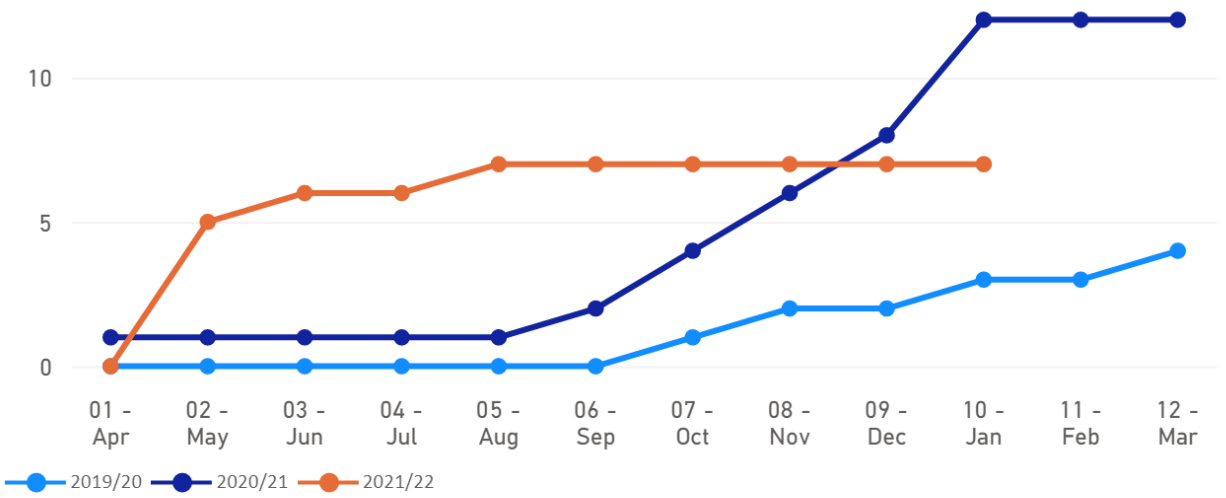
Cancelled Ops - Not Rebooked Within 28 days

Month	Performance	Target	Trend	Assurance
Jan 2022	8	0		



Cancer Operations Cancelled On Day (YTD)

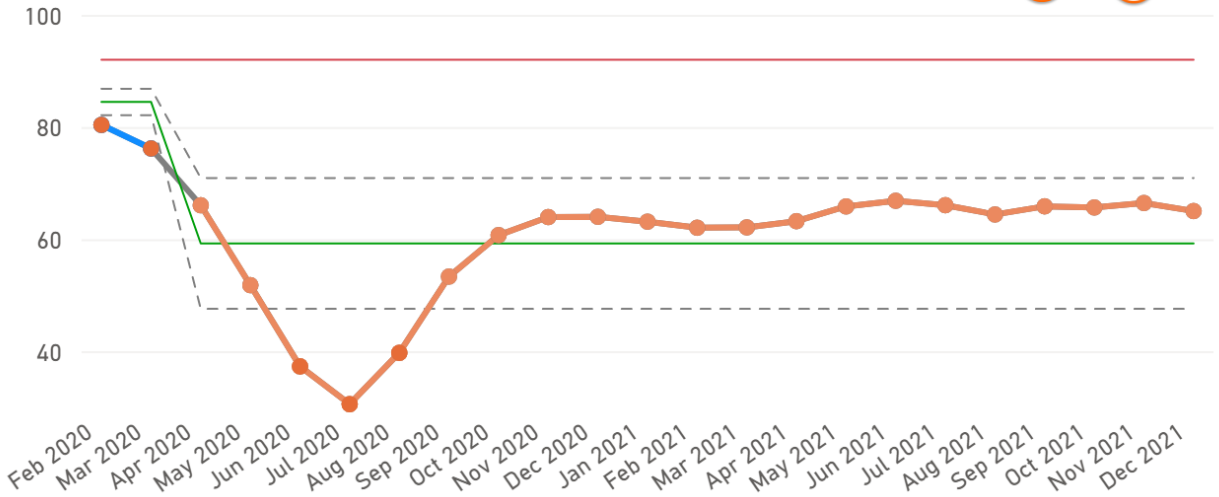
Month	Performance	Target	Trend	Assurance
Jan 2022	7	0	N/A	N/A



RESPONSIVE

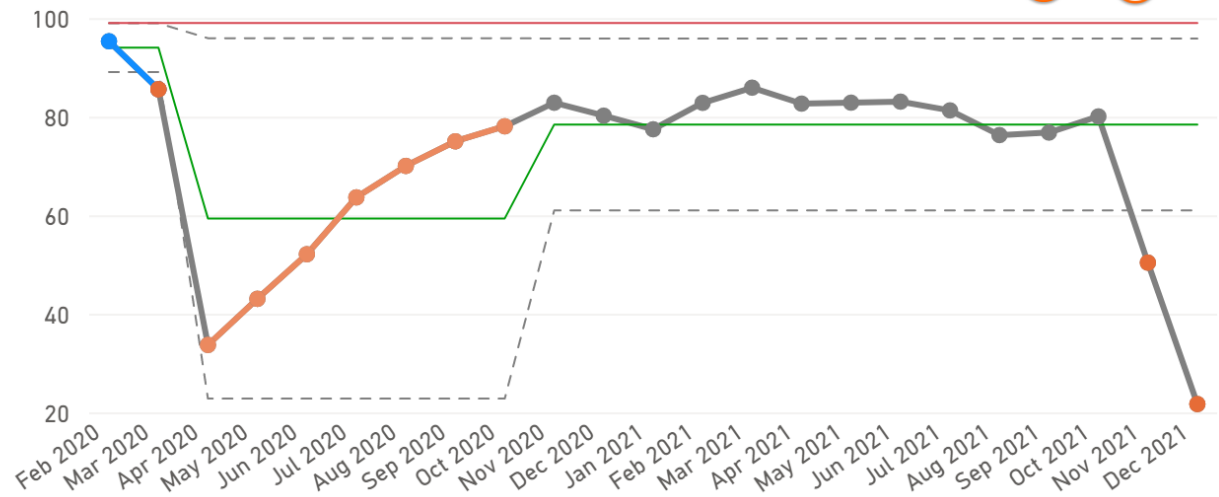
RTT Incomplete Pathways (%)

Month	Performance	Target	Trend	Assurance
Dec 2021	65.01%	92%		



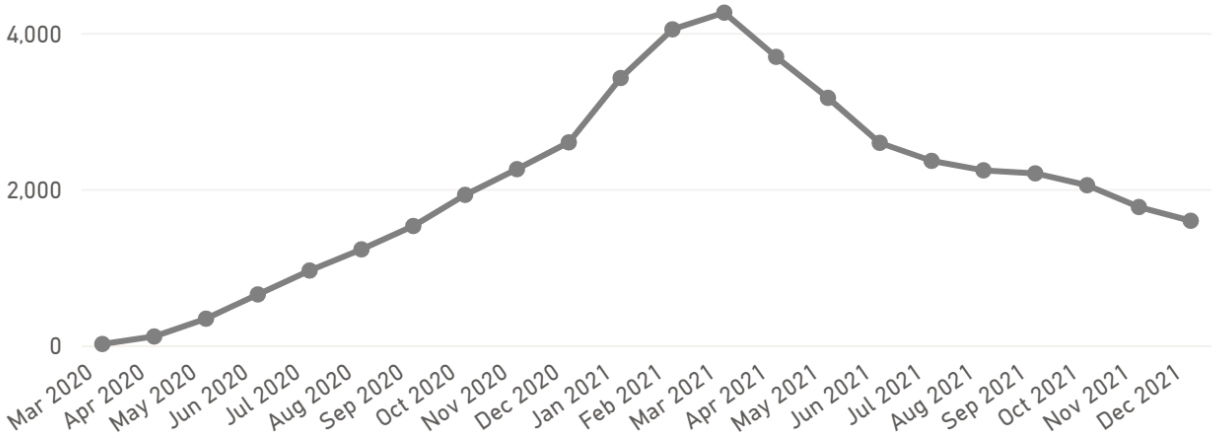
Diagnostic 6 Weeks Standard (%)

Month	Performance	Target	Trend	Assurance
Dec 2021	21.68%	99%		



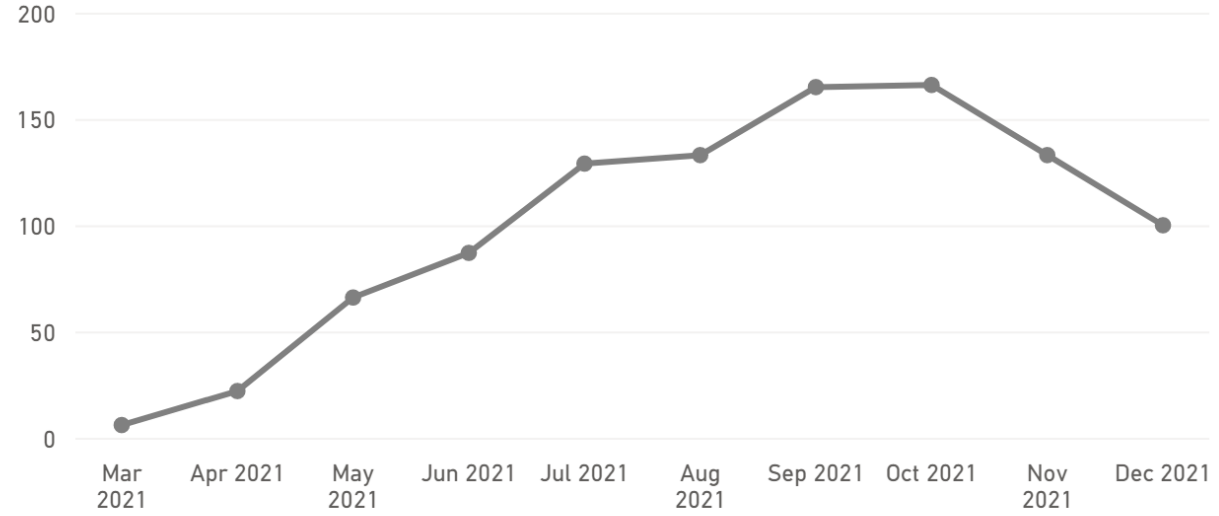
RTT 52 week waiters

Month	Performance	Target	Trend	Assurance
Dec 2021	1593	2512	N/A	N/A



RTT 104 week waiters

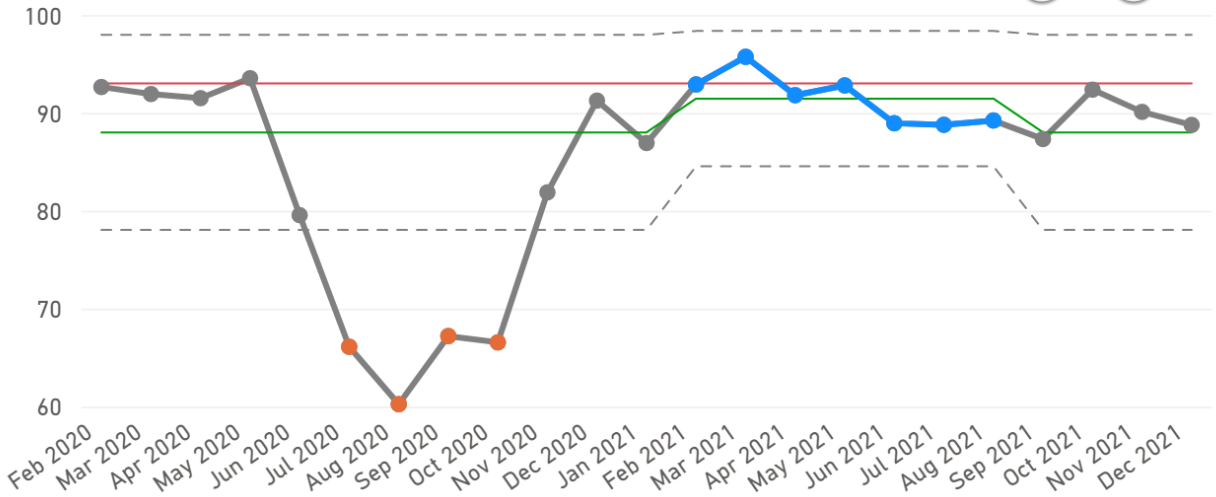
Month	Performance	Target	Trend	Assurance
Dec 2021	100	94	N/A	N/A



RESPONSIVE

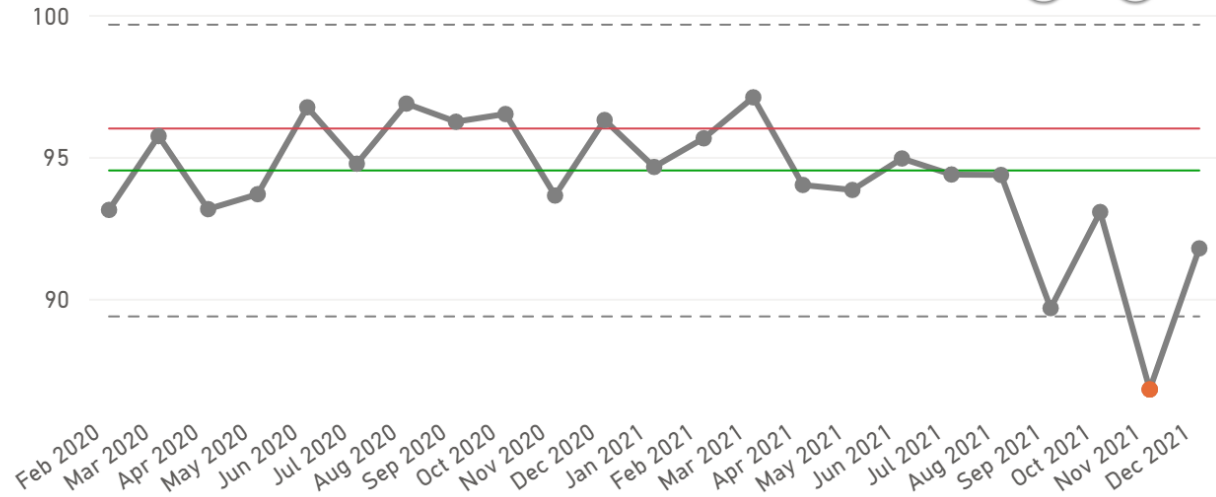
Cancer 14 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Dec 2021	88.76%	93%		



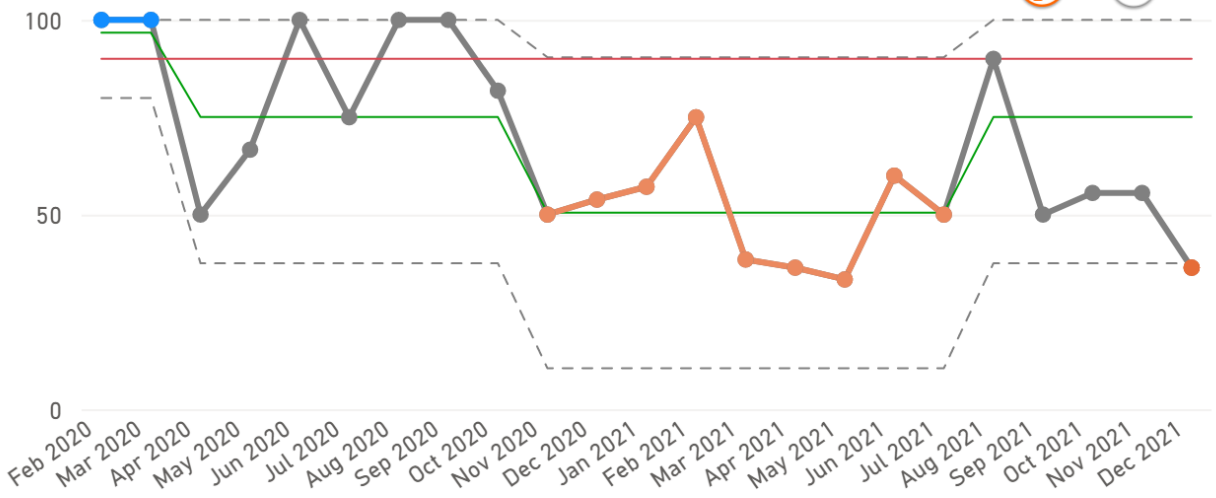
Cancer 31 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Dec 2021	91.77%	96%		



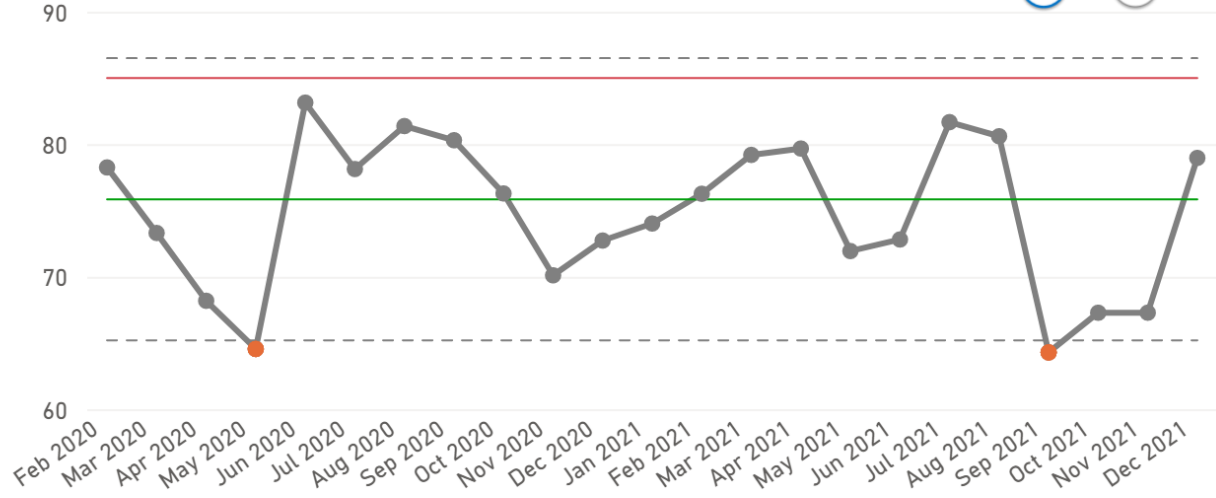
Cancer 62 Day Screening (%)

Month	Performance	Target	Trend	Assurance
Dec 2021	36.36%	90%		



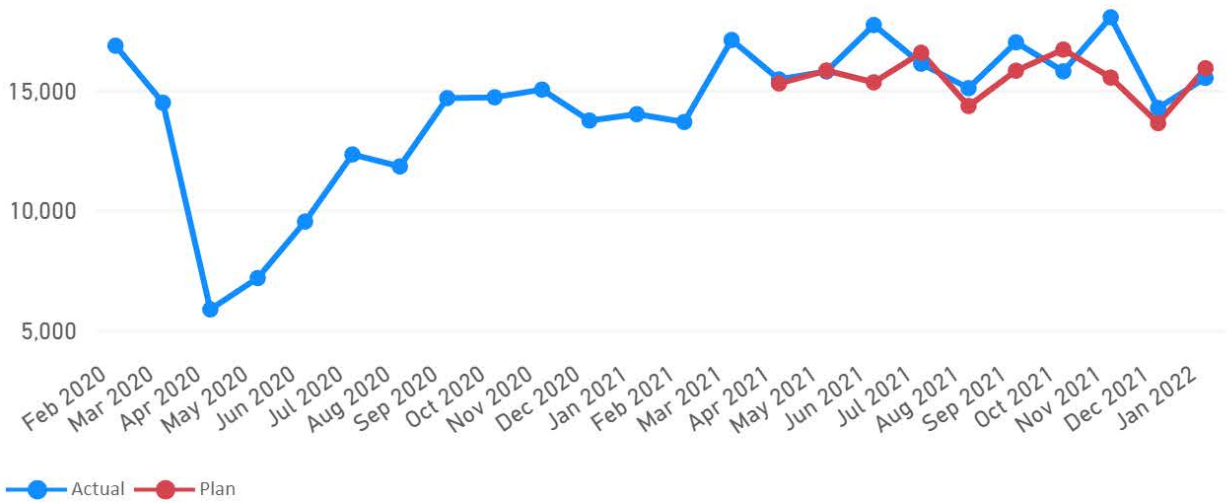
Cancer 62 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Dec 2021	78.96%	85%		

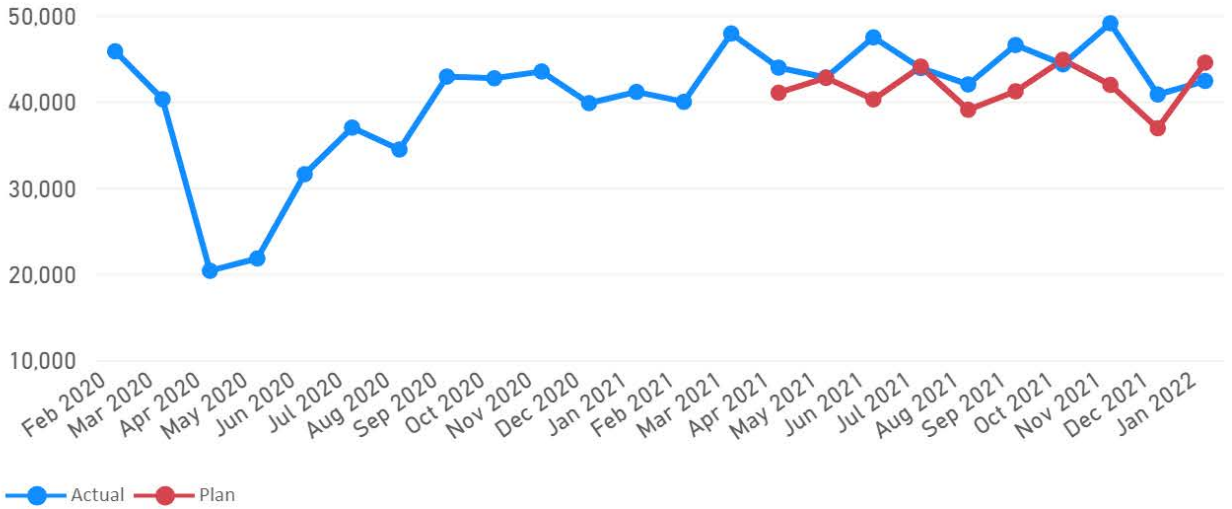


RESPONSIVE

Outpatient New Attendances

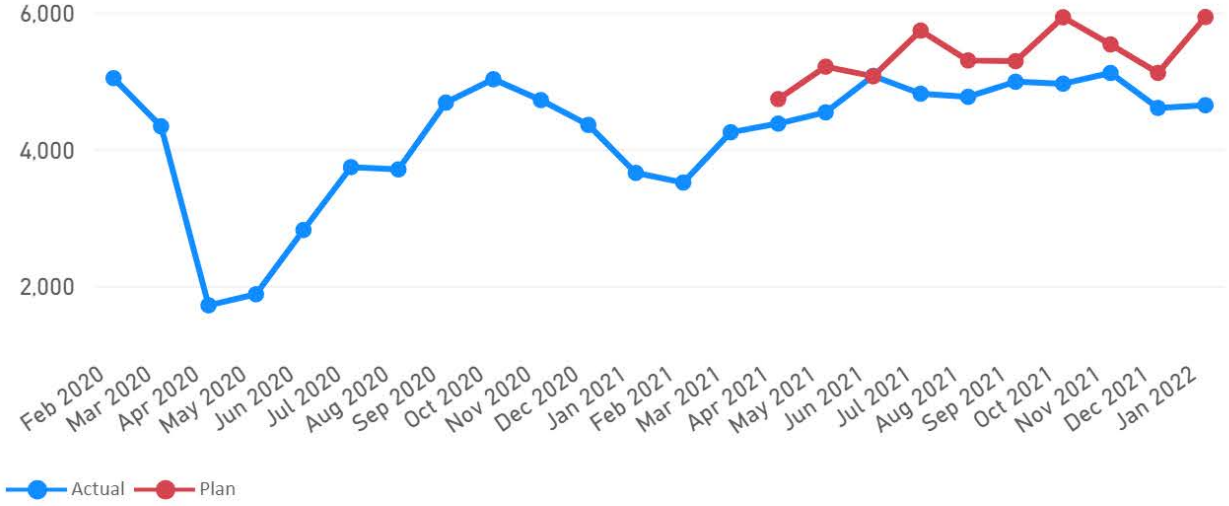


Outpatient Follow-Up Attendances

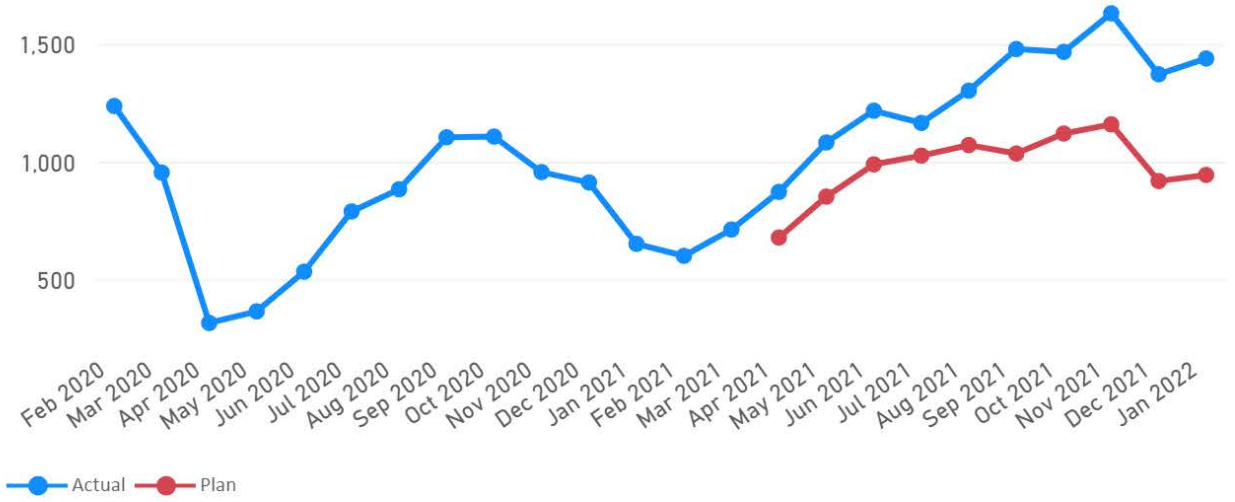


RESPONSIVE

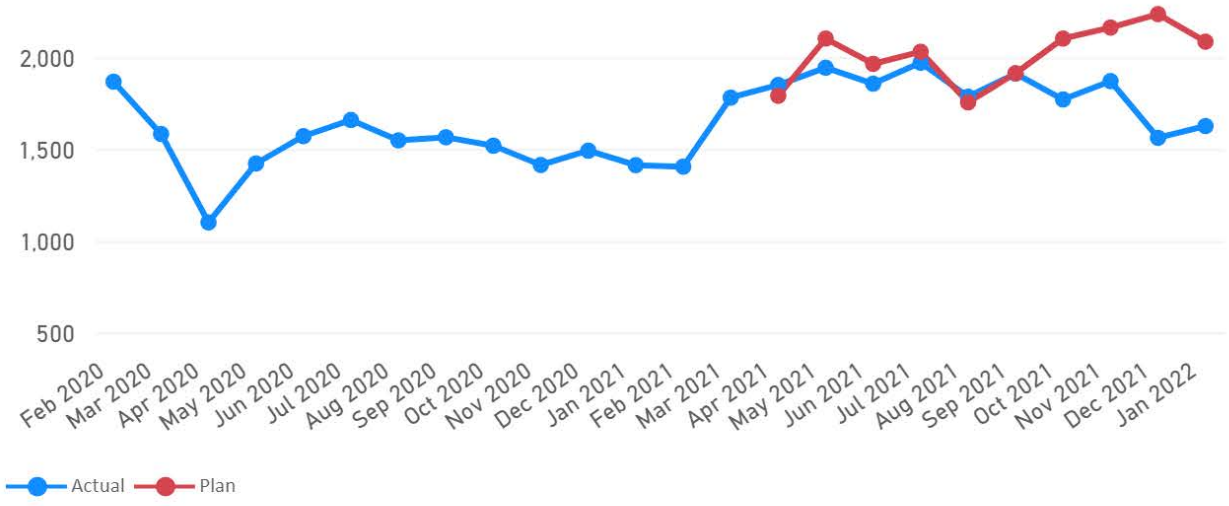
Day Case admissions



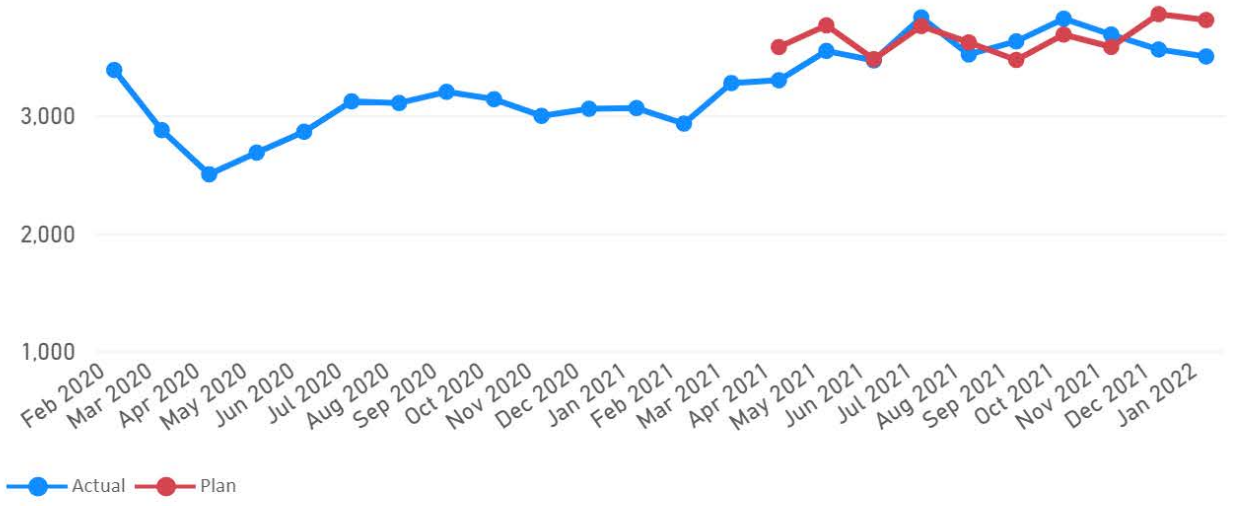
Ordinary Elective admissions



NEL admissions with 0 LOS



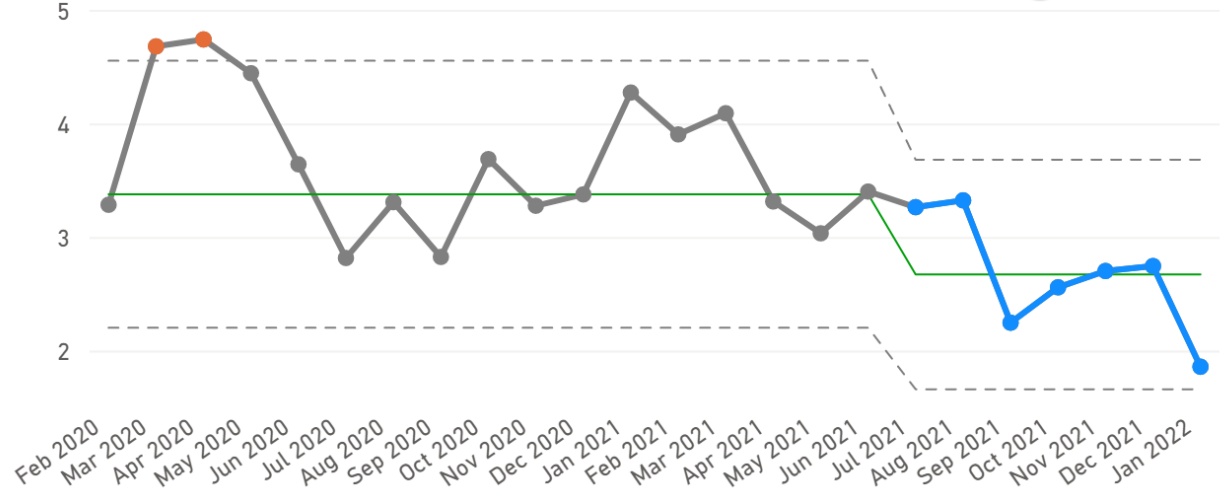
NEL admissions with 1+ LOS



RESPONSIVE

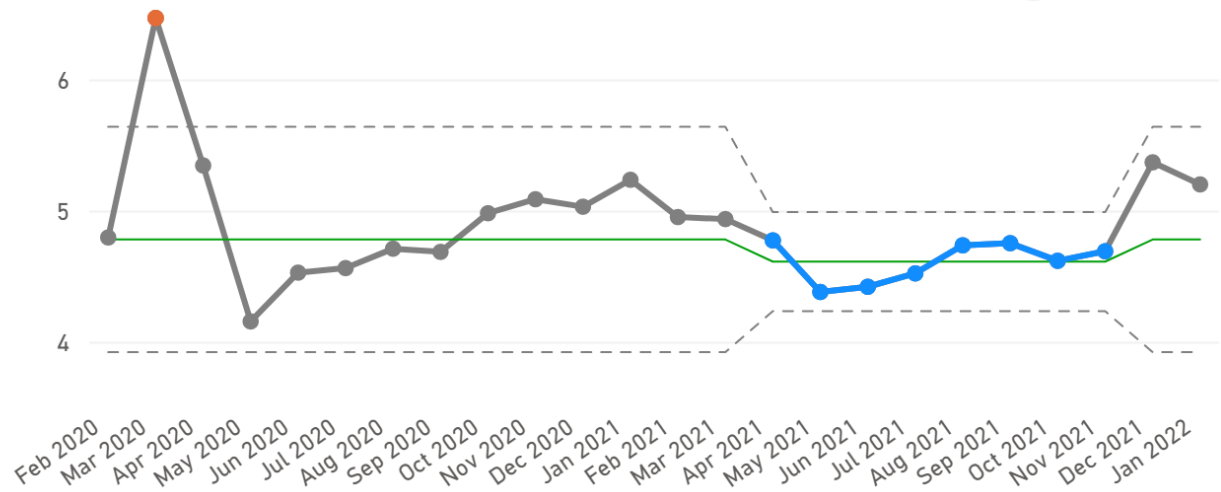
Length of Stay - Elective

Month	Performance	Target	Trend	Assurance
Jan 2022	1.86	N/A		N/A



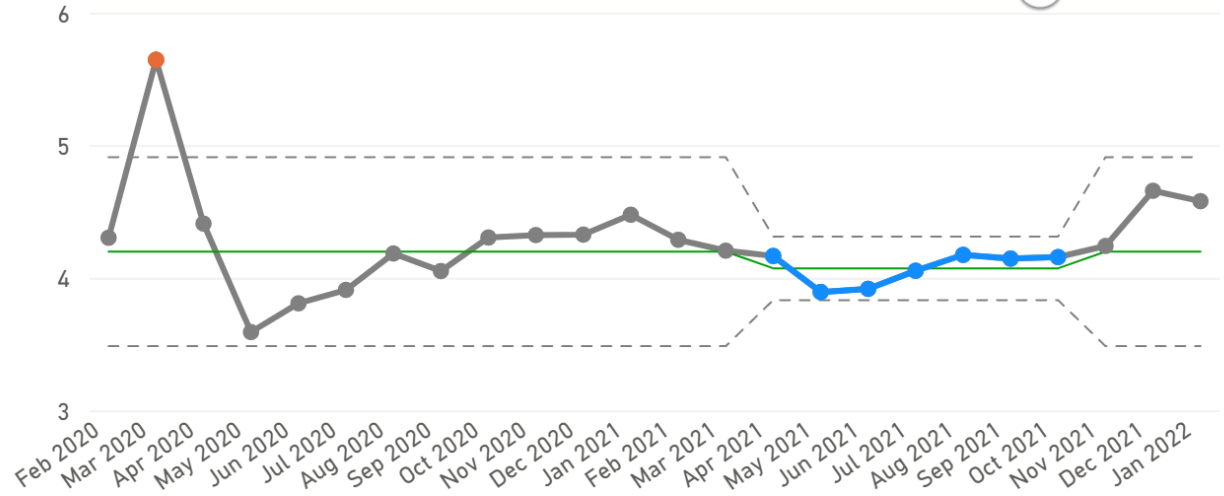
Length of Stay - Emergency

Month	Performance	Target	Trend	Assurance
Jan 2022	5.2	N/A		N/A



Length of Stay - Non-Elective

Month	Performance	Target	Trend	Assurance
Jan 2022	4.58	N/A		N/A



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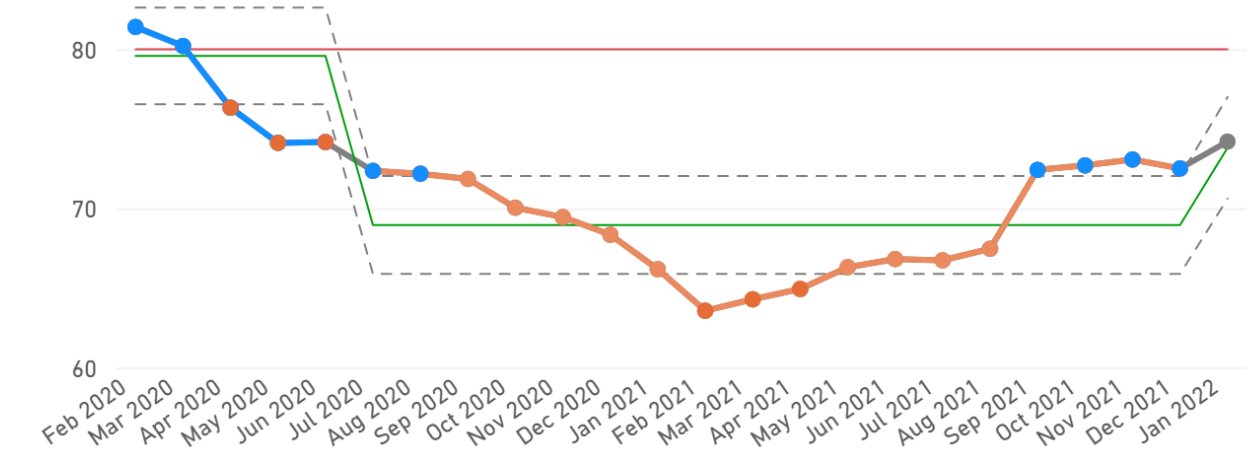
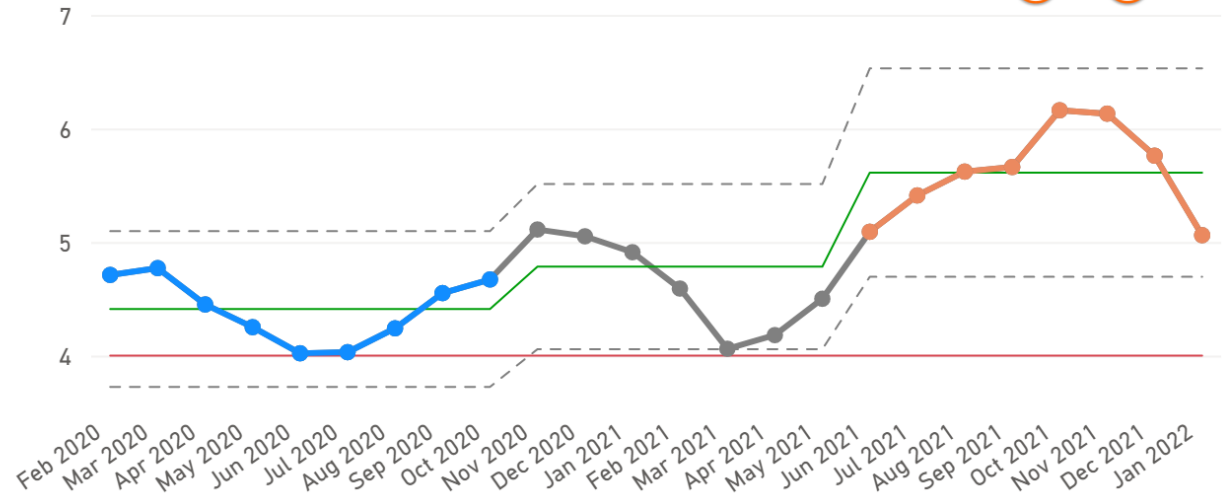
Annual Appraisal (%)

Month	Performance	Target	Trend	Assurance
Jan 2022	74.2%	80%		F



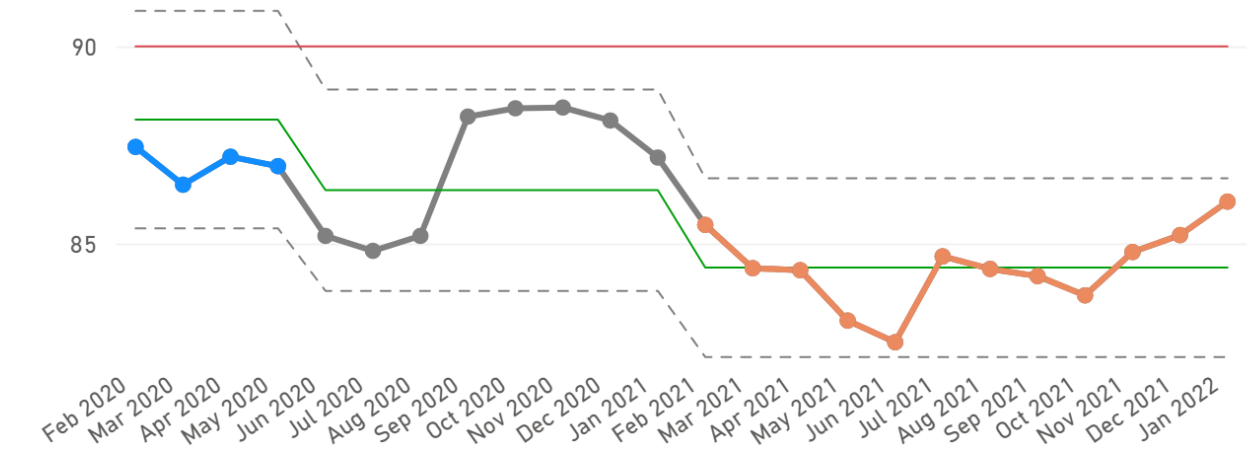
Sickness Absence (%)

Month	Performance	Target	Trend	Assurance
Jan 2022	5.06%	4%	H	F



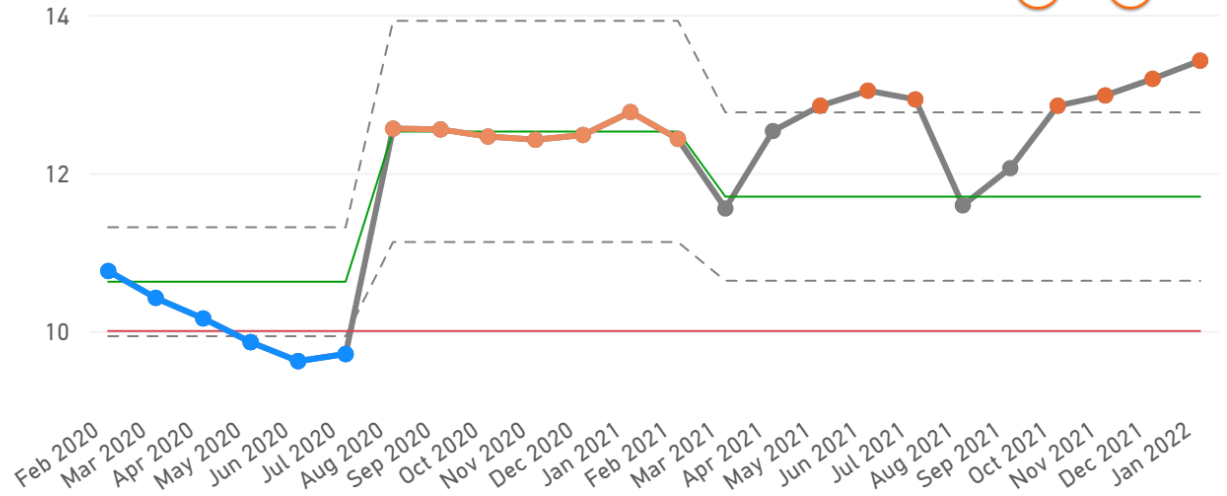
Mandatory Training (%)

Month	Performance	Target	Trend	Assurance
Jan 2022	86.06%	90%	L	F



Staff Turnover (%)

Month	Performance	Target	Trend	Assurance
Jan 2022	13.42%	10%	H	F



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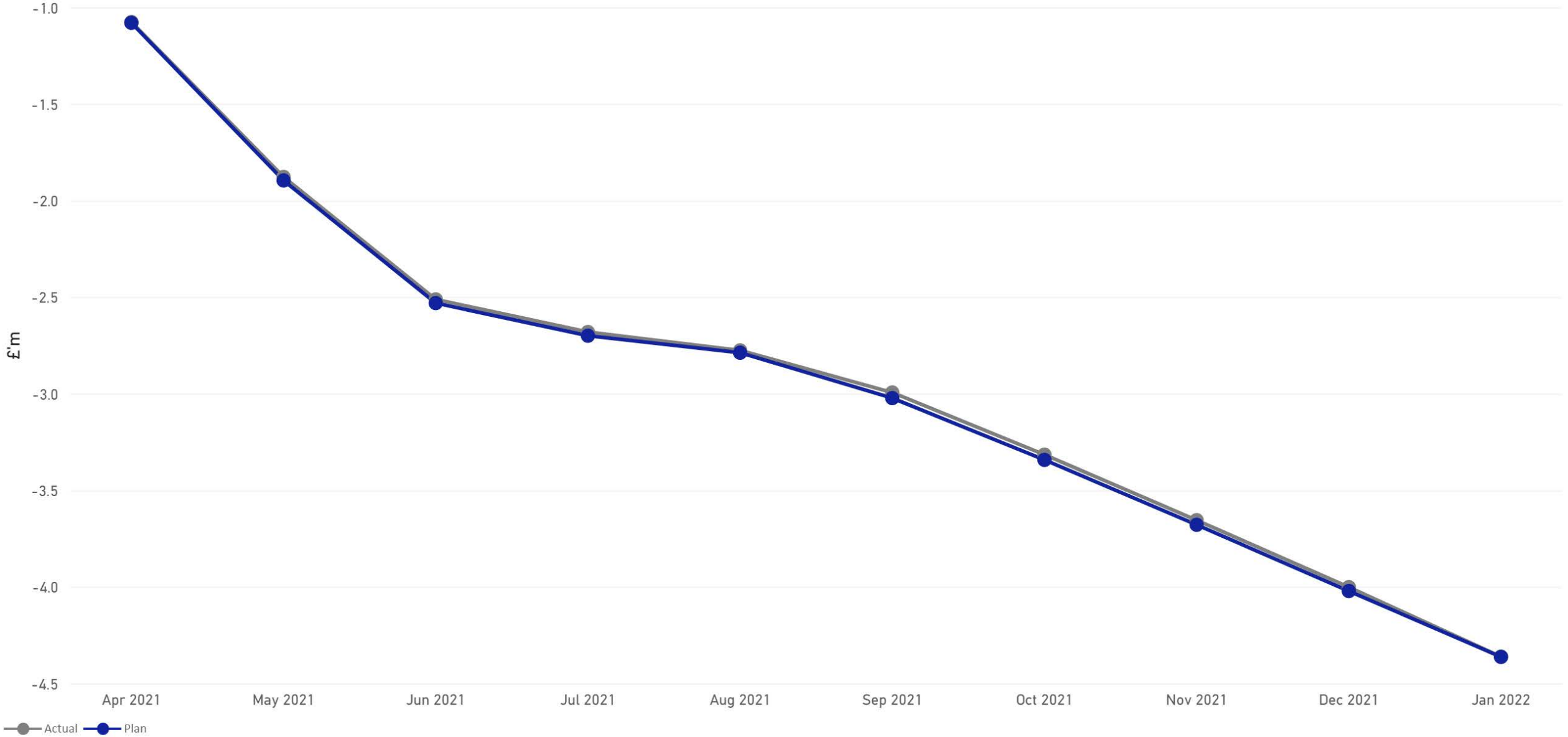
Cumulative YTD Financial Position (£'millions)

Month	Performance	Target
Jan 2022	-£4.362m	-£4.363m



MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 March 2022			
Safe Staffing Report for January 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 January 2022		
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 is 95.8% with RN fill rates at 85.4% on days, as per table 1, demonstrating compliance with safer staffing. Staffing has continued to be a challenge across the trust with continued short notice unavailability associated with Covid isolation and Covid related absence. Stretch staffing ratios have been initiated where necessary based on skill mix, acuity and occupancy levels to keep patients safe, with all actions agreed by senior nurses through twice daily safe care meetings. The introduction of allocate on arrival shifts for RNs and HCAs (6 per day and night at JCUH and 1 per day and night at FHN) has seen improved pick up in January, these shifts are promoted daily via ward managers and NHSp text messaging. This model has been followed in community with impactful pick up Nursing Turnover for January has increased slightly to 8.26%		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐ (select the relevant assurance level)		
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
January 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 532 total shifts (5542.45 hours) logged via SafeCare during January which was an increase on December 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 January 2022

The breakdown by ward is in Table 2

Table 1 – Trust wide Monthly Fill Rates

		November 2021	December 21	January 22
Overall Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	90.5%	84.9%	85.4%
	HCA (%) Average fill rate - DAYS	93.3%	92.2%	94.3%
	NA (%) Average fill rate - DAYS	100%	100%	100%
	TNA (%) Average fill rate - DAYS	100%	100%	100%
	RN/RMs (%) Average fill rate - NIGHTS	92.4%	85.8%	87.7%
	HCA (%) Average fill rate - NIGHTS	109.2%	100.2%	98.9%
	NA (%) Average fill rate - NIGHTS	100%	100%	100%
	TNA (%) Average fill rate - NIGHTS	100%	100%	100%
	Total % of Overall planned hours	**98.8%**	**95.4%**	**95.8%**

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	Occupied Beds January (at midnight)	Total CHPPD	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 (COVID Assessment)	28	28	20	623	77.5%	86.7%	-	100.0%	72.8%	82.8%	-	100.0%	
Ward 2 AAU (Short Stay Staff)	28	28	25	771	74.3%	84.8%	100.0%	-	74.1%	108.5%	100.0%	-	
Ward 3 (COVID)	28	28	17	528	94.7%	124%	-	100.0%	96.6%	101.8%	-	100.0%	
Ward 4	23	23	21	647	74.8%	98.5%	-	-	66.5%	104.8%	-	100.0%	
Ward 5	28	22	14	430	73.4%	75.7%	-	100.0%	73.1%	98.4%	-	-	Redeployment to other areas due to low occupancy
Ward 6	30	30	27	848	85.7%	111%	-	-	90.2%	98.3%	-	-	
Ward 7	30	30	25	765	76.5%	98.4%	100.0%	100.0%	84.6%	93.4%	100.0%	-	
Ward 8	30	30	27	844	79.9%	103%	100.0%	100.0%	76.3%	94.3%	-	100.0%	
Ward 9	28	28	20	628	78.4%	106%	100.0%	-	78.2%	91.4%	-	-	
Ward 10	27	27	24	740	79.9%	69.4%	-	-	72.0%	113.9%	-	-	Temporary reduction from 28 beds to 25
Ward 11	28	28	22	684	82.4%	74.1%	-	100.0%	80.6%	84.7%	-	-	
Ward 12	26	26	24	730	101.5%	108.3%	-	-	67.3%	127.0%	-	-	
Ward 14	23	21	19	577	100.4%	88.6%	-	100.0%	75.4%	104.6%	-	-	
Ward 24	23	23	20	612	90.9%	153.4%	-	100.0%	72.4%	211.0%	-	100.0%	
Ward 25	21	16	8	244	136.3%	246.0%	-	-	103.4%	163.5%	-	-	
Ward 26	18	18	18	543	92.4%	92.1%	-	-	100.1%	111.0%	-	-	
Ward 27	15	15	9	599	60.1%	52.7%	-	100.0%	85.1%	54.3%	-	-	Extreme low occupancy of elective pathway
Ward 28	30	30	22	694	78.9%	76.9%	-	-	90.3%	94.8%	-	-	
Ward 29	27	27	23	712	96.2%	98.9%	100.0%	-	78.2%	130.0%	-	-	

Cardio MB	9	9	8	248	99.8%	202.6%	-	-	98.4%	-	-	-	
Ward 31	35	19	24	747	107.2%	116.7%	100.0%	-	80.9%	128.9%	100.0%	-	
Ward 32	22	21	18	570	97.9%	98.5%	-	-	99.9%	99.9%	-	-	
Ward 33	19	19	16	487	75.7%	96.2%	-	-	67.8%	99.9%	-	-	
Ward 34	34	34	30	926	87.0%	99.1%	-	-	67.2%	95.9%	-	-	
Ward 35	26	26	20	610	88.1%	107.7%	-	-	82.2%	102.8%	-	-	
Ward 36	34	34	29	888	87.3%	87.8%	-	100.0%	71.2%	111.6%	-	100.0%	
Ward 37 - AMU	30	30	24	741	83.5%	83.2%	-	100.0%	81.0%	86.1%	-	100.0%	
Critical Care + Surge	33	33	27	845	97.1%	98.4%	-	-	96.1%	90.4%	-	-	
CICU JCUH	12	10	7	228	75.7%	97.6%	-	-	75.1%	158.1%	-	-	Full adherence to GPIX standards
Cardio HDU	10	10	6	191	76.4%	86.8%	-	-	71.2%	85.6%	-	-	Full adherence to GPIX standards
Ward 24 HDU	8	8	7	221	104.8%	88.6%	-	-	98.7%	64.5%	-	-	
Ainderby FHN	27	22	19	594	69.8%	95.3%	-	-	94.2%	92.7%	-	-	
Romanby FHN	26	26	17	515	66.2%	82.9%	-	-	95.4%	88.7%	-	-	
Gara FHN	21	16	6	195	71.5%	74.8%	-	-	85.6%	21.5%	-	-	
Rutson FHN	17	17	15	468	70.2%	107.8%	-	-	100.0%	92.0%	-	-	
Friary Community Hospital	18	18	11	348	107.2%	93.1%	-	-	102.0%	74.9%	-	-	
Zetland	31	29	29	888	97.5%	77.1%	-	100.0%	112.9%	142.7%	-	100.0%	
Tocketts Ward	30	26	28	865	76.6%	99.3%	-	-	72.9%	107.1%	-	-	
Ward 21	25	25	10	295	77.6%	89.8%	-	-	71.7%	88.7%	-	-	Staff redeployed due to reduced acuity
Ward 22	17	17	5	150	83.8%	55.1%	-	-	77.1%	37.1%	-	-	Staff redeployed due to reduced acuity

JCDS (Central Delivery Suite)	-	-	10	315	92.4%	48.5%	-	100.0%	90.6%	78.9%	-	-	
Neonatal Unit (NNU)	35	35	21	655	82.9%	96.8%	-	-	87.0%	-	-	-	
Paediatric Intensive Care Unit (PCCU)	6	6	2	71	76.9%	69.5%	-	-	77.5%	-	-	-	Staff redeployed due to reduced acuity
Ward 17 JCUH	-	-	24	733	90.8%	68.0%	-	100.0%	95.2%	66.6%	-	-	
Ward 19 Ante Natal	-	-	7	232	79.3%	61.6%	-	-	98.4%	-	-	-	
Maternity Centre FHN	-	-	0	9	117.7%	20.9%	-	100.0%	91.3%	-	-	-	
Spinal Injuries	24	24	17	522	98.7%	123.0%	-	-	200.0%	96.8%	-	-	
CCU JCUH	14	14	10	318	79.2%	145.8%	-	-	77.4%	-	-	-	

Increased staff sickness and COVID isolation continues to be significant during January. Nursing turnover increased slightly from 8.21% to 8.26%.

NHSp Vs Overtime

In order to mitigate staffing gaps additional resource is used to provide a safe and effective workforce. Collaborative working with NHSp allows for a more cost effective provision of staffing. It also allows for a centralised system pairing NHSp and ERoster interface as a single booking point enabling rapid redeployment.

Nurse sensitive indicators

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

Red Flags Raised through SafeCare Live

Table 5 below shows 156 red flags relating to workforce, with shortfall in RN time being the most common (127).

In relation to red flags for less than 2 RNs on shift the introduction of the SafeCare log provides a documented resolution to this particular red flag therefore no shift had less than 2 RNs throughout January.

Table 5 - Red flag reporting January 2022

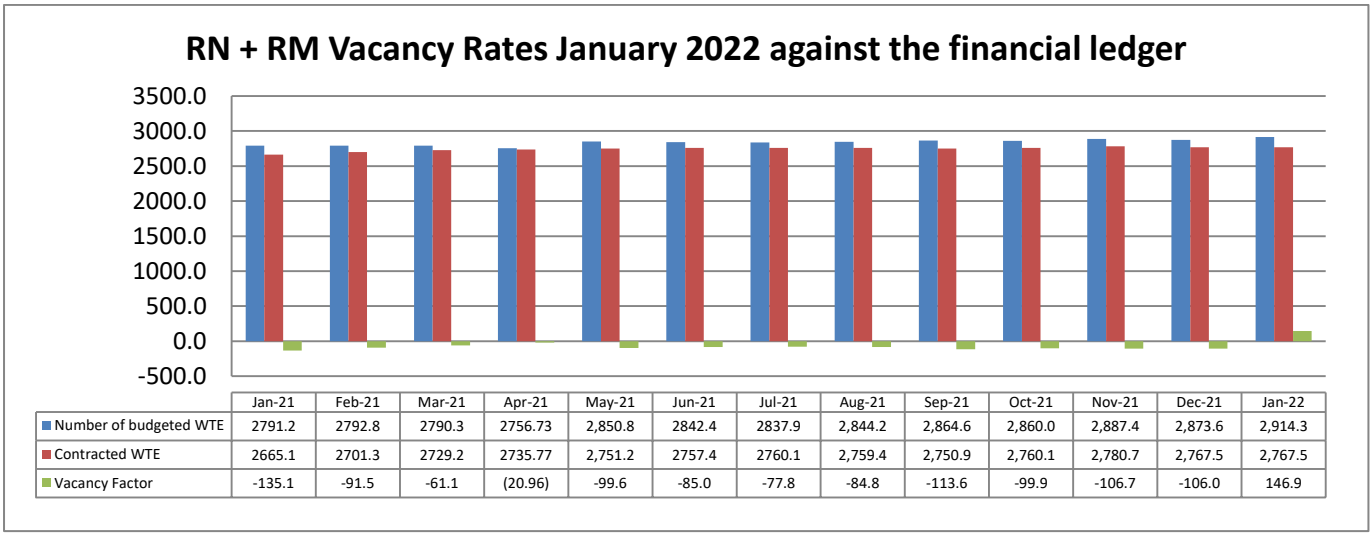
Red Flag Type	Open – Day	Open – Night	Grand Total
Less than 2 RNs on shift	11	18	**29**
Shortfall in RN time	86	41	**127**
Grand Total	**97**	**59**	**156**

There were 87 datix submissions relating to staffing in January. Redeployment decisions were made following safe staffing discussions with Matrons.

Vacancy and Turnover

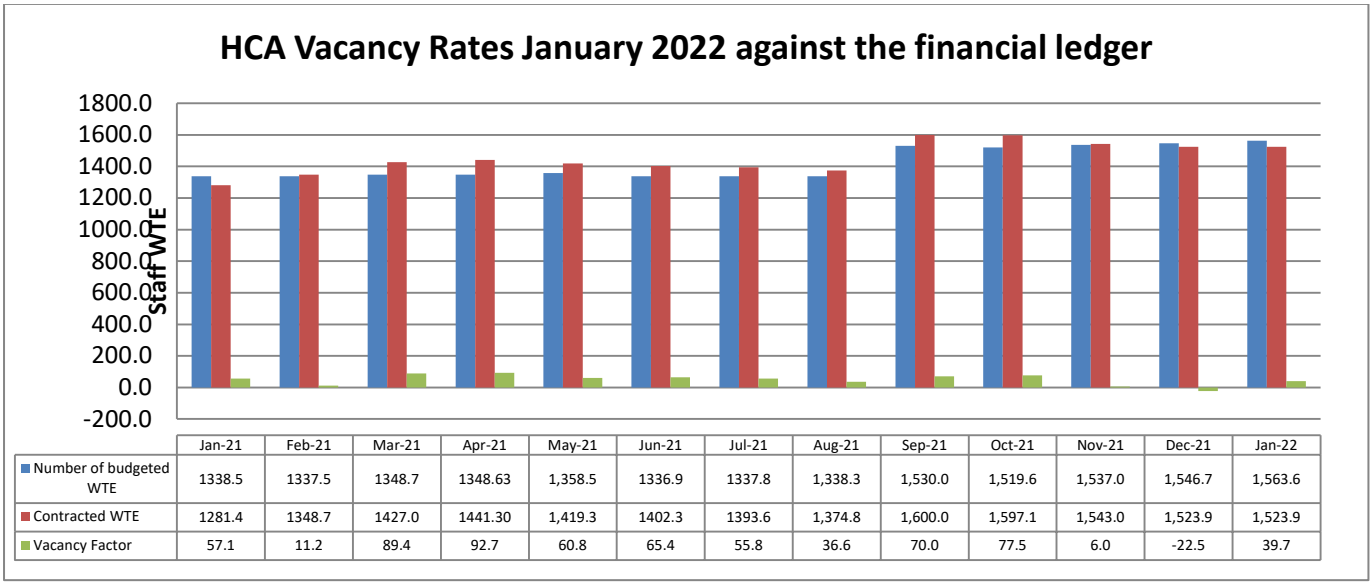
Recruitment of nursing staff continues as vacancies arise. (Fig 1 and 2)

Figure 1 Registered Nursing Vacancy Rate January 2022



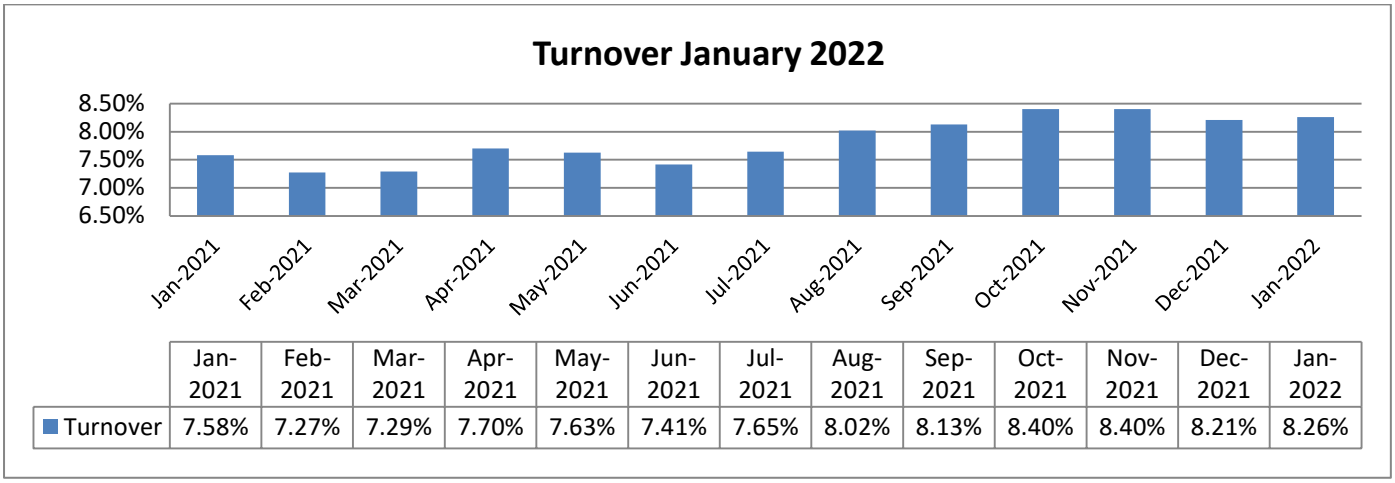
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Number of budgeted WTE	2791.2	2792.8	2790.3	2756.73	2,850.8	2842.4	2837.9	2,844.2	2,864.6	2,860.0	2,887.4	2,873.6	2,914.3
Contracted WTE	2665.1	2701.3	2729.2	2735.77	2,751.2	2757.4	2760.1	2,759.4	2,750.9	2,760.1	2,780.7	2,767.5	2,767.5
Vacancy Factor	-135.1	-91.5	-61.1	(20.96)	-99.6	-85.0	-77.8	-84.8	-113.6	-99.9	-106.7	-106.0	146.9

Figure 2 Health Care Assistant Vacancy Rate January 2022



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Number of budgeted WTE	1338.5	1337.5	1348.7	1348.63	1,358.5	1336.9	1337.8	1,338.3	1,530.0	1,519.6	1,537.0	1,546.7	1,563.6
Contracted WTE	1281.4	1348.7	1427.0	1441.30	1,419.3	1402.3	1393.6	1,374.8	1,600.0	1,597.1	1,543.0	1,523.9	1,523.9
Vacancy Factor	57.1	11.2	89.4	92.7	60.8	65.4	55.8	36.6	70.0	77.5	6.0	-22.5	39.7

Figure 3 Nursing Turnover January 2022



	Jan-2021	Feb-2021	Mar-2021	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022
Turnover	7.58%	7.27%	7.29%	7.70%	7.63%	7.41%	7.65%	8.02%	8.13%	8.40%	8.40%	8.21%	8.26%

Summary

SafeCare staffing review takes place each day to ensure all patients can be cared for safely, with a high number of staff moves to enable management of risk within areas of higher patient acuity.

Staffing remains a challenge with staff working incredibly hard at a time of higher than normal absence due to COVID-19.

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 March 2022			
Maternity Services – First Anniversary of Ockenden			**AGENDA ITEM: 14** **ENC 9**
Report Author and Job Title:	Lynne Staite Head of Midwifery Dr Deepika Meneni, Obstetric Clinical Director	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	To provide an update on the Trusts maternity service following the first anniversary of the publication of the Ockenden report		
Background	As part of the Ockenden review of maternity services, providers were required 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. Once submitted, these were reviewed by NHSE/I, who then provided feedback to each Maternity Unit in the country.		
Assessment	This paper summarises the Trusts current position of maternity services in terms of meeting the Ockenden recommendations and the current maternity workforce assessment and plan. This has been discussed at the Quality Assurance Committee.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	The Committee are asked to note the results of the Ockenden assessment		
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		
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 ☒	

Maternity Services – First Anniversary of Ockenden

1. PURPOSE OF REPORT

The purpose of the report is to provide an update on the Trusts maternity service following the first anniversary of the publication of the Ockenden report.

2. BACKGROUND

As part of the Ockenden review of maternity services, providers were required 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.

Once submitted, these were reviewed by NHSE/I, who then provided feedback to each Maternity Unit in the country.

The review by NHSE/I did not include the assessment of the quality or clinical appropriateness of the evidence; it only determined whether a provider had submitted the evidence or not. This was in the form of documents such as standard operating procedures, board minutes, dashboards etc.

3. OCKENDEN SUBMISSION AND FEEDBACK

NHSE/I's assessment of the Trusts Ockenden submission against the 41 minimal standards was received by the Trust on the 1st November 2021 as follows:

6/41 (15%)	
25/41 (61%)	
10/41 (24%)	

The Trust reviewed the NHSE/I feedback and cross checked this against the original Ockenden submission with the original minimal standards of evidence circulated by the LMS and the regional Chief Midwife.

The feedback showed that for 6/41 the Trust had submitted 100% of the minimal requirements for evidence, 25/41 some evidence had been submitted but not all to the minimum standard, and for 10/41 no evidence was submitted.

On reviewing the feedback from NHSE/I and crossing checking this, it was noted that some evidence did exist with the Trust, but had not been submitted.

4. ACTION TAKEN FOLLOWING FEEDBACK FORM NHSE/I

Following the Ockenden submission, providers were required to put action plans in place for any of the immediate and essential actions (IEA's) that they did not meet, whilst awaiting official NHSE/I feedback. To note, not all IEAs were achievable at the time of the original submission, as some were co-dependant on the LMS/ICS.

Our Ockenden action plan has been updated below and positively it can be seen that we now have either completed or are in the process of completing all of our actions, since the original submission in June 2021. The Trusts Maternity Assurance Board, chaired by the Chief Nurse oversees the progress of this action plan.

Below is a summary status of the action plan against the 7 IEA's and 41 standards.

121 pieces of evidence are required to provide assurance against the 41 standards. The Ockenden feedback in November was that the Trust had provided 47 pieces of evidence. In February 2022 the Trust is able to provide 66 pieces of evidence that shows full compliance with the standard and 55 pieces of evidence that shows partial compliance with the standard.

IEA 1 Enhanced safety		
Standard Required	**Evidence Required**	**Further Actions Required**
Maternity Dashboard to LMS every 3 months	SOP for internal and external reporting Submission of organogram and minutes that shows how this occurs Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken Dashboard	Process not agreed with LMS for submission to and review by LMNS, informal arrangement in place to submit. Formal process to be clarified Organogram from LMNS Development of new SOP for how the Trust reports this both internally and external through the LMNS
External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Policy or SOP for involving external specialists Audit to demonstrate compliance	Awaiting final draft of network policy
Maternity SIs to Trust Board & LMS every 3 months	SOP 3 monthly TB minutes SI reports	Awaiting LMNS process for SI submission
Use of PMRT to review perinatal deaths	Local PMRT report Trust PMRT report SOP for parental involvement Audit of PMRT completion	Review of parental involvement SOP
Submitting data to the Maternity Services Dataset to the required standard	Plan for implementation of all MSDS requirements	Digital transformation plan ongoing
Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit to demonstrate 100% reporting	None
Plan to implement the Perinatal Clinical Quality Surveillance Model	Implementation of full framework by June 2021 SOP and organogram signed off by the Trust LMNS SOP and minutes to describe how this is embedded in the ICS governance structure	Awaiting LMNS SOP re ICS governance structure

IEA2 listening to women and their families		
Standard Required	**Evidence Required**	**Further Actions Required**
Non-executive director who has oversight of maternity services	Name and date of appointment of NED Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed Evidence of link in to MVP; any other mechanisms NED JD	Develop NED role with MVP
Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Evidence of co-production service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	Re-instatement of 15 steps when safe to do so
Trust safety champions meeting bimonthly with Board level champions	Minutes of the meeting and minutes of the LMS meeting where this is discussed.	Awaiting guidance from LMNS and process for discussion
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	None
Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken Role descriptors	Action plan to be formulated for embedding of NED role National role descriptor to be included in local TOR

IEA 3 staff training and working together		
Standard Required	**Evidence Required**	**Further Actions Required**
Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. LMS reports showing regular review of training data (attendance, compliance	Awaiting LMNS process

	coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. A clear trajectory in place to meet and maintain compliance as articulated in the TNA	
Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	SOP created for consultant led ward rounds. Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	Need SOP to be formulated Continue with use of acuity tool to monitor compliance with ward rounds
External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Evidence that additional external funding has been spent on funding including staff can attend training in work time. Evidence of funding received and spent. Confirmation from Directors of Finance MTP spend reports to LMS Evidence from Budget statements.	Need evidence of funding received and spent Need process for MTS funding to be reviewed by LMS
90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	Attendance records - summarised	None
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week	
The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	Awaiting LMNS process

IEA 4 Managing complex pregnancy		
Standard Required	**Evidence Required**	**Further Actions Required**
Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a management plan that has been agreed between the women and clinician	Audit of referrals to tertiary centre Review of SOP
Women with complex pregnancies must have a	SOP that states that both women with complex pregnancies who require referral	Review of SOP Continue with quarterly QIC

named consultant lead	to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	audits which include this standard
Complex pregnancies have early specialist involvement and management plans agreed	SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	Review of SOP Completion of audit
Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	SOP's Audits for each element Guidelines with evidence for each pathway	Continue with quarterly monitoring
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. Criteria for referrals to MMC Agreed pathways	Continue to participate in network

IEA 5 risk assessment throughout pregnancy		
Standard Required	**Evidence Required**	**Further Actions Required**
All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	SOP that includes definition of antenatal risk assessment as per NICE guidance. How this is achieved within the organisation. What is being risk assessed. Review and discussed and documented intended place of birth at every visit. Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	Formulation of SOP to support AN guideline
Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	SOP that includes review of intended place of birth Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. AN guidance and SOPs	SOPs under development
A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This	SOP to describe risk assessment being undertaken at every contact. What is being risk assessed How this is achieved in the organization	SOP under development

is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. Example submission of a Personalised Care and Support Plan	

IEA 6 monitoring fetal well being		
Standard Required	**Evidence Required**	**Further Actions Required**
Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Name of dedicated Lead Midwife and Lead Obstetrician Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. Incident investigations and reviews	Embedding of roles is needed with clear job plan and objectives Implementation of quarterly reporting within new governance process
The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post Improving the practice & raising the profile of fetal wellbeing monitoring Consolidating existing knowledge of monitoring fetal wellbeing Keeping abreast of developments in the field Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	Further work to interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.

IEA 7 informed consent		
Standard Required	**Evidence Required**	**Further Actions Required**
Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	Assessment and rating of patient information by MVP

Women must be enabled to participate equally in all decision-making processes	SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded. An audit of 1% of notes demonstrating compliance. CQC survey and associated action plans	An audit of 1% of notes demonstrating compliance.
Women's choices following a shared and informed decision-making process must be respected	SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	SOP in development to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. An audit of 5% of notes demonstrating compliance
Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Gap analysis of website against Chelsea & Westminster conducted by the MVP Co-produced action plan to address gaps identified Information on maternal choice including choice for caesarean delivery Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	Gap analysis and action plan being co-designed with MVP

Workforce		
Standard Required	**Evidence Required**	**Further Actions Required**
Demonstrate an effective system of clinical workforce planning to the required standard	Most recent BR+ report and board minutes agreeing to fund Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	Awaiting guidance for LMNS/ICS re workforce planning
Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	None
Describe how your	Gap analysis completed against the RCM	

organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	strengthening midwifery leadership: a manifesto for better maternity care Action plan where manifesto is not met	
Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	SOP in place for all guidelines with a demonstrable process for ongoing review. Audit to demonstrate all guidelines are in date. Evidence of risk assessment where guidance is not implemented	All guideline currently being reviewed and uploaded onto intranet Review and ratification process being reviewed as part of new governance process

7 Ockenden IEAs (including 12 Clinical Priorities): **Trust _____ Exec Sign off _____**	Compliant	Partially Compliant	Non-Compliant
1) Enhanced Safety			
A plan to implement the Perinatal Clinical Quality Surveillance Model			
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB			
2) Listening to Women and their Families			
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services			
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion			
3) Staff Training and working together			
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week			
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.			
Confirmation that funding allocated for maternity staff training is ringfenced			
4) Managing complex pregnancy			
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place			
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres			
5) Risk Assessment throughout pregnancy			
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance			
6) Monitoring Fetal Wellbeing			
Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.			
7) Informed Consent			
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.			

The next stage is that the IEAs and associated provider action plans will be monitored by the regional Chief Midwife and ongoing compliance and assurance visits will be undertaken. These are expected to commence in early 2022.

5. RECOMMENDATIONS

The Committee are asked to:

1. Note the results of the Ockenden assessment and maternity workforce plans
2. Note the progress made to date and the action plan put on place to address any gaps.

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 1 March 2022			
Month 10 2021/22 Financial Performance			**Agenda Item 12, ENC 10**
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 10.		
Background	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 agreed its H2 plan. The Trust's requirement for 2021/22 is to deliver a £5.0m deficit.		
Assessment	At Month 10 the Trust reported a deficit of £4.4m at a system control total level. This is in line with the required budget deficit for M10 as agreed within the ICP/ICS. This report has been discussed in detail at the Resources Committee.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the financial position for Month 10.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addressees BAF principle 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 10 2021/22 Financial Performance

1. PURPOSE OF REPORT

The purpose of the report is to update the Trust Board on the financial position of the Trust as at Month 10.

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.

The Trust is required to deliver an overall deficit position of £5.0m for the full year.

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.

The Month 10 YTD actual performance is a £4.4m deficit at a control total level. This has resulted in the Trust being in line with its financial plan.

3. DETAILS

Trust position

The Month 10 position is outlined below; the following sections outline key variances and risks for divisional income, pay, non-pay and technical items.

	NHSE Plan YTD Budget £'000	YTD Actual £'000	NHSE Plan YTD Variance £'000	Adjustment £'000	Revised Internal YTD Variance £'000	NHSE Plan Full Year Budget £'000
NHS Clinical Income	582,065	598,555	**16,490**	(15,779)	**711**	701,043
Other Income	39,156	40,390	**1,234**	39	**1,273**	46,906
Pay	(362,971)	(373,113)	**(10,142)**	9,338	**(826)**	(437,856)
Operating Non Pay	(246,879)	(256,578)	**(9,699)**	5,947	**(3,752)**	(309,670)
Financing Costs	(16,166)	(15,241)	**925**	448	**1,373**	(19,266)
Other Non Operating	(50)	123	**173**	07	**180**	9,299
Surplus / (Deficit)	**(4,845)**	**(5,864)**	**(1,019)**	**0**	**(1,040)**	**(9,544)**
Reconciliation to system control total:						
Impairments	0	0	**0**	0	**0**	3,950
Donated Asset Inc / Depr	482	1,625	**1,143**	0	**1,143**	544
Gains / Losses	0	(123)	**(123)**	0	**(123)**	0
Control Total	**(4,363)**	**(4,362)**	**01**	**0**	**01**	**(5,050)**

Overall the Trust is on plan for Month 10 of 2021/22. The Trust position against the H1 and H2 planning submissions to NHSE/I is shown in the first 4 columns of the table above. This is partly normalised for net neutral budget adjustments, relating to additional income and expenditure such as pass through costs for high cost drugs and devices, and in relation to the Elective Recovery Fund.

The main variances against the adjusted budget are:

- Clinical income is over plan by £0.7m, relating to additional block commissioner income, which is offset by increased expenditure for service delivery.
- Other income is ahead of plan by £1.3m, relating to staff recharge income, maternity pathway income and R&D income.
- Pay expenditure is £0.8m overspent, driven by the recognition of the year to date element of the Flowers legal case and increased spend on premium pay and substantive staffing.
- Operating non pay is overspent by £3.8m overall, with overspends on drugs, premises costs and ICT systems offset by underspends on clinical supplies, and depreciation.
- Financing costs are underspent by £1.4m, relating to Public Dividend Capital (PDC) dividend, reflecting the Trust's current strong liquidity position under the current Covid funding arrangements.

Clinical Income

Under the revised financial arrangements for 2021/22, the Trust's previous aligned incentive contractual arrangement with its commissioners continues to be suspended as in 2020/21. Instead, the Trust is paid under a block arrangement with income fixed for the first half of the year, with the exception of the below items:

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

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

Commissioner Code	Commissioner Name	Block Payment
16C	NHS Tees Valley CCG	318,546
84H	NHS County Durham CCG	12,127
00P	NHS Sunderland CCG	449
01H	NHS North Cumbria CCG	554
13X	NHS England - North East and Yorkshire Commissioning Hub	168,895
13Q	NHS England - Central (CDF, HepC & C&V Variance)	7,264
Y63	NHS England - North East and Yorkshire Commissioning Region	8,881
Y58	South West Regional Office (MoD)	1,469
42D	NHS North Yorkshire CCG	76,452
03Q	NHS Vale of York CCG	1,242
CBF	Cross Boarder Flows	24
	Prior Year Adjustments	79
	Total Income Month 10	**595,982**

Clinical income is shown below split by income type:

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Blocks	514,025	515,435	**1,410**
Top Up	23,860	23,860	**0**
Covid-19	27,478	27,478	**0**
CDF	5,086	4,341	**(745)**
HEPC	636	660	**24**
High Cost Devices	8,720	8,720	**0**
Cost and volume drugs	2,250	2,255	**05**
ERF	7,149	7,149	**0**
TIF	291	324	**33**
Pay award funding	5,736	5,736	**0**
Prior year & cross boarder	40	24	**(16)**
YTD M8	**595,271**	**595,982**	**711**

The clinical income over achievement of £0.7m is due to additional block income being received from Commissioners, this is offset by CDF drugs income being less than plan. CDF Drugs have a corresponding underspend in the expenditure position.

At Month 10 the Trust has recognised income in relation to the H1 Elective Recovery Fund of £7.1m, with a corresponding expenditure value within pay and non-pay. The Trust has received an additional £0.1m ERF income compared to last month.

Other Income

Other income is £1.3m ahead of plan at Month 10.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Education & Training Income	16,820	16,705	**(116)**	20,215
Estates Income	1,836	1,885	**49**	2,204
Misc. Other Income	11,140	11,628	**488**	13,297
Non Patient Care Income	2,332	2,815	**483**	2,751
Other Clinical Income	2,479	2,533	**54**	2,975
Psf, Mret & Top Up	3,321	3,322	**01**	3,411
Research & Development Income	3,751	4,065	**314**	4,401
Total	**41,679**	**42,952**	**1,273**	**49,253**

- Education and Training income is behind plan YTD by £0.1m due to the phasing of the revised Health Education England schedule received for Q3, this income is still expected to be recovered by the year end.
- Non patient care income is overachieving by £0.5m from higher receipts year to date of maternity pathway income.
- Miscellaneous other income is overachieving due to an increase in income for staff recharges.

Pay

In the year to date position, pay is overspent by £0.8m, as outlined in the below table.

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Ahp'S, Sci., Ther. & Tech.	(54,030)	(54,315)	**(285)**	(65,132)
Hca'S & Support Staff	(38,697)	(40,518)	**(1,822)**	(46,727)
Medical And Dental	(110,331)	(112,044)	**(1,713)**	(132,271)
Nhs Infrastructure Support	(52,036)	(52,342)	**(306)**	(62,591)
Nursing & Midwife Staff	(115,887)	(112,204)	**3,683**	(139,773)
Other Pay Costs	(1,306)	(1,689)	**(383)**	(1,567)
Total	**(372,287)**	**(373,113)**	**(826)**	**(448,060)**

- Within the YTD pay position a budget for additional Covid costs of £8.6m is included, assigned to the specific staff group and directorate where costs are being incurred.

- HCAs, Support Staff and Nursing has a combined net £1.9m underspend position. Within both pay categories £3.1m of year to date funding for covid sickness is included, reducing the overall overspend.
- Medical and Dental staff show a year to date overspend of £1.7m. Additional costs relate to increases in premium pay for IPA claims and internal locum shifts, along with increases in headcount for junior doctors.
- Costs have been recognised in relation to the year to date element of the Flowers legal case of £0.6m, split to the relevant pay category. The Trust is working with regional colleagues to agree a standardised approach for his payment to employees later in the last quarter of the year

Total year to date agency spend is £6.7m. Work is ongoing within each collaborative to recruit to hard to fill posts where possible and reduce overall cost. Agency spend will continue to be monitored monthly moving forward.

Non-Pay

Operating Non-pay is overspent by £3.8m at Month 10, as outlined in the table below:

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Clinical Negligence Cost	(15,200)	(15,201)	**(0)**	(18,241)
Clinical Supplies And Services	(86,634)	(79,978)	**6,584**	(104,534)
Depreciation, Amortisation & Impairments	(17,073)	(17,254)	**(180)**	(24,447)
Drugs	(59,824)	(65,075)	**(5,251)**	(71,892)
Establishment	(5,949)	(9,372)	**(3,423)**	(7,272)
Ext. Staffing & Consultancy	(248)	(392)	**(144)**	(291)
General Supplies & Service	(2,544)	(2,228)	**316**	(3,062)
Healthcare Service Purchase	(10,867)	(10,360)	**507**	(12,901)
Miscellaneous Services	(2,183)	(2,578)	**(395)**	(2,609)
Pfi Unitary Payment	(25,540)	(25,927)	**(387)**	(30,538)
Premises & Fixed Plant	(20,792)	(22,111)	**(1,318)**	(25,048)
Research, Education & Training	(2,770)	(2,478)	**292**	(3,231)
Transport	(3,180)	(3,531)	**(351)**	(3,801)
Total	**(252,805)**	**(256,485)**	**(3,752)**	**(307,866)**

- Clinical supplies and services are showing a year to date underspend of £6.5m with this being driven by reduced activity levels within clinical directorates. The underspend has increased in month as expenditure has been recoded to the other non-pay categories, such as Establishment and Premises and Fixed Plant.
- Drugs have an YTD overspend of £5.3m. This overspend is due to increased drugs costs within Gastroenterology, Neurology, Haematology and Ophthalmology, with costs being linked to increased activity levels.

- Establishment costs have a year to date overspend of £3.4m with this driven by increases in ICT systems costs of £1.2m, increased phone charges of £0.2m, increased postage and printing costs of £0.3m and the recoding of expenditure from clinical supplies and services
- The £1.3m overspend on Premises is due to increased minor new works and estates costs linked in part to covid building alterations and increases from utilities charges.

Non-Operating Costs

Non-operating costs are underspent by £1.6m overall, largely relating to an underspend on Public Dividend Capital (PDC) dividends, reflecting the slippage against the capital programme and the Trust's current strong liquidity position under the current Covid funding arrangement.

CIP

Work is ongoing to embed efficiency planning and delivery arrangements through the Clinical Collaboratives, as part of the Trust's financial planning. The Trust monitors CIP planning and supports delivery through fortnightly meetings of the Collaborative Improvement Planning Group. The Trust has now also established a bi-weekly Steering Group, with non-executive director representation, to monitor delivery of the wider financial programme.

For the first 10 months of the year the Trust has a £9.5m CIP target. Year to date performance against the efficiency programme is shown in the below table.

	YTD M10 Plan	YTD delivery	YTD Variance
Agency	208.3	66.0	**(142.3)**
AMD Treatment	200.0	-	**(200.0)**
Clinical Collaboratives	355.0	241.6	**(113.4)**
Clinical Productivity	860.9	860.5	**(0.4)**
Corporate and Technical	4,081.0	5,170.4	**1,089.4**
Drugs (non HCD)	302.3	123.3	**(179.0)**
Estates	210.7	1,861.8	**1,651.2**
Job Plan and Rostering	600.0		**(600.0)**
Non Clinical Workforce	485.0	764.0	**279.0**
Private Patients	583.3	583.3	**(0.0)**
Procurement	1,471.7	1,167.2	**(304.4)**
Sickness absence	187.3		**(187.3)**
Grand Total	**9,545.6**	**10,838.1**	**1,292.6**

Capital

The Trust's capital expenditure at the end of January amounted to £16.6m as detailed below:

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
PFI Lifecycle	7,816	7,822	06	9,380
Site Reconfiguration	10,396	6,897	(3,499)	18,256
Replacement of Medical Equipment	1,739	1,118	(621)	10,084
Network Replacement and Clinical Noting	3,550	744	(2,806)	15,174
Total	**23,501**	**16,581**	**(6,920)**	**52,894**

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000
Financing				
Depreciation	9,102	8,583	(519)	11,878
Internal Reserves	13,901	7,500	(6,401)	15,473
Charitable Funding	498	498	0	6,461
PDC	0	0	0	19,082
Total Financing	**23,501**	**16,581**	**(6,920)**	**52,894**

The programme includes the following identified schemes:

- PFI - £10.4m contractual commitment (£9.4m) to Endeavour SCH LLP with the payment based on the Financial Model;
- Estates – Friarage Rationalisation and Redevelopment (£6.0m), SDEC (£1.5m), Interventional Radiology (£1.0m), Elective Recovery (£1.4m), Critical Care (£4.1m) and Friarage Critical Backlog maintenance (£1.0m);
- IT – Alcidion investment for e-prescribing and licencing (£1.2m), Data Centre Upgrade (£0.8m), Digital Aspirant programme (£5.9m), LIMS (£2.8m), Digitisation of Theatres (£1.7m) and Cyber Investment (£0.5m); and
- Medical equipment – Emergency replacement of medical equipment including committed items from 2020/21.

The current capital programme reflects the Trust's awards of additional national PDC funding in relation to diagnostics, IT and elective recovery. The capital programme is currently underspent by £6.9m year to date, which is mainly due to timing delays, compared to the forecast profile at the time of submitting the original plan. It is anticipated that the revised plan will be delivered in full by 31 March, and this has been reflected in the forecasts provided to NHSE/I and the ICS. The Trust will continue to closely monitor the position from now to the end of March.

Liquidity

The cash balance at 31 January amounted to £62.4m.

To 31 January the Trust had paid 77,287 invoices (total value £373.7m) with 73,154 invoices (total value £346.4m) 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%	-	-

At 31 January total debt amounted to £7.4m consisting of aged debt up to 30 days overdue £0.7m, 31 to 60 days overdue £0.4m, 61 to 90 days overdue £0.6m and debt 91 days plus amounting to £4.2m. The Trust will continue to closely monitor the level of aged debt with East Lancashire Financial Services with the view of reducing the level and age of this portfolio.

Statement of Financial Position (SOFP)

The following table compares the SOFP position between 31 December and 31 January 2022.

	31 December	31 January	Movement between months
	£000	£000	£000
Property, Plant and Equipment	244,182	242,236	(1,946)
Long Term Receivables	1,666	1,966	300
Total Non-Current Assets	245,848	244,202	(1,646)
Currents Assets			
Inventories	13,857	13,571	(286)
Trade and other receivables (invoices outstanding)	6,526	7,311	785
Trade and other receivables (accruals)	17,624	13,867	(3,757)
Prepayments including PFI	20,627	16,429	(4,198)
Cash	51,841	62,365	10,524
Total Current Assets	110,475	113,543	3,068
Current and Non-Current Liabilities			
Borrowings	(90,258)	(89,971)	287
Trade and other payables	(92,032)	(95,090)	(3,058)
Provisions	(2,358)	(1,450)	908
Total Current and Non-Current Liabilities	(184,648)	(186,511)	(1,863)
Net Assets	**171,675**	**171,234**	**(441)**
Equity:			
Income and Expenditure Reserve	(236,066)	(236,507)	(441)
Revaluation Reserve	33,643	33,643	0
Public Dividend Capital	347,622	347,622	0
Other Reserves	26,476	26,476	0
Total Equity	**171,675**	**171,234**	**(441)**

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 1 March 2022			
Care Quality Commission (CQC) Update Report			**AGENDA ITEM: 14** **ENC 11**
Report Author and Job Title:	Dr Sylvia Wood Interim CQC Compliance Professional David Bell Quality, Governance & Mortality Reporting Manager (CQC Project Lead)	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse Moira Angel Interim Director of Clinical Development
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This paper provides an update on the progress the Trust is making in preparation for its next CQC inspection. The ambition is to achieve an overall rating of "Good".		
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 CQC inspection. This report has been discussed in detail at the Quality Assurance Committee.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board of Directors are asked to note the progress		
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 progress the Trust is making in preparation for any future CQC inspection. The Trust Board of Directors is asked to note progress and ongoing work.

2. BACKGROUND

The CQC monitors, inspects and regulates NHS trusts. They monitor potential changes to the quality of care provided using 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.

The Trust is preparing for any future inspection whilst continuing to embed actions developed from the 2019 report to address the 'must do' actions and 'should do' actions. The CQC Compliance Group oversees and monitors the action plan and the preparation work.

DETAILS

a. CQC Focused Visit

The CQC attended the trust on the 9th February and 10th to undertake a focussed visit. The CQC Project Team supported the process for managing the visit. This included co-ordinating the responses data requests made by the CQC team.

Initial feedback has been received and the Trust is working with the CQC prior to submission of a final report.

b. CQC Engagement Meetings

The Trust has welcomed a new relationship manager, Amy Harris. A meeting will be held in March to agree the focus of the engagement meetings.

c. CQC Action Plan

As previously discussed the CQC action plan has been reviewed and a number of actions have been updated or added.

The team is conducting final checks to ensure assured closure of the original CQC action plan and ensure the new plan continues to be comprehensive with actions completed in a timely manner with ongoing assurance within the governance structure. This is being monitored and reported through the daily and weekly CQC huddles.

There are currently 72 defined actions on the new action plan, and all actions have been allocated to member(s) of the CQC project team to follow through.

d. CQC Enquiries

The Trust receives regular enquiries from the CQC and has agreed a response timescale of 28 working days for routine enquiries and 10 working days for urgent queries. The timescale for managing SIs is different and agreed, in line with national reporting timescales by patient safety.

CQC enquiries are a standing agenda item on the weekly CQC huddle and discussed and escalated as appropriate. Learning from enquiries includes record keeping which requires improvement including completion of pain score post analgesia and record keeping in relation to nutritional needs.

A review is being undertaken of actions taken in the last 8 months to ensure embedding.

e. Directorate CQC self-assessments

Meetings continue with directorates to review self-assessments against the key lines of enquiry (KLOE) for each of the CQC key questions.

f. Communications for staff and CQC inspection team in place

Members of the CQC Project team are also invited to various directorate and collaborative meetings to provide key updates.

3. RECOMMENDATIONS

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

People Committee
Chair's Log

Meeting: People Committee	**Date of Meeting**: 22 Feb 2022
Highlights for: Board of Directors	**Date of Meeting**: 1 Mar 2022

Overview of key areas of work and matters for Board.

- Full attendance and agenda reintroduced
- Board Assurance Framework gaps
- People Plan reports on Engagement and Education & Organisation Development
- Junior doctor recruitment and Doctor appraisals
- Staff survey initial results

Actions to be taken	Responsibility / timescale
Reviewed the BAF and acknowledged no new risks but some gap additions and updates included. The new items will reduce the overall risk rating when completed. Assurance received from 6 internal reports. Committee discussed counselling services for staff including those on long-term sick and the need for interim solutions pending the strategic business case.	
CQC highlight paper to be pulled together by Jackie and Rachael then circulated to committee for input	Head of Governance by 22 Feb c/f
Staff Engagement report covered the good feedback received from the induction process and values-based recruitment along with plans to work through areas to improve on. Committee raised the appraisal feedback, particularly in relation to the length of the new form which is under review and will be updated. The engagement team are planning a campaign to raise awareness of who they are and what they do. Action for engagement team and appraisal update to be included in next report. A moderate level of assurance accepted	Head of HR by end May
Education & Organisation development provided detailed updates on delivery and the focus on cohort training, leadership and management skills, strategic and insights training. Committee discussed feedback around insights sessions and challenges with releasing ward/frontline staff to attend sessions. Action for report to be updated with correlation between delivery, outcomes and impact on people measures. A moderate level of assurance was agreed	Dir of Education and HR Dir by end May

AHP recruitment and retention benchmarking showed lots of positive areas when compared to national data. Action to add identified risk areas of dietetics and podiatry to the BAF.	Head of Governance 29 Mar 22
Action to extend the gap analysis against model hospital and NHS benchmarking tools A moderate level of assurance accepted	Head of Professions end May
Workforce plan presented the summary view for each collaborative with demand, supply, action plan and reviews. Working on refining content and amalgamating for medical, nursing, etc. Action to include expected to planned workforce, analysis against model hospital and recruitment benchmarks, and correlation to trust vision and 5-year plan	Head of HR end May Head of Governance 29 Mar 22
Action to add gaps above to BAF	Head of HR end May
Staff overpay update was received and acknowledged further work to be done. Action to deep dive, trends in departments or with specific teams, understanding impact on staff and accessing of hardship fund, and potential to develop targets to measure compliance and improvements	
Junior doctor review underway with vacancy rate showing only 2 gaps and GMC trainee report showing Stees in top 30. Action to deep dive on rosters, training, electronic solutions, and review of structure against strategy	Assoc Medical Dir end May
Doctor appraisals at 92% completion and low number of revalidation referrals. Action to expand assurance on health and wellbeing activities and impacts, trends, and action plans Action to add above to BAF	Assoc Medical Dir end May Head of Governance 29 Mar 22
Violence and aggression training report confirmed actions undertaken and gap identified in numbers booked for level 2 training. Action to add training to induction courses and to highlight which teams or depts need support to release staff for training as a priority	Head of Facilities end May
Staff survey highlighted the key improvement areas from the initial report Action to relate survey to people BAF risks as part of board update. A moderate level of assurance accepted	Head of Governance board staff survey session
IPR demonstrated good progress on attendance, appraisals, and mandatory training with f2f and walkabout sessions planned. Action to review training modules, method of delivery and level required for each role. A limited level of assurance was agreed	Head of HR end May

Other assurances covered an update on the focus on BAME as part of the network activity, cultural strategy, leadership action plans and development sessions. Action to feedback to the equality, diversity, and inclusion group and to engage with reciprocal mentoring programme and to agree any appropriate updates to BAF	Managing Director end May
Board action	Responsibility / timescale
There were no new areas to raise for the attention of the board –	
Risks (Include ID if currently on risk register)	Responsibility / timescale
No new risk areas identified –	