South Tees Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS (PUBLIC)

Date – 5 July 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 5 JULY 2022 AT 13:00 IN THE BOARD ROOM MURRAY BUILDING JAMES COOK UNIVERSITY HOSPTIAL FOR BOARD MEMBERS ONLY

Members of the public to observe via Microsoft Teams

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT
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 3 May 2022	Approval	Chair	ENC 2
5.	Matters Arising / action log	Review	Chair	ENC 3
6.	Chairman's report	Information	Chair	ENC 4
7.	Chief Executive's Report	Information	Chief Executive	ENC 5
8.	Board Assurance Framework	Discussion	Head of Governance & Company Secretary	ENC 6
9.	Integrated Performance Report	Discussion	Chief Operating Officer	ENC 7
SAFE				
10.	Safe Staffing Report	Information	Chief Nurse	ENC 8
11.	Learning from Deaths (Mortality) report	Information	Chief Medical Officer	ENC 9

	ITEM	PURPOSE	LEAD	FORMAT
EXPERIENCE				
12.	Freedom to Speak Up Guardians Report (Whistleblowing)	Information	Guardians	ENC 10
EFFECTIVE				
13.	Consultant appointments	Information	Chief Executive	Verbal
WELL LED				
14.	Finance Report	Information	Chief Finance Officer	ENC 11
15.	CQC update	Information	Chief Nurse	ENC 12
16.	Maternity update - Roles and responsibilities of the Obstetric Consultant (RCOG June 2021) Gap analysis and action plan	Approval	Head of Midwifery	ENC 13
17.	Risk Appetite	Approval	Head of Governance	ENC 14
18.	Improvement plan progress update and refreshed Improvement Plan	Approval	Managing Director	ENC 15
19.	Committee Reports • People Committee • Quality Committee • Resources Committee • Charitable Funds Committee	Information	Chairs	Verbal
	DATE OF NEXT MEETING The next meeting of Board of Directors will take place on TBC			

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 JULY 2022			
Register of members interests			**AGENDA ITEM: 3** **ENC 1**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Derek Bell Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	The Board of Directors are asked to note interests declared by members of the Committee		
Background	The report sets out membership of the Board of Directors and interests registered by members. Conflicts should be managed in accordance to the Constitution para 32 - If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to other Directors.		
Assessment	There are no specific conflicts identified with the agenda. Members will be reminded at the meeting to raise any if they arise.		
Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐		
Recommendation	The Board of Directors are asked to note the Register of Interest.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Ada Burns	Non-Executive Director	2017 2019	Ongoing Ongoing	Role - Governor – Chair of Resources Committee, member of Board of Teesside University. Role – Associate Consultant – Cratus Consultancy, public sector management consultancy
Richard Carter-Ferris	Non-executive Director	1 August 2015	ongoing	Director of Yorkshire Area P2P Club – company generates donations for Yorkshire Air Ambulance. Director/No exec Director – Malton & Norton Golf club ltd.
Debbie Reape	Non-executive Director Senior Independent Director	August 2019 1 October 2019 October 2019	Ongoing Ongoing Ongoing	Associate Director with Northumbria International Alliance (Northumbria NHS Trust and Northumberland County Council) South Tees Healthcare Management Limited - Company number 10166808. School Governor, Ashington Academy.
Jackie White	Head of Governance & Company Secretary	March 2013	Ongoing	Registered with IMAS (NHS interim management & support)
Sue Page	Chief Executive	May 2018	Ongoing	President of British Red Cross – Cumbria.
Kevin Oxley	Director of Estates, Facilities and Capital Planning			No interests declared
Rachael Metcalf	Director of Human Resources			No interests declared.
Mark Graham	Director of Communications			Ad hoc communications support to North Cumbria integrated care NHS Foundation Trust. Registered with IMAS (NHS interim management & support)
Moira Angel	Interim Director of Clinical Development	18 January 2021		Director of Moira Angel consulting Ltd - Company number 09529658 Director of Arista Associates Ltd. - Company number 09986504 Vice president of the red cross in Cumbria.
Robert Harrison	Managing Director			No interests declared
David Jennings	Non-executive Director & Vice Chair	1 January 2021	Ongoing	Trustee Newcastle University Development Trust and Honorary Treasurer. Unremunerated, voluntary role. Chair AuditOne Board NHS internal Audit Consortium. Unremunerated, voluntary role.
David Redpath	Non-executive Director	1 January 2021	Ongoing	Director of DGR Consultancy - Company number 10340661
Michael Stewart	Chief Medical Officer	1 February 2021	Ongoing	No interests declared
Hilary Lloyd	Chief Nurse	15 February 2021	Ongoing	No interests declared

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

South Tees Hospitals NHS
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 3 MAY 2022 AT 13:00 IN THE BOARD ROOM, MURRAY BUILDING JAMES COOK AND VIA MICROSOFT TEAMS

Present

Professor D Bell	Joint Chairman
Ms D Reape	Non-Executive Director
Mr D Redpath	Non-Executive Director
Mr D Jennings	Non-Executive Director
Dr M Stewart	Chief Medical Officer
Dr H Lloyd	Chief Nurse
Mr R Harrison	Managing Director
Ms S Page	Chief Executive

Directors – non-voting

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

STAFF STORY

Sister Amanda Parry and Matron Nicola Metcalf attended and presented the Ward 3 South Tees Accreditation story to the Board.

The Board were pleased to hear the journey to accreditation and the work undertaken by the Ward to maintain the standard achieved.

Sister Parry described the work she did with the team including allocating lead roles for colleagues.

The Board thanked Sister Parry and Matron Metcalf for attending.

BoD/22/021 **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/22/022 **APOLOGIES FOR ABSENCE**

There were apologies from Ms Burns, Vice Chair and Mr Cater Ferris, Non-executive Director and Mr C Hand, Chief Finance Officer.

BoD/22/023 **QUORUM**

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

BoD/22/024 **DECLARATION OF INTEREST**

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

BoD/22/025 **MINUTES OF THE LAST MEETING**

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

BoD/22/026 **MATTERS ARISING**

The matters arising were reviewed and the action log updated.

BoD/22/027 **CHAIRMAN'S REPORT**

The Chairman referred members to his previously circulated report and drew members attention to a number of issues including that the Health and Care Bill had received Royal Assent on 28 April 2022 which set out the creation of Integrated Care Systems.

He advised that the North East Chairs had met and discussed the health and wellbeing of staff in relation to the current financial situation and post covid period which he added that the Trust Board are taking this seriously.

The Chairman reminded members that the Trust was recruiting for new Non-Executive Directors and if interested individuals should get in touch.

He referred to the Board walkrounds today and the really good feedback and discussions with colleagues. Mr Redpath added that he visited the medical engineering department and was pleased to report the positive attitude and great team spirit. Dr Stewart commented that he visited the mortuary and again they go above and beyond and provide such an important and valuable service to Trust and beyond. Ms Reape reported that she visited pharmacy and talked to staff around discharge prescriptions and that they understand how complex discharge pathways can be. Mr Jennings commented that he visited Pathology services and described a sense of commitment to the patient experience and to providing tests as quickly as possible to facilitate the next stage of the patients journey.

The Chairman thanked staff across the Trust for their support.

Finally the Chair advised that he had attended the South Tees Healthwatch awards and a number of staff and departments from the Trust had been nominated for awards.

RESOLUTION

The Board of Directors NOTED the Chairman's report.

BoD/22/028 **CHIEF EXECUTIVE'S REPORT**

The Chief Executive referred the previously circulated report and highlighted a number of areas for consideration. She referred to the most difficult winter she has ever been involved in during her time in the NHS and gave thanks to all staff at every level for getting the Trust through it. She commented that in during the winter Omicron surge, almost one in 15 of our colleagues were absent due to COVID-19 Local Authorities were redeploying staff, GPs were delivering vaccinations and the military was supporting ambulance organisations. She was pleased to report that the Trust is now seeing a reduction in staff absences.

Ms Page reported that the number of over 52-week waiters has significantly reduced. No patients are waiting over 104 weeks and last week the Trust began helping colleagues in Newcastle with some long waits for spinal services.

She reminded colleagues that the Trust delivers world class cancer, spinal, neurosciences, cochlear implant services in this region and beyond, half of the region trauma cases come through James Cook hospital. Reflecting on this she reported that today marks the start of a new partnership with a new Charity 'Day One' which support patients and families who have been through trauma services with help around funding, welfare and advice when patients and families have life changing injuries. This will add to the wellbeing of these patients and help with their ongoing recovery.

RESOLUTION

The Board of Directors NOTED the Chief Executive's update

BoD/22/029 **BOARD ASSURANCE FRAMEWORK**

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

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

Mrs White highlighted a number of assurance reports being received today at Board and a number of additional assurances which the Board Sub committees had received this month.

Ms Reape reported that the Quality Assurance Committee had received a report on managed patient pathways which demonstrated the hard work the Trust had undertaken over the last few years in this area and assured the Committee sufficiently around this including a robust governance framework. She added that the Committee had also received and excellent report on cancer and heard about the services which have delivered well.

Mr Jennings commented that he was pleased to see the Committees having conversations about the principal risks using the BAF to manage the agenda but also to look at what risks are coming across the horizon. He added that using this method of triangulation is really positive and helpful. He asked how the Director Team and SLT are using the BAF to shape their discussions. Mr Harrison commented that the new decision-making structures are progressing through the extension of SLT to include Collaborative Chairs and the Director team. He added that the agenda for the decision-making groups is not formed in the same way as the Committees but that the focus is on quality, safety, performance, finance and risk which operationally touches on the BAF principal risks and threats.

RESOLUTION

The Board of Directors NOTED the BAF

BoD/22/030 **INTEGRATED PERFORMANCE REPORT**

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

Mr Peate highlighted the key messages:

- Trust performance in February to March 2022 reflected changing levels of COVID-19 infections in our communities. This placed significant additional demands on primary, emergency and acute care and

social care, with COVID-19 related staff absences adding considerable pressures to service delivery across the system. In April, there has again been a significant increase in the number of people testing positive for COVID-19.

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

Mr Jennings asked how the Improvement plan was being refreshed and Mr Peate confirmed that each collaborative is updating their area and taking their plans through to CPG. In addition, there are meetings with Chairs of Committees and

Lead Directors to refresh targets and the plan will come into Board in July.

Mr Jennings thanked Mr Peate for the inclusion of the regional picture commentary which was really helpful to get a sense across the system. He asked if in time there is further information on our aspirational targets it would be useful to update on that.

Mr Jennings asked regarding the position on medicines reconciliation despite the fact that incidents remain within normal variation. Dr Stewart commented that it is a focus for us, however we have had to make priorities around where we put our Pharmacy team during the winter period. He added that there is due to be 16 new pharmacists starting with us later in the year, the roll out of ePMA and electronic medicines reconciliation. Dr Stewart commented that the service is safe.

Mr Jennings raised the RTT target and 6-week diagnostic target and asked Mr Peate for an update. He advised that within the diagnostic target there is a bundle of targets which have a recovery plan in place and will start to see improvement in these areas and the overall target in the next 6 months. With regard to RTT Mr Peate advised that whilst our percentage performance has maintained he would expect we should see improvement in compliance but we are reducing down our longest waiters which is significant.

The Chairman raised the increase in C. difficile cases and Dr Lloyd confirmed that this is reflective of the national and regional picture. She added that there was a discussion at the Quality Assurance Committee (QAC) and the CCG Chief Nurses gave assurance to the committee that this is the case and where we would expect with partners across the ICS. She added that there is an improvement plan and weekly huddle in place and we have reviewed and strengthened our processes. In addition, we are looking at hand hygiene, cleaning and decontamination and sharing the learning and accountability. Dr Lloyd reported that the Trust has now successfully appealed 28 cases of CDIFs which is a significant increase. In March 2022 we had the lowest number of cases. Ms Reape confirmed the discussion at the Committee and the assurance provided by the CCG Chief Nurses.

The Chairman asked for an update in relation to SHMI and Dr Stewart advised that SHMI is 'higher than expected' at 117 (3 points better than the previous period), but is trending in the right direction. The work around coding will take another few months to feed in but think this relates to the high number of COVID against emergency numbers.

RESOLUTION

The Board of Directors NOTED the update

BoD/22/031 **SAFE STAFFING REPORT**

Dr Lloyd referred members to the safe staffing report and highlighted the percentage of shifts filled against the planned nurse and midwifery staffing across the trust remains at 97.7% as per table 1 demonstrating good compliance with safer staffing.

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

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

The introduction of allocate on arrival shifts for RNs and HCAs (5 per day and night at JCUH and FHN) has seen improved pick up in March, these shifts are promoted daily via ward manager platforms and NHSp text messaging. This model has been followed in community with impactful pick up Nursing Turnover for March has increased slightly to 8.78%, there has been an increase number of retirements in March.

The Chief Executive highlighted that the staff survey raised redeployment but and that the Allocate on arrival shifts continue to provide an essential resource that gives additional support for critical shifts across the sites.

Ms Reape asked if there was anything similar in maternity in relation to allocate on arrival. Dr Lloyd advised that there wasn't but she would discuss this further with the Maternity team.

RESOLUTION

The Board of Directors NOTED the safer staffing report

BoD/22/032 **CONSULTANT APPOINTMENT**

The Chief Executive updated that no new consultants had joined the Trust in May and the following had left the Trust:

Dieter Dammann (Paediatrics)
Baharul Islam (Respiratory)
Sami Jawad (Radiology)

RESOLUTION

The Board of Directors NOTED the update

BoD/22/033 **OCKENDEN REPORT**

Dr Lloyd presented an update on the Ockenden report and highlighted that the interim Ockenden report required the Trust to submit evidence to NHSE/I in June 2021, to show they had enacted the 7 immediate and essential actions (IEAs), covering 41 minimum standards. The Trust's Ockenden action plan was presented to Board in February 2022 and positively all actions had either been completed or were in the process of being completed.

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

Dr Lloyd reported that a gap analysis has been completed and identified initial actions and the next steps is to develop a full action plan and clear evidence to follow this up. She added that a discussion and the gap analysis has been considered by the Director team this week.

Dr Lloyd reported that the Trust met with NHSE/I Chief Midwife team and she will report in detail through to QAC.

Ms Reape reported that last month's QAC received a report in response to Ockenden and the Ockenden visit planned for 18 May will be very much like an external assessment which will provide additional assurance.

Dr Stewart commented that the visit online with the National Chief Midwife was positive and they were commenting on the improvement in culture and learning.

Mr Jennings thanked Dr Lloyd for the report which was helpful but asked that going forward it would be useful to have a rag rating and assurance through QAC that we are on track or meeting the requirements.

Mr Redpath commented that the report needs to include some timescales so we can see where we are in terms of delivery of the actions and support as necessary to enable this to be delivered. Dr Lloyd acknowledged that this is needed and important to make sure we have these accurately agreed with teams.

RESOLUTION

The Trust Board of Directors NOTED the Ockenden update

BoD/22/034 **FREEDOM TO SPEAK UP**

Mr Jim Woods, the newest FTSU guardians who started in January attended to present the report. Dr Lloyd welcomed Mr Woods to the team and Board.

Mr Woods highlighted that staff continue to speak up within the organisation, with the number of issues reported to the FTSU Guardians in Q4 decreasing from 32 in Q3 to 22 in Q4.

As a result of our staff speaking up a number of organisational learning points have been identified, with recommendations made on how the Trust should continue to improve. The FTSU Guardians will triangulate this data with the recent staff survey results.

The Guardians are also taking action to improve FTSU culture throughout the organisation and beyond, with stronger links being forged with our colleagues in both NHS Professionals, Military and North Tees.

This positive culture is highlighted in the 2021 NHS Staff Survey results which show continued improvement across the board for our speaking up culture which is in contrast to the national trend.

Mr Wood drew the Boards attention to the Board level training and recommended this was undertaken.

The Chairman commented that some of the themes highlighted in the report are closely aligned and Mr Woods concurred and commented that we normally see a number of themes raised in one speak up report.

Ms Reape asked Mr Woods if he had any reflections on his first couple of months in post and if there was anything else the Board should be doing. Mr Woods commented that it's been interesting seeing the organisation from a different view so will start to form opinion as he gets into the role further and at this time can't think of anything else the Board can do.

The Chief Executive commented that by joining all the ambassador roles such as patient safety, FTSU and quality, we should see the message being delivered out to the staff and continued improvements in culture and openness.

RESOLUTION

The Trust Board of Directors NOTED the report

BoD/22/035 **FINANCE REPORT**

Mr Dargue attended the Board on behalf of Mr Hand and referred members to the previously circulated report and highlighted that at Month 12 the Trust reported a deficit of £23.4m, which was in line with the year-end forecast position agreed with the NHSE/I Regional Team, supporting the wider ICS to deliver overall financial balance at a system level issues.

Mr Jennings commented that the Trust is in a good position, meeting the challenges around financial health and that we have exceeded the CIP given everything we have been through.

The Chairman thanked Mr Dargue and commented that the Trust Board have spent a lot of time on reviewing the finances.

RESOLUTION

The Board of Directors NOTED the report

BoD/22/036 **CQC UPDATE**

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

Ms Reape reported that the lead nurse for STACQ attended QAC and we were assured in general with regard to progress and understood dates are in place for ED, Critical Care and Maternity. She did say there is a feel-good factor for those staff who have been through this process so hopefully for those challenged areas this will help with culture and development.

RESOLUTION

The Board of Directors NOTED the report

BoD/22/037 **ANNUAL COMPLIANCE WITH THE PROVIDER LICENCE**

Mrs White referred members to her previously circulated report and updated that an assessment has been undertaken against the NHS provider licence and supporting evidence has been reviewed and the following assessment has been proposed:

1. The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6) – CONFIRMED
2. The provider has complied with the required governance arrangements Condition FT4(8)- NOT CONFIRMED.
3. If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver designated services Condition CoS7(3) – CONFIRMED

Mrs White confirmed that this was in line with the previous year and in light of the Trusts Provider Restrictions.

RESOLUTION

The Trust Board of Directors APPROVED the recommendation

BoD/22/038 **ANNUAL FILINGS**

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

She highlighted that the timetable for submission of the Annual Report and financial statements has been released by NHS England/Improvement (NHSE/I). This includes a final submission date for the Trust signed and audited Annual Report and Accounts of 22 June. NHSE/I and the Department of Health and Social Care (DHSC) have also issued draft accounting policies for providers, as outlined in the Group Accounting Manual (GAM).

Mrs White reported that at this stage there are no issues or risks highlighted with the production of the annual filings. The Audit & Risk Committee have delegated authority to oversee the production and sign off on behalf of the Board.

RESOLUTION

The Board of Directors NOTED the update

BoD/22/020 **COMMITTEE REPORTS**

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

QAC – Ms Reape commented that the Committee continued to receive positive feedback on the closure of open action plans for SIs. The Committee had had its first face to face

meeting since COVID. Where possible we had some clinical leads presenting and it added to the discussion.

Joint Partnership Board – The Chairman commented that there were two externally facilitated sessions in next month. A positive meeting was held last month including update on Pathology joint venture.

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

The next meeting of the Board of Directors will take place on 5 July 2022

Signed: ……

Date: ……

Board of Direction Action Log (meeting held in Public)							
Date of Meeting	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
7.9.21	BoD/20/302	BOARD ASSURANCE FRAMEWORK	Risk Appetite to be undertaken and included on the BAF	J White	Mar-22	Statements issued to Board in July recommended by Committees	Open

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 JULY 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 Non-Executive Director recruitment

The recruitment process has now closed and interviews are scheduled for four non-executive director roles (public health / health inequalities; clinical; people and finance) on Monday 4 July and Thursday 7 July.

2.2 Departmental visits

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

2.3 Joint Partnership Board

Two joint South Tees Hospitals NHS Foundation Trust and North Tees & Hartlepool NHS Trust Board events took place in May and June. The events were productive, and a number of key actions have been agreed.

2.4 Foundation Trust Chairs meeting with Sam Allen, CEO NENC ICS

The Chairs of the Foundation Trusts in the North East and North Cumbria met with Sam Allen on 6th June 2022. There was a discussion regarding the ICS Operating model which had been agreed but was likely to be reviewed as early as September 2022. Nomination to the ICB was discussed including 4 seats for Local Authorities and 2 seats for Foundation Trust representatives. Cultural transformation will be key as we move towards single system and greater collaboration. Clarity regarding PLACE was still ongoing.

2.5 NHS Confederation Chairs session

I attended the NHS Confederation Chairs session on 23 May 2022 which focused on the cost of living and what it means for staff and patients and what Boards need to consider. This along with other aspects of health and wellbeing is a topic of conversation at the People Sub Committee on a routine basis.

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 – 5 July 2022			
Chief Executive update			**AGENDA ITEM:7 ENC 5**
Report Author and Job Title:	Mark Graham, Director of Communications	**Responsible Director:**	Sue Page 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		
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	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

Chief Executive Update

COVID-19 update

Following the decline in COVID-19 infection rates which began in April, recent weeks have seen an increase in community infections.

At the time of this report's writing, patients with COVID-19 continue to be cared for on one ward at the James Cook University Hospital.

Throughout the pandemic, our clinicians have continued to provide life-saving surgery and treatments while providing hospital care for more than 7,000 patients with the virus.

In the last two years for example, clinical colleagues have provided overnight hospital care for more 130,000 patients and delivered 1.3 million outpatient appointments.

At the same time, surgical teams have delivered more than 62,000 operations (of which almost 48,000 have been planned procedures) and community teams have provided care closer to home for patients 2.3 million times.

Over the last two years, obstetric and midwifery colleagues have also helped to deliver almost 10,000 babies into the world.

In line with national guidance, visitors to our hospitals and healthcare sites have no longer been required to wear a face covering unless they are visiting a high-risk area or visiting a patient who is immunocompromised or has suspected or confirmed COVID-19.

High risk areas where face masks will still be required include:

- Emergency department
- Admissions units
- Urgent treatment centres
- Critical care
- COVID wards
- Wards 4, 14 and 33 at James Cook (and associated day areas)
- Chemotherapy day unit
- The Endeavour Unit
- Friarage dialysis unit
- Sir Robert Ogden Macmillan Centre

If any visitors prefer to continue wearing a mask, they are course supported to do so.

Estate

Upgrade work has begun on Ward 8 at James Cook and, when this has completed later this year, the next ward planned for upgrade is Ward 7. Work on ward 7 and CICU is currently expected to start before next April. A schedule for upgrades to remaining wards in the tower block (that have not already been upgraded) will be agreed by our Clinical Policy Group before April.

Other improvements underway include an expanded PACU facility and the expansion of theatre 27 to allow greater theatre capacity and flexibility going forward.

At the Friarage Hospital a new endoscopy unit opens in September and enabling works for a new theatre block continues throughout 2022.

Surgical pre-assessment for children

A new pre-assessment service has been launched for all children and young people undergoing planned surgery at The James Cook University Hospital in Middlesbrough and the Friarage Hospital in Northallerton.

The South Tees Hospitals NHS Foundation Trust paediatric pre-assessment service is one of the first in the UK to offer a comprehensive service for all children and young people attending for planned surgery – and one of the only ones to have its own dedicated area.

Pre-assessment ensures children, young people and their families are prepared for their theatre journey. It also ensures patients are fit for surgery and scheduled to be treated in the right place and at the right time for their needs.

Robotic spinal surgery

Neurosurgeons at James Cook have become the first in the country to use a state-of-the-art imaging robot.

The first of its kind Brainlab Loop-X navigating robot has an independently moving imaging source, allowing surgeons to quickly plan and perform spinal surgery, and detector panels enabling flexible patient positioning.

Thanks to the new wireless machine patients requiring spinal surgery at the Middlesbrough hospital are benefiting from shorter operating times and reduced radiation exposure.

James Cook Cancer Institute

A radiotherapy team from Cork University Hospital recently visited The James Cook University Hospital to learn about its stereotactic ablative radiotherapy (SABR) programme.

The group, made up of a doctor, physicist, radiotherapists and dosimetrists, visited the team at James Cook Cancer Institute to gain first-hand experience of the leading-edge radiotherapy treatment before implementing it at their hospital.

SABR involves delivering multiple, high-dose, beams of radiation therapy to a very precise area within the body such as to the lungs, adrenal, lymph nodes and spine.

The degree of accuracy leads to minimising dose to the surrounding healthy tissue, reducing side effects and hopefully obliterating the tumour.

Cardiothoracic robotic surgery

James Cook is at the forefront of NHS robotic surgery, which uses tiny instruments that are controlled remotely by the surgeon sitting at a console to perform minimally invasive operations. This enhanced precision helps reduce side effects and the length of time patients need to stay in hospital.

The hospital's pioneering use of robotic surgery for heart and lung conditions has recently helped achieve a first for Africa. Cardiothoracic surgeon and lung cancer specialist Joel Dunning has helped to oversee the first cardiothoracic robotic procedure on the continent at the Christiaan Barnard Memorial Hospital in Cape Town, South Africa.

Separately, three months ago a UK heart team led by consultants from James Cook visited Ghana to perform life-saving operations in for a third time. The team gave up their holidays to take the trip to hospitals in Accra and Kumasi on this year's mission, which saw them helping several patients who required cardiac surgery and upskilling the Ghanaian team to perform more advanced procedures.

And the James Cook team is also working with two local charities to raise £650,000 to create a new home for heart research on Teesside.

ePMA (Electronic prescribing and Medicine Administration)

As the board is aware, more than £8 million is being invested in new digital systems which will eliminate clinical teams' historical reliance on burdensome paper-based recordkeeping and ageing IT systems – removing more than 5 million pieces of paper which colleagues currently have to use each year and freeing up more doctors and nurses' time.

As part of the rollout of these new digital clinical systems, the Better Meds electronic prescribing system is now being implemented. Better Meds is a closed-loop medication management system developed to replace paper-based processes for reconciliation, prescribing, pharmacist review and medication administration.

North East and North Cumbria Provider Collaborative Development Session (PvCv)

The NENC Provider Collaborative (PvCv) continues to focus on governance the proposed formal work structure and governance. An outline of the PvCv's Operating Model and 'ambitions' document have been agreed by the 11 members and in due course will be considered by the Board.

2. RECOMMENDATIONS

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

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 5 JULY 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. COVID-19 continues to impact on a number of areas across the Trust including staffing and impact on delivery of the emergency care standards as highlighted in the IPR and Improvement Plan progress report. The roll out of the Digital improvement programme is highlighted in a number of areas including the Chief Executives update on EPMA and the CQC report on replacing paper ward based information.		

	The Improvement Plan Progress Report, Finance report and IPR discuss the financial position for month 2 drawing on the work of the Collaboratives and Improvement Councils established to support the CIP for the Trust. Emergency care services are highlighted in a number of areas including the IPR responsive section of the report and the Improvement Plan Progress report which highlight the improvement work to support delivery of the emergency care pathways.	
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. Since the last report to the Board the risk ratings have been reviewed and are now ***4 extremely high and 3 high***. Two of the principal risks met their target rating (People and Resources).

All Committees continue to have time on their agenda to horizon scan for new threats or risks and since the last meeting the following areas were highlighted:

Resources Committee:

- Estates costs also increasing and backlog
- Supply and demand
- Digital in particular cyber security threat

People Committee:

- Ageing workforce
- Inflation rises and financial wellbeing

Board:

- Partnership and collaboration – ICS and system changes

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
- Learning from Deaths 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
- Freedom to speak up report

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
- Improvement Plan Progress Report

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

- Finance Report
- Integrated Performance Report

- Improvement Plan Progress report

3.2 Additional assurance

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

Resources Committee
- Emergency care pathways improvement support
- Digital programmes update
- PFI update
- Green Plan and sustainability
- Cost improvement programme update

Quality Assurance Committee
- Clinical audit programme
- Research and Development
- Maternity services
- STACQ

People Committee
- Gender pay gap
- Health & Wellbeing of staff

Board Seminar Programme
- Improvement Plan - refresh

3.3 Assurance levels

Over the last 3 months assurance levels were reported for each report being submitted to a Board Committee. The breakdown is as follows:

None	Limited	Moderate	Significant
2	6	44	7

The balance between internal and external assurances was as follows:

Internal	External
58	1

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): June 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	21.6.22	**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 Report on coding improvements to QAC June 2022 **Risk & compliance:** IPR - Quality Dashboard Monthly QAC and Board Quality Priorities Report Qtrly to QAC	Develop AHP Strategy – Ms Mhalanga – revised date *July 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	Health & Safety meeting escalation report to QAC 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 HCAI trajectory report **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)	**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	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*	**Moderate**

	Mortality Reviews Medical Examiner reviews 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	Development of a learning culture and improvement plan journey report to QAC June 2022 **Risk and compliance** 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 Patient Experience report to Board March 2022 Quality Account Report 2021 demonstrating an increase in reporting culture following training on investigation techniques June 2022 **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	*(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 – on hold nationally*	
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 – on hold nationally*	**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 ECIST update to Resources Committee May 2022 **Independent Assurance** ECIS improvement work on patient flow Internal audit of patient flow	Implement recommendations from the Internal audit on flow and waiting times – Mr Peate –April 2022 (Resources Committee)	**Moderate**
1.6 Current estate and infrastructure, if lacking in capital investment, compromises the ability to consistently delivery safe, caring, responsive and efficient patient care, world class services	- Improved access now in place for lifecycle investment - Capital planning group oversight (CPOG) in place - Comprehensive planned maintenance processes in place - Premises assurance model (PAM) undertaken evidencing, overall, compliant estate - Independent, Authorising Engineer (AE) assessments carried out annually - Regular risk assessments and environmental audits Regular PFI monitoring and reporting across all of the contract -Full condition surveys of JCUH site undertaken bi-annually - Agreed 22/23 lifecycle plan of investment and 23/24 indicative plan from our PFI partner - Rolling 5 year capital investment plan	**Management** Estates Centre Board 5 year prioritised Capital Plan received by Resources and Board 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 Ward 8 released for lifecycle work ongoing June 2022 **Risk and Compliance**	Regulatory inspections were not timely due to the covid pandemic and are now recommencing - Cleveland and North Yorkshire fire and rescue RRO inspections (6 between Jan-April 22) - HSE inspection - AE assessments Annual regulated inspections will be completed By March 2023 – Mr Oxley Following COVID, new ventilation standards have been released HTM03-01 which requires investment from the Trust to upgrade to these	**Moderate**

	- Capital investment increases into the estate which includes - complete refurbishment and upgrade of paediatric ED, - improvement works to A&E front of house, - new CT scanner in ED front of house, - ward refurbishment programme recommenced (ward 8 commences April 2022 - new male surgical assessment unit underway, - new PACU commences April 2022, - Two new critical isolation rooms in GHDU completed in 2021, - upgraded renal unit, new trauma and dermatology outpatients department, at JCUH - new SDEC at JCUH, - FHN academic centre, ophthalmic ward and new dialysis unit, - two FHN ward refurbishments - Low levels of backlog maintenance evidenced in model hospital when assessed against peers	**Independent Assurance** Internal Audit of estates services 2022 Internal Audit of PFI contract management Independent Authorising Engineer (AE) reports PLACE Assessments CQC Inspections	standards – Mr Oxley Following COVID, national and Trust need for more HTM compliant isolation rooms – Mr Oxley Lack of storage is an issue across our hospitals with expanding services which sees non clinical converted to clinical space	

South Tees Hospitals
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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	21.6.22	**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 Data Protection and Security Toolkit submission 20/21 Digital update to Resources Committee monthly IG update to Resources Committee June 2022 **Risk and compliance** Board cyber training 2019 Board cyber training 2022 – 29 March **Independent assurance** Cyber internal audit report – weaknesses identified External Audit of data protection and security toolkit	Internal Audit report recommendations on cyber to be implemented – S Orley – October 2021 (Resources Committee)	**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 Report on supply and demand to Resources Committee March 2022 **Risk and compliance** Business Continuity Plan report to Audit & Risk Committee February 2022 **Independent assurance** Premises Assurance Model report EPRR report		**Significant**

		EPRR Core Standards compliance report Water safety report		

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**	**Target**	**Target**	**Risk type**	
Executive Lead	Director of HR	**Likelihood**	5. Almost Certain	3. Possible	3. Possible	**Risk appetite**	MINIMAL
Initial date of assessment	21.5.21	**Consequence**	4. Major	3. Moderate	3. Moderate	**Risk treatment strategy**	
Last reviewed	21.6.22	**Risk Rating**	20. Extreme	9. 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 Limited assurance report on junior doctors including report on roster February 2022 Collaborative Workforce plans report February 2022 Report on hard to recruit medical workforce within quarterly report on workforce March 2022 Update on resilience and metrics being used to assess included in quarterly report on workforce March 2022 Staff survey report to Committee and Board March 2022 Exit interview limited report May 2022 Staff views on their employment report May 2022 Report on eroster and allocate May 2022 **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	AHP workforce plan to be implemented – R Mhalanga *date changed July 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 key financial system to establish best use of resources – Resources Committee – Director of HR, Dr Lal, Dr Lloyd - Independent audit review to be commissioned- May 2022 _____ Ageing workforce – undertake an impact assessment on the workforce to inform future workforce planning including provision of support services to the workforce. Mrs Metcalf – 30 September 2022	**Moderate**

	contractor workforce at the Trust Year on year increase in volunteer workforce Nursing & Midwifery Strategy Workforce plan and accountability framework	CQC inspection report July 2018 NHS staff survey 2020 results showing improvement in a number of areas NHS Staff survey 2021 results showing improvements in a number of areas		
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 March 2022 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 Financial wellbeing report to Committee March 2022 **Risk and compliance** Occupational Health accreditation award in 2021 Bronze **Independent Assurance** NHS staff survey 2020 results showing improvement in a number of areas NHS Staff survey 2021 results - above the average in all 9 domains relating to redployment	Embed wellbeing into leadership and management programmes – 3 month review of feedback programme. Ms J Winnard – February 2022	**Moderate**
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 Workstream on flexible working in place and programme of action agreed. **Risk and compliance** **Independent Assurance** NHS Staff survey 2021 results – deterioration in flexible working indicator		**Moderate**
3.4 Our culture and organisational development programme is not progressed leading to poor staff morale, less empowered teams, lack of	BAME risk assessments ED&I strategy Workshop and roll out of values and behaviours Learning and development programme for staff development Weekly staff communications	**Management** ED&I Annual report WRES and WDES report to People Committee Quarterly report to People Committee on ED&I Quarterly report to People Committee on Engagement Reciprocal mentorship programme in development		**Moderate**

progress of the equality and diversity agenda and less positive engagement.	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	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 NHS Staff survey 2021 results showing improvements in a number of areas		

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	2. Unlikely	2. Unlikely	**Risk appetite**	
Initial date of assessment	21.5.21	**Consequence**	4. Major	4. Major	4. Major	**Risk treatment strategy**	
Last reviewed	21.6.22	**Risk Rating**	16. Extreme	8. High	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 Draft Digital Strategy to Resources Committee May 2022 – limited assurance 40 Wards currently with STACQ accreditation 01 07 22 – STACQ Board update – Seminar May 2022 Board seminar on Improvement Plan June and July 2022 **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	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 – *updated date September 2022*	**Moderate**

		Top 100 Apprenticeship Employer Other external regulator such as UCAS for Urology; Anaesthetic ACSA		
4.2 Failure to deliver a programme of change in support of fragile or vulnerable services leading to a loss of quality, efficiency, outcomes and workforce shortages	Improvement Plan phase 1 and 2 Recovery plan including trajectories for improvement 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	**Management** Recovery plan reported monthly to Resources 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 ECIST report to Resources Committee May 2022 **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 Maternity Assurance visit by NHSE/I undertaken June 2022 Ockenden Assurance visit undertaken June 2022 **Independent Assurance**	ICS review of vulnerable service – M Stewart – ECIS improvement package of support implement recommendations (Resources Committee) Mr Peate – 31.3.22 – updated date May 2022	**Limited**
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 R&D report to QAC May 2022 including work on innovation Cardiology Research Unit Hearts and Mind Campaign **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 & R&D Director - ongoing	**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	**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	Explore CESR program to establish in house training of consultant staff – Dr Lal – date Consider further opportunities for	**Moderate**

	CPG Implement a recruitment campaign and support package for hard to recruit areas	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	joint appointments – Managing Director – ongoing	
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**	Quality dashboard to be developed – ward to Board level metrics – Managing Director / Chief Nurse – July 2022	**Moderate**

South Tees Hospitals NHS Foundation Trust

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	2. Unlikely	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	8. High	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 Review of ICB and Provider Collaborative governance arrangements by Head of Governance & Managing Director June 2022 **Risk and Compliance** Tees Valley Executive Leadership Group attended by Managing Director Member of Provider Collaborative NENC Sam Allen assurance / induction visit to Trust **Independent Assurance** Provider licence modifications lifted in relation to governance	Consider further opportunities for joint appointments – Managing Director – ongoing 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 Provider Collaborative Governance arrangements to be approved by Board July 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	**Limited**

			2022 – Mr Harrison	
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 IPR includes report on health inequalities **Risk and Compliance** Health Inequalities working group established **Independent Assurance**	Recruitment of Joint Director of Public Health with LA colleagues – end of March 2022 – Mr Harrison Appointment of NED with specific oversight of public health / health inequalities – July 2022 – Mrs White	**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	21.5.22	**Consequence**	4. Major	4. Major	4. Major	**Risk treatment strategy**	
Last reviewed	24.3.22	**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
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	**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 PLICs plan report to Resources Committee February 2022 **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 May 2021 Provider licence restrictions – Letter from Tim Savage		**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	**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		**Moderate**

	Tees Valley CEO meeting ICS Management Executive Clinical Strategy and Improvement Group 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	NHSE/I CIP reports to Resources Committee quarterly CIP programme established CIP Steering Group established with NED input Board Development session 15 February 2022 to agree CIP and response to NHSE/I Board sign off of plan March 2022 **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 Letter of acknowledgement of receipt of plan and ICS management Financial plan for H2 2021/22, including CIP target, agreed as part of ICB financial plan.		
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 Letter of acknowledgement of receipt of plan and ICS management PFI costs supported during 2021/22 through Covid-19 financial regime as evidenced in the Planning Guidance and financial reports Safety investment costs supported during 2021/22 through Covid-19 financial regime as evidenced in the Planning Guidance and financial reports		**Moderate**
6.4 Insufficient capital	PFI Contract management	**Management**		**Moderate**

resources available across the ICS to support the phasing of the Trust's capital investment requirements	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	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 ICB Capital allocation **Independent assurance** Internal audit reports		
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 February 2022, March 2022, April 2022, Board reports on 2022/23 financial position and system savings **Independent** ICP/ICS Plan submission approval by NHSE/I Financial risk share agreements agreed for 2021/22. ICB forecast to deliver financial balance in line with plan, with Trust plan delivery on track as evidenced in the Planning Guidance and financial reports		**Moderate**

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	24.03.22	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	**Management** Directorate level finance reports Annual report and accounts Annual Governance Statement National Cost Collection report to Resources Committee September 2021 PLICs plan report to Resources Committee February 2022 Financial structure update to Resource Committee verbally March 2022 **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 February 2022, March 2022, April 2022, Board reports on 2022/23 financial position and system savings **Independent assurance** Internal audit External audit NHSE/I monthly finance monitoring Letter of acknowledgement of receipt of plan and ICS management		**Moderate**
7.2 Potential loss of grip and control during transition to new clinically	Day to day budget management processes in place Finance business partners - qualified Policies and procedures for managing financial control	**Management** Directorate level and department level finance reporting Cost centre level finance reports		**Moderate**

led structure	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 Purchasing via procurement frameworks and NHS supply chain	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 Financial structure update to Resource Committee verbally March 2022 PLICs plan report to Resources Committee February 2022 **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 **Independent** Going concern and financial controls audit as part of External and Internal audit programme Regional finance returns monthly (H1/H2) 2021/22 block contracts agreed for H1 and H2 periods, under the Covid-19 financial framework		
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 Financial structure update to Resource Committee verbally March 2022 **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) Financial risk share agreements agreed for 2021/22. ICB forecast to deliver financial balance in line with plan, with Trust plan delivery on track		**Moderate**
7.4 Inability to agree contracts with commissioners to provide the planned levels of	Resources Committee Contracting team BIU team NHS Standard Contract and guidance	**Management** Finance report Contracting guidance		**Moderate**

clinical income	Costing information Joint NTHT Contract Contract meetings Contracting working group established across NT and ST	**Risk and compliance** Finance report to Board, Resources Committee **Independent** NHSE/I independent costing assurance audits 2021/22 block contracts agreed for H1 and H2 periods, under the Covid-19 financial framework.		
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 ICB Capital allocation **Independent assurance** Internal audit reports		**Moderate**
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 February 2022, March 2022, April 2022, Board reports on 2022/23 financial position and system savings **Independent** ICP/ICS Plan submission approval by NHSE/I Financial risk share agreements agreed for 2021/22. ICB forecast to deliver financial balance in line with plan, with Trust plan delivery on track.		**Moderate**
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	**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	Update to digital strategy – Mr Imiavan – date updated in line with audit June 2022	**Limited**

	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	**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 February 2022, March 2022, April 2022, Board reports on 2022/23 financial position and system savings **Independent assurance** Internal audit reports		
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 IG update to Resource Committee June 2022 **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 – 5 JULY 2022			
Integrated Performance Report			**AGENDA ITEM: 9, ENC 7**
Report Author and Job Title:	Emma Moss Management Information Lead Business Intelligence Unit	**Responsible Director:**	Sam Peate Chief Operating Officer
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	Changes to metrics for May 2022 IPR, are as follows: **SAFE** domain: Caesarean section indicator removed. **EFFECTIVE** domain: New format for presentation of Standardised Hospital Mortality Index (SHMI): The Trust is piloting a new format for the Making Data Count and NHS Digital SHMI teams. The charts show the rolling 12-month SHMI, the number of Observed and Expected deaths (SHMI=Observed divided by Expected) and the contextual indicator "proportion of deaths receiving specialist palliative care". Old format SHMI and HSMR removed. **CARING** domain: Targets for Friends and Family Test agreed for 2022/23, target to exceed 2021/22 national average. **EQUITABLE** domain: Inpatient waiting list by deprivation not available this month.		

	RESPONSIVE domain: New metric: Patients waiting more than 78 weeks on a Referral to Treatment (RTT) pathway. Removed metric: Patients waiting more than 104 weeks on a Referral to Treatment (RTT) pathway; as waiting times have been reduced through our elective recovery programme. **WELL LED** domain: No changes. **Our key messages for May are:** • The Trust was non-compliant with the mandated Single Oversight Framework metrics in **March/April,** and across the themes of the SOF (quality of care, finance and use of resources, operational performance, strategic change, leadership and improvement capability) the Trust is placed in **segment 3, mandated support for significant concerns**. The Trust continues to benefit from external support on emergency care pathways and cost improvement and transformation. • Emergency care performance was generally in line with the regional and national position, reflecting the challenges faced by many Trusts in recovering patient access given the impacts of the Covid pandemic. • Longest waits have reduced very significantly with 104-week waits eliminated by April 2022. The main 62-day cancer pathway, from GP referral performed better than regional and national average. Each diagnostic access modality has a recovery trajectory and data validation focus.	
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐	
Recommendation	Members of the Public Trust Board of Directors are asked to receive the Integrated Performance Report for May 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	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without	Make best use of our resources ☒

report aims to support)	boundaries in collaboration 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 ☒	

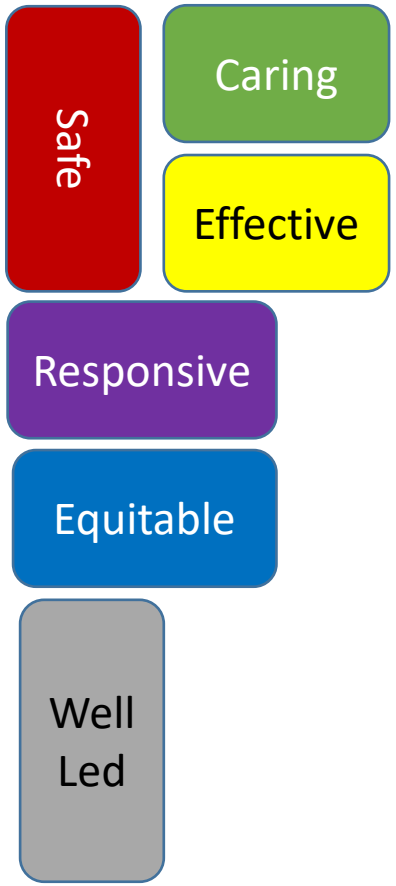
South Tees Hospitals
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT

May 2022

OVERSIGHT

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



Audit and Risk Committee

CHANGES THIS MONTH

SAFE domain:

Caesarean section indicator removed.

EFFECTIVE domain:

New format for presentation of Standardised Hospital Mortality Index (SHMI): The Trust is piloting a new format for the Making Data Count and NHS Digital SHMI teams. The charts show the rolling 12-month SHMI, the number of Observed and Expected deaths (SHMI=Observed divided by Expected) and the contextual indicator "proportion of deaths receiving specialist palliative care". Old format SHMI and HSMR removed.

CARING domain:

Targets for Friends and Family Test agreed for 2022/23, target to exceed 2021/22 national average.

EQUITABLE domain:

Inpatient waiting list by deprivation not available this month.

RESPONSIVE domain:

New metric: Patients waiting more than 78 weeks on a Referral to Treatment (RTT) pathway.

Removed metric: Patients waiting more than 104 weeks on a Referral to Treatment (RTT) pathway; as waiting times have been reduced through our elective recovery programme.

WELL LED domain:

No changes.

NATIONAL CONTEXT

The 10 planning priorities for 22/23 aim to *Restore services, meet new care demands and reduce the backlogs that are a direct consequence of the pandemic*

A) Invest in our workforce

B) Respond to Covid-19 ever more effectively

C) Significantly more elective care - deliver 2019/20 activity plus 10%; eliminate 104 week waits; reduce 52 week waits; deliver cancer pathways to national standards; reduce outpatient follow-ups by 25%; 5% 'patient initiated follow up' pathways in all major specialties; advice and guidance; deliver 120% of diagnostic activity using Community Diagnostic Centres

D) Improve UEC responsiveness and build community capacity – eliminate 12-hour ED waits; minimise ambulance handover delays; use of UTC, virtual wards, community, anticipatory care.

E) Improve access to Primary Care

F) Improve Mental Health, LD and Autism Services

G) Develop approach to Population Health Management

H) Exploit Digital Technologies to transform delivery of care and outcomes – network digital roadmap and investment plans

I) Effective use of resources, delivering better than pre-pandemic productivity levels

J) Establish ICBs and collaborative system working (5 year strategic plan) - ICB level planning, delivery and service configuration

SINGLE OVERSIGHT FRAMEWORK SUMMARY

Provider	A&E 4 hour standard Apr-22	RTT - 18 week standard Mar-22	Cancer 62 day - GP referral Mar-22	Cancer 62 day - screening services Mar-22	Diagnostic 6 week waits Mar-22	Single Oversight Framework triggers			12 hour delay from DTA Apr-22	Ambulance handovers 30-60 mins Apr-22	Ambulance handovers 60+ mins Apr-22	52 week waits Mar-22	104 week waits Mar-22	Total Waiting List Mar-22
	95%	92%	85%	90%	=<1%	This month	Last month	This month triggers	Zero			Zero	Zero	
South Tees Hospitals NHS Foundation Trust	68.8%	65.3%	72.0%	55.6%	31.3%	5	5	A&E; RTT; Cancer 62 (GP); Cancer 62 (Screening); Diagnostics	48	200	183	1,161	1	43,443
Cumbria and North East STP *(including IS providers)*	76.7%	73.7%	70.0%	84.6%	18.5%	35	36	Total for providers in CNE	439	1805	820	7,040	161	341,304
North East & Yorkshire	73.0%	70.4%	68.7%	78.7%	22.6%									
National	72.3%	62.4%	67.4%	74.6%	24.8%									

The Trust was non-compliant with the mandated Single Oversight Framework metrics in March/April, and across the themes of the SOF (quality of care, finance and use of resources, operational performance, strategic change, leadership and improvement capability) the Trust is placed in segment 3, mandated support for significant concerns. The Trust continues to benefit from external support on emergency care pathways and cost improvement and transformation.

Emergency care performance was generally in line with the regional and national position, reflecting the challenges faced by many Trusts in recovering patient access given the impacts of the Covid pandemic.

Longest waits have reduced very significantly with 104-week waits eliminated by April 2022. The main 62-day cancer pathway, from GP referral performed better than regional and national average. Each diagnostic access modality has a recovery trajectory and data validation focus.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
DATIX Incidents	2517	2070	May 2022		
Serious Incidents	5	8	May 2022		
Never Events (YTD)	1	0	May 2022	N/A	N/A
Falls	204		May 2022		N/A
Falls Rate	6.2	6.6	May 2022		
Falls With Harm	5		May 2022		N/A
Falls With Harm Rate	0.2		May 2022		N/A

Incidents

Reporting of incidents remains high since March 2021, setting a new positive norm of around 2,232 incident reports per month. This has increased by 12.6% in the previous 12 months against a target of 10%. High levels of reporting are typically a feature of a positive safety culture. There was 0 NEs reported in May, and 1 previously reported in April. There was a decrease in the number of SIs.

Falls

Where bespoke interventions have been implemented, the number of falls has reduced. The rate of falls with harm per thousand bed days is less and better than the target.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	2.2		May 2022		N/A
Category 2 Pressure Ulcers Community Rate (Per 1000 Bed Days)	1.7		May 2022		N/A
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	0.1		May 2022		N/A
Category 3&4 Pressure Ulcers Community Rate (Per 1000 Bed Days)	1		May 2022	H	N/A
Medication Incidents	156		May 2022		N/A
Medications Reconciled Rate %	63%	80%	Mar 2022		?
C-Difficile (YTD)	25	18	May 2022	N/A	N/A
MRSA (YTD)	0	0	May 2022	N/A	N/A

Healthcare acquired infections

There were no new MRSA reported this month. C-difficile infection is recorded on the Trust risk register with clear tracking, reporting and governance in place.

Pressure Ulcers

There were no category 4 pressure ulcers reported in month. The last Category 4 Pressure Ulcer reported in the community occurred in November 2021 and in the acute setting in January 2022. A reduction in category 3 pressure ulcers is observed in acute setting. The PURPOSE T tool pilot has concluded and been evaluated. Following some minor amendments, a full phased roll out will commence in June 2022. The digital specification is signed off and the technical build is underway. Digital roll is out planned for July 2022.

3 times weekly PU meetings continue, chaired by the Deputy Chief Nurse or Deputy Director of Quality. A business case has been drafted following a capacity and demand modelling exercise. Current resource is based on a historic commissioning agreement.

Medications

Medication incidents remain consistent. Medicines reconciliation reflects impact of staffing absences at that time due to COVID-19. A business case for seven-day working is in process.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
Induction of Labour (%)	47.6%	44%	May 2022		
Still Births (YTD)	8	17	May 2022	N/A	N/A
PPH 1500ml (%)	0		May 2022		N/A

Maternity services

Caesarean Section rates no longer reported in IPR in line with national recommendations. Post-partum haemorrhage rates remain in line with the longer-term average. Induction of labour rates are within normal variation. This is in the context that the Trust is a tertiary centre, taking some of the most complex patients in the region. This is in addition to a greater number of women with a high BMI or from a deprived background, which are risk factors.

Still births reflects the complexity of case mix as a tertiary centre, where pregnancies with foetal anomalies are managed, as opposed to other local maternity units. There were no still births in May.

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

EFFECTIVE

Metric	Latest Month	Target	Month	Trend	Assurance
Readmission Rate %	5.9%		Mar 2022		N/A
Sepsis - Oxygen delivered within 1hr	95.5%	95%	Apr 2022		
Sepsis - Blood cultures within 1hr	54.5%	95%	Apr 2022	L	
Sepsis - Empiric IV antibiotics within 1hr	86.4%	95%	Apr 2022	H	
Sepsis - Serum lactate within 1hr	68.2%	95%	Apr 2022		F
Sepsis - IV fluid resuscitation within 1hr	77.3%	95%	Apr 2022	H	
Sepsis - Urine measurement within 1hr	100%	95%	Apr 2022	H	
Summary Hospital-Level Mortality Indicator	113	100	Jan 2022	L	
Comorbidity Coding	4.1		Jan 2022		N/A
Palliative Care Coding	0		Jan 2022	L	N/A

Readmission rates

The emergency readmission rate is within normal variation and lower than pre-pandemic.

Sepsis

Improvement in compliance has been observed for 4 of the 6 elements, with a reduction in blood cultures and lactate. A time lag of approximately 6 – 8 weeks occurs to receive the patient level data to facilitate audit, therefore sample sourced differs but yielded appropriate patients.

Further actions include:

- Review of audit process to reduce the burden
- Acutely Ill Patient (AIP) champion study days have been planned for 2022 - 3 delivered
- Roll out commenced of Enhanced Care competencies – Train the trainer
- Paediatric Patientrack NPEWs / sepsis workflow progressed to User Acceptance Testing
- AIM / Sepsis study days planned for 2022/23 - x 2 delivered May 2022
- Targeted education to ward-based areas – driven by Patientrack
- Audit compliance to sepsis bundle via digital solution
- Progress work with BIU to develop effective ward level reporting strategies to improve performance. Initial meeting with Patientrack team to support progression.

Mortality

SHMI and HSMR are both stable but divergent. For the latest official reporting period, Feb 2021 to Jan 2022, SHMI is 'higher than expected' at 113 (it has fallen 7 points in 7 months). SHMI rose before the pandemic, peaked and is falling. Observed and expected deaths (in hospital or within 30 days of discharge) fell during the pandemic, due to reduced hospital activity and are returning to normal volumes. 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 service.

Reporting to the Trusts' governance committees shows that Medical Examiner scrutiny remains at >95%, with around 10% referred for further review. Positive learning from ME and mortality review relate to good communication with family and good documentation of those discussions. Learning is cascaded through the Trust governance structures.

Palliative care coding is present on <0.01% of spells coded, which is lower than 2020-21 due to the impact of Covid-19 at that time. However palliative care coding is present in 40-45% of cases where the patient died, which is a positive increasing trend.

CARING

Metric	Latest Month	Target	Month	Trend	Assurance
A&E Experience (%)	77%	78%	May 2022	L	?
Inpatient Experience (%)	96.2%	94%	May 2022		?
Maternity Experience (%)	100%	92%	Apr 2022		?
Outpatient Experience (%)	95.6%	93%	May 2022		P
New Complaints	24		May 2022		N/A
Closed Within Target (%)	61.9%	80%	May 2022		?

Patient experience

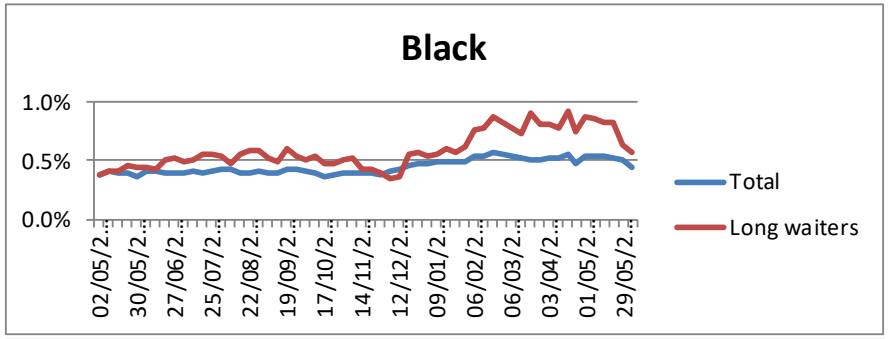
Maternity surveys at the four touchpoints (antenatal, birth, postnatal and community postnatal) are now live on the iPads and have achieved 100% for the second consecutive month.

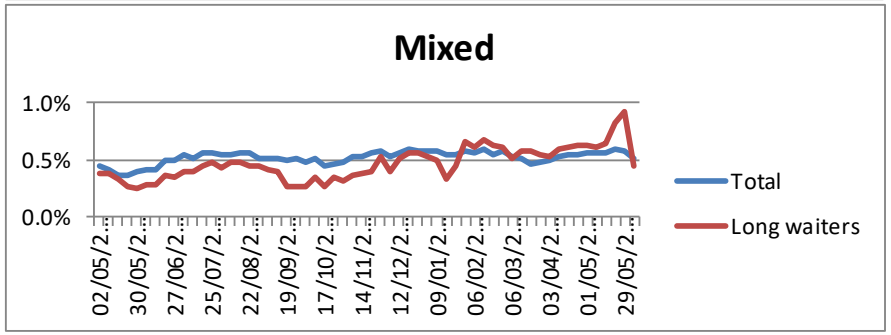
A review was undertaken of the previous targets set for FFT overall percentage positive response rate. The new targets have been gained from the previous financial year's accumulative score for overall percentage positive for each of the areas, thereby ensuring that the targets are in-line with the reporting of FFT scoring from other NHS Trusts in England and based on the data reported to NHSE/I.

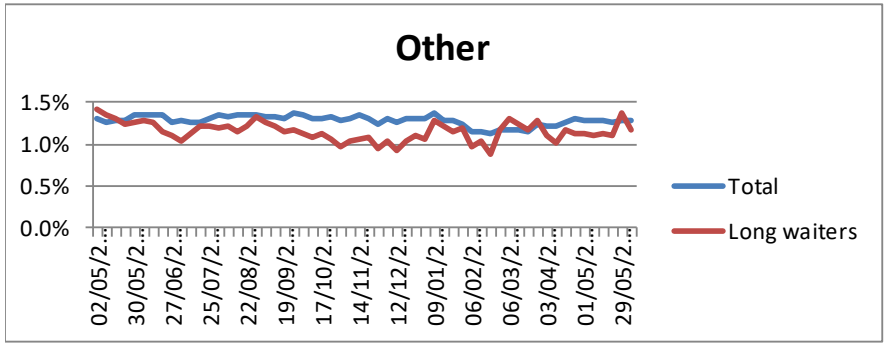
Learning from complaints

The change to 60 working days for complex, multi collaborative and other NHS organisations is expected to improve the timeframe for closure and improve patient satisfaction with the process.

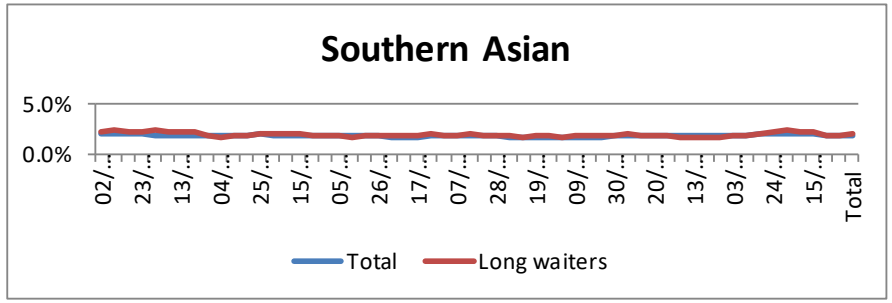
INPATIENT PTL: INEQUALITIES - ETHNICITY

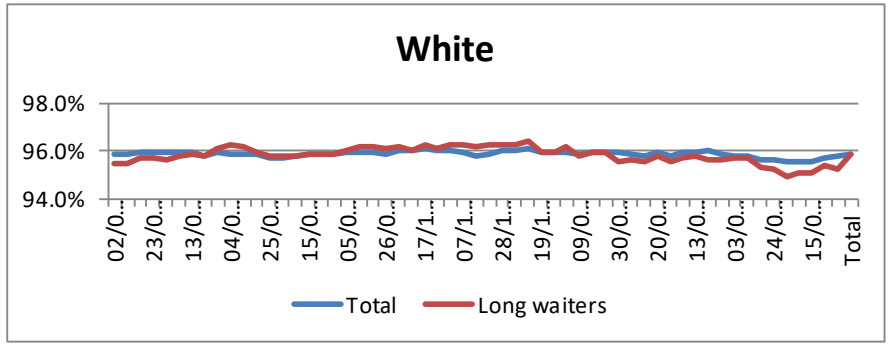






Total	Total		Long waiters		Ratio
Black	39	0.5%	11	0.6%	1.26
Mixed	45	0.6%	16	0.9%	1.58
Southern Asian	146	1.9%	32	1.8%	0.98
White	7,449	95.8%	1,663	95.2%	0.99
Other	99	1.3%	24	1.4%	1.08
N/k	1,151		236		





The trust monitors its waiting list to help ensure that all groups have equitable access and are not disadvantaged due to factors including deprivation or ethnicity. Factors may include people who struggle to take time off work to attend appointments, health inequalities or a correlation between poorer health and multiple long-term conditions. The numbers shown are very small and therefore statistical fluctuations can be exaggerated. It is nonetheless an area which the trust continues to regularly monitor.

RESPONSIVE

Metric	Latest Month	Target	Month	Trend	Assurance
4-Hour A&E Standard	68.8%	95%	May 2022	L	F
12-Hour Waits from Decision to Admit	39	0	May 2022		?
Handovers - Within 15 Mins (%)	68.1%	65%	May 2022	L	?
Handovers - Within 30 Mins (%)	80.6%	95%	May 2022	L	F
RTT Incomplete Pathways (%)	65.3%	92%	Mar 2022	L	F
RTT 52 week waiters	1162	2451	Mar 2022	N/A	N/A
RTT 78 week waiters	89		Mar 2022	N/A	N/A
RTT 104 week waiters	1	0	Mar 2022	N/A	N/A
RTT Waiting List Size	43453	41677	Mar 2022	H	?
Diagnostic 6 Weeks Standard (%)	70.2%	99%	Apr 2022	H	F
Cancer 14 Day Standard (%)	69.6%	93%	Apr 2022	L	?
Cancer 31 Day Standard (%)	93.3%	96%	Apr 2022		?
Cancer 62 Day Standard (%)	73.1%	85%	Apr 2022		?
Cancer 62 Day Screening (%)	45.5%	90%	Apr 2022		?
Cancelled Ops - Non-Urgent Cancelled on Day	25	0	May 2022		F
Cancelled Ops - Not Rebooked Within 28 days	6	0	May 2022		?
Cancer Operations Cancelled On Day (YTD)	0	0	May 2022	N/A	N/A

Urgent and emergency care

The impact of COVID-19 on staffing levels in this staff group and patient flow (segregation of pathways) continues to be observed. Increased levels of urgent and emergency care activity continued throughout May. This impacted on 4-hour standard.

Ambulance handovers continued to be impacted by the volume of activity in May, however handovers within 15 minutes returned to a compliant position. Specific actions are being monitored through the Emergency Care Improvement Group and the Trust continues to be supported by ECIST.

Elective waiting times

Referral to treatment within 18 weeks performance remain at 65%. Operational plans for outpatient and inpatient activity for 22/23 include an increase in activity to reach 104% of pre-pandemic levels, which will impact positively on this metric. The focus remains on the longest waiters – maintaining a zero position with 104 week waits, eliminating 78-week waits and reducing 52-week waits, which are positively reducing ahead of plan. Diagnostic access continues to improve, rising to 70% at end April. All modalities have demand and capacity plans in place with actions and trajectories to work towards compliance, including the use of future Community Diagnostic Hub capacity.

Cancer waiting times

Cancer waiting times performance remains in line with previous months.

Cancelled operations

The number of non-urgent operations cancelled on the day of surgery continues to reduce each month.

RESPONSIVE

Metric	Latest Month	Target	Month	Trend	Assurance
New Attendances	17053	18068	May 2022		
Review Attendances	45326	47114	May 2022		
Day Case admissions	5625	5894	May 2022		
Ordinary Elective admissions	921	1075	May 2022		
NEL admissions with 0 LOS	1782	1951	Apr 2022		
NEL admissions with 1+ LOS	3671	3999	May 2022		
Length of Stay - Elective	4.4		May 2022		N/A
Length of Stay - Non-Elective	5.2		May 2022		N/A

Activity

At Trust level, outpatient first attendances were at over 94%, outpatient follow up at over 96%, elective day cases at over 95%, and elective overnight cases at 86%, although noting that data reconciliation for May month end will be incomplete at this point.

Non-elective admissions remain high, reflecting the trend seen nationally, and the pressures seen in urgent and emergency care and social care.

Length of Stay

Elective length of stay remains lower than the longer-term average, whilst non-elective length of stay remains higher and has increased in May. This reflects ongoing pressures across the social care sector which impact on timely discharge of patients who have ongoing care and support needs. The Trust has worked in partnership with local authorities, to streamline processes, integrate a Transfer of Care Hub, and provide short term care to patients in their own homes to facilitate safe discharge from hospital - the Home First scheme. This work is overseen by our Discharge Board. The Trust has made good progress in reducing delays within its span of control, however pressures in the social care sector continue to have an impact. This results in patients staying in hospital longer than is clinically necessary.

WELL LED

Metric	Latest Month	Target	Month	Trend	Assurance
Cumulative YTD Financial Position (£'millions)	-£7.031m	-£7.092m	May 2022	N/A	N/A
Annual Appraisal (%)	73.5%	80%	May 2022		F
Mandatory Training (%)	89.3%	90%	May 2022	H	F
Sickness Absence (%)	5.1%	4%	May 2022	H	F
Staff Turnover (%)	14%	10%	May 2022	H	F

Finance and use of resources

For month 2 of the 2022/23 financial year the Trust is ahead of plan despite the continued challenge presented by the historic PFI on The James Cook University Hospital which has been externally assessed as adding £20 million in excess costs to the Trust each year. The Trust plan forms part of the ICS financial plan and the ICS is expected to deliver a financial balance at system level for 2022/23. A final ICS plan is still to be finalised and will be submitted to NHSE/I on the 20th June.

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

People

Sickness absence was at 5.08% with long term sickness absence at 3.24%. Short term absence was at 1.84%.

Appraisal compliance across the Trust was at 73.45%. The Appraisal document has been updated following feedback received in the staff survey and is now live on the intranet. The HR teams will continue to support managers in improving Appraisal compliance.

The Trust Mandatory Training compliance was 89.28%.

The latest annual rolling staff turnover rate is lower than the national average. The turnover rate for nursing staff is the third lowest in the country compared to similar trusts.

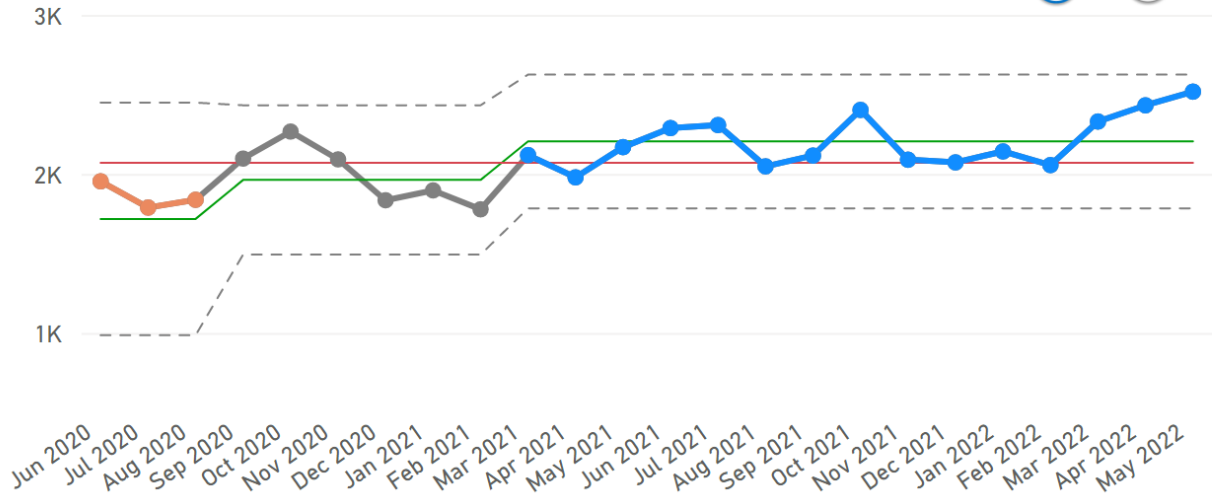
APPENDICES

SPC charts for the metrics summarised above, by domain.

SAFE

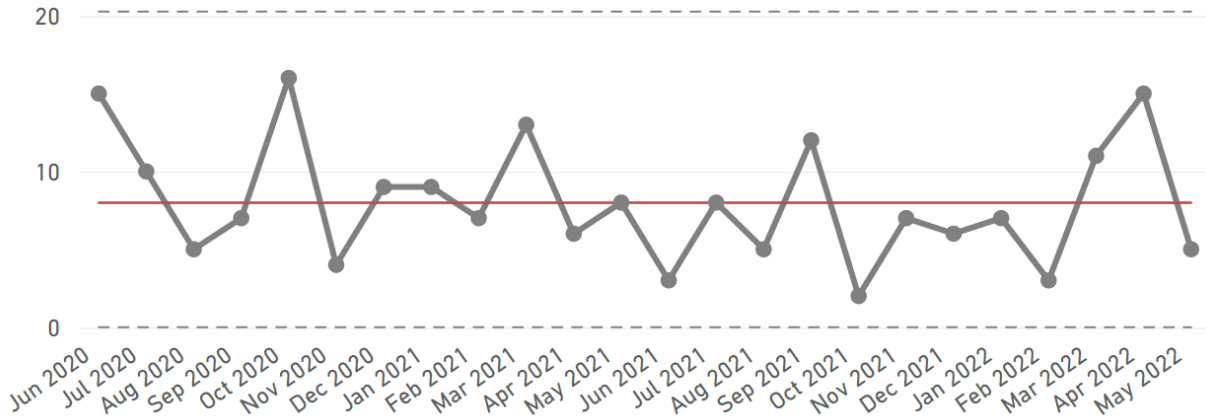
DATIX Incidents

Month	Performance	Target	Trend	Assurance
May 2022	2517	2070		



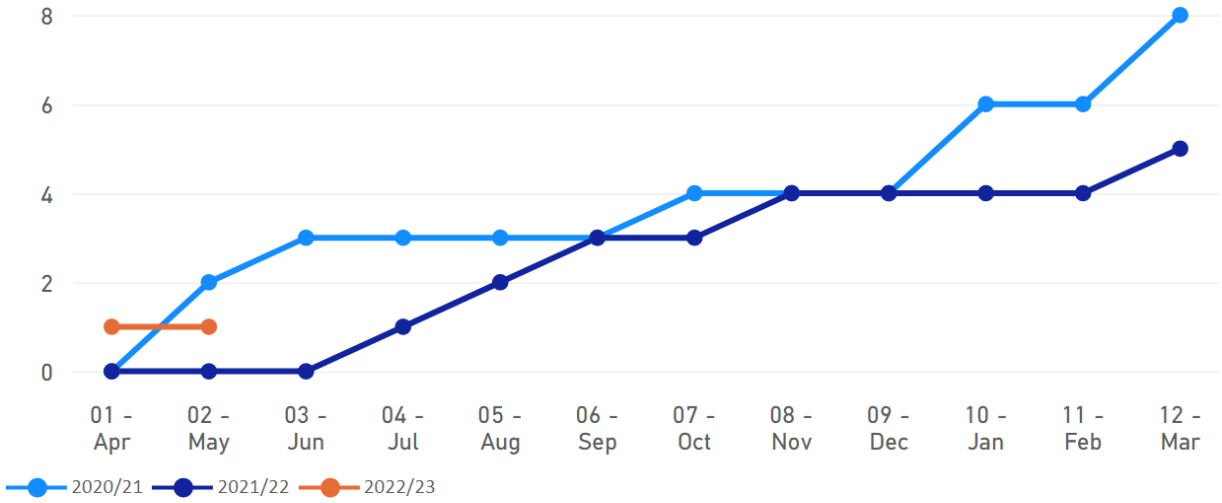
Serious Incidents

Month	Performance	Target	Trend	Assurance
May 2022	5	8		



Never Events (YTD)

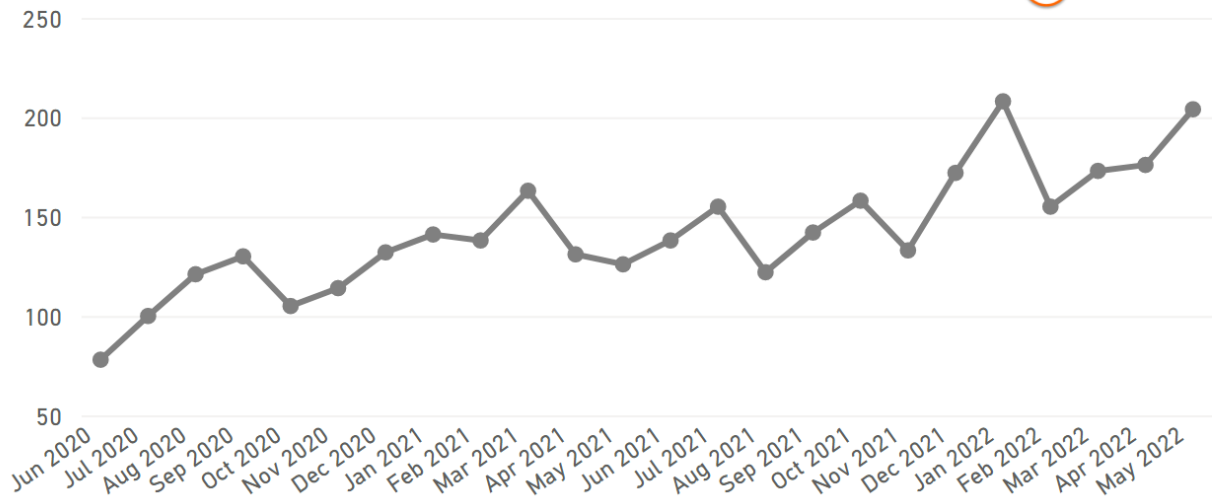
Month	Performance	Target	Trend	Assurance
May 2022	1	0	N/A	N/A



SAFE

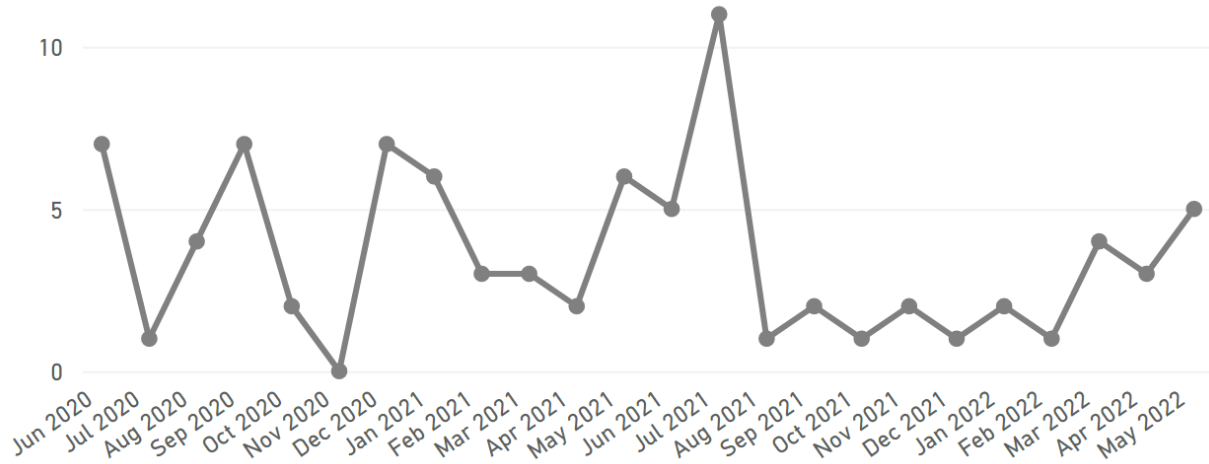
Falls

Month	Performance	Target	Trend	Assurance
May 2022	204			N/A



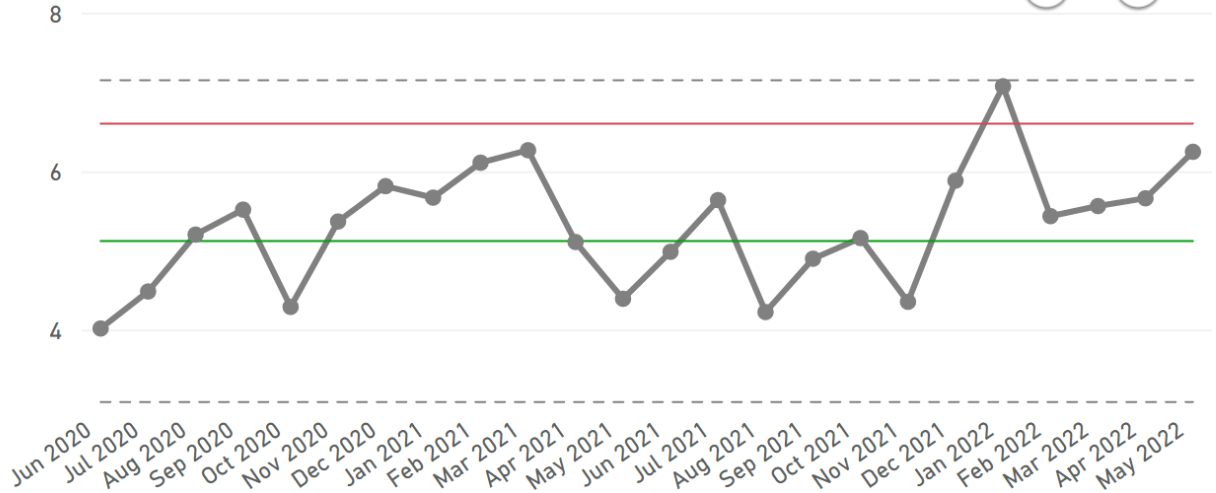
Falls With Harm

Month	Performance	Target	Trend	Assurance
May 2022	5			N/A



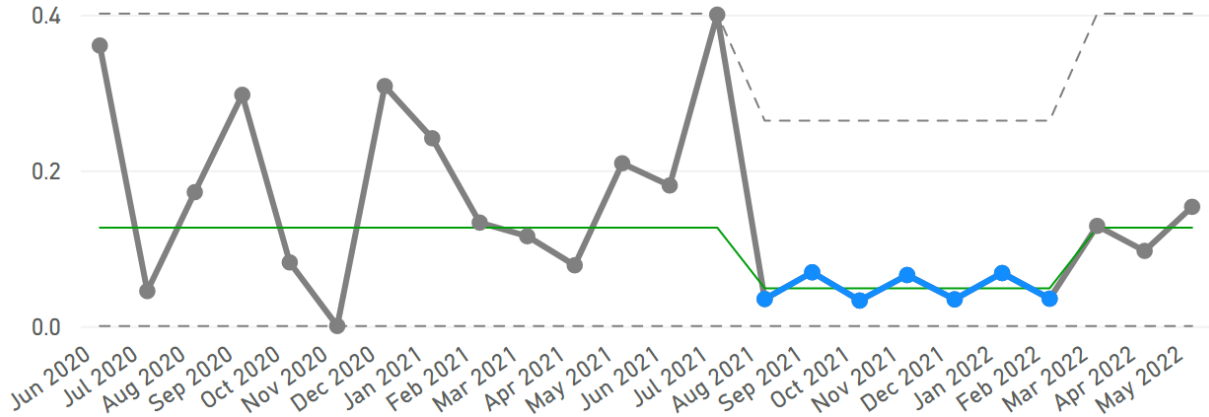
Falls Rate

Month	Performance	Target	Trend	Assurance
May 2022	6.2	6.6		



Falls With Harm Rate

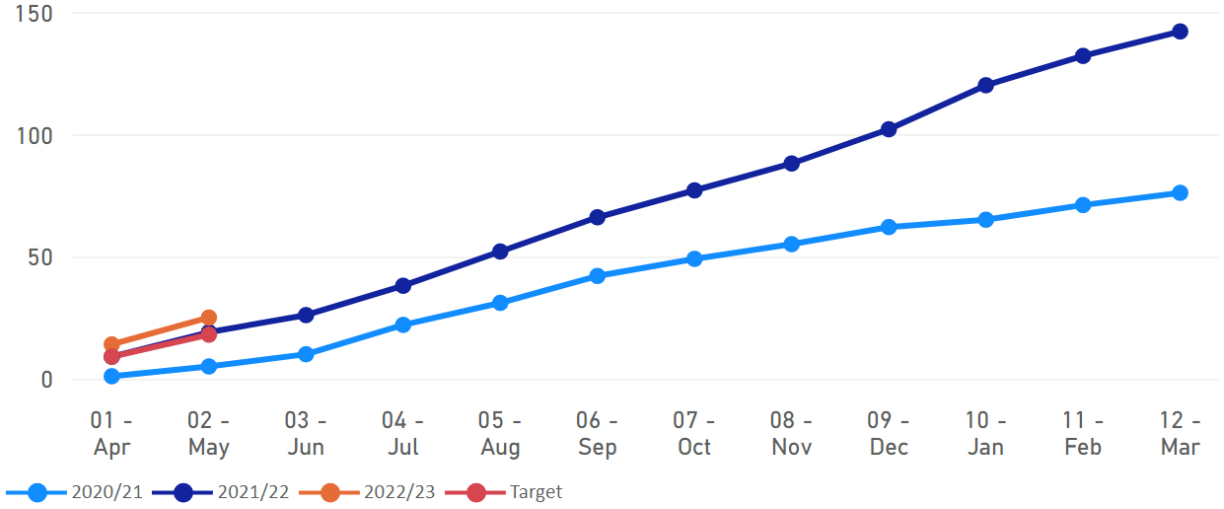
Month	Performance	Target	Trend	Assurance
May 2022	0.2			N/A



SAFE

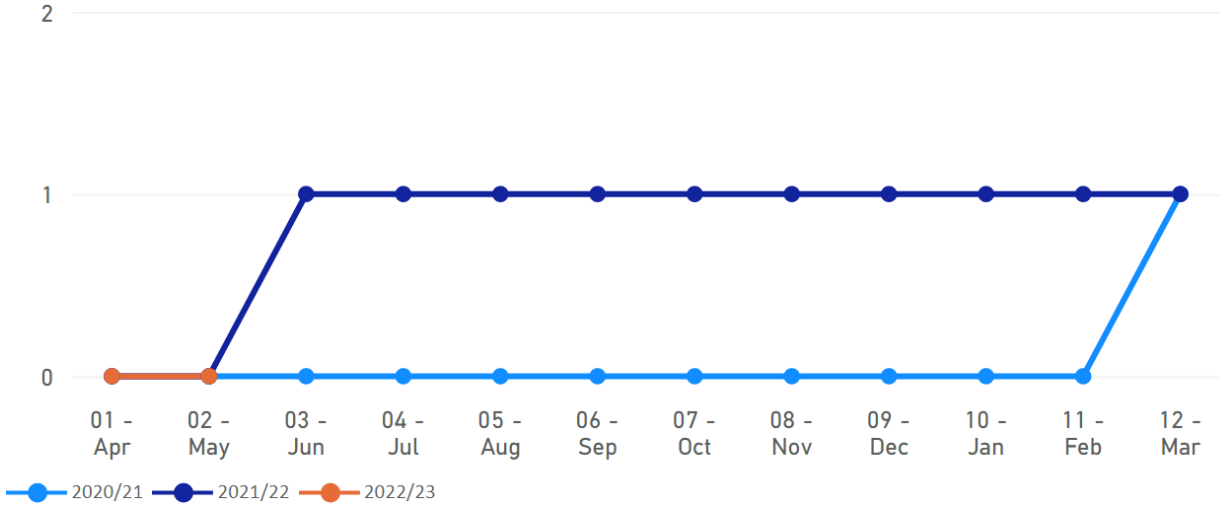
C-Difficile (YTD)

Month	Performance	Target	Trend	Assurance
May 2022	25	18	N/A	N/A



MRSA (YTD)

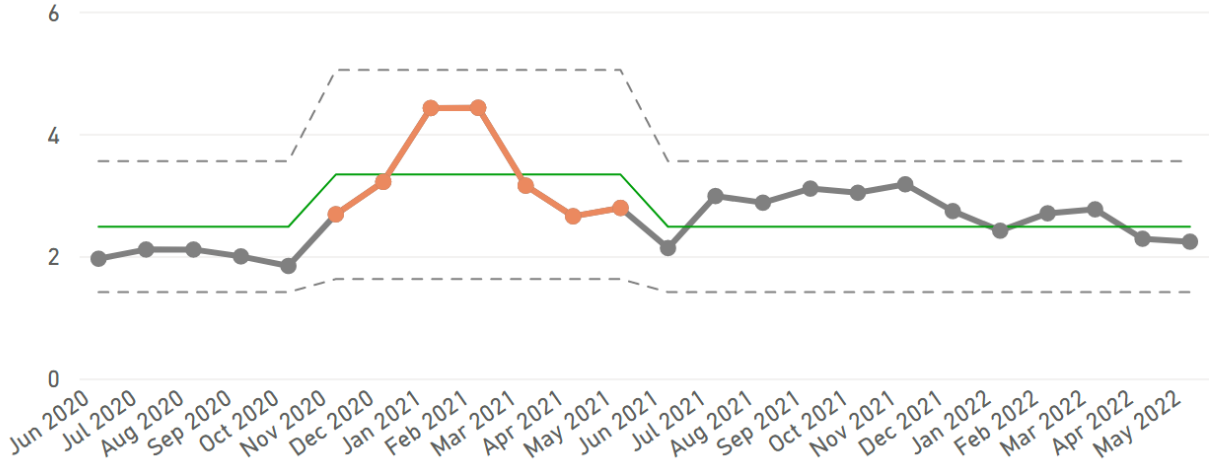
Month	Performance	Target	Trend	Assurance
May 2022	0	0	N/A	N/A



SAFE

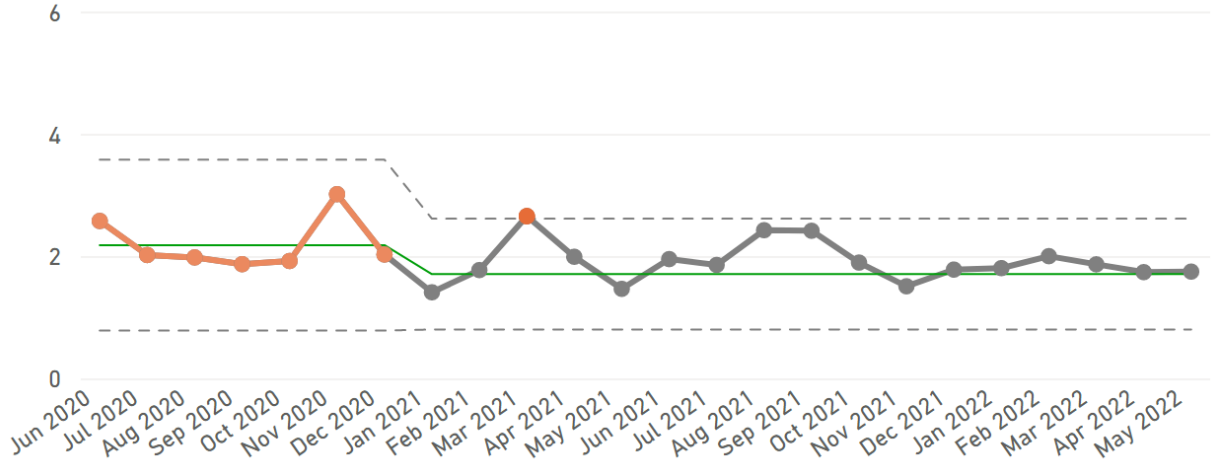
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
May 2022	2.2			N/A



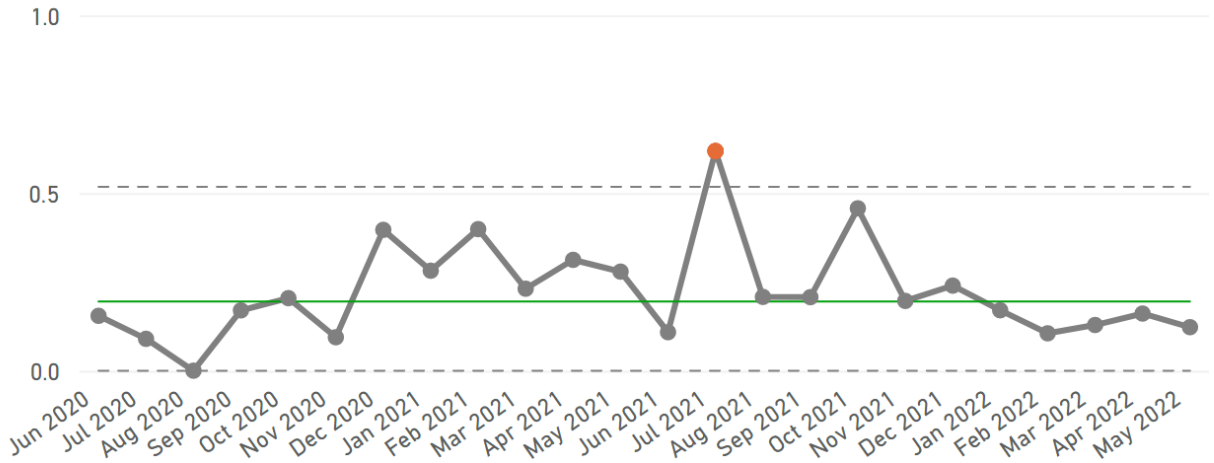
Category 2 Pressure Ulcers Community Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
May 2022	1.7			N/A



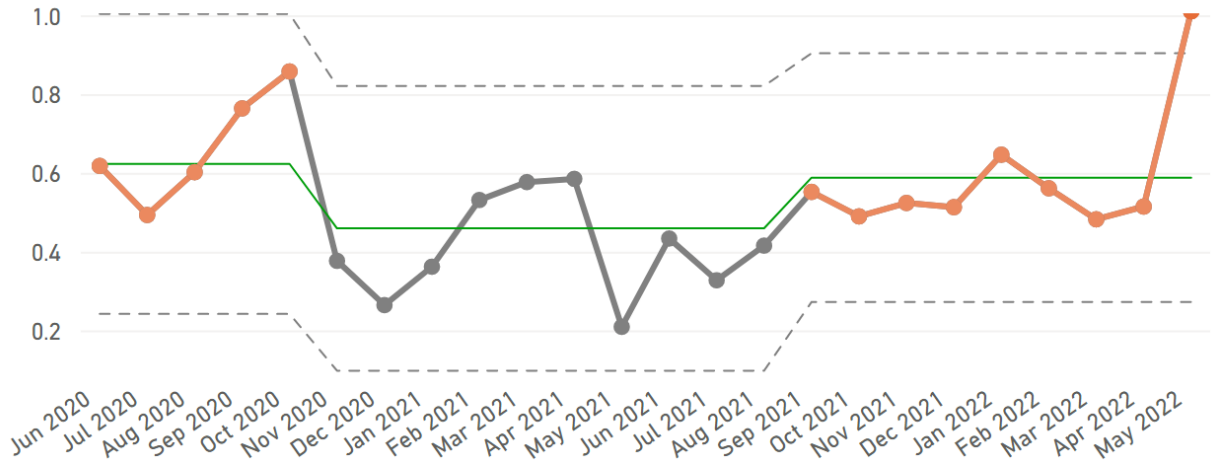
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
May 2022	0.1			N/A



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

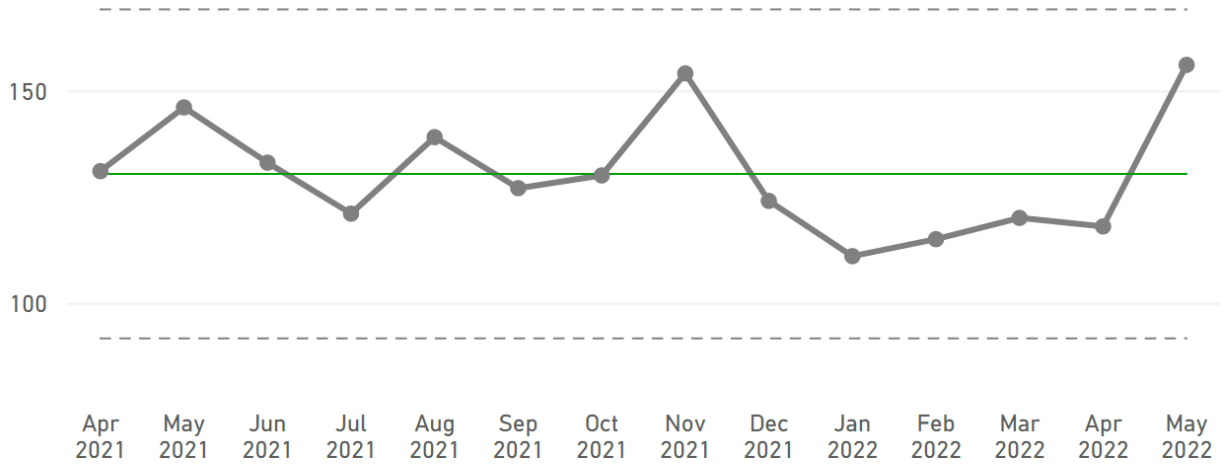
Month	Performance	Target	Trend	Assurance
May 2022	1			N/A



SAFE

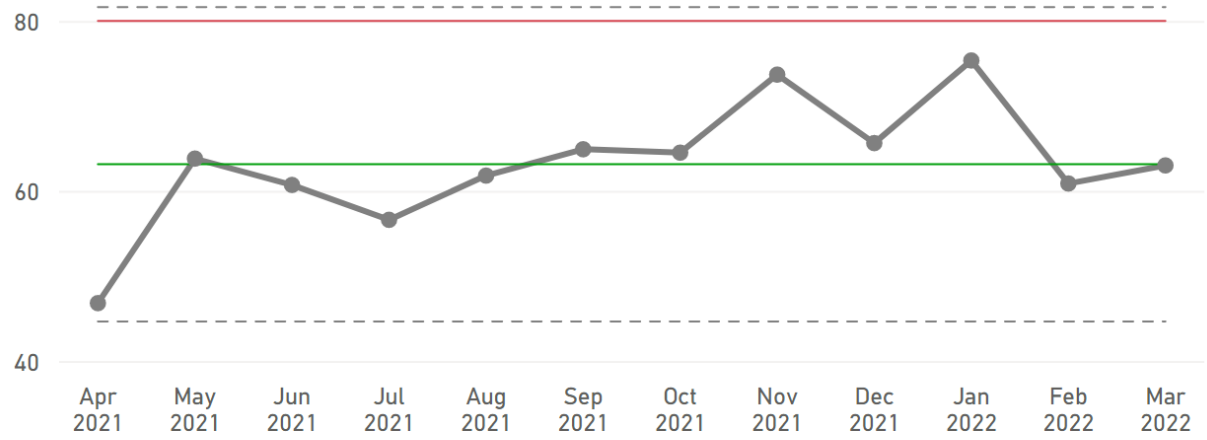
Medication Incidents

Month	Performance	Target	Trend	Assurance
May 2022	156			N/A



Medications Reconciled Rate %

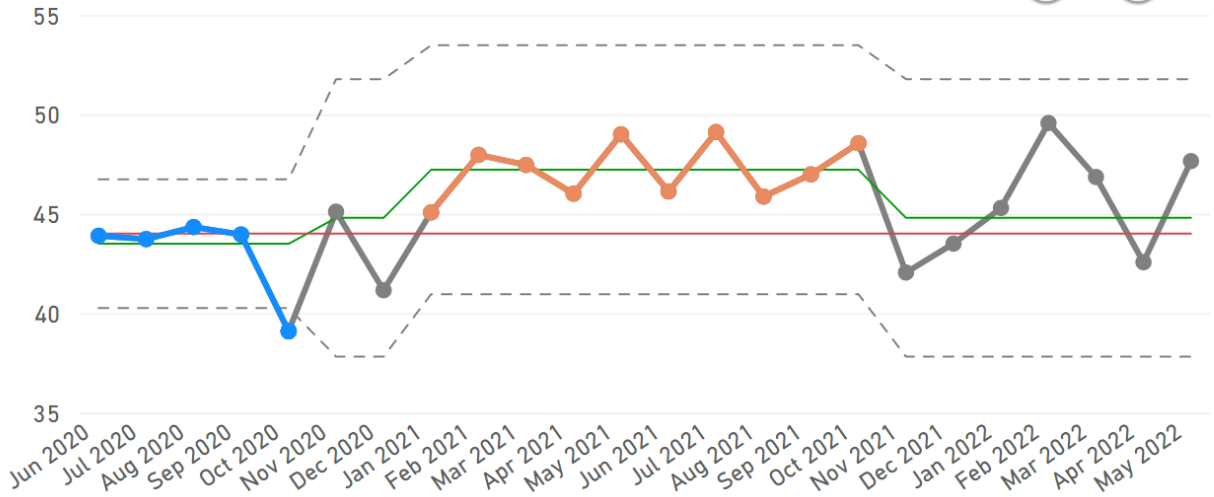
Month	Performance	Target	Trend	Assurance
Mar 2022	63%	80%		



SAFE

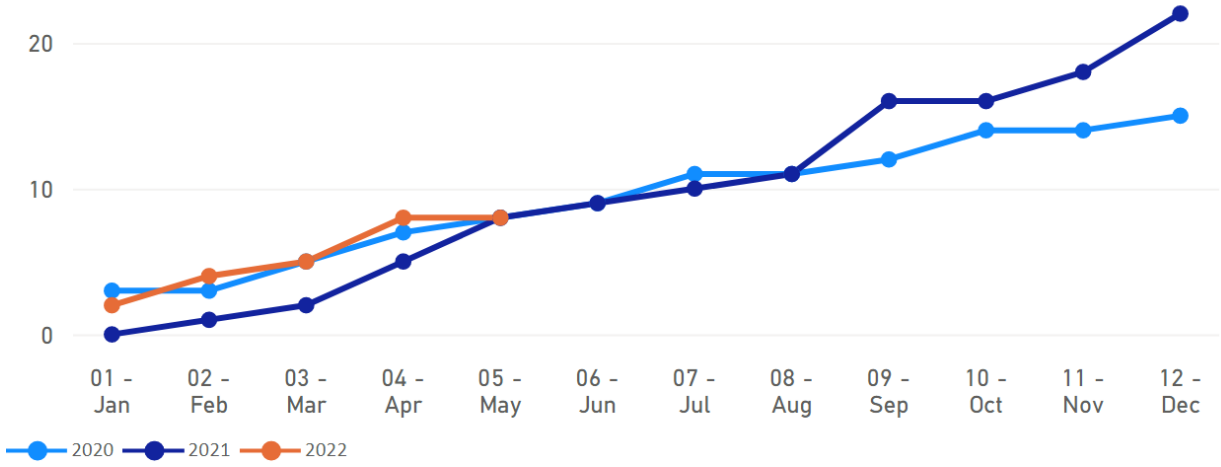
Induction of Labour (%)

Month	Performance	Target	Trend	Assurance
May 2022	47.6%	44%		



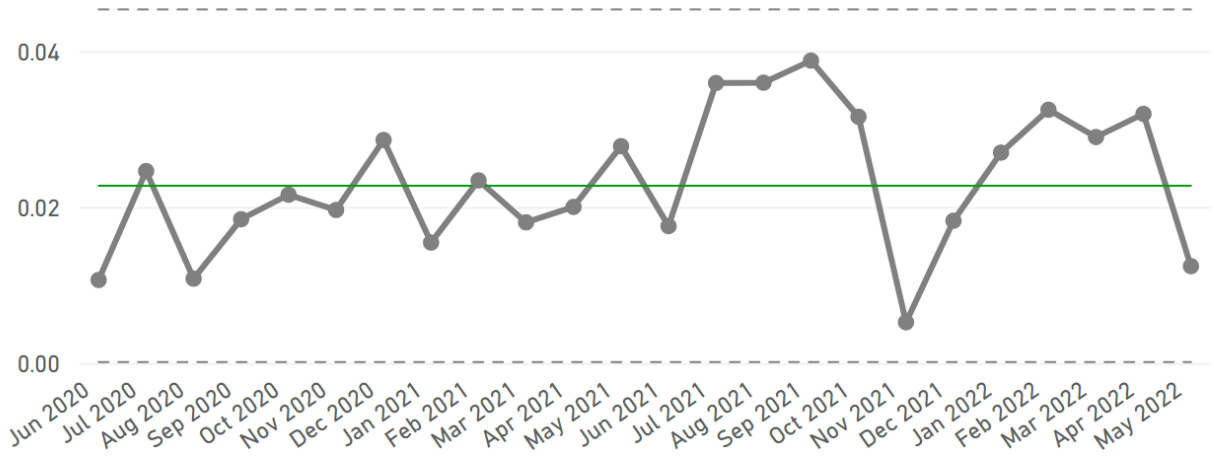
Still Births (YTD)

Month	Performance	Target	Trend	Assurance
May 2022	8	17	N/A	N/A



PPH 1500ml (%)

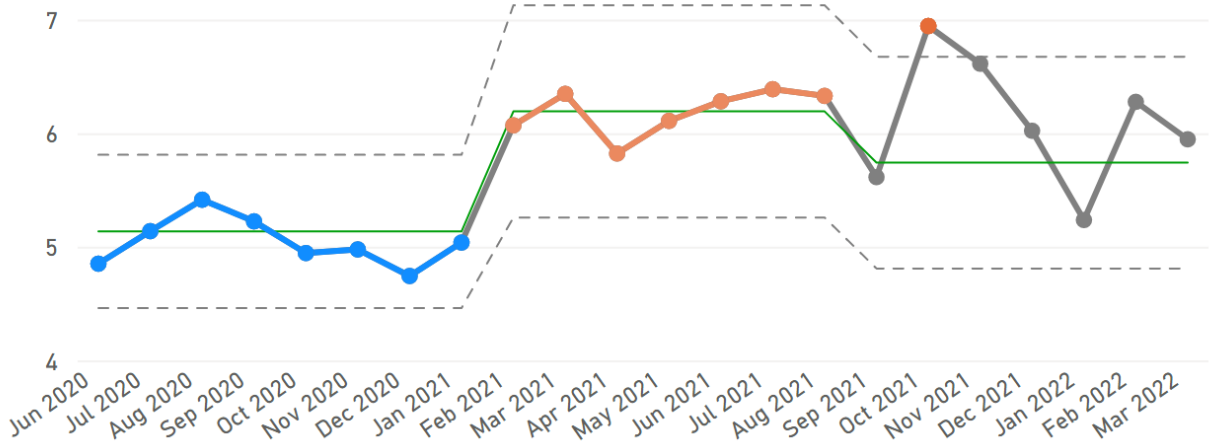
Month	Performance	Target	Trend	Assurance
May 2022	0			N/A



EFFECTIVE

Readmission Rate %

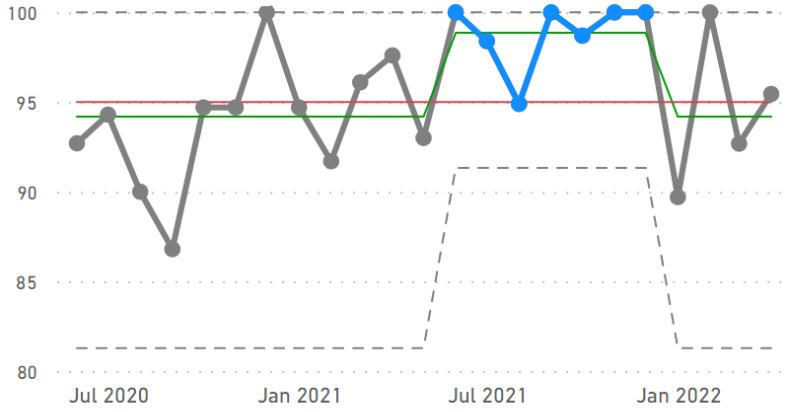
Month	Performance	Target	Trend	Assurance
Mar 2022	5.9%			N/A



EFFECTIVE

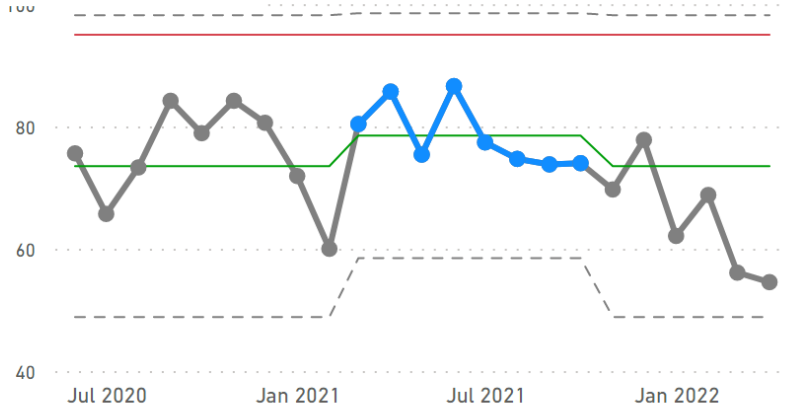
Sepsis - Oxygen within 1hr

Month	Performance	Target	Trend	Assurance
Apr 2022	95.5%	95%		



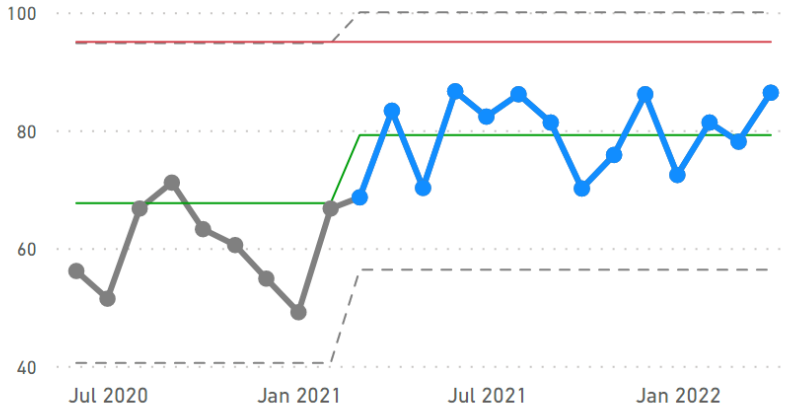
Sepsis - Blood cultures within 1hr

Month	Performance	Target	Trend	Assurance
Apr 2022	54.5%	95%		



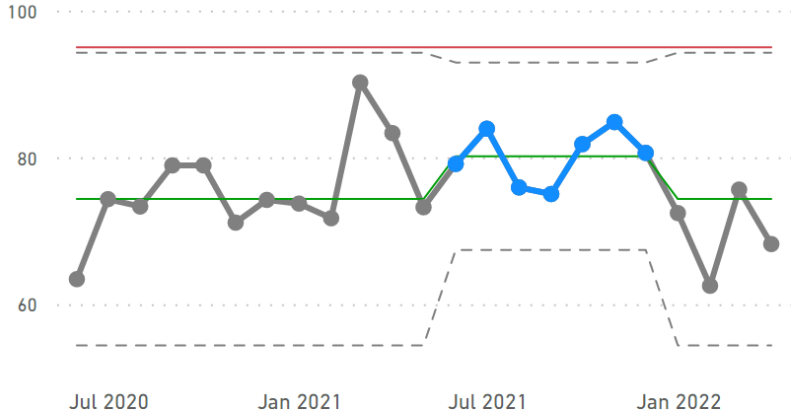
Sepsis - IV antibiotics within 1hr

Month	Performance	Target	Trend	Assurance
Apr 2022	86.4%	95%		



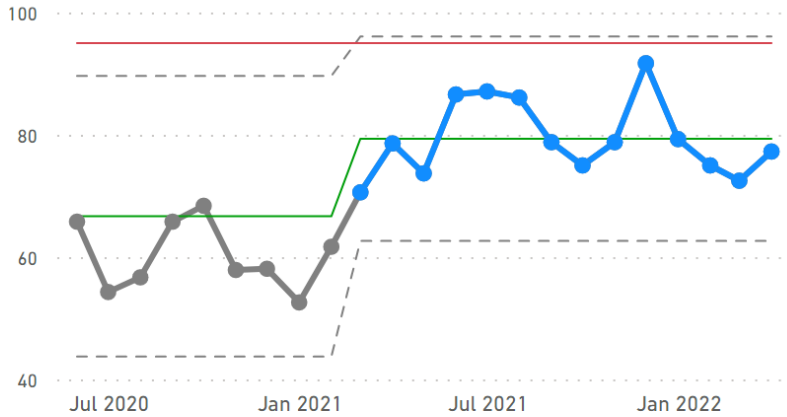
Sepsis - Serum lactate within 1hr

Month	Performance	Target	Trend	Assurance
Apr 2022	68.2%	95%		



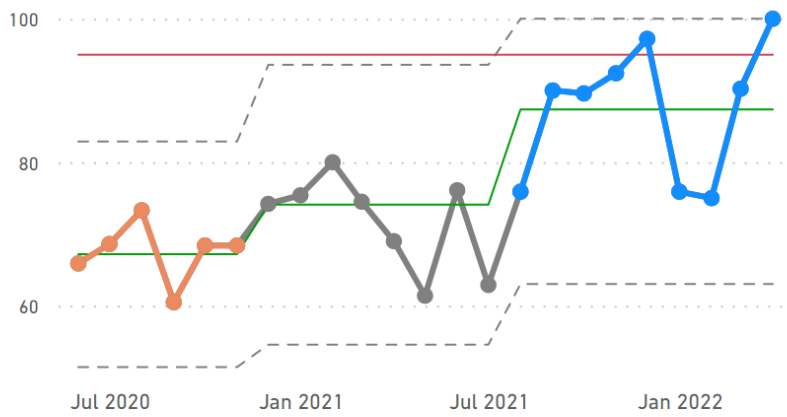
IV fluid resuscitation within 1hr

Month	Performance	Target	Trend	Assurance
Apr 2022	77.3%	95%		



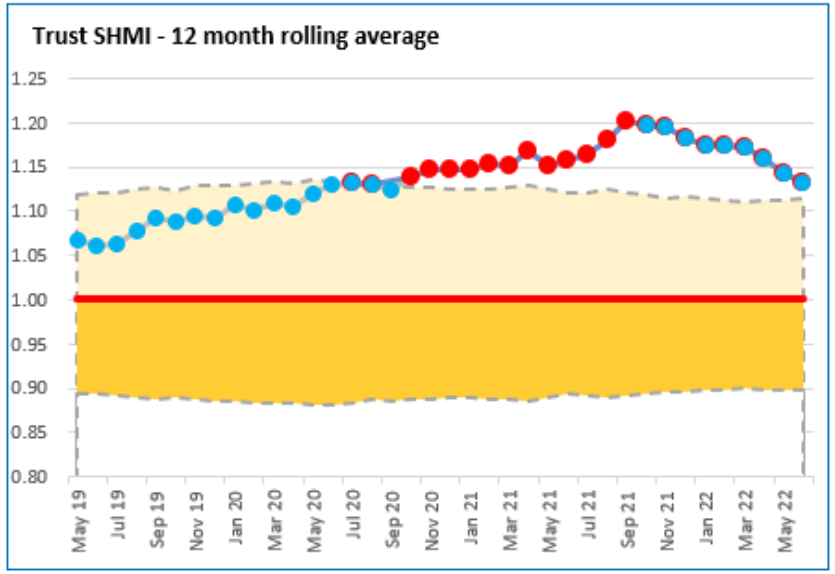
Sepsis - Urine measurement within 1hr

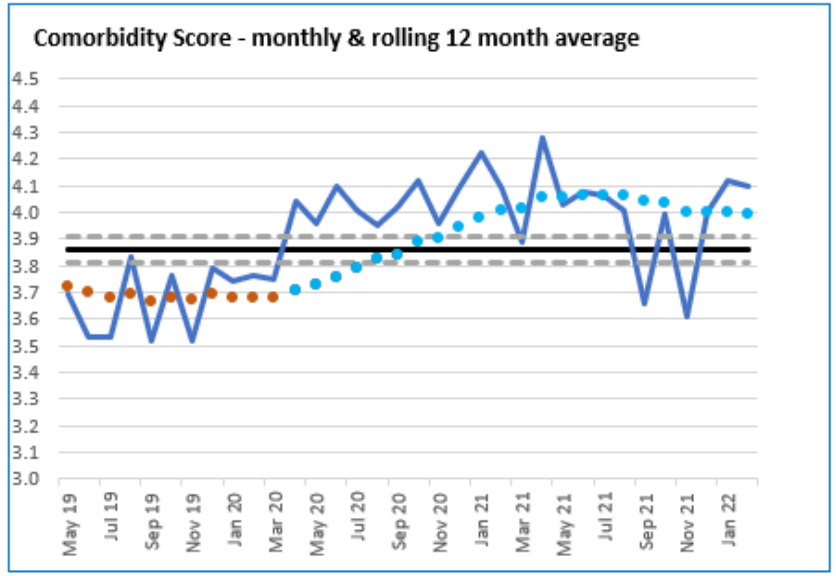
Month	Performance	Target	Trend	Assurance
Apr 2022	100%	95%		

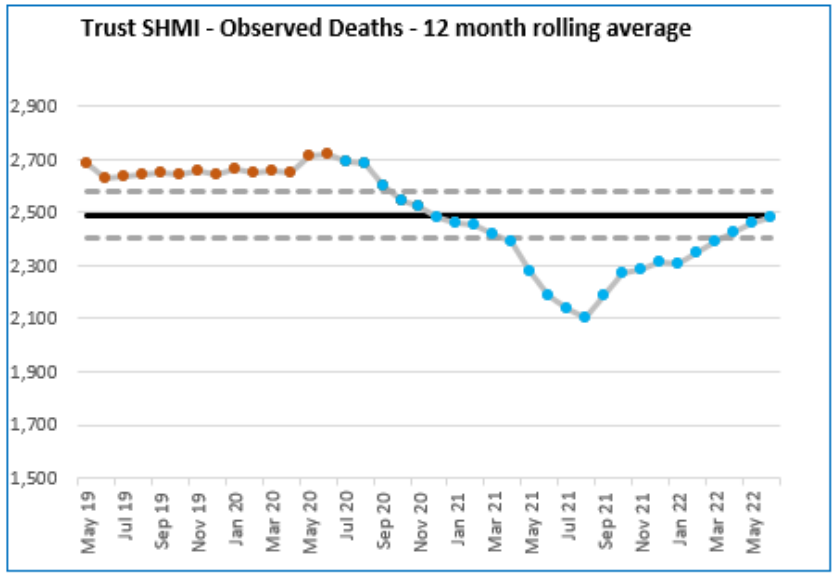


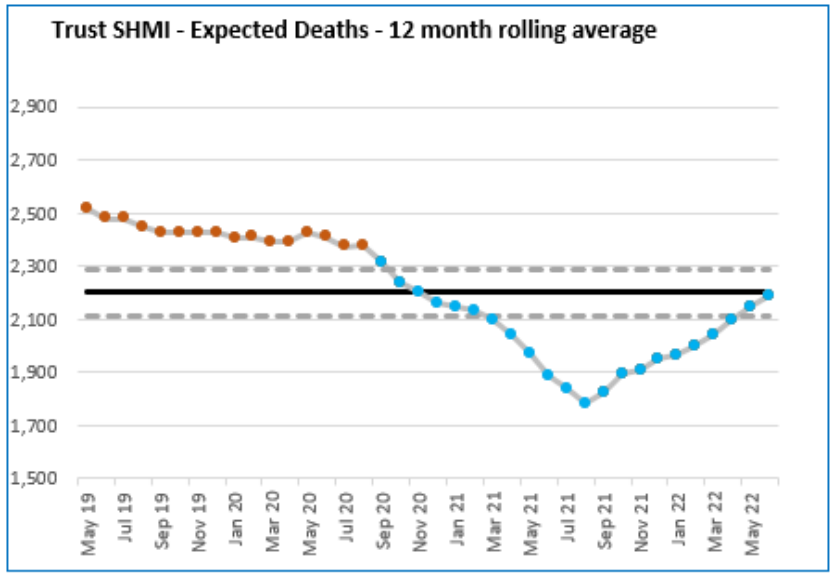
SHMI

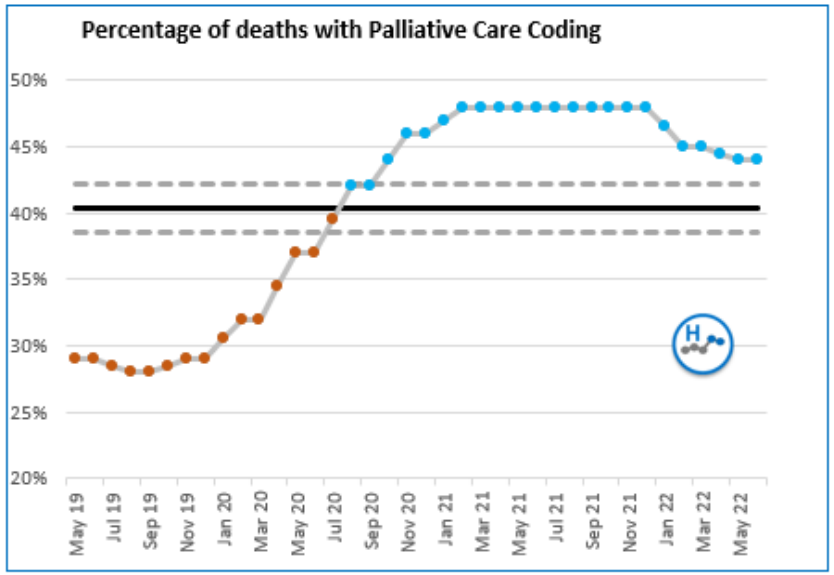
Latest publication month	Jun 22
SHMI (Feb 2021 - Jan 2022)	1.13
Observed deaths	2480
Expected deaths	2190







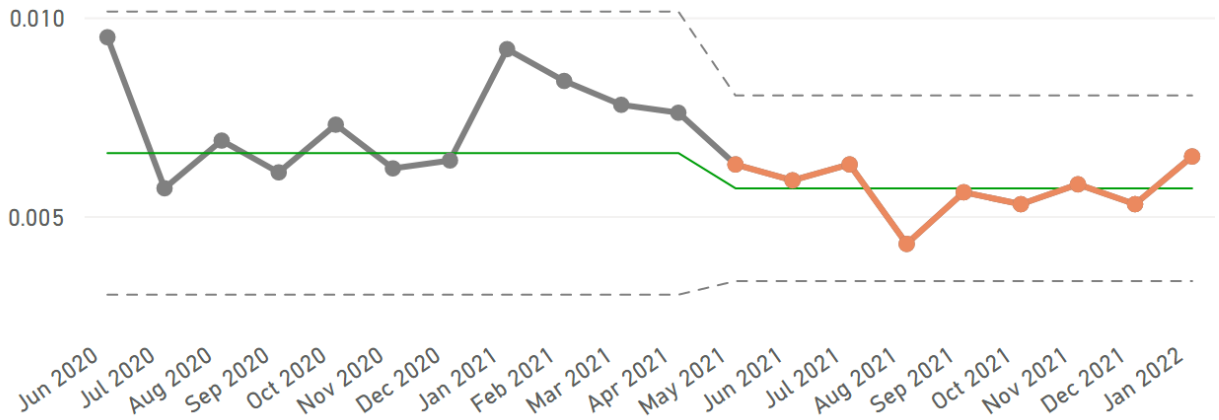




EFFECTIVE

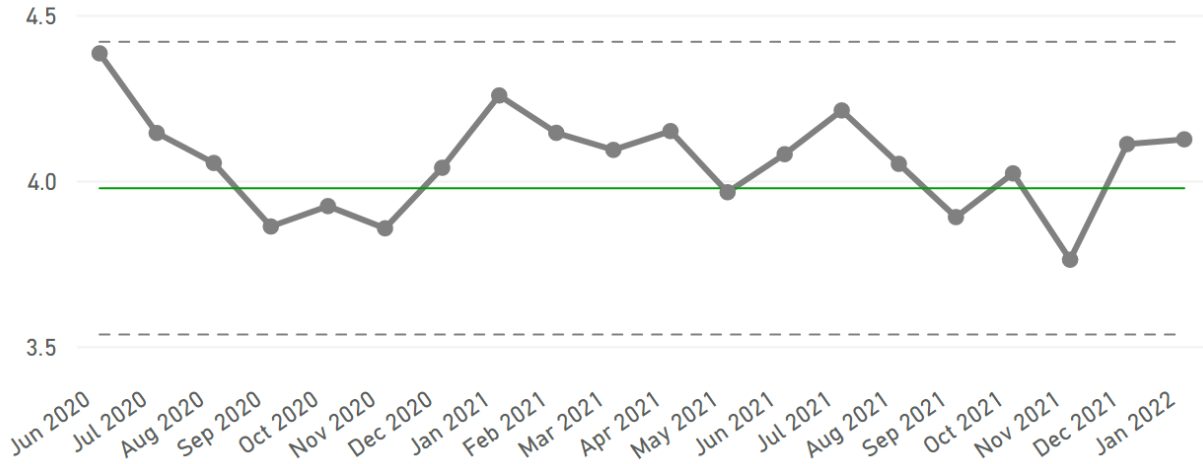
Palliative Care Coding

Month	Performance	Target	Trend	Assurance
Jan 2022	0			N/A



Comorbidity Coding

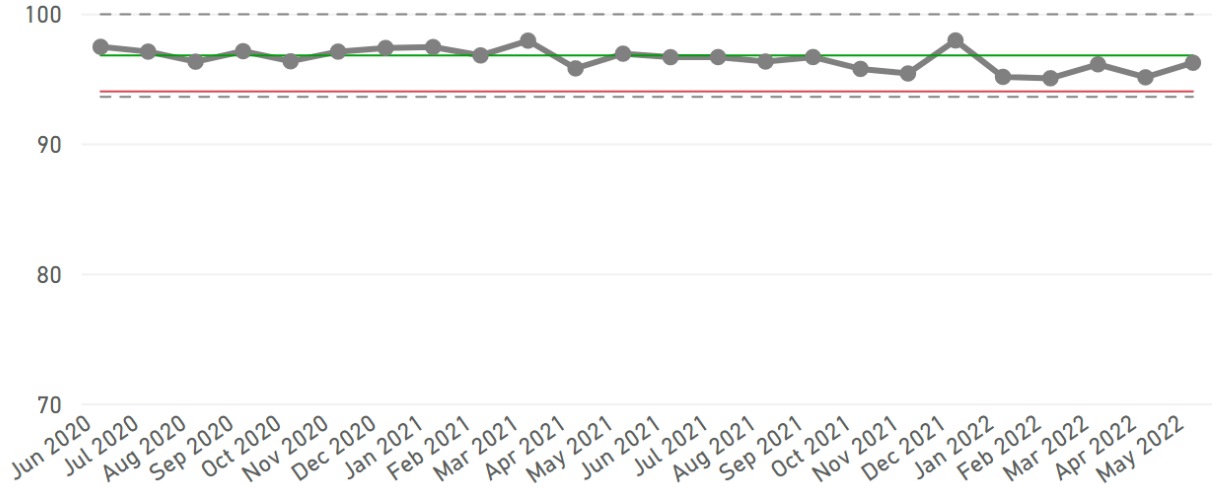
Month	Performance	Target	Trend	Assurance
Jan 2022	4.1			N/A



CARING

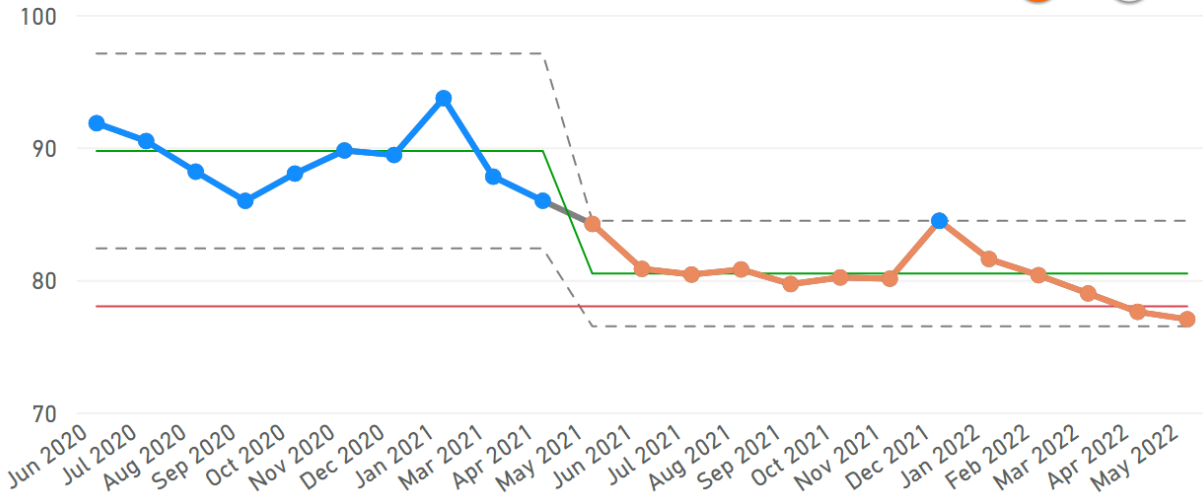
Inpatient Experience (%)

Month	Performance	Target	Trend	Assurance
May 2022	96.2%	94%		



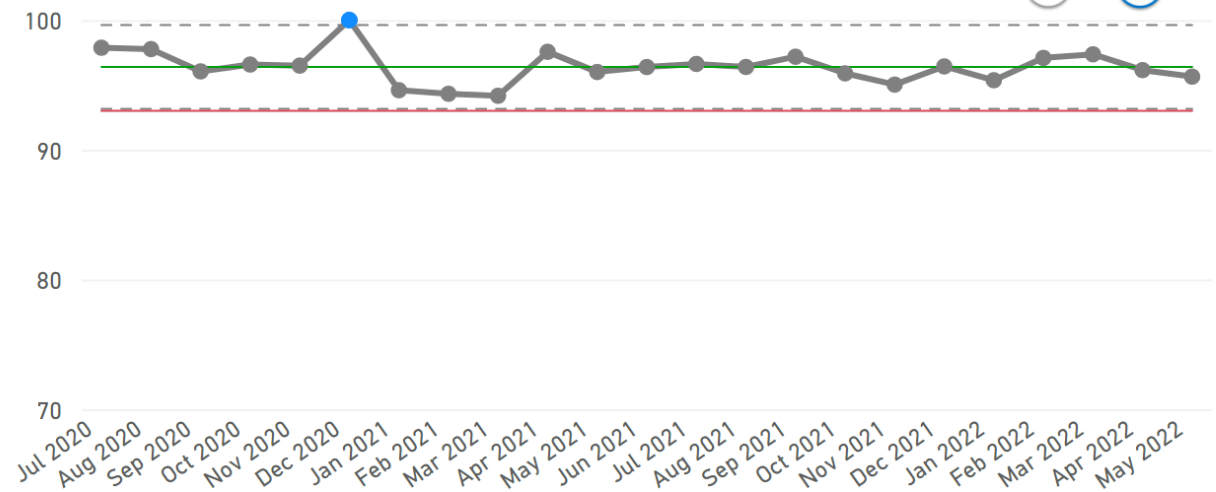
A&E Experience (%)

Month	Performance	Target	Trend	Assurance
May 2022	77%	78%		



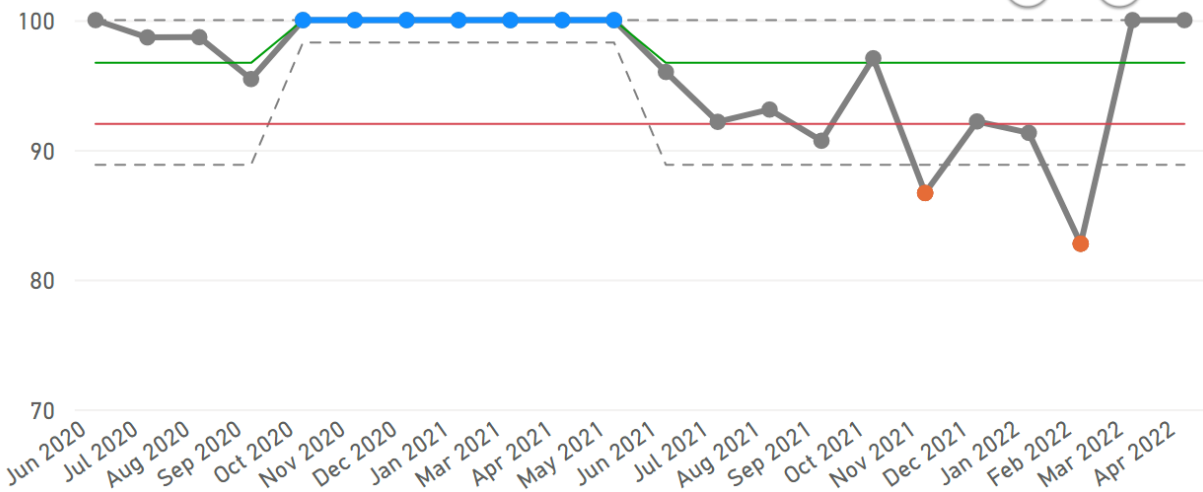
Outpatient Experience (%)

Month	Performance	Target	Trend	Assurance
May 2022	95.6%	93%		



Maternity Experience (%)

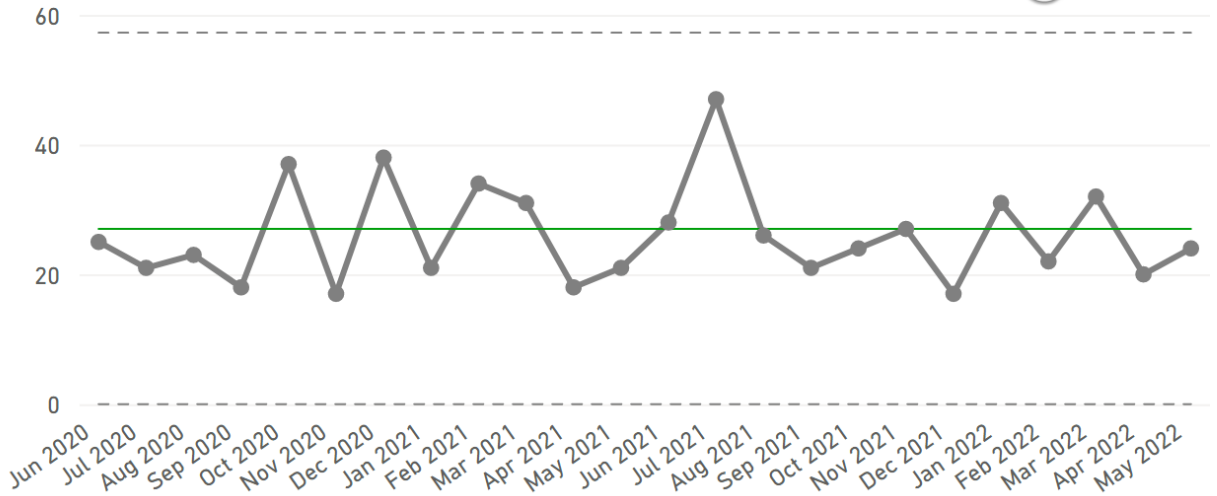
Month	Performance	Target	Trend	Assurance
Apr 2022	100%	92%		



CARING

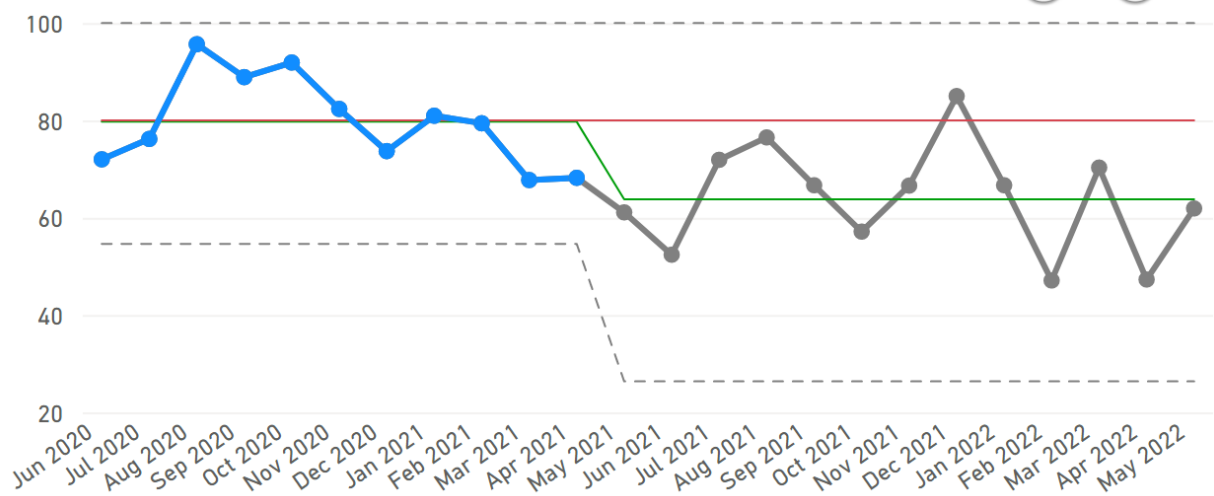
New Complaints

Month	Performance	Target	Trend	Assurance
May 2022	24			N/A



Closed Within Target (%)

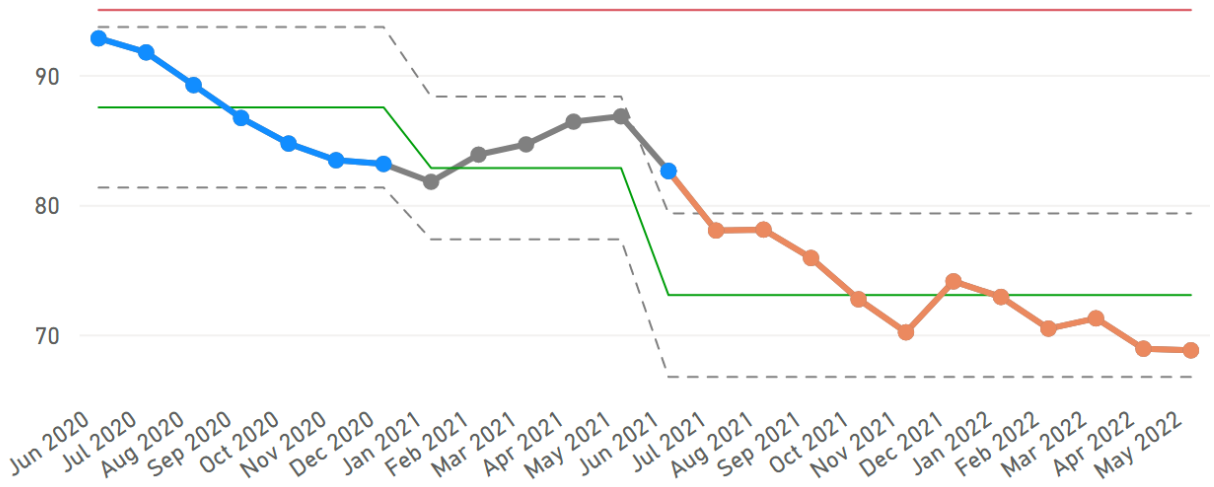
Month	Performance	Target	Trend	Assurance
May 2022	61.9%	80%		



RESPONSIVE

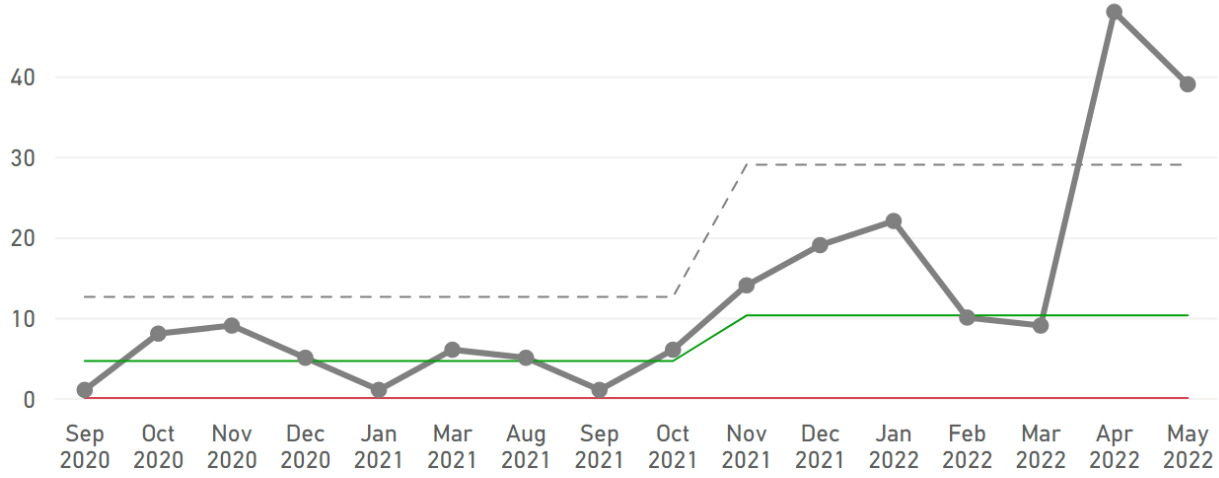
4-Hour A&E Standard

Month	Performance	Target	Trend	Assurance
May 2022	68.8%	95%		



12-Hour Waits from Decision to Admit

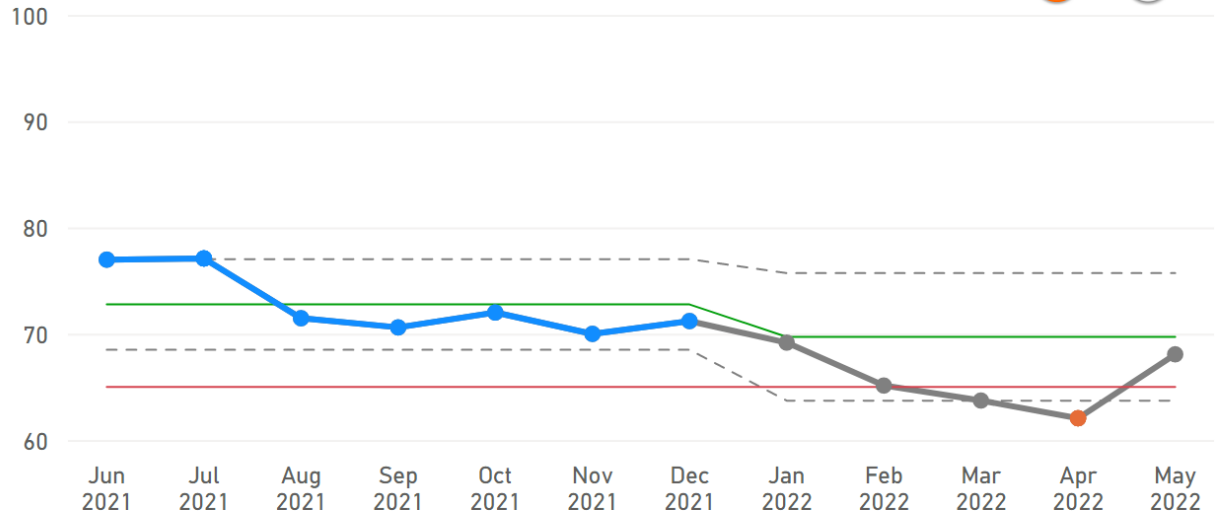
Month	Performance	Target	Trend	Assurance
May 2022	39	0		



RESPONSIVE

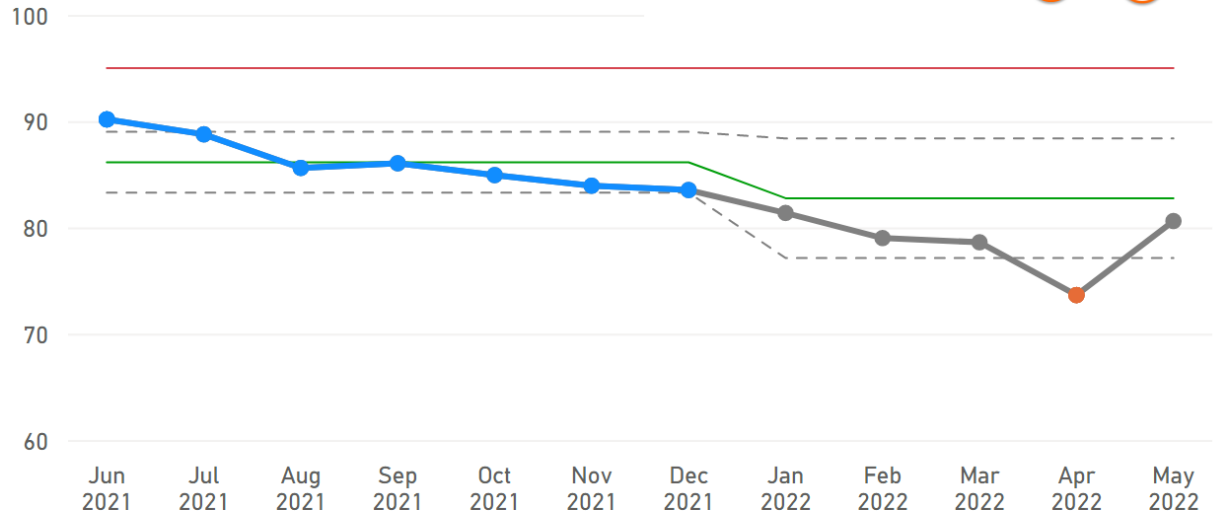
Handovers - Within 15 Mins (%)

Month	Performance	Target	Trend	Assurance
May 2022	68.1%	65%	L	?



Handovers - Within 30 Mins (%)

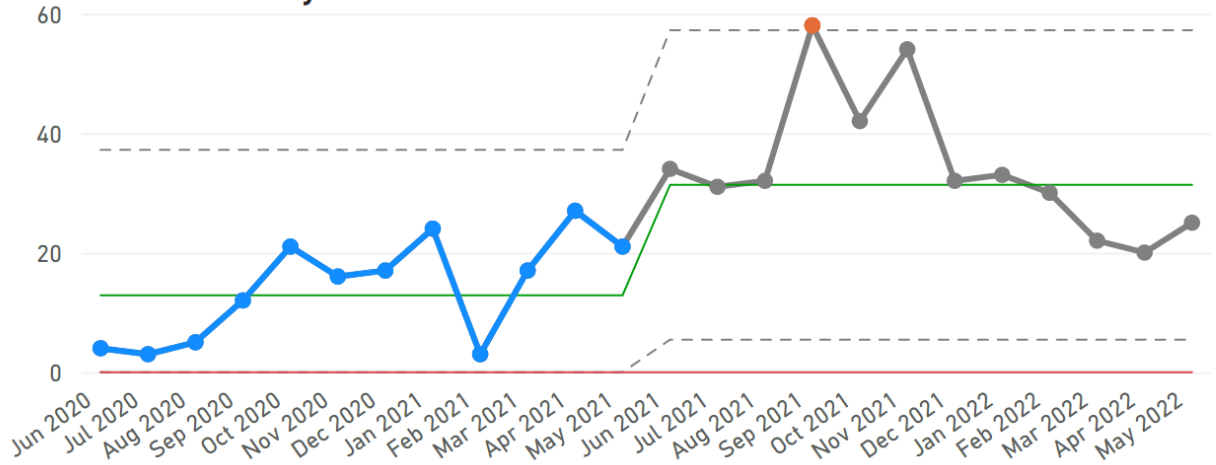
Month	Performance	Target	Trend	Assurance
May 2022	80.6%	95%	L	F



RESPONSIVE

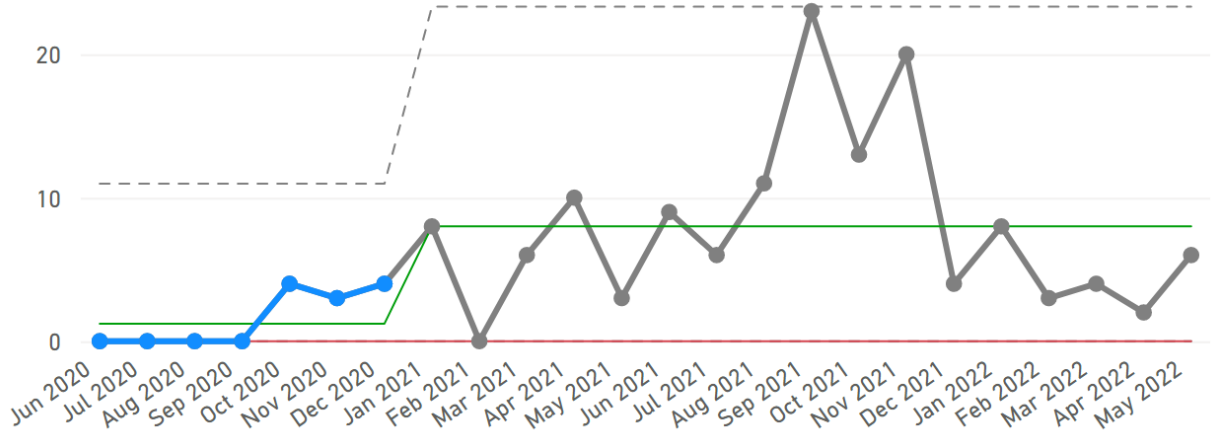
Cancelled Ops - Non-Urgent Cancelled On Day

Month	Performance	Target	Trend	Assurance
May 2022	25	0		



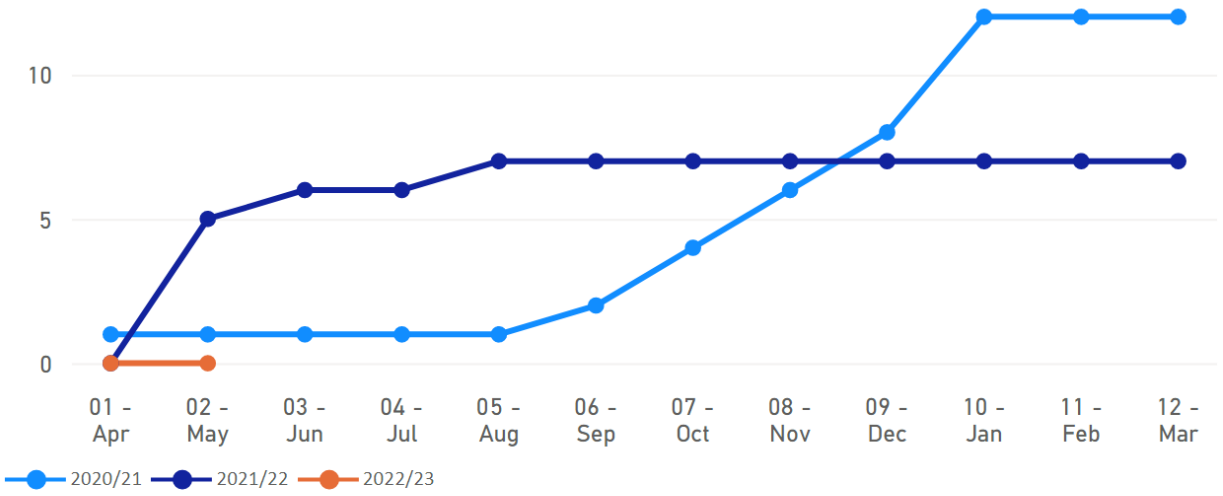
Cancelled Ops - Not Rebooked Within 28 days

Month	Performance	Target	Trend	Assurance
May 2022	6	0		



Cancer Operations Cancelled On Day (YTD)

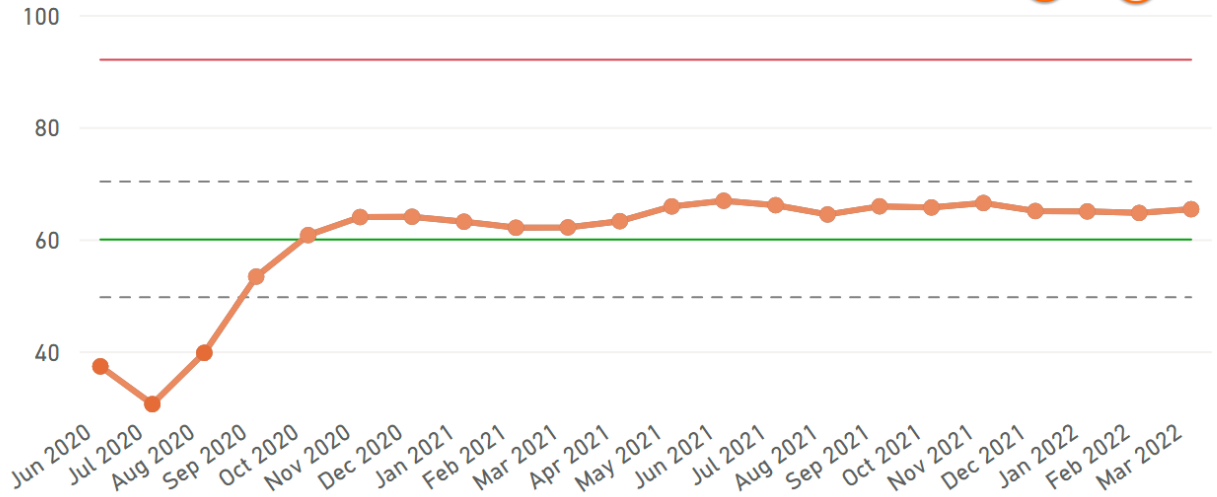
Month	Performance	Target	Trend	Assurance
May 2022	0	0	N/A	N/A



RESPONSIVE

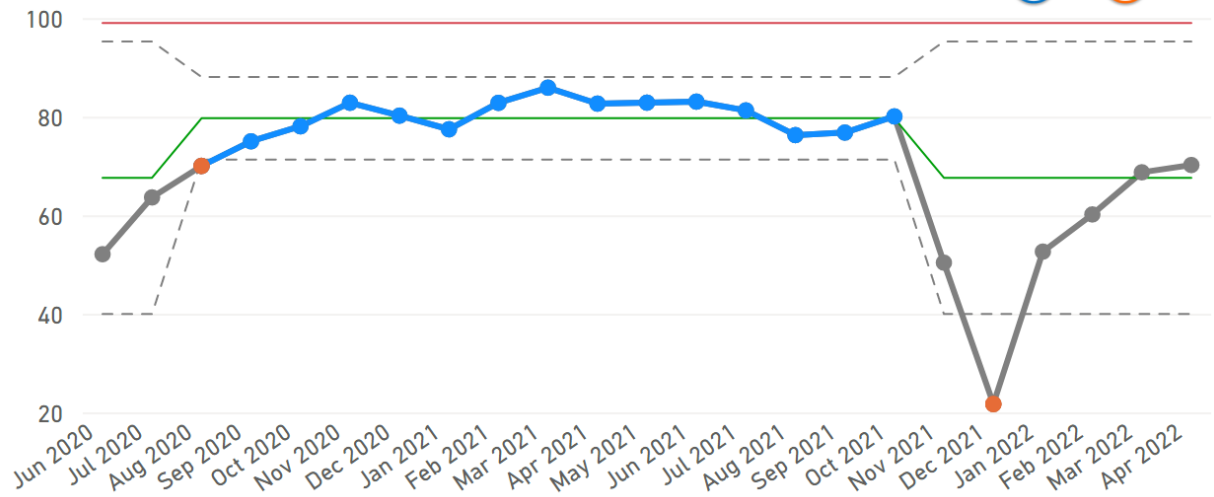
RTT Incomplete Pathways (%)

Month	Performance	Target	Trend	Assurance
Mar 2022	65.3%	92%		



Diagnostic 6 Weeks Standard (%)

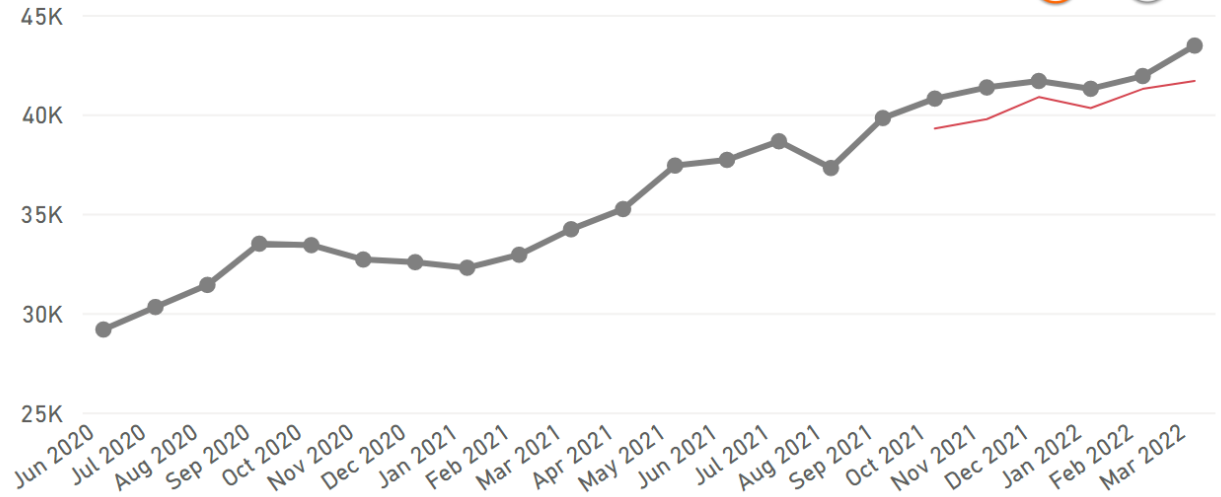
Month	Performance	Target	Trend	Assurance
Apr 2022	70.2%	99%		



RESPONSIVE

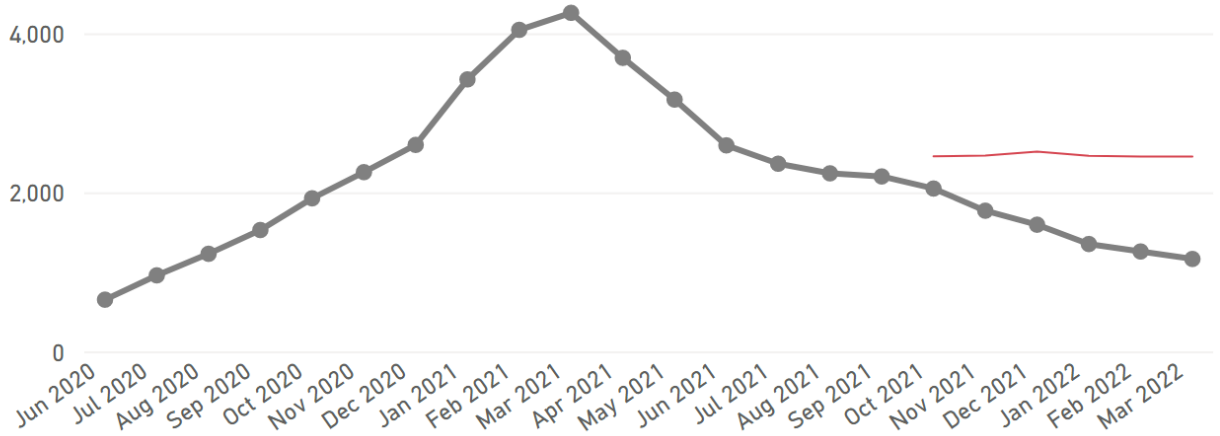
RTT Waiting List Size

Month	Performance	Target	Trend	Assurance
Mar 2022	43453	41677		



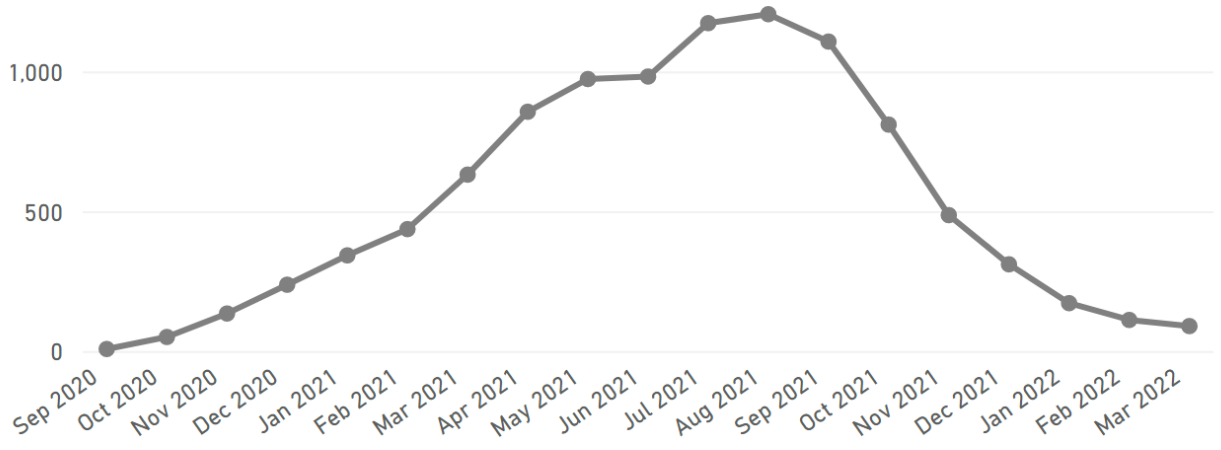
RTT 52 week waiters

Month	Performance	Target	Trend	Assurance
Mar 2022	1162	2451	N/A	N/A



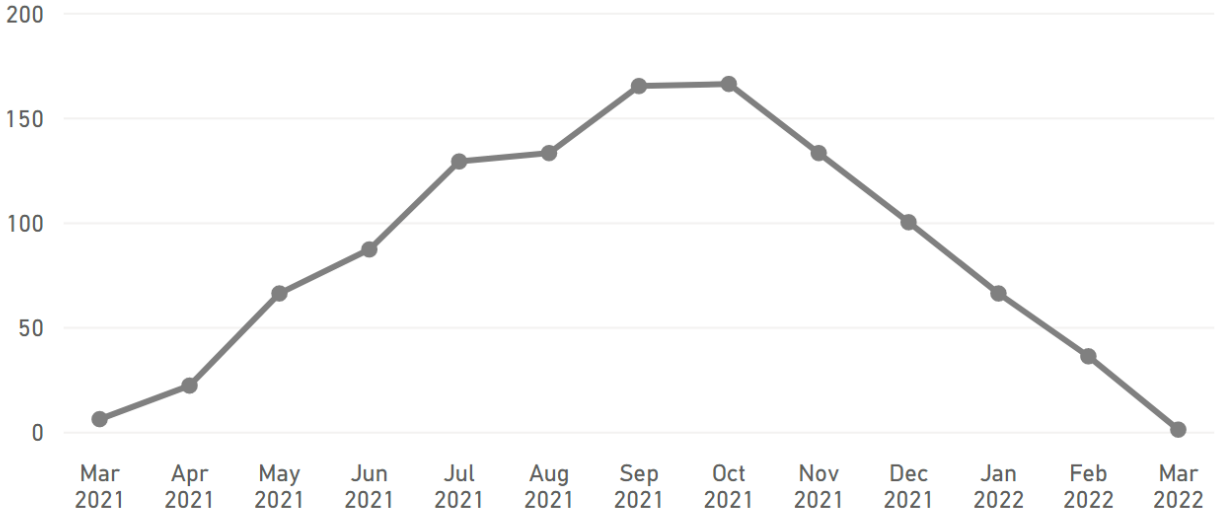
RTT 78 week waiters

Month	Performance	Target	Trend	Assurance
Mar 2022	89		N/A	N/A



RTT 104 week waiters

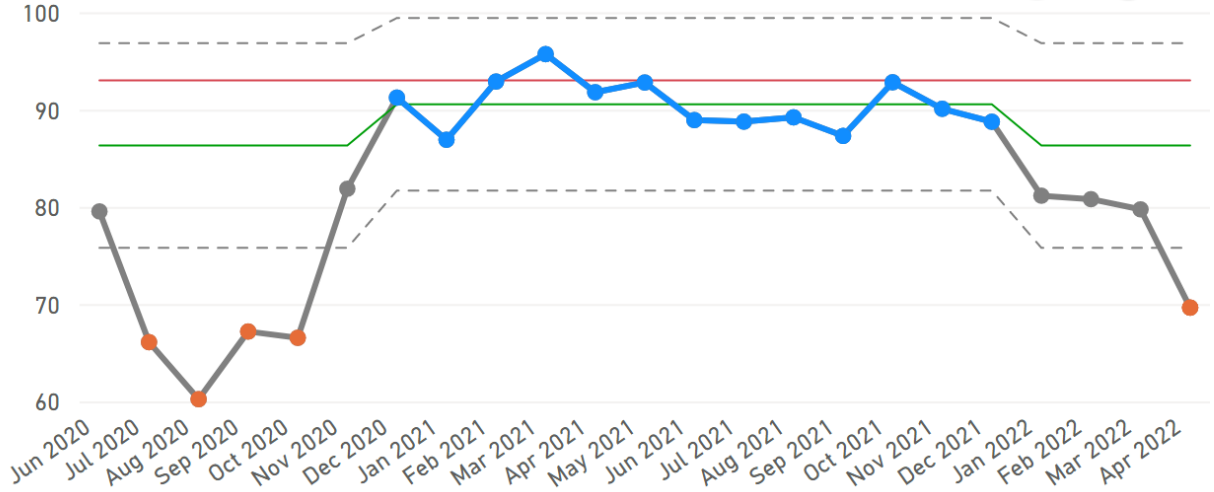
Month	Performance	Target	Trend	Assurance
Mar 2022	1	0	N/A	N/A



RESPONSIVE

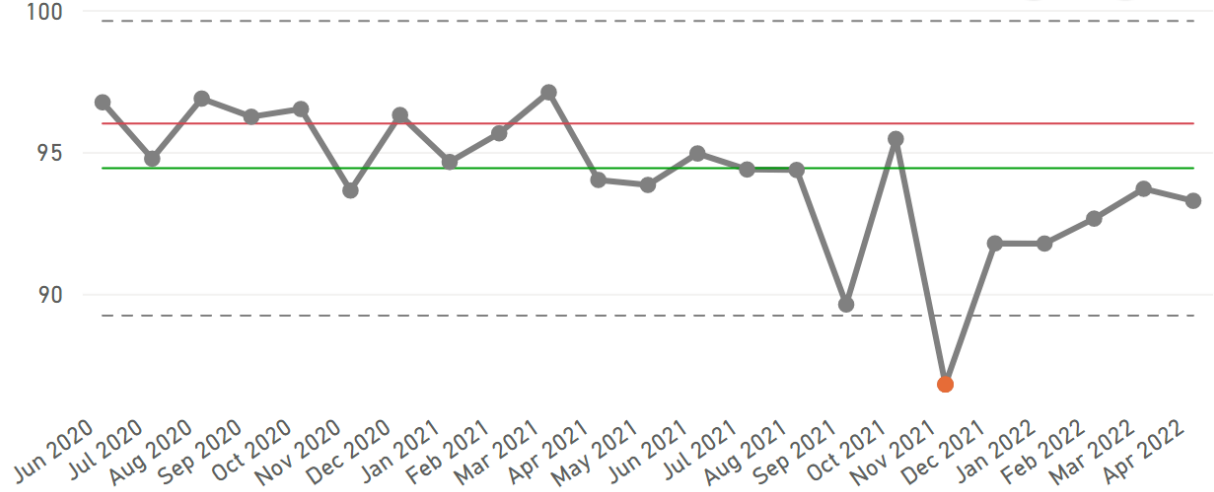
Cancer 14 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Apr 2022	69.6%	93%		



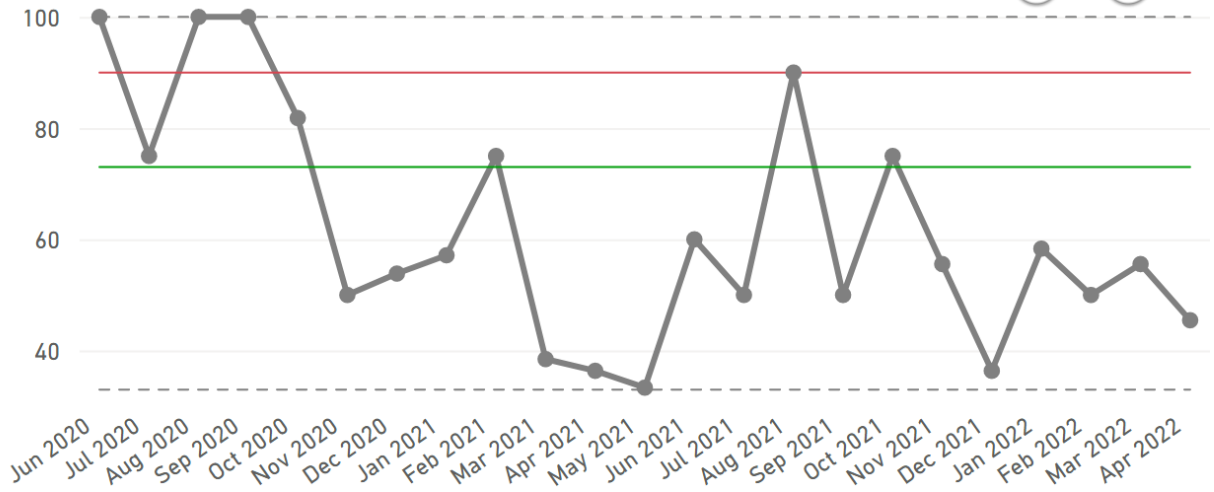
Cancer 31 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Apr 2022	93.3%	96%		



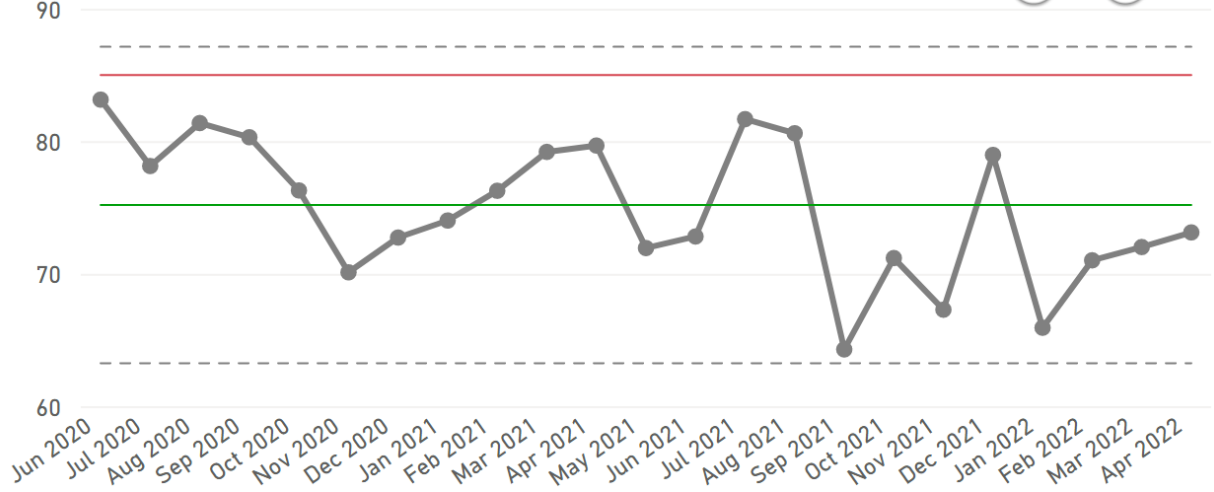
Cancer 62 Day Screening (%)

Month	Performance	Target	Trend	Assurance
Apr 2022	45.5%	90%		



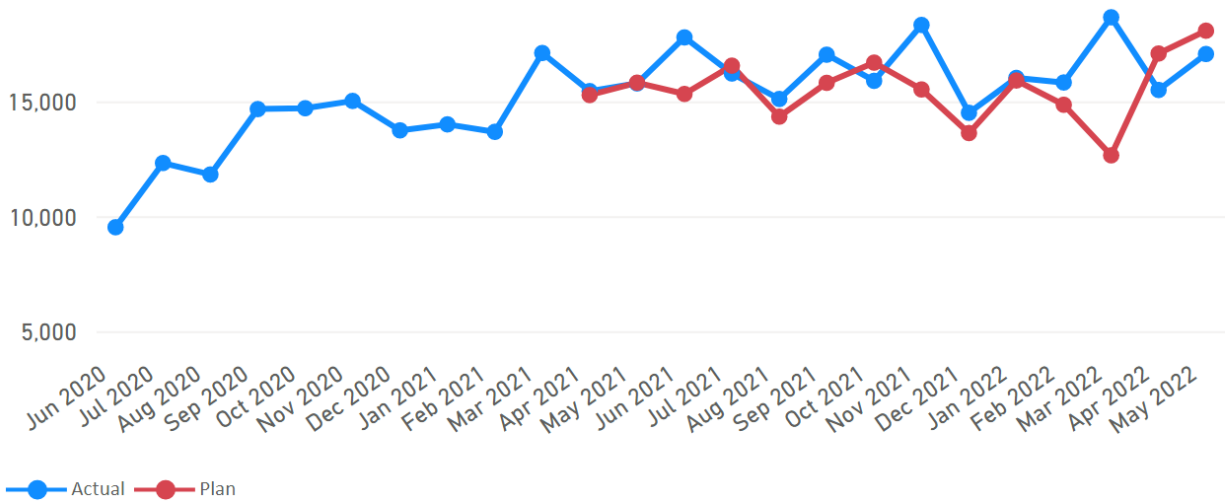
Cancer 62 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Apr 2022	73.1%	85%		

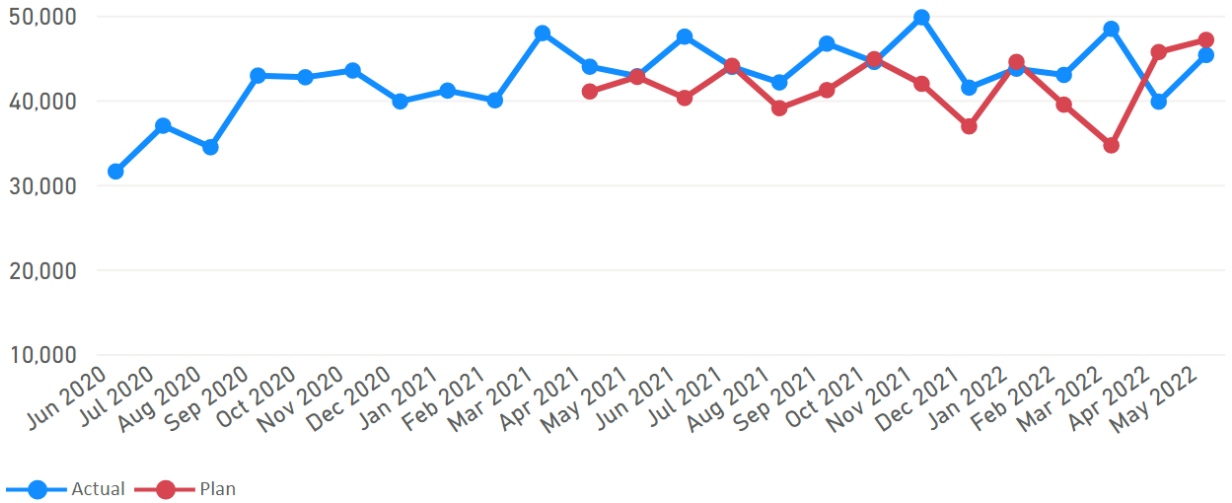


RESPONSIVE

Outpatient New Attendances

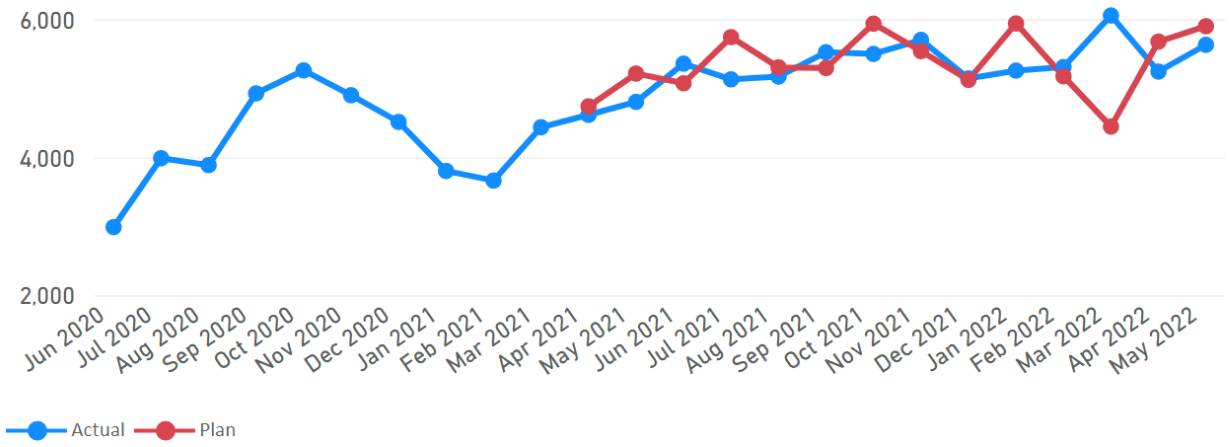


Outpatient Follow-Up Attendances

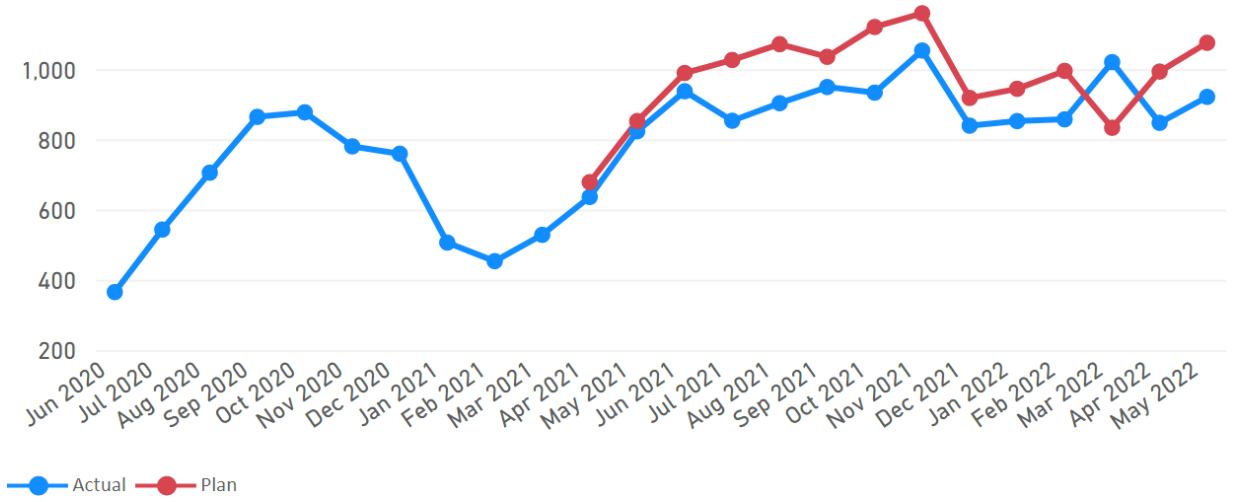


RESPONSIVE

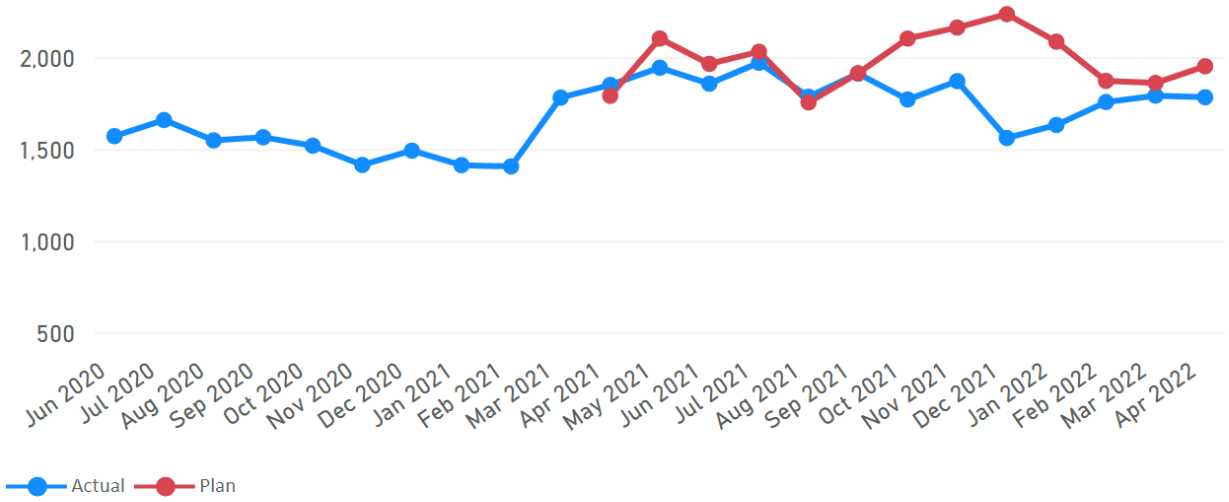
Day Case admissions



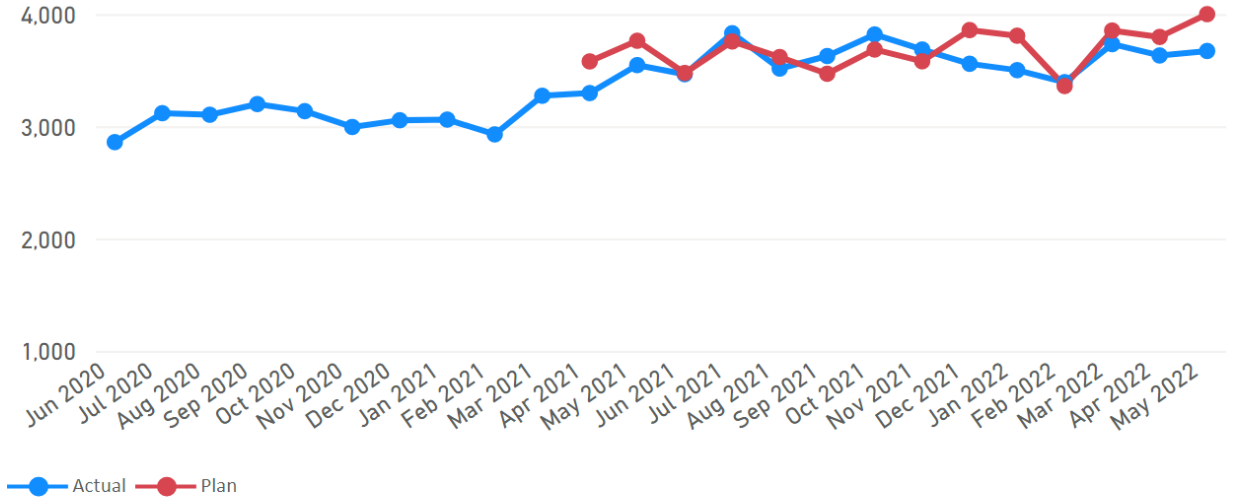
Ordinary Elective admissions



NEL admissions with 0 LOS



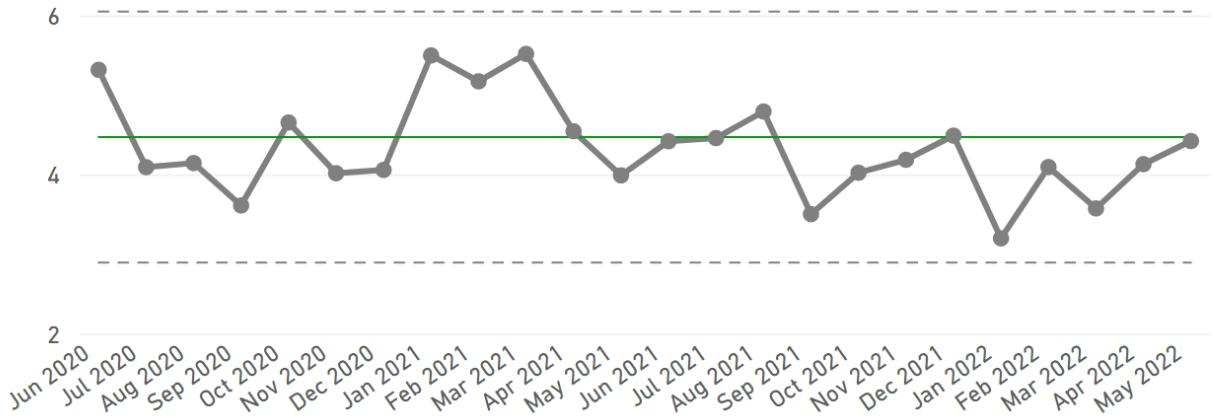
NEL admissions with 1+ LOS



RESPONSIVE

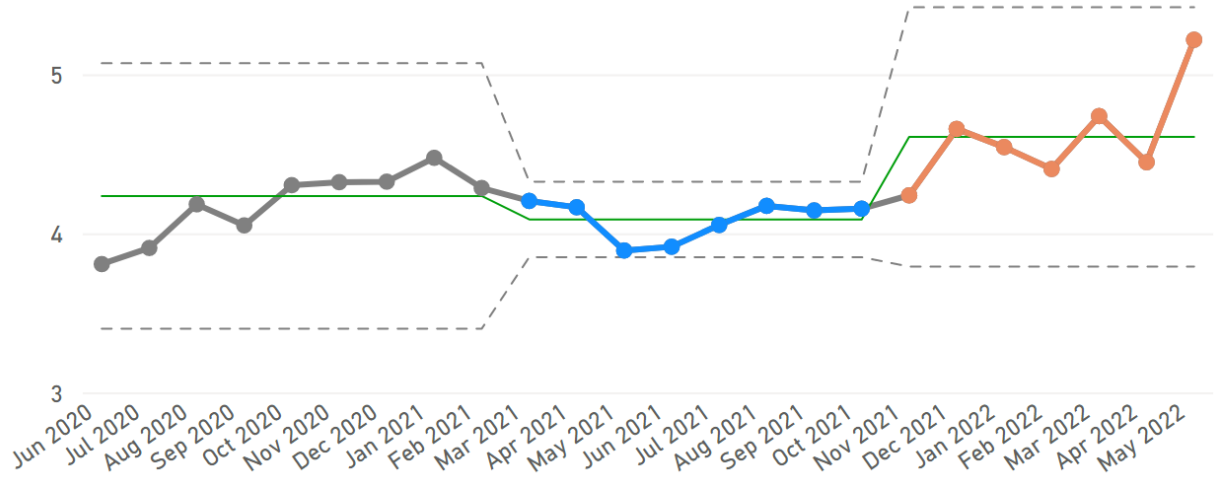
Length of Stay - Elective

Month	Performance	Target	Trend	Assurance
May 2022	4.4			N/A



Length of Stay - Non-Elective

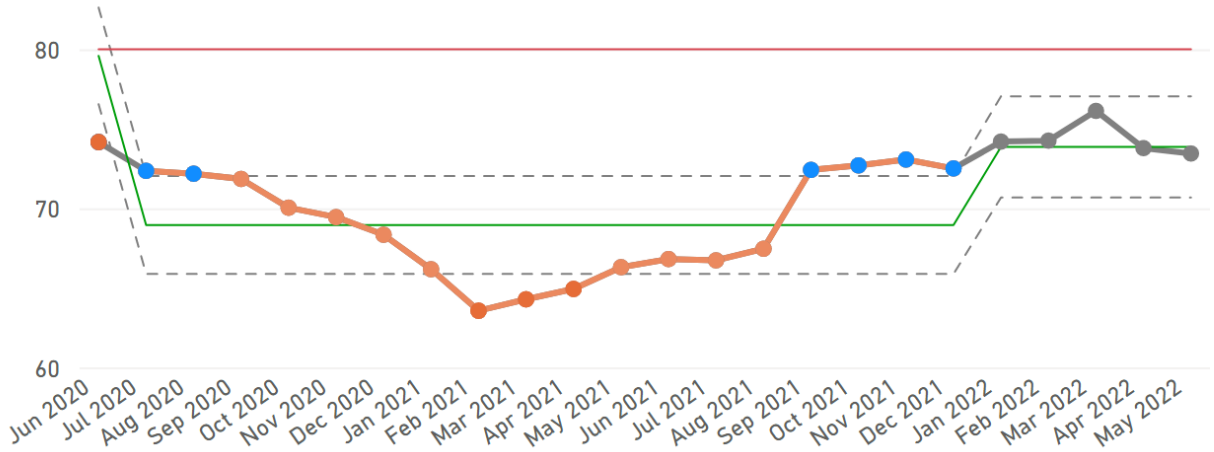
Month	Performance	Target	Trend	Assurance
May 2022	5.2			N/A



WELL-LED

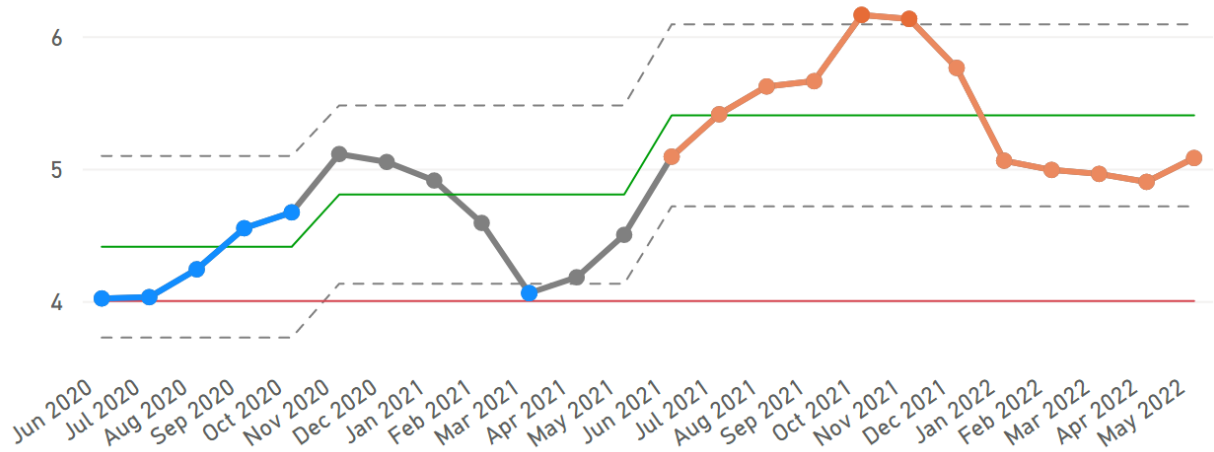
Annual Appraisal (%)

Month	Performance	Target	Trend	Assurance
May 2022	73.5%	80%		



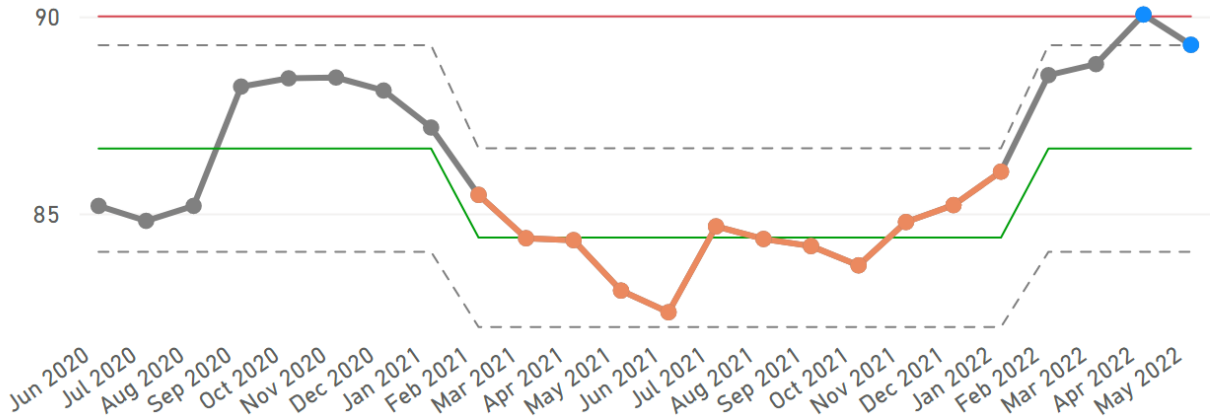
Sickness Absence (%)

Month	Performance	Target	Trend	Assurance
May 2022	5.1%	4%		



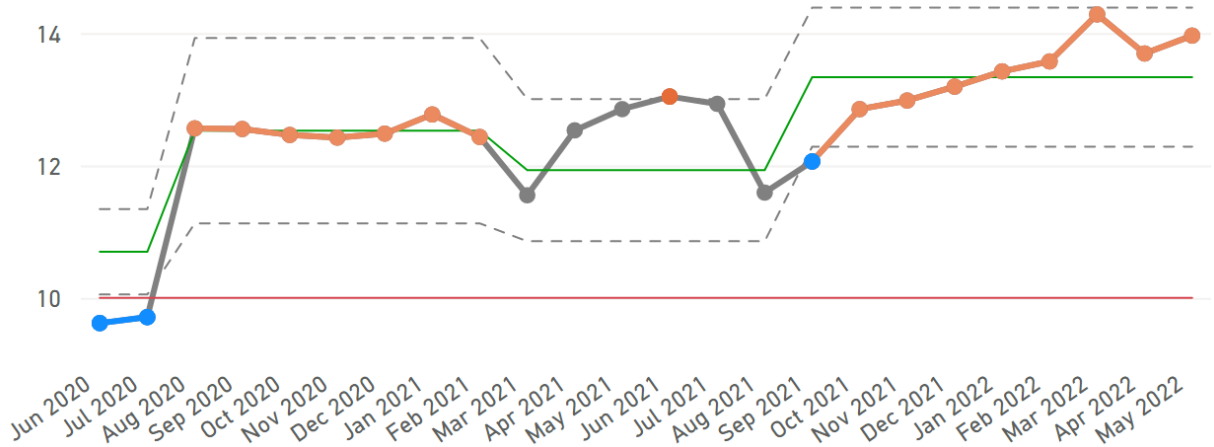
Mandatory Training (%)

Month	Performance	Target	Trend	Assurance
May 2022	89.3%	90%		

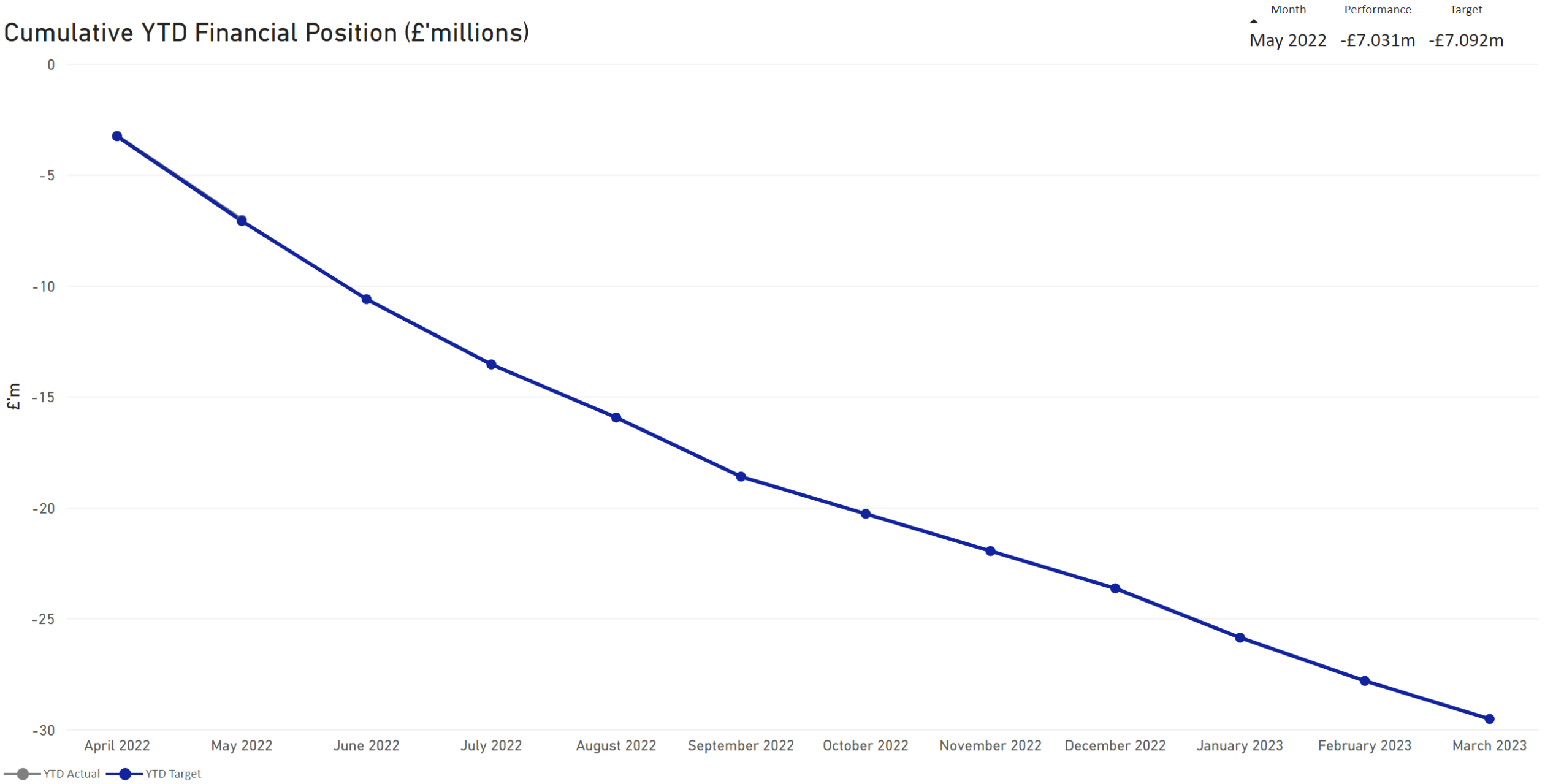


Staff Turnover (%)

Month	Performance	Target	Trend	Assurance
May 2022	14%	10%		

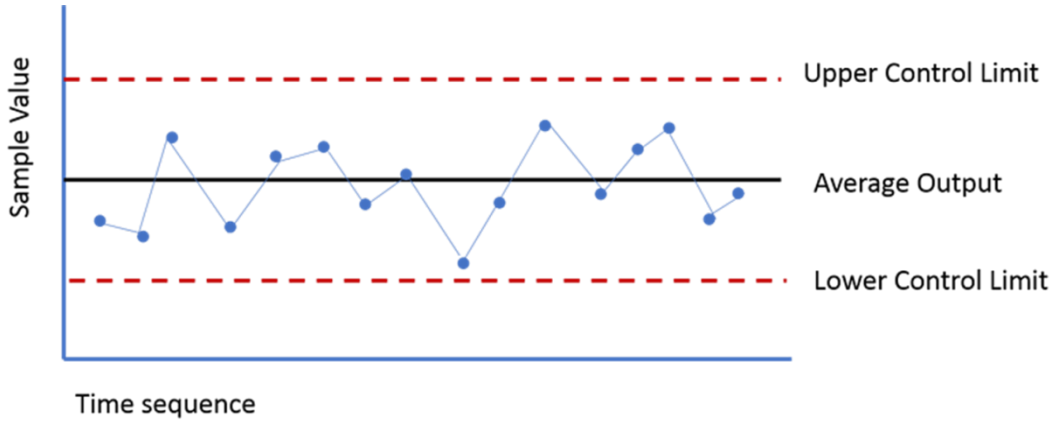


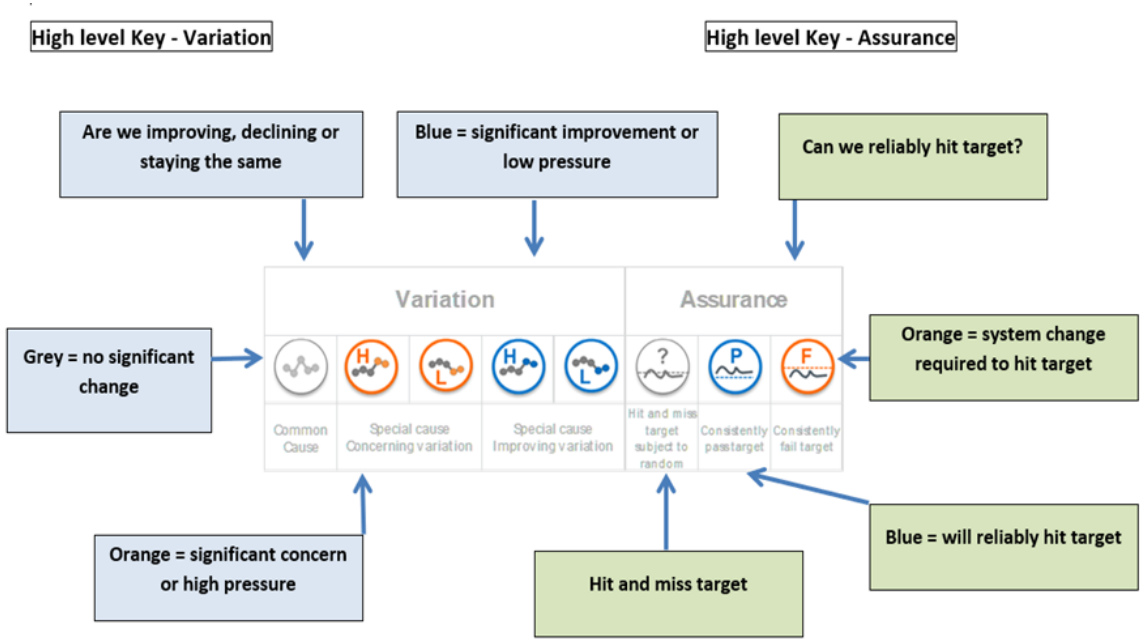
WELL-LED


Cumulative YTD Financial Position (£'millions)
Month
Performance
Target
May 2022
-£7.031m
-£7.092m
0
-5
-10
-15
-20
-25
-30
£'m
April 2022
May 2022
June 2022
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
YTD Actual
YTD Target

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*.





South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 JULY 2022			
Safe Staffing Report for May 2022			**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 May 22		
Background	The requirement to publish nursing & midwifery staffing levels monthly 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 has increased slightly to 96.6% as per Appendix 1 demonstrating good compliance with safer staffing. The introduction of allocate on arrival shifts for RNs and HCAs (5 per day and night at JCUH and FHN) has seen improved pick up in May. These shifts are promoted daily via ward manager platforms and NHSp text messaging. Demand has decreased and a summer reduction in shifts will occur in July. This model has been followed in community with impactful pick up.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to receive this report for information.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 5.1 Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit.		
Legal and Equality and Diversity implications	• Care Quality Commission • NHS Improvement • NHS England		
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 ☐	

Nursing and Midwifery Workforce Exception Report

May 2022

This report provides a monthly update to the Board on nursing and midwifery staffing. It provides an overall picture of staffing in the inpatient areas as an exception report.

1. Safer Staffing Governance

Safer staffing is maintained through twice daily SafeCare (staffing review) meetings to address any immediate issues (on the day) 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 weekend 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.

Table 1 shows overall planned versus actual across the trust. Appendix 1 shows a detailed breakdown for each ward.

	Table 1	March 22	April 22	May 22
Overall, Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	87.3%	85.7%	86.0%
	HCA (%) Average fill rate - DAYS	93.4%	94.8%	95.9%
	NA (%) Average fill rate - DAYS	100.0%	100.0%	100.0%
	TNA (%) Average fill rate - DAYS	100.0%	100.0%	100.0%
	RN/RMs (%) Average fill rate - NIGHTS	89.4%	86.6%	86.3%
	HCA (%) Average fill rate - NIGHTS	103.4%	103.8%	104.3%
	NA (%) Average fill rate - NIGHTS	100.0%	100.0%	100.0%
	TNA (%) Average fill rate - NIGHTS	100.0%	100.0%	100.0%
	Total % of Overall planned hours	**97.7%**	**96.4%**	**96.6%**

Redeployment of staff has taken place on a regular basis to ensure wards are safely staffed with 389 total shifts (3972.27 hours) logged via SafeCare during May which was a decrease on April hours. Work is ongoing to reduce redeployment further as absence due to COVID reduces.

In agreement with the clinical matrons and ward managers the twice daily Safe Care meetings are now chaired by a clinical matron with nurse manager representatives from each collaborative with the intention to further reduce staff redeployment and within collaboratives (Zoning).

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

2. NHSp

To mitigate any staffing gaps additional resource is used to provide a safe and effective workforce. Collaborative working with NHSp enables flexible staffing and a centralised system with NHSp and our eRoster interface as a single booking point enabls rapid redeployment.

3. Nurse Sensitive Indicators

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

4. Red Flags Raised through SafeCare Live

There were 144 red flags relating to workforce, with shortfall in RN time being the most common (106). For red flags for less than 2 RNs, the SafeCare log provides a documented resolution to this red flag, therefore no shifts had less than 2 RNs throughout May.

5. Datix Submissions

There were 87 datix submissions relating to staffing in May. The majority of datixs were for staff shortages in Critical Care, A&E, Ward 10, Ward 28 and Friarage inpatient area Ainderby. These were all escalated through the SafeCare call and logged by a daily SafeCare chair. Redeployment decisions were made following safe staffing discussions with ward managers and matron agreement.

6. Vacancy Turnover

Active recruitment of nursing staff continues. Appendix 2 shows registered nursing and midwifery vacancy rate for May 22. Appendix 3 shows healthcare assistant vacancy rate for May 22 which is a positive position. Appendix 4 shows the nursing turnover for May 22.

International Nurse Recruitment:
Cohort 2 will be 14 nurses; target date for their arrival is on the 6th of July 2022.
Cohort 3 will be 14 nurses who arrive in September; cohort 4 will arrive November 2022 number to be confirmed and this will complete this year's recruitment.

Student nurse recruitment is underway for September qualifiers. Adverts are live for a mobile HealthCare Support Worker team to support reduction in staff movement further. Refreshed recruitment resource and videos are being produced with a focus on "South Tees yes please" strap line to use for all future career promotion.

Model Hospital data shows the Trust achieving the second lowest nursing turnover rate in the country and then lowest in the North East and Yorkshire.

7. RECOMMENDATIONS

The Board is asked to note the content of this report and the progress in relation to key nursing workforce issues.

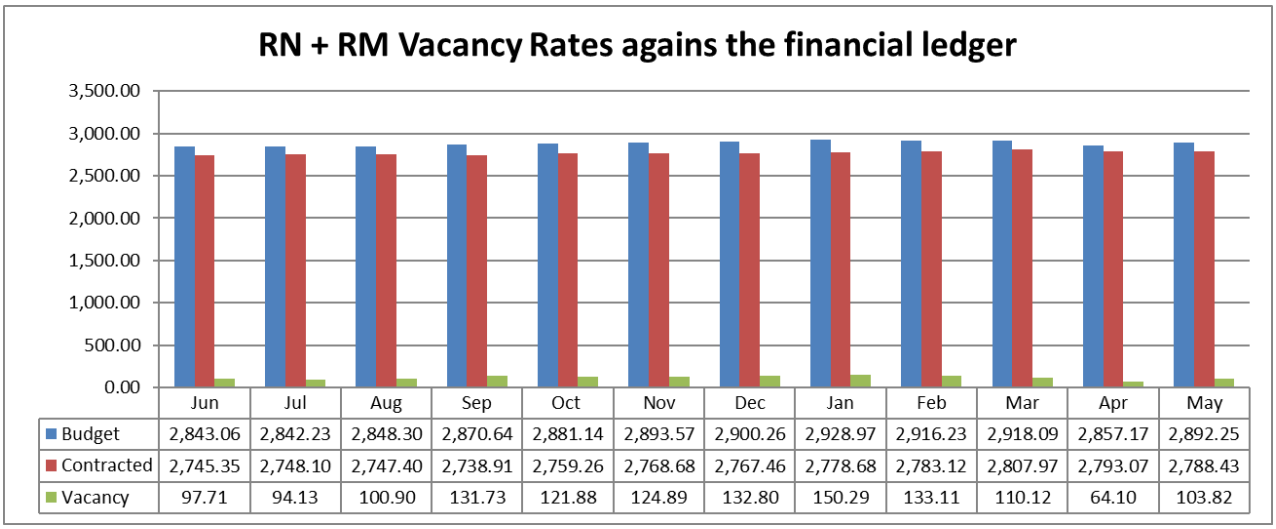
Be assured that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

Appendix 1 - Nursing and Midwifery Planned Vs Actual hours % and Care Hours Per Patient Day

Wards	Physical Bed Capacity	Open Bed Capacity	Total CHPP	Occupied Bed No - May 22 (at midnight)	Average fill rate - Days RN/ RM (%)	Average fill rate - Days HCA (%)	Average fill rate – Days NA (%)	Average fill rate – Days TNA (%)	Average fill rate - Nights RN/ RM (%)	Average fill rate - Nights HCA (%)	Average fill rate – Nights NA (%)	Average fill rate - Nights TNA (%)	
Ward 1	30	30	782	25	80.2%	95.3%	-	-	69.9%	91.5%	-	-	Short Term Sickness
Ward 2	28	28	789	25	81.3%	89.6%	-	100.0%	90.5%	97.6%	-	100.0%	
Ward 3	28	28	648	21	100.6%	149.5%	100.0%	-	93.8%	132.3%	-	-	
Ward 4	23	23	667	22	78.5%	90.7%	-	-	72.4%	113.7%	-	-	Staff for dialysis bay occupancy fluctuates
Ward 5	28	22	611	20	86.3%	66.4%	100.0%	100.0%	81.7%	93.2%	-	100.0%	
Ward 6	30	30	907	29	94.6%	105.4%	100.0%	-	80.3%	132.0%	-	-	
Ward 7	30	30	910	29	97.0%	91.4%	-	100.0%	90.4%	95.6%	-	100.0%	
Ward 8	30	30	546	18	63.4%	64.4%	-	100.0%	55.9%	78.5%	-	-	Ward closed / staff deployed to Ward 31
Ward 9	28	28	722	23	81.0%	137.9%	-	-	79.0%	116.2%	-	-	Amber RSU low
Ward 10	30	30	850	27	67.2%	93.5%	-	-	63.0%	129.7%	-	-	Short Term Sickness. Unfilled vacancies. ^ unfunded beds open
Ward 11	28	28	843	27	76.8%	100.1%	-	100.0%	84.5%	119.2%	-	100.0%	Short Term Sickness
Ward 12	26	26	761	25	88.7%	121.4%	-	-	62.3%	139.4%	-	-	Increased HCA Support
Ward 14	23	21	591	19	98.9%	84.7%	-	100.0%	76.5%	106.5%	-	-	
Ward 24	23	23	675	22	95.3%	123.0%	-	100.0%	81.1%	182.6%	-	-	Increased HCA Support
Ward 25	21	21	302	10	140.0%	219.1%	-	100.0%	96.0%	196.2%	-	-	High acuity patients
Ward 26	18	19	548	18	89.1%	139.1%	-	-	98.5%	113.8%	-	-	Increased HCA Support
Ward 27	15	15	629	20	66.0%	69.0%	-	100.0%	95.3%	77.1%	-	-	Extreme low occupancy
Ward 28	30	30	684	22	79.8%	96.5%	-	-	95.2%	108.1%	-	-	Short Term Sickness
Ward 29	27	27	783	25	97.9%	101.7%	-	100.0%	88.2%	108.1%	-	-	
Cardio MB	9	9	248	8	98.5%	106.4%	-	-	95.2%	-	-	-	
Ward 31	35	26-31	913	29	112.7%	117.7%	100.0%	-	86.8%	154.4%	100.0%	-	Additional staff from Ward 8
Ward 32	22	21	624	20	104.1%	102.9%	-	-	100.0%	104.7%	-	-	

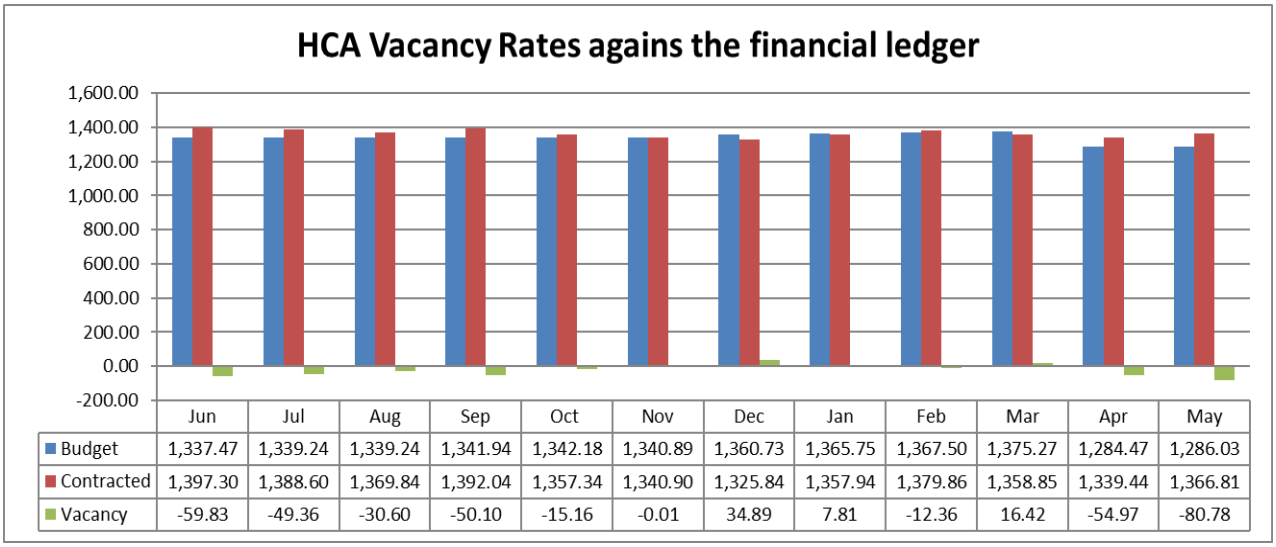
Ward 33	19	19	547	18	68.8%	100.5%	-	-	66.7%	133.2%	-	-	Short Term Sickness
Ward 34	34	34	991	32	78.7%	96.7%	-	-	75.0%	97.7%	-	-	
Ward 35	26	26	714	23	91.4%	106.1%	-	-	71.0%	106.5%	-	-	Short Term Sickness
Ward 36	34	34	961	31	90.8%	97.2%	-	100.0%	74.8%	161.9%	-	100.0%	
Ward 37 - AMU	30	30	821	26	90.5%	95.8%	-	100.0%	81.1%	85.5%	-	-	
Critical Care	33	33	818	26	96.8%	94.2%	-	-	93.0%	77.4%	-	-	
CICU JCUH	12	10	193	6	75.6%	80.6%	-	-	72.7%	116.1%	-	-	Full adherence to GPIX standards
Cardio HDU	10	10	178	6	78.0%	93.5%	-	-	69.7%	90.3%	-	-	Full adherence to GPIX standards
Ward 24 HDU	8	8	202	7	100.3%	98.4%	-	-	99.0%	96.8%	-	-	
Ainderby FHN	27	22	649	21	70.3%	100.8%	-	-	84.0%	97.6%	-	-	Short Term Sickness
Romanby FHN	26	26	689	22	59.4%	47.0%	-	-	94.0%	51.6%	-	-	Short Term Sickness & unfilled vacancies
Gara FHN	21	16	261	8	79.2%	70.6%	-	-	94.0%	34.4%	-	-	Redeployment due to low occupancy
Rutson FHN	17	17	512	17	76.3%	107.6%	-	-	100.0%	97.1%	-	-	Redeployment due to low occupancy
Friary	18	18	509	16	105.2%	102.3%	-	-	90.4%	84.4%	-	-	
Zetland Ward	31	29	839	27	81.7%	74.8%	-	100.0%	82.8%	120.4%	-	-	Increased HCA Support
Tocketts Ward	30	26	857	28	72.8%	111.5%	-	-	81.4%	114.5%	-	-	Increased HCA Support
Ward 21	25	25	455	15	79.4%	54.2%	-	100.0%	73.7%	58.1%	-	100.0%	Newly appointed staff qualify in Sept 22
Ward 22	17	17	216	7	91.7%	72.7%	-	-	77.4%	51.6%	-	-	Newly appointed staff qualify in Sept 22
JCDS (Central Delivery Suite)	-	-	365	12	93.1%	71.9%	-	-	93.7%	83.9%	-	-	
Neonatal Unit (NNU)	35	35	719	23	83.8%	93.5%	-	-	84.9%	-	-	-	
Paediatric Intensive Care Unit (PCCU)	6	6	70	2	71.6%	35.3%	-	-	69.4%	-	-	-	Newly appointed staff qualify in September 22
Ward 17	-	-	743	24	79.4%	85.5%	-	100.0%	71.2%	95.1%	-	100.0%	
Ward 19 Ante Natal	-	-	286	9	70.3%	83.5%	-	-	71.8%	-	-	-	
Maternity Centre FHN	-	-	6	0	102.2%	31.4%	-	-	79.1%	-	-	-	
Spinal Injuries	24	24	746	24	121.7%	155.1%	-	-	198.4%	109.6%	-	-	
CCU	14	14	299	10	85.3%	107.6%	-	-	81.7%	-	-	-	

Appendix 2 - Registered Nursing Vacancy Rate May 2022



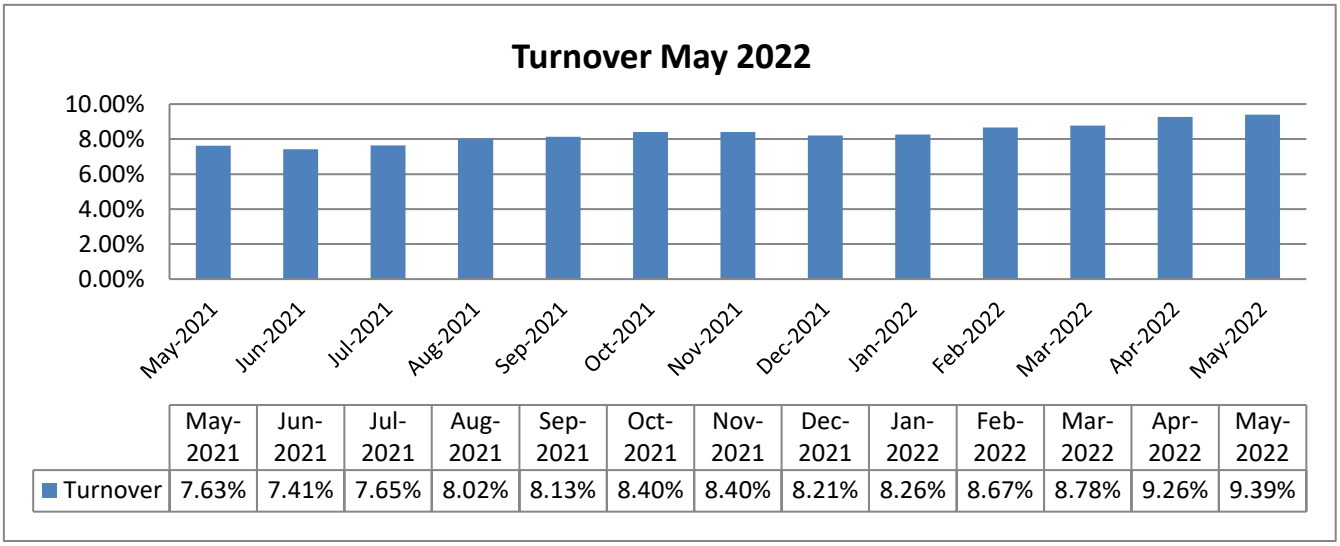
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Budget	2,843.06	2,842.23	2,848.30	2,870.64	2,881.14	2,893.57	2,900.26	2,928.97	2,916.23	2,918.09	2,857.17	2,892.25
Contracted	2,745.35	2,748.10	2,747.40	2,738.91	2,759.26	2,768.68	2,767.46	2,778.68	2,783.12	2,807.97	2,793.07	2,788.43
Vacancy	97.71	94.13	100.90	131.73	121.88	124.89	132.80	150.29	133.11	110.12	64.10	103.82

Appendix 3 - Health Care Assistant Vacancy Rate May 2022



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Budget	1,337.47	1,339.24	1,339.24	1,341.94	1,342.18	1,340.89	1,360.73	1,365.75	1,367.50	1,375.27	1,284.47	1,286.03
Contracted	1,397.30	1,388.60	1,369.84	1,392.04	1,357.34	1,340.90	1,325.84	1,357.94	1,379.86	1,358.85	1,339.44	1,366.81
Vacancy	-59.83	-49.36	-30.60	-50.10	-15.16	-0.01	34.89	7.81	-12.36	16.42	-54.97	-80.78

Appendix 4 - Nursing Turnover May 2022



	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022
Turnover	7.63%	7.41%	7.65%	8.02%	8.13%	8.40%	8.40%	8.21%	8.26%	8.67%	8.78%	9.26%	9.39%

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 5 JULY 2022			
Learning from Deaths May 2022			**AGENDA ITEM: 11, ENC 9**
Report Author and Job Title:	Jo Raine, Data Analyst Mortality Surveillance and Tony Roberts, Deputy Director (Clinical Effectiveness)	**Responsible Director:**	Michael Stewart Chief Medical Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This report provides assurance on the overall quality of care, as measured by hospital mortality and other clinical effectiveness indicators, delivered by the organisation and is based on the report submitted to the Mortality and Morbidity Group in May 2022.		
Background	Overview of mortality within the Trust including that related to COVID-19, relevant mortality indicators and coverage of the Medical Examiner service and Mortality Surveillance activity including lessons learned.		
Assessment	Following the high peak in mortality figures over the initial COVID-19 pandemic, and then the subsequent reduction in mortality over the summer, numbers are beginning to normalize again. SHMI at 114 remains Higher than Expected. 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 service. The Medical Examiner team coverage of mortality continues to be in excess of 95% of all deaths. Mortality Surveillance is continuing though has been affected by the pandemic. New reviewers have been recruited to address the backlog of reviews. Following discussion at PSSG, a section on learning has been added.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of Trust Board are asked to receive this report for information.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Principal risk 1- Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes		
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 ☐	

Learning From Deaths April 2022

1. PURPOSE OF REPORT

1.1. The report is consistent with the mortality reporting required by NHS England in December 2015 and is a response to the National Quality Board published in March 2017 *Guidance on Learning from Deaths* (LFD)[1] including the requirement to publish information on preventable deaths on a quarterly basis; the NHS Patient Safety Strategy, published in July 2019, confirmed the importance of Medical Examiners as a source of Insight into patient safety and the value of mortality reviews as part of the Learning from Deaths policy.

2. BACKGROUND

2.1. **Mortality Indicators**: The Trust reports mortality on a daily, weekly, monthly, quarterly and annual cycle along with trend data going back to 2006. In the light of the ongoing COVID pandemic this has been further developed to distinguish COVID related deaths from the general population. This report utilises HED data (supplied by the University Hospitals Birmingham NHS Foundation Trust) for external benchmarking alongside internally generated information from CBiS and CAMIS.

2.2. **Learning from Deaths:** The Trust Responding to Deaths policy (published Sep 2018, updated Oct 2020) sets out how the trust responds to, and learns from, deaths of patients who die under its management and care[2].

2.2.1. A *Medical Examiner Review* occurs at the time of certification of death. The Medical Examiner Service began in May 2018 and covers around 95% of all deaths in the Trust. The process includes review of the case records, discussion with the attending team and a discussion with the bereaved family.

2.2.2. *A Trust Mortality Review,* is conducted if any potential concerns are identified during the Medical Examiner Review and also for all deaths of patients with learning disabilities, serious mental illness, within 30 days of a surgical procedure or where a 'mortality alert' from a range of sources has occurred, or where a *Patient Safety investigation* is raised following a death or where a complaint has been reported.

3. MORTALITY INDICATORS & LEARNING FROM DEATHS

3.1. **Mortality Indicators**: The dashboard includes the count of deaths from April 2009 to April 2022 (Fig 1). 184 deaths were recorded in January 2022, 153 in February 2022, 180 in March 2022 and 151 in April 2022, all on the lower end of what might be expected for the time of year. COVID continues to be a factor in deaths but most cases are now with incidental COVID rather than being due to COVID. The unadjusted mortality rate is returning to pre-pandemic levels. Rolling 12-month average is 1.32 compared to 1.24 pre-pandemic.

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

[2] https://www.southtees.nhs.uk/about/trust/responding-deaths-policy/

3.2. **Comorbidity Coding** (Fig 2) shows the number of comorbidities included in the Charlson Index recorded per hospital spell. The comorbidity count matters because of its impact on the risk adjustment used in modelling mortality, combined with palliative care coding.

3.3. **Palliative Care Coding**: 2152 patients were coded as being in receipt of palliative care since April 2021 of whom 1133 (52.6%) died (44.6% of all deaths in the period) Note: that March 2022's data was not complete at time of reporting. (Fig 3)

3.4. **COVID-19**: There have been 888 COVID-19 positive deaths recorded (22% of all deaths) since the pandemic began in March 2020.

Fig 1: Count of Deaths and Mortality Rate

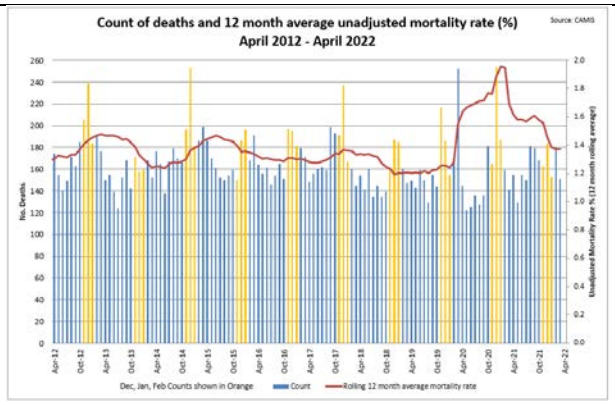


Fig 2: Comorbidity Coding

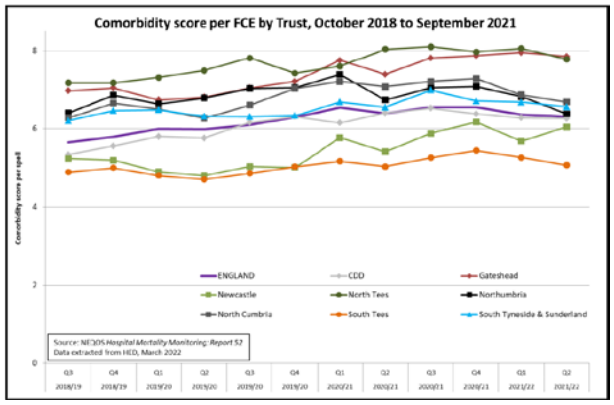


Fig 3: Palliative Care Coding

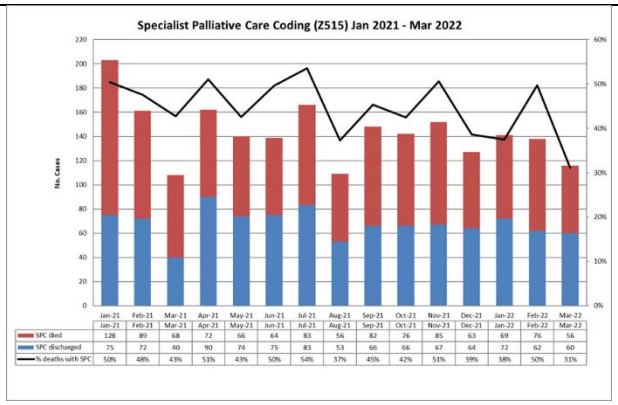
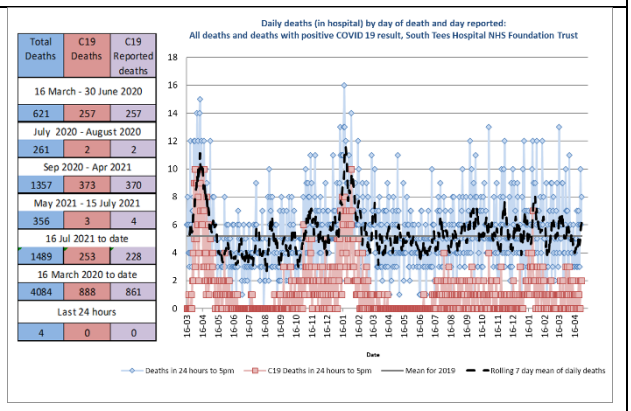


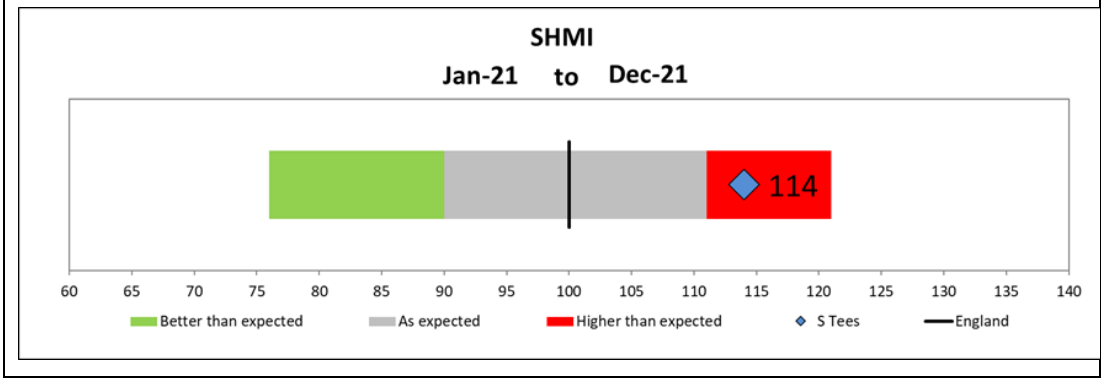
Fig 4: COVID Deaths



3.5. The **Summary Hospital-level Mortality Indicator (SHMI)** includes all in-hospital deaths plus deaths within 30 days of discharge. It is published on a quarterly asis by NHS Digital and is an official government statistic. Current reporting is January 2021 - December 2021. The SHMI is the ratio of observed mortality rate/expected mortality rate (based on a statistical estimate of expected mortality). The SHMI is 114, 'higher than expected' (i.e. outside the variation expected statistically) though down on recent quarters. 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 service. NHS Digital is removing any spell containing a COVID-19 Confirmed or Suspected code. In this release this amounts to 2,755 spells or 3.6% of spells. The indictor is also affected by the fall in activity during the outbreak. For the current period there is a total fall of 14% in the number of spells used to calculate SHMI. (Fig 5)

Fig 5. SHMI



3.6. Work on producing statistics by **Collaborative Group** is currently being developed. 42.9% of deaths were in Medicine and Emergency Care Services and 11.2% in Growing the Friarage and Community Services (Fig 6).

Fig 6: Deaths in South Tees Hospitals NHS Foundation Trust by collaborative. Apr - Dec 2021

Fig 5: Deaths in South Tees Hospitals NHS Foundation Trust: Apr 2021 - Mar 2022

Collaborative	Survived	Died	Total	Unadjusted Mortality Rate	% all deaths
Cardiovascular Care services	6012	124	6136	2.0%	6.4%
Clinical Support Services	906	1	907	0.1%	0.1%
Digestive Diseases, Urology and General Surgery services	21142	168	21310	0.8%	8.7%
Head and Neck, Orthopaedic and Reconstructive services	17775	88	17863	0.5%	4.5%
James Cook Cancer Institute and Speciality Medicine services	19011	191	19202	1.0%	9.8%
Medicine and Emergency Care services	22854	832	23686	3.5%	42.9%
Neurosciences and Spinal Care Services	3843	36	3879	0.9%	1.9%
Perioperative and Critical Care Medicine Services	1346	217	1563	13.9%	11.2%
Women and Children services	22231	32	22263	0.1%	1.6%
Growing the Friarage and Community services: Community Services	276	29	305	9.5%	1.5%
Growing the Friarage and Community services: Primary Care Hospitals	657	45	702	6.4%	2.3%
Growing the Friarage and Community services: Friarage Medical Services	23158	177	23335	0.8%	9.1%
Grand Total	**139211**	**1940**	**141151**	**1.4%**	**100.0%**

3.7. **Medical Examiners:** Between April 2021 and March 2022, of the of the 2,096 deaths that occurred in hospital and in A&E or were very recent discharges from hospital and referred to the Medical Examiner (including 40 GP/Community deaths included in the Medical Examiner system since September 2021), 2,034 were reviewed by the Medical Examiner service – 97.0% of all such deaths.

3.7.1. Of these 90.0% of deaths were judged to be definitely not preventable with 3.5% of cases judged to show some preventability. One case was judged 'Definitely Preventable' but the element of preventability occurred before the patient reached hospital (delays in re-hospital care). 87.1% of deaths were Expected, 11.6% of deaths Unexpected, the remainder ungraded. 174 were recommended for Trust Mortality Review, 48 reviews have so far been undertaken with the rest scheduled. The backlog of cases (currently 140 cases) needing review by Mortality Surveillance from this and the previous year are currently being addressed.

Fig 7: Medical Examiner Service Statistics

Medical Examiner Service Statistics: Month of Death	No. In-Hospital Deaths	A&E Deaths	Community Deaths	Other Deaths	ME Review	% Review	Rec'mend TMR	Received TMR	Specialty Review	Discussed with Coroner	Noted as Coroner Case
May 2018 - Mar 2019	1698	25		19	1432	82.2%	230	221	265	275	137
Apr 2019 - Mar 2020	1902	92		46	1822	89.3%	192	192	393	381	296
April 2020 - Mar 2021	1994	73		39	2041	96.9%	153	153	224	330	279
April 2021 - March 2022	1936	109	40	11	2034	97.0%	174	48	103	297	333

Medical Examiner Service Statistics: Month of Death Apr 2022 -Mar 2023	No. In-Hospital Deaths	A&E Deaths	Community Deaths	Other Deaths	ME Review	In hospital % Review	Rec'mend TMR	Received TMR	Specialty Review	Discussed with Coroner	Noted as Coroner Case
Apr-22	151	9	7		161	96.4%	14		11	17	37
	151	9	7	0	161	96.4%	14	0	11	17	37
	5745	199	7	104	5456	90.1%	763	614	893	1003	749

3.8. **Mortality Surveillance Reviews**: Four new consultant reviewers were appointed and began reviewing in September 2021 taking the number of reviewers to six. 390 reviews were completed between April 2021 – April 2022 (activity badly affected by COVID and change in personnel). (Fig 8)

3.8.1. 76% of case reviews were judged to show good practice with no preventability. 2% showed good practice with some preventability. (Fig 9). 13% showed room for improvement in care but with no preventability, 4% showed both preventability and room for improvement in care and 4% (16 cases) showed strong preventability and/or less than satisfactory care.

Fig 8 No. of Reviews Apr 2021 to date

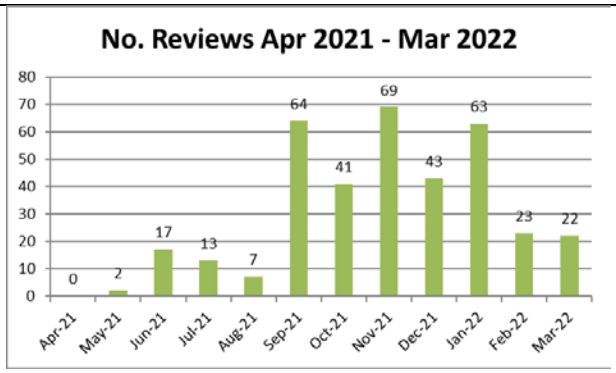
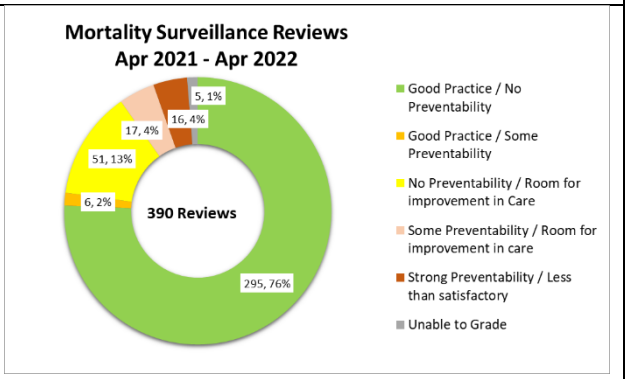


Fig 9 Preventability / Good Practice

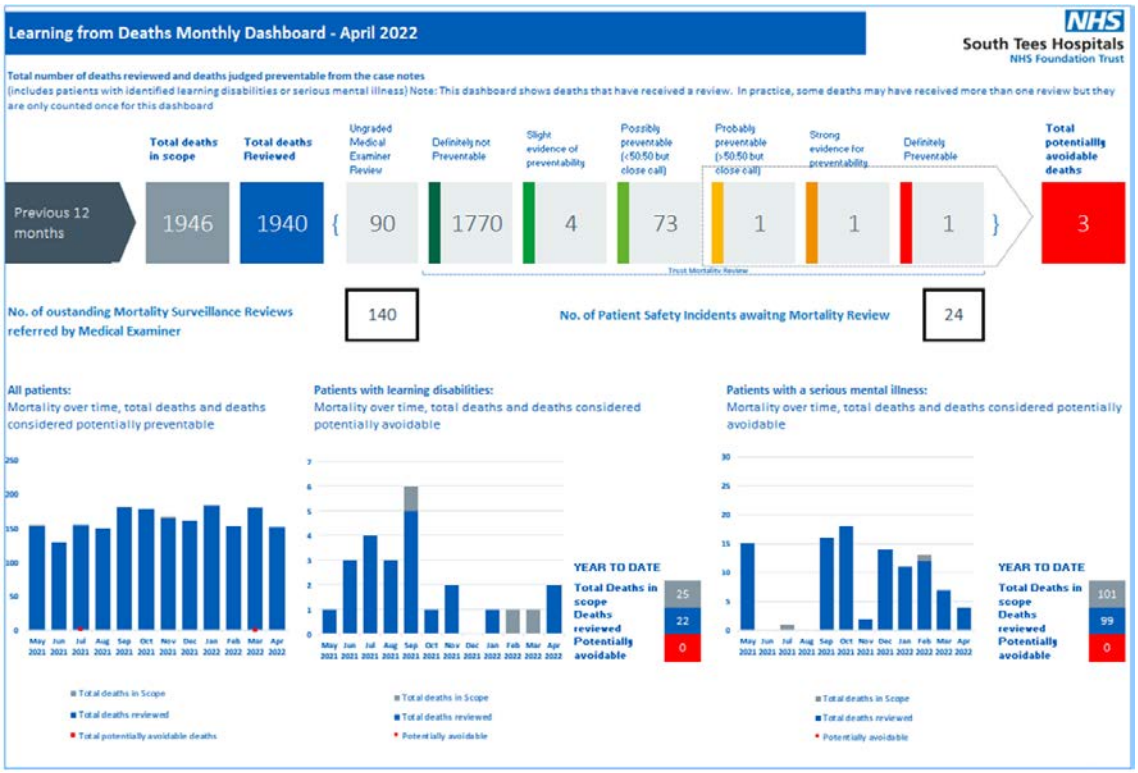


3.8.2. 88% of deaths were Expected, 9% Unexpected. Care in 81% of cases was graded Good-Excellent. 2% of cases were judged to have received sub-optimal care.

3.8.3. In the last month, one review mentioned lessons learned from good care, particularly around good communication with family and good documentation of those discussions.

3.8.4. In the last month, 10 reviews mentioned lessons learned from documentation, coordination of clinical care, senior input and advanced decision-making.

3.9. The **Learning From Deaths Dashboard** reports the number of deaths, the number of Medical Examiner Reviews, the number of deaths with a Trust Level Mortality Review or investigation and the number of those deaths judged to show evidence of preventability. Numbers are reported separately for patients with learning disabilities and known serious mental health illnesses. For the year to end of April 2022, there were 1,946 deaths, of which 1,940 (99.7%) received a review or investigation and 3 deaths were considered to be potentially avoidable. In the same period 88% of deaths in patients with a learning disability and 98% of cases where the patient had a pre-existing mental health condition were reviewed with no deaths considered potentially avoidable.



4. MORTALITY INDICATORS & LEARNING FROM DEATHS

4.1. **Medical Examiner scrutiny and Mortality Reviews** identify aspects of good care and potential or actual problems in care. Where these are specific to a particular clinical team, feedback is provided by the ME or reviewer directly to the team and this will often prompt review and action in the department, specialty or Collaborative: it is not currently possible to collate this centrally. More general themes are collated and summarised below:

- **End of Life Care**. Actions are coordinated through the End of Life Group, which receives information on EoLC themes and cases from ME scrutiny and mortality reviewers and the EoLC G reports through the governance structure to QAC.
- **Documentation** in the medical records. This issue is addressed through the STACQ accreditation and documentation audits, although the longer-term solution is implementation of electronic patient records. Progress on this work is reported to the Miya Programme Board through Trust Committees to Board level.
- **Coordination of care** between specialities. This is not easily identified in medical records as it relies on notes being made of conversations and telephone calls between colleagues. This will improve with implementation of Miya and is reported through the Miya Board.
- **Transfer of patients from other hospitals**. Information about patients prior to, and at the time of, referral is currently in the medical record, usually in a summary form (it currently relies heavily on the doctor accepting referral to make this summary) and there is considerable debate about how to electronically enable this so that greater detail, including from the referrer, can be captured. The trust uses a solution called ‘referapatient’ in neurosurgery and there is a process currently on-going around procurement of a system across the region (led by Newcastle upon Tyne Hospitals NHS FT). The intention is to procure a single system for all Trusts in the North East and North Cumbria but there isn’t currently a timescale for completion of procurement and implementation for cardiac, renal, vascular, orthopaedic and other specialty services.

5 RECOMMENDATIONS

- The unprecedented pattern of deaths, unadjusted and risk adjusted mortality rates during the pandemic has made these measures difficult to interpret. The Trust should continue to monitor these statistics but accept that their use for assurance is diminished and thus the importance of non-statistical approaches to mortality are of greater importance than was the case before covid. The volume of spells used to calculate SHMI is gradually returning to pre-pandemic levels is currently at 86%.
- The Trust should continue to engage with national and regional efforts to understand hospital mortality within the wider context of mortality in all

settings and particularly in relations to disparities (inequalities) in the populations served by the trust.

- SHMI at 114 remains Higher than Expected and so requires specific monitoring, although it is likely that the key reason for this is related to recording of comorbidities, rather than quality of care, and so the trust should remain focused on this problem.
- The Medical Examiner team coverage of mortality continues to be in excess of 95% of all death. Scrutiny is being extended to out of hospital settings and the trust should continue to support the development of this service.
- Mortality Surveillance is continuing though has been affected by the pandemic. New reviewers have been recruited to address the backlog of reviews and the trust should monitor the impact of this over the coming months.

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 JULY 2022			
Freedom to Speak Up Q1 Update			**AGENDA ITEM: 12** **ENC 10**
Report Author and Job Title:	Rick Betts/Afshan Ali/Jim Woods Freedom to Speak Up Guardians Ian Bennett Freedom to Speak Up Guardian & Deputy Director of Quality	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This report provides an update on the work of the Freedom to Speak Up (FTSU) Guardians during Quarter 1 of 2022 (April 1st June 21st)		
Background	The Freedom to Speak Up Guardian role was created across the NHS in response to recommendations from Sir Robert Francis following his review of the Mid Staffordshire Hospital. The FTSU model has now been in operation for a full 22 months and continues to be well received by staff and managers. South Tees FTSU Guardians encourage colleagues to speak up about concerns in the workplace with the aim of continuing to improve patient safety and staff experience. Themes arising from issues raised are shared and used to improve learning and improvement within the organisation.		
Assessment	The number of issues raised by colleagues to the FTSU Guardians in Q1 decreasing from 22 in Q4 of 2021 to 16 in Q1 2022. As a result of colleagues speaking up, several organisational learning points have been identified, with recommendations made on how the Trust should continue to improve. The Guardians are also continuing to improve FTSU culture throughout the organisation and beyond, with stronger links being maintained with Teesside University and the regional FTSU Guardians network.		
Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐		
Recommendation	Members of the Board of Directors are asked to note the content of the paper		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Principal Risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes Principal Risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☐	Make best use of our resources ☐
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐	

Freedom to Speak Up Q1 Update

1. PURPOSE OF REPORT

The purpose of the report is to update the Board on progress made by the Freedom to Speak Up Guardians (FTSUG) since the submission of the previous report in April 2022.

The report provides an overview of the themes and issues raised between 1st April 2022 and 21st June 2022 (Q1).

2. BACKGROUND

Following recommendations from the Francis Report, Freedom to Speak Up (FTSU) Guardians were created in 2016 with the aim of helping to protect patient safety and quality of care, improve the experience of workers and promote learning and improvement.

This is achieved by supporting colleagues to speak up about issues, break down any barriers to speaking up and ensuring that issues raised are used by the Trust as opportunities for feedback, learning and improvement.

The current FTSU model employed in the Trust has now been in place for 22 months with 3 part time guardians and the Lead Guardian (Deputy Director of Quality).

3. DETAILS

Assessment of issues

During Q1, the FTSUG's received 16 new issues, representing a decrease when compared to the previous report submitted in April and as set out in Table 1 below.

The 2020/2021 Annual Speaking Up Data Report from the National Guardians Office (NGO) shows trends and themes around speaking up across organisations, where the average number of cases that were raised with FTSUG's per quarter in medium sized organisations such as ours in 2020/2021 being 26. Therefore the 16 concerns raised in our trust are below the national average for Trusts of our size for Q1.

Year to date figures show that 54.89% of staff are speaking up openly or confidentially with 45.10% speaking up anonymously.

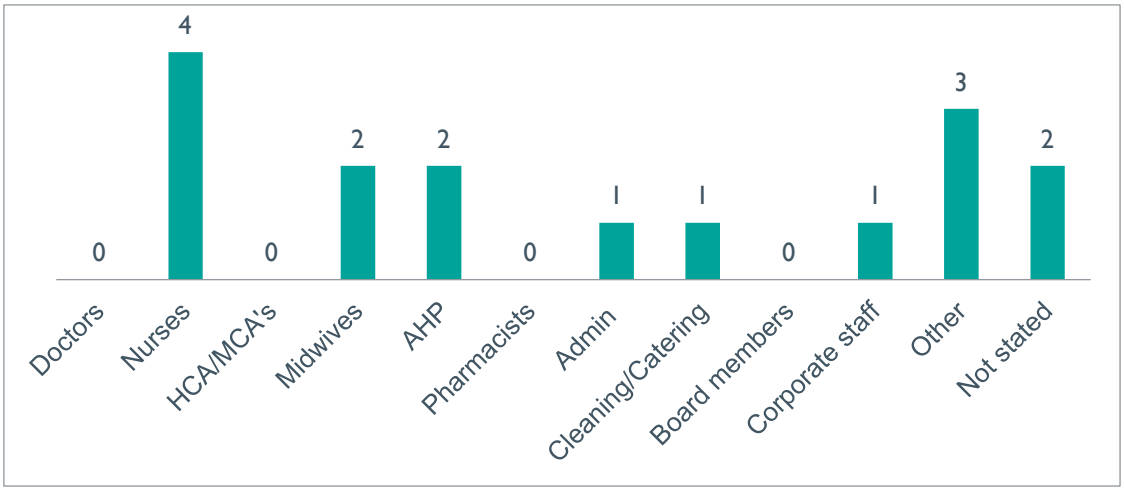
Table 1

Number Issues Raised per Quarter					
	Q2 (2021)	**Q3 (2021)**	**Q4 (2021)**	**Q1 (2022)**	**Year to date**
Open	5 (15.62%)	6 (18.75 %)	8 (36.36%)	3 (18.75%)	22 (21.56%)
Confidential	12 (37.5%)	9 (28.12 %)	8 (36.36%)	5 (31.26%)	34 (33.33%)
Anonymous	15 (46.87%)	17 (53.12 %)	6 (27.27%)	8 (50%)	46 (45.10%)
Total	32	32	22	16	102

Staff Groups

Chart 1 below shows the staff groups who have raised issues in Q1.

Chart 1.



Professional Level

Table 2 shows the professional levels of all staff who have spoken up in Q1.

Table 2

Professional level	Q1
Worker	6 (37.5%)
Manager	2 (12.5%)
Senior	1 (6.25%)
Unknown	7(43.75%)

Key Performance Indicators

As discussed and agreed with the Executive and Non-Executive Leads for FTSU, timeframes for managing issues have now been included in the FTSU metrics and measures. These include:

- The length of time from opening to closure new issues (<7days, <30 days, <90 days)
- The time taken to appoint an examiner from initial contact

The figures in table 3 below show that of the 16 concerns issues in to Q1, 14 (87.5%) were appointed to an examiner with 48 hours.

Table 3

Issue No	Closed/Open	Number of Days Open	Period Open	Days before Investigator Assigned
1	N	1	<7days	1
2	N	23	<30 days	6

3	Y			1
4	Y			0
5	N	7	<7days	1
6	Y			1
7	N			1
8	N			1
9	Y	14	< 30days	1
10	Y	1	< 7 days	0
11	N			4
12	N			1
13	N			1
14	N			1
15	N			1
16	Y			1

Of the 16 issues recorded in the quarter, 10 remain open, 3 were closed within 7 days and 2 within 30 days.

Learning and Improvement

The Guardians team meet with colleagues from Human Resources and Trade Unions to collate and triangulate information and understand any themes and issues across the 3 different teams. An update will be provided to the People Committee.

As a result of colleagues speaking up thematic learning has included:

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

All Guardians have attended and completed the recent Restorative Justice and Learning Culture training. The team looking forward to collaborating with HR, Unions, OD and other stakeholders to help to inform, promote and develop this initiative further.

Coupled with this training the team has also begun a review of the FTSU model and the P39 Freedom to Speak Up: Raising Concerns Policy.

In May 2022, FTSU Guardians nationwide were asked for expressions of interest for a new pilot programme run by the National Guardians Office with the aim of **'**Supporting an inclusive speak up culture for black and minority ethnic people'. The team has secured a place and will be represented by one of the FTSU Guardians. Further details on this will be included in the next update.

Freedom to Speak Up Training & Mandatory Training

The final module of the Freedom to Speak Up e-learning, Follow Up, is now available. Developed for executive and non-executive directors, lay members and governors, this module aims to further promote a consistent and effective FTSU culture across the system.

The other two Freedom to Speak Up training modules - 'Speak Up and Listen Up' are also available. Speak Up is for all colleagues and Listen Up is aimed at middle managers. This is in addition to the follow up module as identified above.

The three modules help colleagues understand the vital role we all play in a healthy speaking up culture which protects patients and service users and enhances worker experience. It is the intention of the FTSU team with support from the Organisational Development Team and ongoing support of the Board and Senior Leadership Team to embed this training within the organisation by making the first module 'Speak Up' a mandatory element for all colleagues as a one-time training requirement.

This will form a major part of our commitment to FTSU in our upcoming annual review of the South Tees FTSU model.

Awareness Raising

The Freedom to Speak Up team is working closely with the Education and Practice Team, delivering sessions to new Health Care Assistants in the Organisation, to raise awareness of the model.

The team continues to deliver sessions to Teesside University and have secured dates to speak to the nursing students across all branches, in addition to Trainee Nursing Associates and Apprenticeship Nursing Students.

As Teesside university caters for students that are from other local Trusts, the team has engaged with the Regional Guardians network to undertake some joint delivery of these sessions.

To continue to increase the team's visible presence across the organisation and within community settings, the team has completed visits to the Friary Hospital, East Cleveland Hospital, Redcar PCH, Guisborough, Low Grange and Friarage Hospitals and going forward hopes to make this a regular feature of its work.

Recommendations

Members of the Board of Directors are asked to note the content of the paper, the actions taken and those which are planned.

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 5 JULY 2022			
Finance Report			**Agenda Item 14, ENC 11**
Report Author and Job Title:	Chris Dargue Deputy Chief Finance Officer	**Responsible Director:**	Chris Hand Chief Finance Officer
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report outlines the Trust's financial performance as at Month 2 of 2022/23.		
Background	For 2022/23, the system-based approach to planning and delivery continues with all systems required to breakeven. The Trust's plan submitted in April 2022 to the NHSE/I regional team for the 2022/23 financial year is a deficit of £29.6m. The national planning round was subsequently extended, following allocation of additional funding to ICBs for inflationary pressures, NHS organisations were asked to make a further plan resubmission in June 2022. Following this submission, the Trust's revised plan is to deliver deficit of £20.7m, which will form the basis of financial reporting from Month 3 onwards. The costs associated with the historical PFI on the James Cook University Hospital remain the largest contributor to the Trust's deficit position.		
Assessment	At Month 2 the Trust reported a deficit of £7.0m at a system control total level. This is £0.1M ahead of the financial plan submitted to the NHSE/I Regional Team in April 2022.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Resource Committee are asked to note the financial position for Month 2 2022/23.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Principal risk 7 - Failure to deliver the Trust's financial recovery plan		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Best for safe, clinically effective care and experience ☐	A great place to work ☐	
	Deliver care without boundaries in collaboration	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 ☐	

Month 2 2022/23 Financial Performance

1. PURPOSE OF REPORT

The purpose of the report is to update the Board on the Trust's financial performance as at Month 2 of 2022/23.

2. BACKGROUND

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

At the time of reporting the month 2 position, the Trust's plan for the 2022/23 financial year is a deficit of £29.6m, measured on a system financial performance basis. The plan has been developed in conjunction with the NHS North East and North Cumbria ICB, with internal review and oversight of provided through the Resources Committee and meetings of the Trust Board.

The ICB financial plan has not been finalised and further funding has been made available to the ICB to the for inflationary pressures, NHS organisations were asked to make a further plan resubmission in June 2022. An updated plan was submitted on the 20 June and the Trust is now required to deliver a £20.7m deficit in 2022/23. This month 2 report does not reflect the plan submitted on the 20 June or the additional income associated with the plan. It is expected that the month 3 report will report against the newly submitted plan.

At Month 2 the Trust reported a deficit of £7.0m at a system control total level. This is £0.1M ahead of the financial plan submitted to NHSE/I in April 2022.

3. DETAILS

Trust Position Month 2 2022/23

The Month 2 position is outlined in the table below.

STATEMENT OF COMPREHENSIVE INCOME	Plan £000	Actual £000	Variance £000
Operating income from patient care activities	119,835	120,433	598
Other operating income	8,662	7,141	(1,521)
Employee expenses	(79,805)	(79,376)	429
Operating expenses excluding employee expenses	(52,470)	(52,160)	310
OPERATING SURPLUS/(DEFICIT)	**(3,778)**	**(3,962)**	**(184)**
FINANCE COSTS			
Finance income	0	86	86
Finance expense	(2,884)	(2,650)	234
PDC dividends payable/refundable	(698)	(698)	0
NET FINANCE COSTS	**(3,582)**	**(3,262)**	**320**
Other gains/(losses) including disposal of assets	0	4	4
Corporation tax expense	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(7,360)**	**(7,220)**	**140**
Add back all I&E impairments/(reversals)	0	0	0
Remove capital donations/grants/peppercorn lease I&E impact	268	194	(74)
Adjusted financial performance surplus/(deficit)	**(7,092)**	**(7,026)**	**66**

The Trust's operating deficit for month 2 was £4.0m and the overall deficit for month was £7.2m. The adjusted financial position for the purpose of system performance was a deficit of £7.0m.

Operating Income from Patient Care Activities

Under the revised financial arrangements for 2022/23, the Trust was paid under a block arrangement with the exception of the below items:

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

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

INCOME FOR PATIENT CARE ACTIVITIES	Plan £000	Actual £000	Variance £000
NHS England	39,368	39,673	305
Clinical commissioning groups	79,972	80,083	111
Non-NHS: private patients	164	78	(86)
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	1	0	(1)
Injury cost recovery scheme	322	588	266
Non-NHS: other	8	11	3
TOTAL INCOME FOR PATIENT CARE ACTIVITIES	**119,835**	**120,433**	**598**

Operating income from Patient Care Activities was £120.4m for month 2 and was £0.6m ahead of plan.

100% of ERF funding is currently assumed in the year-to-date position. The CCG income position also assumes £0.6m of year-to-date ERF funding from North Yorkshire CCG, in line with national planning guidance, which is awaiting CCG confirmation and reflection in revised block contract payments.

NHS England income is ahead of plan and relates to high-cost drugs and devices and can be offset by a overspend in non-pay. CCG income is ahead of plan due to additional contract variations received above plan.

Operating Income from Patient Care Activities received from commissioners will be updated in month 3 to reflect the 20th June submitted NHSE plan and revised block contract values.

Other Operating Income

Other income received during month 2 totalled £7.1m and includes all non-direct patient care income.

OTHER OPERATING INCOME	Plan £000	Actual £000	Variance £000
Research & Development	772	621	(151)
Education and Training	3,736	3,674	(62)
Non Patient Care Income	469	283	(186)
Reimbursement & Top-Up funding	456	379	(77)
Donations - (Assets, Equipment & COVID consumables)	0	2	2
Other	3,229	2,182	(1,047)
TOTAL OTHER OPERATING INCOME	**8,662**	**7,141**	**(1,521)**

Other operating income is behind plan by £1.5m, including an under recovery on R&D income, car parking, maternity pathway income and deferred income. Maternity pathway income is expected to increase as funding moves into commissioner block contracts, following changes in the financial framework for 2022/23.

Employee Expenses (Pay)

The Trust's total expenditure on pay for month 2 of 2022/23 was £79.4m and a breakdown is included in the table below. An estimate of the 2022/23 Agenda for Change pay award has been included in the plan and actuals. The pay award assumptions are consistent with the NHSE/I planning guidance.

PAY	Plan £000	Actual £000	Variance £000
Ahp'S, Sci., Ther. & Tech.	(11,542)	(11,416)	126
Hca'S & Support Staff	(9,001)	(8,421)	580
Medical And Dental	(23,550)	(23,634)	(84)
Nhs Infrastructure Support	(10,836)	(11,024)	(188)
Nursing & Midwife Staff	(24,538)	(24,603)	(65)
Other Pay Costs	(338)	(278)	60
TOTAL PAY	**(79,805)**	**(79,376)**	**429**

Pay is underspent by £0.4M and predominantly relates to HCA and support staff.

Operating Expenses excluding Employee Expenses (Non-Pay)

The Trust's total expenditure on operating non-pay for month 2 of 2022/23 was £52.2m and a breakdown is included in the table below. Expenditure includes all costs relating to clinical delivery and the Trust's response to the COVID pandemic.

NON PAY	Plan £000	Actual £000	Variance £000
Purchase of Healthcare	(2,748)	(2,339)	409
Clinical Supplies & Services	(16,324)	(15,868)	456
Drugs	(13,664)	(13,940)	(276)
External Staff & Consultancy	(56)	(166)	(110)
Establishment	(1,592)	(1,787)	(195)
Premises & Fixed Plant	(3,636)	(4,160)	(524)
Transport	(678)	(744)	(66)
Depreciation & Amortisation	(4,422)	(4,444)	(22)
Research Training & Education	(534)	(338)	196
PFI Unitary Payment	(5,316)	(5,272)	44
Other	(630)	(256)	374
Clinical Negligence	(2,870)	(2,846)	24
TOTAL NON PAY	**(52,470)**	**(52,160)**	**310**

Non-pay is underspent by £0.3M and mainly relates to clinical supplies.

Cost Improvement Programme (CIP)

Total collaborative schemes identified to date exceed the target set for 2022/2023, and focus continues on delivery of these schemes to ensure the cost improvement programme is achieved, and to ensure removal of COVID costs, in line with national funding arrangements and changes in NHS COVID guidance.

Capital

The Trust's capital expenditure at the end of May amounted to £3.4m as detailed below:

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
PFI Lifecycle	2,126	2,127	01	12,760	12,760	0
Site Reconfiguration	0	600	2,711	13,556	13,556	0
Replacement of Medical Equipment	100	247	229	4,000	4,000	0
Network Replacement and Clinical Noting	100	438	338	2,775	2,775	0
Total	**2,326**	**3,412**	**1,086**	**33,091**	**33,091**	**0**

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Full Year Budget £'000	Full Year Forecast £'000	Full Year Variance £'000
Financing						
Depreciation	2,326	2,326	0	19,535	19,535	0
Internal Reserves	0	1,086	1,086	8,206	8,206	0
Charitable Funding	0	0	0	0	0	0
PDC	0	0	0	5,350	5,350	0
Total Financing	**2,326**	**3,412**	**1,086**	**33,091**	**33,091**	**0**

The capital programme is based on a regionally approved programme of £33.1m that will require external support, in the form of Public Dividend Capital (PDC) of £5.4m. Internal funding will be utilised to fund the remainder of the programme. The Trust's ICB Capital Departmental Expenditure Limit (CDEL), included in the above, amounts to £15.0m

Statement of Financial Position (SOFP)

The following table compares the SOFP position between 30 April and 31 May.

	30 April £000	31 May £000	Movement between months £000
Property, Plant and Equipment	269,299	269,843	544
Long Term Receivables	3,662	3,662	0
Total Non-Current Assets	272,961	273,505	544
Currents Assets			
Inventories	14,285	14,587	302
Trade and other receivables (invoices outstanding)	12,514	5,509	(7,005)
Trade and other receivables (accruals)	16,526	14,186	(2,340)
Prepayments including PFI	13,790	10,097	(3,693)
Cash	63,043	64,446	1,403
Total Current Assets	120,158	108,825	(11,333)
Current and Non-Current Liabilities			
Borrowings	(89,293)	(89,087)	206
Trade and other payables	(129,251)	(122,586)	6,665
Provisions	(3,147)	(3,145)	2
Total Current and Non-Current Liabilities	(221,691)	(214,818)	6,873
Net Assets	**171,428**	**167,512**	**(3,916)**
Equity:			
Income and Expenditure Reserve	(261,922)	(265,838)	(3,916)
Revaluation Reserve	39,775	39,775	0
Public Dividend Capital	367,099	367,099	0
Other Reserves	26,476	26,476	0
Total Equity	**171,428**	**167,512**	**(3,916)**

The significant movements between months relate to the receipt of advanced funding from Health Education England on invoices raised in April (£6.9m) and the treatment of one months advanced prepayment on the unitary charge to the PFI Provider (£4.1m). The next quarterly PFI prepayment was due in June 2022. Trade and other payables have fallen between April and May with the payment of aged prior year invoices.

Liquidity

The cash balance at 31 May amounted to £64.4m.In April the Trust paid 16,896 invoices (total value £86.130m) with 16,583 invoices (total value £80.424m) paid within the 30 day target. The Trust's performance against the Better Payment Practice Code (BPPC) target (95%) on invoices paid so far this year equated to:

- April 98.6%; and
- May 98.2%.

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 5 JULY 2022			
Care Quality Commission (CQC) Update Report			**AGENDA ITEM: 15** **ENC 12**
Report Author and Job Title:	Dr Sylvia Wood Interim CQC Compliance Professional Ian Bennett Deputy Director of Quality	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This paper provides an update on work as part of the Trust's COVID-19 recovery to address the findings of the focused CQC inspection which took place in February 2022 and to develop preparedness for future CQC inspections.		
Background	The Trust has an overall rating of Requires Improvement given at the last CQC inspection of the Trust in 2019. The overall rating has not changed following the focused inspection in February 2022.		
Assessment	This paper includes updates about new and ongoing work in relation to: • CQC inspection February 2022 • Action planning • Engagement meetings • STAQC		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	The Board of Directors are asked to note progress with ongoing and planned work.		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	Principal Risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes Principal Risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☒	

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

South Tees Hospitals
NHS Foundation Trust

Care Quality Commission (CQC) Update Report

1. PURPOSE OF REPORT

This paper provides an update on work to address the findings of previous CQC inspections, and to develop preparedness for future CQC inspections.

2. BACKGROUND

The CQC monitors, inspects and regulates NHS trusts. The CQC monitors the quality of care provided using feedback from staff, patients, and partners, and changes to information held in CQC Insight. CQC Insight brings together in one place the information CQC holds about services, and analyses it to monitor services at provider, location, or core service level.

3. DETAILS

CQC inspection February 2022 (published: 25 May 2022)

As previously reported, a focused CQC inspection took place of medical and surgical wards at the James Cook and Friarage Hospital sites on the 9-10 February 2022 in response to risks around a number of the areas which the trust is focussed on as part of its pandemic recovery.

The trust was already taking action on these areas as part of its clinically-led recovery from the winter Omicron surge, which at its peak saw more than 500 COVID-related staff absences, and has now made additional changes following feedback from inspectors. On ward-based documentation for example, more than £8 million is being invested in new digital systems which will eliminate clinical teams' historical reliance on burdensome paper-based recordkeeping and ageing IT systems – removing more than 5 million pieces of paper which colleagues currently have to use each year.

One of these digital tools has now started to replace the paper-based recording of nutrition and hydration assessments and a strengthened approach has been reintroduced around protected mealtimes as part of COVID-19 de-escalation. In addition, a transfer of care hub has been created in collaboration with local authorities to support ward colleagues and social workers to return people safely home after their hospital treatment and help to ensure social care support is available in the community.

As the Omicron wave reduced, colleagues make immediate changes as part of the organisation's clinically-led recovery from COVID-19 and will continue to take forward the actions required to make in response to inspectors' findings.

Section 29A actions

Action plans have been developed and work is progressing to complete, log and save evidence of actions taken. All areas are on track overall for completion as required by 31 August. A further overarching action plan sets out must do and should do actions which is monitored through the CQC compliance group and Quality Assurance Committee and focused on the areas identified in the CQC report including ward-based documentation (risk-assessments), nutrition and hydration, Mental Capacity Act (MCA) and patient discharge.

CQC Engagement meetings

The trust continues to have regular engagement meetings with the CQC to monitor and support progress with addressing the findings of the recent inspection and preparation for future inspections.

STAQC (South Tees Accreditation for Quality of Care)

The STAQC ward accreditation process is part of the trust's assurance mechanisms for ensuring high quality care and the best patient experience.

The accreditation programme was reinvigorated as part of a number of significant changes which the trust has undergone since 2019 through the empowerment of clinicians to take the decisions about how we manage our resources and deliver care across our hospitals and services.

The STAQC programme encompasses assessment of all clinical areas; inpatient wards, day case areas, critical care areas, emergency departments, theatres, out-patient departments, community services, maternity and paediatrics.

The process for each area has been designed to provide consistency of assessment around key core indicators whilst allowing adequate flexibility to adjust the process associated with specialisms and the differences between the clinical areas.

Wards and departments are assessed against multiple standards that are measured against key performance indicators and CQC domains.

Despite the impact of the COVID-19 pandemic, more than 40 wards and services have now achieved diamond or gold accreditation with remaining wards and services planned to undertake their accreditation process during 2022.

4. RECOMMENDATIONS

The Board of Directors are asked to note the Care Quality Commission update report.

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 JULY 2022			
Roles and responsibilities of the Obstetric Consultant (RCOG June 2021) Gap analysis and action plan.			**AGENDA ITEM: 16, ENC 13**
Report Author and Job Title:	Dr Deepika Meneni- Obstetric Clinical Director	**Responsible Director:**	Dr Hilary Lloyd- Chief Nurse
Action Required	Approve ☒ Discuss ☐ Inform ☐		
Situation	The document `Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology` (Royal College of Obstetrics and Gynaecology RCOG June 2021) is a good practice guide defining the organisational support required for maternity services and provides a number of recommendations for practice. The Maternity Incentive Scheme (MIS) year 4 standardises the requirement for Trusts to evidence their position with the recommendations in this document and to evidence the monitoring of consultant attendance at the identified clinical situations on a monthly basis, with learning and action plans from any non-compliance. The attached document sets out a GAP analysis against the recommendations from the report and an action plan to ensure full compliance with the recommendations and MIS standard requirements.		
Background	Successive national maternity reports have identified the important role consultants play in being key clinical decision makers, maintaining standards, reducing variations in patient care and role modeling professional behavior. There is a need for consultants to be visible and effective leaders in obstetrics (RCOG June 2021). This has been emphasised in the recent Ockenden review of maternity services in Shrewsbury and Telford NHS Trust which also emphasised the need for consultant involvement in complex pregnancies and continuous risk assessment at every contact. The Maternity Incentive scheme year 4, which supports the delivery of safer maternity care, has also recognised the essential role of the consultant and standard 4 requires that Trusts commit to the principles of the RCOG document and ensure that consultant attendance is maintained for identified complex clinical situations. The Trust has undertaken a robust gap analysis of practice at South Tees against the recommendations and the findings are presented in this report.		
Assessment	The gap analysis has been undertaken by the clinical director for the service with support from the senior team. It demonstrates good compliance with the RCOG recommendations.		

	There is a process which has been developed to monitor consultant attendance at the identified clinical situations and will commence by the end of June 2022. This requirement is one aspect of the MIS standards. The Maternity Improvement Board was set up to oversee progress with all aspects of maternity requirements and meets on a 2 week basis, this includes ensuring MIS is on track. The quarterly report and updates on the action plan will be presented to the Maternity Safety quality and Effective Care Group and will also be included in the quarterly maternity report to the Quality Assurance Committee. A check and challenge event is set up for November 2022 with executive directors to undertake a full review prior to full submission in early 2023.	
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐	
Recommendation	Members of the Trust Board are asked to approve the content of this report	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives (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 ☒	

Name of Guidance/Report: Roles and Responsibilities of a consultant RCOG	**Date published: June 2021**	**Lead: D Meneni**	**Date at Obs Risk Mgt**	**Date for review**

Report key messages	**Fully, partially or non-compliant**	**Evidence**	**Action plan**	**Lead person responsible**	**Target date**	**Date / Evidence of completion**
Team Leader and Role Model						
1. Adaption of leadership style according to the situation 2. Build positive, cohesive relationships with the Multi-disciplinary (MDT) and other specialities to ensure seamless, person centred care 3. Follow shallow authority gradients as this promotes psychological safety		Local guidance SOP 12A Consultant Roles and Responsibilities	1. Attendance of all consultants at leadership development	Obstetric CD	Within 1 year of appointment	
Clinician						
Situations in which the consultant MUST ATTEND • In the event of high levels of activity e.g a second theatre being opened • unit closure due to high levels of activity requiring obstetrician input • Any return to theatre for obstetrics • Team debrief requested • If requested to do so		Local guidance Maternity escalation policy SOP 12A Consultant roles and responsibilities Consultant rotas Clinical Guidelines; - C10 Sepsis in the maternity setting - C12 Early recognition and response to	1. Develop a monthly monitoring process 2. Quarterly reporting process to maternity governance, TB, maternity champions, LMNS	**CDS medical lead**	**From 29.07.2022** Maternity incentive scheme year 4 target)	

Report key messages	Fully, partially or non-compliant	Evidence	Action plan	Lead person responsible	Target date	Date / Evidence of completion
• Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary • Caesarean birth for major placenta praevia / abnormally invasive placenta • Caesarean birth for women with a BMI >50 Caesarean birth • <28/40 Premature twins (<30/40) • 4th degree perineal tear repair • Unexpected intrapartum stillbirth • Eclampsia Maternal collapse e.g septic shock, massive abruption • PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated		acutely ill obstetric patient - A10 Placenta previa - A7 Maternal obesity - A9 Multiple pregnancy - B14 3rd/4th degree tears - C8 Post partum haemorrhage - B10 Pre term rupture of membranes and pre term labour - B13 Management of Intra uterine Death				
Situations in which the consultant must ATTEND unless the most senior doctor present has documented evidence as being signed off as competent. In these		<u>Local Guidance</u> SOP 12D- Roles and Responsibilities of the senior registrar	1. Develop a monthly monitoring process 2. Quarterly reporting process to maternity	**CDS medical lead**	**29.07.2022**	

Report key messages	Fully, partially or non-compliant	Evidence	Action plan	Lead person responsible	Target date	Date / Evidence of completion
situations, the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure • Any patient in obstetrics with an EBL >1.5litres and ongoing bleeding • Trial of instrumental birth • Vaginal twin birth • Caesarean birth at full dilatation • Caesarean birth for women with a BMI >40 • Caesarean birth for transverse lie • Caesarean birth at <32/40 • Vaginal breech birth • 3rd degree perineal tear repair		- C8 Post partum haemorrhage - B9 Operative vaginal delivery - A7 Maternal obesity - D8 Caesarean section - B1 Breech presentation and delivery - B10 Pre term rupture of membranes and pre term labour - B14 3rd/4th degree tears Assessment of ATSM competency or OSATS	governance, TB, maternity champions, LMNS			
Safe handovers						
1. Consultants providing on-call cover in Obstetrics and Gynaecology must ensure that they maintain their skill set post-CCT, particularly for more complex obstetric scenarios. 2. When on-call, consultants must not be engaged in other activities		Annual obstetric mandatory training attendance Consultant rotas Local Guidance Guideline 12B- SBAR handover SOP 9A CDS huddles	1. Develop quarterly audit process for signed handovers/huddles 2. Formulate business case for e- handover	**CDS Lead and Matron**	**July 2022** **Dec 2022**	

Report key messages	Fully, partially or non-compliant	Evidence	Action plan	Lead person responsible	Target date	Date / Evidence of completion
such as theatre, clinics or off-site work which could delay attendance. 3. Ward rounds and huddles are important to ensure situational awareness is maintained by the whole multidisciplinary team, appropriate plans and decisions are made regarding patient care and that women have the opportunity to receive information and ask questions. 4. Ward rounds should be conducted by consultants twice daily on labour ward, with one of these occurring in the evening. 5. Developing a standardised handover model helps improve communication and reduce omissions and errors. 6. Consultants must be involved in the care given to women who have prolonged admissions, recurrent attendances or those in whom there is not a clearly established diagnosis		Safety huddle proforma				
Trainer and supervisor						
1. Inclusive team working, positive feedback and debriefing following		Allocated educational supervisor with regular appraisal meetings	1. Ensure all new consultants attend Trust leadership development	**Obstetric CD**	**Within 1 year of appointment**	

Report key messages	Fully, partially or non-compliant	Evidence	Action plan	Lead person responsible	Target date	Date / Evidence of completion
difficult situations are key to more junior staff feeling well supported. 2. Shallow authority gradients and all members of the multidisciplinary team feeling able to escalate concerns and ask for help are key to patient safety. A "shallow" rather than a "flat" gradient is desired so that there is an understood chain of communication escalation when a response is required. 3. As well as technical proficiency, there should be an emphasis on teaching leadership and communication skills, particularly during high-pressured situations. 4. Juniors should know who is supervising them and how to contact them. Conversely, consultants should be aware of the level of competency of those they are supervising. 5. Mentorship, in both clinical and non-clinical skills is important at all career stages, but particularly for new consultants.		Assigned college tutor Annual trainee reviews Consultant on call rota Mentorship programme for newly appointed consultants <u>Local Guidance</u> SOP 12 A Roles and responsibilities of the consultant	2. Compliance to be reviewed via appraisal 3. Annual review of trainee survey and implementation of actions as required		**Annually** **Annually**	
Risk manager						

Report key messages	Fully, partially or non-compliant	Evidence	Action plan	Lead person responsible	Target date	Date / Evidence of completion
1. O&G consultants are well placed to adopt the helicopter view required to maintain situational awareness and anticipate risk to women as well as provide a fresh pair of eyes to help decision-making and provide support. 2. Consultants should adopt an approach of active enquiry to ensure they maintain an overview of workload and potential risks in a timely manner. This is important to prevent complex situations or concerns going unrecognised particularly during periods of heightened activity.		Local Guidance SOP 12 A Roles and responsibilities of the consultant	1. Attendance at PS learning and PMRT 2. Review annual attendance via audit and at appraisal	**Obstetric CD**	**Annually** **Annually**	
Patient advocate						
1. Consultants must respect the diversity of women, their individual risks and opinions thus promoting personalised care within a standardised framework. 2. The consultant's role to investigate clinical incidents should focus on social and participative learning and systems adaptations which aim to continually improve patient experience and outcomes.		Local Guidance SOP 12 A Roles and responsibilities of the consultant Maternity governance structure and process FLO training for PS lead National guidance QIC monitoring of PCPs	1. Continue with quarterly audit processes 2. Continue to monitor consultant attendance at OMT 3. Quarterly reports form MVP 3. Annual review of maternity CQC survey and implementation of action plan in partnership with MVP	**Maternity matrons** **Clinical Educator**	**Quarterly** **Quarterly** **Quarterly** **Annually**	

Report key messages	Fully, partially or non-compliant	Evidence	Action plan	Lead person responsible	Target date	Date / Evidence of completion
		Human factor training within obstetric mandatory training Quarterly reports form Maternity Voices Partnership (MVP) Annual Care Quality Commission (CQC) maternity survey				
Innovator						
1. Consultants are experienced clinicians, skilled in anticipating and managing risk and listening to and learning from women. They hold a unique position in being able to evaluate the care given to women and find new and innovative ways of working to develop services and improve patient care and experience. 2. Consultants should engage junior colleagues and the wider multidisciplinary team to initiate and embed improvements. 3. Innovation also requires consultants to regularly reflect upon their own practice and to support		<u>Local Guidance</u> SOP 12 A Roles and responsibilities of the consultant Maternity governance structure and process SOP 12D Roles and responsibilities of the senior registrar Educational supervisor regular meetings Clinical audit	Ensure trainee attendance at PS learning and PMRT meetings Ensure trainee participation in clinical audits	**Educational Supervisors**	**Ongoing**	

Report key messages	Fully, partially or non-compliant	Evidence	Action plan	Lead person responsible	Target date	Date / Evidence of completion
junior colleagues to develop their reflective practice skills.						
Adequate staffing						
1. Levels of activity have been recognised as an important determinant of patient safety. While inadequate activity may hamper training opportunities and hence the ability to maintain technical proficiency, excessive levels of activity may increase likelihood of errors or impair patient experience. 2 If organisations wish to deliver resident obstetric cover, they must recognise the need to increase staff numbers to ensure that such roles enable individuals to fulfil their career aspirations while meeting the needs of the service. 3. Workforce models need to recognise that many consultants are now expressing a wish to work fewer than 10 PA job plans and factor this into future predictions for required workforce numbers.		Maternity escalation policy Increased consultant establishment Awaiting new RCOG staffing tool to enable medical staffing assessment against clinical activity 4 part time consultants in post Flexible job planning	1. Review and implementation of medical staffing assessment tool when available	**Obstetric CD**	**Autumn 2022**	

Report key messages	Fully, partially or non-compliant	Evidence	Action plan	Lead person responsible	Target date	Date / Evidence of completion
Compensatory rest						
1. There is a need for compensatory rest for consultants following overnight on-calls. This is to protect women the following day because fatigue and tiredness following a busy night on call can affect performance and decision making. It is therefore not recommended that the decision to take rest is left to the individual consultant. 2. If consultants are required to 'act down' during on-call shifts, it is essential that they have compensatory rest the following day and are appropriately remunerated		12 hours shifts in place with compensatory rest day following All instances of `acting down` recorded on rota with compensatory rest day Consultant rotas Job plans				
Job planning						
1. There is a growing need to adopt a new approach to consultant job planning which recognises the need for flexible working patterns in order to improve sustainability and workforce recruitment and retention at all career stages. 2. Organisations should consider facilitating sabbaticals for consultants to address burnout and		Flexible job planning in place Patient safety and governance lead with allocated Pas Secretarial support in place	1. Continue with annual review of job plans	**Obstetric CD**	**Annually**	

Report key messages	Fully, partially or non-compliant	Evidence	Action plan	Lead person responsible	Target date	Date / Evidence of completion
to support professional development and skills acquisition. 3. Organisations must allow adequate time and resources to support consultants in investigating adverse incidents and consequent improvement activity. 4. Organisations must dedicate adequate time, resources and support for consultants undertaking leadership roles to ensure adequate staff and patient engagement when developing services. 5. Organisations must recognise the need for adequate admin time to support clinical activities.						
Continuing professional development						
1. Organisations must ensure adequate SPA time is included in job plans so that consultants can maintain and develop their skillsets		SPAs allocated within job planning				
Conflict with scheduled activities						
1. It is recommended that maternity units have a separate multi-professional team to provide elective caesarean births rather than relying		Separate elective list in place Plan to increase weekly sessions	1. Implementation and staffing of extra elective LSCS lists once agreed	**Obstetric CD**	**Summer 2022**	

Report key messages	Fully, partially or non-compliant	Evidence	Action plan	Lead person responsible	Target date	Date / Evidence of completion
on those on-call for labour ward to provide this service.						
Prioritising wellbeing						
1. Organisations need to recognise the potential for work-related trauma in Obstetrics and Gynaecology and ensure adequate support and pastoral care are provided to consultants and other doctors. 2. Social spaces where staff can learn, reflect, get to know their team and debrief after difficult events are essential. 3. Schwartz Rounds and Balint Groups are examples of how teams can reflect together to strengthen team working and develop empathy.		<u>Local Guidance</u> SOP 12F- Obstetric consultant peer and mentorship support Communal rest spaces available and utilised Trust Schwartz round process in place	1. Embed peer and mentorship process with consultant team	**Obstetric CD**	**2022**	

Implementation of Monthly Monitoring of Consultant attendance

Action Plan

Action	Person responsible	Timescale
Formulate database for collection of data	**CDS Lead**	**June 2022**
Liaise with data analyst to supply information monthly from MIS where possible	**CDS Lead**	**June 2022**
Information regarding attendance at other identified situations: • High levels of clinical activity- datix and escalation database • Return to theatre- datix and case review • Team debrief- debrief proformas • Critical deterioration/transfer to HDU/ICU- datix and case review	**CDS Lead**	**June 2022**
Formulate a template for a quarterly report to MSEQC group	**CDS Lead**	**June 2022**
Add quarterly report onto maternity report to QAC, Maternity champions and LMNS	**HOM**	**From 29.07.2022**

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 JULY 2022			
Risk appetite			**AGENDA ITEM: 17** **ENC 14**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	To ask the Board of Directors to discuss and approve for adoption a Risk Appetite Statement following recommendation by the Board Sub Committees.		
Background	The purpose of a Risk Appetite Statement is to articulate what risks the Board is willing or unwilling to take in order to achieve the Trust's strategic objectives. The Board commissioned the Board Sub Committees to develop the Trust risk appetite statements relevant to their areas and these are being recommended to Board. In drafting the Trust's risk appetite across defined areas of strategic risk, reference has been made to the Good Governance Institute's Risk Appetite for NHS Organisations Matrix.		
Assessment	At a recent Board development session, the Board considered the guidance in relation to developing a risk appetite for the Trust and agreed that the Good Governance Institute Risk Appetite for NHS Organisations Matrix should be used. It was further agreed that each of the Board Sub Committee should consider their risk appetite and make a recommendation to the Board. The attached report sets out a recommendation using the guidance for a risk appetite statement for the Strategic Objective and Principal Risks for the Quality Assurance Committee, People Committee and Resource Committee. Two further risk appetite statements which relate to objectives which reside directly with the Board are being presented for discussion and approval if appropriate.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to approve the Trust risk appetite statements recommended from Board Sub Committees		

	and consider the two additional statements and if appropriate approve.	
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 ☒	

Trust Risk Appetite Statements

1. Introduction

Risk is inherent in the provision of healthcare and its services. It is necessary for the Trust to understand and agree the level of risk that it is willing to accept to achieve its strategic objectives.

The purpose of a Risk Appetite Statement is to articulate what risks the Board is willing or unwilling to take in order to achieve the Trust's strategic objectives.

In setting out its approach to and appetite for risk within a Risk Appetite Statement, the Board is defining its strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds.

A Risk Appetite Statement that is clearly articulated by the Board and appropriately communicated to staff adds value by:

- Supporting decision making
- Providing clarity over the risks you are willing to take
- Potentially, supporting effective use of resources, ie by prioritising risks

Articulation of the Board's appetite for risk feeds into the Trust's wider risk management process.

2. Background

Well Led guidance, published by NHS Improvement, references regular review of the Board's risk appetite and tolerance as part of evidence that there are clear and effective processes for managing risks, issues and performance (KLOE 5).

The Trust's current Risk Management Policy states:

"Risk appetite is the type and amount of risk that the Trust is prepared to tolerate and explain in the context of its strategy."

There are no other references to risk appetite either in the policy or in supporting guidance documents to define the Trust's level of risk appetite or to provide guidance on how to use the Trust's risk appetite in reviewing risks.

The Board commissioned the Board Sub Committees to consider and produce a risk appetite statement relevant to their area. Over May and June the Board Sub Committees have considered examples of risk appetite statements, noting a range of approaches and detail.

Following consultation draft Risk Appetite Statements were agreed and are recommended to Board for approval.

3. Draft Risk Appetite Statement

3.1 General Principles

Methods of controlling risks must be balanced. The Trust may accept some high risks either because of the cost of controlling them, or to deliver innovation or use resources creatively when this may achieve substantial benefit.

As a general principle the Trust has a low tolerance for, and will therefore seek to control, all risks which have the potential to:

- Expose patients, staff, visitors and other stakeholders to harm
- Compromise the Trust's ability to deliver operational services
- Adversely impact the reputation of the Trust
- Have severe financial consequences which may impact on the Trust's future viability
- Cause non-compliance with law and regulation.

3.2 Risk Appetite Definitions

Definitions for levels of risk appetite are set out in table 1, below.

These have been adopted from the Good Governance Institute's Risk Appetite for NHS Organisations Matrix2 (Appendix A).

Risk Levels (consequence)	
AVOID	Avoidance of risk and uncertainty is a key organisational objective ALARP (As little as reasonably possible)
MINIMAL	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
CAUTIOUS	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
OPEN	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and Value for Money (VfM)
SEEK	Eager to be innovative and choose options offering potentially higher business rewards despite greater inherent risk
MATURE	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

3.3 Risk Appetite Statement by Areas of Strategic Objective

Strategic Objective - A great place to work	
Principal Risk - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain	
	Risk Level
	MINIMAL
• There are few circumstances where we would accept risks that would impact on the achievement of our Strategic objective to be a great place to work. • We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients, or contradict our Trust Values.	

Strategic Objective - Best for safe, clinically effective care and experience	
Principal Risk - 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	
	Risk Level
	MINIMAL
• We will seek to minimise avoidable risks to patient safety in the delivery of quality care and have a very low appetite for risk in this area. • We will accept risks to the experience of people using services, their relatives and carers if they are consistent with the ultimate goal of achieving patient safety and quality improvements. • We will only accept service redesign and divestment risks in the services we are commissioned to deliver if these are assessed as safe and effective, whilst high quality care is maintained. • We will provide high quality services to our patients and not accept risks that could limit our ability to fulfil this objective. This key value is a driver that directly supports our core objective to be best for safe, clinically effective care and experience • We will tolerate moderate levels of risk when evidence-based assessment is not always available, provided that this does not result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.	

Strategic Objective - Make best use of our resources	
Principal Risks - Inability to agree financial recovery plan with the regulator; Failure to deliver the Trust's financial recovery plan	
	Risk Level

	MINIMAL
• We will deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care and will have a plan to address the financial consequences. • We will ensure that all such financial responses deliver optimal value for money.	

3.4 Risk Appetite Statement by Strategic Objective retained by the Board

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	
Principal Risk - Failure to deliver as a centre of excellence, resulting in a lack of priority and recognition from commissioners and other stakeholders	
	Risk Level
	OPEN
• The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. • The Trust will not, however, compromise patient safety while innovating service delivery • We will continue to conduct our research within relevant governance frameworks.	

Strategic Objective - Deliver care without boundaries in collaboration with our health and social care partners	
Principal Risk - Working more closely with local health and care partners does not fully deliver the required benefits	
	Risk Level
	OPEN
• We are prepared, to take moderate levels of risks with in order to do the right thing in delivering the services we are responsible for to the population we serve. • The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. • We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	

4 Recommendation

The Board of Directors is asked to approve the Risk Appetite Statements as set out above.

Jackie White
Head of Governance & Company Secretary

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 JULY 2022			
Trust Improvement Plan Refresh for 2022/23			**AGENDA ITEM: 18** **ENC 15**
Report Author and Job Title:	Lucy Tulloch Deputy Director Strategy & Planning	**Responsible Director:**	Rob Harrison Managing Director
Action Required	Approve ☒ Discuss ☐ Inform ☐		
Situation	The Trust Improvement Plan is refreshed at the midpoint of our two-year plan to drive our clinically-led recovery.		
Background	Since the autumn of 2019, the Trust has been empowering its clinicians to take the decisions about how the organisation manage its resources and delivers care across our hospitals and services – supported by our scientific teams, administrative, support staff and volunteers. At the start of 2020 the Trust developed its initial improvement plan and formed the organisation's Clinical Policy Group which, in 2021 created 10 Clinical Collaboratives – natural care communities of surgeons, physicians, nurses, midwives, scientists, allied health professionals and administrative and support services – which have come together to make their services even better for our patients and services. This clinically-led approach has been at the heart of the Trust's response to COVID-19 and the overriding goal set by our experienced clinicians during the pandemic to help keep colleagues, patients and service users safe. The Trust's improvement plan was refreshed in 2021 and approved by Board of Directors in July 2021 with significant focus on supporting services' resilience to the challenges of COVID-19 and recovery from the impacts of the pandemic. During March-June 2022 the improvement plan has been refreshed and agreed by the Clinical Policy Group to ensure that it reflects the progress made over the last twelve months and key challenges over the coming year.		
Assessment	The Improvement Plan sets out our vision for a clinically-led organisation that puts safety and quality first. It is delivered through nine enabling strategies. The Plan sets out our priorities to Support, Sustain and Connect our services.		

	Support - support for clinical specialties which require additional assistance as part of COVID-19 recovery, and a focus on cross-cutting areas and themes. **Sustain** – continued focus on sustainability through the development of tertiary and specialist, care closer to home and growing the Friarage Hospital. The content is updated to reflect progress made. **Connect** - connecting our services, working collaboratively and making an impact regionally is the third layer of the plan, and the Trust is engaged in the changing landscape of Integrated Care Boards and provider collaboratives across our two integrated care systems. Enabling Strategies - the enabling strategies have updated to reflect progress and current priorities, but are consistent with the direction of travel set out in 2021.	
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐	
Recommendation	Members of the Trust Board are asked to approve the updated Trust Improvement Plan.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The enabling Strategies mitigate risks across all domains of the BAF. The Improvement Plan specifically mitigates the threat *Lack of a clear vision for the improvement journey…leading to a failure to deliver sustainable change and the improvements required.*	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper. Note that tackling health inequalities with evidence-based measures and interventions to empower and improve population health, is one of four patient-centred outcomes of the clinical strategy.	
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 ☒	

July 2022

South Tees Hospitals
NHS Foundation Trust

Trust Improvement Plan

Mid-point Review 2022

Safety and Quality First

Foreword

This is our plan to continue on our improvement journey as we recover from COVID-19 in the singular interest of our patients and service users. All our teams are a part of this journey and help to lead and engage in the changes that will sustain and develop out services to the benefit of our patients, service users and colleagues.

We have some of the most talented and experienced surgeons, physicians, nurses and other clinicians in the country, but a report published by the Care Quality Commission in July 2019 found that too many did not always feel properly involved in discussions about changes to our services.

Since the autumn of 2019, the trust has undergone a number of significant changes. We are now empowering our clinicians to take the decisions about how we manage our resources and deliver care across our hospitals and services. This clinically-led approach has been at the heart of the way we have responded to the COVID-19.

Since the start of the pandemic began our clinicians have provided care for more than 7,000 patients with COVID-19.

Treating over 7,000 patients with COVID-19 has inevitably had an impact but the measures our experienced clinicians took at the start of the pandemic to separate our hospitals into COVID and non-COVID areas has meant colleagues have been able to continue caring for patients with other health needs that are equally urgent, while working tirelessly for people whose non-urgent care was disrupted by the pandemic.

In addition, new service models have been put in place to enhance same day emergency care, and emergency care for children.

Separately, our significant contribution to the COVID-19 research effort has been a mark of our determination to remain at the forefront of clinical research as a driver of safe, quality care.

Our experienced clinicians have also invested more than £15million in new and replacement medical equipment over the last year. At the same time, almost £17million has been invested in building developments, upgrades and refurbishments at The James Cook University Hospital in Middlesbrough, and £5 million in a new endoscopy and urology diagnostic hub at the Friarage Hospital in Northallerton which is due to open in 2022/23.

More than £8 million is also being invested in new clinical digital tools which will end our clinicians' reliance on paper-based record keeping.

As we continue our clinically-led recovery from COVID-19, we are delivering our Improvement Plan as partners in the wider North East and North Yorkshire health and care system – shaped around Integrated Care Boards with statutory responsibility for resource allocation, performance, patient access and health outcomes across region.

Contents

Summary

Safety and Quality First

Introduction

The clinically-led Improvement Plan for South Tees Hospitals NHS Foundation Trust covers a two-year period from April 2021 to March 2023. It builds upon the original Improvement Plan set out in February 2020 and is refreshed at Q4 2021/22 to reflect progress made and new challenges for the second year as we continue our clinically-led COVID-19 recovery.

The trust's clinically-led strategy is delivered through ten clinical collaboratives, under-pinned by nine enabling strategies and plans, which span clinical and corporate functions.

The Improvement Plan integrates the trust strategy with operational and transformational plans. It sets out delivery plans for 2022/23 alongside how improvements will be measured.

The objectives for 2021-2023 are set out in the Improvement Plan. The plan has been updated to reflect our ongoing response to the pandemic and 'learning to live with' COVID-19. The first phase of the plan focuses on services and areas receiving extra support; and the steps we need to take together to make things easier for patients who are ready to leave hospital, and those who are waiting to come in.

The second phase of the plan centres on the things we have agreed to do together in our community services to support colleagues to help more patients receive the care they need closer to home; how we will continue to grow the range of elective services available at the Friarage; and how we enable our world-class tertiary and specialist services to flourish and thrive at James Cook.

The third phase of the plan will increasingly come to the fore as system-level working, investment, performance, and population health management are mandated. We will contribute to the delivery of more joined-up care which ensures:

- **Quality:** good access to sustainable specialty care
- **Workforce:** stronger and more resilient teams
- **Sustainability:** a firm footing for the long term
- **Health inequalities:** evidence-based measures and interventions to empower and improve population health

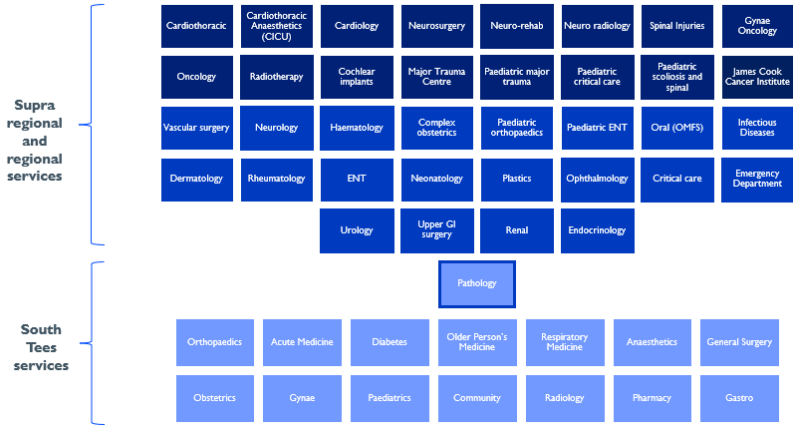
Underpinning the Improvement Plan is an ongoing programme of leadership development and continuous improvement that continues to supports team to put safety and quality first.

A summary plan on a page is set out on page 9, followed by the enabling strategies and delivery plans.

Context

Excellent NHS services are important to the more than 1.5 million patients, service users, carers and families in the Tees Valley, North Yorkshire and beyond who depend and rely on the services we provide and to everyone who works at South Tees NHS Hospitals Foundation Trust.

The Trust is an anchor tertiary provider and our major trauma centre sees half of all trauma cases in the North East and North Cumbria.



Since October 2019, the Trust has been empowering its clinicians to make the decisions around how we allocate our resources and deliver care.

We have done this through our Clinical Policy Group (CPG) which draws its membership from our clinical directors, nursing and allied health professional leaders, chief medical officer, executive team, operational managers, chairs of staff-side, our senior medical staff forum, and our British Medical Association representative.

The CPG has created ten clinically-led Collaboratives - natural care communities of surgeons, physicians, nurses, midwives, scientists, allied health professionals and administrative and support colleagues, which have come together to make their services even better for our patients and service users. At the heart of our Collaboratives is our Leadership Improvement and Safety Academy which encompasses our patient safety faculty and provides a range of support, including leadership and management training, quality improvement skills, team and service support, coaching and human factors training.

Our mission is to put safety and quality first for our patients, service users and each other - underpinned by our values: respectful, supportive and caring.

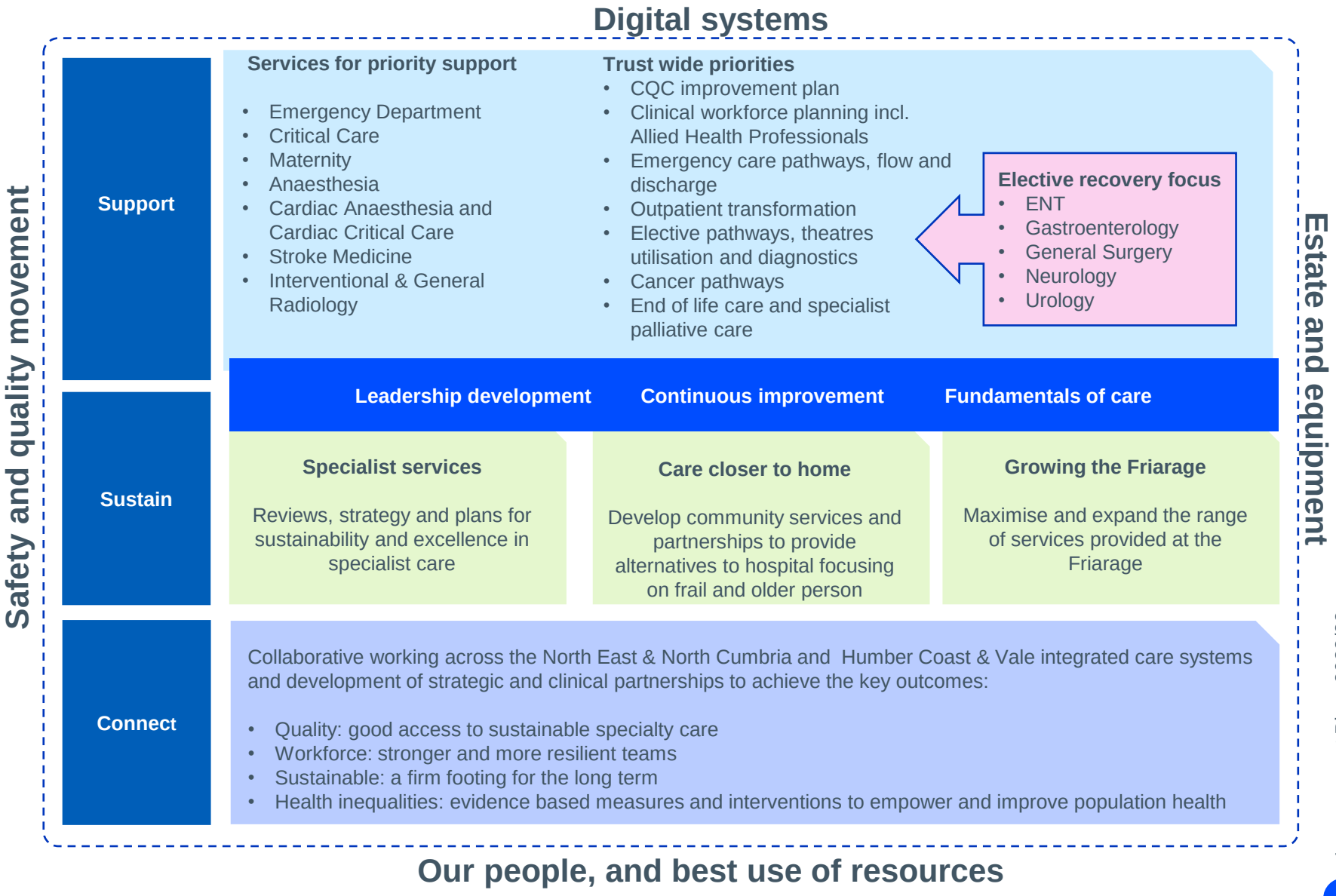
In response to the 2021/22 national planning guidance, our Collaboratives have developed plans for our continued recovery from COVID-19, realigning how resources and estate are managed across all our hospital sites and community services.

An assurance structure of connecting groups is in place to deliver our recovery plans and the long-term clinical strategy. Operational groups guide and deliver clinically-led change and are accountable to the CPG which oversees the delivery of our Improvement Plan.

Our Strategy

The Trust will serve its patients, service users, colleagues and population by putting safety and quality at the heart of what we do.

Improvement Plan 2022/23



Clinical Collaboratives

In order to strengthen our clinical leadership we have organised our services into 10 Clinical Collaboratives supported by a Clinical Policy Group (CPG)

Neurosciences and Spinal Care Services

- Neurosurgery
- Neurology
- Spinal
- Neuro-rehab
- Pain
- Sleep
- Stroke
- Neuroradiology
- SCI
- Back pain services
- Disablement Services
- Neurophysiology
- Neuro HDU

Cardiothoracic & Vascular Care Services

- Cardiothoracic Surgery
- Cardiothoracic Anaesthesia
- Cardiothoracic Critical Care
- Cardiothoracic Theatres
- Cardiology
- Cardiac Catheterisation Laboratories
- Vascular Surgery

James Cook Cancer Institute and Speciality Medicine Services

- Radiotherapy and Clinical Oncology
- Oncology Day Unit
- Medical Oncology Day Unit JCUH
- SROMC Friarage
- Specialist Palliative care
- Haematology
- Haematology Day Unit JCUH
- Renal
- Renal Day Units
- Rheumatology

Head & Neck, Orthopaedic and Reconstructive Services

- ENT and Audiology
- Cochlear Implant Service
- OMFS and Orthodontics
- Plastic Surgery
- Trauma and Orthopaedics
- Dermatology
- Ophthalmology and Orthoptics

Women and Childrens

- Obstetrics
- Midwifery Led Unit JCUH
- Gynaecology
- Paediatrics
- Neonatology
- Midwifery Led Unit FHN
- Paediatric Outpatients FHN
- Specialist Community Children's Service
- Community Midwives

Growing the Friarage and Community Services

- Friarage Medical services
- Friarage Site Management
- Friarage Outpatients
- Friarage UTC
- Oversight of Friarage Strategic Developments
- H&R Community
- Friary Hospital
- Rutson Ward
- Middlesbrough Community Services
- Redcar and Cleveland Community Services
- Redcar and Cleveland Primary Care Hospitals

Digestive Diseases, Urology and General Surgery Services

- Urology
- Gastroenterology
- General Surgery
- Upper GI
- Lower GI
- Endocrine
- Breast Surgery
- Emergency General Surgery

Medicine and Emergency Care Services

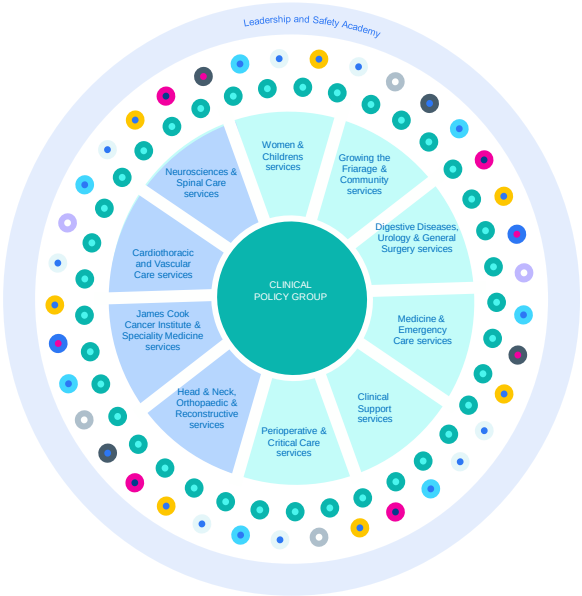
- Acute Medicine
- Diabetes and Endocrinology
- Respiratory Medicine
- Older Peoples Medicine
- Infectious Diseases Medicine
- Emergency Medicine
- JCUH Adult Emergency Department
- JCUH Paediatric ED
- Redcar UTC
- Professional Oversight of Friarage UTC

Perioperative and Critical Care Medicine Services

- Critical Care Medicine
- Anaesthetics
- Theatres JCUH
- Theatres FHN
- Pre-assessment
- Pre-habilitation
- PACU

Clinical Support Services

- Radiology
- Pharmacy
- Pathology Services
- Medical Physics
- Therapy Professional Leadership
- Patient Flow
- Patient Transport
- Phlebotomy
- SPOR
- Complex Discharges
- Bed Bureau
- Discharge Lounge



Enabling Strategies Overview

The Trust Strategy and its Improvement Plan will be delivered through nine enabling strategies and plans.

Clinical Strategy

Safety and Quality First

Clinical Strategy Overview

The Improvement Plan is set out in three concurrent phases, Support, Sustain and Connect which set out the direction of travel of the Clinical Strategy.

Some of our services are still recovering from the impact of the pandemic, and all must manage its continuing impact, whilst others are able to move beyond to strive for and deliver excellence.

The Support phase focuses on services receiving additional pandemic recovery support, our key operational priorities, ensuring colleagues' wellbeing, achieving CQC compliance and to embed our programme of leadership development and continuous improvement in safety and quality.

The Sustain phase seeks to enable specialist services to thrive and grow on the James Cook Hospital site, expand elective services delivered at the Friarage Hospital and develop integrated community services to support timely discharge and admission avoidance.

The Connect phase seeks to work with partners to place services in the Tees Valley and North Yorkshire on a sustainable footing for the long term by ensuring good access for our populations and joined-up care. This will be delivered by stronger and more resilient teams that attract the specialist workforce of today and the future.

We have set four patient-centred outcomes against which closer working can be measured:

Quality: good access to sustainable specialty care

Workforce: stronger and more resilient teams

Sustainability: a firm footing for the long term

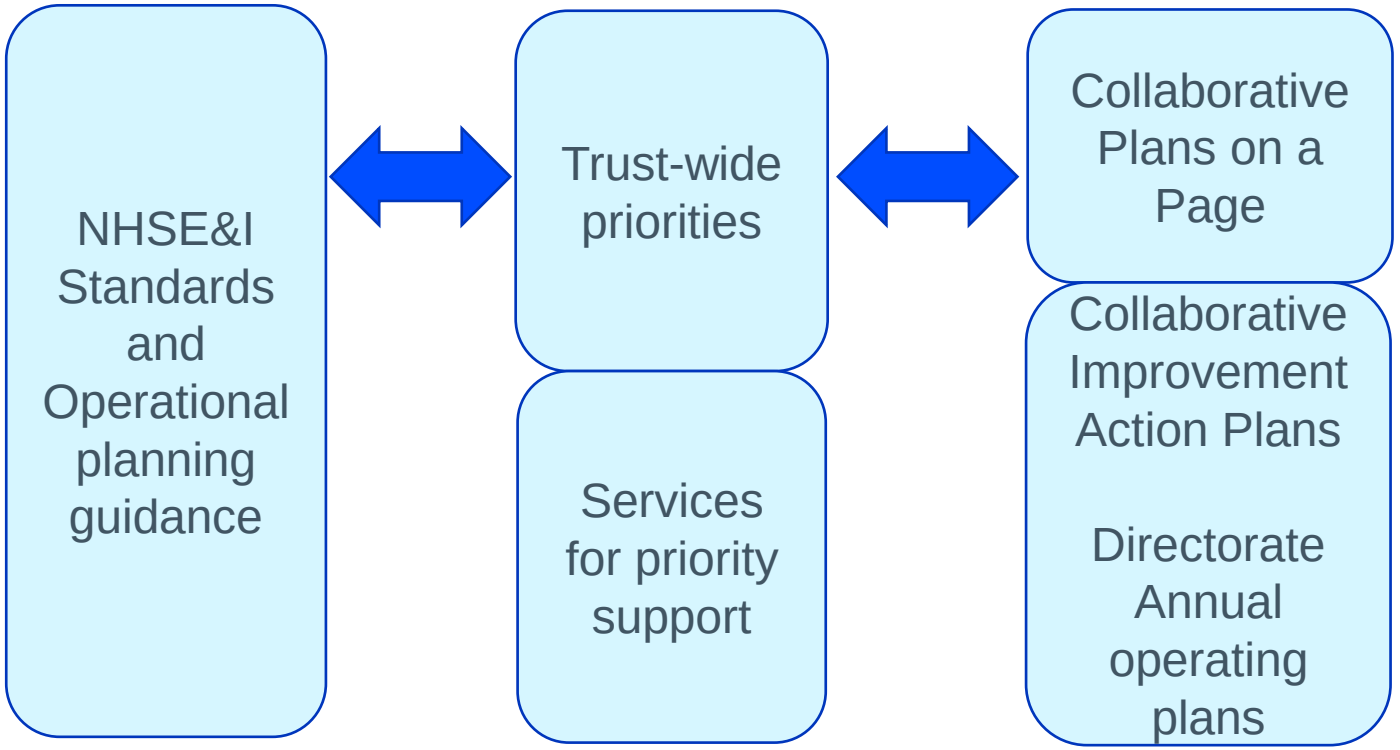
Health inequalities: evidence-based measures and interventions to empower and improve population health

Underpinning each phase of our plan is our social movement to continue putting safety and quality first.

Collaborative leadership teams will work to deliver their improvement plans, and provide assurance of performance, governance and progress towards their milestones in the context of these themes and priorities.

Developing the Clinical Strategy

The Trust Improvement Plan clinical strategy has been developed in an iterative approach, integrating the national operational planning guidance priorities with the priorities of the directorates in response to their specific vision, risks and requirements. This has informed the Trust-wide priorities, which in turn have been triangulated back with the Collaboratives.



National priorities and standards

The Trust Improvement Plan supports delivery of the NHSE&I operational planning guidance priorities and Single Oversight Framework standards for 2022/23.

Urgent care:

- Eliminate 12-hour waits for admission from the Emergency Department
- Minimise ambulance handover delays
- Develop and maximise use of Urgent Treatment Centres, virtual wards, and community crisis response and anticipatory care

Elective care:

- Deliver 2019/20 activity levels plus 10% at system level
- Eliminate 104 week waits, and then 78 week waits for referral to treatment
- Reduce 52 week waits for referral to treatment

Cancer pathways:

- Deliver national standards for referral to first appointment, to diagnosis and to treatment
- Adopt new best practice pathways such as targeted lung health checks

Outpatient services:

- Reduce outpatient follow-up appointments by 25% to ensure that capacity is used most effectively
- Implement patient-initiated follow-up or all major specialties, increasing to 5% of attendances result in a patient-initiated follow-up pathway
- With primary care, maximise use of advice and guidance

Diagnostics:

Deliver 120% of 2019/20 activity at system level

System sustainability:

Develop digital roadmap and investment plans within system networks such as pathology

Integrated Care Board planning, delivery and service configuration

System financial sustainability

Support

All our services are engaging in continued improvement in safety, quality, performance and use of resources. Targeted support for elective recovery will be provided for theatres booking, outpatient transformation, and cancer pathways.

Our original 'Stabilise' phase specialties for focused support. The updated list reflects the our COVID-19 recovery and national areas of focus

Services for priority support	Pressures and opportunities	Support and oversight
Emergency Department	Workforce. Estate. Models of care. ECIST action plan.	Emergency Care Intensive Support Team (ECIST) Emergency Care Improvement Group
Critical Care	Workforce. Staff support ethos and well-being. Capacity and estate.	STRIVE; business case for increased capacity submitted to system; Trust-wide Critical Care Strategy Group
Peri-Operative Care	Workforce. Estate.	Surgical Improvement Group; theatre bookings and clinical productivity projects; Theatre 27 and pre-assessment estate; FHN theatres replacement business case; JCUH PACU investment
Cardiothoracic Anaesthesia & Critical Care	Workforce. Estate	Refurbishment of Cardiac Intensive Care Unit; recruitment support; Trust-wide Critical Care Strategy Group
Interventional & General Radiology	Workforce and recruitment, estate, regional service	Estates and equipment investment; recruitment and outsourcing to add capacity
Stroke & Neurology Services	Consultant workforce, skill mix, hyper acute care pathway, demand and capacity, estate	Recruitment; outpatient project
Maternity	Ockenden Review Parts 1 & 2 response, staff support culture and well-being, estate	STRIVE; Maternity Services Improvement Board

Clinical Strategy - Collaborative Improvement Plans

Safety and Quality First

Neurosciences & Spinal Care Services Collaborative

Strategic focus: Support – Stroke and Neurology / Sustain – Specialist Services / Connect across the Tees Valley, North Yorkshire and beyond

Vision and Objectives

Vision To deliver excellence in tertiary care and outcomes for the population within the Tees Valley and northern region of the England.
Objectives to work across Trust borders to ensure we right size and develop workforce and resource through collaboration utilising both clinical leadership and technology to drive improvements and reduce inequalities in healthcare access.

Safety and Quality First

Achievements STACQ Gold accreditation – spinal injuries and Diamond accreditation Ward 26. Appointed patient safety ambassador for the collaborative to focus on safety and learning. Research across the collaborative reinstated. Neuro cranial GIRFT outcomes highest in UK. Focus on falls and action plan in place to reduce. Increased assurance in access and quality of specialist neuroradiology reporting.
Risks & Issues Medical and nursing cover to be reviewed in line with ward moves.
Priorities Readiness for CQC inspection. Implementation of the Spinal Injuries National transformational programme.

Workforce

Achievements Investment and recruitment across the collaborative to increase capacity and support governance and succession planning. Investment in the non-medical model of service provision. Joint working with North Tees on medical and allied health profession roles. For example, increase in specialist nurse workforce; new bladder and bowel nurse post in spinal injuries; ACP trainee pharmacy and physio in stroke; clinical sisters in Neuro HDU.
Risks & Issues Need for increased recurrent investment (Spinal surgery). Spinal specialist nurse is a single practitioner. Stroke and Neurology medical workforce, national workforce pressures.
Priorities Neurology workforce plan; Stroke workforce planning; Recruitment (Radiology); Embed admin workforce recruitment; 2 trainee ACP for stroke. Sustain and improve people KPI. Support staff by incorporating the staff sickness plan.

Operational Excellence

Compliance achieved In appraisal and training. Performance and improvement plans in place.
Risks & Issues Theatre capacity. Ongoing assured access to capacity at other providers. Stroke KPIs.
Priorities Improve RTT position for all directorates; Implement plan for Diagnostics. Explore further joint working solutions.

Sustainability

Achievements Improved outpatient activity levels to pre-COVID levels, use of remote consultation. Established 5 day intervention service and the '2 providers, 1 service' model for Neurosurgery. Developed the regional Neurosurgical and Spinal networks, and Tees Valley Spinal Service, to support capacity. Commencing OP Flexi cystoscopy service to reduce IP admission by 10 per month for spinal cord injury patients.
Risks & Issues Theatre capacity; Sleep service requires pathway changes
Recurrent funding to support Spinal Service. Stroke service strategic combined model
Priorities Achieve and identify CIP opportunities. Delivery of priority improvement projects.

Enablers and interdependencies

Neuropsychology business cases. Neurology Day Unit new location. Neurology/GP engagement to sustain and improve capacity. Development of Stroke/Neurology IP solution that right sizes capacity. ICS/B support for Spinal surgery, Neuro-rehab level 2a and level 1 investment.

Cardiothoracic & Vascular Care Services Collaborative

Strategic focus: Support – Cardiac anaesthesia; Sustain – Specialist services

Vision and Objectives

To deliver a safe, evidence based and clinically effective service for patients with all aspects of cardiothoracic and vascular disease; to work collaboratively to ensure our service is equitably available to all patients in our region

Safety and Quality First

Achievements Falls prevention; reduction in pressure ulcers; improved compliance with safety huddles and checklists; renewal of LOCSSIPS; appointment of Patient Safety Advisor to increase focus on safety and learning; achievement of Red Trauma call recognition in vascular surgery.
Priorities GPICS and ICNARC compliance; increased focus on clinical outcomes as part of Board assurance with creation of collaborative dashboard of clinical metrics; STACQ – 3 assessments to date (2 Diamond, 1 Gold - 8 to be assessed in 22/23); ongoing review of CQC self-assessment and identifying areas for improvement; GIRFT visit Cardiothoracic due in 2022. Research activity – growth in research portfolio/income and activity, appointment of clinical lecturer posts and establishment of Academic Cardiothoracic Unit

Workforce

Achievements Community Thoracic Nurse (Nursing Times award for Best Surgical Team and shortlisted for 2 other awards); Cardiothoracic Surgical Care Practitioner (SCP) team shortlisted for Society of Cardio Thoracic Surgery SCP team of the year; established vascular middle grade tier; stabilised cardiac interventional service laboratory nursing workforce.
Risks and priorities Delivery of workforce plan including: cardiothoracic anaesthesia; Staffing resilience in theatres and cardiac intensive care; stabilise elective services and on call in Cardiac Catheterisation Laboratories; echocardiographers and Community Diagnostic Centre (CDC) services; succession planning for specialist nurse roles; stabilising administration resources; implementation of staff survey plan; develop apprenticeships.

Operational Excellence

Achievements Maintained cardiothoracic surgical throughput during pandemic; recovery of elective programmes compared to comparator Trusts; improved RTT position and reduction in 52-week waiters; maintained short thoracic cancer waiting times from referral to surgery; developed an agreed model with commissioners to continue to deliver on site percutaneous mitral valve repair.
Risks and priorities Deliver planned activity targets by improved throughput and building resilience within specialist teams; data quality develop PIFU; work towards national markers of excellence in key areas e.g. waiting times for urgent cardiac surgery, carotid intervention post transient ischaemic attack and abdominal aortic aneurysm repair; respond to targeted lung health checks with increased thoracic surgery; develop joint pathways of care wqithother providers in Cardiology; offer mutual aid in Cardiothoracic Surgery; development of CDC at Redcar; develop leg ulcer service.

Sustainability

Achievements Adaptation of outpatient model through increased remote consultation, A&G, better triage; transcatheter aortic valve implantation business case approved; redesign of emergency cardiology consultant rota; creation of Diabetic Foot Unit with reduced LOS and more efficient use of consultant time.
Risks and priorities Theatre and cardiac catheterisation laboratory utilisation to improve patient access and use of resources. Diagnostic and elective validation, training and resourcing the administration target operating model. Heart failure business case; investigate Model Hospital for opportunities; sickness absence management plan; address vascular outpatient estate; re-establishing day of surgery admission; move to 'scan and plan' fistula service.

Enablers and interdependencies

Business case for replacement catheter labs, FHN Cardiology outpatient department redevelopment, refurbishment of Cardiac Intensive Care Unit; Continued input to Cardiac and Vascular Networks; Investigation of use of collective resources across STFHT and NTHFT.

James Cook Cancer Institute & Specialty Medicine Collaborative

Strategic focus: Sustain – Specialist Services / Connect across the Tees Valley, North Yorkshire and beyond

Vision and Objectives
The James Cook Cancer Institute and Speciality Medicine Collaborative (JCCISM) strives to provide safe, efficient, excellent quality services to our patients

Safety and Quality First
Achievements Research and Clinical Trails restarted post COVID. Diamond Accreditation – Chemotherapy Day Unit. CQC IRMER inspected July 2021 (Radiation Safety focused visit). Haematology Day Unit achieved myeloma (bone cancer) accreditation and Macmillan environmental Ward 33 Gold STACQ.
Risks & Issues Research sessions for consultants. Increased consultant new and urgent referrals.
Priorities Planned Macmillan Quality Environment Mark (MQEM) assessment for Ward 14. Review clinic templates to create capacity for new patients. Readiness for CQC inspection. New Linear Accelerator installed April 2022 for patient use from June 2022

Workforce
Achievements Radiographer Apprenticeships, Advanced Care Practitioners and Renal Psychologist appointed. Renal dialysis centre at FHN now open 6 days per week. Supporting and developing administrative staff including STAR award recognition. Recruited to all substantive consultant posts across Collaborative.
Risks & Issues Therapeutic Radiographer workforce. Increased workload for Haematology consultants in relation to new and urgent referrals. Recruitment and retention of administrative staff.
Priorities Recruit permanent Ward 14 Manager. Review Therapeutic Radiographer Workforce. Succession planning for all clinical staff groups. ACP or B7 radiographer from Dexa.

Operational Excellence
Risks & Issues Increase in referrals and complexity of patients in Radiotherapy, Oncology and Haematology. Capital replacement of LINAC and other large equipment replacement programme rerquirements.
Priorities Continue to work towards the National Cancer Waiting Time (CWT) standards. Regional Oncology Review and implementation of outcome (led by Northern Cancer Network). Integration with Haematology Service. Increased numbers for home haemodialysis.

Sustainability
Achievements New bone densitometry scanner in Rheumatology. New Radiotherapy Treatment machine (LINAC) installed,. Refurbishment of Renal Day Unit completed.
Risks & Issues Clinical equipment of life span.
Priorities Continue to review service level resources (staff, estate, budget) to ensure all fully utilised. Capital Equipment Replacement programme.
Cost Improvement Plan delivery: Review staffing budget to ensure budget is being fully utilised; Renal fluids contract.

Enablers and interdependencies
Oncology SDEC (7 Days service) Business Case. Acute Oncology Service (AOS) to be reviewed in line with Oncology SDEC Business Case. Digital systems: ChemoCare Version 6 upgrade. Estates review of Oncology Department Main site and create improvement plan. Renal Home Dialysis Business Case – Request for additional dialysis machines and additional nursing support. New admin training framework for new and existing colleagues.

Head & Neck, Orthopaedic & Reconstructive Surgery Collaborative

Strategic focus: Support - ENT / Sustain – Growing the Friarage / Connect across the Tees Valley, North Yorkshire and beyond

Vision and Objectives
To deliver excellence in patient care and outcomes across all the pathways of care.

Safety and Quality First
Achievements 21/22 – STACQ achievements (3 x diamond), focus on reduction in pressure ulcers across the collaborative, robust action plans to focus on priorities highlighted in CQC self-assessments

Priorities 22/23 – Review of all outstanding GIRFT actions, focus on supporting remaining wards and departments for STACQ accreditation, re-focus on improving outcomes for hip fracture patients.

Workforce
Achievements 21/22 – Workforce people plan in progress with a focus on reviewing workforce models across Directorates, recruitment planning for key Consultant posts and supporting nursing infrastructure. Improved trajectories in appraisals, training and sickness levels

Priorities 22/23- Focus on recruiting to support future workforce models, ensure the Collaborative embeds a team based approach to learning and service improvement. MSK service review to ensure we have the right operating model and one service across the region.

Operational Excellence
Achievements 21/22 – Recovery of elective programme (no 104 week waits at March 22), 15% improvement in the RTT position in Orthopaedics and plastic surgery.

Priorities 22/23 – ENT and audiology are the main priorities with an overarching focus on achieving no 52 week waiters across all the Collaborative by March 2023, Improved performance in head and neck cancer pathway, improving access for SDEC pathways, embedding 6-4-2 process robustly across the Collaborative. Focus on improved coding to reflect work undertaken.

Sustainability
Achievements 21/22 – utilised resources to best effect to support orthopaedic elective pathway, supported plastics and dermatology in securing a new operational base

Priorities 22/23 – plans to streamline elective orthopaedic ward and hip fracture ward to release 15 beds as part of the Collaborative CIP efficiencies, reducing demands into the services (triage, A&G, PIFU pathways) to support the recovery and longer term sustainability of demand for services.

Enablers and interdependencies
Business cases – Mako robot for Orthopaedics, Cochlear Implant business case
Interdependencies – Breast cancer pathway, Maximising Friarage theatres and Outpatient facilities, working across the region to utilise resources to best effect.

Women & Children's Services Collaborative

Strategic focus: Support – Maternity Services – see Maternity slide; Specialist services - Neonatology

Vision and Objectives

Service is committed to delivering safe, high quality, compassionate and effective care. We put our patients at the centre of their care and decision making, ensuring that our services are inclusive and accessible to all, whilst being tailored to each individual. Striving to be leaders and advocates in the pursuit of excellence in women's and children and young peoples' health

Safety and Quality First

Achievements Focus on patient quality and safety data and reflections. Telephone triage has been introduced for acute paediatric pathways, corporate branding for CYP across Trust, enhancement of research activity in paediatric services. Hospital STAQC achieved at Children's Hub FHN and Ward 21.

Priorities -Meet Ockendon standards STACQ accreditation GIRFT compliance . BSGE Endometriosis Centre accreditation . Move towards Colposcopy Centre of excellence Maternity & Neonatal Safety Champions development CNST and Perinatal Mortality Review Tool use for Child Death Reviews. Action plan for exceptions on National Neonatal Audit Programme. LOCSSIPs developed for intubation, long line insertion, and NG tube insertion. Neonatology GIRFT Deep Dive action plan and STACQ assessment. Progressing with improvements for CYP with additional needs working with service users and staff. Plan for accreditations in UNICEF breast feeding standards, autism friendly.

Workforce

Achievements Recruitment of 2 Urogynaecology consultants, a Lead colposcopist,1.6 Gynaecologists, 2 Obstetricians Review of Gynaecology nursing and HCA staff in the gynaecology outpatient to meet compliance with national recommendations. Collaborative Staff and patient experience council – well being coordinators. Development of the Professional Nurse Advocate (PNA) role to provide restorative supervision . Transition nurse , ANP development culture action plans

Priorities Succession planning . SDRs and consultant appraisals targets . civility training. Staff wellbeing. Development of bereavement services. Development of ACP roles.

Operational Excellence

Achievements - Achievement of National Standards Archive access targets

Risks & Issues Gynae oncology resilience, Staffing, Infrastructure

Enablers and interdependencies

Estate, Successful recruitment, Development of Regional Oncology pathway, New ways of working- ACP development

W&C Collaborative – Maternity Services

Strategic focus: Support – Maternity Services

Vision
To provide safe, effective and responsive Midwifery care in partnership with women and their families.

Safety and Quality First
Achievements
Achieved all 10 Maternity Incentive Scheme safety action s , Year 3 (2020-2021)
New maternity governance structure and process launched February 2022 which incorporates monthly safety & quality meetings and clear process for escalation. Structure in place for review of all complaints /PALS. Structure in place to share the learning from incidents and complaints. Maternity Safety Champions walkabout monthly by Non Executive Director and Chief Nurse. Senior maternity staff trained as Family Liaison Officers. Cultural Action Plan implemented which includes team building work and behaviours framework. Implementation of BSOS Triage. All baby deaths reviewed using National Perinatal Mortality Review Tool with external peer review.

Priorities
STACQ assessment preparation relaunched post pandemic.
GIRFT submission is underway.
Ockenden recommendations implemented and a robust action plan in place to ensure assurance is provided.

Workforce
Action Plan implemented which includes team building work and framework.
BirthRate plus workforce tool used to ensure safe midwifery staffing ratios. Actual versus planned midwifery staffing using acuity tool used and “One to One” care in labour and supernumerary status of labour ward coordinator audited 4hourly and staff redeployed as required. Additional funded posts via LMNS & Ockenden funding appointed. Succession planning for senior & specialist midwife roles. Action plans to ensure all staff have timely SDRs. Open staff meetings and open door access to Head of Midwifery. Robust recruitment. Supernumerary Pastoral Support Midwife in position to support preceptor midwives. Professional Midwifery Advocates supported with allocated time and further PMAs currently in training.

Operational Excellence
Maternity services escalation policy reviewed and guidance issued.

Sustainability
Working closely with the improvement leads from STRIVE. Workforce review. Estates review.

Enablers and interdependencies
Digital systems: BadgerNet EPR and electronic prescribing. Continued work with local Maternity & Neonatal System, Maternity Voices Partnership, in regional and National forums for clinical and professional work streams.

Growing the Friarage & Community Services Collaborative

Strategic focus: Support – Emergency care pathways, Frailty and Discharge; Sustain – Care Closer to Home and Growing the Friarage

Vision and Objectives

Growing the Friarage

- Maximise and expand the range of elective services provided at the Friarage.

Care closer to home

- Integrate community services with Primary Care Networks, to support stronger hospital in-reach and timely discharge.
- Develop urgent community response services and partnerships to provide alternatives to acute hospital admissions.

Safety and Quality First

- Established a patient quality and safety collaborative monthly group (SI, SLE and Complaints learning / lessons learned, risk management)
- STACQ accreditations in progress and CQC self assessments in place

Workforce

- Workforce People Plan in progress and monitored via people committee and improvement council.
- Priorities for 22/23 localised recruitment for H&R, careers fairs, integrated recruitment solutions, partnership/ joint recruitment with H&S/C system.

Operational Excellence

- Integrate community services with Primary Care Networks, to support stronger hospital in-reach and timely discharge.
- Develop urgent community response services and partnerships to provide alternatives to acute hospital admissions.

Sustainability

- Full community SystmOne review to drive more efficient use of resources.
- Development of enhanced urgent community response.
- Developed UTC model with enhanced DoS and the Integration UTC GP Out of Hours Service.

Enablers and interdependencies

- Partnership working with PCNs, the Tees Valley and Humber, Coast and Vale ICS and Social Care.
- New Endoscopy and Urology Investigation Units, as well as new FHN Theatres build, and collaboration with elective specialities for increased activity on FHN site.

Digestive Diseases Urology & General Surgery Collaborative

Strategic focus: Support: Services for priority support, Emergency pathways, Elective recovery, and Outpatients transformation; Sustain: Growing the Friarage; Connecting Care

Vision and Objectives

Demonstrate that we place our patients at the heart of our services across outpatient, diagnostic and treatment pathways by:

1. Delivery of care from a motivated and highly performing team of staff, assessed and regularly revalidated with documented and measured standards.
2. Working to agreed common care plans for seamless patient care based on need, with effective reflection on measurements of process and outcome.

Safety and Quality First

21/22 Revised Collaborative governance structure, appointment of patient safety ambassadors improved adoption of National Emergency Laparotomy audit. Risks and issues: STACQ (in progress) focused improvement, pre-habilitation and early supported discharge; data submissions for the college supported surgeon outcome data audits (UGI/Colorectal); implementation of GIRFT recommendations.

22/23 Priorities: Elective process and benchmarks: Theatre and endoscopy schedules and in-list utilisatioin, Job planning, booking process and perioperative pathways, outpatient efficiency review, High Volume Low Complexity benchmarking. Emergency: capacity and process including 'golden patient' initiative in theatres, capacity in critical care, SDEC expansion of activity & home first models of care.

Research activity includes IBD- IBD bio-resource, Elevate ASUC, Profile, Clarity Endoscopy- Colocohort, colodetect, Colon Capsule NHS England pilot luminal and hepatology studies, the latter including UK-AIH, UK-PBC, CALIBRE, PEARL. Colorectal Prehab and Home monitoring pilots.

Workforce

Consultant: Urology recruitment, Gastroenterology time available for specialty, Surgery subspecialisation of Emergency activities. Extended role nursing and AHP workforce well developed in Urology, focus now on Surgery and Gastroenterology, protocols for non-medical triage/vetting, follow-up and criteria led discharge; alignment with Nutrition & Dietetics with wider organisational support. Support and enhance the non-medical workforce, ensuring all staff feel valued and are able to work to the best of their abilities. Challenge and modernise our ways of working.

Operational Excellence

Effective administration functions, processes and capacity, waiting list management (validation and pathways) and booking processes to achieve waiting time standards. Cancer action plans – urology - managing the prostate cancer workload and tracking of variances. Significant increases in capacity enable by Estates developments, which will reduce waiting times and enable timely appointment of surveillance patients. Embedding of the surgical SDEC pathways. Embedding of Tees Valley pathways for urology.

Sustainability

Maximising provision at the Friarage Hospital utilising the facilities and improving access – outpatient clinics, diagnostics, and surgical.
General Surgery Review. Understanding impact of the GRAIL trail on therapeutic endoscopy pathways.

Enablers and interdependencies

.Ring-fenced elective bed base; Interventional radiology; Development of the Friarage Investigations Unit for Endoscopy and Urology, due to open September 2022; 4th Endoscopy Room at JCUH due to open September 2022; longer term estates and capacity plan for JCUH Endoscopy; FHN Theatres.

Medicine & Emergency Care Services Collaborative

Strategic focus: Support– ED and Emergency care pathways

Vision and Objectives

Vision: To deliver excellent clinically led safe and effective care in line with Trust values

Objectives:

- Deliver care closer to home where clinically appropriate
- Provide high quality and timely access to non-elective care
- Incorporate technological aids to deliver improved standards of care
- Contribute to high quality research
- To support development of future workforce inclusive of excellent education, training and development
- Collaborate across the wider Tees Valley and ICS to develop innovative ways of providing health care

Safety and Quality First

Achievements: STACQ Diamond accreditation in Redcar Urgent Treatment Centre, Ward 3 & Ward 11 and Gold accreditation in Ward 2 & Ward 37. Appointed patient safety ambassador for the Collaborative. Continued reduction in falls. Continuous improvement in safety and quality metrics with a significant improvement in response times.
Risks & Issues: Continued nutrition & hydration focus; Medical bed base and non-elective flow.
Priorities: Working to achieve STACQ in remaining areas. Research and development activity. Continued nutrition and hydration improvement.

Workforce

Achievements: Delivery of a more sustainable workforce by replacing locum consultants with permanent consultants in several areas. Appointment and development of nurse Practitioner (NP)/Advanced Clinical Practitioner (ACP) roles in medical specialities. Appointment and development of Paediatric Nurse Practitioners in CYPED. Focus on staff engagement and shared decision making. Staff council in place in ED and also Ward Nutritional Council.
Risks & Issues: Senior medical workforce and ability to recruit substantively in some areas
Succession planning and future proofing of workforce in hard to recruit to specialities.
Priorities: Development of workforce plans in every directorate. Planning and recruitment to alternative workforce models and to further develop NP/ACP roles. Implementation of staff shift rate survey on all wards to enable real time feedback and management responsiveness to staff concerns and suggestions.

Operational Excellence

Achievements: Improved compliance in RTT – all areas now compliant to required standard. Improvement in people KPIs including SDR and mandatory training. Significant improvement in lung cancer pathway performance. Improvement complaints and PALS response time. Successful development of Long COVID service, COVID Medicine Delivery Unit, expansion of Specialist Weight Management Service and delivery of virtual ward.
Risks & Issues: Compliance with constitutional targets (ED)
COVID absence
Priorities: Further expansion of virtual ward capacity and scope. Development and successful implementation of Patient Initiated Follow Up in medical specialities. Exploration of collaboration with regional partners to improve delivery of services. Delivery of ECIST action plan to improve ED quality indicators and reduce ambulance handover delays.

Sustainability

Achievements: Robust plan delivered to achieve required CIP target. Significant progress made towards a more sustainable workforce by successful appointment to several substantive consultant roles reducing the reliance on locum workforce.
Risks & Issues: Further consolidation of senior medical workforce still required in several areas. Ability to be able to continue to deliver COVID and non COVID services with limited resource available. Turnover of staff in some areas making it difficult to retain required skills and specialist knowledge and continue to deliver high quality care.
Priorities: Delivery of CIP schemes. Continued recruitment in locums. Workforce planning and exploration of use of alternative and MDT workforce. Completion of job planning and review and ensuring effective use of available resource.

Enablers and interdependencies

Approval and funding of virtual ward business case. Bed utilisation review and allocation of adequate medical/non elective bed base. High quality support functions including HR, Finance and Business Intelligence services.

Peri-Operative and Critical Care Medicine Collaborative

Strategic focus: Support Critical Care services and Elective recovery / Sustain – Growing the Friarage

Vision and Objectives

Our Collaborative will put patient safety at the centre of our services within the Critical Care and Peri-Operative areas. We aim to deliver excellent outcomes for all our patients and be leaders in operational performance. Our values and behaviours are at the heart of everything we do. Together they set out how we will put our vision into practice by guiding and influencing how we behave.

Safety and Quality First

Critical Care - reviewing allied health profession e.g. dietetics and physiotherapy provision, CQC self assessment, STAQC accreditation, GiRFT action plan.
Theatres - Patient Safety days, World Health Organisation check list audits, Never Event reviews, Serious learning events follow up and sharing across the Trust, Anaesthesia Clinical Services Accreditation, CQC self assessment, GIRFT being updated, training team changes
Pre-assessment – introduction of Synopsis digital system

Workforce

Critical Care: workforce planning, recruitment increase and work on backfills for mat leave, Staff development work with involvement of STRIVE. Consultants leading organisational development work. BAME support group started through the reciprocal mentorship scheme.
Peri-Operative – Standards and Behaviours ongoing work in theatre, development of standards from staff. Aim to reduce agency spend and recruitment drives for theatre staff. Ongoing recruitment within anaesthesia, development of CESR programme for doctors to join the Specialist Register
Pre-assessment – Staffing review to 'right size' nursing and administration teams

Operational Excellence

Critical care – good patient outcomes, demonstrated through Intensive Care National Audit & Research Centre audit programme. Planning for introduction of digital patient record
Theatres – 6-4-2 work ongoing, Surgical Improvement Group lead on theatre allocation, Kingsgate supporting efficiency and bookings, optimising use of theatres at Friarage Hospital, Redcar Primary Care Hospital and One Life Centre
Pre-assessment – building works to increase capacity, work to support bookings
Budget Review for theatres and Critical Care

Sustainability

Critical Care - Workforce sustainability across all professional groups. Tees Valley Managed Clinical Network, operational resilience including Critical Care Operational Planning & Response Group across critical care services (reporting into Trust-wide Critical Care Strategy Group).
Theatres – Post Anaesthetic Care Unit expansion. Refurbishment of theatres 1- 6 complete. New build at FHN to increase capacity on both sites.
Pre-assessment – new area to increase capacity to open August 2022.

Enablers and interdependencies

FHN Theatres business case in progress
Improvement Council projects
6:4:2 Surgical Booking Process
Digital transformation – Theatres and Critical Care systems

Clinical Support Services Collaborative – Medical Physics

Strategic focus: Specialist Services / Connecting care

Vision

To improve patient outcomes through innovation and application of physics and engineering. To provide clinical scientific support to services at South Tees and to offer front line patient services.

Safety and Quality First

Achievements CQC IRMER inspection July 2021, Radiotherapy Physics taking the lead on the inspection alongside the Radiotherapy Department. Radiotherapy Physics and Radiotherapy IS9001 2015 accreditation maintained. DGSA Inspection – operationally good, EA inspection of brachytherapy in Radiotherapy good and ONR inspection reported no incidents, Clinical Trials for Lu-177 have opened in Nuclear Medicine.
Risks & Issues Q-Pulse Cloud, non-urgent cancer diagnostic scans waits in Nuclear Medicine, requirement for SPECT/CT in Nuclear Medicine.
Priorities Maintain accreditations and high standards at inspections, To re-negotiate the contract for both Pathology and Medical Physics for Q-Pulse Cloud. Recruit B6 CTs for Nuclear Medicine to extend the working day to maintain the current standards in cancer waiting time while reducing other waiting lists. To secure funding through BC for mould room refurbishment.

Workforce

Achievements Succession planning 2 new Band 8A roles created and both Clinical Scientists achieved their Medical Physics Expert certification. All Clinical Scientist posts are filled with the vacant post in Radiotherapy Physics being filled in the summer. Medical Physics staff maintain excellent level of mandatory training and SDR completion. Several apprenticeships are ongoing in the department at level 2, 4 ,6 and 7 across all the disciplines. The department is also supporting several clinical scientists in the pursuit of Higher Specialist Scientist Training (HSST) and also in pursuit of advisor certification for Radiation Protection and Radioactive Waste.
Risks & Issues Radiotherapy Technical Group and Medical Photography are two sections within medical physics that require additional recruitment planning.
Priorities Recruit into all vacant posts – availing of apprenticeships where appropriate. Succession planning for all staff groups.

Operational Excellence

Achievements: Reduced the Sechat waiting times by 50%% due to waiting list initiative in Nuclear Medicine. Clinical Trials have opened in Nuclear Medicine for Lu-177 PSMA treatments. LA5 install and acceptance is on track and the machine will be clinical in summer 2022.
Risks & Issues Waiting list focus and measures. SPECT/CT Camera.
Priorities: BC for SPECT/CT Gamma Camera to offer the complexity of scanning expected in a tertiary centre.

Sustainability

Achievements Radioactive waste store identified in Medical Physics for use immediately with no build work. RT Physics leading on the implementation of new Linac(LA5), New QA equipment installed - Water Tank, Delta 4 and IQM. Cost Improvement Plan achieved through workforce skill mix.
Risks & Issues Mould room refurbishment.
Priorities: To continue to develop business cases and review them in line with the capital plan and the requirements of the department and the Trust.

Enablers and interdependencies

BC for B6 CTs in Nuclear Medicine to allow the service to reduce waiting lists and in preparation for the use of SPECT/CT. Capital business cases to remodel the mould room to improve its H&S recommendations and patient experience and staff wellbeing and capital business case to facilitate the purchase of a SPECT/CT gamma camera.

Clinical Support Services Collaborative – Patient Flow and Discharge

Strategic focus: Support – Emergency care pathways / Sustain – Care Closer to Home

Vision and Objectives

To have standardised embedded processes for patient flow and discharges.
To embed the Transfer of Care hub and the Discharge Policy.
To work collaboratively with our local authority partners to ensure patients are in the right pace for their care needs and care is provided in their own homes and where not possible in their own homes as close to home as possible.

Safety and Quality First

- Increased staffing model within the patient flow team to provide additional senior nursing . Providing clinical leadership 24/7 - complete
- Review and sign off of the Full Capacity Protocol to reduce risk in ED – complete
- Reviewing Long Length of Stay patients using an MDT approach
- Reviewing all incidents relating to discharge to capture themes and address these - repeated monthly
- Improve flow and facilities in the discharge lounge - ongoing

Workforce

- Increase in staffing to 2 x 24/7 senior nurses in the site team. Staff operating model for site team has improved morale and resilience in the team – complete
- Increase the number of Discharge Facilitators to create a Transfer of Care Hub to facilitate safe and timely discharges – complete
- Ensure all mandatory training is complete. Staff have meaningful SDR's which identifies career goals and support to develop individuals - complete
- To secure funding for 7 day staffing RN in the discharge lounge - not yet complete

Operational Excellence

Achievements

- Co-working with social care to create a system wide transfer of care hub
- Discharge policy and Patient flow policy
- OP phlebotomy – governance and reduction in reliance on GP's
- CIP has been achieved for the Collaborative

Priorities

- Social care links
- Performance metrics – LOS, discharge of patients prior to 5pm
- Repatriation of patients for care closer to home

Sustainability

CIP has been achieved for the Collaborative. Patient transport services reviews- ongoing

Enablers and interdependencies

Live patient flow dashboard. Embedding regional RAIDR app. Review of regional OPEL. - completed and revision ongoing

Clinical Support Services Collaborative – Pharmacy

Strategic focus: Support emergency care and elective recovery / Connect across the Tees Valley, North Yorkshire and beyond

Vision
To provide a safe and effective service to our patients and colleagues

Safety and Quality First
Achievements: Safer Medication Practice Group meetings. Preparation of safety alerts for display on pharmacy ward board. Medication safety weeks, antibiotic awareness week. Training junior doctors, pharmacy students. Pharmacy Assurances rounds.
Priorities: Implementation of electronic prescribing digital solution (EPMA). Fridge temperature monitoring Trust wide. Incident dashboard reported to pharmacy governance. STACQ accreditation started. Lessons learnt at weekly staff huddle. EL Aseptic audit. Omnicells installation for managed medications supply on the wards.

Workforce
Risks and issues: Recruitment.
Priorities: Pharmacist recruitment - to over recruit by 6 band 6 pharmacists .Technicians - in house training and development programs implemented. Progressive posts, training of ATO to technicians via NVQ. Flexible working requests. Business case for 7 day working being compiled. ACP trainees.

Operational Excellence
Acheivements: New pharmacist posts linked to specialities . Medicine Reconciliation improved.
Priorities: ATMP/ATIMP work started in collaboration with Newcastle. Provision weekend pharmacy clinical service at FHN.

Sustainability
Priorities: Workforce as above. Procurement national contracts. Increased use of Homecare service. Cost Improvement Plan.

Enablers and interdependencies
Business cases - 7 Day working, Omnicell, Store robot, NNU pharmacist, ITU ACP pharmacist, gastro specialist pharmacist.
Collaborative working for pre registration pharmacist and technician posts. Tees Valley technician training post. ACP collaborative formulary for Tees Valley.

Clinical Support Services Collaborative – Radiology

Strategic focus: Strategic focus: Support - Radiology / Sustain – Care Closer to Home

Vision
To provide a timely, quality and caring service for diagnostic imaging

Safety and Quality First
Radiology Governance meetings (RGM). REALM meetings for educational purposes (discussion of reporting discrepancies or interesting cases). Radiology Safety and Learning points bulletin. Radiology Communication briefing. Quarterly MRI Safety presentations. Recent Trust-wide MRI Safety presentation during MRI safety week. IR(ME)R training program for Non-medical referrers. Safety Bulletin noticeboard. Incident dashboard monitored and fed into RGM, DATIX lead within Radiology has provided training and support which has led to a postive increase in reporting of incidents with themes and trends shared at RGM and within briefings. Staff huddles and meetings – minutes shared and displayed on staff modality boards. WHO checklist audit – 100% compliant for over 12 months.
Priorities: Patient feedback shared on patient waiting area notice boards – I-pads purchased to improve response rate. Audit and Research plan in place and underway. Qpulse software purchased and in process of being set up for Radiology. KPIs, daily/weekly operational and PTL supports turnaround time management in delivering timely, quality and caring services. STAQC accreditation assessment for each modality.

Workforce
Achievements: Radiographer posts filled and over recruitment into MRI posts and plain film posts to support Community Diagnostic Centres. Successful recruitment of apprentices for both assistant practitioners and Radiographers – highest uptake within region. Staff charter was very positive, staff take pride in working at South Tees and feel that we provide the most opportunities within the region for advanced practice roles. Staff charter themes were caring, respectful, professional, team working, safety and communication aligning with the trusts core values.
Risks and issues: Medical vacancies due to staff retiring and national shortage of Radiologists. Risks to staffing of CDC due to national shortage of radiographers and sonographers however plans in place for over-recruitment to support the backfill of internal training. Risk that implementing additional scanners will require more staff than can be recruited to. Booking team returned to service however we require works to make the facilities suitable for their return – some capital funds available but estates input required. Nursing workforce significant risk – poor retention and recruitment – need to change rota
Priorities Collaborative recruitment for CDC with North Tees. Collaborative working with Teesside University to increase student training numbers and deliver training differently.

Operational Excellence
Performance was on track until implementation of new PACS/RIS – starting to recover PTL compliance week on week. CBIS to be back up and running to ensure compliance. PACS/RIS early adopter funding is being utilised for additional lists and IS utilised for MRI, PF & USS.
Hybrid installation commenced, new scanners to be installed at RPCH & FHN – this will create additional capacity. New scanner upgrade to FOH ED will also have an impact on performance.

Sustainability
No real CIP due to service developments and additional resources required, however underspent by £300k on revenue.
Need to embed new IT systems and integrate old systems to ensure maintenance of performance.

Enablers and interdependencies
Business cases. Expansion of radiology day unit once hybrid suite installed and extended nurses working day. Handover dates of new scanners. Equipment replacement on acute sites and RPCH.

Clinical Strategy - Trust-wide Priorities

Safety and Quality First

CQC Improvement Plan

The Fundamental Standards of Care are the regulatory requirements set out by the CQC. Following the Trust's CQC inspection in July 2019 the Trust was rated against the CQC Key Lines of Enquiry (KLOES) and it received an overall rating of 'requires improvement'. The CQC improvement plan is focused on the achievement of the fundamental standards and 'getting back to our best'.

Ratings for a combined Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↓ Jul 2019	Requires improvement ↓ Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Requires improvement ↓ Jul 2019	Requires improvement ↓ Jul 2019
Community	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Overall trust	Requires improvement Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019

Our improvement plan is focussed on delivering outstanding care to our patients alongside ensuring that we meet the CQC Fundamental Standards.

We will demonstrate the progress we are making on our journey 'back to best'.

Work is well under way in preparing for our next CQC inspection, which we anticipate will be at some point during the current financial year.

Outstanding care is:

We will focus on:

- Improving nutrition and hydration for all patients
- Ward-based documentation (risk assessments)
- MCA and DoLs assessments and decision making
- Completion, compliance and audit of care
- Emergency care pathways
- Maternity services
- ITU
- Staff wellbeing.

Clinical Workforce Planning - Medical

Medical workforce pressures are a theme across all services for priority support, arising from national workforce pressures in some professions, gaps in local training, and an aging workforce profile. Innovative service models need to be developed to optimise and develop current workforce according to service needs, incorporating the use of clinical nurse and AHP specialists, physicians assistants and advanced clinical practitioners .

Achievements:

- Job Planning Assurance Group (JPAG) established, reviewing medical workforce
- Job planning principles and policy published
- Progress with electronic rostering for medics, with initial junior doctor rotas in development
- Refreshed, digitally enabled recruitment campaigns and military options
- New models to facilitate waiting list initiatives, weekend working etc – GPA scheme and LLP
- Increased training and recruitment into non-medical roles such as Physician Associates

Plans and key deliverables:

- Sustainable options for resourcing and remunerating additional clinical activity
- Clinical productivity review – demand and capacity linked to job plans with initial work in anesthetics, critical care and emergency medicine
- Joint work across CMO and CNO offices on workforce innovation and joint medical/CNS/ACP rostering

Key milestones:

- All Collaboratives to have draft Workforce Plans by end Q1
- eRoster for medical out of hours rota by August 22.
- New surgical junior rotas by August 22
- JPAG job plan review complete by end Q1 and all consultant job plans updated by end Q3

Outcome measures:

- Vacancies by profession and specialty
- Roster and job plan compliance with Working Time Regulations and Royal College standards

Connecting programmes:

- Elective recovery
- Emergency care pathways

Digital enablers:

- E-rostering software
- E-job planning software

Clinical Workforce Planning – Allied Health Professionals

AHP workforce pressures arise from national shortages in some professions, lack of local training and development pathways and an aging workforce profile.

Achievements:

- Increased training and recruitment into non-medical roles such as Advanced Clinical practice, First contact practitioners, research roles.
- Introduction of degree apprenticeships for Occupational Therapy, Physiotherapy and Therapeutic Radiography.
- AHP workforce review supported by HEE funding.
- AHP ESR data cleansing.
- Increased assistant practitioner apprenticeship and adoption of support worker framework across AHP professions

Plans and key deliverables:

- ACP roles…
- Improve recruitment and retention of staff in professions that are difficult to recruit into including Dietetics and Speech and Language Therapy, Orthoptists
- Capacity and demand modelling for AHPs

Key milestones:

- All Collaboratives to have completed Workforce Plans by end Q1
- AHP workforce strategy and report.
- Biannual AHP staffing report and monitoring and mitigation of risk.

Outcome measures:

- Vacancies by profession and specialty
- Turnover rates and recruitment into apprenticeship programs
- Establish unmet need for all AHP services
- E job planning levels of attainment

Connecting programmes:

- Elective recovery and Care closer to home.
- AHPs Deliver- AHP strategy
- COC response

Digital enablers:

- E-rostering
- E job planning for AHPs
- AHP specific KPI dashboard.
- Electronic patient record platforms

Emergency Care Pathways, Flow and Discharge

Our vision is to safely respond to non-elective demand, with patients treated in the right place, right time, with resilient services year-round. Improvement support has been provided to our Emergency Department by Emergency Care Intensive Support Team (ECIST)

Achievements:

- Flexible, clinically-led response to evolving COVID pandemic
- Children & Young Peoples ED opened September 2021
- Integrated Paediatric Same Day Emergency Care (SDEC)
- Adult Medical and Surgical SDEC opened, with acute pathways for multiple specialties
- Virtual Ward for COVID
- Clinical site management - strengthened staffing model 24/7 providing senior nurse leadership
- Full Capacity Protocol and Discharge Policy
- MDT reviews for long stay patients
- Transfer of Care Hub with integral social care workforce

Plans and key deliverables:

- Implement bed model for medical wards
- Implement ED action plan developed with ECIST
- Complete transfer of care process reviews
- Review of discharge lounge process
- Regional OPEL framework review

Key milestones:

- Implement the Clinical Review of Standards, expected April 2022

Outcome measures:

- 4-hour standard and Clinical Review of Standards metrics (average total time in ED, time to first assessment, to decision to admit)
- Ambulance handover metrics
- Long Length of stay (LOS) metrics (patients > 14 days, 21 days, delayed step down from critical care)
- Clinical metrics (acuity, frailty, patients in hospital who do not meet criteria to reside, outliers)
- Community 2-hour crisis response
- Increased discharge to assess

Connecting programmes:

- Care closer to home
- Clinical Coding Strategy

Digital enablers:

- Medworxx upgrade
- Alcidion patient flow module
- PatientTrack
- UEC RAIDR App

Outpatients Transformation

The key driver for outpatient transformation is to improve patient experience from referral to discharge. This will be achieved by delivering care closer to home, increasing use of technology, improving administrative processes and functions including communications with primary care, and stakeholder engagement.

Achievements:

- Introduction of self-check in kiosks
- Introduction of patient initiated follow up (PIFU)
- Reduction in open episodes
- Clinic letter templates review

Plans and key deliverables:

- Complete roll out of kiosks
- Outpatient reception models
- Waiting list management including outcome codes, validation, clinical prioritization
- Clinic utilisation review with Kingsgate
- Advice & Guidance (A&G) activity and reporting
- Maximising use of community locations

Key milestones:

Outcome measures:

- Outpatient patient experience and satisfaction
- RTT metrics
- Activity versus plan – more first attendances, more completed pathways, more A&G, more PIFU, fewer follow ups, maintain balance of remote consultations (plans per specialty as clinically appropriate)
- Outpatient KPIs (slots used, DNAs, new to follow-up)
- Open episodes and other key data quality metrics

Connecting programmes:

- Elective recovery including Diagnostics recovery
- Growing the Friarage
- Estates Plan

Digital enablers:

- Clinic booking and clinic workflow
- Waiting list management with IECCP platform
- Voice recognition, typing work flow and document management
- Digital communications with patients

Elective Pathways, Theatre Utilisation and Diagnostics

Elective demand has not returned to pre-Covid-19 levels in all areas but may yet do so. Clinical teams must ensure that patients are seen in clinical priority and date order, and clear surveillance as well as first-treatment accumulations to meet waiting time standards. To achieve this, we will get back to, and then exceed, pre-COVID activity levels.

Achievements:

- No patients will wait over 104 weeks
- Waiting list validation and clinical prioritisation
- Restoration of all elective surgery, protecting bed base through COVID
- Maintaining cancer services and reducing number of patients waiting over 62 days for treatment
- Improvement in orthopaedics and ophthalmology

Plans and key deliverables:

- Deliver activity to trajectories to 104% of 19/20 Diagnostics recovery
- Implement a needs-led theatre schedule
- Surgical pathways to preassessment and theatre
- Theatres '6-4-2' booking project
- Improve theatre utilisation and efficiency across all sites (JCUH, Friarage, Redcar, One Life Centre)
- Analysis of the impact of activity trajectories and demand scenarios on patient waiting times and sustainable list size
- Waiting list validation and clinical prioritisation – inpatients and diagnostics including patients waiting for surveillance
- Protected ward beds for elective programme

Key milestones:

- Eliminate 78ww ahead of March 2023 target
- Deliver diagnostic waiting times to compliance in major modalities by March 2023

Outcome measures:

- Constitutional standards and waiting times: 18ww RTT, diagnostics 6ww
- Theatre efficiency metrics, booking metrics, cancelled operations

Connecting programmes:

- Growing the Friarage
- Clinical productivity
- Clinical workforce review
- Clinical Coding Strategy

Digital enablers:

- IECCP waiting list management platform
- Theatres system implementation

Cancer Pathways

Achievements:

- Maintained cancer services throughout COVID pandemic
- Collaborative working between Trusts to ensure patients can access treatment
- Reduced back log of patients waiting longest for treatment
- New LINAC

Plans and key deliverables:

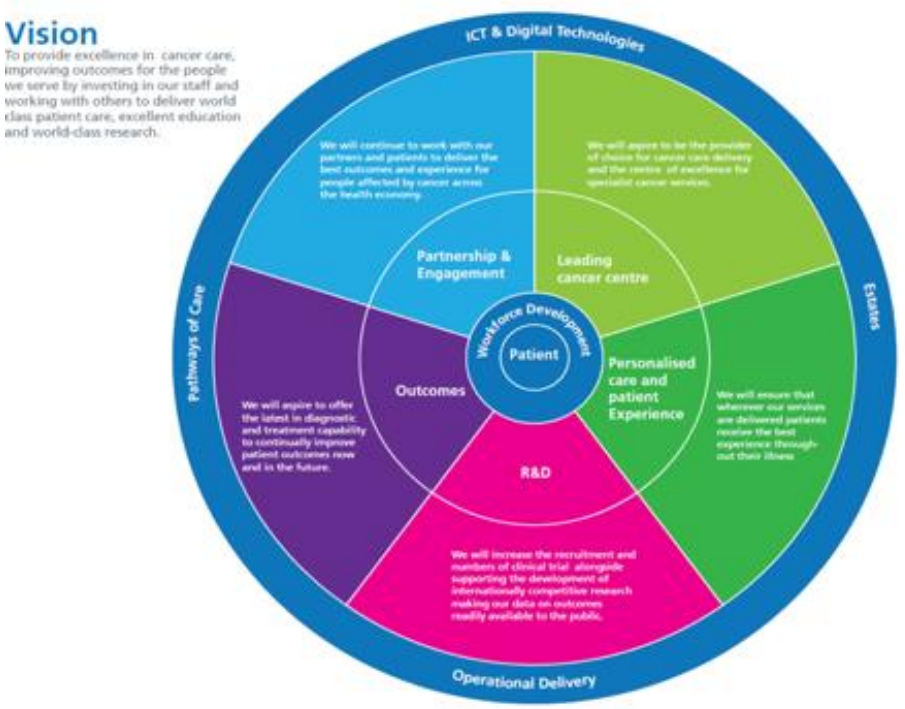
- Cancer Delivery Strategy
- Tumour group reviews
- Implement targeted lung health checks

Key milestones:

- Patient Stratified Follow Up in 3 groups by March 2023

Outcome measures:

- Cancer 14-day referral standard, 28-day faster diagnosis standard, 31-day and 62-day treatment standards
- Cancer surgery cancellations
- Clinical outcomes



Connecting programmes:

- Elective care pathways and diagnostics
- Estates Plan

Digital enablers:

- Pathway Plus (waiting list management)
- Infoflex (cancer pathway management)

End of Life and Palliative Care

End of Life Care and Specialist Palliative Care are a Trust-wide priority to ensure that all patients who need these services receive equitable access. Palliative Care as a specialism faces national medical workforce challenges and we are exploring innovative workforce models to develop a more sustainable service.

Achievements:

- National Audit of Care at End of Life (NACEL) recognised good standard of our documentation
- Appointment of nurser educators and development of education modules and vignettes
- Over 100 named Palliative Care Link Nurses
- Clinical Director support and joint management model across acute and community

Plans and key deliverables:

- Review of specialist palliative care services skill mix and service model
- Business case for funding of seven-day palliative care services
- Training programme in a tiered model universal / general / specialist

Outcome measures:

- Training delivered/accessed
- Recruitment
- CQC Insights indicators (workforce, NACEL)

Connecting programmes:

- Care closer to home
- Emergency care pathways

Digital enablers:

- MIYA electronic patient record

Specialist Services

We deliver Specialist Services to a population of 1.5m extending across Teesside, North Yorkshire and beyond. Our specialist services include: Neurosurgery, Spinal Cord Injuries and Stroke; Cardiovascular Services; James Cook Cancer Institute; Critical Care; Major Trauma Centre, Head, Neck and Reconstructive Surgery; Cochlear Implant Service; Renal Services; Upper Gastro-intestinal Services and Neonatology. Our vision is to sustain the level of specialist services currently commissioned whilst also growing the range of procedures we offer so that we are able to deliver the most up to date care possible using the least invasive interventions

Achievements:

- Delivery of specialist services throughout COVID, extending to offering capacity in neurosurgery and cardiac surgery to patients from out of area
- Development of Clinical Networks across multiple specialist areas to improve patient access and outcomes and service sustainability

Outcome measures:

- Compliance with national service specifications
- Managed clinical networks
- Regional collaboration
- Recruitment to specialties
- Ensuring our Trust contributions to Innovation, Research & Development and Education are recognised nationally

Plans and key deliverables:

- Demand and capacity reviews
- Assessments of sustainability and potential for growth
- Capital plan for specialist care delivery
- Quality dashboards, linked and benchmarked to national audits where appropriate

Connecting programmes:

- Research Strategy
- Academic Programmes
- Estates Plan

Key milestones:

- Demand and capacity reviews complete by end Q1
- Quality dashboards on key outcome measures agreed Q2 and published by end Q3

Digital enablers:

- Pathway Plus (waiting list management)
- Infoflex (cancer pathway management)

Care Closer to Home

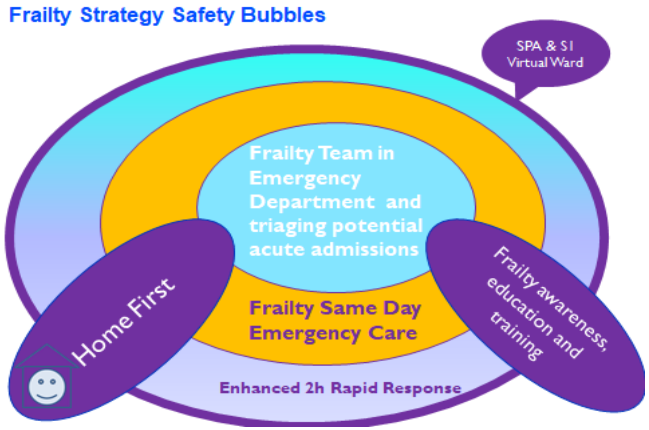
Our vision for Care Closer to Home is developing integrated Community Services locally and across the system. This includes alignment with Primary Care Networks, developing virtual wards, focus on frailty and enhancing our 2 hour urgent response (UCR) to reduce admissions and promote hospital in-reach to support timely discharge.

Achievements:

- Roll out of frailty training
- COVID virtual ward to avoid admission
- Aging Well funding to enhance North Yorkshire UCR

Plans and key deliverables:

- Roll out virtual ward model
- Community frailty SDEC model
- Enhance existing Single Point of Access (SPA)
- Complete Frailty Strategy and develop frailty model to include intensive overnight service and Home First Urgent community response within 2 hours
- Community bed base



Key milestones:

- Community SDEC and virtual ward model implemented North Yorkshire and Tees from April 2022 as integrated ACT service

Outcome measures:

- Reduce hospital admissions, readmissions and length of stay, frailty dashboard metrics
- Reduce long term social care placements
- Reduction in the number of frail people attending A&E services, emergency admissions, and length of stay
- Reduction in the number of falls and pressure ulcers (as a proportion of elderly admissions)
- Increase in the number of patients receiving comprehensive geriatric assessment

Connecting programmes:

- Emergency care pathways, flow and discharge
- Elective pathways, diagnostics

Digital enablers:

- SystmOne

Growing the Friarage

The Friarage Hospital is a key point of delivery for patients from North Yorkshire and the South of Tees. The Growing the Friarage work programme focuses on maximising elective services and diagnostics whilst also sustaining local acute care.

Achievements:

- Outline Business Case for Theatres replacement
- Maintained protected elective capacity

Key milestones:

- Full Business Case for Theatres replacement and elective recovery capacity approval Q2 2022
- Investigations Unit opening September 2022

Plans and key deliverables:

- Maximise elective activity at the Friarage Hospital across orthopaedics, ophthalmology, ENT, OMFS, plastics, urology, gynaecology, pain and spinal surgery.
- New Endoscopy and Urology investigations unit to increase capacity and improve care pathways
- Continue to increase use of the new Friarage Dialysis Centre and outpatient Allerton Eye Unit
- Business case process for a replacement theatres block, to meet current and future demand

Outcome measures:

- Theatre utilisation and efficiency
- Outpatient, surgical and diagnostic activity

Connecting programmes:

- Elective pathways, theatres utilisation and diagnostics
- Outpatient transformation
- Care closer to home

Digital enablers:

- SystmOne
- Theatres systems

Connect across the Tees Valley and North Yorkshire and beyond

Our clinicians will take a lead role in collaborative working that will drive joined-up and sustainable care that ensures quality by providing good access to sustainable specialty care through stronger and more resilient teams, a firm footing for the long-term and supports evidence-based measures and interventions to empower and improve population health.

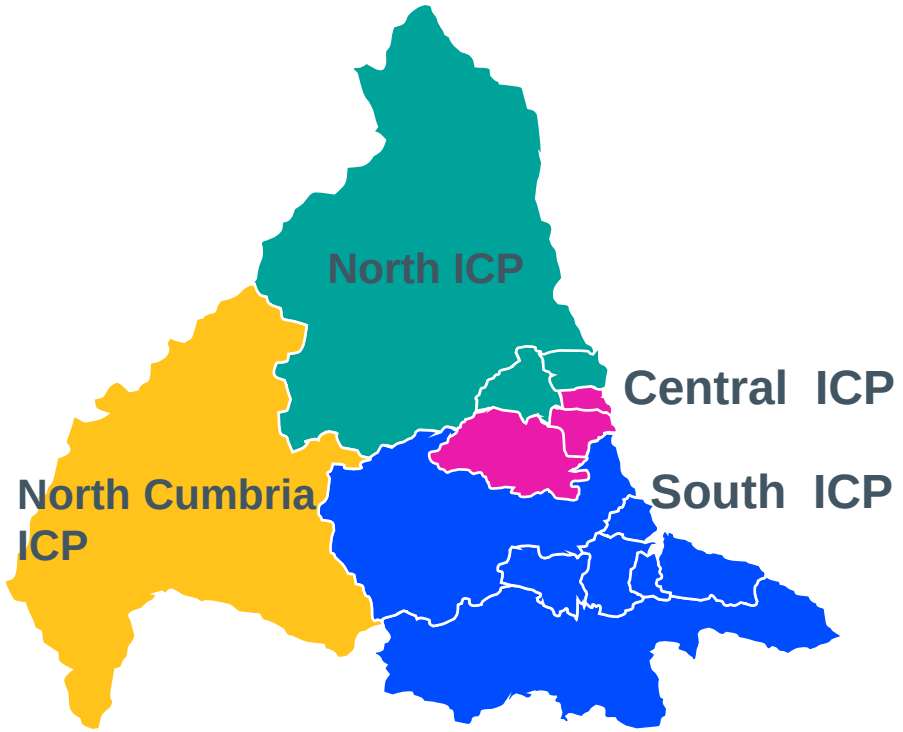
We have been working closely with our colleagues and partner organisations to bring about the patient benefits in:

- North East & North Cumbria Integrated Care System
- Tees Valley Integrated Care Partnership
- Humber Coast and Vale Integrated Care System

This encompasses the system's response to the Health & Social Care White Paper reforms.

The NHS 2021/22 Operational Planning Guidance places great emphasis on whole-systems working to respond to the challenges of Covid-19 recovery, supporting our staff, workforce resilience, and tackling health inequalities. Our performance is measured and managed as a system to deliver for our populations.

Collaborative Improvement Plans include examples of work streams with partner organisations which will improve connectivity and sustainability of both local and specialist clinical services.



Enabling Strategies and Plans

Safety and Quality First

Nursing & Midwifery Strategy: Driving Excellence in Care

Our plans

The key aims of the strategy are:

- Achieving professional excellence in 11 key areas including optimising patient nutrition and hydration, decreasing falls and pressure ulcers, improving care of patients with dementia and enabling timely and safe discharge
- Developing and embedding a collaborative leadership model through collective leadership and shared governance
- Completing our South Tees Accreditation for Quality of Care (STAQC) – enabling and evidencing excellence in care in all areas in the Trust
- Investing in our people; ensuring a highly valued and motivated workforce with clear objectives under the key headings of education, research, innovation, wellbeing and safe staffing

Outcome measures

- Each of the 3 main components of the model of professional practice have their own improvement plans and objectives
- Aligned to the Trust values and vision of putting quality and patient safety first

Quality and Safety Strategy

Driving Excellence Through Quality Improvement

Our plans

This strategy builds upon our improvement journey and sets out our ambition to deliver our vision for the future for quality and excellence by continuing to empower our clinicians to put 'Safety and Quality First.

The key aims are:

- Deliver the Trust's quality priorities
- Achieve a positive patient safety culture
- Encourage an open and just culture with a focus on organisational learning
- Ward to board quality and safety assurance
- Work in partnership with patients and their families
- Be clinically effective to ensure right care, right patient, right time

Key enablers

- Training and Education support by STRIVE
- Robust policies and processes
- Patient safety ambassadors
- Family Liaison Officers

Quality Priorities

We will ensure that patients, their relatives and carers will have the best experience possible in relation to a planned, safe and effective discharge from our hospitals	We will ensure there is a positive safety culture within the organisation in which openness, fairness, accountability and learning from high levels of incident reporting is the norm	We will review and revise our processes for Clinical Audit in order to facilitate effective and evidence based clinical care for our patients
We will ensure that patients have the best experience possible in relation to having their nutrition and hydration needs met.	We will ensure the care that we provide to our patients is safe, and of the highest possible standard by reducing pressure damage	We will review and revise our processes for NICE in order to facilitate effective and evidence based clinical care for our patient
We will ensure that we have effective ways of receiving feedback from our patients, their relatives and carers which will lead to demonstrable improvements in practice.	We will reduce the risk of Clostridium Difficile infection for inpatients	

Outcome measures

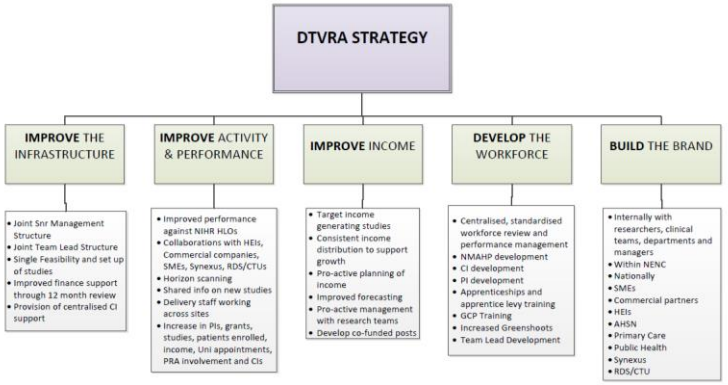
Staff at all levels of the organisation will understand our approach to quality and safety and what it means for their practice and our patients.

Research Strategy

Our Trust research strategy is aligned with strategy of the wider Durham Tees Valley Research Alliance (next slide)

The strategy was initially developed in 2019 to coincide with the launch of the alliance.

Work was completed in 2019/20 to improve the infrastructure. Work on the other four strands is ongoing.



Progress against 2021/22 Improvement plan

Key Themes (STRATEGIC DOMAINS)	Outcome measures	Progress
Improve visibility of research and reporting of our performance data to staff and patients	Monthly reports to clinical directorates established Increased comms and social media presence (internal & external) Positive Patient Research Experience Survey (PRES) feedback Staff research awareness survey	**COMPLETE** Routine Directorate reports sent to all. Comms officer appointed Jan 22. More visible comms and social media. V positive PRES feedback for 21/22 Research awareness survey to be distributed end March 2022 Although increased visibility of research will always be a strategic priority we fell we now have the processes in place to be able to remove this from our immediate Improvement Plan.
Increase participation in research projects across a broad range of clinical specialisms	Increase in data on NIHR portfolio (both raw and complexity adjusted recruitment) data across specialisms	**ONGOING** Activity this year is similar to previous years but not fully recovered from the impact of COVID in all areas. Targeting 4 key specialisms whose activity is v low or hasn't recovered to pre-COVID levels (ENT, Diabetes, Respiratory, Stroke). PB and JG to attend directorate meetings.
Establish dedicated out-patient space for research participants	Establishment of Cardiology Research Unit and additional dedicated out patient clinical areas for research participants from other specialisms	**ONGOING** Academic Research Unit proposals agreed, location of ACU agreed, currently arranging funding for building works. Dedicated outpatient space – scoping exercise identified one single space not needed, but space within existing out-patient areas. Work ongoing – highlighted at CPG/QAC/CPG.as a risk.
Increased engagement from NMAHPs & CRPs	NMAHP PIs, Achievement of targeted NMAHP research strategic objectives, active involvement in NMAHP Best Practice Council CRPs – community of practice (COP) and professional accreditations. Increased student placements in research	**ONGOING** Active involvement in BPRC, engagement with Don and ADoN to operationalise the CNO Nursing strategy for research. 2 successful NMAHP recipients of NIHR fellowship awards. TG invited to be facilitator on National Project to update the research component in NHSE/I Matron's handbook. COP established for CRPs
Improved oversight and forecasting of Trust sponsored grant income	Regular reports to CIs on grant income and expenditure. Accurate, timely financial returns to grant funders. Regular meetings with CTUs for oversight and planning	**COMPLETE** Robust processes implemented and additional personnel employed to ensure robust oversight of finances and timely invoicing/reporting of income within trust and to funders

Research Strategy 22/23 Improvement Plan

Key Themes (STRATEGIC DOMAINS)	Outcome measures	Status
Increased participation in research projects across a broad range of clinical specialisms	Increase in data on NIHR portfolio (both raw and complexity adjusted recruitment) data for studies across all specialisms but specifically: Diabetes, ENT, Stroke & Respiratory Medicine	**ONGOING**
Out-patient space for research participants	Resolve issue of out patient space within clinical areas for research participants	**ONGOING**
Increased engagement from NMAHPs & CRPs	Increased number of NMAHP PIs Achievement of targeted NMAHP research strategic objectives Communities of practices maintained and increased professional accreditations (CRPs). Increased student placements in research Increase academic affiliations and CI led studies from NMAHPs	**ONGOING**
Increase collaboration and mentorship internally and externally	Communities of practice extended to PIs, Greenshoots and CIs Increased collaboration with and between the Academic Research Units, R&D and our academic partners Increased collaboration with external academic partners	**NEW**
Increased focus on commercial partnerships and income	Improved % of Expressions of Interest (EOIs) submitted for commercial trials. Increased commercial and grant income through our Academic Research Units and partnership with TriNetX	**NEW**

Digital Plan

Throughout 2021/22 the organisation worked hard to improve the underlying ICT infrastructure in preparation for the new Alcidion Miya solution and other digital technologies designed to increase our overall digital maturity.

This included:

- Replacing over 3,800 PCs and 1000 laptops across the organisation
- Improving the wifi network to ensure there was good coverage across all clinical areas in preparation for mobile working
- Implementation of kiosk check-in in pilot areas streamlining outpatients and reducing waiting times/queuing
- Upgrade to web-ICE to enable enhanced functionality such as mobile working
- Implementation of a new PACS and RIS (Radiology Information System) replacing the system that was end of life
- Roll out of Single Sign-on to enable quick access to computers in busy areas

In terms of the Alcidion Miya Programme the PatienTrac solution which replaced VitalPAC was successfully rolled out in October 2021. In terms of the other functionality, the programme board agreed, that rather than implement each element separately, the greatest benefit would be from consolidating the functionality focused around the go-live of the ePMA (electronic prescribing). This has meant the new planned go live for the first ward is now July 2022. Miya will now be rolled out as:

- Patient journey boards giving a single ward view of all patients, their current EWS score and vitals with outstanding tasks etc.
- Access to prescribing, Web-ICE, PACS images and RIS reports through the journey board as a single click through
- Access to e-Discharge, assessments and other electronic forms/documents
- Ability to create tasks with alerting – allowing for example the Hospital at Night functionality to be replaced.

Digital Plan – Road Map

Digital Enablers to our Clinical Strategy

Our strategies and plans will only be fully achieved through the development of our IT and digitalisation processes. Historically, stand alone digital solutions have been utlised. We have started a programme of review for all our key IT projects so that we can gain assurance that they are delivering the best value and that they support our transformation programme.

Enabling Strategy / Plan	**Clinical Strategy**	**Clinical Strategy**	**People Plan**	**Clinical Strategy**	**Clinical Strategy**	**Digital Plan**	**Clinical Strategy**	**Clinical Strategy**
Linked to these Sub groups	Outpatient Transformation	Communication and Clinical site management	Workforce Management	Clinical Strategy and Improvement	Clinical Administration systems	IT Systems	Theatre Transformation	Community
Exec Lead	COO	MD	Director of HR / CMO	CMO	COO	Digital Director	CEO	(MA)
IT system	• Notify • Synertec • My Great North Care Record • Healthcall • Kiosks • Attend anywhere • M*Modal Voice recognition & workflow (Currently have front end VR without workflow)	• Vocera • Smart Page • Pagers/ Bleeps • VOIP – Wifi enabled	• Allocate • ESR self-service • Payroll/changes E forms	• Alcidion - Miya: E-Obs E-Prescribing Miya Precision Smartpage	• Pathway Plus • Infoflex • CAMIS • CBIS • Data warehouse • Clinical coding strategy	• N365	• Safe Scan • Synopsis • Theatre productivity • Clinical coding strategy	• System one

Estates Plan

Our estates plan will evolve in line with the emerging Clinical Strategy and subsequent clinical priorities. Our current plans are aligned to the phases of the Improvement Plan including redevelopment at the James Cook site, growing services at the Friarage Hospital alongside longer term capital planning our PFI. We are also working collaboratively across the ICP and ICS to share best practice, provide mutual aid and develop cost and efficiency opportunities.

Our plans

JCUH Redevelopment

- Commission new Pre-Assessment, PACU and Refurbished Wards
- Develop 'blueprint' plan for phased redevelopment of ED,
- Refresh the James Cook Site Development Control Plan
- Complete lifecycle refurbishment
- Undertake development of 8 additional critical care beds

Growing the Friarage

- Complete site clearance and demolition works
- Commission new endoscopy and urology units
- Friarage theatres
- Refresh the site development plans to continue ‘growing the Friarage’

PFI Value for Money

- Release inpatient ward estate for further lifecycle investment
- Increase estate condition surveys and reporting defects
- Implement additional management support recruited to monitor KPIs

Capital Planning

Maintain up to date 5-year capital plan

- Deliver the 22/23 capital programme as approved by CPG
- Complete seed-funded bids for clinical schemes in anticipation of national funding e.g. modular ward
- Support and inform the clinical strategy developments of estate constraints and opportunities

Outcomes delivered 2022/23

- Completed Estates Plan
- Approval of FHN Theatres Full Business Case
- Updated 5-year Capital Plan submitted to ICS
- Completion of the annual lifecycle programme
- Delivery of efficiency programme

People Plan

Our People Plan was published in the summer of 2021 and aims to make South Tees the best place to work. The NHS People Plan (2020) highlights 4 national priority areas deemed as crucial to supporting transformation across the NHS. Our People Plan for 2020/23 articulates how we will deliver on these national priorities by improving the working experience of our people through five key strategic enablers.

We want to be the employer of choice for both existing colleagues and potential new colleagues in all areas of the Trust. To do this we will strive to ensure our people to feel valued, equipped and empowered to provide the best possible experience and outcomes for patients.

Our People Plan is critical in developing our culture and underpinning our values in all that we do to attract, recruit, develop, retain and support our people and teams to meet the needs of our patients across the Tees Valley, North Yorkshire and beyond.

Underpinning our People Plan are five key programmes of work:

- **Addressing workforce shortages** – we have refreshed our welcome day and developed workforce plans with collaborative
- **Improving learning and leadership culture** – human factors training is embedded along with civility and just culture
- **Embedding equality, diversity and inclusion** – our BAME network has over 80 members and we have launched our reciprocal mentor program.
- **Belonging** – our staff survey evidences further improvements and our STAR awards continue to recognise excellence.
- **Improve health and wellbeing** – we have received our bronze award for Better Health at Work, we are a menopause accredited Trust and we have launched our ‘How am I?’ campaign.

Digital enablers: Allocate, ESR

Financial Strategy

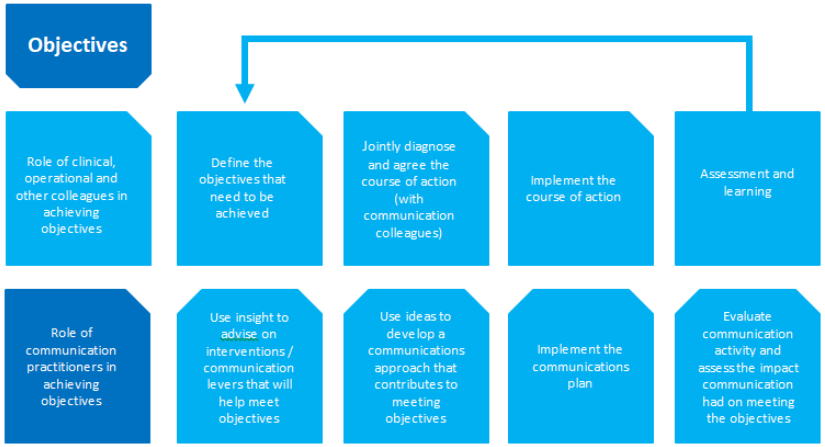
We have developed a set of principles that will guide the development of the Trust's financial strategy to deliver best use of resources and support overall system sustainability.

- Complementary to the organisation's overarching strategy
- Developed with strong clinical engagement
- Whole-system working
- A sustainable solution to the historic James Cook University Hospital PFI contract
- Sustainable capital programme
- Establishing equity of funding
- Improving efficiency and productivity
- Data quality and clinical coding
- Safe and effective patient care
- Delivery of efficiency savings recurrently and safely

Communications & Engagement Strategy

This strategy describes how the Trust's communications and engagement functions will continue play an integral role in driving the journey of clinically-led change at South Tees Hospitals NHS Foundation Trust. The Trust's clinically-led journey underpins the delivery of the communication and engagement strategy's objectives and will be refreshed and updated at regular intervals over its two year lifespan (2021-23).

South Tees strategic communication and engagement framework



Evaluation

Theme	Inputs	Outputs	Outtakes	Outcomes
Safety and quality first	Behavioral insights (EAST framework)	The South Tees way, safety movement and just culture components (eg: South Tees safety promise)	Increase percentage of staff reporting care of patients / service users is STHFT top priority by 5 per cent (evidenced through the NHS Staff Survey)	Generative safety culture: active participation at all levels.
Centre of excellence for specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond	Unprompted message awareness e.g. spontaneous recall metric	Website re-design insights, collaboratives and research & innovation horizon-scanning Website re-launch, patient information automation, patient stories development and placement, research & innovation fact-files	Achieve 10 per cent increase in the proportion of target audience that agree with the message (positive sentiment)	Consistent and coordinated care with high levels of patient confidence & trust and opportunities to take part in a research study (where relevant)
Great place to work	Staff Survey insights and analysis	Staff Facebook content plan (supplement to Talking Point and Weekly News) and LinkedIn marketing	Increase percentage of staff recommending trust as a place to work by 5 per cent (evidenced through the NHS Staff Survey)	Supportive, caring and compassionate work environment
Care without boundaries	Tertiary, acute, community and primary care pathway development insights	Effective communication and engagement to support pathway developments and operation	Increase CQC patient satisfaction survey metrics (eg: adult inpatient, maternity, children and young people, urgent and emergency care, outpatients)	Connected health and care pathways that place the patient and service user at the centre

Audiences

Staff				
Audience	**Think**	**Feel**	**Do**	**How**
Doctors, nurses, allied health professionals, midwives, scientific teams, administrative staff, support staff and volunteers	STHFT is continuing to empower clinicians to put safety and quality first	STHFT is continuing to prioritise my safety and the safety and quality of care which patients and service users receive	Increase percentage of staff reporting care of patients / service users is STHFT top priority	• Timely, relevant and informative staff communication
Patients and service users				
Audience	**Think**	**Feel**	**Do**	**How**
Patients and service users	STHFT is putting my safety and care first	STHFT understands my needs and its clinicians are prioritising my safety and care	Achieve organisational F&F outcome targets (ED, inpatient, outpatient, maternity)	• Direct patient information • Website • Digital channels • Patient stories
Stakeholders				
Audience	**Think**	**Feel**	**Do**	**How**
Stakeholders	STHFT is continuing to empower clinicians to put safety and quality first	STHFT is listening to its clinicians, patients and service users and following the best evidence	Increase stakeholder satisfaction metrics	• Regular briefings to key stakeholders • Timely and responsive and feedback mechanisms

Leadership and Safety Culture

Safety and Quality First

Leadership and Safety Academy

Underpinning all our strategies and plans is supporting our people through a Leadership Development Programme delivered through our Leadership and Safety Academy. We want to deliver a culture of safety, collaboration and continuous improvement where we all behave with respect, support and care. This started two years ago and will continually develop in response to feedback into a sustainable programme of education and practical support to create effective leaders at all levels using leadership development, Quality Improvement and Organisational Development methodologies.

Input	Output	Outtake	Outcome	Organisational impact
Cohort leadership development	Provide monthly bespoke support to teams across the Trust	Teams receive regular leadership support	Teams benefit from a sustained leadership approach	Developing the organisation for safety
Leadership and Improvement training	Provide sustainable education and training to South Tees NHS Foundation Trust	Whole Trust access to leadership, improvement training	Whole Trust benefits from strategic education around leadership and improvement	Consistent co-ordinated leadership development
Organisational Development support for teams	Dedicated team input for South Tees Teams	Areas receive intense bespoke support	Increased ability to speak up and seek support	Safer, open discursive culture
Understanding the effect of your behaviour on others (colleagues and patients)	Provide sustainable simulation, human factors and civility education to South Tees NHS Foundation Trust	Access to training on real time safety issues as well as evidence based culture training	Awareness of the negative effect on patient care of our behaviour towards our colleagues	Development of a Generative Safety Culture

Research, Innovation and Education at South Tees (STRIVE) Academic Programmes

Alongside our Leadership Programme are a series of academic and training programmes demonstrating our commitment to our staff for their education and training. Delivery of these programmes will ensure that we are a centre point for training for the community.

Input	Output	Outtake	Outcome	Organisational Impact
Careers, social mobility, prospect, step into health and kick-start programme	Clear routes into NHS careers at South Tees	Support to our partners in education and combined authority for job pathway	Fill of posts via a range of workstreams at a range of grades	Employer of choice for healthcare careers
Medical School Partnerships	Provision of medical education at South Tees	South Tees is an NHS Teaching Trust	Fill of posts from foundation level onwards by our students	Talent pipeline, employment of local population
Apprenticeships	Bespoke sourcing of apprenticeships across all STFT careers	Learning organisation, areas receive training for for their purpose	Improved knowledge and skills and so improved outcomes in work undertaken	Fit and proper workforce
Work based learning	Provision of on the job education, bespoke to the needs of our departments and systems	Correct training provided in real time appropriate to Trust strategy and direction	Approved level of training required for posts leading to core skill set in key roles	Safer work based culture
Medical Courses and Conferences	Trust provides leading education for the country	Our employees can access locally, highly accredited training	Attraction of speakers and staff to the Trust	Reputation for high quality medical education
Library services	First class library services across 2 sites	Access to support for learners of all levels	More Trust staff are successful with higher level education and research	Employer of choice due to research and education reputation
Human Factors and Civility training	Dedicated, bespoke team training	Awareness of our impact on our colleagues and patients	Improved team working	Safety and quality culture

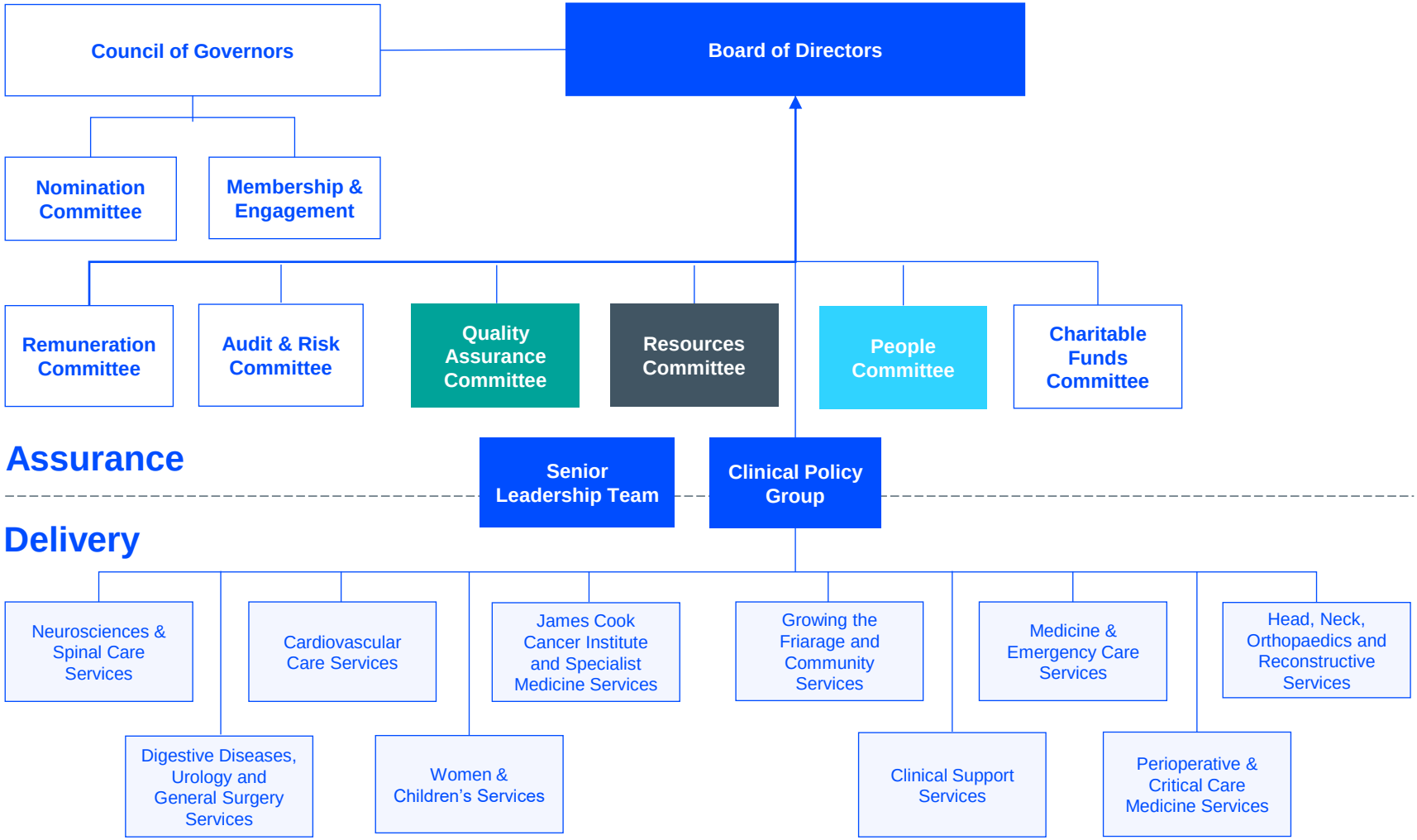
Assurance Framework

Safety and Quality First

Board Assurance and Governance

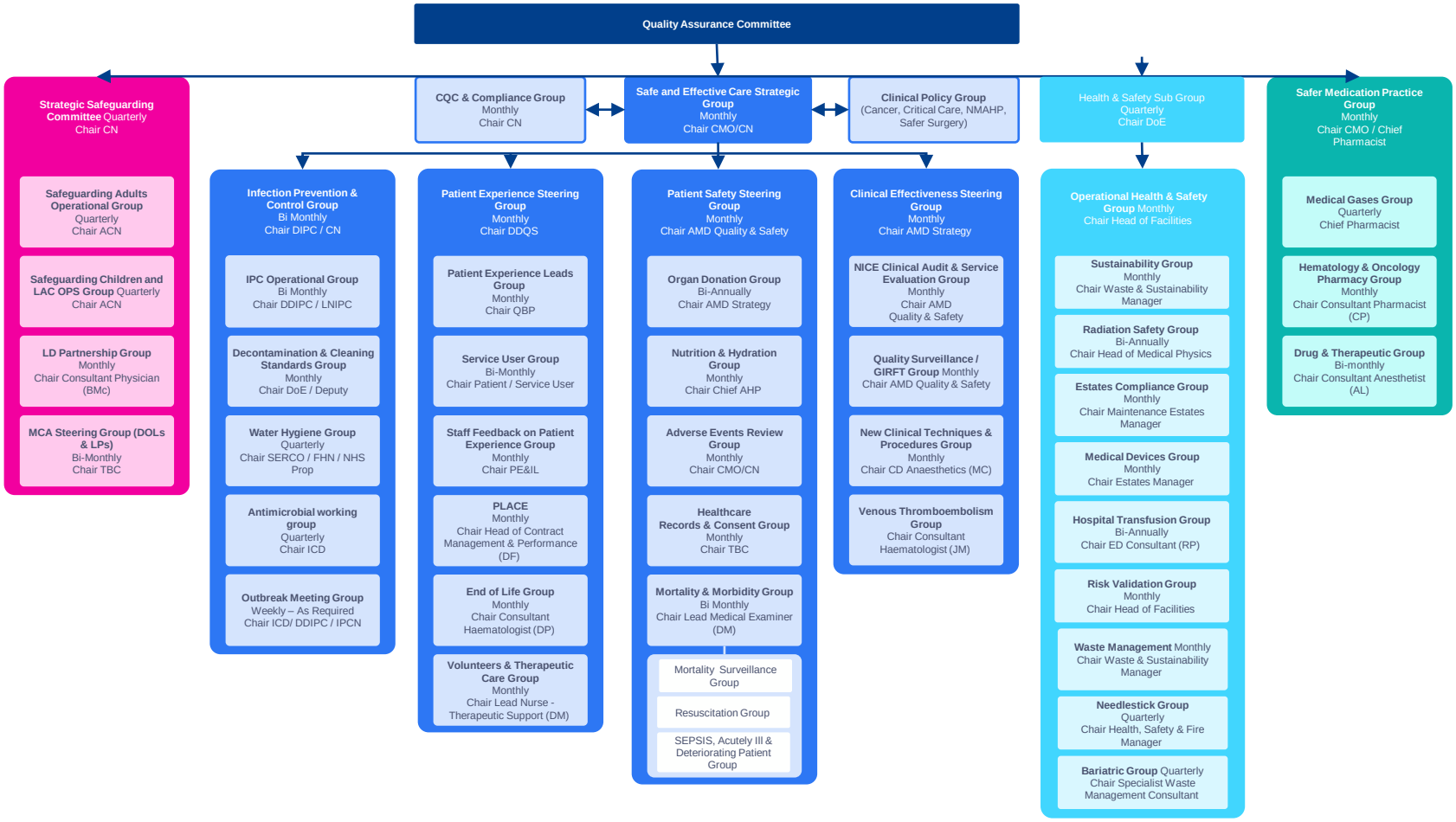
Jackie to confirm

Board assurance is an approach for ensuring that boards get the right information, which is accurate and relevant, at the right time and with a level of assurance. This is delivered through the Board Sub Committees which have authority, power, and responsibilities, and each committee operates under its own terms of reference. The board retains ultimate responsibility for any actions made by the committee. This new structure came into place from 1 April 2021.



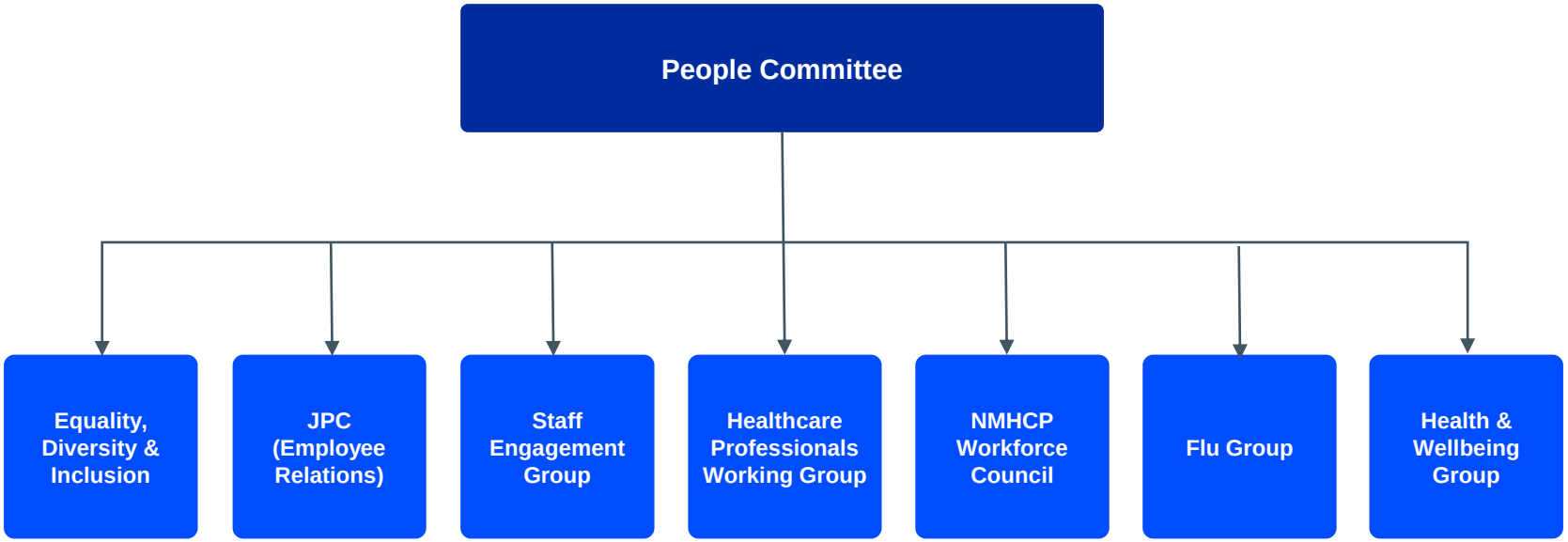
Quality Assurance Committee

The Quality Assurance Committee (QAC) is a sub group of the Trust Board and provides assurance to the Board on all matters relating to Quality and Safety. Outlined below are a series of groups that report QAC. These have recently been reviewed and aligned with the new collaborative structure. QAC will gain assurance on delivery of the Clinical Strategy, Safety and Quality Strategy, Nursing and Midwifery Strategy and Research and Innovation Strategy.



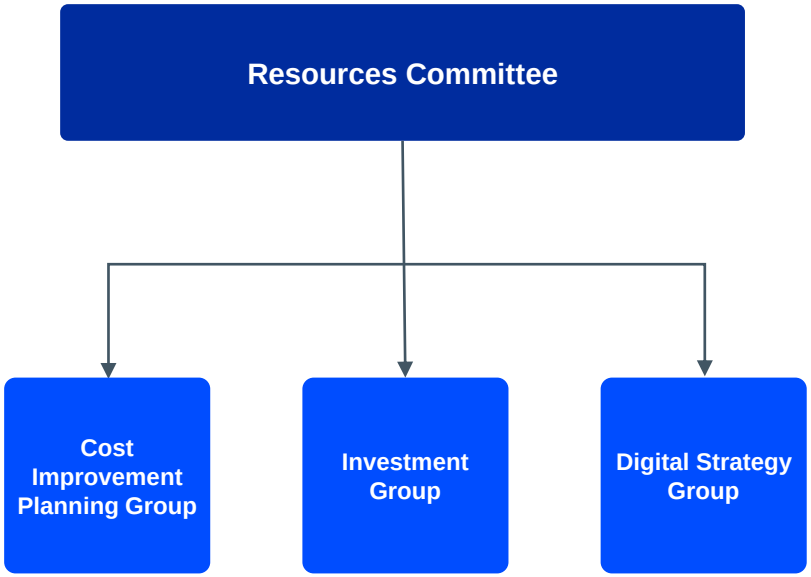
People Committee

The People Committee is a sub group of the Trust Board and provides assurance to the Board on all matter relating to our staff. The reporting groups are aligned to the new clinical collaboratives and the People Committee will provide assurance to the Board on delivery of the People Plan.



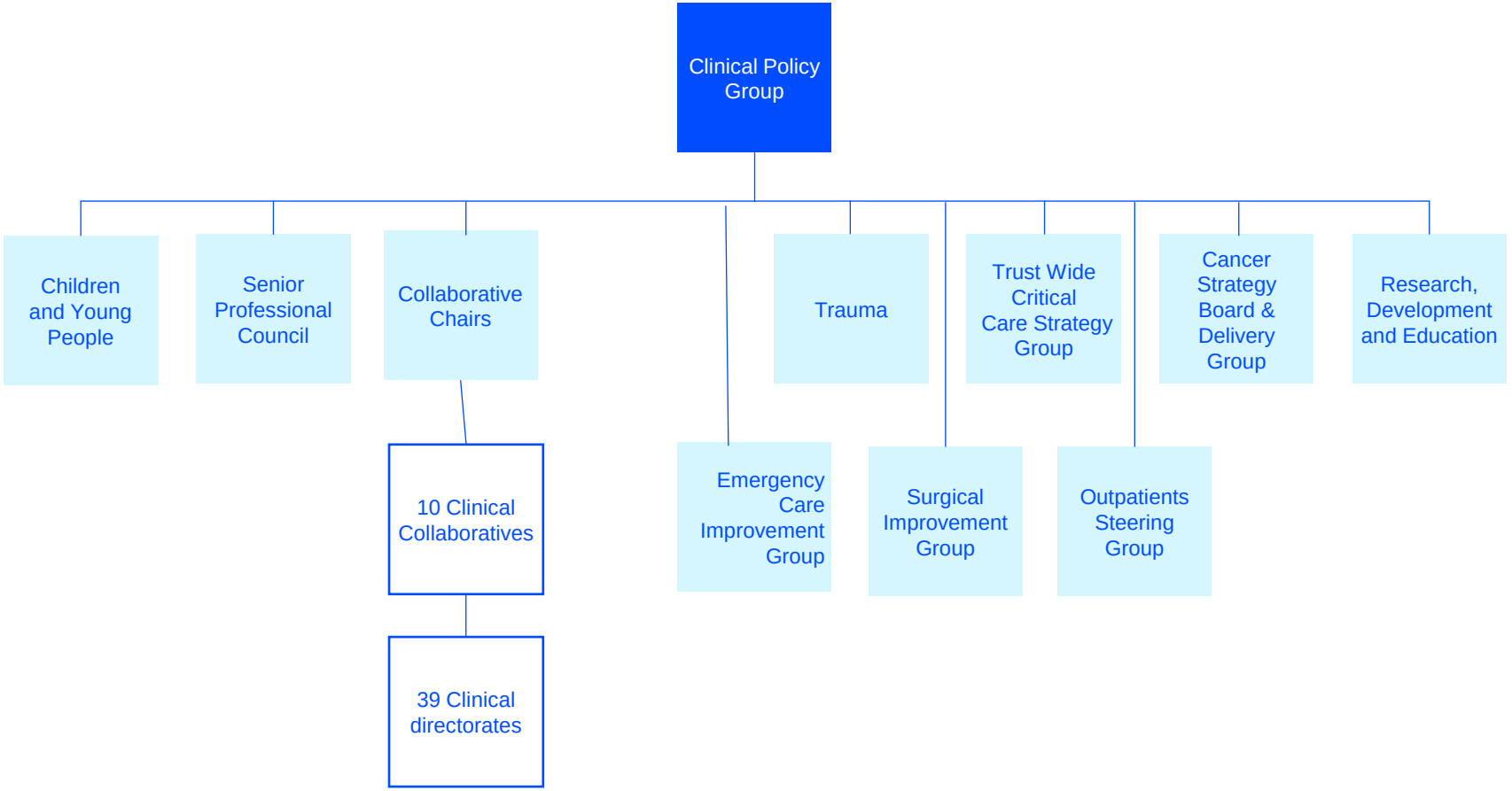
Resources Committee

The Resources Committee is a sub group of the Trust Board and provides assurance to the Board on all matter relating to our resources which includes finance, planning and performance and digital.



Clinical Policy Group Connecting Groups

This Clinical Policy Group has been established by the Board of Directors as the senior delivery and management group of South Tees Hospitals NHS Foundation Trust. The Role of CPG is to oversee the delivery of the Trust Strategy by providing independent, robust and credible strategic clinical advice and leadership to support delivery of the best outcomes for the population we serve. Reporting to CPG are a series of clinical reference groups.



How We Work: Assurance Framework

The Assurance Framework provides clarity around what Directorates and Clinical Collaboratives are responsible for and provides support to manage business and improvement plans and to escalate when support is required to mitigate risk. The framework joins up the governance of quality, performance, finance, workforce and enables the delivery of CQC Fundamental Standards and achievement of CQC compliance. Underpinning the Assurance Framework are a series of strategic and operational groups that bring together key individuals to plan and problem solve through the sharing of information and performance monitoring.

Key meeting	Purpose
Directorate meetings	The forum that brings together service managers and clinicians to plan and deliver safe, effective, caring, responsive and well-led services. Directorates also the manage risk across all their services and where necessary escalate to the Clinical Collaborative Board. Directorates report to Collaborative Boards via a monthly Chairs Log.
Collaborative Boards	The Collaborative Board creates a single line of accountability for delivery of a Clinical Strategy and operational delivery including safety, quality, activity performance, financial and the workforce relating to the clinical services within the Collaborative. Collaborative Boards receive a monthly Chairs Log from each Directorate. The Collaborative Board produces a monthly Chairs Log for Collaborative Chair meeting, and Integrated Performance Report to Collaborative performance meeting with senior leadership team.
Collaborative Chairs Meeting	Weekly meeting chaired by the Chief Medical Officer where all clinical collaborative chairs come together to discuss issues from their collaborative with their peers. In addition to this the meeting serves as a precursor to the Clinical Policy Group (CPG) meaning that the collaborative chairs are sighted and involved with the workstreams which then go to CPG for sign off.
Clinical Policy Group (CPG)	CPG is the main decision-making body of South Tees Hospitals NHS Foundation Trust. In this role the CPG is responsible for taking the decisions around how we allocate our resources and deliver care to ensure safety and quality. CPG attendance includes the Senior Leadership Team, Clinical Chairs, Clinical Directors, Chief and Lead Nurses, Lead Allied Health Professionals.
Governance sub committees	Collaborative Boards are to forward specific information and/or escalate through the formal sub groups of the Trust Board. This joins governance of clinical services with Trust-wide groups and oversight
SLT Support and Assurance	SLT to meet with Collaborative leadership team for support, assurance and problem-solving. Frequency of meetings to be determined. Agenda owned by the Collaborative.

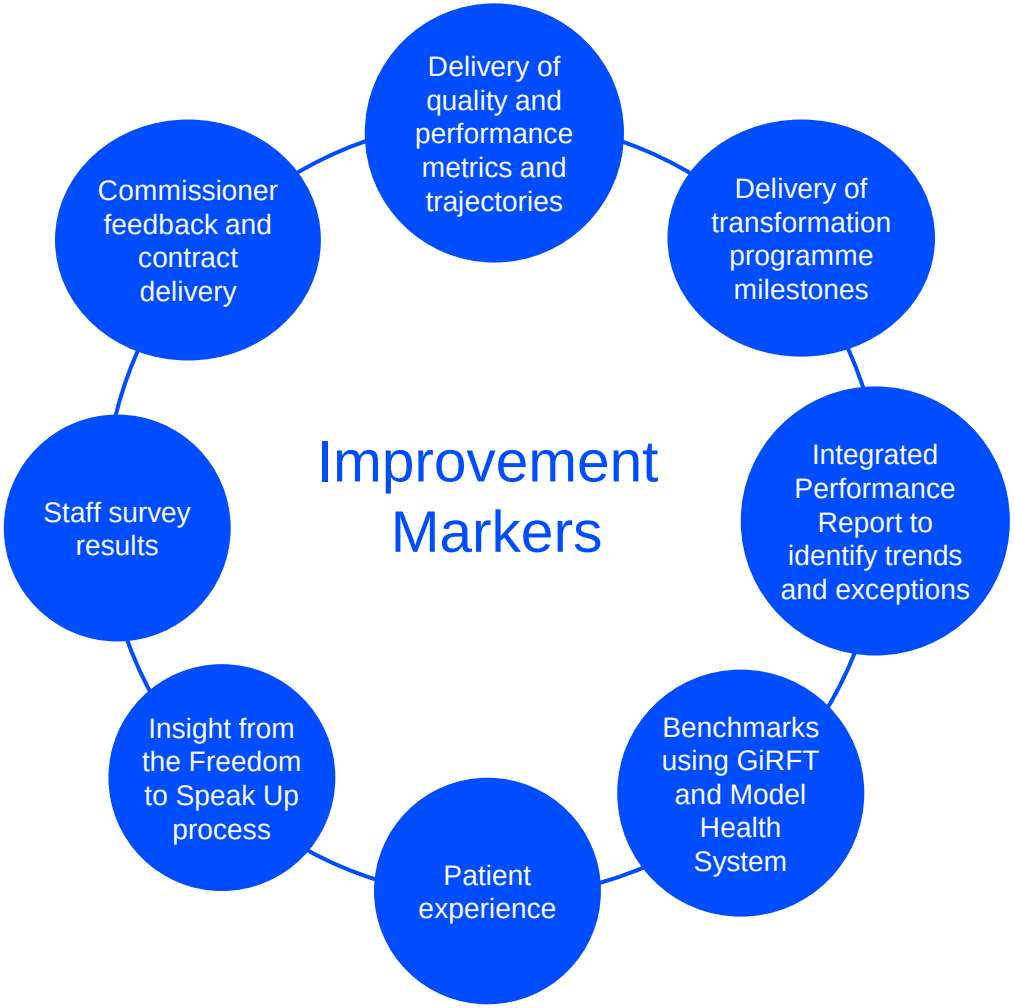
Risks

The Improvement Plan continues to present an ambitious programme of work and the organisation will need to mitigate and manage the risks to delivery. The Board Assurance Framework documents the principle risks to the Trust's strategic objectives. The Improvement Plan and Enabling Strategies and Plans are mitigation to all areas of the BAF.

Principle Risk	Improvement Plan assurance and mitigation
• BAF PR1: Inability to achieve standards of safety and quality of care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes.	• Clinical Strategy: Assurance Framework; Leadership & Safety Academy; Nursing & Midwifery Strategy; Safety & Quality Strategy; Digital Plan; Estates Plan; People Plan; EPRR and COVID management
• BAF PR2: Critical infrastructure failure… compromises ability to deliver high quality care	• Estates Plan, Digital Plan
• BAF PR3: Failure to recruit to full establishment, retain and engage our workforce	• People Plan; Communications & Engagement Strategy
• BAF PR4: Failure to deliver as a centre of excellence resulting in a lack of priority and recognition from commissioners and other stakeholders	• Clinical Strategy; Nursing & Midwifery Strategy; Safety & Quality Strategy; Research & Development Strategy; Leadership & Safety Academy; Estates Plan; People Plan; Communications & Engagement Strategy
• BAF PR5: Working more closely with local health and care partners does not fully deliver the required benefits	• Clinical Strategy
• BAF PR6: Failure to agree with the system and achieve the Trust's financial strategy resulting in regulatory action and inability to deliver strategic objectives	• Financial Plan
• BAF PR7: Failure to deliver Trust's financial recovery plan	• Financial Plan (cross-cutting incl Clinical, Digital and Estates)

Improvement Markers

We use a range of markers and methods to know that we are improving. Quantitative (activity, waiting lists and key metrics) and qualitative information (staff survey, patient feedback, clinical intelligence) will be used. Benchmarking with comparator Trusts helps identify where we can improve and we will seek, adapt and adopt good practice from elsewhere.



Abbreviations

To check last thing

Acronym	Meaning
A&G	Advice & Guidance
BAF, BAF PR	Board Assurance Framework, Principle Risk
CGA	Comprehensive Geriatric Assessment
CMO	Chief Medical Officer
COO	Chief Operating Officer
CPG	Clinical Policy Group
CQC	Care Quality Commission
ECIST	Emergency Care Improvement Support Team
ED	Emergency Department
EDD	Estimated date of discharge
EPRR	Emergency Preparedness, Resilience and Response
FHN	Friarage Hospital Northallerton
GIRFT	Getting it Right First Time
GPICS	Guidelines for the Provision of Intensive Care Services
HCAI	Hospital acquired infection
HR	Human Resources
ICNARC	Intensive Care National Audit and Research Centre
ICP	Integrated Care Partnership
ICB and ICS	Integrated Care Board / System
JPC	Joint Partnership Committee
LOCSSIP	Local Safety Standards for Invasive Procedures

Acronym	Meaning
LOS	Length of stay
MD	Managing Director
MDT	Multi-disciplinary Team
NMHCP	Nursing, Midwifery and Healthcare Professionals
PDD	Planned date of discharge
PIFU	Patient Initiated Follow Up
PSAG	Patient Status at a Glance
PSIRF	patient safety incident response framework
RTT	Referral to treatment
SDEC	Same Day Emergency Care
SOPs	Standard Operating Procedures
SPA	Single Point of Access
SPOR	Single Point of Referral
STAQC	South Tees Accreditation for Quality of Care
UTC	Urgent Treatment Centre

THANK YOU