South Tees Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS (PUBLIC)

Date – 1 November 2022
Time – 14:00 – 14:20 for public access via Microsoft teams
Venue – STRIVE, Friarage

Safety and Quality First

South Tees Hospitals NHS Foundation Trust

MEETING OF THE SOUTH TEES HOSPITALS NHS FOUNDATION TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON TUESDAY 1 NOVEMBER 2022 AT 14:00 IN THE FRIARAGE

Members of the public to observe via Microsoft Teams

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT
STAFF STORY				
CHAIR'S BUSINESS				
1.	Welcome and Introductions	Information	Chair	Verbal
2.	Apologies for Absence	Information	Chair	Verbal
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1
4.	Minutes of the last meetings held on	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 report	Information	Chief Medical Officer	ENC 9

	ITEM	PURPOSE	LEAD	FORMAT
EXPERIENCE				
12.	National Inpatient survey	Information	Chief Nurse	ENC 10
13.	Staff survey update report	Information	Director of HR	ENC 11
EFFECTIVE				
14.	Consultant appointments	Information	Chief Executive	Verbal
WELL LED				
15.	Quality priorities update	Information	Chief Nurse	ENC 12
16.	Ward establishments	Approval	Chief Nurse	ENC 13
17.	Finance Report	Information	Chief Finance Officer	ENC 14
18.	CQC update	Information	Chief Nurse	ENC 15
19.	Use of the seal	Information	Head of Governance & Co secretary	ENC 16
20.	Report on fit and proper	Information	Head of Governance & Co Secretary	ENC 17
21.	Committee Reports	Information	Chairs	ENC 18
	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 – 1 NOVEMBER 2022			
Register of members interests			**AGENDA ITEM: 3** **ENC 1**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Derek Bell Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	The Board of Directors are asked to note interests declared by members of the Committee		
Background	The report sets out membership of the Board of Directors and interests registered by members. Conflicts should be managed in accordance to the Constitution para 32 - If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to other Directors.		
Assessment	There are no specific conflicts identified with the agenda. Members will be reminded at the meeting to raise any if they arise.		
Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐		
Recommendation	The Board of Directors are asked to note the Register of Interest.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

South Tees Hospitals NHS
NHS Foundation Trust

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Ada Burns	Non-Executive Director	2017	Ongoing	Role - Governor – Chair of Resources Committee, member of Board of Teesside University.
		2019	Ongoing	Role – Associate Consultant – Cratus Consultancy, public sector management consultancy
		2022	Ongoing	Role – Governor and Chair of the Board of Governors
Richard Carter-Ferris	Non-executive Director & Vice Chair	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.
Jackie White	Head of Governance & Company Secretary	March 2013	Ongoing	No interests declared
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	December 2020	Ongoing	Role of School Governor at High Tunstall College of Science
Mark Graham	Director of Communications			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 Vice president of the red cross in Cumbria.
Robert Harrison	Managing Director			Board Member of the North East and North Cumbria Academic Health Science Network
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	Visiting Professor at Sunderland – no monetary gain
Chris Hand	Chief Finance Officer	2 July 2021	Ongoing	Director of South Tees Healthcare Management Limited - Company number 10166808 Client Representative ELFS Shared Services Management Board
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

		July 2022	Ongoing	Sel clinical advisor for SDEC
Mark Dias	Non Executive Director	20 July 2015	Ongoing	Director of Be The Change HR Ltd – Company No. 9694576
Miriam Davidson	Non Executive Director	November 2019	November 2022	Head of School of Public Health , HEE North East to end October 2022
Alison Wilson	Non Executive Director	2016 4 January 2022 2017	Ongoing Ongoing Ongoing	Trustee/ Non Executive Director Ad Astra Academy Trust – Company number: 09308398 Civil Partner – Counter Terrorism Policing North East Son – Bupa Global and Bupa UK
Kenneth Readshaw	Non Executive Director	2016 2018 2000	Ongoing Ongoing Ongoing	Treasurer – Leyburn Community Leisure Club Chair – Health Accommodation Trust Chair – Horsehouse School Charity - Charity number: 513060
Rudolf Bilous	Associate Non Executive Director			Occasional teacher undergraduate and postgraduate medicine South Tees NHSFT (unremunerated)
Alyson Gerner	Associate Non Executive Director	2007	Ongoing	Senior Civil Servant working for a central government department – Department for Education
Manni Imiavan	Digital Director			No interests declared

South Tees Hospitals NHS
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE BOARD OF DIRECTORS MEETING HELD IN PUBLIC ON TUESDAY 6 SEPTEMBER 2022 AT 14:00 IN THE BOARD ROOM, MURRAY BUILDING JAMES COOK AND VIA MICROSOFT TEAMS

Present

Professor D Bell	Joint Chairman
Mr D Redpath	Non-Executive Director
Ms A Burns	Non-Executive Director
Ms M Davidson	Non-Executive Director
Mr K Readshaw	Non-Executive Director
Ms A Wilson	Non-Executive Director
Mr M Dias	Non-Executive Director
Dr M Stewart	Chief Medical Officer
Mr R Harrison	Managing Director
Ms S Page	Chief Executive
Dr H Lloyd	Chief Nurse
Mr C Hand	Chief Finance Officer

Associate Directors – non-voting

Dr R Bilous	Associate Non-Executive Director

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 M Imiavan	Digital Director
Mrs M Angel	Interim Director of Clinical Development

PATIENT STORY

Mrs K Jones presented the monthly patient story which centred on the experience of the trust's new Family Liaison Officer role.

BoD/22/062 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/22/062 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr Cater Ferris, Non-executive Director and Ms Gerner, Associate Non-Executive Director.

BoD/22/063 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/22/064 **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/22/065 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on Tuesday 5 July 2022 were reviewed and agreed as an accurate record subject to the following amendment: Mrs White

Page 2, Minutes of the last meeting - the minutes of the meeting held on Tuesday 3 May 2022 were reviewed and agreed as an accurate record.

BoD/22/066 **MATTERS ARISING**

There were no matters arising to discuss with Board.

BoD/22/067 **CHAIRMAN’S REPORT**

The Chairman referred members to his previously circulated report and highlighted a number of elements of his report including that a successful recruitment campaign for non-executive directors took place during July and he welcomed new members. The Chairman advised that he had continued to visit departments across the Trust including ED and maternity services.

The Chairman reported that he visited Newcastle University to discuss how the relationship between the Trust and Newcastle University can be further developed.

RESOLUTION

The Board of Directors NOTED the Chairman’s report.

BoD/22/068 **CHIEF EXECUTIVE’S REPORT**

The Chief Executive referred the previously circulated report and highlighted a number of areas for consideration including reaccreditation as a Veteran Aware (VCHA) organisation and the achievement of a Silver Award in the Defence Employer Recognition Scheme

Also, that the Department of Health and Social Care has given approval for £35.5million of NHS investment to be earmarked for the creation of new modern operating theatres at the Friarage Hospital. The Friarage development is one of more than 50 new surgical hubs that are being created across the country.

The Chairman commented that this is a major step forward, and an important part of delivering and building capacity and support.

Mrs Wilson asked the Chief Executive how the consultation on the establishment of an Urgent Treatment Centre on the James Cook site was progressing. The Chief Medical Officer responded on behalf of the Trust highlighting that the engagement exercise has only just started and Mr Graham added that the consultation will run for 10 weeks and is being led by the ICB – which includes extending opening hours at Redcar Urgent Treatment Centre and development of an Integrated Urgent Care facility at James Cook.

RESOLUTION

The Board of Directors NOTED the Chief Executive's update

BoD/22/069 **BOARD ASSURANCE FRAMEWORK**

Mrs White referred members to the report on the Board Assurance Framework report and highlighted the Lead Executives have reaffirmed that the principal risks identified against the strategic objectives are still appropriate for 2022/23. Mrs White highlighted that work will progress during September to update the BAF which will be considered by the Board Sub Committees in September and signed off by the Audit Committee on behalf of the Board.

RESOLUTION

The Board of Directors NOTED the BAF

BoD/22/070 **INTEGRATED PERFORMANCE REPORT**

Mr Peate presented the Integrated Performance Report (IPR). He highlighted ongoing challenges across the wider health and social care system. Elective access by RTT 18 week standard remained stable, whilst the England trend was a month-on-month deterioration in performance since July 2021. The total waiting list increased but the number of patients waiting more than 52 weeks has remained stable,

78-week waits were fewer than plan, and at May month-end no patients waited over 104 weeks.

Mr Peate added that activity was below plan in May and is recovering in day case. Diagnostic compliance is improving as accumulations and waiting list validation are addressed. Cancer 62-day standard performance is better than average, and more treatments were delivered than planned.

Mr Peate highlighted that the Trust continues to see rise in incident reporting and this positive trend continues to demonstrate a strong safety culture.

The Trust is slightly above trajectories for CDIF infections, and has recently started on a deep clean plan across the trust major sites and clinically agreed.

Finally patient feedback in general high levels of patient experience but ED is slightly below where we expect to be – continued pressure on emergency pathways. Mr Peate advised that levels of attendance in ED is 20% higher than pre pandemic.

Mr Readshaw asked for more information on the 12 hour waits and Mr Peate advised that the Trust has been undertaking work in the ED department, which has been self-led by the teams and a number of new pathways have been developed, including a number of escalation pathways to improve visibility in the area.

Mr Harrison commented that the challenges in ED can been seen across the country and the Trust performance is in line with the escalating issue across the country. He added that it is really important patients are receiving the right care and there is good observation of the patient and if patients are delayed that the care is provided to them in the ED environment, such as intentional rounding's to ensure patients pressure care and nutrition and hydration is taken care off.

Mr Harrison advised that there are real challenges around discharge to home where a home care package is required and we are seeing a 50% for this type of patient. Nationally this is a challenge for social care providers recruitment of staff.

Mrs Wilson commented that the target timelines for closing complaints are not being met and Dr Lloyd advised that during July this had been impacted by vacancies and sickness with the team, however the response rate had now increased to 66% for August. She added that the Trust are reviewing the systems around this to ensure there are much more meetings with families to resolve complaints.

Professor Bilous asked for clarity regarding the cancer data. Mr Peate advised that within endoscopy a decision was made to prioritise referrals and surveillance to ensure right patients are seen at the right time and this has impacted on our response to the 14 day target. The 62 day target is being impacted by the 14 day target. He added that there is a clear plan to address this including additional capacity at the Friarage.

Professor Bilous asked regarding pressures with new lung cancer screening and Mr Peate advised that the Trust is not seeing any issues at the moment but we are seeing a wide variation in referrals to tumour areas. Dr Stewart added that lung cancer numbers are very good and the screening programme is a pilot and has less of an impact for us locally.

RESOLUTION

The Board of Directors NOTED the update

BoD/22/071 **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 is 94.9% demonstrating good compliance with safer staffing.

Staffing has continued to be a impacted with short notice unavailability associated with COVID isolation and COVID related absence.

Stretch staffing ratios have been implemented where necessary based on skill mix, acuity, and occupancy levels, all these actions agreed by senior nurses through safecare meetings.

The introduction of allocate on arrival shifts for RNs and HCAs has improved pick up, these shifts are promoted daily via ward manager platforms and NHSp text messaging. The demand from July is 5 long days, nights and twilights for RN and HCA at JCUH and 3 long days, nights and 2 twilights for RN and HCA at FHN. An evening shift was introduced from 29th July for RNs at JCUH (5) and FHN (2). This model has been followed in community and Paediatrics with impactful pick up.

Nursing Turnover for July 22 has decreased to 9.72%.

The Chairman asked regarding welcoming our internationally nurses. Dr Lloyd advised that there is a robust programme in place for international nurses and Mrs Metcalf advised that

the Trust is setting up a network for staff who have joined the Trust from oversees.

RESOLUTION

The Board of Directors NOTED the safer staffing report

BoD/22/072 **CONSULTANT APPOINTMENT**

The Chief Executive updated on the new consultants who had joined the Trust in August including:

Mona Abouzaid - Diabetes
Krishna Dogiparthi – A&E
Tim Hardy – Gastroenterology
Laura Jackson – ENT
Victoria Kershaw – Obs & Gynae
Eoin McCarthy – A&E
Ramsay Refaie – Trauma & Orthopaedics

She also gave thanks to Jacqui Gedney – Anaesthetics who had left the Trust.

The Chief Executive also reported that three interventional radiologists were due to arrive in September and will make the rota compliant. She commented that this was a massive achievement for the Trust.

RESOLUTION

The Board of Directors NOTED the update

BoD/22/073 **GUARDIAN OF SAFE WORKING REPORT**

Dr Stewart referred members to his report and highlighted the number of Exception reports (ER) raised this quarter is seven. Five of these were raised from the Digestive diseases, Urology and General surgery services Collaborative.

The Chairman commented that the number of reports seemed low compared to number of doctors employed.

RESOLUTION

The Trust Board of Director NOTED the report

BoD/22/074 **FINANCE REPORT**

Mr Hand and referred members to the previously circulated report and highlighted that theTrust's plan submitted to the NHSE/I regional team for the 2022/23 financial year is a deficit of £20.7m.

With the agreement of NHSE, the Trust submitted an uncertified financial return in Month 4 to NHSE, due to the national eFinancials system down-time.

At Month 4 the Trust reported a deficit of £11.0m at a system control total level. This is in line with the plan submitted to the NHSE/I.

Mr Readshaw asked regarding the CIP profile and Mr Hand advised that the CIP is phased. He added that it is core work in collaboratives who are on track to deliver 100%. Mr Hand commented that he is confident in the year end plan and positive around recovery savings.

Ms Burns commented that it was good to see the progress on the CIP noting the areas which were ahead of plan and, regarding the e-rostering element, and asked if the Trust can accelerate this programme. Mr Hand commented that the overall financial plan allows new schemes to be identified all the time which will offset any slippage.

Mrs Wilson asked regarding the ERF funding potential clawback. Mr Hand advised that the ERF clawback will not be undertaken in quarter one and it is likely this will be the case until month 6.

RESOLUTION

The Board of Directors NOTED the report

BoD/22/075 **CQC UPDATE**

Dr Lloyd referred members to the previously circulated report and highlighted updates about new and ongoing work in relation to CQC inspection February 2022, action planning, CQC engagement meetings and STAQC.

The Chairman thanked Dr Lloyd for the update and reminded members of the very full briefing from Dr Lloyd as part of Board development seminar held in the morning.

The Chairman added that as part of the Board Walkround members had the opportunity to meet the nutrition assistant who was very enthusiastic about the role. Dr Lloyd added that she is very patient centred and focussed on individual patient needs such as young people and dementia patients. Dr Lloyd added that it was lovely to she is making a difference.

RESOLUTION

The Board of Directors NOTED the report

BoD/22/076 **COMMITTEE REPORTS**

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

Quality Assurance Committee – Dr Lloyd on behalf of Chair of the Quality Assurance Committee updated that the regional midwife had visited the Trust and assessed compliance against recommendations within the Ockenden report. Dr Lloyd reported that the Trust is compliant with all 7 actions and the visiting team noted open and transparent and positive workforce and culture and commented on good maternity leadership team. Dr Lloyd commented that she was pleased to hear this feedback and the visiting team had suggested sharing work with others.

The Chairman congratulated the team.

BoD/22/077 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Board of Directors will take place on 1 November 2022

Signed: ……

Date: ……

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 NOVEMBER 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 ☒	
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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 Departmental visits

As part of the Board walkround in October I visited the Single Point of Access team and met the winner and runner up of the Call handler of the year Linda Lee and Shereen Qadir. It was great to be able to meet staff in this team who were all enthusiastic and proud of the services they are delivering.

2.2 Non Executive update

The new Non Executive Directors are now all in place and have been undertaking a period of induction. A mentorship programme has been set up to support the new Non Executive Directors.

Two exit interviews have been held with Non Executive Directors who left at the end of August.

A further joint meeting with Non Executive Directors at North Tees & Hartlepool NHS Trust was held in September at the Friarage Hospital. A visit to the ward areas was undertaken.

The Nomination Committee met in September and agreed on the appointment of Richard Carter Ferris as Vice Chair for a one-year fixed term position which was ratified by the Council of Governors.

2.4 Annual General Meeting / Annual Members meeting

The Trust held its Annual General Meeting and Annual Members meeting on 20 September 2022 and I was delighted to chair the event and to see colleagues and members of the public in attendance.

2.5 Regional Chairs meeting

I attended the regional Chairs meeting in October. Sir Liam Donaldson provided an update from an ICB perspective including feedback from the recent first meeting of the ICP. There was also a discussion on maternity issues and Ockenden requirements.

3. Recommendation

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

Professor Derek Bell Joint Chair

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 November 2022			
Chief Executive update			**AGENDA ITEM: 7, ENC 5**
Report Author and Job Title:	Mark Graham, Director of Communications	**Responsible Director:**	Chief Executive
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Chief Executive update		
Background	The following report provides an update from the Chief Executive.		
Assessment	The report provides an overview of the health and wider related issues.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
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Chief Executive Update

COVID-19 update

The number of patients with COVID-19 requiring hospital care continued to increase in October to more than double the numbers seen in August.

At the same time, challenges in the social care sector have continued to be observed and the trust continues to work closely with local authorities and other partners to ensure that everything possible is done to ensure people who are ready to leave hospital, who require social care support, are able to access this as quickly as possible.

Despite pressures across the health and care system, the incredible work of colleagues meant that in the five-week period to 13 October, the trust's clinical teams delivered more than 3,300 operations of which over 2,700 were planned surgical procedures. At the same time, almost 70,000 outpatient appointments took place more than 17,000 people accessed urgent and emergency care services.

Separately, more than seven million people have now received their autumn booster and, as we approach winter, it remains vitally important for people to protect themselves by coming forward for COVID and flu vaccinations, if they are eligible, as soon as they can (if they have not done so already).

Operating framework for NHS England

The Operating Framework for NHS England (NHSE) was published on 17 October and sets out how NHSE will operate in the new structure created by the 2022 Health and Care Act.

The Health and Care Act formally established Integrated Care Boards (ICBs) on a statutory basis. The new operating framework sets out the roles that NHSE, ICBs and providers will now play in the new structure.

The framework has been co-created with 300 system leaders, organisations and stakeholders, including Health Education England and NHS Digital.

Under the new Operating Framework, NHSE will support local decision making and will use input from ICBs to agree the mandate for the NHS with government and the resources needed to deliver it.

National NHS winter resilience plans

On 18 October, NHS England (NHSE) published winter resilience plans for the NHS. These include:

Better support people in the community – reducing pressures on general practice and social care, and reducing admissions to hospital by:

- *Putting in place a community-based falls response service in all systems*
- *for people who have fallen at home including care homes*
- *Maximising the use of virtual wards, and actively considering establishing an Acute Respiratory Infection (ARI) hub to support same day assessment*
- *Providing additional support for care homes through reducing unwarranted variation in ambulance conveyance rates*

- Deliver on ambitions to maximise bed capacity and support ambulance services – bed occupancy continues to be at all-time highs, and the NHS needs to take all opportunities to make maximum use of physical and virtual ward capacity to increase resilience and reduce delays elsewhere in the system. This includes:

- *Supporting delivery of additional beds*
- *All systems setting up a 24/7 System Control Centre to support system oversight and decision making based on demand and capacity across sites and settings*
- *Ensuring all ambulance services deploy 24/7 mental health professionals in emergency operation centres and on-scene*

- Ensure timely discharge and support people to leave hospital when clinically appropriate – more than 10,000 people a day are clinically ready to leave hospital but can't be discharged, and this causes significant and fundamental issues for patient flow. In addition to maintaining focus on the high impact actions from the 100 day challenge, the Government recently announced £500m to support social care to speed up discharge across mental and physical health pathways. More details about distribution of this fund will be shared by NHSE when available.

- Continuing to support elective activity

Clinical colleagues and teams continue to undertake significant winter preparedness work in-line with national and local requirements.

Middlesbrough Urgent Care and out of hours GP access

As previously reported, the NHS North East and North Cumbria Integrated Care Board (ICB) has been engaging on proposals to create a new Integrated Urgent Care Centre (IUC) at The James Cook University Hospital in Middlesbrough, and an expansion to opening times at Redcar Urgent Treatment Centre (UTC).

Integrated Urgent Care (IUC) access is currently in place across the other boroughs within Teesside, with Urgent Treatment Centres at Darlington Memorial Hospital, the University Hospital of North Tees, the University Hospital of Hartlepool and Redcar Primary Care Hospital.

The IUC model will include home visiting, GP out of hours access, and management of minor injuries and illness, with 24/7 primary care presence. A 10-week public engagement exercise concluded on 16 October and the IUC model is proposed to commence in the summer of 2023.

CQC adult inpatient survey

The Care Quality Commission's 2021 adult inpatient survey was published in September (2022).

The annual survey, asked 1,250 adults, aged 16 years or over (who stayed at least one night at The James Cook University Hospital or Friarage Hospital during November 2021) about their experience. The survey results found that the trust has continued to perform above the national average for inpatient care.

Nightingale Awards

Margaret Kitching MBE, regional chief nurse for the North East and Yorkshire, joined teams at James Cook in October to launch this year's Nightingale Awards, and talk to them about their journey over the last three years which has seen nurses, doctors and other health professionals come together to make the decisions about how resources are allocated and care is delivered across the trust.

The Nightingale Awards celebrate nurses and midwives who have gone the extra mile for their patient or service user to ensure an outstanding level of care, and people in the local community can submit nominations.

Prostate cancer trial

In October, researchers based in the STRIVE Academic Centre at The James Cook have recruited their first patient to receive Lutetium-177 PSMA in an international clinical trial.

The Novartis sponsored clinical trial, known as PSMAfore, is an international study investigating whether a new type of treatment using a drug called 177Lu-PSMA-617, can help to prolong the duration and quality of life in patients who have received first-line therapies for incurable prostate cancer.

The trust was only one of four UK centres selected to take part in the clinical trial.

Early palliative intervention care service

A new service, one of the first of its kind in the UK to provide Early Palliative Intervention Care (EPIC), launched at was launched in October by the trust and Macmillan Cancer Support.

Part of the wider specialist palliative care team, the EPIC has involved the creation of two specialist roles at the Friarage Hospital offering services across Hambleton and Richmondshire.

It will initially be focused on those with upper GI (gastrointestinal), colorectal and skin cancers but is expected to open to other tumour groups as the service develops.

The community service aims to bridge the gap between diagnosis and end of life care for patients who have been diagnosed with incurable cancer.

By providing early intervention the team can spot problems before they escalate into something bigger, improving quality of life and avoiding unnecessary hospital admissions.

Love South Tees Admin Awards

In September, the trust held its inaugural Love South Tees Admin Awards which were culmination of a range of activities promoting and recognising the fantastic contributions of admin colleagues across the trust.

2. RECOMMENDATIONS

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

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 1 NOVEMBER 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 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. These objectives and principal risks have been reaffirmed by the Board in July. The Board of Directors tasked the Board sub committees to review the BAF threats and update the BAF for 2022/23 whilst undertaking 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 have received an updated BAF document setting out the principal risks and updated threats at their meetings in October. Gaps in assurance and action have been identified but need further work in terms of timescales and lead manager responsibilities. The Chair's logs from the Committees will demonstrate the Committee has tested the controls in place; received assurances (some positive and some negative); reviewed the gaps in controls or assurance and received assurances to mitigate some of these gaps. A number of assurance reports are being received today at Board. The Finance report and IPR discuss the financial position for month 6 drawing on the work of the Collaboratives and Improvement Councils established to support the CIP for the Trust.		

	COVID19 community infections continues to have an impact on areas across the Trust including performance as identified in the IPR and staffing as identified in the IPR and safer staffing report. However the impact on Mortality has started to settle out as described in the Learning from deaths report. Staffing continues to be highlighted in a number of assurance reports including the annual report on Nurse staffing, capacity and capability annual review for acute inpatient wards and the IPR and safer staffing report due to the ongoing nature of the COVID-19 pandemic, sickness absences remained high, reflected in HR KPI's. The Quality Priorities report sets out the quality priorities identified by the Trust which will provide assurance to a number of BAF areas in particularly around BAF 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 Falls is raised in a number of reports including outstanding work in relation to CQC, the CEO report in terms of winter preparedness and patient quality indicators with regard to the ward establishment annual report.	
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 development of the 2022/23 Board Assurance Framework and 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.

During October Board Sub Committees received updated elements of the Board Assurance Framework relevant to their objectives which set out updated threats and gaps in assurance and action.

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 yet to be agreed for 2022/23.

All Committees continue to have time on their agenda to horizon scan for new threats or risks. These have been considered as part of the BAF update along with a risk report provided by PWC the Trusts internal audit provider.

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

3.1 **Assurance reports Trust Board of Directors**

Several 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
- National Inpatient survey 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
- Nurse staffing, capacity, and capability annual review for acute inpatient wards
- Integrated Performance Report
- CQC update
- Staff survey

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

- Integrated Performance Report

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

- Finance Report
- Integrated Performance Report

4. RECOMMENDATIONS

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

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Board Assurance Framework (BAF) 2022/23 (updated September 2022)

This BAF includes the following Principal Risks (PRs) to the Trust's strategic priorities, reaffirmed by the Board of Directors at the July 2022 Board meeting:

- 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.

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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 appetite**	Minimal
Executive Lead	Chief Nurse/Chief Medical officer	**Likelihood**	4. Likely	4. Likely	3. Possible		
Initial date of assessment	September 2022	**Consequence**	4. Major	4. Major	3. Moderate		
Last reviewed		**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 deterioration in standards of quality and safety of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes	Corporate, Collaborative and Directorate structures, accountability & quality governance arrangements at Trust including: • Tier 1 Board Sub Committee and sub structure • Risk Management Policy and Corporate Risk review group • 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 • Medical Examiner's office in place	**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 Guardian of Safe Working report to People Committee and Board quarterly Safeguarding Annual Report to QAC TBC Freedom to Speak up report to People Committee and Board quarterly Medicines Optimisation Report to QAC quarterly CQC preparation plan for future inspection report to QAC and Board monthly AHP Strategy drafted received by People Committee CQC insights report reviewed by QAC TBC 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 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	Patient experience strategy to be developed to ensure the full extent of patient experience and involvement data is known– Hilary Lloyd - TBC	

		Audit Inpatient Survey 2019, 2020, 2021 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) 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	Effect of decant ward and fogging / deep clean programme required – Hilary Lloyd date to be confirmed Impact of elective programme on spread of infections – Hilary Lloyd date to be confirmed	
1.3 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, Civility and Human factor training Ward accreditation programme Reciprocal mentorship programme Freedom to speak up guardians Patient Safety Faculty Patient Safety Champions / Ambassadors Weekly / monthly safety and quality briefings 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	**Management** Report and feedback on training for just culture, civility and human factors to People Committee Freedom to speak up model assurance provided to Audit & Risk Committee 6 monthly 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 reported through People Committee		

	Patient Safety Ambassadors recruitment and appointment process	**Independent** National Staff survey results Freedom to speak up national survey Feedback from NHSE/I on review of never events		
1.4 Increasing demand leading to a reduction in the quality of care and potential harm to patients, inability to deliver national performance standards and impact on increasing size of waiting list patients;	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 established Weekly touchpoint meeting with Commissioners Daily touchpoint meeting on patient flow	**Management** Reports to Board on Winter preparedness to Resources Committee and CPG Improvement Plan reports to Board Recovery plans for high risk services and updates to Board and Committees and CPG 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 and Board 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	Impact of demand on patients who are waiting for treatment – clinical harm reviews; waiting list validation – Sam Peate – TBC Impact on resources – elective recovery plan clawback – Sam Pate – TBC Hidden impact from COVID – future demand and late presentations – Sam Peate – TBC Accurate data and reporting – data validation – Sam Peate / Manni Imiavan - TBC	
1.5 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	**Management** Estates Centre Board meets monthly and assess compliance 5 year prioritised Capital Plan received by Resources and Board Expression of Interest (EOI) – New Build Hospital Programme – awaiting outcome Elective Recovery Programme – Targeted Investment Fund (TIF) being invested Friarage Hospital Estates Plan Updated FHN Theatres OBC approved Capital Programme for this financial year 22/23, underway Quarterly updates on Capital to Resources Committee	Impact of operational pressures and ability to refurbish wards – next ward (ward 7) due for refurbishment April 23 Kevin Oxley Outcome of new hospital bid – Kevin Oxley TBC Impact of critical infrastructure assessment by PFI company awaited – Kevin Oxley TBC	

	Agreed 22/23 lifecycle plan of investment and 23/24 indicative plan from our PFI partner Rolling 5 year capital investment plan Capital investment increases into the estate which includes - £2m investment in eradicating backlog maintenance in the non-PFI estate over 21/22 and 22/23 financial years - ward refurbishment programme recommenced (ward 8 due completion November 22 - new PACU due completion December 22 FHN new endoscopy unit and Urology unit commissioned September 22 - additional CT scanner work commenced due completion spring 23 - two FHN ward refurbishments - Low levels of backlog maintenance evidenced in model hospital when assessed against peers	Estates paper presented to Board January 2022 Ward 8 released for lifecycle work June 2022 **Risk and Compliance** **Independent Assurance** Internal Audit of estates services 2022 Internal Audit of PFI contract management Independent Authorising Engineer (AE) annual reports PLACE Assessments CQC Inspections		

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Principal risk - 2	**A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of care of services across the Trust which also has a significant impact on the local health care community and failure to effectively plan for a further pandemic situation or other significant business interruption event**	**Strategic Objective**	**Best for safe, clinically effective care and experience**

Lead Committee	Quality Assurance	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**		
Executive Lead	Director of Estates	**Likelihood**	3. Possible	3. Possible	2. Unlikely	**Risk appetite**	Minimal
Initial date of assessment	September 2022	**Consequence**	5. Catastrophic	5. Catastrophic	5. Catastrophic		
Last reviewed		**Risk Rating**	15. 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 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	**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		
2.2 Risk that the Trusts business continuity arrangements are no adequate to cope without damage to patient care or delivery of business activities such as finance with major external or unpredictable events	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** **Risk and compliance** Business Continuity Plan report to Audit & Risk Committee February 2022 **Independent assurance** EPRR report EPRR Core Standards compliance report	Testing of business continuity plans not routinely undertaken in all specialities Aim to test all BCPs during 2023 – K Oxley/D Hurley Review of the Major Incident Plan overdue. Simulation Exercise panned 8 December with MDT and learning from that exercise will inform the update of the Major Incident Plan – March 23 – K Oxley/M Stewart/EPRR Leads	

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		
Executive Lead	Director of HR	Likelihood	3. Possible	3. Possible	3. Possible	Risk appetite	MINIMAL
Initial date of assessment	September 2022	Consequence	3. Moderate	3. Moderate	3. Moderate		
Last reviewed		Risk Rating	9. High	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.	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 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 contractor workforce at the Trust	**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 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 Freedom to speak up report quarterly People Committee review of risks on a monthly basis IPR workforce metrics reviewed by People Committee and Board monthly **Independent Assurance** NHSI use of resources report 2018 CQC inspection report July 2018	Impact of workforce shortages on existing workforce – Rachael Metcalf TBC Lack of systematic approach to talent management and succession planning – Rachael Metcalf TBC Implement retention strategy linking with Belonging objective – Rachael Metcalf - TBC	

	Year on year increase in volunteer workforce Nursing & Midwifery Strategy Workforce plan and accountability framework	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 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 **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 redeployment	Impact of absence of workforce on existing workforce – Rachael Metcalf TBC Impact of flexible working options for staff – Rachael Metcalf	
3.3 Failure to develop a psychologically safe environment for staff as a result of not embedding the cultural improvement journey	Staff engagement strategy Policies for Grievance, Dignity at Work and FTSU Year on year reduction of appeals received STAR awards Specific campaign and communication around Total Rewards Statements ESR and development plan	**Management** Quarterly report to People Committee on Engagement Values based recruitment process roll out January 2022 Quarterly report on belonging to People Committee Report on over / under payments **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; **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	Ability to increase the response rate for completion of the staff survey – Rachael Metcalf – TBC Implementing the ESR automation service to allow further autonomy in the workforce – Rachael Metcalf - TBC	

3.4 Failure to attract, retain and develop a diverse leadership. A culture that perpetuates the current inequalities through a lack of understanding of privilege and how this manifests in recruitment, talent management and succession planning processes.	BAME risk assessments ED&I strategy Just culture and civility saves lives programme Staff networks in place for some protected characteristics	**Management** ED&I Annual report WRES and WDES report to People Committee Quarterly report to People Committee on ED&I Reciprocal mentorship programme in development Values based recruitment process roll out January 2022 **Risk and compliance** Freedom to speak up self-review Board 2019 Freedom to Speak Up Guardian report quarterly to Board Guardian of Safe Working report to Board; Gender Pay Gap report to People Committee **Independent Assurance** NHS staff survey 2020 results showing improvement in a number of areas Critical Care junior doctor survey discussed at People Committee 2021 NHS Staff survey 2021 results showing improvements in a number of areas	Evidence of increasing the workforce to be representative of the communities we serve (Race Pay gap_– Rachael Metcalf TBC Evidence of promotion opportunities for colleagues from protected characteristic backgrounds- Rachael Metcalf - TBC Impact of increased representation of protected characteristics on each recruitment panel – Rachael Metcalf TBC Impact of reciprocal mentorship programme on recruitment and retention - Rachael Metcalf TBC#	
3.5 learning and leadership	Learning and development programme for staff development Schwartz rounds 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 Leadership academy Quality Improvement training and support offers Leadership apprenticeship partnerships Patient safety and quality training Appraisal process in place for all staff clinical and non clinical – new paperwork agreed with staff introduced including a wellbeing discussion	**Management** Quarterly report to People Committee on Engagement Quarterly report on Education to People Committee specific programme to all junior doctors KPI report on training KPI report on appraisals Report on quality of appraisals to People Committee **Risk and compliance** **Independent Assurance** NHS staff survey 2020 results showing improvement in a number of areas NHS Staff survey 2021 results showing improvements in a number of areas HEE report on medical education September 2022		

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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	Quality Assurance Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**		
Executive Lead	Chief Medical Officer	**Likelihood**	2. Unlikely	2. Unlikely	2. Unlikely	**Risk appetite**	Open
Initial date of assessment	September 2022	**Consequence**	4. Major	4. Major	4. Major		
Last reviewed		**Risk Rating**	8. High	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 Improvement plan Phase 1& 2 & 3 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 Leadership and Safety Academy Integrated performance report Assurance Framework for Collaboratives CQC project group STACQ accreditation Improvement Councils established Performance Meetings with Collaboratives Patient Safety Ambassadors Maternity Assurance Group Emergency Care Group Outpatient Improvement group Surgical improvement group	**Management** 2 year strategic plan signed off by Board in July 2022 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 TBC 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		

		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, 2 and 3 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**		
4.3 Failure to ensure the trust has the ability to support and take a leading role in healthcare research and education and that innovation is not embedded in our ways of working resulting in a failure to develop our portfolio	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 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** MOU with Teesside University for strategic links Collaborations with HEIs **Independent Assurance** Elective Recovery Programme – Targeted Investment Fund (TIF)		

4.4 Inability to recruit clinicians in specialist and sub speciality fields	Consultant recruitment panels with NED Chair Recruitment process now managed by CMO office Clear systems and processes on recruitment gaps and risks Alternative workforce development plan discussed at CPG Implement a recruitment campaign and support package for hard to recruit areas	**Management** Report on new consultants and leavers to People Committee, SMSC and Board monthly Weekly report on consultants to CEO/CMO Report to people committee on alternative roles for hard to recruit to roles Workforce plans by Collaboratives developed and reviewed at people Committee February 2022 **Risk and compliance** **Independent Assurance** Actions completed from internal audit report on recruitment	Recruitment and retention of the workforce to deliver service provision and hard to recruit / vulnerable services – Mike Stewart TBC Clarify funding arrangements and investment opportunities for tertiary services, eg gynae oncology – Mike Stewart TBC	

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**		
Executive Lead	Chief Executive / Managing Director	**Likelihood**	3. Possible	2. Unlikely	2. Unlikely	**Risk appetite**	Open
Initial date of assessment	September 2022	**Consequence**	3. Moderate	4. Major	4. Major		
Last reviewed		**Risk Rating**	9. High	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 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 and governance agreed 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		
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**		

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**	Further explore the relationships with universities – Mike Stewart TBC	
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**		
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)		

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

Lead Committee	Resources	Risk Rating	Initial Rating	Current Rating	Target		
Executive Lead	Chief Finance Officer	Likelihood	3. Possible	3. Possible	3. Possible	Risk appetite	
Initial date of assessment	September 2022	Consequence	4. Major	4. Major	4. Major		
Last reviewed		Risk Rating	12. High	12. High	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 CIPG Annual report and accounts Annual Governance Statement Medium Term Financial Assessment and Delivery Plans agreed by Resources Committee & Board and submitted to NHSE PLICs plan **Risk and compliance** Updates to Board and Resources Committee monthly Monthly Financial Review meetings with NHSE and ICB B2B meetings with NHSE Board Development sessions **Independent assurance** Review of PFI costs – Deloitte External audit of annual accounts NHSE monthly finance monitoring ICB monthly finance monitoring	Development of a longer-term financial recovery plan jointly with ICB – Chris Hand, March 2023	
6.2 Insufficient time afforded by the regulator to develop and implement a recovery plan	Medium Term Financial Plan Resources Committee Trust Board Joint Strategy Board ICP Finance Directors ICS Finance Directors Tees Valley CEO meeting ICS Management Executive Clinical Strategy and Improvement Group 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	**Management** Ongoing updates to SLT, CPG and CPIH Annual report and accounts Annual Governance Statement Medium Term Financial Assessment and Delivery Plans agreed by Resources Committee & Board and submitted to NHSE CIP reports to Resources Committee quarterly CIP programme established CIP Steering Group established with NED input Board Development sessions Board sign off of financial plan **Risk and compliance** Updates to Board and Resources Committee monthly Monthly Financial Review meetings with NHSE and ICB	Impact of system allocation and pace of change – re: Fair Share – Chris Hand March 2023	

		B2B meetings with NHSE Board Development sessions **Independent assurance** Review of PFI costs – Deloitte External audit of annual account NHSE monthly finance monitoring Provider licence restrictions – Letter from Tim Savage Letter of acknowledgement of receipt of plan and ICS management Financial plan for 2022/23, 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 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 and ICB Board Development sessions **Independent** ICP/ICS Plan submission approval by NHSE/I Letter of acknowledgement of receipt of plan and ICS management PFI costs supported during through Covid-19 financial regime Safety investment costs supported during through Covid-19 financial regime	Impact of system allocation and pace of change – re: Fair Share – Chris Hand March 2023	
6.4 Insufficient capital resources available across the ICS to support the phasing of the Trust's capital investment requirements	PFI Contract management Capital planning group Planned maintenance programme Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Emergency capital bids 1 year Capital Plan agreed Prioritised 5 year Capital plan developed and submitted to ICS for consideration Medical Devices Group Fixed Asset register Risk register	**Management** Chairs log from H&S Group to QAC regarding Medical Quarterly update to Resources Committee on Capital PFI contract management Lifecycle report to Resources Committee **Risk and compliance** Expression of Interest Capital Planning agreed by Resources Committee LINAC report to Resources Committee Community Diagnostic Hub report recommended by Resources Committee and approved by Board Estates report to Board ICB Capital allocation **Independent assurance** Internal audit reports	Development of a longer term capital plan and link to fair share and transfer of resources within ICB – Chris Hand March 2023	

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 sessions and Board reports on 2022/23 financial position and system savings **Independent** ICP/ICS Plan submission approval by NHSE/I Financial risk share agreements. ICB forecast to deliver financial balance in line with plan, with Trust plan delivery on track	Impact of system allocation and pace of change – re: Fair Share – Chris Hand March 2023	

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		
Executive Lead	Chief Finance Officer	Likelihood	5. Almost Certain	5. Almost Certain	3. Possible	Risk appetite	
Initial date of assessment	September 2022	Consequence	4. Major	4. Major	4. Major		
Last reviewed		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 and PLICs reports to Resources Committee Financial structure update Establishment of CIO External support **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 sessions and 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	HFMA Financial Sustainability self-assessment action plan – Chris Hand, Feb 2023	
7.2 Potential loss of grip and control during transition to new clinically led structure	Day to day budget management processes in place Finance business partners - qualified Policies and procedures for managing financial control Cash flow forecast Finance Investment Board in place quality assuring business cases for revenue Capital Planning Group in place quality assuring business cases for capital Business case process in place	**Management** Directorate level and department level finance reporting Cost centre level finance reports Business cases reviewed by FIB / Capital Planning CPG decision making on budgets and capital planning Budget sign off Annual accounts Update SFI/SOs in line with Collaborative Structure agreed by Audit Committee Financial structure update	HFMA Financial Sustainability self-assessment action plan – Chris Hand, Feb 2023	

	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	**Risk and compliance** Finance report to Board, Resources Committee Procurement report to Resources Committee Board Development sessions **Independent** Going concern and financial controls audit as part of External and Internal audit programme NHSE monthly finance monitoring		
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 **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 NHSE monthly finance monitoring ICB forecast to deliver financial balance in line with plan, with Trust plan delivery on track	HFMA Financial Sustainability self-assessment action plan – Chris Hand, Feb 2023	
7.4 Inability to agree contracts with commissioners to provide the planned levels of clinical income	Resources Committee Contracting team BIU team NHS Standard Contract and guidance Costing information Joint NTHT Contract Contract meetings Contracting working group established across NT and ST	**Management** Finance report Contracting guidance **Risk and compliance** Finance report to Board, Resources Committee **Independent** NHSE independent costing assurance audits Block contracts agreed with commissioners		
7.5 Insufficient capital resources available to support innovation and transformation	Capital planning group in place (CPOG) Planned preventative maintenance (PPM) regime in place Premises assurance model (PAM) undertaken annually Regular risk assessments and environmental audits C£32m capital programme for 22/23 Capital Plan agreed by CPG Prioritised 5 year Capital plan developed and submitted to ICS for consideration Medical Devices Group overseeing medical equipment Asset register maintained	**Management** Chairs log from H&S Group to QAC regarding Medical Quarterly update to Resources Committee on Capital programme PFI contract management Lifecycle report to Resources Committee **Risk and compliance** Expression of Interest in New Hospital Programme 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 ICB Capital allocation **Independent assurance** Internal audit reports		
7.6 Inability of system partners to support or implement system wide opportunities	ICS/ICP Director of Finance meeting ICS Capital Planning / Estates Managers meeting Joint working with NTHT TV Clinical Services Strategy and Board TV CEO meeting ICS Executive Management Meeting Joint Strategy Board ICS/ICP plan	**Management** ICS/ICP updates through Finance report and CEO report to Committees and Board JSB MOU Finance report to JSB on opportunities across the TV **Risk and compliance** Regional Directors (2019) review of system savings report 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 ICB forecast to deliver financial balance in line with plan, with Trust plan delivery on track.		
7.7 Failure of key infrastructure (equipment, IT and Estates) impacting on operational delivery	Capital planning group (CPOG) in place Planned preventative maintenance (PPM) processes in place to maintain assets Premises assurance model (PAM) undertaken annually Annual risk assessments and environmental audits undertaken C£32m capital programme for 22/23 Capital Plan agreed at CPG Prioritised 5 year Capital plan developed and submitted to ICS for consideration Medical Devices Group in place Asset register maintained Digital Director appointment made and commenced in post August 2021	**Management** Chairs log from H&S Group to QAC PFI contract management Lifecycle report to Resources Committee Capital update report to Resources Committee **Risk and compliance** Expression of Interest in New Hospital Programme 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	Review learning for cyber security impact on financial systems and implement actions – Chris Hand - TBC	
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	**Management** Business Case for MIYA approved by Board Digital updates to Resources Committee monthly IG update to Resource Committee June 2022 **Risk and compliance**	Establish process for reviewing business case benefits realisation – Chris Hand – March 2023	

	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	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		
7.9 Potential for cyber breach and data loss due to ever present and escalating cyber-attacks with impact on service delivery	Application of up-to-date cyber security controls including patches and software upgrade Staff training and awareness sessions Surveillance and early warning of potential threats Applying system and management practices that ensure residual risks are mitigated appropriately	**Management** Chair's log from the Digital Strategy Group Digital and IG update to Resources Committee **Risk and compliance** Annual re-certification of NCSC cyber accreditation (CE / CE+) Digital Data Security Centre careCERT notifications and actions Vulnerability scanning and penetration tests **Independent assurance** BitSight cybersecurity rating	Periodic red team exercise that covers unplanned outages of our computer systems and the restoration of service and effectiveness of data backup process Lessons drawn from cyber incidents affecting public and private sector organisations e.g. Advanced One and the eFinancial system	

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 NOVEMBER 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 September 2022 IPR, are as follows: **SAFE** domain: No change. **EFFECTIVE** domain: Change of format: SHMI presentation amended as per NHS pilot of presentation of this metric. **CARING** domain: New metric: Community services 'Friend & Family Test' survey results included. Target is to consistently out-perform 21/22 national average score. **EQUITABLE** domain: No change. **RESPONSIVE** domain: New metric: Type 1 ED and Type 3 Urgent Treatment Centre activity versus plan included.		

	New metric: patients spending > 12 hours in ED added to align with with NHS Oversight Framework. New metric: Cancer 28-days Faster Diagnosis Standard (FDS) included to align with NHS Oversight Framework. **WELL LED** domain: No changes. **Our key messages for September are:** The Trust remains in segment 3, mandated support for significant concerns. The Trust receives external support on emergency care pathways, cost improvement and transformation. Alongside the SOF the Trust continues to focus on safety and quality priorities, guided by our CQC improvement plan. Emergency care performance was below than the regional and national position, reflecting wider challenges within social care and other parts of the health and care system. Elective access by RTT 18 week standard continues to be stable, whilst the England trend is a month-on-month deterioration in performance since July 2021. The number of patients waiting more than 78 weeks for non-urgent elective has remained stable and is ahead of trajectory to meet the national target for waits to be eliminated by April 2023. Outpatient and elective activity is approaching planned levels as services continue their COVID recovery. Diagnostic compliance remains an area of focus, with activity and performance plans in place. Diagnostic activity year-to-date is incorrectly reported due to a technical systems issue, now resolved. 28 day and 62-day standard performance has improved in July.
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐ (select the relevant assurance level)
Recommendation	Members of the Public Trust Board of Directors are asked to: • Receive the Integrated Performance Report for September 2022. Note the performance standards that are being achieved and the remedial actions being taken where metrics are outside expected parameters.

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	All BAF risks	
Legal and Equality and Diversity implications	There are no legal or equality and diversity implications associated with this paper.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒	

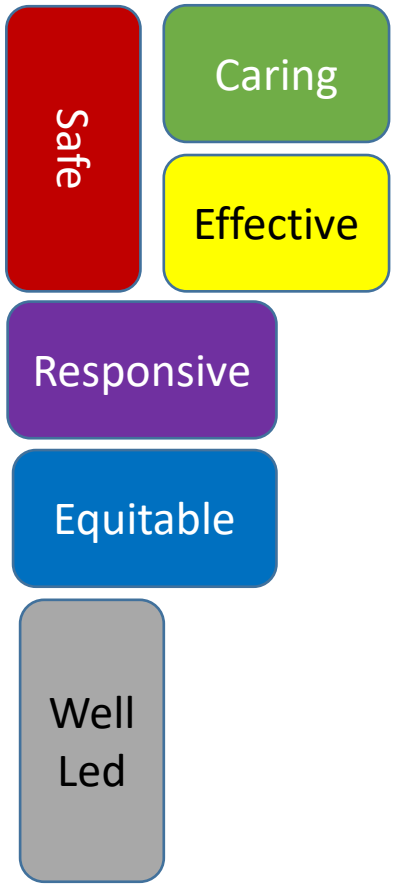
South Tees Hospitals
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT

September 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:

No change.

EFFECTIVE domain:

Change of format: SHMI presentation amended as per NHS pilot of presentation of this metric.

CARING domain:

New metric: Community services 'Friend & Family Test' survey results included. Target is to consistently out-perform 21/22 national average score.

EQUITABLE domain:

No change.

RESPONSIVE domain:

New metric: Type 1 ED and Type 3 Urgent Treatment Centre activity versus plan included.

New metric: patients spending > 12 hours in ED added to align with with NHS Oversight Framework.

New metric: Cancer 28-days Faster Diagnosis Standard (FDS) included to align with NHS Oversight Framework.

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

The Trust Improvement Plan (July 2022) sets out our plans to meet the national planning priorities, as well as our local objectives and safety and quality priorities for 2022/23.

SINGLE OVERSIGHT FRAMEWORK SUMMARY

NHS Oversight Framework Summary	Urgent & Emergency Care				Elective care										Cancer			
Provider	A&E 4 hour standard	12 hour delay from DTA	Ambulance handovers 30-60 mins	Ambulance handovers 60+ mins	RTT - 18 week standard	52+ week waits	78+ week waits	104+ week waits	RTT total Waiting List	OPFU - YTD growth 22/23 v 19/20	1st OP - YTD growth 22/23 v 19/20	Total elective - YTD growth 22/23 v 19/20	Diagnostic activity 22/23 v 19/20	Diagnostic 6 week waits	Cancer 62 day - GP referral	Cancer 62 day backlog	Cancer treatments	Cancer 28 day FD
Data period	Aug-22	Aug-22	Aug-22	Aug-22	Jul-22	Jul-22	Jul-22	Jul-22	Jul-22	Jul-22	Jul-22	Jul-22	Jul-22	Jul-22	Jul-22	Aug-22	Jul-22	Jul-22
Target	95%	Zero			92%	22/23 Plan	22/23 Plan	Zero by Jun 22	22/23 Plan	<=75%	104%	104%	120%	<=1%	85%	22/23 Plan	22/23 Plan	75%
South Tees Hospitals NHSFT	70.6%	29	309	291	65.5%	1,407	92	1	46,322	93%	96%	98%	79%	33.0%	62.9%	216	211	64.8%
NENC ICS Provider level *(including IS providers)*	76.5%	754	2,155	1,160	72.8%	8,535	871	45	368,297	96%	100%	93%	99%	18.7%	62.4%	1,631	1,610	74.7%
North East & Yorkshire	73.1%				68.6%									24.6%	61.8%			74.7%
National	71.4%				61.0%									27.9%	61.6%			71.1%

The Trust remains in segment 3, mandated support for significant concerns. The Trust receives external support on emergency care pathways, cost improvement and transformation. Alongside the SOF the Trust continues to focus on safety and quality priorities, guided by our CQC improvement plan. Emergency care performance was below than the regional and national position, reflecting wider challenges within social care and other parts of the health and care system. 4-hour breaches, patients waiting over 12 hours from decision to admit, and ambulance handovers improved in August, and ED performance declined slightly in September due to external challenges described above and increased patient acuity. Elective access by RTT 18 week standard continues to be stable, whilst the England trend is a month-on-month deterioration in performance since July 2021. The number of patients waiting more than 78 weeks for non-urgent elective has remained stable and is ahead of trajectory to meet the national target for waits to be eliminated by April 2023. Outpatient and elective activity is approaching planned levels as services continue their COVID recovery. Diagnostic compliance remains an area of focus, with activity and performance plans in place. Diagnostic activity year-to-date is incorrectly reported above due to a technical systems issue, now resolved. 28 day and 62-day standard performance has improved in July.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
DATIX Incidents	2250	2070	Sep 2022		
Serious Incidents	8	12	Sep 2022		
Never Events (YTD)	4	0	Sep 2022	N/A	N/A
Falls	158		Sep 2022		N/A
Falls Rate %	4.8	6.6	Sep 2022		
Falls With Harm	10		Sep 2022		N/A
Falls With Harm Rate %	0.3		Sep 2022		N/A

Incidents

There have been consistently high levels of incident reporting within the Trust for a sustained period, with 2,250 reported in September. A new trajectory to maintain this level has been introduced for the next 12 months with a review in 2023 when PSIRF (Patient Safety Incident Response Framework and LFPSE (Learning from Patient Safety Events) are fully implemented . The number of SIs remains within expected variation and learning continues to be shared at a local level with clinical colleagues, as well as across the wider organisation and with our system partners. There have been 4 NE during 2022/23.

Falls

The rate of falls was lower in September than in August. Seasonal variation in rates of falls is well documented and South Tees remains within its falls control limits.

The rate of falls with harm remained within our control limits. There is a consistently lower rate in 2022/23 than that seen prior to February 2022. Focused innovative work continues and structured reviews continue to be utilised as opportunities for learning from the whole multidisciplinary team.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	2.2		Sep 2022		N/A
Category 2 Pressure Ulcers (Community)	58		Sep 2022		N/A
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	0.3		Sep 2022		N/A
Category 3&4 Pressure Ulcers (Community)	21		Sep 2022	H	N/A
Medication Incidents	115		Sep 2022		N/A
Medications Reconciled Rate %	50.4%	80%	Aug 2022	L	F
Omitted Critical Doses	27		Aug 2022		N/A
C-Difficile (YTD)	68	54	Sep 2022	N/A	N/A
MRSA (YTD)	0	0	Sep 2022	N/A	N/A
E-Coli (YTD)	55	67	Sep 2022	N/A	N/A
Klebsiella (YTD)	27	24	Sep 2022	N/A	N/A
Pseudomonas (YTD)	7	6	Sep 2022	N/A	N/A

Pressure Ulcers

The rate of hospital-acquired pressures ulcers in inpatient wards remains stable and within expected variation. The number reported in the community also remains stable and within expected variation.

Ther number of category 3 & 4 pressure ulcers reported as SIs in both the hospital and community setting is slightly above the baseline and within normal variations. The last Category 4 Pressure Ulcer reported in the community occurred in November 2021. There was a slight rise in category 2 pressure ulcers in the community setting.

The PURPOSE T tool (skin assessment) has been introduced at FHN and JCUH hospital and went digital (in Patientrack) in September. Extensive education and training has taking place in the clinical areas and an e-learning video created by the Tissue Viability team. Pressure ulcer review meetings continue, chaired by the Deputy Chief Nurse or Deputy Director of Quality.

Medications

Medication incidents reported in September remain within expected variation. Work takes place to ensure inpatients on critical medication are prioritised for reconciliation. Work is ongoing to skill mix staff to wards. Omitted critical doses below target of 2% for the second month [1.9% in September]. EPMA and clinical teams continue to work to maintain this improvement.

Healthcare acquired infections

Clostridiodes difficile infections have clear tracking, reporting and governance in place. There have been no MRSA cases reported year to date to September 2022. HCAI for *Escherichia coli* are below expected trajectory, year to date. Rates for *Pseudomonas* and *Klebsiella* are as expected.

A group has been established to refresh and review ANTT (Aseptic non-touch technique) practices accompanied with a clear training plan including implementation with the line care passport with outpatient antibiotic therapies team (OPAT).

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
No. of babies born	399		Sep 2022	N/A	N/A
Breast feeding initiated (48 hrs)	60.9%	74.5%	Sep 2022		
Preterm birth rate <26+6 wks	0.5%	6%	Sep 2022		
Preterm birth rate 27 - 36+6 wks	7.1%	6%	Sep 2022		
Induction of Labour (%)	45.2%	44%	Sep 2022		
Number of 3rd/4th degree tear (%)	1.2%	3.5%	Sep 2022		
PPH > 1500ml (%)	1.72%	2%	Sep 2022		
Still Births (YTD)	9	17	Sep 2022	N/A	N/A

Maternity services

The pre-term birth rate for babies 27-36+6 weeks gestation is within expected variation but can be higher than the standard due to the specialist nature of the service and the proportion of high-risk pregnancies managed within the Trust. All pre-term births are reviewed, and all guidelines are followed. Pre-term birth clinics are held weekly with a named consultant and midwife.

Breastfeeding initiation rates are below target, as is reflected in the regional public health statistics. The Trust is UNICEF baby-friendly accredited.

There is no national or regional target set for the Induction of labour (IOL) and therefore this is a Trust indicative standard. A working group has been setup to review the IOL pathway.

Harm as indicated by 3rd/4th degree tears and is consistently better than the expected standard.

Post-partum Haemorrhage (PPH) rate fluctuates month to month, within expected variation. All cases are reviewed to ensure guidelines are followed.

A fuller range of maternity standards are reviewed monthly by the Maternity Improvement Board and reported to Quality Assurance Committee.

EFFECTIVE

Metric	Latest Month	Target	Month	Trend	Assurance
Readmission Rate %	6.2%		Jul 2022		N/A
Sepsis - Oxygen delivered within 1hr	100%	95%	Aug 2022		
Sepsis - Blood cultures within 1hr	71%	95%	Aug 2022	L	F
Sepsis - Empiric IV antibiotics within 1hr	74.2%	95%	Aug 2022	H	
Sepsis - Serum lactate within 1hr	87.1%	95%	Aug 2022		
Sepsis - IV fluid resuscitation within 1hr	71%	95%	Aug 2022	H	F
Sepsis - Urine measurement within 1hr	100%	95%	Aug 2022	H	
Summary Hospital-Level Mortality Indicator	107.6	100	May 2022		
Comorbidity Coding	4.5		Jun 2022	H	N/A

Readmission rates

The emergency readmission rate is within normal variation.

Sepsis

Full compliance has been observed for 2 of the 6 elements (Oxygen within 1 hour and urine output measurement within 1 hour. IV Antibiotics and IV fluids have dipped slightly and remain within normal variation. Compliance with blood cultures and serum lactate remain areas requiring improvement.

Further actions include:

- Data extraction via Patientrack to support audit process
- Roll out commenced of Enhanced Care competencies – Enhanced Care Educator
- Targeted education to ward-based areas – driven by Patientrack
- 92% of all antibiotics delivered within a 3-hour timescale
- Introduction of phase one of smartpage which will ultimately feature close the loop, in the interim soft alerting is live and available
- Stickers have been designed for thermometers educating staff about blood culture requirements in normotensive and hypotensive patients.
- Additional prompts in webice for lactate. When a blood culture is requested, there is now guidance for lactate monitoring in sepsis and a sample can be requested with the blood culture.

Mortality

For the latest official reporting period, June 2021 to May 2022, SHMI is 'as expected' at 108. 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 had been 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 serve..

Reporting to the Trusts' governance committees shows that Medical Examiner scrutiny remains at >95%, with around 10% referred for further review. Learning from ME and mortality reviews included End of Life care, documentation of care, coordination of care for complex patients and transfers from other hospitals. Learning is cascaded through the Trust governance structures.

CARING

Metric	Latest Month	Target	Month	Trend	Assurance
A&E Experience (%)	82.4%	78%	Sep 2022		
Inpatient Experience (%)	96.9%	94%	Sep 2022		
Maternity Experience (%)	91.3%	92%	Sep 2022		
Outpatient Experience (%)	94.7%	93%	Sep 2022		
Community Experience (%)	99.2%	94%	Sep 2022		
New Complaints	20		Sep 2022		N/A
Closed Within Target (%)	45.8%	80%	Sep 2022		

Patient experience
Emergency Department Friends & Family Test score improvement, above target for the second consecutive month, with close overview from within the directorate.

The Inpatient Friends & Family Test score remains above target. The feedback in the Outpatient Friends & Family Test score remains above the target.

The Friends & Family Test score reported in Community services consistently performs above the national average.

The Maternity Friends & Family Test score is captured at the four touchpoints (antenatal, birth, postnatal and community postnatal). The Maternity Voices improvement plan is being updated and will be shared at the next Patient Experience Steering Group. This focuses on addressing service users' concerns and suggestions.

Closed with target
Following last month's improvement, a plan has been developed in collaboration with the patient experience team and the Safe and Effective Care Leads to continue to increase and sustain compliance. This is monitored weekly with a trajectory of completion by end November 2022. It is overseen by the Patient Experience Steering Group.

Learning from complaints
Learning and themes from complaints are systematically shared with clinical colleagues. Changes in response to complaints include procedural changes and training to improve clinical practice and communication.

EQUITABLE

Elective inpatient PTL Inequalities: Deprivation

Latest PTL by IMD quintile

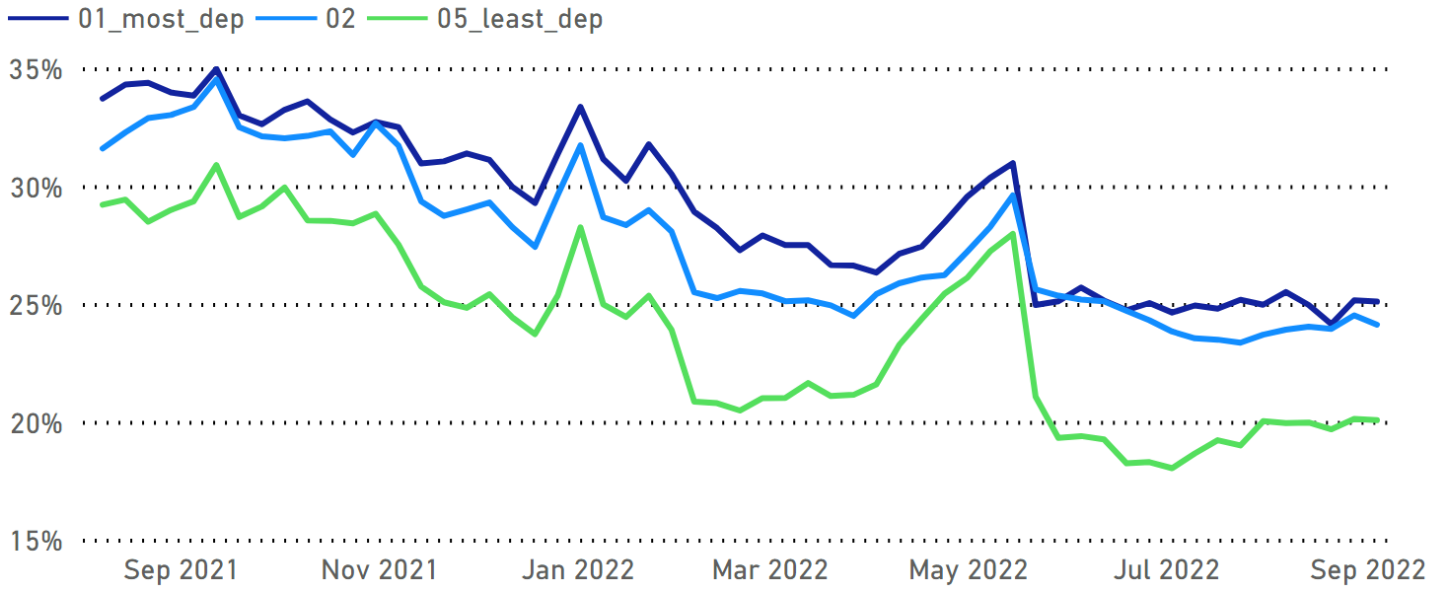
IMD quintile	In Standard	Long waits	% of total	Total
01_most_dep	1784	598	25%	2382
02	1038	330	24%	1368
03	1082	281	21%	1363
04	1609	379	19%	1988
05_least_dep	1155	290	20%	1445
N/k	406	112	22%	518
Total	**7074**	**1990**	**22%**	**9064**

IMD is taken from patient's postcode of residence

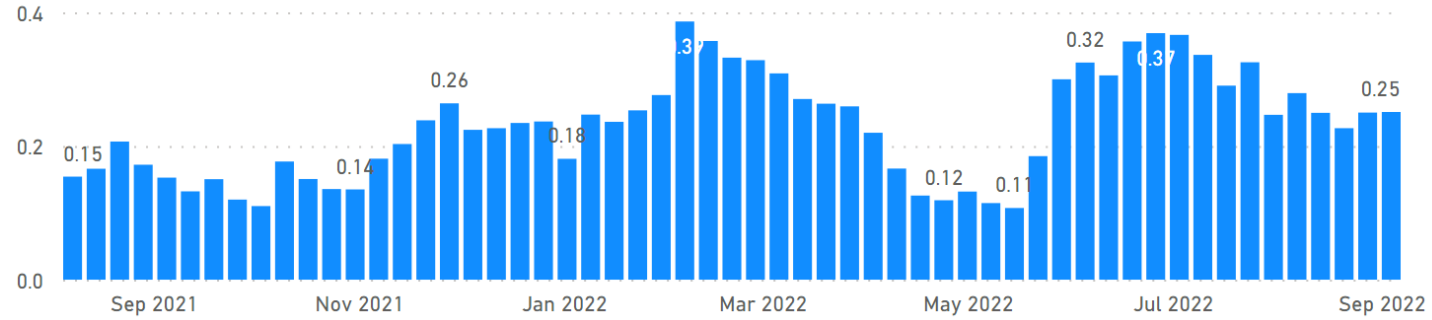
Long Waiters:
P2 › 3 weeks
P3 › 3 months
Any › 52 weeks

In Standard: All others

Long waits as % of total PTL for Quintiles 1, 2 & 5



Variance of Quintile 1 % long waiters to Quintile 5 % long waiters



This graph compares the proportion of long waiters for quintile 1 with the proportion for quintile 5. So if quintile 1 is 25% and quintile 5 is 20% then quintile 1 is 25% higher than quintile 5. If the values are positive quintile 1 patients are more likely to be long waiters than quintile 5 patients

The Trust serves some of England's most deprived wards. The waiting list is monitored to ensure to equitable access. Deprivation may be correlated with patient's ability to attend appointments, and with poorer health, leading to longer and more complex care pathways.

EQUITABLE

Elective inpatient PTL Inequalities: Ethnicity

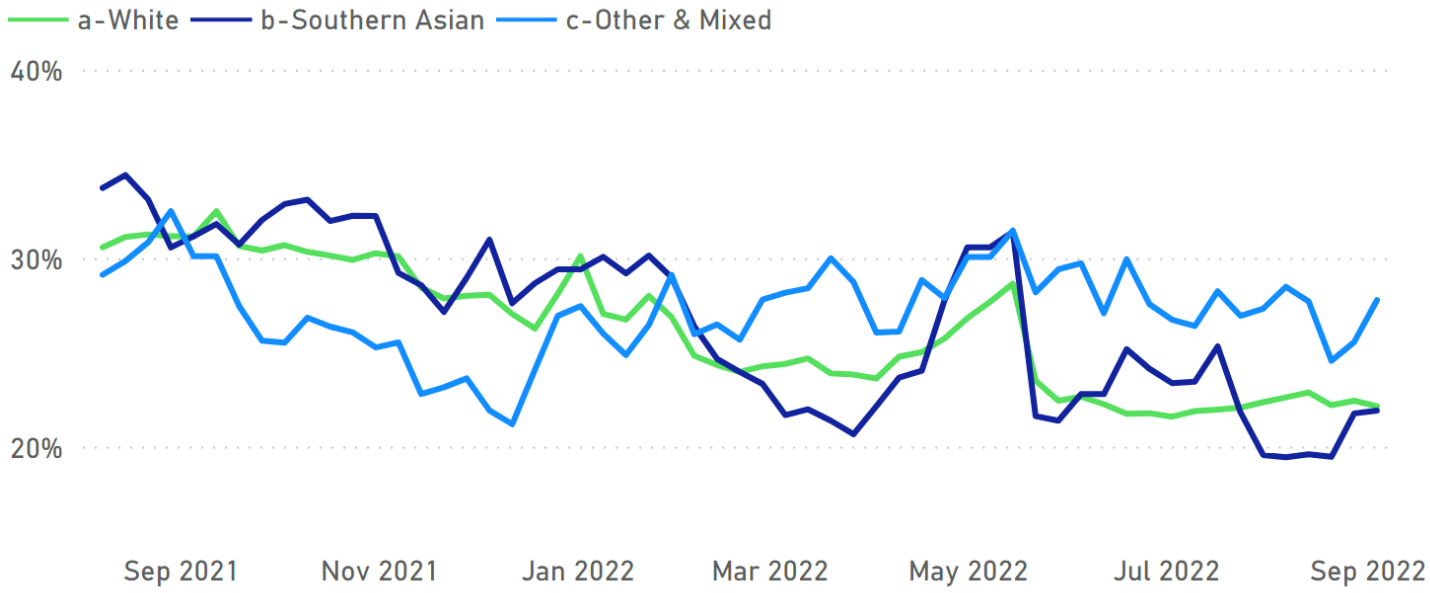
Latest PTL by IMD quintile

Ethnic_cluster (groups)	In Standard	Long waits	% of total	Total
⊞ **a-White**	**5863**	**1668**	**22%**	**7531**
⊞ **b-Southern Asian**	**114**	**32**	**22%**	**146**
⊟ **c-Other & Mixed**	**130**	**50**	**28%**	**180**
Black	15	9	38%	24
Mixed	25	19	43%	44
Other	90	22	20%	112
⊞ **N/k**	**967**	**240**	**20%**	**1207**
Total	**7074**	**1990**	**22%**	**9064**

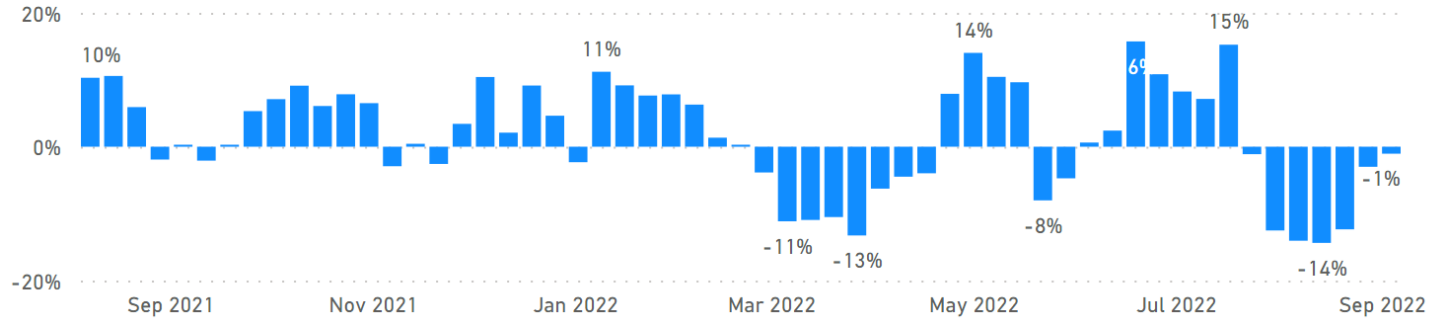
Long Waiters:
P2 › 3 weeks
P3 › 3 months
Any › 78 weeks

In Standard: All others

Long waits as % of total PTL by Ethnic groups



Variance of Southern Asian % long waiters to White



This graph compares the proportion of long waiters for people with Southern Asian ethnicity with the proportion for White ethnicity. So if the Southern Asian group 25% and White is 20% then Southern Asian is 25% higher than White. If the values are positive Southern Asian patients are more likely to be long waiters than White patients

The Trust also monitors waiting time by ethnicity, however due to smaller numbers, large fluctuations in the data can occur. For the largest ethnicity grouping, Southern Asian, there is no consistent trend in variation in waiting times, when compared to White patients. Other ethnicity groupings are combined due to small numbers and any differential is closely monitored as we ensure all long waiters are treated.

RESPONSIVE

Metric	Latest Month	Target	Month	Trend	Assurance
ED Attendances - Type 1 (vs 19/20)	9701	9587	Sep 2022		
ED Attendances - Type 3 (vs 19/20)	5223	3826	Sep 2022		N/A
Handovers - Within 15 Mins (%)	55%	65%	Sep 2022	L	
Handovers - Within 30 Mins (%)	73.1%	95%	Sep 2022	L	F
4-Hour A&E Standard	69.7%	95%	Sep 2022	L	F
12-Hour Waits from Decision to Admit	43	0	Sep 2022		
12-Hour A&E Breaches	270	0	Sep 2022		N/A
RTT Incomplete Pathways (%)	65.3%	92%	Aug 2022	L	F
RTT 52 week waiters	1459	1105	Aug 2022	N/A	N/A
RTT 78 week waiters	102	119	Aug 2022	N/A	N/A
RTT Waiting List Size	46830	41677	Aug 2022	H	
Diagnostic 6 Weeks Standard (%)	64.6%	99%	Aug 2022	L	F
Cancer 14 Day Standard (%)	57%	93%	Aug 2022	L	F
Cancer 31 Day Standard (%)	92.6%	96%	Aug 2022		
Cancer 62 Day Standard (%)	60.2%	85%	Aug 2022	L	
Cancer 62 Day Screening (%)	57.1%	90%	Aug 2022		
Cancer Faster Diagnosis Standard (%)	68.3%	75%	Aug 2022	L	
Cancelled Ops - Non-Urgent Cancelled on Day	40	0	Sep 2022		F
Cancelled Ops - Not Rebooked Within 28 days	6	0	Sep 2022		
Cancer Operations Cancelled On Day (YTD)	0	0	Sep 2022	N/A	N/A

Urgent and emergency care

The impact of challenges across the health and social care system continues to be observed. Increased levels of urgent and emergency care activity continued in September, and although numbers were lower than the July peak, the number of ambulance arrivals and patients with high acuity placed significant demands on ED. Discharge delays improved in September but, due to ongoing challenges in social care, did not offset high bed occupancy which impacted on patient flow into and onwards from ED, ambulance handovers and delivery of 4-hour and 12-hour standards. Evidence-based process improvement work in this area remains an organisational priority and the trust continues to work closely with local authorities and other partners to ensure that everything possible is done to ensure people who are ready to leave hospital, who require social care support, are able to access this as quickly as possible.

Elective, diagnostic and cancer waiting times

Referral to treatment within 18 weeks performance was stable and, at 65.53%, better than the national average 60.8%. 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 as services continue their COVID-19 recovery. The focus remains on the longest waiters – maintaining a zero position with 104 week waits and eliminating 78-week waits ahead of plan.

Diagnostic access was at 65% compliance with the 6-week standard at end of August as urgent cases are prioritised. All modalities have demand and capacity plans in place with actions and are refreshing trajectories to compliance. Tests for waiting list patients must be balanced against increasing volumes of (e.g. in CT) urgent demand and surveillance. Additional capacity has come online in endoscopy at both JCUH and FHN, further capacity comes online in September 2022. This will in turn have a positive impact on metrics. 62-day standard for August 60.2%, with continued focus on long waiters awaiting first definitive treatment (these patients are reported as their treatment takes place). Improvement is on a trajectory to be compliant with plan. 14-day standard remains an area of focus.

RESPONSIVE

Metric	Latest Month	Plan	Month	Trend	Assurance
Outpatient First Attendances	17451	19253	Sep 2022		
Outpatient Follow Up Attendances	44671	45189	Sep 2022		
Day Case admissions	5610	6401	Sep 2022		N/A
Ordinary Elective admissions	989	1132	Sep 2022		
NEL admissions with 0 LOS	1417	1936	Sep 2022		
NEL admissions with 1+ LOS	3376	3697	Sep 2022		
Length of Stay - Elective	4.2		Sep 2022		N/A
Length of Stay - Non-Elective	5.1		Sep 2022		N/A
Not Met Not Discharged	84	90	Sep 2022		
21 Day Stranded Patients (%)	13%	12%	Sep 2022		

Activity

September data reported is not yet fully coded. At Trust level to end August, outpatient first and follow-up attendances YTD are at 96% and 99% of plan. Elective Day Cases are at 98% of plan YTD (impacted by the additional Bank Holiday). Ordinary Elective (overnight) admissions are at 86% of plan YTD. Collaboratives are working through plans for Ordinary Elective, reflected in the growth in volume of activity in August and September.

Non-elective admissions are lower than predicted, however as a consequence of wider health and care system pressures (see below), bed occupancy on assessment units and general medical wards was above the 92% standard.

Length of Stay

Elective length of stay remains lower than the longer-term average, whilst non-elective length of stay remains higher. There are ongoing pressures across the social care sector which impact on timely discharge of patients who have ongoing care and support needs. This particularly impacts on patients awaiting a package of care in their own home. The Trust's winter plans, include the provision of more capacity to care for patients when their acute medical needs have been met, alongside development of out-of-hospital alternatives to acute care such as Virtual Wards. These will bring additional capacity phased in over the winter months.

Patients who no longer meet criteria to reside in an acute bed has continued to improve and was better than target in September. The Trust has made progress in reducing delays within its span of control. However, social care attributable delays remain a feature and increased again in October.

The number of patients staying in hospital longer than 21 days increased when activity returned to pre-COVID levels and remains within the expected variation of this metric post-COVID. The percentage of patients with long stay is driven by our specialist critical care, spinal cord injuries and rehabilitation pathways as a regional tertiary centre.

WELL LED

Metric	Latest Month	Target	Month	Trend	Assurance
Cumulative YTD Financial Position (£'millions)	-£16.262m	-£14.749m	Sep 2022	N/A	N/A
Annual Appraisal (%)	76.6%	80%	Sep 2022		F
Mandatory Training (%)	88.9%	90%	Sep 2022	H	?
Sickness Absence (%)	5.5%	4%	Sep 2022	H	F
Staff Turnover (%)	13.6%	10%	Sep 2022	H	F

Finance and use of resources

The Trust plan is to deliver a £20.7m deficit for the 2022/23 financial year, as part of the ICS plan to deliver financial balance at a system level. At the end of Month 6, the Trust year-to-date financial position shows a £1.5m variance relating to the additional year-to-date cost of the national pay award (and arrears) above the level of pay award funding that has been provisionally allocated to the Trust by the ICB. Discussions are ongoing regionally and nationally regarding the level of pay award funding allocated to the ICB for distribution to provider trusts to meet the full costs of the national pay award.

People

Sickness absence across the Trust was 5.50% for the month of September The Wellbeing and Attendance team review all long-term sickness cases with managers across the Collaboratives.

Appraisal compliance across the Trust has improved again this month and is now 76.62%. Mandatory Training compliance is now 88.95%. HR is meeting with Collaboratives regularly to review compliance and agree plans for further improvement.

The Trust continues to see turnover below the national average, with nursing turnover rates amongst the lowest in the country.

A Restorative Just & Learning Culture Programme workshop took place in October 2022, with key stakeholders. This includes a Programme board, operational group and four workstreams. The introduction of a Restorative Just & Learning Culture across the Trust will support in improving KPI's such as sickness absence and turnover.

The NHS National Staff Survey was launched in the Trust September 2022 There is a weekly review/ update of Collaborative response rates and a plan to visit ward and departmental areas with the lower response rates.

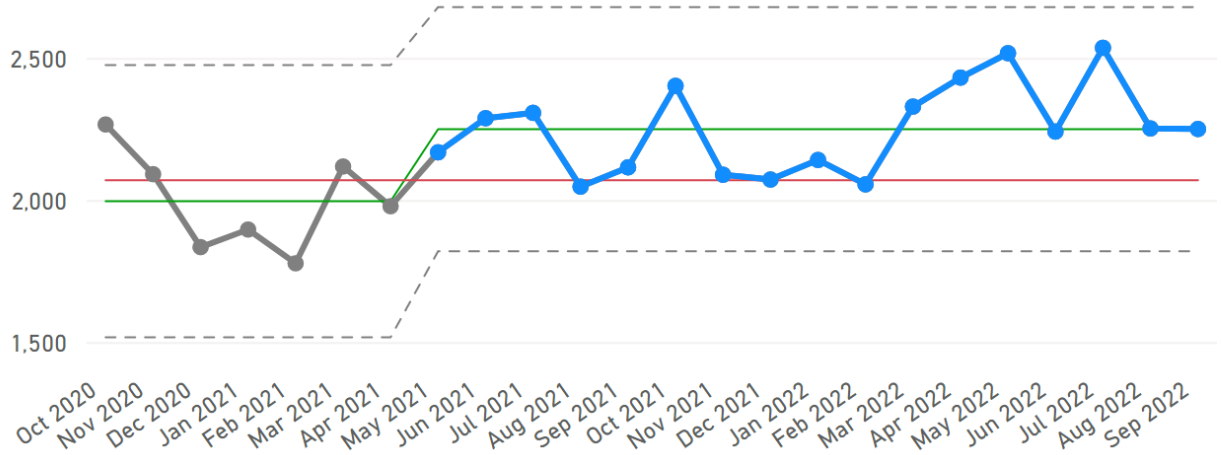
APPENDICES

SPC charts for the metrics summarised above, by domain.

SAFE

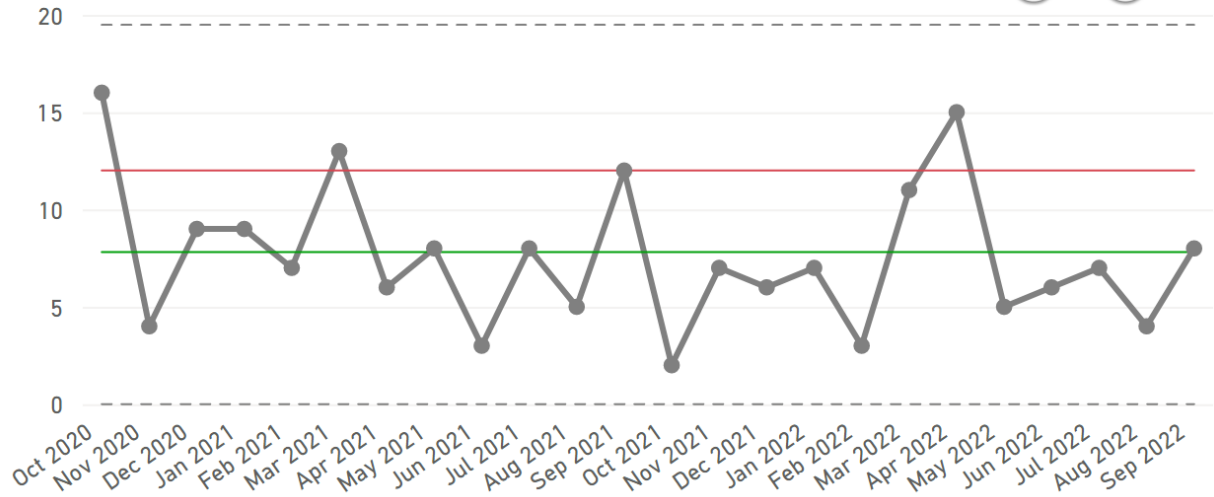
DATIX Incidents

Month	Performance	Target	Trend	Assurance
Sep 2022	2250	2070		



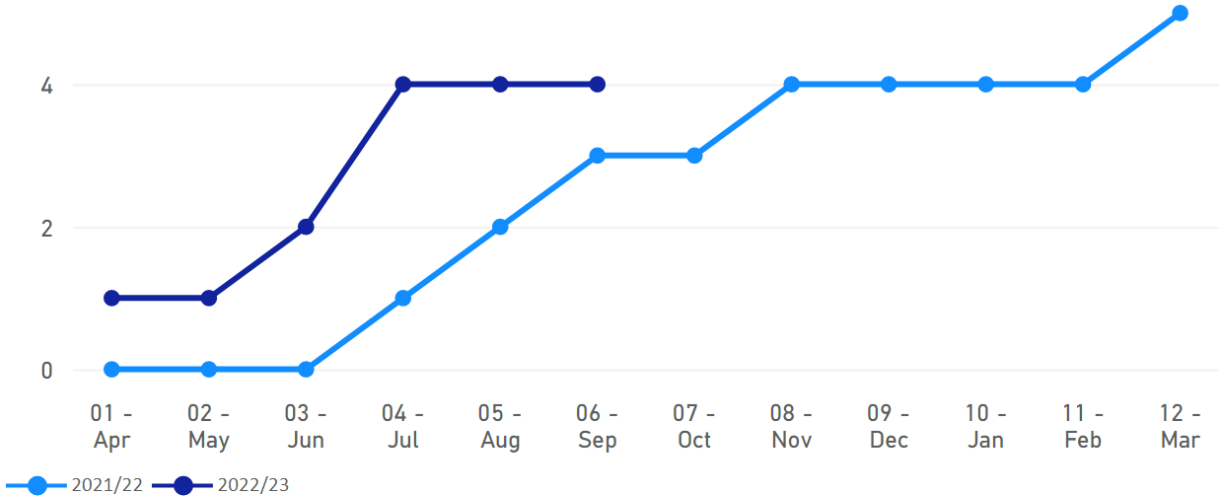
Serious Incidents

Month	Performance	Target	Trend	Assurance
Sep 2022	8	12		



Never Events (YTD)

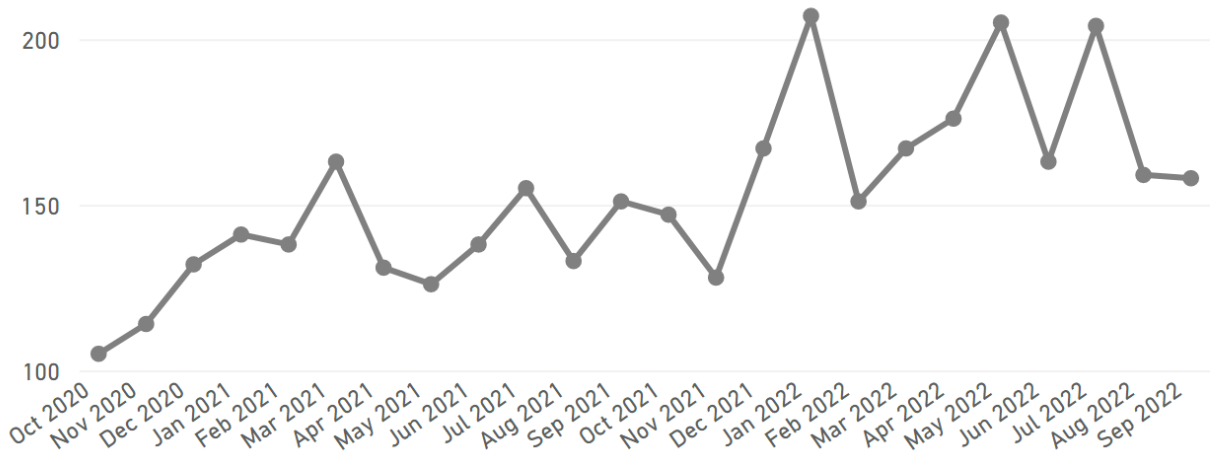
Month	Performance	Target	Trend	Assurance
Sep 2022	4	0	N/A	N/A



SAFE

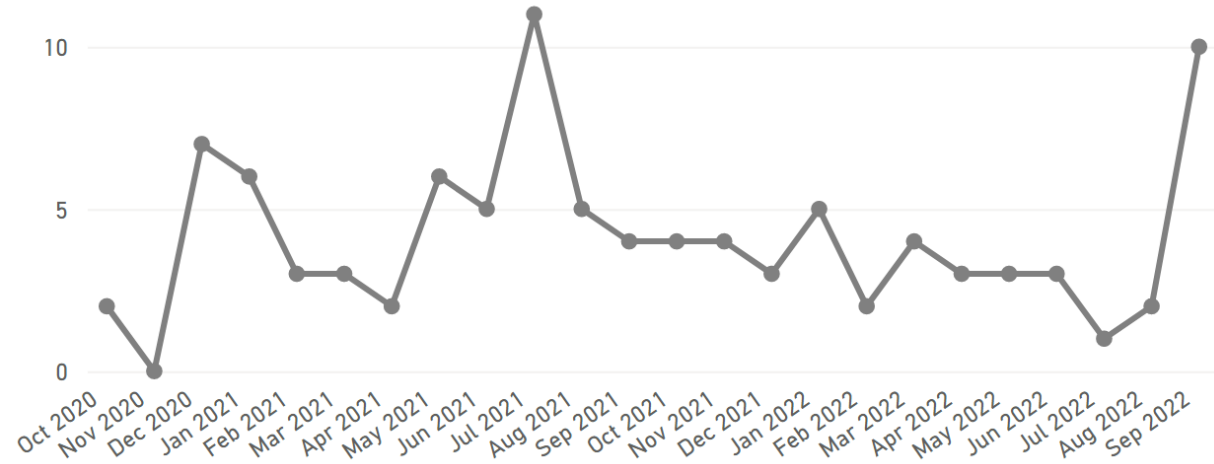
Falls

Month	Performance	Target	Trend	Assurance
Sep 2022	158			N/A



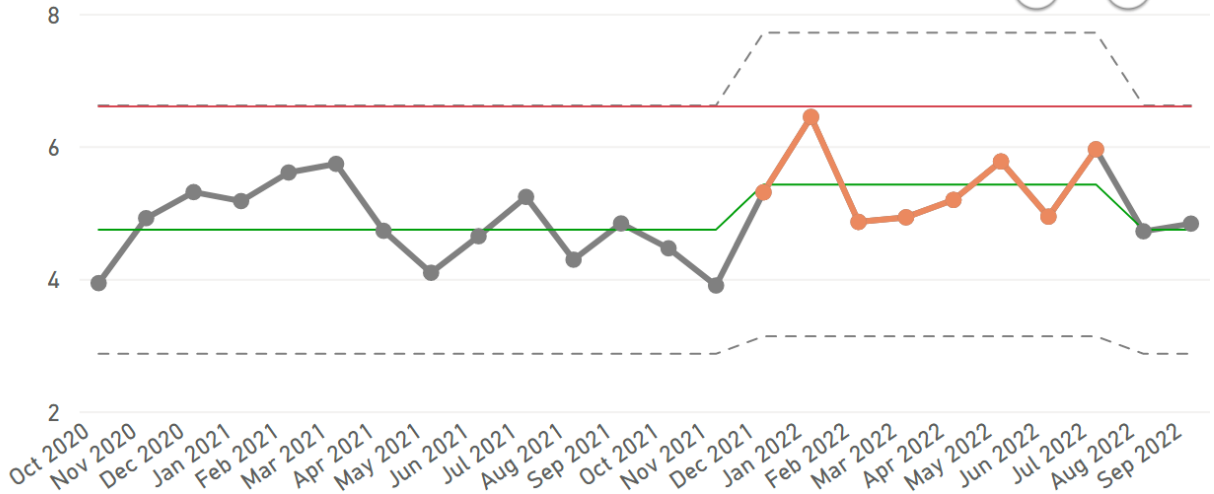
Falls With Harm

Month	Performance	Target	Trend	Assurance
Sep 2022	10			N/A



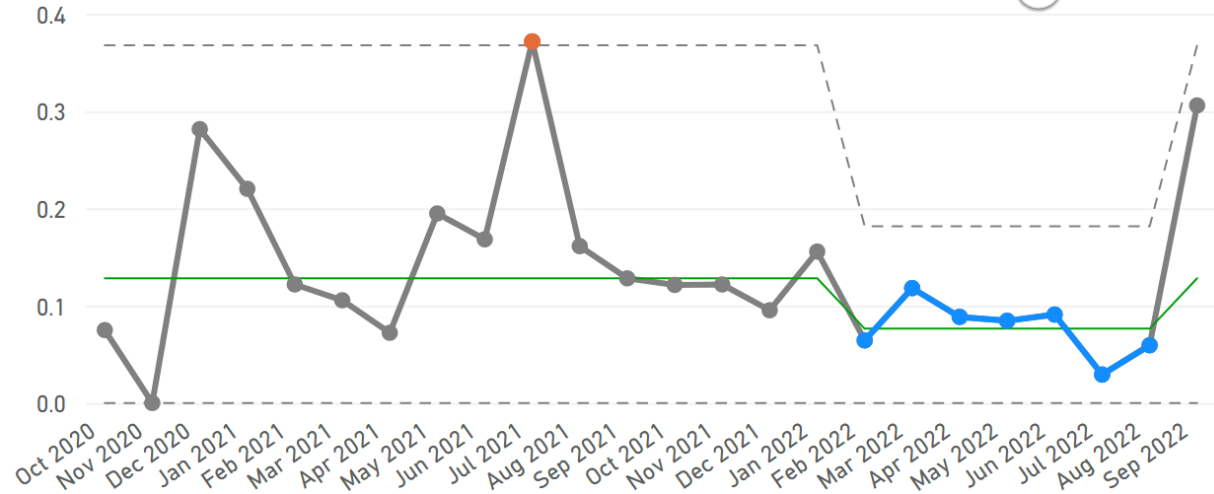
Falls Rate %

Month	Performance	Target	Trend	Assurance
Sep 2022	4.8	6.6		



Falls With Harm Rate %

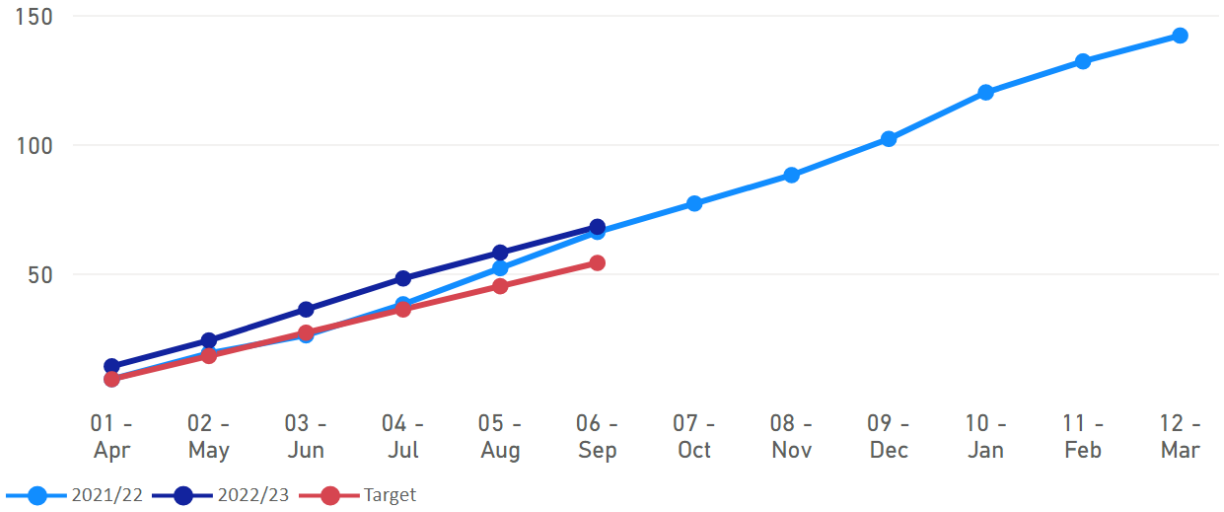
Month	Performance	Target	Trend	Assurance
Sep 2022	0.3			N/A



SAFE

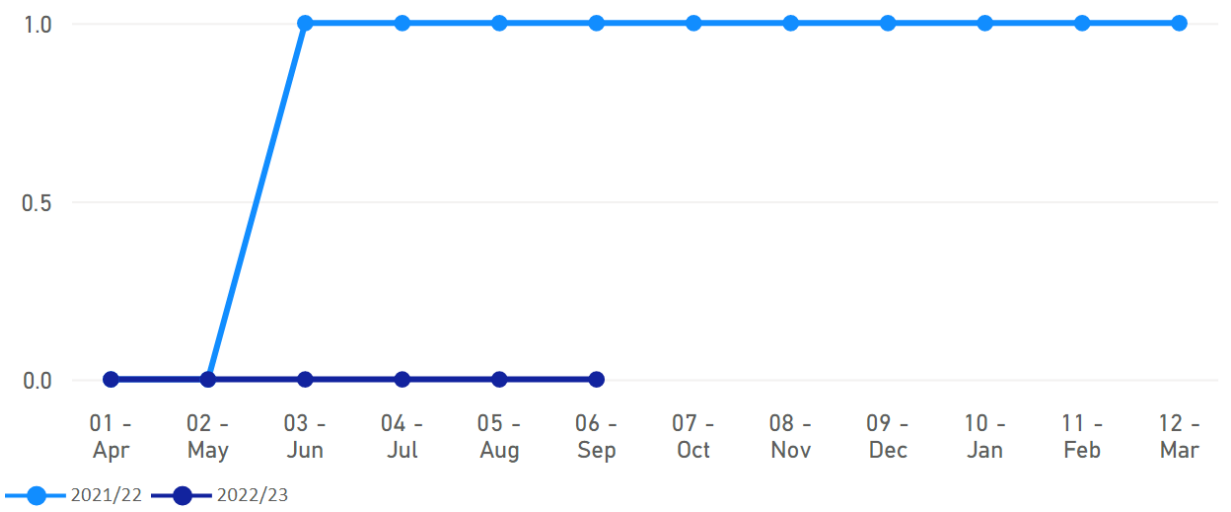
C-Difficile (YTD)

Month	Performance	Target	Trend	Assurance
Sep 2022	68	54	N/A	N/A



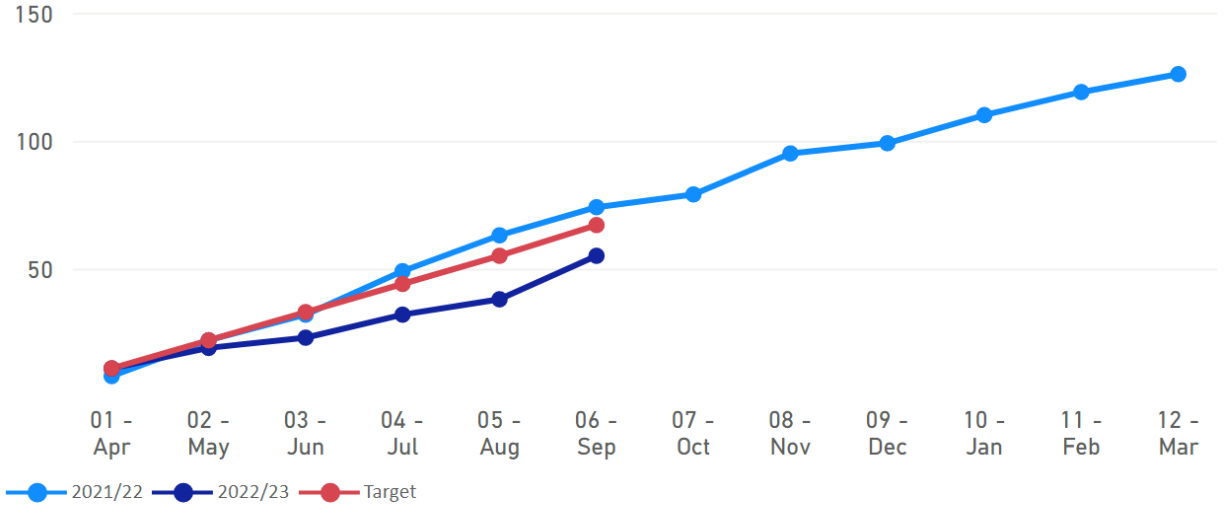
MRSA (YTD)

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



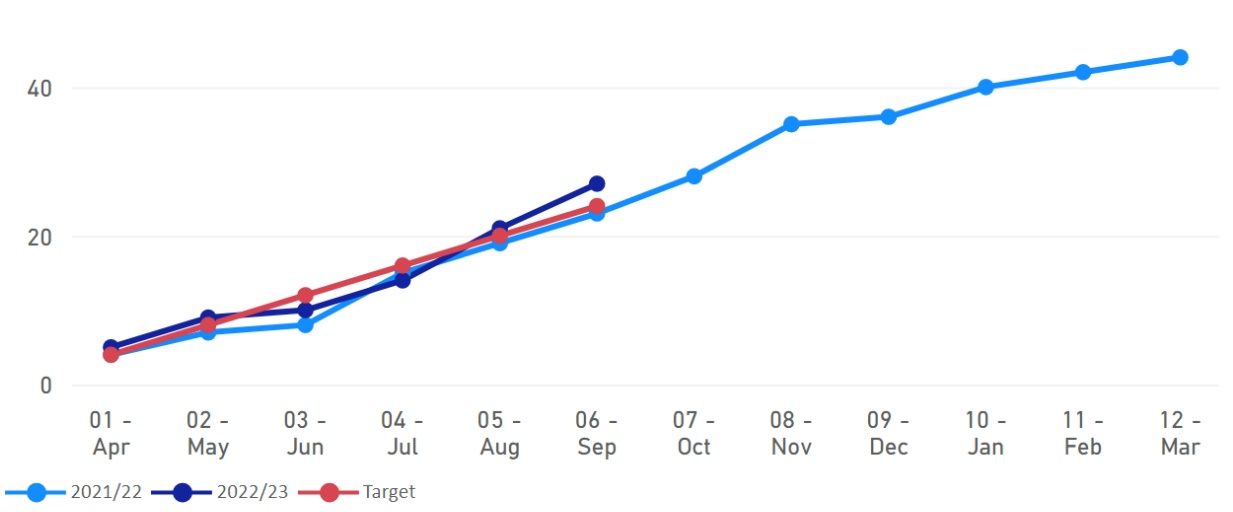
E-Coli (YTD)

Month	Performance	Target	Trend	Assurance
Sep 2022	55	67	N/A	N/A



Klebsiella (YTD)

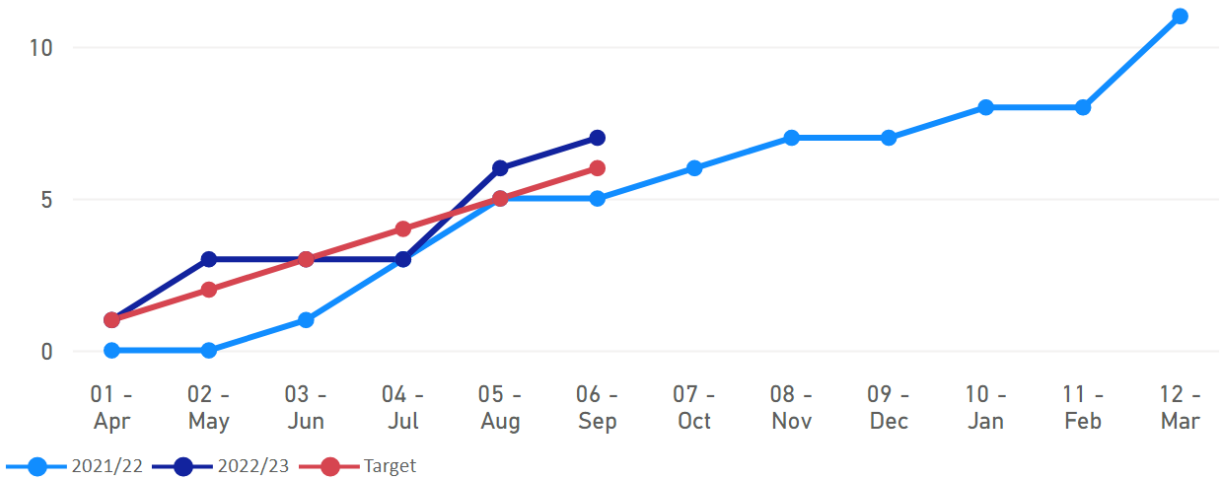
Month	Performance	Target	Trend	Assurance
Sep 2022	27	24	N/A	N/A



SAFE

Pseudomonas (YTD)

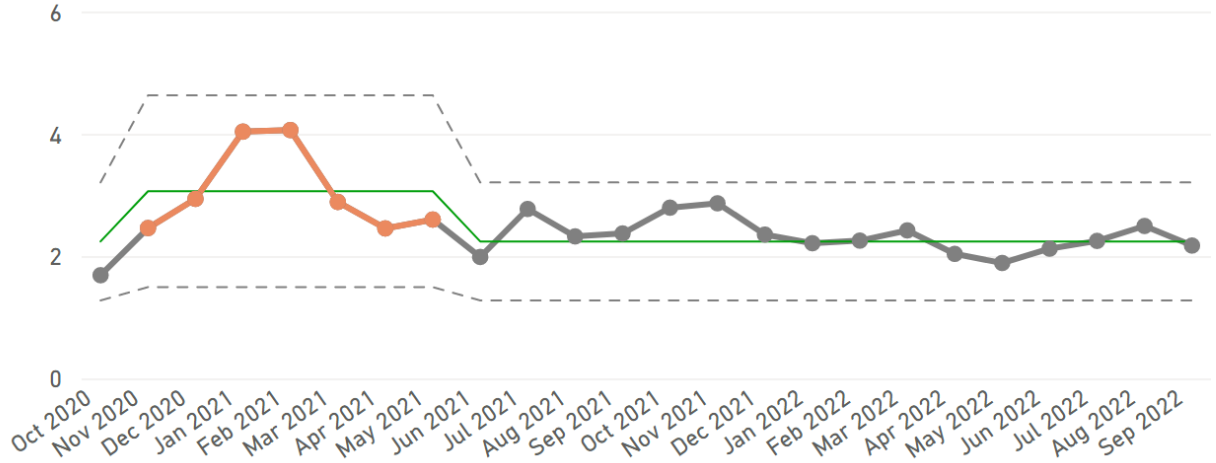
Month	Performance	Target	Trend	Assurance
Sep 2022	7	6	N/A	N/A



SAFE

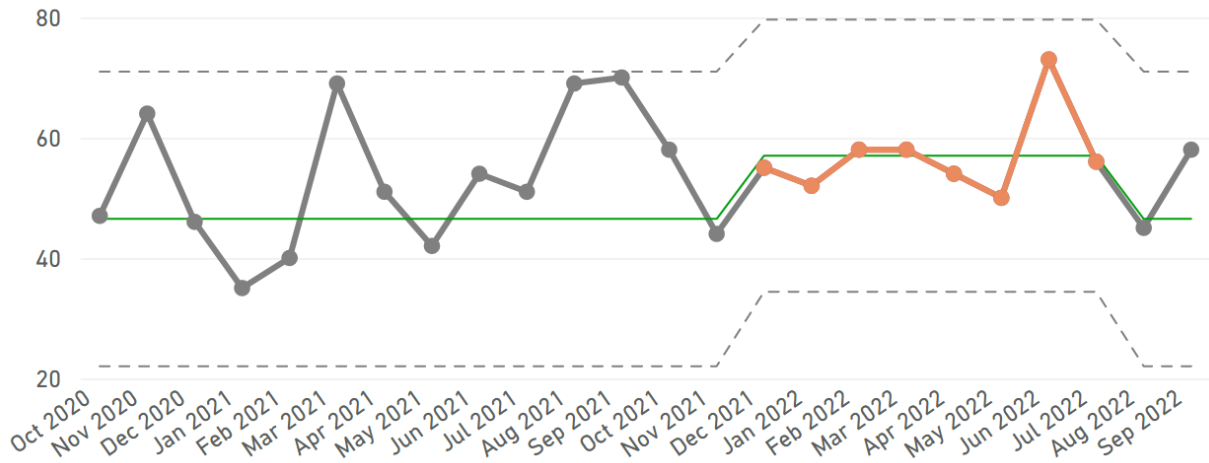
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Sep 2022	2.2			N/A



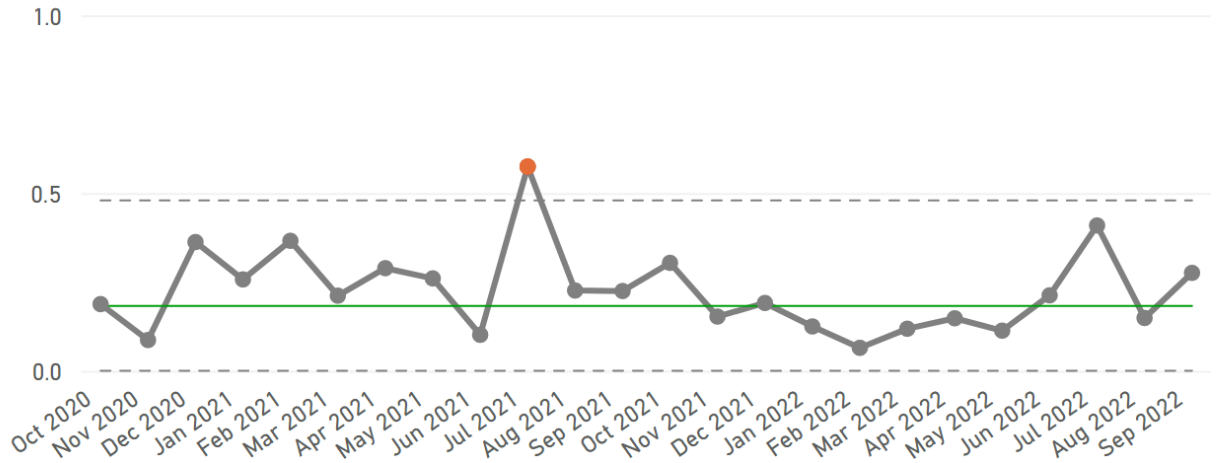
Category 2 Pressure Ulcers (Community)

Month	Performance	Target	Trend	Assurance
Sep 2022	58			N/A



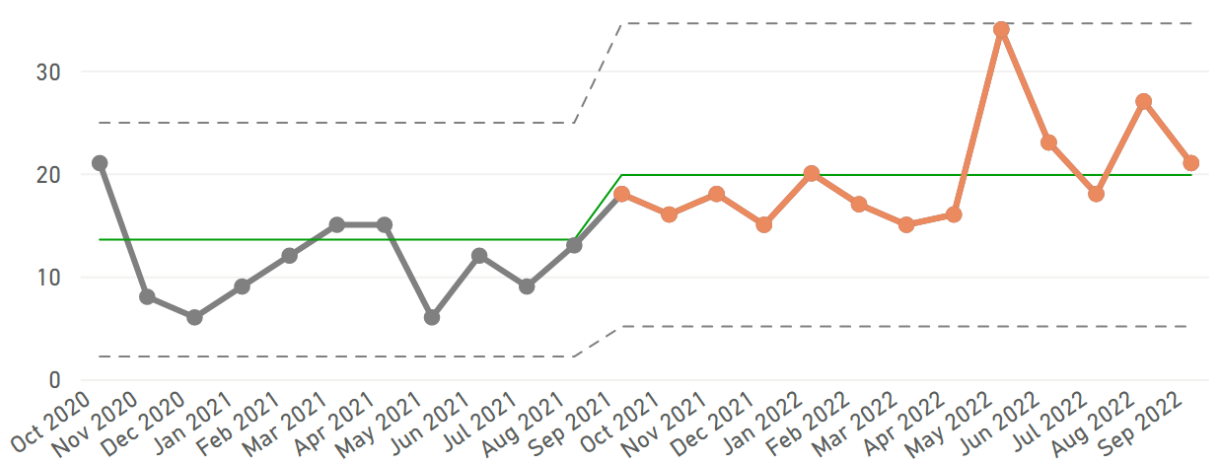
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Sep 2022	0.3			N/A



Category 3&4 Pressure Ulcers (Community)

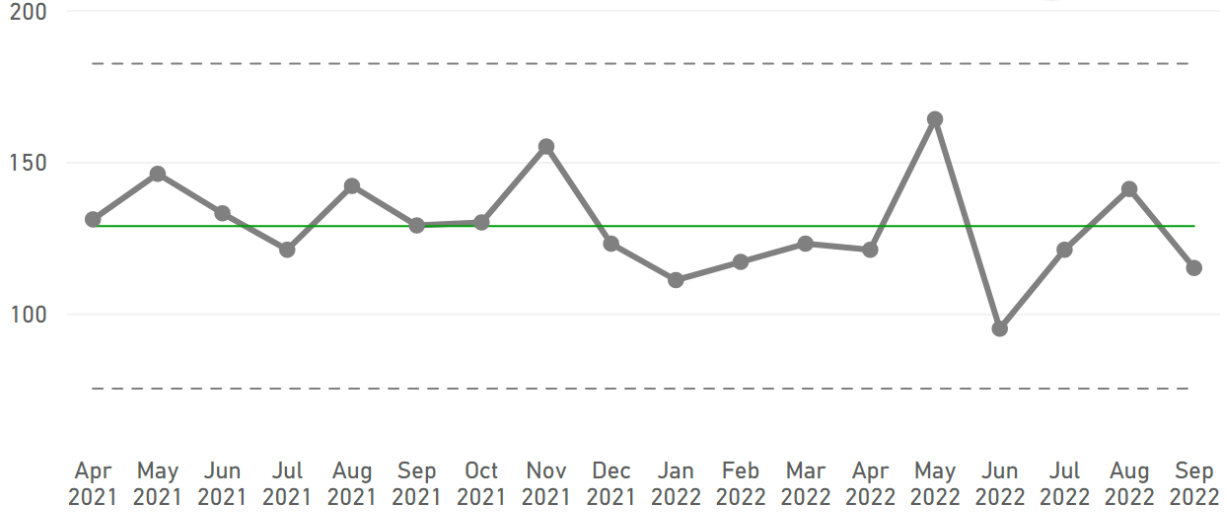
Month	Performance	Target	Trend	Assurance
Sep 2022	21			N/A



SAFE

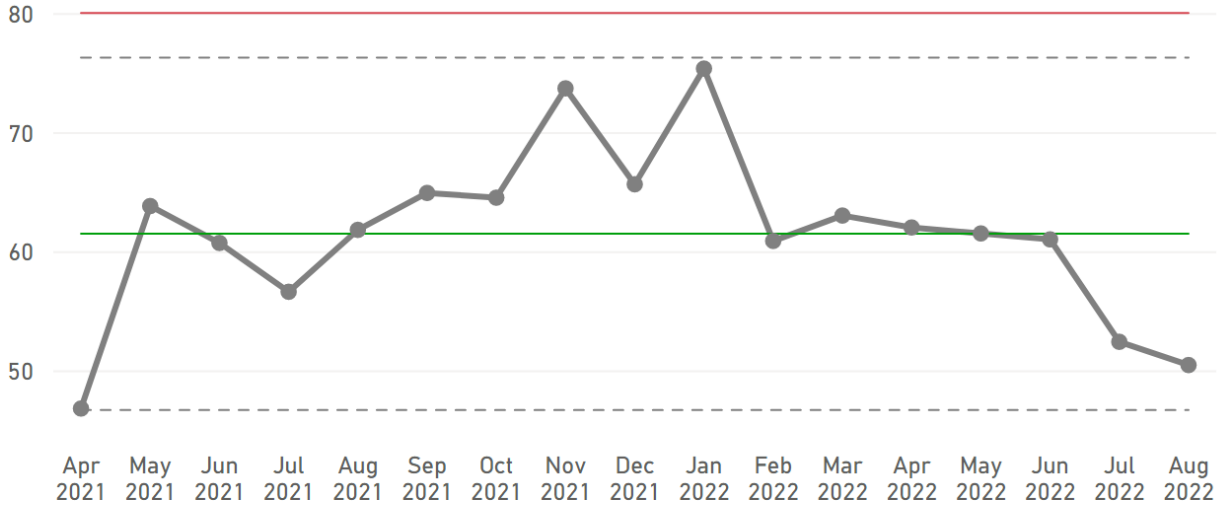
Medication Incidents

Month	Performance	Target	Trend	Assurance
Sep 2022	115			N/A



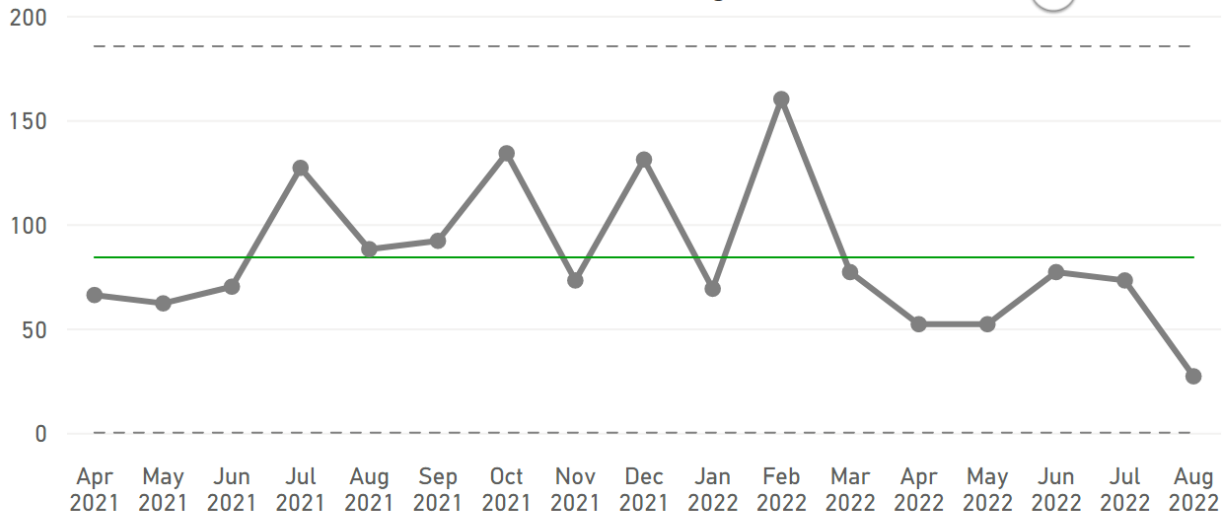
Medications Reconciled Rate %

Month	Performance	Target	Trend	Assurance
Aug 2022	50.4%	80%		



Omitted Critical Doses

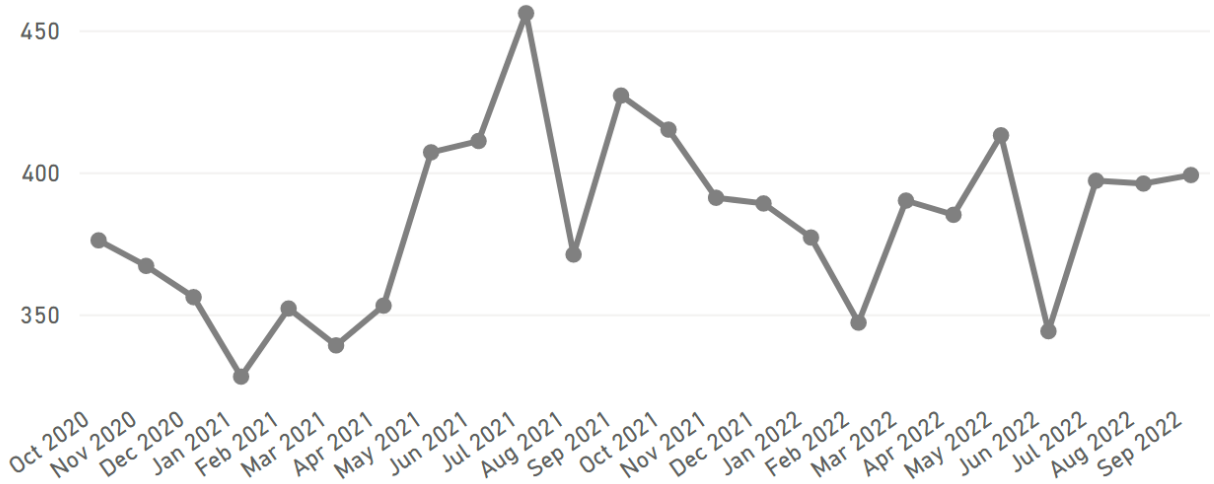
Month	Performance	Target	Trend	Assurance
Aug 2022	27			N/A



SAFE

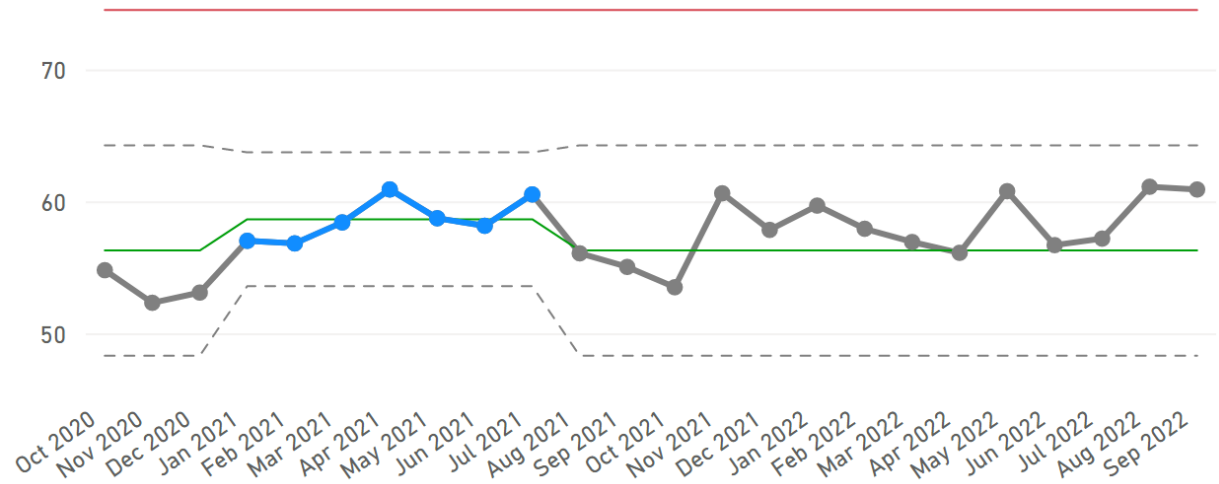
No. of babies born

Month	Performance	Target	Trend	Assurance
Sep 2022	399		N/A	N/A



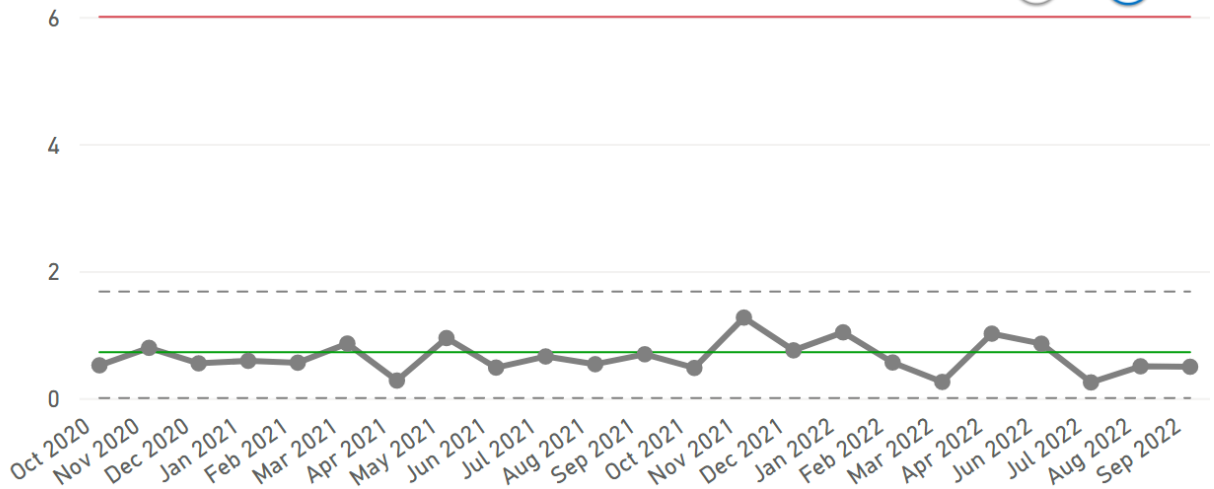
Breast feeding initiated (48 hrs)

Month	Performance	Target	Trend	Assurance
Sep 2022	60.9%	74.5%		F



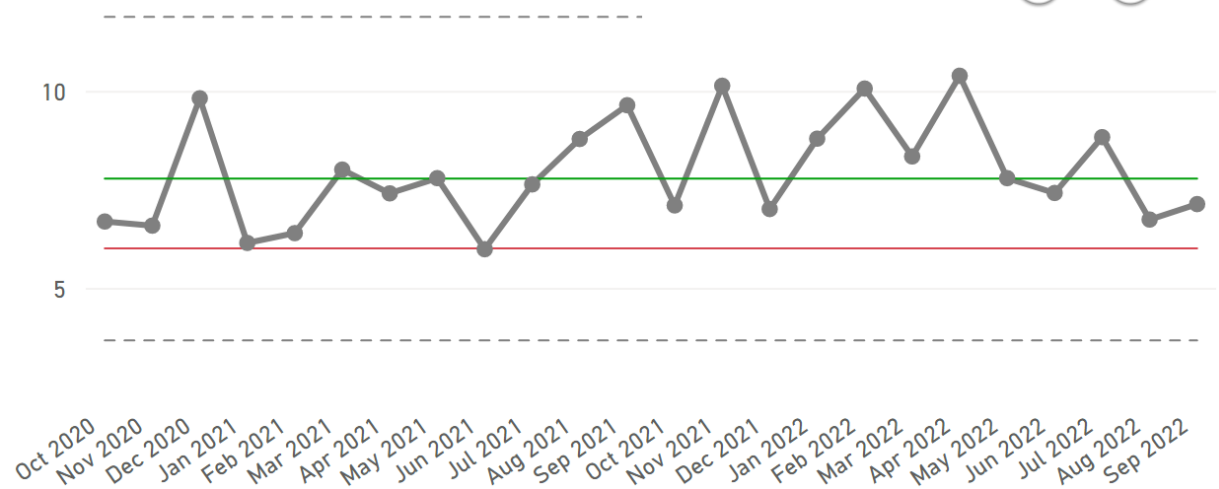
Preterm birth rate <26+6 wks

Month	Performance	Target	Trend	Assurance
Sep 2022	0.5%	6%		P



Preterm birth rate 27 - 36+6 wks

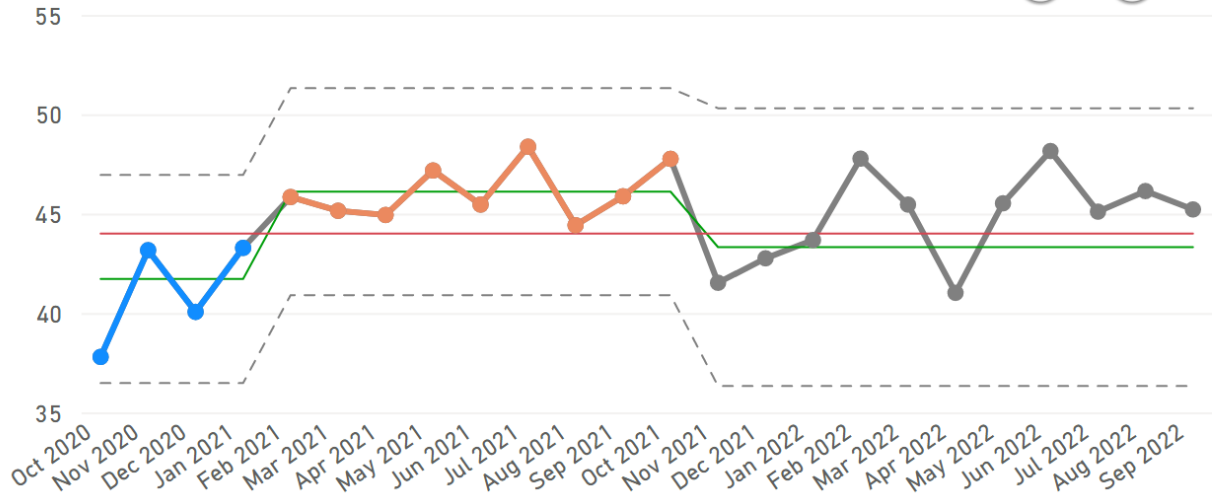
Month	Performance	Target	Trend	Assurance
Sep 2022	7.1%	6%		?



SAFE

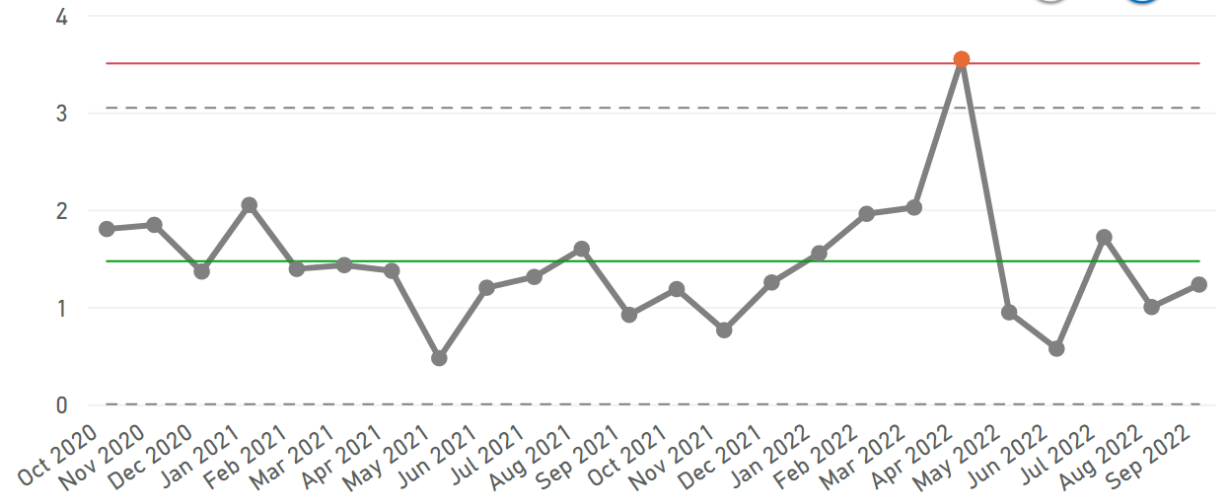
Induction of Labour (%)

Month	Performance	Target	Trend	Assurance
Sep 2022	45.2%	44%		



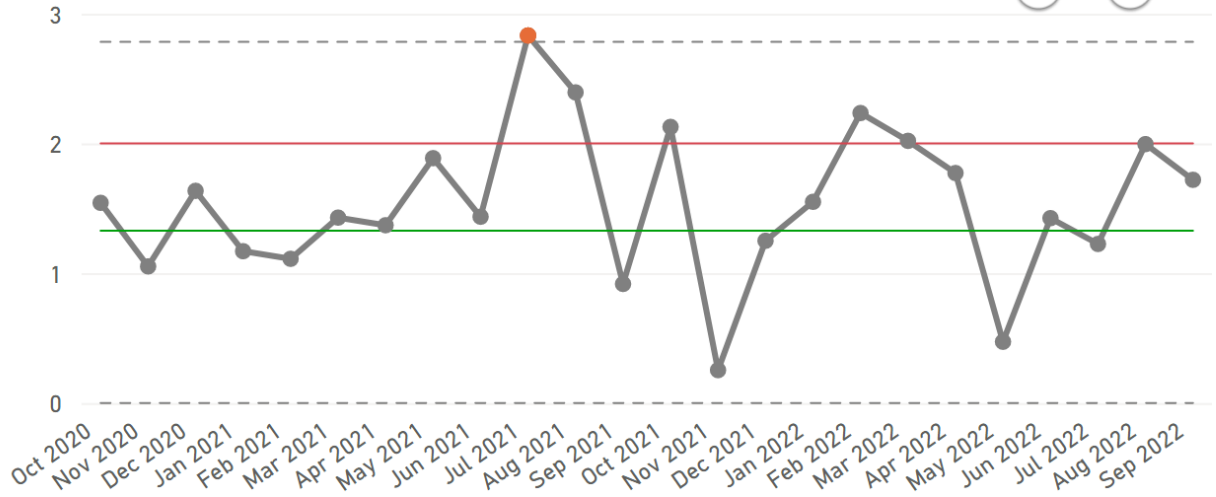
Number of 3rd/4th degree tear (%)

Month	Performance	Target	Trend	Assurance
Sep 2022	1.2%	3.5%		



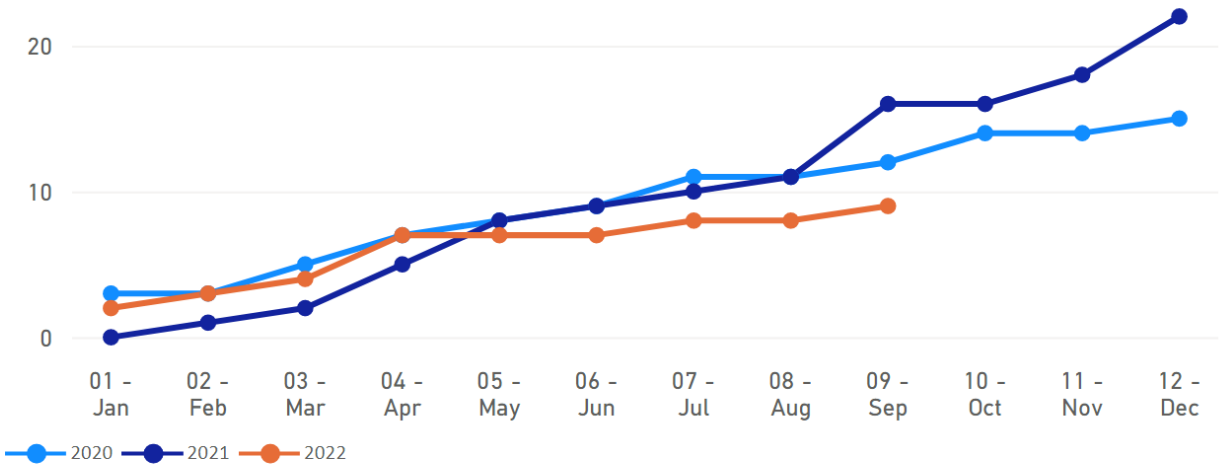
PPH > 1500ml (%)

Month	Performance	Target	Trend	Assurance
Sep 2022	1.72%	2%		



Still Births (YTD)

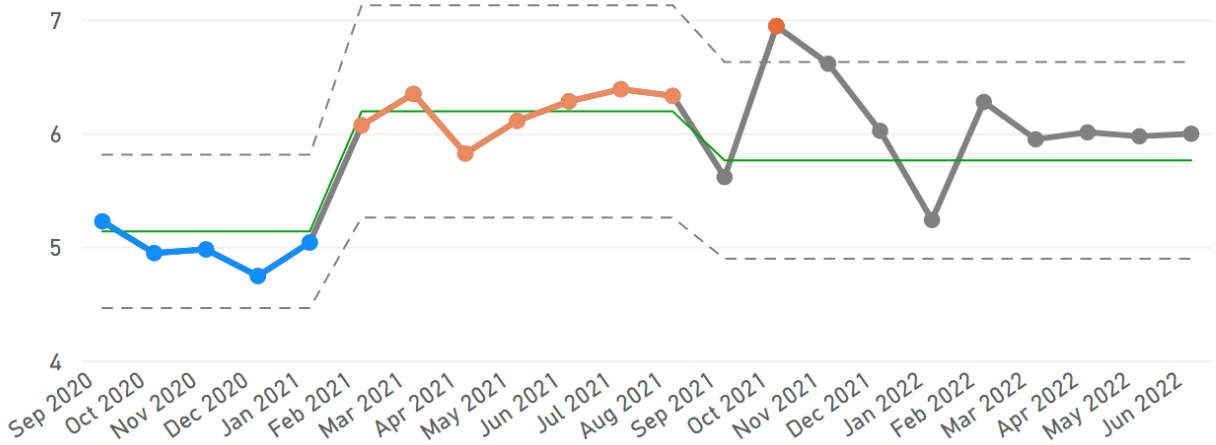
Month	Performance	Target	Trend	Assurance
Sep 2022	9	17	N/A	N/A



EFFECTIVE

Readmission Rate %

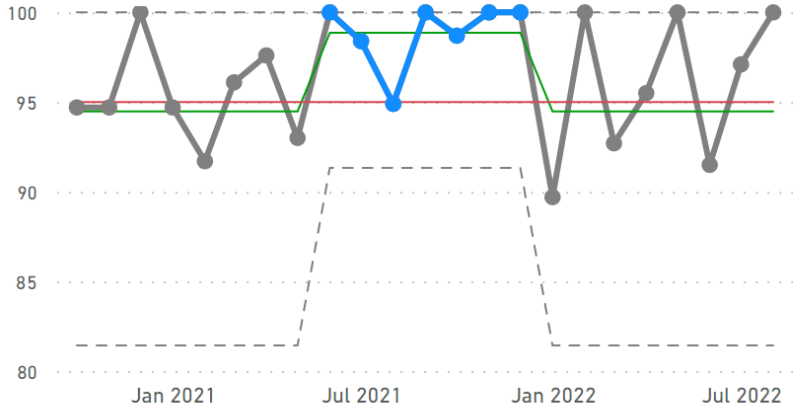
Month	Performance	Target	Trend	Assurance
Jun 2022	6%			N/A



EFFECTIVE

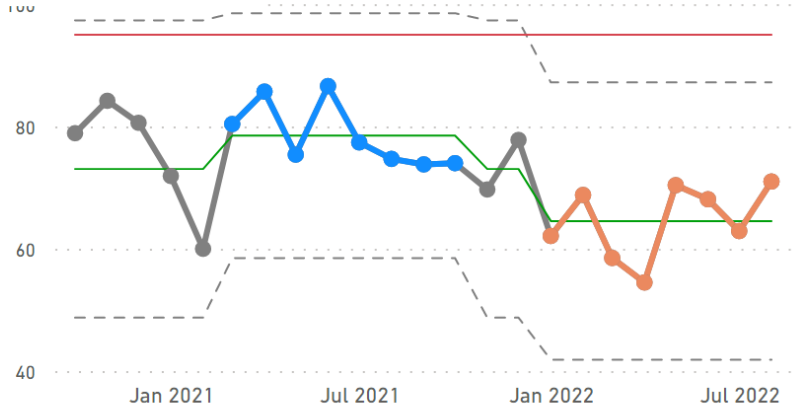
Sepsis - Oxygen within 1hr

Month	Performance	Target	Trend	Assurance
Aug 2022	100%	95%		



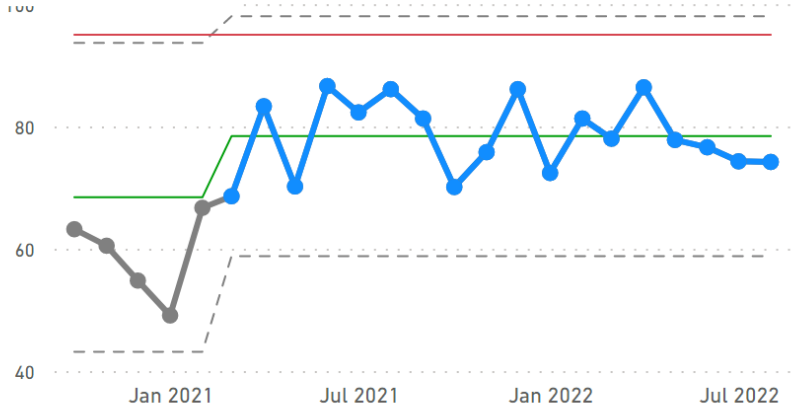
Sepsis - Blood cultures within 1hr

Month	Performance	Target	Trend	Assurance
Aug 2022	71%	95%		



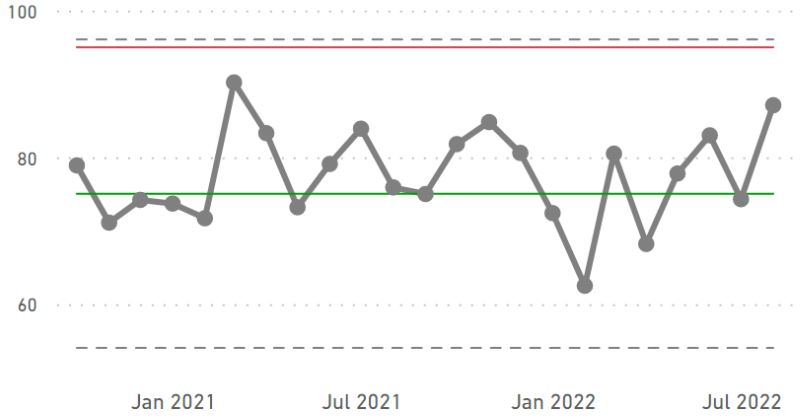
Sepsis - IV antibiotics within 1hr

Month	Performance	Target	Trend	Assurance
Aug 2022	74.2%	95%		



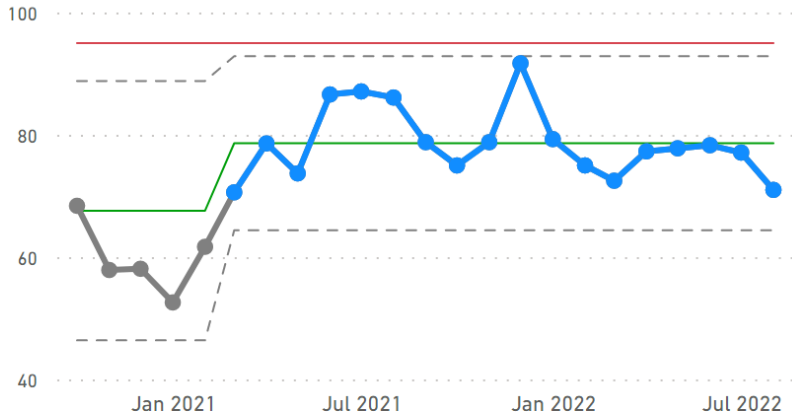
Sepsis - Serum lactate within 1hr

Month	Performance	Target	Trend	Assurance
Aug 2022	87.1%	95%		



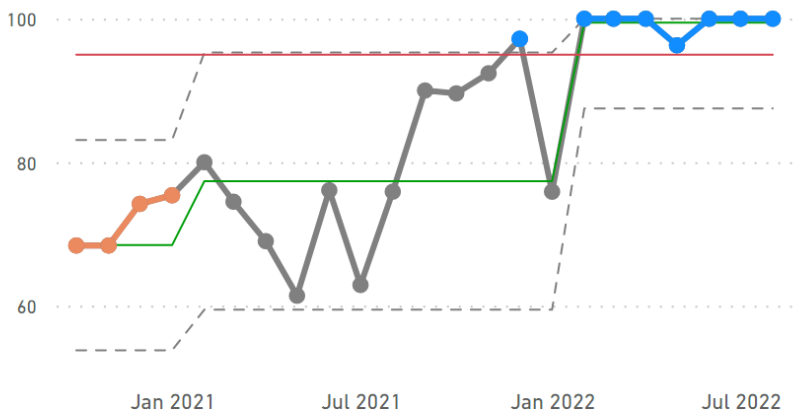
IV fluid resuscitation within 1hr

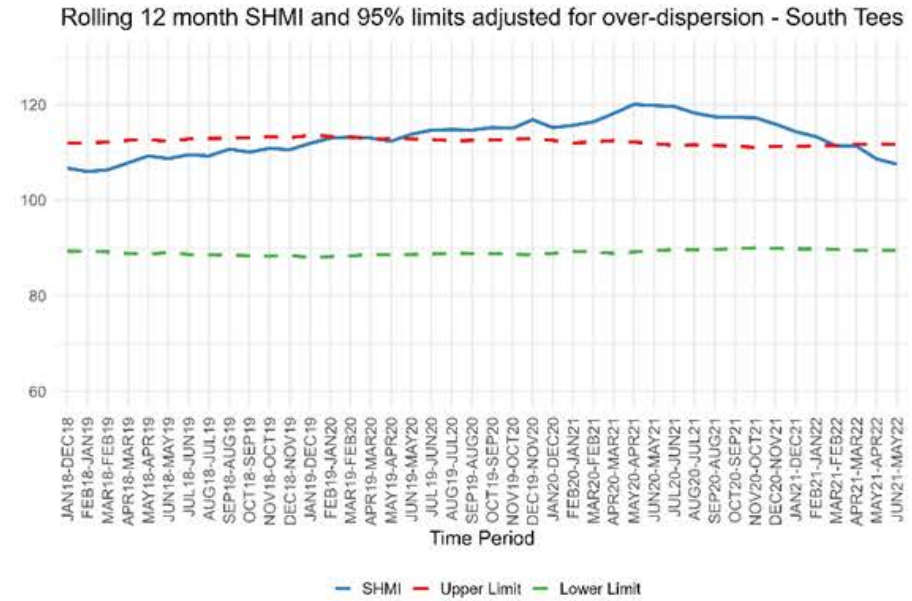
Month	Performance	Target	Trend	Assurance
Aug 2022	71%	95%		

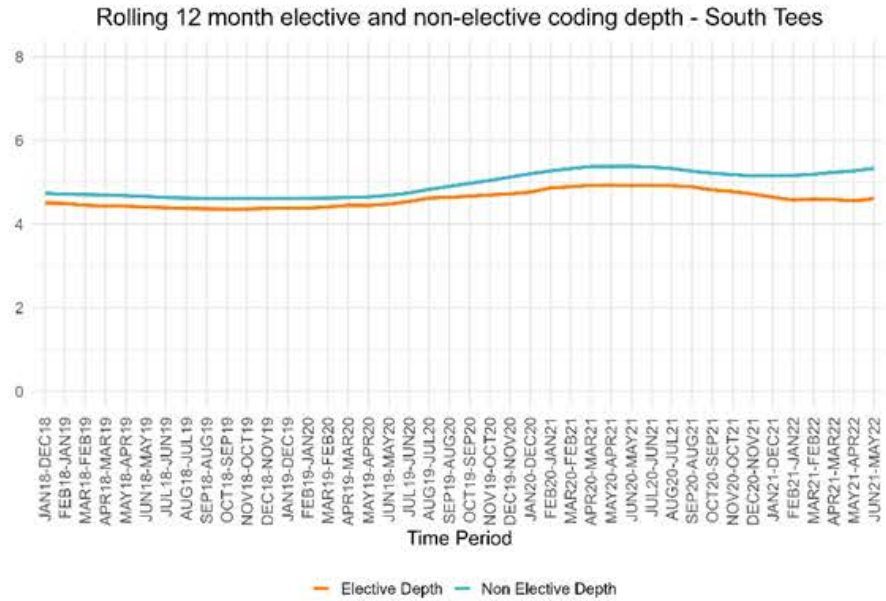


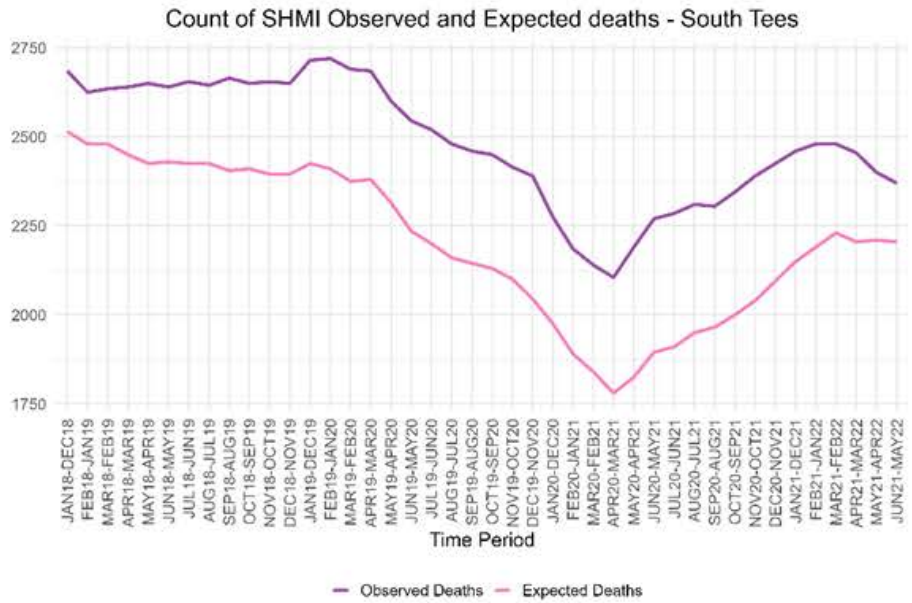
Sepsis - Urine measurement within 1hr

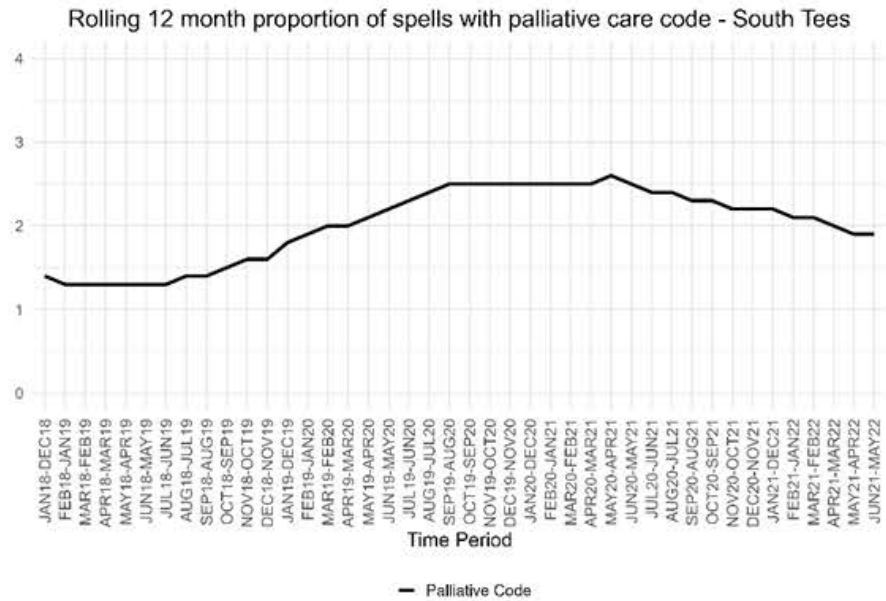
Month	Performance	Target	Trend	Assurance
Aug 2022	100%	95%		











Latest SHMI = 107.6
(June 2021 – May 2022)

Observed deaths = 2370
Expected deaths = 2205

Coding depth (codes / spell)
Elective = 4.6
Non-Elective = 5.3

Palliative care (%) = 1.9

Latest SHMI is:
'as expected'

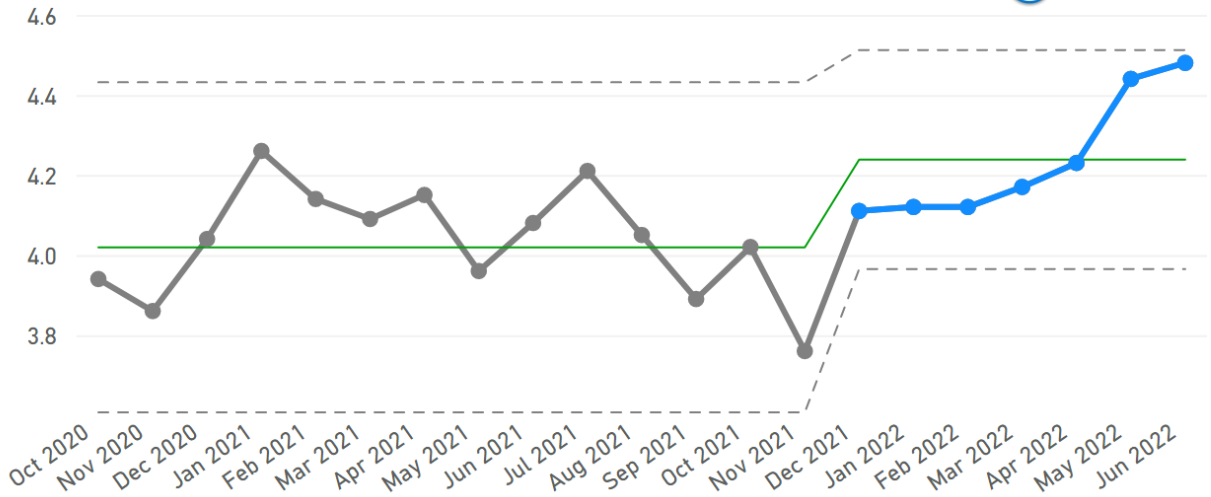
COVID-19 impact for England
Excluded spells = 4.0%
Spells as a % pre-pandemic (2019 spells) = 89%

Data source: NHS Digital
Monthly SHMI publication

EFFECTIVE

Comorbidity Coding

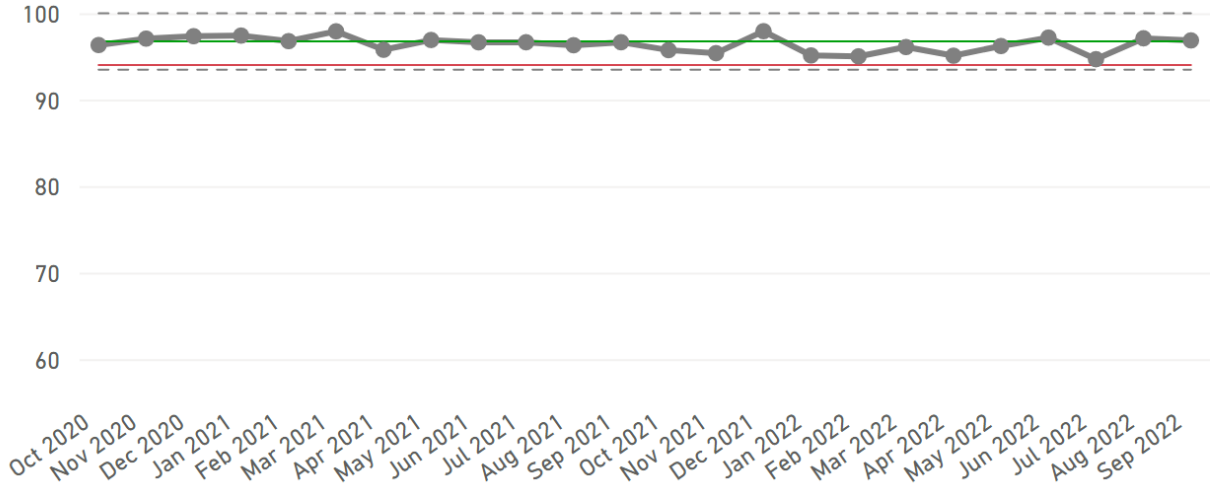
Month	Performance	Target	Trend	Assurance
Jun 2022	4.5			N/A



CARING

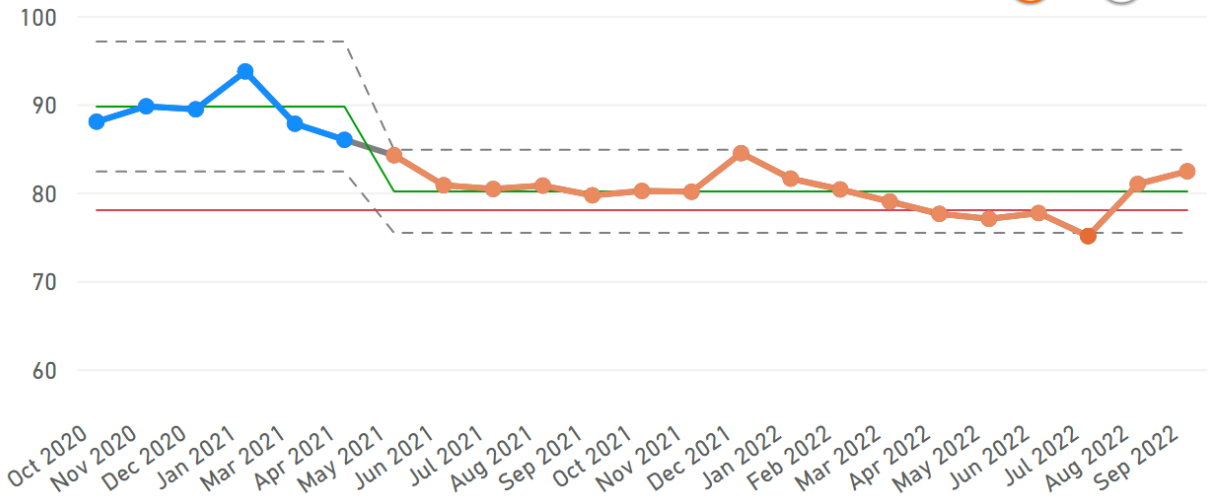
Inpatient Experience (%)

Month	Performance	Target	Trend	Assurance
Sep 2022	96.9%	94%		



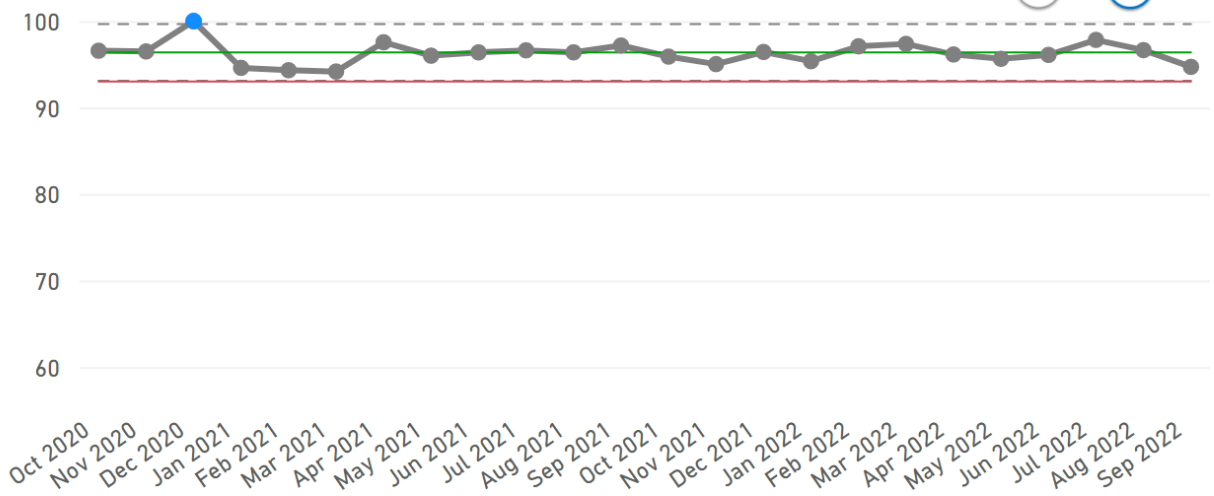
A&E Experience (%)

Month	Performance	Target	Trend	Assurance
Sep 2022	82.4%	78%		



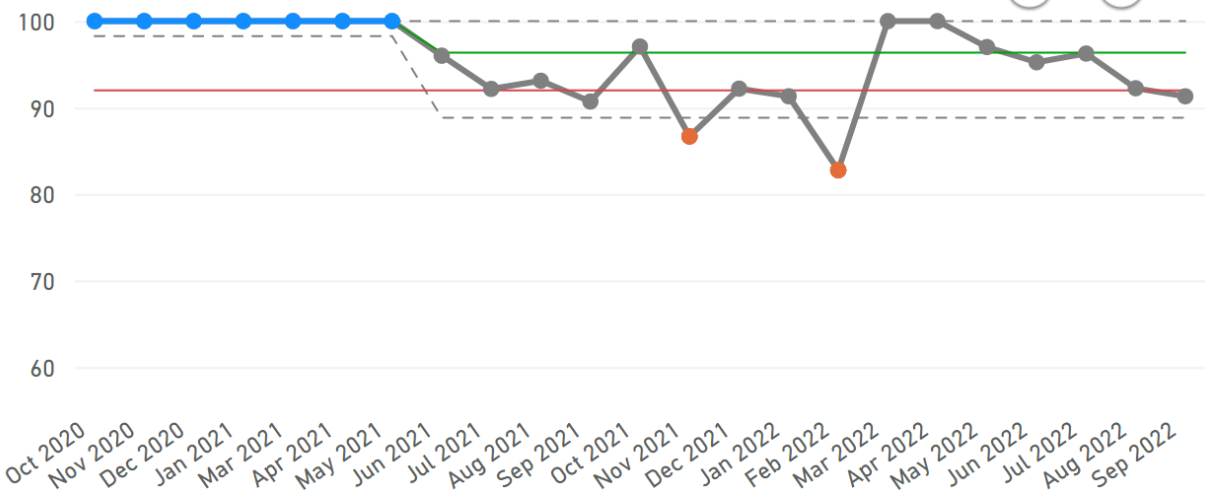
Outpatient Experience (%)

Month	Performance	Target	Trend	Assurance
Sep 2022	94.7%	93%		



Maternity Experience (%)

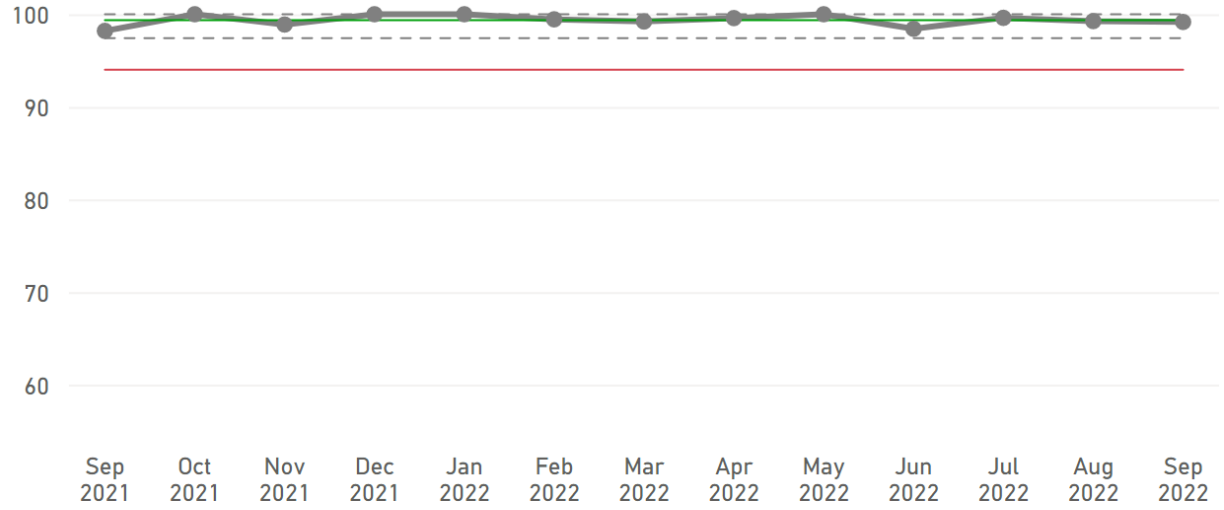
Month	Performance	Target	Trend	Assurance
Sep 2022	91.3%	92%		



CARING

Community Experience (%)

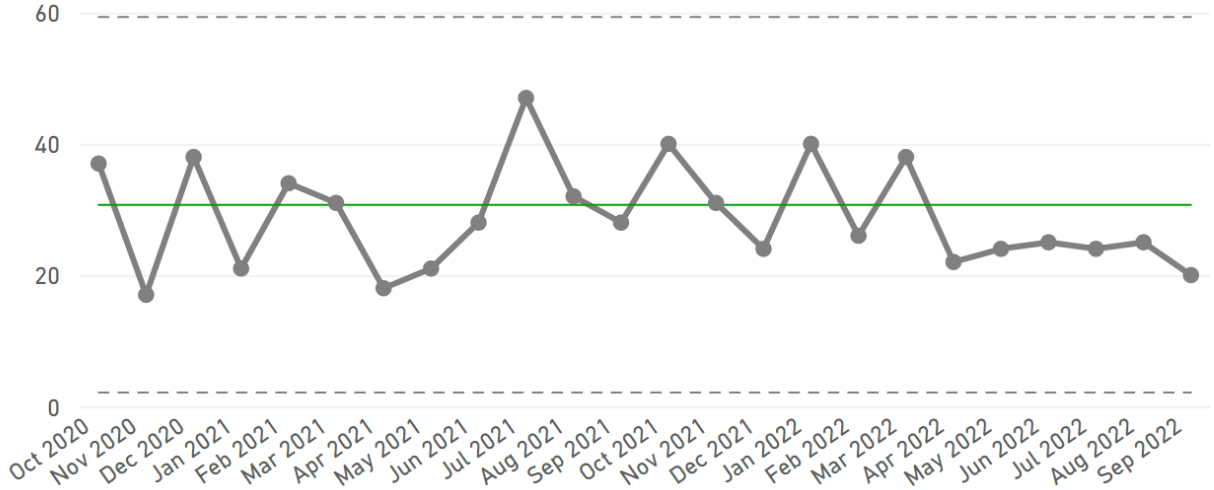
Month	Performance	Target	Trend	Assurance
Sep 2022	99.2%	94%		



CARING

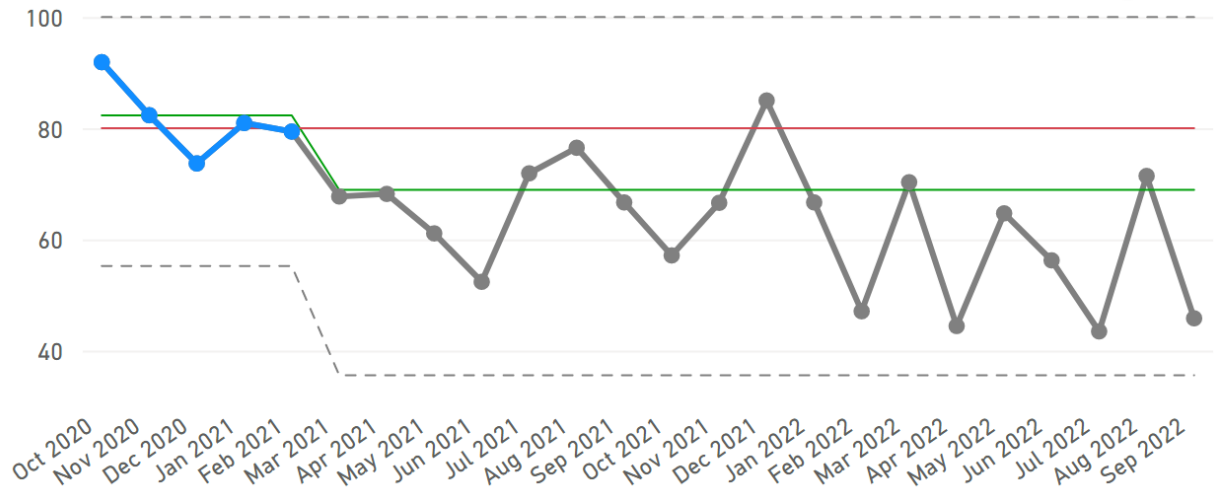
New Complaints

Month	Performance	Target	Trend	Assurance
Sep 2022	20			N/A



Closed Within Target (%)

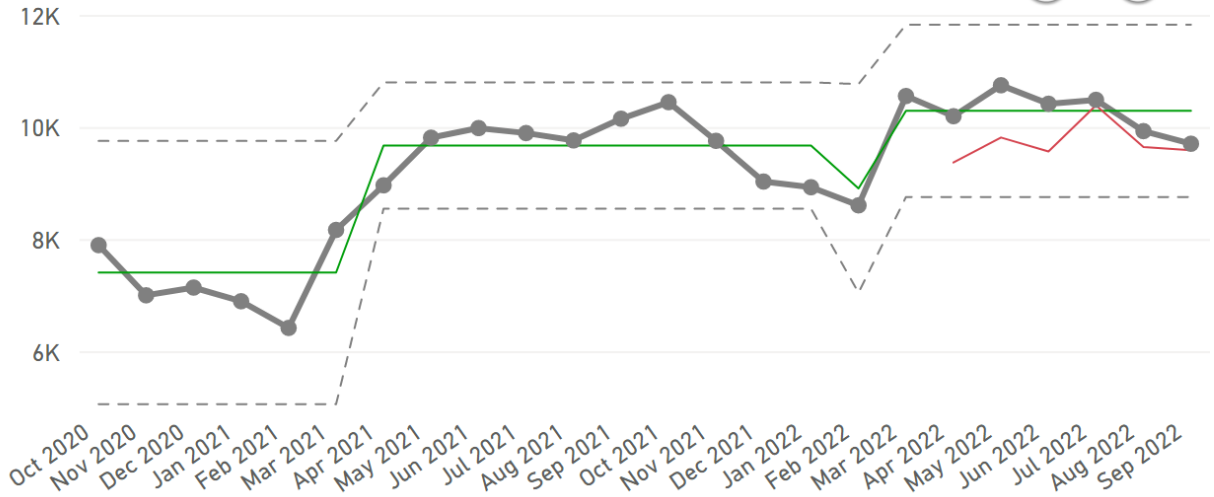
Month	Performance	Target	Trend	Assurance
Sep 2022	45.8%	80%		



RESPONSIVE

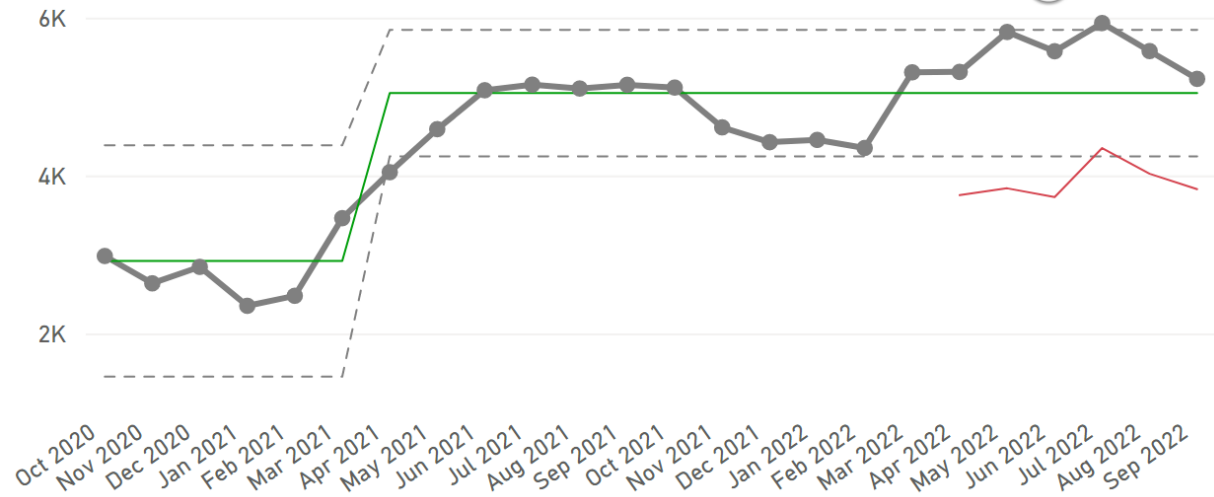
ED Attendances - Type 1 (vs 19/20)

Month	Performance	Target	Trend	Assurance
Sep 2022	9701	9587		



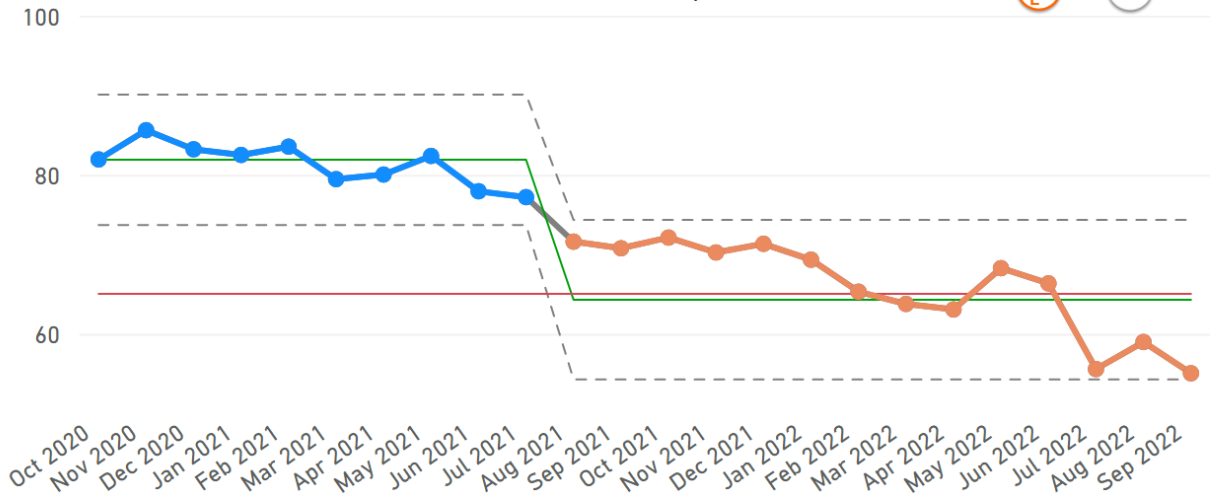
ED Attendances - Type 3 (vs 19/20)

Month	Performance	Target	Trend	Assurance
Sep 2022	5223	3826		N/A



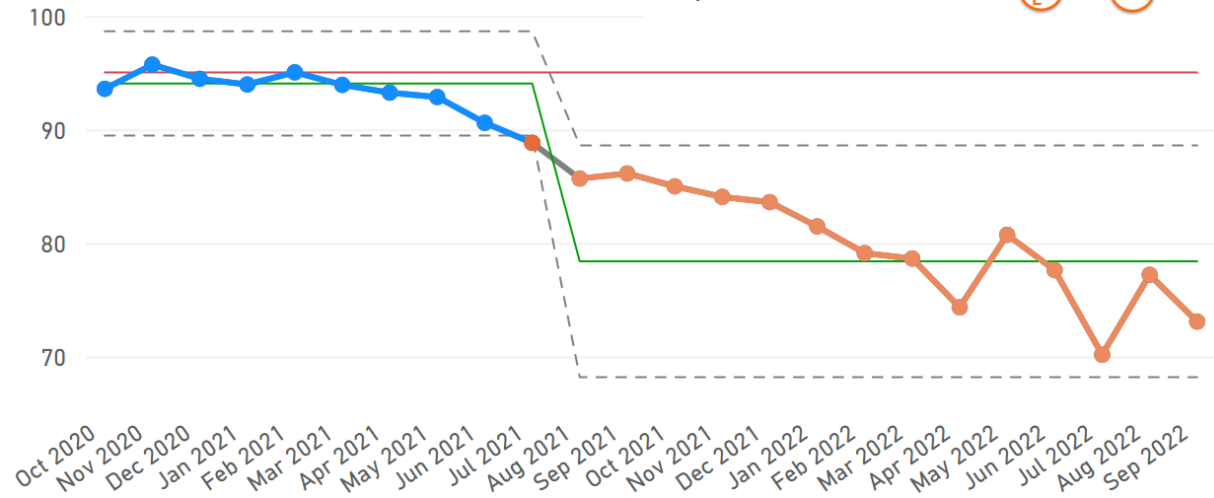
Handovers - Within 15 Mins (%)

Month	Performance	Target	Trend	Assurance
Sep 2022	55%	65%		



Handovers - Within 30 Mins (%)

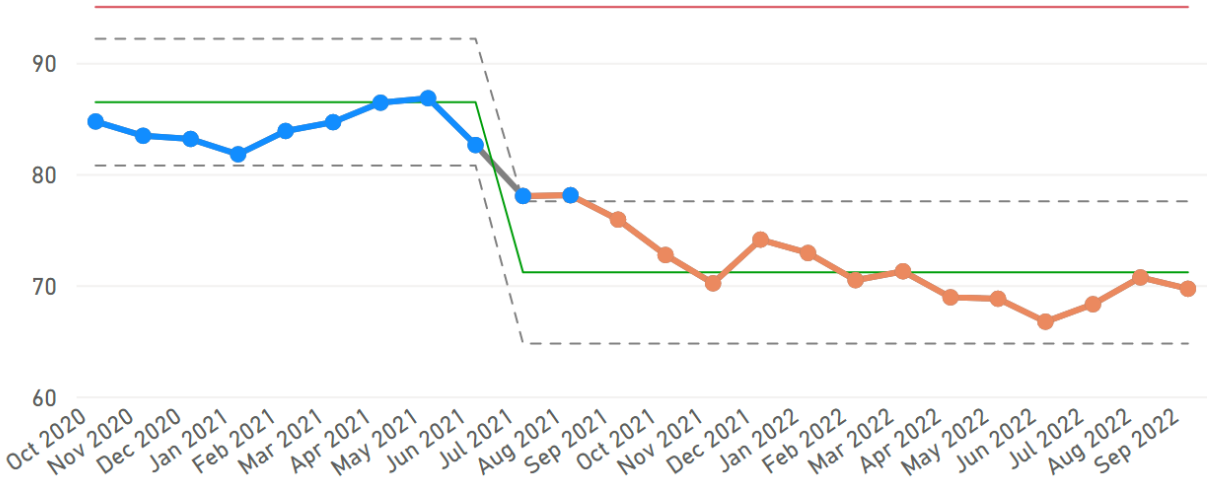
Month	Performance	Target	Trend	Assurance
Sep 2022	73.1%	95%		



RESPONSIVE

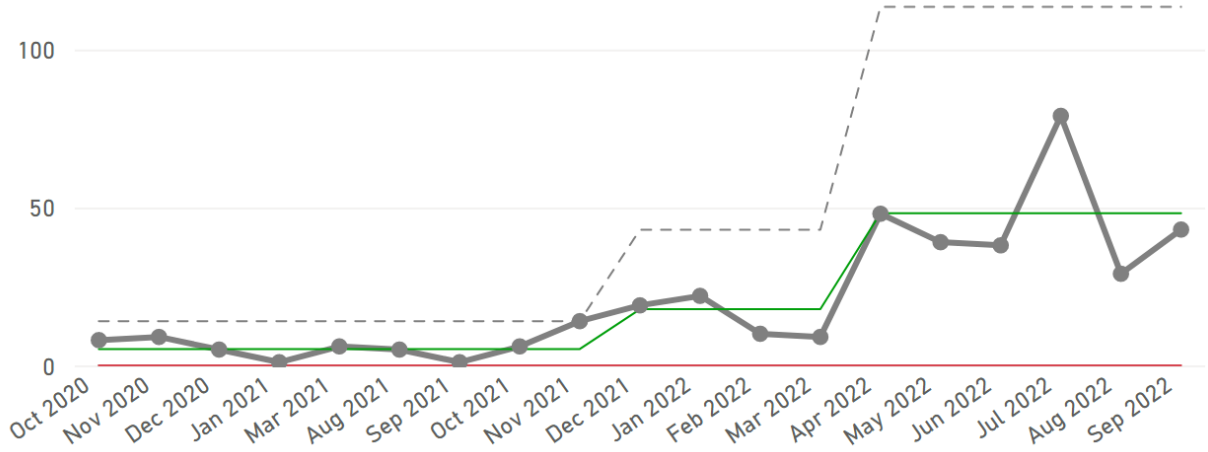
4-Hour A&E Standard

Month	Performance	Target	Trend	Assurance
Sep 2022	69.7%	95%		



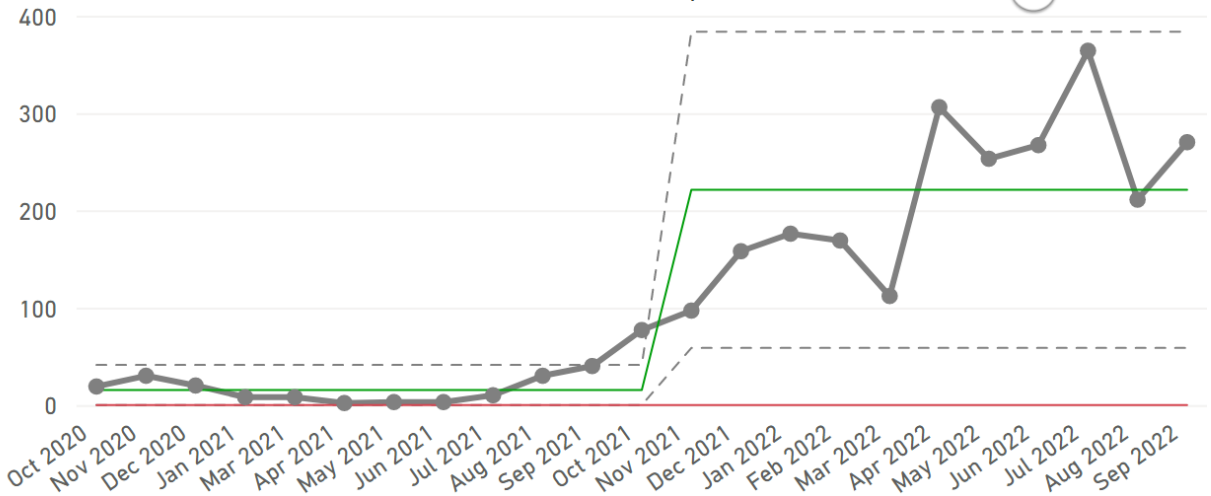
12-Hour Waits from Decision to Admit

Month	Performance	Target	Trend	Assurance
Sep 2022	43	0		



12-Hour A&E Breaches

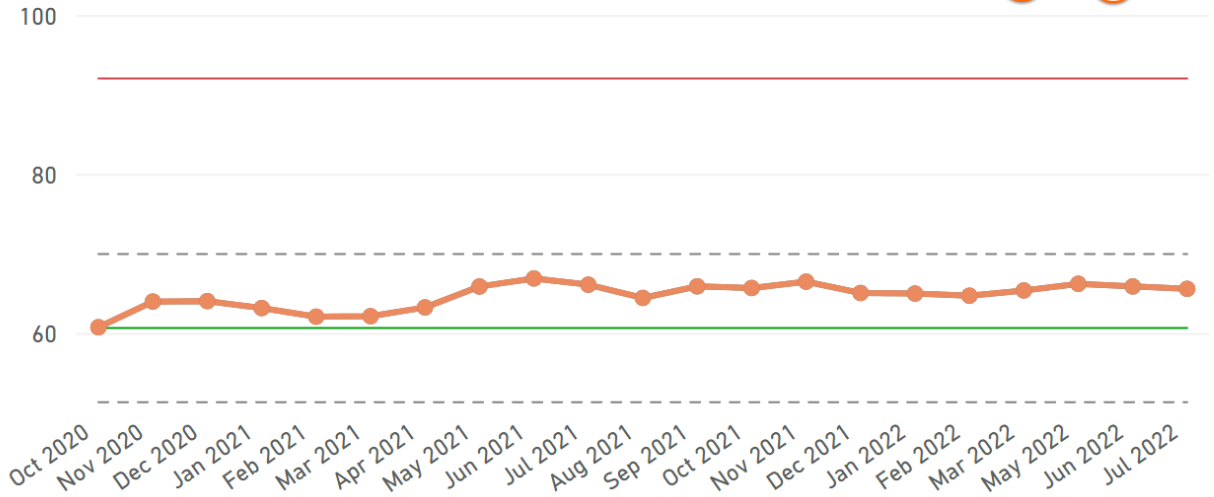
Month	Performance	Target	Trend	Assurance
Sep 2022	270	0		N/A



RESPONSIVE

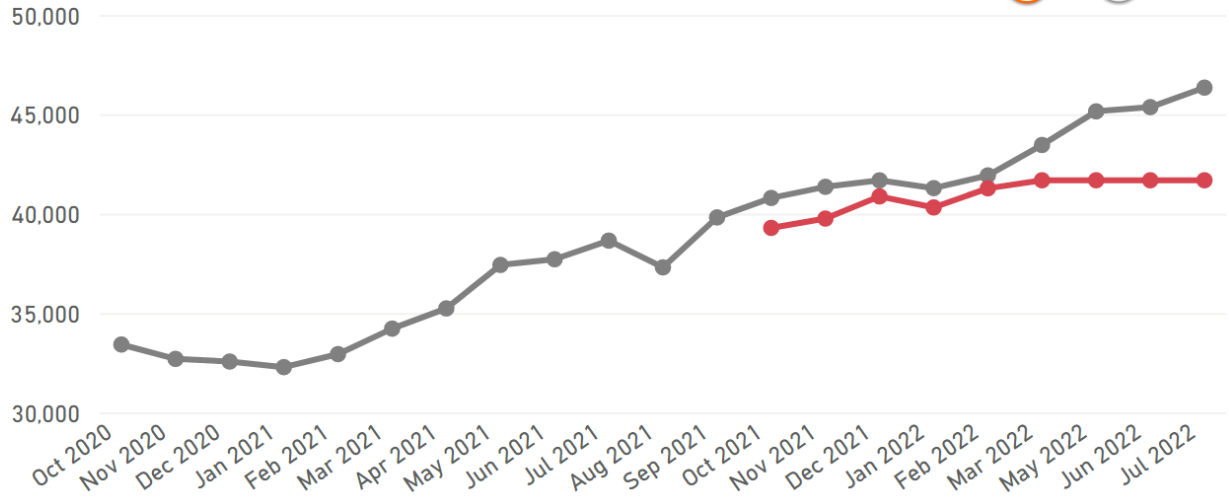
RTT Incomplete Pathways (%)

Month	Performance	Plan	Trend	Assurance
Jul 2022	65.5%	92%		



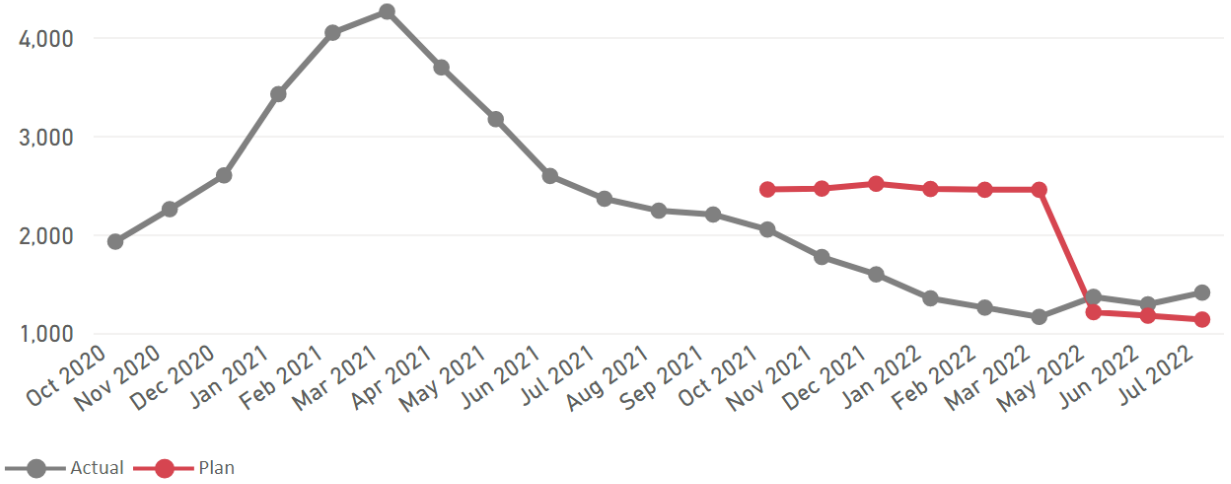
RTT Waiting List Size

Month	Performance	Plan	Trend	Assurance
Jul 2022	46338	41677		



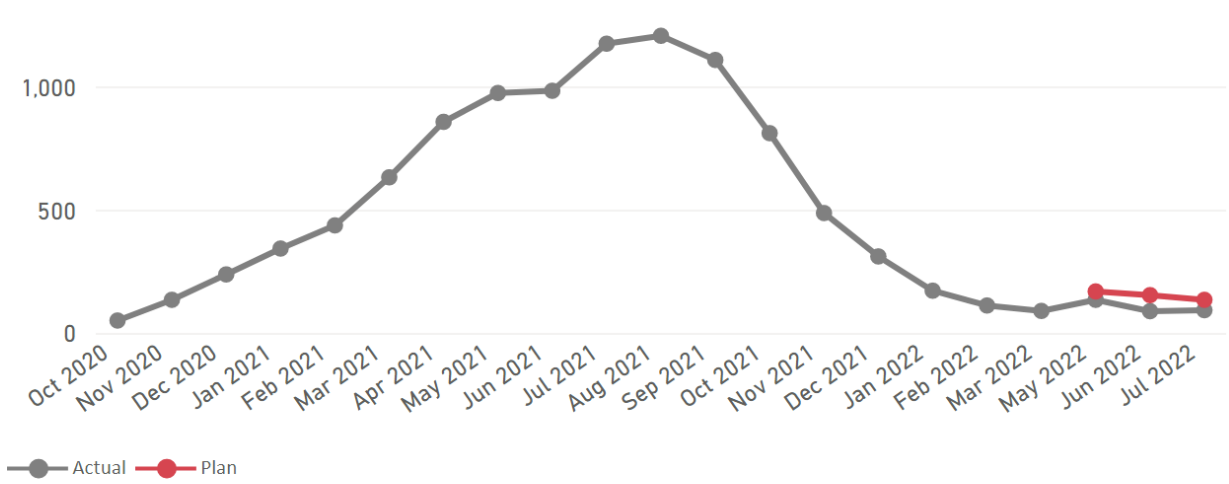
RTT 52 week waiters

Month	Performance	Plan	Trend	Assurance
Jul 2022	1408	1135	N/A	N/A



RTT 78 week waiters

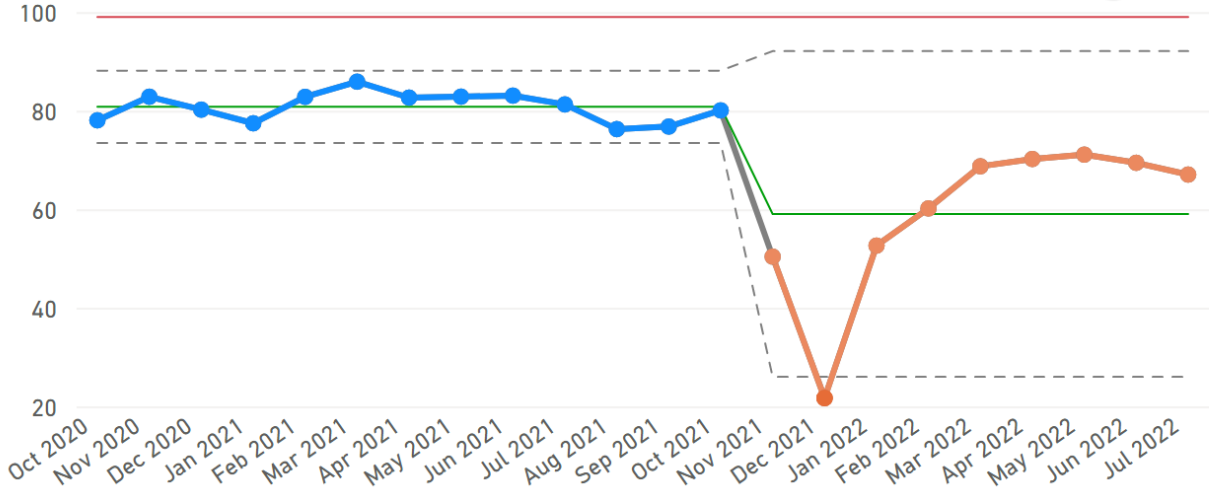
Month	Performance	Plan	Trend	Assurance
Jul 2022	92	134	N/A	N/A



RESPONSIVE

Diagnostic 6 Weeks Standard (%)

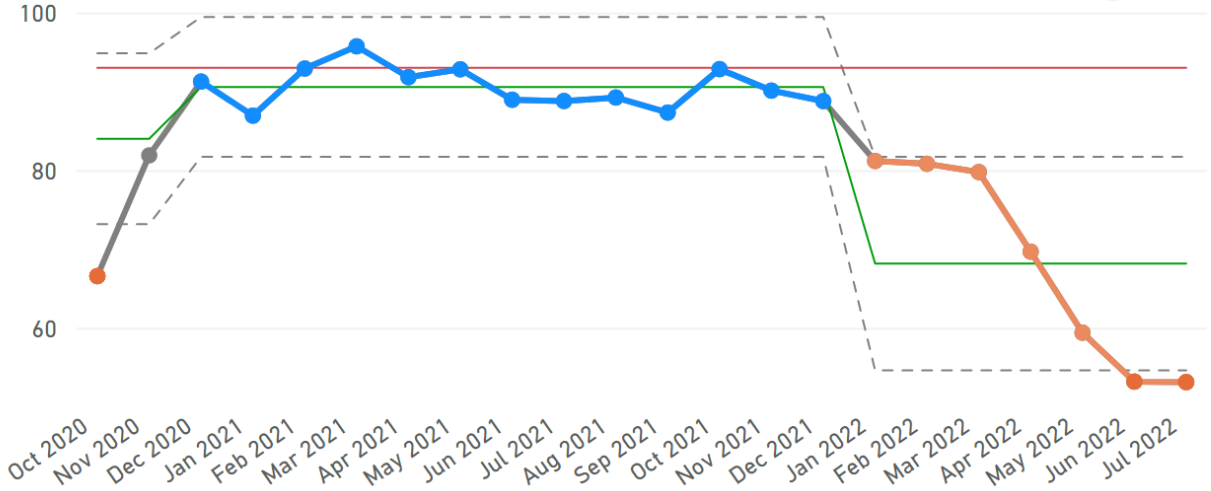
Month	Performance	Target	Trend	Assurance
Jul 2022	67%	99%		



RESPONSIVE

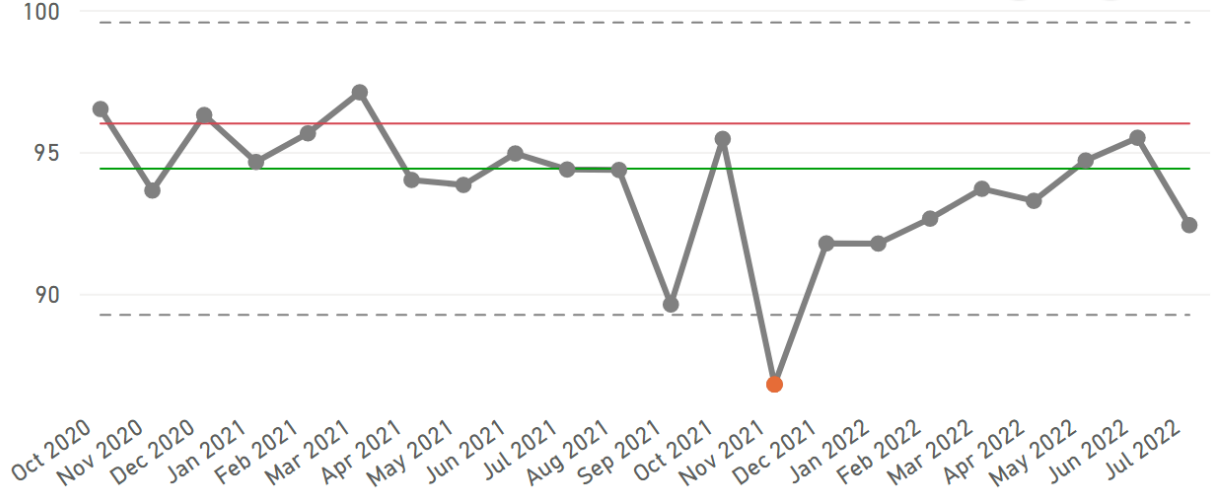
Cancer 14 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Jul 2022	53.1%	93%		



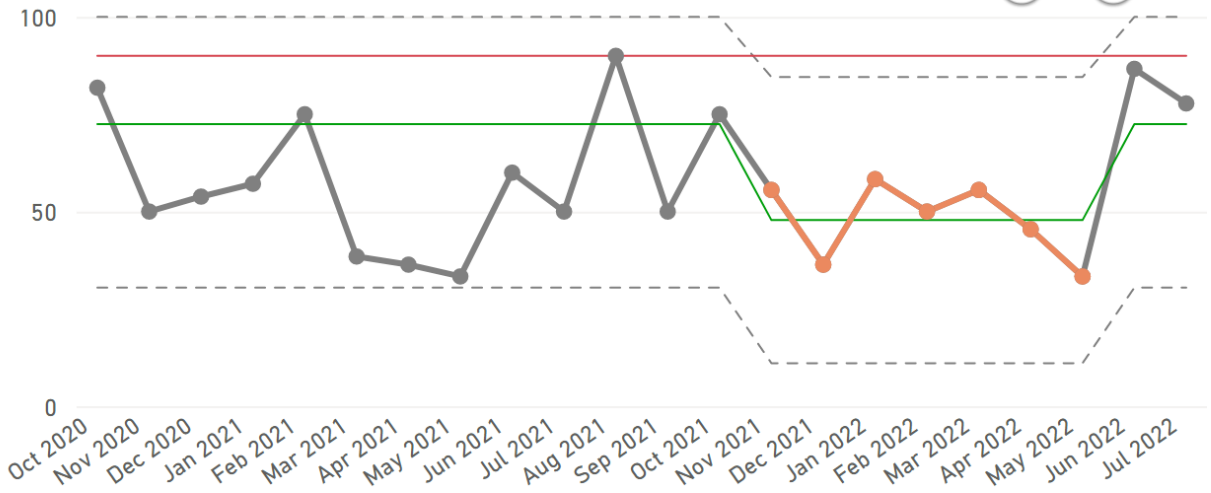
Cancer 31 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Jul 2022	92.4%	96%		



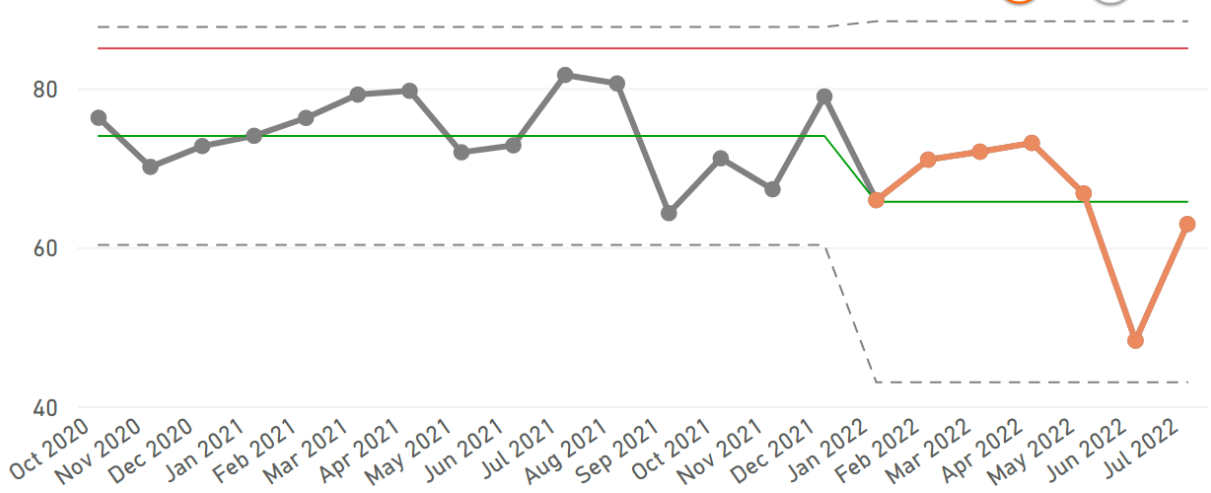
Cancer 62 Day Screening (%)

Month	Performance	Target	Trend	Assurance
Jul 2022	77.8%	90%		



Cancer 62 Day Standard (%)

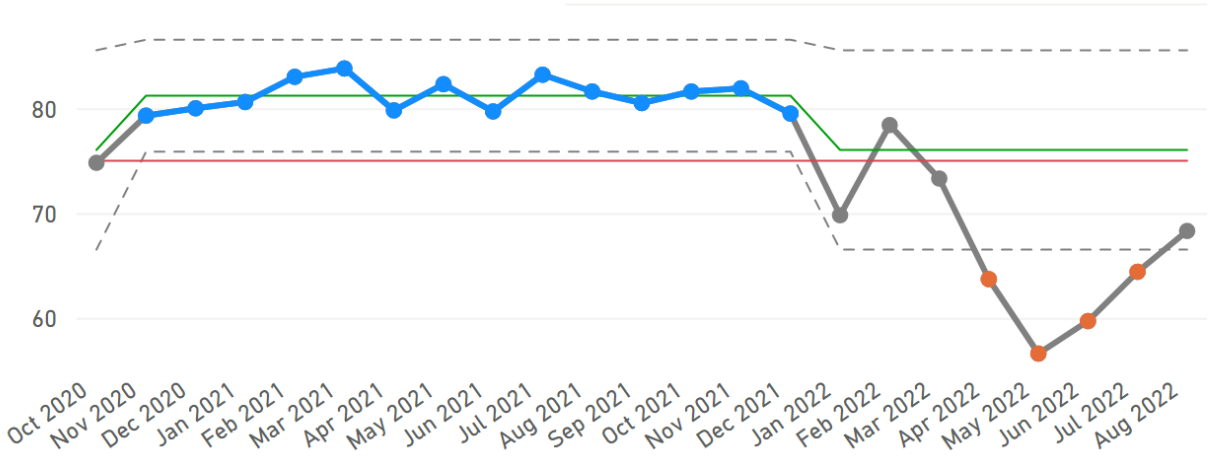
Month	Performance	Target	Trend	Assurance
Jul 2022	62.9%	85%		



RESPONSIVE

Cancer - Faster Diagnosis Standard (%)

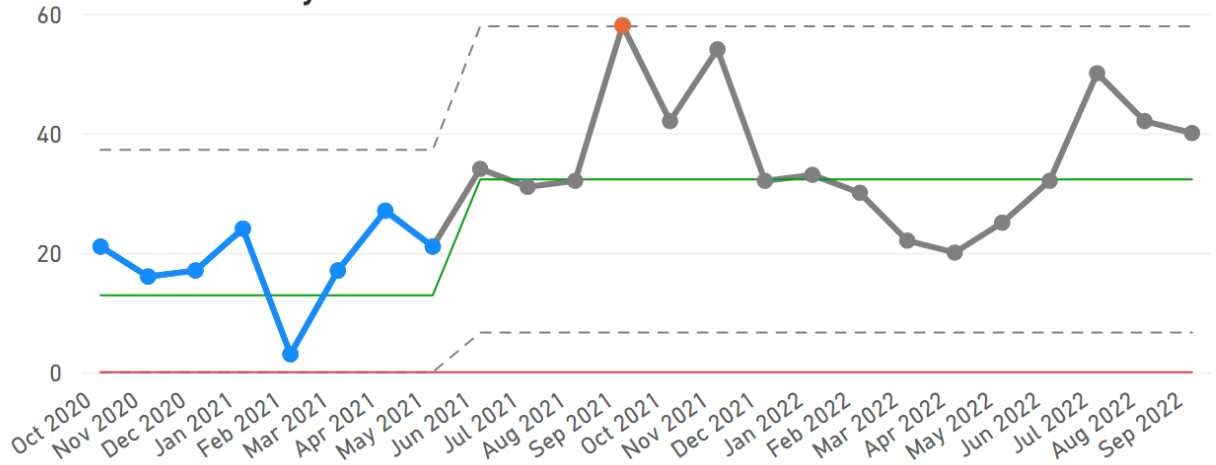
Month	Performance	Target	Trend	Assurance
Aug 2022	68.3%	75%		



RESPONSIVE

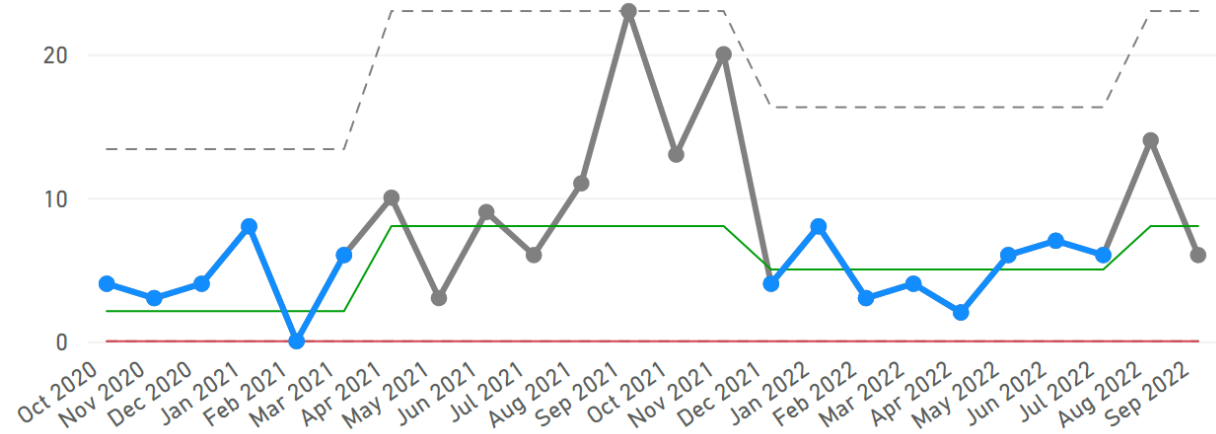
Cancelled Ops - Non-Urgent Cancelled On Day

Month	Performance	Target	Trend	Assurance
Sep 2022	40	0		



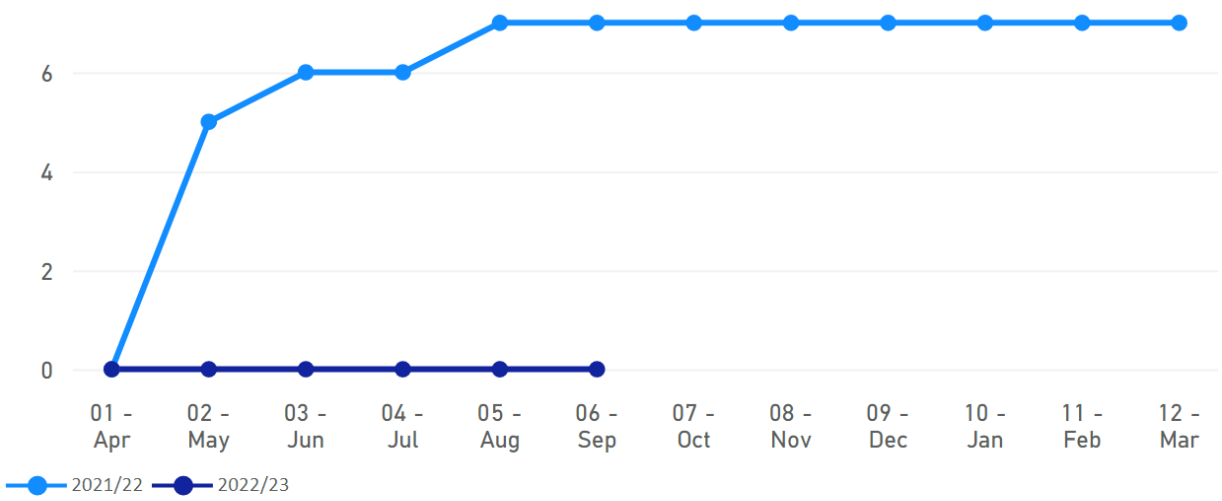
Cancelled Ops - Not Rebooked Within 28 days

Month	Performance	Target	Trend	Assurance
Sep 2022	6	0		



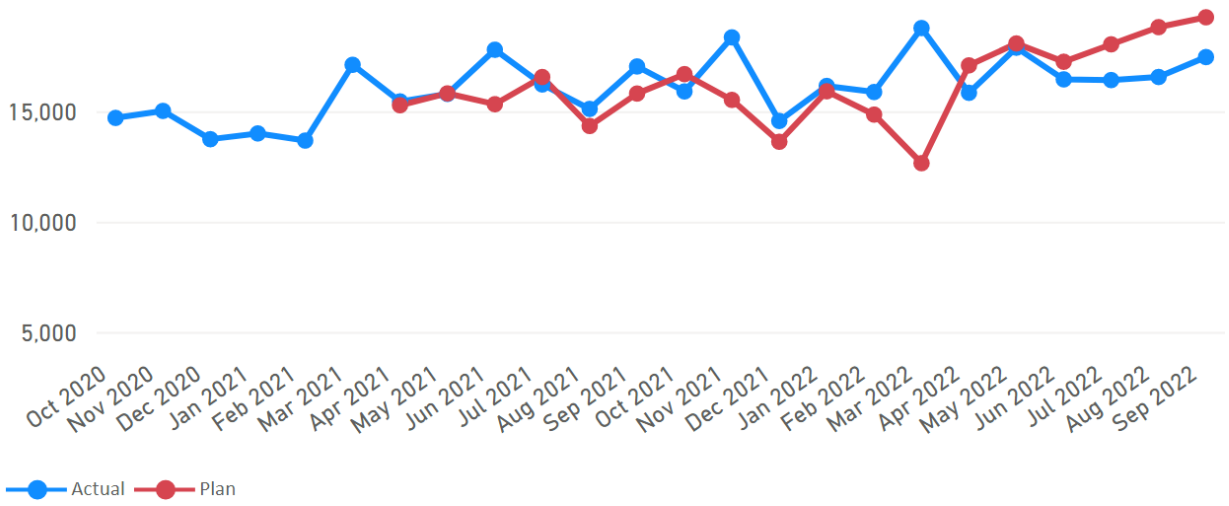
Cancer Operations Cancelled On Day (YTD)

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

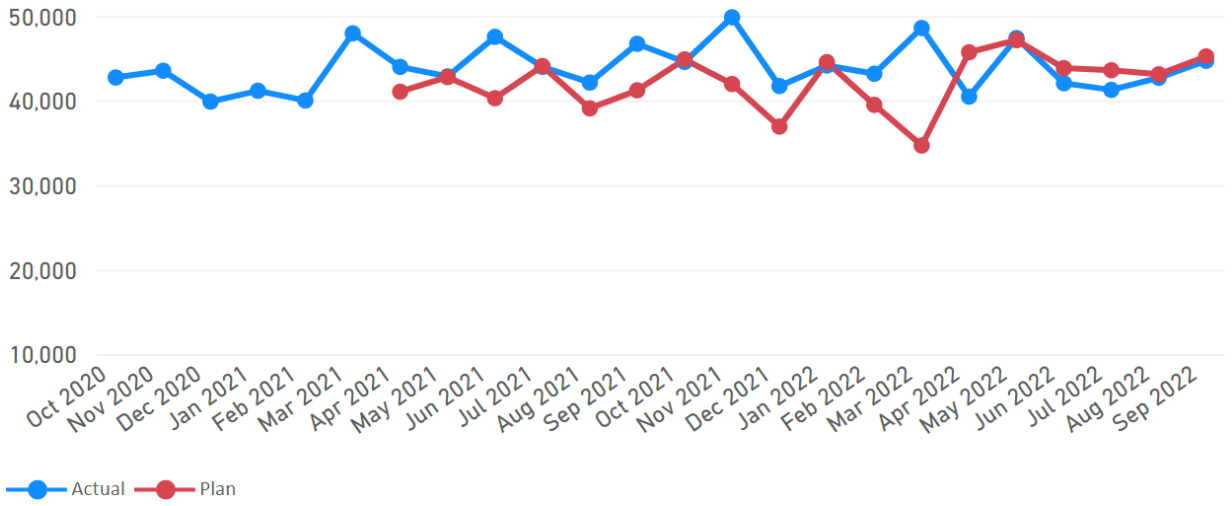


RESPONSIVE

Outpatient New Attendances

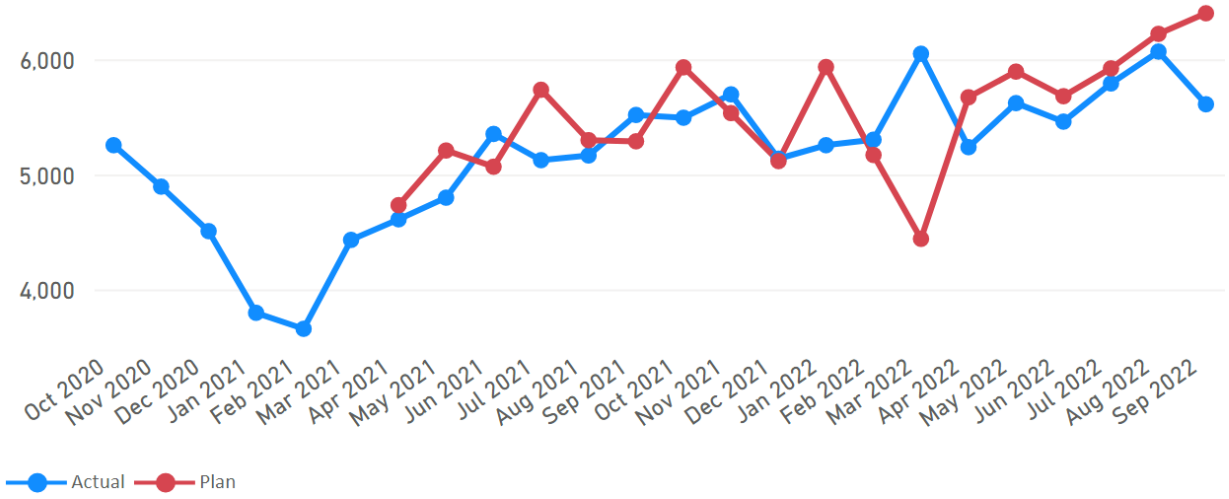


Outpatient Follow-Up Attendances

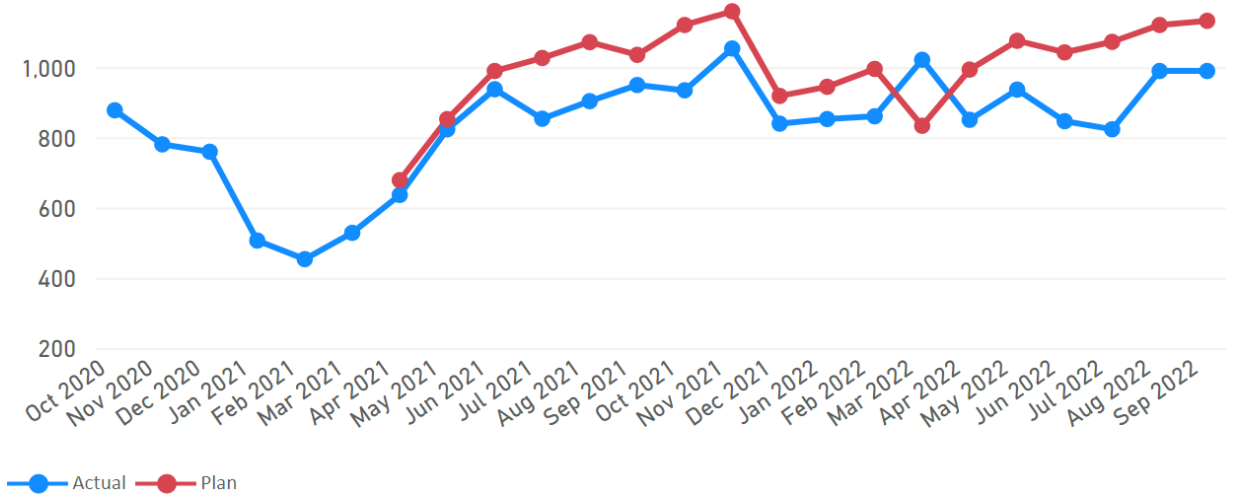


RESPONSIVE

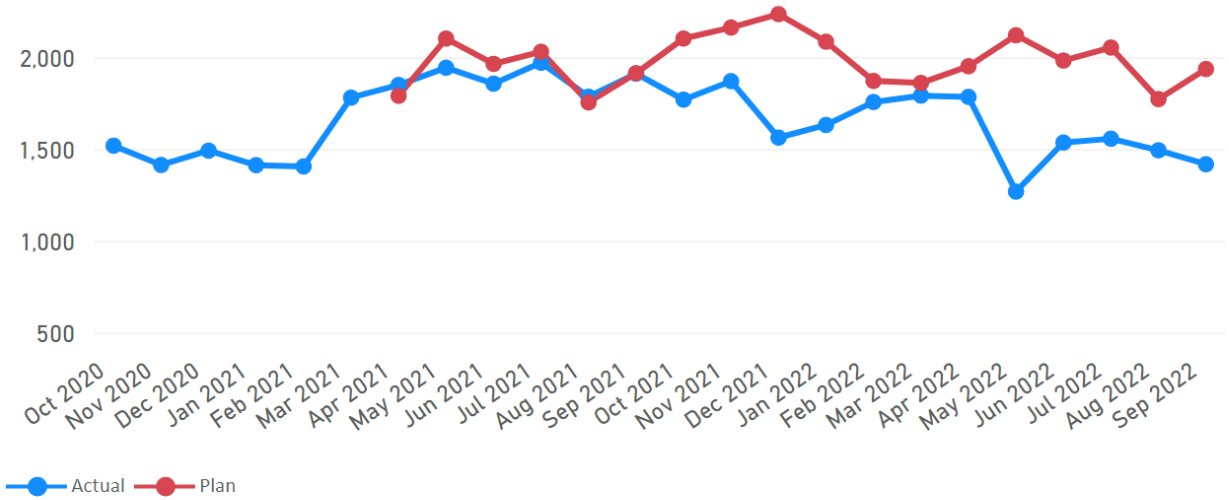
Day Case admissions



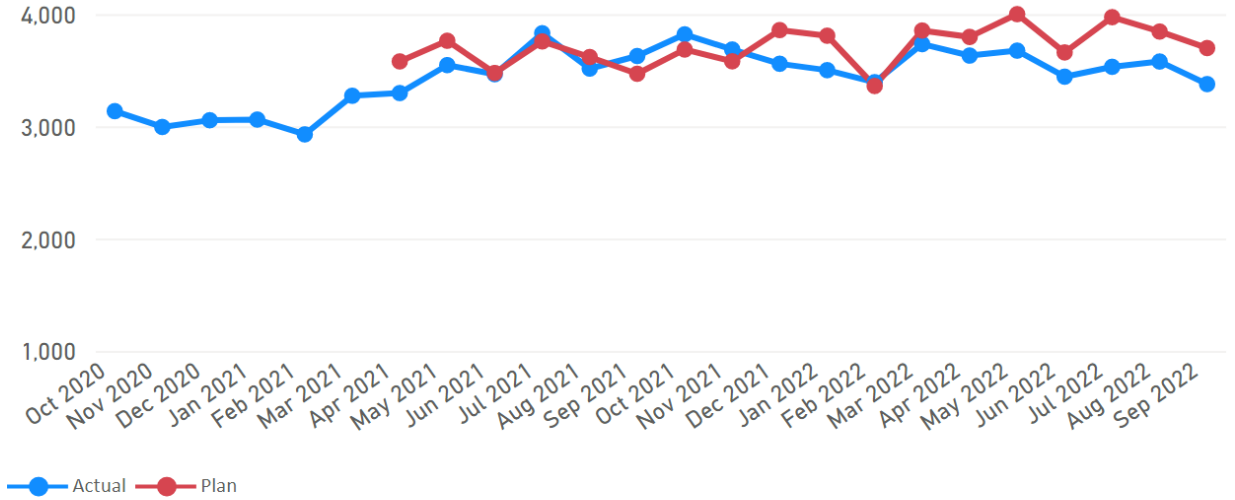
Ordinary Elective admissions



NEL admissions with 0 LOS



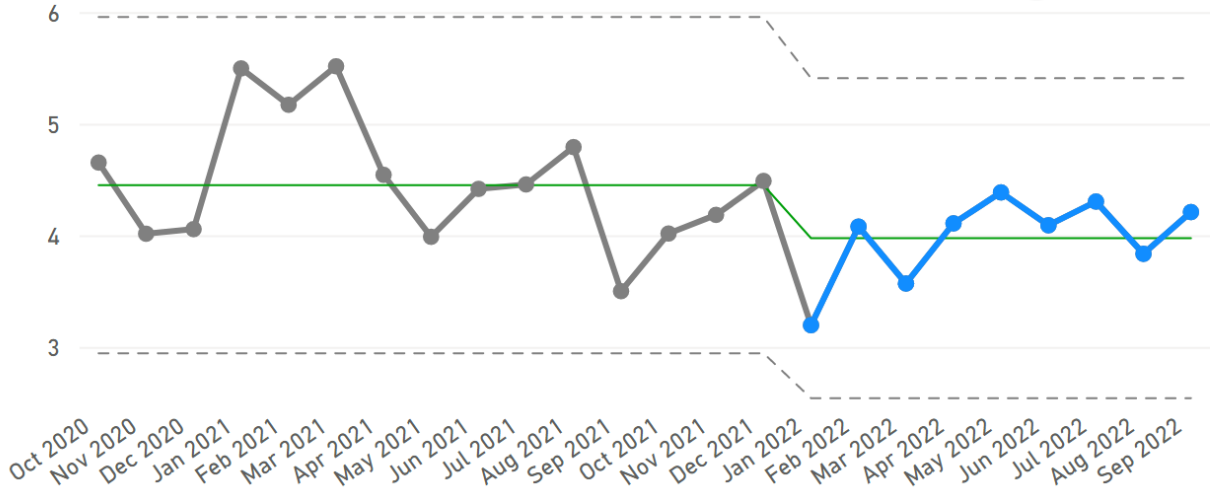
NEL admissions with 1+ LOS



RESPONSIVE

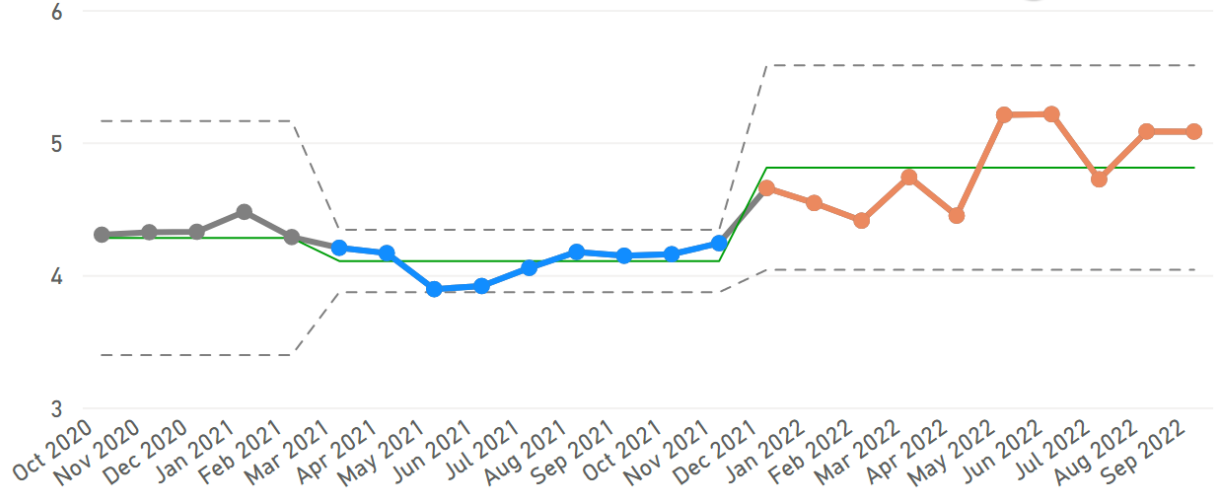
Length of Stay - Elective

Month	Performance	Target	Trend	Assurance
Sep 2022	4.2			N/A



Length of Stay - Non-Elective

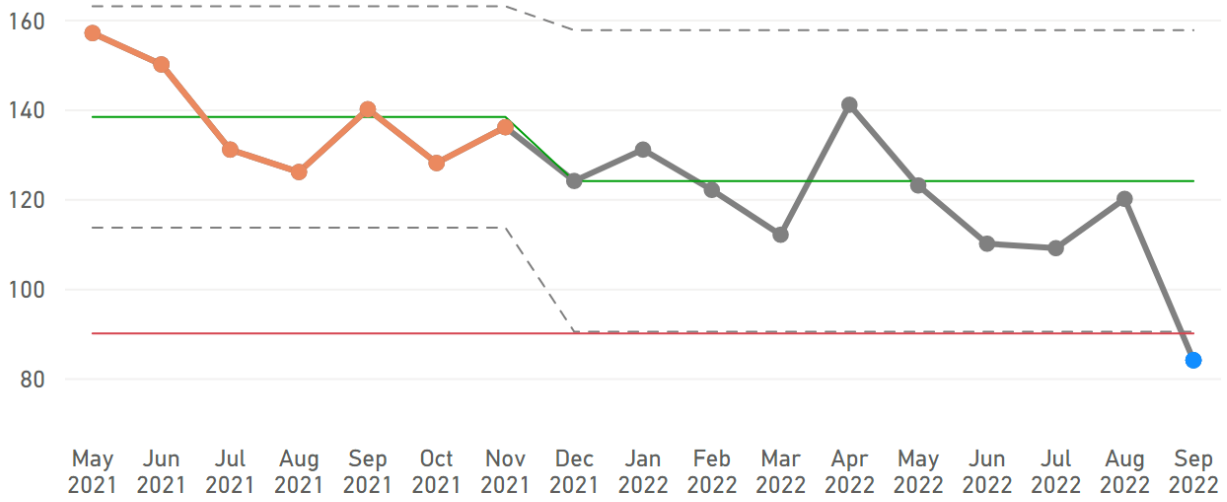
Month	Performance	Target	Trend	Assurance
Sep 2022	5.1			N/A



RESPONSIVE

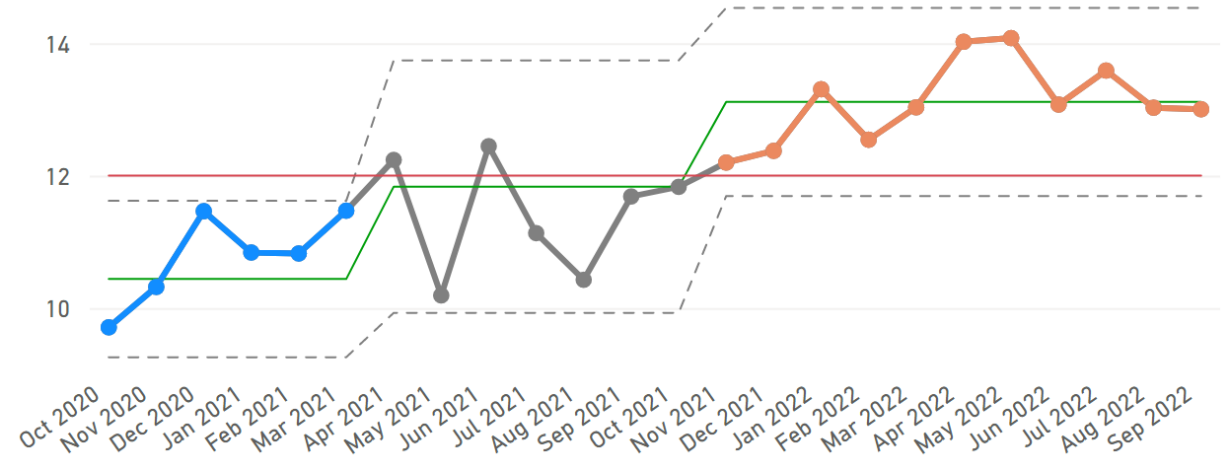
Not Met Not Discharged

Month	Performance	Target	Trend	Assurance
Sep 2022	84	90	L	F



21 Day Stranded Patients (%)

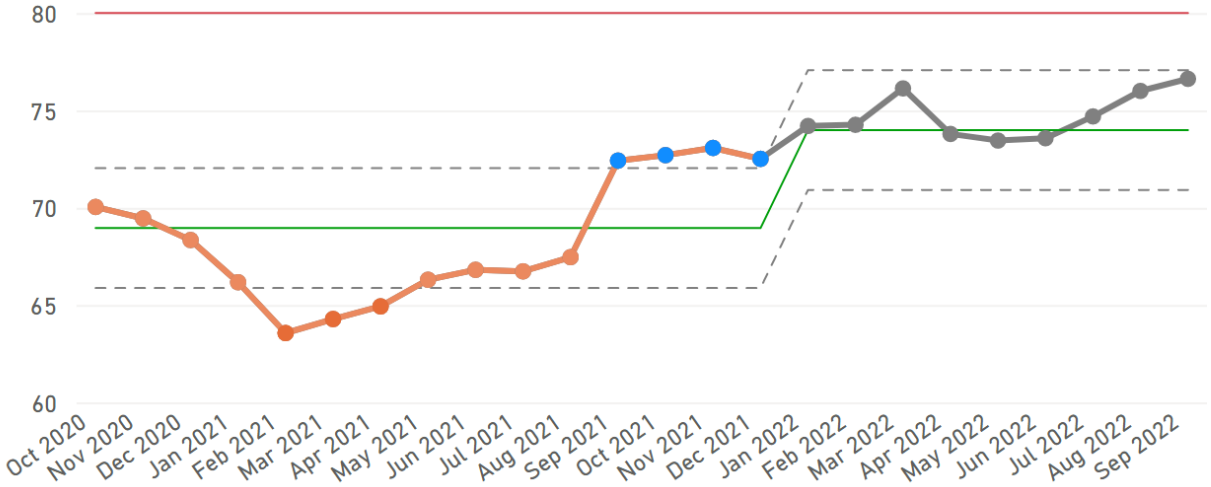
Month	Performance	Target	Trend	Assurance
Sep 2022	13%	12%	H	?



WELL-LED

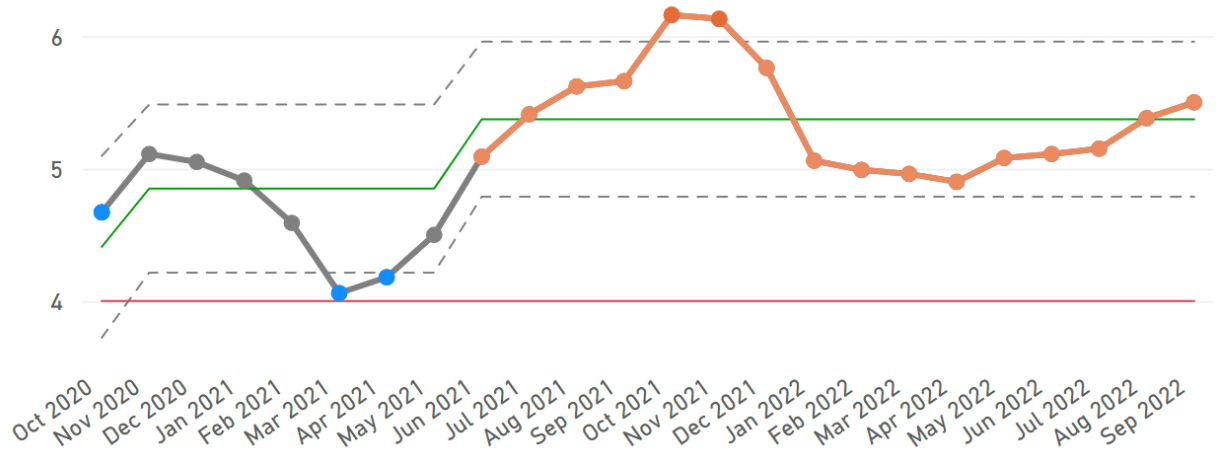
Annual Appraisal (%)

Month	Performance	Target	Trend	Assurance
Sep 2022	76.6%	80%		



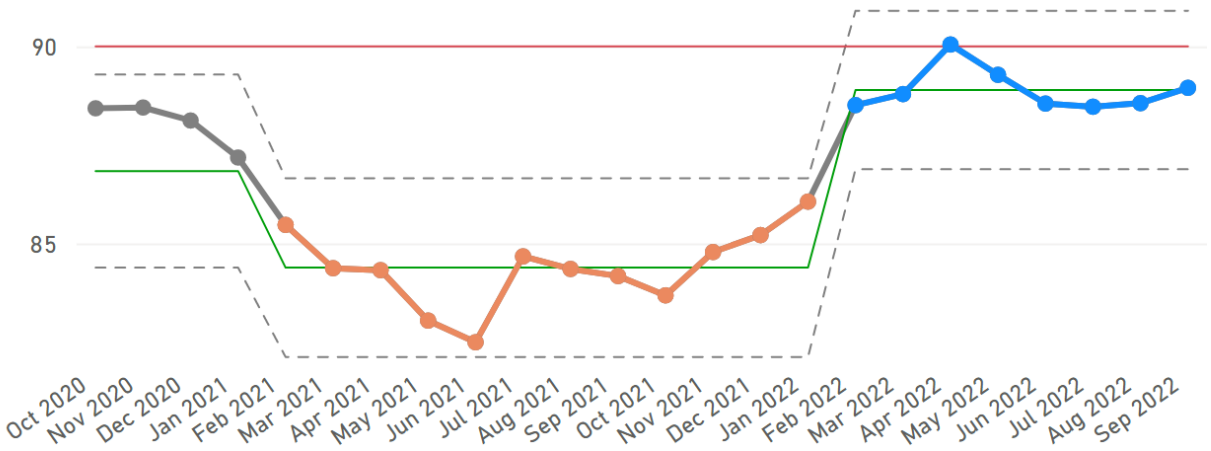
Sickness Absence (%)

Month	Performance	Target	Trend	Assurance
Sep 2022	5.5%	4%		



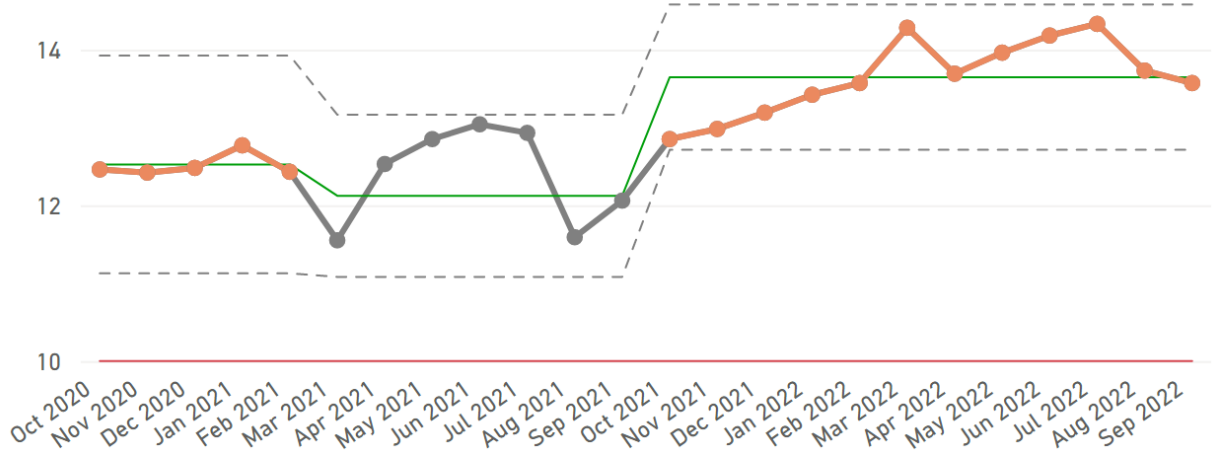
Mandatory Training (%)

Month	Performance	Target	Trend	Assurance
Sep 2022	88.9%	90%		



Staff Turnover (%)

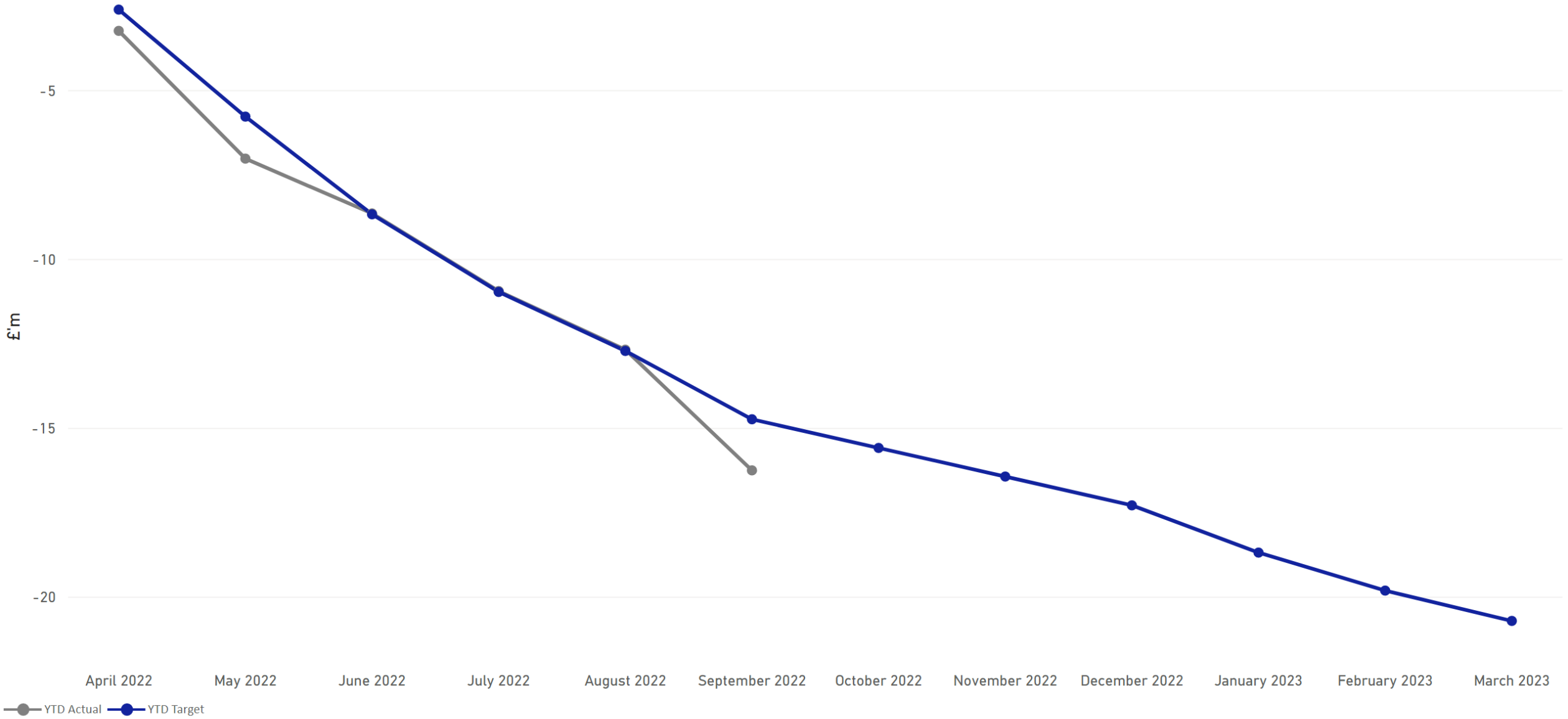
Month	Performance	Target	Trend	Assurance
Sep 2022	13.6%	10%		



WELL-LED

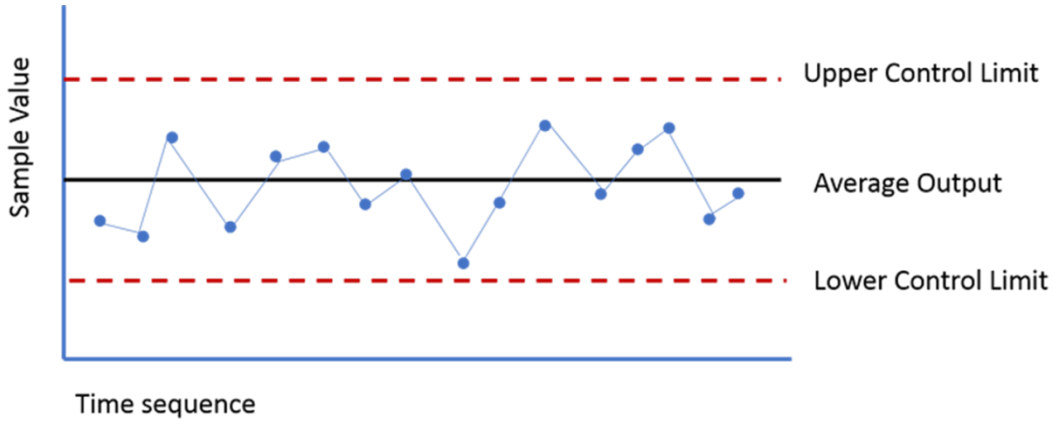
Cumulative YTD Financial Position (£'millions)

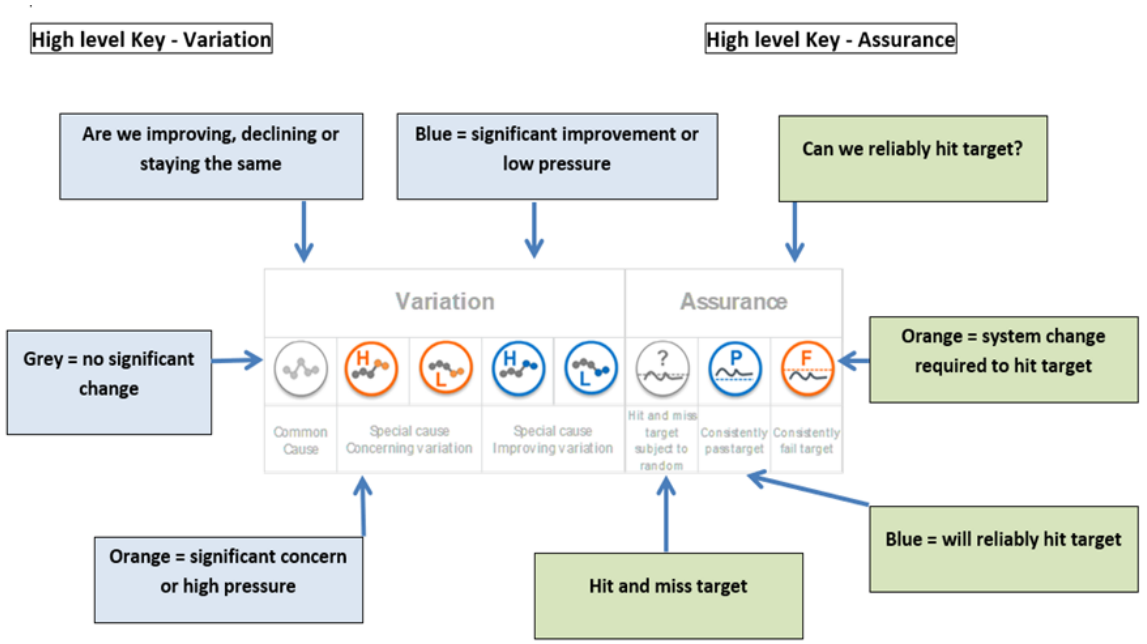
Month	Performance	Target
Sep 2022	-£16.262m	-£14.749m



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 – 1 NOVEMBER 2022			
Safe Staffing Report for September 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 September 22 for inpatient wards.		
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 again to 96.3% as per Table 1 demonstrating good compliance with safer staffing. Stretch staffing ratios in line with national guidance are implemented where necessary based on skill mix, acuity, and occupancy levels, all these actions agreed by senior nurses through safe care meetings.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to: Note the content of this report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 5.1 Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit. Threat - 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		
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	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 ☐	

Nursing and Midwifery Workforce Exception Report

September 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 Trust Planned versus Actual

		July 22	Aug 22	Sep 22
Overall, Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	79.5%	79.4%	80.3%
	HCA (%) Average fill rate - DAYS	93.5%	96.8%	98.6%
	NA (%) Average fill rate - DAYS	100%	100.0%	100.0%
	TNA (%) Average fill rate - DAYS	100%	100.0%	100.0%
	RN/RMs (%) Average fill rate - NIGHTS	83.6%	83.8%	85.7%
	HCA (%) Average fill rate - NIGHTS	102.6%	106.1%	105.6%
	NA (%) Average fill rate - NIGHTS	100%	100.0%	100.0%
	TNA (%) Average fill rate - NIGHTS	100%	100.0%	100.0%
	Total % of Overall planned hours	**94.9%**	**95.8%**	**96.3%**

Redeployment of staff has taken place on a regular basis to ensure wards are safely staffed with 272 total shifts (2622.56 hours) logged via SafeCare during September which was an increase on August 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 every collaborative. The intention is to reduce staff redeployment to a minimum and within own collaborative (Zoning). Staff COVID unavailability is reported daily from the electronic roster data and is broken down by area and staff group. Staff sickness and COVID isolation continues to have an impact during September. Nursing turnover rates continue to be amongst the lowest in the country as measured through Model Hospital

2. Nurse Sensitive Indicators

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

3. Red Flags Raised through SafeCare Live

There were 306 red flags relating to workforce, with shortfall in RN time being the most common (257). 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 September. As part of the revised KPI collaborative staffing meetings additional information has been provided regarding the appropriate use of red flags and the importance of closing red flags to provide correct data.

4. Datix Submissions

There were 85 datix submissions relating to staffing in September. The majority of datixs were for staff shortages in Ward 33, Ward 7 and Ainderby. These were all escalated through the SafeCare call and logged by a daily SafeCare chair. Redeployment decisions were made following safer staffing discussions with ward managers and matron agreement.

5. Vacancy Turnover

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

International Nurse Recruitment:
14 nurses arrived in September as part of cohort 3; cohort 4 will arrive November 2022 number to be confirmed. A further 24 international nurses will be recruited before the end of March 2023.

Student nurse recruitment is complete for September qualifiers, 73 newly qualified nurses joined the organisation. January 2023 student cohort have been interviewed and 62 new nurses offered positions so far.

The new mobile HCSW team complete their full training and induction in October. The team have 20 new appointments with a second advert now live.

6. 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

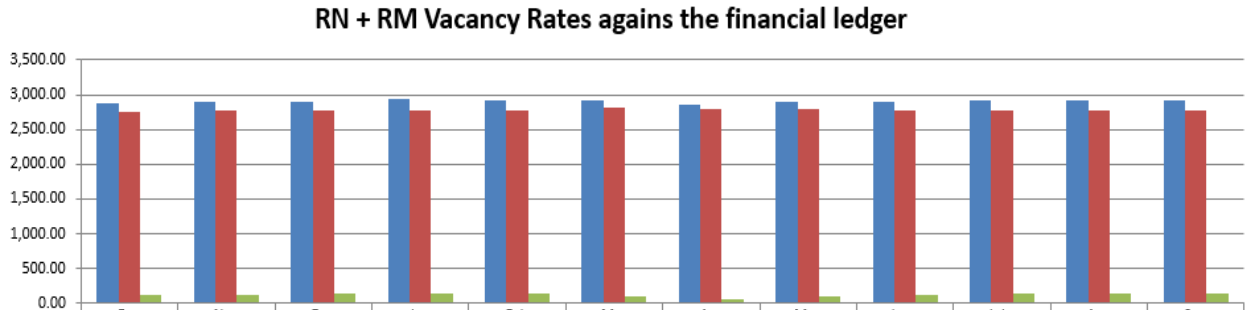
Semi reflective information due to revised establishments

Wards	Physical Bed Capacity	Open Bed Capacity	Total CHPP	Occupied Bed No – Aug 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	684	22	79.8%	111.7%	-	100.0%	74.8%	96.7%	-	100.0%	Short term sickness
Ward 2	28	28	602	19	81.3%	101.8%	-	100.0%	85.0%	111.7%	-	100.0%	19.09.22 moved to ward 31
Ward 3	28	28	674	22	95.5%	145.8%	100.0%	100.0%	94.9%	132.3%	-	100.0%	
Ward 4	23	23	640	21	67.9%	103.5%	-	-	72.3%	132.4%	-	-	Staff deployed based on demand of inpatient dialysis
Ward 5	28	22	714	23	78.4%	86.7%	100.0%	100.0%	86.7%	146.1%	-	100.0%	Short term sickness
Ward 6	31	31	878	28	84.5%	109.2%	100.0%	-	84.4%	104.6%	-	-	
Ward 7	32	32	913	29	86.1%	106.2%	100.0%	100.0%	84.4%	100.6%	-	-	
Ward 9	32	28	897	29	68.5%	163.2%	-	-	68.4%	160.8%	-	-	RN vacancies
Ward 10	24	24	708	23	62.4%	54.3%	-	-	65.5%	87.5%	-	-	6 beds transferred to ward 9 19.09.22 moved to ward 38 with reduction to 10 beds
Ward 11	28	28	812	26	79.9%	105.3%	-	100.0%	74.5%	114.2%	-	100.0%	Short term sickness
Ward 12	26	26	758	24	83.4%	104.9%	-	-	76.6%	103.7%	-	-	RN vacancies - HCA backfill provided
Ward 14	23	21	582	19	80.2%	87.5%	-	100.0%	82.3%	111.0%	-	100.0%	
Ward 24	23	23	646	21	98.8%	107.1%	-	100.0%	88.9%	141.0%	-	-	
Ward 25	21	21	511	16	82.6%	122.8%	-	-	79.6%	131.7%	-	-	RN short term sickness - HCA backfill provided
Ward 26	18	19	547	18	90.3%	140.1%	-	-	100.0%	106.7%	-	-	
Ward 27	15	15	340	11	68.9%	86.5%	-	100.0%	99.3%	91.4%	-	-	Short term sickness
Ward 28	26	26	731	24	76.1%	94.6%	100.0%	-	81.7%	90.6%	100.0%	-	Short term sickness
Ward 29	27	27	778	25	94.2%	86.6%	-	100.0%	90.1%	120.7%	-	-	
Cardio MB	9	9	240	8	100.0%	96.1%	-	100.0%	96.7%	-	-	100.0%	
Ward 31	35	31	697	22	76.0%	85.1%	100.0%	-	86.7%	97.1%	100.0%	-	19.09.22 moved to Ward 10
Ward 32	22	21	601	19	106.2%	103.0%	-	-	99.9%	103.8%	-	-	

Ward 33	21	21	547	18	65.7%	100.0%	-	-	71.7%	103.2%	-	-	Provided support to medicine as acuity of patients allowed
Ward 34	34	34	851	27	61.7%	118.4%	-	100.0%	72.5%	152.2%	-	-	RN vacancies
Ward 35	26	26	655	21	85.8%	104.7%	-	-	82.6%	102.8%	-	-	
Ward 36	34	34	892	29	91.5%	118.3%	-	100.0%	74.1%	131.8%	-	100.0%	RN short term sickness - HCA backfill provided
Ward 37 - AMU	30	30	817	26	81.1%	97.0%	-	100.0%	75.8%	98.7%	-	100.0%	Short term sickness
Critical Care	33	33	798	26	102.0%	124.0%	-	-	102.8%	124.4%	-	-	
CICU JCUH	12	10	225	7	81.8%	102.6%	-	-	79.1%	136.7%	-	-	Short term sickness
Cardio HDU	10	10	196	6	81.1%	99.4%	-	-	78.0%	100.2%	-	-	Staffed according to occupancy – mirrors elective programme e.g., low Sunday and Monday
Ward 24 HDU	8	8	192	6	101.6%	123.4%	-	-	99.0%	153.3%	-	-	
Ainderby FHN	27	22	525	17	63.4%	121.8%	-	-	93.4%	90.3%	-	-	RN vacancies – HCA backfill Reduced beds
Romanby FHN	26	22	290	9	60.1%	71.0%	-	-	92.7%	68.4%	-	-	RN vacancies Reduced Beds
Gara FHN	21	16	230	7	80.2%	106.4%	-	-	92.7%	45.6%	-	-	
Rutson FHN	17	17	493	16	71.4%	132.2%	-	-	100.1%	97.0%	-	-	RN vacancies
Friary	18	18	-	-	-	-	-	-	-	-	-	-	Closed - Staff at FHN
Zetland Ward	31	29	869	28	84.3%	78.5%	-	100.0%	72.8%	113.1%	-	100.0%	Short term sickness
Tocketts Ward	30	26	715	23	78.6%	104.1%	-	-	76.0%	128.2%	-	-	Short term sickness
Ward 21	25	25	437	14	74.6%	75.6%	-	100.0%	71.4%	78.3%	-	100.0%	Fluctuates based on surgical occupancy
Ward 22	17	17	239	8	97.3%	53.8%	-	-	87.8%	50.0%	-	-	
JCDS (Central Delivery Suite)	-	-	329	11	91.4%	83.9%	-	-	93.1%	98.3%	-	-	
Neonatal Unit (NNU)	35	35	580	19	70.6%	77.8%	-	-	74.7%	-	-	-	Low occupancy
Paediatric Intensive Care Unit (PCCU)	6	6	102	3	81.0%	87.5%	-	-	83.0%	10.0%	-	-	
Ward 17	-	-	788	25	88.1%	82.5%	-	-	100.8%	81.6%	-	-	
Ward 19 Ante Natal	-	-	234	8	73.7%	100.0%	-	-	70.6%	-	-	-	Reduced beds
Maternity Centre FHN	-	-	6	0	50.3%	26.4%	-	-	79.9%	-	-	-	Low occupancy

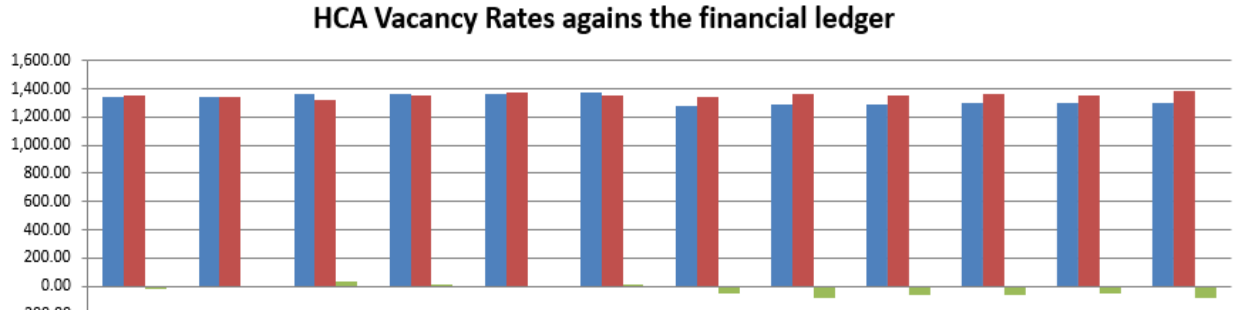
Spinal Injuries	24	24	665	21	89.0%	80.2%	-	-	100.0%	100.0%	-	-	
CCU	14	14	280	9	81.9%	56.9%	-	-	82.2%	-	-	-	

Appendix 2 - Registered Nursing Vacancy Rate Sep 2022



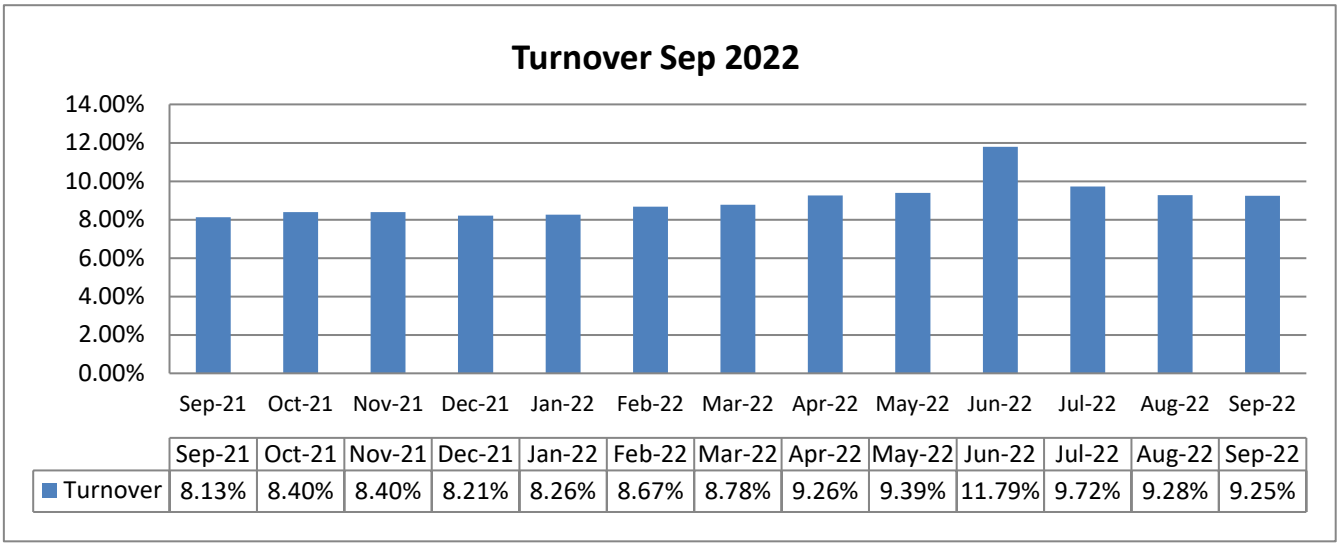
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep
Budget	2,881.14	2,893.57	2,900.26	2,928.97	2,916.23	2,918.09	2,857.17	2,892.25	2,907.50	2,918.67	2,912.41	2,917.93
Contracted	2,759.26	2,768.68	2,767.46	2,778.68	2,783.12	2,807.97	2,793.07	2,788.43	2,780.50	2,774.59	2,777.11	2,778.08
Vacancy	121.88	124.89	132.80	150.29	133.11	110.12	64.10	103.82	127.00	144.08	135.3	139.85

Appendix 3 - Health Care Assistant Vacancy Rate Sep 2022



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep
Budget	1,342.18	1,340.89	1,360.73	1,365.75	1,367.50	1,375.27	1,284.47	1,286.03	1,287.53	1,304.85	1,302.54	1,304.54
Contracted	1,357.34	1,340.90	1,325.84	1,357.94	1,379.86	1,358.85	1,339.44	1,366.81	1,355.44	1,363.67	1,359.11	1,388.28
Vacancy	-15.16	-0.01	34.89	7.81	-12.36	16.42	-54.97	-80.78	-67.91	-58.82	-56.57	-83.74

Appendix 4 - Nursing Turnover Sep 2022



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Turnover	8.13%	8.40%	8.40%	8.21%	8.26%	8.67%	8.78%	9.26%	9.39%	11.79%	9.72%	9.28%	9.25%

South Tees Hospitals
NHS Foundation Trust

MEETING OF PUBLIC BOARD OF DIRECTORS – 1 NOVEMBER 2022			
Learning from Deaths September 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 an update on the report submitted to the Mortality and Morbidity Group in September 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	The number of deaths in 2022/2023 has largely returned to levels seen pre-pandemic, although the unadjusted mortality rate has not fully. SHMI at 109 is As Expected The Medical Examiner team coverage of mortality continues to be in excess of 95% of all deaths. Mortality Surveillance reviewers have been progressing with the waiting list of reviews: 87 reviews were completed in August 2022. Following discussion at PSSG, a section on learning has been added.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of Board of Directors are asked to note this report.		
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 September 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 August 2022 (Fig 1). 162 deaths were recorded in July 2022, 157 in August 2022. The impact of COVID on deaths is falling, and most cases with a positive swab seem to be deaths "with" COVID rather than "from" COVID. The unadjusted mortality rate is returning to pre-pandemic levels. Rolling 12- month average is 1.39 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**: 627 patients were coded as being in receipt of palliative care since April 2022 of whom 298 (38%) died. 1.9% of spells have a palliative care code (Fig 3)

3.4. **COVID-19**: There have been 1008 COVID-19 positive deaths recorded (20.9% of all deaths) since the pandemic began in March 2020.

Fig 1: Count of Deaths and Mortality Rate

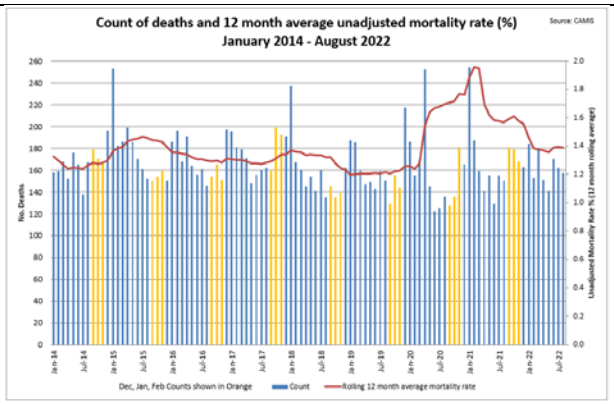


Fig 2: Comorbidity Coding

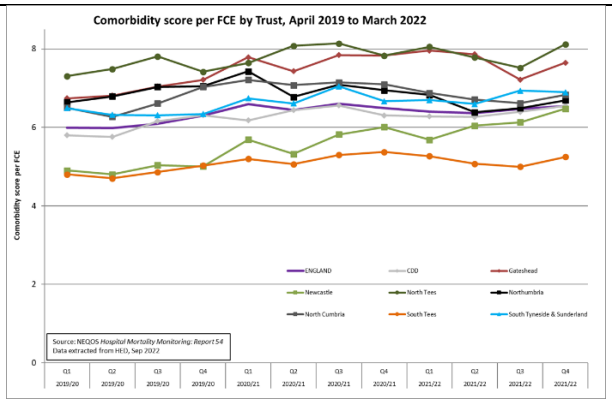


Fig 3: Palliative Care Coding

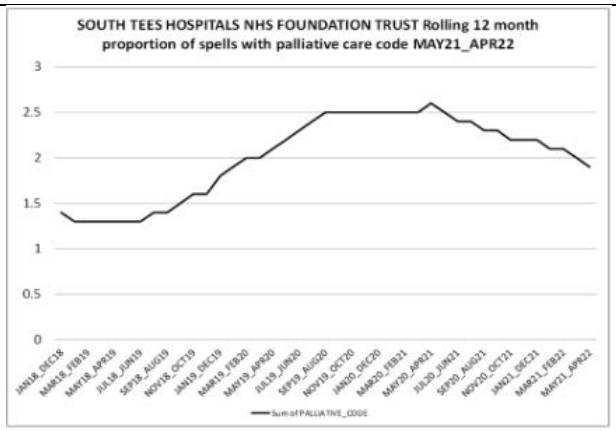
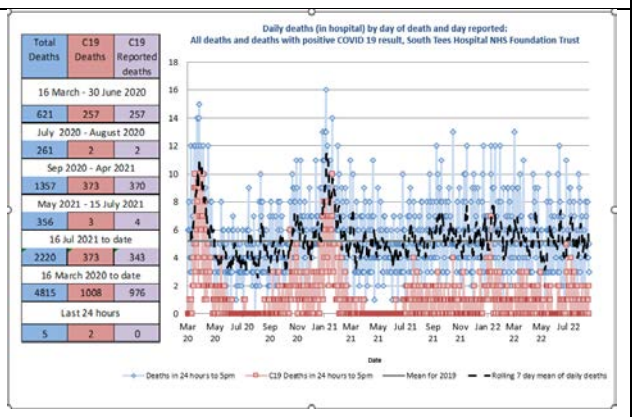


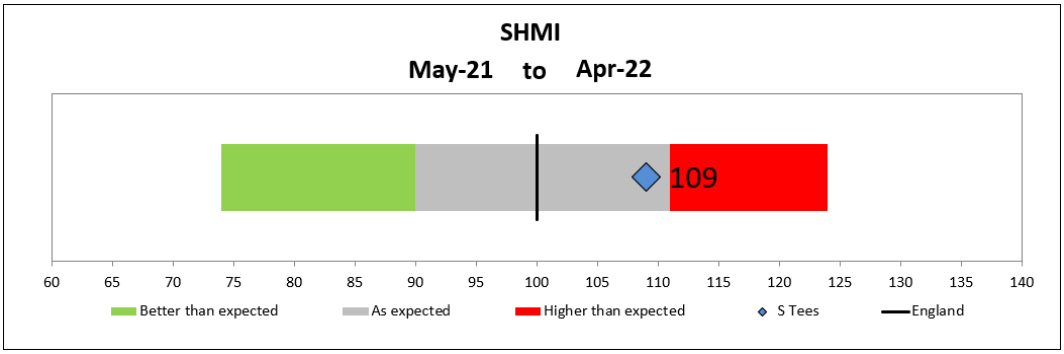
Fig 4: COVID Deaths



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 basis by NHS Digital and is an official government statistic. Current reporting is May 2021 - April 2022. The SHMI is the ratio of observed mortality rate/expected mortality rate (based on a statistical estimate of expected mortality). The SHMI is 109, 'as expected'. NHS Digital are removing any spell containing a COVID-19 Confirmed or Suspected code. In this release this amounts to 2,757 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: Jul 2021-Jun 2022

Collaborative	Survived	Died	Total	Unadjusted Mortality Rate	% all deaths
Cardiovascular Care services	5900	118	6018	2.0%	6.0%
Clinical Support Services	880	1	881	0.1%	0.1%
Digestive Diseases, Urology and General Surgery services	21572	157	21729	0.7%	7.9%
Head and Neck, Orthopaedic and Reconstructive services	18318	88	18406	0.5%	4.4%
James Cook Cancer Institute and Speciality Medicine services	19141	196	19337	1.0%	9.9%
Medicine and Emergency Care services	23526	856	24382	3.5%	43.3%
Neurosciences and Spinal Care Services	3826	36	3862	0.9%	1.8%
Perioperative and Critical Care Medicine Services	1258	226	1484	15.2%	11.4%
Women and Children services	21893	31	21924	0.1%	1.6%
Growing the Friarage and Community services: Community Services	189	22	211	10.4%	1.1%
Growing the Friarage and Community services: Primary Care Hospitals	912	77	989	7.8%	3.9%
Growing the Friarage and Community services: Friarage Medical Services	22858	170	23028	0.7%	8.6%
Grand Total	**140273**	**1978**	**142251**	**1.4%**	**100.0%**

3.7. **Medical Examiners:** Between April 2022 and August 2022, of the 873 deaths that occurred in hospital and in A&E or were very recent discharges from hospital and referred to the Medical Examiner (including 53 GP/Community deaths included in the Medical Examiner system since September 2021), 854 were reviewed by the Medical Examiner service – 97.8% of all such deaths.

3.7.1. Of these 85.0% of deaths were judged to be definitely not preventable with 4.6% of cases judged to show some preventability. 85.1% of deaths were Expected, 11.6% of deaths Unexpected, the remainder ungraded. 78 were recommended for Trust Mortality Review, 2 reviews have so far been undertaken with the rest scheduled. The waiting list of

cases (currently 123 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	230	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	127	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	0	11	17	37
May-22	141	7	12		154	96.3%	20	0	10	15	35
Jun-22	170	8	14		187	97.4%	13	1	7	15	24
Jul-22	162	8	14		182	98.9%	18	1	8	30	36
Aug-22	157	7	6		170	100.0%	13	0	8	29	39
	781	39	53	0	854	97.8%	78	2	44	106	171
	6375	229	53	104	6149	90.9%	827	704	926	1092	883

3.8. **Mortality Surveillance Reviews**: The review team currently consists of four consultant reviewers. 240 reviews have been completed so far in 2022/23 (Fig 8)

3.8.1. 68% of case reviews were judged to show good practice with no preventability. 2% showed good practice with some preventability. 22% showed room for improvement in care but with no preventability, 8% showed both preventability and room for improvement in care and 1% (1 case) showed strong preventability and/or less than satisfactory care.

Fig 8 No. of Reviews Apr 2021 to date

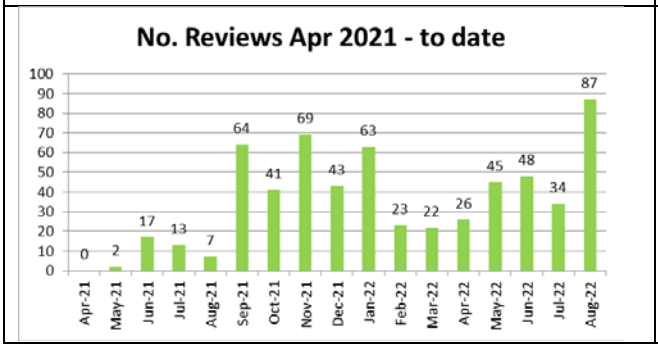
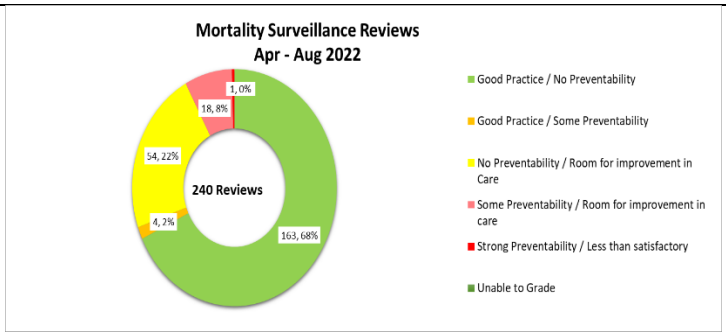


Fig 9 Preventability / Good Practice

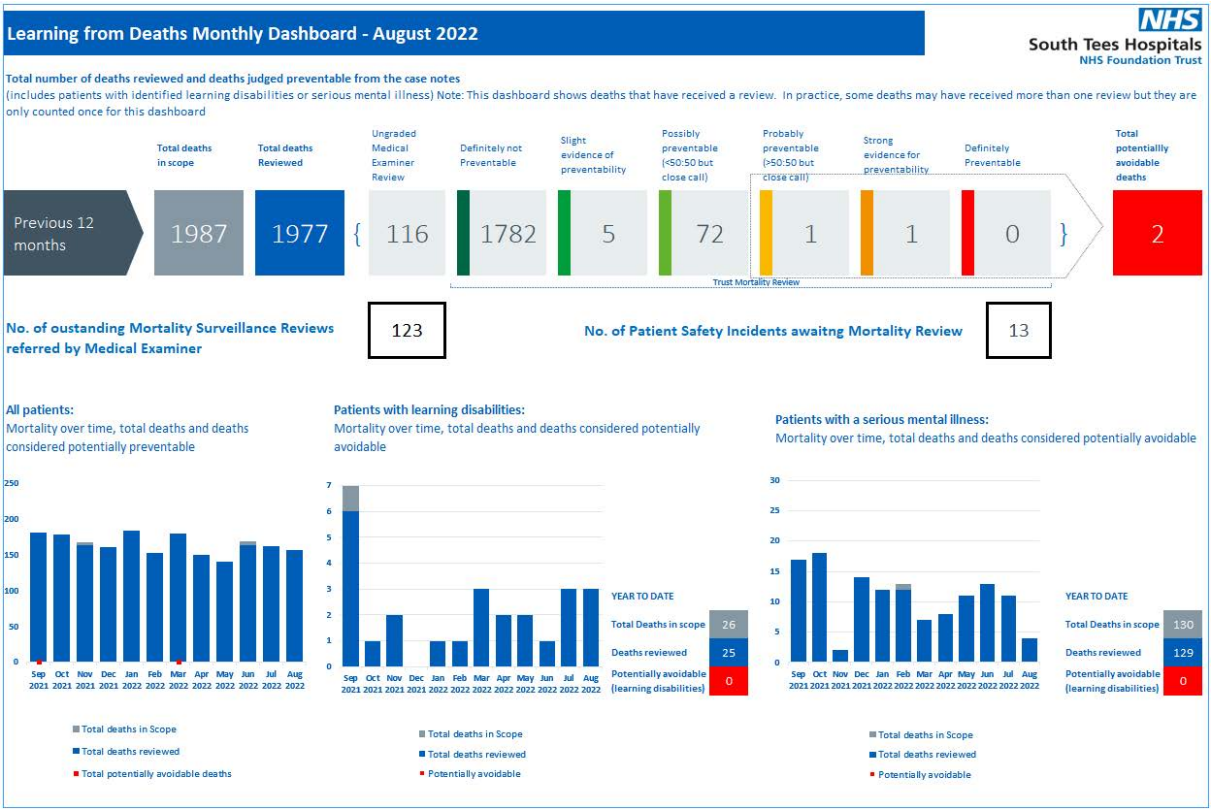


3.8.2. 87% of deaths were Expected, 10% Unexpected. Care in 82% of cases was graded Good-Excellent. Two cases were judged to have received poor care and have been reported through the Patient safety team.

3.8.3. In the last month, 12 reviews mentioned lessons learned from good care, particularly around senior input into care, good liaison with other specialties, good communication with family and delivering high quality treatment.

3.8.4. In the last month, 38 reviews mentioned lessons learned around advance decision making, medication, documentation and handover.

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 August 2022, there were 1,987 deaths, of which 1,977 (99.5%) received a review or investigation and 2 deaths were considered to be potentially avoidable (and also reported by the Patient Safety team). In the same period 96% of deaths in patients with a learning disability and 99% of cases where the patient had a pre-existing serious mental health condition were reviewed with no deaths considered potentially avoidable.



4. MORTALITY INDICATORS & LEARNING FROM DEATHS

1.1 **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 there are four which have tended to recur:

- **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. The DNACPR and audit work at the Friary hospital continues (cycle 12 completed recently).

- **Documentation**. 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. A communications campaigned called “Documenting for great CARE” launched through the Trust News Briefing on 19 July 2022 and is continuing, highlighting the issue and with hints, tips, advice, and guidance to help clinicians ‘keep the chain going’. The campaign is shared through the Trust’s usual channels. This includes what good documentation looks like and how clinicians can support improvement in the clinical coding of the care they have delivered.
- **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. There have been recent discussions the at the Miya Clinical Working Group on developments in this field.

- **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 is not currently a timescale for completion of procurement and implementation for cardiac, renal, vascular, orthopaedic and other specialty services, although the latest update suggest progress towards procurement this financial year is being made.

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 109 is now ‘as expected’ and so the requirement for specific monitoring has reduced, although it is likely that the key reason for this is

related to the improvement of recording of comorbidities and returning column of spells. The trust should remain focused on this issue.

- 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 waiting list 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 BOARD OF DIRECTORS MEETING – 1 NOVEMBER 2022			
NHS Adult Inpatient National Survey Results 2021			**Agenda item 12, ENC 10**
Report Author and Job Title:	Jemma Peacock, Patient Experience Advisor	**Responsible Director:**	Dr Hilary Lloyd, Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	NHS Adult Inpatient National Survey Results 2021		
Background	The enclosed report shows the Trusts' position and findings of the 2021 NHS Adult Inpatient Survey results for 2021. All NHS Trusts are required to participate in and for which the results are published on the CQC website.		
Assessment	The purpose of the report is to inform the Board of Directors of the NHS Adult Inpatient National Survey Results which was carried out in November 2021 For the Trust, 1250 patients, who spent an overnight stay in the trust in November 2021 were surveyed. 471 patients responded to the survey, giving a 41% response rate, just higher than the national response rate of 39%. The report highlights five areas where patient experience is highest compared to other trusts across the country: • Food outside set mealtimes: patients being able to get hospital food outside of set mealtimes, if needed • Changing wards during the night: staff explaining the reason for patients needing to change wards during the night • Dietary needs or requirements: patients being offered food that met any dietary needs or requirements they had • Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital • Getting help from staff: patients being able to get a member of staff to help them when they needed attention The report also highlighted areas for improvement including patients being asked to give their views on the quality of their care and information about discharge and medicine to take home. The finding from this survey have been shared and discussed at the Patient Experience Steering Group, who will oversee the development and progress of the action plan.		

Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐	
Recommendation	Members of the Board of Directors are asked to note 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	Best for safe, clinically effective care and experience ☒	A great place to work ☐
	Deliver care without boundaries in collaboration with our health and social care partners ☐	Make best use of our resources ☐
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☐	

South Tees Hospitals
NHS Foundation Trust

NHS Adult Inpatient National Survey Results 2021

1. PURPOSE OF REPORT

The purpose of the report is to inform the Board of Directors of the NHS Adult Inpatient National Survey results for November 2021.

The Board is asked to review and agree the recommendations.

2. BACKGROUND

The Adult Inpatient National Survey involved 134 acute and specialist NHS trusts. There were 62,235 responses received, with a response rate of 39%.

The sample for the survey included patients aged 16 years or over who spent at least one night, during November 2021, in an NHS hospital in England, and were not admitted to maternity or psychiatric units. Each NHS trust selects a sample 1,250 patients, by including every consecutive discharge that met the eligibility criteria, counting back from 30 November 2021.

The survey was conducted using a push-to-web methodology (offering both online and paper completion) and the field work for the survey was undertaken between January 2022 and May 2022.

There were minor changes to the survey in 2021. 3 questions were added and there were changes to question wording. The 2021 results are comparable with data from the 2020 survey unless a question has changed or there are other reasons for lack of comparability.

For each question in the survey that can be scored, individual responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst.

3. DETAILS

The Trust had a response rate of 41%, with 1,250 patients invited to take part and 471 patients participating in the survey.

As shown in figures 1-3, the female to male respondents was almost a 50:50 split with less than 1% of participants saying their sex is either intersex or different from the sex they were registered with at birth.

Most respondents were aged over 51, and the ethnic group was predominantly white.

Figure 1 – Sex

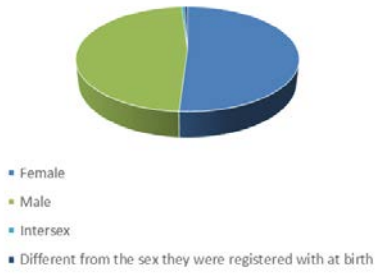


Figure 2 - Age

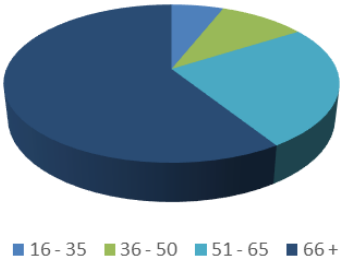
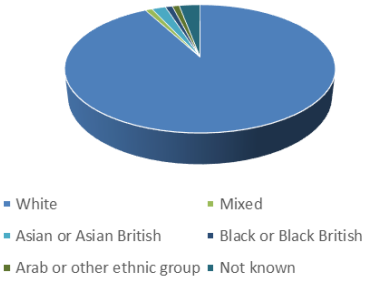


Figure 3 - Ethnicity



The report highlighted five areas where patient experience is highest compared to other trusts across the country:

- Food outside set mealtimes: patients being able to get hospital food outside of set mealtimes, if needed
- Changing wards during the night: staff explaining the reason for patients needing to change wards during the night
- Dietary needs or requirements: patients being offered food that met any dietary needs or requirements they had
- Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital
- Getting help from staff: patients being able to get a member of staff to help them when they needed attention
- The report also highlighted areas for improvement including patients being asked to give their views on the quality of their care and information about discharge and medicine to take home.

The trust scored about the same as other trusts in forty-three questions with five questions scoring lower. To note, if none of the results are below the trust average, then the results closest to the trust average are chosen, meaning a trust's lowest performance may be better than the trust average.

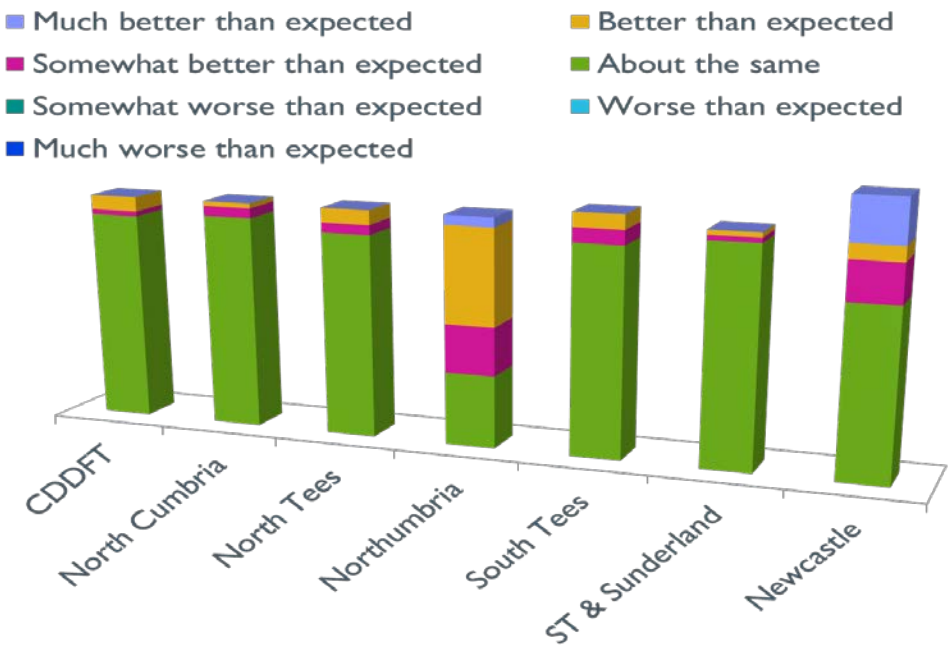
The trust scored below the national trust average in just three questions and the same in two questions as shown in table 1.

Table 1 - Comparison of national average

Question	Trust score	Trust average	Highest score
During your stay, were you ever asked to give your views on the quality of your care?	1.2	1.4	3.4
Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?	7.5	7.6	8.8
Thinking about any medicine you were to take at home, were you given any of the following? *(An explanation of the purpose of the medicine, an explanation on side effects, an explanation of how to take the medicine, written information, no information)*	4.5	4.6	6.2
Were you given enough privacy when being examined or treated?	9.4	9.4	9.9
Before you left hospital, were you given enough information about what you should or should not do after leaving hospital?	8.0	8.0	9.7

Figure 2 shows the comparisons with other NHS trusts in the region.

Figure 2 – Regional comparison



4. Action Plan

Area for Improvement	Lead	Group	Action	CQC Action plan and Trust Recovery plan alignment	Date action to be completed
Patient Experience and Involvement	Jen Little, Patient Experience and Involvement Lead	PESG	Develop a robust Patient Experience Strategy in collaboration with • patients and carers, including hard to reach groups • external stakeholders • Patient Experience Participation Facilitator to be appointed	NA	January 2022
Trust complaint process	Jen Little, Patient Experience and Involvement Lead	PESG	Review the trust complaint process in-line with, • Patient feedback • Staff feedback • PHSO new framework • CQC guidance/ regulations	NA	January 2022
Friends and Family test response rate	Jen Little, Patient Experience and Involvement Lead	PESG	Improve the FFT response rate • Remove the FFT question from local surveys • Send all patients, on discharge, a text message with the FFT question • Continual review of response rates to ensure meeting targets	Actions completed • To set baseline for FFT response rate • To report Trust FFT in line with NHSEI guidance establish trust target • FFT response rate are monitored by PESG, Fundamentals of Practice Group	January 2022
Improving the patient experience	Jen Little Patient Experience and Involvement Lead	PESG	• To review and agree questions in patient survey		December 2022
	Anna Wilson, Dementia Lead Nurse		• Introduction of the carers passport		November 2022
	ADoNs/HoN/ Patient Experience Team		• Comparison of results with inpatient surveys to identify areas of work		December 2022
	Allison Davis, Head of ICT and Healthcare Records		• Accessible Information Standards working group		December 2023
	Paula Taggart, head of Nursing		• Discharge Working Group	Actions ongoing	
	Ruth Mhlanga, Prof Lead SPCC/Head of Physiotherapy		• Nutrition and Hydration Working group	Actions ongoing	

5. RECOMMENDATIONS

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

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 NOVEMBER 2022			
Staff Survey 2021 Update			**AGENDA ITEM: 13, ENC 11**
Report Author and Job Title:	Rachael Metcalf HR Director	**Responsible Director:**	Rachael Metcalf HR Director
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This paper will provide the Board with an update on the actions undertaken following the Staff Survey in 2021.		
Background	The 2021 NHS Staff Survey saw a return of a 31.3% with 2,877 surveys completed. In contrast to a number of other NHS organisations which utilise a sample survey, the trust uses a full census survey. The 2021 NHS Staff Survey results showed that, in comparison to 2020, the Trust continued to improve or maintained across the vast majority of questions, and was in the top-two most improved trusts in the country for the second consecutive year The questions in the staff survey 2021 are aligned to the People Promise 7 elements plus staff engagement and morale. We are above the average in 6 elements, below in 2 and in line with 1 element.		
Assessment	As part of the Staff Survey qualitative insights are used to form our staff survey action plan. The qualitative insights from our 2021 staff survey focused on the following themes: • Redeployment • Appraisal documentation • Flexible Working • Recognition • Administration This paper will provide an updated position in relation to the above 5 themes.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	The Board of Directors are requested to note the content of this paper.		
Does this report mitigate risk included in the BAF or Trust Risk	3.1 Ability to attract and retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources.		

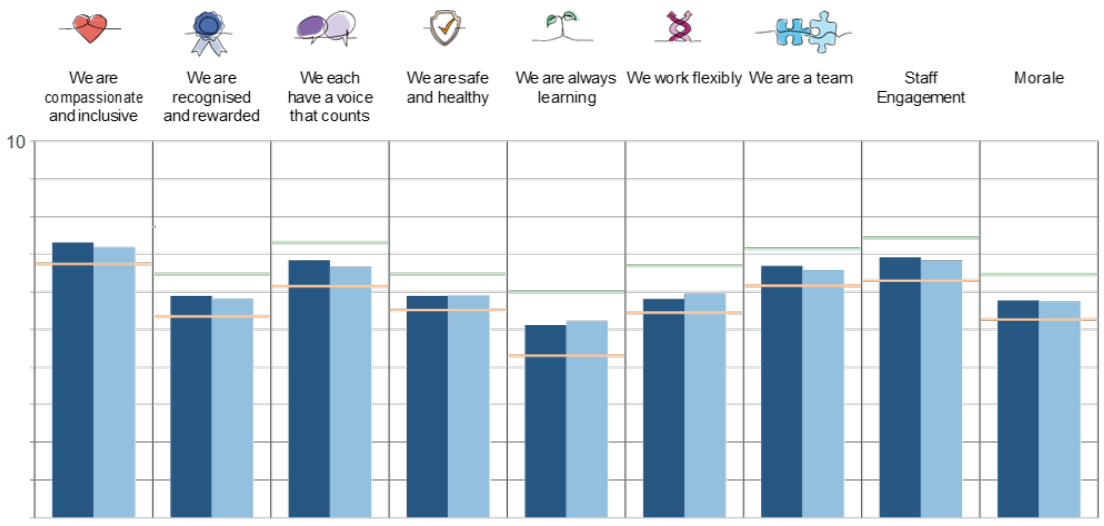
Registers? please outline		
Legal and Equality and Diversity implications	Positive action has been undertaken across a range of protective characteristics including ethnicity, disability and gender, due to the evidence that has emerged as to the significantly higher level of impact it has on people with whom identify within these vulnerable groups identified.	
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 ☐	

1.0 Background

The questions in the staff survey 2021 are aligned to the People Promise. This identifies, in the words of NHS staff, the things that would most improve their working experiences, and is made up of 7 elements plus two of the original themes reported in previous years - staff engagement and morale.

People Promise

- We are Compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff engagement
- Morale



Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.3	5.9	6.8	5.9	5.1	5.8	6.7	6.9	5.8
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3

2.0 Qualitative insights

As part of the Staff Survey qualitative insights are used to form our staff survey action plan. The qualitative insights in our 2021 staff survey focused on the following themes:

- Redeployment
- Appraisal documentation
- Flexible Working
- Recognition
- Administration

This paper will provide an updated position in relation to the above 5 themes.

3.0 Redeployment

The Trust has an embedded review process for nurse staffing establishment for acute inpatient wards which are undertaken utilising the following:

- NICE guidance
- Safer Nursing Care Tool (SNCT) - a NICE endorsed evidence-based tool, which uses acuity and dependency to support workforce planning
- Nurse sensitive outcome indicators
- Professional judgement

This process combines an evidenced based methodology with professional judgement of experienced ward managers, and matrons based on experiential learning to ensure wards are safely staffed and the skill mix is balanced utilising a multifaceted approach to safe staffing.

<u>Nursing Staff redeployment Charter</u>

A Nursing Staff Redeployment Charter was developed to support colleagues when they are required to move to another ward. This covers 5 fundamental asks:

1. Provide a clear reason for requesting the member of staff to move
2. Enables wards to challenge the request if patient care may be compromised
3. Welcome redeployment colleagues and provide appropriate ward orientation and handover
4. Provide a guide around the ward to highlight key areas such as medicines cupboard, crash trolley etc
5. Redeployed colleagues must be introduced to the team, allocated breaks and work within their level of competence

Allocate on arrival

The implementation of this NHSP resource has been adopted well into the safe care process.

Collaborative Approach to redeployment

Matrons and ward managers are empowered to be decision makers in zone staffing. This supports working within collaboratives which enables the retention of specialist skills and knowledge in zones.

Clinical matrons chair safe care twice daily

Prior to meetings, collaborative representatives have an accurate update from their wards and assurance that safe care has been updated, including non-clinical time, occupancy, and acuity issues are only escalated to the safe care meeting once all options have been exhausted within the collaborative. Safe care chair will support and facilitate solutions being found.

4.0 Appraisal Documentation

The new appraisal documentation was launched in April 2020 with a focus on our Trust values, wellbeing conversations and career conversations. The initial documentation was lengthy as it explained the new process, detailed our values and provided support for career and wellbeing conversations.

Following feedback from the staff survey in 2021 this has been reduced to a much simpler version as we become more familiar with the new appraisal process and our values are embedded. The amended version launched in June 2022 has a much more succinct wellbeing section and a simple flow diagram to facilitate a career conversation. Positive feedback has been received about the reduced appraisal documentation.

5.0 Flexible Working

A ‘flexible working is for everyone’ approach has been adopted by the Flexible Working Group with a view that providing more varied options of working to deliver care will help retain staff and improve retention. Based on toolkits released by NHSI, the working group have reviewed the current flexible working policy to include:

- Individual toolkit that will help prepare staff for a positive conversation to make requests in relation to flexible working and support agreement of a solution that works for all parties
- Line manager toolkit to support how to lead a flexible team and how to develop structures and processes to encourage a flexible workplace.

The new policy and associated toolkits will be communicated and promoted in November.

6.0 Recognition

Defence Employer Recognition Scheme

We have recently been successful in achieving a Silver Award in the above scheme, which has contributed to the Trust being accredited as Veteran Aware. Plans are now underway to go for Gold in 2023. This enables the organisation to support veterans within our community as an employer that:

- Veteran Aware Accreditation and DERS Silver Award appears on all our Trust adverts.
- We offer guaranteed interviews for veterans that meet the essential criteria
- Veterans and Reservists can be identified on application

Better Health at Work Award

In November 2021 we received the Bronze award for Better Health at Work Award and will be submitting our application for our Silver Award in December 2022.

Long Service Award

We have recently established a small task and finish group including representatives from our Staff Engagement Group and staff side colleagues to develop our recognition strategy. We currently have in place a long service award – 4 weeks additional leave upon completion of 25 years' service at South Tees NHS FT. However, we would like to introduce other thank you and recognition initiatives both prior to the 25 years mark and also on going for colleagues who remained employed for many years beyond 25.

7.0 Administration

Love South Tees Admin Week was launched on Monday 19 September to Friday 23 September. The aim was to promote and recognise the fantastic contributions of admin colleagues across the trust.

A number of events took place including careers and listening events. We received over 150 nominations for our awards and have already agreed this will be an annual event. The award categories this year were:

- Medical Secretary of the Year
- Admin Team of the Year
- Ward Clerk of the Year
- Receptionist of the Year
- Call handler of the Year
- Admin assistant of the Year
- Administrator of the Year
- Clinic Coordinator if the Year

The listening events were an opportunity for admin colleagues to share their experiences and a number of themes were identified. We are now arranging short task and finish groups from within our admin teams to take these themes forward.

- Recruitment
- Career progression
- Professional development and progression
- Line Management arrangements
- Booking Appointment team responsibilities
- Communication

8.0 Next Steps

We will continue to work through our staff survey priority areas, engaging with our colleagues, to make a positive change to the working lives of our colleagues.

9.0 Recommendations

The Board of Directors are requested to note the content of this paper.

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 1 NOVEMBER 2022			
Quality Priorities 2022/23 Q1 Progress Report			**AGENDA ITEM: 15** **ENC 12**
Report Author and Job Title:	Jane French, Quality Governance Facilitator Ian Bennett, Deputy Director of Quality	**Responsible Director:**	Dr Hilary Lloyd, Chief Nurse
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This paper provides a progress report in respect of the 2022/23 quality priorities that were agreed and included in the 2021/22 Quality Account.		
Background	Providers of NHS healthcare are required to publish a Quality Account each year. These are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 and will be made available to the public. As part of the annual Quality Account, the Trust has to identify its quality priorities for the coming year and demonstrate associated stakeholder engagement.		
Assessment	This report provides a quarter 2 progress report on the quality priorities for 2022/23 and highlights areas where improvements have been made as well as highlighting any areas of concerns and actions planned to address these. The Trust agreed 8 quality priorities for 2022/23 under the domains of patient safety, clinical effectiveness and patient experience. 7 of the priorities are rated green (on track) 1 of the priorities is rated red (off track) –CDi		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	For the Board of Directors to note the progress made with regard to the 2022/23 quality priorities and the actions planned to address any issues of concern. For the Board of Directors to receive assurance that a robust and effective process is in place across the Trust for reporting progress with the agreed quality priorities.		
Does this report mitigate risk included in the BAF or Trust Risk	All relevant risks are included on the risk register		

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

Quality Priorities 2022/23
Progress Report

1. PURPOSE OF REPORT

This report provides a Quarter 2 progress report relating to the 2022/23 quality priorities that were agreed for the Trust and outlined in the 2021/2022 Quality Account.

2. BACKGROUND

Providers of NHS healthcare are required to publish a Quality Account each year. These are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 and will be made available to the public.

As part of the annual Quality Account, the Organisation has to identify its quality priorities for the coming year (2022/23) and demonstrate associated stakeholder engagement.

The 2021/22 Quality Accounts were signed off in July 2022 and have been published externally.

The 2022/23 priorities were reported on as part of the 2021/22 Quality Account and a quarterly progress report requested from the relevant Lead(s) to identify if priorities are being delivered as agreed or to highlight any issues of concern and actions planned to address any areas of concern.

3. DETAILS

2022/23 Quality Priorities

The Trust has agreed the following priorities for 2022/23 following a consultation process. The agreed priorities are areas of importance that will make a difference to our patients.

Some of the organisation's priorities are new, whilst others have been revised and carried over from last year. Agreed actions will be delivered and monitored during a 12-month period from the 1st April 2022 to the 31st March 2023, with regular updates provided through the year via the trust quality governance structure.

The table overleaf shows the quality priorities for each domain – patient safety, clinical effectiveness and patient experience.

Quality Priorities 2022/23		
Safety	**Clinical Effectiveness**	**Patient Experience**
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 embedded	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, 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 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 patients	We will ensure all patients have their nutrition and hydration needs met
We will reduce the risk of Clostridium Difficile infection for inpatients		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

This report highlights progress to date with each of the quality priorities under the three domains.

DOMAIN Patient Safety	
Quality Priority- Safety Culture We will ensure there is a positive safety culture within the organisation in which openness, fairness, accountability, timeliness and learning from high levels of incident reporting is the norm.	
Quarterly Progress Rating: Q2 ***(Please state the quarter)***	**On Track**
Progress	

During Q2, progress has continued against the 12 recommendations identified within the Thematic Review of Never Events.

The Patient Safety Incident Response Framework (PSIRF) documents were published in August 2022, which will inform the infrastructure of how future patient safety incidents are identified for investigation. A Task & Finish Group has been convened to begin the preparations for implementation of the new framework.

The Restorative Just & Learning Culture (RJ&LC) work has progressed well during Q2, with a scoping group to plan the launch of a restorative just culture approach across the Trust, which will take place in the first week of November. Patient safety and experience is one of the workstreams monitored by this group. This approach will then be embedded into Trust policies over the coming months, with a number of RJ&LC Ambassadors in place across the Trust to promote and provide advice regarding the new approach.

The Trust is also further developing restorative and compassionate responses to patients, their relatives and staff involved in patient safety incidents, in order to ensure that the Trust continues to provide effective and tailored support to meet individual needs.

A Task & Finish Group has met during Q2 to plan the implementation of a Peer Support programme for staff involved in adverse or traumatic incidents. A framework has been developed and this work will continue during Q3.

A further cohort of Family Liaison Officers (FLOs) were trained during September, bringing the number of trained FLOs within the Trust to 40. Patients and relatives are now routinely involved in patient safety incident investigations and review drafts of the investigation reports until they are satisfied that the report reflects all perspectives and that it is written with the patient/family as the primary audience.

Work will continue during Q3 to progress the remaining recommendations, including the development of an electronic share point on the Trust intranet for patient safety learning for all staff to access.

The Patient Safety Ambassadors and the newly appointed Safe & Effective Care Leads will work together to ensure an effective communication strategy for patient safety messages to be shared consistently across all clinical collaboratives.

Issues for Escalation
Nothing for escalation in Q2.

DOMAIN Patient Safety	
Quality Priority – Pressure Damage We will ensure the care that we provide to our patients is safe, and of the highest possible standard by reducing pressure damage	
Quarterly Progress Rating: Q2 ***(Please state the quarter)***	**On Track**
Progress	

As part of the trust's clinically-led improvement journey, the tissue viability action plan has been developed to monitor and track improvements within the organisation. The monthly pressure ulcer improvement group continue to meet to track delivery and progress against actions to maintain momentum. This also provides structure and direction and plan is updated following the meeting.

The pressure ulcer risk assessment, Purpose T was introduced to our acute hospitals on 14th September 2022 and has been embedded within the community since early January 2022. Purpose T is launched via the digital platform, Patientrack.

The assessment is for all patients on admission and supports decision making through a standardised list of preventative actions. Patients at risk or who already have a pressure ulcer are highlighted and are visible at clinician, ward and organisation level. The functionality also allows visibility of any outstanding assessments and interventions.

The SSKIN care plan has been digitalised as a full holistic assessment. Registered nurses have received ward-based education on the Purpose T and on the SSKIN care plan. A video has also been made to support the delivery of education with a high uptake from clinical colleagues. It has also been agreed for tissue viability training to become role specific mandatory training.

A pressure ulcer review panel takes place three times per week. The purpose of the panel is to provide a rapid review of the patient, identify immediate findings and to establish shared learning. This process has also improved our timeliness of reporting and escalation. The Pressure Ulcer Safety Huddle (PUSH) tool is now incorporated within DATIX so that a review of care, interventions and the management plan is discussed during the review panel.

The TVN team are currently working on updating WebIce to improve referrals. This includes the addition of prompts for staff which direct them to the pressure ulcer prevention guide and dressings guide. This will facilitate early signposting towards preventative advice in advance of the TVN assessment.

The Fundamentals of Practice monthly meetings, review the pressure ulcer incidence by each collaborative. We have seen an increase in overall incident reporting, yet a reduction in Category 3 and 4 pressure ulcers. In addition to this the CQUIN related to the assessment and documentation of pressure ulcer risk within 6 hours of an admission to a Primary Care Hospital has been achieved for quarter 1.

Issues for Escalation

Nothing identified for escalation in Q2.

DOMAIN Patient Safety	
Quality Priority –CDi We will reduce the risk of Clostridium Difficile infection for inpatients	
Quarterly Progress Rating: Q2 ***(Please state the quarter)***	**Off Track**
Progress	

Clostridium difficile lives harmlessly in the gut of about three in 100 healthy adults, along with lots of other types of bacteria. It is a type of bacteria that can cause diarrhoea and often affects people who have been taking antibiotics.

Rates of clostridium difficile have increased nationally over the last two years and like other trusts, we have also seen a rise in cases.

Treatment includes stopping any antibiotics people have been taking if possible and taking a ten-day course of another antibiotic that can treat the infection. Like other bugs, good hand hygiene is very important to prevent spreading the infection to others. The Trust also use a rolling programme of deep-cleaning which includes hydrogen peroxide fogging of vacated areas.

- Structured review process continues and is embedded with good feedback from ward teams. Good attendance including ICB representation.
- CDI toolbox teaching updated and continued in Q2.
- Increased audit and surveillance to ensure CDI and focus on five covered.
- Deep-cleaning programme completed at FHN and progressing well at JCUH.

Issues for Escalation

- Continued support with medical staff for structured review process

DOMAIN: Clinical Effectiveness	
Quality Priority – Clinical Audit We will review and revise our processes for Clinical Audit in order to facilitate effective and evidence based clinical care for our patients	
Quarterly Progress Rating: Q2 ***(Please state the quarter)***	**On Track**

Progress

Priority 1 - National Audits

Following a restructure within the department to include clinical audit into the wider clinical effectiveness portfolio, work has been ongoing to improve and develop the standard operating procedures (SOP) for the department.

The trust has recently procured a new project management system “InPhase” which will replace the CAT’s database and improve reporting going forward. Work has already started on the logistical planning ahead of migration to this system.

Ongoing collaborative working between the audit team and the Chief Medical Officer’s (CMO) office has assisted with increasing engagement with specialties around priority 1 National Audits.

Benchmarking against National Audit performance SOP is due to be rolled out to all collaboratives which will give an added level of assurance, given that some of the data collected for these National Audits can be historical.

Issues reviewed weekly and escalated as necessary at the fortnightly weekly check in meeting with the CMO's team.

Priority 2: Trust Priority Audits
Following Q1's submission ahead of the deadline for the identified CQUIN measures, focus has now switched to the Q2 submission. The audits have now been included onto Meridian to improve effective data collection and reporting. The audit team have distributed lists and data collection links to relevant teams and will facilitate the action plans around the results to ensure submission ahead of the forthcoming deadlines.

Following the recent review of LocSSIPs across the trust, improvement work has focussed on a collaborative approach between the specialist nurses, audit and Safe and Effective Care Leads; this will improve the results and identify any opportunities for training.

Priority 3 & 4 : Good Practice & Trust Audits
Team continues to register priority 3 & 4 audits as submitted to the department.

Service Evaluations:
Registration of Service Evaluations sit with the Clinical Audit team. Added assurance of fortnightly meeting between Research & Development Governance Manager and Clinical Audit & NICE Advisor to discuss progress and concerns around where specific registrations sit regarding Research, Audit and Service Evaluations.

Issues for Escalation
CAT's database until implementation of InPhase is complete

DOMAIN: Clinical Effectiveness	
Quality Priority – NICE Guidance We will review and revise our processes for NICE in order to facilitate effective and evidence based clinical care for our patients	
Quarterly Progress Rating: Q2 ***(Please state the quarter)***	**On Track**
Progress	

Following re-structuring of the clinical effectiveness portfolio dedicated resource has now been given to NICE. The NICE Facilitator will be working alongside the Clinical Audit Facilitators to ensure a congruence of activity in both areas of work and to define robust processes for reporting of NICE compliance.

Current Position:
Of the 438 Technology Appraisals, 394 are deemed fully implemented with further assurance work to be done through clinical audits for those that have not had clinical audits undertaken.

All new guidance is monitored on a weekly basis and any Technology Appraisals and Highly Specialist Technologies are disseminated at that time. All other new guidance is disseminated at the first opportunity.

Regular meetings to be undertaken with Lead Pharmacist - Antimicrobials & Governance, to discuss any Technology Appraisals and Highly Specialist Technologies as required.

The newly procured InPhase Quality Assurance System will soon give us the effective system for the dissemination, reporting and tracking of all NICE activity required.

Issues for Escalation

Nothing identified for escalation in Q2.

DOMAIN Patient Experience

Quality Priority – Safe & Effective Discharge
We will ensure that patients, their relatives and carers have the best experience possible in relation to a planned, safe and effective discharge from our hospitals

Quarterly Progress Rating: Q2 *(Please state the quarter)*	**On Track**

Progress

Assurance and Governance

To ensure we are sharing important information at all levels, discharge is discussed in several forums across the organisation to guarantee everyone is aware of the challenges and improvement that have and still can be made.

- Discharge checklist visible in clinical areas
- Ward based education and toolbox teaching provided
- Comprehensive yellow discharge resource folder on all wards
- Assurance checks and audit now in place
- Data and learning from events shared at discharge board
- Regular attendance at the Matron and Ward Manager Forum

Next Steps

- Continue to work with local authorities and other partners to ensure patients who have completed their hospital care and require social care support, are able to access this as quickly as possible
- Expand Transfer of Care Hub team and Home First team
- Transfer of care and system - Rapid Process Improvement workshop
- Embracing risk and enabling choice program
- Digitalisation of documentation
- ECIST - best practice benchmark internal processes

- Ongoing Audit
- Relaunch ‘End PJ paralysis’ campaign across all wards as part of pandemic recovery
- Rapid Processing Improvement Workshop
- Learning events
- Continued quantitative and qualitative patient and carer insights

Actions to be considered to improve discharge.

1. Timeliness of social care access
2. Long length of stay review.
3. Review of the Patient Flow structure to support flow and Discharges across all pathways but focusing on pathway 0 patients.

Issues for Escalation

Nothing identified for escalation in Q2.

DOMAIN Patient Experience

Quality Priority – Nutrition & Hydration

We will ensure all patients have their nutrition and hydration needs met

Quarterly Progress Rating: Q2 *(Please state the quarter)*	**On Track**

Progress

Nutrition and Hydration Strategy now completed and launched.

All acute inpatient areas now trained in using the ‘MUST’ assessment. Digital screening on patientrack is fully implemented for nutritional screening.

MUST point prevalence audit shows compliance as:

- 95% for September
- 95% for the 6 months from 1st April to 30th Sept.

Nutrition Link Nurses training programme continues to make good progress.

Non-ward based nurse are supporting with the Assisted Feeding Rota on daily basis. Positive feedback has been received from a recent survey of impact.

Protected mealtimes

Point prevalence audit during September demonstrated protected mealtimes compliance at 97%, showing considerable improvement following the quality improvement review of the mealtime process.

In addition, the SOP has been reviewed and updated; a 'mealtime process' video resource has been produced for staff to guide on what standards staff are expect to meet, to achieve an ideal mealtime experience for our patients. Assisted feeding whiteboards have been introduced, and mealtime bells, to support a coordinated mealtime process.

A new patient experience survey has been developed which focuses on food delivery and quality.

Issues for Escalation
Nothing identified for escalation in Q2.

DOMAIN Patient Experience	
Quality Priority – Patient Feedback 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	
Quarterly Progress Rating: Q2 ***(Please state the quarter)***	**On Track**
Progress	
A proposal to support a patient experience hub in the main hospital, whereby patients, carers and family can seek advice and support, with the intention of increasing face to face contacts is underway. A review has been undertaken of the local inpatient survey questions with nursing, medical and AHP colleagues. There is a plan to separate the Friends & Family Test (FFT) question from local surveys and to send the FFT question to all patients via text message or email to improve the response rate. There was progress in Q1 and Q2 for the response rates to local surveys compared to the full year 2021/22. Of note is the positive completion of surveys in outpatient Emergency Care and Community Services which are responded to electronically and are clearly contributing to our increased response rates. Patient feedback is being obtained through surveys on nutrition and hydration and discharge to support the working groups in Nutrition and Hydration and Discharge and shared with the relevant groups. A new survey is in development to gain feedback following the roll out of the new appointment letters, to identify if the letters are meeting the needs of the patient. A Patient Experience Strategy has been developed and external stakeholders, patients and carers have been invited to support a review of the latest draft of the strategy. The Maternity Voices Partnership Group (MVP) are involved in the reviewing of all patient information for Maternity service and are involved in service development programmes. The Maternity Voices Partnership (MVP) continues to contribute to the review and service development is Maternity and a sub-group in collaboration with Teesside University is looking at gaining feedback from the BAME community regarding their Maternity experiences This year we also see the re-introduction of the annual PLACE assessment whereby all inpatient sites are being visited between September and November with the results being submitted to NHS Digital which will then generate the annual report allowing us to benchmark ourselves against other Trusts within the region. The Trust is, once again, able to invite our patient assessors to join us on these assessments.	
Issues for Escalation	

Nothing identified for escalation in Q2.

Summary

Good progress and work is continuing on the quality priorities as outlined in the individual updates and actions are planned to address issues of concern.

Of the quality priorities the report identifies that 7 are rated green (on track). There is one ‘off track’ priority in Q2 as described above, however actions are in place.

A further progress report on Q3 will be provided in three months.

4. RECOMMENDATIONS

For the Board of Directors to note the progress made with regard to the 2022/23 quality priorities and the actions planned to address any issues of concern.

For the Board of Directors to receive assurance that a robust and effective process is in place across the Trust for reporting progress with the agreed quality priorities.

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 NOVEMBER 2022			
Nurse staffing, capacity and capability annual review for acute inpatient wards			**AGENDA ITEM: 16, ENC 13**
Report Author and Job Title:	Lindsay Garcia Interim Deputy Chief Nurse	**Responsible Director:**	Dr Hilary Lloyd Chief Nurse
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report details the nurse staffing, capacity and capability annual review for acute inpatient wards.		
Background	There is a requirement to conduct an annual nurse staffing review to ensure nurse staffing establishments are sufficient to optimise the delivery of safe nursing care to patients. The review is in line with the requirements set out by the *National Quality Board (NQB), supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time- safe, sustainable and productive staffing (July 2016).* This guidance is supported by a further publication from NHSI *'Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing'* which was published in October 2018.		
Assessment	A review process for nurse staffing establishment for acute inpatient wards has been undertaken utilising NICE guidance, Safer Nursing Care Tool (SNCT), nurse sensitive outcome indicators and professional judgement. Staffing review meetings were held with ward managers, matrons, Heads of Nursing and Associate Chief Nurses to review their ward based staffing establishments against bed base and quality indicators to establish final sign off. An 'uplift' for annual leave (13%), sickness cover (4%), training (4%) equates to 21% is added to the required numbers to set the final establishment. The agreed staffing levels for 2022/23 are tabled within the report. Nurse recruitment, retention and future workforce planning remains a priority at South Tees NHS Foundation Trust. The Trust has 377 more nurses in post than in 2019 and celebrates holding one of the lowest nursing turnover rates in the country, as reported by the Model Hospital.		

Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐	
Recommendation	Members of the Trust Board are asked to: Note the content of this report	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 5.1 Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit. Threat - 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	
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 ☐	

South Tees Hospitals
NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust - Nurse Staffing, Capacity and Capability Annual Review

1 Introduction

This detailed annual report provides a comprehensive review of nurse staffing for South Tees Hospitals NHS Foundation Trust. It is in line with the requirements set out by the National Quality Board (NQB) - *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time- safe, sustainable and productive staffing (July 2016).*

This guidance is supported by a further publication from NHSI *'Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing'* which was published in October 2018.

Recognising that there is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs, NICE guideline (2014) recommends factors that should be systematically assessed at ward level to determine the nursing staff establishment. These have been applied and are as follows;

- Develop procedures to ensure that ward nursing staff establishments are sufficient to provide safe nursing care to each patient at all times

- Ensure that the final ward nursing staff establishments are developed with the registered nurses who are responsible for determining nursing staff requirements at a ward level and approved by the chief nurse

- When agreeing the ward nursing staff establishment, ensure it is sufficient to provide planned nursing staff requirements at all times. This should include capacity to deal with planned and predictable variations in nursing staff available, such as annual, maternity, paternity and study leave

- When agreeing the skill mix of the ward nursing staff establishment, this should be appropriate to patient needs and take into account evidence that shows improved patient outcomes are associated with care delivered by registered nurses

- Enable nursing staff to have the appropriate training for the care they are required to provide

- Ensure that there are sufficient designated registered nurses who are experienced and trained to determine on-the-day nursing staff requirements over a 24-hour period

- Take into account additional workload in nursing hours per day – average patient turnover, ward layout and size, nursing activities and responsibilities, other than direct patient care

It is the intention to continue to monitor whether the nursing staff establishment adequately meets patients' nursing needs by quality indicators that evidence shows to be sensitive to the number of available nursing staff and skill mix.

A detailed review of nurse staffing, led by the Chief Nurse, Deputy Chief Nurses and Workforce Lead has been conducted for all Acute inpatient areas. A review of the following specialist areas is currently underway;

- Critical Care
- Obstetrics
- Paediatrics
- Community Nursing
- Emergency Department

2 Right Staffing

National guidance recommends that inpatient ward staffing is determined using evidence based workforce planning. The Trust has an embedded review process for nurse staffing establishment for acute inpatient wards which are undertaken utilising the following:

- NICE guidance
- Safer Nursing Care Tool (SNCT) - a NICE endorsed evidence-based tool, which uses acuity and dependency to support workforce planning
- Nurse sensitive outcome indicators
- Professional judgement

This process combines an evidenced based methodology with professional judgement of experienced ward managers, and matrons based on experiential learning to ensure wards are safely staffed and the skill mix is balanced utilising a multifaceted approach to safe staffing. Environmental factors such as ward layout and patient visibility are also taken into consideration.

3 Safer Nursing Care Tool

The SNCT is a NICE endorsed evidence-based tool, which uses acuity and dependency to support workforce planning. Originally developed by the Association of United Kingdom University Hospitals (AUKUH). SNCT has been endorsement by NICE since 2014 acknowledging that it meets the requirements set out in the NICE guideline "Safe staffing for adult in-patient wards" (NICE, 2014).

The Developing Workforce Safeguards (NHSI, 2018) guidance states that to use SNCT, the Trust must sign a license to ensure the tool is used appropriately and is free from local manipulation. There is also a requirement to evidence compliance with this guidance as part of the Trust single oversight framework submission.

SNCT data collection involves scoring each patient to an acuity and dependency care level. Staffing multipliers are applied at each acuity and dependency care level. These multipliers factor in nursing time spent on:

- Direct and indirect care
- Ward management
- Education/training
- Staff performance review
- Staff breaks
- Associated work such as administration and clerical
- Bed occupancy

These results are then considered alongside the current establishments and nurse quality indicators.

4 Collaborative Approach to Safer Staffing

Staffing review meetings were held with ward managers, matrons, Heads of Nursing and Associate Chief Nurses to review their ward based staffing establishments against bed base and quality indicators to establish final sign off. The meetings involved detailed discussions and challenge to enable robust decisions to be made regarding agreed staffing levels. Further and final review was then conducted with the Chief Nurse, Deputy Chief Nurses and Workforce Lead.

As part of the review, once any new staffing levels are identified the required establishments are calculated and compared to the current funded establishments to determine whether any adjustments to skill mix and funding are required.
An ‘uplift’ for annual leave (13%), sickness cover (4%), training (4%) equates to 21% is added to the required numbers to set the final establishment.

The agreed staffing levels for 2022/23 are detailed in the table below:

South Tees Hospitals
NHS Foundation Trust

Planned staffing 2020					Planned staffing post bed reconfiguration - July 2022				Comments
Unit	RN Day	HCA Day	RN Night	HCA Night	Actual RN Day	Actual HCA Day	Actual RN Night	Actual HCA Night	
Ward 1	5	4	3	3	6	4	6	4	The increase in establishment from 2019-2022 reflects the change of function from Ward 1 to an assessment unit.
Ward 2	5	4	4	3	5	4	3	3	Reduction of 1 RN overnight This is reflective of the change in patient population and an increased LoS.
Ward 3	4	4	3	2	4	3	3	2	
Ward 4	5	3	3	2	5	3	3	2	In addition to this there are 1.16 WTE RNs to staff the dialysis bay.
Ward 5	5	4	3	3	5	4	3	2	The function of the ward has changed to a short stay surgical unit. The nursing dependency has reduced overnight and is reflected in the reduction of HCAs from 3 to 2.
Ward 6	4	3	3	2	5	4	3	3	HCA provision has increased 24/7 and RN provision by one during the day which allows for the funded increase in bed capacity.
Ward 7	5	4	3	2	5	4	3	3	An additional HCA to support increased activity on the ward – currently covered by NHSP.

Ward 9	5	3	4	2	7	3	6	3	The ward footprint includes 10 RSU beds.
Ward 10	Closed				4	4	3	3	
Ward 11	5	5	3	3	5	5	3	3	
Ward 12	Closed				4	3	3	2	
Ward 14	5	3	3	2	5	3	3	2	
Ward 15	6	4	6	4	Closed				Repurposed as CYPED – Ward 15 (AAU) transferred to ward 1.
Ward 24	4	3	3	2	4	3	3	2	
Neuro HDU	4	1	4	1	5	1	5	1	Increase of 1 RN 24/7 – this allows a supervisory coordinator and achieves GPICS compliance.
Ward 25	3	3	2	1	4	3	3	2	Ward 25 has recently become a fractured hip unit following a capacity and demand modelling exercise. The establishment is reflective of the proportionately high numbers of frail older patients within the specialty.
Ward 26	3	2	2	1	3	3	2	2	An additional HCA to support increased dependency on the ward - currently covered by NHSP.

Ward 27	3	2	2	2	3	2	2	2	The function of the ward has changed, therefore 2019 data is non comparative. The staffing establishment represents increased activity during the day to support elective operating hours.
Ward 28	5	3	4	2	5	4	3	3	The function of the ward has changed, therefore 2019 data is non comparative. The staffing establishment represents increased activity during the day to support elective operating hours.
Ward 29	4	3	3	2	4	3	3	2	
Cardio MB	2	1	2	0	2	1	2	1	HCA provision increased overnight to maintain patient safety whilst caring for patients in the side room and to support the allocation of breaks without resulting in leaving one RN in an enhanced care area.
CCU	7	1	6	0	7	1	6	0	
Ward 31	3	3	2	2	5	4	3	3	2019 data is non comparative as the ward now houses a different patient population. The nursing establishment has been calculated in line with NICE guidance, acuity of illness, complexity of patient population, number of beds and surgical programme.
Ward 32	4	3	3	2	4	3	2	2	The reduction in 1 RN on nights is reflective of the bed base and the change in ward function since 2019.
Ward 33	5	3	3	2	5	3	3	2	
Ward 34	5	5	3	4	7	4	5	3	2 wards / specialities merged onto ward 34 - Neurology (ward 25) and a Hyper Acute Stroke Unit (ward 28). Neurology have 14 beds plus 2 telemetry beds. There are 6 hyper acute beds, 1 admission assessment side room and 11 ward stroke beds. The six Hyper Acute Stroke Unit

									(HASU) beds staffed for 1:2 for the first 72 hours following hyper acute stroke.
Ward 35	4	4	3	3	4	4	3	3	
Ward 36	5	4	3	3	5	5	4	3	Increase in 1 RN overnight reflective of the high acuity of illness, activity of trauma admissions overnight.
Ward 37	6	4	6	4	6	4	6	4	
Spinal Injuries	5	5	2	3	5	5	2	3	
Spinal HDU	2	1	2	0	2	1	2	0	
CDU	5	3	3	2	5	3	3	2	
Ainderby	4	3	2	2	4	4	2	3	The increase in HCAs reflects the increase in nursing dependency of older patients. The rationale for the 50/50 split of registered to non-registered staff is to have an identified role within the non-registered workforce for maintaining patients' nutritional needs.
Romanby	4	3	2	2	4	4	2	3	The increase in HCAs reflects the increase in nursing dependency of older patients. The rationale for the 50/50 split of registered to non-registered staff is to have an identified role within the non-registered workforce for maintaining patients' nutritional needs.
Gara	2	2	2	1	3	2	2	2	The increase in establishment by one HCA reflects the increase in beds from 16 to 21 and supports the overall resilience of the FHN site overnight.

Rutson	3	4	2	2	3	3	2	2	There has been a reduction in establishment by one HCA on a day shift. This is reflective of the significant contribution the AHP workforce. As the AHP workforce only cover weekdays, there is an associated requirement to increase HCAs at weekends and bank holidays.
Friary	3	4	2	1	3	4	2	2	Increase in establishment by 1 HCA overnight due to the remote location and layout of the ward.
Zetland	6	9	3	3	5	8	3	4	The establishment has been adjusted based on activity and acuity of patients – this has resulted in a reduction of 1 RN and 1 HCA during the day and an increase by 1 HCA overnight. The ward is supported by a strong AHP presence during the day reflective of the rehabilitation focus of the ward.
Tocketts	4	5	3	4	4	5	3	4	

5 Recruitment and Retention

Nurse recruitment, retention and future workforce planning is a priority at South Tees NHS Foundation Trust. The Trust has 377 more nurses in post than in 2019 and celebrates holding one of the lowest nursing turnover rates in the country, as reported by the Model Hospital. The trust actively explores recruitment and retention in line with National NHS Employers Retention Guidelines. For those colleagues intending to leave, 'early conversations' are held to explore alternative career options and retire and return opportunities.

The recruitment and retention strategy will always focus on creative, effective and efficient recruitment. Examples of which are;

- centralising HCSW recruitment
- investment in student nurse workforce
- welcome days and contact onboarding for all student nurses
- increase in student nurse placement numbers including virtual placements
- same band recruitment processes and interviews
- pre-registration career planning and staff development
- fast track recruiting
- career discussions
- retire and return conversations
- robust pastoral support programme for international nurses

Recognising that redeployment causes additional anxiety to the existing workforce, all efforts have been afforded to minimise this occurring. This includes:

- movement of staff within collaborative
- allocate on arrival
- production of the staff charter
- devolvement of the safe care process to ward managers with matron chair

The has been received well and is aligned to the safe care process ensuring that staff with the correct skills are deployed only to areas of highest need. The operational management of this through E roster, safe care chair and site team ensures ward staff are not given the pressure of deployment.

6 Capability and Quality

It is essential to consider patient quality indicators alongside patient population, acuity of illness and nursing dependency. This was conducted at each collaborative ward based staffing review meeting. The patient quality indicators reviewed as part of the annual nurse staffing review are indicated below:

- Pressure ulcers
- Falls
- Medication incidents
- Serious incidents
- Formal complaints
- Quality audit data

All aspects of quality care alongside workforce KPIs are reviewed at monthly Fundamental of Practice meetings chaired by the Deputy Chief Nurse. This is to ensure immediate escalation of any areas of concern and enables the ability to be responsive to and wrap around support that may be required.

The Trust provides a monthly safe staffing report to board which details the percentage of shifts filled against the planned nurse and midwifery staffing across the trust. Good compliance with safer staffing is demonstrated, with September 2022 reported as 96.3%. All nurse staffing issues on the risk register are reviewed on a monthly basis.

7 Staff Wellbeing

South Tees Hospitals NHS Foundation Trust is committed to improving the working experience of all staff. Our values are aligned to those set out by NHS England. We want to create an organisational culture of compassionate leadership, improved workforce resilience and support for our staff. The workforce pressures of thE COVID-19 pandemic and the additional challenge this has created for our nursing workforce is well recognised. We want to look after our nurses to the best of our ability, invest in them, support both their academic and professional development and remain committed to enhancing their wellbeing. Many resources are available a number of which are listed below:

- HR Consultant Wellbeing
- Wellbeing coordinators and empathic listeners
- Professional Nurse Advocates
- Psychological skills workshops
- E-resources
- Signposting services
- Peer support
- Self care resources
- Schwartz rounds
- Recreational activities – South Tees Choir, Yoga, walking group
- Outdoor space and gardens

8 Conclusion

This report outlines the agreed ward based nursing establishments following the annual comprehensive review of nurse staffing for South Tees Hospitals NHS Foundation Trust. It is in line with the requirements set out by the National Quality Board (NQB). Evidence based workforce planning has been conducted utilising NICE guidance, Safer Nursing Care Tool (SNCT), nurse sensitive outcome indicators and professional judgement. Patient acuity, nursing dependency, change in patient population and geographical layout of the ward have been given due consideration as part of the shared decision making process.

9 Recommendation

The Board is asked to receive this report for information and assurance

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 NOVEMBER 2022			
Finance Report			**Agenda Item 17, ENC 14**
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 6 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 to the NHSE regional team for the 2022/23 financial year is a deficit of £20.7m. Following the national Advanced eFinancials system down-time, which has impacted on Month 4 and Month 5 reporting, systems and processes are fully recovered and reporting to NHSE has resumed in the usual manner.		
Assessment	At Month 6 the Trust reported a deficit of £16.3m at a system control-total level. A £1.5m variance year-to-date relates to the cost of the national pay award (and arrears) above the level of additional funding that has been provisionally allocated to the Trust.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Board of Directors are asked to note the financial position for Month 6 2022/23.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addressees BAF Principle risk 7 - Failure to deliver the Trust's financial recovery plan		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Best for safe, clinically effective care and experience ☐	A great place to work ☐	
	Deliver care without boundaries in collaboration with our health and social care partners ☐	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of		

	England, North Yorkshire and beyond ☐	

Month 6 2022/23 Financial Performance

1. PURPOSE OF REPORT

The purpose of the report is to update the Resources Committee on the Trust's financial performance as at Month 6 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 ICS system, and all systems have a breakeven requirement.

Trusts are still required to submit organisational plans and these plans must be consistent with their system plan submission. The Trust's plan for the 2022/23 financial year is a deficit of £20.7m, measured on a system financial performance basis.

This financial position in this report reflects the plan submitted in June 2022 and includes the additional inflation income agreed with NHSE. The plan was developed in conjunction with the NENC ICB, with internal review and oversight provided through the Resources Committee and meetings of the Trust Board.

The Trust is required to report on a group basis each month to NHSE, and so the reported financial position shows the consolidated group position including both the Trust and the Trust's subsidiary company, South Tees Healthcare Management.

3. DETAILS

Trust Position Month 6 2022/23

The Month 6 YTD and forecast position against the NHSE plan submitted in June 2022 is outlined in the table below:

STATEMENT OF COMPREHENSIVE INCOME	YTD Plan £000	YTD Actual £000	YTD Variance £000	2022/23 Full Year Plan £000	Actual Forecast £000	Full year Forecast Variance £000
Operating income from patient care activities	364,012	372,552	8,540	728,662	749,174	20,512
Other operating income	25,491	24,333	(1,158)	51,022	47,516	(3,506)
Employee expenses	(237,446)	(244,648)	(7,202)	(471,565)	(483,925)	(12,360)
Operating expenses excluding employee expenses	(157,002)	(159,085)	(2,083)	(313,185)	(318,843)	(5,658)
OPERATING SURPLUS/(DEFICIT)	**(4,945)**	**(6,848)**	**(1,903)**	**(5,066)**	**(6,078)**	**(1,012)**
FINANCE COSTS						
Finance income	0	362	362	0	500	500
Finance expense	(8,652)	(8,393)	259	(17,330)	(16,800)	530
PDC dividends payable/refundable	(1,956)	(1,956)	0	(3,911)	(3,911)	0
NET FINANCE COSTS	**(10,608)**	**(9,987)**	**621**	**(21,241)**	**(20,211)**	**1,030**
Other gains/(losses) including disposal of assets	0	14	14	0	14	14
Corporation tax expense	0	0	0	(5)	0	5
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(15,553)**	**(16,821)**	**(1,268)**	**(26,312)**	**(26,275)**	**37**
Add back all I&E impairments/(reversals)	0	0	0	3,974	3,974	0
Remove capital donations/grants/peppercorn lease I&E impact	804	559	(245)	1,618	1,616	(2)
Adjusted financial performance surplus/(deficit)	**(14,749)**	**(16,262)**	**(1,513)**	**(20,720)**	**(20,685)**	**35**
Less gains on disposal of assets	**0**	**(14)**	**(14)**	**0**	**(14)**	(14)
Adjusted financial performance for the purposes of system achievement	**(14,749)**	**(16,276)**	**(1,527)**	**(20,720)**	**(20,699)**	**21**

At Month 6 the Trust reported a cumulative deficit of £16.3m at a system control total level. The operating deficit at the end of Month 6 was £6.8m and the overall cumulative deficit was £16.8m.

This year-to-date financial position is £1.5m behind plan, relating to the cost of the national pay award. The costs of the pay award (and arrears) are above the level of additional funding that has been provisionally allocated to the Trust year-to-date by the ICB. Discussions are ongoing regionally and nationally regarding the level of pay award funding that has been allocated to the ICB, for distribution to provider trusts to meet the full costs of the national pay award.

The Trust plan for the 2022/23 financial year is to deliver a £20.7m deficit, as part of the ICS plan to deliver financial balance at a system level. At Month 6 the Trust's forecast outturn position was in line with plan for the 2022/23 financial year.

The forecast currently assumes that the estimated £3.0m full year pressure of the pay award will be funded through additional funding, reflecting ongoing discussions and the NHSE letter in July 2022 that stated that 'systems and providers will be funded in full for the pay award on top of existing allocations'.

Operating Income from Patient Care Activities

Under the revised financial arrangements for 2022/23, the Trust is paid under a block arrangement with the exception of the following 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	Operational Plan £000	Actual £000	New Varance £000
NHS England	121,613	122,187	574
ICB/Clinical commissioning groups	249,739	249,065	(674)
Non-NHS: private patients	493	347	(146)
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	3	30	27
Injury cost recovery scheme	969	907	(62)
Non-NHS: other	25	16	(9)
TOTAL INCOME FOR PATIENT CARE ACTIVITIES	**372,842**	**372,552**	**(290)**

The variance position is shown normalised for net neutral budget adjustments, relating to additional income and expenditure such as the 2022/23 pay award and new contract variations for funded developments.

Operating income from Patient Care Activities was £372.5m for Month 6 and was £0.3m behind plan.

The NHS England position is ahead of plan due to additional funding relating to high-cost drugs, this is offset by an equivalent overspend on drugs. The ICB/CCG income is slightly behind plan and relates to expected contract variations that the Trust have currently not received.

The Month 6 position assumes full receipt of agreed ERF funding relating to the first six months of 2022/23, however, there is a potential risk of clawback of this funding later in the financial year, if actual activity delivery is below ICB planned levels.

The ICB/CCG income position also assumes £1.9m year to date ERF funding from Humber and North Yorkshire (HNY) ICB, in line with national planning guidance. However, this still needs to be confirmed by the HNY ICB and reflected in revised block contract payments. The Trust has invoiced HNY ICB for the first 2 quarters on 2022/23 and has escalated the contractual issue with NENC ICB and regional NHSE.

Other Operating Income

Other income received up to Month 6 totalled £24.3m and was behind plan by £0.1m and includes all non-direct patient care income.

OTHER OPERATING INCOME	Operational Plan £000	Actual £000	New Varance £000
Research & Development	1,640	2,138	498
Education and Training	10,814	10,664	(150)
Non Patient Care Income	764	849	85
Reimbursement & Top-Up funding	1,368	899	(469)
Donations - (Assets, Equipment & COVID consumables)	2,118	2,135	17
Other	7,752	7,648	(104)
TOTAL OTHER OPERATING INCOME	**24,456**	**24,333**	**(123)**

Research and Development income is ahead of plan by £0.5m year to date.

Reimbursement funding relates to Covid-19 pass through costs (for vaccination and testing). This is below plan by £0.5m, but can be offset by equivalent underspends in expenditure.

Employee Expenses (Pay)

The Trust's total expenditure on pay for Month 6 of 2022/23 was £244.7m and was underspent by £0.1m a breakdown is included in the table below.

PAY	Operational Plan £000	Actual £000	New Varance £000
Ahp'S, Sci., Ther. & Tech.	(35,959)	(34,995)	964
Hca'S & Support Staff	(26,865)	(26,643)	222
Medical And Dental	(70,712)	(72,399)	(1,687)
Nhs Infrastructure Support	(35,500)	(34,538)	962
Nursing & Midwife Staff	(74,746)	(75,213)	(467)
Other Pay Costs	(1,014)	(860)	154
TOTAL PAY	**(244,796)**	**(244,648)**	**148**

The Pay underspend mainly relates to Allied Health Professions, Scientist, Technical, and NHS infrastructure support staff, which is offset by overspends on Medical and Nursing.

The Month 6 position includes the year-to-date cost of the national pay award (and arrears). The costs of the pay award exceed the provisionally allocated funding received from the ICB by £1.5m year-to-date. Discussions are ongoing regionally and nationally regarding the level of pay award funding for distribution to provider trusts to meet the full costs of the national pay award.

Operating Expenses excluding Employee Expenses (Non-Pay)

The Trust's total expenditure on operating non-pay for Month 6 of 2022/23 was £159.1m 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	Operational Plan £000	Actual £000	New Varance £000
Purchase of Healthcare	(7,949)	(6,761)	1,188
Clinical Supplies & Services	(48,454)	(49,893)	(1,439)
Drugs	(42,029)	(42,381)	(352)
External Staff & Consultancy	(167)	(455)	(288)
Establishment	(4,825)	(5,623)	(798)
Premises & Fixed Plant	(10,745)	(11,722)	(977)
Transport	(2,043)	(2,056)	(13)
Depreciation & Amortisation	(13,257)	(12,207)	1,050
Research Training & Education	(1,495)	(1,237)	258
PFI Unitary Payment	(15,951)	(16,733)	(782)
Other	(1,778)	(1,461)	317
Clinical Negligence	(8,753)	(8,556)	197
TOTAL NON PAY	**(157,446)**	**(159,085)**	**(1,639)**

The non-pay year to date position is £1.6m overspent.

Purchase of healthcare is £1.2m underspent, which is offset by the overspends on premises & fixed plant, establishment and clinical supplies. Depreciation is underspent by £1.1m.

The overspend relating to high-cost drugs and devices expenditure in the position can be offset by NHSE clinical income.

The PFI Unitary Payment includes the financial impact of the increased inflationary charges, including the impact of the national pay award.

Financing Costs

Interest receivable is £0.4m ahead of plan, reflecting higher cash balances and increased interest rates from the Government Banking Service (GBS) Account. It is anticipated that these returns will fall through the remainder of the year as the Trust's liquidity reduces in line with plan.

The finance expenditure position is £0.3m underspent, related to the PFI interest charges from the PFI financial model. This part offsets the inflationary increases in operating PFI expenditure.

PDC Dividend payments are in line with plan.

Cost Improvement Programme (CIP)

Following the Financial Plan resubmission in June 2022, the Trust has an efficiency saving programme totalling £24.9m. Total delivery against the year-to-date plan stands at £6.8m (88%) at Month 6, as show in the table below:

NHSE category	YTD Target £000	YTD Actual £000	YTD Variance £00
Agency	306	243	(63)
Corporate Services	117	0	(117)
Digital transformation	0	23	23
E-Rostering	2,040	786	(1,254)
Estates and Premises	507	643	136
Fleet optimisation	15	0	(15)
Income Non-Patient Care	1,140	1,343	203
Income Other	216	570	354
Income Private Patient	186	68	(119)
Medicines optimisation	459	485	26
Non-pay Other	525	536	11
Pathology & Imaging	267	189	(78)
Pay Other	66	134	68
Procurement	1,173	885	(288)
Service re-design	0	40	40
Skill mix reviews	729	848	119
Grand Total	7,746	6,792	(954)

The Trust monitors the planning and delivery of its efficiency programme through the meetings of the Collaborative Improvement Planning Group, with oversight from the CIP Steering Group (which includes non-executive director membership). Support for the identification and delivery of efficiency schemes is provided to the Collaboratives from the Trust's Service Improvement Office.

Capital

The Trust's capital expenditure at the end of September amounted to £9.7m 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	6,378	6,597	219	12,760	12,760	0
Site Reconfiguration	1,550	1,678	128	13,402	13,402	0
Replacement of Medical Equipment	1,050	414	(636)	5,636	5,636	0
Network Replacement and Clinical Noting	1,025	1,011	(14)	2,475	2,475	0
Total	**10,003**	**9,700**	**(303)**	**34,273**	**34,273**	**0**

The capital programme is based on a regionally approved programme of £34.3m that will require external support, in the form of Public Dividend Capital (PDC) of £6.5m. The PDC includes funding for the Friarage Theatre development (£4.4), Diagnostic Imaging equipment (£1.6m) and £0.5m towards Endoscopy JAG accreditation.

Internally generated funding will be utilised to fund the remainder of the capital programme. The Trust's ICS Capital Departmental Expenditure Limit (CDEL), included in the above, amounts to £15.0m

The capital programme includes:

- PFI - £12.8m contractual commitment to Endeavour SCH LLP with the payment based on the Financial Model;
- Estates – Friarage Rationalisation and Redevelopment (£4.4m), PFI enhancement and Change in Law (£2.0m), Pathology (£1.2m), Critical Care (£1.8m) and Friarage Critical Backlog maintenance (£1.0m);
- IT – Alcidion investment for e-prescribing and licencing (£0.8m), Digital Programmes started in 2021/22 (£0.8m) and planned/emergency replacements (£0.8m); and
- Medical equipment – Emergency and planned replacement of medical equipment (£3.0m), Diagnostic Imaging (£1.6m) and Group C equipment replacement (£1.0m).

Liquidity

The cash balance at 30 September amounted to £47.1m.

As at the end of September the Trust has paid 45,572 invoices (total value £285.038m) with 43,930 invoices (total value £262.768m) 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 equates to:

- April 98.6%;
- May 98.2%;
- June 96.1%;
- July 96.2%;
- August 96.7%; and
- September 96.4%

Statement of Financial Position (SOFP)

The following table compares the SOFP position between 31 August and 30 September.

Statement of financial position	31/08/2022 £'000	30/09/2022 £'000	Movement £'000
Non-current assets			
Intangible assets	4,141	4,004	(137)
On-SoFP IFRIC 12 assets	151,924	155,468	3,544
Other property, plant and equipment (excludes leases)	113,704	111,049	(2,655)
Right of use assets - leased assets for lessee (excludes PFI/LIFT)	101,816	101,816	0
Receivables: due from NHS and DHSC group bodies	1,933	1,933	0
Receivables: due from non-NHS/DHSC group bodies	1,220	1,220	0
Total non-current assets	**374,738**	**375,490**	**752**
Current assets			
Inventories	14,854	15,227	373
Receivables: due from NHS and DHSC group bodies	7,391	11,158	3,767
Receivables: due from non-NHS/DHSC group bodies	18,754	21,115	2,361
Other current assets	4,200	13,605	9,405
Cash and cash equivalents: GBS/NLF	71,653	43,529	(28,124)
Cash and cash equivalents: commercial / in hand / other	448	702	254
Total current assets	**117,300**	**105,336**	**(11,964)**
Current liabilities			
Trade and other payables: capital	(7,644)	(7,900)	(256)
Trade and other payables: non-capital	(129,534)	(121,848)	7,686
Borrowings	(7,393)	(7,421)	(28)
Provisions	(738)	(738)	0
Total current liabilities	**(145,309)**	**(137,907)**	**7,402**
Total assets less current liabilities	**346,729**	**342,919**	**(3,810)**
Non-current liabilities			
Borrowings	(182,789)	(182,662)	127
Provisions	(2,347)	(2,347)	0
Total non-current liabilities	**(185,136)**	**(185,009)**	**127**
Total net assets employed	**161,593**	**157,910**	**(3,683)**
Financed by			
Public dividend capital	367,099	367,099	0
Revaluation reserve	39,775	39,775	0
Other reserves	26,475	26,475	0
Income and expenditure reserve	(271,756)	(275,439)	(3,683)
Total taxpayers' and others' equity	**161,593**	**157,910**	**(3,683)**

4. RECOMMENDATIONS

Members of the Trust Board are asked to:

- Note the financial position for Month 6 2022/23.

South Tees Hospitals NHS
NHS Foundation Trust

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 1 NOVEMBER 2022			
Care Quality Commission (CQC) Update Report			**AGENDA ITEM:** **ENC 15**
Report Author and Job Title:	Dr Sylvia Wood Assistant Director of Compliance 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 to address the findings of the focused CQC visit which took place the James Cook and Friarage Hospital sites on the 9th and 10th 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 unannounced inspection in February 2022.		
Assessment	This paper includes updates in relation to: • CQC focused work including progress with CQC inspection action plans and other improvement work • The CQC single assessment framework		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of QAC are asked to note the progress that has been made, ongoing and planned work.		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	Principal Risk 1 - Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes Principal Risk 3 - Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☒	

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

South Tees Hospitals NHS
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. NHS Trusts, and other individuals, partnerships and organisations that provide regulated activities set out in the Health and Social Care Act 2008 (the 'Act') and its associated regulations, must be registered with the CQC.

The CQC assess compliance with the requirements of the relevant regulations by monitoring the quality of care provided using feedback from staff, patients, and partners, and changes to information held in CQC Insight, and by inspection. CQC Insight brings together in one place the information CQC holds about services, and analyses it to monitor services at provider, location, or core service level. Together with other feedback, and the ongoing relationship management between key members of the Trust and the CQC relationship holder, this enables CQC to decide what, where and when to inspect. Inspections are used to make sure services are compliant with relevant regulations and providing care that is safe, caring, effective, responsive to people's needs and well-led.

As previously reported a focused CQC inspection took place on medical and surgical wards at the James Cook and Friarage Hospital sites on the 9-10 February 2022 in response to areas which the trust was 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. Additional changes have since been made following feedback from inspectors, as documented in specific action plans and evidence of actions taken.

3. DETAILS OF CQC FOCUSED WORK

Regular meetings of key senior staff continue to monitor and support progress with the areas of work described below. The focus is on completing actions, embedding change, supporting staff, and monitoring evidence of learning and improvement.

a. CQC inspection action plans

Four action plans were developed to address the areas identified (29a):

Section 29A action plan	Responsible group	Status
Nutrition and hydration	Nutrition and Hydration Steering Group	Complete
Ward-based documentation (including risk assessmsnts)	Fundamentals of Practice Group	Complete
Safe and timely discharge	Discharge Improvement Board	Complete
Adherence to the Mental Capacity Act, including DoLS	MCA Steering Group	Complete

Table 1: Summary of progress with Section 29A action plans (updated 6/10/2022)

The final completed action plans with associated evidence listed were submitted to CQC on 15/09/2022 ahead of the engagement visit on 22/09/2022. Key staff presented the work done and evidence of improvement to the CQC relationship managers following which they visited some of the areas inspected in February, and the Emergency Department. The CQC had no concerns and made no requests for any further information or assurance.

Work to address other areas for improvement is progressing, with monitoring and oversight via corporate and collaborative governance structures and processes.

b. Other improvement work

Various sources of quantitative and qualitative data are reviewed to identify areas of good practice and areas of focus. This includes clinical assurance rounds, quality, safety and workforce data, local and national audits, staff and patient feedback. In addition, the work on CQC preparation has included:

- Internal preparation of the historic CQC provider information request (PIR).
- Follow up of actions on the 2019 CQC action plan to ensure robust evidence of implementation, improvement, and ongoing oversight in governance processes.
- Self-assessments against CQC key lines of enquiry by all directorates.
- Gap analyses against the regulatory guidance for each of the CQC fundamental standards.
- Regular review of benchmarked data including from NEQOS (the North East Quality Observatory Service) and the CQC Insight dashboard.
- Review of the requirements of a Trust-wide well-led inspection which includes 8 key lines of enquiry:

    1. Leadership
    2. Vision and strategy
    3. Culture of high quality and sustainable care
    4. Governance
    5. Risk, issues and performance
    6. Information management
    7. Engagement
    8. Learning, improvement & innovation

Improvement plans are developed and supported to address any gaps in assurance. In addition, the STAQC (South Tees Accreditation for Quality of Care) programme continues to drive improvement. The 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 Trust's Leadership Improvement and Safety Accademy is an internal team established to build organisational capacity in leadership, QI (quality improvement) and culture. This team has supported the Trust to launch a sustained programme of leadership development, trust-wide culture, and service improvement work. The STRIVE team continue to move the Trust's leadership capacity, organisational culture and improvement work forward post COVID.

4. CQC SINGLE ASSESSMENT FRAMEWORK UPDATE

The new CQC framework is expected to be introduced in January 2023. It will result in a greater focus on workforce equality, diversity and inclusion, on partnership working, and on environmental sustainability.

The CQC will continue to use the same five domains (previously KLOES) (safe, effective, caring, responsive and well-led) to assess providers. And it will continue to use the current four-point scale for ratings (outstanding, good, requires improvement and inadequate).

Beneath each domain is a set of topic areas and quality "we" statements, which replace the current KLOE. The new statements broadly map to the KLOE although framing them as statements rather than inspection categories suggests a shift of emphasis, encouraging organisations to take ownership of the areas covered rather than being the things that are done to them by the CQC.

The CQC has also set out six evidence categories, covering the way evidence is gathered to support the quality statements:

- people's experience
- feedback from partners
- feedback from staff
- observation of processes
- observation of care
- outcomes of care

Evidence will be collected on an ongoing basis and an organisation's ratings can be changed at any time, this is a change to the current process whereby rating tend to be changed only after an inspection.

The CQC has developed its new online provider portal, which is designed to help 'collect data in a structured format that will make it easier and quicker to analyse'. This portal is due to open up to all providers this month.

Until January 2023, the way the CQC undertakes its core activity will be unchanged except the early adopter providers.

Below is an illustration of how 'well led' will change in the new framework:

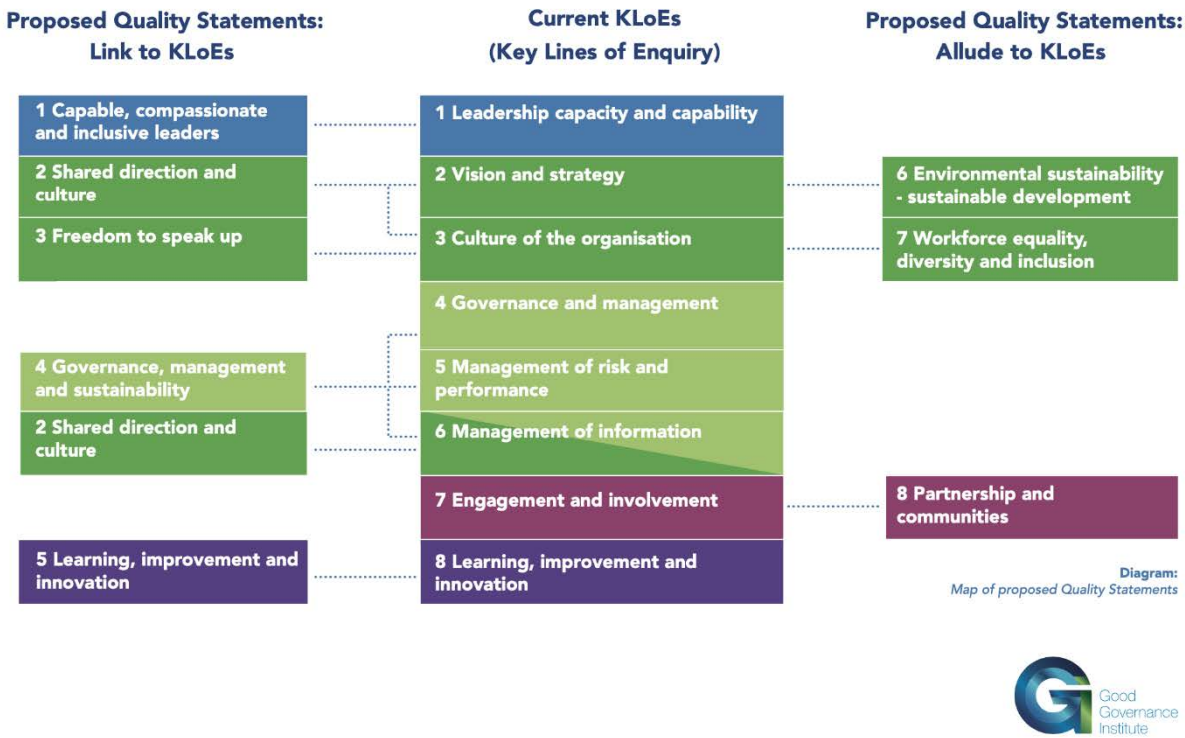


Diagram:
Map of proposed Quality Statements

5. RECOMMENDATIONS

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

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 1 NOVEMBER 2022			
Use of Seal			**AGENDA ITEM: 19, ENC 16**
Report Author and Job Title:	Jackie White Head of Governance & Co Secretary	**Responsible Director:**	Sue Page Chief Executive Derek Bell Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	In line with the Trust's Constitution this report provides information on the documents affixed under seal between 1 April 2021 to 30 September 2022		
Background	In line with the Constitution para 14.5 Register of Sealing - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and attested the seal. A report of all sealing shall be made to the next Board of Directors meeting. (The report shall contain details of the seal number, the description of the document and date of sealing).		
Assessment	There are no underlying issues for discussion regarding this report.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the sealed documents 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	Legal requirement of 2006 Act incorporated in Trust board standing orders		
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 ☒	

1.0 Introduction

The Common Seal of the Trust is affixed to documents under the authority of the Board of Directors in accordance the Trust's Standing Orders.

In line with the Trust's Standing Orders this report provides information on the documents affixed under seal between 1 April 2021 to 30 September 2022:

Table 1. Sealed Documents

Date of Sealing	Seal No	Document	Signed and Sealed by
6 April 2021	2021/01	Letter of indemnity – Emergency Care Variations	Sue Page, CEO Neil Mundy, Interim Joint Chairman
10 May 2021	2021/02	Scheme form agreement between South Tees Hospitals NHS Trust and Integrated Health Projects (Supply chain partner)	Sue Page, CEO Neil Mundy, Interim Joint Chairman
12 August 2021	2021/03	Letter of indemnity – further capital works variations	Sue Page, CEO Neil Mundy, Interim Joint Chairman
22 September 2021	2021/04	P22 FA template A – major works project NEC3 ECC Option C Target contract with activity schedule Executed as a deed (x 3 copies)	Sue Page, CEO Derek Bell, Joint Chairman
5 November 2021	2021/05	Letter of indemnity – pathology category 3 room variation Endeavour SCH PLC	Sue Page, CEO Robert Harrison, Managing Director
5 November 2021	2021/06	Letter of indemnity – pharmacy shop refurbishment variation Endeavour SCH PLC	Sue Page, CEO Robert Harrison, Managing Director
5 November 2021	2021/07	Letter of indemnity – theatre decontamination suite variation Endeavour SCH PLC	Sue Page, CEO Robert Harrison, Managing Director
5 January 2022	2022/001	P22 FA Template A – major works project NEC3 Option C Target contract with activity schedule (x 2 copies)	Sue Page, CEO Robert Harrison, Managing Director
3 March 2022	2022/002	Deed of variation of the occupational agreement which amends the boundary at Guisborough General	Sue Page, CEO Derek Bell, Joint Chairman
23 August 2022	2022/003	Letter of indemnity relating to variation no V0631	Sue Page, CEO Derek Bell, Joint Chairman

2.0 Recommendation

The Board is asked to note the documents included within the report that were affixed under seal during 1 April 2021 to 30 September 2022.

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 1 NOVEMBER 2022			
Fit and Proper Person self-declaration 2021/22			**AGENDA ITEM: 20 ENC 17**
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	The purpose of this report is to confirm that assurance has been provided on compliance with CQC Fit and Proper Person requirements, including completion of the annual fit and proper person self-declaration process for members of the Board of Directors.		
Background	The Care Quality Commission (CQC) introduced requirements regarding the 'Fit and Proper Person Test' for Directors in November 2014, which became law from 1 April 2015 and forms part of Regulation 5: Fit and Proper Persons Requirement (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.		
Assessment	All individuals who were subject to Fit and Proper Person checks during the reporting period and were eligible to take part in an in-year appraisal had done so. Through the appraisal process no matters were raised that cause concerns relating to an individual being fit and proper to carry out their role. Self-declarations for all individuals subject to Fit and Proper Person checks have been completed and a hard copy will be retained on the individual's personnel file. All returns have been reviewed and no issues have been identified that impact on the individual's ability to perform their duties as a member of the Board.		
Recommendation	The Board of Directors are asked to note this report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		

Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives (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 ☒	

Fit and proper personal self-declaration 2021/22

1. Introduction

The purpose of this report is to confirm that assurance has been provided on compliance with CQC Fit and Proper Person requirements, including completion of the annual fit and proper person self-declaration process for members of the Board of Directors.

2. Background

The Care Quality Commission (CQC) introduced requirements regarding the 'Fit and Proper Person Test' for Directors in November 2014, which became law from 1 April 2015 and forms part of Regulation 5: Fit and Proper Persons Requirement (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Fit and Proper Persons Requirement (FPPR) ensures that providers meet their obligations to only employ individuals who are fit for their role and to ensure that appropriate steps have been taken to ensure that they are of good character, are physically and mentally fit, have the necessary qualifications, skills and experience for this role and can supply certain information (including a Disclosure and Barring Service (DBS) check and full employment history, if required).

The regulations also extend to individuals who are prevented from holding the office (for example, under a director's disqualification order).

The Trust has in place a Fit and Proper Person Policy to ensure that the Trust complies with the FPPR. This policy defines checks made on appointment to director-level roles and confirms the practice to assess on-going fitness, both through the annual appraisal process and through an annual self-declaration against compliance.

This policy applies to all members of the Board (Directors) and senior staff in attendance at the Board and/or those with significant influence in reporting information to the Board for decision making. The regulations apply regardless of contract status, whether the post is an associate position and irrespective of voting rights.

3. Details

3.1 Trust Fit and Proper Person Policy and procedure

On appointment checks

All pre-employment checks will be undertaken in accordance with the NHS Employment Check Standards and the Trust's Recruitment & Selection Policy (P24). Commencement of employment cannot be undertaken by any individual with the Trust until the following appropriate checks have been fully completed satisfactorily:

1. Verification of identity
2. Evidence of right to live and work in the UK
3. Professional registration and qualifications
4. Employment history and references
5. DBS check (where relevant)
6. Occupational Health clearance

In addition to the above, a check of the following registers will be undertaken:

1. Disqualified directors
2. Bankruptcy and insolvency
3. Removed Charity Trustees
4. A web search of the individual

The new starter will be required to complete a FPPR declaration form.

Assessment of on-going fitness

The Trust's policy confirms that the annual appraisal process should be used as an opportunity to discuss continued fitness competence. The Chief Executive is responsible for appraising Director members of the Board of Directors, while the Chair is responsible for appraising the Non-executive Directors and the Chief Executive. The Chair's appraisal is led by the Senior Independent Director.

The policy also defines an annual requirement for post holders / office holders to complete a further form of declaration confirming that they continue to be a fit and proper person.

4. Conclusion

All individuals who were subject to Fit and Proper Person checks during the reporting period and were eligible to take part in an in-year appraisal had done so.

Through the appraisal process no matters were raised that cause concerns relating to an individual being fit and proper to carry out their role.

Self-declarations for all individuals subject to Fit and Proper Person checks have been completed and a hard copy will be retained on the individual's personnel file.

All returns have been reviewed and no issues have been identified that impact on the individual's ability to perform their duties as a member of the Board.

5. Recommendation

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

Jackie White
Head of Governance & Company Secretary

Meeting: Resources Committee	**Date of Meeting**: 27/10/22
Key topics discussed in the meeting	
BAF – noted the strategic threats impacting on a number of Committees, cost of living pressures, industrial action, demand pressures Month 6 Finance Report – noted the ongoing discussions to ensure that as indicated the pay award is fully funded; noted the risks to recovery of the elective recovery fund from exceptional demand pressures Cost Improvement Programme – noted the good progress being made within Collaboratives, in delivering against the 2022/23 programme and working up proposals for 2023/24 Procurement – commended the report and the proactive approach of the team Digital Programme Update – noted the development of a broader report to come to November Committee which is to capture the approach to benefit realisation and programme delivery assurance Information Governance – noted the good progress being made Green Strategy Progress – noted the good progress being made	
Actions	Responsibility / timescale
Information Governance – amend assurance from Limited to Moderate Information Governance – re-enforce to the Executive the importance of ensuring full compliance with the training module Green Strategy – to receive an update report twice annually to Committee	Executive
Escalated items	

Commend the success and innovation within the Procurement Team, securing cashable savings for the Trust and supporting quality and productivity improvements across service departments	
Risks	**Responsibility / timescale**

South Tees Hospitals NHS Foundation Trust

Meeting: QUALITY ASSURANCE COMMITTEE	**Date of Meeting**: 26 th October 2022
Connecting to: South Tees Board of Directors	
Key topics discussed in the meeting	
Wide ranging agenda reflecting the Reporting and Connecting Groups that comprise the Quality Assurance Governance arrangements. Key topics included …. • Board Assurance Framework • Integrated Quality and Performance Report • CQC Assurance Report • STAQC Report	
Actions	Responsibility / timescale
• Further work on the Board Assurance Framework , building on discussion about threats and mitigations • Additional detail on support provided to service areas initiating the STAQC accreditation process	Lead…Mrs J White , November 2022 Mrs N Cockfield. January 2023
Escalated items	
1. Chair's Log of Safer Medication Practice Group …1 escalated risk, Insulin Prescribing Audit , following up with Ms H Jones 2. " Reading the Signals" Report following the Independent Investigation into East Kent Maternity and Neonatal Services …..actions to review the recommendations and implications for maternity and neonatal services locally	
Risks (Include ID if currently on risk register)	Responsibility / timescale