South Tees Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS (PUBLIC)

Date – 6 June 2023
Time – 13:00 public access
Venue – Board Room, Murray Building, James Cook University Hospital

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 6 JUNE 2022 AT 13:00 IN THE BOARD ROOM MURRAY BUILDING JAMES COOK UNIVERSITY HOSPTIAL

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT
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 4 April 2023	Approval	Chair	ENC 2
5.	Matters Arising / action log	Review	Chair	ENC 3
6.	Chairman's report	Information	Chair	ENC 4
7.	Chief Executive's Report	Information	Chief Executive	ENC 5
8.	Board Assurance Framework	Discussion	Head of Governance & Company Secretary	ENC 6
9.	Integrated Performance Report	Discussion	Chief Operating Officer	ENC 7
SAFE				
10.	Safe Staffing Report	Information	Chief Nurse	ENC 8
EFFECTIVE				
11.	Consultant appointments	Information	Chief Executive	Verbal

	ITEM	PURPOSE	LEAD	FORMAT
12.	Sustainability Plan Update	Information	Director of Estates, Facilities & Capital Planning	ENC 9
WELL LED				
13.	Finance Report	Information	Chief Finance Officer	ENC 10
14.	Annual Filings update	Information	Head of Governance	ENC 11
15.	Provider Licence self assessment	Approval	Head of Governance	ENC 12
16.	Quality Account	Approval	Chief Nurse	ENC 13
17.	Committee Reports	Information	Chairs	ENC 14
	DATE OF NEXT MEETING The next meeting of Board of Directors will take place on 1 August 2023			

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 6 JUNE 2023			
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	2019 2022	Ongoing Ongoing	Role – Associate Consultant – Cratus Consultancy, public sector management consultancy Role – Governor and Chair of the Board of Governors, Teesside University
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	Registered with IMAS (NHS interim management & support)
Sue Page	Chief Executive	May 2018	Ongoing	President of British Red Cross – Cumbria.
Philip Sturdy	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 September 2022 September 2017 July 2022	Ongoing Ongoing Ongoing Ongoing	Director of DGR Consultancy - Company number 10340661 South Tees Healthcare Management Limited - Company number 10166808. Senior Executive Partner – Gartner Deputy Chairman – Seaton Delaval Football Club
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 April 2018	Ongoing Ongoing	Trustee Royal Medical Benevolent Fund – no remuneration Chair and Trustee Tenovus Scotland (Edinburgh) – no remuneration

		April 2021 July 2022	Ongoing Ongoing	Centre for Quality in Governance – Dormant Ltd Company 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	December 2022	Ongoing	Care and Health Improvement Programme (SLI) Advisor Occasional work with Local Government Association (LGA)
Alison Wilson	Non Executive Director	2016 4 January 2022 2017 September 2022	Ongoing 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 South Tees Healthcare Management Limited - Company number 10166808.
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 Director of LocatED Property Ltd
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 4 APRIL 2023 AT 13:00 IN THE BOARD ROOM, MURRAY BUILDING AND ON MICROSOFT TEAMS

Present

Professor D Bell	Chairman
Mr R Carter Ferris	Vice Chair / Non Executive Director
Ms A Burns	Non-Executive Director
Mr D Redpath	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
Dr H Lloyd	Chief Nurse
Mr C Hand	Chief Finance Officer
Ms S Page	Chief Executive

Associate Directors – non-voting

Ms A Gerner	Associate Non-Executive Director
Professor R Bilous	Associate Non-Executive Director

Directors – non-voting

Mrs J White	Head of Governance & Company Secretary
Mr M Graham	Director of Communications
Mr P Sturdy	Director of Estates, Facilities & Capital Planning
Mr M Imiavan	Digital Director
Mr S Peate	Chief Operating Officer
Mrs M Angel	Interim Director of Clinical Development

Patient Story

Mrs Carole Hirst attended the Board of Directors to share her story regarding her late husband's care, at the end of his life. A number of concerns were raised and discussed with the Board of Directors in a very moving story which also included a discussion regarding the Trust's response to the concerns when they were raised with the Trust.

A recording of Mr & Mrs Hirst experience is being developed, which includes the Head of Nursing discussing the detail of the action plan and the learning which will be used with staff to learn from this experience.

The Chairman on behalf of the Board of Directors thanked Mrs Hirst for attending the meeting.

BoD/23/001 WELCOME AND INTRODUCTIONS

The Chairman welcomed members to the meeting and introduced Mr Philip Sturdy, Director of Estates, Facilities and Capital Planning to his first meeting. The Chairman 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/23/002 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Robert Harrison Managing Director and Rachael Metcalf, Director of HR.

BoD/23/003 **QUORUM**

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

BoD/23/004 **DECLARATION OF INTEREST**

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

BoD/23/005 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on Tuesday 4 April 2023 were reviewed and agreed as an accurate record. Mrs White

BoD/23/006 **MATTERS ARISING**

There were no matters arising to discuss with Board.

BoD/23/007 **CHAIRMAN’S REPORT**

The Chairman highlighted a number of areas within his report including the recent industrial action and thanked to staff for supporting on this. The Chairman updated on the recent Council of Governor meeting and reminded members of the current vacancies. He discussed his routine meetings and a recent board development session which focussed on infection prevention and control, how the Trust was implementing the Patient Safety Incident Response Framework. Finally the Chairman updated on recent board walkrounds which included a presentation from specialist cancer nurses and a visit to their areas to meet the teams.

RESOLUTION

The Board of Directors NOTED the Chairman’s report.

BoD/23/008 **CHIEF EXECUTIVE’S REPORT**

The Chief Executive highlighted a number of areas within her report including the South Tees Cardiovascular Research Unit which has been funded through charitable funds from South Cleveland Heart Foundation and Our Hospitals Charity. Ms Page also updated colleagues that from 1 April the trust will be named as a major revision centre as part of a regional drive to standardise care and ensure all knee revision patients receive the right operation for their individual needs, from the right surgeon, in the right hospital.

Ms Wilson commented on the Cardiovascular Research Unit and asked what impact the Mini Mitral Trial will have in our region in relation to health inequalities and the economy. Dr Stewart advised that the trial looks at health inequalities and deprivation as measure of outcome, and the nature of cardiac valve work is extremely important for the population..

RESOLUTION

The Board of Directors NOTED the Chief Executive's update

BoD/23/009 **BOARD ASSURANCE FRAMEWORK**

Mrs White referred members to the Board Assurance Framework report and highlighted that a number of assurance reports are being received today at Board.

The Chairman asked when the Board of Directors will review the risk appetite and Mrs White confirmed this would be in conjunction with the review of the strategic objectives, BAF and principal risks in July.

RESOLUTION

The Board of Directors NOTED the BAF

BoD/23/010 **INTEGRATED PERFORMANCE REPORT**

Mr Peate referred members to the Integrated Performance Report and provided an update on the September position. Mr Peate highlighted that the Trust remains in segment 3, mandated support for significant concerns as reported previously.

Mr Peate reported that the A&E 4-hour standard and ambulance handover performance improved significantly in January, with the 4 hours standard rising above national average. He added that the number of patients who are medically fit for discharge is high and we continue to work with local authorities on improving this position.

Elective access (RTT 18-week standard) is stable and continues to perform above the national trend. The reduction

in patients waiting more than 78 weeks for non-urgent elective treatment in line with national requirements has received extra focus during January & February. Elective day case activity has driven COVID recovery as planned through the period of winter pressures.

With regard to diagnostic compliance Mr Peate commented that the 6-week standard returned to pre-Christmas levels within weeks of the holiday period. Cancer 62-day accumulation increased and remained higher for longer than anticipated post-Christmas due to pressures in some diagnostic pathways.

SDRs are compliant and he is really pleased to highlight a reduction in long waiters.

Ms Burns asked Mr Peate on his thoughts regarding the cancellation of operations non urgent on the day as this has increased. Mr Peate commented that some of this was driven by an increase in activity as the year has progressed, winter pressures anbd prioritisation for non-elective treatment. The Surgical improvement group are meeting and looking at productivity information and looking to focus on delivering further improvements in these areas.

The Chief Executive commented that the new theatre schedule should see improvements and will align to specialities who need to change their allocations. She added that the Trust has been busy and on an average there are around 100 patients waiting to go home with social care support. Mrs Angel reported that during industrial action some staff will be reassigned so there will be a reduction in activity.

Mrs Angel commented that ongoing challenges in social care placed added pressure across the system, but extra arrangements have been put in place. The transfer of care hub has now moved into the community collaborative, and the new discharge suite opens today.

Dr Stewart commented on the preparation for industrial action which will be a difficult week after a four-day bank holiday but plans are in plan.

The Chairman commented on medicine reconciliation and that the Board are hopeful they will see an uplift in some of the areas we have discussed. The Chief Executive advised that until we get to the 7-day service we will never get there. Dr Stewart commented that challenges remain in recruiting pharmacists, but we will see improvements.

Mr Peate left the meeting 13:55.

RESOLUTION

The Board of Directors NOTED the update

BoD/23/011 **SAFE STAFFING REPORT**

Dr Lloyd referred members to the safe staffing report and highlighted the percentage of shifts filled against the planned nurse and midwifery staffing across the trust remains stable, demonstrating continued good compliance with safer staffing. Staffing has improved across all collaboratives allowing for a reduction in all shift fill incentives via NHSp from 1st April 2023.

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

Dr Lloyd reported that this trust remains one of the lowest in the country for nursing turnover.

Dr Lloyd updated on a number of recruitment sessions which had been held including the work on international recruitment. She updated on a programme working with displaced refugee nurses and a pilot working with the spouses who are registered nurses in their own country working on a programme of employment as healthcare assistants.

Dr Stewart commended the work that team are doing with HR and recruitment.

The Chairman commented that on his recent visit to the Friarage the staff had reported that staffing levels good.

RESOLUTION

The Board of Directors NOTED the safer staffing report

BoD/23/012 **LEARNING FROM DEATHS REPORT**

Dr Stewart referred members to his previously circulated report and highlighted 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 106 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: 38 reviews were completed in February 2023.

He added that 100% of all deaths of Learning Disability patients and 99% of mental health patients received a full mortality review with no care failings in the quarter.

Dr Stewart referred members to the learning which was described in section 4 of the report and also commented that Miya and great north health record will help drive improvements.

Ms Wilson asked if the spread on table 4 is how Dr Stewart would expect to see it and he confirmed that this was in line with expectations.

Ms Davidson commented that the Quality Assurance Committee received the learning from deaths report routinely and there had been a lot of discussion on this at the last meeting. She added that the Committee discussed plans to address the accumulation and prioritisation of cases.

RESOLUTION

The Trust Board of Directors NOTED the report

BoD/23/013 **CONSULTANT APPOINTMENTS**

The Chief Executive commented regarding the consultant appointments and updated members on the starters and leavers:

Starters

Joanne Ashton – Paediatrics
Ahmed Osman – Anaesthetics
Victoria Pennock – Paediatrics
Swathi Pinto – Cardiac Anaesthetics
James Bassett – Trauma & Orthopaedics
George Thomas – Stroke

Leavers

Chris Fisher – Neurology (due to retire 31/3/23)

Dr Stewart commented on the joint appointment of the stroke consultant.

BoD/23/014 **PATIENT EXPERIENCE AND INVOLVEMENT REPORT**

Dr Lloyd presented the patient experience and involvement report and highlighted that the Trust is above or equal to the National average in all services for the Friends and Family Test (FFT).

The Trust achieved 99.30% compliance with the 3 working day acknowledgement of all complaints.

The timeframe to respond to formal complaints remains below the trust 80% target. During the six-month period the timeframe to respond had improved over four consecutive months, however, reduced in February. This continues to be monitored weekly.

The number of further contracts (re-opened complaints), following closure, has decreased from the previous six-months.

The number of informal concerns to PALS has decreased.

Parliamentary and Health Service Ombudsman requests have slightly increased. Three cases were closed at assessment, two final reports were received, one was not upheld, and one was partially upheld.

Finally, Dr Lloyd added that in partnership with Healthwatch, three workshops were held with service users throughout February to support the drafting of the patient experience and involvement strategy.

Mr Redpath commented on Table 2 Complaint closure timeframe which shows that whilst the 80% target has not been achieved. Dr Lloyd advised that the last two years we had Covid which has impacted; but she had reviewed the last 2 months. She added that there is a clear plan for the next quarter working with Collaboratives to get complex cases closed off and she has brought in more staff to support on this.

Mr Redpath thanked Dr Lloyd for her update and asked for more information in relation to re-open complaints which Dr Lloyd agreed to share. Dr Lloyd

Mr Readshaw commented that he recognised we are digitally immature in the area of patient record hopes we can address some of the issues.

Professor Bilous commented on assurance that lessons learned are retained and Dr Lloyd agreed.

Ms Burns reported that there had been a good discussion and examples give at the Council of Governors meeting last week and that there are a set of metrics she is interested in and feel these would be good to have going forward. She added that these would be related to communication eg how fast we answer the telephone and what proportion of calls are abandoned, how many clinics or outpatient appointments are cancelled. Dr Lloyd thanked Ms Burns for raising these and added that communication is one of the key issues which has come out of the workshop which has been held to develop the Patient Experience and Involvement Strategy; metrics on

answering the telephone will be included in the strategy going forward.

Dr Stewart commented that there had been a good discussion at CPG on Patient Connect which will enable those patients who have access to technology to do more on line and free up resource for staff for telephony. He added that CPG will receive more details on this next month and can give assurance through the Chair's report.

Mr Imiavan reported that at the Resource Committee last week considered the patient experience portal was discussed and it was agreed we would have more detailed discussions with partners and suppliers on this in terms of implementation. Using the NHS app, we will use that as part of the experience portal.

Mr Imiavan also discussed data on the issues Ms Burns raised agreed to look into this for her.

The Chairman asked if we can start to build in some preliminary analysis of these issues and Dr Stewart commented that we could, however it's not something we have included before and it would be very good to start looking at these operational issues from a patient experience perspective.

RESOLUTION Mr Imiavan

The Trust Board of Directors NOTED the update

BoD/23/015 **STAFF SURVEY**

Mrs White reported that as Mrs Metcalf was on annual leave and there was a Board development session planned on the staff survey it was proposed that the report was taken for information with the opportunity to discuss the detail in the development session.

RESOLUTION

The Trust Board of Directors NOTED the update

BoD/23/016 **ANNUAL FILINGS UPDATE**

Mrs White updated that the Trust has a statutory requirement to produce a number of key documents as part of its annual filings following the end of the financial year. These include the Annual Report, Annual Accounts, Annual Governance Statement and Quality Report (Account).

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

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

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

RESOLUTION

The Trust Board of Directors APPROVED to delegate responsibility to the Audit & Risk Committee and Quality Assurance Committee for signing off the annual filings on behalf of the Board

BoD/23/017 **FINANCE REPORT**

Mr Hand presented the finance report for month 11 and members noted the Trust reported a deficit of £19.8m at a system control-total level. The Trust is on plan year-to-date. Following regional and national discussions regarding the level of pay award funding allocated to the Trust and ICB the Trust has received further funding to cover the cost of the national pay award.

Ms Wilson commented that the Board should give recognition of the impressive outturn of the CIP program and to give thanks to the finance team and Collaboratives for the work they have done.

The Chairman asked regarding the R&D income which was ahead of plan and if there is there anything specific and Dr Stewart commented that it related to the Novavac income trial.

Mr Hand left the meeting at 13:40

RESOLUTION

The Trust Board of Directors NOTED the update

BoD/23/018 **COMMITTEE REPORTS**

The Chairman offered the Chairs of Committees the opportunity to highlight any issues not already discussed at the Board in relation not the agenda:

QAC – Ms Davidson commented on an excellent presentation from ED colleagues which was full of practical information.

Resources – Mr Redpath added that there had been an extra ordinary meeting to discussed the draft finance plan. Meeting last week and chair's log will be issued next meeting.

Business cases considered and supported in principal but not approved – further work to be undertaken in particularly productivity, benefits realisation and benchmarking. Digital – some concerns with dates of projects and benefits realisation. Going forward there will be an impact on realising benefits and productivity. Hard work and effort from the Finance team who continue to work considerably hard.

People – Mr Dias commented that there had been a deep dive into staff wellbeing and absence management, assurance around work HR team are doing was good and further work to do around leadership capability and quality and application of processes to support staff back to work linking to the values. Thank HR team on supporting collaborative on this piece of work.

Audit & Risk – Mr Readshaw commented on two reports: working on risk management improvement plan with a focus on completeness of risk system, heat mapping and training needs in terms of risk management. Risk Manager appointed and positive step forward.

BoD/23/019 **DATE AND TIME OF NEXT MEETING**

The Board of Directors will meet on Tuesday 6 June 2023.

Signed: ……

Date: ……

Date							
Date	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
04.04.23	BoD/23/014	PATIENT EXPERIENCE AND INVOLVEMENT REPORT	More information in relation to re-open complaints to be shared with D Redpath	Hilary Lloyd	30.06.23		Open
04.04.23	BoD/23/014	PATIENT EXPERIENCE AND INVOLVEMENT REPORT	Data on how fast we answer the telephone and what proportion of calls are abandoned, how many clinics or outpatient appointments are cancelled and a nutrition rate / loose contact with patients to be shared with Ms Burns	Manni Imiavan	30.06.23		Open

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 6 JUNE 2023			
Joint Chairman's update			**AGENDA ITEM: 6, ENC 4**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Professor Derek Bell Joint Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Joint Chairman's update		
Background	The following report provides an update from the Joint Chairman.		
Assessment	The report provides an overview of the health and wider related issues.		
Recommendation	Members of the Trust Board are asked to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

Joint Chairman's Update

1. Introduction

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

2. Key Issues and Planned Actions

2.1 Industrial Action

Further industrial action by Junior Doctors took place over a four day period from 11 – 15 April. Members of the Hospitals and Specialists Association (HCSA) and dental trainee members of the British Dental Association also took part in the strike. I would like to place on record thanks to all staff for their ongoing support.

2.2 Joint Collaborative Working

Earlier this week a further meeting of the Joint Partnership Board took place at the University Hospital of North Tees.

2.3 Joint Council of Governors

A joint Council of Governors meeting between both North Tees and South Tees took place on 16 May. Other joint sessions including membership and engagement are also planned.

2.4 Hewitt Review

The Rt Hon Patricia Hewitt's review into the role and power of integrated care systems (ICS) was published earlier this month. The report outlines the significant opportunity of partnership working across an ICS between local government, NHS social care providers and voluntary care, faith and social enterprises (VCSFE). Key themes included greater collaboration, a smaller number of shared priorities, the balance between freedom and accountability and the use of timely, relevant high-quality data. There were several recommendations in respect of funding which included greater flexibility to allocate funds, invest in prevention and align government departmental budget to reduce small in year funding and associated challenges.

2.5 Tees Valley Integrated Care Partnership (ICP)

A meeting of the Tees Valley Area ICP took place on 31 March. An overview of the structure and governance arrangements of the North East North Cumbria Integrated Care Board (NENC ICB) was provided including the role and expectations of the ICPs. The development of Place Based Working was described, highlighting the link between Place Based Partnerships and Health and Wellbeing Boards and supporting delivery of the Better Health and Wellbeing for All Strategy's four key aims: Longer and healthier lives; Fairer outcomes; Better health and care services and Giving our children the best start in life. A copy of the co-produced TEWV Community Transformation Report by the Tees Valley Healthwatch Network and Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) was circulated, which set out the output from an engagement exercise and subsequent aims to support TEWV in delivering a new mental health community-based offer.

2.6 Routine meetings

I continue to meet with colleagues within the Trust and have recently attended the Board meeting of the Growing the Friarage & Community Services Collaborative, the Trust Patient Safety Day and met with Teesside University with Dr Stewart to discuss collaborative working and future workforce requirements.

2.7 Board development session

We met on 2 May for a Board development session and had a very interesting presentation on health inequalities and discussed the work the Trust has been undertaking in this area and some key measures we may wish to review going forward. The Board also had a good discussion and review of the results of the staff survey focussing on two of the areas. Finally, a board walk around was undertaken with the cancer nurses.

3. Recommendation

The Board of Directors are 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 – 6 JUNE 2023			
Chief Executive update			**AGENDA ITEM: 7** **ENC 5**
Report Author and Job Title:	Mark Graham, Director of Communications	**Responsible Director:**	Chief Executive
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Chief Executive update		
Background	The following report provides an update from the Chief Executive.		
Assessment	The report provides an overview of the health and wider related issues.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒		

Care Quality Commission (CQC)

On 24 May the Care Quality Commission (CQC) published the results of the trust's first full re-inspection since 2019 when the organisation was rated as 'Requires Improvement'.

Since 2019, the trust has undergone significant change. We now place clinical leadership, in the interests of patients, service users and colleagues, at the heart of the way we make decisions on how our limited resources are allocated and care is delivered across the trust – placing the clinical and patient voice at the heart of decision-making.

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

In 2021, our CPG created ten clinically-led collaboratives (service groups) - natural care communities of surgeons, physicians, nurses, midwives, scientists, allied health professionals and administrative and support colleagues, which have come together to make their services even better for our patients.

Each of our ten collaboratives is chaired by an experienced clinician and, together with our executive directors, they form our senior leadership team.

At the heart of our clinical collaboratives is our Leadership Improvement and Safety Academy which provides a range of support, including leadership and management training, quality improvement skills, team and service support, coaching and human factors training.

As one example, through empowering front-line teams, colleagues reinstituted the trust's ward and service quality accreditation programme which had been removed prior to 2019.

In another, since the trust has seen the largest improvement nationally in the number of colleagues who would recommend the organisation as a place to work (+16%) alongside an 11% increase in the number of colleagues who say patient care is the trust's number one priority.

Following our latest inspection, which took place over the winter (2022/23) the CQC has raised the trust's overall national rating from 'Requires Improvement' to 'Good' - making South Tees Hospitals NHS Foundation Trust one of the first acute hospital trust in mainland England since the start of the COVID-19 pandemic in 2020 to achieve an overall rating increase to 'Good'.

In addition, inspectors also raised the trust's leadership rating (well led) from 'Requires Improvement' to 'Good'. The trust was also rated 'Good' in the safe, effective, caring and responsive domains.

These are the foundations of larger change. Our commitment to leading-edge clinical research, education, training and innovation – with the needs of our patients, service users and colleagues at the centre – is at the heart of the next phase of our clinically-led journey.

There is still more work to do, and we are committed to working tirelessly to raise our standards even higher in collaboration with our partners and communities over the coming months and years.

NHS recovery

Over the five weeks to 16 May, our surgical delivered over 3,200 operations, of which more than 2,500 were planned surgical procedures. At the same time, radiology colleagues carried out more than 32,000 diagnostic scans, and clinicians held almost 24,000 outpatient appointments. During the same period, 17,800 people attended our urgent and emergency care services.

Alongside the work taking place in hospitals, our community teams are supporting more patients to receive the care they need, closer to home. In the last month, for example, our urgent community response teams provided urgent care to over 600 people in their homes, helping to avoid unnecessary trips to hospitals.

In addition, the trust continues to work closely with local authorities to seek to ensure that people who are ready to leave hospital with social care support can access this as quickly as possible.

Cancer care award

In April, the James Cook University Hospital's haematology team received the Myeloma UK Clinical Service Excellence Programme (CSEP) Award in recognition of its outstanding care and dedication to patients with myeloma, an incurable blood cancer which claims the lives of 3,000 people in the UK each year.

This is the second time The James Cook University Hospital has received the award, which is only presented to a small number of hospitals every four years.

Radiology awards

Also in April, radiology colleagues were recognised in the annual Society of Radiography National Awards.

Radiology uses imaging technology to diagnose and treat disease and includes X-rays, CT (computed tomography) and MRI (magnetic resonance imaging) scanning.

The team received two national awards for their creation of a training system to help develop and upskill radiographers to become consultant radiologists, and the introduction of changes that have enabled them to more than double the number of test reports they produce for doctors and their patients.

Lung cancer treatment

A new leading-edge procedure for the minimally invasive sampling of possible lung cancers is being offered at The James Cook University Hospital, thanks to a successful collaboration between respiratory and cardiothoracic teams.

In response to the high number of lung cancer cases across the region served by the trust, the organisation invested £500,000 in the Cios Spin Portable CT scanner, to be used alongside Medtronics navigational bronchoscopy equipment, combining the technology of a CT scanner with software that generates a "roadmap" to lung abnormalities.

The procedure, which is only offered in a small number of hospitals across England, involves the insertion of a small tube into the lungs via the mouth, while the patient is under a general anaesthetic.

Having the equipment at The James Cook University Hospital means biopsies on lung abnormalities can be carried out up to six months sooner than they would using exiting pathways, resulting in earlier detection of lung cancer and making curative treatment more likely.

The procedure also significantly reduces risks associated with traditional methods for obtaining lung biopsies – and in six months' time the hospital will also have the ability to use the equipment to ablate (remove) lung tumours from within the lung, as an alternative to radiotherapy treatment.

Extended post anaesthetic care unit (PACU)

From May, patients recovering from surgery at The James Cook University Hospital are now able to do so in The James Cook University Hospital's newly refurbished post anaesthetic care unit (PACU).

The unit cares for patients who are recovering from anaesthesia and major procedures that require closer monitoring and high nursing care initially post op.

Patients typically stay on the unit, which is in the heart of the hospital's operating theatres, for a night or two following their operation.

Previously the unit, which opened in 2019, had room to care for up to five patients at one time.

But thanks to its recent expansion there is now space for eight beds, including four larger areas which can be used as critical care surge beds.

Friarage surgical hub

A ground-breaking ceremony has officially marked the start of building work on the Friarage's new surgical hub, which will enable the hospital to more than double the number of planned operations it carries out each year.

When complete in 2025, the new facility will replace the hospital's six existing operating theatres with a modern surgical hub that will include six main operating theatres, two minor operating theatres, and a surgical admission and day hub.

2. RECOMMENDATIONS

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

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 6 JUNE 2023			
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 continue to review their BAF risks on a monthly basis. The BAF is a live document and therefore as part of the horizon scanning work, new threats can be added at any time. 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 of Directors which are detailed below. In addition, The Chairs report references a meeting which the CMO and Chair attended at Teesside university regarding the further workforce.		

	Health inequalities are mentioned in the Chairs report following the board development session and in the IPR. The Chief Executive briefs in her report the outcome of the recent CQC inspection which provide assurance across a number of gaps.	
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 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 has ***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 range from 9 High to 20 Extreme taking into account the mitigations.

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.

Assurance ratings for each of the BAF threats have been considered by each of the Committees and added to the report IN February 2023.

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

- Integrated Performance Report

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

- Safe Staffing Report
- Integrated Performance Report

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

- Integrated Performance Report

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

- Finance Report
- Integrated Performance Report

3.2 Additional Assurances

The Board received an update on the work of the health inequalities group including the possible measures to review progress at a Board development session in May.

The Board received an update on the staff survey an in particular discussed two areas which the Trust will take forward as a priority at a Board development session in May.

Resource Committee received assurance from NHS England on the "one day" review of finance and financial governance in the Trust.

4. RECOMMENDATIONS

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

South Tees Hospitals
NHS Foundation Trust

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.

South Tees Hospitals
NHS Foundation Trust

Principal risk - 1 (what could prevent us achieving this strategic priority)	**Inability to achieve standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes**	**Strategic Objective**	**Best for safe, clinically effective care and experience**

Lead Committee	Quality Assurance Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**	**Risk 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	19 May 2023	**Risk Rating**	16. Extreme	16. Extreme	9. High		
Date of next review	June 2023						

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	**Management:** Learning from deaths Report to QAC and Board quarterly March 2023 SI/NE report to QAC and Board monthly March 2023 EoLC Strategy and Annual Report to QAC Senior leadership walk arounds weekly Guardian of Safe Working report to People Committee and Board quarterly Safeguarding Adults & Children quarter 3 report to QAC Safeguarding Adults & Children Annual Report 2021/22 to QAC 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 March 2023 AHP Strategy drafted received by People Committee CQC insights report reviewed by QAC 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 March 2023 Health & Safety meeting escalation report to QAC Urgent items for escalation at QAC monthly	Patient experience strategy to be developed to ensure the full extent of patient experience and involvement data is known– Hilary Lloyd – ~~updated date April 2023~~ date changed to May 2023	**Moderate**

	• Shared learning on quality and safety via weekly, monthly briefings Trust wide and at CPG/SLT • Medical Examiner's office in place	**Independent assurance:** CQC Rating and oversight (monthly relationship) ICNARC Quarterly Report to Clinical Effectiveness Group 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 Internal Audit report – quality assurance and clinical governance – low risk – QAC May 2023		
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 IPC report to QAC May 2023 **Risk and Compliance** IPC Committee escalation report to QAC IPR quality metrics report to QAC and Board monthly Cleaning standards report to IPC group Board development session on IPC May 2023 **Independent Assurance** IBAF CQC review PLACE assessment and scores Internal Audit report on data quality (IPC/ANTT) medium risk – QAC May 2023		Moderate
1.3 Arising from a lack of engagement with staff at all levels around cultures and behaviours required to embed best practice,	Trust vales and behaviours agreed and shared with staff Just culture, Civility and Human factor training Ward accreditation programme Reciprocal mentorship programme	**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		**Moderate**

continuously learn and deliver high quality patient care.	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 Patient Safety Ambassadors recruitment and appointment process	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 Monthly Patient Safety Incident Management Report March 2023 **Risk and Compliance** Reciprocal mentorship programme reported through People Committee **Independent** National Staff survey results Freedom to speak up national survey Feedback from NHSE/I on review of never events Internal Audit report – quality assurance and clinical governance – low risk – QAC May 2023		
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 Cancer breaches report to QAC January 2023 ED presentation to QAC February 2023 IPR report to Resources Committee monthly – elective recovery **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		**Moderate**

		Independent Assurance ECIS improvement work on patient flow Internal audit of patient flow Internal Audit report on waiting lists – medium risk – Resources Committee May 2023 Internal Audit report – quality assurance and clinical governance – low risk – QAC May 2023		
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 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	**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 PBC approved and construction commenced Capital Programme for this financial year 22/23, underway Quarterly updates on Capital to Resources Committee Estates paper presented to Board January 2022 Ward 8 released for lifecycle work June 2022 Ward 7 started on 17 April 2023 **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	Outcome of new hospital bid – Phil Sturdy TBC Impact of critical infrastructure assessment by PFI company awaited – Phil Sturdy – initial desk top feedback May 2023) – full physical inspection outcome report (June 2024) Outcome of PLACE assessments 2022/23– May 2023 Phil Sturdy	**Moderate**

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	19 May 2023	**Risk Rating**	15. Extremely High	15. Extremely High	10. High		
Date of next review	June 2023						

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 Cyber report to Resources Committee April 2023 **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 BitSight cybersecurity rating – Advanced March 2023 Internal audit report on IT Disaster recovery – high risk Resources Committee May 2023 Internal Audit report – quality assurance and clinical governance – low risk – QAC May 2023	Periodic red team exercise that covers unplanned outages of our computer systems and the restoration of service and effectiveness of data backup process – date to be confirmed – Manni Imiavan through Resources Committee Lessons drawn from cyber incidents affecting public and private sector organisations e.g. Advanced One and the eFinancial system date to be confirmed – Manni Imiavan through Resources Committee	**Moderate**
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	**Management** **Risk and compliance** Business Continuity Plan report to Audit & Risk Committee February 2022 **Independent assurance** EPRR report	Testing of business continuity plans not routinely undertaken in all specialities – plan to be shared – D Hurley June 2023 Audit & Risk Committee Aim to test all BCPs during 2023 – D Hurley – plan to be shared D Hurley June 2023 Audit & Risk Committee	**Moderate**

	Training and testing exercises undertaken annually Annual assessment against EPRR core standards On call arrangements in place	EPRR Core Standards compliance report Internal Audit report – quality assurance and clinical governance – low risk – QAC May 2023	Review of the Major Incident Plan overdue. D Hurley – Audit & Risk Committee June 2023 Simulation Exercise panned 8 December with MDT and learning from that exercise will inform the update of the Major Incident Plan – ~~March 23~~ – M Stewart/EPRR Leads – updated June / July (pending IA)	

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	19 May 2023	**Risk Rating**	9. High	9. High	9. High		
Date of next review	June 2023						

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	**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**	Impact of workforce shortages on existing workforce (workforce plan) – Rachael Metcalf 31 May 2023 Lack of systematic approach to talent management and succession planning – Rachael Metcalf 31 September 2023 Implement retention strategy linking with Belonging objective – Rachael Metcalf – 31July 2023	**Moderate**

	Staff networks in place for some protected characteristics Contracting arrangements in place for SERCO and sub contractor workforce at the Trust Year on year increase in volunteer workforce Nursing & Midwifery Strategy Workforce plan and accountability framework	NHSI use of resources report 2018 CQC inspection report July 2018 NHS staff survey 2020 results showing improvement in a number of areas NHS Staff survey 2021 results showing improvements in a number of areas		
3.2 Poor health and absence within our workforce creating service pressures impacting their ability to deliver a high quality service	Welfare calls to staff who are absent Health & wellbeing support programme Staff weekly briefing Psychology support and mental health support Occupational Health and counselling and physio service Wobble rooms established across sites for staff to recover and recoup Project Wingman (staff rest and support programme) Long covid clinics for staff Menopause programme insomnia intervention programme and fatigue support Flu and covid vaccination programme Hardship fund for staff Policies and procedures in place for managing absence	**Management** Quarterly reports to People Committee on the Health & Wellbeing 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 Deep Dive into wellbeing include staff absence March 2023 People 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 redployment	Impact of flexible working options for staff – Rachael Metcalf 31 August 2023	**Moderate**
3.3 Belonging	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;	Increase engagement score (staff survey plan and you said we did) – Rachael Metcalf 30 June 2023 Implementing the ESR automation service to allow further autonomy in the workforce – Rachael Metcalf – 31 October 2023	**Moderate**

		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		
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 by Collaborative_– Rachael Metcalf 31 November 2023 Evidence of promotion opportunities for colleagues from protected characteristic backgrounds- Rachael Metcalf – 31 November 2023 (see above) Impact of increased representation of protected characteristics on each recruitment panel – Rachael Metcalf 28 February 2024 Impact of reciprocal mentorship programme on recruitment and retention(breaking the glass ceiling) - Rachael Metcalf 28 February 2024	**Significant**
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	Impact of the Leadership, Improvement and Safety Academy – Ward partnership model; May 2023 Jennie Winnard Impact of Cohort Leadership Development; July 2023 Jennie Winnard Evidence of career progression following attendance at Leadership and Improvement Courses; September 2023 Jennie Winnard and Rachael Metcalf Impact of Distributed leadership programme; August 2023 Jennie Winnard	**Moderate**

			Evidence of impact of large scale education and training; November 2023 Jennie Winnard	
3.6 If industrial action is taken by staff, then it could lead to a reduction in workforce availability and a consequent reduction in our ability to provide services	Trade Union meetings Discussions with Trade Unions on derogations and principals and duties in relation to industrial action Industrial action committee Industrial action protocol Staff information on intranet Safer staffing meetings EPRR coordination in place including links with local, regional and national contingency planning Information for patients Review of lessons learnt following previous industrial actions Business continuity plans in place Ongoing discussions with staff Review of critical and non critical services and delivery impact	**Management** Monthly update to People Committee Safer staffing report to Board EPRR incident coordination and minutes of meetings IA incident group – daily strategic Risk assessments **Risk and compliance** Reports to CPG on planning and assurance **Independent Assurance**		**Significant**

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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	19 May 2023	**Risk Rating**	8. High	8. High	8. High		
Date of next review	June 2023						

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 develop 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 Wards currently with STACQ accreditation 01 07 22 – STACQ Board update – Seminar May 2022 Board seminar on Improvement Plan June and July 2022 Leadership programme – Recovering together 2022 STACQ accreditation update to QAC January 2023 CQC report to QAC March 2023 **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**	Patient Safety Ambassadors – Kate Jones & Vince Connolly – Patient Safety Framework report ~~January 2023~~ date changed to May 2023 Improvement Councils & Transformation Groups -report out of improvement work – Nyree Legge, May 2023	**Moderate**

		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 ED report to QAC February 2023 **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 CNST submission and report to Board January 2023 **Independent Assurance**	Outcome of CQC inspection of surgery, medicine, ITU and emergency care and outcome of improvement journey – carried out November 2022 – ~~January 2023~~ updated to ~~April 2023~~ May 2023 Oversight of the plan for fragile or vulnerable services from a quality assurance perspective as documented in the Improvement Plan v3 – July 2023 Mike Stewart	**Moderate**
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**		**Significant**

		MOU with Teesside University for strategic links Collaborations with HEIs R&D & I event held May 2023 **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** Starters and leavers report to Board **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 via People Committee May 2023	**Moderate**

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	30 May 2023	**Risk Rating**	9. High	8. High	8. High		
Date of next review	June 2023						

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 Communications Cell in place to manage communications	**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 CF report received, discussed and agreed by JPB Communications plan in place for outcome of CF report Meetings with Governors including joint briefings High level timeline of implementation of recommendations agreed by JPB – Derek Bell, February 2023 Programme Group established and TOR drafted March 2023 **Risk and Compliance** Tees Valley Executive Leadership Group attended by Managing Director Member of Provider Collaborative NENC Sam Allen assurance / induction visit to Trust ICB in attendance at JPB Provider Collaborative Clinical Strategy Day 26 May 2023 – CMO / CNO **Independent Assurance** Provider licence modifications lifted in relation to governance		

		NHS E (National) one day review report received by Resources Committee April 2023		
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** Provider Collaborative Clinical Strategy Day 26 May 2023 – CMO / CNO Board Development session - Health Inequalities Group May 2023 **Independent Assurance**	Service reviews to be scheduled on a three year rolling programme, overseen and agreed by CPG – report from CPG – Michael Stewart – TBC Improvement Plan Phase 3 to Board in July 2023	
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 Portability plan in place agreed at JPB March 2023	**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 – report on partnership work to Board - Mike Stewart / Derek Bell June 2023	
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 Board Development session - Health Inequalities Group May 2023	Appointment of Public Health Consultant – joint post with LA – January 2023	

		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 Portability agreement in place for IT and car parking March 2023 Strategic advice in place	**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 Joint Committee (using new HCA 2022) established TOR agreed CF report received, discussed and agreed by JPB Communications plan in place for outcome of CF report Meetings with Governors including joint briefings Schedule 1 delegated authority agreed for approving CF report in JPB – December 2022 Resources Plan agreed March 2023 Principles agreed March 2023 Programme Group established with TOR agreed March 2023 High level programme plan and workstreams agreed March 2023 **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**	MINIMAL
Initial date of assessment	September 2022	**Consequence**	4. Major	4. Major	4. Major		
Last reviewed	19 05 12	**Risk Rating**	12. High	12. High	12. High		
Date of next review	June 2023						

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 NHS E (National) one day review report received by Resources Committee April 2023	Development of a longer-term financial recovery plan jointly with ICB – Chris Hand, March 2023 Outcome of B2B meeting with NHSE scheduled for June 2023, Chris Hand	**Moderate**
6.2 Insufficient time afforded by the regulator to develop and implement a recovery plan	Medium Term Financial Plan Resources Committee Trust Board Joint Strategy Board ICP Finance Directors ICS Finance Directors Tees Valley CEO meeting ICS Management Executive Clinical Strategy and Improvement Group CIP Group established with weekly meetings in place PMO and programme management established Improvement Councils established	**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		**Moderate**

	Additional resource provided and Kingsgate commissioned to support CIP process	Fair share briefing to Resources Committee March 2023 **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 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 ICB Resource Allocation Group Provider Collaborative Group	**Management** ICS/ICP updates through Finance report and CEO report to Committees and Board JSB MOU & TOR COVID financial framework Fair share briefing to Resources Committee March 2023 **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 NHS E (National) one day review report received by Resources Committee April 2023		**Moderate**
6.4 Insufficient capital resources available across the ICS to support the phasing of the Trust's	PFI Contract management Capital planning group Planned maintenance programme Premises assurance model (PAM) undertaken	**Management** Chairs log from H&S Group to QAC regarding Medical Quarterly update to Resources Committee on Capital	Development of a longer term capital plan– Phil Sturdy, ~~March 2023~~ updated timescale June 2023	**Moderate**

capital investment requirements	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 ICB resource allocation task and finish group Provider Collaborative Group	PFI contract management Lifecycle report to Resources Committee Fair share briefing to Resources Committee March 2023 **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 NHS E (National) one day review report received by Resources Committee April 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 ICB resource allocation task and finish group Provider Collaborative Group	**Management** ICS/ICP updates through Finance report and CEO report to Committees and Board JSB MOU & TOR Fair share briefing to Resources Committee March 2023 **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 NHS E (National) one day review report received by Resources Committee April 2023		**Moderate**

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	MINIMAL
Initial date of assessment	September 2022	Consequence	4. Major	4. Major	4. Major		
Last reviewed	19 05 12	Risk Rating	20. Extreme	20. Extreme	12. High		
Date of next review	June 2023						

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 SIO office	**Management** Directorate level finance reports Annual report and accounts National Cost Collection and PLICs reports to Resources Committee Financial structure update Establishment of SIO External support CIP quarterly report to Resources Committee Finance to Board and Resources Committee monthly including CIP progress IPR report to Board and Committees **Risk and compliance** Annual Governance Statement Provider licence self-assessment Board Development sessions and Board reports on 2022/23 financial position and system savings HFMA Financial Sustainability self-assessment to Audit Committee September, November 2022 HFMA Financial Sustainability action plan update / completion report to Audit & Risk Committee April 2023 B2B meeting September 2022 – presentation of model hospital and increase WTE in finance staff **Independent assurance** Internal audit External audit NHSE/I monthly finance monitoring Letter of acknowledgement of receipt of plan and ICS management Business case for additional external support to be agreed	Handover plan from Kingsgate for Trust and SIO – Chris Hand, ~~May 2023~~ June 2023	**Moderate**

		Final Report Financial Sustainability, Final Report to Audit & Risk Committee November 2022 HFMA PWC report to Audit Committee November 2022 NHS E (National) one day review report received by Resources Committee April 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 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	**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 Business case process and benefits realisation report to Resources Committee April 2023 **Risk and compliance** Finance report to Board, Resources Committee Procurement report to Resources Committee Board Development sessions HFMA Financial Sustainability self-assessment to Audit Committee September, November 2022 HFMA Financial Sustainability action plan update / completion report to Audit & Risk Committee April 2023 **Independent** Going concern and financial controls audit as part of External and Internal audit programme NHSE monthly finance monitoring Final Report Financial Sustainability, Final Report to Audit & Risk Committee November 2022 HFMA PWC report to Audit Committee November 2022 NHS E (National) one day review report received by Resources Committee April 2023		**Moderate**
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	**Management** Directorate level and department level finance reporting Budget sign off ICS/ICP updates through Finance report and CEO report to Committees and Board		**Moderate**

	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	Financial structure update Business case process and benefits realisation report to Resources Committee April 2023 **Risk and compliance** Finance report to Board, Resources Committee Procurement report to Resources Committee HFMA Financial Sustainability self-assessment to Audit Committee September, November 2022 HFMA Financial Sustainability action plan update / completion report to Audit & Risk Committee April 2023 **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 Final Report Financial Sustainability, Final Report to Audit & Risk Committee November 2022 HFMA PWC report to Audit Committee November 2022 Procurement and Contract Management Internal Audit Report – Medium Risk – Resources Committee May 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 Internal Audit report on waiting lists – medium risk – Resources Committee May 2023		**Moderate**
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	**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**		**Moderate**

	Medical Devices Group overseeing medical equipment Asset register maintained ICB resource allocation task and finish group	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 NHS E (National) one day review report received by Resources Committee April 2023 Procurement and Contract Management Internal Audit Report – Medium Risk – Resources Committee May 2023		
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 ICB resource allocation task and finish group	**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. NHS E (National) one day review report received by Resources Committee April 2023		**Moderate**
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	**Management** Chairs log from H&S Group to QAC PFI contract management Lifecycle report to Resources Committee Capital update report to Resources Committee Business case process and benefits realisation report to Resources Committee April 2023 Procurement report to Resources Committee January 2023 updating on learning from cyber		**Moderate**

	Asset register maintained Digital Director appointment made and commenced in post August 2021 ICB resource allocation task and finish group	**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 report on IT Disaster recovery – high risk Resources Committee May 2023 Procurement and Contract Management Internal Audit Report – Medium Risk – Resources Committee May 2023		
7.8 Failure to advance digital maturity will impact on efficiency, care quality and safety	Business case for MIYA IT Business Continuity and Incident Management plans Programme for upgrade to Network infrastructure Capital Investment approved and programme of delivery for identified capital plan including infrastructure and desk top hardware Digital Strategy group MIYA programme board Engagement on GNCR SIRO Digital leadership meeting in place fortnightly NED and Associate NED appointed with digital skills background Digital Director appointment made and commenced in post August 2021	**Management** Business Case for MIYA approved by Board Digital updates to Resources Committee monthly IG update to Resource Committee June 2022 Briefing on proposed process for benefits realisation to Resources Committee March 2023 **Risk and compliance** Digital roadmap produced and included in Improvement Recovery Plan for Board Digital operability report to JPB **Independent assurance** NHS digital review of Tees Valley PWC have completed audits of Cyber Security and the Data Security & Protection toolkit. Digital governance audit by PWC – high risk Internal audit report on IT Disaster recovery – high risk Resources Committee May 2023		**Moderate**
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 Cyber report to Resources Committee April 2023 **Risk and compliance** Annual re-certification of NCSC cyber accreditation (CE / CE+)	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	**Moderate**

		qDigital Data Security Centre careCERT notifications and actions Vulnerability scanning and penetration tests **Independent assurance** BitSight cybersecurity rating – Advanced March 2023 Internal audit report on IT Disaster recovery – high risk Resources Committee May 2023	PWC internal audit report on cyber via ITDR report – Manni Imiavan, June 2023	

South Tees Hospitals
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MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 6 JUNE 2023			
Integrated Performance Report			**AGENDA ITEM: 9** **ENC 7**
Report Author and Job Title:	Anna Easby Information Officer 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 April IPR, are as follows: National context reflects 2023/24 NHS Operational Planning Guidance. **SAFE domain:** No change. **EFFECTIVE domain:** No change. **CARING domain:** No change. **EQUITABLE domain:** No change. **RESPONSIVE domain:** **Metrics added:** Ambulance Handovers within 60 minutes RTT List Size within 52 weeks		

	RTT 65 week waiters. **Metrics removed:** Ambulance Handovers within 15 minutes Cancer 62 Day Screening Cancelled Ops not rebooked in 28 days **General adjustments:** 4-Hour A&E Standard target altered to 76% in line with 23/24 national guidance. SPC charts have planned activity added where appropriate and legends for SPC added. **WELL LED domain:** No change. **Our key messages for April are:** The Trust remains in segment 3, mandated support for significant concerns as reported previously. Alongside the SOF the Trust continues to focus on safety and quality priorities, guided by our CQC improvement plan. A&E 4-hour standard and ambulance handover performance continue to show recovery of waits from the winter, with the 4 hours performance representative of the national picture. Challenges within the social care sector continue to be observed with particular delays associated with timely access to domiciliary care. Elective access (RTT 18-week standard) is stable and continues to outperform the national trend. Patients waiting more than 78 weeks for non-urgent elective treatment has received extra focus since January, reducing towards zero in line with national requirements. Elective day case and outpatient activity are the major contributors to total elective growth, placing the Trust as one of the more productive providers in the ICS. Diagnostic activity showed year on year growth with compliance for the 6-week standard improving once again in February, surpassing the national average. Cancer 62-day accumulation rose due to pressures in specific pathways, and Trust achieved the national target for 28-day Faster Diagnosis Standard.
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐

Recommendation	Members of the Public Trust Board of Directors are asked to receive the Integrated Performance Report for April 2023.	
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

April 2023

OVERSIGHT

RESPONSIBLE DIRECTORS		BOARD SUB COMMITTEE
Dr Hilary Lloyd, Chief Nursing Officer	Safe, Caring	Quality Assurance Committee
Dr Michael Stewart, Chief Medical Officer	Effective	Quality Assurance Committee
Samuel Peate, Chief Operating Officer	Responsive	Resources Committee
Dr Michael Stewart, Chief Medical Officer	Equitable	Quality Assurance Committee
Chris Hand, Finance Director	Well Led	Resources Committee
Rachael Metcalf, Human Resources Director		People Committee

Audit and Risk Committee

CHANGES THIS MONTH

National context reflects 2023/24 NHS Operational Planning Guidance.

SAFE domain:

No change.

EFFECTIVE domain:

No change.

CARING domain:

No change.

EQUITABLE domain:

No change.

RESPONSIVE domain:

Metrics added: Ambulance Handovers within 60 mins, RTT List Size within 52 weeks, RTT 65 week waiters.

Metrics removed: Ambulance Handovers within 15 mins, Cancer 62 Day Screening, Cancelled Ops not rebooked in 28 days.

General adjustments: 4-Hour A&E Standard target altered to 76% in line with 23/24 national guidance. SPC charts have planned activity added where appropriate and legends for SPC added.

WELL LED domain:

No change.

NATIONAL CONTEXT

In 2023/24 we have three key tasks. Our immediate priority is to recover our core services and productivity. Second, as we recover, we need to make progress in delivering the key ambitions in the NHS Long Term Plan. Third, we need to continue transforming the NHS for the future.

Recovering our core services and productivity

To improve patient safety, outcomes and experience it is imperative that we:

- improve ambulance response and A&E waiting times
- reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
- make it easier for people to access primary care services, particularly general practice.

Delivering the key NHS Long Term Plan ambitions and transforming the NHS

- Prevention and the effective management of long-term conditions are key to improving population health and curbing the ever increasing demand for healthcare services.
- put the workforce on a sustainable footing for the long term.
- level up digital infrastructure and drive greater connectivity.
- Transformation needs to be accompanied by continuous improvement.

The Trust Improvement Plan is being refreshed to reflect the progress we have made and to be aligned to the 23/24 planning priorities, the Trust's strategic priorities and the ambition of our clinically-led Collaboratives.

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	Mar-23	Mar-23	Mar-23	Mar-23	Feb-23	Feb-23	Feb-23	Feb-23	Feb-23	Feb-23	Feb-23	Feb-23	Feb-23	Feb-23	Feb-23	Mar-23	Feb-23	Feb-23
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	70.7%	158	418	334	66.8%	1,266	25	0	49,898	96%	100%	101%	103%	21.9%	51.9%	184	231	79.4%
NENC ICS Provider level *(including IS providers)*	75.1%	772	1,872	881	69.3%	7,990	721	37	383,308	98%	101%	94%	108%	15.0%	60.1%	952	1,546	81.9%
North East & Yorkshire	72.1%				65.7%									19.7%	59.8%			78.6%
National	71.5%				58.5%									25.1%	58.2%			75.0%

The Trust remains in segment 3, mandated support for significant concerns as reported previously. Alongside the SOF the Trust continues to focus on safety and quality priorities, guided by our CQC improvement plan. A&E 4-hour standard and ambulance handover performance continue to show recovery of waits from the winter, with the 4 hours performance representative of the national picture. Challenges within the social care sector continue to be observed with particular delays associated with timely access to domiciliary care. Elective access (RTT 18-week standard) is stable and continues to outperform the national trend. Patients waiting more than 78 weeks for non-urgent elective treatment has received extra focus since January, reducing towards zero in line with national requirements. Elective day case and outpatient activity are the major contributors to total elective growth, placing the Trust as one of the more productive providers in the ICS. Diagnostic activity showed year on year growth with compliance for the 6-week standard improving once again in February, surpassing the national average. Cancer 62-day accumulation rose due to pressure in specific pathways, and the Trust achieved the national target for 28-day Faster Diagnosis Standard.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
DATIX Incidents	2367	2070	Apr 2023		
Serious Incidents	8	15	Apr 2023		
Never Events (YTD)	1	0	Apr 2023	N/A	N/A
Falls	190		Apr 2023		N/A
Falls Rate %	5.7	6.6	Apr 2023		
Falls With Harm	3		Apr 2023		N/A
Falls With Harm Rate %	0.1		Apr 2023		N/A

Incidents

There have been consistently high levels of incident reporting within the Trust for a sustained period. The trajectory has been updated to indicate our aim to at least maintain this level of reporting for the next 12 months. The trust will review later in 2023 when PSIRF (Patient Safety Incident Response Framework and LFPSE (Learning from Patient Safety Events) is fully implemented. There was one NE in April and the number of Serious Incidents was within expected limits. Learning from incidents continues to be shared at a local level with clinical colleagues, as well as across the wider organisation and with our system partners.

Falls

The rate of all falls and falls with harm is stable and remains within control limits. The number of falls is higher than seen during the height of the COVID-19 pandemic due to reduced admissions at that time. The falls team has commenced a quality improvement project, mapping systems, process and reporting mechanisms, to ensure continued effective, evidenced-based and patient-centred care. First outputs from this are expected in June. The team is also mapping our education offer, so that we can be confident our interventions are being received where they are needed most. We continue to monitor the data for all reported falls so that we remain proactive in targeting support to wards. We have begun to link inpatient and community falls teams, to share learning and experiences.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	2.3		Apr 2023	L	N/A
Category 2 Pressure Ulcers (Community)	61		Apr 2023		N/A
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	0.2		Apr 2023		N/A
Category 3&4 Pressure Ulcers (Community)	24		Apr 2023	H	N/A
Medication Incidents	109		Apr 2023		N/A
Medications Reconciled Rate %	47.8%	80%	Apr 2023	L	F
Omitted Critical Doses (%)	4%		Apr 2023		N/A
C-Difficile (YTD)	13	9	Apr 2023	N/A	N/A
MRSA (YTD)	0	0	Apr 2023	N/A	N/A
E-Coli (YTD)	10	11	Apr 2023	N/A	N/A
Klebsiella (YTD)	2	4	Apr 2023	N/A	N/A
Pseudomonas (YTD)	0	1	Apr 2023	N/A	N/A

Pressure Ulcers

The rate of hospital-acquired pressures ulcers in inpatient wards remains stable and within expected variation.

The PURPOSE T tool and SSKIN assessment were introduced at FHN and JCUH onto the digital platform, Patientrack, in September 2022. Extensive education and training continues in the clinical areas. Whilst the risk assessment is embedded into practice the frequency of completion has been increased to 24 hours for those patients stratified to the green pathway. PURPOSE T was implemented at Tocketts ward in February 2023. Tocketts ward went live with Patientrack on 20 April 2023 and has since shown significant improvement in compliance to their risk assessments. A planned go-live date for Zetland ward has been ascertained. It is the intention to review pressure ulcer investigations in the first phase of PSIRF roll out. The team is currently reviewing how incidence of community pressure ulcers can be meaningfully reported and are trialling reporting by caseload for a month. The Tissue new Viability Lead commenced 24 April 2023.

Medications

Medication incidents reported in April were within expected variation. Omitted doses data has changed to include all omitted doses on EPMA as opposed to a selection audit. EPMA team currently working on live dashboard to go on intranet for all teams to view. Medicines reconciliation continues to remain an area of focus: vacancies have been recruited to and colleagues will commence from September 2023 for 5-day service.

Healthcare acquired infections

There were no new MRSA reported in April. C. difficile is monitored and recorded through the appropriate governance. Structured case reviews are completed, providing assurance that appropriate measures are in place. Targets are based on 2022/23 objectives pending confirmation of 2023/24 contract.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
No. of babies born	361		Apr 2023	N/A	N/A
Breast feeding initiated (48 hrs)	59%	74.5%	Apr 2023		
Preterm birth rate <26+6 wks	0.8%	6%	Apr 2023		
Preterm birth rate 27 - 36+6 wks	7.7%	6%	Apr 2023		
Induction of Labour (%)	45.6%	44%	Apr 2023		
Number of 3rd/4th degree tear (%)	2.2%	3.5%	Apr 2023		
PPH > 1500ml (%)	2.19%	2%	Apr 2023		
Still Births (YTD)	1		Apr 2023	N/A	N/A

Maternity services

The pre-term birth rate for babies 27-36+6 weeks gestation is within expected variation. For our Trust this can be higher than the standard rate due to the specialist nature of the service and the proportion of high-risk pregnancies managed within the Trust. Our data has been cross checked with other similar units and we are not an outlier. All pre-term births are reviewed by Consultant and midwife and all guidelines are followed. Pre-term birth clinics are held weekly with a named consultant and midwife. We work closely with the NENC Preterm Birth Group.

Breastfeeding initiation rates are below target, as is reflected in the regional public health statistics. The Trust is UNICEF baby-friendly accredited. Our initiation figure is following an upward trajectory which is testament to the education and information which is being provided on healthy relationships and infant feeding.

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 created to review the IOL pathway and this work is ongoing.

Harm as indicated by 3rd/4th degree tears during childbirth is consistently better than the expected standard. These are consistently monitored via 3rd/4th degree audit database and review of cases via Maternity Rapid Review.

Post-partum Haemorrhage (PPH) fluctuates month to month and is within expected variation. All cases are reviewed to ensure guidelines are followed. PPH is covered in the annual MDT obstetric emergency training and simulations also occur on a regular basis to ensure staff are well prepared for any emergency situation. We have completed a lookback review of Q3 PPHs and have extended this for all Q4 deliveries. This is being undertaken to identify any themes and commonalities which will help us to reduce PPH.

All 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 %	6.6%		Feb 2023		N/A
Sepsis - Oxygen delivered within 1hr	97.9%	95%	Feb 2023		
Sepsis - Blood cultures within 1hr	70.2%	95%	Feb 2023		
Sepsis - Empiric IV antibiotics within 1hr	70.2%	95%	Feb 2023		
Sepsis - Serum lactate within 1hr	76.6%	95%	Feb 2023		
Sepsis - IV fluid resuscitation within 1hr	70.2%	95%	Feb 2023		
Sepsis - Urine measurement within 1hr	100%	95%	Feb 2023		
Summary Hospital-Level Mortality Indicator	102.4	100	Sep 2022		
Comorbidity Coding	4.5		Sep 2022		N/A

Readmission rates

The emergency readmission rate remains within current expected variation.

Sepsis

Urine output and oxygen delivery remain above target levels.

Actions:

- Compliance targets to be set for acutely ill patient courses for all acute areas, including role specific mandatory training.
- Increase attendance at sepsis courses - remain moderately subscribed with 39 RNs and 21 HCAs booked to date for the remainder of the year.
- Fluid balance module went live 5th April 2023. Preliminary feedback is positive.
- Blood culture screen savers displayed. Review increase in compliance. Meeting with microbiology on 19th April.
- 'Think sepsis' stickers distributed for thermometers.

Compliance to the sepsis care bundle within one hour requires consideration in the context of the Surviving Sepsis Campaign Guidance 2021.

Mortality

For the latest official reporting period, Jan 2022 to Dec 2022, SHMI is 'as expected' at 108. The data processing anomaly with the volume of spells used to calculate SHMI last month has not recurred but the impact of this will remain in the data.

Currently 4.6% of spells in England are removed because they have a COVID code and spells included in SHMI are at 87% of pre-pandemic levels (both metrics similar to last month).

Reporting to the Trust's governance committees shows that Medical Examiner scrutiny remains at >95%, with approximately 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 (%)	84.7%	78%	Apr 2023		
Inpatient Experience (%)	96.9%	94%	Apr 2023		
Maternity Experience (%)	91.2%	92%	Apr 2023		
Outpatient Experience (%)	96.4%	93%	Apr 2023		
Community Experience (%)	99.3%	94%	Apr 2023		
New Complaints	28		Apr 2023		N/A
Closed Within Target (%)	36.8%	80%	Apr 2023		

Patient experience

Emergency Department Friends & Family Test score has improved on the previous month and is above target. The Inpatient Friends & Family Test score remains above target for the second month. The Friends & Family Test score reported in Outpatients and Community services consistently perform above the national average.

The Maternity Friends & Family Test score reflects feedback captured in the Antenatal, Birth and Postnatal surveys. The percentage positive response has improved on the previous month and remains just below the target. Comments from the surveys are continually reviewed by the Maternity team to identify areas for improvement and these are monitored though the Patient Experience Steering Group.

Closed within target

The timeframe for response has increased on the previous month but remains below target. Complaints closed beyond timeframe remains an area of focus and an action plan was implemented in April 2023. This includes, the Safe and Effective Care Facilitators reporting to the Patient Experience, Involvement and Bereavement Lead for a period of ten weeks. Complaints and PALS trajectory is monitored weekly and shared with the Safe and Effective Care Leads, Associate Chief Nurses, and Heads of Nursing. A rapid review of the complaints process is planned for June 2023. This work is overseen by the Patient Experience Steering Group.

Learning from complaints

Learning and themes from complaints are systematically shared with clinical colleagues.

EQUITABLE

Elective inpatient PTL Inequalities: Deprivation

Latest PTL by IMD quintile

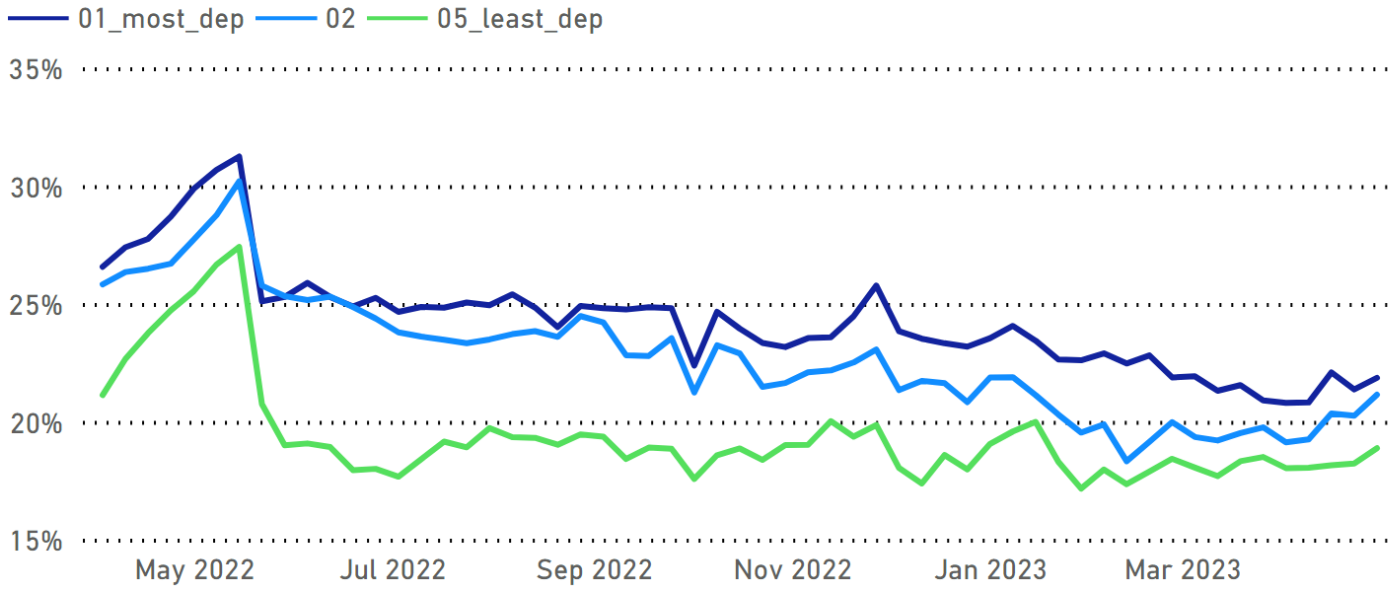
IMD quintile	In Standard	Long waits	% of total	Total
01_most_dep	1940	543	22%	2483
02	1152	309	21%	1461
03	1153	300	21%	1453
04	1804	419	19%	2223
05_least_dep	1250	291	19%	1541
N/k	771	118	13%	889
Total	**8070**	**1980**	**20%**	**10050**

IMD is taken from patient's postcode of residence

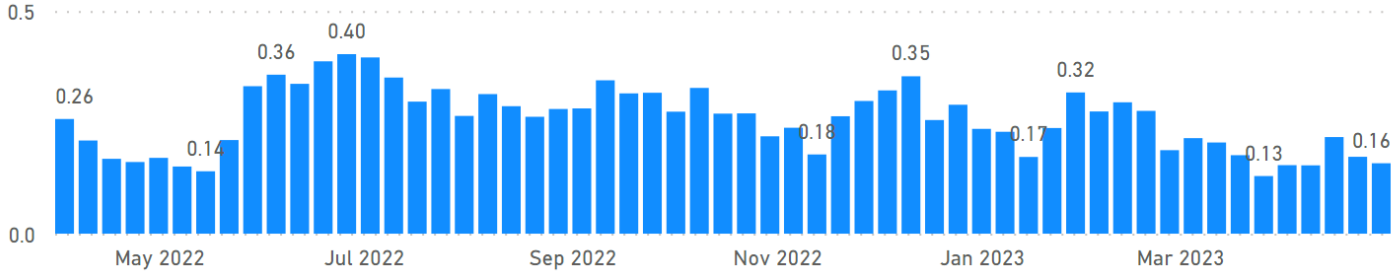
Long Waiters:
P2 › 3 weeks
P3 › 3 months
Any › 52 weeks

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

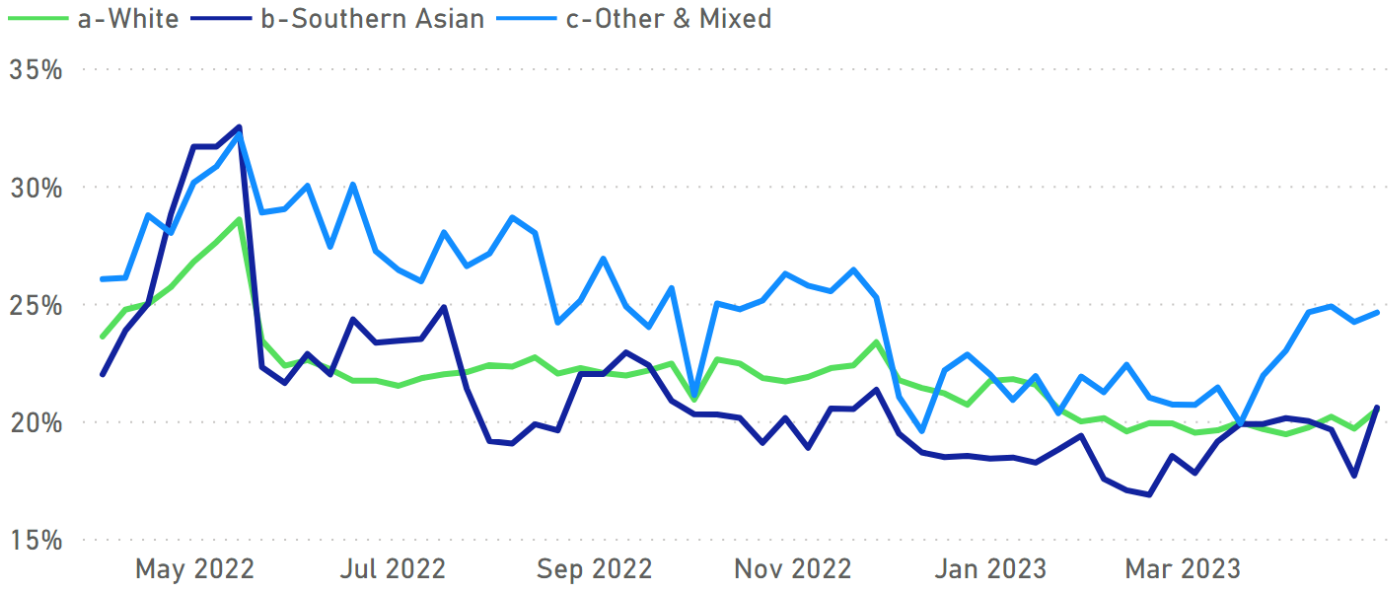
Latest PTL by IMD quintile

Ethnic_cluster (groups)	In Standard	Long waits	% of total	Total
a-White	**6358**	**1637**	**20%**	**7995**
b-Southern Asian	**139**	**36**	**21%**	**175**
c-Other & Mixed	**147**	**48**	**25%**	**195**
Black	29	9	24%	38
Mixed	35	11	24%	46
Other	83	28	25%	111
N/k	**1426**	**259**	**15%**	**1685**
Total	**8070**	**1980**	**20%**	**10050**

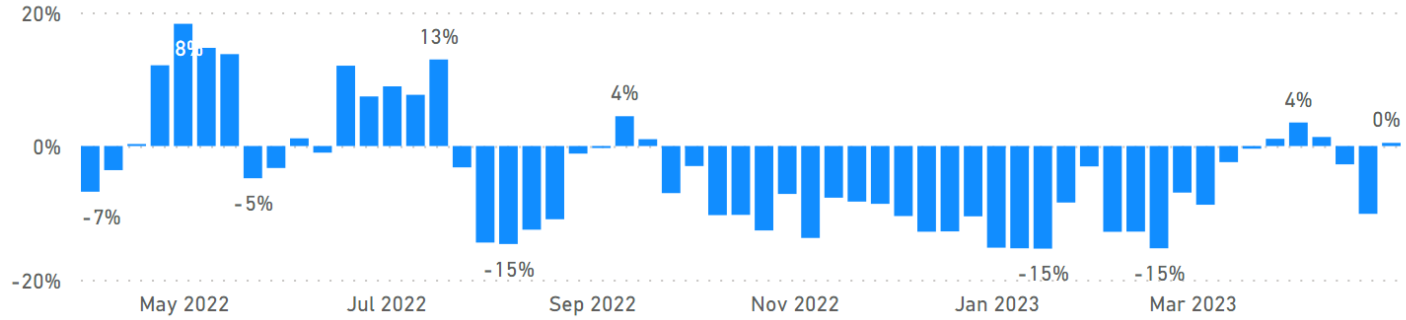
Long Waiters:
P2 › 3 weeks
P3 › 3 months
Any › 78 weeks

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 its waiting list distribution by ethnicity. The numbers recorded in some groups are very low and so they are aggregated to reveal trends, however statistical fluctuations can be exaggerated, even when the data is grouped. It is nonetheless an area which the Trust continues to monitor.

RESPONSIVE

Metric	Latest Month	Target	Month	Trend	Assurance
A&E Attendances - Type 1	9818	10404	Apr 2023		
A&E Attendances - Type 3	5322	5357	Apr 2023		
Handovers - Within 30 Mins (%)	78.6%	95%	Apr 2023		
Handovers - Within 60 Mins (%)	90.2%	100%	Apr 2023		
4-Hour A&E Standard	71.1%	76%	Apr 2023		
12-Hour Waits from Decision to Admit	68	0	Apr 2023		N/A
12-Hour A&E Breaches	292	0	Apr 2023		
RTT Incomplete Pathways (%)	65.6%	92%	Mar 2023		
RTT List Size within 52 weeks (%)	97.5%		Mar 2023		N/A
RTT 52 week waiters	1279	851	Mar 2023	N/A	N/A
RTT 65 week waiters	242		Mar 2023	N/A	N/A
RTT 78 week waiters	4	0	Mar 2023	N/A	N/A
RTT Waiting List Size	50721	41677	Mar 2023		
Diagnostic 6 Weeks Standard (%)	74.3%	99%	Apr 2023		
Cancer 14 Day Standard (%)	81.3%	93%	Mar 2023		
Cancer 31 Day Standard (%)	92.2%	96%	Mar 2023		
Cancer 62 Day Standard (%)	58.4%	85%	Mar 2023		
Cancer >62 Day Backlog	191	168	Apr 2023	N/A	N/A
Cancer Faster Diagnosis Standard (%)	77.3%	75%	Mar 2023		
Cancelled Ops - Non-Urgent Cancelled on Day	38	0	Apr 2023		

Urgent and emergency care

The impact of challenges across the social care system continue to be observed – particularly in relation to timely access to domiciliary care. The Trust is working closely with local authorities and other partners to ensure that people who are ready to leave hospital, who require social care support, can be supported with the care they need. This includes proactively identifying patients to avoid admission, with input from our Frailty team, urgent community response and Home First services.

Performance for the 4-hour standard was steady. Evidence-based process improvement remains an organisational priority with a focus on achieving the national 4-hour standard of 76% by end 2023/24 and ensuring all Ambulance handovers take place within one hour. Observational work is ongoing to drive out unnecessary processes that can delay patient handover.

Elective, diagnostic and cancer waiting times

Referral to treatment within 18 weeks is stable at 66% and remains well above the national average. There is continued focus on the longest waits – maintaining a zero position with 104 week waits, treating over 78-week waiters by end of March and reducing the patients waiting more than 52 weeks.

Compliance with the 6-week diagnostic access standard has steadily improved since October and reached 78% for February. In particular endoscopy waits have been significantly reduced following extra capacity being made available last year.

There are positive signs for the future as performance against the faster diagnosis standard was better than national target for the second month in a row. Cancer 62-day standard compliance remains an area of focus, as longest waiting patients are treated.

Cancer Pathways have been reviewed to identify timeline gains at first appointment and diagnosis intervals and Cancer Action Plans are progressing for each pathway and support service. These are monitored through the Cancer Delivery Group, incorporating recommendations from Pathway Review projects.

RESPONSIVE

Metric	Latest Month	Plan	Month	Trend	Assurance
Outpatient First Attendances	15206	16079	Apr 2023		
Outpatient Follow Up Attendances	39639	40072	Apr 2023		
Day Case admissions	5194	5804	Apr 2023		
Ordinary Elective admissions	842	848	Apr 2023		
NEL admissions with 0 LOS	2789	1759	Apr 2023		
NEL admissions with 1+ LOS	3497	2962	Apr 2023		
Length of Stay - Elective	4.8		Apr 2023		N/A
Length of Stay - Non-Elective	4.2		Apr 2023		N/A
Not Met Not Discharged	87	90	Apr 2023		
21 Day Stranded Patients (%)	13.3%	12%	Apr 2023		

Activity

April total outpatient activity is slightly lower than plan and clinical teams are working to ensure the right ratio of first and follow up capacity is in place so that more patients can attend their first appointment.

Ordinary elective admissions tracked closely to plan but day case admissions were lower.

Both non-elective overnight and same day admissions were higher in April, driven by maternity pathway changes. However because of wider social care system pressures, and an increase in the frailty of patients, bed occupancy on assessment units and general medical wards was significantly above the 92% standard.

Length of Stay

Non-elective length of stay has been persistently high during 2022/23 at circa. 5 days but has improved significantly to 4 days in April. The number of patients who no longer meet criteria to reside in an acute bed has shown sustained improvement in recent months and April performance kept within planned thresholds. The Trust proactively reduces delays within its span of control and has established a therapy-led ward for patients who have completed their medically-led care. However, there are ongoing pressures across the social care sector which impact on timely discharge of patients who have ongoing care and support needs.

tThe percentage of patients with long stay is driven by our specialist critical care, spinal cord injuries and rehabilitation pathways as a regional tertiary centre. For patients who no longer require specialist care, we are focusing on appropriate repatriation for care closer to home.

WELL LED

Metric	Latest Month	Target	Month	Trend	Assurance
Cumulative YTD Financial Position (£'millions)	-£22.158m	-£20.72m	Mar 2023	N/A	N/A
Annual Appraisal (%)	78.6%	80%	Apr 2023		
Mandatory Training (%)	90.7%	90%	Apr 2023		
Sickness Absence (%)	5%	4%	Apr 2023		
Staff Turnover (%)	12%	10%	Apr 2023		

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 12, the Trusts financial position is £1.5m behind plan and the Trust reported a deficit of £22.2m. The position was agreed with the local NHSE team and was reported as part of the ICB agreed position. The variance relates to the estimated cost of the unconsolidated pay award linked to the indexation requirements of the PFI contract. Funding to cover the PFI contract was not included in the additional funding notified by NHSE to the Trust relating to the 2022/23 pay award.

People

Sickness absence across the Trust was 5.0% for the month of April 2023 which is a reduction from March (5.2%). New sickness targets (23/24) by Collaboratives are live and are being considered at Collaborative Board and other meetings. The Wellbeing and Attendance team continue to focus on supporting managers in reducing long-term sickness, , working alongside their HR colleagues. and the review of the Trust's wellbeing policies continues.

Appraisal compliance has reduced slightly to 78.6% for April 23 (March 78.9%) and HR teams continue to discuss Workforce data and KPI plans for compliance with their Collaboratives. Mandatory Training compliance has increased by 1.6% and is at 90.6% for April 23. HR teams provide further detail of mandatory training data to their Collaboratives on a regular basis.

There is continued promotion of the Retention Strategy at Collaborative meetings. HR teams are further analysing NHS Staff Survey data and sharing this with Collaborative teams, to support the development of action plans.

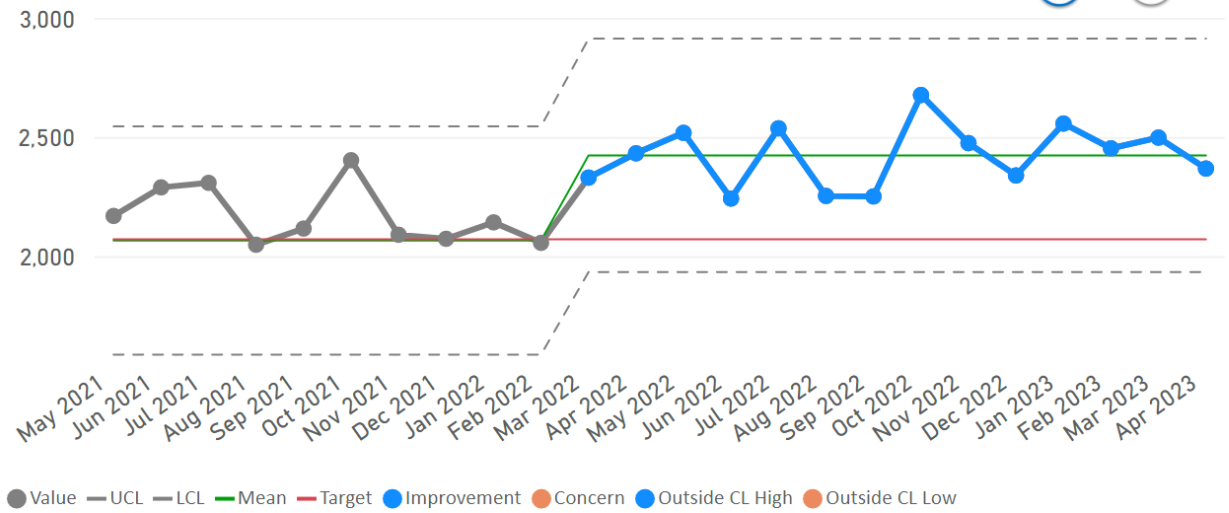
APPENDICES

SPC charts for the metrics summarised above, by domain.

SAFE

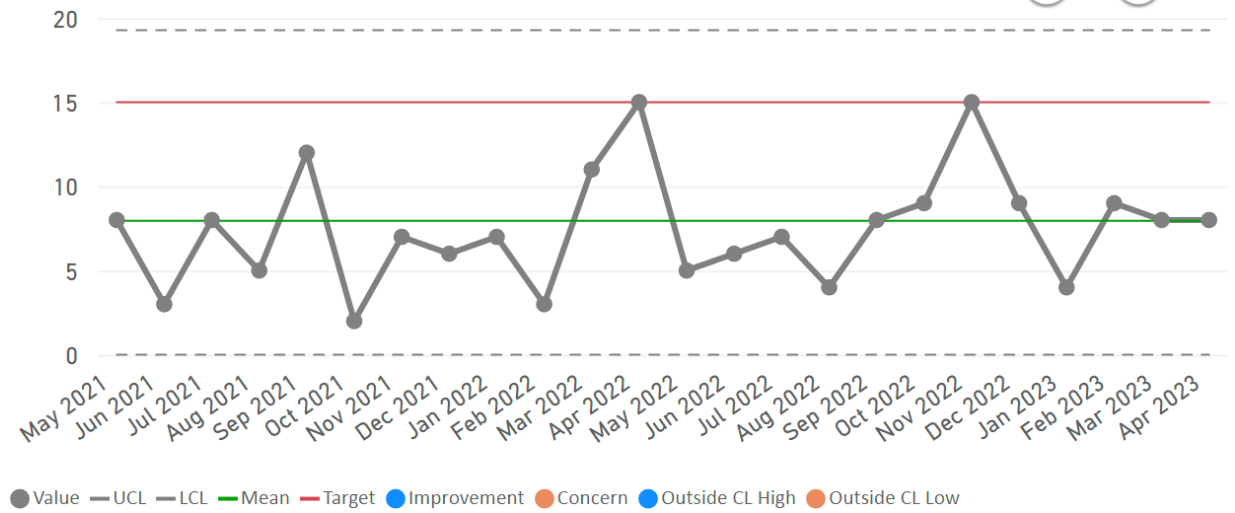
DATIX Incidents

Month	Performance	Target	Trend	Assurance
Apr 2023	2367	2070		



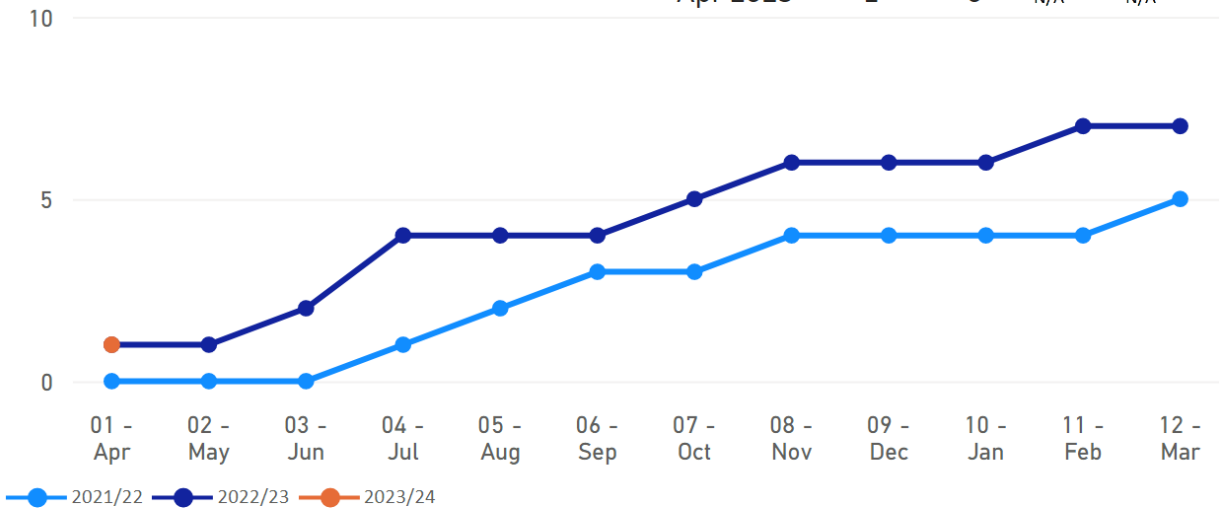
Serious Incidents

Month	Performance	Target	Trend	Assurance
Apr 2023	8	15		



Never Events (YTD)

Month	Performance	Target	Trend	Assurance
Apr 2023	1	0	N/A	N/A



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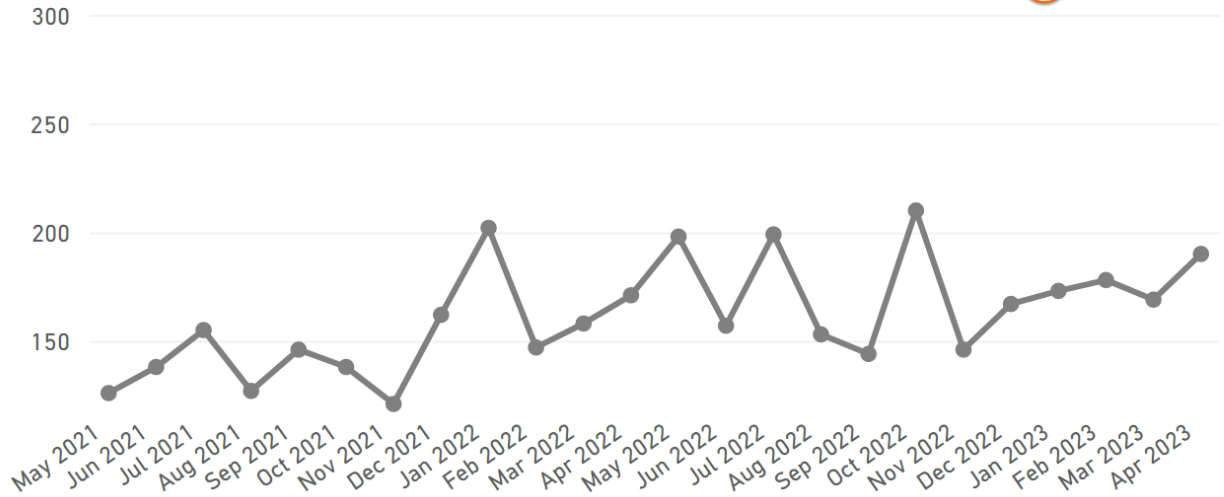
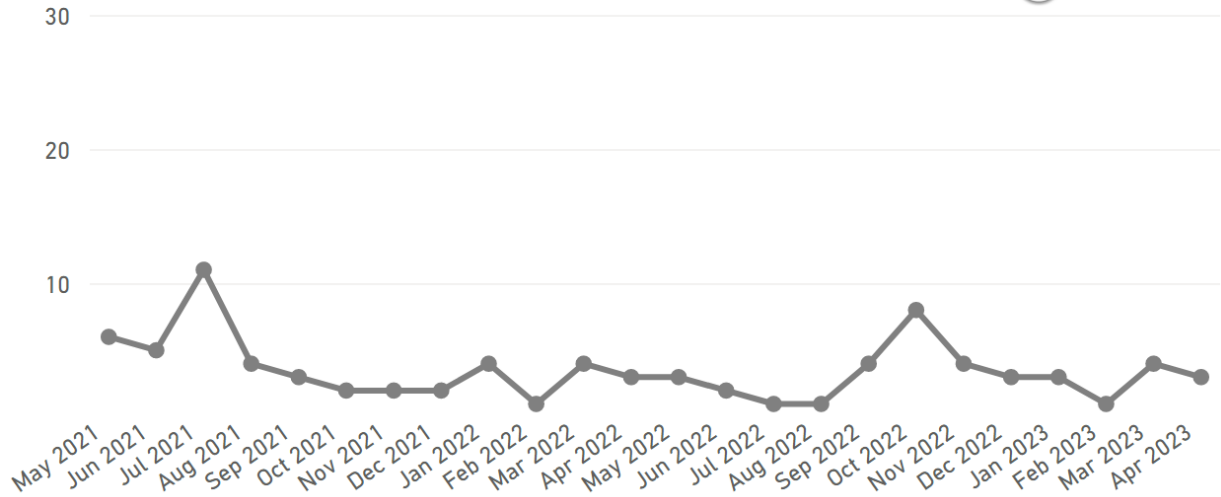
Falls

Month	Performance	Target	Trend	Assurance
Apr 2023	190			N/A



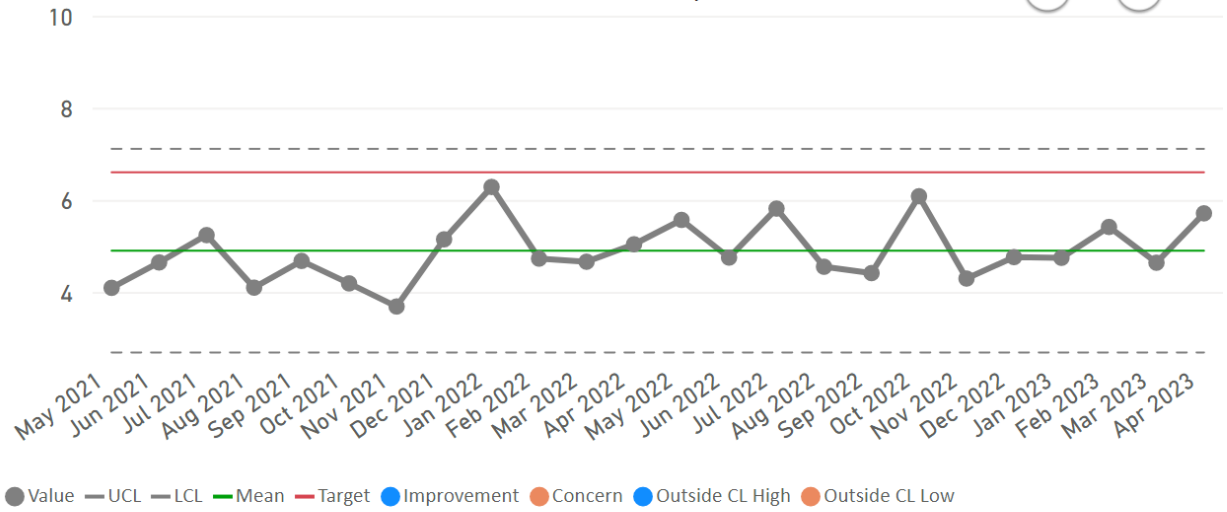
Falls With Harm

Month	Performance	Target	Trend	Assurance
Apr 2023	3			N/A



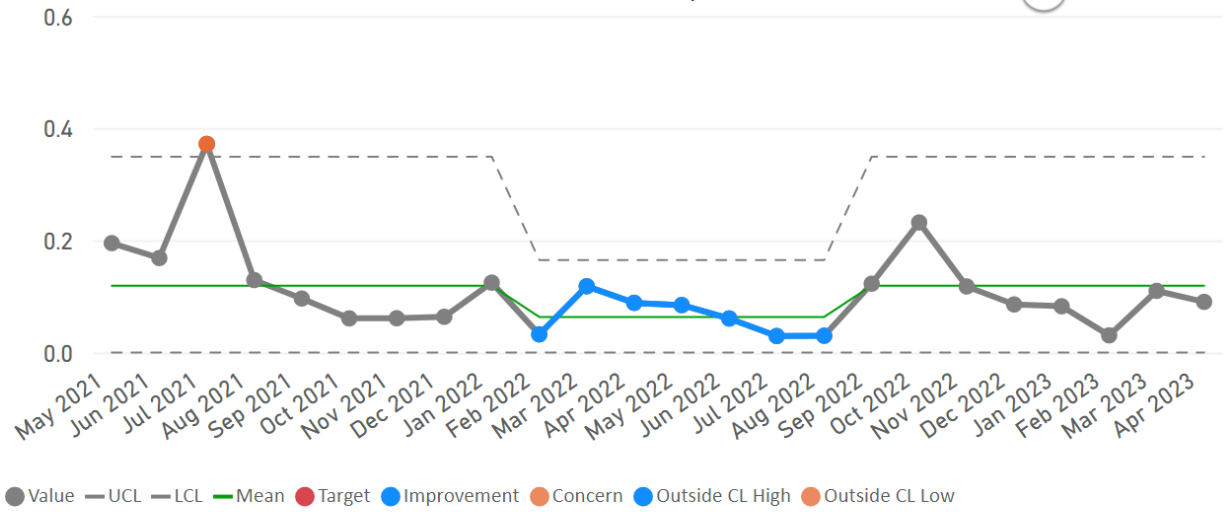
Falls Rate %

Month	Performance	Target	Trend	Assurance
Apr 2023	5.7	6.6		



Falls With Harm Rate %

Month	Performance	Target	Trend	Assurance
Apr 2023	0.1			N/A



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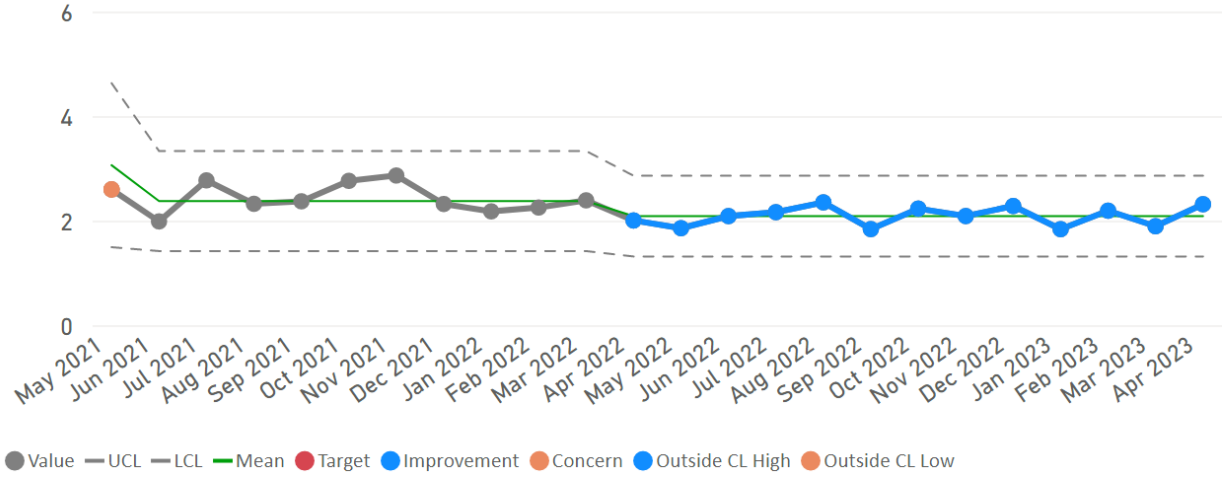
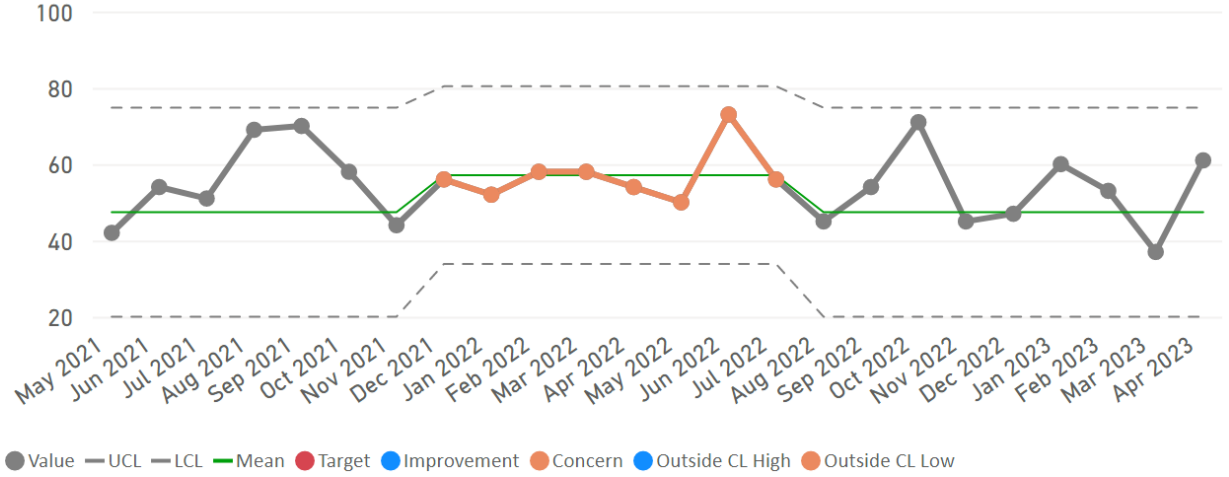
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Apr 2023	2.3			N/A



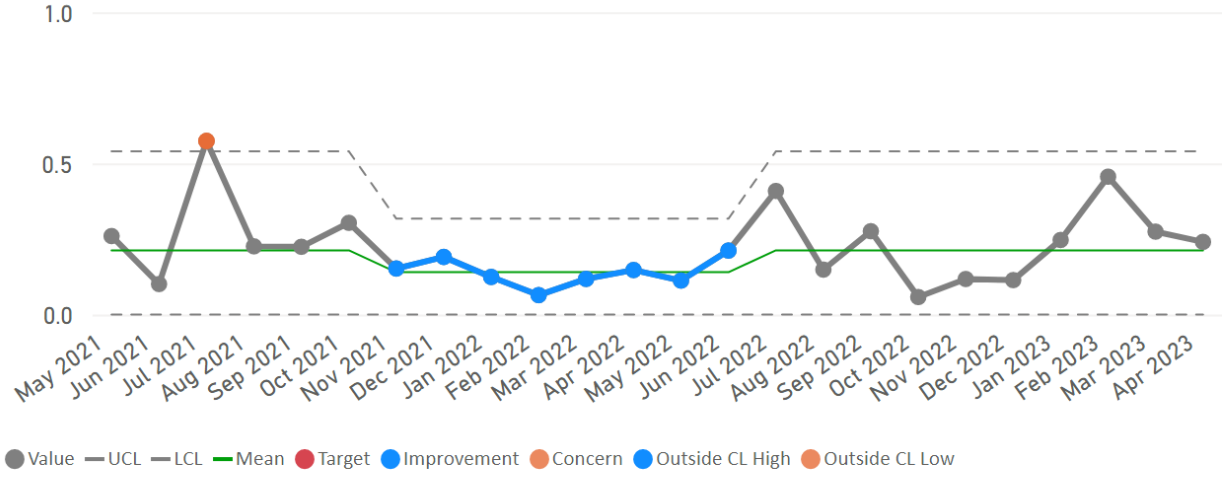
Category 2 Pressure Ulcers (Community)

Month	Performance	Target	Trend	Assurance
Apr 2023	61			N/A



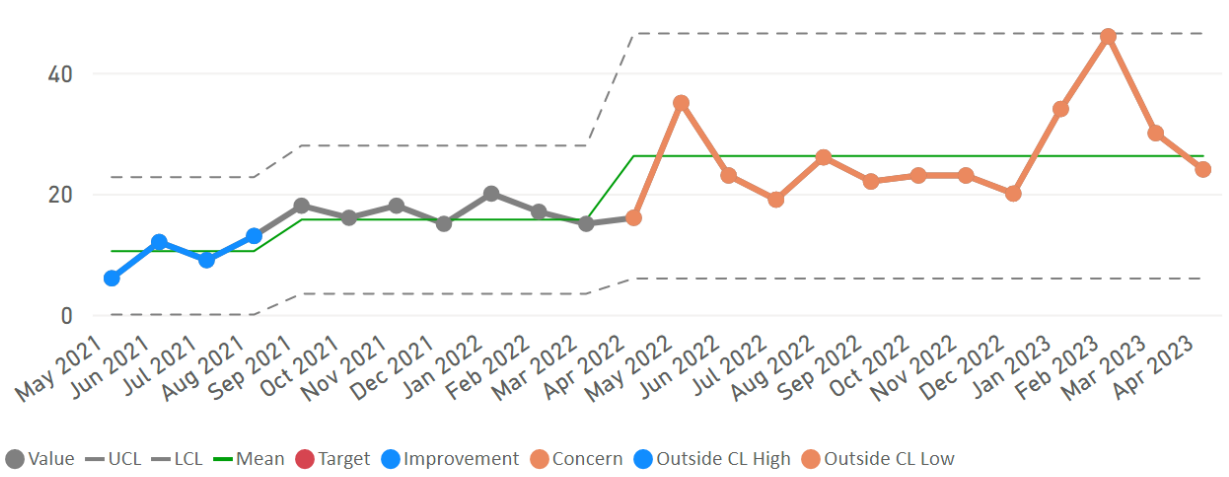
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Apr 2023	0.2			N/A



Category 3&4 Pressure Ulcers (Community)

Month	Performance	Target	Trend	Assurance
Apr 2023	24			N/A



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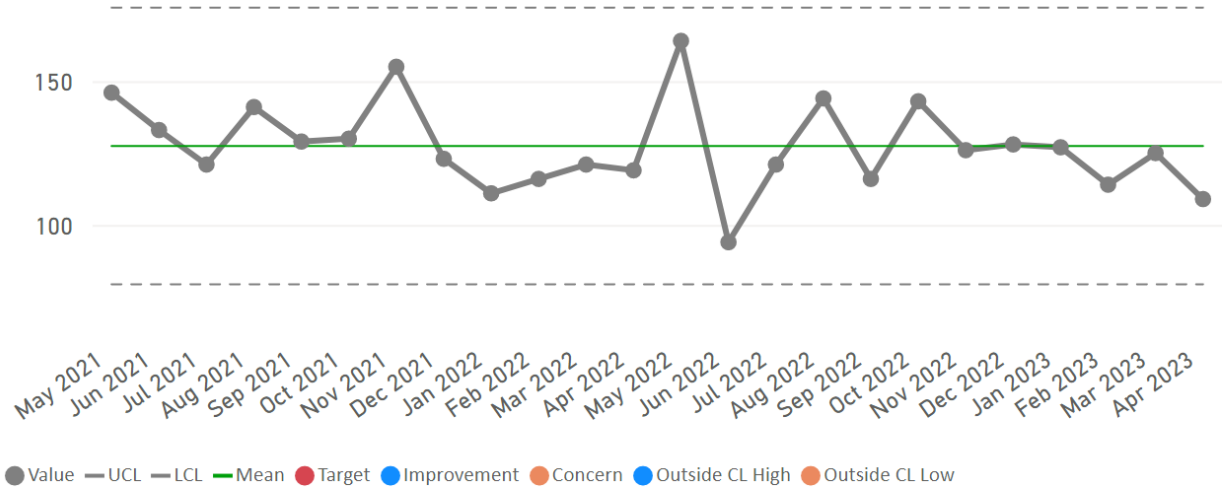
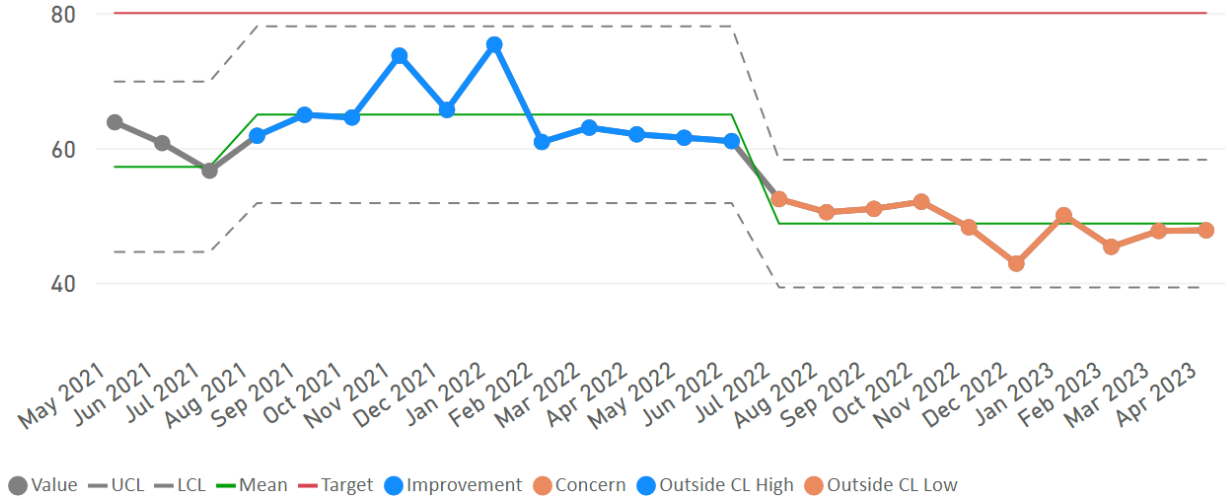
Medication Incidents

Month	Performance	Target	Trend	Assurance
Apr 2023	109			N/A



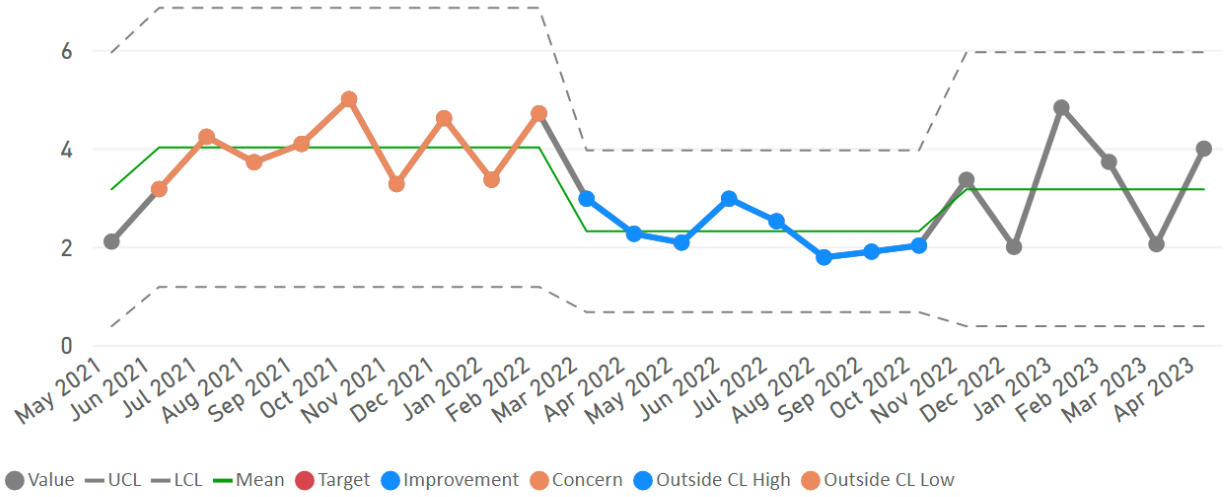
Medications Reconciled Rate %

Month	Performance	Target	Trend	Assurance
Apr 2023	47.8%	80%		



Omitted Critical Doses (%)

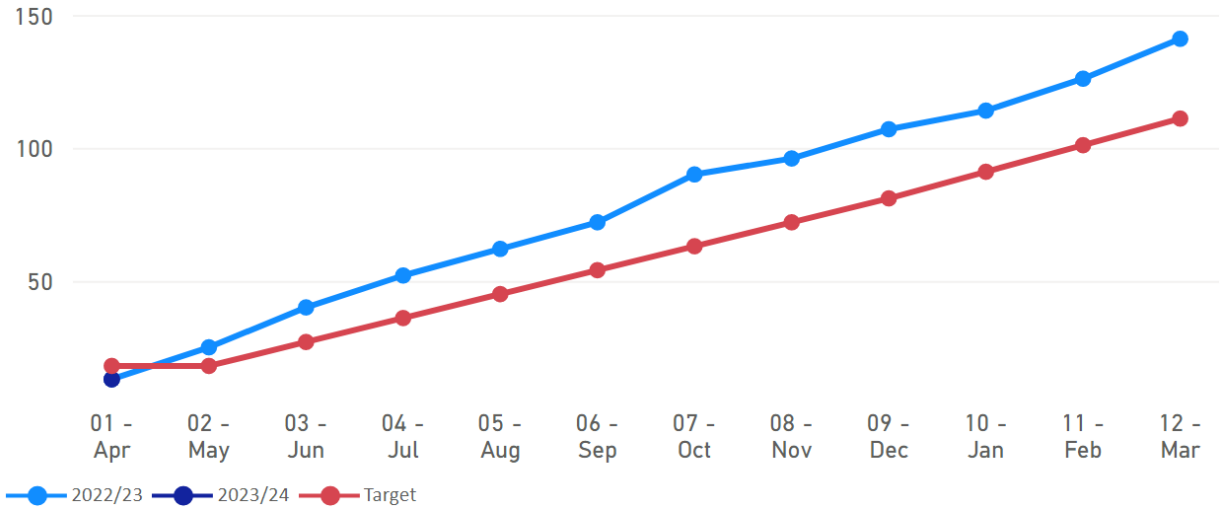
Month	Performance	Target	Trend	Assurance
Apr 2023	4%			N/A



SAFE

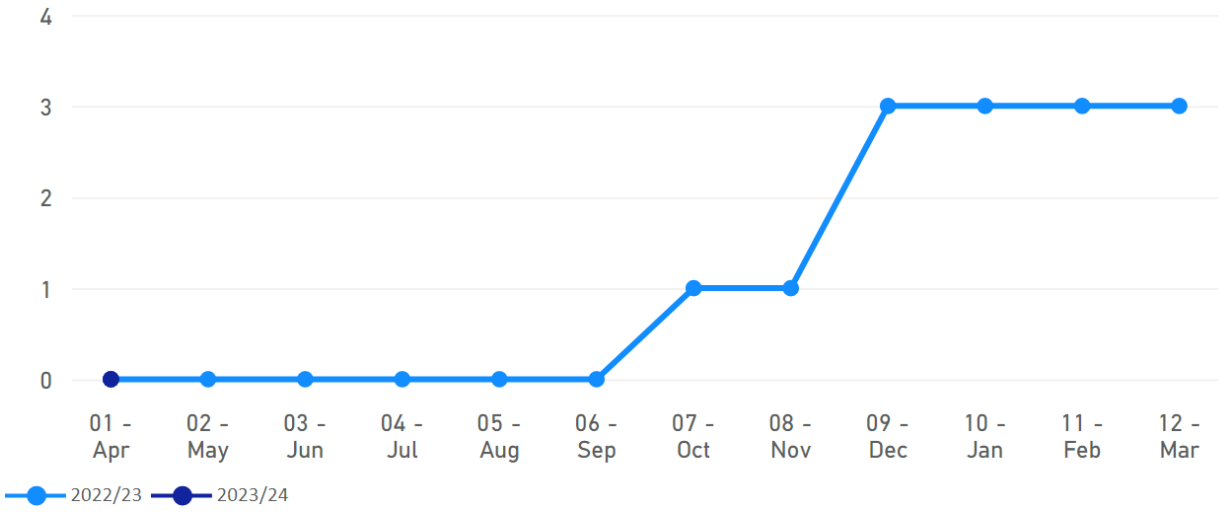
C-Difficile (YTD)

Month	Performance	Target	Trend	Assurance
Apr 2023	13	9	N/A	N/A



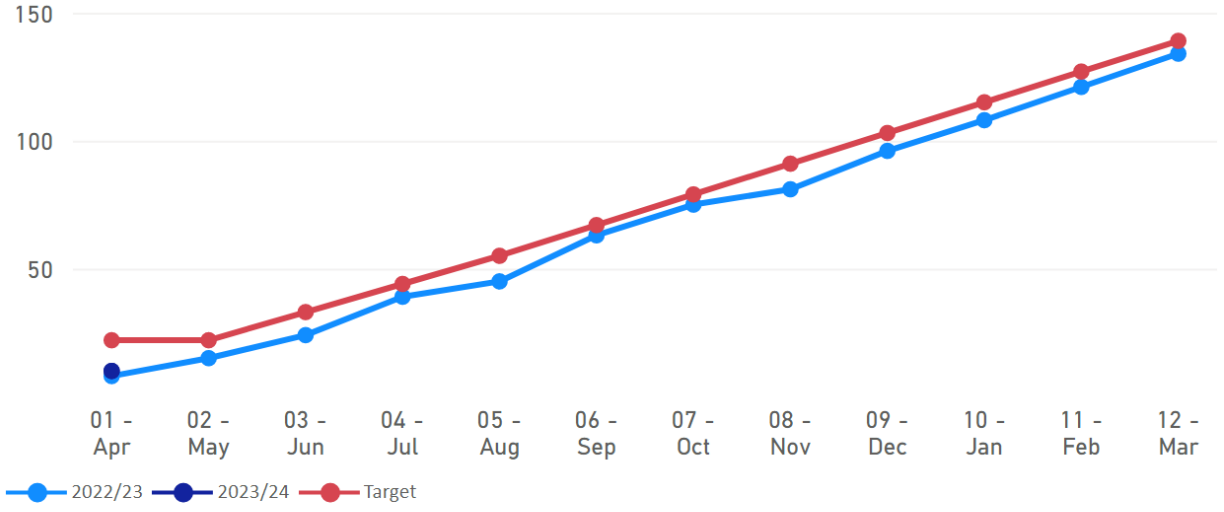
MRSA (YTD)

Month	Performance	Target	Trend	Assurance
Apr 2023	0	0	N/A	N/A



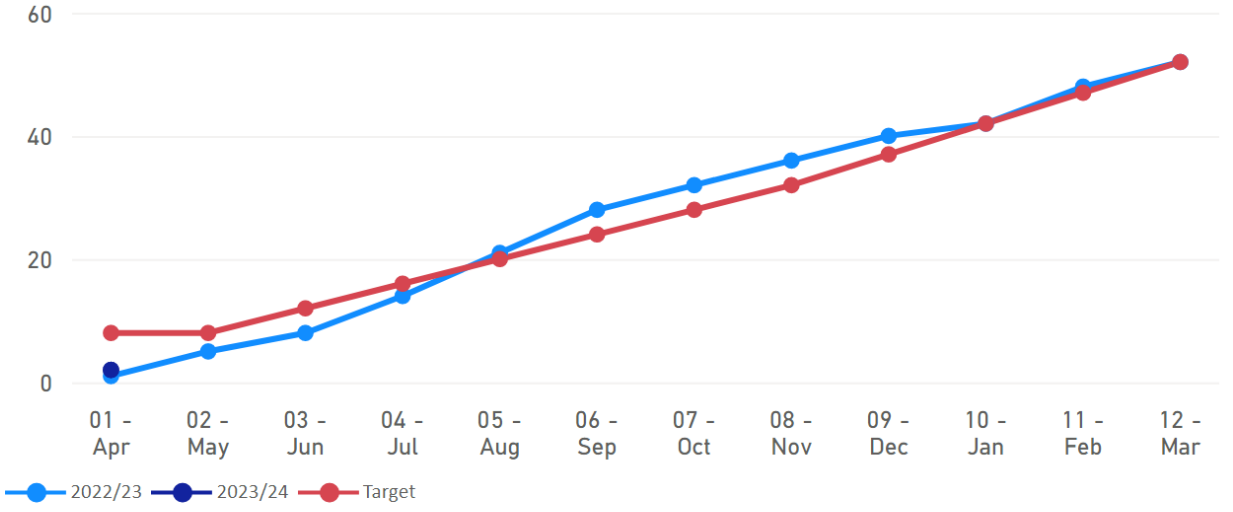
E-Coli (YTD)

Month	Performance	Target	Trend	Assurance
Apr 2023	10	11	N/A	N/A



Klebsiella (YTD)

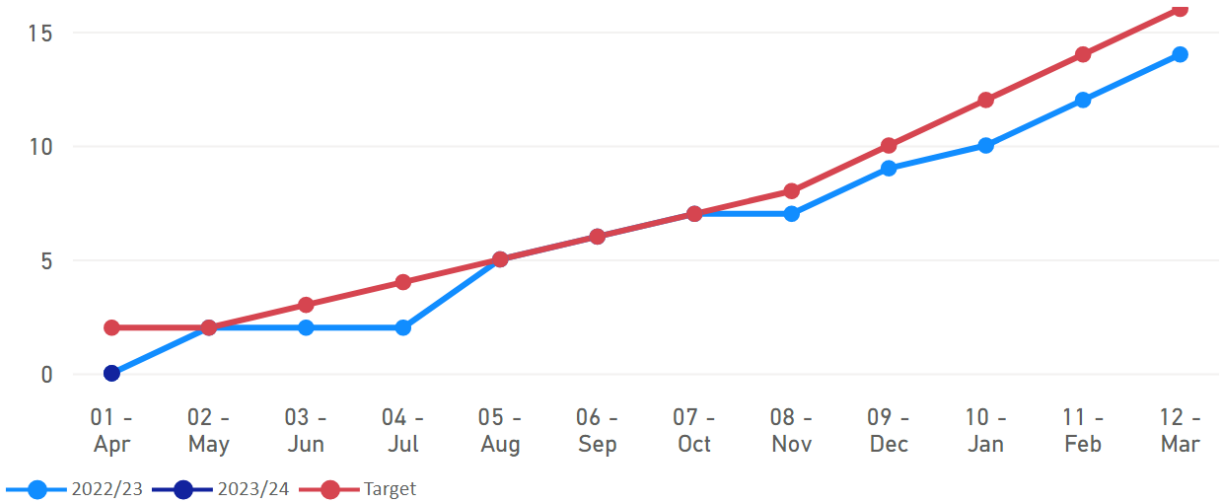
Month	Performance	Target	Trend	Assurance
Apr 2023	2	4	N/A	N/A



SAFE

Pseudomonas (YTD)

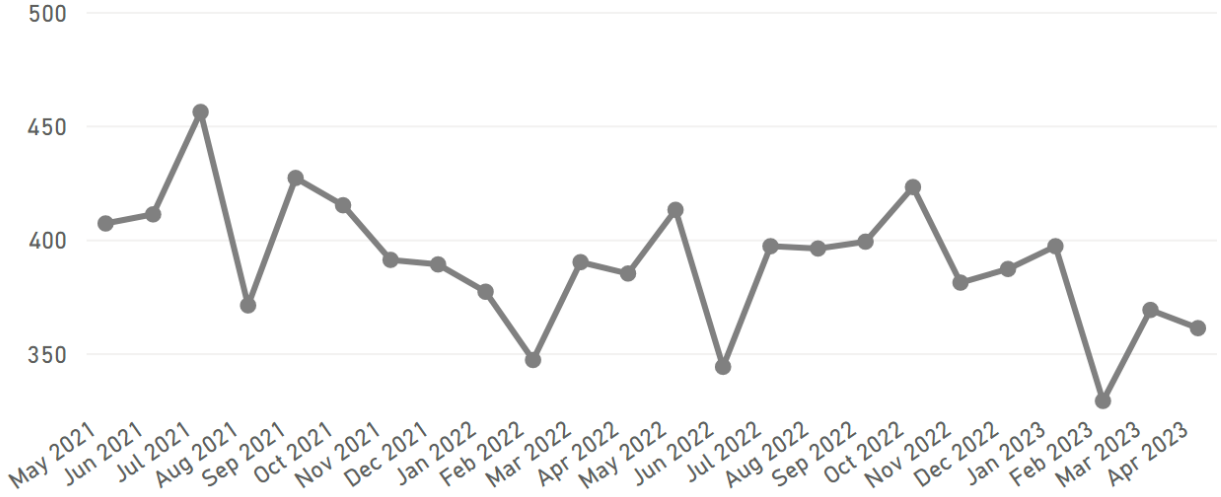
Month	Performance	Target	Trend	Assurance
Apr 2023	0	1	N/A	N/A



SAFE

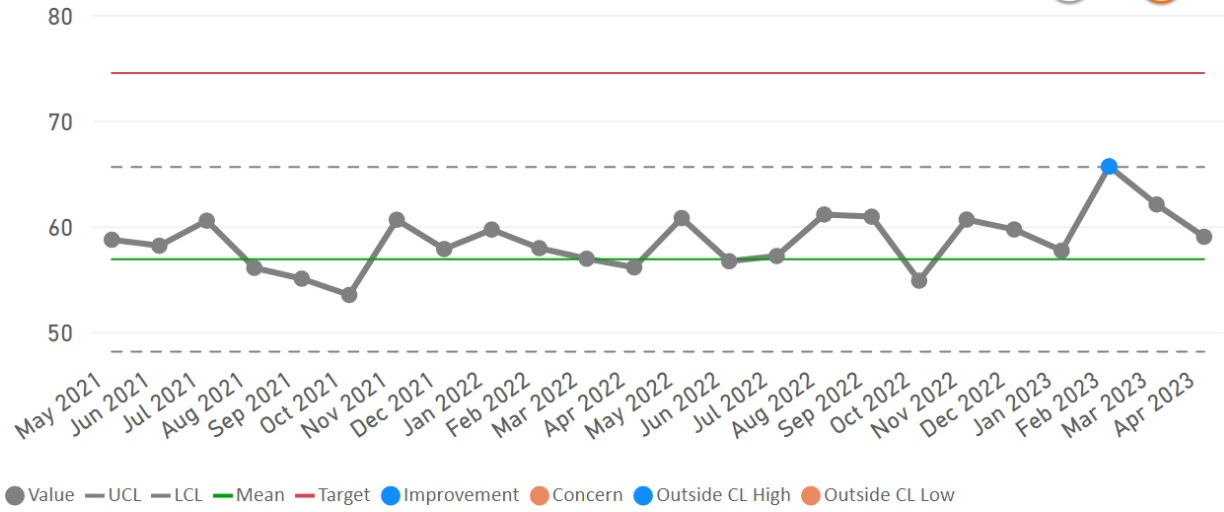
No. of babies born

Month	Performance	Target	Trend	Assurance
Apr 2023	361		N/A	N/A



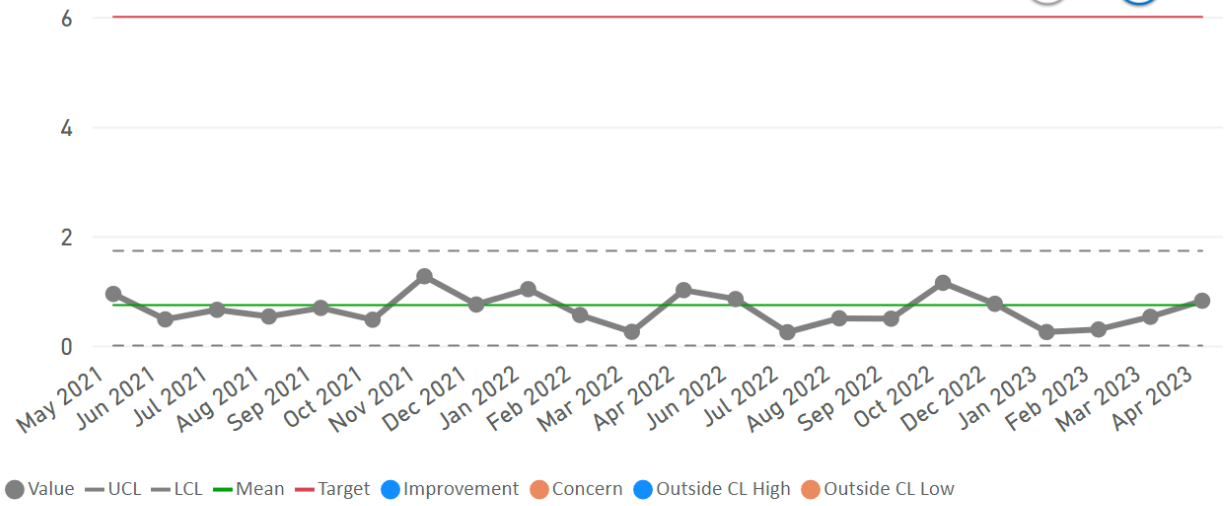
Breast feeding initiated (48 hrs)

Month	Performance	Target	Trend	Assurance
Apr 2023	59%	74.5%		



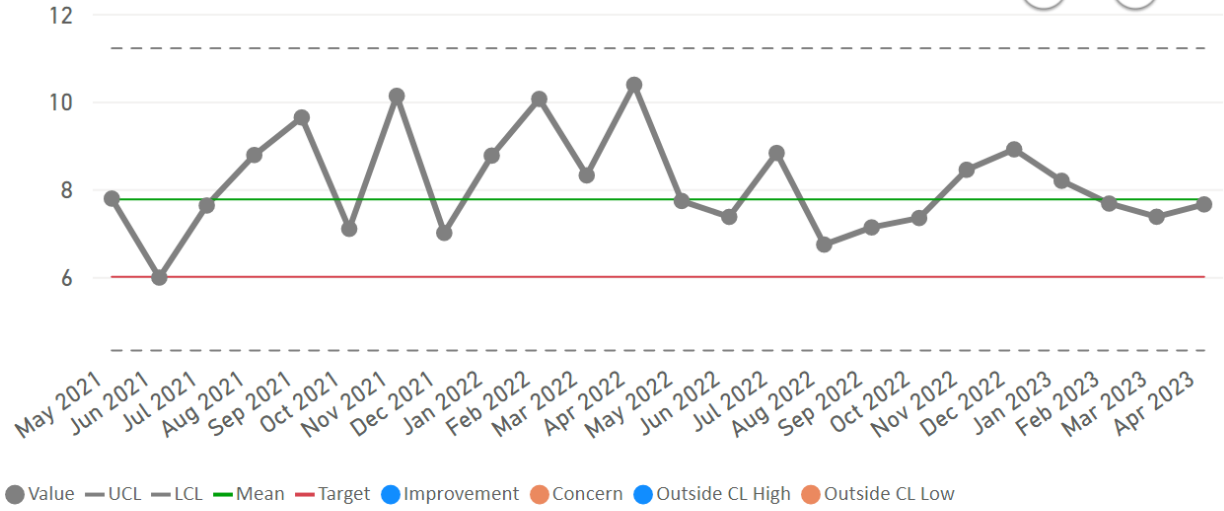
Preterm birth rate <26+6 wks

Month	Performance	Target	Trend	Assurance
Apr 2023	0.8%	6%		



Preterm birth rate 27 - 36+6 wks

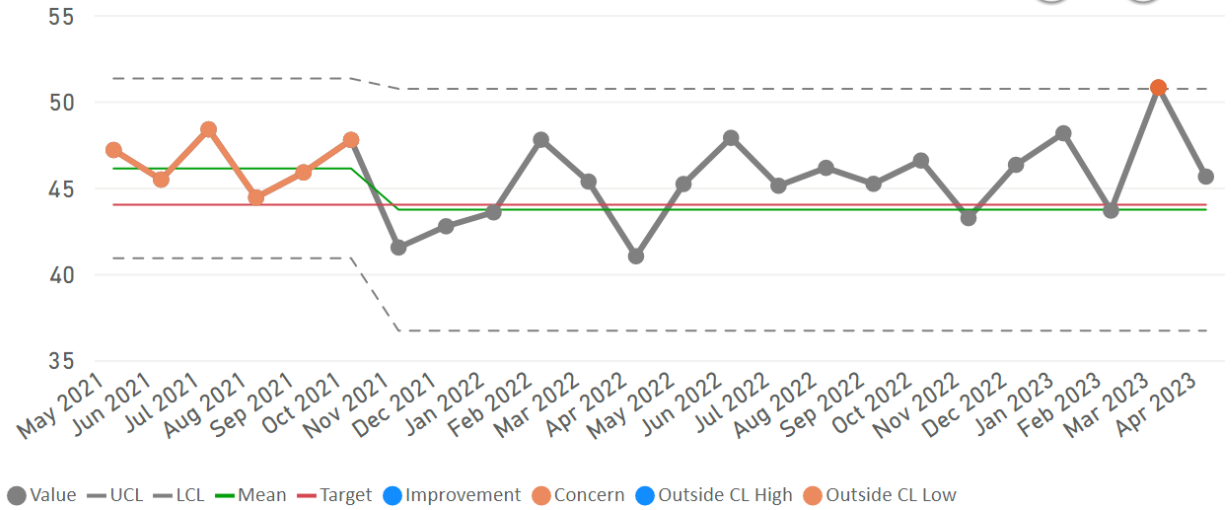
Month	Performance	Target	Trend	Assurance
Apr 2023	7.7%	6%		



SAFE

Induction of Labour (%)

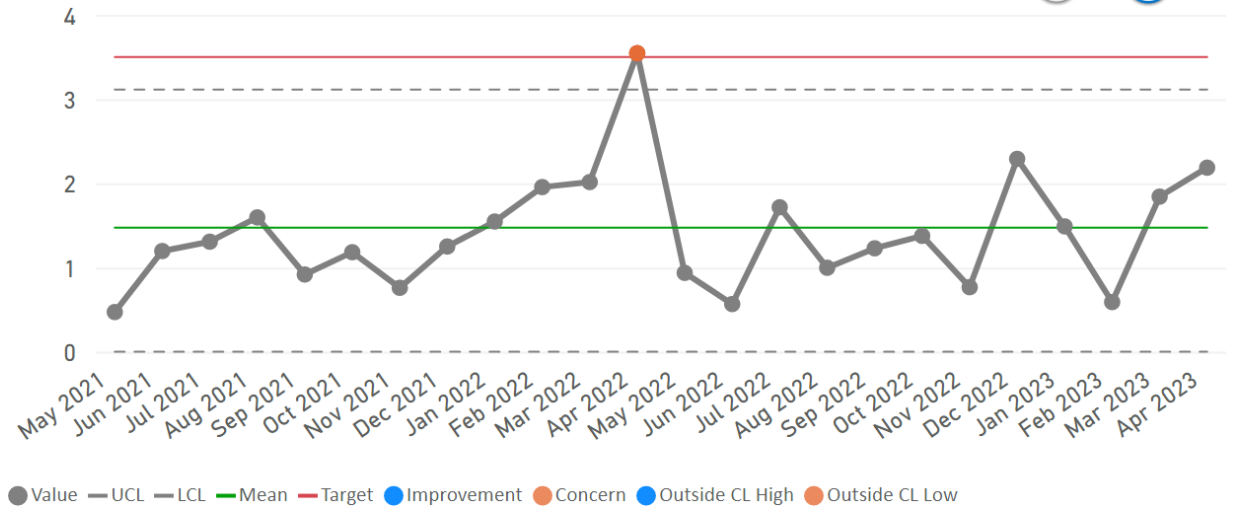
Month	Performance	Target	Trend	Assurance
Apr 2023	45.6%	44%		



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

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

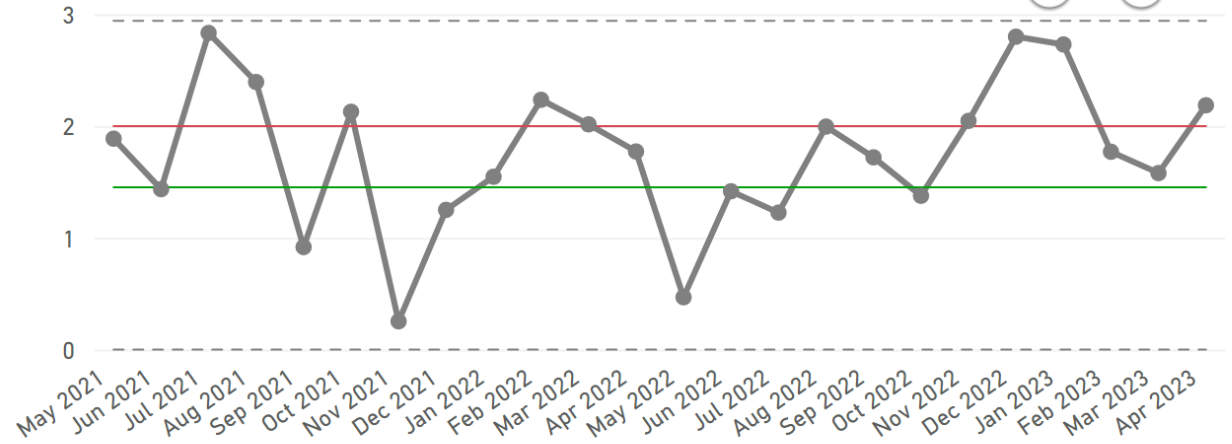
Month	Performance	Target	Trend	Assurance
Apr 2023	2.2%	3.5%		



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

PPH > 1500ml (%)

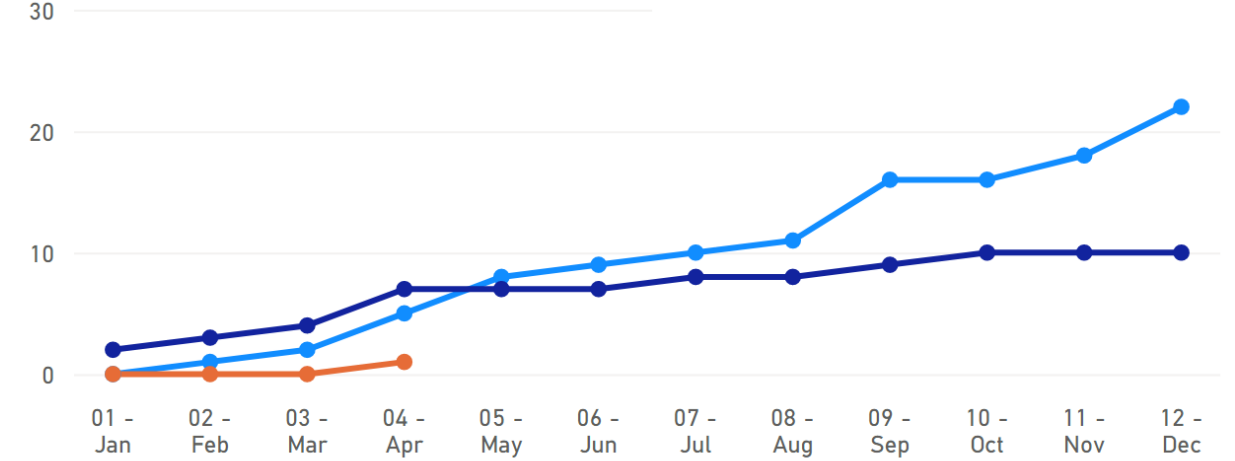
Month	Performance	Target	Trend	Assurance
Apr 2023	2.19%	2%		



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

Still Births (YTD)

Month	Performance	Target	Trend	Assurance
Apr 2023	1		N/A	N/A

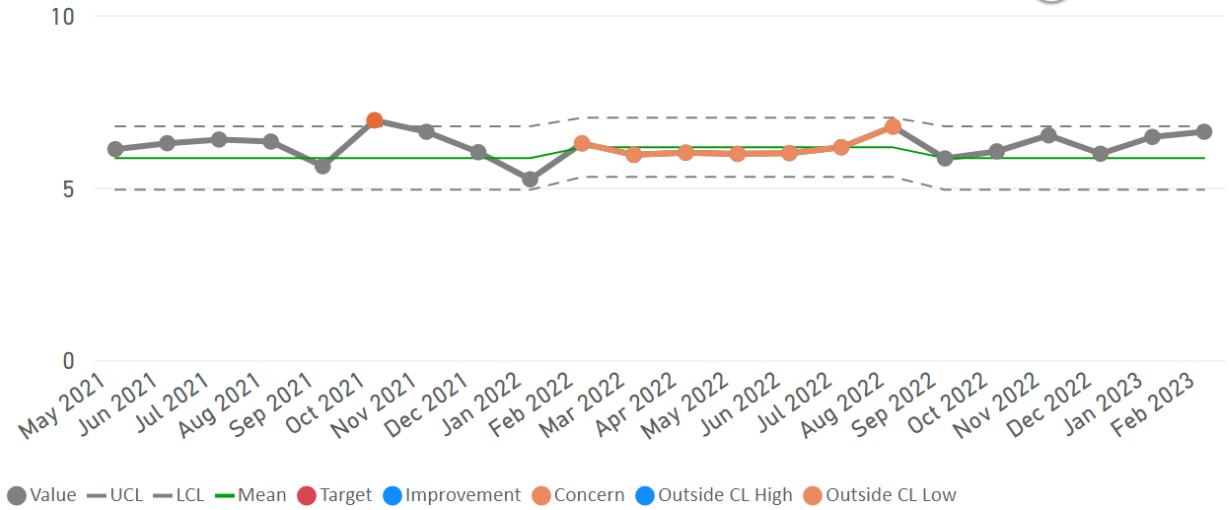


2021 2022 2023

EFFECTIVE

Readmission Rate %

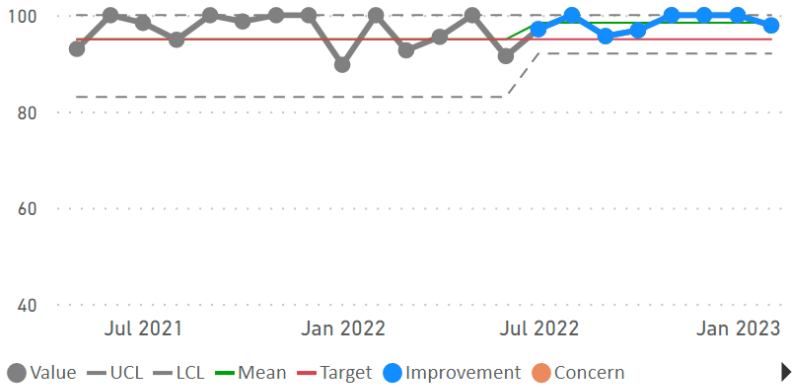
Month	Performance	Target	Trend	Assurance
Feb 2023	6.6%			N/A



EFFECTIVE

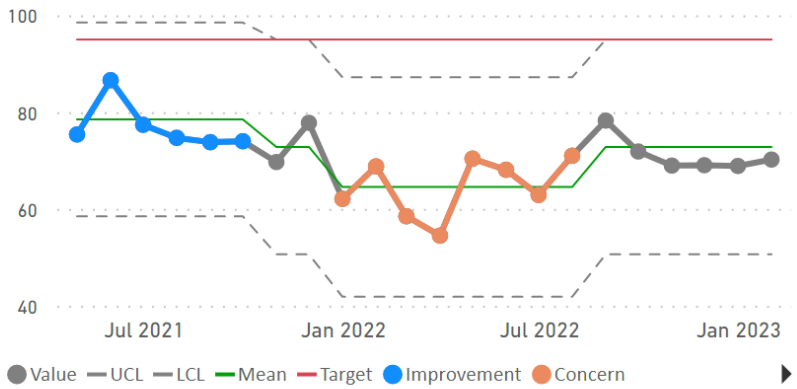
Sepsis - Oxygen within 1hr

Month	Performance	Target	Trend	Assurance
Feb 2023	97.9%	95%	H	?



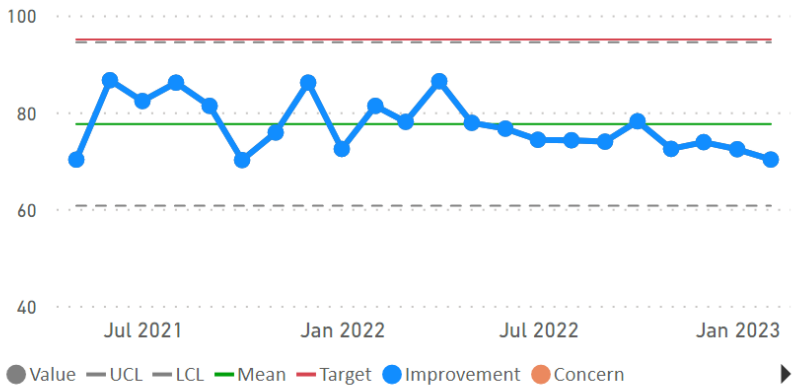
Sepsis - Blood cultures within 1hr

Month	Performance	Target	Trend	Assurance
Feb 2023	70.2%	95%	~	F



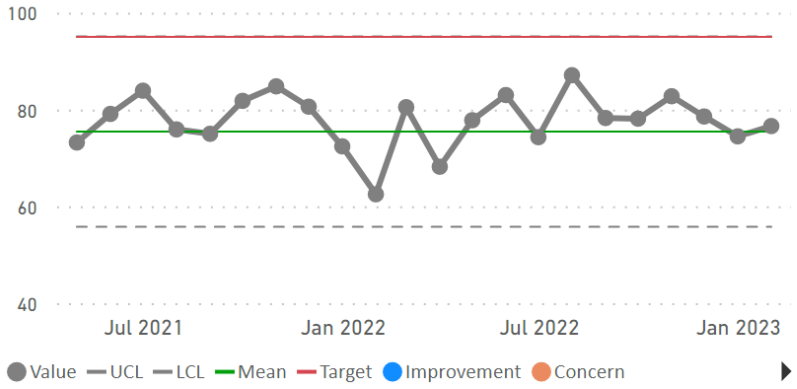
Sepsis - IV antibiotics within 1hr

Month	Performance	Target	Trend	Assurance
Feb 2023	70.2%	95%	H	F



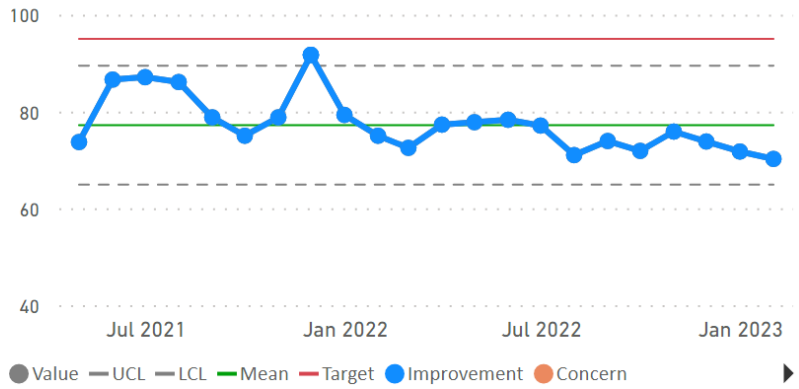
Sepsis - Serum lactate within 1hr

Month	Performance	Target	Trend	Assurance
Feb 2023	76.6%	95%	~	?



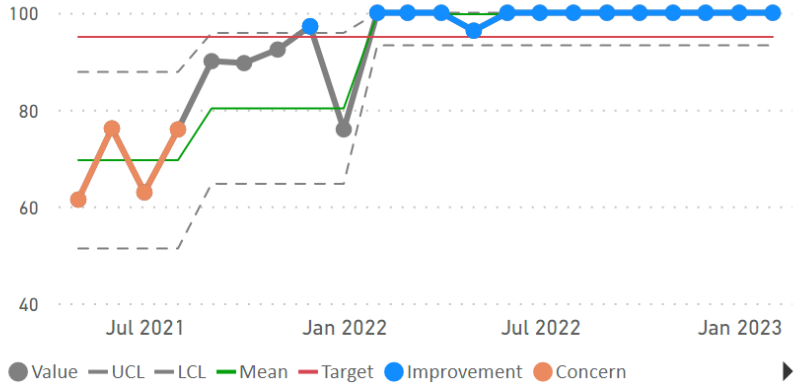
IV fluid resuscitation within 1hr

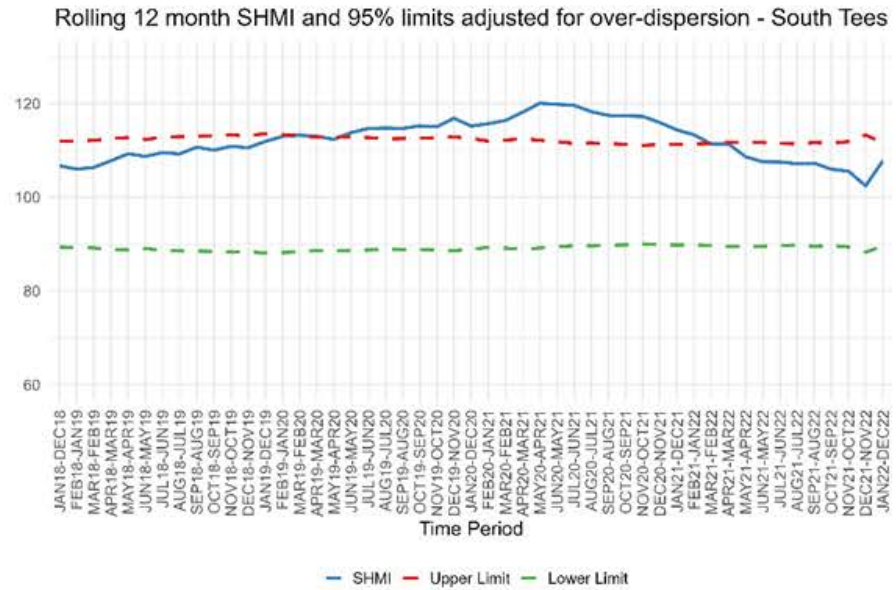
Month	Performance	Target	Trend	Assurance
Feb 2023	70.2%	95%	H	F

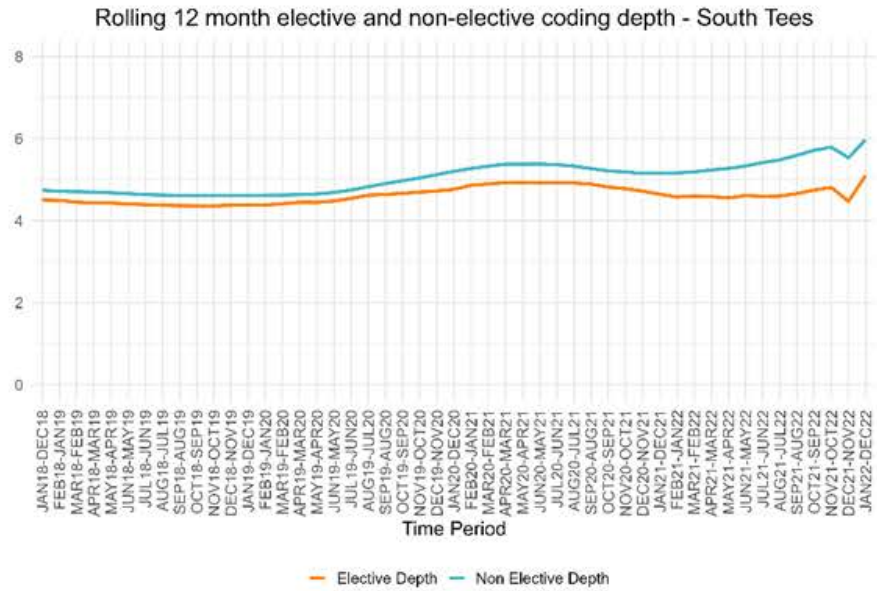


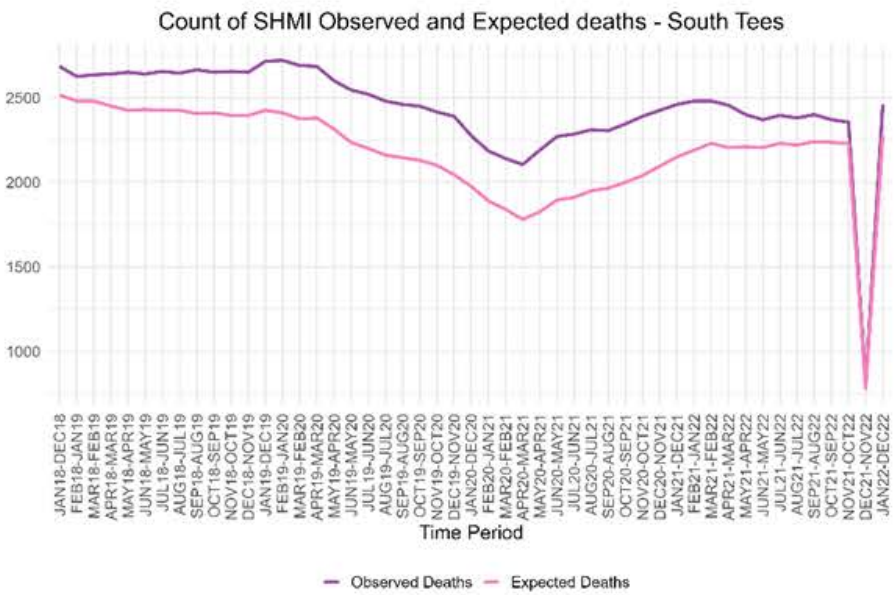
Sepsis - Urine measurement within 1hr

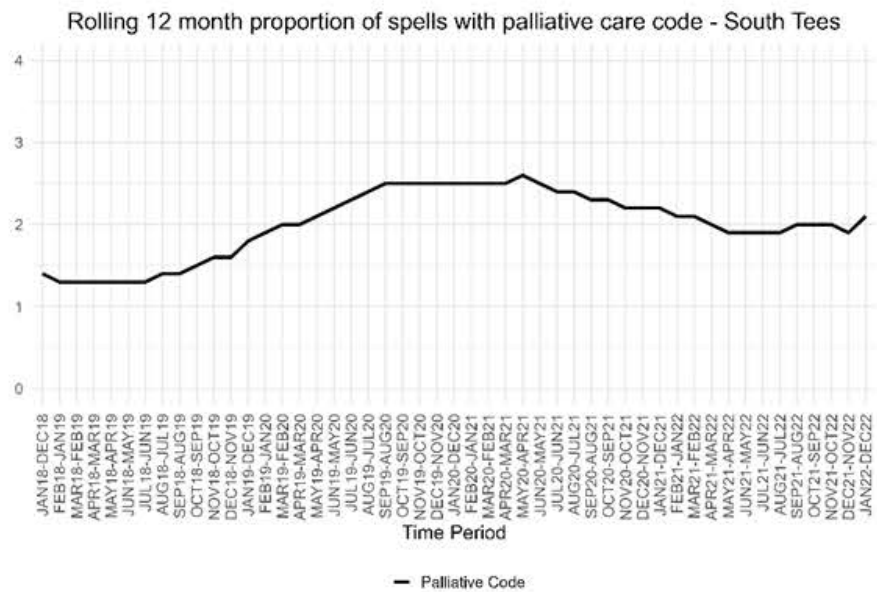
Month	Performance	Target	Trend	Assurance
Feb 2023	100%	95%	H	?











Latest SHMI = 107.8
(Jan 2022 – Dec 2022)

Observed deaths = 2460
Expected deaths = 2280

Coding depth (codes / spell)
Elective = 5.1
Non-Elective = 6.0

Palliative care (%) = 2.1

Latest SHMI is:
'as expected'

COVID-19 impact for England
Excluded spells = 4.6%
Spells as a % pre-pandemic (2019 spells) = 87%

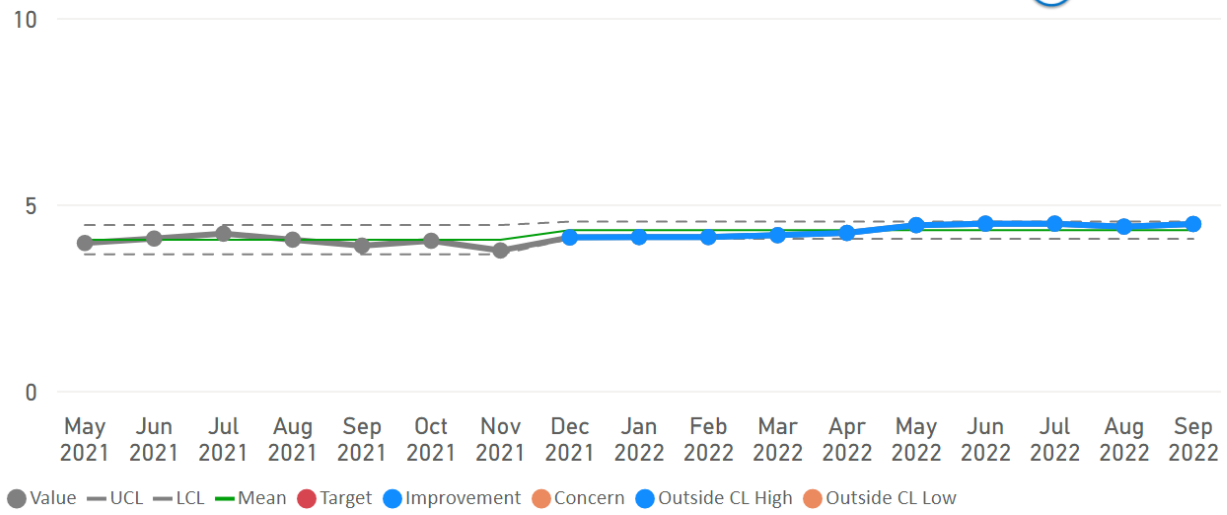
Data source: NHS Digital
Monthly SHMI publication

* There was a large shortfall in the number of observed and expected deaths for the previous month with the volumes reduced to a third of the norm due to an issue with the Trust SUS submission.

EFFECTIVE

Comorbidity Coding

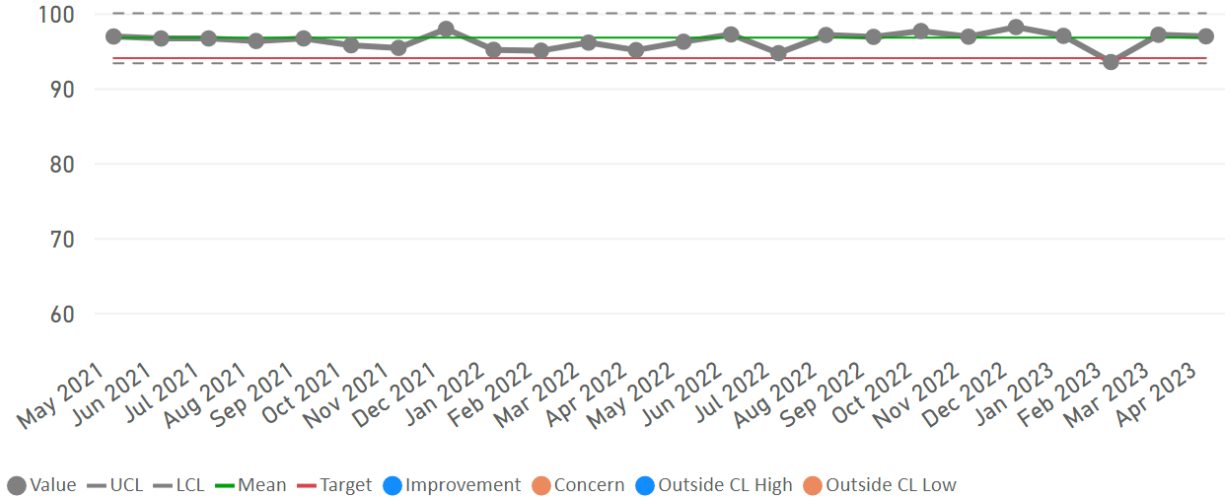
Month	Performance	Target	Trend	Assurance
Sep 2022	4.5			N/A



CARING

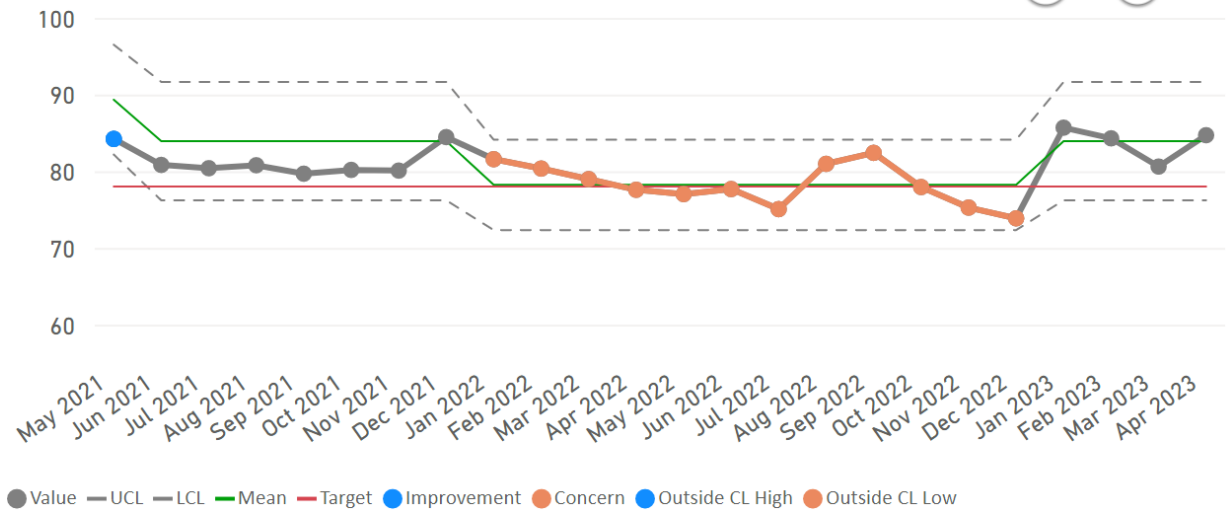
Inpatient Experience (%)

Month	Performance	Target	Trend	Assurance
Apr 2023	96.9%	94%		



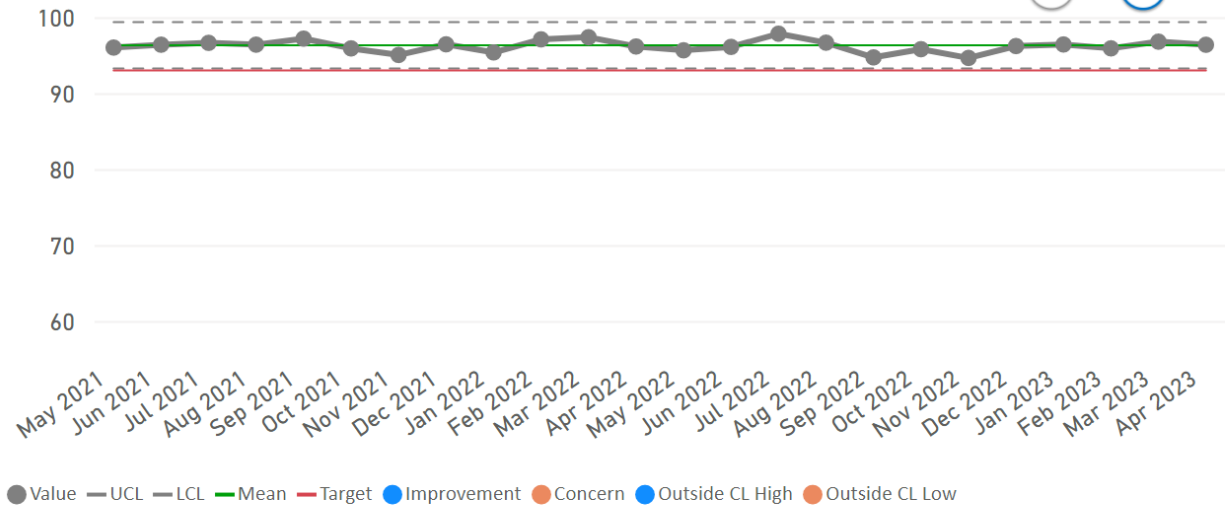
A&E Experience (%)

Month	Performance	Target	Trend	Assurance
Apr 2023	84.7%	78%		



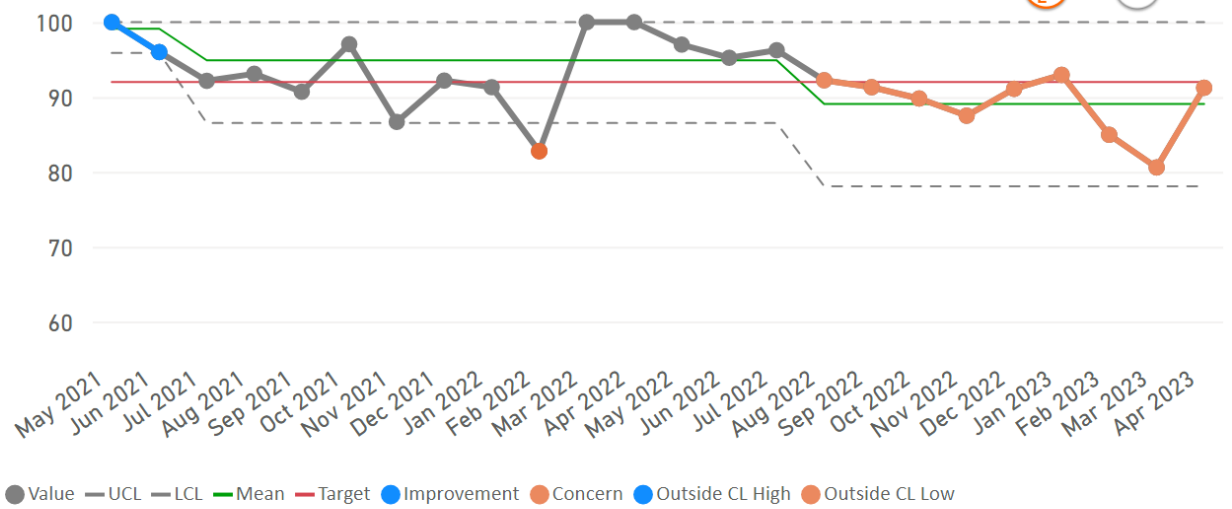
Outpatient Experience (%)

Month	Performance	Target	Trend	Assurance
Apr 2023	96.4%	93%		



Maternity Experience (%)

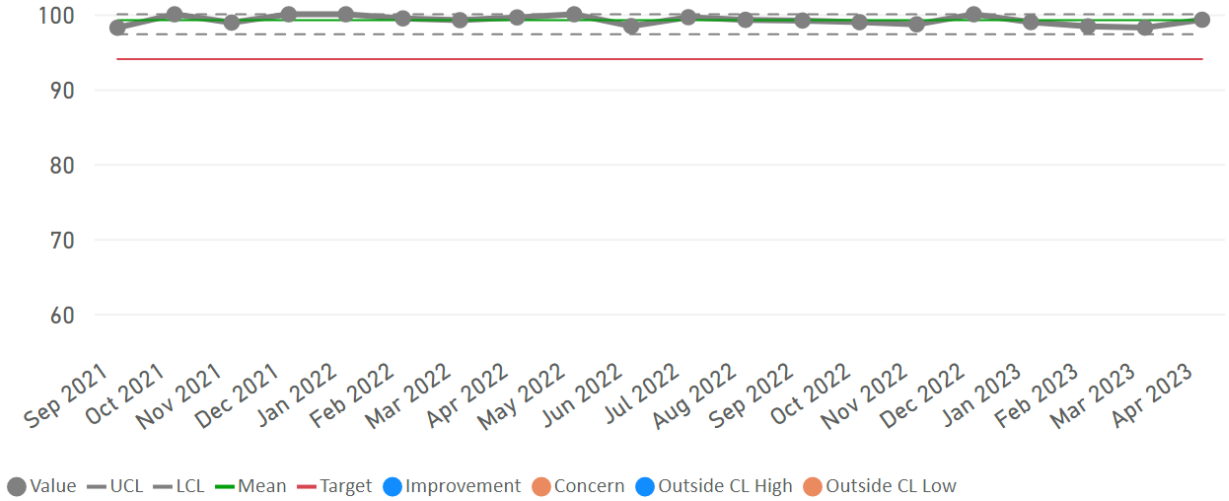
Month	Performance	Target	Trend	Assurance
Apr 2023	91.2%	92%		



CARING

Community Experience (%)

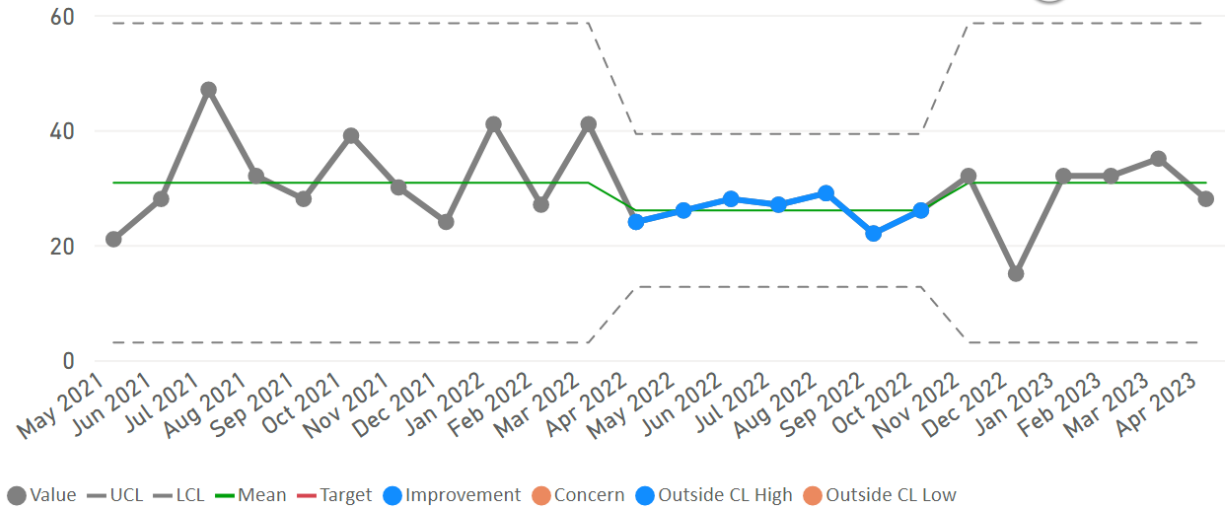
Month	Performance	Target	Trend	Assurance
Apr 2023	99.3%	94%		



CARING

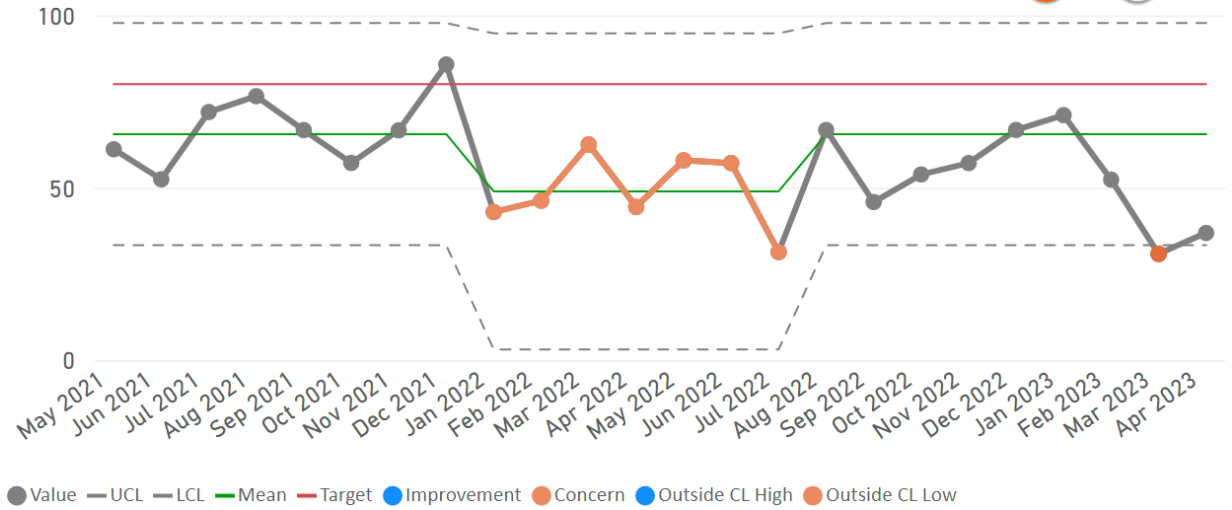
New Complaints

Month	Performance	Target	Trend	Assurance
Apr 2023	28			N/A



Closed Within Target (%)

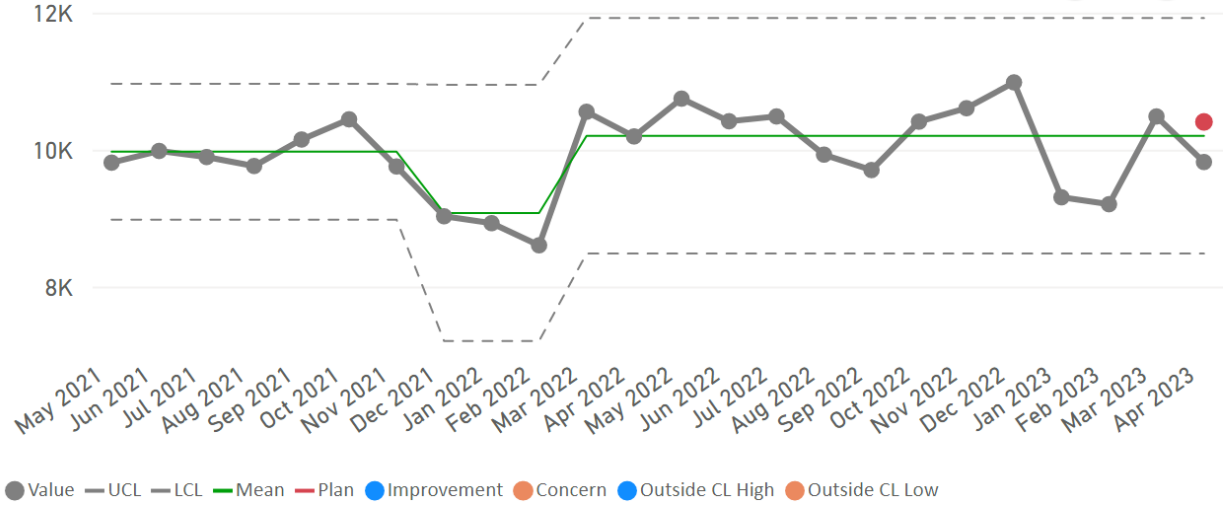
Month	Performance	Target	Trend	Assurance
Apr 2023	36.8%	80%		



RESPONSIVE

A&E Attendances - Type 1

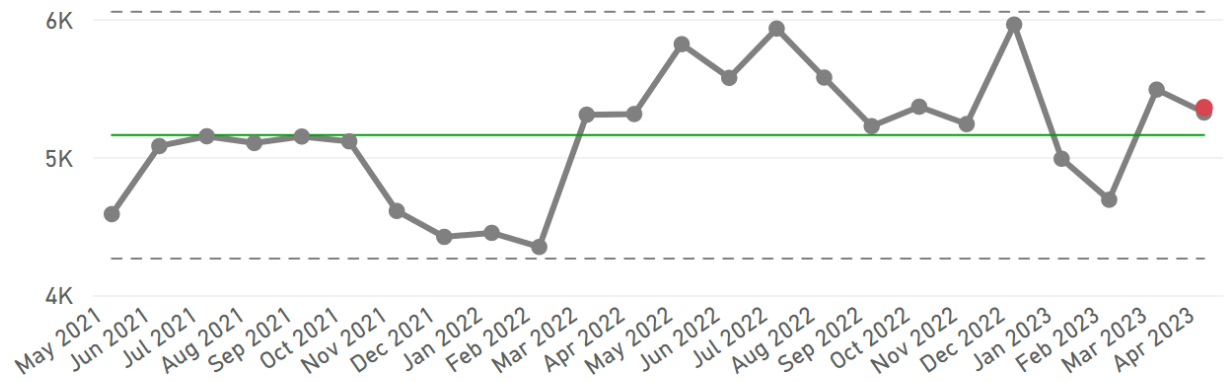
Month	Performance	Plan	Trend	Assurance
Apr 2023	9818	10404		



Value UCL LCL Mean Plan Improvement Concern Outside CL High Outside CL Low

A&E Attendances - Type 3

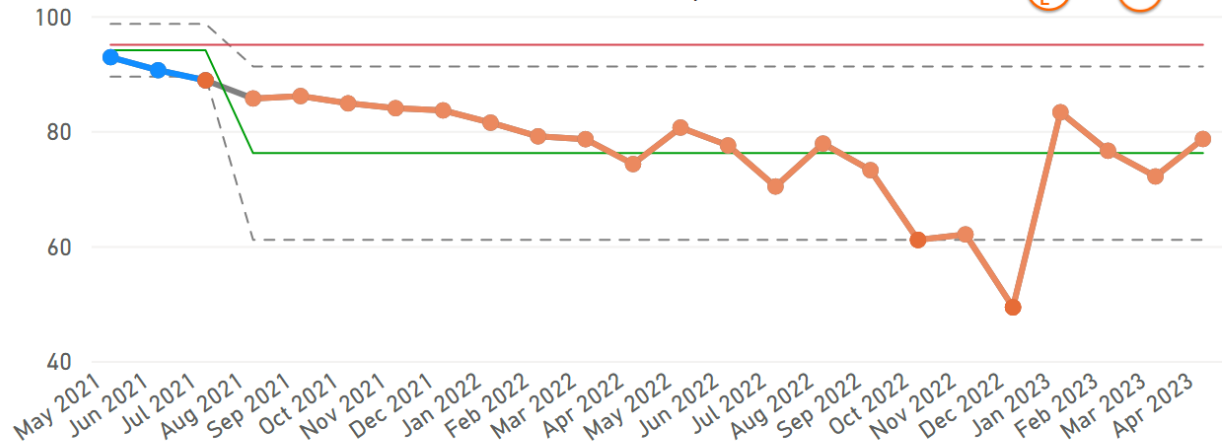
Month	Performance	Plan	Trend	Assurance
Apr 2023	5322	5357		



Value UCL LCL Mean Plan Improvement Concern Outside CL High Outside CL Low

Handovers - Within 30 Mins (%)

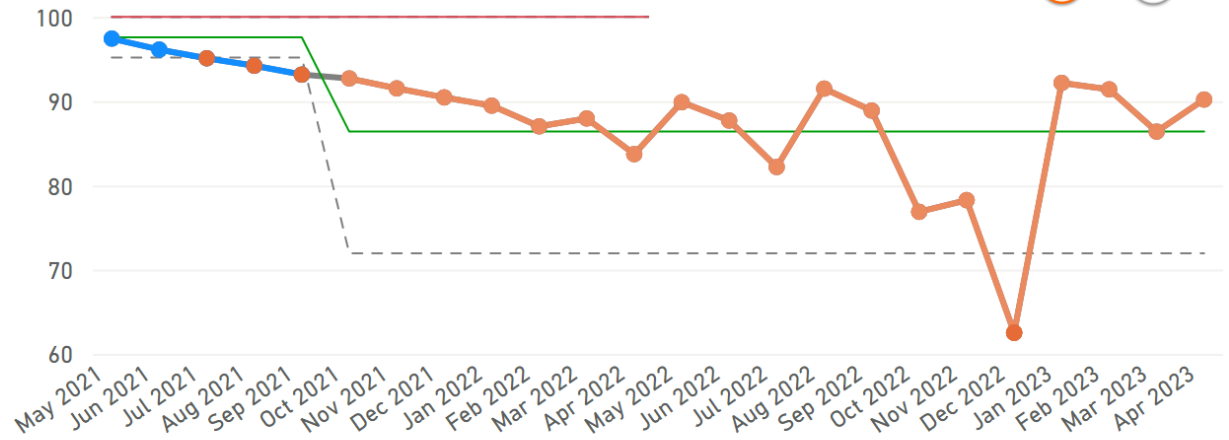
Month	Performance	Target	Trend	Assurance
Apr 2023	78.6%	95%		



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

Handovers - Within 60 Mins (%)

Month	Performance	Target	Trend	Assurance
Apr 2023	90.2%	100%		

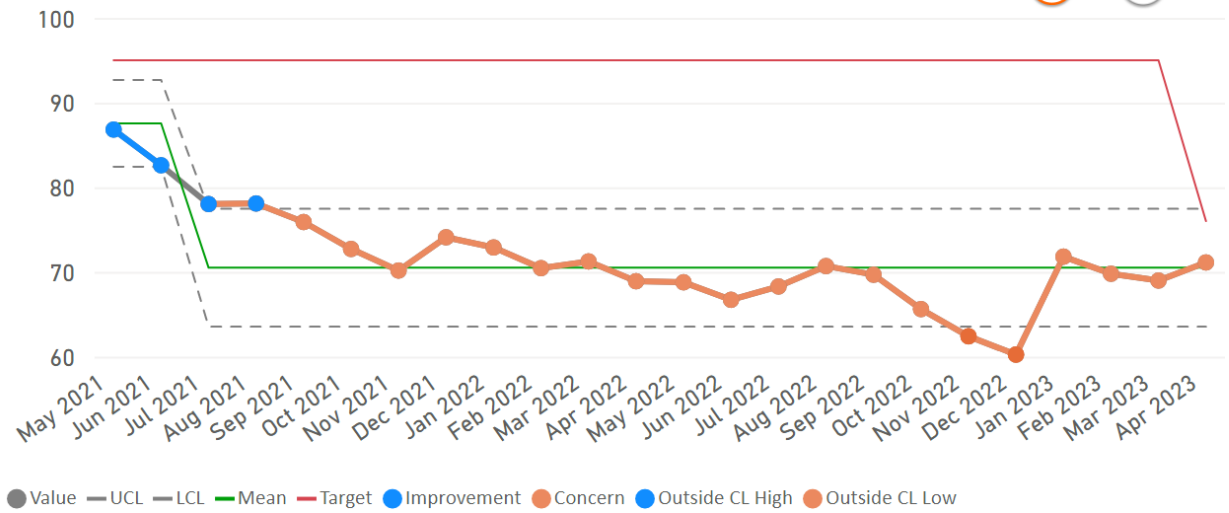


Value UCL LCL Mean Target Improvement Concern Outside CL High Outside CL Low

RESPONSIVE

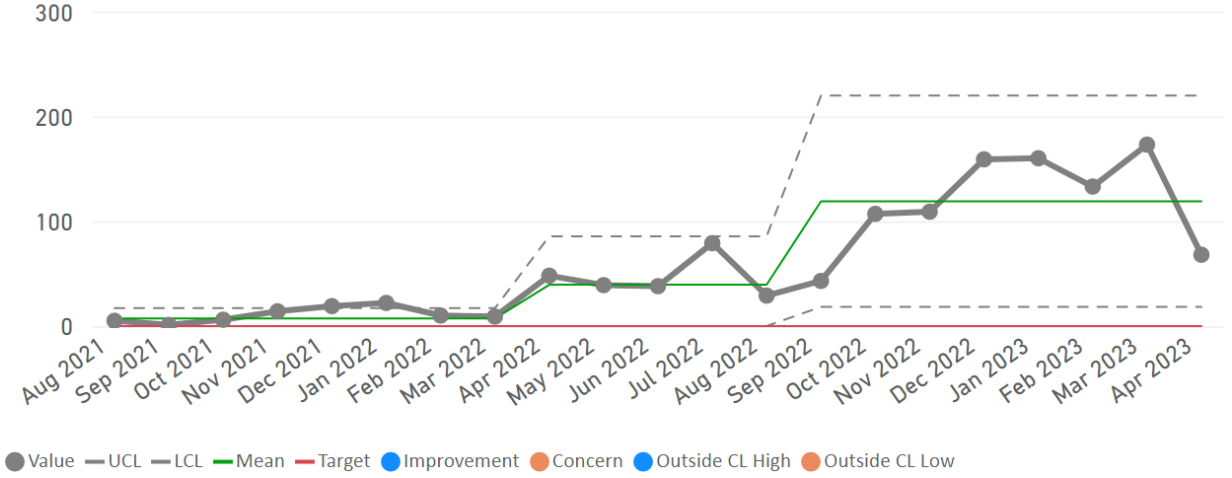
4-Hour A&E Standard

Month	Performance	Target	Trend	Assurance
Apr 2023	71.1%	76%		



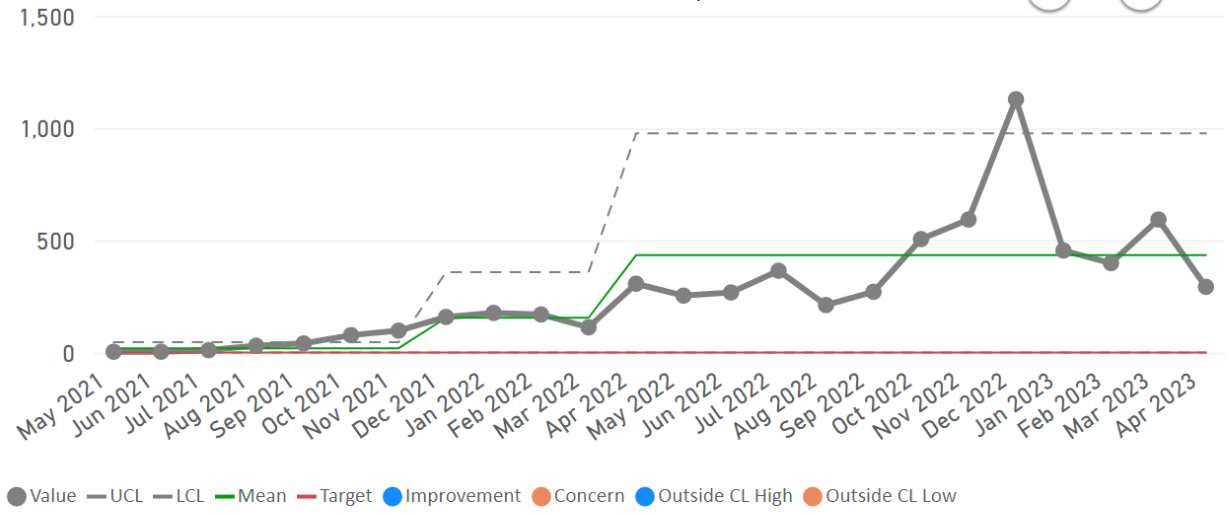
12-Hour Waits from Decision to Admit

Month	Performance	Target	Trend	Assurance
Apr 2023	68	0		N/A



12-Hour A&E Breaches

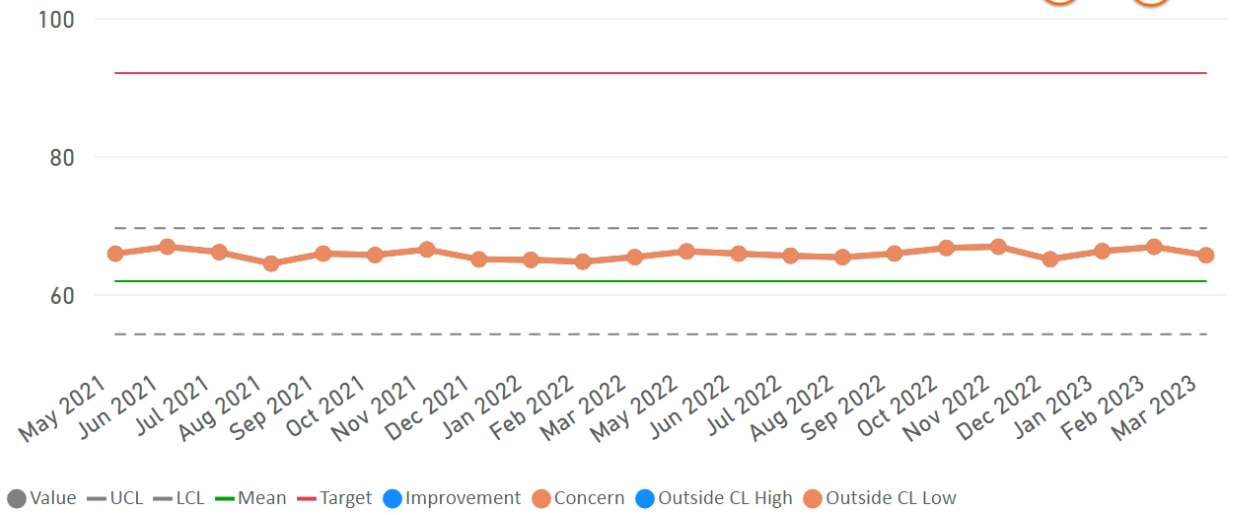
Month	Performance	Target	Trend	Assurance
Apr 2023	292	0		



RESPONSIVE

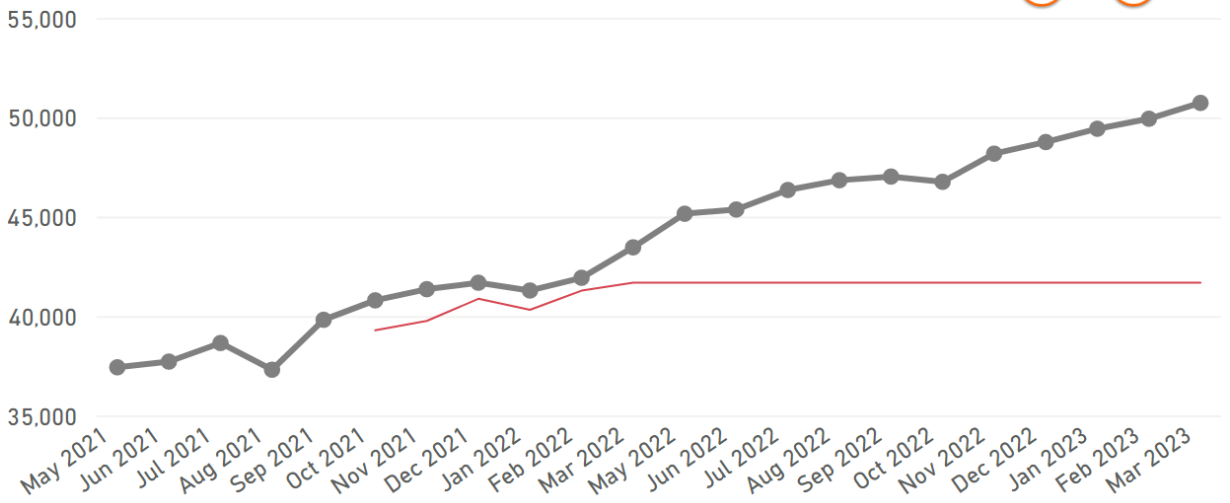
RTT Incomplete Pathways (%)

Month	Performance	Plan	Trend	Assurance
Mar 2023	65.6%	92%	L	F



RTT Waiting List Size

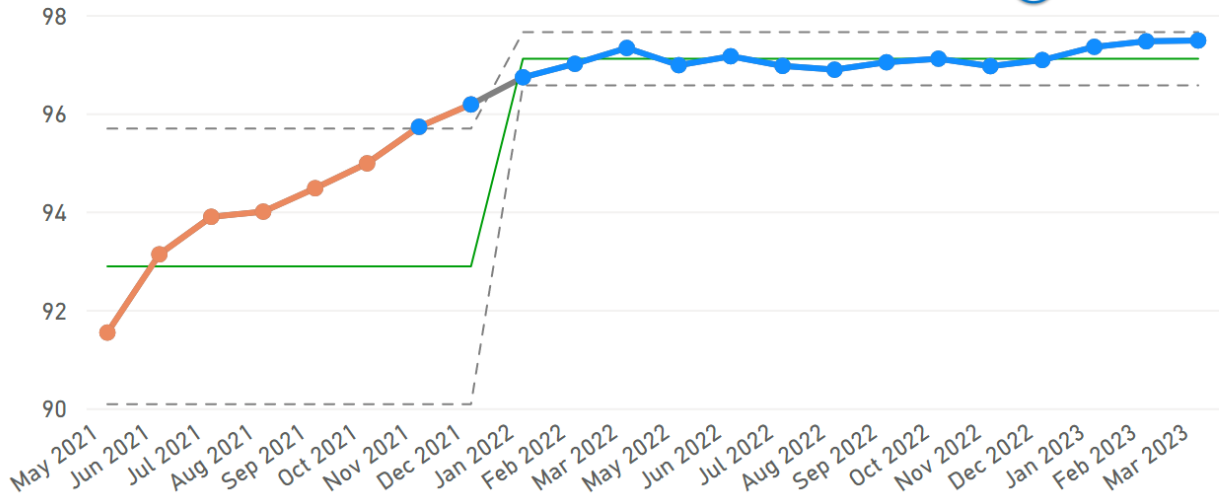
Month	Performance	Plan	Trend	Assurance
Mar 2023	50721	41677	H	F



RESPONSIVE

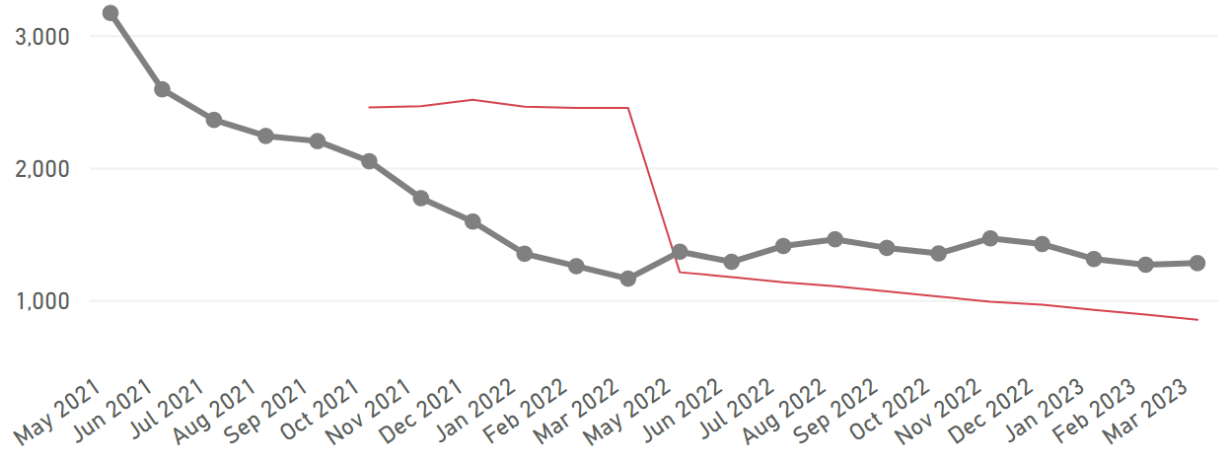
RTT List Size within 52 weeks (%)

Month	Performance	Plan	Trend	Assurance
Mar 2023	97.5%			N/A



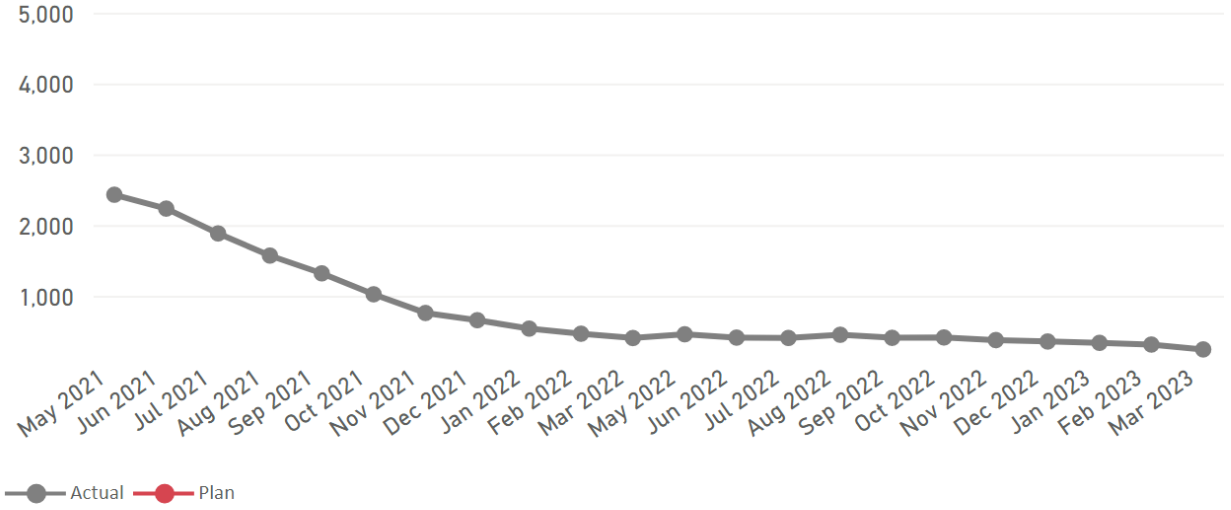
RTT 52 week waiters

Month	Performance	Plan	Trend	Assurance
Mar 2023	1279	851	N/A	N/A



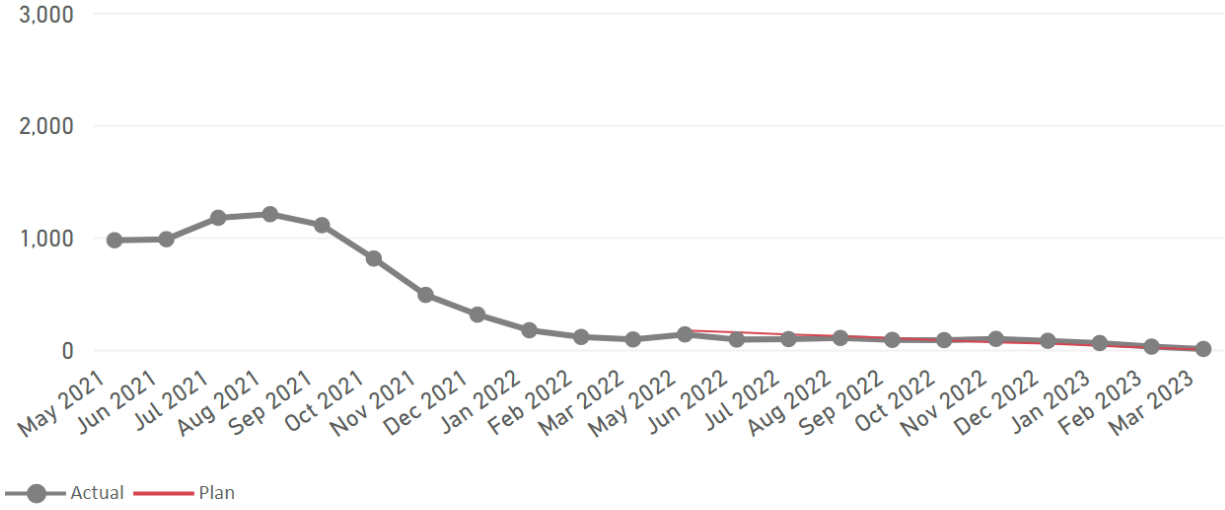
RTT 65 week waiters

Month	Performance	Plan	Trend	Assurance
Mar 2023	242		N/A	N/A



RTT 78 week waiters

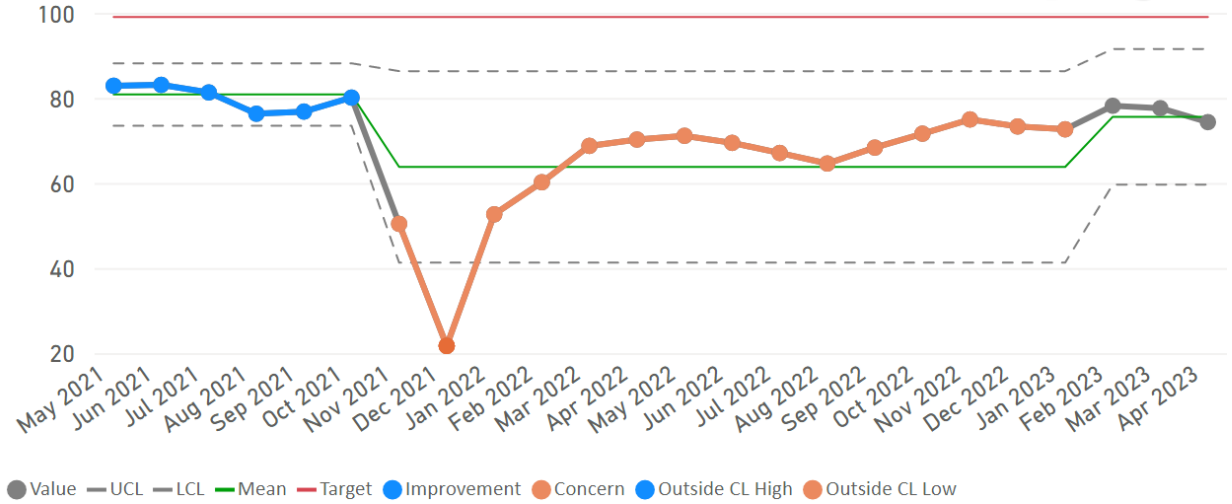
Month	Performance	Plan	Trend	Assurance
Mar 2023	4	0	N/A	N/A



RESPONSIVE

Diagnostic 6 Weeks Standard (%)

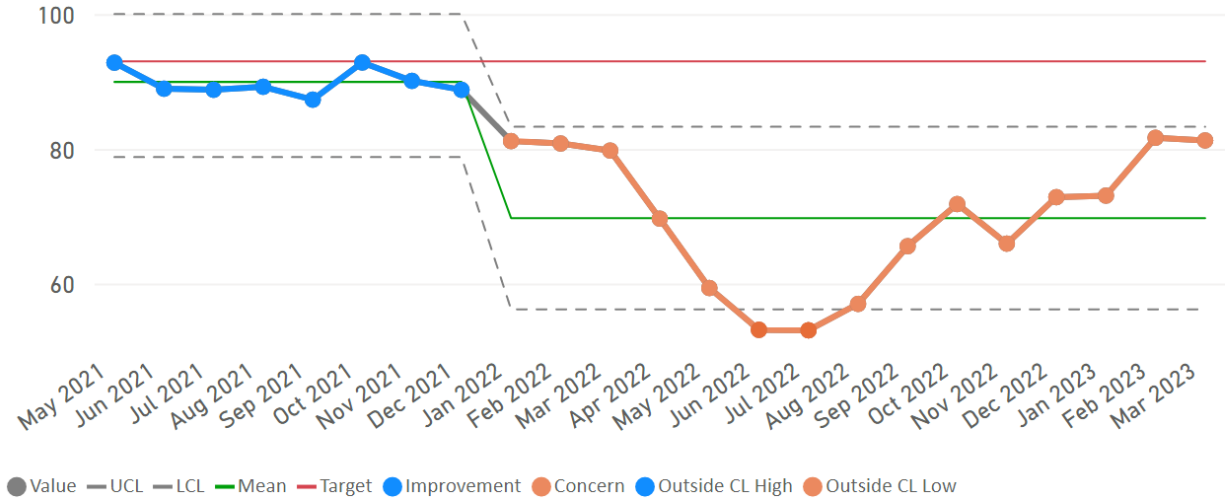
Month	Performance	Target	Trend	Assurance
Apr 2023	74.3%	99%		



RESPONSIVE

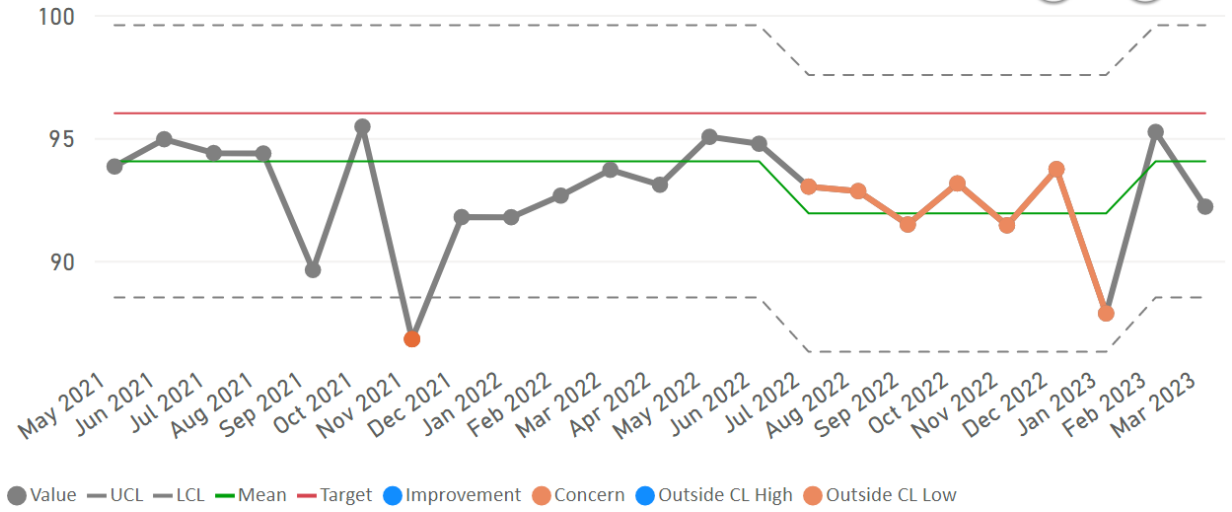
Cancer 14 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Mar 2023	81.3%	93%		



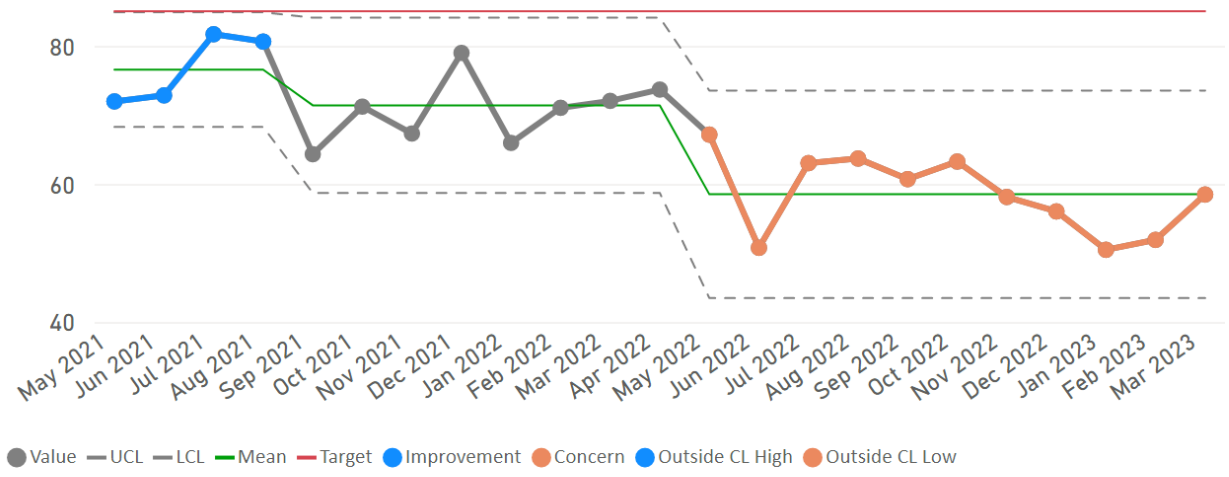
Cancer 31 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Mar 2023	92.2%	96%		



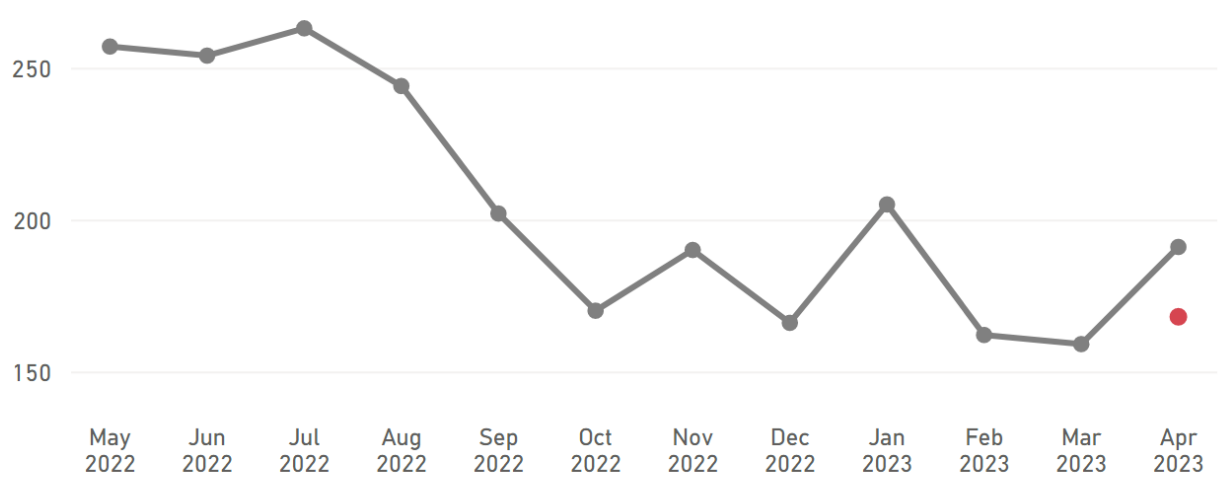
Cancer 62 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Mar 2023	58.4%	85%		



Cancer >62 Day Backlog

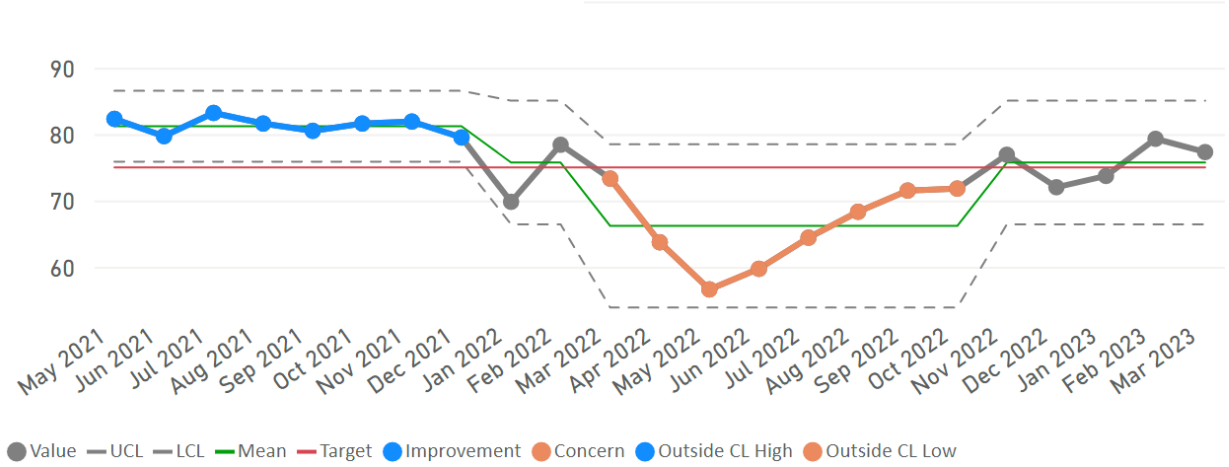
Month	Performance	Target	Trend	Assurance
Apr 2023	191	168	N/A	N/A



RESPONSIVE

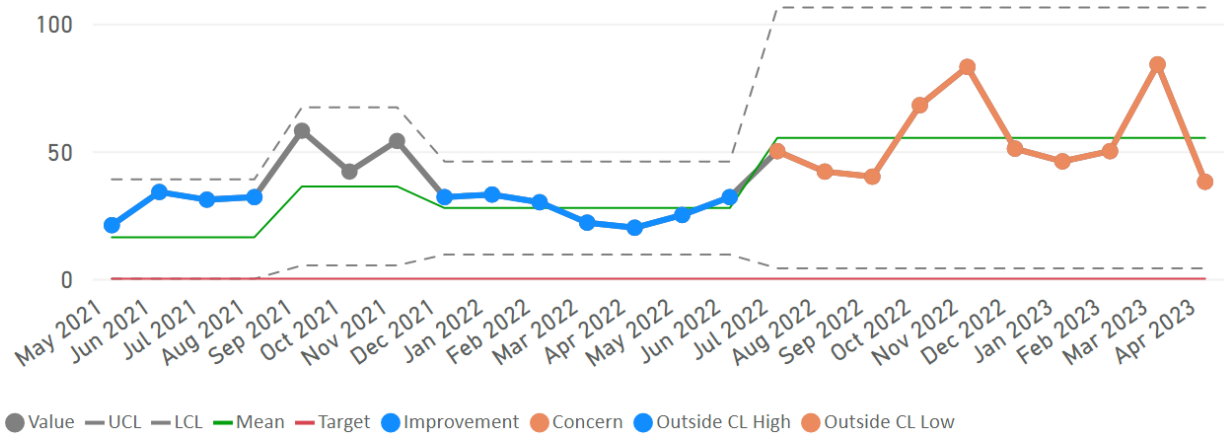
Cancer - Faster Diagnosis Standard (%)

Month	Performance	Target	Trend	Assurance
Mar 2023	77.3%	75%		



Cancelled Ops - Non-Urgent Cancelled On Day

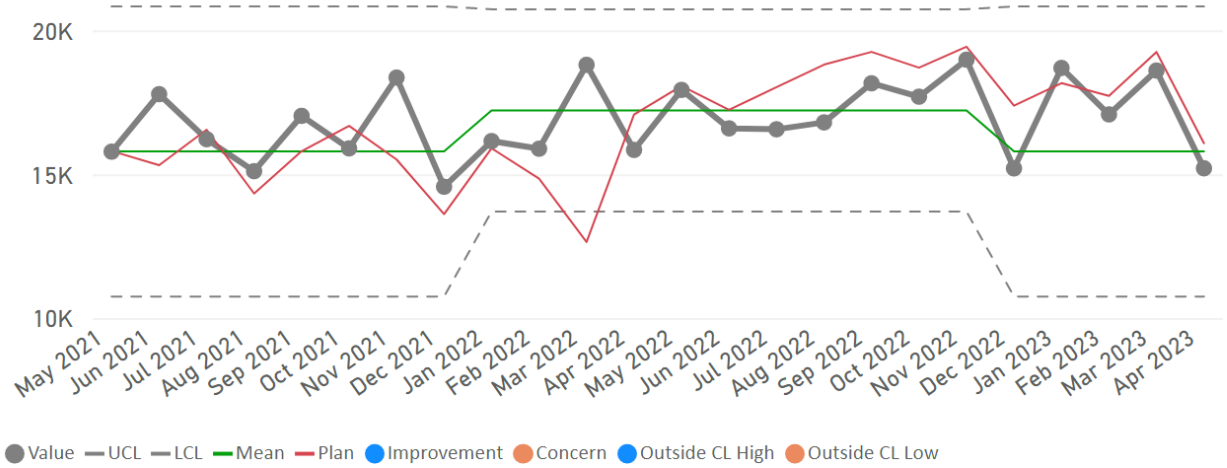
Month	Performance	Target	Trend	Assurance
Apr 2023	38	0		



RESPONSIVE

Outpatient First Attendances

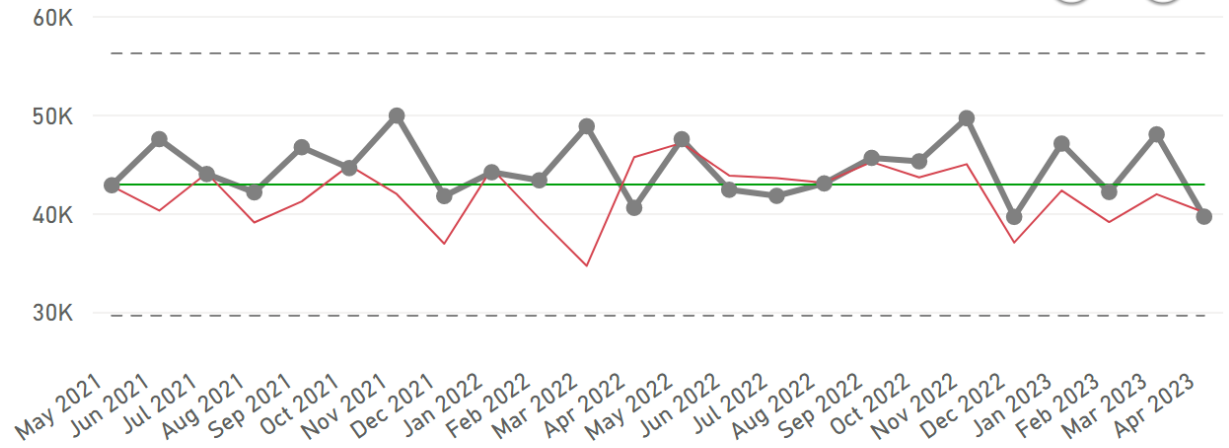
Month	Performance	Plan	Trend	Assurance
Apr 2023	15206	16079		



Value UCL LCL Mean Plan Improvement Concern Outside CL High Outside CL Low

Outpatient Follow Up Attendances

Month	Performance	Plan	Trend	Assurance
Apr 2023	39639	40072		

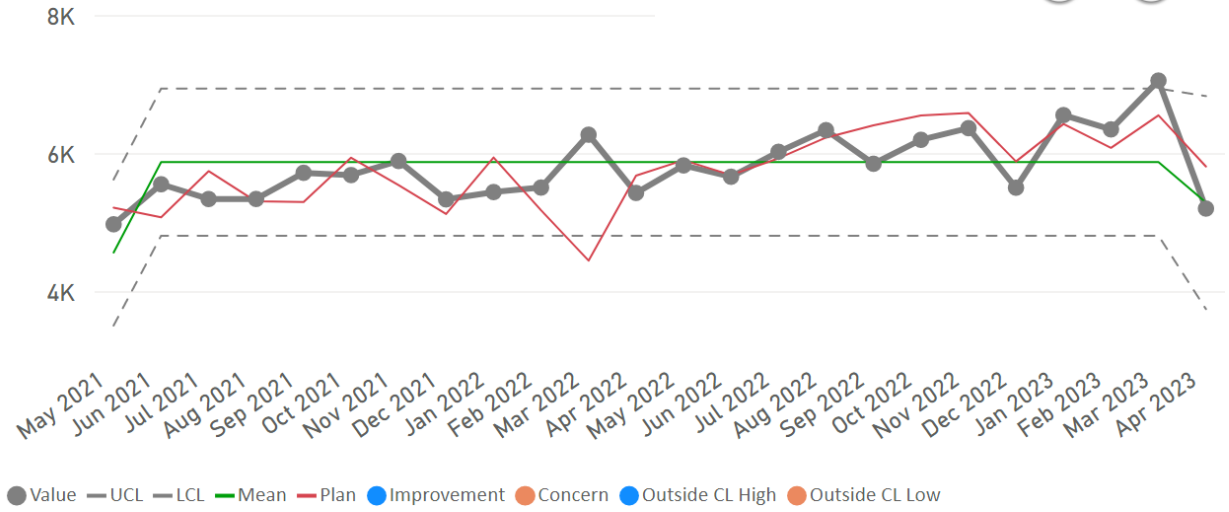


Value UCL LCL Mean Plan Improvement Concern Outside CL High Outside CL Low

RESPONSIVE

Day Case admissions

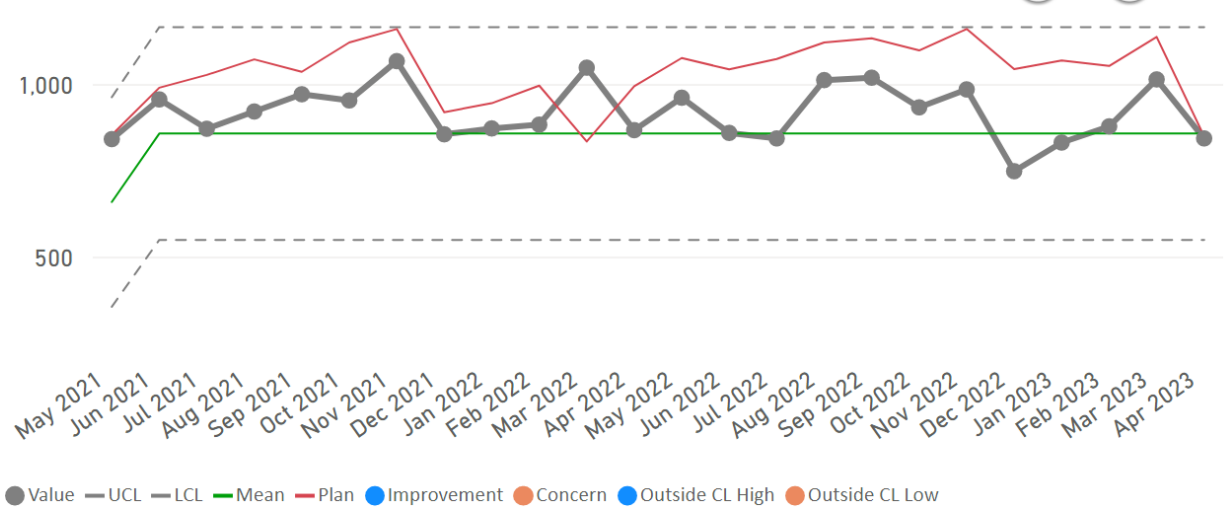
Month	Performance	Plan	Trend	Assurance
Apr 2023	5194	5804		



Value UCL LCL Mean Plan Improvement Concern Outside CL High Outside CL Low

Ordinary Elective admissions

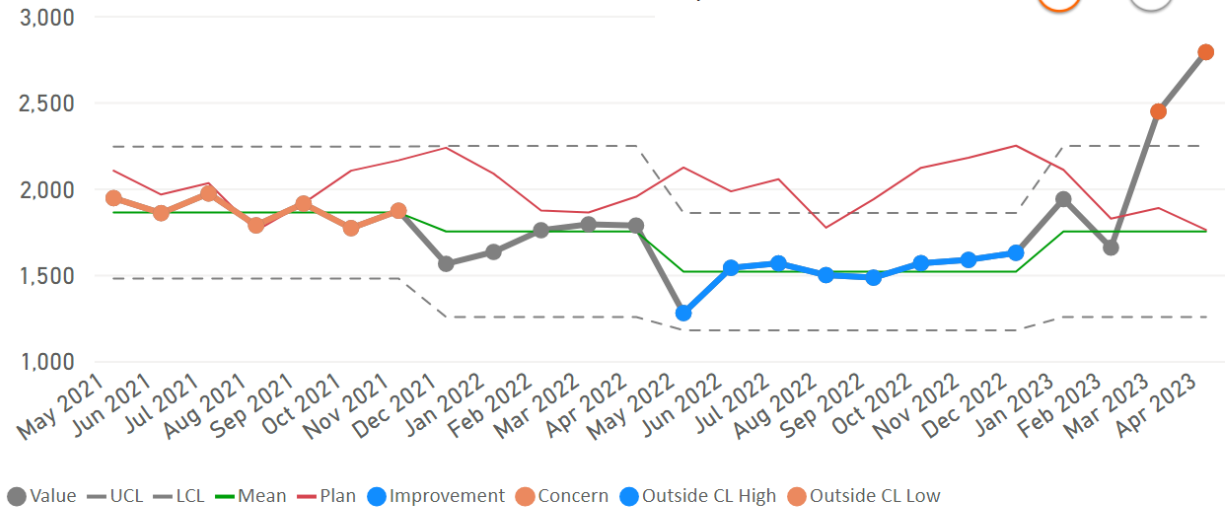
Month	Performance	Plan	Trend	Assurance
Apr 2023	842	848		



Value UCL LCL Mean Plan Improvement Concern Outside CL High Outside CL Low

NEL admissions with 0 LOS

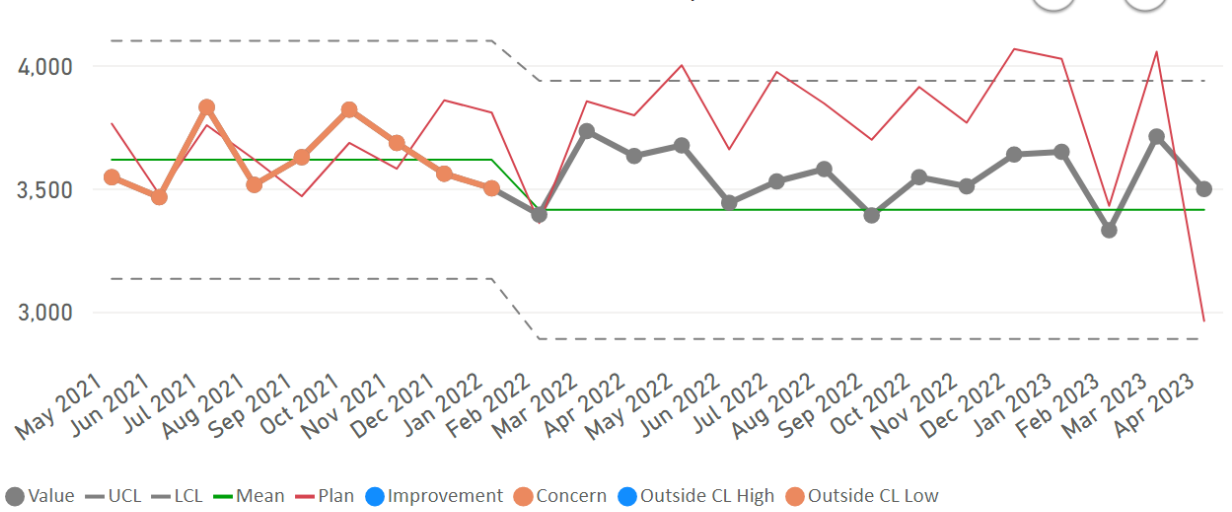
Month	Performance	Plan	Trend	Assurance
Apr 2023	2789	1759		



Value UCL LCL Mean Plan Improvement Concern Outside CL High Outside CL Low

NEL admissions with 1+ LOS

Month	Performance	Plan	Trend	Assurance
Apr 2023	3497	2962		

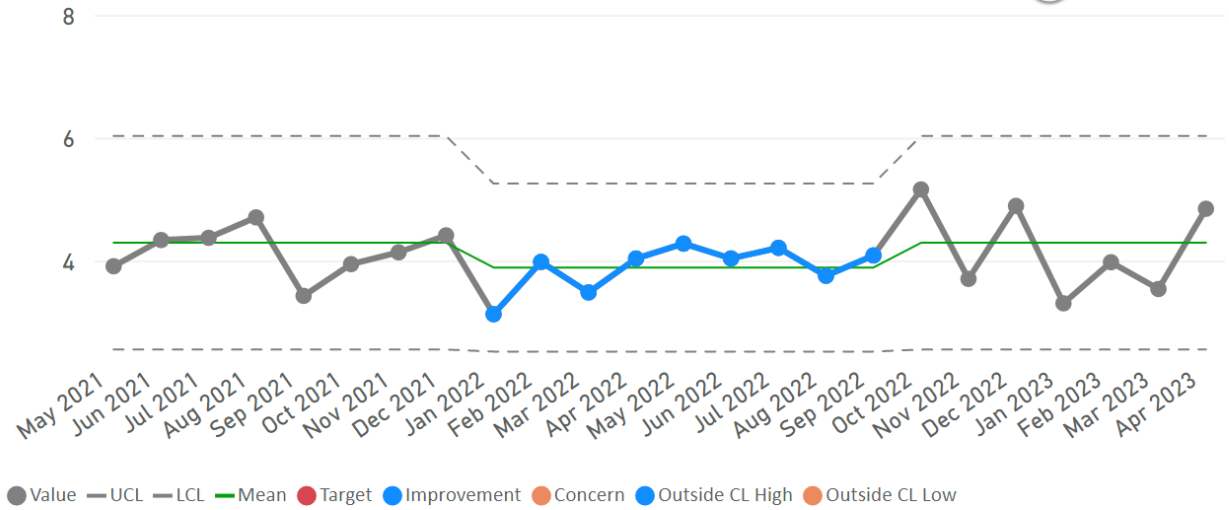


Value UCL LCL Mean Plan Improvement Concern Outside CL High Outside CL Low

RESPONSIVE

Length of Stay - Elective

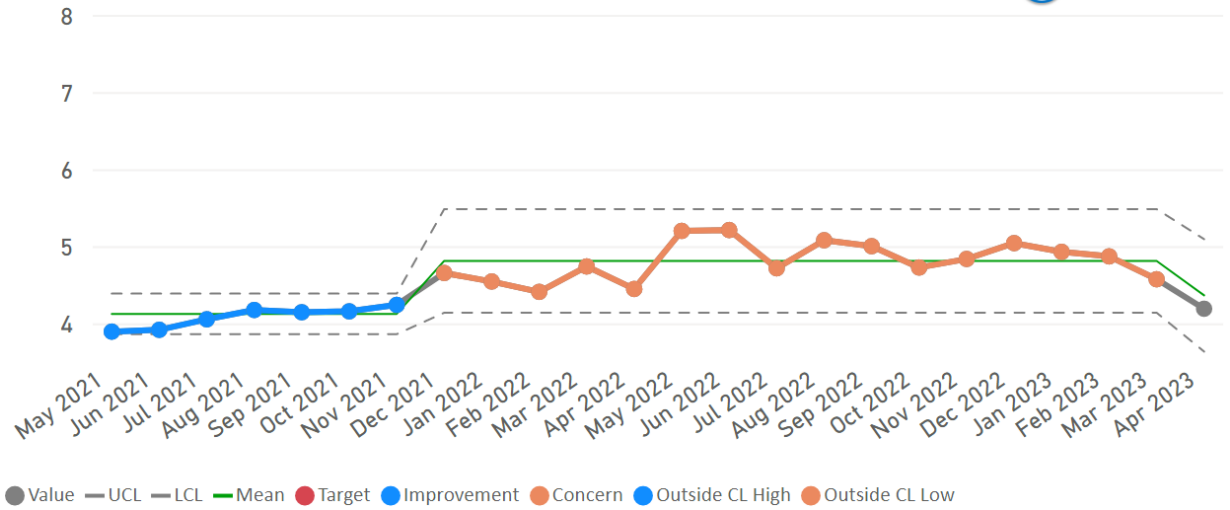
Month	Performance	Target	Trend	Assurance
Apr 2023	4.8			N/A



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

Length of Stay - Non-Elective

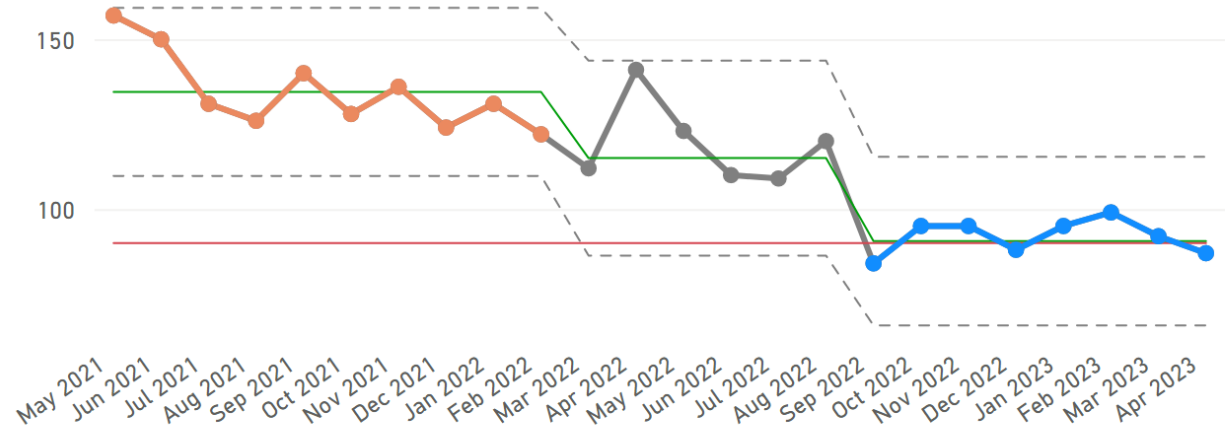
Month	Performance	Target	Trend	Assurance
Apr 2023	4.2			N/A



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

Not Met Not Discharged

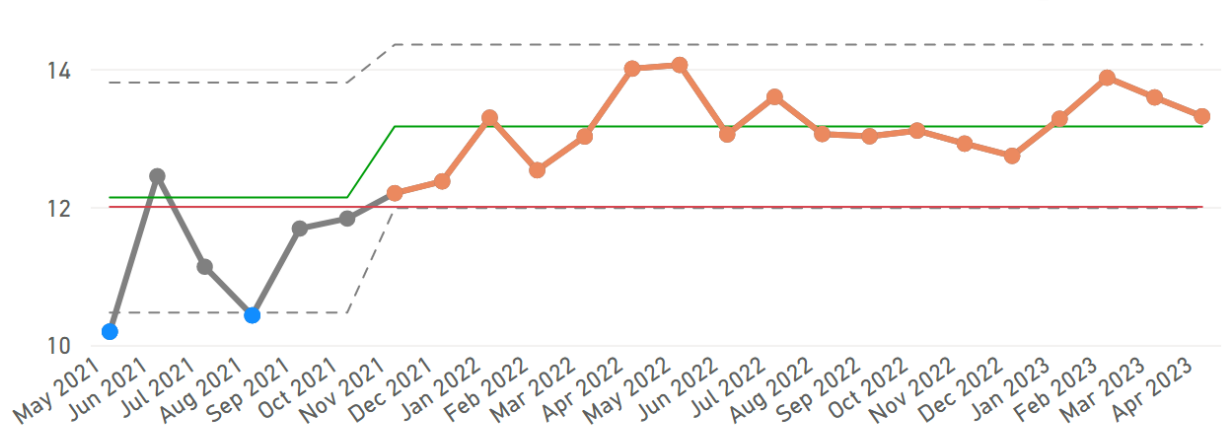
Month	Performance	Plan	Trend	Assurance
Apr 2023	87	90		



Value UCL LCL Mean Plan Improvement Concern Outside CL High Outside CL Low

21 Day Stranded Patients (%)

Month	Performance	Plan	Trend	Assurance
Apr 2023	13.3%	12%		

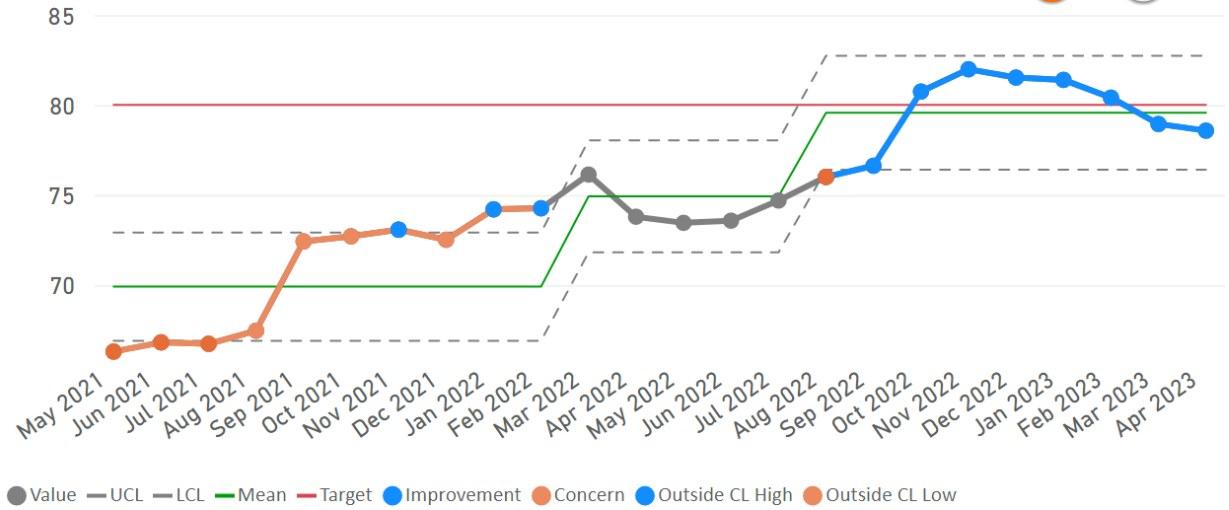


Value UCL LCL Mean Plan Improvement Concern Outside CL High Outside CL Low

WELL-LED

Annual Appraisal (%)

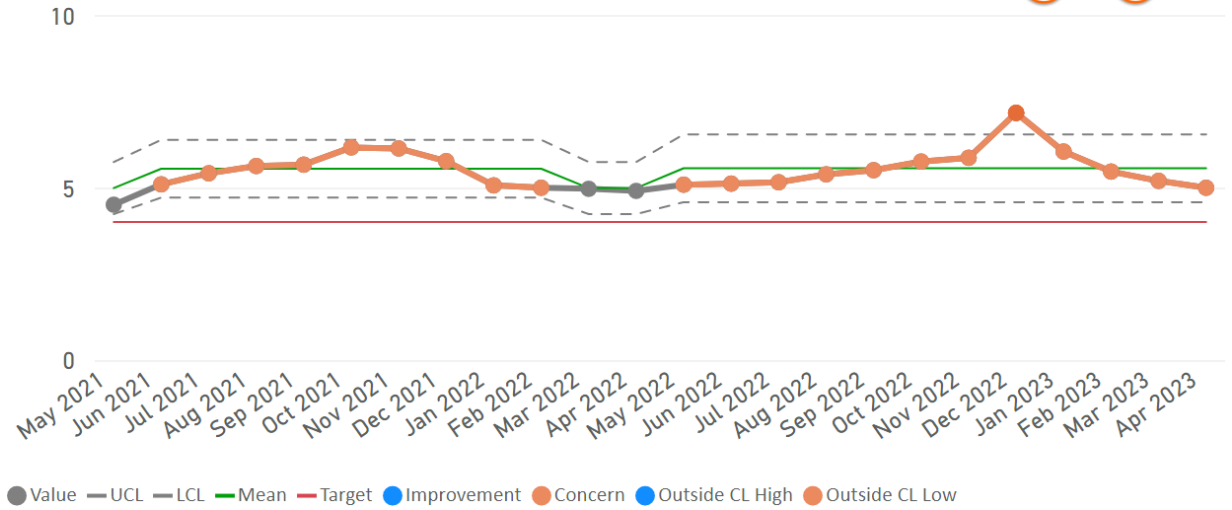
Month	Performance	Target	Trend	Assurance
Apr 2023	78.6%	80%		



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

Sickness Absence (%)

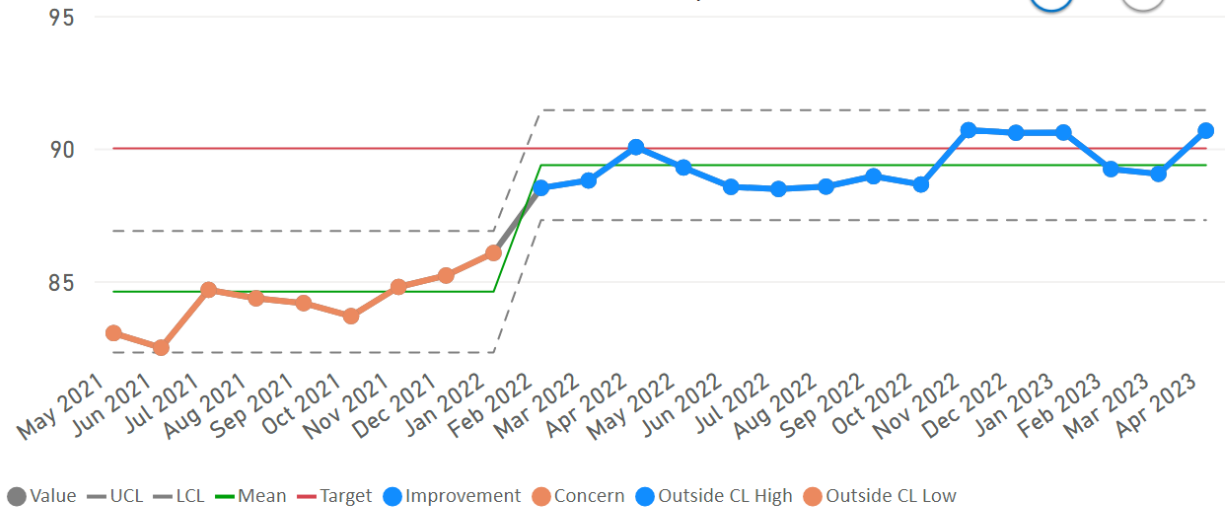
Month	Performance	Target	Trend	Assurance
Apr 2023	5%	4%		



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

Mandatory Training (%)

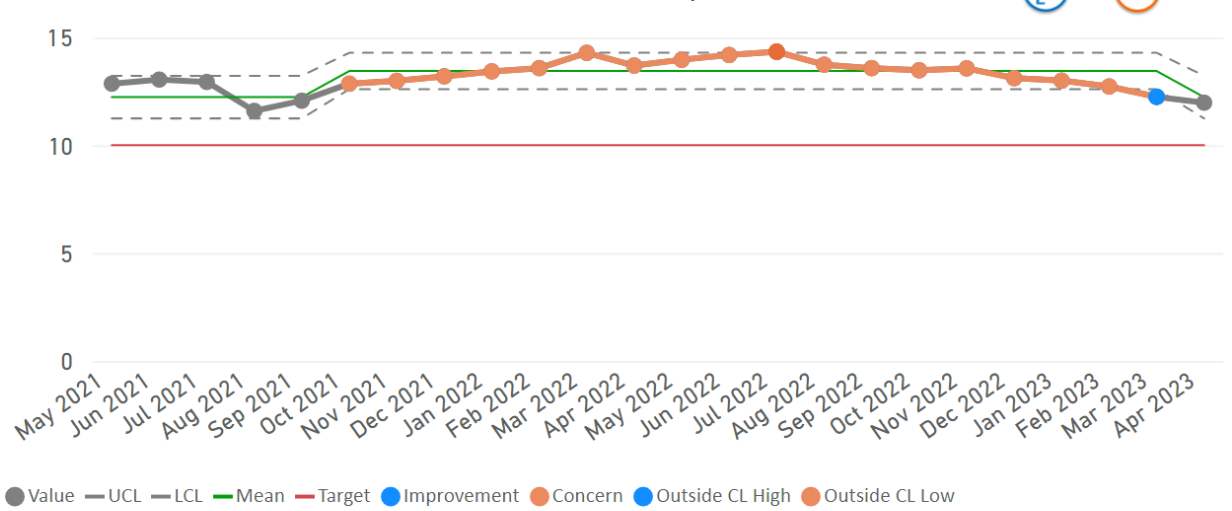
Month	Performance	Target	Trend	Assurance
Apr 2023	90.7%	90%		



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

Staff Turnover (%)

Month	Performance	Target	Trend	Assurance
Apr 2023	12%	10%		

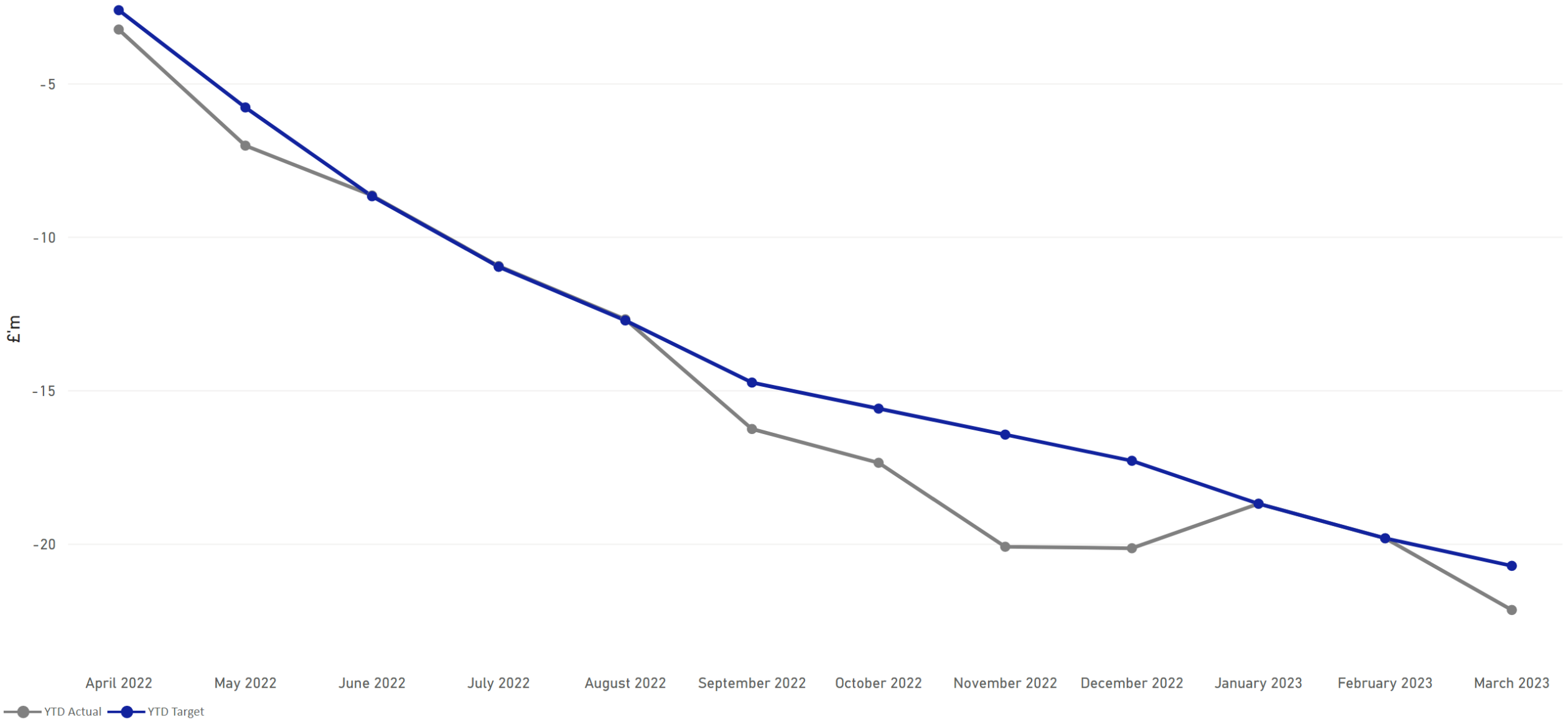


Value UCL LCL Mean Target Improvement Concern Outside CL High Outside CL Low

WELL-LED

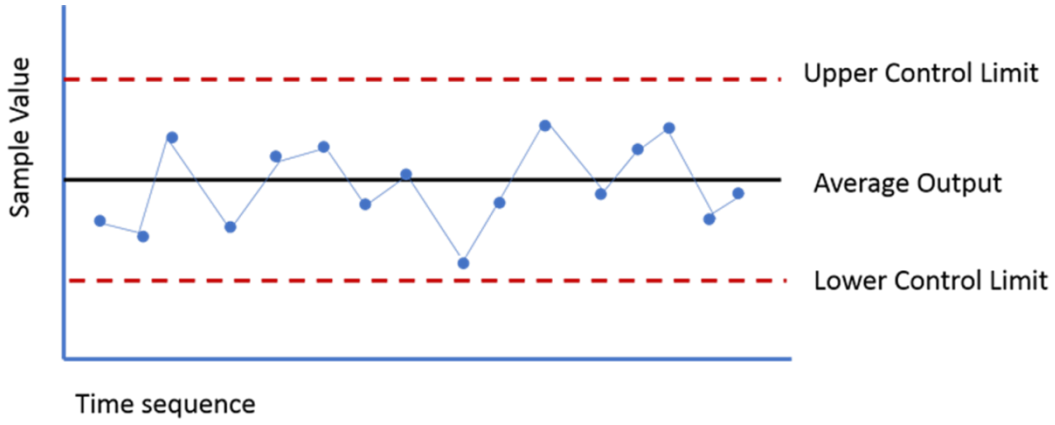
Cumulative YTD Financial Position (£'millions)

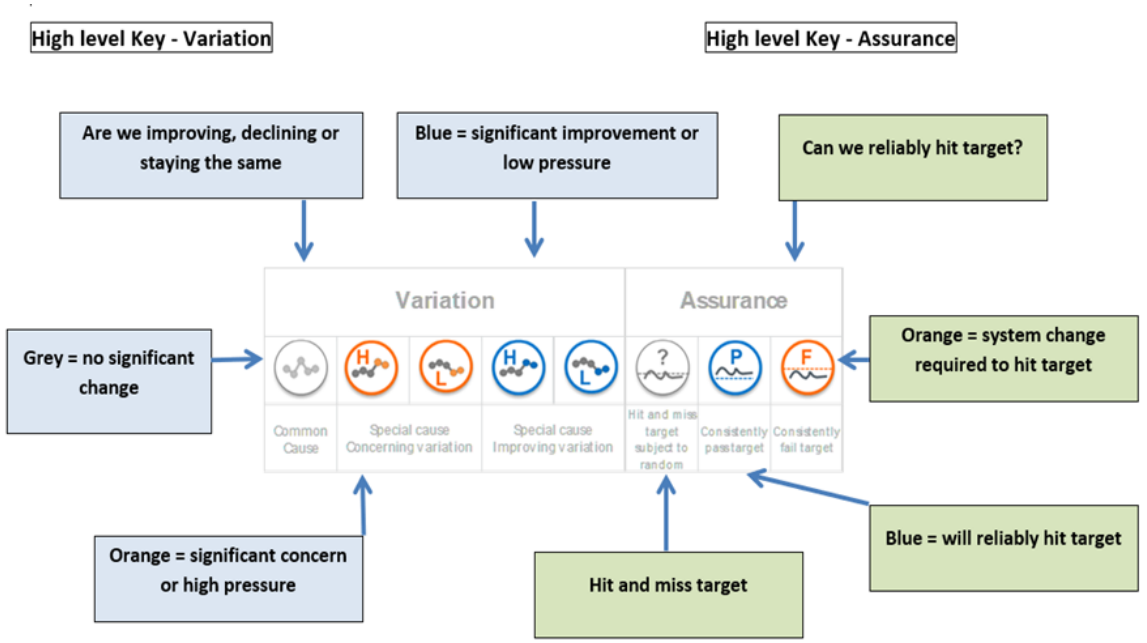
Month	Performance	Target
Mar 2023	-£22.158m	-£20.72m



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 – 6 JUNE 2023			
Safe Staffing Report for April 2023			**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 April 2023 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 slightly to 97.5% as per Table 1 demonstrating continued good compliance with safer staffing. As staffing continues to improve across all collaboratives this has allowed for a further reduction in all shift fill incentives via NHSp throughout May. Stretch staffing ratios in line with national guidance have been implemented where necessary based on skill mix, acuity, and occupancy levels, all these actions agreed by senior nurses through safe care meetings. The trust remains one of the lowest in the country for nursing turnover.		
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 3 Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit and retain BAF 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	• Care Quality Commission • NHS Improvement • NHS England		
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☒	

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

Nursing and Midwifery Workforce Exception Report

April 2023

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 if required. A look forward to the week ahead on Mondays and the weekend on Fridays takes place with Associate Chief Nurses, Heads of Nursing and Matrons. Staff movement takes place to ensure patient safety by Matrons and Ward Managers.

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

		Feb 23	Mar 23	April 23
Overall, Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	80.1%	80.8%	83.1%
	HCA (%) Average fill rate - DAYS	96.1%	96.3%	98.8%
	NA (%) Average fill rate - DAYS	100.0%	100.0%	100.0%
	TNA (%) Average fill rate - DAYS	100.0%	100.0%	100.0%
	RN/RMs (%) Average fill rate – NIGHTS	89.2%	91.4%	91.7%
	HCA (%) Average fill rate - NIGHTS	103.2%	105.9%	106.3%
	NA (%) Average fill rate - NIGHTS	100.0%	100.0%	100.0%
	TNA (%) Average fill rate - NIGHTS	100.0%	100.0%	100.0%
	Total % of Overall planned hours	**96.1%**	**96.8%**	**97.5%**

Redeployment of staff has taken place on a regular basis to ensure wards are safely staffed with 189 total shifts (1874.83 hours) logged via SafeCare during April which was a decrease on March hours. Whilst redeployment remains an unpopular option staff are reassured that every solution is explored prior to any moves.

Nursing turnover has decreased from 7.48 to 6.87%. This excludes transfers and flexi-retirement these reasons however are included in the fortnightly workforce meetings.

2. Nurse Sensitive Indicators

No staffing factors were identified as part of any SI review process in April 2023.

3. Red Flags Raised through SafeCare Live

April has shown the lowest number of red flags raised through SafeCare live. There are 52 open red flags relating to workforce. 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 April. Reminders are sent to ward managers and matrons to review and close red

flags. As part of the refreshed collaborative staffing meetings information is now provided on the appropriate use of red flags and the importance of closing red flags to provide correct resolution and audit data.

4. Datix Submissions

There were 62 datix submissions relating to staffing in April. The majority of datix were for staffing. However, allocate on arrival and in collaborative moves resolved the issues. Redeployment decisions were made following safer staffing discussions with ward managers and matron agreement.

The Nursing Workforce Team continues to work closely with HR senior team and the temporary staffing providers (NHSp) to improve fill rates and maintain safe staffing. Band 5 RN vacancies continue to be monitored closely as this was the most fluctuating and largest group within the nursing workforce. However, the reduction month on month of band 5 vacancies indicates an improving position.

5. Vacancy & Turnover

Active recruitment of nursing staff continues. **Appendix 2** shows registered nursing and midwifery vacancy rate for April 23. **Appendix 3** shows healthcare assistant vacancy rate for April 23.

International Nurse Recruitment: recruitment has continued however based on the reduction of RN vacancies there will be a 3-month break with recruitment. This will create posts for the student cohort qualifying in September.

6. RECOMMENDATIONS

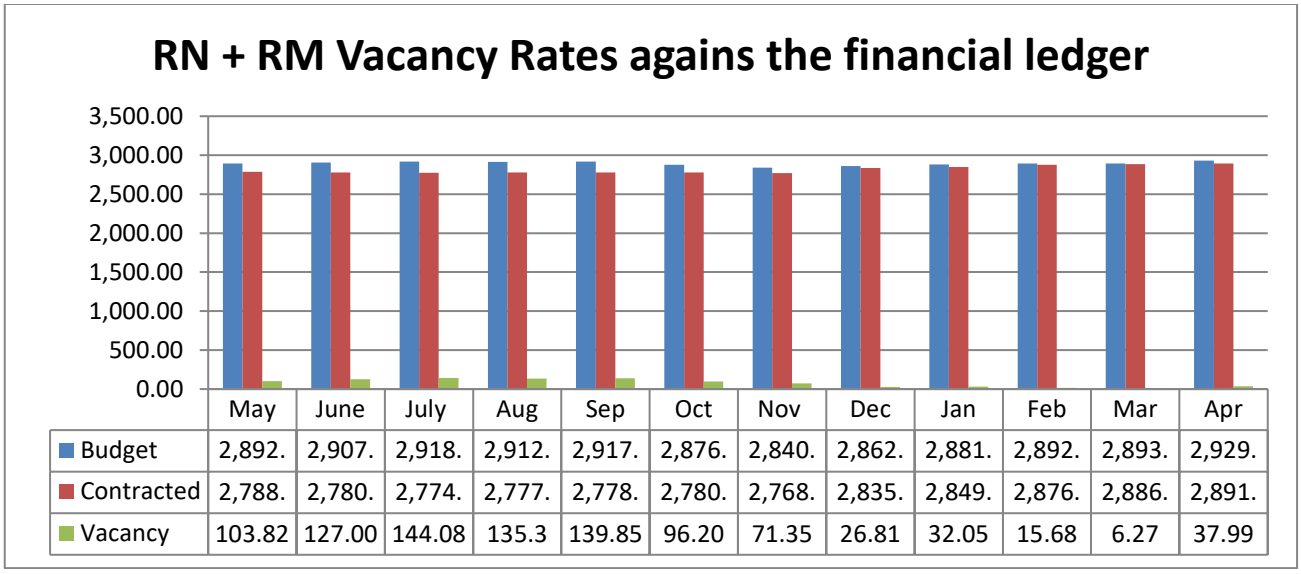
The Board is asked to note the content of this report and the progress in relation to arrangements in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

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

Wards	Physical Bed Capacity	Open Bed Capacity	Total CHPP	Occupied Bed No – Apr 23 (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	752	25	81.6%	102.4%	-	100.0%	75.3%	101.4%	-	100.0%	Short term sickness
Ward 31 (2)	28	28	988	33	77.6%	91.3%	-	100.0%	75.9%	97.9%	-	100.0%	Short term sickness
Ward 3	28	28	703	23	92.0%	140.4%	100.0%	100.0%	97.6%	152.7%	-	100.0%	
Ward 4	23	23	642	21	90.5%	119.4%	-	-	86.6%	101.7%	-	-	
Ward 5	28	22	461	15	84.0%	99.6%	-	100.0%	85.6%	148.4%	-	-	
Ward 6	31	31	850	28	73.9%	131.4%	-	-	75.7%	131.7%	-	-	RN vacancies
Ward 7	32	32	326	11	84.0%	107.1%	100.0%	100.0%	85.6%	98.4%	-	-	
Ward 8	30	30	754	25	76.3%	111.3%	-	100.0%	95.6%	98.9%	-	-	RN vacancies
Ward 9	32	28	907	30	81.3%	159.0%	-	-	92.5%	134.7%	-	-	
Ward 10	24	24	677	23	76.4%	96.3%	-	-	69.0%	141.2%	-	-	RN vacancies and short-term sickness
Ward 11	28	28	815	27	81.8%	97.8%	100.0%	100.0%	75.9%	148.8%	100.0%	100.0%	
Ward 12	26	26	775	26	93.8%	138.5%	-	-	87.0%	170.4%	-	-	
Ward 14	23	21	537	18	80.2%	111.8%	-	-	71.4%	149.5%	-	-	Reduced bed occupancy
Ward 24	23	23	652	22	99.0%	186.0%	-	-	99.0%	265.2%	-	-	
Ward 25	21	21	591	20	87.9%	142.0%	-	-	85.6%	196.9%	-	-	
Ward 26	18	19	562	19	103.0%	135.8%	-	-	95.0%	96.7%	-	-	
Ward 27	15	15	237	8	74.6%	61.6%	100.0%	100.0%	96.8%	76.8%	-	-	Reduced bed occupancy
Ward 28	26	26	733	24	73.6%	93.4%	-	-	90.0%	93.4%	-	-	Short term sickness
Ward 29	27	27	789	26	100.1%	80.6%	-	100.0%	99.6%	81.0%	-	100.0%	
Cardio MB	9	9	240	8	100.0%	94.3%	-	-	100.0%	96.7%	-	-	
Ward 32	22	21	613	20	109.1%	110.6%	-	-	100.0%	106.6%	-	-	

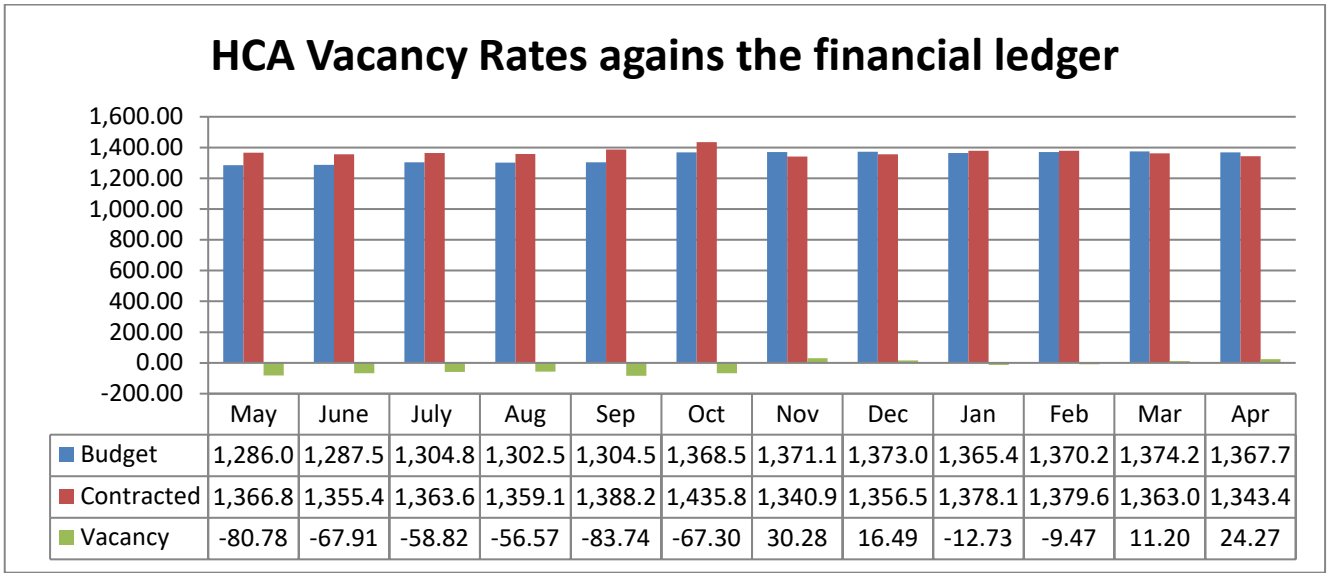
Ward 33	21	21	613	20	78.7%	112.0%	-	-	88.4%	110.7%	-	-	
Ward 34	34	34	868	29	77.5%	123.3%	-	100.0%	93.7%	125.5%	-	100.0%	RN vacancies
Ward 35	26	26	639	21	114.5%	102.5%	-	-	100.5%	105.6%	-	-	
Ward 36	34	34	948	32	96.7%	144.3%	100.0%	-	92.3%	140.6%	100.0%	-	
Ward 37 - AMU	30	30	733	24	91.0%	113.3%	100.0%	-	88.8%	103.0%	100.0%	-	
Spinal Injuries	24	24	656	22	90.2%	73.7%	-	-	198.3%	100.0%	-	-	
CCU	14	14	301	10	96.4%	114.8%	-	-	101.6%	-	-	-	
Critical Care	33	33	758	25	86.1%	80.2%	-	-	87.6%	62.7%	-	-	
CICU JCUH	12	10	215	7	77.7%	76.3%	-	-	76.7%	143.3%	-	-	Short term sickness
Cardio HDU	10	10	208	7	82.8%	103.3%	-	-	75.6%	96.7%	-	-	Short term sickness
Ward 24 HDU	8	8	159	5	80.3%	106.7%	-	-	74.9%	135.0%	-	-	Short term sickness
Ainderby FHN	27	22	645	22	92.9%	83.2%	-	-	131.3%	94.2%	-	-	
Romanby FHN	26	22	783	26	56.9%	34.3%	-	100.0%	76.8%	36.7%	-	-	Reduced Beds
Gara FHN	21	16	158	5	75.8%	63.4%	-	-	76.8%	55.0%	-	-	
Rutson FHN	17	17	490	16	74.9%	120.7%	-	100.0%	100.0%	75.8%	-	100.0%	
Friary	18	18	-	-	-	-	-	-	-	-	-	-	Closed - Staff at FHN
Zetland Ward	31	29	909	30	78.2%	72.7%	-	100.0%	96.7%	76.6%	-	100.0%	Short term sickness
Tocketts Ward	30	26	840	28	91.4%	89.6%	-	-	97.6%	128.3%	-	-	
Ward 21	25	25	449	15	79.7%	81.7%	-	100.0%	76.1%	84.0%	-	100.0%	Short term sickness
Ward 22	17	17	234	8	80.7%	89.8%	-	-	79.6%	55.0%	-	-	Low occupancy
Delivery Suite	-	-	387	13	98.1%	83.6%	-	-	97.0%	81.2%	-	-	
Neonatal Unit	35	35	488	16	75.3%	93.3%	-	-	79.1%	-	-	-	Low occupancy
Paediatric ITU	6	6	46	2	75.9%	93.3%	-	-	74.2%	13.3%	-	-	Low occupancy
Ward 17	-	-	939	31	87.4%	85.8%	-	-	102.1%	86.9%	-	-	
Ward 19 Ante Natal	-	-	309	10	89.0%	96.7%	-	-	98.3%	-	-	-	
Maternity Centre FHN	-	-	9	0	51.7%	25.8%	-	-	79.9%	-	-	-	Low occupancy

Appendix 2 - Registered Nursing Vacancy Rate Apr 2023



	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Budget	2,892.	2,907.	2,918.	2,912.	2,917.	2,876.	2,840.	2,862.	2,881.	2,892.	2,893.	2,929.
Contracted	2,788.	2,780.	2,774.	2,777.	2,778.	2,780.	2,768.	2,835.	2,849.	2,876.	2,886.	2,891.
Vacancy	103.82	127.00	144.08	135.3	139.85	96.20	71.35	26.81	32.05	15.68	6.27	37.99

Appendix 3 - Health Care Assistant Vacancy Rate Apr 2023



	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Budget	1,286.0	1,287.5	1,304.8	1,302.5	1,304.5	1,368.5	1,371.1	1,373.0	1,365.4	1,370.2	1,374.2	1,367.7
Contracted	1,366.8	1,355.4	1,363.6	1,359.1	1,388.2	1,435.8	1,340.9	1,356.5	1,378.1	1,379.6	1,363.0	1,343.4
Vacancy	-80.78	-67.91	-58.82	-56.57	-83.74	-67.30	30.28	16.49	-12.73	-9.47	11.20	24.27

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 6 JUNE 2023			
Sustainability Annual Report			**AGENDA ITEM: 12 ENC 9**
Report Author and Job Title:	Laura Hallett Waste & Sustainability Manager	**Responsible Director:**	Phil Sturdy Director of Estates, Facilities & Capital Planning
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	To provide information to the Trust Board of Directors of South Tees Hospital NHS Foundation Trust on the work to date within the Trust on Net Zero targets within the NHS		
Background	The NHS has committed to Net Zero by 2040 this paper outlines the work within the Trust to date and provide a work plan for 2023/2024 A Green Plan has been established and implemented by the Trust and is regularly reviewed as part of the ISO 14001:2015 Environmental Management Plan. The Trust's Green Plan meets contractual and NHS Requirements as set out by the NHS Standards Contract 2022/23		
Assessment	In April 2023 an external ISO auditor deemed both sites to achieve the ISO accreditation of 14001:2015 The Trust Green plan is in line with the ICS green plan, and we are currently meeting our contractual and NHS requirements as set out by the NHS Standards Contract 2022/23		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	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	No		
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 ☐	

1. Purpose of the report

The purpose of this report is to provide an update on the work being undertaken in support of the NHS to deliver the world's first net zero health service and respond to climate change, improving health now and for future generations.

2. Introduction

The Trust has in place a Green Plan which meets the contractual and NHS requirements as set out by the NHS Standards Contract 2022/2023 to support the reduction targets for carbon emissions as follows:

- The NHS Carbon Footprint, these are emissions that we control directly, to reach net zero by 2040, with an ambition to achieve an 80% reduction by 2028 to 2032

- With regards to the emissions we can influence, our NHS Carbon Footprint plus, to reach net zero by 2045, with an ambition to achieve an 80% reduction by 2036 to 2039

- In February 2023 NHS England published the NHS Net Zero Building Standard which provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future

South Tees NHS Foundation Trust (STHFT) has aligned itself with The North East and North Cumbria Integrated Care System (NENC ICS) and plays an active part in meeting our sustainability challenges within the region, including our North Yorkshire sites. It operates alongside Local Government to deliver its aims, covering a population of 3.1 million people over the North of England.

By working collaboratively with the NENC ICS a regional Green Plan has been approved in order to ensure faster progress towards the 2030 vision to be 'England's Greenest region'.

To support this further the Trust has maintained and accelerated its own Green Plan, which has now been reduced to 3 instead of 5 years. New ideas and concepts are included from all areas of the Trust, thereby giving our patients and staff a 'voice' into how they perceive, and can improve, our environment here at (STHFT) and the local community.

Areas of focus are on:

Workforce and System Leadership
- Sustainable Models of Care
- Digital Transformation
- Travel and Transport
- Estates and Facilities

- Medicines
- Supply Chain and Procurement
- Food and Nutrition
- Adaptation

This list is not exhaustive and STHFT have already added further areas to the list, such as separate sections for waste, green spaces and communication. This will expand further with input from the STHFT 'Greener' NHS Group.

The Green Plan requires senior, expert level input including clinicians, Estates and Facilities, Procurement, Finance, Pharmacy and Dieticians.

3. Achievements 2022/2023

Since the last report the following has been achieved:

- Recruited into the Waste and Sustainability Manager's post Feb 23
- Eco shop opened at James Cook, plans to open one at the Friarage Hospital.
- NHS forest identified NHS sites in areas of deprivation, air pollution, and low greenspace accessibility. This work fits with the Green Plan priorities. Two sites have been identified as priority areas for tree planting: James Cook Hospital and Redcar Hospital.
- Recycling bins increased across James Cook and The Friarage Hospital
- Reupholstery of furniture as part of the sustainability agenda for STHFT in partnership with Northumbria NHS Healthcare Facilities management
- Sustainability event hosted in November 2022
- Monthly Trust's Greener NHS Group – this has a broad staff representation. It is designed to empower staff in order to escalate issues and be involved in decision making processes, thereby contributing to the improvement of our environment whilst promoting sustainability
- Theatres dispose of metal items in a sharpsmart container, this is then sterilised through a less costly alternative treatment process at sharpsmarts facilities and sent for recycling, diverting this waste from high temperature incineration.
- The Green Plan is currently undergoing a review
- Memorial Garden opened on 11 November 2022 at JCUH in remembrance of veterans who have served or are serving within the Trust
- Opened a secret garden at FHN, both staff and visitors are welcome
- Positive recent ISO14001 environmental audit

Travel & Transport

- 12 Electric charging points installed at the James Cook Hospital site. The Charging Robot is 69 % smaller and lighter than other electric chargers, with similar functionality. It weighs only 1.5 kg, saving the environment at least 4 kg of copper and plastic per charge
- 970 staff responded to the ICS travel survey, this focused on reducing carbon and improving air quality through modal shift. The initiative formed part of the "Step Up a Gear" project run by the NHS England Net Zero Travel and

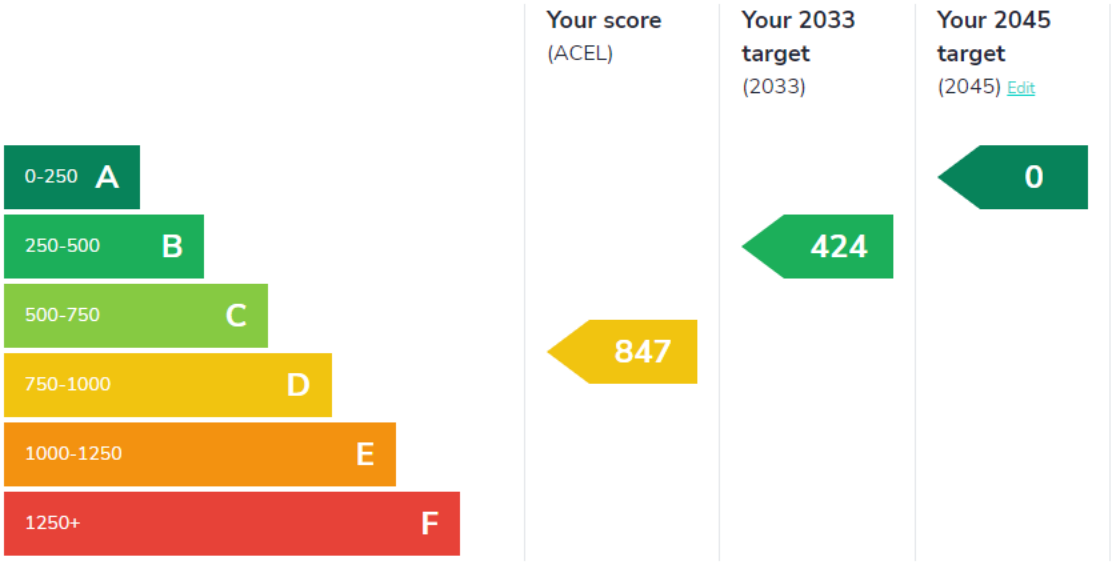
Transport team. The data findings show that STHFT employees currently travel to work an average of 10 miles, each way, on an average of 4 days per week.

Most often employees are conducting their commutes in a car, alone, because they believe this to be the most convenient and quickest mode of transport.

68% of employees showed a legitimate interest in joining a car-sharing scheme, indicating high potential for successful implementation at STHFT NHS.

Like with the full ACEL calculation, UK Government GHG (greenhouse gas emissions) conversion factors are used to determine per mode emissions per KM. Additionally, for Estimate ACEL the Government's annual National Travel Survey data is used to determine the average commute distance (per mode) and the national average journey frequency

STHFT NHS ACEL = 847 This equates to 7,620,479kg of CO2e per year.



- Shuttle bus running between two sites (JCUH & FHN) for staff
- FREE MOT Dr Bike sessions held across JCUH & FHN
- Audit on individual bike lockers to ensure all lockers are occupied
- A hydrogen fuel car was loaned to the Trust by Toyota as part of the Teesside Hydrogen Hub Trial, a £2.5million region-wide trial testing out 100% zero-emission hydrogen-fuelled commercial and support vehicles. The pathology department used the Toyota Mirai hydrogen fuel cell vehicle for three months to transport patient specimens

Waste

The Estates & Facilities department send a yearly return of data to NHS England. Part of this data includes waste volumes which is broken down into the different categories of waste. The Waste and Sustainability Manager can use this data to track our current performance against the target and track progression. As we have seen across both sites the levels of waste going to incineration is low and currently below the 20% target.

For both sites the levels of waste for Alternative Treatment would be an area to focus on. At James Cook Hospital for the last four months there has been very low volumes of offensive waste. In terms of meeting the 2026 target our current data shows we are on the track.

Procurement Achievements

1. Reupholstery of chairs via Northumbria innovation hub. Taking into account the reupholstering of each chair including transport, this equates to 13.5KgCO2e per chair and is a saving of 22.5KgCO2e per chair or 1237.5KgCO2e across the 55 chairs
2. Clinical product evaluation group (CPEG held 4-5 times a year) procurement use a sustainability tool
3. Clinical Procurement Specialist Nurse is a member of the IPS sustainability SIG bringing together sustainability within an IPC aspect
4. Inappropriate glove use reduction
5. Reusable gowns for theatres
6. Nebulisers (promoting single patient use instead of single use)
7. Improved theatre printing process
8. Reducing waste via using prefilled syringes (this also negates needle use for the same task reducing sharps injuries)
9. Pathology are now using a reusable box system to transport samples rather than using pathology bags
10. Reducing blue roll-on couches
11. Potato starch bags for patients to keep wound care and dressings together meaning patients are able to put them in their compost bin or in their green waste bin when they have reached the end of their usable life span

4. Performance

The Trust maintains the ISO 14001:2015 certification, demonstrating our commitment to the environment, whilst also improving upon our Sustainable Development Management Plan (Green Plan). This will now incorporate the requirements of the NHS Long Term Plan, The Adaptation to Climate Change Plan and the NHS Standards Contract

NHS Standard Contract

The NHS Standard Contract for 2022/23 was published in March 2022. The targets set for sustainability remained the same as 2021/22 with one update. In accordance with good practice, to reduce the carbon impacts from the use, or atmospheric release of environmentally damaging gases such as nitrous oxide and fluorinated gases used in anaesthetic agents and as propellants in inhalers; by appropriately reducing the proportion of desflurane to all volatile gases used in surgery down from 10% (2021/22) to 5% or less by volume. The Trust is achieving the 5% or less by volume for reduction in desflurane and further planning is taking place regarding nitrous oxide.

5. Future Activity

Key activities for 2023/2024:-

- To increase the Trust engagement and for staff to understand their personal responsibilities in the NHS achieving Net Zero 2040, we ask that this is done in the following three ways:-
  - All staff have an objective in their appraisal linked to achieving net zero
  - All interview panels to contain a question on sustainability
  - All team meetings have a net zero agenda item - including the Board
- Reduce energy consumption across the Trust sites
- Implement environmental audits across JCUH & FHN
- Sustainability awareness days
- Recruit green champions
- Interact with regional and national initiatives
- Facilitate the culture change of our staff, patients and visitors attitude towards the environment and sustainability
- Development of the heat decarbonisation plan and preparedness for future funding opportunities.
- Reduction in environmentally damaging gases
- To work with North Tees colleagues in establishing a common approach to sustainability.

6. Recommendation

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 – 06 June 2023			
Finance Report			**Agenda Item 13 ENC 10**
Report Author and Job Title:	Chris Dargue Deputy Chief Finance Officer	**Responsible Director:**	Chris Hand Chief Finance Officer
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	Formal external reporting of the Month 1 position is not required by NHSE. This report outlines the Trust's draft financial performance as at Month 1 of 2023/24.		
Background	The national annual planning timetable for 2023/24 was extended, with further submissions required on 4 May 2023. The Trust's plan for the 2023/24 financial year is now a deficit of £31.8m, reflecting the organisation's structural deficit (eg: The James Cook University Hospital PFI scheme) and inflationary pressures. As part of the system-based approach to planning and delivery, the Trust's plan forms part of the NENC ICB system plan for 2023/24. The NENC ICB is currently planning on the basis of a net deficit of £49.9m for 2023/24.		
Assessment	At Month 1 the draft position is a deficit of £1.9m at a system control-total level, which is in line with the year-to-date plan.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the draft financial position for Month 01 2023/24.		
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 1 2023/24 Financial Performance

1. PURPOSE OF REPORT

The purpose of the report is to update the Trust Board on the Trust's draft financial performance as at Month 1 of 2023/24.

2. BACKGROUND

For 2023/24, the system-based approach to planning and delivery continues, with each provider trust fully mapped to a single ICB system. The NENC ICS has a current planned deficit of £49.9m.

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 2023/24 financial year is a deficit of £31.8m, measured on a system financial performance basis. This reflects the Trust's historic structural deficit and inflationary pressures.

The financial position in this report reflects the plan submitted in May 2023. The plan was developed in conjunction with the NENC ICS, with external review by regional and national NHSE, and with internal review and oversight provided through the Resources Committee and meetings of the Trust Board.

The outcome report from the NHSE review found no financial governance concerns and noted the Trust's structural and underlying financial position (eg: The James Cook University Hospital PFI scheme), and the fair shares funding issue apparent within the Tees Valley.

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.

Formal external reporting of the Month 1 position is not required by NHSE.

3. DETAILS

Trust Position Month 01 2022/24

The draft Month 1 position is outlined in the table below.

STATEMENT OF COMPREHENSIVE INCOME	YTD Plan £000	YTD Actual £000	YTD Variance £000
Operating income from patient care activities	64,702	65,411	709
Other operating income	4,156	4,499	343
Employee expenses	(41,224)	(42,584)	(1,360)
Operating expenses excluding employee expenses	(27,614)	(27,547)	67
OPERATING SURPLUS/(DEFICIT)	**20**	**(222)**	**(242)**
FINANCE COSTS			
Finance income	86	215	129
Finance expense	(1,608)	(1,454)	154
PDC dividends payable/refundable	(481)	(481)	0
NET FINANCE COSTS	**(2,003)**	**(1,720)**	**283**
Other gains/(losses) including disposal of assets			0
Corporation tax expense			0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(1,983)**	**(1,942)**	**41**
Add back all I&E impairments/(reversals)			0
Remove capital donations/grants/peppercorn lease I&E impact			0
Remove net impact of consumables donated from other DHSC bodies	98	69	(29)
Adjusted financial performance surplus/(deficit)	**(1,885)**	**(1,873)**	**12**
Less gains on disposal of assets	**0**	**0**	**0**
Adjusted financial performance for the purposes of system achievement	**(1,885)**	**(1,873)**	**12**

The Trust plan for the 2023/24 financial year is to deliver a £31.8m deficit, as part of the ICS plan to deliver a £49.9m deficit at a system level.

At Month 1 the Trust's forecast outturn position remains in line with plan for the 2023/24 financial year.

The Trust's operating deficit for the Month 1 of 2023/24 was £0.2m and the overall deficit for Month 1 was £1.9m. The adjusted financial position for the purpose of system performance was a deficit of £1.9m.

This year-to-date draft financial position is on plan.

An estimate of the expected additional income and expenditure (above planned levels) relating to the 2023/24 Agenda for Change (AFC) pay award is included in the year-to-date position, in line with national NHSE guidance.

Operating Income from Patient Care Activities
Operating income from Patient Care Activities was £65.4m for Month 1 and was £0.7m ahead of plan. The variance relates to the accrued income for the expected 2023/24 Agenda for Change (AFC) pay award which is partially offset by reduced income on excluded drugs and devices income. The year-to-date position assumes full delivery of activity associated with elective recovery targets.

Other Operating Income
Other income received in month totalled £4.5m and was ahead of plan by £0.4m, relating to additional R&D income (which offset additional expenditure).

Employee Expenses (Pay)
The Trust's total expenditure on pay for Month 1 of 2023/24 was £42.6m and was overspent by £1.3m. The overspend mainly relates to the estimated cost of the expected 2023/24 AFC pay award.

The pay position assumes no in-year financial impact from the cost of the prior-year 2022/23 non-consolidated AFC pay award (which was estimated and accrued during 2022/23).

Operating Expenses excluding Employee Expenses (Non-Pay)
The Trust's total expenditure on operating non-pay for Month 1 of 2023/24 was £27.5m and is £0.1m underspent. Underspends on high-cost drugs and devices is offset by overspends on R&D and IFRS16 related expenditure.

Financing Costs
Finance costs totalled £1.7m, including PDC dividends payable of £0.5m, finance costs relating to the PFI contract and IFRS 16 charges. IFRS 16 charges are less than plan in month but are off set by charges in operating expenses.

Interest receivable is £0.2m, reflecting higher cash balances and increased interest rates from the Government Banking Service (GBS) Account.

Cost Improvement Programme (CIP)

The Trust's 2023/24 financial plan includes an efficiency saving requirement of £39.4m. The Trust monitors the planning and delivery of its efficiency programme through the meetings of the Collaborative Improvement Planning Groups, 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 and Corporate departments from the Trust's Service Improvement Office and Finance team. Detailed schemes totalling £32.4m (82% of the target) have been identified through the Trust's efficiency workstreams and PID and EQIA documents are currently being finalised for all the agreed CIP schemes. Work is underway to confirm a number of additional potential efficiency opportunities that have been identified to support delivery of the Trust's overall efficiency target.

Capital

The Trust's capital expenditure for Month 1 of 2023/24 amounted to £2.2m 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	1,140	1,140	0	13,683	13,683	0
Site Reconfiguration	1,290	802	(488)	21,769	21,769	0
Replacement of Medical Equipment	0	74	74	3,200	3,200	0
Network Replacement and Clinical Noting	0	232	232	1,967	1,967	0
Total	**2,430**	**2,248**	**(182)**	**40,619**	**40,619**	**0**

The capital programme includes external support, in the form of Public Dividend Capital (PDC) of £15.0m. The PDC includes funding for the Friarage Theatre development (£14.3m) and Electronic Patient Record support (£0.7m).

Internally generated funding is being utilised to fund the remainder of the capital programme. The Trust's ICS Capital Departmental Expenditure Limit (CDEL), included in the above, amounts to £11.9m.

Liquidity

The cash balance as at the 30th April amounted to £60.5m. The strong position on liquidity has helped support the Trust's performance against the 95% Better Payment Practice Code and the position for April is:

	YTD number	YTD £000's
NHS and Non NHS		
Total bills paid in the year	7,999	40,341
Total bills paid within target	7,820	36,230
Percentage of bills paid with target	**97.8%**	**89.8%**

4. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 1 2023/24.

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 6 JUNE 2023			
Annual Filings 2022-23			**AGENDA ITEM: 14, ENC 11**
Report Author and Job Title:	Jackie White Head of Governance	**Responsible Director:**	Chris Hand Chief Finance Officer Hilary Lloyd Chief Nurse
Action Required	Approve ☒ Discuss ☐ Inform ☐ (select the relevant action required)		
Situation	The Trust has a statutory requirement to produce a number of key documents as part of its annual filings following the end of the financial year. These include the Annual Report, Annual Accounts, Annual Governance Statement and Quality Report (Account). In April 2023 the Board of Directors gave delegated authority to the Audit & Risk Committee and Quality Assurance Committee to monitor and approve the annual filings.		
Background	Guidance has been received on production of the key documents and a small project group has been established to oversee this work on behalf of the Trust Board of Directors.		
Assessment	The Audit & Risk Committee met on 24 May 2023 and received the draft Annual Report, Annual Governance Statement and Annual Accounts. No risks or issues were highlighted with the draft reports. These documents are subject to external audit review which should be concluded by the middle of June for final sign off by the Audit & Risk Committee. The timetable for submission is on track. The Quality Report (Account) has been included on the agenda for the Trust Board of Directors for approval.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the progress in developing the key annual filings documentation .		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care 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

Annual Filings 2022-23

1. PURPOSE OF REPORT

- The purpose of the report is to update members of the Trust Board on the preparation of the annual filings for 2022-23:
  - Quality Report (Account)
  - Annual Accounts
  - Annual Report
  - Annual Governance Statement

2. BACKGROUND

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

Changes to the requirements for 2022/23 are set out below:

- **Performance report**: joint forward plans and capital resource plans. The trust should disclose in the performance report how it has exercised its function with respect to joint forward plans and joint capital resource plans published by its system. This disclosure is required by paragraph 26(1A) of schedule 7 to the National Health Service Act 2006, as inserted by section 11 of the Health and Care Act 2022.

- **Performance report: health inequalities -** Information should be provided about the trust's activities to tackle health inequalities. This disclosure is required by paragraph 26(1B) of schedule 7 to the National Health Service Act 2006, as inserted by section 11 of the Health and Care Act 2022.

- **Fair Pay disclosures: prior year comparatives -** Prior year comparatives are now required for all ratios in this second year of the revised reporting arrangements.

- **Staff survey example disclosure -** Following changes to the format of the staff survey in 2021/22, this means that two years of information in the new format will be disclosed and one year in the old format (or more at the trust's discretion).

- **NHS Oversight Framework disclosure -** The example disclosure for the NHS Oversight Framework has been significantly revised following publication of the NHS Oversight Framework for 2022/23.

- **Remuneration report: part year pensions disclosures -** Guidance has been added regarding pension disclosures for senior managers in post for part of the year.

- **Fair Pay disclosures: 'employees' -** A footnote has been added to make reference to HM Treasury guidance on the definition of 'employees' in applying the Fair Pay disclosure requirements.

- **References to NHS England -** References to Monitor or NHS Improvement in the FT ARM have been updated to refer to NHS England. These changes are not shown in bold italics. They are shown in red for clarity in the model statement of accounting officer's responsibilities (annex 4 to chapter 2), the model annual governance statement (annex 5 to chapter 2) and the example certificate on the summarisation schedules (annex 2 to chapter 1) to help trusts update their disclosures. Documents issued by Monitor (or its operating name of NHS Improvement) are treated from 1 July 2022 as having been issued by NHS England.

3. DETAILS

3.1 Annual report and accounts

The Annual accounts timetable has been developed. External Audit are carrying out their checks. Draft annual report and accounts produced and considered at the Audit & Risk Committee. No risks to identify at this stage.

3.2 Quality Report (Account)

The content, leads and outline structure are all in place. Core indicator reports have been received and we are in the process of receiving statements of assurance and overviews of quality of care. On track no issues identified.

3.3 Annual Governance Statement

The draft annual governance statement has been produced at considered at the Audit & Risk Committee. No risks to identify.

4. TIMETABLE

Friday 30 June 2023 – NHS providers submit month 12 PFR form (including audited TACs) and audited accounts to NHS Improvement including Annual report

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

4. RECOMMENDATIONS

The Board of Directors are asked to note the progress in developing the key annual filings documentation.

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 6 JUNE 2023			
Provider Licence Self Certification			**AGENDA ITEM: 15 ENC 12**
Report Author and Job Title:	Jackie White Head of Governance & Company Secretary	**Responsible Director:**	Derek Bell Chairman Sue Page Chief Executive
Action Required	Approve ☒ Discuss ☐ Inform ☐ (select the relevant action required)		
Situation	An assessment has been undertaken against the NHS provider licence. The results are attached for consideration along with a recommendation to approve the assessment following review by the Audit & Risk Committee.		
Background	All NHS Foundation Trusts are required to self-certify whether or not they have: i) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the NHS Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012 whilst having regard to the NHS Constitution; and ii) the required resources available if providing commissioner requested services (CRS); and iii) complied with governance requirements.		
Assessment	A review of the provider licence and supporting evidence has been undertaken and the following assessment has been proposed: 1. The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6) – **CONFIRMED** 2. The provider has complied with the required governance arrangements Condition FT4(8)- **NOT CONFIRMED**. 3. If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver designated services Condition CoS7(3) – **CONFIRMED**		
Recommendation	Members of the Board of Directors are asked to approve the assessment of compliance against the provider licence		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risk in terms of compliance against the licence are detailed within 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	Best for safe, clinically effective care and experience ☒	A great place to work ☒	

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

South Tees Hospitals
NHS Foundation Trust

NHS Foundation Trust Self-certification

1. PURPOSE OF REPORT

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

2. BACKGROUND

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

The Audit & Risk Committee have considered the self assessment and recommend approval by the Board of Directors.

3. DETAILS

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

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

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

3.1 Condition G6

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

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

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

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

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

3.2 Condition FT4(8)

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

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

3.3 Condition CoS7

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

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

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

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

- agreement of financial recovery plan

4. RECOMMENDATIONS

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

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

South Tees Hospitals NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2022/23**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
2	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Please see Annual Governance Statement
3	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Please see Annual Governance Statement
4	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Please see Annual Governance Statement
5	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Not confirmed	Modifications to the existing additional licence condition imposed on the Trust under section 111 of the Health and Social Care Act 2012 ("the Act") made on 11 November 2019.

6	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Please see Annual Governance Statement
7	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Please see Annual Governance Statement

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature 

Name Sue Page

Signature 

Name Derek Bell

Worksheet "Training of governors"

Financial Year to which self-certification relates 2022/23

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sue Page	**Name**	Derek Bell
Capacity	Chief Executive	**Capacity**	Joint Chairman
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

South Tees Hospitals NHS Foundation Trsut

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2022-23

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

agreement of financial recovery plan

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sue Page	**Name**	Derek Bell
Capacity	Chief Executive	**Capacity**	Joint Chairman
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

South Tees Hospitals NHS Foundation Trust

MEETING OF THE TRUST PUBLIC BOARD OF DIRECTORS – 6 JUNE 2023			
Quality Report (Accounts) 2022/23			**AGENDA ITEM: 16, ENC 13**
Report Author and Job Title:	Sylvia Wood & Philippa Imire	**Responsible Director:**	Dr. Hilary Lloyd Chief Nurse
Action Required	Approve ☒ Discuss ☐ Inform ☐		
Situation	The final version of the annual quality account for 2022/23 has been produced and include a look back at last year's quality priorities and set out the quality priorities for 2023/24. The Quality Accounts has been shared with Stakeholders and representatives from the Council of Governors. Responses from stakeholders received will be added prior to final submission and publication on the 30th of June 2023.		
Background	The processes for producing Quality Accounts remain the same as previous years, with the following exception that NHS foundation trusts are no longer required to produce a Quality Report as part of their Annual Report. There is no national requirement for NHS foundation trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared.		
Assessment	This Quality Account meets all the requirements and is being presented to the Board of Directors for approval.		
Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐		
Recommendation	The Board of Directors are being asked to approve the Quality Account.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF reference 1		
Legal and Equality and Diversity implications	The requirements for producing a quality report are set out in the Health Act 2009 and in the NHS Quality Regulations 2010.		
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

Quality Account 2022/2023

June 2023

PART ONE - Statement on quality from the Chief Executive

PART TWO - Priorities for improvement, statements of assurance from the Board and reporting against core indicators

2.1 Priorities for improvement

a. **Review of progress with the quality priorities defined for improvement in 2022-23**

Patient safety quality priorities

1. Safety Culture
2. Pressure Damage
3. Clostridioides Difficile

Clinical effectiveness quality priorities

1. Clinical Audit
2. NICE

Patient experience quality priorities

1. Safe and Effective Discharge
2. Nutrition and Hydration
3. Patient Feedback

b. **Quality priorities defined for improvement in 2023-24**

2.2 Statements of assurance from the Board

Relevant health services
National clinical audits and national confidential enquiries
Local audits
Research
Use of the CQUIN Payment Framework
Care Quality Commission registration, reviews and investigations
Submission of records to the Secondary Uses Service
Information governance grading
Clinical coding audit
Data quality
Learning from deaths

2.3 Reporting against core indicators

Preventing people from dying prematurely
Summary Hospital Level Mortality Indicator
PROMS
Readmission within 28 days
National inpatient survey
Staff FFT
VTE
Clostridioides *difficile*
Patient safety incidents
Patient FFT

PART THREE – Overview of quality of care, and performance indicators

3.1 South Tees Accreditation for Quality of Care (STAQC)

3.2 Patient safety indicators

1. Safeguarding / Mental Capacity Act / LD
2. Falls
3. Duty of candour
4. Maternity

3.3 Clinical effectiveness indicators

1. Clinical Research
2. Consent
3. Getting It Right First Time and quality surveillance

3.4 Patient Experience Indicators

1. Patient involvement work on strategy and policy
2. Patient surveys – national/local
3. Accessible Information Standard and patient information work

3.5 Performance against key national priorities

Referral to Treatment
A&E 4 hour wait.
Cancer 62 day wait for first treatment.
Clostridioides *difficile* variance from plan (also included in section 2)
Summary Hospital Level Mortality Indicator (also included in section 2.3)
6-week wait for diagnostic tests
Venous thromboembolism risk assessment (also included in section 2.3)

3.6 Additional required information

Seven-day services
Freedom to speak up
Rota gaps for doctors in training

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Annex 2: Statement of directors' responsibilities for the quality report

Glossary

1. Statement on quality from the chief executive of the NHS foundation trust

I am pleased to introduce the 2022/23 Quality Report as Chief Executive of South Tees Hospitals NHS Foundation Trust.

As a clinically led organisation the safety and wellbeing of our patients, service users and colleagues - underpinned by our commitment to clinical research, innovation and training - is at the heart of our mission.

Our clinicians lead by the way they manage our limited resources and deliver safe, quality care across our hospitals and services – aided by the experience, professionalism and skills that exist across our clinical and support areas.

In May 2023, South Tees Hospitals NHS Foundation Trust became one of the first acute hospital trusts in England since the start of the COVID-19 pandemic in 2020, to achieve a rating improvement to 'Good' from the Care Quality Commission (CQC) for the care delivered to patients and service users.

In an endorsement of the trust's improvement journey since its last full inspection in 2019, inspectors also upgraded our rating for leadership at the organisation to 'Good'. When the CQC inspects hospital trusts, the care regulator also reviews whether they are safe, caring, effective and responsive to people's needs, and the trust achieved an overall 'Good' rating in each area.

Over the last three years, our experienced clinicians have laid the foundations of a trust where safety and quality are put first, where colleagues feel empowered to make improvements for their patients and service users, where limited funding is used to invest in the things that experienced clinicians agree will make the biggest difference for the people we serve, and where influence to make positive changes beyond hospital walls is being exercised.

But these are only the foundations of larger change. Our commitment to leading-edge clinical research, education, training and innovation – with the needs of our patients, service users and colleagues at the centre – is at the heart of this next phase of our clinically-led journey.

In parallel, our decision in 2023 to come together with North Tees and Hartlepool NHS Foundation Trust to form a hospital group will support both organisations' shared goals for our patients, service users and colleagues by formalising the way we already work together in the interests of the people and communities we have the privilege to serve.

To the best of my knowledge, the information contained in this Quality Account is accurate.

Sue Page CBE
Chief Executive

2. Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

a. Review of progress with the quality priorities defined for improvement in 2022-23

The quality account provides an opportunity for the Trust to reflect on its achievements over the last 12 months. This includes a look back at the progress made against the quality priorities for 2022/23 that were defined in the 2021/22 Quality Account and summarised in the table below.

Quality priorities for improvement in 2022/23		
Patient Safety	**Clinical Effectiveness**	**Patient Experience**
1. To 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.	1. To review and revise our processes for Clinical Audit to facilitate effective and evidence based clinical care for our patients.	1. To 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.
2. To ensure the care that we provide to our patients is safe, and of the highest possible standard by reducing pressure damage.	2. To review and revise our processes for NICE (National Institute for Health and Care Excellence) in order to facilitate effective and evidence based clinical care for our patients.	2. To ensure all patients have their nutrition and hydration needs met.
3. To reduce the risk of Clostridioides *difficile* infection for inpatients.		3. To ensure that we have effective ways of receiving feedback from our patients, their relatives and carers which will lead to demonstrable improvements in practice.

Our ambition for improvement, agreed actions, aims and progress at the end of 2022/23 for each quality priority are detailed below.

Patient safety quality priorities

1. Positive safety culture

We planned to implement and embed all elements of the action plan developed from the thematic review undertaken in 2021 of ‘never events’ (incidents that should be avoidable if preventative measures have been implemented). This will ensure that there are effective and proactive processes and systems in place to facilitate effective system-based learning and improvements across the organisation.

We agreed to:

- Work with our Patient Safety Ambassadors and Patient Safety Specialists to understand current skills, capability and capacity within the organisation.

- Convene a Working Group by the end of quarter 1 to ensure that all relevant areas of the Trust are involved in the implementation of the action plan.
- Ensure the safety sections of our recently published NHS Staff Survey results are reviewed and discussed, and agree actions needed to improve the patient safety culture.

We aimed to:

1. Achieve a continued reduction in the number of never events occurring within the Trust.
2. Monitor staff survey results and other safety culture assessment tools, and specifically to achieve an improvement in the following staff survey questions:
    - ‘I would feel secure raising concerns about unsafe clinical practice’ (Q17a) from 76.9% in 2021 to above 80% in 2022/23.
    - ‘I am confident that my organisation would address my concern’ (Q17b) from 60.7% in 2021, to above 65% in in 2022/23.

<u>End of year progress</u>

During 2022/23, progress has been made against the recommendations identified within the thematic review of never events. The NHS published the national Patient Safety Incident Response Framework (PSIRF) documents in August 2022, which inform the infrastructure of how future patient safety incidents are identified for investigation, learning and improvement. A task and finish group was convened at South Tees to begin the preparations for implementation of the new framework, and the transition away from the previous Serious Incident Framework (2015). The Trust has 12 months to implement the PSIRF and is now in the third ‘Governance and quality monitoring’’ phase of the implementation journey, where sound processes will be developed to determine how the Trust will respond to patient safety incidents as they arise.

A Patient Safety/Patient Experience Workstream Group is meeting regularly to identify and deliver the activities and practices required to implement a restorative, just and learning culture across the Trust. This approach supports consistent, fair and restorative responses to our staff, patients, their families and carers following their involvement in patient safety, patient experience or safeguarding incidents.

The Trust has been successful in its bid for funding from the Academic Health Sciences Network in relation to developing restorative and compassionate responses to harmed patients, their relatives and staff involved in patient safety incidents. This is to enable the Trust to provide effective and tailored support to meet individual needs. With the funding, the Trust has commissioned two cohorts of accredited Restorative Practice Facilitator training for April and June 2023 which will help to shape the organisation’s responses to patient safety incidents and complaints.

A task and finish group has continued to meet to plan the implementation of a Peer Support Programme for staff involved in adverse or traumatic incidents. A framework has been developed and part of the funding described above was planned to fund an administrative post for this service.

A further cohort of Family Liaison Officer (FLO) training was completed in March 2023, with another planned in June 2023, to ensure the Trust can continue to provide compassionate engagement to patients and their families. Patients and relatives are now routinely involved in patient safety incident investigations and review draft investigation reports until they are satisfied that the report reflects all perspectives and that it is written with the patient and/or family as the primary audience.

Work has progressed within the Trust in relation to locally derived safety standards which apply to invasive procedures (LocSSIP). The Medical Director is the Executive Sponsor for LocSSIP compliance, and the LocSSIP project team is resourced to ensure the effective implementation and ongoing audit programme of LocSSIPs is supported and standards of practice are sustained. An electronic share point on the Trust intranet has been created for staff to access patient safety learning from incidents, which over the coming year will be extended to include learning from inquests, claims, safeguarding and complaints.

The Staff Survey 2022 showed that the Trust ranked third highest (74%) in the region in terms of responses to Q17a 'I would feel secure raising concerns about unsafe clinical practice'. All Trusts in the region experienced a reduction in the number of their staff who agreed with this question during the most recent survey, however the Trust's reduction was the smallest and number of staff agreeing remained well above regional and national average. Similarly, the responses to Q17b 'I am confident that my organisation would address my concern' also saw a region-wide reduction.

Summary

There has been much progress made in relation to facilitating effective system-based learning and improvements across the organisation. However, we have not achieved the outcomes we had hoped for and therefore this quality priority will be revised and carried over; work will continue during 2023/24 to complete the remaining recommendations in order to achieve demonstrable improvement in safety measurements.

2. Skin care and reducing pressure damage.

It is important that all pressure ulcers are recognised as patient safety incidents and reported accordingly. Any pressure ulcer that meets, or potentially meets, the threshold of a serious incident should be thoroughly investigated to ensure any issues in care are identified, understood and resolved to prevent the likelihood of future recurrence. This requires an assessment of whether any acts of omission may have led to the pressure ulcer developing.

It is essential to maintain this level of scrutiny as the investigation process transitions to the national Patient Safety Incident Response Framework (PSIRF). This will bring significant changes to how patient safety processes will look and feel in future and the approach that is taken for pressure ulcer investigations. The focus will be on reviewing themes that emerge to focus organisational learning and subsequent improvement. The Pressure Ulcer Improvement Group will continue to learn and reduce the incidence of avoidable category 3 and 4 pressure ulcers in order to have a positive impact on patients who are most at risk.

We agreed to:

- Ensure staff are appropriately knowledgeable in pressure ulcer prevention.
- Continue the Pressure Ulcer Improvement Group to ensure a strategic approach is taken to pressure damage prevention.
- Implement 'PURPOSE-T' as a pressure ulcer risk assessment framework and audit the impact of this.

We aimed to:

- Monitor the frequency of staff training relating to pressure ulcer prevention and increase if necessary.
- Reduce category 3 and 4 pressure ulcers, and serious incidents, complaints, inquests and claims relating to pressure ulcers.

- Gather category 3 and 4 pressure ulcer data by acute and community setting and identify those which are new and avoidable and attributed to the Trust.
- Identify learning through themed analysis of pressure ulcer investigations.
- Submit an overarching Pressure Ulcer Improvement Plan to Tees Valley Clinical Commissioning Group (TVCCG) rather than individual action plans.

End of year progress

A tissue viability action plan was developed to define and monitor improvements in pressure ulcer prevention and management within the organisation. Members of the Pressure Ulcer Improvement Group continue to meet monthly to track delivery and progress of actions. This has been further developed following an agreement to submit to TVCCG to highlight any organisational learning.

PURPOSE-T is a pressure ulcer risk assessment that consists of three steps: screening, full assessment, and assessment stratification. It has been introduced at South Tees to the acute hospitals, launched via our digital clinical data platform Patientrack, and is being embedded within community services.

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

Over the last quarter of 2022/23, training and education took place in both our community hospitals, on Tocketts and Zetland wards. Tocketts ward introduced PURPOSE-T with success in March 2023 and have subsequently gone digital, completing the risk assessments on Patientrack. A planned go-live date has been identified for Zetland ward.

The related SSKIN care plan for pressure ulcer prevention has also been digitalised. This requires a full holistic assessment, including of the patient's skin by a registered nurse at prescribed intervals. The prescribed care can then be delivered by non-registered staff.

At the time of reporting 91% of all registered nurses have received ward-based education on PURPOSE-T and 89% on the SSKIN care plan. Compliance in training for non-registered nurses has increased to 87%. Multiple videos have been created to support the delivery of education with a high uptake from clinical staff. It has also been agreed for tissue viability training to become mandatory for some staff roles and this will be enacted during 2023/24.

During 2022/23 there has been a reduction in reported serious incidents related to pressure ulcers. There is focused work related to pressure ulcer reporting within community services. Currently pressure ulcers are reported in terms of 'count' which is not contextualised in relation to patient population. It is the intention to capture reported pressure ulcers in relation to local case load so that pressure ulcer prevalence is monitored proportionality and reflective of increase in case load.

As the Trust transitions to PSIRF the Pressure Ulcer Review Panel will take place once a week. Each patient with a category 3 or 4 pressure ulcer, deep tissue or unstageable skin damage will be discussed, and any themes identified. The aim is to ensure a system-based approach to learning from patient safety incidents, with a considered and proportionate response, supportive oversight, and improvement.

In addition to this, the tissue viability (TVN) team now offer weekly clinical supervision to staff in the community collaborative. Further work is required to support engagement with acute colleagues and a flexible approach is required.

The Pressure Ulcer Safety Huddle (PUSH) tool is now incorporated within our incident reporting system DATIX so that a review of care, interventions and management plan can be easily examined. When completed, this allows early identification of any gaps in care by triggering a rapid review safety huddle within the shift that pressure damage is observed on a ward, or within 24 hours in the community.

The TVN team have updated the Web ICE requesting and reporting system to improve the reporting of any new or deteriorating pressure ulcer referrals. This includes the addition of staff prompts which direct them to pressure ulcer prevention and dressings guide, facilitating preventative advice in advance of the TVN assessment.

The Fundamentals of Practice monthly meetings review the pressure ulcer incidence in each collaborative, discussing data for each ward area within the meeting. If a clinical area has had a recent serious incident or themes have been identified, then these are discussed at the meeting. The action plan is reviewed to monitor progress and signed off if actions are completed.

Capacity and demand modelling has been completed which has identified a gap in service provision due to historical commissioning agreements. It was agreed to extend the Band 4 provision to full time hours and to advertise for a Band 8a Tissue Viability Lead. The Tissue Viability Lead is now in post.

Summary

Considerable work has been done during 2022/23 to introduce the PURPOSE-T risk assessment, to digitise the SSKIN care plan, and to embed the PUSH tool within our incident reporting system. Together with staff training, and improvements in the resources available to staff when referring to the TVN team we are confident that the understanding and skills of our staff, and skin care for our patients is improved. The governance processes and the work of the Pressure Ulcer Review Panel and Fundamentals of Practice group are ensuring appropriate review with thematic analysis and actions to ensure learning.

This work will continue in 2023/24 with a focus on pressure ulcer reporting contextualised to patient population, the introduction of tissue viability role specific training, ward level dashboards showing real time data for pressure ulcer risk assessments and replicating clinical supervision forums for acute services that have proven to be effective for the community.

3. Reducing the risk of Clostridioides *difficile* infection for inpatients.

Clostridioides *difficile* infection (CDI) is caused by a type of bacteria and is an important cause of infectious diarrhoea in healthcare settings and in communities. The CDI objective for 2022/23 for South Tees was to have no more than a combined total of 111 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over two years.

The 2021/22 *C. difficile* definitions are as follows:

a. Hospital onset healthcare associated (HOHA): cases detected in the hospital ≥2 days after admission.
b. Community onset healthcare associated (COHA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.

c. Community onset indeterminate association (COIA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks.

d. Community onset community associated (COCA): cases that occur in the community (or within <2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

We aimed for a reduction in the level of CDI in line with national trajectory and agreed to:

- Review, implement and embed all elements of the CDI recovery and action plan learning from the review of 2021/22 in order to improve patient safety and experience.
- Implement and establish the structured review process for all cases of trust assigned CDI.
- Embed the role of dedicated CDI Infection Prevention and Control Nurse (IPCN) and review the impact of the role.
- Update and implement the CDI toolbox training programme with an initial focus on completion in four key priority areas with a full programme offered by the end of 2022/23.
- Implement new assurance audits in relation to the 'focus on five' for CDI in addition to current processes.
- Complete the action plans and CDI recovery plan by the end of 2022/23, ensuring the required standards and good practice are embedded across all clinical areas.

<u>End of year progress</u>

The actions taken during 2022/23 include:

- CDI action plan reviewed for 2022/23 regarding CDI reduction strategy.
- Implementation of the structured review process. This has been strengthened with improved medical and multidisciplinary team (MDT) input.
- Implementation and embedding of the role of the CDI IPCN with a lead IPCN and a deputy to support in their absence.
- A meeting with North Tees and Hartlepool NHS Foundation Trust regarding collaborative working in relation to cleaning and decontamination.
- CDI toolbox teaching which has been reviewed and updated across the year with varying elements and additional changes reflective of current practice. The infection prevention and control (IPC) team and the IPC link practitioners focused this on specific areas initially but have covered all areas of the Trust across the year.
- Increased audit and surveillance in 'hot spots.' This included areas that had any CDI cases, low environmental audit or hand hygiene scores, or increased cases of other infections.
- Implementation of a dedicated cleaning programme. The impact of this was evident at the Friarage Hospital, however due to operational pressures and lifecycle works the implementation of this at JCUH has been disrupted since December. Plans are underway to reintroduce this in 2023/24.
- A 'Focus on Five' campaign in relation to CDI which encompasses the following:

Figure 2: 'Focus on Five' communication campaign information

Summary

Through our robust structured review process, we have identified themes relevant to CDI cases including antimicrobial prescribing, complex patient history and environment.

There will be an ongoing focus on C. *difficile* in 2023/24 to ensure we deliver safe patient care in a suitable environment. We continue to have a clear and detailed CDI plan and will work closely across the ICB and nationally in 2023/24 to review our position and learn from others.

Clinical effectiveness quality priorities

1. Review and revision of clinical audit processes.

We planned to review and implement a Trust-wide approach to clinical audit which is embedded in practice and demonstrates improvement and best practice for our staff and our patients.

We agreed to:

- Have effective systems in place for all elements of the clinical audit and action planning cycle.
- Deliver patient care based on the most up to date evidence and best practice standards.
- Review all level 1, 2, 3 and 4 clinical audits and agree these in the forward plan.
- Have an effective system in place for the reporting and tracking of all clinical audit activity.

We aimed for:

- 100% of relevant clinical audits completed at levels 1.
- 80% of relevant clinical audits completed at levels 2.
- An increase in clinical audits completed at level 3 and 4 against 2021/22 levels.
- 100% of clinical audit action plans completed at levels 1.
- 80% of clinical audit action plans completed at levels 2.
- An increase in clinical audit action plans competed at levels 3 and 4 against 2021/22 levels.

End of year progress

There has been good progress with developing effective systems for the clinical audit and action planning cycle. A Clinical Audit and NICE Operational Group has been established to provide assurance to the Clinical Effectiveness Steering Group (CESG) that there are robust and effective processes in place for national and local clinical audits, NICE guidance and service evaluation. In particular it will ensure:

- The planned participation in national and local audits is effectively prioritised and planned to meet the Trust's objectives and statutory requirements.
- Escalation of non-compliance, delays and risks to CESG and appropriate recording on the Trust's risk register as required.
- Progress updates on national audits, and implementation of action plans for national clinical audits.
- Clinical audits which demonstrate significant risks to the quality of clinical care, and level 1 and 2 clinical audits at risk of non or reduced participation are escalated.
- Horizon scanning for attendance and presenting at local, national and regional events and conferences.

The clinical audit team are in the process of implementing a new digital platform called InPhase. When established, InPhase will integrate audit, incident, patient feedback and performance data and will provide significantly increased quality assurance.

Level 1 clinical audits

The level 1 audits are the national audits, and detailed information regarding participation is included in section 2.2 of this report. In summary, the Trust participated in 92% of national audits it was eligible for, and actions are being taken to resolve any the issues that resulted in non-participation. Once implemented, InPhase will provide visibility of action plans and an improved ability to monitor progress and completion.

Level 2 clinical audits

The level 2 audits include those required to measure compliance with the national Commissioning for Quality and Innovation (CQUIN) scheme, and our locally derived safety standards which apply to invasive procedures (LocSSIP). There are 97 audits in total.

The trust currently has 82 active LocSSIP, 60 of which have been audited. The most recently published will enter a cycle of audit in the coming months.

To facilitate learning within the clinical collaboratives, the results of LocSSIP compliance are included in all Clinical Collaborative Board data packs. The clinical audit team are seeking

evidence of the sharing and discussion of LocSSIP audit results at directorate meetings to ensure learning and improvement where this is required. However, as above we are currently unable to monitor completion of associated action plans.

Level 2 audits	Completion of audits during 2022/23
CQUIN	100%
LocSSIP	73%
Total	77%

Table 1: Percentage of level 2 audits completed during 2022/23

Level 3 and 4 clinical audits

Other clinical audits are reviewed throughout the financial year to provide continued compliance and assurance and there are currently no outstanding risks relating to these. Further work will take place around data and monitoring of level 3 and 4 clinical audits completion and action plans.

Summary

There have been improvements in our processes for clinical audit and action planning cycle, and we achieved 92% participation in level 1 audits (target of 100%), and 77% completion of level 2 audits (target of 80%). These results provide assurance that a significant proportion of patient care is based on the most up to date evidence and best practice standards.

There will be an ongoing focus on improvement work in clinical audit during 2023/24 to ensure we deliver patient care based on the most up to date evidence and best practice standards. A detailed forward plan for clinical audit has been approved, and implementation of InPhase is being prioritised which will improve the visibility and triangulation of data and provide greater assurance.

2. Review and revision of processes for NICE

The National Institute for Health and Care Excellence (NICE) make evidence based, best practice recommendations, publishing quality standards, and guidance that includes NICE guidelines (clinical, social care, public health, medicines practice), technology appraisals, interventional procedures, medical technologies, diagnostics and highly specialised technologies. Implementing these helps to improve patient safety and reduce the risk of harm across the health system.

We planned to review and revise our processes for responding to NICE guidelines and quality standards in order to facilitate effective and evidence based clinical care for our patients.

We agreed to:

- Have an effective system for dissemination, reporting and tracking all NICE activity.
- Review all NICE quality standards to agree relevance and report on levels of compliance.
- Review all NICE guidelines to agree relevance and report on levels of compliance.

We aimed for a 10% increase from 2021/22 compliance with NICE guidelines and quality standards assessed as relevant to the Trust and with good assurance of compliance provided by supporting evidence.

End of year progress

We have had processes in place for disseminating, reporting, and monitoring NICE activity during 2022/23 and the implementation of the Clinical Audit and NICE Operational Group as described above regarding clinical audit has strengthened this. 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.

We have evidence of compliance in 2022/23 for:

- Technology appraisals (TA) with evidence of full implementation - 85%
- NICE guidelines with evidence of compliance – 43%
- NICE quality standards with evidence of compliance – 78%

We now have NICE guidance available within the InPhase platform. Our NICE Facilitator is responsible for assessing the implementation of NICE guidance and assurance of compliance, working alongside the Clinical Audit Facilitators to ensure alignment of activity in both areas of work and to define robust processes for reporting NICE compliance.

Summary

We have had processes in place for disseminating, reporting, and monitoring NICE activity during 2022/23 and have evidence of compliance with 85% of technology appraisals, 43% of NICE guidelines and 78% of NICE quality standards. The InPhase platform will enable the Trust to monitor and report compliance with NICE evidence-based practice much more effectively in the future and use our existing systems and processes to drive increases in compliance.

Patient experience quality priorities

1. Planned, safe and effective discharge from our hospitals.

Safe and effective discharge from hospital is a complex process that needs to ensure people are discharged to the most appropriate place and continue to receive the care and support they need after they leave hospital. We were aware from the feedback from patients, relatives, carers and community colleagues that we did not always get discharge from hospital right. Using various methods, we planned to undertake improvement work in relation to discharge on a selection of pilot wards across Trust sites, to facilitate an effective, co-designed and patient centred process.

We agreed to:

- Establish a training programme with at least 20 members of discharge staff trained.
- Identify wards or departments to implement new ways of working, as identified in the discharge action plan.
- Work with patients, relatives and carers to understand what matters to them in relation to planning a safe and effective discharge and develop an action plan around these standards.
- Complete the actions by the end of 2022/23 and ensure the standards and good practice were fully embedded and disseminated to other clinical areas.
- Enable patients, relatives and carers to expect consistently high standards of care in relation to their discharge, based on co-designed pathways and initiatives, as set out in the Trust's improvement plan.
- Monitor progress with the quality priority at the Discharge Board.

We aimed for:

- Evidence of learning and/or change in practice from patient feedback and incidents.
- Feedback from the patient experience discharge survey.
- At least 95% of patients over the age of 65 leaving hospital and going straight home or to their usual place of residence either on discharge pathway 0 or pathway 1.
- 70% of patients not meeting the criteria to reside in hospital to be discharged by 5pm.
- A reduction in patients re-admitted as an emergency admission within 30 days of a discharge.

<u>End of year progress</u>

- Preceptorship programme for newly qualified staff, promoting good, safe and effective discharge with the patient at the centre of all we do.
- Discharge educator role created for ward-based learning.
- Series of discharge-related workshops held across the Trust and wider system.
- Implementing 'model ward' approaches, including timely ward rounds, improved discharge letters and processes and focus on priority discharges to enable early and good patient flow.
- Opened purpose-built discharge suite to facilitate safe and timely discharge.
- Involvement with patients, carers and families on admission to establish date of discharge and requirements to return home safely.
- Transfer of care hub created in collaboration with local authorities to support ward colleagues and social workers to return people safety home after their hospital treatment and help to ensure social care support is available in the community.
- Patient and carer feedback used to increasingly inform and design discharge pathways and arrangements.
- Single point of access integrated across health and social care in Teesside and North Yorkshire
- Posters and letters sent to all Care Home Managers across Redcar & Cleveland, Middlesbrough and North Yorkshire local authority areas to advise that the transfer of care hub is the main point of contact in relation to hospital discharges.
- To address the national and local challenges in social care, proportionate care implementation used to maximise the care resource and support people at home.
- Rapid improvement methodologies used to achieve a significant 66 per cent reduction in delay for patients moving to primary care hospitals and a 32 per cent increase in the suitability of patients utilising these beds.
- A renewed focus around pathway 0 has been put in place following winter pressures.
- Progress continues to be made against ambitious discharge targets.

Summary

Timely and safe discharge is a quality priority for the Trust, and significant progress has been made during 2022/23. Challenges within social care persist and joint working will continue to focus on addressing these in partnership. In addition, the Trust continues to make improvements in the patient journey through the development of a number of schemes and initiatives. National and local targets are monitored through the discharge board and quality assurance committee.

Figure 3: Discharge related information resources

2. Meeting the nutrition and hydration needs of patients.

Adequate nutrition and hydration are a fundamental standard and a basic human right for all patients in receipt of NHS care. All patients should have their nutrition and hydration needs met, in line with their assessed needs and best practice. To achieve this the trust must have effective systems in place in order to demonstrate this fundamental standard is being achieved.

We agreed to:

- Ensure that patients' nutrition and hydration needs are assessed on admission, reassessed weekly if they stay in hospital longer than 7 days, and that a care plan is in place.
- Ensure that clear processes and systems are in place to ensure that patients receive the best mealtime experience.
- Ensure that we can capture patient experience in relation to nutrition and hydration and be responsive to feedback.
- Implement the Malnutrition Universal Screening Tool (MUST) on our digital clinical data platform Patientrack.
- Establish a Nutrition Link Nurse network across the Trust and a programme of education.
- Conduct a quality improvement review of the mealtime process.
- Develop mechanisms to obtain feedback regarding nutrition and hydration, specifically in relation to vulnerable groups of patients.
- Develop a Nutrition and Hydration Strategy
- Ensure patients, relatives and carers can expect consistently high standards of care in relation to nutrition and hydration, based on co-designed pathways and initiatives.

- Ensure timely visibility of data, with appropriate action taken relating to nutrition and hydration.

End of year progress

The Trust is immensely proud of the work it has done over the last 12 months on nutrition and hydration, as part of its recovery from COVID-19.

- Following staff training, implementation of the digital MUST screening programme has now been rolled out to all inpatients including the primary care hospital wards, enabling daily reports of compliance with MUST screening Trust-wide to review at daily huddles.
- Data for quarter 4 2022-23 shows Trust MUST compliance at 95% overall.
- The Trust nutrition dashboard is under development. This will integrate nutrition metrics regarding compliance, care plans, incidents and complaints to enable staff to react more rapidly to the data.
- We have a programme of learning and professional development for all nutrition link nurses and healthcare assistants to support ongoing patient care. 91 registered nurses and 20 healthcare assistants (HCA) attended training in February 2023.
- Across the Trust, clinical teams demonstrated their focus on improving nutrition and hydration for patients during the March 2023 Nutrition and Hydration Week. See additional detail below.
- Seven wards now have a Ward Nutrition Assistant in post, with a further 4 wards currently recruiting. Part of this role is to support assisted feeding of patients who need support with eating and drinking. In addition to this, we continue to welcome daily support from staff volunteers across the Trust for wards with higher numbers of patients requiring assisted feeding when this is needed. The education team coordinates this using data from the Patientrack reports to identify areas that may require help.
- The Trust-wide catering survey is now providing more detailed information about patients' mealtime experience. Data from quarter 4 reports an overall experience rating of 81%. Key learning points to note from this include:
    - 55.43% of patients report receiving a menu prior to mealtimes; this is a current point of focus for the Nutrition and Hydration Council who are working closely with catering providers to ensure improvement in this area.
    - 94.4% of patients reported they were offered meals that met their specific dietary requirements.
- From April 2023 the newly appointed Trust Food Services Lead Dietitian will take up post, working alongside catering and ward teams, multidisciplinary team members, and the nutrition co-ordinators to address key projects identified from patient experience feedback.
- The Nutrition and Hydration Strategy was developed and implementation over the next two years will be led by the Nutrition and Hydration Steering Group.

Nutrition and Hydration week

Nutrition and Hydration Week aims to highlight, promote and celebrate improvements in the provision of nutrition and hydration locally, nationally and globally. A highlight is the Global Tea Party. It is always an opportunity to learn a bit more about nutrition and hydration for both our colleagues and patients. As part of our improvement plan for nutrition and hydration, there were a lot of initiatives and additional activities planned to start during Nutrition and Hydration Week.
One of these was the 'Thirsty Thursday' focus days when our hydration champions raised awareness of trust's traffic light jug scheme.

The coloured water jug lids are a simple visual way of monitoring how much patients are drinking to help minimise their risk of dehydration and acute kidney injury (AKI). Patients are given a water jug with a red lid first thing in the morning and once they have drunk it all (or the equivalent volume of other fluids), the jug is refilled or the water in the jug is refreshed, and the lid is switched to an amber colour, and then green.

Figure 4: Traffic light jug scheme - coloured water jug lids

Colleagues celebrated and shared all the great activities on social media, alongside the Trusts 'understanding complex nutrition' which is simulation-based training that supports staff to:

- Understand complex nutrition.
- Recognise complications in relation to nutrition.
- Demonstrate A-E assessment.
- Understand mental capacity and decision making around nutrition.
- Make appropriate referrals to the wider multidisciplinary team.
- Build confidence in patient assessment and multidisciplinary team working.

This is just a snapshot of the work that went on across the Trust wards to celebrate Nutrition and Hydration Week 2023. The ideas and enthusiasm were overwhelming, and some fantastic themes observed and shared with colleagues trust wide.

Figure 5: Photographs for staff initiatives to celebrate Nutrition and Hydration Week 2023

Summary

There has been a significant focus on nutrition and hydration across the Trust during 2022/23 and we are confident that staff are engaged in ensuring that planned improvements have been made, and good practice is being embedded and effectively monitored.

Whilst the Trust wide catering survey has been developed further and increasing numbers of patients are contributing to this, there is further work to do during 2023/24 to ensure our more vulnerable patients can provide their feedback more easily.

3. Using feedback from our patients, their relatives and carers to improve practice.

The Trust wanted to create opportunities for increased engagement and involvement with our patients and their relatives and carers in order to develop responsive and receptive patient centred services. We will increase the number of patient experience contacts with patients, their relatives, and carers, particularly face to face by ensuring there are fit for purpose facilities within the organisation.

We agreed to:

- Establish a Patient Participation Group.
- Recruit patients to initiatives across the organisation.
- Maintain or increase annual patient-led assessments of the care environment (PLACE) scores and benchmark to other local and national Trusts.
- Carry out monthly PLACE-Lite assessments focusing on different areas every month and benchmark to other local and national Trusts. PLACE-Lite is recommended good practice to complement the annual PLACE collection and it is an effective way of assessing and monitoring progress in areas identified as requiring improvement and for preparation in advance of the main collection.
- Review the current estate provision for patients, relatives and carers.
- Use quality improvement activity to inform what matters to patients, relatives and carers.

We aimed for:

- An increase in patient experience contacts by at least 10% on the previous year.
- Examples of improvements in practice informed by patient/relative/carer feedback and participation.
- Demonstrable improvement in the environment for the provision of patient experience activity.
- PLACE-Lite benchmarking data and local action plans.

End of year progress

The Patient Experience Steering Group (PESG) includes Trust staff, external partners and governors meeting on a monthly basis to discuss the patient experience at the trust, including hearing patient stories, the monthly and annual patient experience reports, reviewing policies, standard operating procedures and other key documents aligned to assuring the improvement of the patient experience. The group also reviews the national patient experience surveys for adult inpatients and maternity services and oversees the associated action plans.

The group has monitored progress with the quality priority ambitions and has commissioned several pieces of work during 2022/23 based on the feedback received by patients.

Patient involvement and participation

We are recruiting to the patient involvement bank which will include patients, carers, community groups and charities supporting patients and carers. This allows patients and carers the choice and opportunity to be involved in work as and when they are able. The work we will invite them to be involved in currently include the review of written and digital patient information, and the review and development of new pathways of care. Future developments include patient or carer presence at meetings held in the organisation, recruitment panels, and patient participation groups in areas such as cancer services, in collaboration with other NHS trusts.

The Patient Experience Team are also working with community charities, and groups representing deaf and blind people, people living with dementia, BAME people, and young carers to increase engagement and input from all people within our communities.

Patient Experience and Involvement Strategy

In collaboration with Healthwatch South Tees, and patients and carers we ran an engagement event in February 2023 to create a Patient Experience and Involvement Strategy. The event ran over three consecutive workshops and involved patients from different communities in the South Tees, Redcar and Cleveland and North Yorkshire areas.

The workshops were well attended, and the contribution from patients and carers were invaluable to creating the strategy. Feedback from those who attended the workshops included:

"It was great to be involved, I enjoyed capturing the event and obtaining feedback from the delegates. I learned that there are plenty of people who are passionate about improving the NHS and by sharing their knowledge and experiences we have a great opportunity to implement change".

Figure 6: Photographs of collaborative working at the Patient Experience and Involvement Strategy engagement event

The graphic below shows the outcome of this fantastic work. The strategy will be published during quarter 1 of 2023-24. Work is planned to ensure the strategy is embedded in the organisation in partnership with patients and carers and the support of Healthwatch.

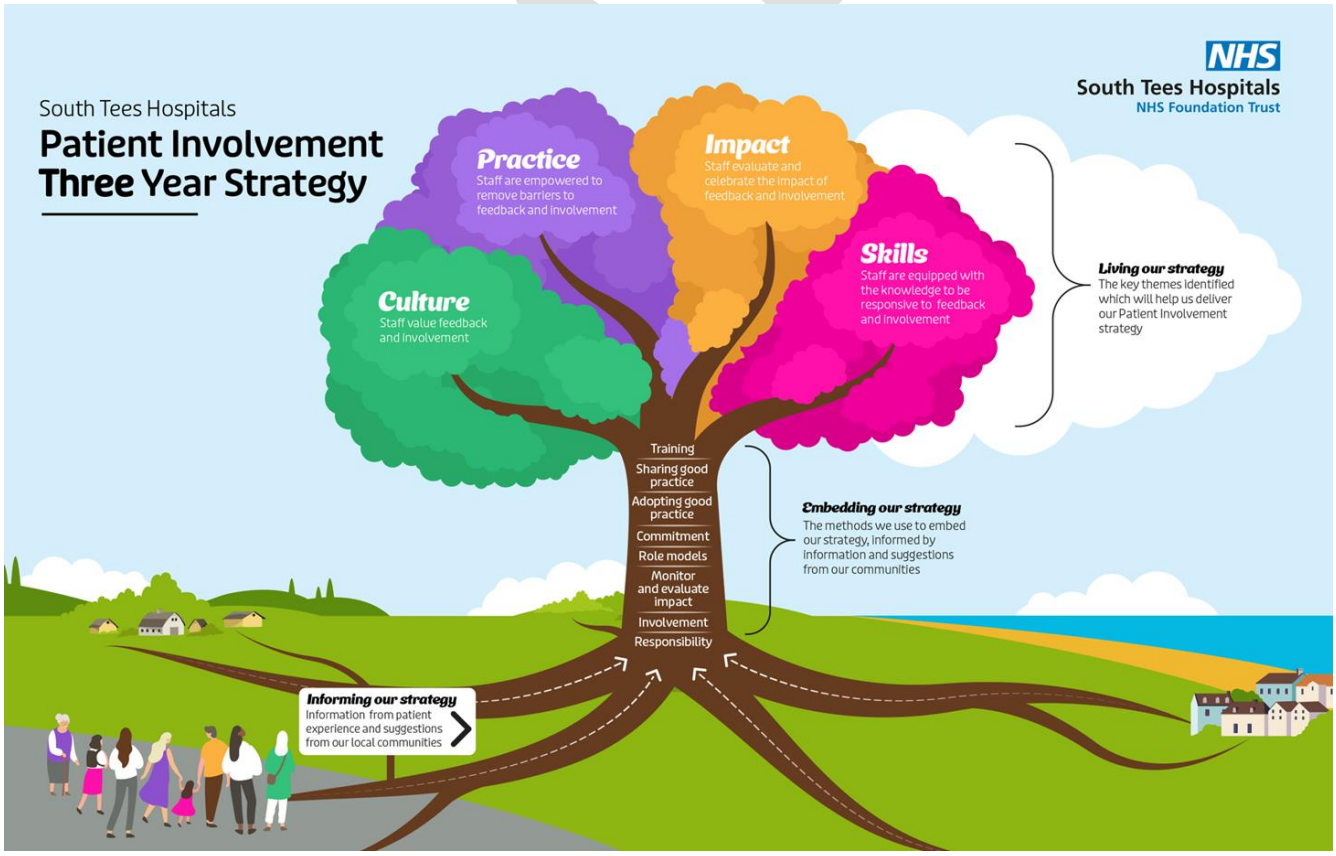


Figure 7: Our Patient Involvement Strategy

Patient-led assessments of the care environment (PLACE)

The annual PLACE assessments of all inpatient sites took place during September to November 2022 following a break due to COVID-19. The results were published on 23 March 2023 and the performance of South Tees NHS Foundation Trust compared against the national average PLACE scores is indicated in the table below.

The overall organisational scores for the Trust are above the national average on all eight domains which represents excellent performance against standards, particularly as the criteria are now stricter.

The results also indicate improvement in all domains and sites except for condition, appearance and maintenance at East Cleveland Primary Care Hospital which reduced from a score of 95.19% in 2019 due to damage to door frames, walls and ceiling tiles noted at the time of the visit. This is being rectified by NHS Property Services. Corrective action plans have been developed to address any other areas of weakness identified during the assessment and these will be monitored until the actions are completed.

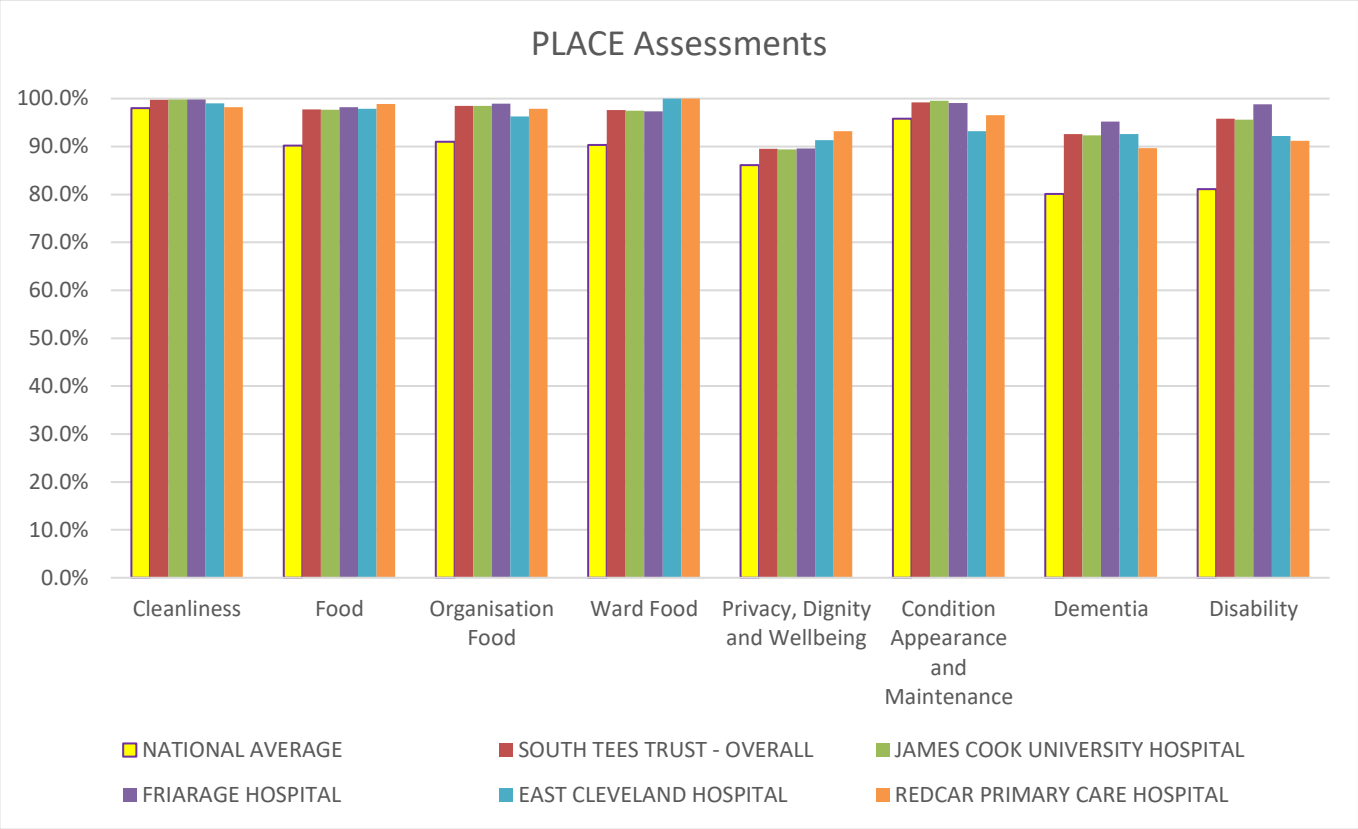


Table 2: Site specific PLACE results for South Tees Trust compared to national average 2023

Place Lite continues monthly across the James Cook Hospital site and we are now expanding to include our community hospitals and the Friarage Hospital in Northallerton. Our patient assessors are fully involved in all assessments and the aim is to visit two wards and two departments each month. Actions to address any areas that require improvement are developed, shared with the relevant parties and followed up to ensure completion.

Improvements in practice informed by feedback.

Based on patient and staff feedback, work was commissioned to understand the translation and interpreting services provided to the Trust and a full review of the service specifications and requirements was completed. Interim actions were taken to improve patient experience including a demonstration of an upgraded portal, use of the telephone interpreter service where appropriate, ensuring processes for access and escalation of complaints, and monthly operational meetings to monitor key performance indicators.

It was identified from patient feedback that carers needed to be recognised in their role and allowed the additional support time required for visiting out of hours, assisting with meals and drinking, and involvement in the patient's care including meetings and discharge plans. The Carers Passport has been developed to provide relevant information and support, including free or discounted car parking tickets and regular drinks.

We also collaborated with Carers Together - South Tees to develop a discharge leaflet to enable carers to understand what to expect at discharge, things to consider and a list of useful contacts. Consent was also gained to share information with the charities, Carers Together - South Tees and Carers Plus – North Yorkshire ensuring that carers were able to access support following discharge.

We have ongoing work being undertaken by the Head of Healthcare Records and Central Appointments on unanswered telephones, with the intention of improving the patient experience by increasing the number of calls answered and reducing the volume of complaints received. A review of all calls received by the trust was carried out looking at total volumes of calls by call centre and those calls received, answered, abandoned and the average wait to answer and duration of the call. This provides a sound basis upon which to commence deep dive analysis to allow targeted reviews and implement actions for improvement.

Other improvements made as a direct result of patient, relative or carer feedback include:

- Creating a more comfortable seating area and hydration station in the Infectious Diseases Clinic
- Introducing a process for ensuring information about delays within the operating theatres is communicated to patients awaiting surgery on the wards. This is being audited to ensure it is effective and embedded in practice.
- The anaesthetic team are reviewing our guidelines regarding the length of pre-operative fasting and ensuring this is in line with best practice and Royal College of Anaesthetists advice.
- Enabling email contact to the Endoscopy Department for patients, relatives and carers who are unable to use telephones.

There is additional information in section 3.4 of this report regarding other patient experience work and progress with other initiatives started during 2022/23.

<u>Summary</u>

There has been some significant progress with work to create opportunities for increased engagement and involvement with our patients and their relatives and carers to develop responsive and receptive patient centred services. And the contribution of the patient-led assessments of the care environment continues to provide important information for improvement and assurance. Unfortunately, our ambition to record and increase patient experience contacts with patients, their relatives, and carers, and to develop improved patient experience facilities within the organisation has not been possible to progress due to limited staff resource.

There are many good examples of the value we place on patient, relative and carer feedback and how we have used this to improve the services and care we provide, and the environment in which we do this. The work with our local Healthwatch and patients to develop our Patient Involvement Strategy is a very significant step forward in collaborative working with our stakeholders and the strategy will be embedded in the organisation in partnership with patients and carers and with the support of Healthwatch.

Quality priorities defined for improvement in 2023-24

The Trust has agreed the following priorities for 2023/24 following a consultation process with clinical colleagues and the Council of Governors.

Quality Priorities 2023/24		
Safety	**Clinical Effectiveness**	**Patient Experience**
We will continue to develop a positive safety culture, in which openness, fairness and accountability is the norm.	We will ensure continuous learning and improved patient care from GIRFT and clinical audits	We will implement the Patient Experience Strategy that has been developed in collaboration with our patients, careers and Healthwatch
We will continue to optimise the Trust's ability to learn from incidents, claims and inquests to improve outcomes for our patients	We will strengthen the mortality review processes, ensuring learning from deaths is triangulated and shared	We will develop and implement a Mental Health Strategy to improve care and share learning for our patients who have mental ill health
We will increase medication safety and optimise the benefits of ePMA		We will develop and implement shared decision making and goals of care

The agreed priorities are areas of importance that will make a difference to our patients. Some of our 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 1 April 2023 to 31 March 2024, with regular updates provided through the year via our quality governance structure.

2.2 Statements of assurance from the Board

Relevant health services

During 2022/23, South Tees Hospitals NHS Foundation Trust provided and/or sub-contracted 91 relevant health services. South Tees Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 91 of these relevant health services. The income generated by the relevant health services reviewed in 2022/23 represents 93.4**%** of the total income generated from the provision of relevant health services by the South Tees Hospitals NHS Foundation Trust for 2022/23.

National clinical audits and national confidential enquiries

South Tees Hospitals NHS Foundation Trust is committed to undertaking effective clinical audit across our clinical services and recognises that this is a key element for providing high quality care. Clinical audit enhances patient care and safety, provides assurance of continuous quality improvement and developing and maintaining high quality patient-centred services.

The Trust has a well-structured clinical audit programme which is regularly reviewed to ensure it reflects the needs of our acute and community services. During 2022/23, 60 national clinical audits and 3 national confidential enquiries covered relevant health services that South Tees Hospitals NHS Foundation Trust provides.

During 2022/23, South Tees Hospitals NHS Foundation Trust participated in 92% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. Eligibility, for the purpose of this report, is defined as those national audits that the Trust could participate in that were not suspended due to the COVID-19 pandemic.

The national clinical audits and national confidential enquiries that the South Tees Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2022/23 are listed below in Table 3, alongside the number of cases submitted to each audit or enquiry as a number or percentage of the number of registered cases required by the terms of that audit or enquiry:

Title	Eligible	Participated	% Cases
Breast and Cosmetic Implant Registry			0%
Case Mix Programme (CMP) Also includes Cardiac Intensive Care (Intensive Care National Audit & Research Centre (ICNARC) data)			100%
Child Health Clinical Outcome Review Programme - National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD) Transition from child to adult health services			33% (3/9)
Elective Surgery - National PROMs Programme (Patient Reported Outcomes Measure)			73%
Emergency Medicine QIP - Pain in Children (care in Emergency Departments)			100%
Emergency Medicine QIP – Assessing for cognitive impairment in older people (care in Emergency Departments)			100%

Title	Eligible	Participated	% Cases
Emergency Medicine QIP – Mental Health – Self Harm (care in Emergency Departments)			Paused July 2021 by RCM, reopened October 2022. Awaiting publication of paper
The Falls and Fragility Fracture Audit Programme (FFFAP) The Fracture Liaison Service Audit (FLS-DB)			60.1%
Falls and Fragility Fractures Audit programme (FFFAP): National Audit Inpatient Falls			100%
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database			94.6% (N=457)
Inflammatory Bowel Disease Audit			0%
Learning Disabilities Mortality Review Programme (LeDeR)			100%
Maternal, New-born and Infant Clinical Outcome Review Programme			100%
Medical and Surgical Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death, NCEPOD) Community Acquired Pneumonia (CAP)			100% N=3
Medical and Surgical Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death, NCEPOD) Testicular Torsion			Ongoing
Muscle Invasive Bladder Cancer Audit			100% N=8
National Acute Kidney Injury Audit			Awaiting publication of paper
National Adult Diabetes Audit – National Diabetes Core Audit			0%
National Adult Diabetes Audit – National Pregnancy in Diabetes Audit			100% N=37
National Adult Diabetes Audit – National Diabetes Foot Care Audit			50% Awaiting publication of paper
National Diabetes Audit – Adults: NaDIA - Safety Audit			0%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Secondary Care			N=46
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care			N=196
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Secondary Care			100%

Title	Eligible	Participated	% Cases
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Pulmonary Rehabilitation-Organisational and Clinical Audit			86.6%
National Audit of Breast Cancer in Older People (NABCOP)			100%
National Audit of Cardiac Rehabilitation (NACR)			100% n=2900
National Audit of Care at the End of Life (NACEL)			100%
National Audit of Dementia			100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)			100% Cohort 3
National Bariatric Surgery Registry			100%
National Cardiac Arrest Audit (NCAA)			100%
National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management			100% n=790
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project MINAP			100% n=1640
National Cardiac Audit Programme (NCAP) - National Adult Cardiac Surgery Audit			100% n=850
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)			100% n= 1600
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit			100% n=330
National Comparative Audit of Blood Transfusion programme - 2022 Audit of Patient Blood Management & NICE Guidelines			76% (114/149)
National Early Inflammatory Arthritis Audit (NEIAA)			Ongoing
National Emergency Laparotomy Audit (NELA)			100%
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer (NOGCA)			100%
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBOCA)			100%
National Joint Registry (NJR)			65.4%
National Lung Cancer Audit (NLCA)			100%
National Maternity and Perinatal Audit (NMPA)			100%
National Neonatal Audit Programme			100%
National Obesity Audit			0%
National Ophthalmology Database Audit			70.9%
National Paediatric Diabetes Audit (NPDA)			100%
National Perinatal Mortality Review Tool			100%
National Prostate Cancer Audit			100%

Title	Eligible	Participated	% Cases
National Vascular Registry			>85% Compliant
Neurosurgical National Audit Programme			100%
Paediatric Intensive Care Audit Network (PICANet)			100%
Respiratory Audits - National Outpatient Management of Pulmonary Embolism			100%
Respiratory Audits - National Smoking Cessation 2021 Audit			100%
Sentinel Stroke National Audit Programme (SSNAP)			Ongoing
Serious Hazards of Transfusion Scheme (SHOT)			100%
Society for Acute Medicine Benchmarking Audit			100%
The Trauma Audit & Research Network (TARN)			100%
UK Cystic Fibrosis Registry			100% N=51
UK Parkinsons Audit			100%
UK Renal Registry Chronic Kidney Disease Audit			100%

Table 3: National Clinical Audits 2022-23 – eligibility and participation

The reports of three national clinical audits were reviewed by the provider in 2022/23 and South Tees Hospitals Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Hip Fracture Database

- The hip fracture team have implemented several governance meetings ranging from bi-weekly to quarterly. Meetings of surgical, orthogeriatric, anaesthetic, nursing, therapy, and management leads take place at least monthly. A formal discussion takes place at each meeting to identify possible reasons for any performance that is significantly below average and to plan a quality improvement project to address it. There are processes in place to review policies and protocols and to compare these with those in other units as described in the Facilities Survey.
- Monthly governance meetings are used to plan appropriate quality improvement interventions, and to monitor the impact of these using the real-time data reported in the National Hip Fracture Database (NHFD) run charts. A new quarterly governance tool is designed to help us do this.
- Key performance indicator (KPI) caterpillar plots are used to identify better-performing neighbouring units, share best practice, and collaborate in designing quality improvement work. For example, the KPIs have been used to monitored initial care, to improve the provision of local anaesthetic nerve blocks and to improve fast-tracking patients to an appropriate ward.
- The hip fracture teams are in the process of minimising inequalities in health care, by reviewing whether support and information is provided in formats and languages appropriate to their patients. They are also signposting patients, their families and carers to the NHFD website resources which are designed to help them understand their care and recovery following a hip fracture.

National Neonatal Audit Programme

- Education of all staff on the Neonatal Intensive Care Unit (NICU) regarding data input has started with training of band 6 staff to ensure each baby has a date of birth entered on admission so that their review date can be captured accurately.
- We have employed an administrator to support data entry and data cleansing.
- There has been productive liaison between the neonatal team and ophthalmologists to ensure relevant examinations are undertaken at the optimal time.
- We have agreed a process with NICU and ophthalmology consultants for robust data entry of results regarding babies who are subsequently seen as an outpatient.

National Paediatric Diabetes Audit

- Additional administrative support is in place to provide quality control of data entry.
- A process has been introduced to ensure data capture of flu vaccinations, sick day rules and ketone measurements is assessed monthly, and the data is entered correctly.
- Quality improvement project is in place to increase the percentage of patients downloading their devices (blood glucose monitoring devices and insulin pumps) at home so their data can be reviewed by the diabetes team. The team will support managing HbA1c within the target range and aim to equip patients with the knowledge and confidence to self-adjust insulin doses through a patient empowerment tool.
- Quality improvement pathway for first year after diagnosis is in place.

Local audit

The reports of three local clinical audits were reviewed by the provider in 2022/23 and South Tees NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Completion of MUST in Critical Care Stepdown Patients

- Findings will be fed back to nursing teams and Patientrack team for system level amendments to be implemented.
- Audit will be repeated to identify if changes to the system have addressed the issues identified in cycle 1.

Clinical Audit of Partial Breast Radiotherapy

- Increased number of reviewers outlining and look at clinical implications of variations in outlining.
- To re-audit the same parameters in six months.

Post-operative wound care understanding in patients sustaining open fractures of the upper and/or lower limb

- Increase departmental awareness that patient understanding of wound care can improve and should involve discussion with the patient prior to discharge.

- Increase patient understanding of wound care both by discussion with patients while in the hospital and by providing information to take home with them.

Clinical Research

The number of patients receiving relevant health services provided or subcontracted by South Tees NHS Foundation Trust (STH) in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 5588 (across 157 studies). This compares favourably with the 3797 patients recruited last year across 145 studies and represents a 47% increase in patient recruitment and is our highest ever recruitment to date.

There is detailed information about our clinical research work in Part 3 of this report.

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of the South Tees Hospitals NHS Foundation Trust's income in 2022/23 is conditional on achieving quality improvement and innovation goals agreed between South Tees Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2022/23 are available on request from the Quality Assurance Team, South Tees Hospitals NHS Foundation Trust, The James Cook University Hospital, Marton Road Middlesbrough TS4 3BW or via email stees.qualityassurance@nhs.net

CQC registration, reviews and investigations

South Tees Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional. The Care Quality Commission took enforcement action against South Tees Hospitals NHS Foundation Trust during 2022/23. South Tees Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2022/2023.

The CQC completed a focused unannounced inspection of the core services for medicine and surgery at James Cook University Hospital and the Friarage Hospital in February 2022 with a report published in May 2022. This was not a full inspection, therefore the significant changes and improvements the Trust had made since 2019 full inspection were not reviewed. During their visit, the CQC recognised the enormous efforts of colleagues in the face of the unprecedented Omicron winter pressure on services at the time of their inspection.

The overall rating remained at requires improvement, with the Trust being served warning notices under Section 29A of the Health and Social Care Act 2008 in relation to regulated activities at James Cook University Hospital. The Trust was required to make significant improvements in the assessment and management of patients' nutrition and hydration needs; assessment and management of patient's individual needs; discharge processes; and adherence to the Mental Capacity Act.

The trust was already acting on these areas as part of its clinically led recovery from the the winter Omicron surge, which at its peak saw more than 500 COVID-related staff absences. However further work was planned and prioritised to ensure significant improvements were made to patient care in all these areas. Much of that work is reflected in this report. The Trust completed all the detailed action plans by September 2022 and presented the work done and outcomes during a

subsequent planned visit, when the CQC also re-visited some of the wards inspected in February and talked to staff and patients.

The CQC subsequently inspected urgent and emergency care and critical care services at The James Cook University Hospital, and medical wards (including services for older people) and surgery at both The James Cook University Hospital and Friarage Hospital. They also inspected the well-led key question for the trust overall. The inspection occurred between November 2022 to January 2023.

The CQC found significant improvements in the quality of care at South Tees Hospitals NHS Foundation Trust, and our overall rating moved up from requires improvement to good. The full report is available at https://www.cqc.org.uk/provider/RTR/inspection-summary

Overall trust quality rating	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Figure 8: South Tees Hospitals NHS Foundation Trust overall CQC rating

All well as the overall trust rating improving, the overall rating for Friarage Hospital and The James Cook University Hospital improved from requires improvement to good overall. Both hospitals are now rated as good in all five key questions of safe, effective, caring, responsive and well-led.

"When we returned to South Tees, we found an effective leadership team who had made significant and widespread improvements since our last inspection. This is reflected in their overall rating change from requires improvement to good, of which all their staff should feel very proud. Our inspectors saw much more effective processes, and management of services which was having a direct positive impact on the quality of care people were receiving. For example, these systems were used to identify risks to people and implement actions to reduce the impact of them, meaning they were much safer, and receiving more effective care.

"This was most evident in critical care which was unrecognisable from our last inspection. It was most impressive they were able to do this during the COVID-19 pandemic.

"Staff across all the services we visited were well engaged and committed to continually learning and improving people's care. It was also very impressive that leaders engaged staff to contribute to decision-making, for example to help avoid financial pressures compromising the quality of care."

Sarah Dronsfield, CQC Deputy Director of Operations in the North

The areas noted for improvement in the inspection and in the report are included in an action plan which is being monitored to ensure actions are progressed to completion and that ongoing assurance of compliance and high-quality care is embedded within the governance systems and processes.

Submission of records to the Secondary Uses Service

South Tees Hospitals NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in The Data Quality Maturity Index (DQMI). This is a monthly publication intended to highlight the importance of data quality.

The percentage of records in the latest published data for November 2022 which included the patient's valid NHS number was:

- 100% for admitted patient care
- 100% for outpatient care, and
- 99.5% for emergency department care.

The percentage of records in the latest published data for November 2022 which included the patient's valid General Medical Practice Code was:

- 99.8% for admitted patient care
- 99.8% for outpatient care, and
- 99.1% for emergency department care.

Information Governance grading

Information governance is assessed as part of the mandatory annual national process of submitting compliance with the NHS Data Security and Protection Toolkit (DSPT), which is currently based upon the National Data Guardian's 10 Data Security Standards. The content of the DSPT is aimed at providing assurance around technical aspects of cyber security, information security and data protection compliance.

The 2021/22 DSPT submission was assessed against compliance with 38 assertion areas which are comprised of over 149 pieces of evidence, 110 of these are mandatory. South Tees Hospitals NHS Foundation Trust DSPT status for 2021/22 was 'Approaching Standards' with an action plan in place. The Trust was non-compliant with five standards at the time of submission in June 2022; two of those standards have since been completed.

The three areas which continue to be non-compliant are:

- 95% of staff compliant with the Data Security Awareness training at the date of final submission (3.2.1).
- Devices that are running out-of-date unsupported software and no longer receive security updates (patches) are removed from the network, or the software in question is uninstalled. Where this is not possible, the device should be isolated and have limited connectivity to the network, and the risk assessed, documented, accepted and signed off by the SIRO (8.1.3).
- All infrastructure is running operating systems and software packages that are patched regularly, and as a minimum in vendor support (8.4.2).

The Trust maintains an action plan regarding compliance which is monitored at the bi-monthly Information Governance Steering Group and reported to the Trust Senior Information Risk Owner (SIRO), as well as being reviewed by the annual DSPT Internal Audit review.

The 2021/22 DSPT review has been performed by PwC (PricewaterhouseCoopers) as part of a national standardisation exercise, the findings of which are monitored and discussed at the Trust Audit and Risk Committee.

At the time of writing, the status of the 2022/23 DSPT is that the Trust has provided 96 of the 113 mandatory evidence items required, and 20 of the 36 assertions in this year's toolkit have been completed. The final submission date is 30 June 2023.

Clinical coding audit

South Tees Hospitals NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

Data quality

South Tees Hospital Foundation Trust will be taking the following actions to improve data quality:

- Data that is collected, recorded, and reported within the trust complies with national data standards outlined in the NHS Data Dictionary and is clinically coded in compliance with data classifications set out by World Health Organisation and NHS Digital ICD10 and OPCS 4.9
- To help and support the clinical collaboratives the Business Intelligence Unit and the Data Quality Team develop analytical tools and reports to help identify operational and clinical efficiencies and to help improve their data quality.
- To maintain compliance with legal and regulatory requirements, the Trust routinely monitors the completeness and quality of data. Monitoring reports and audits are used to improve processes, training documentation and use of computer systems. Examples of monitoring include:

Type of Monitoring	Frequency	Responsibility
External and internal audit of data quality of differing aspects of the Trust's data	Annual (external) Weekly and ad-hoc (internal)	Clinical Coding Team
Check of completeness and validity of data submitted to SUS and other mandatory returns	Weekly	Finance and Business Analysts
Validation of blank or invalid patient demographic details	Weekly	Data Quality Team
Validation of inpatient and outpatient activity	Weekly	Data Quality Team
Investigation of queries, issues, errors as they arise	Ad-hoc	Data Quality Team
Benchmarking of audit inputs and outputs to identify discrepancies that may indicate data quality improvements required	Annual cycle	Clinical Effectiveness

All members of staff involved in recording patient data have the responsibility to ensure they keep up to date with NHS data standards and recording guidance relevant to their role. Online data quality awareness sessions are available via the data quality intranet. These sessions are easily accessible and cover key data recording standards along with a range of guidance documents which keep members of staff updated on any new or changes to data recording.

The guidelines and procedures contain guidance and advice relating to the collection of data along the patient pathway ensuring as a Trust we are following national guidance. Staff are recommended to carry out these sessions on a yearly basis.

Learning from deaths

During 2022/23, 2,083 patients of South Tees Hospitals NHS Foundation Trust died. This comprised the number of deaths which occurred in each quarter of that reporting period:

- 462 in the first quarter;
- 475 in the second quarter;
- 563 in the third quarter;
- 583 in the fourth quarter.

By 31st March 2023, 2,074 case record reviews and 17 investigations have been carried out in relation to 2,083 deaths above. In nine cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 5 in the first quarter;
- 2 in the second quarter;
- 2 in the third quarter;
- 0 in the fourth quarter.

During the reporting period 0.1% were judged to be due more likely than not to problems in care. The Trust established a Medical Examiner Service in May 2018. Approximately 98% of deaths are scrutinised by Medical Examiners. Any death where there may be a problem in care (or that meets specific criteria) is reviewed by a central team of four consultants with expertise across many specialties. Each review results in two grades, one for quality of care and one for preventability of the death. Particularly complex cases are further reviewed by a cross-specialty panel of senior medical and nursing staff.

Learning and actions resulting from death reviews include:

- End-of-Life Care. Actions are coordinated through the End-of-Life Group, which receives information on themes and cases from Medical Examiner scrutiny and mortality reviewers. Documentation of Do Not Attempt Cardiopulmonary Resuscitation and other end of life documentation audit work is conducted as part of health care records audits.
- Documentation in the medical records. This i is addressed through the South Tees Accreditation for Quality of Care (STACQ) and health care records 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. The trust developed a communications campaign called “Documenting for great CARE” highlighting the issue 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. Internal coordination of care is recorded in hospital records by referring and receiving clinicians. Coordination of care will improve with implementation of electronic records.

- Transfer of patients from other hospitals. This is less common but a known problem. 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 on the doctor accepting referral to make this summary) and there is a process currently on-going around procurement of a digital 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 and procurement is nearing completion with an announcement expected in early 2023-24 followed by an implementation plan for cardiac, renal, vascular, orthopaedic and other specialty services.

Four hundred and thirty-five (435) case record reviews and three investigations were completed after 31/03/2022 which related to deaths which took place before the start of this reporting period. Before the reposting period 0.05% are judged to be due more likely than not to problems in care. This number has been estimated using the adapted version of the Preventable Incident, Survival and Mortality Study (PRISM) methodology. During 2021/22, 0.2% are judged to be more likely than not to have been due to problems in care.

2.3 Reporting against core indicators

Summary Hospital-level Mortality Indicator (SHMI)

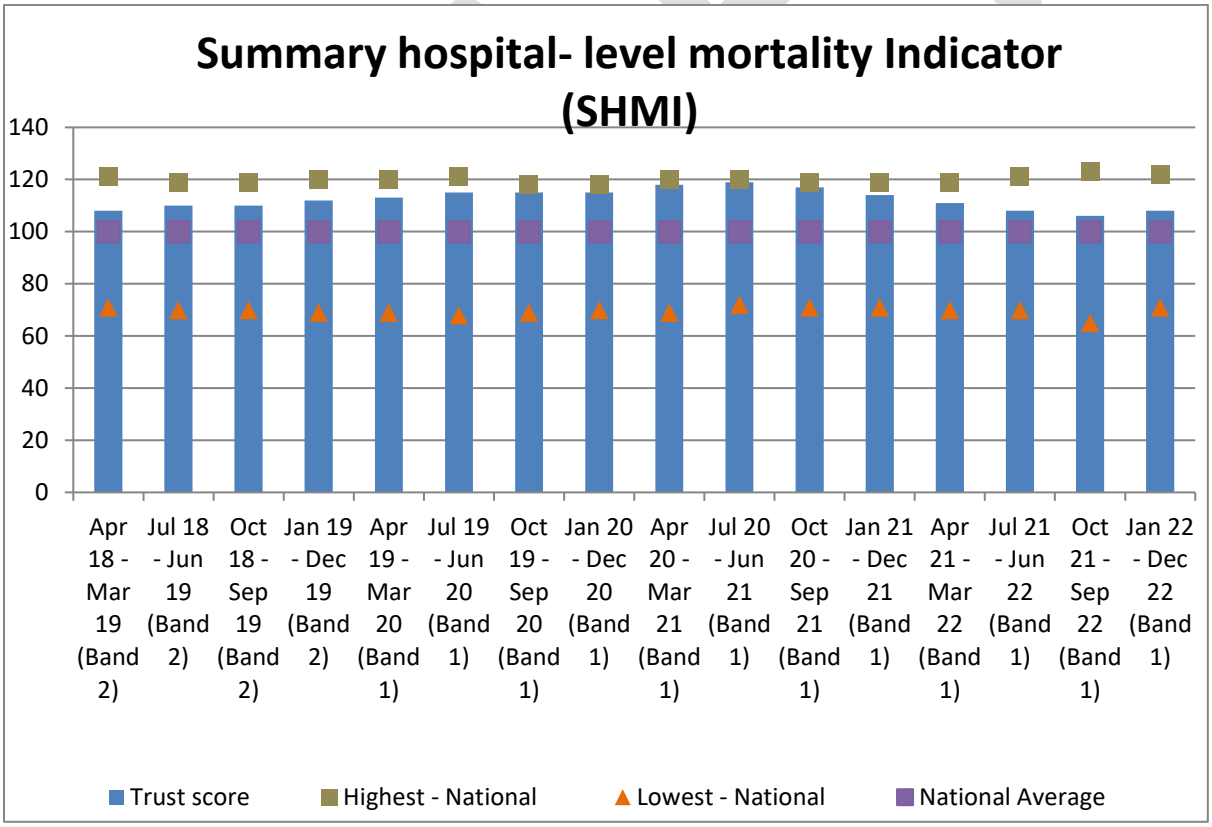


Figure 9: Summary Hospital Level Mortality Indicator (SHMI) (Data source: NHS Digital)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

1. The SHMI is not designed to account for the COVID-19 pandemic and although spells coded for COVID-19 have been removed by NHS Digital from the indicator calculation, the large reduction in the number of admissions to hospital, particularly during wave 1, has had a substantial impact on the expected number of deaths. For the 12 months Jan – Dec 2022 the number of spells included in SHMI is 87% of pre-pandemic levels, partly because 4.6% of spells have been removed by NHS Digital because they contain a spell code for COVID-19. However, SHMI has fallen compared to the pandemic period and is 'as expected' meaning that the number of observed deaths is within the statistical limits, compared to the estimated number of hospital deaths expected given the population of patients cared for in the Trust. The fall in the number of admissions has not been experienced evenly across the country, with areas that had high levels of COVID-19, such as the North-East, experiencing a greater impact.
2. Despite the high level of need in the population the Trust serves, the organisation has historically fallen behind other Trusts in recording the number of other medical conditions patients have, alongside the main illnesses being treated. The Trust is in the process of implementing electronic records systems which are expected to address this comorbidity recording anomaly and an improvement has occurred in the 12 months to December 2022, with further improvements planned as electronic records continue to develop.

   Patients who are treated within a single day for unplanned care without the need for admission are currently removed from the dataset which is used to calculate SHMI to another emergency care dataset and this therefore removes low-risk patients from the datasets calculation. This change in the way patients who are treated within a single day for unplanned care without the need for admission are recorded, has taken place earlier than in other Trusts.

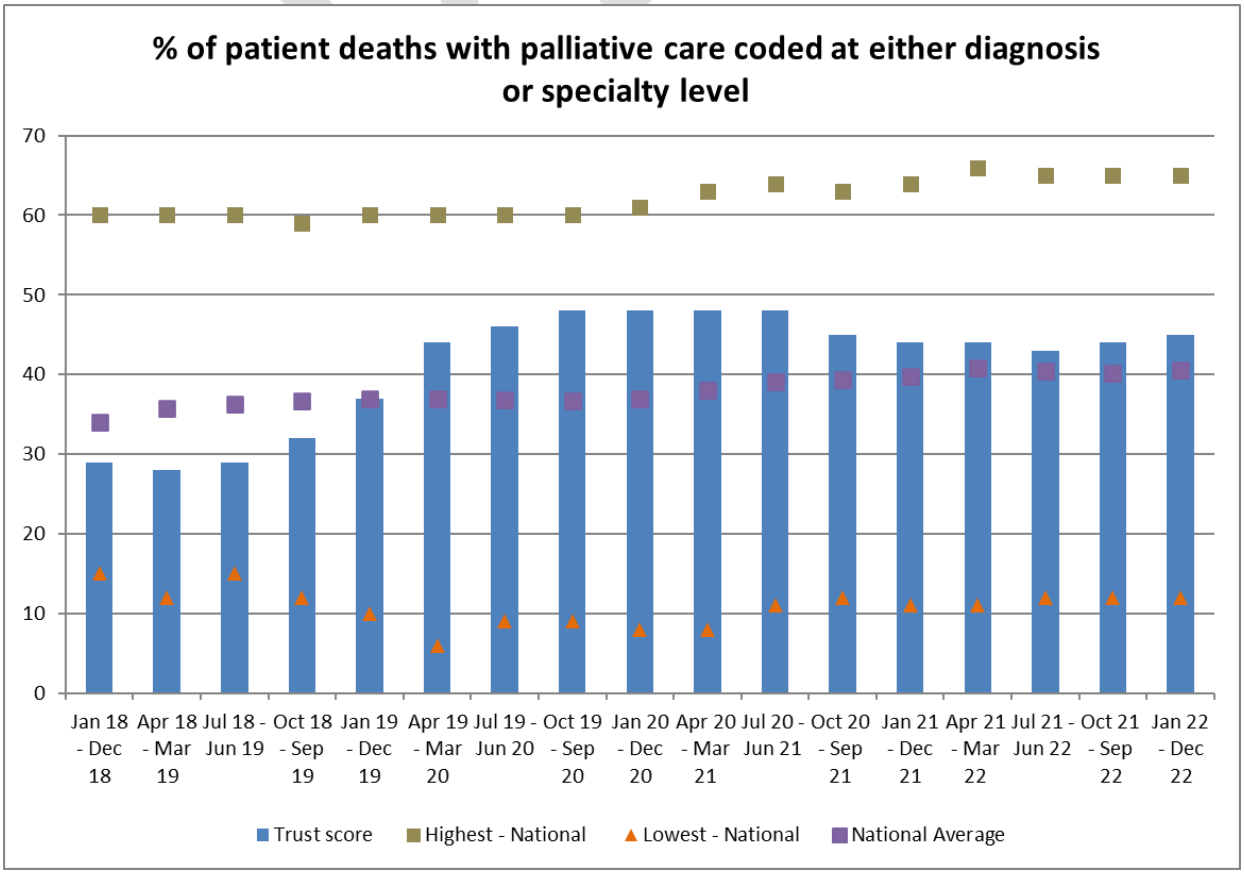


Figure 10: Percentage of Patient Deaths with Palliative Care Coded (Data source: NHS Digital)

The percentage of patient deaths with specialist palliative care coding has been higher than the national average in the last twelve reporting periods and this indicator is stable in the last five at about 45%. This reflects the work that was done to ensure that all the specialist palliative care provided to patients was captured in the coding used to calculate SHMI. This involved a comparison between two digital systems used to record the care provided.

The Trust has taken the following actions to improve the indicators and therefore the quality of its services:

- The Trust has governance committees which monitor and respond to mortality information and the Quality Assurance Committee in particular coordinates hospital safety and improvement activity.
- The Trust regularly reviews the range of statistics available to monitor hospital mortality, establishing the Medical Examiner Service in May 2018 (the first in the North-East), overseeing trust and specialty level case note reviews of hospital deaths so that common themes can be identified, and lessons can be learnt to improve the quality of its services.

The number of deaths in the Trust is variable from year to year, depending on the severity of respiratory and other seasonal infections each year and the pattern during the COVID-19 pandemic was unlike any previous year in the Trusts' history. However, the trend outside the seasonal variations and the pandemic years has remained stable over a long period of time, despite an aging population and increasing complexity of the conditions patients have when admitted to hospital. Work likely to affect mortality rates, particularly in elderly patients admitted to medical wards, includes sustained work on identification and management of deteriorating patients (the National Early Warning Score is electronically recorded in the Emergency Departments and Acute Assessment Units as well as all wards of the hospital), identifying and managing patients with sepsis, prevention of falls, and work identifying patients' level of frailty and providing appropriate support.

Patient reported outcome measures

Patient reported outcome measures (PROMs) measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a healthcare procedure and provides an indication of the outcomes or quality of care delivered to NHS patients (http://www.hscic.gov.uk/proms). The score reported is an adjusted health gain score based on case mix, a higher number indicates a better health gain.

NHS Digital has not released any data beyond the 2020/21 data published in the Quality Account last year.

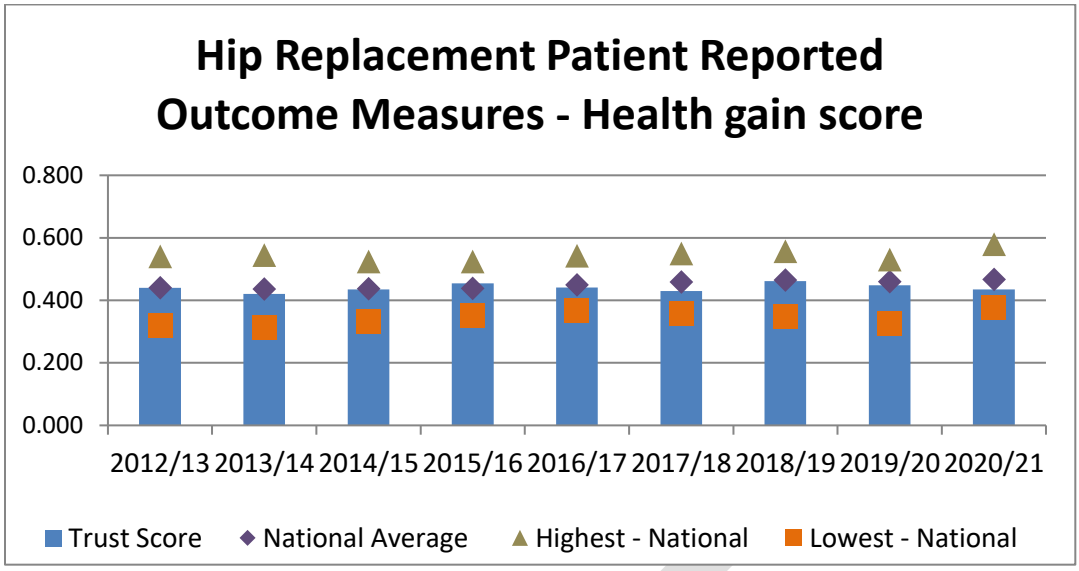


Figure 11: Hip Replacement PROMS (Data source: NHS Digital)

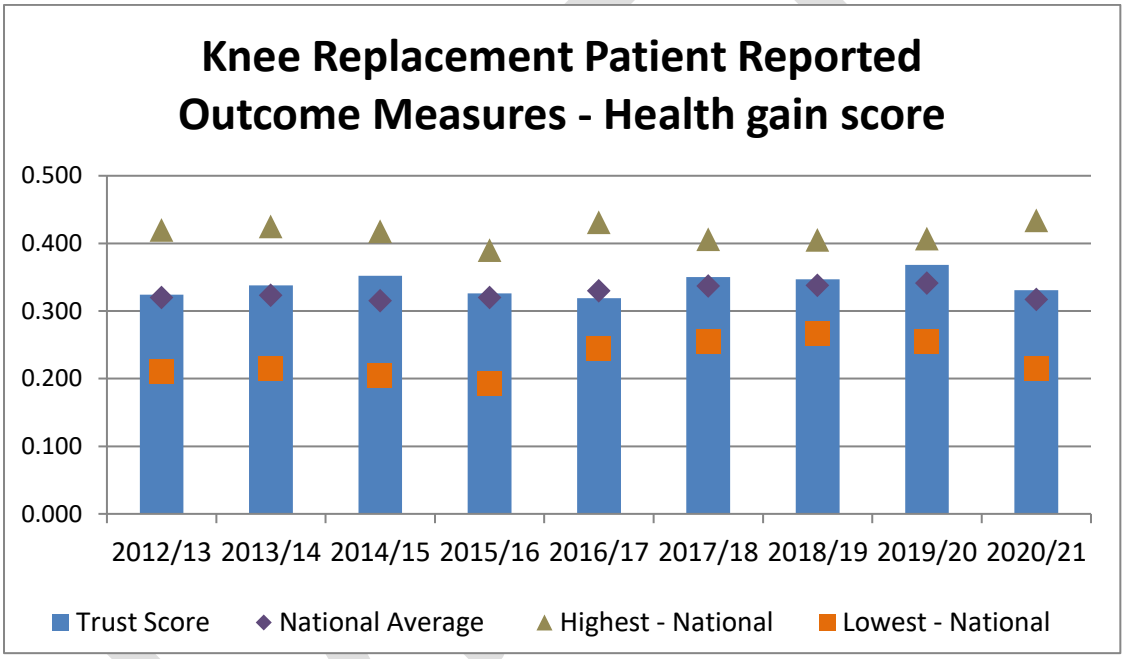


Figure 12: Knee Replacement PROMS (Data source: NHS Digital)

South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The specialist review and pre-assessment process ensures that patients are offered the procedure likely to deliver the most benefit and best outcome.
- The health gain scores for hip replacements and knee replacements are in line with the national average.
- Production of data has been disrupted by the COVID-19 pandemic.

The Trust has taken the following actions to further improve these scores, and therefore the quality of its services:

- Providing regular feedback of the scores to clinical teams and benchmarking performance across the NHS and other hospitals in the North-East, through a regular report produced by the North-East Quality Observatory Service (NEQOS), to ensure the quality of services is maintained.

30-day readmissions

The data from NHS Digital was not available at the time of publication.

Responsiveness to the personal needs of its patients during the reporting period

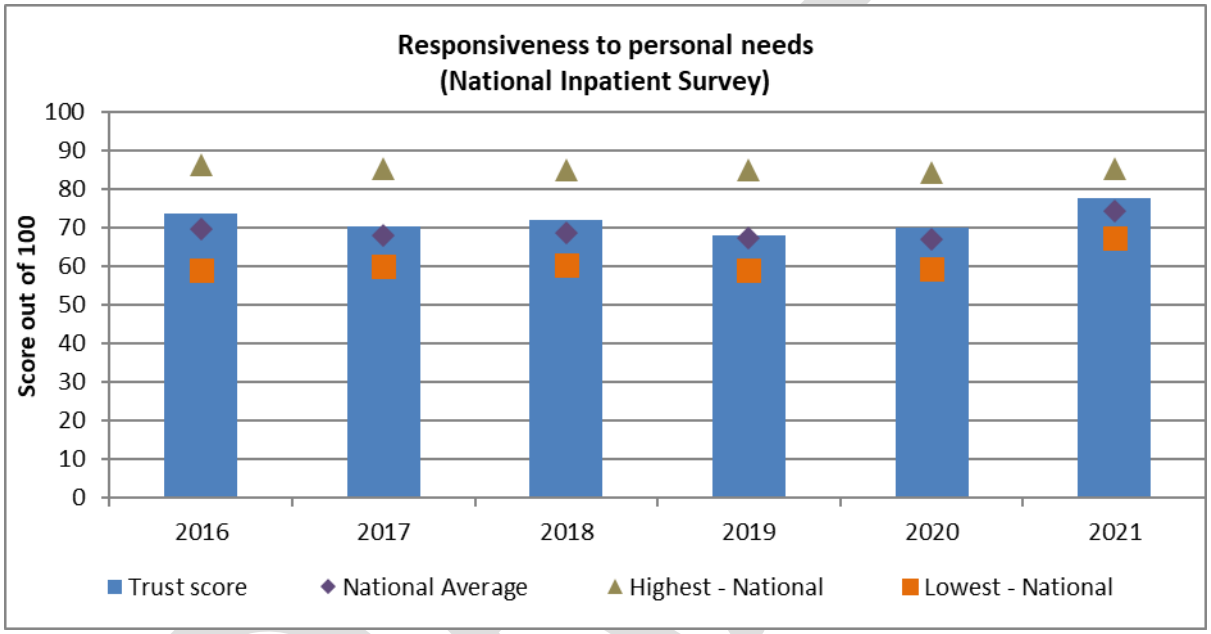


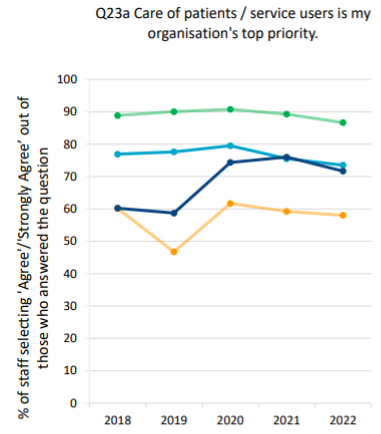
Figure 13: Responsiveness to personal needs results from National Inpatient Survey

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

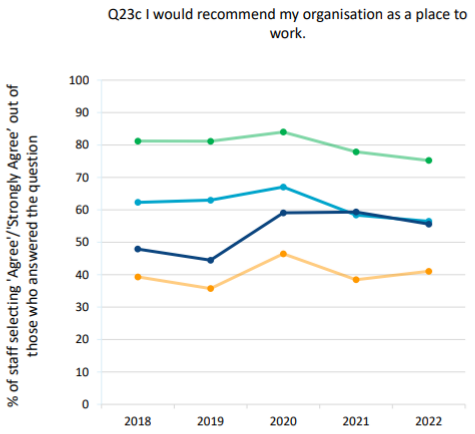
- The data shows that the Trust continues to score above the national average.

The South Tees Hospitals NHS Foundation Trust intends to continue to capture and analyse patient experience to improve its services by creating opportunities for increased engagement and involvement with our patients, their relatives and carers.

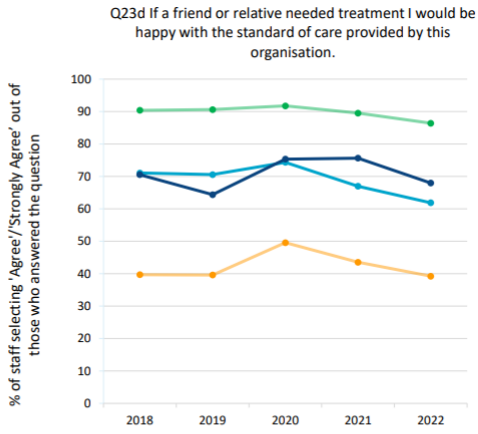
Staff FFT



	2018	2019	2020	2021	2022
Your org	60.2%	58.7%	74.4%	76.0%	71.7%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	406	2227	2441	2846	3324



	2018	2019	2020	2021	2022
Your org	47.9%	44.5%	59.1%	59.4%	55.6%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	46.5%	38.5%	41.0%
Responses	409	2218	2443	2851	3321



	2018	2019	2020	2021	2022
Your org	70.5%	64.4%	75.3%	75.6%	68.0%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	406	2214	2444	2847	3322

Table 4. Percentage of staff who would recommend the Trust (Data source: NHS Digital)

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has made significant improvements over the last three years and this year we remain at or above the sector average. Whilst there has been a slight drop in the score in 2022, this is consistent with the other NHS organisations.

The South Tees Hospitals NHS Foundation Trust intends to take the following actions to further improve this percentage and thereby the quality of its services.

- The Trust will continue to work with staff to improve the quality and safety of care we provide to our patients and has introduced a number of mechanisms to promote the provision of excellent patient care. As well as promoting in the staff bulletin, briefings, and other communication, it has introduced STAQC (South Tees Accreditation for Quality of Care) standards for clinical areas and STAR awards which recognise excellent achievements by staff.
- The Clinical Policy Group, which involves all clinical leaders, continues to make decisions on the best way for the organisation to allocate resources and deliver excellent patient care.

Venous thromboembolism risk assessments

Our most recent data regarding venous thromboembolism (VTE) risk assessment (January 2023) shows 89% compliance against our target of 95%. This is against a figure of 88.8% for the whole year 2022. While we accept that occasional patients do not receive a VTE risk assessment or prophylaxis, we believe that the majority of non-compliances relate to problems with data collection rather than clinical omission. For example, completion of a VTE risk assessment is currently recorded on the CAMIS digital administration system by ward staff manually noting the completion of a risk assessment. Within the past year many wards have moved from paper prescriptions to electronic prescriptions (including VTE risk assessment). When auditing VTE risk

assessment on the electronic prescription system, we see that every ward audited has higher levels of completed VTE risk assessments than recorded on CAMIS.

We aim to move to using the electronic prescription system as our trust wide method of recording and reporting VTE risk assessment once this is fully rolled-out. The majority of non-compliances come from the acute admissions wards, primarily Same Day Emergency Care (SDEC) at JCUH. When we conducted an audit of SDEC in January 2023, all eligible patients had a VTE risk assessment completed, however none had been recorded on the CAMIS system. This ward alone accounted for about half of the recorded non-compliances in the Trust in December 2022.

VTE risk assessment data continues to be reviewed and discussed at quarterly Thrombosis Committee meetings, with escalation to the Clinical Effectiveness Steering Group where appropriate. VTE continues to be a high clinical priority within South Tees Hospitals NHS Foundation Trust.

Clostridioides *difficile* (C. *difficile*) Infections rates

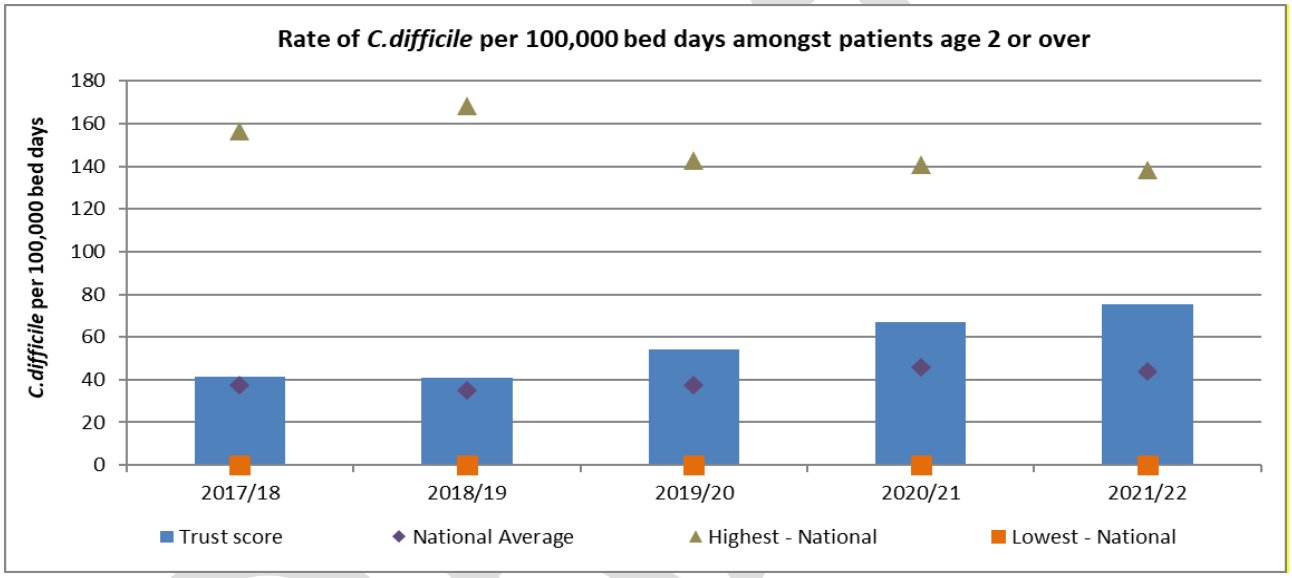


Figure 14: Rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over. (Data source: NHS Digital)

The South Tees Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust is committed to driving down healthcare acquired infections and achieved its lowest ever incidence Clostridioides *difficile* (C. *difficile*) infections in 2018/19, with subsequent slight increases again the following year, which continued through 2020/21 and 2021/22..
- The Trust reports healthcare associated CDI cases to UK Health Security Agency via the national data capture system against the following categories:
    - Hospital onset healthcare associated (HOHA): cases that are detected in the hospital 2 or more days after admission (where day of admission is day 1), and
    - Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.

The Trust is required under the NHS Standard Contract 2022/23 to minimise rates of Clostridium *difficile* infection to below 111 or less so that it is no higher than the threshold level set by NHS England and Improvement.

The South Tees Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services.

- The Trust has a comprehensive recovery action plan for the prevention of trust-attributed C. *difficile* infections which is monitored through the Infection Prevention and Control Strategic Group and reported through to the Safe and Effective Care Strategic Group.
- All trust-attributed cases have a Structured Review panel undertaken. Panel reviews are chaired by the Deputy Director of Infection Prevention and Control (DDIPC) or a senior infection prevention and control (IPC) nurse and supported by integrated care board (ICB) colleagues. If the panel agrees that there were no issues in care, then the case may be discounted from the total for internal performance measurement purposes only, as nationally the financial sanctions for C. *difficile* have been removed and the 'appeals' process is no longer in use. Identifying a single root cause in cases of C. *difficile* is challenging and is often associated with one or more influencing factors; patient factors e.g., existing long-term conditions, and/or medical factors such as the requirement for antibiotics or laxatives and/or processes.
- Learning from the Structured Review process and aligned to the recovery plan the Trust has implemented a monthly C. *difficile* task and finish group and an escalation to the fortnightly senior nursing team meeting to complete actions reporting into the wider organisation.

Patient safety incidents

The national publication of the required patient safety incident data has been delayed meaning that this was not available from NHS Digital at the time of publication. Information about our work on patient safety is included in section 2.1 of this report.

Patient Friends and Family Test

The 2022/23 patient Friends and Family Test (FFT) data is provided in section 3.4 of this report.

3. Overview of quality of care and performance indicators

3.1 South Tees Accreditation for Quality of Care

The South Tees Accreditation for Quality of Care (STAQC) program was established in July 2020 to establish a comprehensive assessment of the quality of care within all clinical areas.

Accreditation is defined as the development of a set of standards so that areas for improvement can be identified and areas of excellence celebrated. Experience shows accreditation programmes can drive continuous improvement in patient outcomes and increase patient satisfaction and staff experience at ward and unit level. Using a collective sense of purpose teams can support communication, encourage ownership, and achieve a robust programme which measures and influences care delivery.

There are 128 wards, units, teams, and departments that are eligible for accreditation, which consists of:

1. Pre-assessment review of key outcome data, for example, nurse sensitive indicators, complaints and patient experience, a staff survey, human resources metrics such as sickness and appraisal records.
2. An 'on the day' assessment: the 'general' assessment tool comprises 163 items under the key headings of Culture of Compassionate Care, Well Led, Safe Care, and Effective Care which are assessed by documentation review, patient interviews, multi-disciplinary team staff interviews, ward manager interview, medical staff interviews and an environmental review.

We have specialist accreditation tools for theatres, paediatrics, maternity, ambulatory departments, Critical Care and the Emergency Department.

Accreditation assesses a balance of process and outcome data, environmental impact on care delivery, teamwork, impact on and relationships with relevant services along the patient pathway, staff and patient feedback, evidence of learning and continual improvement.

Work undertaken during 2022/23

There has been a continued focus during 2022/23 to embed the STAQC accreditation program into all the clinical areas. Baseline accreditations have been included as the starting point of the formal process for some wards and departments, providing the clinical areas with a baseline report detailing their current standard and expected timebound actions required to achieve either gold or diamond accreditation.

The accreditations achieved during 2022/23 were:

- 17 diamond accredited areas
- 22 gold accredited areas
- 8 silver areas
- 10 baseline areas

Post accreditation checks for the areas initially accredited at the start of the program are now underway to ensure robustness and standards are maintained after accreditation. One day per month the team are working through assurance visits. 13 have been completed.

Diamond accreditations	33	**Key actions:** • Ensure genuine readiness vs eagerness to prevent lack of sustained progress and change. • STAQC team maintain comprehensive work plan transparent to all teams. • Constant focus on shared ownership. • To conduct a service evaluation of the programme so far. • Look to further refine and develop the programme.
Gold accreditations	31	
Silver awards	9	
Baseline accreditations	10	
Total eligible wards, teams, or units	128	

Table 5. Summary of STAQC progress and key learning to date.

Summary

There have been significant achievements in 2022/23 and many reasons and opportunities for local teams to celebrate their achievements along their STAQC journey.

It's like a ward managers handbook

A worthwhile challenge with an outcome to make us proud of our everyday work

The whole team took ownership of the STAQC process and used it as an opportunity to celebrate safe and effective practice

STAQC is an apprehensive time but also an exciting time, as we are able to showcase what we do best

Figure 15: Team celebrations and feedback about STAQC

The plan for 2023/24 is to achieve eight accreditations per quarter. This is based on the STAQC team capacity and redeployment, team preparedness and engagement, and operational pressures.

3.2 Patient safety indicators

1. Safeguarding, Mental Capacity Act, learning disabilities

Adult Safeguarding

Safeguarding is a positive duty placed on all staff under Section 42 of the Care Act (2014) to promote the wellbeing of vulnerable people and protect them from harm whether the harm is intentional and irrespective of whoever causes the harm. Safeguarding duties are rooted in law; based around the protection of human rights. As a public authority the Trust must follow the Human Rights Act (1998) in everything it does and treat people in accordance with their rights. The Trust has a clear outline of executive accountability within governance structures, which provides a framework for the sharing of learning across services. This sharing has been strengthened by an ever-growing cohort of Safeguarding Champions (currently over 100) within clinical teams.

During 2022/23 the team have provided regular collaboration with partner agencies within the Teeswide Safeguarding Adult Board (TSAB) and North Yorkshire Safeguarding Adult Board (NYSAB) sub-groups, participating in guidance and policy development, performance reports and multi-agency audits, and engaging with communities during safeguarding weeks.

The Trust has a robust process of monitoring and reporting on activity, trends and themes and linking learning with relevant work streams for the effective use of resources. In 2022/23 there have been 660 safeguarding concerns (1% decrease for the same period in the previous year), with 117 relating to Trust factors (an 18% decrease from the previous year). Key areas of learning have been in relation to discharge, pressure ulcers and medication.

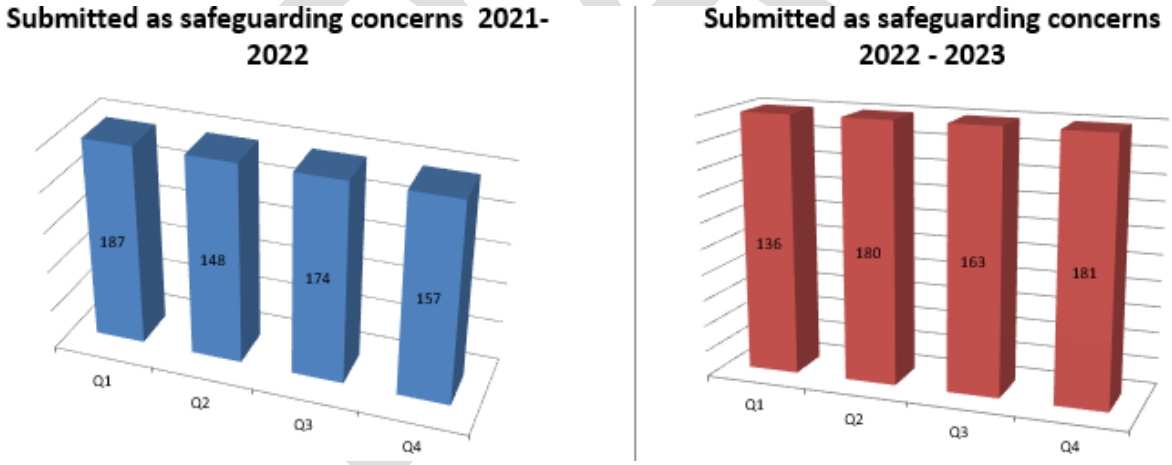


Figure 16: Safeguarding concerns 2021-22 and 2022-23

Summary

Two areas have been identified for development in 2023/24:

1. Strengthening a trauma informed practice approach within safeguarding.
2. Developing a process that allows assurance monitoring for advocacy referrals. This will be led by our Safeguarding Educator and MCA lead.

A new Safeguarding Adults Practitioner has begun working with the team. A dietician by background she has significant experience in safeguarding issues involving nutrition and will lead safeguarding awareness raising during Nutrition and Hydration week 2023.

Safeguarding Children

The Safeguarding Children Team are key members of the multi-agency safeguarding systems that are in place to protect children and young people. The role is to ensure that staff identify and advocate for vulnerable children, identify safeguarding concerns and take action in the form of timely referrals to children's social care and specialist support services. The Team continues to represent the Trust at South Tees Safeguarding Partnership meetings and actively contribute to the multi-agency work programme across the Partnership. They contribute to multiagency Child Safeguarding Practice Reviews and Domestic Homicide Reviews and participate in identifying learning and implement action plans.

- The team take an average of 1400 calls from Trust staff and partner agencies each quarter.
- Trust staff make an average of 450 safeguarding children referrals per quarter.
- Paediatric consultants carry out approximately 130 child protection medicals per year.
- The team undertake regular audits to gain assurances around safeguarding practice and during 2022/23 has completed the following:
    - Quality of SAFER referrals made by Maternity, Paediatric Ward and Emergency Department (ED). The frequency of audits in each area is reduced when good results are sustained, and support provided if any issues are identified.
    - Midwives' attendance at Initial Child Protection Conferences (ICPC's). Sharing results with maternity community managers and reasons for non-attendance has improved attendance from 52% to 71%.
    - Multiagency Hidden Males Audit. The results showed the name of fathers or relevant males was not recorded consistently. This has been a focus of training and another audit is planned.
    - Exploitation Screening Tool in Children and Young Peoples Emergency Department (CYPED). This was a base line audit following changes to questions asked in CYPED. The results showed the tool was effective in identifying children at risk and prompted staff to consider exploitation but was reliant on correct data input at triage.

The safeguarding children team have also led and contributed to the development of several standard operating procedures and have led the development of policies including Domestic Abuse and Children in Hospital (Section 85). They are proactive in disseminating key safeguarding messages and learning from both local and national reviews. To support this process the Safeguarding Educator has created a Safeguarding Facebook page which has been well received by staff and is proving to be an effective means of information sharing across the organisation.

Safeguarding Champions have been identified and are given regular updates and information to disseminate to staff. They are offered one-to-one supervision by the safeguarding team and have secured office space at Friarage Hospital which increases the visibility of the team across the sites. The team also provide supervision to many other staff groups across the organisation. All community midwives are required to have 12 weekly supervisions and compliance has been over 98% throughout 2022-23 despite organisational pressures.

Summary

There has been a significant amount of work undertaken during 2022/23. Key achievements are:

- Establishment of Safeguarding Champions and Facebook page
- Maintaining attendance at supervision despite significant pressures on maternity staff.
- Good attendance at ED liaison meetings and positive feedback from group members.
- Maternity and Neonatal Unit liaison meetings will be embedded in practice this year.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental capacity oversight sits within the safeguarding team. A full time Mental Capacity Act (MCA) Lead commenced in post on 1 September 2022. Revised bespoke and mandatory training was put in place and delivered by our Safeguarding Educator and MCA Lead.

A review of the MCA process and preparation for the new Liberty Protection Safeguards (LPS) which is expected to replace Deprivation of Liberty Safeguards (DoLS) has taken place, with greater visibility of the MCA Lead across the Trust and timely escalation of complex patients to multidisciplinary team meetings. Triangulation of relevant audits with data from other internal sources and from partner agencies is accessed and used throughout the organisation.

Daily ward visits and reinforcing of learning have improved referrals related to DoLS since the MCA Lead started in post in September 2022.

Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
52	64	56	45	46	50	65	113	76	101	95	121

Table 6: Numbers of DoLS referrals April 2022 – March 2023

There have been 884 urgent authorisations or standard applications to assess safeguards in place for patients deprived of their liberty which is 14% increase from 2020-21 when 670 applications were made.

A quality assurance process takes place three times per week scrutinising ward-based MCA/DoLS practice through an audit of 15 criteria ranging from decision specific capacity assessments, risk assessments and LPS compliance. After each audit the ward receive feedback highlighting good practice, areas needing focus and any concerns. This information is also shared with the Assistant Directors of Nursing for each clinical collaborative, matrons and the ward managers.

An MCA pathway was developed following discussions with ward staff in order that there was clarity of process regarding capacity assessments and best interest (BI) decision making. The description of the decision is not limited and staff are provided with a range of different pathways dependent on the decision needed.

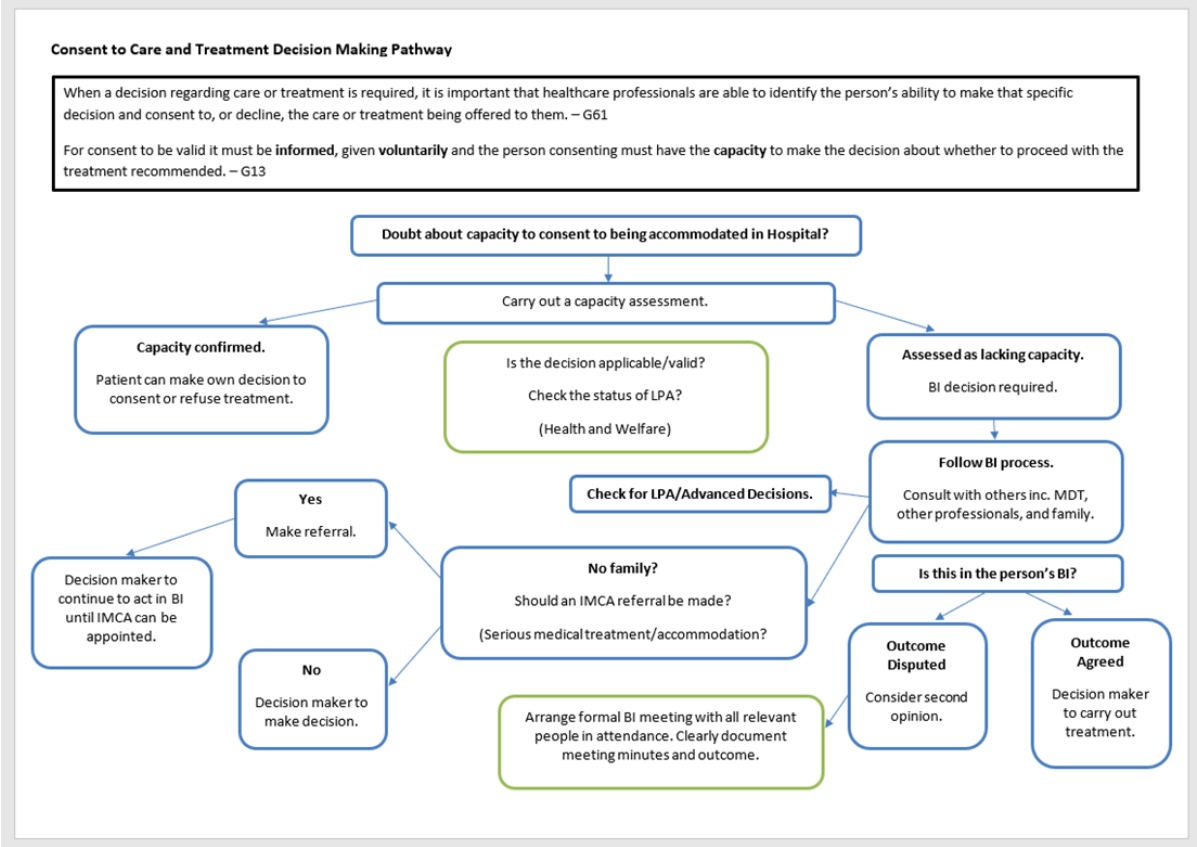


Figure 18: Mental Capacity Act pathway

A new risk assessment was created and introduced in November 2022 for use during triage in the Emergency Department to prompt capacity and consent conversations. This is completed for any patient who presents with self-harm or a mental health presentation at triage.
There are currently 77 MCA champions across the Trust who promote good practice. We also use our dedicated intranet page, Facebook and Twitter posts to communicate key messages to a wide staff population.

Summary
Significant changes have been made to ensure patient safety, staff training, support and the Trust's legal duties are maintained and upheld. The MCA Lead has been involved in local and national networks in order to ensure the Trust was keeping up with the expected changes and was writing a business case to be LPS ready when announcements were made, however LPS has been put on hold by the current Government.

Visibility and engagement with wards across all our clinical collaboratives is in place and the MCA Lead is sighted on all DoLS applications for quality assurance.

This has resulted in significant improvements in documentation of assessment of capacity, best interest decision making and DoLS as noted in the CQC inspection report. There remains work to do to fully embed the processes established, but the robust monitoring of compliance provides good assurance that this will rapidly be achieved.

Learning Disabilities

People with a learning disability tend to have poorer physical and mental health than the general population. On average the life expectancy of women with a learning disability is 17 years shorter than for women in the general population. On average the life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital, 2018).

- Approximately 2.16% of adults in the UK are believed to have a learning disability.
- Approximately 2.5% of children have a learning disability.

The Trust has worked closely with the NorthEast and North Cumbria Learning Disability Network to standardise documents for use across the region. During this period a hospital passport, hospital pack and training pack have been designed and produced.

E-learning in learning disability awareness was made mandatory for all staff in August 2022. The training includes a bespoke film produced by the Twisting Ducks Theatre Company to raise staff awareness of the importance of making reasonable adjustments and the use of the hospital passport. In March 2023 81.59% (7926) staff had completed the learning disability mandatory awareness training.

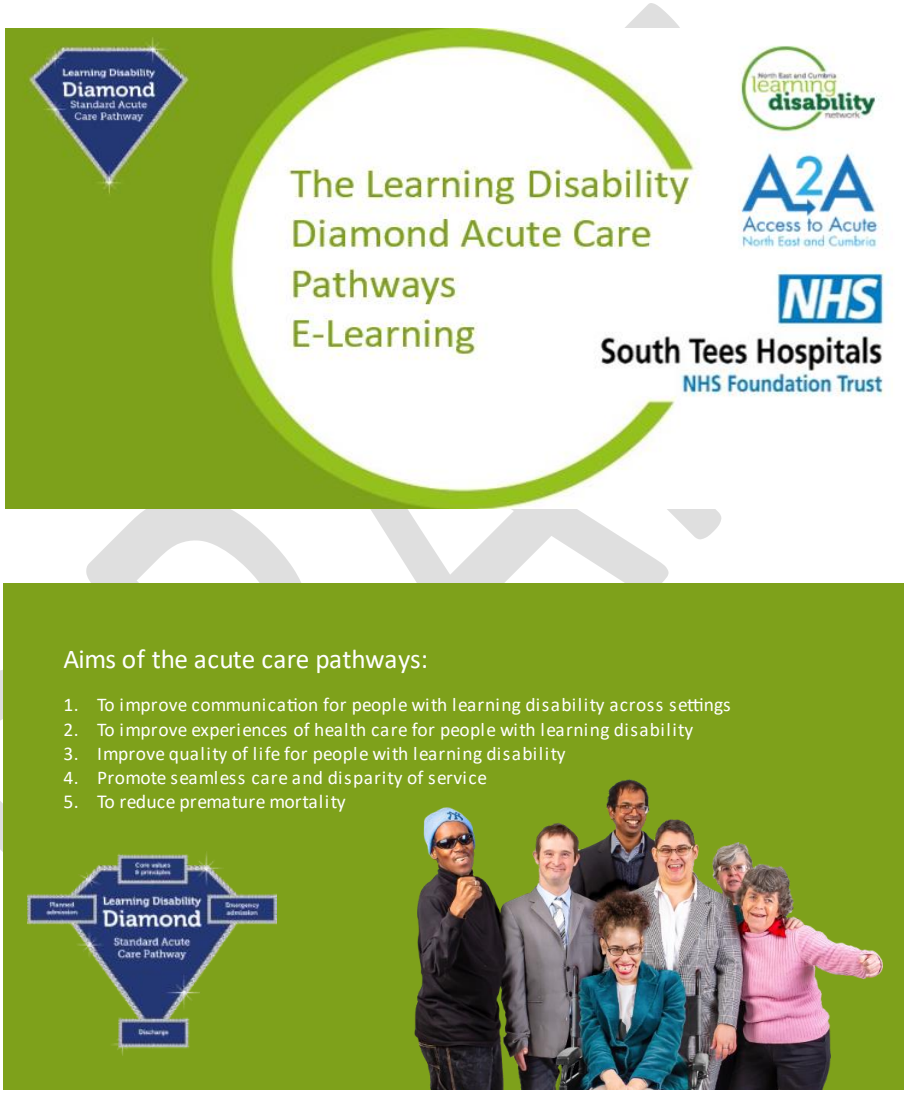


Figure 19: Learning disability diamond acute care pathways e-learning

The Learning Disability Partnership Group meets bimonthly. It is well attended by internal and external representatives, with people with lived experience taking an active role.

The Trust's external website has been redesigned with easy read information accessible from the main page. Easy read appointment letters are sent out to patients who are identified as having a learning disability.

We know the first step to making sure reasonable adjustments are made is the early identification of patients, which depends on safe sharing of information. We have worked closely with Tees Esk and Wear Valley (TEWV) NHS Foundation Trust to draw up a Partnership Sharing Agreement to enable relevant data to be shared from the learning disability trust. Holgate Primary Care Network have also shared data in 2022. During 2022/23 we received data on 553 patients from Tees Esk and Wear Valleys NHS Trust (January 2023) and Holgate PCN (August 2022). At the end of quarter 4 2022/23 we had 1610 patients identified as having a learning disability.

In January 2023 we submitted our national LD audit data for the fifth consecutive year. The results will be published in May 2023. This is linked to the NHS England Learning Disability Improvement Standards, as is the Trust Learning Disability Improvement Plan.

In 2022/23, we have had 17 deaths reported of inpatients with a learning disability (ten male, seven female), the average age at death was 58 years. The death of any patient with a learning disability in the Trust is examined by a Medical Examiner and a subject judgment review (SJR) takes place. The SJR is submitted to the external Learning Disability Mortality Reviewer for scrutiny and data collection. If any concerns or actions are identified, there is a more in-depth focused review. During 2022/23 we had two focused reviews. The Learning Disability Mortality Action Plan is currently being updated to evidence the actions following SJRs and monitor any emerging themes.

Summary

Good progress has been achieved during 2022/23. We have continued to increase the number of patients identified with a learning disability, year on year, with the largest increase in 2022/23. The Trust now employs 18 registered learning disability nurses in a variety of roles across the organisation. Funding for the role of Acute Learning Disability Liaison Nurse has been secured and once appointed, will increase the availability of clinical support to both patients and staff, and ultimately improve patient outcomes.

During 2023 the Oliver McGowan Learning Disability and Autism training tier 1 is expected to be introduced, with tier 2 to follow. Integral to both tiers are people with a learning disability and people with autism. We are in the process of updating our friends and family (FFT) survey to make it more accessible, and to enable relevant patients and carers to be contacted by phone.

Patients who miss outpatient appointments need to be identified and additional support put in place. This is part of the NHS improvement audit and is recognised to improve patient outcomes and reduce health inequalities. A Fairer Access Working Group are meeting monthly with an aim to identify and reduce the number of outpatient appointments where the patient ‘did not attend’ or ‘was not brought’. Using Trust data, the group have identified paediatrics and maternity as services with the greatest number of missed appointments. The safeguarding team are working to produce an adult focussed Was Not Brought Policy in 2023.

2. Falls

Falls can have a physical and psychological impact upon patients and contribute to added health needs, lengthening hospital stays, deconditioning, and increased frailty. Ensuring patients are assessed and care plans developed in a timely manner occurs best when all parts of the system are aware of risks, preventive measures, methods of assessment, evidence-based responses, and where access to expertise, and training and development is robust. The section below sets out what has been achieved during the previous year and what is planned for the coming year.

Work done during 2022/23

- Completed a full trust policy review in relation to falls.

- 250 inpatient healthcare assistants (HCAs) and support staff trained in falls prevention.
- 53 student nurses trained in falls prevention.
- Extended training offer to SERCO staff in ward areas.
- Seven ward areas provided with bespoke training to support their falls prevention work.
- Contributed to the development of electronic assessments, reviewing current provisions and ensuring new systems are NICE guidelines compliant.
- Enabled all allied health professionals (AHPs) to have Patientrack access, which helps to ensure all professionals hold accountability for documenting their role in falls prevention.
- Contributed to creation of best practice guidelines regarding BP measurement as part of patient falls risk assessment.
- Completed Best Practise in Dementia facilitator training to support reducing falls rates within the Trust as part of a broader, comprehensive approach to safer mobility within hospital. Preparing materials for roll out in April 2023 and to develop a cohort of dementia champions in inpatient ward areas.
- Creation of monthly Falls Champions Forum with two identified link nurses in all inpatient areas, and recently addition of physiotherapy, occupational therapy, dietetics and pharmacy staff, stressing the importance of multidisciplinary working.
- Developed workstream directly with therapeutic care and dementia teams to ensure patients are seen at the right time, by the right person.
- Created prompts within existing reporting systems to engage with the Falls Lead if a patient has two or more falls during the same inpatient admission. Thirty reviews have taken place through this process.
- Introduction of yellow socks for patients with elevated falls risk. This visual method helps ensure patients are identified throughout the admission and ward transfer processes.
- Patient care plans introduced on the Clinical Decisions Unit at Friarage Hospital. Falls have reduced since implementation and staff feedback has been positive.
- Contributed to learning following reviews of multiple fallers and serious incidents within ward areas with recommendations for practice and supporting the actions agreed.
- Reduced waiting list for assessment in community from 20 weeks to 10 weeks with further resources identified to reduce further.
- South Tees wide strategy is in development, for which the team has been shortlisted for a Healthwatch award.
- Delivered training across the community pathway. 90 staff members from health, social care and partner organisations have been trained since October 2022.
- 48 therapists booked onto a falls and balance exercise training programme to ensure older people who fall get the best evidence-based interventions.
- Continue to promote www.steadyonyourfeet.org across the pathway which has been developed to inspire behaviour change and reduce the risk of falls. South Tees is an active partner.

Summary

This year has focused on the systems we use to identify and respond to falls for patients, recognising the learning opportunities for the organisation, the delivery of education and increasing awareness of the need for falls prevention assessment for patients at risk. To enhance our work, we have identified the need for a Trust wide Falls Group, who represent inpatient and community services, so that we can share learning, enhance communication, and build a clearer learning and development plan. The following activities have begun and will continue throughout the next 12 months.

- Development and embedding of a Trust wide Falls Steering Group.
- Quality improvement process mapping, to clarify the patient journey from admission through to discharge from the point of the fall. The aim is to review processes, systems, and responses which are working well and those which need further development.
- Benchmarking exercise to identify where falls prevention and post fall work is currently happening, and aligning this with responses to frailty, deconditioning, delirium, and dementia care pathways.
- Review the impact of falls work, including financial cost / benefit analysis, return on investment and productivity data.
- Reimagining the falls curriculum, to identify additional learning approaches and methods for engagement across the Trust.
- Community falls summit planned for 26 April 2023, bringing together our partners and agencies to share learning.

3. Duty of candour

There is a professional duty of candour for healthcare staff and also a statutory duty of candour. They have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. The statutory duty also includes specific requirements for certain situations known as notifiable safety incidents.

During 2022/23, the Trust has continued to strengthen the approach to duty of candour across the organisation. There have been education sessions provided to clinical staff to raise awareness of the regulatory and good practice elements of duty of candour and to promote the potential of the process to drive up the quality of care within the organisation.

Compliance with all elements of the statutory duty of candour is proactively and closely monitored within the Trust, with a monthly compliance report presented at the Patient Safety Steering Group. Any exceptions are routinely followed up by the Patient Safety Team until there is evidence that duty of candour requirements have been fully met. Across the year, the Trust has seen increasing compliance against all aspects of the duty of candour.

To enhance the Trust's approach to fulfilling the duty of candour, the role of the Family Liaison Officer (FLO) has continued to be embedded during 2022/23. The purpose of the FLO role is to facilitate the delivery of duty of candour, engaging with and supporting patients and/or families following the occurrence of a harmful patient safety incident, and enabling the meaningful involvement of the patient and/or family in the subsequent patient safety investigation. There are currently 40 trained FLOs within the organisation, and a further training cohort is planned in June 2023.

To further strengthen the engagement and support provided to patients and/or families involved in patient safety incidents, the Trust has been successful in being awarded funding from the Academic Health Sciences Network to commission Restorative Practice training for two cohorts of staff during 2023. The course will study the ethos of a restorative approach in response to the impact of harmful events and relationship strain within health settings. This focus will explore the needs of impacted individuals and the context for restorative responses to healthcare harm.

In summary, the Trust continues to promote openness and transparency as the default position for working with our patients and their families.

4. Maternity

Our maternity services are a core part of what is delivered both locally and regionally, with ongoing work continuing to improve maternity care, based on the findings and recommendations from recently published national maternity inquiries, investigations and reports. Below is a summary of our achievements, along with some areas which need further attention and focus.

Figure 20: Photograph of some members of the South Tees Maternity Service

During 2022/23 the South Tees Maternity Service has reviewed all the actions from the Shrewsbury and Telford inquiry led by Donna Ockenden and implemented changes to ensure we are meeting the seven immediate and essential actions required of all maternity service providers. This work has included changes in how we review maternity patient safety incidents, the experiences of women, birthing people, babies and families, and how we provide assurance about the quality and safety of our service. The regional maternity team which included service users visited our unit in May 2022 to review how we are meeting these actions. The team were happy that we met all the requirements of these seven actions. The team commented that staff felt comfortable in raising issues, there was a strong training culture, there was clear visibility at Trust Board and Local Maternity System level of the unit. The Trust was also noted as having an active Maternity Voices Partnership (MVP) with good service user involvement.

An MVP is an NHS working group comprising women and their families, commissioners, and providers (midwives and doctors) working together to review and contribute to the development of local maternity care. The local MVP has appointed new co-chairs and is increasing its presence in the community by speaking to women, birthing people and families who are using our services. Members of a working group are reaching out to our ethnic minority women and birthing people who are using our maternity services.

As part of our quality and safety work we have also met all the requirements for the ten national maternity safety standards defined by NHS Resolution.

A preterm birth clinic has been established supported by a preterm birth specialist midwife. This team are working closely with the Local Maternity and Neonatal System and the Maternity and Neonatal Safety Improvement Programme to deliver the best outcomes for the preterm baby.

Results

The national maternity survey results for 2022 showed the South Tees Maternity Services were rated much better than expected for one question, better than expected for six questions and somewhat better than expected for seven questions. The service scored in the top 20% of Trusts on 33 questions and in the bottom 20% on one question out of a total of 59. This question related to choices of where to have your baby. This may have been reflective of the change of use of the co-located midwifery led unit at James Cook University Hospital during the Covid-19 pandemic. Midwifery staffing has meant this unit has not yet fully reopened.

Further details about this and other national surveys reported during 2022/23 are detailed in section 3.4 of this report.

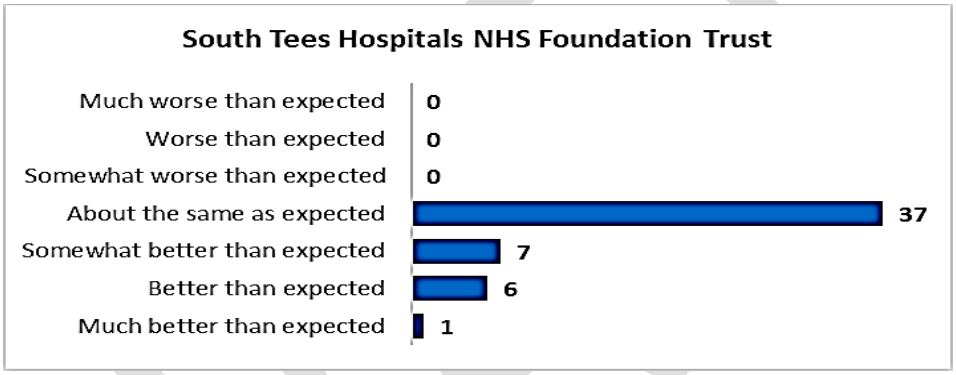


Figure 21: Results of the 2022 National Maternity Survey

We measure how happy women are with their care through patient experience surveys. Our friends and family test results show that on average 90% of women rate their experience of care as either very good or good.

We have achieved all our obstetric training requirements for 2022/23 with over 90% of midwives, obstetric doctors and support workers attending face to face training.

As part of the Saving Lives Care Bundle we are required to undertake carbon monoxide monitoring. We have achieved 90% compliance with this at booking and 85% compliance at 36 weeks since July 2022. Foetal growth risk assessments were also completed in 97% of pregnancies.

Summary and next steps

We have led a project to improve access to maternity care for vulnerable women, birthing people and families. This project is a collaboration with the family hubs which are being coordinated by the local councils.

We are moving to electronic maternity notes (Badgernet) in April 2023, with the aim of improving care for our women/birthing people by giving access to a personalised care plan where they can add comments, see outcomes of visits and work with their midwife to plan their care. The midwifery and obstetric team will also be able to access notes more easily.

Our last maternity CQC inspection was in 2015, when an overall rating of good was given. In line with the new CQC maternity inspection framework, we anticipate the Trust will be inspected again during the next 12 months.

A working group will be established in early 2023 to review induction of labour. We currently have the highest induction of labour rates in the North East. This will look at the whole induction pathway from decision making to labour. This will include how women/birthing people are involved in the decision making around induction. There is also ongoing work being completed around birth choices including place of birth.

Nationally there will be a single delivery plan for maternity services, and this will be implemented across the NHS in 2023.

3.3 Clinical effectiveness indicators

1. Research

The Trust is a partner organisation within the Clinical Research Network for the North-East and North Cumbria (CRN NENC) and supports the CRN NENC to deliver and lead high quality research as part of the National Institute for Health Research (NIHR) portfolio.

We are part of the Tees Valley Research Alliance (TVRA). This alliance combines the research and development departments from our trust and North Tees and Hartlepool NHS trust into one alliance which provides a more efficient research set up and delivery service that attracts external research sponsors. The aim is to share information on studies so that all patients across the Tees Valley are offered the same opportunities to take part in cutting edge clinical trials. A clear strategy and annual improvement plans outline our priorities for research in the TVRA.

There is a clear link between research activity, clinical outcomes and improved patient experience. Over the last year there have been many position statements from professional bodies (Royal College of Physicians, General Medical Council, Nursing and Midwifery Council) highlighting the importance of research and the need for all health professionals to be involved in supporting research, in addition to the need for Trust Board endorsement and support to enable and deliver these objectives.

As noted in part 2 of this report, the number of patients that were recruited during 2022/23 to participate in research approved by a research ethics committee was our highest recruitment to date at 5588 (across 157 studies), a 47% increase from last year. We have opened several large recruiting studies within our children's, and reproductive health portfolios which have contributed to this significant increase.

We have established a core Chief Investigator Support Service within the TVRA to provide sponsor related support and oversight for all TVRA sponsored studies and co-fund a post with MedConnect North to support the development of Med Tech and Investigator Initiated trials with an additional post planned for 2023/24. We have supported the establishment of three new Academic Research Units in the TVRA to provide specialist support and training for Chief Investigator led studies from Cardiology (Academic Cardiovascular Unit (ACU), Surgery (Academic Centre for Surgery (ACeS) and Perioperative care.

(https://www.southtees.nhs.uk/about/strive/research-team/academic-cardiovascular-unit/ and https://www.southtees.nhs.uk/about/strive/research-team/aces/).

These Academic units have been developed in partnership with Newcastle University, Hull York Medical School, Health Sciences at the University of York, and the Royal College of Surgeons (RCS) of England providing new opportunities for research fellows within the Trust. Both the ACU and ACeS have received successful funding awards from prestigious funders for new studies and support a range of existing studies led by STH Chief Investigators.

Successful contingency funding requests from the CRN NENC have enabled us to extend the already successful secondment of heart failure specialist nurses into research roles at NTH and add an additional secondment and initiate a similar scheme at STH with Band 6 nurse and Band 7 Dietician supporting Critical Care research along with a Band 7 Trauma Practitioner and a Paediatric Advanced Practice Nurse. Both TVRA trusts have signed up to become members of the global TriNetX platform (https://trinetx.com). This will allow greater visibility of our trusts to potential commercial research sponsors thus bringing more cutting-edge trials to our populations. It will also allow our own researchers to interrogate our trust-based patient information systems to support study feasibility review.

Nursing, Midwifery, AHP and Clinical Research Practitioner engagement in research

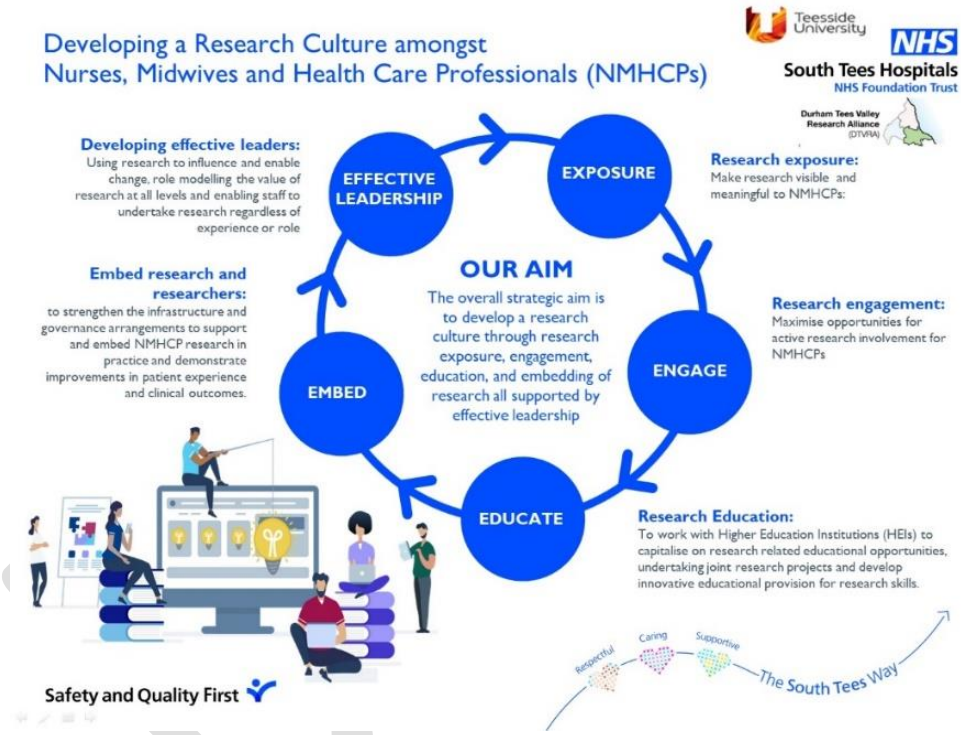


Figure 22: Developing a research culture graphic

Our Cancer Trials Team Leader has been appointed as the regional Clinical Research Practitioner (CRP) Lead for CRN NENC supporting CRP colleagues with accreditation and CRP engagement. Our Clinical & Operations Manager works closely with Directors and Associate Directors of Nursing in both trusts to progress the Nursing Midwifery and Allied Health Professional (NMAHP) research agenda, embed research and develop strategies for implementing the Chief Nursing Officer strategic objectives to increase engagement in research from this large staff group. We have an active “Research Support and Best Practice Council” at STH and “Be curious about research” campaign. We are currently in discussions with Senior Nurse Leaders to extend this council to NTH. We have increased the number of non-medical Principal Investigators this last year from 15 to 24 (16 STH, 8 NTH).

Patient Engagement

Feedback from patients who have participated in NIHR studies within the Trust is sought via the NIHR "Patient Research Experience Survey" with feedback reviewed quarterly at our Research and Development Directorate meetings. This year we have received very positive feedback from 179 research participants so far against an annual target of 190.

We routinely appoint patient representatives to the steering committees of our NIHR grant funded studies and carry out other patient and public involvement activity to inform the development of individual trials. We have significantly improved the content of staff facing and patient facing internet sites and are currently developing animations to explain the purpose of research and how patients can get involved.

Summary

South Tees is proud of its contribution to local and regional research, which drives improved clinical outcomes and improved patient experience. The research and development team are proud to have achieved their highest ever recruitment into NIHR portfolio trials this year, to be the highest recruiter regionally into two clinical specialties anaesthetics and perioperative pain, and diabetes, and having higher numbers of Principal Investigators (PIs) from non-medical staffing groups than ever before.

2. Getting it Right First Time (GIRFT)

GIRFT is part of an aligned set of programmes within NHS England designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS and by sharing best practice between Trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

South Tees Hospitals NHS Foundation Trust (STHFT) has established a central support function to facilitate and co-ordinate the GIRFT programme on behalf of the organisation. This is overseen by the Clinical Effectiveness team, with support from operational and clinical colleagues within the clinical collaboratives. In September 2022 we appointed a Senior Benchmarking Analyst who plays a pivotal role in supporting this process and triangulating our data.

During 2022/23 the trust engaged with deep dive visits within Orthopaedic Trauma Surgery and Pathology, with a further re-visit to the Cardiothoracic service. There was positive feedback for each service:

- The local GIRFT report for Pathology noted areas of exemplar practice, in particular with the working relationships between the pathology service and both Trust and primary care colleagues.
- The Orthopaedic Trauma Surgery visit report noted that *'mobilisation on the day after surgery is recorded as being one of the best in the country*'.
- In February 2023, the GIRFT national team published a delivery guide for '*Optimising the Transcatheter Aortic Valve Implantation (TAVI) Pathway*' based on work from James Cook University Hospital. A further GIRFT case study was also published to highlight this exemplary work from the Cardiothoracic team at South Tees Hospitals NHS Foundation Trust.

'James Cook University Hospital (JCUH) has delivered TAVI to patients who are either at high or intermediate risk for open heart surgery with suitable anatomy for the transfemoral approach under guidance of a multidisciplinary heart team since 2009. The JCUH team list four to five cases a day and have progressively optimised the pathway from referral to discharge and follow up, resulting in efficiencies such as shorter hospital stay, lower hospital costs, increased volume of TAVI procedures, better recovery, and improved clinical outcomes for patients.'

The recommendations GIRFT made following these visits have been added to the individual service implementation plans for review and action by the clinical teams. The Clinical Effectiveness team continues to arrange implementation plan review meetings with every service under the GIRFT remit.

In addition to individual service workstreams, the national GIRFT team have launched a High Volume Low Complexity (HVLC) workstream to support the recovery of elective care services post COVID-19 pandemic. This currently focuses on Day Case, Theatre Utilisation, Orthopaedics, Spinal, ENT, General Surgery, Urology, Ophthalmology and Gynaecology. Clinicians and senior leaders at the Trust have engaged with this programme and are working towards the improvements recommended.

In 2023 work began to overhaul and streamline the policy and process for the management of compliance and regulatory visits, inspections, and accreditation to ensure a robust central register for all external visits to the Trust.

3. Quality surveillance and peer reviews

As part of the Quality Assurance and Improvement Framework (QAIF) all specialised services including cancer are subject to the NHS England quality surveillance programme. There are a total of 74 specialised services on the South Tees Hospitals NHS Foundation Trust's directory of services. Historically trusts were required to complete annual self-declarations against a set of clinical quality indicators where information is not available through existing data sources. The declarations were a statement of compliance endorsed by the Chief Executive (or delegated authority) and were submitted through the Quality Surveillance Information System (QSIS) web portal by the submission deadline of 30 June each year. In February 2022 NHS England (NHSE) notified trusts that to reduce the burden on providers, specialised commissioning had made the decision to stop the annual self-declarations.

Some of these services were also required to submit data as part of the Specialised Services Quality Dashboards (SSQD). NHSE advised that the Specialised Services Quality Dashboard (SSQD) submission process would continue and be mandatory from Q1 2022/23. The QSIS web portal would transition to the Data Collection Framework (DCF) from Q3 2022/23, and subsequently would be through the Model Health System.

There have been 27 specialised services requiring submission of data to the Specialised Services Quality Dashboard (SSQD) against a defined set of metrics during 2022/23. Ten of these services require data that is automatically extracted by NHSE from an external source, 13 services require data to be submitted by the service provider and four services require both external and provider data. From Q4 2022/23 there is a new submission requirement for Cancer: Anal (adults) which will require provider data and bring the total of services on the dashboard to 28.

The Trust continues to monitor progress against actions for services that were deemed non-compliant following annual assessments in 2019/20 using a Service Development Improvement Plan (SDIP). The SDIP is now well embedded within the Trusts governance structure with reporting on a quarterly basis. The table below provides a summary of progress against these actions at the end of 2022/23.

Q4 2022/23		Number of actions	Actions completed	Actions mitigated	Actions ongoing
Total number of services	33	60	**24**	24	12
Number of cancer services (including subservices)	17	30	**8**	14	8
Number of specialised services	16	30	**16**	10	4

Table 7: Summary of progress with actions on the Service Development Improvement Plan.

During 2022/23 improvements made against outstanding actions include:

- Recruitment to interventional radiology with four posts filled which ensures the interventional radiology rotas for major trauma and vascular services were fully staffed from October 2022 and quoracy for some cancer MDT meetings is enhanced. The restorative dentist and chemotherapy day unit manager posts have also been filled. The adult critical care service has secured four consultant locums, and emergency department consultants moved to a 24/7 service on site from September 2022.
- Nurse training within the major trauma service is running at 50% of bands 3-7 in the emergency department completing the appropriate level of training. With the training programme gathering momentum it is anticipated that 85% of nurses will have completed by year end.

The regular peer review programme has not been resumed by NHS England (NHSE) but their Specialised Commissioning Quality Team were requested to undertake an external peer review visit of the spinal cord injury service at the Trust and this took place on 17 November 2022. The report was received in December 2022 and showed the service is fully compliant in all areas. Two areas of improvement were noted:

i. *Sustainability of workforce considerations should include resilience of medical workforce, succession planning within the leadership team, review of therapy services staffing and provision, clinical psychology service provision and the potential for expansion of roles (e.g. advanced nurse practitioners/advanced clinical practitioners).*

ii. *Lack of dedicated speech and language therapy (SLT) within the service.*

The service used the report to bid for monies from the transformation fund granted to the Northeast and Yorkshire region to support a reduction in variation within spinal cord services. £330K has been granted and allocated for SLT, psychology, nursing posts, physiotherapy and equipment.

3.4 Patient experience and involvement indicators

South Tees NHS Trust aims to create opportunities for increased engagement and involvement with our patients their relatives and carers, in order to develop responsive and receptive patient centred services, as described in section 2.1 of this report. We have included here some of the other work of the patient experience team.

1. Patient surveys

Friends and Family Test (FFT)

We continue to provide the FFT percentage positive data to NHS England. This is the proportion of responses of 'good' or 'very good' to the question "Overall, how was your experience of our service?" The results for 2022-23 show we score the same as or above the national average in seven out of nine surveys.

FFT	Total No. of Surveys	Average FFT Score (%)	Average National Score (%)
A&E/UTC	7,192	79	76
Inpatient	7,776	97	94
Outpatient	16,017	96	93
Community	3,084	99	94
Antenatal	506	92	90
Birth	276	90	93
Postnatal Inpatient	455	96	92
Postnatal Community	12	96	91
Long COVID	33	83	94

Table 8 - Friends and Family Test scores (% positive responses) reported to NHS England 2022-2023

The results are shared with staff and monitored as part of the STAQC processes. The Patient Experience Steering Group monitors the results and ensures the feedback is used to make improvements where appropriate. It also monitors the number of responses and when appropriate considers how to increase the number of responses to ensure a representative sample in smaller services such as the long COVID clinic.

Local patient surveys

The Trust continuously collects feedback from patients and carers utilising local surveys, including for adult inpatients, maternity (at the four touch points of antenatal, birth, postnatal ward and postnatal community), outpatients, community, children and young people and emergency care settings. All wards and departments access feedback for their area to analyse. The feedback is shared with the staff highlighting good practice and identifying areas where improvements can be made by the teams.

National Surveys

The 2022 results are expected to be published in August 2023. The latest published inpatient survey results are therefore from 2021 and are summarised below,

In comparison with other trusts, we scored better than expected on 1 question and somewhat better than expected on 3 questions, with a statistically significant increase on one question and a statistically significant decrease on five questions. 1250 patients were asked to take part and 471 responded, a response rate of 41%. Further detail of the results are provided in the table below.

We share the results with staff, thanking them for their contribution to providing a positive experience of inpatient care. Areas of weakness are reviewed, and actions developed to address any areas for improvement are monitored through the quality governance structure.

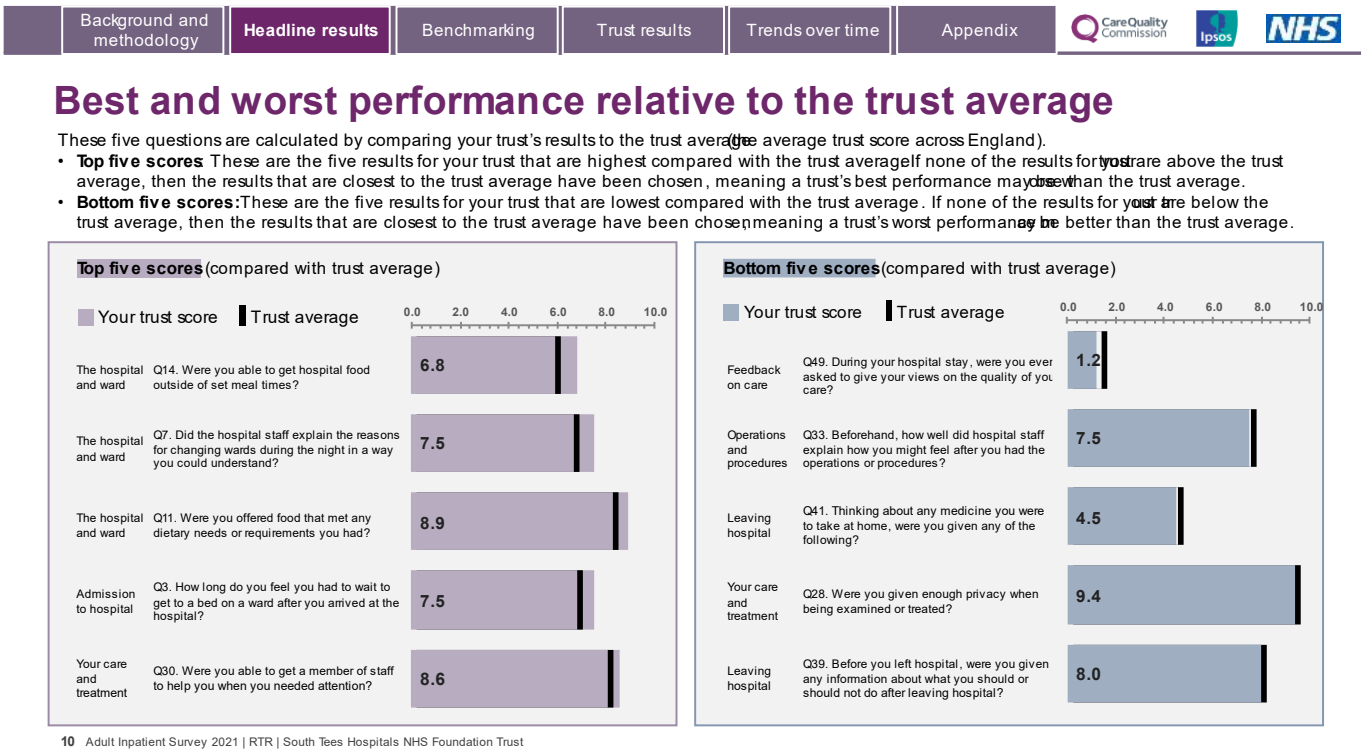


Figure 23: 2021 National Inpatient Survey results of our best and worst performance

National maternity survey

The national maternity survey was undertaken during February 2022 and the results were published by the CQC in January 2023. At the STHFT 321 women were included and 129 responded, giving a response rate of 40.31%. There were 59 questions and comparison is made against 120 NHS trusts. As noted previously in this report, the Trust scored:

- 'Much better than most trusts' in one question
- 'Better than most trusts' in six questions
- 'Somewhat better than most trusts' in seven questions
- 'About the same as other trusts' in 37 questions

None of the questions scored worse than other trusts. The STHFT scored in the top 20% of trusts on 33 questions and in the bottom 20% on one question.

A detailed review of the report and the comments received was undertaken. An action plan was developed to resolve issues with telephones not being answered when arranging a scan, and the birth reflections pathway regarding decisions about where to have a baby was reviewed. An induction working group has been set up to review feedback about inductions and involvement in decision making.

2. Patient information and the Accessible Information Standards

The Patient Information Policy was updated during 2022/23 in line with the current Accessible Information Standards (2016) and was approved in October 2022. All patient information is now placed on the Trust internet site and is easily accessible by patients and staff. To avoid patients being digitally excluded the information is downloadable for printing in the appropriate font size to meet the patient, carer or parents' requirements. The patient information provides two types of contact methods - telephone numbers and email address for patients who, for example, may not be able to use the telephone due to a health condition.

A report was provided to the Patient Experience Steering Group in March 2023 on the current position of patient information leaflets. A bank of patients and carers are in the process of being recruited to review all patient information, written and digital. The trust continues to promote the use of posters with QR codes, to download patient information, to reduce the amount of paper used and cost to the trust.

A workshop was held in October 2022 to review the Trusts position with regards to the Accessible Information Standards (AIS). Four objectives were identified, a baseline audit of current position, the scope was agreed with support from the clinical audit team. Mapping of processes to be held with internal and external stakeholders, providing training for staff to raise awareness and developing a policy and standard operating procedures, to ensure data capture and recording on trust systems and sharing with other sectors of health and social care.

3. Complaints, PALS and compliments

The Trust has a clear process for dealing with complaints, to ensure patients, carers and relatives feel able to raise their concerns without this adversely affecting their care. The process is detailed on ward and departmental noticeboards and can be found on the Trust website and in the patient experience leaflet. All correspondence issued by the Trust informs patients how to provide positive and negative feedback on the service they have received.

In 2022/23 there were 304 formal complaints received by South Tees Hospital NHS Foundation Trust (STHFT) a decrease of 10% on the previous year. The average number of formal complaints received each month is 25.

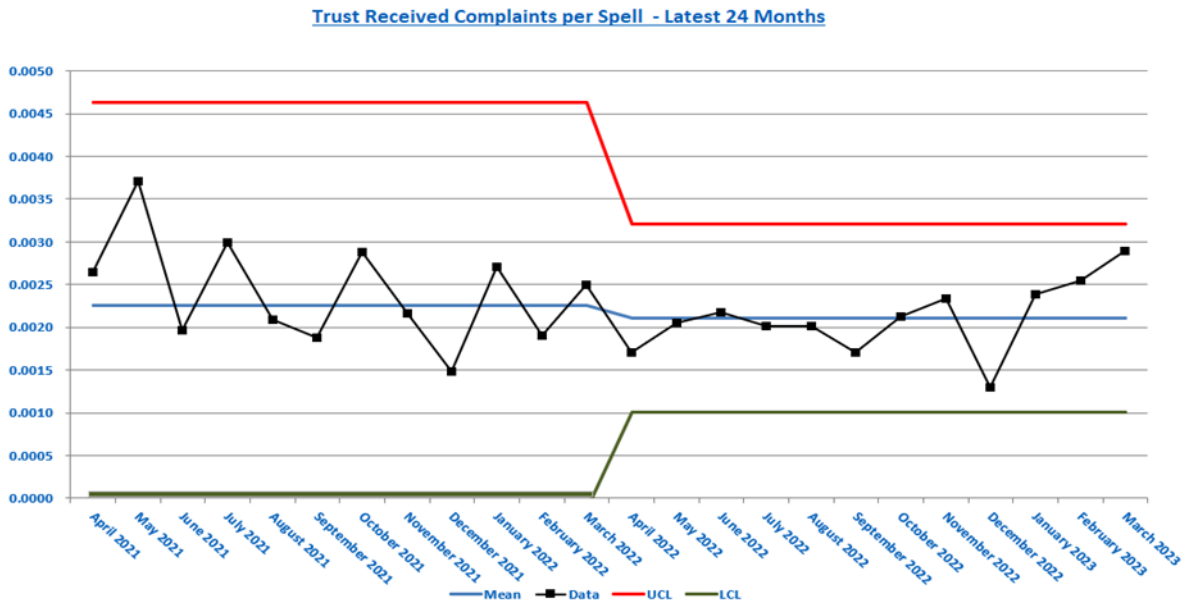


Figure 24: Trust received complaints per spell April 2021 – March 2023

Patient Advice and Liaison Service (PALS) concerns are forwarded to the appropriate clinician to respond to the complainant within the agreed 10 working day timeframe. The Trust has seen a downward trend in concerns being logged which is likely to be due to concerns being dealt with by the ward or department at source.

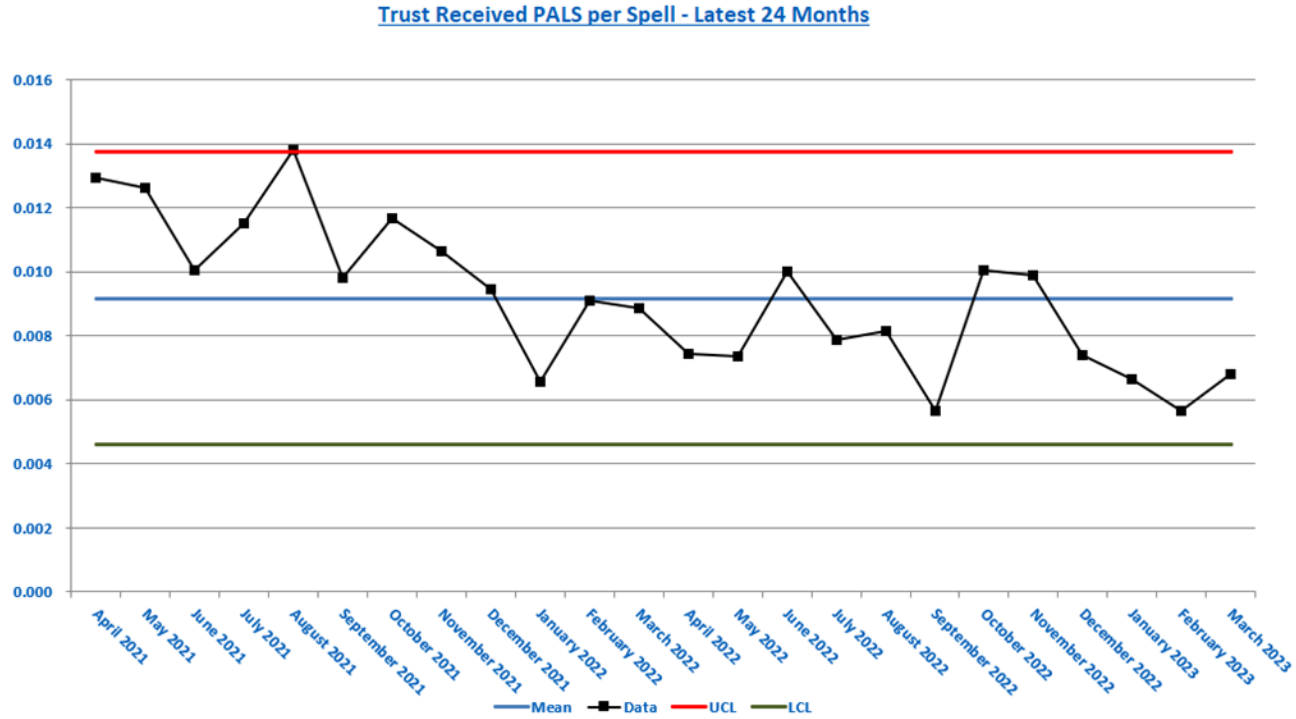


Figure 25: Trust received PALS per spell April 2021 – March 2023

The top three themes from complaints and PALS are;

- All aspects of clinical treatment.
- Communication and information given to patients.
- Delays and cancellations relating to outpatient appointments.

We aim to upload all compliments received by the Patient Experience Team to Datix and these are also shared with the wards and departments.

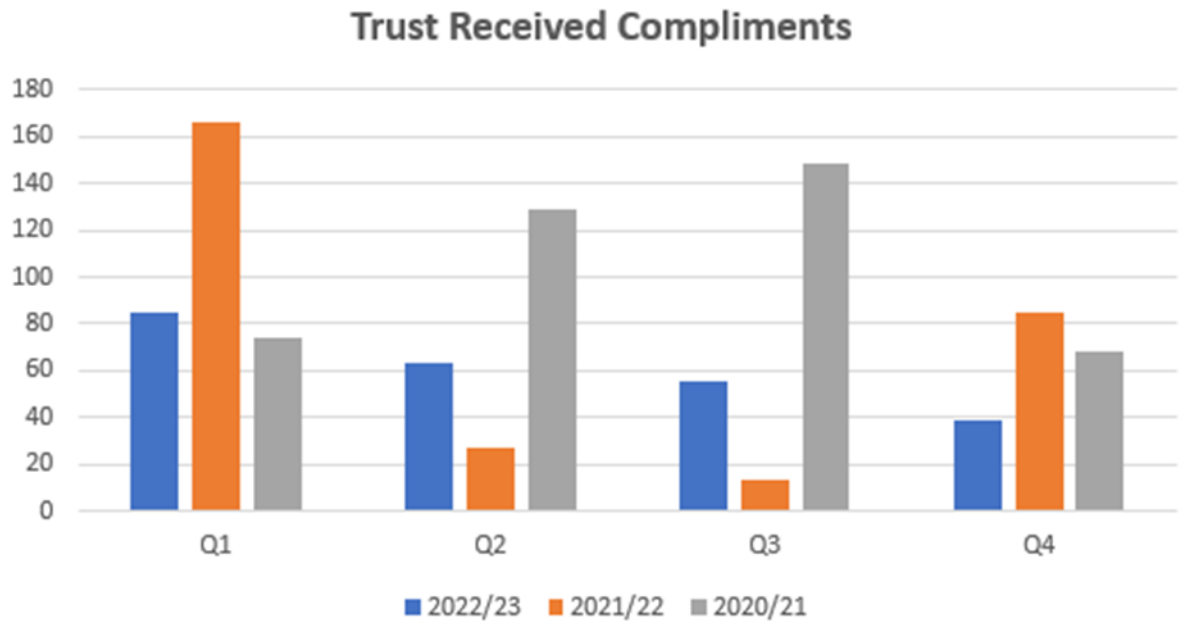


Figure 26: Trust received compliments logged on Datix 2020/21 – 2022/23

It should be noted that many compliments are received locally by the wards and departments, and although there is the facility for local areas to log their compliments on Datix, this is not a priority during times of staffing pressures. The data presented above will therefore under-represent compliments received.

Further work will be undertaken in 2022/23 to analyse the compliments received by the Trust. Themes are being added to Datix to enable further analysis of compliments to understand the patient's perception of good care and treatment.

3.5 Performance against key national priorities

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	22/23 targets
Safety									
Clostridioides (C) *difficile* – meeting the C. *difficile* objective	61	43	48	41	89	79	138	140	N/a
All cancer – 62 day wait for first treatment from									
Urgent GP referral for suspected cancer	79.10%	81.10%	85.44%	82.65%	77.23%	75.52%	73.83%	59.88%	85%
NHS Cancer screening service referral	89.80%	89.00%	94.55%	87.14%	94.41%	62.77%	50.00%	68.71%	90%
18 weeks referral to treatment time (RTT)									
Incomplete pathways	93.20%	92.20%	91.45%	89.49%	83.33%	63.20%	65.37%	65.61%	92%
Accident & Emergency									
4 hour maximum wait in A&E from arrival to admission, transfer or discharge	95.80%	95.33%	95.68%	95.24%	88.35%	87.25%	75.52%	68.22%	95%
Diagnostic Waits									
Patients waiting 6 weeks or less for a diagnostic test	98.82%	99.15%	97.46%	98.26%	94.04%	72.57%	68.71%	77.57%	99%

Table 9: Performance against National Priorities

Key findings:

- C. *difficile.* The Trust recorded 140 cases of C. *difficile* during 2022/23. Further narrative can be found in part 2 of this quality account.
- Urgent GP referral for suspected cancer (62-day cancer wait target for first definitive treatment). Our year end performance was 59.88%. Recovery plans are in place to support improvement in the patient pathway and performance.
- 4-hour Accident and Emergency waiting time target. Year-end performance was 68.22%. Factors affecting the performance include an increase in acuity of patients, very high intensity users attending A&E and continued challenges in social care impacting the timeliness of patient discharge. Capacity within the hospital during the winter period has affected patient flow. Recovery plans are in place to address such issues.
- Referral to Treatment (RTT) 18-week target. Our year-end performance was 65.61%. Recovery plans and trajectories are in place to address areas of concern.
- Diagnostic Waits – (waiting 6 weeks or less). Our year-end performance was 77.57%. Recovery plans and trajectories are in place.
- As of the end of the 2022-23 financial year, the Trust has no patients who had waited more than 104 weeks from referral to treatment.

3.6 Additional required information

1. Seven-day services

Ten NHS Seven Day Hospital Services Clinical Standards were developed in 2013 to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges. The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week. Full details of all the clinical standards are available at: NHS England Seven-day-services clinical standards.

Trust Boards should assess, at least once a year, whether their acute services are meeting the four priority seven-day services clinical standards, using an updated board assurance framework (BAF) and guidance published in February 2022.

After the challenges of the COVID-19 response, the BAF for Seven Day Services re-focuses attention on the four key standards. An assessment against these standards was completed at South Tees in September 2022. The Trust is not comprehensively compliant with Standard 2 for 'consultant review for all new admissions within 14 hours' in every specialty throughout the week. This is due to more limited consultant presence on-site at weekends in specialities with smaller numbers of emergency admissions. The Trust is assured of timely senior clinical assessment for patients admitted as an emergency in all the higher volume specialties and when the patient is unwell or deteriorating. The Trust is also assured that arrangements are in place for daily senior review, and that there is safe access to diagnostic and consultant-led interventional services over the seven-day period, demonstrating compliance with these standards. Prompts for maintaining or improving compliance have been shared with Clinical Directors, and the self-assessment will be repeated annually.

2. Freedom to speak up

The goal of Freedom to Speak Up (FTSU) is to continue to change and improve the culture across the NHS. At South Tees, senior leaders, the Board and Chief Executive have been proactive in ensuring our service was strengthened and that the FTSU Guardians had access to senior leaders when needed. Over the last twelve months the model has seen continued improvements in the way it is implemented. There has been increased visibility, awareness, and accessibility to the FTSU Guardians for the 9,500 + colleagues within the Trust. This increased profile has helped the Trust to resolve concerns raised in a timely manner and seen positive outcomes recorded for the majority of concerns raised.

A wide range of data is collected by the FTSU Guardians and concerns raised are analysed for common themes. Information collected and collated in the last twelve months reflects the positive impact the model for speaking up has had for staff and patients between April 2022 and March 2023. A total of 101 issues were raised with the Guardians over this period, compared to 107 reported during 2021-2022 representing a small decrease of 8%.

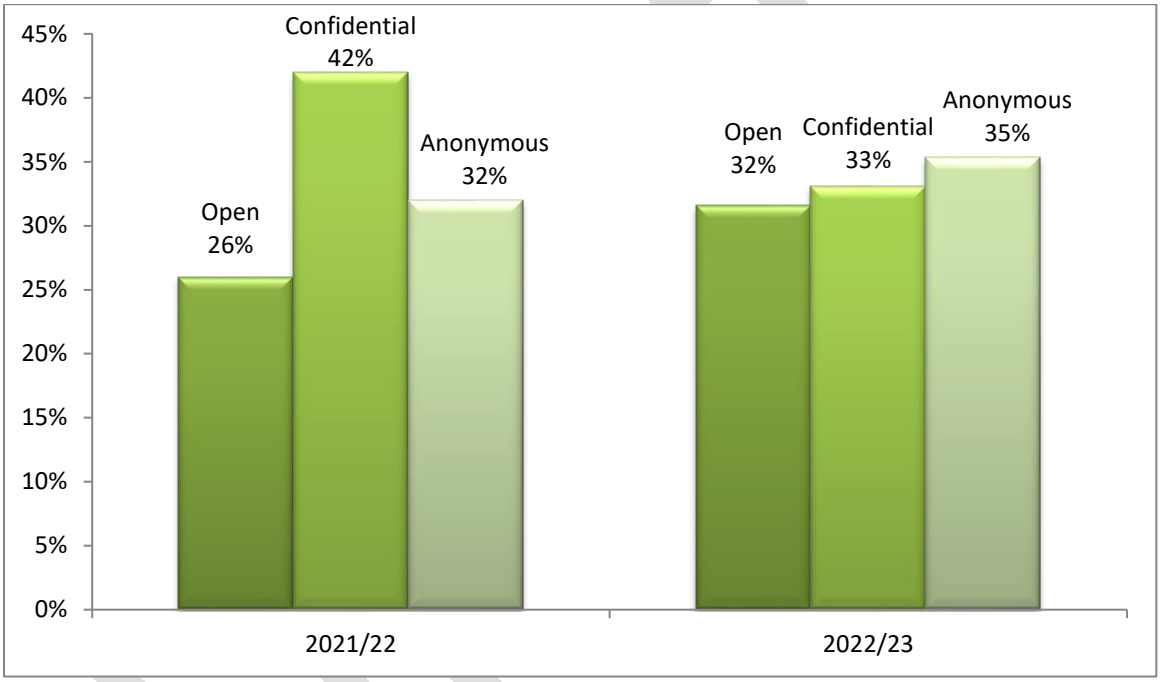


Figure 27: Number of issues raised with FTSU Guardians 2021/22 and 2022/23

The freedom to speak up questions in the NHS staff survey 2022 remain above the national average.

Staff Survey Question		2020/21 results	2021/22 results	2022/23 results	Comparison to 2022/23 national benchmarking
Q19a	I would feel secure raising concerns about unsafe clinical practice.	72.2%	76.9%	74.2%	70.8% (3.4%) ↑
Q19b	I am confident that my organisation would address my concern	58.7%	60.7%	58.3%	55.7% (2.6%) ↑

Q23e	I feel safe to speak up about anything that concerns me in this organisation	63.8%	64.7%	63.1%	60.3% (2.8%)
Q4	If I speak up about something that concerns me, I am confident that my organisation would address my concern	N/A	49.6%	48.1%	47.2% (0.9%)

Figure 28: Results of FTSU related questions in the National Staff Survey 2022

The Freedom to Speak up ethos and message has been embedded successfully across the Trust in all induction and preceptorship programmes. Links with the clinical educators for healthcare assistants (HCAs) and nurses trained overseas are now stronger. The FTSU Guardian team has also forged excellent links with the University of Teesside and we are regularly delivering sessions to student midwives, nurses and allied health professionals (AHPs).

The FTSU Guardian team also continues to reach out to other local organisations and has forged closer working links with our Military Freedom to Speak up colleagues and FTSU Guardians based at North Tees and Hartlepool, Tees Esk and Wear Valley, and County Durham NHS Trusts. There have been joint military South Tees awareness raising days and joint North Tees and South Tees staff inductions sessions at the University of Teesside.

Our network of Freedom to Speak up Champions from across the organisation continues to grow. Our champions range from administrative and clerical staff to consultant and military colleagues. Currently we have 21 confirmed Freedom to Speak Up Champions. The last champions training session was held in September 2022 with the lead FTSU Guardian and ten champions attending.

<u>How staff can speak up</u>

There are a number of ways that South Tees staff can speak up about issues that concern them around areas such as patient safety, staff safety, bullying and harassment, and leadership and communication issues. Whilst the FTSU team is a vital element within this model it is only one of a number of ways that staff can speak up. Detailed in the diagram below are the other ways in which staff who have a concern can speak up if the FTSU team is not their preferred route.

Figure 29: Ways in which staff can speak up about a concern

Staff can speak up either anonymously, confidentially, or openly to anyone in the above diagram. They can also speak up as an individual or as part of a larger group if they wish.

Following the closure of a concern, staff are given feedback from the investigator in relation to the concerns raised as long as this does not breach confidentiality rules. Feedback is given to the concern raisers and any other people or groups affected by the issues raised.

Nationally, one of the main barriers to staff speaking up about concerns they may have in relation to patient safety, staff safety and other issues that can be brought to the FTSU Guardian team is that of detrimental treatment. The latest version of the Trust's Freedom to Speak Up – Raising Concerns Policy now has a section around detriment that describes what detriment is or might look like and details what action will be taken in the event of detrimental treatment arising.

<u>Feedback from staff</u>
Guardians continue to receive feedback either by email or face-to-face depending on the preference of the concern raiser, provided they have passed on their details and not reported their concerns anonymously. Feedback is important to ensure the 'loop is closed' and staff are reassured their concerns are taken seriously and investigated.

A section on the report template provided to investigators requires detail about how feedback was assimilated and used to improve services. Staff are also encouraged to report any detriment to the FTSU Guardians, and this is monitored and reported back to the National Guardians Office.
Feedback received in this reporting period has been overwhelmingly positive. When asked if they would feel happy to speak up about concerns in future, the majority of respondents replied that they would, with just one responding that they would not. When respondents were asked about their experience of raising a concern with the FTSU Guardians, they provided the following responses:

"Very good service listened well and was a good point of contact"
"Guardian Lead was great, listened to my concern"
"Felt comfortable and able to discuss all issues knowing I could proceed at a pace that I felt comfortable with"

3. Rota gaps for doctors and Dentists in training

Schedule 6, paragraph 11a of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires: "*The Board must receive a Guardian of Safe Working Report no less than once per quarter. This report shall also be provided to the Joint Local Negotiating Committee (JLNC), or equivalent. It will include data on all rota gaps on all shifts"*[1]. South Tees is committed to this request; our Guardian of Safe Working (GOSW) along with our medical workforce team provide routine reports to the Trust Board and JLNC.

In addition to this our GOSW meets regularly with the Chief Medical Officer (CMO) and members of his office to ensure we are all working towards addressing issues highlighted to the GOSW through exception reports or other avenues of escalation.

In particular, the CMO office and GOSW are working together, with surgical colleagues, to improve the working life experience of our junior doctors in surgical specialities.

Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires: "A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps (which) shall be included in a statement in the Trust's Quality Account." As a Trust we have faced some difficulties regarding accurate and contemporaneous data regarding our junior doctor establishment and therefore the provision of accurate reports on gaps. We have recently procured a new rostering system which is designed for medical rotas, and we will be seeking to ensure that this rostering system is aligned to our Electronic Staff Record and finance ledger, resulting in accurate information across our systems and more dependable data.

The Trust aspires to triangulate data regarding rota gaps in each collaborative with information on quality and safety incidents as well as the number of exception reports raised in each area, giving us rich data about our clinical productivity as well as the safety of our staff and patients.
Our GOSW has led on work to analyse what 'safe medical rotas' look like in daytime hours and this work is continuing regarding assessing our safe staffing levels out of hours. This planning information will be incorporated into the new rostering system, so we have clarity on where we are, and are not, meeting safe staffing levels on medical rotas.

Over the last year we have implemented new policies regarding the management of gaps on junior rotas to ensure there is a consistent approach throughout the Trust, and adherence to these policies will continue throughout the next year. We continue to fill the majority of gaps on our rotas through realignment of staff (including our non-medical staff who contribute to medical rotas), locums through our regional locum bank (FlexiShift) hosted by the North-East Lead Employer Trust (LET), or our locally employed doctors.

[1] NHS-Doctors-and-Dentists-in-Training-England-TCS-2016-VERSION-11.pdf (nhsemployers.org)

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Annex 2: Statement of directors responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from commissioners dated XX/XX/20XX
    - feedback from governors dated XX/XX/20XX
    - feedback from local Healthwatch organisations dated XX/XX/20XX
    - feedback from overview and scrutiny committee dated XX/XX/20XX
    - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5 May 2023
    - the [latest] national patient survey October 2022
    - the [latest] national staff survey 9 March 2023
    - the Head of Internal Audit's annual opinion of the trust's control environment 23rd May 2023
    - CQC inspection report dated 24/05/2023
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- [this point is only required where the foundation trust is not reporting performance against an indicator that otherwise would have been subject to assurance] as the trust is currently not reporting performance against the indicator [xxx] due to [xxx], the directors have a plan in place to remedy this and return to full reporting by [xxx]
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

.....Date.....Chairman

.....Date.....Chief Executive

Annex 3: Glossary of terms

18 Week RTT (Referral to Treatment)
This refers to the right to start your consultant-led treatment within a maximum of 18 weeks from referral, unless you choose to wait longer, or it is clinically appropriate that you wait longer. The Trust monitors this monthly.

A&E
Accident and Emergency (usually refers to a hospital casualty department) where patients attend for assessment

Acute
A condition of short duration that starts quickly and has severe symptoms.

Allied Health Professional (AHP)
Professionals (other than nurses) who work in health care teams to make the health care system function by providing a range of diagnostic, technical, therapeutic and direct patient care and support services that are critical to the other health professionals they work with and the patients they serve.

Assurance
Confidence, based on sufficient evidence that internal controls are in place, operating effectively and objectives are being achieved.

BadgerNet
BadgerNet's Maternity Notes is an online portal

Black, Asian and minority ethnic (BAME)
All ethnic groups except white ethnic groups; it does not relate to country origin or affiliation.

Board of Directors (of Trust)
The role of the Trusts board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and accountable to the Council of Governors. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.

Care Quality Commission (CQC)
The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk

Clinical audit
Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

CUR (Clinical Utilisation Review)
The CUR is a clinical decision support tool that enables clinicians to make impartial and objective, evidence-based assessments of whether patients are receiving the right care, at the right place, at the right time and for the right duration. It improves patient flow across the health economy.

Clinician
Professionally qualified staff providing clinical care to patients.

Commissioners
Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Clinical Commissioning Groups are the key organisations responsible for commissioning healthcare services for their area. They commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population's health.

Commissioning for Quality and Innovation (CQUIN)
'High Quality Care for All' document included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Consultant
Senior physician or surgeon advising on the treatment of a patient.

Council of Governors
The Governors help to ensure that the Trust delivers services which meet the needs of patients, carers, staff and local stakeholders.

Datix
IT system that records healthcare risk management, incidents and complaints.

Day case
Patient who is admitted to hospital for an elective procedure and discharged without an overnight stay.

Duty of Candour
The duty of candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England.

Elective
A planned episode of care, usually involving a day case or in patient procedure.

Electronic Patient Record
Digital based notes record system which replaces a paper-based recording system. This allows easier storage, retrieval and modifications to patient records.

Electronic Prescribing and Medicines Administration (EPMA)
Allows prescriptions to be transmitted and populated electronically, replacing paper and faxed prescriptions.

Emergency
An urgent unplanned episode of care.

Fall
A fall is defined as an unintentional/unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

Foundation Trust
A type of NHS Trust in England that has been created to devolve decision-making from central government control to local organisations and communities, so they are more responsive to the needs and wishes of their local people. NHS foundation Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay.
NHS Foundation Trusts have members drawn from patients, the public and staff, and are governed by a Board of Governors comprising people elected from and by the membership base.

Governance
A mechanism to provide accountability for the ways an organisation manages itself.

Health care associated infections (HCAI)
These are infections that are acquired because of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

Healthwatch
Healthwatch are the national consumer champion in health and care. They have been given significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

HSMR (Hospital Standardised Mortality Ratio)

This is a scoring system that works by taking a hospital's crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc. It is possible to calculate two scores – the mortality rate that would be expected for any given hospital and its actual observed rate.

Inpatient
Patient requiring an overnight stay in hospital.

InPhase
A suite of Oversight Apps to achieve swift, triangulated, compliance, assurance and monitor continuous improvement in the NHS

Integrated Care Board (ICB)
This is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

Interventional Radiology (IR)

Interventional Radiology" (IR) refers to a range of techniques which rely on the use radiological image guidance (X-ray fluoroscopy, ultrasound, computed tomography [CT] or magnetic resonance imaging [MRI]) to precisely target therapy. Most IR treatments are minimally invasive

alternatives to open and laparoscopic (keyhole) surgery. As many IR procedures start with passing a needle through the skin to the target it is sometimes called pinhole surgery.

LocSSIP (Local Safety Standards for Invasive Procedures)
These are local processes/procedures in place to reduce the number of patient safety incidents related to invasive procedures, in which surgical 'Never Events' can occur.

Malnutrition Universal Screening Tool (MUST)
'MUST' is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is used in hospitals, community and other care settings and can be used by all care workers.

Medical Examiners
Review the death at time of death certification or referral to Coroners. Their work includes contact with the team that cared for the patient at time of death, review of case records and contact with the family to see if they have any questions or concerns.

Multidisciplinary Team (MDT)
A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g., doctors, nurses, physiotherapists etc.), each providing specific services to the patient.

National Institute for Health Research (NIHR)
The NIHR (National Institute for Health Research) funds health and care research and translate discoveries into practical products, treatments, devices and procedures, involving patients and the public in all our work. NIHR ensure the NHS can support the research of other funders to encourage broader investment in, and economic growth from, health research. NIHR work with charities and the life sciences industry to help patients gain earlier access to breakthrough treatments, and train and develop researchers to keep the nation at the forefront of international research.

National Institute for Health and Clinical Excellence (NICE)
The National Institute for Health and Clinical Excellence is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: www.nice.org.uk

NCEPOD
National Confidential Enquiry into Patient Outcome and Death. The website for more information is http://www.ncepod.org.uk/

National Patient Survey Programme
The National Patient Survey Programme, coordinated by the Care Quality Commission, gathers feedback from patients on different aspects of their experience of recently received care, across a variety of services/settings.

NHS England (NHSE)
NHS England NHS England leads the National Health Service (NHS) in England

NEQOS (North-East Quality Observatory Service)
Provides quality measurement for NHS organisations in the North-East (and beyond), using high quality expert intelligence to secure continually improving outcomes for patients.

Overview and Scrutiny Committees
Since January 2003, every local authority with responsibilities for social services (150 in all) has had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS – not just major changes but the on-going operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

PALS (Patient Advice and Liaison Service)
A service that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient Reported Outcome Measures (PROMs)
PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

Payment by Results
A system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated.

Pressure Ulcer
A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful.

Providers
Providers are the organisations that provide relevant health services, for example NHS Trusts and their private or voluntary sector equivalents.

PSIRF (Patient Safety Incident Response Framework)
Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Purpose T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool)
Is a pressure ulcer risk assessment framework (PURAF) intended to identify adults at risk of pressure ulcer development and makes a distinction between primary prevention (applicable to those at risk of pressure ulcer development) and secondary prevention (applicable to those who already have a pressure ulcer). It has been developed for use in adult populations in hospital and community settings by qualified nursing staff.

Regulations
Regulations are a type of secondary legislation made by an executive authority under powers given to them by primary legislation in order to implement and administer the requirements of that primary legislation.

Research
Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

Risk
The possibility of suffering some form of loss or damage or the possibility that objectives will not be achieved.

Risk Assessment
The identification and analysis of relevant risks to the achievement of objectives.

RCA (Root Cause Analysis)
A systematic process for identifying "root causes" of problems or events including serious incidents to prevent a recurrence.

Service user
An individual who uses a health care service, including those who are not in need of treatment, such as blood donors, carers or those using screening services.

Spell
A continuous period of time spent as a patient within a trust, and may include more than one episode.

SSKIN (Surface, Skin inspection, Keep moving, Incontinence and Nutrition)
A 5 step model for pressure ulcer prevention.

STAQC (South Tees Accreditation for Quality of Care)
STAQC is a ward / department accreditation programme which brings together key measures of nursing and clinical care into one overarching framework.

STRIVE (South Tees Research, innovation and education)
Is the academic centre at South Tees for research, innovation and education. The centre also includes library services.

Summary Hospital-level Mortality Index (SHMI)
The Summary Hospital-level Indicator (SHMI) reports mortality at Trust level across the NHS in England using standard and transparent methodology. It looks at deaths following hospital treatment which take place in or out of hospital for 30 days following discharge and is based on all conditions.

South Tees Hospitals NHS Foundation Trust
Includes The Friarage Hospital (FHN) and James Cook University Hospital (JCUH) and community services in Hambleton, Richmondshire, Middlesbrough, Redcar and Cleveland.

TEWV

Tees, Esk and Wear Valleys NHS Trust, supporting Mental Health and Learning Disabilities for County Durham and Darlington, Teesside, North Yorkshire, York and Selby.

South Tees Hospitals NHS Foundation Trust

Meeting: Quality Assurance Committee	**Date of Meeting**: 26th April 2023
Connecting to: Board	**Chair**: Ada Burns

Key topics discussed in the meeting	
The approach to complaints, factors impacting on response times, escalation arrangements and new developments in approach and strategy. Safeguarding children and adults quarter four report Board Assurance Framework Infection Prevention Control quarterly report Progress on implementation of the STAQC process of assurance Health and Safety quarter four report	
Actions	**Responsibility / timescale**
BAF and cyber security: noted and in the absence of dates for training within the BAF took assurance that audit are nearing completion of a review of cyber security and disaster recovery	
From the IPR schedule a discussion at Board development on the performance and factors around 12 hour breaches and 12 delays from decision to admit	Jackie White April/May 2023
Health and Safety - the Executive to progress implementation of the outstanding decision to add Display Screen Equipment risk assessments to mandatory training for designated role.	Jackie White, Phil Sturdy May 2023

Escalated items
Commended the teams for the excellent work on implementation of the STAQC process and agreed to lift the assurance level on the process and approach to Significant. Noted the development work to change and align the processes and approach to resolution of complaints to the work on a Restorative and Just Culture, as a more empathetic way of engaging with patients/families and achieving better resolution. Commended the engagement from the IPC teams in national work examining strategies to address the risks of CDifficile infections, and noted that evidence suggests that a significant proportion 37% are not hospital apportioned

Risks (Include ID if currently on risk register)	Responsibility / timescale

South Tees Hospitals NHS Foundation Trust

April Resources Committee Chair's Log

Meeting: Resources Committee	**Date of Meeting**: 27/04/2023
Connecting to: Main Board	

Key topics discussed in the meeting

Final Financial position for 22/23

The Trust's draft Month 12 reported position is a deficit of £22.2m at a system control-total level. This is £1.5m behind plan. The variance relates to the estimated additional cost of the unconsolidated pay award, linked to the indexation requirements of the PFI contract, compared to the additional pay award funding that the Trust has been notified it will receive. The ICB in aggregate is expected to deliver an underspend.

NHS England Financial review

The outcome report from the NHSE national review found no financial governance concerns and noted the Trust's structural and underlying financial position, and the significant discussions held to date with the region regarding the Trust's comprehensive medium term financial planning in 21/22 and 22/23. The report notes the fair shares funding issue apparent within the Tees Valley, and the opportunities for efficiencies from wider system working.

23/24 Final Submission

Final submission has the Trust at £31.8m deficit, improvement from £49.7m

Important to note that the CIP £39.4m (4.8% of turnover / 4.5% OpEx) is a big ask and will be challenging for the organisation

Procurement update

Last years procurement savings were £500k above target at 2.2m, 2023/24 has a target of £1.35m with 53 projects identified to deliver this. The procurement strategy was presented in draft for feedback from the committee, this was given and the strategy will be update accordingly and brought back for approval

Green Plan

The trusts green plan was presented and although it was noted that the plan met the NHS England guidelines it was agreed that it was not ambitious for focused enough. The newly appointed Director of estates has a keen interest and expertise in this area and will update the plan accordingly and bring back for review and approval in September

Actions			Responsibility / timescale	
27/4/2023	RC23/007	IPR – paper on 12 hour breaches.	Mr Peate	May 2023

27/4/2023	RC23/010	Digital Update – a clear scope of what is will be completed by December 2023.	Mr Imiavan	May 2023
27/4/2023	RC23/010	Digital Update – a document detailing the benefits realization.	Mr Imiavan	June 2023
27/4/2023	RC23/013	Green Plan – updated green plan and decarbonisation strategy.	Mr Sturdy	October 2023

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Escalated items

Key Issues/ Concerns for escalation:

- Nothing escalated from this months meeting
  Important to note the
- Significant effort from the finance team to get responses in to regional and national team

Risks (Include ID if currently on risk register)	Responsibility / timescale
No Additional Risk Identified	

People Committee
Chair's Log

Meeting: People Committee	**Date of Meeting**: 26.04.2023
Highlights for: Board of Directors	**Chair:** Mark Dias

Overview of key areas of work and matters for Board.

- Board Assurance Framework
- People Strategy
  - EDI Update
  - Employee Relations
  - Gender Pay Gap
- Organisation Capacity
  - Volunteers to Employment

Actions to be taken	Responsibility / timescale
Board Assurance Framework BAF reviewed the effectiveness report and performance on the people committee.	
EDI Update Report presented on 'Embedding Equalities, Diversity & Inclusion' and cultural change. Talent pipeline (incl. reciprocal mentoring) and staff networks/groups/	With staff groups. develop metrics to measure effectiveness and engagement. (DCH)
Employee Relations Review of employee relations case management and trends. Positive indication of restorative justice strategy	Measure and report timing of disciplinary and grievance cases
Gender Pay Gap Report and data reviewed. Report approved.	Preparation for Race Pay Gap reporting
Organisation Capacity - Volunteers to Employment Committee met 3 members of staff who career transitioned from volunteer into employment. The volunteers not only play a vital role within hospital life (e.g. patient care) but represent a substantial talent pool. A direct link in positive impacting community health inequality by providing opportunities for volunteer work experience that could lead to paid employment.	

Absence Management (ongoing) Absence remains above plan and trust is carrying and substantial direct (and indirect) cost. HRD is leading on actions to support employees. Four assurance areas identified in deep dive: 1. Capability of line managers in absence management 2. Quality audit of absence processes, e.g. timing and quality of line manager & employee engagements. 3. SMART targets to be finalised by collaborative. 4. Financial impact assessment by collaborative The committee reinforced the need to support employees and for decisions to be mindful of the ST values and just culture.	Head of HR to continue leading process assessment, improvements and leader/user education.
O Board action	Responsibility / timescale
There were no matters for escalation to the board.	
Risks (Include ID if currently on risk register)	Responsibility / timescale
Three ongoing risks identified: *Impact of higher than planned absence on planned services *Industrial action *Payroll errors (and negative impact on employees)	

South Tees Hospitals NHS Foundation Trust

Meeting: Audit & Risk Committee	**Date of Meeting**: 18 April 2023
	Chair: Ken Readshaw
Key topics discussed in the meeting	
Progress on historic outstanding actions in relation to Internal audit – Training video on TrAction has been rolled out so progress can be accelerated External benchmarking shows internal audit days are very low for the size of the organisation. Waiting List audit – Moderate Risk Quality assurance and clinical governance – Low risk Progress on year end audit and Audit Strategy Memorandum discussed External audit– no issues to escalate at this stage Review of committee effectiveness – Assurance from other committee chairs and attendance by executives from areas with weak internal audit reports are areas for development. Freedom to speak up report – Significant assurance. HFMA checklist update – Benchmarking shows we are 'in the pack' or better in most areas. For areas where improvement was needed, all actions have been completed. Risk Appetite review – Process agreed for board consideration. Risk management Improvement plan reviewed – a significant piece of work with a focus on training initially	
Actions	Responsibility / timescale
Update TOR and include deep dive into committee risk management processes	JW May 2023
Escalated items	
None at this stage	
Risks	Responsibility / timescale

South Tees Hospitals NHS Foundation Trust

Meeting: Audit & Risk Committee	**Date of Meeting**: 24 May 2023
	Chair: Ken Readshaw

Key topics discussed in the meeting	
Counter fraud progress report reviewed. Internal Audit - Progress on historic outstanding actions – Progress continues on clearing old actions. Individual overdue actions to be presented from September onwards. Draft 23/4 Internal Audit plan agreed. 210 days including Medication Review deferred from 22/3. Data Quality audit – Moderate Risk External Audit - Progress on year end audit discussed – no issues to escalate at this stage. Clinical Audit - Annual plan reviewed. New InPhase system to document clinical audits will give better assurance and triangulation. This will be reviewed twice a year going forward. Draft Annual Report and Annual Governance Statement reviewed. Draft financial statements reviewed. Significant changes to balance sheet as a result of new standard for accounting for leases (IFRS 16). No effect on income. Provider licence annual self certification reviewed.	

Actions	Responsibility / timescale

Escalated items
The Board should take assurance that the annual filings – annual report, annual governance statement and annual accounts have been reviewed and are on track. Provider licence is recommended for approval

Risks	Responsibility / timescale

South Tees Hospitals NHS Foundation Trust

Meeting: **Quality Assurance Committee**	**Date of Meeting**: 31/05/2023
Connecting to: **Board of Directors**	
Key topics discussed in the meeting	

The Board Assurance report was discussed 2 reports provided "Significant" assurance:

1) The Research and Development 6 Monthly report and
2) The Patient Led Assessment of the Care Environment (PLACE) report.

QAC commended all staff on the outcome of the recent QQC inspection, this has been published since the April QAC meeting. It is a particularly affirming achievement when set in a national context. QAC members acknowledged it reflected an enormous amount of work by ALL staff and while further progress is required, QAC members wished to emphasise the importance of taking time and appreciating the outcome .

QAC congratulated the staff team of the Trust's Research and Development department and the wider Tees Valley Research Alliance (TVRA) on the continued success in research, innovation and academic growth. The 6 monthly report provided a detailed update on activity, performance and the Innovation strategic priorities. The recent CQC report graded 3 areas of R and D as "Good", reflecting successful efforts to strengthen the Trust's research capacity.

Integrated Quality and Improvement Report: QAC members discussed several aspects of the IPR, it is recognised there are a number of " cross-cutting" themes that are considered at a number of Board sub-committees, consideration is being given to making this more explicit , preventing duplication and ensuring these core themes are appropriately addressed. QAC was briefed on the plans underway to implement a new approach to resolving complaints, including a rapid review in June 2023. Falls was discussed and QAC briefed that as part of increased focus on the issue a specific Quality Improvement Project, linked to the PSIRF , has commenced.

The focus on patient safety continued with the Patient Safety Incident Management report, providing moderate assurance. QAC congratulated the team and participating staff on the excellent Safety event held 23 May 2023, this was well received and reinforced messages about " Safety and Quality First".

Safeguarding (Children and Adults) report: the continued focus on training and support provides assurance for QAC.

Two reports for information focussed on Patient Experience and Involvement: a detailed annual report (including key priorities for 2023/2024) and the Patient Experience and Involvement Strategy, developed appropriately in partnership with Healthwatch colleagues and input from partners . Progress reports on the the above strategy will be brought to QAC quarterly.

The Annual Clinical Audit report described the challenges in this area of work and also positives , eg LocSSIPs are well embedded into practice , there are no outstanding risks relating to priority 3 audits and registrations are back to full capacity for priority 4 audits.

Significant assurance was provided to QAC by the Patient Led Assessment of the Care Environment (PLACE) report.

Actions	Responsibility / timescale
• Consideration to be given to how " cross-cutting " themes are addressed across Board sub- committees • Metrics and benchmarking to be developed for the Patient Experience and Involvement Strategy • Following CQC inspection report, a session on next steps will be useful	Mrs J White …September 2023 Ms J Little , Quarterly to QAC Mrs White and Dr H Lloyd tbc

Escalated items

- CQC Inspection report outcomes , congratulations to all staff
- Research and Development team were awarded 1st place in the Bright Ideas for Health Awards
- The PLACE assessment is affirming, the overall organisational scores for the Trust are above the national average in all 8 domains , excellent performance against the standards.
- A report following a Screening Quality Assurance visit for the NHS Antenatal and Newborn Screening Programme has been received , it is a positive report and a detailed account will follow.

Risks (Include ID if currently on risk register)	Responsibility / timescale
No risks to add.	

South Tees Hospitals NHS Foundation Trust

May Resources Committee Chair's Log

Meeting: Resources Committee	**Date of Meeting**: 25/04/2023
Connecting to: Main Board	

Key topics discussed in the meeting

Financial position for Month 1- Month 1 position reviewed and reported a deficit of £1.9m at a system control total level and the Trust is on plan year-to-date. For 2023/24, the system-based approach to planning and delivery continues, with each provider trust fully mapped to a single ICS system, the NENC has a current planned deficit of £50m.

Agency Spend - NHS England has set system agency expenditure limits since 2022 to ensure NHS organisations are working together and taking collective responsibility for reducing agency spend. An update to the agency rules came into effect in April 2023. It was discussed and agreed that ownership and adherence to the rules and process for control is devolved to the collaboratives and reporting via the people committee on workforce planning.

Private Patients strategy - The committee approved the creation of a new post to support the strategy.

Energy purchasing strategy- The committee agreed to the proposed strategy of it is breakdown the energy volume into 25% of the Trusts volume in the Trend strategy and 75% in the Capped strategy. To take advantage of any falls in energy commodity cost and limit exposure to future increases in the Energy market.

Actions — Responsibility / timescale

Date of Meeting	Item	Action	Lead	Due Date	Progress	Status (open, completed, to note)
24/11/2022	RC22/115	Digital Strategy – Articulate the potential negative risk and any mitigation in terms of budget because of the 1-2 months delay in delivering the Alicidion programme.	Mr Imiavan	January 2023	Mr Imiavan to update at next meeting.	Open
27/4/2023	RC23/007	IPR – Benefits realization paper for med recs	Mr Peate	July 2023		Open

27/4/2023	RC23/010	Digital Update – a document detailing the benefits realization.	Mr Imiavan	June 2023		Open
27/4/2023	RC23/013	Green Plan – updated green plan and decarbonisation strategy.	Mr Sturdy	October 2023		Open
25/5/2023	RC23/024	IPR – Response to the letter around Elective Recovery to be brought to the next Committee meeting.	Mr Peate	June 2023		Open
25/5/2023 0	RC23/0	Digital update – Mr Imiavan to arrange for the NEDs to visit Ward 11 before the next Resource Committee	Mr Imiavan	June 2023		Open

Escalated items

Key Issues/ Concerns for escalation:

- Nothing escalated from this months meeting

Risks (Include ID if currently on risk register)	Responsibility / timescale
No Additional Risk Identified	

People Committee
Chair's Log

Meeting: People Committee	**Date of Meeting**: 31.05.2023
Highlights for: Board of Directors	**Date of Meeting**: 06.06.2023

Overview of key areas of work and matters for Board.

- Board Assurance Framework
- People Committee – Annual Cycle of Business
- People Strategy
  - Health & Wellbeing
  - Sickness Absence (Deep Dive Follow Up)
- Culture & Values
  - Annual Staff Survey
  - Restorative Justice & Learning Culture Programme
- Organisation Capacity
  - Pathology
  - Clinical Impact Awards
- Other
  - Payroll Errors
  - Apprenticeships, Prospect & Mobilisation

Actions to be taken	Responsibility / timescale
Annual Cycle of Business Reviewed and to be monitored monthly and shared with NT.	
Health & Wellbeing Report presented on creating positive health and wellbeing culture. SMART aspirations using Better Health at Work Award (BHAWA). Funding challenges discussed.	People Committee to be updated on progress
Annual Staff Survey Data and trend review.	
Restorative Justice & Learning Culture Programme Review of methodology, governance and actions (HR, L&D, Patient Safety & Experience), Communications & Engagement). Open discussion on the cultural change challenge.	People Committee to be updated on progress
Pathology Committee updated on progress and example of collaborative working.	Organisational change learning to be captured for future collaborations.

Clinical Impact Awards Process is ongoing and discussions related to the change (since pandemic). **Payroll** Rectification measures.	Equality Impact Assessment to be completed (RM) NED participate in decisions (MJD) People Committee to be updated in June 2023
O Board action	Responsibility / timescale
There were no matters for escalation to the board.	
Risks (Include ID if currently on risk register)	Responsibility / timescale
Three ongoing risks identified: *Cultural change challenges in attaining a restorative justice culture. *Sharing organizational change learning from collaborative work *Payroll rectification	