South Tees Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS (PUBLIC)

Date – 5 December 2023
Time – 13:00
Venue – Room 10, STRIVE 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 5 DECEMBER 2022 AT 13:00 IN ROOM 10, STRIVE, 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	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	ENC 6
9.	Integrated Performance Report	Discussion	Chief Operating Officer	ENC 7
SAFE				
10.	Safer Staffing report	Information	Chief Nurse	ENC 8
EFFECTIVE				
11.	Consultant appointments	Information	Chief Executive	Verbal
WELL LED				
12.	Responsible Officer Revalidation and Appraisal Report	Information	Chief Medical Officer	ENC 9

	ITEM	PURPOSE	LEAD	FORMAT
13.	Emergency Preparedness Resilience and Response report	Information	Chief Medical Officer	ENC 10
14.	Scheme of delegation	Approval	Chief Finance Officer	ENC 11
15.	Use of the Seal	Information	Co Secretary	ENC 12
16.	Finance Report	Information	Chief Finance Officer	ENC 13
17.	Committee Reports	Information	Chairs	ENC 14
	DATE OF NEXT MEETING The next meeting of Board of Directors will take place on 6 February 2024			

South Tees Hospitals NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 5 DECEMBER 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 ☒		

Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Ada Burns	Non-Executive Director	2019	Ongoing	Role – Associate Consultant – Cratus Consultancy, public sector management consultancy
		2022	Ongoing	Role – Governor and Chair of the Board of Governors, Teesside University
Jackie White	Head of Governance & Company Secretary	March 2013	Ongoing	Registered with IMAS (NHS interim management & support)
		March 2023	Ongoing	Company Secretary of South Tees Healthcare Management Limited - Company number 10166808
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)
Robert Harrison	Managing Director			Board Member of the North East and North Cumbria Academic Health Science Network
David Redpath	Non-executive Director	1 January 2021	Ongoing	Director of DGR Consultancy - Company number 10340661
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
		September 2017	Ongoing	Vice President Senior Executive Partner – Gartner
		July 2022	Ongoing	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
		May 2023	Ongoing	Chief Nurse for Clinical Research Network NENC
Chris Hand	Chief Finance Officer	2 July 2021	Ongoing	Director of South Tees Healthcare Management Limited - Company number 10166808
				Client Representative ELFS Shared Services Management Board
Samuel Peate	Chief Operating Officer	1 April 2021	Ongoing	No interests declared
Prof Derek Bell	Joint Chair	April 2020	Ongoing	Trustee Royal Medical Benevolent Fund – no remuneration
		April 2018	Ongoing	Chair and Trustee Tenovus Scotland (Edinburgh) – no remuneration
		April 2021	Ongoing	Centre for Quality in Governance

		July 2022	Ongoing	Sel clinical advisor for SDEC
Mark Dias	Non Executive Director	20 July 2015	Ongoing	Director of Be The Change HR Ltd – Company No. 9694576
		21 June 2023	Ongoing	Chair – Workforce Committee, Seacole Group
		September 2023	Ongoing	Permanent Deacon in Training (Voluntary Position). Roman Catholic Diocese of Middlesbrough
Miriam Davidson	Non Executive Director	December 2022	Ongoing	Care and Health Improvement Programme (SLI) Advisor Occasional work with Local Government Association (LGA)
		July 2023	Ongoing	Interim Director of Public Health Darlington Council , (Part/time)
Alison Wilson	Non Executive Director	4 January 2022	Ongoing	Civil Partner – Counter Terrorism Policing North East
		2017	Ongoing	Son – Bupa Global and Bupa UK
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
Kenneth Readshaw	Non Executive Director	2016	Ongoing	Treasurer – Leyburn Community Leisure Club
		2018	Ongoing	Chair – Health Accommodation Trust
		2000	Ongoing	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 3 OCTOBER 2023 AT 13:00 IN ROOM 10 STRIVE

Present

Ms A Wilson	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
Mr M Dias	Non-Executive Director
Mr R Harrison	Managing Director
Dr M Stewart	Chief Medical Officer
Dr H Lloyd	Chief Nurse
Mr C Hand	Chief Finance Officer

Associate Directors – non-voting

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

Directors – non-voting

Mrs J White	Head of Governance & Company Secretary
Mr P Sturdy	Director of Estates, Facilities & Capital Planning
Mr M Imiavan	Digital Director
Mr S Peate	Chief Operating Officer
Mrs R Metcalf	Director of HR

In attendance

Mrs J Crampton	Lead Governor
Ms R Shaher	Staff Side Chair

BoD/23/056 **WELCOME AND INTRODUCTIONS**

The Vice Chair welcomed members to the meeting including Mrs J Crampton Lead Governor and Ms R Shaher, Staff Side Rep.

BoD/23/057 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Professor Bell, Chairman, Ms Page, Chief Executive and Mr Graham, Director of Communications.

BoD/23/058 **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/23/059 **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/23/060 **MINUTES OF THE LAST MEETING**

The minutes of the meeting held on Tuesday 1 August 2023 were reviewed and agreed as an accurate record. Mrs White

BoD/23/061 **MATTERS ARISING**

There were no matters arising to discuss with Board.

BoD/23/062 **CHAIRMAN'S REPORT**

The Vice Chair on behalf of the Chairman highlighted a number of issues including Group and joint working; Regional Chairs meeting in which she accompanied the Chairman and there was a discussion on the Letby letter. She was pleased to report on the HSJ nominations and the signing of the Sexual Safety Charter. The Vice Chair reported that she had attended the new Community Diagnostic Centre event in Stockton which was a great example of joint working and finally thanked colleagues on behalf of the Board for supporting the effort with the industrial action and giving safe care during this time.

Professor Bilous asked regarding the recent incident at Newcastle Hospitals in relation to patient correspondence and asked if this had been discussed by the Trust. Mr Harrison advised that the Trust had discussed the incident at the Senior Leadership Team meeting and that Mr Imiavan was reviewing the Trust processes to ensure we have no issues. Mr Imiavan reported that this was raised at Resources Committee last week and he updated that the Trust systems are different to Newcastle, adding that we have four different entries which are pulled together, we cant be 100% sure but we have undertaken some testing on this.

RESOLUTION

The Board of Directors NOTED the Chairman's report.

BoD/23/063 **CHIEF EXECUTIVE'S REPORT**

Mr Harrison on behalf of the Chief Executive thanked colleagues who worked really hard to mitigate the impact of the recent Industrial action. He added that it was disrupting for staff and patients and we need to focus on safe care.

Dr Stewart added that this week is the week where we have juniors and doctors out together. Because we are covering as we would do at Christmas it feels a little bit more safe but elective care has been impacted. Outpatient activity has continued, theatres have been impacted. Emergency theatres have been running. P2 and urgent cardiac surgery has been cancelled and therefore delays to most urgent pathways, no known examples of harm at this stage.

Mr Harrison reported that he had attended the Chair and CEO meeting nationally in September which was a useful day with the launch of NHS impact and Letby case. He reported that he was encouraged that we have been quality improvements and were ahead of the curve, reinforced by walkrounds today.

Mr Harrison commented on the recent Adult inpatient survey and was really pleased with the results for 2022 which are in the report and a fantastic improvement. From the Board walkrounds and the care the staff can give supports this. The Trust is in the top 20 nationally in all trusts and 6th in peer group,– well done and thanks to staff and patients. The Vice Chair commented that the response rate is amazing – really proud.

Ms Burns said very well done on the inpatient survey and asked regarding the patient and carer and involvement banks highlighting these were really important initiatives. Ms Burns asked how the Trust are you recruiting to these and a request that we have feedback in future meetings on how this is working. Mr Harrison commented that this was a new initiative but part of wider patient experience and involvement work and was happy to feedback on this. He added that it was really important and linking to the work on the clinical strategy and development of the group and the approach to co production and involving users is really important.

Dr Lloyd commented that recruitment to the involvement banks was being rolled out through social media to attract users to this and using the network we developed on developing the patient experience and involvement strategy. She added that there will be one for children and one for adults.

RESOLUTION

The Board of Directors NOTED the Chief Executive's update

BoD/23/064 **BOARD ASSURANCE FRAMEWORK**

Mrs White presented the updated Board Assurance Framework following the Board Development Session in July which had considered and approved the strategic objectives and the Improvement Plan.

Mrs White reminded members that the Board had identified the principal risks to achieving the strategic objectives along with the risk appetite and tasked the Board committees to review the BAF threats and update the BAF for 2023/24 whilst undertaking the scrutiny and assurance of the principal risk, controls and gaps.

Mrs White advised that there remains two principle risks which require a review and agreement at Board.

The Chair's logs from the Committees will confirm review and agreement of the new BAF principal risks and threats and 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.

Mr Readshaw commented that it was positive to see the updated BAF and that it was good to see this working well. He added that he hopes to see us reducing the risk to our tolerance levels.

RESOULUTION

The Trust Board of Directors NOTED the update

BoD/23/065 **INTEGRATED PERFORMANCE REPORT**

Mr Peate referred members to the Integrated Performance and highlighted the following:

The Trust is now CQC rated Good in all domains: safe, effective, responsive, caring and well led.

Trust remains in segment 3, mandated support for significant concerns, due to the historic financial position.

A&E 4-hour standard performance is steady and close to the national average. Clear reductions in A&E 12 hour waits and 12 hour delays following a decision to admit are evidenced since the beginning of 2023.

Ambulance handovers within 60 mins shows an improving trend too.

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 maintained and keeps performing ahead of the national trend. Patients waiting more than 78 weeks for non-urgent elective treatment has received extra focus since January, reducing in line with national requirements. Total elective growth at the end of June was slightly behind plan but within that 1st OP appt activity was among the highest in the ICS and overnight elective admissions show promising year on year growth.

Performance against the 6 week diagnostic standard deteriorated in June however plans are in place to increase radiological capacity and access.

The Trust was compliant with the national target for Cancer 28-day Faster Diagnosis Standard and the Cancer 62-day accumulation has improved over the same period, returning to the planned recovery trajectory at July end.

Mr Harrison asked regarding the spike in the length of stay in August and Mr Peate advised this was due to changes to coding in last couple of months.

The Vice Chair commented that she recognises that waiting lists are increasing and asked if there is a process for reprioritisation. Mr Peate advised that there is ongoing validation of waiting list from inpatient perspective, clinicians have responsibility for this and reviews are being undertaken. Validation of the list is allowing contact with patients and a route to escalate for patients is available.

The Vic Chair highlighted that there are some challenges on the quality measures (safe domain), CDIF, medications reconciliation, complaints and asked what is happening on this. Dr Lloyd commented that the Trust does have a handle on this in the Quality Assurance Committee and receive additional reports on areas of concern. She added for in relation to Pressure Ulcers the picture has been similar over the last 18 months and the Trust is not seeing any improvement – community is difficult due to the complexity. In October the Quality Assurance Committee will do a deep dive on Pressure Ulcers and we can share outcome in the Chairs log. Dr Lloyd advised that CDIF is a long standing issue and will discuss this further in the Private Board. Ms Davidson added that there is oversight at Quality Assurance Committee on IPC.

RESOLUTION

The Board of Directors NOTED the update

BoD/23/066 **LEARNING FROM DEATHS REPORT**

Dr Stewart referred members to the previously circulated report on Learning From Deaths. He highlighted that 140 deaths were recorded in July 2023 and 151 deaths in August 2023. Rolling 12 month average mortality rate is 1.32 compared to 1.24 pre-pandemic. The Learning from Deaths dashboard shows that 2,029 of the 2,033 deaths that occurred between September 2022 and August 2023 were reviewed (99.8%).

SHMI at 109 (Mar 2022 – Feb 2023) is As Expected
560 Mortality Surveillance Reviews were completed in 2022/23. A further 205 reviews have been completed since April 2023 and 147 by the Nurse Reviewer

The Trust continue to see a very low number of preventable deaths – one preventable in the last 12 months linked to a delay in resuscitation and airway support and changes made immediately around resuscitation calls going out.

The Vice Chair asked regarding learning and how do we complete the loop that lessons have been learnt. Dr Stewart commented that the themes are consistent but we are still getting the same issues so perhaps we haven't had a meaningful impact but we do feel that the electronic solutions will help for this.

Ms Davidson asked if there is an agreement that the nurse reviewer can continue to provide this role and Dr Stewart advised that the role is not funded so we need to look at this.

The Vice Chair commented that this is one of the places where we get the assurance that we are spotting somewhat untoward and Dr Stewart suggested that we probably need to draw in something more on neonatal and paediatric deaths as this could be lost in the amount of adult deaths.

Ms Davidson reminded members that this information does come to the Quality Assurance Committee as part of the maternity report and Board Champion walkrounds.

Dr Lloyd commented that it was a really good point but its about what they do about the information. As Board safety champions we want more focus on neonates. Maternity has so much scrutiny it gets a lot of time so we are going to refocus.

RESOLUTION

The Trust Board of Directors NOTED the report

BoD/23/067 **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 has increased slightly to 97.4% demonstrating continued good compliance with safer staffing.

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.

Nursing Turnover for August 23 has increased slightly to 7.03%. This trust remains one of the lowest in the country for nursing turnover.

Dr Lloyd highlighted a number of additional points including the work of the Legacy mentors, Overtime, Red flags, 74 newly qualified nurses being interviewed for posts who quality in January and 14 international nurses being deployed.

Mr Harison commented that when he visited the University recently it had been raised that they hadn't filled all their nursing places. Dr Lloyd advised that the numbers have increased and is a much improved position – only concern is learning disabilities for January.

RESOLUTION

The Board of Directors NOTED the safer staffing report

BoD/23/068 **CONSULTANT APPOINTMENTS**

Mr Harrison commented regarding the consultant appointments and updated members on the starters and leavers, welcoming members to the Trust.

Starters

Yewande Babalola – Ophthalmology
Mohammed Bahgat – ENT
Jonathon Catley – Anaesthetics
Gavin Fenton – Orthodontics
Andrew Kane – Anaesthetics
Leanne Wakes – Anaesthetics

RESOLUTION

The Trust Board of Directors NOTED the update

BoD/23/069 **GUARDIAN OF SAFE WORKING**

Dr Stewart reported on the work of the Guardian of Safe Working and highlighted that the report provides an update of the Trust participation in the 2016 Junior Doctor Contract. It encompasses the quarterly period between 1st April 2023 and the 30th of June 2023.

Dr Stewart discussed the following issues:

Implementation of medical specialties junior doctor rotas onto Rota Map – CLW and Medi Rota.
Exception reports raised total of 63, In Quarter 1 (report) 1st April 2023 – 30th of June 2023.
Summary of risks, Issues, and next steps.

Mr Dias commented that the People Committee received the report from Dr Skeath and it was good to hear the work he is doing.

The Vice Chair referred Dr Stewart to Table 4.2 and highlighted the different grades; and asked if there is a propensity to report the more experience you become. Dr Stewart commented that more senior grades are more focussed on speciality training; juniors on more generic training and the Trust might get more concerns raised with the speciality training.

RESOLUTION

The Trust Board of Directors NOTED the update

BoD/23/079 **FINANCE REPORT**

Mr Hand spoke to the report previously circulated which set out the Trust's draft financial performance as at Month 5 of 2023/24. He highlighted that 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 (e.g. 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.

At Month 5 the reported position is a deficit of £11.7m at a system control-total level, which is in line with the year-to-date plan.

Mr Readshaw raised an issue with regard to the variances £800k benefit with PDC dividends and asked what is this covering; Mr Hand commented that he had to distil to this

level, and that there is further information discussed at Resources Committee including collaborative level reporting. Mr Redpath suggested Mr Readshaw may wish to review the more detailed report from Resources Committee.

Mr Readshaw commented that he was seeking further assurance as Finance is a major BAF risk and with restrictions on the licence he wondered if the whole Board should focus on this. Mr Hand reminded Mr Readshaw that the Board tasks the Resources Committee with this oversight on its behalf.

Mr Harrison commented on the planning for next year and confidence of month 5. Mr Hand commented that his confidence for this year depends on the industrial action and ongoing dialogue with treasury. With regard to planning for next year the ICB is working on the medium term financial plan which we are contributing to but until we get the detail of the financial planning guidance and the operational asks we are not sure. The efficiency ask is around 4 % next year and we are starting to work through this.

RESOLUTION

The Trust Board of Directors NOTED the report

BoD/23/071 **COMMITTEE REPORTS**

The Vice Chair 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 highlighted the neonatal and maternity report received; IPC quarter 1 report including some joint work with NT and ST on this area. Patient experience and involvement report, health & safety report and the reduction in sharps incidents

Resources – Mr Redpath commented on the productivity paper which was a complex piece of work but there was a focus nationally on this. Likely to do a Board session on this. Digital updates received, including benefits update and assurance around digital programmes being embedded in the transformation programmes.

Mr Harrison commented regarding the productivity report and advised that he is part of a national working group which is being set up to understand the drivers and initiatives around this which will look to understand this complex picture and he agreed to share this as we receive more on this. Mr Peate added that the Trust has been working on theatre productivity and received report from GIFRT which showed that for capped theatre utilisation measure the Trust was towards the

Mr Harrison

top end of highest quartile and had made some big progress in the period. Mr Harrison added that it is really important in terms of reputation and scrutiny that we make sure we are doing what we need to do as a Trust.

People – Mr Dias reported that the People Plan was received and it was a great concise report, leadership, culture and people and contributed a huge level of detail and from an assurance perspective helped us understand this. Health and wellbeing report was a good update but high levels of referrals to psychology support and will review next month. EDI quarterly report identified an area which needs further support in terms of staff networks. Reviewed the distributed leadership programme and looked forward to this continuing. Reviewed FTSU and the further work around Letby. NHS Impact self assessment was considered and signed off on behalf of the Board. Deep dive into recruitment / retention and led to more questions. What can we influence in terms of people leaving the organisation.

Dr Stewart asked if the Trust had come to any agreement on the psychological support as there has been a really big increase. Mrs Metcalf advised that she is looking at the counselling model and the levels of counselling as the psychological support will cease shortly. Dr Stewart added that we need to make sure staff have support and linked to restorative just culture. Dr Lloyd added that the Trust are looking at adjusting policies around retirement so we don't loose a lot of the workforce. Mrs Metcalf confirmed that this was the case.

Audit & Risk Committee – Mr Readshaw highlighted that the Committee had received the updated financial instructions threshold for tenders – which will come to Board for approval; and that the Audit Committee is not yet able to give the Board assurance on joint working.

BoD/23/072 **DATE AND TIME OF NEXT MEETING**

The Board of Directors will meet on Tuesday 5 December 2023.

Signed: ……

Date: ……

Date							
Date	Minute no	Item	Action	Lead	Due Date	Comments	Status (Open or Completed)
03.10.23	BoD/23/071	Committee Reports	Mr Harrison to share the work on the national productivity group	Mr Harrison	asap		Open

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 DECEMBER 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 Group Development and joint working

We had another positive meeting with both Council of Governors on 26 October 2023 and updated them on key topics including the role of Governors in system working and the Partnership Agreement. The Lead Governors led a discussion session to explore practical solutions to improve communication between both Councils and to learn about each organisation's cultures, structure and values.

The Joint Partnership Board met on 15 November and the Board considered and recommended approval of the Partnership Agreement to the Board of Directors. The JPB received legal advice in support of the governance framework. Feedback was received on the approach to the clinical strategy and development of a digital strategy.

The appointment process for the Group Single Chief Executive concluded on 12 and 13 October with a 'town hall' stakeholder event providing the opportunity for round table discussions with the candidates followed by a formal interview. I am pleased to announce that Stacey Hunter was appointed as the Group Single Chief Executive. She will formally commence in post in January 2024, however, will attend key meetings in the meantime where possible .

2.2 Trust Annual General Meeting

The Trust held its Annual General Meeting on 24 October 2023 in STRIVE at James Cook University Hospital. We had a really good turn out from members of the Foundation Trust, governor and staff colleagues. The Trust's Annual Report and Accounts were formally presented.

2.3 NENC ICS FT Chairs Meeting

I attended the North East North Cumbria Integrated Care System (NENC ICS) FT Chairs meeting on 17 October, themes from the meeting included further development of the Digital Strategy and the requirement for greater cooperation between organisations in respect of the request and provision of mutual aid as we enter winter.

2.4 Staff Engagement

I attended the Friarage for a site visit on 24 October and had the opportunity to walk round and meet staff and learn about their work. I have continued to have local consistency meetings with governors and visited the Friary and Redcar Primary Care Hospital.

I had a positive visit with North Yorkshire Healthwatch where I had the opportunity to meet with them to discuss their work and how they are engaging with the Council of Governors.

I was unable to attend the open day for Trinity at James Cook but understand from Jonny Ferguson, Clinical Lead that it was a great success. I was however able to attend the opening of the Cardiovascular Research Centre, which was funded by a collaboration from Our Hospitals Charity and South Cleveland Heart Foundation and provides a much needed facility for the area.

2.5 Flu and Covid Vaccination Programme

The Trust is continuing to encourage the uptake of both the flu and covid vaccines with our staff to protect themselves, their family and our patients. I would urge as many people as possible to receive both vaccinations to provide the maximum protection as we enter into the winter.to come to fruition.

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 – 5 December 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 ☒		

Urgent Treatment Centre works

Work is continuing to move at pace on the creation of the new James Cook urgent treatment centre (UTC), with the service's new building scheduled for installation (at the time of this report's writing) from 30 November to 4 December.

The creation of the UTC service, through the North East and North Cumbria Integrated Care Board (ICB), is designed to improve access to urgent care and ensure the James Cook emergency department is kept free for emergencies. The new UTC is planned to open in 2024.

South Cleveland Heart Fund Cardiovascular Clinical Research Facility

This year (2023) marks the 30th anniversary of the James Cook heart unit and in November colleagues came together to mark another major milestone – the celebration and opening of the new South Cleveland Heart Fund Cardiovascular Clinical Research Facility.

The new research facility is named after the South Cleveland Heart Fund which has raised millions for heart care at James Cook over the last three decades. The event was also an opportunity to thank the Our Hospitals charity for their support in fundraising for the new facility in partnership with the South Cleveland Heart fund.

The celebration and opening of the new facility was joined by a number of speakers including Professor Liam Donaldson, Dr Jim Hall, Professor Mark de Belder and Professor David Burn.

The facility is the first of its kind in the Tees Valley and will greatly enhance the offer to patients now and in the future, ultimately improving their care. The team also hope that its research will help patients beyond the region, and cement James Cook Hospital's position as a national and international centre of excellence.

Improving Quality in Liver Services (IQILS) programme

Teams at the trust have achieved IQUILS accreditation Level 2. To date there are only 14 trusts nationally to receive this accreditation and the trust first in the North East to reach this landmark.

The latest annual CQC inpatient survey results were published in September and showed the South Tees Hospitals NHS Foundation Trust performing notably better than average in 14 areas.

The aim of the IQILS programme is to improve the quality of medical liver services throughout the UK. The programme is run by the Royal College of Physicians and is supported by the British Association for the Study of the Liver (BASL) and British Society of Gastroenterologists (BSG). IQILS works in partnership with the liver community, professional bodies, societies and patient groups.

Trust of the Year finalist

The trust was one of six finalists in England for the HSJ Trust of the Year award, which was presented on 16 of November 2023 to Oakleas NHS Foundation Trust. South Tees' colleagues were recognised for this year (2023) becoming one of the first NHS trusts in the country since 2020 to achieve a Care Quality Commission ratings improvement to 'Good'.

Trinity Holistic Centre

Patients, colleagues and fundraisers came together in November to celebrate the 20th anniversary of the Trinity Holistic Centre. Based at James Cook Hospital, the Trinity Holistic team helps thousands of people affected by cancer and other long-term conditions by providing emotional, practical and wellbeing support.

Friarage radiology

The Friarage Hospital's imaging department has undergone a £3milllion upgrade as part of a national programme to provide clinical diagnostic services closer to patients' homes.

The radiology department now has two CT scanners including a new state-of-the-art £900,000 machine – which means more than 100 extra patients can be scanned at the Northallerton hospital each week.

The 15-month project has seen the old radiology block undergo a £2.4million transformation into a modern hospital department, creating a spoke site for the Tees Valley Clinical Diagnostic Centre programme which also includes a town centre hub in Stockton and spoke sites at Hartlepool and Redcar.

Delivered by the North East and North Cumbria Integrated Care Board (ICB) in collaboration with North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, the Friarage spoke site is now fully complete, giving patients faster access to diagnostic tests closer to home.

2. RECOMMENDATIONS

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

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 DECEMBER 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. In July 2023 the Board agreed that the strategic plan at Board development session and reviewed the strategic objectives and the Improvement Plan in August 2023. Using both of these key strategic documents the Board identified the principal risks to achieving the strategic objectives along with the risk appetite. The Board of Directors tasked the Board committees to review the BAF threats and update the BAF for 2023/24 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 Committees – People, Quality and Resources in September reviewed the BAF relevant to their area and agreed the threats (what might cause the principal risk to occur), the controls and sources of assurance. They reviewed the gaps in assurance / action and noted in some areas there was further work to be undertaken. The Committees reviewed and agreed the risk appetite statements and risk rating scores. The Chair's logs from the Committees will confirm review and agreement of the new BAF principal risks and threats and 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. There remains a number of areas for further focus on the BAF including dates and leads for addressing the gaps and the level of assurance for each of the principal risks.	
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 2023/24 Board Assurance Framework and the work of the Board 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.

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.

In July 2023 the Board agreed that the strategic plan at Board development session and reviewed the strategic objectives and the Improvement Plan in August 2023.

Using both of these key strategic documents the Board identified the principal risks to achieving the strategic objectives along with the risk appetite.

The Board of Directors tasked the Board committees to review the BAF threats and update the BAF for 2023/24 whilst undertaking the scrutiny and assurance of the principal risk, controls and gaps.

3. DETAILS

The BAF has 6 ***principal risks*** associated with delivery of the 5 strategic objectives. These 6 principal risks are made up of ***23 threats.*** It is to be noted that two principal risks need to be reviewed and threats identified.

Of the 4 principal risks updated, all risks are scored at 9 – High.

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 will be considered by Committees in October.

3.1 Assurance reports Trust Board of Directors

Several assurance reports are being received today at Board and include:

Principal risk 1 - Inability to provide safe, effective patient centred care that delivers the best patient experience and good clinical outcomes

- Integrated Performance Report
- Learning from deaths report

Principal risk 3 - Failure to engage and inspire our people by not attracting, developing, retaining and reforming our workforce

- Safe Staffing Report
- Integrated Performance Report

Principal risk 6 - Failure to achieve financial objectives and responsibilities

- Finance Report
- Integrated Performance Report

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 2023)

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.

Principal risk - 1 (what could prevent us achieving this strategic priority)	**Inability to provide safe, effective patient centred care that delivers the best patient experience and good clinical outcomes**	**Strategic Objective**	**Best for safe, clinically effective care and experience**

Lead Committee	Quality Assurance Committee	**Risk Rating**	**Initial Rating**	**Target**		**Risk appetite**	Moderate
Executive Lead	Chief Nurse/Chief Medical officer	**Likelihood**	3	2		**Risk Level**	Cautious
Initial date of assessment	September 2023	**Consequence**	3	2			
Last reviewed		**Risk Rating**	9	4			
Last changed							

Threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / action to address gaps inc timescales and lead** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
1.1 Failure to identify and learn from patient safety incidents resulting in avoidable harm and poor clinical outcomes including healthcare acquired infections	Quality governance framework PSIRF plan to deliver new framework in place Policies and procedures Medical examiner system Sharing and learning through Patient Safety Ambassadors and bulletins Clinical effectiveness processes including clinical audit, NIC, GIFRT Training and education Governance – adverse events groups / MDT approach revalidation Patient Experience processes for feedback FTSU processes for staff Infection prevention & control programme PFI arrangements and cleaning standards Review panels of all trust apportioned of all infection disease incidents Ward accreditation programme - STAQ	**Management** Collaborative Board / Governance meetings quality metrics Mortality and Morbidity meetings Safeguarding Patient feedback reviewed at Patient Experience Group Clinical audit data and NICE compliance reviewed at Clinical effectiveness Group IPR - Quality Dashboard Monthly QAC and Board Medicines Optimisation Report to QAC quarterly Health & Safety meeting escalation report to QAC Falls and PU reports IPC reporting in line with revised QAC governance structure Reports to IPC Group including Cleaning standards **Risk and compliance** IPC Annual report to QAC Quality account report and annual report to QAC CQUIN report to QAC SI/NE report to QAC and Board monthly Learning from deaths Report to QAC and Board quarterly Clinical Audit forward plan and report to QAC NICE compliance report to QAC FTSU report quarterly to People Committee and Board Guardian of Safe working report to Board	Embed PSIRF and demonstrate improvement in safety – Kate Jones – update position March 2024 Inphase – implement Inphase and demonstrate increase in monitoring and compliance of clinical effectiveness processes – Kate Jones – February 2024 Implement recommendations from PWC internal audit report on clinical audit & effectiveness Kate Jones – March 2024	

		IPC Committee escalation report to QAC **Independent assurance** Internal audit report on Quality Governance Getting it Right First Time (GIRFT) CNST reporting Ockenden review CQC report 2023 – Good rating NEQOS PLACE assessment and scores IBAF CQC review PWC internal audit report on clinical audit – High risk		
1.3 Failure to provide a capability and capacity within the workforce to provide time to care, communicate and train which could result in a poor patient experience.	People Plan PE and involvement strategy PE surveys Safer staffing report Revalidation Individual Learning and development offer including Patient / Quality safety days – leadership and development Complaints / PALS / Therapeutic care Nursing and Midwifery strategy Fundamentals of practice meetings Daily safety and staffing huddles Professional nurse advocates Guardian of safe working Freedom to speak up processes	**Management** People Plan quarterly reports to People Committee Appraisal processes and personal development plans Safe staffing models and report to People Committee and Board **Risk and Compliance** Workforce report to People Committee IRP/KPI on workforce metrics considered at People Committee and Board Nurse establishment review to Board bi annually Midwifery safer staffing report to People Committee **Independent Assurance** UNICEF baby Audit Inpatient Survey 2022 CQC report 2022 National Staff Survey report 2022	Development of Medical safer staffing report – Laura Lucas Hartley / Guardian of Safe Working – March 2024 Development of a Mental Health strategy – Alan Brownrigg – January 2024 Delivery of the Complaints action plan and improvement in metrics – Kate Jones – February 2024	
1.4 Demand for services resulting in services not meeting the expectations of patients leading to poorer outcomes for patients and users and potentially health inequalities	Patient Flow process in place Standard operating procedures and policies in place Trust and System escalation process Trust leadership of and attendance at local A&E delivery 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 CRG review of constitutional standards and escalation of high risk areas SI process Clinical Harm review process Emergency capital funding received for UTC Weekly touchpoint meeting with Commissioners	**Management** Reports to Board on Winter preparedness to Resources Committee and CPG Improvement Plan updated July 2023 and reports to Board Recovery plans for high risk services and updates to Board and Committees and CPG Response to NHSE/I letter of xxxxx on Elective through CPG/SLT Assurance Framework for managing the implementation of the recovery plan with Collaboratives agreed by SLT Report of performance meetings with Collaboratives to SLT August 2023 **Risk and compliance**	Undertake a programme of Service reviews (3 year) – Sam Peate – TBC Establish a Programme of work with commissioners to review referral mechanisms – Sam Peate – TBC Outcome of Surgical improvement group repriorising amount of capacity based on service need – Sam Peate – TBC Growth in physical capacity planned in at Friarage.; increased capacity in endoscopy – Sam Peate – TBC	

	Daily touchpoint meeting on patient flow South Tees Executive Governance Board Performance meetings with Collaboratives Monthly Transformation Improvement groups established	Improvement recovery plan to CPG in July 2023 IPR report to Board monthly and sub committees **Independent Assurance** Internal audit of patient flow	Updates from improvement groups – Sam Peate - TBC	
1.5 Current estate and infrastructure, if lacking in capital investment, compromises the ability to consistently delivery safe, caring, responsive and efficient patient care, world class services	Improved access now in place for lifecycle investment Capital planning group oversight (CPOG) in place Comprehensive planned maintenance processes in place Premises assurance model (PAM) undertaken evidencing, overall, compliant estate Independent, Authorising Engineer (AE) assessments carried out annually Regular risk assessments and environmental audits Regular PFI monitoring and reporting across all of the contract Full condition surveys of JCUH site undertaken bi-annually Agreed 22/23 lifecycle plan of investment and 23/24 indicative plan from our PFI partner Capital investment plan	**Management** Estates Centre Board Capital Plan received by Resources and Board Elective Recovery Programme – Targeted Investment Fund (TIF- Friarage Theatres work) Capital Programme for this financial year 23/24 Quarterly updates on Capital to Resources Committee Ward 7 released for lifecycle work ongoing October 2023 **Risk and Compliance** Environmental health audits **Independent Assurance** Independent Authorising Engineer (AE) reports PLACE Assessments 2023 CQC Inspections 2023	Review and delivery of the Internal Audit review of Fire Safety – Phil Sturdy – December 2023 External audit of Catering at Friarage develop action plan – Phil Sturdy - TBC JAG inspections aligned to environment – Phil Sturdy - TBC Premises assurance model (PAM) report – Phil Sturdy - TBC	
1.6 Failure to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and / or risk of clinical harm because of delays in access to care	Patient Flow process in place Standard operating procedures and policies in place Trust and System escalation process Trust leadership of and attendance at local A&E delivery 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 Clinical Harm review process Performance meetings with Collaboratives Monthly IPR Improvement groups established Assurance Framework for managing performance in Collaboratives in place	**Management** IPR report to Resources Committee and Board Monthly Performance Meetings chaired by COO	Data Quality issues remain. Continue working with team – Sam Peate - TBC Known gap in available bed capacity to meet the level of contracted demand whilst meeting constitutional standards. – Sam Peate - TBC Wide ranging recovery plan in place that included a length of stay reduction plan. – Sam Peate - TBC .	

Principal risk - 2	**A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community**	**Strategic Objective**	**Best for safe, clinically effective care and experience**

Lead Committee	Quality Assurance	**Risk Rating**	**Initial Rating**	**Target**			
Executive Lead	Chief Nurse	**Likelihood**	3	2		**Risk appetite**	Moderate
Initial date of assessment	September 2023	**Consequence**	3	2		**Risk Level**	Cautious
Last reviewed		**Risk Rating**	9	4			
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
2.1 Severe restriction of service provision due to a significant operational incident or other external factor including industrial action	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 and industrial action Trust Resilience Forum and EPRR operational group EPRR Strategy in line with National EPRR framework Training and testing exercises undertaken annually Annual assessment against EPRR core standards On call arrangements in place	**Management** Self assessment report to Director team Check and challenge meeting with ICB and NHSE EPRR report to Audit & Risk Committee November 2023 **Risk and compliance** EPRR report to Board December 2023 **Independent assurance** EPRR report EPRR Core Standards compliance report Check and Challenge at NHS E and ICB level	EPRR action plan to be implemented – Dianne Hurey – May 24	

South Tees Hospitals
NHS Foundation Trust

Principal risk - 3	**Failure to engage and inspire our people by not attracting, developing, retaining and reforming our workforce**	**Strategic Objective**	**A great place to work**

Lead Committee	People Committee	**Risk Rating**	**Initial Rating**	**Target**			
Executive Lead	Director of HR	**Likelihood**	3	2		**Risk appetite**	Moderate
Initial date of assessment	September 2023	**Consequence**	3	2		**Risk Level**	Cautious
Last reviewed		**Risk Rating**	9	4			
Last changed							

Threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / action to address gaps inc timescales and lead** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
3.1 Ability to attract and retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources.	Vacancy management and recruitment systems and processes Safe nurse staffing levels for all wards and departments managed through daily huddles and escalation through to tactical and strategic Temporary staffing approval and recruitment process in place Specialist recruitment campaigns Work / link with university medical school and Nurse recruitment days; AHP recruitment days International nurse recruitment programme Return to practice programme for nursing vacancies Flexible retirement and return process Increased apprenticeship workforce People Plan work stream on addressing workforce shortages HR Policies and procedures Engagement strategy (including rewards and recognition; engagement tools) Staff Engagement Group Visibility of leadership Board walk rounds Health and Wellbeing Strategy Exit interviews Workforce metrics contained in IPR STAR awards Partnership working compact with medical and staff side Pulse survey and staff survey (national) Freedom to speak up process Staff networks in place for some protected characteristics	**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 Safe Midwifery staffing levels report to People Committee quarterly Finance report to Resources Committee on collaborative agency spend Staff survey report to Committee and Board March 2022 **Risk and compliance** Guardian of Safe Working report to Board Freedom to speak up report quarterly to Board IPR workforce metrics reviewed by Board monthly Staff survey reports by Collaboratives to People Committee October 2023 Analysis of voluntary and involuntary turnover in line with retention strategy November 23 Talent management deep dive – November 2023 **Independent Assurance** CQC inspection report May 2023 NHS staff survey 2022 results showing improvement in a number of areas	PWC internal audit on agency spend – Rachael Metcalf - February 2024	

	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			
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 Psychological wellbeing training within Management Essentials Psychological first aiders Health & Wellbeing conversations in Annual Appraisal	**Management** Quarterly reports to People Committee on the Health & Wellbeing Leadership update report regarding embedding wellbeing Report on Workforce Retention regarding health and wellbeing conversations Health & wellbeing conversations embedded in Appraisal documentation and appraisal documentation rolled out across Trust Financial wellbeing report to Committee **Risk and compliance** Staff survey action plans at Collaborative level presented to the People Committee **Independent Assurance** NHS Staff survey 2022 results showing improvement in a number of areas Silver accreditation for Better health at Work Award 2022 Menopause Friendly Organisation accreditation 2022 Mindful employer	Review of the absence management plans by collaborative to assess the impact of absence of workforce on existing workforce – Rachael Metcalf December 23 Assess the impact of workplace environmental health and wellbeing actions - R Metcalf – June 24	
3.3 Staff do not feel cared for / increased pressure and workload on existing staff due to not feeling valued	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 Directorate level staff survey action plans Events to celebrate contributions such as #loveadmin Staff networks for Staff Engagement, Disability and Long-Term Health Conditions, Childless not by Choice and Menopause	**Management** Quarterly report to People Committee on Engagement & belonging Values based recruitment process Report on over / under payments **Risk and compliance** Freedom to Speak Up Guardian report quarterly to Board Guardian of Safe Working report to Board; **Independent Assurance** NHS staff survey 2022 results showing improvement in a number of areas	Ongoing evidence of an increase in the response rate for completion of the staff survey – Rachael Metcalf – February 24 Implementing the ESR automation service to allow further autonomy in the workforce – Rachael Metcalf – October 24 Rewards and Recognition policy to be implemented – Rachael Metcalf – November 23	

		Critical Care junior doctor survey discussed at People Committee 2021		
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 Staff networks and groups which include BAME, Disability and Long Term Health Conditions, LGBT+, Faith, Menopause and Childless not By Choice. Unconscious bias training delivered through the Management Essentials Programme Annual calendar of events raising awareness across a wide range of diversity issues. Reciprocal mentoring programme for BAME and senior leader colleagues, developing 23 reciprocal partnerships and identifying three areas for system change.	**Management** ED&I Annual report WRES and WDES report to People Committee October 2023 Quarterly report to People Committee on ED&I Reciprocal mentorship programme in development Values based recruitment process **Risk and compliance** Freedom to Speak Up Guardian report quarterly to Board Guardian of Safe Working report to Board; Gender Pay Gap report to People Committee Increased the number of staff self-declaring their ethnicity from a BAME background and/or their disability status. **Independent Assurance** Critical Care junior doctor survey discussed at People Committee 2021 NHS Staff survey 202 results showing improvements in a number of areas Undertook an externally lead listening events for all our BAME colleagues.	Evidence of increasing the workforce to be representative of the communities we serve (Race Pay gap_– Rachael Metcalf November 23 Impact of increased representation of protected characteristics on each recruitment panel – Rachael Metcalf February 24 Impact of reciprocal mentorship programme on recruitment and retention - Rachael Metcalf February 24	
3.5 Failure to provide excellent learning and development opportunities to ensure staff have the knowledge skills and confidence to do their job may have an adverse impact on clinical outcomes	Schwartz rounds Leadership academy Appraisal process in place for all staff clinical and non clinical – new paperwork agreed with staff introduced including a wellbeing discussion Leadership Development and Quality Improvement educational sessions Leadership apprenticeship partnerships Interventional OD network (leadership development, coaching support, quality improvement, Civility and Human Factors, Business Intelligence and Service Improvement) for teams based on Improvement Plan. Culture change programme to continually improve quality and safety for our patients and service users. Restorative Just and Learning Culture 100 ‘ambassadors’ and practitioners in restorative practice.	**Management** Quarterly report to People Committee on Improving Learning and Leadership Culture KPI report on training KPI report on appraisals Report on quality of appraisals to People Committee Report on career progression following attendance at Leadership and Improvement Courses October 2023 Report on Distributed leadership programme September 2023 Evidence of impact of large scale education and training **Risk and compliance** **Independent Assurance** NHS Staff survey 2022 results showing improvements in a number of areas Medical Education – HEENE & GMC Reports 2023		

South Tees Hospitals NHS Foundation Trust

Principal risk - 4	**Failure to deliver as a centre of excellence, resulting in a lack of priority and recognition from commissioners and other stakeholders**	**Strategic Objective**	**A centre of excellence, for core and specialist services, research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond**

Lead Committee	Quality Assurance Committee	**Risk Rating**	**Initial Rating**	**Current Rating**	**Target**		
Executive Lead	Chief Medical Officer	**Likelihood**				**Risk appetite**	
Initial date of assessment	October 2023	**Consequence**					
Last reviewed		**Risk Rating**					
Last changed							

Threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / action to address gaps inc timescales and lead** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Fail to ensure the Trust has the ability to deliver excellent research, education and innovation	Research and Innovation Strategy in place Tees Valley Research Alliance in place to support delivery of Trust research strategy. National Institute for Health Research (NIHR) Clinical Research Network (CRN) and NIHR RCF funding allocated to TV Research Alliance to support delivery of research STRIVE centre for innovation R&D Director and team in post Director of Medical Education Director of Education Medical Management Model Research programme Academic Cardio Unit with links to Newcastle Uni Academic Centre for Surgery, linked to HYMS NMAHP research, inc PhD scholarships	**Management** National Institute for Health Research (NIHR) reports reviewed by Tees Valley Research Alliance Reporting arrangements for funders reviewed by TV Research Alliance Quarterly report to Quality Assurance Committee Clinical Effectiveness quarterly report to QAC GIRFT report by speciality and quarterly report to QAC on quality **Risk and compliance** Research and Innovation presentation delivered by the Director of Research to the Board of Directors twice a year MOU with Teesside University for strategic links Collaborations with HEIs **Independent Assurance** NIHR performance and activity reports.	Develop and agree with the Board of Directors a refresh of the Research and Innovation Strategy, with associated delivery plan. Develop research metrics to evidence directorate research performance. Director of Innovation to be appointed	
Failure to deliver a programme of change in support of fragile or vulnerable services	Improvement Plan phase 1, 2 and 3 Recovery plan including trajectories for improvement Winter Plan Strategic & Winter weekly meeting	**Management** Recovery plan reported monthly to Resources Committee, Winter & Strategic Group IPR monthly to Committees and Board	ICB system work on clinical strategy outcome of work (update) – Mike Stewart – February 2023	

leading to a loss of quality, efficiency, outcomes and workforce shortages	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 Recruitment campaign and support package for hard to recruit areas Three year Service review programme	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 Peer Review for ED – Northumbria **Risk and Compliance** Output of Surgery Tees Valley workstream report into Tees Clinical Strategy Group and then Joint Partnership Board Ockenden Assurance visit CNST submission and report to Board **Independent Assurance** Peer Review into ED - Northumbria	Provider collaborative – system review and proactively support development of services – update of work – Rob Harrison – February 2024 Development of academic research units ongoing updates – Mike Stewart University working development of partnership – ongoing updates – Mike Stewart / Hilary Lloyd Clinical effectiveness and use of national audits for best in class outcomes – Mike Stewart	

Principal risk - 5	**Fail to take a proactive role and engage effectively with partners to transform services and improve the health of the communities we serve**	**Strategic Objective**	**Deliver care without boundaries in collaboration with our health and social care partners**

Lead Committee	Joint Partnership Board	**Risk Rating**	**Initial Rating**		**Target**		
Executive Lead	Chief Executive / Managing Director	**Likelihood**				**Risk appetite**	
Initial date of assessment	September 2022	**Consequence**					
Last reviewed		**Risk Rating**					
Last changed							

Threat (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of Assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / action to address gaps inc timescales and lead** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Fail to engage key stakeholders with clarity of purpose	Stakeholder map in place Trust participation in key Integrated Care Board (ICB), Provider Collaborative and Place partnership governance Clinical engagement networks established Mechanisms in place for regular informal dialogue with partners	**Management** Attendees at system wide meetings Updates at each Director / SLT about meetings and discussions with partners. Regular scheduled meetings with local MPs, and other key stakeholders. **Risk and compliance** Individual feedback from attendees at system meetings to Director / SLT and Board through Chair and Chief Executive's reports. **Independent assurance** CQC Inspection Report	Develop Stakeholder Engagement Plan and subsequent regular report to provide assurance – Mark Graham Develop 360-degree feedback from partners about our approach to partnership working – Mark Graham	
Fail to deliver future healthcare to align to the needs of the communities we serve	Ongoing engagement with commissioning teams. Business planning processes understand and respond to changes in needs of patients and communities. Dashboard for inequalities in place and reviewed by Equality, Diversity and Inclusion (EDI) Board. Corporate Strategy in place with annual corporate objectives. Quality Strategy in development, including work on patient engagement and involvement.	**Management** Business planning proposals indicate understanding of the communities we serve and how proposals will support. **Risk and Compliance** Half yearly progress on corporate objectives via a report to the Board of Directors (October 2022). **Independent Assurance**	Develop further our inequalities dashboard, including gaining input from public health teams – Mike Stewart Embed population and health inequalities focus more into our business planning and performance processes – including Directorate reviews and Performance Management Framework – Mike Stewart	

			Seek support from commissioners to review how well we meet needs of our population. Strengthened patient engagement work – Hilary Lloyd	
Failure to work collaboratively with North Tees & Hartlepool NHS Trust (through the Group model) to address these high and varied levels of demand and the Trusts' ability to meet the needs of the shared population will improve	Joint Chair appointed Group CEO appointed – due to start February 2024 Joint Partnership Board (Single joint committee) including TOR in place Joint Board to Board, Council of Governors to Council of Governor meetings and 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, ICS Tees Valley ICP Group Tees Valley ICP Compact Legal advice and framework	**Management** Joint Partnership Board and governance framework in place and approved by Trust Board Chairs log & chairs update from JPB to Trust Board Joint Chair update Joint Committee (using new HCA 2022) established TOR agreed CF report received, discussed and agreed by JPB Communications & engagement plan Meetings with Governors including joint briefings Schedule 1 delegated authority agreed for approving CF report in JPB – December 2022 Financial Sustainability statement agreed Principles agreed March 2023 Programme Group established with TOR agreed March 2023 High level programme plan and workstreams agreed March 2023 Partnership Agreement developed – due to be signed (phase 1) November 2023 **Risk and Compliance** B2B feedback on joint working positive **Independent Assurance**	Assurance to Audit & Risk Committee on JPB – Jackie White	

South Tees Hospitals NHS Foundation Trust

Principal risk - 6	Failure to achieve financial objectives and responsibilities	Strategic Objective	Make best use of our resources

Lead Committee	Resources	Risk Rating	Initial Rating	Target			
Executive Lead	Chief Finance Officer	Likelihood	3	2		Risk appetite	Moderate
Initial date of assessment	September 2023	Consequence	4	3		Risk level	Cautious
Last reviewed		Risk Rating	12	6			
Last changed							

Threat	Controls	Sources of Assurance	Gaps in assurance / action to address gaps inc timescales and lead	Assurance rating
6.1 Uncertainty around funding / contracting arrangements and planned levels of clinical income	Process / system by which we develop assumptions regarding funding, i.e. tangible description of Commissioner engagement, horizon scanning, Strategy development Revised business planning process in place which reflects new funding arrangements Robust business planning process to allow clarity and understanding of cost base enabling support for new funding opportunities/requests Clinical coding improvement plan Clinical Coding oversight group Digital investment programme ICS Resource Allocation Group established and CFO a member 23/24 TV 'pace of change' allocation adjustment NHS Standard Contract and guidance Costing information Joint NTHT Contract Contract meetings Contracting working group established across NT and ST	**Management** Chief finance Officer attendance at ICS Finance meetings Regular finance updates taken to Director Team, SLT and CPG highlight key issues and development of Finance Plan Monthly Finance report to Resources Committee highlighting key issues Regular financial planning updates to Resources Committee Contracting guidance Coding update report - ? **Risk and compliance** Finance report to Board highlighting key issues Regular financial planning updates to Board Board approval of financial plan **Independent** NHSE/I independent costing assurance audits 2021/22 block contracts agreed for H1 and H2 periods, under the Covid-19 financial framework. Internal Audit External Audit of accounts and value for money Submission of financial plan to ICB/NHSE ICB resource allocation group	Strategy (planning and contracting round plan) to maximise all alternative funding streams – C Hand – April 24	
6.2 Lack of long term financial plan with ICB	Trust five-year Financial Plan and Strategy based on agreed financial assumptions / modelling. Development of a robust annual financial plan to underpin the longer-term financial plan, triangulated with workforce and activity.	**Management** Chief finance Officer leads development of assumptions and financial models Finance Plan agreed with Directors, SLT and CPG CPG check ins on Directorate plans	Support development of system MTFP including Trust contribution – Chris Hand – June 24	

		Risk and compliance Annual Financial Plan approved by Resources Committee and Board **Independent** Internal Audit sustainability review audit Internal Audit External Audit of accounts and value for money Submission of financial plan to ICB/NHSE ICB MTFP Development group (inc Deloitt support)		
6.3 Insufficient financial capacity and capability and potential loss of grip and control	Increased Finance team and business partnering capacity Service Improvement Office Targeted external support (Kingsgate) Clinically led collaborative leadership LISA financial management OD programme CIP framework Budget setting principles and budgets in place Clinical Strategy and Improvement Group Delivery of 2022/23 control total YTD delivery of 2023/24 plan Day to day budget management processes in place Finance business partners - qualified Policies and procedures for managing financial control 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) Purchasing via procurement frameworks and NHS supply chain Detailed WTE reconciliation (reviewed by national NHSE) Weekly Vacancy Control Panel (CFO, COO, CNO, HRD) Focus on sickness management, recruitment and retention Optimising Rostering and Job Planning Steering Group 1:1 nursing central oversight (Therapeutic Care Team) Agency controls Non pay controls Cash forecast Delivery of budget holder training workshops and enhancements to financial reporting	**Management** Directorate level finance reports National Cost Collection report to Resources Committee National Cost Collection pre submission assurance report September 2023 PLICs plan report to Resources Committee 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 Update SFI/SOs in line with Collaborative Structure agreed by Audit Committee PLICs plan report to Resources Committee Productivity report September 2023 **Risk and compliance** Finance report to Board and Resources Committee monthly including CIP progress IPR report to Board and Committees Provider licence self-assessment Board Development session 15 February 2022 to agree CIP and response to NHSE/I February 2022, March 2022, April 2022, Board reports on 2022/23 financial position and system savings Procurement report to Resources Committee Annual report and accounts Annual Governance Statement Annual accounts Protecting and Expending Elective Capacity – report to Resources Committee and board **Independent assurance**	Development of productivity reporting – Chris Hand – April 24	

		Internal audit External audit NHSE/I monthly finance monitoring Letter of acknowledgement of receipt of plan and ICS management NHS E national team financial review report and consideration by Board and Resources Committee (date) Internal audit of HFMA self assessment report to Resources Committee (date) Going concern and financial controls audit as part of External and Internal audit programme		
6.4 Failure to deliver the required levels of efficiency savings	Agreed Efficiency Programme Service Improvement office (SIO) resource in place to support delivery of relevant workstreams Agreed process for the recording and monitoring of efficiency schemes Directorate / Collaborative identification of CIP schemes and delivery of schemes monitored CIP groups established	**Management** Review Directorate / Collaborative Efficiency Plans as part of annual Financial / Business Planning process. Monitoring delivery of efficiency plans by SIO Collaborative / Director level review of delivery of efficiency plans. Performance Review meetings co-ordinated by the COO **Risk and Compliance** Monthly financial reports reviewed by CIP Group and Resources Committee Integrated Performance Report (IPR) reviewed by Resources Committee and Board of Directors Outcome of Directorate / Collaborative Reviews reported to SLT Regular reports on CIP progress to Resources Committee. **Independent** Annual external audit of Accounts and Value for Money report.	Internal Audit of relevant financial management areas and CIP Programme – N Legg - October 2023	
6.5 System financial deficit and medium term recovery plan impacting on the ability to deliver safe quality care	5 year long term financial model Working capital support through agreed loan arrangements Annual financial plan and budgets, based on available resources and stretching financial improvement targets. Service Improvement Office Close working with ICB partners to identify system-wide planning, transformation and cost reductions Executive oversight of commitments Development of a three-year Service review Programme Capital Oversight Group Full participation in ICB planning	**Management** Forecast sensitivity analysis and underlying financial position reported to Resource Committee EQIAs etc	Trust engaged with system ICB and Deloitte on MTFP planning process through CEO and CFO groups – report out on 6 monthly basis – Chris Hand -	

	MTFA consistency with ICB and partner plans ICB DoFs Group ICB Operational Finance Directors Group ICB Financial Framework			
6.6 Unexpected cost pressures leading to unplanned overspends	Day to day budget management processes in place Finance business partners - qualified Policies and procedures for managing financial control Cash flow forecast Corporate Governance Framework (SFI/SO, Scheme of delegation in place) Vacancy control plan in place Collaborative Chairs meeting Agency and locum sign off process Purchasing via procurement frameworks and NHS supply chain ICS/ICP Director of Finance meeting Joint working with NTHT CIP group in place with agreed governance and reporting structure	**Management** Directorate level and department level finance reporting Budget sign off ICS/ICP updates through Finance report and CEO report to Committees and Board Financial structure update to Resource Committee verbally March 2022 Improve monthly forecast and risk assessments, with activity and workforce information – Resources Committee paper **Risk and compliance** Finance report to Board, Resources Committee Procurement report to Resources Committee **Independent** Going concern and financial controls audit as part of External and Internal audit programme Regional finance returns monthly (H1/H2) Financial risk share agreements agreed for 2021/22. ICB forecast to deliver financial balance in line with plan, with Trust plan delivery on track	Improve system and process for business case development including internal and externally funded cases – Chris Hand - Nyree Legee – February 2024	
6.7 Capital resources are insufficient to meet organisation requirements resulting in loss of operational capacity and inability to meet strategic aims and priorities, impacting on delivery of financial targets	Capital planning group in place (CPOG) Premises assurance model (PAM) undertaken Regular risk assessments and environmental audits Capital Plan agreed Medical Devices Group Fixed Asset register Group C register Business case process in place Estates Directors meeting (ICS)	**Management** Quarterly update to Resources Committee on Capital Sustainability Report to Resources Committee October 2023 Bid for additional capital for sustainability plan – November 2023 agreed by Resources Committee **Risk and compliance** ICS Capital allocation Sustainability presentation to Board November 2023 **Independent assurance**	Best use of capital resources to support clinical delivery and development – process to be identified – P Sturdy - TBC Business case process – include return on investment - link with Nyree Legee - P Sturdy – February 2024 Strategic long term view on capital investment – P Sturdy - TBC Strategic use of the group estate and capital investment - P Sturdy - TBC	
6.9 Failure to advance digital maturity will impact on efficiency, care quality and safety	Digital roadmap for 2021/23 EPR programme board and sub groups in place Individual projects in place for quality & safety such as MIYA, patient track, inphase DATIX cloud and incident management reporting – reviewed monthly	**Management** Business Case for MIYA approved by Board Digital updates to Resource Committee monthly IG update to Resource Committee capital expenditure in relation to digital maturity / delivery of the digital plan report Resources July 2023	Establish process for reviewing business case benefits realisation –Manni Imiavan – TBC	

	Improvement groups aligned to digital programmes Clinical Digital leads – CCIO, Associate CCIO, CNIO, Digital Midwife – including weekly meetings Dital programmes benefits realisation report monthly to Resources Committee and benefits realisation lead appointed IT Business Continuity and Incident Management plans Capital Investment approved and programme of delivery Digital Steering group SIRO Digital leadership meeting in place fortnightly NED appointed with digital skills background Digital Director in place Engagement with external partners (Public Digital and NHS Providers) to continue to develop digital plan and digital governance	**Risk and compliance** 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	Further develop link with safe and effective care leads to ensure review of quality and safety incidents that has implications for digital – Manni Imiavan - TBC Digital plan for 2023-26 to be developed in conjunction with stakeholders – Manni Imiavan – Tbc Review resources of expertise in the digital team / organisation to delivery the digital plan – October 2023 Undertake a self assessment on the NHSE “What good looks like” / digital maturity self assessment and share this with Resources Committee and agree action plan and exception reporting as appropriate – Manni Imiavan – November 2023	
6.10 Disruption to critical clinical and operational systems as a result of failures associated with outdated systems, legacy hardware, unsupported systems, supply chain distribution resulting in operational service disruption, potential harm, financial implications and possible reputational damage	Firewall rebuild Network access control Yearly pen tests Cyber security and education to staff Annual Board level cyber security Replacement of old software with fully supported new software Replacement of legacy devices programme DATIX cloud reporting of incidents IG Toolkit and Audit Cyber security clauses in contracts with suppliers and evidence of this Information Governance Assurance Framework Cyber security programme Major incident plan in place Spam and malware email notification NHS Care Cert	**Management** IG update to Resource Committee capital expenditure in relation to digital maturity / delivery of the digital plan report Resources July 2023 Information Governance report to Resources Committee October 2023 **Risk and compliance** **Independent assurance** DSP Toolkit Audit – Resources October 2023	Older contracts / suppliers do not have cyber statements – Manni Imiavan IG action plan gaps by exception - Manni Imiavan Implement DSP toolkit audit recommendations – Manni Imiavan March 2024 Review resources of expertise in the digital team / organisation to delivery the digital plan – October 2023	
6.11 Failure to prevent a successful cyber attack or data breach which is likely to have a detrimental impact on the organisations ability to deliver operational services.	Information Governance Assurance Framework Cyber security programme Major incident plan in place Spam and malware email notification	**Management** Data Protection and Security Toolkit submission 22/23 Digital update to Resources Committee monthly IG update to Resources Committee **Risk and compliance** Board cyber training 2022 – November 2023 **Independent assurance** Cyber internal audit report – weaknesses identified	PWC data protection audit – Manni Imiavan – October 2023	

		External Audit of data protection and security toolkit		

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 DECEMBER 2023			
Integrated Performance Report			**AGENDA ITEM: 9** **ENC 7**
Report Author and Job Title:	Alison Buck Information Analyst	**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 October IPR, are as follows: **SAFE** domain: No change **EFFECTIVE** domain: No change. **CARING** domain: No change. **EQUITABLE** domain: No change. **RESPONSIVE** domain: 'Not Met, Not Discharged' metric name has changed to 'Ready for Discharge, Not Discharged' to better reflect the underpinning criteria to reside and use of ready for discharge date. No change in the metric calculation: the average daily number of patients that no longer meet the criteria to reside in a hospital bed.		

	WELL LED domain: No change. **Our key messages for October are:** The Trust is now CQC rated Good in all domains: safe, effective, responsive, caring and well led. Trust remains in segment 3, mandated support for significant concerns, due to the historic financial position. For September, A&E 4-hour standard performance was steady and close to the national average. Clear reductions in A&E 12 hour waits and 12 hour delays following a decision to admit are evidenced since the beginning of 2023. Ambulance handovers within 60 mins shows an improving trend too. Challenges within the social care sector continue to be observed with particular delays associated with timely access to domiciliary care. During August, Elective access (RTT 18-week standard) was maintained and keeps performing ahead of the national trend. Extra focus is being given to reducing the number of patients waiting more than 65 weeks for non-urgent elective treatment, in line with national requirements. Total elective growth was slightly behind plan but within that 1st OP appt activity was among the highest in the ICS. Performance against the 6 week diagnostic standard worsened but a planned increase in radiological capacity and access started in September and is helping reduce the long waits. The Trust was compliant with the national target for Cancer 28-day Faster Diagnosis Standard and the Cancer 62-day accumulation has improved over the same period, returning close to the planned recovery trajectory. The Cancer 62 day standard improved in August to 65%, the national average.
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐ (select the relevant assurance level)
Recommendation	Members of the Public Trust Board of Directors are asked to receive the Integrated Performance Report for October 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

October 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:

'Not Met, Not Discharged' metric name has changed to 'Ready for Discharge, Not Discharged' to better reflect the underpinning criteria to reside and use of ready for discharge date. No change in the metric calculation: the average daily number of patients that no longer meet the criteria to reside in a hospital bed.

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 has been updated for 23/24 to reflect the progress we have made and summarises our strategic priorities, the ambition of our clinically-led Collaboratives and the actions we will be focusing on this year.

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	% A&E Type 1 Attendances >12hrs from arrival	Ambulance handovers 30-60 mins	Ambulance handovers 60+ mins	RTT - 18 week standard	52+ week waits	65+ week waits	78+ week waits	104+ week waits	RTT total Waiting List	OPFU - YTD growth 23/24 v 19/20	1st OP - YTD growth 23/24 v 19/20	Total elective - YTD growth 23/24 v 19/20	Diagnostic activity 23/24 v 19/20	Diagnostic 6 week waits	Cancer 62 day - GP referral	Cancer 62 day backlog	Cancer treatments	Cancer 28 day FD
Data period	Sep-23	Sep-23	Sep-23	Sep-23	Sep-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Aug-23	Sep-23	Aug-23	Aug-23
Target	95%	Zero				92%	23/24 Plan	23/24 Plan	Zero by Mar 23	Zero by Jun 22	23/24 Plan	<=75%	109%	109%	120%	<=1%	85%	23/24 Plan		75%
South Tees Hospitals NHSFT	69.1%	18	1.5%	392	150	63.6%	1,949	518	24	0	53,828	106%	107%	105%	91%	30.7%	64.9%	159	308	75.4%
NENC ICS Provider level *(including IS providers)*	77.0%	585	4.5%	1,931	509	70.0%	9,190	2,097	194	17	409,331	104%	102%	108%	114%	18.7%	64.7%	1,232	1,766	78.4%
North East & Yorkshire	72.9%		6.0%			64.5%										23.3%	64.1%			75.0%
National	71.6%		9.6%			58.0%										27.5%	62.8%			71.6%

The Trust is now CQC rated Good in all domains: safe, effective, responsive, caring and well led. Trust remains in segment 3, mandated support for significant concerns, due to the historic financial position. For September, A&E 4-hour standard performance was steady and close to the national average. Clear reductions in A&E 12 hour waits and 12 hour delays following a decision to admit are evidenced since the beginning of 2023. Ambulance handovers within 60 mins shows an improving trend too. Challenges within the social care sector continue to be observed with particular delays associated with timely access to domiciliary care. During August, Elective access (RTT 18-week standard) was maintained and keeps performing ahead of the national trend. Extra focus is being given to reducing the number of patients waiting more than 65 weeks for non-urgent elective treatment, in line with national requirements. Total elective growth was slightly behind plan but within that 1st OP appt activity was among the highest in the ICS. Performance against the 6 week diagnostic standard worsened but a planned increase in radiological capacity and access started in September and is helping reduce the long waits. The Trust was compliant with the national target for Cancer 28-day Faster Diagnosis Standard and the Cancer 62-day accumulation has improved over the same period, returning close to the planned recovery trajectory. The Cancer 62 day standard improved in August to 65%, the national average.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
DATIX Incidents	2398	2070	Oct 2023		
Serious Incidents	7	9	Oct 2023		
Never Events (YTD)	1	0	Oct 2023	N/A	N/A
Falls	160		Oct 2023		N/A
Falls Rate %	4.4	6.6	Oct 2023		
Falls With Harm	4		Oct 2023		N/A
Falls With Harm Rate %	0.1		Oct 2023		N/A

Incidents

There have been consistently high levels of incident reporting within the Trust for a sustained period. The trajectory was updated to indicate our aim to at least maintain this level of reporting for the 12 months leading up to PSIRF implementation. The trust will review again when PSIRF and LFPSE (Learning from Patient Safety Events) is fully implemented. The number of Serious Incidents reported remains low and within expected limits. There have been no Never Events reported in October. 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

Falls and falls with harm reported across the trust remain within expected range. We continue to remain inside the trust control limits. All fall information submitted via Datix is reviewed daily. Serious incidents are followed up and reports are signed off by the trust fall strategic lead. Our focus is to improve patient experience and work towards preventing falls. Following the extensive quality improvement project, we now have a detailed fall prevention plan. The plan focuses on enhanced patient care, environmental safety, organisational preparedness, engagement with patients, families and carers, organisational responsiveness and engagement and training for staff. We are currently recruiting a falls education coordinator which will help implement the plan, alongside, nursing, AHP and medical colleagues.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
No. of babies born	413		Oct 2023	N/A	N/A
Breast feeding initiated (48 hrs)	61.5%	74.5%	Oct 2023		F
Preterm birth rate <26+6 wks	0.5%	6%	Oct 2023		P
Preterm birth rate 27 - 36+6 wks	7.8%	6%	Oct 2023		?
Induction of Labour (%)	38.7%	44%	Oct 2023		?
Number of 3rd/4th degree tear (%)	1.4%	3.5%	Oct 2023		P
PPH > 1500ml (%)	2.83%	2%	Oct 2023	H	?
Still Births (YTD)	2	17	Oct 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 is cross checked with other similar units via national maternity dashboard and we are following the national average.

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. Our new vulnerabilities team also enhance our public health work.

There is no national or regional target set for the Induction of labour (IOL) and therefore this is a Trust indicative standard. Mechanical induction has been launched and will be evaluated.

Harm as indicated by 3rd/4th degree tears during childbirth is consistently better than the expected standard. These are monitored via 3rd/4th degree audit database.

Post-partum Haemorrhage (PPH) rates fluctuate. All cases are reviewed to ensure guidelines are followed; PPH is in the annual MDT obstetric emergency/simulation training. The Trust PPH rate is in line with national average as seen within the national maternity dashboard. The Trust will be participating in the Obs UK PPH Prevention Study commencing early 2024.

Perinatal Quality Surveillance Model: We reported no serious incidents in October. We reported two baby deaths to the Perinatal Mortality Tool and these cases will be reviewed in full by an MDT team. There were 3 moderate harm incidents. Duty of candour has been completed and all cases have been through the rapid review process. We have achieved 90% training compliance requirements in Quarter 2.

All maternity standards are reviewed monthly by the Maternity Services and reported to Quality Assurance Committee and NENC LMNS.

SAFE

Metric	Latest Month	Target	Month	Trend	Assurance
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	2.5		Oct 2023		N/A
Category 2 Pressure Ulcers (Community)	52		Oct 2023	H	N/A
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)	0.1		Oct 2023		N/A
Category 3&4 Pressure Ulcers (Community)	30		Oct 2023	H	N/A
Medication Incidents	125		Oct 2023		N/A
Medications Reconciled Rate %	31%	80%	Oct 2023	L	F
Omitted Critical Doses (%)	3.8%		Oct 2023	H	N/A
C-Difficile (YTD)	82	63	Oct 2023	N/A	N/A
MRSA (YTD)	0	0	Oct 2023	N/A	N/A
E-Coli (YTD)	66	79	Oct 2023	N/A	N/A
Klebsiella (YTD)	34	28	Oct 2023	N/A	N/A
Pseudomonas (YTD)	13	7	Oct 2023	N/A	N/A

Pressure Ulcers

The rate of hospital-acquired pressures ulcers remains within expected variation throughout the organisation. The PURPOSE T tool and SSKIN assessment are live in all inpatient hospital wards. There are plans to go live in Surgical Admission Units across both sites, followed by Theatre and recovery areas. The Emergency department and same day emergency care (SDEC) department for those patients with a decision to admit will be planned in the future. The risk assessment is embedded into practice and the frequency of completion has been increased to 24 hours for those patients stratified to the green pathway. Education and training continues in clinical areas. Focus has been targeted on completion of the risk assessment tool to comply with NICE guideline and the CQUIN target. The review of pressure ulcer investigations is on-going and pending the first phase of PSIRF roll out. A pilot of pressure ulcer safety huddles has commenced that includes multi-professional reviews at the time of pressure ulcer reporting for new or deteriorating category 2 PU identified on wards. Incidence of community pressure ulcers reporting is being reviewed to report PUs per 1000 in relation to caseload.

Medications

Medication incidents reported in October were within expected variation. Omitted doses remains a key area of focus with the highest areas of non-compliance being reviewed and actions plans produced for local areas. Medicines reconciliation data has now been validated although due to changes in the methodology, the denominator (number of admissions within 24 hours) is higher via this method than the manual data collection producing a lower % in 24 hours. An action plan is being produced to improve this within the 5 day service.

Healthcare acquired infections

There were no new MRSA reported in October. C. difficile cases were higher than anticipated in October but reduced compared to same time last year. IPC precautions for isolating patients with C. difficile continue to be prioritised, followed by additional cleaning with Hydrogen Peroxide vapour across all sites. Structured case reviews are timely, providing assurance that appropriate measures are in place aligning robust with collaborative action plans. Gram negative organisms continue to rise with the Pseudomonas relating to a previous outbreak. Increased focus relating to ANTT (Aseptic Non-Touch Technique) remains a priority along with Antimicrobial Stewardship alignment. Additional to this there is a collaborative regional approach moving forward relating to gram negative organisms.

EFFECTIVE

Metric	Latest Month	Target	Month	Trend	Assurance
Readmission Rate %	6.1%		Aug 2023		N/A
Sepsis - Oxygen delivered within 1hr	98.3%	95%	Sep 2023		
Sepsis - Blood cultures within 1hr	71.2%	95%	Sep 2023		
Sepsis - Empiric IV antibiotics within 1hr	72.9%	95%	Sep 2023		
Sepsis - Serum lactate within 1hr	72.9%	95%	Sep 2023		
Sepsis - IV fluid resuscitation within 1hr	69.5%	95%	Sep 2023		
Sepsis - Urine measurement within 1hr	100%	95%	Sep 2023		
Summary Hospital-Level Mortality Indicator	110	100	Jun 2023		
Comorbidity Coding	4.8		Jul 2023		N/A

Readmission rates

The emergency readmission rate remains within current expected variation.

Sepsis

Urine output and oxygen delivery remain above target levels.

Actions:

- AIM course extended to incorporate core sepsis training alongside the sepsis course.
- Recommendations made re role specific mandatory training.
- The Sepsis antimicrobial guidance is awaiting final amendment. To meet with PR to relaunch campaign.
- AIP courses advertised for 2024. Met with trust videographer (13/11/23) to create pre course videos .
- Meeting regarding embedding national blood culture pathway practice.
- Digital Paediatric sepsis tool completed - achieved >90% compliance in training.
- Further audit breakdown to incorporate proposed new high-risk criteria.
- NICE guidance has opened for national consultation. Guidance reviewed by key members of the AIP team and comments returned. Likely to be published January 2024.

Mortality

SHMI of 110 for the latest official reporting period, July 2022 to June 2023, is 'as expected'. The data processing anomaly with the volume of spells used to calculate SHMI November 2022 remains in the data but has not recurred.

Currently 3.5% of spells in England are removed because they have a COVID code and spells included in SHMI are at 89% of pre-pandemic levels (both broadly stable).

Reports to the Trust's governance committees show that Medical Examiner (ME) 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 (%)	80.6%	78%	Oct 2023		
Inpatient Experience (%)	97.7%	94%	Oct 2023		
Maternity Experience (%)	90.8%	92%	Oct 2023		
Outpatient Experience (%)	96.8%	93%	Oct 2023		
Community Experience (%)	99.3%	94%	Oct 2023		
New Complaints	21		Oct 2023		N/A
Closed Within Target (%)	44.4%	80%	Oct 2023		

Patient experience

Emergency Department Friends & Family Test remains above target since January and continues to be monitored locally. The Inpatient Friends & Family Test score has been stable for several months and continues to perform better than target. Following the pilot in Ward 3, whereby the FFT question was given to all patients as opposed to the longer inpatient survey there was a fifty percent increase in the response rate. Therefore, the plan is to implement the FFT question in all inpatient areas to increase the response rate to the FFT. The detailed patient surveys will be used for a closer review, where the FFT score falls below target.

The Friends & Family Test score reported in Outpatients and Community services consistently perform above target. To increase the response rate in the community discussions are underway and a pilot is planned to increase the response rate to the FFT.

The Maternity Friends & Family Test score reflects feedback captured in the Antenatal, Birth and Postnatal surveys. The percentage positive response has increased slightly, however, remains just below 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. Maternity services continues to send FFT question to all women, separate to the longer surveys and continues to show an improvement in the FFT response rate.

Closed within target

The timeframe for complaints closed in target remains below target. Complaint timeframes continue to be a priority and the actions commenced in April 2023 continue. A rapid review of the complaints process commenced in July 2023, is in process and following the sessions held in July, August, September and October, follow up meetings are in place with key stakeholders, to discuss the ongoing management plans for complaints in the Collaboratives. This work is overseen by the Patient Experience Steering Group.

Learning from complaints

Aspects of clinical care continues to be the main theme coming from upheld complaints. Learning and themes from complaints are systematically shared with clinical colleagues.

EQUITABLE

Elective inpatient PTL Inequalities: Deprivation

Latest PTL by IMD quintile

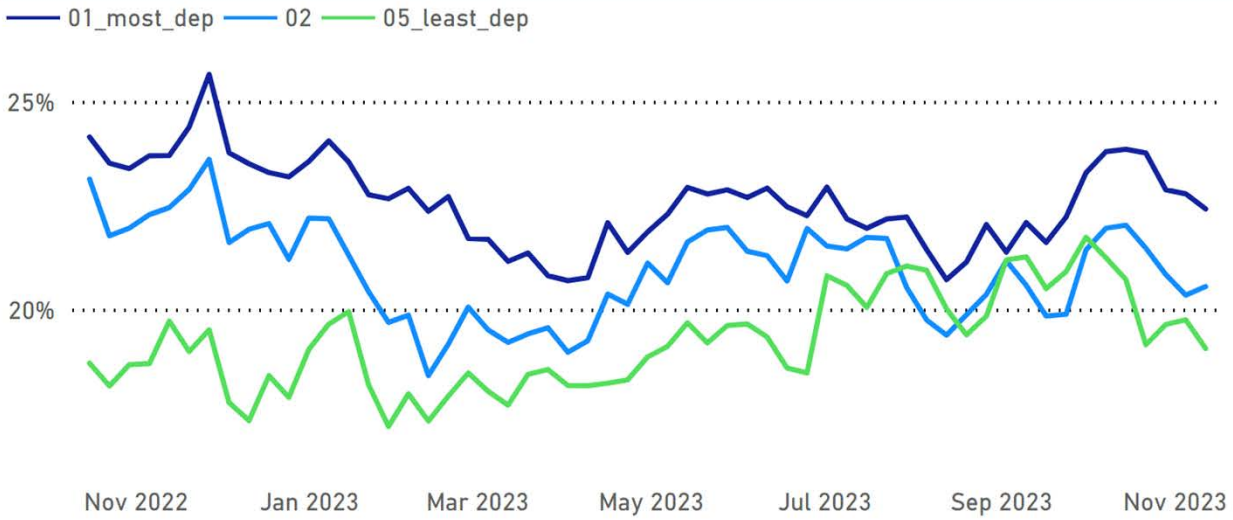
IMD quintile	In Standard	Long waits	% of total	Total
01_most_dep	2014	582	22%	2596
02	1187	307	21%	1494
03	1243	282	18%	1525
04	1768	440	20%	2208
05_least_dep	1291	304	19%	1595
N/k	869	126	13%	995
Total	**8372**	**2041**	**20%**	**10413**

IMD is taken from patient's postcode of residence

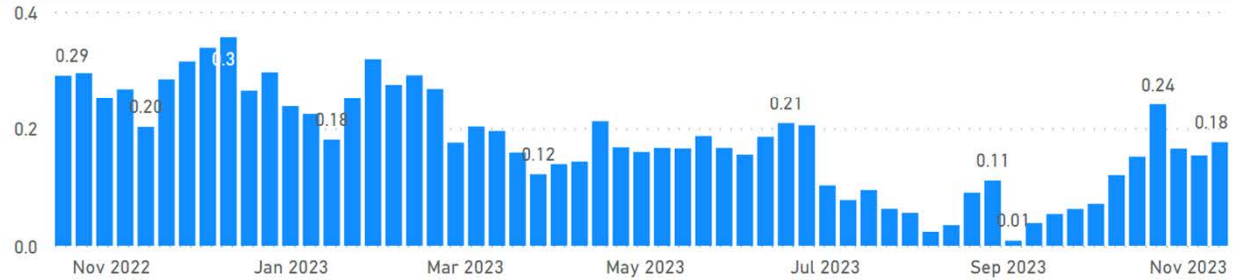
Long Waiters:
P2 › 3 weeks
P3 › 3 months
Any › 52 weeks

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**	**6429**	**1662**	**21%**	**8091**
⊞ **b-Southern Asian**	**144**	**38**	**21%**	**182**
⊟ **c-Other & Mixed**	**149**	**53**	**26%**	**202**
Black	30	8	21%	38
Mixed	33	8	20%	41
Other	86	37	30%	123
⊞ **N/k**	**1650**	**288**	**15%**	**1938**
Total	**8372**	**2041**	**20%**	**10413**

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	10989	10832	Oct 2023		
A&E Attendances - Type 3	5344	5428	Oct 2023		
Handovers - Within 30 Mins (%)	78.3%	95%	Oct 2023		
Handovers - Within 60 Mins (%)	90.2%	100%	Oct 2023		
4-Hour A&E Standard	64%	76%	Oct 2023		
12-Hour Waits from Decision to Admit	44	0	Oct 2023		
12-Hour A&E Breaches	321	0	Oct 2023		
RTT Incomplete Pathways (%)	63.7%	92%	Sep 2023		
RTT Waiting List Size	53310	49239	Sep 2023		
RTT Validated Within 12 Weeks (%)	61.1%	90%	Oct 2023		
RTT List Size within 52 weeks (%)	96.5%		Sep 2023		N/A
RTT 52 week waiters	1878	1074	Sep 2023		
RTT 65 week waiters	509	202	Sep 2023		
RTT 78 week waiters	42		Sep 2023		N/A
Diagnostic 6 Weeks Standard (%)	74.7%	99%	Sep 2023		
Cancer 14 Day Standard (%)	66.6%	93%	Sep 2023		
Cancer 31 Day Standard (%)	91.7%	96%	Sep 2023		
Cancer 62 Day Standard (%)	56%	85%	Sep 2023		
Cancer >62 Day Backlog	141	145	Oct 2023		
Cancer Faster Diagnosis Standard (%)	72%	75%	Sep 2023		
Cancelled Ops - Non-Urgent Cancelled on Day	63	0	Oct 2023		

Urgent and emergency care

The impact of challenges across the social care system continue to be observed , which in turn has an impact on hospital flow and urgent and emergency 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.

The volume of A&E attendances in October tracked expected numbers across all departments. There has been significant reduction since March for numbers of patients experiencing 12 hour waits in A&E, returning to 2021/22 levels. However longer delays in A&E rose for October, in parallel with a 7% increase in non-elective admissions in perhaps the first signs of winter pressure. 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. An external peer review of our Emergency Department and patient flow processes is underway to support with a fresh perspective.

Elective, diagnostic and cancer waiting times

Referral to treatment within 18 weeks trend is consistent at 64% and remains above the national average. There is continued focus on the longest waits - reducing the number of patients waiting more than 65 weeks by March 2024 in line with national requirements.

Compliance with the 6-week diagnostic access standard received a boost during September as extra MRI capacity opened as planned in addition to improvements in nearly all other diagnostics. Planned extra capacity for Ultrasound has started from mid-October.

For cancer, Faster Diagnosis Standard registered just below the 75% national target at 72% but has previously been performing better than target. The 62 day accumulation of patients being investigated for cancer reduced further to 141 at the end of October, below trajectory.

The 62 day to 1st treatment standard dipped as the longest waiters continue to have treatment prioritised. Gynae Oncology, Head & Neck and Urology were the main pathways under pressure.

Cancer Action Plans are reviewed and monitored through the Cancer Delivery Group, informed by a programme of pathway process reviews.

RESPONSIVE

Metric	Latest Month	Plan	Month	Trend	Assurance
Outpatient First Attendances	19479	20906	Oct 2023		
Outpatient Follow Up Attendances	49162	52460	Oct 2023		
Day Case admissions	6353	7250	Oct 2023		
Ordinary Elective admissions	1055	1260	Oct 2023		N/A
NEL admissions with 0 LOS (excluding Maternity)	1922	1764	Oct 2023		
NEL admissions with 0 LOS	3431	2012	Oct 2023		
NEL admissions with 1+ LOS (excluding Maternity)	3432	2772	Oct 2023		
NEL admissions with 1+ LOS	3948	3602	Oct 2023		
G&A Occupied Beds (%)	92.7%	92%	Oct 2023		
Length of Stay - Elective	3.6		Oct 2023		N/A
Length of Stay - Non-Elective (excluding Maternity)	3.2		Oct 2023		N/A
Ready For Discharge, not Discharged	75	90	Oct 2023		
21 Day Stranded Patients (%)	11.5%	12%	Oct 2023		

Activity

Total outpatient activity was 6% lower than planned levels in October. Despite this, year to date first appointments are almost 2% above 19/20 levels with follow up appointments on plan. Within follow up appointments, attendances that include delivery of treatment are 28% more than planned for year to date with ordinary review appointments 10% lower than expected.

Inpatient elective admissions (Day Case and Ordinary) were also lower than plan however non-elective (NEL) same day and overnight admissions registered significantly over plan, with patients staying for 1 or more nights 24% higher than expected. This is the highest monthly number of overnight NEL patients in the last 2 years and the first signs of increasing winter demand. This rise combined with industrial action continues to impact on elective activities as shown in non-achievement of plan for Outpatient new and elective activity.

Length of Stay

Despite increasing non-elective demand, related metrics indicative of patient flow all maintained relatively healthy positions.

The Trust maintained the numbers of patients who are ready for discharge but no longer meet criteria to reside in an acute bed, at their lowest levels for the last 2 years. The Trust proactively reduces delays within its span of control and has embedded a Home First service. However, there are ongoing pressures across the social care sector that impact timely discharge of patients who have ongoing care and support needs.

Non-elective length of stay (excluding maternity) was consistently high during 2022/23 at around 5 days and since April, it has been improving, registering at 3.2 days for October. G&A average bed occupancy did rise beyond target but only slightly and there was still a reduction in the proportion of patients admitted for 21 days or more to under the 12% target

The overall 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)	-£18.162m	-£18.176m	Oct 2023	N/A	N/A
Annual Appraisal (%)	78.1%	80%	Oct 2023		
Mandatory Training (%)	89.1%	90%	Oct 2023		
Sickness Absence (%)	5.8%	4%	Oct 2023		
Staff Turnover (%)	11.1%	10%	Oct 2023		

Finance and use of resources

The Trust's plan for the 2023/24 financial year is an agreed deficit of £31.8m, reflecting the organisation's structural deficit (including the impact of 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 ICS system plan for 2023/24.

At the end of Month 7, the Trust's financial position is a deficit of £18.16m which is line with the year-to-date plan.

People

Sickness absence across the Trust was 5.8% October, continuing an increasing trend since June with both long term sickness and short-term sickness rising slightly. The Wellbeing and Attendance team are monitoring the long-term cases, supported by their HR colleagues to prioritise any hot spot areas and working with managers to support.

Appraisal compliance was just below the 80% target at 78% for the second consecutive month. Similarly, mandatory training compliance was just under target and positively, staff turnover continued to trend lower and make progress towards target.

Collaboratives provided an update for their 2022 Staff Survey action plans at People Committee on 25th October 2023. Plans include actions supporting retention.

The 2023 NHS Staff Survey is ongoing with a fieldwork period up to 24th November 2023. The Trust response rate was 29.7% at 10th November 2023. A weekly prize draw has taken place for staff that complete the survey and wish to participate in the prize draw and prizes have been given to 3 staff each week.

HR teams continue to support Trust service improvement events, reviewing team and workforce requirements. Further workforce planning data templates will soon be shared with Collaboratives.

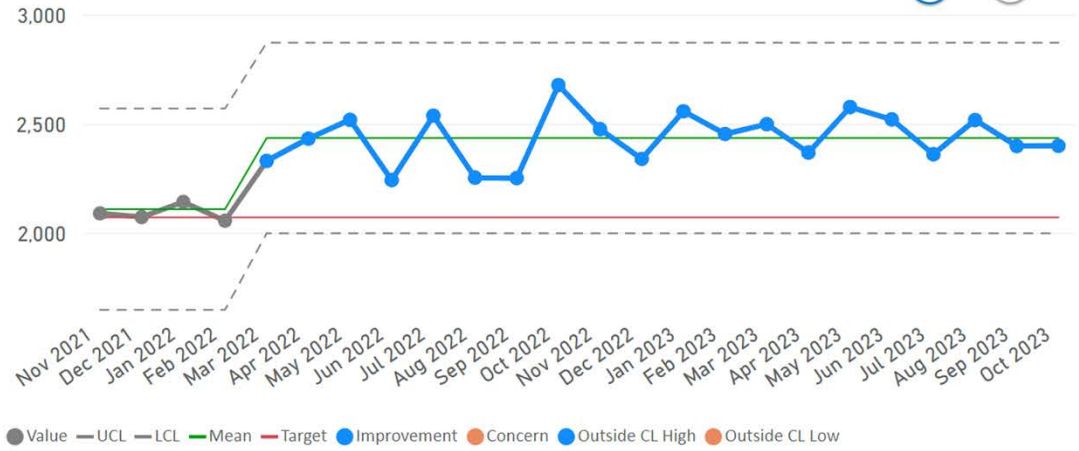
APPENDICES

SPC charts for the metrics summarised above, by domain.

SAFE

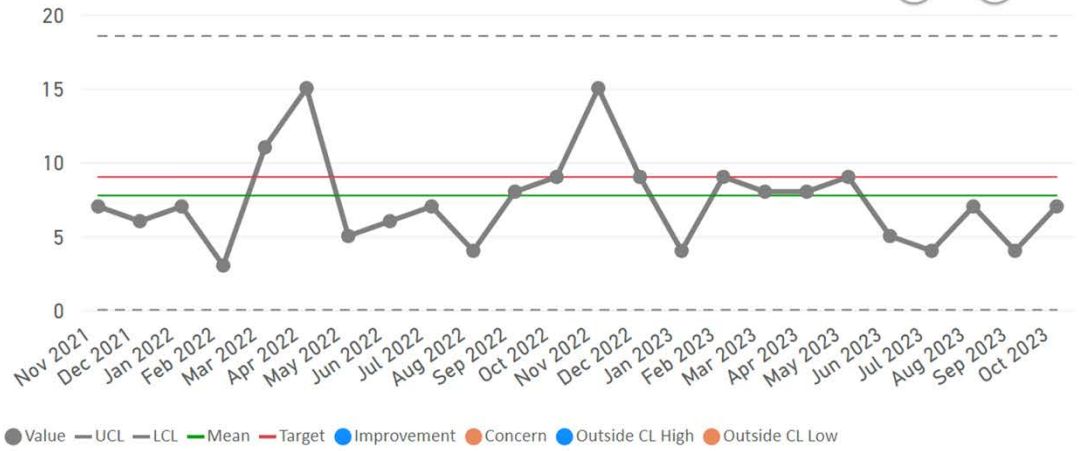
DATIX Incidents

Month	Performance	Target	Trend	Assurance
Oct 2023	2398	2070		



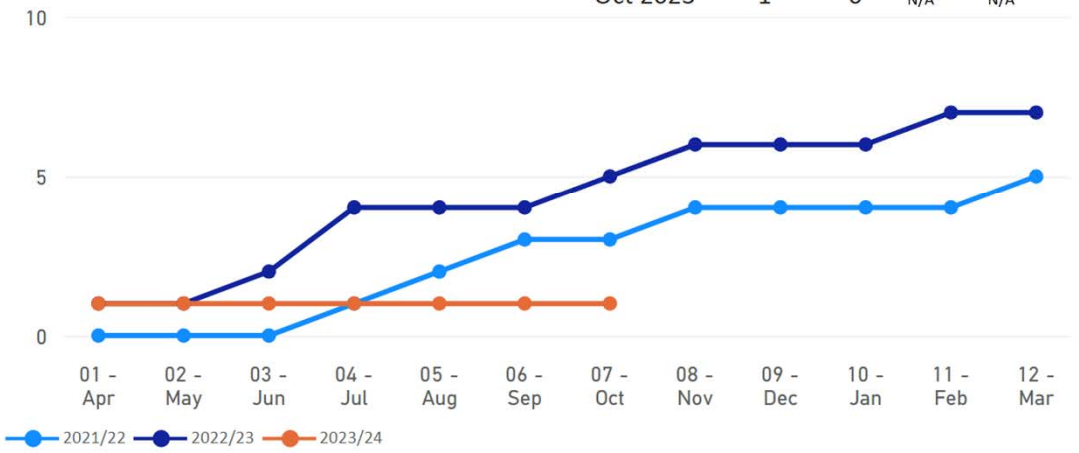
Serious Incidents

Month	Performance	Target	Trend	Assurance
Oct 2023	7	9		



Never Events (YTD)

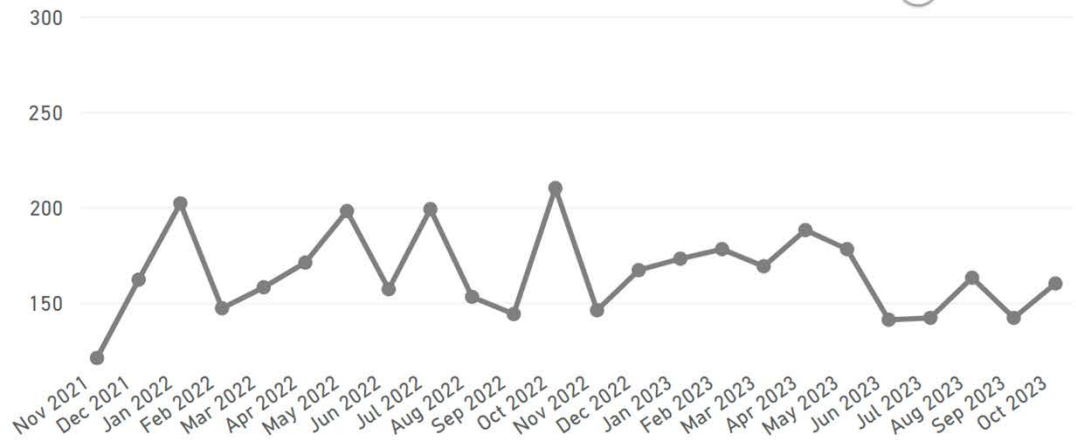
Month	Performance	Target	Trend	Assurance
Oct 2023	1	0	N/A	N/A



SAFE

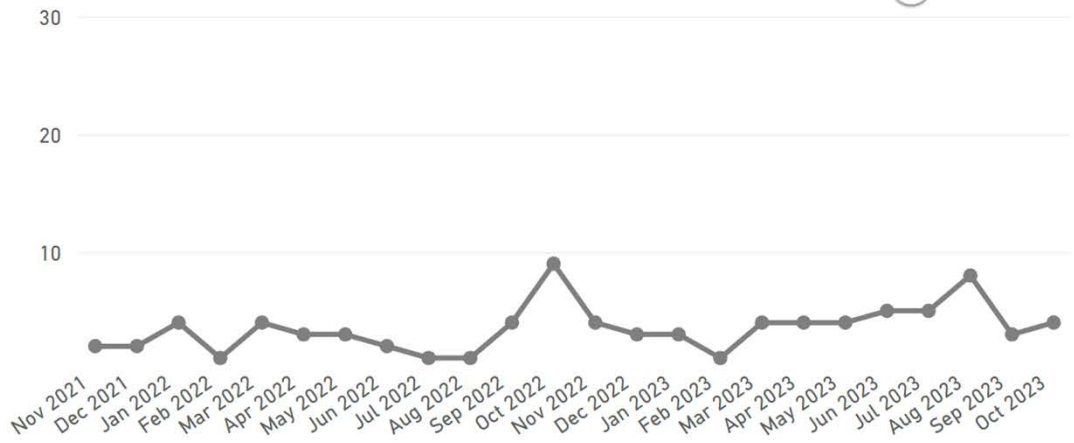
Falls

Month	Performance	Target	Trend	Assurance
Oct 2023	160			N/A



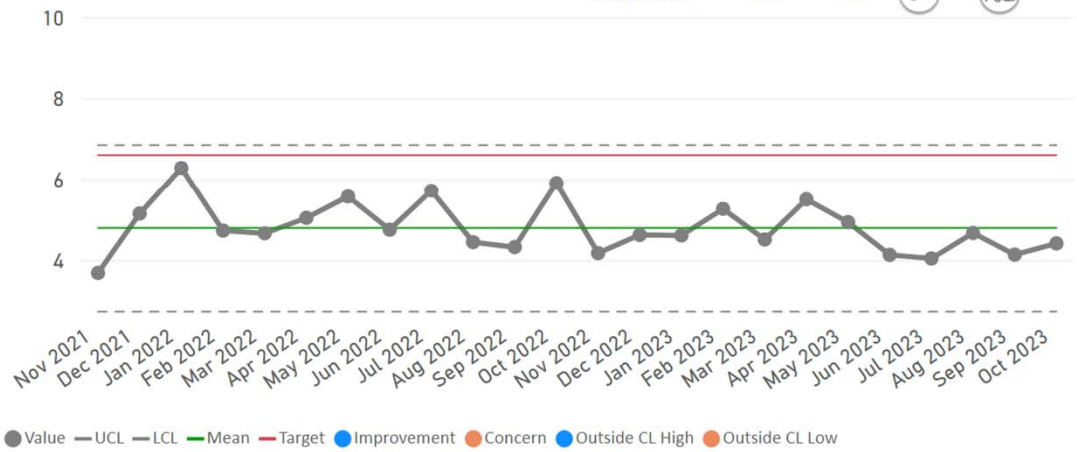
Falls With Harm

Month	Performance	Target	Trend	Assurance
Oct 2023	4			N/A



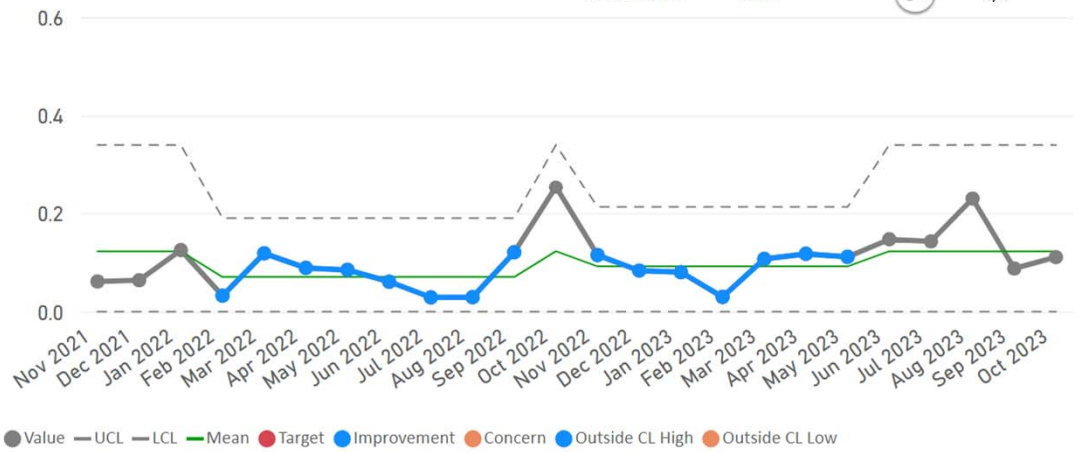
Falls Rate %

Month	Performance	Target	Trend	Assurance
Oct 2023	4.4	6.6		



Falls With Harm Rate %

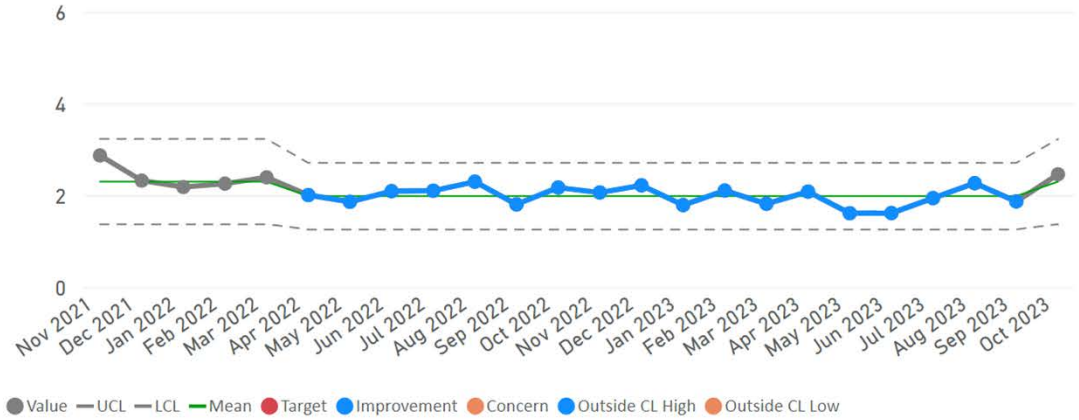
Month	Performance	Target	Trend	Assurance
Oct 2023	0.1			N/A



SAFE

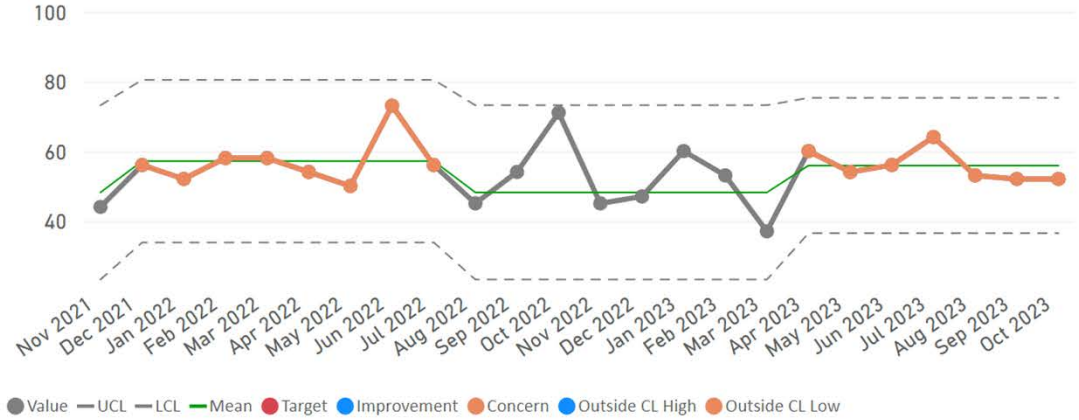
Category 2 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Oct 2023	2.5			N/A



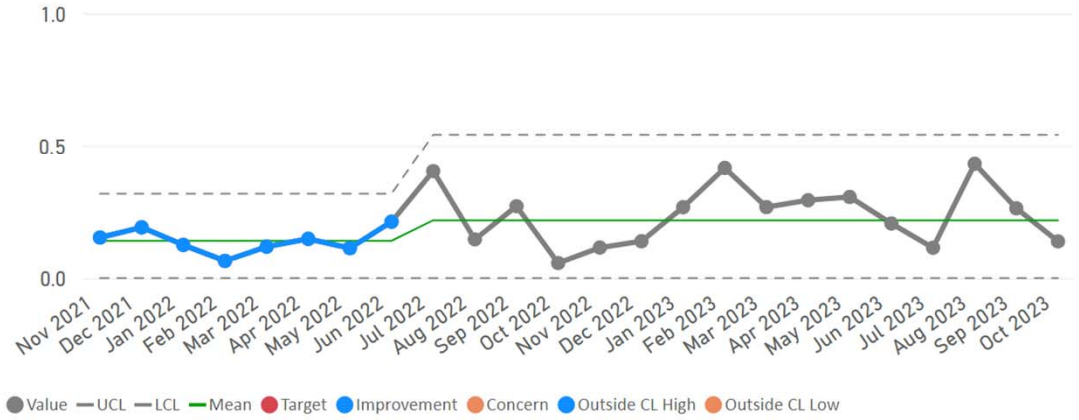
Category 2 Pressure Ulcers (Community)

Month	Performance	Target	Trend	Assurance
Oct 2023	52			N/A



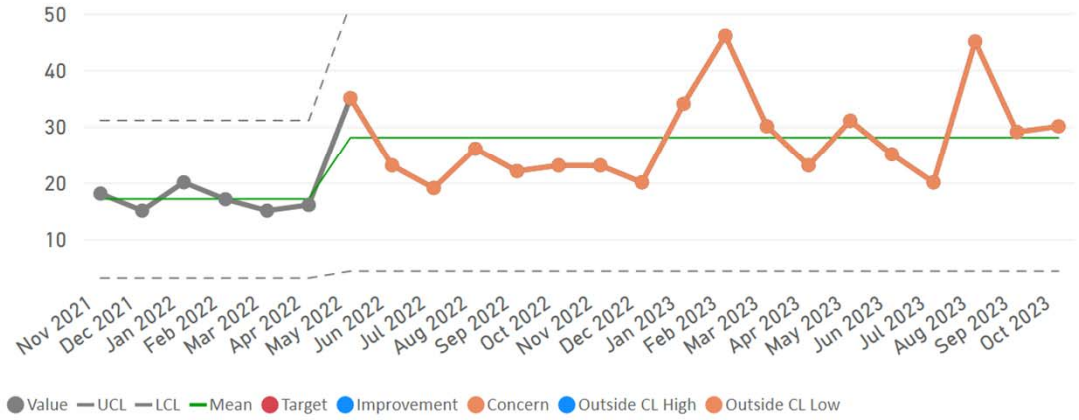
Category 3&4 Pressure Ulcers Inpatient Rate (Per 1000 Bed Days)

Month	Performance	Target	Trend	Assurance
Oct 2023	0.1			N/A



Category 3&4 Pressure Ulcers (Community)

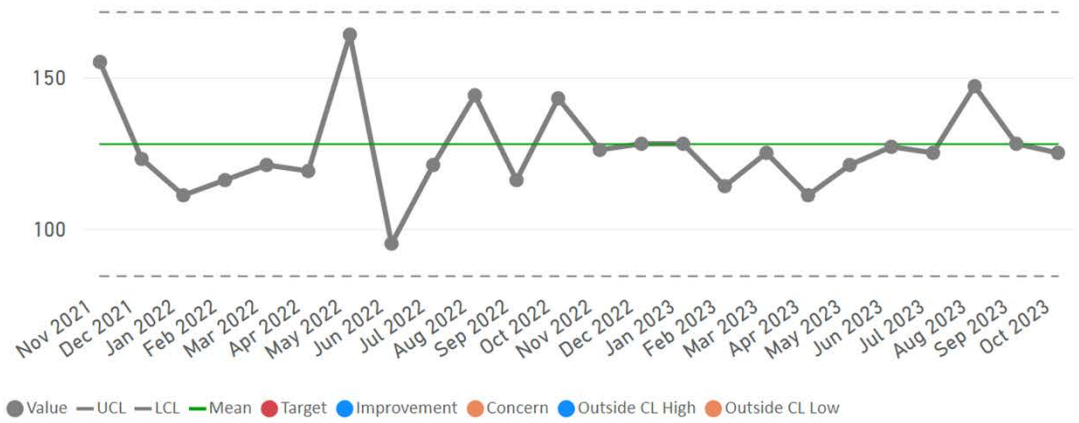
Month	Performance	Target	Trend	Assurance
Oct 2023	30			N/A



SAFE

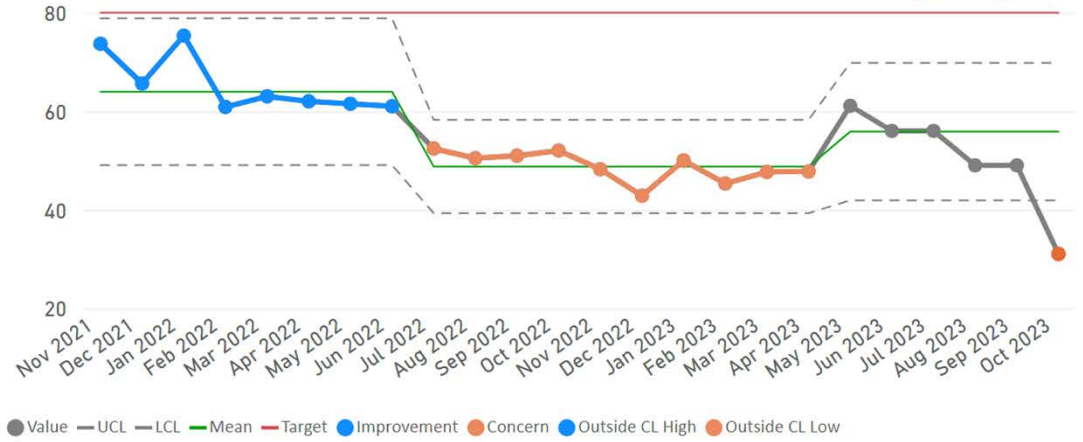
Medication Incidents

Month	Performance	Target	Trend	Assurance
Oct 2023	125			N/A



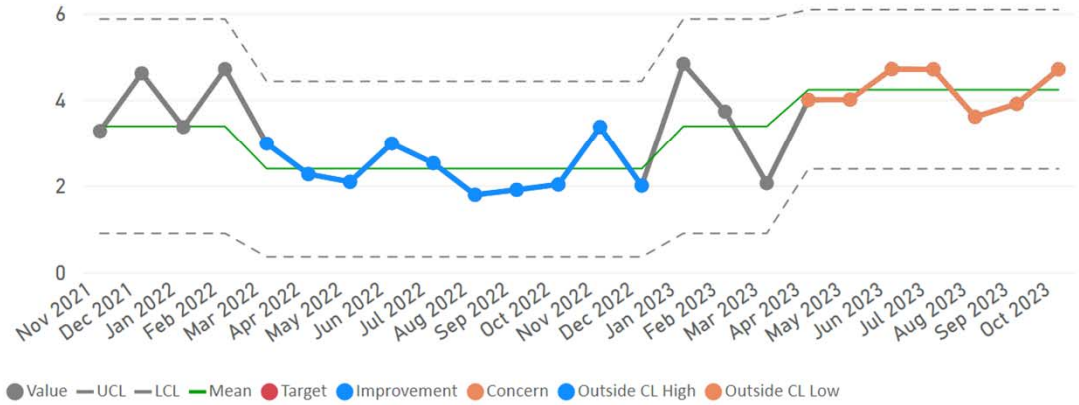
Medications Reconciled Rate %

Month	Performance	Target	Trend	Assurance
Oct 2023	31%	80%		



Omitted Critical Doses (%)

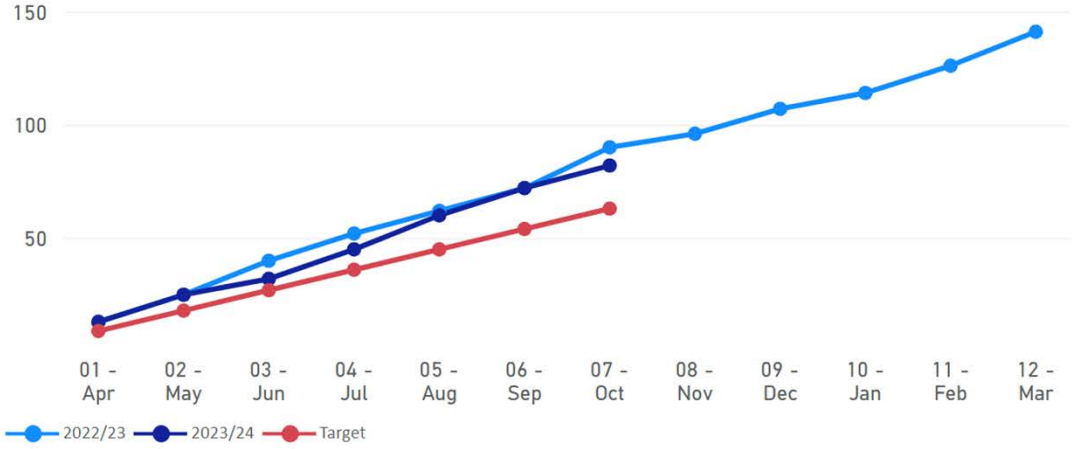
Month	Performance	Target	Trend	Assurance
Oct 2023	4.7%			N/A



SAFE

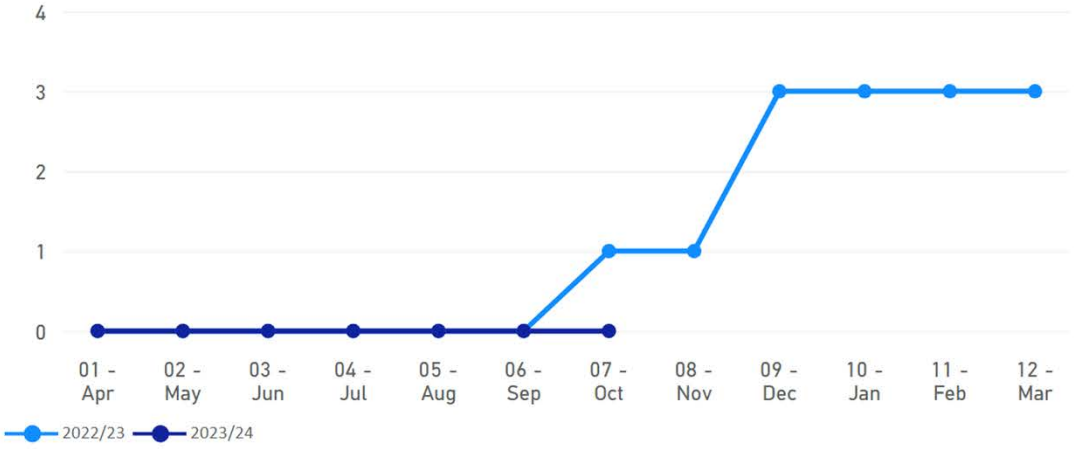
C-Difficile (YTD)

Month	Performance	Target	Trend	Assurance
Oct 2023	82	63	N/A	N/A



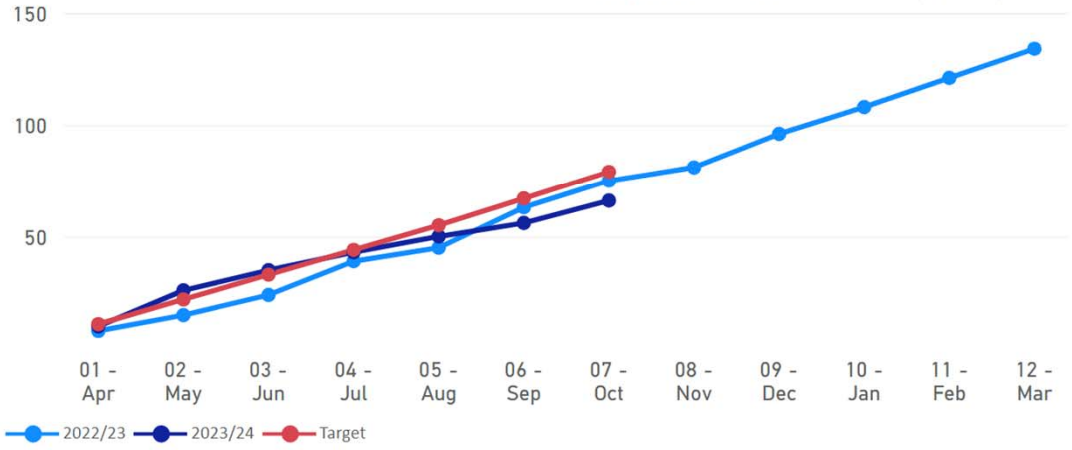
MRSA (YTD)

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



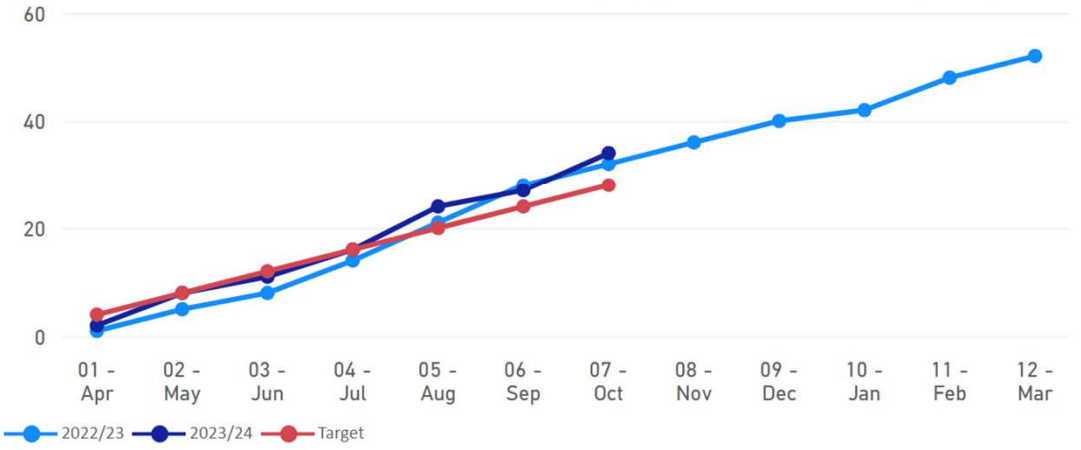
E-Coli (YTD)

Month	Performance	Target	Trend	Assurance
Oct 2023	66	79	N/A	N/A



Klebsiella (YTD)

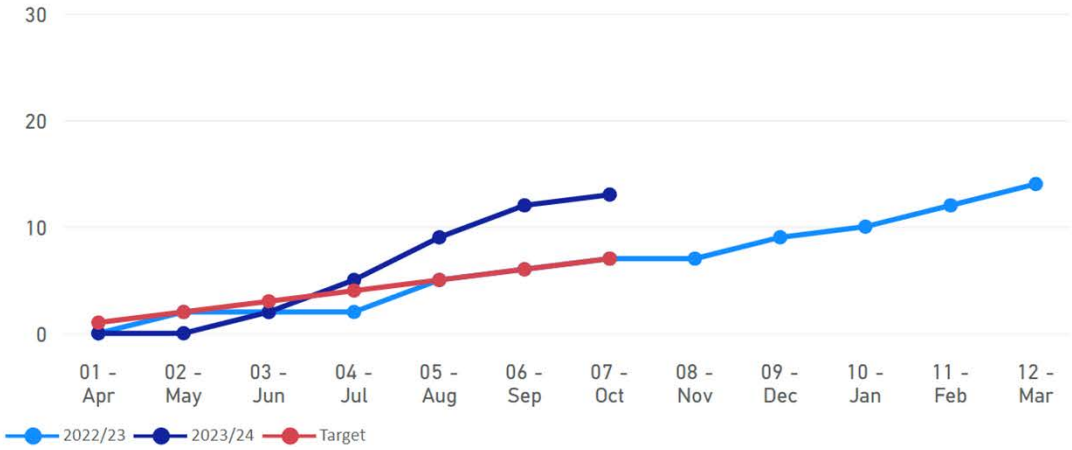
Month	Performance	Target	Trend	Assurance
Oct 2023	34	28	N/A	N/A



SAFE

Pseudomonas (YTD)

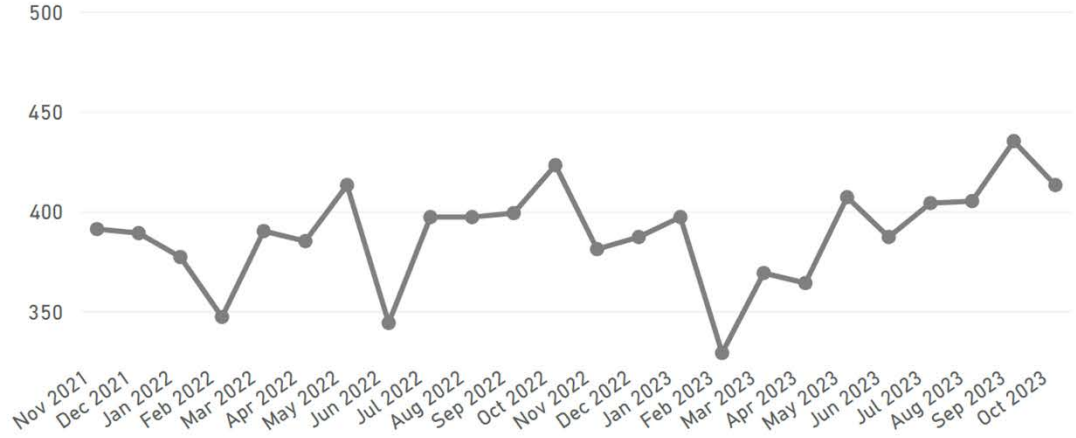
Month	Performance	Target	Trend	Assurance
Oct 2023	13	7	N/A	N/A



SAFE

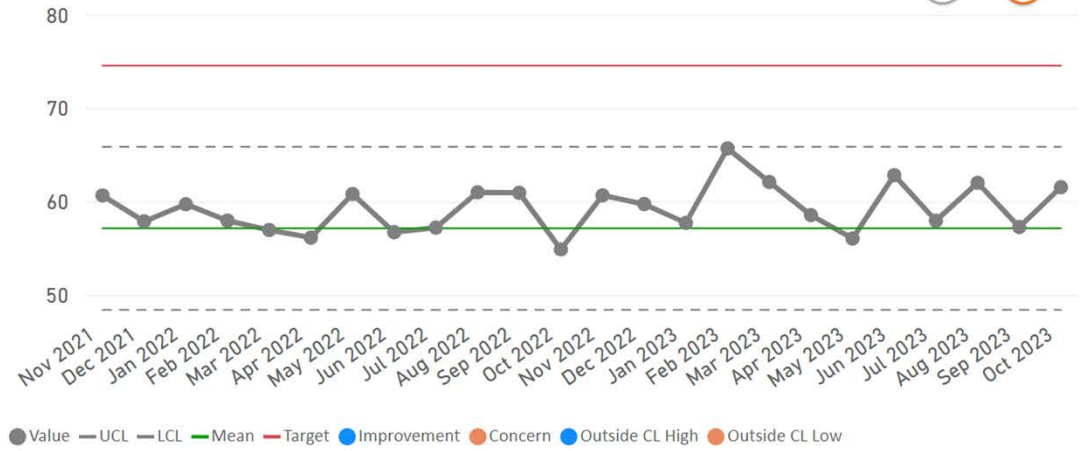
No. of babies born

Month	Performance	Target	Trend	Assurance
Oct 2023	413		N/A	N/A



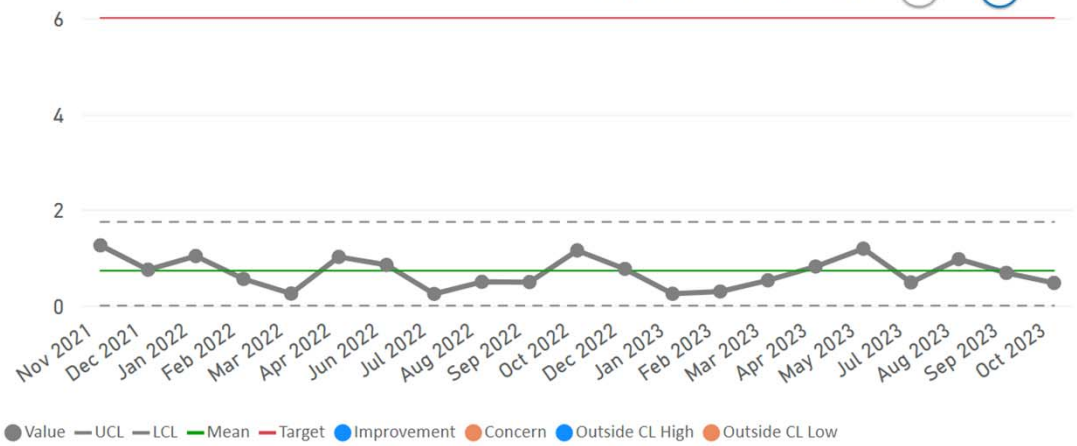
Breast feeding initiated (48 hrs)

Month	Performance	Target	Trend	Assurance
Oct 2023	61.5%	74.5%		



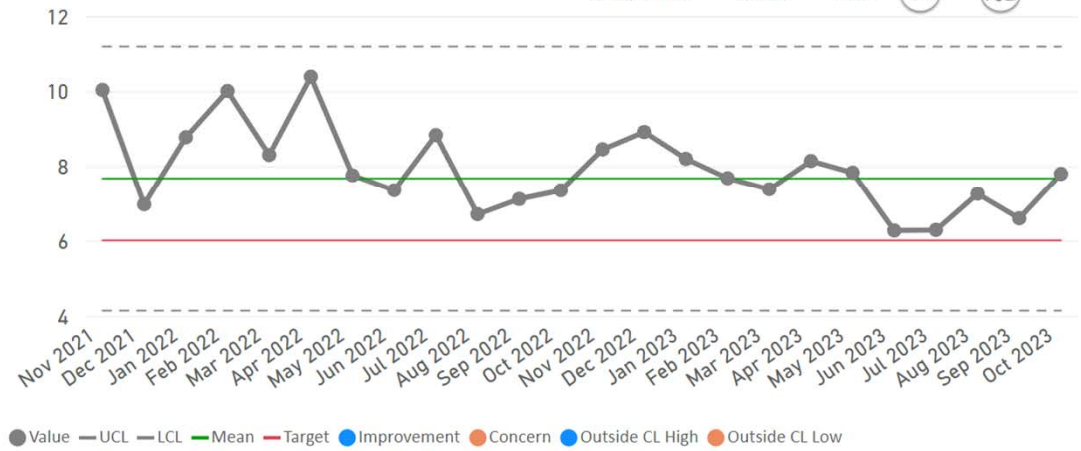
Preterm birth rate <26+6 wks

Month	Performance	Target	Trend	Assurance
Oct 2023	0.5%	6%		



Preterm birth rate 27 - 36+6 wks

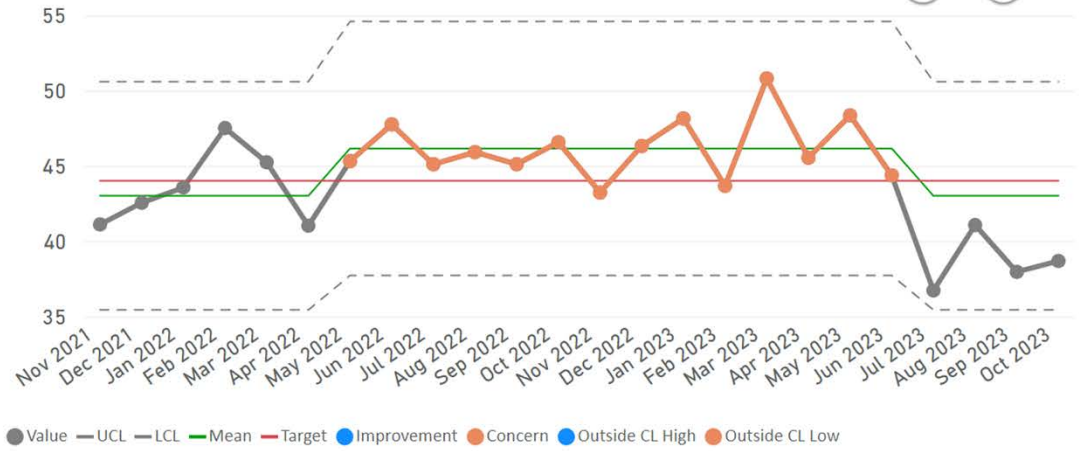
Month	Performance	Target	Trend	Assurance
Oct 2023	7.8%	6%		



SAFE

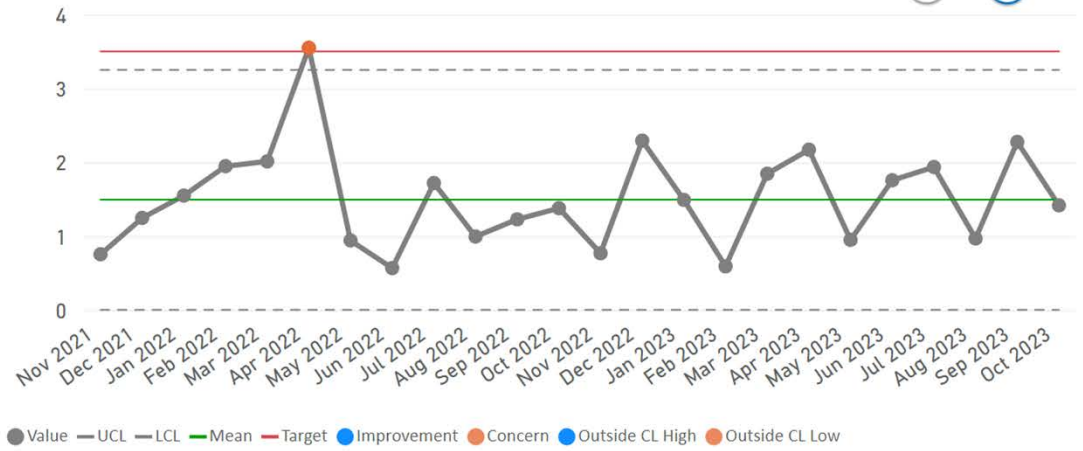
Induction of Labour (%)

Month	Performance	Target	Trend	Assurance
Oct 2023	38.7%	44%		



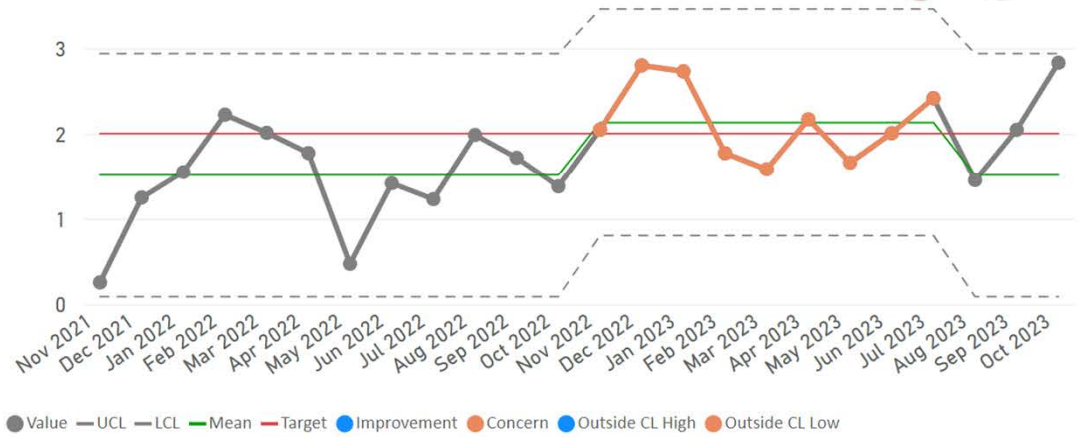
Number of 3rd/4th degree tear (%)

Month	Performance	Target	Trend	Assurance
Oct 2023	1.4%	3.5%		



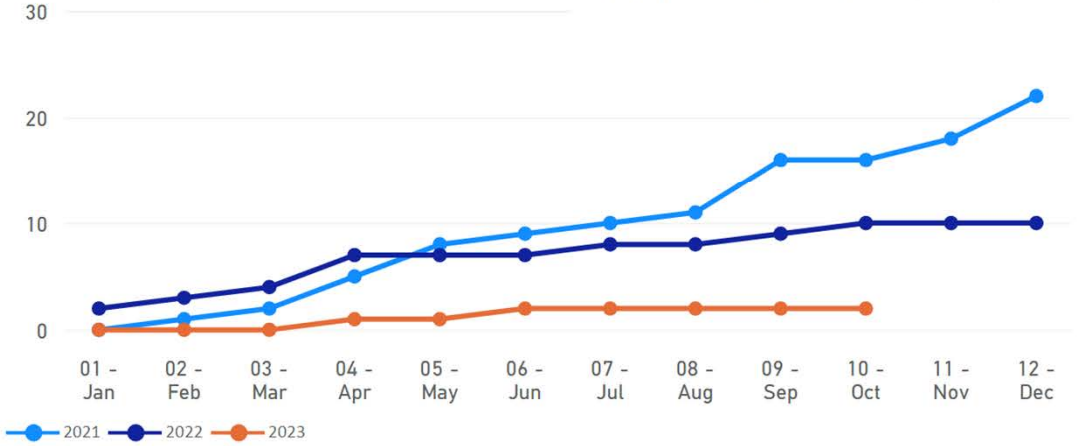
PPH > 1500ml (%)

Month	Performance	Target	Trend	Assurance
Oct 2023	2.83%	2%		



Still Births (YTD)

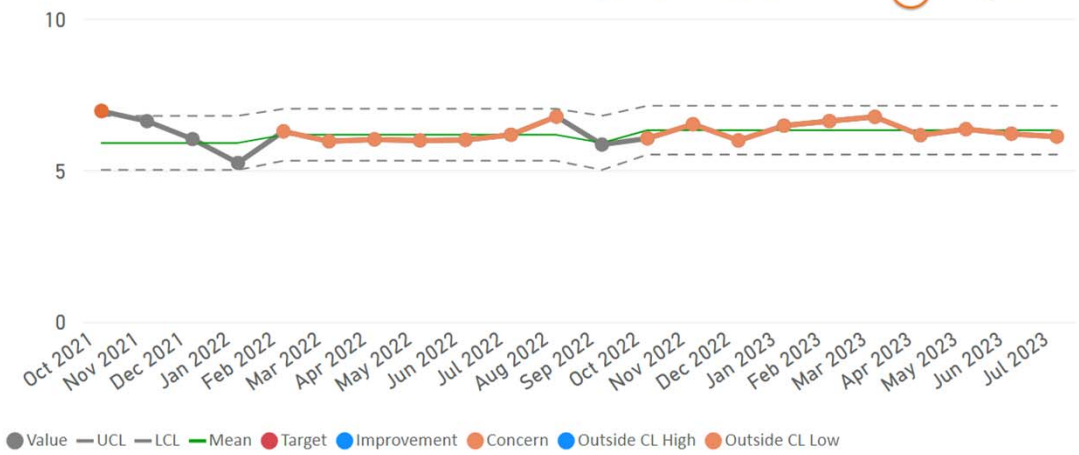
Month	Performance	Target	Trend	Assurance
Oct 2023	2	17	N/A	N/A



EFFECTIVE

Readmission Rate %

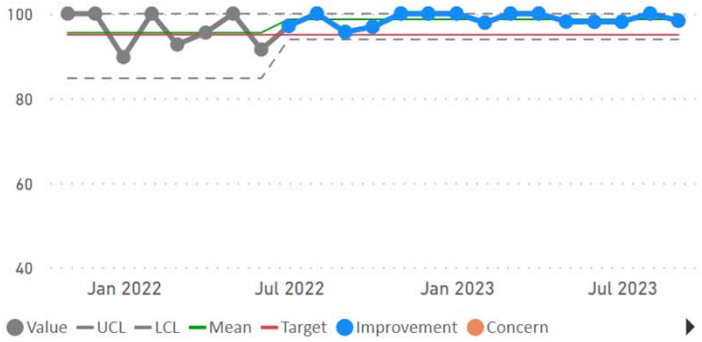
Month	Performance	Target	Trend	Assurance
Jul 2023	6.1%			N/A



EFFECTIVE

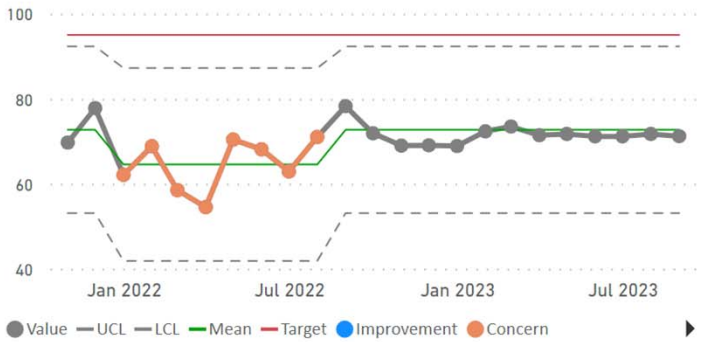
Sepsis - Oxygen within 1hr

Month	Performance	Target	Trend	Assurance
Sep 2023	98.3%	95%	H	?



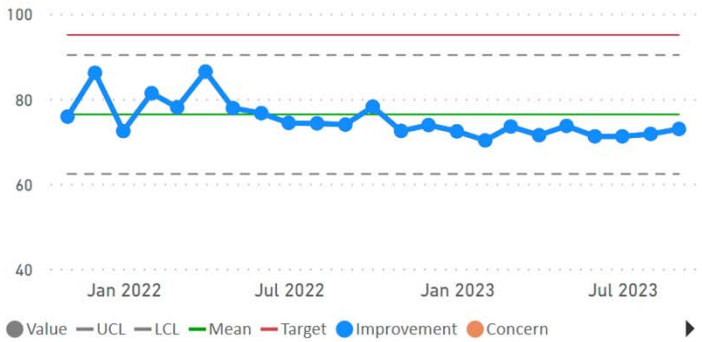
Sepsis - Blood cultures within 1hr

Month	Performance	Target	Trend	Assurance
Sep 2023	71.2%	95%	~	F



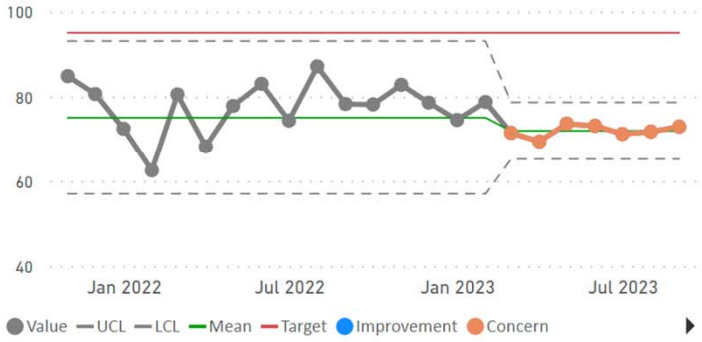
Sepsis - IV antibiotics within 1hr

Month	Performance	Target	Trend	Assurance
Sep 2023	72.9%	95%	H	F



Sepsis - Serum lactate within 1hr

Month	Performance	Target	Trend	Assurance
Sep 2023	72.9%	95%	L	F

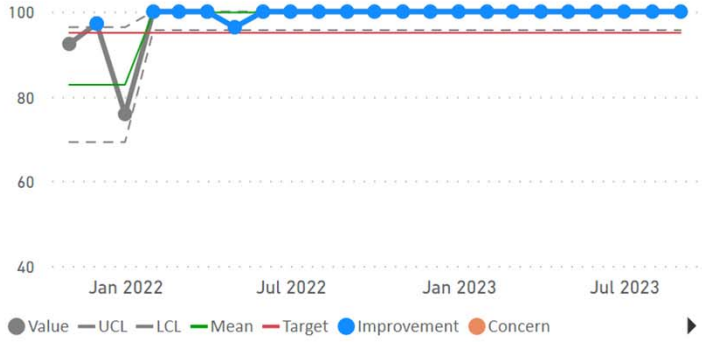


IV fluid resuscitation within 1hr

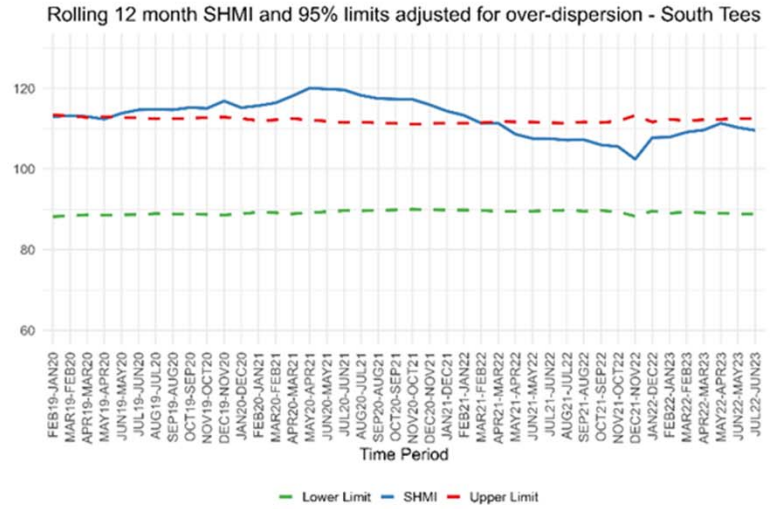
Month	Performance	Target	Trend	Assurance
Sep 2023	69.5%	95%	H	F

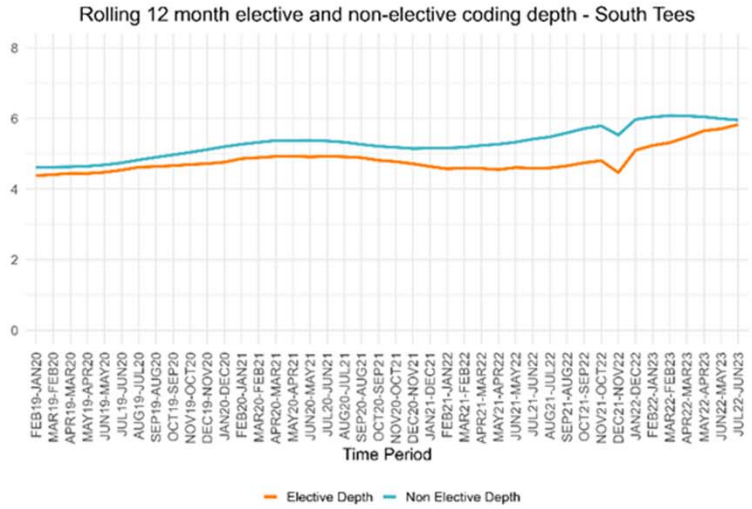
Sepsis - Urine measurement within 1hr

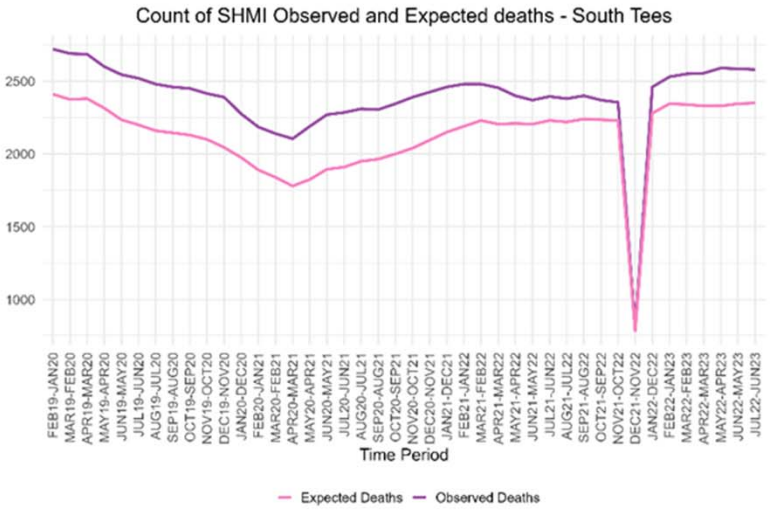
Month	Performance	Target	Trend	Assurance
Sep 2023	100%	95%	H	P

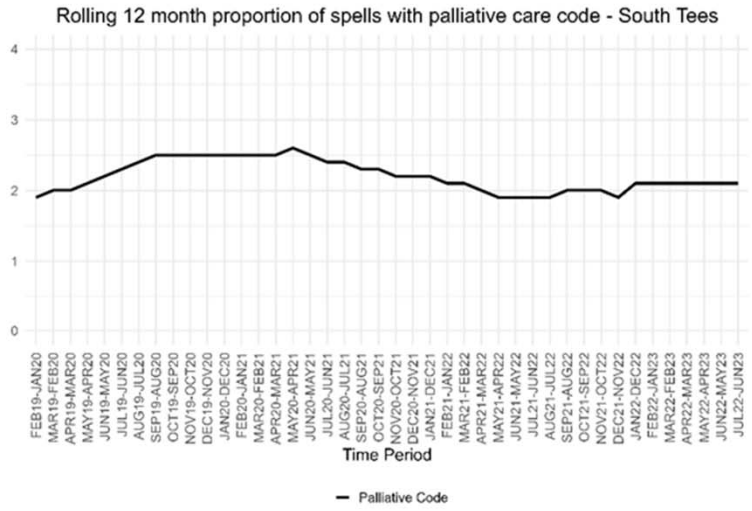


EFFECTIVE









Latest SHMI = 109.6
(July 2022 – June 2023)

Observed deaths = 2580
Expected deaths = 2350

Coding depth (codes / spell)
Elective = 5.8
Non-Elective = 6.0

Palliative care (%) = 2.1

Latest SHMI is:
'as expected'

COVID-19 impact for England
Excluded spells = 3.5%
Spells as a % pre-pandemic (2019 spells) = 89%

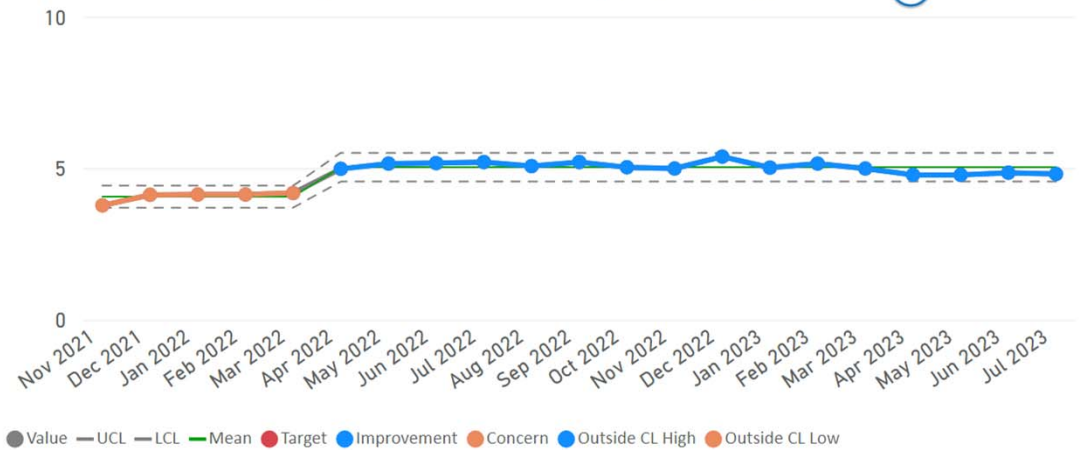
Data source: NHS Digital
Monthly SHMI publication

* The Trust data is as reported by NHS Digital, there was a shortfall in the number of records for 2022/23 in one of the reporting periods which was the reason for the recent fall and rise in the number of observed and expected deaths.

EFFECTIVE

Comorbidity Coding

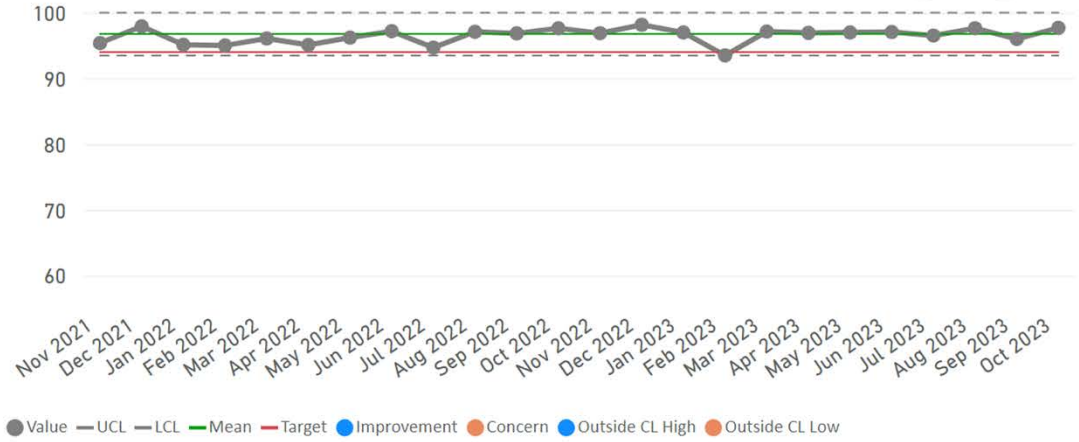
Month	Performance	Target	Trend	Assurance
Jul 2023	4.8			N/A



CARING

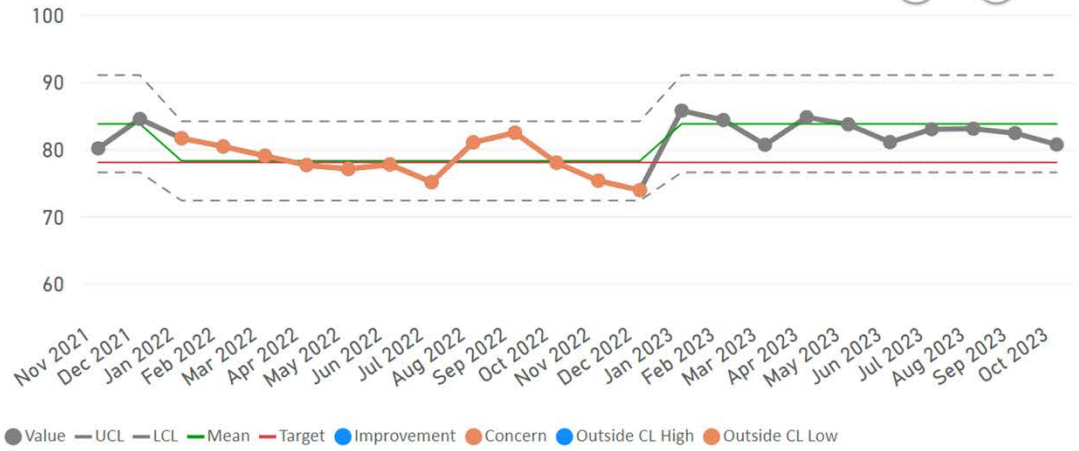
Inpatient Experience (%)

Month	Performance	Target	Trend	Assurance
Oct 2023	97.7%	94%		



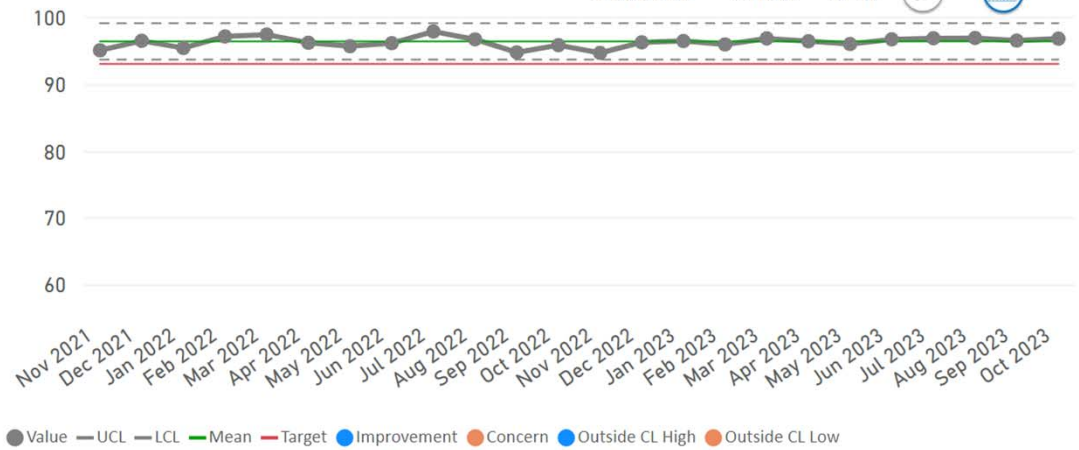
A&E Experience (%)

Month	Performance	Target	Trend	Assurance
Oct 2023	80.6%	78%		



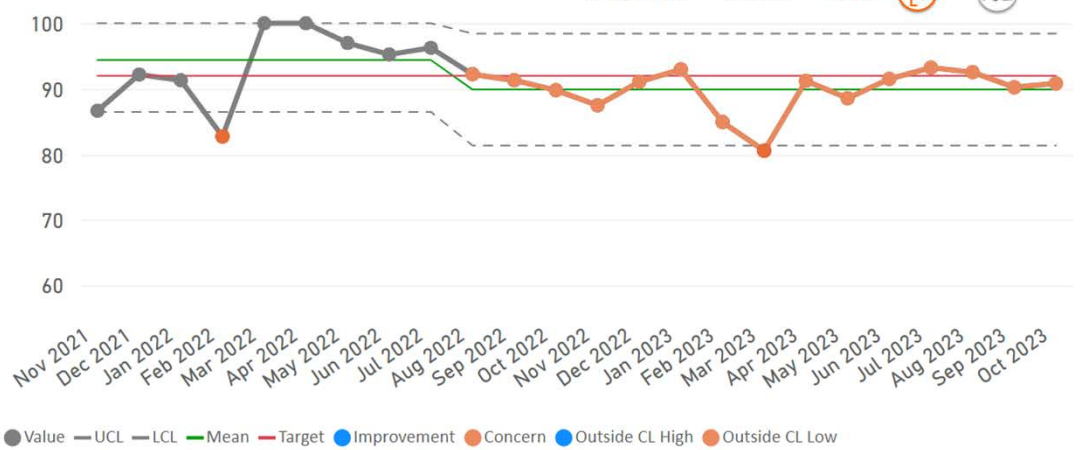
Outpatient Experience (%)

Month	Performance	Target	Trend	Assurance
Oct 2023	96.8%	93%		



Maternity Experience (%)

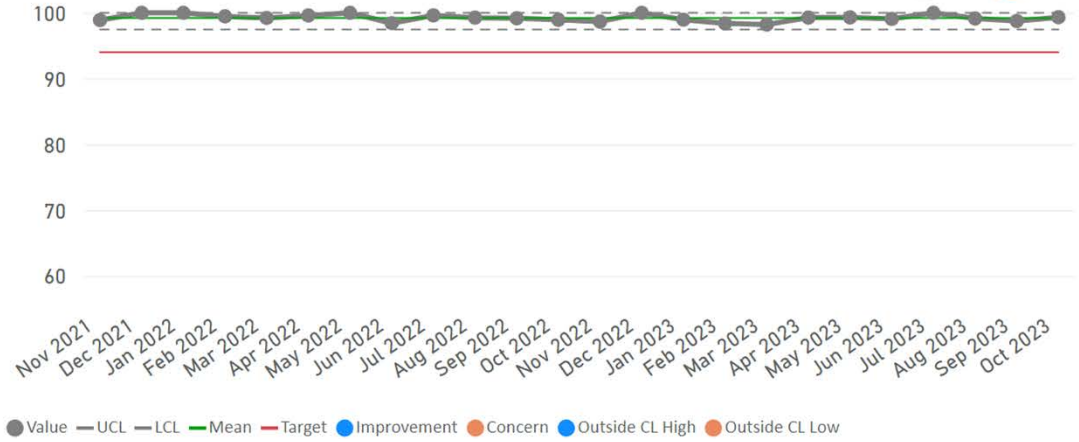
Month	Performance	Target	Trend	Assurance
Oct 2023	90.8%	92%		



CARING

Community Experience (%)

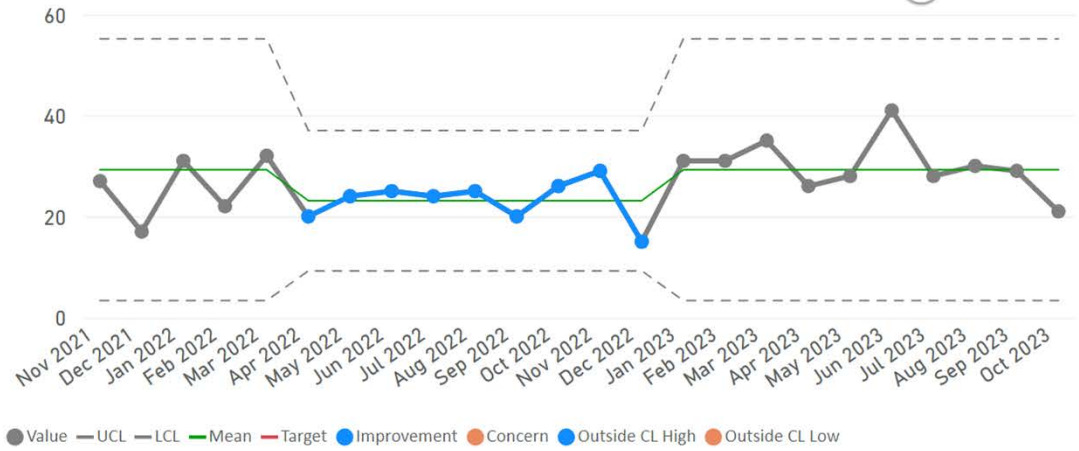
Month	Performance	Target	Trend	Assurance
Oct 2023	99.3%	94%		



CARING

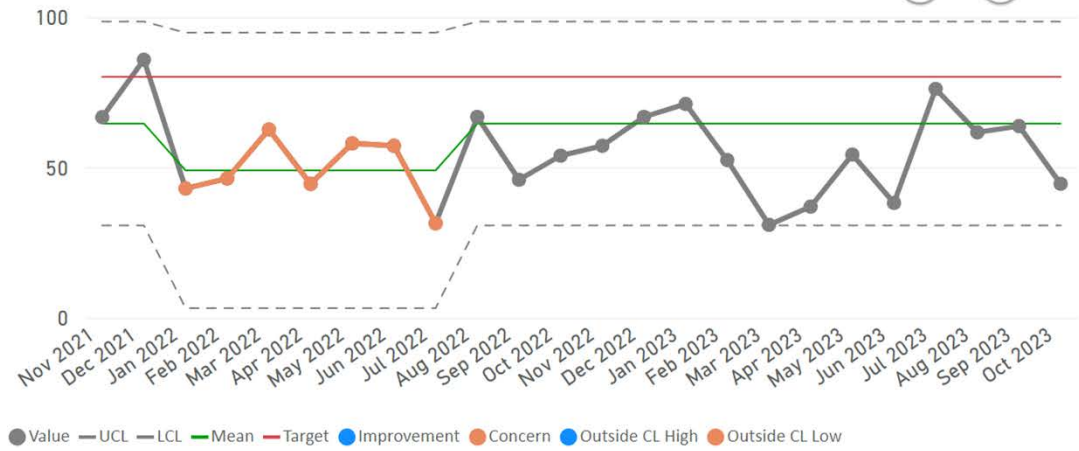
New Complaints

Month	Performance	Target	Trend	Assurance
Oct 2023	21			N/A



Closed Within Target (%)

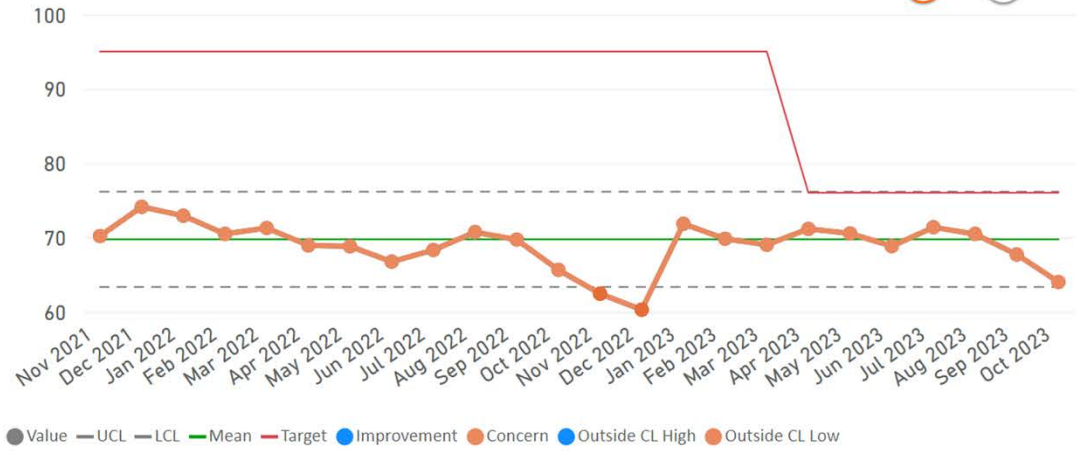
Month	Performance	Target	Trend	Assurance
Oct 2023	44.4%	80%		



RESPONSIVE

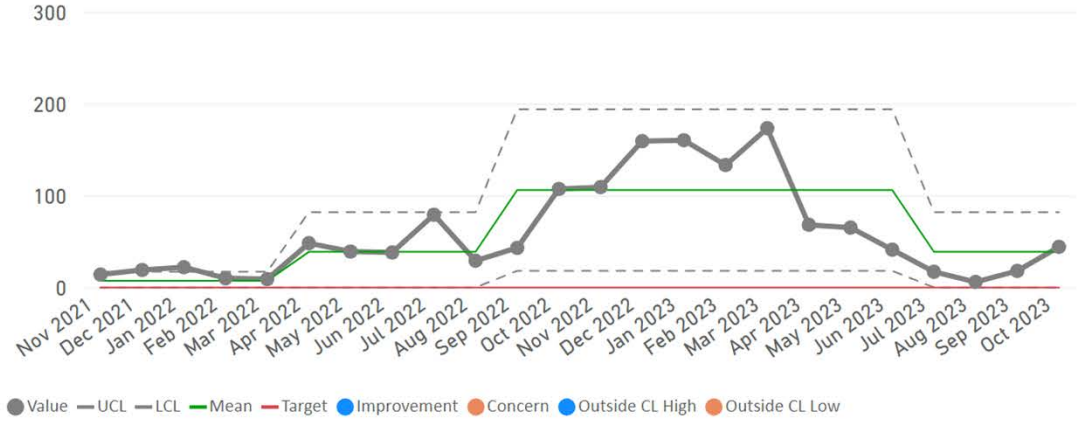
4-Hour A&E Standard

Month	Performance	Target	Trend	Assurance
Oct 2023	64%	76%		



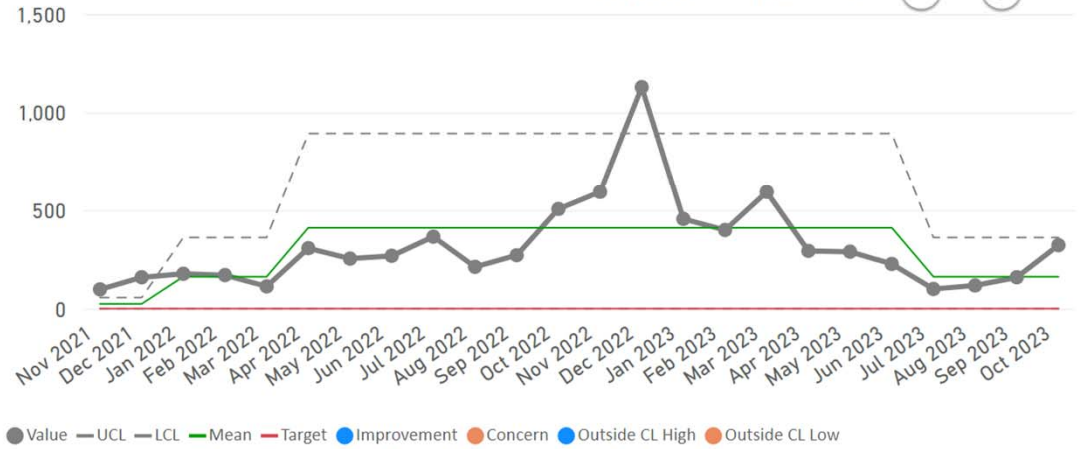
12-Hour Waits from Decision to Admit

Month	Performance	Target	Trend	Assurance
Oct 2023	44	0		



12-Hour A&E Breaches

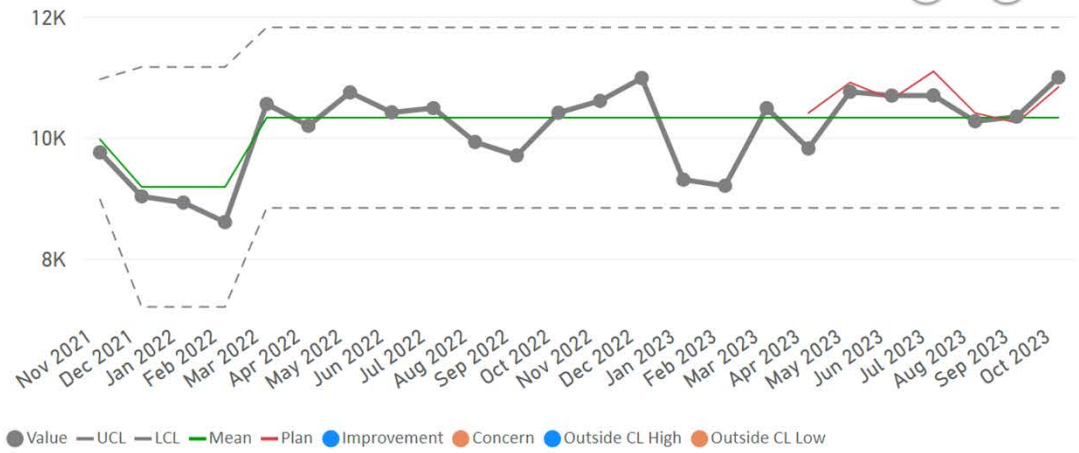
Month	Performance	Target	Trend	Assurance
Oct 2023	321	0		



RESPONSIVE

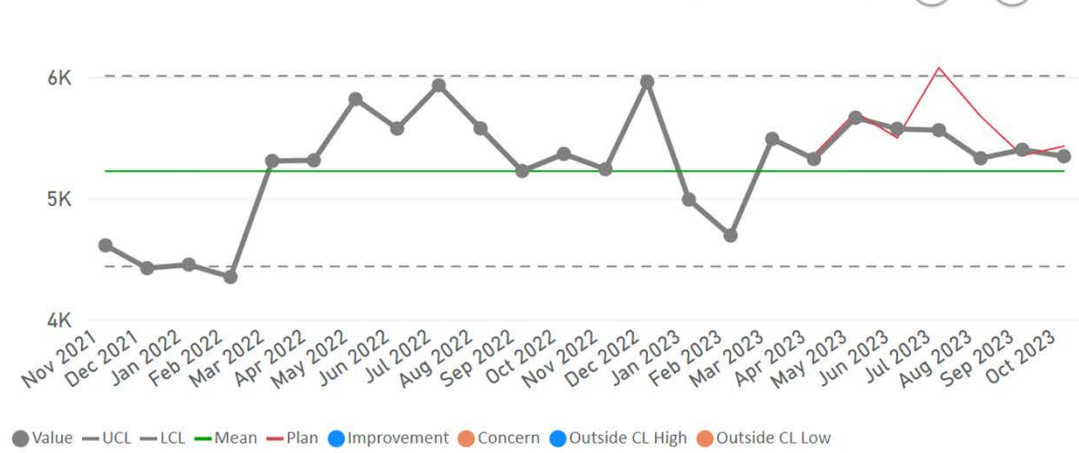
A&E Attendances - Type 1

Month	Performance	Plan	Trend	Assurance
Oct 2023	10989	10832		



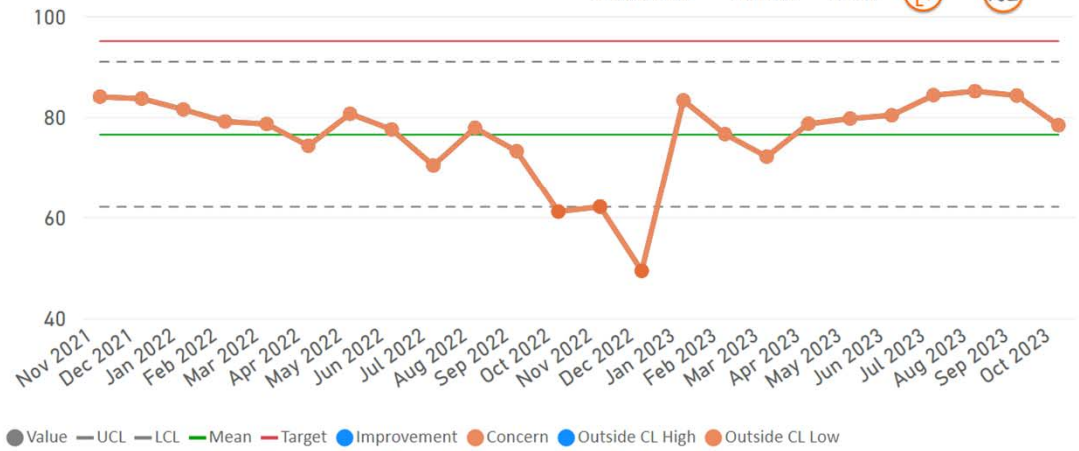
A&E Attendances - Type 3

Month	Performance	Plan	Trend	Assurance
Oct 2023	5344	5428		



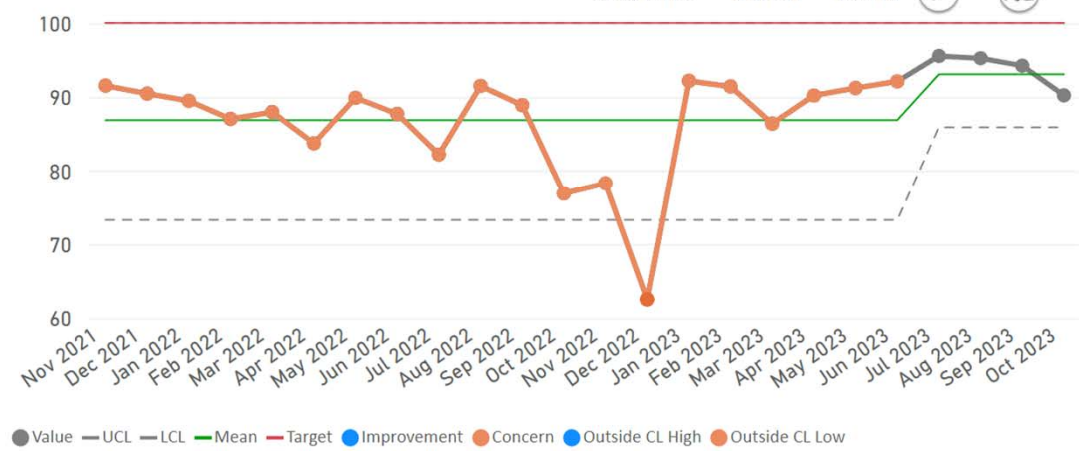
Handovers - Within 30 Mins (%)

Month	Performance	Target	Trend	Assurance
Oct 2023	78.3%	95%		



Handovers - Within 60 Mins (%)

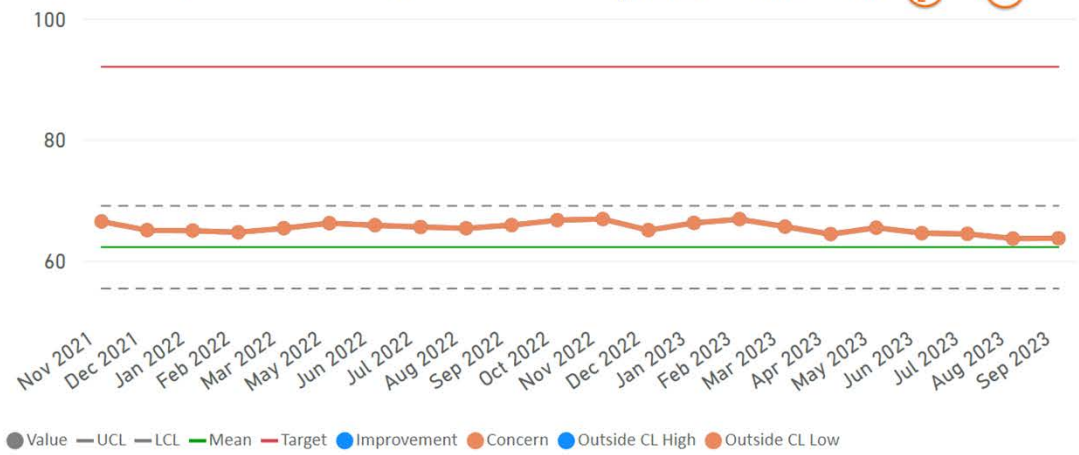
Month	Performance	Target	Trend	Assurance
Oct 2023	90.2%	100%		



RESPONSIVE

RTT Incomplete Pathways (%)

Month	Performance	Plan	Trend	Assurance
Sep 2023	63.7%	92%		

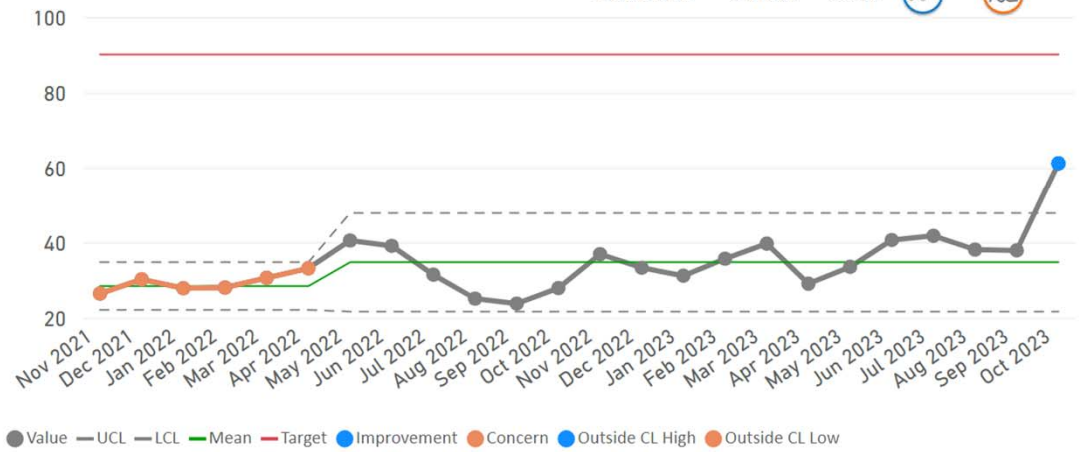


RTT Waiting List Size

Month	Performance	Plan	Trend	Assurance
Sep 2023	53310	49239		

RTT Validated Within 12 Weeks (%)

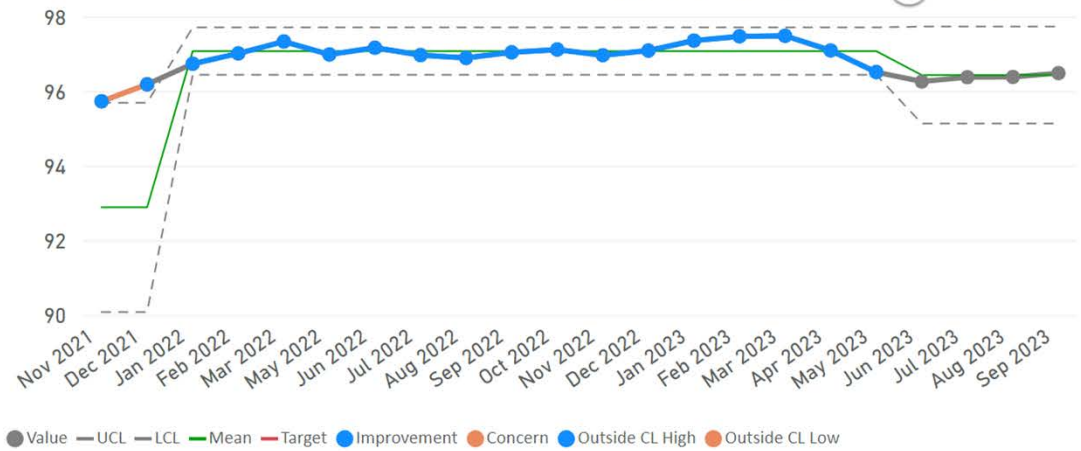
Month	Performance	Target	Trend	Assurance
Oct 2023	61.1%	90%		



RESPONSIVE

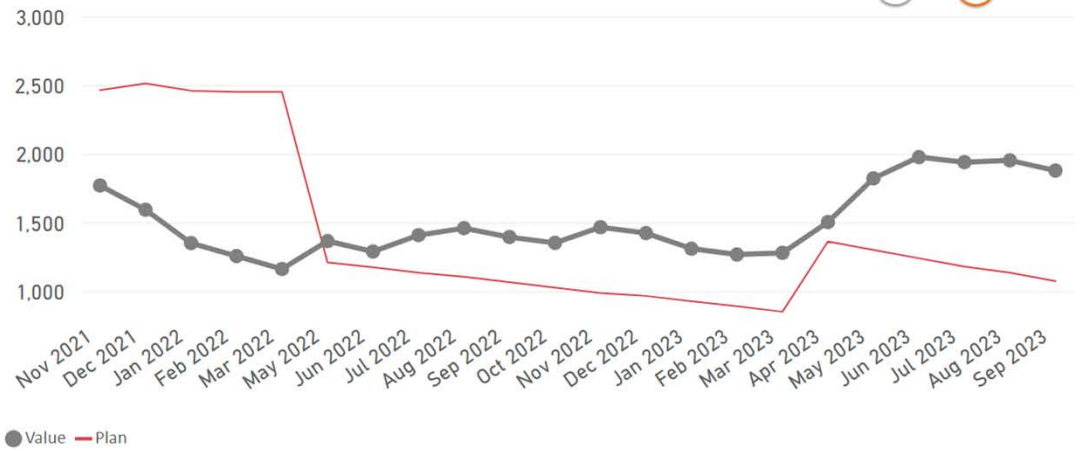
RTT List Size within 52 weeks (%)

Month	Performance	Plan	Trend	Assurance
Sep 2023	96.5%			N/A



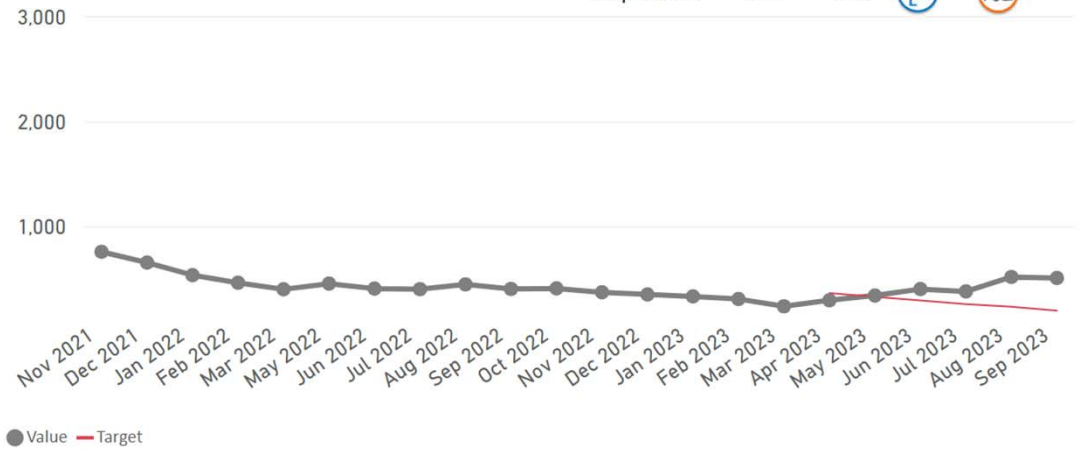
RTT 52 week waiters

Month	Performance	Plan	Trend	Assurance
Sep 2023	1878	1074		



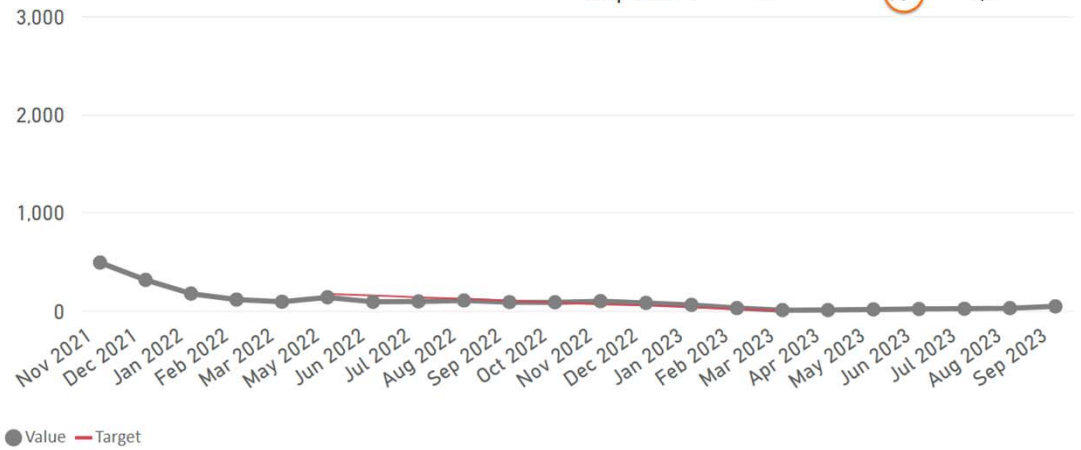
RTT 65 week waiters

Month	Performance	Plan	Trend	Assurance
Sep 2023	509	202		



RTT 78 week waiters

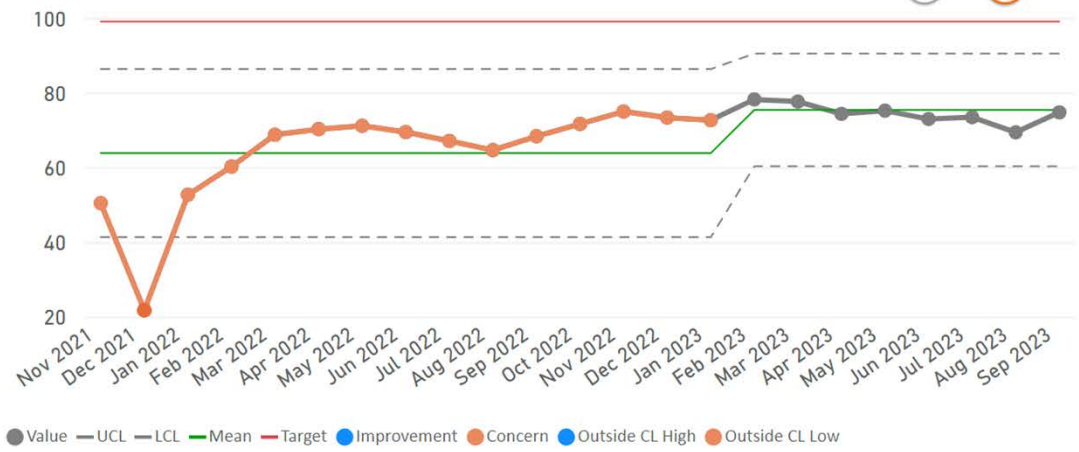
Month	Performance	Plan	Trend	Assurance
Sep 2023	42			N/A



RESPONSIVE

Diagnostic 6 Weeks Standard (%)

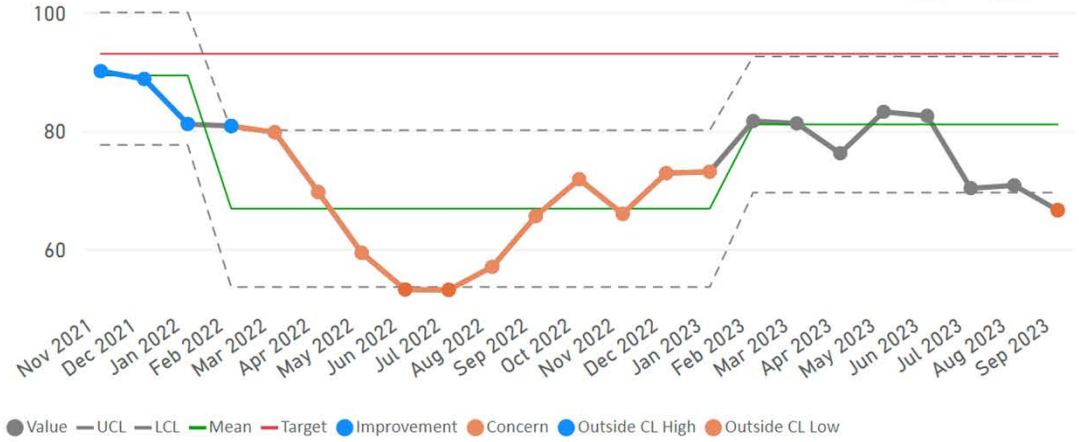
Month	Performance	Target	Trend	Assurance
Sep 2023	74.7%	99%		



RESPONSIVE

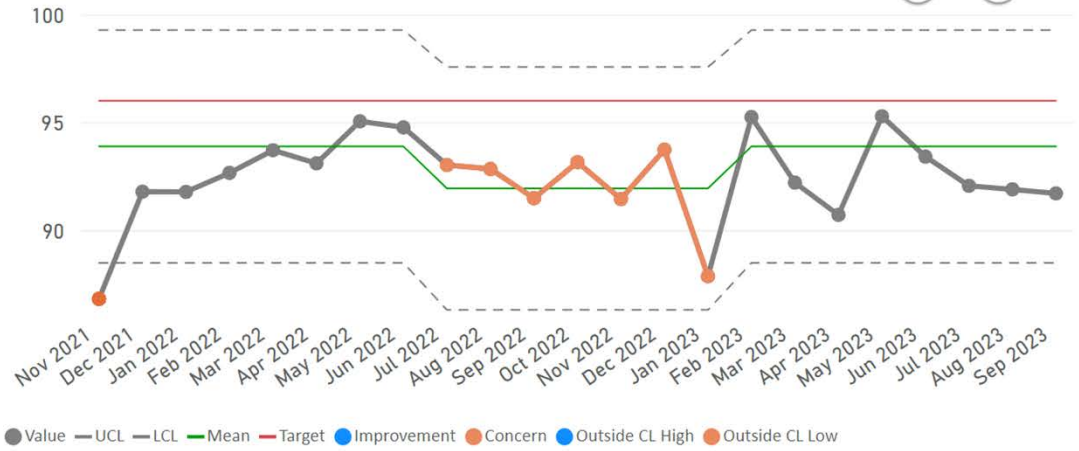
Cancer 14 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Sep 2023	66.6%	93%		



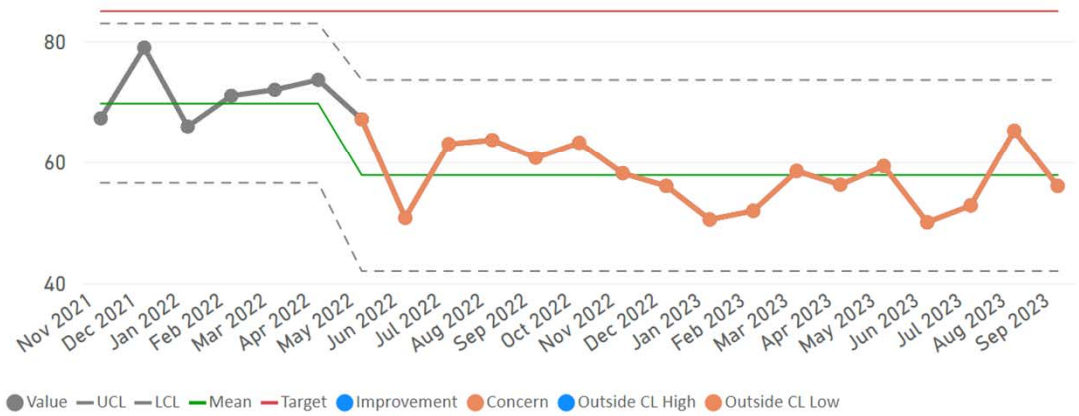
Cancer 31 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Sep 2023	91.7%	96%		



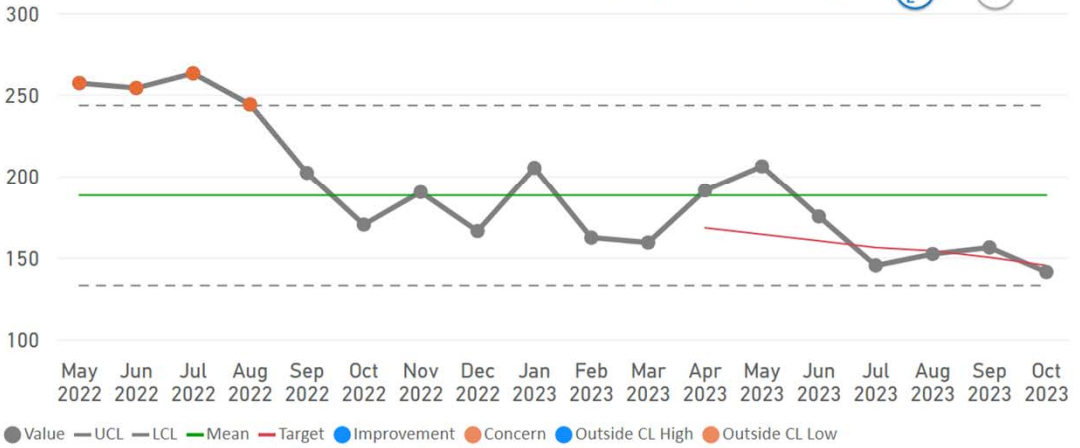
Cancer 62 Day Standard (%)

Month	Performance	Target	Trend	Assurance
Sep 2023	56%	85%		



Cancer >62 Day Backlog

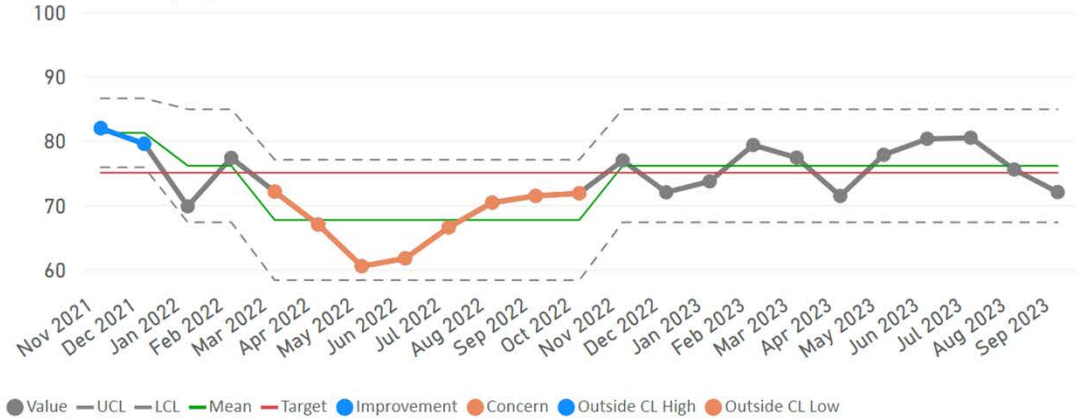
Month	Performance	Target	Trend	Assurance
Oct 2023	141	145		



RESPONSIVE

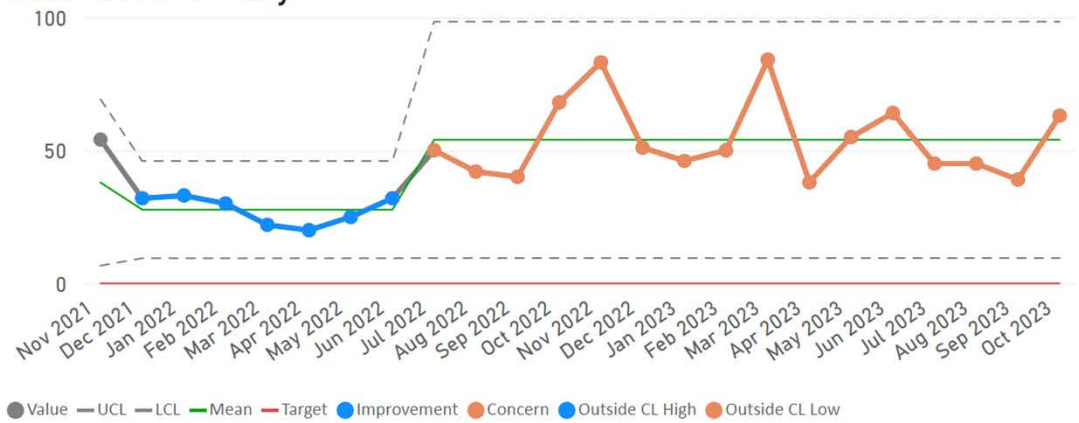
Cancer - Faster Diagnosis Standard (%)

Month	Performance	Target	Trend	Assurance
Sep 2023	72%	75%		



Cancelled Ops - Non-Urgent Cancelled On Day

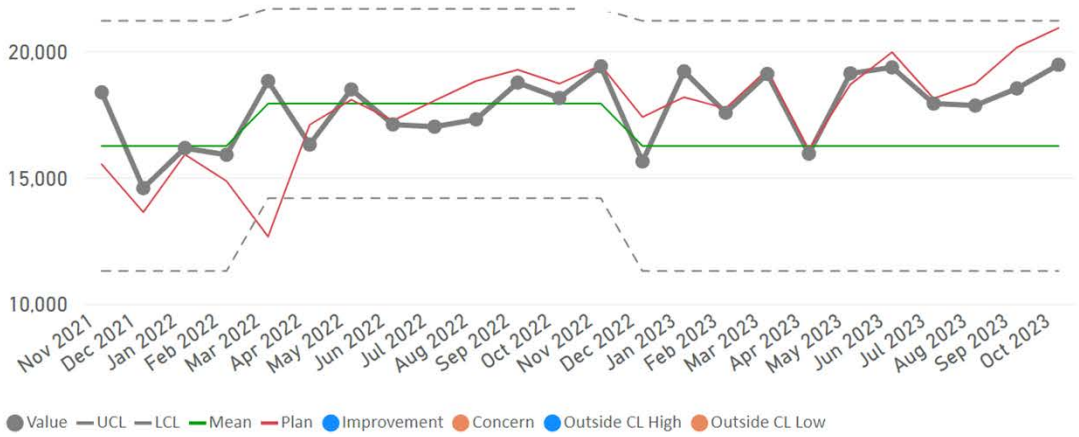
Month	Performance	Target	Trend	Assurance
Oct 2023	63	0		



RESPONSIVE

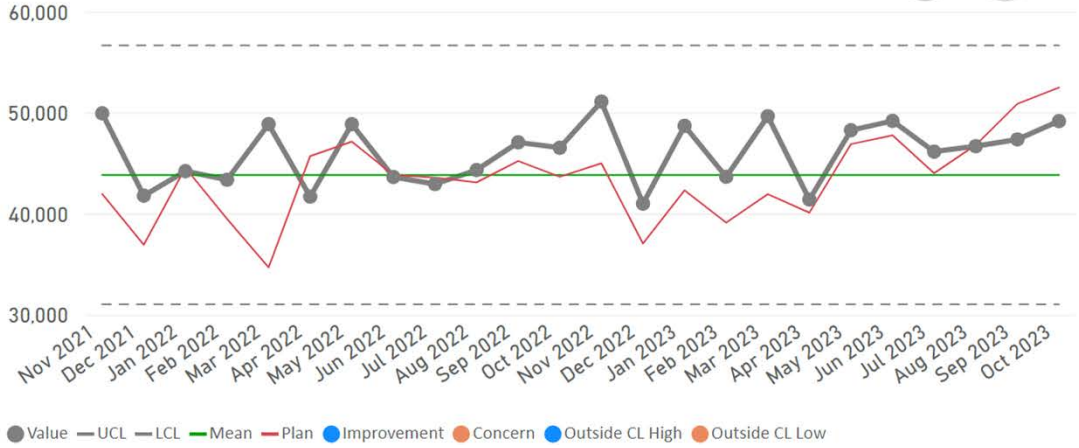
Outpatient First Attendances

Month	Performance	Target	Trend	Assurance
Oct 2023	19451	20906		



Outpatient Follow Up Attendances

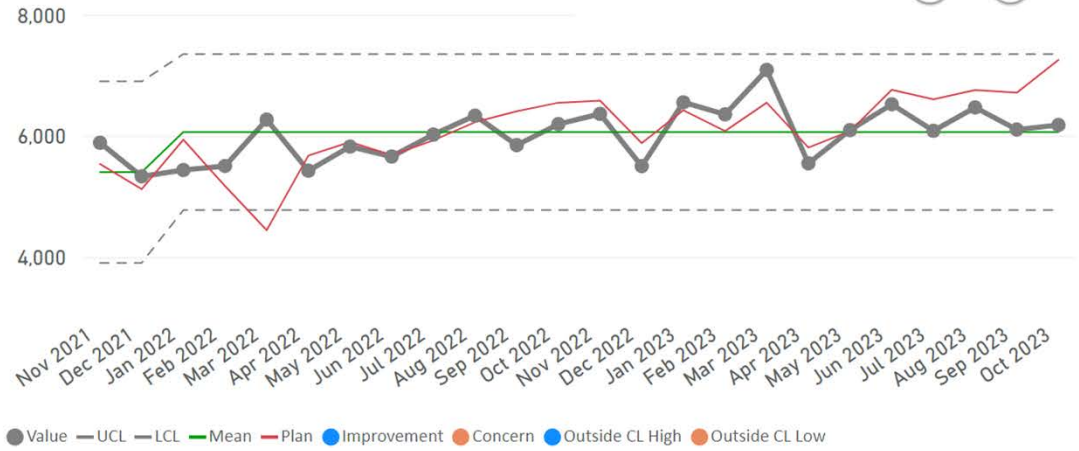
Month	Performance	Plan	Trend	Assurance
Oct 2023	49137	52460		



RESPONSIVE

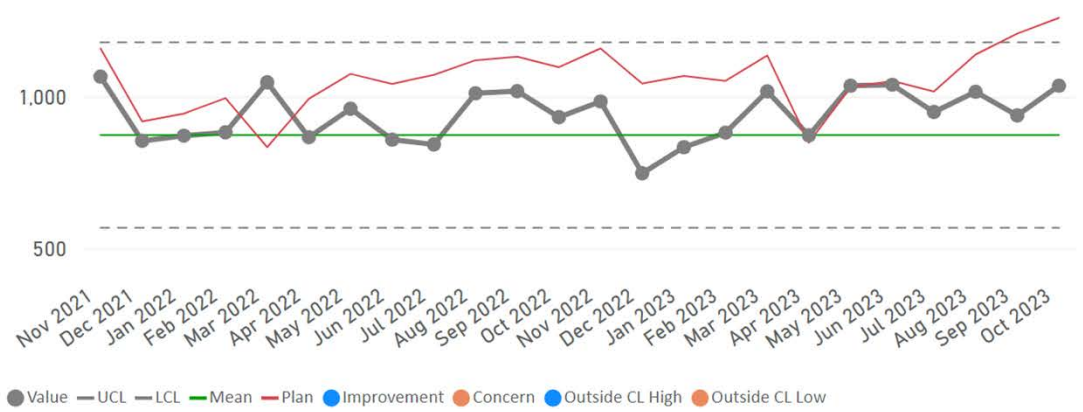
Day Case admissions

Month	Performance	Plan	Trend	Assurance
Oct 2023	6175	7250		



Ordinary Elective admissions

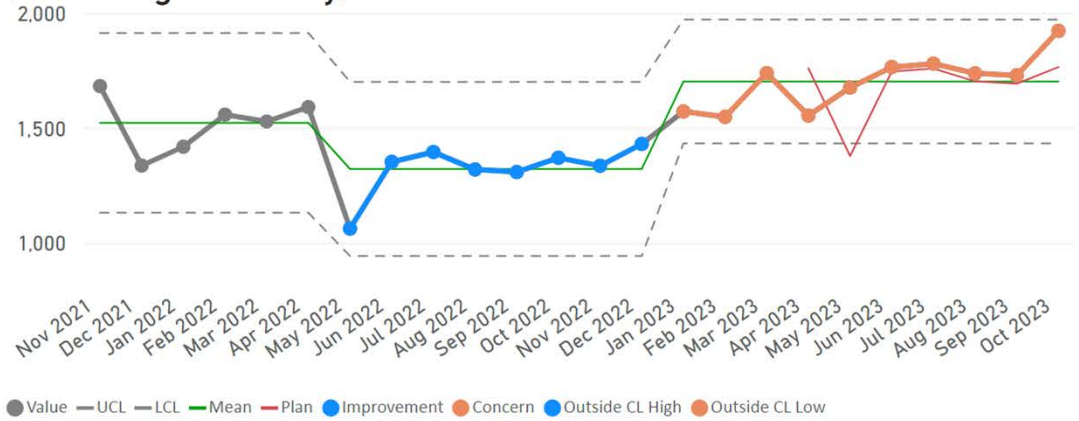
Month	Performance	Plan	Trend	Assurance
Oct 2023	1036	1260		N/A



RESPONSIVE

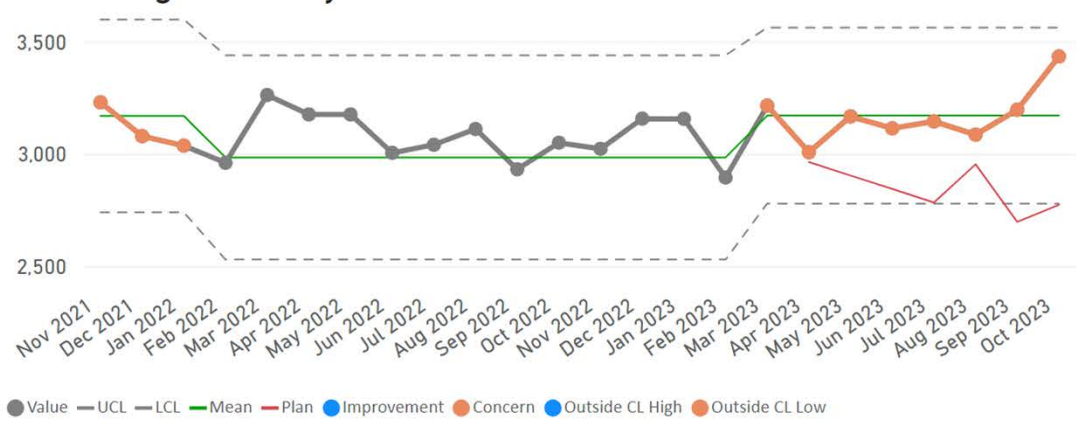
NEL admissions with 0 LOS (excluding Maternity)

Month	Performance	Plan	Trend	Assurance
Oct 2023	1922	1764	H	?



NEL admissions with 1+ LOS (excluding Maternity)

Month	Performance	Plan	Trend	Assurance
Oct 2023	3432	2772	H	F

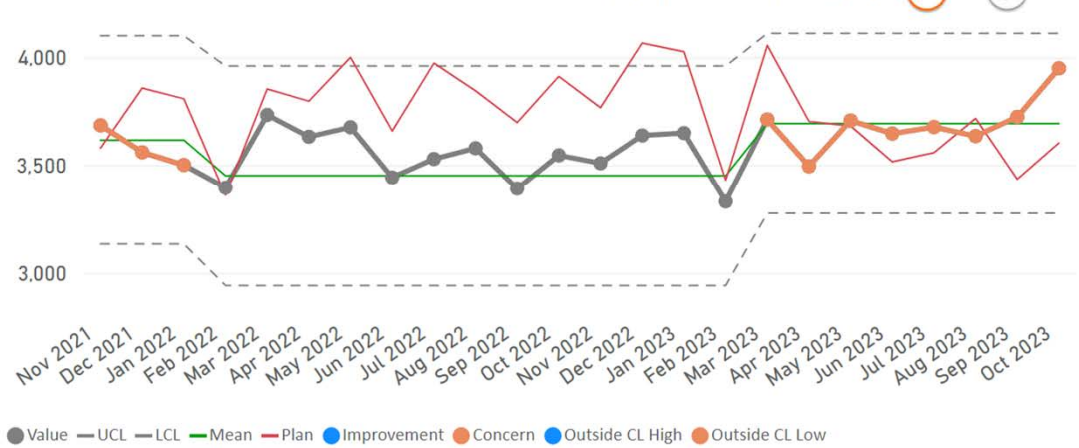


NEL admissions with 0 LOS

Month	Performance	Plan	Trend	Assurance
Oct 2023	3431	2012	H	F

NEL admissions with 1+ LOS

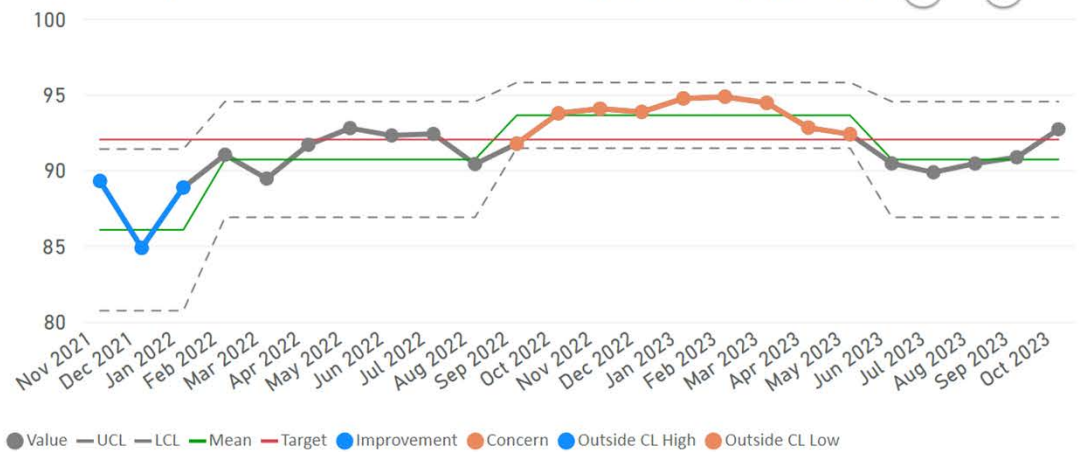
Month	Performance	Plan	Trend	Assurance
Oct 2023	3948	3602	H	?



RESPONSIVE

G&A Occupied Beds (%)

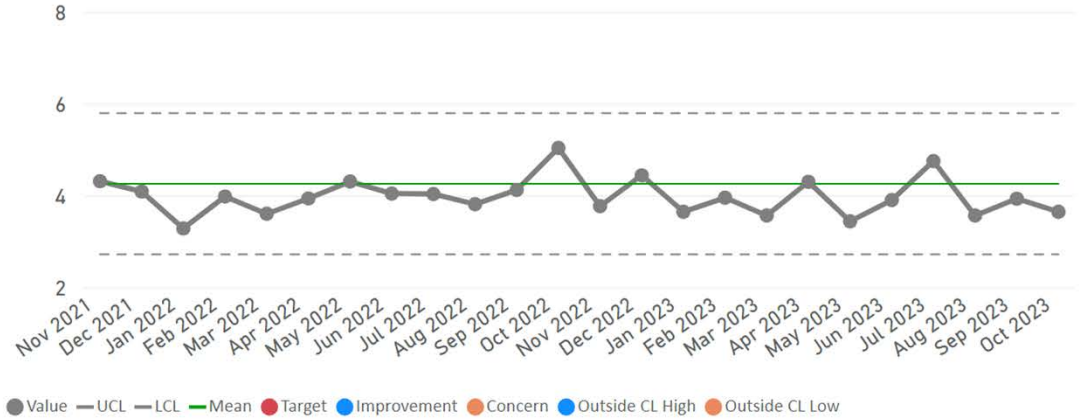
Month	Performance	Target	Trend	Assurance
Oct 2023	92.7%	92%		



RESPONSIVE

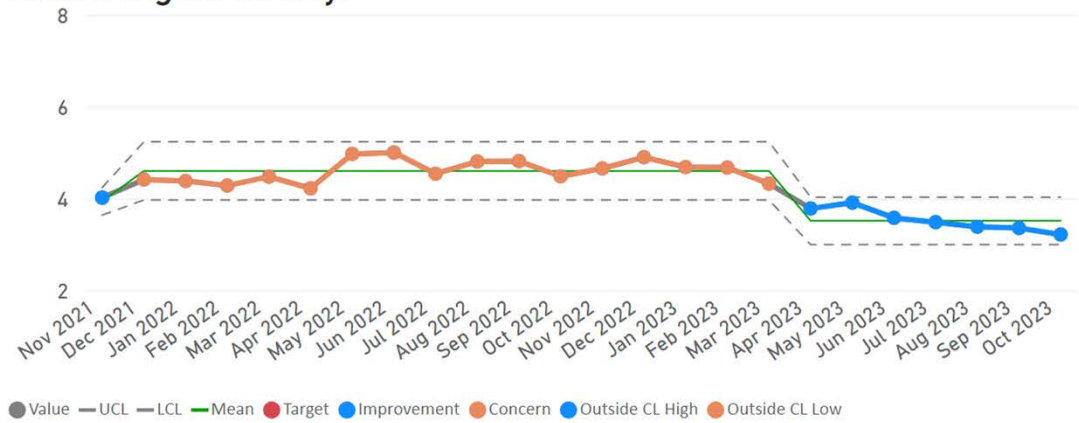
Length of Stay - Elective

Month	Performance	Target	Trend	Assurance
Oct 2023	3.6			N/A



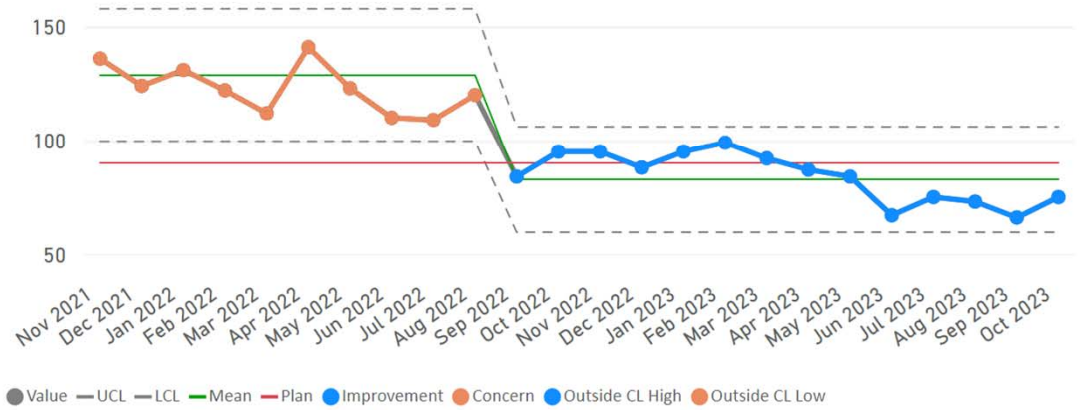
Length of Stay - Non-Elective (excluding Maternity)

Month	Performance	Target	Trend	Assurance
Oct 2023	3.2			N/A



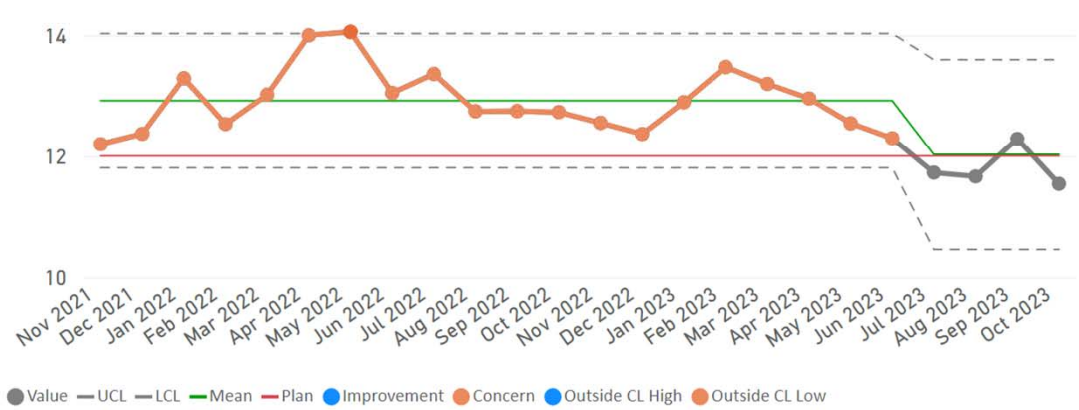
Ready for Discharge, not Discharged

Month	Performance	Plan	Trend	Assurance
Oct 2023	75	90		



21 Day Stranded Patients (%)

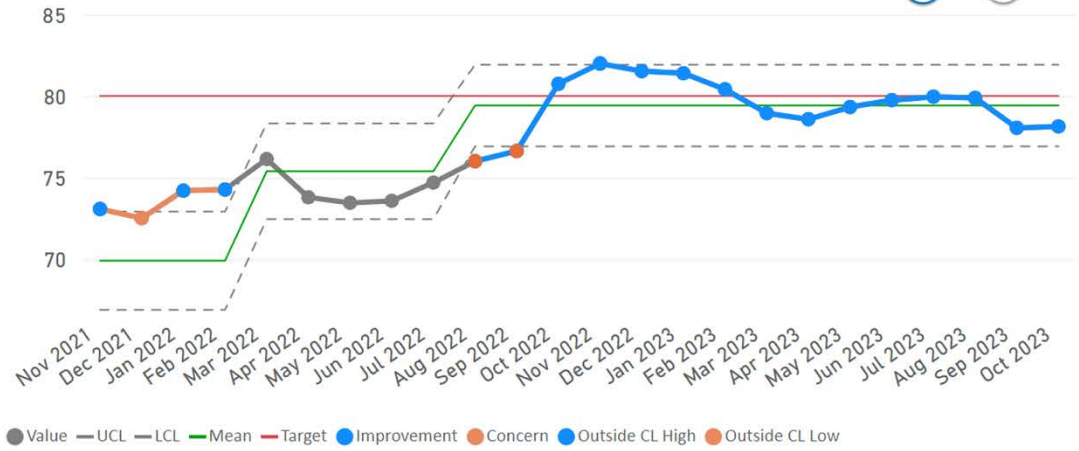
Month	Performance	Plan	Trend	Assurance
Oct 2023	11.5%	12%		



WELL-LED

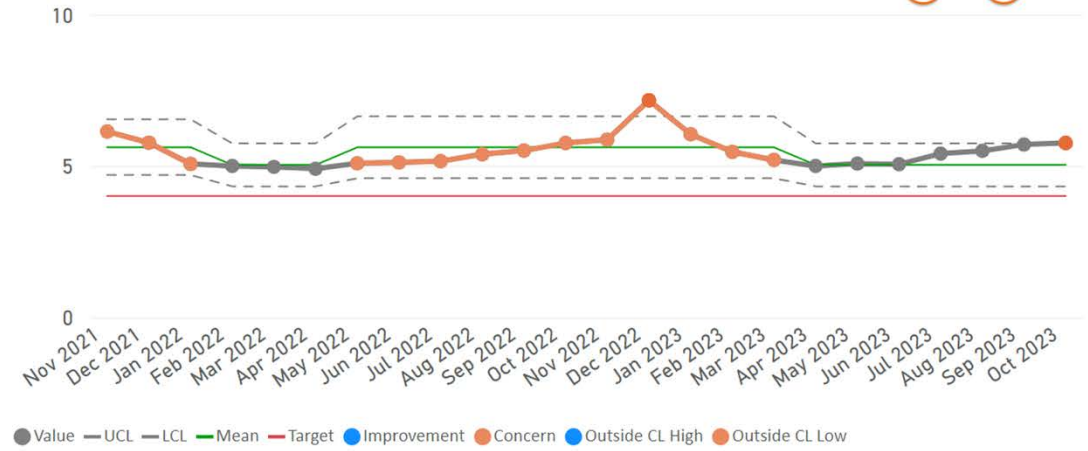
Annual Appraisal (%)

Month	Performance	Target	Trend	Assurance
Oct 2023	78.1%	80%		



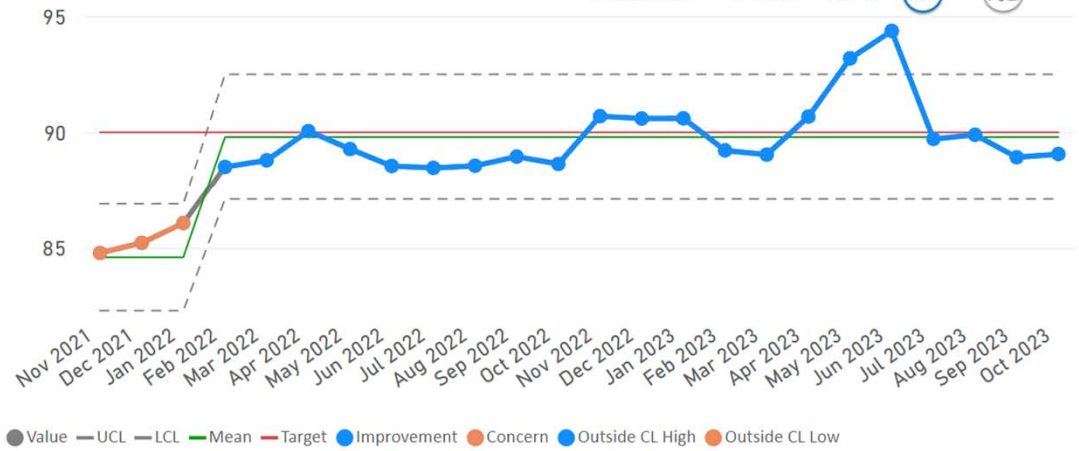
Sickness Absence (%)

Month	Performance	Target	Trend	Assurance
Oct 2023	5.8%	4%		



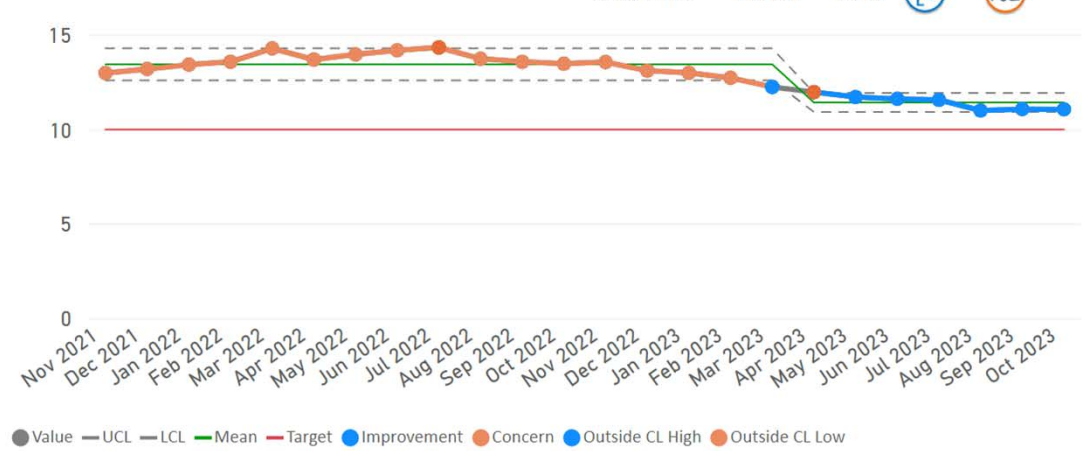
Mandatory Training (%)

Month	Performance	Target	Trend	Assurance
Oct 2023	89.1%	90%		



Staff Turnover (%)

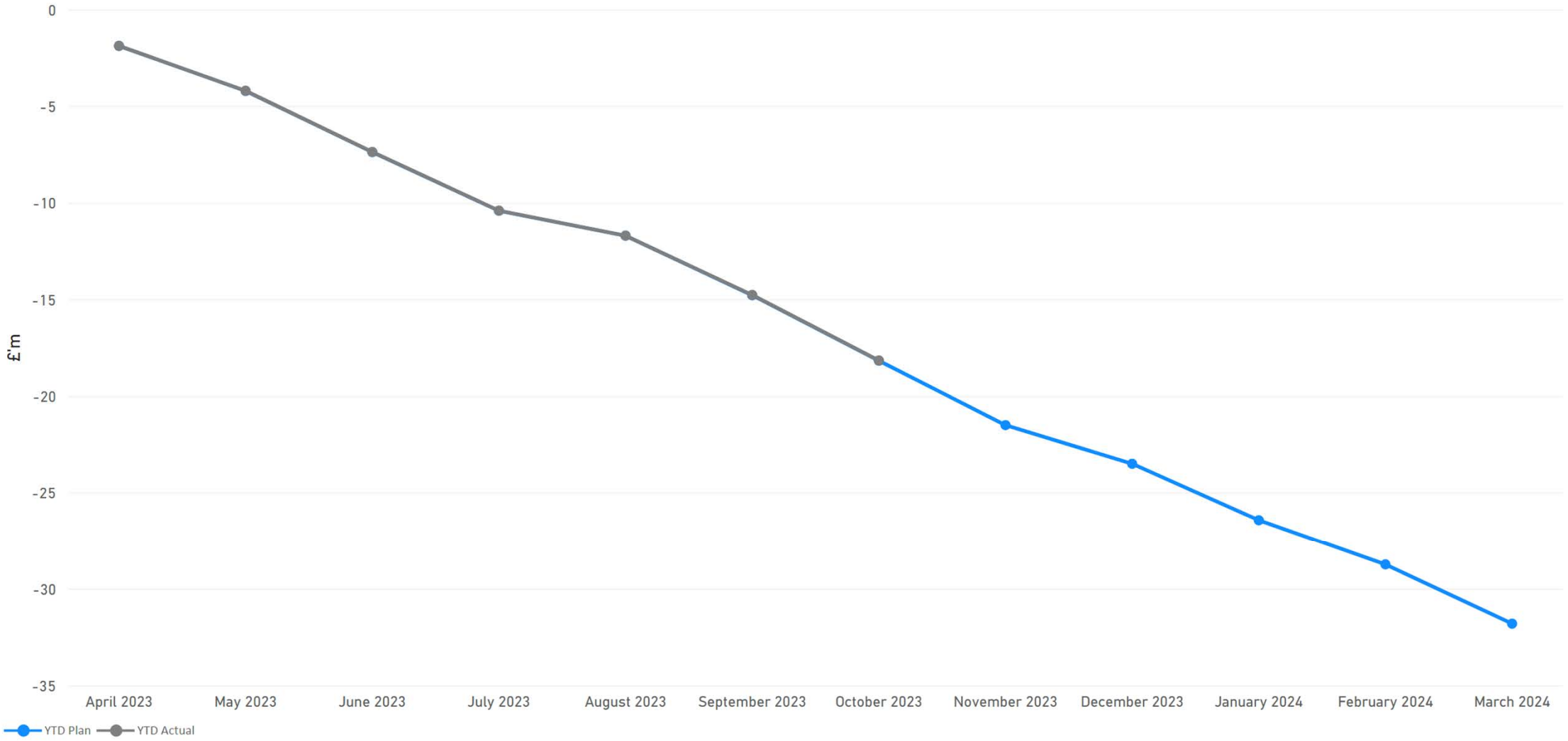
Month	Performance	Target	Trend	Assurance
Oct 2023	11.1%	10%		



WELL-LED

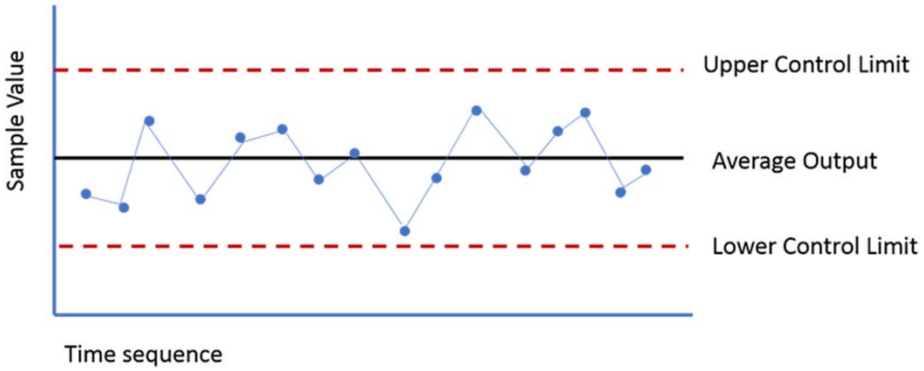
Cumulative YTD Financial Position (£'millions)

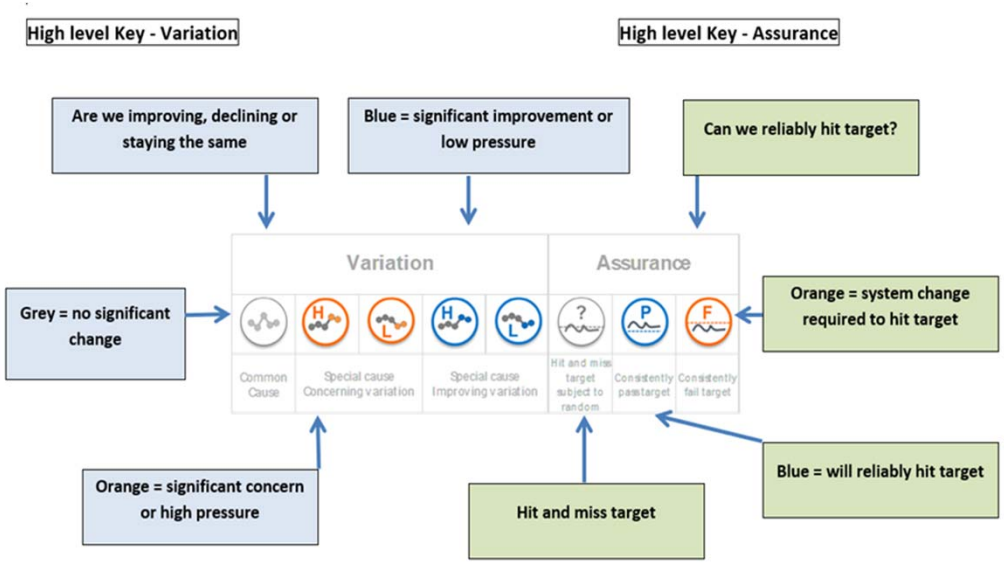
Month	Performance	Target
Oct 2023	-£18.162m	-£18.176m



SPC CHARTS

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





South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 DECEMBER 2023			
Safe Staffing Report for October 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 October 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 to 98% as per Table 1 demonstrating continued good compliance with safer staffing. 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 safecare meetings. Nursing Turnover for October 23 has increased to 7.15%.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to: Note the content of this report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 5.1 Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit. Threat - Ability to attract and retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources. Failure to have effective workforce plans that anticipate and prevent shortages arising from retirements, shortfalls in all recruitment and retention plans		

Legal and Equality and Diversity implications	• Care Quality Commission • NHS Improvement • NHS England	
Strategic Objectives	Best for safe, clinically effective care and experience ☒	A great place to work ☒
	Deliver care without boundaries in collaboration with our health and social care partners ☐	Make best use of our resources ☒
	A centre of excellence, for core and specialist services, research, digitally supported healthcare, education, and innovation in the North East of England, North Yorkshire and beyond ☐	

Nursing and Midwifery Workforce Exception Report
October 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 to the Tactical/Strategic Group as required. A look forward to the week ahead on Mondays and the weekend on Fridays takes place with Associate Directors of Nursing, Heads of Nursing and Clinical Matrons. Staff movement takes place to ensure patient safety with Clinical Matron Huddles and Ward Manager Briefings utilised to ensure full communication of plans and to gain feedback from teams to inform decision making.

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

Table 1 Trust Planned versus Actual

		August 23	September 23	October 23
Overall/Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	80.7%	81.9%	83.9%
	HCA (%) Average fill rate - DAYS	99.5%	97.2%	97.9%
	NA (%) Average fill rate - DAYS	100.0%	100.0%	100.0%
	TNA (%) Average fill rate - DAYS	100.0%	100.0%	100.0%
	RN/RMs (%) Average fill rate - NIGHTS	91.0%	91.5%	92.1%
	HCA (%) Average fill rate - NIGHTS	107.6%	108.7%	109.7%
	NA (%) Average fill rate - NIGHTS	100.0%	100.0%	100.0%
	TNA (%) Average fill rate - NIGHTS	100.0%	100.0%	100.0%
	Total % of Overall planned hours	**97.4%**	**97.4%**	**98.0%**

Redeployment of staff takes place to ensure wards are safely staffed, 297 total shifts (2893.67) were logged via SafeCare during October, a slight increase on September hours. Staff are reassured that every solution is explored prior to any decision regarding redeployment. Review of the SafeCare Standard Operating Procedure has been completed, it now includes support offered from legacy mentors to redeployed staff if required. The SafeCare Chair aims to redeploy within collaborative whenever possible. This is well received by staff and reduced some anxiety around moving to other areas. Ongoing work with the legacy mentors, workforce lead and operational matrons ensures a well being focused redeployment process.
Percentage of overtime has decreased year on year since 2021. The current overtime percentage based on the NHSP (NHS Professionals) vs Overtime report remains the same at 5% and is considerably lower compared to last year's 15% in October.

2. Nurse Sensitive Indicators

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

3. Red Flags Raised through SafeCare Live

October has shown an increase in the number of red flags raised through SafeCare live. There are 49 red flags relating to workforce, with shortfall in RN time being the most common (39). 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 October. Reminders are sent to ward managers and matrons to review and close resolved red flags. This has now been added to the SafeCare log, the SafeCare matron of the day will direct or close open red flags that have been resolved.

4. Datix Submissions

There were 48 datix submissions relating to staffing in October. The majority were for staff shortages in Redcar Community Nursing, Bed Management and General Critical Care. Redeployment decisions were made following safer staffing discussions with ward managers and matron agreement.

The Nursing Workforce Team continues to work closely with People Senior Team and the temporary staffing providers (NHSP) to improve fill rates and maintain safe staffing.

5. Turnover & Vacancies

Nursing turnover has increased slightly from 6.83% to 7.15%. The nursing turnover reported excludes employee external transfer and flexi-retirement, these reasons are however included in 2 weekly workforce meetings.

We are currently fully recruited to all RNs and HCA posts with our next cohort of students commencing in January 2024

6. Nurse Recruitment and Retention

Our final cohort of international nurses for 2023 arrived and were allocated in November. One further group of 12 will complete the Trust's 22/23 allocations. For 2024 the Trust has submitted a request for 12 nurses.

Our 'Celebrating Excellence in Nursing and Midwifery' conference with 250 attendees provided a fantastic opportunity to share all the excellent work around the lived experience of our internationally educated nurses, the impact of our legacy mentors and professional nursing and midwifery advocates on staff wellbeing and retention and the promotion of our @Nextgeneration workforce stream (which includes visiting our local schools to promote nursing and the NHS as a career)

Non-medical job planning continues to be implemented for non ward-based nurses and all onboarding is on target for completion by end of December 2023

7. RECOMMENDATIONS

The Board is asked to:
Note the content of this report and the progress in relation to key nursing workforce issues.
Be assured that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

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

Wards	Physical Bed Capacity	Open Bed Capacity	Total CHPPD	Occupied Beds (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 (%)	Comments
Ward 1	30	30	785	25	88.6%	110.6%	100.0%	-	78.6%	110.1%	100.0%	-	Increased sickness
Ward 31	35	35	1032	33	81.8%	96.7%	-	100.0%	81.3%	90.1%	-	100.0%	
Ward 3	28	28	746	24	89.4%	139.0%	100.0%	100.0%	100.2%	155.5%	-	100.0%	
Ward 4	24	24	619	20	91.6%	104.0%	-	-	79.2%	111.1%	-	-	Support to ward 14 & 33
Ward 5	28	28	680	22	75.4%	79.4%	-	100.0%	83.8%	125.0%	-	-	Low bed occupancy.
Ward 6	31	31	893	29	80.1%	108.7%	-	100.0%	105.3%	128.9%	-	100.0%	
Ward 7	30	30	774	25	79.8%	111.0%	100.0%	100.0%	86.0%	104.4%	-	100.0%	Increased sickness
Ward 8	30	30	864	28	83.8%	83.7%	100.0%	100.0%	96.8%	98.0%	-	100.0%	
Ward 9	32	32	931	30	79.6%	168.8%	-	100.0%	92.6%	159.5%	-	-	Increased sickness
Ward 10	24	24	734	24	89.5%	77.7%	-	100.0%	72.0%	130.0%	-	100.0%	Sickness supplemented by HCA.
Ward 11	28	28	832	27	68.0%	83.9%	100.0%	100.0%	80.4%	136.2%	100.0%	100.0%	Sickness
Ward 12	26	26	827	27	90.3%	147.8%	-	-	89.6%	181.7%	-	-	
Ward 14	23	23	660	21	82.1%	97.1%	100.0%	100.0%	94.8%	111.2%	-	100.0%	
Ward 24	23	23	686	22	94.4%	191.4%	-	100.0%	85.9%	274.7%	-	-	
Ward 25	21	21	570	18	81.4%	125.6%	-	-	81.7%	137.2%	-	-	
Ward 26	18	19	557	18	105.5%	140.8%	-	-	100.1%	101.3%	-	-	
Ward 27	15	15	286	9	67.9%	65.1%	100.0%	100.0%	98.9%	70.8%	-	100.0%	Staff supported/redeployment
Ward 28	30	30	871	28	84.3%	129.6%	-	-	95.4%	132.9%	100.0%	-	
Ward 29	27	27	798	26	96.0%	93.4%	-	100.0%	95.7%	117.5%	-	100.0%	
Cardio MB	9	9	248	8	100.8%	154.9%	-	-	100.0%	167.7%	-	-	
Ward 32	22	21	624	20	110.6%	108.1%	-	-	100.0%	100.1%	-	-	
Ward 33	23	23	639	21	70.9%	111.3%	-	-	92.9%	101.6%	-	-	Short term sickness

Ward 34	34	34	931	30	69.8%	138.8%	-	100.0%	94.6%	142.0%	-	100.0%	RN vacancies – daily support from other wards
Ward 35	26	26	647	21	114.1%	106.3%	100.0%	-	113.7%	104.0%	100.0%	-	
Ward 36	34	34	947	31	95.2%	105.1%	100.0%	100.0%	90.0%	126.2%	100.0%	100.0%	
Ward 37	30	30	805	26	89.6%	112.5%	100.0%	-	88.7%	99.7%	-	-	
Spinal Injuries	24	24	691	22	90.5%	66.6%	-	100.0%	200.1%	99.5%	-	-	
CCU	14	14	297	10	82.5%	122.7%	-	-	98.1%	-	-	-	
Critical Care	33	33	844	27	88.9%	96.0%	-	100.0%	91.7%	100.5%	-	100.0%	
CICU JCUH	12	10	174	6	74.6%	84.5%	-	-	75.2%	106.5%	-	-	Supernumerary
Cardio HDU	10	10	220	7	84.4%	87.9%	-	-	80.6%	93.5%	-	-	
Ward 24	8	8	224	7	87.4%	114.5%	-	-	79.3%	161.6%	-	-	Sickness and supernumerary
Ainderby FHN	27	22	625	20	92.9%	107.4%	-	-	100.6%	97.1%	-	-	
Romanby FHN	26	22	645	21	91.9%	102.9%	-	-	100.1%	94.1%	-	-	
Gara FHN	21	21	222	7	82.6%	81.7%	-	100.0%	98.7%	43.6%	-	-	
Rutson FHN	17	17	504	16	72.9%	123.2%	-	100.0%	100.2%	95.1%	-	100.0%	RN vacancies and sickness
Friary	18	18	425	14	88.7%	69.3%	-	100.0%	100.6%	103.2%	-	-	
Zetland Ward	31	29	922	30	63.6%	85.7%	100.0%	-	87.7%	110.6%	100.0%	-	RN vacancies and sickness
Tocketts Ward	30	26	730	24	76.9%	95.6%	-	100.0%	88.5%	143.1%	-	-	Short term sickness
Ward 21	25	25	569	18	85.6%	102.2%	100.0%	-	84.9%	96.8%	100.0%	-	
Ward 22	17	17	196	6	70.7%	71.9%	-	-	73.8%	48.4%	-	-	
JCDS	-	-	338	11	92.4%	76.4%	-	-	96.8%	85.5%	-	-	
Neonatal Unit	35	35	621	20	74.8%	66.1%	-	-	75.6%	-	-	-	Support from paediatrics
Paediatric (PCCU)	6	6	72	2	63.3%	113.7%	-	-	67.0%	12.9%	-	-	Low activity supported by rest of floor when increased.
Ward 17	-	-	681	22	85.8%	69.7%	-	-	96.3%	78.0%	-	-	
Ward 19	-	-	264	9	96.5%	77.4%	-	-	95.2%	-	-	-	
Maternity FHN	-	-	11	0	63.3%	16.5%	-	-	81.1%	-	-	-	Closure of the unit to support staffing issues

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 5 DECEMBER 2023			
Annual Board Report & Statement of Compliance - Appraisal & Revalidation			**AGENDA ITEM:12 ENC 9**
Report Author / Job Title:	James Auty – Reval. Mgr.	**Responsible Director:**	Mike Stewart - RO
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Bi-annual update to Trust Board on Doctor's appraisals and revalidation		
Background	The purpose of this report is to guide the Trust by setting out key requirements for compliance with regulations and key national guidance in relation to Doctor's appraisals and revalidation - providing a format to review these requirements for the Trust to demonstrate not only basic compliance but continued improvement over time. The report template: a) Helps the Trust in its pursuit of quality improvement, b) Provides the necessary assurance to the higher-level RO, c) Can act as evidence for CQC inspections		
Assessment	The Trust continues to ensure all Doctors engage in appraisal with the Revalidation Team aiming to fully optimise our appraisal software for the management of appraisals and revalidation. Based on the embedded systems and processes in place, the Revalidation Team continues to work from a position of strength and can provide assurance that:- a) Appraisals are undertaken appropriately and in accordance with national and local policies, procedures and guidelines in order for the RO to make revalidation recommendations to the GMC b) Robust quality checking of appraisers is taking place c) Doctors are continually supported by the Revalidation Team with their appraisals and revalidation d) Outstanding appraisals are routinely addressed e) Appraisers have access to dedicated support and training to aid their roles as appraisers		
Level of Assurance	Level of Assurance: Significant ☒ Moderate ☐ Limited ☐ None ☐		
Recommendation	Members of the Trust Board of Directors are asked to receive this report		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 3.1 Ability to attract & retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources. Failure to have effective workforce plans that anticipate and prevent shortages arising from retirements, shortfalls in all recruitment and retention plans	
Legal & E&D implications	- NHS England / General Medical Council	
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 NE England, North Yorkshire and beyond ☐	

South Tees Hospitals
NHS Foundation Trust

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The **board** of **South Tees Hospitals NHS Foundation Trust** can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: **Maintain compliance** Comments: **Dr Michael Stewart – GMC 3139628 (Chief Medical Officer) appointed Responsible Officer 01/02/2021 after handover from previous RO - Dr Sath Nag - with Responsible Officer training previously completed by Dr Stewart in September 2016** Action for next year: **Maintain compliance**

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: **Maintain skills and resources within the team** Comments: **Responsible Officer leads a fully resourced Revalidation Team consisting of:-** **- Medical Lead for Appraisal & Revalidation** **- Lead Appraisers x 4** **- Revalidation Manager** **- Revalidation Advisor** **The Responsible Officer is also supported by the Associate Medical Director for People & Governance** Action for next year: **Maintain skills and resources within the team**

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: **Maintain compliance and implement new appraisal and revalidation software – ensuring a smooth switchover between old and new systems for Doctors, Appraisers and Administrators** Comments: **Within the last appraisal year, the Trust has implemented new and improved appraisal and revalidation software - L2P – with a smooth switchover between old and new systems for Doctors, Appraisers and Administrators achieved.**

The L2P system is utilised to maintain a database of all Doctors holding a prescribed connection to South Tees Hospitals NHS Foundation Trust. The system is continually maintained and cross-checked with GMC Connect by the Revalidation Manager and Revalidation Advisor

Action for next year: **Maintain compliance**

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: **Finalise updates to MHPS policy**

Comments: **Trust policy for Medical Appraisal & Revalidation fully revised and updated in December 2021; Trust policy for Remediation fully revised and updated in June 2022; Trust's MHPS policy fully revised and updated in June 2023**

Action for next year: **Continue to actively monitor Trust policies and review in line with any changes in national guidance**

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: **Maintain attendance at regional revalidation meetings**

Comments: **Peer review process confirmed with Responsible Officer- North East and North Cumbria in July 2023 (copied below):-**

"Some regions have a rolling programme of quality review visits but in the North East and Yorkshire we tend to visit when there is an issue of note (either assurance, or good practice keen to learn more and share etc), usually as an outcome from the desktop review or appointment of a new RO or at the request of the Trust. To reassure this is not part of the statement of compliance / annual assurance as the AOA is no more"

Action for next year: **Maintain attendance at regional revalidation meetings**

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: **Maintain compliance and engagement**

Comments: **All Locum Doctors directly employed by the Trust are expected to participate fully in the appraisal process and agree a PDP within their first three months of joining; Locum Doctors employed for three or more months should undertake a full appraisal. Locum Doctors with a prescribed connection to another organisation e.g. Locum Agency, are afforded the opportunity to have their appraisal with the Trust which can be requested via their Clinical Director.**

Short term placement Doctors i.e. Locally Employed Non-Training Grade Doctors, receive the same level of support from the Revalidation Team as our Consultants. The Trust have an identified Lead Appraiser as the main point of contact for Locally Employed Non-Training Grade Doctors with specifically targeted appraisal training sessions also held for this group of Doctors three times a year. A specifically designed slide pack detailing the appraisal and revalidation process is shared with all new Locally Employed Doctor appointments upon their commencement in post with the Trust.

Action for next year: **Maintain compliance and engagement**

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: **Maintain compliance and promote completion of Whole Scope of Practice forms for work undertaken at different NHS Trusts**

Comments: **The Trust ensures its Doctors undertake annual appraisal in accordance with local policies and procedures and GMC requirements. The Trust utilises the PALS & DATIX Risk Management Systems for the logging of complaints and significant events; reports are extracted from the systems by the Revalidation Team which are forwarded to the Doctor for upload to their appraisal. Doctors are also requested to include any details on complaints or significant events which haven't been captured on the PALS & DATIX Risk Management Systems but which they are aware of. Where a Doctor works for any organisation outside of the Trust, they are asked to complete a separate Whole Scope of Practice Form, declaring the additional duties they undertake, the nature and frequency of these duties and whether or not they have been named in any complaints or significant events within the appraisal period; the form must be completed and signed by the external organisation and uploaded to the Doctor's appraisal**

With increased cross-site working between neighbouring Trusts as part of the North East and North Cumbria Integrated Care System (ICS), Doctors are now also expected to complete a Whole Scope of Practice form for any work undertaken at different NHS Trusts to ensure full transparency and sharing of information between organisations

The Trust adopted the Appraisal 2020 model with the appraisal software updated to reflect the mandatory and non-mandatory sections required from appraisees. Although the updated requirements for appraisal were acknowledged and welcomed by appraisers and appraisees alike at the time of implementation, evidence suggests that

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

individuals still appear to be preparing for their appraisal in the usual manner (pre-MAG-2020) with the same standards of pre-appraisal preparation and supporting evidence presented maintained

Action for next year: **Maintain compliance**

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: **Continue to enforce Trust's escalation policy where appropriate**

Comments: **A record of missed or incomplete appraisals is kept with the Revalidation Manager working closely with the Medical Lead for Appraisal & Revalidation to establish the reasons why and enforcing the Trust's escalation policy for non-participation in appraisal where necessary.**

Action for next year: **Continue to enforce Trust's escalation policy where appropriate**

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: **Update where necessary should national policy change**

Comments: **Trust policy on Medical Appraisal & Revalidation revised in line with latest national policy and published with full sign off by the Trust's Board of Directors in December 2021**

Action for next year: **Update this year to reflect Trust changes in appraisal/revalidation software, MAG 2023 and consideration of updated versions of Framework for Quality Assurance and GMC Good Medical Practice**

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: **Maintain appraiser numbers at current healthy ratio**

Comments: **There are currently 156 appraisers in the Trust to undertake appraisals for approximately 800 Doctors (including Trust employed military Doctors and those with GDC registration rather than GMC. All 156 appraisers have undergone full revalidation and appraisal training.**

Action for next year: **Undertake targeted recruitment of appraisers within specialities where the appraiser to appraisee ratio is not currently at the desired level**

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: **Continue to hold meetings for all appraisers throughout the year and attend regional network meetings**

Comments: **There is on-going training and support from the Revalidation Team. Several workshops led by the Medical Lead for Appraisal & Revalidation, Lead Appraisers and Revalidation Manager have taken place in the last 12 months to allow all appraisers to meet, discuss any issues and share best practice. Our Medical Lead for Appraisal & Revalidation, Lead Appraisers and Revalidation Manager also regularly attend the Northern Regional Medical Appraisal Lead Network meetings, using Trust workshops to cascade learning**

Action for next year: **Continue to hold meetings for all appraisers throughout the year and attend regional network meetings**

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: **Continue with twice yearly reports for Board and implement targeted areas for appraiser development based upon full review of individual quality assurance assessments undertaken by Lead Appraisers over the last 12 months having utilised the PROGRESS tool**

Comments: **Reports for Board are produced on a bi-annual basis covering all aspects of appraisal and revalidation.**

Quality assurance processes have been developed and strengthened in line with National practice, providing feedback to our appraisers on an annual basis, thus driving up the standards of appraisal within the Trust. Appraiser quality assurance utilises a validated national tool (PROGRESS) and is delivered by lead appraisers and the revalidation team. Appraisers are encouraged to use and reflect on this feedback as part of their own annual appraisal. In addition, individual quality assurance common themes/lessons learnt are directly circulated to appraisers via our regular revalidation newsletters.

Action for next year: **Continue to implement targeted areas for appraiser development – building upon learning taken from PROGRESS tool analysis and utilising the much more detailed appraiser feedback resources available within our new L2P appraisal software**

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: South Tees Hospitals NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	773
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	700
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	73
Total number of agreed exceptions	70

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: **Maintain compliance**
Comments: **Recommendations are always timely with the Revalidation Manager ensuring Doctor's portfolios are reviewed in collaboration with the Medical Lead for Appraisal & Revalidation in advance of their revalidation date to ensure that all necessary supporting information required to facilitate a positive revalidation recommendation has been captured and to confirm that no fitness to practice concerns outside of the appraisal process are on-going** **The Trust are continuing to utilise the extended 12 month revalidation recommendation window, regularly communicating with all Doctors under notice over the following 12 month period and recommending revalidation for individuals ahead of time where appropriate to do so**
Action for next year: **Maintain compliance**

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: **Maintain compliance**
Comments: **All Doctors receive a confirmation email from the Revalidation Manager informing them of their revalidation recommendation as soon as this has been processed on GMC Connect. Where the recommendation is one of deferment, the Revalidation Manger ensures appropriate liaison with the individual concerned, clearly communicates the reason for deferral and establishes a plan with the Doctor to ensure a positive revalidation recommendation can be submitted in line with their revised revalidation date. The Trust hasn't submitted any non-engagement recommendations in the last year but would follow the same process described for deferrals should the situation arise**
Action for next year: **Maintain compliance**

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: **Ensure continued effectiveness** Comments: **Revalidation and appraisal forms part of the broader clinical governance framework present in the Trust. Each clinical area has their own systems and processes relating to clinical governance with risk management meetings, directorate meetings, collaborative board meetings, patient safety groups and quality assurance forums all contributing to the wider clinical governance agenda. Robust systems and processes in place ensure relevant information is communicated to the right individuals and escalated to our partners and regulators where appropriate. The Trust encourages individuals to highlight any areas of concern through our DATIX Risk Management System as well as our Raising Concerns (Freedom to Speak Up) policy** Action for next year: **Ensure continued effectiveness**

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: **Maintain compliance** Comments: **The Trust utilises the DATIX Risk Management System for the logging of complaints and significant events; reports are extracted from the system by the Revalidation Team which are forwarded to the Doctor for upload to their e-Appraisal** Action for next year: **Maintain compliance**

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: **Finalise updates to MHPS policy**

Comments: **The Trust follows the Department of Health Maintaining High Professional Standards in the Modern NHS framework with a local adaptation of the framework adopted as Trust policy – fully revised and updated in June 2023**

Action for next year: **Continue to actively monitor Trust MHPS policy and review in line with any changes in national guidance**

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: **Finalise updates to MHPS policy**

Comments: **The above forms part of our local case investigation process following our local MHPS policy. 26 individuals within the Trust have undertaken full Case Investigator Training - providing the Trust with broad knowledge and resilience in this area.**

The Trust's MHPS policy was fully revised and updated in June 2023.

The Trust are also in the process of finalising the terms of reference for a "Good Medical Practice Group" (GMPG) – adopted from one of our neighbouring Trusts and very much seen as an exemplar in this particular area of medical governance. The GMPG will provide further assurance through a formally recognised decision making group for the organisation - supporting the Responsible Officer when considering and managing concerns regarding medical staff. The GMPG will also ensure that support is in place and provided to those Doctors where concerns have been raised and to ensure due process, equity and fairness are followed in all proceedings.

Action for next year: **Finalise terms of reference and implementation of GMPG**

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: **Continue timely completion of forms where required** Comments: **The Trust completes the NHS England Medical Practice Information Transfer (MPIT) form where information or concerns need to be shared between respective Responsible Officers** Action for next year: **Continue timely completion of forms where required**

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: **Maintain safeguards** Comments: **The Trust and senior management uphold good practices relating to handling of concerns about clinical practice based on the GMC governance handbook. Our Responsible Officer deputises for all matters relating to the GMC with quarterly meetings held locally with our GMC Employer Liaison Advisor.** Action for next year: **Maintain safeguards**

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: **Maintain compliance** Comments: **Appropriate pre-employment background checks are carried out by the Trust's recruitment team. HCL Doctors are used as the master vendor for providing Medical Locums across all specialties for all medical roles** Action for next year: **Maintain compliance**

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

General review of actions since last Board report

Very successful implementation of new appraisal and revalidation software – smooth switchover between old and new systems for Doctors, Appraisers and Administrators achieved with positive feedback received from key stakeholders

Targeted areas for appraiser development on-going - based upon full review of individual quality assurance assessments undertaken by Lead Appraisers over the last 12 months having utilised the PROGRESS tool. Scope to further develop in this area with enhanced features within new appraisal software concerning appraiser feedback

Continued promotion of Whole Scope of Practice form completion for work undertaken at different NHS Trusts – message reiterated to appraisers at regular updates and within quarterly newsletters

MHPS policy fully revised and updated within the last year

Actions still outstanding

Nil

Current Issues

Nil

New Actions

Update Trust policy on Medical Appraisal & Revalidation this year to reflect Trust changes in appraisal/revalidation software, MAG 2023 and consideration of updated versions of Framework for Quality Assurance and GMC Good Medical Practice

Undertake targeted recruitment of appraisers within specialities where the appraiser to appraisee ratio is not currently at the desired level

Utilise the much more detailed appraiser feedback resources available within our new L2P appraisal software to further build upon appraiser quality assurance process

Finalise terms of reference and implementation of Trust “Good Medical Practice Group”

Overall conclusion

The Trust continues to ensure all Doctors engage in appraisal with the Revalidation Team aiming to fully optimise the L2P appraisal software for the management of appraisals and revalidation recommendations.

Based on the embedded systems and processes in place within the Trust, the Revalidation Team continues to work from a position of strength and can provide assurance that:-

Appraisals are undertaken appropriately and in accordance with national and local policies, procedures and guidelines in order for the RO to make revalidation recommendations to the GMC
Robust quality checking of appraisers is taking place
Doctors are continually supported by the Revalidation Team with their appraisals and revalidation
Outstanding appraisals are routinely addressed
Appraisers have access to dedicated support and training to aid their roles as appraisers

Section 7 – Statement of Compliance:

The **Board** of **South Tees Hospitals NHS Foundation Trust** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: **South Tees Hospitals NHS Foundation Trust**

Name: **Sue Page**

Signed: 

Role: **Chief Executive Officer**

Date: **25th October 2023**

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication reference: PR1844

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 5 DECEMBER 2023			
2022 -23 EPRR annual statement			**AGENDA ITEM: 13 ENC 10**
Report Author and Job Title:	Laura Mills, Head of Facilities (Deputy EPRR lead)	**Responsible Director:**	Dr Michael Stewart Accountable Emergency Officer
Action Required	Approve ☒ Discuss ☐ Inform ☒		
Situation	The accountable emergency officer (AEO) must provide a report to the Trust Board regarding emergency preparedness, resilience, and response (EPRR) activity no less frequently than annually and the Trust Board must state its readiness and preparedness activities in the report within the organisation's own regulatory reporting requirements.		
Background	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect services or patient care. These could be anything from loss of power or extreme weather conditions to an infectious disease outbreak, major transport accident, cyber security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act (CCA) 2004, the NHS Act 2006 and the Health and Care Act 2022. Under the CCA the Trust is designated as a category 1 responder which means that it must be able to provide an effective response to emergencies whilst maintaining services. It is subject to the full range of civil protection duties as follows: This work is referred to as 'emergency preparedness, resilience and response' (EPRR) and requires NHS organisations to develop plans, policies and procedures, provide training for staff on their role in an incident, exercise these plans to ensure they are fit for purpose and support any response and recovery efforts when an incident occurs.		
Assessment	This year there are 62 standards that the Trust is required to report against, split into 10 domains. The Trust is reporting an overall assessment of '**Partially Compliant'**.		
Level of Assurance	Level of Assurance:		

	Significant ☐ Moderate ☒ Limited ☐ None ☐	
Recommendation	Members of the Board of Directors are asked approve the overall assessment.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Principal risk 2 - A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community	
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

MEETING OF THE PUBLIC BOARD OF DIRECTORS – 5 DECEMBER 2023			
Standing Financial Instructions, Standing Orders and Scheme of Delegation.			**AGENDA ITEM: 14** **ENC 11**
Report Author and Job Title:	Brian Simpson (Head of Financial Governance and Control)	**Responsible Director:**	Chris Hand (Chief Finance Officer)
Action Required	Approve ☒ Discuss ☒ Inform ☐		
Situation	To brief members on required updates to the Trust's Standing Financial Instructions and Scheme of Delegation.		
Background	The Trust's Standing Financial Instructions, Standing Orders and Scheme of Delegation were approved by the Board of Directors in November 2021. The latest updates covered in this report concern changes to Procurement and Funds held in Trust.		
Assessment	The Standing Financial Instructions and Scheme of Delegation have been specifically updated for the following purposes: • to ensure national and regional agreements are complaint with the Public Contract Regulations 2015; • to update formal tendering limits to bring the Trust in line with the majority of the Trusts in the ICB; and • to update procedures from manual to current electronic systems. The following report outlines the existing instructions and delegatory limits followed by the updated text including proposed changes. These are supported by the rationale for the changes and have been recommended by the Audit & Risk Committee for approval		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Board of Directors to approve the proposed changes to the Standing Financial Instructions and Scheme of Delegation		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	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 ☐	

Standing Financial Instructions, Standing Orders and Scheme of Delegation.

1. PURPOSE OF REPORT

The purpose of the report is to brief members on required updates to the Trust's Standing Financial Instructions and Scheme of Delegation.

2. BACKGROUND

The Trust's Standing Financial Instructions, Standing Orders and Scheme of Delegation were approved by the Board of Directors in November 2021. The latest updates covered in this report concern changes to Procurement and Funds held on Trust.

3. DETAILS

Updates to Standing Financial Instructions

The following updates outline the existing and revised wording for each proposed change to the instruction, supported by the rationale for the change.

Ref.	Current wording	Revised wording
7.4.1	The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.	The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money.
Rationale for change	South Tees is required to utilise the Government Banking Service who provide a shared banking service across central government and wider public sector customers. https://www.gov.uk/government/groups/government-banking-service-gbs	
9.4	**Formal competitive Tendering**: Formal tendering will apply to all aggregated expenditure that exceeds, or is likely to exceed, £25,000. The only circumstances in which this can be waivered are outlined in paragraph 9.4.3	**Formal Competitive Tendering:** Formal tendering will apply to all aggregated expenditure that exceeds, or is likely to exceed, £50,000. Where the term of the contract is not defined, the aggregated value of the contract should be estimated over a 4-year period. The only circumstances in which this can be waivered are outlined in paragraph 9.4.3.
Rationale for change	The request to increase the formal tendering limit will bring us in line with the majority of the Trusts in the ICB. There is still a requirement to ensure value for money is achieved but these procedures will be managed through formal quotation. The inclusion of the 4 years aggregation period is a point of clarity and in line with the Public Contracts Regulations 2015.	

Ref.	Current wording	Revised wording
9.4.3	**Exceptions and instances where formal tendering need not be applied**: a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000; e) where national or regional procurement agreements are in place and have been approved by the Board;	**Exceptions and instances where formal tendering need not be applied:** a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000; e) where national or regional procurement agreements are in place;
Rationale for change	a) As per 9.4 above. b) Procurement are responsible for ensuring that national and regional agreements are complaint for the Public Contract Regulations 2015 prior to the Trust accessing the contract. Approval will sought through the standard approval process.	
9.4.3	Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee meetings scheduled to consider the waiver of requirements to competitively tender. In the event of a waiver being approved for the supply of goods or services, the Trust should agree to carry out a tender process to support future requirements.	Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee. In the event of a waiver being approved for the supply of goods or services, the Trust should agree to carry out a tender process to support future requirements.
Rationale for change	The wording has been revised to clear up any ambiguity on when Audit Committee review the tender waivers. This is in line with current practice where waivers are reported at the next scheduled Audit Committee meeting.	
9.5.3	**Opening tenders and Register of tenders** A register shall be maintained by the Chief Finance Officer, or a person authorised by him / her, to show for each set of competitive tender invitations despatched:	**Opening tenders and Register of tenders** A register, electronically or otherwise, shall be maintained by the Chief Finance Officer, or a person authorised by him / her, to show for each set of competitive tender invitations despatched:
Rationale for change	The amended wording takes into account that all formal tenders are managed via the Trust's electronic tender management system.	

Ref.	Current wording	Revised wording
9.5.6	**Acceptance of formal tenders:** b) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted, unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.	**Acceptance of formal tenders:** b) If payment is to be made by the Trust, the MEAT (Most Economically Advantageous Tender) must be accepted. If payment is to be received by the Trust, then the highest payment must be accepted. Such reasons shall be set out in either the contract file, or other appropriate record.
Rationale for change	The Public Contract Regulations stipulates that Contracting Authorities must apply the MEAT criteria when awarding contracts. This takes into account all the requirements outlined in the specification and ensures that the Trust enters into contracts than not only meet those requirements but also provide best value for money. This is likely to change in the near future to require us to implement MAT (Most Advantageous Tender) criteria. We will review the critical difference between these two measures as more information is available.	
9.6.1	**General position on quotations** Quotations are required where formal tendering procedures are not adopted and where the intended aggregated expenditure or income exceeds £10,000 but is not greater than £25,000.	**General position on quotations** Quotations are required where formal tendering procedures are not adopted and where the intended aggregated expenditure or income exceeds £10,000 but is not greater than £50,000.
Rationale for change	As per 9.4 above	
14.4 14.4.1 14.4.2 14.4.3	**Issue of stock** The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Chief Finance Officer. Regular comparisons shall be made of the quantities issued to wards and departments and an explanation recorded of significant variances. All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Chief Finance Officer.	**Management of stock** All stock held at ward and department level, regardless of supply route, (consignment, directly ordered, materials management or replenished by an inventory management system) is the responsibility of the Chair of the Clinical Collaboratives, and as such, systems and processes must be implemented to ensure it is used to support Trust based patient care. It is the responsibility of the Chair of the Clinical Collaboratives to ensure processes are in place to avoid wastage of stock either as a result of damage or exceeding recommended expiry dates. Systems must be implemented in conjunction with the Procurement and Finance departments to ensure there is correlation between high value stock ordered and final consultant episodes.
Rationale for change	The original points date back to a time when manual stock transfer sheets were used to show the value and quantity of stock items which were delivered to a specific area. This is now captured electronically. The revised wording aims to place the responsibility for ensuring stock is owned and managed by the Clinical Collaboratives.	

Update to the Scheme of delegation

Current wording		Revised wording	
Delegated matter	Authority delegated to	Delegated matter	Authority delegated to
5 - Quotation, tendering and contract procedures			
Obtaining informal quotations for goods/services to demonstrate value for money and a common-sense approach up to £10,000.	Budget holders and General Managers in association with Procurement	Obtaining informal quotations for goods/services to demonstrate value for money and a common sense approach up to £10,000.	Budget holders and General Managers in association with Procurement
Obtaining 3 formal quotations for goods/services from £10,001 to £25,000.	Budget holders / General Manager and Service Manager in association with Procurement	Obtaining 3 formal quotations for goods/services from £10,001 to **£50,000.**	Budget holders / General Manager and Service Manager in association with Procurement
Obtaining formal tenders for goods/services over £25,000	Budget Holders / General Manager and Service Managers in association with Procurement	Obtaining formal tenders for goods/services over **£50,000**	Budget Holders / General Manager and Service Managers in association with Procurement
Tenders to comply with OJEU requirements and thresholds.	Head of Procurement	Tenders to comply with OJEU requirements and thresholds.	Head of Procurement
Waiving of tenders exceeding £25,001.	Chief Executive and Managing Director or Chief Finance Officer and reported to Audit Committee.	Waiving of tenders exceeding **£50,001.**	Chief Executive and Managing Director or Chief Finance Officer and reported to Audit Committee.
Rationale for change	The request to increase the formal tendering limit will bring us in line with the majority of the Trusts in the ICB. There is still a requirement to ensure value for money is achieved but these procedures will be managed through formal quotation.		

Current wording		Revised wording	
Delegated matter	Authority delegated to	Delegated matter	Authority delegated to
5 - Quotation, tendering and contract procedures			
- Authorise Single Tender action			
i) £25,001 to £250,000	Chief Executive and Managing Director and Chief Finance Officer	i) **£50,001** to £250,000	Chief Executive **or** Managing Director and Chief Finance Officer
ii) Over £250,001	Chief Executive and Managing Director and Chief Finance Officer and one Executive Director and Chair of Audit Committee and reported to next Board meeting	ii) Over £250,001	Chief Executive **or** Managing Director and Chief Finance Officer and one Executive Director and Chair of Audit Committee and reported to next Board meeting.
Rationale for change	Rationale for £50k limited explained above. The approvers have been amended to allow the Chief Exec or the Managing Director to countersign single tender actions. This is a more practical approach that ensures oversite without creating unnecessary burden.		

Current wording		Revised wording	
Delegated matter	Authority delegated to	Delegated matter	Authority delegated to
5 - Quotation, tendering and contract procedures			
- Authorisation of Tenders			
i) Over £25,001	Chief Finance Officer/Chief Executive / Managing Director	i) Over **£50,001**	Chief Finance Officer/Chief Executive / Managing Director
Rationale for change	Rationale for £50k limited explained above.		

Current wording		Revised wording	
Delegated matter	Authority delegated to	Delegated matter	Authority delegated to
8. Expenditure on charitable funds			
		i) Up to £1000	Fundholders
i) Up to £5,000 per request	Fund-holder - subject to confirmation by Trust Fund Manager, that funds are available.	ii) £1,001 to £5,000 per request	As above counter signed by either Clinical Director,Service Manager or Head of Charity
ii) £5,001 to £25,000 per request	As above and Operations Director	iii) £5,001 to £25,000 per request	As above counter signed by either the Collaborative Chair or Head of Charity Governance
iii) £25,0001 to £100,000 per request	As above and Charitable Funds Committee – ((Urgent decisions in relation to expenditure outside of the Charitable Funds Committee meetings must have the approval of the Chair of the Charitable Funds Committee, the Chief Finance Officer and the Chief Executive. The urgent decision must be reported to the next meeting of the Charitable Funds Committee meeting for formal ratification)	iv) £25,0001 to £100,000 per request	As above and Charitable Funds Committee – ((Urgent decisions in relation to expenditure outside of the Charitable Funds Committee meetings must have the approval of the Chair of the Charitable Funds Committee, the Chief Finance Officer and the Chief Executive. The urgent decision must be reported to the next meeting of the Charitable Funds Committee meeting for formal ratification)
iv) Above £100,001 per request	Corporate Trustee	v) Above £100,001 per request	As above and Corporate Trustee
Rationale for change	Improved governance and fund management with greater control over the approval of expenditure to ensure charitable funds are expended on the intended purpose.		

RECOMMENDATIONS

Members of the Board of Directors are asked to approve the proposed changes to the Standing Financial Instructions and Scheme of Delegation

South Tees Hospitals
NHS Foundation Trust

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS - 5 DECEMBER 2023			
Use of Seal			**AGENDA ITEM: 15** **ENC 12**
Report Author and Job Title:	Jackie White Head of Governance & Co Secretary	**Responsible Director:**	Sue Page Chief Executive Derek Bell Chairman
Action Required	Approve ☐ Discuss ☐ Inform ☒ (select the relevant action required)		
Situation	In line with the Trust's Constitution this report provides information on the documents affixed under seal between 1 October 2022 and 20 November 2023		
Background	In line with the Constitution para 14.5 Register of Sealing - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and attested the seal. A report of all sealing shall be made to the next Board of Directors meeting. (The report shall contain details of the seal number, the description of the document and date of sealing).		
Assessment	There are no underlying issues for discussion regarding this report.		
Level of Assurance	Level of Assurance: Significant ☐ Moderate ☒ Limited ☐ None ☐		
Recommendation	Members of the Trust Board are asked to note the sealed documents report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	Legal requirement of 2006 Act incorporated in Trust board standing orders		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Best for safe, clinically effective care and experience ☒	A great place to work ☒	
	Deliver care without boundaries in collaboration with our health and social care partners ☒	Make best use of our resources ☒	
	A centre of excellence, for core and specialist services,		

	research, digitally-supported healthcare, education and innovation in the North East of England, North Yorkshire and beyond ☒	

1.0 Introduction

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

In line with the Trust's Standing Orders this report provides information on the documents affixed under seal between 1 October 2022 and 30 November 2023:

Table 1. Sealed Documents

Date of Sealing	Seal No	Document	Signed and Sealed by
3 April 2023	2023/001	Settlement agreement – South Tees Hospitals NHS Foundation Trust, Endeavour SCH PLC and SERCO Ltd	Sue Page, CEO Derek Bell, Chairman
17 May 2023	2023/002	P22 FA Template A: major works project NEC3 EEC, South Tees Hospitals NHS Foundation Trust and Integrated Health projects	Sue Page, CEO Derek Bell, Chairman
17 May 2023	2023/003	P23 Framework agreement 05A.C Project Agreement NEC4 Option C Target Contract with activity schedule South Tees Hospitals NHS Foundation Trust and Integrated Health projects	Sue Page, CEO Derek Bell, Chairman
27 June 2023	2023/004	Lease relating to unit 2 Eggleston Court, Riverside Park, Middlesbrough TS2 1RU, South Tees Hospitals NHS Foundation Trust and Kings crown land and Commercial Ltd	Sue Page, CEO Robert Harrison, Managing Director
27 June 2023	2023/005	Letter of indemnity – capital works variation VO669, South Tees Hospitals NHS Foundation Trust and Endeavour SCH PLC	Sue Page, CEO Robert Harrison, Managing Director
27 June 2023	2023/006	Letter of variation – capital works VO632 South Tees Hospitals NHS Foundation Trust and Endeavour SCH PLC	Sue Page, CEO Robert Harrison, Managing Director
27 June 2023	2023/007	Letter of variation – capital works VO607 South Tees Hospitals NHS Foundation Trust and Endeavour SCH PLC	Sue Page, CEO Robert Harrison, Managing Director
16 October 2023	2023/008	Letter of indemnity – capital works variation VO763 – removal of red sheds from site South Tees Hospitals NHS Foundation Trust and Endeavour SCH PLC	Robert Harrison, Managing Director Derek Bell, Chairman
16 October 2023	2023/009	Confirmation of agreement to complete the project within scheme – CT scanner – Deed P22 FA Template A, South Tees Hospitals NHS Foundation Trust and Integrated Health Projects	Robert Harrison, Managing Director Derek Bell, Chairman

2.0 Recommendation

The Board is asked to note the documents included within the report that were affixed under seal during 1 October 2022 and 30 November 2023

South Tees Hospitals NHS Foundation Trust

MEETING OF PUBLIC TRUST BOARD OF DIRECTORS – 5 DECEMBER 2023			
Finance Report			**Agenda Item 16 ENC 13**
Report Author and Job Title:	Chris Dargue Deputy Chief Finance Officer	**Responsible Director:**	Chris Hand Chief Finance Officer
Action Required	Approve ☐ Discuss ☒ Inform ☒		
Situation	This report outlines the Trust's financial performance as at Month 7 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. As per NHSE guidance the Month 7 position excludes the recommendations and funding relating to the Industrial Action which was announced on the 8th of November 2023.		
Assessment	At Month 7 the reported position is a deficit of £18.2m 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 Board are asked to: • Note the financial position for Month 7 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 7 2023/24 Financial Performance

1. PURPOSE OF REPORT

The purpose of the report is to update the Board on the Trust's financial performance as at Month 7 of 2023/24.

As per NHSE guidance the Month 7 position excludes the recommendations and funding relating to the Industrial Action which was announced on the 8th of November 2023.

2. BACKGROUND

For 2023/24, the system-based approach to planning and delivery continues, with each provider trust fully mapped to a single Integrated Care System (ICS). North East and North Cumbria (NENC) Integrated Care Board (ICB) 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.

DETAILS

Trust Position Month 7 2023/24

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.

NHSE have enabled trusts to alter plans for material changes in income and expenditure since the submission in May, however planned profiles and adjusted financial performance surplus/deficits must remain unchanged. Therefore, to minimise variances in income and expenditure the table below reflects the additional expected income and expenditure for the 2023/24 Agenda for Change (AFC) pay award and the Medical Staff pay award.

The Month 7 position against the NHSE plan and current operational budget is outlined in the table below:

STATEMENT OF COMPREHENSIVE INCOME	YTD NHSE Plan £000	YTD Operational Plan £000	YTD Actual £000	YTD Variance £000
Operating income from patient care activities	465,609	470,880	472,111	1,232
Other operating income	28,317	29,567	31,305	1,738
Employee expenses	(296,543)	(306,893)	(309,138)	(2,245)
Operating expenses excluding employee expenses	(202,228)	(200,659)	(201,085)	(426)
OPERATING SURPLUS/(DEFICIT)	**(4,845)**	**(7,106)**	**(6,807)**	**299**
FINANCE COSTS				
Finance income	602	1,783	1,869	86
Finance expense	(11,256)	(11,256)	(10,945)	311
PDC dividends payable/refundable	(3,367)	(2,287)	(2,248)	39
NET FINANCE COSTS	**(14,021)**	**(11,760)**	**(11,324)**	**436**
Other gains/(losses) including disposal of assets	0	0	53	53
Corporation tax expense	0	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(18,866)**	**(18,866)**	**(18,078)**	**788**
Add back all I&E impairments/(reversals)	0	0	0	0
Remove capital donations/grants/peppercorn lease I&E impact	690	690	(84)	(774)
Adjusted financial performance surplus/(deficit)	**(18,176)**	**(18,176)**	**(18,162)**	**14**
Less gains on disposal of assets	0	0	0	0
Adjusted financial performance for the purposes of system achievement	**(18,176)**	**(18,176)**	**(18,162)**	**14**

At the end of Month 7 2023/24, the cumulative system performance deficit was £18.2m, which is in line with the year-to-date plan.

The variance is shown against the current operational budget, which adjusts for the impact of in-year net neutral I&E budget adjustments (such as for pass-through funded high-cost drugs and devices and funded developments).

Operating Income from Patient Care Activities

Under the financial arrangements for 2023/24, the Trust is paid under a block arrangement apart from the following items:

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

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

INCOME FOR PATIENT CARE ACTIVITIES	Operational Plan £000	Actual £000	Variance £000
NHS England	150,250	150,353	103
ICB/Clinical commissioning groups	319,061	320,127	1,066
Non-NHS: private patients	571	764	193
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	119	40	(79)
Injury cost recovery scheme	833	789	(44)
Non-NHS: other	45	38	(7)
TOTAL INCOME FOR PATIENT CARE ACTIVITIES	**470,880**	**472,111**	**1,232**

Operating income from Patient Care Activities was £472.1m for Month 7 and was £1.2m ahead of plan. The operational plan has been adjusted for high-cost drugs and devices that are funded on a pass-through basis.

The NHS England position is £0.1m ahead of plan. The ICB/CCG income is ahead of plan by £1.1m and relates to ERF income and additional contract variations. The Month 7 position assumes £0.7m additional income relating to ERF over performance. The over performance mainly relates to HNY ICB commissioned activity and is in line with the financial value calculated nationally by NHSE for the first 4 months of the financial year.

Private Patient income remains ahead of plan by £0.2m and RTA income is slightly behind plan.

Other Operating Income

Other income received up to Month 7 totalled £31.3m and was ahead of plan by £1.7m and includes all non-direct patient care income.

OTHER OPERATING INCOME	Operational Plan £000	Actual £000	Variance £000
Research & Development	3,292	4,039	747
Education and Training	14,904	15,475	571
Non Patient Care Income	1,393	1,331	(62)
Reimbursement & Top-Up funding	0	0	0
Employee benefits accounted on a gross basis	2,702	2,836	134
Other	7,276	7,624	348
TOTAL OTHER OPERATING INCOME	**29,567**	**31,305**	**1,738**

Research & Development income is ahead of plan by £0.7m year-to-date and can be offset by the expenditure position. Training and Education income is ahead of plan by £0.6m year-to-date, which is offset within the expenditure position.

Other income includes £0.7m donated asset income (which is excluded from reporting the financial position as part of the system control total).

Employee Expenses (Pay)

The Trust's total expenditure on pay for Month 7 of 2023/24 was £309.1m and was overspent by £2.2m; a breakdown is included in the table below.

PAY	Operational Plan £000	Actual £000	Variance £000
Ahp'S, Sci., Ther. & Tech.	(44,472)	(43,744)	728
Hca'S & Support Staff	(34,825)	(34,209)	616
Medical And Dental	(89,809)	(91,807)	(1,998)
Nhs Infrastructure Support	(46,746)	(47,287)	(541)
Nursing & Midwife Staff	(89,856)	(90,545)	(689)
Other Pay Costs	(1,185)	(1,546)	(361)
TOTAL PAY	**(306,893)**	**(309,138)**	**(2,245)**

Pay expenditure includes the actual year-to-date cost of the 2023/24 AFC and medical pay award.

Overspends are apparent in most pay categories, particularly Medical & Dental, NHS infrastructure support staff, and Nursing & Midwife staff. The position includes the

actual and estimated costs of the industrial action relating to the first 7 months of 2023/24.

Agency spend is included within the reported pay expenditure position and totalled £4.1m to the end of Month 7. Overall agency expenditure is broadly in line with the plan, which assumed a further reduction of £400k / 5.5% in agency spend from 2022/23 levels.

Operating Expenses excluding Employee Expenses (Non-Pay)

The Trust's total expenditure on operating non-pay for Month 7 of 2023/24 was £201.1m and a breakdown is included in the table below:

NON PAY	Operational Plan £000	Actual £000	Variance £000
Purchase of Healthcare	(8,669)	(8,606)	63
Clinical Supplies & Services	(59,893)	(60,164)	(271)
Drugs	(53,481)	(53,893)	(412)
External Staff & Consultancy	(627)	(175)	452
Establishment	(9,240)	(8,577)	663
Premises & Fixed Plant	(15,736)	(15,926)	(190)
Transport	(2,919)	(2,813)	106
Depreciation & Amortisation	(13,761)	(13,055)	706
Research	(1,491)	(2,176)	(685)
Training & Education	(1,071)	(1,530)	(459)
PFI Unitary Payment	(21,534)	(21,678)	(144)
Other	(2,195)	(2,450)	(255)
Clinical Negligence	(10,042)	(10,042)	0
TOTAL NON PAY	**(200,659)**	**(201,085)**	**(426)**

The non-pay year to date position is overspent by £0.4m overall.

Expenditure on Clinical Supplies is £0.3m underspent, which is offset by an overspend of £0.4m on Drugs. Research expenditure is overspent £0.7m year-to-date but can be offset by the income position. Training & education is overspent by £0.5m year-to-date and can also be offset by the income position.

Financing Costs

Net finance costs are underspent by £0.4m overall, largely relating to IFRS 16 charges that are less than plan but are partially offset by charges in operating expenses.

Interest receivable is above plan by £0.1m (reflecting higher cash balances and increased interest rates from the Government Banking Service (GBS) Account). It is anticipated that these returns will fall through the remainder of the year as the Trust's liquidity reduces in line with plan.

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.

Total delivery against the year-to-date plan stands at £20.4m (97.0%) at Month 7, as shown in the table below.

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000
Recurrent			
Pay - Recurrent	7,566	4,606	(2,960)
Non-pay - Recurrent	6,096	7,013	917
Income - Recurrent	613	485	(128)
Total recurrent efficiencies	14,275	12,104	(2,171)
Non recurrent			
Pay - Non-recurrent	3,776	3,964	188
Non-pay - Non-recurrent	2,828	2,167	(661)
Income - Non-recurrent	130	2,139	2,009
Total non-recurrent efficiencies	6,734	8,270	1,536
Total Efficiencies	21,009	20,374	(635)

Capital

The Trust's gross capital expenditure plan for the 2023/24 financial year now totals £51.3m.

The Trust's ICS Capital Departmental Expenditure Limit (CDEL) for 2023/24 amounts to £11.3m.

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

The plan also includes expected PFI lifecycle costs of £13.7m.

The Trust's capital expenditure for Month 7 of 2023/24 amounted to £20.7m as detailed below:

	Year to Date £000		
	Plan	Actual	Variance
Estates	2,125	2,158	33
Equipment	800	716	(84)
IT	250	1,509	1,259
Sub Total ICS Allocation	**3,175**	**4,383**	**1,208**
PDC Funded schemes:			
FHN Theatres	7,945	5,719	(2,226)
Digital	150	0	(150)
UTC	0	1,937	1,937
Charitable Funded schemes:			
Cardiovascular investment	0	678	678
Sub Total PDC and Charitable Funded schemes	**8,095**	**8,334**	**239**
PFI Lifecycle	7,981	7,982	1
Total Gross Capital Expenditure	**19,251**	**20,699**	**1,448**

Liquidity

The cash balance as at the 31st October amounted to £38.1m.

The strong year to date position on liquidity has helped support the Trust's performance against the 95% Better Payment Practice Code and the position for the period to date is shown below:

	YTD Number	YTD £000
Total bills paid in the year	55,244	355,819
Total bills paid within target	53,706	335,103
Percentage of bills paid within target	97.2%	94.2%

Statement of Financial Position (SOFP)

The following table shows the SOFP as at 31st October, and the movement since the prior month:

	30 September 2023 £000	31 October 2023 £000	Movement between months £000
Property, Plant and Equipment	338,174	341,048	2,874
Long Term Receivables	1,550	1,401	(149)
Total Non-Current Assets	339,724	342,449	2,725
Current Assets			
Inventories	15,286	15,337	51
Trade and other receivables (invoices outstanding)	10,407	10,436	29
Trade and other receivables (accruals)	18,577	19,520	943
Prepayments including Pfi	19,508	15,954	(3,554)
Cash	28,371	38,075	9,704
Total Current Assets	92,149	99,322	7,173
Current and Non-Current Liabilities			
Borrowings	(184,825)	(184,578)	247
Trade and Other Payables	(144,937)	(154,012)	(9,075)
Provisions	(2,637)	(2,637)	0
Total Current and Non-Current Liabilities	(332,399)	(341,227)	(8,828)
Net Assets	99,474	100,544	1,070
Equity:			
Income and Expenditure Reserve	(347,257)	(350,602)	(3,345)
Revaluation Reserve	33,138	33,138	0
Public Dividend Capital	387,117	391,532	4,415
Other Reserves	26,476	26,476	0
Total Equity	99,474	100,544	1,070

3. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 7 2023/24.

South Tees Hospitals NHS Foundation Trust

JOINT PARTNERSHIP BOARD
Chair's Log

Meeting: Joint Partnership Board	**Date of Meeting**: 15 November 2023
	Chair – Derek Bell

Key topics discussed in the meeting	
• Chair's report covering the appointment of the Group CEO, Joint Council of Governors meeting, NHS confederation briefing and ICS FT chairs briefing • Urgent Care Services mobilisation programme – setting out the next steps to be taken to mobilise (bearing in mind the contract award is not expected until December 2023) • TV diagnostics programme update • Partnership Agreement • Legal advice on the formation of the Group Model and Partnership Agreement • Group digital strategy	
Actions	**Responsibility / timescale**
• Approval of the partnership agreement for final consideration by the statutory boards of each trust on 29 November – Associate Director of Group Development/board secretaries • Proceed with implementation of the steps in the digital strategy – CITO/Digital Director	
Escalated items	
• Approval of the partnership agreement	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Risk register was updated following previous meeting; full session on risk strategy to be planned for early 2024.	

South Tees Hospitals NHS Foundation Trust

Meeting: **Quality Assurance Committee**	**Date of Meeting**: 25/10/2023
Connecting to: **Council of Governors**	Miriam Davidson – Chair of Quality Assurance Committee

Key topics discussed in the meeting	

The following Assurance reports were considered:

- Board Assurance Framework , reports at QAC for assurance reflect the themes and priorities in the Monthly Integrated Quality and Performance report
- Q2 Safeguarding Children and Adults report, the governance and reporting was clearly described. QAC discussed the response to increased referrals, both in volume and complexity.
- Falls report ..initial analysis welcomed, further work is needed to develop a Quality Improvement Plan.
- Patient Safety Incident report, taking account of the transition to PSIRF
- Pressure Ulcer report, detailed actions in the Pressure Ulcer Improvement Plan providing assurance , with additional work ongoing in the community .
- STAQC quarterly report
- The first report from the Health Inequalities Group
- Chairs' Logs from reporting groups

Actions	Responsibility / timescale
• Development of a Quality Improvement Plan to prevent falls	A Brownrigg : January 2024
• Safeguarding leads to check LAC Initial Health Assessment timelines	L.Britton-Robertson. : January 2024

Escalated items
• The Chair's Log reflects an issue raised at the Safe and Effective Care Strategic Group (19/10/2023) about work on Cat 3 and 4 pressure ulcers within community services. QAC welcomed the increase in reporting of pressure ulcers since the introduction of rapid review processes and safety huddles in high frequency wards . This positive practice is being implemented throughout the Trust. • An Ockenden peer review of Neonatal and Maternity services / assurance visit took place , 28/10/2023. Visits are to obtain assurance that providers are compliant in all areas of the Ockenden Immediate and Essential actions. A full report will be available in three weeks following the visit.

Risks (Include ID if currently on risk register)	Responsibility / timescale
No risks to add on 25/10/2023	

South Tees Hospitals NHS Foundation Trust

October Resources Committee Chair's Log

Meeting: Resources Committee	**Date of Meeting** 26/10/2023
Connecting to: Council of Governors	David Redpath – Chair of Resources Committee

Key topics discussed in the meeting

Financial position for Month 6

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. The Trust's cumulative operating deficit at Month 6 of 2023/24 was £5.0m and the overall deficit for was £14.6m. The adjusted financial position for the purpose of system performance was a deficit of £14.8m. This year-to-date financial position is on plan. At Month 6 the Trust's forecast outturn position was in line with plan for the 2023/24 financial year.

Cost Improvement Programme (CIP)

The Trust has reported year-to-date CIP delivery of £17m, which is 97% of the target as at the end of Quarter 2 2023/24. The current forecast year-end delivery is £37.5m, which is 95% of the annual target. Additional schemes being developed will continue to increase the forecast.

For context, the table below compares performance in the same period last year, and shows a significant increase across all areas:

	M6 2022/23 £000	M6 2023/24 £000
Collaboratives	3,042	6,855
Corporate	1,866	3,826
Central / Technical	1,895	6,389
Total	**6,803**	**17,070**

Digital

The committee received the updated digital paper, once again noting the improvement in quality and information contained. Progress is being made and the committee are satisfied that those that the areas that are slightly off track are receiving the required attention. The business case of EDMS (scanning of records) will be presented at the next committee.

Information Governance

The trust achievement of 95% compliance rate in the annual mandatory training in Information Governance is a major step forward given that In the previous 3 years to FY22/23, the Trust had not been able to achieve a "MET" rating in part due to falling short on staff training and legacy software issues.

It should be noted that the different approach, allowing ESR and in class sessions has had a major impact on this and the committee would like to thank the IG, IT, HR and Comms teams for their great work on developing the new approach.

Procurement

The 2023/24 savings target set for the Procurement Department was £2,000,000, with an additional stretch increasing it to £3,000,00 to be achieved across all functions within the department including the contracting team, the operational team, and the logistics team.

The contracting work plan for 23/24 consists of 144 projects with a potential, projected full year saving of £2,741,113. The position at the end of Q2 is as follows: -

- 32 projects have now been completed generating savings totalling £1,817,497 Full Year with £1,728,042 being In Year.
- 31 projects were completed which did not achieve any savings but ensured the trust complied with current procurement regulations.
- The total value of the contracts awarded by the end of Q2 was £39.14m
- 9 I.T projects have now been completed with a contract value of £3.99m
- 22 Capital projects have been completed with a contract value of £33.60m

Green Plan

The updated green plan was presented to the committee and welcomed as a good update – the committee asked for further work to be completed regarding partnership working, particularly local partners and to look into other schemes such as LED lighting replacement which could have zero capital outlay.

In order to deliver the major step change the trust will be reliant on securing funding sources to enable the significant investment required to reduce the organisations reliance on the burning of fossil fuels. Until these are in place the risks cannot be fully mitigated. The trust had submitted the grant request but unfortunately the provider had some technical challenged and as a result all requests need to be resubmitted in November.

Actions	Responsibility / timescale
Green Plan - Mrs White to speak to Trust's Chair regarding NED/Executive sponsorship of the Green Plan	
Green Plan – Look at regional partnerships. Ms Gerner to provide details	

Escalated items	
Key Issues/ Concerns for escalation: Issues with the accommodation for the procurement team – Phil Sturdy to review	
Risks (Include ID if currently on risk register)	Responsibility / timescale
No Additional Risk Identified	

South Tees Hospitals NHS Foundation Trust

PEOPLE COMMITTEE

Chair's Log

Meeting: NHS South Tees – People Committee	**Date of Meeting**: 20.10.2023
Connecting to: Council of Governors	Mark Dias – Chair of People Committee

Key topics discussed in the meeting

- Staff Survey – Action Plans
- Medical Education
- Civility, Human Factors & Simulation
- WRES Annual Report
- WDES Annual Report
- Talent Deep Dive – Deferred (November 2023)

Actions	Responsibility / timescale

Staff Survey – Action Plans
Collaborative review of staff survey data and actions plans. Particular focus on areas identified for improvement, root cause analysis and 'how' interventions will result in positive change. A valuable exercise and time constrained; decision for half day event in 2024 to allow additional scrutiny and assurance.

Medical Education
Review of Newcastle Medical School and Northern Foundation School visit (03.03.2023), annual deans quality management visit (05.05.2023), Hull and York Medical School (HYMS) visit (17.05.2023) and GMC survey results (11.07.2023). Committee noted the positive comments (undergraduate medical education) and areas for improvement (GMC survey). Assurance provided on process for change (w. action plans) and improvements was in place and active.

Civility, Human Factors & Simulation
Committee noted the report and the requirement for board level engagement, support and championing.

WRES Annual Report
Committee noted an excellent report and positive changes (since 2022). There remain areas for improvement (BAME staff network) and assurance there is board level interventions in place.

WDES Annual Report
Committee noted an excellent report and positive changes (since 2022).

Escalated items

Key Issues/ Concerns for escalation:

Absenteeism is moving in the wrong direction (upwards).

Sharing good practice/Things to celebrate:

Staff survey is demonstrating tangible morale and engagement improvements; result of cultural change and leadership development initiatives.

EDI continues to show improvements and a more precise awareness of areas for intervention. Our understanding is maturing and resulting is systemic change.

Risks (Include ID if currently on risk register)	Responsibility / timescale
None	

Audit & Risk Committee
Chair's Log

Meeting: Audit & Risk Committee	**Date of Meeting**: 22 November 2023
Highlights for: Board of Directors	**Chair of committee – Ken Readshaw**

Overview of key areas of work and matters for Board.
Internal Audit - Clinical Audit - High Risk; Cost Improvement Plan - Moderate Risk Outstanding actions continue to be addressed External Audit - Early work to prepare for application of IFRS16 to PFI contracts Accounts for South Tees Charity, South Tees Institute of Learning, Research and Innovation LLP and South Tees Healthcare Management Ltd reviewed and recommended for approval Risk Management - Continued improvements to risk management system. Next major steps in the plan will be the disaggregation of corporate risks and work to assess completeness of the system EPRR – review of annual report and self assessment of EPRR standards agreed and recommended to Board Review of QAC Risk with committee chair Joint Partnership Board assurance - strong assurance received around establishment of this sub committee, but assurance needed by statutory boards around operation of JPB. This is work in progress

Actions to be taken	Responsibility / timescale
None	

Issues to escalate to Board
Accounts for Charity; LLP and Ltd recommended for approval by respective Boards EPRR recommended for approval Good assurance of managing risks in the Quality Assurance Committee Strong assurance received on JPB – further work required as the Trust moves into mobilsation

Risks (Include ID if currently on risk register)	Responsibility / timescale

South Tees Hospitals NHS Foundation Trust

November Resources Committee Chair's Log

Meeting: Resources Committee	**Date of Meeting** 30/11/2023
Connecting to: Main Board	Chair – David Redpath
Key topics discussed in the meeting	

Financial position for Month 7

At Month 7 the reported position is a deficit of £18.2m at a system control-total level, which is in line with the year-to-date plan

Cost Improvement Programme (CIP)

The Trust's 2023/24 financial plan includes an efficiency saving requirement of £39.4m. Total delivery against the year-to-date plan stands at £20.4m (97.0%) at Month 7

EDRMS

The committee was presented with a paper on the way forward with the next phase of the Electronic Document and Records Management System.

Digital

We received the updated Digital paper and are pleased with the progress relating to the EPR.

Achievement of Capital Programme

The 23/24 capital spend allocated to this year's capital programme has previously been apportioned across the approved schemes. The capital programme has been enhanced with the securing of £10m PDC funding for the creation of an Urgent Treatment Centre which will support the enhancement of the ED service.

CT Scanner (FNH and Redcar) FNH

The scheme has now been completed and handed over to the Service. Redcar – Work is on-going to secure the contractual arrangements between the Parties, with a planned start on site of early January 2024.

Friarage Surgical Centre (Theatres), and Urgent Treatment Centre (James Cook)

Work continues in line with the plans.

Green Plan

The updated green plan was presented to the committee and welcomed as a good update – the committee asked for further work to be completed regarding partnership working, particularly local partners and to look into other schemes such as LED lighting replacement which could have zero capital outlay

Actions	Responsibility / timescale
Consideration of resources for the digital agenda within the Group model	
Escalated items	
Key Issues/ Concerns for escalation: No specific issues to highlight	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
No Additional Risk Identified	

South Tees Hospitals NHS Foundation Trust

Meeting: **Quality Assurance Committee**	**Date of Meeting**: 29/11/2023
Connecting to: **Board of Directors**	Chair : M Davidson

Key topics discussed in the meeting

The following Assurance reports were considered:

- Board Assurance Framework
- A 6 monthly report detailing the activity of the Research and Development department,
- Falls report : Quality Improvement Plan.
- Pressure Ulcer Quality Improvement Plan , with additional work ongoing in the community .
- Q2 Quality Priorities Update report,
- A suite of Neonatal and Maternity services reports for assurance that services are meeting national recommendations…these included the Perinatal Quality Surveillance Model reports and staffing reports.Actions are addressed by the Neonatal and Maternity Improvement Group.
- Q2 Patient Experience report , QAC acknowledged the progress made and that with the actions in place provide moderate assurance.
- Adult Inpatient National Survey report, response was higher than national average , the Trust Patient Experience Steering Group will monitor action plans .
- National Cancer Patient Experience survey report
- Chairs' Logs from reporting groups..Safe and Effective Care Strategic Group , Safer Medication Practice Group…no identified escalations to Board of Directors

Actions	Responsibility / timescale
• Deferred Q2 Cancer Pathways report to QAC	J. Ferguson December 2023
• Q2 Clinical Effectiveness report and Clinical Audit report for further discussion at QAC	T .Roberts December 2023
• An update on Sepsis work was requested for QAC and the Board	M. Stewart December 2023

Escalated items
• QAC commended the successful Patient Safety Day ,that was held on 28/11/2023

Risks (Include ID if currently on risk register)	Responsibility / timescale
No risks to add on 29/11/2023	