Group Board

Tuesday 5 November 2024, 1 pm, Room 3 and 4 STRIVE, the Friarage Hospital, Northallerton

Caring Better Together

University Hospitals Tees

MEETING OF THE GROUP BOARD TO BE HELD IN PUBLIC
ON TUESDAY 5 NOVEMBER 2024 AT 1PM
IN ROOM 3 AND 4 STRIVE, THE FRIARAGE HOSPITAL, NORTHALLERTON

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT	TIME
CHAIR'S BUSINESS					
1.	Veteran story	Information	Chairman	Presentation	1:00
2.	Welcome and Introductions	Information	Group Chair	Verbal	1:20
3.	Apologies for Absence	Information	Group Chair	Verbal	
4.	Quorum and Declarations of Interest	Information	Group Chair	ENC	
5.	Minutes of the last meeting of the held on, 3 September 2024	Approval	Group Chair	ENC	
6.	Matters Arising and Action Log	Information	Group Chair	ENC	
7.	Group Chairman's Report	Information	Group Chair	ENC	1:25
8.	Group Chief Executive's Report	Information	Group Chief Executive	ENC	1:35
9.	Board Assurance Framework	Assurance	Director of Assurance	ENC	1:45
QUALITY AND SAFETY					
10.	Quality Committee Chairs Log	Assurance	Chair of Committee	ENC	1:55
11.	Patient Experience and Involvement Annual Report	Assurance	Group Chief Nurse	ENC	2:00
12.	Maternity reports	Assurance	Associate Director of Midwifery	ENC	2:10
PEOPLE					

Group Board – the Group Board is the Board of Directors for North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust.

	ITEM	PURPOSE	LEAD	FORMAT	TIME
13.	People Committee Chairs Log	Assurance	Chair of Committee	ENC	2:20
14.	Safer Staffing report	Assurance	Group Chief Nurse	ENC	2:05
15.	Nurse Staffing, capacity and capability annual review 2024/25	Assurance	Group Chief Nurse	ENC	2:15
16.	Freedom to Speak up report	Assurance	Group Chief Nurse	ENC	2:25
17.	Guardian of Safe Working	Assurance	Group Medical Director	ENC	2:35
18.	Annual EDI report	Assurance	Chief People Officer	ENC	2:45
FINANCE & PERFORMANCE					
19.	Resources Committee Chairs Log	Assurance	Chair of Committee	ENC	2:55
20.	Finance Reports Month 6	Assurance	Group Chief Finance Officer	ENC	3:00
21.	Integrated Performance Report	Assurance	Group Managing Director	ENC	3:10
SOUTH TEES HOSPITALS NHS TRUST UNITARY BOARD					
22.	Audit & Risk Committee Chairs log	Assurance	Chair	ENC	3:20
23.	Use of the Seal	Approval	Company Secretary	ENC	3:25
24.	Audit & Risk Committee Terms of Reference	Approval	Company Secretary	ENC	3:30
NORTH TEES & HARTLEPOOL NHS TRUST UNITARY BOARD					
25.	Audit Committee Chairs Log	Assurance	Chair	ENC	3:35

	ITEM	PURPOSE	LEAD	FORMAT	TIME
26.	Audit Committee Terms of Reference	Approval	Company Secretary	ENC	3:40
CLOSE					
	DATE OF NEXT MEETING The next meeting of the Group Board of Directors will take place on 7 January 2025				

University Hospitals Tees

Register of members interests

Meeting date: 5 November 2024

Reporting to: Group Board

Agenda item No: 4

Report author: Jackie White, Head of Governance & Co Secretary

Action required:
Information

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to:
n/a

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A great place to work ☒

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☒

Deliver care without boundaries in collaboration with our health and social care partners ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All BAF risks

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The report sets out membership of the Group Board interests registered by members. Conflicts should be managed in accordance to the Constitution - If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trusts or Group, the Director must declare the nature and extent of that interest to other Directors.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Careful consideration has been given to the risk that directors may have conflicts of interest by reason of being jointly appointed directors of both Trusts. Under Group arrangements and by delegating jointly exercised functions, there are a number of reference points permitting this to occur;

- Overall NHS legal and policy framework for collaboration
- Specific statutory provisions for managing conflicts
- NHS best practice
- Authorisation of joint director roles

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Robust processes are in place to provide all relevant information to support informed and robust decision making in the best interest of patients and the population the Group serves

Recommendations:

The Group Resource Committee are asked to note the register of interest.

Group Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Ada Burns	Non-Executive Director	2022	Ongoing	Role – Governor and Chair of the Board of Governors, Teesside University
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Alison Fellows	Non-Executive Director		Ongoing	Non-Executive Director and committee chair – Gentoo Group (Housing Association) - Company number 04739226
			Ongoing	Husband Partner at Firm – Ward Hadaway Solicitors
		1.12.23	Ongoing	Governor of the Board and member of the Audit Committee Northumbria University
		6.12.23	Ongoing	Independent Member of the Audit Committee Newcastle City Council
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
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.
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Ann Baxter	Non-Executive Director		Ongoing	Independent Scrutineer of Safeguarding / Chair of Statutory Safeguarding Partnership – Darlington Borough Council
				School Governor at Thirsk High School and Sixth Form College
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Chris Hand	Group Chief Finance Officer	2 July 2021	Ongoing	Director of South Tees Healthcare Management Limited - Company number 10166808
			Ongoing	Client Representative ELFS Shared Services Management Board
		June 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
		April 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Trust on NTH Solutions LLP – Company Number OC419412
Chris Macklin	Non-Executive Director	February 2023	Ongoing	Chair, Audit One
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board

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
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Elizabeth Barnes	Non-Executive Director		Ongoing	Non-Executive Director – Aspire Housing
				Trustee – University of Sunderland
				Trustee – Middlesex University
				Trustee – Peter Coates Foundation
				Member – Queen Elizabeth Grammar School Multi-Academy Trust
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Fay Scullion	Non-Executive Director			School Governor at Jarrow Trust Secondary School
				Associate Tutor – Learning Curve Group
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Hilary Lloyd	Group Chief Nurse	15 February 2021	Ongoing	Visiting Professor at Sunderland – no monetary gain
			Ongoing	Chief Nurse for Clinical Research Network NENC
		May 2023		
			Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
		April 2024		
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
			Ongoing	Daughter and Daughter in law employees of South Tees Hospitals NHS Trust
Ken Anderson	Chief CICO			Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
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
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
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
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Michael Stewart	Group Chief Medical Officer	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Miriam Davidson	Non-Executive Director	December 2022	Ongoing	Care and Health Improvement Programme (SLI) Advisor
				Occasional work with Local Government Association (LGA)
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Neil Atkinson	Group Managing Director	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
		June 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Trust on NTH Solutions LLP – Company Number OC419412
Derek Bell	Group 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
		March 2024	Ongoing	Member of the Council for Newcastle University. No remuneration.
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Rachael Metcalf	Group Chief People Officer	December 2020	Ongoing	Role of School Governor at High Tunstall College of Science
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Rowena Dean	Chief Operating Officer North Tees & Hartlepool NHS Trust			
Ruth Dalton	Group Director of Communications		Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Samuel Peate	Chief Operating Officer South Tees Hospitals NHS Foundation Trust	1 April 2021	Ongoing	No interests declared
Stacey Hunter	Group Chief Executive	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
		July 2024	Ongoing	Partner, Dr Cornelle Parker, ad hoc project work with University Hospitals Tees and other parts of the NHS
Steven Taylor	Group Director of Estates			Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board

Stuart Irvine	Director of Strategies, Assurance and Compliance & Company Secretary	2023	Ongoing	Chair – Hartlepool College of Further Education Trustee of Hospitals Trust of the Hartlepool Wife employed at the Trust Son is employed by NTH Solutions LLP – Company Number OC419412

North Tees and Hartlepool NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

Minutes of a meeting of the University Hospitals of Tees Group Board held in Public on Tuesday, 3 September 2024 at 1.00pm in the Riverview Room, River Tees Watersports Centre, Stockton

Present:
Derek Bell, Group Chair (Chair)
Stacey Hunter, Group Chief Executive
Ann Baxter, Group Vice Chair/Non-Executive Director
Ali Wilson, Group Vice Chair/Non-Executive Director
Liz Barnes, Group Non-Executive Director
Fay Scullion, Group Non-Executive Director
Alison Fellows, Group Non-Executive Director
Miriam Davidson, Group Non-Executive Director
Kenneth Readshaw, Group Non-Executive Director
David Redpath, Group Non-Executive Director
Mark Dias, Group Non-Executive Director
Chris Hand, Group Chief Finance Officer
Mike Stewart, Group Chief Medical Officer
Hilary Lloyd, Group Chief Nurse
Rachael Metcalf, Group Chief People Officer

Directors – non-voting:
Ken Anderson, Group Chief Information Officer
Steve Taylor, Group Estates Director
Ruth Dalton, Group Director of Communications
Rowena Dean, Chief Operating Officer, North Tees & Hartlepool NHS Foundation Trust
Sam Peate, Chief Operating Officer, South Tees Hospitals NHS Foundation Trust
Stuart Irvine, Director of Strategy, Assurance & Compliance/Company Secretary, North Tees & Hartlepool NHS Foundation Trust

In Attendance:
Matt Neligan, Group Chief Strategy Officer designate
Jill Foreman, Specialised Services Manager, North Tees & Hartlepool NHS Foundation Trust (Item 1 only)
Stephanie Worn, Assistant Director of Midwifery, North Tees & Hartlepool NHS Foundation Trust (Item 12 only)
Lynne Staite, Head of Midwifery, South Tees Hospitals NHS Foundation Trust (Item 12 only)
Lucy Johnstone, Anaesthetic Fellow, Cardiothoracic Anaesthetics, South Tees Hospitals NHS Foundation Trust
Rebecca Shae, Strategic System Lead for Transfers of Care, South Tees Hospitals NHS Foundation Trust
Angela Warnes, Lead Governor, North Tees & Hartlepool NHS Foundation Trust
Pam Shurmer, Elected Governor for Hartlepool, North Tees & Hartlepool NHS Foundation Trust
Misra Bano-Mahroo, Elected Governor for Hartlepool, North Tees & Hartlepool NHS Foundation Trust
Lynda White, Elected Governor for Stockton, North Tees & Hartlepool NHS Foundation Trust
Allan Fletcher, Elected Governor for Stockton, North Tees & Hartlepool NHS Foundation Trust
Melanie Fordham, Elected Governor for Stockton, North Tees & Hartlepool NHS Foundation Trust
Jennifer Jones, Elected Staff Governor, North Tees & Hartlepool NHS Foundation Trust
Allison Usher, Elected Governor for Sedgefield, North Tees & Hartlepool NHS Foundation Trust
Sue Young, Elected Governor for Hambleton & Richmondshire
John Fordham, Elected Governor for Patient/Carer, South Tees Hospitals NHS Foundation Trust
Ruth Mhlanga, Elected Staff Governor, South Tees Hospitals NHS Foundation Trust
Jane Passman, Elected Staff Governor, South Tees Hospitals NHS Foundation Trust
John Young, Member of the Public

Heidi Holliday, Secretary to Trust Board, North Tees & Hartlepool NHS Foundation Trust [note taker]

GB/118 Staff Story

Stacey Hunter, Group Chief Executive introduced Jill Foreman, Specialised Services Manager who provided an update in relation to the Community Clinical Board.

The Community Clinical Board's ambition was to provide 'safe and excellent care at home' for all people who do not wish or need to be in a hospital setting, with one community service working together with system partners to meet the needs of its local communities. In order to achieve this ambition five key areas of focus were agreed, which were highlighted in the presentation.

An overview of the Board's initial key priorities and rationale was provided. Broader feedback was being sought from a number of events, which included a Stakeholder Engagement Event, Community Healthwatch Event and a Hospital at Home Event. Following feedback received to date regarding proactive care and frailty 'at pace', the following strapline had been agreed 'improved healthier life expectancy and experience for our communities'.

Positive progress had been made to date and discussions continued between all Clinical Boards to identify ways of working together and to form a Clinical Strategy. Working Groups had been established and next steps had been agreed. Each organisation was asked to take their current Clinical Strategy to the Stakeholder Engagement Event for review and to identify how they could all be aligned moving forward.

The Community Clinical Board recognised that further work was required to focus on community services for the whole age range and not just the elderly. It was noted that frailty could start in younger age categories and that the Hospital at Home catered for any age range. It was also noted that work was ongoing to include Mental Health Services within the Clinical Strategy and community plans.

Finance representatives had been identified for each of the Clinical Boards to help develop financial models and costs of delivery once final proposals had been agreed. Discussions were taking place with the Integrated Care Board (ICB) regarding the delegation of community health budgets through Place-based Committees.

The Group Board thanked Jill Foreman for the comprehensive overview and colleagues for the work that had been progressed to date.

GB/119 Welcome and Introductions

The Group Chief Executive welcomed all attendees and introduced Matt Neligan, newly appointed Group Chief Strategic Officer.

The Group Board placed on record their thanks to Rudy Bilous and Alyson Gerner, Group Associate Non-Executive Directors for all their hard work and dedication during their terms of office.

GB/120 Apologies for Absence

Apologies for absence were reported from Chris Macklin, Group Non-Executive Director, Ada Burns, Group Non-Executive Director, Neil Atkinson, Group Managing Director and Jackie White, Head of Governance/Company Secretary.

GB/121 Quorum and Declaration of Interests

The meeting was confirmed as quorate.

<u>No perceived conflicts of interest</u>

The Chair of the meeting referred to the Trust's declaration of interest register and asked attendees if any new declarations needed to be noted. There was no perceived conflicts of interest from the agreed agenda. Should a conflict arise during the course of the meeting, affected individuals should raise the conflict and a decision will be made to ensure appropriate action is taken.

GB/0122 Minutes of the last meeting held on, 3 July 2024

Resolved: that, the minutes of the meeting held on, Wednesday, 3 July 2024 be confirmed as an accurate record.

GB/0123 Matters Arising and Action Log

There were no matters arising from the minutes of the previous meeting and an update was providing against the action log.

Resolved: that, the update be noted.

GB/124 Group Chair's Report

A summary of the Group Chair's Report was provided with the key points highlighted:

- FT Chairs and ICB Chairs Meeting: 18 June 2024 – there was a strong emphasis on collaboration across the ICB in terms of services. A Provider Collaborative Chief Executives and Chairs Development Session had been scheduled for Friday, 1 November 2024 to discuss this further.
- Annual Members Meeting (AMM)/Annual General Meeting (AGM) – the AMM/AGM meetings were scheduled to take place on 17 and 19 September and attendance at these important meetings was encouraged. Presentations were to be provided regarding the Hospital at Home model and knife injury crimes.
- Academic Ambitions – the organisations academic ambitions and developments continued with the opening of the Hartlepool Health and Social Care Academy on Friday, 6 September 2024 and the collaborative working with Teesside University in developing a Medical School for the Tees Valley.
- Governor Elections – following the successful campaign for the Spring Elections, the same format was to be used for the next round of Elections. Information was being shared by the Communication Teams regarding the importance of being a member of the Trusts and Governor roles.
- Health Inequality and Equality Inclusion – this was a key focus for the organisations and a Group Board Development session was to be arranged to focus on this.

Resolved: that, the content of the report be noted

GB/125 Group Chief Executive's Report

A summary of the Group Chief Executive's Report was provided with key points highlighted:

- Re-appointment of the Group Chair – following discussions at a recent Nominations Committee meeting the re-appointment of the Group Chair had been agreed for a second term of office with effect from 1 September 2024, which would support continued stability and key leadership to the Group Board. Those involved in the re-appointment process were thanked for their contributions.
- University Hospitals Tees Response to 2024 Riots – it was reported that there was an error within the report under section 1.1. The report should have read 'An extensive and sensitive discussion took place with University Hospitals Tees Board of Directors with regards to the recent riots, specifically Hartlepool and **Middlesbrough**'.
- Hearing It Sessions – the Group Chief Executive placed on record her thanks to all staff who had joined a Hearing It Session. Positive feedback had been received, included staff feeling

heard and seen. The Group Board were to undertake further work regarding equality and diversity and an event had been scheduled for later that year.

- The report highlighted the work of the Group Chief Executive, Group Chair and Group Board out in the system, to keep the organisations up to date regarding key information and developments. Discussions took place that morning at the Group Board Development Session regarding a piece of work that was being undertaken across the Provider Collaboratives to identify how organisations could work together across a broader area supporting the development of an overarching Clinical Strategy for the North East and North Cumbria. It was recognised that work had not progressed at the pace required and subsequently provision made for a lead role to take the work forward, noting that an appointment had been made.
- Clinical Strategy – work continued in developing the Clinical Strategy. It was agreed that Board members be invited to attend a regular feedback session in either October or November, which was to be facilitated by the Associate Director of Group Development.
- Health and Care Secretary Visit, 6 August 2024 – at the recent visit to Leeds Teaching Hospitals, Wes Streeting, Secretary of State for Health and Social Care paid tribute to NHS and care workers for their hard work during the current unrest and riots. The three key areas of focus and shift, which would be reflected as the next 10 year plan for health and care was developed, were confirmed as Hospital to Community Care, Analogue to Digital and Prevention – Primary and Secondary.
- Community Diagnostic Centre (CDC) – the Group Chief Executive and a number of Board members visited the CDC site and noted the significant progress made to date, including the completion of the buildings foundations and steel structures. The CDC was an exciting new purpose built facility for patients and for staff to work in modern fit for purpose facilities.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Associate Director of Group Development facilitate an invitation for the Group Board to attend a Clinical Strategy Feedback Session.

GB/126 Finance Reports Month 4, 2024/25

Chris Hand, Group Chief Finance Officer presented the Finance Reports for Month 4, 2024/25 and highlighted the key issues.

- At the end of Month 4 2024/25 the Group was reporting a revenue position of £17.1m, £15.874m relating to STHFT and £1,266m relating to NTHFT.
- Slippage had been seen across the Group on delivery of CIP savings and clinical income ahead of plan relating to additional income relating to additional activity, funded via the Elective Recovery Fund (ERF) income, and work continued to understand the detail. Further updates would be provided as and when further information was available.
- Progress had been seen following NHS England's requirement to reduce agency spend by 5%, at Month 4, agency expenditure was below plan for the Group overall.
- The Group's gross capital expenditure plan for the 2024/25 financial year totalled £100.5m and the Group's year-to-date capital expenditure to the end of Month 4 amounted to £124.1m, which was broadly in line with the plan.
- The cash balance at the end of Month 4 stood at £80.2m for the Group and the strong cash balance supported good compliance with the 90% Better Payment Practice Code.
- The finance teams continued to work with NHS England to address queries raised and remained a key area of focus.

Following a query raised regarding the adverse variance movement as at Month 3 to Month 4, it was reported that STHFT had received income which reversed the variance for the Trust. NTHFT had not received any income therefore, the position remained the same.

The Board were made aware of the following two issues of note:

- CIP – Further work was required at NTHFT in respect of plans for CIP delivery.

- Income was a key challenge and was a key area of focus. At NTHFT, there was a stretched target in respect of ERF and a Delivery Group had been established to manage this. Progress had been seen across all areas including non-planned activity.

A query was raised regarding the increase in staff expenditure and how the Group would deliver and manage the overspend. Recovery work was being carried out with Care Groups and Collaboratives to understand the drivers and Vacancy Control Panels were established at both Trusts as part of the grip and control work. It was noted that a stabilisation in WTE numbers was being seen however, challenge continued. An overview of the vacancy control processes was provided including the challenge against each requested post. Work had been carried out with regards to the nurse establishment as part of the Nurse Establishment Review and a reduction in run rates had been seen. An update was to be provided regarding the review at the next Group Board meeting.

Following a query raised at the previous meeting relating to research posts in STRIVE and reviewing the impact of these posts, it was agreed that a review of research budgets be undertaken to provide information and assurance to Group Board members, along with a review of broader activities in relation to STRIVE and not just research.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, an update in relation to the Nurse Establishment Review be provided at the next Group Board meeting; and
(iii) that, a review be undertaken in relation to the impact of research posts in STRIVE and a wider review of the broader activities to provide information and assurance to the Group Board.

GB/127 Integrated Performance Reports

Rowena Dean and Sam Peate, Chief Operating Officers presented the Group Integrated Performance Report (IPR) and the individual IPRs for each organisation for the reporting period July 2024 and highlighted the key points:

- Across both key emergency care metrics continuous improvements had been seen.
- The Group's performance against ambulance handovers reported at 96.53% against the 100% target.
- The Group's performance against the cancer standards reported at 56.65% against the 70% target. Performance in relation to cancer standards remained a challenge across the system however, a reduction in cancer waits was being seen and were reporting close to annual trajectories.
- The Group's performance against referral to treatment (RTT) reported at 63.30% against the target of 92%. Both organisations had signed up to the eight week national "Validation Sprint", which commenced on Monday, 2 September 2024, with the aim to reduce waiting lists where possible.
- The Group's performance against the diagnostics standard reported at 78.21% against the target of 95%. Diagnostics continued to be an area of challenge at NTHFT in relation to MRI, obstetrics and ultrasound and it was hoped that improvements would be seen in those areas soon. Initiatives implemented at STHFT since summer 2023 in MRI and ultrasound had largely delivered their benefits.
- Sustainable solutions were being put in place and continuous improvements were being seen.

The new IPR format continued to be developed and the excellent work carried out to date was noted.

A discussion ensued regarding the presentation of the quality metrics from a group perspective in an integrated document, acknowledging that further refinement was required.

Resolved: that, the content of the report be noted.

GB/128 Resources Committee Chairs Log

David Redpath, Group Non-Executive Director presented the Resources Committee Chairs Log for the meeting held on 25 July 2024. The key areas to note were:

- The Committee approved the business case for patient transport services being brought in house, which would deliver a saving of £1.2m as well as deliver against significant service improvements for patients.
- Soft FM service provision was an area of escalation and work was ongoing with partners to implement that.

Resolved: that, the content of the report be noted.

GB/0129 Maternity & Neonatal Services Safety & Quality Report and Staffing Report Q1 2024/25

Stephanie Worn, Assistant Director of Midwifery, NTHFT and Lynne Staite, Head of Midwifery, STHFT presented the Maternity & Neonatal Services Safety & Quality Report and Staffing Report Q1 2024/25 and highlighted the key points.

STHFT:

- All perinatal deaths continued to be reported to the Perinatal Mortality Review Tool (PMRT) and action plans developed.
- There had been no serious incidents reported in the last two months.
- Ongoing developments were being seen in Maternity Triage, which had been working well over the past few months. Work was ongoing to look at the management of vaginal bleeding in pregnancy.
- Staffing pressures continued, with only recently trained midwives being recruited.
- Concern was raised regarding midwifery mandatory training and the potential that the Clinical Negligence Scheme for Trusts (CNST) target would not be met that year. A plan had been developed and midwives with outstanding training being prioritised to attend training. It was hoped that an improved position would be seen by December.
- Regular meetings were being held with Coaches with regards to the NHS England Culture Survey.

NTHFT:

- Two incidents were graded moderate and above.
- A positive reduction had been seen in midwifery WTE vacancy rate however, over the last quarter there had been a rise in short-term sickness absence. Sickness absence continued to be managed at weekly operational meetings and daily staffing huddle meetings.
- The development of a maternity triage service work continued. Estate plans and a named Consultant Lead were yet to be confirmed. The remodelling of antenatal clinics was being undertaken as part of the triage work and regular updates would be provided.
- An external review of community services had been undertaken by members of the North East and Yorkshire Regional Midwifery Team supported by the designated Maternity Improvement Advisor (MIA) and a report had been received in November 2023, outlining opportunities such as a review of the workforce model, location of service provision and enhanced models of care. There were 4 key themes identified from the report which led to 3 work streams, led by the community teams:
    - Autonomous working
    - Flexible working
    - Community Hubs as a location base
    - Antenatal and postnatal continuity of carer
- The seven Immediate and Essential Actions (IEAs) set out in the Ockenden Report (2020) had been met and would be monitored through NHS England's Three Year Maternity and Neonatal Service Delivery Plan.
- There were no items to escalate in terms of maternity incentive scheme.

- Neonatal nurse staffing is on the risk register (6600) and the action plan agreed at Trust Board in the previous quarter is reviewed regularly, outlining progress against each of the actions, with oversight from the LMNS and Neonatal Operational Delivery Network (ODN) on a quarterly basis.
- Culture Champions were now in post and work was ongoing as part of the perinatal culture and leadership programme.
- Staff development sessions were led by a Maternity Senior Clinical Matron on a monthly basis for staff to discuss their future professional development and career pathways.

Assurance was sought from the STHFT report regarding the concern raised in relation to midwifery mandatory training and the potential that the Clinical Negligence Scheme for Trusts (CNST) target would not be met that year and whether the Group Board could provide any support. It was reported that the number of training sessions available had been increased, mutual aid was being sought from the LMNS for training to be made available for staff at other venues and a projection of how much essential training was required to meet the target was being developed. All training had been rostered to meet the target therefore, if the plan was maintained the target would be met. An area of concern was around school holidays and work was ongoing to manage annual leave during this period. Vacancies was another main contributor and a plan had been developed to over establish the workforce. The Group Board would provide support if and when required.

The position of mandatory training had also been reported as an area of concern the previous year and the Group Board sought assurance that the position would not continue in to future years and it was agreed that an update on this would be brought to a future meeting.

It was noted that the Trust name at the top of page 21 should read South Tees Hospitals NHS Foundation Trust.

The Group Board were made aware of three emerging risks and were advised that plans had been put in place to manage them.

A query was raised regarding the stillbirth rate graph provided on page one of the report, which showed a decreasing rate and whether it fit with the national trend and the reason it was included in the report. It was noted that over the last year a lot of work was being undertaken with smoking cessation and the data was currently being validated. It was agreed that if this was a contributing factor of the reduction in still births that the success should be celebrated.

Steph Worn and Lynne Staite left the meeting 2.45pm.

Resolved: (i) that, the content of the report be noted; and
(ii) that, a position update regarding midwifery mandatory training compliance to be brought to a future meeting.

GB/130 Quality Committee Chairs Logs

Fay Scullion, Group Non-Executive Director presented the Group Quality Committee Chairs Log for the meeting held on 22 July 2024. The key areas to note were:

- Positive work being carried out across Tees to address health inequalities was noted. However, concern was raised with regards to ongoing funding for some areas of work.
- Positive improvement on the outstanding clinical audits was noted, with actions identified for those remaining clinical audits.
- Positive feedback on the HTA report following the initial inspection included values and attitudes of staff.
- Maternity reports highlighted further work required in relation to mandatory training.

The specific issue regarding health inequalities funding related to Alcohol Support Teams. Funding was currently available via short-term solutions, which was not sustainable and did not provide job

security. Work was to be carried out to look at alternative funding solutions with formal proposals to be taken to a future Group Quality Committee meeting.

The infection prevention and control position reported in the Chair's log was challenged as it was felt that the Group were not in a good position across the North East. The main driver was noted as issues relating to estates.

Resolved: that, the content of the report be noted.

GB/131 Group Patient Experience and Involvement Report Q4 and Q1

Hilary Lloyd, Group Chief Nurse presented the first Group Patient Experience and Involvement Report for Quarter 4 2023/24 and Quarter 1 2024/25.

Both Trusts implemented the new complaints framework in January 2024 and progress was being made. There were still slightly different approaches in each organisation, which would be harmonised. Some enquiries were complex and therefore, could not be completed within the 24 hour timescale and a single approach was to be developed going forward. New processes were being established to identify quality priorities and to highlight areas that were not performing as required, which would be reported to the Group Quality Committee on a regular basis. Improvement work continued to transform the approach to complaints.

In Quarter 1, a total of 251 complaints were opened at STHFT, which was an increase of 57 on the previous quarter with Head and Neck, Orthopaedic and Reconstructive Services receiving the most number in each quarter.

For the same period, at total of 320 complaints were opened at NTHFT compared with 318 in the previous quarter with Responsive Care receiving the most number with 141, which was an increase of eight on the previous quarter.

Work had been undertaken on long delayed complaint responses and leads had been identified to review them on a daily basis.

Data relating to the Mental Health Strategy was to be included in the next report.

A request was made to include the number of complaints as a ratio in future reports.

Following a query raised it was confirmed that the 100% 3-day working target for initial responses was now being met and previous issues relating to this target had now been resolved.

Urology was noted as a theme throughout the report with a range of actions agreed with the Senior Leadership Team and work was ongoing.

Resolved: (i) that, the content of the report be noted; and
(ii) that, future reports to include the number of complaints as a ratio.

GB/132 Workforce Race Equality Standard (WRES) Report and Workforce Disability Equality Standard (WDES) Report

Rachael Metcalf, Group Chief People Officer presented the first Group Workforce Race Equality Standard (WRES) Report and the first Group Workforce Disability Equality Standard (WDES) Report and highlighted the key issues.

A summary of the results for NTHFT and STHFT were highlighted within the report and covered a five-year period (2020 to 2024).

It was positive to note that both Trusts had seen an increase in employed ethnic minority staff for 2024. When compared to the North East's ethnicity data (2021 census), which was reported at 7%, both Trusts reported a higher representation within the overall workforce.

Key areas of note were:

- The number of Black, Asian or Minority Ethnic (BAME) colleagues employed within STHFT had increased each year from 2021 and represented 12.83% of the workforce.
- National research showed that individuals from a BAME background or had a disability were more likely to experience harassment, bullying or abuse. Improvements had been made in this area.
- An Equality, Diversity, Inclusion and Wellbeing Conference was scheduled to take place on 4 November 2024 at James Cook Hospital, where real life experiences were to be shared.
- Following the recent riots, a number of colleagues had come forward and work was ongoing to share their experiences anonymously across the organisation.
- A number of Joint Networks had been established and Executive sponsors were currently being identified.
- Both Trusts had seen an overall positive reduction in the percentage of staff stating they have experienced harassment, bullying/abuse from patients, relatives, public and staff. Further work was being undertaken to ensure that staff felt valued and supported. Group values were to be reviewed in autumn 2024 and would also address this. A lot of work and focus on culture was being undertaken, particularly in STHFT.
- Staff Networks were supporting the work being undertaken around disability reporting. Staff were being encouraged to disclose information at work although, the organisations acknowledged that some colleagues may not want to disclose this information and alternative options were being explored for those members of staff.

It was noted that the Group Board's diversity still required development.

Resolved: that, the content of the report be noted.

GB/133 People Committee Chairs Logs

Mark Dias, Group Non-Executive Director presented the Group People Committee Chairs Log for the meeting held on 25 July 2024. The key areas to note were:

- The first joint meeting was positive and focused on growing the workforce, from demand to development and education, which highlighted the need for much work to do done.
- Joint WRES Report: the Committee recognised there was some stagnation in culture change and sought for further assurance on how executive leadership intended to drive change.
- Joint WDES Report: queries were raised regarding whether employees were disclosing impairments and/or capability of managers to implement reasonable adjustments.

Resolved: that, the content of the report be noted.

GB/134 Audit Committee Chairs Logs

Alison Fellows, Group Non-Executive Director presented the NTHFT Audit Committee Chairs Log for the meeting held on 29 July 2024. The key areas to note were:

- Future Chairs Logs were to be clear which Trust's Audit Committee was being reported on.
- The meeting focussed on the review of the IPR for March 2024, to gain assurance that processes were effective, had gone through the right processes and there were no duplications.
- The Chairs of both Audit Committees were working together to share best practice.

Resolved: that, the content of the reports be noted.

GB/135 Proposed Naming of the Friarage Surgical Hub

Sam Peate, Chief Operating Officer, STHFT presented the Proposed Naming of the Friarage Surgical Hub report and highlighted the key issues.

The chosen name for the new build surgical hub was the Friarage Surgical Centre, which had significant input from staff in the Trust, including staff from NTHFT who attended an engagement event in June 2024. The chosen name had been approved through the Trust's governance procedures, which included the Clinical Operational Group at the Friarage Hospital, the Theatre Project Group and the Growing the Friarage Collaborative Board.

The Group Board formally ratified the decision.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Group Board formally ratified the decision for the name of the new build surgical hub be the Friarage Surgical Centre.

GB/136 Retrospective Approval of Documents Executed Under Seal

Stuart Irvine, Director of Strategy, Assurance & Compliance/Company Secretary presented the Retrospective Approval of Documents Executed Under Seal Report and highlighted the key issues.

As part of the Community Diagnostic Centre Development in Stockton, a Supplemental Agreement between North Tees and Hartlepool Solutions LLP and Stockton Borough Council documenting the £1.436m contribution by Stockton Borough Council for the external works required to be sealed with the Trust's corporate seal. The document was signed by Neil Atkinson, Group Managing Director and Steven Taylor, Group Director of Estates on behalf of the Trust and North Tees and Hartlepool Solutions LLP and was sealed on 12 July 2024.

The Group Board granted retrospective approval for the sealing of the document.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Group Board granted retrospective approval for the sealing of the document.

GB/137 Any Other Business

There was no other business to discuss.

GB/138 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Tuesday, 5 November 2024 at 1.00pm, Rooms 3 and 4, STRIVE, Friarage Hospital.

The meeting closed at 3.20pm.

Signed: 

Date: 5 November 2024

Group Board Public

Date	Ref.		Item Description	Owner	Deadline	Completed	Notes
05 June 2024	GB/069	Research & Development Annual Report	Stacey Hunter would provide an overview on the North East and North Cumbria Health Innovation Board at a future Board seminar	Stacey Hunter	31 October 2024		The NENC Innovation Board was scheduled for November and feedback would be provided as and when necessary.
03 July 2024	GB/101	Freedom to Speak Up Annual Reports	Learning and ideas for improvement be shared across both organisations, as well as exploring excellent group models seen in other organisations.	Hilary Lloyd	05 November 2024		Work was in progress and an update was to be provided in the next FTSU Guardian Report, due in November.
03 September 2024	GB/126	Finance Reports Month 4, 2024/25	A review into the impact of research posts in STRIVE and wider review of the broader activities to be undertaken to provide assurance.	Rachael Metcalf	01 February 2025		Through People Committee
03 September 2024	GB/129	Maternity & Neonatal Services Safety & Quality Report and Staffing Report Q1 2024/25	Position update regarding the compliiance rate of maternity mandatory training to be brought to a future meeting.	Hilary Lloyd	05 November 2024		In Quarter 2 report - November Board
03 September 2024	GB/131	Group Patient Experience and Involvement Report Q4 and Q1	Future reports to include the number of complaints as a ratio.	Hilary Lloyd	01 January 2025		In future reports for Board

University Hospitals Tees

Chairmans report

Meeting date: *5 November 2024*

Reporting to: *Group Board*

Agenda item No 7

Report author: *Jackie White, Company Secretary*

Action required: *(select from the drop down list for why the report is being received)*
Information

Delegation status ***(Board only and completed by the Corporate Secretariat)*****:** ***Jointly delegated item to Group Board***

Previously presented to: *n/a*

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A centre of excellence ☒

A great place to work ☒

Deliver care without boundaries ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The report provides an overview of the health and wider related issues.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

n/a

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

n/a

Recommendations:

The Group Board of Directors are asked to note the report.

Group Chairman's Update

1. Introduction

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

1.1 CQC State of Care report 2023/24

On 25 October 2025, the CQC launched its State of Care report for 2023/24 which set out an assessment of health and adult social care in England in 2023/24, highlighting significant issues around timely access to good care, and persistent inequalities in health and care access, experience and outcomes.

This year State of Care report has a strong focus on inequalities, exposing issues in specific services, such as mental health, maternity and children and young people's care. It also recognises the key role of local systems in addressing inequalities and joining up care.

The report also considers in depth areas of specific concern, including maternity care, Black men's mental health, care for autistic people and people with dementia, and places significant emphasis on the need to improve services for children and young people.

1.2 Vaccinations

National immunisation programmes were launched on 1st September 2024 to prevent respiratory syncytial virus disease (RSV), COVID and flu. The Trust is continuing to encourage the uptake of vaccines with our staff to protect themselves, their family and our patients. I would urge as many people as possible to receive vaccinations to provide the maximum protection as we enter into the winter to come to fruition.

1.3 University Hospital Tees Strategy

Vice Chairs Ann Baxter and Ali Wilson along with the Audit Chair for South Tees Hospitals NHS Trust and Group Non-Executive Director Ken Readshaw spent some time recently with our Group CEO Stacey Hunter and newly into post Matt Neligan, Group Chief Strategy Officer to discuss and start to plan out the key parts of our Strategy for the Group. The discussion focussed on the work undertaken with the Group Board in their Board development sessions around visioning and aspirations for the University Hospital Tees and the work our colleagues have started to set out in the clinical boards, digital and estates workstreams. I look forward to discussing this further in our Board Development session this month.

1.4 Elections for Governors

You will have seen we have been advertising with our members a number of vacancies on our Council of Governors at South Tees Hospitals NHS Trust and North Tees and Hartlepool NHS Trust. At the time of writing the report, the process has not yet concluded but I hope to be able to announce soon our appointments.

1.5 Governor walkrounds

Some Council of Governor members at North Tees & Hartlepool had the opportunity to visit parts of the University Hospital North Tees in October including the Outpatient Department, Business Intelligence Unit, EAU, the People Team, Ward 32 and 33 and Patient Experience.

1.6 Board update

Since my last update, I would like to put in writing my thanks to Alyson Gerner and Rudy Bilous, Associate Non Executive Directors who worked on the Board of South Tees Hospitals NHS Trust and latterly as a member of the Group Board as their term of office came to an end at the end of August.

I would also like to take the opportunity to wish Dr Hilary Lloyd, Group Chief Nurse congratulations for her new appointment as Chief Nurse for the North East and North Cumbria ICB. Hilary will take up the role in the new year.

1.7 Annual members meeting

On 17 September and 19 September, we held our annual members meetings for South Tees Hospitals NHS Trust and North Tees & Hartlepool NHS Trust. This year both events were held in the community to encourage more of our public members to come along and we were really pleased with the attendance. Those who did were treated to some great presentations and I'd like to thank everyone who gave up their time to support these events. Our annual reports and accounts can be found on our websites along with presentations from the two members meetings for those who were unable to join us.

1.8 Celebratory events

Over the month of October, the University Hospitals Tees has enjoyed a number of celebratory events which have focused on promoting and recognising the fantastic contributions of admin colleagues, Allied Health Professions and nursing and midwifery colleagues. My non-executive colleagues have attended and fed back their admiration of the work our colleagues do on a day to day basis with a focus on patients across our Group. Well done to everyone who took part and congratulations to those who received nominations for the work that they do.

2. Recommendation

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

Professor Derek Bell
Group Chair

University Hospitals Tees

Chief Executive report

Meeting date: 5 November 2024

Reporting to: Group Board

Agenda item No 8

Report author: Jackie White, Company Secretary

Action required: (select from the drop down list for why the report is being received)
Information

Delegation status (Board only and completed by the Corporate Secretariat): Jointly delegated item to Group Board

Previously presented to: n/a

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A centre of excellence ☒

A great place to work ☒

Deliver care without boundaries ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The report provides an overview of the health and wider related issues.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

n/a

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

n/a

Recommendations:

The Group Board of Directors are asked to note the report.

Group Chief Executive's Report

1. Introduction

This report provides information to the Board of Directors on key local, regional and national issues and is linked to the strategic objectives of the Trust.

1.2 System oversight framework

At the time of writing this report, South Tees Hospitals NHS Trust and North Tees & Hartlepool NHS Trust are preparing for their oversight meetings with the ICB and NHS England which are scheduled for 28 October 2024. The focus of these meetings and the framework is to work as a system to improve local health and care outcomes, maximise value for taxpayer money and deliver better services for our patients. I will update the Group Board on the outcome of the meetings in due course.

1.3 System recovery board

The new System Recovery Board continues to meet monthly and is focussed on four key areas to help us to recover financial stability across the region. These are: workforce, elective recovery, urgent and emergency care and procurement.

As you will be aware, I lead on the procurement workstream for the Region and the work in this area has focussed on understanding the current opportunities both across the region and at a more local level. NENC Providers have engaged with other parts of the country to understand their procurement collaboration journeys so far.

It is recognised that collaboration in this area takes times to do well and needs a phased approach. There are, however, lots of opportunities to think about in terms of how we might be able to standardise our systems and processes to improve efficiencies.

Given the complexity of this work, we have agreed to work primarily at a local level and within 'nested' collaboratives over the next few years. These are:

- Great North Care Alliance
- University Hospital Tees
- CDDFT and STSFT

Discussions continue with our other Provider partners to see how they can align into the above nested areas.

From a Group perspective, our strategic partner has reviewed opportunities in HR which we are reviewing and is due to do the same in procurement. I have asked our Group CFO to oversee and share any material opportunities via the Group Executive team.

There will be another NENC Chair and CEO session in early December to consider the medium to long term financial sustainability across the integrated care system. It will be important for us to be clear about our ongoing efficiencies and opportunities that arise as we align clinical and corporate services. It is also imperative to ensure that other drivers of deficit PFI legacy and fair shares allocation is recognised and supported by the ICB. It is

clear we need both the internal cost improvement and containment measures plus this external support to avoid a continuation of widening the health inequalities our communities experience or reducing the quality of the services they can access.

1.4 NENC Provider Collaborative Leadership Board

Neil Atkinson and I attended the Provider Collaborative Leadership Board meetings in September and October with both meetings focussing on updates in relation to the key programme deliveries such as elective care in particular 65 week waits, urgent and emergency care, diagnostics and workforce which focussed on the new dashboard.

Elective Recovery work is progressing with a continued focus on 65 week waits. Discussion regarding the new government initiative of 2 million extra appointments (Further Faster 20 Initiative – South Tees) and discussions regarding mutual aid continue. Cancer and particularly urology remains a concern and focus still on early access to diagnostics, people, pathology. Workforce focus continues on reduction of bank & Agency spend with overall WTE trend is downward.

There is a renewed focus in the Provider Collaborative on the strategic approach to clinical services. There is an overview on three 'S's' – standardisation, stabilisation and sustainability and preparatory work around geographic distribution and disparities, co-dependency and associated elements. Mike Stewart is linking in on this work which will be important for our clinical strategy work.

1.5 Board development

Last month we held two ***board seminars*** one focussing on our plans for Winter where we discussed the plans being put place to prepare for the challenging months ahead and learning from our experience last year. Secondly as part of the Freedom to Speak Up month, the Board received an update from the National Freedom to Speak up Guardians office along with our local Freedom to Speak up guardians with Board colleagues making commitments for speaking up. We also received an update on the development and implementation of our new Integrated Performance Report which will be implemented from November.

The Board continue to be supported by MacMillan Associates providing some bespoke support to our Non-Executive Director colleagues and coaching and team building for our newly formed Group Executive Directors which has been well received. I am working with the Chair to progress this jointly going forward to strengthen our overall board effectiveness.

1.6 Annual members meeting

On 17 September and 19 September, we held our annual members meetings for South Tees Hospitals NHS Trust and North Tees & Hartlepool NHS Trust. These coincided with the publication of our annual reports and were a fantastic opportunity to look back at the highlights of the past year.

As a group we have more than 20,000 members in total including our staff who are automatically counted as members. This year both events were held in the community to encourage more of our public members to come along.

Those who did were treated to some great presentations and I'd like to thank everyone who gave up their time to support these events.

Jill Foreman, Lynn Morgan and Michelle Watson from our community teams gave an update about how our Hospital at Home services across both trusts are now working in collaboration.

Amy Moody and Michelle Waters from the alcohol care team talked about the new serious violence reduction navigator role in the emergency department at The James Cook University Hospital, which forms an important part of our multi-agency approach to reducing serious violence across the local area.

1.7 Vaccinations

Our staff vaccination programme launched on Thursday 3 October, and this will be crucial to preventing serious illnesses from winter viruses so I'm urging you all to get vaccinated to protect yourselves, your colleagues, your patients and your loved ones at the earliest opportunity.

I noted we had some of the lowest rates of flu vaccination across the country last year and I am keen to ensure we do much better this year. Many of our patients and colleagues come from communities that are more likely to be significantly impacted by influenza, so it is even more important we all take the opportunity to get vaccinated. We'll be closely watching our vaccination rates over the coming weeks, and we'll regularly share these statistics with you in future bulletins.

1.8 Association of Groups Meeting, Manchester

James Bromiley, associate director of group development, and I attended an event in Manchester organised by the Association of Groups to deliver a presentation about the development of University Hospitals Tees and our group strategy. It was an invaluable opportunity to find out about the various group structures in the country and how each one differs and the common challenges we face. I will be attending the CEO event in London in November and will provide feedback to the Board in due course.

A number of Director colleagues are involved in working with the Association of Groups and other networks sharing their experience of working in a Group.

1.9 South Tees Maternity Services cultural review

We were pleased to welcome a team from NHS England who met with some of us along with the leadership team within Maternity Services, maternity teams and users of the service to undertake a review of the culture within the service. We have received some verbal feedback which we will discuss with the Board in the private session. Once the final report is received, we will share this and our response with the Quality Committee.

1.10 Sexual Misconduct Policy

NHS England launched and signed the first-ever sexual safety in healthcare charter in September 2023. The charter commits to providing staff with clear reporting mechanisms, training, and support across healthcare in relation to sexual misconduct. UHT signed up to the NHS Sexual Safety Charter earlier this year. This month we see this charter move to the second phase with the new Worker Protection (Amendment of Equality Act 2010) Act 2023, which comes into effect in October 2024, and creates a duty on employers to take reasonable steps to prevent sexual harassment of their employees in the workplace. We will be implementing the sexual misconduct national policy framework, which include e-Learning for health module: Understanding Sexual Misconduct in the Workplace and developing a Sexual Safety assurance framework.

1.11 Further Faster 20 initiatives

South Tees Hospitals Trust has been identified as a Trust which will benefit from the Further Faster initiative which is being implemented across the NHS. The Further Faster 20 initiative, announced by Secretary of State, is to target support for systems to improve and streamline pathways for patients and spread good practice in areas with high levels of economic inactivity.

When identifying that South Tees Hospitals NHS Trust would participate in this initiative, NHS England looked at several issues including towns and cities that have the highest percentage of economic inactivity with long term illness; and areas of highest deprivation. These factors were cross referenced against the size of trust wait lists and Middlesbrough was identified as a town which would benefit from this initiative. This is a great opportunity for the Trust to receive resource and focus to support us to reduce the waiting list and our population.

The launch of the programme will take place at the end of October and Sam Peate, Chief Operating Officer for South Tees will be able to appraise the Board of further detail.

1.12 10 Year Plan

Last week the Government launched the beginning of a process which will shape the health priorities of the next decade. As part of the development of the 10 Year Health Plan, members of the public and NHS staff have been invited to contribute to listening events to shape the plan. NHS England and the Department of Health and Social Care working together are keen for everyone to contribute their ideas and experience as part of this process. Engagement events will be held over the coming weeks and I will ensure this information is circulated across University Hospitals Tees.

1.13 PLACE

I continue to meet with my CEO counterparts to progress discussions about further opportunities to integrate services across community health, care, primary care and the VCSE.

The Tees Valley ICP continues to meet monthly, and we have contributed to a piece of work re anchor institutions that is due to report in November. I will ensure this is shared with the Board when it is available.

I have also met with Teesside University again recently in respect of their bid to be a future medical school.

1.14 **Clinical Strategy**

The clinical boards have developed a series of broad options for the longer term clinical model of care across the Group that look forward over a five to ten year period from 2029-2034. These will inform the development of the overarching strategy for the group and the critical enabling work to create the Strategic Outline Case (SOC) for future site development which will be led by Matt Neligan, Group Chief Strategy Officer.

1.15 Mathew Taylor (CEO of NHS Confederation) 'State of the Nation' Presentation to Consultants and Senior Leaders

Matthew Taylor, CEO for NHS Confederation visited James Cook on Friday 20 September to discuss our current challenges and opportunities. He gave a presentation to our senior leaders before meeting with our community clinical board. To round off the visit, he visited our colleagues in theatres who gave a very impressive demonstration of our brain and spinal robotic work.

1.16 **In other news!**

Three new substance use practitioners have begun work at North Tees and Hartlepool NHS Foundation Trust to help identify patients in need and manage their hospital care, share information with other community services and help once they are fit to leave hospital care.

The service will run seven days a week across the University Hospital of North Tees, working closely with departments like urgent and emergency care, hospital wards and community services to ensure patients get the right care both in hospital and in their homes.

https://www.nth.nhs.uk/news/new-team-to-help-patients-with-substance-use-issues/

Two nurses from South Tees community services, Kelly Kirtley, head of nursing, and Emma Docherty, matron, have won the prestigious Queen's Nurse Award by nursing charity The Queen's Nursing Institute. The title recognises Kelly and Emma's exceptional contributions to nursing practice, patient care and leadership.
https://www.southtees.nhs.uk/news/two-community-nurses-win-prestigious-queens-nurse-award/

Artificial intelligence is helping our trusts diagnose lung cancers and other issues faster quickly and more accurately.
The Annalise AI system is now in use for patients getting chest X-rays across University Hospitals Tees.

It will help radiologists and radiographers to safely prioritise chest x-ray workload and make sure we can quickly identify patients who need further tests or specialist appointments. https://www.southtees.nhs.uk/news/quicker-diagnosis-and-treatment-of-lung-cancers-in-teesside-thanks-to-new-artificial-intelligence-investment/

2. **RECOMMENDATIONS**

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

NHS
University Hospitals Tees

Interim Board Assurance Framework Update (NTHFT/STHFT)

Meeting date: 5 November 2024

Reporting to: Group Board of Directors

Agenda item No: 9

Report author: Stuart Irvine, Director of Strategy, Assurance & Compliance / Company Secretary

Action required:
Information

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to:
BAF reports were presented to Board committees in October 2024.

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A great place to work ☒

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☒

Deliver care without boundaries in collaboration with our health and social care partners ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

This report relates to Board Assurance Frameworks of each Trust.

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

This report provides an update to the period 31st August 2024 and provides information relevant to each Trust Unitary Board. The Group Board is asked to note the strategic risks that are outside of the approved risk appetite of the Board committees that are high/red risks or provide negative assurance (i.e. a current risk score of 15 or above).

North Tees & Hartlepool NHS Foundation Trust

By exception, there are four strategic risks that are outside of approved risk appetite of the Resources Committee, which are high/red risks (details are provided in the attached report).

A copy of the full BAF report is provided in the TEAMS reading library.

South Tees Hospitals NHS Foundation Trust

By exception, there is one principal risk with a threat that has been assessed as providing limited/negative assurance (details are provided in the attached report).

A copy of the full BAF report is provided in the TEAMS reading library.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

This report identifies four high/red strategic risks that are outside of the approved risk appetite for North Tees & Hartlepool NHS Foundation Trust and one principal risk which has a threat which is assessed as providing limited/negative assurance for South Tees Hospitals NHS Foundation Trust.

North Tees & Hartlepool NHS Foundation Trust

The four strategic risks that are outside of approved risk appetite have identified controls and assurance and planned actions to manage and mitigate the risks (details are provided in the attached report).

South Tees Hospitals NHS Foundation Trust

The principal risk with a threat that has been assessed as providing limited/negative assurance, has three planned actions to support the management and mitigation of the threat (details are provided in the attached report).

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Independent Assurance

North Tees & Hartlepool NHS Foundation Trust

The Trust receives annual assurance on Board Assurance Framework and Risk Management processes from AuditOne (the Trust's internal auditors). Good assurance was received relating to 2023/24 and the audits for 2024/25 will commence in Q4.

South Tees Hospitals NHS Foundation Trust

The Trust has a planned audit on Board Assurance Framework processes in 2024/25, which will be undertaken by PWC (the Trust's internal auditors) in Q4.

Revised Board Assurance Framework Arrangements

Following the request from the Group Board in April 2024, revised Board Assurance Framework arrangements will take effect from 30th September 2024, which provides standardisation and consistency across both Trusts.

A Board Seminar took place in October 2024, which considered the revised Integrated Performance format, content and reporting. It was agreed that the reported period of the IPR and BAF will now align, to allow the triangulation between reported metrics in the IPR and the correlating current risk score of strategic risks (where relevant). This will allow robust triangulation and discussion in committee and Board meetings.

Meetings of the Board committees in November 2024 will receive the IPR and BAF for each Trust, which will report to 30th September 2024. BAF reports will be reported by domains and the reports will be received by committees, based upon oversight responsibility.

An independent quarterly BAF report will be presented to Audit Committee/Board which provides the full overview of the BAF for each Trust, including appendices which details Strategic Risk Oversight, Risk Radar and Top 10 Operational Risks.

Recommendations:

This report provides the following;

- Assurance by exception for each Trust regarding the management and mitigation of strategic risks to 31st August 2024.
- Details of the four red/high strategic risks that are outside of risk appetite for NTHFT.
- Details of one threat which is linked to a principal risk, which is assessed as providing limited/negative assurance;
- An update on the revised Board Assurance Framework reporting arrangements that take effect from 30th September 2024 and will be reported to Board Committees, Audit Committees and Boards, with effect from November 2024.

North Tees and Hartlepool NHS Foundation Trust/ South Tees Hospitals NHS Foundation Trust

Meeting of the Group Board of Directors

5 November 2024

Interim Board Assurance Framework Update

Report of the Director of Strategy, Assurance & Compliance

1. Introduction/Background

1.1 Following the decision by the unitary boards of South Tees Hospitals NHS Foundation Trust and North Tees & Hartlepool NHS Foundation Trust in April 2024, it was agreed to delegated joint functions to the Group Board, with reserved functions retained at unitary board level.

1.2 The unitary boards of each Trust are required to retain separate Board Assurance Frameworks and risk management processes. These arrangements have been subject to a review over the last four months, leading to standardisation and consistency in a controlled and managed approach. This also includes an ongoing review of the governance arrangements below committee level.

2. Main content of report

2.1 The strategic objectives of South Tees Hospitals NHS Foundation Trust and North Tees & Hartlepool NHS Foundation Trust were approved to be carried forward into 2024/25. The Board Assurance Frameworks for each Trust, link the associated strategic risks to strategic objectives. A series of Board Development sessions are ongoing to determine a vision and strategic objectives for 2025/26 onwards in recognition of Group arrangements. The strategic objectives of both Trusts are set out in the table below;

STHFT

NTHFT

2.2 **North Tees & Hartlepool NHS Foundation Trust**

For the reporting period to 31st August 2024, the Trust is reporting 35 strategic risk across 7 BAF domains. There are four high/red strategic risks that are outside of the approved risk appetite of the committees of the Group Board and are shown in the following table.

BAF Domain	Approved Risk Appetite	Risk Score Range	Number of strategic risks outside of approved appetite
Finance (*)	Open	8-12	1
Trust's Estate (**)	Open	8-12	3

* Delivery of savings (current risk score of 16).
** Failure of Trust infrastructure (current risk score of 15).
** Insufficient capital funding to maintain the Trust's estate (current risk score of 20).
** Reduction of system capacity due to the Trust being unable to provide services, impacting on reputation (current risk score of 15).

2.3 Each risk has at least one planned action that aims to reduce the current risk scores to the target risks scores and within the approved risk appetite range.

2.4 A copy of the full BAF report is provided in the TEAMS reading library.

2.5 **South Tees Hospitals NHS Foundation Trust**

For the period to 31st August 2024, there are 22 identified threats linked to 5 principal risks. There is one threat that has limited/negative assurance, 20 threats have amber/moderate assurance and one threat has green/significant assurance. There are 19 planned actions to mitigate the threats. The principal risks continue to have identified committee oversight.

On an exception reporting basis, the threat assessed with limited/negative assurance is detailed in the below:

BAF Principle Risk	Threat	No. of mitigating actions	Lead
6. Failure to achieve financial objectives and responsibilities.	Failure to advance digital maturity will impact on efficiency, care quality and safety.	3	Group Chief Information Officer

2.6 A copy of the full BAF report is provided in the TEAMS reading library.

3. Revised Board Assurance Framework Reporting Arrangements

3.1 A Board Seminar took place on 1st October 2024, covering the review of the Integrated Performance Report (IPR) and proposed changes to the format, content and reporting period. In order to facilitate robust triangulation with the validated monthly performance position of each Trust, it was recognised that the reporting period of the Board Assurance Framework is required to align with the IPR. This will allow robust triangulation of the reported metrics in the IPR and the current risk score of the related

strategic risks e.g. 18 Week RTT. This revised reporting arrangement will support the Board to ensure the focus and discussion are on key areas.

The revised BAF reporting arrangements will be effective from 30th September 2024 and this will be reported to Committees of the Board in November 2024. The benefits of the revised BAF arrangements for each Trust include;

- A Board Assurance Framework that will focus on 8 **BAF domains**, to reflect the tailored position of each Trust to identify strategic risks that may prevent delivery of strategic objectives.
- Newly proposed **risk appetites** for each BAF domain, including a supporting **risk appetite statement**. This will provide a robust framework for decision making and how this aligns with the approved risk appetite of each Trust.
- Revised **strategic risks** which will be linked to the respective strategic objectives for each Trust.
- **Monthly reporting of BAF domains** into committees responsible for oversight. Escalations from reports can be included in Chair's Log Reports to Board.
- Quarterly **assessment of the effectiveness of assurance** for each strategic risk to be reported to committees for consideration.
- **Quarterly independent reporting** of the Trust BAF to the Audit Committee and the Board. This will include;
    - A strategic risk overview appendix.
    - A risk radar appendix showing the current risk score for all strategic risks in each BAF domain.
    - Top 10 operational risk appendix (limited to ten) providing Audit Committees and Board with visibility key operational risks.
    - An independent opinion regarding the robustness of the content of the BAFs for each Trust and identified areas for further work/improvement.

3.2 Work remains ongoing regarding the governance structures below Board committees and it is anticipated that this work will be completed by 31st December 2024. This is a key piece of work to ensure ward to board and board to ward reporting.

4. Conclusion/Summary/Next steps

4.1 This report identifies the key issues from the BAF for each Trust and provides assurance that planned mitigating actions are in place.

4.2 The revised BAF reporting arrangements will be reported to Board Committees in November 2024, reporting the positon to 30th September 2024 and will align with the reporting period of the IPR. Monthly reporting of the BAF domain will be presented to Board Committees and an independent quarterly reports to respective Audit Committees and Unitary Boards.

5. Recommendation

5.1 This report provides the following;

- Assurance by exception for each Trust regarding the management and mitigation of strategic risks to 31st August 2024.
- Details of the four red/high strategic risks that are outside of risk appetite for NTHFT.

- Details of one threat which is linked to a principal risk, which is assessed as providing limited/negative assurance;
- An update on the revised Board Assurance Framework reporting arrangements that take effect from 30th September 2024 and will be reported to Board Committees, Audit Committees and Boards, with effect from November 2024.

Responsible Director:

Stuart Irvine

Director of Strategy, Assurance & Compliance/Company Secretary

Report Author:

Stephen Green

Associate Director of Risk Management

Quality Assurance Committee

Connecting to: Group Trust Board

Key topics discussed in the meeting:

The following reports and updates were considered at the September meeting. All reports were from across the Group, presenting updates from both Trusts, and the considerable amount of work undertaken across all areas was noted.

- Legal Services Annual Reports
- Safeguarding Annual Reports
- Accreditation Update Report
- Patient Experience Annual Reports
- NHS Adult National Inpatient Survey Results 2023
- Cancer Patient Experience National Survey Results 2023
- Clinical Effectiveness Report
- Maternity & Perinatal Quality Surveillance Model Reports
- Integrated Performance Reports
- Board Assurance Frameworks

It was noted that there were no urgent escalations.

Actions:

There are important standing items from the IPR, and these were agreed to be continually monitored:

1. Infection prevention and control - challenges of maintaining good infection prevention control continue. Infection rates continue to be above the threshold with increased rates of C/difficile. A hotspot at North Tees was discussed and a deep dive on cause is being undertaken. There is a continued focus on developing a microbial stewardship plan and actions to keep infections down, such as the handwashing compliance monitoring programme.
2. Cancer targets remain a concern on 62 day waits, and consistent action is being taken to continually address clinical needs, with extra clinical sessions where appropriate.
3. Complaints being closed within the timeframe remain an issue at both Trusts. Although considerable work has been undertaken to address this with systems and processes, this needs to have focused attention.

Escalated items:

- The committee noted the good work across Tees with a positive improvement in safeguarding which was evident from the Safeguarding Annual Report.
- Maternity services in South Tees remain a focus for the Committee, with training below trajectory for both midwives and doctors, alternative dates have been arranged. Compliance towards the Trust core 10 mandatory training fluctuates in North Tees and alternative ways to achieve consistency in compliance.

Risks (Include ID if currently on risk register):

- South Tees maternity services in relation to staffing, training and estates. The Friarage Maternity Centre continues to be closed at times during the month due to staffing requirements at James Cook Hospital and the JCH alongside birthing unit remains closed.
- There is a sense of positive bias when discussing some key topics from the IPR, and further exploration of key indicators continue.

Quality Assurance Committee

Connecting to: Group Trust Board

Key topics discussed in the meeting:

The following reports and updates were considered at the September meeting. All reports were from across the Group, presenting updates from both Trusts, and the considerable amount of work undertaken across all areas was noted.

- Health and Safety Report Q2
- Fire Audit Update
- Maternity & Perinatal Quality Surveillance Model Reports
- Infection Prevention and Control Reports Q2
- CQC Compliance Update Report
- Integrated Performance Reports
- Board Assurance Frameworks

It was noted that the ICB had issued a safety alert on 29 August regarding the needs of patients with Learning Disabilities receiving care in intensive care. The Group have undertaken training analysis, and an update paper will be brought to next QAC in November.

Actions:

There are important standing items from the IPR, and these were agreed to be continually monitored:

1. Infection prevention and control – infection rates, in particular C Diff continue to rise and the challenges of maintaining good infection prevention control continue. There is a continued focus on developing a microbial stewardship plan and actions to keep

infections down. Site Directors of Nursing are actively monitoring against this position.

2. Cancer targets remain a concern across both sites with regards to 62 day waits, and consistent action is being taken to continually address clinical needs, with extra clinical sessions where appropriate.
3. Complaints being closed within the timeframe remain an issue at both Trusts. Although considerable work has been undertaken to address this with systems and processes, this needs to have focused attention.

Escalated items:

- The committee received a presentation on the ward accreditation programme from a member of the Eye Day Unit in South Tees which was well received and committee noted the plans to progress Ward accreditation on both sites.
- The CQC “must dos” are on track with both sites ensuring check and challenge processes in place.
- Maternity services in South Tees remain a focus, with training below trajectory for both midwives and doctors, although alternative dates have been arranged. Compliance towards the Trust core 10 mandatory training fluctuates in North Tees and alternative ways to achieve consistency in compliance.
- Fire Audit action plan is in place, and it was noted the considerable amount of work having been undertaken to date

Risks (Include ID if currently on risk register):

- Both Maternity services face a challenge in being compliant with training . South Tees have arranged additional dates for midwives and doctors , North Tees are focused on compliance with core mandatory training and have plans in place to address the issue. “

University Hospitals Tees

Group Patient Experience & Involvement Annual Reports 2023 – 2024

Meeting date: 5 November 2024

Reporting to: Public Board of Directors

Agenda item No: 11

Report author: Ian Bennett, Group Deputy Director of Quality, Jen Little, Patient Experience and Involvement Lead, South Tees, Mel Cambage, Interim Deputy Chief Nurse, North Tees & Hartlepool.

Action required: (select from the drop down list for why the report is being received)
Assurance

Delegation status (Board only and completed by the Corporate Secretariat): Jointly delegated item to Group Board

Previously presented to: Group Quality Assurance Committee, Safe and Effective Care Group (ST), Quality Assurance Council (NT&H).

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☐

A centre of excellence ☒

A great place to work ☒

Deliver care without boundaries ☒

Make best use of our resources ☒

CQC domain link:

Caring

Board assurance / risk register this paper relates to:

All risks associated with this paper are recoded on the appropriate risk registers and are aligned with the Board Assurance Framework.

Key discussion points and matters to be escalated from the meeting

The Board of Directors are asked to receive the annual patient experience and involvement annual reports for North Tees & Hartlepool and South Tees Hospitals for the financial year 2023 to 2024.

The South Tees annual report is detailed in Appendix 1 and can be found in the reading room.

The North Tees and Hartlepool annual report is detailed in Appendix 2 and can be found in the reading room.

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

None

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Both Trusts have developed a patient experience or involvement bank, with membership continuing to grow throughout the year.

Both Trusts have participated in relevant national patient surveys, developed appropriate action plans and have monitoring arrangements in place.

Friends and Family Test (FFT) scores remain high and above the national average in all areas apart from birth and post-natal FFT scores at South Tees.

There has been an increase in complaints received in 2023/24, as predicted following the implementation of the new national complaint process in Q4.

The top themes for complaints are, communication, attitude of staff, care and compassion and treatment and procedure delays. These are consistent with previous years reporting across both Trusts and mirror national trends.

The timeframe to respond to complaints has remained a challenge and below the target throughout the year for both Trusts.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Both Trusts have effective systems and processes in place to receive and act on feedback from patients, their relative and carers, which is in line with national guidance.

A range of engagement activities have taken place across both sites, covering the Tees Valley and North Yorkshire.

There are opportunities in place for patients, their relatives and carers to share their stories and experience through a range of formal and informal mechanisms, including opportunities for learning, teaching and training.

Recommendations:

The Board of Directors are asked to:

- Receive the report
- Note the progress and work achieved in 2023/24
- Note the key priorities for 2024/25

University Hospitals Tees

Maternity and Neonatal Safety and Quality Report Quarter 2 2024/25 - North Tees and Hartlepool

Meeting date: 5 November 2024

Reporting to: Group Board of Directors

Agenda item No:12

Report author: Stephanie Worn – Associate Director of Midwifery

Action required: Assurance

Delegation status (Board only): Jointly delegated item to Group Board

Previously presented to: Perinatal Quality Assurance Council and Quality Committee

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☐

A great place to work ☐

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☐

Deliver care without boundaries in collaboration with our health and social care partners ☐

Make best use of our resources ☐

CQC domain link:

Safe

Board assurance / risk register this paper relates to:

Quality and People

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

Two events referred to and accepted by Maternity and Neonatal Safety Investigation (MNSI) branch and by NHS Resolution Early Notification (EN) scheme. One event did not meet the threshold for a MNSI and at Trust level as a Patient Safety Incident Investigation (PSII). An oversight meeting with the perinatal quadrumvirate following the rapid reviews, identified opportunities for further learning and improvement to include:

- Communication: structured process for escalation and documentation
- Fetal wellbeing: embed holistic risk assessments

Maternity Incentive Scheme: Risk of non-compliance for safety action 6 and 8.

Safety action 6 – LMNS validated position is 1 out of 6 elements achieved. An action plan has been developed to address areas for urgent action.

Safety action 8 – training attendance trajectory for anaesthetists is below the expected level. A solution has been sought following appropriate escalation to the appropriate care group and site leadership team.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Service Transformation

- Maternity Triage: on-going developments; estate plans to be confirmed and a named consultant lead to be confirmed. The relevant guideline is under review to reflect current actions and mitigations so that women are seen in a timely manner.
- Community midwifery services: on-going developments.

Progress is being made towards the four key themes of the National Maternity and Neonatal Three Year Service Delivery Plan.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Embedded engagement with the Board Safety Champions and the Perinatal Quadrumvirate.

Supporting staff with career development sessions and health and wellbeing via a staff council.

Recommendations:

The Board of Directors are asked to receive and note the significant on-going work to meet National Maternity recommendations and workforce challenges.
The Board of Directors are asked to receive and note the:

- Culture and leadership developments
- NHS resolution scorecard.
- Quality improvement projects for ATAIN and SBL

The Board of Directors are asked to note and approve the progress made in relation to neonatal transitional care for late preterm newborns.

Appendices linked to this report can be found in the reading room.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Group Board of Directors
5th November 2024
Maternity and Neonatal Services Safety and Quality Report for Quarter 2 2024/25

1. Introduction/Background

The purpose of the report is to inform and provide assurance to the Quality Committee and Group University Hospitals Tees Board of Directors that there is an effective system of clinical governance in place monitoring the safety of our perinatal services with clear direction for learning and improvement.

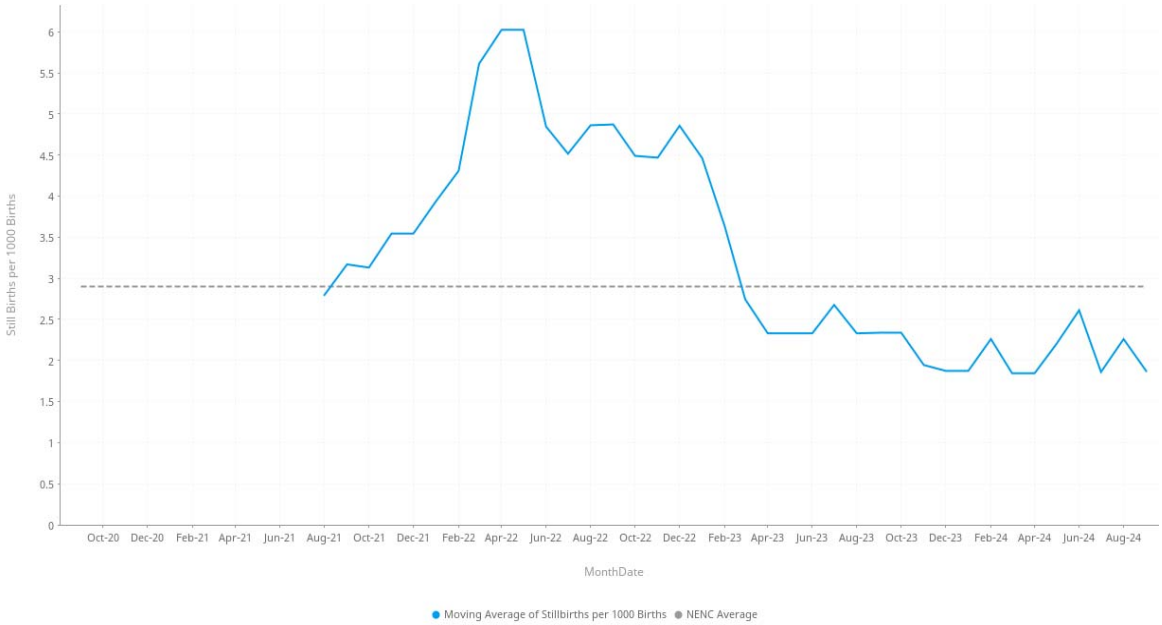
The data within this report is for Quarter 2 of 2024/25. This report contains the perinatal quality surveillance model dashboard (Appendix 1) and the in-month position for September 2024 (Appendix 2), to continue monthly oversight reporting to the Trust Board. Where any data provided sits outside this reporting timeframe, this will be specified within the report. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020).

2. Perinatal mortality rate

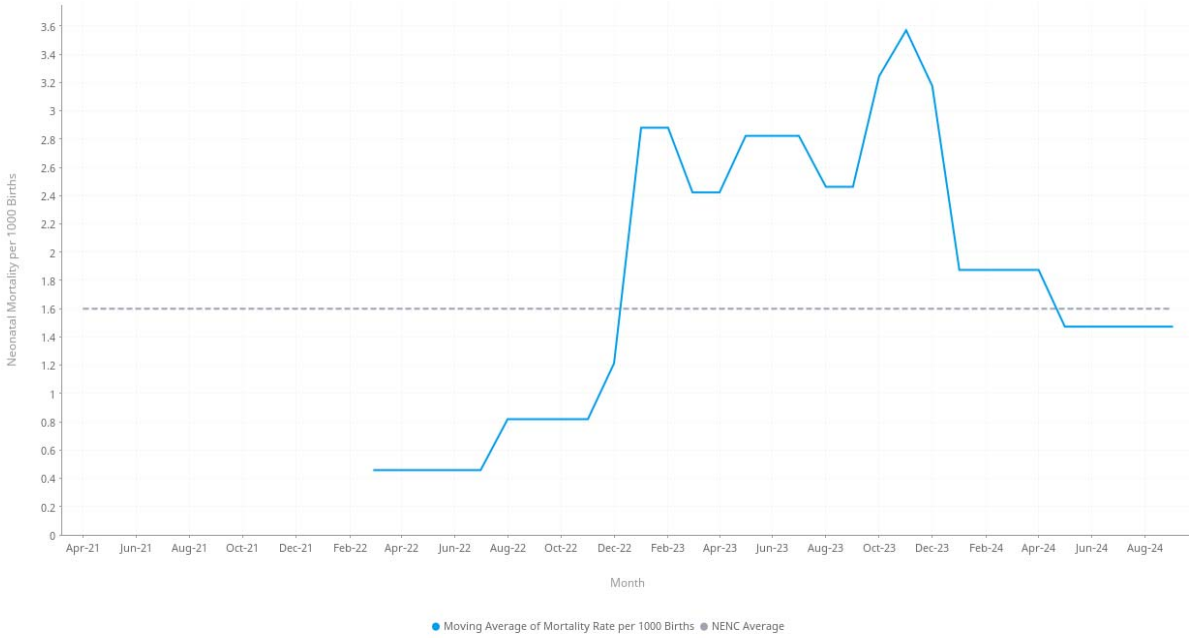
In Quarter 2, two stillbirths were reported and zero neonatal deaths. Graph 1 shows the rolling annual stillbirth rate per 1000 births of 1.87 (exclusive of medical termination of pregnancy). Graph 2 shows the rolling neonatal death rate per 1000 births of 1.47, inclusive of early and late neonatal deaths. On average, the Trust has 200 births per month.

The NENC ICB average rates published on the regional dashboard report the 2023 stillbirth rate per 1000 of 2.9 and 2022 neonatal mortality rate per 1000 of 1.6.

Graph 1. Rolling annual Stillbirth rate per 1000 births



Graph 2. Rolling annual neonatal death rate per 1000 births



2.1 Perinatal Mortality Review Tool (PMRT) real time data monitoring tool

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK (MBRRACE-UK) collects data on perinatal death defined as babies born without signs of life from 22 weeks gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding terminations of pregnancy. The definition for Stillbirths is from 24 weeks.

All eligible perinatal deaths have met the required standards of notification, parental input and multidisciplinary team (MDT) review. On a monthly basis the number of cases and

key learning points are reported to the Quality Committee and quarterly to the Group Board of Directors.

2.2 Learning from PMRT reviews in Quarter 2 2024/25

A rapid response to learning is undertaken to identify and action any immediate learning until the full PMRT review has been completed within the expected timeframe. An incidental finding highlighted the importance of professional curiosity with conflicting clinical assessment and lifestyle choice/history in regards to smoking status. This will be promoted through team meetings and training.

3 Maternity and Neonatal Safety Investigations

3.1 Background

Maternity and Neonatal Safety Investigation team (MNSI) formally known as HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018). Alongside this, NHS Resolution have a proactive approach to investigate specific brain injuries for determining if negligence caused harm, known as the Early Notification (EN) scheme. The intentions for both MNSI and EN are to identify learning, improve processes for transparency and candour, and to meet the needs to the family in real time.

3.1.1 Babies

Babies who meet the criteria for investigation include all term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes are:

- Intrapartum stillbirth.
- Early neonatal death.
- Severe brain injury diagnosed in the first seven days of life.

3.1.2 Mothers

Mothers who meet the criteria for investigation are direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy. MNSI do not investigate cases where suicide is the cause of death.

3.2 Reported and investigation progress update

MNSI were notified of two events that met the eligible criteria in quarter 2, and both cases were reported to NHSR EN scheme. The service has three active investigations. Limited information is shared within this report to minimise patient identifiable details and a full report is provide to the Group Board of Directors In-Committee. Table 1 outlines the compliance requirements for MIS year 6.

Table 1 MNSI reporting compliance

MNSI and NHSR Early Notification scheme	Eligible cases	completed
Eligible cases reported to MNSI	x 2	Yes
Eligible cases reported to NHSR EN	x 2	Yes
Family informed of MNSI, EN scheme and duty of candour	x 2	Yes
Trust Claims reporting wizard completed	x 2	Yes

3.3 Safety recommendations and learning from completed investigations

-

The Trust had no completed MNSI investigations.

3.4 Coroner Reg 28 made directly to Trust

No requests made in this reporting period.

4. Maternity events

In addition to MNSI cases, the service reported one event under the category of a Patient Safety Incident Investigations (PSII) and will be investigated as per the framework process. The service reports seven moderate graded events inclusive of the above events and postpartum haemorrhage of >1.5l. All events that have been graded as moderate harm and above are discussed at the trust response-planning meeting, attended by the patient safety team and chaired by the patient safety operational lead.

Table 2. Grading of events

Event	July	August	September	Total
No Harm	37	27	39	103
Low Harm	21	18	13	52
Moderate Harm	6	0	1	7
PSII	1	0	0	1
Total	**66**	**45**	**53**	**163**

4.1 Maternity and /or neonatal services suspension/divert/closure

The maternity service and the Special Care Baby Unit (SCBU) did not report any closures in Quarter 2.

5. MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust.

In October 2022, the Maternity Services were placed on the Maternity Safety Support

Programme (MSSP) following a review by the CQC, which rated Maternity Services as

Requires Improvement. The Trust are working with the Simon Mehigan - named Maternity Improvement Advisor. In May 2023 the exit criteria from the MSSP was agreed by Trust, ICB and NHSE, with an addition in November 2023. There are 7 elements are:

- Workforce
- Leadership
- Quality, risk and safety
- Digital
- Improvement plan
- CQC
- Communications

The exit criteria review demonstrated the service is making good progress with an expectation of a formal review led by the MSSP lead in Quarter 3.

6. Three year delivery plan for maternity and neonatal services.

In March 2023, NHS England published the Three year delivery plan for Maternity and Neonatal services. The aim of the plan is to make care safer, more personalised and more equitable and outlies four key themes to support attainment of the aim. Compliance status (table 3) will be appended to the maternity operational meeting, Perinatal Quality Assurance Council (PQAC), the Quality Committee and to the Group Board of Directors. The governance approach taken for progress position adopts the BRAG system; completed actions are to remain green until evidence has been reviewed and approved at which point they will change to blue coding.

Table 3: compliance progress

3year Maternity and Neonatal Service Delivery plan	Compliance progress
Listen to and work with women and families	
Grow, retain and support our workforce	
Culture of safety, learning and support	
Personalised and equitable care underpinned by standards	

7. NHS Resolution Maternity Incentive Scheme (MIS)

The Trust received confirmation from NHS Resolution for achieving all ten safety actions in year 5 and a payment equal to the Trust 10% contribution into the Clinical Negligence Scheme for Trusts, plus a share of the surplus funds in respect of Trusts that did not achieve ten out of ten. Year 6 guidance and the monitoring period commenced on the 2nd April 2024.

Table 4 MIS year progress position

Safety Action	Compliance	Update
SA1 PMRT		On track with requirements for compliance
SA 2 MSDS		MSDS quality metrics for July's submission to be confirmed by NHSE
SA 3 Transitional Care		Q1 Audits for review and approval
SA 4 Clinical Workforce Planning		Q1 Audits for review and approval
SA 5 Midwifery Workforce Planning		Monthly Report produced
SA 6 SBLV3 Bundle		Q1 - low compliance against ICB/LMNS targets. Action plan developed
SA 7 Patient Feedback		Further development with BAME population
SA 8 In house Training		Risk of non-compliance for a staff group. Escalation has been activated.
SA 9 Safety Champions		On Track with requirements for compliance
SA 10 MNSI		On Track with requirements for compliance

The service has identified two safety actions at risk of non-compliance

- Safety action 6. See section 8
- Safety action 8. See section 10.1

8. Saving Babies Lives Care Bundle Version 3

The Saving Babies' Lives Care Bundle is a group of actions that have been put together to reduce stillbirth. Each element has a specific action plan against it and together, these have now been shown to save babies' lives. For the purpose of MIS year 6 to achieve compliance the following evidence is required:

- Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.
- Progress against locally agreed improvement aims.
- Evidence of sustained improvement where high levels of reliability have already been achieved.
- Regular review of local themes and trends with regard to potential harms in each of the six elements.
- Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.
- Following a review by the ICB /LMNS, the Trust declared compliance with SBLCBv3.

The Trust and the ICB/LMNS have quarterly meetings dates scheduled for 2024/25. The validated compliance position by the LMNS for Quarter 1 was 1 out of 6 elements. The service has since updated evidence and are waiting an updated position following review by the LMNS. The requirement for MIS compliance is to achieve compliance with all six elements however, where the full implementation is not in place, compliance can still be achieved if the ICB conforms it is assured that all best endeavours and sufficient progress have been made towards full implementation, in line with locally agreed improvement trajectory. The service continues to ensure there is progression. A Quarter 2 meeting is scheduled for November to review progress. The service presented a quality improvement for element 1: smoking cessation in pregnancy (Appendix 3)

9. Avoiding Term Admissions into Neonatal Unit (ATAIN) Rates

This is a programme of work to reduce avoidable admissions to a neonatal unit for infants born at term (over 37 weeks gestation) paralleled by reducing separation of mother and baby. The National ambition is a rate below 6%. A total of 34 (5.4%) >37weeks gestation babies were admitted to SCBU in Quarter 2. The reasons for 70% of admissions were for respiratory distress. The audit meeting has been extended to include the MDT across the perinatal service to strengthen the review and widen the learning. An improvement action plan of learning is shared at the maternity and neonatal safety champions meetings which includes the perinatal quadrumvirate. Monthly updates are reported at the Quality Committee, Board of Directors and quarterly to the LMNS. Respiratory distress is the planned focus for a perinatal Quality Improvement with the aim to reduce the amount of babies requiring admission for this reason, this has been registered on the platform; Life QI (Appendix 3). The service continues progress towards offering transitional care to late preterm babies against the action plan previously approved by the Board of Directors (Appendix 4).

10. NENC Local Maternity and Neonatal System (LMNS)

The service engages with the LMNS and shares quality and safety intelligence via the quarter returns presented at the LMNS Board, learning meetings and shared at the local Trust quarter meetings, The LMNS report into the ICB and regional oversight meetings.

11. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training.

11.1 Core Competency Framework v2 (CCFv2) year 2

The Trust has worked in collaboration with the NENC Local Maternity and Neonatal System (LMNS) to develop a maternity training syllabus to meet the requirements of Core Competency Framework v2 (CCFv2), supporting standardisation of training, servicer user involvement and shared resources. Compliance for MIS year 6 focuses on MDT obstetric

emergency skills, fetal monitoring and new-born life support. It is expected mandated staff groups are to achieve 90% or greater attendance with an overall 90% attendance of all mandated staff groups per training module. The training compliance position is outlined in tables 5 and 6. The training compliance and trajectory is shown in graph 3 and 4.

The service is at risk of non-compliance for MDT obstetric emergency training for the anaesthetist staff group. Scheduling training dates and places began in January 2024 and during this course additional training dates have been arranged. Attendance however, remains below the in-month expected position, due to service pressures, with a forecast of not achieving 90% compliance. The training team has escalated appropriately and following discussions with the respective education and rota teams, a solution has been achieved. The education lead will continue oversight to ensure attendees attend

The obstetric and neonatal department Trust core 10 mandatory training is shown in Table 7. Compliance will continued to be monitored monthly and to support staff to access training. A review of mandatory training modules will be undertaken as an opportunity to ensure the assigned training is appropriate for each of the staff groups.

Table 5. MDT obstetric emergencies skills and newborn life support

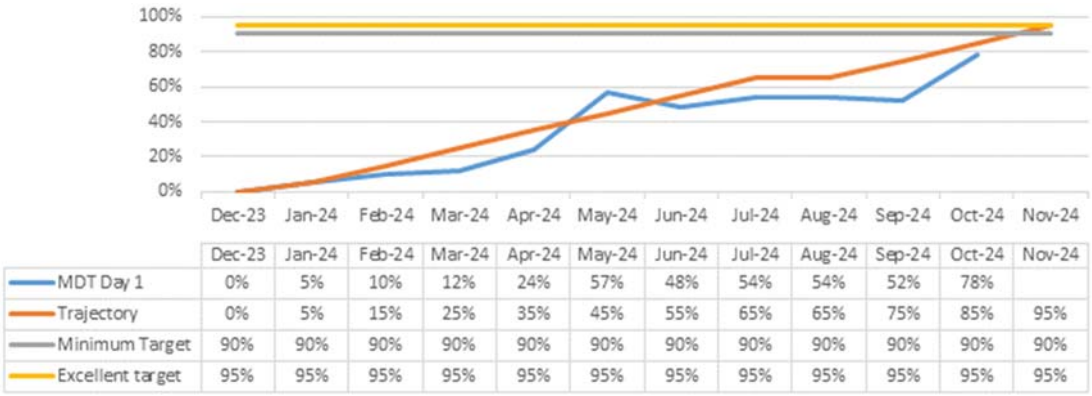
Staff group	July	August	September	MIS year compliance for Q2	Yearly Rolling compliance average
Midwives	59%	59%	70%	70%	92%
Support staff	58%	58%	69%	70%	88%
Obs consultant	62%	62%	64%	70%	86%
Obs trainee	24%	24%	54%	70%	20%
Anaesthetic consultant	60%	60%	60%	70%	90%
Anaesthetic trainee	61%	61%	41%	70%	50%
Theatre staff *	36%	36%	18%	25%	18%

*Theatre staff are not part of mandatory MIS 90% statistics. We have introduced this MDT role in MIS 6 as working towards excellence.

Table 6. Fetal monitoring training

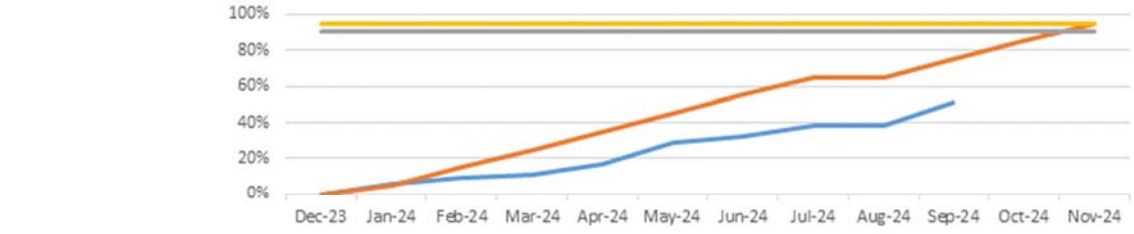
Staff group	July	August	September	MIS year compliance Q2	Yearly Rolling compliance average
Midwives	59%	59%	71%	70%	89%
Obs consultant	54%	54%	64%	70%	93%
Obs trainee	0%	0%	20%	70%	87%

Graph 3. MIS training compliance and trajectory MDT obstetric skills and NLS



	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
MDT Day 1	0%	5%	10%	12%	24%	57%	48%	54%	54%	52%	78%	
Trajectory	0%	5%	15%	25%	35%	45%	55%	65%	65%	75%	85%	95%
Minimum Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Graph 4. MIS training compliance and trajectory for Fetal monitoring



	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
SBL and Fetal Wellbeing Day 2	0%	6%	9%	11%	17%	29%	32%	38%	38%	51%		
Trajectory	0%	5%	15%	25%	35%	45%	55%	65%	65%	75%	85%	95%
Minimum Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Table 7. Maternity workforce Trust Mandatory Core training

Staff group	July	August	September
RM and support staff	91.73%	92.99%	93.28%
Medical	84.24%	83.64%	82.32%
Nursing and support staff	98.71%	99.99%	99.48%

12. Insights from service users

12.1 Complaints and compliments overview

The monthly numbers of both complaints and compliments are outlined in Table 8 and Table 9 formal complaints within quarter 2 related to:

- Care provided
- Lack of compassion
- Communication

The above has been communicated to maternity staff through mandatory training and ward meetings. Complaints are monitored via the trust complaints process.

Table 8. Complaints

Complaints	July	August	September	Total
Stage 0	1	0	0	**1**
Stage 1	3	1	0	**4**
Stage 2	2	1	3	**6**
Stage 3	0	0	0	**0**
Total	**6**	**2**	**3**	**11**

Table 9. Compliments

Compliments	July	August	September	Total
Care provided/compassion	13	20	17	**50**
Communication	2	0	3	**5**
Multiple	6	1	0	**7**
Staff to staff	6	7	3	**16**
Other	1	0	3	**4**
Total	**32**	**28**	**26**	**82**

12.2. Service user insights from Friends and Family Test (FFT)

The service continues to monitor friends and family test feedback. The latest results are identified in the Table 10.

Table 10. FFT

	July	August	September
Positive %	83.3%	100%	94.9%

12.3 Trust Claims Scorecard.

The scorecard is a quality improvement tool that provides insights into claims in support of clinical governance and quality assurance for the Trust. The scorecard provides details of all CNST claims, combined with data from the early notification scheme, providing a full picture of maternity related claims. The information is triangulated with the other feedback

sources to support improvements, such as complaints and compliments. An updated scorecard was published in August and a local improvement plan is attached is appendix 5.

12.4 Service user insights from Maternity and Neonatal Voice Partnership (MNVP)

The MNVP meet with the senior leadership team on a monthly basis where feedback is shared from service users, local and regional forums. Other agenda items include work plans, and engagement opportunities. The MNVP regularly attend meetings within the governance structures, reflected in the Terms of Reference membership such as; Board safety champions, perinatal services improvement group, perinatal quality assurance council, PMRT. Current projects include:

- Engagement with local communities through baby banks within some of the most deprived communities.
- Work on what good co-production looks like.
- Expanding the team and exploring opportunities with South Tees MNVP
- The service continues with the same infrastructure arrangements from 2023/ MIS year 5.
- Progress is being made towards the MNVP work plan 2024.25 (appendix 6).

12.5 Service user insights taken from a recent CQC peer review

Following the National Maternity survey publication in quarter 4 of 2023/24, an improvement plan (appendix 7), previously agreed by the Board of Directors and the LMNS continues to be monitored through the perinatal service improvement group for progress. A formal update will be presented to the LMNS with the quarter 3 return.

13. Community midwifery services

An external review of community services has been undertaken by members of the NEY Regional Midwifery team supported by the designated Maternity Improvement Advisor (MIA). There have been several staff engagement sessions and a survey. The report was received in November 2023, outlining opportunities such as a review of the workforce model, location of service provision and enhanced models of care. There were four key themes identified from the report which led to 3 work streams, led by the community teams:

- Autonomous working
- Flexible working
- Community Hubs as a location base
- Antenatal and postnatal continuity of carer

Representatives from each of the geographical teams will progress the work streams over the next quarter.

13.1 Continuity of Care

There is no longer a national target for Maternity Continuity of Carer (MCoC). Local midwifery and obstetric leaders should focus on retention and growth of the workforce, and

develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths. NHS England expects the trust to continue to review our staffing in the context of the Ockenden final report. The Trust position is to maintain the one MCoC team and not to expand until the building blocks of a workforce are achieved. A project to explore an enhanced maternity model of care is underway; focus on those women from vulnerable groups who will benefit the most from this model. The local LMNS, regional and national colleagues are available to support the trust with this.

13.1 Progress to Date

Table 11 outlines the current percentage on a continuity pathway with the MCoC team (Rowan) i.e. the same team of midwives looking after women throughout their antenatal, intrapartum labour and postnatal care.

Table 11. Maternity Continuity of Carer (Rowan) Percentage

	% of women who are on a MCoC pathway at 29 weeks	% of women who are from the BAME community on a MCoC pathway at 29 weeks	% of women who live in the 10% most deprived on a MCoC pathway at 29 weeks	% of women who were cared for in labour by their continuity team
July	**6.2**	**2.4**	**17.8**	**36.8**
August	**4.2**	**3.2**	**0.9**	**50**
September	**4.2**	**0**	**1.1**	**21.1**

Due to a change in risk factors, the number of women that receive continuity of care through the intrapartum period is lower than the above figures. With support from the Trust's public health team, the service identified there was area for future development to explore enhanced continuity of care to progress the National maternity safety ambitions. A scoping project to understand population demographics will be developed to influence enhanced models of care.

Table 12 shows the current percentage of women who have antenatal care plans recorded by 29 weeks, with CoC pathway indicator and record of teams providing care. The data is submitted to the National maternity dashboard and quarter 2 demonstrates compliance.

Continuity of Care	July	August	September
i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed	97.9%	96.3%	97.6%

ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.	100%	100%	100%

Table 12. Antenatal MCoC antenatal pathways

14. Quality improvement and research

14.1 Research midwifery team

The research team received a visit from professor Andrew Weeks from the COPE trial who recognised the pivotal role the team have to improve maternal outcomes. The team are collaborating with the bereavement specialist midwife to support research for early stillbirths. Table 13 summaries current research activity. Expanding studies to include pharmaceuticals is an area of focus and there are discussions in place to overcome the limited pharmacy capacity.

Table 13. Research activity summary

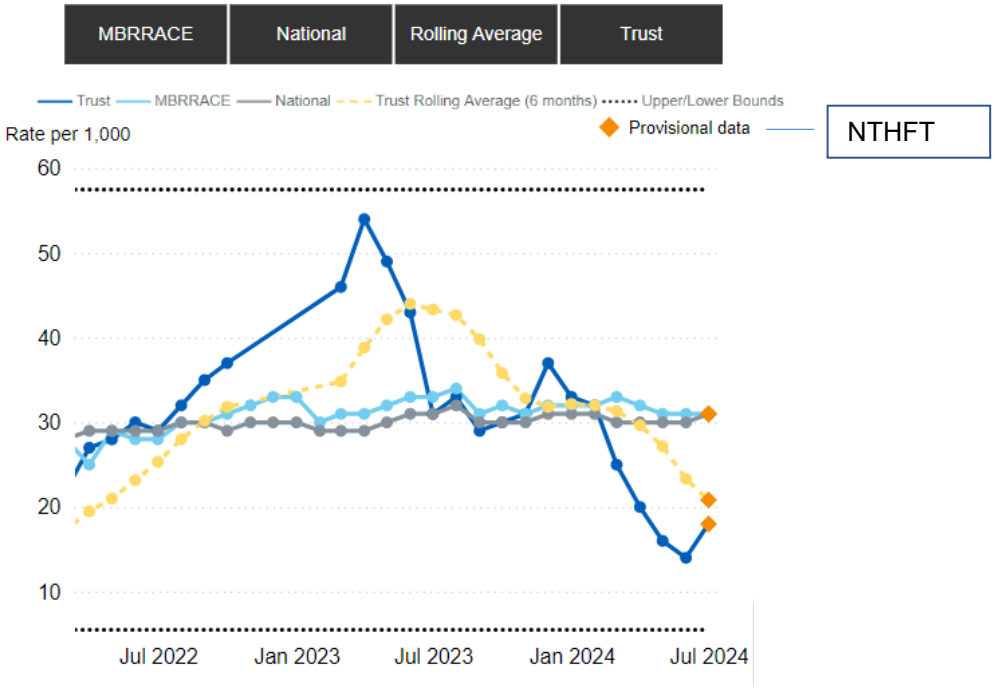
Obstetric study	Status
COPE – Carboprost vs Syntocinon as first line treatment for PPH	Active Recruited 188
ROTATE – RCT of manual vs instrumental rotation of the fetal head in malposition at birth	Active Recruited 18
iGBS3 – Cord blood for research into GBS protection	Active Recruited 2651
iHOLDS – High or low dose syntocinon for IOL	On Hold (pharmacy capacity issue) Recruited 101
MiNESS – Mothers working to prevent early stillbirth	Active Recruited 9
TTTS Registry – Multiple Pregnancy Registry	Active Recruited 34
SNAP3 – Enhanced support NRT offered for preloading, lapse recovery and smoking reduction – impact on smoking in pregnancy – women who smoke 5 or more cigarettes per day	Active Recruited 46
INGR1D2 – Identification of infants with increased type 1 diabetes risk for enrolment into primary prevention trials	Paused (recruitment target achieved)
OBS PPH UK – Obstetric Bleeding Study	Active. Data collection phase
SNAP 2 – smoking, Nicotine and Pregnancy 2 – women who smoke 5 or less cigarettes per day	Active – no recruits yet

14.2 Quality Improvement Lead

There are several quality improvement projects active:

- Post-Partum Haemorrhage continues to show sustained improvement and the service is not an outlier in comparison to other MBRRACE Trusts within our comparator sites (graph 5). The maternity team have been asked to present at the national OBS UK symposium.
- NeoTRIPS: a new national project to improve expressed breast milk (EBM) in pre-term infants less than 34weeks gestation. The service has achieved 100% in the first 24 hours since
- Fetal genotyping: aim is to train staff and develop a new process by September.
- Stop smoking services in Hartlepool has seen a 900% improvement over the last year and this is showing a sustained improvement plans to implement some of the work the in Stockton area are underway so that we can standardise practise.

Graph 5. NTHFT PPH rate



14.3 Retention, Recruitment and Pastoral Support Midwife

- Supporting x 2 Internationally Educated Midwives.
- Progression of band 5s to band 6 of Sept 2023 cohort
- Continuing work around rotations and change list and feedback to senior management
- Focus work on staff returning following a leave of absence, to optimise support
- Intend to recruit a legacy midwife in quarter 2.
- Continuing Wellbeing Project and perinatal Staff council.

14.4 Infant feeding and health in pregnancy specialist services

NTHFT population have some of lowest rates of Breast Feeding at a NENC and national level. In January 2023, NTHFT registered its intent to gain Baby Friendly Initiate (BFI) accreditation and achieved stage 1 in September 2023. The following outlines key activities and achievements for quarter 2:

- Breastfeeding rates increasing from 40% to 50% average.
- UNICEF stage 2 BFI accreditation.
- Improved antenatal education for women.
- Targeted support within the immediate postnatal period for those at increased risk.

14.5 Digital Specialist Midwife

The implementation of the new electronic patient record (EPR) system known as Badgernet was launched across all areas of the maternity services by November 2023. The following outlines achievements, challenges and next steps:

- Interface between BadgerNet and some laboratory results to reduce potential transcript errors
- Electronic referrals: physiotherapy, sexual health Teesside and STH urgent scan request
- Digital inclusion: registered as a digital hub to offer digital and mobile data services to those in need. First step is to gift SIM cards to those most in need.
- Infant referrals via Badgernet: cardiology, BCG.
- Develop maternity theatres optimisation (WHO checklist, peri-operative pathway)
- Explore E-obs and Early Pregnancy (PAC/EPAC) modules

14.6 Bereavement Specialist Midwife

There has been much work on going and the following highlights key activities:

- Official 'opening' of the refurbished Snowdrop Suite to be planned following donations.
- 'Deep dive' into incidence of retained products of conception following a bereavement as an increase in the number of events has been observed.
- Embed bereavement care champions into practice.
-

15. Culture and Leadership

15.1 Board level safety champion meetings

Safer maternity care called on maternity providers to designate and empower individuals to champion maternity safety in their organisation. The board-level maternity safety champion will act as a conduit between the board and the service level champions. The role of the maternity safety champions is to support delivering safer outcomes for pregnant women and babies.

The meetings are held with the Executive Board Champion, Non-Executive Director Maternity Champion, the Obstetric, Midwifery and Neonatal Safety Champions, representative from Maternity and Neonatal Voice Partnership, Neonatal Matron, and Clinical Director, Associate Director of Midwifery, perinatal quadrumvirate and the Patient Safety, Risk and the Governance Lead midwife. The meetings are bi-monthly, followed by a walkabout of the clinical areas. National, Regional and system developments are discussed along with audits, dashboard metrics, service feedback, improvement plans for ATAIN and the optimisation Bundle. The perinatal quadrumvirate provide regular feedback and inform the members of progress and intelligence shared by peer 'perinatal quads'. There are no items for escalation for quarter 2.

The feedback from the perinatal walkabouts are:

- Day assessment unit reported capacity issues with an overflow from antenatal clinic though it was recognised there are mitigation sin progress to support improvement.
- Delivery Suite: staff were positive in terms of service development and culture.

- Culture – staff feel supported and they can see improvements to the service and professional development opportunities.

In response to outstanding actions, IT issues have been addressed for the Stockton based community midwifery services. A communication brief informing staff of maternity metrics is now displayed in all areas with an aim of developing and displaying a live digital dashboard.

15.2 Advocating for education and quality improvement (A-equip) and professional midwifery advocacy themes

The Professional Midwifery Advocate (PMA) continues to offer restorative support, one to one and in groups, as well as signposting to further sources of support, information and assistance. As a critical part of the advocating for education and quality improvement (AEQUIP) model, the PMA focuses efforts on empowering midwives to confidently handle situations themselves, improve relationships with peers and managers, and to seek ways to increase service quality, safety and excellence. The PMAs are developing plans to support those new to the role and a sessional schedule. The following outlines quarter 2 activity:

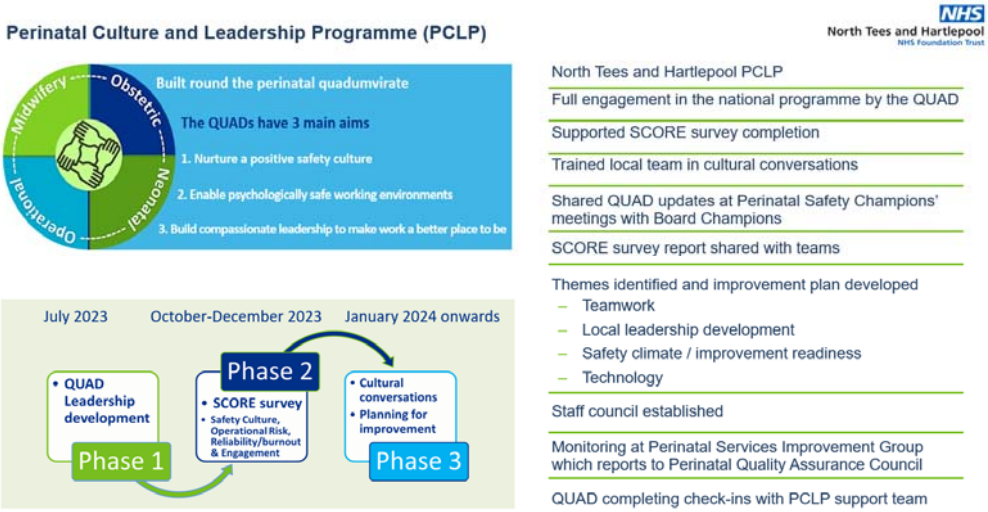
- Launched a formal weekly rota on the 30th August for both group and 1-1 sessions.
- Two midwives are undertaking the PMA course, in addition to the seven already qualified.
- Developing a PMA strategy

15.3 Perinatal Culture and Leadership Programme

The quadrumvirate perinatal leadership engaged fully with the programme led by NHS England. A quadrumvirate action plan was developed to support the team with implementing actions following learning from the SCORE survey. A programme to support the cultural coaches with this work has also been established. The quadrumvirate perinatal leadership engaged fully with the programme led by NHS England. A quadrumvirate action plan was developed to support the team with implementing actions following learning from the SCORE survey (appendix 7). A programme to support the cultural coaches with this work has also been established

Highlight:

- 3x Team building away days at Tees Barrage had been arranged with 40 people booked onto those days.



15.4 Opportunities and development

The senior midwifery team have acknowledged feedback from the workforce and in response have established the following initiatives:

- Perinatal staff health and well-being council: the team have supported 2 team buildings which evaluated well. There is a committed to provide continuous support to staff for wellbeing and team development.
- Staff Development sessions: these are led by a Maternity Senior Clinical Matron on a monthly basis for staff to discuss their future professional development and career pathways. The idea is that the Trust can provide or sign post to opportunities to enable tailored professional development.

16. Risk register

There are nine open risks (appendix 8), graded as:

- 1 x moderate
- 4 x low risk
- 1 x very low

In line with the Trust risk management process, risks raised by the service are developed by the service and are reviewed in the weekly Care Group SMT meeting. From here they go to the weekly Operational Delivery Group meeting for discussion and review by the team and then to Risk Management Group. Additionally, risks are raised at the Maternity Quality Assurance Council, through Quality Assurance Committee to Board.

17. Key issues, updates, significant risks and mitigations

The community midwifery service continues to review and develop a revised care provision model. This may impact workforce morale and culture, which will be mitigated through engagement and communication from the senior midwifery team.

The service plans to implement a maternity triage service, in line with national recommendations, which will require a review of the workforce model, estates and facilities. The service has mitigation in place as there is an established triage system to enable prioritisation and timely assessment. The development of this service may impact workforce morale and culture, which will be mitigated through staff engagement and inclusion in the quality improvement work with communication and support from the senior maternity team.

Other work streams include:

- A review of antenatal clinic and ultrasound capacity and demand

18. Assurance and Recommendations

The Board of Directors are asked to receive and note the significant on-going work to meet National Maternity recommendations and workforce challenges.
The Quality Committee members are asked to receive and note the

- Culture and leadership developments
- NHS resolution scorecard.
- Quality improvement projects for ATAIN and SBL

The Board of Directors are asked to approve the progress towards for neonatal transitional care for late preterm newborns.

Appendices – in the reading room

Appendix 1. Perinatal quality surveillance model dashboard.

Appendix 2. Perinatal quality surveillance model report for September 2024.

Appendix 3. Quality improvement project for SBL and ATAIN.

Appendix 4. Neonatal Transitional care action plan.

Appendix 5. NHS resolution scorecard

Appendix 6. MNVP work plan 2024.25

Appendix 7. Maternity CQC survey action plan

Appendix 8. SCORE action plan

Appendix 9. Risk Register

NHS
University Hospitals Tees

Maternity and Neonatal Staffing Report for Quarter 2 2024 – North Tees & Hartlepool

Meeting date: 5 November 2024

Reporting to: Group Board of Directors

Agenda item No: 12

Report author: Stephanie Worn, Associate Director of Midwifery

Action required:
Assurance

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to: Perinatal Quality Assurance Council and Quality Committee

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☐

Transforming our services ☒

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☐

A great place to work ☐

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☐

Deliver care without boundaries in collaboration with our health and social care partners ☒

Make best use of our resources ☐

CQC domain link:

Safe

Board assurance / risk register this paper relates to:

People

Caring Better Together

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

Workforce: On-going recruitment to the midwifery, obstetric and neonatal workforce. The midwifery workforce has seen an increase in sickness with no trends observed. The obstetric workforce appointed two obstetric and gynaecology consultants.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

On-going work for both the maternity and obstetric workforce. The midwifery vacancy position has improved. However, staffing templates have been below template compounded by an increase in the sickness and maternity leave rates for the months of June, July and August. The team are collecting midwifery workforce data as the Birth Rate + report preceded the Core Competency Framework version 2 which increased the training requirements for the midwifery workforce, the community services was based on a traditional model only and maternity leave allowance was not included in the headroom. The neonatal workforce have provided an action plan to attain BAPM compliance.

Maternity Incentive Scheme year 6

The compliance period commenced on the 2nd April. Monitoring of progress, compliance and evidence will be undertaken on a monthly basis.

Safety Action 4 and 5: The service is demonstrating compliance for quarter 2.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The Board of Directors are asked to receive and note the culture and leadership developments reported in the quality and safety report.

Recommendations:

The Board of Directors are asked to receive and note the significant on-going work to meet national maternity recommendations and to address workforce challenges.

It is recommend for the Board of Directors to note the 97% compliance and completed action plan for obstetric consultant attendance in complex emergency obstetrics.

It is recommended for the Board of Directors to note the neonatal workforce action plan to achieve the BAPM recommended neonatal nursing workforce.

The Board of Directors to approve the lead roles for Preterm Birth services as per Saving Babies Lives recommendations (neonatal nurse, consultant neonatal lead, midwifery and obstetric).

Appendices in relation to this report can be found in the reading room.

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Group Board of Directors
5th November 2024

Maternity and Neonatal Services Staffing Report for Quarter 2, 2024/25.

Background

It is a requirement that as NHS providers, we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously, midwifery staffing data has been included in the nurse staffing paper. However, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided.

1. Minimum safe staffing maternity services

Safe Maternity Staffing Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings. In addition, the final Ockenden report (2022) states minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the Local Maternity and Neonatal System (LMNS). This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational MIS and CQC requirements.

1.1 Midwifery Staffing

The Trust is compliant with the recommended funded midwifery establishment by Birth-rate Plus undertaken in January 2023 (Appendix 1). It is to note the review preceded the Core Competency Framework version 2 which increased the training hours, maternity leave is not accounted for in the recommended headroom and the community midwifery services was based on traditional model only. Therefore the service is re-reviewing the midwifery workforce data. The recommended midwife to birth ratio is 1:19.5 with section 1.2 outlining actions and mitigations to minimise risks when the staffing levels are below template.

The registered midwifery (RM) vacancy position at the end of September was 4.74wte. Table 1 shows the staffing position and Table 2 shows the monthly fill rates.

Table 1. Midwifery staffing position

RM vacancy position	Sum of Budget			Sum of Actual			Sum of Variance			Projected 3 month			Projected 6 month		
	July	August	September	July	August	September	July	August	September	July	November	December	July	February 2025	March 2025
B5/B6 RN's/RM's	106.67	106.67	106.67	100.9 Includes 6.78 on mat leave	99.22 Includes 6.78 on mat leave	99.58 Includes 4.5 on mat leave	-5.77 (5.4%)	-7.45 (6.98%)	-7.09 (6.64%)	-1.03	-2.37 (2.22%)	-4.38 (4.1%)	-0.99	-0.99	+2.27
B7 Clinical and Specialist Midwives	26.31	26.31	26.31	26.75 Includes 1 on mat leave +3.1 externally funded position	27.65 Includes 1.5 on mat leave +3.1 externally funded position	27.65 Includes 2.4 on mat leave +3.1 externally funded position	+0.44	+1.34	+2.35	+0.65	+0.65	+4.01 (mat leave cover)	+1.31 (mat leave returners overlap)	+1.35 (mat leave returners overlap)	+1.01 (mat leave cover)
Grand Total	132.98	132.98	132.98	127.65 130.75 (incl external funded posts)	126.87 130.75 (inc external funded posts)	126.87 130.75 (incl external funded posts)	-5.33 (4.1%)	-6.11 (4.59%)	- 4.74 (4.44%)	-0.38	-1.72 (1.29%)	+0.37	+0.32	+0.36	+3.28

Table 2. Unavailability for qualified staff across maternity services

	July	August	September
Sickness rate	9.52%	6.58%	6.86%
Maternity Leave rate	6.04%	6.88%	6.47%
RM fill rate %	80.5%	80.5%	81.8%
Midwife to birth ratio	1:17.5	1:18.9	1:19.9

1.2 Midwifery staffing safety measures.

Midwifery staffing rates are reviewed weekly and it has been identified that a decrease in compliance occurs out of hours or when the unit is in high acuity and escalation. On these occasions, the escalation policy has been followed with the Clinical Site Manager (CSM) and Trust Manager on Call (MOC) contacted, staff being redeployed internally and the community midwives supporting where appropriate. These measures were taken for very short periods and the situation rectified at the earliest opportunity.

Mitigations and escalation process to address staffing shortfalls have continued during this reporting period. The below outlines the actions and controls in place to mitigate staffing below template.

- Daily staffing huddles with Senior Clinical Matrons.
- Request midwifery staff undertaking specialist roles to work clinically.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically.
- Relocate staffing to ensure one to one care in active labour and dedicated supernumerary Labour Ward Co-ordinator (LWC) roles are optimised.
- Activate the on call midwives from the community to support labour ward.
- Adopted the RESET tool.
- Supporting LWC in the appropriate use of BR+ acuity tool and escalation decision-making.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies. In addition, a significant number of bank hours have been used across the service to cover maternity leave and long and short-term sickness.

2. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). The midwife in charge will then determine the action required (Appendix 2). Red flags are collected through the Birth Rate Plus acuity tool, and reviewed by the perinatal quadrumvirate (Table 3). Seven red flags were documented in Quarter 2 and appropriate clinical and management actions were taken to maintain safety. The reporting process follows the governance structures of the Perinatal Quality Assurance Council (PQAC), Quality Committee and Trust Board of Directors.

Table 3. Midwifery red flags

Red Flag category	July	August	September
Delayed or cancelled time critical activity	1	0	0
Delay between admission for induction and beginning of process.	0	0	3
Labour Ward Coordinator (LWC) not supernumerary.	0	0	1
One - one care in active labour	0	1	0
Delay in Triage	0	0	0
Missed or delayed care	0	0	1

2.1 Supernumerary Labour Ward Co-ordinator (LWC)

Availability of a supernumerary LWC is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward. In Quarter two, one red flag was raised for loss of LWC supernumerary status during the shift for a brief period to support a midwife with a comfort break. In addition, compliance is monitored for the allocated LWC having supernumerary status at the start of every shift, as per MIS year 6 (Table 4).

Table 4. LWC supernumerary status: start of shift

	Number of days per month	Number of shifts per month	Compliance
July	31	62	100%
August	31	62	100%
September	30	60	100%

2.2 One to One in Established Labour

Women in established labour are required to have one to one care (Table 5) and support from an assigned midwife. Care will not necessarily be given by the same midwife for the whole labour. If there is an occasion where one to one care cannot be achieved, then this will prompt the LWC to follow the course of actions above in section 10.2.

Table 5. One to one care compliance.

	July	August	September
One-one care in active labour	100%	100%	100%

Following a review, it was identified women transitioning from the induction of labour phase to augmentation would require one to one midwifery care, in these circumstances midwifery support was escalated from other maternity clinical areas. The actions taken were appropriate to facilitate one to one midwifery care.

3. Obstetric staffing

The service is fully established at consultant grade for Obstetrics and Gynaecology. There have been pressures within the consultant workforce due to sickness and occupational health recommendations, which has affected the consultant workforce available for emergency obstetric work. Since Quarter 4 2023, there have been pressures and in Quarter 2, there was a 25 % deficit in the consultant medical workforce available for on call emergency obstetric work. The department has successfully recruited to one consultant post in Quarter 2 and the new consultant will join the department in Quarter 3. A further post has been advertised with interviews scheduled in Quarter 3. To further mitigate the reduction in emergency cover due to sickness, the existing consultant workforce are undertaking additional shifts to ensure that safe staffing for obstetrics has been maintained. A weekly safe obstetrics and gynaecology staffing meeting is now well established and coordinated by the operational manager, clinical director, rota administration team and the specialty training lead to ensure safe staffing and plan clinical work to fit the training needs of the doctors in training in the department. Locum Consultant support is being explored to help while the recruitment process is ongoing. There were no locum consultants working in the department in Quarter 2.

The department is undergoing a detailed perinatal workforce review and has plans for further consultant recruitment. The Care Group has supported an expansion plan for the medical leadership roles within the department, which will be advertised for in Quarter 3.

There is on-going monitoring of consultant attendance for obstetric emergencies to ensure appropriate consultant attendance for complex obstetric emergency care in line with the national recommendations of Royal College of Obstetrics and Gynaecology. A standardised process and audit tool has been developed by the NENC LMNS. There was 97% compliance with the standard in the Quarter 1 audit. In the one case of non-attendance in the Quarter 1 audit, the consultant had not been contacted. The completed action plan focused on ensuring the trainees and wider team were aware of the criteria for consultant attendance. A Quarter 3 audit is being undertaken for ongoing monitoring of our compliance.

Table 6. Quarter 1 Consultant Attendance in Complex Obstetric Emergencies Audit Action Plan

Item	Problem/Issue/Identified gap in service	Specific proposed actions to be implemented to address the problem / issue:	Date action initiated:	Responsibility:	Date to be evaluated AND Rag Rate	Evaluation Status / Progress Update.
1	Consultant not contacted for PPH>2l	Ensure trainees aware of consultant attendance requirements - trainee feedback	Jun-24	Clinical Director O&G	Jun-24	Complete
		Promote awareness of consultant attendance requirements with MDT - criteria displayed on labour ward	Jun-24	Delivery Suite Ward Matron	Jun-24	Complete
		To share at departmental induction for new trainees	Jun-24	Clinical Director O&G	Aug-24	Complete

There are twice daily multidisciplinary team handovers of care for obstetrics and twice-daily consultant led multidisciplinary ward rounds.

4. Neonatal Nurse Staffing

The staffing compliance rate was 75.82% in comparison to the national average for the Quarter 1 which was 86% for SCBUs. The Trust uses the National Neonatal workforce calculator tool and provides updates to the Neonatal Operational Delivery Network (Appendix 3 and 4). Compliance is managed through escalation of additional shifts paid via NHSP and overtime in times of increased occupancy and acuity. During this period there were a number of shifts escalated due to occupancy and acuity that were not filled contributing to the decrease in compliance this quarter. There has been an agreement for over recruitment of establishment by 1.0WTE following review of age profile in neonatal staffing to ensure skill levels are maintained.

Neonatal nurse staffing is on the risk register (6600) and the action plan (Appendix 5) agreed at Trust Board in the quarter 3 report is reviewed regularly, outlining progress against each of the actions, with oversight from the LMNS and Neonatal Operational Delivery Network (ODN) on a quarterly basis.

5. Neonatal Medical Staffing Compliance

The neonatal medical staffing continues to be compliant with British Association Perintal Medicine (BAPM) guidance in all tiers. The Advanced Neonatal Nurse Practitioner (ANNP) Workforce has been at full establishment from June 2024 with return from maternity leave and two trainees in the first year of study to future proof the establishment following review of age profile of the workforce. This will facilitate ANNPs being able to spend time at James Cook hospital for skills maintenance and development.

6. Preterm Birth service

The service is compliant with the recommendation from Saving Babies Lives, element 5 which states the following must be in place:

- Obstetric lead
- Midwifery lead
- Neonatal consultant lead
- Neonatal nurse lead

7. Anaesthetics

In quarter 2 the service provided a 24hour service.

8. Recommendations

It is recommended that the Board of Directors note the 97% compliance and completed action plan for obstetric consultant attendance in complex emergency obstetrics.

It is recommended that the Board of Directors note neonatal workforce action plan to achieve the BAPM recommended neonatal nursing workforce.

It is recommended that the Board of Directors approval the preterm birth lead roles.

9. Appendices – in reading room

Appendix 1. BirthRate Plus report.

Appendix 2. Midwifery staffing actions and management decisions

Appendix 3. Neonatal workforce tool

Appendix 4. Neonatal workforce summary

Appendix 5. Neonatal nursing workforce action plan.

People Committee

25 September 2024

Connecting to: Group Board

Key topics discussed in the meeting:

- **Board Assurance Framework (BAF)**
    - BAF updates provided for both North Tees and South Tees. Work continued to align BAF w. new version in October.
    - Talent acquisition and retention risks to reflect additional workforce requirements from NHS England
    - Risk associated with Health and Social Care Academy was closed. Chair visited this excellent facility and thank you to Gary Wright for delivering on this project.
- **Integrated Performance Report**
    - Sickness absence remains a concern and are above 4% threshold (6.1% NT 5.36% ST). Annualised trend data would provide assurance (or not) on reduction as per absence cycle.
    - Assurance on appraisal and threshold should be aligned across Group.
    - Key points and areas of exception were highlighted.
- **Medical Revalidation Report**
    - An overview of the FQAI reports for South Tees and North Tees and key highlights were provided. Several actions for improvement were identified for both trusts.
    - Mike Ingrim (Associate Medical Director for People and Governance) provided assurance that both trusts were compliant with the Medical Profession (Responsible Officers) Regulations 2010 (amended 2013). Overall appraisal compliance was 100% for North Tees and 98.75% for South Tees with no late referrals, which was positive.
    - Case management training to be arranged for NED's

- **[APPROVAL]** People Committee approved the revalidation reports for NTH and ST

- **Staff Values**
  - A verbal update on the development of core staff values was provided

- **General Medical Council (GMC) Survey**
  - Results from the July 2024 GMC Survey were presented
  - The Improving Working Lives of Doctors Report prompted discussion on challenges being faced around gaps in rotas and the impact of increased workload.
  - **[ESCALATION]** Issue to maintain rotas and training requirements of the trainees be escalated to Group Board of Directors for monitoring.

- **Impact of Leadership & Management Training**
  - An update on the NT & ST output of leadership and management development training. First steps of integration across Group and work in progress
  - future reports to include performance metrics and measured outcomes to monitor progress and gain assurance

- **Annual Quality Report**
  - Assurance regarding the quality and delivery of clinical education was provided.
  - Assurance on improvement to the hospital accommodation at FH.

- **Improving the Working Lives of Doctors in Training**
  - An update on compliance against the NHS England requirements was provided with gap analysis undertaken.
  - Actions are underway incl. electronic rostering system ‘rotamap’ to improve rota management and reduce pay errors

- **Influenza and Covid Seasonal Vaccination Programme 2024/25**
  - Details of the vaccination programme were presented.

Actions:

- P24/050 – Engagement plans for increasing student nurse intake at Teesside University (December 2024)
- P24/051 - NHS submission on workforce controls (November 2024)
- P24/052 - Occupational Health strategy review (planned for December 2024)
- P24/053 – Staff appraisal timing (January 2025)
- P24/054 – (Medical Revalidation) Case Management investigation training for NED's (TBC)
- P24/055 – Board Escalation re risk of maintaining rotas and training requirements for trainee doctors (November 2024)
- P24/056 – Leadership & Management Training Metrics (March 2025)
- P24/057 – BAF Fisk re Talent Management (October 2024)

Escalated items:

- The risk of maintaining rotas and training requirements for Residents in Training to be escalated to the Group Board of Directors for monitoring.

Risks (Include ID if currently on risk register):

- Additional risk be added to the People Board Assurance Framework in respect of nurturing future talent.

University Hospitals Tees

SAFE STAFFING REPORT MAY-AUGUST 2024

Meeting date: 5 November 2024

Reporting to: Group Board

Agenda item No: 14

Report author: Debi McKeown, Workforce Lead, Lindsay Garcia, Director of Nursing, South Tees

Emma Roberts, Workforce Lead Beth Swanson, Director of Nursing, North Tees

Action required:
Assurance

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to:
Group People Committee October 2024

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☐

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A great place to work ☒

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☐

Deliver care without boundaries in collaboration with our health and social care partners ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

5.1 Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit.

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

None

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

This report details nursing staffing levels for May – August 2024 for inpatient wards across the Group. The report provides assurance that arrangements are in place to staff services with the right skills in the right place to provide safe, sustainable and productive staffing. Daily Safe Care Safer Staffing meetings provide assurance that inpatient areas have been assessed from a staffing perspective.

This assessment is based on skill mix, acuity, and occupancy levels and all actions agreed by Safe Care Chair and escalated to Senior Nurses as required.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The percentage of shifts filled against the planned nurse staffing across the Group from May to August 2024 has increased to 98.1% at STHFT and 97.9% at NTHFT, as per Table 1a demonstrating continued good compliance with safer staffing.

Nursing Turnover between May and August 2024 has decreased to 6.99% at STHFT (Appendix 1) and at NTHFT, the monthly turnover for Registered Nursing is currently 0.23% and for HCSW is 1.5%.

Recommendations:

The Group Board are asked to receive this report for assurance

Workforce Exception Report

May to August 2024

This exception report provides the People Committee, Resource Committee and Board with the bi-monthly, Group wide, nursing safer staffing position across all in patient areas. The report provides the People Committee with the assurance that arrangements are in place to staff services with the right skills in the right place to provide safe, sustainable and productive staffing.

1. Safer Staffing Governance

At University Hospitals Tees, Safer Staffing is maintained through twice-daily safer staffing meetings (using Safe Care Live) to address any immediate safer staffing concerns (on the day) and to ensure that suitable safer staffing arrangements are in place.

Across the Group, all elements of safer staffing are reviewed at the site led workforce group meetings. Any unresolved concerns are escalated to the Tactical and Strategic Group and Site Leadership Team as required. Both sites undertake a look forward exercise to the week ahead, to ensure that a plan is in place to support any gaps in the nursing workforce. The collaborative assurance meetings have full participation from all senior nurses including Heads of Nursing, Clinical Matrons and Ward Managers/Matrons to ensure all decision making is appropriate. Staff redeployment is co-ordinated to ensure patient safety is prioritised and at the forefront of decision making in line with the agreed SOP's. All communication plans in relation to staffing are shared with the site team via OPEL meetings 3 times per day.

Monthly workforce assurance - check and challenge meetings are now embedded in practice. These meetings include all relevant nursing colleagues and service managers.

Table 1a and Table 1b show overall planned versus actual fill across the group. Any areas showing less than 80% for registered nurses are highlighted and rationale provided as to why this has occurred.

Between May and August, the following inpatient areas at STHFT showed a fill rate of less than 80% due to sickness:

- Ward 5, Ward 22, CICU, Ward 7, Neonatal Unit and Paediatric Critical Care. Staff were deployed safely from predominantly within collaborative
- During these months, Ward 5 also relocated to Ward 10 which saw a reduced bed base and their staffing model was adjusted to reflect this

The following areas at NTHFT showed a fill rate of less than 80%;

- Delivery suite – due to sickness and high occupancy in Aug 24, as a result community team members were redeployed to the area to assure safe staffing levels, as per planned internal escalation plans.
- Ward 26 (gastroenterology), this is due to current vacancy position and sickness levels, staff redeployed safely from other wards within the Care Group.

Table 1a Trust Planned versus Actual fill – South Tees

		May 24	June 24	July 24	August 24
Overall Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	91.1%	91.5%	90.0%	89.4%
	HCA (%) Average fill rate - DAYS	91.4%	90.8%	91.8%	93.1%
	NA (%) Average fill rate - DAYS	100%	100.0%	100.0%	100%
	SNA (%) Average fill rate - DAYS	100%	100.0%	100.0%	100%
	RN/RMs (%) Average fill rate - NIGHTS	96.4%	94.9%	93.7%	95.1%
	HCA (%) Average fill rate - NIGHTS	109.2%	110.1%	107.1%	107.1%
	NA (%) Average fill rate - NIGHTS	100%	100.0%	100.0%	100%
	SNA (%) Average fill rate - NIGHTS	100%	100.0%	100.0%	100%
	Total % of Overall planned hours	**98.5%**	**98.4%**	**97.8%**	**98.1%**

Table 1b Trust Planned versus Actual fill – North Tees and Hartlepool

		May 24	June 24	July 24	August 24
Overall Ward Fill Rate	RN/RMs (%) Average fill rate - DAYS	91%	92%	90%	87%
	HCA (%) Average fill rate - DAYS	87%	88%	89%	95%
	NA (%) Average fill rate - DAYS	100%	100%	100%	100%
	SNA (%) Average fill rate - DAYS	100%	100%	100%	100%
	RN/RMs (%) Average fill rate - NIGHTS	99%	98%	98%	93%
	HCA (%) Average fill rate - NIGHTS	104%	105%	112%	108%
	NA (%) Average fill rate - NIGHTS	100%	100%	100%	100%
	SNA (%) Average fill rate - NIGHTS	100%	100%	100%	100%
	Total % of Overall planned hours	**98%**	**98%**	**99%**	**97.9%**

Percentage of overtime for inpatient areas for all staff groups including AHPS, Midwifery and Administration has decreased year on year since 2021. The current overtime percentage based on the NHSP vs Overtime report has remained static at 6% but is still lower compared to last year's 8% in May.

This data is not usually reported at NTHFT but over time use is presented and discussed at the monthly Temporary Staffing Focus Group. For future reports, this data will be presented to identify overtime use and any associated increase or decrease in use across the MDTs.

2. Nurse Sensitive Indicators

No staffing factors were directly identified as part of any PSIRF review across both trusts in May 2024. Although distractions related to activity in areas has been highlighted as a theme in one of the reviews.

3. Red Flags Raised through Safe Care Live

At STHFT, between May and August 2024, the total number of red flags relating to staffing is 24. The themes identified are Shortfall in RN time (22) and less than two RN's on shift (2). For red flags indicating less than two RN's, the Safe Care log provides a documented resolution. Therefore, no shifts had less than two RNs throughout May to August. Reminders are sent weekly via the E-Rostering team to Matrons to review and close any resolved Red Flags.

At NTHFT, between May and August 2024, there were two red flags raised in June 2024, both were from the critical care unit in anticipation of a shortfall in RN time. The staffing levels in Critical Care were discussed at the safer staffing meeting on these days and following review of patient acuity and dependency in the unit at the time, the availability of the Unit Matron and Clinical education, there was no further escalation following both red flag raises. Therefore, the red flags were closed down. It was not specified at the time of reporting that these flags were raised due to non-compliance with GPICs guidance.

4. Datix/In-Phase Submissions

At STHFT between May and August 2024, there were 220 Datix submissions relating to staffing. The majority of Datix submissions highlights staff shortages in Critical Care Outreach, ED, Ward 9, Hambleton Northallerton PCN and Ward 3. All shortages raised were managed through the Safecare process. Redeployment took place and revised community schedules supported safe staffing. There were occasions whereby there was reduced Critical Care Outreach cover – risk was mitigated by the Critical Care registrar covering the bleep and by enacting the escalation plan at the Friarage Hospital.

At NTHFT, between May 2024 and August 2024 there were a total of five In-Phase reports submitted from the in-patient wards in relation to either safe staffing concerns or skill mix concerns. All In-Phase reports are discussed in the safer staffing meetings to ensure Senior Clinical Matrons are fully sighted on the reporting and are able to make safe staffing decisions based on the concerns raised by clinical teams.

The Nursing Workforce Team continues to work closely with the HR senior team and the temporary staffing providers (NHSp) to improve fill rates and maintain safe staffing.

5. Vacancy & Turnover

Across the group, the vacancy position continues to be positive. Both sites have been successful with recruitment and continue to evolve plans to support and future proof the nursing workforce. The ongoing development of staff including investing in health care support workers, trainee nurse associates is supporting the recruitment and retention of the nursing workforce.

At STHFT RN vacancies equate to five. Agreement has been gained through SLT to recruit NQNs from the January cohort based on predicted turnover and future service developments requiring an increase in establishment. Currently STHFT have 12 HCSW vacancies.

At NTHFT, the band 5 RN vacancy position has continued to reduce in line with the planned trajectory. The position for August 2024 reports a 12wte vacancy with plans to appoint into this in January following the recruitment of the January 2025 cohort from both Teesside and Sunderland Universities. Further forecasting to the end January 2024 sees the B5 RN vacancy position move to an over established position of approx. 1wte, which accounts for planned turnover throughout November and December 2024 and the appointment of approx. 25wte pre-registration nurses.

At NTHFT, the HCSW vacancy position, equally, has a positive trajectory and is forecasting an appointed position in January 2025.

At NTHFT, the monthly turnover in August 2024 for Registered Nursing is 0.23% and for HCSW is 1.5%. Appendix 1 shows the monthly turnover break down where RN turnover is reducing month on month, whilst HCA turnover has increase in August 2024.

6. Care Hours Per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward3This relates to the associated variance between the required care hours to safely care for patients and the actual care hours delivered by individual ward nursing workforce models. Table 2 and table 3 show the overall average CHPPD for the group. Most recent breakdown by ward (August) can be reviewed in Appendix 2.

Table 2 South Tees

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
May 2024	9.17	9.00	-0.17
June 2024	9.11	9.22	+0.11
July 2024	8.95	9.30	+0.35
August 2024	9.06	10.23	+1.17

Table 3 North Tees

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
May 2024	8.63	8.51	-0.12
June 2024	8.57	8.86	+0.19
July 2024	7.52	7.77	+0.26
August 2024	8.58	10.36	+1.78

In August the areas highlighting a higher variance level (>1) and thus, not delivering the required CHPPD were wards 25, 40 and 42 (North Tees). This is reflective of the current sickness and absence levels and the vacancy positions at the time of reporting. All unfilled duties within rosters have been managed via the twice daily safer staffing meetings and suitable re-deployment to the areas made. Despite the variance reported, these wards did not require further escalation during the month of August.

7. Nurse Recruitment and Retention

Nurse recruitment and vacancy fill remains healthy across the Group. Both sites have recruited predominantly from the cohorts of newly qualified nurses from Teesside University, Sunderland University and York University. Over establishment with newly qualified nurses has created a ready to go workforce that will support turnover and future proof the nursing workforce. South Tees has now completed all international nurse recruitment, with no further plans to recruit internationally.

At both trusts, the allocation of all pre-registered nurses who qualified in September 2024 is complete. Work remains on going to plan for the recruitment of the January 2025 cohorts of newly qualified nurses at NTHFT, the process has completed at STHFT with all appointable pre-registration nurses allocated. The September nurses continue to attend regular KIT sessions to support positive on boarding prior to them taking up their positions and starting preceptorship.

Safer Staffing workforce initiatives continue to be implemented. Within STHFT, the established monthly nursing workforce assurance meetings provide a platform to fully explore all recruitment and retention issues as well as highlighting best practice for safe and effective rostering.

At NTHFT the check and challenge meetings are becoming well embedded and support the monthly monitoring of workforce models to ensure they remain fit for purpose. The meetings also enable a review of rostering KPIs, vacancy and turnover positions with SCMs, Ward Matrons and the wider Care Group SMTs.

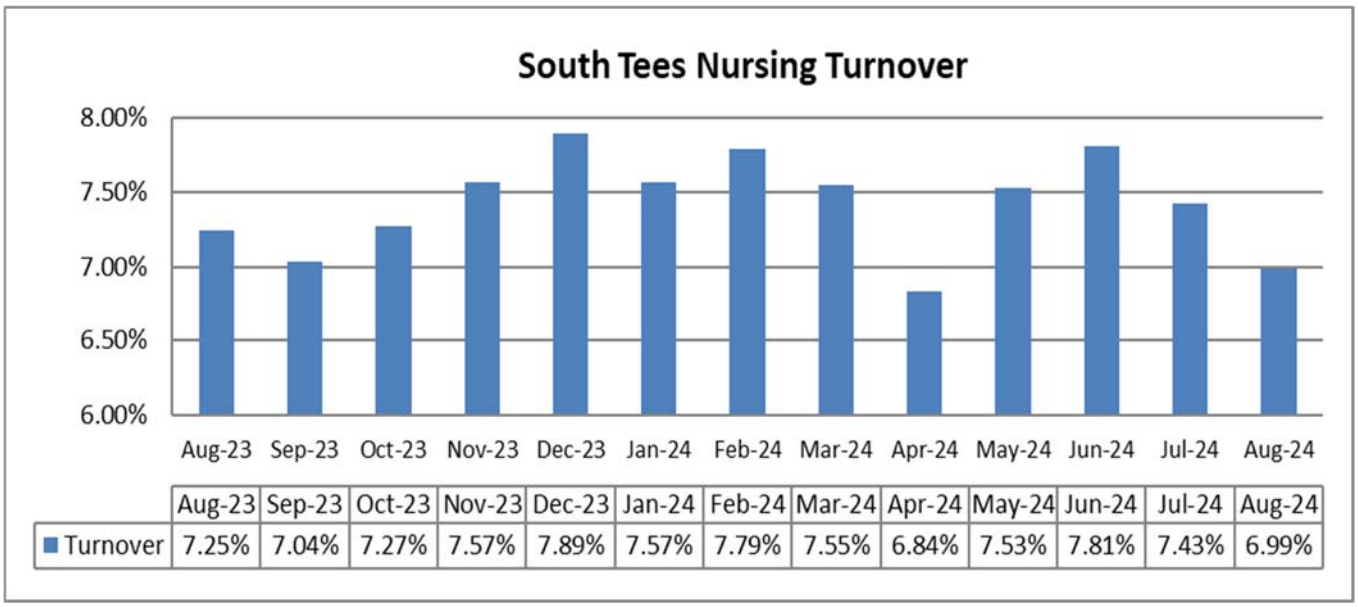
8. RECOMMENDATIONS

The Board is asked:

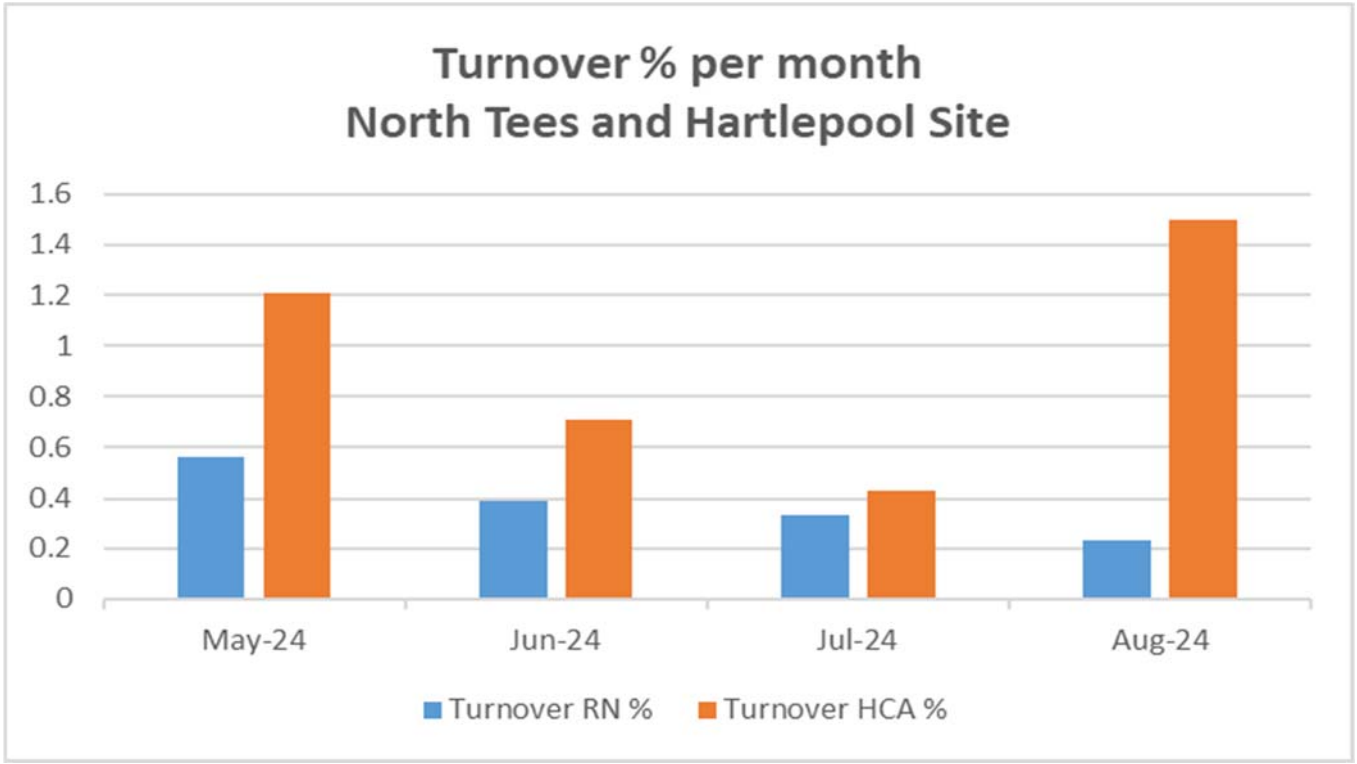
1. To read the content of this report and to note the progress made across both sites in relation to developing and retaining the nursing workforce.
2. The Board are asked to note the assurance presented that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.
3. The Board are asked to acknowledge the development of this report in the coming months to ensure that the two current reporting methods across both site teams continue to align. This will provide the continued assurance that arrangements are in place to staff services with the right skills in in the right place to provide safe, sustainable and productive staffing

Appendix 1

Nursing Turnover August 23 - August 24



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Turnover	7.25%	7.04%	7.27%	7.57%	7.89%	7.57%	7.79%	7.55%	6.84%	7.53%	7.81%	7.43%	6.99%



Appendix 2

South Tees Average CHPPD Breakdown by Ward (August 2024):

Ward	Average of Required CHPPD	Average of Actual CHPPD	Variance
Ward 1	9.50	10.58	+1.08
Ward 31	8.79	7.16	-1.62
Ward 2	5.15	5.71	+0.56
Ward 3	8.03	5.98	-2.05
Ward 4	8.55	6.90	-1.66
Ward 5	4.90	5.21	+0.31
Ward 6	5.81	5.73	-0.08
Ward 7	5.30	4.81	-0.50
Ward 8	4.25	4.07	-0.18
Ward 9	8.87	4.15	-4.72
Ward 11	8.23	7.27	-0.96
Ward 12	9.08	7.04	-2.04
Ward 14	6.20	5.63	-0.56
Ward 24	7.48	8.17	+0.69
Ward 25	9.40	7.39	-2.01
Ward 26	9.22	7.08	-2.14
Ward 27	6.46	13.30	+6.84
Ward 28	8.41	7.43	-0.98
Ward 29	5.86	5.71	-0.15
Cardio MB	5.67	7.16	+1.49
Ward 32	6.80	6.63	-0.17
Ward 33	8.22	6.11	-2.11
Ward 34	8.05	6.56	-1.49
Ward 35	8.55	8.92	+0.38
Ward 36	4.15	3.52	-0.63
Ward 37 - AMU	10.99	10.79	-0.20
Spinal Injuries	13.06	7.39	-5.6
CCU	15.57	12.82	-2.75
Critical Care	19.62	26.43	+6.81
CICU JCUH	24.43	30.37	+5.94
Cardio HDU	10.60	15.61	+5.01
Ward 24 HDU	10.45	23.20	+12.75
CDU FHN	8.19	8.88	+0.68
Ainderby FHN	7.67	7.84	+0.17
Romanby FHN	7.41	8.06	+0.64
Gara FHN	6.64	15.15	+8.50
Rutson FHN	7.65	7.13	-0.52
Friary	8.36	12.31	+3.95
Zetland Ward	8.72	7.55	-1.17
Tocketts Ward	7.97	7.60	-0.37
Ward 21	8.93	13.35	+4.42

Ward 22	14.21	15.25	+1.04
Neonatal Unit (NNU)	10.64	14.36	+3.72
Paediatric Critical Care (PCCU)	16.47	37.66	+21.19
Grand Total (Average)	**9.06**	**10.23**	**+1.17**

North Tees Site - CHPPD by ward for August 2024

Row Labels	Average of Required CHPPD	Average of Actual CHPPD	Variance
Acute Cardiology Unit	6.85	6.15	-0.69
Critical Care North Tees	20.83	27.54	6.70
Elective Care Unit	6.36	16.60	10.23
Emergency AMB	7.03	9.91	2.89
Neonatal Unit	11.09	31.01	19.92
Paediatrics	9.92	17.61	7.68
SDU	12.01	12.02	0.01
Ward 24 (Respiratory)	7.47	5.98	-1.49
Ward 24 RSU	9.73	9.88	0.15
Ward 25 (Respiratory)	7.29	5.28	-2.01
Ward 25 RSU	10.33	10.24	-0.09
Ward 26	6.48	5.74	-0.74
Ward 27 (Gastroenterology)	6.55	6.33	-0.21
Ward 28 (Surgery)	5.81	5.84	0.03
Ward 31 (Surgical Observation Unit)	8.35	9.44	1.09
Ward 32 (Fragility Fracture)	8.23	8.80	0.57
Ward 33 (Orthopaedic & Spinal)	6.25	6.06	-0.19
Ward 36	7.66	6.74	-0.92
Ward 38	6.41	6.03	-0.38
Ward 40 (Acute Elderly)	8.43	7.31	-1.12
Ward 41 (Stroke Unit)	7.85	6.88	-0.98
Ward 42 (Elderly Rehabilitation)	7.75	6.54	-1.21
Grand Total (Average)	**8.58**	**10.36**	1.78

NHS
University Hospitals Tees

Nurse Staffing, capacity and capability annual review 2024/25 – North Tees & Hartlepool

Meeting date: 5 November 2024

Reporting to: Group Board

Agenda item No: 15

Report author: Emma Roberts, Associate Director of Nursing and Professional Workforce & Beth Swanson Director of Nursing North Tees and Hartlepool

Action required: Assurance

Delegation status - Jointly delegated item to Group Board

Previously presented to: People Committee October 2024

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☐

A centre of excellence ☐

A great place to work ☐

Deliver care without boundaries ☐

Make best use of our resources ☐

CQC domain link:

Well-led

Board assurance / risk register this paper relate

Risk 5669 (Critical Care and GPIC)

BAFs:
1A Patient Safety and Outcomes,
1B Patient and Carers Experience,
1C Healthcare Standards
2A Workforce
3A Transforming Our Services.

Caring Better Together

Key discussion points and matters to be escalated from the meeting

The purpose of this report is to provide assurance that the Trust is compliant with the national guidance in relation to nurse safer staffing. The report will present an overview of the annual establishment review of nurse staffing, governance processes and compliance with the guidance, a requirement set out by the National Quality Board (2016). It includes the analysis of the Safer Nursing Care Tool (SNCT) data taken in June 2024 across all adult and paediatric in-patient wards.

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

1. The current sickness and absence levels across the Nursing workforce is higher than the Trust target of 4.0%. Some areas presenting higher than planned sickness levels including the Emergency Assessment Unit, Ward 28 and Ward 38.
2. A number of areas have been identified as showing a potential change in their establishment against this round of the SNCT and the National Institute for Clinical Excellence (NICE) safe staffing recommendations which recommend a nurse to patient ratio of 1:8 or related to requirements of enhanced care needs.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

None to advise

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

1. Safe staffing was maintained throughout this period with an average positive variance between required and actual CHPPD of +0.58.
2. The SNCT recommendations matched the ward establishment for the following areas – Wards 36, 38, Surgical Decision Unit, Emergency Assessment Unit and the paediatric ward.

3. The Board can note the significant assurance provided within this report in relation to Trust compliance with Developing Workforce Safeguards, the delivery of required CHPPD and the use of Nursing and Maternity safe staffing tools and systems.

Recommendations:

Board are asked to receive this report for information and note partial assurance provided in relation to Trust compliance with Developing Workforce Safeguards, the delivery of required CHPPD and the use of Nursing and Maternity safe staffing tools and systems.

There will be a further more in-depth review of ward establishments in areas where SCNT and NICE guidance have highlighted a variance. This review will recommend the number and skill mix of nurse staffing required to meet the needs of patients by triangulating three sources of information which are patient acuity and dependency data, professional judgement and patient quality outcomes information. This will be at ward level, and geographical factors will be given due consideration. These will be presented to Group Board in February 2025.

Plan 2nd cycle of SNCT data collection across adult in-patient and assessment areas for January 2025 & May 2025 to enable 2nd & 3rd cycle prior to next establishment review.

To review the way enhanced care workers are included in workforce models to create greater efficiencies in care provision and reduce the reliance on temporary staffing.

NHS
University Hospitals Tees

North Tees Hospitals NHS Foundation Trust

Nurse Safer Staffing Establishment Inpatient Ward Review 2024/25

Caring Better Together

1. Background / Context

The Developing Workforce Safeguards (DWS, 2018) guidance sets out the requirement to undertake a nurse staffing review on an annual basis with a 6 month review of actions and progress. National Health Service (NHS) provider boards are accountable for assuring their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing that will support safe, effective, caring, responsive and well-led care.

Trusts are required to calculate and recommend the number and skill mix of nurse staffing required to meet the needs of patients by triangulating three critical sources of information which are patient acuity and dependency data, professional judgement and patient quality outcomes information.

Patient acuity and dependency levels are identified using Safer Nursing Care Tool (SNCT). The SNCT is the only nationally approved, evidence-based tool to support safe staffing within in-patient areas; data collection currently takes place for 35 days bi-annually as a minimum. Recommendations from establishment reviews using this tool are then considered whilst over laying the National Institute for Clinical Excellence (NICE) safe staffing recommendations which recommend a nurse to patient ratio of 1:8.

2. Purpose

The purpose of this report is to provide assurance that the Trust is compliant with the national guidance in relation to nurse safer staffing. The report will present an overview of the annual establishment review of nurse staffing, governance processes and compliance with the guidance, a requirement set out by the National Quality Board (2016). It includes the analysis of the Safer Nursing Care Tool (SNCT) data taken in June 2024 across all adult and paediatric in-patient wards.

A review of the nurse staffing establishment for the adult and paediatric Emergency Departments are planned to take place between Jan-Feb25 to capture a winter data set and establishment review across these areas, using the Emergency Department Safe Staffing Tool (EDSST). These will be presented separately.

The national acuity and dependency tool for community district nursing services, the community nurse safer staffing tool (CNSST) was launched in 2023 and the clinical services are due to collect their third cycle of data. However, the CNSST tool has been paused for use nationally whilst NHSE undertake additional validity and beta testing. Further updates from the national team are currently pending.

3. Establishment Setting Review Methodology

A comprehensive nurse staffing establishment review was presented to the Board in October 2023. A number of recommendations were proposed and agreed, an update on these actions was presented to Board in February 2024. This round of the SNCT data collection took place during June 2024 using the new adult in patient and adult assessment unit tool that was updated and released in October 2023. As this is the first data collection (cycle one) using a revised tool, further collections will be needed to ensure confidence.

The SNCT is a nationally approved tool and whilst it provides nursing workforce establishment requirements based on patient acuity and dependency, skill-mix requirements are not included and therefore need to be considered at local level using professional judgement. Changes in skill mix can reflect a range of factors: changing patient needs, technological developments and legislative changes to allow some staff groups to expand the scope of their practice. It is important, however, that nurse sensitive indicators are at the forefront of any skill mix change and that changes are not introduced in an unplanned way.

The review process has taken place throughout September/October 2024 with Care Group Senior Management Teams (SMT) to ensure that the SNCT recommendations, NICE safe staffing recommendations, nurse sensitive indicators and professional judgement have been used to inform recommendations for nurse staffing establishments.

4. Key Finding from Evidence Based SNCT

The SNCT recommendations matched the ward establishment for the following areas – Wards 36, 38, Surgical Decision Unit, Emergency Assessment Unit and the paediatric ward. Ward 4 (Elective Care at the Hartlepool site) did not complete their data collection because of reduced occupancy at the time of the data collection, which did not support the data validation process.

A number of areas have been identified as showing a potential change in their establishment against this round of the SNCT and the National Institute for Clinical Excellence (NICE) safe staffing recommendations which recommend a nurse to patient ratio of 1:8 or related to requirements of enhanced care needs. As mentioned above, further collections will be needed to ensure confidence.

5. Key Findings from Nurse Sensitive Indicators

Nurse Sensitive Indicators are identified as those outcomes which can include patient harm that could be sensitive to the number of available nursing staff, such as falls, medication errors and pressure ulcers. Patient safety meetings take place across the Trust on a weekly basis where all potential and actual harms are discussed from the previous week with attention to any themes or staffing concerns. The continued work

reviewing patient acuity and dependency helps to address whether the harms have occurred because of reduced nurse staffing. The number and category of falls, medication errors and pressure ulcers across the Trust have been reviewed for the period of April 2024 to September 2024 and key findings are as follows:

5.1 Falls

In reviewing incident of falls resulting in low or moderate harm, it can be confirmed numbers of nurses on duty or nurse skill mix and did not feature as a contributory factor.

5.2 Pressure Ulcers

In reviewing hospital acquired pressure ulcers were reported during the time period this did not highlight nursing workforce or staffing skill mix as a contributory factor in any of the cases.

5.3 Medication Errors

The review of in-patient hospital medication errors did not highlight nursing workforce or staffing skill mix as a contributory factor.

6. Key Findings from Professional Judgement

Some wards currently do not always meet the NICE safe staffing recommendations of a nurse to patient ratio of 1:8 plus coordinator, particularly during the day time. Some areas activity does not vary between days and nights, where there are areas of variance with the NICE safe staffing recommendations further review is underway. These areas include reviewing best practice guidance specific to, for example, Respiratory, Acute Cardiology, Surgery and Care of the Elderly.

Additional professional judgement metrics that have been reviewed include vacancies, turnover, sickness and absence which all form part of the agreed headroom of 21% for RN and 19.5% for Health Care Support Workers (HCSW).

Actions and mitigations include:

6.1 Vacancies

- The Trust has made good progress and continues to focus on reducing B5 registered nurse vacancies across all inpatient areas. The band 5 RN vacancy position for September 2024 has reduced to x12 whole time equivalents (WTE) with plans to appoint to these in January from both Teesside and Sunderland Universities.
- Further forecasting to the end January 2025 sees the B5 RN vacancy position move to an established position which accounts for planned turnover throughout November and December 2024.
- The HCSW vacancy position is equally positive and is forecast to be fully recruited to in January 2025.

6.2 Turnover

- The average monthly registered nursing turnover from April 2024 and September 2024 was 0.37% from 0.48% reported within the same time period in 2023.
- The average monthly un-registered nursing turnover from April 2024 and September 2024 was 0.96% from 0.73% reported within the same time period in 2023.

6.3 Sickness and Absence

- The current sickness and absence levels across the Nursing workforce is higher than the Trust target of 4.0%. Much of this sickness is attributed to long term health conditions.
- Maternity leave cover is not included in headroom, however, some wards have higher levels of maternity leave, some being >10%.
- Sickness absence continues to be pro-actively managed as per the agreed Trust process between the Care Group management teams and Workforce Business Managers.

7. Presentation of Additional Workforce Metrics

7.1 Care Hours per Patient Day (CHPPD)

Care Hours per patient day (CHPPD) is a measurement of workforce deployment that can be used at ward and service level or be agreggated to Trust level. It is a unit of measurement recommended in the Carter report (2016) to record and report the deployment of staff working on in-patient wards and captures the registered nurse and HCSW hours. All acute Trusts are required to report their actual monthly CHPPD. The Trust wide CHPPD data for the period of April 2024 to September 2024 has been reviewed and the key points to note are;

- From a Trust wide perspective, safe staffing was maintained throughout this period with an average positive variance between required and actual CHPPD of +0.58.
- All safe staff redeployment is reviewed and agreed within the twice daily, safer staffing meetings where professional judgment of senior clinical matrons (SCMs) is over laid.

7.2 Planned and Actual Staffing

Planned staffing is the amount of time in hours and minutes of Nursing and Midwifery staff that each ward plans to have on duty for each shift and is based on maximum utilisation of the funded establishment. Actual staffing is the amount of time physically on duty each day. This data is triangulated with other ward fill rates to ascertain the variance between the planned and the actual staffing, key points to note are;

- In line with the National Quality Board requirements, the organisation continues to report the planned and actual staffing data on a monthly basis to NHSE and continues to ensure this information is available to the public via the Trust website.
- The average fill rates show a lower fill rate in RN during the day and a high rate of Health Care Assistants on nightshift. This is reflective of the historical RN vacancy position and the increased need for enhanced care.

- Between April 2024 and September 2024 there has been a monthly average of 89% for Registered Nurse hours, 91% of Unregistered Nurse hours and 100% of Nursing Associate Hours during the day. In the same period of time there has been a monthly average of 96% for Registered Nurse hours, 108% of Unregistered Nurse hours and 100% of Nursing Associate Hours during the night.
- There has been an increase in substantive staffing fill due to a reducing vacancy level, and successful recruitment of newly registered nurse cohorts.
- Higher HCA fill at night tends to be due to the enhanced care requirement in some wards and departments.

8. Proposed Actions

Following the completion of the annual professional workforce establishment review the following actions are recommended:

- Undertake a further more in-depth review of ward establishments in areas where SCNT and NICE guidance have highlighted a variance. This review will recommend the number and skill mix of nurse staffing required to meet the needs of patients by triangulating three sources of information which are patient acuity and dependency data, professional judgement and patient quality outcomes information. This will be at ward level, and geographical factors will be given due consideration. These will be presented to Group Board in February 2025.
- Plan 2nd cycle of SNCT data collection across adult in-patient and assessment areas for January 2025 & May 2025.
- To review the way enhanced care workers are included in workforce models to create greater efficiencies in care provision and reduce the reliance on temporary staffing.

9. Risk and Mitigation

This report describes the nursing annual workforce establishment review process which has been completed in accordance with national guidance. To note is a further review is required and data collection is required, a paper will be presented to board in February 2025. Assurance is provided to the Board that three of the strategic risks within the People section of the Board Assurance Framework (BAF) and one risk within the well led section of the Quality BAF are being addressed.

These risks are as follows;

- Risk of not growing our workforce for the future (People BAF)
- Risk of not developing appropriate and new ways of working (People BAF)
- Risk of not having appropriate levels of staff with the right skills to deliver safe services, creating a continued reliance on bank and agency workers (People BAF)
- Risk of suboptimal staffing levels (Quality BAF)

10. Conclusion

This report is to provide the current position in relation to the nursing workforce capacity and its compliance with national guidance. This is partially completed. Compliance with national guidance, will follow a further SNCT data collection has been completed and actions arising from the data analysis will be considered as part

of the annual business planning processes.

There are clear and robust escalation processes in place to identify daily risk associated with staffing shortfalls and ensuring robust mitigation is in place and monitored to ensure that the ability to deliver the right care, in the right place at the right time.

11. Recommendations

Board are asked to receive this report for information and note partial assurance provided in relation to Trust compliance with Developing Workforce Safeguards, the delivery of required CHPPD and the use of Nursing and Maternity safe staffing tools and systems.

University Hospitals Tees

Nurse Staffing, Capacity and Capability Annual Review 24/25 – South Tees

Meeting date: 5 November 2024

Reporting to: Group Board

Agenda item No: 15

Report author: Lindsay Garcia, Director of Nursing

Action required: Assurance

Delegation status (Board only): Jointly delegated item to Group Board

Previously presented to: People Committee October 2024

NTHFT strategic objectives supported:

Putting patients first ☐

Valuing our people ☒

Transforming our services ☐

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A great place to work ☒

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☒

Deliver care without boundaries in collaboration with our health and social care partners ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

BAF risk 5.1 Failure to deliver sustainable services due to gaps in establishment, due to ability to recruit.

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

None to alert.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

A review process for nurse staffing establishment for acute inpatient wards has been undertaken utilising NICE guidance, Safer Nursing Care Tool (SNCT), nurse sensitive outcome indicators and professional judgement.

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

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

Provides a comprehensive review of nurse staffing for South Tees Hospitals NHS Foundation Trust. It is in line with the mandated requirements set out by the National Quality Board (NQB) reportable to Board.

Recommendations:

The Board is asked to receive this report for assurance.

Appendices in relation to this report can be found in the reading room.

Nurse Staffing, Capacity and Capability Annual Review 24/25
South Tees Hospitals NHS Foundation Trust

Caring
Better
Together

Introduction

This detailed annual report provides a comprehensive review of nurse staffing for South Tees Hospitals NHS Foundation Trust. It is in line with the requirements set out by the National Quality Board (NQB). Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time- safe, sustainable and productive staffing (July 2016). This guidance is supported by a further publication from NHSI 'Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing' which was published in October 2018. Recognising that there is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs, NICE guideline (2014) recommends factors that should be systematically assessed at ward level to determine the nursing staff establishment. These have been applied and are as follows;

- Develop procedures to ensure that ward nursing staff establishments are sufficient to always provide safe nursing care to each patient
- Ensure that the final ward nursing staff establishments are developed with the registered nurses who are responsible for determining nursing staff requirements at a ward level and approved by the chief nurse
- When agreeing the ward nursing staff establishment, ensure it is sufficient to always provide planned nursing staff requirements. This should include capacity to deal with planned and predictable variations in nursing staff available, such as annual, maternity, paternity and study leave
- When agreeing the skill mix of the ward nursing staff establishment, this should be appropriate to patient needs and consider evidence that shows improved patient outcomes are associated with care delivered by registered nurses
- Enable nursing staff to have the appropriate training for the care they are required to provide
- Ensure that there are sufficient designated registered nurses who are experienced and trained to determine on-the-day nursing staff requirements over a 24-hour period
- Consider additional workload in nursing hours per day – average patient turnover, ward layout and size, nursing activities and responsibilities, other than direct patient care

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

A detailed review of nurse staffing, led by the Director of Nursing, Deputy Director of Nursing and Workforce Lead has been conducted for all acute inpatient areas. A further review of the following specialist areas will take place:

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

Right Staffing

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

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

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

Safer Nursing Care Tool

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

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

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

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

- Bed occupancy

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

Collaborative Approach to Safer Staffing

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

As part of the review, once any new staffing levels are identified the required establishments are calculated and compared to the current funded establishments to determine whether any adjustments to skill mix and funding are required.

This paper recommends the staffing establishments that are required to deliver ward based care only. There are a small number of wards whereby additional duties have been absorbed over time that they do not have the capacity to maintain within existing ward establishments. These areas include, Ward 32 - Pre-assessment and CDU – Telemetry. This will be presented to the Senior Leadership team for consideration.

Appendix 1 details the planned staffing for 2023/24 and 2024/25. Net totals for RN increase are approx. 14 WTE and 13WTE HCSW, this is mainly due to increased activity (e.g., increase in beds). Further work will be undertaken with finance and operational colleagues to understand the risks and benefits.

Recruitment and Retention

Nurse recruitment, retention and future workforce planning is a priority at South Tees NHS Foundation Trust. The Trust has now achieved full establishment across all inpatient areas and celebrates holding one of the lowest nursing turnover rates in the country, as reported by the Model Hospital. The trust actively explores recruitment and retention strategies in line with National NHS Employers Retention Guidelines. For those staff intending to leave, ‘early conversations’ are held to explore alternative career options and retire and return opportunities. The introduction of the legacy mentors has provided a positive impact across every level of the nursing workforce. The impartial support and guidance has demonstrated an increase in the number of staff retained within the organisation and has had a significant impact on staff wellbeing.

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

- centralising HCSW recruitment
- investment in student nurse workforce
- welcome days and contact onboarding for all student nurses

- increase in RNDA and trainee nursing associates to mitigate the reduction in overall applications to nurse training
- innovative approach to student nurse placement, including virtual placements, service improvement and research
- pre-registration career planning and staff development within a revised and robust preceptorship package
- career discussions
- retire and return conversations
- robust pastoral support programme for international nurses and their development

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

- movement of staff within collaborative
- allocate on arrival – only if essential for safecare
- the staff charter embedded
- devolvement of the safe care process to ward managers with matron chair, extended to 7 days

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

Capability and Quality

It is essential to consider patient quality indicators alongside patient population, acuity of illness and nursing dependency. This was conducted at each collaborative ward-based staffing review meeting. The patient quality indicators reviewed as part of the annual nurse staffing review are pressure ulcers, falls, medication incidents, complaints, quality audit data

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

The Trust provides a monthly safe staffing report to board which details the percentage of shifts filled against the planned nurse staffing across the trust. Good compliance with safer staffing is demonstrated, with September 2024 reported as 97.6%. All nurse staffing issues on the risk register are reviewed on a monthly basis. This report provides further assurance alongside the monthly workforce assurance - check and challenge meetings which are now embedded in practice.

Staff Wellbeing

As Senior Nurses we strive to create an organisational culture of compassionate leadership, improved workforce resilience and support for our staff. The workforce pressures of recent years and the additional challenge this has created for our nursing workforce is well recognised. We want to look after our nurses to the best of our ability, invest in them, support both their academic and professional development and remain committed to enhancing their wellbeing. Many resources are available and a number of which are listed below;

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

Conclusion

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

Recommendation

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

University Hospitals Tees

Freedom to Speak Up Report Quarter 1 & 2

Meeting date: 5 November 2024

Reporting to: Group Board of Directors

Agenda item No: 16

Report author: Jules Huggan, Philippa Imrie, Samantha Sinclair, Jim Woods and, Freedom to Speak up Guardians.

Action required:
Assurance

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to: Group People Committee

NTHFTFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFTFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A great place to work ☒

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☐

Deliver care without boundaries in collaboration with our health and social care partners ☒

Make best use of our resources ☐

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All risks associated with this presentation are recorded on the risk register. BAF alignment: 5.1, 5.

Caring Better Together

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

An increase in the number of anonymous cases being raised at STHFT, ongoing monitoring triangulation and work to address this. The guardians are working with IT to review options for the electronic reporting system, to capture reasons why staff may be reporting anonymously.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

Due to the poor uptake of Speak Up (core workers), Listen Up (Middle Managers) and Follow Up (Executives/Governors) training on ESR at NTHFT, the Freedom to Speak up Guardian (FTSUG) as an alternative to completing the training modules, delivers workshops for all three training modules, using each of the modules as a framework. The FTSUG has delivered twelve workshops in Quarters 1 and 2.

Openly reporting at NTHFT has improved, reporting 20% at Quarter 1 and 44% at Quarter 2, the learning from this is that workers are speaking up and are finding things are not changing so they are going to the FTSUG as an alternative. This helps identify that more Listen Up and Follow Up workshops need to be actioned for Quarter 3.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

One of the longstanding aims of the STHFT Guardians has been to mandate the FTSU training (Speak Up, Listen Up and Follow Up). This became mandatory at STHFT in September 2024.

The Group FTSUG's are recruiting Freedom to Speak Up Champions (FTSUC) through a fair and open process as per the National Guardian's Office (NGO) guidance. This aims to have a diverse FTSUC network to support the workforce.

To strengthen the organisational approach to the triangulation of data, the FTSUG at NTHFT has become a member of the Trust's Culture Steering Group, this group aims to look at the soft intelligence where areas may be suffering difficulty and using the resources to provide an early holistic approach to resolve issues before they become more problematic.

In March 2024, North East North Cumbria Integrated Care Board (NENC ICB) carried out a Freedom to Speak Up Trust Assurance Audit against NGO standards across the 11 Trusts in the region for cases between 2021 and 2023. It was noted that all cases submitted were compliant with the standards, evidencing all Trust Boards have been cited on the results

and any recommendations made to support improvement / compliance. Please see appendix A for full details of the audit.

Recommendations:

The Group Board of Directors are asked to:

1. Review the data provided for North Tees and Hartlepool NHS Foundation Trust in Annexe A and South Tees Hospitals NHS Foundation Trust in Annexe B.

2. Support the identified next steps.

3. Support the NTHFT Freedom to Speak Up Guardian (FTSUG) who has developed detriment presentation material to roll this out across the group and receive a further update in Quarter 3.

North Tees & Hartlepool NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust

Freedom to Speak Up Report
Quarter 1 and 2

1. PURPOSE OF REPORT

The Freedom to Speak Up Guardian (FTSUG) service, is providing a framework to ensure that we support our workers to do the best job that they can, to keep our patients safe, through the delivery of high-quality services. This is by offering a robust service that empowers workers to speak up about anything that concerns them

The report provides an overview of the themes and issues raised between 1 April 2024 and 30 September 2024, training data, current actions and forward plans.

2. BACKGROUND

The NGO and the FTSUG role was established in 2016 following the events at Mid-Staffordshire NHS Foundation Trust and the recommendations from the subsequent inquiry led by Sir Robert Francis.

The Francis Report raised 290 recommendations. One of the recommendations was to have a designated person who was impartial and independent working in every Trust. This role would facilitate staff to speak to in confidence about concerns at work including any public interest disclosure. It was acknowledged that staff should be listened to, taken seriously and would not suffer detriment because of speaking up. The NGO was established to train and support FTSUGs as well as providing appropriate resources to help establish a healthy “Speak Up, Listen Up and Follow Up” culture. All FTSUG are locally employed but are trained by the NGO.

Within University Hospitals Tees we achieve this by supporting colleagues to speak up about concerns, tackling barriers to speaking up and by ensuring issues raised are used as opportunities for feedback, learning and improvement. Guardians act as independent and impartial sources of advice to staff, supporting staff to speak up when they feel unable to do so via other routes and ensuring that an appropriate person investigates the issues raised and provides feedback on the action taken.

3. DETAIL

Philosophy

The FTSU ethos aims to help promote and normalise the raising of staff concerns ultimately for the benefit of patients and workers. Speaking up not only protects patient safety but can also improve the lives of workers. FTSU is about encouraging a positive culture where people feel they can speak up, their voices will be heard and their concerns or suggestions acted upon. In the seven years since Sir Robert Francis recommendations, the FTSUG role continues to evolve and move away from a whistleblowing culture to one of permission, encouragement, openness and transparency.

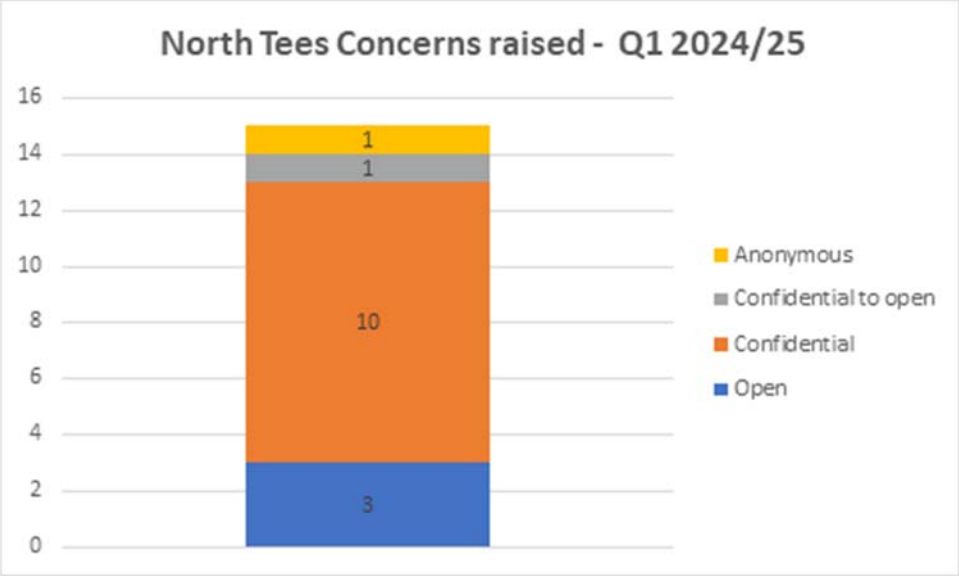
“If we can get the culture right, benefits will follow, including improving patient safety, innovation for improvement, retaining workers and making the National Health Service (NHS) a great place to work”.

Dr Jayne Chidgey-Clark, National Guardian for the NHS
Guardians have handled over 133,000 cases since the NGO first started collecting data.

North Tees & Hartlepool NHS Foundation Trust
Annex A below details NTHFT assessment of concerns. Below is a summary of the data submitted to the National Guardians Office April 2024-September 2024:

Q1 – 15 Cases (April 2024 – June 2024)
Q2 – 16 Cases (July 2024 – September 2024)
Total 31 concerns

Graph1 Q1



3 contacts were received openly (20%)
10 contacts were received confidentially (66.6)
1 contact were received confidentially to open (6.6%)
1 contact was received anonymously (6.6%)

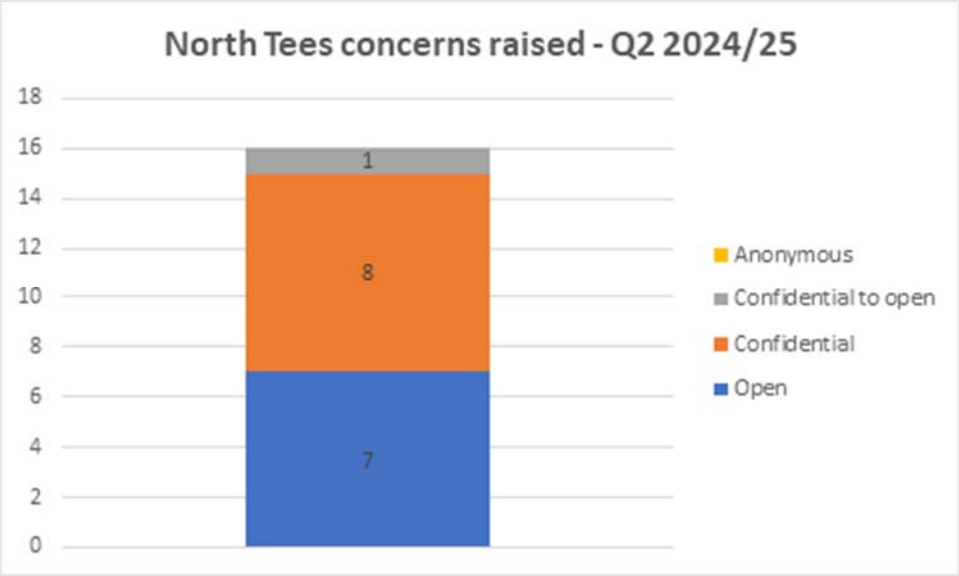
Openly reporting at the Trust has improved and for Quarter 1 is 20% and for Quarter 2 is 44%, the learning from this is that workers are speaking up and are finding things are not changing so coming to the FTSUG. This helps identify that more Listen Up and Follow Up workshops need to be actioned for quarter three.

Most workers are speaking up confidentially, at Quarter 1 it was 66% and for Quarter 2 it was 50%, however the FTSUG is trying to empower workers to speak up openly. There has been a shift of 6% at Quarter 1 and Quarter 2, from workers initially coming to the FTSUG confidentially but then empowered to raise the concern with the line manager or with the person who is causing the concern.

There has been one concern raised anonymously in the period Quarter 1 and 2, this demonstrates that the increased visibility through walkabouts, workshops, staff forums and training, as an organisation we are working hard in shifting our culture, in how workers raise concerns in a more positive way, towards our aim of making speaking up “business as usual”.

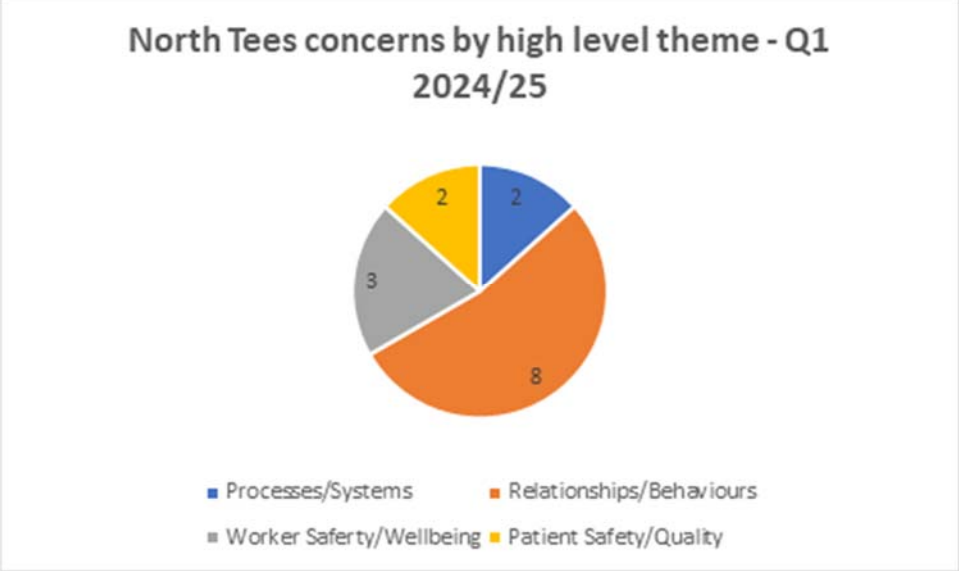
Anonymous reporting at the Trust continues to be low at 3 % compared to the national average of data submitted to the NGO at 9.5 %. This gives assurance that workers are happy to speak up openly or confidentially, as we aim to make speaking up “business as usual” in an open and transparent way.

Graph 2 Q2



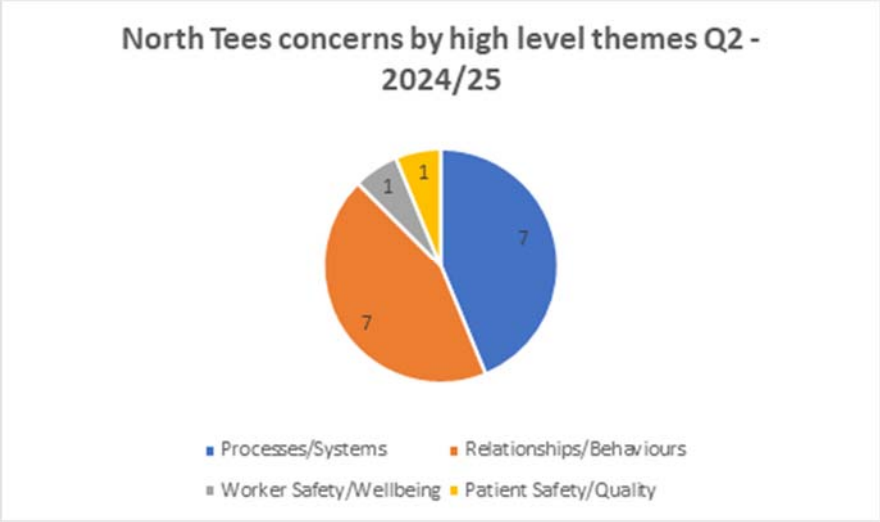
7 contacts were received openly (44%)
8 contacts were received confidentially (50%)
1 contact were received confidentially to open (6%)

Pie Chart Quarter 1



Caring Better Together

Pie Chart 2 Quarter 2

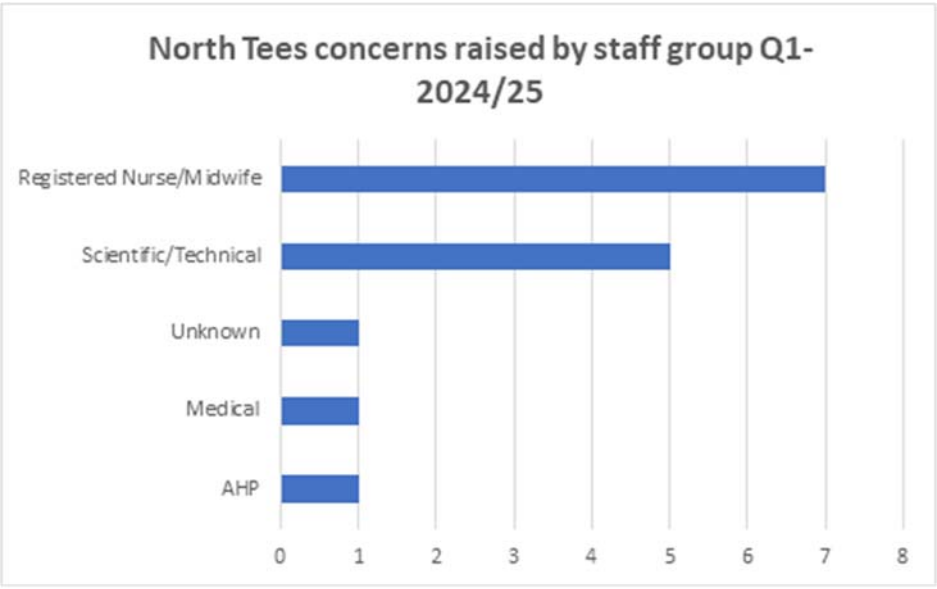


There is a low reporting of patient safety concerns, with only three concerns raised in Quarter 1 and 2. Low reporting of patient safety issues via the FTSUG is represented both locally and nationally. This is believed to be due to the robust reporting structures such as the Patient Safety Incident Response Framework (PSIRF), which encourages such concerns to be reported through the correct channels.

The FTSU, works in collaboration with the Associate Director of Nursing and Patient Safety to seek assurance that patient safety concerns are being addressed effectively when other speaking up routes are being used.

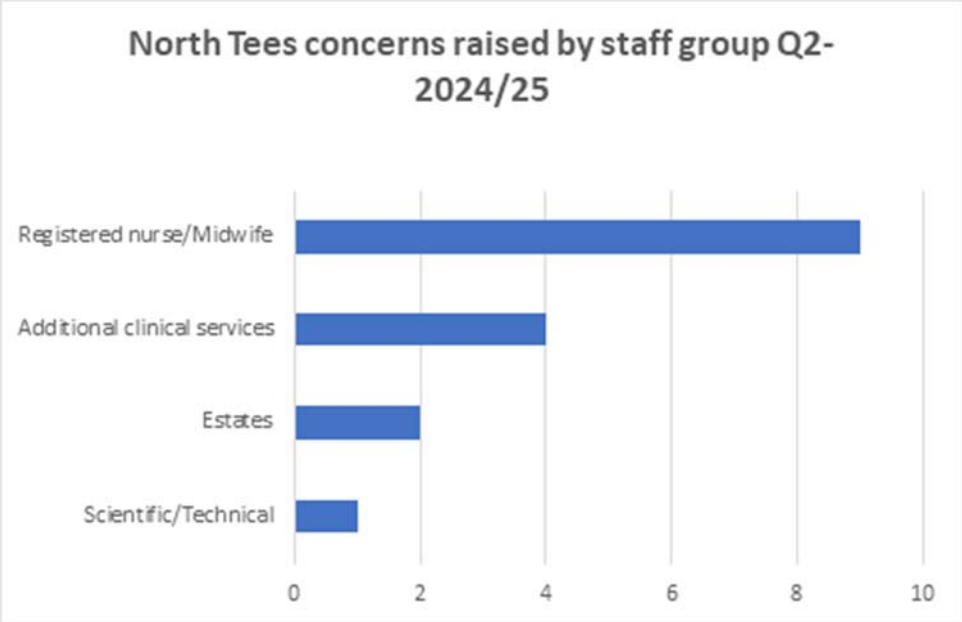
The above figures and themes also represent an increased number of individual staff making contact from a wider number of services and professions. This suggests there is a wider awareness of FTSU as an alternative / additional route to speak up and possibility the growing confidence for staff to raise concerns individually as well as in groups. All open concerns and themes are being progressed or investigated and actioned accordingly. Where applicable, staff have received feedback on follow up recommendations.

Graph 3 Quarter 1



Caring Better Together

Graph 4 Quarter 2



Nurses and Midwives continue to be the highest professional group of staff to raise concerns. This is in line with national reporting trends and they are also the largest staff group across the NHS.

Governance and Support

The FTSUG is supported in the role by the Chief Executive (CE) and other Executive Directors, the Non-Executive Director for FTSU, the NGO and the Regional Guardian network across the Northeast and Yorkshire. The FTSUG reports through the People Group monthly and the Group People Committee and Group Board of Directors quarterly.

Key Achievements

The FTSUG has started the fair recruiting process of Freedom to Speak Up Champions (FTSUC), to expand their FTSUC network, as per national guidance, this has been promoted through the Trust communications. Those potential FTSUC who have expressed an interest, have completed an expression of interest form, line management sign off and information about the role, has been given. An informal conversation will be held in November, with a panel of the FTSUG, Lisa Johnson, Head of People and Fay Scullion, FTSU NED. The successful FTSUC will be trained by the FTSUG, attend quarterly FTSUC network meetings, be buddied up with another FTSUC, have bi-annual informal 1-2-1 with the FTSUG and collect high level data for triangulation.

As a group the FTSUG from both trusts, visited and peer reviewed Liverpool Heart and Chest Hospital, as they were at the top of the NHS staff survey results last year. There were some interesting conversations on creating an open and safe speaking up culture and tackling incivility in the workplace.

The FTSUG continues to broaden their opportunities to present the role of the FTSUG and was fortunate to present to the new cohort of T-Level students and the undergraduate medical students, which will be continued, moving forward.

The report identifies that currently we have no concerns raised about detriment as a result of workers speaking up. However, this does not give assurance that detriment is not a barrier for workers speaking up in the first place or that it is not happening as a result of speaking up. Therefore, the FTSUG has developed a presentation and a standing operational procedure on how to manage concerns about detriment, including feedback forms asking workers if detriment has been suffered as a consequence of speaking up, which will be sent to workers three, six and twelve months after a case has closed. This work aims to educate staff and give them assurance that as an organisation, we do not tolerate detriment, with the hope to mitigate this as a barrier for staff speaking up. This work has been presented at People Group and the FTSUG aims to roll it out in Quarter 3.

As part of the proactive work, the FTSUG continues to promote the role through team meetings, floor walking and ward visits and has a high presence within the Trust, which can be demonstrated in the data. The FTSUG has had an average of one worker speaking up, per week. Those workers who have spoken up are from many different areas of the organisation and a variety of professional backgrounds including doctors, nursing, Allied Health Care Professionals, administration, and students.

As we move to a culture of making speaking up “business as usual”, we continue the proactive aspect of the FTSUG role, to encourage workers to report concerns openly, rather than confidentially, by helping them to feel empowered and psychologically safe.

To support this there are currently three training modules on ESR; Speak Up (core workers), Listen Up (middle managers) and Follow Up (senior leaders). The training is not mandatory at NTHFT and the undertaking of the training is low. The FTSUG as an alternative to completing the training modules, delivers workshops for all three training modules, using each of the modules as a framework, whilst also using research from webinars, podcast, Thirwell inquiry and the work of Chris Turner “Civility Saves Lives” and Meghan Reitz “The power you hold that silences others”. The FTSUG has delivered twelve workshops in Quarter 1 and 2.

Regular “Keep in Touch” meetings take place with the Executive Sponsor, Non-Executive Director for FTSU and Chairman. All other senior leaders have helped create a relational approach to speaking up as well progressing any concerns raised. Monthly meetings will continue with the CE and Managing Director whilst the group model evolves. The FTSUG also presents monthly updates at People Group and quarterly at the Group People Committee and Group Board of Directors.

To strengthen the organisational approach to the triangulation of data, the FTSUG has become a member of the Trust’s Culture Steering Group, this group aims to look at the soft intelligence where areas may be suffering difficulty and using the resources to provide an early holistic approach to resolve issues before they become more problematic.

To help build relationships with the network leads, the FTSUG attends all of the meet the network leads sessions and has been invited to be part of the staff hub, which has been established.

Promoting FTSU.
During the last 2 quarters, FTSU has been promoted in the following ways:

- All staff inductions
- Preceptorship Training
- Undergraduate Medical Students
- Postgraduate Doctors
- T-Level Students
- Teesside University
- Care Group 1-3
- NTHFT Solutions
- Quarterly Community Forum
- Joint Forum
- Schwartz Round Steering Group
- Quarterly Patient Safety Council.
- Quarterly Senior Practitioner Manager Operational Meeting
- Quarterly Matrons Meeting
- Quarterly Care Group Senior Management Team Meetings
- Monthly meetings with Care Group Directors
- Ward/Directorate Meetings

Staff Feedback

For quality assurance purposes, staff are invited to provide feedback during the FTSU process. It was recently clarified by the NGO that this can be given through a feedback form, a card, email or verbal feedback. Some examples of staff feedback are included below:

"Just having someone to listen, has helped me decide on the course of action I want to take."

"Thank you for listening, I feel empowered to speak to the person directly, who is causing me the issue."

"I felt really distressed when I first spoke to you and now I feel in a much better place."

"I was recommended to you by a colleague, who said you were really good and will keep us safe."

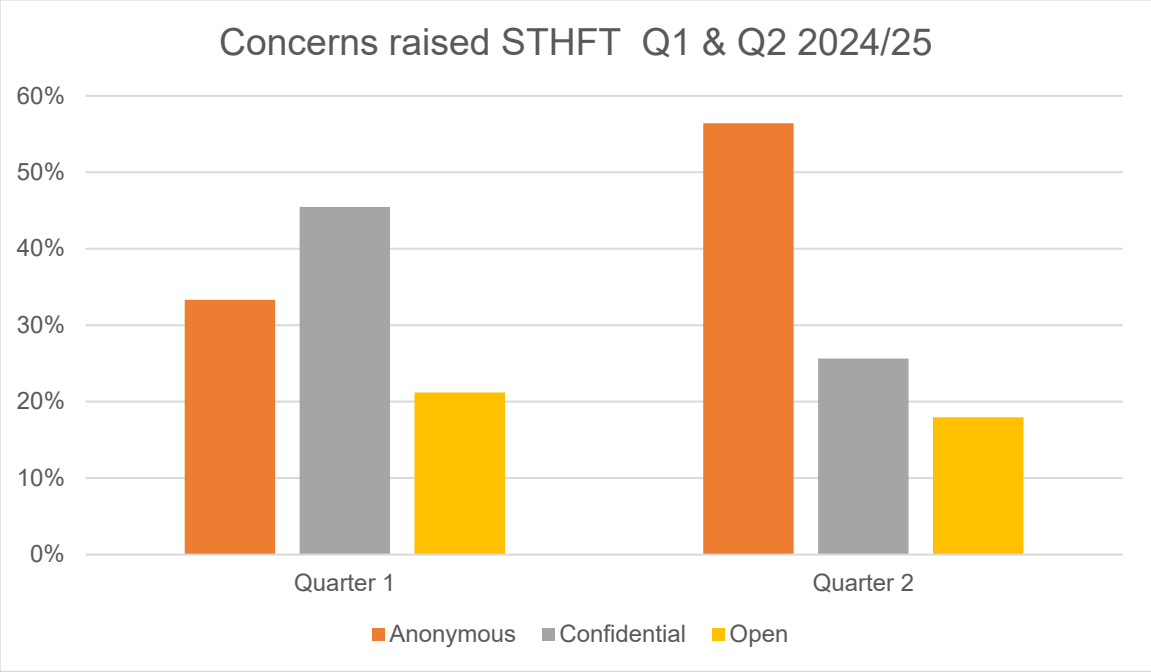
"I have spoken up to several people before and my concern has not been resolved, but I was told you had a good reputation, so I am confident you can help me."

South Tees Hospitals NHS Foundation Trust

(Annexe B) details STHFT assessment of concerns. Below is a summary of the data submitted to the National Guardians Office April 2024-September 2024:

In Quarter 1, the FTSUGs at STHFT received 33 concerns and 39 were received in Quarter 2. Graph 1 shows the breakdown of how these concerns were raised in terms of confidentiality anonymously or openly.

Graph 1



The number of concerns raised anonymously at STHFT in Quarter 1 was 33.3%, which remains similar to previous data reported for STHFT. In Quarter 2, this increased to 56.4% of the total number of concerns. Concerns raised confidentially dropped from 45.5% to 25.6% from Quarter 1 to Quarter 2 and the percentage of open concerns has dropped from 21.2% to 17.9%.

Since April 2024 Guardians at STHFT have presented to over 1,400 staff members at induction, Care Certificate, International Nurses, Military, Collaboratives and Teesside University Students to promote the Freedom to Speak Up Model highlighting the benefits of raising concerns openly and/or confidentially, the support that will be offered and the stance that the organisation will not tolerate detriment towards concern raisers. However, the FTSUGs still actively promote the anonymous route for reporting advising that we would rather receive an anonymous concern than to not receive it at all.

It is worth noting that 5 of 11 anonymous cases for Quarter 1 relate to Growing the Friarage, and 6 of 22 cases for Quarter 2 relate to Medicine and Emergency Care, with 3 of these 6 concerns related to the same issue. Moreover, 5 of the 22 anonymous concerns raised in Quarter 2 explicitly mention fear of detrimental treatment as a reason for not providing contact details.

The FTSUGs have been concerned for some time about the high proportion of anonymous concerns being raised and this has also been discussed at People Committees and Board. STHFT IT have recently added an “alt-text” box to the reporting system which advises that all contacts with the FTSUGs remain confidential, and the reporter will not receive any feedback unless they choose to leave contact details. After a recent discussion with the Chair at the monthly FTSUG/Chair meetings, it was suggested that an additional field is added to the reporting system asking concern raisers why they are choosing the mode of anonymity so we can start to capture the reasons that people are reporting anonymously. We are arranging

a meeting with IT to discuss how to make this change to the reporting tool. It is hoped that the FTSU training becoming mandatory may impact positively, on the number of anonymous cases raised, as awareness of the model and process grows.

Themes

Charts 1 & 2 below show the breakdown of high-level themes identified at STHFT

Chart 1

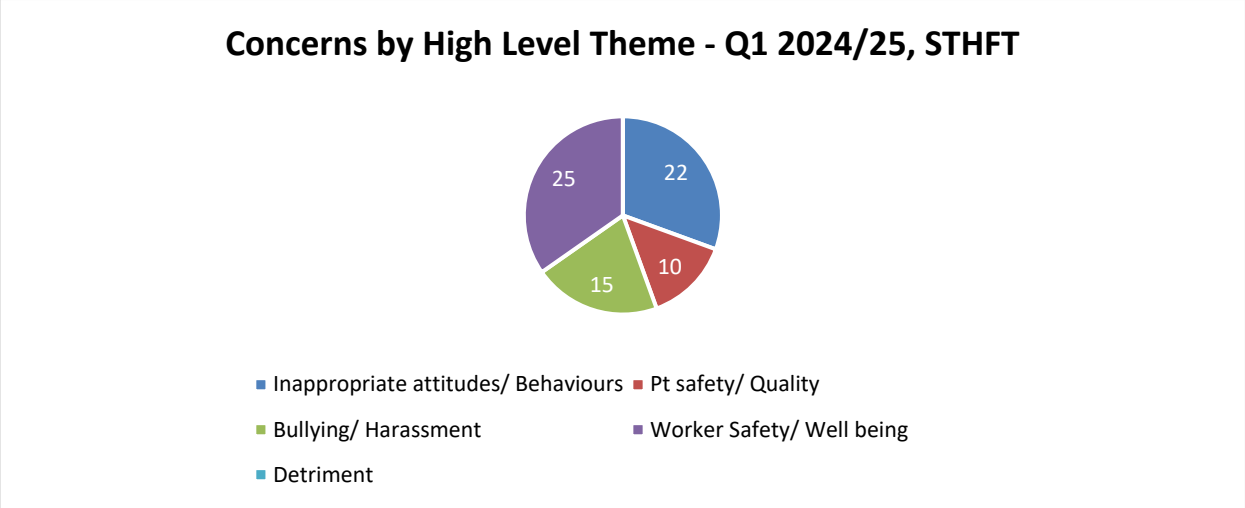
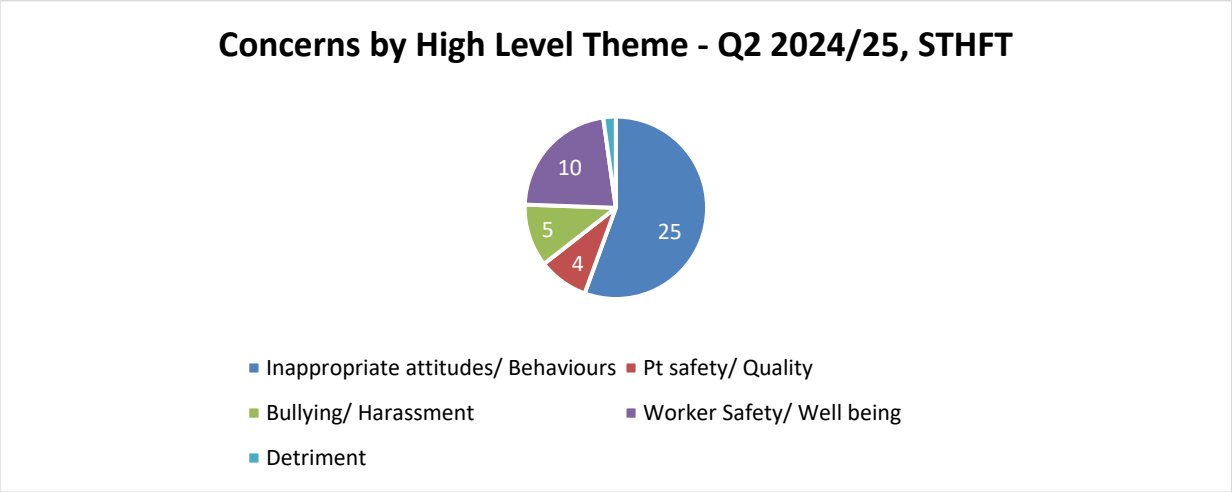
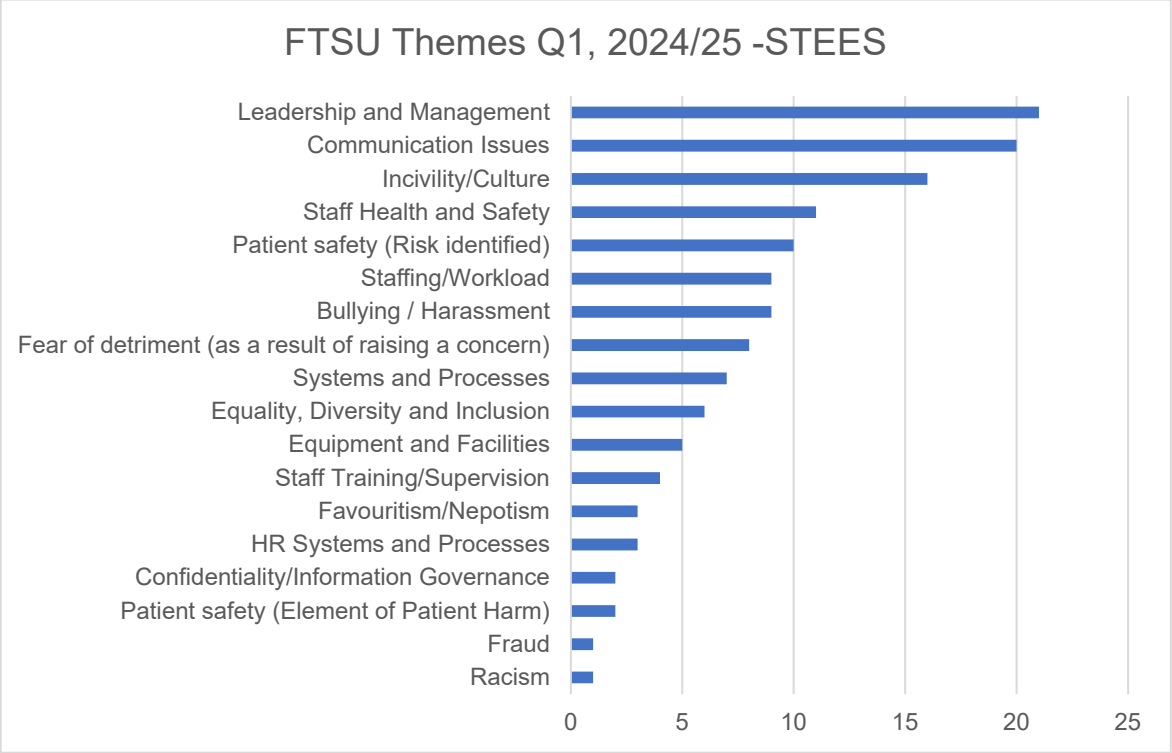


Chart 2

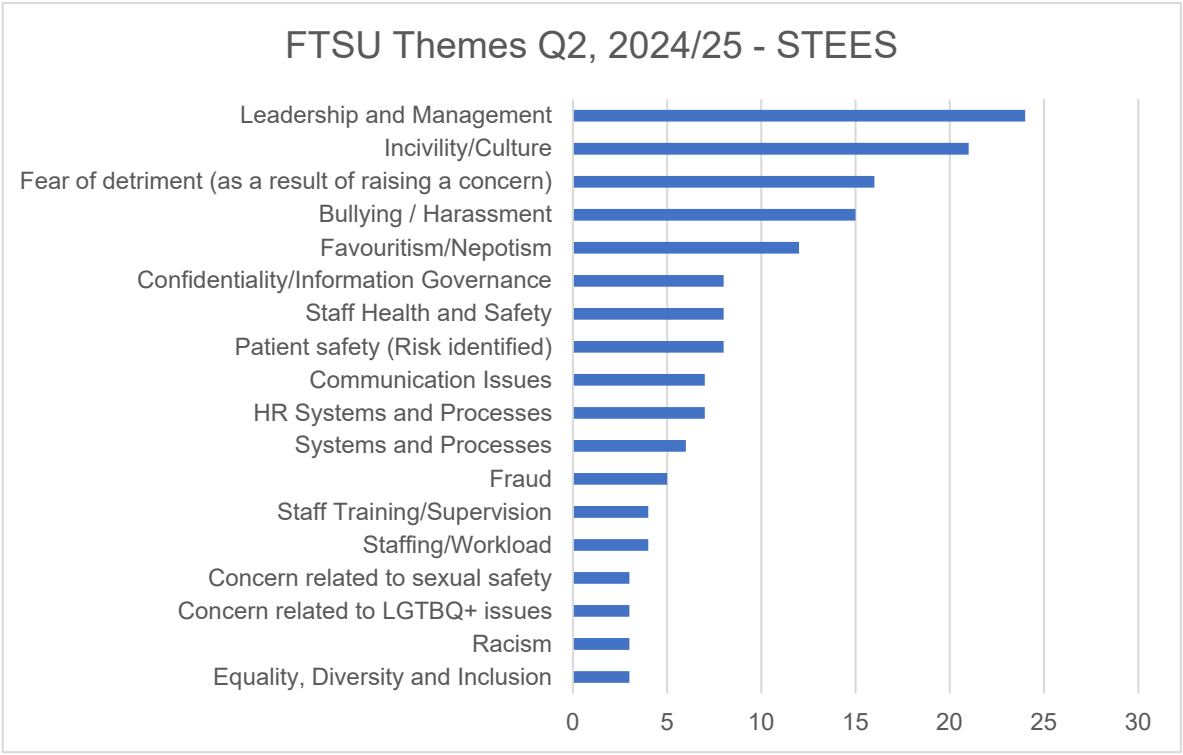


Graphs 2 & 3 below give a breakdown of the more detailed themes, across Quarter 1 and Quarter 2, with Leadership and Management and Incivility/Culture in the top three themes for each quarter and fear of detriment moving from the 8th most prevalent theme in Quarter 1 to the 3rd most prevalent in Quarter 2.

Graph 2



Graph 3

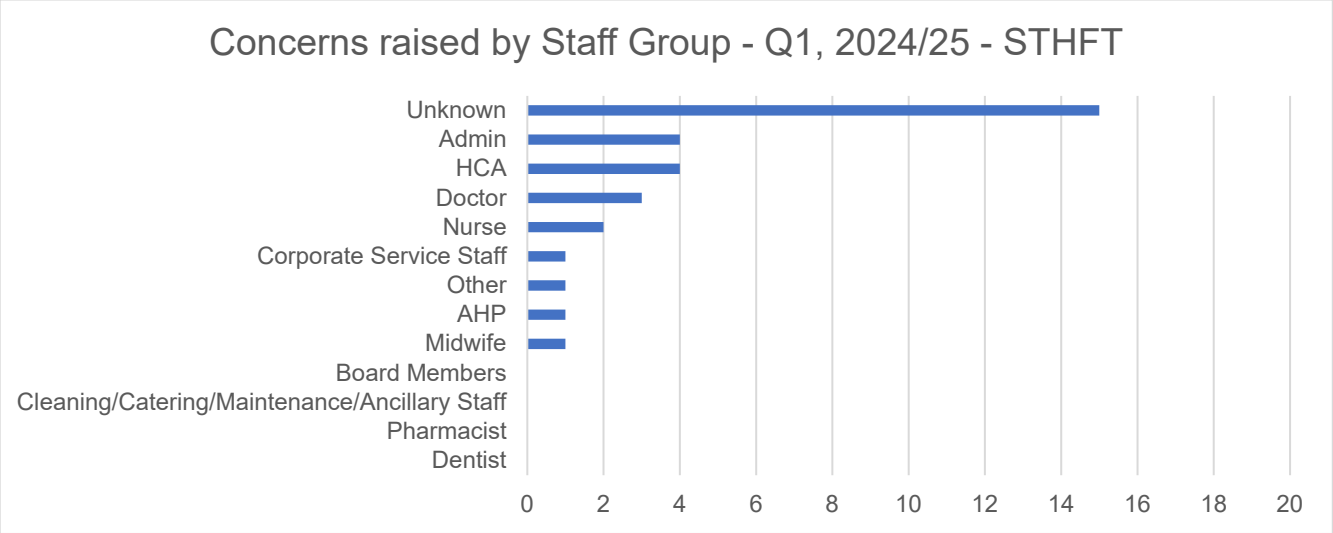


Staff Groups

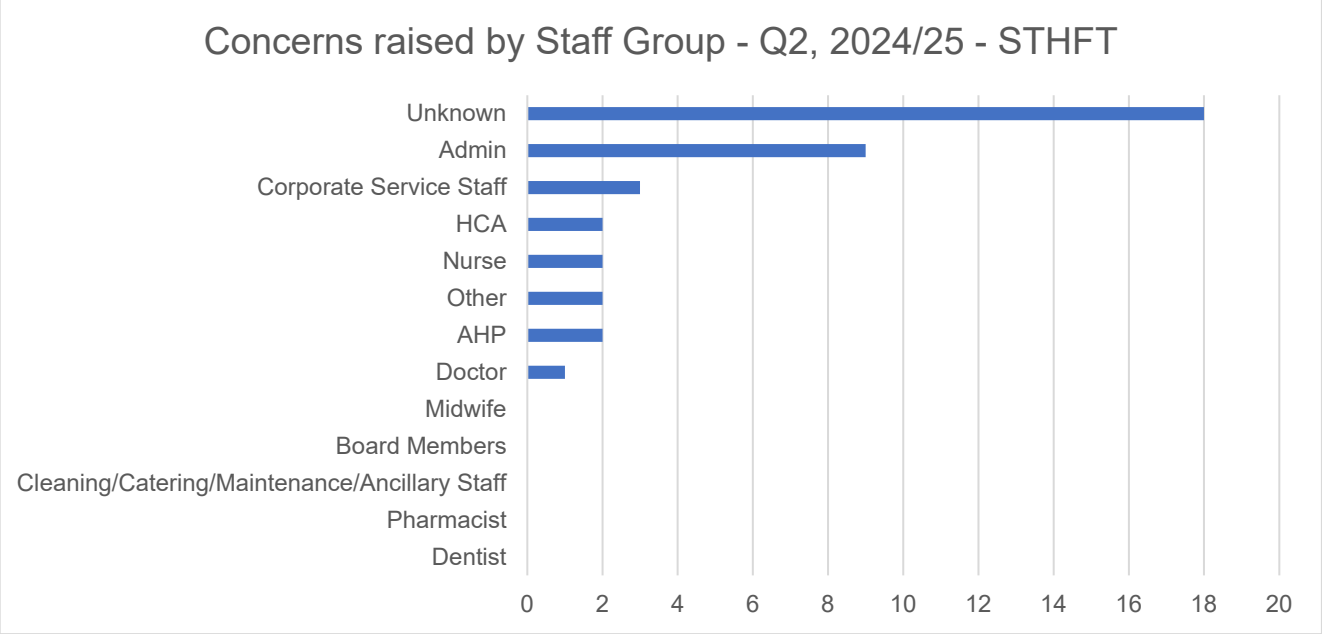
Graphs 4 & 5 below show the staff groups who have raised concerns in Quarter 1 & Quarter 2 across the Group. These are the job titles as used by the NGO. There is further work to be done to understand those that are 'unknown'.

Caring Better Together

Graph 4



Graph 5



Equality, Diversity and Inclusion

Table 1 below shows the breakdown of concerns raised by sex, ethnicity, sexuality and disability. Table 2 shows how may concerns we have received in relation to protected characteristics of sex, ethnicity, sexuality, and disability.

Table 1

EDI Information Q1 & Q2, 2024/25 – STHFT					
Male	8	Female	36	Prefer not to say / Not stated	28
Ethnic Origin of Concern Raisers					
White					20
Asian					2
Mixed					0

Black	1
Not Stated	38
Prefer not to say	11
Sexuality of Concern Raiser	
Heterosexual	14
Gay	0
Bisexual	1
Prefer not to say / Not stated	57
Do you consider yourself to have a disability?	
Yes	35
No	23
Prefer not to say / Not stated	14

Table 2

Concerns linked to reported protected characteristics - Q1 & Q2, 2024/25 - STHFT			
No. of concern raisers who self-reported being from a BAME background	3	No. of BAME staff who raised concerns related to ethnicity or racism	1
No. of Concern Raisers who self-reported having a disability	35	No. of staff who raised concerns related directly to disability	0
No. of Concern Raisers who self-reported being from the LGBTQ+ community	1	No. of staff who raised concerns related directly to sexuality or gender identity	1

The FTSUGs across the Group are continuing work alongside the various EDI staff groups and meet regularly with the EDI lead to triangulate any issues and themes.

Key Performance Indicators

Timeframes for managing concerns have now been included in the FTSU metrics and measures as shown in Table 3 including:

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

Table 3

Concerns raised during Q1 & Q2, 2024/25 - STEES	Concerns Closed	Average No of Days Open (median)	Open >90 Days	Total Outstanding Concerns
72	43	37	8	29

For 62 of the 72 concerns (86.1%) raised in Quarter 1 and Quarter 2 at STHFT, an investigator was assigned within 48 hours with 10 (62.5%) being assigned an investigator within 24 hours. Of the 29 outstanding cases, 18 are from August/September 2024.

Feedback data and examples

As part of the Board development session held at the start of October with the NGO, feedback was discussed and how this is captured. The NGO clarified that feedback can be gathered in different forms and not just using the feedback document. Feedback uptake has been low using the forms alone however other forms of feedback have been received via email or verbally and this can now be captured and recorded. Across Quarter 1 and Quarter 2, 43 cases have been closed and of those we have received 6 pieces of feedback (13.95%). 5 of the staff providing feedback (83%) said they would use the FTSU service again with the 6th not answering the question.

Some examples of feedback from STHFT staff in the last two quarters include:

"The response is great and I'm happy with the outcome. I'm glad that the areas of concerns I've raised have been acknowledged and acted upon. I'm happy to leave this where it is at, at present. I'm grateful for your ongoing support and communication throughout this. I'm also grateful of how you made me feel. I was nervous going into this but you've supported me, believed me and most importantly, listened."

"Thank you for following up, I feel that's things are moving forward now."

"I used the FTSU service and it was really helpful and supportive. I would use it again."

"You supported me with my concern and it made a real difference."

Freedom to Speak Up Training

All modules of the Freedom to Speak Up e-learning "Speak Up" "Listen Up" and "Follow Up" are now mandatory and available via ESR. The modules aim to promote a consistent and effective FTSU culture across the system which enables workers to speak up and be confident they will be listened to, and action taken. Having this training now on ESR means that the guardians will be able to monitor compliance and triangulate this data alongside other sources of information to support focused work.

Awareness Raising

Since April 2024, STHFT guardians have delivered training to approximately 1,400 staff members and students across sites and Teesside University. Guardians support with training on a reoccurring basis within the Trust induction, Care Certificate, International Nurses induction, directorate and audit meetings. Workshops have been developed to further raise awareness alongside collaborative quarterly reports linked to concerns raised and high-level themes.

Peer Review

The Guardians from University Hospitals Tees visited Liverpool Heart and Chest hospital who were the highest scoring organisation in the Staff Survey. The guardians shared examples of good practice, structures and reporting systems.

Comparative work with six organisations NE and Yorkshire (10,000+) regarding anonymous reporting and systems used. In the region STHFT sits highest in anonymous cases, of the six organisations four do not use an electronic reporting system for staff to report concerns. Newcastle use Work in Confidence that allows staff to report concerns anonymously however interaction between the guardian and staff member can take place often resulting in concerns moving from anonymous to confidential.

Conclusion

As we continue the work towards creating a business-as-usual speaking up culture in the group, the delivery of the speak up, listen up and follow up workshops and the proactive work on detriment, is pivotal.

Recommendations

The Group Board of Directors are asked to:

1. Review the data provided for North Tees and Hartlepool NHS Foundation Trust in Annexe A and South Tees Hospitals NHS Foundation Trust in Annexe B.

2. Support the identified next steps.

3. Support the NTHFT Freedom to Speak Up Guardian (FTSUG) who has developed detriment presentation material to roll this out across the group and receive a further update in Quarter 3.

Appendix:

Appendix 1 NENC FTSU Audit Summary – in reading room

NHS
University Hospitals Tees

Guardian of Safe Working Report

Meeting date: 5 November 2024
Reporting to: Group Board
Agenda item No: 17
Report author: CMO Office
Action required: Assurance

Delegation status (Board only and completed by the Corporate Secretariat): Jointly delegated item to Group Board
Previously presented to: People's committee

NTHFT strategic objectives supported:

Putting patients first ☐
Valuing our people ☒
Transforming our services ☐
Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒
A centre of excellence ☒
A great place to work ☒
Deliver care without boundaries ☐
Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting:

Summary from both Trust GOSW reports

ALERT:

NTH: Nine exceptions were marked as an immediate patient safety concern due to staffing shortages, workload, and hours worked/missed breaks.

Twelve fines levied due to breaches in the maximum 13-hours shift length and/or 11 hours rest between shifts.

STH: Work Schedules are not being issued and managed in a timely manner and the Trust is not meeting its contractual obligations in this regard in many areas.

ADVISE:

NTH: Resident doctors continue to report concerns relating to workload and staffing shortages; leading to doctors working beyond their contracted hours.

STH: The current structure for managing medical rostering with the resources available is not sustainable and needs review. This recommendation is under consideration by the Senior Leadership Team at South Tees.

Managing the Guardian of Safe Working fines remains an issue due to lack of confirmed process and agreement on the accounting.

ASSURE:

NTH: High compliance rates with code of practice and national terms and conditions.

Hot food provision now available demonstrating continued work towards BMA wellbeing guidance and overarching improving working lives NHS commitment.

STH: The Exception Reporting process is now embedded and increased reporting is allowing greater awareness of areas of challenge.

Recommendations:

It is requested that this covering paper is noted and acknowledged. Detailed GOSW reports from each Trust are available as appendices to this report found in the reading room.

UNIVERSITY HOSPITAL TEES GUARDIAN OF SAFE WORKING (GOSW) - COVERING REPORT

1. PURPOSE OF REPORT

Both Trusts submitted detailed GOSW reports to People's committee in Oct 24 which were well received, available as appendices to this report. The North Tees and Hartlepool paper covers the Training Year – August 23 - July 24,whilst the South Tees report covers the period April – July 24, which will enable future reports from both Trusts to be aligned to the Training Year. The purpose of this report is to provide high level comparisons of both reports, acknowledging that the time periods covered on these reports are different.

2. RECOMMENDATIONS

It is requested that the content of this report is received for assurance, noting that the reporting cycles of each GOSW reports have now been aligned, so that future comparisons will be more contemporaneous.

3. DETAIL

a. **Exception Reports (ERs) with Immediate Patient Safety Concerns (IPSC).** Both Trusts report small numbers of ERs with IPSC. Themes within these concerns include staffing shortages, workload, handovers and hours worked/missed breaks.

b. **GOSW Fines & Finances**. Both trusts report fines levied due to breaches in the maximum 13-hours shift length and/or minimum 11 hours rest between shifts.

c. **Outcome of majority of ERs- Payment for additional hours**. Payment for additional hours worked continues to be the main outcome for ERs. Both trusts provide information to the respective directorates regarding themes from ERs and outcomes.

4. SUMMARY OF ISSUES, ACTIONS AND RECOMMENDATIONS

a. **Rightsizing of rotas**. The right sizing of rotas across the Group is the priority over the next year. Many of the issues cited in the GOSW reports may be rectified if we are reassured that we have the correct numbers of staffing on these rotas based on clinical need, training requirements, and staff wellbeing. Having accurately costed rotas will also aid financial management.

b. **Compliance information**. The code of practice and national terms and conditions of service requires employers to issue work schedules a minimum of 8 weeks in advance, and provide finalised duty rosters 6 weeks in advance. NTH has stronger compliance rate than STH. Over the next year we will be reviewing and acting on strengthening our contractual responsibilities across the Group.

c. **Exception reporting.** STH has changed the method by which resident doctor can submit ERs which has resulted in a significant increase in reporting. NTH still feel that their system is underutilised. Over the next year we will work to ensure that the systems across the Group are equally accessible.

d. **Administrative staff involved with rostering and medical productivity.** Across the Group the organisation of administrative staff who are involved with the rostering and medical productivity management of medical staff differ and in some areas this feels under resourced.

Over the next year we will work to create a target operating model for this important capability with shared resource across the Group improving resilience.

5. CONCLUSION

Overall, there is positive progress in making University Hospitals Tees an organisation of choice for resident doctors. We continue to work with the residents to listen to their views and include them in workstreams to ensure they have the opportunity to shape their working lives and aiming to ensure we are fully compliant with NHSE guidance “Improving the working lives of doctors in training”, April 2024.

Appendix 1 – NTH GOSW report – reading room
Appendix 2 – STH GOSW report – reading room

University Hospitals Tees

Equality, Diversity and Inclusion Annual Report 2023/24

Meeting date: 5 November 2024

Reporting to: Group Board

Agenda item No: 18

Report author:

Sharon Ollivier & Nicola Hogarth

Action required:
Assurance

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to:
People Committee

NTHFT strategic objectives supported:

Putting patients first ☐

Valuing our people ☒

Transforming our services ☐

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☐

A great place to work ☒

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☐

Deliver care without boundaries in collaboration with our health and social care partners ☒

Make best use of our resources ☐

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

At University Hospital Tees we are dedicated to ensuring equality, diversity and inclusion (EDI) is at the heart of all we do, ensuring our staff have the best experience possible whilst at work, feel supported, are developed and treated fairly regardless of background, personal or protected characteristic.

In addition to this, as a public body we have a duty to eliminate any unlawful discrimination, advance equality of opportunity and foster good relations in line with requirements outlined within the Public Sector Equality Duty (General Duty).

Under the Public Sector Equality Duty (Specific Duty), we are required to publish information on compliance with the General Duty and publish our equality objectives.

Recommendations:

The Group Board are asked:

1. To consider the annual Equality, Diversity and Inclusion reports from both Trusts and to agree the priorities outlined in Section 4 for the Group.
2. To approve the external publication of both reports and the request for moderate assurance for the Board Assurance Framework.
3. Appendices relating to this report can be found in the reading room.

North Tees and Hartlepool NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust

Equality Diversity and Inclusion (EDI) Annual Report 2023/24

1. PURPOSE OF REPORT

The purpose of the report is to assure the Group Board of the EDI work that has taken place over the last twelve months as we continue to strengthen our equality and diversity agenda. The attached reports in Appendix 1 and Appendix 2 pulls this work together to highlight the achievements and progress of the previous year. The reports also provide detail of the workforce information by protected characteristic.

2. BACKGROUND

As a public body we have a duty to eliminate any unlawful discrimination, advance equality of opportunity and foster good relations in line with requirements outlined within the Public Sector Equality Duty (General Duty).

Under the Public Sector Equality Duty (Specific Duty), we are required to publish information on compliance with the General Duty and publish our equality objectives.

The Annual reports (Appendices 1 and 2) provide details of our work and how University Hospital Tees is dedicated to ensuring equality, diversity and inclusion (EDI) is at the heart of all we do to ensure our staff have the best experience possible working in our services, feel supported, are encouraged to thrive and develop and are treated fairly regardless of background, personal or protected characteristic.

3. DETAILS

The EDI work has progressed at both Trusts, and we are now beginning to work more cohesively to make EDI a part of everyday business and everyone's responsibility.

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

We are on a journey and will continue to promote, develop and embed EDI within the organisation both in line with legislative requirements as well as through the hard work and dedication of staff working in collaboration across the Group.

The Trust holds Disability Confident Leader status, which recognises our commitment to removing inequality and ensuring fairness and equity in relation to recruitment and employment processes. We promote an open culture and encourage our staff to collaborate with leaders to improve inclusion, quality and safety across all care groups and corporate areas. Supporting colleagues to thrive at work is incredibly important and we have taken steps towards this by ensuring policy and procedures have the right approach. Our Cultural Ambassadors continue to

provide independent advice in relation to employee cases involving colleagues from an ethnic minority background.

The Trust is committed to ensuring that its education, training and development offer is accessible to all and currently offers a broad range of learning opportunities. We have successfully embedded 6 active Staff Networks. Leads have protected time to focus on the role and to work on key priorities in support of colleagues. This equates to a half day per week, with flexibility over how the time is taken.

As part of the EDI calendar of events, various sessions are held throughout the year including training, employee engagement sessions, monthly/annual themed events, communication bulletins, information leaflets/fact sheets and newsletters in support of the networks

South Tees Hospitals NHS Foundation Trust (STHFT)

We now work more closely with colleagues to raise awareness of EDI from Trust Induction, Preceptorship, Care Certificate and link in with the CQC compliance Group, FTSU and Health Inequalities agenda.

Compliance of objectives is monitored by the HR Compliance lead and links to our people Plan, NHS England High Impact Actions and the Equality Delivery System Report. The CQC well led framework has been updated to reflect a more Human Rights approach with the quality statement focusing on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities to meet these.

The EDI work reflects this vision through our restorative approach and through the training and development of staff in relation to EDI, civility and leadership. We also are working closely with our staff networks to clearly articulate the needs of staff within the workplace.

The information provided in both reports demonstrates the key areas of focus through data collection and analysis and the narrative of colleagues to provide an insight into next steps.

As we progress with the new People Services Structure, there will be a more collaborative approach across both Trusts. The recommendations below highlight the key areas of focus that are required to further progress and enrich the experience of all colleagues and patients in the workplace. These recommendations align to the national, regional and local strategic direction of the EDI agenda.

Having a truly equal, diverse and inclusive workforce will help us to improve the experience of our patients, meaning better health outcomes and create an environment where every individual feels empowered, engaged and supported as an essential member of our team.

4. KEY PRIORITIES

- Review outcomes from the staff survey findings and the Workforce Racial Equality Standard with particular emphasis on, career progression, bullying and harassment and our zero-tolerance approach to Racism.
- Review outcomes from the staff survey findings and the Workforce Disability Equality Standard with emphasis on career progression, discrimination, declaration rates and representation across different levels of the organisation.

- Supporting the growth and development of our staff networks including alignment of executive sponsors, protected time, and allocated funding and collaborative working across the group.
- Addressing findings from the Equality Delivery System to support the EDI work across the Group.
- Review the Gender Pay Gap reports and take active steps to reduce our gender pay gap.
- Consideration of all data from a quantitative and qualitative perspective to gain insight into lived experiences and overarching themes that are occurring and identify impact.
- Introduce an Ethnicity and LGBT+ Pay Gap Report to understand the position of the Group to ensure a safe and fair workplace for all.
- Create a more enhanced comprehensive on boarding experience relating to international nurse/medical recruitment
- Provide education and raise awareness around cultural awareness, intelligence and competency emphasising the importance for leadership roles also.
- Introduction of a generic staff passport, to support staff and facilitate adjustments so they can be as effective as possible in their role.
- Production of Staff Health Inequalities dashboard and completion of the EDI dashboard which will give insight into the workforce community and the challenges and benefits that exist to help create a more inclusive and representative workplace.

5. RECOMMENDATIONS

The Group Board are asked:

1. To consider the annual Equality, Diversity and Inclusion reports from both Trusts and to agree the priorities outlined in Section 4 for the Group.
2. To approve the external publication of both reports and the request for moderate assurance for the Board Assurance Framework.

6. APPENDICES

- **Appendix 1** - North Tees & Hartlepool NHS Foundation Trust – Equality, Diversity and Inclusion Report 2023/2024 - within the reading room

- **Appendix 2** - South Tees Hospitals NHS Foundation Trust - Equality and Diversity Report 2023/2024 - within the reading room

Resources Committee

September 26th and October 31st

Connecting to: Group Board

Key topics discussed in the meeting:

- **Finance Position**
    - The financial position for Month 6 2024/25 is a deficit of £13.6m for the Group, which is an adverse variance of £0.2m against the year-to-date plan.
    - The reported position includes non-recurrent measures totalling £6.9m year-to-date across the Group. Continued and sustained improvements in ERF delivery, achievement of recurrent CIP and reduction in expenditure run-rates will be essential throughout the second half of the financial year to ensure delivery of the financial control total.
    - NENC ICB received an additional allocation of £49.9m, which has been allocated to deficit trusts including an allocation of £17.3m for STH. Consequently, the Trust's financial control total for the year was centrally adjusted by NHSE in Month 6 to reflect this. The Group plan for the 2024/25 financial year is now to deliver an overall deficit control total of £23.1m, with a break-even plan for NTH and a £23.1m deficit plan for STH.
- **WTE**
    - We continue to monitor WTE across the group which is being closely scrutinised by Site teams using appropriate workforce controls.

CIP / Efficiency

- Forecast delivery of group Cip is below target, with site teams identifying efficiency savings and escalation processes in place. A deep dive into North Tees & Hartlepool CIP and South Tees CIP has been undertaken.
- Across the Group, overall year to date delivery is £33.5m (102% of target)

- **Digital Strategy**
    - This will be presented to the board as part of a development session in December 2024
- **Salix PSDS business case approval**
    - This was approved (and has been approved by board)
- **Procurement update**
    - We received an update on south tees procurement – should be noted the quality of the report and the execution of initiatives continues to be a highlight
    - Given the quality and consistency of delivery the Chair believes we should give further consideration to additional resources in this area to delivery additional savings
    - A report on procurement from North Tees & Hartlepool will be considered at the next meeting.
    - The 2024/25 savings target set for the South Tees Procurement Department was £3,000,000 to be achieved across all functions within the department including, the contracting team, the operational team, and the logistics team. Procurement performance to date (achieved and pipeline): Contracting team – £2,423,495 full-year with £2,245,387 being in-year. Logistics team - £516,100 full year with £359,175 being in year.

Actions:

- North tees & Hartlepool procurement update to be brought to November committee

Escalated items:

- CIP is currently behind Target with a focused effort at both Trusts through site teams.
- Procurement update from North Tees & Hartlepool will be brought to the Resources Committee in November 24.
- New Target date for 65 week waits noted, further work required to clarify our anticipated position at this date.
- Change in financial control total for 2024/25

Risks (Include ID if currently on risk register):

- None.

Month 6 2024-25 Finance Report

Meeting date: 5 November 2024

Reporting to: Group Board

Agenda item No: 18

Report author: Chris Hand, Group Chief Finance Officer

Action required:
Information

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to:
Group Resources Committee 31 October 2024

NTHFT strategic objectives supported:

Putting patients first ☐

Valuing our people ☐

Transforming our services ☒

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☐

A great place to work ☐

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☐

Deliver care without boundaries in collaboration with our health and social care partners ☐

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

This report relates to STH Board Assurance Framework risk 6 and section 3C (finance) of the NTH Board Assurance Framework

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The financial position for Month 6 2024/25 is a deficit of £13.6m for the Group, which is an adverse variance of £0.2m against the year-to-date plan.

This report outlines the drivers of the variance, and actions being taken by the respective Site teams to ensure delivery of the financial control totals. Continued and sustained improvements in ERF delivery, achievement of recurrent CIP and reduction in expenditure run-rates will be essential throughout the second half of the financial year to ensure delivery of the financial control total.

A pressure on the CDEL allocation for IFRS16 (right of use) assets is forecast for STH. This pressure largely relates to the impact of indexation increases on the rental payments for leased properties, included significant 5-yearly rent review increases. Following discussion and agreement with the ICB and regional NHSE, this overspend was reported in the Month 6 PFR return (and is part off-set by forecast underspends at an overall system-level. Work is underway internally and across the system to identify options to mitigate the impact of the IFRS16 pressure. In addition, it is anticipated that the system will receive a fair shares allocation from national contingency funding for emerging IFRS16 pressures.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

In September 2024, NHSE confirmed that non-recurrent deficit support will be made available to systems with an agreed deficit plan, to deliver break-even for the 2024/25 financial year.

NENC ICB received an additional allocation of £49.9m, which has been allocated to deficit trusts including an allocation of £17.3m for STH. Consequently, the Trust's financial control total for the year was centrally adjusted by NHSE in Month 6 to reflect this.

The Group plan for the 2024/25 financial year is now to deliver an overall deficit control total of £23.1m, with a break-even plan for NTH and a £23.1m deficit plan for STH.

The plans for the Group include a number of risks and assumptions, that are reported to Resources Committee and will need to be closely monitored over the course of the financial year.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The Resources Committee will receive monthly assurance reports on the financial performance throughout the year.

External assurance on the year-end financial position is received from the Group's external auditors.

Work is ongoing across the Group to review the financial governance arrangements that are in place, to identify best practice and ensure they are consistently applied across both trusts.

The ICB have commissioned a review of arrangements for financial control and CIP across all providers in the system, which will provide assurance of the arrangements in place across the Group and any actions required to strengthen.

Recommendations:

Members of the Board are asked to:

- Note the financial position for Month 6 2024/25.

Group Board
5 November 2024

Month 6 2024/25 Finance Report

1. PURPOSE OF REPORT

The purpose of this report is to update the Board on the financial performance of the individual trusts and overall Group, at the end of Month 6 of 2024/25.

2. BACKGROUND

For 2024/25, the system-based approach to planning and delivery continues, with each provider trust fully mapped to a single Integrated Care System (ICS). Both North Tees and Hartlepool NHS Foundation Trust (NTH) and South Tees Hospitals NHS Foundation Trust (STH) and are aligned to the North Cumbria (NENC) Integrated Care System (ICS).

Following a planning assurance meeting between the ICS and NHSE executives on 22nd May, a system control total deficit of £49.9m was agreed for the ICS overall. An additional £20m funding was provided to the ICS in recognition of the impact of IFRS 16 on PFIs. Consequently, a further plan re-submission was required from all system partners on the 12th June 2024.

In September 2024, NHSE confirmed that non-recurrent deficit support will be made available to systems with an agreed deficit plan, to deliver break-even for the 2024/25 financial year. NENC ICB received an additional allocation of £49.9m, which has been allocated to deficit trusts including an allocation of £17.3m for STH. Consequently, the Trust's financial control total for the year was centrally adjusted by NHSE in Month 6 to reflect this.

Therefore, the Group plan for the 2024/25 financial year is now to deliver an overall deficit control total of £23.1m, with a break-even plan for NTH and a £23.1m deficit plan for STH.

NTH and STH are required to plan and report to NHSE on a consolidated group basis, including the financial position of each of the trust's subsidiary companies. The financial performance in this report therefore includes the consolidated positions of Optimus Health Ltd and North Tees & Hartlepool Solutions LLP for NTH and South Tees Healthcare Management Ltd for STH.

3. MONTH 6 FINANCIAL POSITION

The table below shows the revenue position for the Group as at the end of Month 6 2024/25, shown by trust:

	NTH			STH			GROUP		
STATEMENT OF COMPREHENSIVE INCOME	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Operating income from patient care activities	200,154	201,875	1,721	426,866	433,420	6,554	627,020	635,295	8,275
Other operating income	19,482	18,353	(1,129)	27,910	29,062	1,152	47,392	47,415	23
Employee expenses	(146,358)	(148,599)	(2,241)	(273,801)	(277,561)	(3,760)	(420,159)	(426,160)	(6,001)
Operating expenses excluding employee expenses	(68,460)	(70,041)	(1,581)	(180,135)	(184,709)	(4,574)	(248,595)	(254,750)	(6,155)
OPERATING SURPLUS/(DEFICIT)	4,818	1,588	(3,230)	840	212	(628)	5,658	1,800	(3,858)
FINANCE COSTS									
Finance income	1,248	1,610	362	1,151	1,673	522	2,399	3,283	884
Finance expense	(320)	(347)	(27)	(11,798)	(11,665)	133	(12,118)	(12,012)	106
PDC dividends payable/refundable	(1,140)	(1,138)	2	0	0	0	(1,140)	(1,138)	2
NET FINANCE COSTS	(212)	125	337	(10,647)	(9,992)	655	(10,859)	(9,867)	992
Other gains/(losses) including disposal of assets	0	22	22	0	66	66	0	88	88
Corporation tax expense	(30)	(47)	(17)	0	0	0	(30)	(47)	(17)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	4,576	1,688	(2,888)	(9,807)	(9,714)	93	(5,231)	(8,026)	(2,795)
Add back all I&E impairments/(reversals)	0	0	0	0	0	0	0	0	0
Remove capital donations/grants I&E impact	(5,208)	(2,549)	2,659	323	116	(207)	(4,885)	(2,433)	2,452
Adjust PFI revenue costs to UK GAAP basis	0	0	0	(3,263)	(3,117)	146	(3,263)	(3,117)	146
Adjusted financial performance for the purposes of system achievement	(632)	(861)	(229)	(12,747)	(12,715)	32	(13,379)	(13,576)	(197)

At the end of Month 6 2024/25 the Group is reporting an adverse variance of £0.2m (with an adverse variance of £229k relating to NTH and a favourable variance of £32k relating to STH).

The main drivers of the NTH Month 6 position are:

- Clinical Income is ahead of plan, which mostly relates to increased high-cost drugs and devices income, non-recurrent ICB industrial action funding, and non-NHS income.
- The plan assumes ERF delivery of 121% (against a national target of 112%), as part of delivering the Trust's overall efficiency and productivity target. The Trust's local estimate of year-to-date performance 122%, which is an additional £0.2m against plan (and £2.4m above the national target). (This assumes full payment from HNY ICB in line with a corrected baseline)
- Other operating income (excluding donated asset income) ahead of plan, mainly relating to R&D, education & commercial income.
- Interest receivable is ahead of plan, reflecting current interest rates and cash balances.
- Overspend against block funded high-cost drugs and devices
- Slippage on delivery of CIP savings £1.6m, offsetting with additional non-recurrent measures.

The main drivers of the underlying STH Month 6 position are:

- Clinical Income is ahead of plan, reflecting additional ERF income, passthrough high-cost drugs and devices income and non-recurrent ICB industrial action funding.
- The plan assumed ERF delivery of 113% (against a national target of 108%), as part of delivering the Trust's overall efficiency and productivity target. The Trust's local estimate of year-to-date performance is 118%, which is an additional £3.6m income against plan (and £7.4m above the national target).
- Overspends on drug and devices expenditure, part offset by additional pass-through income, with pressures on block-funded costs
- Overspends on pay budgets, mainly relating to medical pay and ward budgets, including the impact of industrial action and ERF activity delivery.
- Offsetting additional non-recurrent measures.

The NTH and STH Site teams are taking a number actions to address areas of overspend and maximise delivery against CIP and ERF targets, whilst mitigating the impact of non-elective activity pressures.

Agency Expenditure

Reduction in agency expenditure is a national priority set by NHSE, with clear Board accountability expected for agency spend and reporting of plans and actual agency spend. The 2024/25 planning guidance included requirements to reduce agency spend by at least 5% from the prior year, contain agency spend within 3.2% of total pay expenditure and remove all non-framework agency by July 2024.

The table below shows the position on agency expenditure for the Group to the end of Month 6:

	NTH			STH			GROUP		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Nursing	2,067	1,324	-743	188	142	-46	2,255	1,466	-789
AHP and S&T	56	201	145	447	147	-300	503	348	-155
Other Clinical	0	0	0	0	1	1	0	1	1
Consultants	1,066	917	-149	1,709	1,346	-363	2,775	2,263	-512
Career/staff grades	0	23	23	0	0	0	0	23	23
Trainee grades	0	0	0	0	0	0	0	0	0
Non Clinical	0	27	27	106	0	-106	106	27	-79
Total Agency	3,189	2,492	-697	2,450	1,636	-814	5,639	4,128	-1,511
Agency as % of Pay		1.7%			0.6%			1.0%	

The agency plan for 2024/25 assumed a reduction of £2.2m (17%) compared to 2023/24.

At the end of Month 6, agency Expenditure is £1.5m below plan overall for the Group, with an underspend of £0.8m at STH and underspend of £0.7m at NTH.

Agency expenditure represents 1% of total pay expenditure (well within the 3.2% national cap). Both NTH and STH currently have no off-framework agency workers.

Efficiency

The 2024/25 financial plan assumes delivery of an overall efficiency target for the Group of £74.5m. The tables below show the year-to-date delivery against the Group's efficiency targets:

	NTH					STH					GROUP				
YTD Month 6	YTD Plan £000	YTD Target £000	YTD Actual £000	YTD Variance £000	% Delivery	YTD Plan £000	YTD Target £000	YTD Actual £000	YTD Variance £000	% Delivery	YTD Plan £000	YTD Target £000	YTD Actual £000	YTD Variance £000	% Delivery
Care Groups / Collaboratives	5,013	4,878	3,157	-1,721	65%	12,694	13,441	9,095	-4,346	68%	17,707	18,319	12,252	-6,067	67%
ERF Delivery	2,925	2,928	2,928	0	100%	3,700	3,700	3,957	257	107%	6,625	6,628	6,885	257	104%
Corporate	396	456	345	-111	76%	2,158	2,031	1,174	-857	58%	2,554	2,487	1,519	-968	61%
Central	2,575	2,157	4,787	2,630	222%	6,869	3,053	7,999	4,946	262%	9,444	5,210	12,786	7,576	245%
Total	10,909	10,419	11,217	798	108%	25,421	22,225	22,225	0	100%	36,330	32,644	33,442	798	102%

Across the Group, overall year-to-date delivery is £33.4m (102% of target).

Work continues through the Site leadership teams to identify and deliver efficiency savings to meet the targets, with escalation meetings held with Care Groups and Collaboratives. A UHT CIP Steering Group, chaired by the Managing Director, has been established to monitor Site delivery and to provide oversight of the overall efficiency programme at a Group level.

Capital

The Group's gross capital expenditure plan for the 2024/25 financial year totals £100.5m.

The Group's ICS Capital Departmental Expenditure Limit (CDEL) for 2024/25 amounts to £32.7m, including an additional £5m bonus allocation relating to UEC performance at NTH. The ICS is expected to receive an additional CDEL allocation for IFRS16 expenditure, with the Group's plan totalling £5.1m.

The capital programme also includes external support, in the form of Public Dividend Capital (PDC) of £23.8m, including support for the Friarage Theatre development (£15.8m) and the Stockton CDC Hub (£7.2m), and Salix grant funding (£25.6m) for de-carbonisation schemes across the Group. The plan also includes expected PFI lifecycle costs of £12.7m (the cost of which sits outside the ICS CDEL limit).

The Group's capital expenditure to the end of Month 6 amounted to £32.3m, as detailed in the table below.

	NTH £000	STH £000	Group £000
Equipment	477	954	1,431
Digital	171	903	1,074
Estates	2,782	669	3,451
PFI	0	5,879	5,879
Salix	1,984	91	2,075
FHN Hub	0	8,161	8,161
JCUH UTC	0	399	399
CDC Hub	8,611	0	8,611
IFRS 16	1,237	0	1,237
Total Gross Capital	15,262	17,056	32,318

For core CDEL, the Group is currently forecasting delivery by the end of the year to the agreed plans and the respective trusts' share of the system CDEL allocation.

However, against the notional CDEL allocation IFRS16 (right of use) assets, there is currently a significant pressure identified for STH. This pressure largely relates to the impact of indexation increases on the rental payments for leased properties. Following discussion and agreement with the ICB and regional NHSE, the forecast was reported in the Month 6 PFR return (and is part off-set by forecast underspends at an overall system-level). Work is underway internally and across the system to identify options to mitigate the impact of the IFRS16 pressure during 2024/25. In addition, it is anticipated that the system will receive a fair shares allocation from national contingency funding for emerging IFRS16 pressures.

Liquidity

The cash balance at the end of Month 6 stood at £80.5m for the Group (with £59.3m relating to NTH and £21.2m relating to STH).

The continued strong cash balances have supported good compliance with the Better Payment Practice Code for both trusts, as shown in the tables below:

NTH	YTD Number	YTD Value £000
Total bills paid in the year	35,869	107,182
Total bills paid within target	34,692	104,897
Percentage of bills paid within target	96.7%	97.9%
STH	YTD Number	YTD Value £000
Total bills paid in the year	53,276	298,640
Total bills paid within target	51,625	288,755
Percentage of bills paid within target	96.9%	96.7%
GROUP	YTD Number	YTD Value £000
Total bills paid in the year	89,145	405,822
Total bills paid within target	86,317	393,652
Percentage of bills paid within target	96.8%	97.0%

Following Board approval on 7th of August, the Trust made a cash support application on the 16th August for £14.1m support. Following a number of delays, NHSE confirmed on the 16th September that the cash application had been approved, and payment of the cash support from DHSC was received on 23rd September.

On 17th September, NHSE confirmed the non-recurrent deficit support that will be made available to systems with an agreed deficit plan. NENC ICB has distributed its system deficit support allocation to providers in proportion to planned deficits, with the share attributable to STH being £17.4m. The year-to-date proportion of this cash was received on 15th October.

Following distribution of deficit support cash to systems to support break-even, national NHSE's expectations are that no further cash support applications are required by providers. However, given the residual STH deficit plan and working capital requirements, ongoing close monitoring and cashflow forecasting will be essential to minimise any additional cash support requirements.

Statement of Financial Position

The table below shows the balance sheet position for the two Trusts as at the end of Month 6:

	NTH	STH
	£000	£000
Non-current assets		
Intangible assets	912	8,808
On-SoFP IFRIC 12 assets	0	141,410
Other property, plant and equipment (excludes leases)	142,581	155,767
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	19,128	30,930
Receivables: due from NHS and DHSC group bodies	579	1,155
Receivables: due from non-NHS/DHSC Group bodies	1,203	1,046
Credit Loss Allowances	0	(2,045)
Total non-current assets	164,403	337,071
Current assets		
Inventories	7,430	17,060
Receivables: due from NHS and DHSC group bodies	1,305	29,574
Receivables: due from non-NHS/DHSC Group bodies	27,961	40,401
Credit Loss Allowances	(2,975)	(1,300)
Cash and cash equivalents: GBS/NLF	56,017	17,864
Cash and cash equivalents: commercial/in hand/other	3,289	3,303
Total current assets	93,027	106,902
Current liabilities		
Trade and other payables: capital	(1,340)	(12,953)
Trade and other payables: non-capital	(60,398)	(134,278)
Borrowings	(5,284)	(14,189)
Other financial liabilities	0	
Provisions	(5,401)	(1,510)
Other liabilities: deferred income including contract liabilities	(4,027)	
Total current liabilities	(76,450)	(162,930)
Total assets less current liabilities	180,980	281,043
Non-current liabilities		
Borrowings	(33,915)	(261,919)
Provisions	(2,082)	(1,370)
Total non-current liabilities	(35,997)	(263,289)
Total net assets employed	144,983	17,754
Financed by		
Public dividend capital	193,280	439,633
Revaluation reserve	18,226	32,946
Other reserves	0	26,475
Income and expenditure reserve	(66,523)	(481,300)
Total taxpayers' and others' equity	144,983	17,754

4. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 6 2024/25.

University Hospitals Tees

Integrated Performance Report – reporting month August 2024

Meeting date: 5 November 2024

Reporting to: Group Board

Agenda item No: 21

Report author: Lucy Tulloch

Deputy Director Strategy & Planning

Action required:
Assurance

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to: Group Board Committees in October 2024

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A great place to work ☒

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☒

Deliver care without boundaries in collaboration with our health and social care partners ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Board Assurance Framework for both NTHFT and STHFT is being updated and harmonised, mapping of IPR risks to the BAF risk register will then be undertaken.

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

For NTHFT the Board is alerted to:

- *C. difficile* infections reporting 40 cases YTD against a plan of 18. Cross-site collaborative working with NTH Solutions continues, in relation to a decant cleaning programme of equipment and pilot introduction of ward hygienists.
- Pressures to eliminate 65-week waiters within the Chemical Pathology service. The service is currently provided by a single consultant with limited capacity. Plans to increase capacity are in place, however, will not be operational until December 2024/January 2025.
- Diagnostic 6-week wait standard has deteriorated in recent months but is now expected to improve with staffing availability.

For STHFT the Board is alerted to:

- 2 Never Events with risk summit undertaken in ophthalmology. *E. coli* infections have been higher this year.
- Increased numbers of still births this year, reported via the Perinatal Mortality Review Tool and all cases are reviewed.
- Cancelled operations not rebooked within 28 days have been higher this year than previously.
- Overall referral to treatment standard is not improving, and the number of patients waiting more than 52 week is increasing, the focus being on prioritising the longest waiters as well those most clinically urgent.
- Compliance with cancer treatment waiting time standards is recognised as a strategic risk; the position will be improved through delivery of action plans to improve access and processes within specific tumour groups enabling earlier diagnosis. As a result, the number of patients waiting beyond 62 days is decreasing.

- Sickness absence rates are consistently above the Trust's internal plan, ongoing focus on sickness management process leading to some improvement in rates of absence at department level.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

The Board is advised of areas of performance where there is ongoing focus to improve performance and/or or assurance.

For NTHFT the Board is advised:

- In maternity services, breastfeeding rates are improving upon historic levels but remain below the regional average. Post-partum hemorrhage rates are not consistently achieving the local standard set.
- Readmission rates are higher than plan, and this is being investigated by audit.
- The Trust focus continues around elective recovery and reducing the number of long waiters from both an RTT and cancer perspective, in which the Trust has reported improvements. It is anticipated that increases in demand will be evident over the winter months, however winter plans have now been agreed which set out how the Trust will safely manage the increased demand.
- The financial position shows a small adverse variance year to date against month 5 plan. Financial controls are in place, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

For STHFT the Board is advised:

- Within maternity services, breastfeeding rates are improving, as a result of supportive interventions, but remain below the regional average. Patient feedback in maternity services is consistent but lower than historically reported.
- Demonstrated improvement in urgent and emergency care metrics, with the focus being on streaming to the JCUH urgent treatment centre to maximise the patients seen appropriately in UTC and within 4 hours, and reducing ambulance handover delays in the Emergency Department.
- Patient feedback from users of A&E is not consistently above the standard we have set.
- Diagnostic 6-week wait is improving and cancer diagnosis within 28 days performing above the national standard of 77%.
- Financial position in line agreed plan. Financial controls are in place, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

For NTHFT the Board is assured:

- Maternal 3rd/4th degree tears during birth are consistently lower than plan.
- Standardised mortality is 'as expected'.
- A&E 4-hour standard and ambulance handover performance against plan is consistently met.
- Patient experience metrics consistently meet the plans set, across A&E, inpatient, outpatient and community services.

For STHFT the Board is assured:

- Standardised mortality is 'as expected'.
- Community 2-hour urgent response rate consistently exceeds plan and is an important element of plans to manage winter pressures urgent and emergency care.
- Consistently positive patient feedback surveys results for outpatient and community services.

Recommendations:

Members of the Board of Directors and Committees are asked to:

- Receive the Integrated Performance Report for reporting period August 2024.
- Note that separate agenda items into the Committees, as set out in the annual cycles of business, will provide further detailed reporting and assurance.
- Note the performance standards on which assurance is provided; those advised for ongoing monitoring and improvement; and those alerted as exceptions or consistent under-performance against plan; and the improvement actions being taken.
- Note the work completed on the IPR redesign and further development planned.
- The IPR can be found in the reading room

Integrated Performance Report

1. PURPOSE OF REPORT

The IPR uses statistical process control, and expert judgment, to identify performance exceptions / consistent under-performance against plan, to alert to the Board and Committees.

2. RECOMMENDATIONS

The Group Board of Directors are asked to receive this report for Assurance.

3. BACKGROUND

The Integrated Performance Report (IPR) format across NTHFT and STHFT and as University Hospitals Tees group, has been reviewed and redesigned to meet the statutory reporting and governance needs of the trusts and group.

This review has comprised extensive stakeholder engagement, including a non-executive director subgroup, executive directors, COOs, public health consultants, subject matter experts and BI teams producing the IPR. A survey was made of the IPRs of a dozen trusts and groups to benchmark metrics to be included and presentation styles. Advice has also been taken from other organisations and leaders in this field. This developed a set of principles to guide the IPR redevelopment. These were reviewed and agreed by Board members, 1 October 2024.

The principles agreed were:

- A single Group IPR
- Public-facing document and to be a key pillar of the oversight framework
- To be published one month in arrears to enable depth of review of the data
- To include statutory and recommended metrics for each Trust and a Group position
- Format and content benchmarked against other Trusts and Making Data Count
- To use CQC domains and then map to Group strategic objectives from April 2025
- Each metric and domain has clear ownership with an Executive lead and reporting Committee chaired by a non-executive director
- To use PowerBI as the production tool for both Trusts
- Report easy to digest (length, presentation, format) – to focus on key metrics
- Executive summary that sets out headlines and priority areas for Group Board
- SPC charts provide statistical analysis – used to indicate strengthening / declining performance
- Issues of concern to be sufficiently flagged and performance contextualised
- To include the adequate breadth and depth of KPIs
- Information to support accountable conversations

- Narrative includes clear actions
- Landscape format, one metric per page (3 charts NTH, STH, UHT)
- To include a data quality ‘kite mark’ – to be developed
- To integrate information and link metrics to highlight dependencies
- Future development: Board members wish to increase the number of productivity / efficiency and community services metrics to increase focus in these areas.

The new format IPR therefore provides, within one document, a consistent presentation of key metrics for each trust, and an aggregate group view. The narrative highlights performance trends and where applicable the actions in hand to address variance from plan. The alert, advise and assure framework is used to provide a clear line of sight on metric performance. Whilst underpinned by a larger number of measures and other evidence used to govern, manage and improve our services, these can be viewed as the sentinel metrics for the performance of the organisations.

4. DETAIL

For NTHFT the Board is alerted to:

- *C. difficile* infections reporting 40 cases YTD against a plan of 18. Cross-site collaborative working with NTH Solutions continues, in relation to a decant cleaning programme of equipment and pilot introduction of ward hygienists.
- Pressures to eliminate 65-week waiters within the Chemical Pathology service. The service is currently provided by a single consultant with limited capacity. Plans to increase capacity are in place, however, will not be operational until December 2024/January 2025.
- Diagnostic 6-week wait standard has deteriorated in recent months but is now expected to improve with staffing availability.

For STHFT the Board is alerted to:

- 2 Never Events with risk summit undertaken in ophthalmology. *E. coli* infections have been higher this year.
- Increased numbers of still births this year, reported via the Perinatal Mortality Review Tool and all cases are reviewed.
- Cancelled operations not rebooked within 28 days have been higher this year than previously.
- Overall referral to treatment standard is not improving, and the number of patients waiting more than 52 week is increasing, the focus being on prioritising the longest waiters as well those most clinically urgent.
- Compliance with cancer treatment waiting time standards is recognised as a strategic risk; the position will be improved through delivery of action plans to improve access and processes within specific tumour groups enabling earlier diagnosis. As a result, the number of patients waiting beyond 62 days is decreasing.

- Sickness absence rates are consistently above the Trust's internal plan, ongoing focus on sickness management process leading to some improvement in rates of absence at department level.

The Board is advised of areas of performance where there is ongoing focus to improve performance and/or or assurance.

For NTHFT the Board is advised:

- In maternity services, breastfeeding rates are improving upon historic levels but remain below the regional average. Post-partum hemorrhage rates are not consistently achieving the local standard set.
- Readmission rates are higher than plan, and this is being investigated by audit.
- The Trust focus continues around elective recovery and reducing the number of long waiters from both an RTT and cancer perspective, in which the Trust has reported improvements. It is anticipated that increases in demand will be evident over the winter months, however winter plans have now been agreed which set out how the Trust will safely manage the increased demand.
- The financial position shows a small adverse variance year to date against month 5 plan. Financial controls are in place, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

For STHFT the Board is advised:

- Within maternity services, breastfeeding rates are improving, as a result of supportive interventions, but remain below the regional average. Patient feedback in maternity services is consistent but lower than historically reported.
- Demonstrated improvement in urgent and emergency care metrics, with the focus being on streaming to the JCUH urgent treatment centre to maximise the patients seen appropriately in UTC and within 4 hours, and reducing ambulance handover delays in the Emergency Department.
- Patient feedback from users of A&E is not consistently above the standard we have set.
- Diagnostic 6-week wait is improving and cancer diagnosis within 28 days performing above the national standard of 77%.
- Financial position in line agreed plan. Financial controls are in place, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

For NTHFT the Board is assured:

- Maternal 3rd/4th degree tears during birth are consistently lower than plan.
- Standardised mortality is 'as expected'.
- A&E 4-hour standard and ambulance handover performance against plan is consistently met.

- Patient experience metrics consistently meet the plans set, across A&E, inpatient, outpatient and community services.

For STHFT the Board is assured:

- Standardised mortality is 'as expected’.
- Community 2-hour urgent response rate consistently exceeds plan and is an important element of plans to manage winter pressures urgent and emergency care.
- Consistently positive patient feedback surveys results for outpatient and community services.

APPENDICES

IPR – reading room

Audit & Risk Committee – South Tees

Connecting to: South Tees Trust Board

Key topics discussed in the meeting:

Counter fraud - The Annual Report and Counter Fraud Functional Standard Return were approved.

External Audit - The Annual Auditors report for South Tees Hospitals NHS Foundation Trust was received.
A process to appoint auditors for 25/6 needs to be started as the current contract will end.
The accounts for South Tees Hospitals Charity and Associated Funds were reviewed and recommended for approval by the Corporate Trustee. A very satisfactory audit process

Internal Audit- Data Security and Protection review complete. Low risk, substantial assurance (prior year, medium risk)
Patient letters systems – passed to Resources committee. On agenda for October meeting.
Fire Audit follow up - passed to Quality committee to allow assurance to come to November Board
Outstanding Audit actions – progress made clearing older actions, but a significant number remain. More buy in and dialogue with PWC needed from action owners.

Risk management - Q1 BAF reviewed. Limited assurance on advancing digital maturity. This triangulates with the Internal audit findings around patient letters. Risk management report received. Systems for risk management continue to improve. Key operational risks are ready to be shared with the Board.

Group board delegation matrix assessment report received. This was a useful first attempt to show group and statutory decision making in a form that gives us assurance on appropriate decision making (ie not ultra vires) and conflicts of interest management.

Escalated items:

- Patient letters systems
- Fire audit follow up
- Terms of Reference for Board approval

Risks (Include ID if currently on risk register):

- No new risks.

University Hospitals Tees

Use of Seal

Meeting date: 5 November 2024

Reporting to: South Tees Trust Board

Agenda item No: 23

Report author: Jackie White, Head of Governance & Co Secretary

Action required: (select from the drop down list for why the report is being received)
Information

Delegation status (Board only and completed by the Corporate Secretariat): Matter reserved to Unitary Board

Previously presented to: n/a

NTHFT strategic objectives supported:

Putting patients first ☐

Valuing our people ☐

Transforming our services ☐

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A centre of excellence ☒

A great place to work ☒

Deliver care without boundaries ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

In line with the Trust's Constitution this report provides information on the documents affixed under seal between 1 December 2023 and 29 October 2024.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

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).

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

n/a

Recommendations:

The Trust Board of Directors are asked to note the sealed documents report.

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 that were affixed under seal during 1 December 2023 and 29 October 2024.

Table 1. Sealed Documents

Date of Sealing	Seal No	Document	Signed and Sealed by
13 December 2023	2023/010	Lease relating to community services space, Glebe House Surgery, 19 Firby Road, Beadale, DL8 2AT, between Laura Helen Mezas, Rachael Mary Emison, Rhiannon Lorna Olwen Bigham, Lisa Kitson, Alex Hetmanski and South Tees Hospitals NHS Trust	Derek Bell, Chairman Sue Page, Chief Executive
13 December 2023	2023/011	Settlement agreement (Duplicate – 3/4/23 / 001, between South Tees Hospitals NHS Trust and Endeavour SCH PLC, Serco Limited	Derek Bell, Chairman Sue Page, Chief Executive
15 January 2024	2024/001	Tenancy Agreement relating to 85 South Parade, Northallerton, DL7 8SJ between Broadacres Housing Association and South Tees Hospitals NHS Trust,	Rob Harrison, Managing Director Derek Bell, Chairman
15 January 2024	2024/002	Letter of indemnity – Capital Works, Variation VO745 – Urgent Treatment Centre, between South Tees Hospitals NHS Trust and Endeavour SCH PLC	Rob Harrison, Managing Director Derek Bell, Chairman
6 August 2024	2024/003	Letter of indemnity – Capital works Variation VO771 – Creation of new entrance lobby area A&E between South Tees Hospitals NHS Trust and Endeavor SCH PLC	Chris Hand, Chief Finance Officer Derek Bell, Chairman
10 September 2024	2024/004	Engrossment documents – Spinal Works variation V0626, supplementary agreement, notice of assignment between South Tees Hospitals NHS Trust and Endeavour SCH PLC	Stacey Hunter, Chief Executive Derek Bell, Chairman

1 October 2024	2024/005	Supplementary Agreement (Duplicate – 3/4/23 and 13/12/23) between South Tees Hospital NHS Trust and Endeavor SCH PLC and Serco limited	Chris Hand, Chief Finance Officer Stacey Hunter, Chief Executive
29 October 2024	2024/006	UTC Supplementary works V0772 letter of indemnity and notice of assignment between South Tees Hospitals NHS Trust and Endeavour SCH PLC	Chris Hand, Chief Finance Officer Stacey Hunter, Chief Executive

2.0 Recommendation

The Board is asked to note the documents included within the report that were affixed under seal during 1 December 2023 and 29 October 2024.

University Hospitals Tees

Audit & Risk Committee Terms of Reference – South Tees

Meeting date: 5 November 2024

Reporting to: Board of Directors

Agenda item No: 24

Report author: Jackie White, Company Secretary & Head of Governance

Action required: (select from the drop down list for why the report is being received)
Approval

Delegation status (Board only and completed by the Corporate Secretariat): Matter reserved to Unitary Board

Previously presented to: Audit & Risk *Committee*

NTHFT strategic objectives supported:

Putting patients first ☐

Valuing our people ☐

Transforming our services ☐

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A centre of excellence ☒

A great place to work ☒

Deliver care without boundaries ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The Audit & Risk Committee have reviewed their terms of reference following the publication of the HFMA NHS audit committee handbook, taking into account the effectiveness review of the Committee and working in common with the Audit Committee of North Tees & Hartlepool NHS Trust which require Trust Board approval.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

On the 2 April 2024 the Board of South Tees Hospitals NHS Foundation Trust agreed to jointly exercise its powers to delegate functions to the Group Board. This was in line with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions. Items which cannot be delegated would continue to be considered at Unitary Boards.

It was agreed that the Audit & Risk Committee would remain separate and distinct from the Group Board and Group Committees in order to provide assurance to the Unitary Board

The terms of reference will be reviewed on an annual basis in line with the Committee effectiveness review and / or legislation and guidance in relation to the operation of Audit Committees or changes to the Group arrangements.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The terms of reference are in line with good practice, these were considered by the Audit & Risk Committee which included external and internal audit partners.

In line with the governance arrangements for the Group Board, the Audit & Risk Committee will remain independent and provide assurance to the Trust Board of Directors.

Recommendations:

The Trust Board of Directors are asked to approve the terms of reference.

NHS
University Hospitals Tees

Audit & Risk Committee
South Tees Hospitals NHS Trust

Terms of Reference

Table of Contents

1. Introduction

The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Audit & Risk Committee (The Committee). The Committee is a non-executive committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose

2.1 The purpose of the Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports achievement of the organisation's objectives.

2.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board of Directors to obtain outside legal or independent advice and to see the attendance of outsiders with relevant experience and expertise if it considers necessary.

3. Roles and responsibilities

3.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reviews, reporting and self certifications
- the policies and procedures for all work related to counter fraud and security as required by the NHS Counter Fraud Authority.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

As part of its integrated approach, the Committee will have effective relationships with other Trust Board Committees to provide an understanding of processes and linkages and particularly to enable review and oversight of the other Committee's governance of risk. This will include the exchange of their chair's action logs and highlight reports to the Trust Board

3.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards 2017* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors of Directors. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

3.3 External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment (in conjunction with the Council of Governors) and performance of the external auditors, as far as the rules governing the appointment permit

- discussion and agreement with the external auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan and ensuring coordination, as appropriate, with other external auditors in the local health economy

- discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

- reviewing all external audit reports, including the report to those charged with governance (before its submission to the Governing Body) and any work undertake outside the annual audit plan, together with the appropriateness of management responses.

- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

3.4 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality and Assurance Committee the Resource Committee and People Committee.

3.5 Counter Fraud

The Committee will review the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's requirements and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

3.6 Freedom to speak up

To review the adequacy of the Trust's arrangements (whistleblowing arrangements) by which Trust staff and other individuals where relevant, may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control; clinical quality; patient safety or other matters or any other matters of concern. The Committee shall receive its assurance that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action through the Non-Executive Freedom to Speak up champion.

3.7 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit).

3.8 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors of Directors, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques

- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- Letters of representation
- Qualitative aspects of financial reporting

3.9 Risk Management

The Committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the Committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's risk management strategy and recommending its approval to the Board of Directors
- Provide assurance to the Board of Directors that the organisation is compliant with the NHS England EPRR core standards and has an effective business continuity process in place.
- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks
- Overseeing actions plans relating to regulatory requirements in terms of the Single Oversight Framework and Use of Resources
- Providing the Board with assurance over developing partnership arrangements (e.g. accountable care organisations) and mitigation of risks which may arise at the borders between such organisations
- To agree the strategy in place to manage risks on the organisational risk register, including identification of appropriate risk owners, and monitoring the satisfactory operation of the risk management policy.
- Review the Trusts Risk Appetite statement. Ensure that risk is identified and managed proactively in accordance with the Board's risk appetite
- Ensure through the Trust's governance and divisional structures that risk management systems and processes are adhered to across the Trust.
- Ensure that each Collaborative and Corporate Department maintains a robust risk register and risk management processes in line with the Trust's Risk Management Strategy by receiving and testing the risk registers.

The Board will however retain the responsibility for routinely reviewing specific risks.

3.10 Governance regulatory compliance

The committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons test.

The Committee shall satisfy itself that the organisations's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

3.1 Authority

The committee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the UHT Board.
Commission	Commission reports required to help fulfil its obligations.
Obtain advice	Instruct and obtain independent external legal or professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any relevant procedures put in place for obtaining professional advice.

3.2 Delegation by Schedule 1 Scheme of Delegation

Decisions Delegated by Schedule 1 Scheme of Delegation
The Committee is a formal committee of the South Tees Hospitals NHS Foundation Trust Board. The Board has delegated authority to the Committee as set out in in the terms of reference and may be amended from time to time. The Committee holds only those powers as delegated in these terms of reference as determined by the Board.

3.3 Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the South Tees Hospitals NHS Foundation Trust Board. The minutes of meetings shall be formally recorded. The Secretariat formally records the minutes of each meeting. The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, key actions taken with regard to use of resource issues, escalating key risks and any concerns where necessary. The Committee will receive scheduled assurance reports from its delegated subgroups/task and finish groups.
Monitor attendance	Attendance is monitored as part of the agenda at each Committee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings, and read all papers

Accountabilities	Description
Annual Cycle of Business	The Committee produces an annual cycle of business in consultation with the Board. The Committee cycle of business informs the standing agenda items as described within the terms of reference, to ensure all regulatory, statutory, and legislative items are adequately reviewed and acted upon.
Conduct annual self-assessment	The Committee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted for approval by the Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report includes: • A summary of the business conducted • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

4. Committee meetings

4.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements. This section sets out the meeting composition and quoracy requirements. All meetings will be closed and held in private.

Composition/ quoracy	Description of expectations
Chair	The Committee will be chaired by a Non-Executive Member of the Board.
Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the Board.
Absence of Chair or Vice Chair	In the absence of the Chair, or Vice Chair, an alternative Non Executive Director member will be nominated to chair the meeting. If the Chair has a conflict of interest, then the Vice-Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Composition/ quoracy	Description of expectations
Membership	Non Executive Director – 3 including the Chair of the Committee
Attendees and procedure for absence	The Chief Finance Officer, and the Company Secretary, shall normally attend meetings. Representatives of the external auditor and internal audit will attend. The Counter fraud specialist will attend a minimum of two committee meetings a year. Only members of the Committee have the right to attend meetings, but the Chief Executive shall generally be invited to attend routine meetings of the audit and risk committee. The Accountable (or Accounting Officer) should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts. Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager. Representatives from other organisations (for example, NHSCFA) and other individuals may be invited to attend on occasion, by invitation.

Composition/ quoracy	Description of expectations
Quoracy and Procedure for In quoracy	The Committee has no decision making authority unless there are 2 Non Executive Directors present. In the event that a meeting of the Committee is not quorate, the Chair can decide that the meeting will progress, but where decisions are required, they will be deferred to the next meeting when the committee is quorate. **Disqualification:** If any member of the Committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum.

4.2 Frequency and formats

This section on Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Committee will meet five times a year additional meetings may be arranged as required. The chair of the committee, board, Accounting (or Accountable) Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting
Open vs closed	All Committee meetings will be held in private and be closed

4.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The Chair is responsible for agreeing the agenda in advance of the meeting and ensuring matters discussed meet the objectives as set out in these ToR. After the Committee meeting, time is allowed for reflection between the Chair and lead executive to consider action and future agenda.

Procedure	Description of rules and expectations:
Conflicts of interest	**Declarations:** All members, and those in attendance, must declare any actual or potential conflicts of interest. This is recorded in the minutes. **Exclusions:** The Committee will follow and apply the Standards of Business Conduct with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Conduct	Members will be expected to conduct business in line with the values and objectives of the Board. Members of, and those attending, the Committee shall behave in accordance with the Board Constitution, Standing Orders, and Standards of Business Conduct and Declaration's of Interest Policy

5. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the Committee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers no less than five working days before each meetings with the exemption of any urgent papers.
Monitor attendance	Monitor the attendance of those invited to each meeting on an annual basis.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the Chair, circulate minutes promptly according to guidance. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the Chair in preparing reports for the Board. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for committee members

6. Appendix I: Revision History

Version	Date	Approved by	Review	Type of changes
V1.0		Board	Annually	

Review date: September 2025

Audit Committee – North Tees & Hartlepool

Connecting to: North Tees & Hartlepool Trust Board

Key topics discussed in the meeting:

- Received a verbal update from the Trust's external auditors Deloitte LLP on progress with the audit of the Trust's accounts – report has been issued, subsidiary audits ongoing, no issues noted currently.
- Received and reviewed the Internal Audit Progress Report, including the reasonable assurance report issued regarding domestic services. IA confirmed they are on track with progress on planned audits in the current year. Agreed to allocate five days from the 2024/25 contingency allocation to the ICB Financial Controls Review (returning five days to contingency), and to cancel the previously scheduled CIP audit in the light of that ICB review being carried out. Reviewed and noted the number of overdue IA recommendations, including nine which had exceeded their original dates by over a year, and three medium priority recommendations which had been extended three times or more. It was agreed that any IA recommendation which (a) was over one year overdue or (b) had been extended three times or more, must come to the Committee for discussion and for prior agreement of any further extension.
- Also received two IA Benchmarking Reports: (a) IA Recommendations Management and (b) Review of Medical Staff Job Planning Policies.
- Reviewed and noted the Losses and Compensation Payments Report, noting the need for the Trust to work on reducing store losses.
- Reviewed and noted the Statement of Debtors report, noting that the balance of debtor invoices over three months old has decreased, as has the NHS debtors balance.
- Received, discussed and agreed the proposed revised Terms of Reference for the Committee, reflecting the latest guidance in the HFMA NHS Audit Handbook. It was noted that a third NED would be added to the Committee for purposes of quoracy. A draft annual cycle of business for the Committee will be worked up and will come to the next Committee meeting for review and agreement.
- The Group Board Delegation Matrix Assessment was received for information and was noted.
- Received the IPR for August 2024, to gain assurance that processes are effective. It was noted that the IPR no longer needed to come to this Committee, on the basis that relevant sections are reviewed by Board Committees and the whole IPR goes to each Group Board meeting for review.

- Received and noted the Interim BAF as at 31st August 2024, to gain assurance that key risks have been captured and are being managed under the Trust's agreed processes. Noted that the BAF has been fully reviewed for 2024/25, and reporting under the new arrangements will commence with effect from 1st September 2024, aligning with the reporting periods of the revised IPR.

Actions:

- Final Audit Committee ToR to go to the Group Board for approval - JW.
- Third NED to be added to the Committee – Chair and JW to discuss and agree nomination with Trust Chair prior to 31/12/2024.
- Overdue IA recommendations – SI to raise at Executive Team to stress importance of dealing with IA actions, and to reflect new requirements above.
- ICB Audit report will come to this Committee in due course, following its issue.
- IA Reports on (a) Domestic Services Standards of Cleanliness (b) Cancer 62 day Standards (c) Duty of Candour and (d) Single Point of Contact/Multi Agency Protection Arrangements to go to next Quality Committee for information - JW.
- IA Report on ICT Service Desk Incident and Problem Management to go to next Finance & Resources Committee for information - JW.
- IA Benchmarking Report on Medical Staff Job Planning Policies to go to next People Committee for information - JW.
- Draft annual cycle of business to come to the next Committee meeting.

Escalated items:

Following substantial work, the revised BAF will come to the next Committee meeting.

Risks (Include ID if currently on risk register):

- No new risks.

NHS
University Hospitals Tees

Audit Committee Terms of Reference – North Tees & Hartlepool

Meeting date: 5 November 2024

Reporting to: Board of Directors

Agenda item No: 24

Report author: Jackie White, Company Secretary & Head of Governance

Action required: (select from the drop down list for why the report is being received)
Approval

Delegation status (Board only and completed by the Corporate Secretariat): Matter reserved to Unitary Board

Previously presented to: Audit *Committee*

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☐

A centre of excellence ☐

A great place to work ☐

Deliver care without boundaries ☐

Make best use of our resources ☐

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to the matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy.

The Audit Committee have reviewed their terms of reference following the publication of the HFMA NHS audit committee handbook, taking into account the effectiveness review of the Committee and working in common with the Audit & Risk Committee of South Tees Hospitals NHS Trust which require Trust Board approval.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

On the 2 April 2024 the Board of North Tees & Hartlpeool NHS Foundation Trust agreed to jointly exercise its powers to delegate functions to the Group Board. This was in line with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions. Items which cannot be delegated would continue to be considered at Unitary Boards.

It was agreed that the Audit Committee would remain separate and distinct from the Group Board and Group Committees in order to provide assurance to the Unitary Board

The terms of reference will be reviewed on an annual basis in line with the Committee effectiveness review and / or legislation and guidance in relation to the operation of Audit Committees or changes to the Group arrangements.

ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The terms of reference are in line with good practice, these were considered by the Audit Committee which included external and internal audit partners.

In line with the governance arrangements for the Group Board, the Audit Committee will remain independent and provide assurance to the Trust Board of Directors.

Recommendations:

The Trust Board of Directors are asked to approve the terms of reference.

NHS
University Hospitals Tees

Audit Committee
North Tees & Hartlepool NHS Trust

Terms of Reference

Table of Contents

1. Introduction

The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Audit Committee (The Committee). The Committee is a non-executive committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose

2.1 The purpose of the Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports achievement of the organisation's objectives.

2.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board of Directors to obtain outside legal or independent advice and to see the attendance of outsiders with relevant experience and expertise if it considers necessary.

3. Roles and responsibilities

3.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reviews, reporting and self certifications
- the policies and procedures for all work related to counter fraud and security as required by the NHS Counter Fraud Authority.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

As part of its integrated approach, the Committee will have effective relationships with other Trust Board Committees to provide an understanding of processes and linkages and particularly to enable review and oversight of the other Committee's governance of risk. This will include the exchange of their chair's action logs and highlight reports to the Trust Board

3.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards 2017* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors of Directors. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

3.3 External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment (in conjunction with the Council of Governors) and performance of the external auditors, as far as the rules governing the appointment permit

- discussion and agreement with the external auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan and ensuring coordination, as appropriate, with other external auditors in the local health economy

- discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

- reviewing all external audit reports, including the report to those charged with governance (before its submission to the Governing Body) and any work undertake outside the annual audit plan, together with the appropriateness of management responses.

- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

3.4 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality and Assurance Committee the Resource Committee and People Committee.

3.5 Counter Fraud

The Committee will review the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's requirements and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

3.6 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit).

3.7 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors of Directors, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- Letters of representation
- Qualitative aspects of financial reporting

3.8 Risk Management

The Committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks

the Committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's risk management strategy and recommending its approval to the Board of Directors
- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks
- Overseeing actions plans relating to regulatory requirements in terms of the Single Oversight Framework and Use of Resources
- Providing the Board with assurance over developing partnership arrangements (e.g. accountable care organisations) and mitigation of risks which may arise at the borders between such organisations
- To agree the strategy in place to manage risks on the organisational risk register, including identification of appropriate risk owners, and monitoring the satisfactory operation of the risk management policy.
- Review the Trusts Risk Appetite statement. Ensure that risk is identified and managed proactively in accordance with the Board's risk appetite
- Ensure through the Trust's governance and divisional structures that risk management systems and processes are adhered to across the Trust.
- Receive assurance that Care Groups and Corporate Department maintains a robust risk register and risk management processes in line with the Trust's Risk Management Strategy by receiving and testing the risk registers.

The Board will however retain the responsibility for routinely reviewing specific risks.

3.9 Governance regulatory compliance

The committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons test.

The Committee shall satisfy itself that the organisations's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

4.1 Authority

The committee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the UHT Board.
Commission	Commission reports required to help fulfil its obligations.
Obtain advice	Instruct and obtain independent external legal or professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any relevant procedures put in place for obtaining professional advice.

4.2 Delegation by Schedule 1 Scheme of Delegation

Decisions Delegated by Schedule 1 Scheme of Delegation
The Committee is a formal committee of the North Tees & Hartlepool NHS Foundation Trust Board. The Board has delegated authority to the Committee as set out in in the terms of reference and may be amended from time to time. The Committee holds only those powers as delegated in these terms of reference as determined by the Board.

4.3 Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the North Tees & Hartlepool NHS Foundation Trust Board. The minutes of meetings shall be formally recorded. The Secretariat formally records the minutes of each meeting. The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, key actions taken with regard to use of resource issues, escalating key risks and any concerns where necessary. The Committee will receive scheduled assurance reports from its delegated subgroups/task and finish groups.
Monitor attendance	Attendance is monitored as part of the agenda at each Committee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings, and read all papers

Accountabilities	Description
Annual Cycle of Business	The Committee produces an annual cycle of business in consultation with the Board. The Committee cycle of business informs the standing agenda items as described within the terms of reference, to ensure all regulatory, statutory, and legislative items are adequately reviewed and acted upon.
Conduct annual self-assessment	The Committee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted for approval by the Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report includes: • A summary of the business conducted • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

5. Committee meetings

5.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements. This section sets out the meeting composition and quoracy requirements. All meetings will be closed and held in private.

Composition/ quoracy	Description of expectations
Chair	The Committee will be chaired by a Non-Executive Member of the Board.
Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the Board.
Absence of Chair or Vice Chair	In the absence of the Chair, or Vice Chair, an alternative Non Executive Director member will be nominated to chair the meeting. If the Chair has a conflict of interest, then the Vice-Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Composition/ quoracy	Description of expectations
Membership	Non Executive Director – 3 including the Chair of the Committee
Attendees and procedure for absence	The Chief Finance Officer, and the Company Secretary, shall normally attend meetings. Representatives of the external auditor and internal audit will attend. The Counter fraud specialist will attend a minimum of two committee meetings a year. Only members of the Committee have the right to attend meetings, but the Chief Executive shall generally be invited to attend routine meetings of the audit committee. The Accountable (or Accounting Officer) should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts. Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager. Representatives from other organisations (for example, NHSCFA) and other individuals may be invited to attend on occasion, by invitation.

Composition/ quoracy	Description of expectations
Quoracy and Procedure for In quoracy	The Committee has no decision making authority unless there are 2 Non Executive Directors present. In the event that a meeting of the Committee is not quorate, the Chair can decide that the meeting will progress, but where decisions are required, they will be deferred to the next meeting when the committee is quorate. **Disqualification:** If any member of the Committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum.

5.2 Frequency and formats

This section on Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Committee will meet five times a year additional meetings may be arranged as required. The chair of the committee, board, Accounting (or Accountable) Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting
Open vs closed	All Committee meetings will be held in private and be closed

5.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The Chair is responsible for agreeing the agenda in advance of the meeting and ensuring matters discussed meet the objectives as set out in these ToR. After the Committee meeting, time is allowed for reflection between the Chair and lead executive to consider action and future agenda.

Procedure	Description of rules and expectations:
Conflicts of interest	**Declarations:** All members, and those in attendance, must declare any actual or potential conflicts of interest. This is recorded in the minutes. **Exclusions:** The Committee will follow and apply the Standards of Business Conduct with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Conduct	Members will be expected to conduct business in line with the values and objectives of the Board. Members of, and those attending, the Committee shall behave in accordance with the Board Constitution, Standing Orders, and Standards of Business Conduct and Declaration's of Interest Policy

6. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the Committee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers no less than five working days before each meetings with the exemption of any urgent papers.
Monitor attendance	Monitor the attendance of those invited to each meeting on an annual basis.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the Chair, circulate minutes promptly according to guidance. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the Chair in preparing reports for the Board. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for committee members

7. Appendix I: Revision History

Version	Date	Approved by	Review	Type of changes
V1.0		Board	Annually	

Review date: September 2025