NHS
University Hospitals Tees

Group Board Meeting

Thursday, 4 September 2025 at 13:00

Boardroom, 2nd Floor, Murray Building, James Cook University Hospital

Caring Better Together

University Hospitals Tees

MEETING OF THE GROUP BOARD TO BE HELD IN PUBLIC
ON THURSDAY 4 SEPTEMBER 2025 AT 1:00pm
BOARDROOM, 2ND FLOOR, MURRAY BUILDING, JAMES COOK UNIVERSITY HOSPITAL

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT	TIME
1. CHAIR'S BUSINESS					
1.1	Patient/Staff Story	Information	Group Chair	Verbal	13:00
1.2	Welcome and Introductions	Information	Group Chair	Verbal	13:20
1.3	Apologies for Absence	Information	Group Chair	Verbal	
1.4	Quorum and Declarations of Interest	Information	Group Chair	ENC	
1.5	Minutes of the last meeting held on 3 July 2025	Approval	Group Chair	ENC	13:25
1.6	Matters Arising and Action Log	Information	Group Chair	ENC	13:30
1.7	Group Chair's Report	Information	Group Chair	ENC	13:35
1.8	Group Chief Executive's Report	Information	Group Chief Executive	ENC	13:45
1.9	Group Management Team Chairs Log: June and July 2025	Information	Group Chief Executive	ENC	14:00
1.10	University Hospital Tees (UHT) Strategy Update	Assurance	Group Chief Strategy Officer	ENC	14:05
1.11	Board Assurance Framework	Assurance	Director of Risk, Assurance & Compliance	ENC	14:15
2. QUALITY AND SAFETY					
2.1	Quality Committee Chairs Log: July 2025	Assurance	Chair of Committee	ENC	14:25

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
2.2	Perinatal Quality and Safety Report	Assurance	Group Director of Midwifery	ENC	14:35
2.3	Perinatal Staffing Report	Assurance	Group Director of Midwifery	ENC	14:40
3. PEOPLE					
3.1	People Committee Chairs Log: July 2025	Assurance	Chair of Committee	ENC	14:45
3.2	Nurse Safer Staffing Report	Assurance	Group Chief Nurse	ENC	14:55
3.3	WRES Report	Approval	Group Chief People Officer	ENC	15:05
3.4	WDES Report	Approval	Group Chief People Officer	ENC	15:10
4. FINANCE & PERFORMANCE					
4.1	Resources Committee Chairs Log: July and August 2025	Assurance	Chair of Committee	ENC	15:15
4.2	Finance Report - Month 3: 2025/26	Assurance	Deputy Director of Finance	ENC	15:25
4.3	Integrated Performance Report	Assurance	Group Managing Director	ENC	15:35
4.4	Winter Plan 2025/26	Approval	Site Chief Operating Officers	ENC	15:45
4.5	Senior Independent Director Appointment	Approval	Company Secretary	ENC	15:55
4.6	Board Committee Terms of Reference	Approval	Company Secretary	ENC	16:05

	ITEM	PURPOSE	LEAD	FORMAT	TIME
5. SOUTH TEES HOSPITALS NHS TRUST UNITARY BOARD					
5.1	Maggie's Handover	Assurance	Group Managing Director	ENC	16:15
5.2	Audit & Risk Committee Chairs Log: June/July 2025	Assurance	Chair of Committee	ENC	16:20
5.3	AGM Minutes 2024	Approval	Company Secretary	ENC	16:25
6. NORTH TEES & HARTLEPOOL NHS TRUST UNITARY BOARD					
6.1	Audit Committee Chairs Log: July 2025	Assurance	Chair of Committee	ENC	16:30
6.2	AGM Minutes 2024	Approval	Company Secretary	ENC	16:35
CLOSE					
	DATE OF NEXT MEETING The next meeting of the Group Board of Directors will take place on Thursday 6 November 2025 in the Board Room, Murray Building, James Cook University Hospital				

University Hospitals Tees

Register of members interests

Meeting date: 4 September 2025

Reporting to: Group Board of Directors

Agenda item No: 1.4

Report author: Jackie White, Head of Governance/Company Secretary

Executive director sponsor: Jackie White, Head of Governance/Company Secretary

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: *n/a*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

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 due to 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 Board of Directors 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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Alison Fellows	Non-Executive Director		Ongoing	Husband Partner at Firm – Ward Hadaway Solicitors
		December 2023	Ongoing	Governor of the Board and member of the Audit Committee Northumbria University
		December 2023	Ongoing	Independent Member of the Audit Committee Newcastle City Council
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Alison Wilson	Non-Executive Director	4 January 2022	Ongoing	Civil Partner – Counter Terrorism Policing North East
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation 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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Chris Day	Non-Executive Director		Ongoing	Vice-Chancellor and President, Newcastle University
			Ongoing	Institutional Member, Universities UK (UUK)
			Ongoing	Board Member, The Russell Group
			Ongoing	Board Member, Sir Bobby Robson Foundation
			Ongoing	Chair, N8 Research Partnership
			Ongoing	Trustee, Foundation for Liver Research
			Ongoing	Chair of PILOT Institutional Level PCE Panel, Research England (part of UK Research and Innovation)
			Ongoing	Trustee, Newcastle University Development Trust

Board Member	Position	Relevant Dates From	to	Declaration Details
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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		April 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Trust on NTH Solutions LLP – Company Number OC419412
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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Emma Nunez	Group Chief Nurse	April 2025	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Fay Scullion	Non-Executive Director	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		October 2024	Ongoing	Chief Executive, Age UK North Yorkshire & Darlington
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 Foundation Trust
Ken Anderson	Group Chief Information Officer	May 2024	Ongoing	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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
			Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board

Board Member	Position	Relevant Dates From	to	Declaration Details
Matt Neligan	Group Chief Strategy Officer	October 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		May 2025	Ongoing	Founding member, Evolve Collaborative (supported by NHS Confederation and Beamtree)
Mark Dias		20 July 2015	Ongoing	Director of Be The Change HR Ltd – Company No. 9694576
		September 2023	Ongoing	Permanent Deacon in Training (Voluntary Position). Roman Catholic Diocese of Middlesbrough
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		March 2025	Ongoing	Chair of Board of Nicholas Postgate Catholic Academy Trust
Michael Stewart	Group Chief Medical Officer			Wife is employed at South Tees NHS FT
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Miriam Davidson	Non-Executive Director		Ongoing	Local Government Association Associate, occasional work with English councils on Public Health Peer Reviews and facilitation of relevant workshops
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation 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 Foundation 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	NHS South East London Chair of SEL SEEC
		March 2024	Ongoing	Member of the Council for Newcastle University. No remuneration.
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation 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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board

Board Member	Position	Relevant Dates From	to	Declaration Details
Rowena Dean	Chief Operating Officer North Tees & Hartlepool NHS Trust			No declared interest
Ruth Dalton	Group Director of Communications	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Samuel Peate	Chief Operating Officer South Tees Hospitals NHS Foundation Trust	1 April 2021	Ongoing	None
Stacey Hunter	Group Chief Executive	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		March 2024	Ongoing	Director, Health Innovation North East North Cumbria Limited
		July 2024	Ongoing	Partner, Dr Cornelle Parker, ad hoc project work within organisations of the NHS
		April 2025	Ongoing	Chair of NHS Confederation Productivity Group
		May 2025	Ongoing	Member of NHS Confederation Acute Advisory Panel
		April 2025	Ongoing	Member of UHA Executive Steering Committee (hosted by NHS Providers)
		May 2025	Ongoing	Founding member, Evolve Collaborative (supported by NHS Confederation and Beamtree)
		Aug 2025	Ongoing	Lead, Leadership of Planned Care, Provider Leadership Board
		Aug 2025	Ongoing	Supporting national programme regarding neighbourhood health & review of secondary care
Steven Taylor	Group Director of Estates			Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board Son employed by NTH Solutions LLP – ICT Project Officer/Digital Performance Coordinator Wife employed by NTH Solutions LLP – Catering Assistant
Stuart Irvine	Director of Risk, Assurance and Compliance	2023	Ongoing	Chair – Hartlepool College of Further Education Trustee of Hospitals Trust of the Hartlepool Sons (x2) are employees at Hartlepool College of Further Education Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board

University Hospitals Tees

DRAFT Minutes of a meeting of the University Hospitals Tees Group Board held in Public at 1:00pm on Thursday, 3 July 2025 in the Cameron Suite, Health and Social Care Academy, 2nd floor, University Hospital Hartlepool

Present:
Professor Derek Bell, Group Chair (Chair)
Ann Baxter, Group Vice Chair/Non-Executive Director & Maternity Champion
Ali Wilson, Group Vice Chair/Non-Executive Director
Ada Burns, Group Non-Executive Director / Senior Independent Director
Ken Readshaw, Group Non-Executive Director
Fay Scullion, Group Non-Executive Director
Miriam Davidson, Group Non-Executive Director & Maternity Champion
David Redpath, Group Non-Executive Director
Mark Dias, Group Non-Executive Director
Stacey Hunter, Group Chief Executive
Matt Neligan, Group Deputy Chief Executive / Chief Strategy Officer
Neil Atkinson, Group Managing Director
Rachael Metcalf, Group Chief People Officer
Mike Stewart, Group Chief Medical Officer
Emma Nunez, Group Chief Nurse & Maternity Champion
Chris Dargue, Deputy Director of Finance, STHFT on behalf of Chris Hand

Directors – non-voting:
Ken Anderson, Group Chief Information Officer
Steve Taylor, Group Estates Director
Ruth Dalton, Group Director of Communications
Stuart Irvine, Director of Risk, Assurance & Compliance
Sam Peate, Site Chief Operating Officer, South Tees Hospitals NHS Foundation Trust
Jackie White, Head of Governance/Company Secretary

In Attendance:
Pam Shurmer, Elected Governor Hartlepool (for item 1 only)
Rebecca Denton-Smith, Associate Director of Nursing, NTHFT (for item 1 only)
Nanette Parkin, Senior Clinical Matron, STHFT (for item 1 only)
Mel Cambage, Group Deputy Director of Patient Experience and Involvement (for item 1 only)
Bob Norton, Elected Governor, Redcar and Cleveland (observer)
Janet Crampton, Lead Governor, STHFT (virtual observer)
Angela Warnes, Lead Governor, NTHFT (virtual observer)
Sarah Hutt, Assistant Company Secretary (note taker)
Gareth Lightfoot, Local Democracy Reporter, Gazette

GB25/057 Patient Story

The Chair welcomed Pam Shurmer, Elected Governor for Hartlepool who was sharing the story of her daughter Sarah's care, supported by Rebecca Denton-Smith, Associate Director of Nursing, NTHFT, Nanette Parking, Senior Clinical Matron, STHFT and Mel Cambage, Group Deputy Director of Patient Experience and Involvement.

Sarah expressed before she passed away in December 2024 that her story should be shared to improve the care provided to patients with cancer. She had been diagnosed in 2020 with stage 4 ovarian cancer aged 43. The story focused on the last 6 months of her life and the lack of care and

compassion she had received, with a number of examples provided both positive and negative relating to hospital admissions and the uncoordinated approach and knowledge by staff regarding her illness to manage her associated symptoms and complications.

Pam outlined a number of suggestions she wanted the organisation to consider regarding care of patients with cancer. These included staff seeking specialist advice if unsure of treatment, patients to be admitted to the hospital where active treatment was being carried out, staff's communication and compassion with patients, the level of noise in ward areas and offering different menu choices for a variety of dietary requirements. Sarah underwent counselling regarding her experience and made a decision she wished to die at home and not in hospital. As a family there were a number of staff who they wanted to individually thank for their part in Sarah's care.

Stacey Hunter, Group Chief Executive thanked Pam for sharing Sarah's story, which was very impactful for board members conveying that inappropriate behaviour of staff was not acceptable and should be highlighted. In reference to the good levels of care being provided by community teams, the organisation had ambitions as part of the UHT Strategy to support more patients in their homes providing a better experience and to apply the good practice taking place.

Emma Nunez, Group Chief Nurse echoed the sentiment of the Group Chief Executive and thanked Pam for sharing a balanced view of Sarah's care, highlighting what went well as well as what could have been done better.

Rebecca Denton-Smith, Associate Director of Nursing, NTHFT shared the internal improvement plan, which Pam had been involved in developing and highlighted that Sarah's story had been shared with all staff for learning. There were a number of immediate actions that had been implemented, including new accessible and user friendly menus for patients with individual patient needs highlighted in records and during noise levels in ward areas.

GB25/058 Welcome and Introductions

The Chair welcomed everyone to the meeting.

GB25/059 Apologies for Absence

Apologies for absence were reported from Chris Hand, Group Chief Finance Officer, Alison Fellows, Group Non-Executive Director, Professor Chris Day, Group Non-Executive Director and Rowena Dean, Chief Operating Officer, NTHFT.

GB25/060 Quorum and Declaration of Interests

The meeting was confirmed as quorate.

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

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 would be made to ensure appropriate action was taken.

GB25/061 Minutes of the last meeting held on, 8 May 2025

The minutes of the last meeting held on, 8 May 2025 were accepted as a true and accurate record subject to a minor amendment on page 5.

Resolved: that, the minutes of the meeting held on, 8 May 2025 be confirmed as a true and accurate record subject to the minor amendment on page 5.

GB25/062 Matters Arising and Action Log

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

Resolved: that, the verbal update be noted.

GB25/063 Group Chair's Report

The Chair highlighted the key points of the Group Chair's Report that included national, regional and local matters, taking the report as read.

It was noted that the updates reported from NHS England, the Integrated Care Board (ICB) and Trust Chairs meeting and NHS Confederation Expo had been superseded by the publication of the 10 Year Plan for Health, which had been published that day.

The importance of site walkabouts was emphasised providing good opportunities to meet with staff and gain insight into the delivery and function of services, highlighting the visit board members had undertaken that morning to services across the University Hospital Hartlepool site and the visit to the new Surgical Hub and Outpatient Department at the Friarage Hospital Northallerton by Governors on 26 June 2025.

Thanks and congratulations were placed on record for Liz Barnes, Group Non-Executive Director who had left on the organisation on 30 June 2025 to take up the role of Lord Lieutenant of Staffordshire. In addition, Professor Chris Day would be joining the organisation that month as a Group Non-Executive Director from Newcastle University to lead on the academic work streams.

National Veteran's Aware Day took place on Saturday, 28 June 2025 and was the culmination of a number of celebrations planned that week, including recognising Reserves Day on 25 June 2025. It was the ambition of the organisation to achieve the veteran aware accreditation gold standard for both STHFT and NTHFT, with NTHFT currently at silver.

Ada Burns, Group Non-Executive Director / Senior Independent Director congratulated the Chair on his recent honorary degree from Teesside University in recognition of his contribution to academia nationally and globally.

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

GB25/064 Group Chief Executive's Report

Stacey Hunter, Group Chief Executive highlighted the key points of the Group Chief Executive's Report, taking the report as read. Similar to the Group Chair's Report, information reported at the time of writing had been superseded by the launch of the 10 Year Plan for Health.

There were three main focuses or 'shifts' in the plan, which was described by the Secretary of State as a call to arms, the shifts were hospital to community – neighbourhood health, analogue to digital and sickness to prevention, as well as funding flows, which were already at the centre of the UHT Strategy. It was noted that there was still a lot of detail awaited around specific aspects of the plan, once understood the Group Deputy Chief Executive / Chief Strategy Officer would circulate a summary of the plan headlines. The Board would set aside time to assess risk and consider what framework the organisation should be operating within. Thanks was passed to the Group Director Communication for the work of her team in the lead up to the release of the plan with a number of briefings to key stakeholders issued. It was highlighted that the organisation was positively cited three times in the plan for good practice.

Staff had recently been invited to take part in a 'cost of caring' conversation to come up with ideas around resource reduction and it was important to continue to promote the brilliant things staff were doing every day especially whilst in a period of change.

Ali Wilson, Group Vice Chair/Non-Executive Director commended the organisation on the reaccreditation for STHFT as a menopause friendly employer, which was an industry-recognised accreditation, highlighting that during the staff wellbeing walkabouts menopause was an issue often mentioned. Members of staff in need of support at NTHFT were being identified and teams were

working together to provide that support.

Resolved: (i) that, the content of the report be noted; and
(ii) that, a summary of the 10 Year Plan for Health be circulated to board members once further detail was known.

GB25/065 Chair's Log – Group Management Team Meeting

The Group Chief Executive presented the Chair's Log for the meeting of the Group Management Team (GMT) held on 22 May 2025.

Resolved: that, the content of the Chair's Log be noted.

GB25/066 University Hospital Tees (UHT) Group Strategy Update

Matt Neligan, Group Deputy Chief Executive/Chief Strategy Officer provided an update regarding the UHT Group Strategy, which was agreed in May 2025, confirming that regular updates would be provided to Board with selected highlights to ensure visibility and focus.

An important part of the strategy was engagement and it was noted that over 1,000 stakeholders across a variety of forums had been involved in the development of the Strategy. For key service changes requiring formal consultation, this would be agreed through the appropriate channels. Future reporting would be aligned to the three pillars in the Strategy, Patients and populations, People, Partnerships and places. The Clinical Services Strategy was at the centre of the Patients and populations pillar, and the aim was that the role of the clinical boards in developing future clinical strategy would pass to the new clinical leadership teams from September. Rachael Metcalf, Group Chief People Officer was leading the work around a single clinical management and leadership structure across UHT to deliver joined up group wide services, which was currently out to consultation. The focus in September was developing a Strategic Outline Case for the replacement of a substantial part of the North Tees Hospital estate and updated metrics that would demonstrate delivery against the Strategy.

Ali Wilson, Group Vice Chair/Non-Executive Director sought to understand how the patient voice would be embedded in the Strategy. It was noted there had been a number of mechanisms including, stakeholder engagement events, existing community and voluntary sector groups and embedding the expert use of voices into project teams, noting that Governors were part of the engagement groups.

Following a query by Ada Burns, Group Non-Executive Director/Senior Independent Director regarding engagement with the Mayor of the Combined Authority, Stacey Hunter, Group Chief Executive confirmed that the organisation engaged regularly with the combined authority and the relationship was well embedded.

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

GB25/067 Board Assurance Framework

Stuart Irvine, Director of Risk, Assurance and Compliance presented the Board Assurance Framework (BAF) Update to the period 30 April 2025 and highlighted the key points. Standardised and consistent reporting arrangements were now embedded at Committee and Board level and were aligned to the Integrated Performance Report (IPR) to support triangulation of key performance metrics and the mitigation of strategic risks. It was noted that the BAF had been refreshed for 2025/26 and aligned to the new strategic objectives, annual plan submission and consideration of the increased risk environment the organisation was operating in.

For NTHFT:

- 30 strategic risks
- 10 strategic risks outside the approved risk appetite, with 7 red/high risks
- 111 planned mitigating actions

For STHFT:

- 30 strategic risks
- 11 strategic risks outside the approved risk appetite, with 8 red/high risks
- 115 planned mitigating actions

Stacey Hunter, Group Chief Executive posed a question to the Committee chairs to consider whether given the number of reported strategic risks currently outwith of tolerance whether they thought there was anything the organisation should be doing differently or whether current mitigating actions were sufficient. In addition, observed that some of the risk scores were high for example in relation to research and innovation and similarly delivery to date of the alcohol care team and should be reviewed proportionately with one risk in relation to the strategic ambition of the organisation and the other a fundamental operational risk, prompting a productive discussion.

David Redpath, Chair of Resources Committee suggested each Committee should review the risks to identify if any further actions were required. Mark Dias, Chair of People Committee confirmed it should be reviewed formally through the Committees, highlighting that there was good triangulation in place between Committees and Board. The discussion focused on the importance of ensuring the correct mitigating actions were in place and a way to measure the effectiveness of the actions, as well as the level of confidence to manage the risks. Ken Readshaw, Chair of Audit and Risk Committee acknowledged that the BAF had matured and was an effective working document. Stuart Irvine, Director of Risk, Assurance and Compliance explained that a quarterly assessment of the effectiveness of the BAF and assurance gained would be undertaken and reported to Board.

Jackie White, Head of Governance/Company secretary asked whether the Board should consider changing the current risk appetite for the System Working and Reform BAF domain from open to seek, in light of the 10 Year Plan for Health and the organisation's ambition to seek opportunities for reform in progressing delivery of the UHT Strategy, prompting further discussion. It was agreed to have a session in September to review the risk appetite in detail in relation to delivery of the organisation's strategic priorities and report back to Board. Matt Neligan, Group Deputy Chief Executive/Chief Strategy Officer queried whether it was still necessary to have separate BAFs for NTHFT and STHFT rather than one. It was noted that was the legal advice when arrangements for the Group structure were being established and perhaps it was opportune to revisit the position.

Resolved: (i) that, the content of the report be noted and approved; and
(ii) that, a session be arranged in September to fully review the risk appetite and report back to Board.

GB25/068 Quality Assurance Committee Chairs Log

Fay Scullion, Group Non-Executive Director presented the Group Quality Assurance Committee Chairs Log for the meetings held on 27 May 2025 and 23 June 2025, noting there had been some additions to the logs since the time of writing. The quality of reports presented had improved greatly and were mainly presented from a Group perspective.

Key topics included a continued focus to reduce infection rates and maintaining good infection prevention control processes and practice. A dashboard was being developed to monitor progress against actions. Regular audits were being undertaken in areas of concern and it had recently been highlighted nationally that some chlorine cleaning products were no longer deemed effective against certain infections, NHSE guidance was awaited. The UHT IPC Improvement Plan on a Page 2025/26 was commended.

Complaints remained a focus, particularly those responses outstanding over the six months threshold, noting these were mainly complex complaints involving multiple service areas. A multi-disciplinary (MDT) approach was being trialled bringing teams together to work on a collective response, which was working well so far.

The positive work in relation to population health and health inequalities was noted, however there were funding concerns for a number of projects that were funded with non-recurrent monies, which was impacting on service delivery and staff retention. The matter had been raised with the NENC ICB and

consideration needed to be given how to make the projects business as usual.

Cancer standards still remained a challenge particularly in respect of the Urology pathway and robust action plans were in place. Slight improved performance was noticed in respect of the diagnostic standards in May.

In respect of escalated items, stillbirth data was being interrogated regionally due to some reporting discrepancies. The Quality Account 2024/25 were approved for NTHFT and STHFT. The Learning from Deaths (LfD) approach required review to establish an aligned approach across UHT, which was being supported by the Committee.

Mike Stewart, Group Chief Medical Officer emphasised the concern regarding future funding for the Alcohol Care Team and Tobacco Dependency Service across NTHFT and STHFT, with funding only secured for the remainder of the year and therefore placing these core prevention services in an unstable position. Members of staff were leaving because of the lack of future security.

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

GB25/069 STHFT Patient Experience Annual Report 2024/25

Emma Nunez, Group Chief Nurse presented the STHFT Patient Experience Annual Report 2024/25, highlighting that the national focus was shifting more towards effectiveness of care and patient experience. STHFT was an outlier having implemented the Parliamentary and Health Service Ombudsman (PHSO) new complaint framework in January 2024 and was keen to move to addressing concerns real time.

Stacey Hunter, Group Chief Executive advised a summary to support the extensive annual report would have been helpful to highlight key points, however acknowledged the huge amount of work to prepare the report, which was echoed by the Chair, adding aligning it to the UHT Strategy would be beneficial in supporting the organisation's direction of travel. It was noted that future reports would be combined.

Ada Burns, Group Non-Executive Director/Senior Independent Director highlighted the importance of resolving concerns at Stage 1 as this was an indicator of effectiveness, however, the Report did not outline the number of complaints that had been resolved at Stage 1. Emma Nunez, Group Chief Nurse agreed, noting that this data was reported and reviewed by the Quality Assurance Committee (QAC).

Miriam Davidson, Group Non-Executive Director welcomed the plan to increase patient involvement to assist with service development and new initiatives, however, sought assurance that staff/patients had the appropriate knowledge. Emma Nunez, Group Chief Nurse explained that in some areas this was already being done very well and it was important to link the work to the aims of the UHT Strategy going forward.

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

GB25/070 Infection Prevention Control: UHT Improvement Plan 2025/26 and NTHFT & STHFT Annual Reports 2024/25

Emma Nunez, Group Chief Nurse presented the IPC Annual Reports 2024/25 for NTHFT and STHFT and the UHT IPC Improvement Plan on a Page 2025/26. The Annual Reports were taken as read. The Improvement Plan on a Page 2025/26 was based upon national standards and contained five main objectives. It supported delivery of the wider UHT IPC Strategy 2025/28 and had been well received at QAC. It was noted that the standard contract objectives for 2025/26 had now been received and would be built into the Plan. A dashboard was also being developed to underpin achievement of the key objectives. The Chair highlighted that a consistency in language would be helpful and to emphasise the improvement trajectory.

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

GB25/071 People Committee Chairs Log

Mark Dias, Group Non-Executive Director presented the Group People Committee Chairs Logs for the meetings held on 27 May 2025 and 25 June 2025 and highlighted the key points.

Sickness absence continued to remain above plan and rates were slow to reduce. More assurance was required and further discussion was being taken off-line. Appraisal rates and mandatory training were improving, however a continued effort and focus was still required.

Further assurance was required regarding the absence rates used in modelling to determine nursing establishment levels. It was highlighted that a significant amount of work was being undertaken at NTHFT in respect of nurse safer staffing and a review was being undertaken into the differences in metrics and assumptions regarding establishment between both trusts, acknowledging there was further work to do regarding absenteeism. Stacey Hunter, Group Chief Executive added that the use of bank agency nursing at NTHFT was to mitigate any risk to staffing levels, noting the different approaches at each trust.

The Committee would review assurance metrics around cultural improvements in respect of the Maternity Action Plan for STHFT at the July meeting, which would then be presented to Board.

Medical Job Planning had been escalated again to Board with the trajectory set for 100% compliance by 31 July 2025 with intervention requested from the Group Chief Medical Officer. Mike Stewart, Chief Medical Officer highlighted that medical job planning and appraisals were separate processes and would pick-up this up off-line. In terms of medical job planning rates, 100% compliance would not be achieved by the target date, however, was confident that the right discussions were taking place with medical staff. The organisation would either be reporting 100% sign-off or mitigation applied for the shortfall. It was noted NHSE guidance had been received linking job plans to other activities which would make it more challenging to deliver improvements, which was acknowledged by the People Committee Chair.

Stacey Hunter, Group Chief Executive stated it was a fundamental requirement for consultants to have a job plan, so acknowledged that mitigation would need to be applied if 100% would not be achieved by the target date. A continued focus was required to achieve full compliance. It was the basis of obtaining assurance that money was being used in the best way possible. It was important to assess the position at the end of July.

Ali Wilson, Group Vice Chair/Non-Executive Director provided anecdotal feedback that staff did not feel they had appropriate time to complete mandatory training. Stacey Hunter, Group Chief Executive reiterated that it was important to enable staff to have adequate time to complete their training and managers should support staff to do this. For a variety of reasons, one approach did not work for all staff, however, it was clear in accountability frameworks what was expected from staff and managers. Rachael Metcalf, Group Chief People Officer reported that there was currently national work being undertaken regarding mandatory training and the topics to be included.

The Chair reported that the NHS Staff Survey 2024 results were presented at the Council of Governors on 26 June 2025 and it would be helpful to hear what plans there were to improve the response rate. The Group Chief People Officer highlighted it remained a challenge, care groups and collaboratives were focusing on three key areas with delivery at local level, owning their own individual data, which it was hoped would increase participation in future surveys.

Stacey Hunter, Group Chief Executive commented that the issue regarding the response rate being so low could be a question of reliability of data and a fundamental question for the Board to consider was a more reliable way to get a sense of staff's views. David Redpath, Group Non-Executive Director highlighted that a low response rate had been an issue for a number of years and involved a lot of effort with limited time once the results were published to embed any changes. The Group Chief People Officer explained that currently the staff survey was mandatory and were exploring what other options

were available, noting that the organisation had always completed the full survey, where other organisations had used a smaller selection of questions.

Resolved: (i) that, the content of the report be noted; and
(ii) that, an updated position regarding medical job planning compliance be provided at the end of July.

GB25/072 Guardian of Safeworking

Mike Stewart, Group Chief Medical Officer presented the Guardian of Safe Working Report for the period February to April 2025, noting that the report was quarterly and aligned across STHFT and NTHFT and was taken as read.

Both sites continued to report concerns relating to workload and staffing shortages, however, there were no patient safety issues reported, which was reassuring. Work continued to develop the correct sized rotas and to produce generic work schedules. The Guardians of Safe Working and Chief Medical Office continued to work closely to ensure the organisation was an employer of choice for resident doctors.

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

GB25/073 Nurse Safer Staffing Report

Emma Nunez, Group Chief Nurse presented the Nurse Safer Staffing Report for the period April 2025 and highlighted the key points. The report was taken as read and noted that some of the content had already been discussed earlier in the meeting.

The average fill rate for STHFT was 97.6% and 98% for NTHFT, recognising that a round of safer staffing had highlighted gaps in establishment versus activity. The People Committee had oversight of the nursing establishment levels. Daily Safe Care Staffing meetings were undertaken to ensure that for all inpatient areas staffing levels were reviewed and staff deployed if necessary to mitigate risk to the lowest level. The assessment was based upon skill mix, patient acuity, dependency and occupancy levels. Due to the changing demands, temporary staffing was variable with a concerted effort made to redeploy staff before recourse to NHSP. Bank and agency spend continued to reduce at STHFT, however, bank spend at NTHFT was higher than the previous year. Alignment of services was providing the opportunity to review nursing staffing across the organisation.

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

GB25/074 Resources Committee Chairs Log

David Redpath, Group Non-Executive Director presented the Resources Committee Chairs Logs for the meetings held on 28 May 2025 and 25 June 2025 and highlighted the key points. The Reports were taken as read.

Key areas of focus included Whole Time Equivalent (WTE), with a deep dive discussion taking place at the June meeting. It was pleasing to note that Month 2 was reporting a net decrease of 99.41 WTE across the organisation. However, concerns were raised regarding the continued increase in WTE in the NTH LLP and the CMO scheme, with little assurance that the correct actions had been identified. The ambition regarding the sickness absence target and budgeting had been set as an action.

An ongoing action was a review of externally funded posts and whether funding remained in place for the whole of 2025/26 or if not what was the plan to remove costs. Also, a review of past business cases where savings were anticipated to have been achieved, to identify had the benefits been realised as there was no mechanism to review, or to confirm what were the plans to remove the additional roles.

Stacey Hunter, Group Chief Executive reported that Executive colleagues were thinking about whether enough was being done to secure achievement of the financial plan and financial recovery across the

Group was being reviewed to see where it could be strengthened. Subsequently, the Group Chief Executive was meeting with Senior Responsible Officers (SROs) individually to obtain progress updates and challenge decisions where appropriate.

Ken Readshaw, Group Non-Executive Director commended the reported reduction in WTE and sought to understand if the position at Month 2 was in line with plan. The reported position was not quite in line with plan, however, the position over the last two months was encouraging. The challenge would be to sustain the trend during winter. Stacey Hunter, Group Chief Executive reported that she was a member of the NENC ICB System Recovery Board, which closely tracked performance in relation to WTE for all trusts, no issues had been raised to date regarding UHT.

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

GB25/075 Finance Report: Month 2, 2025/26

Chris Dargue, Deputy Director of Finance, STHFT presented the Finance Reports for Month 2, 2025/26 and highlighted the key issues, taking the report as read. The Group plan for 2025/26 was to deliver an overall deficit control total of £9.1m, with a break-even plan for NTHFT and £9.1m deficit for STHFT.

At Month 2, the Group was reporting a deficit of £3.2m, which was an adverse variance of £0.6m against the year to date plan. NHSE had advised that there were changes to the deficit support regime for 2025/26 with regional assurance of plan delivery required to prevent funding being withheld.

Clinical income was ahead of plan for both trusts, by £0.6m at NTHFT and £0.1m at STHFT. Other income variance mainly related to the Salix grant income, which was removed from the Trust's reported control position. Pay expense was underspent at STHFT, however, pay and non-pay at NTHFT and non-pay at STHFT were behind plan.

The focus to reduce bank and agency spend remained, with the year to date agency spend for the Group reporting at £1,207k, which was above plan and bank spend reporting at £4.8m, which was less than plan. WTE was reporting a consecutive reduction for the second month with a net decrease of 99.41, however a close focus remained particularly around non-clinical.

The Group's capital plan for 2025/26 was £66.8m and the spend at Month 2 was £4.4m, which was £1.2m behind plan. The Group's cash position was £136.9m.

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

GB25/076 Integrated Performance Report

Neil Atkinson, Group Managing Director Group presented the Integrated Performance Report (IPR) for the reporting period April 2025 and highlighted the key points, noting a detailed review of the IPR had been undertaken through the Board Committees.

In respect of the items in the Alert category, there were five metrics remaining for NTHFT, including stillbirth rate, breast feeding at first feed, readmission rate, 4-hour A&E standard and sickness absence. A further three metrics had been regraded to Alert, klebsiella, pseudomonas and E.coli infections, as they were more than 20% higher than the internal plan. Two metrics reduced from Alert to Advise, 12 hour A&E breaches and RTT 52 week waiters.

For STHFT, there were six metrics remaining in the Alert category, E.coli infections, breast feeding at first feed, cancelled operations not rebooked in 28 days, cancer faster diagnosis, sickness absence and mandatory training. A further three metrics had been regraded to Alert, C.difficile, pseudomonas and diagnostic 6 week standard. Five metrics reduced from Alert to Advise, MRSA infections, cancer 31 day standard, cancer 62 day standard, RTT incomplete and complaints closed within target %.

Ken Readshaw, Group Non-Executive Director commented that it was now explicit in the new IPR which metrics were the responsibility to be reviewed by which Committee broken down by individual domain,

which was helpful.

Stacey Hunter, Group Chief Executive emphasised the significant work being undertaken by teams regarding difficult to achieve metrics including urgent care targets and cancer standards. The organisation continued to remain ambitious and set challenging targets. In particular the work to improve performance against the 62-day cancer standard and specific pathways was emphasised for STHFT, which was having a positive impact to identify patients with cancer much sooner and ensuring patients were treated curatively within 62 days with innovative ways of working. It was noted that increased demand was being seen in certain tumour sites, with progress being reported into QAC and Resources Committee.

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

GB25/077 Green Plan 2025 to 2028

Steve Taylor, Group Director of Estates presented final Green Plans for NTHFT and STHFT for the period 2025/28 having been reviewed and refreshed. Although it was a requirement for each trust to have an individual plan, the plans had been progressed jointly to reflect the sustainability ambitions of UHT. There were nine areas of key focus, which were in line with the NENC ICB Green Plan and it was pleasing to note that there were currently 90 Green Champions across the organisation.

It was highlighted that the organisation had been successful in securing national funding for three carbonisation projects which were at University Hospital Hartlepool (UHH), the Friarage Hospital and James Cook University Hospital, which supported a number of efficiency upgrades from an energy perspective to reduce the requirement to burn gas. The scheme at UHH had been showcased at the Board walkabout earlier that day, with the level of innovation and enthusiasm of the team noted. There were plans to reduce the use of gases in theatres to reduce negative carbon emissions, noting there was a lot of clinical buy-in.

Resolved: that, the Green Plans 2025/28 be approved for NTHFT and STHFT for submission and publication by 31 July 2025.

GB25/078 Fit and Proper Person Test Annual Submission 2024/25

Jackie White, Head of Governance/Company Secretary confirmed that the annual Fit and Proper Person testing for board members had been concluded for 2024/25 and no issues were reported. Both trust's processes had been reviewed by internal audit and received good assurance/low risk respectively.

The required submission had been made to NHSE within the required timescale.

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

South Tees Hospitals NHS Foundation Trust Unitary Board items only:

GB25/079 Audit and Risk Committee Chairs Log

Ken Readshaw, Group Non-Executive Director presented the STHFT Audit and Risk Committee Chairs Log for the meeting held on 20 May 2025 and provided a verbal update regarding the meetings held on 23 June 2025 and 30 June 2025 to agree the annual accounts submission by the 30 June 2025 deadline.

The May meeting was to largely review end of year work, noting the work programme for CF was for a nine month period, as a tendering exercise was being undertaken for a single auditor. An item of escalation was the Committee responsibilities in relation to the IPR, which had now been addressed.

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

North Tees and Hartlepool NHS Foundation Trust Unitary Board items only:

GB25/080 Audit Committee Chairs Log

Ken Readshaw, Group Non-Executive Director presented the NTHFT Audit Committee Chairs Log for the meeting held on 21 May 2025 on behalf of Alison Fellows, Group Non-Executive Director.

The Committees received the Committee Effectiveness Reviews for the Quality Assurance Committee, People Committee and Resources Committee and provided good assurance that the Committees were effectively discharging their duties.

The annual report regarding declarations of interest, gifts and hospitality had been presented and the revised aligned Standards of Business Conduct Policy for both trusts. It was agreed to undertake a further analysis regarding the response rate and for escalation to Executive colleagues to review, which was agreed by Stacey Hunter, Group Chief Executive.

It was noted that both Audit Committee agendas were now aligned so similar reporting was taking place.

Resolved: (i) that, the content of the report be noted; and
(ii) that, a review of the declaration of interest, gifts and hospitality registers returns be reviewed by Executive Directors.

GB25/081 Good Governance Institute (GGI) Update

Stuart Irvine, Director of Risk, Assurance and Compliance presented an updated position regarding the Good Governance Institute Report, following the review that was commissioned in 2022 by NTHFT, after a number of board changes. The review focused on seven key themes, board membership and profile, governance structures, board and committee business, assurance and reporting, risk management, accountability, communications and stakeholder engagement. Updates had been provided to the Board regarding progress against the 24 recommendations, this was the final update. All recommendations had now been implemented.

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

GB25/082 Any Other Business

No formal any other business was reported. The Chair expressed it was positive to see the embedded triangulation between the Committees and Board.

Stacey Hunter, Group Chief Executive shared with colleagues that Stuart Irvine, Director of Risk, Assurance and Compliance was undertaking some observational work to assess the competency of the Board in achieving its aim to be high performing. Once the output of the assessment had been reviewed, it would be shared with colleagues and concurred that triangulation was evident with the function of the Committees and link back to Board.

GB25/083 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 4 September 2025 in the Boardroom, 2nd floor, Murray Building, James Cook University Hospital.

The meeting closed at 15:40

Signed: Date:

Group Board Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes	Action delegated to Committee
04 March 2025	GB/251	***Quality Assurance Committee Chairs Log*** *Board Development session involving Public Health Consultants to share work regarding population health and health inequalities.*	Jackie White Mike Stewart	04 September 2025	Open	It was agreed it would be helpful to invite the Public Health Consultants to a future Board Development session to share with the Board current projects and progress to date regarding population health and health inequalities linked to the UHT Strategy. MS and JW to agree arrangements.	
04 March 2025	GB/254	***Safer Staffing Report*** *A review of the criteria used to measure turnover data across both trusts to be undertaken to support more aligned reporting going forward.*	Emma Nunez	03 July 2025	Closed	There were stark differences in the reported turnover figures between the Trusts and a review was being undertaken to ensure the same criteria were being measure against. It was noted that the Staffing Report would go through People Committee & reported back to Board via the Chairs Log.	People Committee
04 March 2025	GB/254	***Safer Staffing Report*** *Undertake a Board Seminar in June 2025 linked to the Clinical Strategy around nursing establishment.*	Emma Nunez/ Jackie White	04 September 2025	Open	It was agreed to hold a Board Seminar to share with the Board the work being undertaken across both trusts in respect of nursing establishment. JW & EN to agree arrangements.	
08 May 2025	GB25/027	***People Committee Chair's Log*** Escalated item from People Committee to improve compliance levels regarding medical staffing job planning.	Mike Stewart	31 July 2025	Open	Following escalation from People Committee compliance regarding medical job planning was discussed, noting it was unlikely the organisation would achieve the 100% compliance by 31 July 2025 with mitigation to be applied to areas remaining non-compliant. To maintain focus it was agreed an updated position should be provided at the end of July.	People Committee
08 May 2025	GB25/027	***People Committee Chair's Log*** Escalated item from People Committee regarding low appraisals rate and training compliance for staff.	All	03 July 2025	Closed	Staff appraisal rates and mandatory training compliance remained low. The issue was escalated from People Committee for Executive Directors to review compliance levels within respective teams and consider consequences for non-compliance. It was reported at the 3 July 2025 meeting that there was a continued focus across the organisation to increase the appraisal and mandatory training compliance. Scrutiny would continue via the People Committee.	People Committee
08 May 2025	GB25/030	***Resources Committee Chairs Log*** Escalated item from Resources Committee to consider actions to achieve WTE reduction as part of deep dive and grip and control exercise being undertaken.	Chris Hand/ Neil Atkinson	03 July 2025	Closed	A decrease in WTE was reported at the 3 July 2025 meeting, noting a continued focus remained, following escalation from Resources Committee. The Committee would continue to monitor progress.	Resources Committee
08 May 2025	GB25/034	***Maternity Reports*** Maternity Board Champions to write to National Chief Midwifery Officer regarding increased expectations around safer maternity care.	Ann Baxter Miriam Davidson	03 July 2025	Closed	A response had been received from the National Chief Midwifery Officer regarding the increased expectations on organisations in respect of safer maternity care and Maternity Voices Partnerships, who acknowledged it was a complicated issue and welcomed suggestions. The Chair & CE had been invited to a meeting, which Miriam Davidson would be attending. Following the announcement by the SoS that a new maternity review was being launched, Jim Mackie had invited trusts to write to him outlining any issues, so it was suggested the Maternity Champions could do that on behalf of the organisation.	
08 May 2025	GB25/034	***Maternity Reports*** Clarity to be provided in future maternity report regarding range of specialist midwife roles across the Group.	Steph Worn	03 July 2025	Closed	Following a query regarding specialist midwifery roles across the Group, it was agreed to provide clarity in future reports as to the current roles.	
03 July 2025	GB25/064	***Group Chief Executive's Report*** A summary of the 10 Year Plan for Health to be circulated to board members	Matt Neligan	04 September 2025	Open	It was agreed that once more detail was released in respect of the newly published 10 Year Plan for Health, a summary would be produced and shared with Board members for information.	
03 July 2025	GB25/068	***Board Assurance Framework*** A Board session to be arranged to review risk appetite in relation to delivery of the organisation's strategic objectives.	Stuart Irvine	30 September 2025	Open	Following discussion regarding the risk appetite for each of the domains in the refreshed BAF it was agreed to have a session to fully review risk appetite to ensure it accurately reflected the ambitions and delivery of the UHT Strategy.	

03 July 2025	GB25/080	***Audit Committee Chairs Log*** A review to be undertaken of Gifts and Hospitality and Declaration of Interest Registers	Jackie White	04 September 2025	Open	It was agreed Executives would review the registers and processes for Gifts and Hospitality and Declarations of Interest for oversight.	

University Hospitals Tees

Group Chair's Report

Meeting date: 4 September 2025

Reporting to: Board of Directors

Agenda item No: 1.7

Report author: Jackie White, Company Secretary

Executive director sponsor: Derek Bell, Chairman

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: N/A

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance framework references 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 Board of Directors are asked to note the report.

Chairmans report

1. PURPOSE OF REPORT

The purpose of the report is to provide information to the Board of Directors on key local, regional and national issues.

2. RECOMMENDATIONS

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

3. DETAIL

3.1 NHS UHT - Anti Racism Day

I am really pleased to be able to promote our 'This is our conversation - what does Anti Racism mean to me' day on 7 November 2025.

Joy Warmington (Author of Too Hot to Handle) will be speaking in the morning on racism as a social construct and Windrush colleagues on their experience of whether things have moved forwards, then we welcome back the police and crime commissioner who has done recent focus groups with our staff one year post riot and also are exploring intersectionality and allyship with the Chief pharmacist from Sheffield.

The afternoon will focus on local experience with a refugee charity speaking, lived experience- stories from colleagues and from the riots, information from our networks and the plan for what we do going forwards - what do we need to do differently as an organisation.

It would be great for Board members to join us on the day.

3.2 NHS Providers Chairs and CEO Meeting

I attended the NHS Providers' Chairs and Chief Executives Network on 8 July with a focus on national and regional updates, medium term financial plan and a discussion on service changes process with regard to scrutiny and engagement requirements. Sam Allen, CEO of the North East and North Cumbria ICB gave a presentation and held a discussion on the 10 year plan and what it means for us.

3.3 Armed Forces and Veterans Coffee Session – 10 July 2025

University Hospitals Tees (UHT) continues to demonstrate its commitment to the Armed Forces Covenant. We are fortunate to host a help for heroes nurse across the Group; Armed Forces patients can be referred to her to ensure we are maximising their care by referring them to partner organisations or further care pathways specific for the Armed Forces Community. In terms of our social commitment; a quarterly coffee morning was held at the North Tees site on 10th July 2025, which was well attended and we anticipate an increase in attendance at future planned meetings across UHT sites, which will be shared on our social media platforms with advanced notice. Positive meetings are also being held with Integrated Care Board and Local Authority Armed Forces Leads to ensure the provision of primary and secondary healthcare services are working jointly and collaboratively for the benefit of our Armed Forces Community.

Work has progressed in readiness for a joint accreditation submission on behalf of UHT for the Armed Forces Covenant towards the end of 2025. Further updates will continue to be provided to the Board.

3.4 Non Executive Director update

All Non-Executive Director appraisals have now been concluded, and the nominations committee of the Council of Governors will receive a report on the outcome of the appraisals at their meeting in September. As a result of discussions, a number of changes are being made to champion roles and committee membership during the next quarter.

Interviews are scheduled for two non executive director positions including a clinical non executive director and a non executive director with a finance background for the 7 September 2025. Focus groups involving our Council of Governor and NED colleagues along with an interview process will take place on the day.

3.5 Healthwatch

I was pleased to meet with Christopher Akers Belcher and colleagues from Healthwatch in July. We discussed the 10 year plan and what this means for Healthwatch and their extremely valuable role going forward.

3.6 Unitary Board training

The final session in our current Unitary Board training was held on 7 August 2025 which has been facilitated by Natlie McMillan and Associates. The focus of the third session was on looking back at what we have achieved and looking forward to what a high performing Board needs to be.

3.7 Annual Members Meeting

The Annual Members meeting is taking place on 11 September 2025 at the Digital Centre at Teesside University commencing at 1:30 pm. The meeting will focus on our achievements over the last year with two key note speakers, market stalls from staff showcasing some of their work and a question and answer session. We would encourage all our members to attend.

Derek Bell
Chairman

University Hospitals Tees

Chief Executive Officer Report

Meeting date: 4 September 2025

Reporting to: Group Board of Directors

Agenda item No: 1.8

Report authors: Stacey Hunter CEO / Abigail Smith, Executive Assistant to CEO

Executive director sponsor: Stacey Hunter, Chief Executive Officer

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: N/A

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

N/A

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.

Nothing to alert the Board too from this specific report.

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.

As the Board will be aware from the details contained in the IPR and the Board committee reports there are areas of performance that are meeting the plan we submitted. This is being kept under close review with work ongoing to recover the position. From a financial perspective the team are required to prepare another forecast post month 5 which is due to be submitted mid Sept to NHSE. This will provide an opportunity for the Board to consider the overall position and determine whether there is any further action needed to secure the delivery of the financial plan.

It has been a busy period since the last Board meeting following the launch of the government's 10 year plan for health which has included a call for expressions of interest from places who want to take part in the national neighbourhood health implementation plan. The paper details this position for UHT.

At the time of writing this report the consultation on the new target operating model is due to close today (27th August). There has been good engagement throughout and the executives will consider a number of counter proposals prior to sharing the final target operating model with colleagues on the 29th August. We will update the Board further when we meet in September. I would like to place on record my thanks to our Chief People Officer, Chief Delivery Officer, Chief Nurse and Chief Medical Officer for their leadership of this work. I would also like to recognise the efforts other senior leaders in our site, collaboratives and care groups most of whom are in scope of this review and have continued to support the discussions and 1-1 meetings.

A number of executives joined me at a meeting with the ICB CEO and the Regional Director on the 21st August 2025 whereby we had an opportunity to discuss the work we have been doing over this last 12-18 months to establish University Hospitals Tees (UHT). This included the UHT strategy, values & culture, staff & partner engagement and the proposed target operating model.

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

As detailed in the paper North Tees & Hartlepool NHS Foundation Trust maternity services is being supported by the national maternity improvement advisor to exit the national programme. This will be confirmed at a final meeting in October and I know the Board will want to acknowledge the significant improvements the team have delivered over the last two

years to reach this point. Maintaining and building on these improvements for women and their families who use these maternity services will continue to be a priority.

The clinical boards who have been at the forefront our developing our UHT strategy and setting up the early horizontal integration services have held their last all clinical boards event in August. Their reflections and feedback have been captured by the strategy team, each board have gathered details of their plans which will be shared with the new Clinical Service Units (CSUs) leadership teams once they are in post. There will be a face to face event to supplement this to ensure that the momentum is maintained. The approach with the clinical boards has worked well and given us a good platform for the CSUs to progress from.

Recommendations:

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

Chief Executive's Report

1. Introduction

This report provides information to the Board of Directors on key national, regional and local issues and is linked to the strategic objectives of the Trust. It covers the period since our last Board meeting on July 3rd 2025.

2. National Priorities

2.1. NHS CEO Event on 10 July 2025

Matt Neligan, Deputy Chief Executive/Chief Strategy Officer attended this event on my behalf. Led by Jim Mackey, key focus was on:

- Delivery of 25/26 plans
- Model ICB
- Neighbourhood health and the opportunity for FT trusts to bid on national pilot schemes
- Work on financial flows , MTFP and preparation for planning for 3 years

2.2. National Neighbourhood Health Implementation Programme (NNHIP)

We have worked with partners to develop bids to join this new programme which is seeking to identify 42 places to work as Wave 1 of the NNHIP. The programme will support the development of new approaches to neighbourhood health that were set out in the 10 Year Health Plan, through testing, learning and spreading progress. The initial focus will be on adults with multiple long-term conditions before progressing to other areas. We have developed bids jointly with partners across councils, primary care, the community and voluntary sector and mental health in four places: Stockton-On-Tees, Hartlepool, South Tees (a joint bid as a single place across Middlesbrough and Redcar & Cleveland) and North Yorkshire. The outcome of this initial round of bids is scheduled to be announced on the 5 September 2025.

2.3. National Maternity Safety Support Programme (MSSP)

The maternity service at North Tees and Hartlepool NHS FT (NTHFT) hosted a MSSP review meeting in July 2025 which included membership from NHSE senior lead of the MSSP, North East and Yorkshire Regional Chief Midwife, North East and North Cumbria Integrated Care Board, UHT Chief Nurse and members of the perinatal leadership team. Following a review of progress, members agreed the service could enter onto the sustainability phase given the progress that has been made. At the time of the meeting the exit phase was not considered due to the group model development and South Tees Hospitals FT maternity service entering onto the MSSP.

NTHFT received information from Simon Mehigan, Maternity Improvement Advisor, that following the meeting there had been further discussions and the MSSP lead felt NTHFT had made the necessary progress to progress to the exit phase. Discussions involved the Chief Midwifery Officer for England, and the Chief Obstetric lead, with the outcome to host another meeting in October with the scope of exiting the MSSP. The service is

awaiting the official information. This is excellent news and a testament to the leadership team. For obvious reasons we will maintain close oversight of the improvements to ensure that they are sustained and we remain alert to any adverse variation in the key performance indicators for this service.

2.4. National Maternity Safety Summit – 16 July 2025

This event was hosted by the Royal College of Midwives and the Royal College of Obstetrics and Gynaecology. Emma Nunez, Chief Nurse, attended on behalf of UHT. The event saw presentation from Wes Streeting, Secretary of State for Health (SOSH), with key focus on maternity services and getting it right for patients and families. The SOSH reiterated his commitment to a national maternity investigation which will review of 10 maternity services by the end of December 2025. The aim of the rapid review into Maternity and Neonatal services is to provide truth to families suffering harm and urgently improve care and safety. Subsequent to this meeting government have announced the independent chair who will lead this work (Baroness Amos).

3. Regional Update

3.1. North Yorkshire (NY) Health Collaborative Workshop

I attended the NY Health Collaborative Workshop event on 10 July 2025. Following approval from both the ICB and NY Council the formal launch of the NY Joint Committee took place, this will help keep focus on the ambition for health programme and will be led by a Directors group with representation from system organisations. This work is underpinned by formal delegation from the NY ICB and Council in respect of funding and decision making for community health services.

3.2. NENC CEO Leadership Group

The ICB organised a meeting in July for all Chief Officers from the local authorities, combined authority and NHS providers to discuss the early thinking re the impact of Model ICB in respect of our places and the 10 year health plan. It was a productive session which evidenced the strength of our partnerships locally and the willingness of partners to ensure that the focus on our places remains a priority. There is a follow up session in September.

3.3. NENC ICB System Recovery Board

This programme is providing oversight of the system level programmes of work that are contributing to the delivery of the provider and ICB financial plans for 25-26. Given the challenging context it is also monitoring the broader CIP plans for each organisation and sharing back progress and challenges in delivery via CEOs, Chairs and Chief Finance Officers. The resources committee are sighted on this were relevant for UHT which will be ongoing throughout the remainder of the year. There is a plan to bring key NENC Board members together early October to take stock of the overall position.

3.4. NENC Provider Collaborative Leadership Board (PLB)

I have agreed to step into the SRO CEO role for planned care given the former SRO

Lyn Simpson has gone to cover the CEO role in NHS Humber Health Partnership (Hull Hospitals & North Lincolnshire Goole hospitals **).**The programme consists of the diagnostics projects, elective projects and the cancer alliance work programme.

The focus of work for PLB remains consistent with the work programme agreed at the start of 25-26 with progress monitored at the CEO monthly forum. There are not any exceptions to report to Board this month.

4. Local update

4.1. Clinical Boards

The clinical boards held their final joint meeting on Friday 22 August 2025 as their terms finish on 31 August. This was a slightly different meeting which celebrated the work of the boards together with lessons learned and developing a plan for the future. While there are still inevitably issues to work through and much more to do to implement the major strategic changes we are proposing, our clinical boards have laid the foundations for reforms of clinical services. They have also helped us to take full account of the key shifts envisaged in the Government's Ten Year Plan; helping us to develop our estates Strategic Outline Case. We will be managing the plan for the transition to Clinical Service Units carefully with a "legacy" pack of standard slides supported by a catalogue of data; and we will be organising handover meetings so that the baton for implementing our UHT strategy can be passed successfully.

4.2. Management and Leadership Restructure

As Board colleagues are aware we have proposed a new target operating model aligned to the UHT strategy. This is a significant change and designed to enable delivery of horizontally integrated services and the expansion of care in our communities and neighbourhoods. There are circa 200 colleagues in scope of the review and we have completed the 45 day formal consultation period following socialisation of the proposals prior to this.

The work during September will focus on recruitment to the new management and leadership roles within the context of our change management policies.

I will ask colleagues leading this work to provide a verbal update to Board members in September.

4.3. Performance against plan

As detailed via the IPR and the Board committee reports there are a number of areas where we have a negative variance against the plan we submitted for 25-26.
The Executives continue to have oversight of this and are challenging and supporting colleagues to recover the position over the remainder of the year.
It remains key for the Board to ensure the necessary assurance is received and to use our committees to probe for further details where colleagues feel this is needed.

In addition to this we know that there is an intention to publish league tables for key performance targets albeit there is no definitive date for this as yet. The chair and I have

been receiving weekly sight of key urgent care and RTT indicators over the last few weeks. There are no surprises in this and the data thus far reflects the position we would expect to see.

4.4. Industrial Action

Board members will be aware that resident doctors took strike action from July 25th - July 30th inclusive. Our Chief Operating Officers and their teams worked hard to ensure there was appropriate cover in place for the period and to the extent they were able minimised the impact in respect of reductions in planned care activities. We gained assurance that no urgent priority 1 or 2 patients were cancelled nor any patients on a cancer pathway. The gross costs of covering this period were £360k across UHT. My thanks and appreciation to everyone who planned for the period and to those colleagues who did additional work to cover the gaps.

4.5. Local MPs

I have had opportunity to meet with the majority of our local MPs in this last period to discuss any areas of interest they have and our high level plans we have set out in the UHT strategy. The meetings have been productive and all of them understandably keen to remain involved in any proposed changes and key priorities.

5. In other news!

5.1. Surgical Centre

On Friday 11 July 2025, I was delighted to join staff at the Friarage Hospital to celebrate the opening of the new £35.5million surgical centre. Public health and Prevention Minister Ashley Dalton, MP Rishi Sunak and one of our longest serving scrub nurses Anne Lamb were there to officially cut the ribbon, which will double the number of planned operations. Theatre teams have helped with every stage of the planning to maximise efficiency and ensure they deliver the very best experience to patients across our communities in North Yorkshire and the Tees Valley.

5.2. Community Diagnostics Centre

On Friday 25 July, I joined visitors at the official opening of the Tees Valley Community Diagnostic Centre in Stockton Town which has already carried out more than 15,000 tests for our local community. Visitors included local MPs Chris McDonald, Matt Vickers and Luke Myer as well as Councillor Pauline Beall from Stockton-On-Tees Borough Council and many of our own staff who have been instrumental in making the centre the huge success it has been so far.

5.3. Visit from CEO NHS Providers

On Wednesday 20 August, I hosted a visit from Daniel Elkeles, Chief Executive of NHS Providers. Daniel visited both the Friarage Hospital Northallerton and the University Hospital of North Tees. While at the Friarage Daniel had a tour of the new surgical centre and spent time with the community teams, he was particularly impressed with the way we upskill our urgent treatment centre clinicians and the hospital at home team.

He also enjoyed a tour of the emergency department and maternity services at the University Hospital of North Tees. We explained how we have turned around the midwifery service from one where we sometimes struggled to fill posts to one where all our students wish to start their careers where they are trained. We also showed him the new “fit-to-sit" part of the emergency assessment unit, which opened this week thanks to our recent award of UEC incentive capital funding

Following the visit Daniel has provided good feedback and included a write up of his visit on the NHS Providers website.

5.4. Princess Royal Training Award

The leadership and development team have received the Princess Royal Training Award 2025 for their internal Leadership Development Programme which has been running since 2020. This honour, formally approved by HRH The Princess Royal, celebrates organisations that demonstrate exceptional commitment to learning and development, this year being a milestone year being the awards 10 year anniversary and HRH’s 75th birthday. The Leadership Development Programme is now open to colleagues across University Hospitals Tees with sessions planned at both North and South Tees sites.

6. Conclusion

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

University Hospitals Tees

Chair's Log – Group Management Team Meeting

Meeting date: 4 September 2025

Reporting to: Group Board of Directors

Agenda item No: 1.9

Report author: Louise Murray, Admin Team Lead and EA to Managing Director

Executive director sponsor: Stacey Hunter, Chief Executive Officer

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: N/A

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All Board Assurance Framework domains

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.

There are no alerts to matters for escalation to the Board following the June 2025 meeting of the Group Management 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.

GIRFT Further Faster 20 Update
Work is ongoing in relation to GIRFT Further Faster priorities. South Tees remains one of the trusts within the 20 that has not yet improved the position in relation to elective activity as much as others within this group (18th out of 20 trusts).

Work is ongoing and will be monitored via Group Management Team.

Pressures continue within the breast service because of additional demand from County Durham and Darlington NHS Foundation Trust. The Trust continues to receive a significant number of breast referrals. There is additional demand on MDT discussions, cancer tracking and elective capacity. There has been a spike in positive cancers; this has had an impact on surgical rates. If this continues and puts performance targets at greater risk we will escalate to the ICB.

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

Financial and performance targets discussed and can be reviewed by the Board via the stand alone reports and the IPR.

The CIO updated on plans to move to a single UHT EPR - Indicative delivery milestones and development timeline for producing the outline business case (OBC) date to be agreed. Cyber security - In recent months, the group has experienced an exponential increase in cyber security alerts, reflecting a national trend of escalating cyber threats across the health and social care sector. It is essential we transition everyone to Windows 11 which should be complete by October 2025.

Property managed across UHT was an indicative target of £1M savings.

Recommendations:

The Group Board receive the report; acknowledge the monthly meeting of the Group Management Team meeting and the oversight and assurance it provides to the Executive Team for each Trust.

University Hospitals Tees

Chair's Log – Group Management Team Meeting

Meeting date: 4 September 2025

Reporting to: Group Board of Directors

Agenda item No: 1.9

Report author: Abigail Smith, Executive Assistant to the CEO and Chair

Executive director sponsor: Stacey Hunter, Chief Executive

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: *N/A*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All Board Assurance Framework domains,

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 following matters for escalation to the Board following the Jul 2025 meeting of the Group Management Team.

North Tees and Hartlepool NHS FT;

- The Trust has seen an increase in MSSA as 5 cases were reported.
- The Cancer 62 day standard reported at 58.2% in May and is below the planned trajectory of 71.82%. Specialities with the lowest performance are lung, urology and gynaecology with Breast also showing a decline in performance.
- Overall diagnosed breast cancers from Feb – June 2024 was 377, the same period in 2025 is 451. Work continues locally with CDDFT, commissioners and NCA for a more sustainable approach. Concerns re impact on cancer performance and cost will be escalated to the ICB.

South Tees Hospitals NHS FT;

- 65 week waits remain off target, although the indicative validated June month end 65 week waiters was 95 against a forecast of 100. When compared with other trusts across the region this position is one of the worst. The team are planning a number of additional activities in September to improve the position. Board will want to keep this in view as we progress through quarter 3.
- Cancer 31 day standard has been variable since January 2025 but now demonstrating general sustained deterioration with 7 consecutive months below the previous average performance, driven by increasing radiotherapy waits for subsequent treatments.

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.

Robotic Surgery

- High utilisation of robotic surgical programme leading to delay in treatment, the Group Management Team have agreed to .a short term rental of robot until the end of March 2026 to meet the increasing demand. The business case demonstrates effective and efficient use of the existing robots with increasing demand across several cancer pathways. Whilst the short term rental will help resolve some of the back log in Urology it is clear that going into 26/27 we will have to consider the options for securing another robot on a permanent basis.

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

Site Leadership Team Reports

North Tees and Hartlepool NHS FT;

- Non-clinical WTE has reduced by 9.16 WTE when compared to prior month, a third successive month of reductions.
- The mobilisation of the sexual health contract (The Tees Together Sexual Health Service) is moving forward with the service transferring on 1st August 2025. External partners have given positive feedback about the leadership and contributions from our colleagues who have worked on this on our behalf.

South Tees Hospitals NHS FT

The improvements across the urgent care metrics continue to be sustained with the position nationally and regionally now in the middle of the pack. There is more to do to ensure ambulance handover times can be met during times of peak pressures on bed capacity.

Partnerships

Joint working has taken place through a number of partnership forums on our strategic developments, this paper summarises progress and issues.

Bids for neighbourhood health pilots in line with the national programme will be progressed in line with ambition in each place. UHT is well-positioned in terms of organisational appetite and service configuration to support bids in any of our local places and we will continue work to develop neighbourhood health systems across all of our places regardless of the success of individual bids. We will update at Board in September how many bids were submitted and the progress of each.

Register of Clinical and Non-Clinical External Visits

North Tees and Hartlepool NHS FT;

- During a UKAS Blood Sciences inspection, as a result of a change to technology, and a period of ongoing transition, the technical accreditation for Haematology, Coagulation and Blood Transfusion was temporarily suspended for 3 months. A re-assessment visit is planned for later this year.
- UKAS has carried out site inspections of Cellular Pathology and Blood Sciences between 13 – 15 May 2025. High level feedback was provided identifying findings to be addressed. The team are awaiting UKAS feedback on evidence submitted to address the findings and the final report is awaited.
- The Northern Trauma Network did not identify any immediate risks during their peer review on 13 May 2025. 2 areas of serious concern were identified and an action plan developed and shared with the team within timescale. Several areas of good practice were identified and shared with the team.

South Tees Hospitals NHS FT;

- UKAS has carried out site inspections of Haematology, Blood Transfusion, Biochemistry, Microbiology, Virology and Cellular Pathology on 7 April 2025. High level feedback was provided identifying findings to be addressed. The team are awaiting UKAS feedback on evidence submitted to address the findings and the final report. Nothing to escalate to Board arising from this visit.
- The Office for Nuclear Regulation (ONR) carried out an inspection of the Nuclear Medicine Department on 29 April 2025 and rated the Trust as 'green' with "no significant shortfalls identified in the delivery of safety". Feedback from the inspector was very positive and they indicated the Trust would be a low priority for further inspections.
- The Environment Agency (EA) inspected the Trust on 4 June 2025 in relation to the Trust's permit to hold, use, and dispose of unsealed radioactive materials and radioactive waste. Informal feedback from the inspector was positive with only a single minor non-conformance identified. An action plan has been developed to address this.

Recommendations:

The Group Board receive the report; acknowledge the monthly meeting of the Group Management Team meeting and the oversight and assurance it provides to the Executive Team for each Trust.

NHS
University Hospitals Tees

University Hospitals Tees Strategy Update

Meeting date: 4 September 2025

Reporting to: Board of Directors

Agenda item No: 1.10

Report author: James Bromiley, AD Group Development

Executive director sponsor: Matt Neligan, Deputy Chief Executive Officer/Chief Strategy Officer

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to:

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

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.

Work continues at pace to deliver the ambition set out in our strategy. Horizontal integration work is accelerating; it is becoming clear that while we have a standard set of criteria we will have different challenges in each which will in turn enable learning for the future. The Strategic Outline Case (SOC) work will be completed by the end of September and we are developing a process in conjunction with the ICB and NHSE which can reflect the inter-relationship between our capital "ask" in the SOC and our proposed major service changes.

Recommendations:

The Board are asked to:

- note the progress on implementation of the UHT strategy; and
- comment on the approach being taken.

UHT Strategy Update

1. PURPOSE OF REPORT

This report is the regular update to the Board on progress with implementation of the University Hospitals Tees strategy and the delivery of our ambition. It summarises headline progress against the three pillars of the strategy, the key enablers (specifically the Strategic Outline Case for estates redevelopment) and wider issues around engagement.

2. BACKGROUND

The UHT strategy was approved on 8 May. It confirms the vision, values and strategic objectives for the group and "pillars" of reform:

- **Patients and populations:** our work to reform our clinical services so that we develop new models of care across the UHT footprint that meet the needs of patients and address population health priorities;

- **People:** being an employer of choice for our existing people and potential new colleagues, developing our people through living our values and creating an outstanding experience across all teams in UHT. Ensuring that we are a learning health organisation with a culture of continuous improvement; and

- **Partnerships and places:** our close collaboration with all of our partners to develop and deliver our shared integrated care strategy and ambitions in local places. Working in communities to maximise our impact as an anchor institution.

Supporting these pillars is the transformation of key enabling functions (in particular our work in quality, digital, estates and productivity) and the development of our revised operating model.

3. DETAILS

Strategy finalisation and engagement

The strategy agreed by the board has been put into a design format. While we have engaged widely with external partners in the run-up to and since the agreement of the strategy that needs to continue and also be extended to other stakeholders. Having a more user-friendly strategy format will greatly help us with that. We have a full engagement plan in place that will include roadshows with our own staff and further engagement in partnership with Healthwatch to engage patients in the future approach to services.

There are some relatively minor changes to the text of the strategy (since the 8 May Board meeting) which will appear in the final designed format. These do not require further formal agreement from the Board but include proposed amendments in the following areas:

- updating and clarifying the references to the Government's Ten Year Health Plan *"Fit for the Future"* published in July. In particular, the links between our strategy and the major changes set out in the national plan: moving services into community; digital transformation and preventative health;

- following from this, the ambition to place our community services at the heart of neighbourhood health systems that we develop in partnership with primary care, local authorities, mental health services, ambulance trusts and the voluntary and community sector;

- to clarify timescales following the Board feedback in May, i.e. that we are expecting to complete horizontal integration within the next 2-3 years and this will lead into service transformation and reconfiguration which can be carried out in our existing estate;

- including stronger reference to regional and tertiary services that are an integral part of our UHT service portfolio and our clinical strategy. Feedback from Chief Executives across the system highlighted the importance of us stating our ambition to be able to maintain and develop the range of tertiary services and to make an enhanced contribution to the region;

- further clarifying that specific sites are intended to be maintained as part of the group, e.g. University Hospital of Hartlepool. Stakeholders have fed back that making this explicit rather than implicit would be helpful.

- minor changes to the wording around research, defining research development and research delivery separately.

Potential consultation

We have increased engagement with the ICB and have met NHS England to start to discuss a process for approval of changes which will match our circumstances. In principle the approval of major service changes is a separate process from the approval of estates investment. However in our case the delivery of the most significant changes we want to bring about in clinical services has a high level of interdependence with the changes in estate, so we will need to design a process which reflects those interdependencies.

Pillar 1: Patients and populations

Horizontal integration pilots

Each of the six services has now completed a plan for their proposed target operating model using the standard UHT project management methodology and progress is accelerating. We are finding that – as expected – they are tackling the issues in different ways and that means that while we have a standard set of criteria for what we mean by horizontal integration, success will look different in each of the areas.

The pilots are led by relevant clinical leads and operational managers which means that they hold ownership of the proposed solutions. Having a joined up leadership and management structure; and dedicated project management are two of the lessons coming out of the work to develop the Tees Valley Pathology Service which we have applied here.

We will bring the clinical and operational leaders together in the autumn and then again in January for shared learning across the pilots and to support them and our corporate teams to ensure that we are understanding the learning and effectively addressing the challenges of delivering clinical change across the Group. As well as the immediate delivery of integration in these areas the clear aim is to develop a model which we can scale up to deliver horizontally integrated services across the group within the next 2-3 years.

Pillar 2: People

Leadership and operating model

The ongoing consultation, completed in August, aligns clinical and operational leadership teams into Clinical Service Units. The formal feedback from individuals and teams across the organisations is helping to shape the final leadership structures that are being appointed to from September. A single clinical management and leadership structure across UHT with leadership having clear cross-group responsibility will remove a key barrier to true integration of services and will enable work on aligned pathways, equity of access and single waiting lists to progress more easily. Following the tenure of the clinical boards finishing at the end of August, the responsibility for delivering existing clinical strategy and contributing to strategy on an ongoing basis moves to the Clinical Service Units and this is being captured in the developing accountability framework.

Improvement framework

We are progressing work to secure the right capacity and support so that we can implement and embed an approach to continuous improvement in UHT. As we move towards horizontal integration of services we need an organisation-wide approach which will enable us to rapidly (i) transform services to meet the strategic objectives; (ii) deliver priority improvements in operational service delivery, quality and performance across UHT; and (iii) continuous quality improvement in services driven in individual teams and services against the framework. The Board will receive further updates on this work in future meetings.

Pillar 3: Partnerships and places

Our joint working with local authorities

We now have in place a single executive lead for each local authority and are agreeing a small number of priorities with each council. We are putting in place a robust two-way feedback system with a monthly checkpoint so that we can analyse feedback from each senior lead and also communicate key corporate messages on a consistent basis more easily.

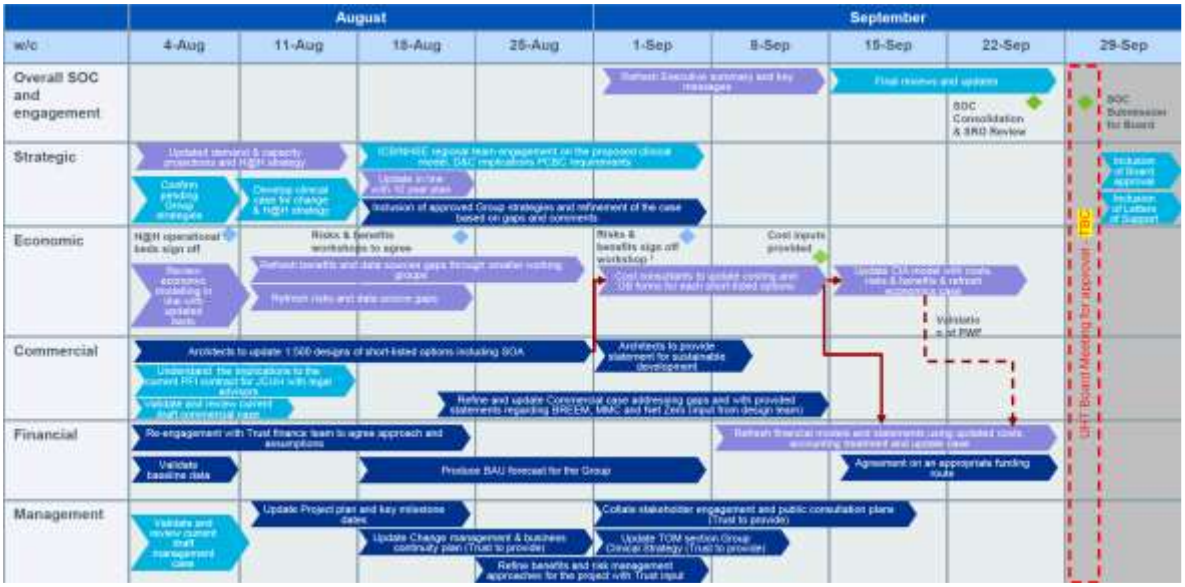
Bids to join Wave 1 of the National Neighbourhood Health Implementation Programme were submitted on 8 August with ICBs and the relevant local authorities. In our area some bids focused on consolidating and accelerating existing work and others suggested new priorities. We will support colleagues in primary care who will provide clinical leadership into the new models. We expect to find our which bids have been approved on 5 September and we are confident that we can align our development of community services to the locally-developed ambitions for neighbourhood health, regardless of the success of this initial wave of bids.

Key enablers

Strategic Outline Case. We are in the final stages of this work in partnership with KPMG and the intention is that this is brought to board in November for consideration.

The redevelopment or replacement of a substantial part of the North Tees estate is both necessary for the longer-term operational viability of the estate on that site but also a critical enabler for the success of our clinical strategy. Our aim to deliver a generational transformation in services through the development of a single hospital system with an acute general hospital on one site and an acute specialist hospital on another has major estates work as a key dependency. The work has involved considerable engagement with the clinical boards in particular on refining the number of beds required on each of the main sites under the proposed model. The proposed final position includes a total number of beds that is broadly equivalent to the numbers now, but configured radically differently. Within the future bed base we would expect absorb likely increases in demand over the next 20 years through making efficiencies in length of stay. In addition we would expect to deliver a significant repositioning of bed capacity and wider hospital services. This will include consolidating specific services where this delivers clinical benefit (between the two major acute sites), developing a new model for neighbourhood-based care building on hospital at home that supports patients to access services closer to home, and radically transforming models of care in outpatients and diagnostics so that these are not reliant on acute hospital estate.

The remaining work includes confirmation of the costings and designs. The timetable runs to 29 September and is set out below:



Ensuring strong governance to provide assurance over delivery

Strategy Programme Board. The Group Strategy Programme Board is now in a monthly cycle and provides the forum to check progress on the strategy through exception reporting and agreeing corrective action where necessary. The Programme Board takes the broad view across the whole of the strategic change programme and can map and address interdependencies.

4. RECOMMENDATIONS

The Board are asked to:

- note the progress on implementation of the UHT strategy; and
- comment on the approach being taken

Caring Better Together

University Hospitals Tees

Board Assurance Framework Report 2025/26 (reporting to 30th June 2025) NTHFT/STHFT

Meeting date: 4 September 2025

Reporting to: Group Board

Agenda item No: 1.11

Report author: Stuart Irvine, Director of Risk, Assurance & Compliance

Executive director sponsor: Stuart Irvine, Director of Risk, Assurance & Compliance

Action required: Assurance

Delegation status: Matter reserved to Unitary Board

Previously presented to: Resources Committee (meeting date: 27th August 2025)

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All sections of the Board Assurance Framework for 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.

Standardised and consistent Board Assurance Framework reporting arrangements are now embedded at Board and Committee level and have been in place since November 2024. This includes the format, content and reporting arrangements. The reporting of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.

The Board Assurance Frameworks have been reviewed and refreshed for 2025/26 and are reported on a monthly basis.

Headlines

NTHFT

- There are 30 strategic risks identified relating to North Tees & Hartlepool NHS Foundation Trust.
- 10 strategic risks are outside of approved risk appetite, of which there are 7 red/high strategic risks outside of approved risk appetite.
- There are two changes to current risk scores.
    - Quality & Safety – patient safety risk increased (9 to 12) due to prevalence of IPC reported cases (approved).
    - Performance & Compliance – diagnostic current risk score reduced (9 to 6) due to 5 months of performance reporting (approved).
- 5 actions are reported as completed (Trust Estate – no change to current risk scores).
- There are 107 planned mitigating actions within the BAF across the 8 domains.
- Planned action timescale range is June 2025 – October 2027.

STHFT

- There are 30 strategic risks identified relating to South Tees Hospitals NHS Foundation Trust.
- 11 strategic risks are outside of approved risk appetite, of which there are 8 red/high strategic risks outside of approved risk appetite.
- There is one changes to current risk scores.
    - Quality & Safety – patient safety risk increased (9 to 12) due to prevalence of IPC reported cases (approved).
- 4 actions are reported as completed (2 for Digital and 2 for Performance & Compliance – no change to current risk scores).
- There are 111 planned mitigating actions within the BAF across the 8 domains.
- Planned action timescale range is June 2025 – April 2035 (this includes planned timescales linked to PFI exit strategy, 2033 and eradicating RAAC, 2035).

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 single University Hospitals Tees Risk Management Policy is now in place and was approved in June 2025.

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

Assurance Statement

This report provides assurance that each Trust's Board Assurance Framework has been reviewed and provides a framework for the strategic risks of each Trust to be managed, mitigated and openly reported.

Mitigating actions (with timescales) are in place for all strategic risks. Full details are reported to the assurance committees of the Group Board, allowing oversight and to allow for further actions to be identified for assurance purposes. Chair Escalation Reports are the mechanism to report assurance concerns to the Group Board.

External Assurance

Planned internal audits will take place on the Board Assurance Framework and Risk Management processes in 2025/26 and will be reported in due course.

Recommendations:

The Group Board is asked to;

- Receive the report and assurance that the Board Assurance Frameworks provide for each Trust.
- Note the content of this report to 30th June 2025.
- Note the 7 red/high strategic risks for NTHFT and 8 red/high strategic risks for STHFT and the planned mitigating actions.
- Advise on any further actions to be taken.

North Tees & Hartlepool NHS Foundation Trust/South Tees Hospitals NHS Foundation Trust – Board Assurance Framework Report (reporting to 30th June 2025)

NTHFT – Key Headlines	STHFT – Key Headlines
• 30 identified strategic risks. • 7 red/high strategic risks that are outside of approved risk appetite. • One step from approved risk appetite. • 107 planned mitigating actions. • 5 actions reported as completed. • Two changes to current risk scores. • Q&S – patient safety risk increased (9 to 12) due to prevalence of IPC reported cases (approved). • P&C – diagnostic current risk score reduced (9 to 6) due to 5 months of performance reporting (approved). • Planned action timescale range - June 2025 – October 2027.	• 30 identified strategic risks. • 8 red/high strategic risks that are outside of approved risk appetite. • One step from approved risk appetite. • 111 planned mitigating actions. • 4 actions reported as completed. • One change to current risk scores. • Q&S – patient safety risk increased (9 to 12) due to prevalence of IPC reported cases (approved). • Planned action timescale range - June 2025 – April 2035.

1. Background

The development and maintenance of a Board Assurance Framework (BAF) has been a mandatory requirement since 2001 for NHS Trusts. The Board Assurance Framework is the key mechanism to reinforce the strategic focus of the Board of Directors to manage strategic risks. It enables the Trust to capture, reporting and monitor key risks that may prevent the delivery of strategic objectives. Operated efficiently and effectively, it provides assurance to the Board of Directors that the Trust is managing strategic risks. The BAF is the key driver to inform the agenda of the Board of Directors and Committee meetings.

2. Purpose

The purpose of this report is to provide assurance to the Group Board (and each Unitary Board) regarding the identification, management and mitigation of strategic risks to support the delivery of strategic objectives. Furthermore, this provides a clear and robust mechanism for Ward to Board and Board to Ward reporting (linking strategic and operational risks).

3. Report Detail

BAF Arrangements

Under Group arrangements an action was to standardise and achieve consistency with Board Assurance Framework format, content and reporting. This action was implemented and reported to the committees of the Group Board from November 2024. Reporting arrangements and timing of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.

BAF Format

University Hospitals Tees has 6 approved strategic objectives for 2025/26 and the Board Assurance Framework makes direct reference to them and identifies the strategic risks that may prevent the delivery of each objective.

The strategic risks are linked to a BAF domain, which reflects key areas of our business/activity and enables an understanding of the nature of the risk.

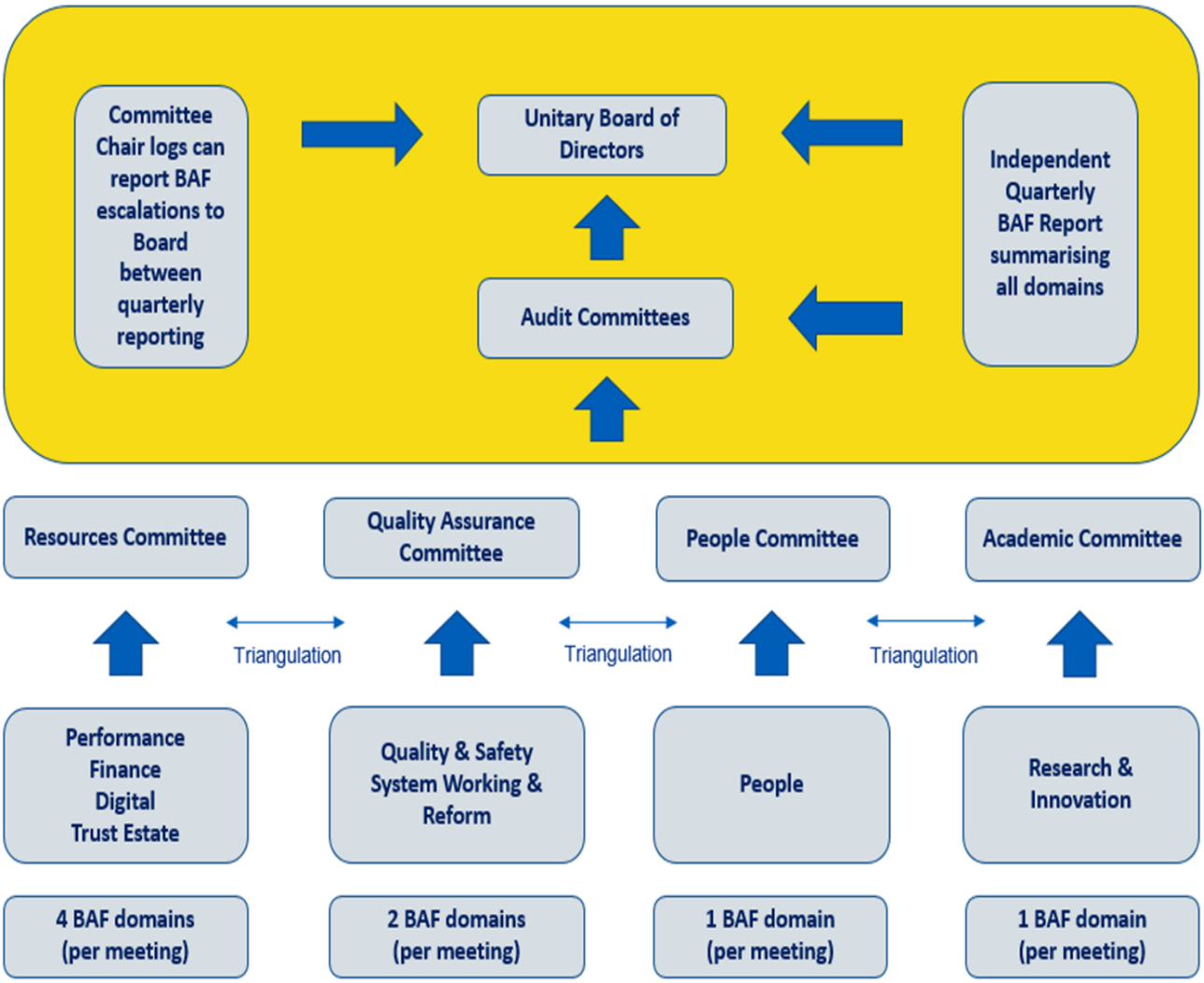
There are 8 BAF domains for each Trust. The BAF domains are informed by national best practice (Good Governance Institute) and benchmarking with regional and national NHS Foundation Trusts.

BAF Domains

The 8 BAF domains for each Trust are led by a Director, with identified BAF authors and the Board Committee that is responsible for oversight and escalation reporting to Board. The table below provides full details.

BAF Domain	Responsible Director	BAF Author	Committee oversight
Quality & Safety	Group Chief Nurse	Group Deputy Director of Patient Safety/Deputy Chief Nurse	Quality Assurance Committee
Performance & Compliance	Group Managing Director/Chief Operating Officers	Deputy Director of Strategy & Planning/ Associate Director of Planning & Performance	Resources Committee
People	Group Chief People Officer	Deputy Director of People Services/ Head of Workforce Planning, Quality & Projects	People Committee
System Working & Reform	Group Chief Strategy Officer	Associate Chief Operating Officer/ Care Group Director, Healthy Lives	Quality Assurance Committee
Finance	Group Chief Finance Officer	Deputy Chief Finance Officer/ Deputy Director of Finance	Resources Committee
Digital	Group Chief Information Officer	Interim Head of IT/ Deputy Chief Information & Technology Officer	Resources Committee
Trust Estate	Group Director of Estates	Associate Director of Estates & Capital (NTH Solutions LLP)/Deputy Director of Estates, Capital and Programmes	Resources Committee
Research & Innovation	Group Medical Director	Associate Director, TVRA/Director of Innovation	Quality Assurance Committee

For continued illustration purposes, the reporting arrangements for the BAF are set out below, with the addition of the Academic Committee, which has now been established and meets on a quarterly basis. The benefit of this approach allow Board Committees to receive BAF reports at each meeting, to focus on their areas of expertise and reports are presented by subject matter experts who manage and mitigate the risks. Key to the management and mitigation of strategic risks is the triangulation between Board Committees.



BAF Domain Alignment to Strategic Objectives

It is important that all strategic objectives of each Trust is aligned to at least one BAF domain to support the delivery of strategic objectives. The BAF domain template require the BAF domain to be linked to at least one strategic objective. The mapping of BAF domains to strategic objectives for 2025/26 has been presented to the Board that confirms the strategic risks are linked to the BAF and are relevant for each organisation.

Risk Appetite

The approved risk appetites for the BAF domains for each Trust are set out in this report and reflecting the increased risk environment and challenges to deliver annual plans.

Risk domain	NTHFT Risk appetite level	STHFT Risk appetite level	Current Risk Score Range
Quality & Safety	Cautious	Cautious	4-6
Trust Estate	Open	Open	8-12

Risk domain	NTHFT Risk appetite level	STHFT Risk appetite level	Current Risk Score Range
Performance & Compliance	Open	Open	8-12
People	Open	Open	8-12
Digital	Open	Open	8-12
Finance	Open	Open	8-12
Research and Innovation	Open	Open	8-12
System Working & Reform	Open	Open	8-12

Risk Appetite Supporting Statements

The approved risk appetites and supporting risk appetite statements of each Trust are consistent. This provides each Trust and the Boards with the ability consider future decision making against approved risk appetites by domain and supporting risk appetite statement. This maintains existing governance arrangements and ensures compliance with good governance requirements. Risk appetite is formally reviewed on an annual basis by the Board and an annual Board seminar on risk appetite is held. Attached at **Appendix A** is the approved risk appetite supporting statements.

Strategic Risk Score Analysis

The following table shows by Trust, the number of strategic risks, number of strategic risks outside of approved risk appetite, steps away from approved risk appetite and the number of planned mitigating actions.

Domain	Number of strategic risks		Number of strategic risks adversely outside of approved risk appetite		Number of steps away from approved risk appetite		Number of planned mitigating actions	
	NT	ST	NT	ST	NT	ST	NT	ST
Quality & Safety	3	3	**3**	**3**	1	1	9	9
Performance & Compliance	3	4	0	**2**	0	1	8	14
Digital	4	3	0	0	0	0	16	12
People	4	4	0	0	0	0	14	14
Finance	4	4	**1**	**1**	1	1	5	5
Trust Estate	5	5	**3**	**2**	1	1	23	22
System Working & Reform	2	2	0	0	0	0	21	21

Domain	Number of strategic risks		Number of strategic risks adversely outside of approved risk appetite		Number of steps away from approved risk appetite		Number of planned mitigating actions	
	NT	ST	NT	ST	NT	ST	NT	ST
Research & Innovation	5	5	**3**	**3**	1	1	11	14
Total Number	**30**	**30**	**10**	**11**			**107**	**111**

NTHFT	STHFT
• The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 10 strategic risks that are outside of approved risk appetite. • All strategic risks are no more than one step from the approved risk appetite. • Planned actions are in place for each strategic risk. • Planned action timescale range is June 2025 – October 2027.	• The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 11 strategic risks that are outside of approved risk appetite. • All strategic risks are no more than one step from the approved risk appetite. • Planned actions are in place for each strategic risk. • Planned action timescale range is June 2025 – April 2035.

Included in the planned timescales are the actions linked to PFI exit strategy (2033) and eradicating RAAC 2035.

NTHFT Red/High Strategic Risks outside Approved Risk Appetite

The table below identifies that there are 7 strategic risks that are red/high and are outside of approved risk appetite. These risks are presented to the respective Board committees noted below and will be continue to be monitored to ensure mitigating actions are robust and progressed as planned.

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan.	Finance	**4 x 4 = 16**	1	Resources Committee
Failure of Trust infrastructure (including buildings).	Trust Estate	**3 x 5 = 15**	5	Resources Committee
Insufficient capital funding to maintain Trust estate.	Trust Estate	**5 x 4 = 20**	2	Resources Committee

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Reduction of system capacity if the Trust is unable to provide services.	Trust Estate	**5 x 3 = 15**	3	Resources Committee
Over-reliance on external income leads to R&D financial uncertainty and limits growth.	Research & Innovation	**4 x 4 = 16**	5	Academic Committee
Innovation growth is limited by investment and resource constraints.	Research & Innovation	**5 x 3 = 15**	2	Academic Committee
Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.	Research & Innovation	**5 x 4 = 20**	1	Academic Committee

The reported position is illustrated and supported by the Trust's Strategic Risk Overview **(See Appendix B)** and the Trust Risk Radar **(See Appendix C).**

STHFT Red/High Strategic Risks Outside Approved Risk Appetite

The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. The table below identifies that there are 8 strategic risks that are red/high and are outside of approved risk appetite. These risks are presented to the respective Board committees noted below and will be continue to be monitored to ensure mitigating actions are robust and progressed as planned.

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Inability to controls costs within allocated resources	Finance	**4 x 4 = 16**	1	Resources Committee
Risk that the referral-to-treatment 18-week NHS Constitution standard is not met	Performance & Compliance	**3 x 5 = 15**	4	Resources Committee
Risk that the cancer referral to treatment 62-day NHS Constitution standard is not met	Performance & Compliance	**3 x 5 = 15**	2	Resources Committee

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Insufficient capital funding to maintain Trust estate	Trust Estate	**4 x 5 = 20**	2	Resources Committee
Trust estate does not allow for the provision of optimal clinical services	Trust Estate	**3 x 5 = 15**	2	Resources Committee
Over-reliance on external income leads to R&D financial uncertainty and limits growth	Research & Innovation	**4 x 4 = 16**	5	Academic Committee
Innovation growth is limited by investment and resource constraints	Research & Innovation	**5 x 3 = 15**	2	Academic Committee
Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.	Research & Innovation	**5 x 4 = 20**	3	Academic Committee

The position is illustrated by the Trust's Strategic Risk Overview **(See Appendix D)** and the Trust Risk Radar **(See Appendix E).**

Trust Operational Risks

Attached as appendices for information are the Top 10 operational risk for each Trust (**Appendix F** – NTHFT and **Appendix G** – STHFT) for information. Operational risks of each Trust are reviewed on a monthly basis by respective Risk Management Groups.

Risk Management Policy

A single University Hospitals Tees Risk Management Policy is now in place and was approved in June 2025.

External Assurance

Planned internal audits will take place on the Board Assurance Framework and Risk Management processes in 2025/26 and will be reported in due course.

4. Conclusion/Summary

The BAF continues to be regularly reported for each Trust and incorporates;

- The requirement to maintain separate BAFs for each Trust as they remain separate legal entities.
- Mapping the BAF domains to the relevant Group strategic objectives.
- Approved risk appetites for each BAF domain and supporting statement for 2025/26.
- The reporting of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.
- Board Committees have full oversight of the BAF report, in additional to the oversight responsibility allocation for BAF domains. A copy of the full BAF report for each Trust is placed in the Reading Library of each Committee and Board.
- Board Committees to escalate any concerns regarding the management and mitigation of strategic risks in BAF domains to the Board of Directors via the Chair's Logs.
- The medium/long term strategy/plan that each BAF domain is linking/referencing strategic risks e.g. UHT Strategy, Quality Priorities, People Plan etc.
- Ensuring strategic risks in each BAF domain are strategic in nature (they may run beyond a 12 month period).
- Ensure mitigating planned actions are strategic and will either maintain a current risk score or achieve a target risk score.
- Review of linked operational risks to ensure they are they up to date and linked to strategic risks. Work in this area remains ongoing.
- The learning from internal audit report findings.
- There are 30 strategic risks relating to NTHFT and there are 7 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- There are 30 strategic risks relating to STHFT and there are 8 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- This report is also presented to respective Audit Committees.

Assurance Statement

This report provides assurance that each Trust's Board Assurance Framework has been reviewed and provides a framework for the strategic risks of each Trust to be managed, mitigated and openly reported.

Mitigating actions (with timescales) are in place for all strategic risks. Full details are reported to the assurance committees of the Group Board, allowing oversight and to allow for further actions to be identified for assurance purposes. Chair Escalation Reports are the mechanism to report assurance concerns to the Group Board.

5. Recommendation

The Group Board is asked to;

- Receive the report and assurance that the Board Assurance Frameworks provide for each Trust.
- Note the content of this report to 30th June 2025.
- Note the 7 red/high strategic risks for NTHFT and 8 red/high strategic risks for STHFT and the planned mitigating actions.
- Advise on any further actions to be taken.

Supporting Appendices

- Appendix A – Risk Appetite Supporting Statements
- Appendix B – NTHFT Strategic Risk Overview
- Appendix C – NTHFT Risk Radar
- Appendix D – STHFT Strategic Risk Overview
- Appendix E – STHFT Risk Radar
- Appendix F – NTHFT Top 10 Operational risks
- Appendix G – STHFT Top 10 Operational Risks

Trust Risk Appetites & Supporting Statements (*)

Board Assurance Framework Domain	Proposed Risk Appetite	Proposed Risk Appetite Supporting Statement
Quality & Safety	**Cautious**	We have a **cautious** attitude to the delivery of the **Quality and Safety** agenda within the Trust to balance low risk against the possibility of improved patient outcomes, ensuring appropriate controls are in place. We will continue to protect the quality and safety of care with a cautious approach to the risks that may have a detrimental impact on patient safety, experience and clinical outcomes.
Performance & Compliance	**Open**	We have an **open** approach to **Performance and Compliance**. This will mean being willing to consider options available to support the delivery of performance targets and recognising the significant challenge to deliver Trust/System level targets and the needs to work with our system partners.
Digital	**Open**	We have an **open** attitude to the **Digital** agenda underpinning clinical innovation and the transformation of services to become more efficient and effective, including system collaboration. While we are prepared to accept some level of risk to implement changes for longer-term benefit, we will ensure that information governance and data security remains a priority.
People	**Open**	We have an **open** risk approach to our **People** challenges as we look at new and innovative ways to recruit, retain and support our people, whilst recognising the importance of a strong focus on engagement and culture.
Finance	**Open**	We have an **open** attitude to risk in relation to **Finance**. It is acknowledged that there are significant finance challenges across the healthcare system and options will need to be considered to support delivery of challenging financial plans and achieve favourable outcomes. The Trust will continue to apply robust financial controls and comply with governance requirements.
Trust Estate	**Open**	We have an **open** attitude to the **Trust Estate** due to the associated risks and need to consider all potential options to ensure the estate remains fit for purpose to deliver safe and effective care.
System Working & Reform	**Open**	We have an **open** approach to **System Working & Reform** to ensure future safe, effective and sustainable services are provided to our population. We will explore new opportunities on an ongoing basis to deliver major reform knowing that will involve taking a measure of risk.
Research & Innovation	**Open**	We have an **open** approach to **Research and Innovation** in recognition of the requirement of new ways of working. In developing and delivering our clinical research and innovation ambitions we accept that these carry a higher level of inherent risk. We will seek opportunities to work collaboratively with system partners, contribute to the delivery of priorities and develop new ways of working through a range of partnerships.

(*) The risk appetites and supporting risk appetite statements are the same for each Trust.

NTHFT - Board Assurance Framework

Risk Appetite				
Avoid 0	Minimal 1-3	Cautious 4-6	Open 8-12	Seek 15 -25

Quality & Safety	Digital	People	Finance	Performance and Compliance	System Working & Reform	Trust Estate	Research & Innovation
Patient safety – Failure to protect people from abuse or avoidable harm	Investment into the implementation of new digital systems not meeting the needs of the Trust (Group) and its transformation agenda	A workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future	Adverse financial impact due to system working requirements (Health & Care Act 2022)	Non-compliance with national standard in accordance with the Oversight Framework, and referral to treatment recovery priorities	The Trust isn't strategically positioned locally and regionally to deliver the UHT strategy	Failure of Trust infrastructure (including buildings)	Lack of integration of research with digital infrastructures prevents the delivery of effective research
Patient experience – Failure to provide care that is compassionate, kind and inclusive	Failure to protect the information / data we hold as a result of non-compliance with legislation and/or non-compliance with Trust policy	A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements	Insufficient funding in existing contract arrangements for services provided to the population	Non-compliance with national standards in accordance with the Oversight Framework, and cancer recovery priorities	The Trust doesn't reform clinical services to meet local and regional need in line with planned timescales	Insufficient capital funding to maintain Trust estate	Growth research is constrained by infrastructure, capacity and culture
Failure to provide clinically effective treatment in line with best evidence	Technical Infrastructure fails to maintain effective cyber defences, negatively impacting operational delivery, security and reputation (Cyber-attack)	Not having a Health and Wellbeing offer that positively supports organisational efficiency and our colleagues ability to deliver quality patient care	Inability to controls costs within allocated resources	Non-compliance with national standards in accordance with the Oversight Framework, and Diagnostics recovery priorities		Trust estate does not allow for the provision of optimal clinical services	Over-reliance on external income leads to R&D financial uncertainty and limits growth
	Pressured resources within Digital teams which poses a risk to the delivery of the digital strategy and BAU activity (People & Process)	Workforce planning and people practices don't support the Trust to deliver its services	Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan			Reduction of system capacity if the Trust is unable to provide services	Innovation growth is limited by investment and resource constraints
						Non-compliance with legal and regulatory standards of the Trust's estate	Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture

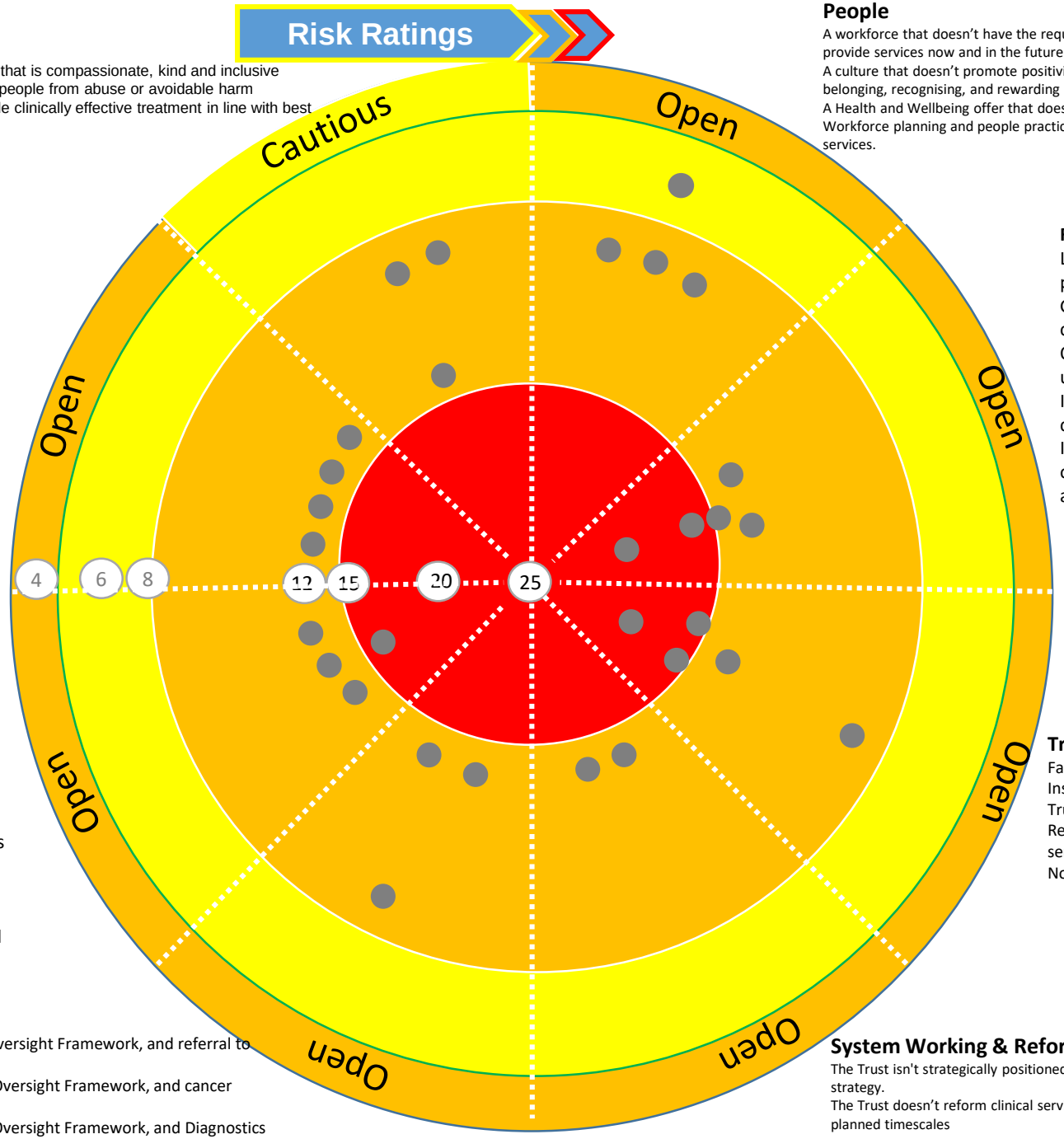
Strategic Risks

Strategic Risk Level			
Very Low 1-3	Low 4-6	Moderate 8-12	High 15- 25

Appendix C

NHS
North Tees and Hartlepool
NHS Foundation Trust

30th June 2025
BAF Risk Radar



High
Moderate
Low

Quality & Safety
Patient safety – Failure to provide care that is compassionate, kind and inclusive
Patient Experience – Failure to protect people from abuse or avoidable harm
Clinical Effectiveness - Failure to provide clinically effective treatment in line with best evidence

People
A workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future.
A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements.
A Health and Wellbeing offer that doesn't meet the needs of our workforce.
Workforce planning and people practices don't support the Trust to deliver its services.

Digital
Investment into the implementation of new digital systems not meeting the needs of the Trust (Group) and its transformation agenda
Failure to protect the information / data we hold as a result of non-compliance with legislation and/or non-compliance with Trust policy
Technical Infrastructure fails to maintain effective cyber defences, negatively impacting operational delivery, security and reputation (Cyber-attack)
Pressured resources within Digital teams which poses a risk to the delivery of the digital strategy and BAU activity (People & Process)

Research & Innovation
Lack of integration of research with digital Infrastructures prevents delivery of effective research.
Growth in research is constrained by infrastructure, capacity and culture.
Over-reliance on external income leads to R&D financial uncertainty and limits growth.
Innovation growth is limited by investment and resource constraints.
Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.

Finance
Adverse financial impact due to system working requirements (Health & Care Act 2022).
Insufficient funding in existing contract arrangements for services provided to the population.
Inability to controls costs within allocated resources.
Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan.

Trust Estate
Failure of Trust infrastructure (including buildings)
Insufficient capital funding to maintain Trust estate
Trust estate does not allow for the provision of optimal clinical services
Reduction of system capacity due to the Trust being unable to provide services, impacting on reputation
Non-compliance with legal and regulatory standards of the Trust's estate.

Performance & Compliance
Non-compliance with national standard in accordance with the Oversight Framework, and referral to treatment recovery priorities
Non-compliance with national standards in accordance with the Oversight Framework, and cancer recovery priorities
Non-compliance with national standards in accordance with the Oversight Framework, and Diagnostics recovery priorities

System Working & Reform
The Trust isn't strategically positioned locally and regionally to deliver the UHT strategy.
The Trust doesn't reform clinical services to meet local and regional need in line with planned timescales

STHFT - Board Assurance Framework

Risk Appetite				
Avoid 0	Minimal 1-3	Cautious 4-6	Open 8-12	Seek 15 -25

Strategic Risks

Quality & Safety	Digital	People	Finance	Performance and Compliance	System Working & Reform	Trust Estate	Research & Innovation
Failure to protect people from abuse or avoidable harm	Failure to implement planned digital programmes and infrastructure projects through lack of adequate funding	A workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future	Adverse financial impact due to system working requirements (Health & Care Act 2022)	Risk that the A&E 4-hour standard is not met	The Trust isn't strategically positioned locally and regionally to deliver the UHT strategy	Failure of Trust infrastructure (including buildings)	Lack of integration of research with digital infrastructures prevents the delivery of effective research
Failure to provide care that is compassionate, kind and inclusive	Failure to adequately maintain and upgrade current systems and infrastructure	A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements	Insufficient funding in existing contract arrangements for services provided to the population	Risk that the referral-to-treatment 18-week NHS Constitution standard is not met	The Trust doesn't reform clinical services to meet local and regional need in line with planned timescales	Insufficient capital funding to maintain Trust estate	Growth research is constrained by infrastructure, capacity and culture
Failure to provide clinically effective treatment in line with best evidence	Failure to prevent a successful cyber attack or data breach	Not having a Health and Wellbeing offer that positively supports organisational efficiency and our colleague's ability to delivery quality patient care	Inability to controls costs within allocated resources	Risk that the diagnostic 6-week NHS Constitution standard is not met		Trust estate does not allow for the provision of optimal clinical services	Over-reliance on external income leads to R&D financial uncertainty and limits growth
		Workforce planning and people practices don't support the Trust to deliver its services	Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan	Risk that the cancer referral to treatment 62-day NHS Constitution standard is not met		Reduction of system capacity if the Trust is unable to provide services	Innovation growth is limited by investment and resource constraints
						Non-compliance with legal and regulatory standards of the Trust's estate	Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture

Strategic Risk Level			
Very Low 1-3	Low 4-6	Moderate 8-12	High 15- 25

Appendix E

NHS South Tees Hospitals NHS Foundation Trust

Quality & Safety

Patient safety – Failure to provide care that is compassionate, kind and inclusive
Patient Experience – Failure to protect people from abuse or avoidable harm
Clinical Effectiveness - Failure to provide clinically effective treatment in line with best evidence

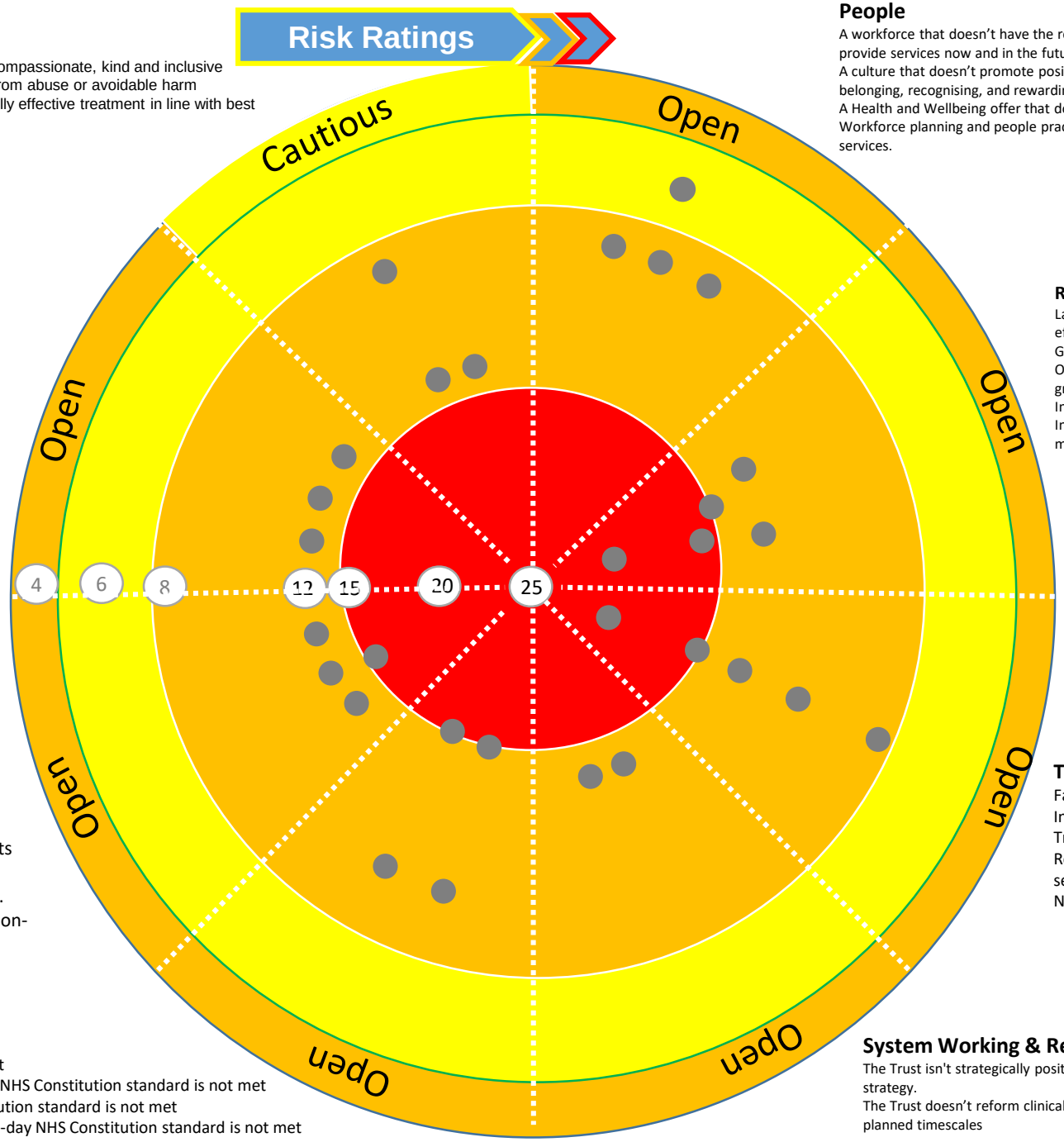
High
Moderate
Low

People

A workforce that doesn't have the required knowledge, skills and experience to provide services now and in the future.
A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements.
A Health and Wellbeing offer that doesn't meet the needs of our workforce.
Workforce planning and people practices don't support the Trust to deliver its services.

Digital

Failure to implement planned digital programmes and infrastructure projects through lack of adequate funding
Failure to adequately maintain and upgrade current systems and Infrastructure
Failure to prevent a successful cyber attack or data breach



Research & Innovation

Lack of integration of research with digital Infrastructures prevents delivery of effective research.
Growth in research is constrained by infrastructure, capacity and culture.
Over-reliance on external income leads to R&D financial uncertainty and limits growth.
Innovation growth is limited by investment and resource constraints.
Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture.

30th June 2025
BAF Risk Radar

Finance

Adverse financial impact due to system working requirements (Health & Care Act 2022).
Insufficient funding in existing contract arrangements for services provided to the population.
Inability to controls costs within allocated resources.
Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan.

Trust Estate

Failure of Trust infrastructure (including buildings)
Insufficient capital funding to maintain Trust estate
Trust estate does not allow for the provision of optimal clinical services
Reduction of system capacity due to the Trust being unable to provide services, impacting on reputation
Non-compliance with legal and regulatory standards of the Trust's estate.

Performance and Compliance

Risk that the A&E 4-hour standard is not met
Risk that the referral-to-treatment 18-week NHS Constitution standard is not met
Risk that the diagnostic 6-week NHS Constitution standard is not met
Risk that the cancer referral to treatment 62-day NHS Constitution standard is not met

System Working & Reform

The Trust isn't strategically positioned locally and regionally to deliver the UHT strategy.
The Trust doesn't reform clinical services to meet local and regional need in line with planned timescales

Appendix F

North Tees and Hartlepool
NHS Foundation Trust

Top 10 Operational Risks (30 June 2025)

InPhase Risk ID	Title of Risk	Department/Area	Risk Owner	Current Risk Score
141	Significant sickness absence and vacancy within the Resus team impacting on the capacity to deliver required Resus training for Trust staff which could impact on patient safety and resus outcomes	Corporate	Rachel Desilva	12
174	There is an expected reduction in newly qualified nurse availability in 2028 which affects nursing safe staffing levels impacting on patient safety, delivery of quality care and services. This will also result in reduction in associated financial tariff coming into NTH	Corporate	Emma Roberts	12
183	Risk of suboptimal outcomes for patients due to being an outlier for the implementation of the National Wound Care Strategy Programme: Lower Limb Lower Recommendations	Corporate	Andy Brown	12
195	Service delay and potential non compliance with GDPR / DPA IG if IG team are unable to provide a full IG service due to insufficient resources.	Corporate	Kerry McLean	12
201	There is a potential that the Trust will not achieve appropriate fire safety training standards following changes to the HTM 05:03 Part A (2024) which emphasises the requirements of bespoke fire safety training, impacted by a lack of resources to deliver the increased volume of training and could lead to a sub optimal response in a fire situation.	Corporate	Stephen Cuthbert	12
21	Poor patient outcomes due to dis-jointed layout of the EAU Assessment Area estate. Potential impact of delays to assessment, diagnosis, and treatment commencement, as well as responding to and managing clinical incidents.	Responsive Care	Claire Ranson	12
223	Poor patient experience linked to unsuitable accommodation in the Wheelchair Service in Stockton	Healthy Lives	Fiona Hardie	12
230	Due to high level of Dentist absence there is inadequate clinical staffing capacity to deliver the commissioned work plan impacting on patient waiting time and experience	Healthy Lives	Wendy McGee	12
239	Inability to appoint more than 1 competent persons to undertake PAS-79 Fire Risk Assessment impacting on the amount of risk assessments that can be completed within a 12 month period	Corporate	Stephen Cuthbert	12

244	Due to increased number of referrals received and vacant posts, there are longer waits for Under 5 Multi-agency autism team (MAAT) assessments resulting in possible reputational damage, possible suboptimal care and unmet health needs	Healthy Lives	Leanne Boyd-Smith	12
256	Lack of a dedicated maternity triage service increasing risk of deterioration of women and babies causing sub optimal outcomes	Healthy Lives	Gemma Gordon	12
267	Due to insufficient FIT Testing provision, there is a number of staff non compliant with HSE FIT testing legislation impacting on staff and patient safety	Corporate	Victoria Hancock	12
271	workforce and skill mix deficit in critical care impacting on service delivery and patient safety	Collaborative Care	Tom Bingham	12
280	Delivery of Aseptic Services to the Trust are at risk due to current estate provision	Healthy Lives	Marco Picone	12
30	Fragility of Infection Prevention and Control Workforce can lead to a loss of service and affect patient outcomes	Corporate	Victoria Hancock	12
53	Sickness absence and vacancy within the Simulation service is reducing the ability to deliver a full simulation service which may impact on the quality and quantity of teaching provided to staff across the Trust	Corporate	Rachel Desilva	12
6404	Risk to service delivery due to ICT Staffing Levels and BAU	Corporate	Mick Fox	12
88	Potential for delayed care and management of paediatric testicular torsion due to lack of approved regional pathway	Collaborative Care	Steve Heavisides	12

Appendix G

South Tees Hospitals NHS Foundation Trust

Top 10 Operational Risks (30th June 2025)*

Datix Risk ID	Title of Risk	Department/Area	Risk Owner	Current Risk Score
829	There is a risk of delays in cellular pathology results being available to support patient pathways, the patient outcome may be sub optimal.	Cellular Pathology	Sharron Pooley	20
797	RAAC - Panels - located in Women's and Children's area - James Cook - Area at risk of uncontrolled structural failure in areas where RAAC is present - Eradication required by 2035	Women and Children Services	Paul Swansbury Deputy Director of Estates, Capital, and Programmes	20
382	Risk of harm to patients due to a lack of access to neuropsychology treatment for neurorehabilitation outpatients.	Neurohabilitation	Jenna Moffitt	16
279	Provision of critical care follow up is non compliant with the adult critical care service specification leading to a risk of patient physical and psychological harm and a proven risk of readmission to hospital because there is no dedicated critical	Critical Care Medicine	Michelle Carey Consultant and Clinical Director, Critical Care Medicine, JCUH	16
382	Risk of harm to patients due to a lack of access to neuropsychology treatment for neurorehabilitation outpatients	Neurohabilitation	Jenna Moffitt	16
857	Risk that patient privacy and dignity is compromised when trying to deliver rehabilitation psychology treatment to patients on ward 26	JCUH Ward 26 - Neuro Rehab JCUH	Glynis Peat	16
866	Risk that complex cognitive patients on Ward 26 may come to harm and have poorer experience as they are not receiving appropriate standards of psychological specialist care according to Neurorehabilitation Standards due to a lack of funding for requirements	JCUH Ward 26 - Neuro Rehab JCUH	Glynis Peat	16
278	The inability to isolate patients in a timely and effective manner, leading to potential onward transmission of infection. Critical care triggers nationally via ICNARC data as an outlier for C-Diff infections.	Critical Care Medicine	Michelle Carey Consultant and Clinical Director, Critical Care Medicine, JCUH	15
39	The trust is commissioned to deliver neurosurgical high dependency care, currently the service is not providing the required ICU consultant sessions in NHDU, the unit is non-compliant with the service specification.	Critical Care Medicine	Michelle Carey Consultant and Clinical Director, Critical Care Medicine, JCUH	15
777	The trust is commissioned to deliver neurosurgical high dependency care, currently the service is not providing the required ICU consultant sessions in NHDU, the unit is non-compliant with the service specification.	Radiology	Callum Pearce Interventional Radiology and Fluoroscopy Modality Manager	15

(*) The Trust continues to work with all risk owners (via Collaborative and Corporate areas) to ensure all risks are validated.

NHS
University Hospitals Tees

Quality Assurance Committee

July 2025

Connecting to: Group Board

Chair of Committee: Fay Scullion

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.

BAF demonstrated an increased risk to patients safety score, due to HCAI. There are some high operational risks that are being monitored, and these will be included in the dashboard development.

Infection control issues continue. C Diff continues to rise, this is being monitored on a weekly basis in line with the fundamentals of practice. This will be reported on the dashboard. There has been an incidence of MRSA in Neonates, 5 babies with the same strain resulting in the restricted shared use of comforting tools. Dedicated decant facilities remain an issue, options are being revised by estates department. The audits remain and staff are being asked what actions are being put in place, rather than repeat audits. Antibiotic prescribing remains an issue across UHT and work is needed to improve on this, and updates will go on the dashboard. The committee agreed that there needs to be a piece of work on public health analysis on what we expect from our population which will help triangulate predicted rates.

Clinical effectiveness reports remain outstanding with issues across both sites. Have explored working on national audits with other Trusts to no avail and currently there is no clarity on how this will be addressed across UHT – committee have asked for what the absolute necessities are and how these can be addressed.

Caring Better Together

There have been 2 Maternity and Neonates Serious Incidents and awaiting the learning from these, although some immediate actions identified 1) translation services need addressed and discussions ongoing 2) referral timeliness from midwives to medics

2 Never events occurred, 1 in orthopaedics and 1 in gynaecology. - multi disciplinary meetings are underway to understand the learning.

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 external evaluation of PSIRF is ongoing, initial findings identified is that Board member training is at 36% which needs to be addressed. Post meeting note – Board member mandatory training requirements do not currently include this training so an action has been taken to include it.

Complaints remain below target, less than 80% being addressed within the timescales, but teams are actively monitoring on a weekly basis and sharing good practice across UHT.

There is a continued suspension of the Rowan Suite and a review is being undertaken by the Director of Midwifery across UHT and report will available Q3.

Cancer standards remain a concern and a request had been made that potential harm is investigated and reported back to 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.

TOR and cycle of business were agreed across UHT and there will be a focus so that elements of risk will be communicated and discussed regularly. Where reports need to be communicated by site this will continue.

There continues to be evidenced of good joint working across UHT with combined reports and action plans as appropriate.

Maternity and Neonates

- CQC actions being progressed and positive.
- £300K has been secured to develop a mental health service across UHT.
- Mandated training for all perinatal staff has increased to 86% and in right direction for compliance.

University Hospitals Tees Perinatal Quality and Safety Report; Quarter 1 2025.26

Meeting date: 4 September 2025

Reporting to: Board of Directors

Agenda item No: 2.2

Report author: *Hannah Matthews; Interim HoM, Tracey Gray; Governance lead midwife and Stephanie Worn; Director of Midwifery*

Executive director sponsor: *Emma Nunez, Chief Nurse*

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

Delegation status: **Jointly delegated item to Group Board**

Previously presented to: *Quality Assurance Committee, Perinatal Services Quality Assurance Council and STHFT Perinatal Leadership Team*

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☒

Using our resources well ☐

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.

NTHFT reported a Hypoxic Ischaemic Encephalopathy (HIE) incident to the Maternity and Neonatal Safety Investigations (MNSI). The Perinatal Leadership Team has responded by initiating regular meetings to examine potential contributing factors, including clinical practices, systems, data, and processes. The service has shared details of the HIE referrals with the North East and North Cumbria Local Maternity and Neonatal System (LMNS). In response, the LMNS are to conduct a comprehensive review of maternity services to focusing on identifying contributing factors such as clinical pathways, systems, data, and processes.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative

NTHFT Intrapartum service for the Rowan Suite at University Hospital Hartlepool remains temporary suspended as workforce pressures remain.

STHFT has formulated plans to address the Care Quality Commission (CQC) actions concerning estate management. Additionally, a revised model of care delivery for The Friarage site is currently under development.

The group maternity services are progressing toward compliance with internally validated safety actions. In August, meetings will be held with the Local Maternity and Neonatal System (LMNS) to review Safety Action 6 – Saving Babies' Lives Care Bundle.

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

Perinatal safety champion engagement sessions across the service have provided positive insights from colleagues.

The group services are collaborating on quality improvement project to improve the rate of antenatal bookings before the 10th week of pregnancy.

The group services are collaborating the ICB commissioners to develop a Maternal Mental Health service.

Recommendations:

Board of Director members are asked to note the content of the report

The Board members are asked to approve the following:

- NTHFT and STHFT Transitional care action plans
- NTHFT and STHFT Maternity survey action plan
- NTHFT and STHFT SCORE action plans

University Hospitals Tees
Meeting of the Board of Directors
Quarter 1 2025.26
Perinatal Services Safety and Quality Report for Quarter 1 2025.26

1. Introduction/Background

The purpose of the report is to inform and provide assurance to the 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 1 of 2025/26. This report contains the perinatal quality surveillance model report for June 2025 and the dashboards (Appendix 1, 2 and 3). 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).

University Hospitals Tees provides a comprehensive community and hospital based maternity and neonatal service. The service provision differs between the 2 main sites. North Tees and Hartlepool (NTHFT) provides a consultant and midwifery led care service with a maternal medicine service and a level one special care unit neonatal service. South Tees (STHFT) is a tertiary unit for neonatal care offering a level three neonatal intensive unit service. The obstetric service provides a consultant and midwifery led care service, maternal and fetal medicine

1.Maternity services overview

The activity for the maternity service is outlined in Table 1.

Table 1 – Maternity activity

	University Hospitals Tees	North Tees & Hartlepool		South Tees	
		North Tees	University Hospital Hartlepool	James Cook	Friarage
Bookings	1986	509	363	979	135
All Births	1760	633	1	1100	26
Home birth	7	1	1	3	2
Elective LSCS	320	101 (16%)	N/A	219 (19.7%)	N/A
Induction of labour	692	178 (28%)	N/A	514 (46.13%)	N/A

In May 2025, the intrapartum service offer by the Maternity Continuity Care (MCoC) for UHH was suspended temporarily due to workforce pressures. A review will be held in July 2025. The Friarage suspended services on 13 occasions in this quarter, due to workforce pressures and high acuity at the JCUH site

2. Perinatal mortality rate

In Quarter 1, the crude 12-month rolling annual stillbirth rate per 1000 births for NTHFT was of 3.61% and STHFT rate was 3.24% (exclusive of medical termination of pregnancy). The crude12-month rolling neonatal death rate per 1000 births for NTHFT was zero%, and STHFT was 1.72 % (inclusive of early and late neonatal deaths) (Table 2 and 3). NTHFT are undertaking a thematic analysis of stillbirths with support from STHFT obstetric colleagues for due diligence. The Group intention is to develop a joint case review meeting.

Table 2 NTHFT Crude Stillbirth Rate

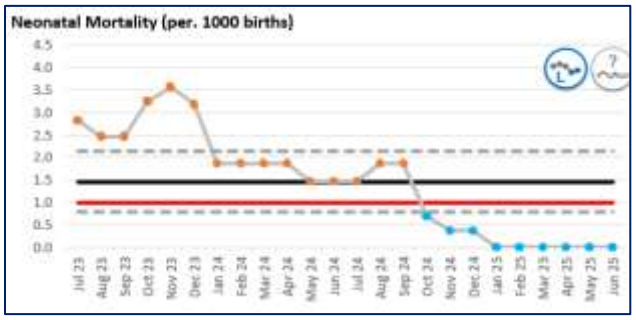
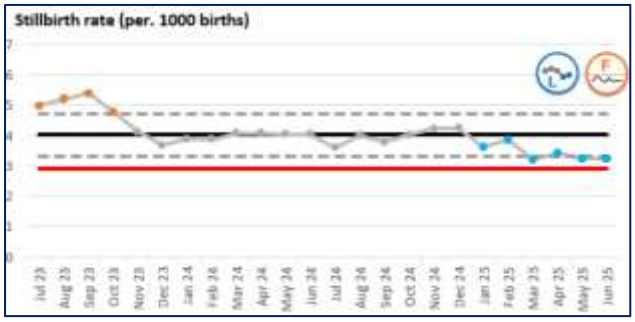
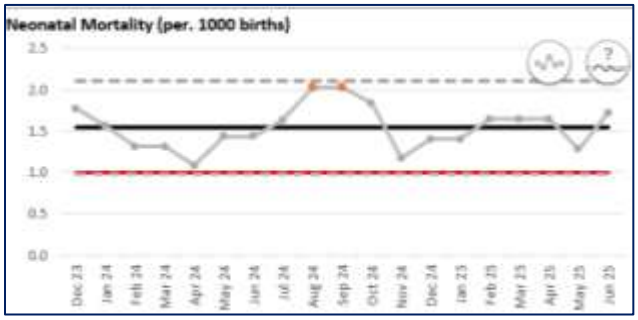


Table 3 STHFT Crude Stillbirth Rate





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 Assurance Committee and quarterly to the Board of Directors.

Learning from PMRT reviews in Quarter

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.

Improvement plans have been developed and further detail are the in quarter 1 perinatal morbidity and mortality report. Learning points from review meetings across the group are:

- To develop a pathway to enable bereaved parents from out of the region to take babies home
- To review patient information leaflets and promote access via BadgerNet notes

3 Maternity and Neonatal Safety Investigations (MNSI)

MNSI team 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.

Reported and investigation progress update

MNSI were notified of less than five events that met the eligible criteria in quarter 1 for both services. Table 4 outlines the compliance requirements for MIS year 7.

Table 4. Independent investigations

	University Hospitals Tees		North Tees & Hartlepool		South Tees	
	Eligible cases	**Notification completed**	**Eligible cases**	**Notification completed**	**Eligible cases**	**Notification completed**
Eligible cases reported to MNSI	2	2	1	1	1	1
Eligible cases reported to NHSR EN	1	1	1	1	0	0
Family informed of MNSI, EN scheme and duty of candour	2	2	1	1	1	1
Trust Claims reporting wizard completed	1	1	1	1	0	0
Eligible cases reported to MNSIA	2	2	1	1	1	1

Safety recommendations and learning from completed investigations

NTHFT and STHFT had zero completed MNSI investigations and both services each have 1 active MNSI. NTHFT reported 1 event to MNSI within relevant timeframes. Limited information is shared within this report to minimise patient identifiable details, and a full report is provided to the Board of Directors In-Committee.

Coroner Reg 28 made directly to the Trusts
No requests made in this reporting period.

4. Maternity and Neonatal events

All events 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. The number of events reported are shown in table 5 and table 6 lists the categories of moderate events reported .

Table 5. Grading of events

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	April	May	June	April	May	June	April	May	June
No Harm	144	142	151	62	73	65	82	69	86
Low Harm	75	81	69	19	22	26	56	59	43
Moderate Harm	<5	<5	<5	<5	<5	<5	<5	<5	<5
PSII / MNSI	0	0	0	0	0	<5	0	0	0
Total	221	226	222	83	96	94	138	130	129

Table 6.Moderate harm events

North Tees & Hartlepool	South Tees
Postpartum Haemorrhage >1.5L	Readmission due to retained products and secondary PPH
	Inadvertent fallopian tube injury at emergency Caesarean section

Maternity and /or neonatal services suspension/divert/closure
Both the Maternity and Neonatal Services reported no diverts for quarter 1

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

- **North Tees and Hartlepool**

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

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

Following a review by the named Maternity Improvement Advisor the service can move to the next stage towards an exit programme, known as a review and set meeting. The meeting is expected to take place in July 2025.

- **South Tees Hospitals**

In April 2025, following a diagnostic report of the maternity culture, a rapid quality review was held, with the outcome of the service being formally accepted onto the Maternity Services Safety Support Programme. The named maternity improvement advisor has discussed Terms of Reference for the programme with the perinatal leadership team and the Director of Nursing, to commence in quarter 2.

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

The service continues to work towards requirements set out in the Maternity and Neonatal Three-year service delivery plan with an objective of meeting. Current compliance is set out in table 7 with a detailed overview in appendix 4. Governance is provided through the Perinatal Services Quality Assurance Committee and the Obstetric Directorate meetings.

Table 7. Delivery plan compliance

Themes	North Tees & Hartlepool	South Tees
Theme 1 – Listening to and working with women and families with compassion. 3 x Objectives / 12 x trust responsibilities	57%	57%
Theme 2 – Growing, retaining and supporting our workforce. 3 x objectives / 12 x trust responsibilities	75%	50%
Theme 3 – Developing and sustaining a culture of safety, learning, and support. 3x objectives / 16x trust responsibilities	75%	87.5%
Theme 4 – Standards and structures that underpin safer, more personalised and more equitable care. 3x objectives / 9x trust responsibilities	75%	75%

7. NHS Resolution Maternity Incentive Scheme (MIS)

The service received confirmation from NHS Resolution that both North Tees and Hartlepool and South Tees Hospitals achieved compliance of all ten safety actions. This has been a significant achievement for all teams and individuals involved. The launch of year 7 was published on the 2nd April 2025, the ten safety actions remain with some minor amendments within the technical guidance. Four safety actions have external oversight for approval:

- Safety action 1 – MBRRACE-UK
- Safety action 2 - Maternity services Data Set (MSDS)
- Safety action 6 – LMNS/ICB
- Safety action 10 – MNSI / EN/
- CQC sense check

The in-quarter position for both services is on track for compliance for the ten safety actions:

Safety Action	North Tees & Hartlepool		South Tees	
1		Q1 PMRT required standards met		Q1 PMRT required standards met
2		July MSDS scorecard to be submitted		July MSDS scorecard to be submitted
3		Transitional care actions plans submitted		Transitional care actions plans submitted
4		Neonatal workforce plans and obstetric attendance audit submitted		Neonatal workforce plans and obstetric attendance audit submitted
5		Q1 Midwifery standards met. BR+ assessment 3 year reassessment commenced		Q1 Midwifery standards met. BR+ assessment 3 year reassessment commenced
6		Data submission to the LMNS due 31st July		Data submission to the LMNS due 31st July
7		Escalated to ICB the lack of funding to support expected requirements. Awaiting an ICB action plan		Escalated to ICB the lack of funding to support expected requirements. Awaiting an ICB action plan
8		Q1 training on track		Q1 training on track
9		Q1 requirements on track for governance reporting		Q1 requirements on track for governance reporting
10		Q1 requirements on track for reporting		Q1 requirements on track for reporting

8. Saving Babies Lives Care Bundle version 3.2

The Saving Babies' Lives Care Bundle (SBLCB) is a group of actions that have been put together to reduce stillbirth. There are six elements and each has specific evidence and process and outcomes indicators that are be met to be deemed compliant (table 8). In May 2025, NHSE published an updated version and monitoring towards compliance will be undertaken at Trust and ICB level. The quarter 1 position is to be reviewed by the LMNS in August.

Table 8 SBLCB standards

Elements	Number of evidence indicators	Number of process and outcomes indicators
1 Smoking in Pregnancy	4	18
2 Fetal Growth Restriction	9	10
3 Reduced Fetal Movements	2	3
4 Fetal Monitoring in Labour	5	6
5 Preterm Birth	9	18
6 Diabetes	1	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%. The site service each have a quality improvement project to support a further reduction in ATAIN rates (table 9). Progress is reported at both Trust and ICB level.

Table 9. ATAIN quality improvement

North Tees & Hartlepool	
ATAIN rate 4.6%	Quality improvement project: Focus on babies with a stay <24 hours.
South Tees	
ATAIN rate 3.6%	Quality improvement project: Prevention and management of neonatal hypoglycaemia

10. Transitional Care Service
The service continues progress towards offering transitional care to late preterm babies against the action plan previously approved by the Board of Directors. Appendix 5 and 6 provides the detailed action plan for NTHFT and STHFT with both sites focusing on the workforce model as per British Association Perinatal Medicine (BAPM) standards such as a nurse lead for transitional care.

11. NENC Local Maternity and Neonatal System (LMNS)
The reporting structure in appendix 7 demonstrates engagement with the LMNS, sharing quality and safety intelligence that reaches regional oversight via:

- Quarter Perinatal Quality Surveillance Provider meeting
- LMNS Board
- LMNS Safety and Quality meetings

Quarter 1 Perinatal Quality Surveillance Provider meetings are scheduled for August 2025.

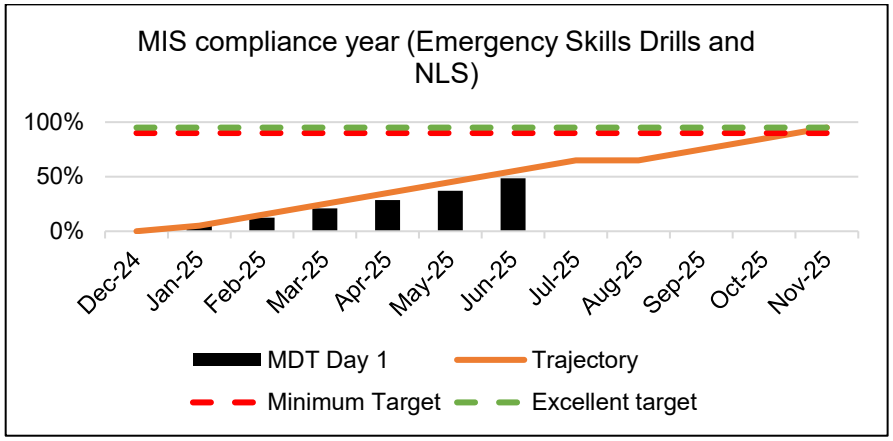
12. Training compliance for all staff groups in maternity related to the core competency framework, MIS and wider job essential training.
The service has worked in collaboration with the NENC Local Maternity and **Neonatal** System (LMNS) to develop a maternity training syllabus to meet the requirements of Core Competency Framework v2 (CCFv2), supporting standardisation of training, servicer user involvement and shared resources. The obstetric and neonatal department Trust core 10 mandatory training is shown in Table 10. Compliance will continue to be monitored monthly and to support staff to access training. Training compliance for MIS year 7 is on track (chart 1) for both services.

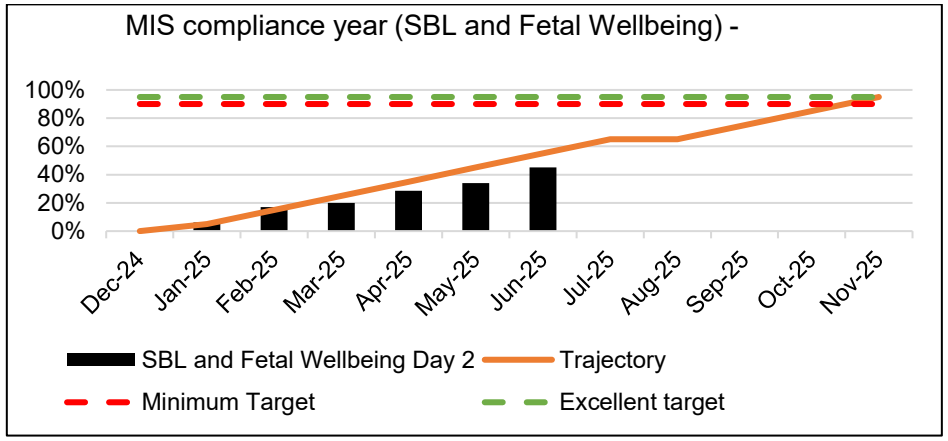
Table 10. Perinatal workforce Trust Mandatory Core training

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	April	May	June	April	May	June	April	May	June
Midwifery and support staff	80.5%	80.5%	82.5%	79%	76%	79%	82%	85%	86%
Medical (obstetrics/neonates)	80.5%	85%	85.6%	78%	85%	87%	83%	84.8%	84.2%
Neonatal Nursing and support staff	86.5%	87.6%	85.5%	96%	96%	94%	77%	79.3%	77%
Total	82.5%	84.3%	84.5%	84%	86%	87%	80%	82.6%	82.3%

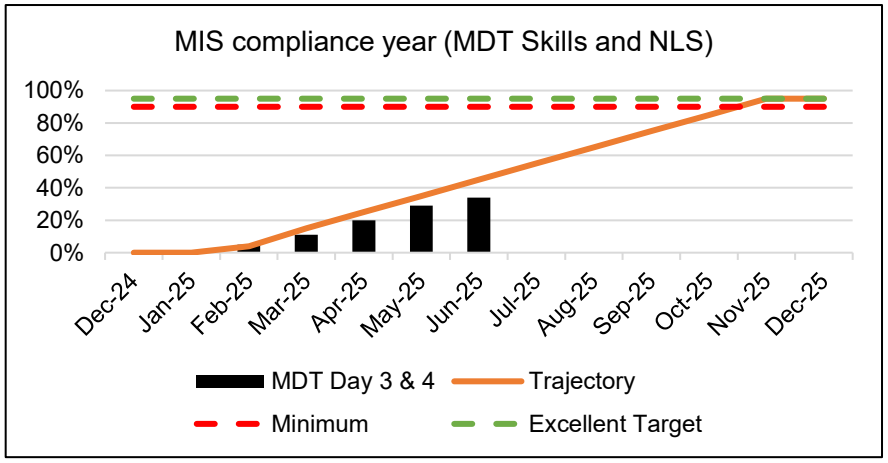
Chart 1. MIS training compliance

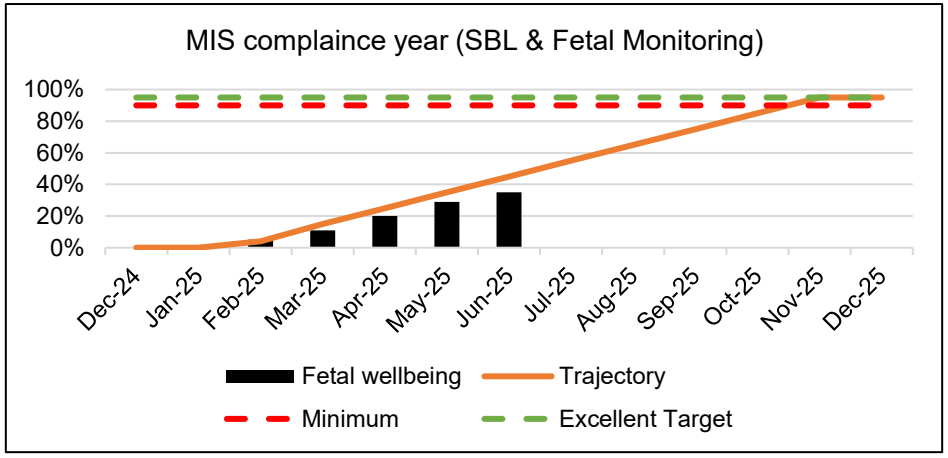
NTHFT





STHFT





13. Insights from service users
Complaints and compliments overview

The monthly numbers of both complaints and compliments are outlined in Table 11 and Table 12 formal complaints within quarter 1 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 11. Complaints

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	April	May	June	April	May	June	April	May	June
Stage 1	4	2	3	2	1	2	2	1	1
Stage 2	1	4	1	1	3	0	0	1	1
Stage 3	5	1	2	0	0	0	5	1	2
Total	10	7	6	3	4	2	7	3	4

Table 12. Compliments

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	April	May	June	April	May	June	April	May	June
Communication	4	5	5	1	1	0	3	4	5
Compassionate care	135	187	132	29	45	30	106	142	102
other	21	18	26	15	12	17	6	6	9
Total	160	210	163	46	57	47	115	152	116

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

The service continues to monitor friends and family test feedback, triangulating data with complaint themes. The latest results outlining positive feedback are identified in the Table 13.

Table 13. FFT

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	April	May	June	April	May	June	April	May	June
FFT %	94.4%	93%	93%	93%	94%	93%	92.88%	92.05%	93.15%

Trust Claims Scorecard.
An overview is provided in appendix 8 and 9.

Maternity and Neonatal Voice Partnership (MNVP)
In April 2025, Safety action 7 of the MIS year 7 requires trusts with an MNVP infrastructure in place, the MNVP chair to be a quorate member of the governance, quality and safety meetings. STHFT have an MNVP infrastructure in place however, the additional capacity required is not achievable nor sustainable. The concern has been escalated to the LMNS/ICB and in addition the Non-Executive Directors Maternity and Neonatal safety champions have written to the National and Regional maternity teams and NHS resolution. The service escalated the concern to the NENC LMNS/ICB. NTHFT does not have an MNVP infrastructure in place. A recruitment process was delayed as the Regional and National maternity team, advised the recruitment process should be provided by the LMNS as per guidance, the service escalated the concern to the LMNS/ICB and have since received approval for the service to progress with the recruitment process.
STHFT current projects include:

- Outreach listening events for ethnic diverse subgroups
- MNVP bereavement event planned increasing engagement with bereaved families to review and co-design services
- Work is ongoing on the trust website to ensure it is fit for purpose, easy to read and easily accessible
- Development of first aid training sessions for families
- Promotion and further development of social media presence

Service user insights taken from a recent CQC peer review
The LMNS approved NTHFT and STHFT action plans in response to the respective 2024 CQC maternity survey reports (appendix 10 and 11).

14. Community midwifery services
There is no longer a national target for Maternity Continuity of Carer (MCoC) following the Ockenden report in 2022. NTHFT had been unable to maintain the MCoC team (Rowan team based in Hartlepool) due to workforce pressures. In quarter one of 2025.26, the workforce model was reviewed due to staffing pressure which led to the decision to suspend the intrapartum service offer, to support safe staffing levels. A review of the workforce model is scheduled for July 2025. STHFT service disbanded the MCoC team which provided antenatal and postnatal care in June 2022 due to workforce pressures.
Enhanced Models of Maternity care (EMoMC)

NTHFT service has a project in development to explore EMoMC. STHFT service offers an EMoMC that provides care to a cohort of women identified using a vulnerabilities screening tool. Once identified care follows one of three pathways dependant on the level of support required. There is further provision of support for vulnerable women in the offer of walk and talk sessions, aquanatal, HENRY preparation for parenthood and baby essentials sessions in the family hubs. The team report quarterly patient outcome data related to demographic

information, qualitative feedback, breastfeeding initiation, birth outcomes, smoking and DNA rates.

15. Quality improvement and research

Research midwifery team

NTHFT: The midwifery research team continue to recruit eligible women to a number of research studies. The team are the highest recruiting site for the iHOLDS Trial and the 3rd highest recruiter to the COPE trial.

STHFT: The service is currently involved in three research studies. The Obs UK obstetric bleeding study, INGR1D2 designed to identify infants with a genetic risk of type 1 diabetes and 'sonobreech' to determine the diagnostic accuracy of handheld ultrasound to determine fetal presentation.

Quality Improvement Lead

NTHFT:

- PPH: Aim for major obstetric haemorrhage to less than 3.2% in line with the national average. The team have been shortlisted as finalists in the national HSJ awards
- Each baby counts learn and support toolkit – to improve clinical escalation and in so doing so reduce incidence of intrapartum and neonatal morbidity.
- ATAIN – Data collection demonstrated a theme around less than 24 hours stay to reduce admissions.
- APGAR - data demonstrating this was a data entry error with regards to and work has begun to educate staff with clear evidence of improvement as well as.
- Mechanical IOL – Patient feedback is positive and will be shared with staff.
- NeoTRIPS –aim of improving Expressed Breast Milk in the first 24 hours.
- Implanon service - this has been put on hold until tender has been taken in August awaiting an update regarding staff training.

STHFT:

- QI project to address compliance with booking by 9+6 weeks commenced in May 2025. Project improvement interventions are currently in progress.
- Prevention of neonatal hypoglycaemia commenced May 2025. PDSA cycles are being utilised to address six areas of focus with the aim for completion in January 2026.

Specialist Midwifery roles

A summary of the roles is provided in appendix 12. The Group service is collaborating with the ICB to fund a group service for Maternal Mental Health.

16. Culture and Leadership

Board level safety champion meetings

The board-level maternity safety champion act as a conduit between the board and the service level champions. The service at both sites at a minimum hold bi-monthly meetings and agendas reflect the required standards including National, Regional and system

developments along with local feedback, performance and service developments. Monthly walkabouts are facilitated and feedback shared with all team members.

The feedback from the perinatal walkabouts are:

North Tees & Hartlepool	
Areas visited: Delivery Suite Ward 22 Neonatal Unit	Feedback. Overall positive walkarounds, pressures felt by staff surrounding social media complaint. Staff feeling anxious about upcoming group changes. Positive patient feedback on wards, staff professional.
South Tees	
Areas visited: Central delivery suite, Triage, Maternity Day Unit, Ward 17 and The Neonatal Unit	Staff were found to be welcoming and responsive. Feedback centred around clinical environment and estate concerns. This included temperature control, provision of digital workspace and challenges associated with estate in the neonatal unit which made minimising contamination during the resent MRSA outbreak difficult.

Perinatal Culture and Leadership Programme

The service has a perinatal leadership aligned to the 2 locations: NTHFT and STHFT. The culture improvement plan for the respective sites have been reviewed (appendix 13 and 14) and will be monitored at the Safety Champion meetings, with escalation to Quality Committee. There are no escalations for the in quarter 1 position.

17. Risk register

There are eleven open risks across Maternity and Neonatal services, graded as:

	North Tees & Hartlepool		South Tees	
Risk Grading	**Maternity**	**Neonates**	**Maternity**	**Neonates**
High Graded risk	0	0	0	1
Moderate graded risk	6	2	21	3
Low graded risk	2	0	2	2
Very low graded risk	0	0	0	0
Within approval process	1	0	3	0

In line with the Trust risk management process, risks raised by the service are developed by the service and are reviewed in the respective risk management and governance meetings. The one high graded risk relates to the neonatal unit and the estate.

18. CQC action

Table 14 demonstrates the position for STHFT against the CQC must and should do's. The outstanding relate to estates, which are in progress. Both sites have benchmarked their respective services against the national maternity services system learning tool that providers can self-assess whether their operational service delivery meets national standards, guidance and regulatory requirement.

Table 14. CQC actions progress

Maternity Actions	Total	Completed	In Progress
Must Do requirements	7	6	1
Should do recommendations	12	11	1

18. Key issues, updates, significant risks and mitigations

North Tees and Hartlepool

- Demand for elective caesarean sections exceeds capacity – capacity and demand exercise to be undertaken, with the potential to request an additional list each week.
- Demand for consultant antenatal clinics exceeds capacity- capacity and demand exercise to be undertaken and a review of templates.
- Maternity Triage has been launched – working 24hours and data collection commenced. Estates project on-going to meet the national requirements.

South Tees Hospitals

- Estate issues which impacts patient flow and appropriate environment for women and families.
- Demand for elective caesarean sections exceeds capacity – capacity and demand exercise to be undertaken, with the potential to request an additional list each week.
- Demand for consultant antenatal clinics exceeds capacity- capacity and demand exercise to be undertaken and a review of templates.

19. Assurance and Recommendations

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

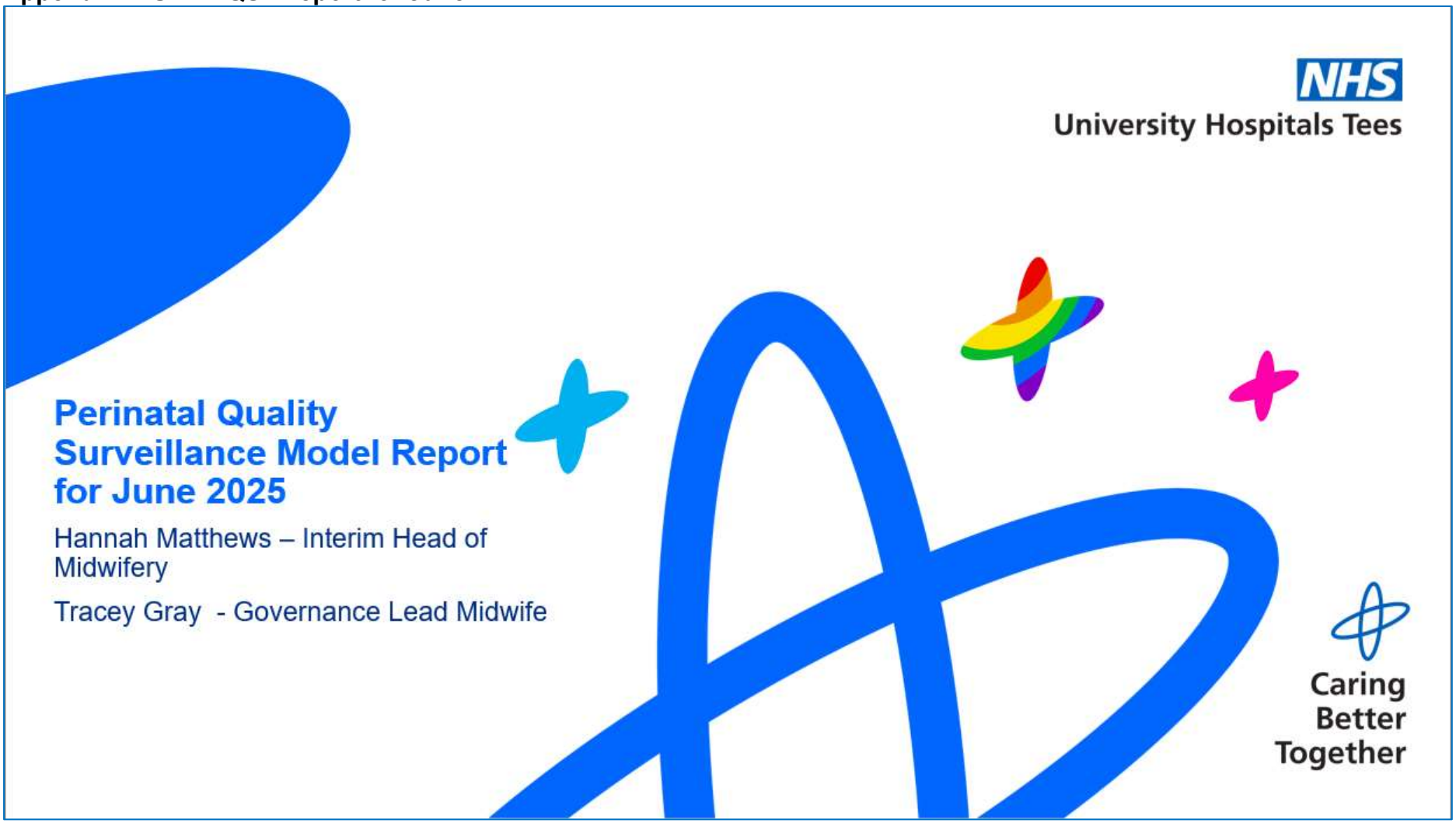
The Board of Directors are asked to approve:

- NTHFT and STHFT Transitional care action plans
- NTHFT Maternity survey action plan
- NTHFT and STHFT SCORE action plans

Appendices

Appendix 1. UHT PQSM report for June
Appendix 2 NTHFT PQSM dashboard
Appendix 3. STHFT PQSM dashboard
Appendix 4. UHT 3yr service delivery plan progress position
Appendix 5. NTHFT Transitional care action plan
Appendix 6. STHFT Transitional care action plan
Appendix 7. LMNS. ICB reporting structure.
Appendix 8. NTHFT NHSR claims scorecard
Appendix 9. STHFT NHSR claims scorecard
Appendix 10. NTHFT CQC maternity survey action plan
Appendix 11. STHFT CQC maternity survey action plan
Appendix 12. UHT Specialist midwives summary
Appendix 13. NTHFT SCORE action plan
Appendix 14. STHFT SCORE action plan

Appendix 1. UHT PQSM report for June



Key Performance Metrics

KPI	Unit	Standard	UHT			NTHFT			STHFT		
			April	May	June	April	May	June	April	May	June
Booking at 9+6	Percent	90%	65.90%	63.40%	67.50%	66.13%	66.15%	68.28%	65.80%	61.50%	66.90%
Smoking status at Booking	Percent	<10%	9.10%	9.60%	7.90%	9.27%	8.53%	9.52%	6.97%	8.10%	8.58%
Right place of birth	Percent	>95%	100%	100%	100%	99%	100%	100%	100%	100%	100%
Births			567	604	594	202	212	213	365	392	381
Preterm birth rate (22-36+6)	Percent	<7%	7.20%	8.80%	9.60%	5.45%	8.96%	8.92%	8.30%	8.70%	10.00%
Induction of labour	Percent		45.81%	44.71%	45.72%	44.06%	38.39%	49.52%	46.63%	48.18%	43.58%
PPH >1.5L	Rate per 1000	31	29	32	33	30	32	32	28	29	32
3/4th degree tear	Percent	<3.5%	2.48%	2.79%	2.39%	2.65%	5.83%	2.91%	2.40%	1.30%	3.40%
Stillbirth rate	Rate per 1000	North South 2.91 3.60				4.00	3.63	3.61	3.43	3.25	3.24
Neonatal death rate	Rate per 1000	North South 0.99 1.84				0.00	0.00	0.00	1.64	1.28	1.72
Smoking status at time of delivery	Percent	<6%	7.10%	7.06%	7.90%	7.80%	9.00%	8.57%	6.60%	5.90%	7.30%
Breast feeding at first feed	Percent	74%	59.90%	60.80%	59.00%	52.79%	51.67%	48.28%	63.90%	65.30%	64.50%
VTE score	Percent	95%	100%	100%	100%	100%	100%	100%	100%	100%	99%
ATAIN	Percent	6%				2.48%	5.66%	3.77%	3.60%	3.40%	5.60%
Apgar <7 at 5mins	Rate per 1000	24	25	18	22	37	37	35	22	15	15

NB.
North Tees and Hartlepool provides a consultant and midwifery led care service with a maternal medicine service and a level one special care unit neonatal service. South Tees is a tertiary unit for neonatal care offering a level three neonatal intensive unit service. The obstetric service provides a consultant and midwifery led care service, maternal and fetal medicine

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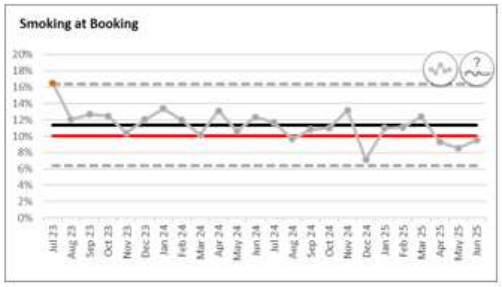
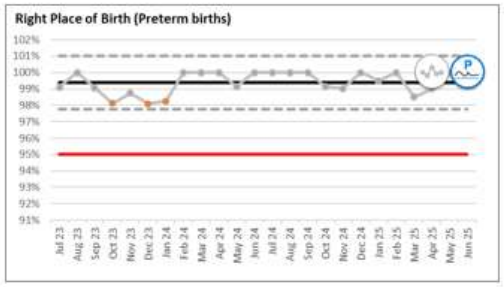
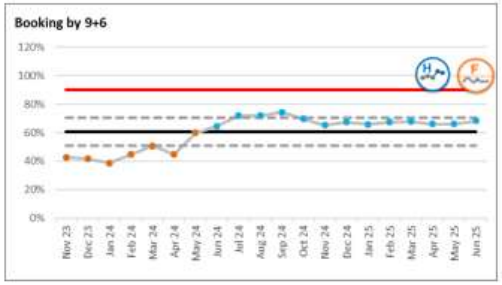
NTHFT KPI overview

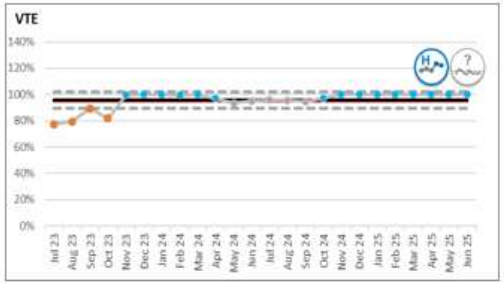
3

Antenatal









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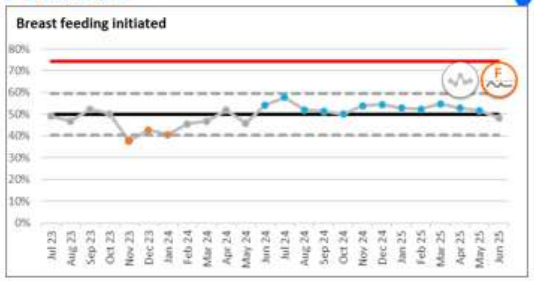

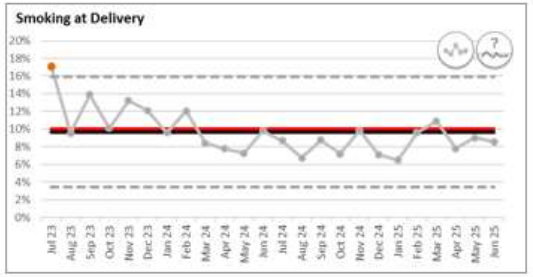

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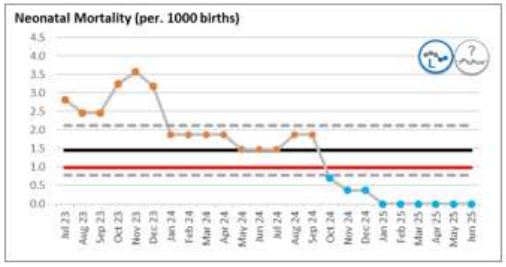

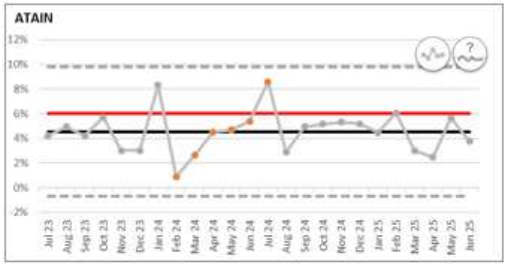

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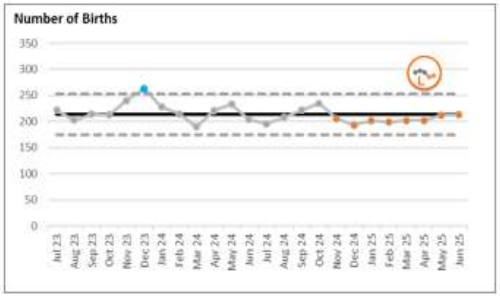
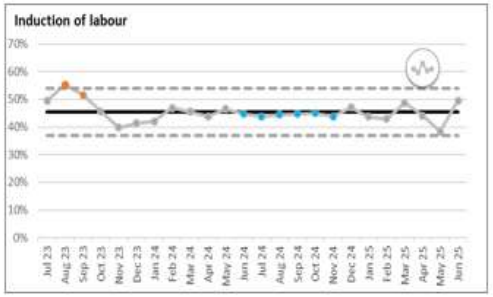
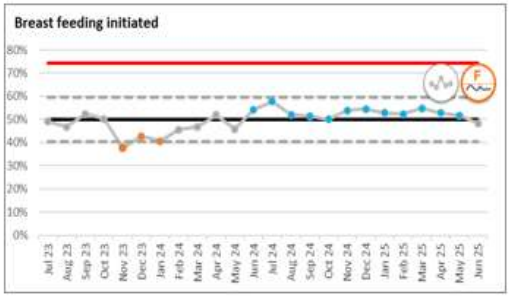
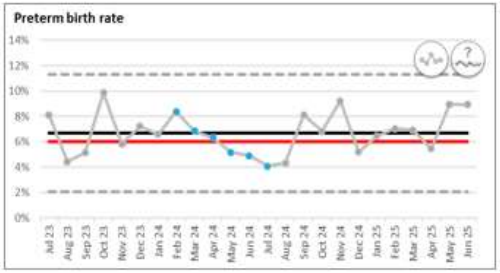
NTHFT KPI overview

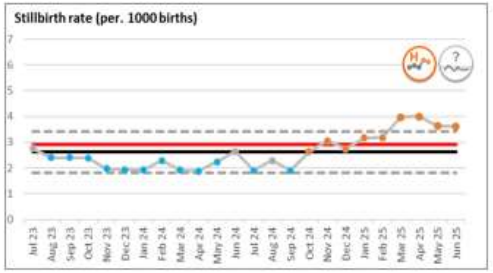
Birth

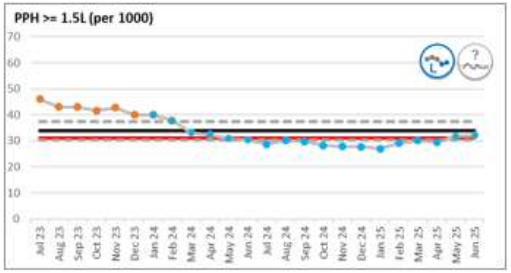


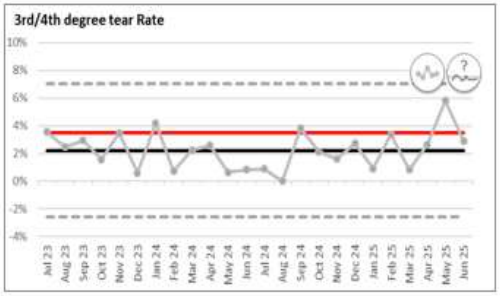












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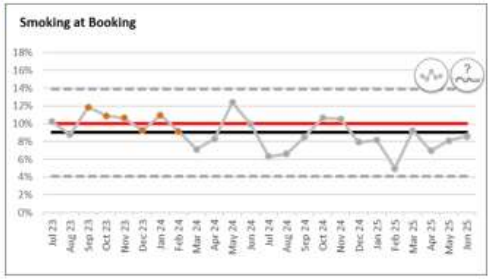
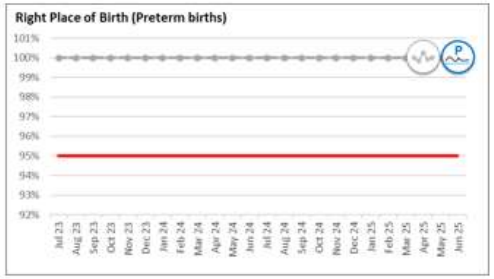
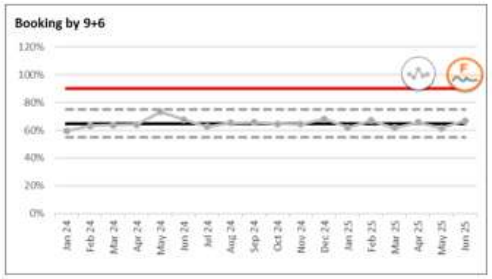
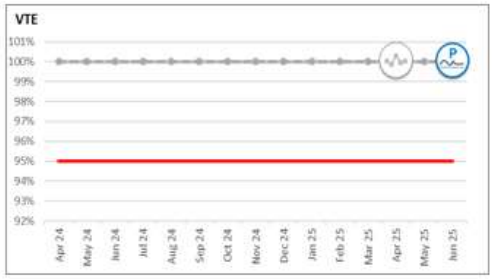
STHFT KPI overview

Antenatal









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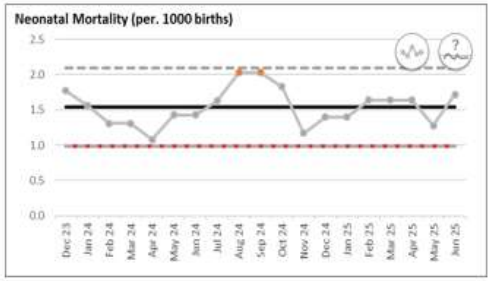

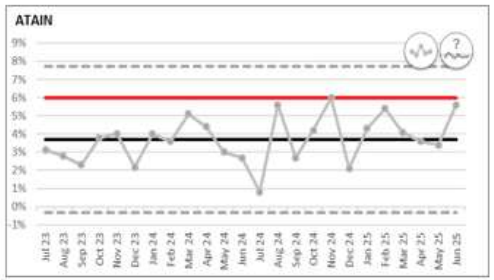

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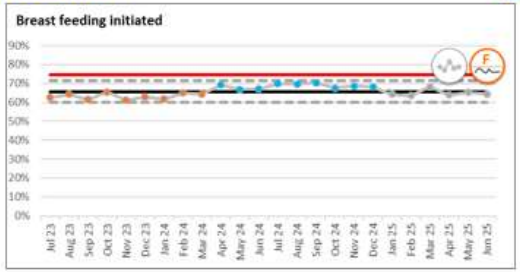

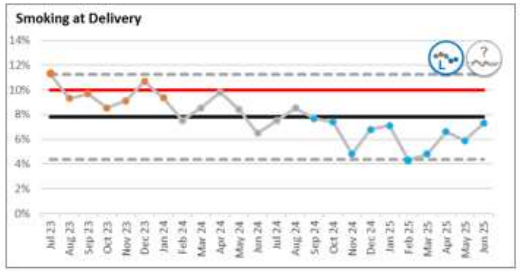

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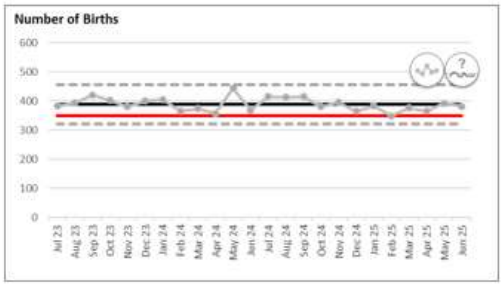
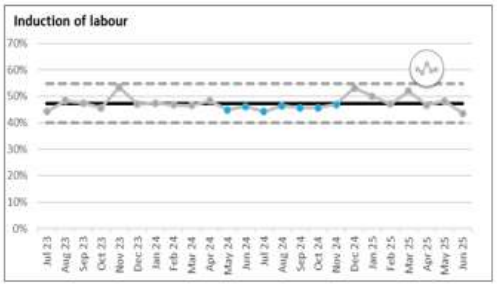
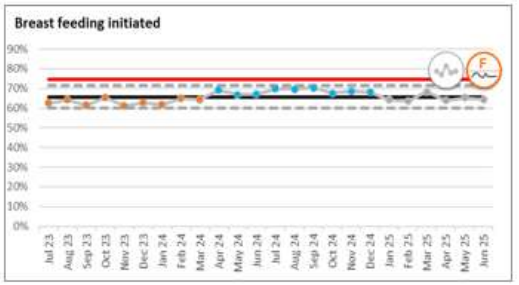
STHFT KPI overview

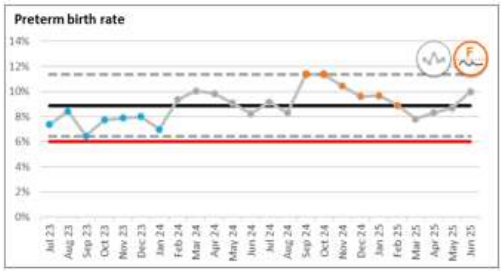
6

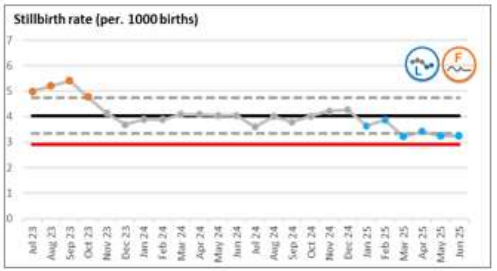
Birth

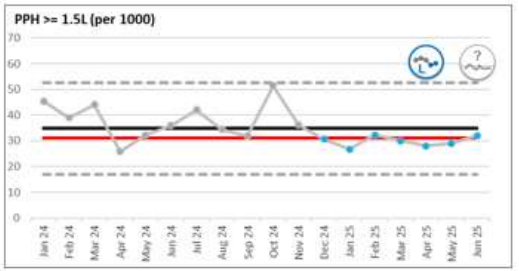


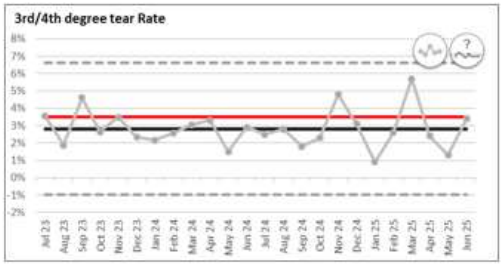












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Insights for Safety, Quality and Learning

Theme	Insight	NTHFT	STHFT
Engagement	Friends & Family Test	80%	93.5%
	MNVP	Active recruitment for a chair	Continue community engagement
	Complaints	Stage 1 x 2 Stage 2 x 0 Stage 3 x 0. Complaint trend being developed following a social media complaint.	Stage 1 x 1 Stage 2 x 1 Stage 3 x 2. Themes are communication, cleanliness and clinical concerns
	Compliments	53	116
	FTSU	0 received	0 received
	Safety Champion engagement	SCBU – positive comments received	CDS, Ward 17 & Triage - positive comments received
	PCLP / SCORE Survey	Action plan developed and monitored via Board safety champion meeting	Action plan developed and monitored via Board safety champion meeting
	% midwives would recommend their Trust as a place to work or receive treatment	50% / 54%	60.5% / 70%
	%speciality trainees responding with excellent or good for clinical supervision out of hours	82%	86%
Safety and learning Regulatory	PMRT reportable and completed	<5 Stillbirth reported. <5 PMRT completed	<5 stillbirth and <5 neonatal deaths reported.
	MNSI / PSII	<5 reported in month MNSI (HIE). <5 active MNSI	0 reported in month. <5 active MNSI
	Moderate events	<5	0
	NHSR claims scorecard	Not reviewed in month	Not reviewed in month
	MIS compliance	On track	On Track
	CQC rating & actions	Requires Improvement. Actions completed.	Require Improvement. 2 outstanding actions, estates related.
	MSSP	Commenced November 2022	Commenced May 2025
	Coroners Reg 28 request	NA	NA
	Safety signals	Stillbirth rate. External review in progress	NA
	Quality Improvement	PPH, ATAIN, APGAR Score	PPH, ATAIN

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Midwifery Workforce

8

Midwifery Establishment

	NTHFT					STHFT				
Budget	Sum of Budget	Sum of Actual	Sum of Variance	Projected 3 month (July 2025)	Projected 6 month (Oct 2025)	Sum of Budget	Sum of Actual	Sum of Variance	Projected 3 month (July 2025)	Projected 6 month (Oct 2025)
B5/B6 RN's/RM's	106.67	101.44	-5.23	+5.03 (+1.15)	+6.73 (+2.37)	174.68	178.07	3.39	173.83	173.83
B7 Clinical and Specialist Midwives	29.51	28.5 Includes 2 on mat leave	-1.01 (3.4%) -3.01 (10.2%)	+0.27 (-0.73)	-0.73	38.18	38.22	0.04	44.30	44.30
Grand Total	136.18	129.94 (125.18)	-6.24	+5.3	+6 (+2.37)	212.86	216.29	3.43	218.13	218.13 (+5.27)

Workforce safe staffing metrics	NTHFT	STHFT
Obstetric labour ward cover	100%	100%
LWC Supernumerary LWC supernumerary start of shift	100%	100%
1-1 care in labour	100%	100%
Midwife to Birth ratio	1: 19.7	1:21.4
Registered midwife fill rate	84%	102%
BAPM compliance	79.6%	89.2%
Trust Core 10 (all staff)	87.6%	82.4%

Red Flags	NTHFT	STHFT	comments
LWC supernumerary			
1-1 care in labour			
Delay in IOL		6	
Time critical		17	Delays in amniotomy. To review descriptors and categories across the group service and NENC system
Missed or delayed care	1	2	
Delay in triage			

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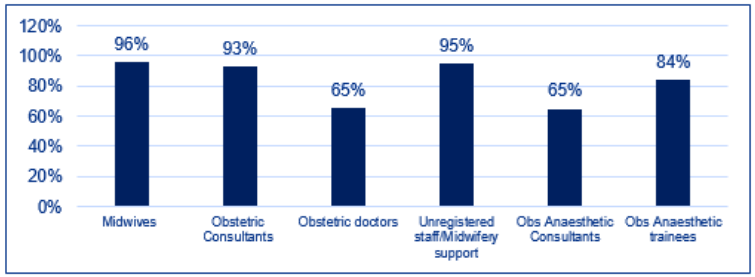
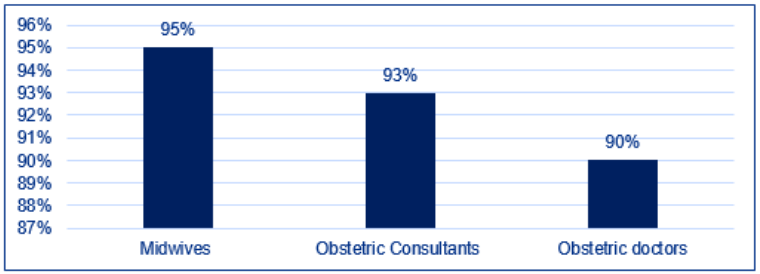
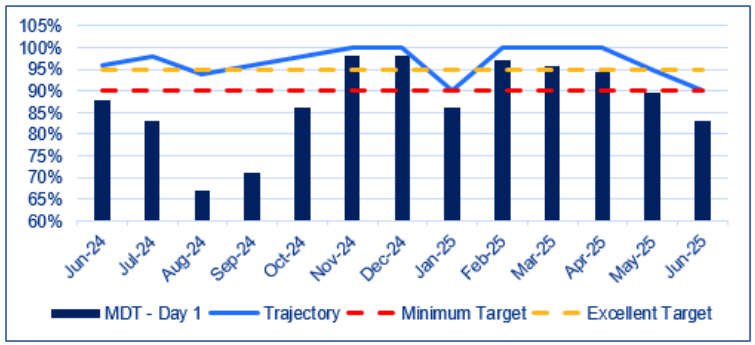
NTHFT 12month rolling compliance overview

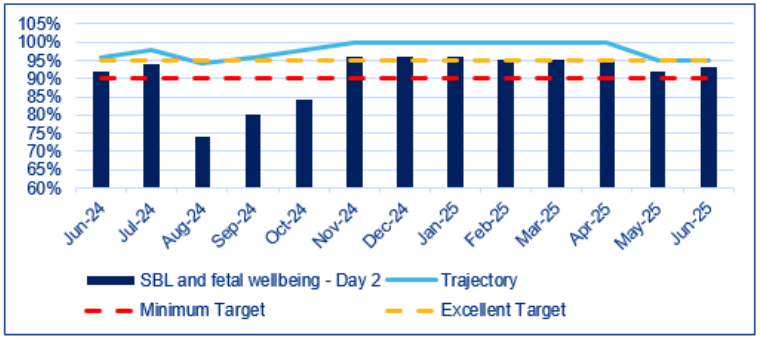
MDT Skills/NLS – staff groups June

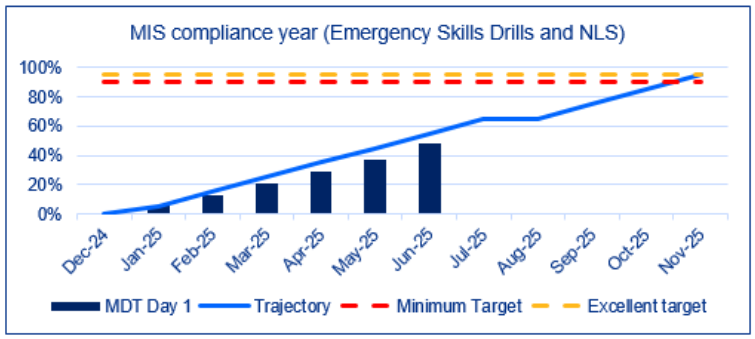


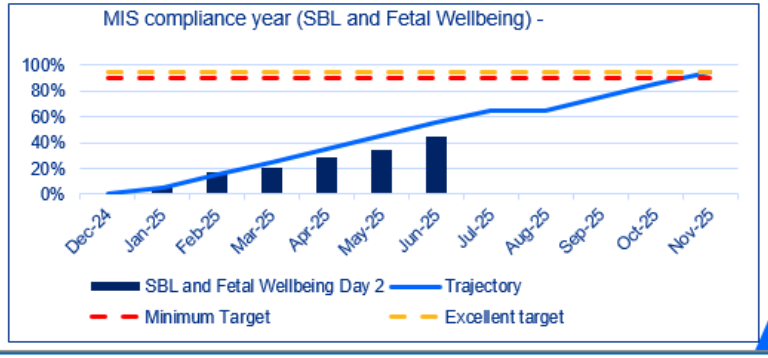
Fetal wellbeing – staff group











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STHFT 12month rolling compliance overview

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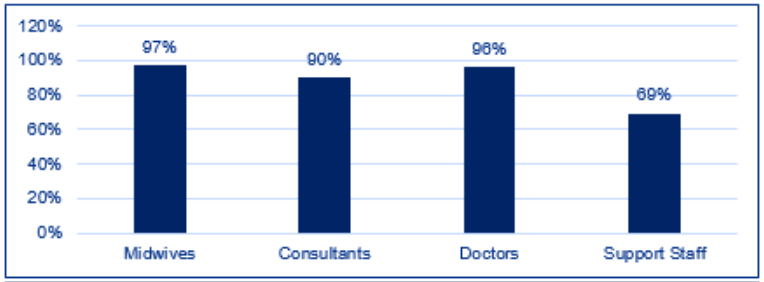
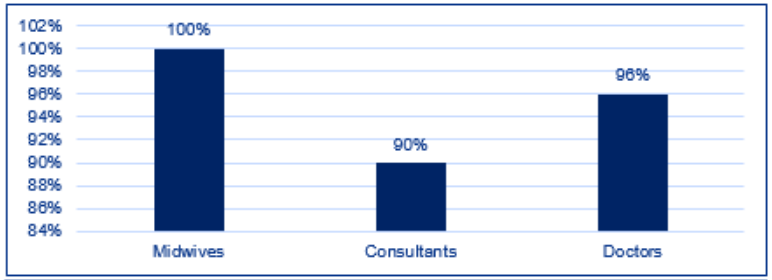
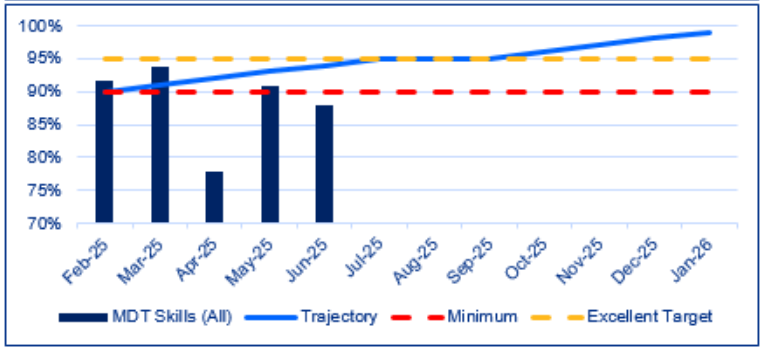
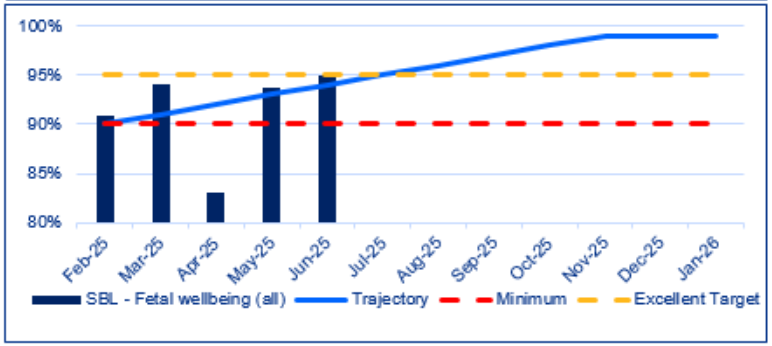
MDT Skills/NLS – staff groups June

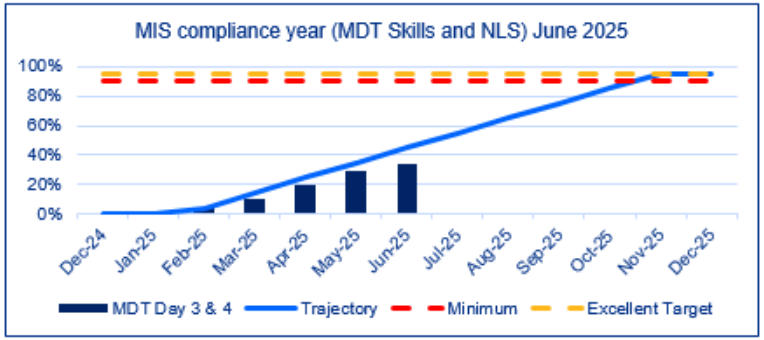


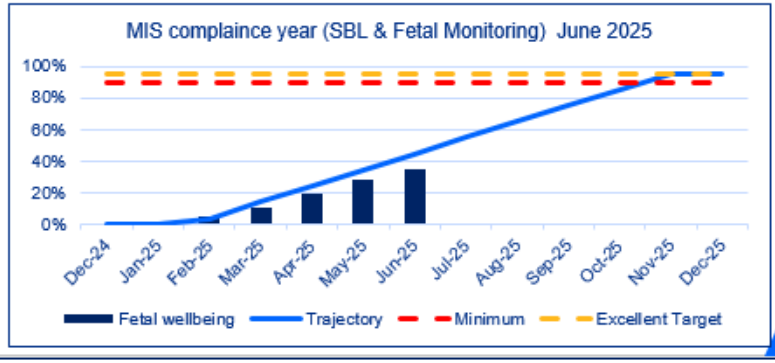
Fetal wellbeing – staff group











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Appendix 1 – NTHFT PQSM dashboard

CQC Maternity Ratings RI	Effective: RI		Caring: Good		Well-Led: RI		Responsive: RI		Maternity Safety Support Programme: YES			
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
1.Findings of review of all perinatal deaths using the real time data monitoring tool	NA	NA	I learning point									
2. Findings of review of all cases eligible for referral to MNSI	NA	3 reports - 10 actions	NA									
Report on: 2a. The number of events logged graded as moderate or above and what actions are being taken	<5	<5	<5									
2b. Training compliance for all staff groups in maternity related to core competency framework **MDT skills** and **fetal wellbeing**	94%	94%	83%									
	95%	92%	93%									
2c. Minimum safe staffing in maternity services to include **Obstetric cover** on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively **(midwife V birth ratio, 1:19**)	100%	100%	100%									
	1:18.4	1:25	1:19.7									
3.Service User Voice Feedback – positive %	100%	100%	80%									
4.Staff feedback from frontline champion and walk-abouts (bi-monthly)	Ward 22	Ward 22	SCBU									
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	NA	NA	NA									
6.Coroner Reg 28 made directly to Trust	No	No	No									
7.Progress in achievement of CNST 10	Yr 7 - In progress	Yr 7 in progress	Yr 7 in progress									
% midwives would recommend their Trust as a place to work or receive treatment 50% / 54%												
%speciality trainees responding with excellent or good for clinical supervision out of hours 70%												

Appendix 3. STHFT PQSM dashboard

CQC Maternity Ratings RI	Effective: RI		Caring: Good		Well-Led: RI		Responsive: RI		Maternity Safety Support Programme: YES			
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
1.Findings of review of all perinatal deaths using the real time data monitoring tool	NA	2 learning point	1 learning point									
2. Findings of review of all cases eligible for referral to MNSI	NA	NA	NA									
Report on: 2a. The number of events logged graded as moderate or above and what actions are being taken	0	<5	<5									
2b. Training compliance for all staff groups in maternity related to core competency framework **MDT skills** and **fetal wellbeing**	78%	88%	88%									
	83%	94%	95%									
2c. Minimum safe staffing in maternity services to include **Obstetric cover** on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively **(midwife V birth ratio, 1:19**)	100%	100%	100%									
	1:19.3	1:21.8	1:21.4									
3.Service User Voice Feedback – positive %	92.8%	92.5%	93.5%									
4.Staff feedback from frontline champion and walk-abouts (bi-monthly)	Inpatient maternity	Neonatal unit	Inpatient maternity									
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	NA	NA	NA									
6.Coroner Reg 28 made directly to Trust	No	No	No									
7.Progress in achievement of CNST 10	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress									
% midwives would recommend their Trust as a place to work or receive treatment 65.7% / 70%												
%speciality trainees responding with excellent or good for clinical supervision out of hours 86%												

University Hospitals Tees

Appendix 4. UHT 3 year service progress position

Ref No:	Theme & Objective	NTHFT	STHFT
	Theme 1: Listening to and working with women and families with compassion		
	Objective 1: Care that is personalised		
1.1	Empower maternity and neonatal staff to deliver personalised care so they have the time, training, tools, and information, to deliver the ambition above.		
1.2	Monitor the delivery of personalised care by undertaking regular audits and seeking feedback from women and parents.		
1.3	Consider roll out midwifery continuity of carer in line with the principles NHS England set out in September 2022		
1.4	Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.		
	Objective 2: Improve equity for mothers and babies		
2.1	Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings		
2.2	Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds and improve care. This data should be used to make changes to services and pathways to address any inequity or inequalities identified.		
	Objective 3: Work with service users to improve care		
3.1	Involve services users in quality, governance and co-production when planning the design and delivery of maternity and neonatal services		
	Theme 2: Growing, retaining and supporting our workforce		
	Objective 4: Grow our workforce		
4.1	Undertake regular local workforce planning, using nationally standardised tools where available, to establish the workforce required for each profession at every stage of care. Where trusts do not yet meet the staffing establishment levels set by Birthrate+ or equivalent tools, do so by 2027/28, and in future meet the expectations from nationally recognised tools for other professions.		
4.2	Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and midwives who wish to return to practice.		
4.3	Provide administrative support to free up pressured clinical time.		
	Objective 5: Value and retain our workforce		
5.1	Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.		
5.2	Implement equity and equality plan actions to reduce workforce inequalities.		
5.3	Create an anti-racist workplace, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource		

5.4	Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey		
5.5	Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.		
5.6	Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.		
	Objective 6: Invest in skills		
6.1	Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.		
6.2	Ensure junior and SAS obstetricians and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.		
6.3	Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.		
	Theme 3: Developing and sustaining a culture of safety, learning and support		
	Objective 7: Develop a positive safety culture		
7.1	Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. Including time to engage stakeholders, including MNVP leads.		
7.2	Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.		
7.3	At board level, regularly review progress and support implementation of a focused plan to improve and sustain maternity and neonatal culture.		
7.4	Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.		
7.5	Ensure all staff have access to Freedom to Speak Up training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.		
	Objective 8: Learn and improve		
8.1	Understand ‘what good looks like’ to meet the needs of their local populations and learn from when things go well and when they do not.		
8.2	Respond effectively and openly to patient safety incidents using PSIRF.		
8.3	Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.		
8.4	Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. This should include a single point of contact for ongoing dialogue with the trust.		
8.5	Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).		
8.6	Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.		
	Objective 9: Support and oversight		
9.1	Maintain an ethos of open and honest reporting and sharing information on the safety, quality and experience of their services.		

9.2	Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the perinatal quality surveillance model and informed by the national maternity dashboard.		
9.3	Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.		
9.4	Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.		
9.5	At Board level listen to and act on Freedom to Speak Up data, concerns raised and suggested innovations in line with the FTSU Guide and improvement tool.		
	Theme 4: Standards and structures the underpin safer, more personalised, and more equitable care		
	Objective 10: Standards to ensure best practice		
10.1	Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.		
10.2	Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.		
10.3	Ensure staff are enabled to deliver care in line with NICE guidelines.		
10.4	Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.		
	Objective 11: Data to inform learning		
11.1	Review available data to draw out themes and trends and identify and address areas of concern including consideration of the impact of inequalities.		
11.2	Ensure high-quality submissions to the Maternity Services Data Set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and National Perinatal Epidemiology Unit.		
	Objective 12: Make better use of digital technology in maternity and neonatal services		
12.1	Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England What Good Looks Like Framework.		
12.2	Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set and can be updated to meet maternity and neonatal module specifications as they develop.		
12.3	Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.		

Appendix 5.NTHFT Transitional Care Action Plan

Action plan Neonatal Transitional Care (Pathway inclusion of 34weeks) **LEAD: Gemma Gordon Review dates:** 9/12/23 5/8/24, 30/09/24 9/10/24, 3/1/2025, 3/3/2025, 30/06/2025 L**MNS Review Dates**: 16TH November 2024

Developed by: Transitional Care Group Date: 21/09/2023

Item	Problem/Issue	Actions	Responsibility	By When	Evaluation Status /%Completed Progress Update Including any further agreed actions
1	Terms of Reference required for regular Neonatal Transitional Care Meeting	Develop Terms of Reference and bring to group for review and sign off	JA	07/09/23 (next NTC meeting)	Completed
2	Review of Agenda for Neonatal Transitional Care Meeting	Review and amend agenda items for Neonatal Transitional Care Meeting	JA	07/09/23 (next NTC meeting)	Completed
3	Review of audit criteria	Review and amend if relevant current audit criteria	all	07/09/23 at NTC meeting	Completed
4	Finalise and approval of audit criteria to commence for Q3.	Agree questions for audit Send to BI team for audit template	GG/JA	07/09/23 at NTC meeting	Completed Completed – awaiting template
5	Involvement of the wider antenatal postnatal team in the Neonatal Transitional Care Meeting needed	Invite to be sent out to all core staff members including Maternity Support Workers, Midwives and Nurses working on the Postnatal Ward	LC – send list of all staff to JA JA – to send out invite	~~05/10/23~~ 31/1/24	LC to allocate MSW to group LB to allocate RM to group and lead Date extended to January 24 due to cureent workforce pressure.
6	New transitional care guideline now available on trust intranet –	'Launch' event for new criteria – posters and display board	JJ	09/10/2023	Launch event next week Completed, eduation and support provided by JJ clinical educator

	new criteria to BAPM standard but not part of routine practice	Training and awareness of differences in new policy			
7	Women and their babies are still being separated for the administration of IV Antibiotics (transfer to SCBU for a short period of time).	Development of training and competency booklet required for all midwives on IV drug administration for the neonates	JJ	07/10/2023	Booklet completed and training pack GG to email JJ to commence training 20/11/2023 19/12/23 Completed and circulated to staff w/c 4/12/23. JA
8	Women and their babies are still being separated for the administration of IV Antibiotics (transfer to SCBU for a short period of time).	Complete IV drug administration training for all registered midwives working on the postnatal.	JJ	~~31/12/2023~~ 31/1/24	GG to email JJ to commence training 20/11/2023 19/12/23 Training commenced W/C 11/12/23 , ongoing due to acuity across the services 27/12/23 Date extended to 31/1/23 due to current workforce pressures and initial delay in starting. JA
9	Women and their babies are still being separated for the administration of IV Antibiotics (transfer to SCBU for a short period of time).	Ensure equipment, secure drug and clean utility area (separate from maternal drugs) set up and ready. Agree start date for change implementation.	LB all	31/1/24 Nov 23 NTC meeting	NIPE table Room to be emptied and consider stock Drugs and drugs cupboard will be needed LB to link up with ANNP with TC and arrange equipment needed. 19/12/23 date extended to end January 24 due o delay in starting training
10	BAPM standards included those babies from 34 weeks and over to be considered for neonatal transitional care however trust guidance currently from 35 weeks for NTC.	Review data regularly of any babies that may have met the BAPM criteria but remain on SCBU due to trust guidance to be presented alongside NTC audit at PIG	JA	30/10/2023	Data continually collated but to be placed on PIG agenda from November to be presented and will inform decision making. JA emailed MB for regular item on agenda to include NTC, 34 week babies and ATTAIN audit – confirmed item on agenda going forward Complete – data collection ongoing
11	BAPM standards included those babies from 34 weeks and over to be considered for neonatal transitional care however trust	Development of training and competency booklet required for all midwives and maternity support	JJ	~~31/3/24~~ 30/09/2024	Guideline to be updated that if NG Tube feeding not required can be admitted to ward 22 if stable. 5/8/24 Agreement in last TC meeting to start admitting 34 weeks to TC from September

	guidance currently from 35 weeks for NTC.	workers for nasogastric tube feeding of the neonate			9/10/24 Not officially commenced due to pressures, decision making between teams re appropriate place of care for 34-35 weeks dependant on acuity in areas. JA 3/1/2025 Plan to review number of babies requiring NG feeds once gestational age extended to 34 weeks ensure competence could be maintained. JA 30/6/26 Guideline still awaiting update- allocated to JK ANNP, will complete this week.JA
12.	BAPM standards included those babies from 34 weeks and over to be considered for neonatal transitional care however trust guidance currently from 35 weeks for NTC.	Complete NGT for the neonate training for all registered midwives and Maternity Support Workers working on the postnatal ward.	JJ	TBC once action 11 complete	5/8/24 To review number of 34 weeks gestation babies admitted to ward 22 that require escalation to SCBU for tube feed only to ensure regular use of skills for NG required. JA 9/10/24 data prepared ready for next meeting. JA 3/1/2025 For introduction of 34 weeks without need for NGT in Q1 with review of need for NG feeds JA
13.	BAPM standards included those babies from 34 weeks and over to be considered for neonatal transitional care however trust guidance currently from 35 weeks for NTC.	Ensure equipment available and part of regular stock order for NGT feeding equipment. Agree start date for change implementation.		TBC once action 11 complete	9/10/24 Paused currently 3/1/2025 remains paused- for stepped approach to 34 weeks gestation.
14.	NEWT2 guidance released BAPM 2023 for review and consideration of trust guidance/SOP	Share guideline and review by next NTC meeting Discuss with LS digital midwife regarding parameters set in Badgernet Decision at next NTC meeting re next steps	JA LB all	30/11/2024 Q1 2025 Q1 2025	Completed JA 5/8/24 pilot site for NEWTT digital- allocated staff meeting with team re introduction. JA 27/12/23 For discussion at next TC meeting due 4/1/24JA

					5/8/24 Discussed in TC meeting 22/7/24 to roll out NEWTT- benchmarking against current criteria and training needs assessed. JA 9/10/24 Information prepared for next TC meeting, Septembers meeting stood down due to clinical pressures.JA 3/1/2025 Observation frequency agreed locally in TC meeting to be sent to teams for comments 30/6/2025 Pilot site for digital NEWT
15	Refresh training on hypothermia and hypoglycaemia fo all staff working with TC	ANNP to devise teaching plan to standardise what is taught to maternity colleagues Poster with QR codes for all TC guidelines to be created once guidelines up to date	ANNPs Ward matron SCM	30/9/25 30/09/25	30/6/25 to be discussed and developed ANNP supervison day Training to commence in September. Guidelines are to finalised
16	Require new Neonatal nurse TC lead	Expressions of interest to current ANNP and band 7 Neonatal nurses for lead position.	SCM	12/8/25	Completed via EOI
17	Badgernet recording of TC babies	Link digital nurse and midwife to address ability to record TC babies once criteria and guideline ratified.	Digital Nurse Digital Midwife	30/9/25	Scoping meeting held on the 14th August. Digital nurse arranging meet with neonatal badger link from systemc to explore options for capture

Appendix 6. STHFT Transitional Care action plan

Directorate(s): STHFT Women and Children's , Ward/Department: Transitional Care, Ward 17

Date (including revisions): 27/06/2025 27/08/24 01/04/2025 Nov 2023

Item	Problem/Issue/Identified gap in service *These should follow logically from the Root and Contributory causes / Recommendations*	Specific proposed actions: *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	Date action initiated:	Responsibility: *Name and job title of identified staff who have agreed to complete the action.*	Planned completion date: *Set a realistic timescale. Extensions will need to be agreed and justified.*	Progress / Update *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	Final Evaluation or Impact *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
1	**Admission criteria for NTC** To introduce NGT feeding with NTC	Develop clear guidelines and admission criteria for provision of NGT within NTC (staggered approach) Roll out training for staff in NTC for NGT feeding	15/8/2023 15/08/2023	Vrinda Nair Neonatal lead Consultant Haley Hutchinson NTC Matron	September 2025 August 2025	Training programme commenced June 2025	**On going** **On going**
	Accept babies with birth weight 1.6kg-1.8kg in NTC	Develop clear guidance and admission criteria	15/08/2023	Vrinda Nair Neonatal lead Consultant	Oct 2025	NGT must be established before accepting 1.6-1.8kg birth weight babies	**Not yet commenced**

Item	Problem/Issue/Identified gap in service *These should follow logically from the Root and Contributory causes / Recommendations*	Specific proposed actions: *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	Date action initiated:	Responsibility: *Name and job title of identified staff who have agreed to complete the action.*	Planned completion date: *Set a realistic timescale. Extensions will need to be agreed and justified.*	Progress / Update *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	Final Evaluation or Impact *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
	Accept babies 'stepping down' from NNU with corrected gestation age >33+0	Develop clear guidance and admission criteria	09/07/2025	Vrinda Nair Neonatal lead Consultant/? DOM/HOM	September 2026	Estate and capacity issues to re-accept mother after discharge for 'rooming in' with baby	**Not yet commenced**
2	**Staffing requirements for NTC** Review over all staffing model for NTC	To develop a team with special interest in TC	15/08/2023	Postnatal ward manager Linsey Gillings	March 2024	27.06.25 Team identified- compromise of 1xMW, 1x adult nurse (with additional TC training), 1x assistant midwifery practitioner (b4) on each shift	Complete
	Appoint lead band 7 Neonatal Nurse	BAPM criteria. To lead NTC team	04/06/2025	Lynne Patterson Consultant neonatal Nurse and Vrinda Nair Neonatal lead	September 2025	?needs business case ?? NNU staff could be seconded	**Not yet commenced**

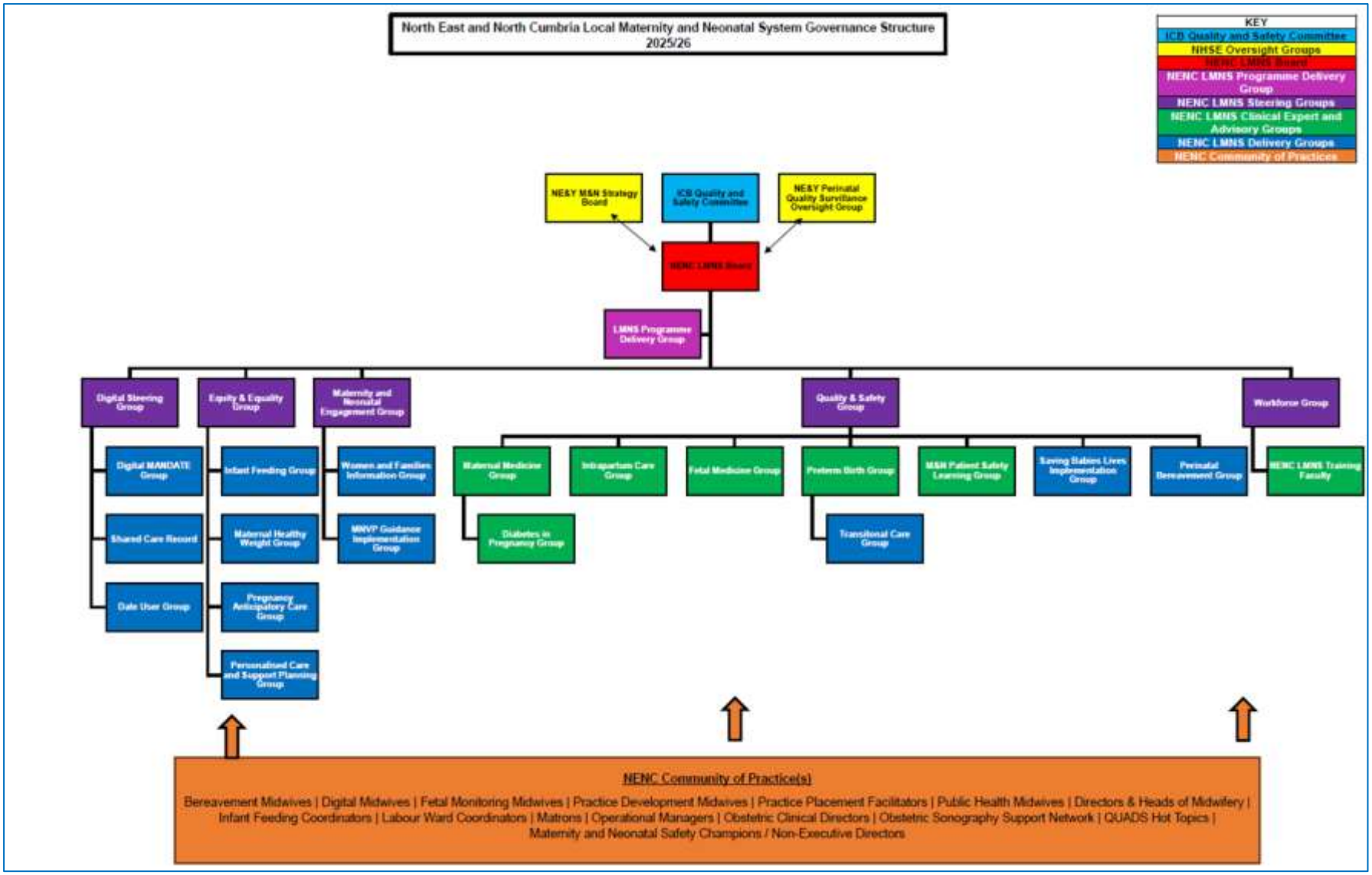
Item	Problem/Issue/Identified gap in service *These should follow logically from the Root and Contributory causes / Recommendations*	Specific proposed actions: *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	Date action initiated:	Responsibility: *Name and job title of identified staff who have agreed to complete the action.*	Planned completion date: *Set a realistic timescale. Extensions will need to be agreed and justified.*	Progress / Update *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	Final Evaluation or Impact *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
	Develop the local staffing model for TC aligning with LMNS TC staffing model	Ensure safety with BAPM ratio 1:4	15/08/2023	Previous NTC Matron Louise Hand. Haley Hutchinson.N TC Matron	May 2024	27/8/24-business case sent to increase staffing to be able to increase TC cots for 10 to 12-declined 01/04/25-new matron- reviewed TC data past year. Average 3.4TC babies at any one time. TC capacity reduced from 10 to 6 (can flex to 8 if can maintain 1:4 ratio)	Complete
3	**Facilities** Relocation of TC and creation of dedicated TC area ion the postnatal ward	Ensure ratio 1:4 is adhered to by cohorting all TC babies. Enable care to be delivered by a specialist TC team. Move to bays F G and H and branding to be done	15/08/2023	Previous NTC Matron Louise Hand. H.Hutchinson	Nov 2023	Nov 2023- complete	Complete
	Increase NTC capacity	Enable all NTC babies to be admitted to TC	15/08/2023	Previous NTC Matron Louise Hand.	May 2025	27/8/24-business case sent to increase staffing to be able to increase TC cots for 10 to 12-declined	Did not action

Item	Problem/Issue/Identified gap in service *These should follow logically from the Root and Contributory causes / Recommendations*	Specific proposed actions: *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	Date action initiated:	Responsibility: *Name and job title of identified staff who have agreed to complete the action.*	Planned completion date: *Set a realistic timescale. Extensions will need to be agreed and justified.*	Progress / Update *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	Final Evaluation or Impact *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
				Haley Hutchinson NTC Matron and Vrinda Nair Neonatal lead		01/04/25-new matron- reviewed TC data past year. Average 3.4TC babies at any one time. TC capacity reduced from 10 to 6 (can flex to 8 if can maintain 1:4 ratio)	
4	**Equipping and supporting staff** NGT specific training	Identify training needs and competencies package for staff feeding babies via NGT and roll out training package for staff	15/08/2023 04/06/2025	Lynne Patterson Consultant neonatal Nurse	May 2024 August 2025	March 2025 Funds secured via neonatal network to use Moodle as training package for transition care July 2025 competency pack developed Training passport required For TC staff to haver SN time on NNU to gain experience and confidence prior to NGT commencing in TC	Complete Complete **On going**

Item	Problem/Issue/Identified gap in service *These should follow logically from the Root and Contributory causes / Recommendations*	Specific proposed actions: *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	Date action initiated:	Responsibility: *Name and job title of identified staff who have agreed to complete the action.*	Planned completion date: *Set a realistic timescale. Extensions will need to be agreed and justified.*	Progress / Update *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	Final Evaluation or Impact *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
5	**Family Centred care** Parent information leaflet for TC	To have expectations for families on TC in conjunction with MNVP	15/08/2023	Lynne Patterson Consultant neonatal Nurse	January 2024	Agenda item for MNVP meeting Jan 2025	Complete
	Discharge from NTC and clear interface with community service	To review discharge pathway and guidelines to promote early facilitated discharges with robust shared care	15/08/2023	Lynne Patterson Consultant neonatal Nurse and community NNU team	May 2024	July 2025 pathway via badgernet- need to ensure TC on badgernet is activated for babies with NGT- training to be given by digital team- completion date push back to September 2025	**On going**
	Financial support for families including free parking, facilities for partners to stay in a bed overnight, area for siblings to be kept occupied and a family room that provides access to relevant	In order to keep families together and remove any barriers that may interfere with them playing a part in their babies care	09/07/25	Haley Hutchinson NTC Matron and Vrinda Nair	October 2025	July - For Quad review: capacity and demand	? ability to facilitate due to maternity estate

Item	**Problem/Issue/Identified gap in service** *These should follow logically from the Root and Contributory causes / Recommendations*	**Specific proposed actions:** *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	**Date action initiated:**	**Responsibility:** *Name and job title of identified staff who have agreed to complete the action.*	**Planned completion date:** *Set a realistic timescale. Extensions will need to be agreed and justified.*	**Progress / Update** *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	**Final Evaluation or Impact** *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
	hospital and local support information						

Appendix 7. LMNS reporting Structure



Appendix 8. NTHFT NHSR claims scorecard

Claims Scorecard (10 years of claims) Quarter 1 2025 (April May June)

Top injuries by volume:	**Top injuries by value:**
• Stillborn (5) • Atdnl / Unnecessary operations (4) • Brain Damage (3) • Fatality (2) • Thrombosis/Embolism(2)	• Brain damage (3) • Cerebral Palsy (1) • Erbs's Palsy (1) • Fatality (1) • Bowel Injury (1)
Top causes by volume:	**Top causes by value:**
• Fail/delay in treatment (7) • Fail to make resp to abnrm FHR (4) • Repeat attempt at forceps (2) • Fail to recognise. Complication of (2) • Fail to diagnose Pre-eclampsia ((2)	• Fail/Delay in treatment (7) • Fail /Delay Admitting to hospital () • Birth Defects (1) • Inhosp Maternal Death post PPH () • Repeat attempt Forcep/Ventouse

Complaints Q1 24-25

Communication – staff attitude
Care Provided – related to decision making
Care related on the postnatal ward
Communication – decision related to
Disjointed appointments

Incidents Q1 24-25

PPH > 1.5litres
Timing of C sections
Apgars <6 at 6 minutes
Term admissions
Escalation (Staffing Issues) impacting on service provision

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

NHS
North Tees and Hartlepool
NHS Foundation Trust

Themes Q1 24-25

- Recording of Apgar's and escalation for resuscitative support
- Escalation
- Communication
- Availability of place of birth

Learning Q1 24-25

Review of the recording of Apgar at time of birth
Effective communication between teams
Management of perineum
Escalation of CTG concerns

Action Plan Q1 Not started | In progress | Completed

Working ongoing related to personalised care plans	By 30.9.25 (HM)	
Implementation of BSOTS	By 30.06.25 (GG)	
Review of stillbirth data	31.03.25 (LS)	
Apgar Audit / CTG	31.03.25 (AST)	
C Section Audit	30.04.25 (JL)	

Appendix 9. STHFT NHSR claims scorecard

Claims Scorecard (10 years of claims) Quarter 1 2025 (April May June)

Top injuries by volume:	**Top injuries by value:**
• Atdnl / Unnecessary operations (8) • Stillborn (7) • Fatality (7) • Unnecessary pain (7) • Loss of baby (6)	• Brain damage (4) • Psychiatric/psychological dmge (4) • Cerebral Palsy (2) • Erbs's Palsy (4) • Wrongful birth (1)
Top causes by volume: • Fail/delay in treatment (22) • Intra-op problems (4) • Forceps delivery(4) • Fail to monitor 2nd stg labour (4) • Inappropriate treatment (3)	**Top causes by value:** • Fail to warn-informed consent (3) • Fail /Delay in treatment (22) • Delay in performing operation (2) • Fail to inform test results (1) • Fail to interpret USS (1)

Complaints Q1 25-26

Care Provided – related to clinical skills
Accurate documentation
Communication – Lack of effective communication
Care provided – infection control
Care provided –pain management

Incidents Q1 25-26

Term admissions to NNU over 37 weeks
Postnatal readmission
Failure to follow local protocol
Failure to follow protocol-antenatal
Postnatal readmission-baby

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

Themes Q1 25-26

- Postnatal readmission
- Escalation
- Communication
- Trust processes

Learning Q1 25-26

Review of the recording of Apgar at time of birth
Management of perineum
Emergency response
Full assessment of fetal wellbeing prior to ARM

Action Plan Q1 Not started | In progress | Completed

Review of postnatal readmissions	By 30.9.25 (JL)	
Review of ATAIN cases	By 31.07.25 (TG)	
OASI care bundle relaunch	30.9.25 (RK)	
Review PPH cases	30.06.25 (SL)	

Appendix 10 NTHFT CQC maternity survey action plan

Section Number	Section	Performance Key (please use drop down to detail current position)	Quality Improvement / Key Action Steps	Timeline	Expected Outcome	Person/Group responsible	Progress/Comments	BRAG Rating
C12 , C16 , C20, C21	**Labour and Birth - Staff caring for you .**	**Worse than expected**	Communication -verbal /written - review the possibilty of developing a video how patients can navigate Badgernet . This is to allow patient to access information leaflets related to care provided . To recommence intentional reounding in the clinical setting . Promotion of Friends and Family , explore how this can be promoted .	6 months	This will help patient to make and informaed choice about the care they receive .	SCM / Ward Matron Delivery Suite	Intentional rounding commenced in the clinical areas	
C17 ,C17	**Labour and Birth - Staff caring for you**	**Somewhat worse than expected**	Dignity and Respect - To explore civility training for staff . To review staff feedback to see how patients interact with staff . Promote campaigns with the support of MNVP and utilisation of facebook page	6 months	Reduced number of complaints received and improve positive patient interaction .	SCM / Ward Matron Delivery Suite	MNVP support paused whilst undertaking recuitment process for an MNVP lead	
F4	**Postnatal Care - Care at home afterbirth**	**About the same as expected**	Contact with a midwife - Campaigns to be shared for postnatal period on facebook (MNVP) . Review of volunteer support in the postnatal period .	6months	Patients feel supported and have support in the early postnatal period .	SCM community midwfery	MNVP support paused whilst undertaking recuitment process for an MNVP lead	

Appendix 11 STHFT CQC maternity survey action plan

Section Number	Section	Performance Key (please use drop down to detail current position)	Quality Improvement / Key Action Steps	Timeline	Expected Outcome	Person/Group responsible	Progress/Comments	BRAG Rating
B8	**During your antenatal check-ups, did your midwives listen to you?**	**About the same as expected**	Just below national average Also highlighted in comments and triangulates with complaints Mandatory training with all staff around personlaised care Consider birth choices clinic with consultant midwife Ongoign work with LMNS personlaised care Patient voices videos	Sep-25	Improved womens experience Reduction in this theme in complaints	Rosie Dawson Consultant Midwife (RD) Lynne Staite Head of Midwifery (LS) Alison Himsworth - Outpatient Matron (AH)		
C9	**If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?**	**About the same as expected**	Below average and worst in region To raise with MNVP for action plan - MNVP workplan includes renumeration for digital media and social media link to improve communication.	Oct-25		MNVP RD LH		
F6	**Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?**	**About the same as expected**	Lowest in region	Above action from B8 and D4		RD LS LH		

Appendix 12. Specialist Midwives summary

Specialist role	North Tees & Hartlepool	South Tees
Preterm birth	Introduction of Actim Partus to replace fetal fibronectin, which is regionally adopted. Continued data collection confirms women are appropriately triaged into preterm prevention clinic and optimisation measures achieved where there is an opportunity.	Recent achievements include the introduction of midwife led postnatal debrief clinics for women who deliver before 34 weeks and sustained improvements for preterm early maternal breastmilk. The service has also recently increased the preterm birth midwife hours in line with funding received
Diabetes	N/A	1.64 WTE midwives in post for diabetes, currently managing care for women with gestational diabetes within MDT diabetes clinics.
Birth reflections	Social media advertising and communications. New Online referral form and QR code for red book.	Currently there are 12 midwife hours per week allocated to this – 6 are externally funded. Birth Reflection clinics are currently at capacity.
Bereavement	Monthly MDT training, review of themes and learning. Implementation of a regional postmortem and tissue sampling consent package.	Bereavement spoke placement introduced for midwifery students. Training of 30 staff in postmortem and tissue sampling consent. Recruitment of band 4 bereavement counsellor/support worker funded for 12 months
Fetal wellbeing	100% pass rate for competency assessment over last quarter. New process under review by LMNS in relation to Saving babies lives. Regular ad hoc training teaching sessions with newly qualified midwives as request on a 1:1 basis.	New LMNS saving babies lives process for audit in progress. 100% pass rate for competency assessment last quarter.
Recruitment & Retention	onboarding/induction of 14 new band 5 midwives (10.64 WTE) Retention • Holding stay conversations • having one to one's with preceptorship midwives • supporting IEM's • Supporting staff returning to work from parenting leave or career breaks • continuing to plan and implement wellbeing initiatives Pastoral - staff across the service, in a variety of roles and banding, accessing pastoral support for a variety of reasons, including after significant events at work, in relation to the reconfiguration of services, escalating cultural issues or with other personal or professional concerns	Band 3 posts recruited to for the antenatal clinic. Challenges surrounding lack of midwifery hours to recruit to for new students

Practice Placement Facilitator	Moving forward with safer learning environment charter. Facilitating placements to ensure third year students are achieving their 40 births. Increased students from other trusts and universities wanting to be facilitated for elective placements.	Student padlet introduced to replace student boards in clinical areas, This includes lots of useful information and celebrates student achievements. Prep for review 2 sessions (one to one) in collaboration with HEI's identifies any cause for concern early and enables individualised programme planning. Reintroduced practice assessor/supervisor session into MMT
Digital	Digital postnatal appointments for community to be live on Badgernet to provide oversight. Digital inclusion service offered to women who are digital excluded – so far 11 women have been gifted data, and 8 women have gifted devices. In May 2025 NTH started sharing Badgernet data into the Great North Care Record (GNCR). Digital midwife attended Digital clinical safety office training.	Collaborative group working in progress to develop hazard log for digital. Clinical safety officer training completed to ensure there is a CSO for maternity systems. The service has volunteered to be early adopters of MEWS and NEWTT2.
Practice development Midwife / Clinical educator	Overall MDT training data below target for this quarter however robust plan in place, due to a cohort of trainee doctors and rota challenges. Ad hoc sessions have been set up to for emergency skills to ensure compliance improves.	Training compliance in target this quarter, new LMNS MMT programme in place. Practice Development Midwife on secondment currently working one day a week
Public Health	N/A	Poverty proofing conference attended and demonstrated areas of improvement. Conference highlighted lack of sustainability with this as services such as vulnerabilities team and bereavement counsellor are externally funded on a short-term basis.
Maternal mental Health	N/A	Continuing funding sourced for mental health midwife for women in Teesside, this does not cover North Yorkshire. Challenges associated with clinic capacity in which to provide care.
Infant Feeding	BFI Stage 2 assessment scheduled for July therefore staff training and preparation continues. Awaiting Infant Feeding MSW to commence in role.	BFI accreditation achieved last quarter. Working towards compliance for 2-day infant feeding training for staff

Appendix 13. NTHFT SCORE action plan

This document presents a simplified version of the perinatal improvement action plan.

Activity	Lead	Planned Completion Date	Progress	Actual Completion Date	Update -Jun 25
Developed cultural coaches from across the perinatal service x 5	QUAD	May 2024	cultural coaches have been trained and have a brief from the QUAD and SCORE survey regarding key function	May 24	Need to develop further culture coaches – due to turnover.
increase awareness of cultural coaches and their role with the clinical and non clinical teams across the perinatal service	Janice Atkinson (Senior Clinical Matron)	end of May 2024	Posters with cultural coach images are displayed around the unit. Aim for theme of the week to go out by SCORE theme to help support further feedback to the cultural coaches	Aug 24	Posters remain in place -Will need to be updated once new culture coaches recruited.
Establish a staff council	Gemma Gordon	end of May 2024	Staff council established to support health and wellbeing of the workforce	Jun 24	Remains compliant and in place
ensure cultural coaches have a regular agenda item on the staff council	Gemma Gordon (Senior Clinical Matron)	Q2 202425	Cultural coaches have regular agenda item on staff council	Jun 24	In place but – due to culture coach turnover updates have been sporadic
Schedule regular meetings with culture coaches and perinatal QUAD	Michael Butler	Q2 202425	meetings in diary between cultural coaches and perinatal QUAD	Jun 24	Regular schedule in place

development of a perinatal operational team (QUAD2)	Michael Butler	Q2 202425	QUAD to review perinatal governance structure.	Oct 25	Awaiting group org change. Have informed org change paper to have perinatal structure in place across group.
recruitment of a neonatal lead with new job description	Michael Butler	Q2 202425	Interview 14/10/24 - appointed new neonatal lead - Sally Hummaida Neonatal lead now on maternity leave – interim lead to be appointed (Attempted group appointment – no interest)	Oct 24	Remains complaint – CD providing neonatal leadership support during maternity leave for substantive lead
Recruitment of additional O&G consultants	Michael Butler	Q3 202425	2x additional consultants recruited to posts – (Oct 24 and Dec 24 – 1x maternity leave)	Dec 24	Remains compliant - complete
Increase admin cover across the delivery suite and Ward 22 to 7 days per week	Michael Butler	Q3 202425	Admin cover increased to 7/7 per week from 5/7 per week. Between 8-4		Admin cover still in place – would like to get to 24 hour cover in the future
Invest in full Neonatal Badgernet EPR to support joining up of information across perinatal services	Michael Butler	Q4 202425	Badgernet project in progress – implementation date TBC	Jan 25	Project in place updates coming to PSIG. Potential go live Dec 25.

Appendix 14. STHFT SCORE action plan

Activity	Lead	Progress	Completion Date	Comments	Status
Quad team to attend all perinatal culture and leadership sessions off site and completion of programme	QUAD	Quad have attended all sessions.	September 2024	Complete and further work on-going	Complete
Culture coaches within perinatal services and STRIVE identified and trained.	Dan Fawkes	3 culture coaches have been trained and are due to attend a further culture and leadership development session in December 2024	December 2024	Further sessions to be arranged to be led by the culture coaches in 2025.	Complete
Perinatal service culture coach awareness	QUAD	From January 2025 culture coaches' details will be displayed to enable reach to teams and a programme of work developed quarterly with the QUAD.	January 2025	Sessions to be arranged for 2025 with MDT teams within perinatal services	Complete
SCORE Survey Results	QUAD	Themes from the score survey to be shared with teams (high level feedback extrapolated into key lines of enquiry	October 2024	Themes have been shared with teams following score survey. All comments were shared as part of the culture improvement work across maternity including the NHSE diagnostic report	Complete

		such as leadership, estate, culture etc)			
Development of perinatal QUAD ops team	QUAD	Development of a secondary Quad for operational in line with structure changes and implementation of DOM	April 2025 – review Oct 25	To be worked through with support from NHSE Team and in collaboration with North Tees & Hartlepool.	Paused during leadership restructure
Perinatal Culture and Leadership External Review (NHSE Team)	Executive Team/QUAD	An external review of perinatal services was commissioned by the executive team/chief nurse and commenced in October 2024. This is an ongoing process, and full report is expected in January 2025 with recommendations.	Q2 2025	Report expected January 2025 and on-going programme of work to be developed and shared with the executive team and QUAD. June 2025 – Report received in January and shared with all teams as part of culture improvement work. All data shared and on going programme of work MSSP commenced in June	On Going Oversight meetings scheduled fortnightly with senior leadership team
Support for manager/matron teams	QUAD	New forum established weekly to share key messages with managers and matrons from trust wide forums such as Risk, SLT, CIPG etc.	October 2024	Meeting established and on-going. June 2025 – Matrons/Managers attending collaborative risk panel and business panel for key messages	Complete

Further programme of work to be established and shared with team through QUAD communication	QUAD/External reviewing team	Detail to be shared following report received by NHSE team.	Q1-2 2025	Culture working group to be established to support on-going work. June 2025 – On going work with regards to culture improvement. Culture action plan and dashboard in development to be shared with people committee	On going. Oversight meetings scheduled fortnightly with senior leadership team

Perinatal Staffing Report: Quarter 1, 2025/26

Meeting date: 4 September 2025

Reporting to: Board of Directors

Agenda item No: 2.3

Report author: Stephanie Worn; Director of Midwifery

Executive director sponsor: Emma Nunez; Chief Nurse

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: Quality Assurance Committee, Perinatal Services Quality Assurance Council and Perinatal Leadership Team meeting

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☒

Using our resources well ☐

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.

NTHFT is actively monitoring progress toward BAPM compliance for neonatal nursing staff, with the matter recorded on the risk register.

NTHFT: there has been a sustained period of pressure with gaps in the consultant workforce available for emergency obstetric work. This has been included on the risk register and there is a recruitment plan in place.

Trust mandated training for all perinatal staff across the services will be promoted throughout quarter 2 to increase compliance and a review of the expected training is in progress to ascertain the time required per 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 midwifery workforce has seen strong recruitment and retention trends, with projections indicating a fully staffed establishment within the next three months.

Recommendations:

The Board of Director members are asked to received and note the content of the report.

Meeting of the Board of Directors

UHT Perinatal Staffing Report Quarter 1 2025/26

1. PURPOSE OF REPORT

The purpose of the report is to inform and provide assurance to the Board of Directors that there is an effective system for monitoring safety staffing within the maternity service.

2. RECOMMENDATIONS

The Board of Director members are asked to note the content of the report.

3. 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.

4. MINIMUM SAFE STAFFING MATERNITY SERVICES

Safe Maternity Staffing 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 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.

Midwifery staffing

The midwifery service is compliant with the recommended funded midwifery establishment by BirthRate+ for North Tees and Hartlepool and South Tees Hospitals (Table 1). Appendix 1 outlines the actions and mitigations to minimise risks when the staffing levels ae below template. The registered midwifery (RM) vacancy position at the end of quarter 1 is shown in table 2, and the rates in table 3. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). In the event of a red flag (table 4), the labour ward co-ordinator along with the obstetric colleague determines the appropriate action to maintain safety; clinical and management (appendices 2 and 3)

Table 1 Birthrate+ recommendations

	North Tees & Hartlepool	South Tees
Recommended establish received	January 2023	October 2022
Midwife to Birth ratio	1:19.5	1:22.6
Recommended funded establishment. Clinical and non-clinical	142.75	236.16

Table 2 Midwifery vacancy position (clinical)

	North Tees and Hartlepool						South Tees					
	Budget	**April**	**May**	**June**	**3month forecast**	**6month forecast**	**Budget**	**April**	**May**	**June**	**3month forecast**	**6month forecast**
B5/6	106.67	102.8	100.16	101.44	106.47	108.17	174.68	176.72	176.21	174.68	173.83	173.83
B7 incl Specialist	29.51	28.81	28.5	28.5	28.77	27.77	38.18	40.22	39.86	38.18	44.30	44.30
Total	**132.98**	**131.61**	**128.66**	**129.94**	**135.24**	**135.94**	**212.86**	**216.94**	**216.07**	**212.86**	**218.13**	**218.13**

Table 3. Midwifery fill rates

	North Tees & Hartlepool			South Tees		
	April	**May**	**June**	**April**	**May**	**June**
Sickness rate	6.22%	3.34%	6.34%	6.48%	6.20%	5.1%
Maternity Leave rate (WTE)	5.76	5.96	3.76	6.12	6.71	5.75
RM fill rate %	81%	84.3%	84.5%	94.5%	92.5%	93.5%
Midwife to birth ratio	1:18.42	1:19.77	1:19.67	1:19.3	1:21.8	1:21.4

Table 4 Red flags

	North Tees & Hartlepool			South Tees		
	April	May	June	April	May	June
Delayed or cancelled time critical activity	0	2	0	11	26	17
Delay between admission for induction and beginning of process.	3	2	0	8	5	6
Labour Ward Coordinator (LWC) not supernumerary.	0	0	0	0	0	0
One - one care in active labour	0	0	0	0	0	0
Delay in Triage	0	0	0	0	0	0
Missed or delayed care	0	0	1	1	1	2

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. For the purpose of Maternity Incentive Scheme year 7, the LWC is to have supernumerary status at the start of every shift (Table 5).

Table 5. LWC supernumerary status: start of shift

	Number of days per month	Number of shifts per month	Compliance North Tees and Hartlepool	Compliance South Tees
April	30	60	100%	100%
May	31	62	100%	100%
June	30	60	100%	100%

One to One in Established Labour

1:1 care is defined as "care provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same midwife for the whole of labour" (NICE 2015). During this reporting period there were no occasions when 1:1 care was recorded as not being provided (table 6).

Table 6. 1-1 care in labour compliance

	April	May	June
North Tees	100%	100%	100%
South Tees	100%	100%	100%

Obstetric Staffing

NTHFT

The service is at full established at consultant grade within the North Tees & Hartlepool Site. Despite appointment of three consultants, pressures within the consultant workforce has continued since quarter 4 of 2023 for consultant medical workforce available for on call emergency obstetric work. This is due to occupational health requirements, acute sickness and maternity leave. Locum Consultant cover is being explored for the duration of maternity leave. The existing Consultant workforce are undertaking additional shifts to provide cover and safe staffing for obstetrics is being maintained. Weekly safe obstetrics and gynaecology staffing meetings coordinated by the operational manager, clinical director, rota administration team and the specialty training lead are taking place to ensure safe staffing and meeting the training needs of the doctors in training in the department. Consultant attendance at Obstetric emergencies was 97% compliant against a national and MIS standard of 80%. An action plan had been developed (appendix 4).

STHFT
The service meets full requirement established at consultant grade. There has been pressure within the consultant workforce since quarter 4, available for on call and elective obstetric work due to occupational health requirements and acute sickness. This has been resolved since. The department has now successfully recruited one Locum Consultant in one gap. The other Consultant has returned to work from sick leave.

In Quarter 2 from August, there will be a new gap in the Consultant rota due to a colleague taking a career break. The plan is to move the existing locum consultant into this rota gap and a substantive Fetal Medicine Consultant post has been advertised. The existing Consultant workforce will be undertaking additional shifts to mitigate the current gaps in the rota. Weekly obstetrics and gynaecology staffing is coordinated by the rota Consultant Rota Lead, rota administration team and the College tutor to ensure safe staffing and meeting the training needs of the doctors in training in the department. There is an emergency rota cover contact every day for resident doctor sickness and absence, reflected on the Medi rota. There are twice daily multidisciplinary team handovers of care for obstetrics and twice daily consultant led multidisciplinary ward rounds taking place. 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. The quarter 1 audit demonstrates 100% compliance (appendix 5)

Neonatal nurse staffing

NTHFT
The staffing compliance rate over quarter 1 was 91 % in comparison to the national average for the quarter of 78 % for SCBUs. The Trust use the National Neonatal workforce calculator tool and have developed an action plan shared with the Neonatal Operational Delivery Network (appendix 6) Compliance is managed through escalation of additional shifts paid via NHSP and overtime in times of increased occupancy and acuity. During this period the occupancy rate in the unit was lower than previous quarters impacting positively on the compliance rate. There has been an agreement for over recruitment of establishment by 1 WTE following review of age profile in neonatal staffing to ensure skill levels are maintained who is now in place. Due to the significant decrease in compliance in this quarter and discussion at Perinatal Quality Assurance Council in December a separate paper for neonatal nurse staffing has been completed and will be presented in SMT in July for consideration and decisions making. Neonatal nurse staffing has been added to the risk register and awaiting approval following review of staffing paper. There is a Neonatal Workforce action plan agreed at Trust Board 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.

STHFT
The neonatal nurse staffing levels for our L3 unit are compliant with the BAPM ask and the same tool as above is being used to calculate this. That is, we have enough staff based on 80% staffing to the activity over one year. Currently we have an agreement to be overstaffed by 5 x WTE (4 of which posts are being held for newly qualified staff who will not register until September 2025 – as per SLT request). Despite this we still do not always have 100% of the

staff required on each shift due to acuity of the patients, sickness and the fact that we are staffed to 80%, despite the uplift. In times of shortages, we utilise our paediatric colleagues to fill shifts and NHSP as required to make us compliant for the shift.

Neonatal Medical staffing

NTHFT

The neonatal medical staffing continues to be compliant with BAPM guidance in all tiers. The Advanced Neonatal Nurse Practitioner (ANNP) Workforce is at over establishment following agreement to facilitate additional trainee posts to ensure skill and competence is maintained given the age profile of this work group. The two trainees have been working in a supernumerary capacity to facilitate gaining skills at South Tees tier 3 unit. They will be working within the rota from October 2025 after completion and sign off year 2 of the ACP course. This will facilitate ANNPs being able to spend time at James Cook hospital for skills maintenance and development which has commenced in quarter 4 and quarter 1 but paused over summer to facilitate leave

STHFT

For Tier 2 the compliance is 95% with 7.6 WTE with recommendation as 8WTE. It is due to LTFT trainees. However, ANNPs and deanery trainees are managing the 0.4 WTE internally with locum cover. For Tier 3, the compliance is 89% as one consultant is on sabbatical for 6 months. Consultant colleagues taking up extra locum shifts are managing this internally. Tier 1 is 100% compliance.

Anaesthetics Staffing

In Quarter 1 the service provided a 24hour service, evidenced via rotas.

Assurance and Recommendations

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

- NTHFT Neonatal workforce improvement plan
- STHFT Neonatal workforce improvement plan

APPENDICES

Appendix 1. Midwifery staffing escalation summary
Appendix 2. NTHFT Midwifery clinical actions to maintain safe staffing
Appendix 3. STHFT Midwifery clinical actions to maintain safe staffing
Appendix 4. NTHFT Consultant attendance for complex obstetric emergency care
Appendix 5. STHFT Consultant attendance for complex obstetric emergency care
Appendix 6. NTHFT Neonatal workforce improvement plan
Appendix 7. STHFT Neonatal workforce improvement plan

Appendix 1

Mitigations and escalation process to address staffing shortfalls have continued during this reporting period. A risk assessment of midwifery staffing is complete and on the risk register for the service with actions and controls in place to mitigate risks as listed below.

- Daily staffing huddles with Senior Clinical Matrons / 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 / maternity centre to support labour ward.
- Supporting LWC in the appropriate use of BR+ acuity tool and escalation decision-making.
- Implement the NENC LMNS escalation policy

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

Appendix 2 NTHFT Staffing Factors and Clinical Actions

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Appendix 3 STHFT Staffing Factors and Clinical Actions

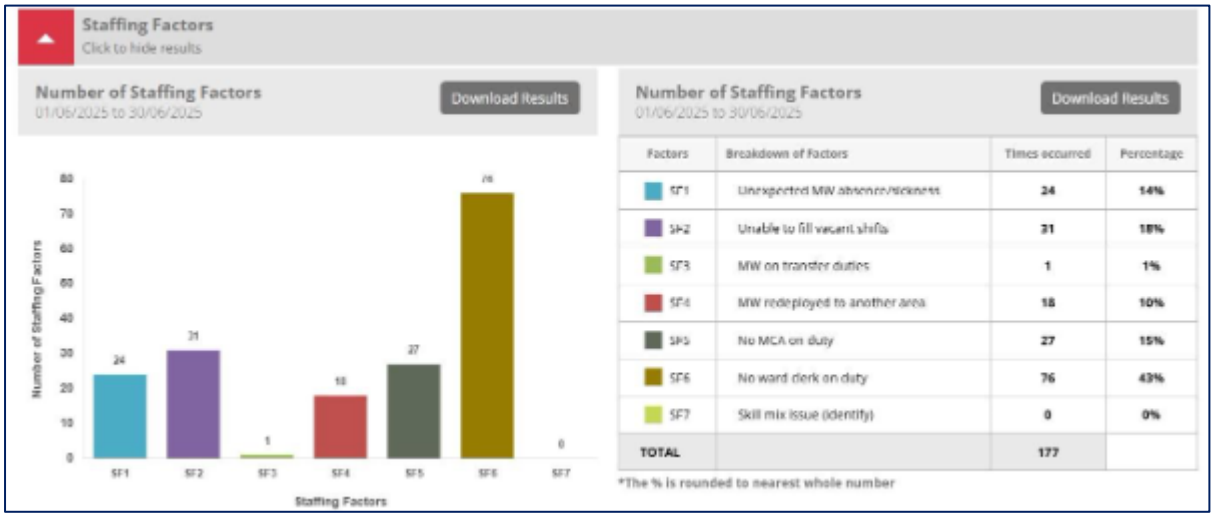
Staffing Factors
Click to hide results

Number of Staffing Factors
01/05/2025 to 31/05/2025
Download Results

Number of Staffing Factors
01/05/2025 to 31/05/2025
Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	27	19%
SF2	Unable to fill vacant shifts	29	20%
SF3	MW on transfer duties	0	0%
SF4	MW redeployed to another area	5	3%
SF5	No MCA on duty	28	19%
SF6	No ward clerk on duty	55	38%
SF7	Skill mix issue (identify)	0	0%
TOTAL		144	

*The % is rounded to nearest whole number



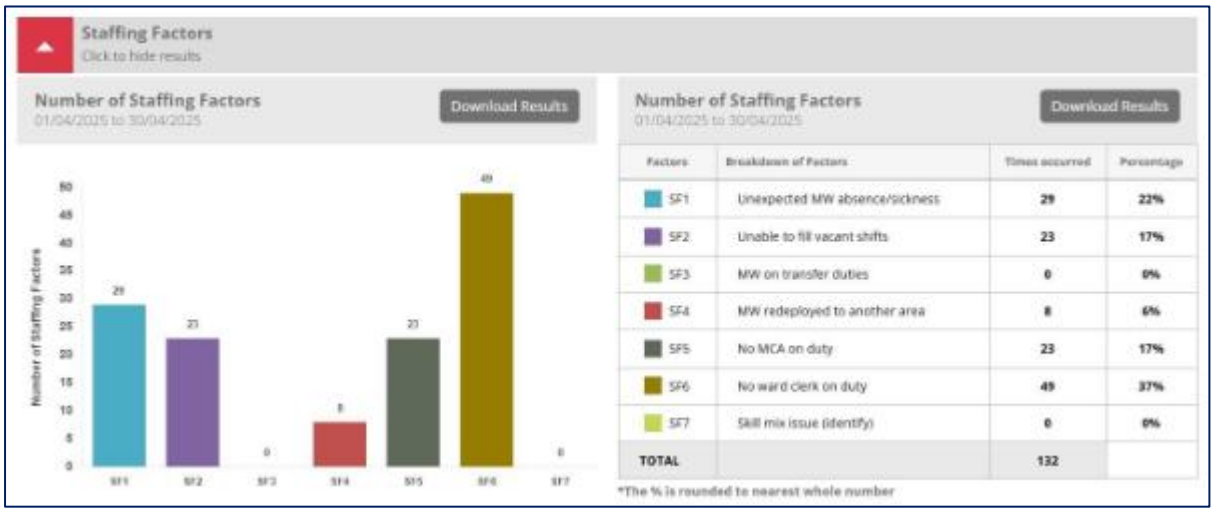
Staffing Factors
Click to hide results

Number of Staffing Factors
01/06/2025 to 30/06/2025
Download Results

Number of Staffing Factors
01/06/2025 to 30/06/2025
Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	24	14%
SF2	Unable to fill vacant shifts	31	18%
SF3	MW on transfer duties	1	1%
SF4	MW redeployed to another area	18	10%
SF5	No MCA on duty	27	15%
SF6	No ward clerk on duty	76	43%
SF7	Skill mix issue (identify)	0	0%
TOTAL		177	

*The % is rounded to nearest whole number



Staffing Factors
Click to hide results

Number of Staffing Factors
01/04/2025 to 30/04/2025
Download Results

Number of Staffing Factors
01/04/2025 to 30/04/2025
Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	29	22%
SF2	Unable to fill vacant shifts	23	17%
SF3	MW on transfer duties	0	0%
SF4	MW redeployed to another area	8	6%
SF5	No MCA on duty	23	17%
SF6	No ward clerk on duty	49	37%
SF7	Skill mix issue (identify)	0	0%
TOTAL		132	

*The % is rounded to nearest whole number

Caring Better Together

Appendix 4: Consultant Attendance Audit Report for Quarter 1 2025/26

Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their serviceroles-responsibilitiesconsultantreport.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

NENC LMNS Audit Tool : Audit of 5 cases (or all if <5) of each of the following triggers.	Q1 Cases	Consultant in attendance Compliant
Consultant MUST attend		
• MEWS >5	2	1
• Caesarean birth for major placenta praevia / abnormally invasive placenta	0	-
• Caesarean birth for women with a BMI >50	1	1
• Caesarean birth <28/40	1	1
• Premature twins (<30/40)	0	-
• 4th degree perineal tear repair	0	-
• Unexpected intrapartum stillbirth	1	1
• Eclampsia	2	2
• Maternal collapse eg septic shock, massive abruption	0	-
• PPH >2L where the haemorrhage is continuing & Massive Obstetric Haemorrhage protocol instigated	4	4
• Any laparotomy	0	-
Consultant must attend unless senior doctor signed as competent		
• Trial of instrumental birth	5	5
• Vaginal twin birth	2	2
• Caesarean birth at full dilatation	5	5
• Caesarean birth for women with a BMI >40	5	5
• Caesarean birth for transverse lie	0	-
• Caesarean birth at <32/40	1	1
• Vaginal breech birth	0	-
• 3rd degree perineal tear repair	5	5
Total	34	33
Overall Compliance		**97%**

NTHFT Consultants Attendance Q1 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
1	Consultant not informed of MEWS >5	Remind all staff of the indications for consultant attendance in departmental safety circular	July 2025	Patient safety team	August 2025
		Ensure the related guideline (M123) continues to be included in the induction/on-boarding for new resident doctors in the department.	July 2025	ST Lead	August 2025

Appendix 5: STHFT Consultant Attendance Audit Report for Quarter 1 2025/26

Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their serviceroles-responsibilities-consultantreport.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

NENC LMNS Audit Tool: Audit of 5 cases (or all if <5) of each of the following triggers.	Cases	Consultant in attendance
Consultant MUST attend		
• MEWS >5	5	5
• Caesarean birth for major placenta praevia / abnormally invasive placenta	2	2
• Caesarean birth for women with a BMI >50	5	5
• Caesarean birth <28/40	4	4
• Premature twins (<30/40)	1	1
• 4th degree perineal tear repair	1	1
• Unexpected intrapartum stillbirth	1	1
• Eclampsia	0	0
• Maternal collapse eg septic shock, massive abruption	1	1
• PPH >2L where the haemorrhage is continuing & Massive Obstetric Haemorrhage protocol instigated	11	11
• Any laparotomy	0	
Consultant must attend unless senior doctor signed as competent		
• Trial of instrumental birth	46	46
• Vaginal twin birth	4	4
• Caesarean birth at full dilatation	19	19
• Caesarean birth for women with a BMI >40	29	29

• Caesarean birth for transverse lie	2	2
• Caesarean birth at <32/40	14	14
• Vaginal breech birth	2	2
• 3rd degree perineal tear repair	14	14
Total	161	161
Overall Compliance		**100 %**

Appendix 6. NTHFT Neonatal workforce improvement plan

Neonatal workforce Improvement Plan

Directorate(s): Women and Children's, Care Group 1 Healthy Lives

Ward/Department: SCBU,
Date (including revisions): 1/4/24, 15/4/24, 1/8/2024, 30/09/24 , 8/10/24, 5/12/254, 9/1/25, 1/4/25,1/7/25.

Item	**Problem/Issue/Identified gap in service** *These should follow logically from the Root and Contributory causes / Recommendations*	**Specific proposed actions:** *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	**Date action initiated:**	**Responsibility:** *Name and job title of identified staff who have agreed to complete the action.*	**Planned completion date:** *Set a realistic timescale. Extensions will need to be agreed and justified.*	**Progress / Update** *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	**Final Evaluation or Impact** *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
1	Medical workforce in the special care baby unit should be compliant with BAPM recommendations as per Optimal arrangements for Local Neonatal Units and Special Care Units in the UK 2018 in all tiers of medical staffing.	Medical staffing should be regularly reviewed to ensure appropriate cover for SCBU.	1/4/2024	Neonatal clinical lead Clinical Director	Ongoing	15/4/24 Over recruited with 2 Trainee Nurse Practioners to ensure succession planning- due to qualify 2025. No concerns with medical workforce, reviewed in 'safe staffing 'meeting weekly. JA. 1/8/24 medical staffing remains compliant. 8/10/24 Medical Workforce remains compliant evidenced on paediatric rota. JA 5/12/24 Medical workforce remains complaint evidenced in paediatric medical rota. JA	**1/8/24 workforce plan review underway currently.**

Item	**Problem/Issue/Identified gap in service** *These should follow logically from the Root and Contributory causes / Recommendations*	**Specific proposed actions:** *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	**Date action initiated:**	**Responsibility:** *Name and job title of identified staff who have agreed to complete the action.*	**Planned completion date:** *Set a realistic timescale. Extensions will need to be agreed and justified.*	**Progress / Update** *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	**Final Evaluation or Impact** *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
						1/7/25 Medical work force maintains compliance reported into perinatal service improvement group. .	
2	Tier 3 Medical workforce are required to evidence 8 hours CPD annually in neonatology	Review compliance with CPD as per ESR	1/4/2024	Clinical Director Clinical Educator	31/3/25	1/8/24 Monitored via ESR and appraisals 5/12/24 Clinical Educator and Clinical Director advised of outstanding CPD forms requiring completion. JA 1/7/25 Compliance managed through clinical educator , learning opportunities shared with all consultants. JA	Ongoing
3	Nurse staffing is not BAPM compliant as team lead is not always supernumerary from direct care in periods of increased acuity and occupancy above 80%	Continue to manage risk on risk register – 6660 via control measures, creating additional shifts to allow 4 RN per shift Compliance to be monitored through perinatal service improvement group, perinatal quality service report , perinatal board report	1/4/24 1/4/24	Paediatric SCM Paediatric Lead Nurse Head of Midwifery Paediatric SCM	Ongoing	1/8/2024 tolerated risk on register. 1/8/24 quarter 1 Perinatal quality service report completed by SW. Reported compliance 75% 8/10/24 Q2 compliance 87%.Ongoing item	Ongoing

Item	Problem/Issue/Identified gap in service *These should follow logically from the Root and Contributory causes / Recommendations*	Specific proposed actions: *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	Date action initiated:	Responsibility: *Name and job title of identified staff who have agreed to complete the action.*	Planned completion date: *Set a realistic timescale. Extensions will need to be agreed and justified.*	Progress / Update *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	Final Evaluation or Impact *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
		Complete Neonatal Nurse Calculator a minimum once a year	1/4/24	Paediatric lead Nurse / Paediatric SCM	31/09/2024	1/8/24 Workforce calculator completed- requirement for 0.95 WTE for 80 % occupancy, planned over recruitment for succession planning successful, to start sept 24 (not included in calculation) 1/8/24 Trail of nursing associate role in neonate, 1 staff member seconded into training post.	Completed
		Review skill mix of nursing staff within unit	1/4/24	Paediatric lead Nurse / Paediatric SCM	Ongoing	1/8/24 All additional duties due to occupancy acuity coded for ease of review 8/10/24 Awaiting SNCT review data feedback from ER. JA	
		Collate and escalate information regarding bank and additional duty spend to inform decision making	1/4/24	Paediatric SCM / Finance	30/9/2024	9/1/25 Data received moved to action 5. JA	

Item	**Problem/Issue/Identified gap in service** *These should follow logically from the Root and Contributory causes / Recommendations*	**Specific proposed actions:** *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	**Date action initiated:**	**Responsibility:** *Name and job title of identified staff who have agreed to complete the action.*	**Planned completion date:** *Set a realistic timescale. Extensions will need to be agreed and justified.*	**Progress / Update** *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	**Final Evaluation or Impact** *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
4	Allied Health Professional workforce within SCBU funded via Ockenden monies.	SALT unable to fill 0.2 WTE due to recruitment difficulties Liaise with service leads re service cover for periods of annual leave / sickness	1/4/24 1/4/24	SLT Lead, Paediatric SCM Ward Matron Individual AHP leads	1/11/24 1/11/24	1/8/2024 Successful recruitment to SLT post 8/10/24 MC emailed for update re provision. JA 8/10/24 Ward matron to liaise with AHP leads re service JA 9/1/25 Dietetic lead has left- discussion re plan for replacement ongoing. 1/7/25 SLT hours in place, psychology replacement awaiting start date. To email for update from dieticians however full support given to unit. JA	Ongoing - oversight provided at Perinatal services quality assurance council
5	Significant decrease in compliance in November 53% and December 54% 2024, despite controls in place	Move and update risk on Inphase system to reflect current risk Request Safer Nursing Care Tool audit results for 2024 Request data on occupancy and acuity from Northern	11/12/24 11/12/24 11/12/24	VW, JA JA JA	Jan 2025 Jan 2025 Jan 2025	31.12.2024 risk added awaiting approval – 232. JA 9/1/25recieved – action complete. JA 9/1/25 Update requested 3.1.25- analyst back to work 6/1/25	

Item	Problem/Issue/Identified gap in service *These should follow logically from the Root and Contributory causes / Recommendations*	Specific proposed actions: *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	Date action initiated:	Responsibility: *Name and job title of identified staff who have agreed to complete the action.*	Planned completion date: *Set a realistic timescale. Extensions will need to be agreed and justified.*	Progress / Update *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	Final Evaluation or Impact *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
		Neonatal Network data analyst for 2023 and 2024 Request data re fill rate of additional shifts created for bank fill with reason – workload increased for 2023 and 2024 Request bank pay data for SCBU from finance Compile report re SCBU nurse staffing and compliance to include above data for sharing with SMT	9/1/2025 9/1/2025 9/1/2025	JA JA JA,VW	Jan 2025 Jan 2025 Jan 2025	1/4/25 Complete 9/1/25 requested. JA 1/4/25 Complete 9/1/25 requested. 1/4/25 complete 9/1/25 will complete once data available JA 13/6/25 report complete and sent to paed lead nurse for presentation at SMT. 1/7/25 presented at SMT. jA	
6	Consider additional nursing associates in neonates	Evaluate effectiveness of role once trainee has qualified	1/7/2025	Ward Matron	1/12/26	1/7/25 Trainee does not qualify until sept 26	
7	Review community neonatal outreach team scope and	Review BAPM document	1/7/2025	SCM	31/8/2025		

Item	**Problem/Issue/Identified gap in service** *These should follow logically from the Root and Contributory causes / Recommendations*	**Specific proposed actions:** *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	**Date action initiated:**	**Responsibility:** *Name and job title of identified staff who have agreed to complete the action.*	**Planned completion date:** *Set a realistic timescale. Extensions will need to be agreed and justified.*	**Progress / Update** *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	**Final Evaluation or Impact** *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
	criteria against the BAPM framework for neonatal outreach to consider extended scope to facilitate earlier discharge	Caseload review of current community workload Review of skills of team against requirements for identified patients that may have earlier discharge date.		Ward matron/SCM Ward matron /SCM/Neonatal outre ach team	31/8/2025 30/9/2025		

Appendix 7. STHFT Neonatal workforce improvement plan

Item	**Problem/Issue/Identified gap in service** *These should follow logically from the Root and Contributory causes / Recommendations*	**Specific proposed actions:** *Specific, Measurable, Achievable, and Realistic. Actions should be designed to reduce the risk of recurrence. This should include the evidence needed to demonstrate the impact of implementation.*	**Date action initiated:**	**Responsibility:** *Name and job title of identified staff who have agreed to complete the action.*	**Planned completion date:** *Set a realistic timescale. Extensions will need to be agreed and justified.*	**Progress / Update** *The improvement plan should be regularly reviewed and progress updated to ensure progress is in line with planned completion date. Where monitoring or audit is proposed, a summary of the results should be provided.*	**Final Evaluation or Impact** *Where monitoring shows no improvement / change in practice, additional actions should be added with timescales for completion and further evaluation.*
1	Medical workforce in the neonatal unit should be compliant with BAPM recommendation	Medical staffing should be regularly reviewed to ensure appropriate cover for neonatal unit and post-natal ward	1/4/2025	Neonatal Clinical Director	Ongoing	15/03/25 : Recruited 2 Tier 1 ANNPs into Tier 2 role. This has improved the 6.1 WTE on tier 2 to 7.6 WTE. With this there is no gap on the tier 2 rota.	15/06/2025: Regular monitoring in monthly directorate meetings

People Committee

29 July 2025

Connecting to: Board of Directors

Chair of Committee: Mark Dias

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.

Industrial Action: Committee acknowledged the co-ordination across the organisation.

WRES: Lack of improvement in the treatment of global majority staff who experience discrimination, bullying and harassment. NTHFT adverse trends on global majority staff experiencing discrimination from manager/team leader. STHFT adverse trend on global majority staff entering a formal disciplinary process. Committee noted the lack of improvement over time.

IPR

- Sickness absence at 5.6% (above threshold)
- Turnover at 7.6% (NTHFT) and 6.6% (STHFT) and below 10% target
- Annual appraisals at 84.9% against a 85% target
- Mandatory training at 87.1% against a 90% target

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.

Medical Job Planning - NHS England set a national target for medical job planning, whereby all NHS organisations were required to achieve a target of 95% sign-off by 31 March 2025. UHT current sign off rate is circa. 90% which represents a significant improvement. Trajectories were set for 100% compliance by July 2025 and these targets will not be attained. People Committee to review in September.

Payroll Improvement Update - Overpayments continue to be a systemic problem at STHFT (not NTHFT). Following a period of assessment this requires a cultural change in respect of accountability and responsibility (line management). Committee expressed its concerns that this issue continues to exist. Strategy for rectification to be presented to people committee in 3 months. Escalated to Group Resource 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.

Committee Terms of Reference (TOR & Cycle of Business (COB) were reviewed and feedback provided. Frequency discussed and to remain unchanged, i.e. 10 per year (no meetings in August and December). Further improvements to the cycle of business to strengthen strategic focus and review of the supporting infrastructure to be undertaken and review of frequency to be undertaken following this work.

AHP Bi-Annual Workforce Report - Assurance provided on staffing levels. Turnover: 72% of leavers (NTHFT) had service 0-5 years. Further assurance required on why (cultural assessment) and comparison across Group.

Safe Staffing Report - Introduction of trainee Health Care Support Worker (HCSW) positions to aid talent pipeline. Opportunity to fill gaps in Newly Qualified Nurses (NQN) in 2027/2028. Recruitment for HCSW to be centralised. Fill rates and turnover within tolerance.

Nursing and Midwifery National Profiles - Update on the National Job Evaluation Group report and the NHS Employers refreshed profiles for Bands 4-9. Assurance provided on implementation.

Perinatal Services Culture, Leadership and Behavioural Update - Follow up to the Feb 2025 meeting on metrics to measure culture, leadership and behaviours (following 2024 STHFT report). A meeting was held in June 2025 supported by the People Committee Chair, Group Chief People Officer, Group Chief Nurse, Director of Midwifery and Site Director of Nursing to ascertain how best to demonstrate cultural improvement and assurance. Focus was on assurance of sustained change. The report was noted.

University Hospitals Tees

Safe Staffing Monthly Report (June 2025 data)

Meeting date: 4 September 2025

Reporting to: Board of Directors

Agenda item No: 3.2

Report author:
Lindsay Garcia, Director of Nursing, South Tees, Beth Swanson, Director of Nursing, North Tees, Emma Roberts, Associate Director of Nursing and Professional Workforce, Debi McKeown, Nurse Workforce Lead

Executive director sponsor: Emma Nunez, Group Chief Nurse

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to:

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partner's ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

CQC domain link:

Choose an item.

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

This report details nursing staffing levels for June 2025 for inpatient wards. The report provides assurance that arrangements are in place to provide a workforce with the right skills in the right place to provide safe, sustainable and productive staffing. Daily Safe Care Staffing meetings provide assurance that inpatient areas have been assessed, staffing levels reviewed, and staff deployed where necessary to mitigate risk to the lowest level.

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

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.

Across the group, the next bi-annual nurse establishment review will be presented to Board in Oct25 – this will be a review paper to determine any requirements to adjust the existing nursing workforce model in preparation for the annual establishment review.

At North Tees and Hartlepool, the next bi-annual nurse establishment review will be presented to Board in Oct25 – this will be a review paper and will continue to highlight the requirement for investment into a number of nursing workforce models as per the bi-annual review carried out in 2024/25.

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 average percentage of shifts filled against the planned nurse staffing across South Tees for June 25 has decreased by 1.4% to 97.1%. Sickness for registered staff increased marginally whilst turnover decreased. Sickness for unregistered staff reduced whilst turnover increased in June 25.

A centralised recruitment process for HCSW's has been approved and interviews were conducted July 2025. Effective redeployment has supported the controls around the use of temporary staffing and is reviewed at the monthly workforce assurance meetings.

The recruitment plan for newly qualified nurses gained approval at Full Executive Team Meeting in July. This collaborative approach to recruitment allows for complete equity for all students as the process is for a fixed term appointment within a collaborative. There will be equal representation from all collaboratives who will undertake the interviews using generic questions for all applicants. Heads of Nursing are providing current vacancy position and upcoming maternity leaves.

At North Tees the overall planned nurse fills for June 2025 is 101% which continues to align with the current enhanced care requirements particular during the night so there remains a continued reliance on temporary staffing to safely staff in patient areas.

Due to continued difficulties with B3 HCSW recruitment at North Tees and Hartlepool, the current vacancy position sits at approx. 70wte. The introduction of the trainee health care support worker role has been approved to mitigate gaps in workforce and to support a 'grow your own' initiative. Supporting new staff members to gain the required clinical experience and academic requirements to move into a B3 position within a 12 month fixed term post. Interviews have commenced in July/August where over 200 candidates will be interviewed for 65wte posts.

To provide further assurance in relation to safer nurse staffing, North Tees will carry out STEP week (Safer staffing, Timely care, Enhanced Care, Planned discharge), this is scheduled in September 2025 and will specifically review patient acuity and dependency data and provide further validation of SNCT data in addition to collecting and collating a number of other data sets/metrics that will support a variety of planned or on-going work streams. Testing of the data collection tools is scheduled for 8 August 2025 and an update of outcomes will be presented in October 2025.

There remains a continued reliance on the enhanced care team to provide 1:1 care to patients across several in-patient wards and departments at North Tees and Hartlepool. A review of the enhanced care service is currently underway with plans in place to use STEP week to collect and collate data sets linked to the provision of enhanced care. This will support moving to a revised model in line with the national collaborative/support. North Tees and Hartlepool are part of the NHSE ETOC workforce planning and deployment group which will further support service review.

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 South Tees, registered nurse and midwives (all bands) turnover for June 25 has decreased to 4.85% and HCSW turnover increased to 7.97%. North Tees and Hartlepool turnover for June 2025 has reduced in all bands with registered nursing reducing to 5.04% and HCSW to 7.87%.

The opportunity to present assurance related to workforce governance cross cutting schemes at Cost Improvement Programme Group (CIPG) was positively received and reinforced the continued commitment to exploring every method of safe and efficient rostering.

At North Tees, the NQN's in the September 2025 cohort have been appointed into permeant and fixed term roles throughout Trust. There has been approval to also appoint into forecasted vacancies to ensure that NQNs feel assured of their employment and reduces the risk of them moving to other Organisations for permanent posts.

Recommendations:

Members of the Trust Board are asked to: Note the content of this report and to note the significant work to ensure safe staffing across the nursing and midwifery workforce throughout June 2025.

Nurse Monthly Safer Staffing Report

This exception report provides the People Committee with the monthly University Hospitals Tees 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.

Safer Staffing Governance

At University Hospitals Tees (UHT), Safer Staffing is maintained through twice daily safer staffing meetings (using Safe Care Live) to address any immediate safe staffing concerns (on the day) and to ensure that suitable safer staffing arrangements are in place in line with patient acuity and dependency levels. Staff redeployment is co-ordinated to ensure patient safety is prioritised and at the forefront of decision making in line with the agreed SOPs. All staffing plans are shared through OPEL meetings and Safe Care meetings.

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 monthly collaborative assurance meetings at both sites have full participation from all senior nurses including Heads of Nursing, Clinical Matrons and Service Managers to ensure all decision making is appropriate.

Monthly workforce assurance and check and challenge meetings are now embedded in practice to ensure compliance with rostering and safer staffing key performance indicators. At North Tees, the current Check and Challenge meetings have recently been reviewed and refreshed to ensure that the required safe staffing and rostering KPIs are reviewed and required actions are agreed on a monthly basis. These meetings will now be known as monthly workforce assurance meeting to support a future UHT approach and to align with South Tees' current process.

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.

The following areas at South Tees, during June 2025 showed a fill rate of less than 80% due to ***patient acuity levels*** and ***staff sickness*****:**

<u>Days</u>

- CICU – Cardio Intensive Care
- Zetland - Stroke Rehabilitation
- Maternity Centre – Friarage
- Ward 11 – Older Persons Medicine

<u>Nights</u>

- CICU – Cardio Intensive Care

- Ainderby – Medical Ward
- Romanby – Medical Ward
- Maternity Centre – Friarage
- NHDU – Neuro High Dependency
- CHDU – Cardio High Dependency

The following areas had less than 80% fill due to a ***reduced elective programme*** during the period of reporting:

Days

- Ward 6 – Short Stay Elective
- Ward 22 – Paediatric Surgical Ward

Nights

- Ward 22 – Paediatric Surgical Ward

In June 2025, the following areas at North Tees and Hartlepool showed a fill rate of less than 80%;

- Low RM and HCSW fill rate continued on delivery suite and ward 22 due to current vacancies - filled by Sep25 student cohort, short term sickness and a high number of WTE on maternity leave.
- Critical Care had low RN fill rate due to reduced acuity during this reporting period.
- Low HCSW fill rate on elective care unit and neonatal unit due to reduced activity.
- Low HCSW fill rate on ward 22 due to increased vacancies and short-term sickness.
- Low HCSW fill rate on SDU due to current adjustments to department templates in this line, this will be adjusted as of Aug25.
- Low HCSW fill rate on Paediatrics due to short term sickness alongside reduced acuity and dependency.
- Wards ACU, 24, 25, 26, 27, 28, 32, 33, 36, 40, 41 and 42 had an increase in HCSW fill up to 110- 174% due to the increasing demands of enhanced care, particularly at night.

All safe staffing concerns were escalated to the daily safer staffing meetings, where appropriate redeployment was carried out based on patient acuity and dependency.

Table 1a Trust Planned versus Actual fill – South Tees:

Overall Ward Fill Rate		**June 25**
	RN/RMs (%) Average fill rate – DAYS	91.5%
	HCA (%) Average fill rate – DAYS	91.7%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	94.8%
	HCA (%) Average fill rate – NIGHTS	99.0%
	NA (%) Average fill rate – NIGHTS	100%
	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**97.1%**

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

Overall Ward Fill Rate		**June 2025**
	RN/RMs (%) Average fill rate – DAYS	90%
	HCSW (%) Average fill rate – DAYS	97%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	97%
	HCSW (%) Average fill rate – NIGHTS	124%
	NA (%) Average fill rate – NIGHTS	100%
	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**101%**

Nurse Sensitive Indicators

At both South and North Tees, staffing was not directly referenced in any concluded PSIRF reviews in June 2025.

Red Flags Raised through Safe Care Live

At South Tees, during June 2025, there were a total of 3 red flags raised relating to staffing. Two of the red flags were logged as “Shortfall in RN time” and one logged as “Missed ‘intentional rounding’”. There were no red flags raised indicating less than 2 RNs on shift, however, the Safe Care log would provide a documented resolution in these instances. Reminders are sent weekly via the E-Rostering team to Clinical Matrons to review and close any resolved Red Flags.

At North Tees, there was a decrease in red flags raised relating to safe staffing during Jun25 to 1. The red flag was raised by ward 40 for ‘vital signs not monitored’ this was in relation to the increased needs of enhanced care patients and a reduced number of enhanced care workers, meaning that ward based HCSW’s were required to support patients on a 1:1 basis, taking them away from the main ward requirements. This was discussed during the daily safe staffing meeting and suitable re-deployment of staff was carried out to provide additional support to the ward.

Datix/In-Phase Submissions

At South Tees during June 25, there were 92 Datix submissions relating to staffing. Staff are encouraged to Datix any staffing related issues are reviewed and discussed as part of workforce assurance and governance meetings. The majority of Datix submissions, highlights a reduction in staffing on Ward 7, Ainderby and Ward 17. All shortages raised were managed through the Safe Care process throughout June.

At North Tees, in Jun25 there was an increase of in-phase reports relating to nurse staffing. A total of 9 were submitted by the Care groups, which have been summarised below;

Delivery Suite - 3 due to delayed care linked to RM staffing levels, internal escalation plans followed to provide safe staffing levels and non-urgent care postponed.

Respiratory - 2 due to increased acuity and dependency of SNCT level 2 patients and not having adequate nursing staff to support patient needs. Escalated out of hours and appropriate escalation plans were made by the clinical site matron.

Enhanced Care - 2 due to lack of enhanced care support, escalated through the safe staffing meeting and ward matrons supported clinically to mitigate risk.

SDU - 1 due to increased acuity and activity out of hours, risk mitigated through internal escalation.

EAU - 1 in relation to a reduction in available nurse staffing of decanted beds on ward 37 from EAU, internally escalated and managed within the care group to support this capacity.

All staffing risks were appropriately escalated through Senior Clinical Matrons (CSMs) or Clinical Site Managers (CSM) at the time of the events and all In-Phase reports were discussed in the safer staffing meetings to ensure mitigation of any risk was put in place.

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

Vacancy & Turnover

Across the group, the vacancy position continues to be positive. Both sites submitted a joint paper to the Full Executive Team meeting and agreement was secured to over recruit NQNs from the September cohort.

As per the South Tees financial ledger for June 2025, vacancies show as –14.50 WTE (RN and RM combined). The vacancy position as per the financial ledger indicates a vacancy of 117.26 WTE for HCSW's. Centralised recruitment of HCSW's took place in July 25 to mitigate against the vacancy / establishment gap increasing in the future. 44 WTE HCSW's were successfully recruited.

At North Tees, the B5 RN vacancy position remains positive across the in-patient wards and departments. In June 2025 the vacancy level is 13.28 WTE, with forecasting to the end of October 2025 seeing this reduce to 0 WTE. All current and forecasted vacancies are now being appointed into by the next NQN cohort for Sep25 following SLT approval in July 2025.

At North Tees, the HCSW vacancy position across all services in Jun25 is 64.47 WTE with a forecasted vacancy exceeding 70wte by Aug25. There is a planned improvement to this position following the approval to flip 65 WTE B3 vacancies into B2 trainee HCSW posts. These posts are being appointed into throughout Jul/Aug25.

Care Hours Per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. This 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 for June 2025 can be reviewed in Appendix 2.

Table 2 South Tees site:

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
April 2025	9.17	9.76	+0.59
May 2025	9.09	9.33	+0.24
June 2025	9.20	9.65	+0.45

June 25 shows that 16 inpatient areas are above the required average of CHPPD provision. Those that are below the required CHPPD are reflective of the current sickness and increased patient acuity. Twice daily safe care reviews plan and implement redeployment into unfilled shifts.

Wards 12 and 9 had the lowest CHPPD due to Ward 12 carrying 1 x HCSW vacancy and had 8.3% of staff off sick in June 25. Ward 9 carries 4 HCSW vacancies and had 12.3% of staff off sick in June 25. The vacancies for HCSW's have just been recruited into (August 25) via the central HCSW process so we should see the negative CHPPD improve over the next few months. The staff sickness is managed appropriately with Health Improvement Plans in place.

June 25 had an average sickness rate of 5.46% (RN's, RM's and HCSW's combined) showing the number of staff off sick is decreasing and will aid in reducing the reliance on temporary staffing. Due to the changing demands temporary staffing is variable, with a concerted effort made to redeploy before exploring NHSP.

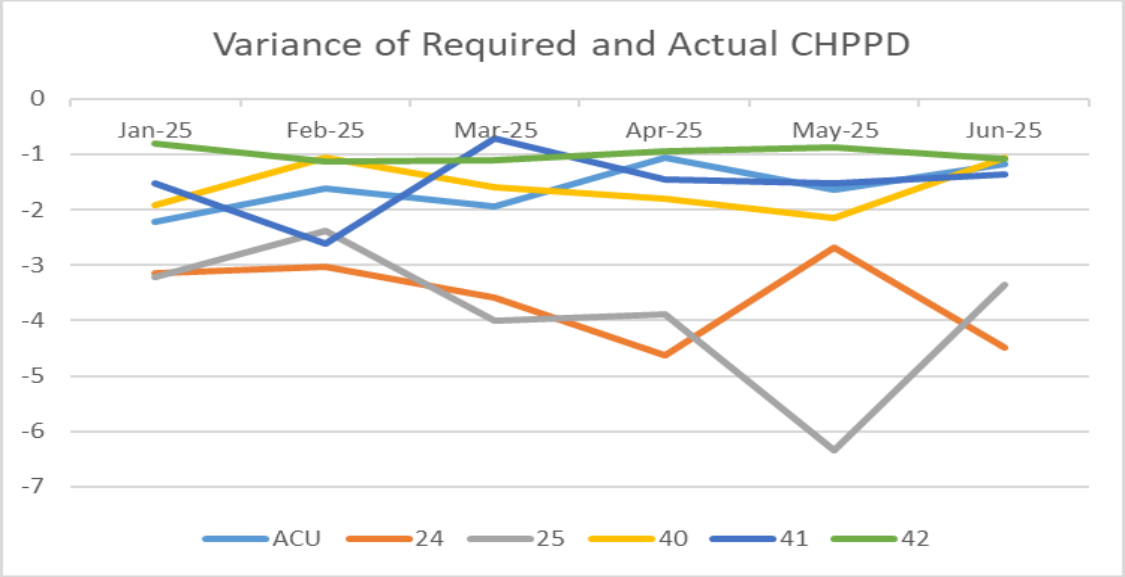
A weekly look forward review and monthly Workforce Assurance meetings with each collaborative allows triangulation of data including sickness and turnover rates. The wards and departments with the largest NHSP spend relate to those areas that have been highlighted as requiring an adjustment in establishment in the biannual SNCT establishment reviews.

Table 3 North Tees site:

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
April 2025	8.94	9.62	+0.67
May 2025	9.55	10.49	+0.95
June 2025	9.25	10.06	+0.81

In June 2025 the areas highlighting a higher variance level (>1) at North Tees, and thus, not delivering the required CHPPD were Cardiology, Respiratory, Gastroenterology, Endocrine, Elderly Care and Stroke wards. This is reflective of the increased acuity in Respiratory and Endocrine (SNCT level 2 patients) and of increased HCSW vacancy in the other departments. These areas have also been the focus of the most recent bi-annual nurse establishment review where the proposed nurse establishment models in line with the formal review process have been presented, indicating that establishments in these areas require investment. **Chart 1** presents the variance of the required and actual CHPPD for these areas across the previous 6 month.

Chart 1



All unfilled duties within rosters have been managed via the twice daily safer staffing meetings and suitable re-deployment to the areas made. The use of temporary nurse staffing continues at North Tees due to sickness levels that continues to exceed 4% (allocated within headroom) and maternity leave that has previously not been backfilled consistently.

To provide further assurance in relation to safer nurse staffing, North Tees will carry out STEP week (Safer staffing, Timely care, Enhanced Care, Planned discharge), this is scheduled in Sep25 and will specifically review patient acuity and dependency data and provide further validation of SNCT data in addition to collecting and collating a number of other data sets/metrics that will support a variety of planned or on-going work streams. Testing of the data collection tools is scheduled for the 8th Aug25.

Work continues with the Business Intelligence team to develop a nursing and midwifery workforce matrix to support the monthly triangulation of workforce metrics, patient quality and safety outcomes and professional judgement. Due to the move to Power BI, this work has been paused by BI so a manual version of this is currently being drafted as an interim measure to enable an element of testing.

Nurse Recruitment and Retention

On the 5th August 2025, a Group 'over recruitment' proposal was approved at Group Management Team meeting, with an agreement to over recruit a total on 90wte B5 NQNs (70wte at South Tees and 20wte at North Tees). This will enable both sites to fill unfilled shifts linked to maternity leave and long-term absence, thus reducing the reliance on NHSP/agency.

All Sep25 NQNs have been allocated positions based on current and forecasted vacancies. Recruitment centres continue on a monthly basis, alternating the recruitment of HCSW and RN posts.

Safer Staffing workforce initiatives continue to be implemented. At both sites the monthly nursing workforce assurance meetings / Professional Workforce Assurance Council (PWAC)

provide a platform to fully explore all recruitment and retention issues as well as highlighting best practice for safe and effective rostering.

Temporary Staffing

At South Tees, nursing and midwifery bank and agency demand for June 25 has decreased by 38% compared to June 24. Bank filled hours have also decreased by 30% when compared to June 24.

Nursing agency use continues to be minimal at South Tees. June 25 showed that there were 28 hours of nursing agency used in Orthopaedic Theatres. ODP agency was utilised in Orthopaedic Theatres (179 hours) and Friarage Theatres (81). This is 248 hours less than June 24.

Bank spend decreased by £372,592 (-25%) when compared to June 24. Agency spend decreased by 55% when compared to June 24.

The overall fill rate for bank and agency in June 25 was 85.9%. This has increased by 11.1% compared to the same period last year. The reduction in demand year on year provides a more reliable reflection of the requirements of the wards and therefore a more accurate fill rate.

At North Tees and Hartlepool, all temporary staffing spend (NMAHP, Medical and Dental, Health Care Scientist and Admin and Clerical) is discussed monthly via the Temporary Staffing Focus Group (TSFG).

Agency spend YTD is £766k lower than the previous year

- Agency spend is still lower than in any month last year but is £22k up on May-25 driven by Cell Path and Finance.
- Mar-25 was high due to Cell Path outsourcing (now coded to non-pay), though insourcing makes up more than 50% of the remaining agency spend

Bank spend YTD is £169k higher than previous year

- At Jun-24 we were still seeing the swap from Agency to Bank
- In M3 we've seen Bank spend reduce back down from April and May, with a reduction seen in Enhanced Care

Locum spend YTD is £119k lower than previous year

- M3 spend has reduced compared to April and May

Overtime spend YTD is £137k lower than previous year

- M3 spend has remained consistent with May

Key Priorities

At North Tees the current key priorities are as follows:

- Continued monitoring of temporary staffing, over time use, sickness/absence & turnover
- Bi-annual nurse establishment review paper (update) to Board in Oct25.

- SNCT data collection planned for Sep25 (cycle 3 of new adult in-patient tool)
- New Paeds SNCT launch planned for Autumn 2025, 1st cycle of data collection to follow
- Introduction of Trainee HCSW (65wte B2) by Oct25 following pre-employment checks.
- STEP week to take place from 1st to 5th Sep25
- Continue to recruit NQN's into established and forecasted vacancies for Sep25 and then Jan26
- Development of the nursing workforce matrix detailed in section 6 of this report – to move this work forward following recent delays
- Enhanced Care service evaluation and movement to ETOC model

At South Tees the current key priorities are as follows:

- Detailed scoping exercise of non-ward based nurses and options to identify costs related to Nurse staffing covering medical rosters
- Continued actions to further reduce the remaining agency spend in Theatres
- Identification of the impact from Industrial Action on the ability to achieve reductions across NHSP.
- Workforce dashboard – launch into live environment

RECOMMENDATIONS

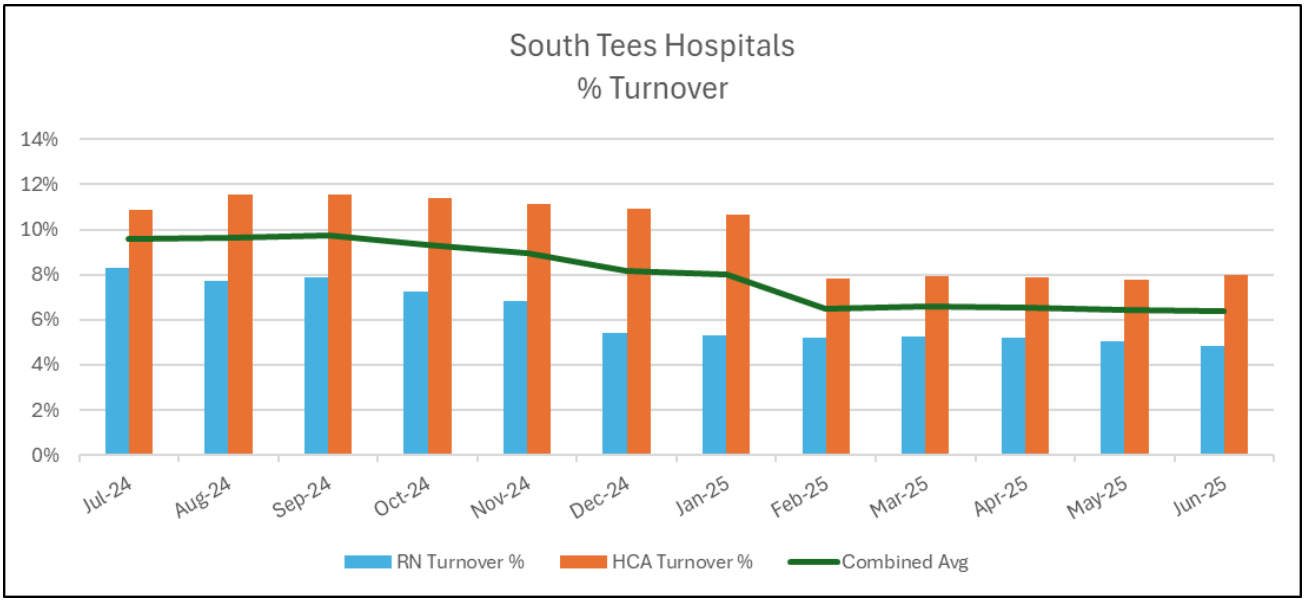
The Board is asked to read the content of this report and to note the progress made across both sites in relation to developing and retaining the nursing workforce.

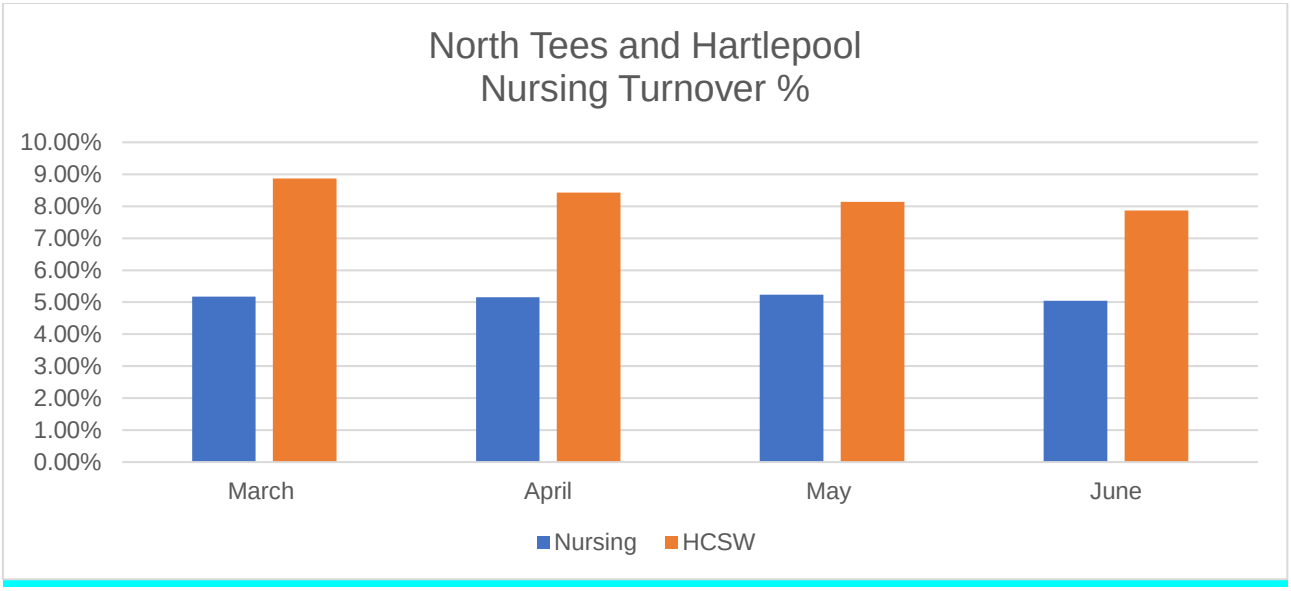
The Board are asked to note the assurance presented that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

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





Caring Better Together

Appendix 2

South Tees Average CHPPD Breakdown by Ward (June 2025):

Ward	Average of Required CHPPD	Average of Actual CHPPD	Variance
Ward 1	9.39	9.50	0.11
Ward 31	9.34	6.65	-2.68
Ward 2	6.34	5.80	-0.53
Ward 3	7.64	5.68	-1.95
Ward 4	8.70	8.45	-0.25
Ward 5	5.70	5.04	-0.66
Ward 6	5.67	5.45	-0.22
Ward 7	5.30	4.73	-0.56
Ward 8	6.13	5.76	-0.37
Ward 9	8.53	4.63	-3.90
Ward 11	8.03	5.84	-2.19
Ward 12	10.32	6.35	-3.97
Ward 14	6.98	6.29	-0.69
Ward 24	7.95	8.50	0.54
Ward 25	8.90	7.38	-1.52
Ward 26	9.04	6.89	-2.15
Ward 27	8.22	10.62	2.40
Ward 28	8.34	6.10	-2.24
Ward 29	5.06	5.41	0.36
Cardio MB	6.33	8.03	1.70
Ward 32	6.78	6.80	0.02
Ward 33	7.20	6.06	-1.14
Ward 34	7.98	6.03	-1.95
Ward 35	7.03	6.98	-0.05
Ward 36	6.09	5.19	-0.90
Ward 37 - AMU	12.15	11.28	-0.87
Spinal Injuries	9.40	8.05	-1.36

CCU	15.52	12.33	-3.18
Critical Care	19.02	26.36	7.33
CICU JCUH	23.73	32.07	8.33
Cardio HDU	10.61	14.25	3.65
Ward 24 HDU	10.75	21.51	10.76
CDU FHN	7.88	8.06	0.18
Ainderby FHN	10.50	8.20	-2.30
Romanby FHN	7.64	7.08	-0.55
Gara FHN	5.98	15.87	9.89
Rutson FHN	8.05	7.10	-0.95
Friary	8.04	8.43	0.39
Zetland Ward	9.18	6.93	-2.25
Tocketts Ward	7.88	6.08	-1.80
Ward 21	9.25	15.56	6.31
Ward 22	13.05	13.88	0.83
Neonatal Unit (NNU)	13.34	12.98	-0.36
Paediatric Critical Care (PCCU)	15.22	25.42	10.20
Grand Total (Average)	**9.20**	**9.65**	**0.45**

North Tees Site - CHPPD by ward for June 2025

Unit Previous month	Required CHPPD	Actual CHPPD	CHPPD Variance
Acute Cardiology Unit	7.47	6.29	-1.18
Critical Care North Tees	20.55	28.98	8.42
Elective Care Unit	6.85	20.85	14.00
Emergency AMB	7.78	10.14	2.35
Neonatal Unit	10.79	12.39	1.60
Paediatrics	10.09	20.55	10.45
SDU	10.78	11.37	0.59

Ward 24 (Respiratory)	8.70	7.08	-1.62
Ward 24 RSU (Respiratory)	13.38	10.49	-2.89
Ward 25 (Respiratory)	9.26	7.05	-2.21
Ward 25 RSU (Respiratory)	13.63	12.49	-1.14
Ward 26 (Gastroenterology)	7.79	6.08	-1.71
Ward 27 (Gastroenterology)	7.40	6.04	-1.36
Ward 28 (Surgery)	6.28	6.10	-0.18
Ward 31 (Surgical Observation Unit)	8.53	8.78	0.26
Ward 32 (Fragility Fracture)	8.00	7.09	-0.91
Ward 33 (Orthopaedic & Spinal)	6.47	6.06	-0.41
Ward 36	8.70	6.48	-2.21
Ward 38	6.92	6.37	-0.55
Ward 40 (Acute Elderly)	8.53	7.46	-1.07
Ward 41 (Stroke Unit)	7.84	6.47	-1.37
Ward 42 (Elderly Rehabilitation)	7.80	6.71	-1.09
Average	**9.25**	**10.06**	0.81

University Hospitals Tees

NHS Workforce Race Equality Standard (WRES) 2025

Meeting date: 4 September 2025

Reporting to: Board of Directors

Agenda item No: 3.3

Report author: Nicola Hogarth, Culture and Inclusion Assurance Partner; Jennie Winnard Group Deputy Director Organisational Development and Culture

Executive director sponsor: Rachael Metcalf, Chief People Officer

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: People Committee

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☒

Using our resources well ☐

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements.

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.

North Tees and Hartlepool NHS Foundation Trust

Key issues highlighted in this year's WRES was the increase of Global Majority staff personally experiencing bullying, harassment and abuse from patients, relatives or the public, and also Global Majority staff experiencing discrimination from a manager/team leader.

South Tees NHS Foundation Trust

Key issues highlighted in this year's WRES was the increase of Global Majority staff personally experiencing bullying, harassment and abuse from patients, relatives or the public, and also the disproportionate number of Global Majority employees entering a formal disciplinary process.

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 committee is advised that due to the reporting nature of the workforce race, equality standard, the report is written for both unitary bodies separately.

North Tees and Hartlepool NHS Foundation Trust

- The number of Global Majority staff employed within the Trust has increased each year from 2021 and represents 16.06% of the workforce. In comparison to the Government's Office for National Statistics, Global Majority employees are well represented in the organisation when compared to the BAME population in the Northeast of England which is reported as 7%.
- Decreased likelihood of applicants with a Global Majority ethnicity being appointed from shortlisting.
- A decrease of Global Majority staff believing the Trust provide equal opportunities for career progression or promotion.
- Global Majority representation at Board level is reported at 0% (please note we can only report on those employees who are directly employed by North Tees and Hartlepool NHS Foundation Trust).

South Tees NHS Foundation Trust

- Decreased likelihood of applicants from Global Majority ethnicity being appointed from shortlisting.
- Global Majority representation at Board level is reported at -3% (please note we can only report on those employees who are directly employed by South Tees Hospitals NHS Foundation Trust).

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

North Tees and Hartlepool NHS Foundation Trust

- We continue to report that we do not have a disproportionate number of Global Majority employees entering a formal disciplinary process.
- There is a greater likelihood of Global Majority employees to access non-mandatory training opportunities.
- A slight decrease in Global Majority staff experiencing harassment, bullying or abuse from staff.

South Tees NHS Foundation Trust

- The number of Global Majority colleagues employed within the Trust has increased each year from 2021 and represents 13.88% of the workforce. In comparison to the Government's Office for National Statistics, Global Majority employees are very well represented in the organisation when compared to the BAME population in the Northeast of England which is reported as 7%.
- A decrease of Global Majority staff experiencing Bullying, Harassment and Abuse from staff
- Equal experience for Global Majority and White employees to access non-mandatory training opportunities.
- An increase of Global Majority staff believing the Trust provide equal opportunities for career progression or promotion.

Recommendations:

This report presents a group update in relation to the Workforce Race Equality Standard (WRES) 2025 across **University Hospitals Tees.** Group People Committee is asked to receive the content of the report and acknowledge the Workforce Race quality Standard (WRES) results for both Trusts.

The committee is requested to support the continued work within race and culture across the group.

University Hospitals Tees

NHS Workforce Race Equality Standard (WRES) 2025

1. Introduction

As set out in the NHS Long Term Plan, respect, equality, and diversity are central to changing culture and are at the heart of the NHS workforce implementation plan.

The Workforce Race Equality Standard (WRES) was introduced as part of the NHS Standard Contract in 2015 and seeks to tackle one aspect of equality – the consistently less favourable treatment of those who identify themselves as Black, Asian or from a Minority Ethnic (BAME) background.

National research shows that those individuals who are from a Black, Asian or Minority Ethnic background (Global Majority) are:

- less likely to be appointed for jobs once shortlisted.
- less likely to be selected for training and development programmes.
- more likely to experience harassment, bullying or abuse.
- more likely to be disciplined and dismissed.

The purpose of this report is to present a group update in relation to the Workforce Race Equality Standard (WRES) 2025.

2. WRES Indicators

A summary of the results for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust is shown in the tables below and includes comparison of the Trust's results covering a five-year period (2021 to 2025).

A copy of the WRES Reports 2025 for each Trust is contained at Appendix 1 and Appendix 2 for information purposes.

North Tees and Hartlepool - WRES Indicators 2025			2021	2022	2023	2024	2025
1	Percentage of BME staff	Overall	11.0%	11.4%	12.80%	14.33%	**16.06%**
		VSM	0.0%	0.0%	0.00%	0.00%	**0.00%**
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		3.24	1.43	2.12	2.40	**2.96**
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		0.93	0.88	0.78	0.99*	**0.64**
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		1.16	0.96	1.1	0.91	**0.84**
			2020	**2021**	**2022**	2023	**2024**
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME	28.1%	34.9%	30.7%	28.3%	**33.9%**
		White	24.8%	26.2%	24.8%	21.8%	**21.2%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	29.2%	30.1%	26.9%	22.8%	**22.4%**
		White	20.4%	18.7%	18.6%	16.1%	**16.9%**
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	BME	55.7%	48.2%	48.1%	50.6%	**47.6%**
		White	61.7%	64.8%	64.9%	63.7%	**58.4%**
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	14.6%	16.8%	12.6%	13.7%	**15.4%**
		White	5.1%	5.2%	4.7%	5.2%	**4.7%**
			2021	**2022**	**2023**	2024	**2025**
9	BME Board membership	BME	5.6%	7.1%	6.3%	0.0%	**0.0%**

South Tees - WRES Indicators 2025			2021	2022	2023	2024	2025
1	Percentage of BME staff	Overall	9.6%	10.0%	11.44%	12.83%	**13.88%**
		VSM				14.30%	**0.00%**
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		2.6	1.6	1.52	1.86	**2.62**
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.8	1.27	0.8	0.78	**1.37**
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		1.09	0.98	1.08	0.99	**1.00***
			2020	**2021**	**2022**	2023	**2024**
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME	23.8%	26.7%	28.8%	23.0%	**24.4%**
		White	24.1%	23.9%	24.8%	22.0%	**21.9%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	27.7%	28.6%	32.9%	30.1%	**28.3%**
		White	23.5%	21.5%	22.2%	20.6%	**24.3%**
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	BME	38.6%	48.2%	43.3%	43.5%	**49.6%**
		White	53.1%	58.2%	58.4%	58.7%	**57.8%**
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	19.7%	19.9%	20.4%	20.0%	**19.7%**
		White	5.1%	5.8%	5.8%	6.2%	**7.1%**
			2021	**2022**	**2023**	2024	**2025**
9	BME Board membership	BME	-1.1%	-9.6%	-10.0%	-13.0%	**-3.0%**

*Remains postive as 1.00 would indicate equal experience of both White and BME Staff

3. WRES Update - North Tees and Hartlepool

A review of the WRES data has highlighted the following points of interest:

- The number of Global Majority staff employed within the Trust has increased each year from 2021 and represents 16.06% of the workforce. In comparison to the Government's Office for National Statistics, Global Majority employees are well represented in the organisation when compared to the BAME population in the Northeast of England which is reported as 7%.

- Decreased likelihood of applicants with a Global Majority ethnicity being appointed from shortlisting.

- We continue to report that we do not have a disproportionate number of Global Majority employees entering a formal disciplinary process.

- There is a greater likelihood of Global Majority employees to access non-mandatory training opportunities.

- A slight decrease in Global Majority staff experiencing harassment, bullying or abuse from staff.

- A decrease of Global Majority staff believing the Trust provide equal opportunities for career progression or promotion.

- Global Majority representation at Board level is reported at 0% (please note we can only report on those employees who are directly employed by North Tees and Hartlepool NHS Foundation Trust).

Key issues highlighted in this year's WRES was the increase of Global Majority staff personally experiencing bullying, harassment and abuse from patients, relatives or the public, and also Global Majority staff experiencing discrimination from a manager/team leader.

4. WRES Update - South Tees

A review of the WRES data has highlighted the following points of interest:

- The number of Global Majority colleagues employed within the Trust has increased each year from 2021 and represents 13.88% of the workforce. In comparison to the Government's Office for National Statistics, Global Majority employees are very well represented in the organisation when compared to the BAME population in the Northeast of England which is reported as 7%.

- Decreased likelihood of applicants from Global Majority ethnicity being appointed from shortlisting.

- A decrease of Global Majority staff experiencing Bullying, Harassment and Abuse from staff

- Equal experience for Global Majority and White employees to access non-mandatory training opportunities.

- An increase of Global Majority staff believing the Trust provide equal opportunities for career progression or promotion.

- Global Majority representation at Board level is reported at -3% (please note we can only report on those employees who are directly employed by South Tees Hospitals NHS Foundation Trust).

Key issues highlighted in this year's WRES was the increase of Global Majority staff personally experiencing bullying, harassment and abuse from patients, relatives or the public, and also the disproportionate number of Global Majority employees entering a formal disciplinary process.

5. WRES Group Update

A review of both Trusts data has highlighted the following key points:

Indicator 1 – Representation.

It is positive to report that both Trusts have seen an increase in employed Global Majority staff for 2025. When compared to the North East's ethnicity data (2021 census) which is reported at 7%, both Trusts report a higher representation within the overall workforce. Also, when compared against our local areas ethnicity data, including Stockton, Hartlepool, Redcar and Cleveland and Hambleton (with the exception of Middlesbrough) both Trusts have also reported a higher workforce representation in comparison to our local communities BAME population.

Indicator 2 – Likelihood of staff being appointed from shortlisting.

Both Trusts continue to report an increase in the likelihood of Global Majority staff being appointed from shortlisting. This will be a priority area and it is recommended that a Group review is undertaken in relation to the overall recruitment journey including advertising, shortlisting, and interviews, including consideration of having Global Majority representation on interview panels. It is also recommended that this information is reviewed amongst the Staff Networks and Leads, considering the use of more inclusive interview panels and support for internal applicants in this area.

Indicator 3 – Likelihood of staff entering formal disciplinary process

North Tees and Hartlepool have consistently reported that there does not appear to be a disproportionate number of Global Majority staff entering formal disciplinary processes. South Tees has reported that Global Majority colleagues are more likely to enter formal disciplinary processes and this figure has increased for 2025. There are plans in place for cultural ambassadors to be introduced at South Tees later in 2025, mirroring the approach currently taken at North Tees and Hartlepool; to support future disciplinary panels where Global Majority staff are involved. We will be continuing to review and compare against regional benchmarks as well as responses from previous years.

Indicator 4 – Likelihood of staff accessing non-mandatory training

Once again, both Trusts report a positive indicator highlighting an increasing likelihood of Global Majority staff accessing non mandatory training. As there is no shortfall in respect of the likelihood of Global Majority staff accessing training as compared to White staff. We are looking to undertake the ethnicity gap within both Trusts and will analyse and review any ethnicity pay gaps across the different pay bandings.

Indicator 5 – Percentage of staff experiencing harassment, bullying/abuse from patients, relatives/public

Both Trusts have reported a negative increase in the percentage of staff stating they have experienced harassment, bullying/abuse from patients, relatives/public, however South Tees figure of 24. 4 still remains below the national average figure of 28.2% for 2025. This has been highlighted as priority area for both Trusts and further analysis of this key finding has been undertaken to identify hotspots, and development of department specific action plans to

address any areas of concern. We are also developing a University Hospitals Tees anti-racism strategy which is planned to be introduced later in the year.

Indicator 6 – Percentage of staff experiencing harassment, bullying/abuse from staff

Both Trusts have seen an overall positive reduction in the percentage of Global Majority staff stating they have experienced harassment, bullying/abuse from staff. Again, it is also positive to note that North Tees and Hartlepool figure of 22.4%, is 2.3% below the national average which is reported at 24.7%.

We will continue to seek feedback from those staff who have been directly involved in cases of bullying and harassment to understand how they felt during the process. Undertake case review to identify areas of good practice and ensure wider learning is cascaded across the Trusts. We will also continue to undertake awareness raising programmes for staff to promote understanding of examples and the effects of workplace bullying, including the actions that staff can take and where they may obtain further support as well as sign posting routes for reporting behaviours.

Indicator 7 – Percentage of staff believing the Trust provides equal opportunities.

The percentage of our Global Majority staff that believe we provide equal opportunities for career progression or promotion has positively increased for South Tees. However, North Tees and Hartlepool has seen a 3% reduction in the percentage reported.

We will continue to review this and the recommendations outlined in indicator 2 in terms of fairer recruitment processes will support the achievement of positive improvement in this indicator. We will continue to explore perceived barriers to equal opportunities and career progression via the Staff Networks and Leads and develop additional actions to address any areas of concern.

Indicator 8 – Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues

South Tees have seen a slight positive decrease (0.3%) to 19.7%, but this still remains above the national average which is reported at 15.7%. North Tees and Hartlepool have seen a negative increase of 1.7% (15.4%) when compared to the 2024 Staff Survey data, however it is positive to note that the figure remains below the national average.

It is important we empower our managers to ensure they are confident to appropriately challenge behaviours and have difficult conversations, deliver difficult decisions, and by doing so, ensuring that staff fully understand the reasons behind decisions – particularly where the outcome could be perceived as discriminatory. We will also continue to review exit information to identify the number of Global Majority staff who are leaving the Trusts and whether or not discrimination has had an impact on the decision to leave.

Indicator 9 –Board Membership

Global Majority representation at Board level is underrepresented for University Hospital Tees, as compared to the overall Global Majority workforce. The Group will continue to implement a fair and transparent recruitment process for all positions at all levels of the organisation.

It is recommended that a review is undertaken in relation Board members in terms of positive action, to encourage Global Majority representation at Board Level to ensure our Board is reflective of our overall workforce, services and local communities. We will also focus on succession planning and talent management (aligned to the NHS EDI Improvement plan).

6. Conclusion and next Steps

The Workforce Race Equality Standard (WRES) has now been collecting data on race inequality for ten years, holding up a mirror to the service and revealing the disparities that exist for black and minority ethnic staff compared to their white colleagues.

We are pleased to report an improvement in some of the metrics for both Trusts for 2025 and note that this reflection of the continued EDI programme of work and the significant investment made in terms of data analysis, our restorative approach and focused interventions to improve staff experience across the range of protected characteristics. However, the disparity gap across a number of the indicators and the level of bullying, harassment and abuse by patients, relatives or the public remains a significant concern.

The Trusts have taken a number of important actions in 2024/2025, to support the Workforce Race Equality Standard and we will focus and work on the recommendations and actions outlined within section 5 of this paper. This will include engagement with our collective workforce and key stakeholders to share these results and jointly develop actions that can be progressed across University Hospitals Tees in the coming year.

7.0 Recommendation

This report presents a group update in relation to the Workforce Race Equality Standard (WRES) 2025 across University Hospitals Tees**.** Group People Committee is asked to receive the content of the report and acknowledge the Workforce Race Equality Standard (WRES) results for both Trusts reported in Section 2 and the key points and recommendations outlined within Section 5. Both Trusts individual reports are included in the appendices for further information.

Appendix 1 - North Tees & Hartlepool NHS Foundation Trust - NHS Workforce Race Equality Standard 2025
Appendix 2 - South Tees Hospitals NHS Foundation Trust - NHS Workforce Race Equality Standard 2025

North Tees & Hartlepool NHS Foundation Trust

NHS Workforce Race Equality Standard 2025

1. Introduction

The Workforce Race Equality Standard (WRES) programme was established in 2015. It requires organisations to report against nine indicators of race equality and supports continuous improvement through robust action planning to tackle the root causes of discrimination.

Inequalities in any form are at odds with our values. Research shows that the fair treatment of our staff is directly linked to better clinical outcomes and better experience of care for patients.

This report represents the tenth publication since the WRES was established. There are some positive findings in this report and there are also areas where further analysis of the information is required to fully understand the results, particularly in relation to staff survey feedback.

We are committed to tackling racial discrimination to bridge the gaps in experience, opportunity and differential attainment in our diverse workforce. A key tool to understanding and correcting these inequities is the presentation of detailed data to key work streams, which will allow us to identify the targets for action.

2. Trust Requirements

In order to meet the requirements for 2025, the Trust is required to publish our WRES data no later than 31 May 2025 to NHS England via the Data Collection Framework (DCF) portal.

Work will then commence to produce the Trust's annual WRES report which will be published on the Trust's internet site no later than 31 October 2025.

3. WRES Indicators 2025

A summary of the results for North Tees and Hartlepool NHS Foundation Trust is shown in the table below. This includes comparison of the Trust's results covering a five-year period (2021 to 2025).

The baseline data has been extracted from ESR, Workforce databases and the Trac recruitment system to calculate a response to each of the nine WRES indicators.

WRES Indicators 2025			2021	2022	2023	2024	2025
1	Percentage of BME staff	Overall	11.0%	11.4%	12.80%	14.33%	**16.06%**
		VSM	0.0%	0.0%	0.00%	0.00%	**0.00%**
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		3.24	1.43	2.12	2.40	**2.96**
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		0.93	0.88	0.78	0.99*	**0.64**
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		1.16	0.96	1.1	0.91	**0.84**
			2020	**2021**	**2022**	2023	**2024**
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME	28.1%	34.9%	30.7%	28.3%	**33.9%**
		White	24.8%	26.2%	24.8%	21.8%	**21.2%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	29.2%	30.1%	26.9%	22.8%	**22.4%**
		White	20.4%	18.7%	18.6%	16.1%	**16.9%**
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	BME	55.7%	48.2%	48.1%	50.6%	**47.6%**
		White	61.7%	64.8%	64.9%	63.7%	**58.4%**
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	14.6%	16.8%	12.6%	13.7%	**15.4%**
		White	5.1%	5.2%	4.7%	5.2%	**4.7%**
			2021	**2022**	**2023**	2024	**2025**
9	BME Board membership	BME	5.6%	7.1%	6.3%	0.0%	**0.0%**

4. Key Findings for 2025

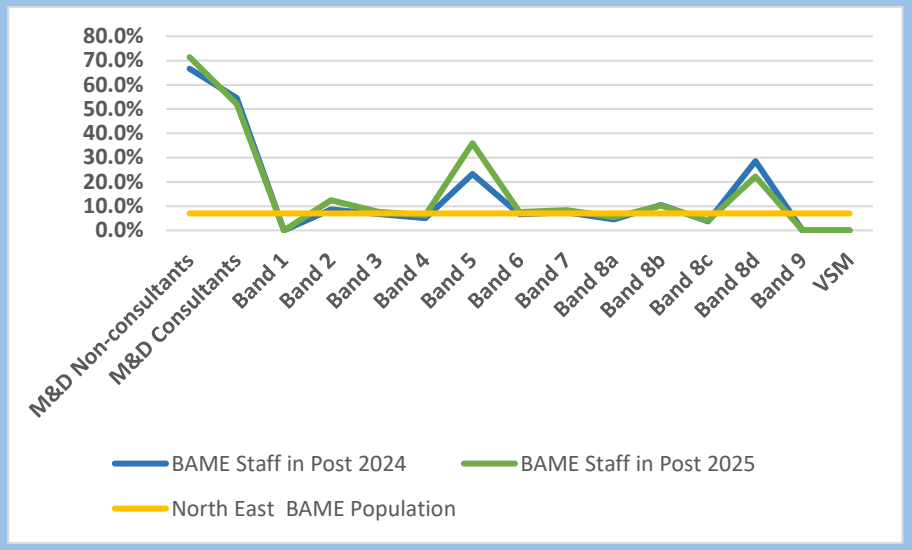
The key findings in respect of the nine WRES indicators for 2025 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 5-8). Full benchmarking information is published by the national WRES team and this is expected for March 2026.

The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's ethnicity profile, which can also be broken down by Region and Local Authority Area.

- UK Population 81.7% White and 18.3% BAME
- North East Population 93% White and 7% BAME
- Stockton Population 92% White and 8% BAME
- Hartlepool Population 96.5% White and 3.5% BAME

Indicators 1 and 9 – Representation across the organisation



Representative Workforce across all protected characteristics at all levels.

This information is obtained from the Trust's ESR system as at 31 March 2025. There has been an increase in the number of Global Majority staff employed by the Trust for 2025 - an increase of 1.73% to 16.06%. When compared to the North East's ethnicity data (2021 census) the Trust has higher representation within the overall workforce, however this is not reflected across all grades.

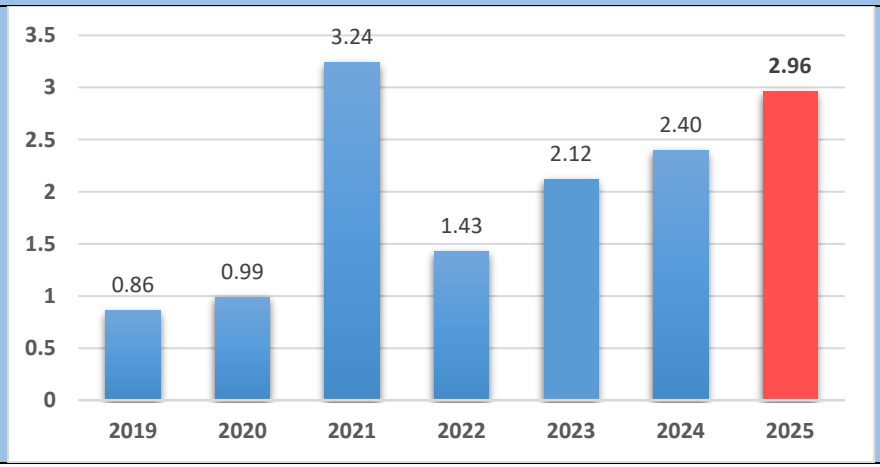
Consistent with previous years, there is higher representation within the medical staffing group and at Band 5 and 8d. There continues to be no representation at VSM level.

Representation of BME at Board and senior management levels.

For reporting purposes we are only able to report on Board members who are directly employed by North Tees and Hartlepool Foundation Trust (NTH)

Representation at Board level is under represented at 0%, as compared to the Trust's overall Global Majority workforce of 16.06%. We have seen a positive increase at Band 8d.

Indicator 2 – Likelihood of staff being appointed from shortlisting

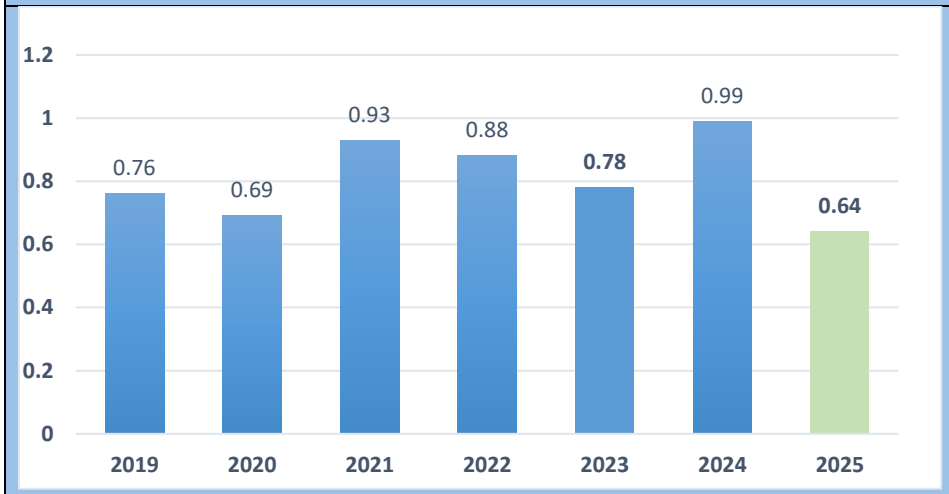


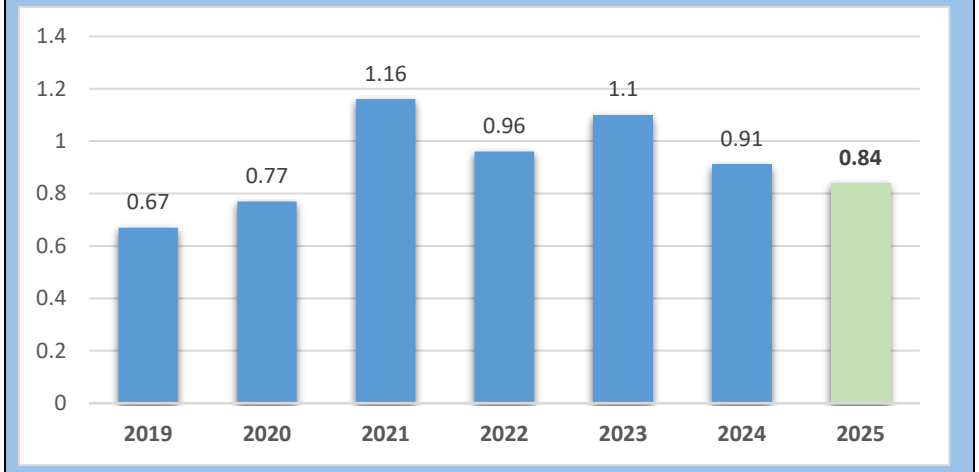
Equity of Experience.

This information is obtained from the Trust's Trac Recruitment System for the period 1 April 2024 to 31 March 2025 and considers a ratio showing the likelihood of being appointed following shortlisting. A figure of 1 indicates equal experience between White and Global Majority applicants.

The data shows Global Majority applicants are less likely to be appointed following shortlisting than white applicants and there has been a negative increase from the figure reported in 2024.

Work will focus on inclusive interview panels and support for internal applicants.

	(A figure above 1:00 indicates that White candidates are more likely than BME candidates to be appointed from shortlisting)
Indicator 3 – Likelihood of staff entering formal disciplinary process	
	**Equality of Experience.** This information is obtained from the Trust's Workforce databases and considers a ratio showing the likelihood of entering formal disciplinary processes. A total of 1 case is recorded, as compared to 8 cases involving staff from a White ethnicity. The Trust has consistently reported that Global Majority colleagues are less likely to enter formal disciplinary processes and the figure for this year has seen a decrease and is reported at 0.64. (A figure above 1:00 indicates that BME staff are more likely than White staff to enter the formal disciplinary process)
Indicator 4 – Likelihood of staff accessing non-mandatory training and continuous personal development	



Belief in Equal Opportunities.

This information is obtained from the Trust's ESR system for the period 1 April 2024 to 31 March 2025.

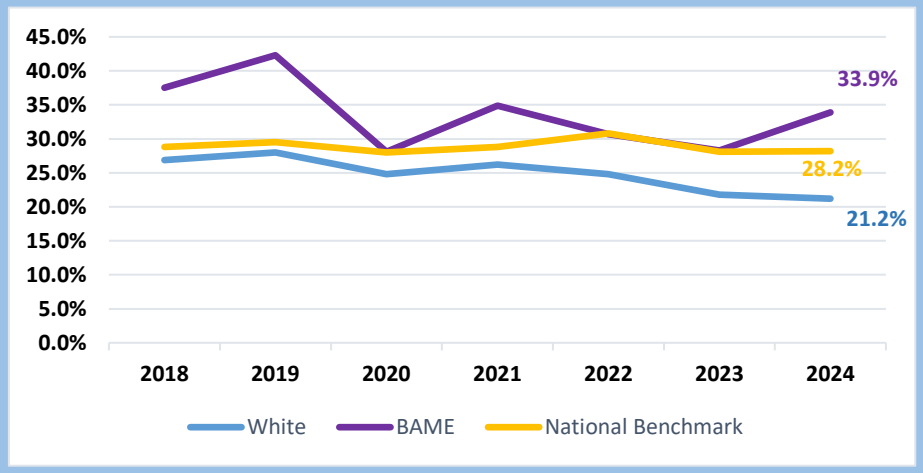
For this reporting cycle, Global Majority staff are more likely to access non-mandatory training and continuous personal development as compared to white Staff.

The ratio continues to remain below 1.0, and the overall differential remains low and does not indicate any real concern in this area.

It is positive to note that the % of Global Majority staff accessing training has increased from 73.61% in 2024, to 81.5% in 2025. The number of white staff accessing training has also increased from 67.3% in 2024, to 68.6% in 2025.

(A figure above 1:00 indicates that White staff are more likely than BME staff to access non-mandatory training and CPD)

Indicator 5 – Percentage of staff experiencing harassment, bullying/abuse from patients, relatives/public



Staff Survey Key Findings - B&H Public

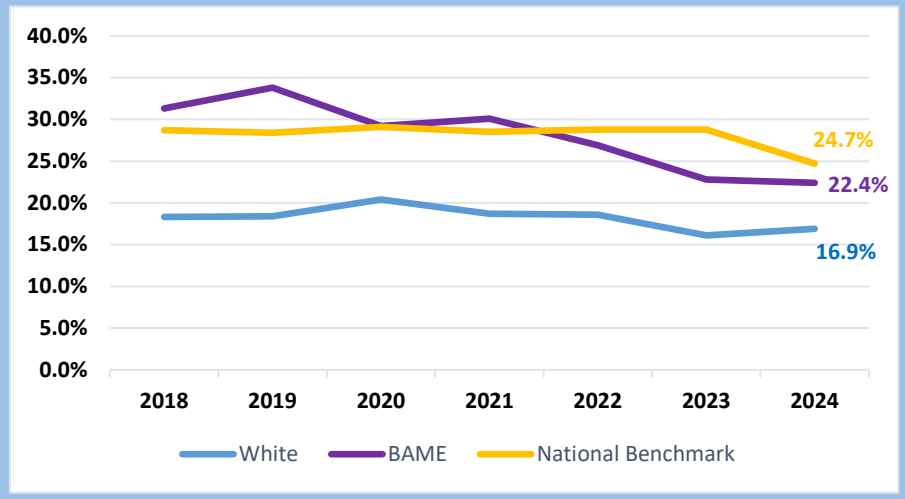
This information is derived from the 2024 staff survey.

Staff survey results show a negative increase in the number of Global Majority staff experiencing harassment, bullying and abuse from patients, relatives/public (33.9% as compared to 28.3% for 2023).

Global Majority staff continue to be more likely to experience harassment, bullying/abuse from patients than white staff and the gap is reported as 12.7%.

Staff are required to log all incidents of service user violence and harassment via Inphase and the information is reported through Yellowfin. The Trust's Keeping People Safe group reviews this information to identify trends and this includes analysis of related themes including race.

Indicator 6 – Percentage of staff experiencing harassment, bullying/abuse from staff



Staff Survey Key Findings - B&H Staff

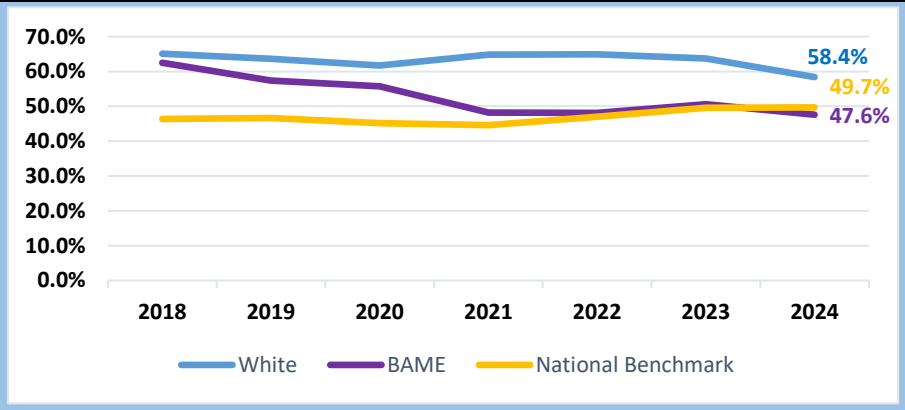
This information is derived from the 2024 staff survey.

Staff survey results show a slight positive reduction in the number of Global Majority staff experiencing harassment, bullying and abuse from staff (22.4 compared to 22.8% for 2023).

Global Majority staff continue to be more likely to experience harassment, bullying/abuse from colleagues than white staff and the gap is reported as 5.5%.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the People Services Team. .

Indicator 7 – Percentage of staff believing the Trust provides equal opportunities for career progression or promotion



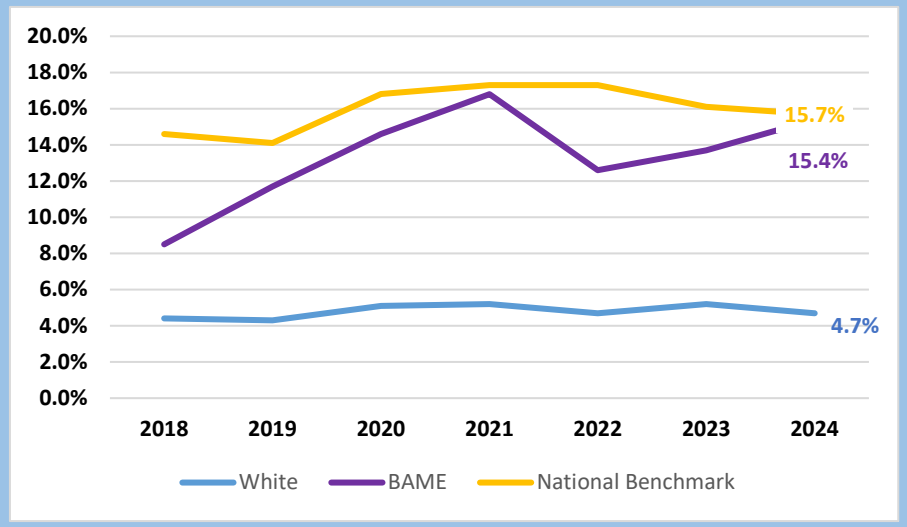
Staff Survey Key Findings - Equal Opportunities

This information is derived from the 2024 staff survey.

The results have decreased in terms of the % of Global Majority staff who believe the Trust provides equal opportunities for career progression/promotion (47.6% as compared to 50.6% in 2023).

White staff report a higher belief in equal opportunities than Global Majority. The gap in experience has narrowed and is currently reported as 10.8% when compared to 13.1% in 2023.

Indicator 8 – Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues



Staff Survey Key Findings - Discrimination.

This information is derived from the 2024 staff survey.

There has been an increase in the % of Global Majority staff who have reported experience of discrimination at work (15.4% as compared to 13.7% in 2023). There is a gap in experience, with Global Majority staff reporting a less positive experience when compared to white staff.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the People Services Team.

5. Conclusion and Next Steps

Our actions to improve the Trust's WDES metrics align with the Group People values specifically 'respect' and support our commitments to the NHS People Plan.

We are pleased to report some improvement in the metrics for 2025 and note that this is a reflection of our EDI programme of work and the investment we have made in terms of data analysis and focused interventions to improve staff experience across the range of protected characteristics.

We will continue to promote the activities and good practice that we already undertake, including: undertaking fair and transparent recruitment processes, delivery of civility and unconscious bias training and promotion of various leadership and development opportunities which exist across the Trust.

We take racial equality seriously and whilst we have already implemented a number of practices which will have a positive impact in this area, we understand that change will require a significant cultural shift within the organisation. We know that our workforce ethnicity profile will not change overnight, however we are starting to see a yearly increase in the number of Global Majority staff working in the Trust. It is also important that we continue to grow the membership of our staff network to help us facilitate the voices of our Global Majority colleagues and improve staff experience overall.

It is noted that this is a high level report based on the overall workforce metrics. The next stage in the reporting process will be to engage with our workforce to share the results and jointly develop the action plan to be included in the WRES annual report for October 2025.

6.0 Recommendation

People Group is requested to:

- Acknowledge the Trust's WRES Results (2025) as reported within section 4 of this paper.

- Note that the WRES annual report will be shared at a future meeting of the People Group/Committee, ahead of the mandatory publication date of 31 October 2025.

Appendix 1

North Tees & Hartlepool NHS Foundation Trust

NHS Workforce Race Equality Standard 2025

6. Introduction

The Workforce Race Equality Standard (WRES) programme was established in 2015. It requires organisations to report against nine indicators of race equality and supports continuous improvement through robust action planning to tackle the root causes of discrimination.

Inequalities in any form are at odds with our values. Research shows that the fair treatment of our staff is directly linked to better clinical outcomes and better experience of care for patients.

This report represents the tenth publication since the WRES was established. There are some positive findings in this report and there are also areas where further analysis of the information is required to fully understand the results, particularly in relation to staff survey feedback.

We are committed to tackling racial discrimination to bridge the gaps in experience, opportunity and differential attainment in our diverse workforce. A key tool to understanding and correcting these inequities is the presentation of detailed data to key work streams, which will allow us to identify the targets for action.

7. Trust Requirements

In order to meet the requirements for 2025, the Trust is required to publish our WRES data no later than 31 May 2025 to NHS England via the Data Collection Framework (DCF) portal.

Work will then commence to produce the Trust's annual WRES report which will be published on the Trust's internet site no later than 31 October 2025.

8. WRES Indicators 2025

A summary of the results for North Tees and Hartlepool NHS Foundation Trust is shown in the table below. This includes comparison of the Trust's results covering a five-year period (2021 to 2025).

The baseline data has been extracted from ESR, Workforce databases and the Trac recruitment system to calculate a response to each of the nine WRES indicators.

WRES Indicators 2025			2021	2022	2023	2024	2025
1	Percentage of BME staff	Overall	11.0%	11.4%	12.80%	14.33%	**16.06%**
		VSM	0.0%	0.0%	0.00%	0.00%	**0.00%**
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		3.24	1.43	2.12	2.40	**2.96**
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		0.93	0.88	0.78	0.99*	**0.64**
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		1.16	0.96	1.1	0.91	**0.84**
			2020	**2021**	**2022**	2023	**2024**
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME	28.1%	34.9%	30.7%	28.3%	**33.9%**
		White	24.8%	26.2%	24.8%	21.8%	**21.2%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	29.2%	30.1%	26.9%	22.8%	**22.4%**
		White	20.4%	18.7%	18.6%	16.1%	**16.9%**
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	BME	55.7%	48.2%	48.1%	50.6%	**47.6%**
		White	61.7%	64.8%	64.9%	63.7%	**58.4%**
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	14.6%	16.8%	12.6%	13.7%	**15.4%**
		White	5.1%	5.2%	4.7%	5.2%	**4.7%**
			2021	**2022**	**2023**	2024	**2025**
9	BME Board membership	BME	5.6%	7.1%	6.3%	0.0%	**0.0%**

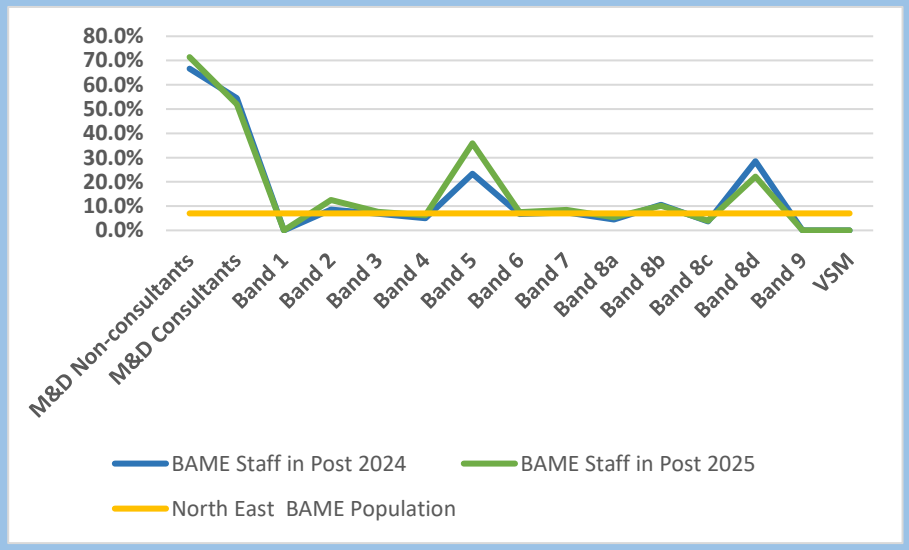
9. Key Findings for 2025

The key findings in respect of the nine WRES indicators for 2025 are summarised below.

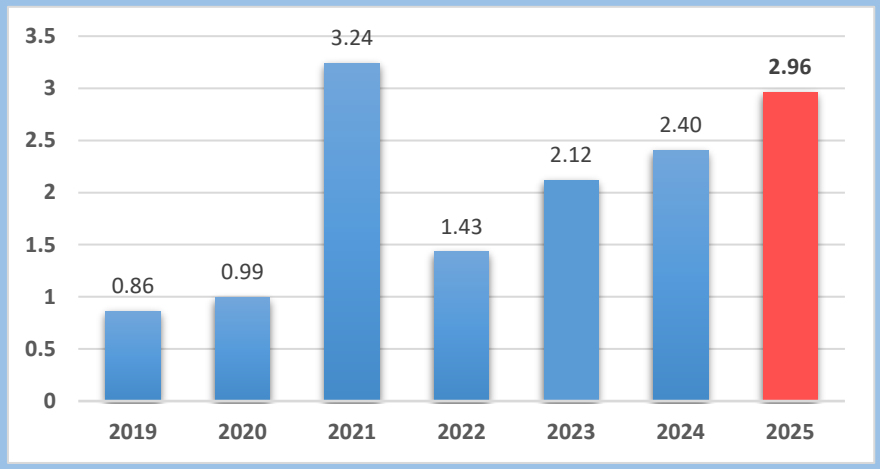
We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 5-8). Full benchmarking information is published by the national WRES team and this is expected for March 2026.

The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's ethnicity profile, which can also be broken down by Region and Local Authority Area.

- UK Population 81.7% White and 18.3% BAME
- North East Population 93% White and 7% BAME
- Stockton Population 92% White and 8% BAME
- Hartlepool Population 96.5% White and 3.5% BAME

Indicators 1 and 9 – Representation across the organisation	
	**Representative Workforce across all protected characteristics at all levels**. This information is obtained from the Trust's ESR system as at 31 March 2025. There has been an increase in the number of Global Majority staff employed by the Trust for 2025 - an increase of 1.73% to 16.06%. When compared to the North East's ethnicity data (2021 census) the Trust has higher representation within the overall workforce, however this is not reflected across all grades. Consistent with previous years, there is higher representation within the medical staffing group and at Band 5 and 8d. There continues to be no representation at VSM level. **Representation of BME at Board and senior management levels.** For reporting purposes we are only able to report on Board members who are directly employed by North Tees and Hartlepool Foundation Trust (NTH) Representation at Board level is under represented at 0%, as compared to the Trust's overall Global Majority workforce of 16.06%. We have seen a positive increase at Band 8d.

Indicator 2 – Likelihood of staff being appointed from shortlisting



Equity of Experience.

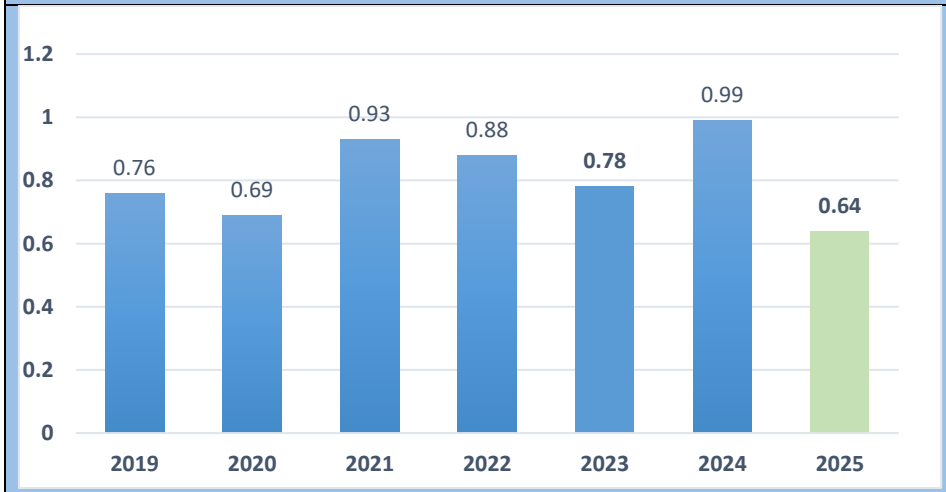
This information is obtained from the Trust's Trac Recruitment System for the period 1 April 2024 to 31 March 2025 and considers a ratio showing the likelihood of being appointed following shortlisting. A figure of 1 indicates equal experience between White and Global Majority applicants.

The data shows Global Majority applicants are less likely to be appointed following shortlisting than white applicants and there has been a negative increase from the figure reported in 2024.

Work will focus on inclusive interview panels and support for internal applicants.

(A figure above 1:00 indicates that White candidates are more likely than BME candidates to be appointed from shortlisting)

Indicator 3 – Likelihood of staff entering formal disciplinary process



Equality of Experience.

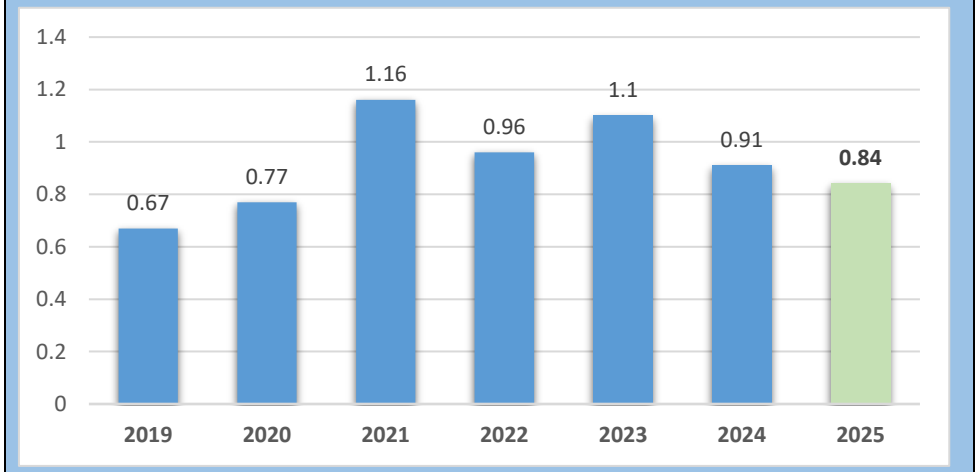
This information is obtained from the Trust's Workforce databases and considers a ratio showing the likelihood of entering formal disciplinary processes.

A total of 1 case is recorded, as compared to 8 cases involving staff from a White ethnicity.

The Trust has consistently reported that Global Majority colleagues are less likely to enter formal disciplinary processes and the figure for this year has seen a decrease and is reported at 0.64.

(A figure above 1:00 indicates that BME staff are more likely than White staff to enter the formal disciplinary process)

Indicator 4 – Likelihood of staff accessing non-mandatory training and continuous personal development



Belief in Equal Opportunities.

This information is obtained from the Trust's ESR system for the period 1 April 2024 to 31 March 2025.

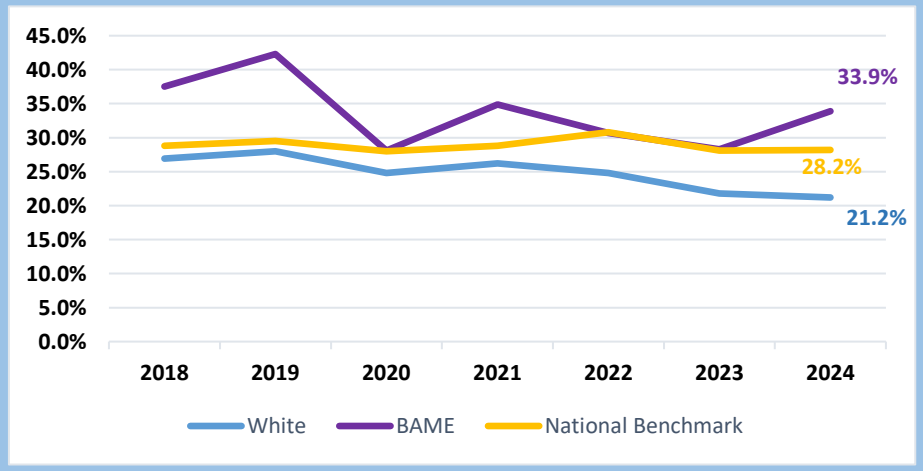
For this reporting cycle, Global Majority staff are more likely to access non-mandatory training and continuous personal development as compared to white Staff.

The ratio continues to remain below 1.0, and the overall differential remains low and does not indicate any real concern in this area.

It is positive to note that the % of Global Majority staff accessing training has increased from 73.61% in 2024, to 81.5% in 2025. The number of white staff accessing training has also increased from 67.3% in 2024, to 68.6% in 2025.

(A figure above 1:00 indicates that White staff are more likely than BME staff to access non-mandatory training and CPD)

Indicator 5 – Percentage of staff experiencing harassment, bullying/abuse from patients, relatives/public



Staff Survey Key Findings - B&H Public

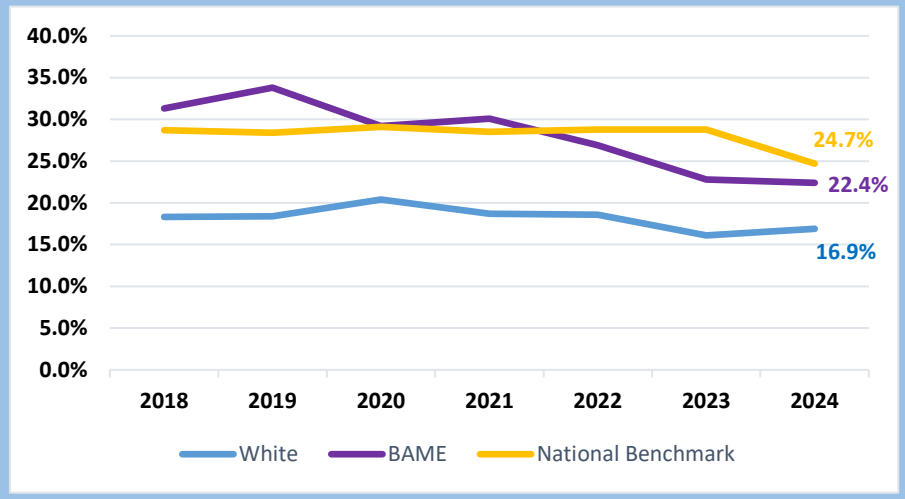
This information is derived from the 2024 staff survey.

Staff survey results show a negative increase in the number of Global Majority staff experiencing harassment, bullying and abuse from patients, relatives/public (33.9% as compared to 28.3% for 2023).

Global Majority staff continue to be more likely to experience harassment, bullying/abuse from patients than white staff and the gap is reported as 12.7%.

Staff are required to log all incidents of service user violence and harassment via Inphase and the information is reported through Yellowfin. The Trust's Keeping People Safe group reviews this information to identify trends and this includes analysis of related themes including race.

Indicator 6 – Percentage of staff experiencing harassment, bullying/abuse from staff



Staff Survey Key Findings - B&H Staff

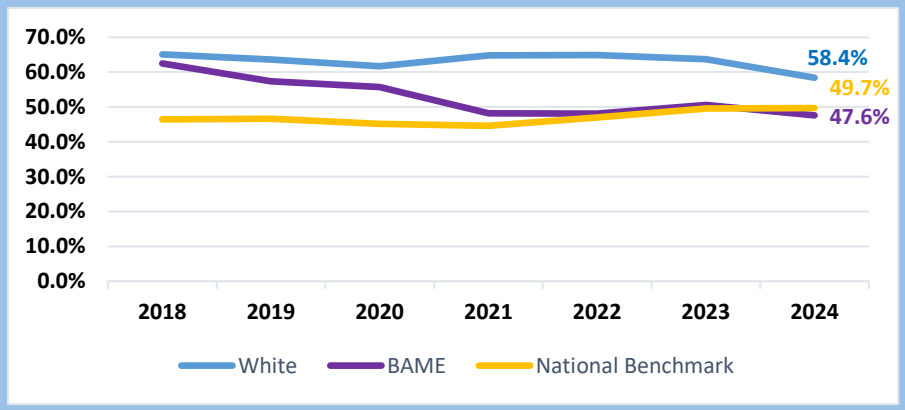
This information is derived from the 2024 staff survey.

Staff survey results show a slight positive reduction in the number of Global Majority staff experiencing harassment, bullying and abuse from staff (22.4 compared to 22.8% for 2023).

Global Majority staff continue to be more likely to experience harassment, bullying/abuse from colleagues than white staff and the gap is reported as 5.5%.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the People Services Team. .

Indicator 7 – Percentage of staff believing the Trust provides equal opportunities for career progression or promotion



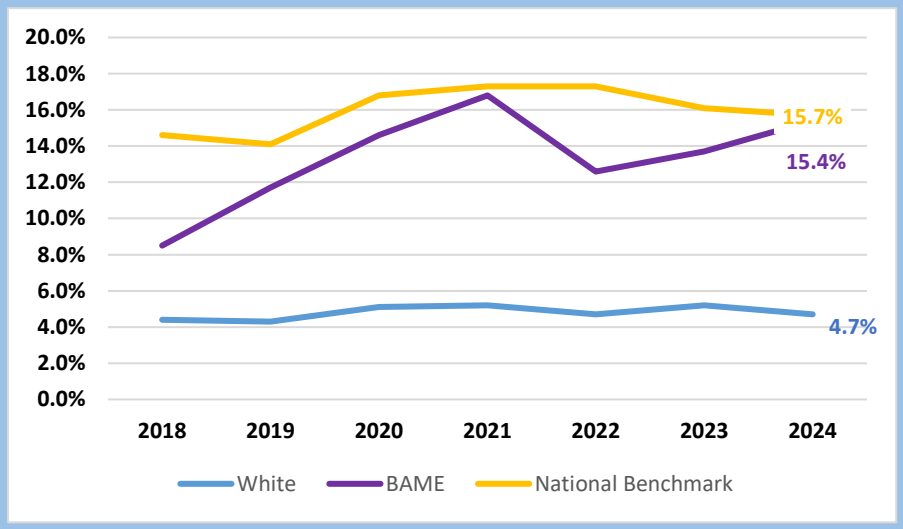
Staff Survey Key Findings - Equal Opportunities

This information is derived from the 2024 staff survey.

The results have decreased in terms of the % of Global Majority staff who believe the Trust provides equal opportunities for career progression/promotion (47.6% as compared to 50.6% in 2023).

White staff report a higher belief in equal opportunities than Global Majority. The gap in experience has narrowed and is currently reported as 10.8% when compared to 13.1% in 2023.

Indicator 8 – Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues



Staff Survey Key Findings - Discrimination.

This information is derived from the 2024 staff survey.

There has been an increase in the % of Global Majority staff who have reported experience of discrimination at work (15.4% as compared to 13.7% in 2023). There is a gap in experience, with Global Majority staff reporting a less positive experience when compared to white staff.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the People Services Team.

10. Conclusion and Next Steps

Our actions to improve the Trust's WDES metrics align with the Group People values specifically 'respect' and support our commitments to the NHS People Plan.

We are pleased to report some improvement in the metrics for 2025 and note that this is a reflection of our EDI programme of work and the investment we have made in terms of data analysis and focused interventions to improve staff experience across the range of protected characteristics.

We will continue to promote the activities and good practice that we already undertake, including: undertaking fair and transparent recruitment processes, delivery of civility and unconscious bias training and promotion of various leadership and development opportunities which exist across the Trust.

We take racial equality seriously and whilst we have already implemented a number of practices which will have a positive impact in this area, we understand that change will require a significant cultural shift within the organisation. We know that our workforce ethnicity profile will not change overnight, however we are starting to see a yearly increase in the number of Global Majority staff working in the Trust. It is also important that we continue to grow the membership of our staff network to help us facilitate the voices of our Global Majority colleagues and improve staff experience overall.

It is noted that this is a high level report based on the overall workforce metrics. The next stage in the reporting process will be to engage with our workforce to share the results and jointly develop the action plan to be included in the WRES annual report for October 2025.

Appendix 2

South Tees Hospitals NHS Foundation Trust

NHS Workforce Race Equality Standard 2025

11. Introduction

The Workforce Race Equality Standard (WRES) programme was established in 2015. It requires organisations to report against nine indicators of race equality and supports continuous improvement through robust action planning to tackle the root causes of discrimination.

Inequalities in any form are at odds with our values. Research shows that the fair treatment of our staff is directly linked to better clinical outcomes and better experience of care for patients.

This report represents the tenth publication since the WRES was established. There are positive findings in this report and there are also areas where further analysis of the information is required to fully understand the results.

We are committed to tackling racial discrimination to bridge the gaps in experience, opportunity and differential attainment in our diverse workforce. A key tool to understanding and correcting these inequities is the presentation of detailed data to key work streams, which will allow us to identify the targets for action.

12. Trust Requirements

This report is intended to provide the high level detail, to confirm the data collection deadline of 31 May 2025, which is where the WRES metrics are uploaded to NHS England via the Data Collection Framework (DCF) portal.

Work will then commence to produce the Trust's annual WRES report, which will be published on the Trust's internet site no later than 31 October 2025

13. WRES Indicators 2025

A summary of the results for South Tees Hospitals NHS Foundation Trust is shown in the table below. This includes comparison of the Trust's results covering a five-year period (2021 to 2025).

The baseline data has been extracted from ESR, Workforce databases and the Trac recruitment system to calculate a response to each of the nine WRES indicators.

WRES Indicators 2025			2021	2022	2023	2024	2025
1	Percentage of BME staff	Overall	9.6%	10.0%	11.44%	12.83%	**13.88%**
		VSM				14.30%	**0.00%**
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		2.6	1.6	1.52	1.86	**2.62**
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.8	1.27	0.8	0.78	**1.37**
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		1.09	0.98	1.08	0.99	**1.00***
			2020	**2021**	**2022**	2023	**2024**
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME	23.8%	26.7%	28.8%	23.0%	**24.4%**
		White	24.1%	23.9%	24.8%	22.0%	**21.9%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	27.7%	28.6%	32.9%	30.1%	**28.3%**
		White	23.5%	21.5%	22.2%	20.6%	**24.3%**
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	BME	38.6%	48.2%	43.3%	43.5%	**49.6%**
		White	53.1%	58.2%	58.4%	58.7%	**57.8%**
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	19.7%	19.9%	20.4%	20.0%	**19.7%**
		White	5.1%	5.8%	5.8%	6.2%	**7.1%**
			2021	**2022**	**2023**	2024	**2025**
9	BME Board membership	BME	-1.1%	-9.6%	-10.0%	-13.0%	**-3.0%**

*Remains postive as 1.00 would indicate equal experience of both White and BME Staff

14. Key Findings for 2025

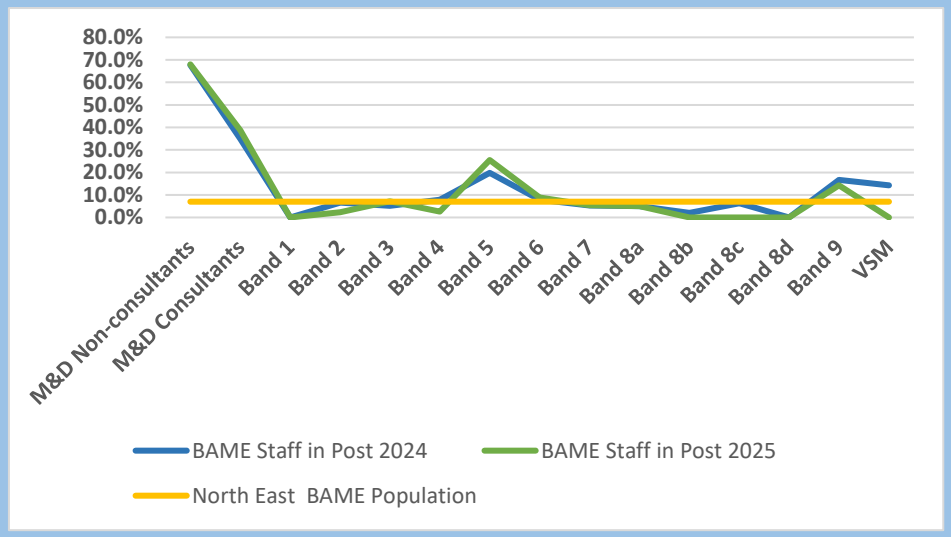
The key findings in respect of the nine WRES indicators for 2025 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 5-8). Full benchmarking information is published by the national WRES team and this is expected for March 2026.

The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's ethnicity profile, which can also be broken down by Region and Local Authority Area.

- UK Population 81.7% White and 18.3% BAME
- North East Population 93% White and 7% BAME
- Middlesbrough 82.4% White and 17.6% BAME
- Redcar and Cleveland 97.7% White and 2.3% BAME
- Hambleton 97.9% White and 2.1% BAME

Indicators 1 and 9 – Representation across the organisation



Representative Workforce across all protected characteristics at all levels.

This information is obtained from the Trust's ESR system as at 31 March 2025. There has been an increase in the number of Global Majority staff employed by the Trust for 2025 - an increase of 1.05% to 13.88%. When compared to the North East's ethnicity data (2021 census) the Trust has higher representation within the overall workforce, however this is not reflected across all grades.

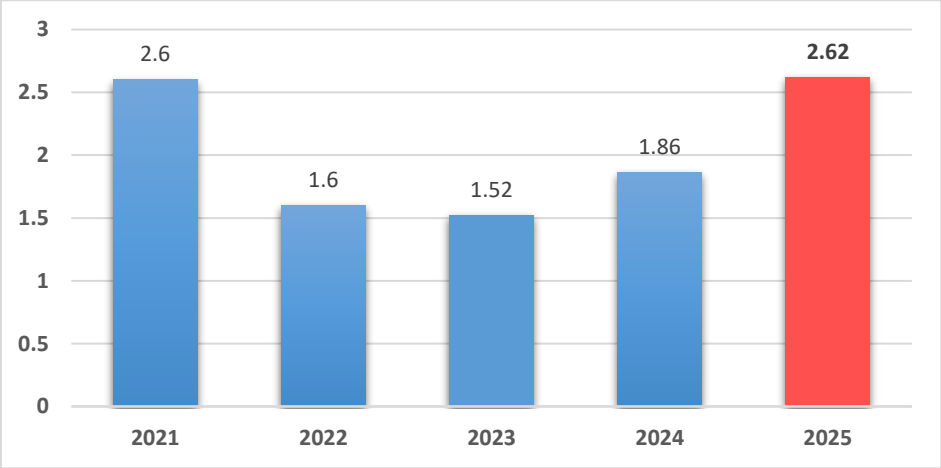
Consistent with previous years, there is higher representation within the medical staffing group and at Band 5. Bands 8a has remained static when compared to the previous year. There is no representation at bands 8b - 8d and VSM level.

Representation of BME at Board and senior management levels.

For reporting purposes we are only able to report on Board members who are directly employed by South Tees Hospitals NHS Foundation Trust.

Representation at Board level is under represented at -3%, as compared to the Trust's overall ethnic minority workforce of 13.88%. Band 9 is reported at 14.3%

Indicator 2 – Likelihood of staff being appointed from shortlisting



Equity of Experience.

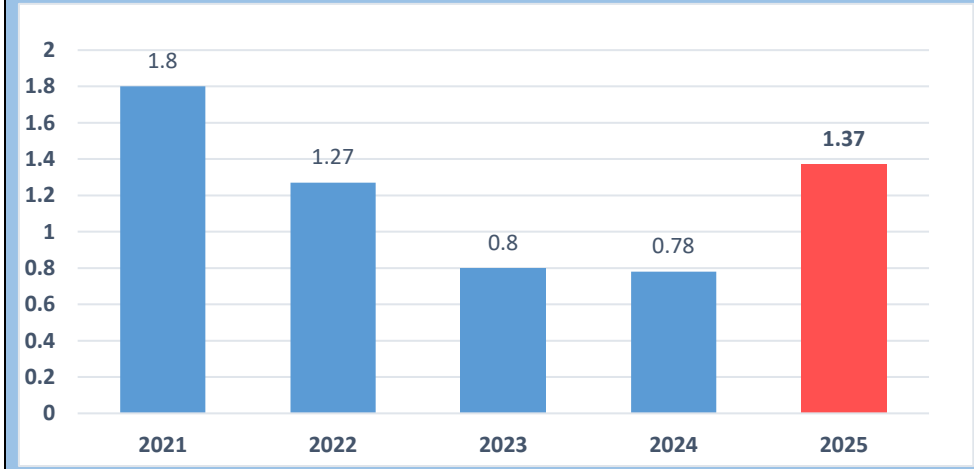
This information is obtained from the Trust's Trac Recruitment System for the period 1 April 2024 to 31 March 2025 and considers a ratio showing the likelihood of being appointed following shortlisting.

Global Majority applicants are less likely to be appointed following shortlisting than White applicants and there has been a negative increase from the figure reported in 2024.

Group work will focus on inclusive interview panels and support for internal applicants.

(A figure above 1:00 indicates that White candidates are more likely than BME candidates to be appointed from shortlisting)

Indicator 3 – Likelihood of staff entering formal disciplinary process



Equality of Experience.

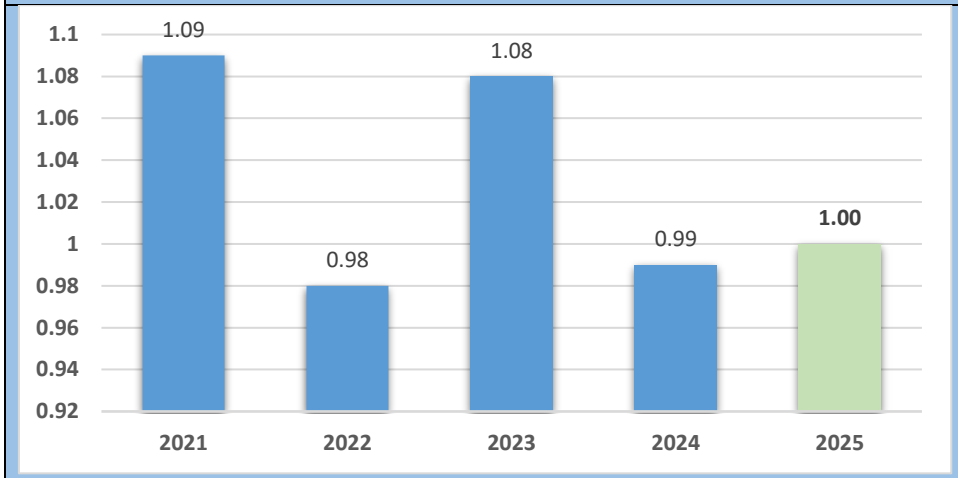
This information is obtained from the Trust's Workforce databases and considers a ratio showing the likelihood of entering formal disciplinary processes.

The information for this metric showed a total of 7 cases recorded, as compared to 32 cases involving staff from a White ethnicity and 2 cases where ethnicity is recorded as unknown.

The Trust has reported that Global Majority colleagues are more likely to enter formal disciplinary processes and this figure has increased for 2025.

(A figure above 1:00 indicates that BME staff are more likely than White staff to enter the formal disciplinary process)

Indicator 4 – Likelihood of staff accessing non-mandatory training and continuous personal development



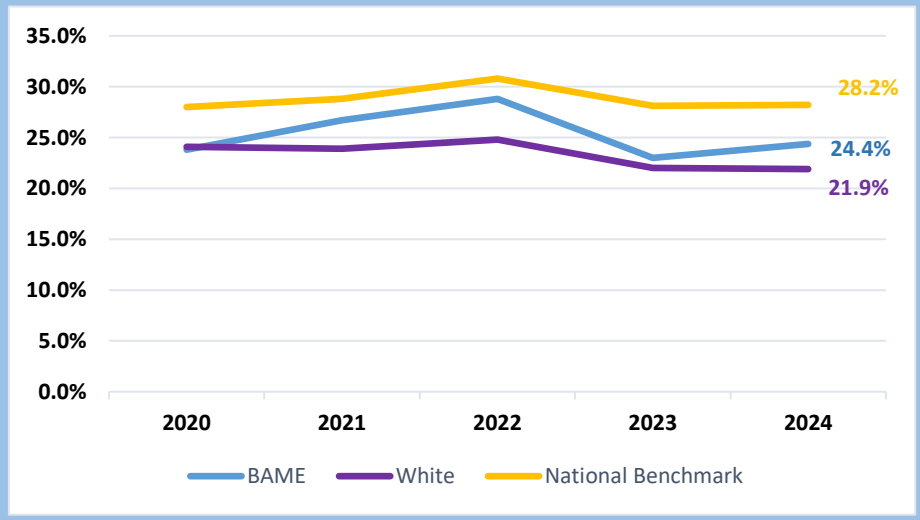
Belief in Equal Opportunities.

This information is obtained from the Trust's ESR system for the period 1 April 2024 to 31 March 2025.

For this reporting cycle, the figure of 1 remains positive as this indicates equal experience of both White and Global Majority staff and does not raise any concern.

(A figure above 1:00 indicates that White staff are more likely than BME staff to access non-mandatory training and CPD)

Indicator 5 – Percentage of staff experiencing harassment, bullying/abuse from patients, relatives/public



Staff Survey Key Findings - B&H Public

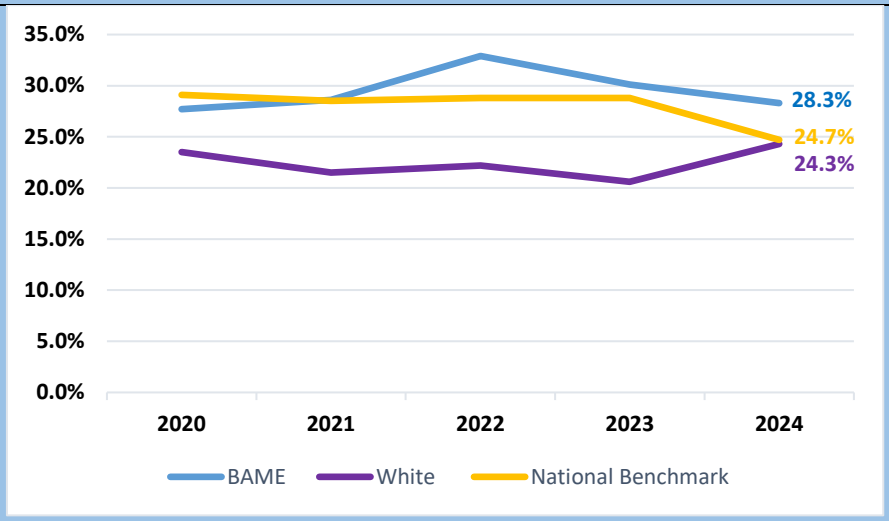
This information is derived from the 2024 staff survey.

Staff survey results show a negative increase in the number of Global Majority staff experiencing harassment, bullying and abuse from patients, relatives/public (24.4% as compared to 23.0% for 2023).

Global Majority staff continue to be more likely to experience harassment, bullying/abuse from patients than White staff and the gap is reported as 2.5%.

Staff are required to log all incidents of service user violence and harassment via Datix.

Indicator 6 – Percentage of staff experiencing harassment, bullying/abuse from staff



Staff Survey Key Findings - B&H Staff

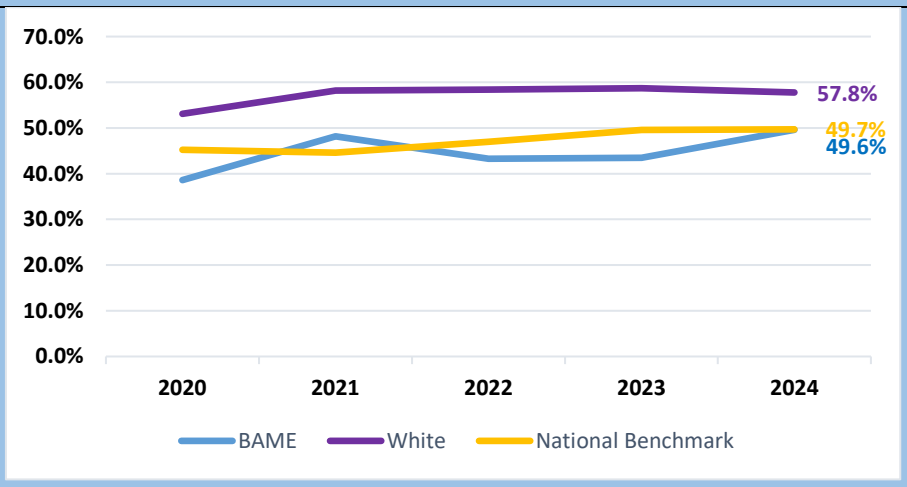
This information is derived from the 2024 staff survey.

Staff survey results show a positive decrease in the number of Global Majority staff experiencing harassment, bullying and abuse from staff (28.3% compared to 30.1% for 2023).

Global Majority staff continue to be more likely to experience harassment, bullying/abuse from colleagues than White staff and the gap is reported as 4%.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the People Services Team.

Indicator 7 – Percentage of staff believing the Trust provides equal opportunities for career progression or promotion



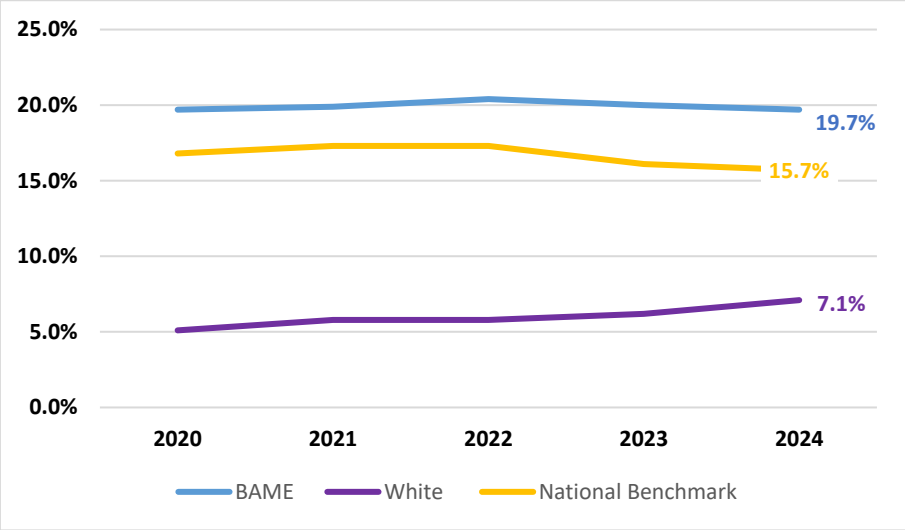
Staff Survey Key Findings - Equal Opportunities

This information is derived from the 2024 staff survey.

The results have shown a positive increase in terms of the % of Global Majority staff who believe the Trust provides equal opportunities for career progression/promotion (49.6% as compared to 43.5% in 2023).

As in previous years, White staff continue to report a higher belief in equal opportunities than Global Majority staff. The gap in experience has narrowed and is currently reported as 8.2% when compared to 15.2% in 2023

Indicator 8 – Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues



Staff Survey Key Findings - Discrimination.

This information is derived from the 2024 staff survey.

There has been a positive decrease in the % of Global Majority staff who have reported experience of discrimination at work (19.7% as compared to 20.0% in 2023). There is a continued gap in experience, with Global Majority staff reporting a poorer experience when compared to White staff

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the People Services Team.

15. Conclusion and Next Steps

Our actions to improve the Trust's WRES metrics align with the Group People values specifically 'respect' and support our commitments to the NHS People Plan.

We are pleased to report some improvement in the metrics for 2025 and note that this is a reflection of our EDI programme of work and the investment we have made in terms of data analysis and focused interventions to improve staff experience across the range of protected characteristics.

We will continue to promote the activities and good practice that we already undertake, including: undertaking fair and transparent recruitment processes, delivery of civility and unconscious bias training and promotion of various leadership and development opportunities which exist across the Trust.

We take racial equality seriously and whilst we have already implemented a number of practices which will have a positive impact in this area, we understand that change will require a significant cultural shift within the organisation. We know that our workforce ethnicity profile will not change overnight, however we are starting to see a yearly increase in the number of Global Majority staff working in the Trust. It is also important that we continue to grow the membership of our staff network to help us facilitate the voices of our Global Majority colleagues and improve staff experience overall.

It is noted that this is a high level report based on the overall workforce metrics. The next stage in the reporting process will be to engage with our workforce to share the results and jointly develop the action plan to be included in the WRES annual report for October 2025.

University Hospitals Tees

NHS Workforce Disability Equality Standard (WDES) 2025

Meeting date: 4 September 2025

Reporting to: Board of Directors

Agenda item No: 3.4

Report author: Nicola Hogarth, Culture and Inclusion Assurance Partner; Jennie Winnard Group Deputy Director Organisational Development and Culture

Executive director sponsor: Rachael Metcalf, Chief People Officer

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: People Committee

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☒

Using our resources well ☐

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

A culture that doesn't promote positivity, respect, inclusion and a focus on belonging, recognising, and rewarding achievements.

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.

The committee is advised of summary relating to the Workforce Disability standard for UHT.

The committee is advised to note that the local population for both NHS Trusts has a higher percentage of disabled population in all areas except Hambleton and Richmond.

Due to the reporting nature of this data, the report is presented for each unitary body.

North Tees NHS Foundation Trust, there has been a negative increase in the number of disabled staff who:

- Experience harassment, bullying/abuse from their manager;
- Feel pressure to attend work when not feeling well enough to do so.

- There has been a negative decrease in the number of disabled staff who:
  - Believe the Trust provides Equal Opportunities for career progression;
  - Feel valued;
  - Have reasonable adjustments in place to enable them to carry out their work.

- The disabled staff engagement score is reported at 6.5 in the 2024 Staff Survey results. This has shown a slight decrease of 0.1 when compared to 6.6 in 2023.

South Tees NHS Foundation Trust, Shortlisted disabled applicants are less likely to be appointed following shortlisting than non-disabled applicants

- The Trust report an increase in capability cases involving staff with a disability or long term health condition in the last 12 months.
- There has been a negative increase in the number of disabled staff who:
  - Experience harassment, bullying/abuse from patients, relatives or the public;
  - Experience harassment, bullying/abuse from their manager;
  - Experience harassment, bullying/abuse from other colleagues.
  - Feel pressure to attend work when not feeling well enough to do so.
- There has been a negative decrease in the number of disabled staff who:
  - Believe the Trust provides Equal Opportunities for career progression;
- The disabled staff engagement score is reported at 6.4 in the 2024 Staff Survey results. This has shown a decrease of 0.5 when compared to 6.9 in 2023.

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 North Tees and Hartlepool NHS Foundation Trust, the Trust continue to report there have been no formal capability cases involving staff with a disability or long term health condition in the last 12 months.

- There has been a positive reduction in the number of disabled staff who:
    - Experience harassment, bullying/abuse from patients, relatives or the public;
    - Experience harassment, bullying/abuse from other colleagues.
- There has been a positive increase in the number of disabled staff who:
    - Are likely to report harassment, bullying or abuse at work.
- For South Tees NHS Foundation Trust, there has been a positive increase in the number of disabled staff who:
    - Are likely to report harassment, bullying or abuse at work.
    - Feel valued;
    - Have reasonable adjustments in place to enable them to carry out their work.

Recommendations:

The committee is respectfully requested to accept the details within this paper relating to Workforce Disability Equality Standard (WDES) 2025 across **University Hospitals Tees.** Group People Committee is asked to receive the content of the report and acknowledge the Workforce Disability Equality Standard results for both Trusts reported in Section 2 and the key points and recommendations outlined within Section 5.

Key areas of focus will be within the areas where negative increase has been seen.

University Hospitals Tees

NHS Workforce Disability Equality Standard (WDES) 2025

1. Introduction

As set out in the NHS Long Term Plan, respect, equality and diversity are central to changing culture and are at the heart of the NHS workforce implementation plan.

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for people with a disability working, or seeking employment, in the NHS.

This report presents a group update in relation to the Workforce Disability Equality Standard (WDES) 2025.

2. WDES Indicators

A summary of the results for North Tees and Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust is shown in the tables below and includes comparison of the Trust's results covering a five-year period (2021 to 2025).

A copy of the WDES Reports 2025 for each Trust is contained at Appendix 1 and Appendix 2 for information purposes.

North Tees and Hartlepool - WDES Indicators 2025			2021	2022	2023	2024	2025
1	Percentage of staff with a disability or long term health condition	Overall	2.0%	3.0%	4.0%	4.9%	6.3%
		Non-Clinical	2.0%	3.0%	4.0%	5.2%	6.3%
		Clinical	2.0%	3.0%	3.0%	4.8%	6.5%
2	The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff		0.94	0.98	1.25	0.90	0.98*
3	The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff		0	0	0	0	0
			2020	2021	2022	2023	2024
4a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Staff with a disability or LTC	29.6%	28.6%	30.7%	28.1%	26.0%
		Staff without	24.1%	26.3%	23.5%	20.1%	21.1%
4b	Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months	Staff with a disability or LTC	18.3%	14.2%	12.5%	10.5%	12.2%
		Staff without	7.5%	7.6%	6.3%	5.1%	4.9%
4c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Staff with a disability or LTC	23.4%	19.9%	23.2%	21.1%	19.6%
		Staff without	13.8%	13.3%	12.7%	11.9%	12.0%
4d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Staff with a disability or LTC	54.3%	46.2%	53.2%	50.3%	50.8%
		Staff without	47.3%	47.3%	48.1%	49.3%	50.2%
5	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Staff with a disability or LTC	54.5%	57.6%	57.3%	55.6%	53.3%
		Staff without	62.6%	65.5%	65.3%	64.8%	58.7%
6	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Staff with a disability or LTC	39.0%	27.8%	26.9%	26.7%	26.8%
		Staff without	24.9%	21.0%	18.0%	15.8%	14.3%
7	Percentage of staff satisfied with the extent to which their organisation values their work	Staff with a disability or LTC	36.9%	37.4%	34.6%	36.3%	35.5%
		Staff without	53.3%	47.6%	48.4%	50.8%	48.8%
8	Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	Staff with a disability or LTC	74.2%	74.1%	72.9%	75.4%	74.3%
9	Staff Engagement Score (0-10)	Staff with a disability or LTC	6.7	6.6	6.6	6.6	6.5
		Staff without	7.3	7.1	7.2	7.1	7.1
		Overall	7.1	6.9	7.0	6.9	6.9
			2021	2022	2023	2024	2025
10	Disabled/LTC Board Membership		0.0%	7.1%	0.0%	3.0%	0.0%

*Remains positive as 1.00 would indicate equal experience of both Non-Disabled and Disabled staff

South Tees - WDES Indicators 2025			2021	2022	2023	2024	2025
1	Percentage of staff with a disability or long term health condition	Overall	2.6%	3.5%	4.6%	4.9%	6.3%
2	The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff		0.82	1.58	1.31	1.30	1.76
3	The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff		2.48	0	0	0	8.4
			2020	2021	2022	2023	2024
4a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Staff with a disability or LTC	28.4%	27.1%	28.9%	26.3%	28.2%
		Staff without	22.8%	23.2%	23.7%	20.5%	19.6%
4b	Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months	Staff with a disability or LTC	17.0%	14.4%	13.9%	10.4%	13.9%
		Staff without	10.8%	8.7%	7.8%	8.6%	9.6%
4c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Staff with a disability or LTC	28.2%	24.5%	25.2%	23.0%	27.7%
		Staff without	16.0%	15.2%	17.1%	16.0%	16.9%
4d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Staff with a disability or LTC	49.6%	50.4%	49.4%	49.2%	52.6%
		Staff without	41.6%	42.3%	45.5%	48.1%	42.2%
5	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Staff with a disability or LTC	44.2%	53.5%	51.5%	53.2%	53.1%
		Staff without	53.9%	58.4%	59.0%	58.6%	58.4%
6	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Staff with a disability or LTC	30.5%	29.9%	26.8%	25.0%	27.7%
		Staff without	23.1%	22.8%	19.1%	19.7%	19.4%
7	Percentage of staff satisfied with the extent to which their organisation values their work	Staff with a disability or LTC	29.2%	32.7%	34.2%	33.4%	34.1%
		Staff without	41.8%	40.7%	39.8%	43.4%	42.8%
8	Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	Staff with a disability or LTC	77.3%	75.6%	69.6%	72.4%	72.6%
9	Staff Engagement Score (0-10)	Staff with a disability or LTC	6.4	6.6	6.5	6.9	6.4
		Staff without	6.9	7	6.9	7	6.9
		Overall	6.8	6.9	6.8	6.9	6.7
			2021	2022	2023	2024	2025
10	Disabled/LTC Board Membership		-2.6%	-3.3%	-4.3%	-3.0%	5.0%

3. WDES Update - North Tees and Hartlepool

A review of the WDES data for 2025 has highlighted the following points of interest:

- There has been a further increase in the number of staff who have reported their disability status on ESR reflecting an increase from 4.9% to 6.3% in 2025.

- For reporting purposes we are only able to report on Board members who are directly employed by North Tees and Hartlepool NHS Foundation Trust. Disability at Board level is under represented at 0%

- Shortlisted disabled applicants are more likely to be appointed following shortlisting than non-disabled applicants.

- The Trust continue to report there have been no formal capability cases involving staff with a disability or long term health condition in the last 12 months.

- There has been a positive reduction in the number of disabled staff who:

    - Experience harassment, bullying/abuse from patients, relatives or the public;
    - Experience harassment, bullying/abuse from other colleagues.

- There has been a positive increase in the number of disabled staff who:
    - Are likely to report harassment, bullying or abuse at work.

The below will be key areas of focus:

- There has been a negative increase in the number of disabled staff who:

- Experience harassment, bullying/abuse from their manager;
- Feel pressure to attend work when not feeling well enough to do so.

- There has been a negative decrease in the number of disabled staff who:
  - Believe the Trust provides Equal Opportunities for career progression;
  - Feel valued;
  - Have reasonable adjustments in place to enable them to carry out their work.

- The disabled staff engagement score is reported at 6.5 in the 2024 Staff Survey results. This has shown a slight decrease of 0.1 when compared to 6.6 in 2023.

4. WDES Update - South Tees

A review of the WDES data for 2025 has highlighted the following points of interest:

- There has been a further increase in the number of staff who have reported their disability status on ESR reflecting an increase from 4.9% to 6.3% in 2025.

- For reporting purposes we are only able to report on Board members who are directly employed by South Tees Hospitals NHS Foundation Trust. Disability at Board level has increased and is represented at 5%, which is a positive increase from previous years.

- There has been a positive increase in the number of disabled staff who:
  - Are likely to report harassment, bullying or abuse at work.
  - Feel valued;
  - Have reasonable adjustments in place to enable them to carry out their work.

The below will be key areas of focus:

- Shortlisted disabled applicants are less likely to be appointed following shortlisting than non-disabled applicants

- The Trust report an increase in capability cases involving staff with a disability or long term health condition in the last 12 months.

- There has been a negative increase in the number of disabled staff who:

  - Experience harassment, bullying/abuse from patients, relatives or the public;
  - Experience harassment, bullying/abuse from their manager;
  - Experience harassment, bullying/abuse from other colleagues.
  - Feel pressure to attend work when not feeling well enough to do so.

- There has been a negative decrease in the number of disabled staff who:
  - Believe the Trust provides Equal Opportunities for career progression;

- The disabled staff engagement score is reported at 6.4 in the 2024 Staff Survey results. This has shown a decrease of 0.5 when compared to 6.9 in 2023.

5. WDES Group Update

1. Key Findings for 2025 – Population Statistics South Tees NHS Foundation Trust

The key findings in respect of the ten WDES indicators for 2025 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 4-9). Full benchmarking information is published by the national WDES team and this is expected for March 2026. The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's disability profile, which can also be broken down by Region and Local Authority Area.

- UK Population 17.8% Disabled and 82.2% Non-Disabled
- North East Population 21.2% Disabled and 78.8% Non-Disabled
- Middlesbrough Population 21.9 % Disabled and 78.1% Non-Disabled
- Redcar and Cleveland Population 21.4% Disabled and 78.6% Non-Disabled
- Hambleton Population 15.4% Disabled and 84.6% Non-Disabled
-

North Tees and Hartlepool NHS Foundation Trust

The key findings in respect of the ten WDES indicators for 2025 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 4-9). Full benchmarking information is published by the national WDES team and this is expected for March 2026. The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's disability profile, which can also be broken down by Region and Local Authority Area.

- UK Population 17.8% Disabled and 82.2% Non-Disabled
- North East Population 21.2% Disabled and 78.8% Non-Disabled
- Stockton Population 20.2% Disabled and 79.8% Non-Disabled
- Hartlepool Population 22.9% Disabled and 77.1% Non-Disabled

2. A review of both Trusts data has highlighted the following key points:

Indicator 1 – Representation.

It is positive to report that both Trusts have seen an increase in employed staff with disabilities or long-term health conditions (LTC), which is reported at 6.3% for both Trusts in 2025.

However, this still remains an area of priority when compared to the North East's disability data (2021 census), which is reported at 21%, therefore significantly lower than the regional population. Also, when compared against the disabilities profile for the local areas, including Stockton, Hartlepool, Redcar and Cleveland, Hambleton and Middlesbrough, both Trusts report less workforce representation in comparison to our local communities disabilities population. It is recommended that a collaborative review is undertaken in relation to local advertising and the reporting and recording of disabilities on the electronic staff record (ESR).

It is encouraging that disability declaration rates continue to increase within both Trusts. We will continue to campaign and promote the ESR self-service and recommend we work on producing a group 'how to' guide that can be included in induction packs and made available on the intranet, as well as strong internal communication activities and focus group workshops

to promote the benefits of declaration and how this data can be used to facilitate the best support for staff.

Indicator 2 – Likelihood of staff being appointed from shortlisting.

Analysis of South Tees recruitment data shows that applicants with a disability appear to be less likely to be appointed from shortlisting, with a reported ratio of 1:76, North Tees and Hartlepool report an increased likelihood of staff with a disability being appointed from shortlisting, with a reported ratio of 0.98.

Both Trusts are a 'positive about people with a disability' employer, which means any applicant who indicates that they have a disability as part of their application and meets the essential criteria of the post being recruited to, will be guaranteed an interview.

We will review actions and best practice in relation to this indicator including feedback from staff networks. South Tees are in the process of applying for Disability Confident Leader Level 3 status. North Tees and Hartlepool were awarded Disability Confident Level 3 status in March 2023 in recognition of the work undertaken to ensure that people with a disability have opportunities to fulfil their potential and realise their aspirations.

Indicator 3 – Likelihood of staff entering formal capability process

North Tees and Hartlepool have consistently reported that there does not appear to be a disproportionate number of staff with a disability entering formal capability processes.

South Tees have seen an increase in capability cases involving staff with a disability or long term health condition in the last 12 months, this is currently reported at 8.4 for 2025.

The group are in the process of developing Restorative facilitators to promote and support a culture of transparency amongst the workforce. We will continue to review and compare against regional benchmarks as well as responses from previous years.

Indicator 4a to 4c – Percentage of staff experiencing harassment, bullying/abuse from patients, relatives/public, managers and colleagues.

North Tees and Hartlepool have seen an overall positive reduction in the percentage of staff with a disability experiencing harassment, bullying/abuse across: patients and colleagues as follows:

- Patients – 26.0% (compared to 28.1% for 2023)
- Colleagues –19.6% (compared to 21.1% for 2023)

The percentage of staff with a disability experiencing harassment, bullying/abuse from manager has increased as follows:

- Managers – 12.2% (compared to 10.5% in 2023)

South Tees have seen a negative increase in the percentage of staff with a disability experiencing harassment, bullying/abuse across all three areas: patients, colleagues and managers as follows:

- Patients – 28.2% (compared to 26.3% for 2023)
- Managers – 13.9% (compared to 10.4% in 2023)

- Colleagues –27.7% (compared to 23.0% for 2023)

Further analysis of this key finding will be undertaken to identify hotspots, and development of department specific action plans to address any areas of concern.

We will continue to seek feedback from those staff who have been directly involved in cases of bullying and harassment to understand how they felt during the process. Case reviews are regularly undertaken to identify areas of good practice to ensure wider learning is shared across the group. We will also continue to raise awareness of staff to the effects of workplace bullying, including the actions that staff can take and where they may obtain further support as well as sign posting routes for reporting behaviours.

We will aim to ensure that the experiences of staff with a disability improve, including signposting to specific avenues such as Freedom to Speak Up. Similarly, we will work closely with our services to understand any hot spot areas where more targeted or specific support may be required.

Indicator 4d - Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Both Trusts have seen an overall positive increase in the percentage of staff saying that the last time they experienced harassment, bullying or abuse at work they reported it. South Tees' results have shown an increase of 3.5% (52.6% compared to 49.2% for 2023) and report above the national average of 51.8%

North Tees and Hartlepool have seen a slight increase of 0.05% (50.8% compared to 50.3% for 2023).

We will be looking to build on the progress which has been achieved so far and aim to enhance our data reported, we are currently developing a group Health Inequalities Dashboard. This will include as many protected characteristics as possible, to allow for more targeted consideration and identification of staff complaints linked to protected characteristics (i.e. ethnicity, disability, sexual orientation, etc.)

Indicator 5 – Percentage of staff believing the Trust provides equal opportunities.

The results for North Tees and Hartlepool have decreased in terms of the percentage of both staff with/ without a disability who believe the organisation provides equal opportunities for career progression or promotion. The figures for staff with a disability are reported as 53.3% compared to 55.6% for 2023.

The results for South Tees show a slight decrease of colleagues with a disability who believe the organisation provides equal opportunities for career progression or promotion, and also colleagues without a disability which has also shown a slight decrease. Staff with a disability are reported as 53.1% compared to 53.2% for 2023.

It is positive to note that both Trusts report above the national average of 51.3%.

We will continue to review this as a group with recommendations to explore perceived barriers to equal opportunities and career progression via the Ability/Disability Staff Networks and Leads and undertake development of additional actions to address any areas of concern.

Indicator 6 – Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Both Trusts have shown an increase in the number of staff with a disability who have felt pressure from their manager to come to work whilst unwell.

Staff with a disability/LTC continue to be more likely to report pressure to attend work whilst unwell than staff without a disability.

We will review processes surrounding the health and wellbeing conversation between managers and colleagues. Both Trusts continue to deliver training to line managers which includes advice surrounding reasonable adjustments and raising awareness of how an individual's disability can impact upon their performance. However we will review the management training and resources, to ensure managers understand the importance of supporting disabled staff, to create a supportive culture, and not apply undue pressure on staff to attend work when ill.

Indicator 7 – Percentage of staff satisfied with the extent to which their organisation values their work.

North Tees and Hartlepool report 35.5% of staff with a disability felt satisfied that the organisation valued their work, this has decreased by 0.8% since 2023. This is above the national average of 34.7%.

South Tees' report 34.1% of staff with a disability reported that they felt satisfied that the organisation valued their work, this has shown a positive increase by 0.7% since 2023.

We will continue to review this as a group with recommendations to host a group Disability Awareness Day for colleagues who have a disability or long-term condition, with the focus of the day to raise awareness, and an opportunity to share areas of good practice and seek suggestions from staff about further improvements.

Indicator 8 – Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work.

South Tees have seen an overall positive increase in the percentage of staff with a disability saying that adequate reasonable adjustment has been made to enable them to carry out their work. This is reported at 72.6% which has shown a 0.2% increased since 2023.

North Tees and Hartlepool have seen a negative decrease in terms of the percentage of staff with a disability saying that adequate reasonable adjustment has been made to enable them to carry out their work. This is reported at 74.3% compared to 75.4% for 2023.

It's positive to note that North Tees and Hartlepool figure of 74.3% is above the national average which is reported at 73.9%.

We will continue to support the embedding of the Reasonable Adjustments in line with policy and provide support and training to managers across the Trusts to apply the policy meaningfully.

Indicator 9 – Staff Engagement Score

The engagement score for staff with a disability has seen a decrease across both Trusts.

South Tees disabled staff engagement score is reported at 6.4 in the 2024 Staff Survey results. This has shown a decrease of 0.5 when compared to 6.9 in 2023. North Tees and Hartlepool disabled staff engagement score is reported at 6.5 in the 2024 Staff Survey results. This has shown a slight decrease of 0.1 when compared to 6.6 in 2023.

Staff with a disability/LTC continue to be more likely to report lower levels of staff engagement than staff who do not have a disability. It is positive to note that both Trusts are not reporting below the national benchmarking data, which indicates that the engagement score for staff with a disability is 6.4.

It is recommended that emphasis is placed on engaging with our workforce and seek to understand their views on an individual level as well as the views of the group.

Indicator 10 – Board Membership

South Tees have seen an increase in disability representation at Board level which is reported at 5%, with North Tees and Hartlepool disability representation at Board reported at 0%. Representation continues to be underrepresented for both Trusts, as compared to the Trust's (6.3%) overall disability workforce. (Please note for reporting purposes we are only able to report on Board members who are directly employed by each Trust).

Both Trusts will continue to implement a fair and transparent recruitment process for all positions at all levels of the organisation. It is recommended that a review is undertaken in relation Board members and utilise positive action principles and targeted recruitment/ engagement measures, where appropriate to strive for a Board of Directors that reflects the diversity of the local population.

6. Conclusion and next Steps

The WDES is an important tool for employers as research shows that a motivated, inclusive and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The implementation of the WDES will enable us to better understand the experiences of our staff with a disability. It supports positive change for existing employees and promotes a more inclusive environment for people with a disability working in the NHS.

We are pleased to report an improvement in some of the metrics for both Trusts for 2025 and note that this is a reflection of the continued EDI programme of work and the significant investment made in terms of data analysis, our restorative approach and focused interventions to improve staff experience across this protected characteristic specifically.

We will continue to promote the activities and good practice that we already undertake, including undertaking fair and transparent recruitment processes, delivery of unconscious bias training and promotion of various leadership and development opportunities which exist across both Trusts.

Both Trusts have taken a number of important actions in 2024/2025, to support the Workforce Disability Equality Standard and key emphasis for 2025/26 will be placed on working as a

group relating to the recommendations and actions outlined within section 5 of this paper. This will include engagement with our collective workforce and key stakeholders to share these results and jointly develop actions that can be progressed across University Hospitals Tees in the coming year.

7. Recommendation

This report presents a group update in relation to the Workforce Disability Equality Standard (WDES) 2025 across **University Hospitals Tees.** Group People Committee is asked to receive the content of the report and acknowledge the Workforce Disability Equality Standard results for both Trusts reported in Section 2 and the key points and recommendations outlined within Section 5.

Both Trusts individual reports are included in the appendices for further information.

Appendix 1 - North Tees & Hartlepool NHS Foundation Trust - NHS Workforce Disability Equality Standard 2025.
Appendix 2 - South Tees Hospitals NHS Foundation Trust - NHS Workforce Disability Equality Standard 2025.

Appendix 1

North Tees & Hartlepool NHS Foundation Trust

NHS Workforce Disability Equality Standard 2025

3. Introduction

The Workforce Disability Equality Standard (WDES) programme was established in 2019. It requires organisations to report against ten indicators of disability equality and supports continuous improvement through robust action planning to tackle the root causes of discrimination.

Inequalities in any form are at odds with our values. Research shows that the fair treatment of our staff is directly linked to better clinical outcomes and better experience of care for patients.

This report represents the seventh publication since the WDES was established. It is pleasing to report that there are some positive findings for the 2025 report, particularly in terms of

declaration rates and improvements to some of the staff survey metrics: reduced experience of bullying and harassment from patients, relatives or the public and also colleagues; increased percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. There are further areas where analysis of the information is required to fully understand the results and to explore the reasons behind the data.

We are committed to tackling disability discrimination to bridge the gaps in experience, opportunity and differential attainment in our diverse workforce. A key tool to understanding and correcting these inequities is the presentation of detailed data to key work streams, which will allow us to identify the targets for action.

4. Trust Requirements

This report is intended to provide the People Committee with the initial high level detail, ahead of the data collection deadline of 31 May 2025, which is where the WDES metrics are uploaded to NHS England via the Data Collection Framework (DCF) portal.

Work will then commence to produce the Trust's annual WDES report, which will be published on the Trust's internet site no later than 31 October 2025.

5. WDES Indicators 2025

A summary of the results for North Tees and Hartlepool NHS Foundation Trust is shown in the table below. This includes comparison of the Trust's results covering a five-year period (2021 to 2025).

The baseline data has been extracted from ESR, Workforce databases and the Trac recruitment system to calculate a response to each of the ten WDES indicators.

North Tees and Hartlepool - WDES Indicators 2025			2021	2022	2023	2024	2025
1	Percentage of staff with a disability or long term health condition	Overall	2.0%	3.0%	4.0%	4.9%	6.3%
		Non-Clinical	2.0%	3.0%	4.0%	5.2%	6.3%
		Clinical	2.0%	3.0%	3.0%	4.8%	6.5%
2	The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff		0.94	0.98	1.25	0.90	0.98*
3	The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff		0	0	0	0	0
			2020	2021	2022	2023	2024
4a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Staff with a disability or LTC	29.6%	28.6%	30.7%	28.1%	26.0%
		Staff without	24.1%	26.3%	23.5%	20.1%	21.1%
4b	Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months	Staff with a disability or LTC	18.3%	14.2%	12.5%	10.5%	12.2%
		Staff without	7.5%	7.6%	6.3%	5.1%	4.9%
4c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Staff with a disability or LTC	23.4%	19.9%	23.2%	21.1%	19.6%
		Staff without	13.8%	13.3%	12.7%	11.9%	12.0%
4d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Staff with a disability or LTC	54.3%	46.2%	53.2%	50.3%	50.8%
		Staff without	47.3%	47.3%	48.1%	49.3%	50.2%
5	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Staff with a disability or LTC	54.5%	57.6%	57.3%	55.6%	53.3%
		Staff without	62.6%	65.5%	65.3%	64.8%	58.7%
6	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Staff with a disability or LTC	39.0%	27.8%	26.9%	26.7%	26.8%
		Staff without	24.9%	21.0%	18.0%	15.8%	14.3%
7	Percentage of staff satisfied with the extent to which their organisation values their work	Staff with a disability or LTC	36.9%	37.4%	34.6%	36.3%	35.5%
		Staff without	53.3%	47.6%	48.4%	50.8%	48.8%
8	Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	Staff with a disability or LTC	74.2%	74.1%	72.9%	75.4%	74.3%
9	Staff Engagement Score (0-10)	Staff with a disability or LTC	6.7	6.6	6.6	6.6	6.5
		Staff without	7.3	7.1	7.2	7.1	7.1
		Overall	7.1	6.9	7.0	6.9	6.9
			2021	2022	2023	2024	2025
10	Disabled/LTC Board Membership		0.0%	7.1%	0.0%	3.0%	0.0%

*Remains positive as 1.00 would indicate equal experience of both Non-Disabled and Disabled staff

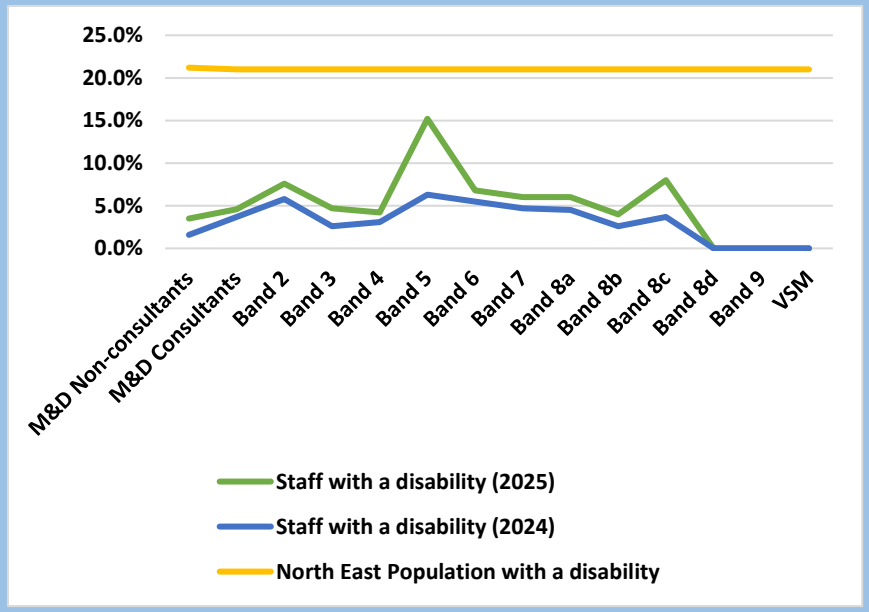
6. Key Findings for 2025

The key findings in respect of the ten WDES indicators for 2025 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 4-9). Full benchmarking information is published by the national WDES team and this is expected for March 2026. The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's disability profile, which can also be broken down by Region and Local Authority Area.

- UK Population 17.8% Disabled and 82.2% Non-Disabled
- North East Population 21.2% Disabled and 78.8% Non-Disabled
- Stockton Population 20.2% Disabled and 79.8% Non-Disabled
- Hartlepool Population 22.9% Disabled and 77.1% Non-Disabled

Indicators 1 and 10 – Percentage of staff with a disability or long term health condition



Representative Workforce across all protected characteristics at all levels.

This information is obtained from the Trust's ESR system as at 31 March 2025. There has been a positive increase in the number of staff who have reported their disability status on ESR - an increase of 1.4% from 4.9% in 2024 to 6.3% in 2025. This is a result of continued staff campaigns, on how to use the online self-declaration service on ESR and also by raising awareness of this during relevant disability and staff network events and the importance of Trust workforce data. The North East's disability data (2021 census) is reported at 21.2% therefore representation within the Trust is lower.

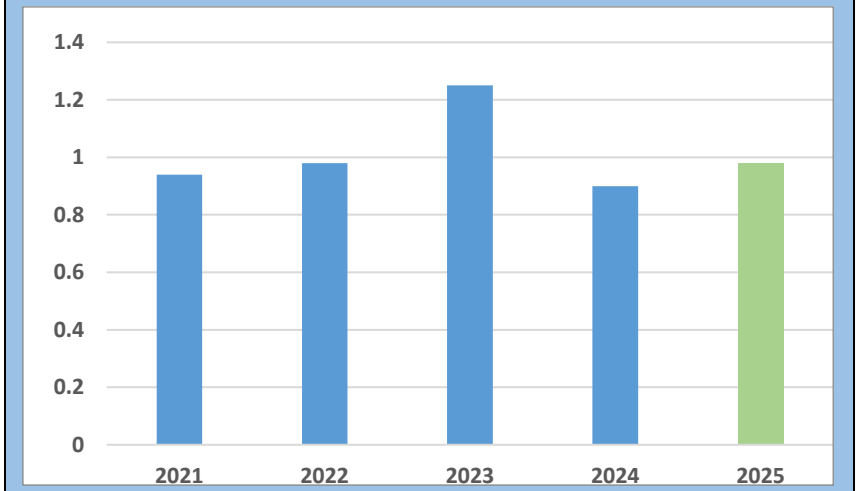
Representation is highest at Band 5, and there are no disabled staff employed at Bands 8d, 9 and VSM.

Representation of Disabled staff at Board and senior management levels.

For reporting purposes we are only able to report on Board members who are directly employed by North Tees and Hartlepool Foundation Trust.

Representation at Board level is under represented at 0%, as compared to the Trust's workforce of 6.3% of staff with a disability/LTC. We have seen a positive increase at Band 8c.

Indicator 2 – The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff



Equity of Experience.

This information is obtained from the Trust's Trac Recruitment System for the period 1 April 2024 to 31 March 2025 and considers a ratio showing the likelihood of being appointed following shortlisting. A figure of 1 indicates equal experience between disabled and non-disabled applicants.

The current figure for 2025 is reported as 0.98 which indicates shortlisted disabled applicants are more likely to be appointed following shortlisting than non-disabled applicants.

(A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting)

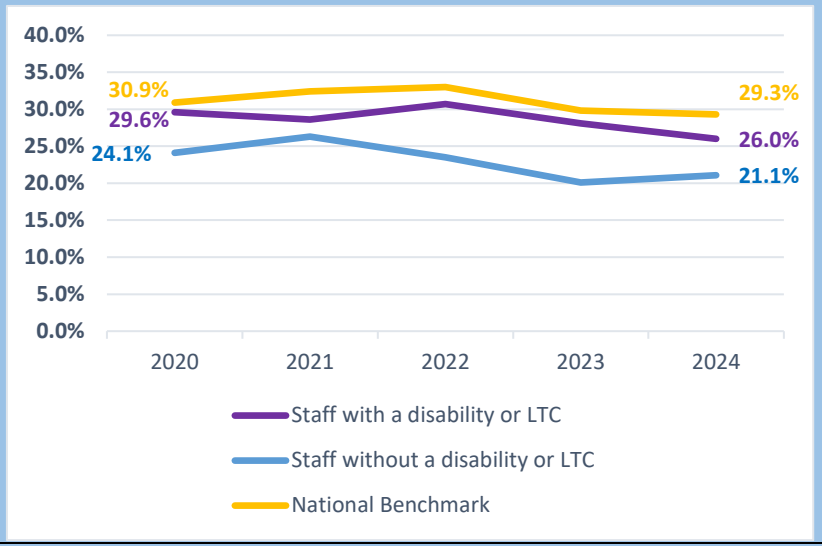
Indicator 3 – The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff

This information is obtained from the Trust's Workforce databases and considers a ratio showing the likelihood of entering formal capability processes. A figure of 1 indicates equal experience between disabled and non-disabled staff.

There have been no formal capability cases involving staff with a disability or long term condition, therefore it remains the case that staff without a disability are more likely to enter a formal capability process.

The data shows us that there were two individuals who had not declared their disability status, which is potentially a missed opportunity where consideration of reasonable adjustments could have taken place to support the member of staff.

Indicator 4a - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



Staff Survey Key Findings - B&H Public

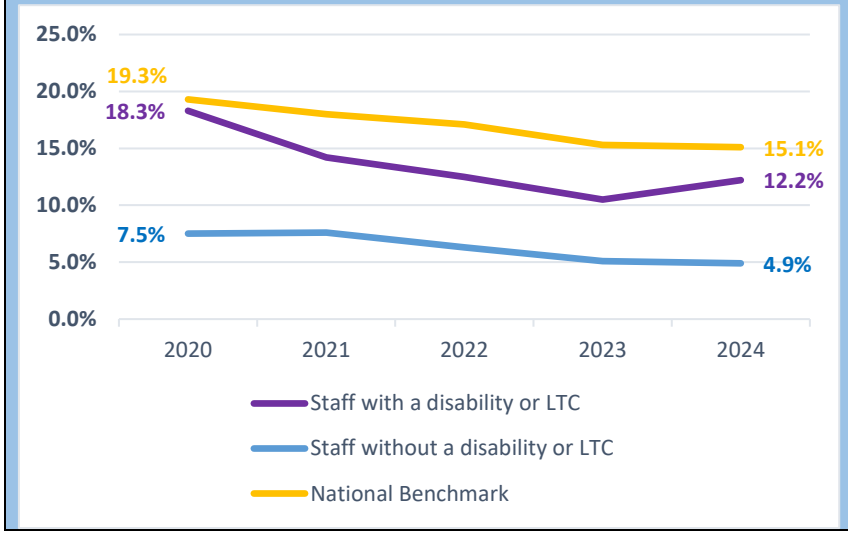
This information is derived from the 2024 Staff Survey.

Staff survey results show a positive decrease in the number of disabled staff who have experienced harassment, bullying and abuse from patients, relatives/public (26% compared to 28.1% for 2023).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from patients than staff who do not have a disability and the gap is reported as 4.9%.

Staff are required to log all incidents of service user violence and harassment via InPhase and the information is reported through Yellowfin. The Trust's Keeping People Safe group reviews this information on a regular basis to identify trends and this includes analysis of related themes where available.

Indicator 4b – Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months



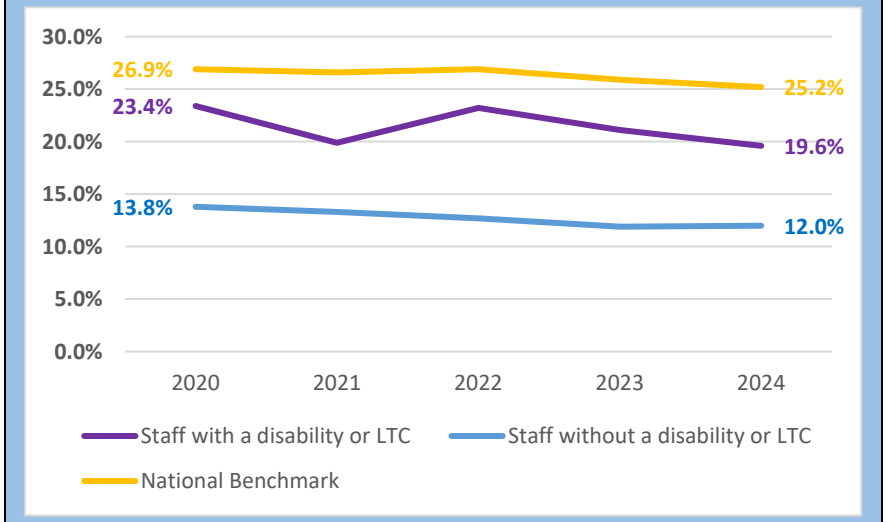
Staff Survey Key Findings - B&H Manager

This information is derived from the 2024 Staff Survey.

Staff survey results show an increase in the number of disabled staff experiencing harassment, bullying and abuse from a manager (12.2% compared to 10.5% for 2023).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from a manager than staff who do not have a disability, the gap has increased for 2024 and this is currently reported as 7.3%.

Indicator 4c – Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months



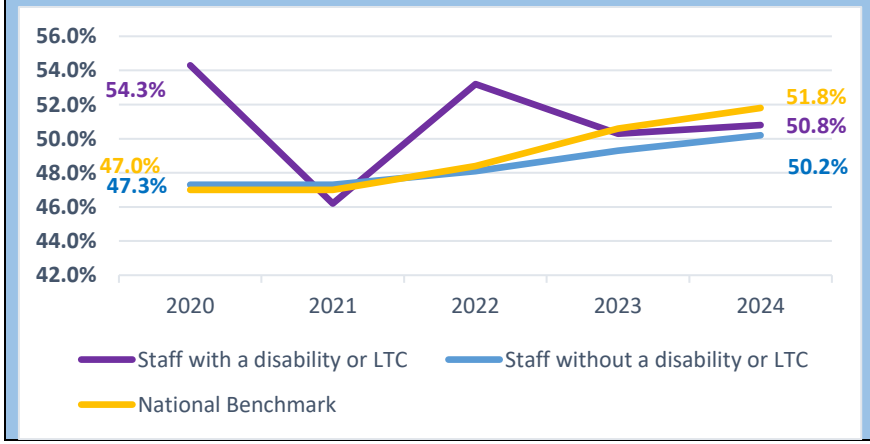
Staff Survey Key Findings - B&H Colleagues

This information is derived from the 2024 Staff Survey.

Staff survey results show a decrease in the number of disabled staff experiencing harassment, bullying and abuse from a colleague (19.6% compared to 21.1% in 2023).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from a colleague than staff who do not have a disability. The gap has decreased for 2024 and this is reported as 7.6% (compared to 9.2% for 2023).

Indicator 4d – Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it



Staff Survey Key Findings - Reporting

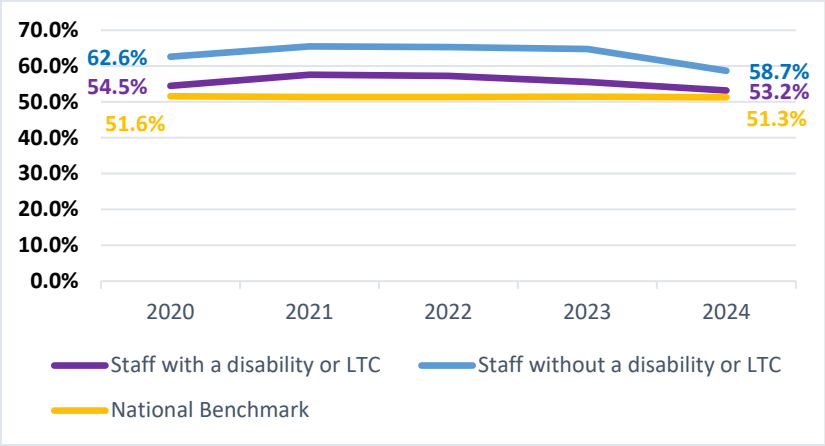
This information is derived from the 2024 Staff Survey.

Staff survey results show a very slight increase in the number of disabled staff who have reported harassment, bullying and abuse (50.8% compared to 50.3% for 2023).

Staff with a disability/LTC are more likely to report harassment, bullying/abuse than staff who do not have a disability, with a reported gap of 0.6%.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the People Services Team.

Indicator 5 – Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion



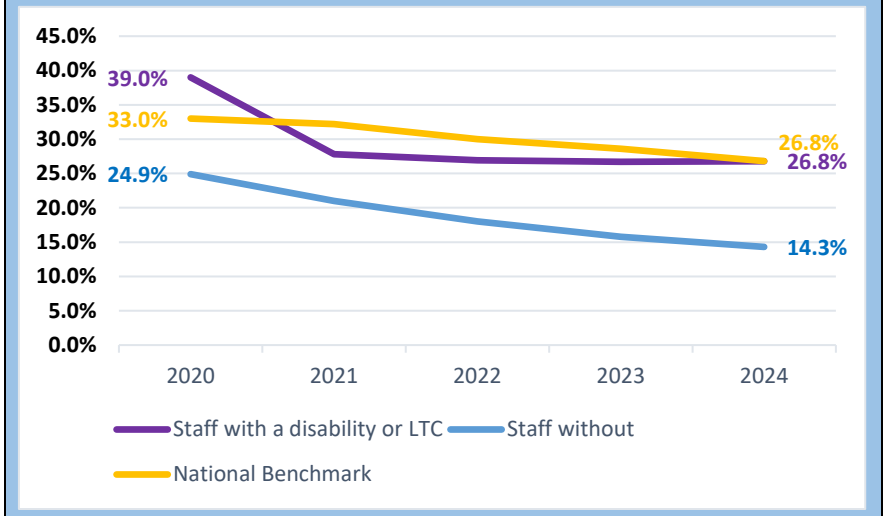
Staff Survey Key Findings - Equal Opportunities

This information is derived from the 2024 Staff Survey.

The results have decreased in terms of the % of both disabled and non-disabled staff who believe the organisation provides equal opportunities for career progression or promotion. The disabled staff figures are reported as 53.2% compared to 55.6% for 2023 and non-disabled staff is reported 58.7 % compared to 64.8% for 2023.

Staff with a disability/LTC continue to report lower levels of equal opportunities than staff who do not have a disability. The gap in experience is currently reported as 5.5%.

Indicator 6 – Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



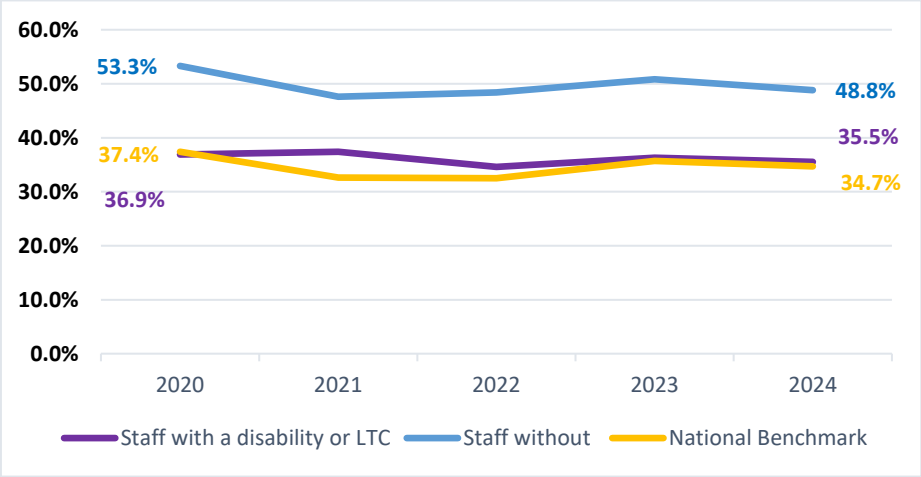
Staff Survey Key Findings - Attendance at work whilst unwell

This information is derived from the 2024 Staff Survey.

The results show a static position in the number of disabled staff who have felt pressure from their manager to come to work whilst unwell (26.8% compared to 26.7% for 2023).

Staff with a disability/LTC continue to be more likely to report pressure to attend work whilst unwell than staff who do not have a disability. The gap has increased for 2024 and this is reported as 14.5%, compared to 10.9% for 2023.

Indicator 7 – Percentage of staff satisfied with the extent to which their organisation values their work



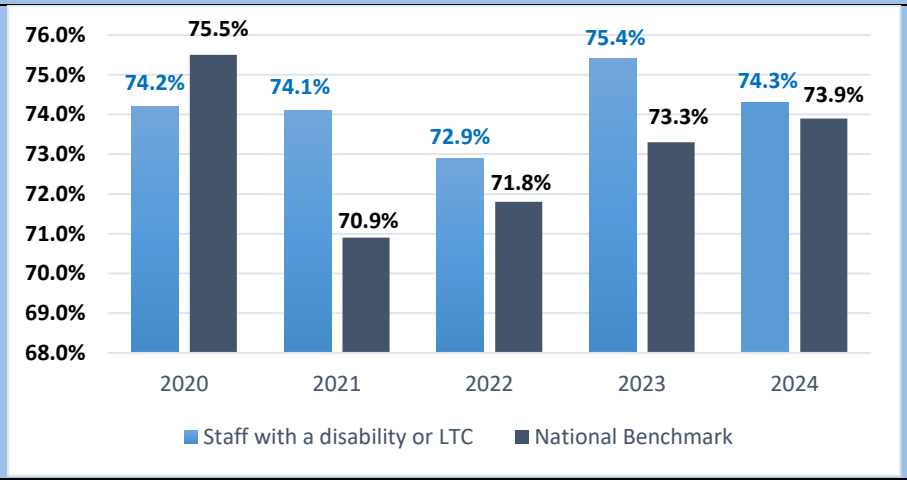
Staff Survey Key Findings - Feeling Valued

This information is derived from the 2024 Staff Survey.

The number of disabled staff who feel satisfied that the organisation values their work has decreased for 2024 to 35.5%, compared to 36.3% for 2023.

Staff with a disability/LTC continue to be less likely to feel valued than staff who do not have a disability and the gap is reported at 13.3% which is a decrease of 1.2% from 2023.

Indicator 8 – Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work



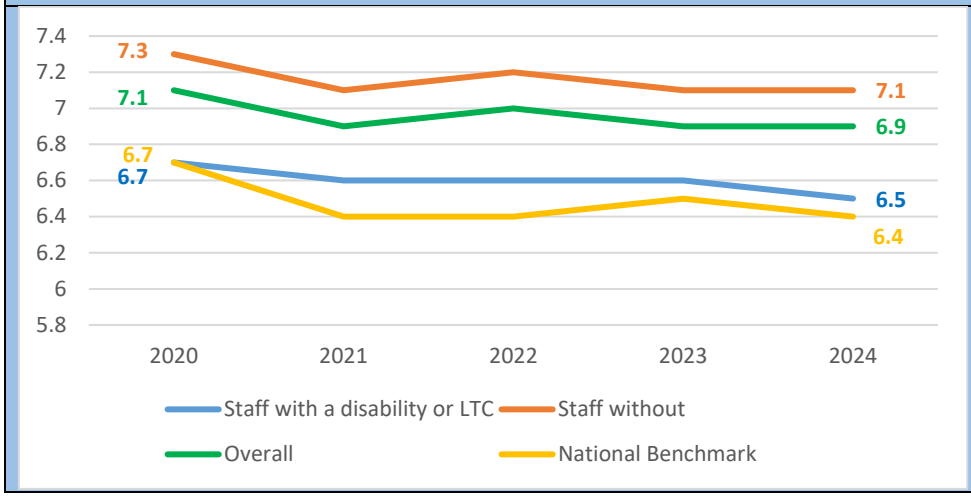
Staff Survey Key Findings - Reasonable Adjustments

This information is derived from the 2024 Staff Survey.

Staff survey results have decreased in terms of the number of disabled staff who have reported that the Trust has made adequate reasonable adjustments to enable them to carry out their work (74.3% compared to 75.4% for 2023), the figure still remains above the national average for this question.

Training continues to be delivered to managers on the application of the policy in practice and the People Clinics are well established within the Care Groups and take place regularly.

Indicator 9 – Staff engagement score (0-10)



Staff Survey Key Findings - Engagement

This information is derived from the 2024 Staff Survey.

Staff survey results show that the staff engagement score for staff with a disability/LTC is 6.5. This has shown a slight decrease of 0.1% when compared to 6.6 in 2023

Staff with a disability/LTC continue to be more likely to report lower levels of engagement than staff who do not have a disability. However it's positive that we continue to report higher than the national benchmarking data which indicates that the engagement score for disabled staff is 6.4, which is 0.1 lower than the Trust figure.

7. Conclusion and Next Steps

Our actions to improve the Trust's WDES metrics align with the Group People values specifically 'respect' and support our commitments to the NHS People Plan.

We are pleased to report an improvement in some of the metrics for 2025 and note that this is a reflection of our EDI programme of work and the investment we have made in terms of data analysis and focused interventions to improve staff experience across the range of protected characteristics.

We will continue to promote the activities and good practice that we already undertake, including: undertaking fair and transparent recruitment processes; delivery of civility and unconscious bias training and promotion of various leadership and development opportunities which exist across the Trust.

We take disability equality seriously and whilst we have already implemented a number of practices which will have a positive impact in this area, we understand that change will require a significant cultural shift within the organisation. We know that our workforce disability profile will not change overnight, however we are continuing to see a gradual increase in the number of disabled staff who have declared their status. It is also important that we continue to grow the membership of our Ability staff network to help us facilitate the voices of our disabled staff and improve staff experience overall.

It is noted that this is a high level report based on the overall workforce metrics. The next stage in the reporting process will be to engage with our workforce to share the results and jointly develop the action plan to be included in the WDES annual report for October 2025.

6.0 Recommendation

People Committee is requested to:

- Acknowledge the Trust's WDES Results (2025) as reported within section 4 of this paper.

- Note that the WDES annual report will be shared at a future meeting of the People Group/Committee, ahead of the mandatory publication date of 31 October 2025.

Appendix 2

South Tees Hospitals NHS Foundation Trust

NHS Workforce Disability Equality Standard 2025

8. Introduction

The Workforce Disability Equality Standard (WDES) programme was established in 2019. It requires organisations to report against ten indicators of disability equality and supports continuous improvement through robust action planning to tackle the root causes of discrimination.

Inequalities in any form are at odds with our values. Research shows that the fair treatment of our staff is directly linked to better clinical outcomes and better experience of care for patients.

This report represents the seventh publication since the WDES was established. It is pleasing to report that there are some positive findings for the 2025 report, particularly in terms of declaration rates and improvements to some of the staff survey metrics: increased percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. We have also seen an increased percentage of staff satisfied with the extent to which the organisation values their work. There are further areas where analysis of the information is required to fully understand the results and to explore the reasons behind the data.

We are committed to tackling disability discrimination to bridge the gaps in experience, opportunity and differential attainment in our diverse workforce. A key tool to understanding and correcting these inequities is the presentation of detailed data to key work streams, which will allow us to identify the targets for action.

9. Trust Requirements

This report is intended to provide the high level detail, to confirm the data collection deadline of 31 May 2025, which is where the WDES metrics are uploaded to NHS England via the Data Collection Framework (DCF) portal.

Work will then commence to produce the Trust's annual WDES report, which will be published on the Trust's internet site no later than 31 October 2025.

10. WDES Indicators 2025

A summary of the results for South Tees Hospitals NHS Foundation Trust is shown in the table below. This includes comparison of the Trust's results covering a five-year period (2021 to 2025).

The baseline data has been extracted from ESR, Workforce databases and the Trac recruitment system to calculate a response to each of the ten WDES indicators.

South Tees - WDES Indicators 2025			2021	2022	2023	2024	2025
1	Percentage of staff with a disability or long term health condition	Overall	2.6%	3.5%	4.6%	4.9%	6.3%
2	The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff		0.82	1.58	1.31	1.30	1.76
3	The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff		2.48	0	0	0	8.4
			2020	2021	2022	2023	2024
4a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Staff with a disability or LTC	28.4%	27.1%	28.9%	26.3%	28.2%
		Staff without	22.8%	23.2%	23.7%	20.5%	19.6%
4b	Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months	Staff with a disability or LTC	17.0%	14.4%	13.9%	10.4%	13.9%
		Staff without	10.8%	8.7%	7.8%	8.6%	9.6%
4c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Staff with a disability or LTC	28.2%	24.5%	25.2%	23.0%	27.7%
		Staff without	16.0%	15.2%	17.1%	16.0%	16.9%
4d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Staff with a disability or LTC	49.6%	50.4%	49.4%	49.2%	52.6%
		Staff without	41.6%	42.3%	45.5%	48.1%	42.2%
5	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Staff with a disability or LTC	44.2%	53.5%	51.5%	53.2%	53.1%
		Staff without	53.9%	58.4%	59.0%	58.6%	58.4%
6	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Staff with a disability or LTC	30.5%	29.9%	26.8%	25.0%	27.7%
		Staff without	23.1%	22.8%	19.1%	19.7%	19.4%
7	Percentage of staff satisfied with the extent to which their organisation values their work	Staff with a disability or LTC	29.2%	32.7%	34.2%	33.4%	34.1%
		Staff without	41.8%	40.7%	39.8%	43.4%	42.8%
8	Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	Staff with a disability or LTC	77.3%	75.6%	69.6%	72.4%	72.6%
9	Staff Engagement Score (0-10)	Staff with a disability or LTC	6.4	6.6	6.5	6.9	6.4
		Staff without	6.9	7	6.9	7	6.9
		Overall	6.8	6.9	6.8	6.9	6.7
			2021	2022	2023	2024	2025
10	Disabled/LTC Board Membership		-2.6%	-3.3%	-4.3%	-3.0%	5.0%

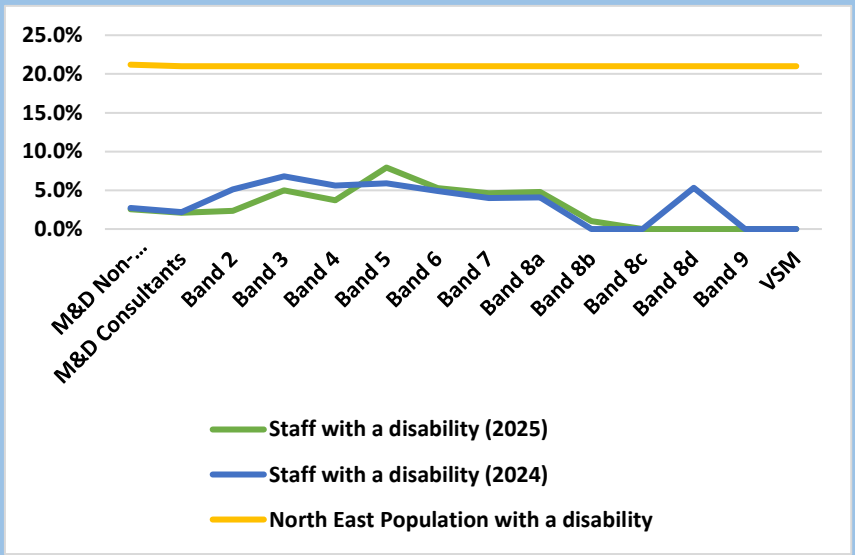
11. Key Findings for 2025

The key findings in respect of the ten WDES indicators for 2025 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 4-9). Full benchmarking information is published by the national WDES team and this is expected for March 2026. The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's disability profile, which can also be broken down by Region and Local Authority Area.

- UK Population 17.8% Disabled and 82.2% Non-Disabled
- North East Population 21.2% Disabled and 78.8% Non-Disabled
- Middlesbrough Population 21.9 % Disabled and 78.1% Non-Disabled
- Redcar and Cleveland Population 21.4% Disabled and 78.6% Non-Disabled
- Hambleton Population 15.4% Disabled and 84.6% Non-Disabled

Indicators 1 and 10 – Percentage of staff with a disability or long term health condition



Representative Workforce across all protected characteristics at all levels.

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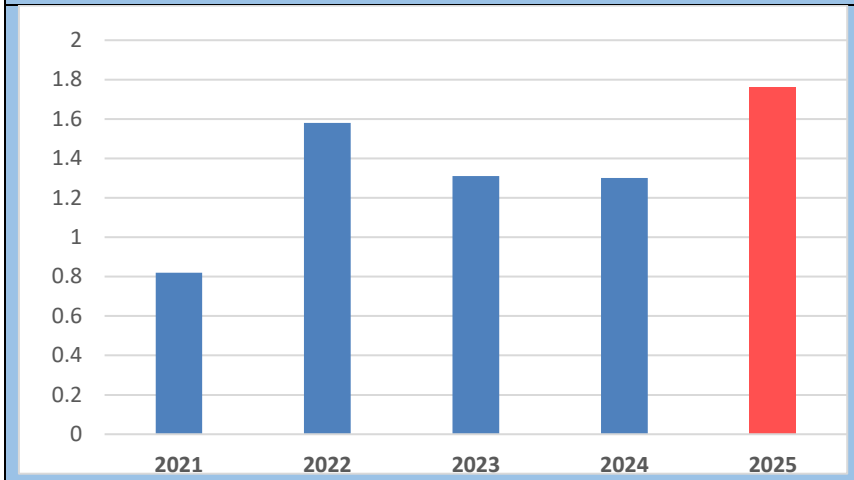
Representation is highest at Band 5 and there are no disabled staff employed at Bands 8c - 8d, 9 and VSM.

Representation of Disabled staff at Board and senior management levels.

For reporting purposes we are only able to report on Board members who are directly employed by South Tees Hospitals NHS Foundation Trust.

There is a total of 9 employees reported on the Board for South Tees with Disability at Board level currently reported at 5.0%, this has seen a positive increase (5.0% in 2025 compared to -3% in 2024). This is reported below the overall workforce figure of 6.3%

Indicator 2 – The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff



Equity of Experience.

This information is obtained from the Trust's Trac Recruitment System for the period 1 April 2024 to 31 March 2025 and considers a ratio showing the likelihood of being appointed following shortlisting. A figure of 1 indicates equal experience between disabled and non-disabled applicants.

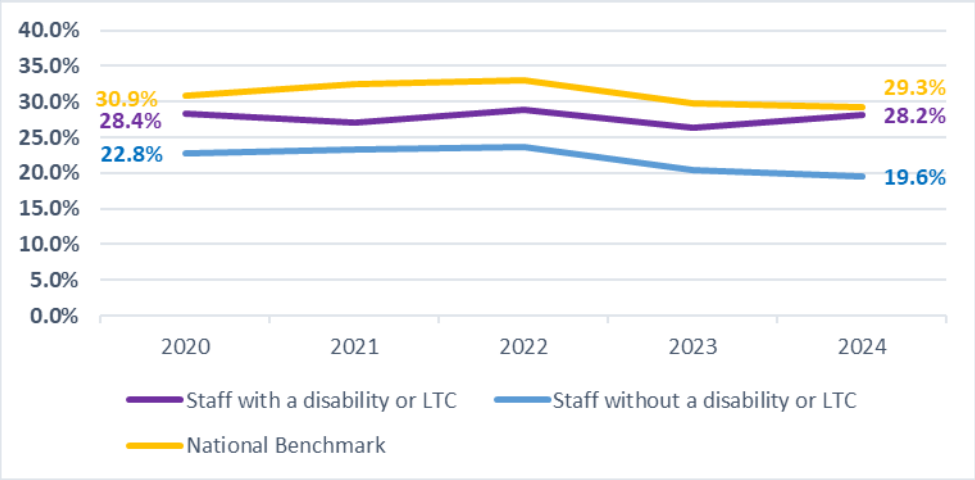
The current figure for 2025 is reported as 1.76 which indicates shortlisted disabled applicants are less likely to be appointed following shortlisting than non-disabled applicants.

Indicator 3 – The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff

This information is obtained from the Trust's Workforce databases and considers a ratio showing the likelihood of entering formal capability processes. A figure of 1 indicates equal experience between disabled and non-disabled staff.

There have been 5 formal capability cases in total with 2 involving staff with a disability or long term condition, therefore the relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff is reported at 8.4. This has seen an increase from previous years where this has been reported at 0.

Indicator 4a - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



Staff Survey Key Findings - B&H Public

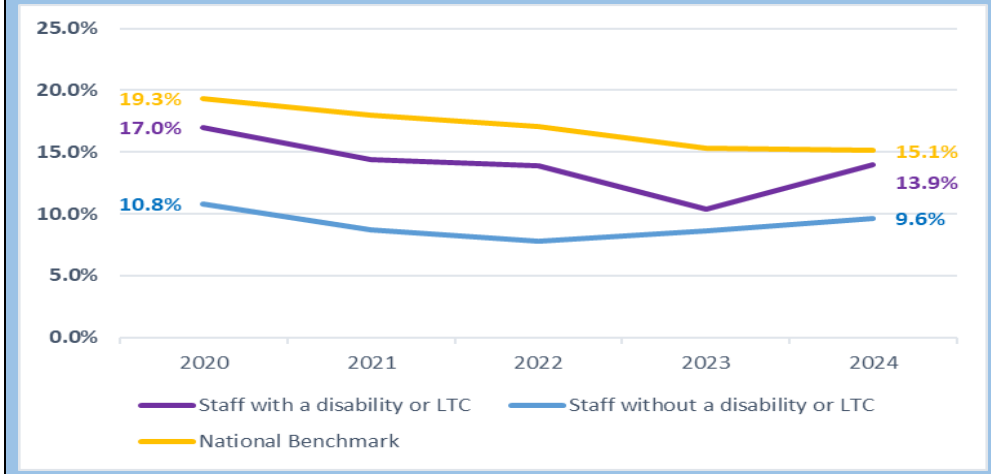
This information is derived from the 2024 Staff Survey.

Staff survey results show a positive decrease in the number of disabled staff who have experienced harassment, bullying and abuse from patients, relatives/public (28.2% compared to 26.3% for 2023).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from patients than staff who do not have a disability and the gap is reported as 8.6%.

Staff are required to log all incidents of service user violence and harassment via Datix and the information is reviewed on a regular basis.

Indicator 4b – Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months



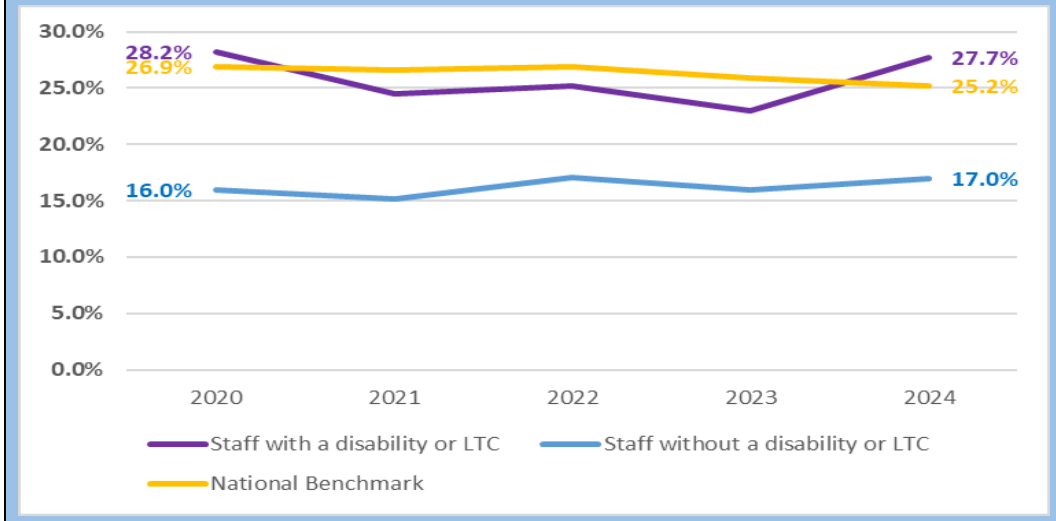
Staff Survey Key Findings - B&H Manager

This information is derived from the 2024 Staff Survey.

Staff survey results show an increase in the number of disabled staff experiencing harassment, bullying and abuse from a manager (13.9% compared to 10.4% for 2023).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from a manager than staff who do not have a disability, the gap has increased for 2024 and this is currently reported as 4.3%. Positive to note we continue to report below the national average of 15.1% for 2024.

Indicator 4c – Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months



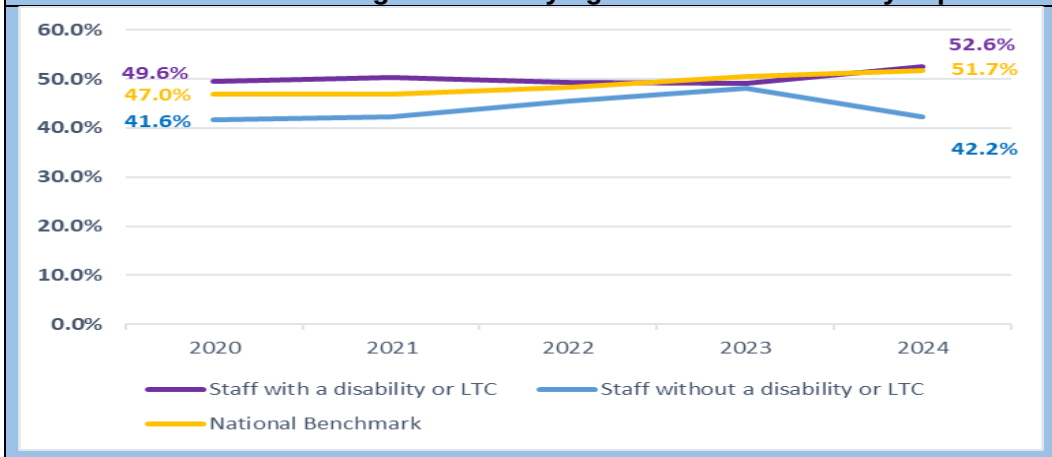
Staff Survey Key Findings - B&H Colleagues

This information is derived from the 2024 Staff Survey.

Staff survey results show an increase in the number of disabled staff experiencing harassment, bullying and abuse from a colleague (27.7% compared to 23% in 2023).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from a colleague than staff who do not have a disability. The gap has increased for 2024 and this is reported as 10.7% (compared to 7% for 2023).

Indicator 4d – Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it



Staff Survey Key Findings - Reporting

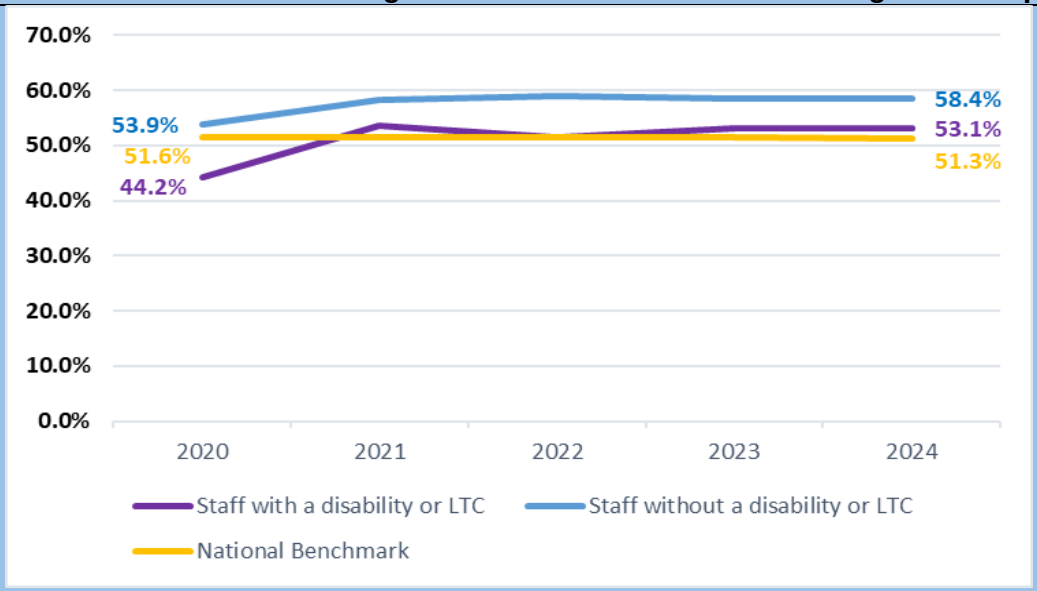
This information is derived from the 2024 Staff Survey.

Staff survey results remain show a positive increase the number of disabled staff who have reported harassment, bullying and abuse (52.6% compared to 49.2% for 2023).

Staff with a disability/LTC are now more likely to report harassment, bullying/abuse than staff who do not have a disability, with a reported gap of 10.4%.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the People Services Team.

Indicator 5 – Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion



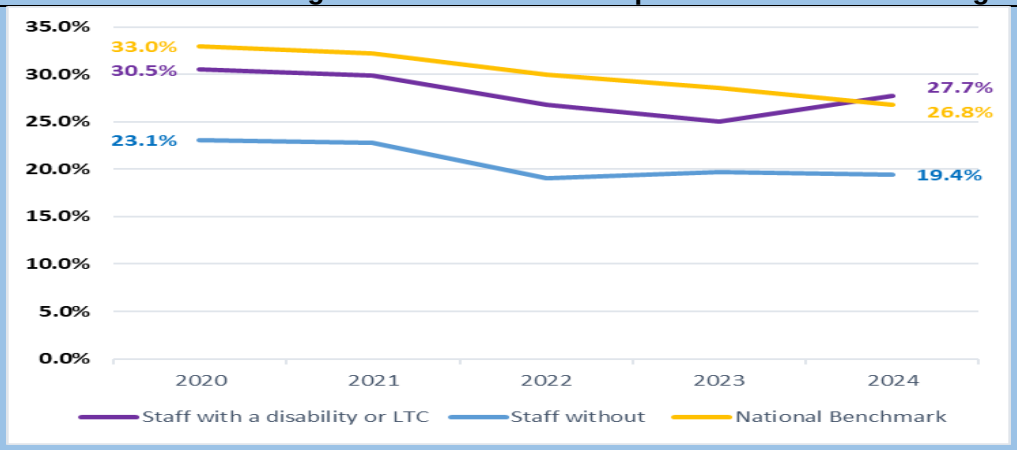
Staff Survey Key Findings - Equal Opportunities

This information is derived from the 2024 Staff Survey.

The results have remained fairly static for 2024, in terms of the % of both disabled (53.1%) and non-disabled staff (58.4) who believe the organisation provides equal opportunities for career progression and promotion.

Staff with a disability/LTC continue to report lower levels of equal opportunities than staff who do not have a disability. The gap in experience is currently reported as 5.3%.

Indicator 6 – Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



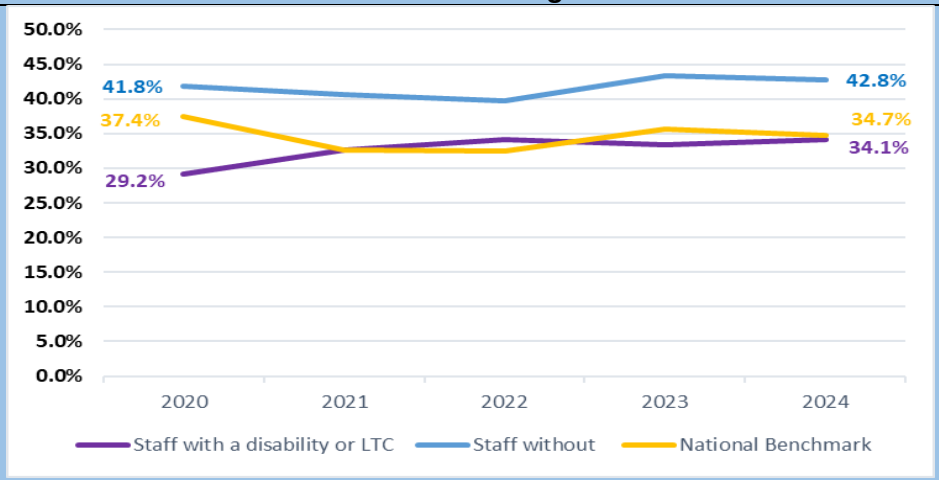
Staff Survey Key Findings - Attendance at work whilst unwell

This information is derived from the 2024 Staff Survey.

The results show an increase in the number of disabled staff who have felt pressure from their manager to come to work whilst unwell (27.7% compared to 25.0% for 2023).

Staff with a disability/LTC continue to be more likely to report pressure to attend work whilst unwell than staff who do not have a disability. The gap has increased for 2024 and this is reported as 8.3%, compared to 5.3% for 2023.

Indicator 7 – Percentage of staff satisfied with the extent to which their organisation values their work



Staff Survey Key Findings - Feeling Valued

This information is derived from the 2024 Staff Survey.

The number of disabled staff who feel satisfied that the organisation values their work has increased for 2024 to 34.1%, compared to 33.4% for 2023.

Staff with a disability/LTC continue to be less likely to feel valued than staff who do not have a disability and the gap is reported at 8.7% which is a decrease of 1.3% from 2023.

Indicator 8 – Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work

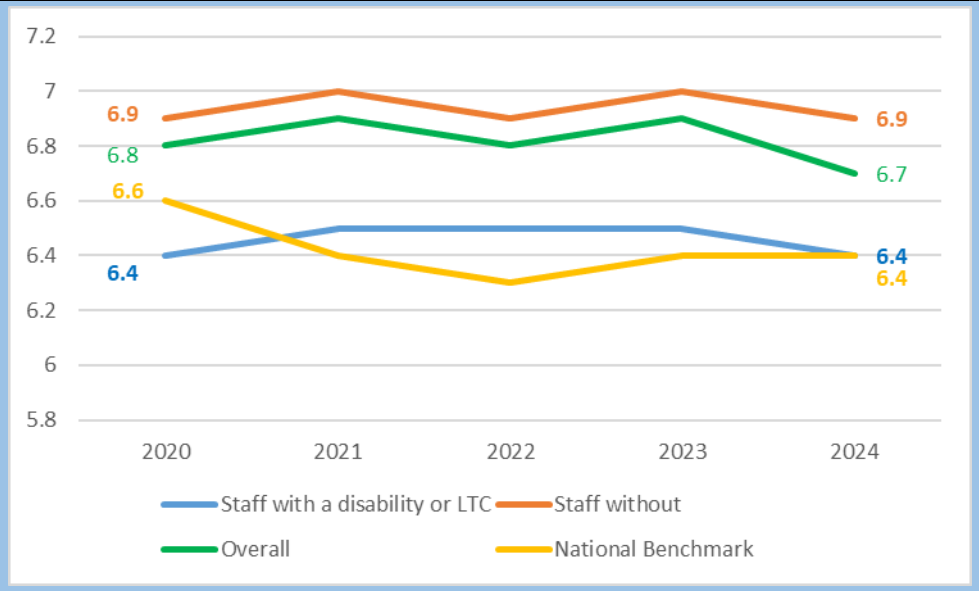
Staff Survey Key Findings - Reasonable Adjustments

This information is derived from the 2024 Staff Survey.

Staff survey results have slightly increased in terms of the number of disabled staff who have reported that the Trust has made adequate reasonable adjustments to enable them to carry out their work (72.6% compared to 72.4% for 2023).

Training continues to be delivered to managers on the application of the policy in practice.

Indicator 9 – Staff engagement score (0-10)



Staff Survey Key Findings - Engagement

This information is derived from the 2024 Staff Survey.

Staff survey results show that the staff engagement score for staff with a disability/LTC is 6.4. This has shown a decrease of 0.1% when compared to 6.5 in 2023.

However we continue to report the same as the national benchmarking data which indicates that the engagement score for disabled staff is 6.4.

12. Conclusion and Next Steps

Our actions to improve the Trust's WDES metrics align with the Group People values specifically 'respect' and support our commitments to the NHS People Plan.

We are pleased to report an improvement in some of the metrics for 2025 and note that this is a reflection of our EDI programme of work and the investment we have made in terms of data analysis and focused interventions to improve staff experience across the range of protected characteristics.

We will continue to promote the activities and good practice that we already undertake, including: undertaking fair and transparent recruitment processes; delivery of civility and unconscious bias training and promotion of various leadership and development opportunities which exist across the Trust.

We take disability equality seriously and whilst we have already implemented a number of practices which will have a positive impact in this area, we understand that change will require a significant cultural shift within the organisation. We know that our workforce disability profile will not change overnight, however we are continuing to see a gradual increase in the number of disabled staff who have declared their status. It is also important that we continue to grow the membership of our Disability and Long Term Conditions staff network to help us facilitate the voices of our disabled staff and improve staff experience overall.

It is noted that this is a high level report based on the overall workforce metrics. The next stage in the reporting process will be to engage with our workforce to share the results and jointly develop the action plan to be included in the WDES annual report for October 2025.

NHS
University Hospitals Tees

Resources Committee

July and August 2025

Connecting to: Group Board

Chair of Committee: David Redpath

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.

Finance

The financial position for Month 4 2025/26 is a deficit of £4.1m for the Group, which is a favourable variance of £22k against the year-to-date plan. The reported position includes over-performance of ERF income of £4.4m (at risk above commissioner affordable levels within contract mandates) and additional non-recurrent measures totalling £5m year-to-date across the Group. Continued focus on de-risking and delivery of recurrent efficiency plans along with reductions in WTE and expenditure run-rates will be essential throughout the remainder of the financial year to ensure delivery of the financial control total.

WTE

Month 4 shows a net overall increase of 45.84 WTE worked across the Group, compared to the previous month. WTEs worked in month are 142.77 more than the position in Month 4 of the previous financial year. This is 2,508.41 WTE (19.4%) higher than the average deployed during 2019/20 (pre-Covid).

We reported a reduction on WTE in July's Board but unfortunately this has been reversed and in fact increased in August. Further work needed to understand the growth and actual budget implications. Board is asked to consider what actions are needed now to ensure this growth doesn't continue

Caring Better Together

Productivity

A report was received on productivity which identified lower quartile performance in the following operational productivity measures:

- NTHFT proportion of outpatient attendances that are for first appointments, or follow up appointments attracting a procedure tariff
- NTHFT BADS day case benchmark (British Association of Day Surgery)
- STHFT ratio of follow up to first appointments
- STHFT proportion of outpatient attendances resulting in PIFU
- STHFT day case rate overall

The report received is enabling a good discussion at speciality level and good assurance is starting to be received via the Committee to the Board on this area.

CIP

Positive progress continues to be made in the development and de-risking of the CIP programme since plan submission. However, at the end of the reporting period £9.5m of the CIP programme remains defined as 'Opportunity' and £12.0m of the programme remains as High Risk. Across the Group, overall year-to-date reported CIP delivery is £21.1m (97% of target). However, this position includes a number of non-recurrent schemes, and delivery of recurrent savings is £4.2m behind plan at the end of Month 4.

Critical Care Service Delivery Model

The business case for the critical care service delivery model for North Tees & Hartlepool NHS Trust was presented,. The committee commended the team for the work on this to date. After a thorough discussion it was agreed that although the business case is good in isolation the committee could not approve additional spend whilst the collaborative is significantly behind its financial plan and part of a group has significant downside risk to delivery the financial plan for 2025/26. The committee agreed that this would need a board level discussion and decision. There was discussion on potential financial benefits around reduction in bank staff usage but this isn't currently reflected in the business case.

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.

Utility Brokerage Report

A report was presented around the energy provision for North Tees & Hartlepool. On current projections this would cost the group an additional £500k per annum. The main cost being the higher rates for gas. Discussion was had around our usage and potential changes in the future. The recommendation presented was rejected and instead the committee asked the team to delay signing up to the scheme (due to cost) and investigate additional options around splitting Gas and Electricity brokerage and potentially delivering further savings.

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

Winter plan

The Winter planning preparation was presented to the committee who commended the effort and work to date. The committee asked for more clarity on the risks with clear view on likelihood, impact and mitigating actions and recommended approval by the Board.

Aseptic Manufacturing Centre

The Committee confirmed agreement to the letter of support for the establishment of a Limited Liability Partnership by the DHSC and HM Treasury for a Medicines Manufacturing Centre for the NENC at its July meeting.

Committee cycle of Business

The July meeting approved the committee terms of reference and cycle of business.

Digital

We received the monthly report on digital and note the good progress in both the contents and format of the reporting. The committee has asked for a deep dive into digital at Septembers meeting.

Month 4 2025-26 Finance Report

Meeting date: 4 September 2025

Reporting to: Group Board of Directors

Agenda item No: 4.2

Report author: Chris Hand, Group Chief Finance Officer

Executive director sponsor: Chris Hand, Group Chief Finance Officer

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to:
Group Resources Committee

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

This report relates to the Board Assurance Framework Finance domain

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 Group plan for the 2025/26 financial year is to deliver an overall deficit control total of £9.1m, with a break-even plan for NTH and a £9.1m deficit plan for STH (including an allocation of £11.5m ICS deficit support for STH).

The financial position for Month 4 2025/26 is a deficit of £4.1m for the Group, which is a favourable variance of £22k against the year-to-date plan.

The reported position includes over-performance of ERF income (at risk above commissioner affordable levels within contract mandates) and additional non-recurrent measures. Continued focus on de-risking and delivery of recurrent efficiency plans along with reductions in WTE and expenditure run-rates will be essential throughout the remainder of the financial year to ensure delivery of the financial control total.

NHSE have advised of changes to the deficit support regime for 2025/26, with regional assurance of plan-delivery required to prevent funding being withheld. NHSE expect strong Board focus on delivery of agreed financial plans, with oversight of progress in de-risking plans and on delivery of efficiency plans and cost control.

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

Month 4 shows a net overall increase of 45.84 WTE worked across the Group, compared to the previous month. WTEs worked in month are 142.77 more than the position in Month 4 of the previous financial year. This is 2,508.41 WTE (19.4%) higher than the average deployed during 2019/20 (pre-Covid).

Positive progress continues to be made in the development and de-risking of the CIP programme since plan submission. However, at the end of the reporting period £9.5m of the CIP programme remains defined as 'Opportunity' and £12.0m of the programme remains as High Risk. Across the Group, overall year-to-date CIP delivery is £21.1m (97% of target). However, this position includes a number of non-recurrent schemes.

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 receives 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.

The CEO chairs FROG meetings, with expanded membership to include wider representation from the Executive team, to ensure continued focus and prioritisation of de-risking of the efficiency programme.

Recommendations:

Members of the Board are asked to:

- Note the financial position for Month 4 2025/26.

Group Board
August 2025

Month 4 2025/26 Finance Report

1. PURPOSE OF REPORT

The purpose of this report is to update the Committee on the financial performance of the individual trusts and overall Group, at the end of Month 4 of 2025/26.

2. BACKGROUND

For 2025/26, 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).

The Group financial plans for NTH and STH for the 2025/26 financial year are consistent with the overall ICS plan re-submission on 30th April. The Trusts' plans were developed based on a number of assumptions, which were reviewed throughout the planning period by the executive team, Resources Committees and meetings of the Trust Board The Group plan for the 2025/26 financial year is to deliver an overall deficit control total of £9.1m, with a break-even plan for NTH and a £9.1m deficit plan for STH.

This includes non-recurrent deficit support provided by NHSE to systems with an agreed deficit plan, to deliver break-even for the 2025/26 financial year. NENC ICB received an allocation of £33.3m (reduced from £49.9m in 2024/25), which has been allocated to deficit trusts including an allocation of £11.5m for STH. The planned deficit excluding non-recurrent deficit support funding is £20.6m.

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.

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

3. MONTH 4 FINANCIAL POSITION

The table below shows the revenue position for the Group as at the end of Month 4 2025/26, shown by trust:

STATEMENT OF COMPREHENSIVE INCOME	NTH			STH			GROUP		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Operating income from patient care activities	142,038	140,855	(1,183)	317,806	318,035	229	**459,844**	**458,890**	**(954)**
Other operating income	11,588	12,301	713	23,368	20,601	(2,767)	**34,956**	**32,902**	**(2,054)**
Employee expenses	(103,083)	(106,781)	(3,698)	(202,835)	(203,573)	(738)	**(305,918)**	**(310,354)**	**(4,436)**
Operating expenses excluding employee expenses	(49,550)	(46,786)	2,764	(131,265)	(132,094)	(829)	**(180,815)**	**(178,880)**	**1,935**
OPERATING SURPLUS/(DEFICIT)	**993**	**(411)**	**(1,404)**	**7,074**	**2,969**	**(4,105)**	**8,067**	**2,558**	**(5,509)**
FINANCE COSTS									
Finance income	752	1,123	371	1,004	1,382	378	**1,756**	**2,505**	**749**
Finance expense	(236)	(195)	41	(7,212)	(7,185)	27	**(7,448)**	**(7,380)**	**68**
PDC dividends payable/refundable	(1,068)	(1,068)	0	0		0	**(1,068)**	**(1,068)**	**0**
NET FINANCE COSTS	**(552)**	**(140)**	**412**	**(6,208)**	**(5,803)**	**405**	**(6,760)**	**(5,943)**	**817**
Other gains/(losses) including disposal of assets	0	830	830	0	1	1	**0**	**831**	**831**
Corporation tax expense	(32)	(11)	21	(4)	0	4	**(36)**	**(11)**	**25**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**409**	**268**	**(141)**	**862**	**(2,833)**	**(3,695)**	**1,271**	**(2,565)**	**(3,836)**
Add back all I&E impairments/(reversals)	0	0	0	0	0	0	**0**	**0**	**0**
Remove capital donations/grants I&E impact	0	148	148	(2,544)	1,164	3,708	**(2,544)**	**1,312**	**3,856**
Remove net impact of consumables donated from other DHSC bodie	0	0	0	0		0	**0**	**0**	**0**
Remove PFI revenue costs on an IFRS 16 basis	0	0	0	21,514	21,105	(409)	**21,514**	**21,105**	**(409)**
Add back PFI revenue costs on a UK GAAP basis	0	0	0	(24,350)	(23,939)	411	**(24,350)**	**(23,939)**	**411**
Adjusted financial performance surplus/(deficit)	**409**	**416**	**7**	**(4,518)**	**(4,503)**	**15**	**(4,109)**	**(4,087)**	**22**

At the end of Month 4 2025/26 the Group is reporting a favourable variance of £22k, with a variance of £7k relating to NTH and £15k relating to STH.

The main drivers of the **NTH Month 4 position** are:

- Clinical Income is behind plan by £1.2m. This is due a net-neutral reclassification of hosted UTC income, which has been offset by ERF assumptions for YTD activity and drugs & devices income. The YTD position assumes payment of £1.2m ERF income above the levels included in commissioner contract mandates, assuming payment in line with PbR rules.
- Other operating income (excluding donated asset income) is £0.7m ahead of plan, mainly relating to education income.
- Interest receivable is ahead of plan by £0.4m, reflecting current interest rates and cash balances.
- Non-Pay is ahead of plan by £2.8m, of relates to reclassification of hosted UTC expenditure to net cost, which is offsetting overspends in clinical supplies and drugs, linked to higher activity levels alongside slippage on CIP delivery.
- Pay is £3.7m behind plan due to increased demand for Enhanced Care, weekend working linked to activity, industrial action, pay award pressures and slippage on CIP delivery.
- The year-to-date position includes the impact of additional non-recurrent measures ahead of the phased plan.

The main drivers of the **STH Month 4 position** are:

- Clinical Income is ahead of plan by £0.2m. This relates to assumed ERF income of £3.2m above commissioner contract mandates, in line with PbR rules.

However, this has been part offset by the under-recovery of planned income for relating to the FHN surgical hub, depreciation funding, and thoracic surgery.

- The Other Operating Income variance mainly relates to the Salix grant income which is removed from the Trusts reported control total position.
- Pay is £0.7m overspent and includes pressures from a shortfall in national pay award funding and Industrial action in July. Underspends on Bank Staff costs continue to offset an adverse variance on Agency expenditure.
- Non-Pay is £0.8m overspent, with overspends on clinical supplies and drugs offset by underspends against energy and estates costs.
- Interest receivable is ahead of plan by £0.4m, reflecting higher than plan cash balances.
- The year-to-date position includes the impact of additional non-recurrent measures ahead of the phased plan.

Agency and Bank Expenditure

Reductions in temporary staffing and premium pay costs are a national priority set by NHSE.

The 2025/26 planning guidance included requirements to reduce agency spend by at least 30% from the prior year and to reduce bank spend by at least 10%.

The tables below show the position on agency and bank expenditure for the Group to the end of Month 4, comparing the year-to-date expenditure with the same period in the previous financial year (adjusted for inflation).

Across the Group, **YTD agency** expenditure was £2.5m. This was £0.6m higher than plan, largely relating to Consultant agency which was £0.4m over at STH and at £0.3m over at NTH.

However, total agency expenditure was £0.7m (21%) less than the agency expenditure incurred at the same point in the previous year (adjusted for inflation), largely relating to nursing agency reductions at NTH.

Across the Group, **YTD bank** expenditure was £9.2m. This was £0.9m less than plan, largely relating to Nursing and HCA Bank at STH which was under by £1.1m overall.

Total bank expenditure was £1.6m (15%) less than the bank expenditure incurred at the same point in the previous year (adjusted for inflation).

AGENCY YTD	NTH					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	313	35	-278	1,134	-1,099	-97%
AHP and S&T	108	220	112	96	124	128%
Other Clinical	0	0	0	0	0	-
Consultants	304	573	269	727	-154	-21%
Career/staff grades	0	0	0	38	-38	-100%
Trainee grades	0	22	22	0	22	-
Non Clinical	0	26	26	31	-5	-17%
TOTAL	**725**	**876**	**151**	**2,026**	**-1,150**	**-57%**

BANK YTD	NTH					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	1,593	1,681	88	1,630	51	3%
AHP and S&T	220	235	15	238	-3	-1%
Other Clinical	1,625	1,912	287	1,619	293	18%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	0	0	0	0	0	-
Non Clinical	249	202	-47	311	-109	-35%
TOTAL	**3,687**	**4,030**	**343**	**3,798**	**232**	**6%**

AGENCY YTD	STH					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	69	37	-32	106	-69	-65%
AHP and S&T	81	212	131	22	190	864%
Other Clinical	14	0	-14	0	0	-
Consultants	904	1,268	364	967	301	31%
Career/staff grades	0	-6	-6	0	-6	-
Trainee grades	0	0	0	0	0	-
Non Clinical	19	69	50	3	66	2096%
TOTAL	**1,087**	**1,580**	**493**	**1,097**	**483**	**44%**

BANK YTD	STH					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	2,958	2,338	-620	3,252	-914	-28%
AHP and S&T	70	42	-28	43	-1	-2%
Other Clinical	2,514	2,072	-442	2,943	-871	-30%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	564	468	-96	459	9	2%
Non Clinical	290	261	-29	330	-69	-21%
TOTAL	**6,396**	**5,181**	**-1,215**	**7,026**	**-1,845**	**-26%**

AGENCY YTD	UHT GROUP					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	382	72	-310	1,240	-1,168	-94%
AHP and S&T	189	432	243	118	314	265%
Other Clinical	14	0	-14	0	0	-
Consultants	1,208	1,841	633	1,693	148	9%
Career/staff grades	0	-6	-6	38	-44	-116%
Trainee grades	0	22	22	0	22	-
Non Clinical	19	95	76	35	60	175%
TOTAL	**1,812**	**2,456**	**644**	**3,124**	**-668**	**-21%**

BANK YTD	UHT GROUP					
	Plan	Actual	Variance	Adjusted Prior Yr	Change	
	£000	£000	£000	£000	£000	%
Nursing	4,551	4,019	-532	4,882	-863	-18%
AHP and S&T	290	277	-13	281	-4	-1%
Other Clinical	4,139	3,984	-155	4,562	-578	-13%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	564	468	-96	459	9	2%
Non Clinical	539	463	-76	641	-178	-28%
TOTAL	**10,083**	**9,211**	**-872**	**10,824**	**-1,613**	**-15%**

Workforce

Growth in workforce remains an area of significant national and regional scrutiny, linked to the reductions in productivity and growth in non-clinical roles that has been noted across the NHS.

The table below shows the WTE actual worked in Month 4 (split between Substantive, Bank, and Agency staff) compared to each of:

- the average monthly WTE worked in 2019/20 (the pre-Covid baseline),
- the average monthly WTE worked in 2023/24,
- the average monthly WTE worked in 2024/25 (the previous financial year); and
- the previous month.

WTE worked data has been used (taken directly from the General Ledger), to ensure consistency between different reporting periods and to provide the best correlation to the actual pay costs incurred.

WTE Worked	19/20 Average p.m.	23/24 Average p.m.	24/25 Average p.m.	Mth 1 25/26	Mth 2 25/26	Mth 3 25/26	Mth 4 25/26	Change from prior month	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg	Change from M4 24/25
NTH												
Agency	20.38	63.89	35.17	15.19	18.59	16.19	14.85	-1.34	-5.53	-49.04	-20.32	-19.33
Bank	186.45	234.11	247.00	235.92	249.09	237.66	248.04	10.38	61.59	13.93	1.04	11.69
Substantive	4,659.47	5,130.23	5,325.94	5,321.47	5,288.04	5,271.19	5,255.78	-15.41	596.31	125.55	-70.16	-31.96
Sub Total	**4,866.30**	**5,428.23**	**5,608.11**	**5,572.58**	**5,555.72**	**5,525.04**	**5,518.67**	**-6.37**	**652.37**	**90.44**	**-89.44**	**-39.60**
STH												
Agency	25.51	34.62	18.73	15.35	13.82	18.36	21.17	2.81	-4.34	-13.45	2.44	1.25
Bank	198.01	393.05	347.40	280.34	278.92	267.82	312.62	44.80	114.61	-80.42	-34.78	-53.00
Substantive	7,836.68	9,235.07	9,492.43	9,626.24	9,588.64	9,577.85	9,582.45	4.60	1,745.77	347.38	90.02	234.12
Sub Total	**8,060.20**	**9,662.74**	**9,858.56**	**9,921.93**	**9,881.38**	**9,864.03**	**9,916.24**	**52.21**	**1,856.04**	**253.50**	**57.68**	**182.37**
UHT GROUP												
Agency	45.89	98.51	53.90	30.54	32.41	34.55	36.02	1.47	-9.87	-62.49	-17.88	-18.08
Bank	384.46	627.16	594.40	516.26	528.01	505.48	560.66	55.18	176.20	-66.49	-33.74	-41.31
Substantive	12,496.15	14,365.30	14,818.37	14,947.71	14,876.68	14,849.04	14,838.23	-10.81	2,342.08	472.93	19.86	202.16
Grand Total	**12,926.50**	**15,090.97**	**15,466.68**	**15,494.51**	**15,437.10**	**15,389.07**	**15,434.91**	**45.84**	**2,508.41**	**343.94**	**-31.76**	**142.77**

Month 4 shows a net overall increase of 45.84wte worked across the Group, compared to the WTE worked reported in the previous month, largely relating to bank staff at STH.

WTEs worked in month were 31.76wte lower than the average of the previous financial year. However, compared to the same period last year (Month 4) WTEs worked were higher by 142.77wte. This remains higher than the average deployed during 2019/20 (pre-Covid), by 2,508.41wte (19.4%)

The table below provides an analysis of WTE worked data split by staff grouping:

WTE Worked	19/20 Average p.m.	23/24 Average p.m.	24/25 Average p.m.	Mth 1 25/26	Mth 2 25/26	Mth 3 25/26	Mth 4 25/26	Change from prior month	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg	Change from M4 24/25
NTH												
Nursing & Midwifery	1,381.12	1,607.51	1,682.30	1,707.14	1,700.56	1,688.89	1,698.04	9.15	316.92	90.53	15.74	35.47
Medical & Dental	535.14	555.47	585.95	604.00	599.78	597.75	592.79	-2.03	62.61	42.28	11.80	30.45
AHP, Sci., Ther.&Tech.	540.32	588.28	603.99	567.81	558.28	561.53	567.12	3.25	21.21	-26.75	-42.46	-41.36
HCAs & Support Staff	949.52	1,051.64	1,050.01	1,014.26	1,030.79	1,019.23	1,019.64	-11.56	69.71	-32.41	-30.78	-16.09
Non Clinical	1,460.20	1,625.34	1,685.87	1,679.37	1,666.31	1,657.64	1,641.08	-8.67	197.44	32.30	-28.23	-4.64
Sub Total	**4,866.30**	**5,428.24**	**5,608.11**	**5,572.58**	**5,555.72**	**5,525.04**	**5,518.67**	**-9.86**	**667.89**	**105.95**	**-73.92**	**3.83**
STH												
Nursing & Midwifery	2,506.06	2,958.13	3,095.50	3,136.66	3,143.74	3,157.27	3,170.34	13.07	664.28	212.21	74.84	117.67
Medical & Dental	1,242.76	1,318.94	1,376.28	1,408.50	1,390.04	1,378.79	1,392.04	13.25	149.28	73.10	15.76	62.89
AHP, Sci., Ther.&Tech.	1,225.20	1,484.76	1,570.58	1,572.08	1,574.76	1,577.82	1,586.08	8.26	360.88	101.32	15.50	35.67
HCAs & Support Staff	1,424.35	1,755.65	1,672.69	1,642.25	1,652.20	1,633.59	1,655.97	22.38	231.62	-99.68	-16.72	1.82
Non Clinical	1,661.83	2,145.27	2,143.50	2,162.44	2,120.64	2,116.56	2,111.81	-4.75	449.98	-33.46	-31.69	-35.68
Sub Total	**8,060.20**	**9,662.74**	**9,858.56**	**9,921.93**	**9,881.38**	**9,864.03**	**9,916.24**	**52.21**	**1,856.04**	**253.50**	**57.68**	**182.37**
UHT GROUP												
Nursing & Midwifery	3,887.18	4,565.64	4,777.80	4,843.80	4,844.30	4,846.16	4,868.38	22.22	981.21	302.74	90.58	153.14
Medical & Dental	1,777.90	1,874.41	1,962.23	2,012.50	1,989.82	1,976.54	1,984.83	11.22	211.89	115.38	27.56	93.34
AHP, Sci., Ther.&Tech.	1,765.52	2,073.04	2,174.57	2,139.89	2,133.04	2,139.35	2,153.20	11.51	382.09	74.57	-26.96	-5.69
HCAs & Support Staff	2,373.87	2,807.29	2,722.71	2,656.51	2,682.99	2,652.82	2,675.61	10.82	301.33	-132.09	-47.50	-14.27
Non Clinical	3,122.03	3,770.61	3,829.37	3,841.81	3,786.95	3,774.20	3,752.89	-13.42	647.42	-1.16	-59.92	-40.32
Sub Total	**12,926.50**	**15,090.98**	**15,466.68**	**15,494.51**	**15,437.10**	**15,389.07**	**15,434.91**	**42.35**	**2,523.93**	**359.45**	**-16.24**	**186.20**

As can be seen the Month 4 position includes a reduction of 40.32wte Non Clinical staff compared to the same period last financial year, with an in-month reduction of 13.42wte across the Group.

Efficiency

The plan assumes delivery of an overall efficiency target for the Group of £73.1m. The table below shows the current planning position against the target:

	NTH				STH				GROUP			
2025/26 Total Plan	**Plan £000**	**Forecast £000**	**(Gap) / Surplus £000**	**% Delivery**	**Plan £000**	**Forecast £000**	**(Gap) / Surplus £000**	**% Delivery**	**Plan £000**	**Forecast £000**	**(Gap) / Surplus £000**	**% Delivery**
Fully Developed	8,756	9,331	575	107%	2,187	36,301	34,114	1660%	10,943	45,632	34,689	417%
Plans in Progress	2,961	6,838	3,877	231%	42,072	11,201	-30,871	27%	45,033	18,039	-26,994	40%
Opportunity	4,839	8,532	3,693	176%	4,241	998	-3,243	24%	9,080	9,530	450	105%
Unidentified	8,017	0	-8,017	0%	0		0	-	8,017	0	-8,017	0%
Total	**24,573**	**24,701**	**128**	**101%**	**48,500**	**48,500**	**0**	**100%**	**73,073**	**73,201**	**128**	**100%**
High Risk	12,860	2,689	-10,171	21%	24,305	9,307	-14,998	38%	37,165	11,996	-25,169	32%
Medium risk	2,426	4,909	2,483	202%	13,403	13,087	-316	98%	15,829	17,996	2,167	114%
Low Risk	9,287	17,104	7,817	184%	10,791	26,106	15,315	242%	20,078	43,210	23,131	215%
Total	**24,573**	**24,701**	**128**	**101%**	**48,500**	**48,500**	**0**	**100%**	**73,073**	**73,201**	**128**	**100%**

Since Final Plan submission in March there has been positive movement in development of schemes and de-risking of the programme, as schemes are progressed to completion of full PID and QEIA documentation. At the end of the reporting period none of the CIP programme remains 'Unidentified', however £9.5m remains defined as 'Opportunity'. £12.0m of the programme remains as High Risk (which is a reduction of £25.2m since plan submission).

The table below show the year-to-date delivery against the Group's efficiency targets:

	NTH				STH				GROUP			
YTD Month 4 Delivery	**YTD Target £000**	**YTD Actual £000**	**YTD Variance £000**	**% Delivery**	**YTD Target £000**	**YTD Actual £000**	**YTD Variance £000**	**% Delivery**	**YTD Target £000**	**YTD Actual £000**	**YTD Variance £000**	**% Delivery**
Pay	4,826	2,804	-2,022	58%	4,413	4,560	147	103%	9,239	7,364	-1,875	80%
Non Pay	2,529	2,792	263	110%	8,038	7,515	-523	93%	10,567	10,307	-260	98%
Income	459	1,812	1,353	395%	1,593	1,635	42	103%	2,052	3,447	1,395	168%
Total	**7,814**	**7,408**	**-406**	**95%**	**14,044**	**13,710**	**-334**	**98%**	**21,858**	**21,118**	**-740**	**97%**
Recurrent	4,438	3,996	-442	90%	10,693	6,958	-3,735	65%	15,131	10,954	-4,177	72%
Non-recurrent	3,376	3,413	37	101%	3,351	6,751	3,400	201%	6,727	10,164	3,437	151%
Total	**7,814**	**7,409**	**-405**	**95%**	**14,044**	**13,710**	**-334**	**98%**	**21,858**	**21,118**	**-740**	**97%**

Across the Group, overall year-to-date delivery is £21.1m (97% of target). However, delivery of recurrent savings is behind plan at the end of Month 4, constituting 72% of YTD delivery across the Group.

Work continues through the Site leadership teams to identify and deliver efficiency savings to meet the targets, with escalation meetings held with Care Groups, Collaboratives and Corporate Services, and with oversight from the UHT FROG meeting. FROG is now chaired by the CEO and membership has been expanded to include wider representation from the Executive team, to ensure continued focus and prioritisation of de-risking of the efficiency programme.

Capital

The Group's gross capital expenditure plan for the 2025/26 financial year totals £66.8m.

The Group's ICS Capital Departmental Expenditure Limit (CDEL) for 2025/26 amounts to £37.9m, including ICS approved Constitutional Standards/Estates Safety schemes (that are funded through additional national PDC). For the 2025/26 financial year there are no separate CDEL allocations for IFRS16 right of use assets, and this capital expenditure must be managed within overall system allocations.

The capital programme also includes external support, in the form of Public Dividend Capital (PDC) of £6.5m, including support for RAAC eradication work and replacement of Linacs. The plan includes further de-carbonisation works, which is supported with further Salix grant funding of £13.9m across the Group. The plan also includes expected PFI lifecycle costs of £8.0m (the cost of which sits outside the ICS CDEL limit).

In addition, NTH has recently received confirmation of an additional £4m of bonus CDEL resource in relation to urgent and emergency care performance in 2024/25; however, this is not cash-backed.

The Group's capital expenditure to the end of Month 4 amounted to £8.5m, as detailed in the table below.

	NTH				STH				Group			
	Plan	YTD Plan	YTD Actual	Variance	Plan	YTD Plan	YTD Actual	Variance	Plan	YTD Plan	YTD Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Equipment	6,066	447	639	192	8,012	2,766	924	-1,842	**14,078**	**3,213**	**1,563**	**-1,650**
Digital	5,117	1,686	859	-827	2,080	524	810	286	**7,197**	**2,210**	**1,669**	**-541**
Estates	10,211	510	2,345	1,835	3,844	580	471	-109	**14,055**	**1,090**	**2,816**	**1,726**
PFI	0	0	0	0	8,163	2,681	2,654	-27	**8,163**	**2,681**	**2,654**	**-27**
Decarbonisation	1	0	0	0	13,928	4,644	928	-3,716	**13,929**	**4,644**	**928**	**-3,716**
RAAC	1,300	65	98	33	2,900	0	7	7	**4,200**	**65**	**105**	**40**
IFRS 16	876	-81	-1,277	-1,196	4,313	0	0	0	**5,189**	**-81**	**-1,277**	**-1,196**
Total Gross Capital	**23,571**	**2,627**	**2,664**	**37**	**43,240**	**11,195**	**5,794**	**-5,401**	**66,811**	**13,822**	**8,458**	**-5,364**

This is £5.4m slippage against the phasing of the 2025/26 year-to-date plan, largely relating to Salix grant funded schemes at STH.

The Group is currently forecasting outturn capital expenditure in line with CDEL allocations (including the additional £4m UEC incentive allocation received by NTH).

Liquidity

The cash balance at the end of Month 4 stood at £114.6m for the Group (with £54.7m relating to NTH and £59.9m relating to STH). The current cash forecast balances are £51.3m for NTH and £6.4m for STH.

NHSE have advised of changes to the deficit support regime for 2025/26, with regional assurance of plan delivery required to prevent funding being withheld. Deficit cash support for Q1 and Q2 has now been confirmed for NENC ICS, with the Q3 deficit support funding expected to be assessed against the Month 5 position.

This additional uncertainty means that continued close monitoring of cash will be essential throughout the course of the financial year. NHSE expect strong Board focus on delivery of agreed financial plans, with oversight of progress in de-risking plans and on delivery of efficiency plans and cost control.

The continued strong cash balances to date 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	25,773	72,673
Total bills paid within target	25,312	71,051
Percentage of bills paid within target	**98.2%**	**97.8%**

STH	YTD Number	YTD Value £000
Total bills paid in the year	34,384	219,792
Total bills paid within target	33,730	204,959
Percentage of bills paid within target	**98.1%**	**93.3%**

GROUP	YTD Number	YTD Value £000
Total bills paid in the year	60,157	292,465
Total bills paid within target	59,042	276,010
Percentage of bills paid within target	**98.1%**	**94.4%**

Statement of Financial Position

The table below shows the balance sheet position for the two Trusts as at the end of Month 4:

	NTH £000	STH £000
Non-current assets		
Intangible assets	2,229	7,683
On-SoFP IFRIC 12 assets	0	142,001
Other property, plant and equipment (excludes leases)	147,314	168,246
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	16,761	34,895
Receivables: due from NHS and DHSC group bodies	607	1,231
Receivables: due from non-NHS/DHSC Group bodies	1,283	2,305
Credit Loss Allowances	0	(2,760)
Total non-current assets	**168,194**	**353,601**
Current assets		
Inventories	7,060	15,237
Receivables: due from NHS and DHSC group bodies	2,530	28,332
Receivables: due from non-NHS/DHSC Group bodies	26,716	35,579
Credit Loss Allowances	(3,485)	(957)
Other Assets	0	3,558
Cash and cash equivalents: GBS/NLF	54,720	57,430
Cash and cash equivalents: commercial/in hand/other	1	2,460
Total current assets	**87,542**	**141,639**
Current liabilities		
Trade and other payables: capital	(2,145)	(9,671)
Trade and other payables: non-capital	(58,263)	(158,947)
Borrowings	(5,363)	(22,077)
Other financial liabilities	(1,192)	0
Provisions	(2,632)	(1,220)
Other liabilities: deferred income including contract liabilities	(7,687)	0
Total current liabilities	**(77,282)**	**(191,915)**
Total assets less current liabilities	**178,454**	**303,325**
Non-current liabilities		
Borrowings	(30,009)	(262,565)
Provisions	(1,578)	(1,368)
Total non-current liabilities	**(31,587)**	**(263,933)**
Total net assets employed	**146,867**	**39,392**
Financed by		
Public dividend capital	196,047	470,376
Revaluation reserve	12,937	32,807
Other reserves	0	26,476
Income and expenditure reserve	(62,117)	(490,267)
Total taxpayers' and others' equity	**146,867**	**39,392**

4. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 4 2025/26

University Hospitals Tees

Integrated Performance Report (reporting to end June 2025)

Meeting date: 4 September 2025

Reporting to: Board of Directors

Agenda item No: 4.3

Report author: Lucy Tulloch, Deputy Director Strategy & Planning and Lynsey Atkins, Associate Director Planning, Performance & Improvement

Executive director sponsor: Neil Atkinson, Managing Director

Action required: Discussion

Delegation status: Jointly delegated item to Group Board

Previously presented to: Resources Committee, Quality Assurance Committee, People Committee

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Quality and Safety

People

Finance Performance and Compliance

Key discussion points and matters to be escalated from the meeting

The UHT Integrated Performance Report (IPR) provides, within one document, a consistent presentation of key metrics for each trust, and an aggregate UHT 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. The IPR reports on the key standards by which Trusts' performance is monitored, reflecting the NHS Operating Framework 2025/26 published June 2025.

The IPR for reporting month of June 2025 is presented for information and discussion on the metrics for which the Board is alerted, advised or assured of performance.

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 IPR uses statistical process control, and expert judgment, to identify performance exceptions / consistent under-performance against plan, to alert to the Board and Committees.

For NTHFT, the following four performance metrics remain as Alert assurance.

- *E. coli* infections
- *Klebsiella* infections
- *Pseudomonas* infections
- Mandatory training (%)

In addition, for NTHFT five metrics have been regraded to Alert from Advise:
SAFE:

- Breast feeding at first feed

EFFECTIVE:

- Readmission rate

RESPONSIVE:

- 4-hour A&E standard
- RTT 52 week waiters (%)

WELL LED:

- Sickness Absence (%)

For STHFT, the following six performance metrics remain as Alert assurance:

- *Pseudomonas* infections
- Breast feeding at first feed
- Cancelled Operations Not Rebooked in 28 Days
- Diagnostic 6 Week standard
- Sickness Absence (%)
- Mandatory Training (%)

In addition, for STHFT two metrics have been regraded to Alert, from Advise:

SAFE:

- *E. coli* infections
- MRSA infections

Healthcare acquired infections (HCAI) trigger Alert where the number of cases year to date is 20% or more above trajectory (noting that plans can be in single figures). MRSA infections regraded from Advise due to one new case against a zero tolerance target. The IPR references the actions in hand to reduce infection cases, specific to each infection and to continuously improve infection prevention and control generally. These include behavioural interventions, antimicrobial stewardship, education, cleaning and fogging.

Breast feeding at first feed for NTHFT regraded from Advise, June 2025 is an outlier and performance needs improvement to meet plan, with focused input from the new infant feeding specialist roles.

Readmission rates (an unplanned readmission within thirty days of an admission) are being explored through focused clinical audit across UHT, to understand the reasons for the higher rates alerted for NTHFT.

4-hour A&E standard, reported in the IPR analysis alerts that the more challenging agreed operational plan for 4-hour standard held by NTHFT was not met, although the national recovery standard of 78% is consistently exceeded for NTHFT as one of the top performing trusts nationally. Data quality is also being investigated with the NTHFT EPR supplier. The lower performance for STHFT remains Advise, as the agreed lower recovery trajectory is within the range of variation of monthly performance.

Cancelled operations not rebooked within 28-days is consistently Alert for STHFT, with a theme of elective capacity constraints. The ambition is to reduce this to zero. There is renewed focus on this and pilots underway at STHFT to learn how best to avoid these breaches.

52 week waits at NTHFT regraded from Advise. June 2025 is outside (worse than) usual variance. Waiting list management is targeted towards the longest waiters.

Diagnostic 6-week standard remains Alert for STHFT as the improvement trend seen in recent months stalled. Whilst compliance in the major imaging modalities is high, some small and more specialist diagnostic services face capacity and demand challenges which increasingly impact on the overall compliance. Modality specific action plans are in place.
Sickness absence returned to Alert for NTHFT after the improvement trend stalled, and remain Alert for STHFT. Allocation of resources to a dedicated absence team to support consistent and compliant management of absence is expected to make a positive impact.

Mandatory training is consistently graded Alert for NTHFT and STHFT. The current focus is to ensure consistent alignment of Training Needs Analysis to roles across UHT. Work is underway to implement the national mandatory training policy, to ensure standardised reporting across UHT and to improve compliance across all face-to-face topics.

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 majority of IPR metrics remain graded Advise, for both Trusts.

In the SAFE domain, the **still birth rate** for NTHFT is regraded from Alert to Advise for NTHFT. The trend of increased still birth rate in the period October 2024 to April 2025 has now stabilised. Since October 2024, the still birth rate has been in line with Trust peer group benchmark and remains so, having previously been lower than benchmark.

In the RESPONSIVE domain, **Ambulance handovers within 45 minutes** is a new indicator for 25/26, replacing the 60-minute target, and graded Advise for STHFT.

Cancer 31 Day Standard regraded from Alert to advise for STHFT. Performance deteriorated August 2024 to March 2025 but has now stabilised.

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, assurance continues for seven metrics:

- Never Events
- *C. difficile* infections
- MSSA infections
- Summary Hospital-Level Mortality Indicator
- Feedback Acknowledged in 3 days
- Staff Turnover
- Annual Appraisal (%)

For STHFT, assurance continues for five metrics:

- *Klebsiella* infections
- Community UCR 2 Hour Response (%)
- Outpatient Experience (%)
- Community Experience (%)
- Staff Turnover

In the SAFE domain, **Neonatal Mortality Rate (rolling 12 months, per 1,000 births)** is a new metric this month, and performance is assured with lower mortality rates than national audit peer group Trusts.

In the RESPONSIVE domain, **Ambulance handovers within 45 minutes** is a new indicator graded Assure for NTHFT.

Recommendations:

Members of the Board are asked to:

- Receive the Integrated Performance Report for reporting period June 2025.
- Note that separate agenda items into the Committees, as set out in the annual cycles of business, 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.

NHS
University Hospitals Tees

Integrated Performance Report (IPR)

Reporting month: June 2025

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Overview

The IPR reports on the key standards by which Trusts' performance is monitored, reflecting the NHS Operating Framework 2025/26. They are underpinned by a broader range of metrics and evidence for clinical governance and operational management.

- **SAFE:** Patient Safety Incident Response Framework is embedded across UHT and thematic reviews are used to derive learning from incidents and near misses. NTHFT report seven consecutive months with no Never Events. There is continued focus in reducing healthcare acquired infections across UHT. Maternity metrics are reviewed against regional and national audit and peer group benchmarks, with both Trusts participating in the Maternity Services Improvement Support Programme.
- **EFFECTIVE:** Standardised mortality is 'as expected' for both Trusts. Readmissions rates differ between the two Trusts and relative to the national average, clinical audit and data quality checks are being undertaken to understand whether this variation is appropriate for the pathways of care, with oversight and monitoring via the Audit & Clinical Effectiveness Council.
- **RESPONSIVE:** Whilst the NHS constitutional standards remain, each Trust has an agreed plan for recovery towards the 25/26 operational standard or improvement ‘stretch’ trajectory relative to 24/25 performance in each metric. This contributes to the regional performance position.
- Ambulance handover delays are now reported against a 45-minute standard (replacing the 60-minute standard previously reported), with an improvement trend at STHFT and >99% compliance with handovers within 45 minutes at NTHFT.
- Both Trusts are focusing on the further improvement required to tackle waiting times for elective care, diagnostics and within cancer pathways. There is ongoing focus on ensuring the very longest waiters receive their treatment, there is not yet consistent improvement/achievement across the core metrics. Productivity improvements such as driving up theatre utilisation to create more capacity for patients awaiting surgery, waiting list validation and cancer pathway action plans are in place. STHFT receive additional performance scrutiny and support for improvement in cancer treatment waiting times under the NHS England performance management regime.
- **CARING:** The IPR demonstrates that both Trusts perform well in patient feedback surveys, around or above national average feedback scores across care settings. At STHFT, managing complaints to a timely closure is being addressed with senior leadership support.
- **WELL LED:** The improvement of working lives, staff retention and attendance is a focus for the People Directorate. The national People Promise will be implemented as part of the Group People Plan. Reduced staff turnover, assured below target, is embedded at both Trusts, and appraisal compliance is on an improvement trajectory. However sickness absence and mandatory training remain improvement priorities. A detailed absence plan and focus on whole time equivalent reduction (e.g. non-essential bank and agency work, scrutiny of recruitment requests) supports the Group's obligation to deliver the agreed financial position.

Regulation and Compliance

Regulated by CareQuality Commission

North Tees & Hartlepool Hospitals NHS Foundation Trust has an overall rating of Requires Improvement. Since the 2022 inspection, the CQC recommendations have been addressed and action plan completed. Independent audit is scheduled to provide further assurance.

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ Sept 2022	Requires improvement ↓ Sept 2022	Good → ← Sept 2022	Good → ← Sept 2022	Requires improvement ↓ Sept 2022	Requires improvement ↓ Sept 2022

South Tees Hospitals NHS Foundation Trust has an overall rating of Good. Since the 2023 CQC inspection 11 Must Do and 15 Should Do actions have been completed. The remaining 2 Must Do and 5 Should Do actions have seen significant progress in assurance around Resuscitation and Safeguarding training in ED improvements in SDR compliance across the Friarage Hospital and Community Services. These actions will continue to be monitored monthly by the CQC Compliance Group. until sustained improvement has been achieved.

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ May 2023	Good ↑ May 2023	Good → ← May 2023	Good → ← May 2023	Good ↑ May 2023	Good ↑ May 2023

CQC assessment ratings per hospital site and service can be found on the CQC website.

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Provider Performance Summary

	Urgent & Emergency Care					Elective care												Cancer			
Provider	A&E 4 hour standard	12 hour delay from DTA	% A&E Type 1 Attendances >12hrs from arrival	Ambulance handovers 30-60 mins	Ambulance handovers 60+ mins	RTT -18 week standard	RTT - 52+ ww %age of WL	RTT - Time to 1st Appt	52+ week waits	65+ week waits	78+ week waits	104+ week waits	RTT total Waiting List	OPFU - YTD growth 25/26 v 24/25	1st OP - YTD growth 25/26 v 24/25	Total elective - YTD growth 25/26 v 24/25	Diagnostic activity 25/26 v 24/25	Diagnostic 6 week waits	Cancer 62 day	Cancer 62 day backlog	Cancer treatments (first and subsequent)	Cancer 28 day FD
Data period	Jun-25	Jun-25	Jun-25	Jun-25	Jun-25	May-25	May-25	Jun-25	May-25	May-25	May-25	May-25	May-25	May-25	May-25	May-25	May-25	May-25	May-25	Jun-25	May-25	May-25
25/26 Ambition	78%	Zero	25/26 Plan			25/26 Plan	< 1%	25/26 Plan	25/26 Plan	Zero	Zero	Zero	25/26 Plan					<=5%	75%			80%
North Tees & Hartlepool NHSFT	84.1%	11	0.0%	104	1	74.5%	1.0%	81.1%	217	0	0	0	20,964	113%	115%	105%	82%	3.7%	58.0%	127	211	78.6%
South Tees Hospitals NHSFT	76.5%	6	3.2%	365	47	62.1%	2.8%	65.4%	1,599	113	4	0	56,476	105%	103%	99%	102%	17.0%	60.4%	168	686	73.8%
NENC ICS Provider level *(including IS providers)*	78.8%	472	4.1%	2,278	515	70.8%	1.3%	74.9%	4,787	253	26	0	364,874	102%	107%	102%	99%	13.3%	67.0%	1,017	3,476	74.7%
North East & Yorkshire	76.8%		5.1%			66.4%												19.3%	65.5%			72.6%
National	75.5%		8.8%			60.9%												22.0%	67.8%			74.8%

Urgent and emergency care metrics continue to show good performance for NTHFT in June compared to regional and national benchmarks. 4-hour performance remains a strategic risk for STHFT with actions reviewed weekly by the operational team. Reducing ambulance handover delays and the longest department waits are a priority, in line with planning guidance, whilst further improving patient experience by developing alternatives to ED pathways.

Elective care metrics show an RTT 18-week standard at NTHFT that is above the national and ICS average. STHFT met operational plan in May and was above national average. Both trusts are committed to improving RTT compliance by 5% in 25/26. Achievement of this standard is a strategic risk for both trusts, with actions focusing increasing outpatient productivity. NTHFT focus is on ensuring patients wait no longer than 52 weeks whilst STHFT services are working to eliminate waits above 65 weeks.

Cancer 62-day standard is a strategic risk for both Trusts. In May, both Trusts were under-performing against recovery trajectories for cancer access standards. STHFT has been in tiering support with NHS England for the 62-day standard since February 2025. Actions and progress are discussed fortnightly, providing NHSE with assurance that all relevant actions are in hand. These focused on reducing delays in specific tumour pathways, whilst investment in cancer navigators in focus specialties helps to ensure individual cases are proactively pursued through the diagnostic and treatment steps. Pathway improvements will however take several months to impact on the headline metrics, interim process measures are used to track progress internally.

North Tees & Hartlepool assurance summary

ALERT

No change in assurance

- *E. coli* infections
- *Klebsiella* infections
- *Pseudomonas* infections
- Mandatory Training (%)

New ALERT indicators

Breast feeding at first feed regraded from Advise. June 2025 is an outlier and performance needs improvement to meet plan, with focused input from the new infant feeding specialist roles.
Readmission rate regraded from Advise, as now consistently higher than national average.
4-hour A&E standard regraded from Advise. NTHFT plan for June 2025 is outside the upper range of variation of recent performance. This reflects a challenging plan agreed with NENC ICB.
RTT 52 Week Waiters (%) regraded from Advise. June 2025 is outside (worse than) usual variance.
Sickness Absence (%) regraded from Advise. Improvement trend stalled in June 2025.

ADVISE

No change in assurance

- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Falls with Harm per 1000 Bed Days
- MRSA infections
- PPH >= 1500ml rate per 1,000 births
- 3rd/4th Degree Tear (%)
- 12-Hour ED Breaches Rate (%)
- Cancelled operations not rebooked in 28 days
- Community UCR 2 Hour Response (%)
- Cancer Faster Diagnosis
- Cancer 31 Day Standard
- Cancer 62 Day Standard
- Diagnostic 6 Week Standard
- RTT Incomplete Pathways
- RTT time to first appointment (%)
- A&E Experience (%)
- Inpatient Experience (%)
- Maternity Experience (%)
- Outpatient Experience (%)
- Community Experience (%)
- Complaints Closed Within Target (%)
- Cumulative YTD Financial Position (£Millions)

New ADVISE indicators

Still birth rate regraded from Alert. The trend of increased still birth rate in the period October 2024 to April 2025 has now stabilised. Since October 2024, the still birth rate has been in line with Trust peer group benchmark and remains so, having previously been lower than benchmark.

ASSURE

No change in assurance

- Never Events
- *C. difficile* infections
- MSSA infections
- Summary Hospital-Level Mortality Indicator
- Feedback Acknowledged in 3 days
- Staff Turnover
- Annual Appraisal (%)

New ASSURE indicators

Neonatal Mortality Rate (rolling 12 months, per 1,000 births) is a new metric this month, and performance is assured with lower mortality rates than national peers.
Ambulance handovers within 45 minutes is a new indicator for 25/26, replacing the 60-minute target.

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South Tees Hospitals assurance summary

No change in assurance — ALERT — New ALERT indicator

- *Pseudomonas* infections
- Breast feeding at first feed
- Cancelled operations not rebooked in 28 days
- Diagnostic 6 Week (%)
- Sickness absence (%)
- Mandatory training (%)

MRSA infections regraded from Advise, one new case in June agaisnt a zero tolerance target.

***E. coli* infections** regraded from Advise. A higher number of infections in June take the year-to-date position to 21% more (worse) than trajectory.

No change in assurance — ADVISE — New ADVISE indicator

- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Never Events
- Falls with Harm per 1000 Bed Days
- *C. difficile* infections
- MSSA infections
- Still birth rate
- PPH >= 1500ml rate per 1,000 births
- 3rd/4th Degree Tear (%)
- Summary Hospital-Level Mortality Indicator
- Readmission rate
- 4-Hour A&E Standard (%)
- 12-Hour ED Breaches Rate (%)
- Cancer Faster Diagnosis
- Cancer 62 Day Standard
- RTT Incomplete Pathways
- RTT 52 Week Waiters (%)
- RTT time to first appointment (%)
- A&E Experience (%)
- Inpatient Experience (%)
- Maternity Experience (%)
- Feedback Acknowledged in 3 Days (%)
- Complaints Closed Within Target (%)
- Annual Appraisal (%)
- Cumulative YTD Financial Position (£Millions)

Ambulance handovers within 45 minutes is a new indicator for 25/26, replacing the 60-minute target.

Cancer 31 Day Standard regraded from Alert. Performance deteriorated August 2024 to March 2025 but has now stabilised.

No change in assurance — ASSURE — New ASSURE indicator

- *Klebsiella* infections
- Community UCR 2 Hour Response (%)
- Outpatient Experience (%)
- Community Experience (%)
- Staff Turnover

Neonatal Mortality Rate (rolling 12 months, per 1,000 births) is a new metric this month, and performance is assured with lower mortality rates than national audit peer group Trusts

Caring Better Together

Index of metrics

SAFE DOMAIN
Responsibility: Quality Assurance Committee

Incidents per 1000 Bed Days
Patient Safety Incident Investigations
Never Events
Falls with Harm per 1000 Bed Days
C. difficile infections
MRSA infections
E. coli infections
MSSA infections
Klebsiella infections
Pseudomonas infections
Babies Born
Still Births Rate (Rolling 12 months, per 1000 Births)
Breast Feeding at First Feed (%)
PPH >= 1500ml Rate per 1,000 births
3rd/4th Degree Tear (%)
Neonatal Mortality Rate (rolling 12 months, per 1,000 births)

EFFECTIVE DOMAIN
Responsibility: Quality Assurance Committee

Summary Hospital-Level Mortality Indicator
Readmission Rate (%)

RESPONSIVE DOMAIN
Responsibility: Resources Committee

NEAS Handovers – Over 45 mins (%)
4-Hour A&E Standard (%)
12-Hour ED Breaches Rate (%)
Community UCR 2 Hour Response (%)
Cancelled Operations Not Rebooked in 28 Days
Cancer Faster Diagnosis Standard (%)
Cancer 31 Day Standard (%)
Cancer 62 Day Standard (%)
Diagnostic 6 Weeks Standard (%)
RTT Incomplete Pathways (%)
RTT 52 Week Waiters (%)
RTT Time to First Appointment (%)

CARING DOMAIN
Responsibility: Quality Assurance Committee

A&E Experience (%)
Inpatient Experience (%)
Maternity Experience (%)
Outpatient Experience (%)
Community Experience (%)
Feedback Acknowledged in 3 Days (%)
Complaints Closed Within Target (%)

WELL LED DOMAIN
Responsibility: People Committee, *Resources Committee (Finance only)

Sickness Absence (%)
Staff Turnover (%)
Annual Appraisal (%)
Mandatory Training (%)
*Cumulative YTD Financial Position (£Millions)

SAFE DOMAIN SUMMARY

Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

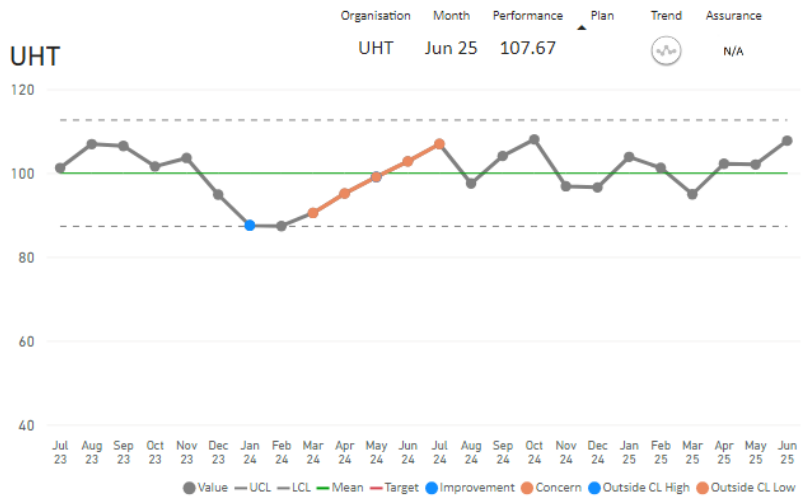
The Patient Safety Incident Response Framework (PSIRF)was implemented across UHT from January 2024. There is an external evaluation of the Group's implementation of PSIRF currently underway, which will further align the arrangements for patient safety across UHT.

Healthcare-acquired infections (HCAI) continue to be closely tracked by the Infection Prevention Committee and an Improvement Plan developed and initiated. The focus continues in respect of embedding the actions across the organisation into practice. The *C. difficile* and MRSA care pathways are now live in the STHFT electronic patient record system, MIYA, with the remaining IPC pathways in development. These will support and prompt clinicians in best practice in prescribing and management of infections. The Antimicrobial Working Group is also being re-established with a clear focus on NHS England KPI's aligned to prescribing to support with the reduction of HCAI's.

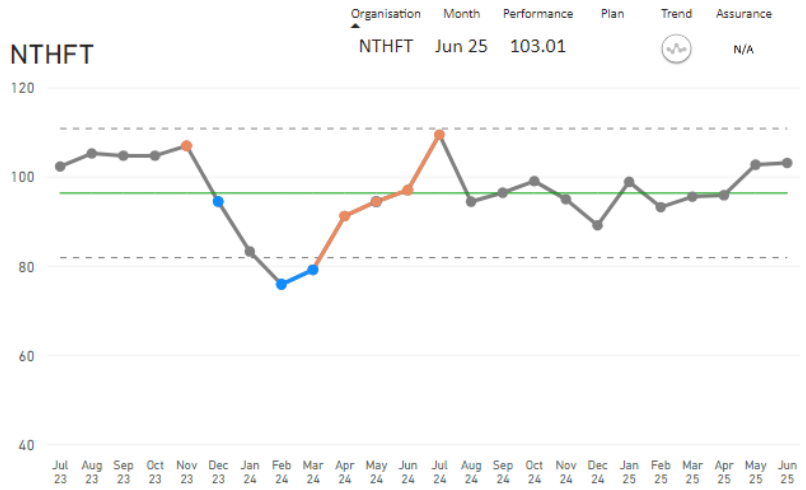
North Tees & Hartlepool NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Incidents Per 1000 Bed Days		109.35	94.32	96.33	98.92	94.86	89.01	98.76	93.1	95.44	95.77	102.61	103.01
Patient Safety Incident Investigations		2	3	1	3	2	0	1	0	1	0	1	1
Never Events	0	0	0	0	1	0	0	0	0	0	0	0	0
Falls With Harm Rate (Per 1000 Bed Days)		0	0.22	0.28	0.07	0.27	0.14	0.19	0.37	0.27	0	0.28	0.29
C-Difficile	5	10	6	3	9	2	1	5	6	7	6	1	4
MRSA	0	0	1	1	1	1	1	0	0	0	0	0	0
E-Coli	6	10	7	13	13	5	3	6	6	4	8	10	6
MSSA	3	2	2	5	6	4	6	9	2	1	3	3	4
Klebsiella	2	2	5	3	4	2	2	1	0	5	4	4	4
Pseudomonas	1	0	2	0	2	2	2	2	0	2	4	3	1

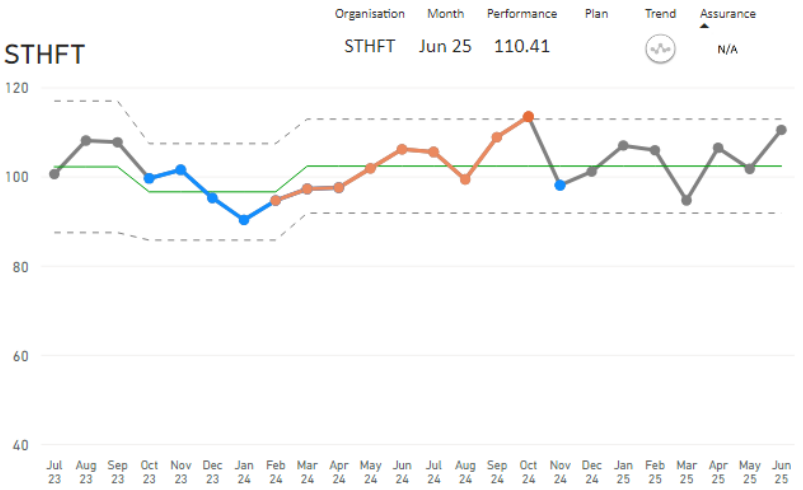
South Tees Hospitals NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Incidents Per 1000 Bed Days		105.47	99.31	108.78	113.38	98.01	101.06	106.9	105.86	94.61	106.4	101.67	110.41
Patient Safety Incident Investigations		1	1	0	1	0	1	0	0	0	1	0	1
Never Events	0	0	1	0	2	0	1	0	0	0	0	0	0
Falls With Harm Rate (Per 1000 Bed Days)		0.12	0.08	0.04	0.16	0.21	0.24	0.12	0.25	0.28	0.37	0.12	0.17
C-Difficile	10	15	13	9	11	17	11	13	15	10	13	11	11
MRSA	0	0	1	0	0	1	0	0	0	3	0	0	1
E-Coli	11	12	13	11	17	12	14	18	10	17	16	11	14
MSSA	4	5	5	8	11	4	6	5	9	11	3	10	5
Klebsiella	5	9	4	6	8	1	3	5	4	2	4	2	3
Pseudomonas	2	3	2	1	3	1	0	1	1	3	3	3	1

SAFE Incidents Per 1000 Bed Days



Metric: Incidents rate per 1000 bed days
Plan: n/a
Rationale: Enables benchmarking.
Data quality: Assured. Each incident is validated. A review has been completed to ensure that bed days data and incident reporting are standardised across UHT. This alignment has brought the reported incidents per 1000 bed days to comparable rates across UHT.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: n/a
Action taken: As national data is not available for comparison, the ICB have been contacted to support regional benchmarking for additional context, Q2 25/26.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

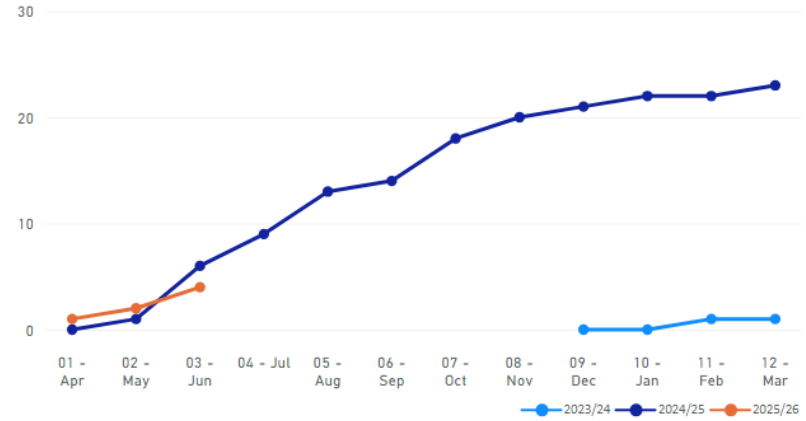




SAFE Patient Safety Incident Investigations (YTD)

UHT

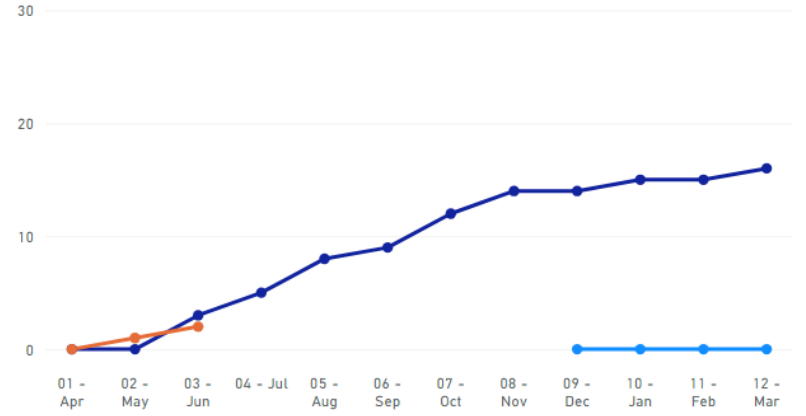
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Jun 25	4		N/A	N/A



Metric: PSIIs initiated, cumulative annually from April.
Plan: n/a. An open reporting culture is encouraged.
Rationale: NHS Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 1 PSII in June 2025. STHFT: 1 PSDII in June 2025.
Assurance: NTHFT: Advise, 2 PSII YTD. STHFT: Advise, 2 PSII YTD.
Action taken: Incidents are reviewed at weekly site LRPs, to determine how they are investigated under PSIRF. An external evaluation of PSIRF across UHT concluded in July 2025; the draft report is being reviewed.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

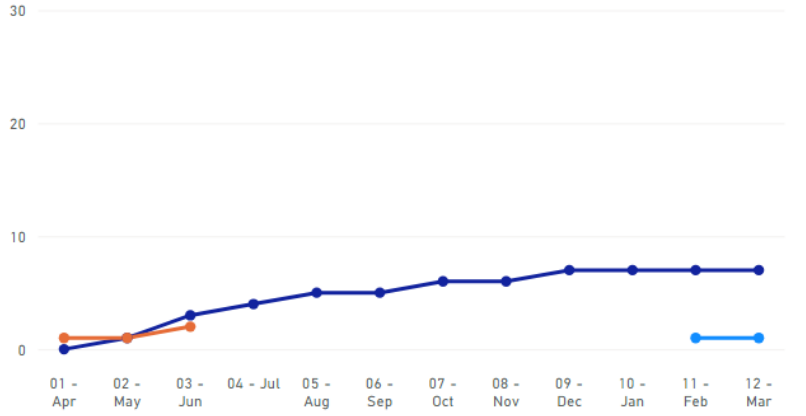
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Jun 25	2		N/A	N/A

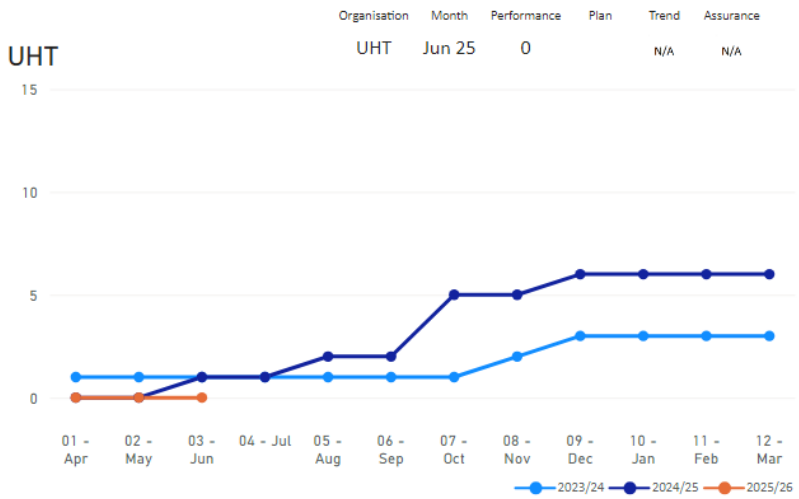


STHFT

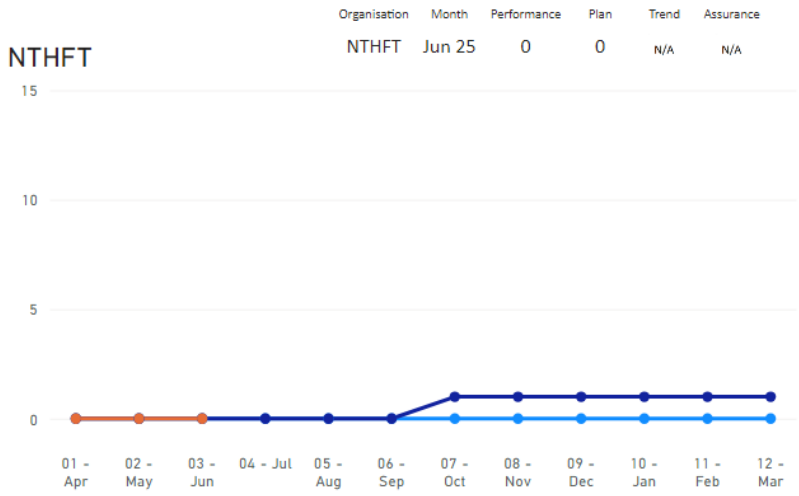
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Jun 25	2		N/A	N/A

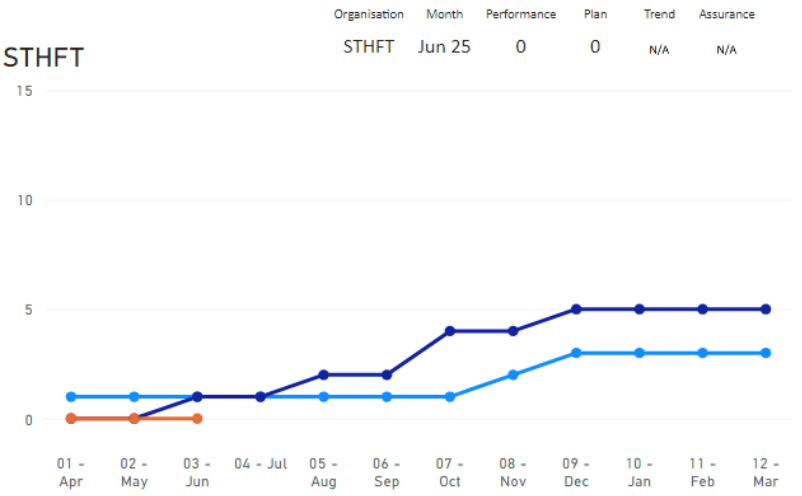


SAFE Never Events (YTD)



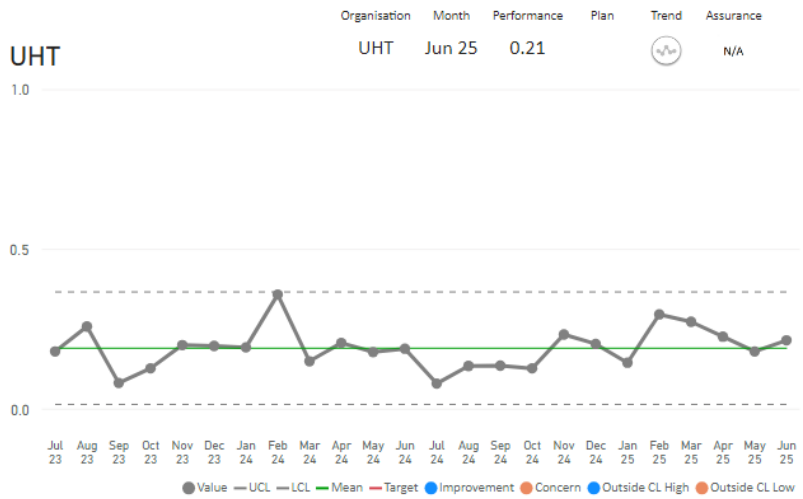
Metric: Never Events (a defined list of serious preventable errors), cumulative annually from April.
Plan: Zero.
Rationale: NHS Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 0 Never Event YTD. STHFT: 0 Never Events YTD.
Assurance: NTHFT: Assure, no new events for 8 months. STHFT: Advise. No new events for 6 months.
Action taken: n/a.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

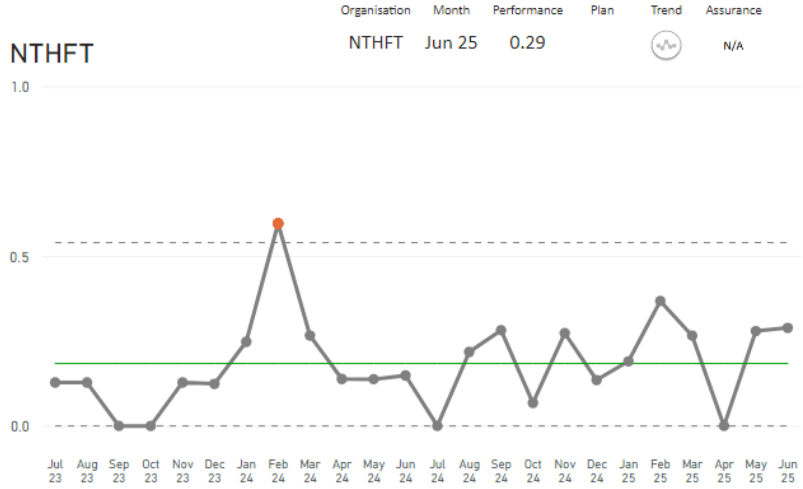


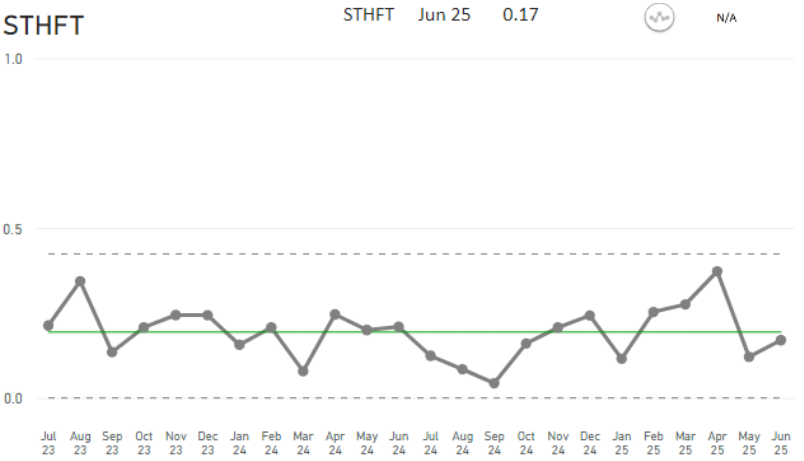


Caring Better Together

SAFE Falls With Harm Rate (Per 1000 Bed Days)





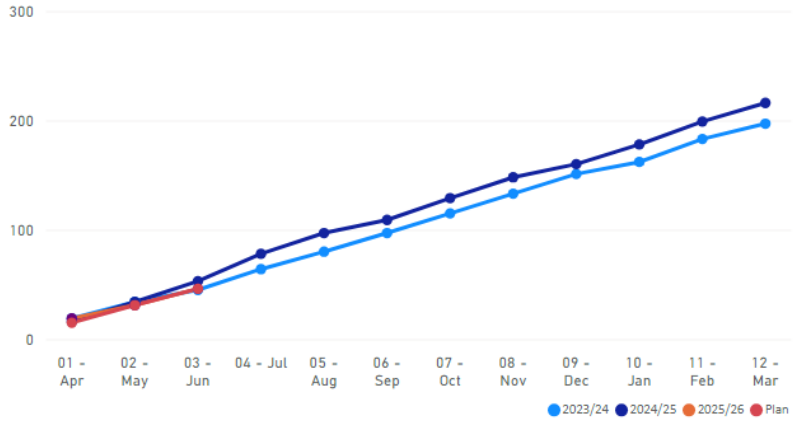


Metric: Falls resulting in harm graded moderate and above, as a rate per 1000 inpatient bed-days.
Plan: n/a
Rationale: NHS Quality Accounts regulatory indicator. National Audit of Inpatient Falls.
Data quality: Assured. Each incident is validated. A review has been completed to ensure that the calculation of falls with harm rate is standardised across UHT. This alignment has brought the reported falls with harm per 1000 bed days to comparable mean rates across UHT.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: n/a
Action taken: The focus is on thematic learning from falls, targeted interventions and bringing together a single UHT approach.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE C-Difficile (YTD)

UHT

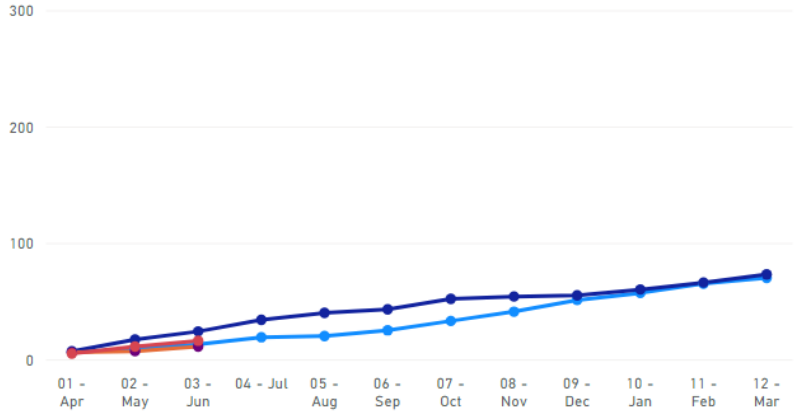
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Jun 25	46	46	N/A	N/A



Metric: Healthcare associated cases of *Clostridioides difficile*, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 4 new cases in June (trajectory of 5).
STHFT: 11 new cases in June (trajectory of 10).
Assurance: NTHFT: Assure, better than trajectory YTD.
STHFT: Advise, 17% more cases than trajectory YTD.
Action taken: Review of cleaning products across UHT.
Process for rapid learning reviews at STHFT underway.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

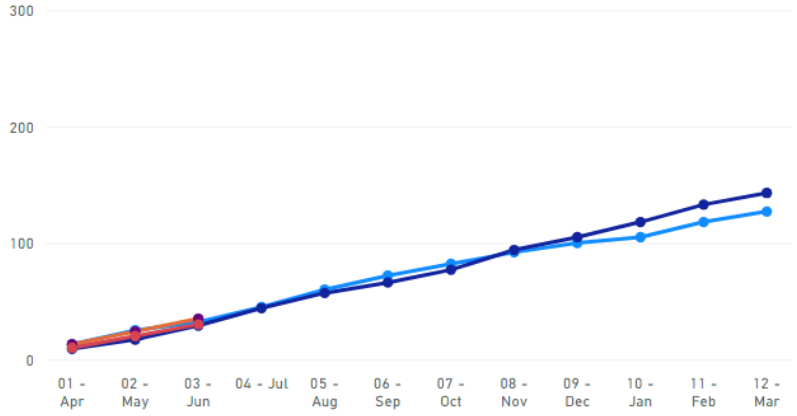
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Jun 25	11	16	N/A	N/A

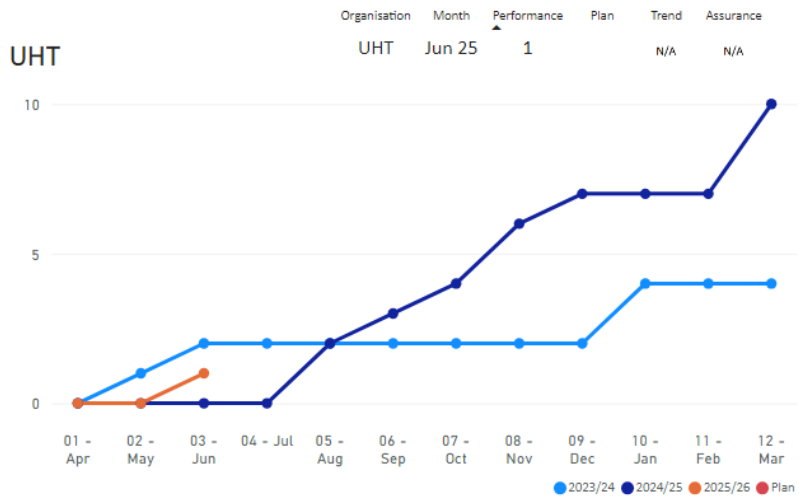


STHFT

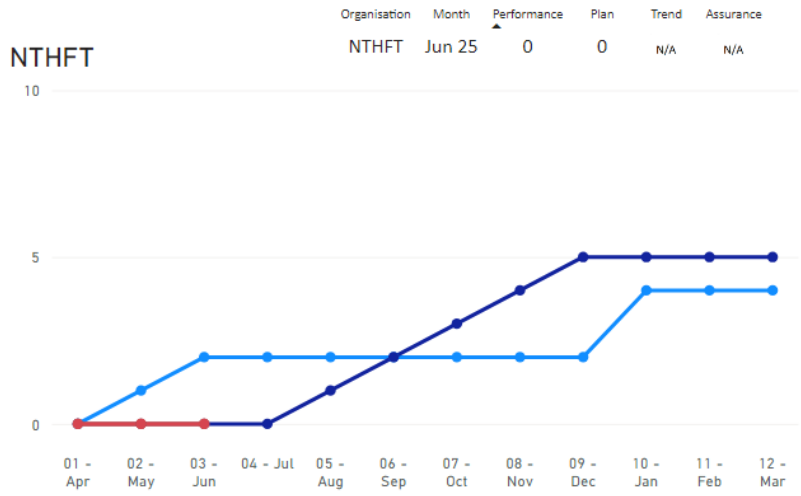
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Jun 25	35	30	N/A	N/A

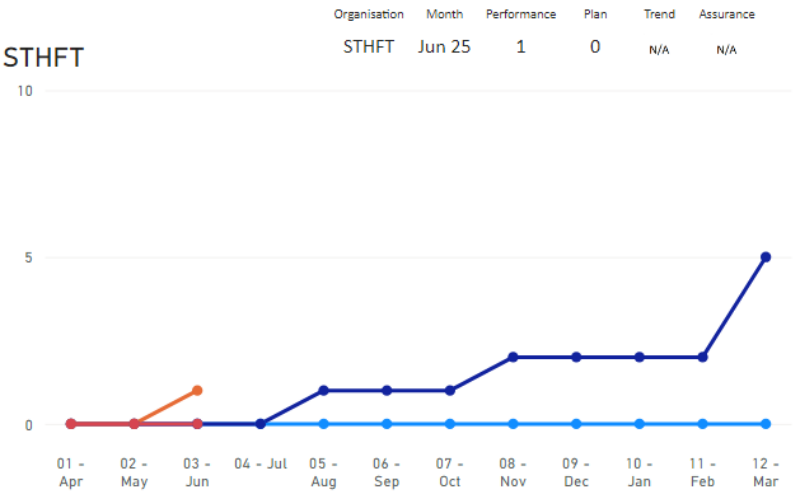


SAFE MRSA (YTD)



Metric: Healthcare associated cases of Methicillin resistant *Staphylococcus aureus*, cumulative annually from April.
Plan: Zero tolerance.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: No new cases for 6 months. STHFT: 1 new case in June 2025.
Assurance: NTHFT: Advise, 0 cases YTD. STHFT: Alert, 1 case YTD. Zero tolerance plan difficult to achieve.
Action taken: Policy adherence audit and education continues across all areas. Screening alert shared regarding screening.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





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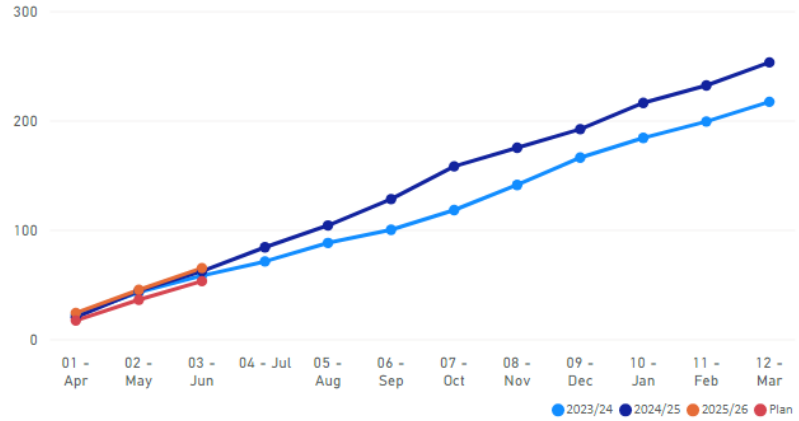
SAFE E-Coli (YTD)

UHT

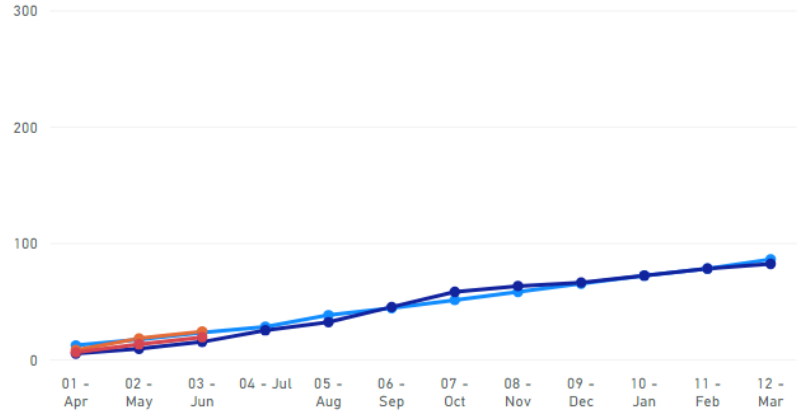
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Jun 25	65	53	N/A	N/A



Metric: Healthcare associated cases of *Escherichia coli*, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 6 cases in June (trajectory of 6). STHFT: 14 cases in June (trajectory of 11).
Assurance: NTHFT: Alert, 26% worse than trajectory YTD. STHFT: Alert, 21% worse than trajectory YTD.
Action taken: Focus remains on invasive devices and VIP. Catheter work aligned across sites with T&F group
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

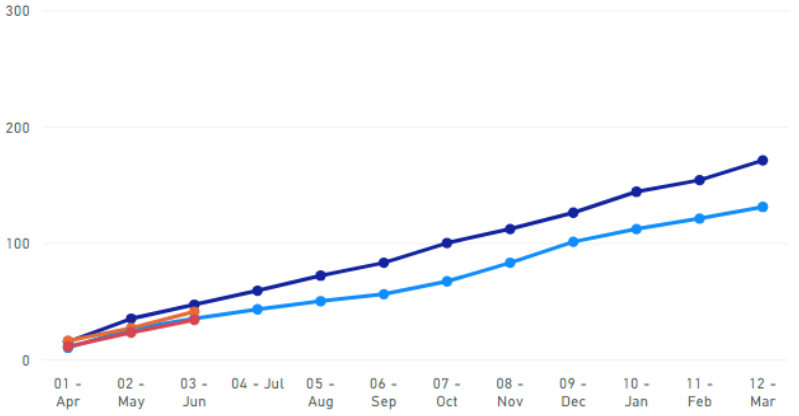
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Jun 25	24	19	N/A	N/A

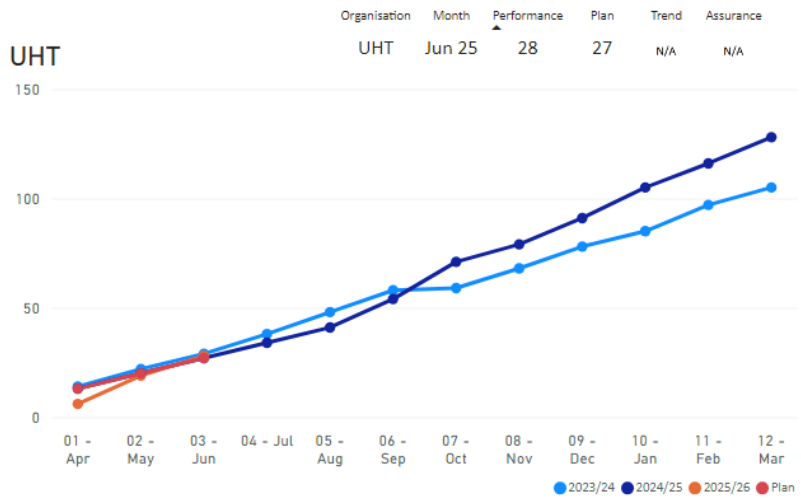


STHFT

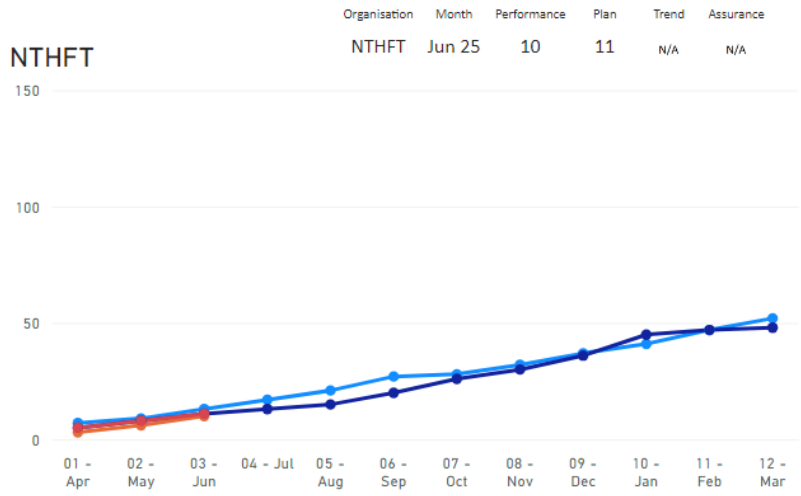
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Jun 25	41	34	N/A	N/A

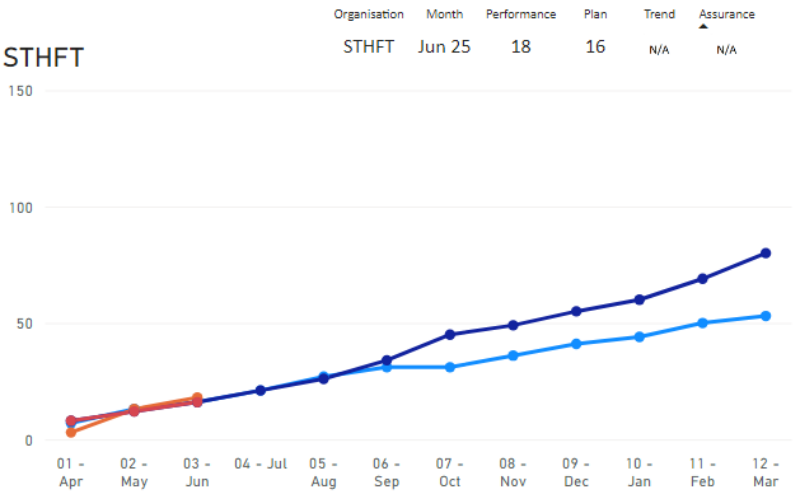


SAFE MSSA (YTD)



Metric: Healthcare associated cases of MSSA annually from April.
Plan: Local plan for 1 case fewer than 2024/25 (no contractual plan).
Rationale: In line with other NHS Contract indicators.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 4 new cases in June (trajectory of 3). STHFT: 5 new cases in June (trajectory of 4).
Assurance: NTHFT: Assure, 1 case better than trajectory YTD. STHFT: Advise, 2 cases, 13% above trajectory YTD.
Action taken: Supported by the work of the invasive devices groups including audit and education.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





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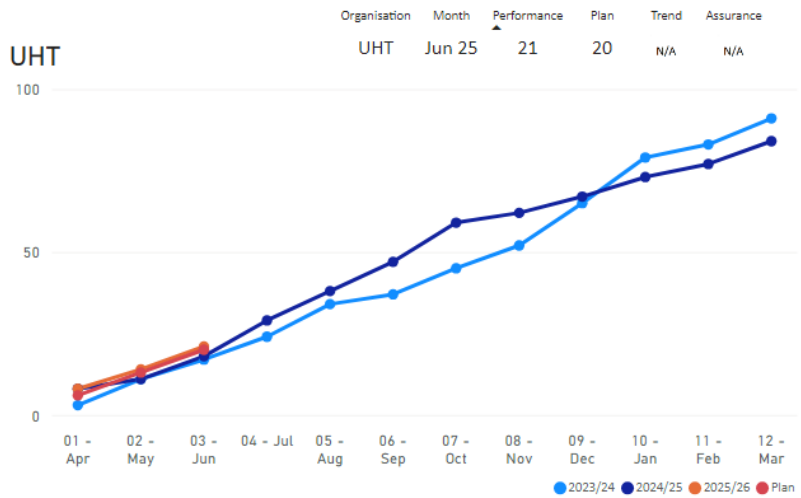
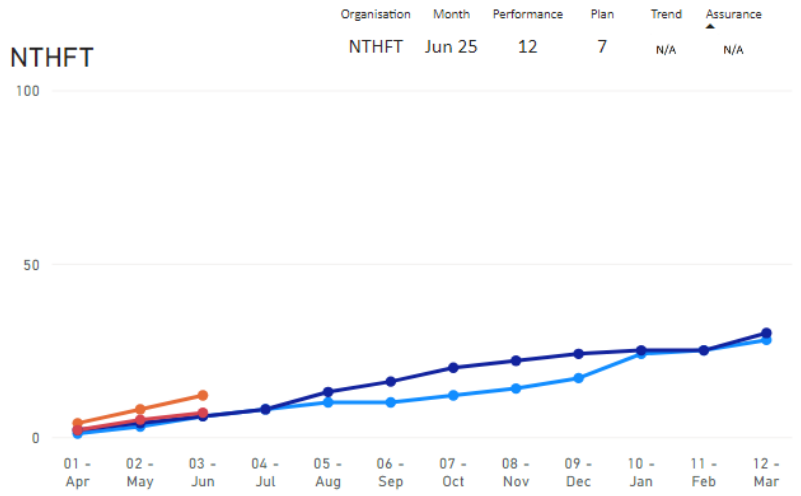
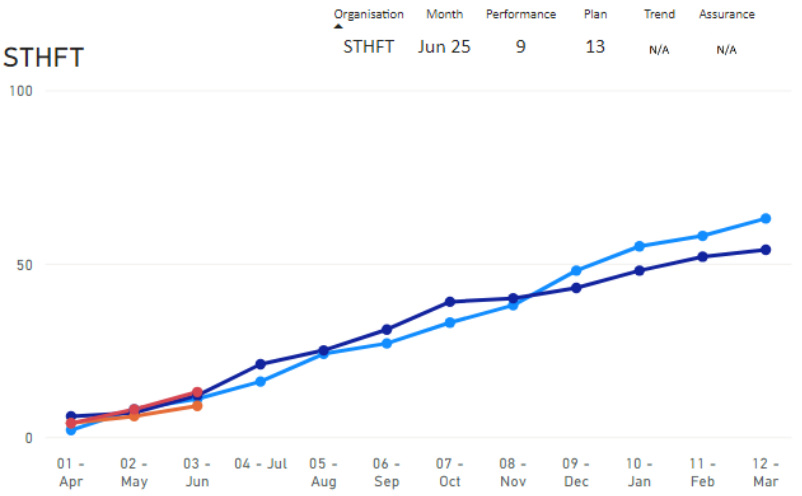
SAFE Klebsiella (YTD)

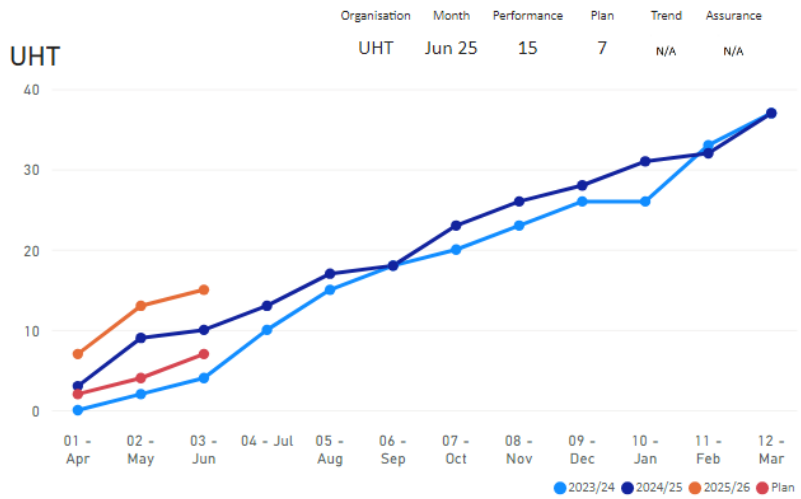


Metric: Healthcare associated cases of *Klebsiella* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 4 new cases in June (trajectory of 2). STHFT: 3 new cases in June (trajectory of 5).
Assurance: NTHFT: Alert, 5 cases, 71% above trajectory YTD. STHFT: Assure, 4 cases fewer than trajectory YTD.
Action taken: Alignment of processes across UHT in respect of catheters and line care. Regional learning shared.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

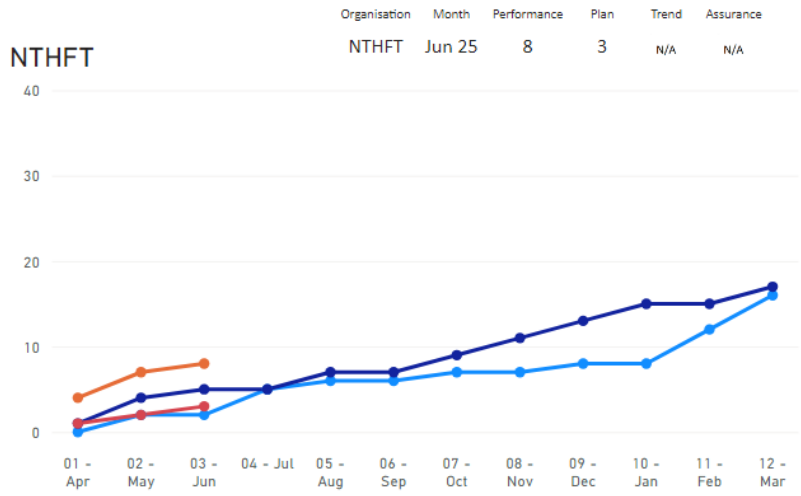


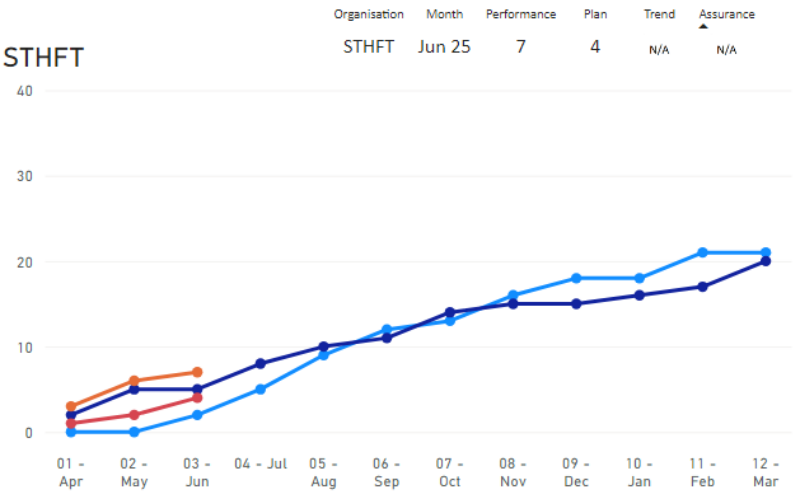


SAFE Pseudomonas (YTD)



Metric: Healthcare associated cases of *Pseudomonas* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 1 new case in June against trajectory of 1. STHFT: 1 new case in June (trajectory of 2).
Assurance: NTHFT: Alert, 5 cases worse than trajectory YTD. STHFT: Alert, 3 cases worse than trajectory YTD.
Action taken: Visit to CDDFT is planned regarding safely reducing the water outlets in areas of concern for water associated infections. Focus on water safety through IPC Committees.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





Caring Better Together

SAFE MATERNITY SUMMARY

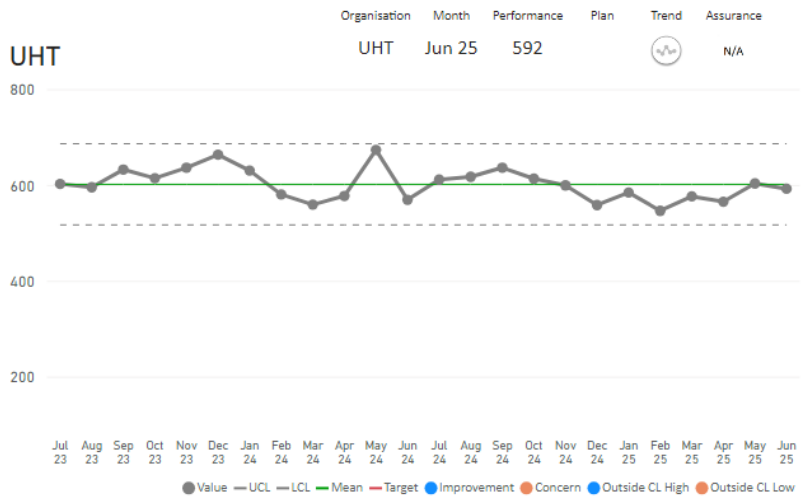
Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

Maternity services metrics reflect the different case mix at the two Trusts, with a greater proportion and the more complex of the high-risk pregnancies being cared for at the James Cook University Hospital. The stillbirth rate at NTHFT has stabilised, around the benchmark, whilst a reducing rate is seen at STHFT. A new indicator, neonatal mortality rate is included providing assurance of performance compared to peers (noting that NTHST and STHFT have different case mix peer groups). Breastfeeding rates are alerted to Board for both Trusts, after the preceding improvement trend at NTHFT was not sustained in June 2025. Infant feeding specialists are providing a continued focus to support and promote breastfeeding. Maternity service across UHT participate in simulation exercises, care bundles and research studies to identify where clinical care can be further improved. Regular in-depth reporting on maternity services takes place through Quality Assurance Committee and the Local Maternity and Neonatal System Board. Both Trusts are participating in the Maternity Services Improvement Support Programme.

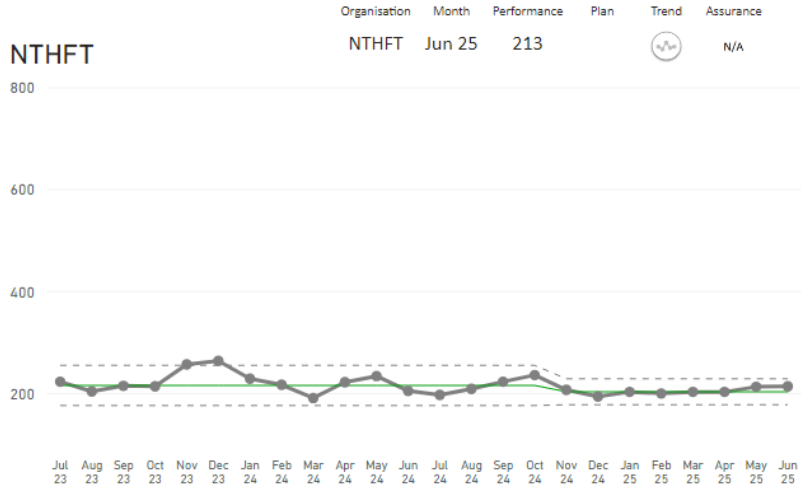
North Tees & Hartlepool NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
No. of babies born		196	208	222	235	206	193	202	199	202	202	212	213
Still Birth Rate (Rolling 12 months, per 1000 births)	2.91	1.9	2.27	1.89	2.62	3.05	2.74	3.17	3.19	3.97	4	3.63	3.61
Breast Feeding at First Feed	72.3%	56.1%	50.2%	50%	48.5%	52.7%	53.9%	52.2%	51.5%	53%	51.5%	50.9%	46%
PPH >= 1500ml Rate per 1000 Births	29	30.5	33.8	27	25.4	34.1	25.5	40	45.5	24.8	29.6	37.7	32.9
3rd/4th Degree Tear (%)		0.5%	0%	2.3%	1.3%	1%	1.5%	0.5%	2%	0.5%	1.5%	3.3%	1.4%
Neonatal Mortality Rate (Rolling 12 months, per 1000 births)	1	0.4	0.4	0.4	0.4	0	0	0	0	0	0	0	0

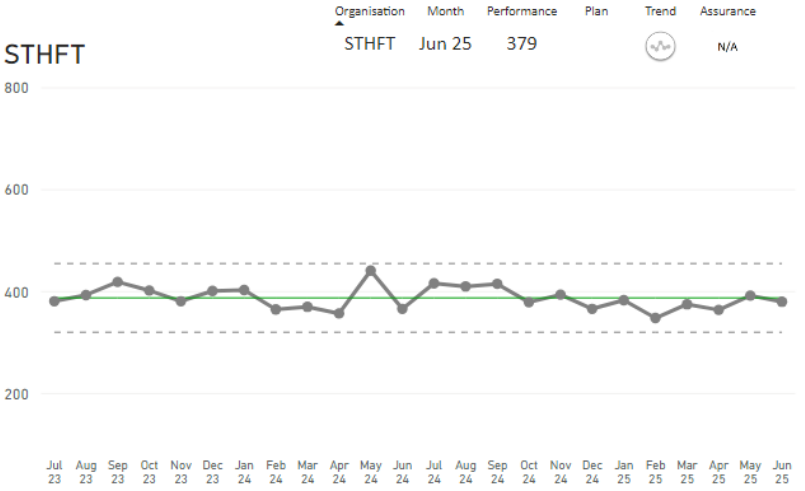
South Tees Hospitals NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
No. of babies born		415	409	414	378	393	365	382	347	374	363	391	379
Still Birth Rate (Rolling 12 months, per 1000 births)	3.6	3.6	4.01	3.8	4.03	4.23	4.26	3.64	3.87	3.22	3.43	3.25	3.24
Breast Feeding at First Feed	77.1%	69.7%	69.5%	70.1%	67.2%	66.3%	67.8%	64.3%	63.4%	68.2%	63.9%	65.3%	64.5%
PPH >= 1500ml Rate per 1000 Births	29	42	34.4	31.9	51.4	36.2	30.6	26.8	32.4	29.6	28.1	28.6	32.1
3rd/4th Degree Tear (%)		2.5%	2.8%	1.8%	2.3%	4%	2.8%	0.9%	2.6%	5.7%	2.4%	1.3%	3.4%
Neonatal Mortality Rate (Rolling 12 months, per 1000 births)	1.8	0.8	1.3	1.3	1.3	1.3	1.5	1.5	1.7	1.7	1.7	1.3	1.7

SAFE No. of babies born

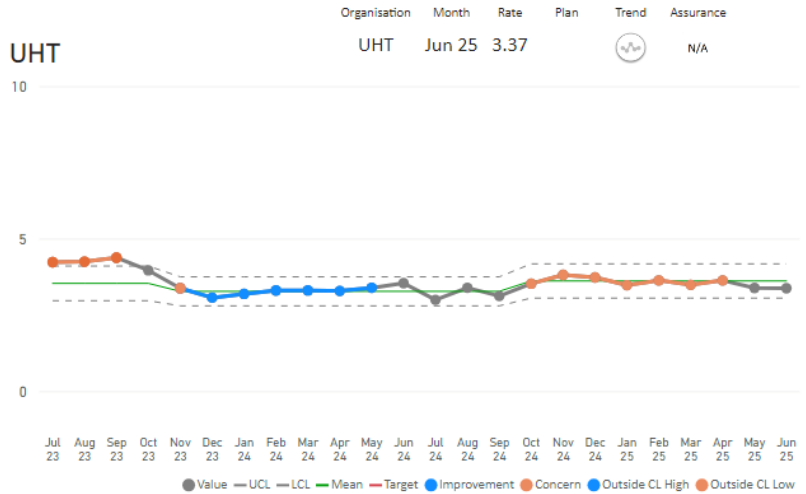


Metric: Count of babies born under care of each Trust.
Plan: n/a
Rationale: Context for maternity metrics.
Data quality: Assured, validated data.
Trend: Number of births at NTHFT and STHFT is stable over 2-year timeframe.
Assurance: n/a
Action taken: n/a
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

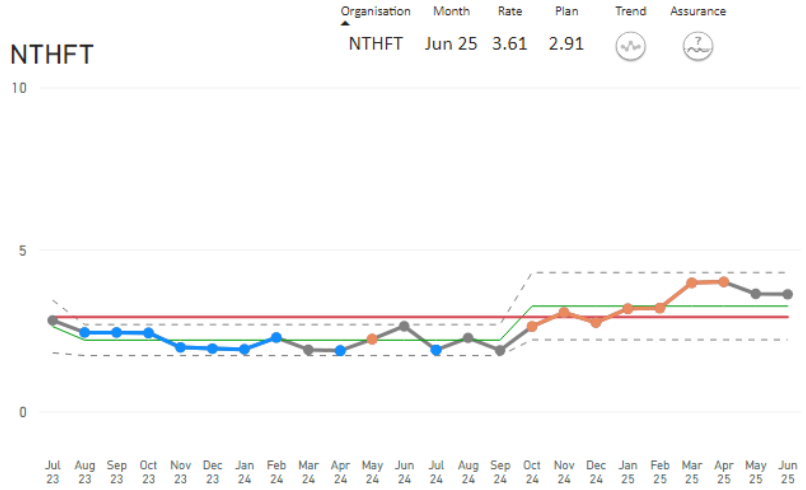


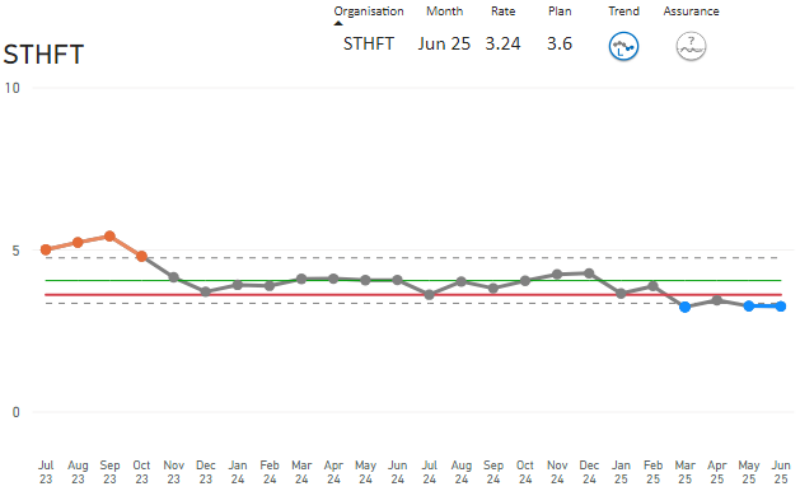


SAFE Still Birth Rate (Rolling 12 months, per 1000 births)

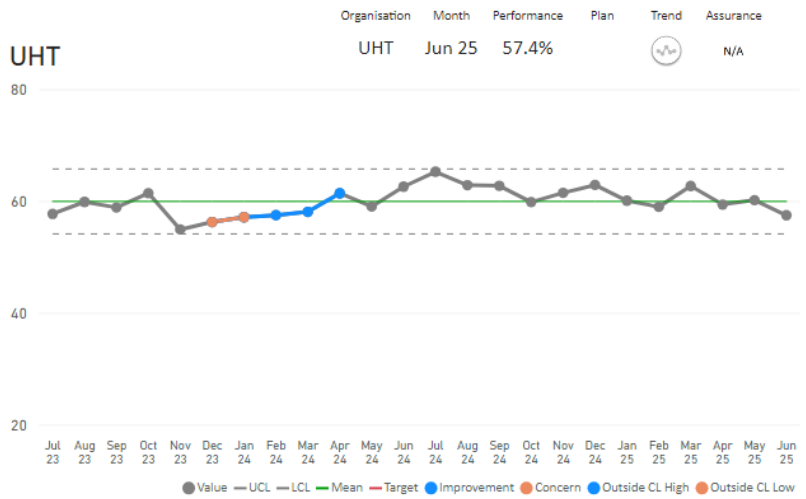


Metric: Still birth rate (rolling 12 months per 1000 births).
Plan: MBRRACE comparator group crude average 2023.
Rationale: National Maternity Indicator.
Data quality: Advised, locally derived rate may differ from nationally derived, and case-mix adjusted rates.
Trend: NTHFT: No trend, recent deterioration stabilised. STHFT: Improvement trend with 3 of last 4 months demonstrating lower (better) than usual expected variance.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Perinatal losses are reported via the Perinatal Mortality Review Tool. All cases are reviewed in full by an MDT team. A thematic review is in progress, report due July 2025.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

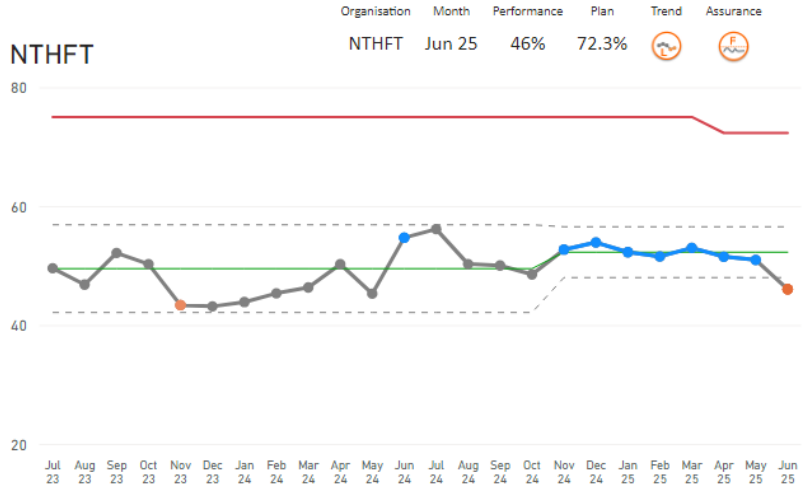


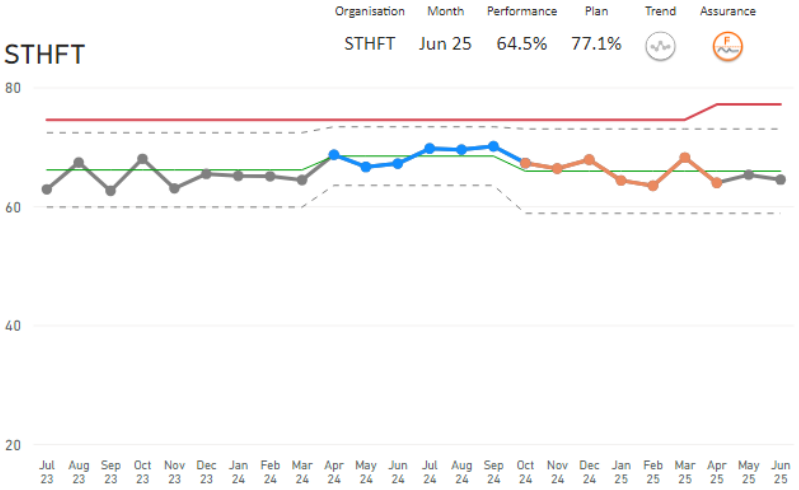


SAFE Breast Feeding at First Feed



Metric: Percentage of births where breast-feeding is initiated, reported at first feed.
Plan: Local plan 25/26 to achieve MBRRACE audit peer group mean (10% tolerance).
Rationale: National maternity dashboard Clinical Quality Improvement Metric (CQIM)
Data quality: Assured, validated data.
Trend: NTHFT: Improvement trend was evident between November 24 and May 25 but June 2025 rate is outside (worse) than expected variance. STHFT: No trend. Recent lower rate has now stabilised.
Assurance: NTHFT: Alert. STHFT: Alert.
Action taken: Both sites are working towards UNICEF breast-feeding initiative accreditation, which includes staff training, support to parents and infant feeding plans.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





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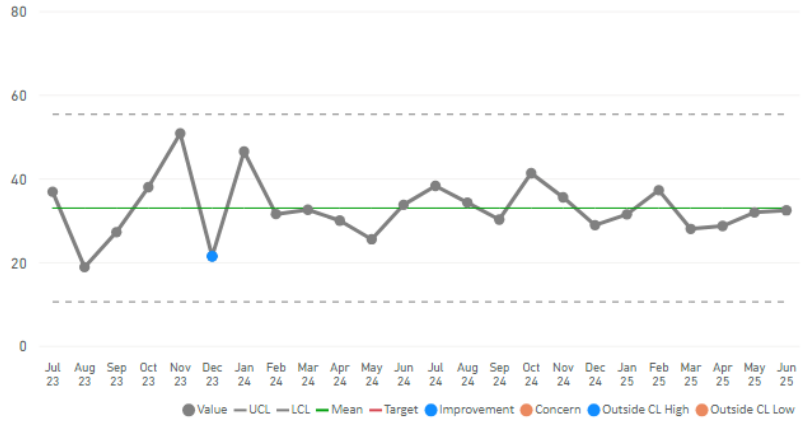
SAFE PPH >= 1500ml Rate per 1000 Births

UHT

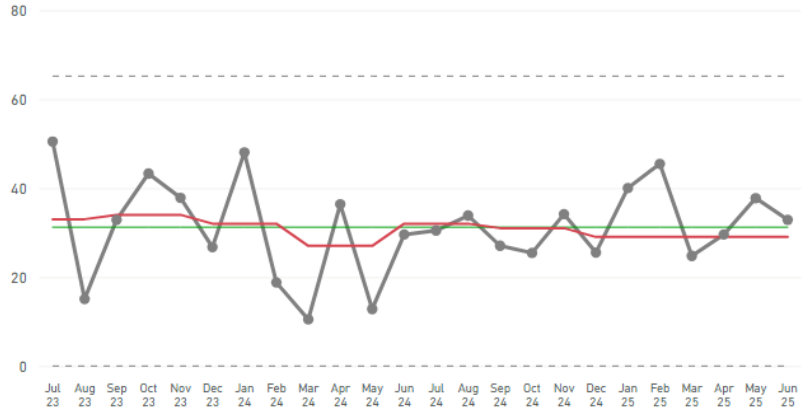
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Jun 25	32.4			N/A



Metric: Post-partum haemorrhage (PPH) greater than or equal to 1500ml, rate per 1000 births
Plan: North East and North Cumbria ICB regional average
Rationale: National Maternity Indicator and Clinical Quality Improvement Metric.
Data quality: Assured, validated data.
Trend: NTHFT: no trend. STHFT: Improvement over 7 months (December 2024 to June 2025).
Assurance: NTHFT: Advise, variable performance where plan is met some months. STHFT: Advise, more consistent performance in last 7 months but plan not always met.
Action taken: NTHFT and STHFT participate in a research study on effectiveness of interventions to reduce PPH.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

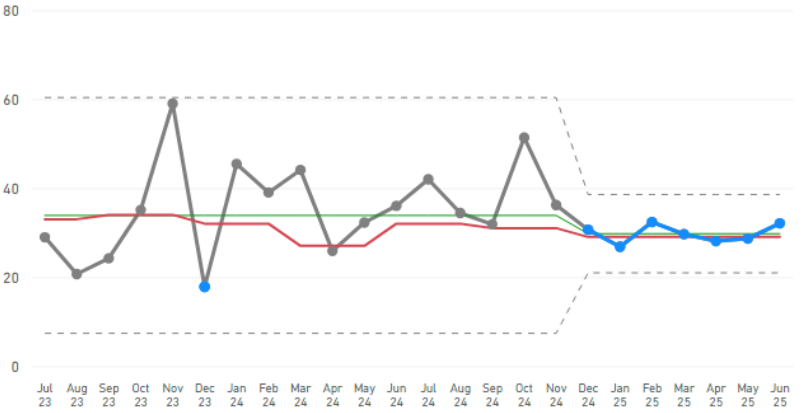
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Jun 25	32.9	29		

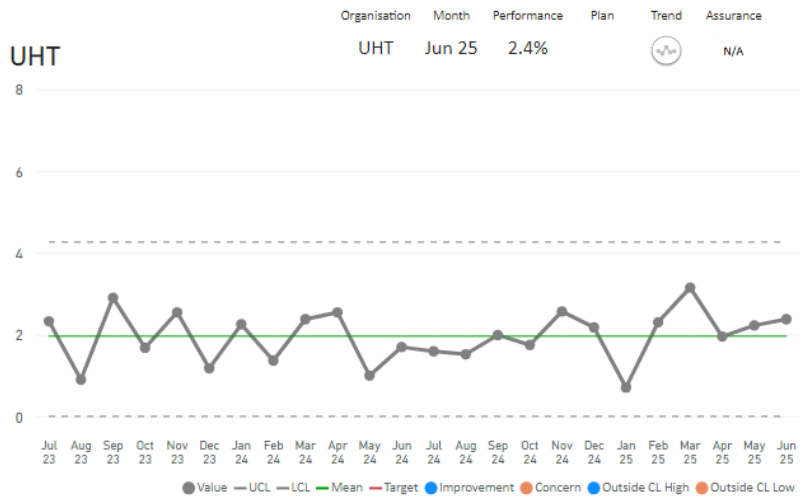


STHFT

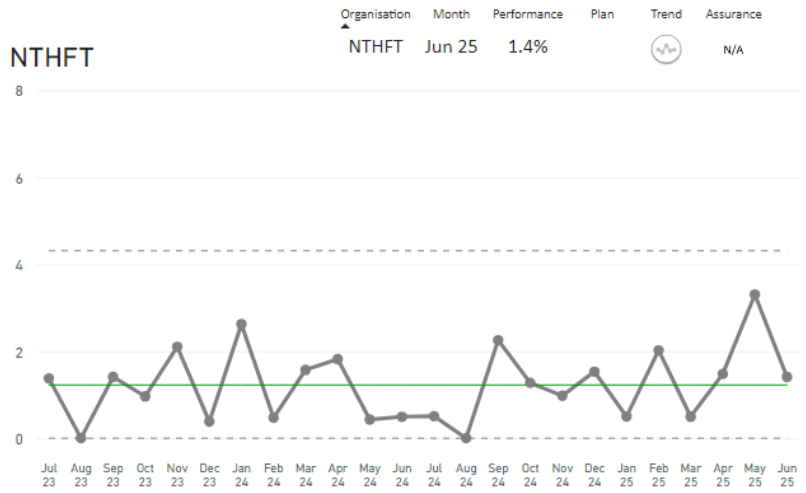
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Jun 25	32.1	29		

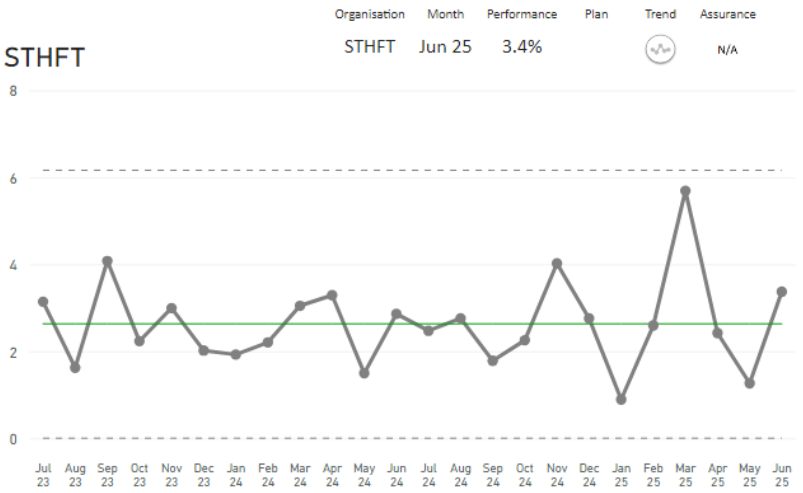


SAFE 3rd/4th Degree Tear (%)



Metric: Percentage of births with 3rd/4th degree maternal tear.
Plan: n/a.
Rationale: National Maternity Indicator.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: n/a
Action taken: Monitored and reviewed monthly as part of the Royal College of Obstetricians & Gynaecologists care bundle (OASI) which continues at across UHT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

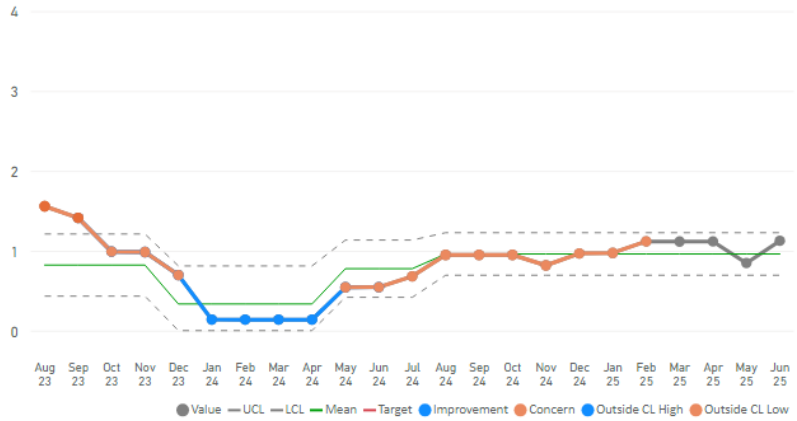




SAFE Neonatal Mortality Rate (Rolling 12 months, per 1000 births)

UHT

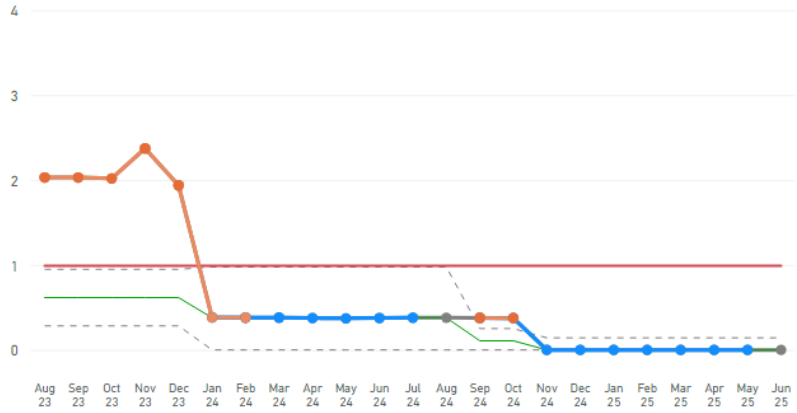
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Jun 25	1.1			N/A



Metric: Neonatal mortality rate**,** rolling 12 months per 1,000 births.
Plan: Local plan 25/26, MBRRACE audit peer group average.
Rationale: National Maternity Indicator.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: Increasing trend, higher rolling 12-month average mortality rate in last 5 months.
Assurance: NTHFT: Assure, no neonatal deaths for 8 months. STHFT: Assure. Mortality rate assured below (better than) peer group average.
Action taken: All perinatal deaths are reported via the Perinatal Mortality Review Tool. All cases are reviewed in full by an MDT team.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

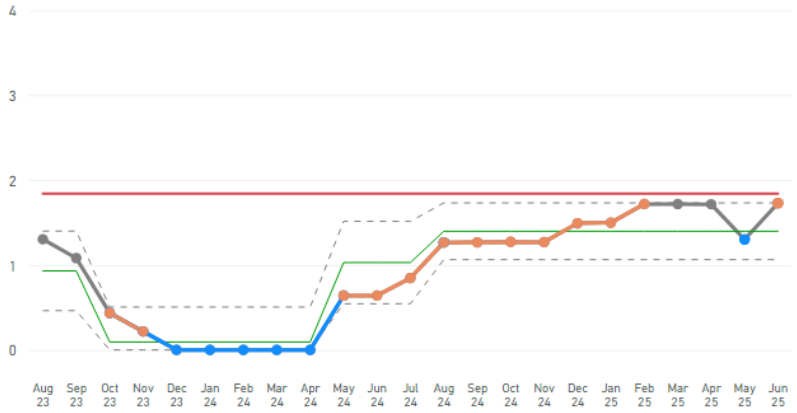
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Jun 25	0	1		



STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Jun 25	1.7	1.8		



EFFECTIVE DOMAIN SUMMARY

Executive lead: Dr Michael Stewart, Chief Medical Officer
Accountable to: Quality Assurance Committee

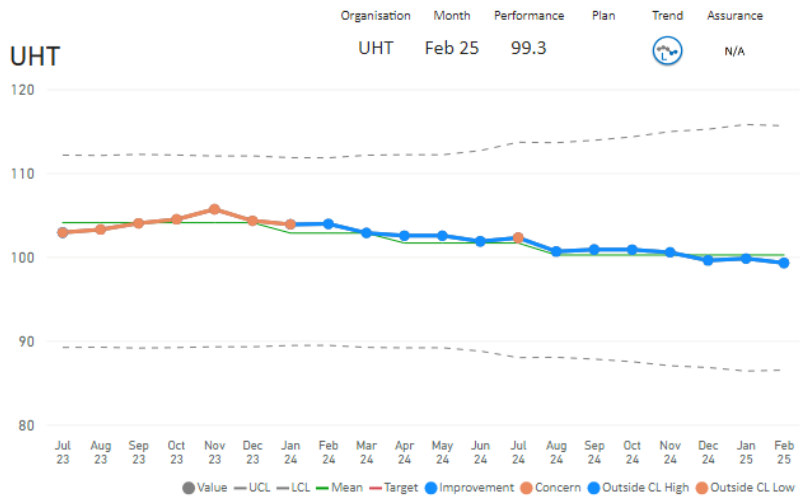
Summary Hospital-level Mortality Indicator (SHMI) is 'as expected' for both trusts. Assurance is also provided by non-statistical approaches: Trust Medical Examiners review >98% of deaths and refer relevant cases to the Trust Mortality Surveillance team for further review/investigation/action where required.

Both trusts are focusing on understanding trends in readmission using clinical audit to identify the most clinically relevant improvement opportunities across medical and surgical care pathways, whilst enabling patients to be cared for out of hospital. This is focusing initially on readmissions of patients with a diagnosis of COPD, as this cohort of patients has a higher readmission rate. The IPR reports a standardised metric to enable benchmarking.

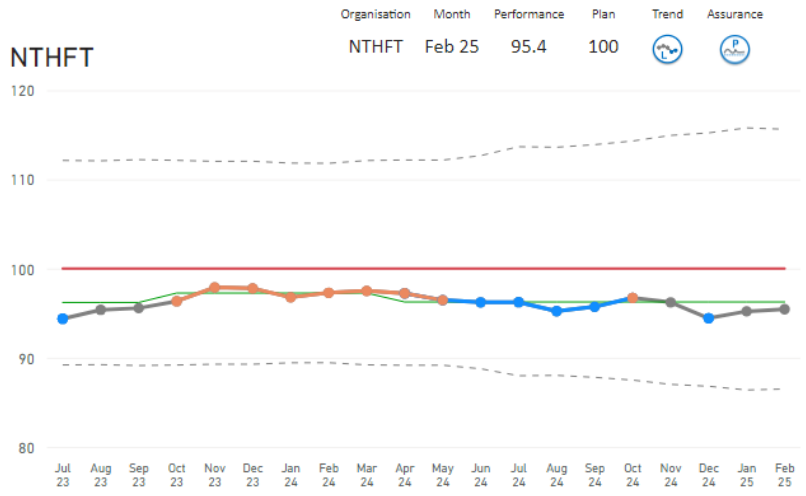
North Tees & Hartlepool NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Summary Hospital-Level Mortality Indicator	100	96.2	95.2	95.7	96.7	96.2	94.4	95.2	95.4		
Readmission Rate (%)	8.4%	10.9%	10.2%	10.4%	10.5%	11.1%	11.2%	11.2%	10.6%	11.6%	11%

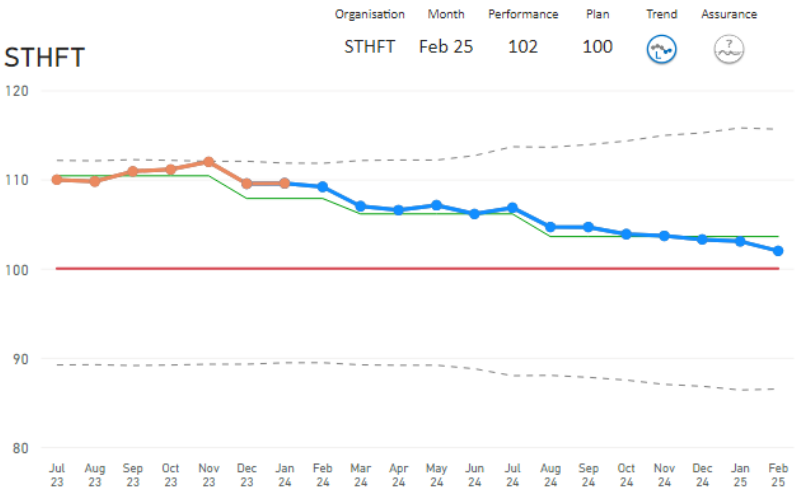
South Tees Hospitals NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Summary Hospital-Level Mortality Indicator	100	106.8	104.7	104.6	103.9	103.7	103.3	103.1	102		
Readmission Rate (%)	8.4%	8.9%	8.7%	9.1%	9.1%	8%	8.9%	8.4%	8.8%	8.7%	8.6%

EFFECTIVE Summary Hospital-Level Mortality Indicator

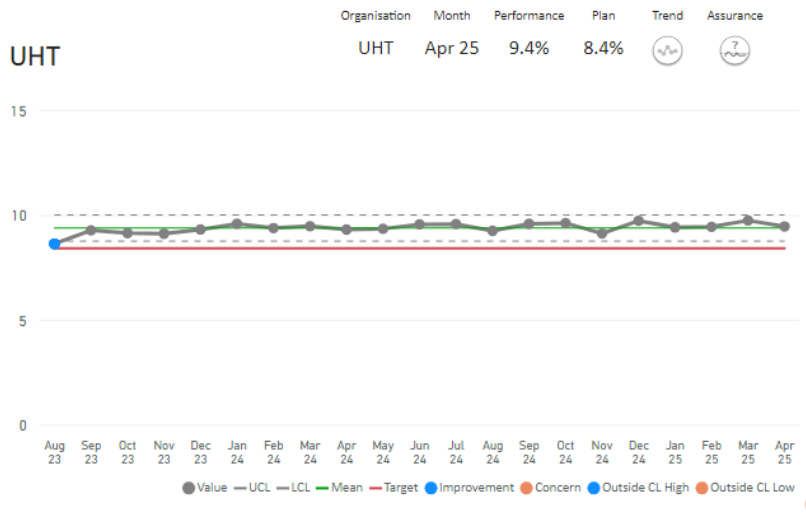


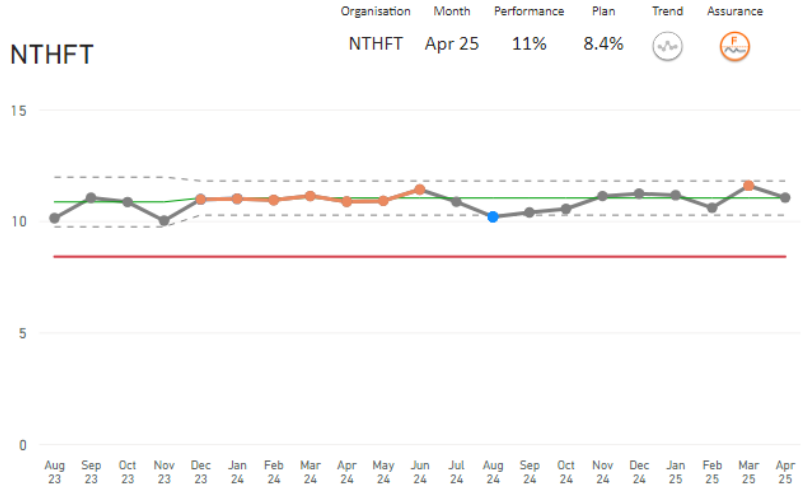
Metric: Summary hospital-level mortality indicator (SHMI), calculated for rolling 12-months, 4-months in arrears.
Plan: Standardised to 100.
Rationale: Quality Accounts regulatory indicator.
Data quality: Assured, validated data.
Trend: NTHFT: Stable rate. STHFT: Improving.
Assurance: NTHFT: Assure. Consistently below (better than) the national benchmark. STHFT: Advise. As expected, within national variation.
Action taken: Continued focus on depth of coding at STHFT may lead to further improvement in SHMI.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

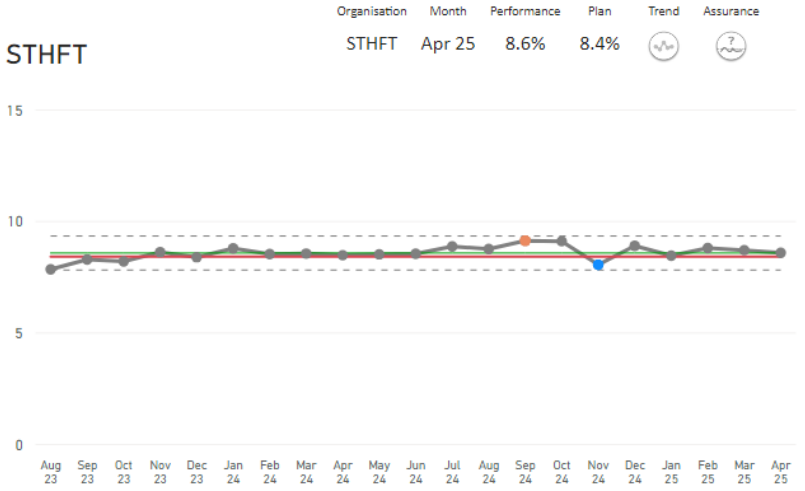




EFFECTIVE Readmission Rate (%)







Metric: Percentage of patients readmitted within 30 days.
Plan: 2023/24 national average.
Rationale: NHS Contract metric.
Data quality: Aligned to published benchmark. Reported two months in arrears to enable the data to be fully coded.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Alert. Readmission rates consistently higher than national average. STHFT: Advise. Rates are close to national average.
Action taken: A pilot audit has now commenced at both Trusts targeting COPD re-admissions. The surgical teams are also preparing to audit their high readmissions. First report expected end September.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Managing Director **Accountable to: Resources Committee**

Urgent and emergency care

Assurance on ambulance handover performance now focuses on handovers completed within 45 minutes, replacing the 60-minute metric. Compliance is assured at >95% at NTHFT, and there is an improvement trend at STHFT.

Whilst the IPR analysis alerts that the more challenging agreed operational plan for 4-hour standard held by NTHFT is not met, the national recovery standard of 78% is exceeded throughout for NTHFT as one of the top performing trusts nationally. Data quality is also being investigated with the NTHFT EPR supplier. There is continued focus at STHFT, including piloting new ways of working, that is helping a return to an improvement trend.

12-hour breaches in ED are stable at both trusts, and significantly lower than the national planning guidance standard of fewer than 10%, but delivery of agreed plans is not assured. This remains an operational focus with also a temporary impact of estates works at NTHFT.

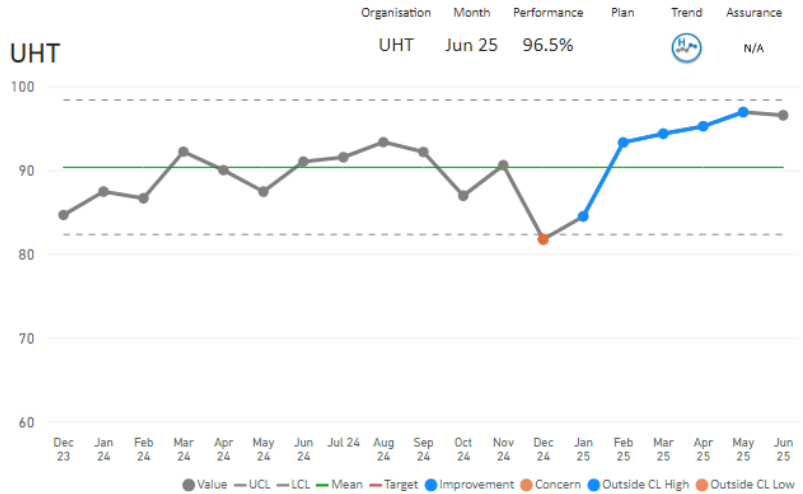
Above-standard performance in the community urgent 2-hour response reflects effective support to EDs by caring for patients in the most appropriate setting.

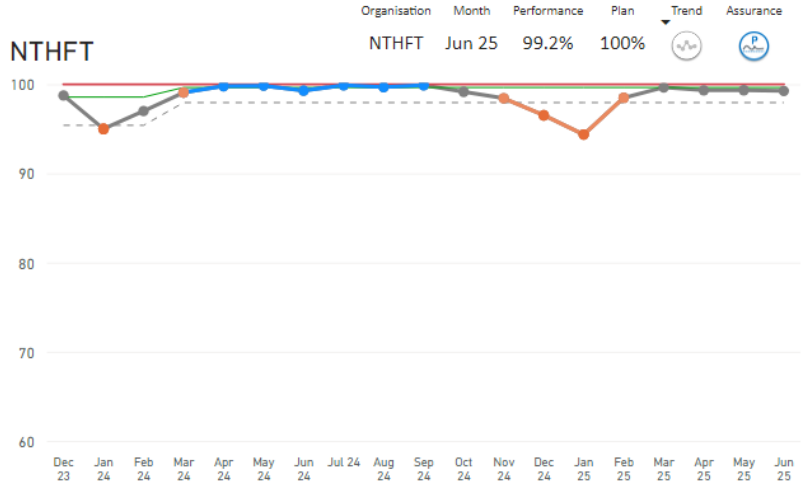
Elective operations cancelled on the day not rebooked within 28 days requires improvement, with case-by-case monitoring in place.

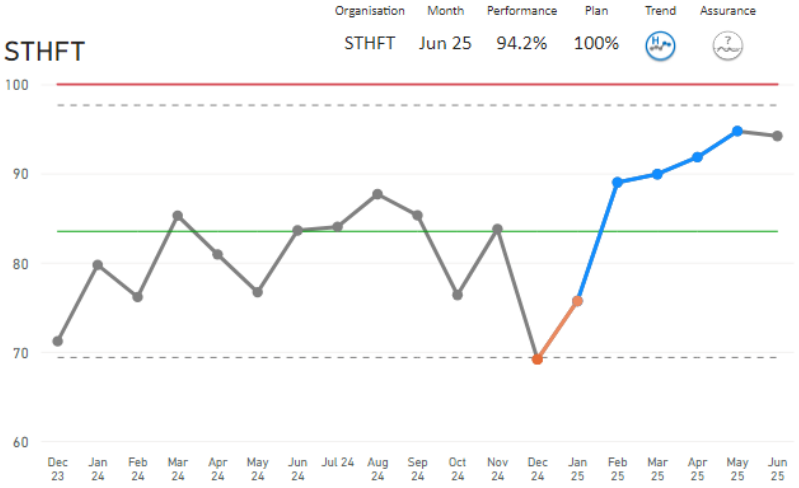
North Tees & Hartlepool NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
NEAS Handovers - Within 45 Mins (%)	100%	99.9%	99.7%	99.9%	99.1%	98.4%	96.5%	94.4%	98.5%	99.6%	99.3%	99.3%	99.2%
4-Hour A&E Standard	90%	87.3%	89.4%	85.6%	83.8%	81.9%	80.9%	81.3%	85.5%	85.6%	83.3%	85.7%	84.1%
12-hour ED breaches rate	0%	0.5%	0.3%	1.4%	2%	3.6%	6.3%	6.4%	1%	1.7%	2.2%	1.4%	3.2%
Community UCR 2hr Response Rate (%)	70%	72%	75%	76%	79%	77%	73%	79%	72%	74%	70%	77%	
Cancelled Ops - Not Rebooked Within 28 days	0	2	2	2	3	3	4	5	10	0	3	4	5

South Tees Hospitals NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
NEAS Handovers - Within 45 Mins (%)	100%	84%	87.7%	85.3%	76.4%	83.8%	69.1%	75.7%	89%	89.9%	91.8%	94.7%	94.2%
4-Hour A&E Standard	77.9%	76.9%	78.7%	77.3%	73.5%	75%	72.1%	74.2%	75.4%	75.7%	77%	77%	76.6%
12-hour ED breaches rate	2.7%	2.1%	1.6%	2.3%	7.9%	4.1%	9.8%	11.6%	5.1%	4.1%	4.4%	2.8%	3.2%
Community UCR 2hr Response Rate (%)	70%	86%	89%	83%	82%	83%	81%	80%	83%	86%	82%	81%	
Cancelled Ops - Not Rebooked Within 28 days	0	13	15	13	21	21	18	19	26	16	10	6	11

RESPONSIVE NEAS Handovers - Within 45 Mins (%)

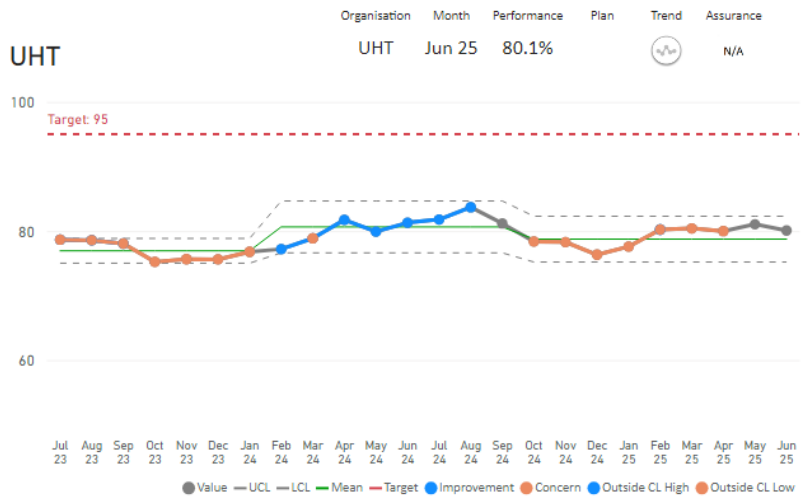


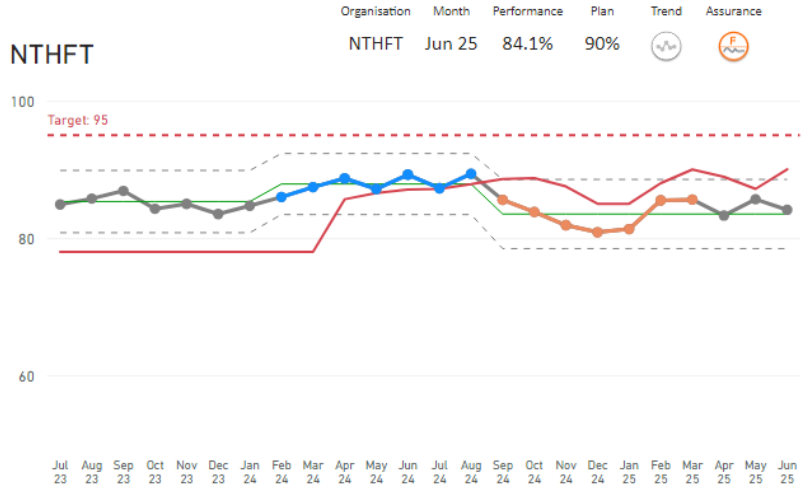


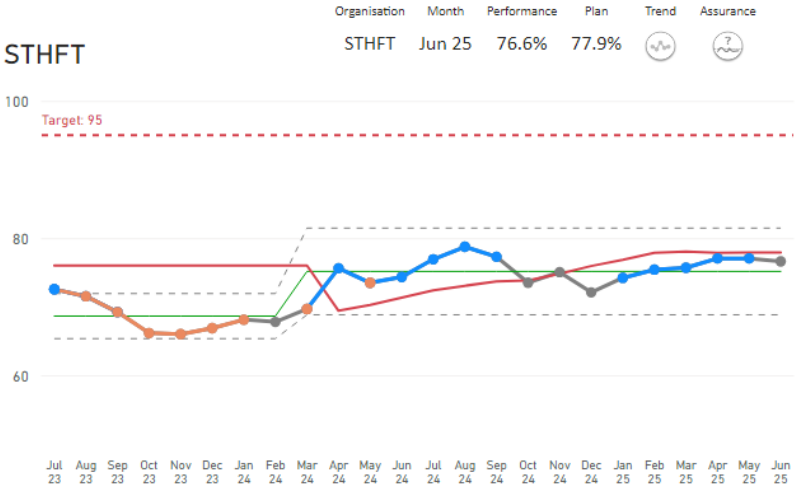


Metric: Percentage of NEAS ambulance handovers completed within 45 minutes of arrival at ED.
Plan: 100% within 45 minutes
Rationale: NHS Contract metric.
Data quality: NEAS data may differ from Trust data.
Trend: NTHFT: No trend. STHFT: Improvement trend.
Assurance: NTHFT: Assure. STHFT: Advise.
Action taken: NTHFT continue focusing on timely release of crews to full compliance, with just 1 handover taking longer than 45 minutes in June 2025. Handover SOP in place and use of corridor in surge to provide timely release of crews. STHFT reinforcing the handover escalation SOP with clinical teams. ED patient flow will become the primary source of escalation to minimise ambulance delays.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE 4-Hour A&E Standard

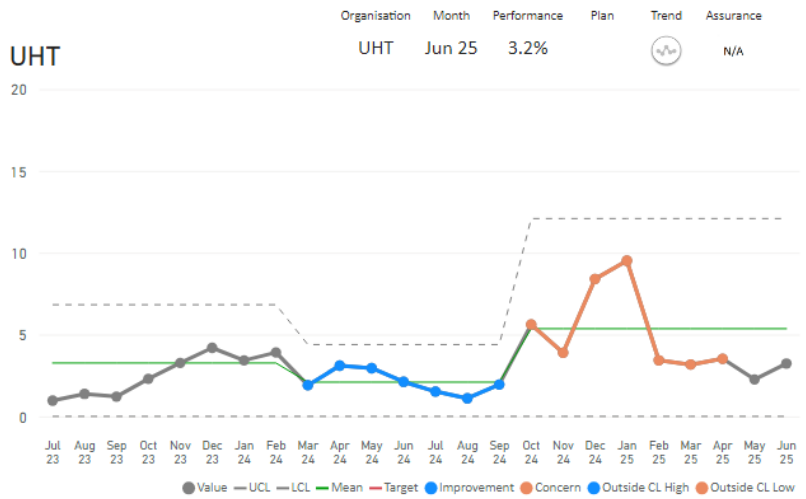


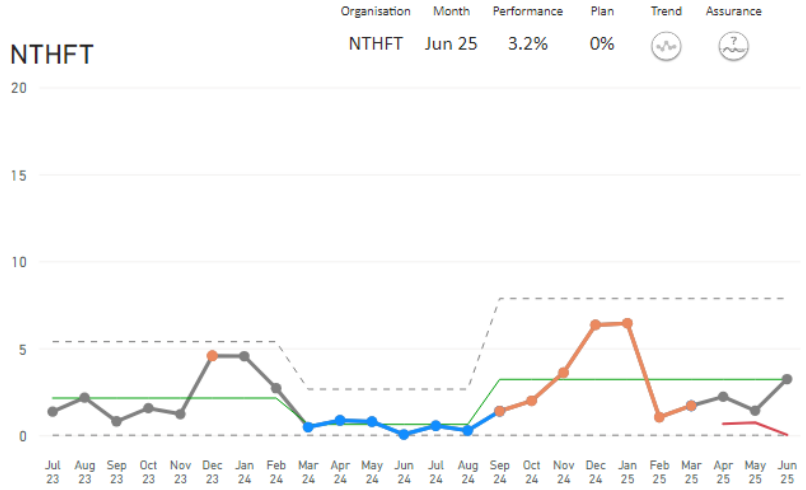


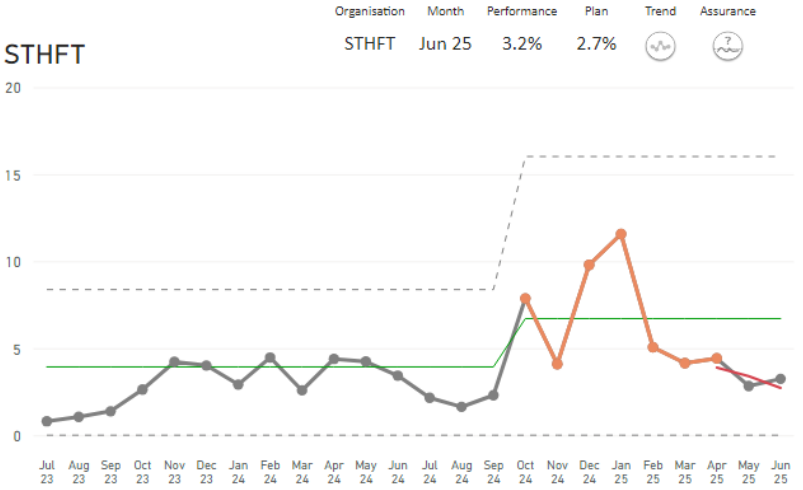


Metric: Percentage of patients admitted, transferred or discharged from A&E (all types) within 4 hours of arrival.
Plan: NHS Constitution standard 95%, agreed operational plan to achieve 90% NTHFT, 78% STHFT by March 2026.
Rationale: NHS Contract metric.
Data quality: NTHFT are working with EPR supplier to ensure accurate reporting of time stamp data.
Trend: NTHFT: No trend. STHFT: No trend, after 5 months improvement from January 2025 to May 2025.
Assurance: NTHFT: Alert, plan for June 2025 outside limits of recent performance variation. STHFT: Advise.
Action taken: NTHFT: Partnership working to improve flow within and out of the Trust, monitored via the 4-hour steering group to meet the higher local plan. STHFT: rapid assessment and triage trial was effective, now working with clinical teams on expansion and consistent delivery model.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE 12-hour ED breaches rate

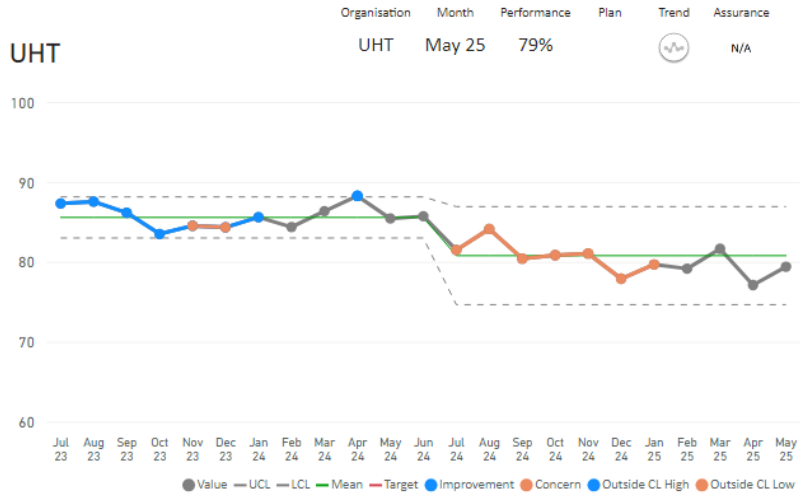




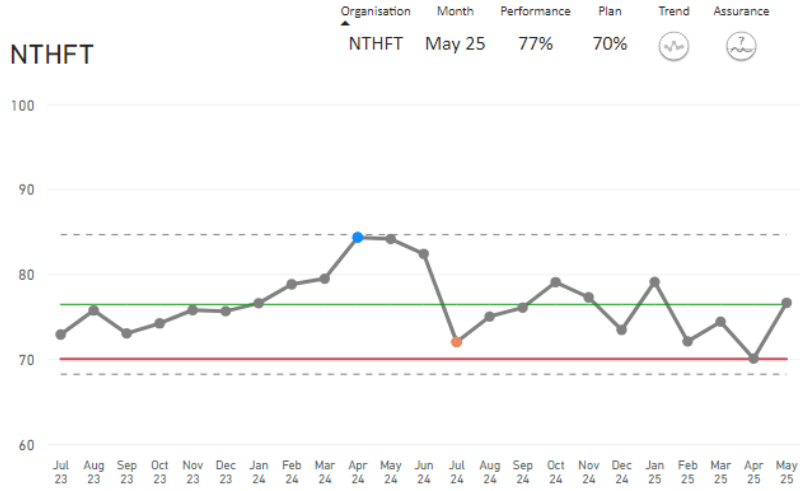


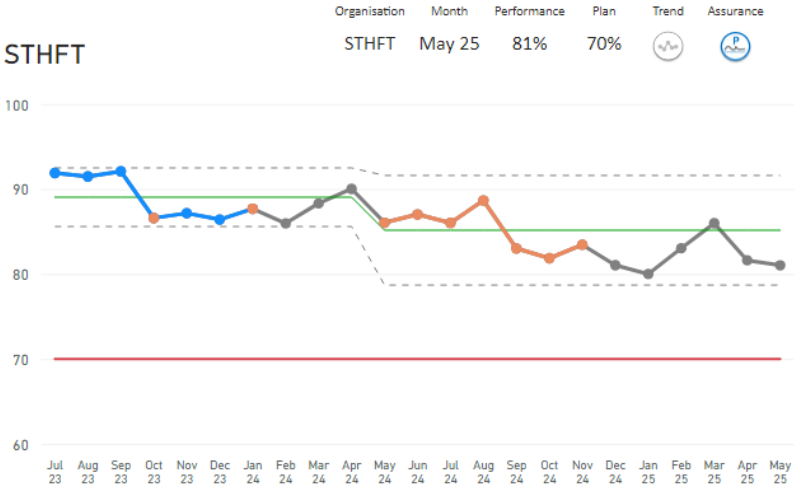
Metric: Percentage of patients admitted or discharged from Type 1 Emergency Department after 12 hours.
Plan: Seasonalised operational plan for 25/26 submitted by each Trust: NTHFT to achieve 1.93% in March 2026; STHFT to achieve 3.22%. National planning guidance standard 10%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT estate works have impacted on medical bed capacity, temporarily, managed through flow escalation processes. All breaches are audited to identify key themes weekly. STHFT implementing breach recovery trajectory following audit findings. Interventions made at 10-hours to avoid 12-hour breaches.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE Community UCR 2hr Response Rate (%)

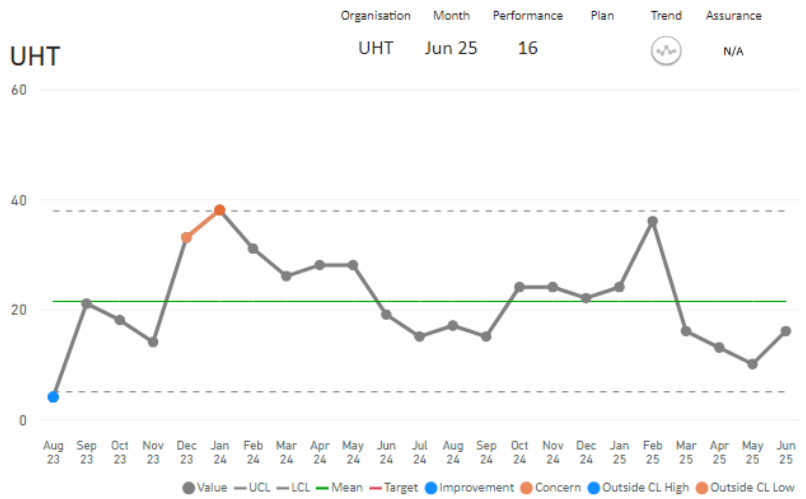


Metric: Urgent community response within 2-hours
Plan: 70%
Rationale: NHS operational planning guidance
Data quality: Advisory, metric calculated from submitted raw community data sets, and available one month in arrears. A national change to the inclusion criteria for this metric has been applied retrospectively, minimal performance impact.
Trend: No trend.
Assurance: NTHFT: Advise. STHFT: Assure.
Action taken: Community rapid response services remain a key element of caring for patients in the most appropriate setting. An integrated UHT care coordination pilot is planned for November 2025, helping to optimise use of community resources to avoid unnecessary admissions.
Executive lead: Managing Director
Accountable to: Resources Committee

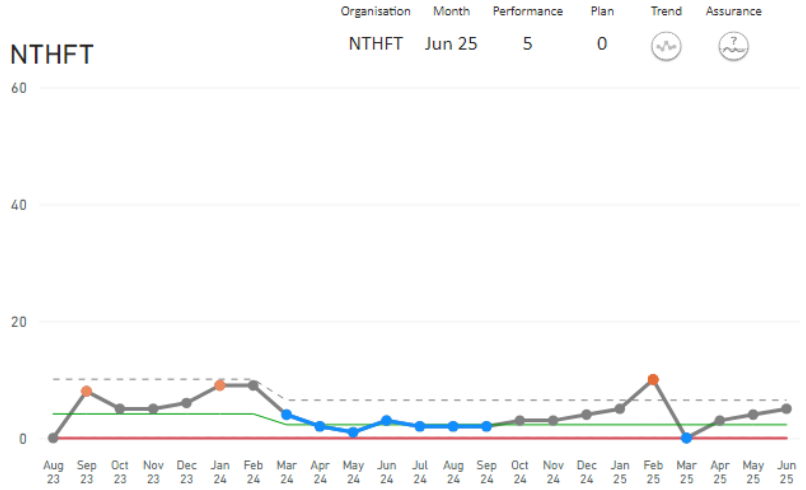


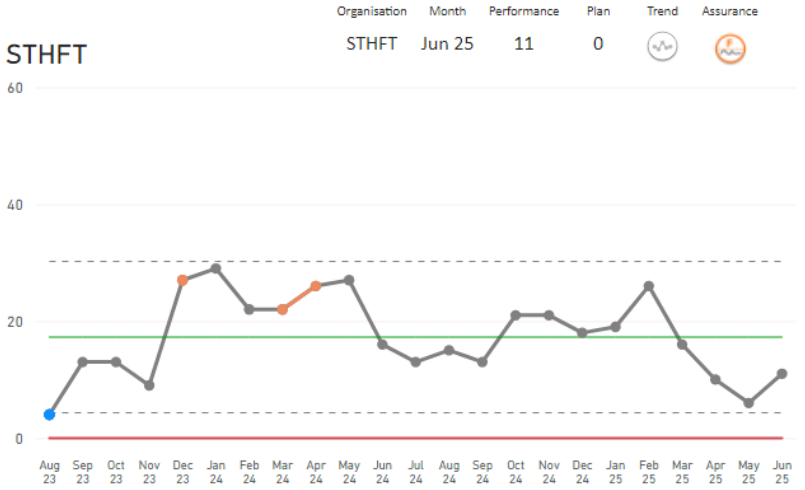


RESPONSIVE Cancelled Ops - Not Rebooked Within 28 days



Metric: Operations cancelled not rebooked within 28-days.
Plan: Zero.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Alert, zero tolerance standard is not achieved.
Action taken: Daily review of all cancellations is in place at NTHFT, and services remain focussed and committed to reappointing patients within the timeframe. At STHFT renewed focus on rebooking is monitored via Collaborative performance and Surgical Improvement Group meetings.
Executive lead: Managing Director
Accountable to: Resources Committee





Caring Better Together

RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Managing Director **Accountable to: Resources Committee**

Elective, diagnostic and cancer care

Achievement of key access targets continues to be challenging and logged as strategic risks for both trusts.

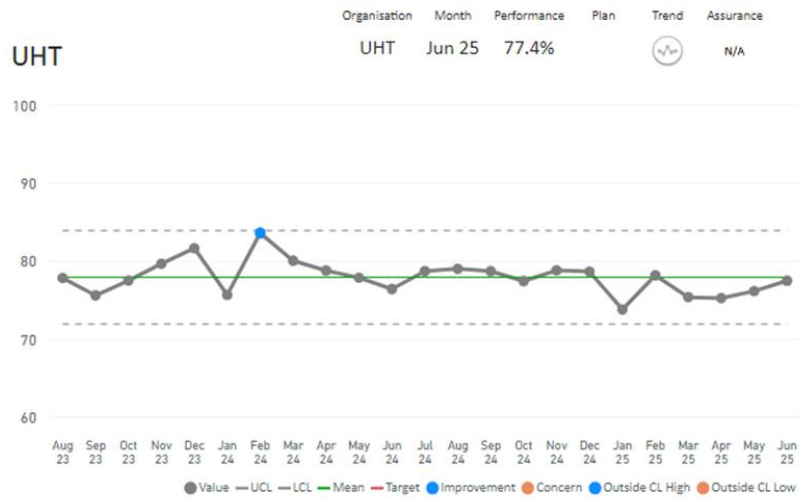
Cancer faster diagnosis standard performance is not assured for NTHFT or STHFT. STHFT tiered support from NHS England on 62-day standard performance continues. Robust action plans are being implemented, beginning with the diagnostic process in the Urology prostate pathway where changes are being closely monitored. STHFT 31-day standard regraded from Alert to Advise as deteriorating performance has stabilised. NTHFT tumour specific pathway improvements are driven by the clinically-led Cancer Delivery Group. Respiratory and Urology pathways have been identified as key focus areas for service improvement. There has been a sustained increase in breast symptomatic referrals from the County Durham and Darlington catchment area since February 2025. This has resulted in a deterioration in cancer standards. The team are working closely with CDDFT and the Cancer Care Alliance to support a collaborative approach to service delivery in the short / medium term and longer term models of delivery across the system. In the shorter term specific interventions are being put in place to reduce pathway delays and improve the standards going forward.

Elective recovery trajectories are supported by waiting list validation, clinic template review and additional 'super clinics' in targeted specialties with the greatest patient access/demand challenges. Patients with the longest waits are prioritised, and no patients at NTHFT wait over 65 weeks; however 52-week waits exceed trajectories at both Trusts.

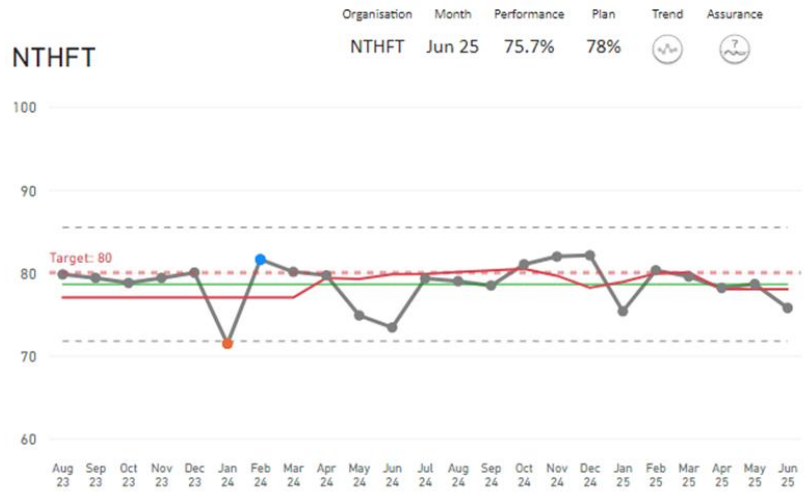
North Tees & Hartlepool NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Cancer Faster Diagnosis Standard (%)	78%	79.3%	79%	78.4%	81%	81.9%	82.1%	75.3%	80.3%	79.5%	78.2%	78.6%	75.7%
Cancer 31 Day Standard (%)	95.8%	96.3%	97.9%	91.8%	94.7%	96.2%	96.6%	96.6%	96.4%	93.8%	97.2%	94.8%	97.1%
Cancer 62 Day Standard (%)	72.1%	62.2%	72.7%	60.1%	70.8%	71.6%	76.2%	72.2%	63.4%	67%	64.3%	58%	56.7%
Diagnostic 6 Weeks Standard (%)	95%	72.9%	72.3%	77.7%	82.7%	86.5%	83.9%	91.6%	95.1%	96.7%	95.1%	96.3%	95.8%
RTT Incomplete Pathways (%)	72.4%	71.7%	71.6%	72.1%	72.4%	71.5%	72.5%	73.2%	74.4%	75.5%	74.5%	74.5%	73.9%
RTT 52 Week Waiters Rate	0.9%	0.9%	0.9%	0.8%	0.9%	1.1%	0.9%	0.8%	0.8%	0.8%	1%	1%	1.2%
RTT Time to First Appointment (%)	79.5%	78.6%	77.3%	77.8%	79.2%	78.6%	79.5%	80.1%	81.8%	82.2%	81.7%	82.3%	81.1%

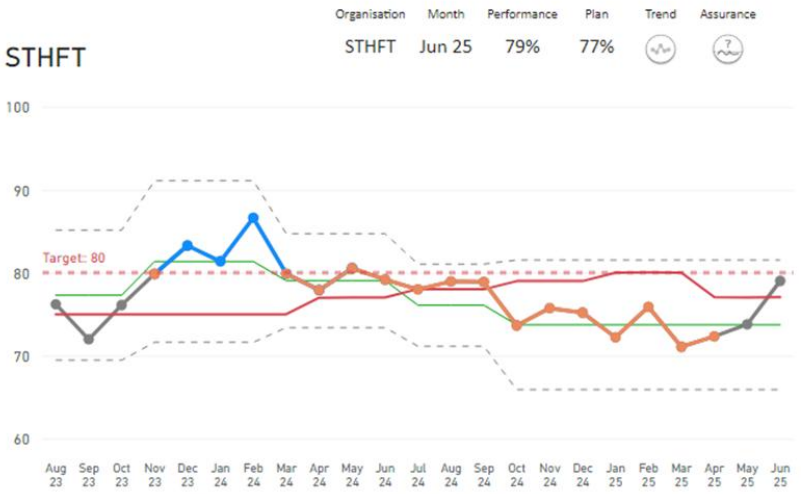
South Tees Hospitals NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Cancer Faster Diagnosis Standard (%)	77%	78%	78.9%	78.9%	73.6%	75.7%	75.2%	72.2%	75.9%	71.1%	72.3%	73.8%	79%
Cancer 31 Day Standard (%)	91.1%	93.1%	92.3%	91.1%	90.5%	89.1%	88.3%	81.1%	86.8%	82.6%	86.6%	82.2%	87%
Cancer 62 Day Standard (%)	63%	63.7%	59.2%	61.9%	56.7%	58.5%	59.9%	63.1%	61%	61.2%	62.3%	60.4%	61.1%
Diagnostic 6 Weeks Standard (%)	95%	83.2%	82.3%	84.9%	85.9%	85.5%	85%	88.7%	88.7%	87.4%	85%	83%	84.4%
RTT Incomplete Pathways (%)	60.9%	60.3%	58.9%	59.1%	60.2%	60%	59.4%	59.5%	59.9%	60.3%	61.1%	62.1%	62.1%
RTT 52 Week Waiters Rate	2.4%	3.7%	3.8%	3.2%	2.6%	2.8%	2.7%	2.9%	2.9%	2.7%	2.8%	2.8%	2.8%
RTT Time to First Appointment (%)	66.4%	64.6%	63.5%	63%	65.1%	65.2%	64.3%	64.3%	64.8%	64.7%	66.2%	66.2%	65.4%

RESPONSIVE Cancer Faster Diagnosis Standard (%)

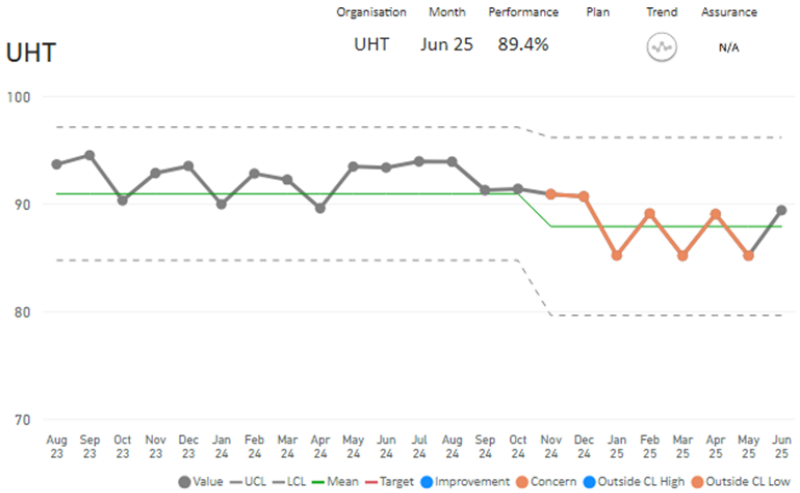


Metric: Percentage of patients on a cancer pathway who receive diagnosis or rule-out within 28 days from referral.
Plan: NHS Constitution standard 80% (from April 2025). Agreed operational planning trajectories: NTHFT 81%, STHFT 80% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT continued focus on compliance in urology and respiratory pathways, STHFT focus on compliance in urology and gastro-intestinal tumour groups. Recent changes in prostate diagnostic pathway are being monitored.
Executive lead: Managing Director
Accountable to: Resources Committee

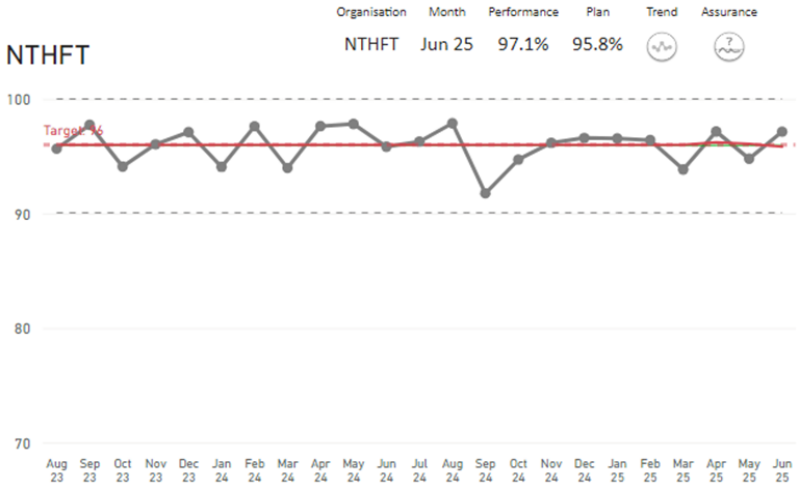


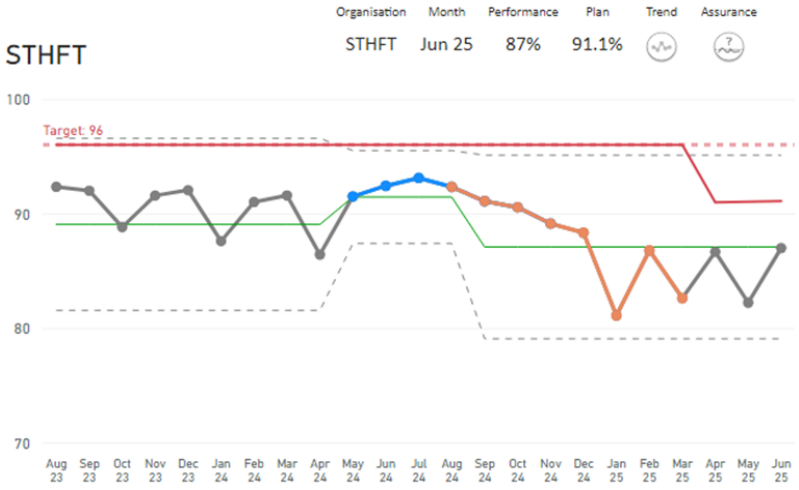


RESPONSIVE Cancer 31 Day Standard (%)



Metric: Percentage of patients on a cancer pathway who start treatment within 31 days of decision to treat.
Plan: NHS Constitution standard 96%. Agreed operational planning trajectories to 96.5% NTHFT, 93.1% STHFT by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT: Urology pathways identified as key focus for performance improvement throughout 25/26**.** STHFT focus is the patients waiting longest for treatment..
Executive lead: Managing Director
Accountable to: Resources Committee



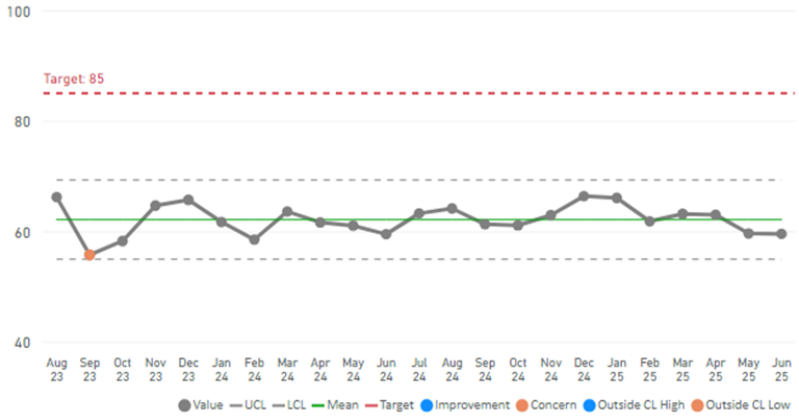


RESPONSIVE Cancer 62 Day Standard (%)

Metric: Percentage of patients on a cancer pathway who start treatment within 62 days of referral.
Plan: NHS Constitution standard 85%. Agreed operational planning trajectories: NTHFT 75%, STHFT 68.3% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: no trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Focus across UHT is the patients waiting longest for treatment, reducing compliance in this metric as they are treated. Service improvement work is underway across tumour groups with recent changes in prostate diagnostic pathway being monitored for improvements however this is not yet impacting on 62-day standard.
Executive lead: Managing Director
Accountable to: Resources Committee

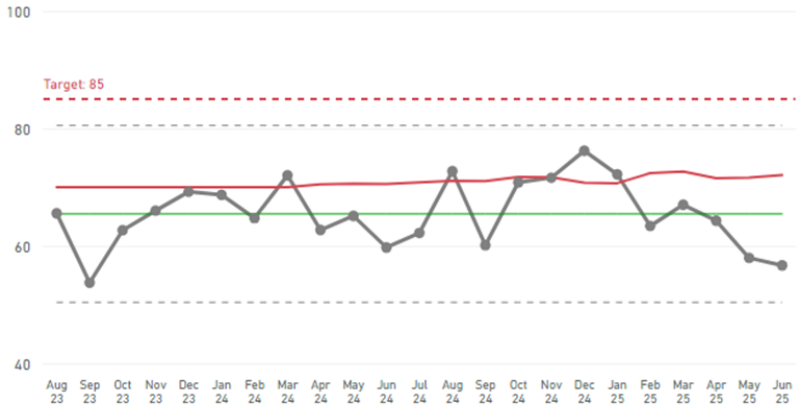
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Jun 25	59.5%			N/A



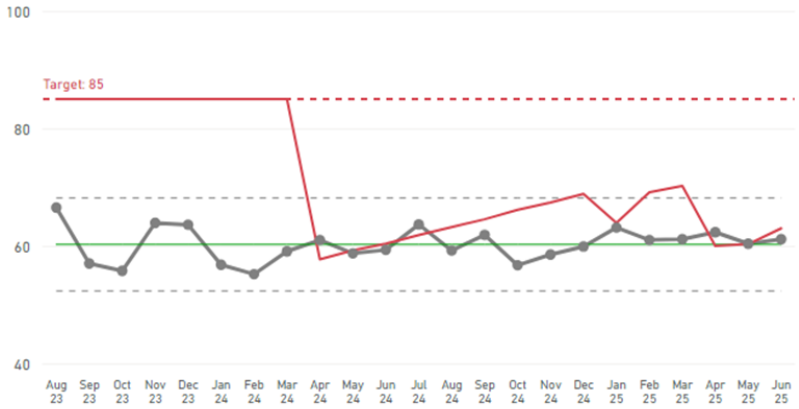
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Jun 25	56.7%	72.1%		

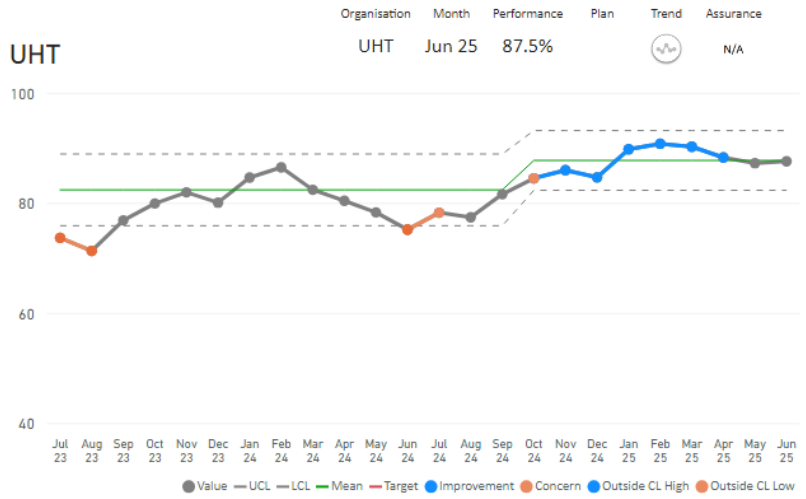


STHFT

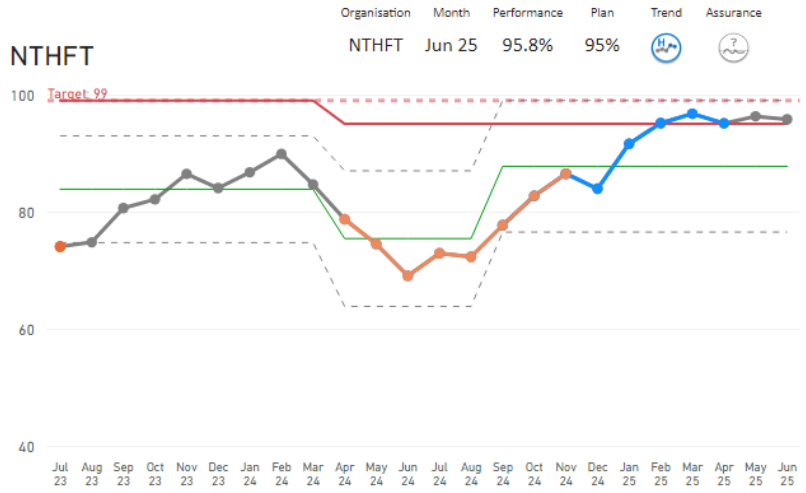
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Jun 25	61.1%	63%		

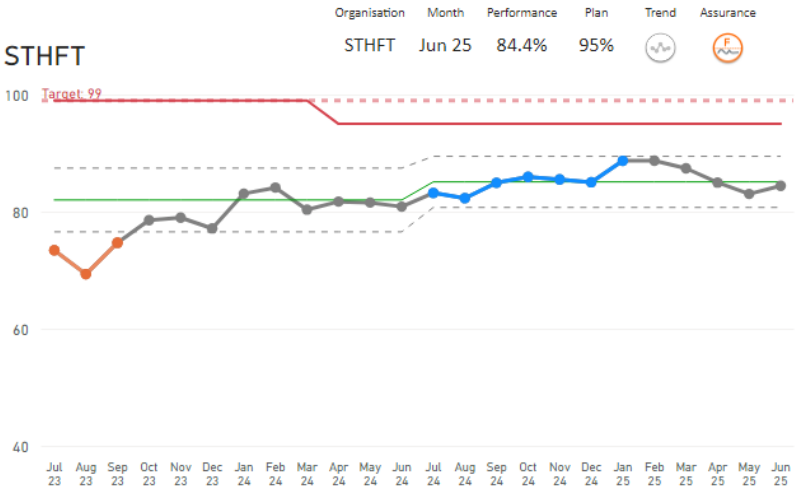


RESPONSIVE Diagnostic 6 Weeks Standard (%)

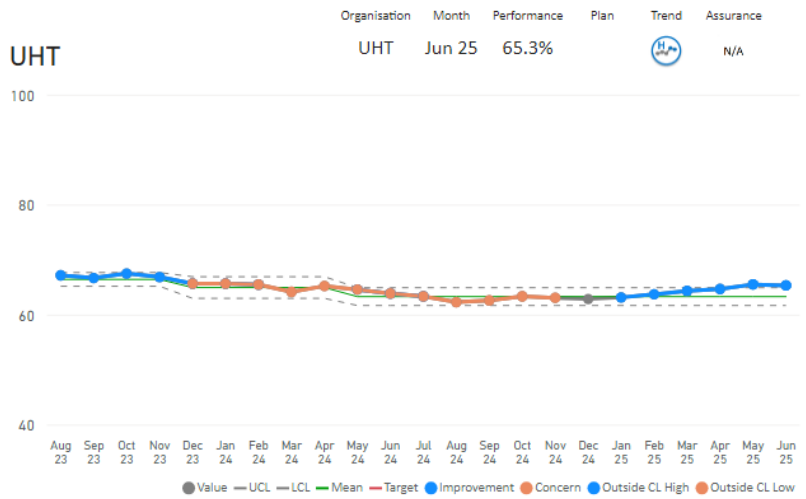


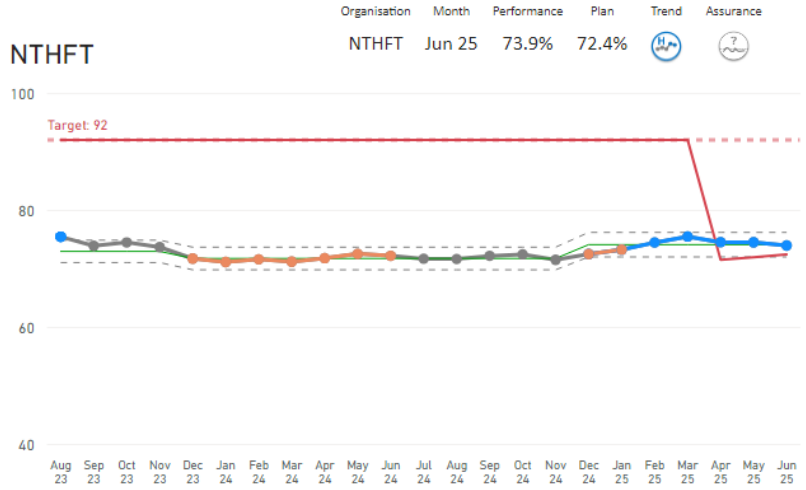
Metric: Percentage of patients waiting for a diagnostic test less than 6 weeks from referral,13 modalities.
Plan: NHSE 24/25 operational standard 95%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Improvement. STHFT: No trend.
Assurance: NTHFT: Advise. Achieved plan in each of last 5 months. STHFT: Alert, as previous improvement trend stalled, impacted by a deterioration in Echocardiography staffing capacity.
Action taken: Improvement work underway in STHFT specialist services will show only incremental improvement over several months. Action plan in place for Echocardiography staffing.
Executive lead: Managing Director
Accountable to: Resources Committee

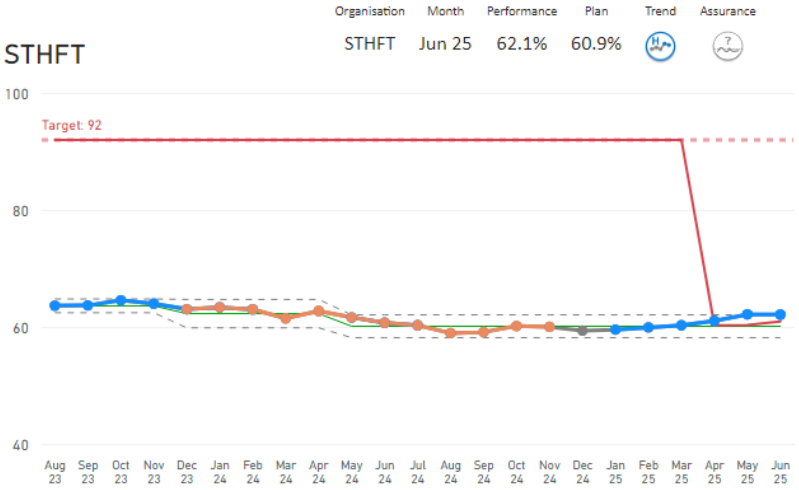




RESPONSIVE RTT Incomplete Pathways (%)

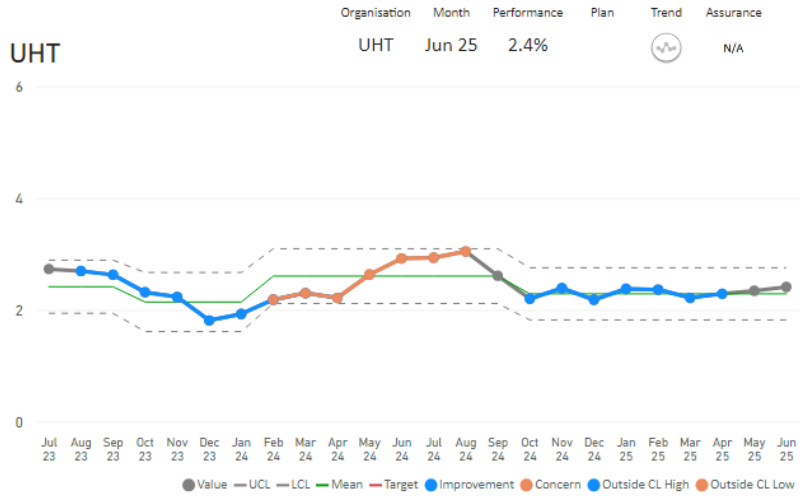


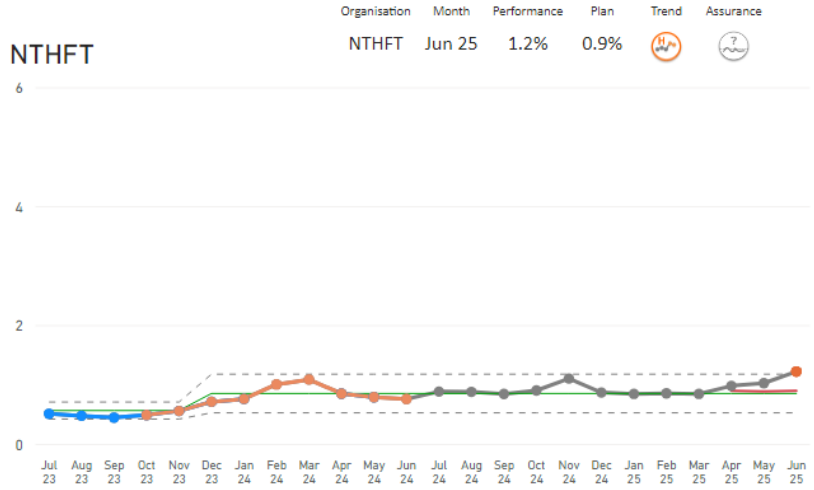


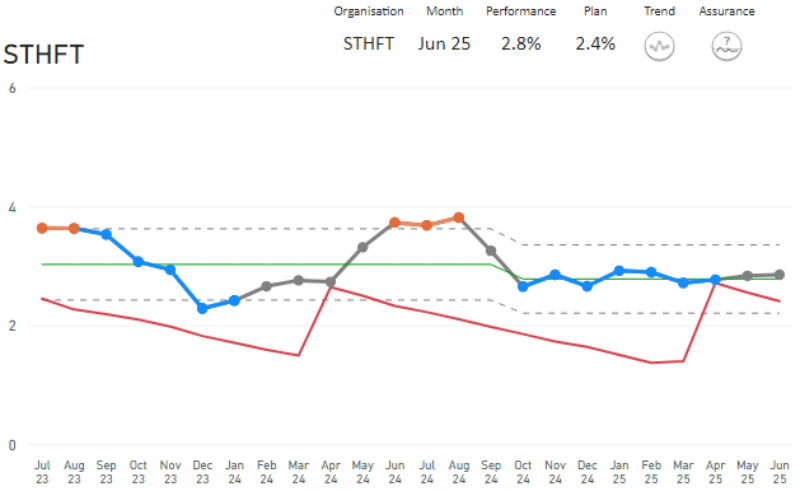


Metric: Percentage of patients awaiting elective treatment who have waited less than 18 weeks from referral.
Plan: NHS Constitution standard 92%. Agreed operational planning trajectories: NTHFT 76.5%, STHFT 65.0% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: Both trusts demonstrating an improvement trend since January 2025.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Focus is on reducing the longest waiters beyond 52 and 65 weeks. Both Trusts out-performed agreed plans for this metric throughout Q1 2025. Q2 June to September validation sprint currently underway.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE RTT 52 Week Waiters Rate

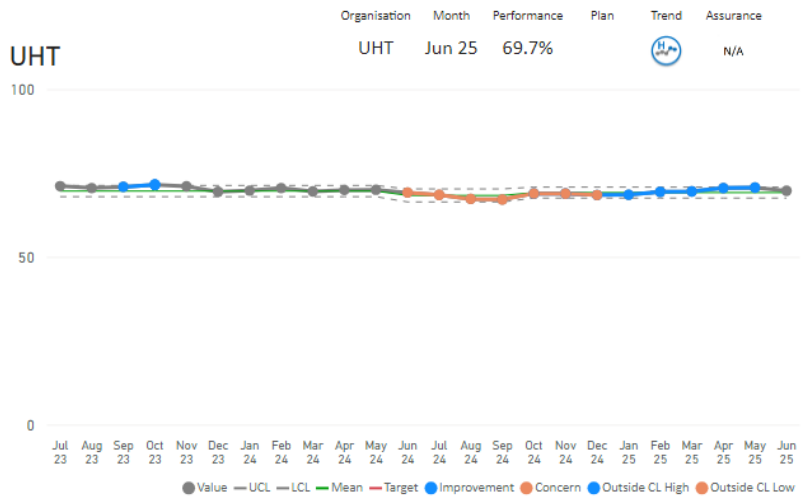




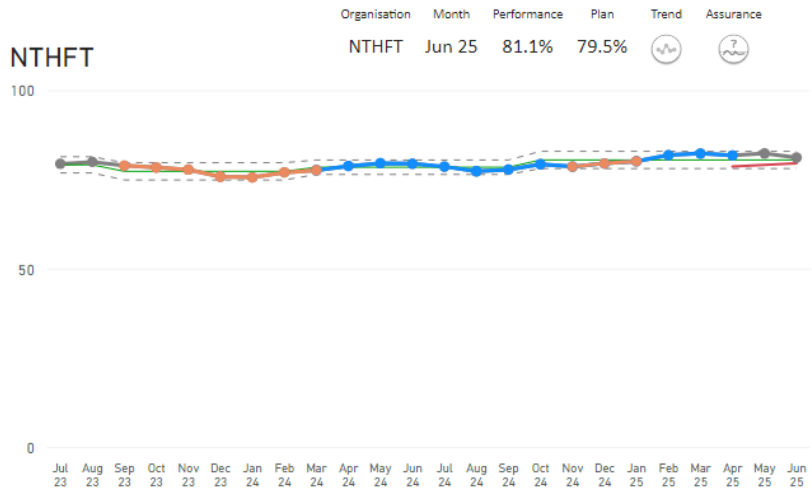


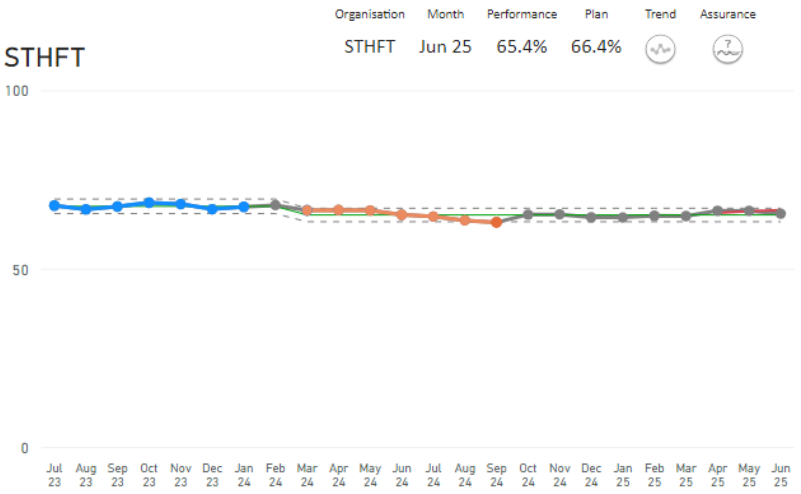
Metric: Rate of patients awaiting elective treatment who have waited more than 52 weeks from referral.
Plan: To reduce the number of 52-week waiters to less than 1% of the waiting list by March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: June 2025 is outside (worse than) usual variance. STHFT: no trend.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: Both Trusts are focused on return to plan. NTHFT are currently refreshing capacity and demand across all specialties. STHFT have increased capacity in Neurology and Urology, and all specialties are required to focus on booking processes to reduce long waits.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE RTT Time to First Appointment (%)



Metric: RTT Referral to First Appointment within 18 weeks.
Plan: Agreed operational planning trajectories: NTHFT 78.5%, STHFT 72.3% by end March 2026.
Rationale: 25/26 NHSE planning guidance priority.
Data quality: assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Waiting list validation sprint Q2 June to September is underway. Outpatient clinic template reviews and resulting clinic template changes being undertaken across UHT to increase clinic capacity within existing resources to reduce long waits for first appointment.
Executive lead: Managing Director
Accountable to: Resources Committee





Caring Better Together

CARING DOMAIN SUMMARY

Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

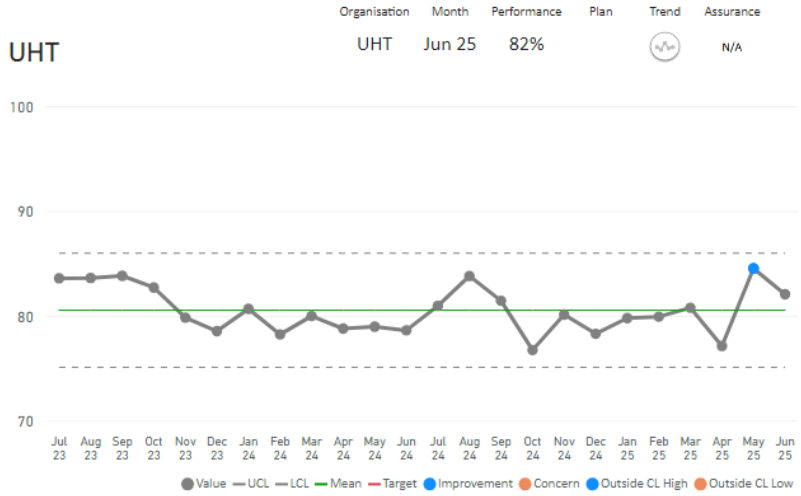
Performance in patient experience surveys is measured as the percentage of respondents rating their experience overall very good or good. In June, NTHFT were on or above plan in four of the five surveys. STHFT were above plan in all surveys, with statistical assurance in outpatient and community services. The focus is on increasing response rates to FFT to provide more assurance of positive experience of care, supported by digital data collection. STHFT are doing a staged approach from Meridian to InPhase, work on the inpatient survey will be completed in August 2025.

Work continues in Q2 25/26 to ensure consistency in timely responses to complaints. Patient experience teams continue to support and escalate to the clinical and operational teams, requiring their focus on resolving these in a timely manner, prioritising those longest in progress.

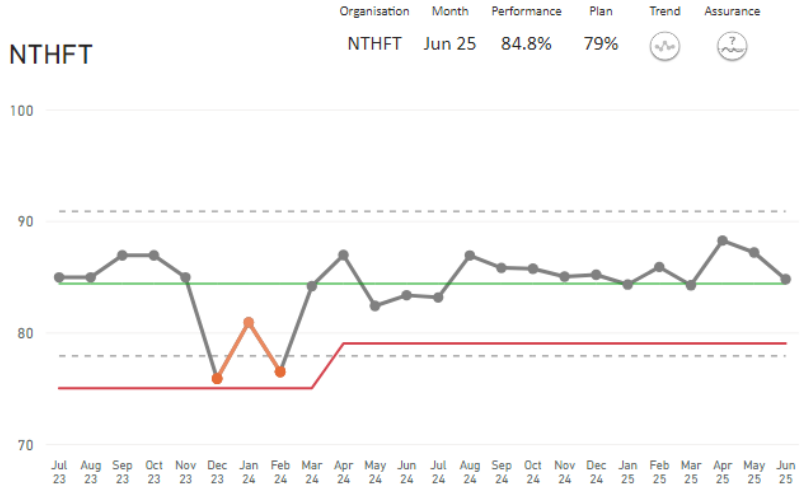
North Tees & Hartlepool NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
A&E Experience (%)	79%	83.1%	86.9%	85.8%	85.7%	85%	85.2%	84.3%	85.9%	84.2%	88.2%	87.2%	84.8%
Inpatient Experience (%)	95%	90.7%	93.5%	95.8%	94.7%	94.8%	94.8%	91.2%	92.4%	91.5%	95%	93.5%	95.4%
Maternity Experience (%)	92%	90.5%	100%	83.3%	87.5%	100%	87.5%	96.3%	100%	100%	93.3%	94.1%	84.8%
Outpatient Experience (%)	94%	94.8%	95.3%	93.6%	93.8%	94.9%	94%	93.8%	94.4%	93.1%	99.4%	95.5%	94.1%
Community Experience (%)	94%	96.8%	96%	96.4%	98.3%	96.9%	97.1%	97.5%	94%	97%	100%	97.7%	96%
Feedback Acknowledged in 3 Days (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Complaints Closed Within Target (%)	80%	60.4%	70.9%	54.4%	52.6%	72.1%	55.4%	60.9%	73.1%	67%	71%	78.5%	65.9%

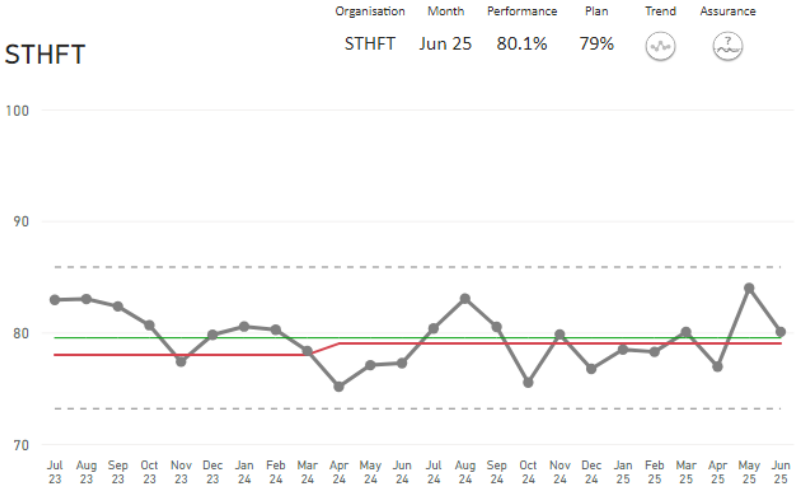
South Tees Hospitals NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
A&E Experience (%)	79%	80.4%	83%	80.5%	75.5%	79.8%	76.7%	78.5%	78.3%	80%	76.9%	84%	80.1%
Inpatient Experience (%)	95%	97.3%	97.8%	97.6%	99.1%	96.8%	96.9%	98.9%	97.8%	98.2%	96.9%	95.1%	97.8%
Maternity Experience (%)	92%	92.7%	91%	94.6%	92.3%	91.7%	87.6%	89.6%	94.3%	93.4%	93.3%	93.8%	93.2%
Outpatient Experience (%)	94%	97.2%	97.2%	97.1%	96.5%	95.5%	96.7%	96.1%	95.8%	95.9%	95.2%	95.9%	96.3%
Community Experience (%)	94%	98.9%	99.4%	97.5%	97.5%	100%	100%	97.3%	100%	100%	100%	100%	100%
Feedback Acknowledged in 3 Days (%)	100%	88.2%	97%	98.7%	100%	100%	100%	100%	100%	96.5%	99%	99.1%	100%
Complaints Closed Within Target (%)	80%	47.4%	16.7%	56.8%	35.6%	38%	40.4%	45.9%	58.7%	47.1%	78.3%	71.4%	55.6%

CARING A&E Experience (%)



Metric: Percentage of respondents who attended A&E rating their experience good or very good in NHS Friends & Family test.
Plan: Local plan set on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured (manual and digital systems). NTHFT response rate low due to lack of digital platform during April and May for FFT returns, resolved in June.
Response rates: NTHFT 5%, STHFT 8.1%.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise, assurance hampered by past variation in performance. STHFT: Advise.
Action taken: Patient feedback appears to correlate inversely with A&E waiting times metrics, so focused improvement of waits is expected to improve experience.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





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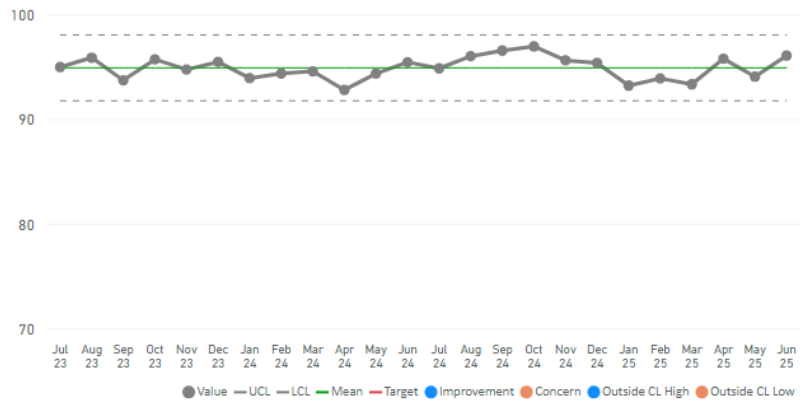
CARING Inpatient Experience (%)

UHT

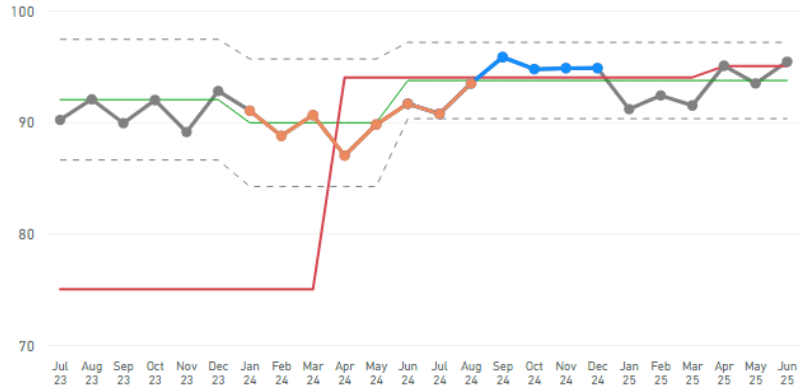
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Jun 25	96%			N/A



Metric: Percentage of respondents rating their inpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 13%, STHFT 14.1%.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: STHFT transitioning from Meridian to InPhase during August 2025. This will standardise patient feedback collection processes and analysis across UHT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

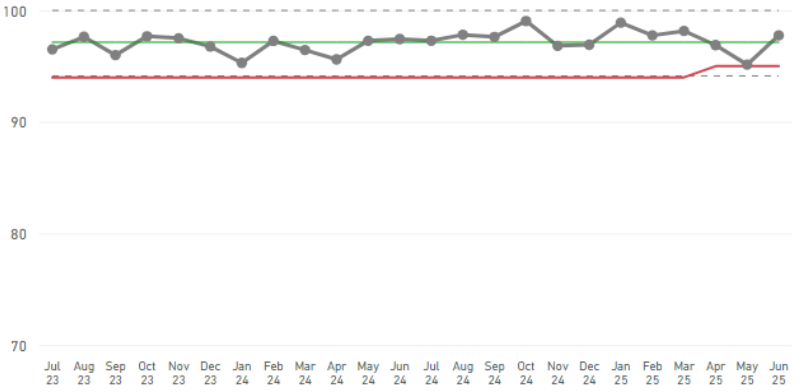
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Jun 25	95.4%	95%		



STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Jun 25	97.8%	95%		



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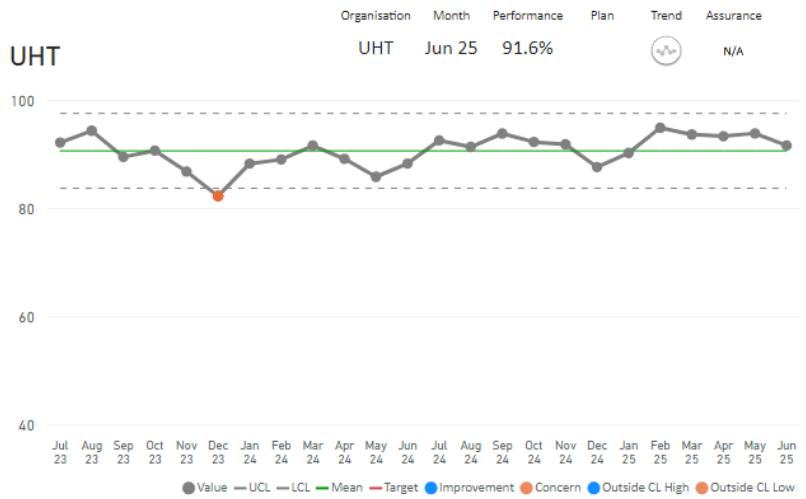
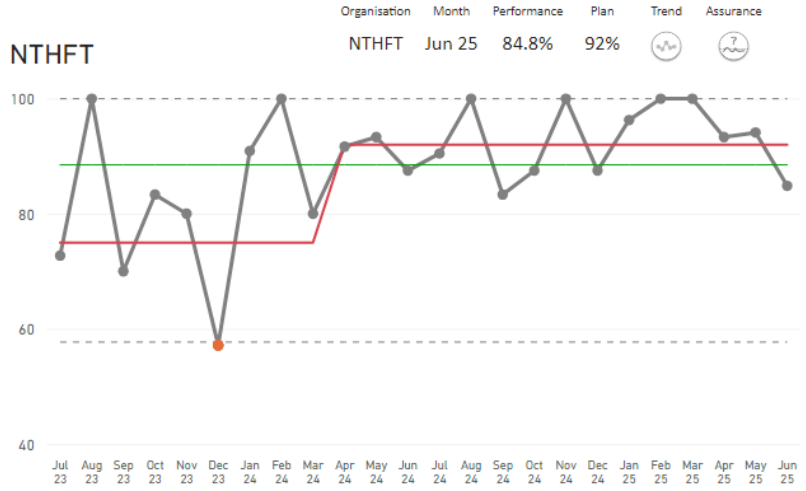
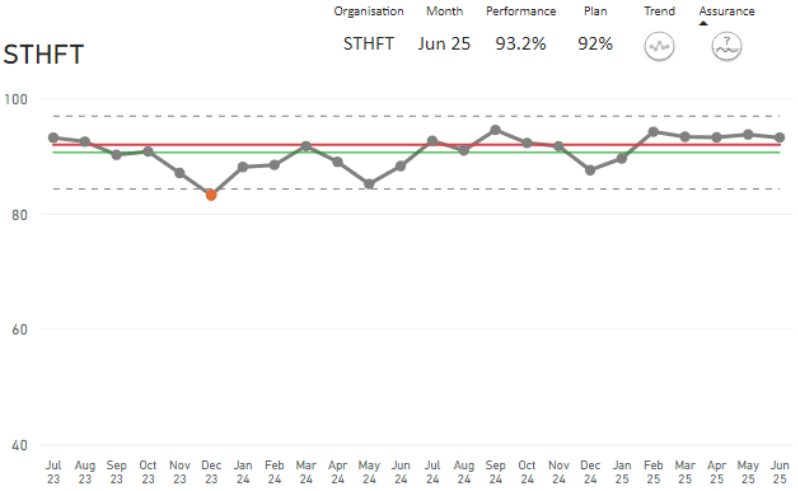
CARING Maternity Experience (%)

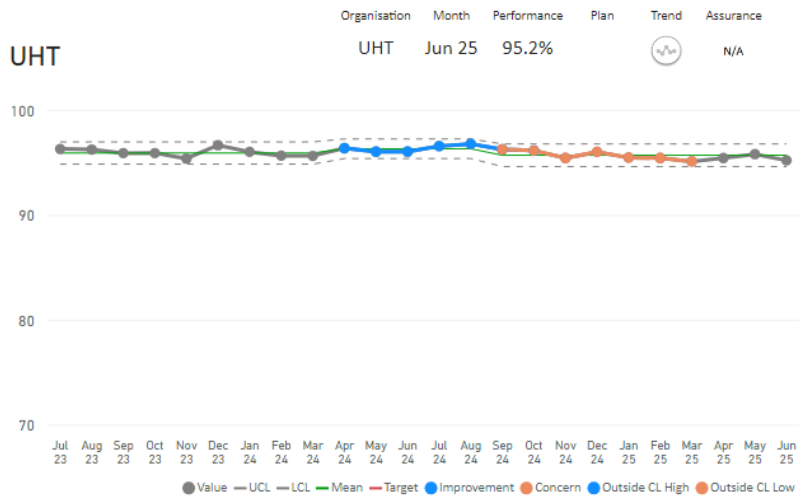




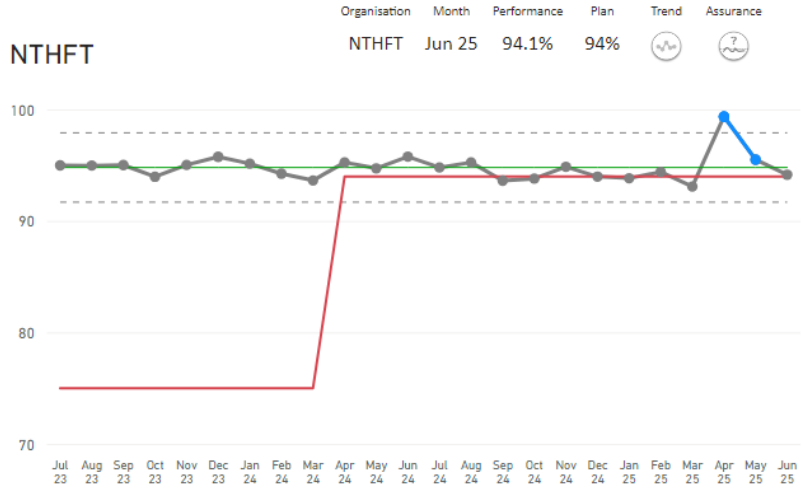


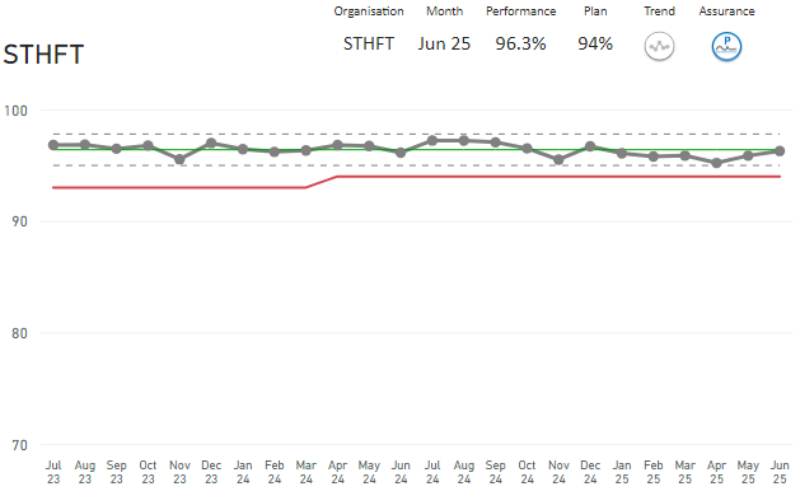
Metric: Percentage of respondents rating their maternity experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates and sample sizes can be low, reported figure is Birth only.
Response rates: NTHFT 13%, STHFT 15.9%.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise, below plan in June 2025 after exceeding in the previous 5 months. STHFT: Advise, exceeded plan for the last 5 months but not assured.
Action taken: To continue to promote engagement with Friends and Family Test. STHFT, transitioning from Meridian to InPhase during August 2025.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Outpatient Experience (%)

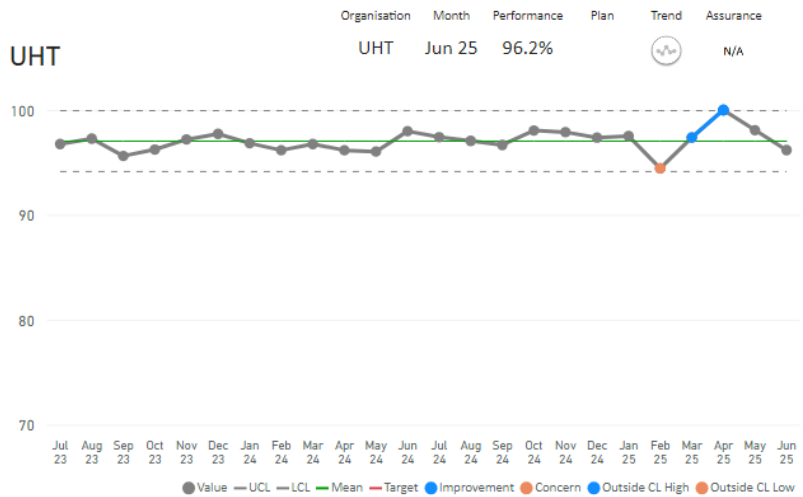


Metric: Percentage of respondents rating their outpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 30%, STHFT 15.0%.
Trend: NTHFT: No trend, June 2025 returns to expected variation. STHFT: No trend.
Assurance: NTHFT: Advise, performance is close to plan each month but does not always achieve. STHFT: Assure.
Action taken: Transitioned to a new digital platform in June 2025 to improve response rates.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

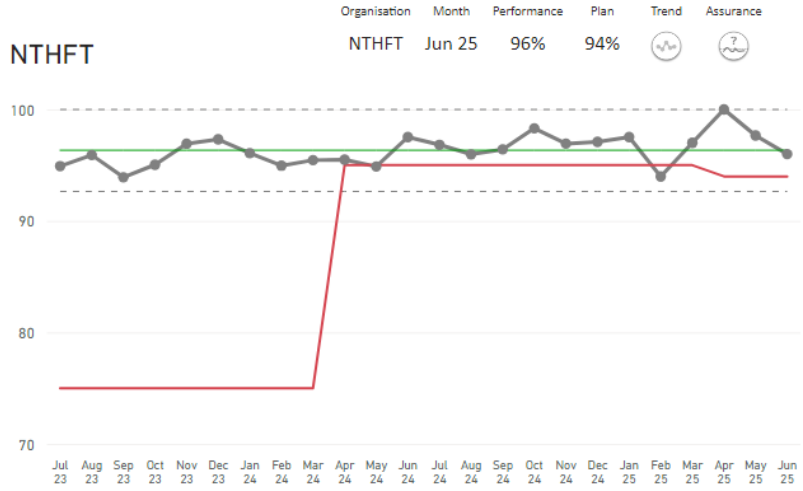


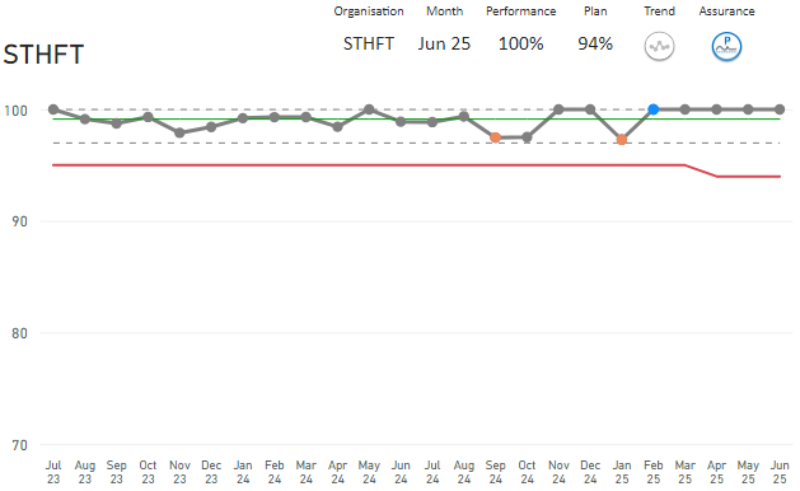


CARING Community Experience (%)



Metric: Percentage of respondents rating their community services experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: 6% NTHFT, STHFT 10.4%.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise, plan not consistently met.
STHFT: Assure, plan consistently met.
Action taken: Further work is required to ensure NTHFT community services consistently achieve positive feedback, and to improve response rates.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





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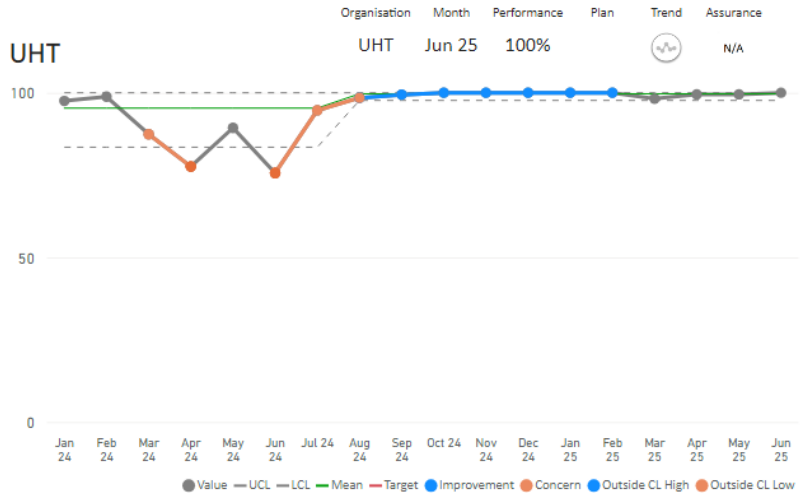
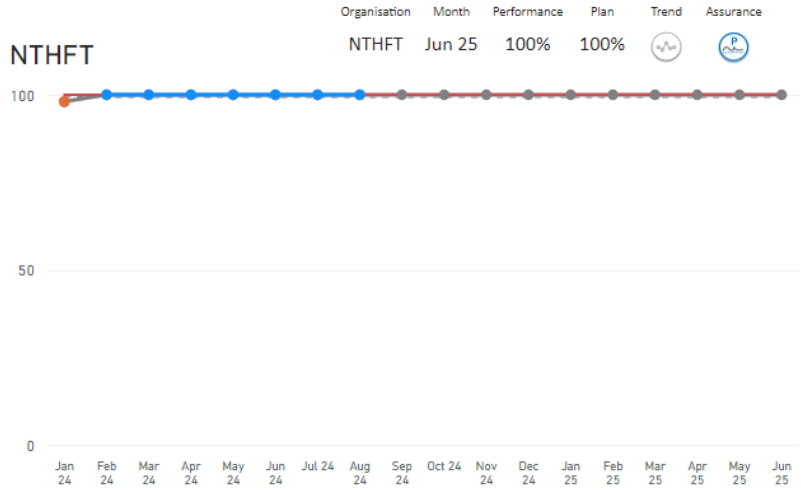
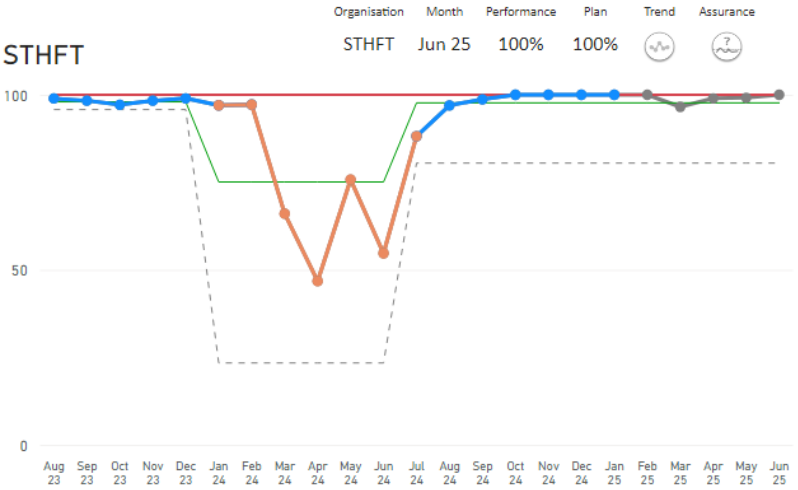
CARING Feedback Acknowledged in 3 Days (%)



Metric: Percentage of complaints acknowledged in 3 days.
Plan: 100%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Assure. STHFT: Advise.
Action taken: STHFT: new process for acknowledging complaints implemented in July 2024 led to improved performance which has been sustained. STHFT statistical assurance is hampered by past poor performance.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





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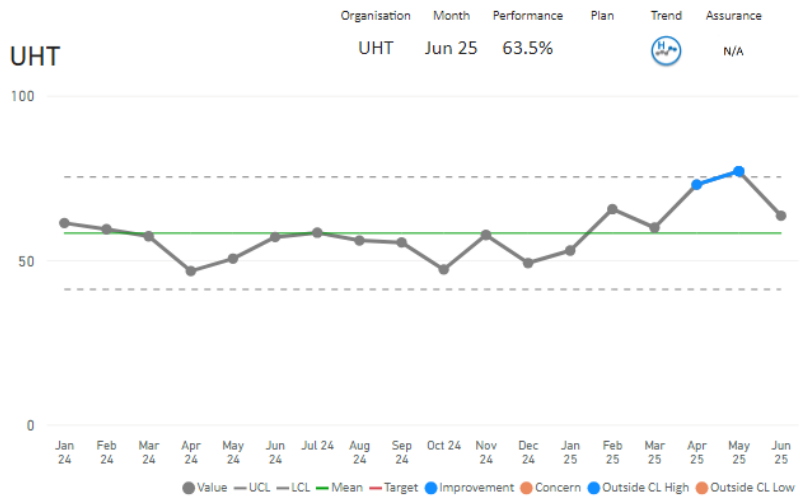
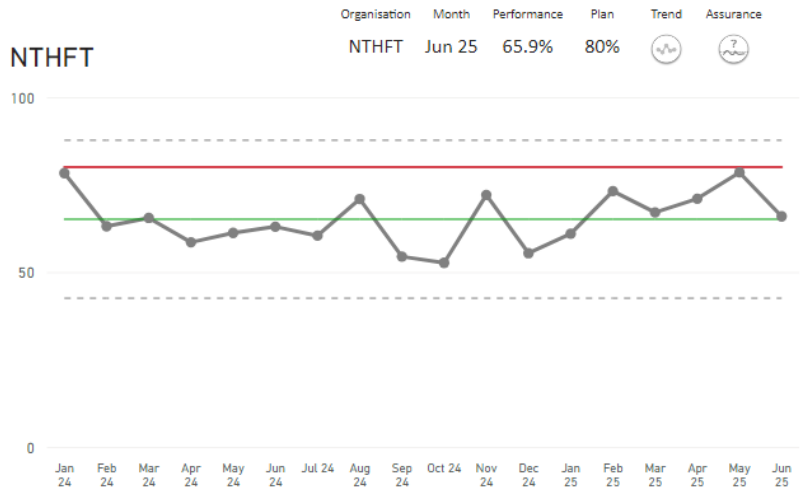
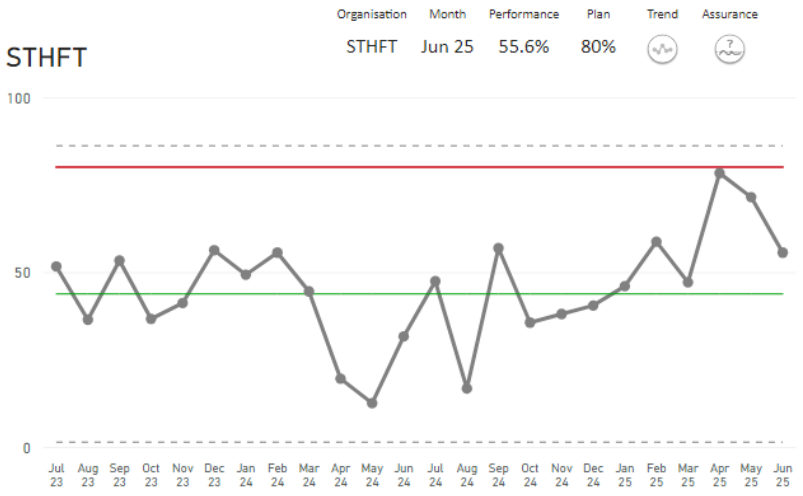
CARING Complaints Closed Within Target (%)



Metric: Percentage of complaints closed in agreed timeframe.
Plan: 80%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend, wide variation.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT: InPhase reporting to be improved to allow increased performance monitoring within Care Groups. STHFT: off-target complaint responses are reported weekly for senior focus and accountability for completing responses by Collaboratives.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





Executive leads: Rachael Metcalf, Chief People Officer
Chris Hand, Chief Finance Officer

Accountable to: People Committee
Resources Committee

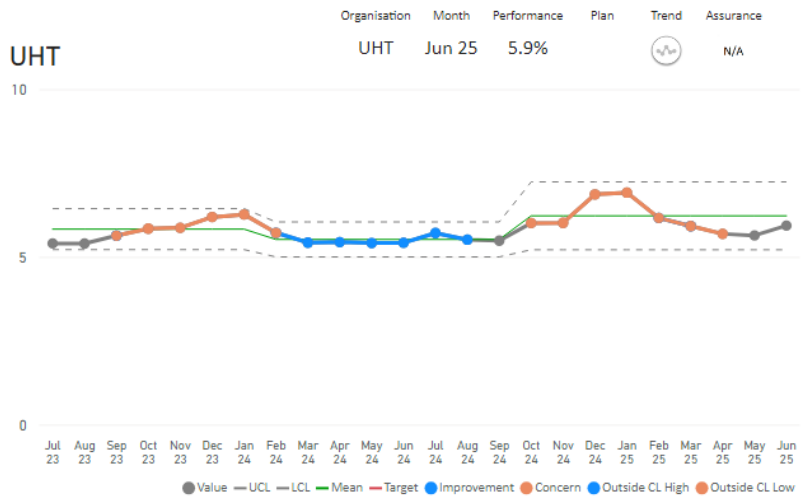
The targeted work programme on absence management across UHT is well underway. Focussed work on ensuring accurate reporting and data analysis of trends and patterns has been undertaken with additional training and development provided for managers on identifying and addressing sickness absence. Long term absence cases have been targeted at STFT with a reduction realised. Work continues to implement a standardised reporting dashboard for mandatory training across UHT. The proposed changes to clinical structures will impact ESR hierarches, leading to revised internal HR KPI performance monitoring.

The Board is advised that financial position shows a small positive variance to plan at the end of month 3 (June) for both NTHFT and STHFT. Financial controls are in place, with a focus on recurrent efficiency delivery, and Resources Committee oversight of financial risks.

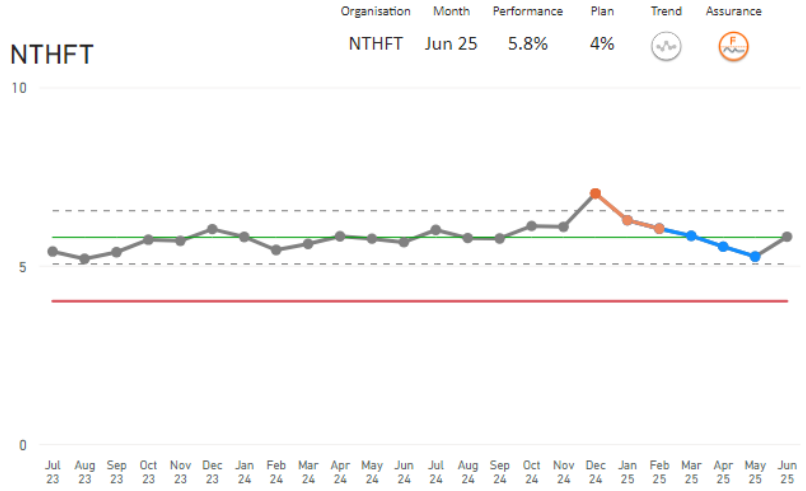
North Tees & Hartlepool NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Sickness Absence (%)	4%	6%	5.8%	5.8%	6.1%	6.1%	7%	6.3%	6%	5.8%	5.5%	5.3%	5.8%
Staff Turnover (%)	10%	7.2%	7.3%	7.3%	7.3%	7.2%	6.9%	7.1%	7%	7.2%	7.5%	7.6%	7.4%
Annual Appraisal (%)	85%	86.9%	86.7%	87.2%	86.9%	86.9%	87%	87.2%	86.6%	85.9%	86.3%	88.5%	88.5%
Mandatory Training (%)	90%	89.4%	89.7%	89.5%	89.8%	89.4%	88.9%	88.9%	88.1%	88.9%	88.7%	88.9%	89.4%
Cumulative YTD Financial Position (£'millions)	£0.638	-£1.266	-£1.24	-£0.861	-£1.114	-£1.289	-£1.404	-£0.994	-£0.473	£0.002	£0.117	£0.28	£0.644

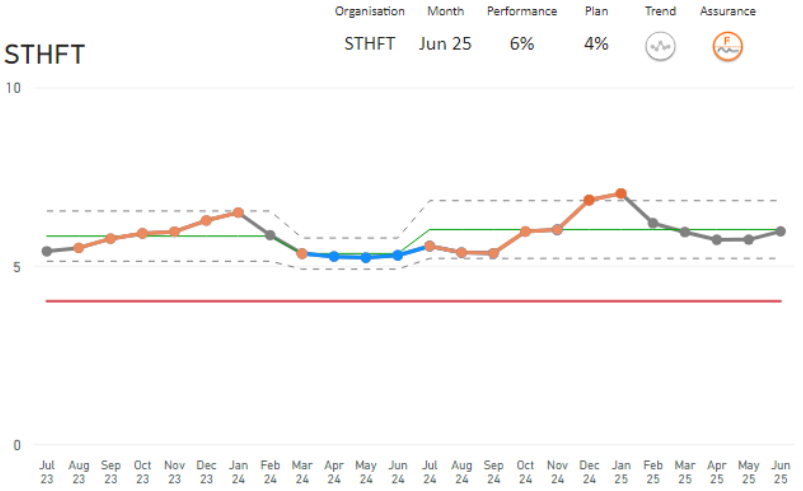
South Tees NHS FT	Plan	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Sickness Absence (%)	4%	5.5%	5.4%	5.3%	6%	6%	6.8%	7%	6.2%	5.9%	5.7%	5.7%	6%
Staff Turnover (%)	10%	10%	10.2%	9.8%	9.3%	6.6%	6.5%	6.6%	6.5%	6.6%	6.7%	6.6%	6.5%
Annual Appraisal (%)	85%	80.3%	80.3%	80%	78.8%	78.7%	78.8%	78.8%	80.2%	82.2%	82%	83.1%	84%
Mandatory Training (%)	90%	90.3%	90%	89.7%	89.2%	87.8%	87.3%	86.8%	86.7%	85.6%	85.6%	85.7%	85.7%
Cumulative YTD Financial Position (£'millions)	-£7.014	-£15.87	-£19.33	-£12.715	-£14.342	-£16.684	-£18.873	-£7.583	-£7.489	-£7.796	-£2.065	-£3.467	-£7.009

WELL LED Sickness Absence (%)

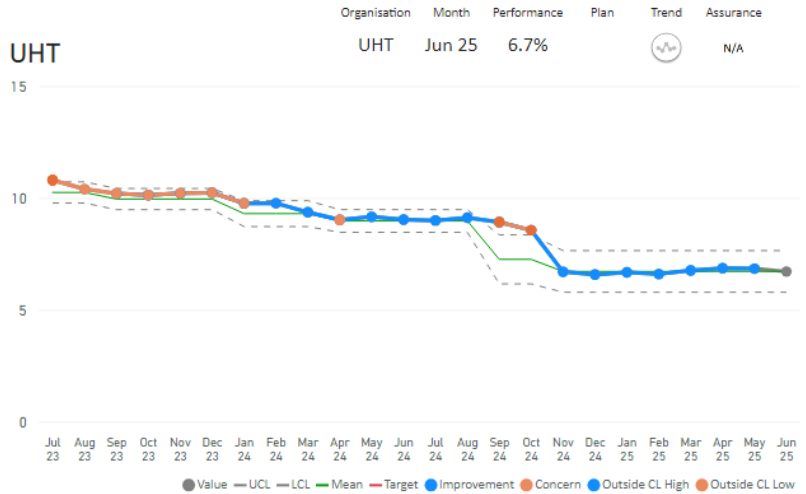


Metric: Percentage of staff working hours lost to sickness absence (all types) in each month.
Plan: Trust internal plans: 4%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data. Data quality issues identified during data analysis have been rectified.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Alert. Deterioration in June 2025 following 5 months of improvement. STHFT: Alert.
Action taken: Standardised UHT policy in development. Coaching/training with managers on absence recording has taken place. A positive impact is expected, this will be monitored and supported to ensure timeliness and accuracy.
Executive lead: Chief People Officer
Accountable to: People Committee

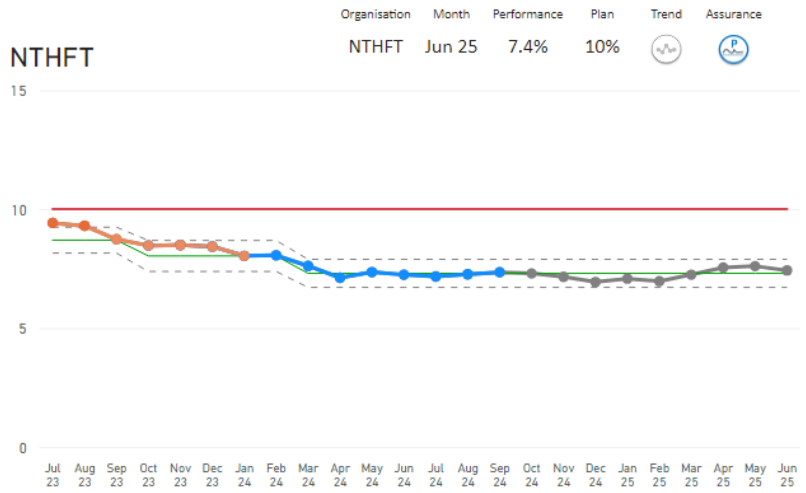


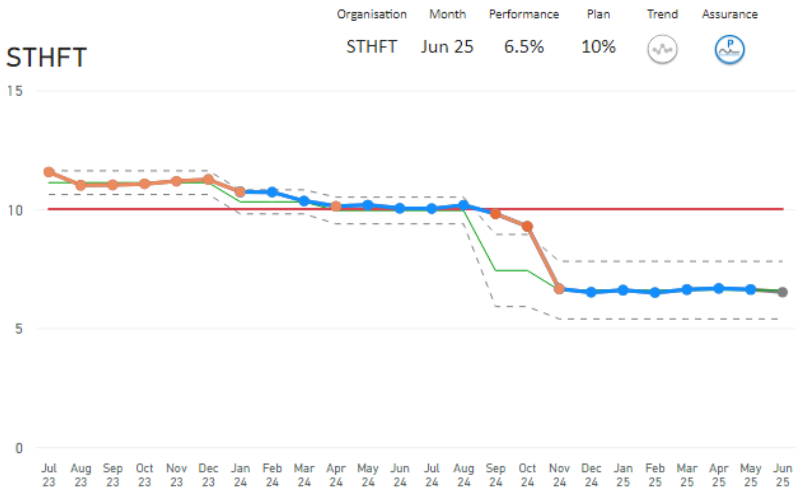


WELL LED Staff Turnover (%)

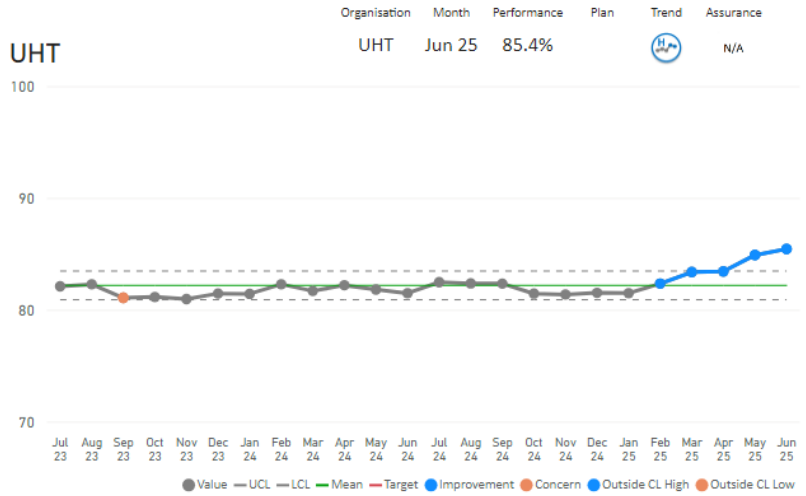


Metric: Percentage of staff changing or leaving job roles in the month (all staff groups, all changes).
Plan: Trust internal plans: 10%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data. Alignment of the metric criteria has improved STHFT reported performance from November 2024.
Trend: NTHFT: No trend. STHFT: no trend, lower turnover now embedded.
Assurance: NTHFT: Assure. STHFT: Assure.
Action taken: Overall turnover is consistently low in both Trusts with none of the eight staffing groups being outliers. Further analysis will be provided to people committee as part of the annual cycle of business in November 2025.
Executive lead: Chief People Officer
Accountable to: People Committee

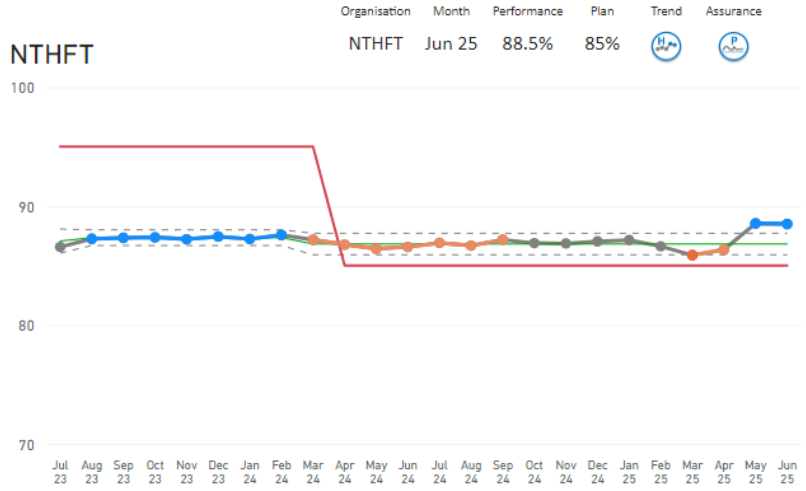


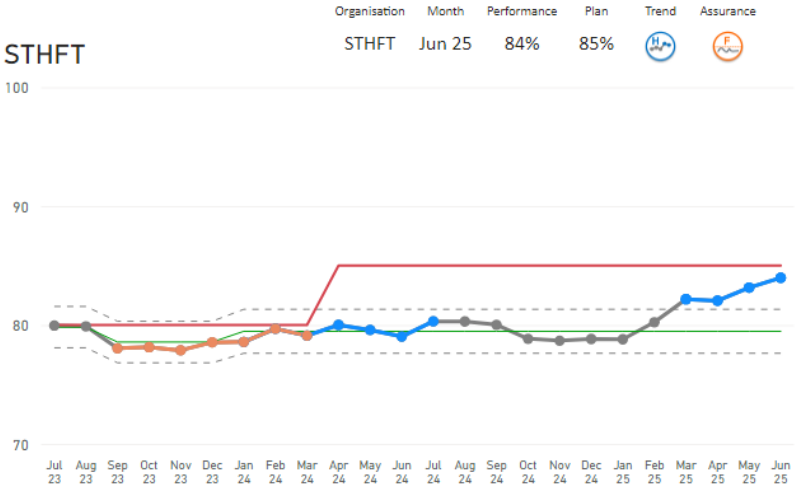


WELL LED Annual Appraisal (%)

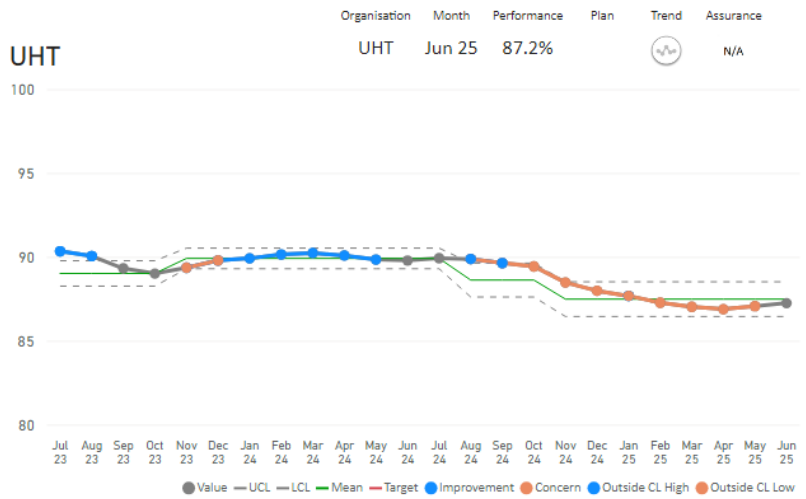


Metric: Percentage of staff with annual appraisal completed in last 12 months, at month end.
Plan: Trust internal plans: 85%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: High outliers for May and June 2025. STHFT: improved performance from March 2025, above expected normal variance.
Assurance: NTHFT: Assure. STHFT: Advise, recent significant improvement.
Action taken: The focus on appraisal compliance has now moved to 18 months non-compliance (NTHFT 615; STHFT 556).
Executive lead: Chief People Officer
Accountable to: People Committee

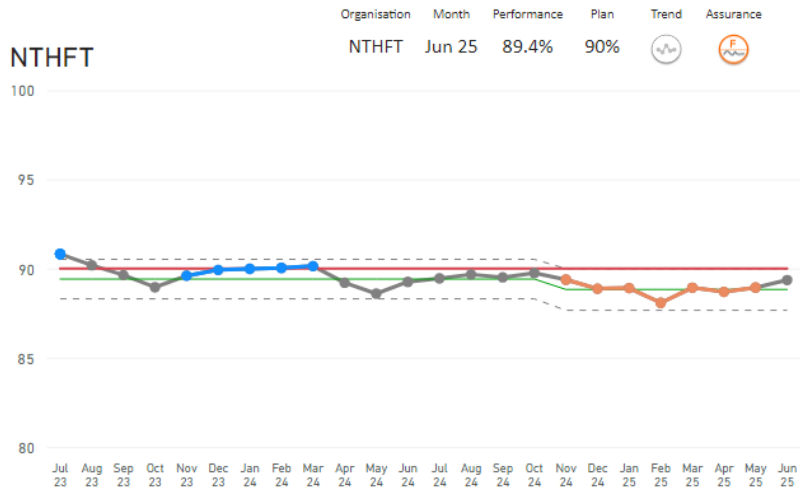


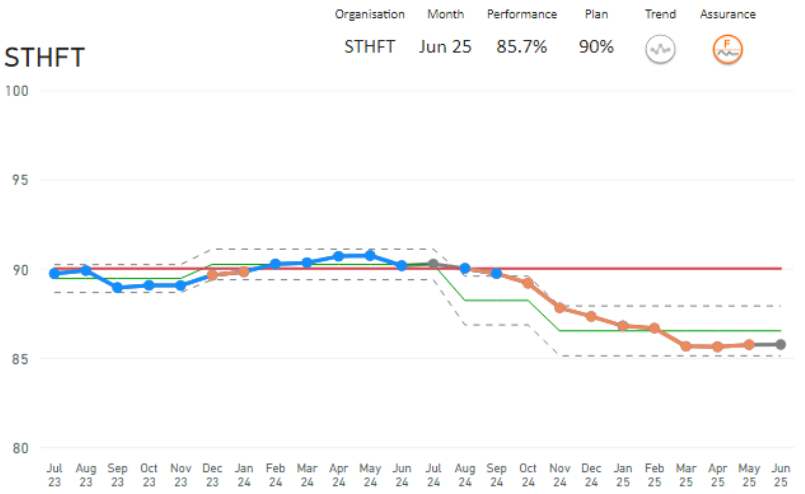


WELL LED Mandatory Training (%)

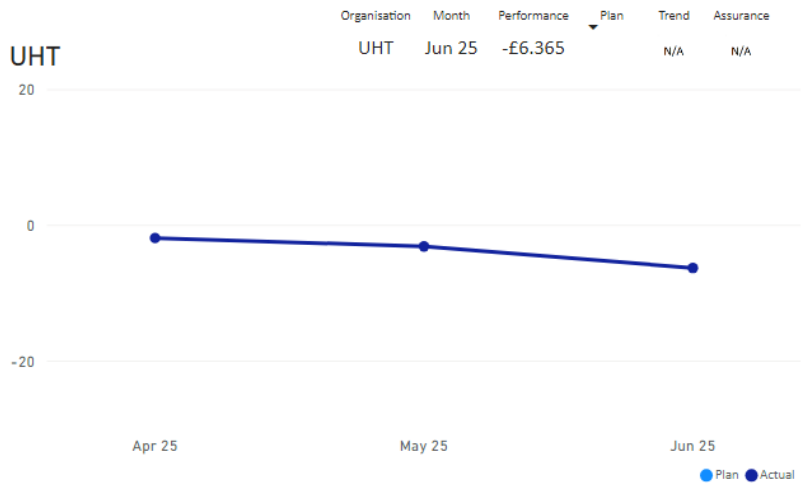


Metric: Percentage of mandatory training elements within date, across all staff groups at month end.
Plan: Trust internal plans: 90%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: reducing compliance stabilised.
Assurance: NTHFT: Alert. STHFT: Alert.
Action taken: .National mandatory training policy to be implemented by Sept 2025. Standardised reporting across UHT via new UHT dashboard progressing. Focused work to improve compliance across topics with focus on resuscitation topics. In addition, a review of the conflict resolution training offer is underway.
Executive lead: Chief People Officer
Accountable to: People Committee





WELL LED Cumulative YTD Financial Position (£'millions)



Metric: Cumulative year to date financial position.
Plan: Trust plans agreed with ICB. NTHFT submitted a breakeven plan for 2025/26. The STHFT control total for 2025/26 is a £9.1m deficit.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: Financial position tracks plans.
Assurance: Advise: Small positive variance to plan at month 3 for both NTHFT and STHFT.
Action taken:. Financial controls in place, focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.
Executive lead: Chief Finance Officer
Accountable to: Resources Committee

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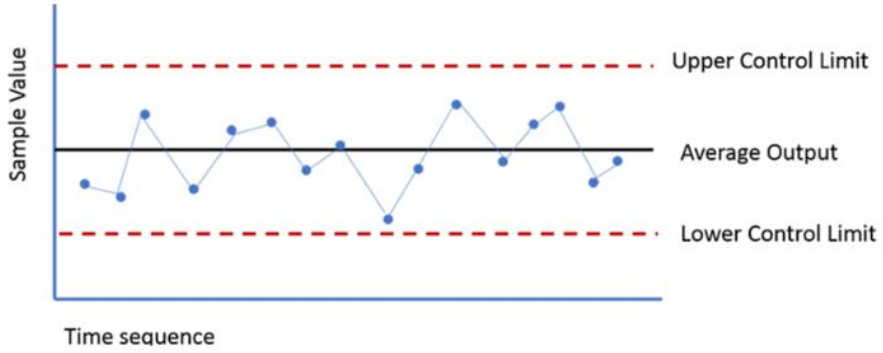
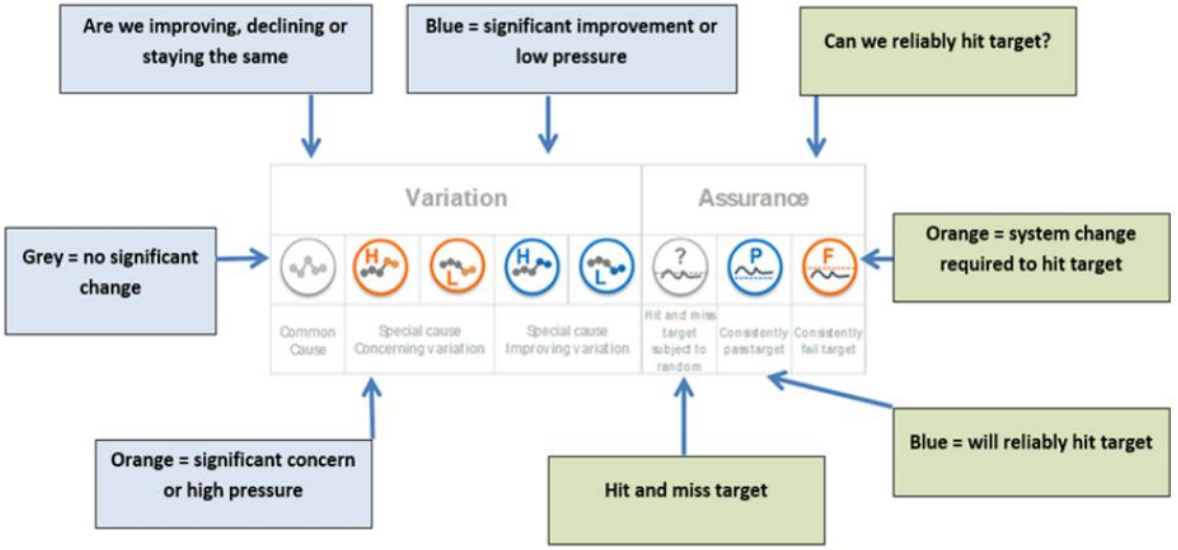
OVERVIEW SPC CHARTS

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



High level Key - Variation

High level Key - Assurance



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Thank you

University Hospitals Tees

UHT Winter Preparedness Plan

Meeting date: 4 September 2025

Reporting to: Board of Directors

Agenda item No: 4.4

Report author: Rowena Dean Chief Operating Officer – NTH / Sam Peate Chief Operating Officer – Stees.

Executive director sponsor: Neil Atkinson, Chief Delivery Officer

Action required: Approval

Delegation status: Jointly delegated item to Group Board

Previously presented to: Resources Committee August 2025

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

CQC domain link:

Responsive

Board assurance framework references 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 ask of all NHS Trusts is to develop an organisational winter plan, completing a draft by end August and to ensure preparatory actions, including staff vaccination programmes, are in progress now.

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 winter preparedness plan details the plans and processes in place which are both site specific and across the group to manage seasonal escalations in demand. A number of risks have been identified as part of the planning which are addressed as part of the responses to escalations.

In addition to our local responses there are escalation process in place across all stakeholder at system level to address pressures in the system which the group is an active participant.

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 group have included an innovative pilot, introducing a group care coordination centre to further support our community response and left shift into the community as detailed in the 10 year plan. This should further support a reduction in patients being admitted into the hospitals.

The plan is built upon the National Urgent and Emergency Care Plan published 6 June 2025 identifying 7 key priorities, GIRFT Clinical Operational Standards Emergency Care Pathways and the UEC Network regional clinical priorities. The group will present Gap analysis report to the resources committee in September against these standards.

The plan was presented to the August Resources Committee with members of the Quality Assurance Committee attending who recommended the plan to the Board.

Recommendations:

The Board is requested to note the content of the winter plan at both site and group level and the further work that is taking place in preparedness for the seasonal escalations in demand across the system.

NHS
University Hospitals Tees

- University Hospital Tees
- Winter Plan 2025/2026

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Winter 2024/2025 (1 Oct – 31 March) Evaluation

North Tees

	23/24	24/25	% difference
A&E & UC attendances	98657	98026	-0.64%
4 hour standard	85.16%	83.13%	-2.02%
12 hours in ED	717	1058	47.56%
Ambulance Handover rate	83.46%	87.08%	3.62%
Ambulance Arrivals to ED	11441	12956	13.24%
Type 1 A&E attendances	28628	29689	3.71%
Type 1 - 4 hour standard	50.27%	45.05%	-5.22%
TES (no of pts using TES)	n/a	612	n/a
A&E Corridor Care (no of pts)	750	1120	49.33%
Bed Occupancy	92.61%	92.82%	0.22%
Medical Bed Occupancy	97.46%	97.87%	0.41%
Long LOS (over 21 days)	11.63%	11.79%	0.16%
Discharge Lounge Use	2324	1729	-25.60%
Weekend discharges	7016	6946	-1.00%
UCR - 2 hour	78.02%	76.29%	-1.73%
Virtual Ward usage	42.42%	50.23%	7.80%
ED & UTC admissions	13678	13415	-1.92%
All other emergency admissions (excluding via ED)	14886	16892	13.48%

South Tees

	23/24	24/25	% difference
A&E & UC attendances	92932	108523	16.80%
4 hour standard	67.40%	74.40%	7.00%
12 hours in ED	2137	3278	53.30%
Ambulance Handover rate	91.20%	88.80%	-2.40%
Ambulance Arrivals to ED	14550	15318	5.28%
Type 1 A&E attendances	61968	45114	-27.20%
Type 1 - 4 hour standard	54.20%	47.02%	-7.18%
TES (no of pts using TES)	N/A	661	
A&E Corridor Care (no of pts)	N/A	658	
Bed Occupancy	92.90%	92.90%	0.00%
Medical Bed Occupancy	91.73%	91.74%	0.01%
Long LOS (over 21 days)	11.90%	10.70%	-1.20%
Discharge Lounge Use	4071	4174	2.50%
Weekend discharges	8005	8146	1.76%
UCR - 2 hour	87.00%	82.30%	-4.70%
Virtual Ward usage	51.00%	83.00%	32.00%
ED & UTC admissions	16988	17000	0.07%
All other emergency admissions (excluding via ED)	12912	13837	7.16%

Impact of increased ambulance conveyance, loss of 8 beds due to estate work, overnight discharge ambulance and ambulant transport hub only
Successful paramedic pathways decongesting ED

Infection control outbreaks impacting on bed availability/flow, delay in opening winter resilience ward, co-located UTC impacting on type 1 attendances

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Group Reflections on 2024/2025

What worked well

Group:

- Early planning – internally and regionally
- Streaming at the front door with co-located UTC's
- SDEC pathways and paramedic access
- Focus on home first provision
- Close working with Local authorities – Transfer of Care Hub / Integrated Coordination Hub
- Use of TES and corridor care
- Action cards for key roles

South Tees:

- Outlier process worked well
- Continuous flow process
- Increased use of discharge suite
- Additional medical bed ward
- Late winter collaboration with NHSE ambulance trajectories
- Flexible RSU capacity
- Ongoing LOS project
- Nursing Home admission avoidance project
- Virtual Ward increase usage

North Tees:

- Action focused OPEL meetings to maximise shared risk across organisation
- 4 hour continuous improvement work and LLOS over 14 day reviews
- Reduced use of P2 beds & DTA pilot
- Additional senior decision makers - 1st 2 weeks January
- Resilience medical rota (October till April)
- Increased ED security

Greatest Challenges:

Group:

- Estate to facilitate surge beds whilst managing IPC outbreaks and decants. JCUH pressured by lifecycle works and North Tees by the Emergency Assessment Suite build
- Workforce – increased sickness levels
- Consistent focus on discharge readiness across the whole organisation
- Bedding down in SDEC/Assessment areas
- Virtual ward occupancy
- Ability to surge often limited by estate and workforce

South Tees:

- Complex discharges with significant LOS >21 remained a challenge
- Engagement and culture
- IPC challenges

North Tees:

- System pressures - re-enablement in S'ton locality led to P1 delays and S'ton DTA work
- Only access to a small transport hub and no facility for patients on beds
- Potential impact to safety and quality for 'boarders'
- Ad hoc catering requests for hot food during FCP implementation
- Additional cost of corridor care and TES in ED and IDT/therapy/pharmacy additional resilience work

National UEC Plan 25/26

Urgent and Emergency Care Plan published 6 June 2025 identifying 7 key priorities:

1. Patients who are categorised as Category 2 – receive an ambulance **within 30 minutes**
2. Eradicating last winter's lengthy handover delays to a **maximum handover time of 45 minutes**
3. **A minimum of 78%** of patients who attend A&E to be admitted, transferred or discharged within 4 hours
4. Reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 24/25, so this occurs **less than 10% of the time**
5. Reducing the number of patients who remain in the emergency department **for longer than 24 hours**
6. Tackling the delays in patients waiting once they are ready to be discharged – starting with reducing 30,000 patients staying **21 days over their discharge ready date**
7. **Seeing more children within 4 hours,** resulting in thousands of children receiving more timely care than in 24/25

Already achieve well across Group but main **focus** in 25/26 will be **no patients waiting longer than 45 minutes for ambulance handover, reducing over 12 hour waits and seeing more children in 4 hours**

Regional NENC Priorities (draft)

- Enhancing the respiratory pathway by proactively reviewing those with long term conditions and improve access to ARI Hub access/H@H and 2 Hour UCR
- Maximising preventative and home facing offer – vaccination, integrated care coordination hubs
- Maximise integrated UTC provision

NHSE Principles for providing safe and good quality care in Temporary Escalation Spaces (TES)

- **Assessment** of risk collectively across pathways
- **Escalation** via FCP and OPEL meetings framework
- **Quality** of care – visibility of leaders
- **Raising concern** and reporting events – In pPhase
- **Data Collection and measuring harm** – governance of long waits and TES via QAC
- **De-escalation** – via OPEL meetings

GIRFT Clinical Operational Standards
Emergency Care Pathways

- Standards for primary care, acute care, speciality care and care of people with frailty
- Winter priorities identified across the Group
  - Use of virtual ward – step up and down
  - Call before Convey alternatives to ED ie hot clinics, SDEC, community services
  - Patients transferring out of critical care should be prioritised for in patient beds
  - Senior decision maker to provide advice to the community with the aim to prevent unnecessary hospital attendance/admission and to facilitate discharge
  - Consideration of enhanced pre determined conditions for specific specialities and patients referred should not wait in ED

UHT Clinical Strategy and Fit for the Future: 10 Year Health Plan

- Left shift into the community: developing a model able to provide continuous accessible and integrated care with partners via **neighbourhood health services.** Moving patient activity to hospital at home and community settings where possible will allow the right care to be provided by the most appropriate team.
- To develop proactive care through population health management.

Seasonal Planning 2025/26

Group preparedness:

- Commitment to Home First principles maximising the community offer
- Review of Escalation Cards in light of new OPEL framework guidance & ICB escalations
- Plans for 45 minute release of ambulance crews and internal escalations agreed
- Internal sign off the agreed surge plans / continuous flow process and full capacity protocol
- Category 3&4 conveyancing work with NEAS
- 4 hour continuous improvement work with ED and specialities
- Additional winter resilience capacity identified
- Maximisation of the use of the Discharge Lounge / Transport Hub
- Measures to increase vaccination rates
- Visibility on ARI Hub capacity

North Tees and Hartlepool Plans

- Continued 24/7 medical and surgical SDEC
- Maximise treatment area in Assessment Suite
- Maintain 7 month medical resilience rota but delay opening of resilience ward with a focus on discharge ready patients (Bradford Model)
- Planned additional theatre lists
- Case mix review and use of elective hub
- Continued front of house frailty work with GP and CoE consultant
- Call Before Convey pilot (Care Homes/ISPA/Acute Medicine)
- Targeted work to increase H@H occupancy/virtual wards – addition of a step down bronchiectasis pathway
- Home First Improvement Week alongside system partners
- Weekly 14 day long length of stay reviews with partners
- Weekend discharge criteria – QI project

South Tees Plans

- Establishment of Care Coordination Centre
- Expansion of Hospital @ Home capacity
- Increase awareness and improve referral rates to SPA/CCC
- Surge ward operationalised as last winter, given success
- MDT board rounds on a regular basis to challenge discharge planning and address themes
- Alternative to ED pathways operationalised and extended SDEC offer
- Long LOS review process
- Calls to ISPA from care homes to explore alternative offers
- Ensure the AAU model impactful
- Continue with Ambulance Handover improvement plan
- Continued implementation of recommended care bundles for respiratory patients and maximise respiratory H@H

Care Coordination Hub

Patient over 64 in the community is unwell and sought help

The patient is reviewed by a health care professional, GP, paramedic, UTC, community teams as requiring an admission to acute care.

Healthcare professional contacts the care coordination hub, either through bed bureau or by directly telephoning the Single Point of Access (SPA)

Discussion with senior decision maker about the patient if suitable to remain in the community, or required the following:

- Transfer back to Bed Bureau for admission to acute medical ward/ED
- Patient admitted onto Hospital @ Home- case transferred
- Patient remains under community care and consultation complete
- Patient directly booked into 'hot clinics'- SDEC, EAU assessment areas.

Easier access to acute care

UCR/Home First Teams

Access to social care

Hospital @Home

Digitally enabled

- 12 week pilot from mid November
- In line with national direction of travel
- Realignment of winter spend
- Within cost envelope
- Robust evaluation post pilot

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Care Coordination

- A 12-week pilot proposed to begin from 10th November -31st January 2025. The pilot will test the formation of a care coordination centre with the aim to reduce the over 64 admissions to acute care on either site by **20%**.

- The care coordination centre aim will be to coordinate the care of patients over 64 who would have ordinarily been admitted through admission routes such as bed bureau. The call will be redirected to the care coordination centre for an alternative discussion with a senior decision maker.

- The Care Coordination Centre will require a senior decision maker to work across the group 7 days a week as well as additional resource to support an increase in community referrals, a rota with interested parties is currently being developed.

- It is proposed this will be done utilising repurposed identified winter budgets across the group.

- Based on current activity, it is approximated that **60 patients** per day will be discussed in the care coordination centre, and approximately **12 patients per day** across UHT will be managed in the community as an alternative to acute care, resulting in **1008 patients** less attending acute care across the 12-week pilot.

- It will work in collaboration with the ambulance services, primary care, secondary care and community services to ensure the most appropriate pathway to support the patients care is sought in a timely manner.

Enhancing the Community offer

- To support effective increase in patients being supported in the community as a result of care coordination, there will be a requirement to increase the occupancy of Hospital@Home and community services across the group.

- Currently there are 82 H@H beds supporting frailty available across the group; 30 beds at South Tees, 30 beds at North Tees and 22 in Hambleton and Richmondshire.

- To support this there will be an element of flexibility across the current H@H,UCR and Home Teams across UHT.

- Winter 24/25 saw the increased occupancy of H@H beds by over 123%. It is expected that the increase of usage will continue over winter 25/26 which the addition of approx. 20% increase due to effective care coordination.

- Acknowledging there is some existing capacity at NT to achieve the expected increase in demand, there will be some additional resource required overnight where there is currently a gap

Key Metrics for the patient cohort

- Reduction in ambulance dispatches / conveyance to ED
- Reduced ED attendances / Improved ED performance.
- Number of ambulance patients attending ED and associated NEWS score.
- Criteria to reside / stranded patient performance in hospital
- Referral / activity data – breakdown by category, ambulance, GP, Care Home, etc
- Referrals into community same day services by week over time
- Average time from referral to service initiation.
- Destination outcome for patients by category.
- Number of patients representing with the same problem nature within for weeks.
- Re-attendance at ED within 7-days & Re-admission rate at 30 days
- Reduction in emergency admissions per 1000 patients
- Improved patient satisfaction and experience
- Experience of staff – referrers / CCC / responding team
- Improved end of life care coordination
- Cases rejected by “receiving” services and why

Infection Prevention & Control

- Drive on fit testing (internal team South Tees, NTH Solutions North Tees) to ensure staff compliance and increased access to competent fit testers
- Dedicated decant facilities being sourced across sites
- Site team alignment in respect of isolation priority and outbreak management
- Early morning visits to assessment units/wards regarding isolation placement and prioritisation
- POCT to be reintroduced again September
- Regional collaboration in respect of shared learning and resources
- Respiratory flowchart updated to be shared for Tees regarding treatment, isolation etc.
- Review of OPEL cards for IPC prioritisation in times of escalation

Finance

WINTER 2025/26

NTEES

Details	WTE	PYE	Period	Updated Notes
29 Bed Winter Ward				
Qualified Nursing	16.59	£418,120	December to March	Repeat Winter 24/25 in 25/26
Unqualified Nursing	15.38	£274,831	December to March	Repeat Winter 24/25 in 25/26
LLP Ward Cover		£101,926	December to March	Repeat Winter 24/25 in 25/26
Baseline funding to support additional Resilience		£88,219	December to March	Repeat Winter 24/25 in 25/26
GRAND TOTAL	**31.97**	**£883,096**		

WINTER 2025/26 South Tees

Details	WTE	PYE	Period	Updated Notes
24 Bed Winter Ward				
Qualified Nursing:	20.78	£354,029	December to March	to repeat Winter 24/25 in 25/26
UnQualified Nursing:	13.40	£169,862	December to March	to repeat Winter 24/25 in 25/26
Ward Clerk Band 2	1.21	£12,020	December to March	to repeat Winter 24/25 in 25/26
Therapy Support	3.60	£58,925	December to March	to repeat Winter 24/25 in 25/26
Pharmacy x Band 7	0.60	£14,996	December to March	to repeat Winter 24/25 in 25/26
Dietetics x Band 6	0.50	£10,604	December to March	to repeat Winter 24/25 in 25/26
Junior Doctor	2.54	£75,000	December to March	to repeat Winter 24/25 in 25/26
SDEC JCUH	5.41	£86,865	January to March	to repeat Winter 24/25 in 25/26
Ward 9	4.48	£83,000	December to March	to repeat Winter 24/25 in 25/26
Transfer Team	2.67	£42,100	December to March	to repeat Winter 24/25 in 25/26
Baseline funding to support care cordination		£145,045	November to March	repurposed budget to provide additional resource for Group Care Coordination Centre Pilot and Hospital @ Home
GRAND TOTAL	**55.19**	**£1,052,446**		

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Risks

- New operating model and ability to remain responsive as new roles become embedded
- Poor patient experience / potential harm
- Long waits for patients, particularly over 65’s waiting for a bed
- Queuing ambulance / handover delays – regional/national zero tolerance to over 45 minute delays
- Staff wellbeing / resilience
- Increased sickness
- Poor uptake of vaccinations for staff
- Ability to vaccinate care home residents without impacting on flow
- Impact on quality / performance standards
- Elective recovery impact
- Reputation
- Discharge delays (mainly ED) due to reduced EMED transport overnight (North Tees)

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Appointment of Senior Independent Director

Meeting date: 4 September 2025

Reporting to: Board of Directors

Agenda item No: 4.5

Report author: Jackie White, Company Secretary

Executive director sponsor: Derek Bell, Chairman

Action required: Approval

Delegation status: Jointly delegated item to Group Board

Previously presented to:

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

CQC domain link:

Well-led

Board assurance framework references 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 current Group Senior Independent Director (SID) Ada Burns, Non-Executive Director's term of office comes to an end at the end of September 2025.

In line with the Constitutions of the Unitary Boards, the Board of Directors shall recommend to the Council of Governors, at a general meeting of the Council of Governors, that one of the non-executive directors is appointed as a vice chair.

The Code states that the appointment of the SID should be made in consultation with the Council of Governors.

The Senior Independent Director role is primarily concerned with the performance of the Chair. They act as a point of contact with the Board should Governors have concerns, which approaches through normal channels have failed to resolve or for which such normal approaches are inappropriate. They lead the appraisal process for the Chair.

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 Chair through the appraisal process has had conversations with Non-Executive director colleagues regarding the role and Ken Readshaw, Non-Executive Director and Audit Chair for South Tees Hospitals NHS Trust has been proposed and agreed to fulfil this role.

Initial discussions have been held with the Nomination Committee on the appointment of a SID following the end of the current term of office of the current post holder and following approval by the Board will ratify the appointment of the SID at their next meeting before recommending the appointment to the Council of Governors meeting in September.

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 and Council of Governors agreed to a Group Senior Independent Director as part of the move to single roles across the Board.

Recommendations:

The Board of Directors are asked to approve the appointment of Ken Readshaw as Senior independent Director with effect from 1 October 2025, subject to support and ratification from the Council of Governors.

University Hospitals Tees

Board Committee Terms of Reference Update

Meeting date: 4 September 2025

Reporting to: Group Board of Directors

Agenda item No: 4.6

Report author: Sarah Hutt, Assistant Company Secretary

Executive director sponsor: Jackie White, Company Secretary

Action required: Approval

Delegation status: Jointly delegated item to Group Board

Previously presented to: Group Quality Committee, People Committee, Resources Committee

UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☐

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.

Following an external review into the new UHT governance arrangements, a number of recommendations/changes were highlighted in respect of the Board Committee Terms of Reference. The updated Terms of Reference were presented to each of the Committees during July for agreement.

The changes included reducing the number of non-executive members at each committee and to provide clarity on members in attendance, noting a Vice Chair was to be appointed for Resources Committee and an explicit reference to the subsidiary companies was required as part of the Committee duties. In addition, it was suggested to address some gaps around the scoring and escalations of risk across all the Terms of Reference.

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 Terms of Reference define the purpose, scope and structure of the Committee. They set out the duties, which have been delegated to it by the Board with expected outcomes, along with the membership for each Committee.

Ongoing monitoring of the Terms of Reference are undertaken by the Committee in terms of attendance at meetings monthly and annually through the Committee effectiveness review to ensure they remain fit for purpose.

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

Assurance can be provided to the Board from the Governance review, which has been fully shared and agreed with members of the Board Committees.

Recommendations:

The Group Board are asked:

- To ratify the updated Terms of Reference for Quality Assurance Committee, People Committee and Resources Committee;
- To note the updated Terms of Reference were approved at the individual Committees on 28 July, 20 July and 30 July 2025 respectively.

University Hospitals Tees

Quality Assurance Committee

Terms of Reference

1. Introduction

North Tees & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established a Single Joint Committee (enabling it to make legally binding decisions) on 19 October 2022 which was reconstituted as the University Hospitals Tees (UHT) Board in April 2024. The terms of reference set out delegated matters from each unitary Board in accordance with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions – Schedule F

2. Establishment

The UHT Board has agreed to bring together the two statutory Trust Board Committees known as the Quality Assurance Committee to form a single UHT Assurance Quality Committee.

The terms of reference (ToR), which form part of the UHT Governance Framework, set out the membership, the remit, responsibilities and reporting arrangements of the committee and may only be changed with the approval of the UHT Board.

The committee is a non-executive member chaired committee of the UHT Board, and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

To gain assurance the appropriate governance systems, structures and processes are in place to ensure delivery of high quality, safe, effective and patient-centred care in all of the services provided by the parties.

In achieving this, the committee will provide assurance that sufficient progress is being made towards delivery of the strategic priorities and UHT ambitions ensuring a fair, safe and just culture, with a focus on health and wellbeing and a more consistent and positive experience for all staff. This includes developing and maintaining highly effective links throughout the organisation (from “board to ward”).

In achieving this, the Committee will seek to promote a culture of continuous improvement and innovation with respect to all aspects of its remit to provide assurance to the UHT Board on the related risks that may impact on the delivery of statutory duties, and agreed organisational strategic and operational plans.

4. Role and responsibilities

The responsibilities of the committee will be authorised by the UHT Board. It is expected that the committee will:

Board Assurance Framework

- Identify, assess and manage strategic risks in relation to the Committee’s area of focus via the Board Assurance Framework;
- Establish and maintain an overview of the quality and safety risks and ensure the effectiveness and implementation of controls for people risks and actions to mitigate these risks;
- Refer any potential people or resource risks identified by the Committee to the appropriate committee
- Commission and oversee assurance deep dives into specific identified risks at the request of either the Committee, the Chair of the UHT Board or the UHT Chief Executive;
- Provide the Audit Committees of the UHT Board and the UHT Board; with assurance on the effectiveness of management of the principal risks relating to the Committee’s purpose and function; and ensure a strong link with other statutory committees as appropriate in respect of identified risks.

Specific Responsibilities:

- Be assured that there are robust processes in place for the effective management of quality, including safety, experience and clinical effectiveness.
- Approve the quality priorities and receive regular updates on their delivery on behalf of the UHT Board.
- Approve the Annual Quality Accounts as delegated by the UHT Board and ensure publication in line with national requirements.
- Receive assurance on delivery of key statutory requirements and performance indicators in relation to quality, safety, experience and clinical effectiveness.
- Review and monitor those risks on the board assurance framework and corporate risk register which relate to quality, and high-risk operational risks which could impact on care. Ensure the UHT Board is kept informed of significant risks and mitigation plans, in a timely manner.
- Oversee and review compliance with all statutory and regulatory requirements, ensure this is adhered to, and improvements are sustained.
- Receive assurance that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by the parties.
- Receive assurance that Duty of Candour (DoC), patient safety incident response framework (PSIRF) incidents requiring investigation (PSII), never events, safety alerts and claims are embedded, in order to disseminate and share learning.
- Receive assurance that effective and transparent processes are in place to monitor mortality and learning from death's metrics. (including coronial inquests).
- To receive assurance that robust and effective arrangements are in place for Infection Prevention and Control, Safeguarding, Health and Safety, Health Inequalities and Mental Health.
- To oversee the development and implementation of the Patient Experience and Involvement Strategy, the collection and use of patient reported experience, including national surveys, and feedback from complaints, in order to disseminate and share learning.
- Have oversight of and approve the terms of reference and work programmes for the clinical governance and groups reporting into the Committee (e.g., quality groups, infection prevention and control, local maternity and neonatal system, safeguarding).
- Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.
- Receive assurance on the robustness of the arrangements compliance with statutory responsibilities for health and safety management ie. Security, decontamination, water safety, fire and medical devices to ensure a safe environment.
- Receive assurance on maternity services across the UHT.
- Receive assurance on clinical effectiveness, including the triangulation of data from Clinical Audit, NICE and GIRFT.

5. 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 Board.
Commission	Commission reports required to help fulfil its obligations.
Obtain advice	Obtain independent 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.
Create sub-groups / task and finish groups	Establish sub-groups/task and finish groups for specific programmes of work. The terms of reference of such sub-groups / task and finish groups, will be approved by the Committee. The Committee may delegate work in accordance with the agreed terms of reference – but no decisions may be delegated to these groups. A clear statement or diagram will be provided of the structures sitting below the Committee.
Escalation of risk	If the Committee is not satisfied by the assurance provided it will escalate this to the Board through the escalation report

6. Delegation by Schedule 1 Scheme of Delegation

Decisions Delegated by Schedule 1 Scheme of Delegation
The Committee is a formal assurance committee of the UHT Board. The UHT Board has delegated authority to the Committee as set out in in Schedule 1 scheme of delegation 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 UHT Board.

7. Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the UHT 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 UHT Board after each meeting and provide a report on assurances received, key actions taken with regard to quality, experience, clinical effectiveness and safety 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 beforehand.
Annual Cycle of Business	The Committee produces an annual cycle of business in consultation with the UHT 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 UHT Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the UHT 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

8. Committee meetings

8.1. Composition and quoracy

This section sets out the meeting composition and quoracy requirements.

The Committee will normally meet 10 times a year, with no committee meetings taking place in August or December. 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 UHT Board.
Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the UHT Board.
Absence of Chair or Vice Chair	In the absence of the Chair, or Vice Chair, an alternative Non-Executive Member will be nominated to Chair the meeting. If the Chair has a conflict of interest, then the Vice-Chair or, if necessary, another Non-Executive Member of the Committee will be responsible for deciding the appropriate course of action.
Membership	Non-Executive Director – Chair Non-Executive Director – Vice Chair Non-Executive Director Lead Executive – Chief Nurse Group Executive Member – Chief Medical Officer In attendance – Deputy Director of Quality, Deputy Director of Safety, Associate Medical Director Quality & Safety, subject specific experts as appropriate

Composition/ quoracy	Description of expectations
Member deputies	Executive Members may ask the Chair to agree a deputy. Those deputies agreed by the Chair will have the same rights and responsibilities as members, and where applicable will form part of the quoracy.

Attendees and procedure for absence	Only members of the Committee have the right to attend Committee meetings, however the Committee may also invite other appropriate individuals to attend all or part of the Committee meetings to provide advice or support particular discussion(s). In addition to the core membership the committee may nominate individuals, the Chair may co-opt additional members as appropriate for specific agenda items. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.
Quoracy and Procedure for Inquoracy	The Committee has no decision making authority unless there are two Non-Executive Directors and one Executive Director 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.

8.2 Frequency and formats

This section on Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Committee shall normally meet 10 times a year on a monthly basis and will not meet in August or December. The time in August and December may be used as a development session or opportunity for horizon scanning. The agenda and supporting papers will be sent to members and attendees no less than five working days before any meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.
Open vs closed	All Committee meetings will be held in private and be closed. .

8.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The Chair is responsible for agreeing the agenda 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.
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 parties. Members of, and those attending, the Committee shall behave in accordance with the parties constitution, standing orders, and standards of business conduct and the Code of Conduct and Accountability policy and Declarations of Interest policy

8.4 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 meeting, 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 Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee provided by the company Secretary.	Support the Chair in preparing reports for the Board. Take forward action points between meetings and monitor progress against those actions. Produce the chairs escalation report and grade all reports with a level of assurance
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for committee members.

9. Revision History

Version	Date	Approved by	Review	Type of changes
V1	April 2024	Group Board	Annually	Developed
V2	August 2025			

Review date: April 2026

University Hospitals Tees

People Committee

Terms of Reference

1. Introduction

North Tees & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established a Single Joint Committee (enabling it to make legally binding decisions) on 19 October 2022 which was reconstituted as the UHT Board in April 2024. The Group is known as University Hospitals Tees (UHT). The terms of reference set out delegated matters from each unitary Board in accordance with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions – Schedule F.

2. Establishment

The UHT Board has agreed to bring together the two statutory Trust Board Committees known as the People Committee to form a single UHT People Committee.

The terms of reference (ToR), which form part of the UHT Governance Framework , set out the membership, the remit, responsibilities and reporting arrangements of the committee and may only be changed with the approval of the UHT Board.

The committee is a non-executive member chaired committee of the UHT Board, and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

To gain assurance that the appropriate governance systems, structures and processes are in place to ensure delivery of effective people, workforce and organisational development strategies in all of the services provided by UHT . University Hospitals Tees has a clear ambition to do things differently by working collaboratively as a Group, and in doing so delivering real benefits for our patients, staff and the wider population served by both Trusts.

In achieving this, the committee will provide assurance that sufficient progress is being made towards delivery of the strategic priorities and UHT ambitions ensuring a fair, safe and just culture, with a focus on health and wellbeing and a more consistent and positive experience for all staff. This includes developing and maintaining highly effective links throughout the organisation (from “board to ward”).

In achieving this, the Committee will seek to promote a culture of continuous improvement and innovation with respect to all aspects of its remit to provide assurance to the UHT Board on the related risks that may impact on the delivery of statutory duties, and agreed organisational strategic and operational plans.

4. Roles and responsibilities

The responsibilities of the Committee will be authorised by the Board. It is expected that the Committee will gain assurance by:

Board Assurance Framework

- Identify, assess and manage strategic risks in relation to the Committee’s area of focus via the Board Assurance Framework;
- Establish and maintain an overview of the people risks and ensure the effectiveness and implementation of controls for people risks and actions to mitigate these risks;
- Refer any potential risks to patient safety or quality identified by the Committee to the UHT Quality Committee;
- Commission and oversee assurance deep dives into specific identified risks at the request of either the Committee, the Chair of the UHT Board or the UHT Chief Executive;

- Provide the Audit Committees of the UHT Board and the UHT Board; with assurance on the effectiveness of management of the principal risks relating to the Committee's purpose and function; and ensure a strong link with other statutory committees as appropriate in respect of identified risks.

People Strategy

- Provide assurance that the UHT People Strategy is aligned to the national workforce agenda reflecting the NHS People Strategy and People Promise
- Obtain assurance and monitor delivery of the People Plan through the associated activity/implementation plan.

People Values

- Evaluate the impact of work to promote the People values of the UHT Board and of the NHS Constitution and the People Plan
- Review and monitor progress against the NHS National Staff Survey with a particular focus on Staff Engagement and Health and Wellbeing.
- Monitor progress against the Freedom to Speak Up strategy and themes arising from speaking up. To provide assurance that the organization promotes a culture where people feel safe and are able to raise concerns, and where bullying and harassment are visibly and effectively addressed.
- Gain assurance from the Guardian of Safe Working on practice relating to doctors working hours
- Oversee and monitor the effectiveness of the Leadership Development programmes in place to support all leaders, evaluating to inform further improvements.

Equality, Diversity and Inclusion

- Oversee the employment related equality, diversity and inclusion agenda, receiving regular reports and assurance from the relevant groups.
- Monitor the legal and regulatory requirements in relation to the workforce, to include diversity and inclusion such as WRES, WDES and Gender Pay Gap.

Use of resources

- Provide assurance to the Board of the effective use of its Human Resource through workforce planning and re-design strategies, succession planning and the monitoring of pay costs (including agency spend/usage)
- Monitor plans to improve productivity of permanent and temporary staff, including the effectiveness and efficiency of their deployment, the best use of skills, and the flexibility and maturity of working practices.
- Consider and monitor the coherence and pace of strategic plans to secure transformational change.

Education and training

- Oversight of current and future educational and training needs to ensure they support the strategic objectives of the UHT Board in the context of the wider health and care system.
- .Ensure plans are developed to sustain and promote a culture of developing a pipeline of trainees/apprenticeships as part of the workforce of the future.
- Assess relationships with academic institutions to ensure a supportive and aspirational plan for workforce development.

Health & Safety Security management – violence and aggression

- Ensuring the Violence Prevention and Reduction Strategy is monitored and reviewed regularly.
- Review the Equality Quality Impact assessment to ensure that inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced.
- Evaluate and assess the Violence Prevention and Reduction Programme, sharing the findings with the Board on a 6 monthly basis.

Performance and Progress Reporting

- Consider and recommend to the Board the key people and workforce performance metrics and targets for the Trust.
- Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case. Assist the UHT Board in its assurances and consistent use of data and intelligence, by working closely with the Audit, UHT Quality, and UHT Resources Committees.

5. 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.
Create sub-groups/sub-committees	Establish sub-groups/task and finish groups for specific programmes of work. The terms of reference of such sub-groups/task and finish groups, will be approved by the Committee. The Committee may delegate work in accordance with the agreed terms of reference– but no decisions may be delegated to these groups. A clear statement or diagram will be provided of the structures sitting below the Committee.
Escalation of risk	If the Committee is not satisfied by the assurance provided it will escalate this to the Board through the escalation report

6. Delegation by Schedule 1 Scheme of Delegation

Decisions Delegated by Schedule 1 Scheme of Delegation
The Committee is a formal committee of the UHT Board. The UHT Board has delegated authority to the Committee as set out in in Schedule 1 scheme of delegation 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 UHT Board.

7. Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the UHT 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 UHT Board after each meeting and provide a report on assurances received, key actions taken with regard to people 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 UHT 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 UHT Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the UHT 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

8. Committee meetings

a. Composition and quoracy

This section sets out the meeting composition and quoracy requirements. This section sets out the meeting composition and quoracy requirements. The Committee will normally meet 10 times a year, with no committee meetings taking place in August or December. 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 UHT Board.
Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the UHT 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 – Chair Non Executive Director – Vice Chair Non Executive Director Lead Executive – Chief People Officer UHT Executive Member In attendance – 4 x Deputy Directors; Associate Medical Director – People, subject specific officers
	Executive Members may ask the Chair to agree a deputy. Those deputies agreed by the Chair will have the same rights and responsibilities as members, and where applicable will form part of the quoracy.

Attendees and procedure for absence	Only members of the Committee have the right to attend Committee meetings, however the Committee may also invite other appropriate individuals to attend all or part of the Committee meetings to provide advice or support particular discussion(s). In addition to the core membership the committee may nominate individuals, the Chair may co-opt additional members as appropriate for specific agenda items. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

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 and 1 Executive Director 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.

b. Frequency and formats

This section on Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Committee shall normally meet 10 times a year on a monthly basis and will not meet in August and December. The time in August and December may be used as a development session or opportunity for horizon scanning. The agenda and supporting papers will be sent to members and attendees no less than five working days before any meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

Open vs closed	All Committee meetings will be held in private and be closed

c. 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 UHT Board. Members of, and those attending, the Committee shall behave in accordance with the UHT Board Constitution, Standing Orders, and Standards of Business Conduct and Declaration's of Interest Policy

9. 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 UHT 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

10. Appendix I: Revision History

Version	Date	Approved by	Review	Type of changes
V1.0		Group Board	Annually	
V2	August 2025			

Review date: April 2026

University Hospitals Tees

Resources Committee

Terms of Reference

1. Introduction

North Tees & Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) established a Single Joint Committee (enabling it to make legally binding decisions) on 19 October 2022 which was reconstituted as the UHT Board in April 2024. The Group is known as University Hospitals Tees (UHT). The terms of reference set out delegated matters from each unitary Board in accordance with NHSE Guidance Arrangements for Delegation and Joint Exercise of Statutory Functions – Schedule F.

2. Establishment

The UHT Board has agreed to bring together the two statutory Trust Board Committees known as the Resources Committees to form a single UHT Resources Committee.

The terms of reference (ToR), which form part of the Governance Framework, set out the membership, the remit, responsibilities and reporting arrangements of the committee and may only be changed with the approval of the UHT Board.

The committee is a non-executive member chaired committee of the UHT Board, and has no executive powers, other than those specifically delegated in these terms of reference.

2.1 Purpose

To gain assurance the appropriate governance systems, structures and processes are in place to ensure effective and efficient use of resources in all of the services provided by UHT including its subsidiary companies . UHT has a clear ambition to do things differently by working collaboratively as a Group, and in doing so delivering real benefits for our patients, staff and the wider population served by both Trusts.

In achieving this, the committee will provide assurance that sufficient progress is being made towards delivery of the strategic priorities and UHT ambitions ensuring a fair, safe and just culture, with a focus on health and wellbeing and a more consistent and positive experience for all staff. This includes developing and maintaining highly effective links throughout the organisation (from “board to ward”).

In achieving this, the Committee will seek to promote a culture of continuous improvement and innovation with respect to all aspects of its remit to provide assurance to the UHT Board on the related risks that may impact on the delivery of statutory duties and agreed organisational strategic and operational plans.

3. Roles and responsibilities

The responsibilities of the Committee will be authorised by the Board. It is expected that the Committee will gain assurance in respect of:

Board Assurance Framework

- Identify, assess and manage strategic risks in relation to the Committee’s area of focus via the Board Assurance Framework;
- Establish and maintain an overview of the resources risks and ensure the effectiveness and implementation of controls for resources risks and actions to mitigate these risks;
- Commission and oversee assurance deep dives into specific identified risks at the request of either the Committee, the Chair of the UHT Board or the UHT Chief Executive;
- Provide the Audit Committees of the UHT Board and the UHT Board; with assurance on the

effectiveness of management of the principal risks relating to the Committee's purpose and function; and ensure a strong link with other statutory committees as appropriate in respect of identified risks.

Specific Responsibilities:

Planning, Performance and Compliance

The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include:

- oversight of the Integrated Performance Report reflecting the position of the UHT Board in regard to performance and recovery objectives aligned to the annual planning round.
- Monitoring key performance, financial, activity and workforce plans over the short, medium and long term, including annual targets (including revenue and capital budgets) for approval by the UHT Board on an annual basis prior to the start of each financial year
- ensuring that all delivery requirements and remedial actions with regard to performance, planning and recovery objectives, give due cognisance to the regulatory requirements of financial performance and effective budget management.
- well founded governance processes for the overall delivery of performance, supported by sub governance processes for each key performance objective.
- clear overview of the annual planning round and the and the alignment to the delivery of the internal Business Planning process, monitoring and reviewing progress against plan, taking decisions to recover areas of underperformance, providing assurance to the UHT Board and escalating as required.
- Ensure operational efficiencies are delivered in line with the requirement to provide viable, clinically sustainable services, fit for the future

Digital Strategy

- To provide oversight and review on the development, implementation and delivery of the Digital, Cyber and I&TS strategies; and to monitor progress against and risks associated with the strategies, including any associated improvement plans
- Oversight of the Information Governance/Data Security agenda including the Data Security and Protection Toolkit submission and external audits in order to gain assurance on compliance with the legislative requirements.
- Gain assurance that information governance has been considered in all decisions and that this can be evidenced, receiving exception reports for non-compliance.
- Regularly review cyber resilience and security risks, ensuring appropriate mitigation, and that regular maintenance of critical systems and equipment takes place, while minimising impact on clinical services during system downtime.
- Ensuring the UHT Board undertake annual cyber awareness training, in addition to the mandatory and statutory information governance training that individual board members are required to complete.

Estates Strategy

- The Committee shall have responsibility for the oversight of the Capital Programme (including individual Business Cases for Capital Investment) and the review of the Estates Strategy and plans relating to Estate development (including the acquisition and disposal of property), and for making recommendations to the UHT Board as appropriate on any issue within its terms of reference.

Procurement Strategy

- To review the UHT Board procurement strategy and policies on a regular basis and to make recommendations to the UHT Board.
- To consider any significant variations to the existing procurement methodology as set out in the UHT Board Standing Orders and Standing Financial Instructions.
- To understand the scope of procurement, the priorities (at national and at integrated care system level) and the challenges of delivering change.

Resource Management

- Full oversight of the monthly financial position of the UHT Board, including ICP/ICS implications/risks/opportunities of system working.
- Regular updates regarding the efficiency, sustainability and the financial control environment and framework, as well capital programme and scrutiny of investment decisions.
- Provide rigorous scrutiny of cost improvement programmes for current and future years, and challenge processes where necessary, ensuring actions are implemented to achieve CIP targets without compromising on quality and to ensure that proposed financial initiatives are rated according to their potential impact on quality.
- Oversight of the adequacy of the financial and demand estimates, forecasts and plans, looking forward over the period as required by NHS England annually, five yearly or longer, depending on the investment.
- Oversight of the adequacy of any external financing arrangements to ensure that they are both adequate in provision and offer value for money for the UHT Board.
- Ensure there is congruence between the future plans and aspirations of the UHT Board, and the availability of adequate resources to support the plan.
- Business Case Investments - ensuring that these support the delivery of the corporate objectives, include the benefits and are linked to the strategic direction and annual plans.
- Receive and scrutinise post implementation reviews on business case and capital investment schemes including benefits realisation
- Seek reports and assurances from sub-committees, directors and managers as appropriate, concentrating the over-arching systems of resource planning, integrated governance, risk management and internal control, together with indicators of their effectiveness
- Receive and consider major Investment Plans for the UHT Board and maintain an oversight of the investments, ensuring compliance with the Strategic Direction and Annual Plans.
- Review and approve or make a recommendation to the UHT Board on recurring or non-recurring revenue schemes that will result in costs that are over those in line with each UHT Board Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation.

Sustainability

- Review the Green Plan of the UHT Board which sets out the aim to achieve carbon neutral for energy emissions by 2030 which can be accomplished by creating a fully sustainable estate, utilising alternative, renewable power sources and making the most of innovation.
- Monitor routinely the actions to deliver this aim including receiving reports on
  - Working collaboratively
  - Resources
  - Procurement and raw materials
  - Waste
  - People
  - Journeys

- Green spaces

Transformation

- Receive regular updates on key issues and progress against plans for strategic transformational change initiatives, improvement programmes, service redesign etc.
- Oversee the implementation of national transformation plans within clinical service areas, including GIRFT, HED, Model Hospital, and Carter. This will include cost improvement and other productivity improvement programmes.

The Committee will agree progress reporting and information requirements relating to its remit on behalf of the UHT Board and will oversee the resulting performance intelligence.

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.
Create sub-groups/sub-committees	Establish sub-groups/task and finish groups for specific programmes of work. The terms of reference of such sub-groups/task and finish groups, will be approved by the Committee. The Committee may delegate work in accordance with the agreed terms of reference– but no decisions may be delegated to these groups. A clear statement or diagram will be provided of the structures sitting below the Committee.
Escalation of risk	If the Committee is not satisfied by the assurance provided it will escalate this to the Board through the escalation report

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 UHT Board. The UHT Board has delegated authority to the Committee as set out in in Schedule 1 scheme of delegation 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 UHT Board.

3.3 Accountability and reporting

Accountabilities	Description
Draft minutes and reports	The Committee is directly accountable to the UHT 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 UHT 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 UHT 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 UHT Board. The Committee utilises a continuous improvement approach in its delegation. The Committee provides the UHT 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. The Committee will normally meet 10 times a year, with no committee meetings taking place in August or December. 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 UHT Board.
Vice Chair	The Vice Chair of the Committee will be a Non-Executive Member of the UHT 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 – Chair Non Executive Director – Vice Chair Non Executive Director Lead Executive – Chief Finance Officer Executive Member In attendance - Deputy Directors of Finance and subject specific (as per cycle of business) – Procurement, Digital, Estates, Resource Management, Business Intelligence, Transformation, Service Improvement
	Executive Members may ask the Chair to agree a deputy. Those deputies agreed by the Chair will have the same rights and responsibilities as members, and where applicable will form part of the quoracy.

Attendees and procedure for absence	Only members of the Committee have the right to attend Committee meetings, however the Committee may also invite other appropriate individuals to attend all or part of the Committee meetings to provide advice or support particular discussion(s). In addition to the core membership the committee may nominate individuals, the Chair may co-opt additional members as appropriate for specific agenda items. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

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 and 1 Executive Director 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 shall normally on a monthly basis. One month the meeting will be face to face and the following month the meeting will be held virtual with a reduced membership and risk based approach to the agenda. The agenda and supporting papers will be sent to members and attendees no less than five working days before any meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

	Additional meetings may be convened on an exceptional basis at the discretion of the Chair.
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 UHT Board. Members of, and those attending, the Committee shall behave in accordance with the UHT 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 UHT 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		Group Board	Annually	
V2	August 2025			

Review date: April 2026

University Hospitals Tees

Trinity Holistic Centre - Transition to Maggie's Update

Meeting date: 4 September 2025

Reporting to: Group Board

Agenda item No: 5.1

Report author: Josh Barritt, Service Improvement Partner

Executive director sponsor: Neil Atkinson, Chief Delivery Officer

Action required: Information

Delegation status: Matter reserved to Unitary Board

Previously presented to: N/A

UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☐

Working with partners ☒

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☐

CQC domain link:

Effective

Board assurance / risk register this paper relates to:

System working and reform domain

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.

Trinity Holistic Centre has been operating at a loss for several years, with a total projected loss of £198k for 2024/25 before transfers from other charity funds. This is not sustainable on an ongoing basis, and the Trust has therefore been considering the strategy for the centre, including its long-term viability.

It was agreed through the Board that the centre will be transitioned over to Maggie's Cancer Care Charity with a £450,000 grant provided over two years. The report provides an update to the Board on the progress of the transition.

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 provides an update on the progress of each work stream ahead of the handover of the Trinity Holistic Centre to Maggie's on 15th September 2025.

The Chair and Chief Executive of UHT have been invited to the launch event of Maggie's on Wednesday 1st October 2025.

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

All work streams are anticipated to be fully completed ahead of the transition date of 15 September 2025.

Maggie's Trinity Holistic Centre Board Update

1. PURPOSE OF REPORT

The purpose of this report is to update the Board on the delivery progress in readiness for the transition and handover of the Trinity Holistic Centre to Maggie's.

RECOMMENDATIONS

This report is an update and there are no recommendations to be made to the Board.

BACKGROUND

The Trinity Holistic Centre is in the grounds of James Cook University Hospital, opposite the Endeavour (radiotherapy) Centre, and predominantly offers complementary therapies, receiving approximately 150 referrals and supporting approximately 1,000 visits per month (70% of which are complementary therapies and 30% other interventions). All therapies are provided free of charge to those that live in the local area, however patients from outside the local area are required to pay to access the services.

Whilst patients (under the care of STHFT) are eligible for services free of charge, they also have the option to pay for additional private treatments. Trust staff can also purchase complementary therapy sessions at a discounted rate as part of the Trust's wellbeing offer. The Trinity Holistic Centre also receives a small amount of income from room hire. Total income generated, from all paid services, was approximately £17k in 2023/24.

Trinity Holistic Centre was initially built using charitable donations from the 'Friends of the Holistic Centre' following a specific fundraising campaign and is funded on an ongoing basis using charitable funds and other direct income. The centre has been running at a loss for several years, with a total projected loss of £198k for 2024/25 before transfers from other charity funds. This is not sustainable on an ongoing basis, and the Trust has therefore considered the strategy for the centre, including its long-term viability.

As part of considering other options, a discussion was held with Maggie's regarding takeover of the Trinity Holistic Centre, Maggie's are a National Cancer Charity and provide free expert care and support in centres across the UK and online.

Maggie's service model is different to that of Trinity Holistic Centre, reflecting that their offering is on a larger scale. They offer less one to one holistic type therapies and more group therapy sessions, such as mindful therapies, behavioural therapies and counselling sessions.

As part of the proposal, Maggie's will use the current staff and continue to provide the services for an agreed period of 24 months from the handover date of 15th September 2025.

DETAIL (Overview of Scheme)

The below information provides an update on the implementation of the agreed transition between South Tees Hospitals NHS Foundation Trust and Maggie's Cancer Care for the lease of the Trinity Holistic Centre (THC) at James Cook University Hospital. The arrangement will result in Maggie's assuming responsibility for the building and associated services, with centre staff transferring under TUPE regulations as highlighted in the Board paper presented in November 2024.

Progress across the five principal work streams to implement the proposals, is summarised below.

1. Grant Funding

Arrangements have been confirmed. As part of the transfer agreement, *Our Hospitals Charity* will provide Maggie's with a £450,000 grant over two years to support the first 24 months of operation.

2. Estates & Legal

Heads of Terms and the Sub-Under Lease have been fully drafted and will be concluded ahead of the transition date.

3. Human Resources (TUPE)

Formal consultation on the TUPE transfer of staff to Maggie's has concluded, with the transfer scheduled to take effect from midnight on 14 September 2025.

4. Communications

A joint communications plan has been developed between the Trust's Communications team, Maggie's PR, Trinity Holistic Centre staff, and Maggie's social media representatives.

5. IT / Systems / Digital – Primary Risk Area

Work has been ongoing to confirm the IT equipment and systems Maggie's will require for operational purposes. In accordance with Trust Policy, Maggie's are unable to access/utilise Trust systems and would need to purchase a SystmOne Standalone add-on. It is anticipated that this will be resolved prior to the transition date.

The Centre Head at Maggie's attended the Trust for a two week period in August 2025 to support the readiness work ahead of the transition date.

CONCLUSION

All five work streams are expected to be fully completed prior to 15 September 2025 handover date. Board are asked to note the update.

NHS
University Hospitals Tees

Audit & Risk Committee – South Tees

23 June 2025

Connecting to: South Tees Hospitals NHS Foundation Trust

Chair of Committee: Ken Readshaw

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.

External audit value for money opinion identified a significant weakness due to underlying deficit. This has been discussed with the CEO as part of the annual audit presentation and included in the Annual Governance Statement.

Head of internal audit opinion – Limited assurance based on the audits completed. Wider work performed (eg ICS grip and control audits gives assurance on the organisational control environment and risk management). This has been reflected in the Annual Governance Statement.

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.

External Audit - Approving Annual Governance Statement, Accounts and Annual report subject to final approval by Chair for any changes prior to final submission. Post meeting note, KR approved submission on 30 June 2025.

Caring Better Together

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

Recommendations:

Board of Directors to note the report.

Audit & Risk Committee – South Tees

30 July 2025

Connecting to: South Tees Hospitals NHS Foundation Trust

Chair of Committee: Ken Readshaw

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.

Internal Audit - 3 internal audits received

Cancer pathways data management - High risk. Agreed action plan and oversight through Management Team.

Data Security and Protection Toolkit - Very high risk. Agreed action plan and oversight through Management 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.

Counter fraud update received. Focus this year on conflicts of interest and gifts and hospitality registers (90% compliance required) to achieve compliance with national requirements. Further work required on this.

Discussion on employee fraud case handling. Agenda item to be prepared to allow further information and debate at next meeting.

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

External Audit - All filings complete for 2024/2025.

Internal Audit - Group governance – Advisory. Giving assurance that the move to group working has been successfully implemented. Recommendations for improvement agreed.

Review of BAF processes. The BAF is becoming embedded and updated by board committees eg increased risk assessment by quality committee (IPC).

Recommendations:

Board of Directors to note the report.

Annual Members Meeting
Tuesday, 17 September 2024
Acklam Green Centre, Stainsby Road, Middlesbrough, TS5 4JS

Present:

Derek Bell, Group Chair (Chair)	DB
Stacey Hunter, Group Chief Executive	SH
Ali Wilson, Group Non-Executive Director (Vice Chair)	AW
Ada Burns, Group Non-Executive Director	AB
David Redpath, Group Non-Executive Director	DR
Mark Dias, Group Non-Executive Director	MDi
Miriam Davidson, Group Non-Executive Director	MDa
Neil Atkinson, Group Managing Director	NA
Chris Hand, Group Chief Finance Officer	CH
Mike Stewart, Group Chief Medical Officer	MS
Rachel Metcalf, Group Chief People Officer	RM
Ken Anderson, Group Chief Information Officer	KA
Steve Taylor, Group Director of Estates	ST
Ruth Dalton, Group Director of Communications	RD
Sam Peate, Chief Operating Officer, STHFT	SP
Jackie White, Company Secretary/Head of Governance	JW

In Attendance:
Lindsay Garcia, Director of Nursing, STHFT
Jill Foreman, Head of Community Services, NTHFT
Sarah Mallett, Clinical Lead, Community Services, STHFT
Amiee Moody, Serious Violence Reduction Navigator
Michelle Waters, Serious Violence Recovery Navigator
Nicola Arkless, Patient Involvement Facilitator, STHFT
Heidi Holliday, Secretary to the Board (note taker)

Governors:

Janet Crampton, Elected Governor, Hambledon and Richmondshire (Lead Governor)
Sue Young, Elected Governor, Hambledon and Richmondshire
Yvonne Bytheway, Elected Governor, Middlesbrough
Rachel Booth-Gardiner, Elected Governor, Middlesbrough
Jean Milburn, Elected Governor, Middlesbrough
John Fordham, Elected Governor, Patient and Carer
Brendan Smith, Elected Governor, Redcar and Cleveland
Zahida Mian, Elected Governor, Redcar and Cleveland
Olufemi Shoyemi, Elected Governor, Rest of England
Jane Passman, Elected Governor, Staff
Sarah Essex, Elected Governor, Staff
Isaac Oluwatowoju, Elected Governor, Staff
David Kennedy, Appointed Governor, Newcastle University

Trust Members:
Angela Seward
Janice Bateman
Jane Tombling
Jill Atkinson
John Young

Kim Gray
Maria Parker
Mary Booth
Sue Porteous

1. Welcome and Introduction

Professor Derek Bell, Group Chair welcomed members to the 2024 Annual Members Meeting of South Tees Hospitals NHS Foundation Trust.

The Group Chair reflected on the year, where both South Tees Hospitals NHS Foundation Trust and North Tees & Hartlepool Foundation Trust had worked together as part of a Group model, which had been an interesting and exciting time. A number of changes had been seen within the previous year, including Board changes and elections now being held bi-annually. Quality remained the highest priority and Finance had been challenging however, the Trust achieved the targets set out for 2023/24.

2. Hospital at Home University Hospitals Tees

Jill Foreman, Head of Community Services, NTHFT and Sarah Mallett, Clinical Lead, Community Services, STHFT attended the meeting and gave a presentation on the Hospital at Home Service that had been developed in collaboration between South Tees Hospitals NHS Foundation Trust and North Tees & Hartlepool Foundation Trust.

The Hospital at Home service supported patients to have their healthcare needs met within their own homes, when previously they would have needed to be delivered within a hospital setting, and it was designed to replicate the level of care and support provided within a hospital environment, safely at home.

When developing the service there were two key areas of focus; respiratory pathways and frailty pathways and a lot was learnt from the exceptional work of both Trust's Respiratory Virtual Ward models of care. The two Trust's models differed slightly at present and work was ongoing to learn together, share experiences and to identify improvements for the future. An overview of each model was provided along with a number of case studies that demonstrated that patients don't always need to be seen in hospital.

There were a number of agreed next steps which included, exploring further pathways, collecting patient level data via questionnaires and expanding digital monitoring with a roll out of Health Care as part of the digital infrastructure.

The trends noted to date were that more patients were being admitted from the community 'step up' instead of 'step down'. Patients were very engaging and positive feedback had been received to date.

Following a query raised regarding IT requirements it was noted that IT had been set up for monitoring patients at home, either by the patient themselves or the staff that visited the home. Further work was being undertaken with the IT department regarding connectivity and for further development.

A further query was raised regarding cost implications. Confirmation was provided that, although the service was not cheap, cost benefits would be seen in the future and work was in progress to look at how to manage finances effectively and how resources could be repurposed.

3. Knife crime and our work to support patients and communities

Amiee Moody, Serious Violence Reduction Navigator and Michelle Waters, Serious Violence Recovery Navigator attended the meeting and gave a presentation on knife crime and the work being undertaken to support patients and communities.

A Violence and Reduction Service had been operating in the Emergency Department of Glasgow Royal Infirmary since December 2015 and provided support to patients affected by violent lifestyles and aimed to connect vulnerable patients with essential support services. The Service expanded in November 2016 when the Navigators started working with patients in the Emergency Department at the Royal Infirmary of Edinburgh. The service was then rolled out further across the country and commenced at South Tees Hospitals NHS Foundation Trust in March 2024.

From August 2023 to the end of July 2024, 186 young people aged 24 and under were victims of a crime involving a knife or a bladed weapon in the Cleveland Police area. Cleveland was ranked as the third highest in the country for knife crime. While the overall figure for murders with a knife or sharp object had fallen by 13%, teenagers remained disproportionally affected by knife crime and faced a higher risk of murder by knife attacks than any other age group. An overview was provided on the amount of patients that had been assessed by Serious Violence Reduction Navigator (SVRN's) in A&E at South Tees Hospitals NHS Foundation Trust.

A challenge for the service was enabling young people to continuously engage with the service.

Following a query raised it was noted that an area of focus for the future was to work with the Pupil Referral Unit and students that were unable to attend mainstream school.

4. Review of 2023/24 including Highlights from the Annual Report

Ms Stacey Hunter, Group Chief Executive presented a review of 2023/24, which included the following highlights from the Annual Report:

<u>People</u>

- Improvements in Staff Survey results including an increase in staff recommending the organisation as a place to work from 55.57% in 2022 to 60.60% in 2023/24.
- Work continued to develop and progress staff. The monthly recognition scheme, STARS Awards, continued to celebrate incredible individuals and teams/services across the organisation.
- The organisation continued to promote an inclusive culture by valuing patient and staff diversity and creating an inclusive workplace.
- The Trust had a dedicated EDI Team and established staff network groups including LGBT+, BAME and disability.
- A number of stories were shared which included the Trust being awarded the Myeloma UK Clinical Service Excellence Programme (CSEP) Award in recognition of its outstanding care for myeloma patients.

<u>Performance</u>

- Urgent Treatment Centre (UTC) at James Cook University Hospital opened on 1 April 2024. The opening of the UTC had helped the organisation with the A&E 4 hour target, which was reporting at 69% compliant.
- 5% reduction in 12 hour waits.
- Increase in the number of 65 week waits due to Covid. Work continued to monitor and manage the position on a daily basis.

Quality

- Appointment of the first ever Mental Health Midwife who would help bridge the gap between maternity and mental health services in the Middlesbrough area.
- The Trust became the first Trust in the North East and North Cumbria Integrated Care System to gain national recognition for its liver services. The Liver Team were awarded the Improving Quality in Liver Services (IQILS) level 2 accreditation by the Royal College of Physicians (RPC).

Finance

- Development commenced on the £35.5m surgical hub development centre in Northallerton.
- Significantly more staff had been employed during 2023/24 to ensure safe and effective care was provided.

5. Quality and Safety Report

Dr Michael Stewart, Group Chief Medical Officer presented the Quality and Safety Report and highlighted the following areas:

- Three of the Quality Priorities for 2023/24 had been delivered. Five priorities had partly been delivered and had been carried forward to the University Hospitals Tees 2024/25 Quality Priorities.
- The Trust had transitioned to the Patient Safety Incident Response Framework (PSIRF) in January 2024 and training had been delivered in line with the National Patient Safety Syllabus.
- Electronic Prescribing and Medicine Administration (ePMA) was implemented in the Trust in June 2022 to improve clinical effectiveness and patient safety. Work continued to rollout ePMA Trustwide and to maximise the utilisation of the system dashboards.
- A revised complaint process had been implemented in January 2024, which was in line with the PHSO Complaint Standards Framework. Further work was being carried out with regards to the quality of responses and timeframes.
- A patient experience dashboard launched in August 2024, which provided an overview of a diverse set of metrics that captured patient experience.
- Area of focus for clinical effectiveness was the thorough participation of mandated national audits, which helped compare clinical management and clinical outcomes.
- Work continued around the implementation of InPhase, which would support improved administration and reporting of Clinical Audit, NICE Guidance and CQC Evidence Collation.
- Around 300,000 people a year in England acquired a healthcare-associated infection (HCAI) as a result of NHS care. Focussed work continued to reduce infections including the screening of Carbapenemase Producing Enterobacteriaceae (CPE), which was a serious public health concern with a high transmission rate.
- The Trust developed the South Tees Accreditation of Quality in Care (STAQC) programme which enabled a comprehensive assessment of the quality of care provided to patients by each clinical area.
- The Trust received an overall Regulation and Compliance Rating of Good by the Care Quality Commission (CQC) and work continued to aspire to move towards an outstanding rating.
- The Group Quality Priorities for 2024/25 had been developed with clinical colleagues and had been shared with the Council of Governors at both South Tees Hospitals and North Tees and Hartlepool NHS Foundation Trusts.

6. Annual Accounts 2023/24

Mr Chris Hand, Group Chief Finance Officer presented the Annual Accounts for 2023/24 and highlighted the following key issues:

- Mazars, External Auditors had been appointed by the Council of Governors to provide an independent opinion on whether the financial statements were true and fair and had been properly prepared in accordance with the requirements.
- Mazars issued an unqualified opinion.
- Significant weakness was identified in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. This had been issued in a previous financial year and related to the October 2019 Additional License Condition regarding the financial recovery plan.

A financial overview was provided, which included:

- Operating income of £931m, with £872m income from clinical activities.
- Operating expenditure of £962m.
- Consolidated Group position of £57.5m deficit and with adjusted financial performance for the purposes of system achievement a £23.3m deficit was achieved.
- Capital investment of c£54m during 2023/24.
- Closing cash balance of £56m with no revenue cash support required.

7. Membership Report

Jackie White, Company Secretary/Head of Governance presented the Membership Report in the absence of Mrs Janet Crampton, Lead Governor. The following key issues were highlighted:

- The role of the Governor was a key role and was responsible for holding the Non-Executive Directors individually and collectively to account for the performance of the Trust.
- Governors were also responsible for representing the interests of members, patients and members of the public.
- The Trust had a total of 13,890 members which comprised of 4,073 public members and 9,817 staff members.
- Newly elected Governors for Hambledon and Richmondshire, Redcar and Cleveland and Staff were highlighted within the presentation.
- A number of statutory duties had been fulfilled from April 2023 with some in conjunction with North Tees and Hartlepool NHS Foundation Trust Council of Governors. These included the approved appointment of the Vice Chair and Senior Independent Director and the agreed process for the appointment of the Non-Executive Directors and Group Board.

Ms Stacey Hunter, Group Chief Executive provided an overview of looking ahead to 2024/25 and the University Hospitals Tees's strategic design approach to working together. At the heart of the approach would be the Clinical Strategy, which was currently in development. University Hospitals Tees would be working together to provide more services to meet the local need, deal with the inequalities faced and to ensure an equitable share of resources.

8. Questions

A number of questions were posed by Governors and members which were responded to during the meeting.

Professor Derek Bell OBE, Group Chairman and Ms Stacey Hunter, Group Chief Executive thanked the presenters and those who attended the meeting and for their feedback.

North Tees and Hartlepool Audit Committee

30th July 2025

Connecting to: North Tees & Hartlepool Unitary Board

Chair of Committee: Alison Fellows

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.

1. Update on Annual Filings by the Trust (position to be confirmed at next Board meeting):

   (a) the Company Secretary verbally updated the Committee on the position with the Trust's statutory filings;

   (b) External Audit Progress Report (for Assurance) – a verbal report was also received from Deloitte on progress with the final position on the Trust's accounts and financial statements, referring to a delay with finalising the wording of the Annual Report, but it was confirmed that this would be finalised by the end of the week of the Committee meeting to enable final filings.

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.

1. Losses and Special Payments Report (for Assurance) – this report provided the Committee with the full year losses and special payments spend for 2024/25, and year to date spend for quarter one 2025/2026. Stock and pharmacy drug write-off levels were

particularly highlighted, and the potential for some cost savings to be investigated was discussed - Audit One referred to the relevant materials management audit they are completing, which will make some recommendations that might assist here.

2. Single Action Waivers Report (for Assurance) – it was again discussed that a significant proportion of the spend highlighted in the report covered expenditure that should not come into the procurement/waiver category, and that the basis of the report needs to be reviewed. An Internal Audit Report on procurement is due shortly and will come to a future Committee meeting.
3. Internal Audit Progress Report (for Assurance) – there had been no changes to the IA plan since the previous meeting. No high priority recommendations were reported as being overdue. Five other recommendations had exceeded their original due date by more than twelve months (Sepsis Guidelines Update, and Volunteers' Induction Checklists); these were discussed and an update was required for the next committee meeting. The Committee emphasised the need for any proposed escalation of overdue recommendations to come to the Committee if a recommendation is overdue by more than a year or has already been extended three times (as previously agreed by the Committee). It was also noted that for ten outstanding recommendations, there had been no update provided to IA by the Trust, which is not satisfactory. However, in overall terms the numbers reflect a decrease in recommendations reported as overdue, against the previous year's programme.

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. Board Assurance Framework – received and noted for assurance. There were 7 high/red risks reported as being outside the approved risk appetite, with 109 planned mitigating actions, and no changes to current risk scores.
2. Annual Internal Audit Report for 2024/2025, including final Head of Audit Opinion (for Assurance) – it was noted that the HoIAO provided a robust overall opinion level of "good assurance". No significant control weaknesses had been identified that would need to be referred to in the Annual Governance Statement. Three 2024/2025 audits were still in progress, but these would be completed by the date of the next committee meeting. Internal Audit's report relating to their Advisory Review of the Group Governance Framework was also received and noted by the Committee by way of assurance.
3. Other Sources of Assurance – the Director of Risk, Assurance & Compliance verbally updated the Committee on the ongoing work to identify and map additional sources of assurance for the Trust; an update report will come back to the Committee when that work is complete.
4. Counter Fraud Progress Report (for Assurance) – this report updated the Committee on progress against the 2025/26 fraud work plan, and an update on fraud referrals and financial fraud values since the previous committee meeting. The Committee also

received and noted the annual counter fraud report for 2024/2025, and the Trust's annual Counter Fraud Functional Standard Return for 2024/25, in which the Trust was rated as green in all the NHS required categories, with the exception of category 12 (Conflicts of Interest Policy and Registers), where there is limited evidence of measuring awareness or knowledge of the policy, and of any results being used to assess whether further awareness training is needed).

Recommendations:

Board of Directors to note the report.

Annual General Meeting
Thursday, 19 September 2024
Riverview Room, River Tees Watersports Centre, The Slipway, North Shore Road, Stockton, TS18 2NL

Present:

Derek Bell, Group Chair (Chair)	DB
Stacey Hunter, Group Chief Executive	SH
Ali Wilson, Group Non-Executive Director (Vice Chair)	AW
Fay Scullion, Group Non-Executive Director	FS
Mark Dias, Group Non-Executive Director	MD
Ken Anderson, Group Non-Executive Director	KA
Neil Atkinson, Group Managing Director	NA
Chris Hand, Group Chief Finance Officer	CH
Mike Stewart, Group Chief Medical Officer	MS
Rachel Metcalf, Group Chief People Officer	RM
Ken Anderson, Group Chief Information Officer	KA
Steve Taylor, Group Director of Estates	ST
Ruth Dalton, Group Director of Communications	RDa
Rowena Dean, Chief Operating Officer, NTHFT	RDe
Jackie White, Company Secretary/Head of Governance	JW

In Attendance:

Lynn Morgan, Community Lead Nurse
Michelle Watson, Associate Chief Operating Officer, STHFT
Amiee Moody, Serious Violence Reduction Navigator
Heidi Holliday, Secretary to the Board (note taker)

Governors:

Angela Warnes, Lead Governor NTHFT/Out of Trust Area
Allan Fletcher, Elected Governor: Stockton
Elliot Kennedy, Elected Governor: Stockton
Lynda White, Elected Governor: Stockton
Patrick Kimmitt, Elected Governor: Stockton
Allan Kellehear, Elected Governor: Hartlepool
Anne Holt, Elected Governor: Hartlepool
Misra Bano-Mahroo, Elected Governor: Hartlepool
Mike Scanlon, Elected Governor: Hartlepool
Sarah Moule, Elected Governor: Easington
Jennifer Jones, Elected Governor: Staff
Dave Russon, Elected Governor: Staff
Ann French, Appointed Governor: Teesside University
Aaron Roy, Appointed Governor: Hartlepool Borough Council

Trust Members:

Jane Easterby
Bernadette Glanville
Andrew Tingle
John Robson
Pauline Robson
John Pond

1. Welcome and Introduction

Professor Derek Bell, Group Chair welcomed members to the 2024 Annual General Meeting of North Tees and Hartlepool NHS Foundation Trust.

The Group Chair reflected on the year, where both North Tees & Hartlepool Foundation Trust and South Tees Hospitals NHS Foundation Trust had worked together as part of a Group model, which had been an interesting and exciting time. A number of changes had been seen within the previous year, including Board changes and elections now being held bi-annually. Quality remained the highest priority and Finance had been challenging however, the Trust achieved the targets set out for 2023/24.

2. Hospital at Home University Hospitals Tees

Lynn Morgan, Community Lead Nurse NTHFT and Michelle Watson, Associate Chief Operating Officer, STHFT, attended the meeting and gave a presentation on the Hospital at Home Service that had been developed in collaboration between North Tees & Hartlepool Foundation Trust and South Tees Hospitals NHS Foundation Trust.

The Hospital at Home service supported patients to have their healthcare needs met within their own homes, when previously they would have needed to be delivered within a hospital setting, and it was designed to replicate the level of care and support provided within a hospital environment, safely at home.

When developing the service there were two key areas of focus; respiratory pathways and frailty pathways and a lot was learnt from the exceptional work of both Trust's Respiratory Virtual Ward models of care. The two Trust's models differed slightly at present and work was ongoing to learn together, share experiences and to identify improvements for the future. Work was also ongoing with the North East Ambulance Service (NEAS) around service development with the aim to bring Hospital at Home into the directory of services offered, utilising the Push/Pull model. An overview of each Trust's model was provided along with a number of case studies that demonstrated that patients don't always need to be seen in hospital.

There were a number of agreed next steps which included, exploring further pathways, collecting patient level data via questionnaires and expanding digital monitoring with a roll out of Health Care as part of the digital infrastructure.

3. Knife crime and our work to support patients and communities

Amiee Moody, Serious Violence Reduction Navigator attended the meeting and gave a presentation on knife crime and the work being undertaken to support patients and communities.

A Violence and Reduction Service had been operating in the Emergency Department of Glasgow Royal Infirmary since December 2015 and provided support to patients affected by violent lifestyles and aimed to connect vulnerable patients with essential support services. The Service expanded in November 2016 when the Navigators started working with patients in the Emergency Department at the Royal Infirmary of Edinburgh. The service was then rolled out further across the country and commenced at South Tees Hospitals NHS Foundation Trust in March 2024.

From August 2023 to the end of July 2024, 186 young people aged 24 and under were victims of a crime involving a knife or a bladed weapon in the Cleveland Police area. Cleveland was

ranked as the third highest in the country for knife crime. While the overall figure for murders with a knife or sharp object had fallen by 13%, teenagers remained disproportionally affected by knife crime and faced a higher risk of murder by knife attacks than any other age group. An overview was provided on the amount of patients that had been assessed by Serious Violence Reduction Navigator (SVRN's) in A&E at South Tees Hospitals NHS Foundation Trust.

A challenge for the service was enabling young people to continuously engage with the service and work was ongoing to look at alternative options for engaging with patients.

4. Review of 2023/24 including Highlights from the Annual Report

Ms Stacey Hunter, Group Chief Executive presented a review of 2023/24, which included the following highlights from the Annual Report:

People

- Improvements in Staff Survey results including an increase in staff recommending the organisation as a place to work from 62.86% in 2022 to 65.64% in 2023/24.
- Work continued to award and celebrate incredible individuals and teams/services across the organisation.
- There was now a significant number of Volunteers at the Trust. Shortlisting had taken place that year for the Unsung Hero Awards and a special Volunteers Thank You Evening was held to show the Trust's appreciation for them.
- The organisation continued to promote an inclusive culture by valuing patient and staff diversity and creating an inclusive workplace.
- A number of stories were shared which included Mel Cambage, Associate Director of Nursing Experience & Improvement being presented with special Queen's Nursing Institute Long Service Award and T-Levels in healthcare now available at the Trust.

Performance

- A&E 4 hour target reporting at 87.09%
- 53% reduction in 12 hour waits.
- At the end of March there were 16, 65 week waits.
- Cancer faster diagnosis was reporting at 80.1%

Quality

- The Cardiac CT Scanning Team had been recognised for their "world-leading" heart scan service.
- The Trust launched aquanatal classes in July as a way of giving women a chance to exercise their body and mind.

Finance

- A £4.2m robotic and emergency maternity theatre at University Hospital of North Tees had started to take shape, with the ten-month construction project started in February 2024.
- The New Health and Social Care Academy based at the University Hospital of Hartlepool had been officially opened on Friday, 6 September 2025.

5. Quality and Safety Report

Dr Michael Stewart, Group Chief Medical Officer presented the Quality and Safety Report and highlighted the following areas:

- An overview of progress was made against the priorities was provided. A number of priorities had been refreshed that were partly delivered and carried forward into the University Hospitals Tees 2024/25 Quality Priorities.
- Evidence showed that high quality care had been delivered with further quality improvement work being undertaken across a number of areas.
- The Trust had transitioned to the Patient Safety Incident Response Framework (PSIRF) in January 2024 and training had been delivered in line with the National Patient Safety Syllabus.
- Following a joint partnership agreement with the Butterwick Hospice the adult in-patient unit had been re-opened and following a visit from the Care Quality Commission (CQC) the full eight beds had been opened in November 2024.
- A revised complaint process had been implemented in January 2024, which was in line with the PHSO Complaint Standards Framework. Further work was being carried out with regards to the quality of responses and timeframes.
- 92.4% of the Friends and Family Test (FFT) returns were very good/good and 3.61% very poor/poor (total 28,943).
- A patient experience dashboard launched in August 2024, which provided an overview of a diverse set of metrics that captured patient experience.
- Area of focus for clinical effectiveness was the thorough participation of mandated national audits, which helped compare clinical management and clinical outcomes.
- Work continued around the implementation of InPhase, which would support improved administration and reporting of Clinical Audit, NICE Guidance and CQC Evidence Collation.
- Around 300,000 people a year in England acquired a healthcare-associated infection (HCAI) as a result of NHS care. Focussed work continued to reduce infections including the screening of Carbapenemase Producing Enterobacteriaceae (CPE), which was a serious public health concern with a high transmission rate.
- A revised Clinical Quality Accreditation Framework (CQAF) was launched in July 2024 and aimed to support clinical teams to deliver outstanding care through a culture of continuous improvement and empowering strong leadership. A new standard had been included around Veteran awareness.
- The Trust received an overall Regulation and Compliance Rating of Requires Improvement by the Care Quality Commission (CQC). Following focussed work all the must do's and should do's now being met. Work continued to ensure changes were being embedded and expected benefits were now being seen.
- The Group Quality Priorities for 2024/25 had been developed with clinical colleagues and had been shared with the Council of Governors at both North Tees and Hartlepool NHS Foundation Trusts and South Tees Hospitals NHS Foundation Trust.

6. Annual Accounts 2023/24

Mr Chris Hand, Group Chief Finance Officer presented the Annual Accounts for 2023/24 and highlighted the following key issues:

- Deloitte External Auditors had been appointed by the Council of Governors to provide an independent opinion on whether the financial statements were true and fair and had been properly prepared in accordance with the requirements.
- Deliotte had issued an unqualified opinion.
- No significant weaknesses had been identified in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources.

A financial overview was provided, which included:

- Operating income of £426m, with £393m (92%) income from clinical activities.
- Operating expenditure of £429m.
- Consolidated Group position of £1.8m deficit, with an adjusted financial performance for the purposes of system achievement of £1.4m deficit, was achieved.
- Capital investment of c£40m during 2023/24.
- Closing cash balance of £72m.

7. Membership Report

Angela Warnes, Lead Governor, NTHFT presented the Membership Report and highlighted the following key issues:

- The role of the Governor was a key role and was responsible for holding the Non-Executive Directors individually and collectively to account for the performance of the Trust.
- The Lead Governors had been involved in the appointment process for the Group Chief Executive Officer.
- A significant area of work had been the collaborative working between the two Council of Governors at both North Tees and Hartlepool NHS Foundation Trusts and South Tees Hospitals NHS Foundation Trust with the majority of meetings now being held In Common.
- Governors were also responsible for representing the interests of members, patients and members of the public.
- The Trust had a total of 11,279 members which comprised of 5,035 public members and 6,246 staff members.
- Newly elected Governors for Stockton, Easington and the Rest of England were highlighted within the presentation.
- A number of statutory duties had been fulfilled from April 2023 with some in conjunction with North Tees and Hartlepool NHS Foundation Trust Council of Governors. These included the approved appointment of the Vice Chair and Senior Independent Director and the agreed process for the appointment of the Non-Executive Directors and Group Board.

Ms Stacey Hunter, Group Chief Executive provided an overview of looking ahead to 2024/25 and the University Hospitals Tees's strategic design approach to working together. At the heart of the approach would be the Clinical Strategy, which was currently in development. University Hospitals Tees would be working together to provide more services to meet the local need, deal with the inequalities faced and to ensure an equitable share of resources.

8. Questions

A number of questions were posed by Governors and members which were responded to during the meeting.

Professor Derek Bell OBE, Group Chairman and Ms Stacey Hunter, Group Chief Executive thanked the presenters and those who attended the meeting for their comments, questions and feedback.