NHS
University Hospitals Tees

Board of Directors Meeting

Thursday, 5 March 2026 at 13:00

Rooms 3 & 4, STRIVE, Friarage Hospital,
Northallerton, DL6 1JG

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University Hospitals Tees

MEETING OF THE BOARD OF DIRECTORS
TO BE HELD IN PUBLIC
ON THURSDAY 5 MARCH 2026 AT 1:00PM
ROOMS 3 & 4, STRIVE, FRIARAGE HOSPITAL, NORTHALLERTON

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT	TIME
1. CHAIR'S BUSINESS					
1.1	Horatio's Garden	Information	Chief Executive	Presentation	13:00
1.2	Welcome and Introductions	Information	Chair	Verbal	13:20
1.3	Apologies for Absence	Information	Chair	Verbal	13:20
1.4	Quorum and Declarations of Interest	Information	Chair	ENC	13:20
1.5	Minutes of the last meeting held on 8 January 2026	Approval	Chair	ENC	13:20
1.6	Matters Arising and Action Log	Information	Chair	ENC	13:25
1.7	Chair's Report	Information	Chair	ENC	13:30
1.8	Chief Executive's Report	Information	Chief Executive	ENC	13:40
1.9	UHT Management Team Chairs Log: 22 January & 19 February 2026	Information	Chief Executive	ENC	13:55
1.10	Board Assurance Framework (31 December 2025)	Assurance	Director of Risk, Assurance & Compliance	ENC	14:00
2. QUALITY AND SAFETY					
2.1	Quality Committee Chairs Log: 26 January & 23 February 2026	Assurance	Chair of Committee	ENC	14:10

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 Quarter 3: 2025/26	Assurance	Director of Midwifery	ENC	14:20
2.3	Perinatal Staffing Report Quarter 3: 2025/26	Assurance	Director of Midwifery	ENC	14:30
3. PEOPLE					
3.1	People Committee Chairs Log: 27 January & 24 February 2026	Assurance	Chair of Committee	ENC	14:40
3.2	Nurse Safer Staffing Report	Assurance	Chief Nursing Officer	ENC	14:50
3.3	Safer Staffing Bi-Annual Establishment Review - STHFT	Assurance	Chief Nursing Officer	ENC	15:00
3.4	Guardian of Safe Working Report	Assurance	Chief Medical Officer	ENC	15:10
3.5	Equality Delivery System Annual Report 2025/26	Approval	Chief People Officer	ENC	15:20
4. FINANCE & PERFORMANCE					
4.1	Resources Committee Chairs Log: 28 January & 25 February 2026	Assurance	Chair of Committee	Verbal / ENC	15:30
4.2	Finance Report Month 10: 2025/26	Assurance	Chief Finance Officer	ENC	15:40
4.3	Integrated Performance Report (31 December 2025)	Assurance	Chief Delivery Officer	ENC	15:50
4.4	Emergency Preparedness Resilience & Response (EPRR) Annual Report	Approval	Chief Delivery Officer	ENC	16:00
5. SOUTH TEES HOSPITALS NHS TRUST UNITARY BOARD					
5.1	Audit & Risk Committee Chairs Log: 29 January 2026	Assurance	Chair of Committee	ENC	16:05

	ITEM	PURPOSE	LEAD	FORMAT	TIME
5.2	Annual Filings	Approval	Director of Corporate Affairs	ENC	16:10
5.3	Use of Seal Report	Approval	Director of Corporate Affairs	ENC	16:15
6. NORTH TEES AND HARTLEPOOL NHS TRUST UNITARY BOARD					
6.1	Audit Committee Chairs Log: 29 January 2026	Assurance	Chair of Committee	ENC	16:20
6.2	Annual Filings	Approval	Director of Corporate Affairs	ENC	16:25
6.3	Use of Seal Report	Approval	Director of Corporate Affairs	ENC	16:30
CLOSE					
	DATE OF NEXT MEETING The next meeting of the Board of Directors will take place on Thursday 7 May 2026 in the Boardroom, University Hospital North Tees				

University Hospitals Tees

Register of members interests

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 1.4

Report author: Sarah Hutt, Assistant Company Secretary

Executive director sponsor: Jackie White, Director of Corporate Affairs

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 UHT 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.

UHT Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Alison Fellows	Non-Executive Director		Ongoing	Husband Partner at Firm – Ward Hadaway Solicitors
		December 2023	Ongoing	Board Governor, member and chair designate (from July 2026) of Audit Committee, member of Business School Advisory Board, 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	April 2024	Ongoing	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
Celia Weldon	Non-Executive Director	February 2026	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
				Non-Executive Director, Leazes Homes
				Member of the Karbon Group Audit and Risk Committee, Karbon Homes
				Independent Member of the Audit and Risk Committee, Cumberland Council
Chris Day	Non-Executive Director		Ongoing	Vice Chancellor and President at Newcastle University
			Ongoing	Institutional Member at Universities UK (UUK)
			Ongoing	Board Member at The Russell Group
			Ongoing	Board Member at Sir Bobby Robson Foundation
			Ongoing	Chair at N8 Research Partnership
			Ongoing	Trustee at Foundation for Liver Research
			Ongoing	Chair of the PILOT Institutional Level PCE Panel for the Research Excellence Framework 2029 – Research England (part of UK Research and Innovation)
			Ongoing	Trustee at Newcastle University Development Trust

Board Member	Position	Relevant Dates From	to	Declaration Details
		1 July 2025	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Chris Hand	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
		April 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Trust on NTH Solutions LLP – Company Number OC419412
		June 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
David Redpath	Non-Executive Director	1 January 2021	Ongoing	Director of DGR Consultancy - Company number 10340661
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
		September 2017	Ongoing	Vice President Senior Executive Partner – Gartner
		July 2022	Ongoing	Deputy Chairman – Seaton Delaval Football Club
		14 August 2025	Ongoing	Director of Optimus Health Limited – Company Number 07415246
		1 October 2025	Ongoing	Chair on behalf of North Tees & Hartlepool NHS Foundation Trust on NTH Solutions LLP – Company Number OC419412
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Emma Nunez	Chief Nursing Officer	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	October 2024	Ongoing	Chief Executive, Age UK North Yorkshire & Darlington
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Jackie White	Director of Corporate Affairs & 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
		March 2023	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
			Ongoing	Daughter and Daughter in law employees of South Tees Hospitals NHS Foundation Trust

Board Member	Position	Relevant Dates From	to	Declaration Details
Ken Anderson	Chief Information Officer	May 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation 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
Matt Neligan	Deputy Chief Executive / 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	Non-Executive Director	20 July 2015	Ongoing	Director of Be The Change HR Ltd – Company No. 9694576
		September 2023	Ongoing	Permanent Deacon in Formation (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	Chief Medical Officer	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
			Ongoing	Wife is employed at South Tees NHS FT
Miriam Davidson	Non-Executive Director	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
			Ongoing	Local Government Association Associate, occasional work with English councils on Public Health Peer Reviews and facilitation of relevant workshops
Neil Atkinson	Chief Delivery Officer	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		June 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Foundation Trust on NTH Solutions LLP – Company Number OC419412
		October 2025	Ongoing	Director of South Tees Healthcare Management Limited - Company number 10166808
		1 November 2025	Ongoing	Trustee, Age UK
Derek Bell	Chair	April 2020	Ongoing	Trustee Royal Medical Benevolent Fund – no remuneration

Board Member	Position	Relevant Dates From	to	Declaration Details
		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	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
Ruth Dalton	Director of Communications	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Stacey Hunter	Chief Executive	March 2024	Ongoing	Director, Health Innovation North East North Cumbria Limited
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		July 2024	Ongoing	Partner, Dr Cornelle Parker, ad hoc project work within organisations of the NHS
		April 2025	Ongoing	Member of UHA Executive Steering Committee (hosted by NHS Providers)
		May 2025	Ongoing	Member of NHS Confederation Acute Advisory Panel
		May 2025	Ongoing	Founding member, Evolve Collaborative (supported by NHS Confederation and Beamtree)
		Aug 2025	Ongoing	Lead, Leadership of Planned Care, Provider Leadership Board
Steven Taylor	Director of Estates	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		1 July 2024	Ongoing	Honorary Contract as Director of Estates and Facilities for NTH Solutions LLP - Company Number OC419412
			Ongoing	Son employed by NTH Solutions LLP – ICT Project Officer/Digital Performance Coordinator
			Ongoing	Wife employed by NTH Solutions LLP – Catering Assistant
Stuart Irvine	Director of Risk, Assurance and Compliance	2023	Ongoing	Chair – Hartlepool College of Further Education
		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
			Ongoing	Trustee of Hospitals Trust of the Hartlepool
			Ongoing	Sons (x2) are employees at Hartlepool College of Further Education

NHS
University Hospitals Tees

Minutes of a meeting of the University Hospitals Tees Board held in Public at 12:05pm on Thursday, 8 January 2026 in Rooms 3&4 STRIVE, Friarage Hospital, Northallerton

Present:
Professor Derek Bell, Chair (Chair)
Ann Baxter, Vice Chair/Non-Executive Director & Maternity Champion
Ali Wilson, Vice Chair/Non-Executive Director (virtual)
Fay Scullion, Non-Executive Director
Alison Fellows, Non-Executive Director
Miriam Davidson, Non-Executive Director & Maternity Champion
David Redpath, Non-Executive Director
Ken Readshaw, Non-Executive Director / Senior Independent Director
Mark Dias, Non-Executive Director
Professor Chris Day, Non-Executive Director
Stacey Hunter, Chief Executive
Matt Neligan, Deputy Chief Executive / Chief Strategy Officer
Chris Hand, Chief Finance Officer
Neil Atkinson, Chief Delivery Officer
Rachael Metcalf, Chief People Officer
Mike Stewart, Chief Medical Officer
Emma Nunez, Chief Nursing Officer & Maternity Champion

Directors – non-voting:
Steve Taylor, Director of Estates
Ken Anderson, Chief Information & Technology Officer
Ruth Dalton, Director of Communications
Stuart Irvine, Director of Risk, Assurance & Compliance
Jackie White, Director of Corporate Affairs/Company Secretary

In Attendance:
Sarah Hutt, Assistant Company Secretary (note taker)
Gareth Lightfoot, Local Democracy Reporter, Gazette
Mohan Kyle, member of staff
Peter Clark, member of staff
Zahida Mian, Lead Governor STHFT (virtual)
Claire McGlade, Corporate Affairs Officer

GB25/190 Welcome and Introductions

The Chair welcomed everyone to the meeting, referencing the meeting time had been brought forward due to anticipated adverse weather conditions and current pressures being faced in the organisation.

GB25/191 Apologies for Absence

There were no apologies for absence.

GB25/192 Quorum and Declaration of Interests

The meeting was confirmed as quorate.

No perceived conflicts of interest

The Chair of the meeting referred to the Trust's declaration of interest register for board members. There were 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.

GB25/193 Minutes of the last meeting held on, 6 November 2025

The minutes of the last meeting held on, 6 November 2025 were accepted as a true and accurate record.

Resolved: that, the minutes of the meeting held on, 6 November 2025 be confirmed as a true and accurate record.

GB25/194 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.

GB25/195 Chair's Report

The Chair highlighted the key points of the Chair's Report that included national, regional and local matters, taking the report as read and acknowledging some of the items were now historic.

- At the North East North Cumbria Integrated Care Board (NENC ICB) Chairs meeting on 11 November 2025, Chairs met with Penny Dash, Chair, NHS England (NHSE) and discussed a number of items including the regional chairs appointment process, new FT arrangements, governors, winter planning and annual planning processes.
- Notification was received on 15 December 2025 that UHT's joint accreditation submission as a Veteran Aware Trust had been approved. The Veterans Covenant Healthcare Alliance (VCHA) recognised the significant work undertaken across the organisation to demonstrate its commitment to the Armed Forces Covenant, which was really positive. The Chair placed on record thanks to Stuart Irvine, Director of Risk, Assurance and Compliance and the team involved.
- As part of the work of the UHT Arts Council, which continued to progress at pace, the South Tees Hospitals NHS Foundation Trust (STHFT) COVID memorial art competition closed in November 2025 and the judging panel met on 9 December 2025 to review 95 pieces of artwork submitted by local schools and colleges. Areas were being identified on the James Cook and Friarage hospital sites to display the artwork prior to the formal launch on 7 April 2026 to coincide with World Health Day. In addition, an inaugural artwork exhibition took place on 9 December 2025 in the Spirituality Centre at the University Hospital North Tees (UHNT) to display pieces of artwork created by students from Yarm School. Following the exhibition, 24 pieces of the artwork were being displayed across the UHNT site.
- The Chair undertook a number of site walkabouts during November and December and also attended the Carol Service at the FHN with the Chief Executive, which was a lovely event.
- Work was progressing with Teesside University regarding the ongoing proposals for Teesside Medical School and opportunities for joint working, with the Chair and Chief Executive attending a meeting on 25 November 2025. It was noted that Eitan Brizman, Consultant Oral and Maxillofacial Surgeon from UHT had been appointed to the University to support the

development of the Medical School. Stacey Hunter, Chief Executive advised she was taking part in a stakeholder panel for the appointment of a new Vice-Chancellor/Chief Executive to replace Professor Paul Croney, who was retiring in September 2026.

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

GB25/196 Chief Executive's Report

Stacey Hunter, Chief Executive highlighted the key points of the Chief Executive's Report, acknowledging that the period since the last meeting in November had been dominated by the planning and response to winter, flu and further strike action by resident doctors. In addition, the organisation was required to submit a draft 3-year plan commencing in 2026/27 by 17 December 2025 with a final submission to be made in February 2026. Acknowledgement and thanks were given to staff, leaders and front-line colleagues for their response during this intense period, noting that there had also been increased sickness levels amongst staff.

- A grievance had been submitted to North Tees and Hartlepool NHS Foundation Trust (NTHFT) by Unison in relation to the terms and conditions for some staff in NTH Solutions LLP (NTHS). The Chief People Officer and Interim Managing Director, NTHS met with the trade union and a number of representatives before Christmas and a positive resolution was anticipated. Due to the confidential nature of the grievance, the Chief People Officer would provide an update to board members in the private board meeting.

- Following a UKAS accreditation visit to STHFT, the accreditation had been suspended for 12 weeks pending completion of a number of recommendations, which was disappointing. Support was being given to staff in meeting the recommendations. A revisit would be arranged in due course. The Chief Executive highlighted that the temporary suspension did not impact on service delivery and did not pose any safety issues. The accreditation was not a statutory requirement, however, was desirable and the organisation was keen for it to be reinstated.

- Following a significant amount of work to create a new target operating model across UHT moving to single management and leadership teams across services, a period of consultation took place during the summer and autumn of 2025. The changes went live in November and whilst still in early days, it was reported that the overall transition to Clinical Service Units (CSUs) had gone well. Thanks were recorded to the Executive Team for their leadership and to those staff involved.

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

GB25/197 Chair's Log – Group Management Team Meeting 23 October & 20 November 2025

The Chief Executive presented the Chair's Logs for the meetings of the Group Management Team (GMT) held on 23 October and 20 November 2025 for noting, with no issues of alert. It was highlighted that following the establishment of the CSUs, Service Directors were invited to join the GMT going forward.

Ali Wilson, Non-Executive Director/Vice Chair sought to understand whether any potential harm to patients waiting cancer treatment was monitored. Mike Stewart, Chief Medical Officer explained that work was underway to strengthen the Cancer Alliance processes, with a robust process in place for delays of over 104 days. The Chair highlighted that the report into County Durham and Darlington NHS Foundation Trust (CDDFT) and elsewhere had provided the opportunity to gain assurance and reassurance around areas already being considered internally in the broader round. Stacey Hunter, Chief Executive reported that at a development session the Board had considered the now public report into breast services at CDDFT with a 'Could this be true for us' review in the spirit of learning. The outcome of the review was expected to be concluded and reported in February. The Chief Medical Officer explained that one aspect of the CDDFT report was in relation to the continued use of locum consultants and a review had commenced internally particularly around the progression of training and

accreditation. No safety concerns had been identified and a focused piece of work was ongoing with a small cohort of individuals who had not progressed with the necessary training to be on the GMC specialist register at consultant grade.

Resolved: (i) that, the content of the Chair's Log be noted; and
(ii) that, the verbal update be noted.

GB25/198 UHT Strategy Deployment Update

Matt Neligan, Deputy Chief Executive/Chief Strategy Officer provided an update regarding the implementation of the UHT Strategy, which continued at pace. The CSUs were now in place and building on the work of the former Clinical Boards to deliver clinical change, developing one, three and five year strategic plans. Progress of delivery against the Strategy continued to be monitored by the Group Strategy Programme Board. Business cases to support horizontal integration across a number of services were being developed, which would seek necessary approval.

To support the implementation of a Continuous Improvement operating model across the organisation, an external strategic partner had been appointed and would be a core enabler of delivering the UHT Strategy. The new approach to improvement would address fragmentation between strategic transformation, major operational improvement programmes and continuous quality improvement through a single coherent improvement framework. The project with the strategic partner was expected to span a 15-month period following which there would be handover to an identified internal resource in Quarter 1: 2027/28.

Proposals of future service changes had been progressed through the appropriate statutory change processes and plans shared with the NENC ICB Service Change Advisory Group, which were progressing through NHSE assurance channels. Engagement with the North East and Yorkshire Clinical Senate was underway, which would ensure external clinical input throughout the process. Engagement with local democratic processes and political landscape was taking place through briefing sessions with local MPs and through the formal mechanism of Overview and Scrutiny meetings in the Tees Valley and North Yorkshire. Other avenues of engagement were taking place including with Healthwatch, who had offered to facilitate public events providing the opportunity for public, partners and staff to contribute to the plans.

Ali Wilson, Non-Executive Director/Vice Chair sought clarity regarding how well the strategic plans integrated and aligned with what the organisation was trying to achieve through the planning process as there was a big ask and large CIP to deliver. The Deputy Chief Executive/Strategy Officer explained that the plans were aligned as closely as possible. There were a set of national planning asks to meet, which were incorporated into the plan. The way to deliver the 3 to 5 year ambition was through ownership by the CSUs with progress being monitored through service quality review meetings. Stacey Hunter, Chief Executive added that the finance ask and the necessity to continue run safe, sustainable services over the next three years was a challenge. The planning process was as important as engagement with stakeholders and partners regarding the plans in the Strategy to improve health and care and meet the needs of the population. The planning submission needed to reflect that direction of travel and the mechanisms to deliver the Strategy.

Ken Readshaw, Non-Executive Director sought assurance that appropriate support from corporate services was in place to facilitate the CSUs to manage their areas of responsibility and requested that for the next UHT Strategy Update a detailed overview of the enabling services in place be provided to provide assurance. The Chief Executive highlighted that corporate services were already streamlined, which was a challenge when the requirement was to reduce spend further and in particular emphasised the importance of having appropriate finance support in place for the CSUs in order for them to deliver their plans. This would require investment and the Chief Finance Officer was developing a business case to support necessary additional resource. Following a query by David Redpath, Non-Executive Director to understand whether the additional support would be in place at the start of 2026/27, the Chief Executive explained that whilst the full detail would not be in place, appropriate arrangements and priorities would be agreed. In order to deliver against the plans, transformation was required with an agreed methodology and appropriate resource. The Finance Business Case would be presented once finalised.

The Chair reiterated the importance of having the correct mechanisms in place to support the CSUs and also sought to understand what future stakeholder engagement in relation to the Strategy would look like for example with staff, member of the public, Governors etc. Ruth Dalton, Director of Communications confirmed plans were being developed which could be shared.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Communications Strategy regarding stakeholder engagement around UHT strategy delivery be shared.

GB25/199 Board Assurance Framework

Stuart Irvine, Director of Risk, Assurance and Compliance presented the Board Assurance Framework (BAF) to the period 31 October 2025 and highlighted the BAF was reviewed on a monthly basis through the Committee structure, however, only Resources Committee had met in December.

For NTHFT:

- 30 strategic risks
- 9 strategic risks outside the approved risk appetite, with 6 red/high risks
- No changes to risk appetite

For STHFT:

- 31 strategic risks
- 11 strategic risks outside the approved risk appetite, with 8 red/high risks
- No changes to risk appetite
- Planned action timescale range August 2025 – April 2035 (this included planned timescales linked to PFI exit strategy, 2033 and eradicating RAAC, 2035

The UHT Risk Management Policy would be updated to reflect the new reporting processes following the establishment of the CSUs. A Board Development session was planned for February 2026 to review and approve the risk appetite for 2026/27, in advance of the annual refresh of the BAF. The refresh exercise would further strengthen the standardisation achieved during 2025/26 with the aim of transitioning towards reporting a single BAF, reflective of each trust.

Stacey Hunter, Chief Executive posed a question whether there was opportunity to realign the BAF to the UHT strategic objectives as part of the refresh exercise. It was acknowledged the current BAF had evolved from two different approaches and was a moving journey. The board session around the risk appetite could move towards that approach.

Resolved: (i) that, the content of the report be noted; and
(ii) that, consideration be given to aligning the BAF to the UHT strategic objectives as part of the refresh exercise for 2026/27.

GB25/200 Quality Committee Chairs Log 24 November 2025

Fay Scullion, Non-Executive Director presented the Quality Committee (QAC) Chairs Log for the meeting held on 24 November 2025 highlighting some items had been discussed earlier in the agenda and some had progressed since the time of writing the report.

- Two urgent escalations to the Committee: temporary suspension of the UKAS accreditation in STHFT Pathology Services, action plan developed with formal review expected end of January. A self-assessment was undertaken following the report into Breast Services at CDDFT, providing reassurance and assurance regarding services across UHT.
- The Human Tissue Authority (HTA) Report highlighted six reportable incidents and storage capacity was at risk due to winter pressures. Alternative storage was being sourced. A recent audit outlined there were some delays noted in patients being transferred from the ward to the mortuary. Further work was being carried to understand the cause of the delays, which could be family preference.

- Moving and Handling training and Infection Prevention Control training were reporting below compliance in the Health and Safety Report as well as an increase in sharps incidents, compared to 2023/24. Further work being undertaken.
- A number of complaints at STHFT remained open over the statutory six months, noting that often the individual complaints were complex and involved a number of different service areas. It was anticipated that utilisation of In Phase would support consistent monitoring of responses.
- Due a lack of resources within the mortality review teams, learning from deaths reviews at NTHFT were significantly delayed. There were plans to appoint a lead mortality reviewer at both NTHFT and STHFT to provide a level offer. Although no national standard for reviews, the internal target was set at 20%.
- The number of Healthcare Acquired Infections (HCAIs) above threshold continued to rise with MRSA being regraded to alert following the report of one case against a tolerance of zero. It was noted that there was an increase in patients coming into hospital with infections and not hospital acquired. The Infection, Prevention and Control (IPC) dashboard would allow a more targeted approach to address areas below threshold. It was suggested a board session on IPC would be useful.
- A number of the Health Inequalities projects with a focus on preventative measures were at risk with no funding confirmed beyond 31 March 2026. Further detail was awaited regarding the Better Care Fund and other funding sources.
- There were no PSII open legacy serious incidents, with only three outstanding actions to be closed and evidence monitored through the governance structures.
- The fit testing service in relation to IPC at NTHFT for NTH Solutions continued to be monitored as concerns had been raised. Flu vaccination rates across UHT remained low.
- The Rowan Suite at University Hospital Hartlepool (UHH) remained suspended, with an extension in place to January 2026 due to workforce pressures. Meaningful engagement with staff and stakeholders was planned. The Birth Centre at the Friarage Hospital, Northallerton (FHN) had closed on 12 occasions due to staff pressures and there was also planned engagement.
- Maternity Incentive Scheme year 7 continued to be monitored with action plans in place to recover the training trajectory.
- Stronger system in place for ongoing monitoring of patient safety activity, with the escalation of recorded overdue incidents and PSII reports progressing through the Quality Oversight Group and being presented by the Medical Directors Team.
- A designated decant ward identified, which would positively impact on cleaning. The clinical leadership group were actively looking at antimicrobial processes and a Triumvirate had been established including pharmacy representation.
- Health and Equalities Report demonstrated a reduction in Did Not Attend (DNAs) across all groups, which was positive.

Emma Nunez, Chief Nursing Officer reported that the NENC ICB were leading on a piece of work regarding HCAI pathways and the impact of community borne infections. To provide context, infection rates nationally were measured against 2019 rates and it was noted that there had been an increase of 29% of MRSA cases and a 42% increase of Clostridium difficile cases. UHT had volunteered to take part in the regional work. In respect of the complaints diagnostic work undertaken at STHFT, performance over a number of years had fluctuated between 65% and 82% against the trajectory of 90% with a number of causative factors. The trajectory set for stage 3 compliance was 31 March 2026 and weekly reporting continued.

Stacey Hunter, Chief Executive commented that for the Health Inequalities projects showing tangible benefits, it was important to consider how to move them from project status to business as usual and review which projects were having the most impact and were aligned to the organisation's priorities noting that there wouldn't always be additional resource available.

Mike Stewart, Chief Medical Officer provided assurance that the DNA project for example was very much about personalised care and targeting those patients more likely to attend clinic and following the success of the pilot it was being explored how to transform the work into business as usual across the organisation. However, in relation to the social prescribing project which was providing support to the

most disadvantaged patients, this was as at the evaluation stage and there was a risk that insufficient data would be available before the current funding was due to end to be able to analyse whether it should be moved to business as usual.

The Chair commended the ongoing triangulation specifically in relation to complaints and IPC, which was helpful. In terms of the work around health inequalities it would be useful to explore how to link to the wider UHT Strategy and business as usual.

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

GB25/201 Academic Chairs Log 3 December 2025

Chris Day, Non-Executive Director presented the Academic Committee Chairs Log for the meeting held on 3 December 2025, noting it was a still relatively new committee.

The two red strategic risks in the Research and Innovation BAF were highlighted, relating to innovation growth and innovation embeddedness. A successful joint workshop with partner organisations had taken place providing the opportunity for invited innovators to meet academics to share and review projects. It was planned to continue these events with university partners. It was noted that NHSEW had issued amended guidance regarding intellectual property (IP) and work was underway to ensure a UHT wide policy was compliant, with identified responsible officers for IP related governance requirements. The role for an Innovation Manager across UHT was being progressed.

An update was provided regarding changes to the National Institute for Health and Care Research funding model and the requirement for UHT to remain compliant in order to maximise receipt of the funding. The draft TVRA structure was shared and feedback by the Academic Research Units would inform the final version. Separate reporting regarding research development and research delivery would be presented going forward, with an update in six months outlining support required by the CSUs, the position on complex studies and impact on the financial elements. Updates were also provided regarding research finance noting future reports would provide separate updates for education, research and innovation.

The Committee received a presentation from the Academic Centre for Surgery and its ambition to become a world leading centre of excellence for surgical pathways. A feasibility study was being undertaken regarding a Surgical Centre of Excellence facility at the James Cook University Hospital (JCUH) site. It was noted that discussions regarding the facility were taking place with the Tees Valley Combined Authority.

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

GB25/202 People Committee Chairs Log 25 November 2025

Mark Dias, Non-Executive Director presented the People Committee Chairs Log for the meeting held on 25 November 2025 and took the report as read.

Areas of Alert:

- The temporary suspension of an accreditation in Pathology Services at STHFT; Quality Committee overseeing the action plan and triangulation with People Committee regarding employee relations and the well-being of staff.
- All race related concerns were treated as never events and recent cases had resulted in dismissal and a potential suspension.
- The Violence and Aggression Strategy was being updated to reflect Martin's Law and would unify existing approaches and build a strong culture of speaking up about violence and aggression, with operational and security teams working closely together. It was planned to implement Martin's Law by April 2027, which would require investment and there would be triangulation with the Resources Committee regarding the investment requirements.

- Sickness absence rates were increasing with 6.2% reported for UHT in November 2025 and the current trend indicated a risk of exceeding 7% in Quarter 1: 2026/27, which presented a significant risk to operational delivery and staff wellbeing.

For Advise:

- High staff turnover amongst staff with less than two years' service reporting at 40.2% and Healthcare Assistant (HCA) turnover continued to rise. Further work was required to understand the drivers.
- Significant increase in Guardian of Safe Working exception reporting with higher reporting noted in medicine, obstetrics, gynaecology, surgery and orthopaedics. Local solutions were being developed.
- A detailed action plan regarding the Committee's consideration of the proposed Talent Management Framework would be presented at the next meeting, with potential risks identified including grievances around process variation and potential challenges regarding inclusion in the talent pool.
- Work was ongoing to define organisational tolerance levels and the reporting culture in relation to violence and aggression.

For Assure:

- The UHT Medical Job Planning compliance rate achieved 96.3% against the 95%. Thanks were noted for the Chief Medical Officer and team.
- The completion rates of exit interviews had increased significantly from 7% to 39%, improving insight into the reasons for leaving.
- Overall staff turnover remained below the 10% threshold and national average.

Recommendations to the Board:

- Review the organisational improvement requirements and necessary cultural changes to achieve a substantial reduction in the persistently high levels of sickness absence.

Miriam Davidson, Non-Executive Director sought to understand whether the information from the staff exit interviews could provide insight into the proportion of staff leaving within two years, prompting a brief discussion. Stacey Hunter, Chief Executive acknowledged the turnover rates, however, explained it was important to look at what priorities had been committed to in our plan and to be able to deliver those priorities within the current resource, noting there was already limited HR resource, therefore there needed to be a focus as to where the resource was being targeted.

Ken Readshaw, Non-Executive Director sought to understand whether the recommendation for the Board to consider the actions required to reduce sickness absence was a new requirement or as part of the ongoing monitoring regarding absence. Mark Dias explained that change was required to improve the current position, which could be considered as part of the continuous improvement work. Stacey Hunter, Chief Executive added that it would be helpful to use the CI methodology to drive us to identify a single factor regarding staff availability, which could be due to sickness absence. Having that data would be beneficial.

The Chair referenced broadly what needed to be put in place to prevent an event such as the Manchester Arena bombing from happening again in the context of introducing Martin's law balanced against standard mandated requirements around safety, noting the increase in violence and aggression to NHS staff nationally. Steve Taylor, Director of Estates highlighted there were a range of estates related requirements to be achieved by the 2027 deadline and assurance regarding the organisation's arrangements were set out in the Violence and Aggression update to People Committee.

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

GB25/203 Nurse Safer Staffing Report

Emma Nunez, Chief Nursing Officer presented the Nurse Safer Staffing Report for the period September 2025 and highlighted the key points, noting there was an ongoing focus to reduce the reliance on temporary staffing. Work continued to align the workforce governance processes regarding

establishment across all sites, as there were still some differences in practice. It was noted that it was planned to produce an enhanced report in future measuring impact against performance indicators.

The outcome of the bi-annual nurse establishment review would be presented to People Committee in January 2026 and to Board in March 2026.

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

GB25/204 Resources Committee Chairs Log 17 December 2025

David Redpath, Non-Executive Director presented the Resources Committee Chairs Logs for the meeting held on 17 December 2025, noting that items for discussion and issues from the November meeting had been superseded. Key highlights included:

- The draft annual plan submission was discussed at length, noting colleagues from NHSE were in attendance at the meeting as observers.
- The financial position for Month 8, 2025/26 was a deficit of £7.2m, for the Group, which was a favourable variance of £48k against the year-to-date plan including over-performance of Elective Recovery Fund (ERF) income of £6.7m. The financial position was noted under Alert due to the risks in respect of ERF income and non-recurring events.
- An overall net increase of 22.64 worked across the Group was reported at Month 8, compared to the previous month. Whole Time Equivalents (WTEs) worked in month were 20.61 lower than the average of the previous financial year. Monitoring of the position remained a focus.
- Positive progress continued to be made in the development and de-risking of the Cost Improvement Programme (CIP) since submission, with £45.4m year to date CIP delivery reported, which was 98% of target. However, at the end of the reporting period, £2.8m remained defined as 'opportunity' and £8.7m remained as 'high risk'.
- The Referral to Treatment (RTT) Incomplete Pathways performance metric moved from Advise to Alert due to performance against the 18-week standard in Month 7, which was outside of the improvement trajectory agreed with the ICB and NHSE.
- The National Cost Collection (NCI) submission was reported, with NTHFT and STHFT both reporting a score of 90, demonstrating that the trusts were delivering the case mix of services at 10% lower cost than the national average.
- An update was provided regarding a business case relating to Robotic Process Automation (RPA). It was agreed a full business case would be required to proceed further, noting concern regarding proposals to sign a 5-year contract and requesting greater understanding around RPA within the wider AI/Digital Strategy, given the rapid changes to technology.
- The planned deep dive into the Electronic Patient Record (EPR) was being deferred from the January meeting to February.

A brief discussion ensued regarding the RPA business case item.

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

GB25/205 Finance Report: Month 8, 2025/26

Chris Hand, Chief Finance Officer presented the Finance Report for Month 8: 2025/26 and highlighted the key issues.

A deficit of £7.2m for the Group was reported, which was a favourable variance of £48k against the year-to-date plan, with a plan for the 2025/26 financial year to deliver an overall deficit control total of £9.1m, a break-even plan for NTHFT and a £9.1m deficit plan for STHFT (including an allocation of £11.5m ICS deficit support for STHFT). NHSE had advised of changes to the deficit support regime for 2025/26, with regional assurance of plan delivery required to prevent funding being withheld. Funding had been confirmed and received up to Quarter 3, it was anticipated Quarter 4 would be assessed based on the Month 8 system position.

The financial plans for the Group included a number of risk and assumptions, which would be closely monitored for the remainder of the financial year through Resources Committee. Significant risks at Month 8 were ERF income, industrial action, CIP delivery, expenditure run-rates and unfunded inflationary pressures. It was noted, there was a continued focus on de-risking and delivery of recurrent efficiency plans along with reductions in WTEs and expenditure run-rates to ensure delivery of the financial control total.

Following the launch of the Clinical Service Units (CSUs), each CSU had received CIP schemes to take forward and a named lead from the PMIO team had been identified to support with planning and delivery.

Reductions in temporary staffing and premium pay costs were a national priority set by NHSE, with the 2025/26 planning guidance requiring reducing agency spend by at least 30% from the prior year and to reduce bank spend by at least 10%. At Month 8, Agency spend was reported at £0.7m (11% less) and Bank spend £3.3m (15% less) than that incurred at the same point in the previous year (adjusted for inflation), which reflected the positive work. The position regarding WTE at Month 8 was a net overall increase 22.64 across the Group compared to the previous month, however, compared to the same period the previous year, there was a reduction in WTE of 42.04.

Capital expenditure to the end of Month 8 amounted to £29.9m, which was a slippage of £4.5m against the phasing of the 2025/26 year to date plan, largely relating to Salix grant and PDC funded schemes at STHFT. The cash balance was £95.3m for the Group and the continued strong cash balance supported good compliance with the Better Payment Practice Code for both trusts.

Stacey Hunter, Chief Executive highlighted the importance of the financial plan for 2026/27 in the context of reported increases in staff spend and WTE, acknowledging that in order to deliver against the plan, there would be a requirement to stop doing certain activity in line with the commitment to remain within the allocated resources whilst continuing to deliver safe services. This would not be possible without undergoing transformation and working differently. There was not an easy solution.

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

GB25/206 Integrated Performance Report

Neil Atkinson, Chief Delivery Officer presented the Integrated Performance Report (IPR) for the reporting period to 31 October 2025 and highlighted the key points noting updates had been provided in earlier agenda items for a number of the metrics. It was noted that there was an opportunity in 2026/27 to consider aligning the IPR to the UHT strategic objectives rather than the Care Quality Commission (CQC) five domains.

In respect of the items in the Alert category, there were nine metrics remaining for NTHFT, five related to HCAIs, two related to maternity, cancer 62-day standard and sickness absence. No new metrics had been added to Alert. Two metrics had been regraded from Assure to Advise in relation to cancelled operations not rebooked in 28 days and staff turnover.

For STHFT, there were eight metrics remaining in the Alert category: one related to HCAIs, maternity, diagnostic 6-week standard, mandatory training, RTT 52 weeks, RTT time to first appointment, sickness absence and complaints closed within target. In addition, three metrics had been regarded to Alert from Advise: MRSA, PPH rate and RTT incomplete pathways. The Chief Delivery Officer reported that two bids had been submitted to assist with the work to improve the RTT position. The majority of IPR metrics remained graded Advise for both Trusts.

Feedback was positive from the first performance review sessions with the Clinical Service Units (CSUs). The focus remained on performance against RTT and cancer standards pathways, with specific groups established to review and monitor progress. Ken Readshaw, Non-Executive Director sought to understand whether future reporting would be amended to provide a breakdown by CSU. It was noted oversight of the monthly performance reviews would be via the Group Management Team with any necessary escalation to Board by exception.

The Chair sought to understand the level of confidence regarding the outcome of the deep dive audit into readmission rates, which had been delayed since October 2025. Mike Stewart, Chief Medical Officer reported that whilst there would be some confidence in respect of the audit, it remained to be seen whether it would have a fundamental change to performance against the metric, highlighting that an area of concern for the Quality Committee was clinical audits due the lack of resource available to undertake this work.

The Chair reported that the BAF and IPR were integral now and it was great to see the triangulation through the Committees, which would be positive in supporting the CSUs with their journey

Resolved: (i) that, the content of the report be noted; and
(ii) that, the IPR be aligned to the UHT strategic priorities as part of the review for 2026/27.

South Tees Hospital NHS Trust Unitary Board

GB25/207 Audit & Risk Committee Chairs Log: 7 November 2025

Ken Readshaw, Non-Executive Director presented the Audit and Risk Committee Chairs Log for the meeting held on 7 November 2025, highlighting that a lot of the content had already been discussed in earlier agenda items.

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

GB25/208 Annual Members Meeting Minutes 11 September 2025

The minutes of the South Tees Hospitals NHS Foundation Trust (STHFT) Annual General Meeting held on, 11 September 2025 were accepted as a true and accurate record.

Resolved: that, the minutes of the STHFT Annual General Meeting held on, 11 September 2025 be confirmed as a true and accurate record.

North Tees and Hartlepool NHS Trust Unitary Board

GB25/209 Audit Committee Chairs Log: 7 November 2025

Alison Fellows, Non-Executive Director presented the Audit Committee Chairs Log from the meeting held on 7 November 2025 and highlighted the key points, noting that approval of the 2024/25 financial statements for the subsidiary organisations and filing with Companies House was now complete.

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

GB25/210 Annual General Meeting Minutes 11 September 2025

The minutes of the North Tees and Hartlepool NHS Foundation Trust (NTHFT) Annual General Meeting held on, 11 September 2025 were accepted as a true and accurate record.

Resolved: that, the minutes of the NTHFT Annual General Meeting held on, 11 September 2025 be confirmed as a true and accurate record.

GB25/211 Board Annual Declaration of Interests Register

Jackie White, Director of Corporate Affairs presented the Board Annual Declaration of Interests Register for 2025/26, highlighting the process to manage conflicts of interest in line with the Constitution and statutory requirements. The Board member register for 2025/26 once approved would be published on both trust's websites.

As part of the requirements set out in the Standards of Business Conduct Policy, the annual process would shortly commence to collect declarations of interest from all staff 8C and above and all finance and procurement staff above Band 6. A copy of the register for those staff was required to be published in a prominent place on the trust's websites once approved by Audit Committee. In addition, the annual process for the Council of Governors would shortly commence with the register being presented at the Council of Governors meeting on 19 February 2026 for approval.

Stacey Hunter, Chief Executive requested a less labour-intensive process be considered to undertake this process going forward. The Director of Corporate Affairs confirmed that a digital method to capture this information via ESR was being explored.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Board Annual Declaration of Interest Register 2025/26 be approved and published on each trust website.

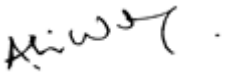
GB25/212 Any Other Business

Jackie White, Director of Corporate Affairs reported that the Council of Governors at the meeting on 18 December 2025 ratified the recommendation by the Nominations Committee to appoint Celia Weldon as Non-Executive Director with the required Finance/Audit qualifications, for which there had been a gap following the retirement of Chris Macklin. A start date would be agreed once all pre-employment checks were complete.

GB25/213 Date of Next Meeting

The next meeting of the Board of Directors will take place on Thursday 5 March 2026 in rooms 3 & 4, STRIVE, Friarage Hospital, Northallerton

Meeting closed: 2:10pm

Signed:  Date: 5 March 2026

Board of Directors 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	05 March 2026	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. It would be included on the board development schedule for 2026 linking in with the Clinical Services Strategy and SOC. The date would confirmed to board members.	
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. An update was provided at September meeting, SH requested item remain open until a review of the mid-year position after Month 5 had taken place. An updated position would be reported to board after month 5 and it was agreed to hold a development session regarding risk appetite / review those risks out of tolerance. It was also agreed at the Nov meeting to hold a board session to review the amber risk appetite scores in the Quality and Safety Domains of the BAF. Session to take place prior to 31 March 2026.	
06 November 2025	GB25/165	***General Medical Council (GMC) Survey 2025 Report*** An update regarding the GMC Survey Action Plan to be presented to the Academic Committee in March 2026	Mike Stewart	31 March 2026	Close	The results of the Annual GMC Survey were presented to the November Board meeting and it was agreed that the actions being developed should be presented to the Academic Committee as a formal update in March 2026. The item was on the agenda for the meeting on 19 March.	
08 January 2026	GB25/198	***UHT Strategy Deployment Update*** The Communications / Stakeholder Engagement Strategy in support of UHT Strategy delivery to be shared.	Ruth Dalton	02 April 2026	Open	Following discussion regarding the plan for future stakeholder engagement in relation to Strategy delivery with staff, member of the public, Governors etc. it was agreed to share the Comms Strategy.	
08 January 2026	GB25/206	***Integrated Performance Report*** Consider aligning the IPR to the UHT strategic objectives rather than the CCQ domains for 2026/27	Neil Atkinson Stuart Irvine	02 April 2026	Open	Following discussion it was agreed to consider aligning both the BAF and IPR to the UHT strategic objectives as part of the refresh exercise in advance of 2026/27.	

University Hospitals Tees

Chairman's Report

Meeting date: Thursday, 5 March 2026

Reporting to: Board of Directors

Agenda item No: 1.7

Report author: Jackie White, Company Secretary

Executive director sponsor: Derek Bell, Chairman

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

Add in BAF reference.

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 Chairs meetings

I attended the NENC Chairs meeting on 12 January and we received updates on the Provider Collaborative, the Advanced Foundation Trust Programme Progress & Future of Governors plus England Regional Chair Role. There was a broad discussion regarding the need for greater collaboration across the North East.

I also took the opportunity to meet the interim Chair of County Durham and Darlington NHS Foundation Trust to be updated on their plans and discuss opportunities to improve patient pathways between our organisations.

I accompanied the Mayor of Hartlepool on 4 March 2026 on a visit to University Hospital Hartlepool when visited the short stay surgical ward and chemotherapy unit.

3.2 Governors

We held our Governor induction event for new governors joining us on 14 January 2026. It was great to welcome new members to the Council and thanks to colleagues who attended and presented. New governors also had the opportunity to have a guided tour of University Hospital North Tees site following induction and James Cook University Hospital at our meeting on 19 February 2026.

I would also like to take the opportunity to put on record my thanks to Angela Warnes, who has stepped down as Out of Area Governor and Lead Governor for North Tees & Hartlepool COG. Angela was instrumental with Janet Crampton who recently completed her term of office from the COG in South Tees as Lead Governor in supporting both Trusts becoming University Hospitals Tees and for bringing COGs together under our collaborative working model.

3.3 Volunteers

Volunteers are a vital part of the services we provide for patients and staff across UHT We have established a Volunteers committee to further support and recognise this increasingly important group of dedicated individuals.

I wish to congratulate Paul Wharton Head of Volunteers on becoming the Chair of National Volunteers for the next 3 years

3.4 Board development / seminar and task and finish group for Planning

There has been lots of Board activities over the last couple of months in order to sign off the annual plan and Board assurance statements this coming year. The Board established a small task and finish group made up of the Chairs of Committees, Vice Chair, and myself along with the Chief Executive, Chief Nurse, Chief Medical Officer, Chief Delivery Officer and Chief Finance Officer. This group meet weekly and the outputs are shared with the full Board after each meeting. In addition, the Board held a Board seminar on 4 December and 5 February to consider the submission of the plan and had a good debate and challenge of the submission.

3.5 Board Capability Assessment

Stacey Hunter, CEO will cover in more detail in her report to the Board that an assessment the Board undertook last year on Assessing Provider Capability aimed at the capabilities and experience of the Board. We have received notification that both Trusts achieved an overall amber–green capability rating, reflecting strong governance foundations and increasing board maturity, while also recognising areas where further development is required.

3.6 Recruitment of Chief Delivery Officer

I was pleased to participate in the recruitment process for our new Chief Delivery Officer on 18 February 2026. Russell Nightingale was appointed who has extensive operational and senior level experience across the NHS. The Board look forward to welcoming him too UHT.

3.7 New artwork from acclaimed artist pays tribute to baby Angelo

I was extremely honoured to be invited to attend the unveiling of a new commissioned artwork by acclaimed artist Macken February 2026 which had been specially commissioned by a family from Teesside to support parents experiencing the loss of a baby following the passing of their own son Angelo.

Parents Alice and Michael Miles who live in Nunthorpe in Middlesbrough, alongside Angelo's grandparents and sister Elle Smith, who is a midwife at the organisation, were at the unveiling which saw the new commissioned artwork officially unveiled by internationally acclaimed artist Mackenzie Thorpe.

Derek Bell
Chairman

University Hospitals Tees

Chief Executive Officer Report

Meeting date: 5 March 2026

Reporting to: UHT Board

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.

The Board are asked to note the ongoing work in relation to the 3-year plans including the request for a resubmission at the beginning of March. Board members are aware via their continued input and oversight of the details and will have signed off this iteration in an extraordinary Board meeting planned for the 27th February 2026.

Board colleagues will be aware that there is issue with the supply of bone cement from of suppliers (Heraeus Medical) who have had to temporarily halt production at its main site. At this stage it is estimated that this could affect supply for 2 months. This company supply circa 75% of the bone cement demand in the NHS which is used knee replacements and, in some hip, and shoulder replacements. We are managing this internally aligned with our EPRR framework and linking into the regional and national discussions as required. This is creating some challenges with specific elective patient appointments which we recognise is disappointing for those patients who surgery is needing to be rearranged. Our teams are working to ensure that alternative activity is taking place.

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.

Board will have the opportunity to review our performance against the 25/26 plan via the IPR and exception reports from Board committees.

South Tees have progressed from Tier 1 for RTT to Tier 2 which is positive. There needs to be continued focus to sustain progress over the coming weeks.

The BMA resident doctor committee reported.

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

Nothing additional to the Board committee reports.

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 8 January 2026.

2. National Priorities

2.1. Planning 2026/27

On 12 February, UHT made our annual planning submissions to NHS England. The Medium-Term Planning Framework (published September 2025) set out a new approach to planning, led by NHSE England regional teams and taking a longer-term approach to planning the annual cycle we have worked with previously, enabling trusts and systems to demonstrate how they are working towards the 10 Year Health Plan aims, financial sustainability and return to constitutional standards for performance, over a 3 year to year time frame. As Board members are aware our submissions comprised:

- 3-year activity and performance trajectories - setting out our expectations of productivity improvements of at least 2% across all points of delivery and returning performance to planning guidance expectations and constitutional standards wherever feasible.
- 3-year workforce plans – setting out our trajectory to reduce WTE, bank and agency usage, and reduce sickness absence, to sustainably affordable levels
- 3 and 4-year finance and capital plans - confirming maintenance of a balanced financial position for NTHFT throughout, and reducing the deficit of STHFT to zero by year 3, underpinned by our cost improvement programme of c. 5.5% per year across UHT
- 5-year integrated delivery plan – providing an overview narrative of how we will deliver these plans in the context of our strategy Caring Better Together, through productivity gains and service reform, taking the opportunities presented by horizontal integration and service consolidation, and the left shift to community and neighbourhood health.
- Board assurance statements and triangulation tool – confirming how the Board have been involved in developing, and challenging, our plans, and that our finance, activity and workforce plans align.

Whilst we are required to make separate submissions per trust, our plans are devised, triangulated and will be delivered as UHT. Plans were worked up with operational engagement across all our CSUs, and under the guidance of the Board planning task and finish group, and signed off by the Board on 5 February.

As Board are aware following this submission in February, we have been asked to review whether there is any further opportunity to improve compliance against specific areas in the plan. At the time of writing this Board report that review is ongoing and will be presented to an extraordinary Board meeting on the 27 February as it has to be submitted on the 2 March.

We will be continuing to work through feedback from NHSE, and with ICB commissioners, on a timetable to contract sign-off by end March 2026. Delivery of our plans is not without its significant risks and challenges and the ongoing engagement and leadership of the Board will be critical as we work with our operational teams to deliver the ask.

2.2. Return To Constitutional Standards (RTCS) Capital bids (Funding - FY26/27, 27/28 and 28/29)

Both Trusts have bid for RTCS capital funding in the following 3 categories (UEC, Diagnostics and Community). Bids were put together collaboratively with supportive narratives from CSUs to bid for our priority projects.

The bids prioritised for submission included:

- Discharge lounge (NTees)
- A&E waiting area and flow improvements (NTees)
- CYPED corridor (STees)
- Resus expansion (STees)
- E- Triage (NTees and STees)
- Admission ward upgrade (STees)
- Critical Care (NTees)

We are told that all bids should be declined or approved by the end of February. Our Estates Director will provide a verbal update to the Board when we meet in March.

3. Regional Update

3.1. NENC Provider Collaborative Leadership Board (PLB)

The PLB received an update on the proposed operating model and resourcing approach for 2026/27. The model reflects the evolving role of the ICB, the System Recovery Board and NHSE. There was a strong emphasis on ensuring that the system focuses its collective effort on areas where NENC scale provides significant opportunities. The PLB endorsed the proposals within the paper, including changes to programmes reporting to the SRB, the proposed organisational structure and resourcing levels. The Managing Director will continue work to secure funding for a small number of posts where confirmation is still outstanding.

The PLB then considered an update on the Secure Data Environment. NECS will no longer be able to provide SDE services beyond April 2026, reinforcing the need for a sustainable shared approach across the system. The Board reaffirmed the importance of supporting shared digital systems and noted that the newly established Digital Board would play a key role in enabling collective digital decision-making. Members supported progressing towards a hosted SDE model with organisations that have the necessary infrastructure, starting with Northumbria, subject to due diligence and a review of the cost and value case.

Recommendations relating to outpatient follow-up, previously supported at the Planned Care Board, were presented and endorsed. These cover clinical validation, clinic templates and use of GIRFT specialty guidance. It was recognised that further and more

detailed engagement with primary care will be essential to achieving the intended impact.

An update from the inaugural Digital Board meeting on 3 February 2026 was considered. The meeting was positive and has helped establish the future direction for the Provider Collaborative's digital work. Agreement was reached to award the Digital Pathology PACS contract, subject to revised pricing remaining within the capital allocation, though concerns were noted regarding potential additional storage costs. The Board approved the funding required to support the first 12 months of digital pathology and radiology global worklists and provided direction for the ongoing development of the visible PTL organisation responsible for ensuring alignment with its own internal plans.

3.2. Regional/ICB planning

The majority of the focus over this last period has been on aligning details across the 3-year plans in respect of allocations, activities and performance standards.

There is ongoing work in respect of delivery of 25-26 plans with our teams providing regular updates on RTT and cancer performance both of which are subject to tiering.

In addition to this South Tees has taken opportunity through the elective sprint to improve the RTT position by the end of March. This is an ambitious plan which has faced some constraints in respect of key personnel who have had to take unplanned time off work. At the time of writing this report the team are working to mitigate this as far as feasible via a range of different routes. The detail of this is being reported to myself and the Chief Delivery Officer on a weekly basis.

4. Local update

4.1. Quality Performance Reviews

Following the introduction of Clinical Service Units (CSUs) in November 2025, monthly Quality and Performance Reviews were established from December 2025. These reviews provide formal oversight of each CSU across six key domains: Quality and Safety, People, Performance, Productivity and Efficiency, Finance and Cost Improvement, and Strategy and Service Development.

Two cycles of Quality and Performance Review meetings have now taken place. The focus of these discussions has been to ensure the continued delivery of safe and effective care for our population, to support CSUs in developing plans that will underpin delivery of the 2026/27 operational plan, and to confirm longer-term strategic plans for the next five years. The executives leading performance reviews are taking feedback to ensure that we maximise the opportunities this key part of our oversight framework provides.

4.2. Maternity Oversight North Tees and Hartlepool NHS Foundation Trust

In January 2026, NHS England confirmed that North Tees and Hartlepool NHS Foundation Trust had met all required exit criteria, bringing the Maternity Oversight Programme to a formal close. Responsibility for ongoing oversight and assurance has now returned to the Trust Board. This is a significant milestone with thanks and appreciation to our colleagues in Maternity services for delivering this.

The way the national team are working has changed and therefore for South Tees who had relatively recently joined the national programme we are working with the national team to be clear about the changes. It is likely that we will seek to deliver the improvements already agreed and discussed at previous Boards over this next 6 months. This progress at an Executive level will be overseen by the CEO, CMO and CNO which is a specific requirement as part of the changes.

Both trusts have had a recent review from NENC LMNS. This was two full days and our Maternity Champions (NEDs) and the CNO attended both. They will ensure anything material is shared with the quality committee and Board.

4.3. Continuous Improvement Operating Model

Work is progressing on the development of the UHT-wide Continuous Improvement (CI) operating model. This programme is designed to strengthen our organisational delivery capability by embedding a single, cohesive framework that aligns strategic transformation, operational improvement and continuous quality improvement across UHT.

The first phase of this work involves a comprehensive readiness assessment. The central team leading the programme is carrying out one-to-one interviews, document reviews, direct observation, focus groups and a staff survey to understand our current position in relation to delivering the UHT strategy. This assessment will provide a baseline view of our strengths, opportunities and level of preparedness for adopting a unified improvement approach.

The outputs from this initial phase will be shared with Executive Team and Board members over the next two months and will form the basis for developing our organisation-wide improvement roadmap.

As Board have agreed this work is fundamental in supporting delivering of the priorities within our 3-year plan. The plan is ambitious and we need to ensure that we are supporting our leaders, managers and front-line teams to contribute effectively.

4.4. Board Capability Assessment

In line with NHS England's Assessing Provider Capability guidance, both Trusts have completed their annual self-assessment against the six domains set out in the Insightful Provider Board framework—covering strategy, leadership and planning, quality of care, people and culture, access and delivery of services, productivity and value for money, and financial performance and oversight. Both Trusts achieved an overall amber–green capability rating, reflecting strong governance foundations and increasing board maturity, while also recognising areas where further development is required. This outcome aligns with NHS England's intended use of the assessment as a tool to strengthen board assurance, promote transparency, and support a 'no surprises' culture between providers and regional oversight teams. Regional teams will use our submissions, triangulated with external evidence, to refine their assessment of organisational capability throughout the year. A consolidated improvement plan is now being developed to address the highlighted development areas and ensure continued progress across both Trusts

4.5. External support for our strategy through Clinical Senate review and NHS England

The Board agreed the University Hospitals Tees Strategy in May 2025. Where the clinical changes proposed within the strategy affect significant numbers of people, we are required to follow a statutory change process with the Integrated Care Board (ICB) and NHS England, which includes defined gateways and checkpoints. My previous report confirmed our progress through the NENC ICB's Strategic Change Advisory Group.

Since then, we have advanced to Stage 1 review by the North East and Yorkshire Region's Clinical Senate. The Clinical Senate provides an independent clinical assessment of our case for change, considering whether the proposals align with clinical evidence, best practice guidance, and national and regional strategic direction. The review panel unanimously concluded that our proposals are compliant with clinical evidence and best practice and offered helpful, detailed advice on several services. They further agreed that the proposals align with both national and regional direction of travel and provide a strong foundation for developing clinically beneficial, sustainable services that improve staffing resilience. The panel also emphasised that continuing this work is important for the health of the population we serve.

We have also presented our Case for Change to the NHS England regional team on 12 February and await formal feedback.

4.6. Cancer and RTT for the Performance Against Plan

Both NTHFT and STHFT remain in Tier 2 regional support for cancer performance. At STHFT, 62 day performance of 69.4% in December, brought 62 day performance across Q3 to 68.5%, above the Tier 2 threshold of 67.5% and ahead of our agreed plan of 68% by end March 2026. Cancer tiering status will be next reviewed in May 2026. Whilst we have further to go to improve performance in line with constitutional standards, this progress is positive and Cancer Improvement Plans across both Trusts are being updated with the support of our newly appointed Group Clinical Lead and Deputy Clinical Leads for Cancer and in line with the National Cancer Plan.

For elective RTT performance, STHFT has now been de-escalated from Tier 1 national monitoring to Tier 2 regional support, recognising the progress that has been made recently regarding patients waiting beyond 52 and 65 weeks over recent weeks. Various elective sprints are underway to deliver additional elective activity across Q4, in line with national and regional initiatives, to target some of the longest waiters. Both cancer and RTT continue to be monitored through Group oversight meetings.

4.6 Recruitment of Chief Delivery Officer

University Hospitals Tees has secured the appointment of Russell Nightingale as our new Chief Delivery Officer. This is an excellent addition to our senior leadership team and will further strengthen the ambitions of UHT, ensuring we maximise the combined strengths of North Tees and Hartlepool and South Tees Hospitals.

Russell joins us from Harrogate and District NHS Foundation Trust, where he is currently

Deputy Chief Executive and Chief Operating Officer. Since joining the organisation in 2021, he has held responsibility for operational delivery across a wide range of specialties and has been instrumental in moving several services from inadequate or requires improvement ratings to good with the Care Quality Commission.

In addition to his operational portfolio, Russell has served as Senior Responsible Officer for elective recovery across the West Yorkshire Association of Acute Trusts and has more recently led the Humber and North Yorkshire elective recovery programme.

Throughout the interview process and stakeholder panel discussions, there was unanimous agreement regarding Russell's dedication to supporting the vision of University Hospitals Tees. The level of due diligence he undertook ahead of the interview demonstrated a clear commitment to meaningful transformation and to improving outcomes for the communities we serve.

We are confident that Russell's leadership will help drive our ambitions for collaborative, transformative, high-quality patient care, underpinned by what he describes as "radical candour." We look forward to welcoming him to UHT and will share further details of his start date in due course. I am certain colleagues will join us in making him welcome and in sharing our journey so far.

As Board colleagues know this has enabled us to refocus Neil Atkinson to provide additional capacity and capability in respect of our financial recovery over the coming years.

5. In Other news!

5.1. ExcelsiusGPS Robotic-assisted System

James Cook became the first hospital to unveil the ExcelsiusGPS robotic-assisted system for patients awaiting spinal surgery – this will help provide enhanced accuracy and safety whilst lowering infection risks, speeding up operation times, and reducing blood loss.

5.2. Prostate Cancer Patients

Patients at James Cook are among the first to trial an experimental injection for advanced prostate cancer that no longer responds to hormone therapy. Along with patients at St Bartholomew's Hospital in London, patients at the James Cook Cancer Institute are among the first in the UK to receive the medicine, called Lutetium (177Lu) rhPSMA-10.1 Injection. It is a type of radioactive treatment intended to find and attack prostate cancer cells.

5.3. Surgical Replacement Unit UHH

Councillor Carole Thompson, the ceremonial mayor of Hartlepool, and her consort councillor Phil Holbrook, took a tour of the surgical replacement unit at the University Hospital of Hartlepool recently – hearing from patients about their experience being cared for in the unit. The unit forms part of the hospital's nationally accredited surgical hub, treating patients having orthopaedic operations including hip and knee replacements as well as gynaecology, surgical and breast procedures.

5.4. National Heart Month

As part of National Heart Month, a patient of our award winning cardiac remote monitoring service shared her experience being cared for by the team. Since being set up across North Tees and Hartlepool in 2023, the service has helped around 250 heart failure patients.

5.5. Palliative Care

Congratulations to Donna Wakefield, palliative care consultant at the University Hospital of North Tees, who won a competition to have her personal story published in the prestigious The Lancet journal – a really significant achievement.

5.6. Sir Robert Ogden Centre FHN

Patients receiving anti-cancer therapies like chemotherapy and immunotherapy at the Sir Robert Ogden Macmillan Centre at the Friarage Hospital have been praising the service – as the service passes eight years since it first opened.

5.7. Integrated Occupational Therapy Service – 20th Anniversary Celebration

We were delighted to welcome Paralympic athlete Baroness Tanni Grey-Thompson to The James Cook University Hospital as part of the 20th anniversary celebrations for the South Tees Integrated Occupational Therapy Service (IOTS).

For two decades, South Tees Hospitals, Middlesbrough Council, and Redcar and Cleveland Council have worked in partnership to deliver a seamless, integrated occupational therapy service for local communities—supporting people of all ages to overcome challenges in daily living and maintain independence.

During her visit, Baroness Grey-Thompson met with occupational therapy leads who showcased examples of outstanding integrated care across areas including falls and frailty, postural management, children and young people's services, and palliative care. She also shared insights from her own lived experiences and presented a commemorative plaque marking 20 years of IOTS, accepted on behalf of the service by Christina Hartley, Head of Occupational Therapy.

6. Conclusion

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

University Hospitals Tees

Chair's Log of UHT Management Team Assurance Meeting – 22 January 2026

Meeting date: 5 March 2026

Reporting to: UHT Board

Agenda item No: 1.9

Report author: Abi Smith, Executive Assistant / Stacey Hunter, Chief Executive

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:

Select:

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.

Nothing to alert.

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

Strategic & Organisational Risks

PFI Exit – James Cook Site

- Work commencing April with a *significant and complex* seven-year exit period.
- Board will need to consider resourcing the capacity needed to manage this effectively
- **Risk:** Potential *financial exposure* and *service disruption* without full understanding of impacts (ongoing modelling required).

Strategic Outline Case – North Tees Estate

- Year 1–5 SOC progressing; Board has requested full development of the single-site option. Whilst there is support for this the return on investment that would be required is likely to be a significant constrain.
- Director of Estates with support from the Board is progressing the SOC and will detail the next steps which will be to work on the Outline Business Case.
- **Risk:** Substantial financial requirement and capacity pressures to maintain pace.

Annual Planning & Workforce

- Region seeking further assurance on delivery of financial commitments.
- Workforce has grown by ~2,500 WTE since 2020, with ~900 WTE not clearly linked to quality needs or business-case expansion and will need to be managed over the coming 3 years.
- **Risk:** Requirement to *significantly reduce WTEs* may affect operational delivery and service change programmes.

Quality, Safety & Clinical Risks

Complaints Handling

- Current practice **non-compliant** with internal standards.
- Significant backlog to be cleared by end of March.
- Chief Nurse is in the process of reviewing the processes end to end and will reorganise the resources to enable more effective delivery of this and broader patient experience matters.
- **Risk:** Patient and family experience, regulatory perception and reputational harm if delays persist.

Private Patient Policy

- Outdated policy and inconsistent compliance with indemnity and secondary employment requirements.
- **Risk:** Legal, regulatory and financial exposure due to insufficient assurance.

Operational Risks & Pressures

Breast Services Workforce

- One consultant has left; another retiring in March.
- Regional future model unresolved; This needs to come to a decision with the support of the Cancer Alliance.
- **Risk:** Capacity constraints impacting cancer performance; risk of fragmented regional model.

Urology Referral Issues

- Patients waiting >6 months dropping off lists due to lack of single point of access (Darlington).
- Task & Finish group active to look at the underlying issues and work together to resolve.
- **Risk:** Patient safety, RTT performance and regulatory scrutiny.

Minor Operations Hubs & GIRFT

- Utilisation has fallen below the **81% target**; urgent review requested.
- **Risk:** Efficiency loss, GIRFT escalation, and deterioration in elective recovery performance.

IT Infrastructure (ICE / LIMS)

- ICE upgrade delays affecting LIMS programme and introducing clinical and cyber security risks.
- **Risk:** Diagnostic turnaround, pathology resilience, and cyber vulnerability.

Evolve Migration

- All open drafts must be closed by end of February to deliver £250k CIP.
- **Risk:** Delay could impact savings and system transition.

Risk Management

- 60% of operational risks review dates are overdue
- InPhase transition delayed to March.
- **Risk:** Limited assurance that risks are being managed optimally

Estates & Capital

Capital Funding

- £15.5m capital + £2.29m for medical equipment must be spent by end of March.
- **Risk:** Delivery and procurement timescales may be unachievable, risking loss of capital or suboptimal spend.

MSA Contract Performance

- 82% KPIs compliant; red risks include:
    - Carbon reduction
    - Unwanted fire alarms
    - Procurement savings
- **Risk:** Compliance and safety implications from ageing estate and environmental requirements.

People & Culture

Leadership Gap

- Departure of Sam Peate (CDO), recruitment for replacement underway.
- **Risk:** Short-term continuity and leadership capacity pressures during major service change and operational challenge. Plans in place to mitigate this.

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

Notable Assurances

- QPR escalation meetings bedding in; work ongoing to improve data quality.
- Policies under review with aim to rationalise and improve consistency ahead of the Well-Led review.
- Clinical Ethics Advisory Group being established.
- Stronger CSU engagement with risk management processes improving overall governance.

Recommendations:

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

University Hospitals Tees

Chair's Log of UHT Management Team Assurance Meeting – 19 February 2026

Meeting date: 5 March 2026

Reporting to: UHT Board

Agenda item No: 1.9

Report author: Abi Smith, Executive Assistant to CEO / Stacey Hunter, CEO

Executive director sponsor: Stacey Hunter, CEO. To note this meeting was chaired by Neil Atkinson.

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:

Select:

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.

Performance & Operational Delivery

RTT position & sprints: South Tees remains below the 65% 18-week standard; Q4 sprint performance is 62% putting the target of 66.1% at material risk. There have been considerable challenges in relation to unexpected sickness contributing to this risk. The team are re-evaluating options to mitigate this which will be monitored and supported by the Executives. This includes funded extra outpatient sessions, extending clinics, converting appropriate appointments, further validation, and additional insourcing to improve the year-end position.

Waiting list risks: Electrophysiology (EP) routine ablations at risk of breaching 65 weeks without immediate capacity; preferred mitigation is continuing weekend insourcing (22 lists; ~£220k) while pursuing medium-term workforce solutions. It is imperative that the team ensure that they are doing a wholesale review of the demand and capacity in the Cardiac Catheter Labs, the workforce and meeting the productivity and efficiency requirements. This will be overseen via performance reviews with this CSU.

Our plan to reduce patients waiting over 65 weeks to zero by the end of February has also been impacted by the unforeseen sickness. This should resolve by the end of March and we have reported this via the tiering meeting.

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.

Strategy & Planning

Strategic Outline Case (SOC): All estate options reviewed, including single-site at comparable depth; single-site ranks third overall given capital and revenue impacts. Updated SOC to Board in April for approval to proceed.

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

Quality, Safety & Assurance

QPR cadence: Second cycle completed; meetings to remain monthly until data assurance improves. SI to return with proposals on frequency once real-time data confidence is stronger.

MSA contract performance: 70/88 KPIs green; four red (carbon reduction, electrical demand, H&S inspections, unwanted fire alarms). Action plan due March; water safety assurance commencing via Water Safety Group; fit-testing action plan due 25 Feb; HCID isolation room works complete by 31

Mar; external ventilation verification to be in place by 30 Apr.

People Directorate

Sickness management & tribunals: Region-wide rise in ETs linked to revised sickness processes; approach remains appropriate.

Voluntary severance: Scheme to reopen for clinical and non-clinical staff (on a case-by-case basis).

LLP/Unison: Agreement to move NTH Solutions staff onto Agenda for Change T&Cs.

Digital & Estates

Single LIMS programme: Go-lives targeted dates; CDDFT July; North Tees September—with ICE upgrades (North Tees installing version 8 in April; and South Tees installation parallel to LIMS in September). Significant testing impact for Tees Valley Pathology; aim to complete before winter.
Outpatients' digitisation: Low kiosk utilisation being addressed; wider OP transformation and standardisation planned next year.

Business Cases

Neuroradiology Assessment Bay (JCUH): Convert under-used space to 2-bed assessment bay supporting 24/7 thrombectomy growth; est. £325k capital + ~£35k equipment and ~£154k recurrent workforce. staffing model review ongoing; potential alignment with 26/27 capital opportunities. The Executive Team agreed for the team to move forward with this but stressed that the revenue impact had to neutral.

Robotic Assisted Bronchoscopy (North Tees): Strong pilot outcomes (diagnostic accuracy 98.8%); Northern Cancer Alliance will support with £375k in 26/27 for up to 90 lists; lease already capitalised. Board-level risks remain around longer-term commissioning; theatre capacity modelling and commissioning case in train. The group agreed to support continuation of the lease for the next 12 months, with a view to providing further updates as the service develops.

Electrophysiology capacity: The Executive Team endorsed non-recurrent insourcing for 12 months with RTT/QPR monitoring, while progressing substantive CRM recruitment.

Risk & Governance

Risk profile and systems: South Tees digital risk downgraded to amber; 71% of risks overdue—owners asked to review. In Phase roll-out underway; Datix migration in progress; ST teams to receive training; many overdue actions remain at South Tees.

Recommendations:

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

University Hospitals Tees

Board Assurance Framework Report 2025/26 (reporting to 31st December 2025) NTHFT/STHFT

Meeting date: Thursday 5th March 2026

Reporting to: UHT Board

Agenda item No: 1.10

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: 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 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.

Headlines

NTHFT

- There are 30 strategic risks identified relating to North Tees & Hartlepool NHS Foundation Trust.
- 9 strategic risks are outside of approved risk appetite, of which there are 6 red/high strategic risks outside of approved risk appetite.
- Mitigating actions are in place to address all strategic risks.
- There are 95 planned mitigating actions within the BAF across the 8 domains.
- There are 9 reported completed actions (1 Digital, 8 Trust Estate).
- There are 6 timescale extension requests (1 Q&S, 1 P&C, 3 Digital, 1 Trust Estate).
- Planned action timescale range – November 2025 – April 2035 (includes eradicating RAAC by 2035).

STHFT

- There are 31 strategic risks identified relating to South Tees Hospitals NHS Foundation Trust.
- 11 strategic risks are outside of approved risk appetite, of which there are 7 red/high strategic risks outside of approved risk appetite (Digital as reduced from red to amber – DSPT).
- Mitigating actions are in place to address all strategic risks.
- There are 96 planned mitigating actions within the BAF across the 8 domains.
- There are two completed actions 2 actions reported as completed (1 Digital, 1 People).
- There are 3 timescale extension requests 3 action timescale extension requests (2 P&C, 1 People).
- Planned action timescale range is October 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.

BAF Reporting 2026/27

As part of the continuous review of BAF reporting, with effect from 1st April 2026, the BAF will be reported against the 6 strategic objectives of University Hospitals Tees (and each unitary Trust). Work has commenced to complete this transition.

Risk Management Policy

A single University Hospitals Tees Risk Management Policy is now in place and was approved in June 2025. Following the formation of the CSUs from 1st November 2025, the policy will need to be updated to reflect new naming conventions and reporting processes. The policy will also need to make reference to the revised BAF reporting arrangements. This will be completed by 31st March 2026.

Risk Appetite

A Board Development Session is planned to review and approve the risk appetite for 2026/27, in advance of the annual refresh of the Board Assurance Framework. The refresh exercise will further strengthen the standardisation and consistency that has been achieved during 2025/26 with the aim to transitioning towards reporting a single Board Assurance Framework, which is reflective of each 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.

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

The internal audit on Board Assurance Framework and Risk Management processes has commenced and this should be concluded in March 2026. The assurance level and findings will be reported in due course.

Recommendations:

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 31st December 2025.
- Note the 6 red/high strategic risks for NTHFT and 7 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 31st December 2025)

NTHFT – Key Headlines	STHFT – Key Headlines
• 30 identified strategic risks. • 6 red/high strategic risks are outside of approved risk appetite (no change). • One step from approved risk appetite. • 95 planned mitigating actions. • 9 reported completed actions (1 Digital, 8 Trust Estate). • No changes to current risk scores. • 6 action timescale extension requests (1 Q&S, 1 P&C, 3 Digital, 1 Trust Estate). • No new mitigating actions. • Planned action timescale range – November 2025 – April 2035.	• 31 identified strategic risks. • 7 red/high strategic risks are outside of approved risk appetite (Digital as reduced from red to amber – DSPT). • One step from approved risk appetite. • 96 planned mitigating actions. • 2 actions reported as completed (1 Digital, 1 People). • No changes to current risk scores. • 3 action timescale extension requests (2 P&C, 1 People). • No new mitigating actions. • Planned action timescale range – November 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.

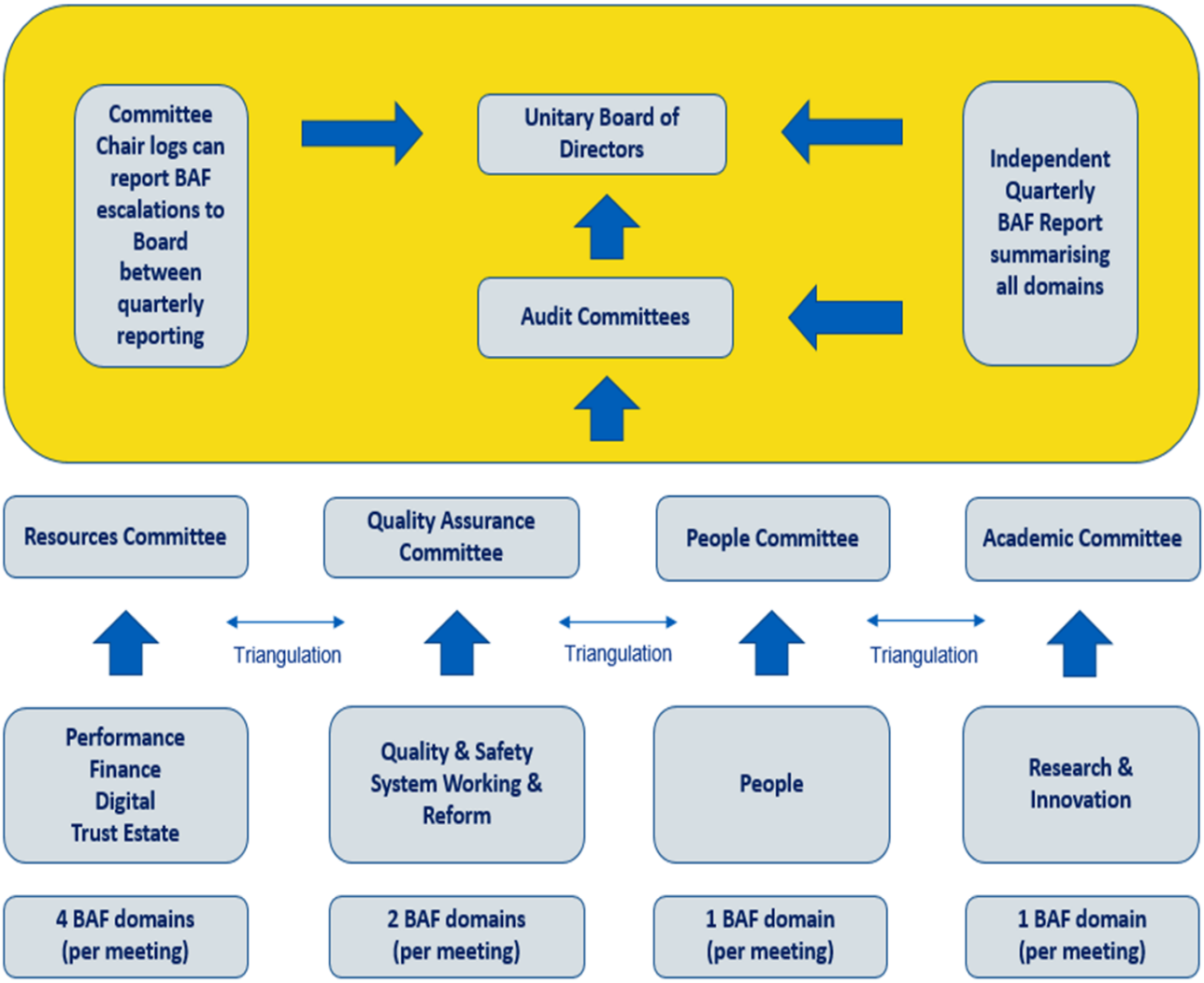
There are 8 BAF domains for each Trust. The BAF domains are informed by national best practice (Good Governance Institute) and benchmarking with regional and national NHS Foundation Trusts.

BAF Domains

The 8 BAF domains for each Trust are Director-led, 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	Chief Nursing Officer	Deputy Director of Patient Safety/Deputy Director of Quality	Quality Assurance Committee
Performance & Compliance	Chief Delivery Officer	Director of Planning & Intelligence / Associate Director of Planning & Performance	Resources Committee
People	Chief People Officer	Deputy Director of People Services/ People Risk & Compliance Manager	People Committee
System Working & Reform	Chief Strategy Officer	Associate Director of Group Development	Quality Assurance Committee
Finance	Chief Finance Officer	Deputy Chief Finance Officer/ Deputy Director of Finance	Resources Committee
Digital	Chief Information Officer	Interim Head of IT/ Deputy Chief Information Officer	Resources Committee
Trust Estate	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
Performance & Compliance	Open	Open	8-12
People	Open	Open	8-12
Digital	Open	Open	8-12
Finance	Open	Open	8-12

Risk domain	NTHFT Risk appetite level	STHFT Risk appetite level	Current Risk Score Range
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	8
Performance & Compliance	3	4	0	**2**	0	1	8	8
Digital	4	4	0	**1**	0	1	16	8
People	4	4	0	0	0	0	16	15
Finance	4	4	**1**	**1**	1	1	5	5
Trust Estate	5	5	**3**	**2**	1	1	6	16
System Working & Reform	2	2	0	0	0	0	22	22
Research & Innovation	5	5	**2**	**2**	1	1	13	14
Total Number	**30**	**31**	**9**	**11**			**95**	**96**

NTHFT	STHFT
• The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 9 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 November 2025 – April 2035.	• The Trust has 31 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 November 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 Trust has 30 identified strategic risks linked to Board Assurance Framework domains. The table below identifies that there are 6 strategic risks that are red/high and are outside of approved risk appetite, which is static from the previous reporting period. 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**	2	Resources Committee
Insufficient capital funding to maintain Trust estate.	Trust Estate	**5 x 4 = 20**	1	Resources Committee
Reduction of system capacity if the Trust is unable to provide services.	Trust Estate	**5 x 3 = 15**	1	Resources Committee
Innovation growth is limited by investment and resource constraints.	Research & Innovation	**5 x 3 = 15**	3	Academic Committee

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
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	2	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 31 identified strategic risks linked to Board Assurance Framework domains. The table below identifies that there are 7 strategic risks that are red/high and are outside of approved risk appetite, which has reduced from 8 since the last report (digital). 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	3	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
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	1	Resources Committee

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
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/UHT Risk Management Group

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 the newly formed UHT Risk Management Group, which replaces two separate meetings.

BAF Reporting 2026/27

As part of the continuous review of BAF reporting, with effect from 1st April 2026, the BAF will be reported against the 6 strategic objectives of University Hospitals Tees (and each unitary Trust). Work has commenced to complete this transition.

Risk Management Policy

A single University Hospitals Tees Risk Management Policy is now in place and was approved in June 2025. Following the formation of the CSUs from 1st November 2025, the policy will need to be updated to reflect new naming conventions and reporting processes. The policy will also need to make reference to the revised BAF reporting arrangements. This will be completed by 31st March 2026.

External Assurance

The internal audit on Board Assurance Framework and Risk Management processes has commenced and this should be concluded in February 2026. The assurance level and findings will be reported in due course.

Risk Appetite

A Board Development Session is planned for March 2026 to review and approve the risk appetite for 2026/27, in advance of the annual refresh of the Board Assurance Framework. The refresh exercise will further strengthen the standardisation and consistency that has been achieved during 2025/26 with the aim to transitioning towards reporting a single Board Assurance Framework, which is reflective of each Trust.

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 Escalation Reports.
- 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.
- The reported position of 30 strategic risks relating to NTHFT and there are 6 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- The reported position of 31 strategic risks relating to STHFT 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.
- Report of the BAF 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

UHT 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 31st December 2025.
- Note the 6 red/high strategic risks for NTHFT and 7 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

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

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)

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
- Not having a Health and Wellbeing offer that positively supports organisational efficiency and our colleagues ability to deliver quality patient care
- Workforce planning and people practices don't support the Trust to deliver its services

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

Performance and 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

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 if the Trust is unable to provide services
- Non-compliance with legal and regulatory standards of the Trust's estate

Research & Innovation

- Lack of integration of research with digital infrastructures prevents the delivery of effective research
- Growth 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

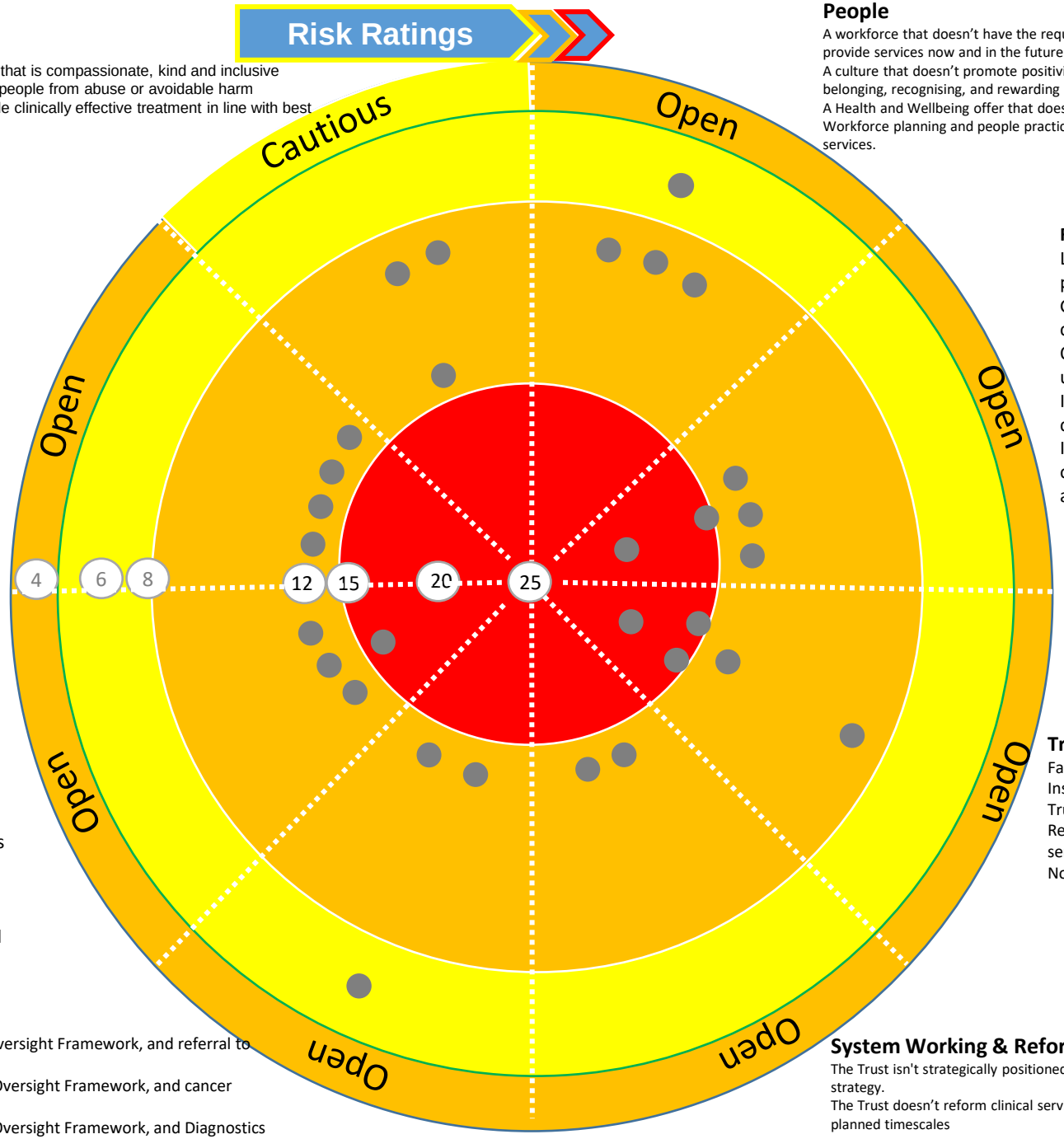
Strategic Risks

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

31st December 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

Quality & Safety

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

Digital

- Failure to adequately maintain and upgrade current hardware and software systems and implement planned digital programmes and infrastructure projects through lack of adequate funding
- Failure to prevent a cyber-attack or data breach
- Failure to protect information / data we hold as a result of non-compliance with legislation and / or non-compliance with Trust policy
- Conflicting demands of maintaining BAU and supporting new programmes within Digital teams poses a risk to the timely and effective delivery of the digital strategy

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
- Not having a Health and Wellbeing offer that positively supports organisational efficiency and our colleague's ability to delivery quality patient care
- Workforce planning and people practices don't support the Trust to deliver its services

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

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

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 if the Trust is unable to provide services
- Non-compliance with legal and regulatory standards of the Trust's estate

Research & Innovation

- Lack of integration of research with digital infrastructures prevents the delivery of effective research
- Growth 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

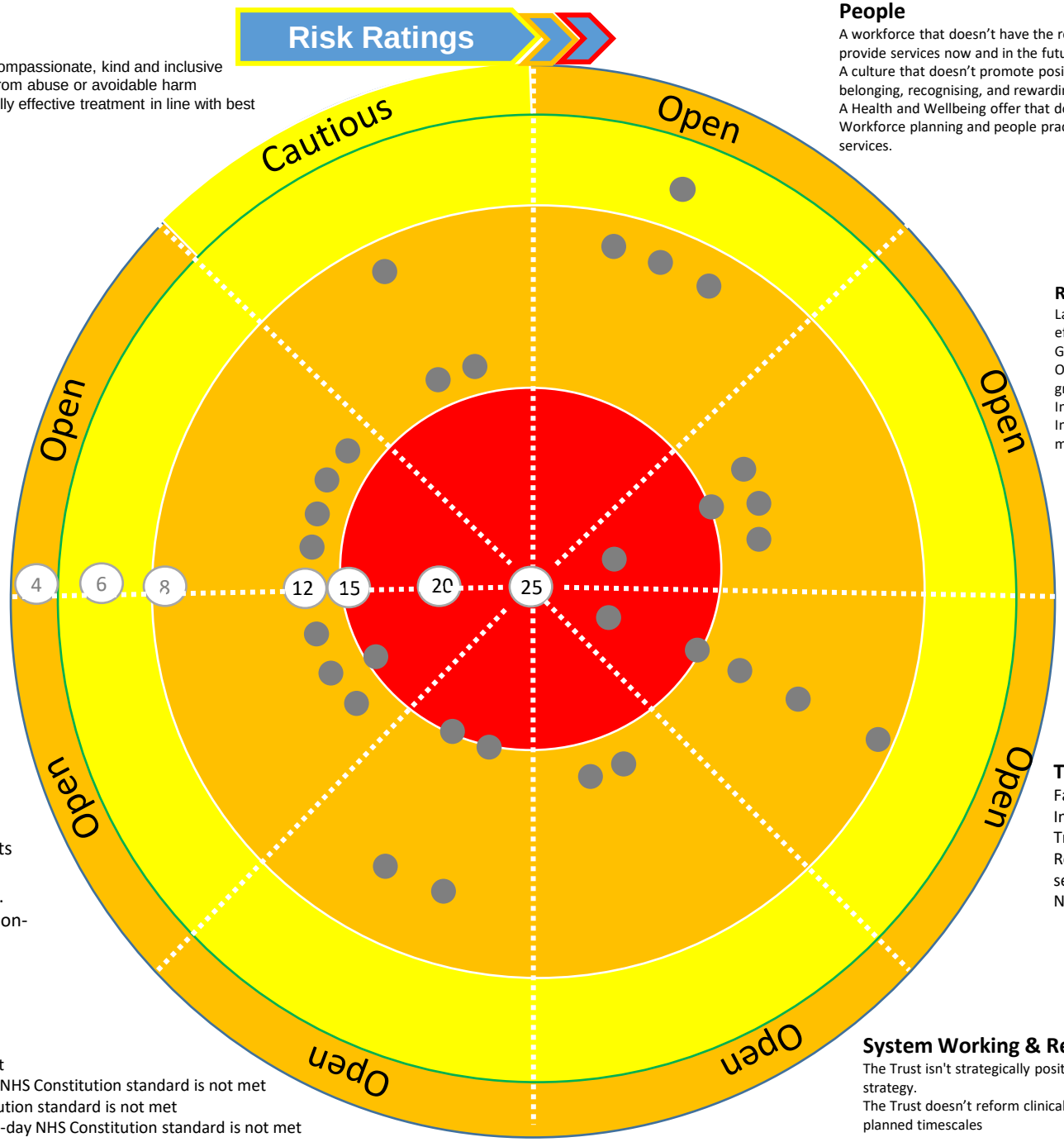
Strategic Risks

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

31st December 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
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.

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

NHS
North Tees and Hartlepool
NHS Foundation Trust

Top 10 Operational Risks (31 December 2025)*

InPhase Risk ID	Title of Risk	CSU/Corporate area	Risk Owner	Current Risk Score
121	Due to increasing demand for Histopathology support there is a potential for delays in results being available to support patient pathways, the patient outcome may be suboptimal.	Clinical Support Services	Sharron Pooley	20
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
223	Poor patient experience linked to unsuitable accommodation in the Wheelchair Service in Stockton	Community & Neighbourhood Health Services	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	Community & Neighbourhood Health Services	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	Family Health Services	Leanne Boyd-Smith	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

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	Neuroscience Services	Tom Bingham	12
280	Delivery of Aseptic Services to the Trust are at risk due to current estate provision	Clinical Support Services	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
320	Due to a lack of confidence in current service delivery by the Stockton Quality Control Laboratory there is potential for service users to terminate contract therefore affecting the financial viability of the service.	Clinical Support Services	Richard Scott	12
88	Potential for delayed care and management of paediatric testicular torsion due to lack of approved regional pathway	Digestive Health, Urology & General Surgery Services	Steve Heavisides	12
246	Due increased demand there is a lack of available elective caesarean capacity to ensure timely access to theatres therefore increasing the likelihood of morbidity and mortality of the mother and fetus	Family Health Services	Gemma Gordon	12
275	Due to vacancies in the Speech and Language Therapy Service, there is a delay in delivering assessments and intervention which may result in poorer patient outcomes and experience	Family Health Services	Leanne Boyd-Smith	12

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

Appendix G

South Tees Hospitals NHS Foundation Trust

Top 10 Operational Risks (31 December 2025)*

Datix Risk ID	Title of Risk	CSU/Corporate area	Risk Owner	Current Risk Score
717	Risk that patients come to harm due to poor image quality of the Neuro angio unit equipment	Neuroscience Services	Richard Bore	25
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	Corporate	Paul Swansbury	20
829	There is a risk of delays in cellular pathology results being available to support patient pathways, the patient outcome may be sub optimal.	Clinical Support Services	Sharron Pooley, Karl Hubbert	20
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	Theatres, Anaesthetics, and Critical Care Services	Michelle Carey	16
382	Risk of harm to patients due to a lack of access to neuropsychology treatment for neuro-rehabilitation outpatients	Neuroscience Services	Jenna Moffitt	16
753	Inability to perform advanced intracranial imaging due to catastrophic failure of unsupported equipment (Neuro 3T MRI)	Neuroscience Services	Richard Bore	16
857	Risk that patient privacy and dignity is compromised when trying to deliver rehabilitation psychology treatment to patients on ward 26	Neuroscience Services	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 Neuro-rehabilitation Standards due to a lack of funding for requi	Neuroscience Services	Glynis Peat	16
937	Cyber breach or service outage by use of unsupported servers/clients/software which may result in business disruption or loss of service of critical operations impacting on patient care	Corporate	Ian Willis	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.	Neuroscience Services	Michelle Carey	15
174	Risk that operational performance of critical care cannot be effectively managed due to Trust Wide Mandatory Training database is not an accurate reflection of Departmental database (2664)	Theatres, Anaesthetics, and Critical Care Services	Martin Johnson	15
278	The inability to isolate patients in a timely and effective manner, leading to potential onward transmission of infection leading to sub optimal outcomes.	Theatres, Anaesthetics, and Critical Care Services	Karen Banks/Michelle Carey	15

777	The Flouroscopy room at JCUH has been condemned reducing capacity, the single remaining equipment has significant downtime due to age, This in impacting on Patient flow and treatment therefore patients may experience sub optimal outcomes.	Clinical Support Services	Callum Pearce	15
809	MGH numbers created by the LIMS are re-used which is not compliant with BSH Blood Transfusion IT guidelines and can lead to two different patients having the same MGH number which could compromise care	Clinical Support Services	Andrew Roberts, Helen Baxter	15
952	Loss of Radiotherapy HDR Brachytherapy Service due to loss of delivery of Ionising material by supplier as a result of Trust equipment not at the current national standard	Cancer Institute	Claire Huntley	15
86	Risk that the Trust does not meet General Provision of Intensive Care Services (GPICS) standards in neurosurgery HDU and spinal HDU	Neuroscience Services	Helen Wilson	15
905	Delayed discharges from critical care causes psychological harm to patients, who are exposed to witnessing distressing events within critical care. This increases length of hospital stay and increased healthcare costs.	Theatres, Anaesthetics, and Critical Care Services	Karen Banks/Michelle Carey	15
293	Risk that there is currently no level 3 cancer patient counselling provision causing patient harm	Cancer Institute	Claire Huntley	15

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

NHS
University Hospitals Tees

Quality Assurance Committee

26 January 2026

Connecting to: Trust 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.

For both North Tees and South Tees there remain a number of high operational risks linked to Quality and Safety that may impact the strategic objectives (patient safety, patient experience and clinical effectiveness). Work is underway to regularly review the risk and mitigations against UHT quality priorities.

The Patient Safety Report demonstrated that PSIIs were taking longer than 6 months (182 days), with timeframes doubling at both North and South Tees. North Tees has 14 open with the oldest from October 2024, and South Tees has 11 with the oldest from July 2024. Action is taken in the form of extra dates for the Patient Safety Review Panel to meet and the development of a monitoring dashboard on Inphase, with the results discussed at the weekly Safety and Quality Panel.

The Cancer Quality and Performance Report demonstrated non compliance with the cancer standards, and this has resulted in additional scrutiny as part of the tiering processes for performance.

Infection, Prevention and Control Improvement Plan Progress Report Q3 showed increased rates of Healthcare Associated Infections which are above trajectory. There are no compliant isolation facilities for High Consequence Infectious Diseases (HCID) at North Tees, and work

Caring Better Together

is underway with estates, although there are no timeframes. Concerns remain for antimicrobial stewardship, as there is a clear need for medical support.

Alerts were raised regarding the high levels of Aspergillus Niger within the Pathology Department and actions taken swiftly.

The Corridor Care and 72 Hours of the Acutely Unwell Adult Care Report showed that at North Tees, the ED estate allows corridor care to be facilitated in full view of the clinical team, whereas at South Tees the department at James Cook has less visibility of the area. This poses a risk in terms of patient safety incidents. The process of Continuous Flow is operationalised in line with OPEL escalation, and this means that an outgoing patient sitting in a chair is recognised as corridor care. There are 15 standards that have been developed for the first 72 hours of care of the acutely unwell, and whilst UHT strive to deliver good practice the evidence is not readily available to provide assurance. The operational team are working with CSUs on how to mitigate the clinical risk but there are resource issues.

Maternity Services at South Tees are unable to declare compliance with Safety Action 8 of the Maternity Incentive Scheme. Training compliance was achieved at 88% which is below the required threshold of 90%, and measures are being put in place to address this.

A Briefing on the Handling and Management of Complaints – Preliminary Diagnostics and Recommendations showed that UHT is failing to achieve a timeliness of response as indicated by the NHS Complaint Standards, as well as not meeting Regulation 16 of the CQC Standard on responsiveness. An internal diagnostic review was requested and is currently being undertaken.

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.

There are no risks within the System Working and Reform Domain that are outside the risk appetite, with planned mitigations. Work is underway to refresh the BAF with Executive sponsors to ensure better alignment and reporting.

The Cancer Quality Report showed marked improvement in performance in the Prostate Pathway due to changes, and the task and finish group has been established for Urology, supporting improvements and allowing for more focused scrutiny. Tsks and finished groups have been established for a range of services, Gynae-oncology, Upper GI, Lower GI, Radiology – Oncology and further groups will be embedded and become Cancer Improvement Groups. Criteria have been developed for both Physical Harm and Psychological Harm grading assessments.

IPC Improvement Plan also reported an incident finding of Aspergillus niger environmental contamination in the microbiology laboratory at South Tees. The source was unknown, but a leak in the roof is a suspected contributory cause, and a tactical group has been established for action.

The Clinical Effectiveness Report Q3 showed that 13 national clinical audits pose a potential risk of non or reduced submission of data across UHT. Support is being given to ensure these are risk assessed and added to the risk register when appropriate.

Maternity services – The Rowan Suite remains suspended with an extension of this to January 2026 due to workforce pressures. There is planned meaningful engagement with workforce and stakeholders. The Birth Centre at the Friarage has been closed 12 times due to staff pressures and there is planned engagement with workforce and stakeholders.

The Quality Priorities Update Q3 demonstrated that all nine priorities have detailed action plans with identified governance groups that are monitoring progress. There are some priorities actions that are off trajectory and these will be monitored by the governance groups.

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

There are stronger systems in place for ongoing monitoring of patient safety activity, escalation of overdue incidents recorded and PSII reports are progressing through the Quality Oversight Group and being presented by the Medical Directors Team.

IPC – work is underway to review and align all policies across UHT, with a plan going to the IPC steering group in February. There will be an internal audit across UHT to commence in January to focus on C. difficile.

The Quality Account Schedule for 2025/26 outlined that both Trusts will publish their Quality Account by 30 June 2026, with reports ready for upload by Friday, 26th June.

The South Tees midwifery bereavement service has been nominated for a Royal College of Midwives Award.

Recommendations:

Quality Assurance Committee

23 February 2026

Connecting to: Trust 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.

For both North Tees & Hartlepool and South Tees there remain a number of high operational risks linked to Quality and Safety that may impact the strategic objectives (patient safety, patient experience and clinical effectiveness), and these relate to infection rates and complaints. Work is underway to regularly review the risk and mitigations against UHT quality priorities on an ongoing basis.

The Pathology Service Accreditation Suspension and Action Plan was outlined following the sanction on South Tees with full compulsory suspension, and North Tees Blood Sciences under partial suspension. A priority action team approach has been implemented, with weekly task and finish groups and action trackers. There is good support in providing the resources needed to regain accreditation, particularly around training and providing evidence of this. However, pathology services are entering into a period of significant change, and coupled with the work needed for accreditation, this poses a risk to morale. Dates for re-assessment have been suggested for June.

Within Maternity Services, South Tees are not declaring compliance for safety action 8 of the maternity incentive scheme year 7. The staff group achieved 88% in training, marginally

below the compliance of 90%, however actions were immediately taken, and the compliance rate in January was 95%. Awaiting any potential impact of this reporting. Board received and signed off the Maternity incentive scheme at an extra ordinary meeting in February.

The UHT Patient Experience and Involvement Report for Q3 demonstrated that there was a 15.5% increase in complaints received at stages 1-5, with a significant increase in complaints of 16% for stage 1. The timeframe for the closure of complaints remains significantly below the 80 % target. There is SOP being developed across UHT on how to deal with all complaints in a systematic way, to align the CSU processes with a focus on increased responsiveness. Complaints remain an area of alert for the Committee and Board.

The Integrated Performance Report continues to highlight the rise in infection rates across all sites, with North Tees showing an alert for E Coli, MSSA, Klebsiella and Pseudomonas. South Tees showing an increase in Pseudomonas. The IPC team are targeting specific areas of hot spots, and the IPC will be monitored on a ¼ basis at QAC. There has been a request that a top-level report is presented to each monthly meeting for oversight and monitoring of action updates. Norovirus is on the increase at North Tees.

The estate remains a challenge at North Tees and dedicated decant facilities remain an issue.

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.

There are no risks within the System Working and Reform Domain that are outside the risk appetite, with planned mitigations. Work is underway to refresh the BAF with Executive sponsors to ensure better alignment and reporting.

The Learning from Deaths Report advised that due to resource issues within the mortality review teams, the reviews are significantly delayed at North Tees & Hartlepool. Whilst the internal target of 20% is not being met, the reviews undertaken noted thematic learning and that Summary Hospital Mortality Indicate (SHMI) for North Tees & Hartlepool and South Tees is “as expected”. Both Trusts are non-compliant with the NHSE requirement to include the Same Day Emergency Care (SDEC), due to awaiting updates in digital technology which is having an impact. There will be an identified Lead for mortality reviews, who will also develop a team of reviewers to support the process.

Within maternity services, both North Tees & Hartlepool and South Tees have seen a slight increase in the crude stillbirth rate. These are being monitored closely, and a deeper dive is

planned. South Tees hosted the NENC Local Maternity and Neonatal System for an assurance visit and received positive feedback. There is a planned review which will focus on estate issues affecting Ward 19.

IPC - The fit testing service at North Tees & Hartlepool for NTH Solutions continues to experience concerns, and reporting seems an issue. Senior leadership is supporting to address these concerns. Flu vaccination rates remain low across UHT.

Maternity services – The Rowan Suite remains suspended with an extension of this to January 2026 due to workforce pressures. There is planned meaningful engagement with workforce and stakeholders. The Birth Centre at the Friarage has been closed 12 times due to staff pressures and there is planned engagement with workforce and stakeholders. Maternity Incentive Scheme year 7 continues to be monitored with both sites having action plans to recover the training trajectory, as training was below the necessary level and led to non compliance. Both North Tees & Hartlepool and South Tees recently underwent a full Local Maternity and Neonatal System peer assurance review, feedback about both services was positive.

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

Within maternity services both North Tees & Hartlepool and South Tees have improved their booking performance for 9 and 6 weeks following the recent quality improvement project. North Tees & Hartlepool is now recommending full compliance with all 10 safety action of the Maternity Incentive Scheme Year 7. North Tees & Hartlepool has received confirmation that the Maternity Safety Support Plan has concluded, with ongoing oversight to remain with the Trust Boards. South Tees has begun a targeted six-month support programme under the new Maternity and Neonatal Improvement Support Team framework.

The Patient Experience and Involvement Report Q3 showed that there was an increase in the Friends and Family Test returns across both sites, and A&E at South Tees had a positive score of 82%, which is higher than the national average. Outpatient, Community and the Maternity Postnatal Community teams also had scores above the national average.

The Organ Donation Report demonstrated an increase in numbers and an upward trend of organ donors. The team are working hard to establish a calm and positive culture within the service, and this was demonstrated by a recent walkabout with Non Executive Directors

and Council of Governors. An organ donation committee has been established with an appointed Chair. A point to note is the positive impact campaigns have on organ donation.

Within IPC, antimicrobial stewardship is starting to have a positive impact with work front of house where prescribing starts.

Recommendations:

The Board utilises a development session to explore IPC in detail

University Hospitals Tees

Perinatal Quality and Safety Report: Quarter 3, 2025/26

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 2.2

Report author: Stephanie Worn, Director of Midwifery

Executive director sponsor: Emma Nunez, Chief Nursing Officer

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: Perinatal Safety Champions meeting and Quality Oversight Group, Quality 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.

South Tees are not declaring compliance for safety action 8 of the maternity incentive scheme year7. The midwifery staff group achieved 88%, marginally below the threshold of 90% within the monitoring period. Actions were immediately taken and the compliance rate by January was 95%.

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.

North Tees has seen an improvement in its crude stillbirth rate, along with an increase in breastfeeding rates. Infant feeding teams across both sites are working jointly to share learning from South Tees initiatives.

South Tees has reported a slight increase in crude stillbirth and neonatal death rates; these will be monitored closely, and a deep review for potential thematic learning is planned. All cases reviewed through the Perinatal Mortality Review Tool have included external reviewers, with no category D findings.

South Tees recently hosted the NENC Local Maternity and Neonatal System for an assurance visit and received positive interim feedback. A planned review will focus on estate issues affecting Ward 19 and the adjoining decant ward.

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

Both North Tees and South Tees have improved their booking performance for 9+6 weeks following the recent quality improvement project. North Tees is now recommending full compliance with all ten safety actions in Maternity Incentive Scheme Year 7.

North Tees has also received confirmation that its Maternity Safety Support Plan has concluded, with ongoing oversight to remain with the Trust Board and executive leadership. South Tees has begun a targeted six-month support programme under the new Maternity and Neonatal Improvement Support Team framework.

The report includes an improvement plan in response to the national request to review Homebirth services. While no safety gaps were identified, the action plan outlines a cohesive University Hospitals Tees approach.

Recommendations:

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

University Hospitals Tees

University Hospitals Tees Board
5 March 2026
Perinatal Services Safety and Quality Report
Quarter 3, 2025/26

1. Introduction/Background

The purpose of the report is to inform and provide assurance to the Board of Director members 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 3 of 2025/26. This report contains the perinatal quality oversight model report for January 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 NHS England revised publication 'Perinatal Quality Oversight Model', previously known as Perinatal quality Surveillance Model.

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) provide 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

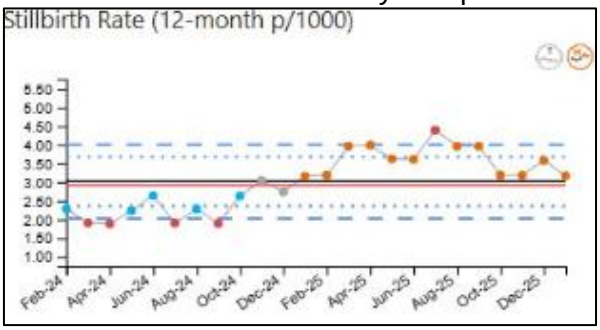
	University Hospitals Tees	**North Tees & Hartlepool**		**South Tees**	
		North Tees	University Hospital Hartlepool	James Cook	Friarage
Bookings	2009	535	388	865	221
All Births	1737	613	0	1104	20
Home birth	7	2	0	3	2
Elective LSCS	370	143		227	
Induction of labour	778	276		502	

In May 2025, the intrapartum service offer by the Maternity Continuity Care (MCoC) team for UHH was suspended temporarily due to workforce pressures. Following a review in January 2026, the intrapartum offer for birth at UHH is to be reinstated in the summer. Workforce planning is in development as the MCoC team will not re-established (appendix 4). The Friarage birth centre offer was not available on 16 occasions; 7 occasions were due to workforce pressures and high acuity at the JCUH site, 4 were attributed to sickness, 4 were due to lack of establishment at FHN and 1 was due to staff attending a homebirth.

2. Perinatal mortality rate

In January the crude 12-month rolling annual stillbirth rate per 1000 births for NTHFT was 3.58 and STHFT rate was 3.96 (exclusive of medical termination of pregnancy). The crude12-month rolling neonatal death rate per 1000 births for NTHFT was 0.40 and STHFT was 2.64% (inclusive of early and late neonatal deaths) (Charts 1 and 2).

Chart 1 NTHFT crude mortality rate per 1000 births



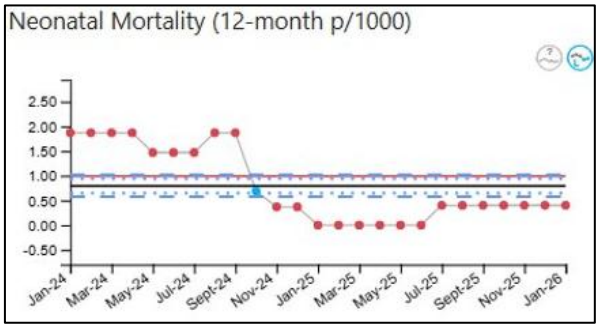
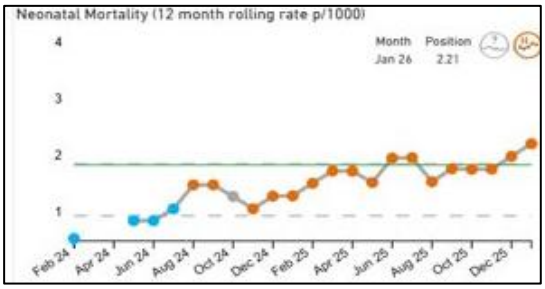


Chart 2 STHFT crude mortality rate per 1000



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

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK (MBRRACE-UK) collects data on perinatal death defined as babies born without signs of life from 22 weeks' gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding terminations of pregnancy. The definition for Stillbirths is from 24 weeks. All eligible perinatal deaths have met the required standards of notification, parental input and multidisciplinary team (MDT) review. On a monthly basis the number of cases and key learning points are reported to the Quality Committee and quarterly to the Group Board of Directors.

Learning from PMRT reviews in Quarter 3

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 details are provided in the quarter 3 perinatal morbidity and mortality report presented to the in-committee to minimise patient identifiable details. Learning points from review meetings across the group are:

- Effective management of hypertension at booking- changes made to hypertension guideline to ensure patients are referred to the appropriate service/clinician

- To ensure clear and consistent management of non-attenders; the DNA policy is being reviewed and guidance related to the booking of Community Midwfery appointments has been updated
- Accessibility to book appointments into the maternity outpatient clinic- the process is under review
- Reminder to all staff placental growth factor can assist in the diagnosis of preeclampsia

3. Maternity and Neonatal Safety Investigation (MNSI)

MNSI teams 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

University Hospitals Tees reported six events to be triaged by MNSI with less than five events accepted Reporting of such events have met compliance requirements for MIS year 7. Limited information is shared within this report to minimise patient identifiable details, and a full report is provided to the Group 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 overall number and moderate of events reported are shown in table 2 and 3.

Table 2. Grading of events

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
No Harm	153	139	127	75	79	66	78	60	61
Low Harm	86	64	104	21	18	34	65	46	70
Moderate and above	7	8	4	1	0	2	6	8	2
Q3 Total	246	211	235	97	97	102	149	114	133

Table 3.Moderate harm events

	University Hospitals Tees	North Tees & Hartlepool	South Tees
Postpartum Haemorrhage >1.5L	<5	0	<5
3/4th degree tear	0	0	0
Shoulder Dystocia	0	0	0
Readmission due to retained products and secondary PPH	0	0	0
Bladder injury at emergency Caesarean section	0	0	0
Admission to ITU	<5	0	<5
Baby fall	0	0	0
Eclamptic Fit	0	0	0
Unplanned return to theatre	0	<1	<5
Scar dehiscence	<5	0	<5

Maternity and /or neonatal services suspension/divert/closure

There were no suspension/divert or closures for North Tees and South Tees.

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 January 2026, the service received confirmation that the Maternity Safety Support Programme (MSSP) had concluded, having successfully met all required standards. I would like to take this opportunity to express my sincere thanks to all colleagues within the maternity service for their dedication, commitment, and exemplary teamwork. Ongoing sustainability and oversight will continue to be maintained through our established safety and quality governance arrangements.

South Tees Hospitals

In January 2026 the service received confirmation the MSSP had formally transitioned to the new framework called the Maternity and Neonatal Improvement Support Team (MNIST), after being formally accepted onto the programme in May 2025. The new arrangement is a 6month focused programme that will cover the below themes and monthly progress meetings with the executive team:

- Culture and leadership
- Workforce development
- Governance and board effectiveness
- Obstetric leadership

- Clinical leadership

7. NHS Resolution Maternity Incentive Scheme (MIS)

The launch of year 7 was published on 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 – Local Maternity and Neonatal System (LMNS) / ICB
- Safety action 10 – MNSI / EN
- CQC sense check

The end of the monitoring period compliance position for each safety action is outlined in table 4. The Board of directors received a presentation by the Director of Midwifery and Service Director for Family Health in February 2026.

Table 4. MIS progress

Safety Action	NTHFT	comments	STHFT	comments
1				
2				
3				
4				
5				
6				
7				
8				Midwifery staffing group achieved 88% of a compliance threshold of 90%
9				
10				

	Not compliant
	Partial compliance, work underway
	Compliant evidence not yet received
	Compliant evidence received

8. Saving Babies Lives Care Bundle version 3.2

The Saving Babies' Lives Care Bundle is a group of actions that have been put together to reduce stillbirth. Each element has a specific action plan against it and together, these have now been shown to save babies' lives. In May 2025, NHSE published an updated version and monitoring towards compliance will be undertaken at Trust and ICB level. Both North Tees and South Tees received confirmation of compliance for each of the six elements.

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 5). Progress is reported at both Trust and ICB level.

Table 5. ATAIN quality improvement

North Tees & Hartlepool	
ATAIN rate Oct 3.15 Nov 3.0% Dec 4.5% **Q3 = 3.5%**	Quality improvement project: To reduce monthly term admissions by 1% • Teaching sessions commenced across labour and postnatal ward for intravenous antibiotic administration. • MDT review for respiratory admissions • Review of Tier 1 attendance at deliveries when escalated
South Tees	
ATAIN rate Oct= 4.6% Nov = 4.2% Dec = 5.2% **Q3 = 4.6%**	Quality improvement project: Prevention and management of neonatal hypoglycaemia • Reaudit completed and themes identified • Hypoglycaemia to be theme of the month in January • Teaching sessions in progress

10. Transitional Care Service

South Tees continues progress towards offering transitional care to late preterm babies against the action plan previously approved by the Board of Directors. All staff have been trained with nasogastric feeding and trust policies have been developed and are awaiting approval from the team. At North Tees, progress continues against the ongoing transitional Care action plan that is reviewed regularly through the perinatal governance structure and MIS. The guideline has been updated in relation to babies 34 weeks and over to be considered for neonatal transitional care.

11. NENC Local Maternity and Neonatal System (LMNS)

Both North tees and South engage with the LMNS through several opportunities for, sharing quality and safety intelligence that reaches regional oversight via:

- Quarter Perinatal Quality Surveillance Provider meeting
- LMNS Board
- LMNS Safety and Quality meeting
- LMNS Perinatal patient safety learning network

South Tees hosted the NENC Local maternity and neonatal system for an assurance visit with positive interim feedback. An aspect to review is the estate issue on Ward 19 and the adjoining decant ward. North Tees assurance visit received positive interim feedback. An aspect to consider was the estate and environment within the triage and day assessment unit. Both North Tees and South Tees are expected to receive a completed report within 28days, and any recommendations will be considered within an action plan.

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 6. Compliance will continue to be monitored monthly and to support staff to access training.

MIS training compliance

South Tees training compliance achieved 88% for the midwifery group, which is marginally below the required threshold of 90%. Measures were immediately taken to address the shortfall, and by 1st January 2026, the compliance rate was 95%

Table 6. Perinatal workforce Trust Mandatory Core training

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
Midwifery and support staff %	78	80	78	84	87	87	73	74	70
Medical (obstetrics/neonates) %	84	83	81	89	89	86	79	77	77
Neonatal Nursing and support staff %	88	86	86	95	91	94	82	81	79
Total %	83%	83%	82%	89%	89%	89%	78%	77%	75%

13. Insights from service users

Complaints overview

The monthly numbers for complaints are outlined in table 7 and the themes are:

- 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 7. Complaints

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
Stage 1	2	8	5	2	5	4	0	3	1
Stage 2	2	1	0	1	1	0	1	0	0
Stage 3	1	1	2	0	0	0	1	1	2
Total	5	10	7	3	6	4	2	4	3

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 9.

Table 9. FFT

	University Hospitals Tees			North Tees & Hartlepool			South Tees		
	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
FFT %	97%	96	93	94	95	95	95	97	90

Trust Claims Scorecard

An update will be provided in quarter 4

Maternity and Neonatal Voice Partnership (MNVP)

Both NTHFT & STHFT chairs meet quarterly with the maternity and neonatal teams, and provide updates to the LMNS/ICB as per requirements (appendix 5 and 6).

Service user insights taken from a recent CQC peer review

The service received results of the 2025 CQC maternity survey, immediate actions were developed within the services, and a report is being prepared by patient experience. Both sites are currently developing actions plans which will be co-produced with MNVP leads.

14. Community midwifery services

Following the Ockenden report in 2022, there is no longer a national target for Maternity Continuity of Carer (MCoC). NTHFT had been unable to maintain the MCoC team (Rowan team based in Hartlepool) due to workforce pressures which led to the decision to suspend the intrapartum service offer, to support safe staffing levels. Following a review in January 2026, the intrapartum offer for birth at UHH is to be reinstated in the summer though the MCoC will not be reinstated. STHFT service disbanded the MCoC team which provided antenatal and postnatal care in June 2022 due to workforce pressures. Both services provide a bespoke offering to vulnerable women and their families. The models have been supported by external funding, that has enabled the team to expand from midwifery support such as social prescribers

15. Quality improvement and research
Research

NTHFT: The midwifery research team continue to recruit eligible women to several research studies as below. The team will also be starting an exciting new screening study called GENERATION very soon along with James Cook.

Study Name – Obstetrics	Status
COPE – Carboprost vs Syntocinon as first line treatment for PPH	Finished Recruiting 230 participants
ROTATE – RCT of manual vs instrumental rotation of the fetal head in malposition at birt	Finished Recruiting 18 participants
iGBS3 – Cord blood for research into GBS protection	Finished Recruiting 2811 participants
iHOLDS – High or low dose syntocinon for IO	Active Recruited 214
MiNESS – Mothers working to prevent early stillbirt	Active Recruited 13
TTTS Registry – Multiple Pregnancy Registr	Active Recruited 34
SNAP3 – Enhanced support NRT offered for preloading, lapse recovery and smoking reduction – impact on smoking in pregnancy	Active Recruited 57
INGR1D2 – Identification of infants with increased type 1 diabetes risk for enrolment into primary prevention trials.	Active Recruited 2940
OBS PPH UK – Obstetric Bleeding Stud	Active Recruited 3570
SNAP2 – Smoking, Nicotine & Pregnancy 2	Active Recruited 3

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

NTHFT:

Each baby counts learn and support toolkit – to improve clinical escalation and in so doing so reduce incidence of intrapartum and neonatal morbidity. Diagnostics were ran as recommended by the RCOG toolkit to establish what the issues were and working groups have been established to progress the project:

- Working group to look at improving decision to birth time interval. The data currently shows a marked improvement from decision to birth interval in line with NICE recommendations.
- Working group established to look at a process for timely escalation. A pilot has been established to test a traffic light system for escalation across the whole MDT.

- Process in place for all medical team to have coloured name badges (representing tier levels) to support escalation.
- Ward boards in all areas to support team of the shift
- Resources to identify and support team awareness of escalations.

Mechanical IOL – Patient feedback is positive and will be shared with staff. Delay in data collection due to workforce pressures within the team. The medical team are supporting this project following escalation for support.

Antenatal bookings – project is to increase booking by 9+6weeks. Following data collection 70% of late bookings had made early contact via the online referral system. Work is underway to work with the community teams to look at the process and systems to identify areas for improvement

Smoking in pregnancy –Retrospective look back for those who continue to smoke at delivery to understand what the reasons and challenges are to support clinical pathway improvements

STHFT:

- **Booking by 9+6-** QI project to address compliance commenced in May 2025. Project improvement interventions have been implemented, and current data has shown an improvement in booking by 9+6 of 10% during the quarter.
- **Prevention of neonatal hypoglycaemia-** QI project commenced May 2025. PDSA cycles are being utilised to address six areas of focus with the aim for completion in January 2026.
- **Postpartum Haemorrhage (PPH)-** Due to increasing rates staff have been allocated to case review to extrapolate learning and improvements.
- **3rd/4th degree tears-** Due to increasing rates of 3rd and 4th degree tears a member of the medical team has been allocated to work with the pelvic health midwife to review the cases to determine where improvements can be made. The service has reviewed education of OASI and implemented online training for all staff.

Specialist Midwifery roles

A summary of the roles is provided in appendix 7. The Group service is collaborating with the ICB to fund a group service for Maternal Mental Health Service, expected to commence in quarter one of 2026.27

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: Triage UHH, Ward 22 and SCBU.	Feedback. Overall positive workarounds, Staff requesting further communication regarding the group model and how this will affect them. Staffing levels and skills mix continue to be a challenge.
South Tees	
Areas visited: Tees Community midwives, Wards 16, 17, 19, triage, ANC, CDS and neonates.	Overall staff were engaged and positive during walkrounds. Community midwives expressed concerns around support provided for staff when caring for women birthing outside of guidance and estate pressures were highlighted as a concern by staff within clinical areas.

Perinatal Culture and Leadership Programme

The service has a perinatal leadership aligned to the 2 locations: NTHFT and STHFT. The culture improvement plan (appendix 8 and 9) for the respective sites is monitored at the Safety Champion meetings, with escalation to Quality Committee. There are no escalations for the in quarter 3 position.

17. Risk register

There are twenty-three open risks across Maternity and Neonatal services, table 10 summaries the grading. 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.

Table 10 grading of risks

	North Tees & Hartlepool		South Tees	
	Maternity	**Neonates**	**Maternity**	**Neonates**
High Graded risk	0	0	0	0
Moderate graded risk	5	0	12	4
Low graded risk	0	1	1	2
Very low graded risk	1	0	0	0
Within approval process	0	0	7	1

18. CQC action

Table 11 demonstrates the position for STHFT against the CQC must and should do's. The outstanding relate to estates, which are in progress; waterbirth pool instalment at the James Cook site which is expected to open by March 2026.

Table 11. 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

- Estate issues which impact patient flow and appropriate environment for women and families particularly with triage and antenatal clinic.
- Demand for elective caesarean sections exceeds capacity – a business case has been developed and to be shared through the appropriate governance arrangement.
- Demand for consultant antenatal clinics exceeds capacity- capacity and demand exercise is in progress.

South Tees Hospitals

- Estate issues which impact patient flow and appropriate environment for women and families under review.
- Demand for elective caesarean sections exceeds capacity – a business case has been developed and to be shared through the appropriate governance arrangement.
- Demand for consultant antenatal clinics exceeds capacity- capacity and demand exercise is in progress.

National/Regional/System updates

In October the North East and Yorkshire regional midwifery team launched the Regional Heatmap tool to identify trusts early for support or intervention. Information is published to each service monthly.

In November NHSE launched a new maternity dashboard; Maternity Outcomes Signal System (MOSS). It is a system of monitoring routinely collected maternity and neonatal outcomes to detect potential declines in safe care in a timely way, focused on potential safety issues in intrapartum care. MOSS is not a performance management or investigation tool; it is part of a wider critical safety management system (CSMS). Together, these systems are essential tools that help organisations deliver consistently safe care. Signals do not necessarily mean that a service is unsafe but prompt a service-led critical safety check: providing early insights into potential intrapartum care safety issues and enabling rapid intervention to reduce harm. Information is available to each service monthly.

In December each maternity service a letter from the Chief Midwifery officer for NHSE to prompt a review of homebirth services. This was instigated following an adverse event in the North West and following a coroner's investigation, a Future prevention of death notice was issued. Each service was asked to look at the following:

- Operational delivery
- Care planning and risk assessment

- Governance & oversight, including date discussed or when it will be discussed at Trust Board

A review of the current homebirth service provision is outlined in appendix 10.

In December a new daily Operational Pressures SitRep data collection was commenced for all maternity and neonatal services. One of the main purposes are to support maternity services OPEL levels within a regional footprint. The other purpose is to provide periodic reporting for national oversight of maternity and neonatal safety pressures for monitoring performance, perinatal quality oversight and other strategic purposes as necessary

In January NHSE published the maternal care bundle, a set of standards across 5 areas of clinical care, for implementation by NHS providers and commissioners across England b March 2027. The aim is to reduce maternal mortality and morbidity and reduce inequalities in these adverse outcomes. The five elements are:

- Element 1: Venous thromboembolism
- Element 2: Pre-hospital and acute care
- Element 3: Epilepsy in pregnancy
- Element 4: Maternal mental health
- Element 5: Obstetric haemorrhage

The service is reviewing the publication and will undertake a benchmarking exercise.

19. Assurance and Recommendations

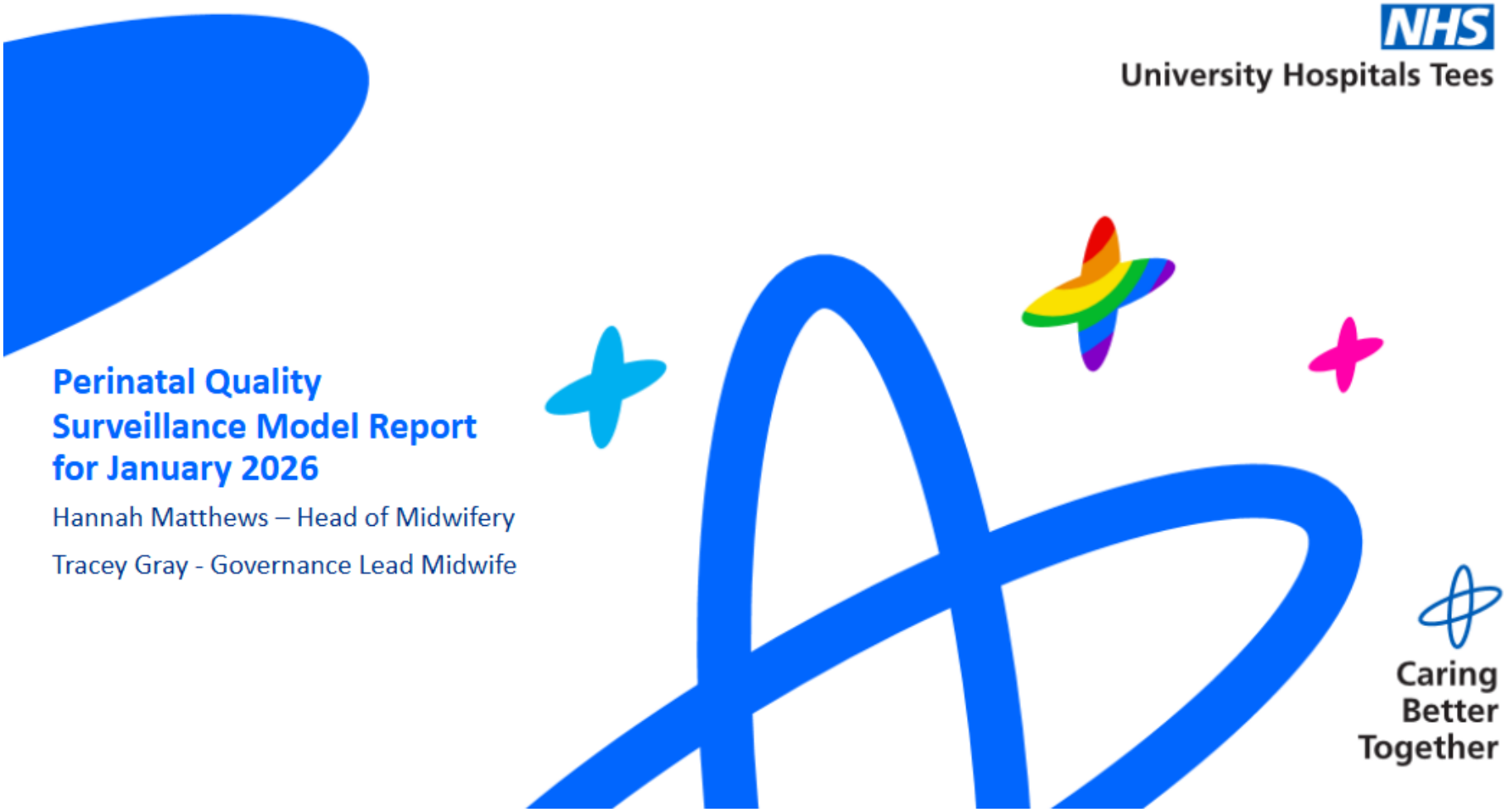
The Board of Director members are asked to receive and note the significant on-going work to meet National Maternity recommendations.

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

Appendices

Appendix 1. PQOM September report
Appendix 2. PQOM dashboard NTHFT
Appendix 3. PQOM dashboard STHFT
Appendix 4. Birth availability offer for UHH
Appendix 5. NTHFT MNVP update
Appendix 6. STHFT MNVP update
Appendix 7. Specialist midwives update
Appendix 8. NTHFT SCORE cultural action plan
Appendix 9. STHFT SCORE cultural action plan
Appendix 10. Homebirth service provision

Appendix 1. UHT PQOM report for January 2026



Key Performance Metrics

KPI	Unit	Standard	UHT			NTH			STH		
			Nov-25	Dec-25	Jan-26	Nov-25	Dec-25	Jan-26	Nov-25	Dec-25	Jan-26
Booking at 9+6	Percent	90%	65.15%	69.11%	73.91%	69.10%	76.67%	70.63%	67.24%	71.47%	60.00%
Smoking status at Booking	Percent	<10%	7.21%	6.79%	5.78%	7.31%	3.67%	5.94%	5.75%	7.65%	6.61%
Right Place of Birth	Percent	>95%	100%	99%	96%	100%	85%	100%	100%	100%	100%
Births	Numeric		613	626	603	213	188	214	382	351	389
Preterm birth rate (22-36+6)	Percent	<7%	6.53%	8.80%	10.41%	6.60%	6.42%	3.74%	10.20%	10.20%	7.80%
Induction of Labour	Percent		46.59%	42.90%	43.73%	48.80%	40.22%	46.01%	47.88%	45.61%	48.57%
PPH >1.5L	Rate per 1000	31	25	47	32	38	11	9	31	44	26
3/4th degree tear	Percent	<3.5%	2.15%	2.79%	1.10%	2.52%	1.16%	3.64%	5.19%	1.08%	3.15%
Stillbirth Rate	(12 mnth) Rate per 1000	North 2.91 South 3.60				3.18	3.58	3.17	3.51	3.53	3.96
Neonatal Mortality Rate	(12 mnth) Rate per 1000	North 0.99 South 1.84				0.40	0.40	0.40	1.54	2.20	2.21
Smoking status at Delivery	Percent	<6%	6.48%	6.16%	6.07%	10.95%	8.65%	1.41%	4.19%	4.68%	3.64%
Breastfeeding at first feed	Percent	74%	61.34%	59.02%	58.82%	52.36%	42.78%	55.14%	66.30%	68.11%	65.49%
VTE Score	Percent	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
ATAIN	Percent	6%				3.03%	4.57%	5.83%	4.20%	5.23%	4.18%
Apgar <7 at 5 mins	Rate per 1000	24	24	22	27	20	29	0	23	26	17
HIE Rate	12 mnth - Rate per 1000					1.19	1.20	1.19	0.44	0.44	0.44
Baby re-admissions	Percent	<6%	2.73%	1.52%	3.72%	0.47%	1.07%	2.35%	2.09%	2.57%	1.55%
Mother re-admissions	Percent	74%	3.58%	4.44%	1.89%	6.67%	5.95%	1.40%	3.20%	2.34%	3.12%

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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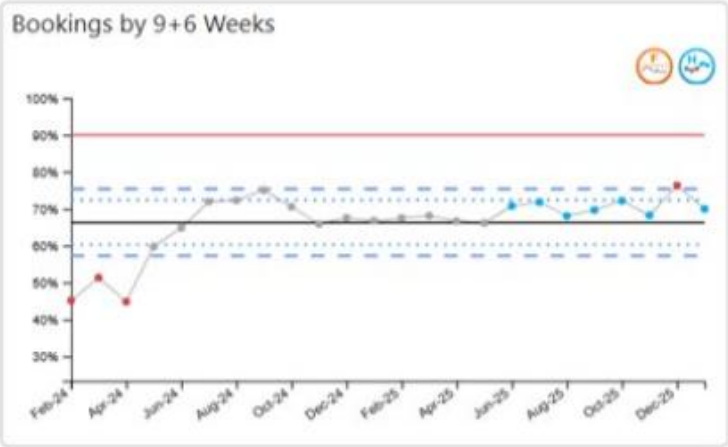
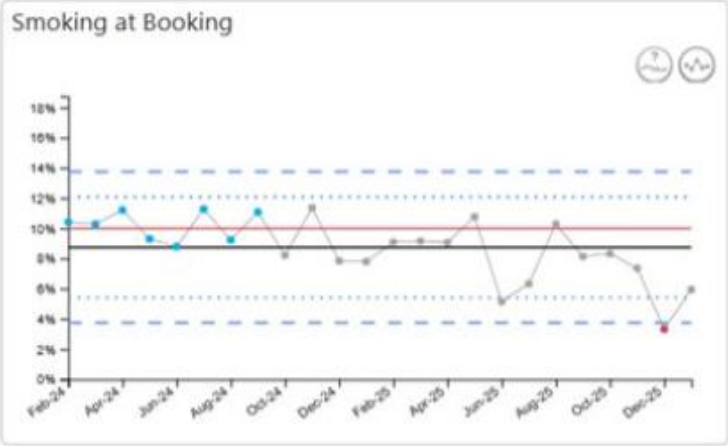
Antenatal NTHFT KPI overview





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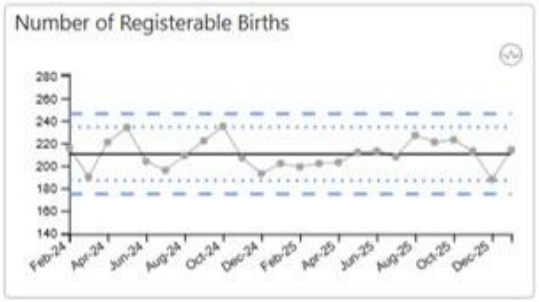
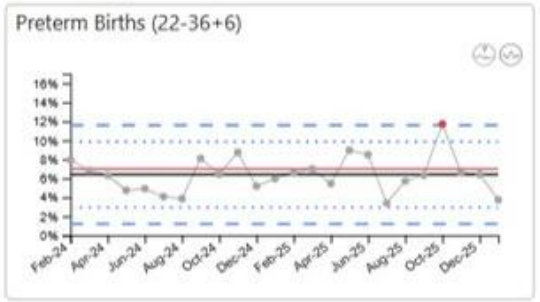
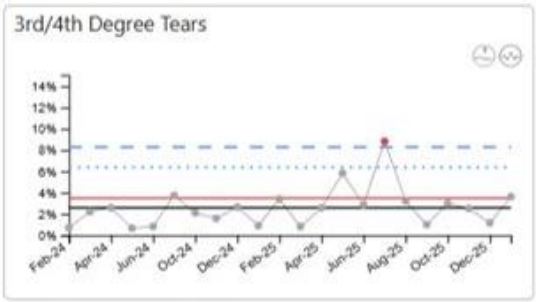
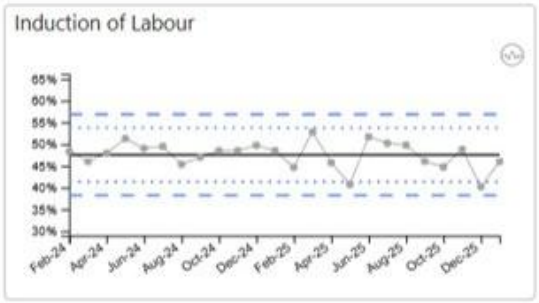
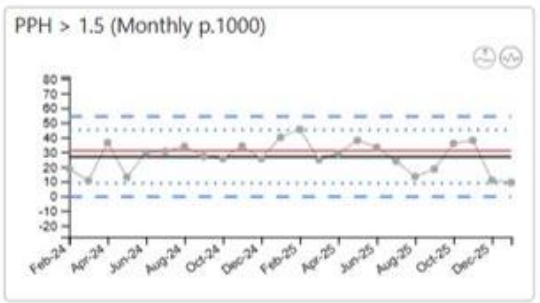
Births NTHFT KPI overview

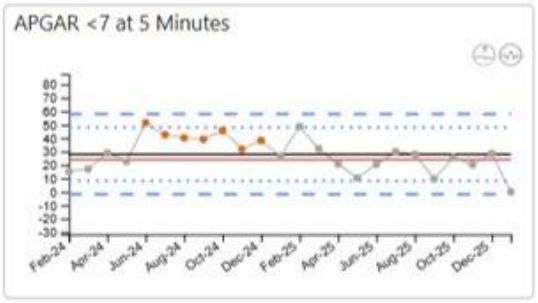


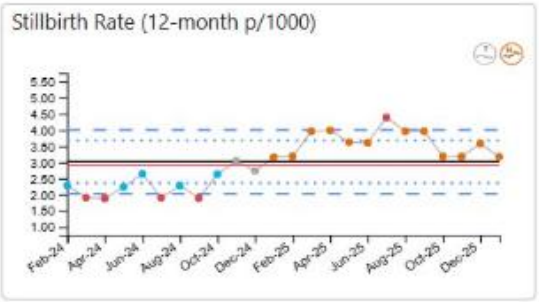












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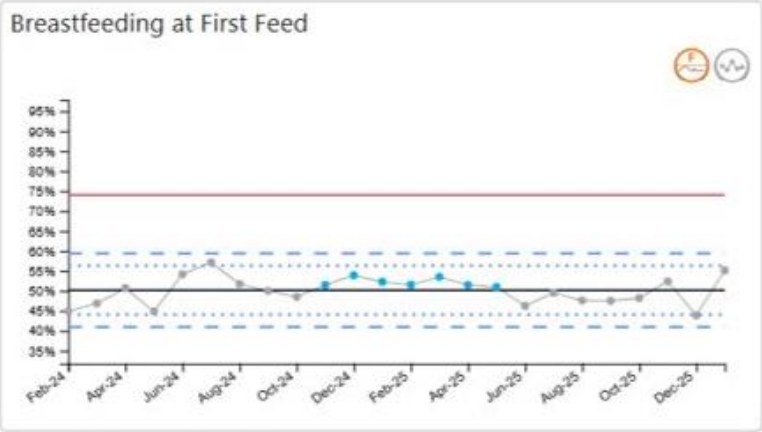
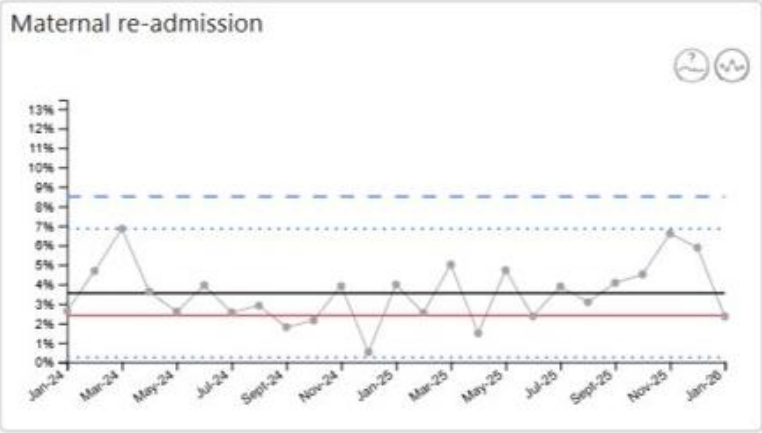
Postnatal NTHFT KPI overview





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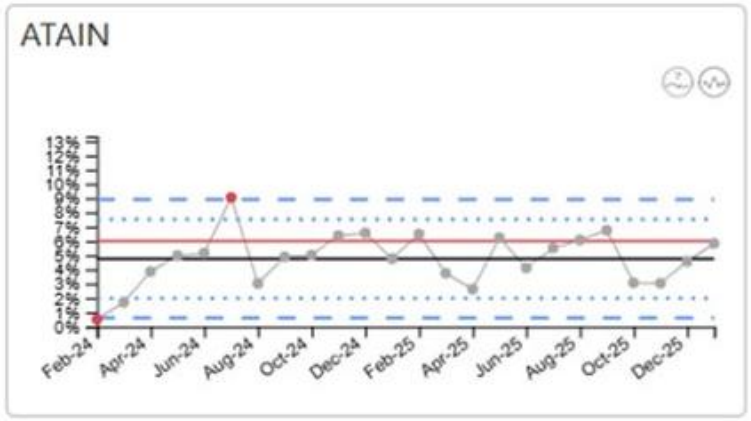
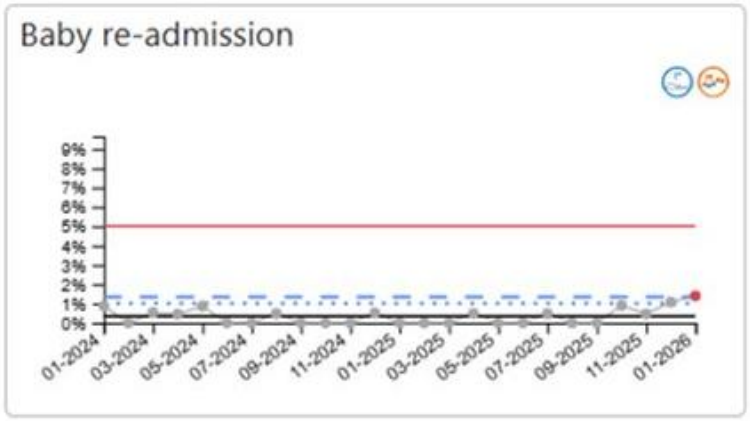
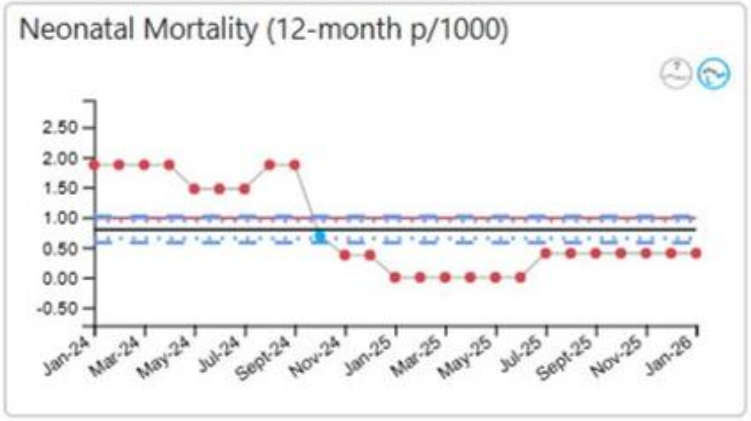
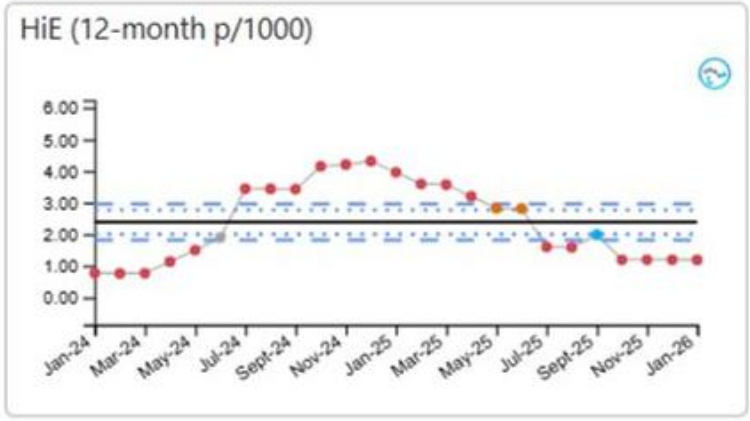
Neonatal NTHFT KPI overview









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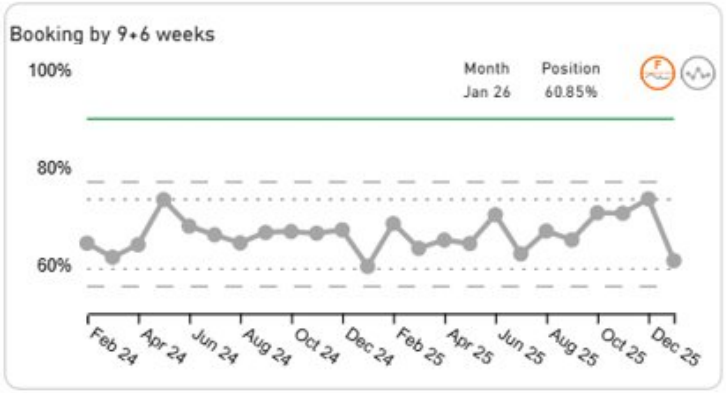
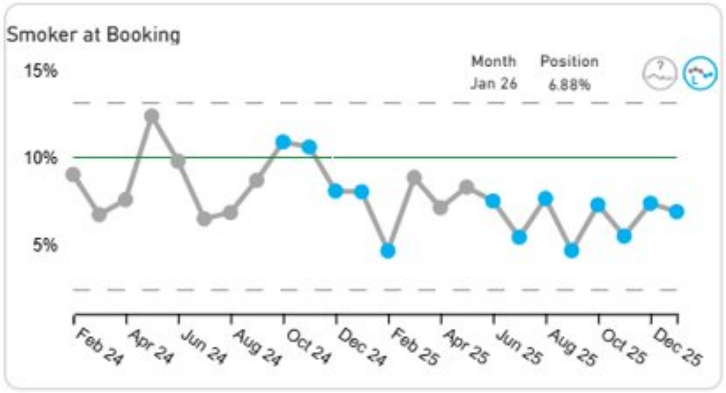
Antenatal STHFT KPI overview





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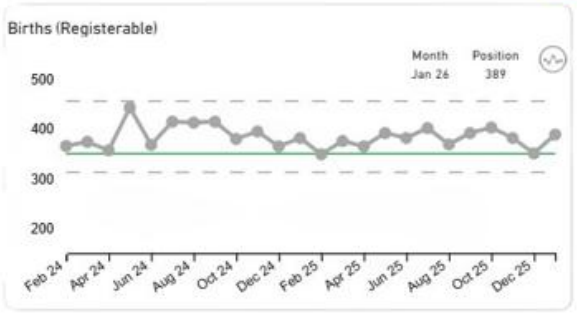
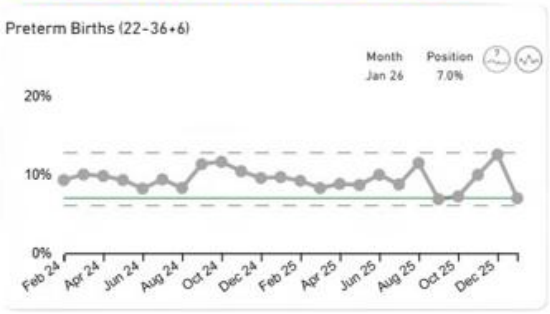
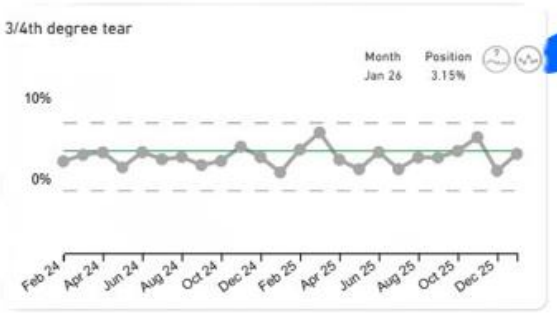
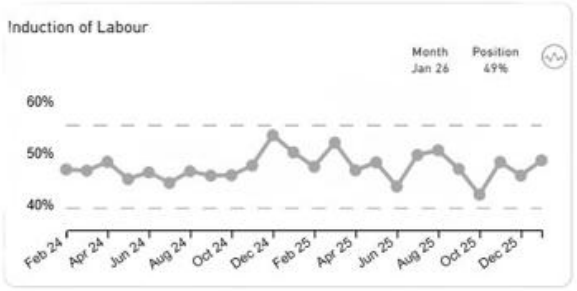
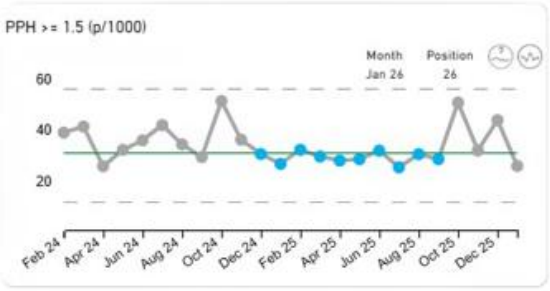
Births STHFT KPI overview

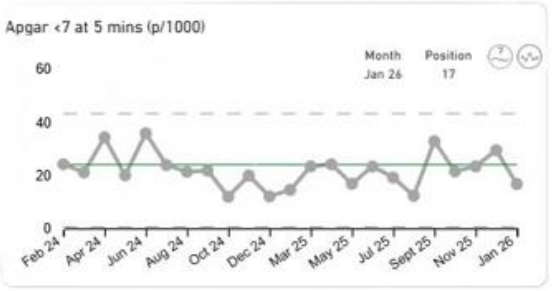












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Postnatal STHFT KPI overview

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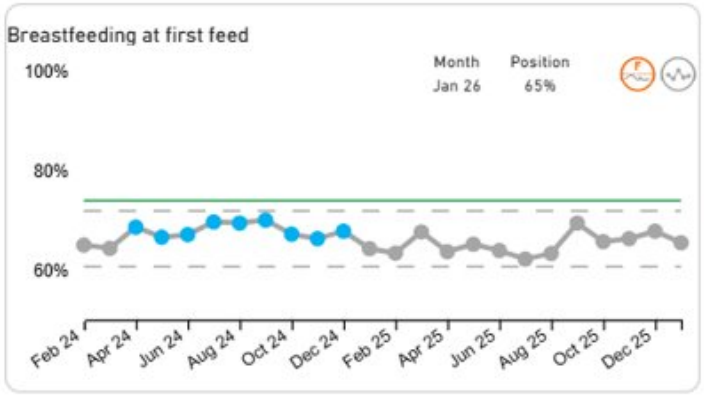

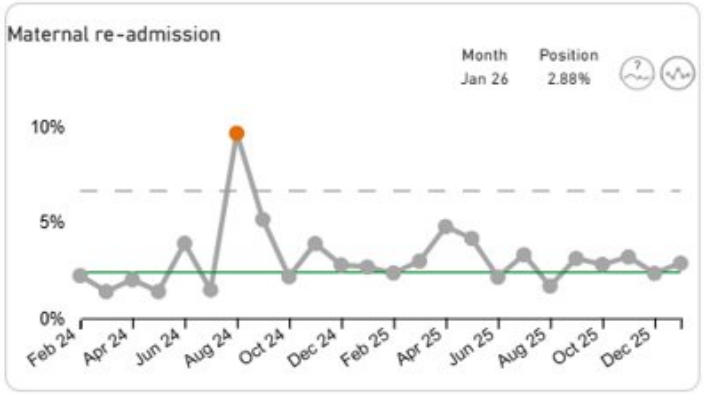

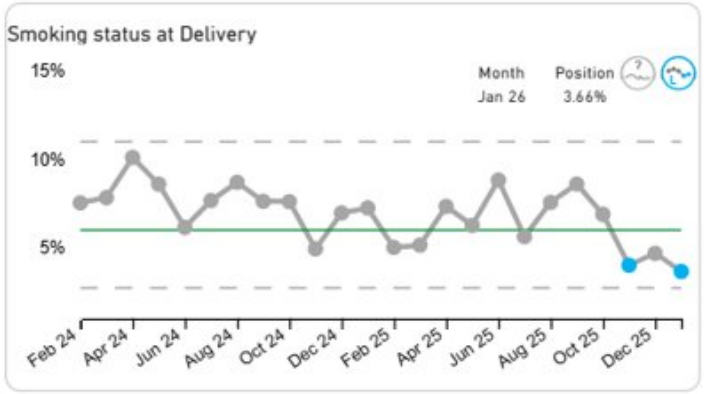

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Neonatal STHFT KPI overview

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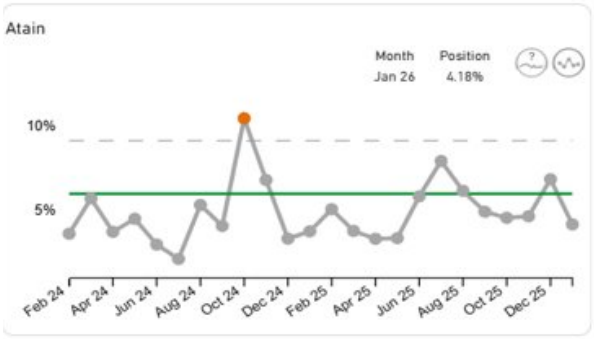

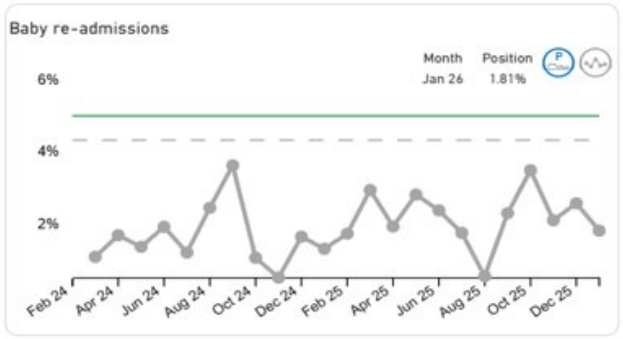

Caring Better Together

Insights for Safety, quality and learning: January

Theme	Insight	NTHFT	STHFT
Engagement	Friends & Family Test	Unable to retrieve data from inphase.	Unable to retrieve data from meridian
	MNVP	Quarterly review undertaken in January, themes identified was hunger, communication and information giving. Continues social media presence to engage with service users. Attended both the HIE review and maternity mandatory training.	Engagement session held in the neonatal unit this month. Positive feedback received from the LMNS regarding patient experience. Ongoing collaborative work with the CQC action plan and environment for the placement of birthing pool Meeting held with digital company to further develop information for patients and work ongoing with the family hubs to install screens for public health information in clinic and triage
	Complaints	Stage 1 – 3, Stage 2 – 1, Stage 3 – 1.	Stage 1-4, Stage 2-0, Stage 3-1
	Compliments	71	2 submitted via datix, unable to retrieve data from meridian
	FTSU	None	None
	Safety Champion engagement	Walk around in Delivery Suite – Discussed concerns around cross service working and escalation, pressure on experienced staff and numbers of newly qualified midwives. UHT position and need for ongoing communication with clinical staff. Discussion around changing birth landscape increased elective CS and IOL.	
	PCLP / SCORE Survey	Action plan ongoing 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	0 Stillbirth reported. 0 Neonatal deaths reported.	2 stillbirth 4 neonatal deaths reported
	MNSI / PSII	0 reported in month. 0 active MNSI/ 1 active PSII.	1 reported in month but declined at triage, 3 active MNSI, 1 final report received this month. 1 PSII completed this month
	Moderate events	0 moderate harm,	7 moderate physical harm/10 moderate psychological events
	NHSR claims scorecard	Presented Nov	Presented November
	MIS compliance	On track. SA8 (training) compliance met.	Board declared compliance with 9/10 safety actions for MIS year 7
	CQC rating & actions	Requires improvement. Actions completed.	Requires improvement. 2 outstanding actions, estates related.
	MSSP – now MNIST	Completed MSSP,. For regional oversight	6month focused support programme commenced January 2026
	Coroners Reg 28 request	N/A	N/A
	Safety signals	Stillbirth rate. HIE LMNS review undertaken in Nov, awaiting report.	N/A
	Quality Improvement	ATAIN, APGAR score, EBC.	PPH, ATAIN, 3rd/4th degree tears, Use of oxytocin

Midwifery Workforce: January

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Midwifery Establishment

Budget	NTHFT					STHFT				
	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 (Dec 2025)	Projected 6 month (Mar 2026)
B5/B6 RN's/RM's	107.27	110.53	+3.26	+6.3	+10.56	174.68	172.87	-1.81	175.47	175.47
B7 Clinical and Specialist Midwives	29.42	27.34	-2.08	-2.28	-2.28	38.32	44.00	5.68	44.46	44.36
Grand Total	136.69	137.87	-1.18	+4.02	+8.28	213.00	216.87	3.87	219.83	219.83

Workforce safe staffing metrics	NTHFT	STHFT
Obstetric labour ward cover	100%	100%
LWC supernumerary start of shift	100!%	100%
1-1 care in labour	100%	100%
Midwife to Birth ratio	1:19	1:21
Registered midwife fill rate	85%	99%
BAPM compliance	66%	100%

Red Flags	NTHFT	STHFT	comments
1-1 care in labour	0	0	
Delay in IOL	0	18	
Time critical	0	43	
Missed or delayed care	0	1	
Delays in Triage	0	0	

Caring Better Together

Training compliance for MIS year 8: Overall staff groups

Key Updates

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NTHFT

- An improved stillbirth rate to 3.17 and will continue to monitor. All reviews have had external reviewers with zero cases being graded as D
- Rowan suite remains suspended, with a plan to reopen by June 2026 with a new workforce model
- Completed MSSP – regional oversight

STHFT

- Transitioned onto the Maternity and Neonatal Improvement Support Team formally the MSSP. Focused programme for 6months, with monthly progress meetings hosted by the executive team

National, Regional, System

- NHSE released an alert notice for fetal growth charts: IG21. all trusts are to cease use of IG21 by March 2026. NENC Fetal medicine lead reviewed options and WHO charts chosen. All 8 Trusts in the LMNS have worked through the plans and training and put in mitigations where there may be transition gaps.
- The Amos review of maternity and neonatal services released a survey for service users and staff. The surveys are open until March 2026.
- Published maternal care bundle – five elements to consider. Webinars will be facilitated throughout February and march for all staff briefings

Caring Better Together

Appendix 2. NTHFT PQOM dashboard

CQC Maternity Ratings RI	Effective: RI		Caring: Good		Well-Led: RI		Responsive: RI		Safe: RI		MSSP: 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	4 learning points	NA	NA	NA	NA	NA	NA		
2. Findings of review of all cases eligible for referral to MNSI	NA	3 reports - 10 actions	NA	NA	NA	1 report – 1 action	NA	NA	NA	NA		
Report on: 2a. The number of events logged graded as moderate or above and what actions are being taken	<5	<5	<5	<5	<5	<5	1	0	2	0		
2b. Training compliance for all staff groups in maternity related to core competency framework **MDT skills** and **fetal wellbeing** - MIS monitoring period	94%	94%	83%	83%	95%	69%	76%	95%	95%	11%		
	95%	92%	93%	93%	89%	56%	80%	98%	98%	11%		
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%	100%	100%	100%	100%	100%	100%	100%		
	1:18.4	1:25	1:19.7	1:19.7	1:19.9	1:21	1:25	1:19	1:19	1:19		
3.Service User Voice Feedback – positive %	100%	100%	80%	80%	100%	100%	100%	95	95	Data unavailable		
4.Staff feedback from frontline champion and walk-abouts (bi-monthly)	Ward 22	Ward 22	SCBU	MDAU	DS	HPL	Triage	PTL	WD 22	Triage		
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
6.Coroner Reg 28 made directly to Trust	No	No	No	No	No	No	No	No	No	No		
7.Progress in achievement of CNST 10	Yr 7 - In progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	10/10		

% midwives would recommend their Trust as a place to work or receive treatment 54%

%speciality trainees responding with excellent or good for clinical supervision out of hours 70%

Appendix 3. STHFT PQOM dashboard

CQC Maternity Ratings RI	Effective: Good		Caring: Good		Well-Led: RI		Responsive: RI		Safe: RI		MSSP: 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	1 learning point	NA	NA	NA	2	2	NA		
2. Findings of review of all cases eligible for referral to MNSI	NA	NA	NA	NA	NA	NA	NA	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	0	0	6	6	8	2	7		
2b. Training compliance for all staff groups in maternity related to core competency framework **MDT skills** and **fetal wellbeing**	78%	88%	88%	87%	79%	79%	85	90	90	8%		
	83%	94%	95%	77%	77%	77%	85	90	90	8%		
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%	100%	100%	100%	100%	100%	100%	100%		
	1:19.3	1:21.8	1:21.4	1:22	1:22	1:21	1:20.8	1:21	1:18	1:21		
3.Service User Voice Feedback – positive %	92.8%	92.5%	93.5%	91%	91%	90%	95	97	90	Data unavailable		
4.Staff feedback from frontline champion and walk-abouts (bi-monthly)	Inpatient maternity	Neonatal unit	Inpatient maternity	CDS & NNU	FHN centre	Inpatient maternity	triage	FHN	NNU	CDS		
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
6.Coroner Reg 28 made directly to Trust	No	No	No	No	No	No	No	No	No	No		
7.Progress in achievement of CNST 10	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr 7 in progress	Yr7 completed = 9/10			
% midwives would recommend their Trust as a place to work or receive treatment 70%												

%speciality trainees responding with excellent or good for clinical supervision out of hours 86%

Appendix 4 Birth choice: Rowan Suite, University Hospitals Hartlepool

Purpose of the Report

To update the Local Authority Health and Wellbeing Board on the suspension of births at UHH, workforce position, interim birth options, timeline, and the planned on-call model reopening of Rowan Suite

Background to the Temporary Suspension

Births at UHH were temporarily suspended in May 2025 due to significant staffing pressures affecting safe provision of intrapartum, antenatal and postnatal care. Continued workforce pressures led to an extension into January 2026.

Current Workforce Position

The service has seen some reduction in workforce pressures such as sickness and absence and has successfully recruited into the current midwifery vacancies. Community midwifery stabilisation remains a priority before intrapartum services can resume.

Interim Birth Options

Homebirth is offered for all uncomplicated pregnancies. Women choosing hospital, births are supported to use low-dependency and waterbirth rooms at North Tees.

Future Provision at Rowan Suite

Birth provision for uncomplicated pregnancies will be offered though with a different workforce model than previously offered. Workforce modelling, escalation and transfer pathways will be defined.

Phase 1 (Jan–Apr 2026): Stabilisation, return-to-work support, engagement, plan training

Phase 2 (April - May 2026): Confirm model and governance approval

Phase 3 (June 2026): implement birth availabity option for Rowan Suite, UHH

Engagement and Partnership Working

Engagement events with service users and staff are to be planned to understand what is important for expectant families to shape and influence future maternity services, supported by the Maternity and Neonatal Voice Partnership/

We ask for ongoing work with system partners to enhance community wellbeing and maternity outcomes: prevention and early intervention for population health

Appendix 5 NTHFT MNVP update

MNVP Update for MNEG
Quarter: January 2026
Completed by: Jade Wilcock & Catherine Dillon-Goodier

North East and North Cumbria Local Maternity and Neonatal System

Escalation and risks to take forward

- EoI Funding
- NICU Lead only just in post
- Trust Division

Surveys and listening events undertaken:

- Refugee Services Fair
- Stockton Parent Carer Forum
- National Health Visitor Training- the NICU voice
- Stockton wellbeing hub
- Walk the patch- NICU/ Antenatal
- Trust Professional Skills involvement
- Stockton Borough Library
- "What Families want"- survey with ST
- Neurodiversity Family Passport
- Neoangels volunteering
- Community Midwives
- Glitter tattooing- Family Hubs

Actions/ Improvements undertaken / planned

- Neurodiversity Family Passport
- Bereaved Families Creative event with Write yourself well
- Refugee Futures event linked with Grow Baby & Family Hubs
- NICU books with Stockton Libraries
- CQC Action planning
- Digital handset drive
- "What families want"
- "Day 5" Mandatory training involvement
- Reading well for families

Perinatal service user feedback themes

- Hunger on the ward
- Neurodiversity's not fully understood, communication can become a problem
- Religion and respect- multiple pregnancies
- NICU feedback incredibly positive
- Trust Division- causing uncertainty
- Excellent feedback regarding MAU telephone line
- Concern surrounding seeing different professionals during care- wanting consistency is the most desired aspect of the entire pregnancy journey
- Being Heard

Appendix 6 STHFT MNVP update

MNVP Update for MNEG
Quarter:
Completed by:

North East and North Cumbria Local Maternity and Neonatal System

Escalation and risks to take forward

- The MNVP lead is invited to all governance meetings, however there is not capacity for attendance at all meetings this is currently on the service risk register

Surveys and listening events undertaken:

- Bereavement workshops have been completed and well received by parents and families. The findings from these have been developed to form an action plan to work towards
- Neonatal engagement sessions underway

Actions / Improvements undertaken / planned

- Increase social media presence
- Personalised care work regionally
- peer support for bereaved families and place-based working with 4 Louis

Perinatal service user feedback themes

Digital notes and understanding terminology
Induction of Labour – communication and expectations

Appendix 7. Specialist Midwives summary

Specialist role	North Tees & Hartlepool	South Tees
Preterm birth	Detection of issues relating to data collection in relation to preterm optimisation. Progesterone 200mg at night to be offered to all women who have previously had a spontaneous preterm birth prior to 34 weeks. Actim Partus test now available.	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	• Currently reviewing processes for antenatal education following diagnosis of GDM • Setting up group education sessions for all newly diagnosed with GDM, including the addition of content to be sent out on Badgernet • Process for re-use of blood glucose monitoring equipment for cost saving and carbon footprint • Shadowing and liaising with other DSM's across the region to learn from what is working well in other areas • Participating in clinics to reduce wait times and increase women's satisfaction with care provided.	1.64 WTE midwives in post for diabetes, currently managing care for women with gestational diabetes within MDT diabetes clinics.
Birth reflections	Self-referral forms have lowered the DNA rates and proved successful, plan to audit in Q4.	Currently there are 12 midwife hours per week allocated to this – 6 are externally funded. Birth Reflection clinics are currently at capacity.
Bereavement	Focus on education, quality improvement and direct family support following pregnancy and baby loss. Key activities have included developing and delivering bereavement teaching sessions to 2 large groups of theatre staff. It was recognised that it is becoming more common for women to require care from theatre staff during the loss of their baby for differing reasons such as, retained placenta, PPH etc. The feedback from these sessions has been extremely positive. Continued to share learning from case reviews. Learning posters have been displayed in relevant areas, updated information folders, ensured learning is shared on weekly updates and on Tea Trolley Teaching.	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

	Most importantly, I have continued to provide care, support and be a single point of contact to every bereaved family that unfortunately requires the perinatal bereavement service.	
Fetal wellbeing	focused on strengthening fetal wellbeing governance, supporting clinical learning, and improving multidisciplinary practice across the Trust. • **HIE Review Processes**: Co-led on Hypoxic-Ischaemic Encephalopathy (HIE) reviewing in collaboration with the NENC LMNS, ensuring robust analysis, consistent local learning, and a clear action plan has been embedded. • **Ongoing Review of Adverse Outcome Measures**: continued to review all adverse outcome indicators, including ATAIN cases, APGAR scores, HIE occurrences, and low cord gas results. Themes and emerging trends have been collated and disseminated. This has included targeted 1:1 staff support, focused case discussions, and sharing of key learning across the wider MDT to promote continuous improvement and safer practice. • **Regular MDT Education Sessions**: Led regular multidisciplinary teaching sessions, using recent cases to explore learning opportunities, strengthen shared understanding, and embed consistent clinical standards across teams. • **SBL Element 4 Audit**: The audit for Q3 has been completed and demonstrated an ongoing consistently high achievement in hourly risk assessment (93.14%) and hourly peer review (96.6%)	New LMNS saving babies lives process for audit in progress. 100% pass rate for competency assessment last quarter.
Recruitment & Retention	Organised and facilitated induction for 5 new band 5 midwives. Shortlisted and held recruitment event - appointed 7 band 5 midwives and 2 band 6 midwives. Progressed 6 band 5 midwives to band 6, on completion of their preceptorship. Worked collaboratively, with nursing and AHP, to rewrite the preceptorship policy. Continued to focus on retention of staff through holding staff council, having stay conversations and offering pastoral support - feeding back themes to senior management. Supported managers with staff requiring additional support.	Band 3 posts recruited to for the antenatal clinic. Challenges surrounding lack of midwifery hours to recruit to for new students

Practice Placement Facilitator	The practice placement facilitator (PPF) role continues to support the quality, capacity and governance of students placements across the organisation. • Ongoing monitoring and improvement of placement quality through regular engagement with clinical areas students and universities • Timely identification and resolution of placement issues, which contributes to improved learner experience and patient safety • Contribution to workforce planning by supporting recruitment • Collaboration with HEIs and stakeholders to ensure alignment between education and practice placement • Supported Chinese Midwife on exchange programme to gain experience within maternity services • Collaboration with South Tees PPF to develop and implement Safe Learning Environment Charter (SLEC) Spoke • Initial talks with South tees and Trusts south of the region to develop and implement a standard approach to Practice Assessor and Practice Supervisor in house training.	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	Developed additional diaries on BadgerNet to be used for clinical work such home visits, safeguarding meetings etc and created similar diaries for the Midwifery Assistants to capture activity. Continued Badgernet training and support, working alongside the Digital Programme Team with proposal for TraKCare to be installed on an Ipad device. Conducted testing with InterSystems to enable neonates to be admitted on TraKCare via BadgerNet at birth. Ongoing work with NEWTT2 and transitional care documentation. Successfully recruited a Perinatal System Administrator.	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	MIS compliance met for year; momentum continues to ensure business as usual. Midwifery passports due to be rolled out at first mandatory training in January. Working with LMNS to look at curriculum for new educational year.	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 / Perinatal mental health	N/A	External funding sourced for Perinatal mental health midwife for women Middlesbrough.
Infant Feeding	The service was successful in achieving Stage 2 BFI accreditation. Training for staff continues and an ongoing action plan to improve BF at delivery rates.	BFI accreditation achieved last quarter. Working towards compliance for 2-day infant feeding training for staff

Appendix 8 NTHFT SCORE improvement plan

Activity	Lead	Planned Completion Date	Progress	Actual Completion Date	Update -Nov 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. 'Moments' training to be provided externally to members of staff identified from each clinical area to facilitate the work of the cultural coaches.
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/ staff trained.
Establish a staff council	Gemma Gordon (Senior Clinical Matron)	end of May 2024	Staff council established to support health and wellbeing of the workfrorce	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. Following training of staff to attend council.
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.		Group org changed finalized Oct 25. Some roles not in situ until Jan 2026 therefore to await new structure to commence.
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		Project in place go live Dec 2025.

Appendix 9. STHFT SCORE improvement 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 such as leadership, estate, culture etc)	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
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 January 2026	To be worked through with support from NHSE Team and in collaboration with North Tees & Hartlepool. Operational UHT QUAD established	Complete
Perinatal Culture and Leadership	Executive Team/QUAD	An external review of perinatal services was commissioned	Q2 2025	Report expected January 2025 and on-going programme	On Going

External Review (NHSE Team)		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.		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 ongoing programme of work MSSP commenced in June January 2025- Cultural action plan ongoing Continue newly established MNIST programme with end date June 2026.	
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	Complete

Appendix 10 Homebirth service provision

Operational Running of the Service Ensuring 24-hour availability of prompt midwifery care; verifying that staff are adequately equipped, trained, prepared, and skilled for homebirth and neonatal care; confirming access to senior multi-disciplinary support at all times; guaranteeing sufficient rest periods for staff; and clarifying transfer and extraction processes for each birth.				
Current state	**Future state**	**Lead**	**Completion date**	**BRAG**
24hr cover. If called out overnight, staff are not expected to work the following day	Remodel to reduce work commitment on day of on-call	Community matrons x2	June 2026	
Training. North: CCFv2, community skill drills, and external training scheduled for 2026. South: CCFv2, NLS every 3 years.	UHT community midwifery training package.	Practice development Midwives x2	May 2026	
Equipment provided and checked at point of delivery to home (within date of range of on-call)	Continue same process	Community matrons x2	December 2025	
On-call Homebirth staffing: North: B6 only and B5 supernumerary only South: both B5 and B6	Consistent approach for eligible midwives to attend a homebirth:	HoM x2	May 2026	
Senior support available via LWC and consultant on-call; midwifery team contactable informally.	Provision of an out of hours senior midwifery on-call	DoM	May 2026	

Service fragility Fragile service at North due to Occupational health restrictions caused by anxiety of homebirth, in particular out of guidance requests	Reduce staff anxiety for attendance at out of guidance homebirth, via training	Practice development Midwives x2	June 2026	
	Reduce staff anxiety for attendance at out of guidance homebirth via bespoke conversations and regular reviews of OH recommendations	Community matrons x2	On-going	
Guidelines Homebirth and out-of-guidance guidelines available at both sites. North: Discussed at patient safety meetings. South: Individual care plans with consultant midwife for out-of-guidance cases.	UHT Homebirth and Out of Guidance guideline	Consultant midwife	Draft February 2026	
	UHT MDT out of guidance panel	Consultant midwife	March 2026	

Care Planning and Risk Assessment:

Implementing systematic assessments of complexity and risk; adopting a personalised, multidisciplinary approach to care planning, particularly when homebirth is not recommended; maintaining effective communication with women and between teams, including ambulance services; and managing dynamic risk assessments throughout pregnancy, birth, and the postnatal period.

Current state	Future state	Lead	Completion date	BRAG
Guidance North have additional guidance for out of guidance birth, discussion forum at patient safety meetings	UHT Out of Guidance guideline and MDT 'panel'	Consultant midwife	Draft February 2026	
Care planning	UHT Out of Guidance guideline and MDT 'panel'	Consultant midwife	Draft February 2026	

North & South offer Individual discussions with community midwife, and a consultant. Friarage community midwives facilitate monthly discussions as a team if required. Consultant midwife at South Tees facilitates bespoke supportive discussions for out of guidance requests.				
External partners No dedicated forum with ambulance service	UHT Out of Guidance guideline and MDT 'panel'	Consultant midwife	Draft February 2026	
Governance and Oversight: Strengthening governance structures to provide robust organisational oversight, including executive board involvement; establishing an audit programme covering outcomes, clinical, and operational guidance to drive continual improvement; and developing comprehensive homebirth guidance with standard operating procedures for all stages of care.				
Current state	**Future state**	**Lead**	**Completion date**	**BRAG**
Homebirth dashboard Care plans discussed in individual forums or meetings.	Monthly reporting mechanism to include number of homebirths, out of guidance and escalation of concerns. UHT tracker to be developed for ease of oversight.	Community matrons x2	February 2026	
Governance process report into Quality Committee and Board of Directors. North and south report into different forums at site level	Revision of governance process as a UHT approach	DoM and Obstetric CD	March 2026	

University Hospitals Tees

Perinatal Staffing Report: Quarter 3, 2025/26

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 2.3

Report author: Stephanie Worn, Director of Midwifery

Executive director sponsor: Emma Nunez, Chief Nursing Officer

Action required: Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: Perinatal Leadership Team, Perinatal Safety Champions and Quality Oversight Group, Quality 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.

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.

Obstetric lead job planning is in development to support a university hospitals tees approach, where deemed appropriate.

Advanced neonatal nurse practitioners from North Tees will have opportunities to maintain and develop clinicals by spending time at South Tees.

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 perinatal workforce meets the standards for maternity incentive scheme.

Recommendations:

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

University Hospitals Tees Board
5 March 2026
Perinatal Staffing Report
Quarter 3, 2025/26

PURPOSE OF REPORT

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

1. 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.

2. 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.

3. 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 are below template. The registered midwifery (RM) vacancy position at the end of quarter 3 is shown in table 2, and the rates are 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 consultant determines the appropriate action to maintain safety; clinical and management (appendix1, 2 and 3).

Perinatal staffing levels, including midwifery, nursing and medical as well as activity are monitored and reviewed through daily safety huddles, during which staff discuss current workload, patient acuity and staffing allocations. These huddles provide an opportunity for the team to identify potential risks, escalate concerns and implement appropriate actions to maintain safe staffing and quality care.

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 and actual funded establishment. Clinical and non-clinical	142.75	236.16

Table 2 Midwifery vacancy position (clinical)

	North Tees and Hartlepool						South Tees					
	Budget	Oct	Nov	Dec	**3month forecast**	**6month forecast**	**Budget**	Oct	Nov	Dec	**3month forecast**	**6month forecast**
B5/6	107.3	106.16	105.14	107.98	+9.56	+9.56	174.68	176.63	174.79	174.59	175.74	175.74
B7 incl Specialist	29.42	28.02	28.58	27.62	-2.88	-2.88	38.32	41.43	41.87	41.87	44.36	44.36
Total	**136.69**	134.18	133.72	**135.6**	**+6.68**	**+6.68**	**213.0**	**218.06**	**216.66**	**216.46**	**+7.1**	**+7.1**

Table 3. Midwifery fill rates

	North Tees & Hartlepool			South Tees		
	October	Nov	Dec	Oct	Nov	Dec
Sickness rate	9.94%	8.21%	9.05%	6.40%	5.65%	5.41%
RM fill rate %	87%	84%	88%	102%	100%	100%
Midwife to birth ratio	1:25	1:19	1:17	1:20.8	1:21	1:18

Table 4 Red flags

	North Tees & Hartlepool			South Tees		
	Oct	Nov	Dec	Oct	Nov	Dec
Delayed or cancelled time critical activity	9	5	7	22	51	25
Delay between admission for induction and beginning of process.	5	0	0	3	7	7
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	8	3	5	0	0	0

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
Oct	31	62	100%	100%
Nov	30	60	100%	100%
Dec	31	62	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

	Oct	Nov	Dec
North Tees	100%	100%	100%
South Tees	100%	100%	100%

4. Obstetric staffing

South Tees hospital

The service meets full requirement established at consultant grade. There has been some pressure within the consultant workforce since October, available for on call and elective obstetric work due to Maternity leave, occupational health requirements, and sabbatical leave. This has led to 3 rota gaps in the consultant rota. The department has successfully recruited one Locum Consultant starting in February covering maternity leave vacancy.

Return to work plans have been made for the consultant on planned sick leave with intention for phased return from February and full duties from May. In addition to this 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 departmental support for enhancing perinatal medical leadership has continued with job planned dedicated time for the preterm birth and fetal monitoring consultant lead roles in place.

North Tees Hospitals
The service is at full establishment at consultant grade for Obstetrics and Gynaecology. The pressures within the consultant workforce relate to cover for the emergency work within obstetrics due to long term sickness absence, occupational health recommendations and maternity leave. This has resulted in the requirement for additional cover for one third of the emergency obstetrics and on-call sessions. The has been covered by the existing consultant workforce. Recruitment to a new consultant post advertised in quarter 2 was not successful and the recruitment plan is being reviewed. A further Consultant post with Gynaecology oncology special interest which also includes obstetric emergency on call cover has been advertised. The department has not recruited any long-term locum consultants during 2025.

5. Neonatal nurse staffing

North Tees and Hartlepool

The staffing compliance rate over quarter 3 was 82.51% in comparison to the national average for the quarter of 85.72% for SCBUs. The service used the National neonatal workforce calculator tool and have developed an action plan shared with the Neonatal Operational Delivery Network previously agreed by the Board of directors in quarter 1. 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 has been higher than previous quarter in November 2025 with 93% of shifts being over 80% occupancy, alongside the unit seeing an increase in acuity including babies requiring High Dependency care, has impacted negatively on the compliance rate in November (70%) reducing the overall quarter compliance. Qualification in Speciality (QIS) qualified staff remains at 91% due to two new starters but remains well above the national standard of 70% of registered nurses with QIS qualification. The neonatal nurse workforce has a nominated lead for preterm birth.

South Tees Hospitals
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, 100% compliance had not been achieved on some shifts due to acuity of the patients, sickness and the fact that we are staffed to 80%, despite the uplift. In times of shortages, paediatric colleagues are used to fill shifts and NHSP as required to make us compliant for the shift. The neonatal nurse workforce has a nominated lead for preterm birth

6. Neonatal Medical staffing

North Tees and Hartlepool
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 with the two trainees finishing Year 2 and joining the rota in October 2025. 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. Due to sickness this was paused but is resuming in January 2026. The neonatal lead will return from maternity leave in January 2026.

South Tees Hospitals

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

For quarter 3, 24hour anaesthetic provision was provided for both services evidenced via rotas.

APPENDICES

Appendix 1 Clinical excess activity actions
Appendix 2 NTHFT Staffing Factors and Clinical Actions
Appendix 3 STHFT Staffing Factors and Clinical Actions

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 safety huddles with Senior Clinical Matrons / Matrons/ MDT team.
- 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

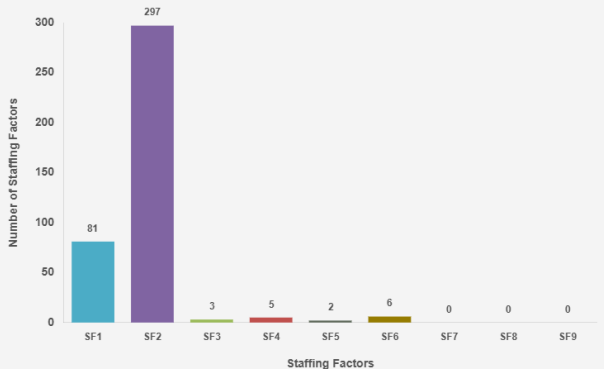
All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies. In addition, a significant number of bank hours have been used across the service to cover maternity leave and long and short-term sickness.

Appendix 2 NTHFT Staffing Factors, clinical actions and red flags

Staffing Factors

01/10/2025 to 31/12/2025

Download Results



Number of Staffing Factors

01/10/2025 to 31/12/2025

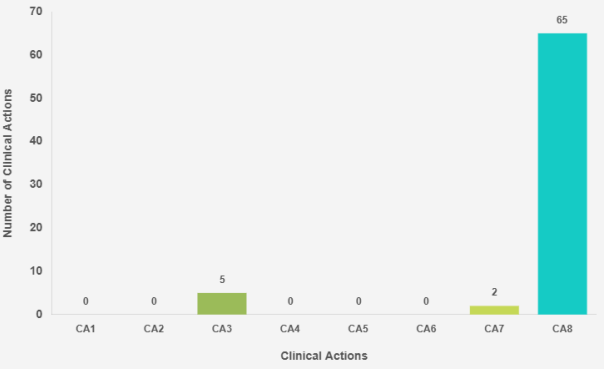
Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	81	21%
SF2	Unable to fill vacant shifts	297	75%
SF3	Staff redeployed to another area	3	1%
SF4	MW on transfer duties	5	1%
SF5	MW redeployed to another area	2	1%
SF6	Support staff less than rostered numbers	6	2%
SF7	More than 3 band 5 MWs on duty	0	0%
SF8	No Band 7 Coordinator available	0	0%
SF9	Coordinator taking AN/PN care	0	0%
TOTAL		394	

Clinical Actions

01/10/2025 to 31/12/2025

Download Results



Number of Clinical Actions

01/10/2025 to 31/12/2025

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Decline in-utero transfer	0	0%
CA2	Delay in accepting transfers	0	0%
CA3	Delay in commencing IOL (as per Trust guidelines)	5	7%
CA4	Delay/cancel planned procedures e.g. ECV, Ferrinject, cervical suture	0	0%
CA5	Delay in transfer of cases to theatre (perineal repair, MROP)	0	0%
CA6	Delay Elective LSCS > 24hrs	0	0%
CA7	Delay admissions for IOL	2	3%
CA8	Delay in ongoing IOL/ARM	65	90%
TOTAL		72	

Management Actions

01/10/2025 to 31/12/2025

Download Results

Number of Management Actions

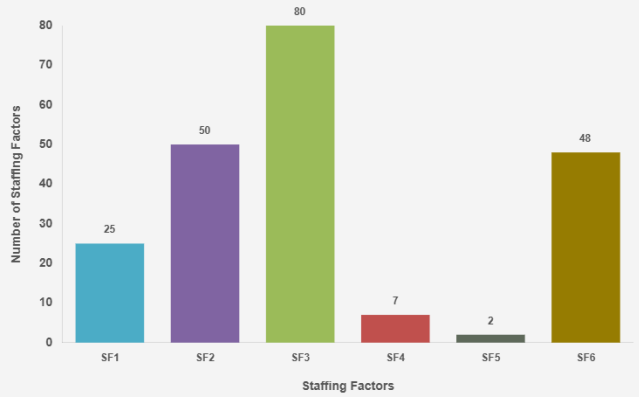
01/10/2025 to 31/12/2025

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	91	97%
MA2	Redeploy staff from community	2	2%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	1	1%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist MW working clinically	0	0%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	0	0%
MA10	Maternity unit on Divert	0	0%
MA11	Home Birth Service suspended	0	0%
TOTAL		94	

Appendix 3 STHFT Staffing Factors, clinical actions and red flags

Staffing Factors
01/10/2025 to 31/12/2025
Download Results

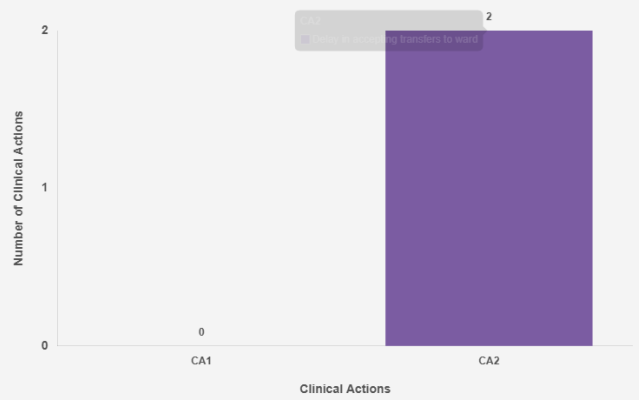


Number of Staffing Factors
01/10/2025 to 31/12/2025
Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence	25	12%
SF2	Unexpected support staff absence	50	24%
SF3	Unable to fill vacant shifts	80	38%
SF4	Midwife redeployed to other area	7	3%
SF5	Staff on transfer	2	1%
SF6	No ward clerk on duty	48	23%
TOTAL		212	

*The % is rounded to nearest whole number

Clinical Actions
01/10/2025 to 31/12/2025
Download Results

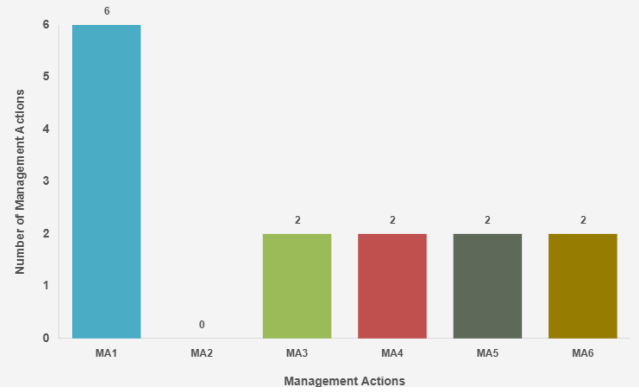


Number of Clinical Actions
01/10/2025 to 31/12/2025
Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay IOL	0	0%
CA2	Delay in accepting transfers to ward	2	100%
TOTAL		2	

*The % is rounded to nearest whole number

Management Actions
01/10/2025 to 31/12/2025
Download Results



Number of Management Actions
01/10/2025 to 31/12/2025
Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	6	43%
MA2	Redeploy staff from training	0	0%
MA3	Staff unable to take allocated breaks	2	14%
MA4	Manager working clinically	2	14%
MA5	Specialist MW working clinically	2	14%
MA6	Source staff from bank	2	14%
TOTAL		14	

*The % is rounded to nearest whole number

People Committee

27 January 2026 & 24 February 2026

Connecting to: University Hospitals Tees - Board

Chair of Committee: Mark J 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.

Sickness Absence remains elevated and off-trajectory, with UHT sickness at 6.7%, significantly above the level required to achieve the 1% reduction target for 2025/26. The sustained pressure is affecting safe staffing, financial controls, and operational delivery. Registered nursing sickness at South Tees has risen further to 10.98%, illustrating the scale of the challenge. The Committee sought clear assurance that leadership has a grip on the cultural and performance factors driving continued high absence levels and that decisive action is being taken to reverse the trend.

Workforce Planning, Financial Challenges, and Assurance Mechanisms. Committee requested strengthened, prospective assurance following NHSE/ICB feedback identifying "a significant gap… between planned WTE and financial targets", emphasising that assurance must operate throughout the workforce-planning and financial-modelling cycle rather than retrospectively. Such assurance should demonstrably inform decisions on organisational restructuring, talent management, and the prioritisation of critical human-capital resources, and must ensure that long-term strategic oversight is protected from operational interference.

GMC Survey Report Trainer survey ranking has fallen sharply at North Tees & Hartlepool (75/220 → 185/220 nationally). South Tees has also deteriorated. Committee was concerned with the report indicating the formation of the group structure and the changes this has brought may be reflected within the results and could influence the feedback for both Trusts. There is a broader governance issue for the Board where a group operating model - particularly under regulatory or process-driven reporting requirements - may create

imbalances in how performance is presented, resulting in one site or statutory body appearing comparatively underperforming despite shared systems, leadership structures, and workforce dynamics.

Mandatory Training Trust-wide compliance remains below the 90% threshold, with Resuscitation (72.56%) and Moving & Handling (81.02%) posing the highest clinical risk. Variation in training cycles between sites is contributing to persistent gaps. Resuscitation training has been escalated to Quality Assurance Committee for oversight.

Staff Survey (data embargoed) Results of the Staff Survey were discussed, noting the information currently remained under embargo.

Safer Staffing Bi-Annual Establishment Review The review reported *"a significant shortfall in Registered Nurse staffing relative to Safer Nursing Care Tool (SNCT) recommendations and budget"*. However, the data highlighted notable discrepancies between current budgeted establishments, actual staffing levels, and the recommendations derived from the SNCT tool, alongside professional judgement assessments. Triangulated with QAC for additional assurance.

Locum Consultant Governance Risk Within confines of LPP, the committee was assured with the planned actions to address this identified risk.

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.

Race and Disciplinary Cases Current cases were discussed, noting the ongoing monitoring of case progression and outcomes to provide assurance.

Emerging Statutory Requirements. The Committee noted the need for further work in relation to the Employment Rights Act 2024, the Immigration White Paper consultation—particularly its implications for Bands 2–3 and the sustainability of future international recruitment pipelines—and the organisational changes required to ensure compliance with the For Women Scotland Ltd v The Scottish Ministers Supreme Court ruling, including the provision of unisex facilities. The Committee also noted that the implications of the latter had been triangulated with the Resource Committee

Freedom to Speak Up STHFT saw an increase in concerns, with inappropriate behaviours and organisational change as leading themes.

Gender Pay Gap Reports. NTHFT saw a negative increase in the median and mean pay gaps, while STHFT saw mixed movement. The People Committee formally approved the Gender Pay Gap Reports for NTHFT and STHFT.

Resident Doctors 10 Point Plan. Committee received an update on required improvements to rest facilities, on-call parking, annual leave processes, and payroll accuracy, noting the importance of ensuring that enhancements made for resident doctors

do not inadvertently disadvantage other staff groups or create inequities across the wider workforce.

GMC Survey Report General Surgery at South Tees lacks an educational lead. Anaesthesia and Critical Care at North Tees require continued monitoring following concerns raised by the School.

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

Talent Management Plan. The Committee endorsed the final plan, noting alignment with national guidance and integration of leadership development, apprenticeships and talent pools. The BAF action was formally closed.

Maternity - Cultural Improvement. The Committee noted positive work within maternity, including the development of a culture dashboard, strengthened multi-professional leadership, and OD-supported improvement cycles.

Safer Staffing Report. Nurse turnover reduced across both Trusts, and NTHFT saw a fall in sickness absence. Committee was assured with the Group approach to collaborating on Band Two to Band Three pipeline programmes to address Healthcare Support Worker (HCSW) vacancies and above-establishment recruitment of newly qualified nurses was proceeding as planned.

Anti-racism. An anti-racism charter has been developed, with Board training planned and affinity groups being established to support inclusive culture change

Mandatory Training Improvements. New UHT-wide dashboard enhances visibility and accountability. Advanced resuscitation course expansion planned for March is expected to improve compliance.

Recognition IMPACT Framework. A unified, evidence-based recognition framework has been developed, responding directly to staff feedback and supporting cultural improvement. The Committee sought assurance that the management of poor performance is being applied consistently and proportionately alongside this framework, ensuring that recognition and performance management operate as coherent, aligned elements of the overall people strategy rather than in isolation.

Recommendations:

Sickness absence remains a significant and sustained organisational risk. The Board is asked to consider a more cultural and performance-based assessment of the underlying causes, recognising that failure to reduce sickness absence has direct implications for

financial stability, workforce sustainability, and the quality and safety of patient care moving forward.

Performance, culture and continuous improvement remain closely linked, and the Board is challenged to consider whether the management of poor performance is sufficiently robust and consistently applied to shape the cultural expectations required for sustained improvement. The concern is that without a firmer, more systematic approach to underperformance, the organisation may struggle to embed the behaviours, standards and accountability needed to meet its continuous-improvement and financial-efficiency requirements, limiting the impact of wider cultural initiatives

Group Operating Model (as two statutory bodies). A broader governance risk arises within the group operating model, where regulatory and process-driven reporting requirements can create structural imbalances in how performance is presented. This may result in one site or statutory body appearing comparatively underperforming, even where systems, leadership structures and workforce dynamics are shared across the group. The Board is therefore asked to consider the implications of operating as two statutory bodies within a single group, and the potential for reporting frameworks to distort comparative performance rather than reflect underlying organisational reality.

University Hospitals Tees

Safe Staffing Monthly Report (Dec 25 data)

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 3.2

Report author: Lindsay Garcia, Group Director of Nursing, Emma Roberts, Associate Director of Nursing and Professional Workforce, Debi McKeown, Nurse Workforce Lead

Executive director sponsor: Emma Nunez, Chief Nursing Officer

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: Group People Committee

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 provides assurance on inpatient nursing staffing for December 2025. Robust processes are in place to ensure staff with the appropriate skills are deployed to meet patient

need and maintain safe care. Daily Safe Care Staffing meetings review ward acuity, dependency and occupancy, enabling timely redeployment and escalation where required. Staffing risks are actively mitigated to the lowest feasible level through agreed actions overseen by senior nursing leadership.

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.

Sickness absence at South Tees increased month on month for both registered and unregistered staff in December 2025. Registered staff sickness reached 10.98% (+1.18%) and unregistered increased to 7.41% (+0.31%) Despite this, shift fill rates remained stable, reflecting effective management of workforce pressures.

The largest variances between actual and required CHPPD were observed on Ward 9, Ward 11, Ward 25, Ward 26, Ward 31 and Ainderby, indicating potential misalignment between staffing and patient acuity. The financial ledger reports a vacancy position of 121.78 WTE for HCSWs. The highest number of Datix incidents relating to staff shortages and skill mix were reported in Ward 9, Ward 12, and Middlesbrough Holgate PCN.

At North Tees, NHSP fill rates declined for registered nurses from 79.5% in November 2025 to 70.9% in December 2025 and a similar decline for unregistered staff, from 86.1% to 79.5%. However, NHSP fill rates declined for registered and unregistered staff (81.7%, -2.2%; 86.1%, -0.3%). Nurse turnover also reduced for both groups.

At North Tees the overall CHPPD variance for December 2025 is +0.05, with variances >1 identified in multiple wards, including cardiology, respiratory, gastroenterology, stroke, orthopaedics/frailty and endocrinology. These areas align with findings from the biannual nurse establishment review that was presented to Board in July 2025, reinforcing the need for further establishment reviews as CSU service delivery models are developed.

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.

Across South Tees, the average proportion of planned nurse shifts filled in December 2025 decreased slightly to 96.5%. Staff turnover remained stable, with small month on month reductions in both registered and unregistered staff (registered: 4.41%, -0.26; unregistered: 7.72%, -0.11). Overall turnover remains significantly lower than in December 2024, indicating continued year on year improvement in workforce retention.

Total nursing sickness and absence at North Tees has reduced from 7.2% in November 2025 to 6% in December 2025. Total nursing turnover has reduced at North Tees from 6.4% in November 2025 to 5% in December 2025. At North Tees, the Band 3 HCSW vacancy position across the in-patient wards and clinical departments has reduced to 35.35wte in December 2025 from 59.2wte in November 2025.

The Band 2–3 pipeline programme remains in place, supporting trainee HCSWs to achieve the required competencies through a 12month fixed term post. Centralised recruitment continues, with the next recruitment centre scheduled for February 2026.

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

Staff sickness at South Tees continues to be actively managed through Health Improvement Plans, with twice-daily Safe Care reviews helping to mitigate the impact of sickness and increased patient acuity on CHPPD compliance. Workforce oversight enables timely redeployment to maintain safe staffing levels.

HCSW vacancies are being addressed through centralised recruitment, with new starters having commenced in December 2025 and further cohorts planned for February 2026. The registered nurse over-establishment position (17.57 WTE) is proactively managed through Workforce Assurance meetings and vacancy controls to ensure alignment with approved posts and statutory reporting.

Temporary staffing use remains demand-led, with redeployment prioritised over NHSP. Weekly and monthly workforce reviews support triangulation of sickness, turnover and establishment data.

At North Tees, the Band 5 RN vacancy position reduced to 18.5wte in December 2025 from 33.18wte in November 2025, with further reductions occurring in January 2026 following appointment of the January NQN cohort and planned over recruitment. Full assurance is in place that all Trust home NQNs have been appointed.

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 December 2025.

Board of Directors
5 March 2026
Nurse Monthly Safer Staffing Report: February 2026

This exception report provides the Board of Directors with the monthly University Hospitals Tees nursing safer staffing position across all in patient areas. The report provides the Board of Directors 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. All CSUs 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 workforce assurance meetings at both sites have full participation from all appropriate senior nurses including Heads of Nursing, Clinical Matrons and Service Managers to ensure all decision making is appropriate.

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.

During December 2025, several areas at South Tees reported fill rates below 80% for Registered Nurses, primarily due to ***patient acuity levels*** and ***staff sickness***:

<u>Day Shifts:</u>

- Zetland - Stroke Rehabilitation
- Maternity Centre Friarage
- PCCU – Paediatric Critical Care
- Cardio HDU – Cardio High Dependency
- CICU – Cardio Intensive Care
- Victoria Ward – Friary Hospital
- Ward 11 – Older Persons Medicine

Night Shifts:

- Maternity Centre Friarage
- Cardio HDU – Cardio High Dependency
- CICU – Cardio Intensive Care
- Ward 25 – Hip/Femur Unit
- Ward 29 - Cardiology

In addition, the following areas reported fill rates below 80% due to a ***reduced elective programme*** during the reporting period:

- Ward 22 – Paediatric Surgery (Days)
- Ward 27 – Elective Orthopaedics (Days and Nights)

These figures highlight the impact of clinical demand and service changes on staffing fill rates and support ongoing efforts to align workforce planning with patient care needs.

In December 2025, the following areas at North Tees and Hartlepool presented a fill rate of less than 80%

- Low RM and HCSW fill rate on delivery suite and ward 22 due to vacancies – have been appointed into but not taking up posts till March 2026. NQM cohort from September 2025 remain supernumerary in December 2025.
- Low RN fill during the day on 26 and 42 due to sickness and redeployment off ward 42
- Low HCSW fill rate during the day on SCBU, Maternity, 28 and 32.
- High HCSW fill rate during the night on EAU, Maternity and 28.
- High HCA fill during the day and night in Care of the Elderly due to high enhanced care needs, and Respiratory due to high acuity needs.

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		**December 2025**
	RN/RMs (%) Average fill rate – DAYS	87.9%
	HCA (%) Average fill rate – DAYS	90.4%
	NA (%) Average fill rate – DAYS	100.%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	92.3%
	HCA (%) Average fill rate – NIGHTS	101.5%
	NA (%) Average fill rate – NIGHTS	100%

	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**96.5%**

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

Overall, Ward Fill Rate		**December 2025**
	RN/RMs (%) Average fill rate – DAYS	86.9%
	HCSW (%) Average fill rate – DAYS	89.4%
	NA (%) Average fill rate – DAYS	100%
	SNA (%) Average fill rate – DAYS	100%
	RN/RMs (%) Average fill rate – NIGHTS	98.5%
	HCSW (%) Average fill rate – NIGHTS	108.5%
	NA (%) Average fill rate – NIGHTS	100%
	SNA (%) Average fill rate – NIGHTS	100%
	Total % of Overall planned hours	**96.5%**

- **Nurse Sensitive Indicators**

At both South Tees and North Tees, safe staffing was not directly referenced in any concluded PSIRF reviews in December 2025. Future reports will provide nurse sensitive indicators in line with patient safety and quality metrics.

- **Red Flags Raised through Safe Care Live**

During December 2025, a total of **10** staffing-related red flags were raised at South Tees. These included:

- **6** flagged as *Shortfall in Registered Nurse (RN) time*
- **1** flagged as *PCN – Shortfall HCA*
- **2** flagged as *Less than 2 RN's on shift*
- **1** flagged as *Missed intentional rounding*

Documented resolutions are available via the SafeCare log, providing assurance that appropriate action was taken following escalation.

To support timely resolution and oversight, weekly reminders are issued by the Workforce Assurance Team to Clinical Matrons, prompting review and closure of any resolved red flags.

During December 2025, a total of 7 staffing-related red flags were raised at North Tees and Hartlepool. 6 flags were raised for a Shortfall in Registered Nurse time, and one flag was raised for having 2 RN on duty.

- **5** flagged by Critical Care – due to a shortfall in RN due to acuity levels. (internal escalation plans followed to maintain safe staffing)
- **1** flagged by ward 27 due to a shortfall in RN – mitigation and appropriate redeployment in place via daily safe staffing meeting.
- **1** flagged by ward 41 due to having only 2 RN on duty – one NA also on duty and mitigation in place with Ward Manager working clinically.

- **Datix/In-Phase Submissions**

At South Tees during December 25, there were 138 Datix submissions relating to staffing. This is a 2.8% reduction in comparison month on month. Staff are encouraged to Datix any staffing related issues which are reviewed and discussed as part of workforce assurance and governance meetings. The majority of Datix submissions, highlight a reduction in staffing on Ward 9, Ward 12 and Middlesbrough Holgate PCN. All shortages raised were managed through the Safe Care process throughout December 25.

At North Tees, in December 2025 there was an increase of in-phase reports relating to nurse staffing, total of 19 were submitted compared to 3 in November 2025. 12 of the reports were submitted from the medical wards and departments due to high levels of acuity and several additional surge beds being opened. 6 reports were submitted from the Maternity teams due to internal escalation being put in place to manage the safe staffing of the wards/teams. Safe staffing plans maintained via actions from the safer staffing meetings in December 2025. Both sites safe staffing meetings have aligned.

- **Vacancy & Turnover**

The vacancy and turnover position across South Tees remain stable. Targeted over-recruitment of newly qualified nurses has supported the safe opening of the winter ward. A paper was submitted and approved by the Executive Team regarding the planned intake of newly qualified nurses in January 2026.

As per the South Tees financial ledger for December 2025, vacancies show as –17.57 WTE (RN and RM combined). The vacancy position as per the financial ledger indicates a vacancy of 121.78 WTE for HCSW's

The third centrally coordinated recruitment campaign for Clinical Support Workers was completed in December, resulting in the successful recruitment of 29 applicants. This cohort is expected to support a reduction in Clinical Support Worker vacancies and enhance workforce resilience, thereby contributing to the maintenance of safe staffing levels across services.

A fourth centrally coordinated recruitment cohort is planned, with interviews scheduled for February 2026. This planned recruitment activity will further support vacancy management, mitigate reliance on temporary staffing, and strengthen safer staffing arrangements moving into winter and early 2026.

At North Tees, the Band 5 RN vacancy position reduced to 18.5wte in December 2025 from 33.18wte in November 2025, with further reductions occurring in January 2026 following appointment of the January NQN cohort and planned over recruitment. Full assurance is in place that all Trust home NQNs have been appointed.

At North Tees, the Band 3 HCSW vacancy position has reduced to 35.35wte in December 2025 from 59.2wte in November 2025 due to a proportion of the vacancies being offset by the appointment of B2 Trainee HCSWs. The Band 2 to band 3 pipeline programme remains in place and is supporting the new trainee HCSW's to gain the required clinical experience and academic requirements to move into a B3 position within a 12-month fixed term post. Centralised advertising and recruitment remain in place for this staff group with the next recruitment centre planned for February 2026.

- **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 December 2025 can be reviewed in Appendix 2.

Table 2 South Tees site:

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
October 25	9.21	8.94	-0.27
November 25	9.26	9.26	0.00
December 25	9.08	8.80	-0.28

During December 25, data indicates that 14 inpatient areas exceeded the required average for CHPPD. Areas falling below the required CHPPD levels were primarily impacted by elevated staff sickness rates and increased patient acuity. To mitigate these challenges, twice-daily Safe Care reviews continue to support the planning and redeployment of staff into unfilled shifts.

The greatest variance between required and actual CHPPD (<3) was observed on Ward 9, Ward 11, Ward 25, Ward 26, Ward 31 and Ainderby.

- **Ward 9:** The ward carried 2.32 WTE CSW vacancies during December. These posts were successfully appointed through the central CSW recruitment process, with new starters due to commence in late January or early February 2026. Staff sickness increased compared with November: registered staff sickness rose to 9.5% (+4%), and unregistered sickness to 5.4% (+3.6%).

- **Ward 11:** Experienced a significant rise in registered staff sickness, increasing from 3.3% in November to 14.4% in December. Unregistered sickness also increased from 6.7% to 10%. The ward held a 1.0 WTE CSW vacancy, which was appointed to through the December central interview process

- **Ward 25:** Registered staff sickness remained stable at 13.5%. Unregistered sickness reduced by 6.6% to 22.6%, though levels remain high. Temporary staffing was required to maintain safe staffing levels, particularly for patients requiring enhanced supervision due to falls risk.

- **Ward 26:** Reported month on month increases in sickness: registered staff sickness rose by 2% to 6.8%, and unregistered sickness increased by 5.1% to 18%. CHPPD variance was largely driven by high acuity and increased demand for falls watch cover throughout December.

- **Ward 31:** Registered staff sickness increased marginally by 0.9% to 13%, while unregistered sickness rose more markedly from 9.1% to 18.4%. Elevated patient acuity and the need for falls watch support contributed to CHPPD falling below required levels.

- **Ainderby:** Registered staff sickness increased slightly by 0.5% to 4.7%, while unregistered sickness rose by 4.7% to 12.8%. Higher patient acuity, including 1:1 support needs, is reflected in the increased number of NHSP CG47 Level 3 shifts requested.

Wards with CSW vacancies are anticipated to see an improvement in CHPPD following completion of their supernumerary periods.

The reasons for NHSP bookings were consistent with the staffing challenges outlined above **(Appendix 3).**

Table 3 North Tees site:

	Required CHPPD (Average)	Actual CHPPD (Average)	Variance
October 2025	9.04	8.84	-0.21
November 2025	9.03	8.87	-0.16
December 2025	8.97	9.02	+0.05

In December 2025, the total variance is in a slightly positive position. The areas highlighting a higher variance level (>1) at North Tees, and thus, not delivering the required CHPPD were;

- Acute Cardiology Unit
- Ward 24 - Respiratory

- Ward 25 - Respiratory
- Ward 26 - Gastroenterology
- Ward 27 - Gastroenterology
- Ward 36 - Endocrinology
- Ward 32 – Orthopaedics/Frailty
- Ward 41 - Stroke

Many of 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.

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. The proposed over recruitment of NQNs from the January 2026 cohort will support this position.

The presentation of monthly workforce rostering KPI's and metrics now allows for more detailed correlation between various metrics and planned and actual CHPPD. The monthly reports are used in the monthly workforce assurance meetings to provide a clear identification of areas with low or no compliance and support discussion for planned actions to improve positions.

- **Temporary Staffing**

At South Tees, demand for nursing and midwifery bank and agency staffing in December 2025 decreased by **18%** compared to December 2024. Additionally, bank filled hours declined by **14%** over the same period. These trends suggest that ongoing initiatives to optimise staff deployment are delivering measurable results.

Nursing agency use continues to be minimal at South Tees. In December 2025, a total of **176** nursing agency hours were booked; this is a reduction of 67 hours month on month.
113 nursing agency hours in December 25 were utilised within Friarage Theatres, 40 hours in Cardio Theatres and 23 hours in Orthopaedic Theatres.
ODP agency usage remains present within the Trust. In December 2025, a total of **679** hours were utilised across the following areas:

- **Friarage Theatres:** 118 hours
- **Cardio Theatres:** 94 hours
- **Orthopaedic Theatres:** 467 hours

This reflects both a yearly and month on month decrease.

The current directive from the vacancy control panel is to review agency staffing requirements for the FHN site in January 2026 and the JCUH site in March 2026. All agency usage is subject to appropriate governance and has been approved through the vacancy control panel.

An exit strategy is in place, aligned with the training matrix and competency progression of NQN's and ODP's.

In December 2025, bank staffing spend decreased by £122,593 (**-10%**) compared to December 2024, reflecting improved workforce stability. Conversely, agency staffing spend for nursing increased by £4,257 year on year while agency ODP spend saw a reduction of £9,214.

The overall fill rate for bank and agency staffing in December 2025 was **76%,** representing a **9%** month on month reduction. This decline aligns with the typical seasonal pattern, where fill rates routinely fall during December due to reduced workforce availability.

At North Tees and Hartlepool, currently all temporary staffing spends (NMAHP, Medical and Dental, Health Care Scientist and Admin and Clerical) is reviewed on a monthly basis via the Temporary Staffing Focus Group (TSFG). The summary for December 2025 reflects all staff groups.

Agency spend YTD is £1,503k lower than previous year

- Agency spend is still lower than in any month last year and has remained consistent with prior months
- After reductions in Pharmacy agency use, Cell Path insourcing now makes up 60% of the remaining agency spend

Bank spend YTD is £3k higher than previous year but is down £31k compared to November. Of which £50k is attributable to in nursing.

Overtime spend YTD is £335k lower than previous year

- M9 spend is consistent with prior month

Key Priorities

Following the Group workforce assurance meeting in November, priorities identified for alignment include:

- Monthly Workforce Assurance Group
- Daily Safe Care and safe staffing processes including merge of both sites SOP's and policies
- Workforce Assurance business cycle reviewed for both sites with draft of 25/26 plan

- Nursing establishment review cycle to align SNCT collection and Board reporting dates and data validation processes as per NHSE requirements.
- Combined work across both sites in relation to the National Nursing and Midwifery job profiling review.
- Attendance and contribution to the Regional Workforce Planning for Better Care Forum February 2026.

Recommendations

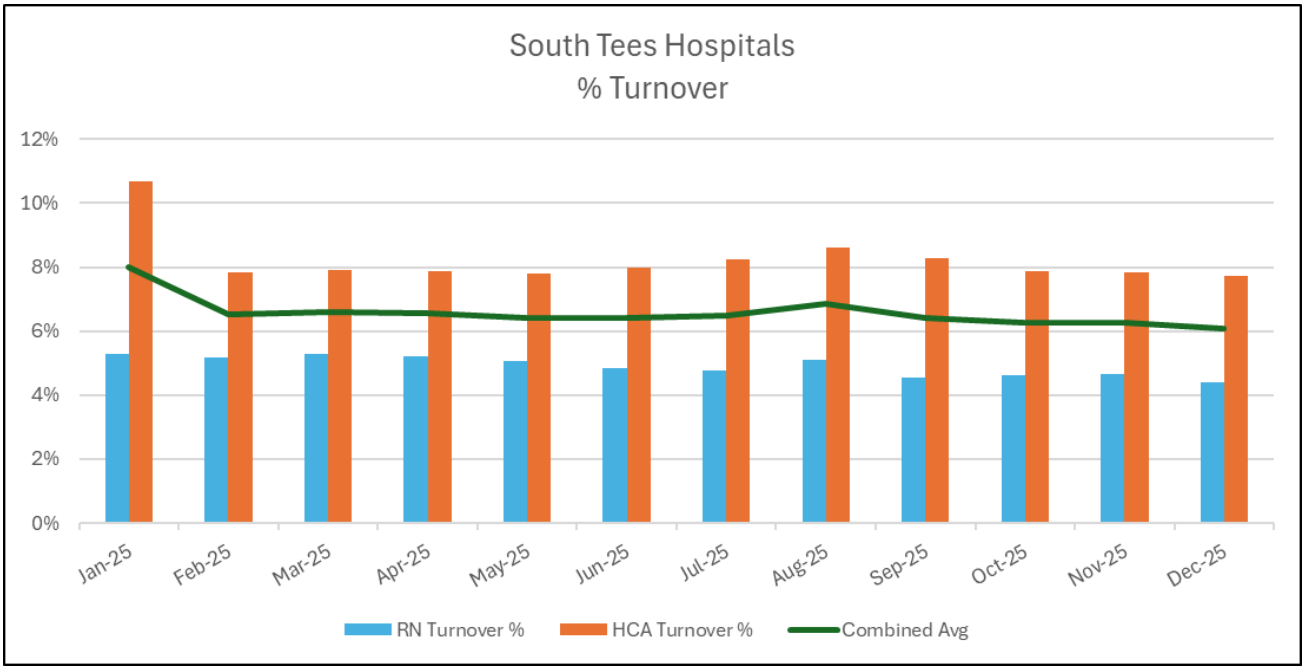
The Board is asked to read the content of this report and to note the progress made across both sites in relation to developing and retaining the nursing workforce.

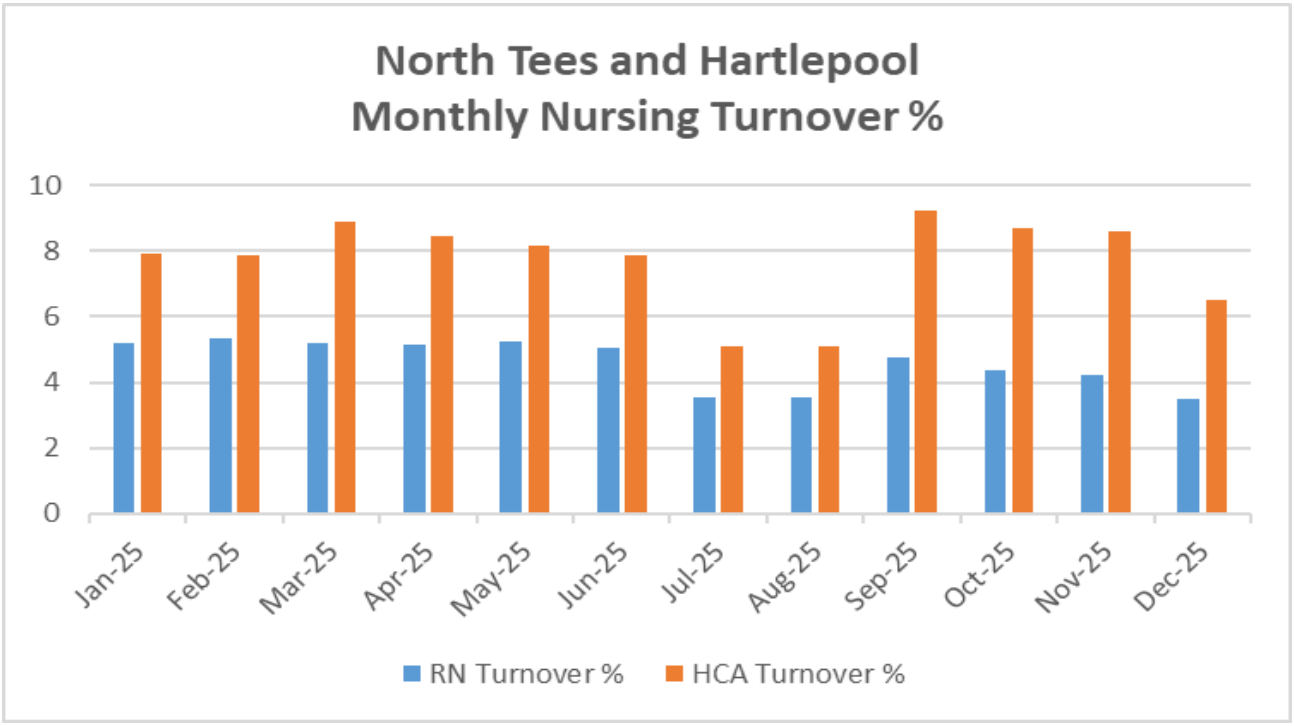
The Board are asked to note the assurance presented that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

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 December 2025





Caring Better Together

Appendix 2

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

Ward	Average of Required CHPPD	Average of Actual CHPPD	Variance
Ainderby Ward	11.53	6.99	-4.54
CADU	3.17	1.96	-1.21
Cardio HDU	9.94	13.65	3.71
Cardio MB	5.95	9.42	3.46
CCU JCUH	15.05	12.39	-2.65
CDU FHN	8.11	7.96	-0.15
CICU	23.24	24.12	0.88
Critical Care	19.84	27.20	7.37
Friary Ward	8.16	7.42	-0.74
Gara Ward	7.21	12.19	4.99
NNU	12.18	12.99	0.81
PCCU	14.84	20.71	5.87
Romanby Ward	7.66	6.27	-1.39
Rutson Rehab Ward	8.18	7.12	-1.06
Spinal Injuries Ward	10.81	8.13	-2.68
Tocketts Ward	7.62	6.11	-1.50
Ward 01	8.25	7.84	-0.41
Ward 02	6.45	4.75	-1.70
Ward 03	7.37	4.89	-2.48
Ward 04	8.34	6.46	-1.88
Ward 05	6.11	5.45	-0.66
Ward 06 - Short Stay Elective	5.15	6.02	0.87
Ward 07	4.45	4.02	-0.44
Ward 08	5.25	4.94	-0.31
Ward 09	8.75	4.43	-4.32
Ward 11	9.33	6.11	-3.22
Ward 12	9.03	6.18	-2.85

Ward 14	6.13	5.48	-0.64
Ward 21	9.04	11.34	2.30
Ward 22	13.12	17.42	4.30
Ward 24	7.74	7.84	0.10
Ward 24 HDU	11.92	20.38	8.46
Ward 25	9.70	6.39	-3.31
Ward 26	9.73	6.33	-3.40
Ward 27	4.47	6.61	2.14
Ward 28	9.03	6.11	-2.92
Ward 29	5.62	4.93	-0.69
Ward 31	9.94	6.61	-3.33
Ward 32	6.98	5.92	-1.06
Ward 33	8.48	6.63	-1.84
Ward 34	7.64	5.63	-2.01
Ward 35	8.02	8.70	0.68
Ward 36	6.16	4.84	-1.31
Ward 37	11.17	8.90	-2.27
Zetland Ward	8.40	6.82	-1.58
Grand Total	**9.08**	**8.80**	**-0.28**

North Tees Average CHPPD Breakdown by Ward (December 2025):

Unit Previous month	Required CHPPD	Actual CHPPD	CHPPD Variance
Acute Cardiology Unit	6.97	5.26	-1.71
Critical Care North Tees	21.75	26.86	5.11
Elective Care Unit	4.10	12.29	8.19
Emergency AMB	7.71	9.08	1.37
Neonatal Unit	10.69	14.96	4.26
Paediatrics	9.86	10.45	0.59
SDU	9.11	12.74	3.63
Ward 24 (Respiratory)	9.35	6.26	-3.08
Ward 24 RSU (Respiratory)	13.25	10.01	-3.24
Ward 25 (Respiratory)	8.92	6.68	-2.24

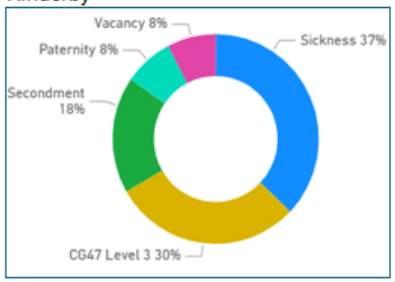
Ward 25 RSU (Respiratory)	12.18	9.09	-3.09
Ward 26 (Gastroenterology)	7.70	5.75	-1.95
Ward 27 (Gastroenterology)	7.57	6.12	-1.45
Ward 28 (Surgery)	6.57	6.09	-0.48
Ward 31 (Surgical Observation Unit)	7.97	8.87	0.90
Ward 32 (Fragility Fracture)	8.46	7.84	-0.63
Ward 33 (Orthopaedic & Spinal)	6.58	7.14	0.56
Ward 36	9.19	7.09	-2.10
Ward 37	6.16	6.06	-0.10
Ward 38	7.56	7.76	0.20
Ward 40 (Acute Elderly)	8.66	7.33	-1.32
Ward 41 (Stroke Unit)	7.97	6.41	-1.56
Ward 42 (Elderly Rehabilitation)	7.90	7.26	-0.64
Average	**8.97**	**9.02**	0.05

Appendix 3

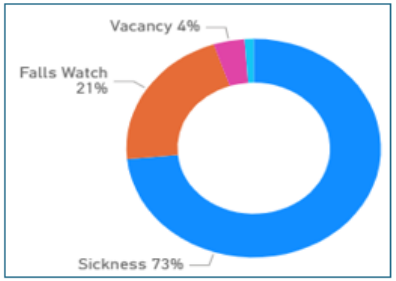
NHS
University Hospitals Tees

Analysis of NHSP booking reasons in South Tees areas with highest CHPPD variance (December 2025)

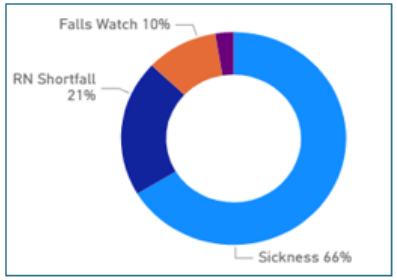
Ainderby



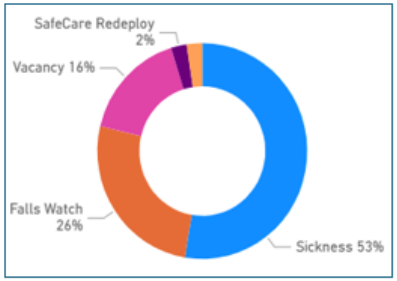
Ward 11



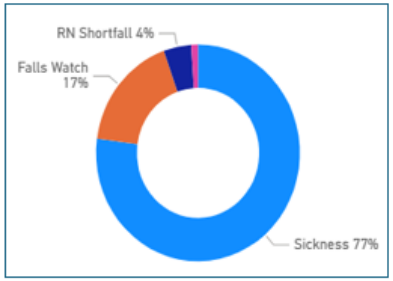
Ward 25



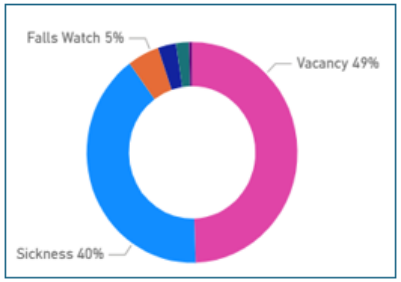
Ward 26



Ward 31



Ward 9



University Hospitals Tees

Safe Staffing Bi-Annual Establishment Review

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 3.3

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

Executive director sponsor: Emma Nunez, Chief Nursing Officer

Action required: Approval

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:

Choose an item.

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 Trust may face difficulties in attracting and retaining competent staff, leading to critical workforce gaps in key clinical services. This could adversely impact service delivery, patient safety, and the efficient use of resources.

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 planned over-recruitment of newly qualified nurses will provide additional resilience within the workforce and support the staffing gaps identified through the SNCT and professional judgement data collection. In most instances this is already highlighted in the 'actual WTEs'.

The data demonstrates consistency in patient scoring across most acuity levels, with a notable shift in the classification of patients previously recorded as Level 2, now coded more appropriately as Level 1c. This change reflects improved accuracy in identifying patients requiring enhanced observations, aligning with the updated SNCT descriptors.

Professional Judgement (PJ) templates have been agreed with the Deputy Director of Nursing and Heads of Nursing. In addition to patient acuity and dependency, several contextual factors are considered when determining staffing requirements. This blended approach ensures that staffing establishments are not only data-driven but also contextually appropriate, reflecting the unique operational demands of each ward.

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

Compliance with daily data collection has continued to improve throughout the period, providing increased assurance regarding data validity and the robustness of the overall SNCT results.

Looking ahead to the next data collection period in March 2026, a peer review process will be undertaken by the Workforce Lead and Therapeutic Care Lead. This will focus specifically on patients recorded as Level 1c and 1d, to ensure assessments are accurate and consistent. Additionally, the data will be cross validated with MIYA and ETOC systems to confirm that the number of patients recorded during the collection period aligns with electronic patient records.

Recommendations:

The Board of Directors is asked to note the contents of this report and to be assured that robust systems and processes are in place to ensure that registered nurse staffing levels are sufficient to support the delivery of safe, high-quality patient care across the Trust.

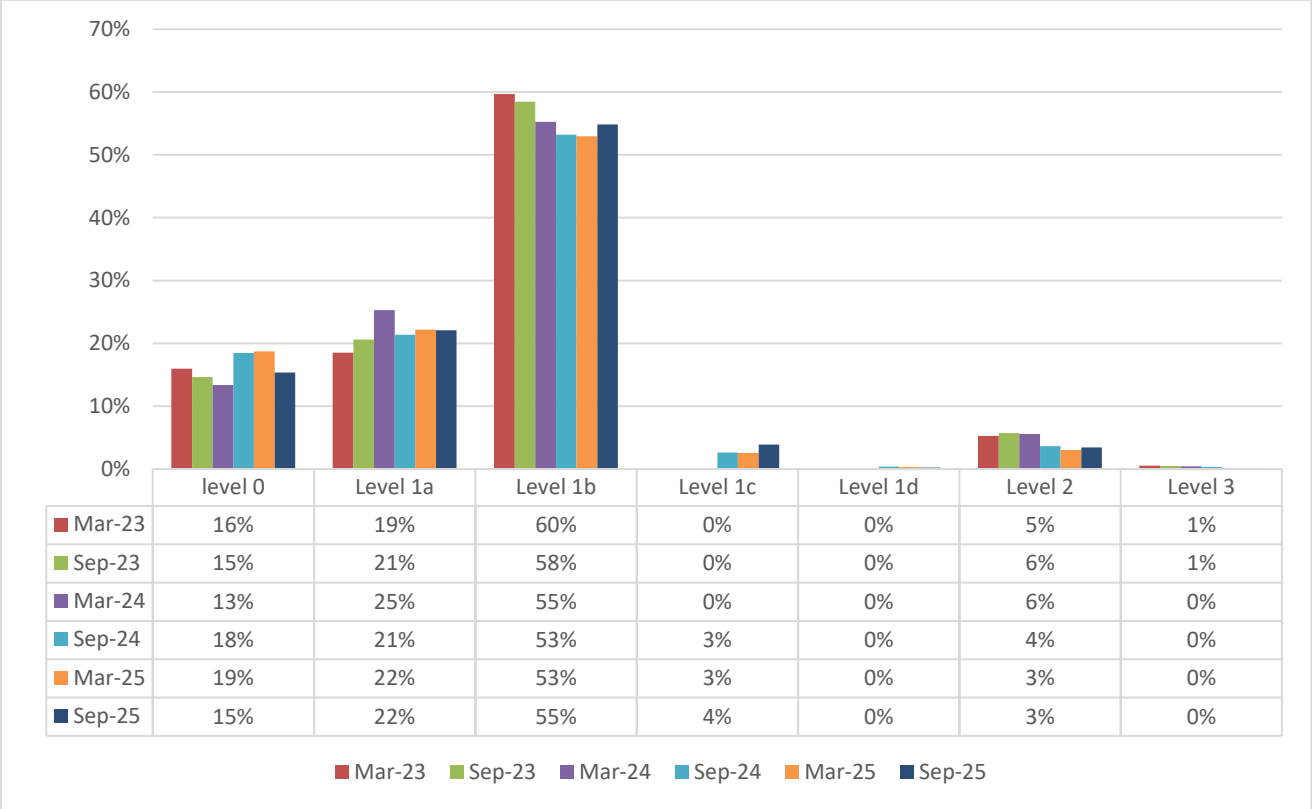
South Tees Hospitals NHS Foundation Trust Safer Staffing Bi-Annual Establishment Review

1. Establishment Review September/October 25

1.1 SNCT Patient Acuity Levels Trust Wide

The figure below shows a summary of the overall patient acuity levels for the Trust as a percentage for all areas collected over 30 days in September/October 2025 compared to previous reports from March 2023.

Figure 1: Trust Acuity Levels by total %



	level 0	Level 1a	Level 1b	Level 1c	Level 1d	Level 2	Level 3
Mar-23	16%	19%	60%	0%	0%	5%	1%
Sep-23	15%	21%	58%	0%	0%	6%	1%
Mar-24	13%	25%	55%	0%	0%	6%	0%
Sep-24	18%	21%	53%	3%	0%	4%	0%
Mar-25	19%	22%	53%	3%	0%	3%	0%
Sep-25	15%	22%	55%	4%	0%	3%	0%

The data demonstrates consistency in patient scoring across most acuity levels, with a notable shift in the classification of patients previously recorded as Level 2, now more appropriately coded as Level 1c. This change reflects improved accuracy in identifying patients requiring enhanced observations, aligning with the updated SNCT descriptors.

Looking ahead to the next data collection period in March 2026, a peer review process will be undertaken by the Workforce Lead and Therapeutic Care Lead. This will focus specifically on patients recorded as Level 1c and 1d, to ensure assessments are accurate and consistent. Additionally, the data will be cross validated with MIYA and ETOC systems to confirm that the number of patients recorded during the collection period aligns with electronic patient records.

1.2 Headroom Review

When planning ward staffing, it is essential to incorporate an uplift allowance to ensure adequate nurse availability during periods of leave. This ensures continuity of care and supports the delivery of safe, high-quality services.

At South Tees Hospitals NHS Foundation Trust, the uplift applied to ward establishments is:
Registered Nurses – 21% uplift per WTE (excluding parenting leave):

- 14% (273 hours) – Annual leave
- 3.9% (70.2 hours) – Sickness absence
- 2.0% (39 hours) – Study leave
- 1.1% (19.5 hours) – Working Day (e.g., management/non-clinical duties)

Care Support Workers – 19.7% uplift per WTE:

- 14% – Annual leave
- 3.9% – Sickness absence
- 1.8% – Study leave

This headroom calculation is specific to South Tees Hospitals NHS Foundation Trust and has been formally agreed by the Trust Board. It ensures that staffing establishments are resilient and capable of meeting planned service demands while accommodating predictable leave patterns.

1.3 Skill Mix review

The Royal College of Nursing (RCN) recommends a minimum skill mix ratio of 65:35 Registered Nurses to Clinical Support Workers. At South Tees Hospitals NHS Foundation Trust, the agreed average ratio across all inpatient areas is 60:40 Registered Nurses to Health Care Support Workers. This ratio has been established to reflect the specific needs and staffing models within the Trust.

Critical Care areas are excluded from this ratio, as they are subject to a separate staffing review aligned with the Guidelines for the Provision of Intensive Care Services (GPICS) standards.

In some less acute areas, such as specialised rehabilitation units, the ratio of Registered Nurses to Health Care Support Workers may be lower. This is due to the contribution of other roles in delivering patient care, including:

- Registered Nursing Associates (NAs)
- Assistant Practitioners (APs)
- Allied Health Professionals (AHPs)

These roles play a significant part in meeting patient needs and are considered within the overall staffing model to ensure safe and effective care delivery.

1.4 Quality Indicators

Nurse Sensitive Indicators (NSIs) are recognised as key quality metrics that are directly influenced by nursing care. At South Tees Hospitals NHS Foundation Trust, NSIs are used in conjunction with data from the Acuity and Dependency Tool to inform evidence-based workforce planning. This approach supports both the optimisation of existing services and the development of new care models.

NSIs provide valuable insight into the relationship between ward staffing levels and nursing-sensitive outcomes, enabling the Trust to monitor and evaluate the impact of staffing decisions on patient care. By triangulating NSI data with acuity and dependency scores, the Trust ensures that workforce plans are responsive to patient needs and aligned with quality and safety standards.

1.5 Professional Judgement (PJ)

At South Tees Hospitals NHS Foundation Trust, professional judgement is used alongside the Safer Nursing Care Tool (SNCT) to confirm appropriate nurse staffing levels. This professional judgement standardised tool is used in the UK to determine nursing establishments based on patient acuity and staffing needs. It has been influential in healthcare staffing practices, although recent research indicates that staffing is complex and cannot solely be addressed with a formula. The formula helps in calculating the required number of nurses based on patient classification and shifts, ensuring that nursing units have the appropriate number of staff for effective care and relies on the expertise of experienced nursing staff to determine the number and grade of staff required to deliver safe and effective care on each ward.

Professional Judgement (PJ) templates have been agreed with the Deputy Director of Nursing and incorporate the Trust's uplift allowance (headroom) to calculate the required Whole-Time Equivalents (WTEs) for each ward. In addition to patient acuity and dependency, several contextual factors are considered when determining staffing requirements:

- Ward layout and design: Wards with multiple single rooms or bays may require increased staffing capacity to maintain visibility and responsiveness.
- Availability of support staff: The presence of ward clerks, housekeepers, and other non-clinical staff can reduce the burden on nursing teams by undertaking non-patient-facing tasks.
- Patient throughput: High turnover areas may require additional staff to support patient flow and maintain care standards.
- Supervisory and management time: Time allocated for Ward Managers to fulfil leadership responsibilities, including staff supervision, mentoring of students and newly appointed staff, and completion of management duties.

This blended approach ensures that staffing establishments are not only data-driven but also contextually appropriate, reflecting the unique operational demands of each ward.

1.6 Agreed Funded Establishments vs Professional Judgement - September 25

Here is a visual comparison of authorised funded establishments, professional judgement recommended establishments, and actual staffing levels (in WTE) for Registered Nurses and Clinical Support Workers at South Tees Hospitals NHS Foundation Trust:

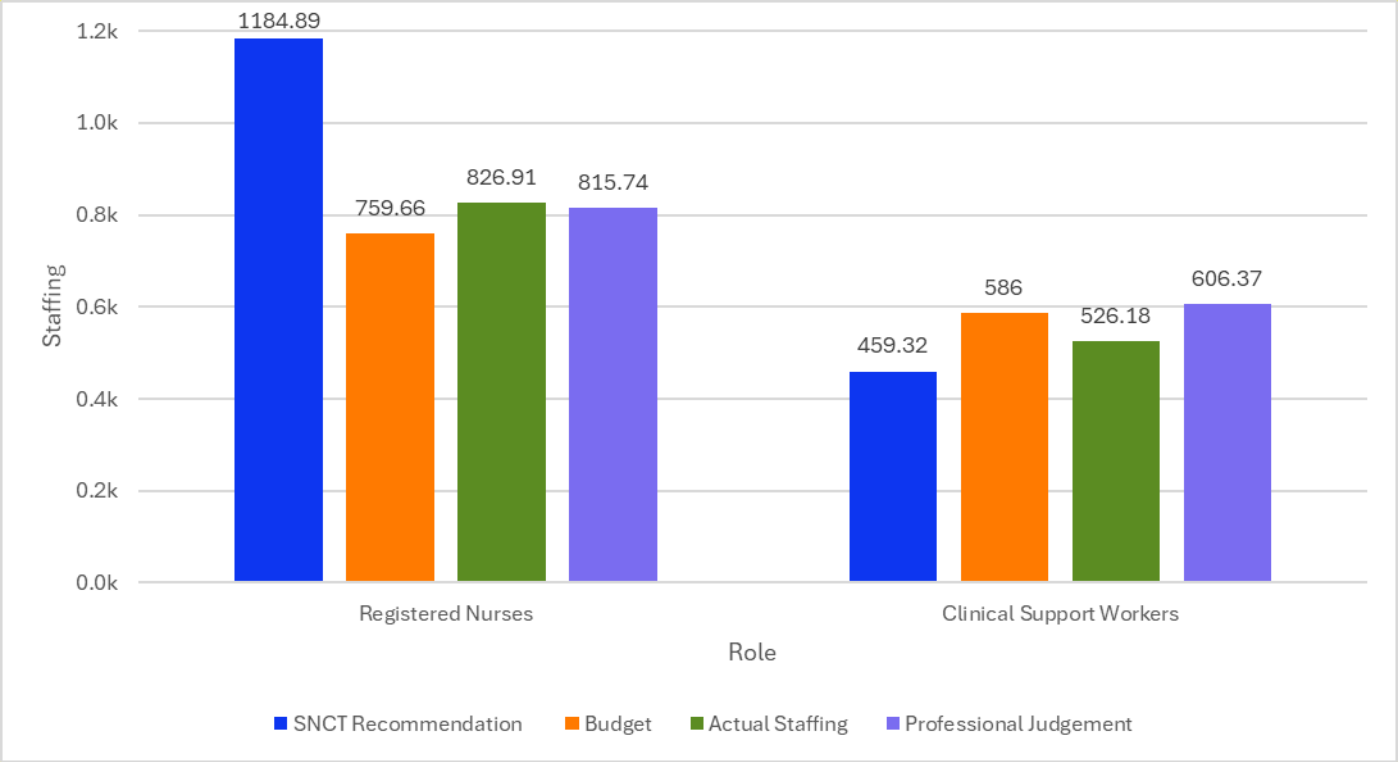
Key Insights:

- Registered Nurses:
  - Budgeted: 759.66 WTE
  - Professional Judgement: 815.74 WTE
  - Actual Staffing: 826.91 WTE
  - Budget vs Actual Staffing: Surplus 67.25 WTE
  - Budget vs Professional Judgement: Deficit 56.08 WTE
- Clinical Support Workers:
  - Budgeted: 586.00 WTE
  - Professional Judgement: 606.37 WTE
  - Actual Staffing: 526.18 WTE
  - Budget vs Actual Staffing: Deficit of 59.82
  - Budget vs Professional Judgement: Deficit of 20.37 WTE

This chart supports the narrative that current staffing levels exceed budgeted figures for RNs but fall short for HCAs, reinforcing the rationale for establishment adjustments to ensure safe care delivery. However, it demonstrates the requirement determined through professional judgement. The shortfall in HCAs reflects the vacancies frequently carried.

1.7 Safer Care Nursing Tool Results vs Funded Establishment - September 25

Here is a visual comparison of SNCT recommended establishments, authorised funded establishments, and actual staffing levels (in WTE) for Registered Nurses and Clinical Support Workers across South Tees Hospitals NHS Foundation Trust:



Key Insights:

- Registered Nurses (RNs):
  - SNCT Recommended: 1184.89 WTE
  - Budget (2023/24): 759.66 WTE
  - Actual Staffing: 826.91 WTE
  - Budget vs SNCT: Deficit of 425.23 WTE
  - Actual Staffing vs SNCT: Deficit of 357.98 WTE

- Clinical Support Workers (CSWs):
  - SNCT Recommended: 459.32 WTE
  - Budget: 586 WTE
  - Actual Staffing: 526.18 WTE
  - Budget vs SNCT: Surplus 126.68 WTE
  - Actual Staffing vs SNCT: Surplus of 66.86

This chart highlights the significant shortfall in RN staffing relative to SNCT recommendations and budget, while CSW staffing shows a surplus against budget but still falls slightly short of SNCT recommendations.

Table 1: South Tees Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE broken down by Collaborative for Registered Nurses

Collab	RN						
	Current Budget 23/24	**Actual Staffing**	**Professional Judgement (PJ)**	**SNCT RN**		**Variance**	
	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**
Cardio Vas	97.89	102.04	100.27	119.34	116.36	-21.45	-2.38
DDUGs	64.89	85.45	85.82	117.55	116.49	-52.66	-20.93
Growing FHN & Comm	114.58	112.71	118.57	224.02	197.37	-109.44	-3.99
Head, Neck & Ortho	82.27	94.58	91.02	145.87	136.79	-63.60	-8.75
JCCI & Spec Med	63.88	69.52	65.04	87.52	83.34	-23.64	-1.16
Med & Emerg	192.84	213.32	208.68	329.18	306.40	-136.34	-15.84
Neuro & Spinal	92.36	98.40	94.85	131.63	112.62	-39.27	-2.49
Women & Children	50.95	50.89	51.49	29.78	29.78	21.17	-0.54
Totals	**759.66**	**826.91**	**815.74**	**1184.89**	**1099.14**	**-425.23**	**-56.08**

Table 2: South Tees Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE broken down by Collaborative for Clinical Support Workers

Collab	CSW						
	Current Budget 23/24	**Actual Staffing**	**Professional Judgement (PJ)**	**SNCT CSW**		**Variance**	
	Budget CSW WTE	Sep 25 Contracted CSW WTE	Required CSW WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**

Cardio Vas	52.00	44.88	53.63	45.91	44.77	6.09	-1.63
DDUGs	70.17	59.21	68.94	45.23	44.82	24.94	1.23
Growing FHN & Comm	125.19	115.07	133.41	86.17	75.93	39.02	-8.22
Head, Neck & Ortho	70.69	59.44	71.51	56.12	52.63	14.57	-0.82
JCCI & Spec Med	35.78	38.48	45.59	33.67	32.06	2.11	-9.81
Med & Emerg	139.15	125.26	150.16	126.61	117.89	12.54	-11.01
Neuro & Spinal	70.12	66.44	67.04	50.64	43.33	19.48	3.08
Women & Children	22.90	17.40	16.09	14.97	14.97	7.93	6.81
Totals	**586.00**	**526.18**	**606.37**	**459.32**	**426.39**	**126.68**	**-20.37**

1.8 Recommendations

The Board of Directors is asked to receive this report for information and assurance, and to note that the data presented supports the Trust's commitment to maintaining safe and effective nurse staffing levels across all inpatient areas.

1.9 Conclusion

The data highlights notable discrepancies between current budgeted establishments, actual staffing levels, and the recommendations derived from the SNCT tool, alongside professional judgement assessments. These variations emphasise the importance of robust, consistent data collection, as the SNCT tool's effectiveness is contingent on accurate daily submissions reflecting the previous 24 hours of patient care. Operational factors such as ward layout and clinical demand can influence both compliance and data integrity.

As the Trust advances its Workforce Staffing Assurance Programme, it will enable enhanced visibility and understanding of staffing metrics contextualised with Nurse Sensitive Indicators across all Clinical Support Units (CSUs). This strategic initiative will reinforce the critical link between accurate data input, patient acuity, and clinical outcomes—empowering staff to make informed decisions that support safe, high-quality care.

The daily SafeCare process remains a cornerstone of operational delivery, ensuring staffing levels are optimised through dynamic workforce deployment and, where necessary, the integration of temporary staffing solutions. This approach supports the Trust's commitment to maintaining safe staffing and delivering responsive, patient-centred care. As we advance the group model the importance of the group values impact hugely on our workforce and how we recruit and retain an efficient and well supported workforce.

We know that safe staffing is essential for delivering high-quality, compassionate care. Our values guide how we achieve this every day:

- Respect
    - We listen to our colleagues' concerns about staffing levels without judgment.
    - We treat each other with dignity, ensuring workloads are fair and manageable.
    - Respecting staff means valuing their time, skills, and wellbeing—key to retaining a safe and stable workforce.
- Support
    - We support each other during challenging shifts, ensuring no one feels alone or overwhelmed.
    - We advocate for safe staffing levels that allow us to care for patients with kindness and compassion.
    - Supporting staff wellbeing helps prevent burnout and ensures consistent, safe care.

- Collaborate
    - We work together to solve staffing challenges, share responsibilities, and maintain continuity of care.
    - Collaboration across teams ensures that patient needs are met even during times of pressure.
    - By communicating and planning together, we create a safer, more resilient care environment.

It is acknowledged that this report details the bi-annual safer staffing position for the South Tees site only. It has been agreed that the exercise of producing a collective safe staffing report will be brought forward in order to conduct establishment reviews aligned to CSUs and service delivery models.

Debi McKeown
Nursing Workforce Lead

1.10 Appendices

Appendix 1 Nursing Workforce Establishment Reviews by Collaborative including SNCT Results compared to Agreed Funded Establishment and Professional Judgement

1.11 References

The Shelford Group. (2018). Safer Nursing Care Tool: Safer Nursing Care Tool - Shelford Group

NHS Improvement. (October 2018). Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing. https://improvement.nhs.uk/documents/3320/Developing_workforce_safeguards.pdf

Lord Carter of Coles, P. (2016, February). Operational productivity and performance in English NHS acute Hospitals: Unwarranted variations. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

The Royal College of Nursing (2021) Nursing Workforce Standards: Supporting a safe and effective nursing workforce. RCN, London. https://www.rcn.org.uk/professional-development/publications/rcn-workforce-standards-uk-pub-009681

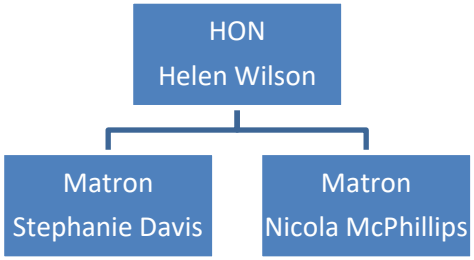
Appendix 1

Nursing Workforce Establishment Reviews by Collaborative

Using the data gathered in the SNCT audit and Professional Judgement template assessment, the overall summary indicates whether the Collaborative is optimally staffed against the SNCT criteria or not, comparing Audit 1 (March 25) and Audit 2 (September 25). Helping to identify the areas requiring further workforce planning and support.

Contents

1. Cardiovascular Care



1.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Cardiovascular Care Services

Table 3 below presents the average bed occupancy across the collaborative during September 2025, which stood at 95.48%. The skill mix for this care setting comprised 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs).

Workforce Budget vs. Professional Judgement

- Registered Nurses (RNs):
  - Budgeted WTE: 97.89 WTE
  - Professional Judgement Requirement: 100.27 WTE
  - Deficit: 2.38 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 52.00 WTE
  - Professional Judgement Requirement: 53.63 WTE
  - Deficit: 1.63 WTE

SNCT Tool Analysis

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 21.45 WTE
- CSW Budget Surplus: 6.09 WTE

Table 3: Cardiovascular Care Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

				RN							CSW						
	Bed Management			Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT CSW		Variance	
Ward	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget CSW WTE	Sep 25 Contracted CSW WTE	Required CSW WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	CSW Variance **Budget to PJ**
CCU	14	12.60	90.00%	34.90	33.68	32.52	21.76	21.39	13.14	2.38	1.94	2.16	2.68	8.36	8.23	-6.42	-0.74
Ward 28 Vas	30	28.90	96.33%	17.30	20.40	21.68	39.80	39.40	-22.50	-4.38	18.10	16.12	18.77	15.32	15.16	2.78	-0.67
Ward 29	27	26.43	97.90%	18.67	20.12	18.97	24.73	24.73	-6.06	-0.30	13.90	8.64	13.41	9.52	9.52	4.38	0.49
Cardio MB	9	8.70	96.67%	10.93	8.56	10.84	11.18	8.96	-0.25	0.09	5.16	6.16	5.36	4.30	3.45	0.86	-0.20
Ward 32 (JCCT)	21	19.80	94.29%	16.09	19.28	16.26	21.87	21.87	-5.78	-0.17	12.90	11.80	13.41	8.41	8.41	4.49	-0.51
Totals	**101**	**96.43**	**95.48%**	**97.89**	**102.04**	**100.27**	**119.34**	**116.36**	**-21.45**	**-2.38**	**52.00**	**44.88**	**53.63**	**45.91**	**44.77**	**6.09**	**-1.63**

Table 4: Cardiovascular Care Audit 1 comparison with Audit 2

				RN								CSW							
	Bed Management			Current Budget 23/24	Professional Judgement (PJ)	Variance						Current Budget 23/24	Professional Judgement (PJ)	Variance					
Ward	% Occupancy Audit 1	% Occupancy Audit 2	*% Occupancy Average*	Budget RN WTE *includes WM	Required RN WTE *includes WM	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	RN Variance Budget to PJ Audit 1	RN Variance Budget to PJ Audit 2	RN Variance Budget to PJ Average	Budget CSW WTE	Required CSW WTE	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	CSW Variance Budget to PJ Audit 1	CSW Variance Budget to PJ Audit 2	CSW Variance Budget to PJ Average
CCU	103.57%	90.00%	*96.79%*	34.90	32.52	12.81	13.14	*12.97*	-1.70	2.38	*0.34*	1.94	2.68	-6.56	-6.42	*-6.49*	-0.74	-0.74	*-0.74*
Ward 28 Vas	95.57%	96.33%	*95.95%*	17.30	21.68	-23.19	-22.50	*-22.85*	-4.98	-4.38	*-4.68*	18.10	18.77	3.36	2.78	*3.07*	-0.66	-0.67	*-0.66*
Ward 29	95.07%	97.90%	*96.49%*	18.67	18.97	-3.78	-6.06	*-4.92*	-0.89	-0.30	*-0.59*	13.90	13.41	5.26	4.38	*4.82*	0.50	0.49	*0.50*
Cardio MB	97.78%	96.67%	*97.22%*	10.93	10.84	2.41	-0.25	*1.08*	-0.51	0.09	*-0.21*	5.16	5.36	7.65	0.86	*4.26*	5.57	-0.20	*2.69*
Ward 32 (JCCT)	96.52%	94.29%	*95.40%*	16.09	16.26	-6.05	-5.78	*-5.92*	-0.76	-0.17	*-0.47*	12.90	13.41	7.48	4.49	*5.98*	2.69	-0.51	*1.09*
Totals	**96.94%**	**95.48%**	***96.21%***	**97.89**	**100.27**	**-17.80**	**-21.45**	***-19.63***	**-8.84**	**-2.38**	***-5.61***	**52.00**	**53.63**	**17.19**	**6.09**	***11.64***	**7.36**	**-1.63**	***2.87***

Table 4 provides a comparison of bed occupancy across both audits, with an average occupancy rate of 96.21%. It also presents the average variance between the current budget, the Safer Nursing Care Tool (SNCT) recommendations, and professional judgement for both Registered Nurses (RNs) and Clinical Support Workers (CSWs).
Across both audits:

- The average variance between the current RN budget and SNCT indicated a deficit of 19.63 WTE.
- For CSWs, the same comparison showed an average surplus of 11.64 WTE.
- When comparing the current budget to professional judgement, there was an average RN deficit of 5.61 WTE, and a CSW surplus of 2.87 WTE.

1.2 Patient Acuity and Dependency Scores for Cardiovascular Care Services by Ward

Figure 2: Patient Acuity and Dependency scores during the audit period broken down by percentage

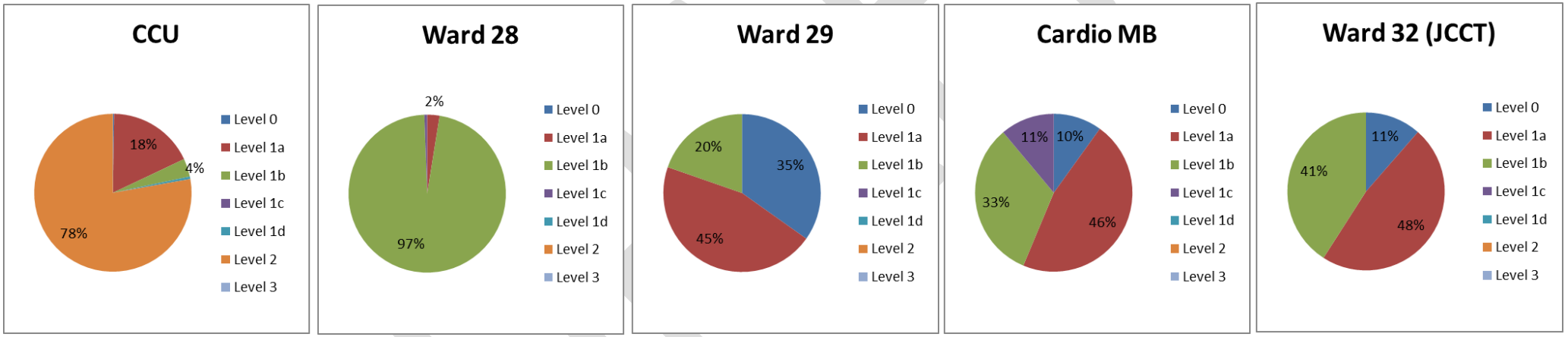
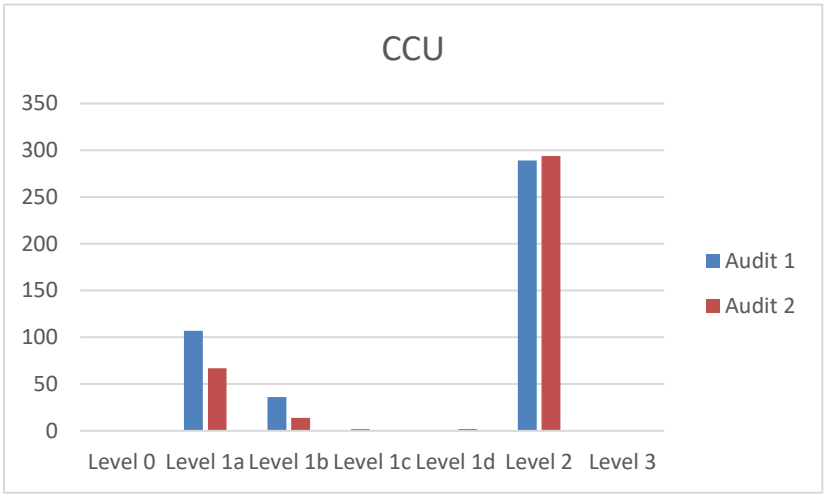
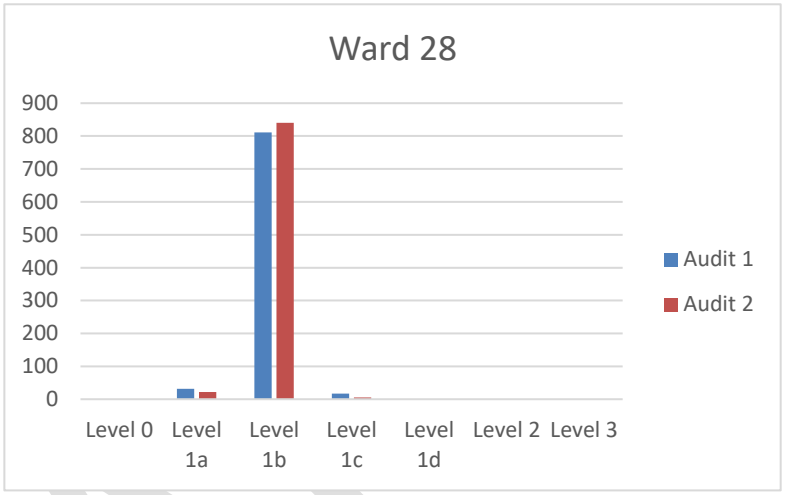
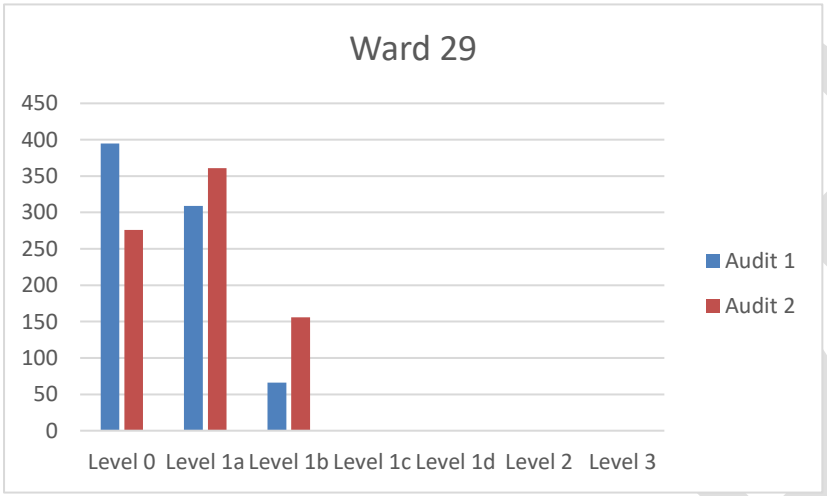
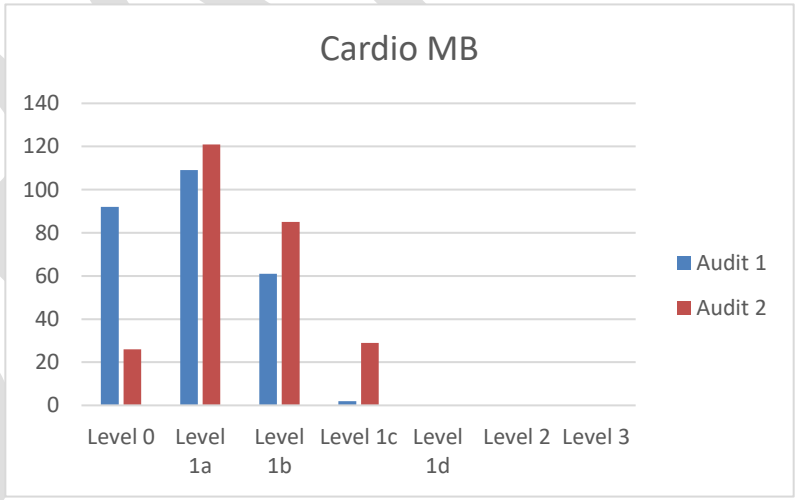


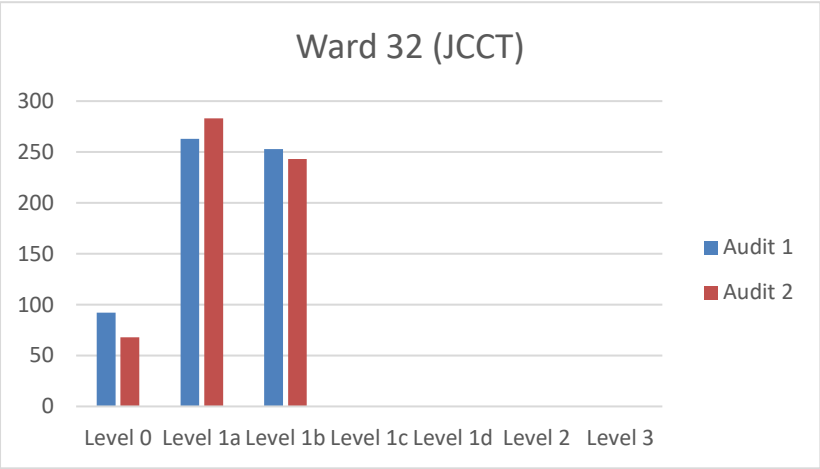
Figure 3: Cardiovascular Patient Acuity and Dependency scores comparison between both audits











1.3 Cardiovascular activity and patient harms recorded during the audit period

Table 5: Activity and Patient Harms by Ward for Audit 1 (March 25) vs Audit 2 (September 25)

Ward	Audit	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
CCU	Audit 1	119	70	33	39	1	5	81	1	11	6				1		100%
	Audit 2	107	63	23	33	0	6	80	7	7	13				1		96.2%
Ward 28	Audit 1	25	66	49	13	0	2	2	0	0	0	7			12		88%
	Audit 2	43	81	67	25	0	1	0	0	0	0	5	3	1	2		100%
Ward 29	Audit 1	55	134	88	25	1	4	21	4	2	3	3	1		4		95%
	Audit 2	70	109	77	30	0	1	13	5	0	0			1	1		100%
Cardio MB	Audit 1	26	39	22	2	0	0	4	1	3	3			2			100%
	Audit 2	13	13	17	4	0	0	4	0	25	8				1		-
Ward 32 (JCCT)	Audit 1	77	98	134	78	19	0	9	0	0	3				1	1	100%
	Audit 2	92	90	113	61	32	0	0	0	0	1				2		100%

1.4 Head of Nursing Comments and Actions – Helen Wilson

Ward 29 – The SNCT recommendation of less HCAs does not reflect the need of additional HCA support to ensure safe patient care at night when there is an increased risk of falls. I recommend the increase in RN numbers for 1 extra nurse during the day as currently no coordinator for a 36 bedded ward, to support the flow throughout the department and coordinate the ACS transfers.

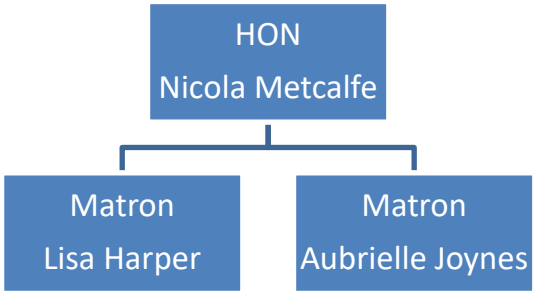
Ward 29 Monitored Bay – Staffing establishment is at the correct levels. We cannot reduce the number of RN's as suggested as we currently only have 2 Nurses for 9 patients and require a HCA around the clock for support and to ensure telemetry is monitored and alarms responded to.

Ward 28 – Based on the current footprint and high acuity, the staffing establishment should remain the same at least with a firm argument to increase numbers to 4 RNs on a night as they currently struggle due to patient acuity. The percentage of level 1B captures the number of patients with complex wounds that takes a considerable amount of time, and numbers of amputee patients who require the assistance of 2 or more nursing team members. Recommend Further review of this on the next SNCT audit.

Ward 32 – SNCT supports the need for an additional RN on nights but not the reduction in HCA numbers as already minimal HCA numbers.

CCU – It is a challenge to determine the exact need on CCU using the SNCT tool due to the level of patient acuity in this area. The audit tool is not fit for purpose for this level of acuity and the responsiveness required to leave the unit for emergency care provision outreaching (cath labs, cardiac arrest bleep).

2. Digestive Diseases, Urology and General Surgery



2.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Digestive Diseases, Urology and General Surgery

During September 2025, the average bed occupancy across this collaborative was 92.27%. The skill mix for this care setting remained at 60% Registered Nurses (RNs) and 40% Care Support Workers (CSWs).

Workforce Budget vs. Professional Judgement

- Registered Nurses (RNs):
  - Budgeted WTE: 64.89 WTE
  - Professional Judgement Requirement: 85.82 WTE
  - Deficit: 20.93 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 70.17 WTE
  - Professional Judgement Requirement: 68.94 WTE
  - Surplus: 1.23 WTE

SNCT Tool Analysis

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 52.66 WTE
- CSW Budget Surplus: 24.94 WTE

These findings highlight that the current staffing budget does not align with the actual requirements of this collaborative. Although the previous establishment review recommended an increase in both RN and CSW staffing levels, the approved budget fell significantly short of the requested establishment. The acuity of patients within this collaborative supports the higher staffing requirements indicated by both professional judgement and SNCT outcomes.

Table 6: Digestive Diseases, Urology and General Surgery Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

	Bed Management			RN							CSW						
				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT CSW		Variance	
Ward	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget CSW WTE	Sep 25 Contracted CSW	Required CSW WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	CSW Variance **Budget to PJ**
Ward 5 Gastro	31	30.10	97.10%	16.39	20.09	20.78	30.75	30.52	-14.36	-4.39	20.31	16.05	17.99	11.83	11.74	8.48	2.32
Ward 6 Short Stay Elective	27	23.17	85.80%	15.78	18.76	21.68	24.63	24.63	-8.85	-5.90	14.74	13.76	13.41	9.48	9.48	5.26	1.33
Ward 7 Colo	31	28.70	92.58%	15.46	22.68	21.68	30.58	30.58	-15.12	-6.22	17.06	13.80	18.77	11.76	11.77	5.30	-1.71
Ward 8	30	27.83	92.78%	17.26	23.92	21.68	31.60	30.76	-14.34	-4.42	18.06	15.60	18.77	12.16	11.83	5.90	-0.71
Totals	**119**	**109.80**	**92.27%**	**64.89**	**85.45**	**85.82**	**117.55**	**116.49**	**-52.66**	**-20.93**	**70.17**	**59.21**	**68.94**	**45.23**	**44.82**	**24.94**	**1.23**

Table 7: DDUGs Audit 1 comparison with Audit 2

	Bed Management			RN								CSW							
				Current Budget 23/24	Professional Judgement (PJ)	Variance						Current Budget 23/24	Professional Judgement (PJ)	Variance					
Ward	% Occupancy Audit 1	% Occupancy Audit 2	*% Occupancy Average*	Budget RN WTE *includes WM	Required RN WTE *includes WM	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	RN Variance Budget to PJ Audit 1	RN Variance Budget to PJ Audit 2	RN Variance Budget to PJ Average	Budget CSW WTE	Required CSW WTE	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	CSW Variance Budget to PJ Audit 1	CSW Variance Budget to PJ Audit 2	CSW Variance Budget to PJ Average
Ward 5	99.45%	97.10%	*98.27%*	16.39	20.78	-12.59	-14.36	*-13.47*	-5.89	-4.39	*-5.14*	20.31	17.99	9.16	8.48	*8.82*	1.55	2.32	*1.94*
Ward 6 Gastro	85.26%	85.80%	*85.53%*	15.78	21.68	-13.79	-8.85	*-11.32*	-5.59	-5.90	*-5.75*	14.74	13.41	3.37	5.26	*4.32*	-3.25	1.33	*-0.96*
Ward 7 Colo	93.65%	92.58%	*93.11%*	15.46	21.68	-17.38	-15.12	*-16.25*	-7.82	-6.22	*-7.02*	17.06	18.77	4.82	5.30	*5.06*	-1.70	-1.71	*-1.71*
Ward 8	95.43%	92.78%	*94.11%*	17.26	21.68	-13.75	-14.34	*-14.04*	-5.02	-4.42	*-4.72*	18.06	18.77	6.13	5.90	*6.02*	-0.70	-0.71	*-0.71*
Totals	**93.43%**	**92.27%**	***92.85%***	**64.89**	**85.82**	**-57.51**	**-52.66**	***-55.09***	**-24.32**	**-20.93**	***-22.63***	**70.17**	**68.94**	**23.48**	**24.94**	***24.21***	**-4.10**	**1.23**	***-1.44***

Table 7 provides a comparison of bed occupancy across both audits, with an average occupancy rate of 92.85%. It also presents the average variance between the current budget, the Safer Nursing Care Tool (SNCT) recommendations, and professional judgement for both Registered Nurses (RNs) and Clinical Support Workers (CSWs).
Across both audits:

- The average variance between the current RN budget and SNCT indicated a deficit of 55.09 WTE.
- For CSWs, the same comparison showed an average surplus of 24.21 WTE.
- When comparing the current budget to professional judgement, there was an average RN deficit of 22.63 WTE, and a CSW deficit of 1.44 WTE

2.2 Patient Acuity and Dependency Scores for DDUGs by Ward

Figure 4: Patient Acuity and Dependency scores during the audit period broken down by percentage

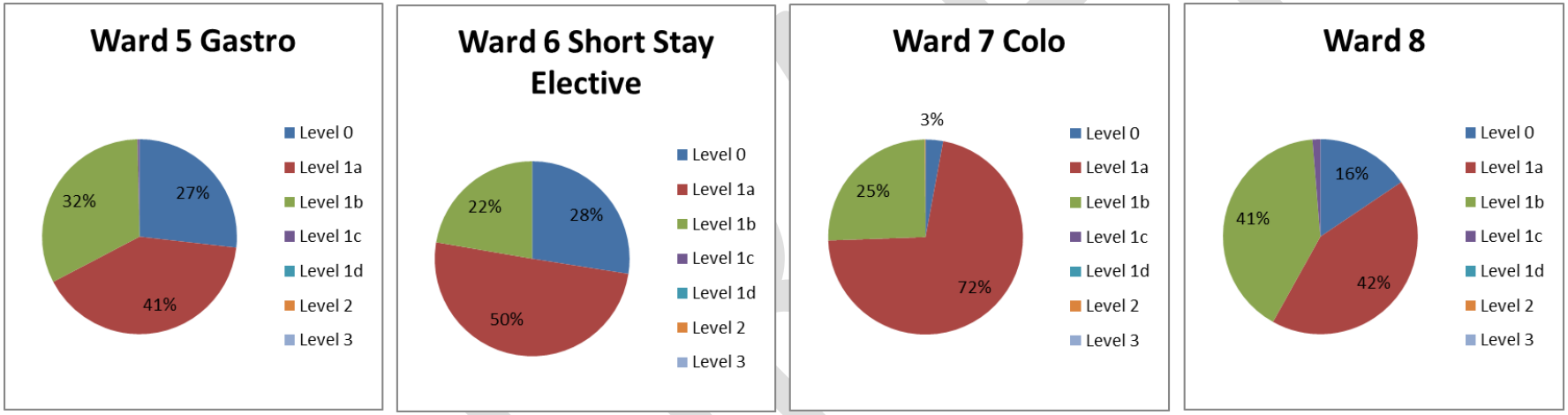
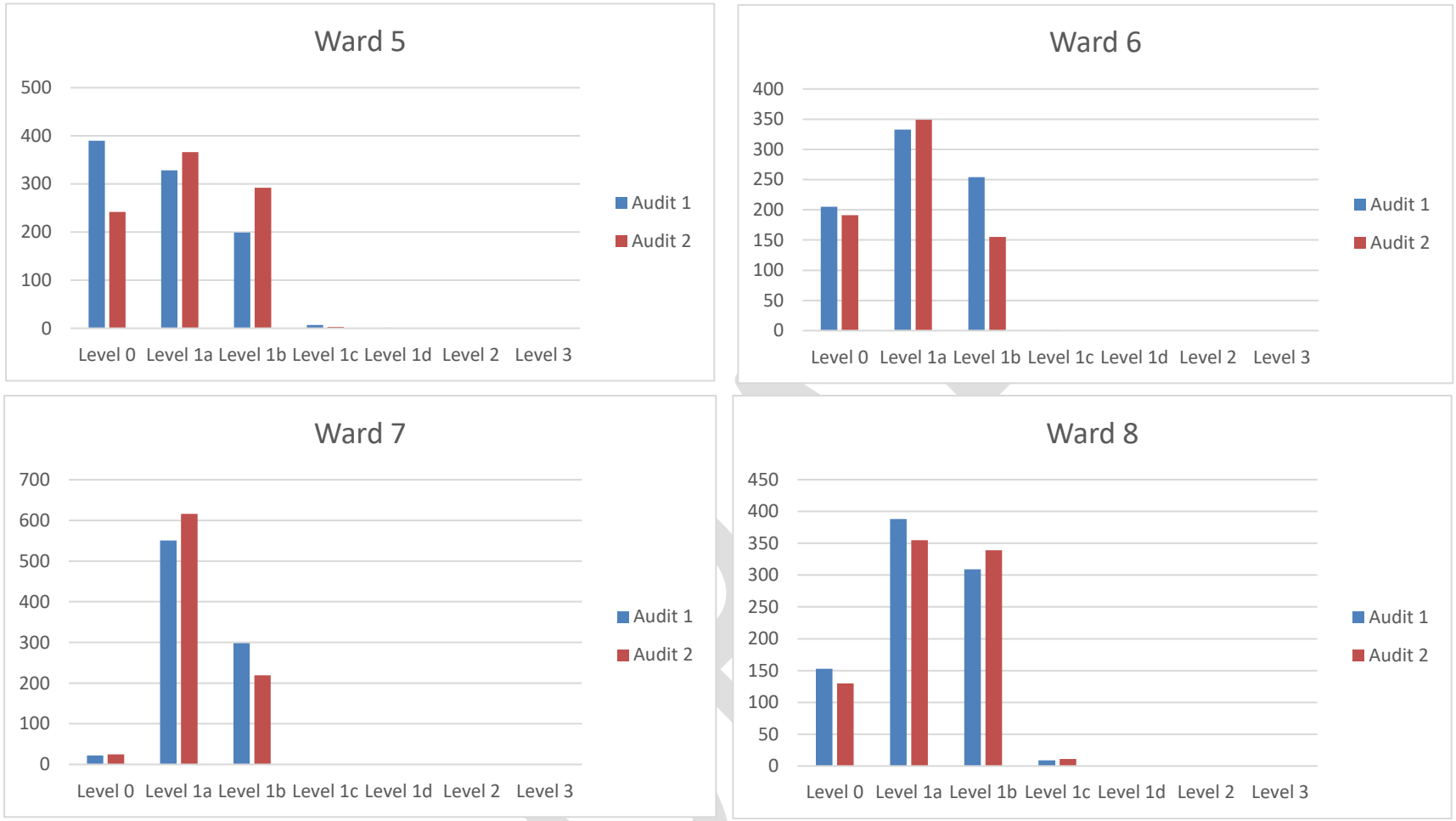


Figure 5: DDUGs Patient Acuity and Dependency scores comparison between both audits



2.3 DDUGs activity and patient harms recorded during the audit period

Table 8: Activity and Patient Harms by Ward for Audit 1 (March 25) vs Audit 2 (September 25)

Ward	Audit	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 5	Audit 1	48	73	58	22	1	4	84	6	4	8	3		5	4		94%
	Audit 2	44	79	104	42	0	3	70	1	2	3			3	3		100.0%
Ward 6 Gastro	Audit 1	84	204	273	192	0	1	18	3	0	4			1	4		97%
	Audit 2	56	208	291	223	0	1	14	0	0	0			1	2	1	83.3%
Ward 7 Colo	Audit 1	51	119	90	25	2	5	10	1	2	0	1		6	8	1	78%
	Audit 2	53	100	97	36	0	2	26	0	0	1					4	81.8%
Ward 8	Audit 1	92	148	135	66	2	2	16	0	1	10	4		1	3	1	100%
	Audit 2	97	148	106	28	0	1	74	0	4	6	1	1	2	7	3	-

2.4 Head of Nursing Comments and Actions – Nicola Metcalfe

Ward 5 Gastroenterology – The patient cohort for this ward is highly dependent on extensive support from staff. The impact on behaviours due to the nature of their conditions often leads to a higher need for 1:1 support to ensure the patients are safely cared for. This is reflected in the professional judgement and SNCT outcomes. The patient cohort is also known to rapidly deteriorate requiring a higher level of care from Registered Nurses.

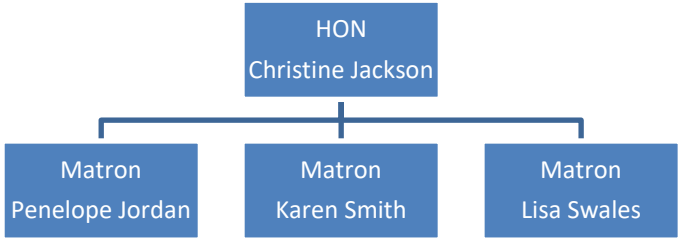
Ward 6 Short Stay Elective Unit – This ward area is currently open to 27 beds as they are currently displaced onto Ward 10 whilst the life cycle work is completed on Ward 6. The current staffing budget for the ward is for 28 beds. The ward is planned to reduce to 16 beds over the weekend period and as a result staffing is reduced on a weekend. However, to support the non-surgical admissions across the organisation it is continuously open to 27 beds including the weekend. This will account for the variation between current and actual staffing against professional judgement and SNCT recommendations. From the 17 November 25 the ward will move back into its usual footprint on Ward 6 and will have a total of 29 beds.

Ward 7 – The SNCT outcomes show an excessively high requirement for RNs. The acuity of the patients and the often-rapid decline would show the higher need for RN provision. The ward also takes the majority of critical care and PACU step downs who require higher need to RN provision due to TPN, IVAB's, chest drains, complex nutritional patients and complex wound dressings. However, the care provided from the HCAs ensures that safe care is provided alongside the clinical interventions from registered staff.

Ward 8 – Ward 8 continues to have a high number of medical outliers; therefore, the professional judgement demonstrated the need for additional nursing staff. The ward also accepts critical care steps downs, patients discharged from PACU and urology patients across the Tees Valley including patients from County Durham and Darlington.

3. Growing the Friarage & Community

3.1 Friarage Hospital & H&R Community Services



3.1.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for FHN & H&R

During September 2025, the average bed occupancy across this collaborative was 90.33%. The standard skill mix for this care setting is 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs), with the exception of Romanby, which operates on a 50/50 split.

Workforce Budget vs. Professional Judgement

- Registered Nurses (RNs):
  - Budgeted WTE: 74.65 WTE
  - Professional Judgement Requirement: 77.92 WTE
  - Deficit: 2.27 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 71.97 WTE
  - Professional Judgement Requirement: 77.10 WTE
  - Deficit: 5.13 WTE

SNCT Tool Analysis

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 63.88 WTE
- CSW Budget Surplus: 18.29 WTE

Operational Considerations

It is important to note that the Frailty and Health Needs (FHN) unit frequently absorbs the demand for enhanced patient observations, supported by therapeutic care staff and a reliance on NHS Professionals (NHSP) to fill short-notice staffing requests.

Table 9: FHN & H&R Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

	Bed Management			RN							CSW						
				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT CSW		Variance	
Ward	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget CSW WTE	Sep 25 Contracted CSW	Required CSWWTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	CSW Variance **Budget to PJ**
Ainderby	22	20.43	92.88%	14.87	15.33	15.58	39.69	20.35	-24.82	-0.71	16.10	16.88	17.99	15.27	7.83	0.83	-1.89
CDU	22	18.20	82.73%	19.39	18.73	20.78	26.82	26.82	-7.43	-1.39	9.36	9.22	12.85	10.32	10.32	-0.96	-3.49
Friary	18	15.07	83.70%	12.97	9.24	12.99	22.44	22.44	-9.47	-0.02	14.84	12.91	15.42	8.63	8.63	6.21	-0.58
Romanby	22	21.90	99.55%	15.45	16.10	15.58	26.27	25.75	-10.82	-0.13	18.31	16.18	17.99	10.11	9.91	8.20	0.32
Rutson	17	15.63	91.96%	12.97	13.13	12.99	24.31	21.51	-11.34	-0.02	13.36	12.09	12.85	9.35	8.28	4.01	0.51
Totals	**101**	**91.23**	**90.33%**	**75.65**	**72.53**	**77.92**	**139.53**	**116.87**	**-63.88**	**-2.27**	**71.97**	**67.28**	**77.10**	**53.68**	**44.97**	**18.29**	**-5.13**

Table 10: FHN & H&R Audit 1 comparison with Audit 2

	Bed Management			RN								CSW							
				Current Budget 23/24	Professional Judgement (PJ)	Variance						Current Budget 23/24	Professional Judgement (PJ)	Variance					
Ward	% Occupancy Audit 1	% Occupancy Audit 2	*% Occupancy Average*	Budget RN WTE *includes WM	Required RN WTE *includes WM	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	RN Variance Budget to PJ Audit 1	RN Variance Budget to PJ Audit 2	RN Variance Budget to PJ Average	Budget CSW WTE	Required CSW WTE	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	CSW Variance Budget to PJ Audit 1	CSW Variance Budget to PJ Audit 2	CSW Variance Budget to PJ Average
Ainderby	96.56%	92.88%	94.72%	14.87	15.58	-18.11	-24.82	-21.46	-1.31	-0.71	-1.01	16.10	17.99	3.41	0.83	2.12	-1.89	0.83	-0.53
CDU	100.77%	82.73%	91.75%	19.39	20.78	-7.05	-7.43	-7.24	-4.58	-1.39	-2.99	9.36	12.85	-0.81	-0.96	-0.89	-3.48	-0.96	-2.22
Friary	86.50%	83.70%	85.10%	12.97	12.99	-9.55	-9.47	-9.51	-0.61	-0.02	-0.32	14.84	15.42	6.18	6.21	6.19	-0.57	6.21	2.82
Romanby	91.59%	99.55%	95.57%	15.45	15.58	-13.26	-10.82	-12.04	-1.73	-0.13	-0.93	18.31	17.99	7.64	8.20	7.92	0.32	8.20	4.26
Rutson	94.29%	91.96%	93.13%	12.97	12.99	-7.62	-11.34	-9.48	-0.61	-0.02	-0.32	13.36	12.85	5.44	4.01	4.73	-0.22	4.01	1.89
Totals	**94.21%**	**90.33%**	***92.27%***	**75.65**	**77.92**	**-55.59**	**-63.88**	***-59.74***	**-8.84**	**-2.27**	***-5.56***	**71.97**	**77.10**	**21.86**	**18.29**	***20.08***	**-5.84**	**-5.13**	***-5.49***

Table 10 provides a comparison of bed occupancy across both audits, with an average occupancy rate of 92.27%. It also presents the average variance between the current budget, the Safer Nursing Care Tool (SNCT) recommendations, and professional judgement for both Registered Nurses (RNs) and Clinical Support Workers (CSWs).
Across both audits:

- The average variance between the current RN budget and SNCT indicated a deficit of 59.74 WTE.
- For CSWs, the same comparison showed an average surplus of 20.08 WTE.
- When comparing the current budget to professional judgement, there was an average RN deficit of 5.56 WTE, and a CSW deficit of 5.49 WTE

3.1.2 Patient Acuity and Dependency Scores for FHN & H&R

Figure 6: Patient Acuity and Dependency scores during the audit period broken down by percentage

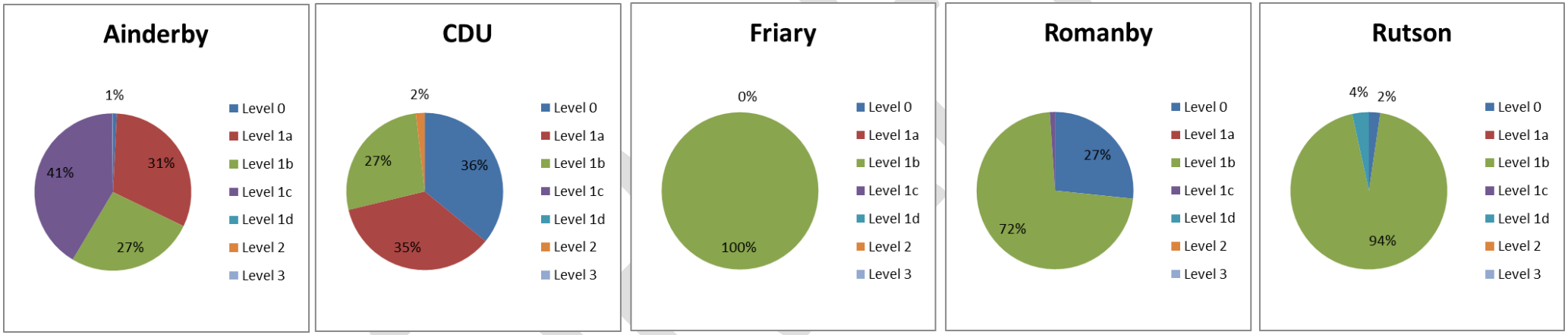
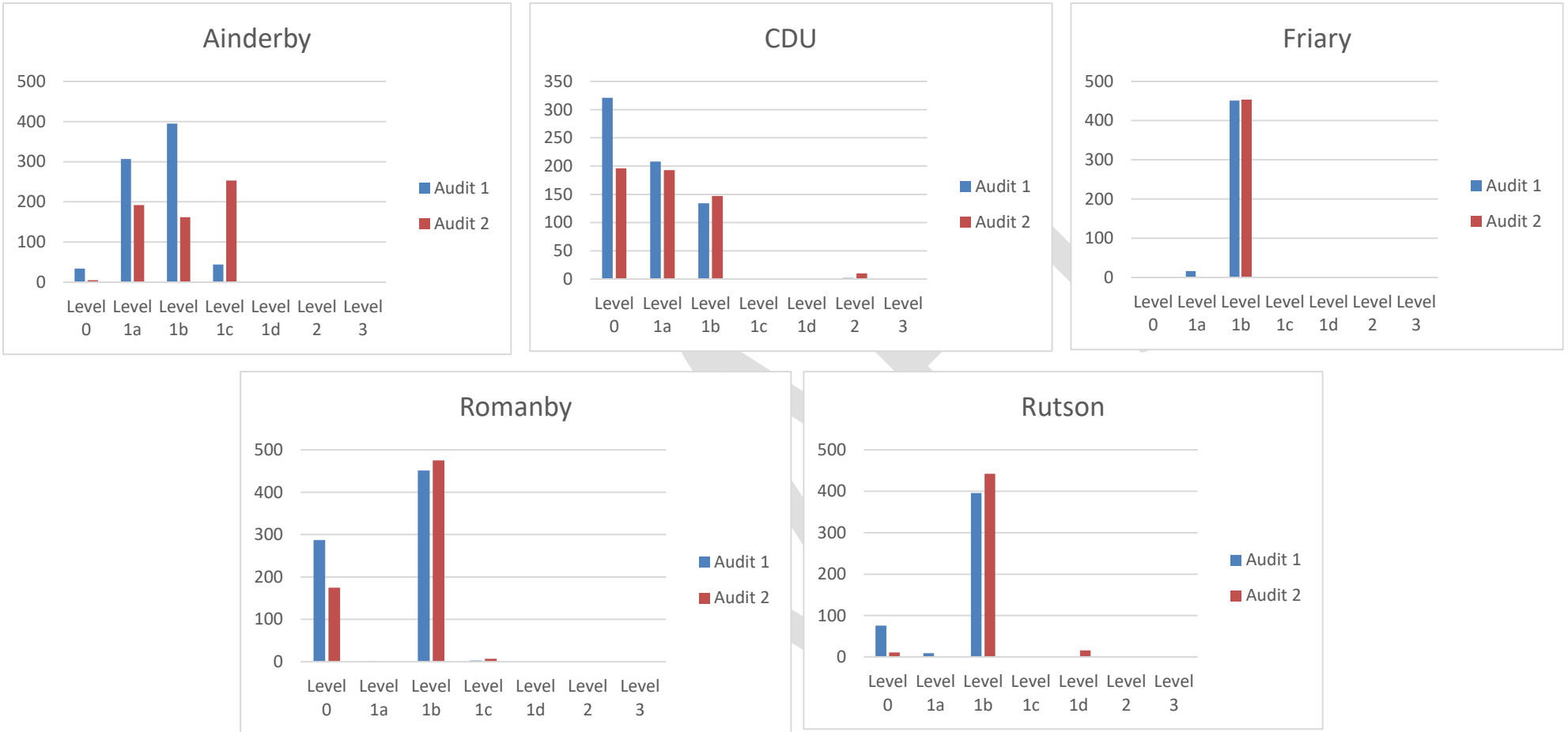


Figure 7: FHN & H&R Patient Acuity and Dependency scores comparison between both audits



3.1.3 FHN & H&R activity and patient harms recorded during the audit period

Table 11: Activity and Patient Harms by Ward for Audit 1 (March 25) vs Audit 2 (September 25)

Ward	Audit	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ainderby	Audit 1	6	43	53	19	9	7	44	0	44	8	2		2	4		91%
	Audit 2	3	64	69	9	0	6	38	0	43	11	2			4		91.7%
CDU	Audit 1	272	146	28	147	0	6	218	0	5	9	4			4		88%
	Audit 2	224	151	57	119	1	2	217	4	21	4	4		2	7	2	81.5%
Friary	Audit 1	19	16	2	3	0	3	0	0	16	2	1			3		100%
	Audit 2	26	17	1	6	0	5	0	0	0	0	1			1		100%
Romanby	Audit 1	2	62	74	12	0	6	17	2	4	0			1	2	1	91%
	Audit 2	0	39	49	8	0	1	10	1	7	0				4		90.9%
Rutson	Audit 1	5	19	19	5	0	2	0	5	0	76			1	3		100%
	Audit 2	3	23	21	0	0	0	2	0	0	0						100.0%

3.1.4 Head of Nursing Comments and Actions – Christine Jackson

Ainderby ward (FHN) – This ward with frail and complex medical patients has a need for additional RN support.

Clinical Decision Unit (FHN) – is a 22 bedded admission ward for medical patient admissions. The need to cover telemetry over a 24 hour period would require additions to the RN workforce on nights.

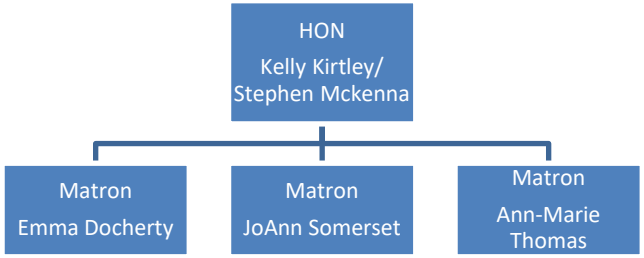
Victoria ward (The Friary Hospital Richmond) – This ward is based in a remote area with no internal support structures, therefore the recommendation from SNCT to increase the nursing establishment does reflect the current need. The ward could run on 1 RN with support from Community staff if syringe drivers were needed for EoL patients.

Romanby ward (FHN) – This 22 bedded medical ward is providing safe care within the current establishment.

Rutson Ward – is a 17 bedded primary care rehabilitation ward with 10 stroke beds and 7 general rehab beds. This ward is ensuring safe care with the current establishment.

The Staffing establishment for FHN does not take into account that the Band 7's and some 6's have to carry the site management 627 bleep from 4pm to 8pm on week days and 8am to 8pm on weekends.

3.2 Tees Community



3.2.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Tees Community

During September 2025, the average bed occupancy across this collaborative was 95.85%. The standard skill mix for this care setting is 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs).

Workforce Budget vs. Professional Judgement

- Registered Nurses (RNs):
  - Budgeted WTE: 38.93 WTE
  - Professional Judgement Requirement: 40.65 WTE
  - Deficit: 1.72 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 53.22 WTE
  - Professional Judgement Requirement: 56.31 WTE
  - Deficit: 3.09 WTE

SNCT Tool Analysis

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 45.55 WTE
- CSW Budget Surplus: 20.73 WTE

Operational Considerations

Both community hospitals within this collaborative are located in remote areas, with no adjacent wards available to support staffing shortfalls. Additionally:

- Tocketts Ward has a layout that presents visibility challenges, necessitating increased CSW staffing to maintain patient safety.
- Zetland Ward consists entirely of single rooms, and its layout similarly requires additional CSW support to ensure safe patient care.

Table 12: Tees Community Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

	Bed Management			RN							CSW						
				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT CSW		Variance	
Ward	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget csw WTE	Sep 25 Contracted CSW WTE	Required HCA WTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	CSW Variance **Budget to PJ**
Tocketts	30	28.20	94.00%	16.67	18.45	18.97	37.52	36.67	-20.85	-2.30	23.22	21.79	24.13	14.43	14.11	8.79	-0.91
Zetland	31	30.27	97.63%	22.26	21.73	21.68	46.96	43.83	-24.70	0.58	30.00	26.00	32.18	18.06	16.85	11.94	-2.18
Totals	**61**	**58.47**	**95.85%**	**38.93**	**40.18**	**40.65**	**84.48**	**80.49**	**-45.55**	**-1.72**	**53.22**	**47.79**	**56.31**	**32.49**	**30.96**	**20.73**	**-3.09**

Table 13: Tees Community Audit 1 comparison with Audit 2

	Bed Management			RN								CSW							
				Current Budget 23/24	Professional Judgement (PJ)	Variance						Current Budget 23/24	Professional Judgement (PJ)	Variance					
Ward	% Occupancy Audit 1	% Occupancy Audit 2	*% Occupancy Average*	Budget RN WTE *includes WM	Required RN WTE *includes WM	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	RN Variance Budget to PJ Audit 1	RN Variance Budget to PJ Audit 2	RN Variance Budget to PJ Average	Budget CSW WTE	Required CSW WTE	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	CSW Variance Budget to PJ Audit 1	CSW Variance Budget to PJ Audit 2	CSW Variance Budget to PJ Average
Tocketts	93.57%	94.00%	93.78%	16.67	18.97	-21.28	-20.85	-21.06	-2.89	-2.30	-2.60	23.22	24.13	8.62	8.79	8.70	-0.91	8.79	3.94
Zetland	97.42%	97.63%	97.53%	22.26	21.68	-18.39	-24.70	-21.55	-1.02	0.58	-0.22	30.00	32.18	14.74	11.94	13.34	-2.16	11.94	4.89
Totals	**95.52%**	**95.85%**	***95.69%***	**38.93**	**40.65**	**-39.67**	**-45.55**	***-42.61***	**-3.91**	**-1.72**	***-2.82***	**53.22**	**56.31**	**23.36**	**20.73**	***22.05***	**-3.07**	**20.73**	***8.83***

Table 13 provides a comparison of bed occupancy across both audits, with an average occupancy rate of 95.69%. It also presents the average variance between the current budget, the Safer Nursing Care Tool (SNCT) recommendations, and professional judgement for both Registered Nurses (RNs) and Clinical Support Workers (CSWs).

Across both audits:

- The average variance between the current RN budget and SNCT indicated a deficit of 42.610 WTE.

- For CSWs, the same comparison showed an average surplus of 22.05WTE.
- When comparing the current budget to professional judgement, there was an average RN deficit of 2.82 WTE, and a CSW surplus of 8.83 WTE

3.2.2 Patient Acuity and Dependency Scores for Tees Community

Figure 8: Patient Acuity and Dependency scores during the audit period broken down by percentage

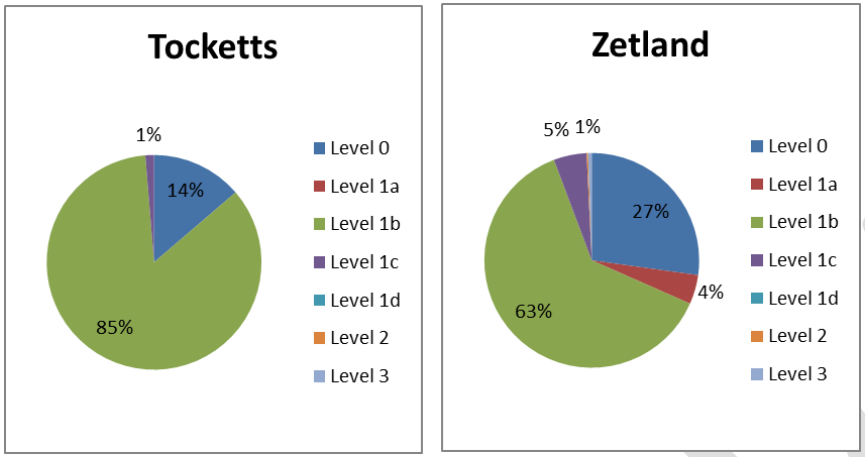
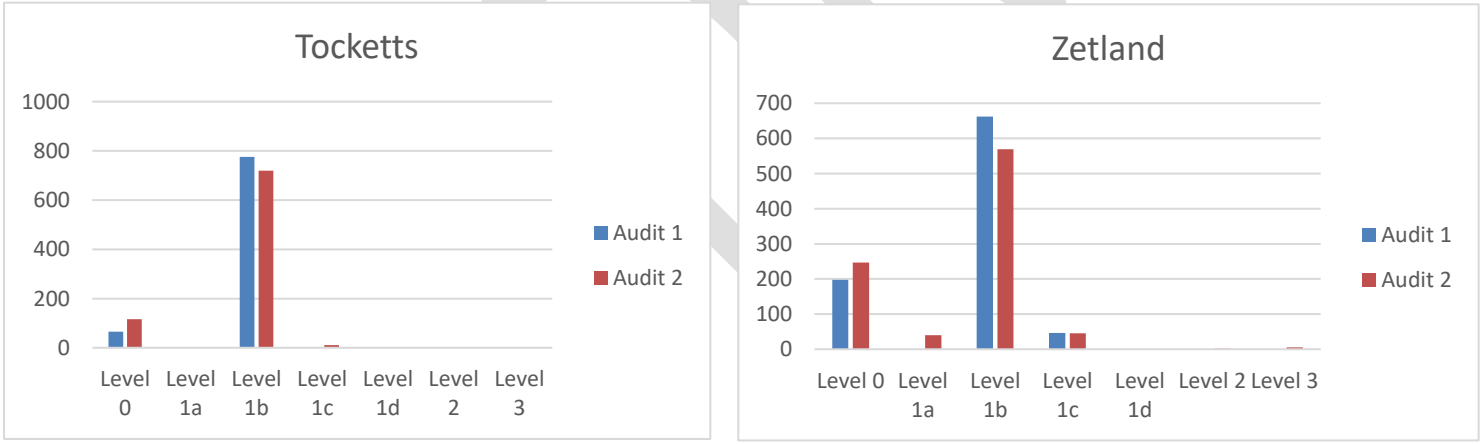


Figure 9: Tees Community Patient Acuity and Dependency scores comparison between both audits



3.2.3 Tees Community activity and patient harms recorded during the audit period

Table 14: Activity and Patient Harms by Ward for Audit 1 (March 25) vs Audit 2 (September 25)

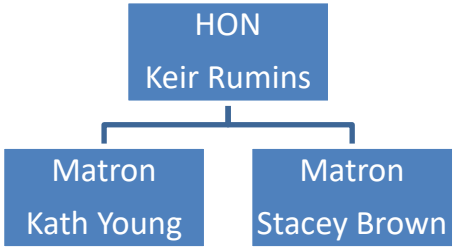
Ward	Audit	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Tocketts	Audit 1	33	29	25	4	10	2	0	3	1	9		1		6	1	96%
	Audit 2	40	35	27	6	9	0	2	7	9	17			1	6		100.0%
Zetland	Audit 1	31	21	1	6	3	2	0	7	45	24	4	1		6	1	93%
	Audit 2	21	24	1	1	10	3	5	5	46	30	5			6		92.0%

3.2.4 Head of Nursing Comments and Actions – Stephen McKenna

Zetland Ward (Redcar Primary Care Hospital) – This 31 bedded rehabilitation ward provides care in single rooms. This is the reason that SNCT recommends a decrease in HCAs, however due to the risk to patients in this side room layout there should not be a reduction to HCA workforce. The estate is very problematic and has a difficult footprint being a H- shape with arms coming off intermittently.

Tocketts Ward (East Cleveland Hospital) – The nurse to patient ratio when fully established provides safe care to the patients. The recommendations from SNCT do not match the patient need.

4. Head, Neck, Orthopaedic and Reconstructive



4.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for HNOR

During September 2025, the average bed occupancy across this collaborative was 81.14%. The standard skill mix for this care setting is 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs), with the exception of Ward 25, which operates on a 50/50 split.

Workforce Budget vs. Professional Judgement

- Registered Nurses (RNs):
  - Budgeted WTE: 82.27 WTE
  - Professional Judgement Requirement: 91.02 WTE
  - Deficit: 8.75 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 70.69 WTE
  - Professional Judgement Requirement: 71.51 WTE
  - Deficit: 0.82 WTE

SNCT Tool Analysis

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 63.60 WTE
- CSW Budget Surplus: 14.57 WTE

Table 15: HNOR Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

	Bed Management			RN							CSW						
				Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT CSW		Variance	
Ward	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget CSW WTE	Sep 25 Contracted CSW	Required CSWWTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	CSW Variance **Budget to PJ**
Gara	21	13.63	64.92%	11.97	13.37	12.99	19.68	19.68	-7.71	-1.02	10.89	8.41	10.28	7.57	7.57	3.32	0.61
d 25 Hip/Femur Fracture	21	19.53	93.02%	18.67	19.00	18.97	34.69	32.04	-16.02	-0.30	12.90	12.15	13.41	13.34	12.33	-0.44	-0.51
Ward 27 Elec Ortho	15	6.77	45.11%	10.97	14.33	12.99	14.23	13.91	-3.26	-2.02	9.89	10.28	10.28	5.47	5.35	4.42	-0.39
Ward 35	26	22.83	87.82%	19.78	23.44	21.68	36.47	34.20	-16.69	-1.90	16.37	14.52	18.77	14.03	13.16	2.34	-2.40
Ward 36 Trauma	34	32.17	94.61%	20.88	24.44	24.39	40.80	36.96	-19.92	-3.51	20.64	14.08	18.77	15.70	14.23	4.94	1.87
Totals	**117**	**94.93**	**81.14%**	**82.27**	**94.58**	**91.02**	**145.87**	**136.79**	**-63.60**	**-8.75**	**70.69**	**59.44**	**71.51**	**56.12**	**52.63**	**14.57**	**-0.82**

Table 16: HNOR Audit 1 comparison with Audit 2

	Bed Management			Current Budget 23/24	Professional Judgement (PJ)	Variance						Current Budget 23/24	Professional Judgement (PJ)	Variance					
Ward	% Occupancy Audit 1	% Occupancy Audit 2	*% Occupancy Average*	Budget RN WTE *includes WM	Required RN WTE *includes WM	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	RN Variance Budget to PJ Audit 1	RN Variance Budget to PJ Audit 2	RN Variance Budget to PJ Average	Budget CSW WTE	Required CSW WTE	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	CSW Variance Budget to PJ Audit 1	CSW Variance Budget to PJ Audit 2	CSW Variance Budget to PJ Average
Gara	58.10%	64.92%	*61.51%*	11.97	12.99	-6.73	-7.71	*-7.22*	-1.61	-1.02	*-1.32*	10.89	10.28	3.70	3.32	*3.51*	0.62	3.32	*1.97*
d 25 Hip/Femur Fracture	85.57%	93.02%	*89.29%*	18.67	18.97	-13.50	-16.02	*-14.76*	-0.89	-0.30	*-0.59*	12.90	13.41	0.52	-0.44	*0.04*	-0.50	-0.44	*-0.47*
Ward 27 Elec Ortho	67.13%	45.11%	*56.12%*	10.97	12.99	-4.57	-3.26	*-3.92*	-2.61	-2.02	*-2.32*	9.89	10.28	3.91	4.42	*4.17*	-0.38	4.42	*2.02*
Ward 35	74.62%	87.82%	*81.22%*	19.78	21.68	-16.50	-16.69	*-16.60*	-2.50	-1.90	*-2.20*	16.37	18.77	2.41	2.34	*2.37*	-2.39	2.34	*-0.03*
Ward 36 Trauma	93.32%	94.61%	*93.97%*	20.88	24.39	-22.00	-19.92	*-20.96*	-4.11	-3.51	*-3.81*	20.64	18.77	4.15	4.94	*4.54*	-0.80	4.94	*2.07*
Totals	**78.09%**	**81.14%**	***79.62%***	**82.27**	**91.02**	**-63.30**	**-63.60**	***-63.45***	**-11.72**	**-8.75**	***-10.24***	**70.69**	**71.51**	**14.69**	**14.57**	***14.63***	**-3.45**	**-0.82**	***-2.14***

Table 16 provides a comparison of bed occupancy across both audits, with an average occupancy rate of 79.62%. It also presents the average variance between the current budget, the Safer Nursing Care Tool (SNCT) recommendations, and professional judgement for both Registered Nurses (RNs) and Clinical Support Workers (CSWs).
Across both audits:

- The average variance between the current RN budget and SNCT indicated a deficit of 63.45 WTE.
- For CSWs, the same comparison showed an average surplus of 14.63 WTE.
- When comparing the current budget to professional judgement, there was an average RN deficit of 10.24 WTE, and a CSW deficit of 2.14 WTE

4.2 Patient Acuity and Dependency Scores for HNOR

Figure 10: Patient Acuity and Dependency scores during the audit period broken down by percentage

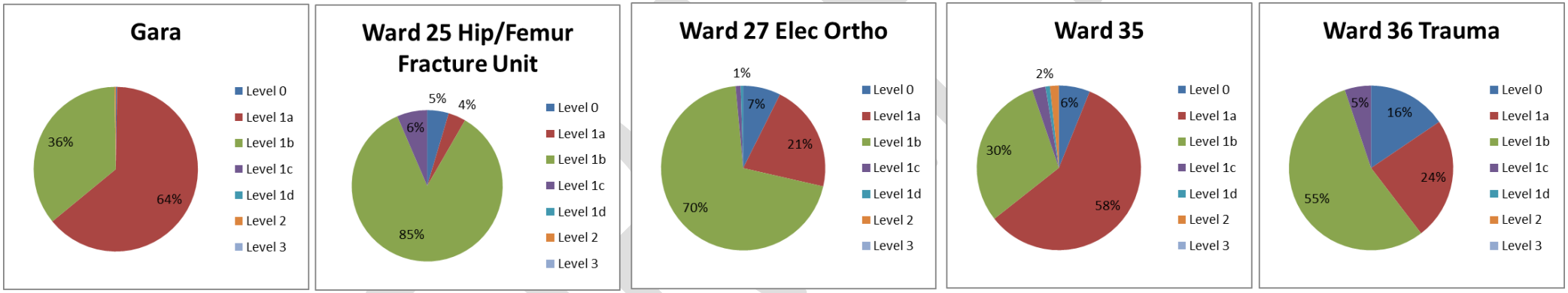
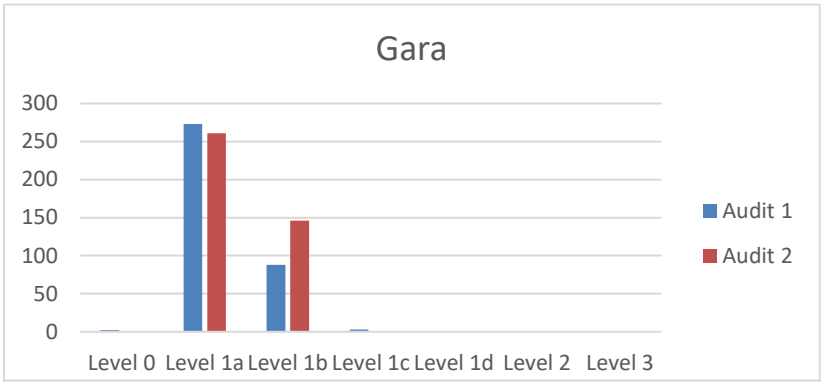
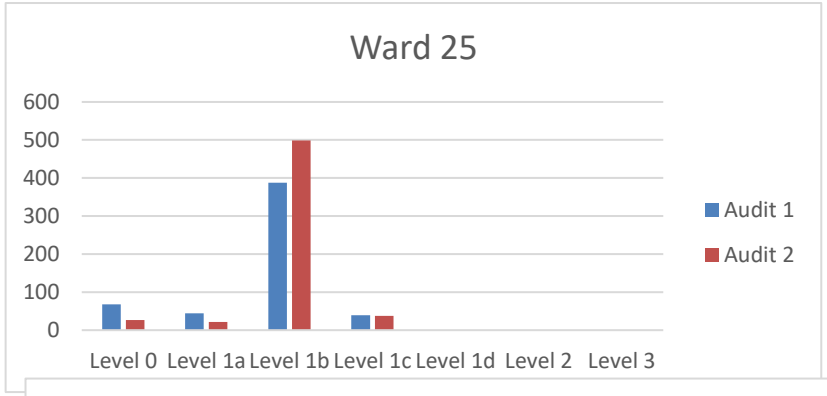
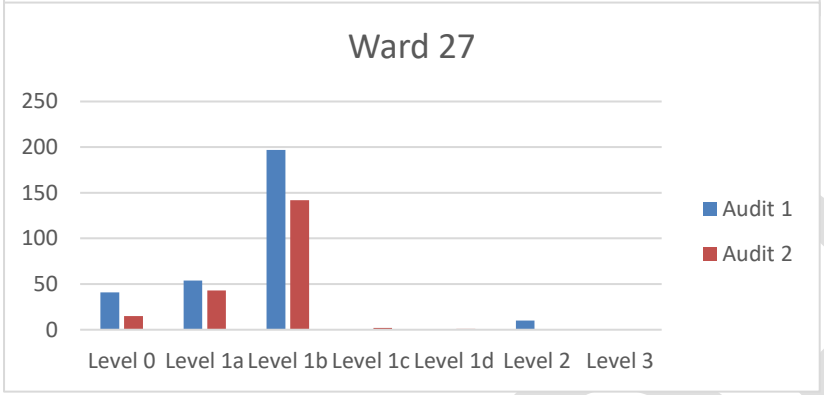
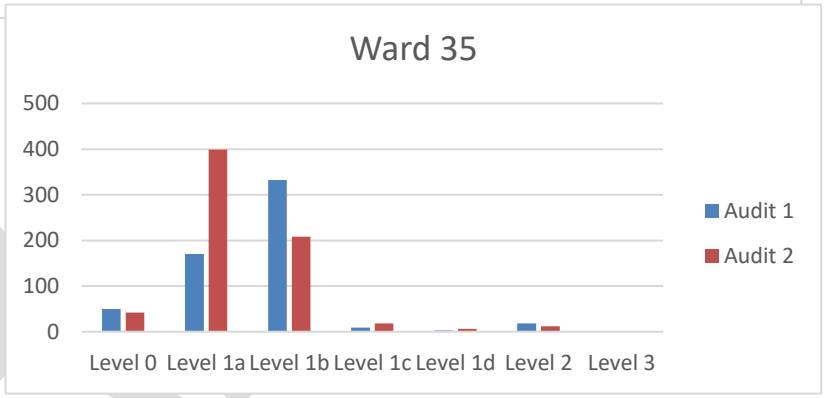


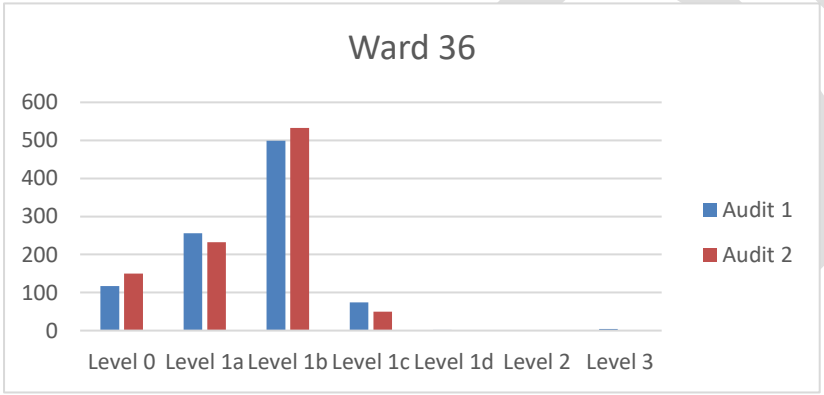
Figure 11: HNOR Patient Acuity and Dependency scores comparison between both audits











4.3 HNOR activity and patient harms recorded during the audit period

Table 17: Activity and Patient Harms by Ward for Audit 1 (March 25) vs Audit 2 (September 25)

Ward	Audit	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Gara	Audit 1	103	179	95	1	11	0	0	0	1	0			1	1		100%
	Audit 2	149	151	1	1	4	0	0	1	0	2				2	1	100%
l 25 Hip/Femur Fracture	Audit 1	47	39	11	18	0	1	68	1	27	15	2		1	4		86%
	Audit 2	51	38	28	28	0	3	57	3	0	6	4			2		100%
Ward 27 Elec Ortho	Audit 1	42	57	25	0	56	0	65	0	0	14	2			2		100%
	Audit 2	50	28	11	3	35	0	31	2	3	3	1		1	2		100%
Ward 35	Audit 1	113	149	84	42	0	0	4	0	4	4			3	2		96%
	Audit 2	136	166	79	37	3	0	9	0	9	4	1		2	3		92.9%
Ward 36 Trauma	Audit 1	118	116	38	37	2	2	0	0	27	31	2	1	3	2		96%
	Audit 2	126	104	43	61	0	1	0	0	12	20	1	1	3	6		98.2%

4.4 Head of Nursing Comments and Actions – Keir Rumins

Gara (FHN) – Gara has a fully established workforce, with the surgical hub at FHN now opened - I have requested a review (data submitted previously) to ensure appropriate staffing levels are maintained and staffing is incorporated with this focus (SOP produced with surgical hub lead), for the inpatient bed base of 21 and incorporating day case/day zero patients allocated bed space on the ward footprint (who attend the ward for post-surgical care). This will allow for review of elective capacity/footfall aligned with appropriate nurse staffing for the patient group.

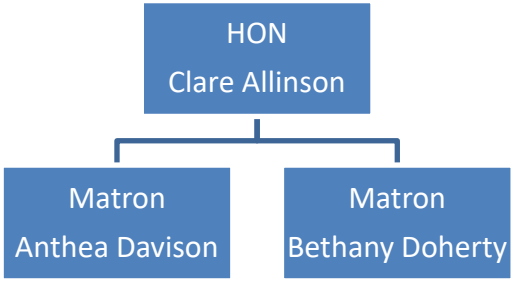
Ward 25 – Staffing establishment (due to complexity of patient group, NHSP consistent request/spend re falls risk and frail vulnerable patients requiring intervention on a continual focus, that however do not reach the CG47 threshold (some do)), has been reviewed for both day allocation/ratio and night shift allocation/ratio on current budget, combined with the above data evident/SNCT data.

Ward 27 – 15 bedded elective orthopaedic ward, no change is required to the current staffing establishment currently. Regional elective work to be incorporated as this progresses to review staffing and elective footprint/capacity for this green ring fenced ward.

Ward 35 - The ward requires (and has been agreed) an extra RN support (matches the above 2.20 wte suggested) two to three times per week for complex care post-surgery (L2) and to support any emergency high level patients (free flap/trach) (L2) requiring 1:1 observation and oversight. This is factored into the professional judgement calculation above. There is high complexity of patients and patient throughput, daily. The ward also supports the plastics clinics and other drop-in services that is not factored into the ward staffing calculations (PDC is on the ward however has own staffing model, separately). On a weekend and out of hours the ward supports any patient requiring urgent plastics treatment. An agreement has been given verbally via SLT to have the increase in RN, this needs to progress to budget alignment to allow and recruitment and training.

Ward 36 - The trauma ward is a critical care step down area and sees high numbers of overnight trauma and major trauma patient admissions, as well as in hours (24/7). The ward consistently sees complex patients beyond the trauma speciality in terms of need and mixed speciality care input. As such the staffing template will continue to be reviewed within CSU going forward and escalation as needed to review as skill mix is required to maintain patient safety and patient interventions – this so far comprises of RN and registered NA, + HCSW colleagues.

5. James Cook Cancer Institute & Specialty Medicine



5.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for JCCISM

During September 2025, the average bed occupancy across the collaborative was 94.13%, indicating sustained demand for inpatient services. The current skill mix within this care setting comprises 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs).

Workforce Budget vs. Professional Judgement

Registered Nurses (RNs):

- Budgeted WTE: 63.88
- Professional Judgement Requirement: 65.04
- Deficit: 1.16 WTE

- Clinical Support Workers (CSWs):
  - Budgeted WTE: 35.78
  - Professional Judgement Requirement: 45.59
  - Deficit: 9.81 WTE

SNCT Tool Analysis

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 23.64 WTE
- CSW Budget Surplus: 2.11 WTE

Operational Considerations

- Ward 14 and Ward 33 provide an out-of-hours support line aimed at admission avoidance. While beneficial, this service requires RN time, with calls ranging from 15 minutes to one hour, impacting direct patient care capacity.
- Patients undergoing chemotherapy or living with cancer require enhanced clinical oversight, including:
  - Prolonged psychological support
  - Intensive monitoring
  - Complex discharge planning

Table 18: JCCISM Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

				RN							CSW						
	Bed Management			Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT CSW		Variance	
Ward	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget CSW WTE	Sep 25 Contracted CSW	Required CSWWTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	CSW Variance **Budget to PJ**
Ward 4	24	23.00	95.83%	22.36	21.60	21.68	32.55	29.68	-10.19	0.68	11.94	12.00	16.09	12.52	11.42	-0.58	-4.15
Ward 14 Oncology	23	22.13	96.23%	21.26	23.60	21.68	26.93	26.07	-5.67	-0.42	11.94	11.68	13.41	10.36	10.03	1.58	-1.47
Ward 33 Specialty	23	20.76	90.26%	20.26	24.32	21.68	28.04	27.58	-7.78	-1.42	11.90	14.80	16.09	10.79	10.61	1.11	-4.19
Totals	**70**	**65.89**	**94.13%**	**63.88**	**69.52**	**65.04**	**87.52**	**83.34**	**-23.64**	**-1.16**	**35.78**	**38.48**	**45.59**	**33.67**	**32.06**	**2.11**	**-9.81**

Table 19: HNOR Audit 1 comparison with Audit 2

				RN								CSW							
	Bed Management			Current Budget 23/24	Professional Judgement (PJ)	Variance						Current Budget 23/24	Professional Judgement (PJ)	Variance					
Ward	% Occupancy Audit 1	% Occupancy Audit 2	*% Occupancy Average*	Budget RN WTE *includes WM	Required RN WTE *includes WM	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	RN Variance Budget to PJ Audit 1	RN Variance Budget to PJ Audit 2	RN Variance Budget to PJ Average	Budget CSW WTE	Required CSW WTE	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	CSW Variance Budget to PJ Audit 1	CSW Variance Budget to PJ Audit 2	CSW Variance Budget to PJ Average
Ward 4	98.75%	95.83%	*97.29%*	22.36	21.68	-11.05	-10.19	*-10.62*	-1.08	0.68	*-0.20*	11.94	16.09	-0.91	-0.58	*-0.75*	-4.14	-4.15	*-4.15*
Ward 14	93.17%	96.23%	*94.70%*	21.26	21.68	-3.13	-5.67	*-4.40*	-1.02	-0.42	*-0.72*	11.94	13.41	3.56	1.58	*2.57*	-0.46	-1.47	*-0.97*
Ward 33 Sepcialty	81.17%	90.26%	*85.72%*	20.26	21.68	-1.83	-7.78	*-4.81*	-2.02	-1.42	*-1.72*	11.90	16.09	3.40	1.11	*2.26*	-4.18	-4.19	*-4.19*
Totals	**91.14%**	**94.13%**	***92.64%***	**63.88**	**65.04**	**-16.01**	**-23.64**	***-19.83***	**-4.12**	**-1.16**	***-2.64***	**35.78**	**45.59**	**6.05**	**2.11**	***4.08***	**-8.78**	**-9.81**	***-9.30***

Table 19 provides a comparison of bed occupancy across both audits, with an average occupancy rate of 92.64%. It also presents the average variance between the current budget, the Safer Nursing Care Tool (SNCT) recommendations, and professional judgement for both Registered Nurses (RNs) and Clinical Support Workers (CSWs).
Across both audits:

- The average variance between the current RN budget and SNCT indicated a deficit of 19.83 WTE.
- For CSWs, the same comparison showed an average surplus of 4.08 WTE.
- When comparing the current budget to professional judgement, there was an average RN deficit of 2.64 WTE, and a CSW deficit of 9.30 WTE

5.2 Patient Acuity and Dependency Scores for JCCISM

Figure 12: Patient Acuity and Dependency scores during the audit period broken down by percentage

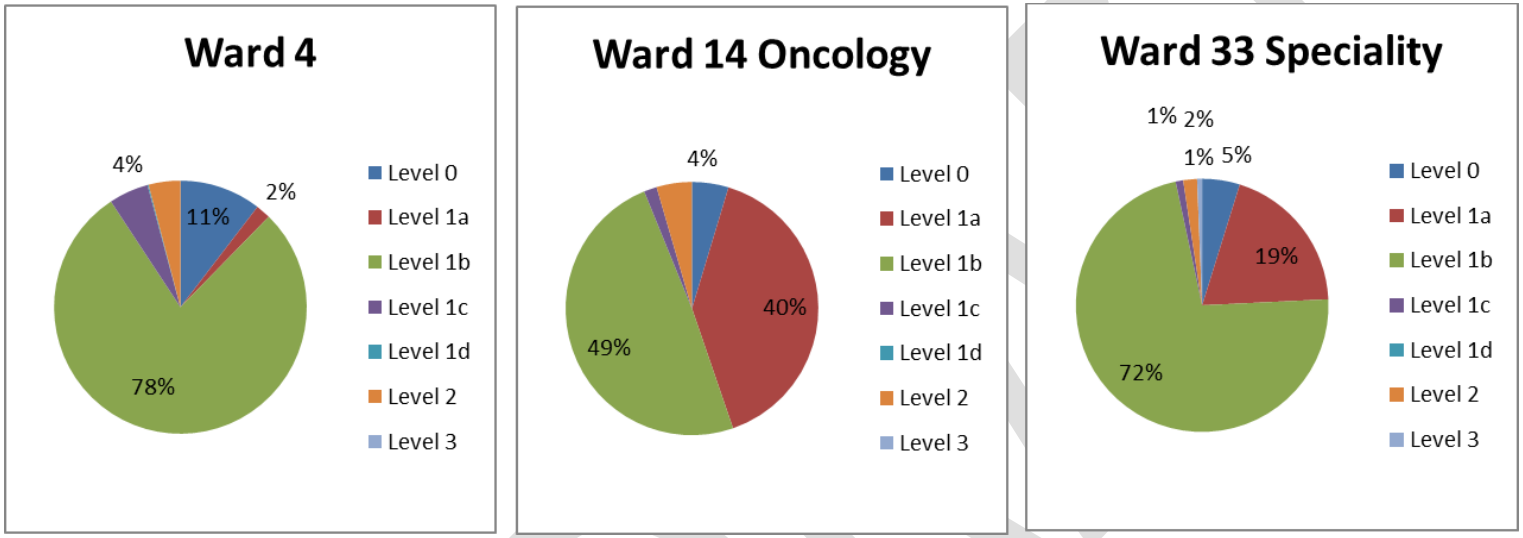
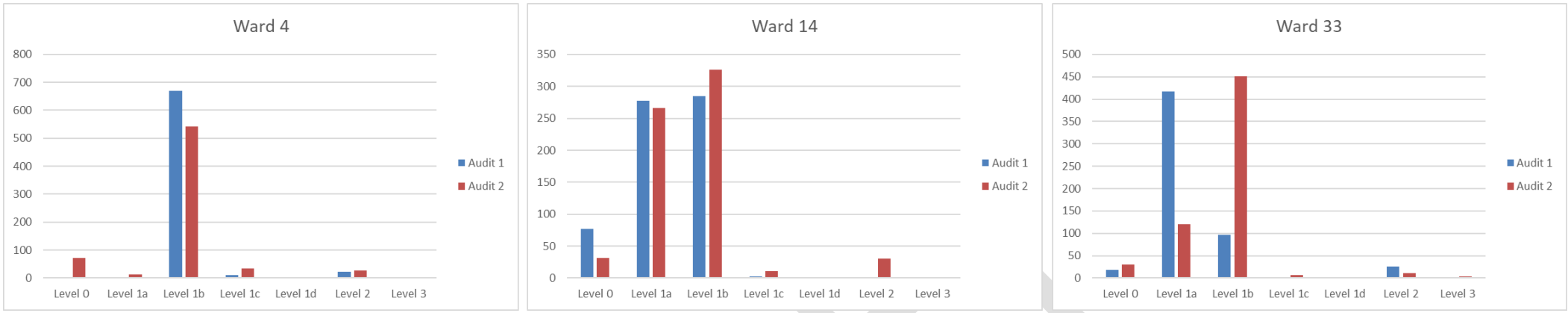


Figure 11: JCCISM Patient Acuity and Dependency scores comparison between both audits



5.3 JCCISM activity and patient harms recorded during the audit period

Table 20: Activity and Patient Harms by Ward for Audit 1 (March 25) vs Audit 2 (September 25)

Ward	Audit	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 4	Audit 1	44	71	64	31	15	6	72	0	2	11	3			3		89%
	Audit 2	54	79	53	17	18	4	76	3	3	11		1	1	5		100%
Ward 14 Oncology	Audit 1	70	81	11	9	15	7	31	0	6	8			2	9		100%
	Audit 2	76	101	16	9	16	7	45	4	9	7			2	1		-
Ward 33 Specialty	Audit 1	32	45	22	9	7	2	19	1	1	14				1		93%
	Audit 2	56	63	22	7	20	4	22	0	10	10	1		1	1		100%

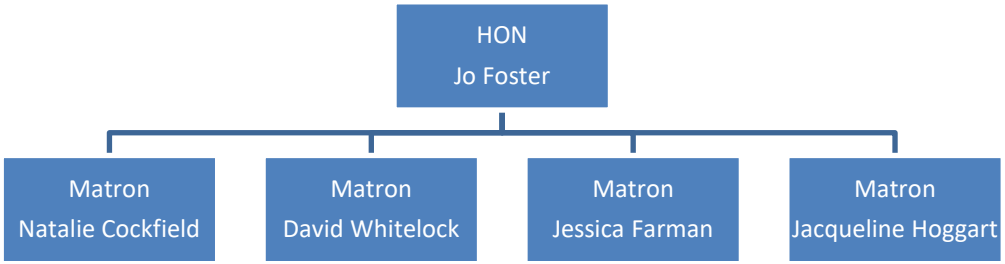
5.4 Head of Nursing Comments and Actions – Clare Allinson

Ward 4 Renal – Whilst the nursing establishment currently provides safe care, the need to increase HCAs has been reflected in professional judgement and SNCT outcomes. Ward 4 offers a telephone support line at night and weekends for patients requiring Nephrology advice this includes renal transplantation open access. Ward 4 also delivers a vascular access service, which requires the assistance of a HCA with the procedure I would support the additional HCA for this as it has never been factored in the establishment, we also have a higher risk of falls due to the patient group and the value for a third HCA overnight would be safer care.

Ward 14 Oncology – No change to establishment is required. Ward 14 offers a telephone support line at nights and weekends for patients requiring oncology advice as per UKONS guidance. It was expected additional HCA support recommendation given the complexities of EOLC patients and complexities of pain management and syringe drivers.

Ward 33 Haematology – Ward 33 offers a telephone support line at nights and weekends for patients requiring haematology advice as per UKONS guidance. The British Society for Haematology staffing guidance for patients who are neutropenic is a ratio of 1:4, the agreed ward staffing on ward 33 is 1:5 during the day and 1:8 during the night as not all patients on the ward are neutropenic, therefore a requirement to increase nurse staffing is recommended.

6. Medicine & Emergency Care



6.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Medicine & Emergency Admission Units

During September 2025, the average bed occupancy across the collaborative reached **97.60%**, reflecting a consistently high demand for inpatient care.
The current skill mix for this care setting is composed of **70% Registered Nurses (RNs)** and **30% Clinical Support Workers (CSWs)**, aligning with the complexity and acuity of patient need.

Workforce Budget vs. Professional Judgement

- Registered Nurses (RNs):
  - Budgeted WTE: 91.16
  - Professional Judgement Requirement: 94.85
  - Deficit: 3.69
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 64.50
  - Professional Judgement Requirement: 67.03
  - Deficit: 2.53

SNCT Tool Analysis

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 47.67
- CSW Budget Surplus: 11.10

Table 21: Admissions Units Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

				RN							CSW						
	Bed Management			Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT CSW		Variance	
Ward	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget CSW WTE	Sep 25 Contracted CSW	Required CSWWTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	CSW Variance **Budget to PJ**
Ward 1 AAU	31	29.17	94.09%	31.58	35.80	32.52	46.66	41.61	-15.08	-0.94	20.64	19.32	21.45	17.95	16.01	2.69	-0.81
Ward 31 AAU	35	35.23	100.67%	28.00	29.68	29.81	51.71	46.33	-23.71	-1.81	23.22	21.76	24.13	19.90	17.82	3.32	-0.91
Ward 37 (AMU)	30	29.30	97.67%	31.58	33.56	32.52	40.46	40.20	-8.88	-0.94	20.64	19.44	21.45	15.56	15.46	5.08	-0.81
Totals	**96**	**93.70**	**97.60%**	**91.16**	**99.04**	**94.85**	**138.83**	**128.13**	**-47.67**	**-3.69**	**64.50**	**60.52**	**67.03**	**53.40**	**49.29**	**11.10**	**-2.53**

Table 22: Admissions Units Audit 1 comparison with Audit 2

				RN								CSW							
	Bed Management			Current Budget 23/24	Professional Judgement (PJ)	Variance						Current Budget 23/24	Professional Judgement (PJ)	Variance					
Ward	% Occupancy Audit 1	% Occupancy Audit 2	*% Occupancy Average*	Budget RN WTE *includes WM	Required RN WTE *includes WM	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	RN Variance Budget to PJ Audit 1	RN Variance Budget to PJ Audit 2	RN Variance Budget to PJ Average	Budget CSW WTE	Required CSW WTE	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	CSW Variance Budget to PJ Audit 1	CSW Variance Budget to PJ Audit 2	CSW Variance Budget to PJ Average
Ward 1 AAU	91.61%	94.09%	92.85%	31.58	32.52	-13.10	-15.08	-14.09	-2.53	-0.94	-1.74	20.64	21.45	3.84	2.69	3.27	-0.80	-0.81	-0.81
Ward 31 AAU	99.23%	100.67%	99.95%	28.00	29.81	-25.77	-23.71	-24.74	-2.40	-1.81	-2.11	23.22	24.13	2.54	3.32	2.93	-0.91	-0.91	-0.91
Ward 37 (AMU)	95.33%	97.67%	96.50%	31.58	32.52	-9.05	-8.88	-8.96	-1.53	-0.94	-1.24	20.64	21.45	5.01	5.08	5.04	-0.80	-0.81	-0.81
Totals	**95.55%**	**97.60%**	***96.58%***	**91.16**	**94.85**	**-47.92**	**-47.67**	***-47.79***	**-6.46**	**-3.69**	***-5.08***	**64.50**	**67.03**	**11.39**	**11.10**	***11.24***	**-2.51**	**-2.53**	***-2.52***

Table 22 provides a comparison of bed occupancy across both audits, with an average occupancy rate of 96.58%. It also presents the average variance between the current budget, the Safer Nursing Care Tool (SNCT) recommendations, and professional judgement for both Registered Nurses (RNs) and Clinical Support Workers (CSWs).
Across both audits:

- The average variance between the current RN budget and SNCT indicated a deficit of 47.79 WTE.
- For CSWs, the same comparison showed an average surplus of 11.34 WTE.
- When comparing the current budget to professional judgement, there was an average RN deficit of 5.08 WTE, and a CSW deficit of 2.52 WTE

6.2 Patient Acuity and Dependency Scores for Med & Emerg Admissions Units

Figure 12: Patient Acuity and Dependency scores during the audit period broken down by percentage

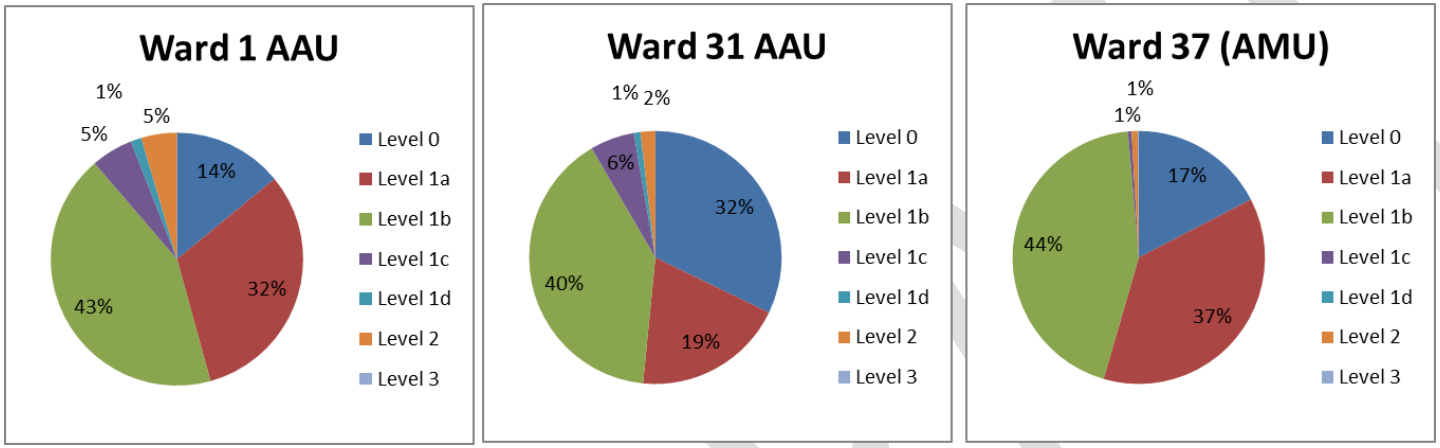
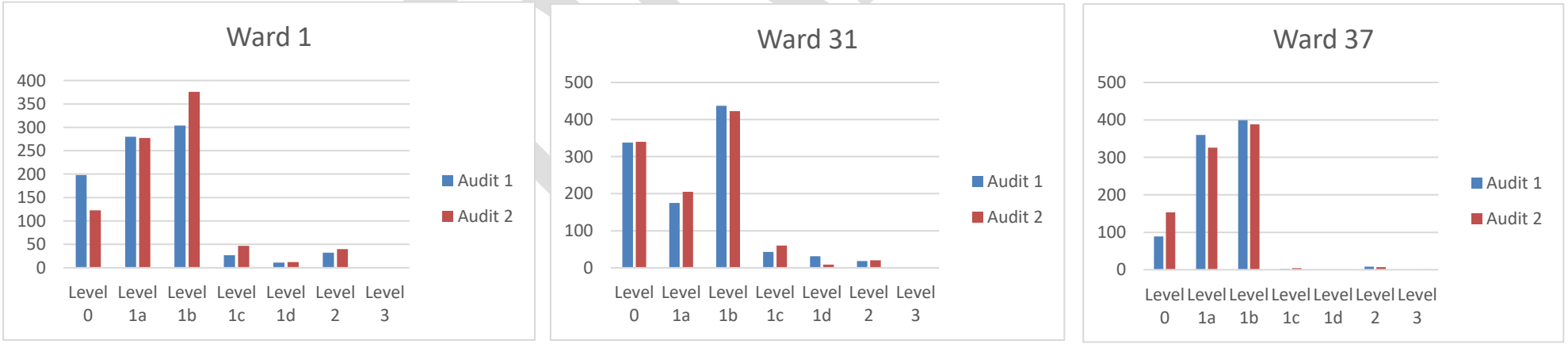


Figure 13: Admissions Units Patient Acuity and Dependency scores comparison between both audits



6.3 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Medicine & Emergency Acute Inpatient Wards

During September 2025 the bed occupancy across this collaborative was an average of 96.58%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs.

Workforce Budget vs. Professional Judgement

- Registered Nurses (RNs):
  - Budgeted WTE: 101.68
  - Professional Judgement Requirement: 113.83
  - Deficit: 12.15
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 74.65
  - Professional Judgement Requirement: 83.13
  - Deficit: 8.48

SNCT Tool Analysis

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 88.67
- CSW Budget Surplus: 1.44

Operational Considerations

To note ward 9 has x 2 Respiratory Support Unit bays requiring 1:2 staffing for the first 24hrs of BIPAP and ward 3 multispecialty assessment ward.

Table 23: Med & Emerg AIW Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

				RN							CSW						
	Bed Management			Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT CSW		Variance	
Ward	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget CSW WTE	Sep 25 Contracted CSW	Required CSWWTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	CSW Variance **Budget to PJ**
Ward 2	30	29.87	99.56%	16.92	22.45	18.97	32.76	30.86	-15.84	-2.05	13.36	12.13	13.41	12.60	11.87	0.76	-0.05
Ward 3	28	26.07	93.10%	18.23	18.43	18.97	33.84	31.34	-15.61	-0.74	12.75	11.53	13.41	13.02	12.06	-0.27	-0.66
Ward 9 incl RSU	34	33.83	99.51%	30.40	32.72	35.24	46.68	46.13	-16.28	-4.84	9.84	8.72	16.09	17.95	17.75	-8.11	-6.25
Ward 11 (OPM)	28	26.87	95.95%	20.46	21.84	21.68	38.81	36.51	-18.35	-1.22	20.64	18.64	21.45	14.93	14.05	5.71	-0.81
Ward 12 OPM	27	25.33	93.83%	15.67	18.84	18.97	38.25	33.44	-22.58	-3.30	18.06	13.72	18.77	14.71	12.86	3.35	-0.71
Totals	**147**	**141.97**	**96.58%**	**101.68**	**114.28**	**113.83**	**190.35**	**178.27**	**-88.67**	**-12.15**	**74.65**	**64.74**	**83.13**	**73.21**	**68.59**	**1.44**	**-8.48**

Table 24: Acute Inpatient Wards Audit 1 comparison with Audit 2

				RN								CSW							
	Bed Management			Current Budget 23/24	Professional Judgement (PJ)	Variance						Current Budget 23/24	Professional Judgement (PJ)	Variance					
Ward	% Occupancy Audit 1	% Occupancy Audit 2	*% Occupancy Average*	Budget RN WTE *includes WM	Required RN WTE *includes WM	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	RN Variance Budget to PJ Audit 1	RN Variance Budget to PJ Audit 2	RN Variance Budget to PJ Average	Budget CSW WTE	Required CSW WTE	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	CSW Variance Budget to PJ Audit 1	CSW Variance Budget to PJ Audit 2	CSW Variance Budget to PJ Average
Ward 2	96.10%	99.56%	97.83%	16.92	18.97	-14.08	-15.84	-14.96	-1.86	-2.05	-1.96	13.36	13.41	1.43	0.76	1.10	0.52	-0.05	0.23
Ward 3	92.96%	93.10%	93.03%	18.23	18.97	-20.18	-15.61	-17.90	-0.55	-0.74	-0.65	12.75	13.41	-2.03	-0.27	-1.15	-0.09	-0.66	-0.38
Ward 9 incl RSU	85.21%	99.51%	92.36%	30.40	35.24	-12.36	-16.28	-14.32	-9.16	-4.84	-7.00	9.84	16.09	-6.60	-8.11	-7.35	-5.57	-6.25	-5.91
Ward 11 (OPM)	97.39%	95.95%	96.67%	20.46	21.68	-14.18	-18.35	-16.27	-1.82	-1.22	-1.52	20.64	21.45	7.32	5.71	6.51	1.88	-0.81	0.54
Ward 12 OPM	97.52%	93.83%	95.67%	15.67	18.97	-24.07	-22.58	-23.33	-6.61	-3.30	-4.96	18.06	18.77	2.77	3.35	3.06	-0.70	-0.71	-0.71
Totals	**93.49%**	**96.58%**	***95.03%***	**101.68**	**113.83**	**-84.88**	**-88.67**	***-86.77***	**-20.00**	**-12.15**	***-16.08***	**74.65**	**83.13**	**2.89**	**1.44**	***2.16***	**-3.96**	**-8.48**	***-6.22***

Table 24 provides a comparison of bed occupancy across both audits, with an average occupancy rate of 95.03%. It also presents the average variance between the current budget, the Safer Nursing Care Tool (SNCT) recommendations, and professional judgement for both Registered Nurses (RNs) and Clinical Support Workers (CSWs).
Across both audits:

- The average variance between the current RN budget and SNCT indicated a deficit of 86.77 WTE.
- For CSWs, the same comparison showed an average surplus of 2.16 WTE.
- When comparing the current budget to professional judgement, there was an average RN deficit of 16.08 WTE, and a CSW deficit of 6.22 WTE

6.4 Patient Acuity and Dependency Scores for Med & Emerg Acute Inpatient Wards

Figure 14: Patient Acuity and Dependency scores during the audit period broken down by percentage

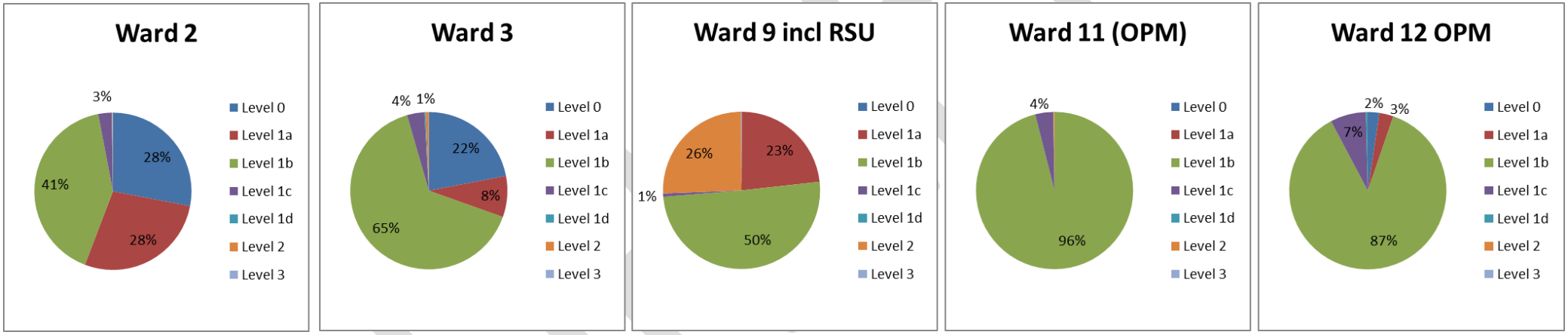
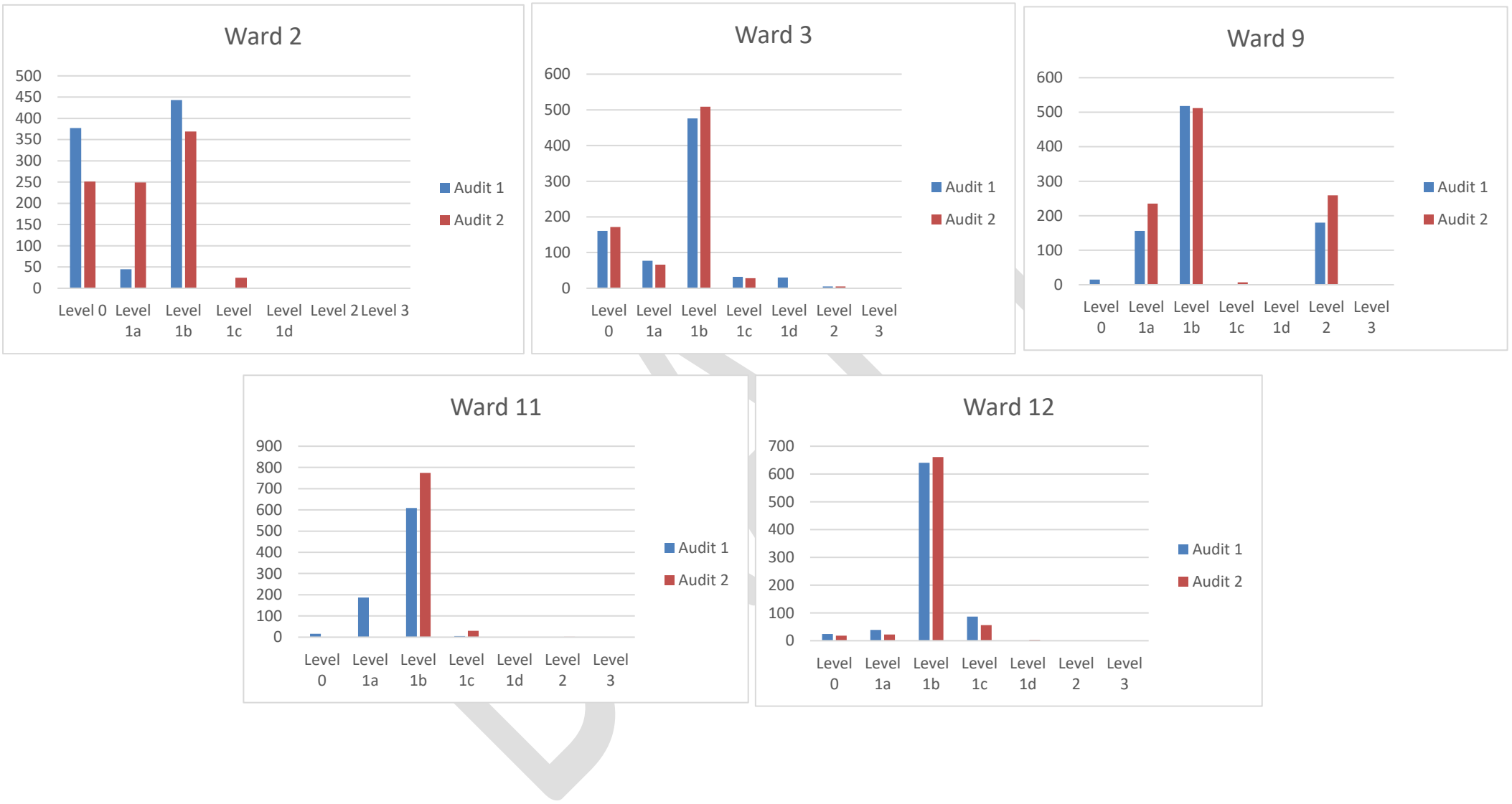


Figure 15: Acute Inpatient Wards Patient Acuity and Dependency scores comparison between both audits



6.5 Med & Emergency Care activity and patient harms recorded during the audit period

Table 25: Activity and Patient Harms by Ward for Audit 1 (March 25) vs Audit 2 (September 25)

Ward	Audit	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 1 AAU	Audit 1	343	233	395	470	54	10	377	0	27	30	3		4	11		91%
	Audit 2	613	213	344	501	15	13	170	12	11	9			1	6		100%
Ward 2	Audit 1	53	77	11	10	12	4	72	20	13	12	4			13		75%
	Audit 2	45	45	4	10	1	4	27	12	12	14	2	1	2	15		100%
Ward 3	Audit 1	3	85	106	6	9	2	66	4	24	19	3	1		5		80%
	Audit 2	12	103	120	18	0	8	80	0	2	21	5		2	6		96%
Ward 9 incl RSU	Audit 1	92	78	8	4	19	10	240	0	2	0	10	1	2	7	1	25%
	Audit 2	99	74	4	8	34	6	270	0	12	6	8	2	1	4	1	75%
Ward 11 (OPM)	Audit 1	48	49	17	5	2	7	35	1	12	25	3			8		100%
	Audit 2	46	59	27	7	0	8	44	3	25	51			2	11	1	100%
Ward 12 OPM	Audit 1	11	47	43	4	0	2	45	0	58	36	1	1	1	9		100%
	Audit 2	23	51	41	6	0	6	43	1	29	46	2		3	8	1	66.7%
Ward 31 AAU	Audit 1	356	347	9	7	2	3	304	0	37	45	1		2	2	2	100%
	Audit 2	378	352	0	19	17	6	365	0	20	59		1		4	1	100%
Ward 37 (AMU)	Audit 1	604	207	7	271	0	12	1057	0	8	3	6		4	10		93%
	Audit 2	643	230	20	302	11	6	1200	51	6	5		1	5	9	1	96.6%

6.6 Head of Nursing Comments and Actions – Jo Foster

Ward 1 Male Assessment Unit – Takes direct admissions from the Emergency Department. There is a high activity level on Ward 1 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base, the ward has patients waiting for admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward.

Ward 37 Female Assessment Unit – It takes direct admissions from the Emergency Department and via GP's. There is a high activity level on Ward 37 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base the ward has patients waiting admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward.

Ward 31 Short Stay – Professional judgement and actual staffing are appropriate for Ward 31; no change is required.

Ward 3 Infectious Diseases – No change is required, as the SNCT recommendation has included the CMD unit which no longer functions on Ward 3.

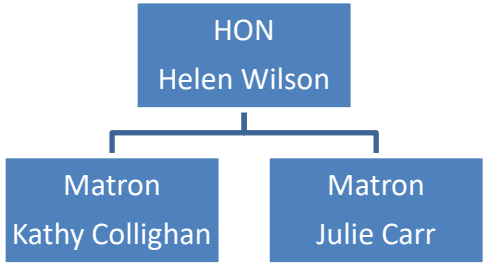
Ward 9 Respiratory - is a 34 bedded respiratory ward. The ward footprint includes 10 ring fenced beds that are used for patients requiring high levels of respiratory support split over 2 bays and 2 siderooms, offering dedicated male and female beds. The ward footprint is large, and this is challenging to manage as there is often a requirement to provide additional respiratory support in side rooms. All RSU beds require British Thoracic Society recommended level 2 nurse to patient ratios (1:2 – 1:4) and this is reflected in the wards funded establishment. In winter the ward's activity, acuity and dependency predictably increase. SNCT and professional judgement both indicate a requirement for an increase in both RN and HCA numbers in this area. This is reflective of the patient need.

Ward 12 –The ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce.

Ward 11 Older Peoples Medicine – The ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce.

Ward 2 – SNCT recommendations exceeds the requirement of staffing required to provide safe care. The ward has an increase in patients with a higher level of acuity during the collection period. This is not a reflection of usual activity across a full year.

7. Neurosciences & Spinal Care



7.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Neurosciences & Spinal Care

During September 2025 the bed occupancy across this collaborative was an average of 86.53%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs except for ward 26 which was 50/50.

Workforce Budget vs. Professional Judgement

- Registered Nurses (RNs):
  - Budgeted WTE: 92.36
  - Professional Judgement Requirement: 94.83
  - Deficit: 2.49
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 70.12
  - Professional Judgement Requirement: 67.04
  - Surplus: 3.08

SNCT Tool Analysis

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 39.27
- CSW Budget Surplus: 19.48

Table 26: Neurosciences & Spinal Care Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

				RN							CSW						
	Bed Management			Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT CSW		Variance	
Ward	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget CSW WTE	Sep 25 Contracted CSW	Required CSWWTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	CSW Variance **Budget to PJ**
Spinal Injuries +HDU	20	20.23	101.17%	29.60	32.72	29.81	29.67	27.61	-0.07	-0.21	24.22	22.00	21.45	11.42	10.63	12.80	2.77
Ward 24	23	19.37	84.20%	19.67	18.40	18.97	31.14	22.29	-11.47	0.70	13.90	12.84	13.41	11.98	8.58	1.92	0.49
Ward 26	19	17.47	91.93%	13.51	15.08	13.55	25.80	22.51	-12.29	-0.04	12.90	12.48	13.41	9.92	8.66	2.98	-0.51
Ward 34 NASU	34	26.00	76.47%	29.58	32.20	32.52	45.02	40.21	-15.44	-2.94	19.10	19.12	18.77	17.32	15.46	1.78	0.33
Totals	**96**	**83.07**	**86.53%**	**92.36**	**98.40**	**94.85**	**131.63**	**112.62**	**-39.27**	**-2.49**	**70.12**	**66.44**	**67.04**	**50.64**	**43.33**	**19.48**	**3.08**

Table 27: Neurosciences & Spinal Care Audit 1 comparison with Audit 2

				RN								CSW							
	Bed Management			Current Budget 23/24	Professional Judgement (PJ)	Variance						Current Budget 23/24	Professional Judgement (PJ)	Variance					
Ward	% Occupancy Audit 1	% Occupancy Audit 2	*% Occupancy Average*	Budget RN WTE *includes WM	Required RN WTE *includes WM	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	RN Variance Budget to PJ Audit 1	RN Variance Budget to PJ Audit 2	RN Variance Budget to PJ Average	Budget CSW WTE	Required CSW WTE	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	CSW Variance Budget to PJ Audit 1	CSW Variance Budget to PJ Audit 2	CSW Variance Budget to PJ Average
Spinal Injuries +HDU	113.00%	101.17%	*107.08%*	29.60	29.81	-5.18	-0.07	*-2.63*	-1.40	-0.21	*-0.80*	24.22	21.45	10.84	12.80	*11.82*	0.10	2.77	*1.44*
Ward 24	86.65%	84.20%	*85.43%*	19.67	18.97	-6.89	-11.47	*-9.18*	-0.89	0.70	*-0.09*	13.90	13.41	4.07	1.92	*2.99*	-4.86	0.49	*-2.19*
Ward 26	94.05%	91.93%	*92.99%*	13.51	13.55	-17.65	-12.29	*-14.97*	-1.85	-0.04	*-0.95*	12.90	13.41	0.91	2.98	*1.95*	-0.50	-0.51	*-0.51*
Ward 34 NASU	84.91%	76.47%	*80.69%*	29.58	32.52	-17.00	-15.44	*-16.22*	-8.96	-2.94	*-5.95*	19.10	18.77	1.18	1.78	*1.48*	-6.17	0.33	*-2.92*
Totals	**92.99%**	**86.53%**	***89.76%***	**92.36**	**94.85**	**-46.72**	**-39.27**	***-43.00***	**-13.10**	**-2.49**	***-7.80***	**70.12**	**67.04**	**17.00**	**19.48**	***18.24***	**-11.43**	**3.08**	***-4.18***

Table 27 provides a comparison of bed occupancy across both audits, with an average occupancy rate of 89.76%. It also presents the average variance between the current budget, the Safer Nursing Care Tool (SNCT) recommendations, and professional judgement for both Registered Nurses (RNs) and Clinical Support Workers (CSWs).
Across both audits:

- The average variance between the current RN budget and SNCT indicated a deficit of 43 WTE.
- For CSWs, the same comparison showed an average surplus of 18.24 WTE.
- When comparing the current budget to professional judgement, there was an average RN deficit of 7.80 WTE, and a CSW deficit of 4.18 WTE

7.2 Patient Acuity and Dependency Scores for Neurosciences & Spinal Care

Figure 16: Patient Acuity and Dependency scores during the audit period broken down by percentage

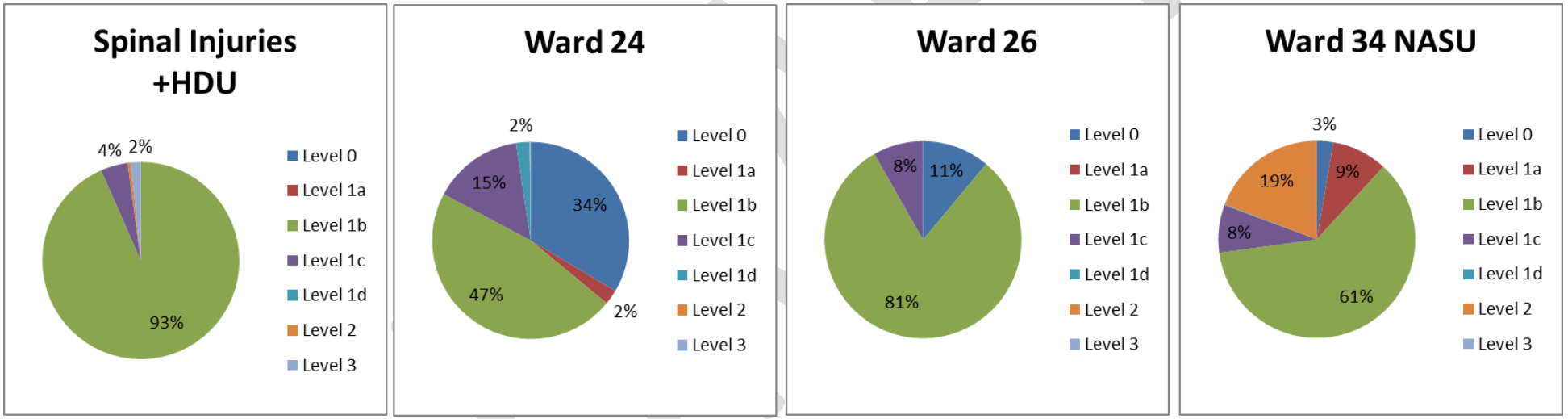
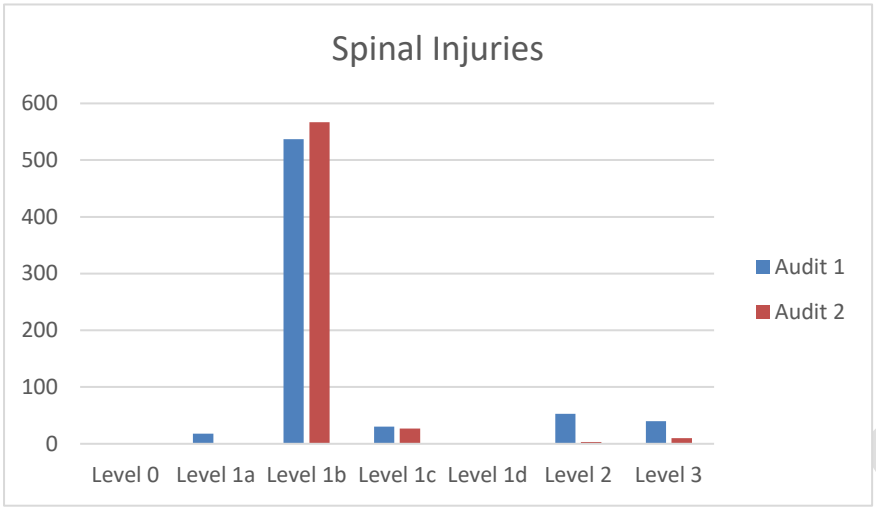
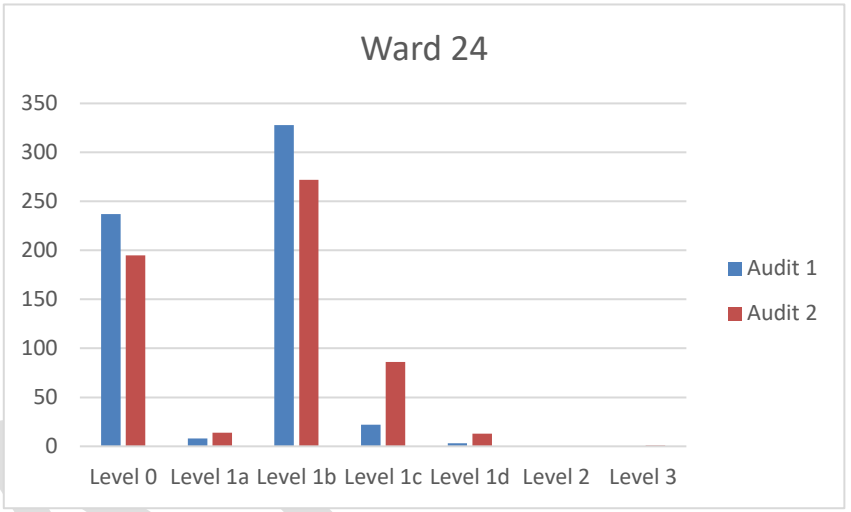
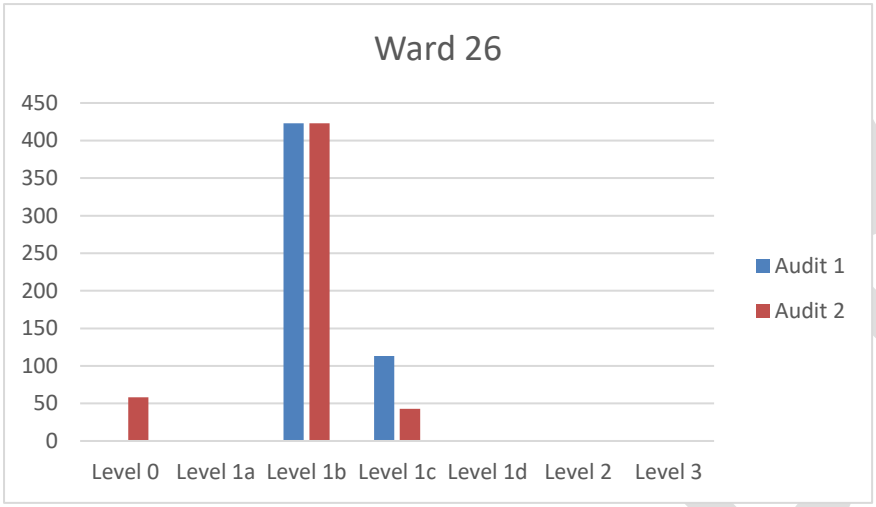
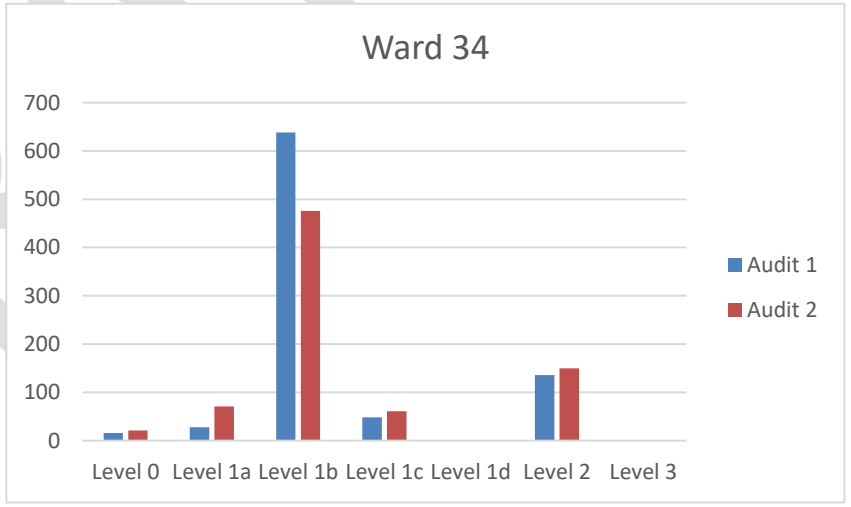


Figure 17: Neurosciences & Spinal Care Patient Acuity and Dependency scores comparison between both audits









7.3 Neurosciences & Spinal Care activity and patient harms recorded during the audit period

Table 28: Activity and Patient Harms by Ward for Audit 1 (March 25) vs Audit 2 (September 25)

Ward	Audit	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Spinal Injuries +HDU	Audit 1	18	18	2	0	0	0	0	0	1	0						100%
	Audit 2	23	13	7	2	1	0	2	2	10	16			2	1		100%
Ward 24	Audit 1	44	75	63	29	40	0	27	0	20	14						100%
	Audit 2	32	73	67	25	22	1	20	2	59	53	1			6		100%
Ward 26	Audit 1	0	7	9	0	14	0	6	0	100	15				2		100%
	Audit 2	6	10	5	0	4	0	7	0	24	3				5		90%
Ward 34 NASU	Audit 1	85	60	12	12	25	5	157	7	44	27	2			3		100%
	Audit 2	87	58	22	19	30	5	104	0	38	57	1	1	1	5		-

7.4 Head of Nursing Comments and Actions – Helen Wilson

Ward 24 – There has been an ongoing requirement for an increase in HCAs with a consistent additional spend on NHSP for falls and acuity, we have asked for this to be added into the budget each year however has not been realised in the budget. It is not safe to reduce NHSP spend on this ward for HCSW however the number of RNS in budget is appropriate.

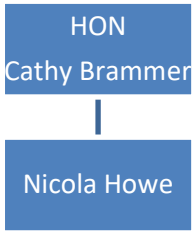
Ward 26 – The data suggests the ward would benefit from an increase in RN establishment which I would agree as it feels we have a short fall of RN's during the day requiring an increase to 4 rather than 3. We have requested an increase year on year for HCA on this ward due to the number of patients requiring 1-1 level care due to the risk of falls and cognitive problems, again unable to reduce NHSP spend due to the requirement to maintain safety.

Ward 34 - Ward 34 is a 34 bedded NASU including a 6 bedded hyper acute stroke bay and 1 thrombolysis side ward. The remaining beds are a combination of Acute Strokes and Neurology patients and 2 telemetry beds Monday to Friday which are constantly monitored by a Health care assistant with the beds used for sleep studies on a weekend. As a combined ward, there is a requirement to increase both RNs and HCAs to ensure that safe care is provided across the ward and monitored bay area. The monitored bay requires an increase in RN's to 3 day and nights, due to patient acuity and being a level 2 facility. In addition the nurses spend a significant amount of time away from the ward with emergency admissions having diagnostics as part of the pathway for example. Although SNCT recommends a further uplift the investment requested here would be adequate.

Spinal injuries – As a regional spinal injury unit, the unit should be commissioned for 1 RN and 1 HCA per 4 patients with a supernumerary coordinator for the ward during the day with 3 RNs overnight. The Spinal HDU should be 2 RNs days and night with an HCA. The recommendations from professional judgement and SNCT support this requirement. However, the reduction in the number of HCA wouldn't allow the spinal injuries unit to run safely and patient care and safety couldn't be maintained at the levels if reduced to SNCT figures. The HCA figures are not capturing the level of support and care that is required for this type of injury.

Overall for the majority of the areas the increase in the numbers of the RNs including level 1C and D should be represented in the HCA column which would justify the increase that has been requested over recent years.

8. Women & Children



8.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Women & Children

During September 2025 the bed occupancy across the paediatric ward areas was an average of 53.73%. The skill mix ratio for this care setting is 70% RNs to 30% HCAs.

Workforce Budget vs. Professional Judgement

- Registered Nurses (RNs): 50.95
  - Budgeted WTE:
  - Professional Judgement Requirement: 51.49
  - Deficit: 0.54
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 22.90
  - Professional Judgement Requirement: 16.09
  - Surplus: 6.81. However, these surplus hours are filled by play support staff who appear on the HCA budget line and have a very separate, non-clinical role.

SNCT Tool Analysis

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Surplus: 21.17
- CSW Budget Surplus: 7.93

Operational Considerations

Paediatric surgery has a lot of short stay patient activity, as can be seen on ward 22 with children only staying overnight if necessary following surgery.

Table 29: Women & Children Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

				RN							CSW						
	Bed Management			Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT RN		Variance		Current Budget 23/24	Actual Staffing	Professional Judgement (PJ)	SNCT CSW		Variance	
Ward	Open Bed Capacity	No of Patients Mar 25	% Occupancy	Budget RN WTE *includes WM	Sep 25 Contracted RN WTE *includes WM	Required RN WTE *includes WM	Trust Headroom 21% (including 1c&1d)	Trust Headroom 21% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	RN Variance **Budget to PJ**	Budget CSW WTE	Sep 25 Contracted CSW	Required CSWWTE	Trust Headroom 19.7% (including 1c&1d)	Trust Headroom 19.7% (not including 1c&1d)	Excess or deficit (-) SNCT against the **Current Budget**	CSW Variance **Budget to PJ**
Ward 21	25	13.90	55.60%	33.20	32.12	32.52	18.72	18.72	14.48	0.68	13.20	9.68	10.73	9.41	9.41	3.79	2.47
Ward 22	17	8.67	50.98%	17.75	18.77	18.97	11.05	11.05	6.70	-1.22	9.70	7.72	5.36	5.56	5.56	4.14	4.34
Totals	**42**	**22.57**	**53.73%**	**50.95**	**50.89**	**51.49**	**29.78**	**29.78**	**21.17**	**-0.54**	**22.90**	**17.40**	**16.09**	**14.97**	**14.97**	**7.93**	**6.81**

Table 30: Women & Children Audit 1 comparison with Audit 2

				RN								CSW							
	Bed Management			Current Budget 23/24	Professional Judgement (PJ)	Variance						Current Budget 23/24	Professional Judgement (PJ)	Variance					
Ward	% Occupancy Audit 1	% Occupancy Audit 2	*% Occupancy Average*	Budget RN WTE *includes WM	Required RN WTE *includes WM	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	RN Variance Budget to PJ Audit 1	RN Variance Budget to PJ Audit 2	RN Variance Budget to PJ Average	Budget CSW WTE	Required CSW WTE	Excess or deficit (-) SNCT against the Current Budget Audit 1	Excess or deficit (-) SNCT against the Current Budget Audit 2	*Excess or deficit (-) SNCT against the Current Budget Average*	CSW Variance Budget to PJ Audit 1	CSW Variance Budget to PJ Audit 2	CSW Variance Budget to PJ Average
Ward 21	83.20%	55.60%	*69.40%*	33.20	32.52	5.73	14.48	*10.10*	0.20	0.68	*0.44*	13.20	10.73	-0.63	3.79	*1.58*	1.20	2.47	*1.84*
Ward 22	62.94%	50.98%	*56.96%*	17.75	18.97	4.16	6.70	*5.43*	-0.17	-1.22	*-0.70*	9.70	5.36	2.83	4.14	*3.49*	0.46	4.34	*2.40*
Totals	**75.00%**	**53.73%**	***64.37%***	**50.95**	**51.49**	**9.89**	**21.17**	***15.53***	**0.03**	**-0.54**	***-0.25***	**22.90**	**16.09**	**2.20**	**7.93**	***5.06***	**1.66**	**6.81**	***4.24***

Table 30 provides a comparison of bed occupancy across both audits, with an average occupancy rate of 64.37%. It also presents the average variance between the current budget, the Safer Nursing Care Tool (SNCT) recommendations, and professional judgement for both Registered Nurses (RNs) and Clinical Support Workers (CSWs).

Across both audits:

- The average variance between the current RN budget and SNCT indicated a surplus of 15.53 WTE.

- For CSWs, the same comparison showed an average surplus of 5.06 WTE.
- When comparing the current budget to professional judgement, there was an average RN deficit of 0.25 WTE, and a CSW Surplus of 4.24 WTE

8.2 Patient Acuity and Dependency Scores for Women & Children

Figure 18: Patient Acuity and Dependency scores during the audit period broken down by percentage

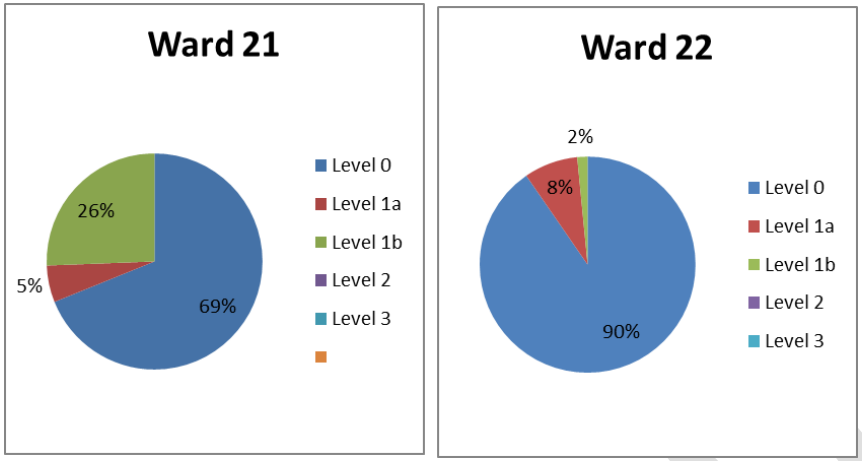
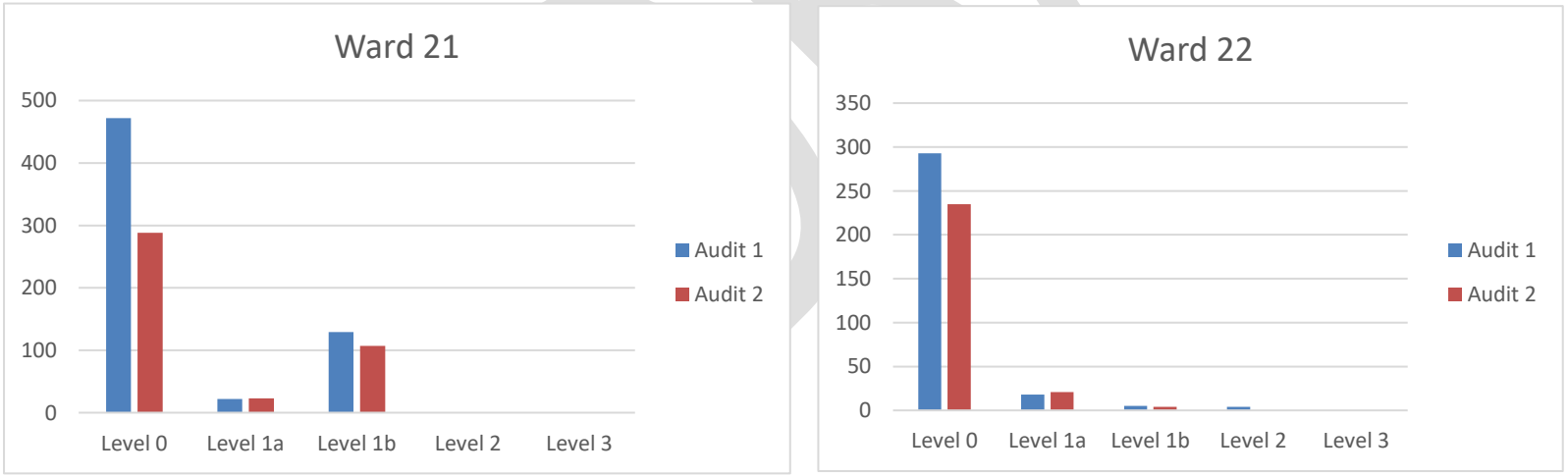


Figure 19: Women & Children Patient Acuity and Dependency scores comparison between both audits



8.3 Women & Children activity and patient harms recorded during the audit period

Table 31: Activity and Patient Harms by Ward for Audit 1 (March 25) vs Audit 2 (September 25)

Ward	Audit	Admissions	Discharges	Transfers in	Transfers Out	Ward Attenders	Deaths	Escorts on site	Escorts off Site	No of Patients requiring 1:1 care	No of Patients requiring Level 2	New or Deteriorating PU 2's (inpatient)	New or deteriorating PU 3's (inpatient)	Medication Incidents	Falls	Complaints	Inpatient Survey
Ward 21	Audit 1	153	153	23	4	16	0	12	1	0	0						95%
	Audit 2	187	172	8	3	7	0	23	1	0	0						100%
Ward 22	Audit 1	160	155	20	11	30	0	323	0	0	0						97%
	Audit 2	151	146	22	1	51	0	269	0	0	0						100%

8.4 Head of Nursing Comments and Actions – Cathy Brammer

The data suggests a significant surplus of registered nursing staff across both wards based on bed occupancy at the time of the data collection HCA establishments would suggest being accurate when taking into consideration play staff. Bed occupancy and levels of acuity fluctuate greatly on a day-to-day basis across children and young people services. Bed occupancy on Ward 22 (children's surgery) is greatly impacted by the frequency and population of theatre lists for children and young people and this is continuing to increase but is not yet back to a level seen pre-covid. Ward 21, children's medicine sees continued higher levels of occupancy throughout October to April.

The Royal College of Nursing staffing guidance for CYP (RCN 2013) is available to benchmark staffing against and is used nationally when setting nursing establishments for CYP areas. It forms part of CQC inspection criteria when evaluating staffing establishments. This guidance stipulates a set of core standards to be applied in services providing health care for children and young people which includes a nurse-to-patient ratio of 1:3 for patients under 2 years and 1: 4 for over. NHSE&I have published a Children's safer nurse staffing framework for inpatient care in acute hospitals (NHSE&I, 2021). It also suggests a 70/ 30% ration of registered to unregistered staff rather than 66%/ 36% used above and a headroom of 25% as opposed to the Trusts 21%. This document identifies as a minimum; there should be a co-ordinating nurse on each shift who is supernumerary. Further guidance published by the Association of British Paediatric Nursing in September 2025 reinforces RCN guidance and suggests higher headroom of 27% (Standards for safe staffing in Children and Young Peoples wards and departments, ABPN, 2025)

There is a general perception that children always have carers present however this is not an accurate reflection of reality. Children in general are a vulnerable patient group who are unable to be left unsupervised due to their age and development. Parents and carers often also need a high level of support, education and reassurance. There has been a noticeable increase in the number of young people admitted requiring mental health/ social care support with increased pressure on inpatient mental health beds locally and nationally. These patients need an enhanced level of care and support.

Staffing within neonatal and all paediatric areas including PCCU and CYPED is reviewed on a daily basis and reallocated as needed, as due to the skill set, help cannot be sourced from any other areas of the Trust. Due to this, NHSP spend across paediatrics and neonates is minimal.

Actions

- Continue to review staffing on a 6 monthy basis in line with NHSI workforce Safeguards
- Promote robust data entry particularly in relation to day case/ ward attender patients
- Review staffing as part of group model and streamline any efficiencies

Appendix 2

Actual staffing v SNCT outcomes

Collab	Ward	SNCT Outcome RN	Actual RN	Variance (- deficit)	SNCT Outcome HCA	Actual HCA	Variance (- deficit)	HON Comments
Cardiovascular Care	CCU	21.74	33.68	11.94	8.36	2.16	**-6.20**	It is a challenge to determine the exact need on CCU using the SNCT tool due to the level of patient acuity in this area. The audit tool is not fit for purpose for this level of acuity and the responsiveness required to leave the unit for emergency care provision outreaching (cath labs, cardiac arrest bleep).
	Ward 28 Vas	39.79	20.40	**-19.39**	15.31	16.12	0.81	Based on the current footprint and high acuity, the staffing establishment should remain the same at least with a firm argument to increase numbers to 4 RNs on a night as they currently struggle due to patient acuity. The percentage of level 1B captures the number of patients with complex wounds that takes a considerable amount of time, and numbers of amputee patients who require the assistance of 2 or more nursing team members. Recommend Further review of this on the next SNCT audit.
	Ward 29	24.73	20.12	**-4.61**	9.52	8.64	**-0.88**	The SNCT recommendation of less HCAs does not reflect the need of additional HCA support to ensure safe patient care at night when there is an increased risk of falls. I recommend the increase in RN numbers for 1 extra nurse during the day as currently no coordinator for a 36 bedded ward, to support the flow throughout the department and coordinate the ACS transfers.
	Cardio MB	11.18	8.56	**-2.62**	4.30	6.16	1.86	Staffing establishment is at the correct levels. We cannot reduce the number of RN's as suggested as we currently only have 2 Nurses for 9 patients and require a HCA around the clock for support and to ensure telemetry is monitored and alarms responded to.
	Ward 32	21.87	19.28	**-2.59**	8.41	11.80	3.39	SNCT supports the need for an additional RN on nights but not the reduction in HCA numbers as already minimal HCA numbers.
Digestive Diseases, Urology & Gastro	Ward 5	30.75	20.09	**-10.66**	11.83	16.05	4.22	The patient cohort for this ward is highly dependent on extensive support from staff. The impact on behaviours due to the nature of their conditions often leads to a higher need for 1:1 support to ensure the patients are safely cared for. This is reflected in the professional judgement and SNCT outcomes. The patient cohort is also known to rapidly deteriorate requiring a higher level of care from Registered Nurses.
	Ward 6	24.63	18.76	**-5.87**	9.48	13.76	4.28	This ward area is currently open to 27 beds as they are currently displaced onto Ward 10 whilst the life cycle work is completed on Ward 6. The current staffing budget for the ward is for 28 beds. The ward is planned to reduce to 16 beds over the weekend period and as a result staffing is reduced on a weekend. However, to support the non-surgical admissions across the organisation it is continuously open to 27 beds including the weekend. This will account for the variation between current and actual staffing against professional judgement and SNCT recommendations. From the 17 November 25 the ward will move back into its usual footprint on Ward 6 and will have a total of 29 beds.
	Ward 7	30.59	22.68	**-7.91**	30.26	13.80	**-16.46**	The SNCT outcomes show an excessively high requirement for RNs. The acuity of the patients and the often-rapid decline would show the higher need for RN provision. The ward also takes the majority of critical care and PACU step downs who require higher need to RN provision due to TPN, IVAB's, chest drains, complex nutritional patients and complex wound dressings. However, the care provided from the HCAs ensures that safe care is provided alongside the clinical interventions from registered staff.

	Ward 8	31.60	23.92	**-7.68**	30.42	15.60	**-14.82**	Ward 8 continues to have a high number of medical outliers; therefore, the professional judgement demonstrated the need for additional nursing staff. The ward also accepts critical care steps downs, patients discharged from PACU and urology patients across the Tees Valley including patients from County Durham and Darlington.
Friarage Hospital & H&R Community Services	**Ainderby**	39.71	15.33	**-24.38**	15.28	16.88	1.60	This ward with frail and complex medical patients has a need for additional RN support.
	CDU	26.83	18.73	**-8.10**	10.32	9.22	**-1.10**	is a 22 bedded admission ward for medical patient admissions. The need to cover telemetry over a 24 hour period would require additions to the RN workforce on nights.
	Friary	22.44	9.24	**-13.20**	22.20	12.91	**-9.29**	This ward is based in a remote area with no internal support structures, therefore the recommendation from SNCT to increase the nursing establishment does reflect the current need. The ward could run on 1 RN with support from Community staff if syringe drivers were needed for EoL patients.
	Romanby	26.29	16.10	**-10.19**	10.12	16.18	6.06	This 22 bedded medical ward is providing safe care within the current establishment.
	Rutson	24.33	13.13	**-11.20**	9.36	12.09	2.73	is a 17 bedded primary care rehabilitation ward with 10 stroke beds and 7 general rehab beds. This ward is ensuring safe care with the current establishment.
Tees Community	**Tocketts**	37.50	18.45	**-19.05**	14.43	21.79	7.36	This 31 bedded rehabilitation ward provides care in single rooms. This is the reason that SNCT recommends a decrease in HCAs, however due to the risk to patients in this side room layout there should not be a reduction to HCA workforce. The estate is very problematic and has a difficult footprint being a H- shape with arms coming off intermittently.
	Zetland	46.94	21.73	**-25.21**	18.06	26.00	7.94	The nurse to patient ratio when fully established provides safe care to the patients. The recommendations from SNCT do not match the patient need.
Head, Neck, Orthopaedic and Reconstructive	**Gara**	19.68	13.37	**-6.31**	7.57	8.41	0.84	Gara has a fully established workforce, with the surgical hub at FHN now opened - I have requested a review (data submitted previously) to ensure appropriate staffing levels are maintained and staffing is incorporated with this focus (SOP produced with surgical hub lead), for the inpatient bed base of 21 and incorporating day case/day zero patients allocated bed space on the ward footprint (who attend the ward for post-surgical care). This will allow for review of elective capacity/footfall aligned with appropriate nurse staffing for the patient group.
	Ward 25	34.69	19.00	**-15.69**	13.34	12.15	**-1.19**	Staffing establishment (due to complexity of patient group, NHSP consistent request/spend re falls risk and frail vulnerable patients requiring intervention on a continual focus, that however do not reach the CG47 threshold (some do)), has been reviewed for both day allocation/ratio and night shift allocation/ratio on current budget, combined with the above data evident/SNCT data.
	Ward 27	14.25	14.33	0.08	5.48	10.28	4.80	15 bedded elective orthopaedic ward, no change is required to the current staffing establishment currently. Regional elective work to be incorporated as this progresses to review staffing and elective footprint/capacity for this green ring fenced ward.

	Ward 35	36.47	23.44	**-13.03**	14.03	14.52	0.49	The ward requires (and has been agreed) an extra RN support (matches the above 2.20 wte suggested) two to three times per week for complex care post-surgery (L2) and to support any emergency high level patients (free flap/trach) (L2) requiring 1:1 observation and oversight. This is factored into the professional judgement calculation above. There is high complexity of patients and patient throughput, daily. The ward also supports the plastics clinics and other drop-in services that is not factored into the ward staffing calculations (PDC is on the ward however has own staffing model, separately). On a weekend and out of hours the ward supports any patient requiring urgent plastics treatment. An agreement has been given verbally via SLT to have the increase in RN, this needs to progress to budget alignment to allow and recruitment and training.
	Ward 36	40.79	24.44	**-16.35**	36.57	14.08	**-22.49**	The trauma ward is a critical care step down area and sees high numbers of overnight trauma and major trauma patient admissions, as well as in hours (24/7). The ward consistently sees complex patients beyond the trauma speciality in terms of need and mixed speciality care input. As such the staffing template will continue to be reviewed within CSU going forward and escalation as needed to review as skill mix is required to maintain patient safety and patient interventions – this so far comprises of RN and registered NA, + HCSW colleagues.
James Cook Cancer Institute & Speciality Medicine	**Ward 4**	32.55	21.60	**-10.95**	12.52	12.00	**-0.52**	Whilst the nursing establishment currently provides safe care, the need to increase HCAs has been reflected in professional judgement and SNCT outcomes. Ward 4 offers a telephone support line at night and weekends for patients requiring Nephrology advice this includes renal transplantation open access. Ward 4 also delivers a vascular access service, which requires the assistance of a HCA with the procedure I would support the additional HCA for this as it has never been factored in the establishment, we also have a higher risk of falls due to the patient group and the value for a third HCA overnight would be safer care.
	Ward 14	26.91	23.60	**-3.31**	10.35	11.68	1.33	No change to establishment is required. Ward 14 offers a telephone support line at nights and weekends for patients requiring oncology advice as per UKONS guidance. It was expected additional HCA support recommendation given the complexities of EOLC patients and complexities of pain management and syringe drivers.
	Ward 33	28.04	24.32	**-3.72**	10.79	14.80	4.01	Ward 33 offers a telephone support line at nights and weekends for patients requiring haematology advice as per UKONS guidance. The British Society for Haematology staffing guidance for patients who are neutropenic is a ratio of 1:4, the agreed ward staffing on ward 33 is 1:5 during the day and 1:8 during the night as not all patients on the ward are neutropenic, therefore a requirement to increase nurse staffing is recommended.
Medicine & Emergency Care	**Ward 1 AAU**	46.66	35.80	**-10.86**	17.95	19.32	1.37	Takes direct admissions from the Emergency Department. There is a high activity level on Ward 1 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base, the ward has patients waiting for admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward.
	Ward 31 AAU	32.79	22.45	**-10.34**	12.61	12.13	**-0.48**	Professional judgement and actual staffing are appropriate for Ward 31; no change is required.

	Ward 37 AMU	33.82	18.43	**-15.39**	13.01	11.53	**-1.48**	It takes direct admissions from the Emergency Department and via GP's. There is a high activity level on Ward 37 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base the ward has patients waiting admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward.
	Ward 2	46.68	32.72	**-13.96**	17.96	8.72	**-9.24**	SNCT recommendations exceeds the requirement of staffing required to provide safe care. The ward has an increase in patients with a higher level of acuity during the collection period. This is not a reflection of usual activity across a full year.
	Ward 3	38.80	21.84	**-16.96**	14.93	18.64	3.71	No change is required, as the SNCT recommendation has included the CMD unit which no longer functions on Ward 3.
	Ward 9	38.24	18.84	**-19.40**	14.71	13.72	**-0.99**	is a 34 bedded respiratory ward. The ward footprint includes 10 ring fenced beds that are used for patients requiring high levels of respiratory support split over 2 bays and 2 siderooms, offering dedicated male and female beds. The ward footprint is large, and this is challenging to manage as there is often a requirement to provide additional respiratory support in side rooms. All RSU beds require British Thoracic Society recommended level 2 nurse to patient ratios (1:2 – 1:4) and this is reflected in the wards funded establishment. In winter the ward's activity, acuity and dependency predictably increase. SNCT and professional judgement both indicate a requirement for an increase in both RN and HCA numbers in this area. This is reflective of the patient need.
	Ward 11	51.19	29.68	**-21.51**	19.69	21.76	2.07	The ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce.
	Ward 12	40.49	33.56	**-6.93**	15.58	19.44	3.86	The ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce.
Neurosciences & Spinal Care	**Spinal Injuries & HDU**	29.69	32.72	3.03	11.42	22.00	10.58	As a regional spinal injury unit, the unit should be commissioned for 1 RN and 1 HCA per 4 patients with a supernumerary coordinator for the ward during the day with 3 RNs overnight. The Spinal HDU should be 2 RNs days and night with an HCA. The recommendations from professional judgement and SNCT support this requirement. However, the reduction in the number of HCA wouldn't allow the spinal injuries unit to run safely and patient care and safety couldn't be maintained at the levels if reduced to SNCT figures. The HCA figures are not capturing the level of support and care that is required for this type of injury.
	Ward 24	31.16	18.40	**-12.76**	11.99	12.84	0.85	There has been an ongoing requirement for an increase in HCAs with a consistent additional spend on NHSP for falls and acuity, we have asked for this to be added into the budget each year however has not been realised in the budget. It is not safe to reduce NHSP spend on this ward for HCSW however the number of RNS in budget is appropriate.

	Ward 26	25.81	15.08	**-10.73**	9.93	12.48	2.55	The data suggests the ward would benefit from an increase in RN establishment which I would agree as it feels we have a short fall of RN's during the day requiring an increase to 4 rather than 3. We have requested an increase year on year for HCA on this ward due to the number of patients requiring 1-1 level care due to the risk of falls and cognitive problems, again unable to reduce NHSP spend due to the requirement to maintain safety.
	Ward 34	45.04	32.20	**-12.84**	17.33	19.12	1.79	Ward 34 is a 34 bedded NASU including a 6 bedded hyper acute stroke bay and 1 thrombolysis side ward. The remaining beds are a combination of Acute Strokes and Neurology patients and 2 telemetry beds Monday to Friday which are constantly monitored by a Health care assistant with the beds used for sleep studies on a weekend. As a combined ward, there is a requirement to increase both RNs and HCAs to ensure that safe care is provided across the ward and monitored bay area. The monitored bay requires an increase in RN's to 3 day and nights, due to patient acuity and being a level 2 facility. In addition the nurses spend a significant amount of time away from the ward with emergency admissions having diagnostics as part of the pathway for example. Although SNCT recommends a further uplift the investment requested here would be adequate.
Women & Children	**Ward 21**	18.72	32.12	13.40	9.41	9.68	0.27	The data suggests a significant surplus of registered nursing staff across both wards based on bed occupancy at the time of the data collection HCA establishments would suggest being accurate when taking into consideration play staff. Bed occupancy and levels of acuity fluctuate greatly on a day-to-day basis across children and young people services. Bed occupancy on Ward 22 (children's surgery) is greatly impacted by the frequency and population of theatre lists for children and young people and this is continuing to increase but is not yet back to a level seen pre-covid. Ward 21, children's medicine sees continued higher levels of occupancy throughout October to April. The Royal College of Nursing staffing guidance for CYP (RCN 2013) is available to benchmark staffing against and is used nationally when setting nursing establishments for CYP areas. It forms part of CQC inspection criteria when evaluating staffing establishments. This guidance stipulates a set of core standards to be applied in services providing health care for children and young people which includes a nurse-to-patient ratio of 1:3 for patients under 2 years and 1: 4 for over. NHSE&I have published a Children's safer nurse staffing framework for inpatient care in acute hospitals (NHSE&I, 2021). It also suggests a 70/ 30% ration of registered to unregistered staff rather than 66%/ 36% used above and a headroom of 25% as opposed to the Trusts 21%. This document identifies as a minimum; there should be a co-ordinating nurse on each shift who is supernumerary. Further guidance published by the Association of British Paediatric Nursing in September 2025 reinforces RCN guidance and suggests higher headroom of 27% (Standards for safe staffing in Children and Young Peoples wards and departments, ABPN, 2025) There is a general perception that children always have carers present however this is not an accurate reflection of reality. Children in general are a vulnerable patient group who are unable to be left unsupervised due to their age and development. Parents and carers often also need a high

	Ward 22	11.05	18.77	7.72	5.56	7.72	2.16	level of support, education and reassurance. There has been a noticeable increase in the number of young people admitted requiring mental health/ social care support with increased pressure on inpatient mental health beds locally and nationally. These patients need an enhanced level of care and support. Staffing within neonatal and all paediatric areas including PCCU and CYPED is reviewed on a daily basis and reallocated as needed, as due to the skill set, help cannot be sourced from any other areas of the Trust. Due to this, NHSP spend across paediatrics and neonates is minimal. Actions • Continue to review staffing on a 6 monthy basis in line with NHSI workforce Safeguards • Promote robust data entry particularly in relation to day case/ ward attender patients • Review staffing as part of group model and streamline any efficiencies

University Hospitals Tees

Guardian of Safe Working Reports: November 2025 – January 2026

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 3.4

Report author: Dr Rajesh Nanda (NTH), Dr Cat Lane (STH), Dr Tom Skeath (Deputy Associate Medical Director)

Executive director sponsor: Dr Mike Stewart, Chief Medical Officer

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: People Group 18 February 2026 and People Committee 24 February 2026.

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.

NTH: Seven breaches of the 13-hour rule and three ISCs recorded, mainly due to workload, staffing shortages, and rest concerns. Ongoing pressure continues in Medicine, Surgery, and O&G.

STH: Safe working fines have been unpaid for several months. This was only identified recently and work is underway to resolve it. Eight breaches of the 13-hour rule.

CMO: Overtime and breach data will be systematically reviewed alongside rota reviews to ensure workloads are accurately reflected in rota design. Resilience during peak periods will be strengthened through appropriate staffing, clearer escalation pathways, and optimal skill mix. This is particularly evidenced in areas with increased exception reporting such as respiratory.

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.

NTH: Reports of missed breaks, particularly during periods of reduced staffing, indicate the need for review to support staff wellbeing. O&G rostering has improved after earlier administrative gaps, continued oversight is needed to ensure stability.

STH: Further work is required on how ER data is shared and used to improve working conditions under the new ER reforms. Recruitment is underway following the resignation of the GOSW, with interviews planned for February 2026.

CMO: Anonymised, high-level ER learning data will be shared, with safeguards in place for small departments in line with ER reform. Guardian cover will remain uninterrupted throughout recruitment, and rest prioritisation is being addressed as part of the 10-point plan.

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

NTH: Strong compliance with the code of practice and national terms and conditions. ERs and fines have reduced compared with the previous quarter, and recent system improvements are supporting more accurate reporting of missed breaks.

STH: ER reporting has been more accurate since February 2023, supporting clearer trend analysis, and compliance with the code of practice remains strong.

CMO: Content with code of practice compliance rates. Having auditable cost centres in place is a positive step and strengthens compliance with ER reforms. Safe working continues to be

a priority, and current workload pressures are being addressed through ongoing rota review and optimisation work.

Recommendations:

It is requested that the content of this report is noted and acknowledged.

NORTH TEES AND HARTLEPOOL GUARDIAN OF SAFE WORKING (GOSW)
REPORT - 01 NOVEMBER 2025 to 31 JANUARY 2026

1. **PURPOSE OF REPORT**. This quarterly report covers the period from 1 November 2025 to 31 January 2026 and summarises issues and themes raised by resident doctors through the Exception Reporting (ER) system and the Doctors' Forum. The report fulfils the organisation's obligations under the national Terms and Conditions of Service.

2. **RECOMMENDATIONS**. **I**t is requested that the contents of this report are reviewed and noted for assurance.

3. **DETAIL**

a. **Numbers of Doctors in Training / Locally Employed Doctors**:

Number of doctors / dentists in training (total):	256*
Of these (*) number who are LET	254
Of these (*) number who are military doctors in training (have access to ER system)	2
Number of locally employed doctors (non-consultant and SAS grades)	86
Total number of Resident Doctors	**342**

b. **ERs with Immediate Safety Concerns (ISC).** During this period, 37 doctors (11%) submitted 134 exceptions. Three reports were marked as ISCs due to work intensity, staffing levels, and working patterns/rest. Problems with equipment and interdepartmental coordination.

c. **GOSW Fines**. Seven fines issued for breaches of the maximum 13-hour shift length, totalling £700. Of which £263 goes to the doctors in question and the remaining £437 allocated to the Guardian. This increases the Guardian's reserve fund to £3,060. Finance has established an auditable cost centre to support management of the fines account in line with the ER reform agreement.

d. **Payment for additional hours**. Exception reporting captured 153 additional hours worked; 144 hours paid as unplanned overtime and 2.5 hours taken as TOIL at the doctor's request. The remaining hours are pending outcome agreement.

e. **Data**. A summary of ERs is given in appendix one.

4. **SUMMARY OF ISSUES, ACTIONS AND RECOMMENDATIONS**

a. **ER Reforms.** From 6th August 2025, supervisors were removed from the ER process in line with the national 2024 pay deal reforms intended to improve ER confidentiality and effectiveness. Reports now go directly to Medical Workforce and the GOSW for additional hours worked, reducing conflicts of interest and mitigating fears of detriment. An increase in reporting is expected and intended under the new system.

b. **ER Trends.** A total of 134 ERs were submitted this quarter, compared with 165 in the previous quarter, and 66 in the same period last year (Nov 24 – Jan 25). Main causes remain the same; excess daytime workload and increased pressures due to staffing shortages. The

number of fines has reduced compared to the 21 fines levied in the previous quarter (Aug-Oct 25).

c. **Medicine**. ER activity remains consistent with the previous quarter. Resident doctors continue to report high workload and staffing shortages resulting in extended working hours. A total of 84 exceptions submitted, with Respiratory, Gastroenterology, and EAU being the top three areas. A high volume of respiratory illness within the community may have impacted workload. Three ISCs and two fines were issued. A stronger emphasis on inadequate staffing levels and skill mix has emerged. Clinical Rota Leads are reviewing rotas based on resident feedback and liaising with STH colleagues on best practice.

d. **Obs & Gynae.** ERs reduced to 23, down from 43 last quarter. Reported issues include theatre overruns, changes to rostered duties, workload, and staffing shortages. One fine levied. The department is addressing previously raised concerns, including risks associated with limited rostering administrative capacity.

e. **Surgery**. ERs decreased to 13 from 21 in the previous quarter. Common reasons include; ward-based workload and emergency cases occurring close to handover. Three fines were issued.

f. **Paediatrics**. A new trend emerged with 11 ERs submitted for additional hours due to longer-than planned handovers, driven by high patient acuity. The department has been informed so the appropriate action can be taken. No fines were issued.

g. **Orthopaedics**. ERs reduced significantly to 2, down from 15 last quarter. The cause for those submitted was additional hours due to workload. One fine issued.

h. **December Work Schedules**. December 2025 compliance with the work schedule contractual code of practice was 99%. Rota compliance 99%.

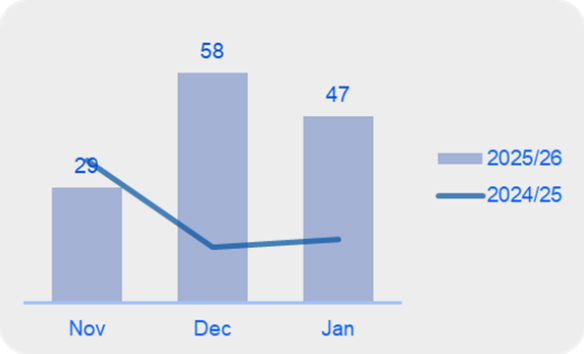
i. **Breaks.** Ten ERs were submitted specifically for missed breaks. Anecdotal reports in other ER categories also indicate missed breaks. Recent enhancements to the ER system (implemented late January) should improve the capture of this data. Departments are advised to review current break arrangements, particularly in high-pressure areas or during reduced staffing periods (e.g. out-of-hours, teaching days).

5. **CONCLUSION**. We will continue to work collaboratively with all stakeholders to maintain compliance with the code of practice and national terms and conditions. Medicine, Surgery, Obstetrics & Gynaecology, and Paediatric rotas will remain key areas of focus.

Exception reporting 1st November 2025 to 31st January 2026

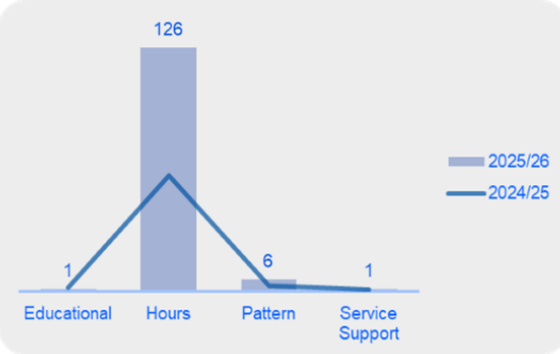
Exception Reporting

November 2025 to January 2026



134 exception reports by 37 doctors

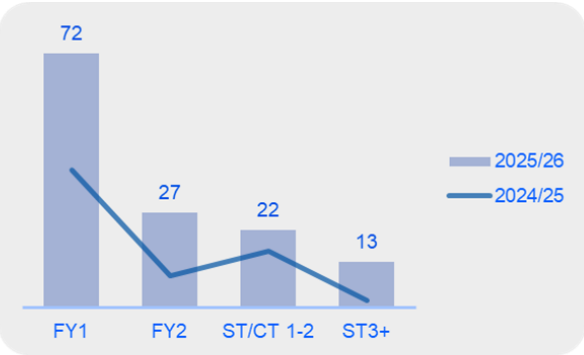
3 marked as immediate safety concerns



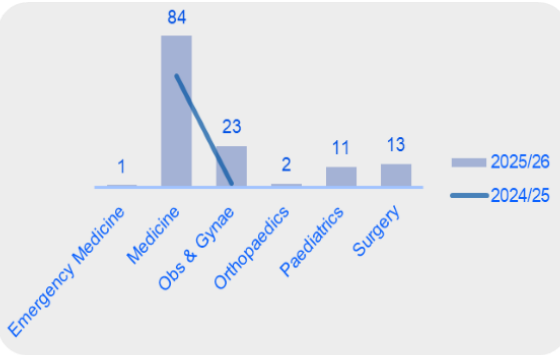
Majority (94%) relate to hours worked

82% (110) payment given

1.5% (2)TOIL given



Majority (74%) by Foundation doctors



63% Medicine

17% Obs & Gynae

10% Surgery

8% Paediatrics

7 Fines Levied

SOUTH TEES GUARDIAN OF SAFE WORKING (GOSW) REPORT
NOV 2025 TO JAN 2026

1. **PURPOSE OF REPORT**.

a. Provide an overview of the safe working patterns of all resident level doctors and dentists at South Tees Hospitals NHS foundation Trust. This report is in alignment with the 2016 junior doctor contract T&Cs and intended to provide assurance of the Trust's compliance with safe working hours and to highlight any areas and detail of concerns.

b. The report covers the period from the 1st November 2025 – 31st January 2026.

2. **RECOMMENDATIONS**. It is requested that the content of this report is acknowledged for assurance.

3. **DETAIL**

a. **Numbers of Doctors in Training / Locally Employed Doctors**:

Number of doctors / dentists in training (DiTs) (total):	472
Of these (*) number who are military DiTs (also have access to the exception reporting system)	16
Number of locally employed doctors (non-consultant and SAS grades)	263
Total number of Resident Doctors	**751**

b. **Exception reports (ERs) with Immediate Patient Safety Concerns (IPSC)**. There were no reports highlighting IPSCs.

c. **GOSW Fines & Finances**. There were 8 fines issued within this reporting period. All were >13-hour shifts. The fines totalled £337.2 with £126.46 going to the Resident doctors and £210.84 going to the GOSW funds. There were 6 fines for Nov 24 – Jan 25, although the payment amounts were higher. The current GOSW funds sit at £3679.11.

d. **Payment for additional hours**. There were 192 hours of overtime claimed during this reporting period which is higher than the same period in 2024/5 (172). There were 27 hours of TOIL and £3640.61 of overtime awarded.

e. **Data**. A summary of ERs is given in appendix 1.

4. **SUMMARY OF UPDATE, ISSUES AND RECOMMENDATIONS**

a. **ER themes.** Themes remain very similar to previous months with most of the overtime at the end of normal working days. Excess workload and reduced staff numbers are the cause of this. There is an increased number of reports compared to this time last year (196 vs 154 in 2024/5).

b. **Areas of concern.** Not much progress has been made with areas of high reporting. Direct visibility of ERs for departments is poor under the new ER reform procedures. Also, little can be done around high workloads and poor staffing in the current financial climate of the organisation. Rotas simply cannot be increased, and doctors can only be recruited within the confines of budgets. The information provided by ERs is shared with the deputy AMD for Resident Doctor Workforce. Respiratory is likely to be exceptionally high this reporting period,

due to thigh volume of respiratory illness in the community and the obvious knock on effect to the workload.

c. **December 2025 Work Schedule and Rotas**. Dec 2025 compliance with contractual code of practice deadlines for work schedules was 82% and for rotas 100%.

d. **GOSW fines account**. Unfortunately, the process for payment of fines has not been as effective and swift as previously thought. No payments have been made to the GOSW (or Resident doctors) for fines awarded after April 25. Reasons behind this are being investigated, as many such processes should have been automated with the introduction of PayPulse in June 25.

e. **ER process**. Amendments to the ER process continue to be made with the team from Pay Pulse. One area that still could be improved is how we disseminate useful but not identifiable information to departments, so that they can understand their ER levels, themes and costs, without compromising the confidentiality of the reporting Resident Doctor. Discussions are ongoing with PayPulse as to how this might be possible.

f. **GOSW Resignation**. Dr Cat Lane resigned from the role in November due to being appointed to another role within the Deanery. An advert has gone out to replace her, and interviews are being held in February.

g. **TOIL.** There has been a noticeable increase in the number of doctors requesting TOIL for ERs rather than payment. Currently this is awarded via a voucher issued on the PayPulse system. This will need to be monitored to ensure Resident Doctors are managing to take this and that the process for recording this is manageable for the CMRT/Clinical Rota leads.

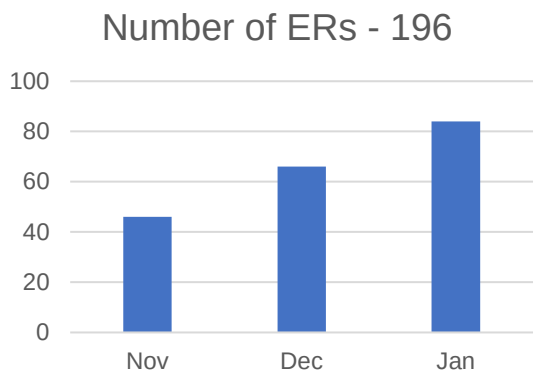
5. **CONCLUSION**. Exception reports are increased compared to the same time last year as well as the number of associated overtime hours. Fines amounts are reduced although numbers of penalty incurring ERs remain similar. Bedding in of the ER reforms is still required and solutions to making onward improvements are being sought. The finance processes remain challenging.

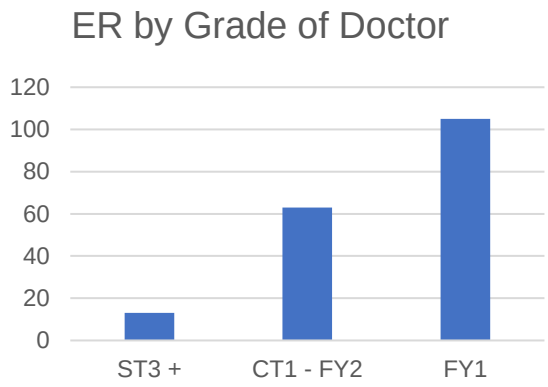
APPENDIX 1

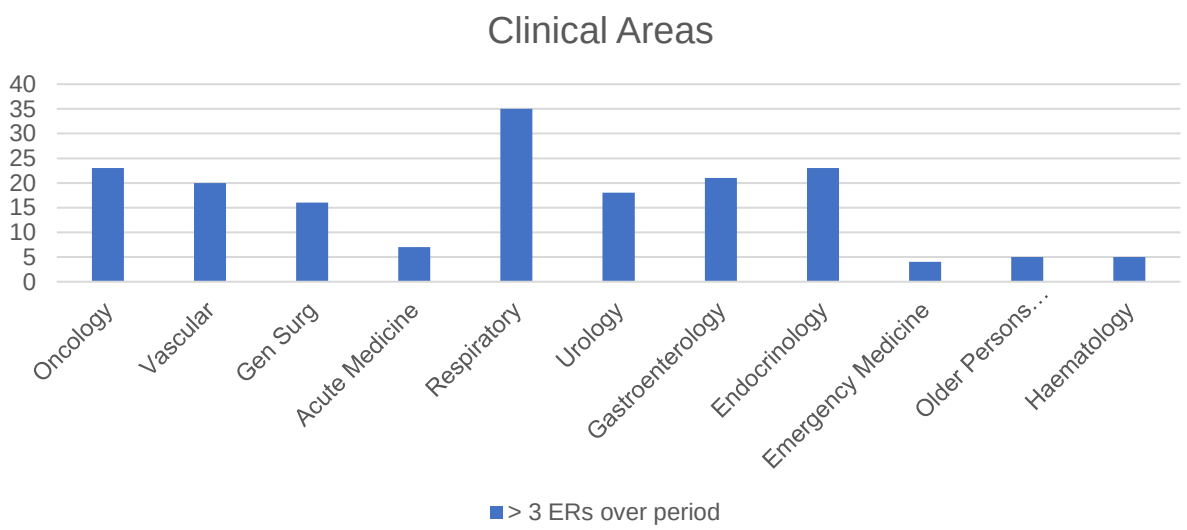
Summary of Exception Report Data

Total for period: 212.

Rejected/Withdrawn: 14







University Hospitals Tees

CMO OFFICE RESPONSE TO GOSW NOV 25 TO JAN 26 REPORTS

1. **PURPOSE OF REPORT**. Provide a response to the NTH and STH GOSW reports during the period of Nov 2025 to Jan 2026.

2. **RECOMMENDATIONS**. It is requested that the content of this report is acknowledged for assurance.

3. **DETAIL**

a. **Seasonal pressures.** The group faced sustained pressure on resident doctors this quarter, shown by higher exception reporting and frequent overruns, likely driven by winter demand. Activity surges will be built into the rota review work to ensure services are better prepared through appropriate staffing, clear escalation routes and improved skill-mix.

b. **Overtime and fines**. Areas in which these frequently occur will be considered as part of rota review and safe staffing work. The failure to process fines remains a compliance risk, and we are addressing this urgently, supported by the introduction of auditable cost centres.

c. **December Work Schedules compliance**. Compliance rates remain strong across the group for both LET and LED resident doctors. Challenges persist in meeting timescales for less-than-full-time doctors, and we continue to work with stakeholders to improve processes.

d. **Break compliance.** ER data suggests that breaks are likely under-reported. While system updates should improve this. This is ongoing work as part of the 10-point plan.

e. **ER process and reform**. Supervisors have been removed from the ER process to strengthen confidentiality. Although this reduces visibility of themes for departments, we plan to address the gap by introducing anonymised high-level data and learning summaries, with safeguards for small teams. We will work with our BMA/RDF colleagues and system providers to ensure full compliance with ER Reform guidance.

f. **GOSW:** We would like to thank the outgoing Guardian of Safe Working at South Tees for their hard work and valuable contribution to supporting safe working for our resident doctors. Cover will be uninterrupted while recruitment is underway

g. **Resident Doctor Forum (RDF)**. We are now rotating monthly between site based and joint RDFs. This ensures that site-based issues are addressed as well as working together across the group on polices.

4. **CONCLUSION**. We remain committed to work with our resident doctor colleagues to improve their working lives. We continue to triangulate ER data with other sources of information and feed this into the rota redesign work.

University Hospitals Tees

Group Equality Delivery System Report (2025/26)

Meeting date: 5 March 2026

Reporting to: UHT Board

Agenda item No: 3.5

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: 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:

BAF strategic risk: A culture that doesn't promote positivity, respect, inclusion and a focus on recognising, respecting 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.

This paper advises the Board on the Group Equality Delivery System assessment, the Board are requested to acknowledge the information contained within this report.

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

To support continued improvement on the EDS, the Group has a Workforce EDI Action Plan and a Health Inequalities Programme aligned to the six High Impact Actions. Both support improvement across the EDS Outcomes and progress against them is regularly provided to Board.

The development of the EDI and High Impact workforce dashboard will help gain insight into the workforce challenges and how staff can be supported.

The newly developed Cultural Development team is better aligned to work across the Group to identify challenges and embed working practices to support patients and staff to progress to improved outcomes.

Board of Directors

5 March 2026

Group Equality Delivery System Annual Report 2025/26

1.0 PURPOSE OF REPORT

Implementation of the Equality Delivery System (EDS) is mandatory under the NHS Standard Contract.

The EDS is specifically designed to encourage the collection of better evidence and insight across the range of people with protected characteristics as described in the Equality Act 2010, and so help NHS organisations meet their obligations under the Public Sector Equality Duty (PSED).

A third version of the EDS was commissioned by NHS England and NHS Improvement and launched in 2022/23. It consists of three separate domains covering: patient services, workforce and leadership.

Publication of the EDS is an annual requirement and the Trusts are required to publish our EDS rating on our public facing website.

2.0 BACKGROUND

EDS is a data-driven system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, whilst meeting the requirements of the Equality Act 2010 and the Public Sector Equality Duty.

EDS considers all protected characteristics under the Equality Act 2010 for our communities, patients and workforce alike, and considers health inequalities including from 2022, the Core20Plus5 priorities.

We are proud to work with the EDS system to ensure we are developing and improving services, free from discrimination, to meet the needs of our patients, service users, communities and our staff.

EDS 2022 is the latest version that we completed in 2025/26. Compliance against the EDS is managed and reviewed by the EDS Steering Group. This consists of representatives from across UHT. The Group reports to both the EDI Steering Group and People Committee.

3.0 DETAIL

Discussions were held at a meeting of the Site Leadership Team where three service areas where agreed. For 2025/26 the decision was Urology, Endoscopy and Paediatric Services (North Tees) /Children and Young Person Emergency Department (South Tees).

Working collaboratively with the South Tees Accreditation for Quality of Care (STAQC) which brings together key measures of nursing, leadership and clinical care into one overarching framework enabling a comprehensive assessment of the quality of care at ward, department, and unit or team level. The accreditation process has been reviewed and updated to take

into account the specific details required for this EDS report and has created a robust and comprehensive account of the three identified areas in line with the three domains.

Domain 1

South Tees - For all three domains the STAQC team undertook an assessment using the criteria requested as part of this report for South Tees.

North Tees and Hartlepool – For domain 1 all department leads for urology, endoscopy and paediatrics have supported the relevant EDS assessments.

The Patient Experience teams have used patient feedback collated from surveys and other engagement methods to support the assessments.

Domain 2

The Group Head of Occupational Health and Well Being used data from the staff survey and the Group Health Needs Assessment to further enhance the data gained from the accreditation. They have undertaken a evidence gathering exercise, drawing on a range of workforce data to analyse staff experience across a number of outcomes. This information has been considered at a detailed level to understand how experiences may differ according to an individual's differing protected characteristics. When assessing the four outcomes, the impact on protected characteristics were considered.

Domain 3

EDS 2022 includes a focus on how leaders and Board members show evidence of how they personally commit and contribute to the Equality, Diversity and Inclusion and health inequalities agenda within their organisations.

The Group People Risk and Compliance Manager collated evidence from various sources as detailed in the main presentation report in appendix 1.

4.0 GRADING

The assessment ratings for domain1, 2 and 3 for 2025/26 are summarised in the table below. All ratings have been agreed in full consultation with our stakeholders and align with the EDS Ratings and Score Card Guidance issued by NHS England.

Domain 1: Commissioned or provided services		UHT 2025-26
1A	Patients (service users) have required levels of access to the service.	Achieving Activity 2 Points
1B	Individual patients (service users') health needs are met.	Achieving Activity 2 points
1C	When patients (service users) use the service, they are free from harm.	Developing Activity

		1 point
1D	Patients (service users) report positive experiences of the service.	**Achieving Activity** **2 Points**

Domain 2: Workforce health and well-being		**UHT**
2A	When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions.	**Achieving Activity** **2 Points**
2B	When at work, staff are free from abuse, harassment, bullying and physical violence from any source.	**Achieving Activity** **2 points**
2C	Staff have access to independent support and advice when suffering from stress, abuse, harassment and physical violence from any source.	**Achieving Activity** **2 points**
2D	Staff recommend the organisation as a place to work and receive treatment.	**Developing Activity** **1 point**
Domain 3: Inclusive Leadership		**UHT**
3A	Board Members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.	**Achieving Activity** **2 Points**
3B	Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.	**Achieving Activity** **2 points**
3C	Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage poor performance and monitor progress with staff and patients.	**Achieving Activity** **2 points**

Under EDS, the scoring matrix assigns points for each grade:

0 points Undeveloped
1 point Developing Activity
2 points Achieving Activity
3 points Excelling Activity

Grading was undertaken by the EDS Steering Group early February based on the evidence provided within the report presentation.

UHT combined score for 2025/26 is reported as 20 points. This is within the range of 8 to 21 points therefore the UHT EDS Organisation Rating is confirmed as **Developing** for 2025/26.

It is positive to note that no outcomes were graded as ‘Underdeveloped’ as part of the 2025/26 assessment process across all domains

For all domains a total of 2 outcomes were graded as Developing, with 9 outcomes graded as Achieving.

The score card guidance contains a series of measures which are used to assign the rating for each of the domains.

5.0 ACTION PLANNING

Action Plans have been developed – please refer to appendix 1. EDS actions will be embedded into the overall EDI action plan.

6.0 RECOMMENDATIONS

The Board are requested to acknowledge the EDS Ratings (2025-26) for all domains as reported within section 4 of this paper.

APPENDICES

Appendix 1 – University Hospital Tees - EDS Report 2025/26 (in Reading Room)

NHS
University Hospitals Tees

Resources Committee

25 February 2026

Connecting to: UHT Board

Chair of Committee: Celia Weldon

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.

Productivity

The Committee considered the lower quartile performance reported in the following measures including receiving an update on the work to improve performance.

NTHFT:

- Proportion of outpatient attendances that are for first appointments, or follow up
- appointments attracting a procedure tariff
- Proportion of outpatient attendances resulting in PIFU
- BADS day case benchmark (British Association of Day Surgery)
- Capped Theatre Utilisation

STHFT:

- Ratio of follow up to first appointments
- Proportion of outpatient attendances resulting in Patient Initiated Follow Up (PIFU)
- Day case rate overall
- British Association of Day Surgery (BADS) day case benchmark
- Capped Theatre utilisation

Caring Better Together

Finance

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 10 2025/26 is a deficit of £9.9m for the Group, which is a favourable variance of £19k against the year-to-date plan.

The Group has received a fair share allocation of national pressures funding for industrial action totalling £2.9m, which has helped to reduce risk. Continued focus will be essential throughout the remainder of the financial year to ensure delivery of the financial control total. 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.

CIP

The Group has reported year-to-date CIP delivery of £58.2m, which is 98% of the target as at month 10. The current forecast year-end delivery is £73.1m, which is 100% of the annual target.

Whilst overall performance is at 98% of target, this is supported by non-recurrent measures at each Trust. The CSUs are significantly behind target for 2025/26, which has a material impact on the overall performance given the majority of the spend, and CIP targets, are within these areas. The Committee received an update on specific action being taken to address areas of underperformance. Work continues with individual CSUs and corporate areas that are behind plan.

Emergency Preparedness Resilience and Response (EPRR)

All NHS Trusts are required to present the public Board with an annual update regarding EPRR activities together with a statement of compliance with the annual EPRR core standards self-assessment.

The outcome of the annual EPRR core standards assessment is that both Trusts are declaring partial compliance for 2025/26. A programme of work will be implemented throughout 2026 to address the gaps identified by the assessment and to align response arrangements across University Hospitals Tees. However, these assessments do not impact on the ability of either of the Trusts to respond to incidents and is similar to the majority of Trusts across the North East and North Cumbria ICB area.

The Committee recommended approval by the Board.

Estates Strategy

The Committee received an update on the Estates Strategy for the Group. Individual trust issues were detailed.

At NTHFT, as identified in the Trust wide 6-facet survey in 2022 Trust buildings no longer meet the required standards to provide healthcare services, and are not compliant with current Health Building Notes and other standards in specific locations.

At STHFT three landlord assurance letters from NHSPS (NHS Property Services) relating to contracts from 3rd party owners, are missing. Regular discussions are taking place between the landlord and NHSPS to gather compliance documentation, however there is a lack of assurance due to the documentation/certification not being shared sufficiently.

The impact of these are other issues for NTHFT and STHFT were further described in the Capital update report to the Committee.

Performance

For NTHFT, the Cancer 62 Day Standard remains as Alert with three further RESPONSIVE metrics were regraded to Alert in December 2025.

- 12-Hour ED Breaches Rate (%) has been regraded to Alert, from Advise
- RTT Incomplete Pathways (%) has triggered Alert, from Advise
- RTT time to first appointment (%) has been regraded to Alert, from Advise,

For STHFT, the following three performance metrics remain as Alert assurance:

• Diagnostic 6 Week standard

• RTT Incomplete Pathways (%)

• RTT time to first appointment

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.

Sustainability

At NTHFT The take up on Green Champions has been disappointing and efforts are being made to explore how we can increase numbers. The Champions have a direct influence on the Trust's Green Plan by assisting in reducing our carbon footprint and making financial savings.

At STHFT there has been ongoing monitoring in relation to waste-management compliance. Areas of monitoring include hazardous waste storage arrangements, and the completeness of Duty of Care documentation.

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

Capital

NTHFT The FY25/26 capital plan for Estates is being progressed and is currently on track. STHFT At the time of writing all schemes are progressing to programme and allocated spend targets will be met by the end of the financial year.

Other

There were several areas where assurance was received across all the reports in the agenda, including receipt of funding for the installation of rapid electric vehicle chargers at NTHFT to support the new fleet of NEAS electric ambulances. At JCUH, Environmental Health visited the SERCO catering service for inspection on 1 December 2025 and a 5-star rating was awarded.

Month 10: 2025-26 Finance Report

Meeting date: *5 March 2026*

Reporting to: Board of Directors

Agenda item No: *4.2*

Report author: *Chris Hand, Chief Finance Officer*

Executive director sponsor: *Chris Hand, Chief Finance Officer*

Action required: *Assurance*

Delegation status: *Jointly delegated item to Group Board*

Previously presented to: *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.

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 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 10 2025/26 is a deficit of £9.9m for the Group, which is a favourable variance of £19k against the year-to-date plan.

The reported position includes over-performance of ERF income of £5.9m (at risk above commissioner affordable levels within contract mandates) and additional non-recurrent measures. The Group has received a fair share allocation of national pressures funding for industrial action totalling £2.9m, which has helped to reduce the risk relating to ERF income assumptions.

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.

Deficit support funding has been confirmed and received up to and including Quarter 4, based on the ICS overall position at Month 8. This has contributed to a stronger cash flow forecast position for STH for the remainder of the financial year, meaning that an application to access revenue cash support is no longer required.

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 are closely monitored over the course of the financial year through the Resources Committee. Significant risks include ERF income, industrial action, CIP delivery, expenditure run-rates and unfunded inflationary pressures.

Month 10 shows a net overall decrease of 53.39 WTE worked across the Group, compared to the previous month. WTEs worked in month were 174.80 wte lower than the average of the previous financial year, and 401.68wte less than the March 2025 position. Compared to the same period last year (Month 10 2024/25) WTEs were lower by 237.41wte. WTEs worked remains higher than the average deployed during 2019/20 (pre-Covid), by 2,365.37wte (18%); however the increase over this time period includes wte investment to remedy CQC safety and quality concerns and also to deliver additional commissioner funded services

Reductions in premium pay expenditure continue, with Agency spend £1.6m (21%) less and Bank spend £3.5m (13% less) than that incurred at the same point in the previous year (adjusted for inflation).

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 £2.6m of the CIP programme remains defined as 'Opportunity' and £9.5m of the programme remains as High Risk. Across the Group, overall year-to-date reported CIP delivery is £58.2m (98% of target). However, this position includes a number of non-recurrent schemes.

The Group is currently forecasting outturn capital expenditure in line with CDEL allocations and additional PDC allocations received in-year, including significant additional allocations received late in the financial year

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

The Resources Committee receives monthly assurance reports on the financial performance throughout the year, including a BI dashboard that provides aggregate financial information across UHT to support the leadership teams of the new Clinical Service Units (CSUs).

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

The Financial Recovery Oversight Group, chaired by the CEO with membership including the wider representation Executive team, ensures continued senior focus and prioritisation of planning, de-risking and delivery of the UHT efficiency programme.

Recommendations:

Members of the Board are asked to:

- Note the financial position for Month 10: 2025/26.

Board of Directors
5 March 2026

Month 10: 2025/26 Finance Report

1. PURPOSE OF REPORT

The purpose of this report is to update the Board on the financial performance of the individual trusts and overall Group, at the end of Month 10 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 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.

3. MONTH 10 FINANCIAL POSITION

The table below shows the revenue position for the Group as at the end of Month 10 2025/26, shown by trust:

	NTH			STH			GROUP		
STATEMENT OF COMPREHENSIVE INCOME	**Plan £000**	**Actual £000**	**Variance £000**	**Plan £000**	**Actual £000**	**Variance £000**	**Plan £000**	**Actual £000**	**Variance £000**
Operating income from patient care activities	355,092	358,545	3,453	794,151	800,129	5,978	**1,149,243**	**1,158,674**	**9,431**
Other operating income	28,970	28,736	(234)	59,653	66,055	6,402	**88,623**	**94,791**	**6,168**
Employee expenses	(258,106)	(268,232)	(10,126)	(505,283)	(507,354)	(2,071)	**(763,389)**	**(775,586)**	**(12,197)**
Operating expenses excluding employee expenses	(124,343)	(118,877)	5,466	(328,794)	(342,315)	(13,521)	**(453,137)**	**(461,192)**	**(8,055)**
OPERATING SURPLUS/(DEFICIT)	**1,613**	**172**	**(1,441)**	**19,727**	**16,515**	**(3,212)**	**21,340**	**16,687**	**(4,653)**
FINANCE COSTS									
Finance income	1,880	2,302	422	1,591	3,056	1,465	**3,471**	**5,358**	**1,887**
Finance expense	(587)	(593)	(6)	(18,030)	(17,906)	124	**(18,617)**	**(18,499)**	**118**
PDC dividends payable/refundable	(2,670)	(2,670)	0	0		0	**(2,670)**	**(2,670)**	**0**
NET FINANCE COSTS	**(1,377)**	**(961)**	**416**	**(16,439)**	**(14,850)**	**1,589**	**(17,816)**	**(15,811)**	**2,005**
Other gains/(losses) including disposal of assets	0	833	833	0	9	9	**0**	**842**	**842**
Corporation tax expense	(80)	(39)	41	(10)	(19)	(9)	**(90)**	**(58)**	**32**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**156**	**5**	**(151)**	**3,278**	**1,655**	**(1,623)**	**3,434**	**1,660**	**(1,774)**
Add back all I&E impairments/(reversals)	0	0	0	0		0	**0**	**0**	**0**
Remove capital donations/grants I&E impact	0	170	170	(6,254)	(4,635)	1,619	**(6,254)**	**(4,465)**	**1,789**
Remove net impact of consumables donated from other DHSC bodies	0	0	0	0		0	**0**	**0**	**0**
Remove PFI revenue costs on an IFRS 16 basis	0	0	0	53,896	53,817	(79)	**53,896**	**53,817**	**(79)**
Add back PFI revenue costs on a UK GAAP basis	0	0	0	(60,986)	(60,903)	83	**(60,986)**	**(60,903)**	**83**
Adjusted financial performance surplus/(deficit)	**156**	**175**	**19**	**(10,066)**	**(10,066)**	**0**	**(9,910)**	**(9,891)**	**19**
Less Non-Recurrent Deficit Funding	0	0	0	(9,885)	(9,885)	0	**(9,885)**	**(9,885)**	**0**
Adjusted financial peformance surplus (deficit) excluding Non-Recurrent Deficit Funding	**156**	**175**	**19**	**(19,951)**	**(19,951)**	**0**	**(19,795)**	**(19,776)**	**19**

At the end of Month 10 2025/26 the Group is reporting a year-to-date (YTD) favourable variance of £19k, with a variance of £19k relating to NTH and £0k relating to STH.

The main drivers of the **NTH Month 10 position** are:

- Clinical Income is ahead of plan by £3.5m. This is due to net-neutral reclassifications of income for UTC and SALT hosted services, offset by ERF assumptions, variable drugs & devices income, and additional funding for the recently commissioned sexual health service of £1.9m. The YTD position includes £1.2m of industrial action funding which has been confirmed by NHS England. The YTD position assumes payment of £2.3m ERF income (including Advice & Guidance) above the levels included in commissioner contract mandates.
- Other operating income is £0.2m behind plan, largely relating to donated asset income (which is excluded from the control total calculation).
- Interest receivable is ahead of plan by £0.4m, reflecting current interest rates and cash balances.

- Pay is £10m behind plan due to increased demand for Enhanced Care, weekend working linked to activity, industrial action, pay award pressures and slippage on CIP delivery and the allocation of targets for unidentified CIP at initial plan submission.
- Non-Pay is underspent by £5.5m, relating to hosted UTC expenditure which is offsetting increases in clinical supplies and drugs, linked to activity levels alongside slippage on CIP delivery, and additional spend to deliver the newly commissioned sexual health service.
- The year-to-date position includes the impact of additional non-recurrent measures of £2.3m, ahead of the phased plan.

The main drivers of the **STH Month 10 position** are:

- Clinical Income is ahead of plan by £6.0m. The position includes additional funding for 'winter surge' and Quarter 4 sprint activity. Assumed ERF income is £3.6m above commissioner contract mandates, in line with PbR rules. (This is net of the receipt of £1.7m additional pressure funding received for strikes.) However, this has been offset by the under-recovery of planned income for the FHN surgical hub, depreciation funding, and NHSE thoracic surgery expansion. The position includes the impact of net neutral reclassification of income for activity delivered under sub-contract arrangements and variable income for High-Cost Drugs and Devices.
- Other Operating Income is £6.4m ahead of plan, relating to the neutral reclassification of CDC income and favourable variances on R&D income. Salix grant income is £1.6m behind plan, however the impact is removed from the assessment of control total delivery.
- Pay is overspent by £2.1m, including the YTD pressure from a funding shortfall for the national pay award and the costs of industrial action. Bank staff underspends continue to offset an adverse variance on agency expenditure.
- Non-Pay is £13.5m overspent, with overspends on clinical supplies and drugs, and the impact of the net-neutral reclassification of UTC income, part offset by underspends against energy and premises. The position also includes additional expenditure for winter surge and Quarter 4 sprint activity.
- Interest receivable is ahead of plan by £1.5m, reflecting higher than plan cash balances.
- The position includes the impact of additional non-recurrent measures of £16.3m, 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 10, comparing the year-to-date expenditure with the same period in the previous financial year (adjusted for inflation).

AGENCY YTD	NTH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	884	94	(790)	1,803	(1,709)	-95%
AHP and Sci&Tech	269	529	260	479	50	11%
Other Clinical	0	0	0	0	0	-
Consultants	585	1,249	664	1,634	(385)	-24%
Career/staff grades	0	35	35	6	29	457%
Trainee grades	0	31	31	20	11	56%
Non Clinical	0	36	36	43	(7)	-16%
TOTAL	**1,738**	**1,974**	**236**	**3,985**	**(2,011)**	**-50%**

BANK YTD	NTH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	3,928	4,541	613	4,348	193	4%
AHP and Sci&Tech	555	573	18	555	18	3%
Other Clinical	3,929	4,683	754	4,480	203	5%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	0	0	0	0	0	-
Non Clinical	554	489	(65)	745	(256)	-34%
TOTAL	**8,966**	**10,286**	**1,320**	**10,127**	**159**	**2%**

AGENCY YTD	STH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	172	208	36	248	(40)	-16%
AHP and Sci&Tech	209	682	473	302	380	126%
Other Clinical	36	0	(36)	1	(1)	-100%
Consultants	2,249	2,927	678	3,023	(96)	-3%
Career/staff grades	0	0	0	0	0	-
Trainee grades	0	0	0	0	0	-
Non Clinical	47	191	144	0	191	-
TOTAL	**2,713**	**4,008**	**1,295**	**3,574**	**434**	**12%**

BANK YTD	STH					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	7,422	6,370	(1,052)	8,145	(1,775)	-22%
AHP and Sci&Tech	176	181	5	198	(17)	-9%
Other Clinical	6,308	5,418	(890)	7,003	(1,585)	-23%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	1,416	947	(469)	1,275	(328)	-26%
Non Clinical	728	882	154	799	83	10%
TOTAL	**16,050**	**13,798**	**(2,252)**	**17,420**	**(3,622)**	**-21%**

AGENCY YTD	UHT GROUP					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	1,056	302	(754)	2,051	(1,749)	-85%
AHP and Sci&Tech	478	1,211	733	780	431	55%
Other Clinical	36	0	(36)	1	(1)	-100%
Consultants	2,834	4,176	1,342	4,657	(481)	-10%
Career/staff grades	0	35	35	6	29	457%
Trainee grades	0	31	31	20	11	56%
Non Clinical	47	227	180	43	184	429%
TOTAL	**4,451**	**5,982**	**1,531**	**7,559**	**(1,577)**	**-21%**

BANK YTD	UHT GROUP					
	Plan	Actual	Variance	Adj 24/25	Change	
	£000	£000	£000	£000	£000	%
Nursing	11,350	10,911	(439)	12,493	(1,582)	-13%
AHP and Sci&Tech	731	754	23	753	1	0%
Other Clinical	10,237	10,101	(136)	11,483	(1,382)	-12%
Consultants	0	0	0	0	0	-
Career/staff grades	0	0	0	0	0	-
Trainee grades	1,416	947	(469)	1,275	(328)	-26%
Non Clinical	1,282	1,371	89	1,544	(173)	-11%
TOTAL	**25,016**	**24,084**	**(932)**	**27,548**	**(3,464)**	**-13%**

Across the Group, **YTD agency** expenditure was £7.6m. This was £1.6m higher than plan, largely relating to Consultant agency (which was £0.7m over at NTH and at £0.7m over at STH), and £0.6m on Scientific staff across the Group. However, total agency expenditure was £1.6m (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 £24.1m. This was £0.9m less than plan, largely relating to Nursing and HCA Bank at STH which was under by £1.9m overall, offset by increased usage at NTH (partly linked to agency reductions). Total bank expenditure was £3.5m (13%) less than the bank expenditure incurred at the same point in the previous year (adjusted for inflation).

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 10 (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),
- the wte worked in Month 12 of 2024/25
- the wte worked in the equivalent month in 2024/25; 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	Q1 Avg 25/26	Q2 Avg 25/26	Q3 Avg 25/26	Mth 10 25/26	Change from prior month	Change from M10 24/25	Change from M12 24/25	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg
NTH										
Agency	16.66	15.30	13.90	12.83	1.11	(20.93)	(13.51)	(7.55)	(51.06)	(22.34)
Bank	240.89	248.10	238.13	246.75	21.68	(7.80)	(32.71)	60.30	12.64	(0.25)
Substantive	5,293.57	5,227.35	5,276.35	5,213.94	(54.33)	(118.17)	(169.45)	554.47	83.71	(112.00)
Sub Total	**5,551.11**	**5,490.75**	**5,528.38**	**5,473.52**	**(31.54)**	**(146.90)**	**(215.67)**	**607.22**	**45.29**	**(134.59)**
STH										
Agency	15.84	20.35	27.71	25.92	1.68	6.90	9.33	0.41	(8.70)	7.19
Bank	275.69	293.62	276.38	293.86	26.71	(47.54)	(59.40)	95.85	(99.18)	(53.54)
Substantive	9,597.58	9,557.95	9,574.44	9,498.57	(56.24)	(49.87)	(135.94)	1,661.89	263.50	6.14
Sub Total	**9,889.11**	**9,871.92**	**9,878.53**	**9,818.35**	**(27.85)**	**(90.51)**	**(186.01)**	**1,758.15**	**155.61**	**(40.21)**
UHT GROUP										
Agency	32.50	35.66	41.61	38.75	2.79	(14.03)	(4.18)	(7.14)	(59.76)	(15.15)
Bank	516.58	541.72	514.52	540.61	48.39	(55.34)	(92.11)	156.15	(86.54)	(53.79)
Substantive	14,891.14	14,785.30	14,850.78	14,712.51	(110.57)	(168.04)	(305.39)	2,216.36	347.21	(105.86)
Grand Total	**15,440.23**	**15,362.67**	**15,406.91**	**15,291.87**	**(59.39)**	**(237.41)**	**(401.68)**	**2,365.37**	**200.90**	**(174.80)**

Month 10 shows a net overall decrease of 53.39wte worked across the Group, compared to the WTE worked reported in the previous month, largely apparent in substantive staff WTE. The in-month change in WTE was a 31.54wte reduction at NTH and a 27.85wte reduction at STH.

WTEs worked in month were 174.80wte lower than the average of the previous financial year, and 401.68 less than the final month of the previous year. Compared to the same period last year (Month 10 2024/25) WTEs were lower by 237.41wte. WTEs worked remains higher than the average deployed during 2019/20 (pre-Covid), by 2,365.37wte (18.3%)

The table below provides an analysis of WTE worked data split by staff grouping:

WTE Worked	Q1 Avg 25/26	Q2 Avg 25/26	Q3 Avg 25/26	Mth 10 25/26	Change from prior month	Change from M10 24/25	Change from M12 24/25	Change from 19/20 avg	Change from 23/24 avg	Change from 24/25 avg
NTH										
Nursing & Midwifery	1,698.86	1,698.04	1,712.72	1,709.53	7.07	18.93	(17.52)	328.41	102.02	27.23
Medical & Dental	600.51	586.73	608.99	593.35	(13.20)	(13.13)	(21.35)	58.21	37.88	7.40
AHP, Sci., Ther.&Tech.	562.54	566.28	567.43	560.70	(6.13)	(34.54)	(35.61)	20.38	(27.58)	(43.29)
HCAs & Support Staff	1,021.43	1,019.66	1,053.61	1,051.31	(1.59)	5.28	(6.45)	101.79	(0.33)	1.30
Non Clinical	1,667.77	1,620.03	1,585.64	1,558.63	(17.69)	(123.44)	(134.74)	98.43	(66.71)	(127.24)
Sub Total	**5,551.11**	**5,490.75**	**5,528.38**	**5,473.52**	**(31.54)**	**(146.90)**	**(215.67)**	**607.22**	**45.28**	**(134.59)**
STH										
Nursing & Midwifery	3,145.89	3,151.02	3,158.50	3,162.31	8.39	42.33	(21.87)	656.25	204.18	66.81
Medical & Dental	1,392.44	1,395.16	1,409.77	1,389.32	(12.10)	(14.49)	(11.45)	146.56	70.38	13.04
AHP, Sci., Ther.&Tech.	1,574.89	1,596.20	1,618.48	1,616.31	2.78	27.54	20.59	391.11	131.55	45.73
HCAs & Support Staff	1,642.68	1,638.32	1,636.74	1,631.78	(4.38)	(37.92)	(30.73)	207.43	(123.87)	(40.91)
Non Clinical	2,133.21	2,091.23	2,055.05	2,018.63	(22.54)	(107.97)	(142.55)	356.80	(126.64)	(124.87)
Sub Total	**9,889.11**	**9,871.92**	**9,878.53**	**9,818.35**	**(27.85)**	**(90.51)**	**(186.01)**	**1,758.15**	**155.61**	**(40.21)**
UHT GROUP										
Nursing & Midwifery	4,844.75	4,849.06	4,871.21	4,871.84	15.46	61.26	(39.39)	984.67	306.20	94.04
Medical & Dental	1,992.95	1,981.89	2,018.76	1,982.67	(25.30)	(27.62)	(32.80)	204.77	108.26	20.44
AHP, Sci., Ther.&Tech.	2,137.43	2,162.48	2,185.91	2,177.01	(3.35)	(7.00)	(15.02)	411.49	103.97	2.44
HCAs & Support Staff	2,664.11	2,657.98	2,690.34	2,683.09	(5.97)	(32.64)	(37.18)	309.22	(124.20)	(39.62)
Non Clinical	3,800.99	3,711.26	3,640.69	3,577.26	(40.23)	(231.41)	(277.29)	455.23	(193.35)	(252.11)
Sub Total	**15,440.23**	**15,362.67**	**15,406.91**	**15,291.87**	**(59.39)**	**(237.41)**	**(401.68)**	**2,365.37**	**200.89**	**(174.80)**

The Month 10 position includes a reduction of 237.41wte Non Clinical staff compared to the same period last financial year, with an in-month reduction of 40.23wte 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	18,136	9,380	207%	2,187	48,500	46,313	2217%	10,943	66,636	55,693	609%
Plans in Progress	2,961	3,875	914	131%	42,072	0	-42,072	0%	45,033	3,875	-41,158	9%
Opportunity	4,839	2,562	-2,277	53%	4,241	0	-4,241	0%	9,080	2,562	-6,518	28%
Unidentified	8,017	0	-8,017	0%	0	0	0	-	8,017	0	-8,017	0%
Total	**24,573**	**24,573**	**0**	**100%**	**48,500**	**48,500**	**0**	**100%**	**73,073**	**73,073**	**0**	**100%**
High Risk	12,860	2,525	-10,335	20%	24,305	6,933	-17,372	29%	37,165	9,458	-27,707	25%
Medium risk	2,426	3,493	1,067	144%	13,403	7,018	-6,385	52%	15,829	10,511	-5,318	66%
Low Risk	9,287	18,555	9,268	200%	10,791	34,549	23,758	320%	20,078	53,104	33,026	264%
Total	**24,573**	**24,573**	**0**	**100%**	**48,500**	**48,500**	**0**	**100%**	**73,073**	**73,073**	**0**	**100%**

There continues to be positive movement in development of schemes and de-risking of the programme since Final Plan submission in March, 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 £2.6m remains defined as 'Opportunity'. £9.5m of the programme remains as High Risk (which is a reduction of £27.7m since plan submission). This is a slight reduction in high-risk schemes from the previous month, reflecting plan development for additional identified CIP schemes.

Continued de-risking of the programme and maximising recurrent in-year delivery continues to be a key area of focus for the Financial Recovery Oversight Group and CSU CIP meetings.

The table below show the year-to-date delivery against the Group's efficiency targets:

	NTH				STH				GROUP			
YTD Month 10 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	12,900	8,633	-4,267	67%	12,950	14,254	1,304	110%	25,850	22,887	-2,963	89%
Non Pay	6,150	7,019	869	114%	21,037	21,126	89	100%	27,187	28,145	958	104%
Income	1,183	3,319	2,136	281%	5,210	3,817	-1,393	73%	6,393	7,136	743	112%
Total	**20,233**	**18,971**	**-1,262**	**94%**	**39,197**	**39,197**	**0**	**100%**	**59,430**	**58,168**	**-1,262**	**98%**
Recurrent	11,798	11,747	-51	100%	32,706	22,818	-9,888	70%	44,504	34,565	-9,938	78%
Non-recurrent	8,435	7,223	-1,212	86%	6,492	16,379	9,887	252%	14,927	23,602	8,676	158%
Total	**20,233**	**18,971**	**-1,262**	**94%**	**39,197**	**39,197**	**0**	**100%**	**59,430**	**58,168**	**-1,263**	**98%**
Recurrent %	58%	62%	4%	-	83%	58%	-25%	-	75%	59%	-15%	-

Across the Group, overall year-to-date delivery is £58.2m (98% of target). However, this position includes a number of non-recurrent schemes. Delivery of recurrent savings is £9.9m behind plan at the end of Month 10, constituting 59% of YTD delivery across the Group.

Capital

The Group's gross capital expenditure plan for the 2025/26 financial year totalled £66.8m at the start of the financial year. The Group's ICS Capital Departmental Expenditure Limit (CDEL) for 2025/26 totals £37.8m, 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 plan also includes expected PFI lifecycle costs of £8.0m (the cost of which sits outside the ICS CDEL limit).

The capital programme also included externally funded schemes for RAAC eradication and replacement of Linear Accelerators (funded by Public Dividend Capital (PDC) of £6.6m, and de-carbonisation schemes, supported with Salix grant funding of £13.9m across the Group.

Since plan submission, NTH has received 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 has also received additional national PDC funding for equipment, diagnostics and digital.

The Group is currently forecasting outturn capital expenditure in line with total CDEL and all additional PDC allocations received to date. To support delivery of this, the Group Executive has agreed to deploy £1.9m of CDEL at STH (to enable further mitigation of Medical Equipment replacement risks) and will show off-setting under and overspends across the two trusts. Completion of the NTH UEC scheme will be prioritised within the Group's overall capital allocations in 2026/27.

The Group's capital expenditure to the end of Month 10 amounted to £40.2m, as detailed in the table below.

	NTH						STH						Group					
	YTD Plan	YTD Actual	YTD Variance	Plan	FOT	Variance	YTD Plan	YTD Actual	YTD Variance	Plan	FOT	Variance	YTD Plan	YTD Actual	YTD Variance	Plan	FOT	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Equipment	3,945	4,871	926	6,066	9,255	3,189	4,487	1,236	(3,251)	8,012	24,403	16,391	**8,432**	**6,107**	**(2,325)**	**14,078**	**33,658**	**19,580**
Digital	3,261	3,337	76	5,117	6,297	1,180	1,694	2,607	913	2,080	3,928	1,848	**4,955**	**5,944**	**989**	**7,197**	**10,225**	**3,028**
Estates	6,462	4,359	(2,103)	10,211	12,561	2,350	2,720	5,029	2,309	3,844	5,713	1,869	**9,182**	**9,388**	**206**	**14,055**	**18,274**	**4,219**
PFI	0	0	0	0	0	0	6,815	6,636	(179)	8,163	8,063	(100)	**6,815**	**6,636**	**(179)**	**8,163**	**8,063**	**(100)**
Decarbonisation	0	0	0	1	0	(1)	11,610	9,837	(1,773)	13,928	13,928	0	**11,610**	**9,837**	**(1,773)**	**13,929**	**13,928**	**(1)**
RAAC	823	780	(43)	1,300	2,846	1,546	2,400	15	(2,385)	2,900	2,900	0	**3,223**	**795**	**(2,428)**	**4,200**	**5,746**	**1,546**
IFRS 16	2,706	1,496	(1,210)	2,825	2,220	(605)	0	0	0	4,313	4,313	0	**2,706**	**1,496**	**(1,210)**	**7,138**	**6,533**	**(605)**
Total Gross Capital	**17,197**	**14,843**	**(2,354)**	**25,520**	**33,179**	**7,659**	**29,726**	**25,360**	**(4,366)**	**43,240**	**63,248**	**20,008**	**46,923**	**40,203**	**(6,720)**	**68,760**	**96,427**	**27,667**

This is £6.7m slippage against the phasing of the 2025/26 year-to-date plan, largely relating to Salix grant and PDC funded schemes at STH, for Decarbonisation works, Linac replacement and RAAC removal.

Liquidity

The cash balance at the end of Month 10 stood at £71.2m for the Group. The month end revenue cash balance at NTH was £41.1m (equating to 33.5 operating expenditure days) and £20.4m at STH (equating to 7.0 operating expenditure days). The current revenue cash forecast balances are £51.3m for NTH and £6.6m 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. 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.

Deficit support funding has been confirmed and received up to and including Quarter 4, based on the ICS overall position at Month 8. This has contributed to a stronger cash flow forecast position for STH for the remainder of the financial year, meaning that an application to access revenue cash support is no longer expected to be required. However, continued close monitoring of cash will be essential throughout the course of the financial year. Weekly meetings of the STH cash committee are held to monitor cash flows and manage creditor and debtor balances within forecast cash resources.

The continued strong cash balances have supported good compliance with the Better Payment Practice Code for both trusts, as shown in the tables below:

Better Payment Practice Code	NTH		STH		GROUP	
	YTD Number	YTD Value £000	YTD Number	YTD Value £000	YTD Number	YTD Value £000
Total bills paid in the year	59,687	166,147	89,061	597,665	148,748	763,812
Total bills paid within target	58,490	162,630	86,980	564,919	145,470	727,549
Percentage of bills paid within target	**98.0%**	**97.9%**	**97.7%**	**94.5%**	**97.8%**	**95.3%**

Statement of Financial Position

The table below shows the balance sheet position for the two Trusts as at the end of Month 10:

	NTH £000	STH £000
Non-current assets		
Intangible assets	2,637	5,454
On-SoFP IFRIC 12 assets	0	144,279
Other property, plant and equipment (excludes leases)	148,922	171,849
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	16,141	33,542
Receivables: due from NHS and DHSC group bodies	607	1,231
Receivables: due from non-NHS/DHSC Group bodies	1,458	1,456
Credit Loss Allowances	0	(3,269)
Total non-current assets	**169,765**	**354,542**
Current assets		
Inventories	7,157	15,139
Receivables: due from NHS and DHSC group bodies	3,129	28,637
Receivables: due from non-NHS/DHSC Group bodies	34,810	35,949
Credit Loss Allowances	(3,586)	(1,052)
Other Assets	0	3,558
Cash and cash equivalents: GBS/NLF	40,762	27,377
Cash and cash equivalents: commercial/in hand/other	37	3,045
Total current assets	**82,309**	**112,653**
Current liabilities		
Trade and other payables: capital	(1,593)	(10,260)
Trade and other payables: non-capital	(55,192)	(137,476)
Borrowings	(4,198)	(20,474)
Other financial liabilities	(1,068)	0
Provisions	(1,919)	(1,132)
Other liabilities: deferred income including contract liabilities	(6,173)	0
Total current liabilities	**(70,143)**	**(169,342)**
Total assets less current liabilities	**181,931**	**297,853**
Non-current liabilities		
Borrowings	(29,088)	(252,595)
Provisions	(1,568)	(1,378)
Total non-current liabilities	**(30,656)**	**(253,973)**
Total net assets employed	**151,275**	**43,880**
Financed by		
Public dividend capital	200,720	470,376
Revaluation reserve	12,937	32,808
Other reserves	0	26,476
Income and expenditure reserve	(62,382)	(485,780)
Total taxpayers' and others' equity	**151,275**	**43,880**
Debtor Days	**31.6**	**23.8**
Creditor Days	**167.6**	**142.8**

4. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 10: 2025/26

University Hospitals Tees

Integrated Performance Report (reporting to end December 2025)

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 4.3

Report author: Lucy Tulloch, Group Director Planning & Intelligence and Lynsey Atkins, Associate Director Planning, Performance & Improvement

Executive director sponsor: Neil Atkinson, Chief Delivery Officer

Action required: Assurance

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 December 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 seven performance metrics remain as Alert.

- *E. coli* infections
- MSSA infections
- *Klebsiella* infections
- *Pseudomonas* infections
- Breast feeding at first feed
- Cancer 62 Day Standard
- Sickness Absence (%)

In addition, **12-Hour ED Breaches Rate (%)** has been regraded to Alert, from Advise, following a decline in performance towards the upper limits of expected variance for two of the last three months (October and December 2025). However, the submitted plan from October 2025 anticipated increasing seasonal demand and acuity and NTHFT remained under the national planning guidance benchmark.

RTT Incomplete Pathways (%) has triggered Alert, from Advise, due to a low performance outlier for December 2025. **RTT time to first appointment (%)** has also been regraded to Alert, from Advise, after a more sustained general deterioration in compliance over the last seven months. Focus from Clinical Service Units is on reducing the longest waits which will, in turn, improve the overall compliance with the 18-week standard.

For STHFT, the following seven performance metrics remain as Alert assurance:

- *Pseudomonas* infections
- Breast feeding at first feed
- Diagnostic 6 Week standard
- RTT time to first appointment
- Sickness Absence (%)
- Mandatory Training (%)

- RTT Incomplete Pathways (%)

Four additional metrics were regraded as Alert for STHFT. In the SAFE domain, one **Never Event** was recorded in December 2025. Work is underway to promote the involvement of patients in safety checks prior to procedures in addition to strengthening UHT's approach to using National and local safety standards for invasive procedures.

***Klebsiella* infections (%)** have been elevated above in-month targets between October and December leading to year to date infection numbers at 20% worse than target. Hepatobiliary and urinary patients continue to be the majority of cases. Catheter associated work continues. Links to Health Inequalities reviewed with regional focus.

In maternity care, **PPH >= 1500ml rate per 1,000 births** is regraded from Advise after elevated outlier rates were reported in 2 of last 3 months to December 2025.

Within the CARING domain, **Complaints Closed Within Target (%)** has been regraded from Advise on the back of poorer recent performance covering the last 6 months to December 2025. Statistically, the achievement of planned targets is no longer achievable within usual monthly performance until a change in focus within Clinical Service Units is evident. Additional senior staff support has been allocated to review off-target complaint responses and targets are to be agreed with each Clinical Service Unit.

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.

For NTHFT, three metrics have been regraded to Advise in December 2025.

Ambulance handovers within 45 minutes has been regraded from Assure due to a low performance outlier in December 2025 compared to usual performance. NTHFT are still assured to achieve >=95% handovers within 45 minutes and December was 96.5%. There remains focus on full compliance. A handover SOP is in place with corridor and ambulatory areas used in periods of surge to provide timely release of crews.

4-Hour A&E Standard has improved assurance, moving from Alert, after December performance exceeded the agreed, expected lower trajectory.

Annual Appraisal (%) regraded from Assure due to compliance in December 2025 falling outside recently improved expected variance. Performance remains better than plan.

For STHFT, four metrics have moved to Advise.

There were no new **MRSA infections** for December leading to a regrade from Alert. Alignment of policies is underway to support across UHT supported by increased audit and education.

Neonatal Mortality Rate (rolling 12 months, per 1,000 births) moved from Assure as December 2025 reported as an outlier to usual performance but remained in line with MBRRACE audit peer group average.

Community UCR 2 Hour Response (%) is regraded from Alert following the stabilisation of recent reduced performance. The standard has been met for every month over the last 2 years as the teams have sought to increase both the number of referrals and referrals from different sources, including NEAS, 111 and the Care Home sector to support care in the most appropriate settings for patients and easing delays for those that require care in an acute setting.

Outpatient Experience (%) regraded from Assure following low outlier performance in December 2025. For the prior 23 months, the rate of positive feedback exceeded the national average.

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 eight metrics:

- Never Events
- *C. difficile* infections
- Summary Hospital-Level Mortality Indicator
- Discharge Delay average days
- Cancelled operations not rebooked in 28 days
- Community 52-week waits (%)
- Feedback Acknowledged in 3 days (%)
- Staff Turnover (%)

No further metrics have been regraded to Assure for NTHFT in December 2025.

For STHFT, assurance continues for four metrics:

- Summary Hospital-Level Mortality Indicator
- Discharge Delay average days
- Community 52-week waits (%)
- Staff Turnover (%)

No further metrics have been regraded to Assure for STHFT in December 2025.

Recommendations:

Members of the Board are asked to:

- Receive the Integrated Performance Report for the reporting period December 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: December 2025

Caring Better Together

Overview

The IPR reports on the key standards by which Trusts' performance is monitored, reflecting the NHS Operating Framework 2025/26. The IPR is underpinned by a broader range of metrics and evidence for clinical governance and operational management.

SAFE: During November and December, the rate of incidents per 1000 days has reduced to just below the expected variance for NTHFT. Initial analysis has identified potential causes and Clinical Service Units have been asked to examine and promote reporting. Patient Safety Incident Response Framework is embedded across UHT and thematic reviews are used to derive learning from incidents and near misses. NTHFT report 14 consecutive months with no Never Events. There is continued focus on reducing healthcare acquired infections across UHT, with the focus on antimicrobial stewardship and medical leadership as a priority, and cleaning with a dedicated decant cleaning programme to be established. Maternity metrics are reviewed against regional and national audit and peer group benchmarks.

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. Better than national average performance in the Discharge delay metric for both Trusts highlights the effective processes for patient flow and providing care in the most appropriate environment. There is a focus on utilisation of Home First in cases of delays.

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 reported against a 45-minute standard, with a recent significant improvement trend evident at STHFT and >95% compliance with handovers within 45 minutes at NTHFT. 12-hour breach performance and 4-hour standard showed resilience against early seasonal acuity.

Both Trusts are focusing on the further improvement required to tackle waiting times for elective care, diagnostics and within cancer pathways. For RTT, 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 specialty specific recovery plans are in place. From November 2025, NTHFT joined STHFT in receiving additional performance scrutiny and support for improvement in cancer treatment waiting times under the NHS England performance management regime (Tier 2). Cancer action plans are in place and for STHFT, there is clear evidence of improvement in the cancer 62-day standard arising from planned actions in diagnostic pathways.

CARING: The IPR demonstrates that both Trusts perform well in patient feedback surveys, around or above national average feedback scores across care settings. This includes evidence of recent improved A&E experience at STHFT. Managing complaints to a timely closure at STHFT 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 shows recent improvement trends at both Trusts. However, sickness absence and mandatory training remain improvement priorities with a small improvement now evident for Mandatory Training at NTHFT. An in-depth 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. Financial performance is on plan; papers on finance and productivity are presented to Resources Committee.

Regulation and Compliance

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 report received and due to be reviewed at the UHT Regulation and Compliance Group.

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 on Resuscitation and Safeguarding training in ED, and improvements in SDR compliance across the Friarage Hospital and Community Services. These actions are monitored by the Regulation and Compliance Group.

CQC assessment ratings per hospital site and service can be found on the CQC website.

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 45+ 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	Dec-25	Dec-25	Dec-25	Dec-25	Dec-25	Dec-25	Nov-25	Nov-25	Nov-25	Nov-25	Nov-25	Nov-25	Nov-25	Nov-25	Nov-25	Nov-25	Nov-25	Nov-25	Nov-25	Nov-25	Dec-25	Nov-25	Nov-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	83.3%	33	6.9%	233	70	33	72.8%	0.8%	80.7%	182	0	0	0	21,991	108%	110%	104%	80%	4.5%	63.0%	154	239	82.2%
South Tees Hospitals NHSFT	78.5%	11	5.5%	396	264	139	61.7%	2.2%	64.7%	1,255	71	8	0	56,009	105%	102%	103%	104%	14.3%	70.6%	131	720	75.3%
NENC ICS Provider level *(including IS providers)*	77.0%	483	5.8%	2,551	1,651	940	70.3%	1.2%	75.6%	4,539	162	9	0	366,521	102%	105%	102%	98%	13.8%	70.5%	1,120	3,574	72.1%
North East & Yorkshire	74.4%		7.3%				65.6%												20.4%	69.3%			73.8%
National	73.8%		10.5%				61.6%												21.7%	70.2%			76.5%

For urgent and emergency care metrics, NTHFT again demonstrated good comparative performance for the 4-hour standard in December in relation to regional and national benchmarks, and in the context of rising seasonal demand and acuity. STHFT performed better than regional benchmarks but the 4-hour standard 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, whilst improving patient experience by developing alternatives to ED pathways.

Elective care metrics show an RTT 18-week standard at both NTHFT and STHFT fell below plan, however noting NTHFT exceeded the national and regional average and STHFT performing in line with the 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 on 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 and have entered tiered support with NHS England to provide assurance of action plans to achieve this. This remains very challenging whilst demand and capacity imbalances in several specialties are addressed.

Cancer 62-day standard is a strategic risk for both Trusts. STHFT has been in tiered 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. An improvement trend in STHFT 62-day standard is now evident and exceeds the agreed improvement trajectory. NTHFT performance shows the impact of a sustained increase in breast symptomatic referrals from the County Durham and Darlington catchment area since February 2025 on cancer standard compliance. The Trust has commenced tiering support with NHS England from November.

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
Total births
Still Births Rate (Rolling 12 months, per 1000 Births)
Neonatal Mortality Rate (rolling 12 months, per 1,000 births)
Breast Feeding at First Feed (%)
PPH >= 1500ml Rate per 1,000 births
3rd/4th Degree Tear (%)

EFFECTIVE DOMAIN
Responsibility: Quality Assurance Committee

Summary Hospital-Level Mortality Indicator
Readmission Rate (%)
Discharge Delays Average (days)

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 (%)
Community over 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)

North Tees & Hartlepool assurance summary

No change in assurance

- *E. coli* infections
- MSSA Infections
- *Klebsiella* infections
- *Pseudomonas* infections
- Breast feeding at first feed
- Cancer 62 Day Standard
- Sickness absence (%)

ALERT

- **12-Hour ED Breaches Rate (%)** regraded from Advise following a decline in performance, towards the upper limit of expected variance.
- **RTT Incomplete Pathways (%)** regraded from advise following a low performance outlier in December 2025.

New ALERT indicators

- **RTT time to first appointment (%)** regraded from advise following declining performance.

No change in assurance

- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Falls with Harm per 1000 Bed Days
- MRSA Infections
- Still Births Rate (Rolling 12 months, per 1000 Births)
- Neonatal Mortality Rate (rolling 12 months per 1,000 births)
- PPH >= 1500ml rate per 1,000 births
- 3rd/4th Degree Tear (%)
- Readmission Rate
- Community UCR 2 Hour Response (%)
- Cancer Faster Diagnosis
- Cancer 31 Day Standard

ADVISE

- Diagnostic 6 Week Standard
- RTT 52 Week Waiters (%)
- A&E Experience (%)
- Inpatient Experience (%)
- Maternity Experience (%)
- Outpatient Experience (%)
- Community Experience (%)
- Complaints Closed Within Target (%)
- Mandatory Training (%)
- Cumulative YTD Financial Position (£Millions)

New ADVISE indicators

- **Ambulance handover within 45 minutes** regraded from Assure following performance lower than expected variation in December 2025.
- **4 Hour A&E Standard** regraded from Alert due performance exceeding the lower agreed compliance target for December.
- **Annual Appraisal (%)** regraded from Assure due to compliance in December 2025 falling outside recently improved expected variance. Performance remains better than plan.

No change in assurance

- Never Events
- *C. difficile* Infections
- Summary Hospital-Level Mortality Indicator
- Discharge Delay average days

ASSURE

- Cancelled operations not rebooked in 28 days
- Community 52-week waits (%)
- Feedback Acknowledged in 3 days (%)
- Staff Turnover (%)

New ASSURE indicators

Caring Better Together

South Tees Hospitals assurance summary

No change in assurance	ALERT	New ALERT indicator
• *Pseudomonas* infections • Breast feeding at first feed • Diagnostic 6 Weeks Standard (%) • RTT Incomplete Pathways (%) • RTT time to first appointment (%) • Sickness absence (%) • Mandatory training (%)	• One new **Never Event** recorded in December 2025, three year to date. • ***Klebsiella* infections** have been elevated above in-month targets between October and December leading to 20% worse than plan YTD and a regrade from Advise.	• **PPH >= 1500ml rate per 1,000 births** regraded from Advise after outlier rates were reported in 2 of last 3 months. • **Complaints Closed Within Target (%)** regraded from Advise due to target no longer statistically within usual range of performance following poorer recent compliance.

No change in assurance	ADVISE	New ADVISE indicator
• Incidents per 1000 Bed Days • Patient Safety Incident Investigations • Falls with Harm per 1000 Bed Days • *C. difficile* infections • *E. coli* infections • MSSA infections • Still birth rate • 3rd/4th Degree Tear (%) • Readmission rate • Ambulance handovers within 45 minutes • 4-Hour A&E Standard (%) • 12-Hour ED Breaches Rate (%) • Cancelled operations not rebooked in 28 days	• Cancer Faster Diagnosis • Cancer 31 Day Standard • Cancer 62 Day Standard • RTT 52 Week Waiters (%) • A&E Experience (%) • Inpatient Experience (%) • Maternity Experience (%) • Community Experience (%) • Feedback Acknowledged in 3 Days (%) • Annual Appraisal (%) • Cumulative YTD Financial Position (£Millions)	• No new **MRSA infections** for December means a regrade from Alert. • **Neonatal Mortality Rate (rolling 12 months, per 1,000 births)** reported as an outlier to usual performance but performed in line with MBRRACE audit peer group average. • **Community UCR 2 Hour Response (%)** regraded from Alert following stabilisation of recent reduced performance. • **Outpatient Experience (%)** regraded from Assure following low outlier performance in December.

No change in assurance	ASSURE	New ASSURE indicator
• Summary Hospital-Level Mortality Indicator • Discharge delay average days	• Community over 52-week Waiters (%) • Staff Turnover (%)	

Caring Better Together

SAFE DOMAIN SUMMARY

Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

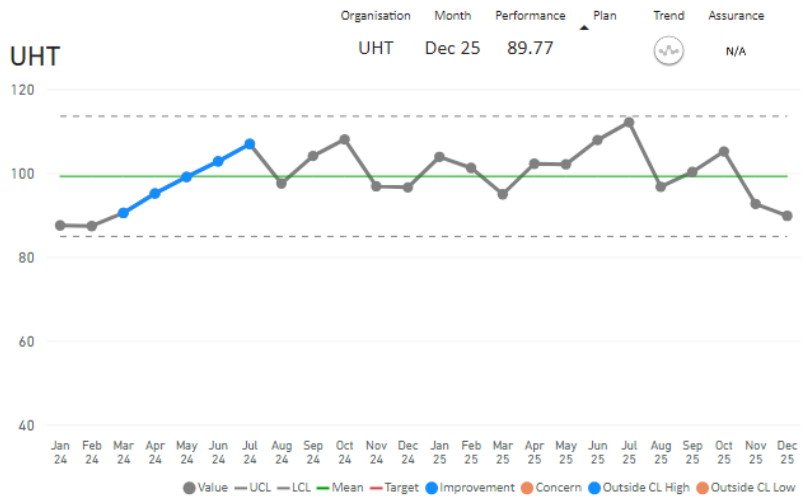
An external evaluation of the Group's implementation of PSIRF has been completed; the report identified positive progress and made recommendations to strengthen the Group's approach to patient safety, with improvement actions developed. These form the measures within one of the Group's Quality Priorities. The reporting of incidents is seen as a positive indicator of a safety culture, with the planned move from Datix to InPhase for STHFT, this will be monitored closely as there is a known risk of reporting being temporarily impacted by a change in reporting systems.

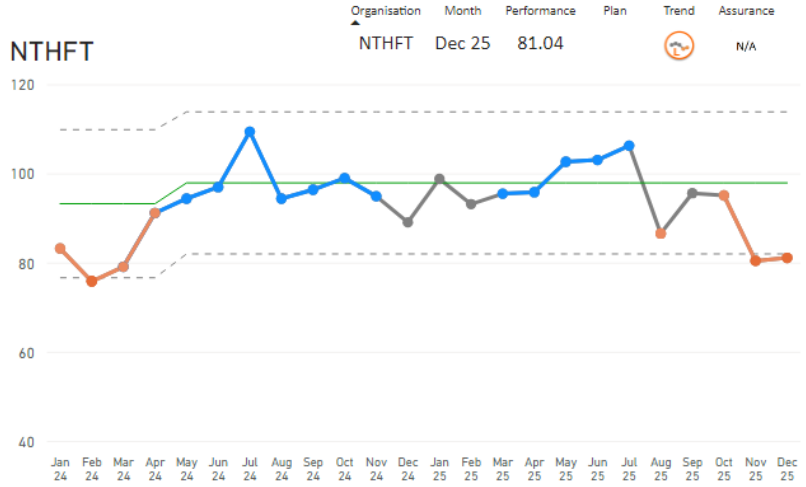
Healthcare-acquired infections (HCAI) plans are mapped against the NHS England target trajectories. HCAI continue to be closely tracked by the Infection Prevention Strategic Group and an Improvement Plan developed and monitored, this is also aligned to the Trust Quality Priorities for 2025/26. Opportunities for reducing HCAIs is centred on Antimicrobial Stewardship with the Trust Antimicrobial Working Group having a clear focus on NHS England KPIs aligned to prescribing. Identified and defined medical leadership is an organisational priority for this.

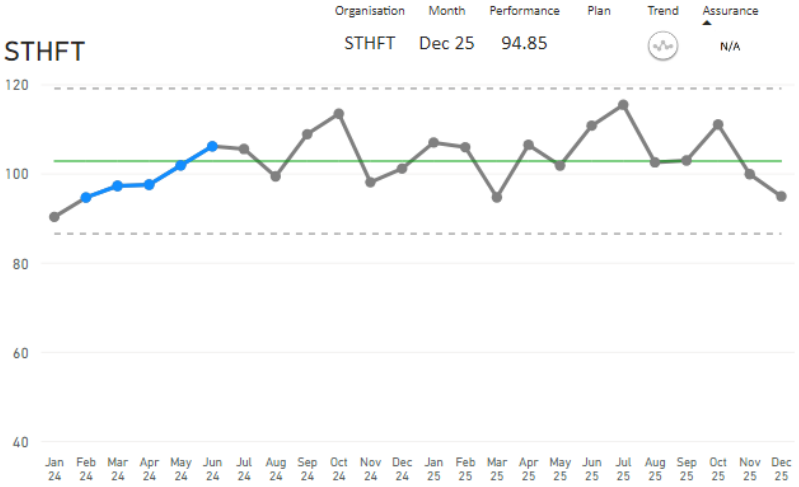
North Tees & Hartlepool NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Incidents Per 1000 Bed Days		98.76	93.1	95.44	95.77	102.61	103.01	106.22	86.51	95.56	95.05	80.38	81.04
Patient Safety Incident Investigations		1	0	1	0	1	1	3	1	2	0	0	0
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0
Falls With Harm Rate (Per 1000 Bed Days)		0.19	0.37	0.27	0	0.28	0.29	0.14	0.21	0.07	0.21	0.07	0.21
C-Difficile	5	5	6	7	6	1	4	4	6	8	2	8	5
MRSA	0	0	0	0	0	0	0	0	0	1	1	0	0
E-Coli	6	6	6	4	8	10	6	12	12	10	9	6	12
MSSA	3	9	2	1	3	3	4	3	5	5	6	1	3
Klebsiella	3	1	0	5	4	4	4	2	0	2	3	2	4
Pseudomonas	1	2	0	2	4	3	1	2	0	1	0	0	1

South Tees Hospitals NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Incidents Per 1000 Bed Days		106.9	105.86	94.61	106.4	101.73	110.69	115.38	102.47	102.88	110.94	99.83	94.85
Patient Safety Incident Investigations		0	0	0	1	0	1	2	1	1	0	0	1
Never Events	0	0	0	0	0	0	0	2	0	0	0	0	1
Falls With Harm Rate (Per 1000 Bed Days)		0.12	0.25	0.28	0.33	0.12	0.17	0.21	0.08	0.25	0.08	0.21	0.12
C-Difficile	10	13	15	10	13	11	11	9	8	13	13	12	7
MRSA	0	0	0	3	0	0	1	1	1	0	2	1	0
E-Coli	11	18	10	17	16	11	14	14	14	14	8	11	13
MSSA	6	5	9	11	3	10	5	8	11	6	7	5	6
Klebsiella	4	5	4	2	4	2	3	4	5	9	9	5	7
Pseudomonas	1	1	1	3	3	3	1	4	1	1	3	1	3

SAFE **Incidents Per 1000 Bed Days**





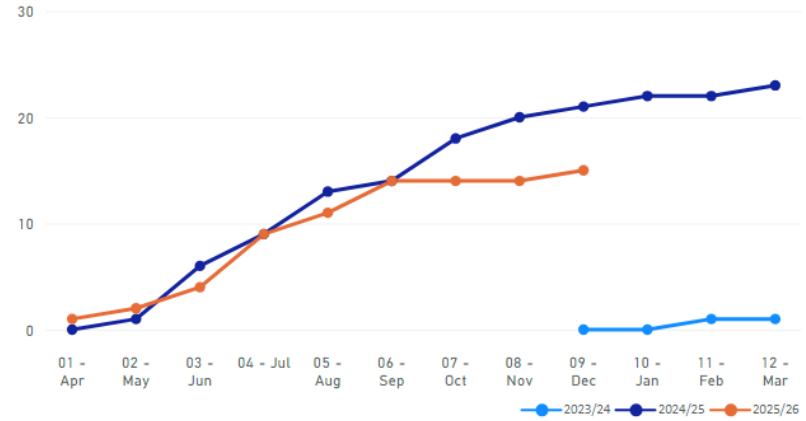


Metric: Incidents rate per 1000 bed days
Plan: n/a
Rationale: Overview of incident reporting.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: Lower level of incidents reported in November and December, outside of than expected variation. STHFT: No trend.
Assurance: n/a.
Action taken: The fluctuation in incident reporting across both trusts is noted; the notable drop in the NTHFT to just below expected variation has been analysed; there was some changes in reporting of Pressure ulcers in August 2025 and also the change over to the CSU structure in November . This is being examined in more depth for greater understanding. Clinical Service Units have been asked to examine all areas of their reporting and to implement actions to further promote reporting.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Patient Safety Incident Investigations (YTD)

UHT

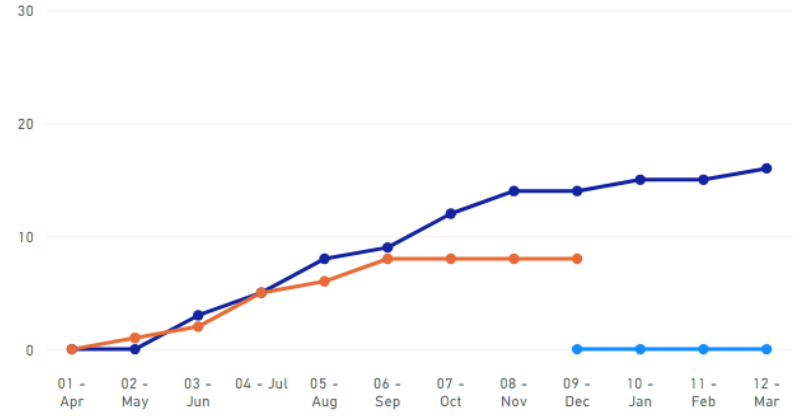
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Dec 25	15		N/A	N/A



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: No new PSIIs recorded in December, 8 PSIIs year to date. STHFT: 1 new PSII in December, 7 PSIIs year to date.
Assurance: n/a
Action taken: Incidents are reviewed at weekly group panels to determine how they are investigated under PSIRF. An external evaluation of PSIRF across UHT concluded in July 2025; and recommendations are being actioned.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

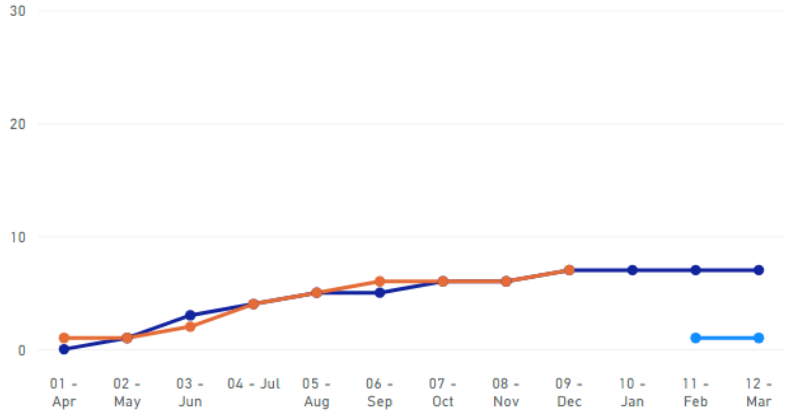
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Dec 25	8		N/A	N/A



STHFT

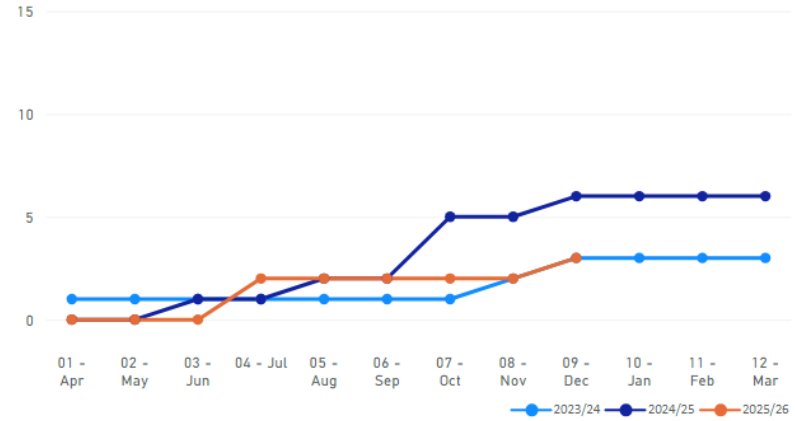
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Dec 25	7		N/A	N/A



SAFE Never Events (YTD)

UHT

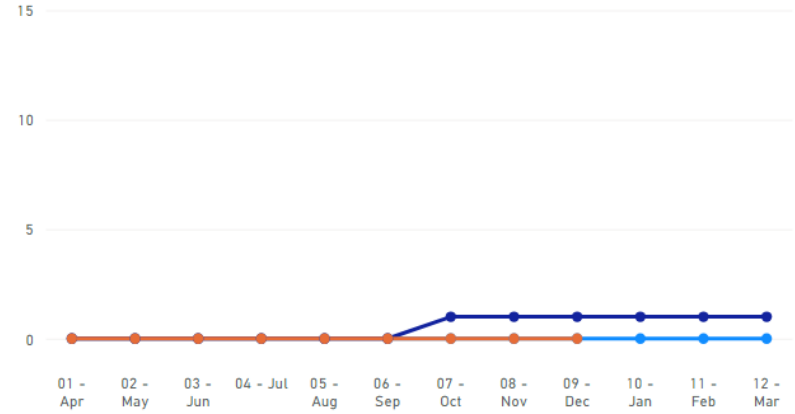
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Dec 25	3		N/A	N/A



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: No Never Events YTD. STHFT: One new event recorded in December 2025.
Assurance: NTHFT: Assure, no new events for 14 months. STHFT: Alert, two Never Events in July 2025, one new event in December 2025; 3 YTD.
Action taken: Work is underway to promote the involvement of patients in safety checks prior to procedures in addition to strengthening the UHT's approach to using National and local safety standards for invasive procedures. NHSE consultation has been completed; further workshops will be held in 2026 to review the future of the NE framework.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

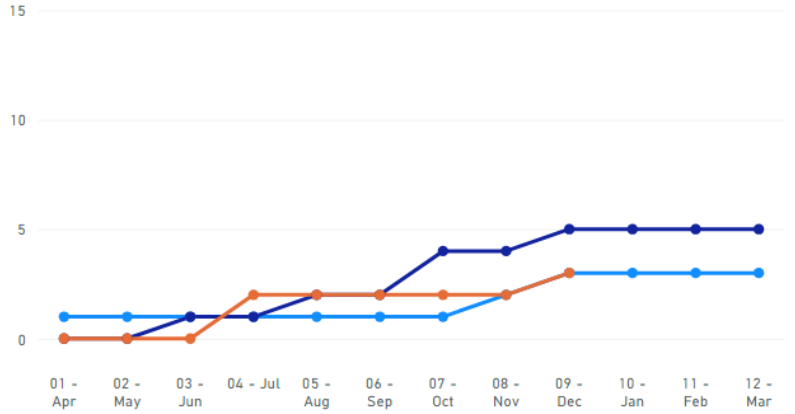
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Dec 25	0	0	N/A	N/A

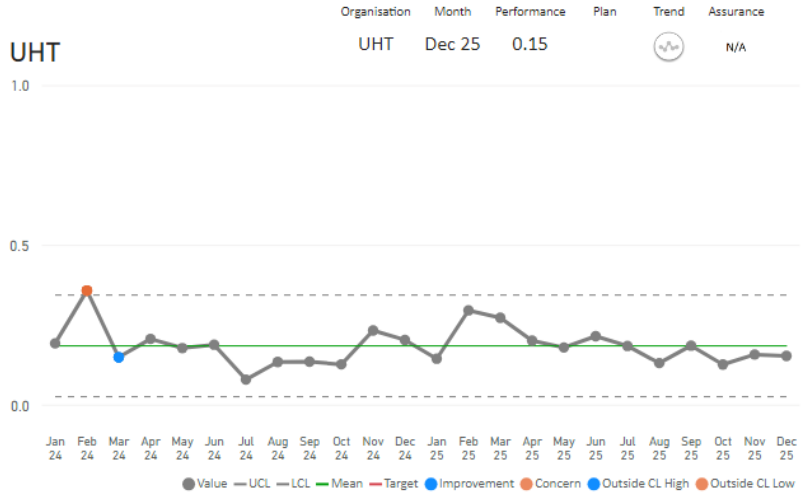


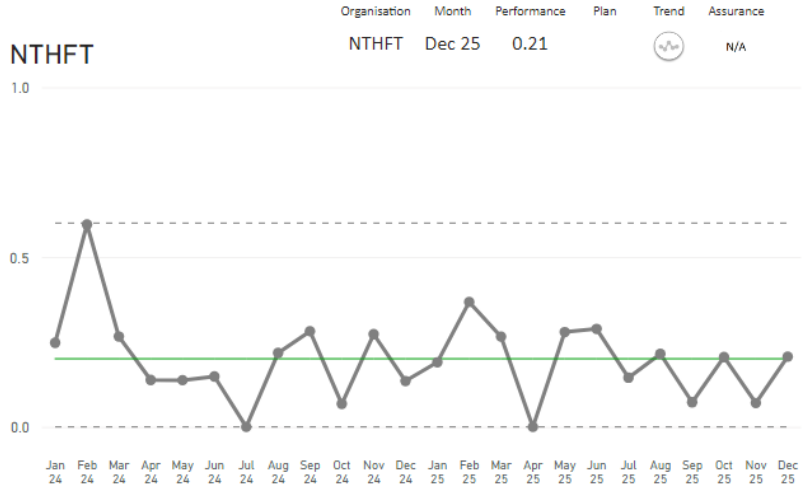
STHFT

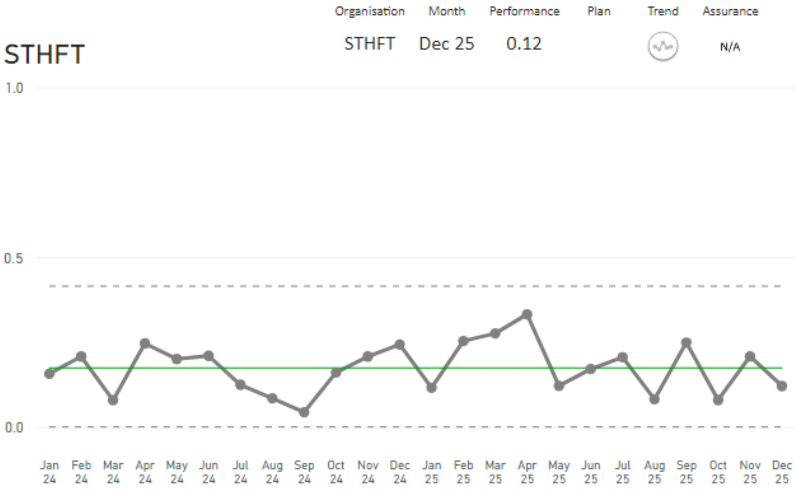
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Dec 25	3	0	N/A	N/A



SAFE Falls With Harm Rate (Per 1000 Bed Days)





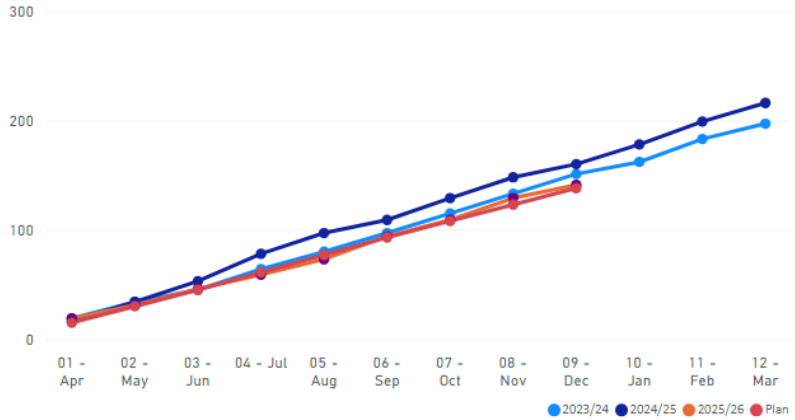


Metric: Falls resulting in harm graded moderate and above, as a rate per 1000 inpatient bed-days.
Plan: n/a
Rationale: NHS Quality Accounts regulatory indicator. National Audit of Inpatient Falls.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: n/a
Action taken: The focus is on thematic learning from falls, targeted interventions and bringing together a single UHT approach to improve care for patients at risk of falls.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE C-Difficile (YTD)

UHT

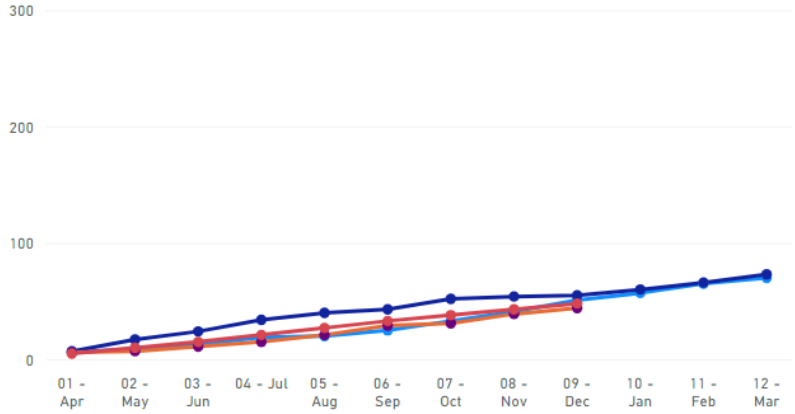
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Dec 25	141	138	N/A	N/A



Metric: Healthcare associated cases of *Clostridioides difficile*, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 5 new cases in December (trajectory of 5). STHFT: 7 new cases in December (trajectory of 10).
Assurance: NTHFT: Assure; 8%, 4 cases, better than trajectory YTD. STHFT: Advise; 8%, 7 cases, worse than trajectory YTD.
Action taken: Hydrogen peroxide fogging continues after all *C. diffiicile* infections as gold standard across all sites, some derogations at NT, additional actions implemented. Appropriate decant facility to be established.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

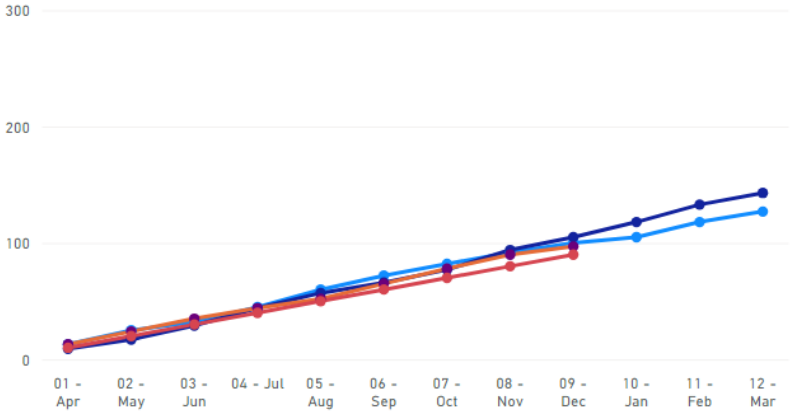
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Dec 25	44	48	N/A	N/A

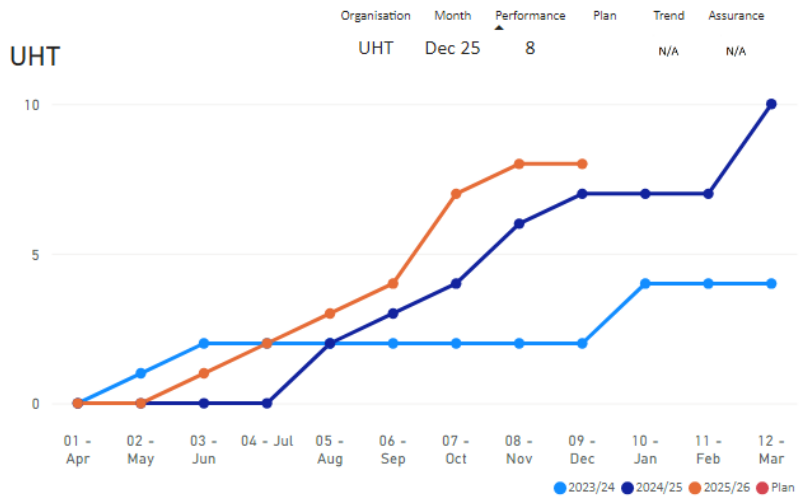


STHFT

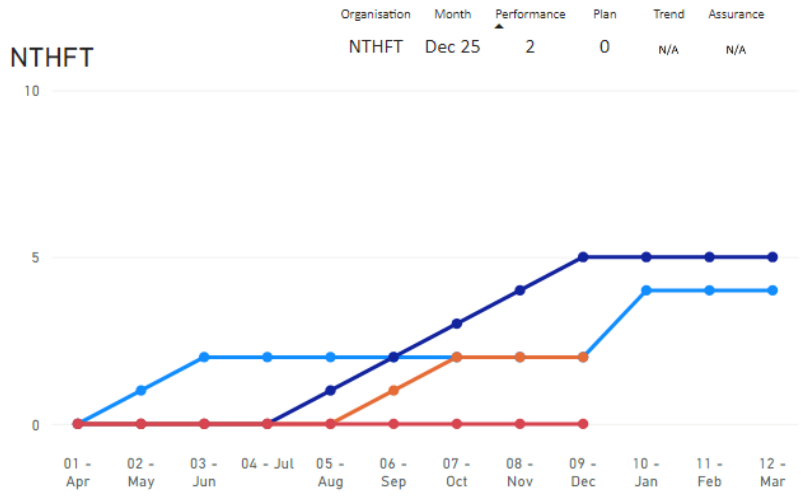
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Dec 25	97	90	N/A	N/A

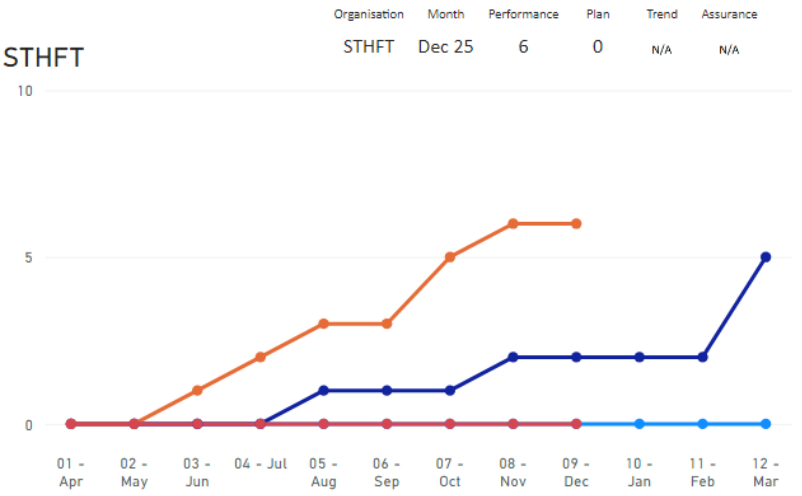


SAFE MRSA (YTD)



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: No new cases in December 2025 at either Trust
Assurance: NTHFT: Advise, no new cases in December, 2 cases YTD. STHFT: Advise, no new cases in December, 6 cases YTD.
Action taken: Alignment of policies underway to support across UHT. Increased audit and education. Region to organise an IV device focussed Leads forum.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

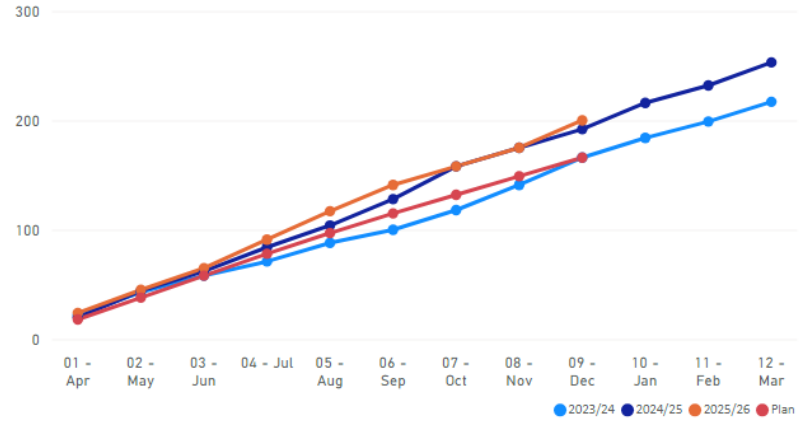




SAFE E-Coli (YTD)

UHT

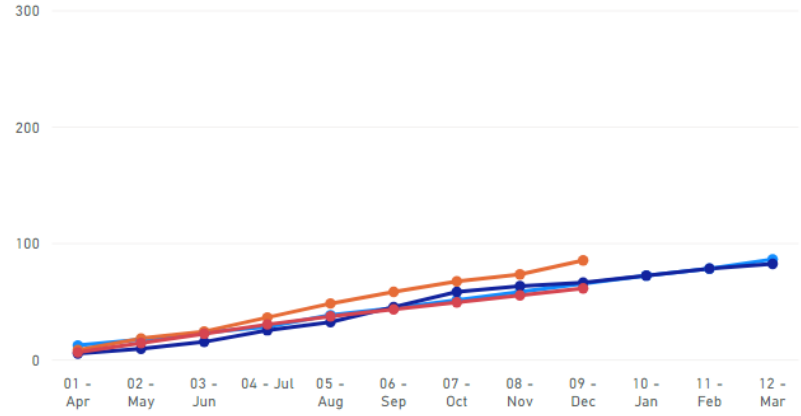
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Dec 25	200	166	N/A	N/A



Metric: Healthcare associated cases of *Escherichia coli*, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 12 cases in December 2025 (trajectory of 6). STHFT: 13 cases in December 2025 (trajectory of 11).
Assurance: NTHFT: Alert, 39% worse than trajectory YTD. STHFT: Advise, 10% worse than trajectory YTD.
Action taken: Links also to the promotion of robust antimicrobial stewardship across the organisation. Further regional work continues for shared learning. Catheter audit refreshed and further support from BD regarding catheters.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

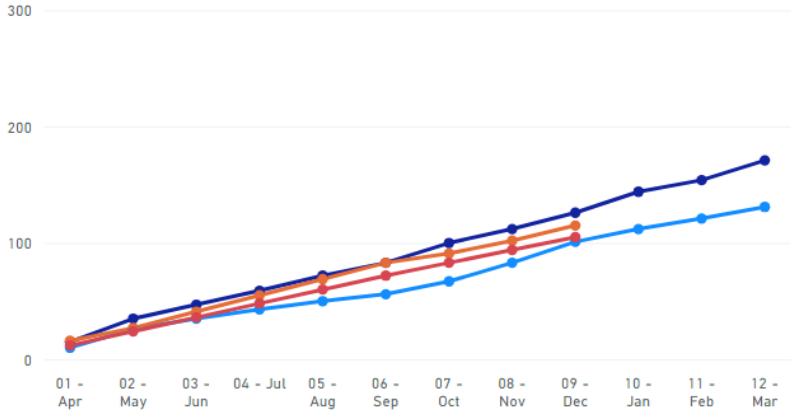
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Dec 25	85	61	N/A	N/A



STHFT

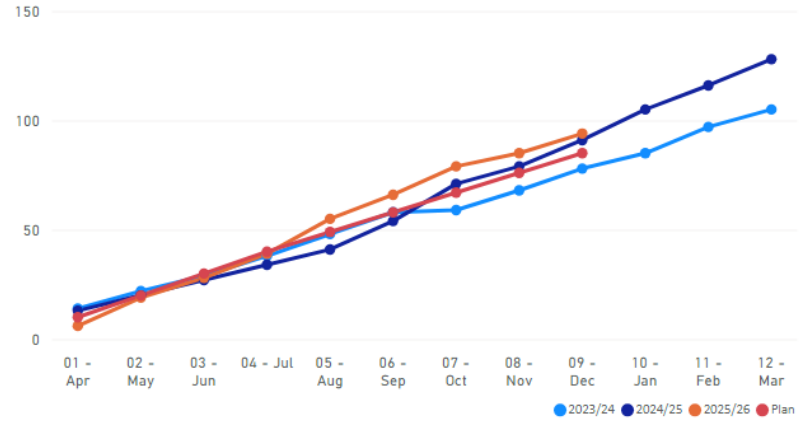
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Dec 25	115	105	N/A	N/A



SAFE MSSA (YTD)

UHT

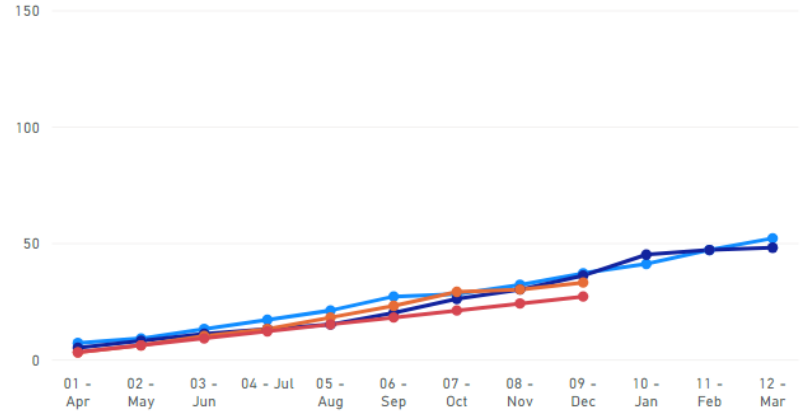
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Dec 25	94	85	N/A	N/A



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: 3 new cases in December (trajectory of 3). STHFT: 6 new cases in December (trajectory of 6).
Assurance: NTHFT: Alert, 6 cases, 22% worse than trajectory YTD. STHFT: Advise, 3 cases, 5% worse than trajectory YTD.
Action taken: UHT focus group continues with alignment of processes in respect of line care. Surgical prophylaxis for MSSA under review with further detail sought including decolonisation therapy.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

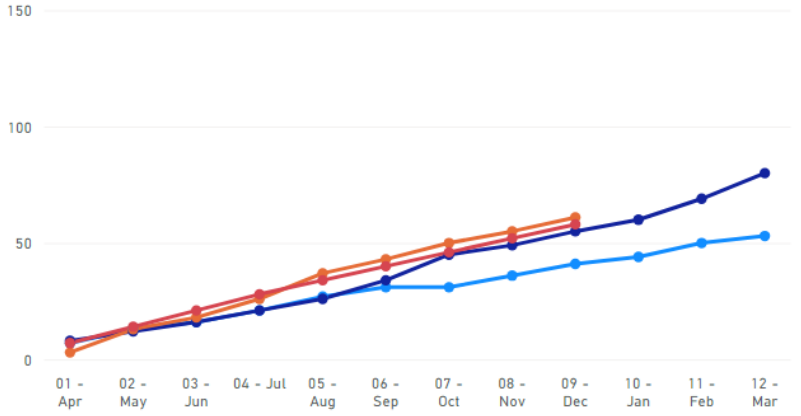
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Dec 25	33	27	N/A	N/A



STHFT

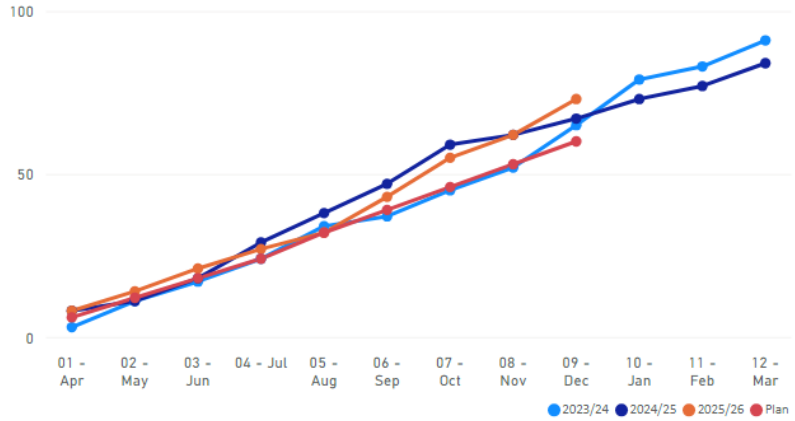
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Dec 25	61	58	N/A	N/A



SAFE Klebsiella (YTD)

UHT

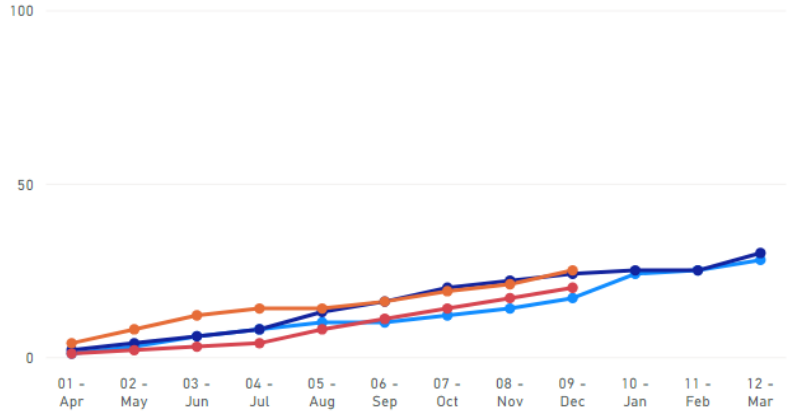
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Dec 25	73	60	N/A	N/A



Metric: Healthcare associated cases of *Klebsiella* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 4 new cases in December (trajectory of 3). STHFT: 7 new cases in December (trajectory of 4).
Assurance: NTHFT: Alert, 5 cases more, 25% worse than trajectory YTD. STHFT: Alert, 8 cases, 20% worse than trajectory YTD.
Action taken: Hepatobiliary and urinary patients continue to be the majority of cases. Catheter associated work continues. Links to Health Inequalities reviewed with regional focus.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

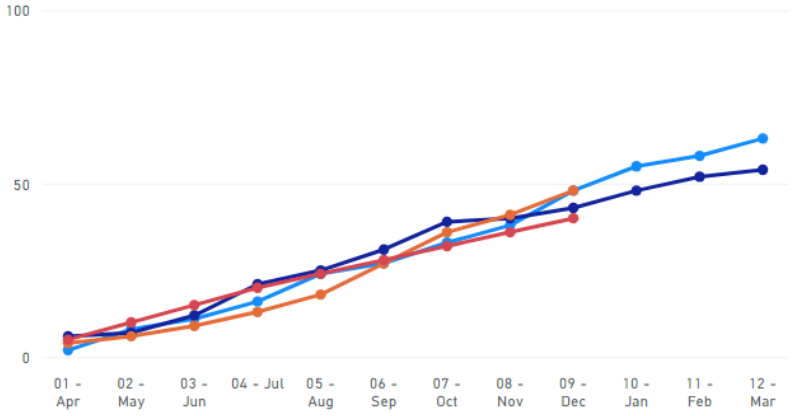
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Dec 25	25	20	N/A	N/A

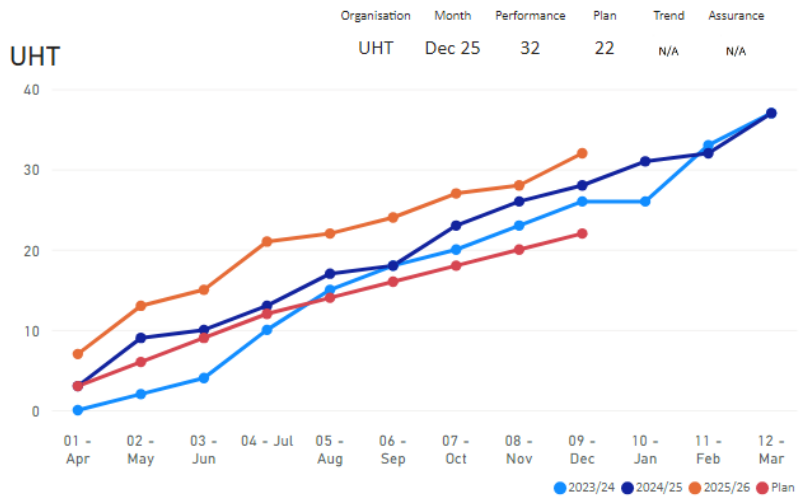


STHFT

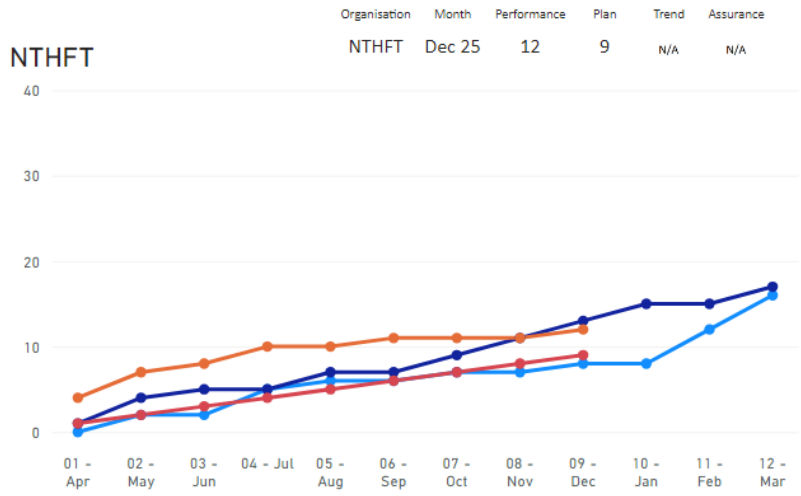
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Dec 25	48	40	N/A	N/A

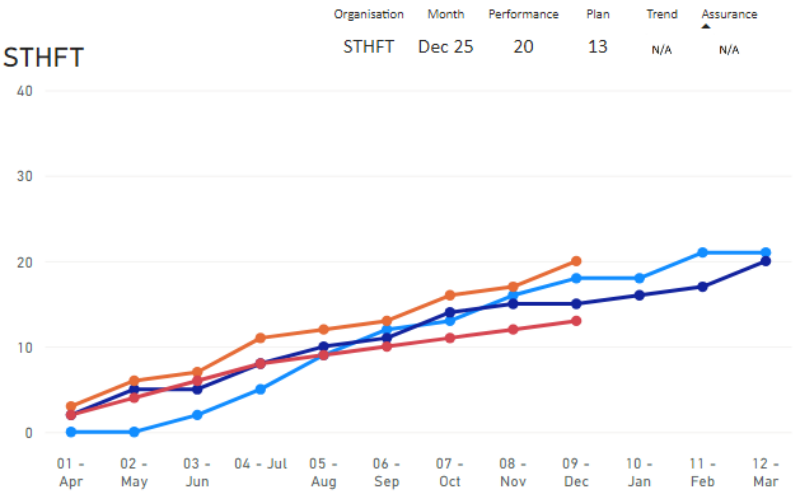


SAFE Pseudomonas (YTD)



Metric: Healthcare associated cases of *Pseudomonas* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: 10% decrease on 2024 calendar year cases. Updated plan this month.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 1 new case in December (trajectory of 1). STHFT: 3 new cases in December (trajectory of 1).
Assurance: NTHFT: Alert, 3 cases, 33%, worse than trajectory YTD. STHFT: Alert, 7 cases, 54%, worse than trajectory.
Action taken: Focus on water safety reporting and governance. Authorised Engineer visited NTHFT in November to support work on this. Assessment of water outlets and reduction where possible in lifecycle works.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





Caring Better Together

SAFE MATERNITY SUMMARY

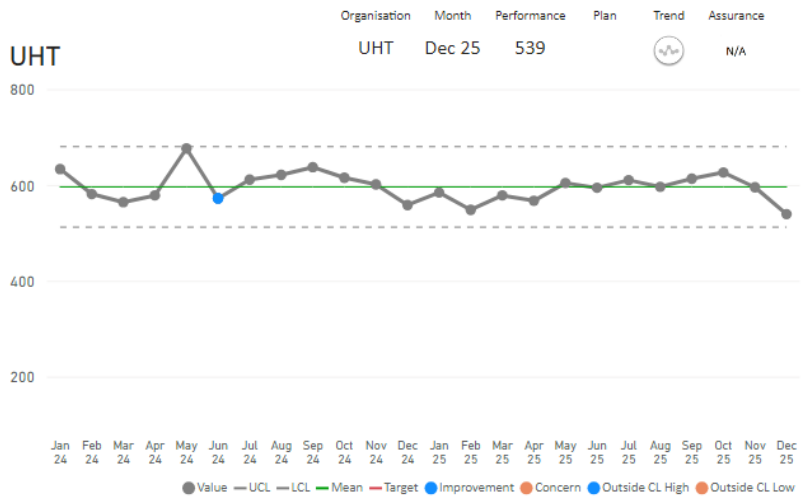
Executive lead: Emma Nunez, Chief Nursing Officer **Accountable to: Quality Assurance Committee**

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 a decreasing rate. Neonatal mortality rate triggers Advise at NTHFT due to recent incidence following an extended period of no mortality however provides 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. 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.

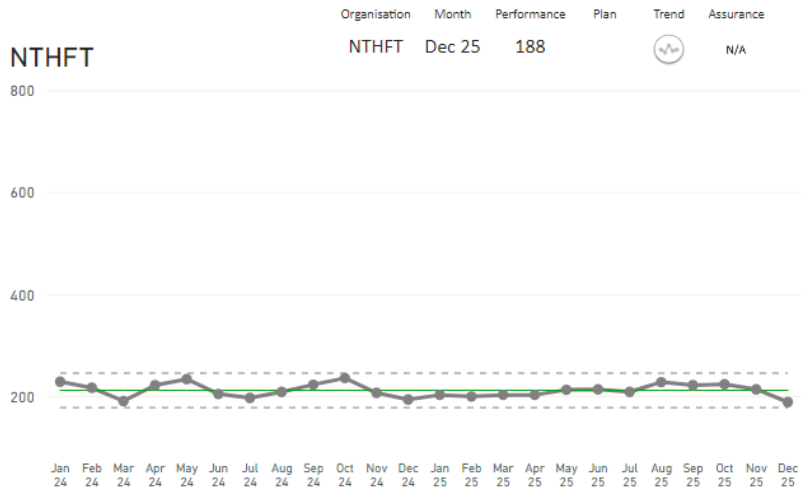
North Tees & Hartlepool NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Total Births		202	199	202	202	212	213	208	227	221	223	213	188
Still Birth Rate (Rolling 12 months, per 1000 births)	2.91	3.17	3.19	3.97	4	3.63	3.61	4.4	3.97	3.97	3.19	3.18	3.58
Neonatal Mortality Rate (Rolling 12 months, per 1000 births)	1	0	0	0	0	0	0	0.4	0.4	0.4	0.4	0.4	0.4
Breast Feeding at First Feed	72.3%	52.2%	51.5%	53%	51.5%	50.9%	46.2%	49.5%	46.3%	47.5%	47.3%	52.4%	42.8%
PPH >= 1500ml Rate per 1000 Births	31	40	45.5	24.8	29.6	37.7	32.9	24	13.2	18.4	40.9	37.9	10.8
3rd/4th Degree Tear (%)		0.9%	3.4%	0.8%	2.7%	5.8%	2.9%	8.9%	3.2%	1%	3%	2.5%	1.2%

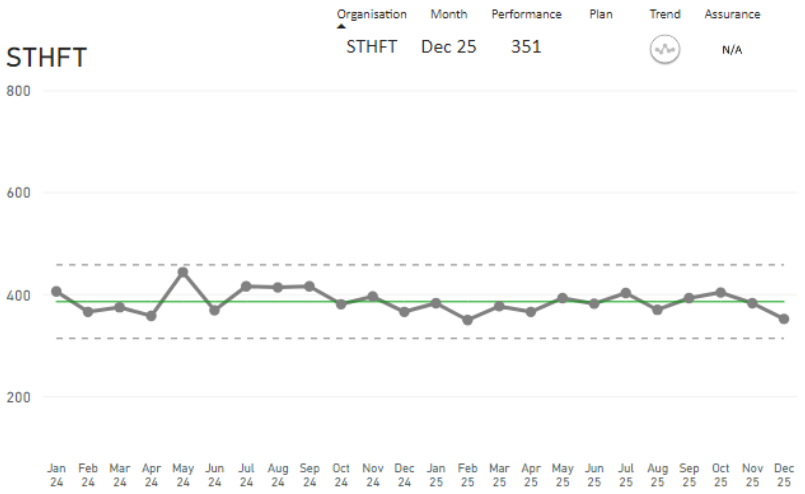
South Tees Hospitals NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Total Births		382	349	376	365	392	381	402	369	392	403	382	351
Still Birth Rate (Rolling 12 months, per 1000 births)	3.6	3.64	3.87	3.22	3.43	3.25	3.24	3.68	3.72	3.52	3.5	3.51	3.52
Neonatal Mortality Rate (Rolling 12 months, per 1000 births)	1.8	1.5	1.7	1.7	1.7	1.3	1.7	1.7	1.3	1.5	1.5	1.5	1.8
Breast Feeding at First Feed	77.1%	64.3%	63.4%	68.2%	63.9%	65.3%	64.5%	62.3%	63.5%	69.5%	65.7%	65.7%	68.1%
PPH >= 1500ml Rate per 1000 Births	31	26.8	32.4	29.6	28.1	28.6	32.1	25.4	27.9	28.6	50.8	32	40.9
3rd/4th Degree Tear (%)		0.9%	2.6%	5.7%	2.4%	1.3%	3.4%	1.3%	1.8%	2.7%	3.5%	5.2%	1.1%

SAFE Total Births

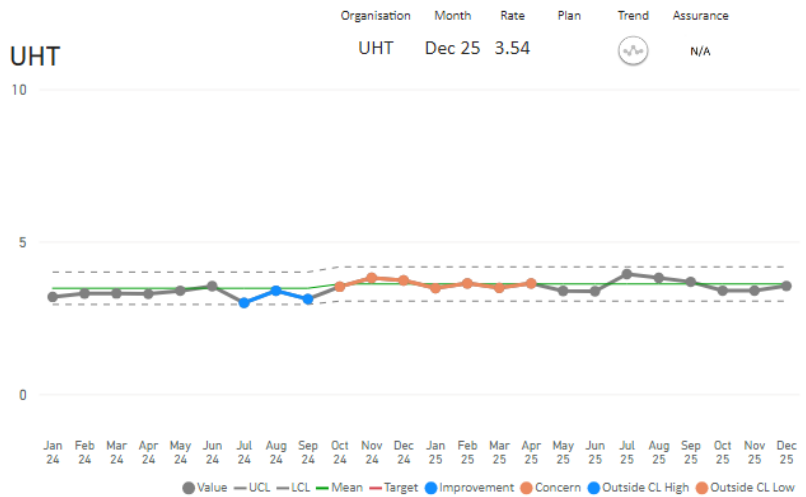


Metric: Total births (includes all registerable live and still births) under care of each Trust.
Plan: n/a
Rationale: Context for maternity metrics.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: n/a
Action taken: Number of births at NTHFT and STHFT is relatively stable over 2-year timeframe.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

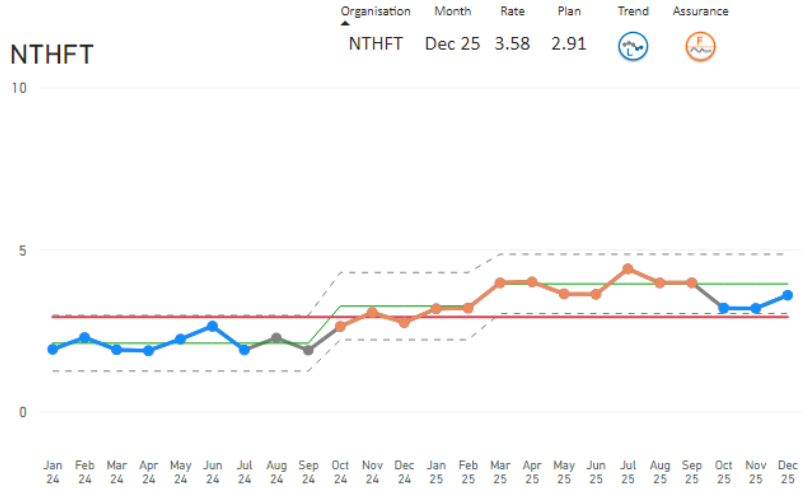


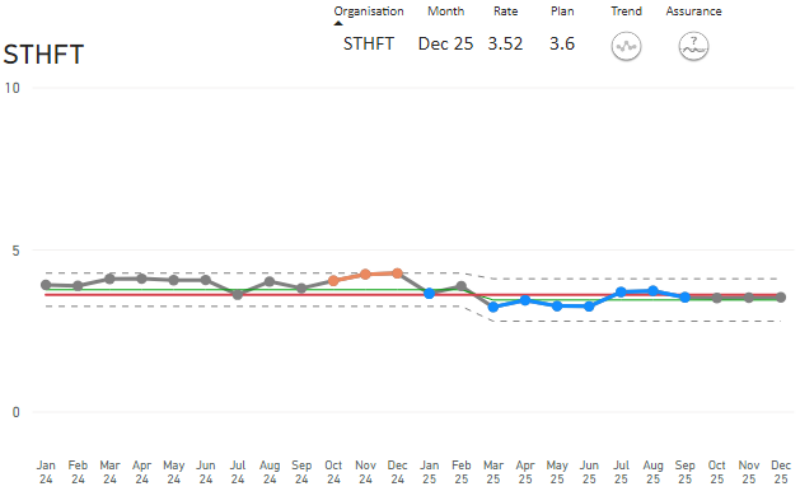


SAFE Still Birth Rate (Rolling 12 months, per 1000 births)



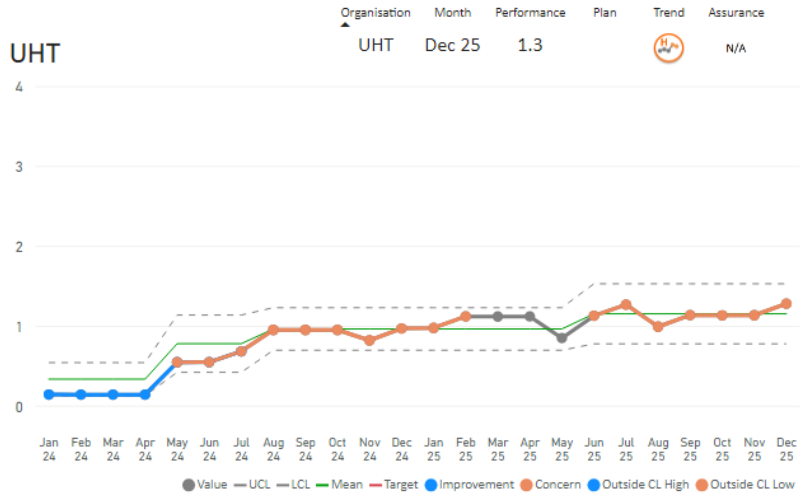
Metric: Still birth rate (rolling 12 months per 1000 births).
Plan: MBRRACE comparator group crude average 2023.
Rationale: National Maternity Indicator.
Data quality: Advised, locally derived rate may differ from nationally derived, and case-mix adjusted rates.
Trend: NTHFT: October and November 2025 had positive, reduced rates close to the expected limits of usual variance. STHFT: No trend.
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.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee



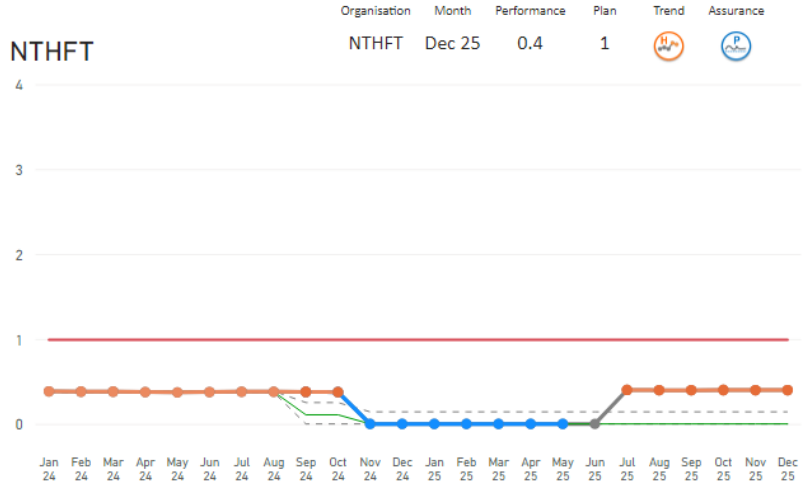


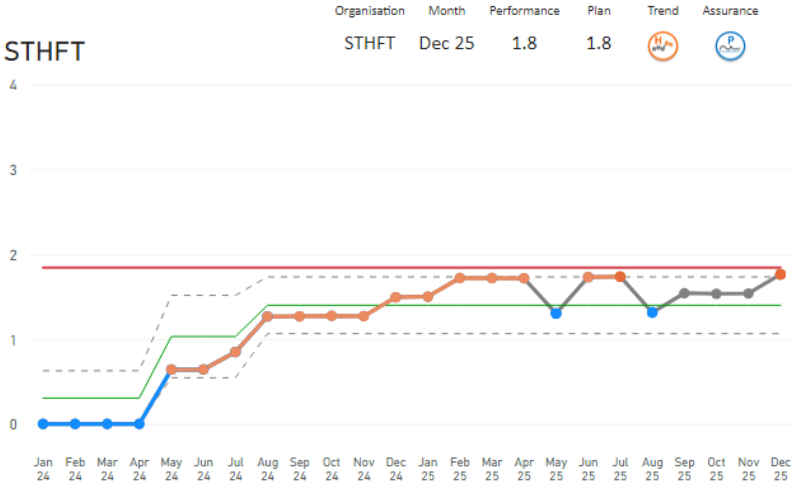
Caring Better Together

SAFE Neonatal Mortality Rate (Rolling 12 months, per 1000 births)



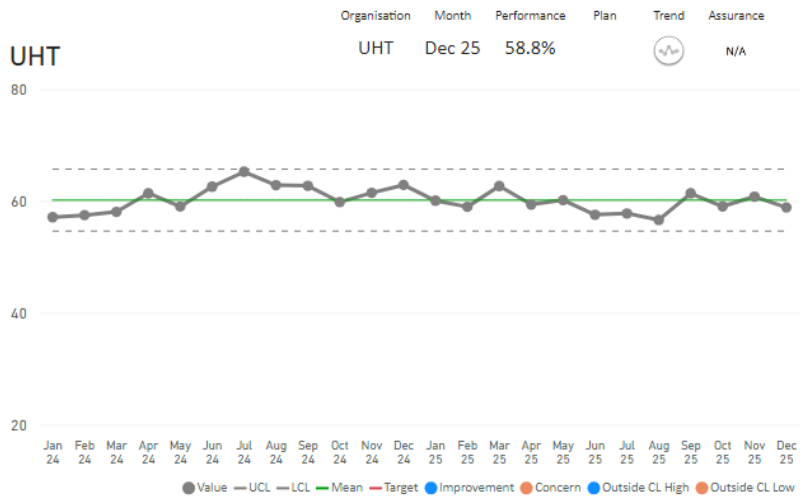
Metric: Neonatal mortality rate**,** rolling 12 months per 1,000 births.
Plan: Local plan 25/26, MBRRACE audit peer group average.
Rationale: National Maternity Indicator.
Data quality: Assured, validated data.
Trend: NTHFT: Increased trend, following an extended period with no neonatal mortality. STHFT: December rate flags as an outlier to usual variance but still below audit peer group average.
Assurance: NTHFT: Advise. STHFT: Advise.
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



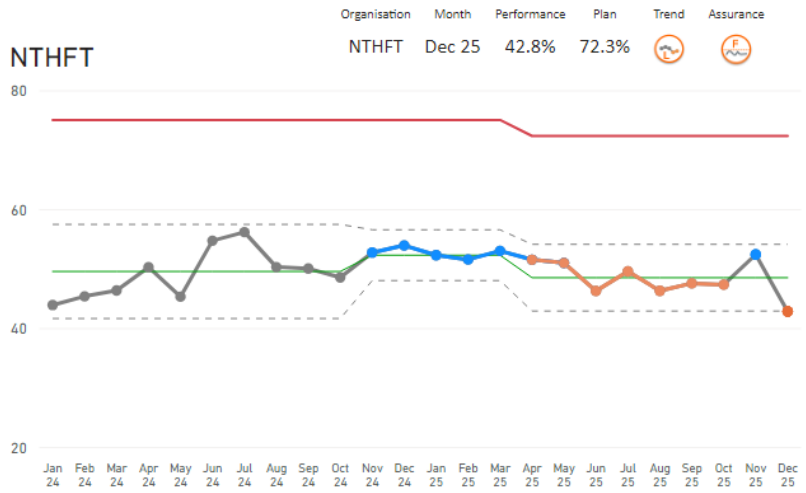


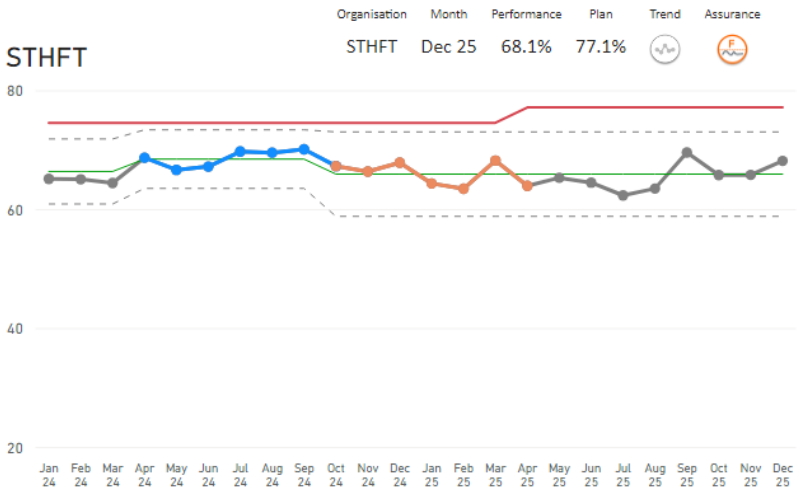
Caring Better Together

SAFE Breast Feeding at First Feed

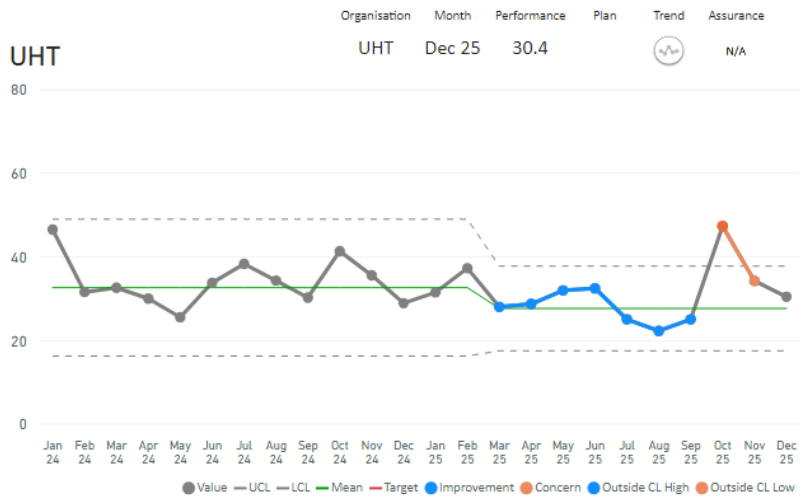


Metric: Percentage of births where breast-feeding is initiated, reported at first feed.
Plan: Local plan 25/26 to achieve MBRRACE audit peer group mean (10% tolerance).
Rationale: National maternity dashboard Clinical Quality Improvement Metric (CQIM)
Data quality: Assured, validated data.
Trend: NTHFT: Low outlier performance in December compared to usual variance. STHFT: No trend.
Assurance: NTHFT: Alert. STHFT: Alert.
Action taken: NTHFT are collaborating with STHFT infant feeding team, as a learning opportunity to support an increase in breast feeding.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

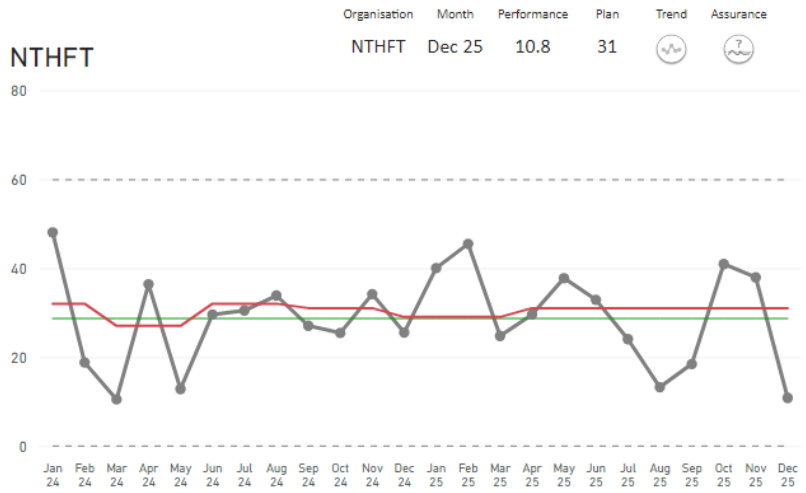


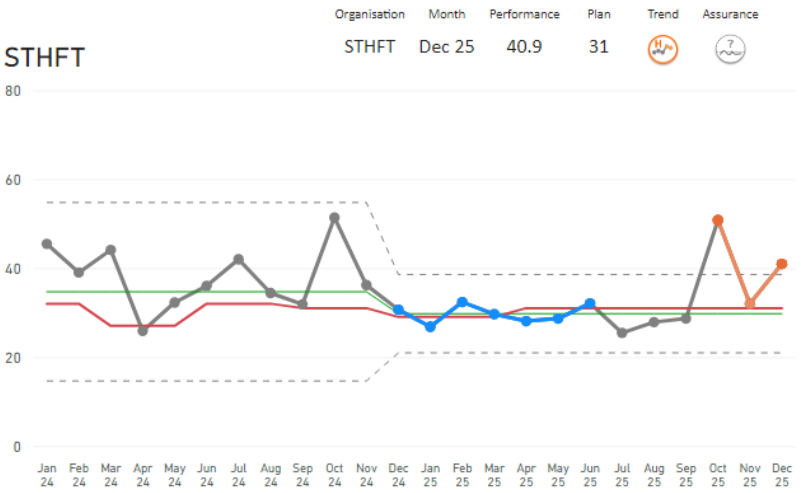


SAFE PPH >= 1500ml Rate per 1000 Births

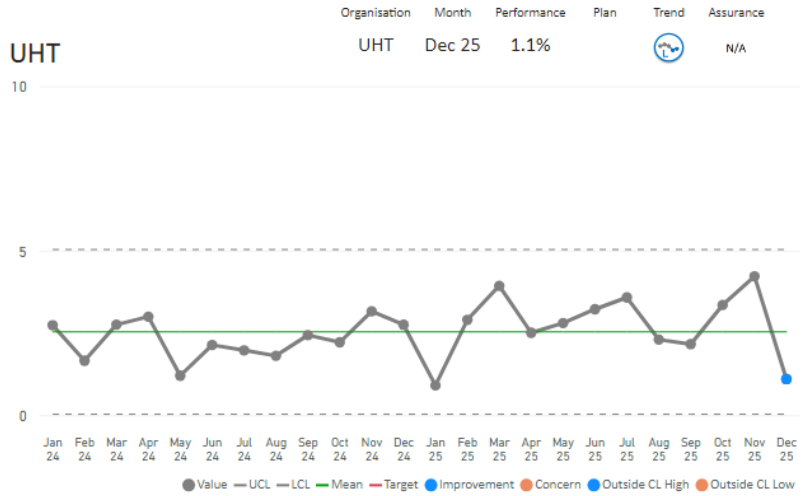


Metric: Post-partum haemorrhage (PPH) greater than or equal to 1500ml, rate per 1000 births.
Plan: North East and North Cumbria ICB regional average.
Rationale: National Maternity Indicator and Clinical Quality Improvement Metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: High outliers in October and again in December 2025.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: NTHFT and STHFT participate in a research study on effectiveness of interventions to reduce PPH. STHFT are undertaking an additional review of all PPH >1500mls to highlight any learning.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

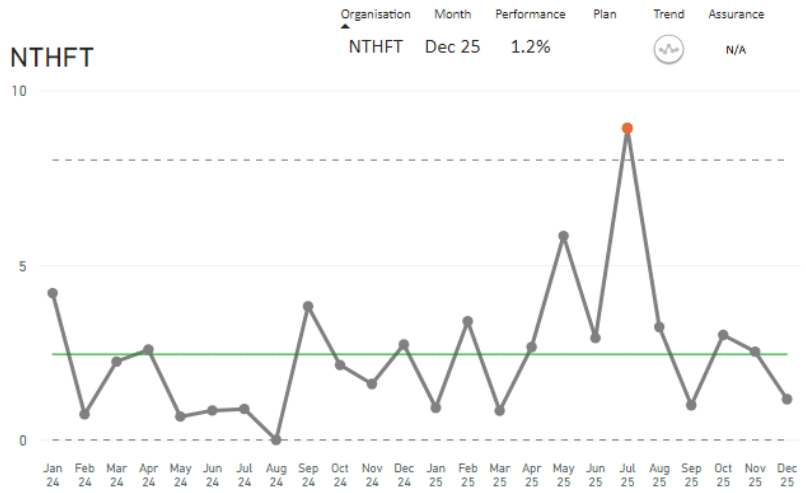


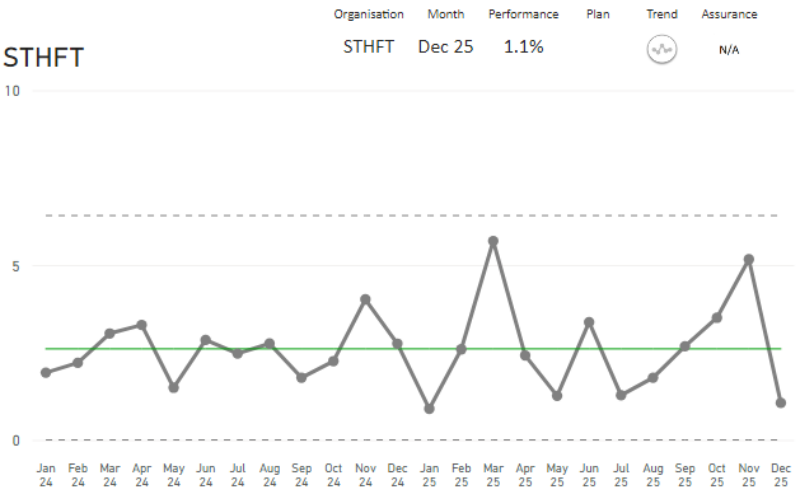


SAFE 3rd/4th Degree Tear (%)



Metric: Percentage of births with 3rd/4th degree maternal tear.
Plan: n/a.
Rationale: National Maternity Indicator.
Data quality: Assured, validated data. NTHFT data descriptor amended to reflect national descriptor, from July 2025, new rate close to limits of previous range of variation.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: n/a
Action taken: All cases have a joint review to identify any learning points; no common themes have emerged.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





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 as well as demonstrating improvement trends. 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.

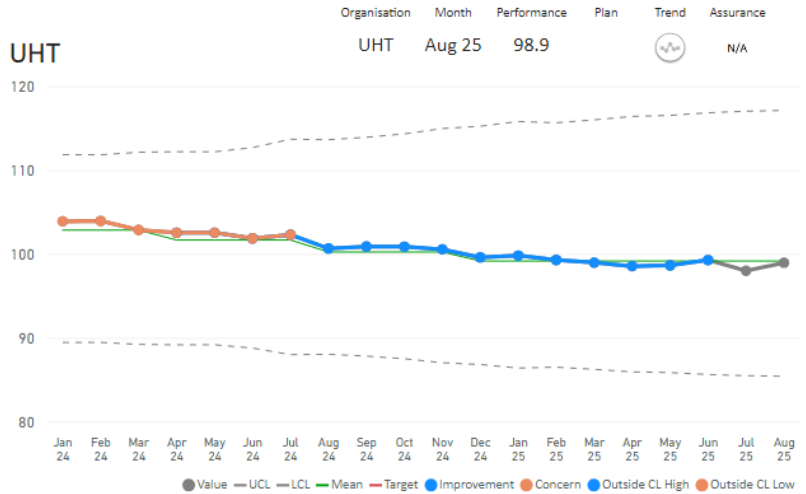
Both trusts are focusing on understanding trends in readmission using clinical audit to identify the most clinically relevant improvement opportunities across medical and surgical care pathways, whilst enabling patients to be cared for out of hospital. This is focusing initially on readmissions of patients with a diagnosis of COPD, as this cohort of patients has a higher readmission rate. The COPD audit is complete and the findings are scheduled to be discussed in the Quality Oversight Group in March 2026.The IPR reports a standardised metric to enable benchmarking.

Discharge Delay Average (days) is reported to align to the National Oversight Framework. This metric highlights differences in access to social care provision across our footprint. There is a focus on utilisation of Home First in cases of delays. Both Trusts consistently perform better than the national average for 24/25.

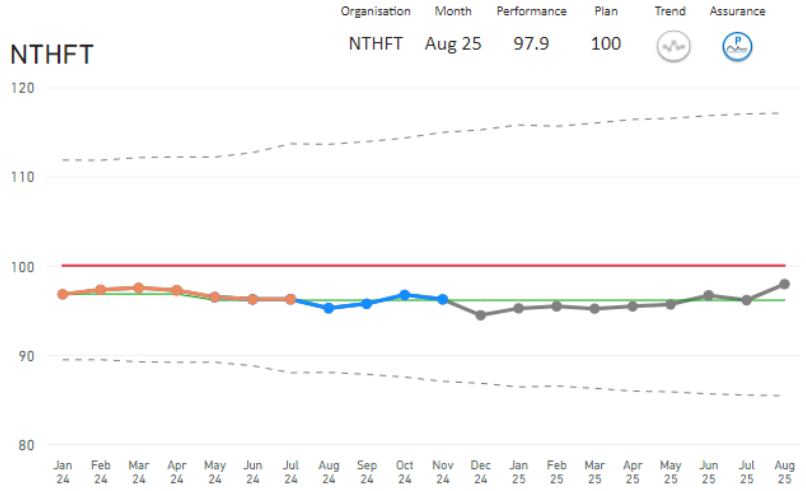
North Tees & Hartlepool NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
Summary Hospital-Level Mortality Indicator	100	95.2	95.4	95.2	95.4	95.6	96.6	96.1	97.9			
Readmission Rate (%)	8.4%	11.2%	10.6%	11.6%	11.3%	10.5%	10.3%	10.5%	10%	10%		
Discharge Delay Average (days)	0.825	0.605	0.61	0.577	0.626	0.623	0.559	0.681	0.67	0.574	0.553	0.632

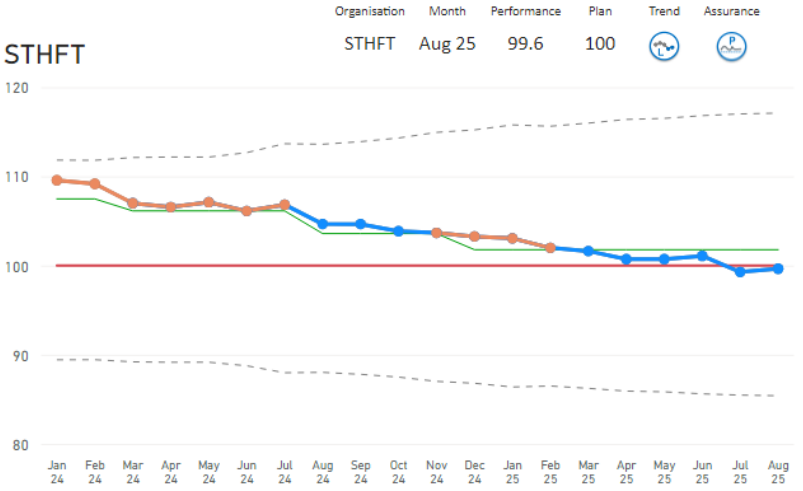
South Tees Hospitals NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
Summary Hospital-Level Mortality Indicator	100	103.1	102	101.6	100.7	100.7	101.1	99.3	99.6			
Readmission Rate (%)	8.4%	8.4%	8.8%	8.8%	8.8%	8.4%	9.1%	8.6%	8.4%	8.5%		
Discharge Delay Average (days)	0.825	0.7	0.658	0.652	0.534	0.626	0.594	0.617	0.601	0.688	0.671	0.594

EFFECTIVE Summary Hospital-Level Mortality Indicator

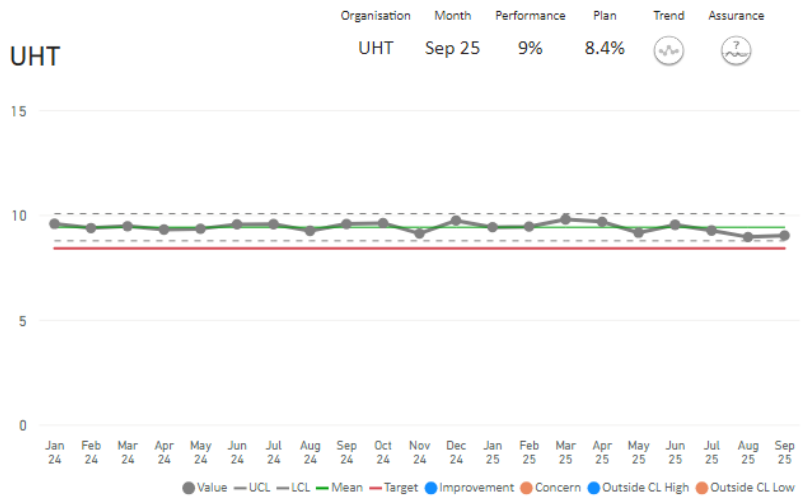


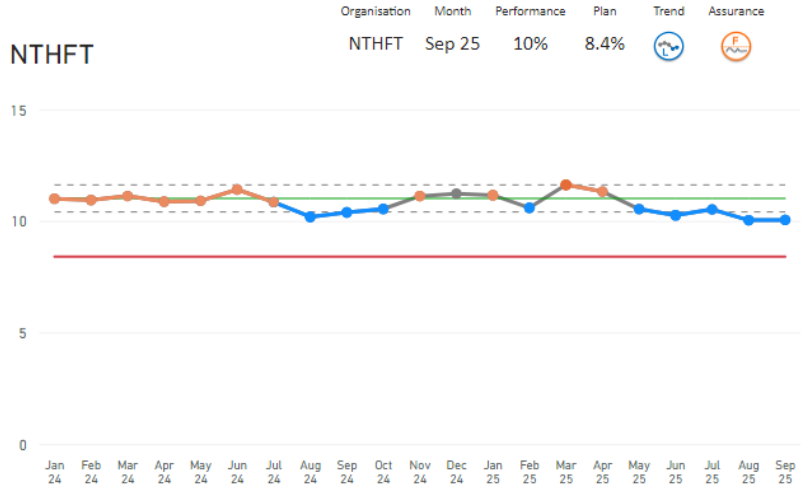
Metric: Summary hospital-level mortality indicator (SHMI), calculated for rolling 12-months, 4-months in arrears.
Plan: Standardised to 100.
Rationale: Quality Accounts regulatory indicator.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: Improving.
Assurance: NTHFT: Assure. STHFT: Assure.
Action taken: Coding audit work is underway focusing on diagnoses with higher mortality. Coding audit is being undertaken at NTHFT with a focus on coding depth (co-morbidities).
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

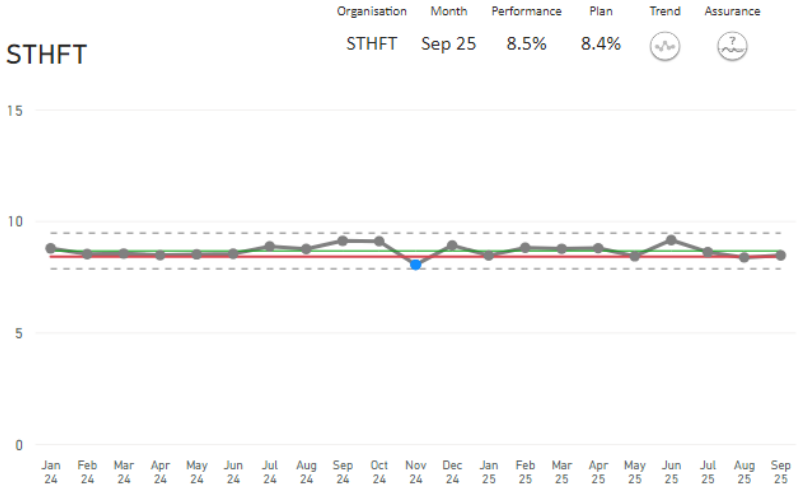




EFFECTIVE Readmission Rate (%)

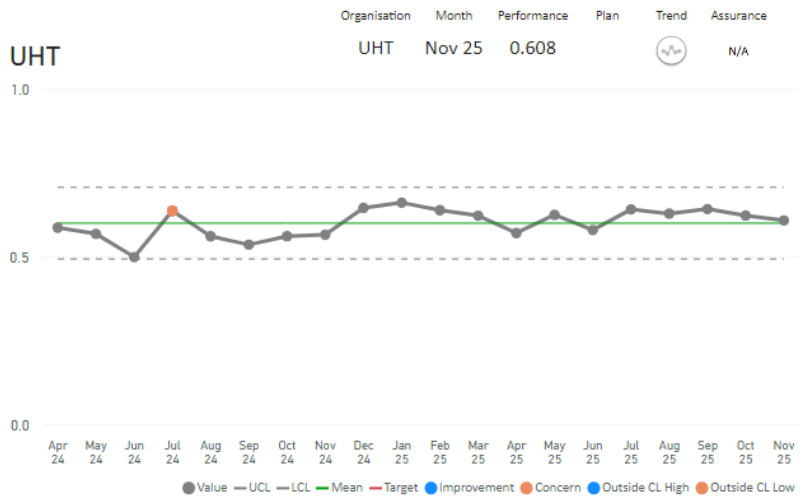


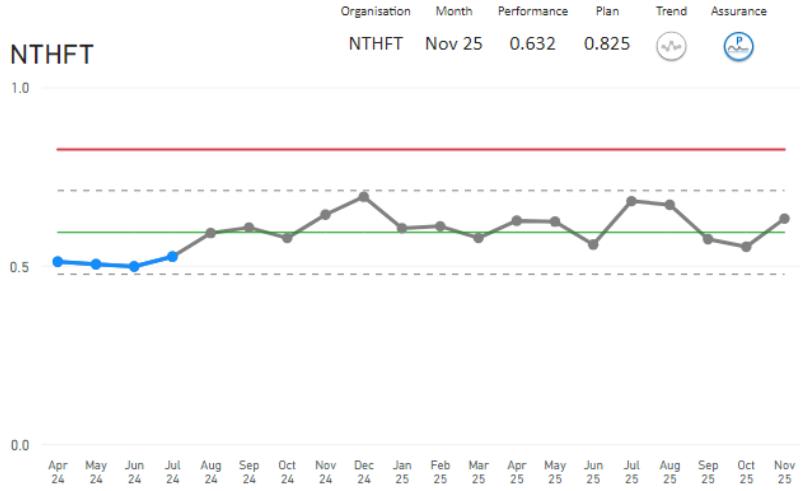


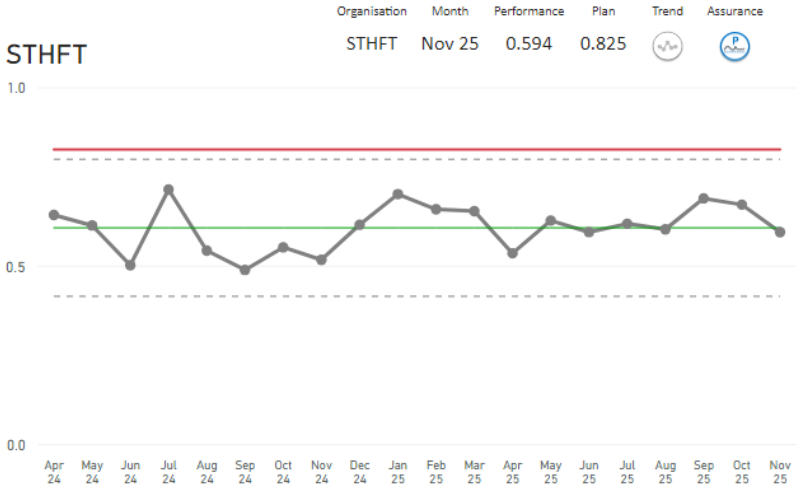


Metric: Percentage of patients readmitted within 30 days.
Plan: 2023/24 national average.
Rationale: NHS Contract metric.
Data quality: Aligned to published benchmark. Reported two months in arrears to enable the data to be fully coded.
Trend: NTHFT: Improved performance, better than expected variation, since May 2025. STHFT: No trend.
Assurance: NTHFT: Advise. Readmission rate consistently higher than plan but reducing. STHFT: Advise.
Action taken: Working group met and paper to be presented at Quality Oversight Group in March with highlights and trends. COPD audits completed at both sites. CSU's to be sent outlier report in February.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

EFFECTIVE Discharge Delay Average (days)







Metric: Average number of days between discharge ready date and discharge date, including zero-day length of stay.
Plan: No published standard, local plan to perform significantly better than national mean rate for 24/25.
Rationale: NHS Oversight Framework 25/26 core metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Assure. STHFT: Assure.
Action taken: Renewed focus on ensuring plans and escalations are in place for patients with longer lengths of stay, including patients awaiting repatriation. Utilisation of Home First in cases of delays in access to social care which varies between the local authorities of each Trust.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Chief Delivery Officer **Accountable to: Resources Committee**

Urgent and emergency care

Ambulance handover performance compliance is assured at >95% within 45 minutes at NTHFT, and a significant improvement trend February to August 2025 at STHFT, has been maintained since and brings the standard within capability.

NTHFT A&E 4-hour standard performance is better than the agreed trajectory for December and the national recovery standard of 78% has been exceeded throughout the year for NTHFT as one of the top performing trusts nationally. There is continued focus at STHFT to secure delivery to trajectory, including implementing a rapid assessment and treatment model. To date, compliance is demonstrating good resilience to seasonal demand compared to last year.

12-hour breaches in ED show seasonal variation with patient acuity and are 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.

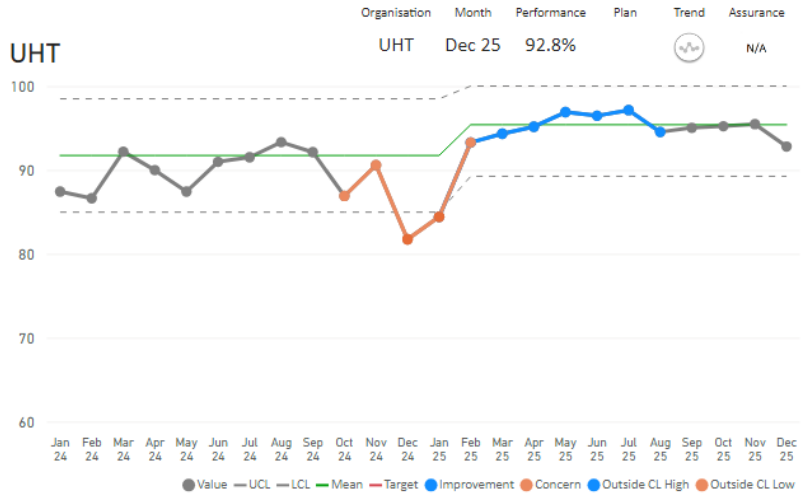
Above-standard performance in the community urgent 2-hour response reflects the continued focus on supporting urgent and emergency care pathways by caring for patients in the most appropriate setting. The introduction of a UHT care co-ordination centre in November supports making the optimal use of community resources to avoid unnecessary admissions during the seasonal increase in demand for care.

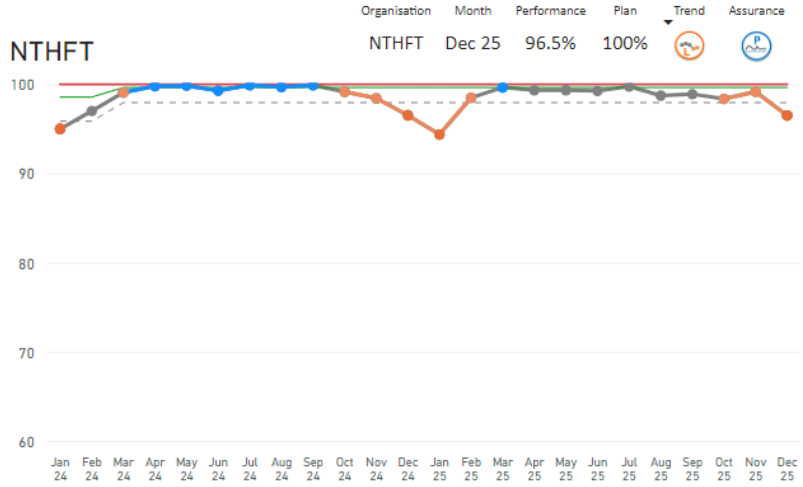
Elective operations cancelled on the day not rebooked within 28 days is consistently less than 5 per month at NTHFT and STHFT has demonstrated significant improvement from March 2025 after re-invigorating focus on re-booking through collaborative performance meetings and the Surgical Improvement Group.

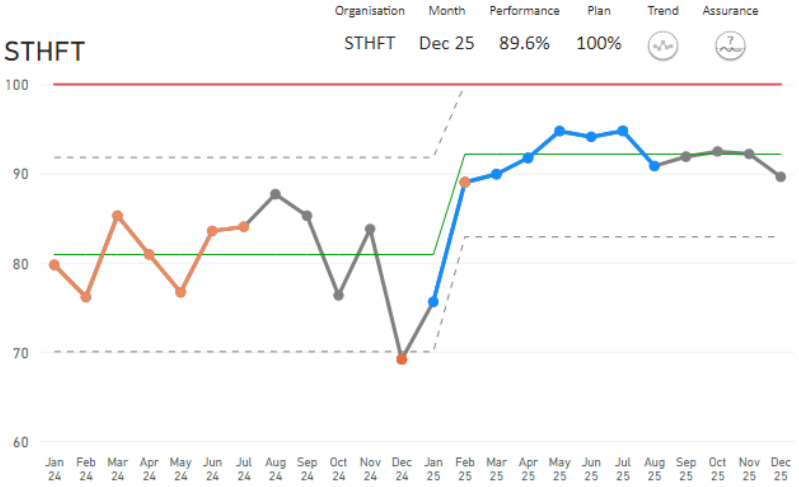
North Tees & Hartlepool NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
NEAS Handovers - Within 45 Mins (%)	100%	94.4%	98.5%	99.6%	99.3%	99.3%	99.2%	99.7%	98.7%	98.9%	98.4%	99.2%	96.5%
4-Hour A&E Standard	81.2%	81.3%	85.5%	85.6%	83.7%	86.4%	84.6%	84.9%	84.6%	83.4%	82%	82%	83.3%
12-hour ED breaches rate	5.6%	6.4%	1%	1.7%	2.2%	1.4%	3.2%	1.5%	1.4%	4.5%	6.4%	5.5%	6.9%
Community UCR 2hr Response Rate (%)	70%	79%	72%	74%	70%	75%	75%	76%	80%	76%	73%	75%	
Cancelled Ops - Not Rebooked Within 28 days	0	5	10	0	3	4	5	1	0	3	4	2	2

South Tees Hospitals NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
NEAS Handovers - Within 45 Mins (%)	100%	75.6%	89%	89.9%	91.7%	94.7%	94.1%	94.8%	90.8%	91.9%	92.5%	92.2%	89.6%
4-Hour A&E Standard	78%	74.2%	75.4%	75.7%	77%	77%	76.6%	78.5%	78%	76.7%	77.3%	77.7%	78.5%
12-hour ED breaches rate	8.5%	11.6%	5.1%	4.1%	4.4%	2.8%	3.2%	2.7%	4.6%	5.6%	5.2%	5.5%	5.5%
Community UCR 2hr Response Rate (%)	70%	80%	83%	86%	82%	81%	78%	76%	77%	71%	76%	77%	
Cancelled Ops - Not Rebooked Within 28 days	0	19	26	16	10	6	11	10	10	9	16	10	16

RESPONSIVE NEAS Handovers - Within 45 Mins (%)

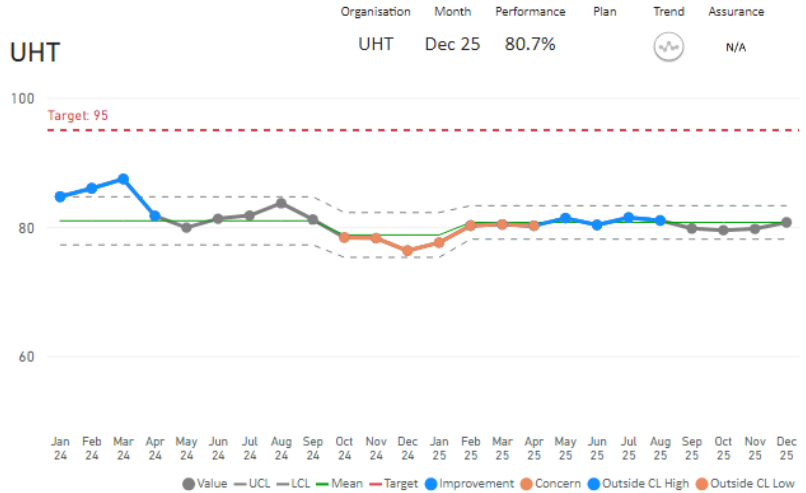


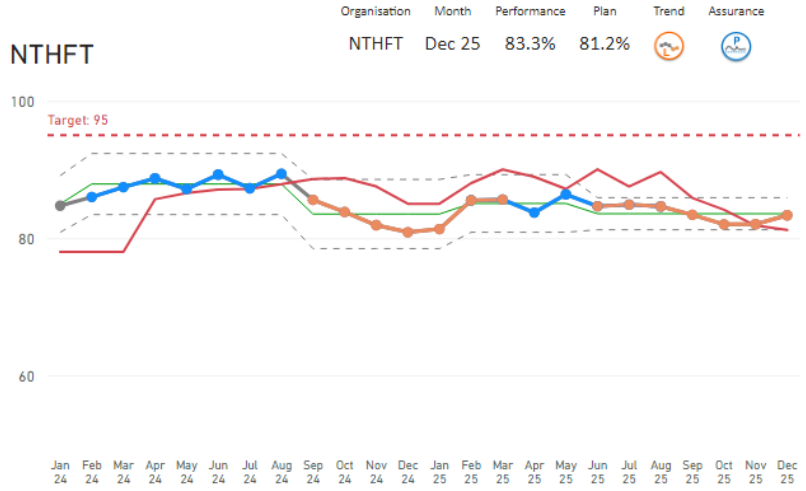




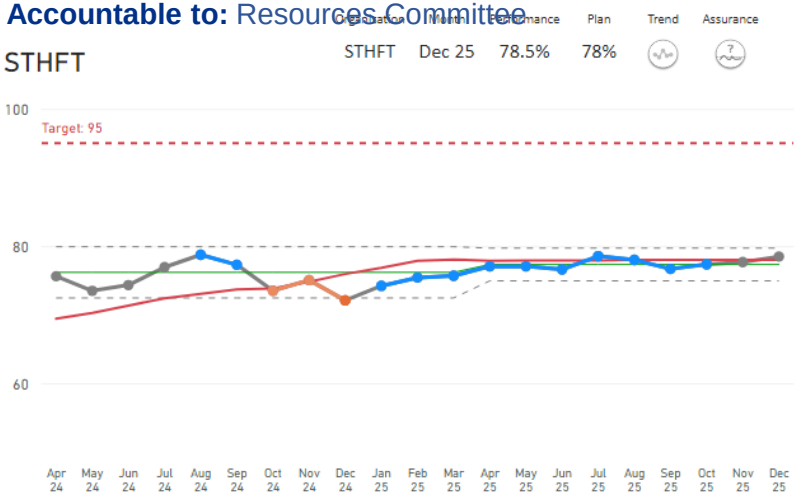
Metric: Percentage of NEAS ambulance handovers completed within 45 minutes of arrival at ED.
Plan: 100% within 45 minutes
Rationale: NHS Contract metric.
Data quality: NEAS data may differ from Trust data.
Trend: NTHFT: No trend, lower than expected variation December 2025. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT continue focus on full compliance. Handover SOP in place and use of corridor and ambulatory area in surge to provide timely release of crews. STHFT reinforce the handover escalation SOP with clinical teams. ED patient flow will become the primary source of escalation to minimise ambulance delays.
Executive lead: Chief Delivery Officer
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: Assured, validated data.
Trend: NTHFT: Performance declined since September 2025. STHFT: No trend. Outside of expected variation in December 2025.
Assurance: NTHFT: Advise STHFT: Advise.
Action taken: NTHFT: Continued collaborative working through 4-hour steering group to progress improvement opportunities. Work continues with Police on the custody suite pathway. STHFT: Rapid assessment and treatment trial was effective and, since September, this is now sustained for 20 hours over 5 days. Pressures within the admitted pathway due to high occupancy and acuity; focus on the turnaround of non-admitted patients.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee



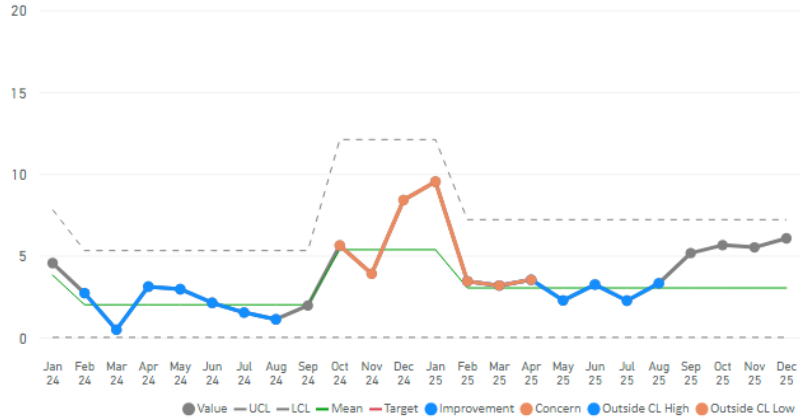
Caring Better Together

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: Higher rate of breaches in 2 of the last 3 months (October and December). STHFT: No trend.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: NTHFT: Ongoing weekly audit of breaches to identify key themes; NTHFT Discharge Lounge relocated in November to care for bedded patients. STHFT: Continued focus on interventions at 10-hours to avoid 12-hour breaches. Full capacity protocol enacted when required to support admitted patient flow.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

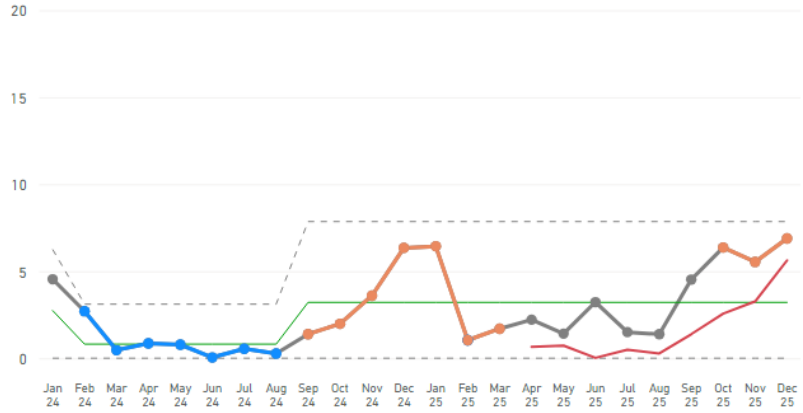
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Dec 25	6.1%			N/A



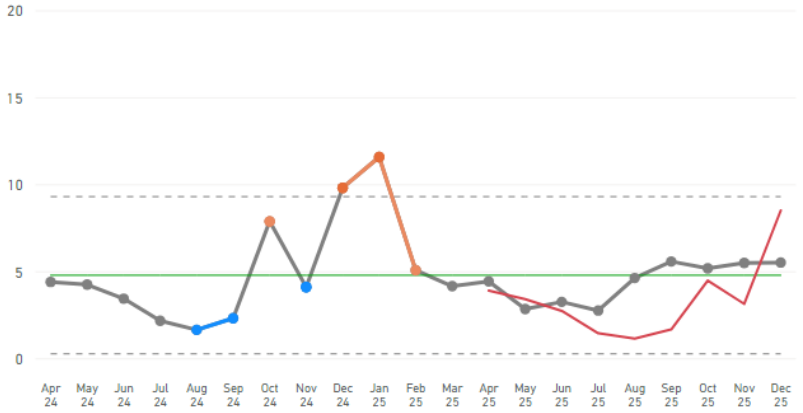
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Dec 25	6.9%	5.6%		

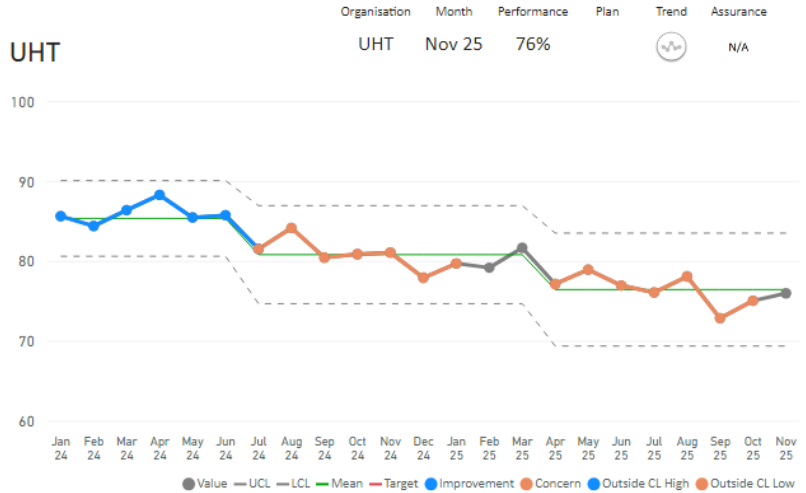


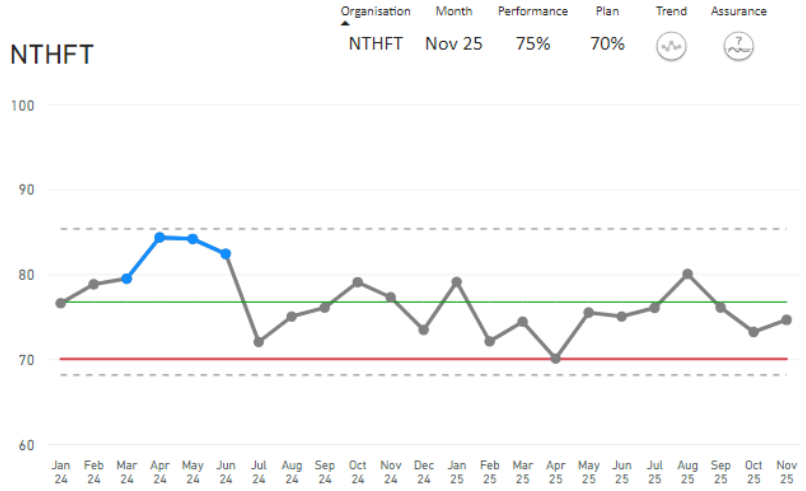
STHFT

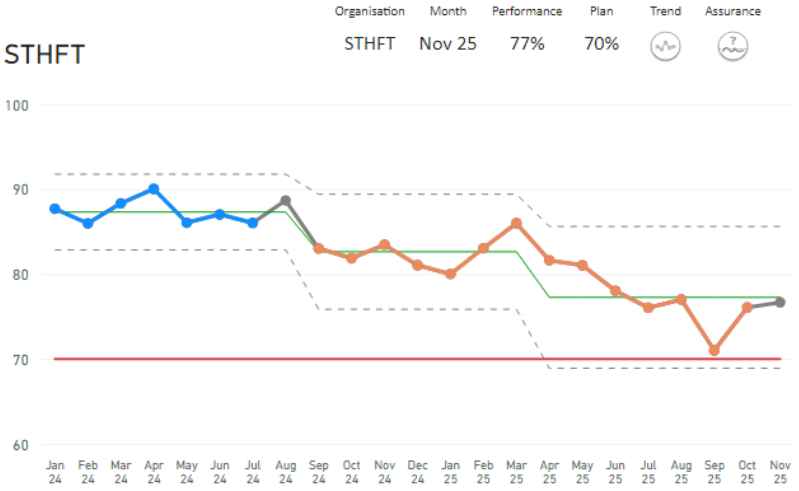
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Dec 25	5.5%	8.5%		



RESPONSIVE Community UCR 2hr Response Rate (%)

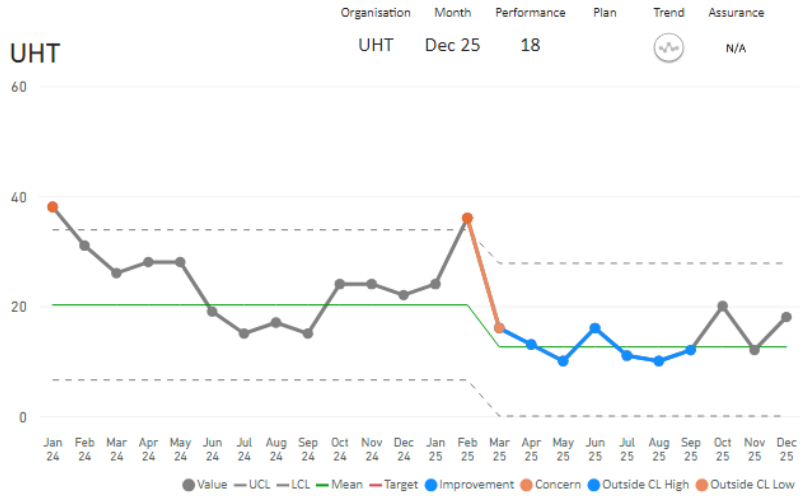




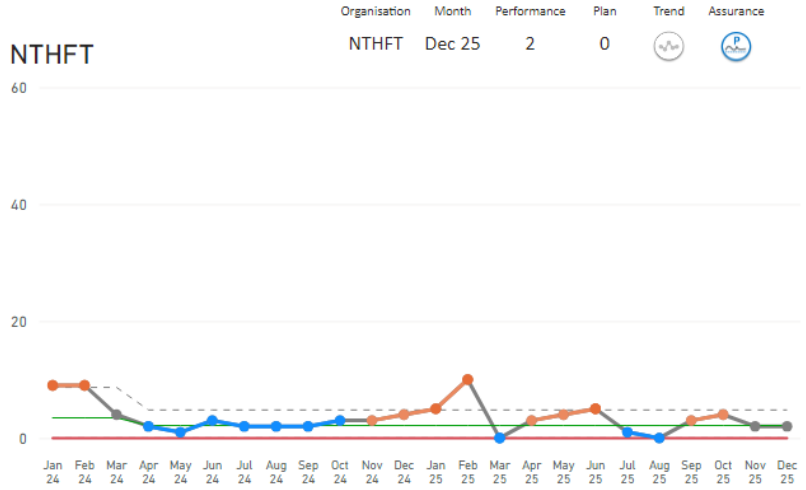


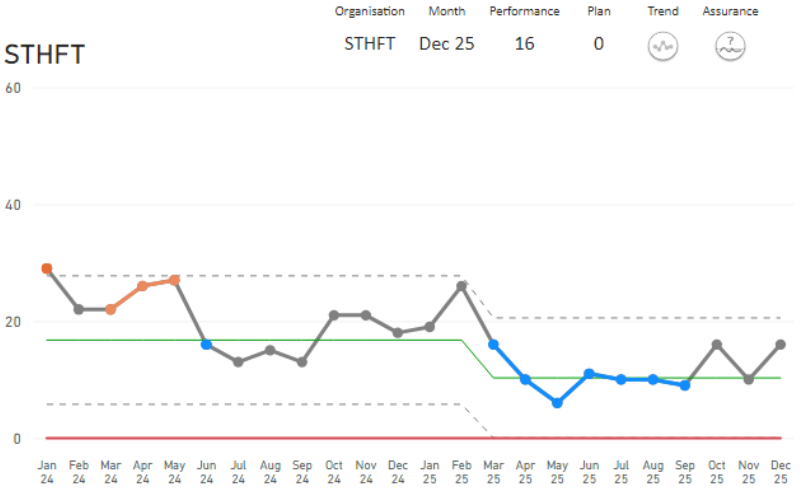
Metric: Urgent community response within 2-hours
Plan: 70%
Rationale: NHS operational planning guidance
Data quality: Advisory, metric calculated from submitted raw community data sets, available one month in arrears.
Trend: NTHFT: No trend. STHFT: Seven consecutive months of below average performance from April 2025, no longer assured of consistently meeting plan each month.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Recent focus has been on increasing both the number of referrals and referrals from different sources, including NEAS, 111 and the Care Home sector. An integrated UHT care coordination centre pilot is underway, helping to optimise use of community resources to avoid unnecessary admissions. As a result, UCR activity has increased with performance maintained above the national standard. Clinical prioritisation of responses across UCR and H@H caseloads continues. A review of UCR approach and reporting across NENC is planned to ensure consistency of approach; UHT will feed into this.
Executive lead: Chief Delivery Officer
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: Assure. STHFT: Advise.
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 Clinical Service Units performance and Surgical Improvement Group meetings.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee





RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Chief Delivery Officer **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 is not assured for NTHFT or STHFT, and 31-day compliance at STHFT in 2025 is lower than in 2023/24, largely driven by increased demand for subsequent radiotherapy treatments. However, STHFT compliance with 62-day standard now shows a significant recent improvement trend and is ahead of plan. Tiered support from NHS England continues. NTHFT 31-day and 62-day performance compliance has shown impacts of a sustained increase in breast symptomatic referrals from the County Durham and Darlington catchment area since February 2025. 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. Specific interventions are being put in place to reduce pathway delays across respiratory and urology services, as the next two pathways with lower performance against the standard. Tumour specific pathway improvements are driven by the clinically-led Cancer Delivery Groups with oversight from the Performance Recovery Oversight Group.

Elective recovery trajectories are supported by waiting list validation, clinic template review, additional capacity in targeted specialties with the greatest patient access/demand challenges. Patients with the longest waits are prioritised with NTHFT performing close to the NHS operational standard for 52-week waits each month. For STHFT, 52-week waits is demonstrating the start of an improvement trend although still exceeds the planned trajectory. STHFT entered tiered support arrangements with NHS England in November with the aim of eliminating 65 week waits.

North Tees & Hartlepool NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Cancer Faster Diagnosis Standard (%)	79%	75.3%	80.3%	79.5%	78.2%	78.6%	75.7%	78.4%	79%	78.3%	82%	82.2%	83.2%
Cancer 31 Day Standard (%)	96.1%	96.6%	96.4%	93.8%	97.2%	94.8%	97.1%	92.5%	88.8%	92.4%	94.2%	93.3%	97.2%
Cancer 62 Day Standard (%)	74.2%	72.2%	63.4%	67%	64.3%	58%	56.7%	52.3%	51.7%	56.7%	61%	63%	62.1%
Diagnostic 6 Weeks Standard (%)	95%	91.6%	95.1%	96.7%	95.1%	96.3%	95.8%	96.6%	94.5%	96.1%	94.9%	95.5%	95%
RTT Incomplete Pathways (%)	75.1%	73.2%	74.4%	75.5%	74.5%	74.5%	73.9%	74.2%	72.7%	73.3%	73.8%	72.8%	71.3%
RTT 52 Week Waiters Rate	0.9%	0.8%	0.8%	0.8%	1%	1%	1.2%	0.9%	0.8%	0.7%	0.9%	0.8%	1%
Community Over 52 Week Waiters Rate	7.1%	0.6%	0.3%	0.1%	0.6%	1.5%	2.9%	3%	3.4%	3.2%	1.5%	3.1%	2.9%
RTT Time to First Appointment (%)	82.2%	80.1%	81.8%	82.2%	81.7%	82.3%	81.1%	81%	79.9%	79.5%	80.5%	80.7%	78.6%

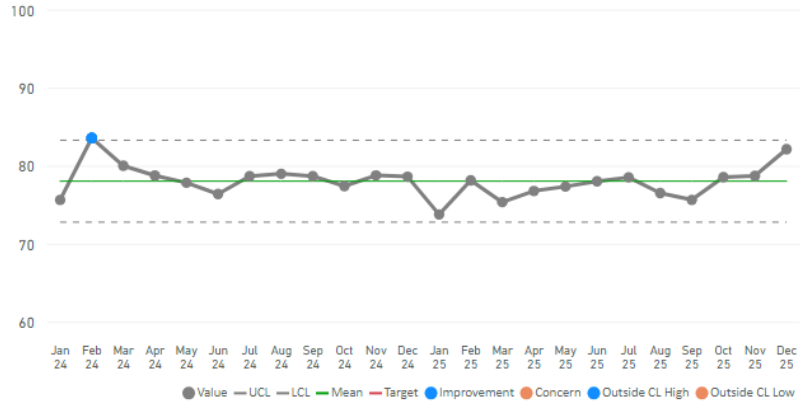
South Tees Hospitals NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Cancer Faster Diagnosis Standard (%)	79%	72.2%	75.9%	71.1%	75.6%	76.3%	79.9%	78.6%	74%	73.2%	75.1%	75.3%	81.1%
Cancer 31 Day Standard (%)	93.1%	81.1%	86.8%	82.6%	86.6%	82.8%	87.1%	86.1%	81.7%	83.9%	83.3%	82.5%	80.7%
Cancer 62 Day Standard (%)	66%	63.1%	61%	61.2%	63.8%	64.4%	62.3%	68.7%	66.8%	65.2%	65.7%	70.6%	69.4%
Diagnostic 6 Weeks Standard (%)	95%	88.7%	88.7%	87.4%	85%	83%	84.4%	86.9%	82.2%	85.4%	86.6%	85.2%	84.1%
RTT Incomplete Pathways (%)	63.2%	59.5%	59.9%	60.3%	61.1%	62.1%	62.1%	61.9%	61.1%	61.7%	62.1%	61.8%	61.9%
RTT 52 Week Waiters Rate	1.5%	2.9%	2.9%	2.7%	2.8%	2.8%	2.8%	2.7%	2.9%	2.7%	2.4%	2.2%	1.9%
Community Over 52 Week Waiters Rate	7.1%	2.1%	2%	1.7%	1.6%	2.3%	2.2%	2%	1.9%	1.9%	1.8%	2%	2.2%
RTT Time to First Appointment (%)	68.9%	64.3%	64.8%	64.7%	66.2%	66.2%	65.4%	64.3%	64%	63.8%	64.7%	64.7%	63.8%

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, to note that performance in December is at the highest in 24 months. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT Focus on compliance improvement in urology and respiratory pathways, STHFT focus on compliance in urology and gastro-intestinal tumour groups. Recent changes in prostate diagnostic pathway are evident and with new changes in bladder pathway and a natural reduction in the extra seasonal skin referrals, performance is has rebounded positively in December.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

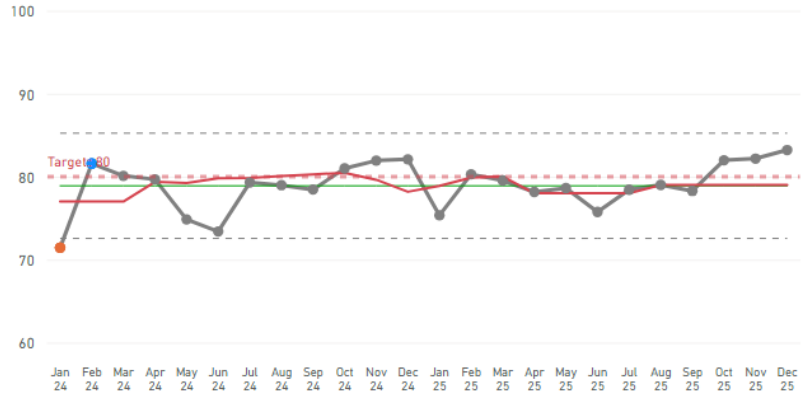
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Dec 25	82.1%			N/A



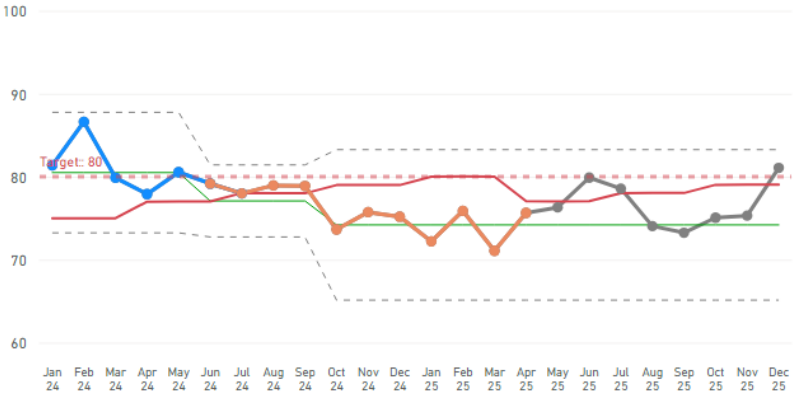
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Dec 25	83.2%	79%		



STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Dec 25	81.1%	79%		

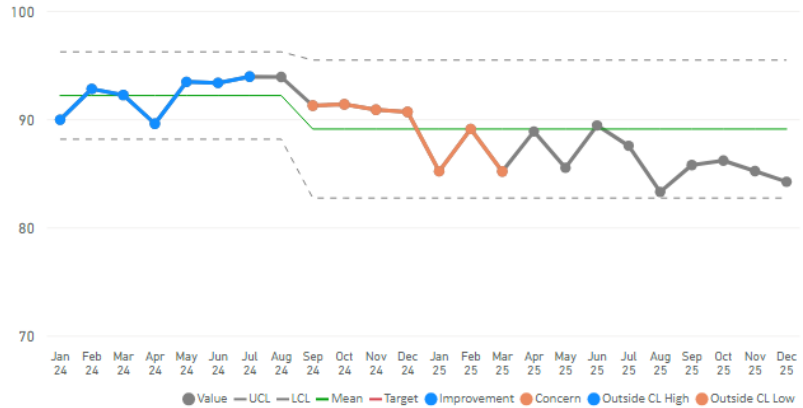


RESPONSIVE **Cancer 31 Day Standard (%)**

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: For both NTHFT and STHFT breast pathway demand is challenging to compliance. Ongoing collaboration with CDDFT to support their service delivery. There is continued wider strategic discussion with the ICB for a longer-term regional response. STHFT focus is the patients waiting longest for treatment and managing constraints of radiotherapy capacity.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

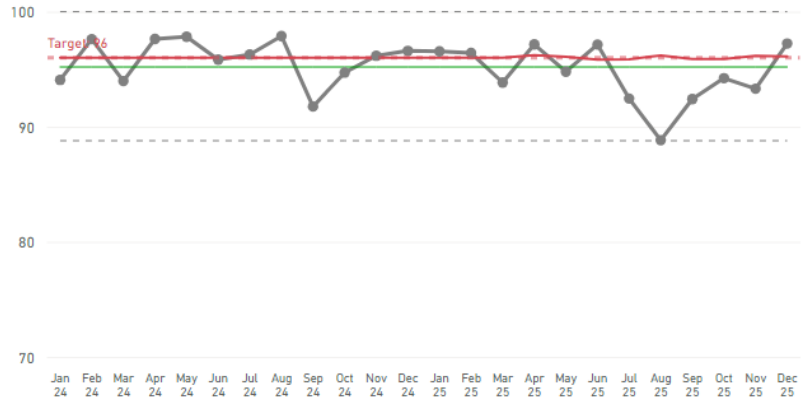
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Dec 25	84.2%			N/A



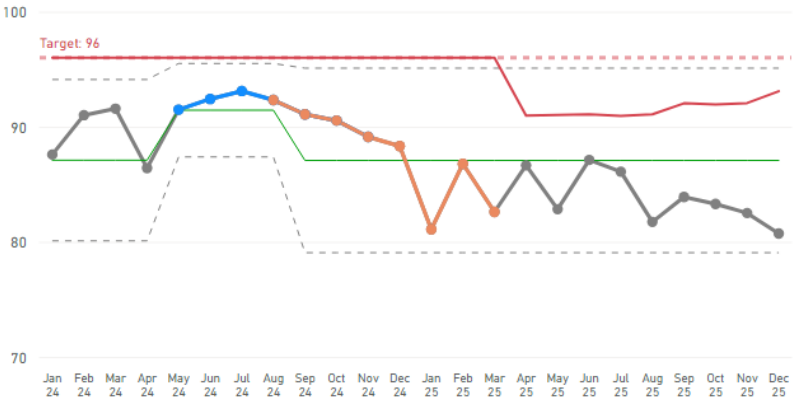
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Dec 25	97.2%	96.1%		

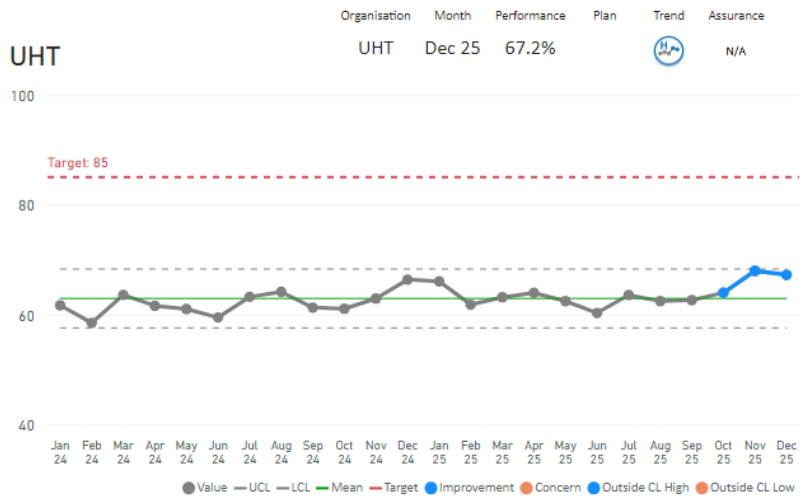


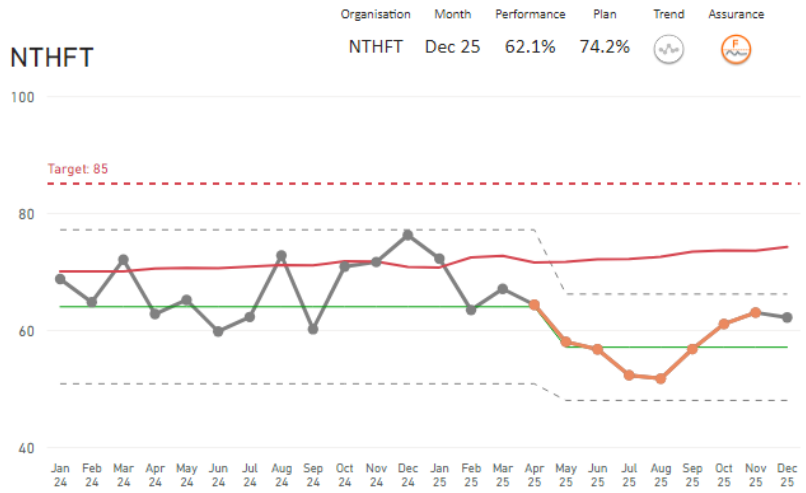
STHFT

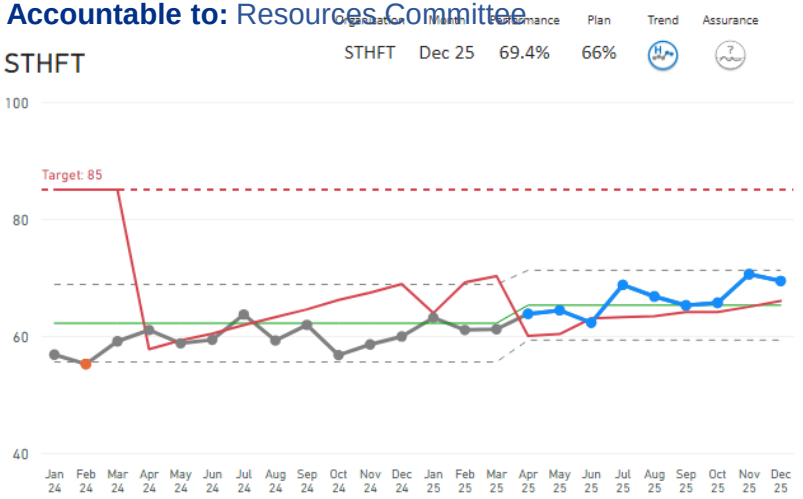
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Dec 25	80.7%	93.1%		



RESPONSIVE Cancer 62 Day Standard (%)

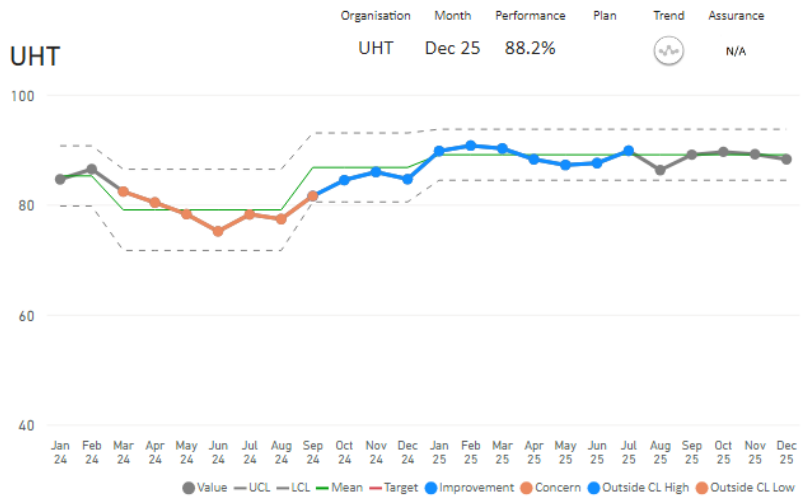


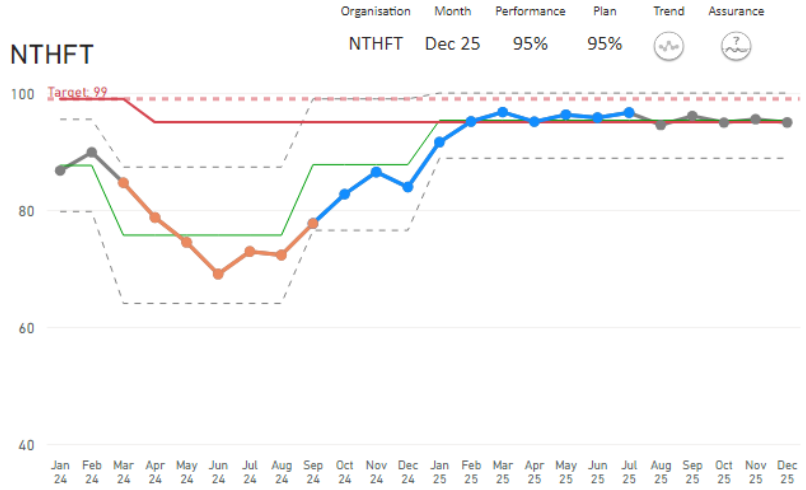




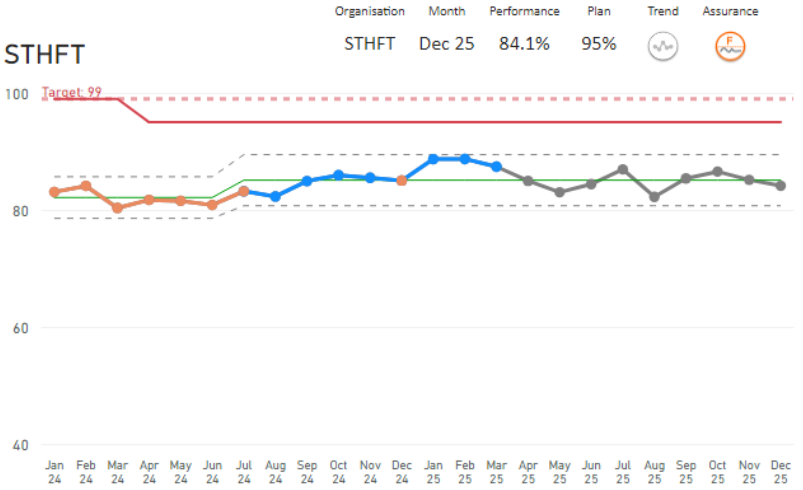
Metric: Percentage of patients on a cancer pathway who start treatment within 62 days of referral.
Plan: NHS Constitution standard 85%. Agreed operational planning trajectories: NTHFT 75%, STHFT 68.3% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Deterioration compared to 24/25 now stabilised. STHFT: Improvement trend evident.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: NTHFT breast pathway demand is challenging to compliance. On going collaboration with CDDFT to support service delivery is taking place. There is wider strategic discussion with the ICB for a longer-term regional response. Both Trusts are in NHSE tiered support for cancer 62-day performance with recovery plans including focus on urology, respiratory and gynaecological pathways. Recent pathway improvements implemented are noted to have improved performance at both Trusts and this focus will continue.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

RESPONSIVE Diagnostic 6 Weeks Standard (%)

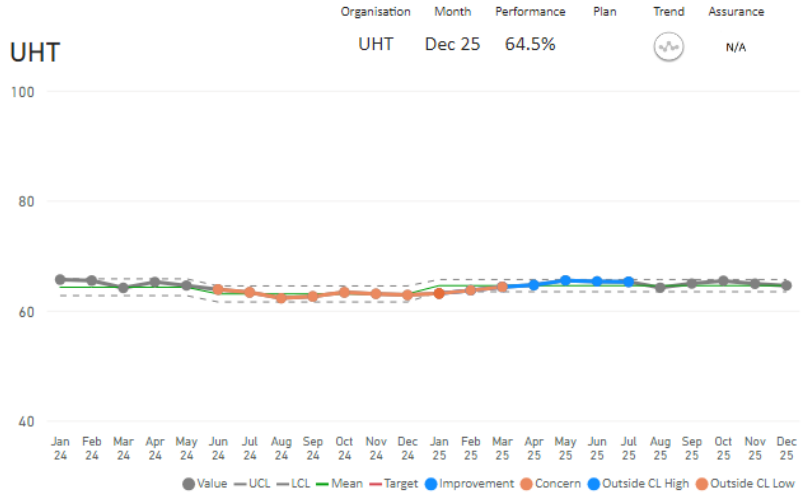


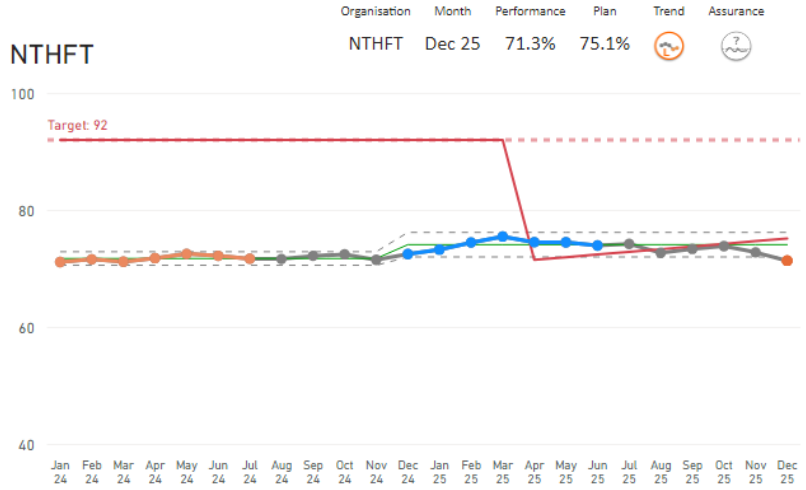


Metric: Percentage of patients waiting for a diagnostic test less than 6 weeks from referral,13 modalities.
Plan: NHSE 24/25 operational standard 95%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Improvement work underway in STHFT specialist services will show only incremental improvement over several months. Recent deterioration in Echocardiography staffing capacity has been addressed. Performance is improving but will take several months to recover.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

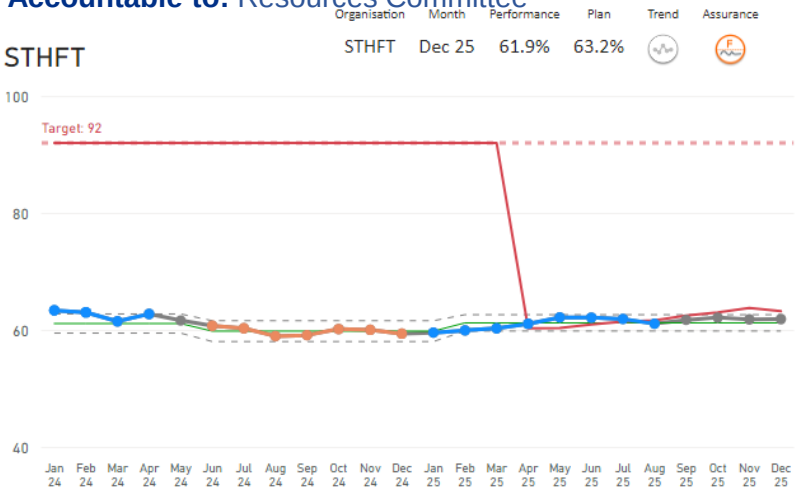


RESPONSIVE RTT Incomplete Pathways (%)

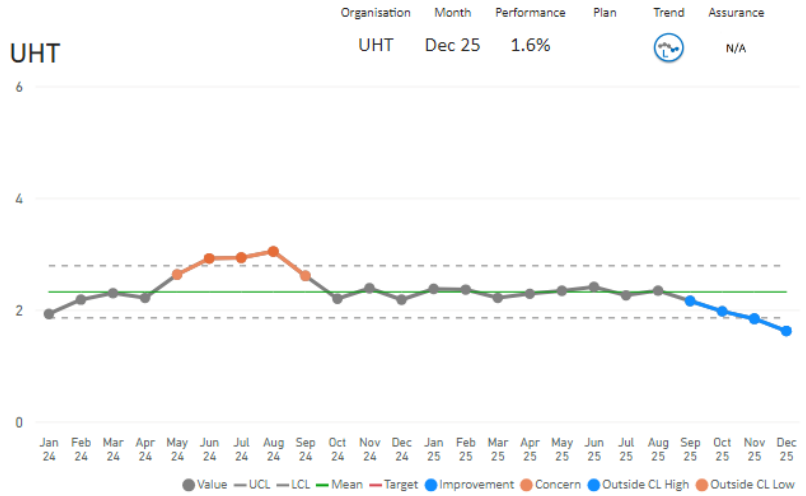




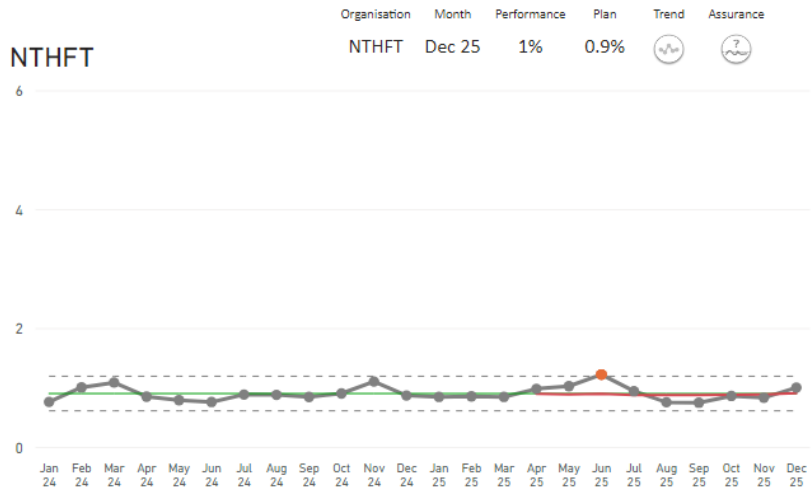
Metric: Percentage of patients awaiting elective treatment who have waited less than 18 weeks from referral.
Plan: NHS Constitution standard 92%. Agreed operational planning trajectories: NTHFT 76.5%, STHFT 65.0% by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: December performance lower than the usual expected variance. STHFT: No trend.
Assurance: NTHFT: Alert. STHFT: Alert, performance not keeping pace with recovery trajectory.
Action taken: Focus is on reducing the longest waiters beyond 52 and 65 weeks which will support compliance improvements. There is a wider strategic focus in reducing long waits through proactive mutual support. STHFT submitted plans for the NHSE Q4 Elective Sprint to further recover the RTT position.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

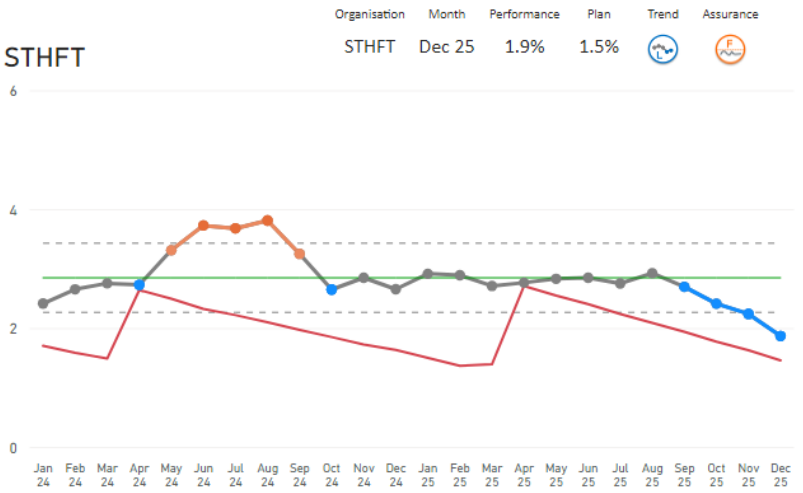


RESPONSIVE RTT 52 Week Waiters Rate

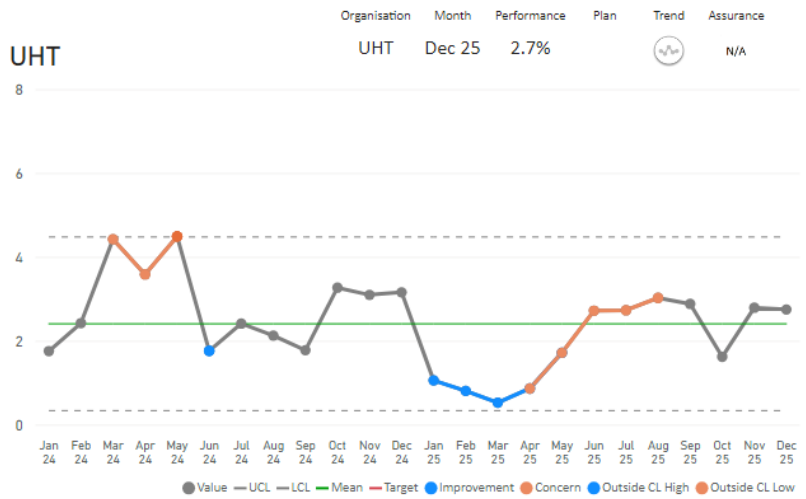


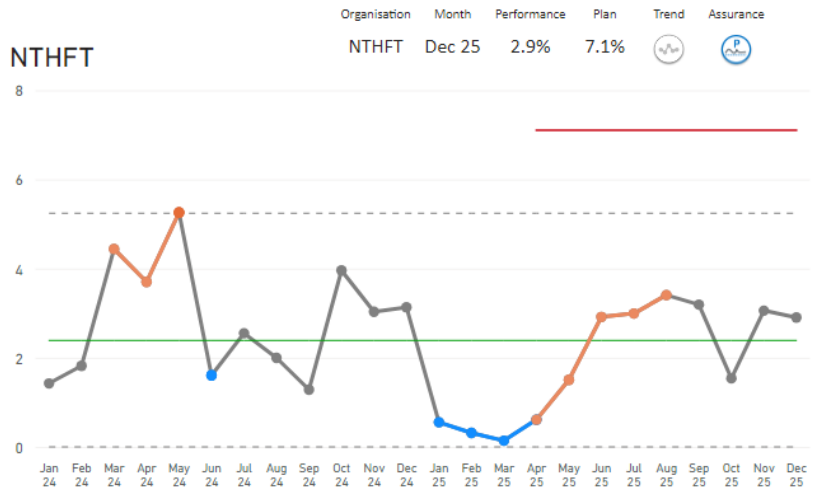
Metric: Rate of patients awaiting elective treatment who have waited more than 52 weeks from referral.
Plan: To reduce the number of 52-week waiters to less than 1% of the waiting list by March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: Improving trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Both Trusts are focused on return to plan. STHFT has been working towards eliminating 65-week waits through refreshed recovery plans which also reduces 52-week waits. Chronic Pain and Urology services at STHFT and NTHFT continue working together to treat the longest waiters.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

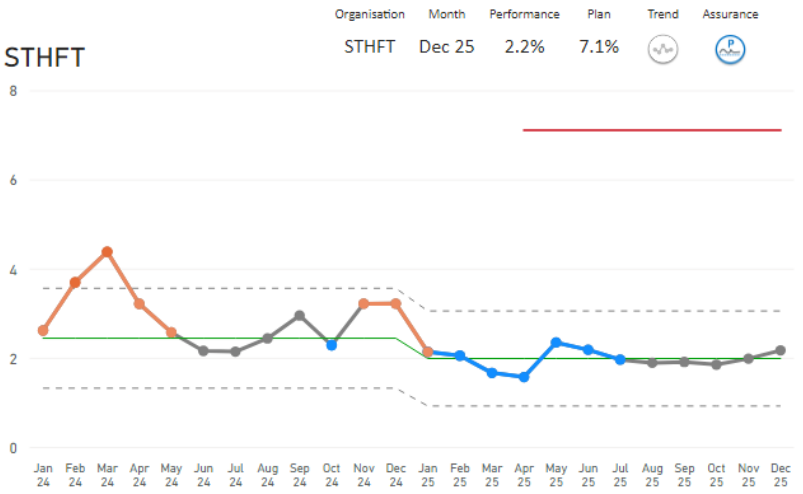




RESPONSIVE Community Over 52 Week Waiters Rate

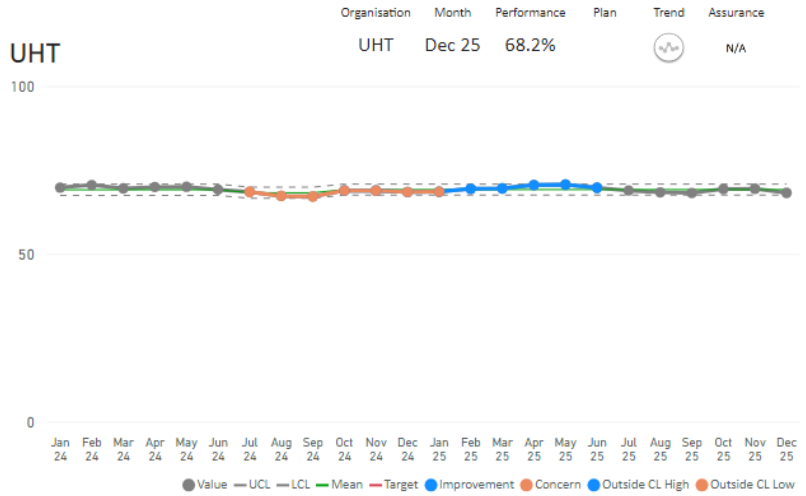


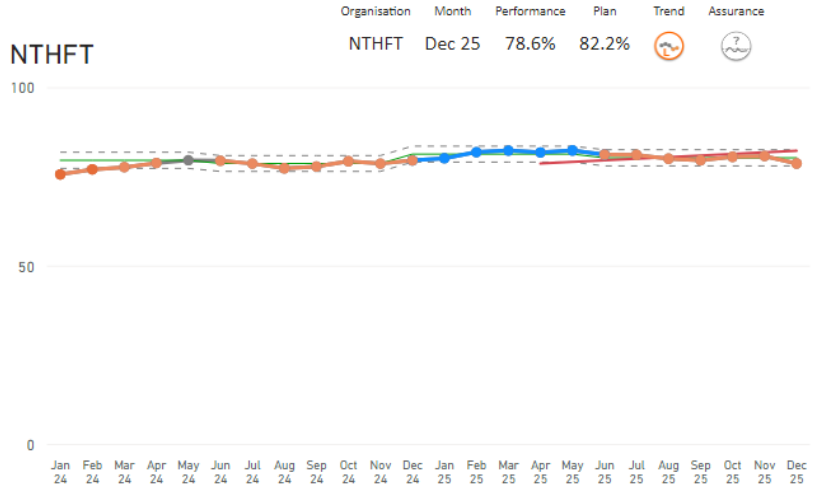


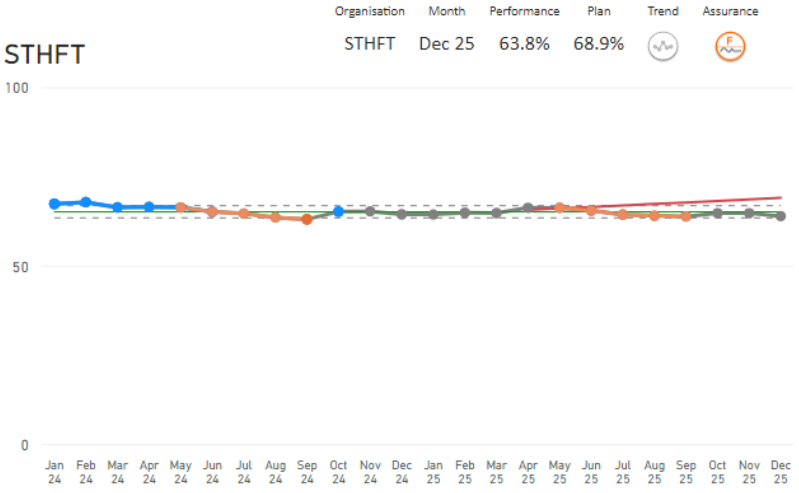


Metric: Rate of community patients awaiting treatment who have waited more than 52 weeks from referral.
Plan: No published standard, local plan to perform significantly better than national mean rate March 2025.
Rationale: NHS Oversight Framework metric.
Data quality: Advisory, variation in reported position. further validation may be required.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Assure. STHFT: Assure.
Action taken: Focused validation of reported position and bringing forward longest waiters, improvement trajectory for next 3 months to return NTHFT position to previous performance. Long delays associated with Paediatric therapy interventions are being addressed.
Executive lead: Chief Delivery Officer
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 83.57%, STHFT 72.3% by end March 2026.
Rationale: 25/26 NHSE planning guidance priority.
Data quality: assured, validated data.
Trend: NTHFT: Declining performance trend. STHFT: No trend.
Assurance: NTHFT: Alert. STHFT: Alert, performance not keeping pace with planned trajectory.
Action taken: Outpatient clinic template reviews and resulting clinic template changes being undertaken across UHT to increase capacity. Revisit *Getting it Right First Time* guidance and benchmarking to identify further improvement priorities. At STHFT, majority of waits for 52 and 65 weeks are for outpatients so ongoing recovery plans are expected to also improve time to first appointment.
Executive lead: Chief Delivery Officer
Accountable to: Resources Committee

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. NTHFT were above plan on four of the five surveys for the month of December and STHFT were above plan for three of the five. The focus is on increasing response rates to FFT to provide more assurance of positive experience of care, supported by digital data collection. STHFT have completed the transition from Meridain to InPhase for the outpatient survey and community surveys. NTHFT will transition from an external service provider (Formfinity) to InPhase.

Consistency in timely responses to complaints remains a key priority. Patient experience teams support and escalate to the clinical and operational teams, those complaints that require their focus on resolving in a timely manner, prioritising the longest in progress. Complaints acknowledged in 3 days remains high at 95-100% across UHT.

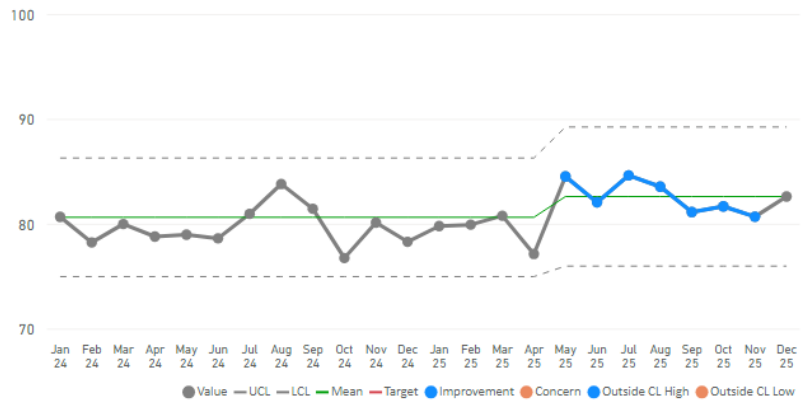
North Tees & Hartlepool NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
A&E Experience (%)	79%	84.3%	85.9%	84.2%	88.2%	87.2%	84.8%	84.9%	85.8%	82.3%	82.3%	79.7%	83%
Inpatient Experience (%)	95%	91.2%	92.4%	91.5%	95%	93.5%	95.4%	92.7%	93.4%	96.1%	95.8%	94.3%	94.4%
Maternity Experience (%)	92%	96.3%	100%	100%	93.3%	94.1%	84.8%	94.3%	96.2%	95%	93.8%	94.8%	95.3%
Outpatient Experience (%)	94%	93.8%	94.4%	93.1%	99.4%	95.5%	94.1%	94.2%	94.4%	94.1%	94.9%	94.7%	95.7%
Community Experience (%)	94%	97.5%	94%	97%	100%	97.7%	96%	94.5%	96%	93.4%	96.8%	96.3%	95.6%
Feedback Acknowledged in 3 Days (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Complaints Closed Within Target (%)	80%	60.9%	73.1%	67%	71%	78.5%	65.9%	62%	73.6%	76.8%	73.5%	80.5%	69%

South Tees Hospitals NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
A&E Experience (%)	79%	78.5%	78.3%	80%	76.9%	84%	80.1%	84.4%	82.3%	80.4%	81.2%	81.4%	82.3%
Inpatient Experience (%)	95%	98.9%	97.8%	98.2%	96.9%	95.1%	97.8%	98.2%	99.3%	99.3%	95.9%	95.6%	95.6%
Maternity Experience (%)	92%	89.6%	94.3%	93.4%	93.3%	93.8%	93.2%	89%	91.2%	91.3%	96.6%	91.5%	89.9%
Outpatient Experience (%)	94%	96.1%	95.8%	95.9%	95.2%	95.9%	96.3%	95.8%	95.7%	96%	95.3%	96.6%	93.8%
Community Experience (%)	94%	97.3%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96.8%	98.2%
Feedback Acknowledged in 3 Days (%)	100%	98.1%	100%	94%	96%	98.3%	99.1%	100%	97.1%	100%	99.2%	95%	98.5%
Complaints Closed Within Target (%)	80%	50%	59.2%	51.1%	69%	71.4%	48.3%	40%	31.6%	21.7%	33.3%	15.8%	21.2%

CARING A&E Experience (%)

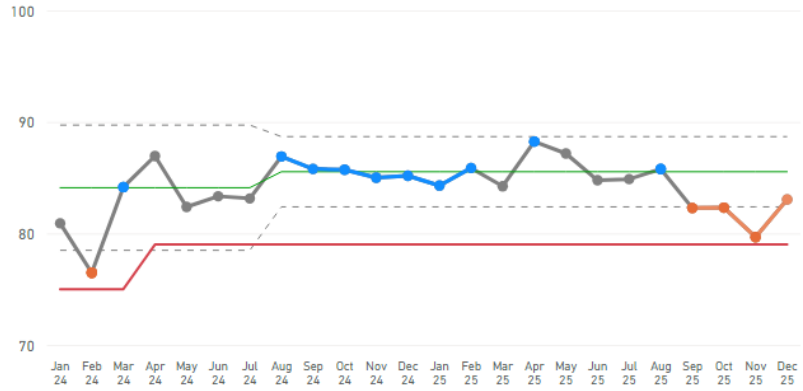
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Dec 25	82.6%			N/A



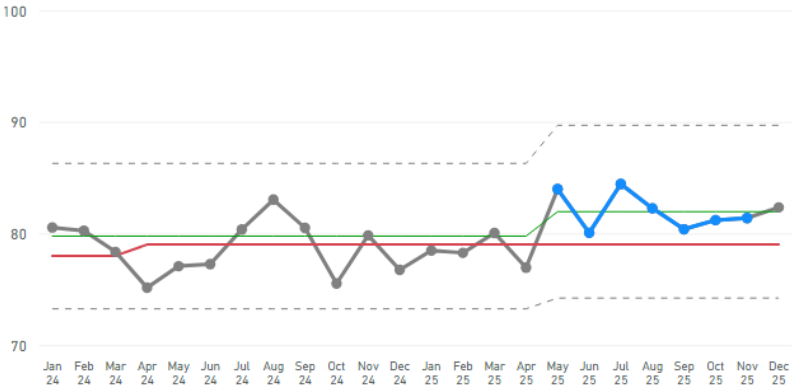
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Dec 25	83%	79%		



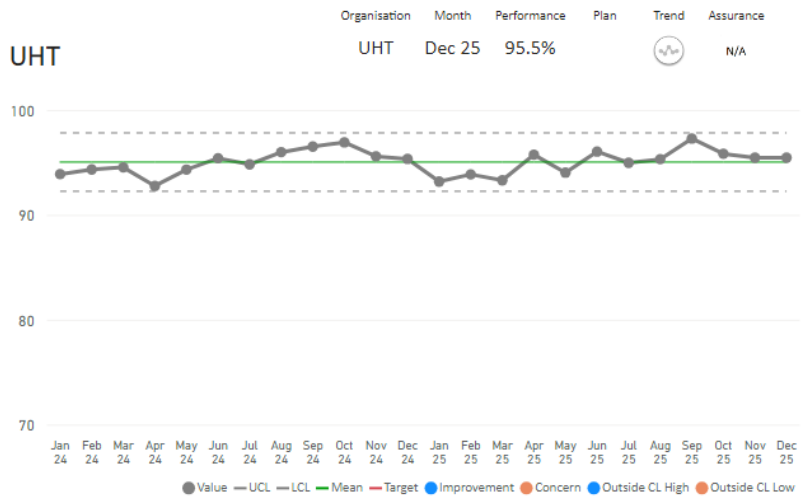
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Dec 25	82.3%	79%		

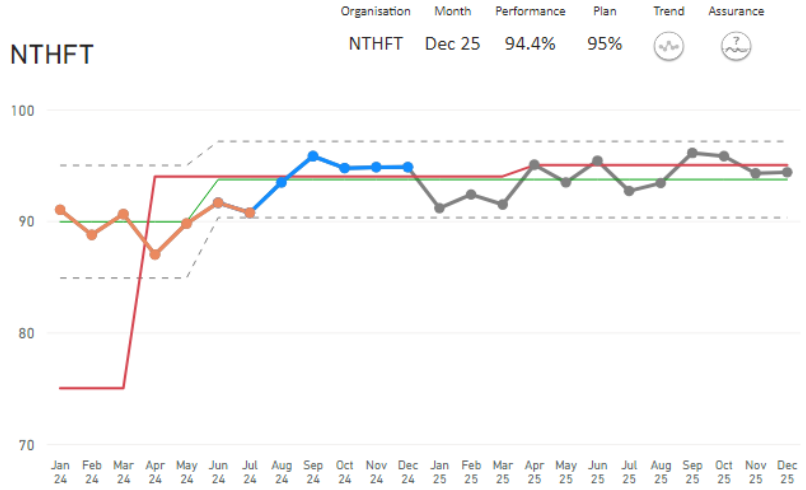


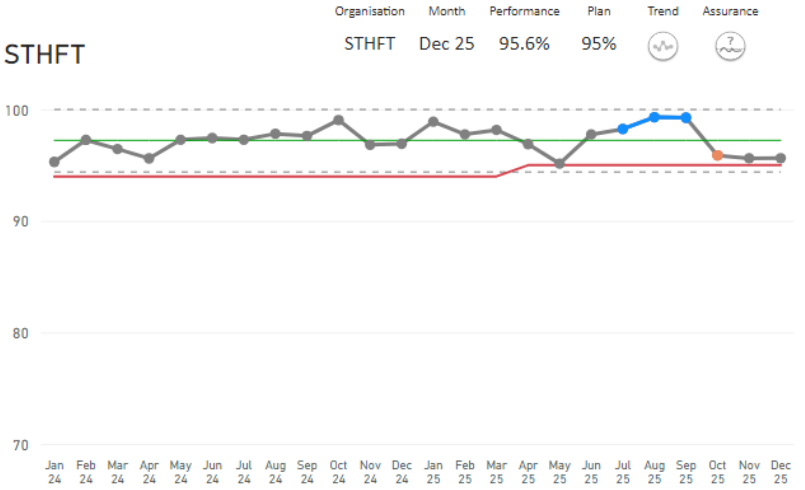
Metric: Percentage of respondents who attended A&E rating their experience good or very good in NHS Friends & Family test.
Plan: Local plan set on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured (manual and digital systems).
Response rates: NTHFT 4.5%, STHFT 8%.
Trend: NTHFT: Performance close to or below expected variance limits since September 2025. STHFT: Improved performance since May 2025.
Assurance: NTHFT: Advise, consistently exceeds national average but performance close to or below expected variance limits since September 2025. STHFT: Advise.
Action taken: Waiting times continues to be the main theme noted in the survey comments. Maintaining ED wait times through actions in the Winter Plan will help address patient experience.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Inpatient Experience (%)

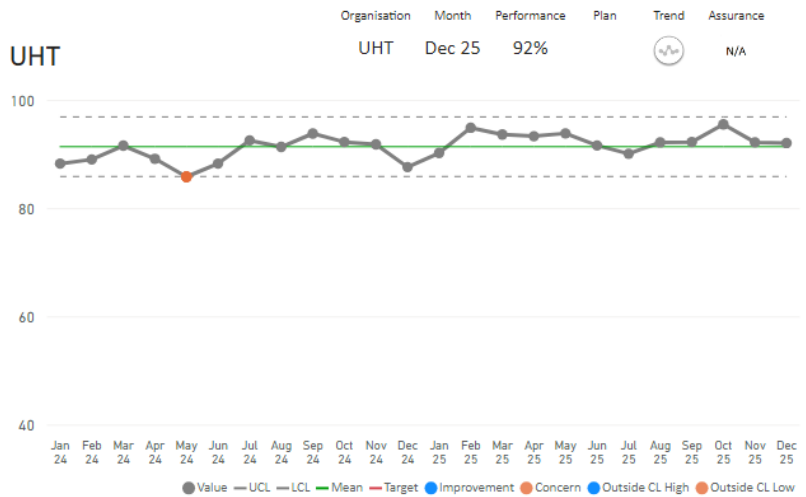


Metric: Percentage of respondents rating their inpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 11%, STHFT 23%.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: STHFT transition from Meridian to InPhase is complete, NTHFT transitioning from external service provider to InPhase. This will standardise patient feedback collection processes and analysis across UHT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

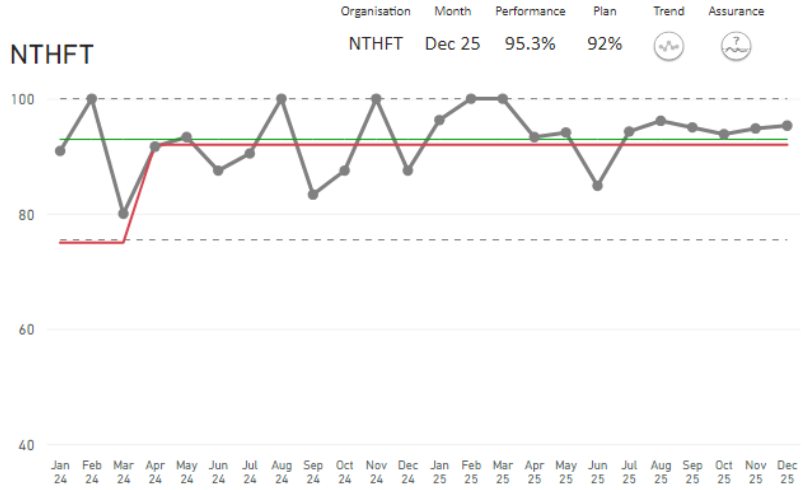


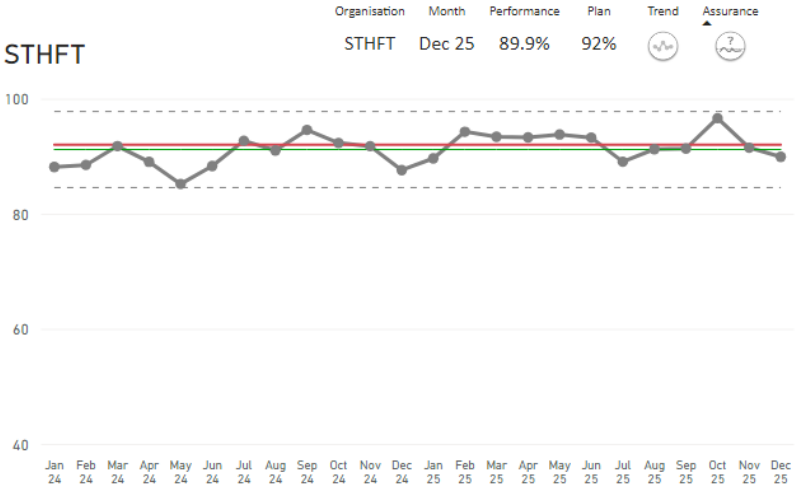


CARING Maternity Experience (%)

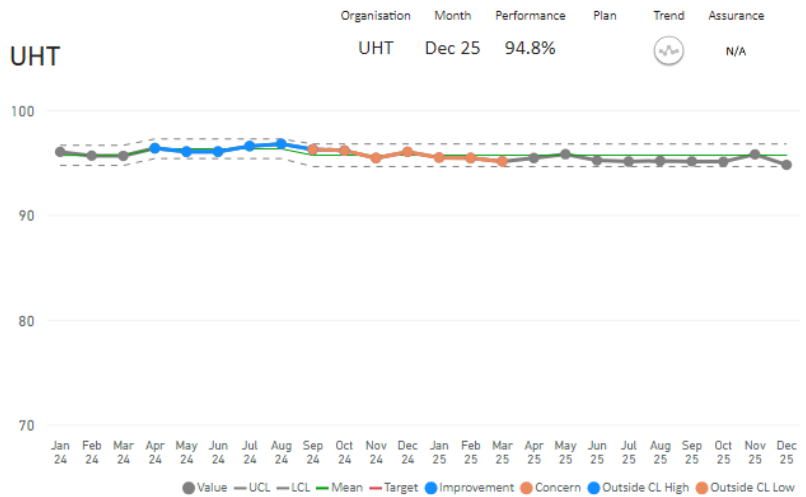


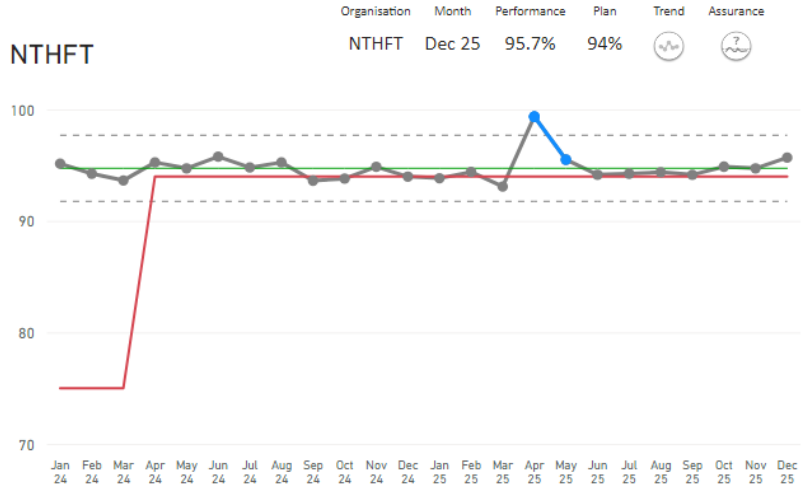
Metric: Percentage of respondents rating their maternity experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates and sample sizes can be low, reported figure is Birth only.
Response rates: NTHFT 26.5%, STHFT 16%.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Continue to promote engagement with Friends and Family Test. STHFT has transitioned from Meridian to InPhase. NTHFT: plan to transition to InPhase
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

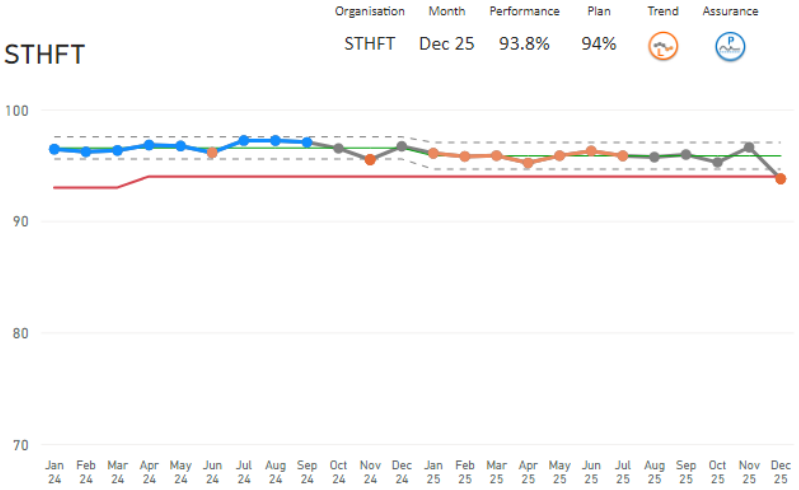




CARING Outpatient Experience (%)

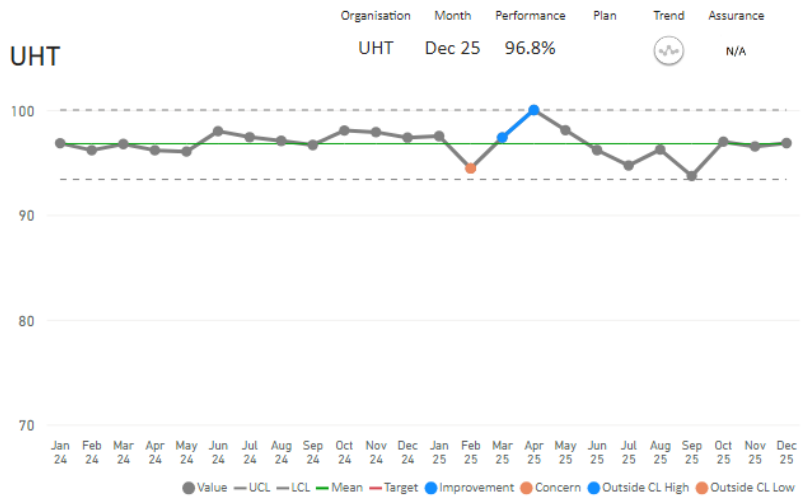


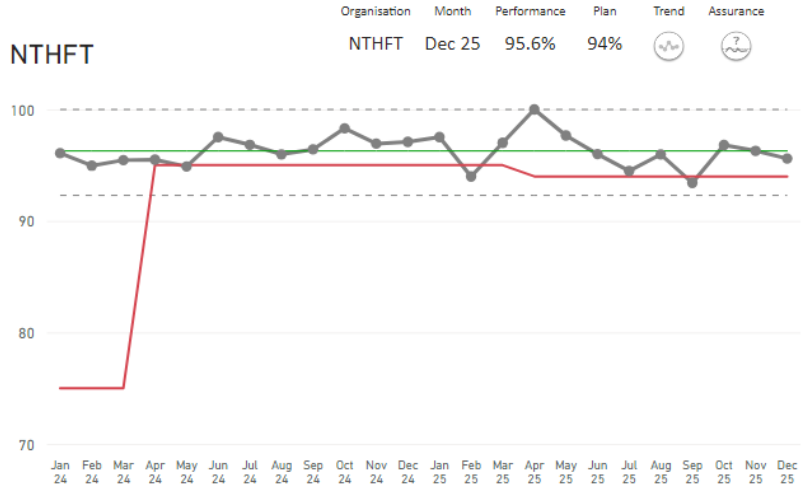


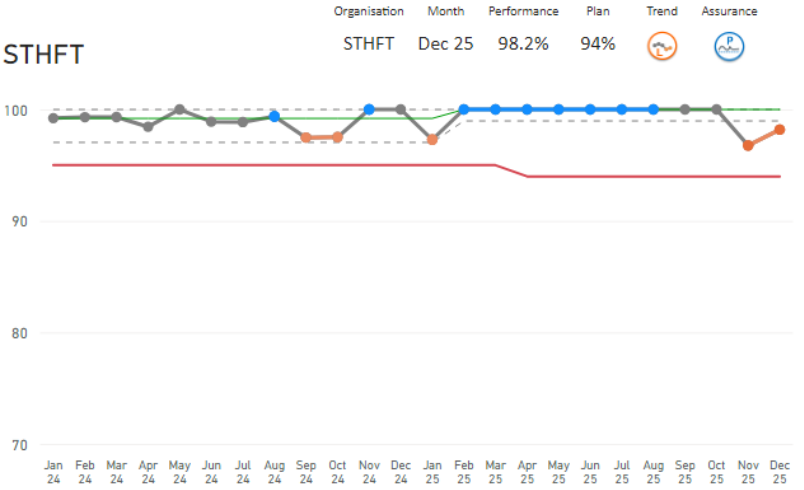


Metric: Percentage of respondents rating their outpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 18%, STHFT 15%.
Trend: NTHFT: No trend. STHFT: Low outlier in December 2025.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT transitioned to a new digital platform in June 2025 and response rates have improved. STHFT: transitioning from Meridian to InPhase, patients will receive a text messages post appointment.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Community Experience (%)

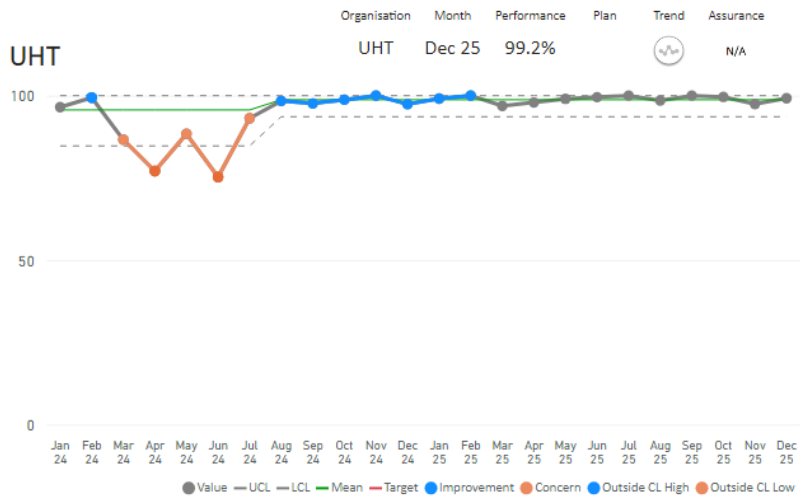




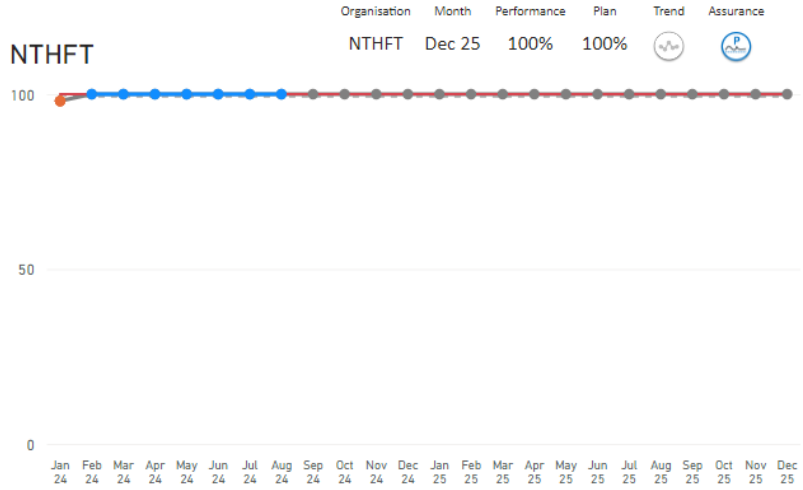


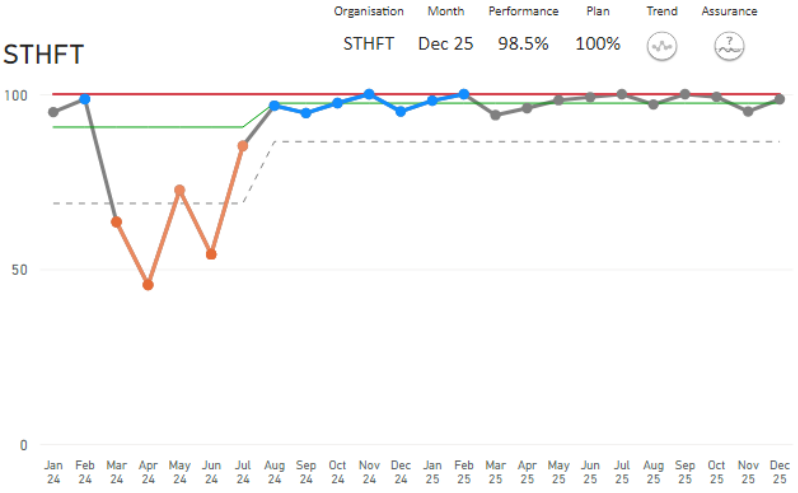
Metric: Percentage of respondents rating their community services experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 24/25.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 6%, STHFT 4%.
Trend: NTHFT: No trend. STHFT: Stable 100% positive feedback since February 2025 until October. Lower performance in November and December but still consistently meets target.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: Further work is required at NTHFT and STHFT to improve response rates in community services, a staged approach from Meridian to InPhase has been completed.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Feedback Acknowledged in 3 Days (%)

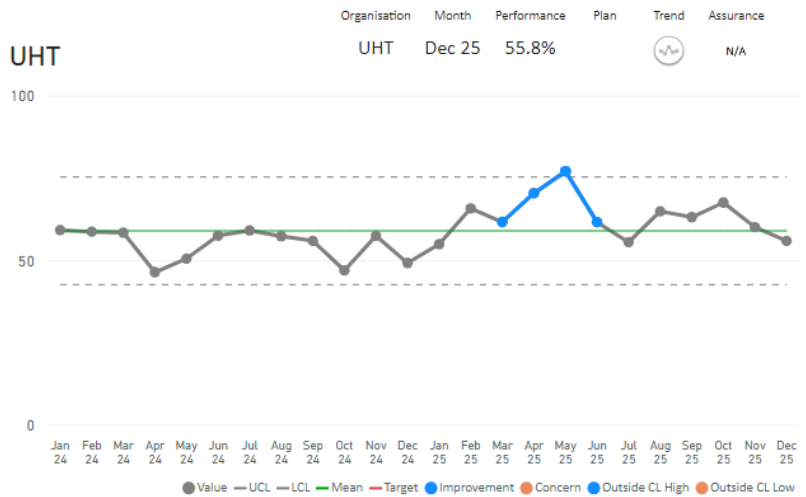


Metric: Percentage of complaints acknowledged in 3 days.
Plan: 100%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend. STHFT: No trend.
Assurance: NTHFT: Assure. STHFT: Advise.
Action taken: STHFT: mapping process is underway to align NT & ST process to ensure the 3 working day target is met. This is not yet statistically assured due to lower compliance March to August 2024.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

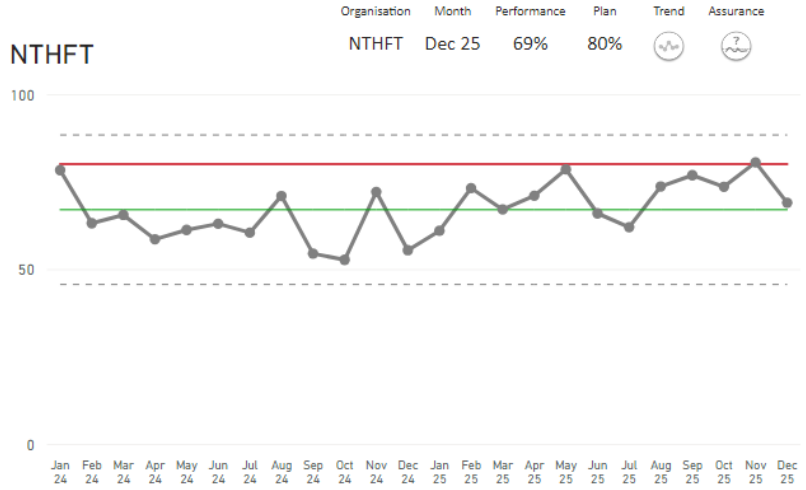


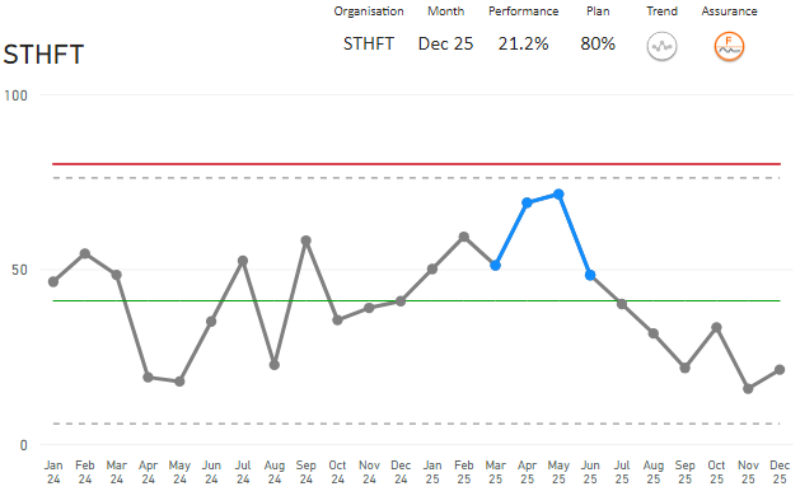


CARING Complaints Closed Within Target (%)



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.
Assurance: NTHFT: Advise. STHFT: Alert, plan is not statistically within usual range of performance.
Action taken: NTHFT: InPhase reporting functionality to be improved to allow increased performance monitoring within Clinical Service Units (CSUs). STHFT: Additional senior staff support allocated to review off-target complaint responses. Targets to be agreed with each CSU.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee





WELL LED DOMAIN SUMMARY

Executive leads: Rachael Metcalf, Chief People Officer
Chris Hand, Chief Finance Officer

Accountable to: People Committee
Resources Committee

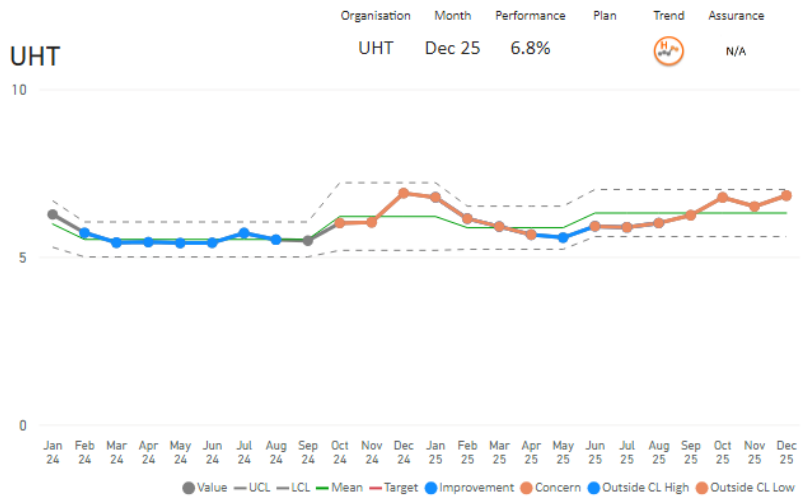
On track to implement 5 UHT People policies by end March 2026 with next 5 identified. Review of people policies has reduced number from 48 to 18, focussing on statutory policies supported by SOPs/management guidance. National planning submission has identified need to reduce significant WTE over next 3 years, and workforce team developing enhanced strategy to reduce absence in support of WTE reduction, which will also impact on bank and agency spend. The first CSU People Week took place at the end of January 2026. People Plans are being developed for each of the CSUs with metrics to support their individual people requirements and challenges.

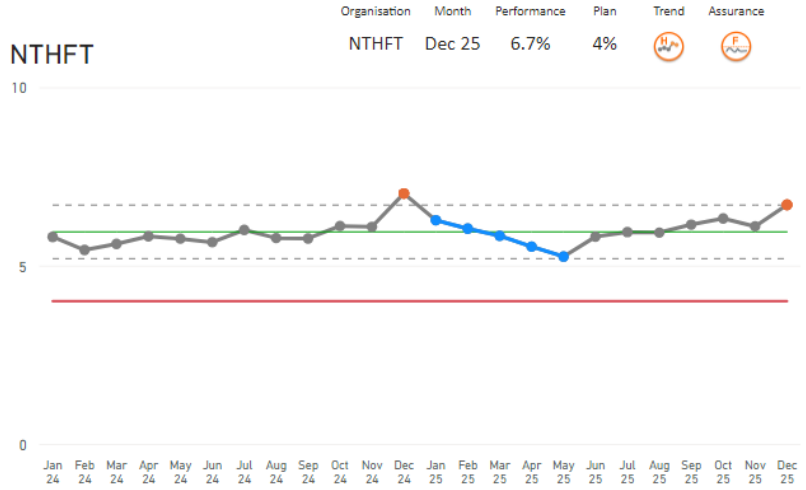
The Board is advised that financial position shows a small positive variance to plan at the end of Month 9 (December) for NTHFT and on plan for STHFT. Financial controls are in place, with a focus on recurrent efficiency delivery, and Resources Committee oversight of financial risks.

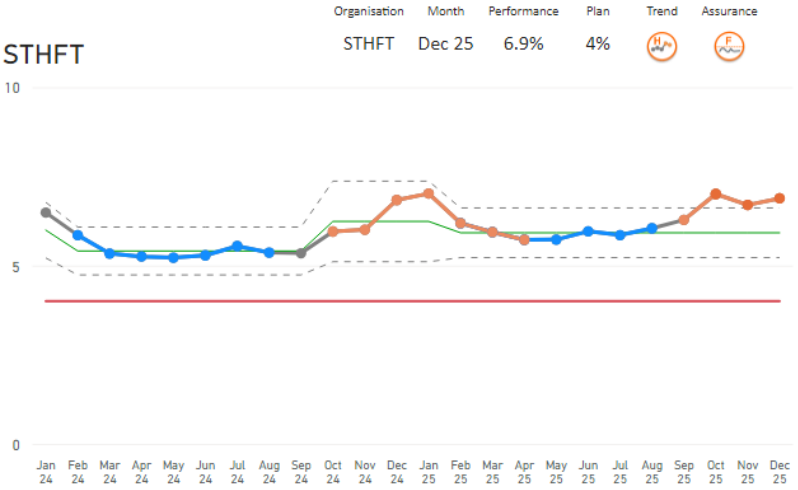
North Tees & Hartlepool NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Sickness Absence (%)	4%	6.3%	6%	5.8%	5.5%	5.3%	5.8%	5.9%	5.9%	6.1%	6.3%	6.1%	6.7%
Staff Turnover (%)	10%	7.1%	7%	7.2%	7.5%	7.6%	7.4%	7.4%	7.6%	7.5%	7.6%	7.7%	7.6%
Annual Appraisal (%)	85%	87.2%	86.6%	85.9%	86.3%	88.5%	88.5%	88.6%	87.9%	88.1%	87.9%	87.5%	86.5%
Mandatory Training (%)	90%	88.9%	88.1%	88.9%	88.7%	88.9%	89.4%	89.8%	90.2%	90%	89.5%	89.1%	89.5%
Cumulative YTD Financial Position (£'millions)	£0.584	-£0.994	-£0.473	£0.002	£0.117	£0.28	£0.644	£0.416	£0.833	£0.85	£0.693	£0.389	£0.601

South Tees NHS FT	Plan	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Sickness Absence (%)	4%	7%	6.2%	5.9%	5.7%	5.7%	6%	5.9%	6%	6.3%	7%	6.7%	6.9%
Staff Turnover (%)	10%	6.6%	6.5%	6.6%	6.7%	6.6%	6.5%	6.5%	6.8%	6.7%	6%	6.8%	6.8%
Annual Appraisal (%)	85%	78.8%	80.2%	82.2%	82%	83.1%	84%	83.1%	83.5%	83.3%	82.9%	81.6%	81.1%
Mandatory Training (%)	90%	86.8%	86.7%	85.6%	85.6%	85.7%	85.7%	86.2%	85.9%	84.7%	84.8%	84.7%	84.6%
Cumulative YTD Financial Position (£'millions)	-£9.293	-£7.583	-£7.489	-£7.796	-£2.065	-£3.467	-£7.009	-£4.503	-£5.725	-£6.232	-£6.813	-£7.596	-£9.293

WELL LED Sickness Absence (%)

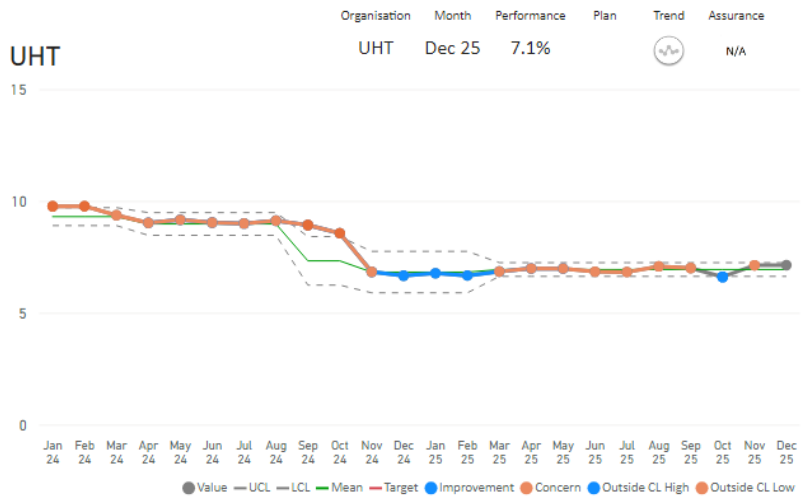




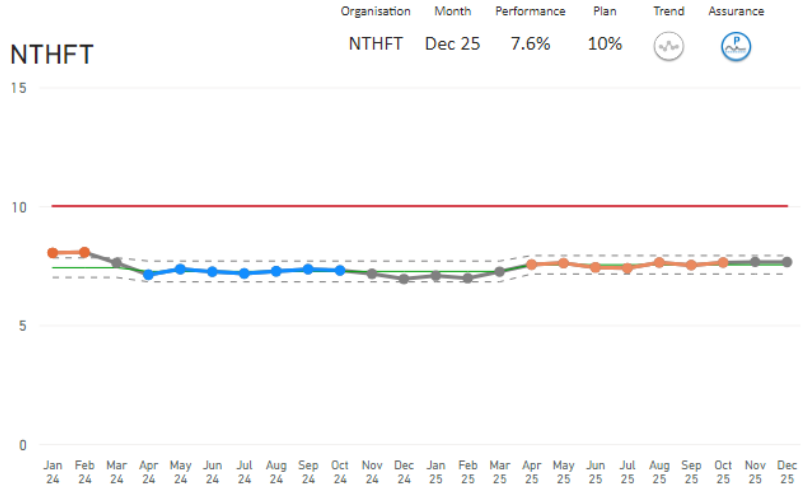


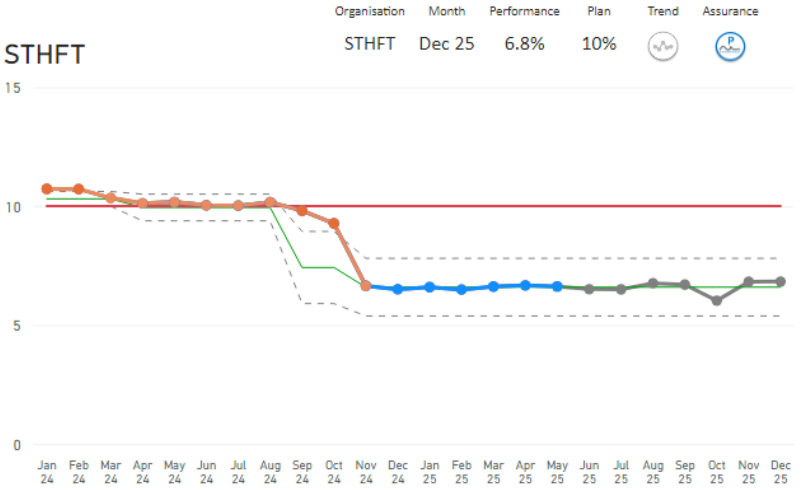
Metric: Percentage of staff working hours lost to sickness absence (all types) in each month.
Plan: Trust internal plans: 4%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: High outlier in December 2025. STHFT: Marked deterioration in last 3 months to December 2025.
Assurance: NTHFT: Alert. STHFT: Alert.
Action taken: Health and wellbeing messages to be sent to staff absent with MSK and Stress/Anxiety to signpost early intervention to OH services. Absence reduction action plan and trajectory being developed for UHT and CSU/Corporate areas. Target 1% reduction by March 2027.
Executive lead: Chief People Officer
Accountable to: People Committee

WELL LED Staff Turnover (%)

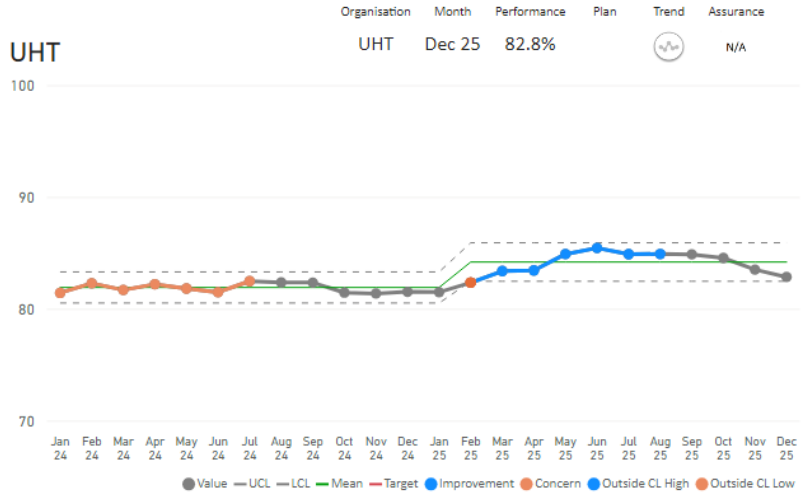


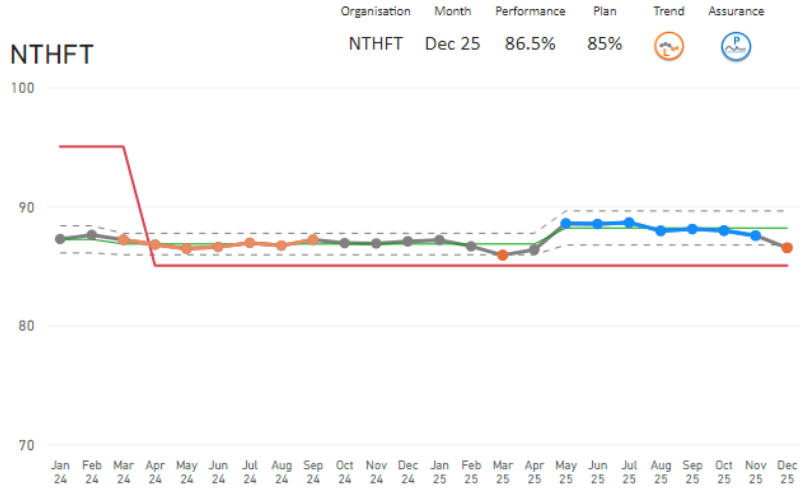
Metric: Percentage of staff changing or leaving job roles in the month (all staff groups, all changes).
Plan: Trust internal plans: 10%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data. Alignment of the metric criteria has improved STHFT reported performance from November 2024.
Trend: NTHFT: No Trend. STHFT: No trend.
Assurance: NTHFT: Assure. STHFT: Assure.
Action taken: A review of exit interview process is now complete and will feed into the overall development of culture and learning. Overall turnover is consistently low in both Trusts with none of the eight staffing groups being outliers.
Executive lead: Chief People Officer
Accountable to: People Committee

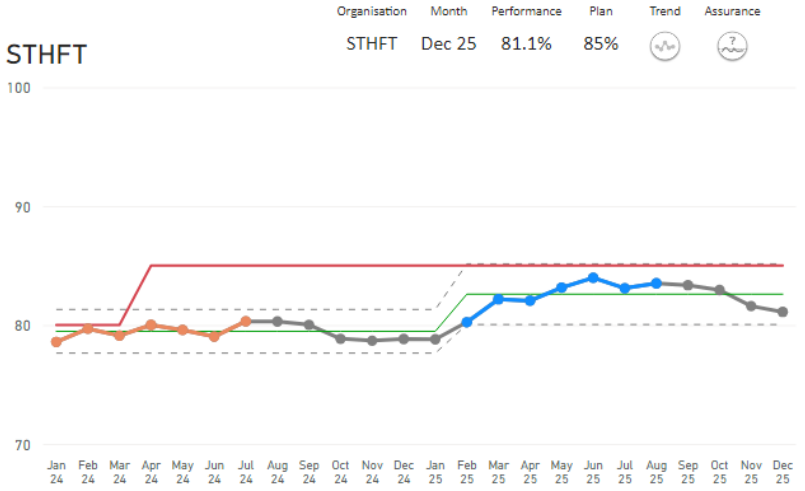




WELL LED Annual Appraisal (%)

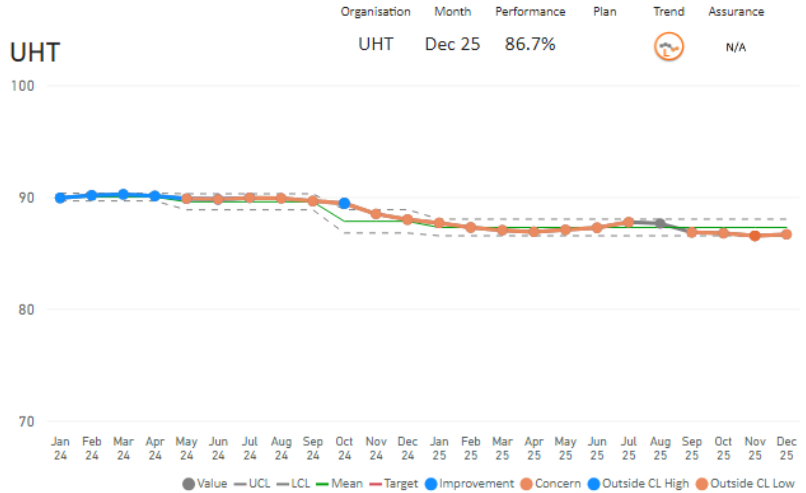




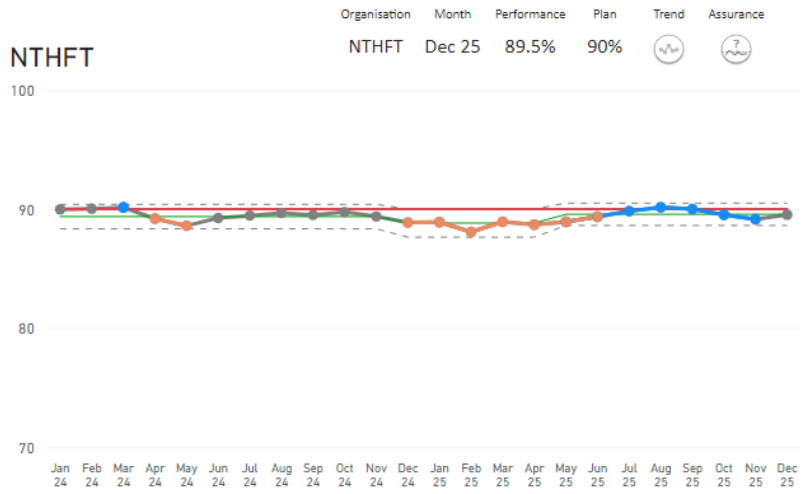


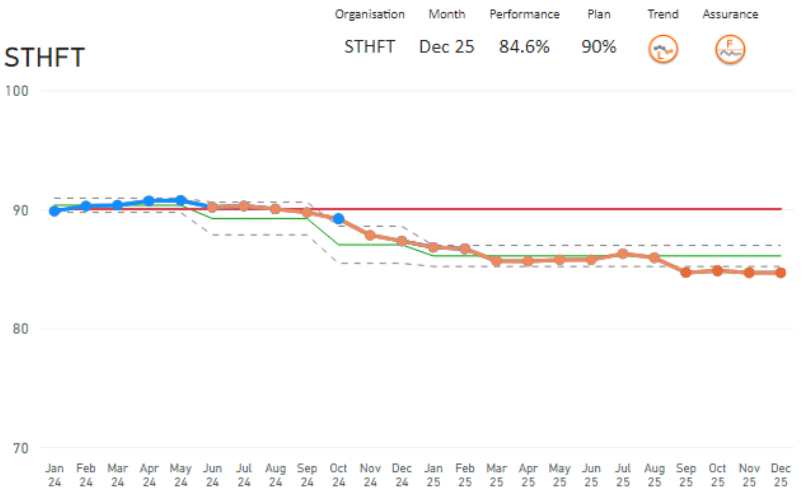
Metric: Percentage of staff with annual appraisal completed in last 12 months, at month end.
Plan: Trust internal plans: 85%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Improved between May and November 2025 but a lower December compliance flags as an low outlier. STHFT: No trend.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: A reduction in appraisal completion has identified the need to undertake further data analysis to provide support to those areas that are falling below threshold. Exploring alternatives ways to complete appraisals i.e. group appraisals for support workers
Executive lead: Chief People Officer
Accountable to: People Committee

WELL LED Mandatory Training (%)

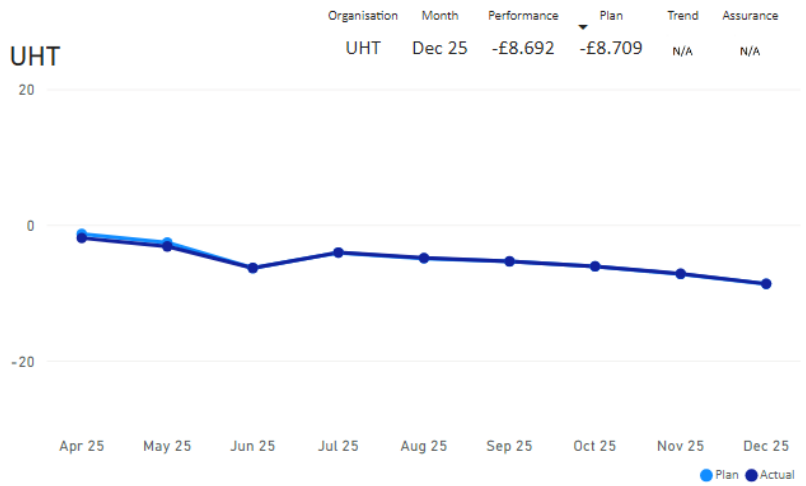


Metric: Percentage of mandatory training elements within date, across all staff groups at month end.
Plan: Trust internal plans: 90%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Improvement trend from June 2025 has now stabilised. STHFT: Deteriorating trend, with performance from September close to lower limits of expected variation.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Standardised reporting across UHT via new UHT dashboard developed and now aligned to CSUs. Mandatory Learning Oversight Group overseeing alignment to national core framework. Check, challenge and support via People Group. Supporting national reform work with new policy close to ratification.
Executive lead: Chief People Officer
Accountable to: People Committee

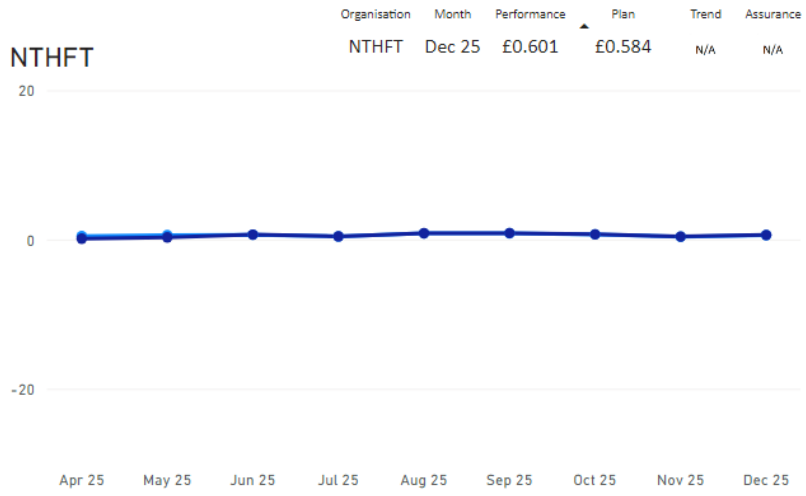


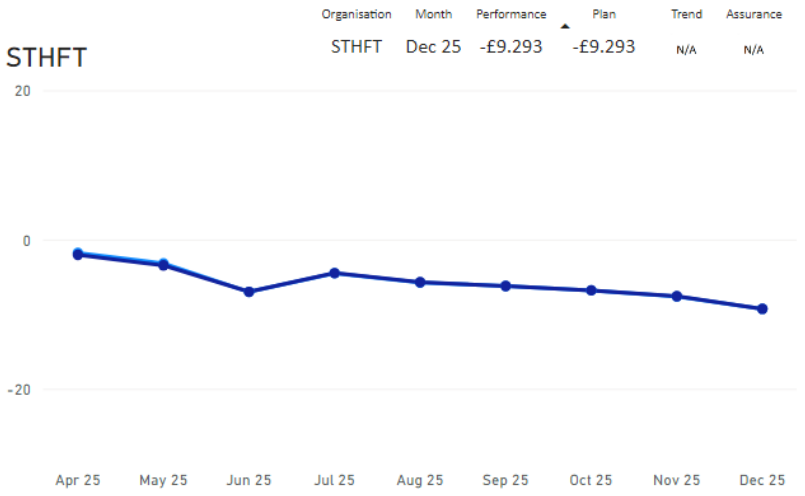


WELL LED Cumulative YTD Financial Position (£'millions)



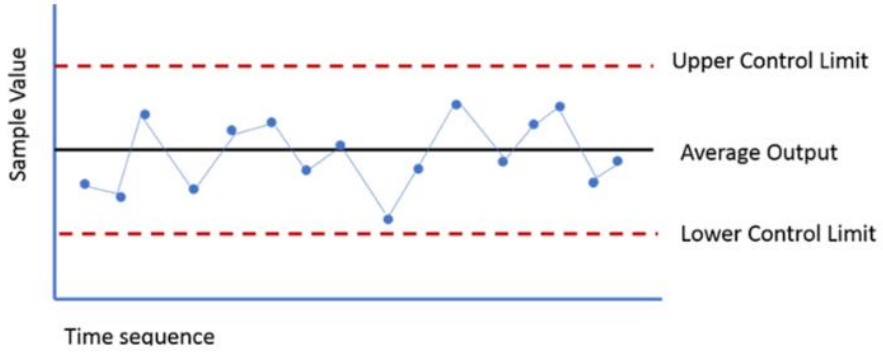
Metric: Cumulative year to date financial position.
Plan: Trust plans agreed with ICB. NTHFT submitted a breakeven plan for 2025/26. The STHFT control total for 2025/26 is a £9.1m deficit.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: Financial position tracks plans.
Assurance: Advise: At month 9, NTHFT reported a small positive variance to plan and STHFT is on plan.
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





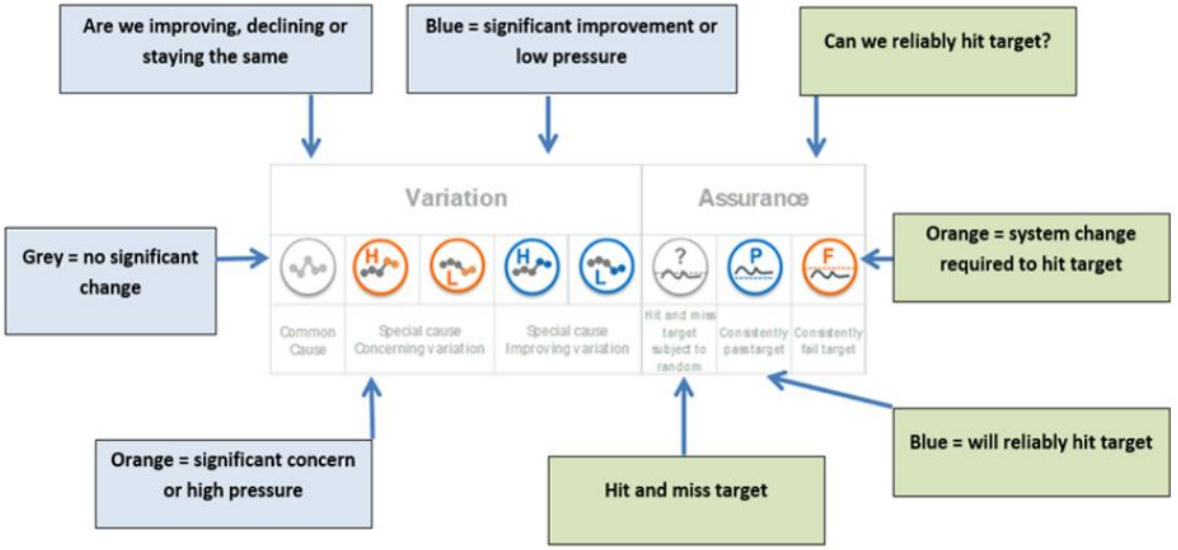
OVERVIEW SPC CHARTS

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



Caring Better Together

Thank you

University Hospitals Tees

2025 EPRR annual report and core standards assessment

Meeting date: *5 March 2026*

Reporting to: *Board of Directors*

Agenda item No: 4.4

Report author: *Diane Hurley, Head of EPRR*

Executive director sponsor: *Neil Atkinson, Chief Delivery Officer / Accountable Emergency Officer (AEO) for EPRR*

Action required:
Approval

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

Previously presented to: *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:

Choose an item.

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.

All NHS Trusts are required to present the public Board with an annual update regarding emergency preparedness, resilience and response (EPRR) activities together with a statement of compliance with the annual EPRR core standards self-assessment.

The outcome of the EPRR core standards assessment is that both Trusts are declaring **partial compliance** for 2025/26. A programme of work will be implemented throughout 2026 to address the gaps identified by the assessment and to align response arrangements across University Hospitals Tees. However, these assessments do not impact on the ability of either of the Trusts to respond to incidents and is similar to the majority of Trusts across the North East and North Cumbria ICB area.

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:

The Board is asked to receive this report as assurance that NTHFT and STHFT comply with the statutory requirements for EPRR and note the statements of **partial compliance** made by both Trusts to the North East and North Cumbria ICB and NHS England in respect of the 2025/26 EPRR core standards.

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-2026

STATEMENT OF COMPLIANCE

South Tees Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v2.4

Where areas require further action, South Tees Hospitals NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of **Partial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Neil Atkinson

Date signed: 12th November 2025

25th February 2026 Date of Board/governing body meeting	05/03/2026 Date presented at Public Board	_____ Date published in organisations Annual Report

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-2026

STATEMENT OF COMPLIANCE

North Tees and Hartlepool NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v2.4

Where areas require further action, North Tees and Hartlepool NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of **Partial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Chief Operating Officer

30th October 2025
Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

NHS
University Hospitals Tees

Audit & Risk Committee: South Tees

29 January 2026

Connecting to: Unitary Board

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.

The decision log was reviewed. Three items to return to statutory boards for ratification to ensure compliance.

Council of Governors decision log requested.

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 - 24/5 Audit process complete. Planning for 25/6 commencing, no significant changes in requirements anticipated.

Internal audit - Audit on cash management completed. Medium risk.

Progress on completing outstanding actions was made.

Counter fraud risks need to be moved to our risk register, following a change in requirements. It is anticipated that this can be completed by 31st March.

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.

The Board Assurance Framework and its associated systems were reviewed.

Recommendations:

The Board are asked to note the update.

University Hospitals Tees

Annual Filings – STHFT

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 5.2

Report author: Jackie White, Director of Corporate Affairs & Company Secretary

Executive director sponsor: Jackie White, Director of Corporate Affairs

Action required: Approval

Delegation status: Matter reserved to Unitary 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:

Choose an item.

Board assurance framework references this paper relates to:

Add in BAF reference.

Key discussion points and matters to be escalated from the meeting

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

None.

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

None.

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 timetable for submission of the annual filings has been released by NHS England (NHSE). This includes a final submission date for the Trusts signed and audited Annual Report and Accounts of 26 June 2026. NHSE and the Department of Health and Social Care (DHSC) have also issued draft guidance for providers, as outlined in the Group Accounting Manual (GAM).

The Trusts external auditors, Mazars, will continue to undertake the majority of the audit in line with how the audit was performed for 2024-25. A number of amendments have been made to the Trusts Accounting Policies following the release of the GAM and these are outlined in the report.

Recommendations:

The Board of Directors are asked for delegated authority to the Audit & Risk Committee and Quality Assurance Committee for ongoing monitoring and approval of the annual filings on behalf of the Board.

Annual Filings – STHFT

1. PURPOSE OF REPORT

The purpose of the report is to update members of the Trust Board on the preparation of the annual filings for 2025-26:

- Quality Report (Account)
- Annual Accounts
- Annual Report
- Annual Governance Statement

- To provide an update on the submission of the Annual Report and financial statements and provide an update on amendments to the Trusts Annual Report and Accounting Policies for 2025-26.

- and to ask for delegated authority to the Audit & Risk Committee and Quality Assurance Committee for ongoing monitoring and approval of the annual filings on behalf of the Board.

2. RECOMMENDATIONS

The Trust Board of Directors are asked to approve the delegation to the Audit & Risk Committee and Quality Assurance Committee for the ongoing monitoring and approval of the annual filings on behalf of the Board of Directors.

3. BACKGROUND

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

The timetable for submission of the Annual Report and financial statements has been released by NHSE. This includes a final submission date for the Trusts signed and audited Annual Report and Accounts of 26 June 2026. The DHSC have issued guidance for providers, as outlined in the Group Accounting Manual (GAM), however NHSE guidance is still outstanding.

4. DETAIL

4.1 Annual report

Changes to the requirements for 2025-26 are set out below.

New and changed requirements

Task force on climate-related financial disclosures (TCFD) - 2025/26 is the final year of the three year implementation of TCFD. From 2025/26 entities should disclose how the

organisation's operations, strategy and financial planning are affected by actual and potential climate-related risks and opportunities.

NHS Oversight Framework 2025/26 - The NHS Oversight Framework has been updated in 2025/26. The disclosure requirements in annual reports have not changed but the example disclosure has been updated to reflect changes to the oversight framework.

Very Senior Manager (VSM) pay framework - The new very senior manager pay framework applies from 2025/26. The remuneration report must include a statement of compliance with the VSM pay framework and confirm approvals for pay cases where required. Any departures from the framework should be disclosed.

Minor changes and clarifications

Accounting officer signature - Further guidance on signatures of the accounting officer within the annual report and accounts has been added. There is no change to the requirements.

Fees and charges guidance - Updated guidance on how to measure the 'full' cost of a service for the purposes of fees and charges as provided in Managing Public Money (MPM) has been referenced in the relevant footnote of the FT ARM.

Fair pay guidance - HM Treasury has clarified that non-executive directors are outside the scope of the fair pay disclosures. This has been updated within the fair pay disclosure requirements.

Exit packages approval - DHSC now has delegated authority to approve non-contractual exit packages up to £300,000 that are not novel, contentious or repercussive. Previously all non-contractual exit packages required HM Treasury approval. The template disclosure has been updated. There is no change to the requirement for NHS foundation trusts to seek approval (via england.vsmcases@nhs.net) before committing to any payment.

Certificate on summarisation schedules - Minor updates have been made to the example certificate on the summarisation schedules (often referred to as 'TAC consistency statement') to improve accuracy and clarity. There are no changes to the principles or requirements for consistency. Separate reference to NHS England's template provider accounting policies has been deleted because these are consistent with the GAM.

3.2 Timetable

Accounts and Annual Report Timetable

The following table provides a summary of the key submission dates as circulated as part of year end guidance by NHSE for the 2025/26 final accounts process:

Detail	Submission Date
Submission of Month 12 PFR (including unaudited TACs and draft Accounts)	27 April
Submission of Month 12 PFR form (including audited TACs) and audited Accounts to NHSE. To include Accounts, Annual Report, Auditors ISA 260 Report, Audit Report and Opinion and Auditors report on summarisation schedules (TAC schedules)	26 June
Submission of full Annual Report including full statutory Accounts in one document to NHSE.	TBC
Trust to lay Annual report and Accounts before Parliament.	TBC

Accounting Policies

As part of the circulation of year end guidance, the DHSC Group Accounting Manual (GAM), published updated in January 2026, includes updated guidance to be used by NHS Providers. The Trust has reviewed the year end guidance currently available
and the changes to the Trust's Accounting Policies for 2025/26 are outlined as follows:

- Provisions - updated for changes to discount rates per the DHSC GAM. The discount rate on post-employment benefits provisions applicable at 31 March 2026 is 2.95% (the 2024/25 rate was 2.40%). This rate is applicable for all provisions for continuing obligations arising from previous employment service.

- Compensation Recovery Unit (CRU) - When estimating lifetime expected credit losses in relation to Injury Cost Recovery receivables, the GAM has revised the credit loss allowance to reflect income that is not expected to be recoverable. The CRU advises on the percentage probability of not receiving the income and the figure for 2025/26 is 24.62% (the 2024/25 figure was 24.45%).

- Accounting standards - The following presents a list of recently issued IFRS Standards and amendments that have not yet been adopted within the FReM, and are therefore not applicable to DHSC group accounts in 2025/26.

  - IFRS 14 Regulatory Deferral Accounts - Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

  - IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. Application required for accounting periods beginning

- IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

- IFRS16 - For the 2025 calendar year, the HM Treasury incremental borrowing rate has been set at 5.32% (2024 calendar year, 4.81%). This discount factor will be relevant for newly commenced leases, relevant lease modifications and relevant lease remeasurement scenarios occurring in 2025/26.

  IFRS17 - IFRS 17 Insurance Contracts has replaced IFRS 4 Insurance Contracts and is effective for periods beginning on or after 1 April 2025. NHSE have outlined that IFRS 17 is not expected to apply to the majority of providers and requested that if any material arrangements where the Trust is the issuer of insurance then the accounting policy should be tailored appropriately based on materiality. In our case, the Trust does not have any instances where contracts have been issued that includes material insurance terms and conditions.

University Hospitals Tees

Retrospective approval of documents executed under Seal - STHFT

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 5.3

Report author: Jackie White, Director of Corporate Affairs & Co Secretary

Executive director sponsor: Jackie White, Director of Corporate Affairs & Co Secretary

Action required: Approval

Delegation status: Matter reserved to Unitary 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:

Choose an item.

Board assurance framework references this paper relates to:

Add in BAF reference.

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 NHS Act 2006, paragraph 29(1), Schedule 7 set out the requirement for foundation trust constitutions to make provision for the authentication of the fixing of the company's seal to execute documents as required and a report of all sealing to be made to the Board of 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.

Seal No	Document	Signed and Sealed by
2025/006	Sale purchase agreement for the sale and purchase of certain shares of Healthcall Solutions Limited, between 1. Northumbria Healthcare NHS Foundation Trust 2. South Tees Hospitals NHS Foundation Trust (seller)	Stacey Hunter, CEO Derek Bell, Chair Sealed on 5 March 2025
2025/007	Supplemental agreement to a concession agreement dated 16 August 1999 in relation to V0810 (Mortuary variation) between 1. South Tees Hospitals NHS Foundation Trust 2. Endeavour SCH PLC	Chris Hand, CFO Derek Bell, Chair Sealed on 17 September 2025
2025/008	Supplemental agreement to a concession agreement dated 16 August 1999 in relation to V0809 (Cath Lab 1) between 1. South Tees Hospitals NHS Foundation Trust 2. Endeavour SCH PLC	Derek Bell, Chair Stacey Hunter, CEO Sealed on 22 October 2025
2026/001	Letter of indemnity – Capital works variation VO904 (previously VO821) and V0914 – MTHW (Medium	Stacey Hunter, CEO

	Temperature Hot Water) to LTHW (Low Temperature Hot Water) conversion scheme, between 1. South Tees Hospitals NHS Foundation Trust 2. Endeavour SCH PLC	Chris Hand, CFO Sealed on 6 January 2026
2026/002	Supplemental agreement to a concession agreement dated 16 August 1999 in relation to Variation VO678, between 1. South Tees Hospitals NHS Foundation Trust 2. Endeavour SCH PLC	Stacey Hunter, CEO Chris Hand, CFO Sealed on 6 January 2026
2026/003	Certificate of Commencement Energy and Energy Management facilities scheme at James Cook University Hospital, between 1. South Tees Hospitals NHS Foundation Trust 2. Vital Energi Solutions Ltd	Stacey Hunter, CEO Chris Hand, CFO Sealed on 10 February 2026
2026/004	Deed of Guarantee for Energy and Energy Management facilities scheme at James Cook University Hospital, between 1. South Tees Hospitals NHS Foundation Trust 2. Vital Energi Solutions Ltd	Stacey Hunter, CEO Chris Hand, CFO Sealed on 10 February 2026
2026/005	Project Agreement for Energy and Energy Management facilities scheme at James Cook University Hospital, between 1. South Tees Hospitals NHS Foundation Trust 2. Vital Energi Solutions Ltd	Stacey Hunter, CEO Chris Hand, CFO Sealed on 10 February 2026
2026/006	Certificate of Commencement Energy and Energy Management facilities scheme at Friarage Hospital, between 1. South Tees Hospitals NHS Foundation Trust 2. Vital Energi Solutions Ltd	Stacey Hunter, CEO Chris Hand, CFO Sealed on 10 February 2026

2026/007	Deed of Guarantee for Energy and Energy Management facilities scheme at Friarage Hospital, between 1. South Tees Hospitals NHS Foundation Trust 2. Vital Energi Solutions Ltd	Stacey Hunter, CEO Chris Hand, CFO Sealed on 10 February 2026
2026/008	Project Agreement for Energy and Energy Management facilities scheme at Friarage Hospital, between 1. South Tees Hospitals NHS Foundation Trust 2. Vital Energi Solutions Ltd	Stacey Hunter, CEO Chris Hand, CFO Sealed on 10 February 2026
2026/009	Lease relating to 2 rooms at Lambert Memorial Hospital, Chaple Street, Thirst, YO71LU, between 1. South Tees Hospitals NHS Foundation Trust 2. North Yorkshire Hospice Care	Chris Hand, CFO Neil Atkinson, CDO Sealed on 12 February 2026

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 documents were signed and executed under seal in line with the provisions set out in the Trust's Constitution.

Recommendations:

The Board are asked to grant retrospective approval for the sealing of this document.

NHS
University Hospitals Tees

Audit Committee: North Tees & Hartlepool

29 January 2026

Connecting to: Unitary Board

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.

The decision log was reviewed. Three items to return to statutory boards for ratification to ensure compliance. By way of strengthening the overall governance process for Board meetings, a second review of the reports and agenda prior to publication would be built into the schedule and undertaken by the Director of Corporate Affairs & Company Secretary.

Council of Governors decision log requested.

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 received a report on the Board Assurance Framework (BAF). There were no significant changes to the BAF since the last report.
The Committee received and reviewed the Losses and Compensation Payments Report. Stock write-off was low and equated to 0.1% of overall trust stock value.

The Committee received and noted a summary of Single Tender Waivers for the period Quarter 3: 2025/26 and noted the ongoing wok in this area.

Forvis Mazars presented their first External Audit Progress Report since their

Caring Better Together

appointment as external auditor across both Trusts. Preparatory work was being undertaken regarding the external audit of the financial accounts for the year ended 31 March 2026, with draft accounts to be prepared by 27 April 2026 and final accounts by 26 June 2026. It was confirmed that there had been no issues reported as part of the handover from the previous external auditors Deloitte.

Internal Auditors Audit One presented their Internal Audit Progress Report, which the Committee noted. There were no significant control issues to date that could adversely impact on the audit opinion for 2025/26.

Audit One presented its Counter Fraud report to the Committee. It was noted that going fraud, bribery and corruption risk assessments were required to be compliant with the new Government Counter Fraud Profession (GCFP) standards and methodology, and fraud risks must be recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers. A template had been provided and a process agreed with the Trust.

The Director of Corporate Affairs & Company Secretary reported on the changes being implemented regarding data collection for the Trust's declarations of interest process and the planned use of the ESR Conflicts of Interest module for the 2025/26 process.

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

Recommendations:

The Board are asked to note the update.

University Hospitals Tees

Annual Filings – NTHFT

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 6.2

Report author: Jackie White, Director of Corporate Affairs & Company Secretary

Executive director sponsor: Jackie White, Director of Corporate Affairs

Action required: Approval

Delegation status: Matter reserved to Unitary 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:

Choose an item.

Board assurance framework references this paper relates to:

Add in BAF reference.

Key discussion points and matters to be escalated from the meeting

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

None.

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

None.

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 timetable for submission of the annual filings has been released by NHS England (NHSE). This includes a final submission date for the Trusts signed and audited Annual Report and Accounts of 26 June 2026. NHSE and the Department of Health and Social Care (DHSC) have also issued draft guidance for providers, as outlined in the Group Accounting Manual (GAM).

The Trust appointed a new external auditor, Mazars, who will undertake the audit.. A number of amendments have been made to the Trusts Accounting Policies following the release of the GAM and these are outlined in the report.

Recommendations:

The Board of Directors are asked for delegated authority to the Audit Committee and Quality Assurance Committee for ongoing monitoring and approval of the annual filings on behalf of the Board.

Annual Filings – NTHFT

1. PURPOSE OF REPORT

The purpose of the report is to update members of the Trust Board on the preparation of the annual filings for 2025-26:

- Quality Report (Account)
- Annual Accounts
- Annual Report
- Annual Governance Statement

- To provide an update on the submission of the Annual Report and financial statements and provide an update on amendments to the Trusts Annual Report and Accounting Policies for 2025-26.

- and to ask for delegated authority to the Audit Committee and Group Quality Assurance Committee for ongoing monitoring and approval of the annual filings on behalf of the Board.

2. RECOMMENDATIONS

The Trust Board of Directors are asked to approve the delegation to the Audit Committee and Quality Assurance Committee for the ongoing monitoring and approval of the annual filings on behalf of the Board of Directors.

3. BACKGROUND

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

The timetable for submission of the Annual Report and financial statements has been released by NHSE. This includes a final submission date for the Trusts signed and audited Annual Report and Accounts of 26 June 2026. The DHSC have issued guidance for providers, as outlined in the Group Accounting Manual (GAM), however NHSE guidance is still outstanding.

4. DETAIL

3.1 Annual report

Changes to the requirements for 2025-26 are set out below.

New and changed requirements

Task force on climate-related financial disclosures (TCFD) - 2025/26 is the final year of the three year implementation of TCFD. From 2025/26 entities should disclose how the

organisation's operations, strategy and financial planning are affected by actual and potential climate-related risks and opportunities.

NHS Oversight Framework 2025/26 - The NHS Oversight Framework has been updated in 2025/26. The disclosure requirements in annual reports have not changed but the example disclosure has been updated to reflect changes to the oversight framework.

Very Senior Manager (VSM) pay framework - The new very senior manager pay framework applies from 2025/26. The remuneration report must include a statement of compliance with the VSM pay framework and confirm approvals for pay cases where required. Any departures from the framework should be disclosed.

Minor changes and clarifications

Accounting officer signature - Further guidance on signatures of the accounting officer within the annual report and accounts has been added. There is no change to the requirements.

Fees and charges guidance - Updated guidance on how to measure the 'full' cost of a service for the purposes of fees and charges as provided in Managing Public Money (MPM) has been referenced in the relevant footnote of the FT ARM.

Fair pay guidance - HM Treasury has clarified that non-executive directors are outside the scope of the fair pay disclosures. This has been updated within the fair pay disclosure requirements.

Exit packages approval - DHSC now has delegated authority to approve non-contractual exit packages up to £300,000 that are not novel, contentious or repercussive. Previously all non-contractual exit packages required HM Treasury approval. The template disclosure has been updated. There is no change to the requirement for NHS foundation trusts to seek approval (via england.vsmcases@nhs.net) before committing to any payment.

Certificate on summarisation schedules - Minor updates have been made to the example certificate on the summarisation schedules (often referred to as 'TAC consistency statement') to improve accuracy and clarity. There are no changes to the principles or requirements for consistency. Separate reference to NHS England's template provider accounting policies has been deleted because these are consistent with the GAM.

3.2 Timetable

Accounts and Annual Report Timetable

The following table provides a summary of the key submission dates as circulated as part of year end guidance by NHSE for the 2025/26 final accounts process:

Detail	Submission Date
Submission of Month 12 PFR (including unaudited TACs and draft Accounts)	27 April
Submission of Month 12 PFR form (including audited TACs) and audited Accounts to NHSE. To include Accounts, Annual Report, Auditors ISA 260 Report, Audit Report and Opinion and Auditors report on summarisation schedules (TAC schedules)	26 June
Submission of full Annual Report including full statutory Accounts in one document to NHSE.	TBC
Trust to lay Annual report and Accounts before Parliament.	TBC

Accounting Policies

As part of the circulation of year end guidance, the DHSC Group Accounting Manual (GAM), published updated in January 2026, includes updated guidance to be used by NHS Providers. The Trust has reviewed the year end guidance currently available
and the changes to the Trust's Accounting Policies for 2025/26 are outlined as follows:

- Provisions - updated for changes to discount rates per the DHSC GAM. The discount rate on post-employment benefits provisions applicable at 31 March 2026 is 2.95% (the 2024/25 rate was 2.40%). This rate is applicable for all provisions for continuing obligations arising from previous employment service.

- Compensation Recovery Unit (CRU) - When estimating lifetime expected credit losses in relation to Injury Cost Recovery receivables, the GAM has revised the credit loss allowance to reflect income that is not expected to be recoverable. The CRU advises on the percentage probability of not receiving the income and the figure for 2025/26 is 24.62% (the 2024/25 figure was 24.45%).

- Accounting standards - The following presents a list of recently issued IFRS Standards and amendments that have not yet been adopted within the FReM, and are therefore not applicable to DHSC group accounts in 2025/26.

  - IFRS 14 Regulatory Deferral Accounts - Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

  - IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. Application required for accounting periods beginning

- IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

- IFRS16 - For the 2025 calendar year, the HM Treasury incremental borrowing rate has been set at 5.32% (2024 calendar year, 4.81%). This discount factor will be relevant for newly commenced leases, relevant lease modifications and relevant lease remeasurement scenarios occurring in 2025/26.

  IFRS17 - IFRS 17 Insurance Contracts has replaced IFRS 4 Insurance Contracts and is effective for periods beginning on or after 1 April 2025. NHSE have outlined that IFRS 17 is not expected to apply to the majority of providers and requested that if any material arrangements where the Trust is the issuer of insurance then the accounting policy should be tailored appropriately based on materiality. In our case, the Trust does not have any instances where contracts have been issued that includes material insurance terms and conditions.

University Hospitals Tees

Retrospective approval of documents executed under Seal - NTHFT

Meeting date: 5 March 2026

Reporting to: Board of Directors

Agenda item No: 6.3

Report author: Sarah Hutt, Assistant Company Secretary

Executive director sponsor: Jackie White, Director of Corporate Affairs & Co Secretary

Action required: Approval

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:

Well-led

Board assurance framework references this paper relates to:

Add in BAF reference.

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 NHS Act 2006, paragraph 29(1), Schedule 7 set out the requirement for foundation trust constitutions to make provision for the authentication of the fixing of the company's seal to execute documents as required and a report of all sealing to be made to the Board of 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.

Lease relating to Retail Units B&C, Main Entrance Concourse, University Hospital North Tees, Stockton on Tees TS19 8PE Between 1. North Tees & Hartlepool NHS Foundation Trust 2. Gentian Investments Limited Date of lease: 22 January 2026 Duration: 10 years	Signed by: Neil Atkinson, Chief Delivery Officer Chris Hand, Chief Finance Officer Sealed: 14 January 2026

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 document was signed and executed under seal in line with the provisions set out in the Trust's Constitution.

Recommendations:

The Board are asked to grant retrospective approval for the sealing of this document.